Salinas Valley Memorial Healthcare System
A Public Healthcare District

March 18, 2021

TO: Members of the Board of Directors

Victor Rey, Jr. – President
Regina M. Gage – Vice President
Juan Cabrera – Secretary
Richard Turner – Treasurer
Joel Hernandez Laguna – Assistant Treasurer

Legal Counsel

Ottone Leach & Ray LLP

News Media

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

The Regular Meeting of the Board of Directors of the Salinas Valley Memorial Healthcare System will be held **THURSDAY, MARCH 25, 2021, AT 3:00 P.M., IN THE DOWNING RESOURCE CENTER, ROOMS A, B & C AT SALINAS VALLEY MEMORIAL HOSPITAL, 450 E. ROMIE LANE, SALINAS, CALIFORNIA, OR BY PHONE OR VIDEO (Visit svmh.com/virtualboardmeeting for Access Information)**.

Please note: Pursuant to Executive Order N-25-20 issued by the Governor of the State of California in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

Pete Delgado
President/Chief Executive Officer

REGULAR MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

THURSDAY, MARCH 25, 2021
3:00 P.M. – DOWNING RESOURCE CENTER, ROOMS A, B & C
SALINAS VALLEY MEMORIAL HOSPITAL
450 E. ROMIE LANE, SALINAS, CALIFORNIA
OR BY PHONE OR VIDEO
(Visit svmh.com/virtualboardmeeting for Access Information)

Please note: Pursuant to Executive Order N-25-20 issued by the Governor of the State of California in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

AGENDA

		Presented By
I.	**Call to Order/Roll Call**	Victor Rey, Jr.
II.	**Closed Session** (See Attached Closed Session Sheet Information)	Victor Rey, Jr.
III.	**Reconvene Open Session/Closed Session Report** (Estimated time 5:00 pm)	Victor Rey, Jr.
IV.	**Report from the President/Chief Executive Officer**	Pete Delgado
V.	**Public Input**	Victor Rey, Jr.

This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.

VI.	**Board Member Comments**	Board Members
VII.	**Consent Agenda—General Business** (A Board Member may pull an item from the Consent Agenda for discussion.)	Victor Rey, Jr.

A. Minutes of the Regular Meeting of the Board of Directors, February 25, 2021
B. Financial Report
C. Statistical Report
D. Policies Requiring Board Approval
   1. Space Planning Policy
   2. Utilities Management Plan
   3. Hazardous Materials & Waste Management Plan
   4. Medical Equipment Management Plan
   5. Emerging Infectious Disease Infection Prevention Pandemic Plan
   6. Care of the Patient, Continuous Subcutaneous Insulin Pump
   7. Safety-Newborn Clinical Procedure
   8. Patient and Family Education

9. Care of the Renal, Hemodialysis and CAPD Patient
10. NICU Orientation and Training
11. Case Management: Standard for Admission Review
12. Uses and Disclosures of Protected Health Information

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

VIII. Reports on Standing and Special Committees

A. **Quality and Efficient Practices Committee** - Minutes from the March 22, 2021 Quality and Efficient Practices Committee meeting have been provided to the Board. Additional Report from Committee Chair, if any. — Juan Cabrera

B. **Finance Committee** - Minutes from the March 22, 2021 Finance Committee meeting have been provided to the Board. Seven proposed recommendations have been made to the Board. — Richard Turner

1. Recommend Board Approval of the Unified Communications System Managed Services Agreement from Carousel Industries, Inc. as Competitive Solicitation and Contract Award
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
2. Recommend Board Approval of the Help Desk Services Agreement for CloudWave as Competitive Solicitation and Contract Award
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
3. Recommend Board Approval of Project Budget Augmentation and Award of Construction Contract to DMC Commercial, Inc. for the Lab Analyzers Replacement Project
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

4. Recommend Board Approval of Project Budget and Award of Construction Contracts to Val's Plumbing and Heating, Inc. and Central Electric for the SVMH Heart Center Air Handler Unit Upgrade Project
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
5. Recommend Board Approval of Project Budget for the OB Cesarean Conversion Project
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
6. Recommend Board Approval for the Purchase of Cardiac Ultrasound Equipment
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
7. Recommend Board Approval of Project Funding for the SVMHS Retail Pharmacy Project
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

C. **Personnel, Pension and Investment Committee –** Minutes from the March 23, 2021 Personnel, Pension and Investment Committee meeting have been provided to the Board. Two proposed recommendations have been made to the Board. — Regina M. Gage

1. Recommend Board Approval of (i) the Findings Supporting Recruitment of Daniel Gallegos, MD (ii) the Contract Terms for Dr. Gallegos' Recruitment Agreement, and (iii) the Contract Terms for Dr. Gallegos' Family Medicine Professional Services Agreement
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

2. Recommend Board Approval of (i) the Findings Supporting Recruitment of Patricia Mayer, MD (ii) the Contract Terms for Dr. Mayer's Recruitment Agreement, and (iii) the Contract Terms for Dr. Mayer's Family Medicine Professional Services Agreement
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

D. **Corporate Compliance and Audit Committee –** Minutes from the March 23, 2021 Corporate Compliance and Audit Committee have been provided to the Board. Additional Report from Committee Chair, if any. — Juan Cabrera

IX. **Report on Behalf of the Medical Executive Committee (MEC) Meeting of March 11, 2021, and Recommendations for Board Approval of the following:** — Rachel McCarthy Beck, M.D.

A. From the Credentials Committee:
   1. Credentials Committee Report

B. From the Interdisciplinary Practice Committee:
   1. Interdisciplinary Practice Committee Report

C. Policies
   1. 2021 Influenza Pandemic Plan

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

X. **Extended Closed Session** (if necessary) — Victor Rey, Jr.
(See Attached Closed Session Sheet Information)

XI. **Adjournment** – The next Regular Meeting of the Board of Directors is scheduled for **Thursday, April 29, 2021, 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.

Notes: 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 Executive Assistant during regular business hours at 831-755-0741. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM 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

[ ] LICENSE/PERMIT DETERMINATION
(Government Code §54956.7)

Applicant(s): (Specify number of applicants)_____

[ ] CONFERENCE WITH REAL PROPERTY NEGOTIATORS
(Government Code §54956.8)

Property: (Specify street address, or if no street address, the parcel number or other unique reference, of the real property under negotiation): _____

Agency negotiator: (Specify names of negotiators attending the closed session):_____
_____
Negotiating parties: (Specify name of party (not agent):_____
Under negotiation: (Specify whether instruction to negotiator will concern price, terms of payment, or both):__
_____

[ ] CONFERENCE WITH LEGAL COUNSEL-EXISTING LITIGATION
(Government Code §54956.9(d)(1))

Name of case: (Specify by reference to claimant's name, names of parties, case or claim numbers):
_____, or
Case name unspecified: (Specify whether disclosure would jeopardize service of process or existing settlement negotiations):_____

[ ] CONFERENCE WITH LEGAL COUNSEL-ANTICIPATED LITIGATION
(Government Code §54956.9)

Significant exposure to litigation pursuant to Section 54956.9(d)(2) or (3) (Number of potential cases): _____

Additional information required pursuant to Section 54956.9(e):_____

Initiation of litigation pursuant to Section 54956.9(d)(4) (Number of potential cases):_____

[ ] LIABILITY CLAIMS
(Government Code §54956.95)

Claimant: (Specify name unless unspecified pursuant to Section 54961):_____
_____

Agency claimed against: (Specify name):_____

[ ] THREAT TO PUBLIC SERVICES OR FACILITIES
(Government Code §54957)

Consultation with: (Specify name of law enforcement agency and title of officer):_____

[ ] PUBLIC EMPLOYEE APPOINTMENT
(Government Code §54957)

Title: (Specify description of position to be filled):_____

[ ] PUBLIC EMPLOYMENT
(Government Code §54957)

Title: (Specify description of position to be filled):_____

[ ] PUBLIC EMPLOYEE PERFORMANCE EVALUATION
(Government Code §54957)

Title: (Specify position title of employee being reviewed): _____

[ ] PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE
(Government Code §54957)

(No additional information is required in connection with a closed session to consider discipline, dismissal, or release of a public employee. Discipline includes potential reduction of compensation.)

[ ] CONFERENCE WITH LABOR NEGOTIATOR
(Government Code §54957.6)

Agency designated representative: (Specify name of designated representatives attending the closed session):_
_____

Employee organization: (Specify name of organization representing employee or employees in question):
_____, or

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

[ ] CASE REVIEW/PLANNING
(Government Code §54957.8)

(No additional information is required to consider case review or planning.)

[X] 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):
Strategic planning/proposed new programs and services

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

[X] 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 Medical Staff Quality and Safety Committee
2. Report of the Medical Staff Credentials Committee
3. Report of the Interdisciplinary Practice Committee

[ ] CHARGE OR COMPLAINT INVOLVING INFORMATION PROTECTED BY FEDERAL LAW (Government Code §54956.86)

(No additional information is required to discuss a charge or complaint pursuant to Section 54956.86.)

ADJOURN TO OPEN SESSION

CALL TO ORDER/ROLL CALL

(VICTOR REY, JR.)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

(VICTOR REY, JR.)

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

(VICTOR REY, JR.)

REPORT FROM THE PRESIDENT/ CHIEF EXECUTIVE OFFICER

(VERBAL)

(PETE DELGADO)

PUBLIC INPUT

BOARD MEMBER COMMENTS

(VERBAL)

REGULAR MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

THURSDAY, FEBRUARY 25, 2021 – 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C
SALINAS VALLEY MEMORIAL HOSPITAL
450 E. ROMIE LANE, SALINAS, CALIFORNIA AND BY PHONE
OR VIDEO (VISIT svmh.com/virtualboardmeeting FOR ACCESS INFORMATION)

Pursuant to Executive Order N-25-20 issued by the Governor of the State of California in response to concerns regarding COVID-19, Board Members of Salinas Valley Memorial Healthcare System, a local health care district, are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

Present: President Victor Rey, Jr., Director Regina M. Gage, in person; Directors Juan Cabrera, Richard Turner, and Joel Hernandez Laguna by teleconference.

Also Present: Pete Delgado, President/Chief Executive Officer; Rachel McCarthy Beck, M.D., Chief of Staff, in person; Gary Ray, Esq., District Legal Counsel, by teleconference.

A quorum was present and the meeting was called to order by President Victor Rey, Jr, at 4:05 p.m.

Closed Session

President Victor Rey, Jr., announced that the closed session items to be discussed in Closed Session as listed on the posted Agenda are: (1) Report Involving Trade Secret – strategic planning/proposed new programs and services; and (2) Hearings/Reports – Report of the Medical Staff Quality and Safety Committee, Report of the Medical Staff Credentials Committee, and Report of the Interdisciplinary Practice Committee.

The meeting was recessed into Closed Session under the Closed Session Protocol at 4:06 p.m.

The Board completed its business of the Closed Session at 5:00 p.m.

Reconvene Open Session/Report on Closed Session

The Board reconvened Open Session at 5:01 p.m. President Rey announced that in Closed Session the Board discussed: (1) Report Involving Trade Secret - strategic planning/proposed new programs and services; and (2) Hearings/Reports – Report of the Medical Staff Quality and Safety Committee, Report of the Medical Staff Credentials Committee, and Report of the Interdisciplinary Practice Committee. In Closed Session, the Board received and accepted the Medical Staff Quality and Safety Committee Report. No other action was taken by the Board.

Mr. Rey stated that Agenda Item XI. – Extended Closed Session will not be held.

Richard Turner excused himself from the meeting at approximately 5:10 p.m.

Report from the President/Chief Executive Officer (CEO)

The President/CEO's Report by Pete Delgado, President/CEO, members of Hospital Leadership and others, began with a Mission Moment about vaccinations at SVMHS, the Spanish Flu pandemic in 1918, and a review of SVMHS COVID-19 patients by zip code. A summary of key highlights, centered around the pillars that are the foundation of the Hospital's vision for the organization, and industry news, is as follows:

- Service
  - Megan Lopez, MSN, RN, CNL, VA-BC, Co-Chair of the Quality Practice Council, provided an overview of the following key areas:
    - Areas of Focus
      - Patient Experience Data
        - Press Ganey Surveys
        - Report out from the Patient Experience Department
        - Patient Complaints
      - Nurse Sensitive Indicators (falls, infection rates, pressure injuries)
      - Peer Feedback Focus – process/safety measures
      - Nursing Engagement Scores
      - BSN & Certification Rates
    - Data Displays
      - Every six months, data displays are updated by Quality Champions from each unit/cluster
      - Each unit then decides what strategies or interventions their unit will use to improve outcomes
      - Data displays are constantly assessed and reassessed to better patient care and outcomes
      - Goals include continuing to provide top notch and safe patient care to the community
- Quality
  - Work continues in preparation for the Magnet® virtual site visit set for March 10-12, 2021, to validate and amplify the Magnet submission document. Feedback from the site visit is expected in May. A mock site visit was held in February with great enthusiasm. Only about 8% of hospitals in the country have achieved Magnet status. Clement Miller, Chief Operating Officer/Interim Chief Nursing Officer, and the Magnet team were commended for their tremendous work toward this initiative.
- Finance
  - Industry News
    - Google opening office in Minnesota to advance Mayo Clinic Partnership
    - Walmart may roll back its ambitious push into healthcare
    - Walmart, Amazon & more: 5 retail giants' virtual care strategies
    - Sutter to cut 277 jobs, mostly in IT
    - Chicago's Mercy Hospital files for bankruptcy
    - 7 latest hospital closures
    - CMS cuts payments to 774 hospitals over patient complications
  - Legislative activities at the state and federal levels were reviewed.

- Growth
  - An excellent team has been assembled to provide a COVID-19 Vaccine Clinic at 611 Abbott Street for the community, with capacity to administer between 500-1000 vaccines per day. The Epic system has also been leveraged to conduct outreach and quickly engage patients in the community.
- People
  - The mobile COVID screening application has been rolled out to all employees.
- Community
  - Harlan Grogin, MD, Patrik Zetterlund, MD, Andreas Sakopoulos, MD, Christopher Oh, MD, and SVMHS Executive Chef Jason Giles were featured presenters during Heart Month's Ask the Experts virtual events focused on non-invasive cardiac procedures and healthy cooking demonstrations.
  - Earned Media included the Hospital's community staff support project, diabetes program, COVID-19, and the 1918 Spanish Flu pandemic.

There was brief discussion among the Board and Executive Leadership regarding the total number of COVID-19 patients by zip code, vaccine education, and the Magnet journey.

Public Input

An opportunity was provided for persons in the audience to make a brief statement, not to exceed three (3) minutes, on issues or concerns not covered by the agenda.

None.

Board Member Comments

Director Joel Hernandez Laguna thanked Carla Spencer, Associate Chief Nursing Officer, for the recent tour of the COVID-19 unit, and expressed tremendous respect for hospital staff and everyone he encountered on the tour. He commended the team for maintaining positive energy and helping community members who are going through the pandemic. Director Hernandez Laguna also commented on the excellent work of the Community Advocacy Committee and the Blue Zones team, including the Hospital's partnership with Hartnell College, the Service League Volunteers who will be brought back to provide patient and guest support services at the Hospital, development of a community garden in east Salinas, and Blue Zones work sites.

President Victor Rey echoed the sentiment of Director Hernandez Laguna regarding the community garden, and commented on the excellent work of the Community Advocacy Committee and reports presented in February.

Director Juan Cabrera expressed an interest in scheduling a tour of the Hospital's COVID-19 unit and recognized the wonderful work of staff.

Director Regina Gage was pleased to note that Meals on Wheels is in the process of becoming a Blue Zones work site.

Consent Agenda – General Business

A. Minutes of the Regular Meeting of the Board of Directors, January 28, 2021
B. Financial Report
C. Statistical Report
D. Policies Requiring Board Approval
   1. RC NICU Laryngeal Mask Airway Clinical Procedure
   2. Cardiac Telemetry Monitoring and Management
   3. Skin-to-Skin Contact in the NICU
   4. Enteral Tubes Insertion Maintenance
   5. Discharge/Transition Planning Guidelines
   6. Specimen/Foreign Body
   7. Temporary Transvenous and Epicardial Pacing
   8. Chest Tube Management
   9. Observation Status Charge Generation
   10. Circumcision
   11. Fire Safety Management Plan
   12. Ordering Supplies from Materials Management
   13. Student Affiliations
   14. The Emergency Medical Treatment and Active Labor Act (EMTALA)
   15. Quality Assessment and Performance Improvement Plan 2021
   16. Safety Management Plan

Mr. Rey presented the consent agenda items before the Board for action. This information was included in the Board packet.

No Public Comment.

> MOTION: The Board of Directors approves Consent Agenda – General Business, Items (A) through (D), as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Hernandez Laguna; Noes: None; Abstentions: None; Absent: Turner; Motion Carried.

Reports on Standing and Special Committees

Quality and Efficient Practices Committee

Joel Hernandez Laguna, Committee Vice Chair, reported the minutes from the Quality and Efficient Practices Committee Meeting of February 22, 2021, were provided to the Board. No action was taken by the Committee.

Finance Committee

Juan Cabrera, Committee Vice Chair, reported the minutes from the Finance Committee Meeting of February 22, 2021, were provided to the Board. The following recommendation was made by the Committee:

1. Recommend Board Approval of Board Resolution No. 2021-01 Declaring Its Intent to Reimburse Project Expenditures from Proceeds of Indebtedness

Mr. Cabrera noted that this recommendation will be considered under Board Agenda Item IX – Consider Board Resolution No. 2021-01 Declaring Its Intent to Reimburse Project Expenditures from Proceeds of Indebtedness.

Personnel, Pension and Investment Committee

Regina M. Gage, Committee Chair, reported the minutes from the Personnel, Pension and Investment Committee Meeting of February 23, 2021, were provided to the Board. Background information supporting the proposed recommendation made by the Committee was included in the Board packet and summarized by Director Gage.

1. Recommend Board Approval of (i) the Findings Supporting Recruitment of Adrian Jordan, MD, (ii) the Contract Terms for Dr. Jordan's Recruitment Agreement, and (iii) the Contract Terms for Dr. Jordan's Hospitalist Services Professional Services Agreement

No Public Comment.

MOTION: The Board of Directors makes the following findings supporting recruitment of Adrian Jordan, MD: (i) the recruitment of a Hospitalist to Salinas Valley Medical Clinic is in the best interest of the public health of the communities served by the District; and (ii) the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract an appropriately qualified physician to practice in the communities served by the District; and further, approves the contract terms of the Recruitment Agreement for Dr. Jordan, and the contract terms of the Hospitalist Services Professional Services Agreement for Dr. Jordan, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Hernandez Laguna; Noes: None; Abstentions: None; Absent: Turner; Motion Carried.

Ms. Gage also reported that the Personnel, Pension and Investment Committee received a report from the Chief Human Resources Officer regarding the employer contribution to the defined contribution plan, and a financial and statistical review from the Chief Financial Officer.

Community Advocacy Committee

Regina M. Gage, Committee Chair, reported the minutes from the Community Advocacy Committee Meeting of February 23, 2021, were provided to the Board. The Committee received a report from the SVMH Foundation, a report from the SVMH Service League, and an overview of the Patient Family Advisory Council. No action was taken by the Committee.

Committee Vice Chair Joel Hernandez Laguna commented on the positive transformation the Hospital's community project initiatives have made in people's lives, such as the mobile clinic. He suggested the Community Advocacy Committee explore how the community can be referred

to the Blue Zones Project and other programs within the organization, and suggested the Hospital or Salinas Valley Medical Clinic consider establishing a family resource center.

Consider Board Resolution No. 2021-01 Declaring Its Intent to Reimburse Project Expenditures from Proceeds of Indebtedness

Juan Cabrera, Finance Committee Vice Chair, reported that Board Resolution No. 2018-09 Declaring Its Intent to Reimburse Project Expenditures from Proceeds of Indebtedness has been updated to Resolution No. 2021-01. This information was included in the Board packet.

Board Resolution No. 2021-01 Declaring Its Intent to Reimburse Project Expenditures from Proceeds of Indebtedness, authorizes the District to reimburse itself from tax-exempt proceeds for amounts expended on capital projects. This Resolution reflects the following changes: (i) incorporates the project name of parking garage annex and related improvements; and (ii) raises the principal amount of the potential tax-exempt financing from $300 million to $450 million. The tax-exempt bonds would need to be issued no later than 18 months after the project is placed in service and no more than three years after the date any expenditure for the project is paid.

No Public Comment.

Board Discussion: There was brief discussion among the Board and Executive Leadership regarding the purpose of Resolution No. 2021-01 which authorizes the financing of certain projects for SVMHS and declares the District's intent to reimburse prior project cost expenditures with proceeds of debt.

> MOTION: The Board of Directors adopts Board Resolution No. 2021-01 Declaring Its Intent to Reimburse Project Expenditures from Proceeds of Indebtedness, as presented. Moved/ Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Hernandez Laguna; Noes: None; Abstentions: None; Absent: Turner; Motion Carried.

Report on Behalf of the Medical Executive Committee (MEC) Meeting of February 11, 2021, and Recommendations for Board Approval of the following:

The following recommendations from the Medical Executive Committee (MEC) Meeting of February 11, 2021, were reviewed by Rachel McCarthy Beck, M.D., Chief of Staff, and recommended for Board approval.

Recommend Board Approval of the Following:

A. From the Credentials Committee:
    1. Credentials Committee Report
B. From the Interdisciplinary Practice Committee:
    1. Interdisciplinary Practice Committee Report

No Public Comment.

Dr. Beck noted the following technical change to the Department of OB/Gyn: Clinical Privileges Delineation OB Hospitalist and OB/Gyn Forms – the Laparoscopic or Supracervical Hysterectomy procedure should read *Laparoscopic Hysterectomy Total or Supracervical,* which does not change the privilege.

Dr. Beck also reported that the Annual Medical Staff Meeting is March 9, 2021, and noted that at least two physicians will participate in the Magnet survey.

> MOTION: The Board of Directors approves Recommendations (A) through (B) of the February 11, 2021, Medical Executive Committee Meeting, with change, as presented. Moved/ Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Hernandez Laguna; Noes: None; Abstentions: None; Absent: Turner; Motion Carried.

Extended Closed Session

As previously announced, Mr. Rey noted that an Extended Closed Session will not be held.

Adjournment – The next Regular Meeting of the Board of Directors is scheduled for Thursday, March 25, 2021, at 3:00 p.m. There being no further business, the meeting was adjourned at 6:05 p.m.

Juan Cabrera
Secretary, Board of Directors

/ks

SALINAS VALLEY MEMORIAL HOSPITAL
SUMMARY INCOME STATEMENT
February 28, 2021

	Month of February,		Eight months ended February 28,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 46,109,720	$ 44,597,995	$ 387,872,641	$ 386,247,717
Other operating revenue	832,158	868,925	9,984,146	10,736,327
Total operating revenue	46,941,878	45,466,920	397,856,787	396,984,044
Total operating expenses	39,520,624	38,004,458	330,401,319	310,021,000
Total non-operating income	(4,214,247)	(580,126)	(24,585,594)	(10,353,380)
Operating and non-operating income	$ 3,207,006	$ 6,882,336	$ 42,869,874	$ 76,609,664

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
February 28, 2021

	Current year	Prior year
ASSETS:		
Current assets	$ 407,222,979	$ 294,141,241
Assets whose use is limited or restricted by board	139,025,487	124,820,350
Capital assets	257,682,447	251,678,323
Other assets	190,080,576	187,334,439
Deferred pension outflows	83,379,890	62,468,517
	$ 1,077,391,379	$ 920,442,870
LIABILITIES AND EQUITY:		
Current liabilities	147,593,441	83,319,375
Long term liabilities	14,780,831	17,159,668
	126,340,336	108,929,468
Net assets	788,676,771	711,034,359
	$ 1,077,391,379	$ 920,442,870

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF NET PATIENT REVENUE
February 28, 2021

	Month of February,		Eight months ended February 28,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,504	1,843	13,603	15,400
Medi-Cal	949	1,092	8,566	8,647
Commercial insurance	799	648	6,388	6,642
Other patient	(3)	183	977	956
Total patient days	3,249	3,766	29,534	31,645
Gross revenue:				
Medicare	$ 79,986,402	$ 87,751,402	$ 648,594,024	$ 686,848,146
Medi-Cal	50,494,488	56,150,260	423,917,094	425,581,947
Commercial insurance	44,391,373	43,716,569	391,373,773	388,502,380
Other patient	4,875,532	8,858,821	65,355,046	69,052,287
Gross revenue	179,747,795	196,477,051	1,529,239,937	1,569,984,761
Deductions from revenue:				
Administrative adjustment	324,543	110,621	2,695,024	2,574,694
Charity care	611,769	619,155	7,128,155	7,832,625
Contractual adjustments:				
Medicare outpatient	21,655,997	25,941,505	188,481,658	207,571,921
Medicare inpatient	34,164,212	40,771,266	294,055,295	319,676,209
Medi-Cal traditional outpatient	2,288,082	2,783,006	16,015,049	23,992,537
Medi-Cal traditional inpatient	5,776,297	9,595,988	61,166,579	48,458,754
Medi-Cal managed care outpatient	17,849,948	22,192,366	141,591,247	164,362,907
Medi-Cal managed care inpatient	12,950,839	14,726,527	145,369,514	139,050,933
Commercial insurance outpatient	16,311,380	15,977,637	122,613,432	116,253,773
Commercial insurance inpatient	18,919,549	13,477,755	126,984,548	116,116,845
Uncollectible accounts expense	3,345,330	3,329,908	28,164,603	27,822,233
Other payors	(559,871)	2,353,322	7,102,192	10,023,612
Deductions from revenue	133,638,075	151,879,056	1,141,367,296	1,183,737,044
Net patient revenue	$ 46,109,720	$ 44,597,995	$ 387,872,641	$ 386,247,717
Gross billed charges by patient type:				
Inpatient	$ 99,383,505	$ 103,276,044	$ 854,242,856	$ 834,636,098
Outpatient	60,232,467	66,782,221	507,817,168	522,027,928
Emergency room	20,131,823	26,418,787	167,179,913	213,320,735
Total	$ 179,747,795	$ 196,477,051	$ 1,529,239,937	$ 1,569,984,761

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES
February 28, 2021

	Month of February,		Eight months ended February 28,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 46,109,720	$ 44,597,995	$ 387,872,641	$ 386,247,717
Other operating revenue	832,158	868,925	9,984,146	10,736,327
Total operating revenue	46,941,878	45,466,920	397,856,787	396,984,044
Operating expenses:				
Salaries and wages	14,191,483	14,444,693	127,457,148	116,321,094
Compensated absences	2,377,407	2,684,547	21,066,388	20,799,320
Employee benefits	6,774,423	6,632,163	58,750,416	59,099,818
Supplies, food, and linen	5,920,149	5,348,851	49,728,604	45,013,903
Purchased department functions	3,525,839	3,308,142	24,974,701	24,406,797
Medical fees	1,695,506	1,856,217	13,643,020	13,498,459
Other fees	2,064,591	846,656	11,143,976	8,397,727
Depreciation	1,813,887	1,699,801	14,301,790	13,491,102
All other expense	1,157,339	1,183,388	9,335,276	8,992,780
Total operating expenses	39,520,624	38,004,458	330,401,319	310,021,000
Income from operations	7,421,254	7,462,462	67,455,468	86,963,044
Non-operating income:				
Donations	166,667	166,667	1,833,333	1,337,533
Property taxes	333,333	333,333	2,666,667	2,666,667
Investment income	(1,339,005)	2,009,290	698,737	4,032,615
Taxes and licenses	0	0	0	0
Income from subsidiaries	(3,375,242)	(3,089,416)	(29,784,331)	(18,390,195)
Total non-operating income	(4,214,247)	(580,126)	(24,585,594)	(10,353,380)
Operating and non-operating income	3,207,006	6,882,336	42,869,874	76,609,664
Net assets to begin	785,469,764	704,152,022	745,806,897	634,424,695
Net assets to end	$ 788,676,771	$ 711,034,359	$ 788,676,771	$ 711,034,359
Net income excluding non-recurring items	$ (2,544,585)	$ 6,882,336	$ 35,499,174	$ 76,785,021
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	5,751,591	0	7,370,700	(175,357)
Operating and non-operating income	$ 3,207,006	$ 6,882,336	$ 42,869,874	$ 76,609,664

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF INVESTMENT INCOME
February 28, 2021

	Month of February,		Eight months ended February 28,	
	current year	prior year	current year	prior year
Detail of other operating income:				
Dietary revenue	$ 117,586	$ 171,609	$ 1,063,349	$ 1,364,367
Discounts and scrap sale	293,854	228,757	516,508	1,296,916
Sale of products and services	8,317	4,649	169,566	164,058
Clinical trial fees	0	0	46,128	0
Stimulus Funds	0	0	0	0
Rental income	154,696	140,992	1,270,199	1,144,290
Other	257,705	322,918	6,918,396	6,766,696
Total	$ 832,158	$ 868,925	$ 9,984,146	$ 10,736,327
Detail of investment income:				
Bank and payor interest	$ (57,868)	$ 270,304	$ 914,746	$ 1,904,582
Income from investments	(1,280,498)	1,735,986	(244,002)	2,121,376
Gain or loss on property and equipment	(639)	3,000	27,994	6,657
Total	$ (1,339,005)	$ 2,009,290	$ 698,737	$ 4,032,615
Detail of income from subsidiaries:				
Salinas Valley Medical Center:				
Pulmonary Medicine Center	$ (169,232)	$ (11,086)	$ (1,424,955)	$ (744,688)
Neurological Clinic	(89,966)	(124,312)	(658,171)	(624,735)
Palliative Care Clinic	(41,086)	(82,619)	(586,094)	(459,315)
Surgery Clinic	(204,322)	(145,390)	(1,373,609)	(729,820)
Infectious Disease Clinic	(2,318)	(73,069)	(214,095)	(241,111)
Endocrinology Clinic	(131,361)	(168,381)	(1,464,188)	(1,062,733)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(710,275)	(639,962)	(4,173,911)	(3,642,924)
OB/GYN Clinic	(397,565)	(110,335)	(2,939,223)	(1,305,203)
PrimeCare Medical Group	(754,435)	(1,037,557)	(7,437,080)	(4,779,482)
Oncology Clinic	(389,832)	(320,907)	(2,203,994)	(1,737,901)
Cardiac Surgery	(165,335)	(222,057)	(1,397,092)	(833,671)
Sleep Center	(55,288)	(119,277)	(535,623)	(608,599)
Rheumatology	50,962	(48,021)	(351,876)	(197,479)
Precision Ortho MDs	(364,547)	(365,235)	(3,207,215)	(2,234,040)
Precision Ortho-MRI	(152)	(10,752)	(1,515)	(4,115)
Precision Ortho-PT	(47,481)	(23,003)	(376,977)	(26,670)
Dermatology	(17,352)	(30,687)	(244,804)	(1,437)
Hospitalists	0	1	0	(1)
Behavioral Health	(73,690)	(53,412)	(578,334)	(387,724)
Pediatric Diabetes	(7,031)	(44,617)	(242,632)	(251,866)
Neurosurgery	377	(26,712)	(249,288)	(149,807)
Multi-Specialty-RR	21,551	5,148	19,673	88,052
Radiology	(187,923)	0	(1,651,045)	0
Total SVMC	(3,736,301)	(3,652,242)	(31,292,048)	(19,935,269)
Doctors on Duty	(26,617)	39,475	181,071	538,584
Assisted Living	(4,811)	(2,623)	(54,359)	(43,486)
Salinas Valley Imaging	0	(228)	(19,974)	22,616
Vantage Surgery Center	20,012	19,349	165,351	153,596
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	159,239	(69,680)	705,025	956,306
Aspire/CHI/Coastal	181,314	261,394	(125,158)	(784,810)
Apex	(2,482)	213,660	36,707	332,640
21st Century Oncology	44,623	34,238	(72,284)	140,569
Monterey Bay Endoscopy Center	(10,219)	67,243	691,337	229,058
Total	$ (3,375,242)	$ (3,089,416)	$ (29,784,331)	$ (18,390,195)

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
February 28, 2021

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 296,248,136	$ 196,158,086
Patient accounts receivable, net of estimated uncollectibles of $23,731,931	94,723,928	77,499,968
Supplies inventory at cost	8,402,003	5,994,483
Other current assets	7,848,912	14,488,704
Total current assets	407,222,979	294,141,241
Assets whose use is limited or restricted by board	139,025,487	124,820,350
Capital assets:		
Land and construction in process	48,322,022	60,936,449
Other capital assets, net of depreciation	209,360,425	190,741,874
Total capital assets	257,682,447	251,678,323
Other assets:		
Investment in Securities	147,486,496	146,003,323
Investment in SVMC	11,224,045	11,880,286
Investment in Aspire/CHI/Coastal	4,474,433	4,135,779
Investment in other affiliates	24,456,160	21,772,590
Net pension asset	2,439,442	3,542,461
Total other assets	190,080,576	187,334,439
Deferred pension outflows	83,379,890	62,468,517
	$ 1,077,391,379	$ 920,442,870
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	$ 55,187,757	$ 55,865,786
Due to third party payers	74,273,203	9,972,532
Current portion of self-insurance liability	18,132,481	17,481,058
Total current liabilities	147,593,441	83,319,375
Long term portion of workers comp liability	14,780,831	17,159,668
Total liabilities	162,374,272	100,479,043
Pension liability	126,340,336	108,929,468
Net assets:		
Invested in capital assets, net of related debt	257,682,447	251,678,323
Unrestricted	530,994,324	459,356,036
Total net assets	788,676,771	711,034,359
	$ 1,077,391,379	$ 920,442,870

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
February 28, 2021

	Month of February,				Eight months ended February 28,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 179,747,795	$ 167,181,192	12,566,603	7.52%	$ 1,529,239,937	$ 1,341,649,805	187,590,132	13.98%
Dedutions from revenue	133,638,075	127,310,122	6,327,953	4.97%	1,141,367,296	1,018,409,120	122,958,176	12.07%
Net patient revenue	46,109,720	39,871,070	6,238,650	15.65%	387,872,641	323,240,685	64,631,956	19.99%
Other operating revenue	832,158	919,590	(87,432)	-9.51%	9,984,146	7,356,717	2,627,429	35.71%
Total operating revenue	**46,941,878**	**40,790,660**	**6,151,218**	**15.08%**	**397,856,787**	**330,597,402**	**67,259,385**	**20.34%**
Operating expenses:								
Salaries and wages	14,191,483	13,676,741	514,742	3.76%	127,457,148	111,774,809	15,682,339	14.03%
Compensated absences	2,377,407	2,108,332	269,075	12.76%	21,066,388	22,107,021	(1,040,633)	-4.71%
Employee benefits	6,774,423	7,112,605	(338,182)	-4.75%	58,750,416	58,087,012	663,404	1.14%
Supplies, food, and linen	5,920,149	4,828,402	1,091,747	22.61%	49,728,604	40,415,755	9,312,849	23.04%
Purchased department functions	3,525,839	3,101,959	423,880	13.66%	24,974,701	24,857,236	117,465	0.47%
Medical fees	1,695,506	1,707,116	(11,610)	-0.68%	13,643,020	13,593,600	49,420	0.36%
Other fees	2,064,591	806,306	1,258,285	156.06%	11,143,976	6,782,250	4,361,726	64.31%
Depreciation	1,813,887	1,789,255	24,632	1.38%	14,301,790	14,314,043	(12,253)	-0.09%
All other expense	1,157,339	1,332,418	(175,079)	-13.14%	9,335,276	11,213,119	(1,877,843)	-16.75%
Total operating expenses	**39,520,624**	**36,463,134**	**3,057,490**	**8.39%**	**330,401,319**	**303,144,844**	**27,256,475**	**8.99%**
Income from operations	**7,421,254**	**4,327,526**	**3,093,728**	**71.49%**	**67,455,468**	**27,452,557**	**40,002,911**	**145.72%**
Non-operating income:								
Donations	166,667	166,667	0	0.00%	1,833,333	1,333,333	500,000	37.50%
Property taxes	333,333	333,333	(0)	0.00%	2,666,667	2,666,667	0	0.00%
Investment income	(1,339,005)	160,094	(1,499,099)	-936.39%	698,737	1,280,748	(582,011)	-45.44%
Income from subsidiaries	(3,375,242)	(3,368,593)	(6,649)	0.20%	(29,784,331)	(30,330,807)	546,476	-1.80%
Total non-operating income	**(4,214,247)**	**(2,708,500)**	**(1,505,747)**	**55.59%**	**(24,585,594)**	**(25,050,059)**	**464,465**	**-1.85%**
Operating and non-operating income	**$ 3,207,007**	**$ 1,619,026**	**1,587,981**	**98.08%**	**$ 42,869,874**	**$ 2,402,498**	**40,467,376**	**1684.39%**

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Feb and eight months to date

	Month of Feb		Eight months to date		
	2020	2021	2019-20	2020-21	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	41	36	362	350	(12)
Other Admissions	97	84	884	758	(126)
Total Admissions	138	120	1,246	1,108	(138)
Medi-Cal Patient Days	71	55	590	523	(67)
Other Patient Days	171	132	1,524	1,221	(303)
Total Patient Days of Care	242	187	2,114	1,744	(370)
Average Daily Census	8.6	6.7	8.7	7.2	(1.5)
Medi-Cal Average Days	1.8	1.5	1.7	1.6	(0.2)
Other Average Days	0.9	1.5	1.7	1.6	(0.1)
Total Average Days Stay	1.8	1.5	1.7	1.6	(0.1)
ADULTS & PEDIATRICS					
Medicare Admissions	408	254	3,186	2,516	(670)
Medi-Cal Admissions	307	208	2,069	1,879	(190)
Other Admissions	395	245	2,624	2,221	(403)
Total Admissions	1,110	707	7,879	6,616	(1,263)
Medicare Patient Days	1,650	1,268	13,882	1,344	(12,538)
Medi-Cal Patient Days	1,100	969	8,795	1,048	(7,747)
Other Patient Days	917	1,020	8,074	27,144	19,070
Total Patient Days of Care	3,667	3,257	30,751	29,536	(1,215)
Average Daily Census	131.0	116.3	126.5	121.5	(5.0)
Medicare Average Length of Stay	4.0	4.4	4.4	0.5	(3.8)
Medi-Cal AverageLength of Stay	3.6	3.7	3.6	0.5	(3.2)
Other Average Length of Stay	2.3	3.0	2.3	9.2	6.9
Total Average Length of Stay	3.3	3.7	3.4	3.8	0.4
Deaths	29	36	218	320	102
Total Patient Days	3,909	3,444	32,865	31,280	(1,585)
Medi-Cal Administrative Days	8	0	60	164	104
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	8	0	60	164	104
Percent Non-Acute	0.20%	0.00%	0.18%	0.52%	0.34%

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Feb and eight months to date

	Month of Feb		Eight months to date		
	2020	2021	2019-20	2020-21	Variance
PATIENT DAYS BY LOCATION					
Level I	264	302	2,276	2,088	(188)
Heart Center	355	315	2,819	2,721	(98)
Monitored Beds	882	699	7,292	7,001	(291)
Single Room Maternity/Obstetrics	333	308	3,346	2,765	(581)
Med/Surg - Cardiovascular	746	627	6,191	5,879	(312)
Med/Surg - Oncology	245	32	2,034	1,367	(667)
Med/Surg - Rehab	418	389	3,409	3,454	45
Pediatrics	101	137	879	746	(133)
Nursery	242	187	2,114	1,744	(370)
Neonatal Intensive Care	100	150	881	1,039	158
PERCENTAGE OF OCCUPANCY					
Level I	70.03%	82.97%	71.75%	65.83%	
Heart Center	81.61%	75.00%	77.02%	74.34%	
Monitored Beds	112.64%	92.46%	110.69%	106.27%	
Single Room Maternity/Obstetrics	31.03%	29.73%	37.06%	30.63%	
Med/Surg - Cardiovascular	57.16%	49.76%	56.38%	53.54%	
Med/Surg - Oncology	64.99%	8.79%	64.12%	43.10%	
Med/Surg - Rehab	55.44%	53.43%	53.74%	54.45%	
Med/Surg - Observation Care Unit	0.00%	62.61%	0.00%	59.69%	
Pediatrics	19.35%	27.18%	20.01%	16.99%	
Nursery	50.57%	40.48%	26.25%	21.66%	
Neonatal Intensive Care	31.35%	48.70%	32.82%	38.71%	

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Feb and eight months to date

	Month of Feb		Eight months to date		
	2020	2021	2019-20	2020-21	Variance
DELIVERY ROOM					
Total deliveries	128	115	1,225	1,090	(135)
C-Section deliveries	40	37	392	329	(63)
Percent of C-section deliveries	31.25%	32.17%	32.00%	30.18%	-1.82%
OPERATING ROOM					
In-Patient Operating Minutes	17,979	13,104	179,084	156,630	(22,454)
Out-Patient Operating Minutes	25,981	16,135	217,292	170,695	(46,597)
Total	43,960	29,239	396,376	327,325	(69,051)
Open Heart Surgeries	13	7	95	90	(5)
In-Patient Cases	146	108	1,351	1,100	(251)
Out-Patient Cases	274	174	2,279	1,876	(403)
EMERGENCY ROOM					
Immediate Life Saving	30	30	255	264	9
High Risk	667	404	5,153	4,054	(1,099)
More Than One Resource	2,744	1,987	22,094	16,859	(5,235)
One Resource	1,754	725	12,532	10,119	(2,413)
No Resources	57	26	407	304	(103)
Total	5,252	3,172	40,441	31,600	(8,841)

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Feb and eight months to date

	Month of Feb		Eight months to date		
	2020	2021	2019-20	2020-21	Variance
CENTRAL SUPPLY					
In-patient requisitions	13,768	14,610	122,313	116,728	-5,585
Out-patient requisitions	10,562	7,876	84,843	75,843	-9,000
Emergency room requisitions	2,755	1,424	25,474	12,697	-12,777
Interdepartmental requisitions	6,776	5,941	57,774	55,585	-2,189
Total requisitions	33,861	29,851	290,404	260,853	-29,551
LABORATORY					
In-patient procedures	33,935	32,614	283,285	286,349	3,064
Out-patient procedures	10,082	10,501	84,377	86,563	2,186
Emergency room procedures	9,927	8,343	83,468	69,277	-14,191
Total patient procedures	53,944	51,458	451,130	442,189	-8,941
BLOOD BANK					
Units processed	236	321	2,250	2,317	67
ELECTROCARDIOLOGY					
In-patient procedures	1,102	783	8,593	7,349	-1,244
Out-patient procedures	491	378	3,905	3,084	-821
Emergency room procedures	933	848	7,834	6,990	-844
Total procedures	2,526	2,009	20,332	17,423	-2,909
CATH LAB					
In-patient procedures	98	81	686	593	-93
Out-patient procedures	97	92	705	663	-42
Emergency room procedures	0	0	0	1	1
Total procedures	195	173	1,391	1,257	-134
ECHO-CARDIOLOGY					
In-patient studies	321	267	2,479	2,300	-179
Out-patient studies	175	163	1,633	1,425	-208
Emergency room studies	1	1	12	17	5
Total studies	497	431	4,124	3,742	-382
NEURODIAGNOSTIC					
In-patient procedures	154	136	1,411	1,245	-166
Out-patient procedures	15	32	174	201	27
Emergency room procedures	0	0	1	0	-1
Total procedures	169	168	1,586	1,446	-140

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Feb and eight months to date

	Month of Feb		Eight months to date		
	2020	2021	2019-20	2020-21	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	1	1
Out-patient procedures	189	186	1,669	1,501	-168
Emergency room procedures	0	0	0	0	0
Total procedures	189	186	1,669	1,502	-167
RADIOLOGY					
In-patient procedures	1,402	1,175	10,787	10,883	96
Out-patient procedures	489	408	3,571	4,731	1,160
Emergency room procedures	1,496	928	11,795	8,867	-2,928
Total patient procedures	3,387	2,511	26,153	24,481	-1,672
MAGNETIC RESONANCE IMAGING					
In-patient procedures	106	121	1,103	981	-122
Out-patient procedures	85	150	683	1,103	420
Emergency room procedures	8	9	91	89	-2
Total procedures	199	280	1,877	2,173	296
MAMMOGRAPHY CENTER					
In-patient procedures	3,152	2,856	29,728	23,766	-5,962
Out-patient procedures	3,136	2,837	29,611	23,627	-5,984
Emergency room procedures	0	0	7	3	-4
Total procedures	6,288	5,693	59,346	47,396	-11,950
NUCLEAR MEDICINE					
In-patient procedures	10	9	154	95	-59
Out-patient procedures	77	65	684	571	-113
Emergency room procedures	1	1	4	5	1
Total procedures	88	75	842	671	-171
PHARMACY					
In-patient prescriptions	88,441	79,238	728,988	715,594	-13,394
Out-patient prescriptions	16,347	12,494	132,571	112,472	-20,099
Emergency room prescriptions	8,670	5,034	64,285	42,017	-22,268
Total prescriptions	113,458	96,766	925,844	870,083	-55,761
RESPIRATORY THERAPY					
In-patient treatments	19,066	17,938	129,168	174,395	45,227
Out-patient treatments	638	291	4,605	3,682	-923
Emergency room treatments	621	194	3,559	1,373	-2,186
Total patient treatments	20,325	18,423	137,332	179,450	42,118
PHYSICAL THERAPY					
In-patient treatments	2,169	2,190	19,885	18,299	-1,586
Out-patient treatments	222	228	2,170	1,979	-191
Emergency room treatments	0	0	0	0	0
Total treatments	2,391	2,418	22,055	20,278	-1,777

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Feb and eight months to date

	Month of Feb		Eight months to date		
	2020	2021	2019-20	2020-21	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,412	1,528	11,771	10,931	-840
Out-patient procedures	127	146	1,030	943	-87
Emergency room procedures	0	0	0	0	0
Total procedures	1,539	1,674	12,801	11,874	-927
SPEECH THERAPY					
In-patient treatments	348	344	2,970	3,026	56
Out-patient treatments	29	47	204	218	14
Emergency room treatments	0	0	2	0	-2
Total treatments	377	391	3,176	3,244	68
CARDIAC REHABILITATION					
In-patient treatments	0	0	0	0	0
Out-patient treatments	427	497	3,813	3,134	-679
Emergency room treatments	0	0	0	1	1
Total treatments	427	497	3,813	3,135	-678
CRITICAL DECISION UNIT					
Observation hours	323	301	2,511	2,167	-344
ENDOSCOPY					
In-patient procedures	61	99	723	725	2
Out-patient procedures	39	21	253	180	-73
Emergency room procedures	0	0	0	0	0
Total procedures	100	120	976	905	-71
C.T. SCAN					
In-patient procedures	578	523	5,192	4,326	-866
Out-patient procedures	247	421	2,129	4,019	1,890
Emergency room procedures	529	432	4,982	3,640	-1,342
Total procedures	1,354	1,376	12,303	11,985	-318
DIETARY					
Routine patient diets	18,936	15,458	161,504	128,612	-32,892
Meals to personnel	23,848	17,975	201,395	162,191	-39,204
Total diets and meals	42,784	33,433	362,899	290,803	-72,096
LAUNDRY AND LINEN					
Total pounds laundered	104,319	92,379	1,031,211	802,467	-228,744

Salinas Valley Memorial Healthcare System

Memorandum

To: Board of Directors

From: Allen Radner, M.D. CMO

Date: March 25, 2021

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.	Space Planning Policy	Added expectations of leaders and notifications to affected departments.	Clement Miller
2.	Utilities Management Plan	Updated Organization & Responsibility section and Plan Management section. Updated Processes Managing Utility System Risks section.	Clement Miller
3.	Hazardous Materials & Waste Management Plan	Updated Definitions and Responsibility sections.	Clement Miller
4.	Medical Equipment Management Plan	Updated Processes for Managing Medical Equipment Risks bullet H, "Safe Medical Devices Act". Removed all references to "Senior Director of Quality". Updated section Testing of High Risk and Non-High Risk Equipment.	Clement Miller
5.	Emerging Infectious Disease Infection Prevention Pandemic Plan	Updated title. Updated Scope section and Objectives/Goals section. Updated Plan Management section. Updated References.	Allen Radner M.D.
6.	Care of the Patient, Continuous Subcutaneous Insulin Pump	Updated overall process. Moved information listed under Policy Statement to General Information section. Removed Attachment A.	Clement Miller

7.	Safety-Newborn Clinical Procedure	Removed text listed under Policy Statement to General Information section as this is a Procedure.	Clement Miller
8.	Patient and Family Education	Removed reference to Patient Education Committee which has not been existence for some time. Moved information listed under Policy Statement to General Information section. Updated References.	Clement Miller
9.	Care of the Renal, Hemodialysis and CAPD Patient	Minor updates to Definitions bullet B. Under Procedure minor updates to entire section. References updated. Education statement updated to standard verbiage.	Clement Miller
10.	NICU Orientation and Training	Moved information listed under Policy Statement to General Information section. Added bullet E to Procedure section.	Clement Miller
11.	Case Management: Standard for Admission Review	Updated to current practice. Moved information listed under Policy Statement to General Information.	Clement Miller
12.	Uses and Disclosures of Protected Health Information	Combined all HIPAA policies into one policy and added some new content. Moved content listed under Policy Statement to General Information section.	Augustine Lopez

Salinas Valley Memorial Healthcare System

SPACE PLANNING POLICY

Reference Number	6641
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	

I. POLICY STATEMENT:

A. All requests for space allocation will be reviewed and approved by the Space Planning Committee for:
- Changing use of space
- Relocation of services
- Department or office moves
- New employee positions space / needs planning

II. PURPOSE:

A. To ensure effective, economical and efficient use of space throughout the hospital facilities.
B. To ensure the CDPH licensing requirements are met and the required Client Accommodation list is accurate.

III. DEFINITIONS:

A. Client Accommodations: requirement from California Department of Public Health (CDPH) that defines licensed spaces.

IV. GENERAL INFORMATION:

A. Space is a hospital resource. It does not belong to a particular program or service.
B. The following guiding principles will be used for the assigning of space.
1. Space allocation should aid the advancement of the Hospital's Strategic Plan.
2. Space allocation should be guided by the Hospital's Master Plan.
3. Functionality should be of prime consideration in the assigning of space.
4. In recruitment of individuals and activities for any program or service the identification of space, within their program or service must be included. If there is no space available then an impact analysis form must be sent to the Space Planning Committee for approval, PRIOR to the recruiting of said individual or service.

5. No individual will have more than one office. Workspaces for those who have a primary office at another facility or work less than full time will be assigned shared workspace within the program or service.
6. Conference rooms are a corporate resource and will be available according to the Conference room scheduling policy.

C. Factors to be considered in assigning space are as follows:
1. The interest SVMHS as a whole.
2. The suitability of the space and the possible future uses with anticipated or ongoing construction, renovation and planning of major space reallocations.
3. The costs incurred by granting the space and who will bear them
4. The effects on people who must be relocated if the space request is granted.
5. Best interest of the unit's strategic plan.

D. The Space Planning Committee will be comprised of the following persons (or their designees):
- Chief Operating Officer/designee
- Chief Nursing Officer/designee
- Chief Clinical Officer
- Facilities
- Patient Safety
- Regulatory & Licensing
- Human Resources Leadership (Ad hoc for new position planning)
- Others as needed

V. **PROCEDURE:**

A. Space requests must be reviewed and approved by the requesting Program or Service Director and its Vice President / Executive leader prior to submission to the Space Planning Committee.
1. New Employee Positions for Hire:
   a. When a director submits request for a new position, a notice will be sent to the Space Planning Committee chair.
2. Replacement Positions
   a. The committee will review for changes in their position and related needs for space.
3. Change of Space Use or Office/Department/Personnel/Function Moves
   a. A request must be submitted to the Space Planning Committee via the electronic form.
4. Space Planning Committee Follow-up
   a. Committee will include the department leaders and/or others for discussion as needed.

b. Upon approval the director will be notified.

B. Expectation of Leader:

1. The "Request for Space Assessment" form must be completed for all requests for space, including relocation of services or staff and new position. Assure all signatures are obtained prior to submission to the Space Planning Committee.
2. After notification of approval from the Space Planning Committee, coordinate enhancements / move with necessary services:
   - Involved individuals
   - Facilities / Engineering (remodel, room enhancements etc.)
   - Facilities Project Manager
   - Furniture needs
   - IT / Phone needs
3. Communication of move to affected services / departments.
   a. The leader is responsible to notify all applicable departments / services of the new location. The following are examples of services / departments needing to be informed of the move:

Information Technology	Leadership (as applicable)
Facilities	FNS (as applicable)
Materials Management	Unit staff
Regulatory (as applicable)	

~~B.~~C. Documentation

~~1. The Request for Space Assessment form must be completed for all requests for space, including relocation of services or staff and new position.~~

1. All requests for space are maintained in the Space Planning Committee master file.

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. NA

Salinas Valley Memorial Healthcare System

UTILITIES MANAGEMENT PLAN

2021

~~Effective Date: 1/28/20~~

TABLE OF CONTENTS

I. SCOPE 3

II. GOALS 3

III. DEFINITIONS 3

IV. ORGANIZATION & RESPONSIBILITY 3

V. PLAN MANAGEMENT 3

VI. PROCESSES MANAGING UTILITY SYSTEM RISKS 4

VII. PROCESSES MANAGING ELECTRICAL SYSTEMS 12

VIII. MANAGING EMERGENCY POWER SYSTEMS 14

IX. MANAGING THE MEDICAL GAS AND VACUUM SYSTEM 16

X. EVALUATING THE MANAGEMENT PLAN 20

XI. PERFORMANCE STANDARDS 20

I. SCOPE:

A. The Utility Systems Program provides a process for the proper design, installation and maintenance of appropriate utility systems and equipment to support a safe patient care and treatment environment at Salinas Valley Memorial Healthcare System (the hospital and its licensed offsite locations are covered by this management plan). The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the utility systems, and manage risks associated with the operation and maintenance of utility systems. Finally, the Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education, and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at Salinas Valley Memorial Healthcare System.

II. GOALS:

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

III. DEFINITIONS:

A. SVMHS: Salinas Valley Memorial Healthcare System

B. EOC: Environment of Care Committee

C. AEM: Alternate Equipment Maintenance

IV. ORGANIZATION & RESPONSIBILITY:

A. The Chief Engineer works under the general direction of the ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations. They are responsible for operation and maintenance of the utility systems and management of contractors working on the utility systems.

V. PLAN MANAGEMENT:

A. **FUNDAMENTALS**~~The complexity of utility systems required to support complex patient care continues to increase. Selecting new or upgraded utility system technology requires research and a team approach to assure all functional and medical needs are met.~~

1. Patient care providers ~~need training~~are trained to understand how utility systems support patient care, limitations of system performance, safe operating

conditions, safe work practices, and emergency clinical interventions during interruptions.

2. Hospital utility systems are highly complex. When upgrades and new installations are proposed, a multidisciplinary group approach is used to ensure that patient care needs, regulatory requirements and industry standards are met.

~~2.~~3. ~~Critical components of utility systems require maintenance to minimize the potential for failures.~~Utility systems are maintained to ensure proper operation and reduce potential for failures.

~~3.~~4. Emergency response procedures are required to manage utility system failures or service disruptions.

VI. PROCESSES MANAGING UTILITY SYSTEM RISKS:

A. Management Plan

1. The organization develops and maintains the Utility Systems Management Plan to effectively manage the utility system risks to the staff, visitors, and patients at Salinas Valley Memorial Healthcare System.

B. Design and Maintenance of Utility Systems

1. The ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations is responsible for managing the planning, design, construction, and commissioning of utility systems to meet the patient care and the operational needs of Salinas Valley Memorial Healthcare System. The construction and commissioning programs are designed to assure compliance with codes and standards, and to meet the specific needs of the occupants throughout the facility. The ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations is responsible for setting maintenance standards and implementing a program of planned maintenance and customer service to ensure a safe comfortable environment.

C. Utility Inventory

~~1. The Salinas Valley Memorial Healthcare System maintains an inventory of selected operating components of the utility systems categorized by physical risk associated with use and system incident history. This includes all life support utility systems. The Plant Operations / Engineering Department evaluates new types of utility systems before initial use to determine whether to include these in the inventory.~~

~~2.~~1. SVMH maintains an inventory of all operating components of the utility systems. These are categorized by potential impact to the safety of patients, staff and visitors in the event of failure. The Director, or designee, assesses systems and components to identify the appropriate maintenance strategies based on risk and impact. Added expectations of leaders and notifications to affected departments written criteria are used to identify risks associated with utility

systems. Some of the risks include infections, occupant needs, and systems critical to patient care needs, including life support systems. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of the utility systems. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.

~~3.~~2. Systems requiring a program of planned maintenance are listed as part of a maintenance inventory. The list includes operational components of utility systems maintained by in-house staff as well as equipment maintained by vendors.

D. **Testing Utility Systems Prior to Initial Use**

1. The organization tests utility system components on the inventory before initial use and after major repairs or upgrades. The completion date of the tests is documented. The Facility Director, or designee, is responsible for implementation of the program of planned inspection, testing, and maintenance.

E. **Maintaining, Inspecting, and Testing Activities**

1. The ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations identifies in writing the activities used for maintaining, inspecting, and testing all of the operational components of the utility systems in the inventory to assure safety and ~~maximum useful life~~equipment longevity. The determination of the appropriate activity is made as part of the initial evaluation of equipment, as well as failure trends and equipment history.
2. Potential activities may be selected to ensure reliable performance including:
   a. ~~Predictive~~ Preventive maintenance based on manufacturer's recommendations
   b. Reliability-centered maintenance based on equipment history
   c. Interval-based inspections, ~~based on specified intervals between~~ tests, inspections, ~~or~~ and preventive maintenance activity
   d. Corrective maintenance based on direct observation of deficiency or failure of designated testing protocol ~~a request for service or failure of the equipment to pass internal self-tests~~
   e. Metered maintenance based on manufacturer's recommendation, as applicable.
3. The results of assessment ~~of the various utility systems and operational components~~ are used to identify appropriate~~the~~ maintenance strategies, and to identify which equipment may be included in preventive maintenance program.~~, corrective maintenance and the other types of maintenance programs used at Salinas Valley Memorial Healthcare System.~~

4. The results of assessing the risks of failures of the utility systems are also used to identify those systems and areas for which emergency management plans are needed to assure ongoing safety of patient care as well as the safety of staff and visitors.

F. **Maintenanceaining, Inspectionng, and Testing Frequencies**

1. The organization identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all all applicable operating components of utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or associated with strategies offollow an Alternative Equipment Maintenance (AEM) program.

2. Potential frequency for conducting these activities may be selected to ensure reliable performance including:

   a. Predictive Preventive maintenance based on manufacturer's recommendations

   b. Reliability-centered maintenance based on equipment history

   c. Interval-based inspections based on specified intervals between tests, inspections, or maintenance activity

   d. Corrective maintenance based on a request for service or failure of the equipment to pass internal self-testsdirect observation of deficiency or failure of designated testing protocol

   e. Metered maintenance base on manufacturer's recommendation, as applicable.

3. The strategies of an AEM program do not reduce the safety of equipment and must be based on accepted standards of practice. A reference of guidelines for physical plant equipment maintenance is the American Society for Healthcare Engineering (ASHE) book Maintenance Management for Health Care Facilities.

4. A computerized maintenance management system is used to schedule and track timely completion of scheduled maintenance and servicepreventive maintenance activities. The Assistant Director is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements. The frequency of maintenance is determined at the time of initial evaluation of the utility system based on the following:

   Added expectations of leaders and notifications to affected departments

G. **Testing High-Risk Components of the Utility System**

1. All high-risk components of the utility system , including life support components, on the inventory are tested, maintained, and inspected by manufacturer's recommendation or AEM program. A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment.

~~2. Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate. The scheduled maintenance activities for high-risk utility systems components in the AEM program inventory must have a 100% completion rate.~~

~~3.~~2. Reports of the completion rate of scheduled inspection and maintenance are presented to the EC Committee each quarter. If the rate of completion falls below 100%, there will be ~~Assistant Directorwill also present~~ an analysis to determine the cause of the problem and make recommendations for corrective actions. ~~The corrective actions and retest of the systems will be documented.~~

H. **Testing Critical Components Supporting Infection Control**

1. All Critical Component of the utility system supporting infection control on the inventory are tested, maintained, and inspected by manufacturer's recommendation or AEM program. The completion date and the results of the activities are documented.

2. The required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate. The scheduled maintenance activities for infection control utility systems components in the AEM program inventory must have a 100% completion rate

3. Reports of the completion rate of scheduled inspection and maintenance are presented to the EOC Committee each quarter. If the rate of completion falls below 100%, the Facility Director will also present an analysis to determine the cause of the problem and make recommendations for corrective actions. The corrective actions and retest of the systems will be documented.

I. **Testing Non-High Risk Components of the Utility System**

1. All Non-high-risk utility system components on the inventory are tested, maintained, and inspected by manufacturer's recommendation or the AEM program. The completion date and the results of the activities are documented. The required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate.

2. The scheduled maintenance activities for non-high-risk utility systems components in the (AEM) program inventory may be deferred as defined by organization policy, provided the completion rate is not less than 90%

3. Reports of the completion rate of scheduled inspection and maintenance are presented to the EOC Committee each quarter. If the rate of completion falls below 90%, the Assistant Director will also present an analysis to determine the cause of the problem and make recommendations for corrective actions. The corrective actions and retest of the systems will be documented

J. **Maintaining Specific Components of Utility Systems**

1. Specific inspecting, testing, and maintaining activities, and frequencies intervals for the following components of a utility system are conducted in accordance with the manufacturers' recommendations:

    a. Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements
    b. New operating components with insufficient maintenance history to support the use of alternative maintenances strategies.

2. The maintenance history used to determine the activities and frequencies may include, records provided by contractors used to service the utility systems, and information made public by nationally recognized sources. Experience of testing, maintaining, and inspecting components of the utility systems by the Facilities Management Department will also be used as history to determine the activities and frequencies required.

K. **Identifying Risk Criteria Used for Inclusion in AEM program**

1. A qualified individual uses written criteria to support the determination whether it is safe to permit components of the utility systems to be maintained in an AEM program. The written criteria includes:

    a. How the equipment is used, including the seriousness and prevalence of harm during normal use
    b. Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
    c. A availability of alternative or back-up equipment in the event the equipment fails or malfunctions
    d. Incident history of identical or similar equipment
    e. Maintenance requirements of the equipment

2. Once the appropriate program is determined, the information is entered into the record for the utility system in the inventory.

L. **Identifying Components Included in the AEM program**

1. The hospital identifies operating components of utility systems on the inventory that is included in an AEM program. These are reviewed by the Assistant Director at appropriate intervals.

M. **Labeling Controls for Emergency Shutdown**

1. The ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations, or designee is responsible for labeling the locations of critical or emergency controls for a partial or complete shutdown of the utility systems. Critical or

emergency operating components of utility systems are identified on historical documents or computerized drawings. A variety of techniques such as legends, symbols, labels, numbers, and color-coding are used to identify the location and type of critical or emergency controls. The corresponding physical control is identified by a tag or other indicator attached to the device. This process is designed to provide technicians with accurate information about the function of a control before it is activated for scheduled maintenance or during an emergency.

N. **Utility System Disruptions and Shutting off Malfunctioning System**

1. Salinas Valley Memorial Healthcare System has identified and implemented procedures for responding to utility system disruptions or failures. These procedures are developed to include the criteria for implementing a utility response plan. The staff is responsible for making the decisions; activities and resources used to mitigate the emergency (e. g., an emergency power system to mitigate external power failure); and preparation for the failure (e. g., flashlights, staff training about how to respond to a power failure). The response plans are also included in a quick chart which is widely distributed and posted in a number of locations throughout the facility. The recovery plans focus on return to normal conditions, and the resetting and recovery of emergency equipment and supplies.
2. The Utility Systems include the following:
    a. Electrical Distribution
    b. Emergency Power
    c. Medical Gas
    d. HVAC
    e. Boiler & Steam
    f. Plumbing
    g. Vertical & Horizontal Transport
    h. Vacuum Systems
    i. Communication Systems

O. **Emergency Clinical Interventions**

1. Salinas Valley Memorial Healthcare System has identified and implemented emergency procedures for responding to utility system disruptions or failures that require emergency clinical interventions. This is focused on clinical staff and support staff as well. The Environment of Care Committee will assist in obtaining the necessary procedures for those utility systems that could impact on the life support equipment. The clinical staff will be trained on the proper response to the disruption of life support utility services and the method of notifying the appropriate group. The response plans are also included in a quick chart which is widely distributed and posted in a number of locations throughout the facility.

P. **Emergency Repair Services**

1. Salinas Valley Memorial Healthcare System has identified and implemented procedures for the emergency repair of operational components of the utility systems. The staff has been provided with a chart that identifies the major utility systems and the contact information to obtain repair services. Those components that have a direct impact on patient care have been identified and repair plans developed. The staff should contact their supervisor immediately to report disruption. The supervisor, or staff member, then contacts the Plant Operations / Engineering Department who will respond to assess the situation and contact additional assistance if needed.

Q. **Management of Waterborne Pathogenic Agents**

1. The organization has identified and implemented processes to minimize pathogenic biological agents in cooling towers, domestic hot and cold water systems, and other aerosolizing water systems through the proactive periodic treatment of these systems.

2. When the monitoring program of incidents for hospital-acquired infections identifies the presence of pathogenic biological agents in water systems, the Infection Control Manager and the ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations collaborate to identify an effective treatment and future growth prevention program.

3. When an outbreak of an infectious, waterborne disease (e. g., Legionella) is identified, the Salinas Valley Memorial Hospital Infection Control staff notifies the Plant Operations / Engineering Department staff that treats the affected domestic water system to eliminate the hazard.

4. Any ornamental water fixture within the facility is periodically treated and the potential aerosol is controlled by ventilation, or other methods acceptable to the Infection Control Practitioner.

R. **Maintenance of Air Pressurization, Filtration, & Filter Efficiency**

1. Salinas Valley Memorial Healthcare System designs, installs, and maintains ventilation equipment to provide appropriate pressure relationships, air-exchange rates, and filtration efficiencies for ventilation systems serving areas specially designed to control air-borne contaminants (e. g., biological agents, gases, fumes, dust).

2. The air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by the Plant Operations / Engineering Department. The schedule of regular inspection of filter performance monitoring equipment, air pressure sensing equipment, and air flow rate sensors is managed by the Engineering staff.

3. A qualified service provider is engaged to verify volume flow rates (air exchange rates, and positive or negative pressure rates) and pressure relationships as part

of the commissioning of all new building projects and major space renovations. In addition, the air volume flow rates and pressure relationships are tested periodically throughout the hospital including investigation of complaints related to indoor air quality. The results of testing are used to adjust the performance of air handling systems by changing control software parameters and mechanical or electrical controls.

4. If system performance cannot be adjusted to meet code requirements or occupant needs, the Engineering Staff works with appropriate Infection Control and clinical staff to develop temporary management practices to mitigate issues. In addition, a recommendation for upgrading or replacing the equipment involved is prepared and submitted to the CEO and Board as appropriate.

S. **Maintaining Appropriate Environment in Non-critical Areas**

1. In non–critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity. These areas include general care nursing units; clean and soiled utility rooms in acute care areas; general laboratories and pharmacy areas, diagnostic and treatment areas, food preparation areas, and other support departments.

2. An inventory of spaces requiring appropriate ventilation is maintained that includes the frequency and task for monitoring the environment affected. Periodic measurements pressure relationships, temperature, and humidity are taken in these areas throughout the organization at a frequency describe by the risks of that area. The frequency is reviewed periodically to determine the appropriate time-frame for monitoring.

T. **Mapping Utility Systems**

1. Current documentation of the maps for distribution of all utility systems is maintained. The documents include “as-built” and record drawings, one line drawings, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations.

2. Hard copies of the documentation are maintained in Facility Management. Documents that are available in electronic format are maintained in the Facility Department server and are available to work stations throughout the organization.

U. **Maintaining Medical Gas Storage, Manifold, and Transfer Areas**

1. Medical gas storage rooms and transfer and manifold rooms maintain the appropriate environment, including ventilation and temperature in accordance with NFPA 99-2012: 9.3.7. Indoor storage area, area containing a gas manifold and storage, such as manifold buildings for medical gases and cryogenic fluids shall be provided with natural ventilation or mechanical exhaust ventilation. The trans-filling of gas cylinder is prohibited in any compartment with patient care rooms.

V. **Maintaining Emergency Power Supply Systems & Environment**

1. The emergency power supply system's equipment and environment are maintained per manufacturers' recommendations, including ambient temperature not less than 40°F; ventilation supply and exhaust; and water jacket temperature (when required). The environmental condition are monitored daily during period of cold weather to insure the appropriate environmental and water-jacket temperature are maintained. This information is documented.

W. **Managing Patient Risk during Repair or Maintenance Activities**

1. When performing repairs or maintenance activities, an assessment is conducted to manage risks associated with air-quality requirements; infection control; utility requirements; noise, odor, dust, vibration; and other hazards that affect care, treatment, or services for patients, staff, and visitors. This assessment may be conducted by individuals trained in the Pre-construction or other Risk Assessment procedures. The results of the assessment, list of measures implemented to minimize or eliminate risk, and documentation of implementation of necessary measure will be documented.

VII. PROCESSES MANAGING ELECTRICAL SYSTEMS:

A. **Providing Essential Electrical Circuitry**

1. The facility has the appropriate essential electrical systems. For those portions of the facility that was constructed since 1983, or had a change in occupancy type, or have undergone an electrical system upgrade have a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. The essential electrical system is divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch. The transfer of power and operation of the automatic transfer switch are tested regularly.

B. **Electrical Distribution in the organization**

1. Electrical distribution in the organization is based on the following categories:

   a. Category 1: Critical care rooms served by a Type 1 essential electrical system (EES) in which electrical system failure is likely to cause major injury or death to patients, including all rooms where electric life support equipment is required.

   b. Category 2: General care rooms served by a Type 1 or Type 2 EES in which electrical system failure is likely to cause minor injury to patients.

   c. Category 3: Basic care rooms in which electrical system failure is not likely to cause injury to patients. Patient care rooms are required to have a Type 3 EES where the life safety branch has an alternate source of power that will be effective for 1 1/2 hours.

C. **Electrical Receptacles**

1. Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered are tested after initial installation, replacement, or servicing. In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, play rooms, and activity rooms are listed tamper-resistant or have a listed cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking.

D. **Power Strips**

1. Power strips in a patient care vicinity are only used for components of movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. In non–patient care rooms, power strips meet other UL standards.

E. **Extension Cords**

1. Extension cords are not used as a substitute for fixed wiring in a building. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was intended.

F. **Wet Procedure Locations**

1. Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment authorized by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection.

G. **Testing Line Isolation Monitors**

1. Line isolation monitors (LIM) are tested at least monthly by actuating the LIM test switch per NFPA 99, which activates both visual and audible alarms. For LIM circuits with automated self-testing, a manual test is performed at least annually. LIM circuits are tested per NFPA 99 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.

H. **Maintaining the Environment for Electrical Distribution**

1. The environment for the Emergency Power Supply (EPS) generator will be maintained for ventilation and temperature in accordance with NFPA 99-2012. This includes, but limited to:

    a. The EPS shall be heated as necessary to maintain the water jacket temperature determined by the EPS manufacturer for cold start and load acceptance for the type of EPSS.

b. With the EPS running at rated load, ventilation airflow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer.
c. The EPS shall be heated as necessary to maintain the water jacket and battery temperature determined by the EPS manufacturer for cold start and load acceptance for the type of EPSS.
d. With the EPS running at rated load, ventilation air flow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer.
e. Ventilation air supply shall be from outdoors or from a source outside of the building by an exterior wall opening or from a source outside the building by a 2-hour fire-rated air transfer system.
f. Ventilation air shall be provided to supply and discharge cooling air for radiator cooling of the EPS when running at rated load.

VIII. MANAGING EMERGENCY POWER SYSTEMS:

The ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations is responsible for managing a program of inspection, maintenance, and testing of the following essential electrical systems.

A. Emergency Electrical Power Systems

1. Reliable emergency electrical power is supplied within 10 seconds of loss of "normal" power to specific the utility systems, including:

    a. Alarm systems, as required by the Life Safety Code
    b. Exit route and exit sign illumination, as required by the Life Safety Code
    c. Emergency communication systems, as required by the Life Safety Code
    d. Equipment that could cause patient harm when it fails, including life support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems
    e. Areas in which loss of power could result in patient harm, including operating rooms, recovery rooms, obstetrical delivery rooms and nurseries
    f. Emergency lighting at emergency generator locations with a remote manual stop station with identifying label to prevent inadvertent or unintentional operation and a remote annunciator (powered by storage battery) located outside the generators location.
    g. Elevators (at least one for non-ambulatory patients)

B. Energizing Equipment by Emergency Power

1. Equipment designated to be powered by emergency power supply are energized by the organization's design. Staging of equipment start up is permissible.

C. Battery and Flashlight Availability

1. Battery lamps and flashlights are available in areas not serviced by the emergency supply source.

D. **Emergency Lighting Systems and Exit Signs**

1. The ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations, or designee, is responsible for identifying all battery-powered lights installed to provide exit path illumination or for illumination of offsite patient care services.
2. The organization performs a functional test of emergency lighting systems and EXIT signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other EXIT signs. The test results and completion dates are documented.
3. Every 12 months, the organization performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 ½ hours. The results and completion dates are documented.
4. The annual test meets the requirements of applicable codes and standards and manufacturer recommendations. An alternate process for some systems is the annual replacement of batteries with random testing of 10% of all batteries for 1-1/2 hours. The date of the testing is recorded.

E. **Emergency Power Supply Systems (SEPSS)**

1. Every quarter, the organization performs a functional test of stored emergency power supply systems (SEPSS) for 5 minutes or as specified for its class (whichever is less). The organization performs an annual test at full load for 60% of the full duration of its class. The completion dates of the tests are documented.

F. **Inspecting Emergency Generator Systems**

1. At least weekly, the emergency power supply system (EPSS), including all associated components and batteries, is inspected in accordance with. NFPA 110. The results and completion dates of weekly inspections are documented.

G. **Monthly 30-Minute Emergency Generator Test**

1. The ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations or designee, tests emergency generators twelve times a year at intervals not less than 20 days or more than 40 days for at least 30 continuous minutes. The tests are conducted with a dynamic load of at least 30% of the nameplate rating of the generator or meet the recommendations of the manufacturers for prime mover of gas temperature. The completion date of the test is documented.
2. Appropriate notice of each test run is forwarded to departments throughout the organization. Tests will be delayed if a critical medical procedure is underway and unanticipated failure of the essential electrical system would result in

immediate life threatening conditions, but testing is conducted within the defined time frames.

3. Testing is conducted for at least 30 minutes under full connected load at operating temperature. The test begins with a cold start, and the cool down period is not part of the 30 continuous minutes. Testing time starts when the generator reaches defined operating conditions, generally full operating temperature of either the exhaust system, or coolant water. Appropriate testing parameters are recorded and evaluated by the ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations, or designee. Any indication of performance below code requirements or expectations is immediately evaluated to determine the source of the problem and rectified.

4. If any diesel engine powered motor/generator is not loaded to 30% or more of its nameplate capacity during connected load tests, temperature measurements are made to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Any engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process required by NFPA® 99 and NFPA® 110.

H. **Tri-annual Four-hour Generator Test**

1. Additionally, all generators are tested for a minimum of four (4) continuous hours at least every three (3) years. The tests are conducted with a dynamic load of at least 30% of the nameplate rating of the generator or meet the recommendations of the manufacturers for prime mover of gas temperature. Test results and completion dates are documented.

I. **Monthly Automatic Transfer Switch Test**

1. All automatic transfer switches are tested twelve times per year at intervals not less than 20 day or more than 40 days as part of the monthly generator load test. Test results and completion dates are documented. Their performance is generally verified during generator testing, as well as annual maintenance of each switch.

J. **Testing Generator Fuel Quality**

1. At least annually, the organization tests the fuel quality to ASTM standards in accordance with NFPA 110-2010: 8.3.8. The test results and completion dates are documented.

IX. MANAGING THE MEDICAL GAS & VACUUM SYSTEM:

The ~~Assistant Director, Facilities Development & Real Property Management~~Director of Facilities and Construction, Plant Operations, or designee, is responsible for managing a program of inspection, maintenance, and testing of the following essential medical gas systems.

Plant Operations / Engineering Department conduct a preventive maintenance (PM) program on the system at an annual frequency. The maintenance program includes inspecting, testing, and maintaining the critical components of the piped medical gas systems. Components that are maintained include the master signal panels (i. e., high and low pressure, transfer from normal to reserve indicators), area medical gas alarms, automatic pressure switches (high and low pressure), zone and main shutoff valves, flexible connectors (where installed), and medical gas outlets.

The PM activity is conducted by contractors who are engaged to conduct the tests and inspections of elements that require special equipment and training. Documentation of the testing is maintained by the Plant Operations / Engineering Department.

Containers, cylinders, and tanks are designed, fabricated, tested and marked in accordance with NFPA 99-2012.

A. **Designation of Medical Gas Systems**

1. Medical gas, medical air, surgical vacuum, waste anesthetic gas disposal (WAGD), and air supply systems are designated as follows:

    a. Category 1: Systems in which failure is likely to cause major injury or death to patients or caregivers

    b. Category 2: Systems in which failure is likely to cause minor injury to patients or caregivers

    c. Category 3: Systems in which failure is not likely to cause injury to patients or caregivers, but can cause patient discomfort.

B. **Alarm Systems**

1. All master, area, and local alarm systems used for medical gas and vacuum systems comply with the category 1–3 warning system requirements.

C. **Storage Room Requirements**

1. Locations containing only oxygen or medical air have doors labeled "Medical Gases: NO Smoking or Open Flame." Locations containing other gases have doors labeled “Positive Pressure Gases: NO Smoking or Open Flame. Room May Have Insufficient Oxygen. Open Door and Allow Room to Ventilate Before Opening.”

    a. A precautionary sign readable from five feet away is on each door or gate of a cylinder storage room, where the sign, at a minimum, includes the wording "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING.”

    b. Storage is planned so cylinders are used in order of which they are received from the supplier. Only gas cylinders and reusable

shipping containers and their accessories are permitted to be stored in rooms containing central supply systems or gas cylinders.

D. **Threshold Pressure for Cylinders with Integral Pressure Gauge**

1. When the organization uses cylinders with an integral pressure gauge, a threshold pressure considered empty is established when the volume of stored gases is as follows:

    a. When more than 300 but less than 3,000 cubic feet, the storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklers) or enclosed in a cabinet of noncombustible construction having a minimum 1/2-hour fire protection rating.

    b. When less than 301 cubic feet in a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in NFPA 99-2012.

E. **Maintaining Bulk Oxygen System and Connection**

1. Any above ground, bulk oxygen system is placed in a locked enclosure (such as a fence) at least 10 feet from vehicles and sidewalks. There is permanent signage stating “OXYGEN – NO SMOKING – NO OPEN FLAMES in accordance with NFPA 99.

2. In addition, an emergency oxygen supply connection is installed in a manner that allows a temporary auxiliary source to be connected in accordance with NFPA 99-2012.

F. **Testing Installed, Modified, or Repaired Systems**

1. Salinas Valley Memorial Healthcare System uses certified contractors, or specially trained staff to test and certify piped medical gas and vacuum systems when the systems are initially installed, modified, or invasively repaired. Testing includes verification that there is no cross-connection of piping and outlets; testing the piping for content purity and particulates, and verification that the pipes maintain pressure. Testing is done to demonstrate the system meets at least NFPA 99 and CGA 1 requirements. The results and completion dates are documented.

G. **Labeling Main Supply Valves**

1. The organization makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. Piping is labeled by stencil or adhesive markers identifying the

gas or vacuum system, including the name of system or chemical symbol, color code (see NFPA 99-2012: Table 5.1.11), and operating pressure if other than standard. Labels are at intervals of 20 feet or less and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency.

H. **Handling and Transporting Gas Cylinders**

1. The organization has implemented a policy on all cylinders within the organization that includes labeling, handling and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012. See MEDICAL GAS CYLINDER HANDLING AND STORAGE (#6024)

I. **Transfilling Gas Cylinders**

1. At no time is transfilling done in any patient care room. A designated area is used away from any section of the organization where patients are housed, treated, or examined. The designated area is separated by a barrier of at least one-hour–fire-resistant construction from any patient care areas. Transfilling cylinders is only of the same gas (no mixing of different compressed gases). Transfilling of liquid oxygen is only done in an area that is mechanically ventilated, with a sprinkler system, and has a ceramic or concrete flooring. Storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections NFPA 99-2012

J. **Medical Gas and Vacuum Systems Installation, Testing, and Maintenance**

1. In time frames defined by the organization, the organization inspects, tests, and maintains critical components of piped medical gas and vacuum systems; waste anesthetic gas disposal (WAGD); and support gas systems on the inventory. This inventory of critical components includes at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases and inlets and outlets. Activities, dates, and results are documented. Persons maintaining the systems are qualified by training and certification to the requirements of the American Society of Sanitary Engineers (ASSE) 6030 or 6040.

2. Deficiencies found during testing that present a high risk to patient care will be reported immediately. Other deficiencies will be reported at the end of the testing day. Corrective action will be conducted and Respiratory Therapy will be notified. Interim patient safety measures will be implemented based on the assessment of the risk of the deficiency. The results of the assessment process, corrective actions, and interim measures will be documented.

K. **Areas Designated for Administration of General Anesthesia**

1. Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows:

a. Zone valves are located immediately outside each anesthetizing location for medical gas or vacuum, readily accessible in an emergency, and arranged so shutting off any one anesthetizing location will not affect others.

b. Area alarm panels are installed to monitor all medical gas, medical-surgical vacuum, and piped waste anesthetic gas disposal (WAGD) systems. Alarm panels include visual and audible sensors and are in locations that provide for surveillance, including medical gas pressure decreases of 20% and vacuum decreases of 12-inch gauge HgV.

2. Areas designated for the administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are as follows:

a. Heating, cooling, and ventilation are in accordance with ASHRAE 170, medical supply and equipment manufacturers' instructions are considered before reducing humidity levels to those allowed y ASHRAE.

b. Existing smoke control systems automatically vent smoke, prevent the recirculation of smoke originating within the surgical suite, and prevent the circulation of smoke entering the system intake, without interfering with exhaust function. New occupancies have no smoke control requirement.

c. For hospitals that use Joint Commission accreditations for deemed status purposes: Existing smoke control systems are maintained according to the edition of NFPA 101 adopted by the Centers for Medicare & Medicaid Service at the time of installation.

3. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies.

a. Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101 and NFPA 99 as follows:

i. The essential electrical system's (EES) critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits. The EES equipment system supplies power to the ventilation system.

X. EVALUATING THE MANAGEMENT PLAN:

A. On an annual basis, the EOC Committee evaluate the scope, objectives, performance, and effectiveness of the Plan to manage the utility system risks to the staff, visitors, and patients at Salinas Valley Memorial Healthcare System.

XI. PERFORMANCE STANDARDS:

A. The performance measurement process is one part of the evaluation of the effectiveness of the Utility Systems Program. Performance measures are established to measure at least one important aspect of the Utility Systems Program and are meant to focus on areas that need improvement or affect the overall safety of patient, staff, or visitors.

HAZARDOUS MATERIALS & WASTE MANAGEMENT PLAN

2021

~~Effective Date: 01/29/20~~

TABLE OF CONTENTS

I. SCOPE 3

II. GOALS 3

III. DEFINITIONS 3

IV. RESPONSIBILITY 3

V. PLAN MANAGEMENT 4

VI. PERFORMANCE STANDARDS 9

VII. DOCUMENTATION 9

VIII. EVIDENCE-BASED REFERENCE 9

I. SCOPE

A. The 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 Memorial Healthcare System (the hospital and its licensed offsite locations are covered by this management plan). 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 Salinas Valley Memorial Healthcare System. The program is designed to assure compliance with applicable codes and regulations as applied to the buildings and services at Salinas Valley Memorial Healthcare System. The processes include education, procedures for safe use, storage and disposal, and management of spills or exposures.

II. GOALS

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, ~~Incident~~ occurrence ~~R~~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. Salinas Valley Memorial Healthcare System (SVMHS)

~~E.~~F. EHS: Environmental Health & Safety

IV. RESPONSIBILITY

A. The ~~Environmental Health and Safety Manager~~EHS Manager, in collaboration with the ~~committee~~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

~~A.~~E. NM: Nuclear Medicine

V. PLAN MANAGEMENT

A. FUNDAMENTALS

- The Scope of the hazardous materials and waste management program is determined by the materials in use and the waste generated by the hospital.
- 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.
- 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.
- 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.
- 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
- 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**
  - 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**
  - 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 ~~Environmental Health and Safety Manager~~Safety Officer.
  - 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**
  - The ~~Environmental Health and Safety Manager~~EHS Manager, or designee, develops and maintains emergency procedures for the Hazardous Materials and Waste program.
  - 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.
  - 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 housekeeping 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 to handle chemical exposures that exceed their training, or the PPE they have available.
  - Incidents involving spill kits, or a response from any outside agency are documented on Incident Report Forms.
- **Hazardous Chemical Risks**
  - Salinas Valley Memorial Hospital 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 ~~Environmental Health and Safety Manager~~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 contractor. The contractor lab packs the chemicals, completes the manifest and removes the packaged waste. ~~A disposal copy of the manifest is returned to Safety Office to verify legal disposal of the waste~~The uniform hazardous waste manifest records are maintained by Safety Office.

- **Radioactive Risks**
  - 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 is responsible for evaluating Safety Data Sheets and other documentation for hazards before purchase of departmental supplies to assure they are appropriate, and the least hazardous alternate practical. The department managers work with ~~the Plant Operations/Engineering Department~~Safety Office and appropriate individuals, such as the Radiation Safety Officer or Infection Prevention Manager, to develop procedures for handling of hazardous 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**
  - 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 equipment. The Department Director or a designated representative will conduct identification and evaluation of hazardous energy sources.
  - 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 ~~Directors~~ leaders will maintain required documentation

including applicable regulations, required permits and licenses for each hazardous energy source.

- **Hazardous Drugs**
  - 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 is 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., ~~, if are not recyclable.~~
    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**
  - The ~~Environmental Health and Safety Manager~~EHS Manager is responsible for managing the program for monitoring hazardous gases and vapors.
  - If a test result was above the Cal/OSHA Permissible Exposure Limit (PEL), corrective action and additional testing ~~should~~ will be done to ~~demonstrate~~ ensure a safe working environment.
- **Permits, Licenses, Manifests and SDS**
  - 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.
  - Each shipment of hazardous waste removed from the facility is documented on a Uniform Hazardous Waste Manifest
- **Process for Labeling Hazardous Material & Waste**

- 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 cans or 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**

    - 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**

    - 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**

    - SVMHS 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 Service is responsibility for this process and reports and discrepancies to the Environment of Care Committee as needed.

- **Managing regulated medical waste, including sharps**
    - The management of the disposal of regulated medical wastes is the responsibility of the Infection Prevention Manager with assistance from the Environmental Services (ES) department. 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**

    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.

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

A. The Joint Commission Standards, Environment of Care Chapter

Salinas Valley Memorial Healthcare System

MEDICAL EQUIPMENT MANAGEMENT PLAN

2021

~~Effective Date: 01/29/20~~

Table of Contents

I. SCOPE 3

II. GOALS 3

III. DEFINITIONS 3

IV. RESPONSIBILITY 3

V. FUNDAMENTALS 4

VI. PERFORMANCE ACTIVITIES 4

VII. PROCESSES FOR MANAGING MEDICAL EQUIPMENT RISKS 4

VIII. PERFORMANCE STANDARDS 14

IX. DOCUMENTATION 14

X. EVIDENCE-BASED REFERENCE 13

~~**ATTACHMENT A**~~ 14

I. SCOPE:

A. The Medical Equipment Management Program is designed to assure proper selection, of the appropriate medical equipment to support a safe patient care and treatment environment. The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the equipment, and manage risks associated with the use of medical equipment technology Finally, the Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at Salinas Valley Memorial Healthcare System (SVMHS). The hospital and its licensed offsite locations are covered by this management plan.

II. GOALS:

A. The annual goals for the Medical Equipment Program are developed from information gathered during routine and risk assessment activities, annual evaluation of the previous year's program, performance measures, and environmental tours.

~~B. Align SVMH PM due date with the Manufacturer due date~~

~~C. Assign and identify Alternate Equipment Maintenance (AEM), Contracted Maintenance, and in house Biomed Maintenance in TMS database.~~

~~D. Assign and identify End of Life devices in TMS database~~

III. DEFINITIONS:

A. Salinas Valley Memorial Healthcare System (SVMHS)

B. Environment of Care Committee (EOC)

C. "High-risk" medical equipment: medical equipment on the inventory for which there is an identified risk of serious harm or death to a patient or staff member should the equipment fail. The high-risk medical equipment includes life-support equipment.

IV. RESPONSIBILITY:

A. The Chief Biomed Engineer, in collaboration with the Environment of Care Committee, assures that the Medical Equipment Program is implemented in all key clinical areas.

B. The Chief Biomed Engineer, implements the in-house medical equipment maintenance program and tracks maintenance provided by original equipment manufacturers, and other contractors who provide maintenance and repair services for specific items of equipment.

V. FUNDAMENTALS:

A. The sophistication and complexity of medical equipment continues to expand. Selecting new medical equipment technology requires research and a team approach.

B. Patient care providers need information to develop an understanding of medical equipment limitations, safe operating conditions, safe work practices, and emergency clinical interventions during failures.

C. Medical equipment may injure patients or adversely affect care decisions if not properly maintained.

VI. PERFORMANCE ACTIVITIES:

A. The performance measurement process is one part of the evaluation of the effectiveness of the Medical Equipment Program. Performance measures ~~have been~~are established to measure at least one important aspect of the Medical Equipment Program and are meant to focus on areas that need improvement or affect the overall safety of patient, staff, or visitors.~~.~~

~~B. The performance measures for the Medical Equipment Program are:~~

~~1. Reduce the number of unable to locate PMs as impacted by asset tracking. Will develop the goal based on prior experience.~~
~~2. Increase the completion rate of corrective maintenance work orders for the year (90%).~~

VII. PROCESSES FOR MANAGING MEDICAL EQUIPMENT RISKS:

A. **Management Plan**

1. The organization develops and maintains the Medical Equipment Management Plan to effectively manage the medical equipment risks to the staff, visitors, and patients at Salinas Valley Memorial ~~Hospital~~Health Care System. The Chief Biomed Engineer works collaboratively with the ~~Sr. Administrative Director~~Environmental Health and Safety Manager, Plant Operations and Hospital Construction maintain and effective plan.

B. **Selection & Acquisition**

1. The Chief Biomed Engineer helps in coordinating the medical equipment selection and acquisition process. Department heads and others, as appropriate, collaborate to select and acquire medical equipment. Department heads develop recommendations related to equipment to purchase. The Chief Biomed Engineer ensures medical equipment considered for purchase meets appropriate standards of performance and safety.
2. The Chief Biomed Engineer works with design professionals and medical staff to identify needs for space and support of new equipment. They also manage the commissioning of new equipment. The commissioning process includes assembly, installation, and testing of new equipment prior to initial use.
3. The managers of clinical departments where new equipment is installed collaborate with Materials Management, Information & Technology, Biomedical Equipment, Plant Operations and equipment suppliers to assure appropriate education and training are provided to all initial users of the equipment and a program for training additional future users is developed.
4. Capital equipment requests for medical equipment are included as part of the annual budget process. The CEO has final approval over all new medical equipment purchases. The Biomedical Department maintains documentation related to the Medical Equipment.

C. **Criteria & Inventory**

1. The Salinas Valley Memorial ~~Hospital~~ Healthcare System maintains an inventory of selected medical equipment categorized by physical risk associated with use and equipment incident history. This includes all life support equipment. The Biomedical Department evaluates new types of equipment before initial use to determine whether to include this equipment in the inventory.
2. Written criteria are used to identify risks associated with medical equipment. The risks include, equipment function, physical risks associated with use, and equipment incident history as it relates to patient safety. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of medical equipment. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.
3. Equipment requiring a program of planned maintenance is listed as part of a maintenance inventory. The list includes equipment maintained by in-house staff as well as equipment maintained by vendors.

D. **Identifying activities and frequencies**

1. The organization identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations, or with strategies of an Alternative Equipment Maintenance (AEM) program. The strategies of an AEM program

will not reduce the safety of equipment and must be based on accepted standards of practice.

2. A computerized maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities. The Director is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements, including medical equipment maintained by vendors.

3. The frequency of maintenance is determined at the time of initial evaluation of the utility system based on the following:

   a. Interval testing

   b. Run-time based inspections

   c. Corrective maintenance

   d. Metered maintenance based on hours of use, or other time of use processes (This strategy uses on-board clocks or event recorders to trigger specific tests, inspections or service)

E. **Maintaining specific medical equipment**

1. The organization's activities and frequencies for inspecting, testing, and maintaining the following items are conducted in accordance with manufacturers' recommendations or accreditation standards if frequency is increased:

   a. Medical equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements

   b. Medical laser devices

   c. Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes)

   d. New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies

2. The maintenance history used to determine the activities and frequencies may include, records provided by the organization's contractors used to service the equipment, and information made public by nationally recognized sources, such as ECRI. The organization's experience of testing, maintaining, and inspecting medical equipment will also be used as history to determine the activities and frequencies required.

F. **Assessing the equipment for maintenance with written criteria**

1. The organization identifies a qualified individual, or individuals if necessary, that will use written criteria to support the determination whether it is safe to

permit medical equipment to be maintained in an AEM (alternate equipment maintenance) program. The written criteria will include:

a. How the equipment is used, including the seriousness and prevalence of harm during normal use

b. Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm

c. A availability of alternative or back-up equipment in the event the equipment fails or malfunctions

d. Incident history of identical or similar equipment

e. Maintenance requirements of the equipment

2. Once the appropriate program is determined, the information is entered into the record for the medical equipment in the inventory.

G. **Identifying medical equipment that is using the AEM program**

1. The medical equipment that will be included in the AEM program will be clearly identified in the medical equipment inventory. The inventory is updated at the time of this determination.

H. **Safe Medical Devices Act**

1. ~~The Senior Administrative Director/Qualityand~~ Risk Management is responsible for monitoring and reporting all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. ~~The Senior Administrative Director/Quality and~~ Risk Management collects information about potentially reportable events through the incident reporting and investigation process. The appropriate clinical staff conduct investigations of medical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration.

2. ~~The Senior Administrative Director/Quality and~~ Risk Management uses the Sentinel Event Process to investigate and document reportable incidents and prepares quarterly reports for the Safety Committee on those incidents determined to be reportable. ~~The Senior Administrative Director/Quality and~~ Risk Management is also responsible for completing all reports and handling other communications with medical equipment manufacturers and the FDA required by the Safe Medical Devices Act.

3. Appropriate changes in processes and training are made through the performance improvement process. The changes are communicated to all appropriate staff.

I. **Emergency Procedures**

1. The Chief of Biomed assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The head of each department that uses life support or other life-critical medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.
2. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.
3. Each department head maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.
4. Each department head reviews the department specific medical equipment emergency procedures annually.

J. **Testing of Medical Equipment Prior to Initial Use**

1. The Biomedical Department will test all medical equipment on the inventory before initial usage. Salinas Valley Memorial ~~Hospital~~ Healthcare System performs safety, operational, and functional checks. The inventory includes, equipment owned by the Salinas Valley Memorial ~~Hospital~~Healthcare System, leased, and rented from vendors. These inspection, testing and maintenance documents are maintained in the Biomedical Department for review. The Chief of Biomed manages the program of planned inspection and maintenance.

K. **Testing of High Risk and Non High Risk ~~Life Support~~ Equipment**

~~1.~~ The Chief of Biomed assures that scheduled testing of all ~~life support~~ medical equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EOC Committee each quarter. If the quarterly rate of completion falls below 100%, the Chief of Biomed will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing, and maintenance documents are maintained in the Biomedical Department for review.

~~L. **Testing of Non-Life Support Medical Equipment**~~

~~The Chief of Biomed assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EOC Committee each quarter. If the quarterly rate of completion falls below 90%, the Chief of Biomed will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing and~~

~~maintenance documents are maintained in the Biomedical Department for review.~~

1.

~~M.~~L. **Testing of Sterilizers**

1. The Plant Operations Department is responsible for testing and maintaining of all types of sterilizers used in Salinas Valley Memorial ~~Hospital~~Healthcare System. Records of load testing and regular maintenance are maintained by Plant Operations/Engineering Department. Any improper results are documented as patient safety incidents and reported to the EOC Committee for evaluation and action. Documentation of the testing and maintenance activities are maintaining in the Plant Operations/Engineering Department for review.

~~N.~~M. **Testing of Dialysis Equipment**

1. The Salinas Valley Dialysis Services ~~(Davita)~~ is responsible for performing equipment maintenance and chemical and biological testing of water used in hemodialysis at Salinas Valley Memorial ~~Hospital~~Healthcare System. The program of maintenance includes, regular cleaning and disinfection of all dialysis equipment, and testing for compliance with biological and chemical standards for the dialysis water supply. Documentation of the testing and maintenance activities is maintained in the Biomedical Department for review.

~~O.~~N. **Equipment Used in Oxygen-Enriched Atmospheres**

1. Equipment listed for use in oxygen-enriched atmospheres are clearly and permanently labeled (withstands cleaning/disinfecting) as follows:

    a. Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier.

    b. Oxygen-metering equipment and pressure reducing regulators are labeled "OXYGEN–USE NO OIL."

    c. Labels on flowmeters, pressure-reducing regulators, and oxygen-dispensing apparatuses designate the gases for which they are intended.

    d. Cylinders and containers are labeled in accordance with Compressed Gas Association (CGA) C-7.

~~P.~~O. **Maintenance of Anesthesia Apparatus**

1. The hospital performs equipment maintenance on anesthesia apparatus. The apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas flow and an oxygen analyzer is used to verify oxygen concentration. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables.

~~Q.~~P. Establishing Quality Control & Maintenance of Diagnostic Imaging Equipment

1. The Director of Radiology in collaboration with the Medical Physicist and the Chief of Biomed Engineering establish effective quality control measures and defined maintenance intervals that are consistent with manufacturer's recommendations and/or accreditation requirements to assure equipment functionality and quality of the following imaging equipment:
    a. CT (computed tomography)
    b. NM (nuclear medicine)
    c. Mammography
    d. Special Procedures
    e. General X-ray
    f. Alliance Imaging maintains PET (positron emission tomography) and MRI (magnetic resonance imaging) equipment – Service records and Physicist reports are provided to Bio-med and the Director of Imaging Services by Alliance Imaging.
    g. All ultrasound equipment is maintained and serviced by a qualified service engineer per manufacturer's guidelines and/or accreditation requirements. An annual medical physicist equipment check is not required.

~~R.~~Q. Monitoring Diagnostic Imaging Equipment Quality Performance

1. The organization assures that the quality of the diagnostic imaging modalities equipment performance is maintained. The Medical Physicist is responsible for these activities. The results of the quality program are reported to the Chief of the Biomedical Engineering department periodically and is reported up to the Environment of Care Committee (EOC) when appropriate.
2. At least annually, the Diagnostic Medical Physicist or MRI scientist evaluates performance for computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), magnetic resonance imaging (MRI), and x-ray equipment. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist or MRI scientist
3. This includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy.

~~S.~~R. Monitoring Radiation Dose from CT Equipment

1. At least annually, a qualified Medical physicist evaluates the radiation doses from diagnostic computed tomography (CT) services. This includes:

2. Measures the radiation dose (in the form of volume computed tomography dose index (CTDIvol) produced by each diagnostic CT imaging system. The radiation dose for following four CT protocols will be monitored:

    a. adult brain
    b. adult abdomen
    c. pediatric brain
    d. pediatric abdomen

3. If one or more of these protocols is not used by the (critical access) hospital, other commonly used CT protocols may be substituted.

4. Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. This applies only for systems capable of calculating and displaying radiation doses. The dates, results, and verifications of these measurements are documented.

5. Even though the Medical physicist is accountable for these activities, they may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. Physicist annual reports are located in Bio-med and Diagnostic Imaging.

~~T.~~S. **Evaluating performance of CT equipment**

1. At least annually, the Medical physicist evaluates the performance for all diagnostic computed tomography (CT) services. The evaluation results, along with recommendations for correcting any problems identified are documented and reported to the Director of Diagnostic Imaging.

2. The evaluation includes the use of phantoms to assess the following imaging metrics:

    a. image~~ing~~ uniformity

    b. ~~slice thickness~~scout precision accuracy

    ~~c. slice position accuracy (when prescribed from a scout image)~~

    ~~d.~~c. alignment light accuracy

    ~~e.~~d. table travel accuracy

    ~~f.~~e. radiation beam width

    ~~g.~~f. high~~-~~-contrast resolution

    ~~h.~~g. low~~-~~-contrast resolution

    ~~i.~~h. geometric or distance accuracy

    ~~j.~~i. CT number accuracy and uniformity

    ~~k.~~j. artifact evaluation

3. This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

4. Even though the Medical Physicist is accountable for these activities, they may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist.

~~U.~~T. **Evaluating performance of MRI imaging equipment**

1. At least annually, the Medical Physicist or Magnetic Resonance Imaging (MRI) Scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified are documented and reported to the Chief, Biomedical Engineering Department.

2. The evaluation includes the use of phantoms to assess the following imaging metrics:

   a. imaging uniformity

   b. signal to noise (SNR) for all coils used clinically

   c. slice thickness accuracy

   d. slice position accuracy

   e. alignment light accuracy

   f. high contrast resolution

   g. low contrast resolution (or contrast to noise ratio)

   h. geometric or distance accuracy

   i. geometric or distance accuracy

   j. magnetic field homogeneity

   k. artifact evaluation

~~V.~~U. **Evaluating performance of Nuclear Medicine imaging equipment**

1. At least annually, the Medical Physicist or Nuclear Medicine Physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified are documented and reported to the Chief of the Biomedical Department.

2. The evaluations are conducted for the entire image types produced clinically by each NM scanner (for example, planar and/or tomographic). This includes the use of phantoms to assess the following imaging metrics:

   a. imaging uniformity/system uniformity

   b. high contrast resolution/system spatial resolution

c. sensitivity

d. energy resolution

e. count rate performance

f. artifact evaluation

3. The tests for low contrast resolution or detectability for non-planar acquisitions may also be conducted, even though it is not required.

~~W.~~V. **Evaluating the performance of PET imaging equipment**

1. At least annually, the Diagnostic Medical Physicist evaluates the performance for all positron emission tomography (PET) imaging equipment. The evaluation results, along with recommendations for correcting any problems identified are documented and reported to the Chief, Biomedical Department.

2. The evaluations are conducted for all of the image types produced clinically by each PET scanner (for example, planar and/or tomographic). A phantom is used to assess the following imaging metrics:

   a. imaging uniformity/system uniformity

   b. high contrast resolution/system spatial resolution

   c. low contrast resolution or detectability (not applicable on planar acquisitions)

   d. artifact evaluation

3. The scanner tests for sensitivity, energy resolution, and count rate performance may also be conducted, even though it is not required. Even though the Diagnostic Medical Physicist is accountable for these activities, they may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the Diagnostic Medical Physicist

W. **Evaluating the performance of Fluoroscopy equipment**

1. At least annually, a diagnostic medical physicist conducts a performance evaluation of fluoroscopic imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes an assessment of the following:

   a. Beam alignment and collimation

   b. Tube potential/kilovolt peak (kV/kVp) accuracy

   c. Beam filtrations (half-layer value)

   d. high-contrast resolution

   e. low-contrast detectability

   f. maximum exposure rate in all imaging modes

g. displayed air-kerma rate and culmative-air kerma accuracy (when applicable)

~~3.~~2. Medical physicists conducting performance evaluations may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. This does not apply to fluoroscopy equipment used for therapeutic treatment planning or delivery.

X. **Evaluating the Management Plan**

~~1.~~ On an annual basis, the Biomedical Department and EOC Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage the medical equipment risks to the staff, visitors, and patients at Salinas Valley Memorial ~~Hospital~~Healthcare System.

1.

~~VIII. PERFORMANCE STANDARDS:~~

~~1. Percentage of Completion of scheduled Preventative maintenance and testing of clinical alarms on Biomedical Equipment (threshold >90%)~~

~~2. Number of Biomedical equipment user errors (Equipment Failure: User Education Needed/ Alarm-User Edu. Needed/ Alarm-User Error (threshold; 1.0 %, new)~~

~~3. Number of Biomedical equipment user abuse work orders (threshold: 1%)~~

~~4. Percentage completion of corrective maintenance work orders (85%)~~

~~IX.~~VIII. DOCUMENTATION:

A. N/A

~~X.~~IX. EVIDENCE-BASED REFERENCE:

A. N/A

ATTACHMENT A

Medical Equipment Risk-Based Analysis

Risk Category I: Equipment Function (E)

This category includes various areas in which therapeutic, diagnostic, analytical, and miscellaneous equipment are used.

Added expectations of leaders and notifications to affected departments	
EM #	Sub-Category
10	Life Support
9	Surgical and Intensive Care
8	Physical Therapy and Treatment
7	Surgical and Intensive Care Monitoring
6	Additional Physiological Monitor and Diagnostics
5	Analytical Laboratory
4	Laboratory Accessories
3	Computer and Related
2	Patient Related
1	Non-Patient Related

Risk Category II: Physical Risks / Clinical Application (A)

Lists the potential patient or equipment risk during use.

PHYSICAL RISK CATEGORY	
EM #	Sub-Category
5	Patient Death
4	Patient or Operator Injury
3	Inappropriate Therapy or Misdiagnosis
2	Minimal Impact or Risk
1	No Significant Risk

Risk Category III: Preventive Maintenance (P)

Describes the level and frequency of PM required.

MAINTENANCE REQUIREMENTS CATEGORY	
EM #	Sub-Category
5	Extensive
4	Above Average
3	Average
2	Below Average
1	Minimal

Risk Category IV: Likelihood of Equipment Failure (F)

Documents the anticipated mean time-between-failure rate, based upon equipment service and incident history. User determined.

LIKELIHOOD OF FAILURE CATEGORY	
EM #	Sub-Category
5	Less Than Three Months
4	Approximately Six Months
3	Approximately One Year

2	Approximately Three Years
1	Greater Than Five Years
0	N/A

Risk Category V: Environmental Use (U)

Lists the primary equipment use area.

ENVIRONMENTAL FUNCTION CATEGORY	
EM #	Sub-Category
5	Anesthetizing Locations
4	Critical Care Locations
3	Wet Locations
2	General Care Areas
1	Non-Patient Areas
0	N/A

Points Formula

Each risk category includes specific sub-categories that are assigned points, which when added together according to the formula listed below, yield a total score. If the total score is equal to or greater than the threshold of between 8 and 20, it should be included in the hospital management program and added to the clinical equipment inventory. If the score is between 4 and 7, the equipment is maintained as recommended by manufacturer but is not included in inventory for scheduled PM'S. Equipment scoring below a score of 4 (1-3) is not included in the scheduled PM'S inventory and is maintained as required.

EM # in all tables denotes Equipment Management numbers derived from recognized standards.

The formula used to calculate the total number of points to establish preventive maintenance inclusion into the medical equipment inventory for scheduled PM'S is:

Preventive Maintenance (PM) = E + A + [(P+F+U) /3]

Determining Suggested Maintenance Frequency

Normally, if Risk Category III: Preventive Maintenance, is a score of four (Above Average) or five (Extensive), this suggests performing preventive maintenance on the affected equipment every six months or less. If the score is one (Minimal), two (Below Average), or three (Average), this suggests performing preventive maintenance on affected equipment every twelve months or less.

An exception to this recommendation involves the overall PM score. If, after using the formula, the overall score is Fourteen or greater, then the suggested frequency for performing preventive maintenance is every six months or less, even if the Category III value is less than four (Above Average). The following table depicts minimum preventive maintenance frequencies utilized at SVMH and PM scores for inclusion into inventory of Scheduled PM'S based on industry standards, manufacturers recommendations, risks levels, current hospital experienced and those pieces of equipment PM'S that will benefit from scheduled activities to minimize clinical and physical risks:

PM INCLUSION / SCHEDULE CRITERIA	
PM SCORE	PM SCHEDULE
20	Quarterly
14-19	Semi-Annually

11-13	Annual
Added expectations of leaders and notifications to affected departments	Added expectations of leaders and notifications to affected departments
4-7	N/A (Maintenance is Performed but not included in scheduled PM'S)
1-3	N/A

~~Emerging Infectious Diseases~~

Infection Prevention Pandemic Plan

Emerging Infectious Diseases
2021

Table of Contents

I. SCOPE....4

II. OBJECTIVES/GOALS....4

III. DEFINITIONS....4

IV. PLAN MANAGEMENT....5

V. REFERENCES....7

I. SCOPE

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

B. The intent of this document is to provide guidelines for how Salinas Valley Memorial Hospital SVMH, under Salinas Valley Memorial Healthcare System (SVMHS) will respond to the event and to ensure, to the greatest extent possible, the health and safety of the organization's patient population, volunteers, employees, and providers.

C. Emerging Infectious Disease events will be managed in concert with activation of the SVMH EMERGENCY OPERATIONS PLAN (EOP).

II. OBJECTIVES/GOALS

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

A. **Objectives**

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

B. **Goals**

1. The goals for the Emerging Infectious Diseases, Infection Prevention Pandemic Plan are developed from information gathered during routine and special risk assessment activities, alerts from Monterey County Public Health Department (MCPHD), California department of Public Health (CDPH), Centers for Disease Control (CDC) and World Health Organization (WHO), annual evaluation of the previous year's program activities, the goals for this plan are:
    a. ~~The Facility~~SVMH will follow guidelines and ~~,~~ comply with all ~~regulations and reporting~~ ~~and~~ reporting requirements issued by the CDC, CMS, State and Local Departments of Health.

III. DEFINITIONS

A. **Infectious disease** - whose incidence in humans has increased in the past two decades or threatens to increase in the near future. These diseases, which respect no national boundaries, include:
   1. New infections resulting from changes or evolution of existing organisms.
   2. Known infections spreading to new geographic areas or populations.
   3. Previously unrecognized infections appearing in areas undergoing ecologic transformation.
   4. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

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

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

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

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. Ability of SVMH's~~S~~ management of known or unknown infectious diseases may be defined by the impact to the facility such as resources, staffing, and influx of patients. SVMH~~S~~ response would be in collaboration with ~~of~~ local, state and federal guidelines and requirements.

2. The plan covers the following currently known infections, examples of Emerging Infectious Diseases are:
   a. Influenza or new novel virus
   b. Zika,
   c. Ebola,
   d. COVID-19,
   e. Dengue Fever,
   f. Typhoid Fever,
   g. West Nile,
   h. Vaccine preventable diseases such as Measles, Diphtheria, Pertussis, Polio, etc.
   i. Other diseases that may emerge that are currently unknown.

B. **Plan Management ~~(diseases)~~**

1. SVMH~~S~~ will utilize emerging and/or current guidelines from local county, state and federal bodies MCPHD, CDPH, California OSHA, CDC and WHO for implementation and management of an infectious disease in our community.

2. Methods for temporary negative pressure isolation and related infrastructure support.

   ~~The~~a. The SVMH E~~e~~ngineering ~~team~~Department will:

   i. ~~ensure~~ensure that state and local legal requirements as well as air exchange rates are met.

   ~~.~~ii. ~~The engineering team will~~ refer to the guideline for creating temporary enhanced filtered environments for patient care as needed. https://www.health.state.mn.us/communities/ep/surge/infectious/airbornenegative.pdf

C. **Plan Responsibility**

1. The Emergency ~~Preparedness~~Management Committee ~~and/or Infection Prevention Committee~~is responsible to oversee this Plan.

2. ~~On the approval of changes by both committees; the chair persons of the committees above are empowered by~~ By approval of this Plan the SVMHS ~~the~~ Board of Directors has authorized the Chairperson of the Emergency Management Committee to make necessary updates / changes to this document, without prior approval, to support ongoing emergency response prior to ~~the next~~each review cycle.

D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of this Plan. Performance measures have been established to measure at least one important aspect of this Plan.

2. On an annual basis, the Emergency Management Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage risks to the staff, visitors, and patients at Salinas Valley Memorial Hospital.

E. **Orientation and Education**

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

V. REFERENCES

A. Centers for Disease Control (CDC). https://www.cdc.gov/
B. California Department of Public Health (CDPH). https://www.cdph.ca.gov/
C. California Occupational Safety and Health (CalOSHA). https://www.dir.ca.gov/dosh/
D. World Health Organization (WHO). HTTPS://WWW.WHO.INT/
E. Monterey County Public Health Department, Communicable Disease Unit. https://www.co.monterey.ca.us/government/departments-a-h/health/public-health/communicable-disease-unit
~~E.~~F. **AIRBORNE INFECTIOUS DISEASE MANAGEMENT. METHODS FOR TEMPORARY NEGATIVE PRESSURE ISOLATION.** https://www.health.state.mn.us/communities/ep/surge/infectious/airbornenegative.pdf

Salinas Valley Memorial Healthcare System

CARE OF PATIENT, CONTINUOUS SUBCUTANEOUS INSULIN PUMP

Reference Number	946
Effective Date	Not Approved Yet
Applies To	ALL NURSING UNITS, OUTPATIENT NURSING UNITS
Attachments/Forms	~~Attachment A: Hospitalized Patient Responsibilities While Wearing An InsulinA CSII - Pump~~ Attachment A~~B~~: Libre Pro Sensor

I. POLICY STATEMENT:

A/ N/A

~~As part of an initial patient admission assessment, nurses should ask all diabetic patients if they are using an insulin pump for management of their diabetes.~~

~~If the patient is using an insulin pump, the nurse conducting the initial patient assessment must confirm that the admitting physician is aware.~~

~~Patients may continue their insulin therapy using an insulin CSII pump during hospitalization with a physician order and the patient demonstratinges knowledge of safe self-administration of insulin.~~

~~The patient may be an appropriate candidate if he or she is alert, physically capable, able to properly work the pump functions, and willing to manage the pump during hospitalization.~~

~~Contraindications to self-management of the pump during hospitalization may include:~~

~~Altered state of consciousness, including prescribed medications that could alter consciousness~~
~~Lack of orientation to person, place, and time~~
~~Any physical, cognitive, or behavioral problem that could preclude self-management~~
~~Presence of diabetic ketoacidosis (DKA) or hyperosmolar hyperglycemia~~
~~Any condition that warrants IV administration of insulin~~
~~Critical illness~~
~~Suicidal ideation~~
~~The patient is unwilling or unable to provide essential information about the pump and insulin doses~~
~~The patient is unwilling to sign an agreement that delineates self-management responsibilities.~~
~~a. The patient cannot provide needed pump supplies during hospitalization.~~

~~An Endocrinologist consult will be ordered for all patients admitted with an insulin pumpthat will continue using their insulinCSII pump during hospitalization. , However, if an Endocrinologist is not immediately available this will not preclude the patient from using their pump so long as all assessment criteria are met and an order is received from the attending physician or designee.~~

CARE OF PATIENT, CONTINUOUS SUBCUTANEOUS INSULIN PUMP

1. Order sets for insulin pump will be used when prescribing patient self-management of insulin via the patient's insulin pump. .

The insulin pump should be discontinued and alternative insulin orders should be obtained for patients who exhibit the following:

Patient management of the insulinCSII pump will be suspended by physician order if continued insulinCSII pump use presents a threat to the health and safety of patient and/or if the patient is incapacitated.

The patient exhibits any of the contraindications listed above during ongoing assessment of the patient.

The insulin pump malfunctions and cannot be remedied within one (1) hour.

The insulin pump is temporarily halted for longer than one (1) hour

The patient has had two consecutive blood glucose values greater than 240 mg/dl that have not been reduced by the following interventions:

Change of insertion site or tubing

Adjustment with insulin administration dosing by the physician

a. Changes in insulin pump setting as ordered by the physicianCh
b. Alternative insulin therapy is provided per physician order whenever the pump is suspended or discontinued for more than one (1) hour
c. A patient presenting with DKA will have their CSII pump discontinued, unless physician orders otherwise.

When an insulin pump is discontinued, the insulin pump should be labeled with patient identification and should be sent home with a responsible family member.

If insulin pump is discontinued, suspended or turned off the registered nurse assists the patient to discontinue insulin therapy. If the patient is unable to discontinue own insulin therapy the registered nurse discontinues the insulin pump.

If unable to send the discontinued insulin pump home, the labeled insulin pump should be sent to pharmacy for storing until patient's discharge or when able to re-start.

Any decision to reinstate the insulin pump should be based on the same admission assessment criteria.

Location of the discontinued insulin pump should be documented in the electronic medical record.

The registered nurse is present when the patient performs the following:

A. Daily Quality Control (QC) of their own glucometer prior to checking their morning's blood glucose

1. When self-monitoring of blood glucose (SMBG) using own glucometer

2. When the patient administers insulin boluses via their insulinCSII pump

3. For insulin pump refills

B. For changes of the insulin pump's s insertion site when unexplained hyperglycemia occurs consecutively (BG > 240 x 2)Insulin provided by the patient in an open container or an unlabeled reservoir /cartridge is not recommended for use in the hospital since the integrity of the medication cannot be validated. The physician will determine whether or not the insulin reservoir will need to be replaced, and if the insulin will be changed the physician must communicate the rationale to the patient. The hospital will provide the insulin indicated by the physician order.

1. Patient's own insulin vial is labeled with patient identification and should be sent to pharmacy for storage, and not kept at their bedside. Full insulin reservoirs/cartridges are sent home.

C. When a patient converts to NPO status, a finger stick blood glucose will be checked every one hour until frequency of finger-stick blood glucose is clarified with physician order.

D. Surgical or sedated patients will have a finger stick blood glucose/ testing done pre-operatively and then hourly during the surgical procedure and recovery period to evaluate glycemic status while the patient is in an altered state of consciousness.

E. Patient may not use their own blood glucose meter. if performed quality control passed. If failed, then Only the hospital blood glucose meter will be is used.

F. If CSII pump is discontinued, suspended or turned off the registered nurse assists the patient to discontinue CSII therapy. If the patient is unable to discontinue own CSII therapy the registered nurse discontinues the CSII pump according to manufacturer's guidelines.

Patients admitted with an insulin pump that has a continuous glucose monitor, sensor, either within the pump itself or out, will require /perform independent glucose measurement / calibration via a fingerstick blood glucose at a minimum of every twelve (Q12) hours (– Sensor Glucose and Blood Glucose).

The patient will need to should sign an agreement delineating the patient responsibilities and clarifying the conditions that may lead to insulin pump discontinuation (Attachment A- Insulin Pump Agreement).

II. PURPOSE:

A. To guide the registered nurse in assisting the diabetic patient in management of their own insulin regimen via continuous subcutaneous insulin infusion (CSII "insulin pump therapy") pump.

III. **DEFINITIONS:**

A. **CSII pump**: Continuous Subcutaneous Insulin Infusion pump is a~~A~~ computerized device programmed to deliver basal insulin and carb [meal] or correction boluses. Rapid acting insulin is delivered from a reservoir through a plastic catheter inserted into subcutaneous tissue.

B. **Basal Rate**: Continuous infusions of insulin programmed keep the blood glucose stable between meals and during the night. This is the amount of insulin the patient requires to maintain a normal metabolic state *when fasting*. To maintain good glucose control the patient may have several different basal profiles to meet the patient's specific needs

C. **Insulin to Carbohydrate Ratio**: The amount of insulin required to cover a given number of carbohydrates. This ratio is used to determine how much insulin is needed to cover the amount of carbohydrate the patient is going to eat for a particular meal. For example: insulin to carbohydrate ratio of 1-15 means that one unit of insulin covers 15 grams of carbohydrate

D. **Nutritional~~Meal~~ Bolus**: The amount of insulin to cover meals (carbs) or correction (hyperglycemia). The patient adjusts this dose based on blood glucose reading and planned food intake

E. **Correction Bolus**: The amount of insulin required to correct a pre-meal glucose result. An adjustment to the insulin to carbohydrate ratio bolus is made. The patient will add or subtract insulin from meal bolus based on how much one (1) unit of insulin might be expected to decrease the blood glucose level.

F. **Sensitivity~~e~~ Factor:** Factor (or number) that represents just how sensitive the patient's body is to insulin: how many milligrams per deciliter one (1) unit of insulin will lower blood glucose

G. **Total Daily Insulin Dose:** The total amount of insulin from both basal rate(s) and bolus doses that the patient has taken via insulin pump in the last 24 hours.

H. **Finger Stick:** Blood glucose test performed by piercing the finger to draw blood that's applied to a test strip

I. **Self-Monitoring of Blood Glucose (SMBG):** patient performs self-finger-stick for measurement of current glucose level

J. **DKA:** Diabetic ketoacidosis

K. **Continuous glucose monitor (CGM), sensor**: is a device that does not directly measure the concentration of glucose but instead uses a sensor that's placed under the skin to measure the concentration of glucose in the interstitial fluid. The sensor can be within the insulin pump or as a stand-alone device which displays the glucose reading

and can also sound an alarm if the levels are out of range of the preset levels. It is~~'s~~ used as a guideline and must be calibrated periodically with a finger stick to ensure~~increase~~ accuracy.

IV. GENERAL INFORMATION:

A. As part of an initial patient admission assessment, nurses should ask all diabetic patients if they are using an insulin pump for management of their diabetes.

1. If the patient is using an insulin pump, the nurse conducting the initial patient assessment must confirm that the admitting physician is aware.

B. Patients may continue their insulin therapy using an insulin pump during hospitalization with a physician order and the patient demonstrating knowledge of safe self-administration of insulin.

1. The patient may be an appropriate candidate if he or she is alert, physically capable, able to properly work the pump functions, and willing to manage the pump during hospitalization.

2. Contraindications to self-management of the pump during hospitalization may include:

a. Altered state of consciousness, including prescribed medications that could alter consciousness
b. Lack of orientation to person, place, and time
c. Any physical, cognitive, or behavioral problem that could preclude self-management
d. Presence of diabetic ketoacidosis (DKA) or hyperosmolar hyperglycemia
e. Any condition that warrants IV administration of insulin
f. Critical illness
g. Suicidal ideation
h. The patient is unwilling or unable to provide essential information about the pump and insulin doses
i. The patient is unwilling to sign an agreement that delineates self-management responsibilities.
j. The patient cannot provide needed pump supplies during hospitalization.

C. An Endocrinologist consult will be ordered for all patients admitted with an insulin pump. However, if an Endocrinologist is not immediately available this will not preclude the patient from using their pump so long as all assessment criteria are met and an order is received from the attending physician or designee.

1. Order sets for insulin pump will be used when prescribing patient self-management of insulin via the patient's insulin pump.

D. The insulin pump should be discontinued and alternative insulin orders should be obtained for patients who exhibit the following:

1. Patient management of the insulin pump will be suspended by physician order if continued insulin pump use presents a threat to the health and safety of patient and/or if the patient is incapacitated.
2. The patient exhibits any of the contraindications listed above during ongoing assessment of the patient.
3. The insulin pump malfunctions and cannot be remedied within one (1) hour.
4. The insulin pump is temporarily halted for longer than one (1) hour
5. The patient has had two consecutive blood glucose values greater than 240 mg/dl that have not been reduced by the following interventions:

a. Change of insertion site or tubing
b. Adjustment with insulin administration dosing by the physician
c. Changes in insulin pump setting as ordered by the physician

E. When an insulin pump is discontinued, the insulin pump should be labeled with patient identification and should be sent home with a responsible family member.

1. If insulin pump is discontinued, suspended or turned off the registered nurse assists the patient to discontinue insulin therapy. If the patient is unable to discontinue own insulin therapy the registered nurse discontinues the insulin pump.
2. If unable to send the discontinued insulin pump home, the labeled insulin pump should be sent to pharmacy for storing until patient's discharge or when able to re-start.

a. Any decision to reinstate the insulin pump should be based on the same admission assessment criteria.

3. Location of the discontinued insulin pump should be documented in the electronic medical record.

F. Insulin provided by the patient in an open container or an unlabeled reservoir /cartridge is not recommended for use in the hospital since the integrity of the medication cannot be validated. The hospital will provide the insulin indicated by the physician order.

1. Patient's own insulin vial is labeled with patient identification and should be sent to pharmacy for storage, and not kept at their bedside. Full insulin reservoirs/cartridges are sent home.

G. When a patient converts to NPO status, a finger stick blood glucose will be checked every one hour until frequency of finger-stick blood glucose is clarified with physician order.

H. Surgical or sedated patients will have a finger stick blood glucose/ testing done pre-operatively and then hourly during the surgical procedure and recovery period to evaluate glycemic status while the patient is in an altered state of consciousness.

I. Patient may not use their own blood glucose meter. Only the hospital blood glucose meter will be used.

J. Patients admitted with an insulin pump that has a continuous glucose monitor, sensor, either within the pump itself or out, will require /perform independent glucose measurement / calibration via a fingerstick blood glucose at a minimum of every twelve (12) hours (Attachment A – Sensor Glucose and Blood Glucose).

~~A.~~K. The patient will need to sign an agreement delineating the patient responsibilities and clarifying the conditions that may lead to insulin pump discontinuation (Insulin Pump Agreement).

V. PROCEDURE:

A. On admission

~~4.~~1. Assess at a minimum the presence of an insulin~~CSII~~ pump, brand of the insulin~~CSII~~ pump and the type and name of insulin.

~~5.~~2. Obtain pump-prescribing physician, contact person phone number of primary care center managing insulin~~CSII~~ pump.

~~6.~~ Notify admitting physician and obtain an order to initiate the insulin pump order set~~for continuous use of CSII pump infusion from the physician managing the CSII pump~~. ~~Refer to Orders to include:~~

~~7. May use own~~

~~8. Insulin pump~~

~~9. Glucose meter~~

~~10. Insulin type and concentration~~

~~11. Basal rate~~

~~12. Insulin sensitivity factor~~

~~13. Carbohydrate ratio~~

~~14. Meals and correction bolus~~

~~15. Target glucose range~~

~~16. Frequency of self-monitoring blood glucose (SMBG)~~

~~17. Patient may keep pump supplies at bedside~~

3. ~~Treatment of hypoglycemia otherwise follows~~ TREATMENT OF HYPOGLYCEMIC REACTIONS~~-~~TREATMENT OF HYPOGLYCEMIC REACTIONS

4. Ensure consultation order for endocrinologist is entered if admitting physician is not an endocrinologist.

   ~~Ensure consultation order for diabetic educator is entered.~~

5. Ensure consultation for dietitian assessment.

~~1.~~6. The nurse will provide diabetic education.

~~18.~~7. Notify Pharmacy of patient's admission.

   a. Pharmacist verifies ~~available new/unopened insulin vial brought in by the patient for use in the insulin pump is~~what the physician has ordered for insulin use in the hospital. Refer to MEDICATION USE.~~, CMP #272~~
   b. Pharmacist provides correct medication (insulin) labeling for placement on infusion set (tubing).

   Note: Due to the nature of insulin delivery by an insulin pump; it is not possible to label the reservoir / cartridge or identify type of insulin currently infusing at time of admission. The registered nurse will document~~ make note~~ in the medical record that patient stated type of insulin currently infusing via insulin pump.

~~19.~~8. Assess the patient's ability to continue self-management of his/her insulin~~CSII~~ pump, including cognitive abilities, orientation (to person, place), and cooperation.

~~20.~~9. Review with and have~~give~~ patient sign the "Insulin Pump Agreement~~Hospitalized Patient Responsibilities While Wearing a CSII – Pump~~" sheet (Attachment A)~~. See Appendix 'A".~~

~~21.~~10. Have patient demonstrate and/or explain the following:

   a. Basal Rate setting and the most recent bolus history
   b. His/her blood glucose target
   c. How often he/she does ~~SMBG~~blood glucose monitoring
   d. When the last ~~SMBG~~ blood glucose test was done and the results
   e. How often he/she experience blood glucose above or below target
   f. How he/she corrects the blood glucose to maintain target

~~22.~~11. Confirm that the patient has adequate insulin~~CSII~~ pump supplies. Assist patient in arranging for supplies to be brought from home.

a. ~~Insulin~~Empty insulin pump reservoir / cartridge
b. Infusion set / tubing
c. Infusion set dressing plus skin prep products
~~c.~~d. Extra batteries

~~B. Notify Diabetic Educator of admission of patient with an CSII pump~~

~~C.~~B. Routine Care

1. Assess the infusion site and insulin~~CSII~~ pump settings minimally every shift:

   a. Check infusion site on admission, every shift, and prn.
   b. Infusion site is changed every three (3) days or prn by the patient with nurse assistance/observation. Signs that an infusion set and site needs to be changed more frequently than every three days may include:
   c. Site is itching, red, swollen, or warm to the touch
   d. Bleeding and/or discomfort noted at the site
   e. When unexplained hyperglycemia occurs consecutively (BG > 240 mg/dL x2)
   f. Any delivery alarm alerts.

2. Document the ongoing patient treatment/assessment in the electronic medical record (EMR).

   a. On the Medication Administration Record (MAR): Initiation of the infusion and any insulin~~CSII~~ pump refills
   ~~b. On the Patient Management Ability Screen:~~
   ~~c. On admission: patient's ability (competency) to self-manage CSII pump~~
   ~~d.~~b. On the "Insulin Pump" Screen: on admission and minimally every shift~~daily~~
      - Site Assessment
      - Patient Management Ability (competency to self-manage insulin pump)
      - Pump Infusion (settings)

3. The registered nurse is present when the patient performs the following:

   a. ~~Daily Quality Control (QC) of their own glucometer prior to checking their morning's blood glucose~~When self-monitoring of blood glucose (SMBG) using hospital's ~~own~~ glucometer
   b. When the patient administers insulin boluses via their insulin pump
   c. For insulin pump refills
   d. For changes of the insulin pump's insertion site when unexplained hyperglycemia occurs consecutively (BG > 240 x 2)

e. Temporary disconnection from insulin pump for any reason and storage of insulin pump is noted in the patient care note. Patient disconnects insulin pump with nurse assistance/observation.
f. Patients may be allowed to disconnect their insulin pumps temporarily (under one (1) hour) to shower or bath.

4. Prior to discharge with an insulin pump, the registered nurse will confirm that the patient knows how to fully use the insulin pump and the importance of regular follow-up with the physician managing their pump. Referral to SVMC Diabetes Center or their designated primary care center as ordered by the discharging physician.

~~D. Insulin Basal Rate (units/hour)~~

~~E. Insulin pre-meal and correction (hyperglycemic) bolus doses for each meal and correction (bolus)~~

~~F. Total Daily Dose: Basal, plus pre-meal and correction boluses~~

~~G. Site Assessment to include infusion site condition and location~~

~~H. Site changes, with new location when applicable.~~

~~I. Supervision by nurse to include:~~

~~J. QC of own meter~~

~~K. Performance of blood glucose (BG) using Patient's own meter~~

~~L. Administering pre-meal and correction bolus~~

~~M. Pump refills~~

~~N. Pump insertion site changes~~

~~O. Temporary disconnection from CSII pump for any reason and storage of CSII pump is noted in the patient care note. Patient disconnects CSII pump with nurse assistances.~~

~~P.~~C. Physician notification

1. Notify the **physician managing the insulin~~CSII~~ pump when:**

a. Patient condition changes that may necessitate discontinuation of the insulin~~CSII~~ pump or any presence of contraindications.
b. When orders are needed to c~~C~~onvert~~ing~~ from an insulin ~~CSII~~ pump to other routes of insulin therapy, (i.e. IV insulin infusion or subcutaneous insulin). The changeover must occur simultaneously in order to avoid hyperglycemia.
c. Patient converts to NPO status
d. BG > 240 mg/dL or as ordered.
e. BG < 70 mg/dL or as ordered.

CARE OF PATIENT, CONTINUOUS SUBCUTANEOUS INSULIN PUMP

Q.D. Patient requiring MRI, CT, X-Ray, or any DI procedure

1. The insulinCSII pump is temporarily disconnected by the patient with nurse assistance/observation prior to the procedure. Document the time insulin CSII pump is removed/ disconnected from the patient and where the insulinCSII pump will be stored.
2. The infusion set is not removed and remains in the patient's subcutaneous insertion site (ensure that the infusion set is covered with appropriate cap or sterile dressing). Once the procedure is completed, the insulinCSII pump is resumed per physician order
3. Additional finger sticks blood glucose / testing and insulin replacement will be necessary if insulinCSII pump is disconnected for greater than one (1) hour.
4. If pump will be disconnected for greater than one (1) hour obtain physician orders for insulin coverage, i.e., subcutaneous or IV.

   NOTE: It is not safe to expose the pump to radiation or magnetic resonance imaging. Radiation could disrupt the programming and memory of the pump whereas MRI's could not only disrupt the memory but depending in the magnetic force could literally tear apart the mechanical parts of the pump. DO NOT allow insulin pump in direct line of x-rays.

R.E. Discontinuation or disconnection of insulinCSII pump

1. The registered nurse assists/observest's the patient withto discontinuinge or disconnecting of the insulin pump, and places the insulinCSII pump in suspend mode.
2. The tubing is **never clamped** when discontinuing or disconnecting the insulinCSII pump;
   a. Remove the subcutaneous needle and tubing from the patient
   b. Suspend the insulinCSII pump according to manufacturer's guidelines and . cCall the customer support800 number on the back of the insulinCSII pump for direction on how to suspend the insulin CSII pump, if needed.
3. Note: **DO NOT** discontinue insulin pump without receiving further orders for continued insulin therapy.
4. In an **emergency** where patient is incapacitated:
   a. First: Discontinue the insulinCSII pump at insertion site by removing the subcutaneous needle/cannula.

b. Second: Suspend the insulin~~CSII~~ pump. Call the customer support~~800~~ number on the back of the insulin~~CSII~~ pump for direction on how to suspend the insulin~~CSII~~ pump, if needed.
c. DO NOT remove the batteries; which could turn off the insulin~~CSII~~ pump. Removal of the batteries may cause loss of infusion memory.

~~S.~~F. Documentation: Documentation is completed in the electronic medical record as stated above.

VI. EDUCATION/TRAINING:

A. Education and/or training is provided as needed

~~VII.~~ REFERENCES:

~~VIII.~~VII. ~~**The Paradigm Insulin Pump Therapy Workbook, Medtronic, 2/02**~~

A. American Diabetes Association. (2016). Standards of medical care in diabetes. *Diabetes Care*, *39*, S1-S112.

B. Medtronic. (2016). *Getting started with continuous glucose monitoring*. Northridge, CA: Medtronic Diabetes.

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C. ~~Hughes. L. (2002), Flexibility in Pump Therapy. *Nursing Spectrum*. Retrieved from http://community.nursingspectrum.com/MagazineArticles/article.cfm?ADI=5867~~Institute for Safe Medication Practices. (2016). Managing hospitalized patients with ambulatory pumps: Part 2 – Guidelines for the use of insulin pumps during hospitalization.

~~B. Institute for Safe Medication Practices. (2015). Managing hospitalized patients with ambulatory pumps: Findings from an ISMP survey part 1.~~

~~C. Bolderman, Karen M. Rd, LD, DCE, (2002) Putting You Patients On The Pump, ADA~~

~~D. American Diabetes Association, (2002). Smart Pumping for people with diabetes. Wolpert, H. MD, Editor~~

~~E. Professional Practice Recommendations for Safe Use of Insulin in Hospitals, American Society of Health-System Pharmacists, 2004~~

~~F. Walsh, J. & Roberts, R. (2006). *Pumping Insulin, 4th Edition*. San Diego: Torrey Pines Press.~~

~~G. AADE (2010), The Art and Science of Diabetes Self-Management Education Desk Reference, 2n Edition, 2011, Chicago Illinois~~

~~ATTACHMENT A~~

~~AGREEMENT FOR PATIENT'S SELF-MANAGEMENT OF INSULIN PUMP~~

~~For your safety and optimal medical care during your hospitalization, Salinas Valley Memorial Hospital (SVMH) requests that you agree to the following recommendations if you would like to continue use of your insulin pump. If you feel that you cannot agree to these recommendations, your insulin pump will need to be discontinued and SVMH would treat your diabetes with alternative methods of insulin therapy as ordered by your attending physician. This could be insulin injections or insulin administered intravenously (IV).~~

~~During my hospitalization I agree to:~~

1. ~~Provide all necessary supplies for my insulin pump, including a minimum of one (1) of each; reservoir/cartridge, infusion set/pod and batteries (tape if applicable) for all expected site changes.~~
    a. ~~Supplies will be kept at the bedside~~
    b. ~~SVMH will supply the insulin for the reservoir/cartridge. Any insulin that I brought in will be sent home with family/friends or sent to the pharmacy with my identification on it and I will receive it at discharge to take back home.~~
2. ~~Maintain my insulin pump settings according to the physician order and will only change my settings when ordered by the physician and in the presence of the registered nurse (RN).~~
3. ~~Bolus according to physician orders only and have the RN verify and observe all nutritional boluses and correction boluses given.~~
4. ~~Verify basal setting with the RN at least once per shift.~~
5. ~~Change the infusion set/pod every 72 hours during hospitalization and as needed for any skin problems or other blood glucose management problems that may occur.~~
6. ~~Report abnormal blood glucose readings (low or high) or symptoms of low blood sugar to the RN.~~
7. ~~Report signs of insulin pump problems such as ALL alarms or alerts to the RN.~~
8. ~~Utilize the hospital's blood glucose meter for all treatment and monitoring. I will not use my personal meter or continuous glucose monitoring system.~~
9. ~~I agree to disconnect the insulin pump for ALL radiology procedures to prevent malfunction of the insulin pump.~~
10. ~~I understand that my insulin pump may need to be discontinued and insulin therapy given to me in a different way for any of the following reasons:~~
    a. ~~I am going to have a procedure that will be one (1) hour or greater~~
    b. ~~There is a change in my level of awareness or clinical condition that will not allow me to take care of my insulin pump.~~
    c. ~~Other reasons deemed necessary by my physician.~~

~~My signature below indicates that:~~

1. ~~I have read and understood the information provided in this form~~
2. ~~I have had the chance to ask and have questions answered~~
3. ~~I agree to the guidelines set forth by SVMH~~
4. ~~I accept full responsibility for the proper maintenance and function of my diabetes equipment~~

ATTACHMENT AB~~B~~
Libre Pro Sensor

Usage:

Worn on the back of the patients' upper arm and continually measures and stores blood sugar levels for up to 14 days. The glucose sensor measures glucose in the fluid surrounding the cells in the interstitial fluid. Because of how glucose moves between blood and interstitial fluid, the BG (blood glucose) readings and sensor glucose readings will be close, but will rarely match exactly. This difference is normal and should be expected.

This sensor is water resistant up to 3 feet for a duration of 30 minutes.

Medical procedures:

Sensor **MUST** be removed prior to MRI, CT Scan or a diathermy treatment.

To Remove:

Pull up the edge of the adhesive that attaches the sensor to the skin and slowly peel away in one motion. (Any remaining residue on the skin can be removed with warm water or isopropyl alcohol).

Post Procedure:

Patient will replace with new adhesive (they should have received instructions from their physician).

Salinas Valley Memorial Healthcare System

SAFETY-NEWBORN CLINICAL PROCEDURE

Reference Number	317
Effective Date	Not Approved Yet
Applies To	L & D, Mother/Baby, NICU
Attachments/Forms	

I. POLICY STATEMENT:

A. N/A~~Staff will be aware of preventive measures utilized in providing a safe environment for infants in the LD Unit, Mother/Baby Unit, Well-Baby Nursery, and NICU. It is the responsibility of all staff members assigned to work in these units to implement these measures as part of their duties.~~

II. PURPOSE:

A. To guide staff in providing a safe environment for care of the newborn infant while hospitalized.

III. DEFINITIONS:

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

IV. GENERAL INFORMATION:

A. ~~N/~~Staff will be aware of preventive measures utilized in providing a safe environment for infants in the LD Unit, Mother/Baby Unit, Well-Baby Nursery, and NICU. It is the responsibility of all staff members assigned to work in these units to implement these measures as part of their duties.

~~A~~

V. PROCEDURE:

A. Standard Precautions

B. Utilize equipment and supplies specific for the newborn

C. Bottles should never to be propped.

D. Place infants in a supine position, “back-to-sleep”, for sleeping.

1. Infants in the NICU on monitors with alarms set may be placed in other positions for comfort or as necessitated by their individual conditions.

E. Radiant warmers (free standing and intensive care beds).

1. Infants under radiant warmers should have the temperature probe attached. Radiant warmers will be set to servo control.
2. Temperature probe alarms should be checked immediately by staff and adjusted accordingly.

F. Infants on intensive care beds or isolettes:

1. Sidewalls should remain upright and locked except during procedures or feedings with staff at beside.
2. Isolette doors should be closed with latch in place and ports should remain closed except during procedures or feedings with staff at bedside.

G. Infants on monitors in the NICU should have alarm limits set at all times MEDICAL DEVICE ALARM SAFETY AND MANAGEMENT POLICY. Infants connected to monitors should be observed to prevent entanglement of extremities and other body parts with the connected wires.

H. Transporting Newborn:

1. Infants should be transported via crib or stabilet between the LD Unit, Mother/Baby Unit and Well-Baby Nursery.
2. Instruct parents/guardians/family/visitors that infants should not be carried in the arms outside of the mother's room.
3. Bassinet should be positioned flat in crib frame and only one (1) crib transported at a time.

I. Transport off the LD Unit, Mother/Baby Unit, Well-Baby Nursery or NICU:

1. Refer to INTRAFACILITY TRANSPORT - NEWBORN CLINICAL PROCEDURE

J. Infants should never be left unattended.

K. Observe and/or question visitors, strangers, or staff from other units who should not be in the LD Unit, Mother/Baby Unit, Well-Baby Nursery or NICU. IDENTIFICATION, SECURITY AND PREVENTION OF ABDUCTION - NEONATES

L. Resuscitation equipment should be checked with each shift. Crash carts should be checked daily.

M. Staff should follow appropriate resuscitation procedures according to neonatal resuscitation guidelines. Refer to NEWBORN RESUSCITATION

N. All sharp objects should be placed in the sharps containers immediately after use. Sharp objects should never be left in/at the bedside. When possible, needleless equipment or protected sharps should be used.

VI. **EDUCATION/TRAINING:**

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

VII. **REFERENCES:**

A. California Children's Services (CCS) Guidelines, 1999 (Per Annette Lindeman this is the most current version 2/19/21)

Salinas Valley Memorial Healthcare System

PATIENT AND FAMILY EDUCATION

Reference Number	64
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	~~ATTACHMENT A: GENERAL PRINCIPALS AND CONCEPTS IN PROVIDING EDUCATION~~

I. POLICY STATEMENT:

A. N/A

~~A. Patient education is intended to communicate self-care, health instructions and information to patients and/or their families. The education may be verbal, written, visual, audio visual and/or computer generated and culturally diverse.~~

~~1. Patient and family will be involved in decisions about their healthcare education.~~

~~2. Education will be ongoing throughout the patient's care experience.~~

~~3. When available, education is provided in the patient's preferred language through written or visual materials, and/or through the use of interpreter services.~~

~~4. When called for by the age of the patient and the length of stay, the hospital assesses and provides for the patient's academic educational needs.~~

II. PURPOSE:

A. To provide a framework for improving patient health outcomes by promoting healthy behavior and involving the patient in care that will help optimize a healthful lifestyle.

B. To encourage and provide interactive participation in healthcare decisions.

C. To provide information to help patients maximize their ability to function within a life changing disease process.

D. To define a mechanism for arranging the continuation of academic educational services for child or adolescent patients.

III. DEFINITIONS:

A. Prolonged hospitalization is defined as being hospitalized for greater than a 30- day consecutive period.

~~B. PEC: Patient Education Committee~~

IV. GENERAL INFORMATION:

PATIENT AND FAMILY EDUCATION

A. Patient education is intended to communicate self-care, health instructions and information to patients and/or their families. The education may be verbal, written, visual, audio visual and/or computer generated and culturally diverse.

1. Patient and family will be involved in decisions about their healthcare education.
2. Education will be ongoing throughout the patient's care experience.
3. When available, education is provided in the patient's preferred language through written or visual materials, and/or through the use of interpreter services.
4. When called for by the age of the patient and the length of stay, the hospital assesses and provides for the patient's academic educational needs.

B. General Principles And Concepts In Providing Education

1. The goal(s) of patient/family education should be to enable the recipient to maximize his/her ability to engage in behaviors that will optimize a healthful lifestyle.
2. The provision of patient/family education is based primarily upon identified need. The level and intensity of this education should be consistent with the needs of the patient and/or family.
3. The provision of patient/family education is interactive in nature. Active involvement of the patient/family in developing and implementing educational "plans" is recommended.
4. The provision of patient/family education is collaborative in nature. Members of the healthcare team work together to assure that the needs of the patient/family are met.
5. The patient/family should be evaluated to determine if they have received the education that was intended for them. For education that is didactic in nature, this evaluation can be accomplished by having the patient/family provide verbal feedback. If the education is "skill" driven, then evaluation is ideally accomplished by return demonstration.
6. Patients should be provided with appropriate after-care instructions when discharged from any care setting. The scope and intensity of this instruction should be consistent with the needs of the patient/family.
7. Patients should be provided with instruction on specific drug / drug and food/drug interactions when discharged from any care setting, if they have been provided with the medication by the Organization at the time of discharge.
8. Provision of education should be conducted in a manner appropriate to the patient/family's developmental/functional age.

~~A. N/A~~

V. **PROCEDURE:**

Salinas Valley Memorial Healthcare System

PATIENT AND FAMILY EDUCATION

A. Upon admission the Hospital gives a copy of "Patient's Rights and Responsibilities", which makes clear to patients and families what their rights are regarding the patient's ongoing health care needs, and gives them the knowledge and skills they need to carry out their responsibilities.

B. Health care personnel deliver patient/family/community education.

1. Staff to contact appropriate resources to provide specific education,

C. Assessment of individual/family educational needs is made prior to developing a teaching plan. This assessment will enable them to engage in healthy behavior and recover disease and illness. The patient's learning needs, abilities, preferences, and readiness to learn are assessed.

1. Complete the education assessment in the electronic medical record
2. Assessing the following barriers:
    a. Learning preferences.
    b. Readiness to learn.
    c. Culture and religious beliefs.
    d. Physical and emotional barriers.
    e. Financial
    f. Language and reading skills
    g. Cognitive skills
    h. Family involvement.
    i. Understanding of disease process and treatment plan.
    j. Age of the patient and length of stay.

D. Types of learning knowledge assessed but not limited to:

1. Nutrition
2. Medication
3. Pain management
4. Disease process and health problem
5. Activities of daily living
6. Role of patient and family in ongoing healthcare maintenance

E. Roles of the Healthcare Team

1. Healthcare Team to include but not limited to:
    a. Physicians and Physician Assistants

b. Nurses
c. Clinical Dietitian
d. Pharmacist
e. Respiratory Therapist
f. Physical, Occupational, and Speech Therapists
g. Social Workers and Case Managers

2. Explanation of all procedures and rationales for procedures.

F. Nursing staff, physicians, and other members of the health care team are encouraged to develop/revise patient education materials in consultation with ~~the Patient Education Committee (PEC) or designee~~ content experts, according to appropriate regulatory agencies.

1. Teaching methods/materials follow adult learning principles to provide instruction to patients/families/community that best meets their identified needs.
2. With due regard for privacy, healthcare personnel teaches and helps patients maintain good standards for personal hygiene and grooming, including bathing, brushing teeth, caring for hair and nails, and using the toilet.
3. Patients are educated about the safe and effective use of medical equipment.
4. Patients are educated about rehabilitation techniques to help them adapt or function more independently in their environment.
5. Patients are informed about access to additional resources in the community.
6. Patients are informed about when and how to obtain any further treatment the patient may need.

G. Nonjudgmental support and encouragement is offered patient/family throughout the teaching process.

H. Healthcare personnel give discharge instructions to the patient or family, and provide these instructions to the organization or individual responsible for the patient's continuing care.

I. Review/Develop materials:

1. Patient Education Committee/designee will review new and/or revised materials.
2. The Flesch/Kincaid computer score will be used to determine "Readability" (8th grade or less).

J. Academic education for child/adolescent patients will be provided by the hospital or through other means when appropriate.

K. All patient education materials developed by staff members are the property of Salinas Valley Memorial Healthcare System. Hospital departments are responsible for ensuring the information is complete, accurate, and meets standards.

L. PROVISION OF ACADEMIC EDUCATION TO PEDIATRIC PATIENTS (Ages Six through Seventeen)

1. ~~It is the policy of the Organization to~~ SVMH will make all reasonable attempts to provide pediatric patients with continued academic instruction during periods of prolonged hospitalization.

2. Nursing Services and/or the child's Physician is responsible for identifying and referring to Social Services those children who are hospitalized for a prolonged period. Social Services is responsible for assessing the feasibility of providing academic educational services and for coordinating the provision of such services if so indicated.

M. Documentation:

1. When an instruction is given, health care personnel document understanding of patient's comprehension.

   a. Patient's ability to perform any return demonstration as needed.

   b. Staff documents clarification and/or reinforcement of information in the patient medical record.

VI. EDUCATION/TRAINING:

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

~~1. Staff is kept up-to-date on information and teaching strategies through periodic bulletins, in-services and staff meetings.~~

VII. REFERENCES:

A. Joint Commission Standards PC.02.03.01 & PC.02.02.07.

B. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2010)*Tool kit for making written material clear and effective ~~(CMS Product No.11476).~~* Retrieved from CMS.gov/outreach-and-education/outreach/written Materials Toolkit. (Feb 2020)

~~B. http://www.cms.gov/outreach&education~~

PATIENT AND FAMILY EDUCATION

~~ATTACHMENT A~~

~~A. GENERAL PRINCIPLES AND CONCEPTS IN PROVIDING EDUCATION~~

- ~~The goal(s) of patient/family education should be to enable the recipient to maximize his/her ability to engage in behaviors that will optimize a healthful lifestyle.~~
- ~~The provision of patient/family education is based primarily upon identified need. The level and intensity of this education should be consistent with the needs of the patient and/or family.~~
- ~~The provision of patient/family education is interactive in nature. Active involvement of the patient/family in developing and implementing educational "plans" is recommended.~~
- ~~The provision of patient/family education is collaborative in nature. Members of the healthcare team work together to assure that the needs of the patient/family are met.~~
- ~~The patient/family should be evaluated to determine if they have received the education that was intended for them. For education that is didactic in nature, this evaluation can be accomplished by having the patient/family provide verbal feedback. If the education is "skill" driven, then evaluation is ideally accomplished by return demonstration.~~
- ~~Patients should be provided with appropriate after-care instructions when discharged from any care setting. The scope and intensity of this instruction should be consistent with the needs of the patient/family.~~
- ~~Patients should be provided with instruction on specific drug / drug and food/drug interactions when discharged from any care setting, if they have been provided with the medication by the Organization at the time of discharge.~~
- ~~Provision of education should be conducted in a manner appropriate to the patient/family's developmental/functional age.~~

Salinas Valley Memorial Healthcare System

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Reference Number	474
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	ATTACHMENT A – GUIDELINES FOR CARE OF THE RENAL PATIENT ATTACHMENT B – GUIDELINES FOR CARE OF THE RENAL PATIENT/MEDICATION ADMINISTRATION ATTACHMENT C ATTACHMENT D – FLUID RESTRICTIONS ATTACHMENT E – HIGH POTASSIUM FOODS ATTACHMENT F – AVOID FOODS HIGH SODIUM ATTACHMENT G – LIMIT FOODS HIGH PHOSPHORUS

I. POLICY STATEMENT:

A. The primary nurse maintains primary responsibility for the patient's care.

1. Certified dialysis nurses as contracted by the hospital will perform patient dialysis.
2. Emergency Department registered nurses may discontinue a dialysis needle from either a fistula or graft upon order from the Emergency Department physician or the nephrologist; *this applies to an Emergency Department patient only*.

II. PURPOSE:

A. To delineate interventions necessary to maintain hygiene, comfort and safety for the patient undergoing renal, hemodialysis, or peritoneal dialysis treatments.

III. DEFINITIONS:

A. Hemodialysis is a process in which substances move across a semi permeable membrane to remove unwanted solutes and fluid and restore acid base and electrolyte balance.

B. CAPD: Continuous ambulatory peritoneal dialysis is a type of ~~self-dialysis~~self-dialysis done 7 days a week where the solution inside the peritoneal cavity is drained and new solution is instilled. Four to five exchanges of new solution are performed each day.

C. CCPD: Continuous cycler peritoneal dialysis is a form of automated peritoneal dialysis. The exchange of dialysis solution is performed by a machine (cycler) while the patient sleeps.

IV. GENERAL INFORMATION:

A. N/A

V. PROCEDURE:

A. Patient placement

1. Refer to guidelines for Care of the Renal Patient (Attachment A and B)
2. Patient assigned rooms
   a. MS~~CV3~~ rooms 310-313
      i. Dialysis Treatment Suite 305-306
   b. Heart Center rooms 154-156
   c. ICU Extension 119-122 – ~~Is this still true?~~
   d. 1Main~~Level I~~ 127-138
   e. Fifth Floor Tower rooms 523 - 536
   f. Fourth Tower rooms 423 - 434
   g. Third Tower rooms 323-334
   h. Identified rooms are equipped for hemodialysis. Patients may be admitted directly to these rooms or transferred from another floor or unit. The Dialysis Nurse will notify the unit to coordinate the approximate time the patient will be dialyzed.

B. Contact isolation patients may be dialyzed in a semi-private dialysis equipped room. Wear gloves and gowns when within 3 feet of the contact isolation patient. Treat the 3 foot area around the patient as the “isolation room.”

C. Droplet isolation patients must be at least 3 feet away from other patients. Wear a mask when within 3 feet of the droplet isolation patient. A patient on droplet isolation should wear a regular surgical mask when outside of his/her normal patient room for any procedure.

D. Airborne isolation patients must be dialyzed in a private dialysis equipped room with a HEPA filter or in a negative pressure room.

E. Enhanced precaution isolation patients must be 6 feet away from other patients. Wear a N95 respirator within 6 feet of the enhanced precaution isolation patient. The enhanced isolation patient should wear a regular surgical mask when outside of their normal patient room. Refer to ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS

F. Responsibilities of the hemodialysis nurse toward patient care before, during and after hemodialysis.

1. Obtain report on patient condition, including pertinent lab data and specific medications. Dialysis nurse should review what physician's preference is about giving routine medications and review with primary RN.
2. Monitor patient's vital signs while on hemodialysis and record on hemodialysis flow sheet. Vasoactive drips will be titrated by the primary nurse.
3. Draw pre and post labs ordered specifically for dialysis.
4. Obtain and document pre and post dialysis weights
5. Administer only those medications and treatments that pertain to hemodialysis, e.g., Heparin, dialysis access care, blood transfusions.
6. At the completion of dialysis, control bleeding from access and apply a pressure dressing, which should remain in place for 4 hours. The primary nurse may remove the dressing and apply a bandage.
7. In an arrest, the hemodialysis nurse will:
   a. Return blood from dialyzer to patient.
   b. Maintain access needles until after the arrest or otherwise ordered.
8. Following dialysis, the dialysis nurse will report to the primary nurse or charge nurse when primary nurse is not available. Report will include patient tolerance, dialysis fluid removal, medications given, and any unusual events.
9. Call Nephrologist as needed for adverse events, hypotension, etc.

G. Responsibilities of the primary nurse before, during and after hemodialysis:

1. Obtain patient consent for treatment CONSENT: PATIENT'S RIGHTS AND THE BASICS TO CONSENT
2. Give report about patient to dialysis nurse to include patient status, medications given, current laboratory results, vital signs, and any other pertinent data.
3. Assist the physician as needed with insertion of access catheter.
4. Assess patient independent of the assessment made by dialysis nurse.

5. Monitor patient for post dialysis problem, e.g. bleeding from access site, delirium or other changes in LOC, adverse changes in vital signs. Be alert for signs and symptoms of septicemia. Notify physician as needed.
6. Following dialysis, the primary nurse or charge nurse will receive report from the dialysis nurse. Report will include patient tolerance, fluids removed, medications given, and any unusual events. The primary nurse will do a complete assessment when receiving the patient.
    a. Vital Signs:
        i. After dialysis vital signs will be taken every fifteen (15) minutes for one (1) hour then ~~every four (4) hours or~~ per unit standard. Notify physician for systolic blood pressure less than 80 or greater than 185 mm Hg. A drop in B/P is an expected outcome of dialysis.
        ii. Notify physician for temperature greater than 101 degrees F, or slight elevation with chills and/or rigors.
        iii. Blood pressures will not be taken on the graft fistula side. It may be necessary to take the B/P on a thigh. Post a sign above the bed "No B/P's or venipuncture on _ _arm" indicating which arm (Attachment C)
            1) Apply pink arm band to communicate "limb alert" (see COLOR-CODED WRISTBAND USE)
7. Weight/ Intake and Output
    a. The patient will be weighed on admission, daily and pre and post dialysis.
    b. Intake and output will be monitored and documented each shift. Oliguria and anuria may or may not be present. It is not necessary to notify physician unless specifically ordered.
    c. Fluid restriction sign should be posted above bed if ordered. (See Attachment D). Nutrition Service will provide half the fluid allotment on meal trays/snacks and nursing can supply the remaining half.
    d. Per nephrology MD's po supplements (i.e. Nepro or Glucerna) are not counted in total daily po fluid allowed.
8. Dietary Guidelines:
    a. If patient experiences hypoglycemia, give apple or cranberry juice. Avoid citrus and prune juice due to high potassium content.
    b. Patients on renal diets may have dietary restrictions on protein, sodium, potassium, phosphorous, fluids and others. It is important to be aware of the renal patient's current dietary prescription in order to guide them appropriately. Attachment E details some common renal diet restrictions

c. Patient should not eat during dialysis because eating shunts blood to the gut, causing decrease in BP and/or vomiting.

9. Hygiene:~~The noc shift will bathe, change bed linen and weigh patient when treatment is scheduled before 9:00 am.~~

a. Administer skin care every shift. Pruritus is a common problem for dialysis patients.

b. Patients with a hemodialysis catheter may not shower.

10. Activity and Safety:

a. Assess patient for activity intolerance and maintain pre-admission activity level as able.

b. Patients should be up in chair three hours daily as tolerated to ensure that the patient tolerates upright position for outpatient dialysis treatments.

c. Provide adequate pressure relief when positioning patient.

d. There is a potential for seizures during or after dialysis due to Disequilibrium Syndrome.

11. Medication Administration

a. Prior to dialysis, hold medications as prescribed by the physician. Administer medications after dialysis. (See Attachment B)

H. Care of Access Sites and Removal of Percutaneous Catheters

1. Percutaneous Dialysis Catheters

a. Assess every shift to ensure clamps are closed and caps are tight.

b. Dialysis nurses will change the dressing with each dialysis treatment. If the dressing becomes soiled or loose in between dialysis treatments, the RN~~/LVN~~ changes dressing according to # 455 CENTRAL VASCULAR ACCESS DEVICES

c. Percutaneous catheters will only be used for dialysis unless there is an order from a Physician to do otherwise. The blue port is to be used by nursing staff if infusion port not available

i. Following infusion, flush with NS and instill amount of ml (Heparin 1000 units/ml) noted on catheter into port or per physician order.

ii. During critical situations, either port can be used under the direction of the physician.

iii. For removal of a hemodialysis catheter or for Heparin instillation, see Nursing Policy # 455 CENTRAL VASCULAR ACCESS DEVICES

d. **Emergency Department patient only:**

Procedure for discontinuation of a dialysis needle:

i. Wash hands

ii. Put on personal protective equipment (e.g., gloves goggles, etc.)

iii. Ensure that both venous and arterial needles are clamped

iv. Remove tape from needle insertion site. Asses needle site.

v. Place sterile 2x2 gauze gently but firmly over needle insertion site.

vi. Remove needle at same or similar angle of insertion. After needle is completely out, apply pressure. Removing the needle at the same or similar angle and applying pressure after the needle is removed reduces trauma to the access and the cannulation site.

vii. Apply sufficient pressure to stop the leakage from the needle insertion site but not enough to occlude blood flow through the access. Excessive pressure on the access may lead to stenosis, which may cause clotting of the vascular access.

viii. Apply pressure to the site for at least 5 – 10 minutes before checking to see if bleeding has stopped.

ix. Apply adhesive bandage or sterile dressing over cannulation site. If a sterile dressing is used, apply tape lightly. Do not wrap tape completely around the extremity.

x. Observe for edema, redness, prolonged bleeding and presence of thrill/bruit.

xi. Repeat the above steps for the other needle.

2. Peripheral Vascular Access (A-V Fistulas, Grafts):

a. Check thrill and bruit every four (4) hours and document.

i. A bruit is audible when a stethoscope is placed over the fistula. A whooshing sound should be heard. Document the character of this sound, i.e. strong, faint, etc.

ii. A faint thrill is palpable when the fingers are placed over the fistula. A slight vibrating sensation will be felt. **Notify physician if bruit or thrill is absent**.

iii. Elevate arm above the heart level with pillows if swelling is present.

iv. Notify physician of any change in circulation, movement or sensation in affected hand (loss of bruit or thrill).

v. No BP, blood draws or IV's in arm with permanent dialysis access. Post sign above bed. Apply pink armband to communicate "limb alert".

I. Care of CAPD patient

1. This patient will be maintained on peritoneal dialysis by an automated peritoneal dialysis cycling machine "APD". This modality is seven (7) day/week, twenty-four (24) – hour/day therapy. It does not require the continued presence of a dialysis nurse. There is a dialysis nurse on call for any problems or questions.
2. The peritoneal dialysis staff will maintain and care for the operation of this machine and be responsible for hanging solutions and sending dialysate cell counts and cultures.
3. Do not attempt to disconnect any part of the tubing system for any reason. Do not add medication to the bags.
4. When the peritoneal dialysis cycler is functioning properly, there should be no beeping or alarms sounding.
5. If an alarm sounds (constant beeping) in fill or drain mode, you may press the "Standby" button. An intermittent beep will sound. Wait approximately thirty (30) seconds. Check the patient line for kink or occlusions. Press the "Operation" button. If further alarms sound, press "Standby" and call the dialysis nurse on call.
6. The dialysis nurse on a daily basis will do catheter exit site care.
7. For any leakage noted around the catheter exit site, please contact the dialysis nurse on call. For any type of tubing disconnection, place a blue plastic Kelly clamp on that portion of tubing remaining in patient and call the dialysis nurse on call **STAT**.
8. Hospital staff is responsible for weighing the patient daily. Patient to be weighed at the same time each day (preferably AM) while the patient is in **dwell mode**.
9. Maintain accurate I & O per hospital record. The dialysis nurse will monitor and document the ultrafiltration
10. Hospital personnel, with the exception of peritoneal dialysate cell counts and cultures, will draw labs.
11. Hospital staff per standard of care or physician order will obtain vital signs.

J. Order Entry: All dialysis treatments (hemodialysis, peritoneal dialysis, CRRT) to be ordered electronically. In the event of a downtime period, downtime forms to be utilized for treatment orders and patient documentation.

K. Documentation/Evaluation:

1. Patient profile/documentation will include the following:

a. Dialysis schedule

b. Daily weight including scale used

c. Lung sounds: Observe for rales or dyspnea. (Could be indicative of CHF or pulmonary edema).

d. Changes in vital signs. An orthostatic B/P may be ordered. (B/P is indicative of volume status). A positive orthostatic B/P is when the systolic drops more than twenty (20) mmHg and the pulse increases more than fifteen (15) beats per minute when the patient moves from a sitting to standing position.

e. Apical pulse (dysrhythmias may occur related to electrolyte imbalance).

f. Document the location and appearance of the access site every four (4) hours. Include assessment of bruit and thrill if appropriate.

g. Monitor condition of skin and oral mucosa. (Mouth ulcerations may occur due to uremia). Report changes to the physician.

h. Document and be aware of the last BM. Notify Physician if no bowel movement in 3 days.

i. Document ~~-~~strict I & O including the dialysis output in the patient care record.

j. Emergency Department RNs document findings and/or the discontinuation procedure.

VI. EDUCATION/TRAINING:

A. ~~Education is provided through department orientation, policy fairs, and/or annual competencies.~~Education and/or training is provided as needed.

VII. REFERENCES:

A. Center for Disease and Prevention. (201903). Guideline for Environmental Infection Control in Health- Care Facilities.

B. Kelley, K.T. (2004). How peritoneal dialysis works.*Nephrology Nursing Journal*, 31(5), 481-491.

C. Bodin, S. ~~Molzahn, A. & Butera, E.~~ (201706). *Contemporarary Nephrology Nursing~~: Principles and Practice~~*, (3rd ~~2nd~~ ed.) Pitman, NJ: American Nephrology Nurses' Association.

ATTACHMENT A

Guidelines for Care of the Renal Patient

~ ASSESSMENT GUIDELINES ~

Assessment Guidelines *Note: this is only a partial list, refer to the Hemodialysis Patient Care Orders*	**Pre ESRD** CKD 5 Stage 4-5 GFR<30	**Hemodialysis**	**Peritoneal**
Daily weight (kg), post dialysis weight (same time, same clothing, accurate!)	Daily weight (kg)	Obtain in AM daily and pre and post dialysis.	Obtain in AM daily when patient is in "DWELL" mode.
Vital signs: • Temperature: tend to be hypothermic.	• Report elevations >101 degrees or even slight elevations if associated with chills and/or rigors.	• Report elevations >101 degrees F, or even slight elevations if associated with chills and/or rigors.	• Report elevations >101 degrees F, or even slight elevations if associated with chills and/or rigors.
Vital signs: • Blood Pressure		• Caution when BP < 80 mmHg sys Note: hypotension can cause fistula to clot.	• Report Sys BP < 100 mmHg
Dialysis Access	• Save non-dominant arm for future fistula access. • No blood draws or IVs in the non-dominant arm. • No PICC lines in either arm! • No *subclavian* central lines.	**Fistula:** • Assess every shift for: • bruit, thrill • s/s infection • circulation of the involved extremity distal to the fistula **Hemodialysis catheter:** • *Do not shower!* • Do not use hemodialysis catheter for IVs without approval from Nephrologist. • Assess every shift to ensure clamps are closed and caps are on tight: • Change dressing if soiled, wet, or loose (hibliclens & hydrogen peroxide are ok; no	**Peritoneal dialysis catheter:** • May shower. Use antibacterial soap. Assess every shift for: • Catheter taped securely. • Intact dressing if in place (note: not all will have a dressing). • Change dressing if soiled, wet, or loose. During change, check for s/s infection. • Notify dialysis

		betadine). During change, check for intact sutures (2) & S/S of infection. • No BPs, blood draws or IVs in the non-dominant arm. • No PICC lines in either arm! • No *subclavian* central lines.	nurse of any exudate or fluid drainage from the site. • S/S of peritonitis (abdominal pain, nausea/vomiting, increased temperature, cloudy drainage). • No *subclavian* central lines. • No PICC lines in either arm! • Avoid IV, blood draws on non-dominant arm. • Ensure that the tip of the waste line is not submerged beneath the water level in a toilet or in a drain or touching the toilet surfaces.

~ CONTINUED ~

Salinas Valley Memorial Healthcare System

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Assessment Guidelines *Note: this is only a partial list, refer to the Hemodialysis Patient Care Orders*	**Pre ESRD** (Creatinine ≥ 3)	**Hemodialysis**	**Peritoneal**
Labs	GFR (MDRD) Pre Hemo 15-30 ml/min/1.73 squared	Typical lab results for stable, well-nourished hemo patient: • BUN: ~ 60 (H) • Creatinine: ~ 8 (H) • Hct: 33 – 36 • Hb: 11 – 12 • K: normal limits • Na: often low due to dilution Lab draws: • Most accurate results are obtained pre-dialysis. • Draw clotting times pre-dialysis or at least 5 hours post dialysis to avoid the effects of the Heparin administered during dialysis. • ***Never*** draw clotting times through the dialysis catheter! • CBC must be drawn *pre-dialysis* (i.e. before patient placed on dialysis machine; white cell counts are immediately changed by dialysis). Okay to draw the H&H.	Typical lab results for stable, well-nourished PD patient: • BUN: ~ 60 (H) • Creatinine: ~ 8 (H) • Hct: 33 – 36 • Hb: 11 – 12 • K: normal limits • Na: normal limits
Diet	• There may be a restriction of protein, sodium, potassium, & phosphorous. These components may be ordered individually or as a "combo diet" • Generally no fluid restriction. In the EHR diet may be ordered as a combo called "Renal Non Dialysis" = No Added	• No eating during dialysis because this would shunt blood to the gut possibly causing a decrease in BP and/or vomiting. • There may be a restriction of sodium, potassium, & phosphorous. These components may be ordered individually or as a "combo diet"	• Patients may be able to tolerate a "Regular" diet. Often po supplements are given as an additional protein source. • No fluid restriction generally required.

	Salt, 60mEq Potassium, 60gm Protein, Low Phosphorus	• In the EHR diet may be ordered as a combo called "Renal Dialysis" = No Added Salt, 60mEq Potassium, Low Phosphorus • ***For hypoglycemia can give apple or cranberry juice.*** • Many hemo patients need fluid restrictions; if none ordered check with Nephrologist. • Available Fluid restrictions are: 1000ml, 1200ml, 1500ml, 1800ml, 2000ml • Fluid is provided 50% by nursing, 50% by Nutrition Service.	

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

ATTACHMENT B
Guidelines for Care of the Renal Patient
~ MEDICATION ADMINISTRATION ~

Medications **Note: this is only a partial list, refer to the Hemodialysis Patient Care Orders**	**Pre ESRD** **(Creatinine ≥ 3)**	**Hemodialysis**	**Peritoneal**
Acetaminophen	Use with dose modification as ordered by the Physician	Remedicate post dialysis (dialyzed off)	Give as ordered
Antibiotics	Give as ordered. Exception: Avoid nephrotoxic antibiotics (e.g. aminoglycosides)	**Hold all antibiotics two hours prior to dialysis, give scheduled dose post dialysis**	Give as ordered Note: some antibiotics are given through the dialysate.
Apixaban	Use with dose modification as ordered by the Physician	Use with dose modification as ordered by the Physician	Use with dose modification as ordered by the Physician
Digoxin	Give as ordered	Give as ordered	Give as ordered
Enoxaparin	Use with dose modification as ordered by the Physician	Never	Never
Famotidine	Use with dose modification as ordered by the Physician	Use with dose modification as ordered by the Physician	Use with dose modification as ordered by the Physician
Fondaparinux	Use with dose modification as ordered by the Physician. Contraindicated if CrCl < 30 mL/min	Never	Never
Furosemide	Give as ordered	Usually ineffective.	Usually ineffective.
Insulin	Give as ordered	Give as ordered	Give as ordered
Intravenous Solutions for TKO	**Use only 0.9%NaCl or D5NS; Set rate at 15 ml/hr.**	**Use only 0.9%NaCl or D5NS; Set rate at 15 ml/hr.**	**Use only 0.9%NaCl or D5NS; Set rate at 15 ml/hr.**
Iron	**Never** give with phosphate binders. Give 2 hours after meals.	**Never** give with phosphate binders. Give 2 hours after meals.	**Never** give with phosphate binders. Give 2 hours after meals.
Maalox/Mylanta	Never	Never	Never
Magnesium Citrate	Never	Never	Never
Magnesium Hydroxide	Never	Never	Never
Meperidine	**Never**	**Never**	**Never**
Metformin	Never	Never	Never
Mylanta	Never	Never	Never

Salinas Valley Memorial Healthcare System

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Medications **Note: this is only a partial list, refer to the Hemodialysis Patient Care Orders**	**Pre ESRD** **(Creatinine ≥ 3)**	**Hemodialysis**	**Peritoneal**
Narcotics	Use with dose modification as ordered by the Physician	Reduce dose with dialysis as ordered by the Physician	Give as ordered
Nephrotoxic Drugs (i.e. aminoglycosides, etc.)	Never	Use with dose modification as ordered by the Physician	Use with dose modification as ordered by the Physician
Nitrates	Give as ordered	Reduce or hold with dialysis as ordered by the Physician	Give as ordered
NSAIDS	Never	Use with caution.	Use with caution.
Pantropazole (Protonix)	Give as ordered	Give as ordered	Give as ordered
Parenteral contrast dye	Never	May need dialysis after contrast exposure.	Okay
Phenobarbital	Give as ordered	Supplement post dialysis, check with Nephrologist	Give as ordered
Phosphate Binders Calcium Acetate (PhosLo), Calcium Carbonate (TUMS), Lanthanum Carbonate (Fosrenol), Sevelamer (Renagel)	Give with meals	Give with meals	Give with meals
Potassium sparing diuretics (e.g. spironolactone, eplerenone, triamterene, amiloride)	Use with caution; may be used with dose modification as ordered by the Physician	Never	Never
Potassium Supplements	Give as ordered	Only if K<3.2 as ordered by the Physician	Give as ordered
Rivaroxaban	Use with dose modification as ordered by the Physician	Never	Never
Sodium Phosphate	Never	Never	Never

ATTACHMENT C

NO VP
NO B/P

IN
ACCESS
ARM

ATTACHMENT D

FLUID RESTRICTIONS

7 – 3 ~

3 – 11 ~

11 – 7 ~

- Nutrition Service provides ½ (50%) of the total daily fluid allotment with meal trays/snacks.
- Per hospital guidelines po supplements (Nepro etc) are not counted in total fluid unless so ordered.

ATTACHMENT E

High Potassium Foods (Refer STARnet for the approved online diet manual for additional more detailed information.

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

•Eating more than the serving size for a moderate or low-phosphorus food will make it a high-phosphorus food. Foods made with high-phosphorus foods will also be high in phosphorus.

•Unless otherwise noted, all foods are cooked: meat is roasted, fish is cooked with dry heat, and vegetables are cooked from fresh. Fruit is raw.

•This is a guide. Actual values may vary depending on product processing. Vegetables that are frozen or canned may have higher phosphorus values.

•Values are rounded to the closest 5-milligram (mg) increment and may be averaged with similar foods in the same group.

High Phosphorus (more than 100 mg)

Food Serving mg

Almonds 1 oz 140

Biscuit, 4” 1 each 140

Beef or veal, retail cuts, composite, lean only 3 oz 200

Cereal, bran ½ cup 140-350

Cheese: American, cheddar, mozzarella, Swiss, provolone 1 oz 150

Chicken, white meat 3 oz 200

Milk, condensed, sweetened ½ cup 390

Cheese, ricotta ½ cup 225

Cheese, cottage ½ cup 170

Cream, light or half-and-half ½ cup 110

Dried beans and peas, cooked or canned ½ cup 100-140

Milk, evaporated ½ cup 260

Fish: pollock, walleye, swordfish, cod, halibut, salmon, tuna 3 oz 200-280

Granola ½ cup 150

Hot cocoa, prepared 6 oz 100

Lentils ½ cup 180

Milk, all kinds 1 cup 240

Milkshake 1 cup 260

Nuts, most varieties 1 oz 100-130

Oatmeal ½ cup 160

Organ meats 1 oz 125

Baked potato, with skin	1 medium	925
Soy milk	1 cup (8 oz)	600
White beans, canned	½ cup	595
Avocado	½ fruit	487
Fish: halibut, tuna, cod, snapper	3 oz	480
Swiss chard	½ cup, cooked	480
Banana	1 medium	425
Spinach	½ cup cooked	420
Papaya	1 small	391
Milk: fat free, low fat, whole, buttermilk	1 cup (8 oz)	350-380
Lima beans	½ cup	353
Artichoke, cooked	1 medium	343
Tomato or vegetable juice	½ cup (4 oz)	275
Dates	5 pieces	270
Raisins	¼ cup (2 oz)	270
Potato, boiled	½ cup	255
Brussels sprouts	½ cup	250

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Turkey	3 oz	250
Sunflower or pumpkin seeds	1 oz	240
Yogurt	½ cup (4 oz)	238
Orange	1 fruit	237
Broccoli	½ cup	230
Cantaloupe	½ cup	215
Nuts: almonds, peanuts, hazelnuts, Brazil, cashew, mixed	1 oz	200
Tuna fish, canned		

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

ATTACHMENT F

High Sodium (more than 300 mg)

Food	Serving	Milligrams (mg)
Bacon	2 slices	300
Bagel, 4″: egg	1 each	450
Bagel, 4″: plain, onion, or seeded	1 each	400
Barbecue sauce	2 Tbsp	350
Beans, baked, plain	½ cup	435
Beans, garbanzo	½ cup	360
Beans, kidney, canned	½ cup	440
Beans, lima, canned	½ cup	405
Beef, dried	1 oz.	790
Biscuit, 2½″	1 each	350

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Food	Serving	Milligrams (mg)
Catsup	2 Tbsp	335
Cheese, American	1 oz	400
Cheese, cottage	½ cup	460
Cheese, feta	1 oz	315
Corn, creamed, canned	½ cup	365
Croissant	2 oz	425
Fish, salmon, canned	3 oz	470
Fish, salmon, smoked	3 oz	670
Fish, sardines, canned	3 oz	430
Frankfurter, beef or pork	1 each	510
Ham	3 oz	1,125
Lobster	3 oz	325

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Food	Serving	Milligrams (mg)
Miso	½ cup	1,280
Mushrooms, canned	½ cup	330
Pickle, dill	1 large	570
Potatoes, au gratin or scalloped	½ cup	500
Pretzels	1 oz	400
Pudding, instant, chocolate, prepared with milk	½ cup	420
Salad dressing, Italian, commercial	2 Tbsp	485
Salami, dry or hard	1 oz	600
Salt, table	1 tsp	2,325
Sauerkraut, canned	½ cup	780
Soup, canned	1 cup	700-1,000
Soy sauce	1 Tbsp	900

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Food	Serving	Milligrams (mg)
Teriyaki sauce	1 Tbsp	690
Tomato or vegetable juice, canned	½ cup	325
Tomato sauce, canned	½ cup	640
Tomato sauce, spaghetti or marinara	½ cup	510
Vegetable or soy patty	1 each	380

ATTACHMENT G

Limit these high phosphorus foods to 1 serving per day and take your Phosphate binders when you eat.

- Eating more than the serving size for a moderate or low-phosphorus food will make it a high-phosphorus food. Foods made with high-phosphorus foods will also be high in phosphorus.
- Unless otherwise noted, all foods are cooked: meat is roasted, fish is cooked with dry heat, and vegetables are cooked from fresh. Fruit is raw.
- This is a guide. Actual values may vary depending on product processing. Vegetables that are frozen or canned may have higher phosphorus values.
- Values are rounded to the closest 5-milligram (mg) increment and may be averaged with similar foods in the same group.

High Phosphorus (more than 100 mg)

Food	Serving	mg
Almonds	1 oz	140
Biscuit, 4”	1 each	140
Beef or veal, retail cuts, composite, lean only	3 oz	200
Cereal, bran	½ cup	140-350
Cheese: American, cheddar, mozzarella, Swiss, provolone	1 oz	150

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Food	Serving	mg
Chicken, white meat	3 oz	200
Milk, condensed, sweetened	½ cup	390
Cheese, ricotta	½ cup	225
Cheese, cottage	½ cup	170
Cream, light or half-and-half	½ cup	110
Dried beans and peas, cooked or canned	½ cup	100-140
Milk, evaporated	½ cup	260
Fish: pollock, walleye, swordfish, cod, halibut, salmon, tuna	3 oz	200-280
Granola	½ cup	150
Hot cocoa, prepared	6 oz	100
Lentils	½ cup	180
Milk, all kinds	1 cup	240

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Food	Serving	mg
Milkshake	1 cup	260
Nuts, most varieties	1 oz	100-130
Oatmeal	½ cup	160
Organ meats	1 oz	125
Oysters	3 medium	180
Peanut/nut butters	2 Tbsp	115
Pork, loin	3 oz	200
Potato, baked w/ skin	1 medium	120
Pudding or custard, made w/ milk	½ cup	150
Sardines	3 oz	420
Seeds, sunflower or pumpkin	1 oz	340
Shrimp or crab	3 oz	110

CARE OF THE RENAL, HEMODIALYSIS AND CAPD PATIENT

Food	Serving	mg
Soybeans	½ cup	210
Soy milk	1 cup	130
Tofu, firm	¼ block	100
Tortillas, 6” corn	2 each	120
Tuna, canned in water, drained	3 oz	140
Turkey, light or dark	3 oz	180
Veggie or soy patty	1 each	145
Wheat germ	1 Tbsp	115
Waffle or pancake, 4”	1 each	120
Yogurt, plain or fruited	6 oz	220-360

Salinas Valley Memorial Healthcare System

NICU ORIENTATION AND TRAINING

Reference Number	176
Effective Date	Not Approved Yet
Applies To	NICU
Attachments/Forms	

I. POLICY STATEMENT:

A. N/A

~~Nurses hired for the NICU will participate in house-wide and unit-specific orientation and training.~~

~~Basic nursing requirements include:~~

~~Valid RN License~~

~~Current BLS certification~~

~~Current NRP certification, or obtained within six (6) months of hire~~

~~Current STABLE certification (optional)~~

~~IV training process initiated within orientation/introduction period~~

~~Show evidence of previous experience or active involvement in acquiring experience and knowledge in Neonatal Nursing, either as part of orientation and training, or prior to hire.~~

~~Orientation/Training is conducted by a NICU staff RN identified as the preceptor (link to preceptor policy)~~

~~Resources include the assigned preceptor, Clinical Manager/ Educator and Perinatal CNS the NICU Assistant Clinical Director, the NICU/Peds Clinical Educator.Nurse Specialist (CNS), and the NICU Director.~~

II. PURPOSE:

A. To assure competent, safe, and effective care using a competency based orientation system that provides individualized training and continuous evaluation of knowledge, skills, and attitude.

III. DEFINITIONS:

A. Experienced RNs (Staff RN II) new to the Neonatal Nursing are defined as those RNs with at least two-thousand and eighty (2080) hours of acute care experience on units other than Intermediate or Tertiary NICUs.

B. Experienced Level II or Level III NICU RNs (Staff RN II) are defined as those having at least one (1) year of experience in an Intermediate or Tertiary NICU respectively.

C. Staff RN I is defined as an RN with less than two-thousand and eighty (<2080) hours of acute care experience.

IV. GENERAL INFORMATION:

A. Nurses hired for the NICU will participate in house-wide and unit-specific orientation and training.

B. Basic nursing requirements are in accordance with Job Description.

C. Orientation/Training is conducted by a NICU staff RN identified as the preceptor. PRECEPTOR POLICY

D. Resources include the assigned preceptor, Clinical Manager, and/or Perinatal CNS Clinical Educator.

SCOPE OF SERVICE: ADMINISTRATION

~~Completed checklists and competencies are maintained in the employee's personnel files.~~

~~Current certifications (i.e. BLS, NRP) are maintained in the employee's personnel files.~~

~~IV.~~V. PROCEDURE:

A. Duration of orientation and training is based on individual educational background and experience. Formal content is explained and may be modified in collaboration with the NICU Clinical Manager/Educator~~Assistant Clinical Director~~, ~~the NICU/Peds Clinical Educator, CNS~~ or designee, as appropriate to meet demonstrated learning needs.

B. RNs will participate in house-wide General and Nursing Orientation provided by the Department of Education. Completion within thirty (30) days of hire is expected.

C. Unit orientation consists of, but is not limited to:

1. Supervised clinical opportunities that provide orientation to NICU nursing procedures and equipment specific to the needs of the Neonatal population.
2. Initiation of emergency procedures.
3. Recognition, interpretation, and documentation of pertinent assessments, related signs and symptoms, and conditions requiring notification of a physician.
4. Review of NICU policies, procedures, standards of care, and guidelines.
5. Introduction to and participation in NICU Performance Improvement projects.
6. Attendance at NICU in-services, staff development days, and skills/simulation labs (Neonatal care courses may occur during or after unit orientation).

D. It is the orientee's responsibility to obtain signatures and turn in required documentation of skills and competencies to the NICU ~~/Peds~~ Clinical Manager/Educator, ~~NICU Clinical Assistant Director~~ or designee.

1. Unit-Specific Orientation Competencies by the end of the introductory period (HR.6), C.N.A.(6 months) EDUCATION AND STAFF DEVELOPMENT

2. Self-Learning Modules and test(s) within six (6) months of hire

~~D.~~E. Completed checklists and competencies are maintained in the employee's personnel files. Current certifications (i.e. BLS, NRP) are maintained in the employee's personnel files.

~~V.~~VI. EDUCATION/TRAINING:

A. Education and/or training is provided as needed.~~Education is provided during general or department specific orientation and periodically as practice or policy change.~~

~~Department Director or designee will provide for education and training as identified by staff/unit need.~~

~~VI.~~ SCOPE OF SERVICE: ADMINISTRATION

~~A. Completed checklists and competencies are maintained in the employee's personnel files.~~

~~VII. Current certifications (i.e. BLS, NRP) are maintained in the employee's personnel files~~

~~VIII.~~VII. REFERENCES:

A. ~~National Association of Neonatal Nurses & American Nurses Association. (2013).~~ Neonatal Nursing: -Scope and Standards of Practice (2nd ed.).

Salinas Valley Memorial Healthcare System

CASE MANAGEMENT: STANDARD FOR ADMISSION REVIEW

Reference Number	532
Effective Date	Not Approved Yet
Applies To	CASE MANAGEMENT
Attachments/Forms	

I. POLICY STATEMENT:

~~A.~~ N/A~~The Case Manager will review the patient's medical record within twenty-four (24) hours of admission or the first working day after the weekend or holiday.~~

~~B.~~A. ~~The Case Manager will apply~~ the Patient Status Software ~~(MCG)~~InterQual ~~criteria to determine severity of illness and intensity of service.~~appropriate admission status.~~

II. PURPOSE:

A. To determine the medical necessity and appropriateness of the patient's admission.

III. DEFINITIONS:

A. "Inpatient" means any person who has been admitted to SVMH for bed occupancy for purposes of receiving Inpatient hospital services.

B. "Outpatient" means a person who has not been admitted to SVMH as an Inpatient but is registered on the SVMH records as an Outpatient and receives services from SVMH. The duration of services and time of day are not determinative of Outpatient Status. Observation Services are considered an Outpatient level of care.

C. "Patient Status" means Inpatient or Outpatient.

D. "Level of Care" means the level of Inpatient or Outpatient Services a patient receives. Level of Care may include Observation Services, Telemetry, Acute, Step-Down Unit and other Levels of Care designated by SVMH.

E. "Observation Services" or "Observation" means assessment, short-term treatment, reassessment, and stabilization before decision to admit to inpatient or discharge.

~~"Inpatient" means any person who has been admitted to SVMH for bed occupancy for purposes of receiving Inpatient hospital services.~~

~~"Outpatient" means a person who has not been admitted to a SVMH as an Inpatient but is registered on the SVMH records as an Outpatient and receives services from the SVMH. The duration of services and time of day are not determinative of Outpatient Status. Observation Services are considered an Outpatient level of care.~~

~~"Patient Status" means Inpatient or Outpatient.~~

~~"Level of Care" means the level of Inpatient or Outpatient Services a patient receives. Level of Care may include Observation Services, Telemetry, Acute, Step-Down Unit and other Levels of Care designated by SVMH.~~

~~"Observation Services" or "Observation" means assessment, short-term treatment, reassessment, and stabilization before decision to admit to inpatient or discharge.~~

IV. GENERAL INFORMATION:

A. The Case Manager will review the patient's medical record within twenty-four (24) hours of admission or the first working day after the weekend or holiday.

~~A.~~B. The Case Manager will apply the Patient Status Software (MCG) criteria to determine appropriate admission status. ~~N/A~~

V. PROCEDURE:

A. For third party payers and self-~~-~~pay patients:

- The Case Manager will document in Allscripts ~~the UR electronic documentation tool~~ under review notes the following information:
  1. The time, route, admission source, and admission status of the patient upon entering the hospital. For example, "Patient BIBA was admitted through the ED at 2330 hours." Or, "Patient admitted at 1430 hours, direct admit from MD office." Or, "Patient brought by family and admitted through the ED to OBS status at 1900 hours."
  2. The time of onset of the patient's symptoms, i.e. within twenty-four (24) hours, within one week, etc.
  3. Whether or not the symptoms were treated unsuccessfully as an outpatient, i.e. "Patient failed outpatient diagnosis."
  4. Indicate if patient recently discharged.
  5. Abnormal lab values, results of diagnostic~~is~~ tests, and the treatment plan for the current day.
  6. The following information is to be included in reviews for SRMC/GYN and Nursery:
     a. In the infant's review, the date ~~baby~~infant became sick.
     b. If mom is discharged before the ~~baby~~infant, the date of mom's discharge should be documented in the infant's review.
     c. If ~~baby~~infant is discharged before mom, the date of the infant's discharge should be documented in the mom's review.

i. Apply Patient Status Software (MCG) ~~InterQual~~ criteria and upload document findings into Allscripts.

- If the patient meets criteria for inpatient admission, assign next review date.
- If patient does not meet criteria for admission, ~~assign next review date~~ contact the attending physician for additional information documentation to support the admission and/or refer to On Call Physician Advisor.
- Assess that the admission order matches the patient's admission status. If it doesn't follow the appropriate steps to correct it.
- ~~If after speaking with the attending physician the additional information does not qualify the patient for admission, contact the Um panel physician and complete a physician referral form.~~

B. For Medi-cCare / Medi-Cal patients:

- The Case Manager will apply the Patient Status Software (MCG)~~InterQual~~ criteria to determine the appropriate admission status and level of care. ~~severity of illness.~~
- ~~In the UR document on the SI/IS level of care.~~
- ~~In the SI determination box the Case Manager will enter the date, which criteria set is being used and the SI criteria that is being used.~~
- ~~The Case Manager will then apply the same criteria set used to determine SI to determine IS.~~
- ~~In the IS determination box the Case Manager will enter the date, criteria set being used and the IS criteria that is being used.~~
- ~~In the box "S.I. met" the Case Manager will enter "Y" for yes if the criteria is met and "N" for no if it is not met.~~
- ~~In the box "I.S. met" the Case Manager will enter "Y" for yes if the criteria is met and "N" for no if it is not met.~~
- ~~If the patient is not meeting criteria the Case Manager will apply discharge screens and then document in the "D.S. met" a "Y" for yes or an "N" for nIf the patient is not meeting either severity of illness or intensity of service the Case Manager will contact the attending physician for additional information to support the admission.~~
- ~~If after speaking with the attending physician the admission is not supported the Case Manager will contact the UM panel physician (for a second level of review) and issue an admission non-coverage letter.~~
- If the patient meets criteria for inpatient admission, assign next review date.
- If patient does not meet criteria for admission, contact the attending physician for additional information documentation to support the admission and/or refer

Secondary level of review (On Call Physician Advisor or ~~Executive Health Resources~~ R1 Physician Advisors).

- The Case Manager will enter ~~the days to~~ next review date in the appropriate box and then file the worksheet.

C. Documentation: Case Management electronic documentation tool

VI. EDUCATION/TRAINING:

A. Education and training provided as needed.~~During orientation~~

VII. REFERENCES:

A. CMS Conditions of Participation

Salinas Valley Memorial Healthcare System

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Reference Number	6652
Effective Date	Not Approved Yet
Applies To	HIM
Attachments/Forms	

TABLE OF CONTENTS

A. Accounting of Disclosures
B. Amendment of PHI
C. Disposing and Destruction of PHI
D. Confidential Communications – Alternate Means or Location
E. Creation of Limited Data Sets
F. Breach Investigation and Response
G. Breach Notification
H. Minimum Necessary
I. Business Associate Agreement
J. Privacy Complaints/Waiver of Rights
K. Uses and Disclosures Requiring Opportunity to Agree or Object
   Patient Care & Notification Purposes
   Patient Directory
   Clergy Services
L. Media & Public Release of PI
M. Notice of Privacy Practices
N. Releases - No Authorization Required
O. Releases - Authorization Required
P. Valid Authorization
Q. Who May Give Authorization
R. Secretary of Health and Human Services
S. Family/Relative/Close Personal Friend/Other Person Identified by Individual – Individual Present & Individual not Present or Cannot Agree/Object
T. Use of Patient's PIN
U. Request for Restrictions
V. Subpoena or Discovery Request
W. Court Order
X. Research
Y. Denying Patient's Request to Access or Obtain Copies of Own Record
Z. Psychotherapy
AA. Release to Law Enforcement Officers
BB. De-Identified and Re-Identification of PHI
CC. Release to Attorney
DD. Sale of PHI

EE. Marketing
FF. Inspection of Record By Individual
GG. HIPAA Training
HH. Fundraising
II. Anti-Intimidation and Anti-Retaliation

Salinas Valley Memorial Healthcare System

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

I. POLICY STATEMENT:

A. N/A~~The purpose of this policy is to define the uses and disclosures of protected health information (PHI). To comply with state and federal regulations.~~

II. PURPOSE:

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

III. DEFINITIONS:

A. **Disclosure** – The release, transfer, provision of access to or divulging in of information outside of entity holding the information.

B. **PHI** - Protected Health Information is Individually-identifiable Health Information that is transmitted or maintained in any media. There is an exception when the PHI is covered by or described in the Family Educational Rights and Privacy Act, or employment records held by SVMHS

C. **Individual** – The person who is the subject of PHI.

D. **Individually-Identifiable Health Information** – Information that is a subset of health information (including demographic information collected form an individual) and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
    a. That identifies the individual; or
    b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

E. **Minimum Necessary** – When a provider requests, uses, or discloses PHI from another provider, it must make reasonable efforts to limit the PHI to the minimum necessary to accomplish the task.

F. **Breach** – The unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of PHI in a manner not permitted by the Privacy Rule.

G. **Amendment** – An addition to an individual's PHI.

H. **Designated Record Set** - The medical and billing records maintained by or for SVMHS; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by a health plan; or records used, in whole or in part ~~that are used~~ to make decisions about individuals treatment or determining financial responsibility. This does not include monitoring by electrocardiograms, electroencephalograms or electromyography, nor bedside monitoring devices unless those devices upload the data to the electronic health record. CA Health & Safety Code 123100-123149.5; 45 CFR 164.501.

I. **Workforce Members** - Employees, volunteers, trainees, and other persons whose conduct in the performance of work for SVMHS is under the direct control of SVMHS, whether or not they are paid by SVMHS or a business associate.

J. **Business Associate** – (BA) Generally, a person or entity who performs functions or activities on behalf of or for SVMHS that involves the use or disclosure of protected health information. Refer to 45 CFR 160.103 and CHA Privacy Manual for a more complete definition.

K. **Data Use Agreement** – (DUA) An agreement into which a covered entity enters into with the intended recipient of a limited data set that establishes the ways in which the information in the limited data set may be used and how it will be protected.

L. **Limited Data Set –** (LDS) Protected health information that excludes specific identifiers of the individual, and of relatives, employers or household members of the individual as defined in the HIPAA Privacy Rule.

M. **Organized Healthcare Agreement** - (OHCA) A clinically integrated setting in which individuals typically receive healthcare from more than one provider, such as in a hospital. Example: the OHCA created by the Medical Staff of Salinas Valley Memorial Hospital.

N. **Unsecured PHI –** Protected Health Information that is not encrypted and rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the California State Law or by the Secretary of the Department of Health and Human Services (HHS).

O. **Provider -** SVHMS Medical Staff members and affiliates.

P. **Use -** The sharing, employment, application, utilization, examination, or analysis of individually-identifiable health information by workforce members and providers of the entity that creates and maintains the information.

Q. **Health Care Operations** – Activity of the Covered Entity performed to run their business (covered functions). Refer to Section N.17 of this policy for a more expanded discussion of the definition and CHA Section on Health Care Operations under HIPAA vs. CMIA.

R. **Chemical Dependency** – Alcoholism and drug addiction; the compulsively repeated alteration of brain chemistry by means of a toxin in order to produce temporary relief from frustration, grief or pain quickly without changing the thoughts or behavior that cause these negative feelings.

S. **Mental Illness** – Medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Serious mental illnesses include: depression; schizophrenia; bipolar disorder, obsessive compulsive disorder (OCD); panic disorder; post traumatic stress disorder (PTSD); and borderline personality disorder. The Diagnostic and Statistical Manual of Mental Disorders (DSM) which is the American Psychiatric Association's standard reference for psychiatry includes over 400 different definitions of mental disorders.

T. **Sexually transmitted disease (STD)** – Diseases that are spread through sexual intimacy such as vaginal intercourse, oral sex, anal sex or sometimes skin to skin contact. STDs include: chlamydia; gonorrhea; syphilis; human papilloma virus (HPV); genital herpes; hepatitis B; human immunodeficiency virus (HIV); acquired immune deficiency syndrome (AIDS); pubic lice; scabies; and pelvic inflammatory disease (PID).

U. **Substance Abuse** – A patterned use of a substance in which the user consumes the substance in amounts or with methods neither approved nor supervised by medical professionals. Some of the drugs most often associated with the term include alcohol, amphetamines, barbiturates, benzodiazepines, cocaine, methaqualone and opioids.

V. **Adult** – An individual age 18 or older or an emancipated minor.

W. **Competent** – Having the ability to comprehend needs and risks.

X. **Emancipated Minor** – An individual who has been declared emancipated by the court; a minor who entered into a valid marriage or domestic partnership, whether or not the marriage or domestic partnership has been dissolved; or a minor on active duty with the armed forces of the United States.

Y. **Secretary** – The Secretary of Health and Human Services (HHS) or any other officer or employee of HHS to whom the authority involved has been delegated.

Z. **Individual Review Board (IRB)** – A committee that has been formally designated to approve, monitor and review research involving humans.

AA. **Qualified Protective Order** – An order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which such information was requested, and requires the return to the covered entity or the destruction of the PHI, including all copies made, at the end of the litigation or proceeding.

AB. **Psychotherapy Notes** – Notes recorded (in any medium) by a health care provider who is a mental health provisional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

AC. **More Stringent** – With respect to the rights of an individual who is the subject of the individually identifiable health information regarding access, permits greater rights of access. With respect to information to be provided to an individual who is the subject of the individually identifiable health information about a use, a disclosure, rights, and remedies, provides the greater amount of information. With respect to any other matter, provides greater privacy protection for the individual who is the subject of the individually identifiable health information except as required by the Secretary of Health and Human Services in connection with determining whether a covered entity or business associate is in compliance with HIPAA.

AD. **Contrary** – When used to compare a provision of state law to HIPAA, contrary means SVMHS would find it impossible to comply with both the state and federal requirements, or the provisions of state law stand as an obstacle to the accomplishment and execution of the full purposes and objectives of the Privacy Rule.

AE. **CMIA** – Confidentiality of Medical Information Act. Civil Code Section 56. CMIA is California's primary health information confidentiality law for non-mental health patients, and also covers mental health patient information that is not covered by the Laterman-Petris Short (LPS) Act. HIPAA regulations preempt contrary state law, with certain exceptions.

AF. **Treatment** – The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

AG. **Payment** – Activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care or a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan.

AH. **Marketing** – A communication about a product or service that encourages recipients of the communication to purchase or use the product or service.

AI. **Financial Remuneration** – A direct or indirect payment from or on behalf of a third party whose product or service is being described. Direct or indirect payment does not include any payment for treatment of an individual.

AJ. **Record – Any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for SVMHS.**

IV. **GENERAL INFORMATION:**

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

V. **PROCEDURE:**

A. **ACCOUNTING OF DISCLOSURES** – HIPAA gives Individuals or their personal representatives the right to an accounting of how their PHI outside of SVMH has been disclosed for up to 6 years prior to the Individual's request. The accounting must be requested in writing. In an attempt to be specific on behalf of

the Individual, ask the Individual questions that may identify the specific area of concern. 45 CFR 164.528

1. Exceptions to the accounting of disclosures:

    a. Disclosures to carry out treatment, payment, or hospital operations.

    b. Disclosures made to the individual who is the subject of the PHI, or the individual's personal representative.

    c. Disclosures that are incidental to a permitted disclosure, e.g. the patient in one bed overhears the conversation between physician and patient in the next bed.

    d. Disclosures made pursuant to the patient's authorization.

    e. Disclosures from the facility's directory.

    f. Disclosures of PHI to family, friends and others involved in the patient's care, appropriate to their involvement.

    g. Disclosures used to notify a family member, personal representative or other person of the individual's location, general conditional or death.

    h. Disclosures to authorized federal officials for the conduct of lawful intelligence and security, protective services, or investigations.

    i. Disclosures to a correctional institution or law enforcement official that has custody of the patient.

    j. Disclosures of de-identified data or a limited data set.

    k. PHI disclosed prior to the date of compliance to this policy.

2. Maintaining an Accounting

    a. Providers must account for the following disclosures of PHI when made without a HIPAA-compliant authorization from the patient:

        i. In connection with judicial and administrative proceedings (for example, a subpoena or a court order).

        ii. For public health activities and reporting (for example, births, deaths, communicable diseases, lapses of consciousness, pesticide illness, burn and smoke inhalation injuries, cancer registry).

iii. To the FDA (for example, medical device malfunctions, adverse events, vaccine reactions, lookback, post market surveillance).

iv. To report injuries by firearms, assaultive or abusive conduct.

v. About victims of abuse, neglect, domestic violence.

vi. For health oversight activities (unless for treatment, payment or healthcare operations).

vii. To a law enforcement official pursuant to order, search warrant, regarding crime on premises, for identification and locating suspect and fugitives.

viii. To coroners, medical examiners, funeral directors.

ix. For cadaveric organ, eye or tissue donation.

x. For certain specialized government functions (military and veterans activities, national security and intelligence activities, protective services, correctional institutions and other law enforcement custodial situations)

xi. For workers' compensation purposes.

xii. To or by business associates (and regarding their disclosures) unless for TPO.

xiii. To researchers.

xiv. To the Secretary of U.S. Department of Health and Human Services.

xv. To avert a serious threat to health or safety.

xvi. Disclosures required by law.

xvii. Unlawful and unauthorized disclosures (breaches).

3. Content of the Accounting

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

the individual of the basis for the disclosure or Individual may be given a copy of the request for disclosure.

b. If SVHMS has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures provide the required information for the first disclosure during the accounting period, the frequency, periodicity, or number of disclosures made during the accounting period; and the date of the last such disclosure during the accounting period.

c. RESEARCH: Special rules apply to accounting related to research based on an IRB or privacy board waiver of individual authorization, the provision of access to a researcher using only records of deceased individuals. Legal counsel should be consulted.

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

i. The name of the protocol or research activity;

ii. A description in plain language of the research protocol or other research activity including the purpose of the of the research and the criteria for selecting particular records;

iii. A brief description of the type of PHI disclosed;

iv. The date or period of time during which such disclosures occurred, or may have occurred, including the date of the last such disclosure during the accounting period;

v. The name, address, and telephone number of the entity that sponsored the research and the researcher to whom the information was disclosed; and

vi. A statement that the PHI of the individual may or may not have been disclosed for a particular protocol or research activity.

vii. If SVMHS provides an accounting, and if it is reasonably likely that the PHI of the individual was disclosed for such a research protocol activity, SVMHS shall, at the request of the individual, assist in contacting the entity that sponsored the research and the researcher.

4. Requesting an Accounting

a. SVMHS will provide an individual who requests an accounting of disclosures a *Request for An Accounting of Disclosure* form. Refer the individual to Health Information Management staff or Manager of the Clinical Practice to obtain the form.

b. The individual accepting the completed authorization form will take reasonable steps to verify the identity of the individual. If the individual is unknown to the workforce member, the workforce member will:

i. Verify the requestor's signature matches one on file or verify the individual's identity by examining government issued photo identification.

ii. The individual accepting a completed authorization form will verify the form is filled out completely and will obtain missing information before the requestor leaves the hospital or clinic.

iii. The authorization form will be routed or given to the Privacy Officer who will be responsible for processing the request.

5. Providing the Accounting

a. The Privacy Officer will provide the requesting individual or personal representative with a written accounting of disclosures that occurred during the six years (or such shorter time period) at the request of the individual, including disclosures to or by business associates within 60 days of the request with the following exceptions:

b. The personal representative can be denied access to the accounting if SVMHS has a reasonable belief that the individual has been or may be subject to domestic violence, abuse, or neglect by the personal representative and in the exercise of professional judgment decides that it is not in the best interest of the individual to treat the person in question as the individual's personal representative.

c. Disclosures made to health oversight agencies or law enforcement officials shall be temporarily excluded from an accounting if SVMHS has been notified by the oversight agency or law enforcement official that providing a client or personal representative with an accounting of the disclosures made to them

could impede the progress of their activities (e.g. fraud investigation or investigation of possible criminal activities when a client should not be aware of such scrutiny). Such request from a health oversight agency or law enforcement official should be in writing; however, an oral request may be accepted with stipulations, as noted below. Suspensions requested in writing shall remain in effect for the duration specified in the written request, unless the request for suspension is rescinded earlier by the health oversight agency or law enforcement official.

d. If a health oversight organization or law enforcement official requests this temporary suspension orally, SVMHS shall perform the following:

   i. Document the statement including the identity of the agency or official making the statement;

   ii. Temporarily exclude from the accounting of disclosures those disclosures made to an oversight agency or law enforcement official based upon the oral information in the statement; and

   iii. Limit the temporary exclusion to no more than 30 days from the date of the oral statement unless a written statement is submitted during that time specifying the duration.

   iv. If SVMHS is unable to provide the accounting within 60 days, it may extend the time by no more than 30 days provided that:

      1) Within the first 60 days it provides the individual with a written statement of the reasons for the delay and the date by which it will provide the accounting.

      2) SVMHS can have only the one 30 day extension.

e. A *Response to Request for an Accounting of Disclosures* form may be used to respond to the individual or personal representative if needed.

   i. Refer to a list of recommended “Disclosures That Must Be Accounted For” as assistance from the California Hospital Association.

ii. The Privacy Officer will provide the individual or personal representative with the first accounting at no charge. The Privacy Officer may impose a reasonable cost based fee for subsequent accountings.

iii. The Privacy Officer or designee will record on the accounting request their signature, title, the date, and a note that the accounting was provided.

iv. HIM/Medical Records will retain the request and the accounting in the individual's record for not less than six years from the date the accounting was provided.

v. The request and disposition will also be logged in an Accounting of Disclosures Log maintained by the Privacy Officer. (The log is not required by law, but will make demonstration of compliance easier should SVMHS be audited)

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

1. SVMHS may deny the request if it determines that the protected health information (PHI) that is the subject of the request:

   a. Was not created by SVMHS, unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;

   b. Is not part of the designated record set (DRS);

   c. Would not be available for inspection by the individual under HIPAA section 164.524 (restriction on access to records); or

   d. Is accurate and complete.

2. An employee or medical staff member who is a patient has the same rights to request an amendment; however, they must adhere to the same procedures as any other patient.

3. SVMHS workforce members will provide the individual who requests a correction to his or her PHI with:

   a. A *Request to Amend Protected Health Information* form.

b. Assistance in completing the form at individual's request.

4. Deciding Whether to Grant or Deny the Amendment

a. Upon receipt of the completed Request to Amend PHI form, the Privacy Officer/Clinic Manager or designee will review the request and in consultation with other individuals as appropriate (e.g. the author of the entry) will decide whether to accept or deny the requested amendment.

b. The Privacy Officer/Clinic Manager, or designee will act on the individual's request for an amendment as promptly as required under the circumstances but no later than 60 days after receipt of the request. If SVMHS is unable to act on the amendment request within the 60 days, SVMHS may extend the time for such action by no more than 30 days, provided:

c. That within the 60 days, SVMHS provides the individual with a written statement of the reasons for the delay, the date by which SVMHS will complete its action on the requests;

d. SVMHS may have only one such extension of time for action on a request for an amendment.

5. Accepting the Amendment- If the request is accepted, the author, Privacy Officer/Clinic Manager or designee will:

a. Identify the records in the designated record set affected by the amendment.

b. Append the amendment or create a link or notation indicating where the amendment is located.

c. SVMHS must notify persons identified by the individual as having received protected health information about the individual and needing the amendment; (Refer to the "Notification of Amendment to Protected Health Information" form) and

d. Persons, including business associates, that the covered entity knows have the protected health information that is the subject of the amendment and that may have relied or could foreseeably rely on such information to the detriment of the individual.

6. Denying the Amendment

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

a. The basis for the denial.

b. The individual's right to submit a "Statement of Disagreement" to the SVMHS and how to file such a statement.

c. A statement that, if the individual does not submit a "Statement of Disagreement," the individual may request that SVMHS include the amendment request and the denial with all future disclosures of the PHI that is the subject of the amendment request.

d. A description of how the individual may complain to SVMHS or the Secretary of DHHS. The description of how to complain to SVMHS must include the name or title and telephone number of the contact person or office that is designated to receive complaints.

e. Review the amendment request forms for assistance.

7. Statement of Disagreement

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

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

a. Designated HIM or Clinic staff will identify the record that is the subject of the disputed amendment and append or otherwise link the request for amendment, the denial of the request, the statement of disagreement (if any) and the rebuttal (if any) to the record.

b. If a statement of disagreement has been submitted, SVMHS must include this information with any subsequent disclosure of the PHI to which the disagreement relates.

c. If a statement of disagreement has not been submitted, the provider must include the request for amendment and the denial

with any subsequent disclosure of PHI, but only if the individual has requested that the provider do this.

d. If a subsequent disclosure is made using a standard transaction that does not permit the additional material to be included with the disclosure, the provider may separately transmit this material.

9. SVMHS Receives an Amendment from another Covered Entity

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

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

C. DISPOSING & DESTRUCTION OF PHI AND CONFIDENTIAL INFORMATION

1. SVMH is to disposes and destroy all paper, floppy disk, CDs and any other medium that may or may not contain PHI or other confidential matter.

2. For hard drive destruction and disposal, contact Information Technology and refer to DATA CONFIDENTIALITY. Information Technology advises against storing sensitive data on local workstation hard drives in order to protect the security and integrity of the data.

3. All paper, floppy disk or CDs with PHI or confidential information will be disposed of in the designated locked grey shred bins.

4. Once paper documents, floppy disk or CDs are placed in the shred bin it should be considered shredded at that point. The following are the steps taken when a document or item is accidentally discarded and the shred bin needs to be opened:

a. Department management or Administrative Supervisor will be called for approval of need to open shred bin. Consider if the document can be recreated.

b. Call the Security Office. The shred bin will be opened by a Security Officer. The Security Officer is to remain on location until the shred bin can be locked.

c. An Occurrence Report is to be completed by Security.

5. Materials Management will maintain the vendors shred schedule. Contact them regarding any shred box pickup issues.

6. Once the process is complete, a receipt of destruction for each shred bin will be received from the shred company. The receipt of destruction is then kept on file by Materials Management and retained according to the RECORDS RETENTION POLICY

D. **CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS OR LOCATION REQUEST -** Individuals may request that we communicate with them through alternative means or at an alternative location.

1. Any request for alternative means of communication will be forwarded to the Privacy Officer for the Hospital or the Clinic Manager.

2. The Individual will be provided a "*Request for Alternative Means of Confidential Communications"* form. If the Individual does not use this form, they must provide their request in writing.

3. If the individual is not known by the workforce member, the workforce member will:

a. Verify the signature matches one on file; or

b. Verify the individual's identity by examining government issued photo identification.

4. The Privacy Officer or Clinic Manager is to determine the reasonableness if the request. SVMHS may condition the provision of a reasonable accommodation on how payment will be handled and specification of an alternative address or other method of contact. SVMHS may not inquire as for the reason of the request.

5. Inform the individual if SVMHS can accommodate the request.

6. SVMHS has to ensure the PHI is communicated via the alternative means or location. If this cannot be ensured, do not agree to the request.

7. The Individuals request is to be filed in the medical record and kept for the record retention period.

8. A log may be maintained to use as a quick reference. This is not required but will make documentation of compliance easier to track. C.F.R. 164.522 (b)(1)

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

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

1. Limits use and disclosure of the LDS to research, public health or health care operations.
2. Establishes who is permitted to use or receive the LDS.
3. Establishes permitted uses and disclosures by the LDS recipient.
4. Provides that the LDS recipient will:
   a. Not use or further disclose the information other than as permitted by the agreement or as otherwise required by law
   b. Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the agreement
   c. Report to the SVMHS Privacy Officer any use or disclosure of the information not provided for by the agreement of which it becomes aware
   d. Ensure that any agents, including a subcontractor, to whom it provides the LDS agrees to the same restrictions and conditions that apply to the recipient with respect to such information
   e. Not re-identify the information or contact the individuals.
5. The Privacy Officer will make arrangements internally or with a Business Associate to produce the PHI that excludes the following identifiers of the Individual, relatives of the Individual, employers and household members:
   a. Names

b. Street or P.O. Address

c. Telephone numbers

d. Fax numbers

e. Electronic mail addresses

f. Social Security numbers

g. Medical record numbers

h. Health plan beneficiary numbers

i. Account numbers

j. Certificate/license numbers

k. Vehicle identifiers and serial numbers, including license plate numbers

l. Device identifiers and serial numbers

m. Web Universal Resource Locators (URLs)

n. Internet Protocol (IP) addresses

o. Biometric identifiers including voice and fingerprints

p. Full face photographic images and comparable images

6. Violation of Privacy Regulations regarding LDS. If SVMHS knows of a pattern of activity or practice of the recipient that is in violation or material breach of the Data Use Agreement or contract/agreement, unless SVMHS takes reasonable steps to cure the breach or end the violation, as applicable, and if such steps are unsuccessful:

   a. Discontinues disclosure of PHI to the recipient; and

   b. Reports the problem to the DHHS secretary.

7. If a covered entity is the LDS recipient, violation of the agreement is considered a violation of the privacy regulation by such recipient. Refer to [45 C.F.R. Section 164.514(e)(4)(iii)].

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

1. The SVMHS Breach Response Team will consist of the Privacy Officer/Designee, Senior Administrative Director Quality Management, and Chief Human Resources Officer/Designee, and department/clinic management. As appropriate the Chief Information Officer, IT Security Officer, Compliance Officer, Risk Manager and other staff will be included in the team.
2. Any SVMHS workforce member who becomes aware of a potential breach of PHI will notify his/her supervisor of the suspected breach immediately.
3. The SVMHS workforce member or supervisor will document the facts related to the potential breach by completing an Occurrence Report in the Managing Events software and contact the Privacy Officer/designee as soon as possible.
4. Any medical staff member or business associate who becomes aware of a breach to SVMHS PHI will notify the SVMHS Privacy Officer/Designee.
5. A breach is considered discovered as of the first day on which the breach is known by SVMHS. This requirement does not include the offending workforce member knowing about the event and not telling another workforce member about the event.
6. Preliminary Investigation.
    a. The Privacy Officer/Designee will interview as appropriate anyone having knowledge of the potential breach, and document findings on the HIPAA Questions form and as needed the HIPAA Breach Decision Tool and Risk Assessment Documentation form. There will be consideration of at least the following risk factors:
        i. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.
        ii. The unauthorized person who used the PHI or to whom the disclosure was made.
        iii. Whether the PHI was actually acquired or viewed and the extent to which the risk to the PHI has been mitigated.
7. No Breach of PHI. If the breach assessment indicates there was no breach, the event will be logged on the Event Tracker. If related

documentation is generated, it will be maintained in the Occurrence Reporting system.

8. Breach of PHI/No Breach of Computer System. If the breach investigation and assessment indicates there is a breach of PHI, but the breach did not occur as a result of a problem related to computer technology, the Privacy Officer/Designee will:

   a. Pull together an Incident Response Team appropriate to the breach.

   b. Lead the team in development, implementation and oversight of an action plan that:

      i. Notifies the individual(s), California Department of Public Health (CDPH), HHS and media as required in the HIPAA Breach Notification Rule.

      ii. Mitigates to the extent practicable, any harmful effects of the breach.

      iii. Improves processes to minimize the possibility of recurrences.

      iv. Applies sanctions in accordance with the Sanction Policy or Business Associate Agreement.

   c. Log the event in the Event Tracker and maintain investigation and assessment documentation in the Occurrence Reporting system.

9. Breach of PHI Involving Computer System. If the breach investigation and assessment indicate there has been a breach in security of the computer system, the Privacy Officer and Security Officer will:

   a. Pull together an Incident Response Team appropriate to the breach.

   b. Lead the team in development, implementation and oversight of an action plan that:

   c. Notifies the individual(s), California Department of Public Health (CDPH), HHS and media as required in the HIPAA Breach Notification Rule.

   d. Addresses the computer technology or security issue.

   e. Mitigates to the extent practicable, any harmful effects of the breach.

f. Improves processes to minimize the possibility of recurrences.

g. Applies sanctions in accordance with the Sanction Policy or Business Associate Agreement.

h. Log the event in the Event Tracker and maintain investigation and assessment documentation in the Occurrence Reporting system.

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

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

1. SVMH. A breach of unsecured PHI is to be reported to California Department of Public Health (CDPH) and to the patient or their personal representative within 15 business days of discovering the breach.

a. The breach reporting letter, letter to the patient and additional information should be made to the hospital's CDPH Licensing and Certification district office. A list of district offices may be found at: http://www.cdph.ca.gov/CERTLIC/FACILITIES/Pages/LCDistrictOffices.aspx.

b. Content of reporting letter to CDPH. Include the following:

i. Date and time of reported incident

ii. Facility Name

iii. Facility address/location

iv. Facility contact person

v. General Information about the circumstances surrounding the breach

c. Any additional information needed to make the determination for an onsite investigation may be included in an attached memo.

2. SVMHS Reporting to DHHS. If a breach involves fewer than 500 patients, the breaches discovered in a calendar year must be submitted within 60 days after the end of each calendar year. The deadline is March 1st in most years, February 29th in leap year. Report as specified at www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html. DHHS requires Individuals to be notified a soon as possible but less than 60 days.

3. SVMH. If a determination regarding an event cannot be completed within the 15 business days, a decision needs to be made regarding the reporting to CDPH. This decision is to be documented well and may be needed in an appeal. The fine for late reporting is $100 a day per patient.

4. SVMHS. Law enforcement request for delayed reporting, notification, or posting. If a law enforcement agency or official determines that a notification, notice, or posting would impede a criminal investigation or cause damage to national security, the organization must delay the activity. Note that CA does not have a provision for delayed reporting at the request of law enforcement.

   a. The law enforcement agency or official may provide a written or oral statement that notifying the patient would likely impede the agency's investigation of the breach. A date upon which the delay must end needs to be provided. The delay is not to exceed 60 days after a written request or 30 days after an oral request is made.

   b. If the law enforcement agency or official provided an oral request/statement, do the following:

      i. Document the oral statement, including the identity of the law enforcement agency or official making the oral statement. Document the date of the oral statement.

      ii. Limit the delay in reporting the breach to the date specified in the oral statement, not to exceed 30 days from the date of the oral request.

   c. A law enforcement agency or official may request an extension of the delay. SVMHS is to receive a written declaration that there exists a bona fide, ongoing, significant criminal investigation or serious wrongdoing related to the unlawful or unauthorized access to, use or disclosure of a patient's medical information and that notification of patients will undermine the law enforcement agency's investigation. The written statement must specify a date upon which the delay must end. This date cannot be beyond 60 days after the "end" date of the original delay request.

5. Notification to Individual:

   a. SVMH. Notification to CDPH and patient is to proceed no later than 15 business days after the date designated as the end of the delay.

   b. SVMHS. Notification to the patient is to be as soon as possible but less than 60 days after the date designated as the end of the delay.

6. Individual Notification. Written notice must be in plain language at an appropriate reading level with clear syntax and language with no extraneous materials. Americans with disabilities Act (ADA) and Limited English Proficiency (LEP) requirement must be met.

   a. Written notification is to be provided to the patient or if the patient is deceased, the next of kin or personal representative. If the patient is incapacitated/incompetent, the notification is to be sent to the personal representative.

7. Content of the Patient/Legal Representative Notification:

   a. Brief description of the breach and the date of the discovery of the breach.

   b. Description of the types of unsecured PHI involved in the breach.

   c. Steps individuals should take to protect themselves from potential harm resulting from the breach.

   d. Brief description of what SVMHS is doing to investigate the breach, to mitigate harm to the individual(s) and to protect against any further breaches; and

   e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll free telephone number, an e-mail address, web site, or postal address.

8. Means of Notification

   a. The individual whose information was breached must be notified by first class mail sent to the individual's last known address, or if the individual agrees to electronic notice and such agreement has not be withdrawn, by encrypted electronic mail.

   b. If SVMHS knows the individual is deceased and has the address of the next of kin or personal representative, written notice by first

class mail to either the next of kin or personal representative may be provided in one or more mailings as information is available.

c. E-mail notification is not permitted if the patient is deceased.

d. If patient or their representative will not provide address or email address, SVMHS may telephone patient to come pick up the notification letter. If patient cannot do this, provide the contents over the phone. Document well. 78 Fed. Reg. 5566, 5651, Jan. 25, 2013.

e. Substitute Notice – In the case where there is insufficient or out-of-date contact information:

i. For less than ten (10) individuals that precludes direct written notification to the individual, a substitute form of notice shall be provided such as a telephone call.

ii. In the case that there are ten (10) or more individuals for which there is insufficient or out of date contact information and contact information is not obtained:

1) Post a conspicuous notice for 90 days on the home page of the SVMHS website; or

2) Provide notice in a major print or broadcast media in the geographic are where the individuals affected by the breach likely reside.

3) Include a toll-free number that remains active for at least 90 days.

4) Work with Administration and Marketing regarding wording.

9. Breaches affecting >500 Individuals.

a. The Privacy Officer/designee will work with the Compliance Officer, HIPAA Team and Director of Public Relations, and others as needed when there is a breach within the same state or jurisdiction.

b. A press release containing the same information provided in the notice to the individual will be authored and sent to prominent media outlets within 15 business days of the discovery of the breach.

c. Provide direct written notice to the Individual as describer earlier in this policy.

d. Report via the Office for Civil Rights breach portal without unreasonable delay and in no case later than 60 days of when the breach was discovered. 45 CFR 164.400; HITECH 13402, 17932

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

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

1. Minimum necessary, in regards to system access, will be sustained through authorization, access, and audit controls (role-based access) and should be implemented for all systems that contain identifiable patient information. Providers and workforce members with system access may only access what they need to perform their job functions.

2. SVMHS must identify classes of providers and workforce members who need access to PHI to carry out their job function by the following:

   a. List the categories of providers and workforce members within the organization.

   b. Identify the degree (level) of PHI that each category of provider and workforce member is permitted to access.

3. The following categories of Providers and workforce members are permitted unrestricted access to PHI for the purpose of providing patient care or healthcare operations:

   a. Attending physician
   b. Consulting physicians (medical, surgical and specialists)
   c. Nursing personnel (example: registered and licensed nurses and nursing assistants)
   d. Clinical support staff (example: Unit Assistants, Clinical Informatics)
   e. Health Information Management Personnel
   f. Quality Management

g. Case Management, Disease Management, Infection Control
h. Clinical Administrative Management & Support Staff

4. The following categories of Providers and workforce members are permitted access to restricted PHI for the purposes of providing an element of patient care or healthcare operations:

a. Laboratory
b. Diagnostic Imaging
c. Pharmacy
d. Social Services
e. Clinical Nutrition Services & Nutrition Services Staff
f. Patient Financial Services
g. Registration
h. Compliance & Auditing
i. Information Technology
j. Financial & Data Support
k. Non Clinical Administrative Management and Support Staff
l. Volunteers
m. Professional Program Students, Interns, Residents

5. The following categories of workforce members are not permitted access to PHI:

a. Security
b. Environmental Services
c. Engineering

6. Providers and workforce members with unrestricted access to PHI are limited to use and disclosure of information for which they are responsible for the provision of health care.

7. Providers and workforce members with restricted access to PHI are expected to request permission to view the information that is necessary to achieve the purpose of providing the element of healthcare. The Privacy Officer/designee will review the requests on an individual basis.

8. Providers and workforce members are not permitted to access PHI for those individuals whom they are not responsible for providing care. This means that a provider or workforce member is not permitted to review PHI of a patient in another care area, review PHI of a friend or relative, review PHI upon request of another patient, or a patient from whom payment is not expected for healthcare services (as in the case of physicians, etc.).

Access to PHI of friends or relatives as part of the job function is not to be performed if it is possible for a co-worker to perform the task. Request a coworker handle the job task.

9. Providers and workforce members may not access their own medical information except as allowable through the Patient Portal.

10. Providers may be granted access to PHI if needed for their treatment, payment or operations as defined in the GRANTING ACCESS TO ELECTRONIC MEDICAL INFORMATION policy # 967.

11. SVMHS may provide limited PHI upon request if the request is made by another provider for care purposes, health insurance agency with whom patient has coverage, or health information clearinghouse or if requested by a business associate for the purpose of providing professional services to the healthcare system/patient.

12. SVMHS may provide limited PHI if requested for research purposes and according to the policies on research activities.

    a. Providers and workforce members may not use, release or request an entire medical record unless the entire record is identified as being the minimal amount of information needed to accomplish the intended purpose.

    b. SVMHS may rely on the judgment of the party requesting the disclosure as to the minimum amount of information that is needed. The reliance is permitted when the request is made by:

        i. A public official or agency who states that the information requested is the minimum necessary for a purpose permitted under 45 CFR 164.512 of the Rule, such as for public health purposes.

        ii. Another covered entity.

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

iv. The minimum necessary requirement does not apply to:

1) Disclosures to or requests by a health care provider for treatment.

2) Uses or disclosures made to individuals.

3) Uses or disclosures made pursuant to an authorization.

4) Disclosures made to the Secretary of DHHS for an investigation or compliance review.

v. Other uses or disclosures that are required by law under 45 C.F.R Section 164.512 (a)-e.g. where a state or other law requires disclosure, such as disclosure pursuant to a subpoena or court order, for workers' compensation purposes, or any other use or disclosure of PHI that is enforceable in a court of law.

1) Uses or disclosure required for the provider to comply with HIPAA.

2) Limited data sets and de-identified information.

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

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

1. The Privacy Officer will work with Administration and legal counsel to ensure SVMHS has a business associate agreement (BAA) that complies with the requirements of the Health Insurance Portability and Accountability Act's Privacy Rule and any subsequent Federal or State law on the subject.

2. Any contract or agreement where patient information will be accessed, used, or disclosed will be evaluated for the need of a BAA by the Privacy Officer. Any question if a BAA is needed, contact the Privacy Officer.

3. Refer to the Privacy Officer any BAA agreements wherein the vendor wants to use their own language or proposes changes to the SVMHS BAA language.

4. The Privacy Officer will compare the proposed language with HIPAA's requirements and discuss and work through with stakeholders language change proposals.

5. The signed BAA must be secured with the service contract prior to the provision of services by the vendor or payment for services by SVMHS.

6. A BAA must have a related contract or agreement. It cannot be a stand-alone document.

7. On receipt of a signed BAA, the signed contract or agreement and BAA are scanned into the contracting software central repository.

8. The scanned or hard copy will be retained no less than the expiration of the BA contract plus six years.

9. If and when a material change in the BAA language is necessary, the Privacy Officer will coordinate acquisition of the revised BAA for all BAs.

10. Breach of BAA.

    a. SVMHS shall investigate compliance with the BAA and contract/agreement if a complaint is made that the BA has violated the terms of the contract or if presented with information that contains substantial and credible evidence of a violation.

    b. In the event of a breach, the SVMHS should procure in writing an immediate assurance from the BA that the problem has been corrected.

    c. If after determining a BA is in breach of contract and the hospital finds it not feasible to terminate the contract, the hospital shall notify the Secretary of Health and Human Services.

11. Out of Office Coverage: If Privacy Officer is out of the office, send BAA to the Director of Internal Audit and Compliance for review and approval.

12. BAA Sign Off: The BAA is to be signed by whoever has the authority to sign the contract/agreement.

13. All Senior Management Team members responsible for contracts will be responsible to ensure that BAs have been identified and that the appropriate BAA or BA language is in place by the effective date.

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

1. When the Privacy Officer/designee is unavailable, staff may collect relevant information from the individual, and communicate that information to the Privacy Officer/designee via the Occurrence Reporting System or internal e-mail.

2. If a complaint is reported verbally, try to obtain it in writing via e-mail, fax, or mail. The reason for this is to ensure all the information is accurate and obtained for use in the investigation.

3. The Privacy Officer/designee will work with colleagues and leadership to investigate the complaint, and evaluate the need for sanctions, opportunities to improve policy, process, education and training, and communication.

4. The Privacy Officer/designee will document in the Privacy Investigation log and/or Occurrence Reporting System each complaint and its resolution.

5. SVMHS may not require individuals to waive their rights to file a complaint with DHHS or to waive any of their other privacy rights as a condition for treatment, payment, enrollment in a health plan, or eligibility for benefits. 45 CFT 164.530(h)

6. The Privacy Officer will retain information for not less than 6 years, information about each complaint, investigative findings and action taken.

K. **USES & DISCLOSURES REQUIRING AN OPPORTUNITY FOR THE PATIENT TO AGREE OR TO OBJECT** - SVMHS may use or disclose (PHI) provided that the patient is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure. SVMHS

may orally inform the patient of and obtain the patient's oral agreement or objection to a use or disclosure covered in this section. (164.510)

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

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

   b. SVMHS may use or disclose PHI to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the patient, or another person responsible for the care of the patient of the patient's location, general condition, or death.

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

      i. Uses and Disclosure with The Patient Present - SVMHS may disclose to the family member, personal representative, or another person responsible for the patient's care, the patient's location and general condition, if the individual is present, and has the capacity to make health care decisions and SVMHS:

         1) Obtains the patient's agreement;

         2) Provides the patient with the opportunity to object to the disclosure and the patient does not express an objection; or

         3) Reasonably infers from the circumstances that the patient does not object to the disclosure.

      ii. Limited Uses and Disclosures When Patient is Not Present or Cannot Agree or Object - If the patient is not present, or the opportunity to agree or object cannot practicably be provide because of the patient's incapacity or an emergency circumstance, SVMHS may in the exercise of professional judgment, determine whether the disclosure is in the best

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

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

iii. Disaster Relief Purposes – SVMHS may use or disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the patient, or another person responsible for the care of the patient of the patient's location, general condition, or death, to the extent that SVMHS, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

d. Basic information including the patient's name, city of residence, age, sex, and general condition (see general condition listing in Section L, Media and Public Release of PHI may be disclosed.

e. **However**, If patient is present and has the capacity to make health care decisions and unless SVMHS determines that the following requirements interfere with the ability to respond to the emergency circumstances, SVMHS must follow the steps below before disclosing the information.

i. Obtain the patient's agreement, or

ii. Provide the patient with the opportunity to object to the disclosure (if the patient objects, no disclosure may be made); or

iii. Reasonably infer from the circumstances based on the exercise of professional judgment that the patient does not object to the disclosure.

f. If patient is not present or is unable to agree or object to the use or disclosure due to incapacity or an emergency circumstance, the

SVMHS may determine whether the disclosure is in the best interest of the patient and, if so, disclose only the PHI that is directly relevant to the disaster relief organization's involvement with the individual's health care.

g. It is best to notify next-of-kin before releasing patient information, in disaster situations involving multiple casualties it may be necessary to share patient information with other hospitals and/or rescue/relief organizations prior to next-of-kin being contacted. (Normally, obtain legal representative authorization prior to making any disclosure.)

2. Patient is Deceased - If the patient is deceased, SVMHS may disclose to a family member, personal representative or another person responsible for the patient's care or payment for health care prior to the patient's death, PHI of the patient that is relevant to such person's involvement, the patient's location and the fact the patient is deceased, unless doing so is inconsistent with any prior expressed preference of the individual known to SVMHS. Refer to Section Q on Authorization of Use and Disclosure.

3. SVMH Directory – A Patient Directory is provided for use by Concierge Staff and others as needed. This directory includes patient name and location.

a. The patient or their legal representative has the opportunity to object to use and disclosure of their PHI in the Patient Directory by choosing to become a Confidential patient at registration or at any time during their stay. 164.520(e)

b. Patient's location is provided if the information is requested by patient name.

c. Any inquiry regarding a Confidential patient will receive an "we have no patient by that name" response.

d. In an emergency, if the patient does not have the opportunity to object, use the previous patient preference and in the exercise of professional judgment, what is in the patient's best interest.

e. Upon full registration or when practicable to do so, provide the patient the opportunity to object to the Patient Directory listing and the option to become Confidential. CFR 164.520(e)

4. Clergy Services – A patient's religious preference is collected at registration. During the Nursing Assessment, patient agreement or objection regarding pastoral visits is documented in the patient's medical record. SVMH clergy will receive a notice with the patient's agreement or objection regarding a clergy visit. Any further notification to clergy is at the patient's request.

L. **MEDIA AND PUBLIC RELEASE OF PATIENT INFORMATION** – SVMHS will not disclose protected health information (PHI) to the media except as permitted by federal and state laws and regulations. All requests for information from the media will be referred to the Public Relations Department.

1. The Public Relations Department has the responsibility of notifying Administration (Chief Strategic Communications Officer), Security and Administrative Supervisor if media is scheduled to be on the premises. All members of the media will be escorted by the Public Relations Department or authorized designee.

2. Employees need to notify ~~Administration~~ Public Relations ~~or the Administrative Supervisor~~ immediately if members of the media arrive at the h~~H~~ospital and are not accompanied by designated h~~H~~ospital p~~P~~ersonnel.

~~2.~~3. Public Relations will not release any information about "confidential" patients.

~~3.~~4. Public Relations will not release any information to the media regarding attending physician's name without the permission of the physician (as well as the patient).

~~1. A healthcare provider, upon an inquiry concerning a specific patient, may release basic information unless the patient specifically requests that such information be withheld (Civil Code Section 56.16). If the patient has not specified what information should be withheld, the basic information discussed below may be released to the public if the inquiry is by patient name:~~

~~4.~~ Any inquiry must be by patient name. If patient is not Confidential, the following Basic Information that does not communicate specific medical information, may be used.

5. Basic Information is defined to include: ~~(see below for restrictions on releasing information concerning death, IV.F.bullet #1,1.b.v.).~~

a. The patient's name, ~~address,~~ age and sex.

b. The general condition of the patient. Definition of General Condition:

i. UNDETERMINED – Patient waiting physician assessment.

ii. GOOD – Vital signs are stable and within normal limits. Patient is conscious but may be uncomfortable. Indicators are excellent.

iii. FAIR – Vital signs are stable and within normal limits. Patient is conscious but may be uncomfortable. Indicators are favorable.

iv. SERIOUS – Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.

v. CRITICAL – Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.

~~vi.~~

~~vii.~~vi. DECEASED – Announcement of death is not to be made by the SVMHS. Obtain the patient's legal representative's authorization prior to making any announcement or providing any information.

6. HIPAA requires an authorization for release of a general description/nature of the reason for treatment, such as an injury, a burn, poisoning, or some other condition. This is considered medical information.

7. Patient Location should not be released to the media.

8. SVMHS may disclose that a patient was treated and released.

9. SVMHS must obtain a written authorization before media may use photographs, videotape, and interview a patient.

~~i. The general nature of the injury, burn, poisoning, or other condition.~~

a. For CA Civil Code, although the Act states that "basic information" includes any information that is NOT "medical information" (Civil Code Section 56.06 (b)), it is NOT advisable to

release information other than those items listed above, unless the patient specifically authorizes the release of other information.

~~Community Disasters - Disasters require special handling. When the hospital is handling a large number of victims from a disaster, every attempt should be made to keep news media informed without violating the patient's confidentiality rights. Hospitals should include policies and procedures for dealing with the media in their disaster plans. Basic information, including the patient's name, city of residence, age, sex and general condition may be released to a state or federally recognized disaster relief organization (such as the Red Cross) for the purpose of responding to disaster welfare inquiries. (Civil Code Section 56.10(c)(15).~~

10. **Disaster Situations** – Requirements for releasing patient information do not change. Media must have a patient's name before any information can be released as described above.

11. SVMSH may tell the media the number of patients that have been brought to our facility by:
    - Gender
    - Age group (adults, teens, children, etc.)
    - General cause of treatment need (an explosion, earthquake, etc.) as long as it is not identifiable to a specific person.

~~12.~~ The Secretary of DHHS may issue a waiver for release of specific patient information. Note, there is no process to waive penalties for violations of state health information privacy laws.

~~13.~~12.

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

1. The Privacy Officer will ensure that the NPP meets the content requirements of the HIPAA Privacy Rule and will promptly revise, post and distribute the NPP when there is a material change in uses or disclosures, or legislation/regulation that changes its required content.

2. Whenever the NPP is revised, the Privacy Officer will coordinate replacement of the NPP on the organization's web site, where posted in

registration areas, and where paper copies are made available to individuals by Registration staff.

3. The Privacy Officer will maintain a copy of each version of the NPP with its effective dates. Each NPP version will be retained not less than six years from the date it becomes obsolete.

4. Whenever the NPP is revised, the Privacy Officer will coordinate replacement of the NPP on the organization's web site, where posted in registration areas, and where paper copies are made available to individuals by Registration staff.

5. Responsibilities of Registration Leadership and Staff:

   a. Registration Leadership will ensure that Registration Staff have the procedures, training and oversite necessary to ensure distribution of the NPP.

   b. Registration staff will provide the notice:

      i. No later than the date of the first service delivery or in an emergency treatment situation, as soon as reasonably practicable.

      ii. Electronically and concurrently if the first service is delivered electronically.

   c. When acknowledgement of the NPP cannot be obtained, the registration staff member will document good faith efforts to obtain acknowledgement and the reason why the acknowledgement was not obtained.

   d. The Registration staff will file the acknowledgement in the designated location in the individual's record.

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

1. When the information has been de-identified (See Section on De-identification of PHI).

2. To the individual or their legal representative; however, to validate identity of the individual and provide written evidence, ask for an Authorization for Disclosure or Use of Medical Information form to be completed if possible.

3. For its own treatment, payment, or healthcare operations. See section below on Operations for an expanded discussion.

4. To another covered entity for treatment. PHI can be disclosed to health care providers, health care service plans, contractors, or other health care professionals and facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission or other means between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a licensed health facility.

5. To another covered entity for payment activities of the receiving entity.

6. To another covered entity for health care operations if each entity has had a relationship with the individual and the information pertains to that relationship and the purpose is listed in paragraph (a) or (b) of the expanded definition of health care operations as described in item #15 below, or use or disclosure and in accordance with the minimum necessary standard (See Section on Minimum Necessary standard).

7. To another covered entity for detection of fraud and abuse or compliance with regulations.

8. A provider participating in an "organized health care arrangement" (as defined by HIPAA) may disclose patient information to other participants in the arrangement for any health care operations activities of the organized health care arrangement. (Example: hospital and medical staff share PHI for credentialing, quality assurance, and other peer review activities.

9. To Law Enforcement Officer who is trying to identify or find patient. Only disclose the information as displayed in Facility Directory. Any other information requires a subpoena.
See Section AA of this policy re: Law Enforcement.

10. When the use or disclosure is required by law.

11. To Business Associates with whom SVMHS has a valid business associate agreement.

12. To a health oversight agency or public health authority authorized by law to investigate or otherwise oversee relevant conduct or conditions of SVMHS or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by SVMHS.

13. To an attorney retained by or on behalf of a workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate with regard to unlawful business practices.

14. To law enforcement by a workforce member who is the victim of a criminal act provided that the information is about the suspected perpetrator of the criminal act and the information disclosed is limited to: the name and address; date and place of birth; social security number; ABO blood type and Rh factor; type of injury; date and time of treatment; date and time of death, if applicable; and description of distinguishing physical characteristics including: height; weight; gender; race, hair and eye color; presence or absence of facial hair; scars and tattoos.

15. To the following without obtaining special authorization:

    a. Coroners or medical examiners
    b. Organ procurement (Donor Network)
    c. As part of a research project

16. Probate Court Investigator for Guardianship/Conservatorship Proceedings. CMIA permits medical information to be disclosed, HIPAA does not. HIPAA permits disclosure for judicial or administrative proceedings if there is an order from the court or administrative tribunal compelling disclosure; or in response to a subpoena, discovery request, or other lawful process. The patient notice process is to be followed.

17. Healthcare Operations. The following is an expanded review of the definition of Operations and means any of the following activities:

    a. Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalized knowledge is

not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing heath care costs; protocol development, case management and care coordination; contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.

b. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of heath care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities.

c. Except as prohibited under 45 CFR section 164.502(a)(5)(i), underwriting enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract to health insurance or health benefits, and ceding, securing, or placing a contract for re-insurance of risk relating to claims for heath care (including stop-loss insurance and excess of loss insurance), provided that the requirements of section 45 CFR 164.514(g) are met, if applicable.

d. Conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse detection and compliance programs.

e. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

f. Business management and general administrative activities of the entity, including, but not limited to:

i. Management activities relating to implementation of and compliance with the requirements of this subchapter.

ii. Customer service including the provision of data analyses for policy holders, plan sponsors, or other customers,

provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer

iii. Resolution of internal grievances.

iv. The sale, transfer, merger, or consolidation of all or part of a covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

v. Consistent with the applicable requirements of 45 CFR 164.514 creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

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

a. Physicians – Physicians can release PHI to the Individual as needed. Physicians are not to provide Individuals with complete copies of their medical records. Refer Individuals to the HIM Department.

b. Releases to Providers – Any provider who states they are actively treating the patient has a right to PHI. Log any release that is not part of the normal documentation process. Refer any other release to HIM.

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

a. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefits claims;
b. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
c. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess-of-loss insurance) and related health care data processing;

d. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness or care or justification of charges;
e. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
f. Disclosure to consumer reporting agencies of and of the following PHI relating to collection of premiums or reimbursement:

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

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

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

1. SVMHS workforce members will provide an Individual requesting copies of his/her records for themselves or copies be sent to a 3rd party with either:

a. The Authorization for Use or Disclosure of Health Information form used to request copies of records and directions for completing and submitting the form;
b. Instructions for obtaining the form on the SVMHS web site; or
c. Directions to the HIM/Medical Records Department in the Hospital or the front desk in a Clinic.

2. The staff member accepting a written authorization will review the document to make sure the authorization clearly specifies what the individual wants used or disclosed and that it is signed and dated.

3. The staff member accepting the authorization will give the authorization to the HIM/Medical Records Department or designated Clinic staff. Staff will also review the authorization to ensure it contains the required content.
   a. Validate the Individual's identity with a valid legal identification card with photo. Ensure signature on the authorization matches the one on file.
   b. Obtain or validate phone number for contact information.
   c. Make a copy of the requested information (when applicable).
   d. Mailing or making arrangements to securely transmit or provide the information to the specified recipient.
   e. Recording the disclosure in the release of information software application.
   f. Scanning the authorization into the Individual's record.

4. HIM or the designated Clinic staff will return an incomplete or invalid authorization to the individual with an explanation and directions for correcting and resubmitting the authorization.

5. The authorization will be retained in the patient's record according to the record retention policy but no less than 6 years from the expiration date.

6. Data Format.

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

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

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

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

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

f. Any Individual requesting records of a deceased patient is to provide a Death Certificate, proof of their identity, and proof of one of the above items.

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

9. Minors – Personal Representative of a minor may act on the patient's behalf:
    i. Parent
    ii. Guardian
    iii. Other person in loco parentis (person acting as parent)

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

6. Foster Parent Request.

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

7. Ancillary Release of PHI – Hospital Only

a. Nursing - If the patient or patient's physician requests that the patient receive specific PHI such as a test result, nursing staff may provide the patient a copy. Document the event in the medical

record. Staff are to ensure there is a valid authorization that has not expired in the patient's medical record completed by the patient or legal representative. If the patient is being cared for at the time of request and is standing in front of you, documentation may be given without completing the authorization form.

b. Lab – Staff may provide test results to patients who frequent the Lab multiple times a month due to a serious medical condition. Any other type of request for release of PHI is to be completed through HIM. Staff are to ensure there is a valid authorization that has not expire in the patient's medical record completed by the patient or legal representative.

c. Diagnostic Imaging – On occasion there will be a need to provide test results to the Individual. Staff are to ensure there is a valid authorization that has not expired in the medical record completed by the patient or legal representative. Any other type of request for release of PHI is to be completed through HIM.

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

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

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

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

11. HIV – An authorization is required identifying the release of HIV test results specifically and an authorization is required for each release. HIV

Disease does not need special authorization. See the RELEASE OF INFORMATION - HIM PROCEDURE

12. California Pre-Empt HIPAA Requiring an Authorization - The following situations require a patient authorization before releasing medical records. HIPAA allows release of information but California does not recognize such a request.

    a. Exception would be if separate federal law expressly requires or permits. CFR164.512 (k)
        i. Disclosure of PHI involving certain military and veterans activities (e.g., disclosure of information about armed services personnel to military authorities for activities deemed necessary by the authorities.)
        ii. Disclosure of PHI to authorized federal officials conducting lawful intelligence, counter intelligence, or other national security activities
        iii. Disclosure of PHI to allow appropriate governmental agencies to provide protective services for government officials

        iv. Disclosures to Funeral Directors. CFR 164.512(g)

        v. Certain disclosures to Employer if:
            - SVMHS is retained by employer to provide health care to patient in course of evaluating workplace or determining whether patient has a work-related illness or injury
            - PHI disclosed consists of such findings
            - Employer needs information to comply with OSHA laws, and
            - Provider gives specific notice to employee or posts a general notice at workplace. 45 CFR 164.512(b)(1)(v)

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

P. **VALID AUTHORIZATION** – SVMHS will provide the Individual a valid authorization form called **Authorization For Disclosure or Use of Medical**

Information. Designated HIM Department or Clinic staff will review the authorization to ensure that it is valid and complete and meets the following requirements:

1. Authorization is in plain language and printed in > 14 point typeface on SVMHS stationary or name of SVMHS is clearly identified. CA Civil Code 56.11a.

2. The name or other identification of the person(s), or class of persons authorized to make the requested use or disclosure

3. The name or other specific identification of the person(s) or class of persons to whom SVMHS may make the requested use or disclosure

4. A description of the information to be used or disclosed

5. A description of the purpose of the requested use or disclosure

6. The date on which the authorization expires

7. The signature of the patient or the patient's legal representative and date signed. If someone other than the patient is signing the authorization form, that individual's relationship to the patient must be stated.

8. Notification of the patient's or patient's personal representative right to revoke the authorization in writing, the exceptions to the right to revoke and a description of how the individual may exercise the right to revoke the authorization.

9. Notification of SVMHS's inability to condition treatment on whether or not the individual signs the authorization

10. Statement that the recipient of the PHI under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. [CA Civil Code 56.13 superseding HIPAA.]

11. Notification to the individual of their right to receive a copy of the authorization when SVMHS requests an authorization for use or disclosure of PHI. [HIPAA supersedes 45 CFR 164.508(c)(4).

12. Authorizations for use or disclosure of chemical dependency, mental illness, and sexually transmitted disease must explicitly state that that information can be used or disclosed pursuant to the authorization.

13. Expiration date is provided if other than the one year date provided with authorization.

14. An authorization is not valid if the document submitted has any of the following defects:

    a. The expiration date has passed [CA Civil Code 56.11(h) supersedes]
    b. The authorization was not filed out completely (ex. Signature & date)
    c. The authorization is known by SVMHS to have been revoked
    d. Material information in the authorization is known by SVMHS to be false

15. An authorization cannot be combined with another kind of document except when the authorization is for use and disclosure of information for research and a consent to participate in the same research.

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

1. The person who may authorize disclosure of protected health information (PHI) or exercise the patient's information privacy rights under federal and state law is the same person who can consent to medical treatment. That person is the competent adult patient, emancipated minor patient, or the minor patient provided the right to consent to treatment for a specific condition under applicable state law.

2. An individual exercising an adult patient's rights must make decisions in accordance with the patient's instructions or, if those wishes are not known, authorize the access, use or disclosure or exercise the HIPAA privacy right, in the patient's best interest.

3. Generally speaking, no representative may authorize disclosure or exercise the patient's privacy rights under HIPAA if a person of higher priority has refused to give such authorization or if there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.

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

5. Adults:

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

e. Appointed guardian
f. Durable power of attorney encompassing the authority to make health care decisions
g. Advance Healthcare Directive Agent
h. Person legally obligated to financially support adult patient
i. The patient's spouse
j. Children of the patient who are at least 18 years of age
k. Parents of the patient
l. Adult brothers and sisters of the patient
m. Any relative who represents himself or herself to be an appropriate, responsible person to act under the circumstances
n. Any other competent individual representing himself or herself to be responsible for the health care of such person.

6. Minors - Persons who may authorize disclosure of PHI or exercise the patient's privacy rights when a minor is not competent because of age are as follows:

a. The parent, appointed guardian or legal representative
b. A person authorized by the court to consent to medical care
c. Either parent of the minor
d. The individual to whom the minor's parent has given a signed authorization to make health care decisions for the minor patient
e. A competent adult representing himself to be a relative responsible for the health care of the minor patient or a competent adult who has signed and dated a declaration under penalty of perjury.

Minors afforded rights to consent for a specific treatment or condition under state law also have the right to authorize disclosure to others (including the parent or legal representative). Refer to the **Medical Treatment of Minors Chart**. The minor may designate the parent or

legal representative to be treated as the minor's personal representative and therefore have access to PHI.

Billing for minor services: The minor's parents or guardian is generally responsible for the payment of treatment. However, parents of a minor are not financially responsible for healthcare or related services to which the minor may legally consent. (Exception is emancipated minors living in the home of the parent(s) or parents are participating in counseling with the minor.) Welfare and Institutions Code Section 14010

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

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

Situations where SVMHS must provide specific information to the parents:

a. Self-Sufficient Minors: Provider may (but is not required to) inform the minor's parents or guardian of treatment given or needed with or without the minor's consent, if the minor has told SVMHS where the parents or guardian may be contacted. Exercise caution for privacy rights of minor.

b. Sexual Assault: SVMHS must attempt to contact the minor's parents or guardian, unless the professional person reasonably believes that the parent(s) or guardian committed the sexual assault on the minor.

c. Substance Abuse Diagnosis and Treatment: Where the parent or guardian has sought the treatment and the minor receives the treatment, the physician must disclose information regarding the treatment to the parents or guardian upon request, even where the minor objects. Requests are to be directed to the minor's physician for disclosure.

d. Noncustodial Parent: Access to records and PHI may not be denied to a parent solely because that parent is to the minor's custodial parent. However, noncustodial parents (or custodial parents) do not have the right to access where the minor has the legal authority to consent to the treatment. See **Medical Treatment of Minors Chart.** Family Code section 3025.

e. Dependent Children of the Juvenile Court and Mental Health/Psychotherapy Records: Refer to California Health Information Privacy Manual.

f. Social Worker, Probation Officer, or Foster Care Public Health Nurse or other person legally authorized to have custody or care of a minor may receive PHI for the purpose of coordinating healthcare services and medical treatment. Psychotherapy notes may not be released. Minor must be a dependent child or ward of the juvenile court.

g. Dependent Child of the court may have legal counsel access records for the purpose of legal representation.

h. Foster Parent: Access to records depends on placement with the foster parent:
   - By court order or with the consent of the child's legal custodians; or
   - On a temporary basis before a detention hearing has been held

i. Abandoned or Safely Surrendered Newborns: No information may be disclosed by any personnel regarding a parent or other person who surrenders a newborn pursuant to the safe surrender law.

7. Deceased - The following persons in descending order of priority may authorize disclosure or exercise the individual's privacy rights under HIPAA.

   a. Executor of the estate
   b. Trustee under Revocable Living Trust or Beneficiary
   c. Court appointed individual
   d. Living Will and Durable Power of Attorney if the document authorizes the individual to make such decisions

e. Spouse
f. Adult children
g. Parents
h. Adult siblings
i. Adult grandchildren
j. Grandparents

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

R. **SECRETARY OF HEALTH & HUMAN SERVICES** – SVHMS and its BAs will submit compliance reports containing the information, including PHI, the Secretary determines necessary to determine whether SVMHS or its BAs have complied or are complying with the Privacy, Security and Breach Notification Rules.

1. SVMHS and its BAs will permit access by the Secretary during normal business hours.

2. The Privacy Officer will be provided with and will respond fully to written requests by the Secretary.

3. The Privacy Officer will record on the Secretary's request for information document, the information disclosed, the date the information was disclosed, the recipient, the Privacy Officer's name and title.

4. The Privacy Officer will be notified, will accompany, and will see that the Secretary's needs are addressed if/when there is an onsite visit made by the Secretary to investigate a privacy related complaint or a compliance review of SVMHS or its BAs.

5. Executive Leadership Group, Risk Management, and the HIPAA Team will be notified as soon as possible.

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

S. **FAMILY / RELATIVE / CLOSE PERSONAL FRIEND / OTHER PERSON IDENTIFIED BY INDIVIDUAL** - SVMHS may disclose to a family member, other relative, close personal friend of the individual, or any other person identified by the individual, PHI directly relevant to such person's involvement

with the individual's health care or payment related to the individual's health care.

1. Individual Present - SVMHS may disclose to the family member, relative, close personal friend, or other person identified by the individual, PHI relevant to such person's involvement if the individual is present, or otherwise available prior to a use or disclosure and has the capacity to make health care decisions and:

    a. Provides the individual with the opportunity to object to the disclosure and the individual agrees to the disclosure or does not express an objection; or
    b. Reasonably infers from the circumstances that the individual does not object to the disclosure.
    c. Under these circumstances, for example:

        i. A doctor may give information about a patient's mobility limitations to a friend driving the patient home.

        ii. A hospital may discuss an elderly patient's payment options with her adult daughter.

        iii. A doctor may instruct a patient's roommate about proper medicine dosage when she comes to pick up her friend from the hospital.

        iv. A physician may discuss a patient's treatment with the patient in the presence of a friend when the patient brings the friend to a medical appointment and asks if the friend can come into the treatment room.

2. Individual Not Present or Cannot Agree or Object - If the individual is not present, or the opportunity to agree or object cannot practicably be provided because of the individual's incapacity or an emergency circumstance, SVMHS may use professional judgment and experience with common practice, to make reasonable inferences about whether a disclosure is in the best interests of the individual. When doing so, SVMHS may disclose only the PHI that is directly relevant to the person's involvement with the individual's care or payment related to the individual's health care.

    a. Under these circumstances, examples include:

i. A physician informs the patient's spouse, who accompanied her to the emergency room that his wife has suffered a heart attack and provide periodic updates as to the patient's progress and prognosis.

ii. A doctor, consistent with professional judgment, discusses an incapacitated patient's condition with a family member over the phone.

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

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

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

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

1. Upon Admission, the patient will be assigned a unique code number- the last 4 digits of their account number. This confidential code (PIN Number) will be printed in English or Spanish upon admission by staff on the nursing unit.

2. Patients unable to make healthcare decisions (unconscious or demented, etc.)

a. When the emergency contact or next of kin cannot be verified, PHI may be shared with family, friends, or other individuals as long as the RN determines based on professional judgment, it is in the best interest of the Individual.

b. In these cases, staff should always verify that the individual requesting the information has a relationship with the patient and is involved in the care of the patient.

c. When patients are unable to make healthcare decisions, nursing staff will provide the PIN number to the next of kin/caregiver or guardian.

d. Also, in these types of scenarios staff should rely on the emergency contact information that has been specified on the Registration sheets.

e. If you have any questions, contact the Administrative Supervisor.

3. When possible, calls regarding a patient should be transferred to the patient's room, to enable the patient to speak directly to the caller.

4. When releasing information at the bedside to the patients when visitors are present, staff should respect the patients right to privacy by verifying with the patient if discussing their care in front of the visitor is ok.

5. The RN will discuss the purpose of the PIN Number with the patient and leave the form with the patient. (Mother /Baby Unit shall follow this policy when releasing information on the mother/surrogate in a language they understand. ~~However when releasing information on newborns, the Mother/Baby Unit Policy on Release of Information on Newborns should be followed.)~~

6. The PIN Number Form provides a brief explanation of the health info that can be given to persons who provide this code when asking health questions. The PIN Number form will also be automatically printed to the unit's designated printer when the RN completes the Admission History queries. This second form may be filed in the consent files section of the patients' record. The Emergency Room shall follow practices established in that department based on patient needs and emergency situations.

7. Patients will also be instructed that any person(s) asking about the patient's health who does not provide the PIN Number will be told only the patient's room number and a one word description of their condition (good, fair, serious, critical) The nursing staff may offer to transfer the telephone call to the patient's room or direct the individual to the patient's room.

8. When an individual telephones the nursing unit or approaches the nursing unit requesting information regarding a patient the following needs to be provided before any information can be divulged:

a. The person's identification (relationship to patient)
b. PIN Number

U. **REQUEST FOR RESTRICTIONS**

1. A patient may request for restrictions on uses or disclosures for:
   a. Treatment, Payment, or Healthcare Operations
   b. Disclosure to individuals involved in patient's care or notification purposes CFR 164.522

2. SVMHS is not required to agree to a request for restrictions.

3. If SVMHS agrees to a restriction, it must honor the request and ensure restriction until such time as the restriction is terminated by the Individual or by SVMHS.

   a. Emergency Treatment. SVMHS may not use or disclose PHI in violation of a restriction except that, if the individual who requested the restriction is in need of emergency treatment and the restricted PHI is needed to provide emergency treatment, SVMHS may use the restricted PHI or may disclose such information to a health care provider to provide treatment to the individual. If restricted PHI is disclosed to a health care provider for emergency treatment, SVMHS must request that such health care provider not further use or disclose the information.

   b. Requests for restrictions to SVMHS heath care exchanges must be made directly by the individual to the exchange. Contact HIM Department for assistance.

   c. SVMHS workforce members will provide an individual who requests a restriction to the way his/her PHI is used or disclosed with either:
      i. A request for Restriction form
      ii. Directions to the HIM/Medical Records Department in the Hospital or front desk at the Clinic.

   d. The workforce member accepting the completed Request for Restriction will take reasonable steps to verify the identity of the Individual. If the Individual is unknown to the workforce member, the workforce member will:

i. Verify the requestor's signature matches one on file; or

ii. Verify the individual's identity by examining government issued photo identification.

e. The workforce member accepting a completed Request for Restriction form will verify the form is filled out completely and will obtain missing information before the requestor leaves the Hospital or Clinic.

f. The Request for Restriction form will be routed or given to the Privacy Officer/Designee who will be responsible for processing the request.

g. The Privacy Officer/Designee will work with colleagues at SVHMS to determine the reasonableness of any non-required restriction request.

h. Once a decision is made, the Privacy Officer/Designee will notify the requestor as to the decision.

i. The Individual's request will be filed in the Individual's record with a notation as to the date, name of the Privacy Officer/Designee, and disposition of the request.

j. The request and disposition will also be logged in a Request for Restrictions of Uses and Disclosures Log maintained by the Privacy Officer/Designee. (The log is not required by law but will make demonstration of compliance easier should SVHMS be audited.)

k. SVMHS may terminate its agreement to a restriction if:

i. The Individual agrees to or requests the termination in writing. (The individual may use the Request for Restriction form for this purpose.)

ii. The Individual agrees verbally and the agreement is documented in the individual's record.

iii. The restriction pertained to a health plan when the Individual (or another party other than the health plan) paid the bill for the health care item or service in full.

iv. SVHMS informs the Individual that it is terminating its agreement to a restriction except that such termination is only effective with respect to PHI created or received after it has so informed the Individual.

l. Documentation of the request for restriction and disposition will be retained for not less than six years from when the restriction was last in effect. File the documentation with the patient's non-legal portion of the medical record.

m. Documentation of any termination will be retained for not less than six years from when the restriction was last in effect. File the documentation with the patient's non-legal portion of the medical record.

V. **SUBPOENA OR DISCOVERY REQUEST** - For SVMH, all subpoenas and discovery requests for PHI will be referred to the HIM/Medical Record Department for appropriate processing. For SVMC, all Subpoenas and discovery requests for PHI are to be referred to the practice manager for appropriate processing with a Release of Information vendor. On receipt of the subpoenas or discovery request, the designated HIM/Medical Records staff will ensure the subpoena or discovery request:

1. Directs SVMHS or a SVMHS physician to disclose an individual's PHI; and

2. Is accompanied by a valid authorization; or

3. Is accompanied by a written statement and supporting documentation demonstrating:

a. The requestor has made a good faith attempt to provide written notice to the individual; and
b. The notice to the individual included sufficient information about the litigation or proceeding to permit the individual to raise an objection to the court; and
c. The time for the patient to raise objections to the court has elapsed and no objections were filed, or all objections filed have been

resolved by the court and the disclosures being sought are consistent with such resolution; or

d. Is accompanied by a written statement and supporting documentation demonstrating:

i. The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court; or

ii. The requestor has sought a qualified protective order from the court.

4. Information received or generated by a program subject to the Confidentiality of Alcohol and Drug Abuse Patient Record Rule will be disclosed only in response to a valid authorization specific to those records or a Court Order that imposes safeguards for the information once disclosed by SVMHS.

5. If/when the proper documentation is secured, the designate HIM/Medical records staff will:

a. Consult SVMHS's legal counsel with any questions or concerns they may have.

b. Notify Risk Management if/when the subpoena suggests the possibility of a claim against SVMHS, one of its physicians or affiliates.

c. Determine whether a copy of an original paper record needs to be generated and the original locked up to prevent tampering.

d. Determine whether a second copy of all information is required by the SVMHSs attorney.

e. Coordinate acquisition of the required PHI content that HIM/Medical Records is unable to produce.

f. Make copies of only that information expressly authorized by the subpoena or discovery request.

g. Note the disclosure on the subpoena or discovery request with a signature and date.

h. Record the disclosure in the release of information software application.

i. Scan the subpoena or discovery request into the individual's record; and

j. Make arrangements to mail or securely transmit or transport the required information to the designated recipient.

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

The following is more detailed information regarding subpoenas.

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

1. When served with a subpoena, identify what kind received:
   a. The entity which issued the subpoena
      State Court
      i. State Administrative Agency
      ii. Federal Court
      iii. Federal Administrative Agency; and

   b. The type of proceeding for which it was issued
      i. Civil action
      ii. Administrative Agency Hearing or Investigation
      iii. Criminal Action

2. PHI Exempt from Subpoenas:
   a. HIV test results. These require an authorization from the patient for each release or a court order.
   b. Test results for rhesus blood type, hepatitis B and HIV performed pursuant to Health and Safety Code sections 125080 and 125085 (Prenatal Testing) and protected from disclosure under Health and Safety Code Section 125105. These require an authorization from the patient.
   c. Information requested by Law Enforcement Officers.

3. Civil Subpoenas

a. Validity of Subpoena. Determine the validity of the subpoena. The subpoena must be properly served, appropriately designates the hospital or clinic/practice, and, when required is accompanied by the certification of notice to the patient and meets the time requirements specified for production.

b. A subpoena is to be served to the hospital or clinic/practice in person. A subpoena sent by mail has not been properly served. Contact the party who requested subpoena and object.

c. When necessary, the witness fee and mileage are to be paid if employee appears at court.

d. Subpoena Duces Tecum. This subpoena is for the delivery of records to court and must specify the exact documents to be produced. The patient is to be clearly identified in the subpoena and the records requested identifies that particular patient.

e. Affidavit. The civil subpoena must be accompanied by an affidavit or declaration of the requesting attorney or other witness. Check for the following documentation in the affidavit:
   i. Description of the facts showing there is "good cause" for the production of records and a description of how the records are "material" to the issues involved in the case;
   ii. Directions on how the documents are to be produced; and
   iii. State that SVMHS has the desired records in its possession or under our control.

f. Personal Appearance. The personal attendance of the qualified custodian (HIM Staff or Clinic Management) of the patient record and production of the original records is required if the subpoena duces tecum contain a clause which reads:
   i. "The personal attendance of the custodian or other qualified witness and the production of the original records is required by this subpoena. The procedure authorized pursuant to subdivision (b) of Evidence Code Section 1560 and Evidence Code Sections 1561 and 1562 will not be deemed sufficient compliance with this subpoena."

4. Deposition Subpoena for Production of Business Records.
   a. This subpoena will tell SVMHS whether we are to deliver a copy of the requested records to a deposition officer (at SVMHS or elsewhere) or we are to make the records available for copying by the attorney's representative. This subpoena cannot require the personal appearance of a SVMHS representative (custodian of the medical records).

b. Before delivering these records, attach an affidavit of the "custodian of records".

c. The affidavit from the requesting party or declaration is not required for a deposition subpoena.

5. Deposition Subpoena for Personal Appearance and Production of Documents and Things.
   a. This subpoena will request the personal appearance of an SVMHS representative (custodian of medical records) and provide instructions.

   b. The affidavit or declaration is not required for a deposition subpoena.

6. Discovery Request. If a Discovery Request is accompanied by a court order, a Notice to the patient is not required.

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

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

8. Notice to the patient.
   a. CA State Law. CA Code of Civil Procedure Section 1985.3. This applies only when the subpoena is served in connection with a state civil action or proceeding and in certain state administrative action or proceedings. It does not apply in criminal actions or in federal proceedings (ex. Cases in the U.S. District Court or out-of-state court) Section 1985.3 preempts HIPAA in cases where it applies. Otherwise HIPAA procedures for Notice or Protective Order are to be followed.

b. Authorization for release of records. Part of the Notice process for Section 1985.3 is the production of patient authorization by the subpoenaing party.
   i. The patient can sign an authorization to release their records; or
   ii. The patient's attorney of record can sign the authorization to release the patient's records. (HIPAA does not recognize an attorney of record to be a representative who may authorize the disclosure of patient records. Contact Risk Management regarding the attorney signature.)
   iii. The authorization form must provide SVMHS patient signature and date, states that the patient or his or her attorney authorizes the release of records to the subpoenaing party.
   iv. If the Attorney authorized the release, the authorization needs to include a statement that the attorney represents the patient.
   v. If the authorization is not received before the date of production of the records, contact the subpoenaing party stating the records will not be produces until a proper authorization is received by SVMHS.

c. Proof of Service. Another part of the Notice process for Section 1985.3 is the Proof of Service provided by the subpoenaing party. The Proof of Service is to attest the service of documents and include four items:
   i. Subpoena;
   ii. Supporting Affidavit;
   iii. Proof of Service of Subpoena on SVMHS; and
   iv. Notice to the patient/attorney within the required time period. Which is before SVMHS is required to produce records. A subpoena that requires records before the end of the applicable waiting period is defective.

      1) If SVMHS does not receive a Proof of Service listing all four items, contact the subpoenaing party stating that the records cannot be release until SVMHS receives a proper Proof of Service.

      2) A Deposition subpoena served upon SVMHS must be accompanied by the patient's written authorization for release of the records or a copy of the Proof of Service of the Notice to the patient.

d. Notice time requirement. Notice is to be provided to the patient by the subpoenaing party for state civil and administrative proceeding.
   i. A copy of the subpoena and if applicable, supporting affidavit or declaration is to be provided as well.
   ii. This Notice to the patient is to be completed at least 10 days before the date SVMHS is to produce the patient's records, and at least 5 days prior to service of the subpoena upon SVMHS.
   iii. The timeline for the Notice can be extended by an additional 5 days if the Notice is served on the patient by mail at a CA address.
   iv. The timeline for the Notice can be extended by an additional 10 days if served on the patient by mail at an address in another state.
   v. The timeline for the Notice can be extended by an additional 20 days if served on the patient by mail at an address in a foreign country.

e. Waiting Period. The waiting period is designed to give the patient an opportunity to assert any objection to the release of records. The records may be released before the expiration of the waiting period if the patient (or his/her attorney of record) explicitly consents to the release of records. The patient's (or attorney) authorization is to be in writing and state that the patient has no objections and consents to the release of records pursuant to the subpoena. This allows the records to then be released before the expiration of the waiting time period.
   i. Patient is Party to Lawsuit. If the patient is a party to the lawsuit, the Notice and supporting documents can be sent to the patient's attorney.
   ii. Patient is Subpoenaing Party. If the subpoenaing party is the patient, the Notice to the Consumer document is not required.
   iii. The Notice to the patient is to state that:
      1) Records about the patient are being sought from the hospital named in the subpoena;
      2) If the patient objects to the hospital releasing the records, the patient must file papers with the court or serve a written objection prior to the date specified in the subpoena for production of the records; and

3) If the party who is seeking the records will not agree in writing to cancel or limit the subpoena, the patient should consult with an attorney about how he or she may protect his or her interests and right of privacy.
4) The form used by CA is called the "Notice to Consumer or Employee and Objection".

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

g. Objection. If the patient wishes to object to the production of records pursuant to a subpoena duces tecum, the patient is to do one of the following:
i. If the patient is party to the civil action subpoena, the patient should bring a motion to quash or modify the subpoena prior to the date of production and give notice to SVMHS and the disposition officer at lease 5 days prior to production
ii. If the patient is not a party to the civil action subpoena, the patient may, prior to the date of production, serve on the requesting party and SVMHS a written objection that specifies the specific grounds on which production of the records should be prohibited.
iii. After motion to quash, objection, or request to modify the subpoena, SVMHS is not required to produce the records except upon order of the court in which the action is pending or upon agreement of the persons affected (patient, requesting party, and SVMHS).
iv. If the patient calls the hospital or clinic indicating that they are unsure about whether they will object to the release of records or if the patient indicates that they plan to object to the release of records, do not release the records according to the subpoena duces tecum until the waiting period has expired and release only if:
1) SVMHS has not received notice that the patient has brought a motion under Code of Civil Procedure Section 1987 to quash or modify the subpoena, and
2) SVMHS has received from the subpoenaing party a written statement or other documentation that no objections to the production of records was filed or

that any objections were resolved and the disclosure requested is consistent with the resolution.

h. Withholding Compliance with Subpoena Upon Notification of Written Objection or Pending Motion to Quash or Modify Subpoena.
   i. If SVMHS receives notice that the patient has brought a motion to quash or to modify the subpoena, or SVMHS has received a written objection to production of records from the patient, the records should not be released.
   ii. Once the motion to quash or modify the subpoena has happened, the court in which the action is pending can order the release of the patient's records, or
   iii. The parties and the patient can come to agreement and request the release of the records.
   iv. Require a written copy of the parties/patient agreement before disclosing the records.

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

4) No objections were filed; or
5) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

iii. The Individual cannot raise their objections to SVMHS. Objections are to be raised before the court of other body having jurisdiction over the proceedings. Refer the patient to their attorney.

iv. Also, the subpoenaing party must provide a written statement or other documentation notifying SVMHS of the following:
1) No objections to the production of records were filed, or
2) The objections were resolved and the disclosure requested is consistent with the final resolution.

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

v. Timeline for production of records under HIPAA. The party seeking records has provided adequate documentation of compliance with HIPAA requirements for notice or qualified protective order, the time for compliance with the subpoena is the following:
1) Subpoena Duces Tecum (non-deposition subpoena): the subpoena must itself must allow SVMHS reasonable time for preparation and travel to the place of attendance; no exact time limits are established.
2) Deposition Subpoena for Production of Business Records: production cannot be demanded earlier than 20 days after issuance of the subpoena, or 15 days after it is served on SVMHS, whichever date is later.
3) Deposition Subpoena for Personal Appearance and Production of Documents and Things: no specific time requirements are established; SVMHS must have "a reasonable opportunity" to locate

9. <u>SVMHS is Party to the Action</u>. Any documents received that involve any part of SVMHS are to be forwarded to Risk Management. Risk

Management will provide instructions on what is needed to comply with request.

10. Protective Order vs. Notice. A Protective Order for PHI is an order from a court or administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding.

    a. HIPAA allows a Protective Order to be used instead of the Notification to the Individual. In this situation, SVMHS is to receive from the party requesting the PHI a written statement and accompanying documentation demonstrating:
        i. The parties to the dispute giving rise to the request for PHI have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or
        ii. The party seeking the PHI has requested a qualified protective order from such court or administrative tribunal.

    b. Protective Order under CA Code of Civil Procedure Section 1985.3.
        i. Requires that the subpoenaing party give notice of the subpoena to the patient or their attorney. This requirement applies only when the subpoena is served in connection with a state civil action or proceeding and in certain state administrative proceedings.

        ii. If the Protective Order is in regarding to a criminal action or federal proceeding, the requirement for the subpoenaing party to give notice does not apply.

    c. For the order to be "qualified", SVMHS needs the following documentation to be included in the order:
        i. Statement that prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which such information was requested; and
        ii. Requires the return to the covered entity or destruction of the PHI (including all copies made) at the end of the litigation or proceeding.

11. Improper Subpoena. If the subpoena fails to comply with the legal requirements as discussed in the sections above, the staff should notify the

subpoenaing party that, on the basis that the subpoena is defective, SVMHS will not comply with the subpoena.

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

12. Administrative Agency Subpoena.
    a. Subpoena for Hearing. The subpoena must also include an affidavit like the one used in a civil procedure.
    b. Investigatory Subpoena. These subpoenas should include a declaration that explains the purpose for which the records a sought. There is also to be a notice to the patient process. Contact Risk Management if SVMHS receives an investigatory subpoena to determine what requirements apply.
    c. Witness Fees are the same for administrative agency proceedings as those for civil actions in state courts. Refer to the California Hospital Association section on FEES for up to date rates and when fees should be paid.
    d. Service of Subpoena. The administrative subpoena can be served in person, or delivered by certified mail with the return receipt requested; or by messenger. Service by messenger requires SVMHS to acknowledge receipt of the subpoena to the sender by telephone, mail, or in person. In person method will require staff to use some identifying information like a date of birth or driver's license number.

13. Criminal Actions in State Courts.
    a. Criminal Trial Subpoena. The subpoena to compel the attendance of a witness and the production of documents at a criminal trial is to have a statement that describes the required books, papers or documents. The affidavit must be attached to the subpoena.
    b. Servicing of Subpoena. Subpoena served in connection with a criminal proceeding may be served either by mail or by any person (except the defendant). SVMHS is to acknowledge receipt of the subpoena to the sender by phone, mail, over the internet by email or by completion of the sender's online form, or in person and identifies himself or herself by reference to his or her date of birth

and driver's license number of Department of Motor Vehicles identification card number.

i. Document the identifying information provided to the sender in the ROI module.

ii. Failure to comply with a subpoena served and acknowledged in accordance with Penal Code Section 1328d may be punished as contempt by a court, although an arrest warrant may not be issued on this basis.

iii. Disclosure of PHI to Law Enforcement. Refer to the section on Disclosure of PHI to Law Enforcement Officers and Court Orders.

1) Records that are sealed and addressed to the courts, and hence are not directly disclosed to the law enforcement officials, may be released to the law enforcement officials for delivery to the court.

iv. HIPAA requirement for attempts to provide notice to the patient or to obtain a qualified protective order does apply.

c. Search Warrant. Records may be produced in a criminal investigation pursuant to a valid search warrant.

14. Federal Courts and Federal Administrative Agencies. A subpoena duces tecum issued for federal requirements as similar to the requirement for state civil proceedings. The subpoena is to specify the articular documents sought. Contact Risk Management and follow their instructions. HIPAA requirement for reasonable attempts to provide notice to the patient or to obtain a qualified protective order does apply.

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

a. Information that is privileged:

i. includes information transmitted in confidence between the patient and the physician or psychotherapist and during the course of their relationship;

ii. Includes information obtained by an examination;

iii. Includes a diagnosis made, even if uncommunicated;

iv. Includes advice given by the physician or psychotherapist in the course of the relationship.

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

c. Other individuals can claim the privilege to prohibit disclosure of confidential communications:
   i. Any person authorized by the holder of the privilege to claim the privilege; or
   ii. The person who was the physician or psychotherapist at the time of the communication. This person must claim the privilege on behalf of an absent privilege holder unless otherwise instructed by a person authorized to permit disclosure; or
   iii. Legal counsel for a child who has been adjudged to be a dependent child of the court under Welfare and Institutions Code Section 300 (but the child's informed consent is required if the child is found by the court to be of sufficient age and maturity to give informed consent)
   iv. If the patient died leaving no conservator or personal representative, there are some limits on these persons claiming the privilege. Seek advice of Risk Management.

d. Waiving the Privilege. A holder of the privilege may give up the privilege by disclosing a significant part of the communication or by consenting to disclosure by someone else. Consent to disclosure is implied if the holder fails to claim the privilege in any proceeding in which the holder could claim the privilege.

i. Exceptions. There are a number of situations in which these privileges cannot be claimed to prevent disclosure of confidential information. Consult Risk Management.

ii. Notice to Patient. If the party who caused the subpoena to be issued is not required to notify the patient of the subpoena and SVMHS is unable to notify either the patient or the physician because neither can be located, consult Risk Management before responding to the subpoena.

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

1. On receipt of a court order from a court or administrative tribunal, the designated HIM/Medical Records staff will verify that the order:

   a. Is signed by a judge;

   b. Directs a SVMHS physician to disclose an individual's PHI;

2. A court order does not need to be accompanied by an authorization.

3. The designated HIM/Medical Records staff will:

   a. Coordinate acquisition of the required PHI content that HIM/Medical Records is unable to produce;

   b. Make copies of only that information expressly authorized by the order;

   c. Note the disclosure on the court order with a signature and date;

   d. Record the disclosure in the release of information software application;

   e. Scan the court order into the individual's record; and

f. Make arrangements to mail, or securely transmit or transport the required information to the designated recipient if investigators are not present to receive records.

X. **RESEARCH** - Prior to using or disclosing PHI for research purposes, SVMHS will obtain either the individual's written authorization, or a copy of the Institutional Review Board's explicit permission to forego patient authorization. Refer to the Manager of Research Programs.

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

1. SVMHS may deny individuals access to the health information maintained about them in a designated record set (DRS) in the relatively few situations described below CFR 164.524:
   a. The information is psychotherapy notes.

   b. The information was compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding.

   c. CA Health and Safety Code 1233110 (a)(h) supersedes HIPAA.

   d. N/A in CA. The individual is an inmate and access to the information would jeopardize the health, safety, security, custody, or rehabilitation of the inmate or other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting the inmate.

   e. The information was created or maintained in the course of research that includes treatment and the individual consented to a temporary suspension of their right to access as long as they are participating in the research. (The individual's right of access will be reinstated upon completion of the research.)

   f. The information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. CA Health & Safety Code 123105 (d)

   g. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably

likely to endanger the life or physical safety of the individual or another person.

h. The protected health information (PHI) makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

i. The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgement that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

2. Any SVMHS workforce member contemplating making a denial of health information to a patient or legal representative will contact the Privacy Officer/Designee.

3. To the extent possible, SVMHS will segregate health care information to which access will be denied, from information to which access cannot be denied and permit the individual to examine or obtain a copy of the disclosable information.

4. The Privacy Officer will work with the workforce member to apply the concepts of the contrary and more stringent requirements in HIPAA, as well as federal and state laws and regulations related to denials.

5. If SVMHS denies the patient's request in whole or in part, the Privacy Officer will provide the individual with a written denial within 5 days of receipt of the request. CA Health & Safety Code 123110(a) The denial will be in plain language and include:

a. The basis for the denial;
b. If applicable a statement of the individual's rights to have the decision reviewed and a description of how the individual may exercise their review rights; and
c. A description of how the individual may complain to SVMHS or the Secretary of HHS.

6. If the individual requests a review of the denial, SVMHS will appoint a licensed health care professional who was not directly involved in the denial, to review the decision within a reasonably period of time.

7. SVMHS will then provide written notice to the individual of the determination and take other action as required to carry out the reviewing official's determination.

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

1. Third Party Request. Medical information may not be released related to a patient's participation in outpatient treatment with a psychotherapist unless the requestor of the information submits a special written request (described below) to the clinic/practice and to the patient within 30 days of the release of information. (Patient's may sign a written waiver.) Refer to Civil Code Section 56.104.

2. The requirement for a special written request applies to medical information that "specifically relates to the patient's participation in outpatient treatment with a psychotherapist". Thus any reference in the hospital's or physician's record to the fact that the patient received outpatient mental health treatment may require the special written request.

   a. Maintain a list of offices where Psychotherapy is practices. There is a list of who (types of individuals) is or reasonably believed by the patient to be a Psychotherapist at Civil Code Section 56.104; Evidence Code Section 1010.

3. Required Elements of the Written Request:

   a. The signature of the person requesting the information or an authorized agent of the entity requesting the information.

   b. The specific information relating to a patient's participation in outpatient treatment with a psychotherapist being requested and its specific intended use or uses.

4. The length of time during which the information will be kept before being disposed of or destroyed. The person or entity that requested the

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

5. A statement that the information will not be used for any purpose other than its intended use.

6. A statement that person or entity requesting the information will destroy the information and all copies in its possession or control, will cause to be destroyed, or will return the information and all copies before or immediately after the stated time frame.

7. If patient has signed a Written Wavier, the waiver letter is to be signed by the patient and received by the clinic/practice notifying us of the waiver. Note: If the patient is a minor or incompetent, the law does not say who should sign the waiver letter.

8. Patient Request. If a patient request release of all of his/her mental health information to a 3rd party, including psychotherapy notes, the disclosure requires two authorizations – one for the mental health information and a second for the psychotherapy notes. HIPAA prevails over state law.

9. Exception to obtaining the separate authorization for any use or disclosure of psychotherapy notes:

    a. To carry out treatment, payment or health care operations in any of the following cases:
        i. Use by the originator of the psychotherapy notes for treatment;

        ii. Use or disclosure by the clinic/practice for its own training programs in which students, trainees or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling; or

        iii. Use or disclosure by the clinic/practice to defend itself in legal action or other proceeding brought by the Individual;

    b. Use or disclosure that is required by the Secretary of DHHS to investigate or determine compliance with the requirements of HIPAA;

c. Use or disclosure is required by law. This includes reporting child or elder adult abuse, responding to subpoenas, and complying with similar requirements;

d. Use or disclosure for health oversight activities related to the originator of the notes, such as licensure or disciplinary actions, fraud investigations, etc.

e. Disclosure to a coroner or medical examiner to identify a deceased person, determine a cause of death, or other duties authorized by law;

f. Use or disclosure where necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat. Notify Risk Management of the issue being acted upon.

AA. **RELEASE OF PHI TO LAW ENFORCEMENT OFFICERS**

1. Disclosure With a Patient Authorization. Information and records may be disclosed to law enforcement officers due to a written authorization by the patient or the patient's legal representative.

2. Disclosure Without a Patient Authorization. Law enforcement official under Penal Code sections 1543-1545 means the California Attorney General, every district attorney, and every agency expressly authorized by law to investigate or prosecute law violators. The Penal Code is to be used instead of Civil Code Section 56.30(g).

   a. Information that must be disclosed to law enforcement officers – SVMHS is required to make oral and written reports to local authorities in the following situations involving persons who:

      i. Have a physical injury resulting from a firearm or assaultive or abusive conduct;

      ii. May be victims of child abuse;

      iii. Have an injury or condition resulting from neglect or abuse of patient transferred from another health facility;

      iv. May be victims of sexual assault, including rape;

      v. Have injured or threatened on-duty hospital personnel; or

      vi. May be victims of elder or dependent adult abuse.

b. The above information may also be provided upon request of the law enforcement officers.

c. Subpoena with Court Order. If SVMHS is provided with a subpoena and a court order, information may be disclosed as authorized.

d. Search Warrant. Contact Risk Management and follow their instructions regarding release to a "special master" vs. law enforcement officer.

e. Information Generated Pursuant to the Request of Law Enforcement Officers. Law enforcement officers may bring an arrestee to the hospital and request that hospital personnel evaluate the arrestee in order to determine whether it is appropriate to incarcerate him or her, or perform procedures in order to gather evidence (under influence of alcohol or drugs). Initially it must be determined whether it is appropriate for hospital personnel to perform the requested procedure. If procedures are performed, the hospital must then determine whether the information obtained as a result of the performance of such procedures should be released to law enforcement personnel.

CA is stricter than HIPAA. Consult Risk Management. Page 5.44 in CHA Manual. Also if information requested includes HIV test results, consult chapter 4 of CHA Manual.

BB. **DE-IDENTIFICATION & RE-IDENTIFICATION PHI - 164.514**

De-Identification**:** Occasionally PHI will need to be used in a De-Identified Format. SVMHS may use or disclose PHI to create information that is not individually identifiable. PHI must meet the standards listed in the procedure in order to qualify as de-identified.

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

1. A person with appropriate knowledge and experience with statistical and scientific principles/methods for rendering the health information "not individually identifiable" determines that the risk is very small and that the

information could be used, alone or in combination with other reasonably available information, by a recipient to identify an Individual who is a subject of information; and

2. Documentation the method and results of the analysis justifies the determination that the information is "not individually identifiable"; or

3. The following identifiers must be removed from the PHI. These identifiers apply to information about the Individual and relatives, employers, or any household members of the Individual:

    a. Names

    b. All geographic subdivisions smaller than a state. This includes street address, city, county, zip code, and their equivalent geocodes. Exception is the first three digits of the zip code, if according to the current publicly available from the Bureau of the Census;

        i. The geographic unit formed by combing all zip codes with the same three initial digits contains more than 20,0000 people, and

        ii. The initial three digits of a zip code for all such geographic units containing 20,0000 fewer people is changed to 000.

    c. All elements of dates (except year) for dates directly related to an Individual, including the birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be assigned into a single category of age 90 or older.

    d. Telephone number

    e. Fax numbers

    f. Electronic Mail Address

    g. Social Security Numbers

    h. Medical Record Numbers

    i. Health Plan Beneficiary Numbers

j. Account Numbers

k. Certificate/License Number

l. Vehicle Identifiers and Serial Numbers, Including License Plate Numbers

m. Device identifiers and Serial numbers

n. Web Universal Resource Location (URLs)

o. Internet Protocol (IP) Address Numbers

p. Biometric Identifiers, Including Finger and Voice Prints

q. Full Face Photographic Images And Any Comparable Images

r. Any Other Unique Identifying Number, Characteristic, or Code (Except As Permitted By the Re-Identification Procedure) and

s. SVMHS does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

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

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

1. Any release of PHI is to include only that information required by the signed patient authorization.

2. When the requesting attorney has employed a professional photocopier as his or her representative to obtain or review the records on the attorney's behalf, no copying may be done by SVMHS or its business associate. Presentation of a valid authorization is sufficient proof that the agent is the attorney's representative.

3. On receipt of valid authorization signed by the patient or patient's legal representative, SVMHS will process and disclose the requested records within five to 10 days.

4. The HIM/Medical Records workforce member or Clinic Manager will notify the Risk Manager of any request for PHI that signals possible litigation against SVMHS, its affiliates or clinicians.

5. Fees. Refer to the RELEASE OF INFORMATION - HIM PROCEDURE Subpoena Section for current applicable fees.

DD. **SALE OF PHI** – SVMHS and our business associates may not sell PHI.

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

2. Sale of PHI does not include the disclosure of PHI:

   a. For public health purposes.

   b. For use per a Limited Data Set.

   c. For research purposes. However, SVMH does not participate in remuneration for PHI in research.

   d. For treatment and payment purposes pursuant to a consent or authorization.

   e. For the sale, transfer, merger, or consolidation of all or part of the covered entity and for related due diligence regarding PHI needed by other participants in the organized health care arrangement for any health care operations activity of the organized health care arrangement.

f. To or by a business associate for activities that the business associate undertakes on behalf of a covered entity, or on behalf of a business associate in the case of a subcontractor, and only the remuneration provided is by the covered entity to the business associate, or by the business associate to the subcontractor, if applicable, for the performance of such activities.

g. To an individual when requested through access or an accounting.

h. Required by law for public health activities, reporting abuse, neglect or domestic violence, health oversight, judicial and administrative proceedings and law enforcement purposes.

i. For any other purpose permitted by 164.502(a)(5)(ii) where the only remuneration received by the covered entity or business associate is a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by other law.
45CFR 164.502 (a)(5)(ii)

EE. **MARKETING** - Salinas Valley Memorial Healthcare System (SVMHS) will not use or disclose a patients Protected Health Information (PHI) for marketing purposes without prior authorization by the patient.

1. HIPAA and CMIA allow some exceptions to the authorization requirement. The preemption rule permits a use or disclosure only if it falls within an exception under both HIPAA & CMIA.

2. SVMHS will analyze each proposed use or disclosure for marketing purposes keeping the requirements of each law (HIPAA & CMIA) in mind, to determine whether the proposed use or disclosure violates either or both laws.

3. If a question arises about whether disclosure is permissible, an authorization from the individual or the individuals 'representative is the safe course of action.

4. A blanket authorization for marketing is not permitted.

5. If a patient's photograph will be used for marketing purposes, it is required that SVMHS will obtain written consent of the patient, which specifically grants permission for such marketing uses.

6. Marketing is permitted without a patient authorization if the communication it makes to patients describes a health-related product or service provided by SVMHS that is for the purposes of:
    a. Treating the patient
    b. Case management or care coordination of the patient (e.g., for directing or recommending alternative treatments, therapies, healthcare providers, or
    c. care settings).

7. If marketing is to be conducted in a face-to-face meeting with the patient, SVMHS may, but is not required to, obtain a written authorization from the patient prior to the marketing meeting.

8. If a promotional gift of nominal value (e.g. a pen or glass with the SVMHS logo or name embossed on it) is given or sent to the patient, SVMHS may, but is not required to, obtain a written authorization from the patient prior to providing or sending the promotional gift.

9. If the Marketing is going to involve financial remuneration from a third party, the patient authorization must state that such remuneration is involved.45 C.F.R. Sections 164.501 (definition of "marketing"); 164.508(a)(3)&(c)(1)(iii)Civil Code Sections 56.05 (f) and 56.10(d) & 3344

10. The SVMHS Marketing Department will maintain a copy of all consents obtained for the purpose of marketing.

11. All documentation will be maintained for a period of six years.

12. Documentation will be maintained in the office of the Marketing Director.

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

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

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

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

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

GG. **HIPAA TRAINING** - SVMHS will train its workforce members regarding the privacy and security policies and procedures as appropriate for the workforce members to carry out their job functions. 45 CFR 164.530(b)(1).
1. New hires will have HIPAA privacy and security included in the new hire orientation program.
2. Additional training will be provided when laws, procedures or policies are changed.
3. Additional training will be provided as appropriate to job duty changes.
4. Documentation of training is tracked through the Health Stream Learning program and department records.

HH. **FUNDRAISING -** Salinas Valley Memorial Healthcare System (SVMHS) may use or disclose PHI to a business associate or an institutionally–related foundation to raise funds for the benefit of SVMHS, Salinas Valley Memorial Hospital, and/or Salinas Valley Medical Clinics. 42 USC 17936; 45 CFR 164.514(f)

1. The PHI used or disclosed pursuant to this policy and procedure will be at the discretion of the HIM Director/Privacy Officer and shall be limited to the minimum necessary and no more than the following:
   a. Demographic information, including name, address, other contact information, age, gender, and date of birth;
   b. Dates of healthcare provided;
   c. Department or Service (for example, cardiology, surgery, oncology, obstetrics, etc.);
   d. Treating physician;
   e. Outcome Information (for example, death, suboptimal outcome, successfully treated);

2. All fundraising efforts using PHI will be coordinated through Salinas Valley Memorial Hospital Foundation ("SVMH Foundation").
3. SVMHS's Notice of Privacy Practices must state that SVMHS may use or disclose PHI for fundraising purposes.
4. Each fundraising communication (written or verbal) must include a clear and conspicuous opportunity to elect not to receive any further fundraising communications.
5. SVMHS may offer an opt-out for a specific fundraising campaign only, or for all fundraising campaigns undertaken by the SVMH Foundation.
6. The method for an individual to opt-out of receiving fundraising communications must be simple, quick, and inexpensive, such as pre-printed post cards, toll-free phone number, or e-mail addresses. Upon receipt and processing of an opt-out request, no fundraising communications may be sent by SVMHS or the SVMH Foundation.
7. It is not acceptable to require the patient to send a letter in order to opt out.
8. The SVMH Foundation will put systems and processes in place to manage lag times between compiling fundraising lists and solicitations.
9. SVMHS will not condition treatment on the individuals' choice regarding the receipt of fundraising communications.
10. The SVMH foundation may provide a method for individuals to opt back in to receiving fundraising communications.
11. The SVMH Foundation shall maintain logs of individuals who choose to opt out of fundraising activities.
12. All documentation is required to be maintained for a period of six (6) years.
13. Documentation will be maintained by the SVMH Foundation.

II. **ANTI-INTIMIDATION AND ANTI-RETALIATION**

1. Neither SVMHS, members of its workforce or medical staff will threaten, intimidate, coerce, harass, discriminate against or take any other retaliatory action against any individual or other person for:
   a. Filing a privacy or security related complaint
   b. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under HIPAA's Administrative Simplification Rules; or
   c. Opposing any act or practice made unlawful by HIPAA's Administrative Simplification Rules, providing the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of PHI in violation of the HIPAA Administrative Simplification Rules.

2. Any workforce member who observes an intimidating or retaliatory act on the part of another SVMHS workforce member, medical staff member or business associate will call this policy to that individual's attention immediately so that the individual can rectify the situation.

~~1.~~3. If/when such action is not practical, or the situation is not immediately rectified by the offending workforce member, medical staff member or business associate, the observing workforce member will contact his/her manager or the Compliance Officer immediately.

~~2.~~4. Any individual who thinks they have been intimidated, threatened, coerced, discriminated against or otherwise retaliated against for exercising rights or participating in a process provided for by the HIPAA Privacy Rule should be directed to the Compliance Officer.

5. The SVMHS leader with whom an observation or complaint related to intimidation or retaliation is communicated may consult with the Compliance Officer and/or take those actions needed to correct the situation.

6. If/when appropriate, the offending workforce member or medical staff member will be educated, counseled or sanctioned.

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

VI. **EDUCATION/TRAINING:**

A. Education and/or training provided as needed by Privacy Officer and Department Heads.

VII. REFERENCES:

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

QUALITY AND EFFICIENT PRACTICES COMMITTEE

Minutes from the March 22, 2021 meeting of the Quality and Efficient Practices Committee will be distributed at the Board Meeting

(JUAN CABRERA)

FINANCE COMMITTEE

Minutes from the March 22, 2021 meeting 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

(RICHARD TURNER)

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

Board Paper: Finance Committee

Request:	Managed Services From Carousel Industries to Provide Managed Services for Our Unified Communications System (Telephone System)
Executive Sponsor:	Augustine Lopez, CFO Audrey Parks, CIO
Date:	March 12, 2021

Executive Summary

The intent of Salinas Valley Memorial Healthcare System (SVMHS) Information Technology (IT) is to procure managed services to best support and maintain our current Cisco Unified Communications Management or Cisco VOIP Telephone system (UCS). 24x7x365 support is increasingly essential as we transition off of our legacy-analog telephone system. There are around 20 clinics left on the old analog phone system that are in planning stages of migration to the new Cisco Unified Communications system. As we migrate and grow our system over the Salinas Valley Medical Clinic (SVMC) locations it is imperative to have the “safety net” of support and maintenance to provide high availability or uptime of all communications including telephones/video conferencing/instant messaging/auto attendants/call queuing/call transfers/emergency calls etc.

In addition, as Salinas Valley Memorial Hospital transitions off of the legacy Avaya telephone system, we will lose the existing next business day support we have now with Avaya. In the past year, we also hired a Communications Engineering Manager, a new position, to better support and manage our growing communications system. To fill the support gap on Cisco when compared with what we have with Avaya, however, we are seeking 24 x 7 x 365 support as the system grows to support both the Hospital and SVMC.

Expert service and support is not as comprehensive as it was on legacy analog environments. In the past, we bought an insurance/maintenance policy from suppliers that entitled the ability to call for help or diagnose and repair defective hardware. The UCS solution introduces multiple complexities: data networks, quality of service settings to enable proper communications, multiple telephone carriers (AT&T, Comcast, MetTel) and security, to name a few. The need for secure monitoring tools, real-time visibility and having appropriate skills to support the UCS have become an investment area to ensure we keep our critical communication systems always on and available for our critical healthcare operations.

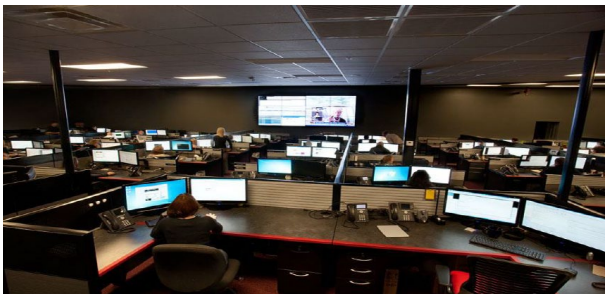
The comprehensive approach of managed services includes real time and historic reporting, onboarding and service transition, configuration management, continuous service improvement, incident management (triage and troubleshooting, complex resolution), chronic problem management, patches and updates, health and performance monitoring (to alert us to fix issues before our customers feel the pain of these issues) health checks, and designated management resources.

Background/Situation/Rationale

With managed services for our Cisco Unified Communications System (UCS) 24x7x365, we ensure the highest level of availability, support and security for our UCS system. The UCS system supports telecommunications operations for Salinas Valley Memorial Hospital (SVMH) and Salinas Valley Medical Clinics (SVMC).

From 2020 to present, we are actively working to fully migrate off of our legacy Avaya telephone system onto a modern system by Cisco (UCS. As we continue to integrate SVMC sites onto the same enterprise telecommunications platform, we are seeking ways to ensure consistency, standardization, high availability, performance and supportability of our UCS. After completing a competitive solicitation process, we selected Carousel Industries, Inc. as the service provider due, in part, to their comprehensive and cost-effective support model.

Views of the operations and customer service centers that ultimately deliver high availability and telecommunications systems performance to both SVMH and SVMC.



During the vendor selection process, we carefully reviewed pricing, breadth of support services, experience and the security architecture of each solution proposed to ensure the confidentiality, integrity, and availability of SVMHS critical data. The solutions under consideration were Axelliant, Elevate and Carousel Industries. We ultimately selected Carousel Industries based on the comprehensiveness of their response and price point.

RFP scorecard and legal review are on file.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

It is the mission of Salinas Valley Memorial Healthcare System (SVMHS) to provide quality healthcare to our patients and to improve the health and well-being of our community. Toward this end, we are seeking to improve the telecommunications services we offer through Information Technology to minimize avoidable phone/communication system disruptions across SVMHS.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications: Finance

<table>
<tr><th>Key Contract Terms</th><th>Vendor: Carousel Industries, Inc.</th></tr>
<tr><td>1. Proposed effective date</td><td>April 1, 2021</td></tr>
<tr><td>2. Term of agreement</td><td>July 1, 2021 – June 30, 2024 (36 months)</td></tr>
<tr><td>3. Renewal terms</td><td>Annually renewable after initial term</td></tr>
<tr><td>4. Termination provision(s)</td><td>May terminate as needed if contractor is not meeting service level agreements.</td></tr>
<tr><td>5. Payment Terms</td><td>Net 45</td></tr>
<tr><td>6. Annual cost(s)</td><td>$ 392,477 over three (3) year term
<table><tr><td>One-time</td><td>6,377</td></tr><tr><td>Year 1</td><td>128,700</td></tr><tr><td>Year 2</td><td>128,700</td></tr><tr><td>Year 3</td><td>128,700</td></tr><tr><td>TOTAL</td><td>$ 392,477</td></tr></table>
Fees increase are over a three year term.</td></tr>
<tr><td>7. Cost over life of agreement</td><td>$ 392,477</td></tr>
<tr><td>8. Budgeted (indicate y/n)</td><td>Yes. Incremental and budgeted.</td></tr>
<tr><td>9. Contract</td><td>1001.4099</td></tr>
</table>

Recommendation

Request the Finance Committee to recommend to the Board of Directors the approval of the unified communications system managed services agreement from Carousel Industries, Inc. as competitive solicitation and contract award in the amount of $392,477 over a three-year contract term.

Attachments:

1. RFP documentation
2. Proposal dated February 24, 2021

Carousel INDUSTRIES®

customer success OBSESSED

Proposal for

Salinas Valley Memorial Healthcare System

Managed Services & Support

Cisco Unified Communications

Proposal Date: November 5, 2020
Presented to: Audrey Parks, Chief Information Officer
Presented by: Anthony Ciampa, Account Executive

Table of Contents

Cover Letter **3**
Executive Summary **4**
Carousel's Approach **5**
Proposed Solution **7**
Optional Service & Features: **18**
Pricing Summary **22**
Carousel Overview **23**
Cisco Expertise **25**
References **26**
RFP Terms and Conditions **27**

Attachments:

- A: Vendor Info.....28
- B: Carousel Project and Service Delivery Structure.....29
- C: Covid-19 Preparedness.....30

Cover Letter

Dear Audrey and the SVMHS IT Team,

It's been a pleasure partnering with you all over the last couple of years as we work together to grow and transform your network infrastructure and achieve your team's strategic goals. Through this partnership we have become intimately knowledgeable of your business drivers, challenges, and vision. We use this knowledge to create a tailored response, one we're confident will add value to your organization.

Aside from growth, refresh, and upgrade projects, we've proactively worked with you to better optimize resources in your existing Smartnet Support and Carrier Services environments. We strive to go beyond your expectations of a vendor by continuing to help you do more with less and drive innovation.

Allowing another organization to help monitor, maintain, and manage your unified communications and collaboration system is one of the most strategic and honorable business partnerships in our space. We understand the gravity of this managed services contract and are fully prepared and ready to rise to the occasion and take on more responsibility as your trusted business partner.

Carousel would make a great choice for your trusted business partner because of our deep understanding of your operational challenges, our comprehensive approach to overcome those challenges, and our continued investments in our NOC and Managed Services offering like our enhanced tooling solutions, optimized service delivery functions, and strengthened security framework.

Thank you for giving Carousel the opportunity to grow the partnership between our organizations by allowing us to participate in your Cisco UC RFP. Please feel free to reach out to me directly with any follow-up questions or feedback you may have.

Sincerely,

Anthony Ciampa

Carousel Industries
1901 S Bascom Ave Ste 1650 | Campbell, CA 95008
Mobile: 603-455-5933
ACiampa@Carouselindustries.com

Executive Summary

SVMHS & Industry Challenges

The rise of smart phones, Unified Communications, Wi-Fi access almost anywhere, mobile applications, and cloud-based solutions has put powerful IT solutions directly into the end-user's hands. The consumerization of IT has made the end-user more tech savvy and consequently they have greater demands of the technology they use. Consumer technology has trained users that technology is easy, can be effortlessly deployed, and is "always on", and they expect to be able access their data and services anytime, anywhere and on any device.

At the same time, consumer technology is getting simpler to use, but the complexity is increasingly hidden behind the scenes. This becomes a difficult dichotomy managing user expectations and the technical complexity reality. You have already invested in a Cisco UC solution to help transform the current communication and collaboration experience. Throughout multiple conversations, we have discussed your challenges to be:

- **Current operating model**
    - Limited staff and skillsets to manage the existing Cisco UCM while trying to expedite the onboarding of additional sites to gain efficiencies and standardization, resulting in a true ROI on the investment already made in Cisco.
    - Limited visibility into current environment
- **Financial challenges**
    - Limited skillset leads to lengthy mean time to repair
    - More time focused on tactical vs strategic
    - Run, Grow, Transform
    - Task Talent Misalignment
- **End User Experience**
    - No consistency between systems and sites
    - Limited focus on transformation slows down the adoption of advanced technologies to improve the patient experience
    - Severe time pressures to deploy technology solutions and drive user adoption.

Proper service and support are not as simple or straight forward as it was on legacy PBX environments. In the past, firms bought an insurance/maintenance policy from suppliers that entitled the ability to call for help or diagnose and repair defective hardware. The Cisco UC solution introduces multiple complexities including the data network, Quality of Service, telco/SIP carrier and security just to name a few. The need for proper monitoring tools, real-time visibility and having the talent to support the Cisco System now become an additional investment area.

Carousel's Approach

To address the situation, Carousel has developed a comprehensive 7x24x365 support plan to manage the day-to-day voice operations, for less financial impact than a qualified Cisco Voice administrator, to allow SVMH the ability gain the most value from the Cisco technology platform in the shortest amount of time.

Carousel has developed the ability to provide a comprehensive solution that can include the following:

- Onboarding and Service Transition
- Secure Remote Connectivity to the SVMH architecture
- Health & Performance Monitoring
- Real Time & Historical Reporting
- 7x24 Service Desk
- 7x24 Event and Incident Management including vendor and carrier agency
- Problem Management for chronic/recurring incidents with full RCA delivery
- Proactive Patch Management on a consistent cadence for the Cisco ecosystem
- Infrastructure Change Management for the Cisco environment
- Designated Service Management Resources

With the ability to provide optional services and features, such as:

- Advanced SIP Monitoring with real time synthetic voice & video transactions
- End user service requests (MACD) for voice & contact center
- Named and assigned technical oversight, guidance, & management
- e-Bonding capability for improved and consistent reporting and management
- Training for SVMHS team within Cisco UC environment as needed on a T&M basis

Why You Should Trust Carousel to be Your UC Partner

Carousel has made multiple million-dollar investments over the last 24-months to strengthen, improve and secure our delivery functions for our clients. For example:

Tooling – Carousel has restructured both our ITOM (IT Operations Management) solution and ITSM (IT Service Management) solution for improved performance, visibility, reporting and compliance. The ITOM allows for improved event suppression and correlation, acting as a MOM (Manager of Managers) to allow a single pane of glass from multiple tools and improved contextual awareness, or the ability to have one-click access to important and vital information. The ITSM system has provided for improved reporting (SLA threshold measurement, dispatching accuracy and more consistent project and service delivery).

Service Factory Philosophy – We believe our service factory philosophy has allowed us to accomplish 3 main goals: Improve service delivery & NPS, drive cost out of the business, provide improved career pathing for both retention and talent acquisition. By breaking up the service delivery functions into "PODS", (Event, Incident, Problem, Patch, Change and Service Requests), we have been able to reduce missed events from roughly 14% 2-years ago to now averaging less the .1% misses, with the majority of those being devices that were not onboarded to the platform. Another example would be our Service Request "MAC Factory", which are completing over 90% of MAC requests within 24-hours and 76% completed in the same day. This is a dramatic improvement from just a short year ago where MAC requests were averaging over 6-days for completion. The Service Factory model has also allowed Carousel to reduce delivery costs by more than $3 Million in 2019, allowing us to pass that savings on to our clients.

Security – Carousel is acutely aware that one of the biggest threats to any organization is to the 3rd party remote connectivity that external business partners require to deliver service. This situation was a main contributing factor of why we invested in a fulltime Chief Information Security Officer late in 2017. Part of the CISO's responsibility is to make sure we would not introduce additional risk to the clients we support. To that endeavor, following NIST 8-53, Carousel has strengthened our delivery framework. Today, all engineers are required to log into all internal systems with multi-factor authentication, we have leveraged password vaulting for all managed devices, and we have developed our Secure Service Delivery Platform (SDP). The SDP is a series of OVA files installed in the clients VM environment that have been hardened and spun up on demand to reduce footprint and resource requirements. The SDP, combined with the ITOM platform provides for secure monitoring, access and compliance. Every session through the SDP has a complete recording of the engineer, time-of-day, key stroke logging and the work performed.

We believe our comprehensive solutions can provide the powerful intelligent platform and services SVMHS requires for ongoing operational support, intelligent IT planning, continuous improvement and optimization to provide IT Transformation. By subscribing to our service, not only do you reap the benefits of using the contextual knowledge our solution captures to enhance your infrastructure, get access to our industry experts that become an extension of your team, but also increase the level of service you provide to your end user community, customers, prospects and business partners. We are excited at the opportunity to expand our relationship for the desired success of both organizations. Please continue below for our detailed approach of how Carousel will provide managed service functions for the SVMHS Cisco Environment.

Proposed Solution

Onboarding & Service Transition

Carousel will provide a services transition plan to achieve steady-state operation augmenting the Client's ongoing day-to-day IT operations. Carousel's service transition process manages and performs the following transition phases:

- **Planning Phase** —a detailed data-gathering including a series of internal reviews culminating with a transition kick-off meeting.
- **Execution Phase**— quickly get supported items loaded and configured in the monitoring tool, validate connectivity and response
- **Quality Assurance/Testing Phase** - a full quality and testing review of the proposed solution with refinement and enhancements
- **Tuning Phase -** tuning of the environment to eliminate noise, false positives and ensure that the monitoring and reporting functions are optimized and working as expected. Additionally, Carousel will finalize all delivery process and procedures
- **Steady-State Phase**— Carousel will deliver the services specified in this Statement of Services and provide regular reports on performance against agreed upon SLA metrics.

Estimated Service Transition Timeframe

Carousel estimates the entire service transitioning process will be completed within 8 weeks. The estimated timeframe begins when Carousel receives the client required information (inventory details, passwords, response procedures, etc.) Upon engagement of Carousel's Managed Services, we will work collaboratively with your team throughout the service transition process toward steady state support from Carousel's Support Centers. The following high-level schedule and process overview will provide you an understanding of the transition process:

Phase	Weeks							
	1	2	3	4	5	6	7	8
Planning Phase								
Execution Phase								
QA/Testing Phase								
Tuning Phase								
Steady State (Go Live)								

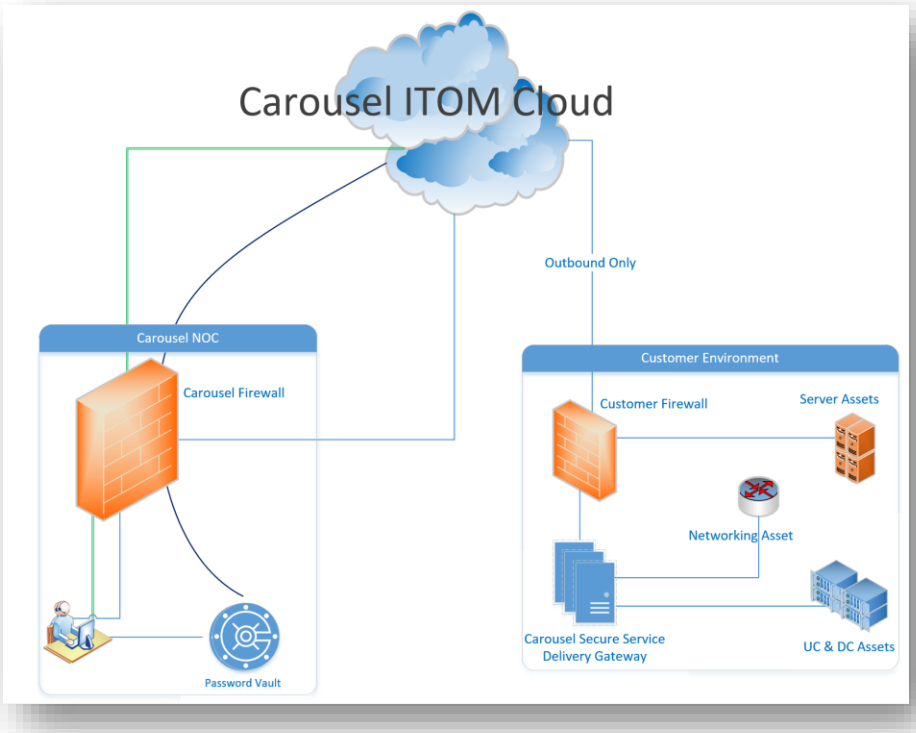
Secure Remote Connectivity to the SVMHS architecture

Carousel Secure Service Delivery Gateway

The delivery of Carousel's Managed Services requires the implementation of our Service Delivery Gateway (SDG). The SDG is architected to provide device auto-discovery, monitoring, performance management, secure remote access, device level authentication, and tools for improved diagnostic capabilities.

The SDG is deployed with a secure abstraction layer between Carousel's Network Operation Center and the Client's environment ensuring the confidentiality, integrity, and availability of the Client's critical data. Our National Institute of Standards and Technology (NIST) based architecture guarantees the highest levels of authentication, access control, auditability, availability, and scalability.

The Service Delivery Gateway allows Carousel's managed services team to obtain alert, alarms, and performance information from The Client's environment. As abnormal, degraded, and service affecting conditions occur Carousel's service personnel can securely authenticate to the support devices, and investigate, evaluate, diagnose, and resolve detected incidents. In addition, our SDG maintains an audit trail of all access and records all session for detailed auditability.



- **Personnel** - All Carousel Managed Services personnel undergo comprehensive and intensive background screening including criminal history, past employment verification, credit history, and more.
- **Multi-Factor Authentication** - All employees must use multi-factor authentication to access our managed services platform.
- **Abstraction Layers** - We keep our corporate network isolated from clients with a proxy gateway to monitoring, support, and maintain your environment without the need for having direct access to your network. This multi-tenancy approach allows for secure authentication, session recording and extensive logging capabilities.
- **Auditing** - Our real-time auditing tools ensure we continuously meet regulatory mandates like SOX, HIPAA, NERC, GDPR, and more to meet your data security and compliance requirements.
- **Password Management** - We maintain sensitive information like passwords and digital identities in a secure, centralized, high-availability, and encrypted vault (FIPS 140-2) for data in-transit and data-at-rest with robust role-based access control management.
- **Session Recording** - Ability to video record, archive and play back privileged sessions.

Health & Performance Monitoring

Our Service Delivery Platform measures network connectivity at regular intervals via ICMP polling (PING) to ensure the monitored elements are reachable on the network from an IP address availability perspective.

Our Service Delivery Platform monitors identified elements utilizing standard SNMP data collection, SNMP trap receiver, syslog monitoring and available APIs to receive specific information, alerts, alarms, faults and performance data.

Real Time & Historical Reporting

Carousel provides the client with access to two web-based portals. Our first portal, service management, provides direct access to our Information Technology Service Management (ITSM) system. Our service management portal provides core features such as reporting issues, submitting service requests, general questions, viewing open and closed tickets, and creating/exporting reports. An extranet will also be provided, with access to shared support documentation and static reports.

Our second portal, performance management, provides direct access to our Information Technology Management (ITOM) system. This web-based portal provides access to real time performance dashboards, KPI management tool and on-demand performance reporting. It will allow the measurement and tracking performance against predefined SLAs, streamline service delivery and better support the business with metrics and analytics.

7x24 Service Desk

Carousel will provide 7x24x365 live access to meet the communication needs of Client IT staff via phone, email or web portal. Our service desk is the focal point for reporting and updating status for existing issues, opening new incidences, and initiating a change or service request.

The Service Desk will:

- Answer incoming calls and capture valid information
    - Service request/problem description

  Site and contact information
    - Determine Severity by assessing urgency and impact
- Review emails to understand the issue and contact information

7x24 Event and Incident Management including vendor and carrier agency

Carousel provides Event Management functionality from our operations located in the United States and India. Event Management is the process that monitors all alarms, alert, and events related to the operation of the IT environment. Our objective is to detect alarms, alerts, and events, analyses them, and determine the correct control action. Our Event Management function provides a strong foundation for service assurance, reporting, and service improvement. Event management responsibilities include:

- **Event Capture, Validation & Recording** - Our Service Delivery Platform monitors for a detectable or discernible occurrence that has significance for the management of the IT Infrastructure. We evaluate the event and record the identified conditions in our Information Technology Management System (ITSM).

- **Event Correlation & Suppression** - Our Service Delivery Platform has a powerful event correlation and suppression engine which uses advanced technology for making sense of a large number of events and pinpoint the few events that require attention. This is accomplished by looking for and analyzing relationships between events. Our Service Delivery Platform monitors for detectable or discernible occurrence that has significance for the management of the IT Infrastructure. Carousel will evaluate the event and record the identified conditions in our Information Technology Management System (ITSM).

Incident Management is designed to help restore normal service operation within a reasonable time to help contain the adverse impact on the Client's business operations, service quality and systems availability. When an incident is opened, it is important that the appropriate priority is assigned to reflect the current service impact. As ITIL defines it, incident priority is primarily formed out of its Impact and its Urgency. There are also additional elements, like size, scope, complexity, and resources required for resolution.

The Impact of the incident is the measure of the criticality of the incident to the business. Traditionally, Impact is tied to the number of users or business processes affected. Urgency is a measure of the necessary speed of resolving an incident.

Based on the assessment of Urgency and Impact, the chart below is leveraged to assign the appropriate Priority level.

		Impact		
		High	Mid	Low
Urgency	High	1	2	3
	Mid	2	3	4
	Low	3	4	4

Incident Classification

Priority	Definition
One (P1)	Occurs when there is critical impact to the business operations and urgent action is required to resolve the incident. For example, network is unavailable, a site is partially down and/or impacting a significant part of the business operations and no work-around is available.
Two (P2)	Occurs when performance of a supported service or environment is severely degraded causing a high to medium level of impact. Functionality may be noticeably impaired, but most business operations continue. P2 incidents have a high to medium level of urgency requiring responsiveness, the activation of SOPs, on-call procedures, and invoking vendor support.
Three (P3)	Occurs when operational performance is impaired while most of the business operations remain functional. Limited devices (PC, printer, terminal, extension) are not operational. There is degradation of services although issue is not mission-critical. P3 incidents are responded to using standard operating procedures and operating within the standard workflow and operational structures.
Four (P4)	Occurs when you require information or assistance on Carousel-provided product capabilities, installation or configuration. There is clearly little or no impact to your business operations. P4 incident are responded to using standard operation procedures as time allows.

Incident Notification - As incidents are prioritized and entered into the Information Technology Service Management (ITSM) platform, the Client is notified via automated email response. The automated email response will contain the incident number, details collected during the event identification process, and affected device, system, service, or location information, and all actions taken. Any time an incident is open, updated, and closed automated email notification is sent to the Client. In addition, to automated email notifications, Carousel can provide automate SMS notification, if requested by the Client. SMS notification is not a bi-directional SMS texting features rather it's an informational message sent from the ITSM to the Client. Carousel recommends that this function is only enabled for incidents containing the highest level of priority. Carousel can provide additional telephonic notification for all P1 incidents, if requested by the Client.

Triage & Troubleshooting - Once the Carousel incident management team receives a service ticket, an engineer will follow step-by-step instructions to achieve predictable, standardized, and desirable results to quickly restore any unplanned interruption. This function covers the Analysis, diagnosis, resolution, and recovery of the incident.

Complex Resolution - Carousel will work with the Client IT staff or other 3rd parties through resolution when the incident may be a result of multiple technologies contributing to the incident.

Bug & Security Patch Resolution - When service affecting software anomalies (bugs) and security related vulnerability have been identified, our service delivery team will drive the resolution process. Carousel will identify the issue, work with the vendor to find a software resolution, begin an emergency service request process, and deploy the appropriate patch, service pack, or upgrade as part of the change management process.

Carrier Management - For the supported environment, Carousel owns identification, troubleshooting, and resolution of Carrier related issues. Carousel acts as an agent of the Client and drives Carrier escalations for MPLS, Ethernet, broadband, dedicated Internet, SIP trunks, PRIs, or analog circuits in the event of link down, service outage, timing & slips, or high interface errors. Carousel will:

- Create and maintain the appropriate documentation in Carousel's ITSM system
- Drive escalation with the appropriate Carrier or service provider
- Notify and communicate the issue to Client including carrier ticket number, time of outage and expected time of restoration
- Act as an intermediary between Client and the service provider
- Track and drive activities required to resolve the issue
- Update the Carousel Incident as required
- Validate the resolution of the incident
- Update and close the incident when the issue is resolved
- If available, obtain root cause.

Note: Carousel resolution SLAs do not apply to Carrier Management Services.

Note: Client is required to sign LOA (Letter of Authorization) for each service provider during the service transition process for Carousel to perform Carrier Management. Limited to circuits connected to devices under Carousel Management. Any signed LOA (Letter of Authorization) is for incidents only, Carousel will not be responsible or accountable for any procurement, payment, ordering or decommissioning of circuits.

Vendor Management - For the supported environment, Carousel owns identification, troubleshooting, and resolution of third-party vendor related issues. Carousel drives the third-party vendor escalation process and provides follow-up of a supported vendor related issue. When required, Carousel creates a ticket directly with the third-party vendor on the Clients behalf. We drive the third-party vendor to identify the issue, troubleshoot the defined issues, and ultimately obtain resolution. Carousel notifies and communicates all third-party vendor issues with the Client including, ongoing status, available work arounds, and expected time of resolution. Carousel works the incident through closure, and if available, obtains the root cause. When required, Carousel drives the escalation processes to resolve configuration, software, and hardware anomalies, manage hardware replacement, software bug fixing and patch management, and on-site engineering dispatch. Carousel will:

- Create and maintain the appropriate documentation in Carousel's ITSM system
- Drive escalate with the appropriate third-party vendor
- Notify and communicate the issue to Client including ticket number, time of outage and expected time of restoration
- Act as an intermediary between Client and the third-party vendors
- Track and drive activities required to resolve the issue
- For hardware replacement, Carousel drives the replacement process until replacement is shipped, received, installed, configured IP addressing, restore last known configuration and update serial numbers Carousel's ITSM/CMDB
- Update the Carousel Incident as required
- Validate the resolution of the incident
- Update and close the incident when the issue is resolved
- If available, obtain root cause.

Note: Client is required to sign LOA (Letter of Authorization) for each service provider during the service transition process for Carousel to perform Vendor Management.

Incident Escalation - Incident escalation is a process used to highlight or flag certain issues within an Incident, so that the appropriate personnel can respond to these situations and monitor the resolutions. Carousel's escalation management process identifies, tracks, monitors and manages situations that require increased awareness and swift action. Carousel's carefully created escalation processes can ensure that unresolved problems don't linger, and issues are promptly addressed. Using Incident Escalation Management can re-prioritize, reassign, and monitor a situation to a satisfactory completion. There are two types of escalations: hierarchical and functional. Hierarchical escalation is used to ensure attention for notification, action or resolution is moving the technical levels of operation. For example, 1st level support is unable to resolve the issue, so it is escalated to 2nd level support. In case they are also not able to solve the issue, they are escalating it to 3rd level support and so on until the issue is resolved. During the hierarchical escalation the workflow management is evaluating the incident priority against resolution progress. Functional escalation is used in case that the support team is unable to resolve the issue or stick within the agreed timeline (targeted time for resolution is exceeded). Functional escalation is the process used to assign an incident from one team to another team based on the skills required to resolve the incident. For example, escalating an incident from the unified communications team to the network team when it becomes apparent that the lack of performance is due to network conditions.

Problem Management for chronic/recurring incidents with full RCA delivery

Root Cause Analysis - Our service delivery team conducts root cause analysis to determine the underlying cause of an incident, document the findings and take appropriate corrective action. Root cause analyses are performed to understand the cause of critical outages, prevent future incidents from occurring, eliminate chronic incidents, and minimize future impact to problems and outages.

1. Perform problem determination and problem resolution;
2. Perform tracking and management of outage to closure;
3. Perform root cause analysis for individual P1 and P2 incidents
4. Identify chronic problems

Chronic Problem Management - Our service delivery team will drive the identification and resolution of chronic incidents. Chronic issues are defined as the same problem occurring multiple times in a 30-day period. We will attempt to reproduce the problem, identify incident triggers, document the current state, define remediation paths and work around scenarios and provide detailed root cause analysis.

Proactive Patch Management on a consistent cadence for the Cisco ecosystem

The purpose of Patch & Release Management is to facilitate the physical control of software assets and their release into the production environment.

(a) **Major Software Release** - Major Release is a major change to the software that introduces new optional features and functionality. Major Releases are typically designated as a change in the digit(s) to the left of the first decimal point (for example, **[N],** y.z) are out of scope.

(b) **Minor Software Releases** (aka "dot" release) - A Minor Release is a change to the software that introduces a limited number of optional features and functionality. Minor Releases are typically designated as a change in the digit to the right of the first decimal point (for example, n**.[Y].** z) and are out of scope.

(c) **Patch Release** – Patch Release is a change to the software to stabilize the code based upon reported bug related issues or to correct/harden a potential security vulnerability. Patch Releases are typically designated as a change in the digit to the right of the second decimal point (for example, n.y**.[Z]**) and are included as part of release management.

Note: Product correction updates may require system hardware upgrades to comply with current manufacturer's specifications. In these cases, the hardware must be upgraded before the update can be implemented. Hardware upgrades are not included as part of this service.

Note: If Carousel determines the patch is appropriate, it will follow Change Management procedures and policies

Note: Additional installation, implementation and/or customization services necessary to implement software releases are not included in this service and are defined as projects.

Note: Client must retain entitlement to receive software and/or firmware updates from their manufacturers. Carousel does not provide an alternative to upgrade entitlement or leverage Carousel entitlements on Client 's behalf. Carousel does not supply any software or firmware of any kind other than for Carousel owned equipment and systems.

Application Release Management - Carousel follows a semantic versioning model for application for select business enablement applications. The model is defined as MAJOR.MINOR.PATCH. We provide quarterly assessment, notification, and recommendation of patches. We provide quarterly patch implementation or more immediate if service effecting or security related. Carousel will report on MAJOR.MINOR.PATCH, but will only implement on PATCH. Any MAJOR or MINOR releases will be quoted as a project and be considered out of scope and quoted as a project.

Device Release Management & Firmware - Carousel follows a semantic versioning model for device patches. The model is defined as MAJOR.MINOR.PATCH. We provide quarterly assessment, notification, and recommendation of patches. We provide semi-annual patch implementation or more immediate if service effecting or security related. Carousel will report on MAJOR.MINOR.PATCH, but will only implement on PATCH. Device level firmware will be considered a PATCH.

Infrastructure Change Management for the Cisco environment

Carousel's IT asset change management function ensures that a standardized set of procedures is used to promptly handle all requests for service or change. It ensures that all changes are recorded, assessed, approved, prioritized, and deployed in a manner that meets business requirements and protects the stability and reliability of critical IT systems.

The main objective of change management is to control the lifecycle of while minimizing disruption to IT services. Service or change request can be broadly classified as "Standard", "Complex" and "Emergency":

- **Standard** change tasks are well known, defined, documented, and proven. The change management workflow is pre-established, and no approval is necessary.
- **Emergency** change requests need to be executed immediately to resolve imminent Critical/Sev-1/P1 incidents that threaten business continuity. Emergency request requires approval from the eCAB and will follow the workflow defined in the emergency change request.
- **Complex** change request is pervasive, less defined, and the impact of the request is not known. Complex request could change the configuration of an existing feature, enable existing capabilities, or focus resolving a known issue. Complex requests require Change Advisory Board (CAB) approval, and the specification of a maintenance window.

As part of the overall process, Carousel will provide the following where applicable:

- Manage and implement system level configuration changes
- define the changes required;
- measure the impact of the proposed change;
- develop a back-out plan;
- obtain any relevant approvals for change;
- schedule the implementation of the change;
- implement the change;
- post-implementation testing and verifying expected outcomes; and in the event of an unsuccessful change, implement the back-out plan in relation to the change

Standard Change Request - Our Service Delivery team will manage and implement "system wide" level configuration changes where the implementation process and the risks are known upfront, documented, proven, and the risk is low and well understood, and the change workflow has been pre-established. These changes are managed according to policies that have been established during Service Transitioning. Standard change request approval can be automatically granted.

Emergency Change Request - Our Service Delivery team will manage and implement emergency change requests when an unexpected error, threat occurs, or events that effect business continuity emerge. Emergency request are evaluated on the basis that the risk of not implementing the request is greater than implementing the request. Emergency request bypass the normal Change Advisory Board (CAB) process and is reviewed by the eCAB requiring a single board members approval. All emergency change requests undergo a post-implementation review process.

Complex Change Request - Complex Requests must be reviewed by the Change Advisory Board (CAB) who examines the request, assesses the associated risk and impact, and ultimately approves the request for implementation. For complex changes to be implemented, requires a minimum of 51% CAB member approval. Usually a complex request involves a significant change to the service or infrastructure, and it carries some degree of risk. All complex changes require comprehensive planning, documentation, workflow analysis, and governance. If the request is determined to be high-risk, the CAB must decide whether, when and how the request will be implemented or if the complex change request needs to be treated as project. The following list of criteria are used to determine if the complex change request should be treated as a project:

- **On site** – When the service/change request requires onsite Carousel Engineers to complete the request
- **Testing** – When the service/change request requires extensive testing by our engineering team, client team or combination or both
- **Expansion** – When the service/change request adds new devices, locations or features that fundamentally change the nature of the supported environment
- **Design** – When the service/change request changes the fundamental design, architecture or the operations of the supported environment
- **Platform** – When the service/change request impacts multiple supported platforms across the supported environment
- **Coordinate** – When the service/change request requires the Carousel team to coordinate multiple resources – vendors, people, locations or multiple phases of change implementation

Note: Based on the above defined criteria and the nature of the complex change, some request could be managed as a project and billed outside the scope of this proposal.

Designated Service Management Resources

Carousel will provide additional Service Delivery Manager (SDM) functions to expand the communications, reporting, procedural and contractual activities if/as the services grow. The SDM(s) will help pursue the client's growth, innovation and performance agendas through proactive management of their supported environment.

Carousel's Service Delivery Manager functions will be named resource(s) available during the standard hours of operations (Monday through Friday, 08:00 to 17:00). The assigned SDM standard hours are aligned with the center of IT operations.

The SDM(s) focus is on maintaining service excellence each day by working closely with the client's leadership to translate essential business requirements to the broader support team such as business changes, critical system sensitivity, blackout periods for change, etc.

During all projects and onboarding of new or modified services, the SDM will continue to collaborate closely with the Project Manager though participation in service reviews with your team covering both project status and service management updates.

The following are some of the responsibilities of the assigned Service Delivery Manager:

- **Service Delivery Leadership -** During the service transition, the communication cadence between the client and the Service Delivery Manager is established. At any point during the term of the agreement, the communication cadence can be adjusted to meet the client's changing needs. These service focused touch points will discuss upcoming service requests, change requests, patch and release management status and significant projects. Also, the Service Delivery Manager will review and update any organizational changes, process changes, and modification to client response procedures.
- **Service Level Performance Monitoring -** The Service Delivery Manager reviews open tickets queues providing feedback and direction to the services delivery team ensuring proper workflow management. During their review, the SDM will identify service trends, potential problems, and opportunities to improve the service delivery quality. Also, the SDM monitor overall service performance and reviewing Service Level Agreement attainment and escalation workflow.

- **Major Incident Management Leadership -** During the ordinary course of IT operations, significant incidents will occur, and they can have an extreme impact on the steady-state operation of the business/organization. Any events for which the timescale of disruption – to even a relatively small percentage of users – becomes excessive could be regarded as a major incident. When necessary, the major incident procedure could include the dynamic establishment of a separate Major Incident Team subject to the direct leadership of the Service Delivery Manager. The SDM's direction ensures that adequate resources and focus are provided for finding a resolution. If the incident is escalated to the point that requires a formal meeting between and should arrange a formal meeting with all invested parties. The SDM will organize, facilitate, and drive this crucial meeting with the purpose of reviewing progress and determining the best course of action. Throughout the major incident, the Service Delivery Manager ensures all activities are recorded, and the client is informed of progress. Communication is an important activity in handling major incidents.
- **Executive Business Reviews -** An Executive Business Review (EBR) is a face-to-face meeting that is strategic—rather than tactical—in nature. EBR is scheduled and conducted by the assigned Service Delivery Manager, and this briefing is not the time or place to discuss the details of specific service issues, support questions or the status of particular projects. The SDM will lead a conversation to gain a deeper understanding of the client's business and plans, and to strategize as to how Carousel can deliver more value based on those factors. At the same, the Service Delivery Manager will provide insight on Carousel's business goals and objectives, overall performance, and new solution sets. Also, the SDM will provide comprehensive insight on overall service delivery performance, areas for improvements, capacity planning recommendation and life-cycle management advice. Carousel will conduct Quarterly executive business reviews per year with the expectation is that the EBR would include critical members of the client IT team including but not limited to executive leadership. Carousel goal is to ensure that all EBR have a face-to-face experience whether through the use of technology or an in-person meeting.

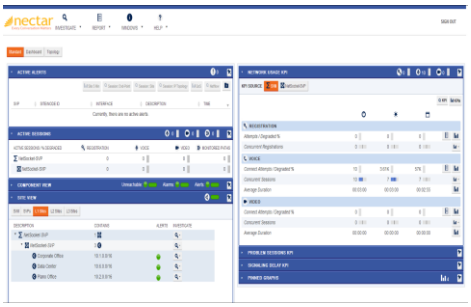
Note: Carousel has included an average of an additional 16 hours per month (not to exceed 192 hours per year) for SDM functions above and beyond the existing SDM work currently being performed.

Optional Service & Features:

Advanced SIP Monitoring

Advanced software will be installed as Nectar's UC Professional Package that is comprised of UCF (UC Foundations), Perspective QOS and UCD (Unified Communications Diagnostics).

Unified Communications Diagnostics



Live SIP Information

Nectar's Unified Communication Diagnostics (UCD) platform provides enterprises and service providers with comprehensive insight into UC issues for fast resolution, lower TCO and a superior user experience. The UCD platform automatically correlates session, content and topology data in real time, without probes, enabling managers to anticipate, isolate and remediate network problems. The UCD platform provides real-time visibility into the quality of the UC user's experience (e.g., MOS, R-factor, packet loss, jitter, delay, echo and signal-to-noise ratio) for the real-time IP services monitored. The Platform unobtrusively monitors content, session and network topology data via passive taps or span ports (port mirrors).

Real Time Synthetic Voice & Video Transactions:

Extreme Visibility – Leveraging CMP's real-time communications structure along with its distributed agent technology, a network operator can experience QoS perspective from different reaches of their wide area network – simultaneously.

Measurements for QoS – Perspective generates synthetic transactions that mimic real traffic situations based on your corporate QoS design. The module measures not only jitter, packet loss and latency for traffic types such as voice and video, it also models different applications with varying QoS requirements.

Real Time Alerts – When QoS is not being honored by the network infrastructure, Perspective displays configuration mismatches and simultaneously broadcasts alarms to CMP live dashboards in the client premise, and to their voice support service bureau provider.

End User Service requests (MACD) for Voice & Contact Center

Carousel will execute a standardized set of procedures to promptly handle end-user related changes. The service request process ensures that all requests are recorded, assessed, approved, prioritized, and deployed in a manner that meets the business requirements.

End-user service request will be broadly classified as "Standard". Where standard service request tasks are well known, defined, documented, and proven. The service request management workflow is pre-established, and no approval is necessary.

As part of the overall process, Carousel will provide the following where applicable:

- Ensure that the client's IT personnel requesting the change is authorized;
- manage and implement end-user level service request;

- define the changes required to complete request;
- schedule the implementation of the service requests;
- implement the end-user service request; and
- notification of the completion of the service request.

Upon the receipt of the service request, a priority scale of 1 through 4 will be applied. The assigned priority will determine the timeline for implementation where P1s are deployed within 2 hours, P2s within the same day, P3s within three business days, and P4 within five business days.

- Carousel will provide remote simple MACD services for supported IP Telephony and Contact Center. Simple MACDs are defined as administrative work performed at the user level and an unlimited number of them are included as part of the base services offered. Carousel will perform remote MACD activities during normal business hours, which are from 6:00 a.m. to 6:00 p.m. local site time, Monday through Friday, excluding Carousel-observed holidays.
- Carousel can provide remote complex MACD services for supported IP Telephony and Contact Center. Complex MACDs are defined as administrative work performed at the system level or any contact center programming beyond agent creation and removal. Complex MACs will be considered a project and will become a billable event. Carousel will perform remote Complex MACD activities during normal business hours, which are from 6:00 a.m. to 6:00 p.m. local site time, Monday through Friday, excluding Carousel-observed holidays.
- On-site MACD (Simple and Complex) activities would be performed during normal business hours, which are from 8:00 a.m. to 5:00 p.m. local site time, Monday through Friday, excluding Carousel-observed holidays. All onsite MACD (simple or complex) will be performed as a billable event.

The table below is a sample description for simple and complex MACDs:

Simple	Complex
• Abbreviated Dial Lists • Call Coverage Paths • Class of Service Assignment • Extension Assignment • Station Add/Delete • Agent Add/Delete • Administrative changes to a Voice Mailbox • Name change • Number change • Password reset – VM or station • Call pick-up groups configuration • Non ACD Hunt Group • Configuring a new user to be a Presence User • Configuring a User for Single Number Reach • Call Coverage path • Station designation • Call pick-up groups	• Feature Access codes • VDN/Vector Configuration & Changes • Abbreviated Dial Lists • Classes of Restriction Assignment • Announcement Set-up (End User will record all announcements) • Classes of restriction configuration • World class routing • Hunt group configuration • AAR routing analysis & changes • Class of Service configuration • ANI/CLI configuration • Number ranges creation to be used for specific tasks • IP address configuration • Route pattern configuration • Trunk Group configuration • Allocate DTN's to lines • Creating threshold classes • Time of day changes • Supervisor Login Administration • Classes of restriction configuration • Skill / Hunt Group administration • Agent Aux Reason Code administration • After call work codes administration

Based on the above defined criteria, complex end user service requests will be billed as time increments of 30-minutes as Time & Materials or deducted from a pre-paid block of hours. Any service request not listed in the criteria above will be evaluated by Carousel and discussed with the Client to determine classification.

Technical Oversight, Guidance, & Management

Carousel has incorporated Lead Support Engineer (LSE) functions as part of our per-port pricing. The LSE will be the technical conduit between your team and the Carousel support team, and functions as the technical lead and escalation point as it relates to your support program. The LSE can attend scheduled calls with your team to review any open incidents, specific areas of concern, and make recommendations towards improvement.

- Named and assigned Subject Matter Expert
- Technical Oversight & Guidance
- Change Management Approval
- Input & Assistance during Major Incident Resolution
- Owns Problem Management
- Owns Root Cause Analysis
- Services Review
    - Major Incidents
    - SLAs
    - General Questions/Concerns
- Quarterly Business Review
    - Trends/Capacity
    - Lifecycle Management
    - Improvement Areas
    - New Solution Ideas

Note: Carousel has included an average of an additional 16 hours per month (not to exceed 192 hours per year) for LSE functions above and beyond the existing LSE work currently being performed.

e-Bonding capability for improved and consistent reporting and management

Clients that subscribe to partner with Carousel for managed services solutions are looking to control cost, simplify their operations and improve the efficiency and value of the IT staff. For many clients, the standard service delivery model is effective. For mid and large-scale clients, standard communication channels are not enough, and collectively we look for additional areas to improve. One common approach is eBonding. The service from Carousel builds an integration between the service delivery platforms of Carousel and our Client's system. The integration enables real time and accurate information exchange by removing any dual entry needs or "swivel-seat" data entry, removing clutter from email communication as additional phone calls for updates. eBonding allows for co-developed reporting to reduces process disruption.

Carousel's eBonding offering typically is developed for incidents (trouble ticket) data. Other aspects of ITSM – Problem, Change, CMDB/Assets, Service Requests and Knowledge management add to both scope and / or budget.

For most clients, eBonding makes sense when the average ticket volume is 100 or more, but workflow and client team involvement can make smaller expected ticket volumes cost justify the development expense.

What to plan for with eBonding

Depending on the complexity of the client integration, the amount of consulting hours required to complete the effort will vary from client to client.

The following table outlines “guidelines” for a general estimate of three types of integrations based on expected complexity. As guidelines, there is no guarantee on the actual effort

Complexity Level	Description	General Estimate
Low	An example of a Low complexity level integration would be a straight ServiceNow to ServiceNow bi-directional Incident Management integration where the customers ServiceNow system is not highly customized and follows standard ITIL processes with little process flow modifications to the OOB workflows. There will be field mapping required and minor data transformation with standard SLA requirements.	Total Hours: 100-180
Medium	An example of a Medium complexity level integration would be a bi-directional ServiceNow to ServiceNow where SN has been highly customized or another industry standard Incident Management ticketing system that follows similar ITIL based nomenclature and Incident Management. The system will have a published API available for data access. There will be field mapping required and minor data transformation with standard Service Level Agreement (SLA) requirements.	Total Hours: 180 -250
High	An example of a High complexity level integration would be a bi-directional ServiceNow to another Incident Management system with an available API and customer experience in accessing the data. Systems with non-standard Incident Management workflows and/or scripting that perform automatic actions that will require additional configuration to ensure updates are received and processed correctly. There may be extensive data transformation services required to properly configure the integration and complex assignment and SLA requirements.	Total Hours: > 250

Pricing Summary

Inventory Assumptions & Budgetary Pricing

Service Bundle	OEM	Description	Qty	Monthly Price	One Time Fee
Proposed Solution:					
N/A	Carousel	Business Review - Quarterly	1	**$6,433**	**$6,377**
N/A	Carousel	Service Delivery Manager (SDM)	1		
Operate	Xima	XIMA Chronicall	1		
Optimize	Cisco	Contact Center Express	2		
Optimize	Cisco	Cisco Business Edition 7000	2		
Optimize	Cisco	VG Series Gateway	5		
Optimize	Cisco	SRST Server/Branch Router	3		
Optimize	Cisco	Unified Communications Manager	3		
Optimize	Cisco	Unity Voicemail	2		
Optimize	Cisco	Expressway C & E	2		
Optimize	Cisco	Paging Server	2		
Optimize	Cisco	Attendant Console	1		
Optimize	Cisco	UCS C-Series Server - + 1*Hypervisor	1		
Optimize	Cisco	Cisco Catalyst 3850 Series Switches	1		
Optional Service & Features:					
Nectar	Nectar	Advanced SIP Monitoring (CC Agents)	32	**$1,436**	TBD
Nectar	Nectar	Advanced SIP Monitoring (VOIP Users)	975		
N/A	Carousel	Technical Oversight, Guidance, & Management (LSE)	1	**$2,856**	N/A
Optimize	End User	End User Service requests (MACD) for Contact Center	32	**$2,301**	N/A
Optimize	End User	End User Service requests (MACD) for VOIP	975		
N/A	Carousel	ITSM eBonding	1	N/A	TBD

Pricing Assumptions

Carousel's pricing is based on our current understanding of the Client environment, the scope defined in this proposal, and the assumptions stated below. If during the course of this engagement any of these assumptions prove to be invalid, both parties will agree to revisit the scope of this proposal.

- Quoted pricing is based upon a 36-month agreement
- Quoted pricing is based on inventory assumptions
- Quoted pricing is based on Monthly billing via the Clients purchase order/invoice process.
- Additional scoping will be required for Advanced SIP Monitoring which will drive one time fees comprised of hardware and professional services.
- The Terms & Conditions as outlined within the Master Services Agreement in place between Carousel & SVMHS dated 12/1/2018 shall govern.

Carousel Overview

Carousel helps healthcare clients address strategic technology issues, using the right platforms to deliver safely, efficiently, and cost effectively. Our deep knowledge of the healthcare environment enables us to provide clear guidance to expedite the most appropriate solutions and meet your business goals.

With deep expertise across a vast portfolio of technologies, including security, unified communications and collaboration, data center, networking, managed services, and cloud solutions, Carousel can design, implement, and support solutions tailored to meet the unique needs of each customer. By offering professional and managed services with flexible deployments in the cloud, Carousel ensures customers achieve agility and use technologies in the way most effective for their business.

A legion of 1,300, the Carousel team has been committed to the art of customer success for its more than 6,000 highly satisfied customers since 1992. Our company has been recognized by multiple publications and industry consortiums as a top technology integrator and managed services and cloud solution provider—including the Inc. 500/5000, Healthcare Informatics 100, and CRN MSP Elite 150. Headquartered in Exeter, RI, we have offices across the United States and internationally—with three Network Operations Centers.

Healthcare Experience

Carousel's extensive portfolio of collaboration, communication and security solutions provide healthcare organizations with a one-stop-shop for time-sensitive technology needs. Through our partnerships with some of the industry's top providers including Cisco, Avaya, and Microsoft, we're able to identify the right solutions for our customers and assist them in gaining the most value from their technology platforms in the shortest amount of time.

Our knowledge of the healthcare sector's unique challenges enables us to balance patient care delivery against time, resource, and regulatory constraints. With COVID-19 cases growing, hospitals and physician organizations face complex challenges in delivering quality healthcare to patients, ensuring the safety of care givers and the public, maintaining awareness of the risks to their patient populations, and managing scarce resources—all while complying with rigorous data privacy mandates.

Carousel understands the health care industry's complexities and strict regulatory challenges especially during COVID-19. We have worked with numerous clients in healthcare including the following managed services Carousel customers:

- Acadia Healthcare
- Ardent Health Services
- Blue Cross Blue Shield
- Boston Medical System
- Erlanger Health Systems
- Health Choice Arizona
- Maine Health
- Ohio Health
- Tenet Health System
- Quest Diagnostics … and numerous others

Managed Services Organization

Carousel Managed Services is built to meet the challenges facing IT today and designed to modernize your IT operations. Our solution is the perfect blend of the right tools, a highly talented staff, a precise services delivery framework, and decades of experience.

Carousel's managed service provides you with access to our team of technical experts who maintain the most current levels of industry knowledge and certifications, and our performance monitoring provides you the visibility needed to get ahead of business impacting issues 24x7x365. The Carousel NOC is also available 24x7x365 to answer phone calls, monitor and respond to email as well as portal requests.

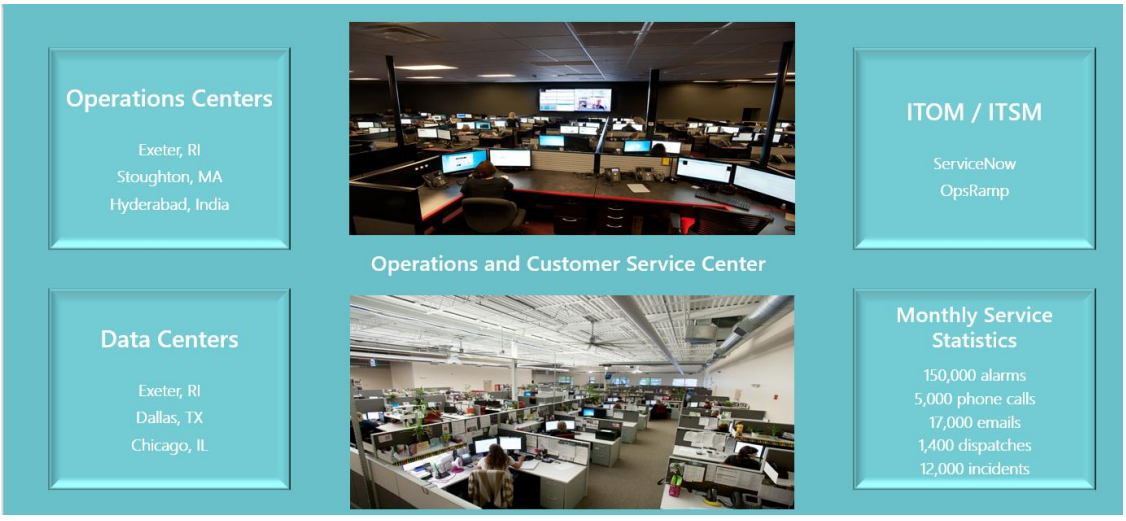
All incidents and service requests will be entered, tracked, maintained, and reported in Carousel's ITIL-based Service Desk tracking system. Carousel will become your single point of contact to resolve technology issues spanning your supported environment, and the multiple vendors this may include.

Modeling many of the attributes of modern advanced manufacturing environment, Carousel has incorporated LEAN based process improvement and innovation into our managed service offering. Focusing on the elimination of noise, automation, machine learning, and artificial intelligence, Carousel is reducing human touch dependency on non-value-added operations and activities.

This year heralded the implementation of infrastructure, connectivity, and application discovery engine, a strong event correlation system, an advanced scripting and automation function, and stronger asset management systems. Security enhancements were a significant focal point in 2018 with the implementation of two-factor authentication, enterprise password vaulting, uni-directional secure connectivity, complete session recording, and enhanced reporting and audit functionality.

The Carousel Advantage

- Full-Service Technology Solutions Integrator
- Large Portfolio of "Best of Breed" Products
- Highest Levels of Partner Certification
- Focus on Customer Satisfaction
- Nationwide Footprint, Global Reach and Coverage
- Complete Design, Implementation, Training and Day-2 Support Services
- 24/7 Monitoring through Network Operation Center



Cisco Expertise

Carousel holds top partner status and certification with many leading technology companies. Through these relationships, we provide complete end-to-end services and solutions. These certifications are only given to business partners who have met rigorous requirements for technical expertise and customer satisfaction. These distinctions are a direct result of the talent, dedication, and commitment of the Carousel team including pre-sales engineering, project management, post-sales support, account management, and training.

Cisco is both our fastest growing and largest overall manufacturer business partner. Because of Cisco's continued innovation and growth in the industry, Carousel is committed to growing our capabilities internally to build, deploy, and support our client's Cisco solutions.

Our consulting practice is made up of experts who are highly specialized in Cisco's entire portfolio of technology solutions. As a Gold Cisco partner, Carousel was honored with the 2019 Collaboration Partner of the Year Award for its innovation, leadership, and best practice as a Cisco business partner across the country

- Cisco Gold Certified Partner
- Cloud and Managed Services Express
- Master Collaboration Architecture Specialization
- Advanced Data Center Architecture Specialization
- Master Enterprise Network Architecture Specialization
- Master Security Architecture Specialization
- Advanced Video Specialization
- 40+ Cisco Certified UC&C Consultants
- 400+ Carousel held Cisco Certifications

Individual Cisco Technical Certifications	Qty
CCNA – Cisco Certified Network Associate	100
CCNA-DC: CCNA – Data Center	4
CCNA-S: CCNA – Security	13
CCNA-V: CCNA – Voice	20
CCNA-WL: CCNA Wireless	8
CCDA: Cisco Certified Design Architect	29
CCDP: Cisco Certified Design Professional	6
CCNP: Cisco Certified Network Professional	27
CCNP-DC: CCNP Data Center	2
CCNP-S: CCNP Security	1
CCNP-V: CCNP Voice	10
CCIE: Cisco Certified Internetworking Expert	**Qty**
CCIE – Routing & Switching	6
CCIE – Security	2
CCIE – Cisco Certified Systems Instructor	2
CCIE – Data Center	1
CCIE – Collaboration	2
TOTAL CERTIFICATIONS	**232**

References

Temple University Health System

Phil Smolinsky

IT Manager

Temple University Health System is a 722 bed, non-profit academic healthcare network based in Philadelphia, PA. Carousel partners with Temple on their Vidyo videoconferencing and Cisco datacenter, calling and contact center environments. Our existing managed services contract includes over 7 locations, 5,304 total phones, 7355 PBX Ports, and Advanced SIP Monitoring services (Nectar UC Professional Package).

Children's Friend and Family Services

Joe Lezon

Chief Information Officer

Children's Friend and Family Services is a Non-Profit family and child services organization based in Providence, RI. A longtime client of Carousel's, we partner with Children's Friend in their security, virtualization, and network infrastructure.

Our existing managed services contract today includes proactive monitoring and support on, Microsoft Active Directory, VMware VCenter, HP SimpliVity, Fortinet Firewall, SSO, and Email Security, and Cisco UCS, Catalyst Switches, Wireless Controllers, Access Points, and Integrated Services Routers.

Philips Healthcare & Home Monitoring

Pat Riley

Head of Telecommunications Services, Philips Home Monitoring

Philips USA is a healthcare products and services company providing diagnostic, treatment, and preventative care. Domestically, Philips is based in Andover, MA. Philips is a longtime client of Carousel's. We partner with Philips Healthcare in their ServiceNow, Viptela, Cisco network infrastructure, and Avaya UC. We partner with Philips Home Monitoring in their Avaya UC, Juniper Networking, Calabrio Call Recording, and Cisco UCS environments.

Our current managed services contract with Philips Healthcare includes technical oversight, guidance, and management (LSE), Advanced SIP Monitoring, and dedicated staffing resources providing service desk functions and tier 1 support for Philips cloud healthcare application solution which leverages technology inside the AWS environment. Our current Managed Services contract with Philips Home Monitoring includes Advanced Monitoring (Nectar) and support on their Avaya UC, Cisco UCS, and VMware environments.

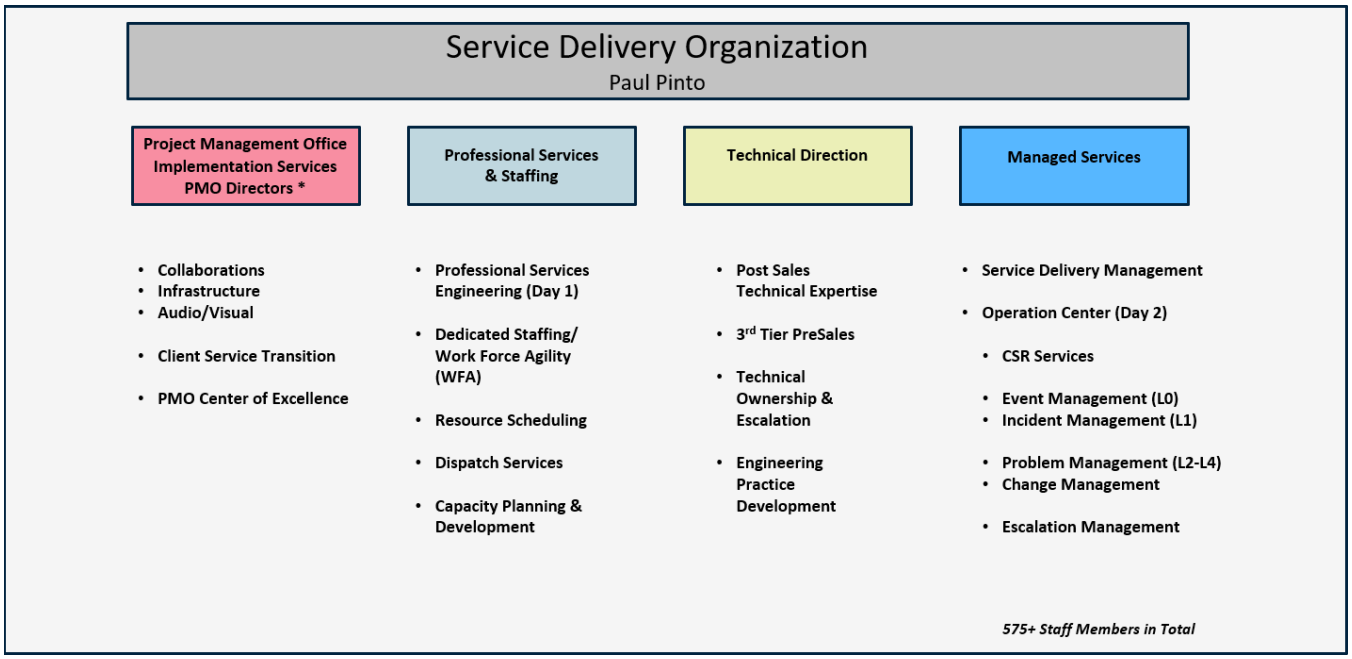
RFP Terms and Conditions

Carousel understands and complies with the T&Cs set forth in this RFP. The existing Carousel MSA and SVMSH BAA in place today covers terms and condition of Carousel's Managed Services (reducing legal review needed in onboarding).

Attachment A: Vendor Info

Name of Vendor:	Carousel Industries		
Name of Owner/CEO:	Jeffrey Gardner, CEO		
Name and Title of Contact/Proposer:	Anthony Ciampa, Account Executive		
Address:	1901 S Bascom Ave Ste 1650	Number:	603-455-5933
(city, state, zip)	Campbell, CA 95008	Email:	ACiampa@Carouselindustries.com
Number of Employees:	1,300		
References: (no more than three; name, title, email)	1. Temple University Health System 2. Children's Friend and Family Services 3. Philips Healthcare & Home Monitoring *See reference section for details.*		

Attachment B: Carousel Project and Service Delivery Structure



COVID-19 Preparedness

As HEALTHCARE organizations face unprecedented demand and hurdles, Carousel Stands Ready

Healthcare organizations are experiencing extraordinary spikes in demand. Staff are overwhelmed with huge volumes of patient requests and providers must quickly expand their ability to triage incoming contacts.

With COVID-19 cases growing, hospitals and physician organizations face complex challenges in delivering quality healthcare to patients, ensuring the safety of care givers and the public, maintaining awareness of the risks to their patient populations, and managing scarce resources—all while complying with rigorous data privacy mandates. Carousel helps healthcare clients address strategic technology issues, using the right platforms to deliver care safely, efficiently, and cost effectively. Our deep knowledge of the healthcare environment enables us to provide clear guidance to expedite the most appropriate solutions and meet your business goals.

YOUR CHALLENGES:

Work at home:

- Severe time pressures to deploy technology solutions and drive user adoption.
- Increased patient activity coming from multiple sides—large inbound call volumes along with an influx of patients arriving at your physical locations.
- Ability to maintain compliance with HIPAA and other privacy regulations.
- Existing technology tools and workflows are undersized, underutilized, or unable to quickly pivot to handle larger patient volumes.
- Integration with other systems within the IT stack may be hindered by propriety technology or limited interoperability.

KEY BENEFITS:

- Fast implementation of patient-facing technology solutions, enabling your organization to meet increased demand for services without requiring additional staff.
- Improved patient experience through the use of convenient communication tools that can be accessed from the safety of the home.
- More efficient triaging of patients, resulting in reduced staff workloads and the ability to identify and focus on those requiring the most urgent care.
- Support increased patient volumes while preserving the quality of care, adherence to data privacy management obligations, and insight into operational performance and risks.

THE CAROUSEL OFFERING:

Carousel's extensive portfolio of collaboration, communication and security solutions provide healthcare organizations with a one-stop-shop for time-sensitive technology needs. Through our partnerships with some of the industry's top providers, including Cisco, Avaya, and Microsoft, we're able to identify the right solutions for our customers and assist them in gaining the most value from their technology platforms in the shortest amount of time. Our knowledge of the healthcare sector's unique challenges enables us to balance patient care delivery against time, resource, and regulatory constraints.

Need to connect with a Carousel representative on COVID-19 considerations or concerns?
Email PandemicPreparedness@carouselindustries.com or call 800-285-2502

Carousel Helps Our Healthcare Clients Address Their Most Pressing Mission-Critical Issues.

ASSESSMENT OF NEEDS & EXISTING TECHNOLOGY CAPABILITIES:

The current environment makes prioritization a key first step. Assessments should include evaluation of your organization's top-tier needs—which may vary by region or level of healthcare services offered—and the pain points identified by internal staff as well as patients and patient advocates. A review of existing infrastructure capabilities and solutions is necessary to identify gaps and drive the best technology decisions.

RELIEVE PRESSURE ON STAFF:

Work-at-home agents can help healthcare provider organizations leverage employees and contractors located in other regions. Chatbots also provide value, enabling you to automate more calls, reduce the number of agents needed to handle the growth in call volume, and decrease the strain on trunks and bandwidth. Callback assist further supports flattening your agent pool capacities, reducing hang-ups and providing a better customer experience for patients.

EXPAND CONTACT CENTER CAPACITY:

By confirming your existing inbound/outbound trunk capacities and quality, you can avoid abandons and retries. To accommodate volume increases, a license expansion agent will enable enough people to login to the queue and take calls. If you already have an IVR, sufficient licenses will ensure adequate calls/sessions can flow through your system. Cloud-based agents can help rapidly expand the number of physical bodies your business has available to take calls. Where infrastructure constraints exist, a scale-up of SIP trunking and/or bandwidth will increase your interaction volume capabilities.

ENABLE DELIVERY OF REAL-TIME HEALTHCARE SERVICES:

Emergency departments and physician offices are struggling to process large numbers of incoming patients. Telemedicine is becoming a preferred delivery method for non-urgent care, enabling your providers to quickly triage potentially infected individuals without exposing them to others, and remotely monitor those whose conditions don't require an in-office visit. This technology and other UC/collaboration solutions can reduce walk-in traffic and limit call center volumes. Automated Q&A hotlines may also help you more effectively manage incoming requests, transferring callers into your current solution as needed or directing them to lower-cost channels such as SMS, IVR, or a chatbot.

SUPPORT TEMPORARY FACILITIES:

As you activate new locations to serve priority COVID-19 patients—including testing, isolation, treatment, recovery, morgue, and material/equipment staging sites—collaboration technologies are critically important for patient triage and care in those facilities. Long-range Ethernet may serve as the primary LAN backbone by providing enhanced distance capabilities through existing cabling, while mesh wireless and other mobility solutions can extend network connectivity where a physical infrastructure is impractical or time consuming. VPN and VDI deployments help maintain network and endpoint security in temporary locations, enabling you to centrally control and protect desktops, mobile devices, and corporate data assets.

BOLSTER REMOTE ACCESS:

Portions of your administrative and support staff may be transitioning to a work-from-home structure. UC and collaboration tools provide a key link to enable these groups to maintain communications with the rest of your organization. VPN and VDI capabilities ensure these remote connections are protected, and additional security solutions may be recommended to comply with data privacy rules and avoid the risks posed by the use of workers' personal devices and home networks.

Need to connect with a Carousel representative on COVID-19 considerations or concerns?
Email PandemicPreparedness@carouselindustries.com or call 800-285-2502

Deep Portfolio of Technology Solutions to Support Healthcare

Whether your organization is already in the midst of a vigorous coronavirus response or you're still monitoring surges around your area, Carousel offers an extensive portfolio of communication, collaboration, cloud, networking, and security solutions to help you deliver quality patient care. We offer leading solutions from top vendors including Cisco, Avaya, Microsoft, VMware, InContact, twilio, Fortinet, Aruba, and Cylance. Our experts hold more than 1,000 high-level certifications from our partner ecosystem of 35+ top-tier providers. We have the experience to help you deploy new solutions, expand existing solutions, and migrate your organization to your desired future state. Our fully staffed, 24-hour NOC is ready to support your day-to-day operations to ensure your organization can meet the evolving needs of your patient populations.

Managed Services

Carousel Managed Services

Unified Communications

Statement of Services

This document provides a high-level service definition for:

Salinas Valley Memorial Healthcare System

Proposal Date:	3/2/2021
Proposal #:	588006
Presented to:	Audrey Parks
Presented by:	Scott Schubert
Architected by:	Sammy Homsi

Table of Contents

Managed Services Agreement 3
Services Overview 3
List of Exhibits in this Agreement 4
Pricing 5
One Time Charges (OTC) 5
Monthly Recurring Charges (MRC) 5
Pricing Assumptions 6
Out of Scope and Service Limitations 6
Signatures 7
Exhibit A – Service Delivery Gateway (SDG) 8
Exhibit B – Service Transition Details 18
B.1. Planning Phase 18
B.2. Execution Phase 18
B.3. Quality Assurance/Testing Phase 19
B.4. Tuning Phase 20
B.5. Steady State Phase 20
Exhibit C – Steady State Entitlements 21
C.1. Monitoring 21
C.2. Reporting & Portals 21
C.3. Configuration Management 21
C.4. Event Management 21
C.5. Incident Management 22
C.6. Problem Management *(Optimize Only)* 24
C.7. Patch & Release Management *(Optimize Only)* 24
C.8. IT Asset Change Management *(Optimize Only)* 25
C.11. Continuous Service Improvement 26
C.12. Service Management 27
Exhibit D – Service Level Agreement 29
Exhibit E - Supported Items 31
Phase 1 **Error! Bookmark not defined.**
Phase 2 **Error! Bookmark not defined.**
Exhibit F - Terms and Conditions 32
1. **ORDER, PROVISION AND SCOPE OF SERVICES** 32
2. **INVOICING AND PAYMENT.** 32
3. **CUSTOMER RESPONSIBILITIES** 32
4. **SOFTWARE LICENSE** 33
5. **CONFIDENTIAL INFORMATION** 33
6. **WARRANTIES** 34
7. **LIMITATION OF LIABILITY** 34
8. **GOVERNING LAW AND DISPUTE RESOLUTION** 34
9. **TERM AND TERMINATION** 34

10. **MISCELLANEOUS** 34

Managed Services Agreement

This Statement of Services Agreement (the "Agreement") is entered into between Carousel Industries of North America, Inc. (“Carousel”), with an office at 659 South County Trail, Exeter, RI 02822 ("Carousel") and Salinas Valley Memorial Healthcare System ("Client") at 450 E Romie Ln, Salinas, CA 93901, . The effective date of this Agreement is TBD (the "Effective Date"). Where the Effective Date is not defined above, this Agreement will be effective on the date that Carousel countersigns this Agreement.

This Agreement defines Carousel’s IT Managed Services (“Managed Services”) based upon the Carousel’s 7x24 Service Delivery Platform which is driven by tight ITIL alignment from Carousel’s US (primary support) and India (secondary support) service delivery centers. For this agreement, Carousel will provide a services transition plan, steady-state services to augment the client’s ongoing day-to-day network operations and reduce the internal resources needed to provide operational support.

Carousel is providing Managed Service for a 36-month term length, preceded by Four weeks of service transition. The effective start date for the steady state operation will begin 60 days following receipt of client acceptance of service agreement (Signed SOS and/or PO) in all instances unless associated with a project implementation. Managed Services associated with a project implementation will commence at project cutover. The infrastructure and services herein are structured to support the Client’s current locations, with committed pricing to scale based upon growth or Carousel assuming increased responsibilities at the Client’s discretion. Future grow, expansion, or contraction of this agreement can be facilitated through our Change Request (CR) process.

Services Overview

Carousel will provide a services transition plan and steady-state services to augment the Client’s ongoing day-to-day IT operations and reduce the internal resources needed to provide operational support.

Service Transition

Carousel will manage and perform the following transition phases in which activities required for delivery are planned, designed and implemented:

- **Planning Phase** —a detailed data-gathering including a series of internal reviews culminating with a transition kick-off meeting.
- **Execution Phase**— quickly get supported items loaded and configured in the monitoring tool, validate connectivity and response
- **Quality Assurance/Testing Phase** - a full quality and testing review of the proposed solution with refinement and enhancements
- **Tuning Phase** - tuning of the environment to eliminate noise, false positives and ensure that the monitoring and reporting functions are optimized and working as expected. Additionally, Carousel will finalize all delivery process and procedures
- **Steady-State Phase**— Carousel will deliver the services specified in this Statement of Services and provide regular reports on performance against agreed upon SLA metrics.

Estimated Service Transition Timeframe

Carousel estimates the entire service transitioning process will be completed within Four weeks. The estimated timeframe begins when Carousel receives the client required information (inventory details, passwords, response procedures, etc.) Upon engagement of Carousel's Managed Services, we will work collaboratively with your team throughout the service transition process toward steady state support from Carousel's Support Centers. The following high-level schedule and process overview will provide you an understanding of the transition process:

Phase	Weeks			
	1	2	3	4
Planning Phase				
Execution Phase				
QA/Testing Phase				
Tuning Phase				
Steady State (Go Live)				

Please see Exhibit B for detailed service transition description

Steady State Delivery

Carousel offers a bundled approach to service delivery, with the most common services bundled together. The bundles aligned to your agreement are as follows:

- **OPTIMIZE** – Proactive Monitoring, Event Management, Incident Management, Problem Management, Network Configuration Management, Patch Management, Change Management and Quality Assurance Reviews

Carousel will perform the following Service Bundles by technology for the Client:

- Carousel will provide OPTIMIZE for Voice
- Carousel will provide an SDM for Service Management

Please refer to Exhibit C for Steady State Entitlement Details

List of Exhibits in this Agreement

Exhibit #	Description	Acknowledgement	
Exhibit A	Service Delivery Gateway (SDG)	**Initials:**	
Exhibit B	Service Transition Details	**Initials:**	
Exhibit C	Steady State Entitlements	**Initials:**	
Exhibit D	Service Level Agreement	**Initials:**	
Exhibit E	Supported Items	**Initials:**	
Exhibit F	Terms and Conditions	**Initials:**	

Pricing

One Time Charges (OTC)

Service Description	Quantity	Charge	Notes
Managed Services Transition Charges.	1	$ 4,582	Due at Contract Signing
Total One Time Charge		**$ 4,582**	

Monthly Recurring Charges (MRC)

Service Description	Months	Monthly Rate	Notes
Steady State Managed Services Recurring Monthly Charges	36	$ 6,460	Managed Services charges commence 60 days following receipt of client acceptance of service agreement (Signed SOS and/or PO).
Total Monthly Recurring Charges		**$ 6,460**	

Payments are due Net 45. Local, state and federal taxes are not included in the numbers listed above and will be added at time of invoice.

Pricing Assumptions

Carousel's pricing is based on our current understanding of the Client environment, the scope defined in this support agreement, and the assumptions stated below. If during the course of this engagement any of these assumptions prove to be invalid, both parties will agree to execute a change order and revisit the scope of this support agreement.

- Quoted pricing is based upon a 36-month agreement
- Quoted pricing is based on Monthly billing via the Client's purchase order/invoice process.
- All work will be performed remotely from Carousel Operation Centers located in the United States and India.
- Any desk side assistance required to diagnose or resolve infrastructure issues will be performed by Client.
- Client is responsible for ensuring that manufacturer's maintenance and support contracts are maintained for all software and hardware components managed by Carousel.
- Performance issues or application failure due to faulty hardware or improperly configured or faulty software caused by Client is outside the scope of the services agreement and will be the responsibility of Client to remedy. Carousel will make reasonable efforts to work with Client to troubleshoot and rectify problems.
- This proposal is based on a system configuration list and specifications contained within this Statement of Services. Any changes to these specifications may result in new requirements or price changes for this program.

Out of Scope and Service Limitations

- Any project-based work is not included in this Statement of Services.
- We assume that all solutions under this agreement are designed, configured, and implemented correctly and any redesign, reconfiguration, or re-implementation are out of scope.
- We assume that all solutions covered in this agreement are operational and performing at an optimal level and any additional remediation efforts are not covered under the agreement.
- This agreement is a remote managed service offering and by default does not provide on-site support, engineering, and consulting. Any on-site requirements are out-of-scope unless clearly defined in Exhibit C (Steady State Entitlement Details).
- Any custom errors, logs, and/or parameters to monitoring.
- Any customizations to Carousel standard monitoring templates.
- Investigation and analysis of root cause of problems for P3 and P4 issues.

Signatures

Signature below indicates Client has read and agrees to all Terms and Exhibits of this Statement of Services.

Accepted By: (Client Authorized Signature)	**Accepted By: (Carousel Authorized Signature)**
Audrey Parks, Chief Information Officer **On:**	**Mark Moretti, VP Managed Services** **On:**
Bill to Address:	**Address:**
	659 South County Trail Exeter, RI 02822
ATTN:	**ATTN:**
	Service Contracts Dept. 800-401-0760 maintenanace@carouselindustries.com

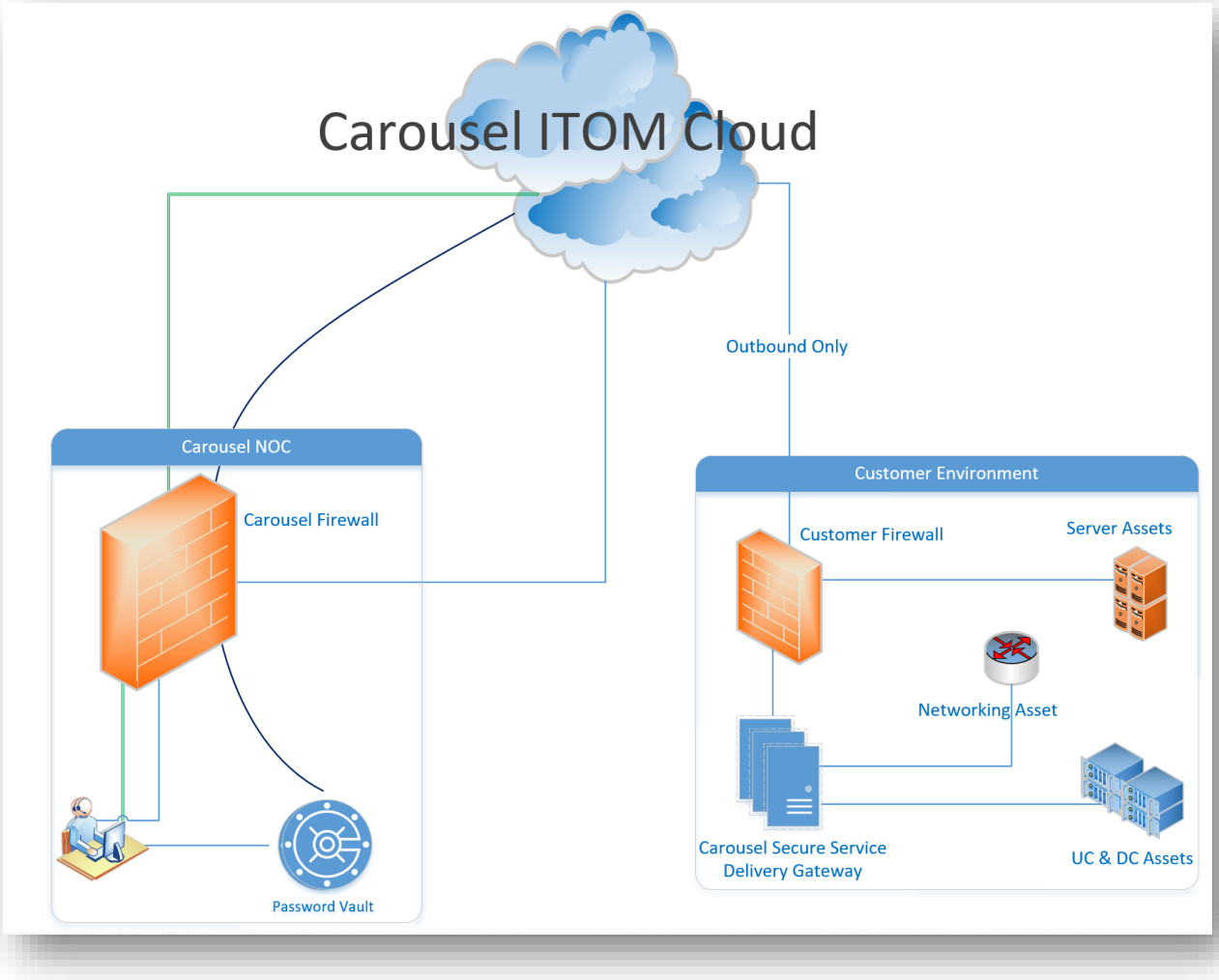
Exhibit A – Service Delivery Gateway (SDG)

Carousel Secure Service Delivery Gateway

The delivery of Carousel's Managed Services requires the implementation of our Service Delivery Gateway (SDG). The SDG is architected to provide device auto-discovery, monitoring, performance management, secure remote access, device level authentication, and tools for improved diagnostic capabilities.

The SDG is deployed with a secure abstraction layer between Carousel's Network Operation Center and the Client's environment ensuring the confidentiality, integrity, and availability of the Client's critical data. Our National Institute of Standards and Technology (NIST) based architecture guarantees the highest levels of authentication, access control, auditability, availability, and scalability.

The Service Delivery Gateway allows Carousel's managed services team to obtain alert, alarms, and performance information from The Client's environment. As abnormal, degraded, and service affecting conditions occur Carousel's service personnel can securely authenticate to the support devices, and investigate, evaluate, diagnose, and resolve detected incidents. In addition, our SDG maintains an audit trail of all access and records all session for detailed auditability.



Connectivity

Carousel's Service Delivery Gateway requires a minimum of three (3) virtual machines for secure connectivity, performance data collection and our managed services support tools. Carousel may also to choose to install additional Gateways, Agents or Master Agents for increased services, capabilities and visibility to assets, based the defined support requirements.

Infrastructure Requirements

Carousel requires that the client provides a minimum of three (3) virtual machine to deliver a best in class managed services experience. The client will provide the hardware platform to support the Service Delivery Gateway, and they will provide the Virtual Machine environment and all associated licenses. Also, the client must provide all Operating System licensing associated with each Virtual Machine. Carousel will provide all licensing for the all monitoring and diagnostic tools for the supported environment. In addition, Carousel provide all operational maintenance and support of the Service Delivery Gateway once service transitioning is complete.

Each virtual machine must be configured properly to manage the supported environment. The below are the requirement for the distinct, security hardened gateways:

Service Delivery Gateway 1- (Monitoring Gateway)

Description	A virtual appliance that collects data from the managed environment (Servers, Voice, Switches, Routers, Firewalls, Storage, etc.). The Gateway establishes a secure connection to the ITOM Cloud over the internet via: 1. OpenSSH tunnel with 256-bit encryption 2. HTTPS with TLS 1.2
Form Factor	The Gateway is a Virtual Appliance that runs on VMware vSphere and Citrix XenServer platforms.
Operating System	Hardened configuration of Ubuntu Server. Hardening includes the following measures: 1. Minimal software is installed 2. All unnecessary services are turned off 3. Applying latest patches and updates 4. All unnecessary users and groups are removed
Access Controls	1. All configuration updates for the Monitoring Gateway are pushed from the ITOM Cloud using a 256-bit encrypted channel created by the Monitoring Gateway. End users do not have access to the Monitoring Gateway. 2. The Gateway password is stored with SHA-512 encryption in a 16-character salt. Single mode login is disabled to prevent unauthorized access or prevent users from entering in single user mode. The Gateway allows only 2 new sessions for every 60 seconds and after 5 wrong passwords, the account locked for 3 minutes.

Infrastructure Size	Virtual Instance Requirements
Up to 25 devices	• 2 Virtual CPUs, 2 GB RAM / 40 GB HDD / 1 NIC • Supported hypervisors are VMware ESXi, Citrix XenServer, Microsoft Hyper-V and KVM
Up to 100 devices	• 4 Virtual CPUs, 4 GB RAM / 40 GB HDD / 1 NIC • Supported hypervisors are VMware ESXi, Citrix XenServer, Microsoft Hyper-V and KVM
Up to 500 devices	• 8 Virtual CPUs, 8 GB RAM / 100 GB HDD / 1 NIC • Supported hypervisors are VMware ESXi, Citrix XenServer, Microsoft Hyper-V and KVM
Greater than 500 devices at single site	• Deploy multiple Gateways

Service Delivery Gateway 2- (Support Gateway)

Description	A virtual appliance that is used to support the client's managed environment (Servers, Voice, Switches, Routers, Firewalls, Storage, etc.). The Service Delivery Gateway 2 can only be accessed through secure connection from the ITOM Cloud via RDP.
Form Factor	The Gateway is a Virtual Appliance that runs on VMware vSphere and Citrix XenServer platforms.
Operating System	Microsoft Windows Server 2016 1. Configured with a full tool set for the support of all managed services and devices. 2. Configured with a Just in Time Toolset (JiTT) so that services are only active during the time of action needed. This greatly reduces any potential exposure window.
Access Controls	1. Engineers must be granted access to the client environment to gain access. 2. All initial access is funneled through the Carousel ITOM Cloud 3. Secure authentication is provided through API integration with the Carousel Password Vault: (See Password Vault Details below)
Tools (JiTT)	**Include but are not limited to**: RDP, Web Browser (HTTPS), Putty, InformaCast Log Tool, LX Tool, Skype 4 Business, Cisco Agent, Cisco Supervisor, Cisco Attendant Console, RTMT, IP Communicator, configured with a virtual audio driver, CCX Editor, Kiwi Syslog Tool, Translator X, Skype Debugging Tools, Wireshark…

Infrastructure Size	Virtual Instance Requirements
Service Delivery Gateway	• 2 Virtual CPUs, 8 GB RAM / 100 GB HDD (Min) / 1 NIC • Supported hypervisors are VMware ESXi, Citrix XenServer, Microsoft Hyper-V and KVM

Service Delivery Gateway 3- (Performance Monitoring Gateway)

Description	Foundations Version This deployment provides for enhanced performance by focusing on the entire UC ecosystem via integrated capabilities such as resource trending and utilization, capacity monitoring and planning, and comprehensive reporting and analytics. Further, the UC Monitoring Gateway module provides simple access to voice quality metrics that include trace route and IP network visibility, real-time media analysis, and immediate UC network awareness. Comprehensive troubleshooting tools enable synthetic call testing, remote access and call tracing, file transfer and secure chat capabilities, alarm management, and SLA tracking and management. 1. UCF Features a. √ Health & Availability b. √ Performance & Capacity c. √ UC Auto-Discovery & Inventory d. √ Voice & Video Quality e. √ Multi-Vendor Neutrality	Diagnostics Version This deployment provides for real-time visibility into signaling and the UC user's voice and video quality (for example, MOS, R-factor, packet loss, jitter, and delay). It unobtrusively monitors the network topology as well as content and session data via passive taps or span ports (port mirrors). After collection, the UCD module automatically transforms and correlates this information. It learns network topologies and the status of available network resources by using standard network and IP routing protocols. The UCD module also obtains session information by passively listening to control traffic or by interacting with application servers and session control nodes and adds media content analysis into this correlated view. 2. UCD Features a. √ Real Time Media Analysis b. √ Signaling Capture & Analysis c. √ Route Topology d. √ Network Session Correlation e. √ Lync SDN API Integration
Form Factor	The Gateway is a Virtual Appliance that runs on VMware vSphere and Citrix XenServer platforms.	Hardened Network Appliance

Infrastructure Size	Virtual Instance Requirements
UCF: up to 1,000 users PC: up to 1,000 simultaneous RTCP streams	• 4 Virtual CPUs, 8 GB RAM / 180 GB HDD / 1 NIC • Supported hypervisors are VMware ESXi, Citrix XenServer, Microsoft Hyper-V and KVM
UCF: up to 7,500 users PC: up to 7,500 simultaneous RTCP streams	• 8 Virtual CPUs, 16 GB RAM / 280 GB HDD / 1 NIC • Supported hypervisors are VMware ESXi, Citrix XenServer, Microsoft Hyper-V and KVM
UCF: up to 30,000 users PC: up to 30,000 simultaneous RTCP streams	• 8 Virtual CPUs, 8 GB RAM / 380 GB HDD / 1 NIC • Supported hypervisors are VMware ESXi, Citrix XenServer, Microsoft Hyper-V and KVM
UCD-P: 250 - 600 sessions per second UCD-A: 16 - 28K concurrent RTP streams	• Appliance deployment: Depending on customer requirements a stand-alone appliance deployment may be required.

Note: In the event that a client is unable to provide virtual server environment, Carousel will provide hardware-based gateway(s) for an additional charge that will be listed as part of One-time Charges (OTC) in service transition cost.

Connectivity Requirements

The Service Delivery Gateway connects to Carousel's ITOM cloud platform. This connectivity requires that the client enables outbound access from their network. Listed below are the connectivity requirements:

Inbound connectivity: The Carousel SSD Gateway does not impose any inbound connectivity requirements.

Outbound connectivity: The Agent and Gateway 1 need DNS access to resolve ***api.opsramp.com***. If the client's organization has firewall policies to limit outbound access to specific IP addresses, then the Agent and Gateway must have access to the specified IP ranges. Gateway 2 is only accessible via the ITOM Cloud, therefore requires no inbound connectivity. Gateway 3 requires outbound connectivity only over TCP port 443.

Gateway 1 Outbound Connectivity Requirements		
Description	**IP/CIDR**	**Ports**
Data Center 1	63.251.89.0/24	TCP:443/8443
Data Center 2	206.80.7.128/26 140.239.76.0/24	TCP:443/8443
Gateway 2 Outbound Connectivity Requirements		
Description	**IP/CIDR**	**Ports**
Data Center 1	63.251.89.0/24	TCP:443/8443
Data Center 2	206.80.7.128/26 140.239.76.0/24	TCP:443/8443
Gateway 3 Outbound Connectivity Requirements		
Description	**IP/CIDR**	**Ports**
Data Center 1	52.3.3.211	TCP:443
Data Center 2	52.207.89.34	TCP:443
Data Center 3	35.169.184.165	TCP:443

A Day in the Life of a Managed Services Engineer

As an Engineer I will begin by logging into my company provided laptop with my Active Directory (AD) domain credentials. I will start my day by logging into the Carousel ITOM cloud by launching my web browser and go to our HTTPS secured Carousel Industries ITSM portal. If I am on the Carousel domain I will prompted via Multifactor Authentication (MFA) for my secure token. If I am not on the Carousel domain I will be prompted for my login information consisting of my email address and AD password. I will then be prompted via MFA for my secure token. I will then access our monitoring platform via HTTPS secure portal. Much like our ITSM portal we will also leveraging MFA driven authentication. Now, I am securely authenticated into our multi-tenant structured Carousel ITOM cloud. I am prepared to support our clients.

Once an incident or alert is assigned, I can then begin our troubleshooting and remote access process. This begins by accessing the client tenant and based on my role only the assets I am allowed to access will be made available. Once I have identified the asset I need to support, I will launch a secure remote access session (e.g. SSH, RDP, HTTPS). All sessions are recorded and archive for audit purposes. Leveraging a secure API connection back to our enterprise password vault that is encrypted via AES 256 our monitoring platform retrieves the proper credentials for the asset I am supporting. This API validates that I should have access to this asset. Any credentials retrieved from the vault are obfuscated and are not cached. Once my access is validated in the password vault, the asset service account information is then passed the device and the connection is made with no further interaction from me.

Our gateway is designed to use Just in Time Tools (JiTT). JiTT is a device hardening technique that keeps minimal services running to only allow the initial RDP connection only from the Carousel ITOM Cloud. Once a connection is established only the tools I specifically require will be enabled. Once I have completed my work and log out, the gateway will return to its hardened steady state.

Best in class security practices are the foundation of the Carousel ITOM Cloud. Every user and system interface is tracked, logged and archived. Every interaction from incident updates, to accessing the client's assets leaves and audit trail that can be retrieved and reviewed.

Remote Access

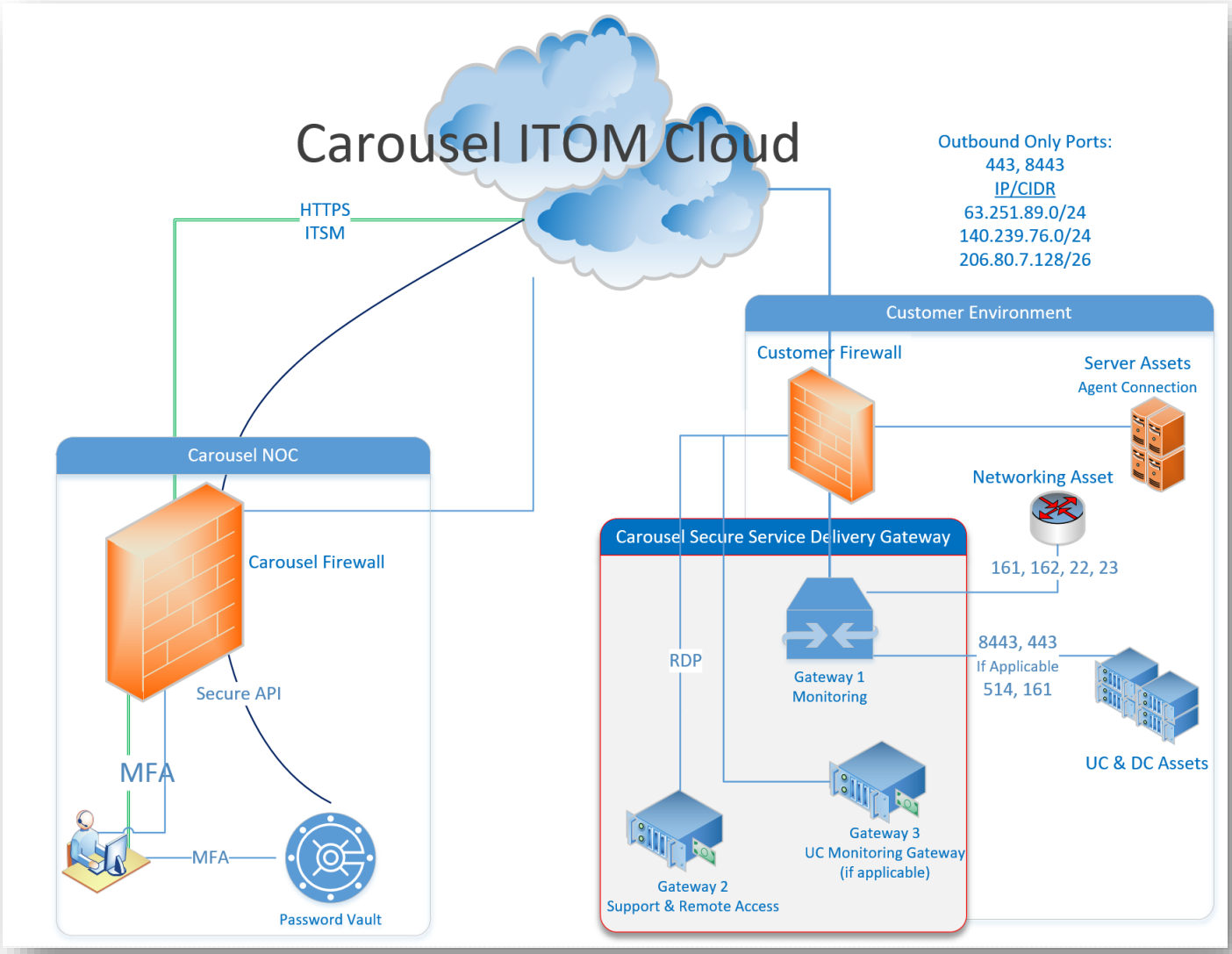
The Service Delivery Gateway gives our engineers a secure, one-click access to the support devices, including those in remote data centers that require connecting to remote access servers first and then hopping to the target devices. Secure Remote Access centralizes the management of all client credentials and access controls, so Carousel's engineers don't have to authenticate themselves at each stage of a remote access. It handles all login and authentication steps automatically, giving us one-click secure access to our client's remote resources.

Engineers assigned to support our client's environment are required to use an individualised 12-character minimum password. Additionally, each login requires a secondary authentication factor so that secure user authentication is assured. All interactions with our client's environments are logged, audited and recorded. This coupled with a single service account with a randomized password of least 15-characters or more, on our client's supported environment. Leveraging machine to machine secure API, the device level service account remains hidden from the engineering and support staff. This ensures that even an authorized engineer will not know the service account information that was used to make the connection.

The Service Delivery Gateway maintains a complete record of 'who', 'what' and 'when' of password access and provides intuitive reports on entire password management scenario in the supported enterprise. Carousel provides Real-time alerts on the occurrence of various password events through integration with Carousel's Security Information and Event Management (SIEM) solutions. Privileged sessions launched from the Service Delivery Gateway can be completely video recorded, archived and played back for forensic audits.

We take our clients trust seriously and execute measures to protect the sharing of service account credentials and resource access. All service accounts information is stored in our enterprise password vault.

Remote Access and Support Diagram



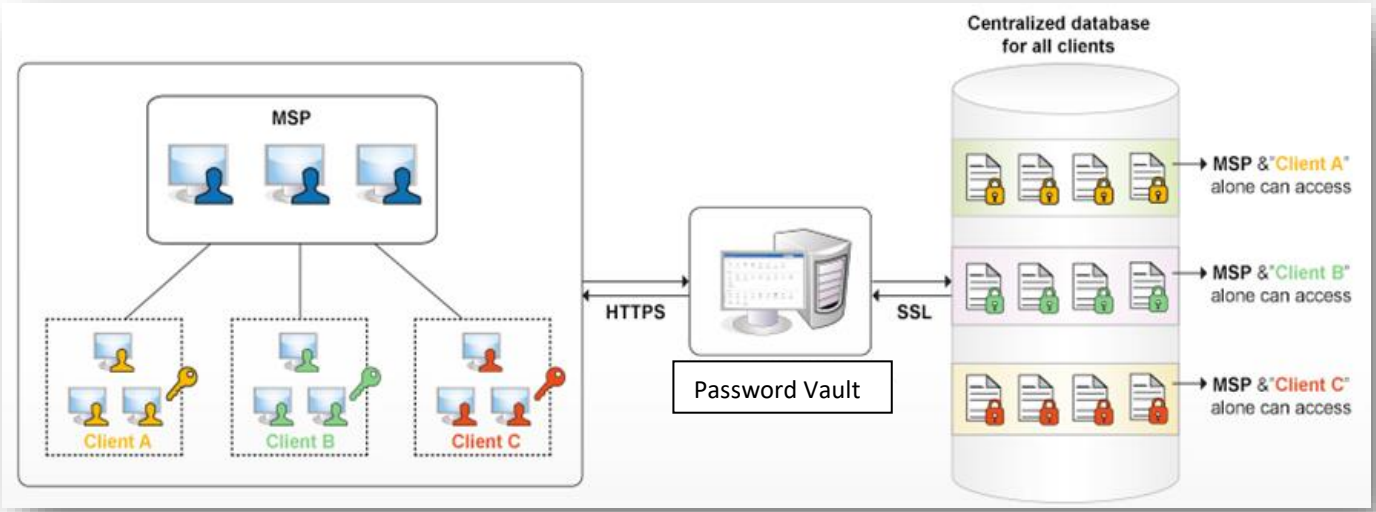
Password Vaulting

Carousel's Service Delivery Gateway provides an enterprise password vault solution to protect IT assets in the supported environment. The Enterprise Password Vault is a platform for secure storing and managing of shared sensitive information such as enterprise-passwords, privileged accounts, shared accounts, documents and digital identities in a centralized repository. This ensures Carousel can offer critical data protection above and beyond our customer's best practice security guidelines for sensitive information.

Secure Features include:

- Confidentiality, Integrity & Availability
  - High Availability Architecture
  - Passwords & sensitive data are encrypted using AES 256-bit encryption.
- Multi-Factor Authentication
  - Enforced MFA for logging in to the Password Vault.
- Automated Password Resets
  - Reset the passwords of remote resources when required or automatically through scheduled tasks.
- Enforced Password Policies

- Enforce industry standard and custom password policies.
- Comprehensive Audit Trails & Reporting
  - Complete record of 'who', 'what' and 'when' of credential access.
- Real-time Notifications, SIEM Integration
  - Real-time alerts on the occurrence of various password events with integration with Carousel's Security Information and Event Management (SIEM) solutions
- Industry Standard Secure API integration
  - RESTful API and XML-RPC API allow for application to application interaction and database instances.



Data Security and Management

Data Center Overview

The Carousel Secure Service Delivery Gateway is comprised of the various components running on company and partner infrastructure and in Data Centers that are owned and operated by 3rd party 'Best in Class' Data Center providers. Data Center providers are publicly listed U.S firms.

Locations	Data center 1: Santa Clara, California Data center 2: Rancho Cordova (Sacramento), California Data center 3: Dallas, Texas Data center 4: Chicago, Illinois
Security Certifications	Security certifications that these data centers have include: SOC Certifications, ISO7001, PCI DSS and others.

Data Collection

Carousel collects and stores only data necessary to perform IT operations management and support functions on devices that it manages.

Type of Data	Data Collected	Data Storage and Security
Performance Statistics	System level information necessary to monitor the performance and health of managed devices: • CPU and Memory utilization • OS Events • Hardware Events	Device performance statistics are stored only in the Carousel ITOM Cloud. The Agent and Gateway collect and transmit this data to the Carousel ITOM Cloud
Events and SNMP Traps	Operating System events and traps generated by SNMP agents.	The Monitoring Gateway and Agent processes events and traps locally and send resultant alerts to the ITOM Cloud via a secure channel. Raw event data is not stored in the Cloud.

Device Configuration and Device Metadata	System level information necessary to asset device configuration status: • DNS Names • Make/Model • OS and Application Configuration Parameters	The Monitoring Gateway and Agent sends configuration data to the ITOM Cloud via a secure channel.
Device Credentials	Credentials (username / password) necessary to discover devices, access performance and configuration data, and log into devices to run automation scripts.	Device credentials are stored in the Carousel Enterprise Password Vault, using industry standard FIPS level encryption.
Support Information	Information needed to support Incident, Problem and Change Management • Contact Information • Asset Information	

Types of Data Carousel Does Not Collect

Carousel does not collect, and has no means to collect, any data processed by applications that Carousel monitors. Examples of such data includes data within database tables, content of application transactions, user credentials of applications, etc.

Data Management

Data Classification	Carousel only collects and stores data required for IT operations management on devices and applications managed by it. Data that Carousel collects is limited to device performance metrics, performance and failure events, and configuration information.
Data Isolation	Carousel implements strict multi-tenancy controls to ensure data access is strictly isolated between customers.
Data Encryption (in-flight)	All data transmitted between the Carousel Agent/Gateway and the Carousel Cloud is encrypted with SSL and TLS/SSH (for gateway).
Data Encryption (at-rest)	Device credentials stored in the Carousel cloud is encrypted using 1024-bit RSA encryption.
Authentication	Carousel Cloud offers SAML and OAuth2 based authentication. Carousel additionally supports third party authentication services such as OneLogin, Okta and ADFS. Carousel Cloud offers two-factor authentication.
User Access Management	Carousel has extensive role-based access controls. Carousel access controls are granular to the managed device, user, and feature.
APIs	Carousel provides REST APIs for integration with Carousel cloud. Carousel REST APIs are backed by OAuth2 based authentication.
Regulatory and Compliance Requirements	Carousel does NOT collect any Personally identifiable information (PII). Carousel is hosted in co-location facilities provided by two U.S based data center providers. Each provider has their own security certifications including SAS and SSAE.

Data Security

Carousel supports an extensive set of security features to ensure that management data collected by Carousel is accessed only by authorized users.

Encryption	All sensitive data is encrypted to FIPS (Federal Information Processing Standards) in Carousel. Customer data (inventory, metrics, alerts, and tickets) is logically partitioned and stored under the client tenant. Customer data is accessible, via Role-based Access Controls (RBAC) only to authorized users of the tenant.
Role Based Access Control (RBAC)	Carousel supports comprehensive Role-based Access Controls. Users' access to devices and actions within Carousel is controlled by fine-grained permissions. Permissions are assigned based on users' roles.
Identity Management	Carousel provides multiple options to manage user identity: • Built-in user management system within Carousel • Integration with Microsoft Active Directory • Integration with single sign-on service OneLogin via SAML 2.0.

Authentication and Passwords	Carousel follows standard practices for passwords: • NIST based rules of password strengths • CAPTCHA code-based validation • Automated lockout after multiple unsuccessful login attempts • Carousel supports two-factor authentication using, FortiToken, Google Authenticator and Yubico YubiKey.

Data Retention

Definitions	
Active and Inactive Devices	A managed device is considered inactive if it meets all of the following criteria for 90 consecutive days or longer: No metrics are collected. No consoles are launched. No jobs, scripts, patches, or anti-virus updates are applied. An active device is one that does not meet the above criteria.
Active and Inactive Clients	A client is considered inactive if they meet one of the following criteria for 90 consecutive days or longer: Client has no active devices. Client has been marked as inactive within Vistara. An active client is one that does not meet the above criteria.

Type of data	Criteria	Retention
Devices	Inactive devices	90 days
Clients	Inactive clients	90 days
Tickets	Closed tickets	12 months
	Open tickets	For as long as ticket is open
Metrics	Metrics collected from managed devices	12 months
Alerts	Suppressed and closed alerts	90 days
	Open alerts	For as long as alert is open
Graphs	Graphs with no data	15 days
Reports	Recurring reports	Last 5 generated reports
	One-time reports	90 days
Job, Script, and Patch Activity	Jobs results	90 days
	Custom script results	90 days
Patches	Missing patches, once detected, but not re-detected for 180 consecutive days or longer	90 days
Secure Console Recordings	Rolling history of console recordings for each device.	90 days

Upon contract expiration Carousel inactivates the client "tenant" in the Carousel ITOM Cloud. An inactive tenant's instance inventory, metrics, and alerts data will be available in passive state, however, monitoring, alerting and other management functionality is no longer available.

Based upon an agreement between Carousel and the Client, Carousel will delete all the tenant information from the Carousel ITOM Cloud. Due to a ninety-day data archival retention policy, deleted tenant data will be available in archival repository for ninety days.

The Carousel Commitment

The Carousel Service Delivery Gateway provides secure end-to-end visibility and remote access into your most critical managed systems' health and performance. We support the world's most complex and dynamic environments and can monitor any element or service in your data center or cloud.

Our NIST based world-class practices, manage events from across your network with a laser focus on your most critical managed infrastructure, ensuring the highest levels of system security, integrity and availability for your business.

Exhibit B – Service Transition Details

Carousel's service transition management methodology is based on the Project Management's Institutes' Project Management Body of Knowledge, the most comprehensive and globally recognized standard for project management. It outlines the critical path to planning and managing the service delivery lifecycle and is tailored to meet the Client's service transition requirements as necessary. It includes tools and templates used to manage Scope, Risk, Quality, Communications, Human Resources, Procurement, Time, and Cost. Carousel's service transition activities, based on the information received from the Client, are proposed to be executed in the following phases:

Note: During Service Transition, Carousel will provide best effort reactive support for incidents. Service level metrics will be enforced ninety (90) days after service transition acceptance.

B.1. Planning Phase

Carousel will begin the service transition with a series of internal reviews culminating with a transition kick-off meeting. Carousel's Due diligence conducted during the Planning Phase plays a vital role in understanding, documenting and delivering the proposed managed services, as per its expectations and requirements. Carousel welcomes the opportunity to perform a collaborative due diligence session to assess the client IT landscape.

The objectives of the Planning Phase include:

- Conduct Service Transition kick-off meeting with Client
- Agreement Review
  - Confirm Scope of Services
  - Establish Priorities and Timelines
  - Review Supported Technologies
  - Validate Locations Supported
  - Items Supported
- Response Procedures/runbook
  - Review and Define Escalation and Prioritization Process
  - Collect Escalation Matrix details (Off Hours & Business Hours)
  - Review Vendor Management Requirements (LOA)
  - Review and Define Change Management Process
  - Discuss and Review Out-of-Scope Service Request
- Review the Project Timeline
  - Confirm Communications Plan / Contacts
  - Schedule Weekly Status Meetings
  - Take and publish Meeting Minutes
  - Establish Transition Steering Committee
- Design and formulate a knowledge transfer calendar and plan
- Review Monitoring tool requirements
  - Review Service Delivery Gateway Requirements
  - Review and Plan Service Delivery Gateway Deployment
  - Review Access Credentials
  - Security considerations
- Readiness Assessment

B.2. Execution Phase

Carousel's Service Transition Execution phase is where the plan designed in the prior phase is put into action. The purpose of the Execution phase is to deliver the project expected results (deliverable and other direct outputs). Typically, this is the longest phase of the Service transition lifecycle, where most resources are applied.

The execution team utilizes all the schedules, procedures and templates that were prepared and anticipated during the Planning phase. The Execution Phase is not a blind implementation of what was written in advance but a watchful process where doing things goes along with understanding what is being done to ensure execution corresponds to what was intend and expected.

The focus for the Execution Phase is to enable the supported environment, activate and configure the supported items, and validate connectivity and response. Here is an overview of what is accomplished during this phase:

- Gather the Technical Environment Support Information
  - Network Connectivity Diagrams
  - ISP Information
  - Custom Tasks and Procedures
  - IP Subnets to perform the discovery
  - SNMP read only string for network Devices
  - Windows Administrator credentials for Windows Servers
- Deployment of Services Delivery Gateway
  - Deploy Service Delivery Gateway
  - Configure Service Delivery Gateway
  - Ensure Bi-directional Communication with SDG
  - Perform Auto-Device Discovery
  - Configure the Identified Devices for Services
- Deploy the basic and advanced templates on managed devices and applications
- Validate the data generated by the monitoring system
- Configure Proactive Management Tasks
  - Patch Management
  - Server re-boot schedule
  - Network configuration back-up schedule
  - Application back-up scripts and scheduling
- Conduct Knowledge Transfer sessions
  - Load Client assets into ServiceNow ITSM System
  - Ensure Client Device Level Entitlement are Mapped to Appropriate Assets
  - Load Client Response Procedures into ServiceNow ITSM System
  - Collection of Standard Operating Procedures
  - Knowledge Transfer Sessions on Client's Environment and Architecture
  - Knowledge Transfer Sessions on Standard and Custom Operating Procedures
  - Knowledge Transfer Sessions on Jobs, Maintenance plans.
  - Identifying and documenting the critical items
- Identify risks and formulate a risk mitigation / readiness plan

B.3. Quality Assurance/Testing Phase

After the completion of the Service Transition Execution Phase, services will be started in a pre-steady state environment. During this phase, Carousel will focus on stabilizing the monitored environment by performing a full quality review and operational assurance testing of the managed solution. Further refinement and enhancements are also elements of this phase. The following are the critical activities performed during the phase:

- Identify devices generating higher than average alerts and provide recommendations to reduce alerts
- Building dependency maps for event correlations and noise reduction
- Build custom automation scripts to reduce noise and improve resolution
- Review the Client environment for potential change recommendation and recommend thresholds adjustments
- Review of existing support contract documentation (i.e. Cisco SmartNet,)
- Review and documentation of existing Carrier circuit ID's
- Validation of the monitoring tools and network connectivity to the Carousel Service Delivery Platform
  - All devices configured into monitoring
  - Development of monitoring dependencies
  - Additional Probes and Agents as required
- Review and update response procedures
- Validate ticket workflow

- Identify gaps and additional requirements

B.4. Tuning Phase

This phase is focused on optimizing the managed environment to eliminate noise, false positives and ensure that the monitoring and reporting functions are working as expected. Additionally, Carousel will finalize all delivery process and procedures which include:

- Finalize escalation notification processes
- Initiate 24x7x365 alert processing, validation and escalation
- Execute Standard Operating Procedures (SOPs)
- Test and Review SLAs
- Review Response Procedures/runbook with the Client to identify any changes.

B.5. Steady State Phase

During steady state support, the Carousel service delivery team incorporates a quality assurance and continuous improvement processes as a proactive component of our managed services offering. Our service delivery team compares month-to-month key performance indicators (KPIs) such as “First to Know” trends, SLA attainment, mean time to resolution measurements, “alert to incident” ratios, “alert to device” ratios, and noisy element analysis to drive continual service improvements. And daily, our team reviews a subset of incidents leading to runbook changes, new runbook development, runbook automation, increased event correlation, and improved alert aggregation. The Quality Assurance Review begins during service transitioning and continues throughout the entire contract lifecycle.

- Provide services as per agreed SLAs
- Monitor alerts 24x7x365
- Perform alert triaging and ticketing
- Escalate incidents
- Prepare new SOPs based on alerts
- Execute proactive management tasks
- Report SLAs
- Plan Service Improvement
- Perform monthly reviews
- Portal credentials and review
- Lessons learned review
- Transition closure meeting and final signoff

The Transition Closure meeting will be a key milestone that triggers steady state invoicing.

Exhibit C – Steady State Entitlements

C.1. Monitoring

C.1.1. Reachability Monitoring

Our Service Delivery Platform measures network connectivity at regular intervals via ICMP polling (PING) to ensure the monitored elements are reachable on the network from an IP address availability perspective.

C.1.2. Incident & Performance Monitoring

Our Service Delivery Platform monitors identified elements utilizing standard SNMP data collection, SNMP trap receiver, syslog monitoring and available APIs to receive specific information, alerts, alarms, faults and performance data.

Incident & Performance Monitoring provides 24x7x365 monitoring of supported devices for those Products listed in Appendix D with our Service Delivery Platform to help raise awareness of specific events that have the potential to cause a significant adverse impact to business operations.

C.2. Reporting & Portals

Carousel provides the client with access to two web-based portals. Our first portal, service management, provides direct access to our Information Technology Service Management (ITSM) system. Our service management portal provides core features such as reporting issues, submitting service requests, general questions, viewing open and closed tickets, and creating/exporting reports. An extranet will also be provided, with access to shared support documentation and static reports.

Our second portal, performance management, provides direct access to our Information Technology Management (ITOM) system. This web-based portal provides access to real time performance dashboards, KPI management tool and on-demand performance reporting. It will allow the measurement and tracking performance against predefined SLAs, streamline service delivery and better support the business with metrics and analytics

C.3. Configuration Management

C.3.1 Network Backup

Our best practice approach for network device configuration backup is a weekly cadence with immediate backup on a device configuration change. Backups will be stored within our cloud-based service delivery platform and we will maintain the last three months of archived configurations.

C.4. Event Management

Carousel provides Event Management functionality from our operations located in the United States and India. Event Management is the process that monitors all alarms, alert, and events related to the operation of the IT environment. Our objective is to detect alarms, alerts, and events, analyses them, and determine the correct control action. Our Event Management function provides a strong foundation for service assurance, reporting, and service improvement. Event management responsibilities include:

C.4.1 Service Desk

Carousel will provide 7x24x365 live access to meet the communication needs of Client IT staff via phone, email or web portal. Our service desk is the focal point for reporting and updating status for existing issues, opening new incidences, and initiating a change or service request.

The Service Desk will:

- Answer incoming calls and capture valid information
    - Service request/problem description

  Site and contact information
    - Determine Severity by assessing urgency and impact
- Review emails to understand the issue and contact information

- Service desk may reach out to sender for clarification or additional information before opening a ticket
- Open ticket and assign to Incident Management, Change Management or Service Request queue
- Review portal requests and validate assignment to appropriate queues.

C.4.2 Event Capture, Validation and Recording

Our Service Delivery Platform monitors for a detectable or discernible occurrence that has significance for the management of the IT Infrastructure. We evaluate the event and record the identified conditions in our Information Technology Management System (ITSM).

C.4.3 Event Correlation & Suppression

Our Service Delivery Platform has a powerful event correlation and suppression engine which uses advanced technology for making sense of a large number of events and pinpoint the few events that require attention. This is accomplished by looking for and analysing relationships between events. Our Service Delivery Platform monitors for detectable or discernible occurrence that has significance for the management of the IT Infrastructure. Carousel will evaluate the event and record the identified conditions in our Information Technology Management System (ITSM).

C.5. Incident Management

Incident Management is designed to help restore normal service operation within a reasonable time to help contain the adverse impact on the Client's business operations, service quality and systems availability. When an incident is opened, it is important that the appropriate priority is assigned to reflect the current service impact. As ITIL defines it, incident priority is primarily formed out of its Impact and its Urgency. There are also additional elements, like size, scope, complexity, and resources required for resolution.

The Impact of the incident is the measure of the criticality of the incident to the business. Traditionally, Impact is tied to the number of users or business processes affected. Urgency is a measure of the necessary speed of resolving an incident.

Based on the assessment of Urgency and Impact, the chart below is leveraged to assign the appropriate Priority level.

		Impact		
		High	Mid	Low
Urgency	High	1	2	3
	Mid	2	3	4
	Low	3	4	4

Incident Classification

Priority	Definition
One (P1)	Occurs when there is critical impact to the business operations and urgent action is required to resolve the incident. For example, network is unavailable, a site is partially down and/or impacting a significant part of the business operations and no work-around is available.
Two (P2)	Occurs when performance of a supported service or environment is severely degraded causing a high to medium level of impact. Functionality may be noticeably impaired, but most business operations continue. P2 incidents have a high to medium level of urgency requiring responsiveness, the activation of SOPs, on-call procedures, and invoking vendor support.
Three (P3)	Occurs when operational performance is impaired while most of the business operations remain functional. Limited devices (PC, printer, terminal, extension) are not operational. There is degradation of services although issue is not mission-critical. P3 incidents are responded to using standard operating procedures and operating within the standard workflow and operational structures.
Four (P4)	Occurs when you require information or assistance on Carousel-provided product capabilities, installation or configuration. There is clearly little or no impact to your business operations. P4 incident are responded to using standard operation procedures as time allows.

C.5.1 Incident Notification

As incidents are prioritized and entered into the Information Technology Service Management (ITSM) platform, the Client is notified via automated email response. The automated email response will contain the incident number, details collected during the event identification process, and affected device, system, service, or location information, and all actions taken. Any time an incident is open, updated, and closed automated email notification is sent to the Client.

In addition, to automated email notifications, Carousel can provide automate SMS notification, if requested by the Client. SMS notification is not a bi-directional SMS texting features rather it's an informational message sent from the ITSM to the Client. Carousel recommends that this function is only enabled for incidents containing the highest level of priority.

Carousel can provide additional telephonic notification for all P1 incidents, if requested by the Client.

C.5.2 Triage & Troubleshooting *(Operate & Optimize Only)*

Once the Carousel incident management team receives a service ticket, an engineer will follow step-by-step instructions to achieve predictable, standardized, and desirable results to quickly restore any unplanned interruption. This function covers the Analysis, diagnosis, resolution, and recovery of the incident.

C.5.3 Complex Resolution *(Operate & Optimize Only)*

Carousel will work with the Client IT staff or other 3rd parties through resolution when the incident may be a result of multiple technologies contributing to the incident.

C.5.4 Bug Resolution (Operate & Optimize Only)

When service affecting software anomalies (bugs) have been identified, our service delivery team will drive the resolution process. Carousel will identify the issue, work with the vendor to find a software resolution, begin an emergency service request process, and deploy the appropriate patch, service pack, or upgrade as part of the change management process.

C.5.5 Carrier Management *(Operate & Optimize Only)*

For the supported environment, Carousel owns identification, troubleshooting, and resolution of Carrier related issues. Carousel acts as an agent of the Client and drives Carrier escalations for MPLS, Ethernet, broadband, dedicated Internet, SIP trunks, PRIs, or analog circuits in the event of link down, service outage, timing & slips, or high interface errors.

Carousel will:

- Create and maintain the appropriate documentation in Carousel's ITSM system
- Drive escalation with the appropriate Carrier or service provider
- Notify and communicate the issue to Client including carrier ticket number, time of outage and expected time of restoration
- Act as an intermediary between Client and the service provider
- Track and drive activities required to resolve the issue
- Update the Carousel Incident as required
- Validate the resolution of the incident
- Update and close the incident when the issue is resolved
- If available, obtain root cause.

Notwithstanding anything herein to contrary, Carousel resolution SLAs do not apply to Carrier Management Services.

Note: Client is required to sign LOA (Letter of Authorization) for each service provider during the service transition process for Carousel to perform Carrier Management. Limited to circuits connected to devices under Carousel Management.

Note: Any signed LOA (Letter of Authorization) is for incidents only, Carousel will not be responsible or accountable for any procurement, payment, ordering or decommissioning of circuits.

C.5.6 Vendor Management (Operate & Optimize Only)

For the supported environment, Carousel owns identification, troubleshooting, and resolution of third-party vendor related issues. Carousel drives the third-party vendor escalation process and provides follow-up of a supported vendor related issue. When required, Carousel creates a ticket directly with the third-party vendor on the Clients behalf. We drive the third-party vendor to identify the issue, troubleshoot the defined issues, and ultimately obtain resolution.

Carousel notifies and communicates all third-party vendor issues with the Client including, ongoing status, available work arounds, and expected time of resolution. Carousel works the incident through closure, and if available, obtains the root cause.

When required, Carousel drives the escalation processes to resolve configuration, software, and hardware anomalies, manage hardware replacement, software bug fixing and patch management, and on-site engineering dispatch. Carousel will:

- Create and maintain the appropriate documentation in Carousel's ITSM system
- Drive escalate with the appropriate third-party vendor
- Notify and communicate the issue to Client including ticket number, time of outage and expected time of restoration
- Act as an intermediary between Client and the third-party vendors
- Track and drive activities required to resolve the issue

- For hardware replacement, Carousel drives the replacement process until replacement is shipped, received, installed, configured IP addressing, restore last known configuration and update serial numbers Carousel's ITSM/CMDB
- Update the Carousel Incident as required
- Validate the resolution of the incident
- Update and close the incident when the issue is resolved
- If available, obtain root cause.

Note: Client is required to sign LOA (Letter of Authorization) for each third-party vendor during the service transition process for Vendor Management.

C.5.7 Incident Escalation *(Operate & Optimize Only)*

Incident escalation is a process used to highlight or flag certain issues within an Incident, so that the appropriate personnel can respond to these situations and monitor the resolutions. Carousel's escalation management process identifies, tracks, monitors and manages situations that require increased awareness and swift action.

Carousel's carefully created escalation processes can ensure that unresolved problems don't linger, and issues are promptly addressed. Using Incident Escalation Management can re-prioritize, reassign, and monitor a situation to a satisfactory completion. There are two types of escalations: hierarchical and functional.

Hierarchical escalation is used to ensure attention for notification, action or resolution is moving the technical levels of operation. For example, 1st level support is unable to resolve the issue, so it is escalated to 2nd level support. In case they are also not able to solve the issue, they are escalating it to 3rd level support and so on until the issue is resolved. During the hierarchical escalation the workflow management is evaluating the incident priority against resolution progress.

Functional escalation is used in case that the support team is unable to resolve the issue or stick within the agreed timeline (targeted time for resolution is exceeded). Functional escalation is the process used to assign an incident from one team to another team based on the skills required to resolve the incident. For example, escalating an incident from the unified communications team to the network team when it becomes apparent that the lack of performance is due to network conditions.

C.6. Problem Management *(Optimize Only)*

C.6.1 Root Cause Analysis *(Optimize Only)*

Our service delivery team conducts root cause analysis to determine the underlying cause of an incident, document the findings and take appropriate corrective action. Root cause analyses are performed to understand the cause of critical outages, prevent future incidents from occurring, eliminate chronic incidents, and minimize future impact to problems and outages.

1. Perform problem determination and problem resolution;
2. Perform tracking and management of outage to closure;
3. Perform root cause analysis for individual P1 and P2 incidents
4. Identify chronic problems;

C.6.2 Chronic Problem Management *(Optimize Only)*

Our service delivery team will drive the identification and resolution of chronic incidents. Chronic issues are defined as the same problem occurring multiple times in a 30-day period. We will attempt to reproduce the problem, identify incident triggers, document the current state, define remediation paths and work around scenarios and provide detailed root cause analysis.

C.7. Patch & Release Management *(Optimize Only)*

The purpose of Patch & Release Management is to facilitate the physical control of software assets and their release into the production environment.

(a) **Major Software Release** - Major Release is a major change to the software that introduces new optional features and functionality. Major Releases are typically designated as a change in the digit(s) to the left of the first decimal point (for example, **[N],** y.z) are out of scope.

(b) **Minor Software Releases** (aka "dot" release) - A Minor Release is a change to the software that introduces a limited number of optional features and functionality. Minor Releases are typically designated as a change in the digit to the right of the first decimal point (for example, n**.[Y].** z) and are out of scope.

(c) **Patch Release** – Patch Release is a change to the software to stabilize the code based upon reported bug related issues or to correct/harden a potential security vulnerability. Patch Releases are typically designated as a change in the digit to the right of the second decimal point (for example, n.y.**[Z]**) and are included as part of release management.

Note: Product correction updates may require system hardware upgrades to comply with current manufacturer's specifications. In these cases, the hardware must be upgraded before the update can be implemented. Hardware upgrades are not included as part of this service.

Note: If Carousel determines the patch is appropriate, it will follow Change Management procedures and policies

Note: Additional installation, implementation and/or customization services necessary to implement software releases are not included in this service and are defined as projects.

Note: Client must retain entitlement to receive software and/or firmware updates from their manufacturers. Carousel does not provide an alternative to upgrade entitlement or leverage Carousel entitlements on Client 's behalf. Carousel does not supply any software or firmware of any kind other than for Carousel owned equipment and systems.

C.7.1 Server Patch Management *(Optimize Only)*

Carousel follows an industry best practice methodology of Scan, Assess, Approve and Install for updating Microsoft and Linux server patches. We provide weekly assessment, notification, and recommendation of patches. We provide monthly patch implementation or more immediate if service effecting or security related.

C.7.2 Network Device Release Management *(Optimize Only)*

Carousel follows a semantic versioning model for network device patches. The model is defined as MAJOR.MINOR.PATCH. We provide quarterly assessment, notification, and recommendation of patches. We provide semi-annual patch implementation or more immediate if service effecting or security related. Carousel will report on MAJOR.MINOR.PATCH, but will only implement on PATCH.

Any MAJOR or MINOR releases will be quoted as a project and be considered out of scope.

C.7.3 Application Release Management *(Optimize Only)*

Carousel follows a semantic versioning model for application for select business enablement applications. The model is defined as MAJOR.MINOR.PATCH. We provide quarterly assessment, notification, and recommendation of patches. We provide quarterly patch implementation or more immediate if service effecting or security related. Carousel will report on MAJOR.MINOR.PATCH, but will only implement on PATCH.

Any MAJOR or MINOR releases will be quoted as a project and be considered out of scope.

C.8. IT Asset Change Management *(Optimize Only)*

Carousel's IT asset change management function ensures that a standardized set of procedures is used to promptly handle all requests for service or change. It ensures that all changes are recorded, assessed, approved, prioritized, and deployed in a manner that meets business requirements and protects the stability and reliability of critical IT systems.

The main objective of change management is to control the lifecycle of while minimizing disruption to IT services. Service or change request can be broadly classified as "Standard", "Complex" and "Emergency":

- **Standard** change tasks are well known, defined, documented, and proven. The change management workflow is pre-established, and no approval is necessary.
- **Emergency** change requests need to be executed immediately to resolve imminent Critical/Sev-1/P1 incidents that threaten business continuity. Emergency request requires approval from the eCAB and will follow the workflow defined in the emergency change request.
- **Complex** change request is pervasive, less defined, and the impact of the request is not known. Complex request could change the configuration of an existing feature, enable existing capabilities, or focus resolving a known issue. Complex requests require Change Advisory Board (CAB) approval, and the specification of a maintenance window.

As part of the overall process, Carousel will provide the following where applicable:

- Manage and implement system level configuration changes

- define the changes required;
- measure the impact of the proposed change;
- develop a back-out plan;
- obtain any relevant approvals for change;
- schedule the implementation of the change;
- implement the change;
- post-implementation testing and verifying expected outcomes; and
- in the event of an unsuccessful change, implement the back-out plan in relation to the change.

C.8.1 Standard Change Request *(Optimize Only)*

Our Service Delivery team will manage and implement "system wide" level configuration changes where the implementation process and the risks are known upfront, documented, proven, and the risk is low and well understood, and the change workflow has been pre-established. These changes are managed according to policies that have been established during Service Transitioning. Standard change request approval can be automatically granted.

C.8.2 Emergency Change Request *(Optimize Only)*

Our Service Delivery team will manage and implement emergency change requests when an unexpected error, threat occurs, or events that effect business continuity emerge. Emergency request are evaluated on the basis that the risk of not implementing the request is greater than implementing the request. Emergency request bypass the normal Change Advisory Board (CAB) process and is reviewed by the eCAB requiring a single board members approval. All emergency change requests undergo a post-implementation review process.

C.8.3 Complex Change Request *(Optimize Only)*

Complex Requests must be reviewed by the Change Advisory Board (CAB) who examines the request, assesses the associated risk and impact, and ultimately approves the request for implementation. For complex changes to be implemented, requires a minimum of 51% CAB member approval. Usually a complex request involves a significant change to the service or infrastructure, and it carries some degree of risk. All complex changes require comprehensive planning, documentation, workflow analysis, and governance. If the request is determined to be high-risk, the CAB must decide whether, when and how the request will be implemented or if the complex change request needs to be treated as project. The following list of criteria are used to determine if the complex change request should be treated as a project:

- **On-site** When the service/change request requires onsite Carousel engineers to complete the request.
- **Testing** When the service/change request requires extensive testing by our engineering team, client's team, or a combination of both.
- **Expansion** When the service/change request adds new devices, locations, or features that fundamentally change the nature of the supported environment.
- **Design** When the service/change request changes the fundamentally design, architecture, or the operations of the supported environment.
- **Platform** When the service/change request impacts multiple supported platform across the supported environment.
- **Coordinate** When the service/change request requires the Carousel team to coordinate multiple resources – vendors, people, locations or multiple phases of change implementation

Based on the above defined criteria and the nature of the complex change, some request could be managed as a project and billed outside the scope of this contract.

C.11. Continuous Service Improvement

Carousel's service delivery team incorporates a quality assurance and continuous improvement processes as a proactive component of our managed services offering. Our service delivery team compares month-to-month key performance indicators (KPIs) such as "First to Know" trends, SLA attainment, mean time to resolution measurements, "alert to incident" ratios, "alert to device" ratios, and noisy element analysis to drive continual service improvements. And daily, our team reviews a subset of

incidents leading to runbook changes, new runbook development, runbook automation, increased event correlation, and improved alert aggregation. The Quality Assurance Review begins during service transitioning and continues throughout the entire contract lifecycle.

C.12. Service Management

Carousel will provide a Service Delivery Manager (SDM) who will establish a framework for communications, reporting, procedural and contractual activities for the Services. The SDM helps the clients confidently pursue their growth, innovation and performance agendas through proactive management of their supported environment.

Carousel's Service Delivery Manager is an assigned resource available during the standard hours of operations (Monday through Friday, 08:00 to 17:00). The assigned SDM standard hours are aligned with the client's center of IT operations.

The SDM's focus is on maintaining service excellence each day by working closely with the client's leadership to translate essential business requirements to the broader support team such as business changes, critical system sensitivity, blackout periods for change, etc.

During all projects and onboarding of new or modified services, the SDM will collaborate closely with the Project Manager though participation in service reviews with your team covering both project status and service management updates.

The following are some of the responsibilities of the assigned Service Delivery Manager:

Service Delivery Leadership

During the service transition, the communication cadence between the client and the Service Delivery Manager is established. At any point during the term of the agreement, the communication cadence can be adjusted to meet the client's changing needs. These service focused touch points will discuss upcoming service requests, change requests, patch and release management status and significant projects. Also, the Service Delivery Manager will review and update any organizational changes, process changes, and modification to client response procedures.

Service Level Performance Monitoring

The Service Delivery Manager reviews open tickets queues providing feedback and direction to the services delivery team ensuring proper workflow management. During their review, the SDM will identify service trends, potential problems, and opportunities to improve the service delivery quality. Also, the SDM monitor overall service performance and reviewing Service Level Agreement attainment and escalation workflow.

Major Incident Management Leadership

During the ordinary course of IT operations, significant incidents will occur, and they can have an extreme impact on the steady-state operation of the business/organization. Any events for which the timescale of disruption – to even a relatively small percentage of users – becomes excessive could be regarded as a major incident.

When necessary, the major incident procedure could include the dynamic establishment of a separate Major Incident Team subject to the direct leadership of the Service Delivery Manager. The SDM's direction ensures that adequate resources and focus are provided for finding a resolution.

If the incident is escalated to the point that requires a formal meeting between and should arrange a formal meeting with all invested parties. The SDM will organize, facilitate, and drive this crucial meeting with the purpose of reviewing progress and determining the best course of action.

Throughout the major incident, the Service Delivery Manager ensures all activities are recorded, and the client is informed of progress. Communication is an important activity in handling major incidents.

Executive Business Reviews

An Executive Business Review (EBR) is a face-to-face meeting that is strategic—rather than tactical—in nature. EBR is scheduled and conducted by the assigned Service Delivery Manager, and this briefing is not the time or place to discuss the details of specific service issues, support questions or the status of particular projects.

The SDM will lead a conversation to gain a deeper understanding of the client's business and plans, and to strategize as to how Carousel can deliver more value based on those factors. At the same, the Service Delivery Manager will provide insight on Carousel's business goals and objectives, overall performance, and new solution sets. Also, the SDM will provide comprehensive insight on overall service delivery performance, areas for improvements, capacity planning recommendation and life-cycle management advice.

Carousel will conduct Quarterly executive business reviews per year with the expectation is that the EBR would include critical members of the client IT team including but not limited to executive leadership. Carousel goal is to ensure that all EBR have a face-to-face experience whether through the use of technology or an in-person meeting.

Exhibit D – Service Level Agreement

Carousel requires full access/shared control with the Client of the supported items that are at Operate and/or Optimize level of service. Client needs to inform Carousel of any device additions, deletions, or changes to supported items.

The following table describes the various priority levels and Service Level Objectives (SLO). The start of the process can originate from monitoring system alerts or from user requests entered via the ticketing system, phone or e-mails.

Commitment	Definition	Priority	Objective	Quarterly Measurement
Speed to Answer				
Speed to Answer is measured across all client calls.	**Service Desk live answer**		**<=20 Seconds**	90% Aggregate
Incident Response				
Incident Response is measured from receipt of notification via email, call, or alarm.	**Notification to Incident**	**P1**	**<=15 Minutes**	90% Aggregate
	- All Emails considered as P2 by default	**P2**	**<=30 Minutes**	
		P3	**<=30 Minutes**	
		P4	**<=30 Minutes**	
Incident Assignment *(Operate & Optimize Only)*				
Incident Assignment period is measured from the time the incident has been opened.	**Incident to Engineer Assignment**	**P1**	**<=30 Minutes**	90% Aggregate
		P2	**<=1-hour**	
		P3	**<=4-hour**	
		P4	**<=8-hour**	
Incident Resolution *(Operate & Optimize Only)*				
Incident Resolution period is measured from the time the incident has been opened.	**Incident Creation to Incident Resolution**	**P1**	**<=4-hour**	80% Aggregate
		P2	**<=8-hour**	
		P3	**<=4 Business Days**	
		P4	**<=10 Business Days**	
Problem Management *(Optimize Only)*				
Problem Management is measured from time of client request for RCA.	**Root Cause Analysis (RCA) Inputs**	**Draft**	**3 Business Days**	80% Aggregate
		Delivery	**10 Business Days**	
Change Management Response *(Optimize Only)*				
Change Management Request Response is measured from receipt of the request to the creation of the Service Request (SR).	Emergency Change Critical	**P1**	**<=15 Minutes**	90% Aggregate
	Emergency Change Default	**P2**	**<=30 Minutes**	
	Complex Change Default	**P3**	**<=30 Minutes**	
	Standard Change Default	**P4**	**<=30 Minutes**	
Change Management Implementation *(Optimize Only)*				
Change Management Implementation is measured from the time of the change approval or from the start of the authorized change window.	Emergency Change Critical	**P1**	**<=2-hour**	80% Aggregate
	Emergency Change Default	**P2**	**<=Same Bus Day**	
	Complex Change Default	**P3**	**<=Next Bus Days**	
	Standard Change Default	**P4**	**<=3 Business Days**	

Resolution SLO timer is paused when ticket status is changed to “Handed-over to Client and/or Partner,” “On-Hold,” “Under observation,” “Work around” or “Resolved”

Below is a list of conditions that will trigger a pause in the resolution SLO timer:

Resolution SLO timer pause conditions
• Waiting for remote access/connectivity to client environment • Waiting for the arrival of replacement hardware • Waiting for the arrival of dispatched on-site engineering/resources • Waiting for 3rd Party (Carrier, Courier) • Waiting on client to perform validation, testing, • Scheduled or planned downtime

Resolution SLO timer are stopped when the INCDIENT is experiencing the following conditions:

Exclusions
• Force Majeure conditions • Lack of power to facilities and inadequate power backup • Lack of Wide Area connectivity without appropriate redundancy • Lack of appropriate manufacturer support coverage on critical elements

Exhibit E - Supported Items

Location	Service Bundle	Manufacturer	Description	Quantity
Account Level, , ,				
	Not Applicable	**Carousel**	Business Review - Quarterly	1
	Not Applicable	**Carousel**	Service Delivery Manager - SDM	1
HQ, 450 E Romie Ln, Salinas, CA 93901				
	Operate	**Verint**	Verint Verba (Ping + VM Only)	1
	Optimize	**Cisco**	Cisco Business Edition 7000	2
	Optimize	**Cisco**	VG Series Gateway	5
	Optimize	**Cisco**	SRST Server/Branch Router	2
	Optimize	**Cisco**	Unified Communications Manager	3
	Optimize	**Cisco**	Unity Voicemail	2
	Optimize	**Cisco**	Emergency Responder	2
	Optimize	**Cisco**	Paging Server	1
	Optimize	**Cisco**	Contact Center Express	2

Exhibit F - Terms and Conditions

1. **ORDER, PROVISION AND SCOPE OF SERVICES**

In return for the payment of the fees specified in the Statement of Services (SOS), Carousel will provide the Services and Service Level Agreement **(Exhibit D)** for locations and/or products specified in Carousel's Supported Items List **(Exhibit E).** Orders are subject to acceptance by Carousel. Carousel may accept an order by beginning to perform the Services. Terms and conditions contained in Client purchase orders or other Client documents will have no effect, unless explicitly approved and noted on the SOS.

Remote Monitoring and Access. Carousel may remotely monitor or access Products and Systems serviced under this agreement for the following purposes: (i) for remote diagnostics and corrective actions; (ii) to determine system configuration and applicable charges; (iii) to verify compliance with applicable software license terms and restrictions; (iv) when providing managed Services, to assess Client's needs for additional products or Services.

Error Correction. Some Services options may include correction of Errors. An "**Error**" means a failure of a Supported Product to conform in all material respects to the manufacturer's specifications that were currently applicable when the Supported Product was purchased or licensed.

Replacement Hardware. Replacement hardware provided as part of Services may be new, factory reconditioned, refurbished, re-manufactured or functionally equivalent. It will be furnished only on an exchange basis. Returned hardware that has been replaced by Carousel, will become Carousel's property. Title to Carousel-installed replacement hardware provided as part of Services will pass to Customer when installed. Title to all other hardware provided as part of Services will pass to Client when it arrives at the Supported Site.

Added/ Removed Products. A. Added/ Removed Products. A. If Client acquires additional products of the same type and manufacturer(s) as the existing Supported Products and locates them with existing Supported Products at a Supported Site or networks them at a remote location as part of an existing Supported Products at a Supported Site, they will be considered "**Added Products**", and will be added to the order automatically for the remainder of the term. Added Products purchased from a party other than Carousel may be subject to certification by Carousel at Carousel's then current rates for such certification. If Added Products fail certification, Carousel may choose not to add them to the Supported Items. Services coverage will be effective immediately after Carousel certifies the added products. Charges for added products will be at the then current rate and coverage will be coterminous with the coverage for the existing Supported Items. B. **REMOVED PRODUCTS.** In the event that the Client removes components or equipment from a Carousel-supported system, any change in components, administered TDM and/or IP port counts may be accounted for on next billing date. If Client removes equipment covered under a Carousel SOS, Carousel agrees that upon receiving 30 day written notification of the removal, complete with inventory detail, the monthly pricing of the SOS will be adjusted accordingly for the Client's next billing cycle, and at the rates originally agreed in the pricing section.

General Limitations. Unless the (**Exhibit C)** provides otherwise, Carousel will provide software Services only for the unaltered current release of the software and the prior release. For software versions that are older than 1 release prior to the then current release, software Services will be limited only by the manufacturer end of support policies. The following items are included in the Services only if (**Exhibit C)** specifically includes them: (i) support of user-defined applications; (ii) support of Supported Items that have been modified by a party other than Carousel (except for installation of standard, self-installed updates provided by the manufacturer); (iii) making corrections to user-defined reports; (iv) data recovery services; (v) services associated with relocation of Supported Items; (vi) correction of Errors arising from causes external to the Supported Items (such as power failures or surges); and (vii) Services for Supported Items that have been misused, used in breach of their license restrictions, improperly installed or configured, or that have had their serial numbers altered, defaced or deleted.

2. **INVOICING AND PAYMENT.**

Invoicing. Carousel will invoice Client for Services in advance unless another payment option is specified in the order, or as otherwise specified in **the pricing section of this document**.

Payment. Payment of undisputed invoices is due within forty- five(45) days from the date of Carousel's invoice. Client will pay all bank charges, taxes, duties, levies and other costs and commissions associated with nonstandard methods of invoicing and payment. Overdue payments will be subject to a late payment charge of the lesser of 1.0% per month or the maximum rate allowed by applicable law. Unless Client provides Carousel with a tax exemption certificate, Client is solely responsible for paying all required taxes, (including, but not limited to, property, sales, use or excise taxes with respect to the provision of Carousel Equipment) except for any income tax assessed upon Carousel.

3. **CUSTOMER RESPONSIBILITIES**

General. Client will cooperate with Carousel as reasonably necessary for Carousel's performance of its obligations, such as: (i) providing Carousel with full, free and safe access to its facilities; (ii) providing telephone numbers, network addresses and passwords necessary for remote access; and (iii) providing interface information for Supported Items and necessary third-party consents and licenses to access them. Client shall provide to Carousel a technical resource or onsite contact person who shall assist Carousel Technicians, Engineers and Support Staff in remotely troubleshooting issues, including, but not limited to providing data logs, or assisting in reboots/ resets of certain components. All items will be provided by Client at Client's expense. If Carousel provides an update or other new release of software as part of the Services, Client will implement it promptly. Client will reasonably use, safeguard and return to Carousel any items that Carousel loans to Client ("Carousel Tools") for the purpose of providing Services under this SOS, such as, but not limited to, the Service Delivery Gateway ("SDG"). Carousel Tools shall not be considered Products.

Provision of Supported Products and Systems. Except for Carousel hosted facilities, Client will provide all Supported Items, Supported Systems and Supported Sites. Client continuously represents and warrants that: (i) Client is either the owner of, or is authorized to access and use, each of them; and (ii) Carousel, its suppliers, and subcontractors are authorized to do the same to the extent necessary to provide the Services in a timely manner.

Moves of Supported Products. Client will notify Carousel in advance before moving Supported Items. Carousel may charge additional amounts to recover additional costs in providing the Services as a result of moved Supported Items.

Vendor Management. Where Carousel is to instruct or request products or services on Client's behalf from third party vendors under Client's supply contracts with third-party vendors ("**Vendor Management**"), Client will provide Carousel upon request a letter of agency or similar document, in form reasonably satisfactory to Carousel and Client, permitting Carousel to perform the Vendor Management. Where the third-party vendor's consent is required for Carousel to be able to perform Vendor Management in a timely manner, Client will obtain the written consent of the vendor and provide Carousel a copy of it upon request.

Third Party Hosting. In the event one or more network address(es) to be monitored by Carousel are associated with systems owned, managed, and/or hosted by a third party service provider ("**Host**"), Customer will: (i) notify Carousel of the Host prior to commencement of the Services; (ii) obtain the Host's advance written consent for Carousel to perform the Services on the Host's computer systems and provide Carousel with a copy of the consent upon request; and (iii) facilitate necessary communications between Carousel and the Host in connection with the Services.

Access to Personal Data. From time to time, Client may require Carousel to access a Supported Item or Supported System containing employee, customer or other individual's personal data (collectively, "**Personal Data**"). Where Client instructs Carousel to access any Personal Data, or to provide Client or a third party identified by Client with access, Client will (i) notify all relevant employees and other individuals of the fact that Carousel will have access to such personal data in accordance with Client instructions and (ii) indemnify Carousel and its officers, directors, employees, subcontractors and affiliates against, and hold each of them harmless from, any and all liabilities, costs, damages, judgments and expenses (including reasonable attorney's fees and costs) arising out of Carousel accessing or providing access in accordance with Client's instructions.

OEM Requirements: In order to receive manufacturer support or gain access to intellectual property such as software patches and updates, manufacturers may require an end user to maintain manufacturer-direct content in the form of licensing or software subscriptions, or another type of manufacturer-direct entitlement. It is the responsibility of the customer to ensure that all subscriptions, licensing fees, software support agreements, and other manufacturer entitlements are active and up to date at commencement of, and at all times during the term of the SOS. In some cases, the OEM requires that the support provider (Carousel) contract directly with the manufacturer on behalf of the end user, with an associated cost for services. In the event of early termination of the SOS, the Customer, at a minimum, shall be subject to an early termination fee of the prorated, net amounts due to the manufacturer for all established backend OEM support as defined on this SOS, in addition to any penalty as defined in section 10. (Termination) herein.

End of Support/Extended Support: Periodically, manufacturers may declare "end of life," "end of service," "end of support," "manufacture discontinue" or similar designation ("End of Support") for certain Supported Items. For Products subject to End of Support, Carousel will continue to provide the support described, except for the End of Support exceptions listed therein ("Extended Support"). Products declared end of support/extended support, will be supported under the terms of Extended Support until contract end date, at which time the Supported Product may be removed from coverage and rates will be adjusted accordingly. Extended Support is best effort, support will be provided with the following exceptions: At the end of manufacturer support, Tier IV R&D product developer support and going forward maintenance updates (e.g., Product Correction Notices ("PCN's"), "bug fixes," interoperability / usability solutions) are no longer provided by the manufacturer. Therefore, certain complex faults or functionality issues may not be resolvable without the Client upgrading the system to a version currently supported by the manufacturer. In addition, as replacement parts are manufacturer discontinued, some products or components may become increasingly scarce or require replacement with substitute parts. This may result in delays in response or repair intervals, or may require upgrades to other components at Client's expense in order to ensure compatibility and preserve Supported Item functionality.

4. SOFTWARE LICENSE

WHERE SERVICES INCLUDE PROVISION OF PATCHES, UPDATES OR FEATURE UPGRADES FOR SUPPORTED PRODUCTS ("**NEW SOFTWARE**"), THEY WILL BE PROVIDED SUBJECT TO THE LICENSE GRANT AND RESTRICTIONS CONTAINED IN THE ORIGINAL AGREEMENT UNDER WHICH CLIENT LICENSED THE ORIGINAL SOFTWARE FROM THE OEM. WHERE THERE IS NO EXISTING LICENSE FROM THE OEM, NEW SOFTWARE WILL BE PROVIDED SUBJECT TO THE MANUFACTURERS THEN CURRENT LICENSE TERMS AND RESTRICTIONS FOR THE NEW SOFTWARE. NEW SOFTWARE MAY INCLUDE COMPONENTS PROVIDED BY THIRD PARTY SUPPLIERS THAT ARE SUBJECT TO THEIR OWN END USER LICENSE AGREEMENTS. CUSTOMER MAY INSTALL AND USE THESE COMPONENTS IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE END USER LICENSE AGREEMENT ACCOMPANYING THEM.

5. CONFIDENTIAL INFORMATION

"Confidential Information" means business and/or technical information, pricing, discounts and any other information or data that by its nature would be reasonably deemed confidential, regardless of whether in tangible or other form, including but not limited to information communicated verbally. Confidential Information excludes information that: (i) is publicly available other than by an act or omission of the receiving party; (ii) subsequent to its disclosure was lawfully received from a third party having the right to disseminate the information without restriction on its dissemination and disclosure; (iii) was known by the receiving party prior to its receipt and was not received from a third party in breach of that third party's confidentiality obligations; or (iv) is required to be disclosed by court order or other lawful government action, but only to the extent so ordered, provided the receiving party provides prompt written notification to the disclosing party of the pending disclosure so the disclosing party may attempt to obtain a protective order. In the event of a potential disclosure in the case of subsection (iv) above, the receiving party will provide reasonable assistance to the disclosing party should the disclosing party attempt to obtain a protective order. Each party will protect the secrecy of all Confidential Information received from the other party with the same degree of care as it uses to protect its own Confidential Information, but in no event with less than a reasonable degree of care. Neither party will use or disclose the other party's Confidential Information except as permitted in this Section or for the purpose of performing obligations under this SOS. The confidentiality obligations of each party will survive expiration or termination of the SOS. Upon termination of the SOS, each party will cease all use of the other party's Confidential Information and will promptly return, or at the other party's request destroy, all Confidential Information, including copies, in tangible form in that party's possession or under its control, including Confidential Information stored on any medium. Upon request, a party will certify in writing its compliance with this Section.

6. **WARRANTIES**

Carousel warrants to Client that Services will be carried out in a professional and workmanlike manner by qualified personnel. If the Services have not been so performed and Carousel receives Client's detailed request to cure a non-conformance within 30 days of its occurrence, Carousel will re-perform those Services. This remedy will be Customer's sole and exclusive remedy and will be in lieu of any other rights or remedies Customer may have against Carousel with respect to the non-conformance of Services.

EXCEPT AS REFERENCED AND LIMITED IN THIS SECTION, NEITHER CAROUSEL NOR ITS LICENSORS OR SUPPLIERS MAKES ANY OTHER EXPRESS OR IMPLIED REPRESENTATIONS OR WARRANTIES WITH RESPECT TO THE SERVICES. IN PARTICULAR, THERE IS NO WARRANTY THAT ALL SECURITY THREATS AND VULNERABILITIES IN A SUPPORTED PRODUCT, SUPPORTED SYSTEM OR NETWORK WILL BE DETECTED OR THAT SERVICES WILL RENDER THEM SAFE FROM SECURITY BREACHES. TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, CAROUSEL DISCLAIMS ALL IMPLIED OR STATUTORY WARRANTIES, INCLUDING, BUT NOT LIMITED TO, ANY WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, AND NON-INFRINGEMENT.

7. **LIMITATION OF LIABILITY**

IN NO EVENT WILL EITHER PARTY OR ITS RESPECTIVE LICENSORS OR SUPPLIERS HAVE ANY LIABILITY FOR ANY INCIDENTAL, SPECIAL, STATUTORY, INDIRECT OR CONSEQUENTIAL DAMAGES, LOSS OF PROFITS OR REVENUE, LOSS OR CORRUPTION OF DATA, TOLL FRAUD, COST OF COVER, OR SUBSTITUTE GOODS OR PERFORMANCE. EXCEPT FOR CAROUSEL'S MISAPPROPRIATION OF CLIENT'S PROPRIETARY OR CONFIDENTIAL INFORMATION, THE LIABILITY OF EITHER PARTY FOR ANY CLAIM ARISING OUT OF OR IN CONNECTION WITH THIS SOS WILL NOT EXCEED AN AMOUNT EQUAL TO THE AGGREGATE TOTAL AMOUNT OF ALL FEES PAID OR PAYABLE UNDER IN THE TWELVE (12) MONTH PERIOD IMMEDIATELY PRECEDING THE DATE OF THE EVENT GIVING RISE TO THE CLAIM. THE LIMITATIONS OF LIABILITY IN THIS SECTION WILL APPLY TO ANY DAMAGES, HOWEVER CAUSED, AND ON ANY THEORY OF LIABILITY, WHETHER FOR BREACH OF CONTRACT, TORT (INCLUDING, BUT NOT LIMITED TO, NEGLIGENCE), OR OTHERWISE, AND REGARDLESS OF WHETHER THE LIMITED REMEDIES AVAILABLE TO THE PARTIES FAIL OF THEIR ESSENTIAL PURPOSE. HOWEVER, THEY WILL NOT APPLY IN CASES OF WILFULL MISCONDUCT, PERSONAL INJURY OR BREACHES OF OEM'S LICENSE RESTRICTIONS. THE LIMITATIONS OF LIABILITY IN THIS SECTION ALSO WILL APPLY TO ANY LIABILITY OF DIRECTORS, OFFICERS, EMPLOYEES, AGENTS AND SUPPLIERS.

8. **GOVERNING LAW AND DISPUTE RESOLUTION**

Choice of Law. Any controversy or claim, whether based on contract, tort, strict liability, fraud, misrepresentation, or any other legal theory, related directly or indirectly to the SOS ("Dispute") shall be resolved solely in accordance with the terms of this Section 8. The SOS shall be governed by the laws of the State of California and interpreted and determined in accordance with the laws of the State of California. The parties hereto irrevocably: (a) agree that any suit, action, or other legal proceeding arising out of the SOS shall be brought exclusively in the courts of record of either the Commonwealth of Massachusetts or the courts of the United States located in the State of California; (b) consent to the jurisdiction of each such court in any such suit, action or proceeding; and (c) waive any objection which it may have to the laying of venue of such suit, action or proceeding in any of such courts.

Injunctive Relief. Either party may, at its option and at any time during the dispute resolution process, seek injunctive relief in any court of competent jurisdiction (including but not limited to preliminary injunctive relief). The parties acknowledge that each of them has a vital interest in enjoining any violation of confidentiality obligations, including unauthorized use of the Software, because damages would not adequately compensate a party for any infringements of that party's intellectual property rights.

No Withholding. Disputes will not be a basis for withholding payment of any undisputed amounts due under the SOS or offsetting other amounts due whether or not the disputed Item is on the same order or invoice, nor will any amount be retained in anticipation of a Dispute for which notice has not been received.

9. **TERM AND TERMINATION**

Term. The SOS will be effective from the date Carousel accepts the order unless terminated earlier in accordance with this Section. Unless a different term is defined, Carousel will provide Services for an initial term of one year. Services will be renewed automatically for successive one-year terms (unless specifically mandated) applying the then most similar current generally available support plan offering and then current rates, unless either party gives the other written notice of its intent not to renew at least 60 days prior to the expiration of the applicable initial or renewal term. Unless otherwise specified, Client may terminate Services in whole or in part upon sixty (60) days prior written notice. Client will be subject to termination fees comprised of the net amounts due to OEM for all established backend OEM support, as defined on the SOS. For prepaid SOS's, Carousel will refund or credit the prorated price of the remaining term less the applicable termination charge. Either party may terminate the SA by written notice to the other party effective immediately upon receipt if the other party fails to cure any material breach of the SA within a thirty (30) day period after having received a written notice from the non-breaching party detailing the breach and requesting the breach is cured.

Termination Notice. Client's written notice of cancellation or intent not to renew must be sent by: (i) letter via certified mail to the following address: Carousel Industries of North America, Inc., 659 South County Trail, Exeter, Rhode Island 02822 Attn: Termination; (ii) email to cancelmailto:contract@carouselindustries.com; or (iii) fax to 401-667-5492.

10. **MISCELLANEOUS**

With Client's prior written consent, Carousel may assign the SOS or any associated order to any of its affiliated entities or to any entity to which Carousel may sell, transfer, convey, assign or lease all or substantially all of the assets used in connection with its performance under this SOS. Carousel may subcontract any or all of its obligations, but will retain responsibility for them. Neither party will be liable for any delay or failure in performance to the extent the delay or failure is caused by events beyond the party's reasonable control, including without limitation, fire, flood, act of God, explosion, war or the engagement of hostilities, strike, embargo, labor dispute, government requirement, civil disturbances, civil or military authority, and inability to secure materials or transportation facilities. The failure of either party to assert any of its rights under the SOS is not a waiver by that party of its right later to enforce the SOS in accordance with its terms. These Terms constitute the entire understanding of the parties with respect to its subject matter and will supersede all previous and contemporaneous communications,

representations or understandings, either oral or written, between the parties relating to that subject matter. It will not be contradicted or supplemented by any prior course of dealing between the parties. All notices under the SOS and any modifications or amendments must be in writing which in no event shall include any form of electronic communication (such as e-mail).

Board Paper: Finance Committee

Request: Augment Help Desk Services Through Purchased Services from CloudWave and GuideIT

Executive Sponsor: Augustine Lopez, CFO
Audrey Parks, CIO

Date: March 12, 2021

Executive Summary

The intent of Salinas Valley Memorial Healthcare System (SVMHS) Information Technology (IT) is to augment our current help desk services to better support our current and anticipated needs for tier 1 technical support services. Expected outcomes from the services provider are as follows with respect to our tier 1 service requests:

- improve end-user satisfaction; currently at 75%, targeting 85% or better.
- estimated average response time is within 2 hours*
- improve resolution times, currently averaging 15 minutes*
- reduce support costs; higher resolution times result in increasing labor costs

* These estimations are based on tier 1 service requests such as password resets, software installations or access, remote access support

Each respondent to the request for proposal (RFP) was expected to provide specifics regarding pricing and capabilities that meet our stated requirements. Based on our evaluation of responses, we selected CloudWave OpSus Cloud Care Technical Service Desk powered by GuideIT.

All support services will be conducted remotely and from within the United States.

Background/Situation/Rationale

With growing demands on Information Technology Help Desk services ranging from department and staff relocations, software implementations, many iPad deployments, and routine maintenance on our desktops (workstations-on-wheels, high priority computers in the Emergency Department and Education), we are struggling to meet service level commitments in a timely fashion that is satisfactory to our staff and other clients.

Here's our Help Desk by the Numbers

- 5 full-time equivalent staff, we currently have one vacancy
- Operating 24 hours/day, 7 days/week, 365 days/year
- Opened 15,200 service requests in the past 12 months
- Backlog Averaging 400 service requests

The proposal is expected to be budget neutral. We will not back-fill the vacancy (estimated at $139,300/year) and we will reduce the amount of on-call and overtime pay (valued at

$121,000/year). Additionally, with augmented services for help desk support, we should be able to restore work-life-balance for the current Help Desk staff.

Common service request types include the following:

- Password resets and account unlocks
- Application user administration
- End-user device support – hardware, OS performance
- End-user mobile support – hardware, mobile OS, mobile applications
- Printer support – mapping, scan-to-email, issue troubleshooting
  - Peripheral support – scanning, credit card machines, fax machines
  - Network support – troubleshooting and triage of WAN/LAN issues
  - Hosting/virtualization support – user session troubleshooting (Citrix, RDS, etc.)
- VPN support – software installation, access management, remote connectivity
- Telecom support – hardware, user/extension management
- File management – personal/shared network drives, SharePoint document libraries
- Productivity software support – Installation and troubleshooting of Office, Webex, Adobe, etc.

We evaluated three vendors, CloudWave provided by GuideIT, The IT Support Center, and Navin-Haffty & Associates provided by Engage. CloudWave/GuideIT was the mid-priced solution whose pricing was nominally higher than The IT Support Center. We ultimately made our selection based on experience in supporting the healthcare provider industry, comprehensiveness of proposal and pricing.
RFP scorecard and legal review are on file.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

It is the mission of Salinas Valley Memorial Healthcare System (SVMHS) to provide quality healthcare to our patients and to improve the health and well-being of our community. Toward this end, we are seeking to improve the services we offer at our Information Technology Help Desk so staff experience the least disruption due to system errors or user requests for technical resolutions.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications: Finance

Key Contract Terms	Vendor: CloudWave
1. Proposed effective date	April 1, 2021
2. Term of agreement	April 1, 2021 – March 31, 2025 (48 months)
3. Renewal terms	Auto renews for one-year terms after initial term.
4. Termination provision(s)	May terminate as needed if contractor is not meeting service level agreements.
5. Payment Terms	Net 45

<table>
<tr><td>6. Annual cost(s)</td><td>$ 1,003,561 over four (4) year term
<table><tr><td>One-time</td><td>$80,386</td></tr><tr><td>Year 1</td><td>$184,635</td></tr><tr><td>Year 2</td><td>$246,180</td></tr><tr><td>Year 3</td><td>$246,180</td></tr><tr><td>Year 4</td><td>$246,180</td></tr><tr><td>TOTAL</td><td>$1,003,561</td></tr></table>
Fees are based on projected service volumes.</td></tr>
<tr><td>7. Cost over life of agreement</td><td>$1,003,561 (4 year initial term)</td></tr>
<tr><td>8. Budgeted (indicate y/n)</td><td>Yes. Budget neutral.</td></tr>
<tr><td>9. Contract</td><td>1001.4098</td></tr>
</table>

Recommendation

Request the Finance Committee to recommend to the Board of Directors the approval of the Help Desk services agreement from CloudWave as competitive solicitation and contract award in the amount of $1,003,561 over the four-year term.

Attachments:

1. RFP documentation
2. Proposal dated February 11, 2021

Audrey Parks
Chief Information Officer
aparks@svmh.com
450 East Romie Lane, Salinas, CA 93901
(831) 759-1935

Dear Audrey,

We are grateful for the opportunity to provide a proposal for a technical service desk solution for Salinas Valley Memorial Healthcare System. CloudWave and GuideIT are partnering to support your mission of providing quality healthcare to patients and improve the health and well-being of the community. Our leadership teams have decades of experience uniting technology with the practice of caring for people to create a better patient experience, better medical outcomes and the advancement of business objectives. In today's dynamic environment, our healthcare expertise and technology solutions are central to enhancing the return on investment from EMR's, achieving the targeted outcomes from acquisitions, and strengthening the operational technology foundation in support of healthcare providers through infrastructure, applications, service desk and security solutions.

CloudWave and GuideIT partner to provide cost-effective, end user solutions to the Healthcare market. CloudWave's OpSus Cloud Care IT Service Desk offering bridges the gap between end users and infrastructure issues with integration between organizations, ITSM platforms, and rigorous process and procedures for level 2/3 escalations under Cloud Care support. This integration is intended to improve time to resolution for complex IT issues while also improving first call resolution rate.

CloudWave and GuideIT both have a mission of improving IT operations for our customers with a customer first approach. Our leadership teams have an established relationship based on trust and proven track records that makes for a strong partnership.

Our companies are united in the belief that there is a better way to serve customers. This belief drives a commitment not only to provide great service, but also shapes how we serve you, conduct business and interact with every member of your team. Illustrative of this is the independent research published by KLAS.

In the 2018 AMS and Help Desk report, GuideIT:

- Was the top-rated Broad Firm with a 93.2 overall performance score received through customer feedback.
- Received above market average ratings for overall satisfaction, value for money, service delivery met timelines, quality of service staff, strategic expertise, executive involvement, innovative tools and/or processes, and avoids nickel-and-diming
- Achieved a 100% rating for, "Would you buy again?".

- Had customers highlight our accountability for meeting timelines and SLA's, its focus on building collaborative relationships with internal IT teams, and the level of executive experience for a smaller company.

To aid in your evaluation process, we will provide customer references and contact information. We are confident in

Based on the requirements, we propose a scalable service desk solution that enhances the quality of your existing operation, drives an exceptional end user experience, and provides a cost-effective, unit-based cost structure that represents value for money. We emphasize continual improvement by leveraging analytics and automation to reduce contact volumes over time driving enhanced efficiency.

Scope of Services

Our solution will meet the following specifications:

- **Operational Scope** – We will provide a us-based 24x7x365 IT Level 1 service desk, which will serve as a single point of contact for IT incidents and management of service requests. We will provide four methods for service desk contact, including telephone, email, chat and self service portal.
- **Service Management** - Our ITSM platform provides a effective cost model for service management. The solution is built around ITIL standards and implemented through policies, processes, and documentation that govern and streamline the solution's design, delivery and management. The solution provides continual operational improvements and API integration between client and partner ITSM platforms.
- **Process Optimization** – We emphasize both tactical service desk execution and strategic process optimization to drive incremental efficiency. Starting with an effective, scalable cost model, we work to reduce the number of service desk contacts through four processes: (1) leveraging knowledge base of articles for rapid self-resolution of IT issues; (2) Optimizing ticket management procedures to ensure contacts are resolved within the appropriate cost tier, and (3) analytics and trend analysis to reveal preventable causes of contacts and opportunities for contact reductions through automation and tools.
- **Service Level Agreements** – We embrace the establishment of service level agreements to govern operational standards. We will work collaboratively with you to implement the required agreements, including calculation and exclusions. We are confident that our service quality will achieve the established benchmarks of the agreements and provide financially-focused remedies to ensure consistent service quality.

Pricing

With a focus on driving first call resolution, our pricing is based on an 8-minute average handle time for service desk contacts. There will be a Base Monthly Volume of Contacts of 21,00 through phone, email,

portal, or chat channels. Pricing determined by number of contacts through each channel. Invoicing is based on the Base Monthly Volume and applicable overages. The first 105 additional contacts, or 5%, above the Base Monthly Volume will result in no incremental expense. Monthly contacts above 105% of Base Monthly Volume, will be invoiced at a per contact rate. In addition, a fixed service management fee will be included to provide continual operational improvements as well as API ITSM platform integration and development (currently provided with Freshservice). Because process improvements can have inverse effects on contact quantity and the average contact time, we will collaboratively work with you during the transition and every six months to implement initiatives that reduce contact value to adjust the Base Monthly Volume and associated cost per contact. Pricing is based on assumptions and is subject to change based on changes to Scope of Services, Base Monthly Volume, and other factors.

Transition

We launch transitions with a project initiation workshop that establishes the project plan necessary for an orderly transition of services. We will regularly report statuses of transition items.

Transition activities include:

- Configuration of the ITSM platform and API integrations
- Documentation processes procedures, and knowledge articles
- Deploying and training a team for service desk cutover
- Coordinating modifications to your telephone system
- Integrating Active Directory with the ITSM system

Qualifications & Experience

The combination of our solution and industry expertise is critical to the results we produce for customers. Our solution experts perform to best-in-class standards, while our healthcare specialists understand how to make these solutions work for healthcare businesses. This breadth of expertise is not only important to the service desk solution, but also represents a resource pool that we can deploy if needed. In terms of solution-specific qualifications, we:

- Provide service desk services to hospitals, ambulatory, post-acute and senior care, assisted living, and home health organizations
- Support approximately 70 applications and regularly assume support for new applications and technologies
- Implement, maintain and enhance Electronic Health Records, Clinical Workflow, Templates, and interface

- Architect, design, implement and support clinical infrastructure
- Our service desk offering receives an SSAE18 SOC2 audit each year

We believe that great long-term relationships are based on well-defined operational relationships, collaborative approaches focused on ongoing improvement, and cultural match. We are an organization founded on a set of values and beliefs that define what anyone working with our company should expect. In addition, we believe how we approach relationships is an important as the technical aspects of a solution. Our customer approach is based on an overall experience that delivers in all respects because of the way we partner with customers, simplify the complex and inspire confidence.

We look forward to working with you.

Sincerely,

Jeff Smith

Vice President, Healthcare

GuideIT, A Perot Company

Mike Donahue

Director, Sales Engineering

CloudWave

REQUEST FOR PROPOSAL

Help Desk Services Provider
for
Salinas Valley Memorial Healthcare System

Prepared by:
Salinas Valley Memorial Healthcare System
450 East Romie Lane
Salinas, California, 93901

Contact:
Audrey Parks
450 East Romie Lane
Salinas, California 93901
aparks@svmh.com
(831) 759-1947

Dear Prospective Help Desk Services Provider:

Your firm has been selected as a potential provider of help desk services for Salinas Valley Memorial Healthcare System (SVMHS). The SVMHS Information Technology group is exercising the method of engagement and is seeking responses to our request for proposal (RFP) for the provision of services as detailed below.

Please deliver your proposal directly to the contact identified on the cover sheet. Provide a soft copy proposal no later than the deadline stated below.

Introduction

About Salinas Valley Memorial Healthcare System (SVMHS).

Salinas Valley Memorial Healthcare System is a Local Health Care District organized and operated pursuant to Division 23, Sections 32000 et seq, of the California Health and Safety Code ("Local Health Care District Law," formerly known as Local Hospital District Law). By an election held pursuant to Local Health Care District Law, the voters in Monterey County approved the formation of Salinas Valley Memorial Hospital District on June 9, 1947. By resolution dated June 20, 1947, the Board of Supervisors for Monterey County formed Salinas Valley Memorial Hospital District. In 1995, the District's name was changed to Salinas Valley Memorial Health Care District by District Board Resolution Number 1995-03. Then on March 20, 1997, the Board of Directors of the District adopted District Board Resolution Number 1997-02 changing the name of the District to its current name Salinas Valley Memorial Healthcare System.

Serving Communities in Monterey County, CA since 1953, Salinas Valley Memorial Hospital, founded in 1953, is the cornerstone of what would eventually become Salinas Valley Memorial Healthcare System (SVMHS). Today, we serve thousands of individuals and families just like you throughout the Salinas Valley, Monterey Peninsula and the surrounding region. Each year, our highly trained team of healthcare professionals takes our renowned quality of patient care to the next level. Our team actively utilizes the latest medical techniques with our state-of-the-art technology to improve your health and well-being. In many cases this provides you and your family the opportunity to receive specialized care right here in your own community, without the need for travel. Our 266-bed acute care hospital employs more than 1,600 people and has a medical staff of more than 300 board- certified physicians across a broad spectrum of specialties, all dedicated to your care.

Each day we deliver exceptional, compassionate and culturally sensitive care, holding true to our Mission of improving the health and well-being of our community.

Our SVMHS family takes great pride in the quality of our many medical specialties all focused on providing you with patient-oriented care.

Purpose:

The intent of Salinas Valley Memorial Healthcare System (SVMHS) Information Technology (IT) is to procure help desk services and engage in a three (3) to four (4) year contract relationship with a service provider. This Request for Proposal (RFP) is intended to solicit detailed information regarding your organization's capability to provide help desk services that best supports our current and anticipated near term needs. Expected outcomes from this initiative are improved end-user satisfaction, increased ticket response and resolution times, increased first response resolution, and a reduction in support costs. Respondents to this RFP are expected to provide specifics regarding pricing and capabilities that meet our stated requirements. Based on our evaluation of responses, a short list of possible providers will be selected. Providers on the short list should be prepared to present the proposal to the selection committee.

Once a service provider is selected from this process, SVMHS will begin negotiations with the selected service provider to agree upon and execute the appropriate written agreement, which includes the agreed upon service level agreements.

Scope:

Salinas Valley Memorial Healthcare System (SVMHS) currently maintains its main network infrastructure presence at its Data Center in Salinas, California, where its internet presence and connectivity to members of the Salinas Valley Memorial Healthcare System is managed. This Data Center is the primary hub for all connectivity to SVMHS clinics and physician offices. There are multiple help desks at SVMHS and this RFP is restricted to the one managed by IT. The other help desks are related to specific categories of support related to clinical informatics, medical informatics, and ambulatory informatics.

Table of Contents

Introduction 2

Purpose: 3

Scope: 3

I. Executive Summary 5

II. Salinas Valley Memorial Healthcare System Overview 5

III. Evaluation Process and Schedule 6

IV. Part III: RFP Requirements 6

V. Part IV: RFP Terms and Conditions 6

VI. Vendor Instructions 8

VII. Part I: Vendor Information 9

VIII. About Our Environment 9

IX. Proposal Requirements 10

Supporting Documentation Index 22
Appendix A: RFP Terms and Conditions 33
Evaluation Criteria 34
Appendix B: NONDISCLOSURE AGREEMENT 35

I. Executive Summary

SVMHS is currently providing in-house information technology services which includes help desk functions. We are in the process of evaluating alternative approaches to its current Help Desk delivery approach and as a result is issuing this request for proposal (RFP) to organizations with a scalable business model that focuses on timely responsiveness, world class customer service and a quality assurance methodology that results in increased caller satisfaction. Our goal is to identify an external contact center to handle inbound communications for calls, emails, chat, and portal tickets via contacting the SVMHS Information Technology (IT) Help Desk. The contact center and its staff must be located in the United States. The provider will be responsible for the day to day operations of the contact center, including but not limited to, the hiring, training, and managing the contact center staff.

II. Salinas Valley Memorial Healthcare System Overview

Salinas Valley Memorial Healthcare System (SVMHS) is an integrated network of health care programs, services and facilities. Our goal is to improve the overall health of patients by providing better care, improving clinical outcomes, and lowering the cost of care.

Salinas Valley Memorial Hospital (SVMH), being at the core of the system, is a 263-bed, District Public Municipal Hospital. The hospitals 350 member medical staff represents all leading medical specialties across a broad spectrum of care. SVMH employs 1800 individuals supported by a team of 300 volunteers.

Taylor Farms Family Health and Wellness Center (TFFH&WC) is a hospital based rural health clinic (RHC) operating under SVMHS as an outpatient department of the hospital.

Salinas Valley Medical Clinic (SVMC) operates as a 1206(b) district clinic and is owned and operated by SVMHS. With 15 different location, SVMC includes over 130 providers who practice 25 specialties & sub specialties throughout Monterey County.

Doctors on Duty (DOD) is an urgent care network, which offers primary care, occupation health and specialty services. With nine locations throughout Monterey and Santa Cruz counties, DOD provides the most comprehensive employer-related healthcare services, injury prevention and wellness programs on the California Central Coast. SVMHS has 85% ownership in the organization.

Clinical Affiliations include eleven (14) independent outpatient clinics throughout Monterey County that rely on SVMH for hosting services of an ambulatory electronic medical records, e-MDs and Epic.

Central Coast Health Connect (CCHC) is a countywide health information exchange (HIE) in which SVMHS is a principle partner with Montage Health and Natividad Medical Center. CCHC's goal is to provide patients and the health care community with a trusted, integrated and efficient infrastructure to enable the exchange of health information in order to facilitate high quality, patient-centered care and population health.

III. Evaluation Process and Schedule

Our organization will evaluate responses to our request for proposal (RFP) based on how well each response addresses our stated objectives and overall Healthcare System goals. In addition, we use the following criteria in the selection process:

1. Compliance with bid requirements
2. Quality of the methodologies proposed to meet intended objectives
3. Customer service, support
4. Relevant experience
5. Cost effectiveness of professional services
6. Availability to start immediately

RFP Schedule:

Activity	Due Date
Request for Proposal Issued	December 14, 2020
Clarifying Questions Deadline	January 8, 2021
Submission Deadline	January 15, 2021
Anticipated Preferred Vendor Selection Notification	January 22, 2021
Contract Negotiations	Ending February 5, 2021

IV. Part III: RFP Requirements

Notice: SVMHS reserves the right to withdraw the RFP at any time before proposals are due, to waive any irregularity in the proposal documents or the solicitation procedures, or to reject any or all proposals submitted in response to the RFP, and is not liable to any respondent for the return of any proposal, or proposal materials sent by the Proposer.

Schedule for selection (RFP timeline, evaluation, ideal start date, etc.)

1. Deadline for submission of all proposals.
2. Notice of SVMHS contact to whom proposals shall be mailed
3. Request for one original, one duplicate copy, and one electronic copy (in Word or PDF format) of the proposal.
4. Notice of any planned pre-proposal meeting to discuss RFP (if applicable)
5. Vendor's willingness to agree to SVMHS's requested changes to a master agreement or similar.

V. Part IV: RFP Terms and Conditions

By participating in this RFP, respondent agrees to abide by the following terms:

A. Contractual status of RFP

1. This RFP is issued for and on behalf of SVMHS, and is intended to be a RFP only. The RFP is not intended to create legal relationships between SVMHS and any vendor. Subject to the foregoing, nothing contained in this RFP or any other communication made by SVMHS or its representatives to any other party or parties as part of this RFP process shall constitute an agreement, contract, representation or warranty by SVMHS to any other party.
2. This RFP is not an offer by SVMHS with any vendor. Acceptance of a proposal neither commits SVMHS to award a contract to any Vendor (even if all requirements stated in this RFP are satisfied) nor does it limit SVMHS' right to negotiate in its best interest. SVMHS reserves the right in its absolute discretion to contract with a Vendor for reasons other than the lowest price.
3. SVMHS reserves the right to change any aspect of, or cease, the RFP and/or a subsequent RFP process at any time.

B. Accuracy of Information
1. This RFP does not purport to contain all of the information which a Vendor may require for the purposes of the RFP. The information is necessarily selective and is subject to change in the future.
2. Although SVMHS has taken all reasonable steps to ensure that, as of the date of this document, the facts which are contained in this RFP are true and accurate in all material respects, SVMHS does not make any representation or warranty as to the accuracy or completeness or otherwise of this RFP or the reasonableness of any assumption on which this document may be based. In the absence of fraud, SVMHS accepts no liability to any Vendor whatsoever and howsoever arising out of or in connection with their participation in this RFP process, or their reliance on this RFP, or any omissions from, or deficiencies in, the provided as part of the RFP process.
3. SVMHS may use the information included in a Vendor's response for any reasonable purpose connected with this RFP.

C. Confidentiality
1. The information contained in this RFP and/or provided to you through other written or verbal communications relating to the RFP process is strictly confidential. In consideration of SVMHS providing such information to you and as a condition to your review of this RFP, you agree that you will:
   a. Use all information and material disclosed to you exclusively for the purposes of responding to the RFP (the "Purpose") and will not use such information or materials to obtain any other commercial, trading, financial or other advantage or for any other purpose;
   b. Maintain confidential all information and materials relating to the RFP that you may acquire in any manner and make copies of such information only to the extent that the same is strictly required for the Purpose;
   c. Not disclose whether directly or indirectly any information or materials relating to the RFP (or any part thereof) except to your own personnel and/or professional advisers and then only to the extent strictly required for the Purpose and under conditions of confidentiality;
   d. Not make any announcement, press release or other public statement in connection with the RFP and/or your participation in the RFP process without the prior written consent of SVMHS.
   e. Upon request by SVMHS, immediately return or destroy all information and materials relating to the RFP in your possession, custody or control including all relevant working papers and electronic copies of the foregoing. If requested by

SVMHS you shall confirm in writing that all such information has been returned or destroyed.

2. Information received in response to this RFP will be held by SVMHS in confidence and, subject to any applicable legal or regulatory requirements, will not be disclosed to any party, other than to its own personnel and professional advisers and engaged consultants, without the express written consent of the Vendor.
3. SVMHS is under no obligation to share any of the results or conclusions of the RFP process with any Vendor.

D. Ownership of Intellectual Property
   1. All intellectual property rights in this RFP and all materials provided by SVMHS or its professional advisers in connection with this RFP are and shall remain the property of SVMHS.
   2. SVMHS may exclude any Vendor from this process who has been found to be in breach of the above obligations in relation to confidential information and/or intellectual property rights and may pursue any remedy or take any other action for such breach as it considers appropriate.

E. No collaboration between bidders
   1. You are prohibited from discussing the RFP with any other Vendor to whom the RFP has been provided. If you wish to include third party products and/or services as part of your proposal you must obtain the prior written consent of SVMHS before providing details of the RFP to such other Vendor.

F. Non-solicitation of SVMHS employees
   1. No Vendor shall, during the RFP process and for a period of six (6) months thereafter, directly or indirectly offer employment to or otherwise endeavor to entice away from SVMHS any of its employees with whom such Vendor came into contact during the RFP process. This provision will not restrict any Vendor from engaging such employee pursuant to a bona fide recruitment advertisement not specifically directed at any employee of SVMHS and published in a national, regional or trade publication and where the employee responds to such advertisement without any form of prior approach by, or on behalf of, the Vendor.

G. Costs
   1. Each Vendor will bear its own cost in preparing a response to this RFP and any associated work effort regardless of whether a contract is awarded. SVMHS will not accept any liability or responsibility for any costs incurred by the Vendor in preparing a response to this RFP document or any associated work effort.

H. Timing of responses
   1. All responses must be received no later than the deadline specified. Any responses received after that date and time may, subject to SVMHS' absolute discretion, be eliminated from further consideration.

VI. Vendor Instructions

- **Submission Deadline:** On or before January 15, 2021.
- **Response Submission Instruction:** Proposals should be submitted via electronic mail to the below contact:

  Audrey Parks
  Chief Information Officer
  aparks@svmh.com
  450 East Romie Lane, Salinas, CA 93901

(831) 759-1935

- **Clarifying Questions:** If your organization has any questions pertaining to the contents of this RFP, you are encouraged to send your questions or comments to the contact above and no other contacts at SVMHS to ensure all responses are shared among the participants of this RFP. Answers to the questions from any vendor shall be provided to all participating vendors.
- **Attachments:** Vendors are encouraged to provide concise answers and provide relevant attachments or web links as necessary.
- **Notice:** SVMHS reserves the right to withdraw the RFP at any time before proposals are due to waive any irregularity in the proposal documents or the solicitation procedures, or to reject any or all proposals submitted in response to this RFP. SVMHS is not liable to any respondent for the return of any proposal or proposal materials sent by the proposer.

VII. Part I: Vendor Information

Name of Vendor:	CloudWave		
Name of Owner/CEO:	Erik Littlejohn, President & COO, CloudWave		
Name and Title of Contact/Proposer:	Mike Donahue, Director Sales Engineering, CloudWave		
Address:	100 Crowley Dr	Number:	978.761.2768
(city, state, zip)	Marlborough, MA 01752	Email:	mwdonahue@gocloudwave.com
Number of Employees:	127		
References: (no more than three; name, title, email)	1. Stephanie McDonell, SVP/CIO United Regional Healthcare System 2. Chuck McQuerry, COO Advocare 3. Dr. Christopher Crow, CEO StratiFi Health Contact details will be provided in coordination with GuideIT and CloudWave consistent with customer agreements.		

VIII. About Our Environment

SVMHS support locations include approximately 2,300 employees, 300 providers (such as physicians, physician assistants), and 500 contracted clinic-based staff principally located at 450 East Romie Lane or within Monterey County.

Currently, our IT infrastructure, including hardware, network and software support, consists of the following:

- Largely a Windows environment with virtual desktop infrastructure technologies by both VMware and Citrix
- Approximately 600 virtual servers supporting applications and providing desktop virtualization

- Approximately 170 distinct applications with 30 of them being cloud-based
- Approximately 2,200 end user devices (excluding printers and peripherals)
- Approximately 4,500 active users with an estimated 3,000 likely to call our current Help Desk
- Approximately 18 separate locations (addresses) for our main Hospital and its departments

The current call average is about 2,100 per month. Enterprise projects will occur occasionally that may increase current support requirement levels by approximately 2% - 5% during implementation.

IX. Proposal Requirements

Service provider's description of prior experience providing this type of service. Include attachments as necessary.

The objectives for the outsourced Help Desk services are as follows. **For this section, "Proposal Requirements," please provide any additional information that will help us in our selection process. If there is an item the service provider cannot meet, please provide additional details.**

Criteria	Response/Acknowledgement
a. Describe on-boarding process	***CloudWave and GuideIT are leveraging the benefits and strengths of both organizations to provide a solution. This joint relationship will be referenced in this document as "Partner."*** Partner's onboarding process begins with a project kickoff to identify stakeholders, review deliverables and timeline, and begin scheduling tasks for each workstream. The Transition is broken into four workstreams: • ITSM System Configuration • Process & Procedure Documentation • Service Desk Training • Infrastructure Access **ITSM System Configuration** is the workstream for Partner's Service Management Organization to build Partner's ITSM system components to mirror SVMHS's existing configurations within its own ITSM system (e.g. ticket categorization, team names, etc.). Partner has a standard process and template to capture this information. This workstream will also be responsible for coordinating with the SVMHS resource to configure the bi-directional API between systems, which is documented in more detail in a response below. **Process & Procedure Documentation** is the workstream responsible for creating the process and procedures for Service Desk support and transitioning any existing knowledge documentation into Partner's ITSM system for consumption. As part of this workstream, the Service Management Organization will also review and

Criteria	Response/Acknowledgement
	optimize processes for knowledge and ticket management. Transition leaders will identify key SVMHS stakeholders and schedule sessions with various support groups in advance to review and document each group's workflow and understand how the Service Desk best integrates into existing ticket management process. The Transition team will also need access to the existing Service Desk team or team leader to transition existing Service Desk specific documentation and understand any existing support processes. **Service Desk Training** is responsible for converting the knowledge articles into training materials and providing comprehensive training to all Service Desk team members who will be supporting SVMHS. Training is instructor-led and includes both exercises and assessments to confirm Service Desk team member readiness. Prior to go-live, mock calls are also facilitated as a final milestone. **Infrastructure Access** is the workstream that facilitates connectivity and access to the SVMHS system resources needed to support. This is typically a point-to-point VPN tunnel to allow Partner resources to access required systems like Active Directory Users & Computers. Partner can also make use of an existing external solution like Citrix Remote Access, SecureLink, etc. This workstream is also used to identify account permission requirements for the Service Desk into various systems needed for support.
b. 24 by 7 by 365 live support coverage (on-shore)	Partner will make available a Service Desk staffed 24x7x365 with on-shore resources. The staff supporting SVMHS end-users will be trained on SVMHS specific support processes and have the appropriate access required to resolve all applicable incidents and requests.
c. Level 1 phone and chat support, based in the United States for all service provider employees/contractors/business partners with access to SVMHS systems	Partner will work with SVMHS to generate or forward a phone number into Partner's Service Desk. Partner will also provide SVMHS with a web URL to Partner's Service Desk chat. Both phone and chat workflows utilize the Gartner Magic Quadrant leader for Contact Center as a Service, NICE inContact enterprise contact center.
d. Work directly with SVMHS IT staff for end user device issues	Partner will attempt to resolve end-device issues as part of its routine troubleshooting, leveraging knowledge articles gathered during the Transition period. If Partner determines the end-device needs to be physically reviewed, a ticket will be reassigned to the appropriate deskside support queue with detailed troubleshooting documentation and physical location of the asset.

Criteria	Response/Acknowledgement
e. Provide details on how the transition plan will be executed along with acceptance criteria and schedule	Please see response (a.) above for an overview of the Transition plan. Partner has developed a Transition project plan with milestones. ***Please see Supporting Document A for Transition Plan***.
f. Describe effects of termination of agreement	Partner will provide two termination methods in its agreement: 1. Termination with sixty days' notice if Partner fails to meet any particular SLA for three consecutive months or any four months in a rolling six-month period. 2. Termination with ninety days' notice at the end of the agreement term If termination is requested, Partner will provide the services to facilitate transfer to a new entity. An estimate will be provided for any transition effort required that will be completed outside of Partner personnel currently dedicated to providing the service. All documentation, including knowledge articles and other process documents, as well as ticket history, will be provided back to SVMHS in the appropriate format during the transition.
g. Describe tools used for remote support	Partner uses Bomgar as its remote control tool. Bomgar can be configured to the client's needs and does not require an agent to connect. Partner does recommend installing the unattended agent on end-devices to increase speed to remote control.
Service Desk Staff On-Going Training	
• SVMHS will provide access to training materials for relevant SVMHS systems and services as well as provide initial training if requested by service provider. Service provider is responsible for subsequent training to its current and new Service Desk staff.	Partner will take a train-the-trainer approach toward training, both during and after the initial Transition period. Partner has a dedicated training and quality team whose focus is to create training materials and coordinate training across all team members. ***See Supporting Document B for training framework.***
• Work with Subject Matter Experts to gather and update knowledge base articles to improve resolvability over time	Partner accepts the responsibility of drafting all knowledge articles for Service Desk support. Partner will work with SVMHS staff as needed to request information, validate article accuracy prior to publication, and ensure articles are kept up-to-date over time. Partner will monitor for resolution opportunities and initiate the request for information and/or access through SVMHS's designated

Criteria	Response/Acknowledgement
	points of contact. Additional resolution opportunities will be tracked through the Continual Improvement program.
Service Desk Process for Incident Escalation	
• Service provider must have a clearly articulated procedure for escalation of incidents using prioritization	Partner's standard for prioritization is an ITIL-aligned matrix for prioritizing by urgency to restore service and impact to the business. Prioritization is output on a numeric scale from 1 to 4, where 1 is used for major enterprise outages. Partner will work with SVMHS during the Transition to determine critical IT Services and any unique processes that drive certain prioritizations as well as to ensure that Partner's priority standard integrates into SVMHS's standard, if different. In addition, Partner will follow a streamlined procedure for escalating Partner hosted issues directly to Partner support. This reduces the burden of SVMHS's technical teams from spending time troubleshooting, triaging, and coordinating issues with Partner hosted services.
• Describe service provider's processes for integrating into existing level 2 or higher support models	During the Transition period, sessions will be held with each major support group to review a series of discovery questions. The following outcomes will be accomplished through these sessions: • Turnover of support documentation for the Service Desk's use • Identifying services that each team supports • Identifying desired ticket handoff process for each team (warm, cold, etc.) • Documenting troubleshooting/documentation requirements for each team
• Describe incident escalation and notification tools such as text messages, email distribution groups, or other. Service provider must be able to communicate incident status through closure to all parties	In the support model that Partner is proposing, regular ticket assignment notifications would be sent via SVMHS's ticketing system workflow. In addition to regular ticket assignment emails, Partner can configure these additional notifications as required during the Transition period: • Email and SMS notifications to pre-defined lists by support team (e.g. high priority ticket assignment) • Warm hand-off and escalation by the Service Desk to designated SVMHS personnel for high priority tickets or after-hours escalations The Service Desk will maintain access to every ticket and all updates within to provide status to the end-user when requested.
• Describe service provider's preferred process for escalation	The Service Desk will work to identify trends based on repeat calls, communicating internally amongst the team

Criteria	Response/Acknowledgement
of major incidents to the appropriate SVMHS contact	to identify a larger scale pattern. Partner's preferred process for major incident escalation is as follows: 1. The Service Desk identifies a trend in issue reports, or is proactively notified by a L2 or L3 team of a major service interruption 2. If call volume is high, a front-end message may be placed on the phone line to proactively notify callers of a new service event 3. A "parent" ticket is identified, generally the first report of the incident, and classified as a Major Incident with a Priority 1 or 2 4. If SVMHS has a major incident response team, the Service Desk will escalate to that team per SVMHS's process 5. If SVMHS does not have a major incident response team, the Service Desk prefers to ensure a warm hand-off occurs to the L2 or L3 team responsible for service restoration 6. After the major incident is reported, the Service Desk will track all subsequent issue reports as "child" tickets, linking records to the parent ticket to ease of closure when service is restored 7. During service restoration, the Service Desk will leverage any updates provided to them to update the front-end message with issue status and provide callers with detail 8. When service is restored, the Service Desk can assist with end-user validation as needed
Service Desk Service Level Agreements	
SVMHS and Service provider will arrive at mutually acceptable Service Level Agreements (SLAs) for which support is contracted, and these SLAs will become part of the written agreement. SLA's will be reviewed by both parties annually for the life of the agreement.	Partner acknowledges and agrees to this requirement.
The following is a list of current risk and performance standards to be measured, evaluated and tied to performance monitoring and penalties. Additional SLA's not listed may be negotiated and agreed to.	Partner is not proposing any additional SLA's in its submission.
• Percentage of First Contact Resolution – 85% or greater	Partner agrees to this SLA with the following exclusions: • Contacts involving Incidents that should be resolved by an organization other than the IT Service Desk.

Criteria	Response/Acknowledgement
	• Contacts deemed unresolvable by the IT Service Desk because a Ticket has already been opened for the Incident or because the Incident is among those included on a predefined list of unresolvable or in-action items. • Incidents for which a knowledge base article documenting the process for First Contact Resolution does not exist. • Partner or CW Customer system/ application outages not within the control of Partner.
• Average speed to answer (ASA) phone call to Service Desk – 85% or greater answered within 45 seconds	Partner agrees to this SLA with the following exclusions: • Calls where the End User selects the option to leave a voicemail message. • Abandoned Calls (as defined below). • Calls where the End User selects the option for a call back. • Calls related to SVMHS system/ application outages not within the control of Partner.
• Percentage of abandoned calls – 7% or less	Partner agrees to this SLA with the following exclusions: • Calls answered by an IT Service Desk representative. • Calls not answered due to the End User hanging up or disconnecting the telephone call 30 seconds or less after entering the system hold queue. • All telephone calls made to the Service Desk where the End User leaves a voicemail. • Calls where the End Users selects the option for a call back. • Calls related to SVMHS system/ application outages not within the control of Partner.
• SVMHS Satisfaction Scores – average 3 or greater out of 4	Partner agrees to this SLA with the following exclusions: • Surveys where both parties agree that the survey was not related to Partner's services. • Clear and obvious surveys where the submitter made a mistake when completing the survey.
Service provider should be prepared to have the above performance standards incorporated into a service level agreement and be enforceable with monetary penalties for non-compliance. SVMHS is open to adopting the Service provider's standard SLA language assuming	Partner is prepared to incorporate both monetary penalties for monthly SLA misses as well as a contract termination clause for failure to perform over multiple consecutive months.

Criteria	Response/Acknowledgement
that language can support the performance standards.	
Service Desk Incident Tracking	
• Level 1 email and self-service portal support, based in the United States, utilizing SVMHS's IT service management (ITSM) system or Service provider's ITSM system with an interface between the Service provider's ITSM system and SVMHS's ITSM system to send and receive tickets, ticket updates, and communications	Partner will provide Level 1 technical support, using staff in the United States, through the contact channels of phone, chat, email and self-service portal. For email and portal channels, the ticket will originate in SVMHS's ITSM platform and create an identical ticket record in Partner's ITSM platform for the Service Desk to action. To accomplish this, Partner proposes a bi-directional API integration between Partner's ITSM platform and SVMH's ITSM platform to generate tickets and send updates through the lifecycle of each ticket. For phone and chat tickets, the ticket will be created in Partner's ITSM system and an API request will be made to SVMHS's ITSM system to generate the record. If the ticket is updated (e.g. notes added, assignment updated) in Partner's ITSM system, updates will be passed into the corresponding SVMHS ticket. ***Please see Supporting Document C for technical overview of ITSM integration.***
• Service provider must either have tools and technology in place to track each incident/request reported, or adopt or integrate with SVMHS's ITSM system to track all incidents/requests. Ability to track average handle time per call	Using the API integration described in the response above, Partner will maintain access to all tickets and their respective notes, assignments, and other details at all times. Partner also can track handle time per call as well as many other ACD metrics.
• Service provider must have tools and methodologies to analyze patterns drawn from documented incidents and immediately notify SVMHS of system issues	Partner will leverage its major incident process for issue identification and escalation of any systematic issues impacting multiple users. Partner's preferred process is documented in the response to Criteria Item: *Describe service provider's preferred process for escalation of major incidents to the appropriate SVMHS contact* Partner will also perform trending analysis, leveraging an internal Business Intelligence tool, to provide observations of issue patterns and remediation recommendations where possible. Trending analysis reporting will be incorporated as part of the Continual Improvement Program.
• Describe Service Level Agreements to limit "hold time" waiting for Help Desk call availability	The proposed SLA for answer speed at 85% or greater answered within 45 seconds is sufficient to ensure a high degree of phone availability to the Service Desk. If this SLA is being met, we generally see the actual average answer speed is around 30 seconds or less with a

Criteria	Response/Acknowledgement
	significant percentage of calls routing to an immediately available analyst.
• Generate a ticket in the designated ITSM system for each incident or request received from end-user	The Service Desk will create a ticket for each new incident or request submitted via phone call and chat. Partner has audit and reconciliation reporting in place to ensure tickets are being generated consistently.
• Ability to use remote access to resolve technical issues with their provided tool	Partner uses Bomgar for screen share and mouse/keyboard control; this includes the ability to elevate privileges locally on the end-device, if permitted by SVMHS. Privilege elevations allows for the Service Desk to perform activities such as approved software installation, reinstallation, Window setting changes that require User Access Control, etc. It is standard procedure for the Service Desk to initiate remote control for advanced support to maximize resolvability.
Service Desk Service Performance Evaluations	
• Service provider must supply reports to SVMHS on a weekly, monthly, quarterly and annual basis any reports supporting service level agreements	Partner agrees to this requirement and expands on reporting in the below Criteria section *Service Desk Service Reports and Deliverables.*
• At least monthly communication with a designated SVMHS leader(s) and provider's counterpart	Partner agrees to this requirement; monthly reporting on metrics and improvement initiatives will be delivered to the designated SVMHS leader for discussion.
• Meet all service levels agreed upon and report on a monthly basis	Partner agrees to the SLAs described in this RFP and will provide a monthly SLA report which measures Partner performance against the SLA targets.
• Escalation of repetitive, unresolved issues to appropriate SVMHS IT management	Repetitive, unresolved issues are identified through trending analysis and SVMHS will be notified as part of the Continual Improvement Program.
Service Desk Service Reports and Deliverables	
• Service providers must include sample reports as part of their responses	Partner has included sample reports as their response to the below desired metric reports.
• Key metric reports must include, at a minimum, the following:	
○ Automated call distribution reports (weekly, monthly) containing week to week and month to month service level metrics regarding calls	Partner utilizes a Business Intelligence platform to consolidate and combine data from multiple sources (e.g. contact center platform and ITSM platform). Partner will formally deliver a Service Level report at the completion of each calendar month which reports the month's performance against the agree upon Service Levels. In addition, reports can be generated for other ACD data points. Additional report requirements, scheduling and distribution can be decided upon during the Transition period.

Criteria	Response/Acknowledgement
– volume of calls received by week	Partner can deliver this metric - see sample report.
– average hold time	We do not provide average time a caller spends on hold as a standard report but have the data available to provide on request.
– answer time	Partner can deliver this metric - see sample report.
– abandoned calls	Partner can deliver this metric - see sample report.
○ Volume of tickets	Partner can deliver this metric - see sample report.
– Types of incidents and requests	Partner can deliver this metric - see sample report.
– Categorization of tickets	Partner can deliver this metric - see sample report.
– First call resolution rate	Partner can deliver this metric - see sample report.
○ Business impact reports – monthly comparison of service levels that include call stats, ticket volumes, top incident categories and SLA trends	Partner can deliver this metric - see sample report.
○ Service Level Attainment Summary – monthly review of service levels, SLA trend analysis, and root cause for any issues	Partner can deliver this metric - see sample report.
Customer Satisfaction	
• Service provider and SVMHS shall develop a formal program for measuring satisfaction at the management and end-user levels	Partner will work with SVMHS over the Transition period to define the end-user survey associated with tickets, including the questions, frequency, and scoring to adapt to the 4-point scale score established in the SLA. Partner will also conduct a project survey at the end of the Transition as well as an annual survey for Management satisfaction of the services being provided.
• Satisfaction surveys will be sent from the SVMHS's ITSM system which the Service Provider will have access to for survey reporting	Partner acknowledges and agrees to this requirement.
• Satisfaction measurement results are to be shared with SVMHS quarterly with scoring from 1 to 4 with a minimum of 3 success rating.	Partner will report on results of end-user satisfaction surveys monthly as part of the agreed upon SLA. Any data associated with surveys will be provided to SVMHS as needed.
• Service provider will review all low surveys pertaining to the Service Desk service and report on actions taken to remediate the cause of a dissatisfied survey	During the transition period, Partner will develop a process for receiving and reviewing low survey scores. As applicable, Partner leadership may contact the end-user directly to clarify or expound on any survey feedback. A recurring report of all low score reviews and outcomes will be tracked and shared with SVMHS, including incorrectly completed surveys that need to be excluded per Partner's

Criteria	Response/Acknowledgement
	exclusion request documented in our Satisfaction Score SLA response.
Account Manager	
There will be a leader at SVMHS who will serve as the business contact for the selected service provider. A service provider Account Manager shall be assigned to SVMHS and the individual will be responsible for the following:	Partner will assign a dedicated Customer Success Manager (CSM) to act as a single point of contact for any issues or escalations of the service. The CSM will also be responsible for providing and presenting all reporting metrics captured as a part of the service.
• Be available during standard business hours via phone and email	Partner acknowledges and agrees to this requirement.
• Be able to be reached in emergency off-hours via cell phone or make arrangements for emergency contact	Partner acknowledges and agrees to this requirement.
• Have a backup contact identified if the account manager cannot be reached within a reasonable amount of time or four (4) business hours	Partner acknowledges and agrees to this requirement.
• Account Manager shall not change more than once every eighteen (18) months unless at the request of SVMHS	Partner acknowledges and agrees to this requirement.
Continual Service Improvement	
SVMHS expects the service provider to implement and manage an Information Technology Infrastructure Library (ITIL)-based continual service improvement practice to recommend and action improvements to the service over time. These improvements may be a mixture of observations and trending causing a recommendation for the SVMHS to action, or an improvement within the responsibility of the provider to action. Provider will maintain a continual improvement register which will be used to identify improvements, baseline, track progress, and measure value output from completion. The following areas are expected to be evaluated for continual improvement:	Partner will implement a Continual Improvement Program, incorporating the below Criteria into continual Areas of Focus. Each Area will be reviewed on an ongoing basis to identify trends and to either make recommendations back to SVMHS for an improvement or generate an actionable item for the Partner delivery team to complete. The improvement register will be tracked by a Partner's Service Management team and updates will be provided no less than monthly on progress. The primary goals for the Continual Improvement Program will be to: • Increase efficiency and speed to resolution • Increase quality of support processes and integration into SVMHS's support teams • Increase quality of customer experience • Reduce Support cost through maximizing Service Desk resolvability • Reduce Service Desk cost through ticket elimination
• Proactively monitor for repeat issues that may be part of a	Partner agrees to this requirement and will incorporate into its Continual Improvement Program.

Criteria	Response/Acknowledgement
larger problem, and escalate to SVMHS leadership with detailed analysis	
• Create the template for knowledge articles, recommend and create new articles to improve service, and ensure articles are kept updated	Partner agrees to this requirement and will incorporate into its Continual Improvement Program.
• Continually analyze existing processes to identify ways to increase service delivery efficiency and quality	Partner agrees to this requirement and will incorporate into its Continual Improvement Program.
• Identify, recommend, and drive opportunities to shift-left work items to the Service Desk for increased Level 1 resolution	Partner agrees to this requirement and will incorporate into its Continual Improvement Program.
• Recommend ITSM improvements for better data capture, workflow, etc.	Partner agrees to this requirement and will incorporate into its Continual Improvement Program.
• Maintain a Quality Assurance program that measures Service Desk staff against SVMHS processes	Partner will incorporate SVMHS's specific support requirements into its larger Quality Assurance program. The Quality Assurance program will be overseen as a component of the Continual Improvement program. ***See Supporting Document D for sample QA workflow.***
• Regular meetings (phone or in-person) with SVMHS staff to discuss operational improvements, recent problems, trends and management issues. At minimum these meetings should be bi-weekly.	During transition, Partner and SVMHS will identify key stakeholder teams and leadership that the Service Desk will interact with most regularly. Recurring, agenda-driven meetings will be scheduled to promote operational improvements. Improvement examples may be a request for knowledge, team-to-team assignment changes, communication of upcoming changes, etc. Discussions and action items will be tracked and reviewed during each meeting. Some items discussed during these meetings may be transferred to or shared with the overall continual improvement program for tracking.
• Monthly Summary – Deliver trend observations, recommendations for improvements, and provide update on continual improvement program's active initiatives and results from previously completed initiatives	Partner agrees to this requirement and will incorporate into its Continual Improvement Program.
• Describe scope of services provided and excluded from proposed solution.	Partner provides a leveraged Service Desk service that scales to your support volume needs, with 24x7x365 access to trained professionals through up to four contact channels (phone, chat, email, portal).

Criteria	Response/Acknowledgement
	The Service Desk team will be a single point of contact to attempt resolution at user-initiated issues and service requests. If unresolved, the Service Desk will escalate to the appropriate team for additional support using defined and agreed upon methods of ticket transfer and communication. The Service Desk will make use of a remote-control tool, capable of viewing the user's screen and controlling mouse/keyboard as well as local administrator rights elevation on the device when necessary. The Service Desk will be trained on SVMHS support processes, applications and services and have access to knowledge articles follow any task where resolution steps are documented. Absent a knowledge article, the Service Desk will perform off-script troubleshooting, using their technical skillset and online resources to attempt resolution. The Service Desk will intake any type of technical support issue or request, including basic user administration to common systems like email. Below are the types of support items that are most frequently supported: • Software Issues (OS, Commercial Off-The-Shelf) • Clinical Application Issues • Business Applications Issues • Password Resets / Account Unlocks • Hardware Break / Fix (PCs, Desk Phones) • Peripheral Break / Fix (Printers, Scanners) • Access Management, including provisioning and deprovisioning • How To / Education requests • Software installations • Telecom (extension management) • Mobile Devices (Mobile Mail, mobile OS) • VPN Support

X. Supporting Documentation Index

A: Transition Plan

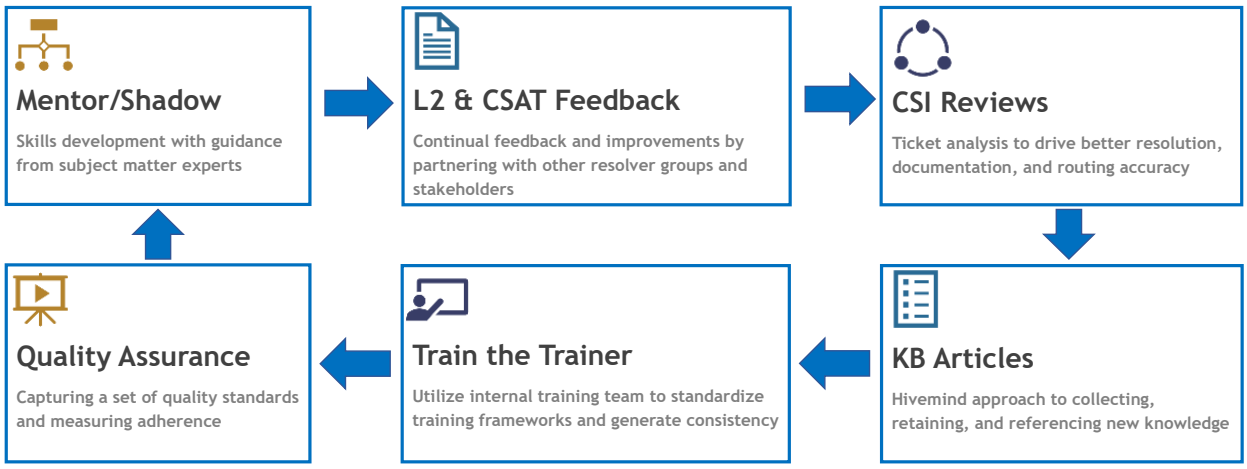
See Attached Document:

"*SVMHS Transition Master Plan 012121.pdf*"

B: Training Framework

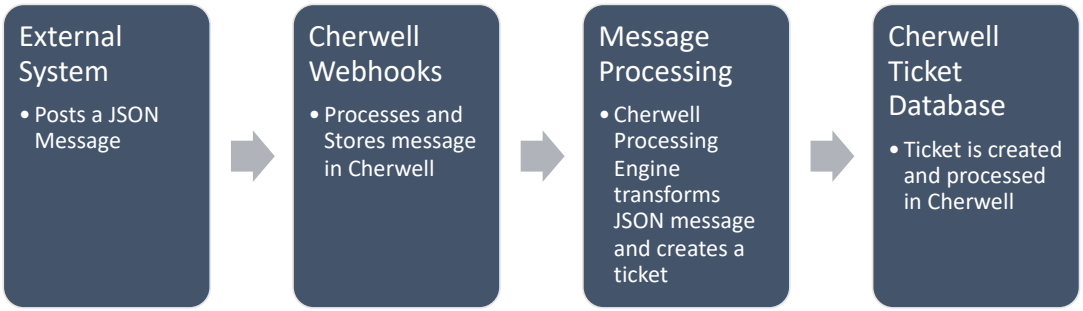
Technical Service Desk Training Framework

Training & Collaboration



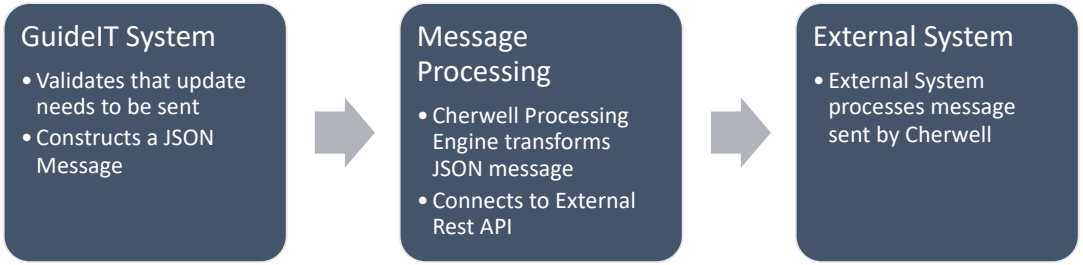
C. Technical overview of ITSM integration.

GuideIT API – Normal Messages (Incoming) - Asynchronous

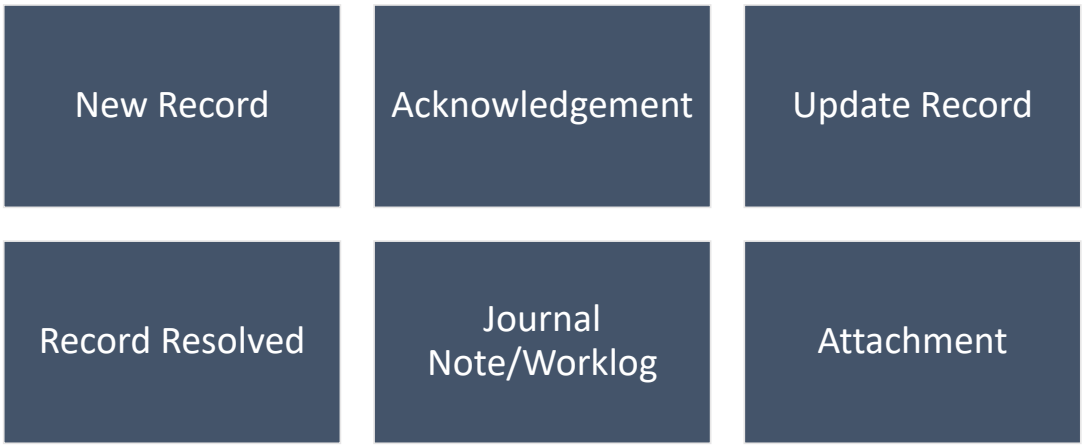


GuideIT API – Normal Messages (Incoming) - Synchronous

GuideIT API – Outgoing Messages - Normal



GuideIT API – Typical Messages Exchanged



GuideIT API - New Incident Record Creation

Required Fields

- Customer Email
- Short Description
- Description
- Service
- Category
- Description
- Priority
- Call Source
- Owned by Team
- Vendor Ticket Number
- Vendor Ticket ID

Non-Required Fields

- Impact
- Urgency

GuideIT API - Record Closure

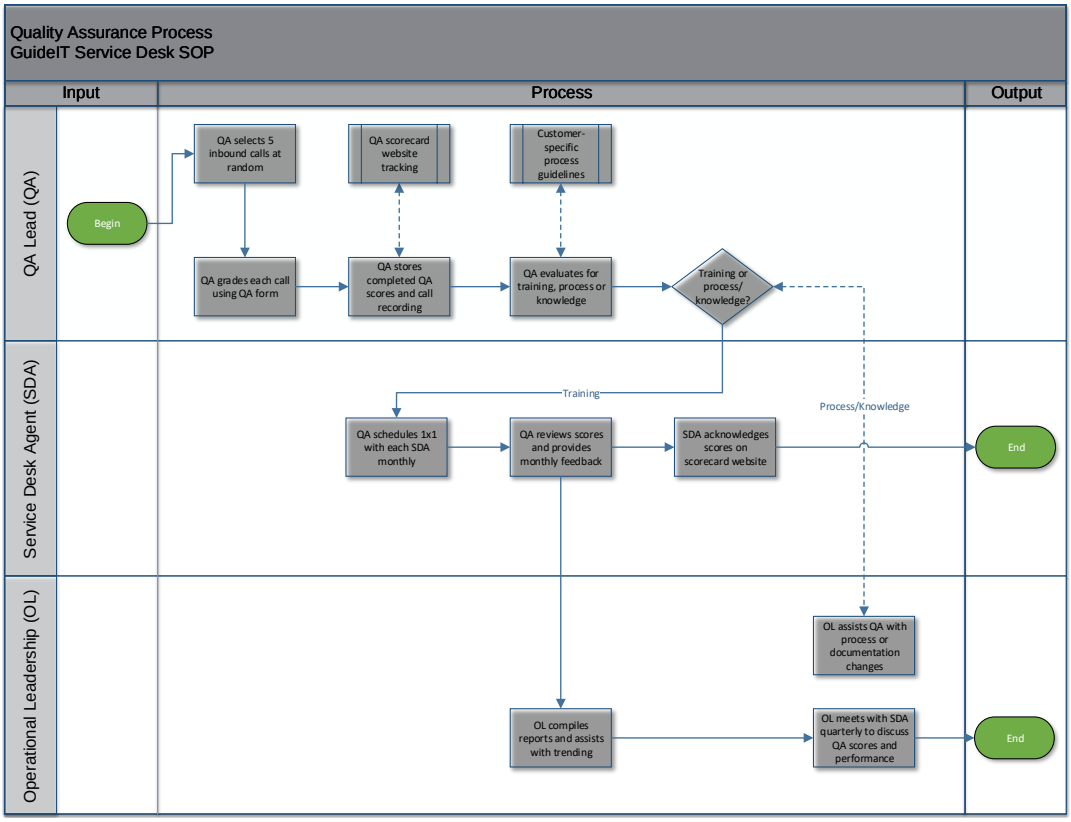
Required Fields

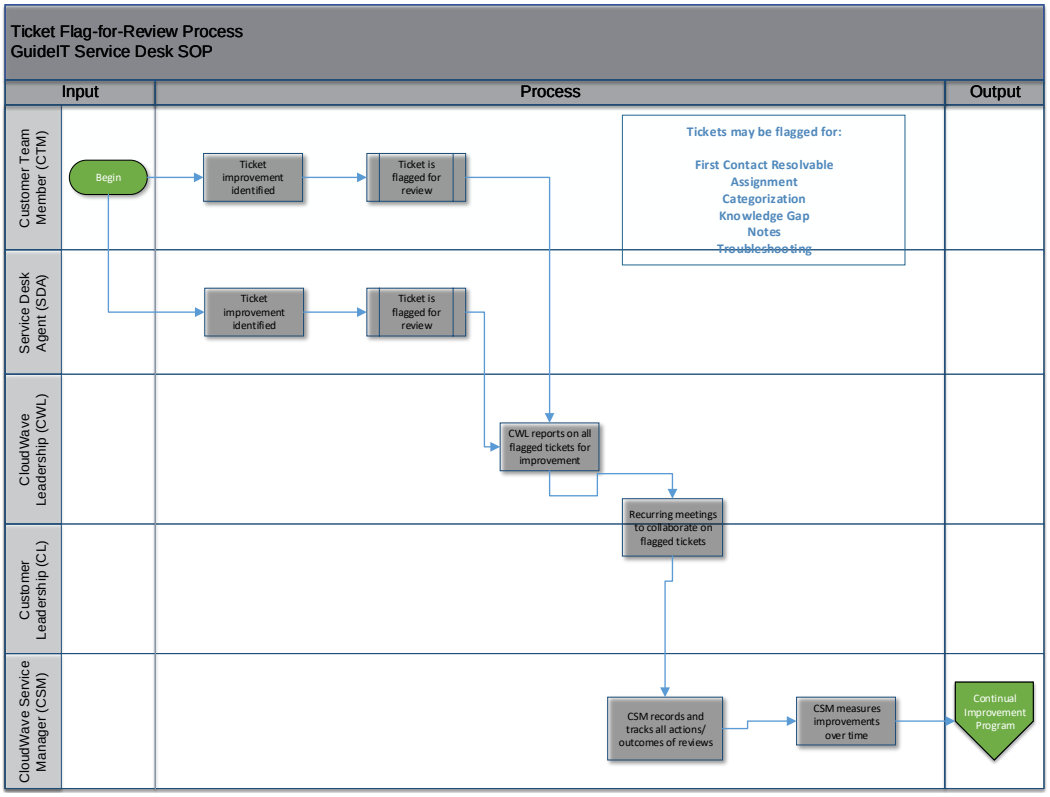
- Close Description
- Resolution Code

Non-Required Fields

- Impact
- Urgency

D. Sample Quality Assurance Workflow





E. Partner Profiles – Qualifications & Experience
(Go to referenced section)

See Attached Documents:

"Levi Pagsuberon Resume.pdf"

"Nicole Woods Resume.pdf"

"Taylor Walker Resume.pdf"

"Rahul Sharma Resume.pdf"

F. Pricing Schedule by Month

Based on information provided in the RFP and consistent with the model presented in the cover letter, the table below represents pricing per month for the proposed 48 months of the agreement.

Month	1-3 (Transition)	4-12	13-24	24-36	37-48	Total
FEE*	**$134,052**	**$253,941**	**$344,900**	**$353,472**	**$362,259**	**$1,448,625**

*Excluding future volume growth or decline adjustments

G. Proposed Service Level Agreements

Priority Matrix		Impact		
		Major	Moderate	Minor
Urgency	High	Critical	High	Medium
	Medium	High	Medium	Low
	Low	Medium	Low	Low

Impact	
Major	• The Customer Facility is down for all Customer employees and they are not able to perform their work. • If not resolved promptly, the Incident may result in lost revenue for Customer. • The Incident requires notification to Customer's Senior Leaders (C-suite).
Moderate	• A significant number, but not all, Customer employees are unable to work due to the Incident. • There is currently no workaround or corrective action that is readily available to correct the Incident. • The Incident requires notification to the Customer.
Minor	• A single, or minimum, number of Customer employees are impacted by an outage or slow-down of the Incident. • Only a selected amount of impact to Customer's employees and a solution is known or can be readily implemented. • No damage to the reputation of the Customer's business, the business unit, or the Customer is likely to be noticed.
Urgency	
High	• The damage caused by the Incident increases rapidly. • No workaround is available or the Incident cannot be immediately rectified. • Several End Users with VIP status are affected.
Medium	• The damage caused by the Incident increases considerably over time. • A workaround may be implemented or known but has not been tested. • A single End User with VIP status is affected.
Low	• The damage caused by the Incident only marginally increases over time. • A workaround is available but has not been implemented for the Incident. • Default for all non-VIP End Users, standard entry point into ITSM.

Table 1 – Service Level Agreements (SLAs)

SLA No.	Service Area - Name of SLA	Description	Effective Date / Hours of Operation	Data Capture	SLA Target	Exclusions	Calculation
1	IT Service Desk &–Speed to Answer	The time within which a telephone call placed to the IT Service Desk by an End User (each, a "Call") is answered ("Speed to Answer"). The duration is measured from the time that the Call enters the hold queue until the Call is answered by an IT Service Desk representative, as applicable	Contract Month 6 IT Service Desk Hours, as applicable	GuideIT PBX System	Speed to Answer Rate not more than 45 seconds for 85.0% of Calls received in a month	• Calls where the End User selects the option to leave a voicemail message. • Abandoned Calls (as defined below). • Calls where the End User selects the option for a call back. • Calls related to Customer system/application outages not within the control of GuideIT.	Speed to Answer Rate = (number of Calls with a 45 second or less Speed to Answer in a month / total number of Calls in that month * 100% (Results for IT Service Desk are aggregated for measurement purposes)
2	IT Service Desk– Abandon Rate	The percentage of Calls during a month where the caller stayed on the line for more than 30 seconds from the time the call enters the hold queue, then abandons the call (each, a "Abandoned Call") as a percentage of the Calls received by the IT Service Desk during the same month.	Contract Month 6 IT Service Desk Hours, as applicable	GuideIT PBX System	Abandon Rate not to exceed 7.0%	• Calls answered by an IT Service Desk representative. • Calls not answered due to the End User hanging up or disconnecting the telephone call 30 seconds or less after entering the system hold queue. • All telephone calls made to the IT Service Desk where the End User leaves a voicemail. • Calls where the End Users selects the option for a call back.	Abandon Rate = (# of Abandoned Calls / Total # of Calls) * 100% (Results for IT Service Desk are aggregated for measurement purposes)

SLA No.	Service Area - Name of SLA	Description	Effective Date / Hours of Operation	Data Capture	SLA Target	Exclusions	Calculation
						• Customer system/application outages not within the control of GuideIT. • Any month in which the volume of Calls is less than 300.	
3	IT Service Desk – First Contact Resolution	The percentage of Eligible First Contacts during a month that are resolved by an IT Service Desk representative responding during the first telephone call to the IT Service; *or* by the first response to an email or web portal entry by a IT Service Desk representative, as the case may be (the "First Response"). "Eligible First Contact" means a Contact by an End User via Call, email or web portal reporting an Incident for which a knowledge base article documenting the process for resolution of the Incident has been agreed upon and documented.	Contract Month 6 IT Service Desk Hours, as applicable	ITSM System	Not less than 85.0% of Eligible First Contacts are resolved by the First Response.	• Contacts involving Incidents that should be resolved by other than the IT Service Desk. • Contacts deemed unresolvable by the IT Service because a ticket has already been opened for the Incident or because the Incident is among those included on a predefined list of unresolvable or in-action items. • Incidents for which a knowledge base article documenting the process for First Contact Resolution does not exist. • Customer system/application	First Contact Resolution = (number of Eligible First Contacts during the period resolved by the First Response / total number of Eligible First Contacts during the period) * 100%. (Results for IT Service Desk are aggregated for measurement purposes)

SLA No.	Service Area - Name of SLA	Description	Effective Date / Hours of Operation	Data Capture	SLA Target	Exclusions	Calculation
						outages not within the control of GuideIT.	

Table 2 – Service Level Objective (SLO)

SLO No.	Service Area - Name of SLO	Description	Effective Date / Hours of Operation	Data Capture	SLO Target	Exclusions	Calculation
1	Service Management – End User Customer Satisfaction Survey	Provide quantifiable feedback from End Users to measure GuideIT's performance against End User expectations and assist in identifying opportunities for improvement in service.	Contract Month 6 IT Service Desk Hours, as applicable	ITSM System	Average score for all returned surveys in the aggregate of three point zero (3.0) or greater on a scale ranging from one to four (1 to 4), with a score of four (4.0) being the highest level of satisfaction. The following are sample survey questions: • How satisfied are you with the way this request for service was handled from start to finish? • How satisfied are you with the way your request was handled at the IT Service Desk? • How satisfied are you with the overall communication throughout the process of	• None	For each satisfaction question, the following scale will apply: • Very Unsatisfied (1) • Unsatisfied (2) • Satisfied (3) • Very Satisfied (4) Every closed Incident Ticket or Request Ticket will generate an automated email that will present the End User with a web-based form to report End User's satisfaction with the response or resolution for the particular Incident or requested Service. Changes to the frequency with which End Users will be surveyed will be agreed-upon

SLO No.	Service Area - Name of SLO	Description	Effective Date / Hours of Operation	Data Capture	SLO Target	Exclusions	Calculation
					resolving your Incident or Request?		between Customer and GuideIT. Average customer satisfaction = (total of scores received on all surveys / total number of surveys). Non-returned surveys will be excluded from the scoring.

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Appendix A: RFP Terms and Conditions

Questions

Any questions must be submitted by email to Audrey Parks, aparks@svmh.com, by January 8, 2021 close of business. The questions will be answered and issued to **all** participating vendors by close of business within one week from the deadline for clarifying questions. Full consideration will be provided for all responsible responses to our request for proposal (RFP) received no later than the deadline for responses. See "RFP Schedule" for details.

RFP Terms and Conditions

1. **Salinas Valley Memorial Healthcare System (SVMHS) will evaluate the written responses received and may choose to invite firms offering satisfactory solution proposals to meet with SVMHS IT to further refine and revise the project scope, the scope of services to be provided, and the implementation approach.**
2. Evaluation may involve the identification and correction of proposal weaknesses, ambiguities or other deficiencies.
3. Evaluation will be structured to safeguard information and ensure that all firms are treated fairly.
4. SVMHS reserves the right to withdraw the request for solutions at any time before proposals are due, to waive any irregularity in the proposal documents or the solicitation procedures, or to reject any or all proposals submitted in response to the RFP, and is not liable to any respondent for the return of any proposal, or proposal materials sent by the Proposer.
5. Preparation and submission of a proposal by interested providers will be at no cost or obligation to SVMHS.
6. Proposals and other materials submitted will become the property of SVMHS and will not be returned. Your proposal must not be marked proprietary or confidential. SVMHS is subject to the California Public Records Act and cannot honor such request for confidentiality.
7. Withdrawal of proposals may be made by email by an authorized representative of provider organization to Jim Garrett, jgarrett@svmh.com.
8. Proposals must be valid for a period of six months following submission deadline.

Evaluation Criteria

The following evaluation criteria, not necessarily listed in order of significance, will be used to evaluate project proposals received in response to this RFP:

1. The contractor's general and detailed approach and plans to meet the project requirements.
2. The contractor's documented experience in successfully completing projects of a similar size and scope. (Provide references.)
3. The qualifications and experience of the contractor's personnel assigned to the project, with emphasis on documented experience in successfully completing work on projects of similar size and scope. (See Supporting Document E)
4. The overall ability of the contractor to mobilize, undertake and successfully complete the project.
5. The contractor's proposed implementation approach for project completion. As this is an MSSP proposal, SVMHS expects that the solution provider will provide sufficient resources to execute the project management, architecture, engineering, integration, training, testing, and operational support on all facets of the deliverable.
6. The cohesiveness of solution and the integration of products and resources supporting the proposal. It is the expectation that the solution provides a Cyber Security Ecosystem for SVMHS, where threats, vulnerabilities, remediation identified in each deliverable feed back into each other and support ongoing recommendations for improvement, investment, and organizational or process change.
7. Cost effectiveness of the proposed solution. Although **this is not a Request for Quote**, the proposal should demonstrate a flexible solution approach that enables SVMHS to engage in a best practice and high quality MSSP framework at a low entry cost and then to mature the solution in subsequent phases. SVMHS is a California State Hospital.
8. Acceptance of our Business Associate Agreement. See sample below.

Appendix B: NONDISCLOSURE AGREEMENT

This Nondisclosure Agreement ("NDA") is made and effective on _____, 202_ ("Effective Date"), by and between _____ ("Vendor"), and **Salinas Valley Memorial Healthcare System**, a local health care district ("SVMHS").

RECITALS

A. Related to discussions and/or negotiations between the parties and Vendor's review of information related to SVMHS's information technology systems, technologies, architecture and operations ("IT Information"), Vendor may receive and review SVMHS's Confidential Information. SVMHS's IT Information, whether subject to trade secret, trade dress, trademark or copyright protection, protected by privacy laws, or not capable of being so protected but otherwise a proprietary method of doing business, is highly confidential and proprietary to and constitutes trade secrets of SVMHS.

B. SVMHS is willing to disclose to Vendor certain IT Information, reports, and documents as Confidential Information only if Vendor, on behalf of itself, its affiliates, subsidiaries, employees, agents, successors, and assigns, agrees to make no use or disclosure of such information except as provided in this NDA. Both parties wish to protect the confidentiality of, maintain its rights in and prevent the unauthorized use and disclosure of all such information exchanged.

The parties agree as provided below.

1. **Confidential Information**. For purposes of this NDA, the term "Confidential Information" means and includes any and all (i) IT Information, (iI) operating, information or other process, business and affairs of either party considered a trade secret, data, know-how, processes and ideas, services and patient census, referral figures and statistics and billing data, insurance company and other payor arrangement, reimbursement rates, scope of services and specialties provided, population studies, referral statistics, market studies, business plans, information technology status, physician and other staff recruitment contracts, plans and pay arrangements, utilization and plans, know-how, vendor agreements, and any other information, however documented, that is a proprietary, confidential or trade secret within the meaning of applicable law, and (iIi) information concerning the business and affairs of a party, which includes historical financial statements, financial projections and budgets, historical capital spending budgets and plans, the names and backgrounds of key personnel, personnel training techniques and materials, however documented, that have been or may hereafter be provided or shown by one party to the other party or its representatives or is otherwise obtained from review of a party's documents or property or discussions with the disclosing party's representatives by the other party or its representatives, irrespective of the form of the communication, and also includes all notes, analyses, compilations, studies, summaries, forecasts and other material prepared by the recipient party's representatives containing or based on any information included in the foregoing.

2. **HIPAA/Confidentiality of Medical Information Act**. The parties agree that Protected Health Information ("PHI") as such term is defined in under the Health Insurance Portability and Accountability Act (HIPAA) is Confidential Information if disclosed pursuant under this NDA.

3. **Excluded Information**. Notwithstanding any provision of this NDA, Confidential Information shall not include information that: (i) is or becomes generally available to the public without breach of confidentiality obligations by Vendor; and (ii) is lawfully received by Vendor on a non-confidential basis from a third party without breach by such third party of any legal, contractual, or fiduciary obligation to SVMHS. However, Confidential Information disclosed under this NDA shall not be considered within the foregoing exception merely because (a) it is specific and embraced by more general information in the public domain or Vendor's prior possession, or (b) it is a combination which can be pieced together to reconstruct the Confidential Information from multiple sources, none of which shows the whole combination, its principle(s) of operation or method(s) of use.

4. **Obligations of Vendor**. Vendor and its Representatives will: (i) hold Confidential Information in strict confidence and use their reasonable best efforts to prevent the unauthorized disclosure of Confidential Information; (ii) not disclose the Confidential Information in any manner whatsoever, except as required by applicable law, regulation or legal process, and only after compliance with Paragraph 5 of this NDA; (iii) use Confidential Information only for the purpose discussions between SVMHS and Vendor and for no other purpose; and (iv) not copy, reproduce, modify, alter, disassemble, reverse engineer or decompile any of the Confidential Information. Vendor will provide access to the Confidential Information to only those of its Representatives who have a need to know the Confidential Information. Vendor will cause its Representatives to observe the terms of this NDA and will be responsible for any breach of this NDA by any of its Representatives.

5. **Certain Permitted Disclosure**. In the event that Vendor or any of its Representatives are requested pursuant to, or required by, applicable law, regulation or legal process to disclose any of the Confidential Information, Vendor will notify SVMHS promptly in writing of such request or requirement and the documents or Confidential Information requested (unless prohibited from doing so by law or regulation), so that SVMHS may seek a protective order or other appropriate remedy or, in its sole discretion, waive compliance with the terms of this NDA. If no such protective order or other remedy is obtained, or if SVMHS does not waive compliance with the terms of this NDA, Vendor will furnish only that portion of the Confidential Information legally required and will exercise all reasonable efforts to obtain reliable assurance that confidential treatment will be accorded the Confidential Information to the extent possible.

6. **Return of Information**. Upon SVMHS's request, Vendor shall either promptly return to SVMHS all the Confidential Information or certify in writing to SVMHS that all media containing Confidential Information has been destroyed, except to the extent stored solely

due to back up archiving, in which case such archival storage shall not be accessed for any other purpose after the termination of this NDA, or otherwise used inconsistent herewith, regardless of whether this NDA has terminated by its terms.

7. **Limited Relationship**. This Agreement will not create a joint venture, partnership or other formal business relationship or entity of any kind, or an obligation to form any such relationship or entity. Each party will act as an independent contractor and not as an agent of the other party for any purpose, and neither will have the authority to bind the other.

8. **No Obligation Regarding Potential Relationship or Contract**. Neither this NDA nor the disclosure or receipt of Confidential Information will constitute or imply any promise to or intention to make or consummate a potential relationship or Contract by SVMHS with Vendor, whether currently or in the future.

9. **No Creation of Ownership Rights or License**. The Confidential Information shall be deemed the exclusive property of SVMHS and shall remain the valuable scientific, trade and engineering secrets of SVMHS. Nothing in this NDA, nor any action taken by either party, shall be construed to convey to Vendor any right, title or interest in the Confidential Information, or any license to use (except to evaluate as stated in this NDA), sell, exploit, copy or further develop in any way any Confidential Information. No license is granted or implied under any patent, copyright or trademark, or any trade name, trade secret or other proprietary information, in which SVMHS has any right, title or interest.

10. **Governing Law**. This NDA shall be construed under and according to the laws of the State of California without regard to its conflict of law provisions. Jurisdiction and venue for any actions relating to this NDA will be in the state or federal courts located in Monterey County, California. Both parties consent to the jurisdiction of such courts.

11. **Remedies; Legal Fees**. Vendor acknowledges that remedies at law may be inadequate to protect SVMHS against any actual or threatened breach of this NDA by Vendor, and, without prejudice to any other rights and remedies otherwise available, Vendor agrees that SVMHS shall be entitled to seek injunctive relief. In the event of litigation relating to this NDA, if a court of competent jurisdiction determines that this NDA has been breached by Vendor, then Vendor will reimburse SVMHS for its costs and expenses (including legal fees and expenses) incurred in connection with all such litigation.

12. **Term**. A party's obligations under this NDA shall terminate shall terminate two (2) years from the Effective Date of this NDA.

13. **Dispute Resolution**

    13.1 **Informal Dispute Resolution**. The parties desire to avoid the cost and delay attendant to litigation. To that end, all parties agree that if any dispute arises relating to this Agreement, including but not limited to its meaning, interpretation, effect, or

the enforcement of the provisions hereof, then the party who believes a dispute has arisen shall give written notice of such to the other party. For a period of thirty (30) days after such notice, the parties shall attempt to resolve the dispute by informal discussions among themselves, using the services of a mediator if the parties agree that such a mediator would facilitate resolution of the dispute.

13.2 **Arbitration**. All claims and disputes arising under this Agreement and after an attempt to resolve the dispute and/or claim informally pursuant to Section 13.1, shall be submitted to neutral, binding arbitration in Monterey, California, pursuant to the Streamlined Arbitration Rules and Procedures of JAMS, except that the provisions governing the right to discovery as set forth in Cal. Code of Civil Procedure §1283.05 are incorporated into this Agreement. The arbitrator may construe or interpret but shall not ignore the terms of this Agreement and shall be bound by substantive California law. The parties hereby agree to give up any rights they might possess to have any such claim or dispute litigated in a court or jury trial. The costs of the arbitration shall be divided equally between both parties. Each party shall pay its own expenses and the fees and costs of its attorneys, other professional advisors, experts, and other witnesses.

14. **Severability**. If any provision or portion of this NDA is held invalid, illegal, void or unenforceable by reason of any rule of law, administrative or judicial provision or public policy, all other provisions of this NDA shall nevertheless be construed so as to remain in full force and effect.

15. **No Waiver**. Vendor agrees SVMHS's failure or delay in exercising any right, power or privilege under this NDA will not operate as a waiver, nor will any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any of SVMHS's right, power or privilege under this NDA.

16. **Entire Agreement**. This NDA contains the entire agreement between the parties concerning the subject matter of this NDA. No modifications of this NDA or waiver of the terms and conditions of this NDA will be binding on the parties, unless approved in writing by the parties.

The parties execute this NDA as of the Effective Date first set forth above.

SVMHS	**VENDOR**
Salinas Valley Memorial Healthcare System	
By: _____	By: _____
_____	_____
Pete Delgado, President/CEO	
Date: _____	Date: _____

Appendix C: BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is made and entered into effective _____ ("Effective Date") by and between **Salinas Valley Memorial Healthcare System**, a public health care district organized and operating pursuant to Division 23 of the California Health and Safety Code ("SVMHS"), and ("Business Associate").

RECITALS

A. SVMHS is the owner and operator of Salinas Valley Memorial Hospital, an acute care hospital located at 450 East Romie Lane, Salinas, California 93901, and is a "Covered Entity" as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including but not limited to, Title 45 Code of Federal Regulations ("C.F.R.") Part 160.3.

B. Business Associate provides services to SVMHS pursuant to an arrangement between Business Associate and SVMHS ("Principal Agreement"). Under the Principal Agreement, Business Associate provides certain services to SVMHS ("Services").

C. The parties are entering into this Agreement to assist SVMHS in complying with HIPAA, and to set forth Business Associate's obligations under the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act"), and 45 C.F.R. Parts 160 and 164 Subpart C, Security Standards for the Protection of Electronic Protected Health Information ("Security Rule"), Subpart D ("Breach Notification Rule") and Subpart E, Privacy of Individually Identifiable Health Information ("Privacy Rule") (collectively, the HIPAA Regulations).

D. "Business Associate" shall mean as that term is defined in the Privacy Rule, the Security Rule, and the HITECH Act, including but not limited to, 42 U.S.C. 17938 and 45 C.F.R. 160.103.

E. In connection with the Services provided by Business Associate, SVMHS discloses to Business Associate Protected Health Information ("PHI"). PHI means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such tern under the Privacy Rule, including, but not limited to, 45 C.F.R. 160.103. PHI includes Electronic Protected Health Information ("EPHI") as defined in 45 CFR 160.103, 164.501. For purposes of this Agreement, PHI also includes medical information, as defined in California Civil Code §56.05(g).

F. SVMHS and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to the Principal Agreements in compliance with HIPAA, the HITECH Act, the California Confidentiality of Medical Information Act (Civil Code §§56 et seq.), and all regulations promulgated thereunder, as they may be amended from time to time.

G. Pursuant to California law, which includes the Confidentiality of Medical Information Act and the Health and Safety Code, certain health facilities are required to prevent unlawful or unauthorized access to, or use or disclosure of, a patient's medical information, and to report such unlawful or unauthorized activity.

H. This agreement applies to any PHI Business Associate receives from SVMHS, or creates,

receives or maintains on behalf of SVMHS, under its Principal Agreements with SVMHS.

The parties agree as follows:

ARTICLE I
DEFINITIONS

1.1 Unless otherwise provided in this Agreement, which shall include the Recitals, terms not defined in this Agreement have the meanings assigned to them as set forth in the Privacy and Security Rules.

ARTICLE II
SCOPE OF USE AND DISCLOSURE BY BUSINESS ASSOCIATE OF PROTECTED HEALTH INFORMATION

2.1 Business Associate shall be permitted to access, use and disclose PHI that is disclosed to it by SVMHS as necessary to perform its obligations under the Principal Agreement, provided that such access, use or disclosure would not violate the HIPAA regulations or California law if so accessed, used or disclosed by SVMHS.

2.2 Unless otherwise limited by this Agreement, in addition to any other access, uses and/or disclosures permitted or authorized by this Agreement or required by law, Business Associate may:

2.2.1 Make use of the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of Business Associate;

2.2.2 Disclose the PHI in its possession to a third party for the purpose of Business Associate's proper management and administration or to fulfill any legal responsibilities of Business Associate; provided, however, that the disclosures are required by law or Business Associate has received from the third party written assurances that: (i) the information will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the third party; and (ii) the third party will notify Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached;

2.2.3 Aggregate the PHI with that of other Covered Entities for providing SVMHS with data analyses relating to the health care operations of SVMHS. Business Associate may not disclose the PHI of one Covered Entity to another Covered Entity without the written authorization of the Covered Entity involved; and

2.2.4 De-identify any and all PHI created or received by Business Associate under this Agreement; provided, that the de-identification conforms to the requirements of the Privacy Rule.

ARTICLE III
OBLIGATIONS OF BUSINESS ASSOCIATE UNDER PRIVACY RULES

In connection with its access, use and disclosure of PHI and/or EPHI, Business Associate agrees that it will:

3.1 Access, use or further disclose PHI only as permitted or required by this Agreement or as

required by law.

3.2 Use reasonable and appropriate safeguards, and comply, where applicable, with HIPAA Security Rule with respect to electronic protected health information, to prevent access, use or disclosure of PHI other than as provided for by this Agreement.

3.3 To the extent practicable, mitigate any harmful effect that is known to Business Associate, regarding any access, use or disclosure of PHI by Business Associate in violation of this Agreement.

3.4 Report to SVMHS in writing within ten (10) calendar days of any access, use or disclosure of PHI not provided for by this Agreement of which Business Associate becomes aware.

3.5 Ensure that any Business Associate's subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree in writing to the same restrictions and conditions that apply to Business Associate with respect to such information, including compliance with HIPAA Security Rule with respect to EPHI. Business Associate shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation (45 CFR 164.30(f) and 164.530(e)(1).

3.6 To the extent that Business Associate carries out SVMHS' obligations under the Privacy Rule, comply with the requirements of the Privacy Rule that apply to SVMHS in the performance of such obligations.

3.7 Make available to the US Secretary of Health and Human Services Business Associate's internal practices, books and records relating to the access, use and disclosure of PHI for purposes of determining compliance with Privacy and Security Rules, subject to applicable legal privileges.

3.8 For each Disclosure for which Business Associate is required to keep record within fifteen (15) days of receiving a request from SVMHS, make available the information necessary for SVMHS to make an accounting of access, use and disclosures of PHI about an individual.

3.9 Within ten (10) days of receiving a written request from SVMHS, make available PHI necessary for SVMHS to respond to an individuals' requests for access to PHI about him or her in the event that the PHI in Business Associate's possession constitutes a Designated Record Set.

3.10 Within fifteen (15) days of receiving a written request from SVMHS incorporate any amendments or corrections to the PHI in accordance with the Privacy Rule in the event that the PHI in Business Associate's possession constitutes a Designated Record Set.

3.11 Maintain for a period of six (6) years an accounting of all access, use and disclosures of PHI as required to be maintained under 45 C.F.R. §164.528 of the HIPAA regulations. Such accounting will include the date of access, use and disclosures, the name of the recipient, a description of PHI accessed, used or disclosed and the purpose for such access, use or disclosure.

ARTICLE IV
OBLIGATIONS OF BUSINESS ASSOCIATE UNDER SECURITY RULES

In connection with its retention and transmittal of EPHI, Business Associate agrees that it will:

4.1 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits, as required by the Security Rule.

4.2 Report to SVMHS in writing no later than ten (10) calendar days of any security incident with respect to EPHI of which Business Associate becomes aware, including breaches of unsecured PHI as required by the Data Breach Notification Rule (45 CFR 164.410), and any security incident of which Business Associate becomes aware.

ARTICLE V
REIMBURSEMENT OBLIGATIONS OF BUSINESS ASSOCIATE

5.1 Business Associate acknowledges that SVMHS is responsible for notifying the Individual(s), and in certain circumstances the California Department of Public Health, the Secretary of HHS and the media of any access, use or disclosure of PHI by Business Associate in violation of this Agreement.

5.2 Business Associate shall reimburse SVMHS for all reasonable and actual notification costs SVMHS incurs which arise out of any access, use or disclosure of PHI by Business Associate in violation of this Agreement. Actual costs may include, but are not limited to costs of drafting and mailing notifications, legal costs, the responding to follow up questions from Individual(s), the California Department of Public Health, the Secretary of HHS, and if applicable, any fines or penalties imposed on SVMHS.

ARTICLE VI OBLIGATIONS OF HOSPITAL

SVMHS agrees that it:

6.1 Has included, and will include, in SVMHS' Notice of Privacy Practices required by the Privacy Rule that SVMHS may disclose PHI for Health Care Operations purposes.

6.2 Has obtained, and will obtain, from Individuals consents, authorizations and other permissions necessary or required by laws applicable to SVMHS for Business Associate and SVMHS to fulfill their obligations under the Principal Agreement and this Agreement.

6.3 Will promptly notify Business Associate in writing of any restrictions on the access, use and disclosure of PHI about individuals that SVMHS has agreed to that may affect Business Associate's ability to perform its obligations under the Principal Agreement or this Agreement.

6.4 Will promptly notify Business Associate in writing of any change in, or revocation of, permission by an individual to access, use or disclose PHI, if such change or revocation may affect Business Associate's ability to perform its obligations under the Principal Agreement or this Agreement.

6.5 Will promptly notify individual(s) in writing of any breaches the Business Associate reports to SVMHS, and if required under State or Federal law, the California Department of Public Health, the Secretary of HHS and/or the media.

ARTICLE VII
TERMINATION

7.1 Termination for Breach. SVMHS may terminate this Agreement if SVMHS determines that Business Associate has breached a material term of this Agreement. Alternatively, SVMHS

may choose to provide Business Associate with notice of the existence of an alleged material breach and afford Business Associate an opportunity to cure the alleged material breach. In the event Business Associate fails to cure the breach to the satisfaction of SVMHS, SVMHS may immediately thereafter terminate this Agreement.

7.2 Automatic Termination. This Agreement will automatically terminate upon the termination or expiration of the Principal Agreement.

7.3 Effect of Termination.

7.3.1 Termination of this Agreement will result in termination of the Principal Agreement.

7.3.2 Upon termination of this Agreement or the Principal Agreement, Business Associate will return or destroy all PHI received from SVMHS or created or received by Business Associate on behalf of SVMHS that Business Associate still maintains and retain no copies of such PHI; provided that if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

ARTICLE VIII
GENERAL PROVISIONS

8.1 Amendment. SVMHS may amend this Agreement by providing thirty (30) days prior written notice to Business Associate in such manner as SVMHS determines necessary to maintain compliance with the Privacy Rule and other applicable law. Such amendment shall be binding upon Business Associate at the end of the notice period and shall not require the consent of Business Associate. Upon receipt of the notice, Business Associate may elect to terminate the Principal Agreement as permitted by its terms.

8.2 No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

8.3 Survival. The obligations of Business Associate under Section 7.3.2 of this Agreement shall survive any termination of this Agreement.

8.4 Indemnification. SVMHS and Business Associate shall, to the fullest extent permitted by law, protect, defend, indemnify and hold harmless the other party and its directors, officers and employees from and against any and all losses, costs, claims, penalties, fines, liabilities or legal actions in association with third-party claims from or related to their acts or omissions of its employees, directors, agents, contractors or consultants related to the performance or nonperformance of this Agreement, or in Breach of HIPAA or HITECH.

8.5 Interpretation. Any ambiguity in this Agreement shall be resolved to permit SVMHS to comply with the HIPAA, the HITECH Act, or with California law where California law is more stringent than HIPAA, and the regulations promulgated thereunder, as amended from time to time.

8.6 Inconsistent Provisions. In the event of any inconsistency between this Agreement and the Principal Agreement, this Agreement shall prevail.

The parties hereby executed this Agreement as of the Effective Date first set forth above.

SVMHS	**Business Associate**
Salinas Valley Memorial Healthcare System	
By: _____	By: _____
Date: _____	Date: _____

Audrey Parks
Salinas Valley Memorial Healthcare System
450 E Romie Ln
Salinas, CA 93901

February 11th, 2021

Audrey:

CloudWave is pleased to provide Salinas Valley Memorial Healthcare System (Customer) with this Statement of Work for OpSus Cloud Care Technical Service Desk, powered by GuideIT. CloudWave's mission is to help hospitals achieve *Operational Sustainability* so that your organization can focus on delivering best-in-class Healthcare IT Services to your end users that meet your goals for patient care, financial management, and compliance.

OpSus Cloud Care Technical Service Desk uses state-of-the-art tools and proven ITIL processes, the Technical Service Desk team provides a single point of entry and first-touch support for Tier 1 incidents and service requests. Routing of incidents that can't be resolved during initial contact are handled according to pre-defined and agreed upon escalation procedures. The team is able to address and resolve many issues right away, with an extensive knowledge base that includes documentation of known support issues and resolution information.

The remainder of this Statement of Work describes our services and includes specific pricing and service plans for Salinas Valley Memorial Health System. We look forward to discussing your Information Technology and organizational requirements further and would like to set up a time to present our proposal in person or via web conference so that we may directly address your questions. CloudWave is grateful for the opportunity to earn your business.

Sincerely,

Lori Nepini and Mike Donahue
Regional Sales Team

OpSus Cloud Care – Technical Service Desk
Solution Overview

The technical service desk services ("TSD Services") will feature:

- Single point of entry and first-touch support for Tier 1 incidents and service requests
- Routing of incidents that can't be resolved during initial contact to 2nd and 3rd level support with agreed upon escalation procedures
- 2 channels to reach support directly: phone and chat
- Email and self-service web portal tickets supported by TSD via integration between CloudWave ITSM and Customer ITSM
- Access management, including password resets and support for employee onboarding, transition, and offboarding
- Development, use and maintenance of a knowledge base to document all known support
- Available 24x7x365 with fully trained and proficient agents regardless of time of day
- Use of industry leading tools to support service desk function
- Standard reporting for CSAT, volume by channel and service level by channel
- Transition and on-going training for CloudWave agents
- Provision of remote connectivity support

Commencement Dates for the Services.

- The "TSD Transition Services Commencement Date" is: *TBD*
- The "TSD Services Commencement Date" is: *TBD*

Service Level Effective Dates.
The "TSD Service Level Effective Date" is: 60 days after the TSD Services Commencement Date

Hours of Operation
The hours of operation for the TSD Services (following the TSD Commencement Date) are as follows:

- 24x7x365 ("TSD Hours")

OpSus Cloud Care – Technical Service Desk
Statement of Work

Commencing on the TSD Transition Services Commencement Date and continuing for the remainder of the agreement term, in exchange for Customer's payment of the Fees and Costs set forth in Acceptance and Authorization below, CloudWave will perform the TSD Services for the Supported Applications during the defined TSD Hours by performing its responsibilities in this Statement of Work (or SOW) as set forth below. Customer acknowledges and agrees that the TSD Services may be delivered by CloudWave's subcontractor and that all references to CloudWave herein are deemed to refer to CloudWave and its subcontractor. Capitalized terms used in this SOW and defined in the Solution Overview will have the same meanings in the SOW as the Solution Overview.

1. Transition Services. The period beginning on TSD Transition Services Commencement Date and ending on the TSD Services Commencement Date (the "Transition Period") is Phase 1 for onboarding into the OpSus Cloud Care Technical Service Desk. This transition will move the operational responsibility for the TSD Services from Customer. Throughout the Transition Period, Customer will provide the necessary access to documentation, Customer employees and contractors as needed to plan for and provide the Transition Services. The "Transition Services" consist of the following:

    - Project Initiation Workshop. During the initiation phase of the Transition Services, Customer will participate in a Project Initiation Workshop conducted by the CloudWave. Customer will bring the appropriate stakeholders and resources together to identify, define and clarify the objectives, scope, schedule, resources, risks, issues and assumptions for the Transition Services and will set the foundation and schedule for the Transition Services.

    - Transition Plan. During the Transition Period, CloudWave will work with Customer to develop an initial transition plan. The initial transition plan will be reviewed by each Party, which upon each Party's approval, will be the "Transition Plan." During the Transition Services, the services provider and Customer agree to utilize the Change Control Procedures in the management of material changes to the Transition Plan.

    - Execute the Transition Services Plan. CloudWave will transition the Customer's identified services into an operational support structure as described in the Transition Plan. Each Party agrees to perform its obligations set forth in the Transition Plan.

    - ITSM System Interface. The Customer will collaborate on the development and implementation of an interface between the information technology service management tool (the "ITSM System") used to provide the TSD Service and Customer's ticketing system. Each Party will be responsible for its own expenses associated with their vendor's efforts to develop and implement the interface.

    - Close-out of the Transition Services. During the shutdown stage of the Transition Services, CloudWave will verify steady state operations are in place and request Customer approval to close out the Transition Services.

- Control of the Transition Services. Throughout the Transition Period, CloudWave will coordinate the necessary project meetings, status reports and management of RAID (Risks, Assumptions, Issues and Definitions).

- Duration. The Parties anticipate completing the Transition Services on or before Insert Date for completed Transition Phase

2. Service Desk Services. Beginning on the TSD Services Commencement Date, CloudWave will provide the Service Desk Services described as its responsibility in the table in the Operational Responsibility Matrix attached as Exhibit A (the "Operational Responsibility Matrix") to this SOW as provided in the SLA Agreement (defined below) for the TSD Supported Applications during the TSD Hours. In the event of a failure to achieve a service level under the SLA Agreement, CloudWave will promptly investigate, and report to Customer, the cause of such failure. Customer acknowledges and agrees that the Service Desk Services may be provided remotely, unless otherwise specifically noted.

3. Reports. As part of the TSD Services, CloudWave will provide Customer with the following recurring reports:

Report Name	Distribution Frequency
Incident and Request Management	Weekly, Monthly
Incident and Request Trending	Monthly
Service Level Attainment	Weekly, Monthly

4. Termination Assistance Services. In the event of termination of this SOW and at Customer's request, CloudWave will provide the services that are reasonably necessary to facilitate the transfer of the TSD Services from CloudWave to Customer or a new services provider (the "Termination Assistance Services"). Customer agrees to pay for any requested Termination Assistance Services at CloudWave's commercially reasonable rates. Termination Assistance Services may include, but are not limited to:
   - Assistance in developing a transition of TSD Services plan.
   - TSD Services process documentation knowledge transfer.
   - Training of Customer personnel on the TSD Services.
   - Other information, documentation or services as reasonably requested by Customer.
   - Third party vendor management transition.

   In the event of termination of this SOW by CloudWave for non-payment, CloudWave will provide Customer with a reasonable estimate of CloudWave's fees for the Termination Assistance Services to be provided during each month and Customer will pay CloudWave in advance of providing such services. Customer acknowledges and agrees that, in the case of such a termination, the provision of Termination Assistance Services is contingent upon CloudWave's receipt of payment for such services.

5. Changes. Changes to the TSD Services are subject to the Change Control Procedures defined in Exhibit B.

6. Additional Definitions. In addition to terms defined throughout this document, the following terms will have the meanings provided below:

   "Contact" means any contact requiring attention from Service Desk personnel, including all Service Desk inquiries, reports of incidents and requests for assistance whether made via telephone call, email, automated system, web portal, chat, reporting, or otherwise.

“End User” means an individual authorized by Customer to receive or utilize the TSD Services.

“Incident” means any event which is not part of the standard operation of the Customer’s systems or applications which are supported by CloudWave as part of the Services that causes, or may cause, an interruption to, or reduction in, the quality of service provided by those systems or applications.

“Problem” means the cause of one or more Incidents.

“Service Desk” or "Technical Service Desk" means the personnel that receive and respond to Contacts from End Users and the actual receipt and responses to those Contacts.

Customer Responsibilities

In addition to its responsibilities as set forth in in the Operational Responsibility Matrix, Customer will perform all its specific responsibilities and obligations set forth in this SOW and will reasonably cooperate with CloudWave in timely facilitating the performance of the Services by CloudWave.

1. Customer will:
   - Provide CloudWave with timely access to Customer personnel and systems, cause Customer's other service providers and vendors to reasonably cooperate with CloudWave and make and communicate Customer decisions to CloudWave.
   - Provide CloudWave with information and issue approvals and acceptances or communicate the fact that they are being withheld and the reasons therefor.
   - Provide CloudWave onsite personnel (if any) with a reasonable work environment required by such personnel to perform the TSD Services.
   - Provide access and use any third-party hardware or software licensed by Customer in order for CloudWave to provide the TSD Services.
   - Provide CloudWave with the right to access and use such software and hardware at no expense to CloudWave. Unless otherwise specifically provided in this SOW.
   - Be responsible for backing up data on its systems and for disaster recovery and business continuity. Except to the extent that Customer has contracted for specific assets for OpSus Backup, OpSus Live, and/or OpSus Recover.
   - Ensure Customer's approvals, consents and agreements are in writing and signed by an authorized Customer representative.

2. The CloudWave Executive may agree in advance in writing that, as to certain specific matters, oral approval, consent, or agreement will be sufficient. To the extent CloudWave is required under this SOW, or applicable policies and procedures, to work with Customer's vendors or other third parties in the performance of this SOW, Customer will:
   - Ensure the necessary cooperation of the Third Parties.
   - Use reasonable efforts to keep CloudWave informed about aspects of Customer's business that could reasonably be expected to have a material effect on the demand for, or provision of, the Services.
   - Provide to CloudWave information regarding Customer's business volumes and plans that CloudWave reasonably requests in order to assist CloudWave in performing resource and capacity planning for the Services.

Acceptance and Authorization

OpSus Cloud Care Technical Service Desk Pricing	
Description:	
Transition Fees (One Time)	$80,386.00
Monthly Cost (Months 4-48) (adjusted pursuant to Terms and Conditions)	$20,515.00

OpSus Cloud Care Technical Service Desk – 4 Year Contract (adjusted pursuant to Terms and Conditions)	$1,003,541.00

Terms and Conditions

- Prices quoted are in US Dollars and are valid until March 31st, 2021 unless modified in writing by CloudWave before your order is accepted
- "SLA Agreement" means: Exhibit D to this SOW
- Any applicable sales & use taxes are not included in the above fees and are the Customer's responsibility
- Payment Schedule:
  - For full details, see Exhibit C: "Charges and Financial Responsibility"
- Changes to the equipment and services proposed may result in changes to this SOW and pricing

By signing below, I represent that I am a duly authorized individual or officer of Customer.

Accepted: Salinas Valley Memorial Healthcare System

_____		_____
Customer Signature		PO #
_____	_____	_____
Print Name	Title	Date

_____		
CloudWave Signature		
_____	_____	_____
Print Name	Title	Date

If you are tax exempt, please fax your Tax Exemption Certificate along with this signed page to: 800-829-5457.

EXHIBIT A
Operational Responsibility Matrix

TSD Services	CloudWave	Salinas
Service Desk		
1. Adhere to ITIL-based Service Management processes for the operation of the Service Desk.	X	
2. Develop and maintain Service Desk procedures.	X	
3. Approve Service Desk procedures that apply to delivery of TSD Services.		X
4. Review Service Desk procedures with Customer and advise appropriate Customer personnel on relevant aspects of the procedures.	X	
5. Maintain the Service Desk operation to be available during the TSD Hours.	X	
Single Point of Contact		
1. Provide a single point of communication on the Service Desk for each Contact. Contacts may be submitted by:	X	
a) Telephone.	X	
b) Chat.	X	
c) Web Portal		X
d) Email		X
2. Publish the telephone number and chat link for End Users to contact the Service Desk.		X
3. Manage Contacts with End Users via telephone, email, web portal, chat and tickets received through the integration with the Customer's ITSM system.	X	
4. Escalate all non-resolvable Contacts that require Customer support into CloudWave's ITSM system or Customer's ITSM system, as applicable.	X	
Ticket-Tracking System		
1. Document, publish and maintain Service Desk procedures.	X	
2. Educate and encourage all End Users to contact the Service Desk with all requests for service.		X
3. Provide a ticket-tracking system to expedite management of Contacts.	X	
4. Escalate all non-resolvable Contacts into the Customer's ITSM system	X	
5. Maintain and support CloudWave's end of the interface with the ITSM System.	X	
6. Maintain and support Customer's end of the interface with the ITSM System.		X
7. Publish a customer satisfaction survey upon ticket closure and provide data to CloudWave upon request.		X
8. Review customer satisfaction surveys on a monthly basis.	X	
Level 1 Support		
1. Utilize ticket-tracking system to expedite management of Contacts.	X	
2. Open tickets with respect to Contacts and log and assign priority of tickets.	X	
3. Query the End User for all relevant information concerning the Contact, including name, location/department, phone number, impact and description of request or Incident.	X	

TSD Services	CloudWave	Salinas
4. Perform Incident and Contact management in accordance with approved handling requirements.	X	
5. Maintain appropriate Level 2 Support and Level 3 Support contact information for personnel to whom Incidents and Contacts will be assigned.	X	
6. Route tickets regarding Incidents and Contacts to appropriate Customer Personnel, CloudWave or Third-Party Level 2 Support and/or Level 3 Support, as appropriate, for resolution.	X	
7. Provide status and updates on tickets at End User request or according to approved ticket handling and/or Incident escalation procedures.	X	
8. Re-open ticket if End User indicates that the ticket regarding a Contact was not resolved.	X	

Problem, Incident and Request Management	CloudWave	Salinas
Problem Management		
1. Develop and maintain an ITIL-based Problem management process.	X	
2. Review ITIL-based Problem management process with Customer and advise appropriate Customer personnel on relevant aspects of the process.	X	
3. Implement the ITIL-based Problem management process.	X	
• For Services within CloudWave's scope, determine and resolve Problems that cause Critical Incidents and Incidents that cause a missed Service Level, in each case through a written root cause analysis.	X	
• Provide access to and cause End Users to cooperate with reasonable requests from CloudWave in determining and resolving Problems.		X
• Document workarounds or knowledge management articles with solutions designed to reduce Incidents.	X	
• Approve workarounds or knowledge management articles with solutions designed to reduce Incidents.		X
• Provide access to and cause End Users to cooperate with reasonable requests from CloudWave in creating and documenting workarounds and solutions designed to reduce Incidents.		X
• Maintain a repository of solutions and workarounds to Problems and place solutions and workarounds into knowledge database or within the ITSM System.	X	
Incident Management		
1. Develop and maintain the ITIL-based Incident management process.	X	
2. Review ITIL-based Incident management process with Customer and advise appropriate Customer personnel on relevant aspects of the process.	X	
3. Implement the ITIL-based Incident management process as follows:	X	
• Verify Incident reports contain accurate information and are routed correctly.	X	

Problem, Incident and Request Management	CloudWave	Salinas
• Verify the process is flexible and is designed to facilitate coordination across functions; sites; End Users; and other Third Parties providing services to Customer.	X	
• Establish end-to-end responsibility and ownership of each Incident.	X	
• Clearly define and develop different levels of support with specific identification of roles, responsibilities and skills required for each level of Incident.	X	
• Work with Customer to develop and approve knowledge-based articles to commonly recurring Incidents.	X	
• Assist CloudWave in the development of knowledge-based articles as developed and documented.		X
4. Track and manage Incidents as follows:	X	
• Categorize and document the relative importance of each Incident.	X	
• Employ procedures for proactive monitoring, logging, tracking, escalation, review, and reporting (historical and predictive) for Incidents.	X	
• Indicate clear accountability for Incidents.	X	
• Coordinate Incident tracking efforts and notification to End Users through the Service Desk; maintain regular communications until Incident resolution.	X	
Request Management		
1. Develop and maintain an ITIL-based request management process.	X	
2. Review ITIL-based request management process with Customer and advise appropriate Customer personnel on relevant aspects of the process.	X	
3. Implement the ITIL-based request management process as follows:	X	
• Receive proposed requests from Customer and End Users. At a minimum, each request will contain the following:	X	
o A description of the request.		X
o The purpose and justification for the request.		X
4. Route tickets for Contacts that are requests to the appropriate Third Party or other resolver group for appropriate action.	X	

Continual Service Improvement	CloudWave	Salinas
Continual Service Improvement		
1. Develop and maintain an ITIL-based Continual Service Improvement (“CSI”) Program.	X	
2. Review ITIL-based CSI process with Customer and advise appropriate Customer personnel on relevant aspects of the process.	X	
3. Implement the ITIL-based CSI process.	X	
• Maintain a CSI registry to track all CSI initiatives.	X	

Continual Service Improvement	CloudWave	Salinas
• Implement Knowledge Article template for the Service Desk's use and maintain articles to ensure they are kept up to date.	X	
• Analyze tickets no less than monthly to identify and report Incident and Request trends to the Customer.	X	
• Implement recurring operational review meetings with designated Customer's support teams to review tickets for improvement opportunities.	X	
• Cause Customer's support teams to participate in the operational review meetings.		X
• Provide CloudWave with documentation as requested to create Knowledge Articles and provide training to the Service Desk personnel.		X
• As identified, provide recommendations for operational improvements.	X	
• Approve operational improvement recommendations as needed.		X

EXHIBIT B
Change Control Procedures

The Parties shall use the following Change Control Procedures to implement Changes. "Changes" are defined as any:

- Changes to the hardware and software used by CloudWave to provide the Services
- Changes to the scope of Services, including any changes to the Customer's obligations under this SOW
- Changes to the provisions of this SOW, including changes to the Charges.

Changes shall be implemented only by mutual written agreement of the parties through these Change Control Procedures. All requests for Changes shall include a reasonably detailed description of the requested Change together with the basis for such Change. All requests for Changes by Customer shall be communicated in writing through the Customer's designated representative or his or her authorized designee. CloudWave shall have no obligation to implement Changes requested by other Customer personnel. All requests for Changes by the services provider shall be communicated in writing to Customer through the designated representative.

Promptly after any approval of a Change by CloudWave and Customer's designated representatives, the parties shall execute a change order ("Change Order"), the form of which shall be mutually agreed by the parties, to incorporate the Change and jointly communicate their requirements to the project teams as appropriate. No Change Order shall be valid unless

- It is executed by both parties
- The Change Order specifically refers to the SOW
- The Change Order expressly states any and all Changes to the fees payable by Customer and any schedules or exhibits to this SOW.

Within ten business days after CloudWave receives a request from Customer for a Change, CloudWave shall prepare and provide to Customer a written response summarizing the impact, if any, of the proposed Change on

- any applicable schedule for performing the Services, including but not limited to Customer's obligations under this SOW
- The resources required to perform services resulting from the proposed Change
- The additional Charges, if any, for the proposed Change to the services.

If Changes are initiated by CloudWave, CloudWave will provide to Customer a written proposal summarizing the effect, if any, of the proposed Change on:

- Any applicable schedule for performing the Services, including but not limited to Customer's obligations under this SOW.
- The resources required to perform Services resulting from the proposed Change.
- The additional Charges, if any, for the proposed Change to the Services.

Within ten business days, or other time period as the Parties may agree in writing, after receiving such information Customer shall approve or reject CloudWave response or withdraw the request for such

Change as applicable. Customer’s failure to approve or reject CloudWave's response or withdraw the request within the applicable time period shall be deemed a rejection of CloudWave's response, and the Change shall not be implemented by CloudWave.

EXHIBIT C
Charges and Financial Responsibility

1) Charges

a) Transition Services Fee. On or about the execution of this SOW by both Parties, CloudWave will deliver an invoice to Customer in the amount of the Transition Fee set forth in Authorization and Acceptance.

b) Monthly Cost. Commencing on or about the TSD Services Commencement Date occurs and or about the first of each month thereafter for the remainder of the term of the SOW Term, CloudWave will invoice Customer for the applicable Monthly Cost set forth In Authorization and Acceptance TSD Services to be provided during that month.

c) IT Resource Baselines. The Monthly Cost includes up to the following maximum number of Contacts per month (collectively, the "IT Resource Baselines"):

(a) 1,900 Contacts via phone, web portal and email ("PWE Contact Baseline"); and

(b) 200 Contacts by chat ("Chat Contact Baseline").

ii) In any month in which the number of phone, web portal and email Contacts exceeds the PWE Contact Baseline, CloudWave will invoice Customer in the following month for an additional amount equal to $7.38 for each such Contact in excess of the PWE Contact Baseline; and

iii) In any month in which the number of chat Contacts exceeds Chat Contact Baseline, CloudWave will invoice Customer in the following month for an additional amount equal to $5.54 for each such Contact in excess of the Chat Contact Baseline.

d) Cost of Living Adjustment. The rates for the Fees and Costs in this SOW will be adjusted, effective on the applicable anniversary of TSD Transition Services Commencement Date, for the increase, if any, in the cost of living by multiplying the rates for the Fees and Costs in effect immediately prior to such anniversary by the following factor (if the Current ECI is greater than the Prior ECI):

i) Current ECI/Prior ECI

ii) Where: “ECI” means the Employment Cost Index, Total Compensation, Not Seasonally Adjusted, Private Industry for Professional Specialty and Technical Occupations published by the Bureau of Labor Statistics of the United States Department of Labor or, if such index ceases to be published, a comparable index published by the United States Department of Labor or another reputable source agreed to by the parties.

iii) “Current ECI” means the ECI most recently published at the time of the applicable anniversary.

iv) “Prior ECI” means the ECI most recently published prior to (i) with respect to the first anniversary, the TSD Transition Services Commencement Date and (ii) with respect to all subsequent anniversaries, the immediately preceding anniversary on which an adjustment was made or, if no prior adjustment has been made, the TSD Transition Services Commencement Date.

e) IT Resource Baseline Adjustment. During the SOW Term, CloudWave will record the actual number of telephone, web portal and email Contacts and chat Contacts for each month. Based upon the data collected, the IT Resource Baselines will be evaluated for change as follows:

2) Twice annually during the SOW Term, the Parties will meet to determine whether each of the Contacts baselines should be adjusted to the average number of its corresponding Contacts during the prior 6 months with an agreed adjustment in the Monthly Cost.

3) During the SOW Term, in the event Customer incurs a significant event with respect to its business operations that could reasonably be expected to impact the IT Resource Baselines or actual monthly Contacts by more than 20%.

i) Upon the occurrence of any of the events described above, the Parties will work through the Change Control Procedures to document any agreed upon changes to the Contacts Baselines, the Monthly Cost, and any other provisions. The Parties will execute an amendment to this SOW to reflect all such agreed adjustments.

Additional terms.

1. Any applicable sales & use taxes are not included in the above fees and are the customer's responsibility
2. Payment Schedule:
3. Transition Fees will be invoiced upon full execution of this SOW.
    a. Subsequent payments for OpSus Cloud Care – Technical Service Desk monthly services are billed in advance on or about the first of each month thereafter for the remainder of the contact.
    b. Initial term will be for a period of 48 months from full execution of this SOW.
    c. At the end of the initial term and for each year thereafter, the term will automatically renew for successive twelve (12) month periods unless either party gives the other party written notice at least ninety (90) days prior to the expiration of the then current term that such party does not want the agreement to be renewed.
    d. Travel and living expenses are not included in the above and will be billed at actual cost.
4. Standard payment terms: Net 45 from date of invoice

EXHIBIT D
SLA Agreement

1. Service Levels and Service Level Targets. The Service Levels (or "SLAs") and associated targets for each of the Service Levels (the "SLA Targets") for the TSD Services are described in the table below. All Service Levels will be effective on the TSD Service Level Effective Date. Each Service Level calculation will be rounded to the smallest place value included in the applicable Service Level. Both Parties acknowledge that, as of the SOW Effective Date, little reliable baseline data exists for the Service Levels and that the Parties will work together to address any process, personnel, hardware, or technology issues affecting CloudWave's ability to meet the SLA Targets.

2. Service Level Limitations. Service Levels are intended to provide an objective measure of service performance but are not without their limitations and bias. For example, performance metrics for a Service Level that are based on a percentage are especially sensitive to variations in the denominator. A small denominator to begin with can yield major swings in the overall performance indicator with only minor unit changes in the numerator. Likewise, as CloudWave works to improve the overall quality of the TSD Services, one result may be a decrease in the overall number of events that are counted in a particular metric. The potential unintended consequence of these service improvement efforts is the appearance of a decline in the service metric that are calculated as a percentage. As the overall number of counted events used in the denominator decline, the impact of an exception in the numerator increases giving the appearance of an overall service decline. It is CloudWave's intent to work with Customer to develop and report performance metrics for each of the Service Levels in a manner that objectively reports service performance and encourages ongoing service improvement.

3. Reporting. Commencing with the TSD Service Level Effective Date, CloudWave will provide Customer with soft copy reports on CloudWave's performance against the applicable Service Levels on a monthly basis, no later than the 15th calendar day after the end of each month. Upon Customer request, available supporting data for any Service Level report will be provided to Customer.

4. Failure to Meet SLA Targets. In the event CloudWave fails to meet any particular SLA Target (the "Service Level Default"), and the cause of such Service Level Default is not excused pursuant to Section 5 below, CloudWave will provide Customer with a credit ("Service Level Credit") on CloudWave's next monthly invoice in an amount equal to two percent of the Monthly Cost for the month in which the Service Level Default occurred. Service Level Credits are subject to the following:

   4.1 If more than one Service Level Default has occurred in a single month, the sum of the corresponding Service Level Credits shall be provided to Customer.

   4.2 In no event shall the amount of Service Level Credits credited to Customer with respect to all Service Level Defaults occurring in a single month exceed, in total, four percent of the Monthly Cost for the month in which the Service Level Defaults occurred.

   4.3 With respect to a Service Level Default involving the End User Customer Satisfaction Survey (SLA No. 4), no Service Level Credit will be provided.

5. Excused Performance. CloudWave will not be responsible for its failure to meet any SLA Targets to the extent its performance of the TSD Services is adversely affected by (i) Customer's failure to perform its obligations under the agreement or this SOW; (ii) the wrongful acts or omissions of Customer or its third party vendors; (iii) the failure of any of Customer employees to adequately perform their tasks related to the TSD Services; (iv) unreasonable, untimely, incomplete or inaccurate information from Customer; (v) Customer's failure to make available information, materials, software, hardware, equipment, third party services or personnel in the manner required by the agreement or this SOW; (vi) the failure of equipment or software or in a manner that is not CloudWave's fault; (vii) the applicable provisions of the agreement, or (viii) other reasons outside of CloudWave's control.

6. Classifications of Service Levels. CloudWave will classify the Severity Level of each Incident using the table and definitions below. For any given Incident CloudWave and Customer may mutually agree to escalate in priority as the business may require.

Priority Matrix		Impact		
		Major	Moderate	Minor
Urgency	High	Critical	High	Medium
	Medium	High	Medium	Low
	Low	Medium	Low	Low

Impact	
Major	• An entire location or site is down for all Customer employees and they are not able to perform their work. • The Incident if not resolved quickly will result in lost revenue for Customer. • The Incident requires notification to Senior Leaders (C-suite).
Moderate	• A significant number, but not all (i.e. a Business Unit or Department), Customer employees are unable to work due to the Incident. • There is currently no workaround or corrective action that is readily available to correct the Incident. • The Incident requires notification to Business Unit or Department Owner.
Minor	• A single, or minimum, number of Customer employees are impacted by an outage or slow-down of the Incident. • Only a selected amount of impact to Customer's employees and a solution is known or can be readily implemented. • No damage to the reputation of the Customer's business, the business unit, or the Customer is likely to be noticed.

Urgency	
High	• The damage caused by the Incident increases rapidly. • No workaround is available, or the Incident cannot be immediately rectified. • Several End Users with VIP status are affected.
Medium	• The damage caused by the Incident increases considerably over time. • A workaround may be implemented or known but has not been tested. • A single End User with VIP status is affected.
Low	• The damage caused by the Incident only marginally increases over time. • A workaround is available but has not been implemented for the Incident. • Default for all non-VIP End Users, standard entry point into ITSM.

Attachment 1 to Exhibit D
Service Level Table

SLA No.	Name of SLA	Description	Hours of Operation	Data Capture	SLA Target	Exclusions	Calculation
1	Average Speed to Answer	The time within which a telephone call placed to the Service Desk by an End User (each, a "Call") is answered (the "Speed to Answer"). The duration is measured from the time that the Call enters the hold queue until the Call is answered by an IT Service Desk representative	TSD Hours	CloudWave PBX System	Speed to Answer Rate not more than 45 seconds for 85.0% of Calls received in a month	• Calls where the End User selects the option to leave a voicemail message. • Abandoned Calls (as defined below). • Calls where the End User selects the option for a call back. • Calls related to Customer system/application outages not within the control of CloudWave.	Speed to Answer Rate = (number of Calls with a 45 second or less Speed to Answer in a month / total number of Calls in that month * 100%
2	Abandon Rate	The percentage of Calls during a month where the caller stayed on the line for more than 30 seconds from the time the call enters the hold queue, then abandons the call (each, a "Abandoned Call") as a percentage of the Calls received by the Service Desk during the same month.	TSD Hours	CloudWave PBX System	Abandon Rate not to exceed 7.0%	• Calls answered by a Service Desk representative. • Calls not answered due to the End User hanging up or disconnecting the telephone call 30 seconds or less after entering the system hold queue. • All telephone calls made to the Service Desk where the End User leaves a voicemail. • Calls where the End Users selects the option for a call back. • Customer system/application outages not within the control of CloudWave.	Abandon Rate = (# of Abandoned Calls / Total # of Calls) * 100%

SLA No.	Name of SLA	Description	Hours of Operation	Data Capture	SLA Target	Exclusions	Calculation
3	First Contact Resolution	The percentage of Eligible First Contacts during a month that are resolved by a Service Desk representative responding during the first telephone call to the Service Desk or by the first response to an email, web portal, or chat conversation by a Service Desk representative, as the case may be (the "First Response"). "Eligible First Contact" means a Contact via telephone call, email, web portal or chat reporting an Incident for which a knowledge base article documenting the process for resolution of the Incident has been agreed upon and documented.	TSD Hours	CloudWave ITSM System	Not less than 85.0% of Eligible First Contacts are resolved by the First Response.	• Contacts involving Incidents that should be resolved by an organization other than the Service Desk. • Contacts deemed unresolvable by the Service Desk because a Ticket has already been opened for the Incident or because the Incident is among those included on a predefined list of unresolvable or in-action items. • Incidents for which a knowledge base article documenting the process for First Contact Resolution does not exist. • Customer system/application outages not within the control of CloudWave.	First Contact Resolution = (number of Eligible First Contacts during the period resolved by the First Response / total number of Eligible First Contacts during the period) * 100%.

SLA No.	Name of SLA	Description	Hours of Operation	Data Capture	SLA Target	Exclusions	Calculation
4	End User Customer Satisfaction Survey	Provide quantifiable feedback from End Users to measure CloudWave's performance against End User expectations and assist in identifying opportunities for improvement in service.	7x24x365	Customer's ITSM System	Average score for all returned surveys in the aggregate of three point zero (3.0) or greater on a scale ranging from one to four (1 to 4), with a score of four (4.0) being the highest level of satisfaction. The following are sample survey questions: • How satisfied are you with the way this request for service was handled from start to finish? • How satisfied are you with the way your request was handled at the Service Desk? • How satisfied are you with the way your request was handled by other IT personnel (if applicable)? • How satisfied are you with the overall communication throughout the process of resolving your incident or request?	• Surveys where both parties agree that the survey was not related to CloudWave services • Clear and obvious surveys where the submitter made a mistake when completing the survey	For each satisfaction question, the following scale will apply: • Very Unsatisfied (1) • Unsatisfied (2) • Satisfied (3) • Very Satisfied (4) Every closed Incident Ticket or Service Request Ticket will generate an automated email that will present the End User with a web-based form to report End User's satisfaction with the response or resolution for the particular Incident or requested Service. Changes to the frequency with which End Users will be surveyed will be agreed-upon between CloudWave and Customer. Average customer satisfaction = (total of scores received on all surveys / total number of surveys). Non-returned surveys will be excluded from the scoring.

Board Paper: Finance Committee

Agenda Item:	**Consider Recommendation for Board Approval of Project Budget Augmentation and Award Construction Contract to DMC Commercial, Inc. for the Lab Analyzers Replacement Project**
Executive Sponsor:	Clement Miller, Chief Clinical Officer Arnulfo Delgado, Director of Laboratory/Pathology Services
Date:	March 4, 2020

Executive Summary:

Salinas Valley Memorial Hospital's main laboratory is located on the first level of the hospital and provides various specimen collection, transport and testing. SVMHS is pursuing equipment replacement activities within the main laboratory to replace two Siemens chemistry analyzers that are at their end of useful life with two of Siemens' Atellica Solution packaged units which feature chemistry analyzers that are automated and scalable. In addition to the equipment replacement, renovations include code required upgrades to the existing heating, ventilation and air conditioning system, upgrades to the high purity water system, removal of barriers to accessibility and optimization of workflow.

Facilities Management approached the Board and received approval in October 2020 for capital funding to complete design, permitting and equipment procurement for the SVMH Lab Analyzer Replacement in the total estimated amount of $1,900,000. Facilities Management is now returning to the Board to request comprehensive funding approval in the total estimated amount of $2,220,000 and recommend award construction contract to DMC Commercial, Inc. in the amount of $875,000.

Background/Situation/Rationale:

In late 2015, two Siemens Vista 500 chemistry analyzers were installed at the core of the department to accelerate sample analysis and improve workflow. Currently, the laboratory has been experiencing continuous failure to both instruments and in some cases simultaneous failure which is crippling to the department's workflow, clinical mission and support of the main hospital. The Laboratory Department has received approval under a sole source justification to procure two of Siemens' Atellica Solution packaged units which include a Sample Handler, CH930 Analyzer, IM Analyzer and Decapper to replace the obsolete Vista 500 units.

To facilitate the installation of the new Siemens Attelica packaged units, upgrades to existing infrastructure are required including; (A) new electrical panel and distribution, (B) modification to the existing heating, ventilation and air conditioning system and installation of a supplementary cooling unit to bridle additional heat loads, (C) upgrades to the existing high purity water system to produce the specified reagent water requirements, (D) removal of barriers to accessibility and (E) optimization to workflow in an already congested area. Salinas Valley Memorial Hospital has acquired two (2) competitive bids for construction services with DMC Commercial, Inc. submitting the lowest responsive and responsible bid.

Timeline/Review Process to Date:

March 2021 – Anticipated approvals from Finance Committee and Board of Directors for construction services.
April 2021 – Secure building permit with the Authority Having Jurisdiction
May 2021 – Commence with construction activities.
December 2021 – Project substantial completion.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

Fiscal year capital budgeting:
Fiscal year 2021 approved capital budget allocated funding to complete design, permitting, equipment procurement and administration for the SVMH Lab Analyzer Replacement Project in the amount of $1,487,512. Additional funding in fiscal year 2021 and 2022 is being requested to complete construction, implementation and administration required for the Lab Analyzers Replacement Project in the total estimated amount of $2,220,000. The budget augmentation of $320,000 is required to cover the following items not contemplated in the original scope; (A) hazardous material abatement, (B) new electrical infrastructure, (C) labor and material price escalation and (D) extended general conditions due to equipment validation period.

Fiscal Year 2021 Approved Capital	**$1,487,512**
October 2020 Board Approved Capital Project Costs	**$1,900,000** (forcast was $1.5m in FY21, $400k in FY22)
Fiscal Year 2021 Estimated Spend	**$1,658,150**
Fiscal Year 2022 Estimated Spend	**$ 561,850**
Total Project Spend	**$2,220,000**

Project Spend to Date:
Total project spend to date is $121,720 which procured planning, design and administration.

Recommendation:

Consider recommendation to Board of Directors (i) to approve the total estimated project costs for the SVMH Lab Analyzers Replacement Project in the amount of $2,220,000 and (ii) award construction contract to DMC Commercial, Inc. for the SVMH Lab Analyzers Replacement Project in the amount of $875,000.

Attachments:

(1) Total project estimated costs prepared March 4, 2021 at procurement phase.
(2) Proof of publication for the advertisement for bids.
(3) Bid results for construction services from March 4, 2021.

Salinas Valley Memorial Healthcare System (10348)

Project Cost Summary: Lab Analyzer Replacement - C.I.P. 01.1250.3595
Architect: Smith Karng Architecture
Budget Generated at Procurement Phase
Budget Date: *3/4/2021*
Print Date: *3/4/2021*

BOGARD CONSTRUCTION, INC. Since 1947

Budget Summary

			A	B	A + B	Cash Flow	
Line Item		Description	Original Budget	Budget Changes	Current Budget	FY21 Projection	FY22 Projection
	1	**Construction**					
0100		Construction Contract	$555,000	$320,000	$875,000	$612,500	$262,500
0102		Owner Construction Contingency	$50,000	$0	$50,000	0	$50,000
	2	**Design**					
0200		Professional Fees - Fixed	$160,000	$0	$160,000	$144,000	$16,000
	3	**Inspections and Consultation**					
0300		Inspector of Record	$25,000	$0	$25,000	$17,500	$7,500
0301		Special Inspections	$10,000	$0	$10,000	$8,000	$2,000
0303		Environmental / Abatement Testing	$4,000	$0	$4,000	$4,000	$0
	4	**AHJ Fees**					
0400		OSHPD	$21,000	$0	$21,000	$19,950	$1,050
	5	**Soft Costs**					
0502		Construction Management	$270,000	$0	$270,000	162,000	108,000
0503		Abatement	$10,000	$0	$10,000	10,000.00	$0.00
	7	**FF&E**					
0701		Other Medical Equipment - *Siemens Atellica Solution*	$656,000	$0	$656,000	$623,200	$32,800
0702		Non-Medical Equipment - *Quality Water Enterprises*	$30,000	$0	$30,000	$30,000	$0
0703		Data and Phone Equipment	$20,000	$0	$20,000	$18,000	$2,000
0704		Furnishings	$9,000	$0	$9,000	$9,000	$0
	99	**Contingency**					
9900		Contingency	$80,000	$0	$80,000	0	$80,000
Totals			**$1,900,000**	**$320,000**	**$2,220,000**	**$1,658,150**	**$561,850**

Proof of Publication

(2015.5 C.C.P.)

Salinas Newspapers, Inc.
1093 S Main ST STE 101
Salinas CA 93901
831-424-2222/Fax: 831-754-7156

State Of California ss:
County of Monterey

SALINAS VALLEY MEMORIAL/LEGALS
450 E ROMIE LN

SALINAS CA 93901

I am a citizen of the United States and a resident of the County aforesaid; I am over the age of eighteen years, and not a party to or interested in the above-entitled matter. I hereby certify that the attached advertisement appeared in said newspaper on the following dates:

Newspaper: **The Salinas Californian**

02/17/2021

I acknowledge that I am a principal clerk of the printer of said paper, which is published in the City of Salinas, County of Monterey, State of California. The Salinas Californian is printed and published daily, except Sunday and has been adjudged a newspaper of general circulation by the Superior Court of the County of Monterey, State of California. El Sol is printed and published weekly on Saturday and has been adjudged a newspaper of general circulation by the Superior Court of Monterey, State of California.

I certify under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct. Executed on this
2nd of March 2021.

Declarant

Ad#:0004600209
P O :
Net Order Cost: 820.75

This is not an invoice

# of Affidavits: 1

Sealed proposals will be received by Salinas Valley Memorial Healthcare System ("SVMHS") located in Salinas, California, for the furnishing of all labor, materials, equipment and services to SVMHS necessary for and incidental to the construction of:

SVMH Lab Analyzers Replacement

General Description. Salinas Valley Memorial Hospital's main laboratory is located on the first level of the hospital and provides various specimen collection, transport and testing. SVMHS is pursuing equipment replacement activities within the main laboratory to replace two Siemens chemistry analyzers that are at their end of useful life with two of Siemens' Atellica Solution packaged units which feature chemistry analyzers that are automated and scalable. In addition to the equipment replacement, renovations include code required upgrades to the existing heating, venting and air conditioning system, upgrades to the high purity water system, removal of barriers to accessibility, and optimization of workflow.

Bids. Sealed bids will be received by SVMHS at the Construction Office located at 535 E Romie Lane, Suite 6, Salinas, California, until 2:00 p.m. on March 4, 2021 at which time all bids will be publicly opened. Bids will be referred to a subsequent SVMHS Board of Directors meeting for appropriate action. All Bid Proposals shall be submitted on forms furnished by SVMHS. Bid Proposals must conform with, and be responsive to, the Bid and Contract Documents, copies of which may be obtained from SVMHS as indicated below. Only Bid Proposals submitted to SVMHS prior to the date and time set forth above for the public opening and reading of Bid Proposals shall be considered. Note: Bids submitted orally or by telephone, electronic transmission (email) or facsimile will be considered invalid and will not be accepted. Each Bid Proposal shall be accompanied by:

1. Bid Letter (including acknowledgement of receipt of Addenda)
2. List of Subcontractors
3. Statement of Bidder's Qualifications
4. Compliance with Immigration Reform and Control Act of 1986
5. Bidder's Guaranty: Bidder's Bond or Irrevocable Standby Letter of Credit
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Dated: February 12, 2021

Salinas Valley Memorial Healthcare System
A Local Health Care District

Feb 17, 2021 (4600209)

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Dated: February 12, 2021

Salinas Valley Memorial Healthcare System
A Local Health Care District

Feb 17, 2021 (4600209)

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
PROJECT: Lab Analyzers Replacement
PROJECT CIP: 01.1250.3595
PROJECT LOCATION: 450 E Romie Lane, Salinas CA 93901

BID RESULT SUMMARY

Single Prime Bid Package

DATE: March 4, 2021
BID TIME: 2:00PM
BID OPENING: 535 E Romie (SUITE 6), Salinas, CA 93901

	CONTRACTOR	CONTACT	EMAIL	PHONE	BASE BID + ALLOWANCES	COMMENTS
1	****DMC Commercial Inc. 194 Skypark Drive Monterey, CA 93940**	**Dan McAweeney**	**dan@dmcmp.com**	**831.656-1600**	**$875,000**	
2	FTG Builders 1735 N. 1st Street San Jose CA 95112	Rodney Terra	rodney@ftgbuilders.com	669.231.0010	$964,795	
	****Apparent Low Bidder**					
	SVMHS reserves the right to reject any or all bids and to waive any informalities in the bidding, or in any bid received.					

	Documents Accompanying Bid	Contractor 1	Contractor 2
a	**Bid Letter**	✔	✔
b	**Addenda**	✔	✔
c	**List of Subcontractors**	✔	✔
d	**Disqualification Questionnaire**	✔	✔
e	**Insurance Requirements**	✔	✔
f	**Non-Collusion Affidavit**	✔	✔
g	**Bid Bond (Security)**	✔	✔
h	**Alternate Bid Item Proposal**	✘	✘

Board Paper: Finance Committee

Agenda Item:	**Consider Recommendation for Board Approval of Project Budget and Award of Construction Contracts to Val's Plumbing and Heating, Inc. and Central Electric for the SVMH Heart Center Air Handler Unit Upgrade Project**
Executive Sponsor:	Pete Delgado, Chief Executive Officer Earl Strotman, Sr. Administrative Director of Plant Operations and Construction
Date:	March 4, 2021

Executive Summary:

SVMHS is pursuing activities to install and commission a new rooftop air handler unit that will specifically feed the heating, ventilation and air conditioning needs of the Heart Center nursing unit located at the first floor of the main hospital. Approved plans and permitting have been secured by the Office of Statewide Health Planning and Development.

Facilities Management is approaching the Board to request approval for comprehensive capital funding to complete construction, implementation and administration required for the SVMH Heart Center Air Handler Unit Upgrade Project. The total estimated cost for the project is $1,700,000.

Background/Situation/Rationale:

Salinas Valley Memorial Hospital's Heart Center department located on the first level is currently served by an existing Trane air handler unit located at the basement level Cislini Plaza. In addition to the Heart Center, the existing Trane unit provides heating, ventilation and air conditioning to areas at the basement level including Cardiology, Nuclear Medicine, Endoscopy and administrative space. With the age and size of the Trane air handler, the unit is running at full capacity and cannot keep up with the current demands of the various areas to maintain appropriate air balances and pressurization. With the installation of a new Temtrol rooftop air handler to service the Heart Center department, the existing Trane air handler can be throttled back to extend the life of the unit until funding becomes available to upgrade.

Notable scope for the installation of the new rooftop air handler unit will include; (A) new electrical and hydronic piping distribution, (B) structural anchorage and service platform, (C) variable frequency drives and integrated controls to the hospital's building management system (D) roofing patch back and (E) testing and air balancing at the affected areas.

Salinas Valley Memorial Healthcare System publicly advertised a request for contractor bids for a multi-prime contract delivery method. Advertisements for Bid Package #1 (HVAC/Plumbing/Controls) and Bid Package #2 (Electrical) were circulated in the Californian and Central Coast Builder's Exchange. At the close of the bid period on February 4th, two bids were received for Bid Package #1 and one bid was received for Bid Package #2. Due to bidder's mistake, the low bid contractor for Bid Package #1 withdrew their bid pursuant to Public Contract Code 5103. To perform due diligence for the SVMHS, Bid Package #1 was re-bid with one contractor submitting a proposal on February 18th. After review of the bid packages submitted, SVMHS identified Vals Plumbing and Heating, Inc. as the lowest responsive, responsible bidder for Bid Package #1 and Central Electric as the lowest responsive, responsible bidder for Bid Package #2.

Timeline/Review Process to Date:

March 2021 – Anticipated approvals from Finance Committee and Board of Directors for project funding and construction services.
April 2021 – Execution of construction contracts and equipment procurement
May 2021 – Commence with construction activities.
September 2021 – Anticipated completion for construction activities

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

Fiscal year capital budgeting:

Fiscal year 2021 capital budgeting allocated funding for planning, design, permitting and procurement for the new Heart Center Air Handler Unit Upgrade Project in the amount of $600,000. Additional funding in fiscal year 2021 and 2022 is being requested to complete construction, implementation and administration required for the Heart Center Air Handler Unit Upgrade in the total estimated amount of $1,700,000. The budget augmentation of $1,100,000 is required to cover the following items not contemplated in the original scope; (A) additional structural steel service platform, (B) roofing replacement to install structural steel platform, (C) labor and material price escalations, (D) enhancements to the building's automation system and (E) temporary provisions necessary to support patient safety during unit transition.

Fiscal Year 2020 Budgeted Amount	**$150,000**
Fiscal Year 2021 Budgeted Amount	**$600,000**
Fiscal Year 2021 Estimated Spend	**$1,269,250**
Fiscal Year 2022 Estimated Spend	**$ 430,750**
Total Estimated Project Spend	**$1,700,000**

Project Spend to Date:

Total project spend to date is $191,976 which procured planning, design, permitting and administration.

Recommendation:

Consider recommendation to Board of Directors (i) to approve the total estimated project costs for the SVMH Heart Center Air Handler Unit Upgrade Project in the amount of $1,700,000 (ii), award construction contract for Bid Package #1 (HVAC/Plumbing/Controls) to Vals Plumbing and Heating, Inc. for the SVMH Heart Center Air Handler Unit Upgrade Project in the amount of $1,048,681 and (iii) award construction contract for Bid Package # 2 (Electrical) to Central Electric for the SVMH Heart Center Air Handler Unit Upgrade Project in the amount of $56,992.

Attachments:

(1) Total project estimated costs prepared March 4, 2021 at procurement phase.
(2) Proof of publication for the advertisement for bids
(3) Bid results for construction services from February 4, 2021.
(4) Bid results for construction services from February 18, 2021.

Salinas Valley Memorial Healthcare System (10348)

Project Cost Summary: Heart Center Air Handler Unit Upgrade - C.I.P. 01.1250.3610
Architect/Engineering: SmithKarng Architecture
Budget Generated at Procurement Phase
Budget Date: *3/4/2021*
Print Date: *3/4/2021*

BOGARD CONSTRUCTION, INC.
Since 1947

BUDGET SUMMARY						
					Cash Flow	
Line Item		Description	Original Budget	Notes	FY21 Projection	FY22 Projection
	1	**Construction**				
0100		Construction Contract	$1,106,000	Multi-Prime Delivery Method (2 Bid Packages)	$884,800	$221,200
0102		Owner Construction Contingency	$55,000	Owner Held Contingency	$0	$55,000
	2	**Design**				
0200		Professional Fees - Fixed	$215,000	Architectural & Consulting Engineers	$193,500	$21,500
	3	**Inspections and Consultation**				
0300		Inspector of Record	$25,000	Agency Required Inspection	$18,750	$6,250
0301		Special Inspections	$20,000	Agency Required Inspection	$18,000	$2,000
0303		Testing and Monitoring(Hazardous Materials)	$3,000	Hazardous Material Testing	$3,000	$0
	4	**AHJ Fees**				
0400		OSHPD	$21,000	Agency Fees	$19,950	$1,050
	5	**Soft Costs**				
0502		Construction Management - PM/CM	$175,000	Program Management	$131,250	$43,750
	99	**Contingency**				
9900		Contingency	$80,000	~5% of Project	$0	$80,000
Totals			**$1,700,000**		**$1,269,250**	**$430,750**

Proof of Publication

(2015.5 C.C.P.)

Salinas Newspapers, Inc.
1093 S Main ST STE 101
Salinas CA 93901
831-424-2222/Fax: 831-754-7156

State Of California ss:
County of Monterey

SALINAS VALLEY MEMORIAL/LEGALS
450 E ROMIE LN

SALINAS CA 93901

I am a citizen of the United States and a resident of the County aforesaid; I am over the age of eighteen years, and not a party to or interested in the above-entitled matter. I hereby certify that the attached advertisement appeared in said newspaper on the following dates:

Newspaper: **The Salinas Californian**
01/13/2021

I acknowledge that I am a principal clerk of the printer of said paper, which is published in the City of Salinas, County of Monterey, State of California. The Salinas Californian is printed and published daily, except Sunday and has been adjudged a newspaper of general circulation by the Superior Court of the County of Monterey, State of California. El Sol is printed and published weekly on Saturday and has been adjudged a newspaper of general circulation by the Superior Court of Monterey, State of California.

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Declarant

Ad#:0004542934
P O :
Net Order Cost: 851.06

This is not an invoice

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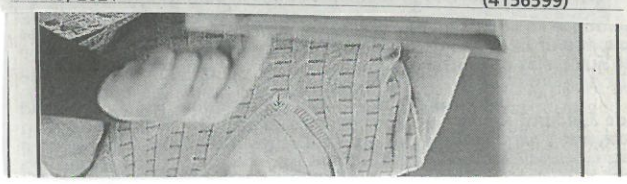
Dated: January 11, 2021

Salinas Valley Memorial Healthcare System
A Local Health Care District
Jan 13, 2021 (4156599)



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A Local Health Care District
Jan 13, 2021 (4156599)

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
SALINAS VALLEY MEMORIAL HOSPITAL (10348)
PROJECT: HEART CENTER AIR HANDLER UNIT UPGRADE
OSHPD PROJECT NO: S201438-27-00
BID RESULT SUMMARY

Salinas Valley Memorial Healthcare System

Bid Package No. 1 - HVAC / PLUMBING / CONTROLS

DATE: February 4, 2021
BID TIME: 2:00PM

	CONTRACTOR	CONTACT	EMAIL	PHONE	BASE BID	COMMENTS
1	Vals Plumbing and Heating, Inc. 413 Front Street Salinas, CA 93901	Claude Bastianelli	claude@valsplumbing.com	831.424.1633	$1,055,316	
2	**Geo H. Wilson 250 Harvey West Blvd. Santa Cruz, CA 95060	Richard Wilson	blue@geowilson.com	831.423.9522	$723,000	
	**Apparent Low Bidder					
	SVMHS reserves the right to reject any or all bids and to waive any informalities in the bidding, or in any bid received.					

	Documents Accompanying Bid	Contractor 1	Contractor 2
a	Bid Proposal	✔	✔
b	Addenda	✔	✔
c	List of Subcontractors	✔	✔
d	Statement of Qualifications	✔	✔
e	Non-Collusion Affidavit	✔	✔
f	Compliance with Immigration Reform and Control Act of 1986	✔	✔
g	Bid Bond (Security)	✔	✔

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
SALINAS VALLEY MEMORIAL HOSPITAL (10348)
PROJECT: HEART CENTER AIR HANDLER UNIT UPGRADE
OSHPD PROJECT NO: S201438-27-00
BID RESULT SUMMARY

Salinas Valley Memorial Healthcare System

Bid Package No. 2 - ELECTRICAL

DATE: February 4, 2021
BID TIME: 2:00PM

	CONTRACTOR	CONTACT	EMAIL	PHONE	BASE BID	COMMENTS
1	**Central Electric Co. 430 Walker Street Watsonville, CA 95076	Matt Love	matt@centralelectric.com	831.724-6321	$56,992	
	**Apparent Low Bidder					
	SVMHS reserves the right to reject any or all bids and to waive any informalities in the bidding, or in any bid received.					

	Documents Accompanying Bid	Contractor 1
a	Bid Proposal	✔
b	Addenda	✔
c	List of Subcontractors	✔
d	Statement of Qualifications	✔
e	Non-Collusion Affidavit	✔
f	Compliance with Immigration Reform and Control Act of 1986	✔
g	Bid Bond (Security)	✔

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
SALINAS VALLEY MEMORIAL HOSPITAL (10348)
PROJECT: HEART CENTER AIR HANDLER UNIT UPGRADE
OSHPD PROJECT NO: S201438-27-00
BID RESULT SUMMARY

Salinas Valley Memorial Healthcare System

Bid Package No. 1 - HVAC / PLUMBING / CONTROLS

DATE: February 18, 2021
BID TIME: 2:00PM

	CONTRACTOR	CONTACT	EMAIL	PHONE	BASE BID	COMMENTS
1	**Vals Plumbing and Heating, Inc. 413 Front Street Salinas, CA 93901	Claude Bastianelli	claude@valsplumbing.com	831.424.1633	$1,048,681	
	**Apparent Low Bidder					
	SVMHS reserves the right to reject any or all bids and to waive any informalities in the bidding, or in any bid received.					

	Documents Accompanying Bid	Contractor 1
a	Bid Proposal	✔
b	Addenda	✔
c	List of Subcontractors	✔
d	Statement of Qualifications	✔
e	Non-Collusion Affidavit	✔
f	Compliance with Immigration Reform and Control Act of 1986	✔
g	Bid Bond (Security)	✔

Board Paper: Finance Committee

Agenda Item:	**Consider Recommendation for Board Approval of Project Budget for the OB Cesarean Conversion Project**
Executive Sponsor:	Clement Miller, Chief Clinical Officer Annette Lindeman, Director of Women's and Children's Services
Date:	March 4, 2021

Executive Summary:

Salinas Valley Memorial Hospital's main operating and recovery room to perform cesarean delivery is located on the second floor of the main hospital. Amid the COVID-19 pandemic, the District is pursuing activities to convert the existing recovery room into a second cesarean delivery room to mitigate exposure and the risk of spread from patients affected with the virus.

To facilitate the conversion, upgrades to existing infrastructure are required including; (A) new electrical panel and distribution, (B) modifications to the existing medical gas and heating, ventilation and air conditioning system, (C) installation of a new surgical light and general room lighting and (D) procurement and installation of a new anesthesia system, medication dispensing unit, fetal monitoring system and surgical table.

Facilities Management is requesting capital funding to complete design, permitting, construction, and equipment procurement for the SVMH OB Cesarean Conversion Project. The total estimated cost for the project is $1,030,202.

Background/Situation/Rationale:

Salinas Valley Memorial Healthcare System continually strives to provide evidence-based care to ensure optimal outcomes on a daily basis. An evidence-based practice to provide timely interventions and scheduled procedures was recognized in 1991 by Salinas Valley Memorial Hospital and the California Department of Public Health. This recognition granted SVMH the licensure to perform all cesarean sections on the Obstetric unit. After training the nursing staff in the practice of perioperative nursing, our physicians, staff and patients began utilizing the existing delivery suites/operating rooms. These are mirror image rooms and both have all essential components to provide safe, reliable care to patients in need of a surgical intervention for both maternal and/or fetal necessity.

As SVMH continues to provide best practice medicine during the COVID-19 pandemic, our team has reviewed our preparedness with the current modalities available to provide care to the maternal newborn dyad as the complexities of care for the laboring woman as a PUI/positive mother are extensive. Active labor is often a rapidly changing situation. Due to physiologic changes of pregnancy, women compensate to alterations in homeostasis for longer periods of time, but once they are not able to meet their own physiologic needs, they decompensate quickly and are difficult to stabilize. In a woman with COVID 19, this pathology can alter the woman's ability to compensate and may put the well-being of her and her fetus (es) in jeopardy. The potential need for an emergency cesarean section requires multiple personnel to facilitate transport to a different floor in the hospital. It takes several minutes to move patient, equipment and staff which provides potential exposure during transport putting others at risk. Having the ability to have a second operating room open equipped and ready to go with minimal exposure risk is crucial to safe and efficient patient outcomes during this time.

At the time of the initial licensure, the OB operating room performed all scheduled and non-scheduled cesarean sections, including emergent life-saving cases. All cases are performed in this setting unless a second operating room is needed when an emergency happens in the midst of an ongoing surgery. The second room was not completed as an operating room and became a space for recovering patients from surgery. However, a preferred model of care is to provide pre-operative and post-operative care in the same patient care room.

Now faced with the COVID-19 pandemic, SVMH is continually planning and utilizing proven resources within its structures to minimize exposure and risk of spread in an unprecedented time. In an effort to provide patient safety and improve our ability to respond to crisis during the PUI/COVID-19 pandemic, it is essential to anticipate these needs and have preparation readiness at all times.

Timeline/Review Process to Date:

March 2021 – Design development and production of construction documents.
March 2021 – Anticipated approvals from Finance Committee and Board of Directors for project funding.
March 2021 - July 2021-February 2021 – OSHPD plan review and permitting.
May - July 2021 – Procurement of construction services and equipment
July 2021 – Anticipated approvals from Finance Committee and Board of Directors for construction services.
August 2021 – Commence with construction activities.
Nov 2021 – Complete construction activities and change of use with CDPH
Nov 2021 – Project substantial completion

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

Fiscal year capital budgeting:
Funding in fiscal year 2021and 2022 is being requested to complete design, permitting, construction, equipment, implementation and administration required for the SVMH OB Cesarean Conversion Project in the total estimated amount of $1,030,202.

Fiscal Year 2021 Budgeted Capital	**$0**
Fiscal Year 2021 Estimated Spend	**$182,745**
Fiscal Year 2022 Estimated Spend	**$847,457**
Total Estimated Project Spend	**$1,030,202**

Recommendation:

Consider recommendation to Board of Directors to approve the total estimated project costs in the amount of $1,030,202 for the SVMH OB Cesarean Conversion Project.

Attachments:

(1) Total project estimated costs prepared 3/4/2021 at 100% construction documents phase.

Salinas Valley Memorial Healthcare System (10348)

Project Cost Summary: 2nd Floor OB C-Section - C.I.P. 01.1250.3610
Architect/Engineering: SmithKarng Architecture
Budget Generated at Design Development
Budget Date: 3/2/2021
Print Date: 3/4/2021

BOGARD CONSTRUCTION, INC. Since 1947

BUDGET SUMMARY

					Cash Flow	
Line Item		**Description**	**Original Budget**	**Notes**	**FY21 Projection**	**FY22 Projection**
	1	**Construction**				
0100		Construction Contract	$384,000	Single Prime Delivery Method	$0	$384,000
0102		Owner Construction Contingency	$20,000	Owner Held Contingency	$0	$20,000
	2	**Design**				
0200		Professional Fees - Fixed	$120,000	Architectural & Consulting Engineers	$92,400	$27,600
	3	**Inspections and Consultation**				
0300		Inspector of Record	$10,000	Agency Required Inspection	$0	$10,000
0301		Special Inspections	$10,000	Agency Required Inspection	$0	$10,000
0303		Testing and Monitoring(Hazardous Materials)	$7,000	Hazardous Material Testing and Monitoring	$3,500	$3,500
	4	**AHJ Fees**				
0400		OSHPD	$13,161	Agency Fees	$11,845	$1,316
	5	**Soft Costs**				$0
0502		Construction Management - PM/CM	$150,000	Program Management	$75,000	$75,000
	7	**FF&E**				
0701		Medical Equipment				
		Skytron Surgical Light	$29,029		$0	$29,029
		Surgical Table	$38,329		$0	$38,329
		Anesthesia System	$114,862		$0	$114,862
		Fetal Carts x2	$21,328		$0	$21,328
		BOVI Cauterizer and Smoke Evac	$28,675		$0	$28,675
		Scanner	$8,740		$0	$8,740
		Anesthesia Pyxis	$25,078		$0	$25,078
	99	**Contingency**				
9900		Contingency	$50,000	~5% of Project	$0	$50,000
Totals			**$1,030,202**		**$182,745**	**$847,457**

Board Paper: Finance Committee

Agenda Item:	Consider Recommendation for Board Approval for the Purchase of Cardiac Ultrasound Equipment
Executive Sponsor:	Clement Miller, Chief Operating Officer / Interim Chief Nursing Officer Christianna Kearns, Sr. Admin Director Cardiovascular, Pulmonary & Sleep Medicine Services
Date:	March 8, 2021

Executive Summary

Current Cardiac Ultrasound fleet have reached their end of useful life. The systems have been frequently breaking down indicating they need to be replaced. These machines are critical to our Heart program and Structural Heart program as well as others that require cardiac testing including research and oncology. This project will be done in two phases: Hospital units to be replaced first, then the remaining three units at the Outpatient centers replaced next fiscal year.

Timeline/Review Process to Date:

03/01/21 Items entered in Axiom for review. Sent to MM for review of GPO pricing

Pillar/Goal Alignment

x Service ☐ People x Quality ☐ Finance x Growth ☐ Community

Financial/Quality/Safety/Regulatory Implications:

Fiscal year 2021 capital budgeting allocated funding for the Cardiac Ultrasound Replacement equipment in the amount of $739,519.00. Proposed funding in fiscal year 2022 allocates $554,638.00 for the remaining equipment replacements for Outpatient centers.

Fiscal 2021 Budget	**$739,519.00**	
Capital Equipment Purchase Request GE Healthcare	**$771,375.00**	
Operational Expense for GE Healthcare 5 year Service Agreement	**$261,390.00**	($52,278 per year for 5 years to start in 2022 after 1 year warranty)

Recommendation

Consider Recommendation to Board of Directors (i) to approve the capital equipment purchase from GE Healthcare in the amount of $771,375.00 and (ii) to approve the GE Healthcare Service Agreement in the amount of $261,390.

Board Paper: Finance Committee

Agenda Item:	Consider Recommendation for Board Approval of Project Funding for the SVMHS Retail Pharmacy Project
Executive Sponsor:	Clement Miller, SVMHS COO John S. Choi, SVMHS Director of Pharmacy Dave Sullivan, SVMHS Facilities Management
Date:	March 9, 2021

Executive Summary

SVMHS is pursuing tenant improvements to the first level portion of the parking structure located at 446 E Romie, Salinas, CA. The planned renovations include architectural finish replacements (flooring, paint, drywall finishes), low voltage cabling, office furniture, technology equipment, office equipment, and furnishings necessary to facilitate the retail pharmacy use of the space. Facilities Management is approaching the Board to request approval of capital funding to complete renovations and procure furnishings, furniture and equipment. The total estimated cost for the project planning, design, permitting, construction, and equipment is $450,000.

Background/Situation/Rationale

The primary objectives of the retail pharmacy are to support (i) employees & covered lives prescription program, (ii) fulfill discharge prescriptions & medications to hospital beds, (iii) 340B contract pharmacy to SVMH and qualifying clinics and (iv) support SVMH Infusion Center & specialty medications.

Timeline/Review Process to Date:

March 2021:	Secure city of Salinas Building Department approvals and commence construction
June 2021:	Anticipated completion of renovations
November 2021:	Board of Pharmacy approvals to operate pharmacy

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

Medication management and prescription plans continue to change and evolve in the US healthcare system. SVMHS' strategic plan to provide continuity of care and services to our community and employees and covered lives beyond acute care setting includes management of ambulatory prescription distribution and participation in specialty pharmacy program that is in a rapid growth. Our retail pharmacy plan meets the immediate needs of patient's discharge prescriptions, convenience of employee prescription plans. The plan will also provide a long term business growth in support of the infusion center pharmacy and their needs for specialty pharmacy procurement.

Pillar/Goal Alignment:

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

Recommendation

Consider recommendation for Board Approval of project funding for the SVMHS Retail Pharmacy Project in the total project estimate amount of $450,000.

Attachments

Project Cost Model prepared March 3, 2021

Salinas Valley Memorial Healthcare System (10348)

Project Cost Summary: DRC Retail Pharmacy Renovations
Architect/Engineering: WRD Architects
Budget Generated at Procurement Phase
Budget Date: *3/3/2021*

BOGARD CONSTRUCTION, INC.
Since 1947

BUDGET SUMMARY				
			A	
Line Item		Description	Original Budget	Notes
	1	**Construction**		
0100		Construction Contract	$160,000	Multi-Prime Contract Delivery Method
0102		Owner Construction Contingency	$7,500	Owner Held Contingency
	2	**Design**		
0200		Professional Fees - Fixed	$75,000	Architectural & Consulting Engineers
	3	**Inspections and Consultation**		
0301		Special Inspections	$5,000	Agency Required Inspection
	4	**AHJ Fees**		
0401		City Fees (Entitlement and Permitting)	$9,000	Agency Fees
	5	**Soft Costs**		
0502		Construction Management - PM/CM	$78,500	Program Management
	7	**FF&E**		
0703		Technology Infrastructure	$95,000	Pioneer Rx Point of Sale Software and IT Infrastructure
	99	**Contingency**		
9900		Contingency	$20,000	~5% of Project
Totals			**$450,000**	

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Minutes from the March 23, 2021 meeting of the Personnel, Pension and Investment Committee will be distributed at the Board Meeting

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

(REGINA M. GAGE)

- *Committee Chair Report*
- *Board Questions to Committee Chair/Staff*
- *Motion/Second*
- *Public Comment*
- *Board Discussion/Deliberation*
- *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 Daniel Gallegos, MD (ii) the Contract Terms for Dr. Gallegos' Recruitment Agreement, and (iii) the Contract Terms for Dr. Gallegos' Family Medicine Professional Services Agreement**

Executive Sponsor: Allen Radner, MD, Chief Medical Officer
Stacey Callahan, Physician Services Coordinator

Date: March 10, 2021

Executive Summary

In consultation with members of the medical staff, hospital executive management has identified the recruitment of a physician specializing in family medicine as a recruiting priority for the hospital's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in October 2019, the specialty of Family Medicine is recommended as a top priority for recruitment. Furthermore, Salinas Family Practice Medical Clinic (SFP), a private practice, will be transitioning into Salinas Valley Medical Clinic (SVMC) PrimeCare North Salinas on April 1, 2021. One of the long-standing physicians at SFP will be retiring in April, thus emphasizing the need for an additional physician to join the group.

The recommended physician, Daniel Gallegos, MD, will be completing his Family Medicine residency this June at Stony Brook University South Hampton Hospital in New York. Dr. Gallegos received his Doctor of Medicine degree from St. George's University School of Medicine in Grenada, West Indies. A native of Los Gatos, California, Dr. Gallegos is looking forward to setting down roots in our community while still being close to his family and hometown.

Background/Situation/Rationale

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:

- Professional Services Agreement that provides W-2 relationship for IRS reporting
- Two (2) year agreement
- Full-time: 1.0 FTE
- Base guarantee salary of two hundred sixty-five thousand dollars ($265,000) per year, and to the extent it exceeds the base salary, productivity compensation of fifty seven dollars and sixty five cents ($57.65) work Relative Value Unit (wRVU).
- Access to SVMHS Health Plan. Physician premium is projected based on 15% of SVMHS cost
- Access to SVMHS 403(b) and 457 retirement plans. 5% base contribution to 403b plan that vests after three years. Based on federal contribution limits this contribution is capped at fourteen thousand five hundred dollars ($14,500) annually
- Three (3) weeks off for vacation
- Two thousand dollars ($2,000) annual stipend for Continuing Medical Education (CME)
- Occurrence based professional liability policy through BETA Healthcare Group

(2) **Recruitment Agreement** that provides a sign-on bonus of thirty thousand dollars ($30,000).

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

The recruitment of Dr. Gallegos is aligned with our strategic priorities for the growth and finance pillars. We continue to develop Salinas Valley Medical Clinic (SVMC) 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 access to care regardless of insurance coverage or ability to pay for services.

Pillar/Goal Alignment:

☐ Service ☐ People ☐ Quality X Finance X Growth ☐ Community

Financial/Quality/Safety/Regulatory Implications:

The addition of Dr. Gallegos to SVMC has been identified as a need for recruitment while also providing additional resources and coverage for the SVMC PrimeCare North Salinas practice.

The compensation proposed in these agreements have been reviewed by independent valuation and compensation consulting firms to confirm that the terms contemplated are fair market value and commercially reasonable.

Recommendation

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

(i) The Findings Supporting Recruitment of Daniel Gallegos, MD,

- **That the recruitment of a family medicine physician to Salinas Valley Medical Clinic 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;**

(ii) The Contract Terms of the Recruitment Agreement for Dr. Gallegos; and

(iii) The Contract Terms of the Family Medicine Professional Services Agreement for Dr. Gallegos.

Attachments

(1) Curriculum Vitae – Daniel Gallegos, MD

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Daniel A. Gallegos, MD, MPH

Education

Stony Brook University – Southampton Hospital Family Medicine Residency	Expected 6/2021
St. George's University School of Medicine: Doctor of Medicine	May 2018
St. George's University School of Public Health: Master's of Public Health	May 2015
Loyola Marymount University: Bachelor's of Science in Biology	May 2011

Certifications & Licensure

USMLE Step 1
USMLE Step 2 CK
USMLE Step 2 CS
USMLE Step 3
Training License, State of New York

Credentialing

ACLS
BLS
PALS
Suturing
Casting/Splinting
Skin Biopsies
Joint Injections (Shoulder, Knee, Elbow, Carpal Tunnel)
TMJ, Migraine treatment
Filler injections using a micro-cannula device
Filler for mid-face volume
Filler in tear troughs
Filler in the temple region
Filler in pre-jowl sulcus
Filler in mandibular area
Filler in fine lines (smoker's lines, etc.)
Sclerotherapy
Micro-tox
Micro Renew (combining micro-tox with HA filler)
Sculptra

Employment and Positions

Resident Physician, Stony Brook Southampton Hospital	2018-Present
Medical Intern, Spalding Cosmetic Surgery and Dermatology	2011-2013

Professional Associations

American College of Physicians (ACP)	2017-Present
American Academy of Family Physicians (AAFP)	2018-Present

Honors & Awards

Dean's List, Loyola Marymount University	2010-2011

Volunteer Experience

St. George's University Public Health Student Association; Grenada, West Indies	2013 – 2015
President	

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- Organized and recruited volunteers for Grenada Health Fair
- Raised money to provide resources to the underserved community
- Educated local community on safe sex practices, prostate cancer, and diabetes
- Provided physical exams and preventative modalities

Marymount California University Men's Lacrosse Team; Los Angeles, CA 2009 – 2011
President/Founder

- Assembled first lacrosse team in program history
- Responsible for implementing practice and game schedule

Loyola Marymount University Intramural Athletics; Los Angeles, CA 2010 – 2011
President

- Organized all intramural athletics and transportation
- Participated in basketball, football, soccer, softball

Tijuana Immersion Trip; Tijuana, Mexico 2009
Volunteer

- Worked with community members to build homes
- Director of fundraising for trip (food, clothes, personal donations)
- Director of resource allocation while in Mexico

Personal Interests
Bay Area Sports Teams, Fishing, Golf, Skiing, Cooking, Spending time with family and friends

References
Provided Upon Request

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of (i) the Findings Supporting Recruitment of Patricia Mayer, MD (ii) the Contract Terms for Dr. Mayer's Recruitment Agreement, and (iii) the Contract Terms for Dr. Mayer's Family Medicine Professional Services Agreement**

Executive Sponsor: Allen Radner, MD, Chief Medical Officer
Stacey Callahan, Physician Services Coordinator

Date: March 16, 2021

Executive Summary

In consultation with members of the medical staff, hospital executive management has identified the recruitment of a physician specializing in family practice as a recruiting priority for the hospital's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in October 2019, the specialty of Family Medicine is recommended as a top priority for recruitment. Furthermore, Salinas Family Practice Medical Clinic (SFP), a private practice, will be transitioning into Salinas Valley Medical Clinic (SVMC) PrimeCare North Salinas on April 1, 2021. In addition to the retirement of an established physician, we anticipate the need for an experienced physician, proficient with the electronic health record retained to support the practice transition for the immediate need as well as long-term to support the growth of the practice.

The recommended physician, Patricia Mayer, MD, received her Doctor of Medicine Degree from University of Minnesota Medical School. Dr. Mayer worked for the United States Air Force as a Family Medicine physician prior to her dedicated career as a family medicine physician in Minnesota, Hawaii and Washington. Dr. Mayer is relocating to the Monterey Peninsula to be closer to family. Dr. Mayer is an experienced Family Medicine physician who has held various leadership roles, including Chief of Primary Care and Chief of Family Medicine, working to achieve quality improvement and primary care redesign. Dr. Mayer will complement the provider team and the mission of Salinas Valley Medical Clinic.

Background/Situation/Rationale

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:

- Professional Services Agreement that provides W-2 relationship for IRS reporting
- Two (2) year agreement
- Full-time: 1.0 FTE
- Base guarantee salary of two hundred sixty-five thousand dollars ($265,000) per year, and to the extent it exceeds the base salary, productivity compensation of fifty seven dollars and sixty five cents ($57.65) work Relative Value Unit (wRVU).
- Access to SVMHS Health Plan. Physician premium is projected based on 15% of SVMHS cost
- Access to SVMHS 403(b) and 457 retirement plans. 5% base contribution to 403b plan that vests after three years. Based on federal contribution limits this contribution is capped at fourteen thousand five hundred dollars ($14,500) annually
- Four (4) weeks off for vacation

- Two thousand dollar ($2,000) annual stipend for Continuing Medical Education (CME)
- The physician will receive an occurrence based professional liability policy through BETA Healthcare Group

(2) **Recruitment Agreement** that provides a sign-on bonus of thirty thousand dollars ($30,000).

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

The recruitment of Dr. Mayer is aligned with our strategic priorities for the growth and finance pillars. We continue to develop Salinas Valley Medical Clinic (SVMC) 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 X Finance X Growth ☐ Community

Financial/Quality/Safety/Regulatory Implications:

The addition of Dr. Mayer to SVMC has been identified as a need for recruitment while also providing additional resources and coverage for the SVMC PrimeCare North Salinas practice.

The compensation proposed in these agreements have been reviewed by independent valuation and compensation consulting firms to confirm that the terms contemplated are fair market value and commercially reasonable.

Recommendation

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

(i) The Findings Supporting Recruitment of Patricia Mayer, MD,

- **That the recruitment of a family medicine physician to Salinas Valley Medical Clinic 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;**

(ii) The Contract Terms of the Recruitment Agreement for Dr. Mayer; and

(iii) The Contract Terms of the Family Medicine Professional Services Agreement for Dr. Mayer.

Attachments

(1) Curriculum Vitae – Patricia Mayer, MD

Patricia Marie Mayer, MD

Licensure/Certification:

1997 – present	American Board of Family Medicine
2021 – present	Medical Board of California, Active #C 171560
2017 – present	Washington State, Active #60770051
2014 – present	State of Hawaii Medical License, Active #17836
1995 – present	State of Minnesota Medical License, Active #38022
2018 – present	ACLS Certification
2018 – present	BSL Certification
2020 – present	PALS Certification

Employment:

October 2017 – present	**Providence Medical Group, Spokane, WA** Urgent Care Family Physician
October 2014 – October 2017	**Kauai Medical Clinic, Lihue, Hawai'i** Family Medicine Physician Outpatient Primary Care Physician and Chief of Primary Care
September 2001- October 2014	**PS Rudie Medical Clinic, Duluth, MN** Family Medicine Physician Inpatient/outpatient/OB/nursing home/office procedures
September 1998-July 2001	**United States Air Force, Grand Forks AFB, ND and Kunsan AFB ROK** Major; Family Medicine Physician Outpatient and brief time included inpatient Primary Care

Education:

July 1994 - June 1997	**Duluth Family Practice Residency Program** Duluth, MN
July 1992 - June 1994	**Doctor of Medicine Degree** University of Minnesota Medical School Minneapolis, MN
November 1992 - July 1993	Rural Physician's Associate Program Bigfork, MN
September 1990 - June 1992	University of Minnesota Duluth School of Medicine Duluth, MN
September 1985 - May 1989	**Bachelor of Arts in Natural Science** College of St. Benedict; St. Joseph, MN

Professional Memberships:

American Academy of Family Physicians

	Washington Academy of Family Physicians

Administrative:

January 2017 – October 2017	Physician Lead for CPC+, Kauai Medical Clinic, Lihue, Hawai'i
September 2015 - October 2017	Section Chief Family Medicine Department, Kauai Medical Clinic
July 2015 – October 2017	Chief Primary Care Main Clinic, Kauai Medical Clinic
October 2014 – October 2017	Hawai'i Pacific Health (HPH) Primary Care Redesign Workgroup
October 2014 – October 2017	HPH Adult Ambulatory Quality Workgroup
October 2014 – October 2017	Hawai'i Health Partners (HHP) Primary Care Dashboard Governance Group
October 2001 – Oct 2014	Quality Improvement Committee, St. Luke's Hospital, Duluth, MN
2006 - 2008	Vice President, NorthStar Physicians Group, Duluth, MN

Teaching:

2019 – present	Preceptor for Spokane Family Medicine Residency - Urgent Care rotation
2018 – present	Preceptor for First- and Second-Year Medical Students; Elson S. Floyd College of Medicine, Washington State University, Spokane, WA
October 2001 – October 2014	Preceptor for University of Minnesota-Duluth First-year Medical Students

Awards:

2007	NorthStar Physicians Quality Award
1998 – 2001	Meritorious Service Medal, USAF
1997-1998	Air Force Achievement Medal, USAF

Volunteer Activities:

2014, 2015, 2016	Wilcox Hospital Kid's Fest; Lihue, Hawai'i
2016, 2017	Keiki Bike Helmet and Safety Day; Lihue, Hawai'i
2015-2017	Kauai Mental Health Consortium; Lihue, Hawai'i
2016	Wilcox Hospital Walk with a Doc speaker; Lihue, Hawai'i
2017	Wilcox Hospital Bike with a Doc speaker; Lihue, Hawai'i

Hobbies:

outdoor activities including biking, golf, hiking

CORPORATE COMPLIANCE AND AUDIT COMMITTEE

Minutes from the March 23, 2021 meeting of the Corporate Compliance and Audit Committee will be distributed at the Board Meeting

(JUAN CABRERA)

Medical Executive Committee Summary
March 11, 2021

The following items from the meeting of the Medical Executive Committee (MEC) are presented to the Board of Directors and recommended for approval or as informational as indicated:

Items for Board Approval:

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Garcia-Rivera, Ricardo MD	Neurology	Medicine	Tele-Neurology: Core

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Bajaj, Tarun, MD	General Surgery	Surgery	General Surgery Regional Wound Care Center
Carroll, Catherine, MD	Internal Medicine/ Hospitalist	Medicine	Adult Hospitalist
De, Ajanta, MD	Interventional Cardiology	Medicine	Cardiology Interventional Cardiology Peripheral Endovascular
Chen, Tracy, DO	Diagnostic Radiology	Surgery	Diagnostic Radiology Mammography Screening Center for Advanced Diagnostic Imaging (CADI) at Ryan Ranch
Cole, Mario, MD	Critical Care/ Pulmonology	Medicine	Critical Care/Pulmonary Medicine General Internal Medicine
Goldberg, Steven, MD	Interventional Cardiology	Medicine	Cardiology Interventional Cardiology
Gram, Kelly, MD	Internal Medicine/ Hospitalist	Medicine	Adult Hospitalist
Gray, Kelsey, MD	Critical Care/ Pulmonary Medicine	Medicine	Critical Care/Pulmonary Medicine General Internal Medicine
Halamandaris, Gus, MD	Neurological Surgery	Surgery	Neurological Surgery
King, Allen, MD	Endocrinology	Medicine	Medicine - Active Community
Martinez, Cristina, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Slack, Robert S, MD	Critical Care/ Pulmonology	Medicine	Critical Care/Pulmonary Medicine General Internal Medicine
Thompson, Maxwell, MD	Anesthesiology	Anesthesiology	Anesthesiology

Modification and/or Addition of Privileges:

NAME	SPECIALTY	RECOMMENDATION
Fiorenza, Jeffrey, MD	Gastroenterology	Ambulatory Core privileges at Taylor Farms Family Health & Wellness Center "TFFH&WC"
Le, Michael, MD	Gastroenterology	Ambulatory Core privileges at Taylor Farms Family Health & Wellness Center "TFFH&WC"

Luba, Daniel, MD	Gastroenterology	Ambulatory Core privileges at Taylor Farms Family Health & Wellness Center "TFFH&WC"
Mendoza, Michael, MD	Gastroenterology	Ambulatory Core privileges at Taylor Farms Family Health & Wellness Center "TFFH&WC"
Vegesna, Neelima, MD	OB Hospitalist	C-Section privileges for the remainder of current reappointment.

Staff Status Modifications:

NAME	SPECIALTY	RECOMMENDATION
Leyenson, Vadim, MD	Critical Care/ Pulmonology	Advance from Provisional Status to Active Status
Solomon, Nitikul, MD	Pediatrics	Advance from Provisional Status to Active Status
Zhang, Zachary, MD	Interventional Radiology	Advance from Provisional Status to Active Status
Borenstein, Yehonatan, MD	Tele-Psychiatry	Resignation effective April 1, 2021
Resendez, Elpidio, MD	Emergency Medicine	Leave of Absence effective February 18, 2021
Rudny, Kevin, MD	Tele-Radiology	Resignation effective February 2, 2021
Sugar, Richard, MD	Anesthesiology	Leave of Absence effective March 31, 2021

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

ITEM	RECOMMENDATION
Application Request Form - Revisions	The Committee reviewed and recommended accepting the revisions to the Application Request form.

Interdisciplinary Practice Committee

Modification and/or Addition of Privileges:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Chen, Bryant, PA-C	Physician Assistant	Emergency	Furnishing or ordering of Schedule II-V drugs
Ramirez, Alberto, PA-C	Physician Assistant	Emergency	Furnishing or ordering of Schedule II-V drugs

Policies: 2021 Influenza Pandemic Plan ***(Attached)***

Informational Items:

The following items were approved/accepted as appropriate:

I. Committee Reports:

a. Quality and Safety Committee
b. Medical Staff Excellence Committee

II. Other Reports:

a. Financial Performance Review – January 2021
b. Executive Update
c. Summary of Executive Operations Committee Meetings
d. Summary of Medical Staff Department/Committee Meetings
e. Health Information Management Update
f. Medical Staff Treasury
g. Medical Staff Statistics

III. Order Sets Approved:

Admission General Medical
ADM Labor-Induction-Augment
Admission Short Set
Adm.Labor-Delivery
Admit COVID Hospitalist
Cardiac Cath-Angio Post InPt
Cesarean Delivery Post Op
Cesarean Delivery Pre Op
Comfort Care Infusions
Comfort Care Orders
Epidural Intrathecal Labor
General-Abd-Vascular Post Op
Hospitalist ProgGenCare Adm
Insulin Infusion for Hypertriglyceridemia Induced Pancreatitis
Interventional Post Proc
Knee Replacement Post Op
Lexiscan Cardiology INPATIENT
Lexiscan Cardiology OUTPATIENT
Pacemaker Defib Impl Post Proc
Pediatric Admit Short Set
Post Vaginal Delivery
VTE Prophylaxis

IV. Informational/Educational Items:

a. Update of Medical Staff Stipends
    i. Secretary Treasurer
    ii. Chair, Interdisciplinary Practice Committee
    iii. Chair, Practitioner Health and Wellness Committee
b. SVMH Foundation Update - March 2021

Salinas Valley Memorial Healthcare System

Medical Staff Services
Rachel McCarthy Beck, MD, Chief of Staff
Allen Radner, MD, Chief Medical Officer
Kate DeSalvo, CPHQ, Dir Medical Staff Svcs

Dear Doctor:

Thank you for your interest in membership and privileges on the Medical Staff of Salinas Valley Memorial Hospital. Our Board of Directors, upon recommendation of the Medical Staff, have adopted general and particular qualifications for membership and privileges in order to maintain our high standard of patient care. An excerpt from the Medical Staff Bylaws outlining these requirements is attached for your information.

All applicants must, at minimum, possess the following:

1. A current and unrestricted license to practice medicine in the State of California
2. An unrestricted federal DEA registration (if applicable)
3. Board Certification (if required for your specialty)
4. Ability to participate in Federally funded healthcare programs
5. Evidence of satisfactory completion of an accredited postgraduate residency training program
6. Documentation of clinical activity which complies with Medical Staff criteria for your specialty
7. Qualified professional liability insurance in the amount of $1/3 million.
8. An office and home that are located close enough to the hospital to provide appropriate continuity of patient care (required physical response time to the hospital is 30 minutes) or an approved written plan for providing continuity of patient care (backup coverage).
9. Applicants must have a designated member of the Medical Staff, with like privleges, who will agree to provide emergency backup coverage.
10. Ability to participate in emergency room call in their specialty for unassigned patients.
11. Ability to keep medical records current.
12. Willingness to uphold the Medical Staff Code of Conduct agreement.
13. ***All practitioners requesting clinical privileges must demonstrate activity at an accredited hospital or other organization within the previous 24 months.***

Deleted: *Hospital affiliation and inpatient*

Deleted: *activity at a Joint Commission approved*

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If you agree to these standards, please complete the enclosed forms and return them with a copy of your current curriculum vitae and a list of the specific types of privileges you expect to request.

If you meet our general membership standards**, you will receive an e-mail with a link and access information to our online application.** Please note that there is a $500 non-refundable application fee as well as a $150.00 fee for a background check due at the time of application. Should the cost of the background check be less than $150.00, the difference will be refunded to you once your application is complete. In addition, there are Medical Staff dues of $400 per year paid prospectively upon appointment and every 2-years thereafter. If we can be of any assistance to you, please don't hesitate to contact our offices.

Sincerely,

Kate DeSalvo

Katherine DeSalvo, CPMSM, CPHQ
Director, Medical Staff Services

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Salinas Valley Memorial Healthcare System

INFLUENZA PANDEMIC PLAN
2021

TABLE OF CONTENTS

I. SCOPE 3

II. OBJECTIVES 3

III. DEFINITIONS 4

IV. PLAN MANAGEMENT 6

V. PERFORMANCE STANDARDS 16

VI. DOCUMENTATION 16

VII. EVIDENCE-BASED REFERENCE 16

I. SCOPE

A. To prevent the spread of ~~pandemic~~ influenza' by: vaccination, early detection and treatment with antiviral medications and the use of infection control measures to prevent transmission during patient care.

B. To limit transmission in healthcare settings ~~will rely heavily~~ by use of ~~on the~~ appropriate ~~and thorough application of~~ infection control measures.

C. To minimize close contact of known or suspect patients with~~,~~ influenza. T ~~t~~ransmission requires close exposure to large droplets (droplet transmission), direct contact (contact transmission), or near-range exposure to aerosols (airborne transmission)

D. To establish guidance based on our current knowledge of routes of influenza transmission (S4-II.A),~~novel H1N1 CalOSHA requirements~~, the pathogenesis of influenza (S4-II.B), and the effects of influenza control measures used during past pandemics.

E. Given some uncertainty about the characteristics of any new pandemic strain, all aspects of preparedness planning for pandemic influenza must allow for flexibility and real-time decision-making that take new information into account as the situation unfolds.

II. OBJECTIVES

A. Prevention and control of influenza or any other unknown communicable respiratory condition will be through a set of well-established strategies that include:

- vaccination of patients and healthcare personnel;
- early detection of influenza cases in a facility;
- use of ~~antivirals~~antiviral medications to treat ill persons and, if recommended, as prophylaxis;
- isolation of infectious patients in private rooms or cohort units;
- ~~use of appropriate b~~Barrier precautions during patient care, as recommended for Standard and Droplet Precautions~~and Enhanced Precautions for H1N1~~.
- Administrative measures, such as restricting visitors, educating patients and staff, and cohorting healthcare workers assigned to an outbreak unit.

B. Salinas Valley Memorial Healthcare System (will follow the guidelines established by the Center for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH), and Cal OSHA for detection, treatment to minimize the transmission and treatment of influenza

C. Salinas Valley Memorial will follow the ~~directions~~ recommendation of ~~set forth by~~ the Monterey Public Health Department in the event of untoward influx of patients identified as having a communicable disease

D. ~~Salinas Valley Memorial~~ SVMHS will initiate ~~it Code Purple~~ surge capacity ~~policy and~~ and - activate additional components of the Emergency Management Plan as needed

III. DEFINITIONS

A. ***Modes of transmission of influenza*** - Epidemiologic pattern observed for seasonal influenza is generally consistent with spread through close contact (i.e., exposure to large respiratory droplets, direct contact, or near-range exposure to aerosols through small particle aerosols.

- ~~There is little evidence of airborne transmission over long distances or prolonged periods of time (as is seen with M. tuberculosis).~~

B. ***Droplet transmission*** - Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism.

- Droplets are generated from the source person primarily during coughing, sneezing, or talking and during the performance of certain procedures such as suctioning and ~~bronchoscopy~~bronchoscopy.
- Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances (about 3 – 6 feet) through the air. Because droplets do not remain suspended in the air, special air handling and ventilation are not required to prevent droplet transmission.

C. ***Contact transmission*** - Contact (direct) transmission involves skin-to-skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when personnel turn patients, bathe patients, or perform other patient-care activities that require physical contact.

- Direct-contact transmission also can occur between two patients (e.g., by hand contact), with one serving as the source of infectious microorganisms and the other as a susceptible host.
- Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the patient's environment.
- Contact transmission of influenza may occur through either direct skin-to-skin contact or through indirect contact with virus in the environment.
- Transmission via contaminated hands and ~~fomites~~fomite has been suggested as a contributing factor in some studies.

D. ***Airborne transmission*** - Airborne transmission occurs by dissemination of either airborne droplet nuclei or small particles in the respirable size range containing the infectious agent. Microorganisms carried in this manner—such as M.

tuberculosis— may be dispersed over long distances by air currents and may be inhaled by susceptible individuals who have not had face-to-face contact with (or been in the same room with) the infectious individual.

- Organisms transmitted in this manner must be capable of sustaining infectivity, despite desiccation and environmental variation that generally limit survival in the airborne state.
- Preventing the spread of agents that are transmitted by the airborne route requires the use of special air handling and ventilation systems (e.g., negative pressure rooms).
- The relative contribution of airborne transmission to influenza outbreaks is uncertain. Evidence is limited and is principally derived from laboratory studies in animals and some observational studies of influenza outbreaks in humans, particularly on cruise ships and airplanes, where other mechanisms of transmission were also present. Additional information suggesting airborne transmission was reported in a Veterans Administration Hospital study that found lower rates of influenza in wards exposed to ultraviolet radiation (which inactivates influenza viruses) than in wards without UV radiation.
- Another study indicated that humidity can play a role in the infectivity of aerosolized influenza, although the influence of humidity on the formation of droplet nuclei was not evaluated.
- It is likely that some aerosol-generating procedures (e.g., endotracheal intubation, suctioning, nebulizer treatment, and bronchoscopy) could increase the potential for dissemination of droplet nuclei in the immediate vicinity of the patient. (Although transmission of SARS-CoV was reported in a Canadian hospital during an aerosol-generating procedure [intubation], it occurred in a situation involving environmental contamination with respiratory secretions.) Although this mode of transmission has not been evaluated for influenza, additional precautions for healthcare personnel who perform aerosol-generating procedures on influenza patients may be warranted. When these aerosol-generating procedures are performed on patients known or suspected of having an aerosol transmissible disease, healthcare workers will use a ~~of an N95 respirator. In September 2010, the minimum standard will be~~ standard will be a PAPR (powered air purifying respirator.)

E. ***Pathogenesis of influenza and implications for infection control*** - The cellular pathogenesis of human influenza indicates that infection principally takes place within the respiratory tract. While conjunctivitis is a common manifestation of systemic influenza infection, the ocular route of inoculation and infection has not been demonstrated for human influenza viruses. This may not be true with certain avian species of influenza (e.g., H7N7) that have been associated primarily with conjunctivitis in humans. This information suggests that preventing direct and indirect inoculation of the respiratory tract is of utmost importance for preventing person-to-person transmission when caring for infectious patients.

IV. PLAN MANAGEMENT

A. ***Control of transmission in healthcare facilities*** - These are the primary infection control measures recommended in this plan. They will be updated, as necessary, based on the observed characteristics of the pandemic influenza virus.

B. ***Recommendations for Infection Control in Healthcare Settings*** - The recommendations for infection control described below are generally applicable throughout the different pandemic phases. In some cases, as indicated, recommendations may be modified as the situation progresses from limited cases to widespread community illness.

- Basic infection control principles for preventing the spread of pandemic influenza in healthcare settings. The following infection control principles apply in any setting where persons with pandemic influenza might seek and receive healthcare services (e.g. hospitals, emergency departments, out-patient facilities, residential care facilities, homes). Details
- Limit contact between infected and non-infected persons
  1. Isolate infected persons (i.e., confine patients to a defined area as appropriate for the healthcare setting).
  2. Limit contact between nonessential personnel and other persons (e.g., social visitors) and patients who are ill with pandemic influenza.
  3. Promote spatial separation in common areas (i.e., sit or stand as far away as possible—at least 3 feet—from potentially infectious persons) to limit contact between symptomatic and non-symptomatic persons.
- Protect persons caring for influenza patients in healthcare settings from contact with the pandemic influenza virus. Persons who must be in contact should:

~~1.~~ Wear a surgical or procedure mask for close contact with infectious patients. ~~For patients suspected of H1N1, use an N95 respirator.~~

~~2. Use contact and airborne precautions, including the use of N95 respirators, when appropriate [S4-IV.C]. For patients suspected of H1N1, use Enhanced Precautions.~~

  a. Wear gloves (gown if necessary) for contact with respiratory secretions.
  b. Perform hand hygiene after contact with infectious patients

  1. Contain infectious respiratory secretions:
     a. Instruct persons who have "flu-like" symptoms (see below) to use respiratory hygiene/cough etiquette (See Box 2).
     b. Promote use of masks by symptomatic persons in common areas (e.g., waiting rooms in physician offices or emergency departments) or when being transported (e.g., in emergency vehicles).

C. ***Symptoms of influenza*** include fever, headache, myalgia, prostration, coryza, sore throat, and cough. Otitis media, nausea, and vomiting are also commonly reported among children. Typical influenza (or "flu-like") symptoms, such as fever, may not

always be present in elderly patients, young children, patients in long-term care facilities, or persons with underlying chronic illnesses (see Supplement 5, Box 2).

D. ***Management of infectious patients***

- ***Respiratory hygiene/cough etiquette*** - Respiratory hygiene/cough etiquette has been promoted as a strategy to contain respiratory viruses at the source and to limit their spread in areas where infectious patients might be awaiting medical care (e.g., physician offices, emergency departments) (see S4-IV.B.2).
- The impact of covering sneezes and coughs and/or placing a mask on a coughing patient on the containment of respiratory secretions or on the transmission of respiratory infections has not been systematically studied. In theory, however, any measure that limits the dispersal of respiratory droplets should reduce the opportunity for transmission. Masking may be difficult in some settings, e.g., pediatrics, in which case the emphasis will be on cough hygiene.
- The elements of respiratory hygiene/cough etiquette include:
  1. Education of healthcare facility staff, patients, and visitors on the importance of containing respiratory secretions to help prevent the transmission of influenza and other respiratory viruses
  2. Posted signs in languages appropriate to the populations served with instructions to patients and accompanying family members or friends to immediately report symptoms of a respiratory infection as directed
  3. Source control measures (e.g., covering the mouth/nose with a tissue when coughing and disposing of used tissues; using masks on the coughing person when they can be tolerated and are appropriate)
  4. Hand hygiene after contact with respiratory secretions, and
  5. Spatial separation, ideally >3 feet, of persons with respiratory infections in common waiting areas when possible.

E. ***Droplet precautions and patient placement***

- Patients with known or suspected pandemic influenza should be placed on droplet precautions for a minimum of ~~5~~7 days from the onset of symptoms. Because immunocompromised patients may shed virus for longer periods, they may be placed on droplet precautions for the duration of their illness. Healthcare personnel should wear appropriate PPE (see S4-IV.C). The placement of patients will vary depending on the healthcare setting (see setting-specific guidance). If the pandemic virus is associated with diarrhea, contact precautions (i.e., gowns and gloves for all patient contact) should be added. CDC will update these recommendations if changes occur in the anticipated pattern of transmission.
- For patients suspected of H1N1 influenza, the patient will be placed on Droplet~~Enhanced~~ Precautions for at least 7 days. Patients with suspected H1N1 influenza should remain ~~i~~on Droplet~~Enhanced~~ precautions until clearance to discontinue ~~Enhanced~~ Precautions has been obtained from an infectious disease physician, a pulmonologist, or consultation with Infection Prevention ~~and Control~~.

F. ***Infection control practices for healthcare personnel***

- Infection control practices for pandemic influenza are the same as for other human influenza viruses and primarily involve the application of standard and droplet precautions (Box 1) during patient care in healthcare settings (e.g., hospitals, nursing homes, outpatient offices, emergency transport vehicles). This guidance also applies to healthcare personnel going into the homes of patients.
- Infection control practices for H1N1 influenza require Droplet~~Enhanced~~ Precautions and use of a~~n~~ regular face mask~~N95 respirator at a minimum~~.
- During a pandemic, conditions that could affect infection prevention ~~control~~ may include shortages of antiviral drugs, decreased efficacy of the vaccine, increased virulence of the influenza strain, shortages of single-patient rooms, and shortages of personal protective equipment. These issues may necessitate changes in the standard recommended infection control practices for influenza. CDC will provide updated infection control guidance as circumstances dictate. Additional guidance is provided for family members providing home care (S4-IV.G) and for use in public settings (e.g., schools, workplace) where people with pandemic influenza may be encountered (S4-V and S4-VI).

1. **Personal Protective Equipment for standard and droplet precautions -** PPE is used to prevent direct contact with the pandemic influenza virus. PPE that may be used to provide care includes surgical or procedure masks, as recommended for droplet precautions, and gloves and gowns, as recommended for standard precautions (Box 1). Additional precautions may be indicated during the performance of aerosol-generating procedures (see below). Information on the selection and use of PPE is provided at www.cdc.gov/ncidod/dhqp/gl_isolation.html.
2. **Masks (surgical or procedure)**
   a. Wear a mask when entering a patient's room. A mask should be worn once and then discarded. If pandemic influenza patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between patients and hand hygiene performed.
   b. Change masks when they become moist.
   c. Do not leave masks dangling around the neck.
   d. Upon touching or discarding a used mask, perform hand hygiene.

~~3. **For H1N1 patients**, an N95 respirator will be used. The respirator may be re-used during shortages of respirators as outlined in the Practice Guideline, Re-use of N95 respirators.~~

4.3. **Gloves**
   a. A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of latex, vinyl, nitrile, or other synthetic materials are appropriate for this purpose; if possible, latex-free gloves should be available for healthcare workers who have latex allergy.
   b. Gloves should fit comfortably on the wearer's hands.
   c. Remove and dispose of gloves after use on a patient; do not wash gloves for subsequent reuse.
   d. Perform hand hygiene after glove removal.

e. If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive patient or environmental contact with blood or body fluids, including during suctioning.

~~f. Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.~~

~~5.~~4. **Gowns**

a. Wear an isolation gown, if soiling of personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated. Most patient interactions do not necessitate the use of gowns. However, procedures such as intubation and activities that involve holding the patient close (e.g., in pediatric settings) are examples of when a gown may be needed when caring for pandemic influenza patients.

b. A disposable gown made of synthetic fiber or a washable cloth gown may be used.

c. Ensure that gowns are of the appropriate size to fully cover the area to be protected.

d. Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.

e. If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., patient gowns) could be used. ~~It is doubtful that disposable aprons would provide the desired protection in the circumstances where gowns are needed to prevent contact with influenza virus, and therefore should be avoided. There are no data upon which to base a recommendation for reusing an isolation gown on the same patient. To avoid possible contamination, it is prudent to limit this practice.~~

~~6.~~5. **Goggles or face shield**

a. In general, wearing goggles or a face shield for routine contact with patients with pandemic influenza is not necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for standard precautions. Additional information related to the use of eye protection for infection control can be found at http://www.cdc.gov/niosh/topics/eye/eye-infectious.html.

G. ~~B~~*PPE for special circumstances*

- **PPE for aerosol-generating procedures**

During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a Powered Air Purifier (PAPr) ~~N95 respirator~~ or other appropriate particulate respirator. Respirators should be used within the context of a respiratory protection program that includes fit-testing, medical clearance, and

training. If ~~possible,~~possible and when practical, use of an airborne isolation room may be considered when conducting aerosol-generating procedures.

- **PPE for managing pandemic influenza with increased transmissibility**
  The addition of airborne precautions, including respiratory protection (an N95 filtering face piece respirator or other appropriate particulate respirator), may be considered for strains of influenza exhibiting increased transmissibility, during initial stages of an outbreak of an emerging or novel strain of influenza, and as determined by other factors such as vaccination/immune status of personnel and availability of antivirals. As the epidemiologic characteristics of the pandemic virus are more clearly defined, CDC will provide updated infection control guidance, as needed.
- **Precautions for early stages of a pandemic**
  Early in a pandemic, it may not be clear that a patient with severe respiratory illness has pandemic influenza. Therefore precautions consistent with all possible etiologies, including a newly emerging infectious agent, should be implemented. This may involve the combined use of airborne and contact precautions, in addition to standard precautions, until a diagnosis is established.

H. ***Caring for patients with pandemic influenza*** - Healthcare personnel should be particularly vigilant to avoid:

- Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.
- Contaminating environmental surfaces that are not directly related to patient care (e.g., door knobs, light switches)

I. **Hand hygiene** - Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings (see http://www.cdc.gov/handhygiene/pressrelease.htm) and is an essential element of standard precautions. The term "hand hygiene" includes both hand washing with either plain or antimicrobial soap and water and use of alcohol-based products (gels, rinses, foams) containing an emollient that do not require the use of water.

- If hands are visibly soiled or contaminated with respiratory secretions, wash hands with soap (either non-antimicrobial or antimicrobial) and water.
- In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior micro-biocidal activity, reduced drying of the skin, and convenience.
- Always perform hand hygiene between patient contacts and after removing PPE.
- Ensure that resources to facilitate hand washing (i.e., sinks with warm and cold running water, plain or antimicrobial soap, disposable paper towels) and hand disinfection (i.e., alcohol-based products) are readily accessible in areas in which patient care is provided. For additional guidance on hand hygiene see http://www.cdc.gov/handhygiene/.

J. ***Disposal of solid waste*** - Standard precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with a pandemic influenza virus:

- Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of medical waste, including used needles and other sharps, and non-medical waste.
- Discard as routine waste used patient-care supplies that are not likely to be contaminated (e.g., paper wrappers).
- Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

K. ***Linen and laundry*** - Standard precautions are recommended for linen and laundry that might be contaminated with respiratory secretions from patients with pandemic influenza:

- Place soiled linen directly into a laundry bag in the patient's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area.
- Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
- Wear gloves for transporting bagged linen and laundry.
- Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
- Wash and dry linen according to routine standards and procedures (www.cdc.gov/ncidod/hip/enviro/guide.htm).

L. ***Dishes and eating utensils*** - Standard precautions are recommended for handling dishes and eating utensils used by a patient with known or possible pandemic influenza:

- Wash reusable dishes and utensils in a dishwasher with recommended water temperature (http://www.cdc.gov/ncidod/dhqp/gl_environinfection.html).
- Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of patients) should be discarded with other general waste.
- Wear gloves when handling patient trays, dishes, and utensils.

M. ***Patient-care equipment*** - Follow standard practices for handling and reprocessing used patient-care equipment, including medical devices:

- Wear gloves when handling and transporting used patient-care equipment.
- Wipe heavily soiled equipment with ~~ana~~ ~~EPA-approved~~ hospital approved disinfectant before removing it from the patient's room. Follow current recommendations for cleaning and disinfection or sterilization of reusable patient-care equipment.

- Wipe external surfaces of portable equipment for performing x-rays and other procedures in the patient's room with ~~ana~~ ~~EPA-approved~~ hospital approved disinfectant upon removal from the patient's room.

N. ***Environmental cleaning and disinfection*** - Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic influenza follow the same general principles used in healthcare settings.

O. ***Cleaning and disinfection of patient-occupied ~~rooms~~ ~~Wear~~rooms:***

- Wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with droplet precautions. Gowns are not necessary for routine cleaning of an influenza patient's room.
- Keep areas around the patient free of unnecessary supplies and equipment to facilitate daily cleaning.
- Use any ~~EPA-registered~~ hospital approved detergent-disinfectant. Follow manufacturer's recommendations for use-dilution (i.e., concentration), contact time, and care in handling.
- Follow facility procedures for regular cleaning of patient-occupied rooms. Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes, ventilator surfaces) in addition to floors and other horizontal surfaces.
- Clean and disinfect spills of blood and body fluids in accordance with current recommendations for Isolation Precautions.
-
- Cleaning and disinfection after patient discharge or transfer
- Follow standard facility procedures for post-discharge cleaning of an isolation room.

1. Clean and disinfect all surfaces that were in contact with the patient or might have become contaminated during patient care. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.
2. Do not spray (i.e., fog) occupied or unoccupied rooms with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

~~O.~~P. ***Postmortem care***

1. Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids. For H1N1 patients, use gown, gloves, regular face mask~~N95 respirators~~, and eye protection at a minimum.

~~P.~~Q. ***Laboratory specimens and practices*** - Follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

~~Q.~~R. ***Occupational health issues*** - Healthcare personnel are at risk for pandemic influenza through community and healthcare-related exposures. Once pandemic influenza has reached a community, healthcare facilities must implement systems to

monitor for illness in the facility workforce and manage those who are symptomatic or ill.

- Implement a system to educate personnel about occupational health issues related to pandemic influenza.
- Screen all personnel for influenza-like symptoms before they come on duty. Symptomatic personnel should be sent home until they are physically ready to return to duty.
- Healthcare personnel who have recovered from pandemic influenza should develop protective antibody against future infection with the same virus, and therefore should be prioritized for the care of patients with active pandemic influenza and its complications. These workers would also be well suited to care for patients who are at risk for serious complications from influenza (e.g., transplant patients and neonates).
- Personnel who are at high risk for complications of pandemic influenza (e.g., pregnant women, immunocompromised persons) should be informed about their medical risk and offered an alternate work assignment, away from influenza-patient care if possible, or considered for administrative leave until pandemic influenza has abated in the community.
- Reducing exposure of persons at high risk for complications of influenza - Persons who are well, but at high risk for influenza or its complications (e.g., persons with underlying diseases), should be instructed to avoid unnecessary contact with healthcare facilities caring for pandemic influenza patients (i.e., do not visit patients, postpone nonessential medical care).

~~R.~~S. ***Hospitals*** - Detection of persons entering the facility who may have pandemic influenza - Post visual alerts (in appropriate languages) at the entrance to hospital outpatient facilities (e.g., emergency departments, outpatient clinics) instructing persons with respiratory symptoms (e.g., patients, persons who accompany them) to:

- Inform reception and healthcare personnel when they first register for care, and
- Practice respiratory hygiene/cough etiquette (see http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm). Sample visual alerts are available on CDC's SARS website: http://www.cdc.gov/ncidod/hip/INFECT/RespiratoryPoster.pdf
- Triage patients calling for medical appointments for influenza symptoms
- Discourage unnecessary visits to medical facilities.
- Instruct symptomatic patients on infection control measures to limit transmission in the home and when traveling to necessary medical appointments.
- As the scope of the pandemic escalates locally, consider setting up a separate triage area for persons presenting with symptoms of respiratory infection. Because not every patient presenting with symptoms will have pandemic influenza, infection control measures will be important in preventing further spread.
- During the peak of a pandemic, emergency departments and outpatient offices may be overwhelmed with patients seeking care. A "triage officer" may be useful for managing patient flow, including deferral of patients who do not require emergency care.

- Designate separate waiting areas for patients with influenza-like symptoms. If this is not feasible, the waiting area should be set up to enable patients with respiratory symptoms to sit as far away as possible (at least 3 feet) from other patients.

~~S.~~T. "Source control" measures to limit dissemination of influenza virus from respiratory secretions - Post signs that promote respiratory hygiene/cough etiquette in common areas (e.g., elevators, waiting areas, cafeterias, lavatories) where they can serve as reminders to all persons in the healthcare facility. Signs should instruct persons to:

- Cover the nose/mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions.
- Dispose of tissues in the nearest waste receptacle after use.
- Perform hand hygiene after contact with respiratory secretions.
- Facilitate adherence to respiratory hygiene/cough etiquette by ensuring the availability of materials in waiting areas for patients and visitors.
- Provide tissues and no-touch receptacles (e.g., waste containers with pedal-operated lid or uncovered waste container) for used tissue disposal.
- Provide conveniently located dispensers of alcohol-based hand rub.
- Provide soap and disposable towels for handwashing where sinks are available.
- Promote the use of masks and spatial separation by persons with symptoms of influenza.
- Offer and encourage the use of either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties or elastic) by symptomatic persons to limit dispersal of respiratory droplets.
- Encourage coughing persons to sit as far away as possible (at least 3 feet) from other persons in common waiting areas.

~~T.~~U. ***Hospitalization of pandemic influenza patients***

- Patient placement
  1. Limit admission of influenza patients to those with severe complications of influenza who cannot be cared for outside the hospital setting.
  2. Admit patients to either a single-patient room or an area designated for cohorting of patients with influenza.

- Cohorting
  1. Designated units or areas of a facility should be used for cohorting patients with pandemic influenza. During a pandemic, other respiratory viruses (e.g., non-pandemic influenza, respiratory syncytial virus, parainfluenza virus) may be circulating concurrently in a community. Therefore, to prevent cross-transmission of respiratory viruses, whenever possible assign only patients with confirmed pandemic influenza to the same room. At the height of a pandemic, laboratory testing to confirm pandemic influenza is likely to be limited, in which case cohorting should be based on having symptoms consistent with pandemic influenza.
  2. Personnel (clinical and non-clinical) assigned to cohorted patient care units for pandemic influenza patients should not "float" or otherwise be assigned to

other patient care areas. The number of personnel entering the cohorted area should be limited to those necessary for patient care and support.

3. Personnel assigned to cohorted patient care units should be aware that patients with pandemic influenza may be concurrently infected or colonized with other pathogenic organisms (e.g., Staphylococcus aureus, Clostridium difficile) and should adhere to infection control practices (e.g., hand hygiene, changing gloves between patient contact) used routinely, and as part of standard precautions, to prevent nosocomial transmission.
4. Because of the high patient volume anticipated during a pandemic, cohorting should be implemented early in the course of a local outbreak.

- Patient transport
  1. Limit patient movement and transport outside the isolation area to medically necessary purposes.
  2. Consider having portable x-ray equipment available in areas designated for cohorting influenza patients.
  3. If transport or movement is necessary, ensure that the patient wears a surgical or procedure mask. If a mask cannot be tolerated (e.g., due to the patient's age or deteriorating respiratory status), apply the most practical measures to contain respiratory secretions. Patients should perform hand hygiene before leaving the room.

- Visitors
  1. Screen visitors for signs and symptoms of influenza before entry into the facility and exclude persons who are symptomatic.
  2. Family members who accompany patients with influenza-like illness to the hospital are assumed to have been exposed to influenza and should wear masks.
  3. Limit visitors to persons who are necessary for the patient's emotional well-being and care.
  4. Instruct visitors to wear surgical or procedure masks while in the patient's room.
  5. Instruct visitors on hand-hygiene practices.

~~U.~~V. ***Control of healthcare acquired (nosocomial~~)~~pandemic~~)~~ pandemic influenza transmission*** - Once patients with pandemic influenza are admitted to the hospital, nosocomial surveillance should be heightened for evidence of transmission to other patients and healthcare personnel. (Once pandemic influenza is firmly established in a community this may not be feasible or necessary.) If limited nosocomial transmission is detected (e.g., has occurred on one or two patient care units), appropriate control measures should be implemented. These may include:

- Cohorting of patients and staff on affected units
- Restriction of new admissions (except for other pandemic influenza patients) to the affected unit(s)
- Restriction of visitors to the affected unit(s) to those who are essential for patient care and support

- If widespread nosocomial transmission occurs, controls may need to be implemented hospital wide and might include:
- Restricting all nonessential persons
- Stopping admissions not related to pandemic influenza and stopping elective surgeries

~~V.~~W. ***Care of pandemic influenza patients at alternative sites*** - If an influenza pandemic results in severe illness that overwhelms the capacity of existing healthcare resources, it may become necessary to provide care at alternative sites (e.g., schools, auditoriums, conference centers, hotels). Existing "all-hazard" plans have likely identified designated sites for this purpose. The same principles of infection control apply in these settings as in other healthcare settings. Careful planning is necessary to ensure that resources are available and procedures are in place to adhere to the key principles of infection control.

V. PERFORMANCE STANDARDS

N/A

VI. DOCUMENTATION

N/A

VII. EVIDENCE-BASED REFERENCE

A. Reed C, Biggerstaff M, Finelli L, et al. Novel Framework for Assessing Epidemiologic Effects of Influenza Epidemics and Pandemics. *Emerging Infectious Diseases*. 2013;19(1):85-91. doi:10.3201/eid1901.120124.

B. Qualls N, Levitt A, Kanade N, et al. Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017. MMWR Recomm Rep 2017;66(No. RR-1):1–34. https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

C. Summary of Influenza Risk Assessment Tool (IRAT) Results. https://www.cdc.gov/flu/pandemic-resources/monitoring/irat-virus-summaries.htm

~~F. U.S Department of Health and Human Services (5/2007). Pandemic Planning Guidelines for Healthcare facilities.~~

~~G. CalOSHA Aerosol Transmissable Diseases Standard, Title 8, Chapter 4, 8/2009~~

~~H. CalOSHA Interim Enforcement Policy on H1N1 and Section 5199, 10/22/2009~~

~~I. CDC Updated Guidelines Regarding Infection ControlProcedures for H1N1, 10/14/2009~~

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Table 1. - Summary of Infection Control Recommendations for Care of Patients with Pandemic Influenza

COMPONENT	RECOMMENDATIONS
	STANDARD PRECAUTIONS
Hand hygiene	Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items; after removing gloves; and between patient contacts. Hand hygiene includes both handwashing with either plain or antimicrobial soap and water or use of alcohol-based products (gels, rinses, foams) that contain an emollient and do not require the use of water. If hands are visibly soiled or contaminated with respiratory secretions, they should be washed with soap (either non-antimicrobial or antimicrobial) and water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbicidal activity, reduced drying of the skin, and convenience.
Personal protective equipment (PPE) • Gloves • Gown • Face/eye protection (e.g., surgical or procedure mask ~~or N95 for H1N1 patients~~ and goggles or a face shield	• For touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and non-intact skin • During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions~~is~~ anticipated • During procedures and patient care activities likely to generate splash or spray of blood, body fluids, secretions, excretions
Safe work practices	Avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces with contaminated gloves and other PPE that are not directly related to patient care (e.g., door knobs, keys, light switches).
Patient resuscitation	Avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions.
Soiled patient care equipment	Handle in a manner that prevents transfer of microorganisms to oneself, others, and environmental surfaces; wear gloves if visibly contaminated; perform hand hygiene after handling equipment.
Soiled linen and laundry	Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves (gown if necessary) when handling and transporting soiled linen and laundry; and perform hand hygiene.
Needles and other sharps	Use devices with safety features when available; do not recap, bend, break or hand-manipulate used needles; if recapping is necessary, use a one-handed scoop technique; place used sharps in a puncture-resistant container.
Environmental cleaning and disinfection	Use ~~EPA-registered~~ hospital approved detergent-disinfectant; follow standard facility procedures for cleaning and disinfection of environmental surfaces; emphasize cleaning/disinfection of frequently touched surfaces (e.g., bed rails, phones, lavatory surfaces).
Disposal of solid waste	Contain and dispose of solid waste (medical and non-medical) in accordance with facility procedures and/or local or state regulations; wear gloves when handling waste; wear gloves when handling waste containers; perform hand hygiene.
Respiratory hygiene/cough etiquette Source control measures for persons with symptoms of a respiratory infection; implement at first point of	Cover the mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacles; perform hand hygiene after contact with respiratory secretions; wear a mask (procedure or surgical) if tolerated; sit or stand as far away as possible (more than 3 feet) from persons who are not ill.

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encounter (e.g., triage/reception areas) within a healthcare setting.	
Droplet Precautions	http://www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html
Patient placement	Place patients with influenza in a private room or cohort with other patients with influenza.* Keep door closed ~~or slightly ajar~~; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet precautions to all persons in the room. *During the early stages of a pandemic, infection with influenza should be laboratory-confirmed, if possible. Personal protective equipment Wear a surgical or procedure mask for entry into patient room; wear other PPE as recommended for standard precautions.
Patient transport	Limit patient movement outside of room to medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.
Other	Follow standard precautions and facility procedures for handling linen and laundry and dishes and eating utensils, and for cleaning/disinfection of environmental surfaces and patient care equipment, disposal of solid waste, and postmortem care.
Aerosol-Generating Procedures	During procedures that may generate small particles of respiratory secretions (e.g., endotracheal intubation, bronchoscopy, nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 respirator or other appropriate particulate respirator.
COMPONENT	ENHANCED PRECAUTIONS FOR H1N1
Patient Placement	Place patients with H1N1 influenza in a private room or cohort with other patients with H1N1 influenza.* Keep door closed; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet ~~enhanced~~ precautions to all persons in the room. Personal protective equipment Wear a regular face mask ~~N95 respirator~~ for entry into patient room; wear other PPE as recommended for standard precautions.
Patient transport	Limit patient movement outside of room to medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.
Other	Follow standard precautions and facility procedures for handling linen and laundry and dishes and eating utensils, and for cleaning/disinfection of environmental surfaces and patient care equipment, disposal of solid waste, and postmortem care.
Aerosol-Generating Procedures	During procedures that may generate small particles of respiratory secretions (e.g., endotracheal intubation, bronchoscopy, nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 respirator or other appropriate particulate respirator.

Box 2. Respiratory Hygiene/Cough Etiquette

To contain respiratory secretions, all persons with signs and symptoms of a respiratory infection, regardless of presumed cause, should be instructed to:

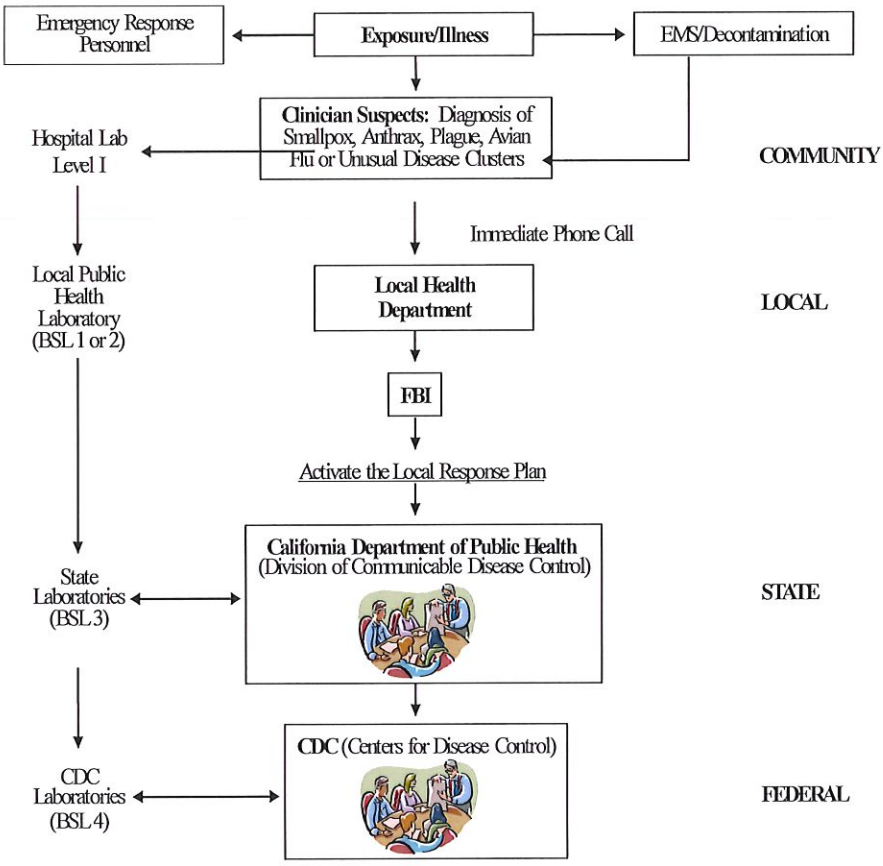
- Cover the nose/mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions.
- Dispose of tissues in the nearest waste receptacle after use.
- Perform hand hygiene after contact with respiratory secretions and contaminated objects/materials.

Healthcare facilities should ensure the availability of materials for adhering to respiratory hygiene/cough etiquette in waiting areas for patients and visitors:

- Provide tissues and no-touch receptacles for used tissue disposal.
- Provide conveniently located dispensers of alcohol-based hand rub.
- Provide soap and disposable towels for handwashing where sinks are available.

Masking and separation of persons with symptoms of respiratory infection:
During periods of increased respiratory infection in the community, persons who are coughing should be offered either a procedure mask (i.e., with ear loops) or a surgical mask (i.e., with ties) to contain respiratory secretions. Coughing persons should be encouraged to sit as far away as possible (at least 3 feet) from others in common waiting areas. Some facilities may wish to institute this recommendation year-round.

Reporting Influx of Communicable Illnesses



SEE ATTACHMENTS

LEFT HAND ICON

CALOSHA ATD.pdf

CDPH_NasopharyngealSwabCollection_042009.pdf

Enhanced_Precautions_Sign_-_English.pdf

Enhanced_Precautions_Sign_-_SPANISH.pdf

Executive Strategic Plan 9.9.09.xls

OSHA Instruction.pdf

Visitor and Family Members Guide to Enhanced Isolation.doc

Visitor and Family Members Guide to Enhanced Isolation - SPANISH.doc

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

ADJOURNMENT – THE NEXT REGULAR MEETING OF THE BOARD OF DIRECTORS IS SCHEDULED FOR THURSDAY, APRIL 29, 2021, AT 4:00 P.M.