May 19, 2023

TO: Legal Counsel

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

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, MAY 25, 2023, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** or via **TELECONFERENCE** (*visit* **SalinasValleyHealth.com/virtualboardmeeting** *for Access Information*).

Pete Delgado
President/Chief Executive Officer

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

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

THURSDAY, MAY 25, 2023, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C
SALINAS VALLEY HEALTH MEDICAL CENTER
450 E. ROMIE LANE, SALINAS, CALIFORNIA
or via TELECONFERENCE

(Visit salinasvalleyhealth.com/virtualboardmeeting for Access Information)

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 5:30 pm)*	*Victor Rey, Jr.*
IV.	**EDUCATION PROGRAM – LABORATORY SERVICES UPDATE**	*Clement Miller*
V.	**REPORT FROM THE PRESIDENT/CHIEF EXECUTIVE OFFICER**	*Pete Delgado*
VI.	**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.

VII. BOARD MEMBER COMMENTS *Board Members*

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

A. Minutes of April 20, 2023 Regular Meeting of the Board of Directors
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
   Patient Safety Program Plan
   Scope of Service: Pharmacy
   Scope of Service Transport
   Scope of Service: Outpatient Infusion
   Tuition Assistance

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

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

IX. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. **Quality and Efficient Practices Committee** — *Catherine Carson*

Minutes of the May 22, 2023 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

B. **Finance Committee** — *Joel Hernandez Laguna*

Minutes of the May 22, 2023 Finance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board:

1. Consider Recommendation for Board Approval of Microsoft Enterprise Agreement Licensing Renewal Through CDW Government, a Supplier of Salinas Valley Health's Group Purchasing Organization and Contract Award

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

2. Consider recommendation for Board approval to engage Guidehouse to conduct an organizational-wide Assessment and Strategy Plan (Phase 1) for Financial Performance Improvement

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

C. **Personnel, Pension and Investment Committee** — *Juan Cabrera*

Minutes of the May 23, 2023 Personnel, Pension and Investment Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

D. **Community Advocacy Committee** — *Joel Hernandez Laguna*

Minutes of the May 23, 2023 Community Advocacy Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

X. CONSIDER BOARD RESOLUTION NO. 2023-04 ADOPTING AMENDED AND RESTATED DISTRICT BYLAWS — *District Legal Counsel*

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

XI. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF MAY 11, 2023, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING: *Theodore, Kaczmar, Jr., MD*

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

B. Policies/Procedures/Plans:
   1. Risk Management Plan
   2. Quality Assessment and Performance Improvement Plan

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

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

XIII. ADJOURNMENT

The Regular Meeting of the Board of Directors is scheduled for **Wednesday, June 21, 2023, at 4:00 p.m.**

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

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

SALINAS VALLEY HEALTH BOARD OF DIRECTORS

AGENDA FOR CLOSED SESSION

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

CLOSED SESSION AGENDA ITEMS

REPORT INVOLVING TRADE SECRET
(Government Code §37606 & Health and Safety Code § 32106)

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

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

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):
Araujo et al vs. Salinas Valley Memorial Healthcare System

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, hospital internal audit report, or report of quality assurance committee):

1. Report of the Medical Staff Credentials Committee
2. Report of the Medical Staff Interdisciplinary Practice Committee
3. Report of the Medical Staff Quality and Safety Committee
4. Report of the Quality and Efficient Practices Committee
5. Receive & Accept Quality and Safety Reports
    a. Medical Staff Quality and Safety Committee Report
        i. Transitions of Care
        ii. Critical Care Services
        iii. MedSurg Cluster/Peds/In-patient Wound Care Program
        iv. HIM (Health Information Management)
        v. Nursing Admin/Transporters/Interpreter Services
        vi. Nursing Education
        vii. Taylor Farms
        viii. Community/Volunteer Services
        ix. Food Services
        x. Respiratory Care
        xi. Rehab Services (PT, OT, Speech)
        xii. Sleep Medicine
    b. Quality and Efficient Practices Committee Reports
        i. CMS Data Report July 2023
        ii. CMS Star Report July 2023
        iii. Accreditation and Regulatory Report

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: 5:30 P.M.)

(VICTOR REY, JR.)

LABORATORY SERVICES UPDATE

(MILLER)

REPORT FROM THE PRESIDENT/ CHIEF EXECUTIVE OFFICER

(VERBAL)

(PETE DELGADO)

PUBLIC INPUT

BOARD MEMBER COMMENTS

(VERBAL)

SALINAS VALLEY MEMOPRIAL HEALTHCARE SYSTEM[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
APRIL 20, 2023

Present:
Catherine Carson, Assistant Treasurer
Rolando Cabrera, MD, Secretary
Joel Hernandez Laguna, Vice-President
Juan Cabrera, Treasurer

Absent: Victor Rey, Jr., President

Also Present:
Pete Delgado, President/Chief Executive Officer
Theodore Kaczmar, Jr., MD, Chief of Staff
Matthew Ottone, Esq., District Legal Counsel

Juan Cabrera joined the meeting at 5:25 p.m.

CALL TO ORDER/ROLL CALL

A quorum was present and President Rey called the meeting to order at 4:04 p.m.

CLOSED SESSION

Vice-President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are (1) *Conference with Labor Negotiator*, (2) *Report Involving Trade Secrets*, and (3) *Hearings/Reports*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:06 p.m. The Board completed its business of the Closed Session at 5:15 p.m.

RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 5:22 p.m. Vice-President Hernandez Laguna reported that in Closed Session, the Board discussed (1) *Conference with Labor Negotiator*, (2) *Report Involving Trade Secrets*, and (3) *Hearings/Reports*. The Board received the reports listed on the Closed Session Agenda. No additional actions were taken.

EDUCATION PROGRAM – HEALTH SCHOLARS PROGRAM

Adrienne Laurent, Chief Strategic Communication Officer, introduced Michelle McCarty, COPE Program Manager, Alexis Pierce, COPE Regional Manager, Jennifer Mendoza, student, who provided an overview of the COPE Health Scholars Program. The report included a program overview, program objectives to support professional development, student scope of practice (and restrictions) and practice competencies. Salinas Valley Health 28 has sponsored 29 participants/alumni and 19 are currently enrolled. Students rotate through Oncology, Med/Surg and Progressive Care. Health Scholar Jennifer Mendoza, reported she was part of the pilot cohort and her experience has been valuable. Ms. Mendoza is currently attending Hartnell College studying nursing.

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REPORT FROM THE PRESIDENT/CHIEF EXECUTIVE OFFICER

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

A Mission Moment video was presented featuring Maria Munoz, RN, who lost her father to COVID-19 and the Rose River Memorial Project. Each rose represents a person who lost their life to COVID. 853 people died in our county.

Mr. Delgado presented a summary of how the District is meeting each of its foundational pillars Service, Quality, Growth, Finance, People, and Community.

Celina Medina, MSN, RN, ICU, Research & Evidence-Based Practice (REBP) Council Co-Chair provided a report on the REBP Council. A full report was provided in the packet.

PUBLIC INPUT

No public input.

BOARD MEMBER COMMENTS

Director Rolando Cabrera, MD: No comment.

Director J. Cabrera commented that he is pleased Salinas Valley Health is investing in youth, providing opportunities for future employees and assisting nurses to continue to learn and develop.

Director Carson commented that she enjoyed the REBP presentation.

Director Joel Hernandez Laguna: No comment.

CONSENT AGENDA – GENERAL BUSINESS

A. Minutes of the Annual Meeting of the Board of Directors of March 23, 2023.
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
    Infection Prevention Program Plan

No public comment received.

MOTION:

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

Ayes: Directors: Carson, J. Cabrera, Dr. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: None. Absent: Director Rey; Motion Carried.

REPORTS ON STANDING AND SPECIAL COMMITTEES

Quality and Efficient Practices Committee

Chair Carson reported the minutes from the Quality and Efficient Practices Committee meeting of April 17, 2023, were provided to the Board of Directors for review. No recommendations were made.

Finance Committee

Chair Hernandez Laguna reported the minutes from the Finance Committee meeting of March 20, 2023, were provided to the Board of Directors for review. Background information supporting the proposed recommendations made by the Committee was included in the Board packet.

The Committee made the following recommendations:

1. ***Consider recommendation for Board of Directors approval of Seventh Amendment California Commercial Property Management Agreement.***

No public comment received.

MOTION:

Upon motion by Director Carson, second by Director J. Cabrera, the Board of Directors approves the Seventh Amendment to Management Agreement between Salinas Valley Health and California Commercial Real Estate Services for a 3 (three) year term commercial property services contract in the amount of $1,661,776.00.

Ayes: Directors: Carson, J. Cabrera, Dr. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: None. Absent: Director Rey; Motion Carried.

2. ***Consider recommendation for Board of Directors approval of Change Healthcare Stratus Imaging Proposal as sole source and contract award.***

No public comment received.

MOTION:

Upon motion by Director J. Cabrera, second by Director Carson, the Board of Directors approves the Change Healthcare Stratus Imaging proposal as sole source and contract award in the estimated amount of **Error! Reference source not found.**over a 5-year term.

Ayes: Directors: Carson, J. Cabrera, Dr. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: None. Absent: Director Rey; Motion Carried.

3. ***Consider recommendation for Board of Directors approval of the human capital management project as competitive solicitation and contract award subject to final negotiation and legal review of contracts and agreements.***

No public comment received.

MOTION:

Upon motion by Director J. Cabrera, second by Director Carson, the Board of Directors approves the Human Capital Management Project with an amount not to exceed $3,900,000 over a long-term contract subject to final negotiation and legal review of contracts and agreements.

Ayes: Directors: Carson, J. Cabrera, Dr. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: None. Absent: Director Rey; Motion Carried.

Personnel, Pension and Investment Committee

Vice-Chair Carson reported the minutes from the Personnel, Pension and Investment Committee meeting of April 18, 2023, were provided to the Board of Directors for review. Background information supporting the proposed recommendations made by the Committee was included in the Board packet.

The Committee made the following recommendations:

1. ***Recommend the Board of Directors approve (i) the Findings Supporting Recruitment, (ii) the Contract Terms of the Recruitment Agreement, and (iii) the Contract Terms of the Neurology Professional Services Agreement for Christopher Bird, MD.***

No public comment received.

Discussion: Clarification on the Professional Services agreement, the base guarantee salary is $350,000. Two-year term is standard.

MOTION:

Upon motion by Director Carson, second by Director R. Cabrera, the Board of Directors *approves (i) the Findings Supporting Recruitment, (ii) the Contract Terms of the Recruitment Agreement, and (iii) the Contract Terms of the Neurology Professional Services Agreement for Christopher Bird, MD.*

Ayes: Directors: Carson, J. Cabrera, Dr. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: None. Absent: Director Rey; Motion Carried.

2. ***Recommend the Board of Directors approve (i) the Findings Supporting Recruitment, (ii) the Contract Terms of the Recruitment Agreement, and (iii) the Contract Terms of the Family Medicine Professional Services Agreement for Natali Lopez Silva, MD.***

No public comment received.

Discussion: Clarification on the Professional Services agreement, the base guarantee salary is $270,000. The recruitment agreements are based on fair market value.

MOTION:

Upon motion by Director Carson, second by Director J. Cabrera, the Board of Directors approves (i) the Findings Supporting Recruitment, (ii) the Contract Terms of the Recruitment Agreement, and (iii) the Contract Terms of the Family Medicine Professional Services Agreement for Natali Lopez Silva, MD.

Ayes: Directors: Carson, J. Cabrera, Dr. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: None. Absent: Director Rey; Motion Carried.

3. ***Recommend the Board of Directors approve (i) the Findings Supporting Recruitment, (ii) the Contract Terms of the Recruitment Agreement, and (iii) the Contract Terms of the Endocrinology Professional Services Agreement for Aileen Wang, MD.***

No public comment received.

Discussion: Clarification on the Professional Services agreement, the base guarantee salary is $260,000.

MOTION:

Upon motion by Director Carson, second by Director R. Cabrera, the Board of Directors approves (i) the Findings Supporting Recruitment, (ii) the Contract Terms of the Recruitment Agreement, and (iii) the Contract Terms of the Endocrinology Professional Services Agreement for Aileen Wang, MD.

Ayes: Directors: Carson, J. Cabrera, Dr. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: None. Absent: Director Rey; Motion Carried.

4. ***Recommend the Board of Directors approve (i) the Findings Supporting Recruitment, (ii) the Contract Terms of the Recruitment Agreement, and (iii) the Contract Terms of the Radiology Professional Services Agreement for Bruce Lin, MD.***

No public comment received.

Discussion: Clarification on the Professional Services agreement, the base guarantee salary is $530,000.

MOTION:

Upon motion by Director Carson, second by Director R. Cabrera, the Board of Directors approves (i) the Findings Supporting Recruitment, (ii) the Contract Terms of the Recruitment Agreement, and (iii) the Contract Terms of the Radiology Professional Services Agreement for Bruce Lin, MD.

Ayes: Directors: Carson, J. Cabrera, Dr. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: None. Absent: Director Rey; Motion Carried.

5. ***Recommend the Board of Directors approve the following for Elaine Lee, DO, Liane De Guzman, DO, Nancy Mutoro, MD, Joseph Shin, MD and Rebecca Adams, MD:***

   (i) The Findings Supporting Recruitment
   - ***a. That the recruitment of hospitalist physicians to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and***
   - ***b. 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 Elaine Lee, DO, Liane De Guzman, D), Nancy Mutoro, MD, Joseph Shin, MD and Rebecca Adams, MD
   - ***a. Professional Services Agreement between Salinas Valley Health and the five (5) physicians listed, contracted under a W-2 based professional services agreement;***
   - ***b. Recruitment Agreement between Salinas Valley Health and the five (5) physicians with recruitment incentives of $40,000 for Elaine Lee, DO, Liane De Guzman, DO, Nancy Mutoro, MD, and Joseph Shin, MD and a recruitment incentive of $20,000 for Rebecca Adams, MD.***

No public comment received.

Discussion: To clarify, this motion accepts terms of five physicians, all Hospitalists with the same incentive based on full time or part time. Board members are pleased the hospital is recruiting physicians. Director Cabrera has a family member in the heart program and staff was very responsive and helpful. Gary Ray recognized Stacey Callahan who has done most of the physician recruiting.

MOTION:

Upon motion by Director Carson, second by Director R. Cabrera, the Board of Directors approves for Elaine Lee, DO, Liane De Guzman, DO, Nancy Mutoro, MD, and Joseph Shin, MD and Rebecca Adams, MD. (i) the Findings Supporting Recruitment, (ii) Professional Services Agreement between Salinas Valley Health and the five (5) physicians listed, contracted under a W-2 based professional services agreement and (iii) the Recruitment Agreement between Salinas Valley Health and the five (5) physicians

with recruitment incentives of $40,000 for Elaine Lee, DO, Liane De Guzman, DO, Nancy Mutoro, MD, and Joseph Shin, MD and a recruitment incentive of $20,000 for Rebecca Adams, MD.

Ayes: Directors: Carson, J. Cabrera, Dr. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: None. Absent: Director Rey; Motion Carried.

Transformation, Strategic Planning and Governance Committee

Vice-Chair Cabrera reported the minutes from the Transformation, Strategic Planning and Governance Committee meeting of April 19, 2023, were provided to the Board of Directors for review. No recommendations were made.

CONSIDER RESOLUTION NO. 2023-04 ADOPTING AMENDED AND RESTATED DISTRICT BYLAWS

It was noted Resolution No. 2023-04 was excluded from the published packet. This item was tabled until the May Board Meeting.

REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON APRIL 13, 2023, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING

Theodore Kaczmar, Jr., MD, Chief of Staff reviewed the reports of the Medical Executive Committee (MEC) meeting of April 13, 2023, and Rules and Regulations revision. A full report was provided in the Board packet.

Recommend Board Approval of the Following:

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

No public comment received.

MOTION:

Upon motion by Director J. Cabrera, second by Director Carson, the Board of Directors receives and approves the Medical Executive Committee Credentials Committee Report and the Interdisciplinary Practice Committee Report

No public input received.

Ayes: Directors: Carson, J. Cabrera, and Hernandez Laguna. Noes: None. Abstentions: Director R. Cabrera; Absent: Director Rey; Motion Carried.

ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, May 25, 2023 at 4:00 p.m.** There being no further business, the meeting was adjourned at 7:16 p.m.

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Rolando Cabrera, MD
Secretary, Board of Directors

/KmH

SALINAS VALLEY MEMORIAL HOSPITAL
SUMMARY INCOME STATEMENT
April 30, 2023

	Month of April,		Ten months ended April 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 58,084,461	$ 44,660,977	$ 524,322,042	$ 491,250,497
Other operating revenue	8,114,714	3,775,273	15,725,228	12,458,130
Total operating revenue	66,199,175	48,436,250	540,047,270	503,708,627
Total operating expenses	47,009,348	43,229,245	473,621,809	423,726,205
Total non-operating income	(1,527,865)	(1,550,911)	(19,591,386)	(34,712,155)
Operating and non-operating income	$ 17,661,962	$ 3,656,094	$ 46,834,075	$ 45,270,267

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
April 30, 2023

	Current year	Prior year
ASSETS:		
Current assets	$ 430,752,880	$ 422,735,565
Assets whose use is limited or restricted by board	158,016,957	146,810,333
Capital assets	241,433,633	239,351,739
Other assets	178,199,484	217,878,519
Deferred pension outflows	95,857,027	50,119,236
	$ 1,104,259,981	$ 1,076,895,392
LIABILITIES AND EQUITY:		
Current liabilities	103,980,309	123,397,382
Long term liabilities	16,902,107	14,288,063
Lease deferred inflows	1,642,999	0
Pension liability	79,111,485	83,585,120
Net assets	902,623,081	855,624,827
	$ 1,104,259,981	$ 1,076,895,392

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF NET PATIENT REVENUE
April 30, 2023

	Month of April,		Ten months ended April 30,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,929	1,674	20,121	17,491
Medi-Cal	1,109	999	11,752	9,790
Commercial insurance	581	647	7,465	7,450
Other patient	152	183	1,258	1,114
Total patient days	3,771	3,503	40,596	35,845
Gross revenue:				
Medicare	$ 109,557,112	$ 93,225,740	$ 1,049,911,497	$ 924,185,201
Medi-Cal	72,464,646	58,209,733	707,174,003	559,457,298
Commercial insurance	50,466,973	44,310,607	517,001,393	493,913,448
Other patient	8,568,032	10,595,381	87,190,984	81,268,150
Gross revenue	241,056,763	206,341,461	2,361,277,877	2,058,824,096
Deductions from revenue:				
Administrative adjustment	179,008	367,745	2,455,388	3,008,759
Charity care	698,431	504,804	6,287,557	7,909,502
Contractual adjustments:				
Medicare outpatient	29,810,038	28,685,432	301,126,654	272,802,485
Medicare inpatient	48,513,678	40,098,977	469,900,601	406,257,943
Medi-Cal traditional outpatient	2,622,546	2,948,238	33,571,156	29,000,089
Medi-Cal traditional inpatient	4,319,253	3,990,943	53,344,209	59,513,148
Medi-Cal managed care outpatient	30,187,198	22,370,434	280,854,145	216,647,521
Medi-Cal managed care inpatient	20,842,201	22,499,784	256,758,356	189,430,844
Commercial insurance outpatient	19,417,708	17,395,413	181,006,667	164,183,995
Commercial insurance inpatient	21,085,097	16,068,753	198,135,138	172,719,401
Uncollectible accounts expense	3,986,399	3,794,554	38,603,709	37,609,598
Other payors	1,310,745	2,955,406	14,912,255	8,490,315
Deductions from revenue	182,972,302	161,680,484	1,836,955,835	1,567,573,600
Net patient revenue	$ 58,084,461	$ 44,660,977	$ 524,322,042	$ 491,250,497
Gross billed charges by patient type:				
Inpatient	$ 130,582,607	$ 108,442,170	$ 1,276,374,759	$ 1,103,993,431
Outpatient	79,568,284	72,684,563	794,568,648	692,222,939
Emergency room	30,905,873	25,214,728	290,334,469	262,607,727
Total	$ 241,056,764	$ 206,341,461	$ 2,361,277,876	$ 2,058,824,096

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES
April 30, 2023

	Month of April,		Ten months ended April 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 58,084,461	$ 44,660,977	$ 524,322,042	$ 491,250,497
Other operating revenue	8,114,714	3,775,273	15,725,228	12,458,130
Total operating revenue	66,199,175	48,436,250	540,047,270	503,708,627
Operating expenses:				
Salaries and wages	14,576,020	15,122,043	169,148,524	154,528,275
Compensated absences	3,492,842	2,951,866	28,855,854	27,134,409
Employee benefits	9,813,071	5,051,787	79,273,460	67,785,168
Supplies, food, and linen	7,173,182	6,487,735	68,469,985	63,395,655
Purchased department functions	3,823,713	3,888,172	41,313,987	34,227,839
Medical fees	1,982,177	2,065,564	20,903,402	18,665,726
Other fees	2,688,657	3,760,758	29,332,930	25,305,205
Depreciation	1,826,428	1,888,084	20,334,222	18,447,243
All other expense	1,633,258	2,013,236	15,989,445	14,236,685
Total operating expenses	47,009,348	43,229,245	473,621,809	423,726,205
Income from operations	19,189,827	5,207,005	66,425,461	79,982,422
Non-operating income:				
Donations	2,606,456	166,667	8,366,424	1,742,540
Property taxes	333,333	333,333	3,333,333	3,333,333
Investment income	1,714,706	(416,004)	6,059,942	(12,561,289)
Taxes and licenses	0	(29,074)	0	(29,074)
Income from subsidiaries	(6,182,360)	(1,605,833)	(37,351,085)	(27,197,665)
Total non-operating income	(1,527,865)	(1,550,911)	(19,591,386)	(34,712,155)
Operating and non-operating income	17,661,962	3,656,094	46,834,075	45,270,267
Net assets to begin	884,961,119	851,968,733	855,789,006	810,354,560
Net assets to end	$ 902,623,081	$ 855,624,827	$ 902,623,081	$ 855,624,827
Net income excluding non-recurring items	$ 17,661,962	$ 3,656,094	$ 46,834,075	$ 38,977,891
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	6,292,376
Operating and non-operating income	$ 17,661,962	$ 3,656,094	$ 46,834,075	$ 45,270,267

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF INVESTMENT INCOME
April 30, 2023

	Month of April,		Ten months ended April 30,	
	current year	prior year	current year	prior year
Detail of other operating income:				
Dietary revenue	$ 276,024	$ 141,986	$ 1,624,817	$ 1,402,810
Discounts and scrap sale	93,965	5,354	920,956	1,051,533
Sale of products and services	14,617	23,370	356,902	680,597
Clinical trial fees	0	0	0	27,700
Stimulus Funds	0	0	0	0
Rental income	129,320	140,571	1,681,484	1,590,269
Other	7,600,788	3,463,992	11,141,069	7,705,221
Total	$ 8,114,714	$ 3,775,273	$ 15,725,228	$ 12,458,130
Detail of investment income:				
Bank and payor interest	$ 1,128,137	$ 82,818	$ 8,325,132	$ 859,867
Income from investments	586,568	(2,468,427)	(1,062,940)	(15,078,244)
Gain or loss on property and equipment	0	1,969,605	(1,202,250)	1,657,088
Total	$ 1,714,706	$ (416,004)	$ 6,059,942	$ (12,561,289)
Detail of income from subsidiaries:				
Salinas Valley Medical Center:				
Pulmonary Medicine Center	$ (261,690)	$ (171,117)	$ (1,758,198)	$ (1,849,362)
Neurological Clinic	(99,820)	(55,365)	(684,269)	(547,074)
Palliative Care Clinic	(48,441)	(83,836)	(680,898)	(812,948)
Surgery Clinic	(166,338)	(144,483)	(1,442,101)	(1,249,419)
Infectious Disease Clinic	(26,832)	(17,279)	(309,055)	(251,957)
Endocrinology Clinic	(209,283)	(104,702)	(1,735,710)	(1,229,607)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(887,922)	(192,694)	(4,866,901)	(4,083,951)
OB/GYN Clinic	(500,970)	(561,539)	(3,279,205)	(3,422,705)
PrimeCare Medical Group	(1,552,589)	(582,525)	(6,778,156)	(4,443,028)
Oncology Clinic	(360,011)	192,754	(2,623,735)	(2,142,976)
Cardiac Surgery	(349,825)	(248,018)	(2,856,186)	(1,724,022)
Sleep Center	(62,467)	(25,462)	(363,687)	(299,976)
Rheumatology	(108,738)	(52,833)	(624,749)	(536,205)
Precision Ortho MDs	(661,438)	(98,206)	(3,924,354)	(2,675,316)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(35,266)	(13,753)	(370,515)	(470,198)
Vaccine Clinic	0	314	(683)	(52,549)
Dermatology	(23,756)	(13,870)	(186,516)	(153,534)
Hospitalists	0	0	0	0
Behavioral Health	(40,052)	(64,813)	(334,835)	(649,825)
Pediatric Diabetes	(44,115)	(37,333)	(457,224)	(418,176)
Neurosurgery	(51,795)	(37,014)	(309,145)	(243,938)
Multi-Specialty-RR	474	26,547	71,140	101,503
Radiology	(1,442,282)	(163,456)	(2,963,763)	(2,302,440)
Salinas Family Practice	(141,183)	(135,089)	(1,037,683)	(933,019)
Urology	(158,411)	(100,593)	(962,549)	(170,595)
Total SVMC	(7,232,750)	(2,684,365)	(38,478,977)	(30,561,317)
Doctors on Duty	694,466	800,563	707,517	601,655
Vantage Surgery Center	0	20,418	0	240,972
LPCH NICU JV	0	0	(1,387,567)	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	222,191	225,918	1,448,559	2,236,764
Coastal	34,034	(13,413)	4,595	(252,051)
Apex	0	0	0	103,759
21st Century Oncology	24,758	(2,134)	(28,622)	64,888
Monterey Bay Endoscopy Center	74,941	47,180	383,411	367,665
Total	$ (6,182,360)	$ (1,605,833)	$ (37,351,085)	$ (27,197,665)

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
April 30, 2023

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 321,753,911	$ 308,893,695
Patient accounts receivable, net of estimated uncollectibles of $25,469,267	83,591,939	89,712,467
Supplies inventory at cost	8,103,578	7,891,918
Current portion of lease receivable	546,861	0
Other current assets	16,756,591	16,237,485
Total current assets	430,752,880	422,735,565
Assets whose use is limited or restricted by board	158,016,957	146,810,333
Capital assets:		
Land and construction in process	53,803,445	38,387,373
Other capital assets, net of depreciation	187,630,188	200,964,366
Total capital assets	241,433,633	239,351,739
Other assets:		
Right of use assets, net of amortization	5,622,496	0
Long term lease receivable	1,186,426	0
Investment in Securities	145,492,305	127,635,026
Investment in SVMC	5,420,585	13,546,591
Investment in Coastal	1,648,295	1,735,316
Investment in other affiliates	22,561,651	21,784,222
Net pension asset	(3,732,274)	53,177,364
Total other assets	178,199,484	217,878,519
Deferred pension outflows	95,857,027	50,119,236
	$ 1,104,259,981	$ 1,076,895,392
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	$ 64,164,293	$ 60,652,678
Due to third party payers	18,368,337	44,383,634
Current portion of self-insurance liability	18,676,725	18,361,070
Current portion of lease liability	2,770,954	0
Total current liabilities	103,980,309	123,397,382
Long term portion of workers comp liability	13,801,058	14,288,063
Long term portion of lease liability	3,101,049	0
Total liabilities	120,882,416	137,685,445
Lease deferred inflows	1,642,999	0
Pension liability	79,111,485	83,585,120
Net assets:		
Invested in capital assets, net of related debt	241,433,633	239,351,739
Unrestricted	661,189,448	616,273,088
Total net assets	902,623,081	855,624,827
	$ 1,104,259,981	$ 1,076,895,392

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
April 30, 2023

	Month of April,				Ten months ended April 30,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 241,056,763	$ 208,963,673	32,093,090	15.36%	$ 2,361,277,877	$ 2,080,109,062	281,168,815	13.52%
Dedutions from revenue	182,972,302	161,820,561	21,151,741	13.07%	1,836,955,835	1,607,390,388	229,565,447	14.28%
Net patient revenue	58,084,461	47,143,112	10,941,349	23.21%	524,322,042	472,718,673	51,603,369	10.92%
Other operating revenue	8,114,714	1,374,687	6,740,027	490.30%	15,725,228	13,746,866	1,978,362	14.39%
Total operating revenue	**66,199,175**	**48,517,799**	**17,681,376**	**36.44%**	**540,047,270**	**486,465,540**	**53,581,730**	**11.01%**
Operating expenses:								
Salaries and wages	14,576,020	16,240,125	(1,664,105)	-10.25%	169,148,524	161,960,690	7,187,834	4.44%
Compensated absences	3,492,842	2,591,696	901,146	34.77%	28,855,854	28,730,038	125,816	0.44%
Employee benefits	9,813,071	7,309,849	2,503,222	34.24%	79,273,460	71,776,385	7,497,075	10.45%
Supplies, food, and linen	7,173,182	6,213,598	959,584	15.44%	68,469,985	62,950,045	5,519,940	8.77%
Purchased department functions	3,823,713	3,490,994	332,719	9.53%	41,313,987	34,910,027	6,403,960	18.34%
Medical fees	1,982,177	2,026,754	(44,577)	-2.20%	20,903,402	20,267,543	635,859	3.14%
Other fees	2,688,657	2,125,854	562,803	26.47%	29,332,930	20,105,881	9,227,049	45.89%
Depreciation	1,826,428	1,945,170	(118,742)	-6.10%	20,334,222	19,241,818	1,092,404	5.68%
All other expense	1,633,258	1,732,165	(98,907)	-5.71%	15,989,445	17,461,636	(1,472,191)	-8.43%
Total operating expenses	**47,009,348**	**43,676,205**	**3,333,143**	**7.63%**	**473,621,809**	**437,404,062**	**36,217,747**	**8.28%**
Income from operations	**19,189,827**	**4,841,593**	**14,348,234**	**296.35%**	**66,425,461**	**49,061,477**	**17,363,984**	**35.39%**
Non-operating income:								
Donations	2,606,456	166,667	2,439,789	1463.87%	8,366,424	1,666,667	6,699,757	401.99%
Property taxes	333,333	333,333	(0)	0.00%	3,333,333	3,333,333	(0)	0.00%
Investment income	1,714,706	129,915	1,584,790	1219.86%	6,059,942	1,299,155	4,760,787	366.45%
Income from subsidiaries	(6,182,360)	(3,298,672)	(2,883,688)	87.42%	(37,351,085)	(34,614,030)	(2,737,055)	7.91%
Total non-operating income	**(1,527,865)**	**(2,668,756)**	**1,140,891**	**-42.75%**	**(19,591,386)**	**(28,314,875)**	**8,723,489**	**-30.81%**
Operating and non-operating income	**$ 17,661,962**	**$ 2,172,837**	**15,489,125**	**712.85%**	**$ 46,834,075**	**$ 20,746,602**	**26,087,473**	**125.74%**

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Apr and ten months to date

	Month of Apr		Ten months to date		
	2022	2023	2021-22	2022-23	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	31	33	396	371	(25)
Other Admissions	87	77	957	854	(103)
Total Admissions	118	110	1,353	1,225	(128)
Medi-Cal Patient Days	53	61	615	604	(11)
Other Patient Days	131	145	1,568	1,439	(129)
Total Patient Days of Care	184	206	2,183	2,043	(140)
Average Daily Census	6.1	6.9	7.2	6.7	(0.5)
Medi-Cal Average Days	1.8	1.9	1.6	1.7	0.1
Other Average Days	0.7	1.9	1.7	1.7	0.1
Total Average Days Stay	1.6	1.9	1.6	1.7	0.1
ADULTS & PEDIATRICS					
Medicare Admissions	380	373	3,480	3,995	515
Medi-Cal Admissions	277	263	2,391	2,928	537
Other Admissions	387	295	3,027	3,106	79
Total Admissions	1,044	931	8,898	10,029	1,131
Medicare Patient Days	1,459	1,611	14,996	17,019	2,023
Medi-Cal Patient Days	1,016	1,152	10,125	12,085	1,960
Other Patient Days	1,530	1,077	10,819	11,647	828
Total Patient Days of Care	4,005	3,840	35,940	40,751	4,811
Average Daily Census	133.5	128.0	118.2	134.0	15.8
Medicare Average Length of Stay	3.9	4.4	4.3	4.3	(0.0)
Medi-Cal AverageLength of Stay	3.6	3.8	3.5	3.6	0.1
Other Average Length of Stay	4.1	2.9	2.8	3.0	0.2
Total Average Length of Stay	3.9	3.7	3.5	3.6	0.1
Deaths	31	27	285	256	(29)
Total Patient Days	4,189	4,046	38,123	42,794	4,671
Medi-Cal Administrative Days	21	4	212	85	(127)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	21	4	212	85	(127)
Percent Non-Acute	0.50%	0.10%	0.56%	0.20%	-0.36%

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Apr and ten months to date

	Month of Apr		Ten months to date		
	2022	2023	2021-22	2022-23	Variance
PATIENT DAYS BY LOCATION					
Level I	331	293	2,778	3,005	227
Heart Center	409	354	2,950	3,498	548
Monitored Beds	728	644	7,483	6,732	(751)
Single Room Maternity/Obstetrics	351	313	3,569	3,349	(220)
Med/Surg - Cardiovascular	841	760	7,200	9,176	1,976
Med/Surg - Oncology	131	308	2,683	2,810	127
Med/Surg - Rehab	524	448	4,609	5,171	562
Pediatrics	149	86	1,005	1,241	236
Nursery	184	206	2,183	2,043	(140)
Neonatal Intensive Care	123	179	1,131	1,421	290
PERCENTAGE OF OCCUPANCY					
Level I	84.87%	75.13%	70.29%	76.04%	
Heart Center	90.89%	78.67%	64.69%	76.71%	
Monitored Beds	89.88%	79.51%	91.17%	82.02%	
Single Room Maternity/Obstetrics	31.62%	28.20%	31.73%	29.77%	
Med/Surg - Cardiovascular	62.30%	56.30%	52.63%	67.08%	
Med/Surg - Oncology	33.59%	78.97%	67.89%	71.10%	
Med/Surg - Rehab	67.18%	57.44%	58.31%	65.42%	
Med/Surg - Observation Care Unit	0.00%	89.22%	0.00%	84.13%	
Pediatrics	27.59%	15.93%	18.37%	22.68%	
Nursery	37.17%	41.62%	21.76%	20.36%	
Neonatal Intensive Care	37.27%	54.24%	33.82%	42.49%	

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Apr and ten months to date

	Month of Apr		Ten months to date		
	2022	2023	2021-22	2022-23	Variance
DELIVERY ROOM					
Total deliveries	108	99	1,279	1,171	(108)
C-Section deliveries	28	36	415	383	(32)
Percent of C-section deliveries	25.93%	36.36%	32.45%	32.71%	0.26%
OPERATING ROOM					
In-Patient Operating Minutes	19,284	16,444	192,150	199,591	7,441
Out-Patient Operating Minutes	24,898	28,776	250,247	272,004	21,757
Total	44,182	45,220	442,397	471,595	29,198
Open Heart Surgeries	6	15	115	140	25
In-Patient Cases	161	110	1,413	1,368	(45)
Out-Patient Cases	255	307	2,518	2,792	274
EMERGENCY ROOM					
Immediate Life Saving	30	40	325	333	8
High Risk	481	828	4,662	6,221	1,559
More Than One Resource	2,739	2,875	25,795	29,401	3,606
One Resource	1,578	1,818	16,399	20,610	4,211
No Resources	84	109	837	964	127
Total	4,912	5,670	48,018	57,529	9,511

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Apr and ten months to date

	Month of Apr		Ten months to date		
	2022	2023	2021-22	2022-23	Variance
CENTRAL SUPPLY					
In-patient requisitions	14,733	14,686	150,898	152,969	2,071
Out-patient requisitions	10,069	10,072	92,737	95,155	2,418
Emergency room requisitions	728	961	10,150	7,613	-2,537
Interdepartmental requisitions	6,327	6,219	60,447	69,338	8,891
Total requisitions	31,857	31,938	314,232	325,075	10,843
LABORATORY					
In-patient procedures	36,386	38,458	348,393	397,296	48,903
Out-patient procedures	10,550	10,945	112,874	104,290	-8,584
Emergency room procedures	11,807	13,479	109,463	129,409	19,946
Total patient procedures	58,743	62,882	570,730	630,995	60,265
BLOOD BANK					
Units processed	332	260	3,025	3,091	66
ELECTROCARDIOLOGY					
In-patient procedures	997	1,179	9,822	11,312	1,490
Out-patient procedures	330	407	3,689	3,615	-74
Emergency room procedures	1,056	1,234	10,257	11,459	1,202
Total procedures	2,383	2,820	23,768	26,386	2,618
CATH LAB					
In-patient procedures	83	130	899	1,007	108
Out-patient procedures	102	85	907	813	-94
Emergency room procedures	0	0	0	1	1
Total procedures	185	215	1,806	1,821	15
ECHO-CARDIOLOGY					
In-patient studies	380	467	3,549	3,973	424
Out-patient studies	263	267	2,169	2,429	260
Emergency room studies	1	1	8	12	4
Total studies	644	735	5,726	6,414	688
NEURODIAGNOSTIC					
In-patient procedures	133	130	1,518	1,401	-117
Out-patient procedures	24	20	255	197	-58
Emergency room procedures	0	0	0	0	0
Total procedures	157	150	1,773	1,598	-175

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Apr and ten months to date

	Month of Apr		Ten months to date		
	2022	2023	2021-22	2022-23	Variance
SLEEP CENTER					
In-patient procedures	0	1	0	2	2
Out-patient procedures	153	160	1,725	1,401	-324
Emergency room procedures	0	0	0	1	1
Total procedures	153	161	1,725	1,404	-321
RADIOLOGY					
In-patient procedures	1,280	1,401	12,415	14,480	2,065
Out-patient procedures	370	458	4,044	3,936	-108
Emergency room procedures	1,411	1,506	12,711	15,168	2,457
Total patient procedures	3,061	3,365	29,170	33,584	4,414
MAGNETIC RESONANCE IMAGING					
In-patient procedures	165	187	1,307	1,515	208
Out-patient procedures	100	119	1,087	1,023	-64
Emergency room procedures	5	2	71	59	-12
Total procedures	270	308	2,465	2,597	132
MAMMOGRAPHY CENTER					
In-patient procedures	3,659	3,891	35,921	39,718	3,797
Out-patient procedures	3,649	3,856	35,675	39,355	3,680
Emergency room procedures	2	0	12	9	-3
Total procedures	7,310	7,747	71,608	79,082	7,474
NUCLEAR MEDICINE					
In-patient procedures	19	17	154	191	37
Out-patient procedures	75	76	754	902	148
Emergency room procedures	0	0	5	2	-3
Total procedures	94	93	913	1,095	182
PHARMACY					
In-patient prescriptions	79,602	91,756	856,459	960,490	104,031
Out-patient prescriptions	14,089	15,650	148,408	150,085	1,677
Emergency room prescriptions	7,862	8,782	70,354	87,097	16,743
Total prescriptions	101,553	116,188	1,075,221	1,197,672	122,451
RESPIRATORY THERAPY					
In-patient treatments	14,296	19,381	180,757	181,557	800
Out-patient treatments	892	1,296	11,756	11,147	-609
Emergency room treatments	129	467	2,243	4,110	1,867
Total patient treatments	15,317	21,144	194,756	196,814	2,058
PHYSICAL THERAPY					
In-patient treatments	2,403	2,210	23,590	25,604	2,014
Out-patient treatments	262	278	2,968	1,987	-981
Emergency room treatments	0	0	0	2	2
Total treatments	2,665	2,488	26,558	27,593	1,035

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Apr and ten months to date

	Month of Apr		Ten months to date		
	2022	2023	2021-22	2022-23	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,269	1,251	14,630	15,866	1,236
Out-patient procedures	120	187	1,536	1,675	139
Emergency room procedures	0	0	0	0	0
Total procedures	1,389	1,438	16,166	17,541	1,375
SPEECH THERAPY					
In-patient treatments	544	592	4,454	4,706	252
Out-patient treatments	18	17	278	251	-27
Emergency room treatments	0	0	0	0	0
Total treatments	562	609	4,732	4,957	225
CARDIAC REHABILITATION					
In-patient treatments	0	0	0	1	1
Out-patient treatments	462	644	5,539	5,210	-329
Emergency room treatments	1	0	1	0	-1
Total treatments	463	644	5,540	5,211	-329
CRITICAL DECISION UNIT					
Observation hours	276	437	3,311	4,259	948
ENDOSCOPY					
In-patient procedures	88	66	904	830	-74
Out-patient procedures	19	59	294	604	310
Emergency room procedures	0	0	0	0	0
Total procedures	107	125	1,198	1,434	236
C.T. SCAN					
In-patient procedures	695	749	5,923	7,390	1,467
Out-patient procedures	347	455	3,513	4,022	509
Emergency room procedures	685	723	6,117	6,798	681
Total procedures	1,727	1,927	15,553	18,210	2,657
DIETARY					
Routine patient diets	19,084	20,660	186,503	235,669	49,166
Meals to personnel	21,426	23,295	217,479	246,257	28,778
Total diets and meals	40,510	43,955	403,982	481,926	77,944
LAUNDRY AND LINEN					
Total pounds laundered	95,294	100,446	982,277	1,020,928	38,651

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: May 16, 2023

Re: Policies Requiring Approval

As required under Title 22, CMS, and The Joint Commission (TJC), please find below a list of regulatory required policies with summary of changes that require your approval.

	Policy Title	Summary of Changes	Responsible VP
1.	Quality Assessment and Performance Improvement Plan	Name change, addition of pain management, opiod and health equity to goals. Committee structure Org Chart updated.	Allen Radner, CMO
2.	Risk Management Plan	Addition of Just Culture to Scope.	Allen Radner, CMO
3.	Patient Safety Program Plan	Name change, addition of Just Culture and BETA Healthcare Group and minor grammatical corrections	Allen Radner, CMO
4.	Scope of Service: Pharmacy	Name change	Clement Miller, COO
5.	Scope of Service: Transport	Name change, updated hours of operation, updated definition of practice and required staff to align with current practice.	Lisa Paulo, CNO
6.	Scope of Service: Outpatient Infusion	Name change and updates to staffing plan per practice.	Lisa Paulo, CNO
7.	Tuition Assistance	Template corrected and policy updated to align with new expanded tuition assistance process.	Michelle Barnhart Childs, CHRO

Status **Pending** PolicyStat ID **13233581**

Last Approved	N/A	Owner	Aniko Kukla: Director Quality & Patient Safety
Last Revised	04/2023	Area	Plans and Program
Next Review	1 year after approval		

Patient Safety Program Plan

I. PURPOSE

A. To describe the components of the Patient Safety Program at Salinas Valley ~~Memorial Hospital~~Health Medical Center (~~SVMH~~SVHMC) under the Salinas Valley ~~Memorial Healthcare System (SVMHS)~~Health, which supports and promotes the mission, vision, and strategic plan for the organization. The program plan is designed to reduce medical errors and hazardous conditions and reduce preventable patient safety events by utilizing a systematic, coordinated and continuous evidence based approach to maintenance and improvement of the health and safety of our patients. The components are outlined in the following sections:

- Patient Safety Program Scope and Purpose
- Patient Safety Plan Annual Goals and Objectives
- Patient Safety Program Organizational Structure & Responsibilities
- Patient Safety Program Elements
- Patient Safety Plan Management

B. To deliver health care to our community with the commitment to provide safe and equitable high quality health care to all patients we serve.

- The organization recognizes that a patient has the right to a safe environment, and an error free care experience. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors.
- The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error does occur.
- The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results.

II. PATIENT SAFETY PROGRAM SCOPE AND PURPOSE

A. The purpose of the organizational Patient Safety Program Plan is to develop, implement and evaluate a patient safety program that improves patient safety and reduces risk to patients through an environment that encourages:

- Recognition and acknowledgement of risks to patient safety and medical/health care errors that impact achieving better outcomes.
- The initiation of actions to promote a culture of safety throughout the facility which includes but are not limited to safe integration of technology when possible.
- Creation of a non-punitive approach for reporting, analyzing and evaluating errors and problems.
- Facilitation of sharing knowledge to effect behavioral changes and organizational improvement to reduce risk and improve patient safety.
- Implementation of known proactive practices that promote patient safety and decrease variation and defects (waste).
- Promotion of the rapid redesign of unsafe care processes, methods and systems in response to actual and potential adverse events that are validated, to ensure reliability.
- Development of methods for analyzing systems and processes to track and monitor patient safety.
- The internal reporting/communication of identified risks and the action taken to promote a standardized way for interdisciplinary teams to communicate and collaborate.
- Organization-wide education about medical/health care errors.
- Adherence to regulatory and accreditation standards related to Patient Safety.

B. The Patient Safety Program Plan establishes mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

C. As patient care and patient services are coordinated and collaborative efforts, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise patient safety activities. The Patient Safety Program Plan outlines the components of the organizational Patient Safety Program.

D. The purpose of the Patient Safety Program is:

- To improve patient safety and reduce patient risk throughout ~~SVMH~~SVHMC with emphasis on reduction of morbidity and mortality.
- To ensure the ~~SVMH~~SVHMC Board of Directors, Medical Staff, Leadership, and Staff consistently evaluate, monitor, improve and document patient safety activities.
- To provide a mechanism to assist ~~SVMH~~SVHMC in accomplishing its strategic goals

and objectives relative to the quality and safety of patient care.

- To promote and encourage staff participation in patient safety incidents and to emphasize finding system and design flaws (the "how" of events/errors) and not on individuals (the "who" of events/errors).
- To ensure the Patient Safety Program Plan elements are integrated into the Organization's Quality and Performance Improvement Plan and the strategic vision.

E. Salinas Valley Health supports a Just Culture philosophy and approach to adverse event investigation and response and has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner.

F. The Patient Safety Program is an organization-wide program and applies to all sites, services and care settings under ~~SVMH~~SVHMC. The program spans all these areas and encompasses all administrative, medical staff, nursing and support activities and includes integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

G. The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, and maintain and improve patient safety. The program encompasses the patient population, visitors, volunteers, students and staff (including Medical Staff) to address maintenance and improvement in patient safety issues in every department throughout ~~SVMH~~SVHMC. There will be an emphasis on important ~~SVMH~~SVHMC and patient care functions as outlined by regulatory and accreditation requirements (i.e. CMS Conditions of Participation, The Joint Commission, Title 22, Health and Safety Codes, etc.)

H. The Patient Safety Program Plan is evaluated and reviewed annually and will include objectives to meet ~~SVMH~~SVHMC's annual patient safety goals and Strategic Plan:

- The Patient Safety Plan is approved by the ~~SVMH~~SVHMC Quality and Safety Committee, Medical Executive Committee and the ~~SVMH~~SVHMC Board of Directors on an annual basis.
- The Board of Directors delegates the responsibility for ~~SVMH~~SVHMC Patient Safety Program oversight to the ~~SVMH~~SVHMC Medical Executive Committee and the Quality and Safety Committee.
- The designated Patient Safety Officer for ~~SVMH~~SVHMC will have administrative responsibility for the program and review and update the Patient Safety Plan as needed.
- ~~SVMH~~SVHMC staff will report unusual occurrences and/or unexpected events as part of the patient safety program, (which includes the full range of safety issues, from potential or no harm errors, to hazardous conditions and sentinel events), that may affect patient safety and/or quality of patient care as outlined in the Sentinel Event/Unexpected Occurrence policy.
- The Patient Safety Program also considers data obtained from other organizational needs assessments, such as Information Management Needs Assessment, Risk Reduction Plans, which includes information regarding barriers to effective communication among caregivers.

I. All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to their direct supervisor (Manger/Director), Patient Safety Officer, Risk Manager or via Incident Reporting System. A report to the appropriate ~~SVMH~~SVHMC Committees occurs in accordance with the established Quality Oversight Structure. The report may contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken and patient outcome. The Quality & Safety Committees will analyze the report information and determine further patient safety activities as appropriate.

III. PATIENT SAFETY PLAN ANNUAL GOALS/ OBJECTIVES

I. The overall purpose of the Patient Safety Program is to create a safe environment. The patient safety plan and program strives to meet or exceed the annual Patient Safety Goals and Objectives.

- ~~SVMH~~SVHMC Patient Safety Program Plan Goals and Objectives:

1. Support department efforts to adhere to The Joint Commission and other regulatory standards as a baseline of Quality and Patient Safety.
2. Support department efforts to adhere to National Patient Safety Goals and Patient Safety Licensing Requirements and to continuously evaluate standards to attain and / or achieve sustained compliance.
3. Oversee the process of tracking, reporting (as needed) and evaluating all adverse events or potential adverse events as described in the Section 1279.1 of the Health and Safety Code, that are determined to be preventable, and facility-acquired infections (HAIs), as defined by the NHSN, that are determined to be preventable.
4. Review Sentinel Event and other Patient Safety Alerts.
5. Improve patient safety through use of Proactive Risk Assessments and/or Root Cause Analysis (RCA)/Comprehensive Systematic Analysis teams as needed.
6. Promote a Culture of Safety by minimizing blame or retribution against staff involved in patient safety incidents and to emphasize finding system and design flaws (the how" of events/errors) and not on individuals (the "how" of events/errors).
7. Improve patient safety awareness by enhancing Proactive Patient Safety Initiatives by increasing patient safety awareness for patients among our employees, medical staff, patients and the community.
8. Integrate and prioritize the patient process and outcome improvement initiatives in accordance with the QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN
9. Evaluate and identify opportunities for improvement regarding medication management and patient safety.

10. Participate in Beta Healthcare Pro-Active Risk Assessments and Initiatives.
11. Partner with California Healthcare Patient Safety Organization (CHPSO), National Patient Safety Foundation and the Emergency Care Research Institute (ECRI) to eliminate preventable harm and improving the quality and safety of health care delivery at ~~SVMH~~SVHMC.

IV. PATIENT SAFETY PROGRAM ORGANIZATIONAL STRUCTURES/ RESPONSIBILITIES

A. The ~~SVMH~~SVHMC operational structure is aligned to meet the function of the Patient Safety Program. The goals and objectives of the Patient Safety Program are integrated into the functions of each of the following organizational / operational groups: ~~SVMH~~SVHMC Quality & Safety Committees, Medical Executive Committee and the ~~SVMH~~SVHMC Board of Directors. At all levels ~~SVMH~~SVHMC leaders provide the foundation for an effective patient safety system by: Promoting learning; Motivating staff to uphold a fair and just safety culture; Providing a transparent environment in which quality measures and patient harms are freely shared with staff; Modeling professional behavior; Removing intimidating behavior that might prevent safe behaviors and Providing the resources and training necessary to take on improvement initiatives.

1. **Board of Directors**
    - The ~~SVMH~~SVHMC Board of Directors, through the approval of this document, authorizes the establishment of a planned and systematic approach to preventing and addressing patient safety. The Board delegates the implementation and oversight of this program to the Patient Safety Officer. It is the ultimate responsibility of the ~~SVMH~~SVHMC Board of Directors to ensure quality and safe patient care throughout the organization. Key responsibilities of the Board of Directors regarding Patient Safety are seen in activities such as:
        a. Critically examines ~~SVMH~~SVHMC and medical staff processes to assure high standards.
        b. Monitors the adequacy and appropriateness of the Medical Staff processes.
        c. Delegates' oversight of medical care to the Medical Staff per California law.
        d. Approves the Patient Safety Program Plan.
        e. Reviews ~~SVMH~~SVHMC performance on key quality and safety indicators including sentinel/never events, and holds senior leadership, physician leadership, mid-level management, and frontline caregivers directly accountable for results.
2. **Patient Safety Officer**

- The Patient Safety Officer is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Patient Safety Officer will establish the structures and processes necessary to accomplish this objective.
- The Patient Safety Office will review, and in collaboration with relevant leaders, identify and implement actions as necessary for all critical events within 5 days of the event. The Patient Safety Officer or designee will review non critical incidents for trends / patterns or concerns and share with appropriate leaders, Quality Management and/or medical staff as necessary.
- The Patient Safety Officer communicates and collaborates with Administration and department leaders and others in an effort to ensure coordination in reduction of harm and promote safe practices as well as a safe culture of reporting.
- Oversees the Culture of Safety survey as defined by the organization.
- Meets routinely with leaders and staff on the Patient safety Program goals, objectives and outcomes.
- Is available to all persons under ~~SVMH~~SVHMC when questions or concerns are raised concerning the safety of patients. Collaborates with the Environmental Health and Safety Officer for other safety concerns.

3. **Medical Executive Committees (MEC)**
    - As delegated by the ~~SVMH~~SVHMC Board of Directors and consistent with its bylaws, policies and rules and regulations, the Medical Executive Committee is responsible for the day-to-day implementation and evaluation of the processes and activities noted in this program. These Patient Safety responsibilities include but are not limited to:
        a. Reviewing Patient Safety initiatives and activities.
        b. Approving the Patient Safety Program Plan and providing subsequent recommendations for approval to the Board.
        c. Identifying opportunities to improve patient care, patient safety, and ~~SVMH~~SVHMC's performance. This responsibility is shared with Quality and Safety Committees of ~~SVMH~~SVHMC.
4. **Senior Leadership Team**
    - As delegated by the ~~SVMH~~SVHMC Board of Directors, the Senior Leadership Team responsibilities include:
        a. Incorporating Patient Safety function into the Strategic Plan.
        b. Reviewing and approving the Patient Safety Program Plan.
        c. Ensuring that processes are in place for communicating relevant Patient Safety information throughout ~~SVMH~~SVHMC and identifying opportunities to improve Patient Safety. Allocating sufficient resources needed to improve Patient Safety.

d. Evaluating the culture of safety and quality as indicated, using valid and reliable tools and using the reliable tools to create a culture of safety and quality.

e. Promoting a culture of safety in which staff is encouraged to identify and communicate opportunities for improvement, report patient safety risks, disclose significant process / protocol variances ('near misses') and participate in performance improvement activities.

5. **Quality and Safety Committees**

- The Quality and Safety Committee's responsibilities for patient safety include:

a. Overseeing all Patient Safety activities, which include approving, prioritizing and facilitating operationalization of the Plan.

b. Reviewing and evaluating the Patient Safety Plan and provides its subsequent recommendations for approval to medical staff, Senior Leadership and the Board.

c. Reviewing Patient Safety reports and identifying opportunities to improve Patient Safety. This responsibility is shared with medical staff and Leadership.

d. Reviewing action plans resulting from teams for intensive assessment of adverse events.

e. Reviewing and evaluating reports regarding the progress and effectiveness of Patient Safety initiatives and improvement activities.

f. Ensuring that Patient Safety is incorporated in the design of processes, functions and services.

g. ~~Oversight~~Oversees the committee for the Safety and Reliability Council

6. **Patient Safety Advisory Team (PSAT)**

- This ad-hoc committee is comprised of key representatives from leadership to:

a. Evaluate reported events related to patient safety and quality care that occur within ~~SVMH~~SVHMC to determine whether the event is treated as a sentinel event and/or is reportable according to state and regulatory requirements.

b. The Regulatory and Accreditation team ~~oversights~~oversees the PSAT process and collaborates with the Quality and Risk Departments for evaluation of events as necessary.

7. **Medical Staff**

- The Medical Staff supports Patient Safety through the following:

a. Incorporates ~~SVMH~~SVHMC patient safety goals into various section, committee and department meetings.

b. Provides patients with continuing care and quality of care meeting the professional standards of the medical staff, which incorporates patient safety goals.

c. Participates in educational and other collaborative activities (proactive risk assessment, event investigation, and performance improvement activities).

8. **Staff**

- To achieve the goal of delivering safe and high quality care, employees are given the empowerment with responsibility and authority to actively participate in ~~SVMH~~SVHMC's Patient Safety Program. ~~SVMH~~SVHMC uses department level resources or educational resources to conduct focused patient safety monitors, support additional education and awareness, and to provide timely feedback on patient safety issues and the effectiveness of our patient safety program. The Patient Safety Committee supports staff to embed quality and patient safety initiatives into consistent daily practice and to assist management in monitoring compliance and progress toward a goal.

V. PATIENT SAFETY PROGRAM ELEMENTS

A. Designing or Re-designing Processes - When a new process is designed (or an existing process is modified) the organization will use information from both internal and external sources on reducing medical errors and incorporate this information into its design or re-design strategies.

B. Identification of Potential Patient Safety Issues - As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care process that, through the occurrence of an error, would have a significant negative impact on the health and well-being of the patient. Areas of focus include:

1. Processes identified through a review of the literature.
2. Processes identified through the organization's performance improvement program.
3. Processes identified through occurrence reports and sentinel events.
4. Processes identified as the result of findings by regulatory and/or accrediting agencies.
5. Processes as identified under patient safety organizations, including but not limited to CHPSO, NQF, The Joint Commission Safety / Sentinel Event Alerts, ECRI, National Patient Safety Foundation, etc.

C. Performance Related to Patient Safety - Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety.

1. Performance measurement data will be collected, aggregated, and analyzed as

necessary to determine if opportunities to improve safety and reduce risk are identified. If so, the organization will prioritize those processes that demonstrate significant variation from desired practice, and allocate the necessary resources to mitigate the risks identified.

D. Opportunities to reduce errors that reflect system issues are addressed through use of failure mode effect analysis through the organization's performance improvement program.

E. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s).

F. Proactive Risk Assessments - The organization is committed to ongoing proactive risk assessments using internal and external knowledge and experience to prevent error occurrence, as well as maintain and improve patient safety.

G. At least every 18 months, the organization will select at least one high-risk care process upon which to proactively improve performance. The process selected will be subjected to a failure-mode-effect analysis based on accepted standards of care. Those gaps that are felt to be most critical will be subjected to intensive analysis. The process will then undergo redesign (as necessary) to mitigate any risks identified. This may be accomplished through review of internal data reports and reports from external sources (including, but not limited to, The Joint Commission sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from State and Federal sources and current literature), and through the performance improvement priority criteria grid. All elements of high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams).

H. Reporting of Process or System Failure and/or medical/health care errors and response.

1. The organization is committed to responding to errors in care in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and where appropriate root/causative cause(s) of the error. To that end, the organization has established a variety of policies and procedures to address these issues:
    - Medical/health errors and occurrences including sentinel events will be reported internally to the appropriate administrative or medical staff entity.
    - Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements.
    - Taylor Farms Family Health and Wellness Incidents resulting in hospitalization or death will be reported to The Compliance Team (TCT) within 48 hours.
2. The organization has established mechanisms to report the occurrence of medical errors both internally and externally, per policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Immediately upon identification, the patient care provider will:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.
- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary;
- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report and in the medical record **as appropriate** to organizational policy and procedure;
- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report via the Occurrence Reporting System.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings in an occurrence report or contact the Patient Safety Office.

3. Staff response to provide/system failures and/or medical/health care errors is dependent upon the type of error identified
4. The Sentinel Event Policy will determine the organizational response to process/system failures and/or medical/health care errors and occurrences.
5. Supporting Staff Involved in Errors - An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive, just culture approach in its management of failures, errors and occurrences.
    - All personnel are **required** to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to ensure appropriate course of action to prevent reoccurrence rather than punish/place blame on staff.
    - As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by

the organization may report these concerns to The Joint Commission or the California Department of Public Health. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to The Joint Commission.

- Staff will be queried regarding their willingness to report medical/health care errors via the Patient Safety Culture Survey. The goal of the survey is to validate the following:
    a. Staff and leaders value transparency, accountability, and mutual respect.
    b. Safety is everyone's first priority.
    c. Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by staff, patients, and families for the purpose of fostering risk reduction
    d. Collective mindfulness is present, wherein staff realizes that systems always have the potential to fail and staff are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed. Staff does not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.
    e. Staff who do not deny or cover up errors, but rather want to report errors to learn from mistakes and improve the system flaws that contribute to or enable patient safety events. Staff knows that their leaders will not focus on blaming providers involved in errors, but rather focus on the systems issues that contributed to or enabled the patient safety event.
    f. By reporting and learning from patient safety events, staff creates a learning organization.
- The organization recognizes that individuals involved in an error may need emotional and psychological support. To that end, the organization has defined processes to assist employees and members of the Medical Staff.
    a. Employees can be referred to the organizations "Employee Assistance Program" for assistance.
    b. Members of the Medical Staff can be referred to the "Physician Health/Well Being Committee" for assistance.

I. Educating the Patient on Error Prevention - The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.
    1. The Patient Safety Program includes a survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to

patients and requests suggestions for improving patient safety.

J. Patients, and when appropriate their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. Informing the Patient of Errors in Care - The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated. The Attending physician / other physician is responsible for assuring that the patient is informed of errors in care.

K. Dissemination of Information - Lessons learned from root cause/comprehensive causative analyses, system or process failures, and the results of proactive risk assessments shall be disseminated to appropriate staff that provides care, treatment and service pertinent to the specific issue.

VI. PATIENT SAFETY PLAN MANAGEMENT

A. **Patient Safety Program Resources**

1. Designated resources have been provided to assist the organization to meet the goals and objectives of the Patient Safety Program and to facilitate the implementation of the Patient Safety Program Plan.
2. The Risk Management, Quality Management and Patient Safety Divisions and all Departments are the primary source of support for patient safety improvement activities within ~~SVMH~~SVHMC. These departments include staff to assist with the integration of event investigation, data management, analysis, clinical processes and patient outcomes.
3. ~~SVMH~~SVHMC is committed to providing psychological support to staff involved in serious patient safety events or critical/sentinel events. Sources of support include:
    - Human Resources
    - Employee Assistance Program
    - Clinical Social Work Department
    - Rights and Ethics Committee

B. **Patient Safety Problem Identification, Notification & Resolution Process**

1. When a situation occurs that may risk patient safety, ~~SVMH~~SVHMC staff is requested to report unusual occurrences and/or unexpected event as outlined in the ADVERSE EVENTS - REPORTABLE Policy using any of the following reporting mechanisms:
    - On-line Occurrence/Event Report or can elect to notify Administration directly.
        a. Direct Notification can include:
            - Notification to Department manager/supervisor
            - Notification to the Patient Safety Officer
            - Notification to Administrative Supervisor
            - Notification to Quality, Risk, Infection Control

2. When a situation arises that requires immediate response to a patient safety event, the staff makes any necessary changes to prevent further harm to the patient, communicates with the patient and/or patient's family and notifies the Administrative Supervisor. The Administrative Supervisor is responsible for informing the Administrator on-call, the Patient Safety Officer or their designee. DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY

C. **Patient Safety Program - ~~SVMH~~SVHMC Staff & Medical Staff Education**

1. ~~SVMH~~SVHMC communicates patient safety information throughout the organization to effect behavioral changes in itself and other healthcare organizations. Examples of communication methods include:
    - Posters in key locations.
    - Medical Staff intranet portal.
    - Patient Safety on STARnet (http://starnet/)
    - Patient Safety Awareness Events.
    - Leadership, medical staff and employee meetings.
2. Education programs are designed and provided to the staff upon hire and on an ongoing basis to provide timely information regarding the Patient Safety Program, its annual goals and objectives and its accomplishments. Education includes the staff member's right to report any safety or quality of care concerns to The Joint Commission and the California Department of Public Health. Because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
3. Ongoing education is provided through various mechanisms such as but not limited to:
    - In-service training to increase knowledge of patient safety requirements
    - In-service training to encourage reporting of unanticipated adverse events and near misses and in identifying patient safety events that should be reported
    - Educational updates addressing patient safety issues, including Sentinel Event Alerts.
    - Patient Safety Awareness activities.
    - Computer based learning modules.

D. **Patient Safety Program Patient & Community Education**

1. Patients are given information about their rights and responsibilities while receiving services. Patients and, when appropriate, their families are informed about the outcomes of care, treatment and services, including unanticipated outcomes.).
2. Patients may be given patient safety awareness materials, such as The Joint Commission's "Speak Up" brochure.

VII. REFERENCES

A. Center for Medicare Services (CMS) Conditions of Participation
B. Joint Commission Sentinel Event Policy
C. The Joint Commission Standards.
D. To ERR is Human: Building a Safer Health System
E. Crossing the Quality Chasm: A New Health System for the 21st Century
F. OIG Report on Medical Error 12-00
G. HSC §442.5, HSC §1254.4, HSC §1255.8, HSC §1279.6, HSC §1279.7, HSC §1288.6, HSC §1288.7, HSC §1288.8, HSC §1288.9, HSC §1288.95
H. National Patient Safety Foundation
I. The Just Culture Community, www.justculture.org
J. California Senate Bill 1058, (Infection Control and Prevention)
K. California Senate Bill 444 (Patient Safety Plan)

Attachments

ATD.pdf

Cal-oshaguidanceswineflu.pdf

Interim_enforcement_H1N1 CAL OSHA 09082009.pdf

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	05/2023
QSC	Aniko Kukla: Director Quality & Patient Safety	05/2023
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2023
Policy Owner	Aniko Kukla: Director Quality & Patient Safety	05/2023

Standards

No standards are associated with this document

History

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> Added JC language

Draft saved by Kukla, Aniko: Director Quality & Patient Safety on 3/9/2023, 1:09PM EST

Draft discarded by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 3/9/2023, 1:36PM EST

Comment by Kukla, Aniko: Director Quality & Patient Safety on 4/3/2023, 10:12PM EDT

> Changed name of the hospital and medical center. Added the word equitable to the purpose under point B. And Risk Manager added Just Culture language.

Draft saved by Kukla, Aniko: Director Quality & Patient Safety on 4/12/2023, 1:52PM EDT

Draft discarded by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/25/2023, 6:20PM EDT

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> Name changes made

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> Typos corrected. Name changes made.

Last Approved by Kukla, Aniko: Director Quality & Patient Safety on 5/1/2023, 2:05PM EDT

> Approved - Quality and Safety Committee 4/6/2023

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 5/4/2023, 1:12PM EDT

> Previously approved by Policy Committee

Last Approved by Kukla, Aniko: Director Quality & Patient Safety on 5/4/2023, 1:14PM EDT

> Previously approved by QSC April 6th, 2023.

Last Approved by DeSalvo, Katherine: Director Medical Staff Services on 5/4/2023, 2:16PM EDT

> Approved by MEC 04-13-23

Status **Pending** PolicyStat ID **13541334**

Last Approved	N/A	Owner	Mark Danek: Director of Pharmacy
Last Revised	04/2023	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Pharmacy

I. SCOPE OF SERVICE

The Pharmacy Department supports the Mission, Vision, Values and Strategic Plan of Salinas Valley ~~Memorial Healthcare System~~Health Medical Center (~~SVMHS~~SVHMC) and has designed services to meet the needs and expectations of patients, families and the community.

The purpose of the Pharmacy Department is to enhance patient services and health programs that help Salinas Valley ~~Memorial Healthcare~~Health Medical Centercare System remain a leading provider of medical care. The goal of the Pharmacy Department is to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible.

A. Pharmaceutical Care

1. Provide direct clinical patient centered services to all medical, surgical, pediatric, neonatal, critical care, and outpatient infusion patient areas.
2. Establish an appropriate pharmacist/patient relationship with all patients in areas served by clinical pharmacists. All patients requiring this service receive care. The department prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
3. Enhance pharmacists' skills in prioritizing patients' pharmaceutical care needs and addressing those needs according to the priorities established by the department.
4. Advance efforts to promote a continuum of care from the inpatient to the outpatient setting.
5. Review therapy regimens to assure that patients receive optimum medication therapy.
6. Confirm the intent of the Department of Pharmacy Services to comply with all standards set forth by the Joint Commission on the Accreditation of Health Care Organizations (TJC).

B. Clinical Services

1. The Pharmacy and Therapeutics Committee has oversight to develop and update drug therapy protocols that reflect current standards of care, which improve patient outcomes.
2. Promote the development and application of clinical pathways and order sets for health care providers.
3. Develop treatment guidelines for medications that require intensive management for optimal clinical outcomes.
4. Assess and develop parenteral nutrition orders in collaboration with clinical nutrition staff and physicians when ordered per protocol. Ordering, monitoring, and documentation will be in accordance with the current TPN protocol.
5. Review patient medication histories in complicated at risk patients on multiple drug regimens and participate in multidisciplinary rounds.
6. Provide pharmacists with access to treatment guidelines, therapeutic monitoring tools and clinical information on a network shared drive and/or hospital intranet to facilitate provision of pharmaceutical care.
7. Develop and implement an Antibiotic Stewardship Program (ASP) to improve quality of care and enhance patient safety.
8. Develop strategic plan for current and future staffing needs.

C. Distributive Inpatient Services

1. Utilize Pyxis Medstation ES to improve timeliness and accuracy of medication delivery and administration.
2. Invest in automation of unit dose packages, bar coding and bedside medication verification to assure the safety of medication dispensing and administration.
3. Continue the provision of pharmacy services to underserved patients.
4. Proactively consider formulary agents as an alternative to non-formulary medications and utilize therapeutic interchange as appropriate.
5. Provide medications in ready-to-administer unit dose form to promote patient safety and drug security.
6. Monitor and adjust inventory levels based on patient care needs.
7. Continue to utilize pharmacy automations with implementation of Pyxis Anesthesia machines in the OR region.

D. Education and Training

1. Provide educational programs to pharmacists, medical staff, and ancillary personnel.
2. Provide educational programs to physicians, nurses and other health care practitioners that enhance their knowledge of drug therapy and that cultivate the multidisciplinary collaborative approach to patient care.

3. Identify and provide appropriate and necessary educational opportunities for pharmacists, technicians, and other hospital staff.

E. Drug Information/Computer Services

1. Update our technological resources including computer hardware, software, and databases through the purchase of software so that drug information can be more efficiently stored, retrieved, and disseminated in a timely manner.
2. Continually review and revise drug use policies as necessary to support analysis leading to improvement in the medication use process.
3. Update drug information resources in the Pharmacy Library, including reference texts and disease state files.
4. Develop and update a searchable Intranet Hospital Formulary as necessary based upon additions and deletions approved by the Pharmacy and Therapeutics Committee.
5. Support and promote prescriber order entry.

II. GOALS

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

The goals of the Pharmacy Department are:

A. To provide pharmaceutical care to all patients through the provision of drug therapy for the purpose of achieving definite outcomes that improves patients' quality of life through the integration of clinical practice and the effective provision of medication therapy.

B. To provide clinical pharmacy services to patients and staff in order to support the goal of providing total pharmaceutical care to all patients.

C. To provide for the efficient procurement, distribution and control of all pharmaceuticals.

D. There are sufficient personnel, equipment and supplies maintained to adequately perform the pharmacy services that are offered at Salinas Valley ~~Memorial Healthcare System~~Health Medical Center.

E. To provide educational opportunities to pharmacists and other health care practitioners for enhancement of their skills and knowledge base to improve the quality of patient care and patient health outcomes.

F. To disseminate accurate, comprehensive, and timely drug information to health care practitioners to improve the medication use process and promote cost effective patient outcomes.

G. To support the mission of the Department in providing pharmaceutical care through continuous quality improvement activities to accomplish overall performance improvement.

III. DEPARTMENT OBJECTIVES

A. To support ~~SVMHS~~SVHMC objectives.

B. To deliver safe, effective, and appropriate care in a cost-effective manner.

C. To plan for the allocation of human/material resources and to ensure that staff believe their department staffing patterns are adequate to provide safe pharmaceutical care on most days.

D. To provide high level medication management with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to as high a level of wellness as possible.

E. To collect data about the department function, staff performance, and patient care related to medication use for quality management purposes and continuous quality improvement.

F. To provide a therapeutic environment appropriate for the patient population which promotes healing of the whole person.

G. To provide necessary expertise, technology, instrumentation and equipment for the management of patients.

H. To support nursing care based on the nursing process and medication management.

I. To develop/implement/evaluate standards utilized in the pharmaceutical services arena.

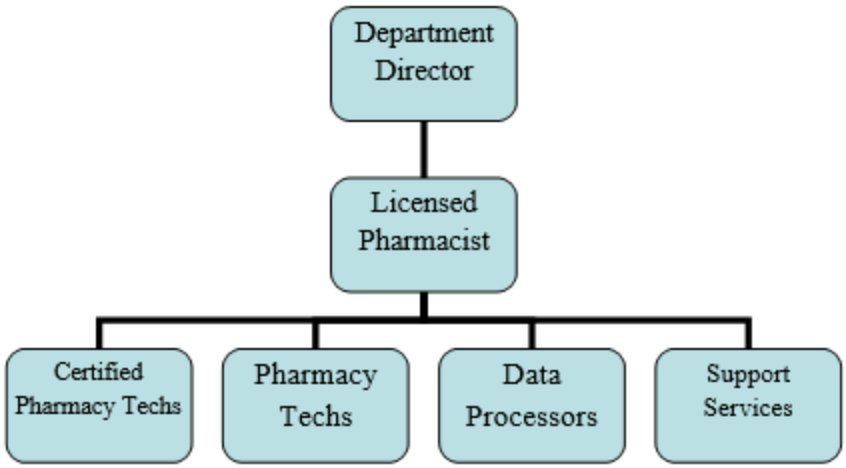
J. To evaluate staff performance on an ongoing basis.

K. To provide appropriate staff orientation and development.

IV. POPULATION SERVED

Pharmacy provides care for all medical, surgical, pediatric, neonatal, critical care, and outpatient infusion patient areas.

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation:

The Unit/Department provides services 24 hours per day, 365 days per year.

B. Location of department:

The licensed Pharmacy is located in the basement of the Main Hospital. Specified drug storage areas are located in all patient care units throughout the hospital in accordance with currently accepted State and Federal regulatory standards for pharmaceuticals. The organization has an adequate complement of well-qualified and trained pharmacists to work in specialty areas or provide services to specialty populations that represent a substantial portion of the organization's patient population.

C. Admission, Discharge, Transfer Criteria:
N/A

D. Major Services / Modalities of care may include:

Primary Services:

- Unit dose medication distribution with automated dispense machines.
- Preparation of IV medication, admixtures, large volume, parenteral nutrition and chemotherapy.
- Reviews patient medication for appropriateness, including identification of allergies, drug/drug interactions, food/drug interactions, and therapeutic duplication.
- Consultative (per protocol) services.
- Educational services.
- Drug Utilization Review.
- Code Blue Team participation.
- Development of drug protocols/nomograms.
- Development and maintenance of the hospital formulary through the Pharmacy and Therapeutics Committee.
- Participation in patient rounds.

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

A. The pharmacy team is composed of management, and licensed clinical staff pharmacists, pharmacy technicians, data processor and support services according to the needs of the patients serviced. Services are provided based upon medical staff orders and patients' plans of care.

B. All personnel within the department are under the guidance and direction of the Pharmacy Director. In the Director's absence, the position is filled by the Assistant Director of Pharmacy in collaboration with a Licensed Pharmacist or their designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

C. This department is under the direct supervision of a Pharmacist, licensed by the State Board of

Pharmacy, and having a current license from the State of California to dispense medications. Also, a physician is available by phone or in person when required in dealing with pharmaceutical issues.

D. The Director of the Pharmacy department is directly responsible to the Chief Operating Officer. It is the Pharmacy Director's duty to attend all administrative and technical functions within the department.

E. Under the pharmacist supervision, pharmacy technicians duties may include but not limited to:
    - Removing drugs from stock
    - Counting, pouring, or mixing pharmaceuticals
    - Placing the product into a container and affixing labels to the container
    - Packaging and repackaging
    - Filling medication orders
    - Preparing IV medications such as TPN, chemotherapy, and large volume fluids
    - Floor stock replenishment
    - Medication delivery
    - Procurement and stocking

F. Pharmacy Buyer is responsible for the procurement, maintenance, and evaluation of contract pricing for all inventory of medications as authorized.

G. Billing Clerk is responsible for ensuring accuracy and compliance of billing procedures and updating current pricing information.

H. The Charge Master is responsible for ensuring accurate and timely changes to the electronic medical record drug dictionaries. This position is also responsible for maintaining the Talyst dictionaries and coordinates maintenance of the Pyxis ES dictionary with the Pharmacy Distribution Technician (Pyxis Tech) and the buyer. This person is also responsible for the continuity and compliance evaluation of our 340B program.

I. Pharmacy Administrative Assistant assists in maintaining employee records. Also supports the Director, Assistant Director, and Clinical Coordinator with projects, reports, data collection, schedules, and record keeping as directed.

J. All Staff Clinical Pharmacists participate in medication review, order entry, pharmacokinetic dosing, and medications per protocol. A full range of clinical services are provided including, but not limited to, medication therapy review, patient counseling, provision of drug information, medication/dose selection, managing anticoagulant therapy, medication history, medication order clarification, medication reconciliation, pharmacokinetics management, assisting in investigational studies, protocol development, medication utilization, Adverse drug reactions, medication errors and quality control.

K. The Assistant Director oversees performance of staff clinical pharmacists, develops clinical pharmacy services, and is responsible for ensuring staff development and competency. Provides input for performance evaluations regarding clinical activities and conducts evaluations for Clinical Pharmacists.

L. The Assistant Director oversees operations, conducts performance evaluations for all

technicians and maintains oversight of inventory management/control of controlled substances records.

M. Director of Pharmacy oversees all aspects of pharmacy operations and conducts performance evaluations for the Assistant Director.

VII. REQUIREMENTS FOR STAFF

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

A. Licensure / Certifications:

The basic requirements for ***Pharmacists*** include:

1. California State Board of Pharmacy license

The basic requirements for ***Certified Pharmacy Technicians*** include:

1. Board certification for technicians

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

- Change in regulations and licensing requirements
- Needs assessment completed by Nursing Education

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements.

General Staffing Plan:

Staffing is based on patient volume procedure count and activity. An effective back-up plan has been established for days when staffing is short due to illness, vocation, educational absences and fluctuations in patient acuity and workload. In the event staffing requirements cannot be met, Pharmacy will meet staffing requirements by authorizing overtime.

A licensed Pharmacist by the State of California Board of Pharmacy is always present in the Pharmacy during the hours of operation in the Pharmacy.

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is: based on census. Correct pharmacist to tech ratios must be kept at all times. 2 techs to 1 pharmacist is required by state law.

IX. EVIDENCED BASED STANDARDS

The ~~SVMHS~~SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice

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

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

Performance Improvement processes may include:

1. Develop strategies which enhance the impact of the Medication Safety Team, as part of the Pharmacy and Therapeutics Committee.
2. Enhance the quality management program of the Department through performance improvement team efforts including the continuation of periodic meeting to evaluate medication error trending and to identify opportunities for improvement in the medication use process.
3. Develop strategies and implement changes in the medication use process to improve patient safety and lower the incidence of medication errors.

4. Track indicators of departmental performance through Quality Management reports to identify areas of opportunity for improvement, to focus resources appropriately, and to improve customer service.
5. Systems and patient care services are evaluated to determine timeliness, appropriateness, clinical necessity, and the extent to which the level of care or services provided meets the patient's needs through any one or all of the following quality improvement practices:
    a. Multidisciplinary performance improvement teams
    b. Clinical pertinence reviews
    c. Patient/caregiver and staff surveys
    d. Focused studies
    e. Patient relations services
    f. Employee forums
6. TJC compliance – Medication Management Standards.
7. Medication Reconciliation program.
8. Maintain drug dictionary updates.
9. Develop and maintain a hospital based Antibiotic Improvement Program.

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

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

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

Attachments

Department Director

Approval Signatures

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

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2023
Policy Owner	Mark Danek: Director of Pharmacy	04/2023

Standards

No standards are associated with this document

History

Sent for re-approval by Danek, Mark: Director of Pharmacy on 4/25/2023, 1:49AM EDT

Last Approved by Danek, Mark: Director of Pharmacy on 4/25/2023, 1:49AM EDT

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/26/2023, 4:32PM EDT

> Policy number removed. Hospital name change corrections.

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/26/2023, 4:32PM EDT

> Policy Committee approved. No changes noted.

Status **Pending** PolicyStat ID **13545671**

Last Approved	N/A	Owner	Marian Fox: Clinical Manager
Last Revised	05/2023	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Services: Transport

I. SCOPE OF SERVICE

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

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

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

The department provides services seven days a week. Weekdays ~~0600-2200 and 0700-2200~~0600-2300 and 0700-2300 on weekends.

II. GOALS

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

The goal(s) of Transport Services is to:

A. To provide high quality transport services to inpatients and outpatients in a safe, professional, and expedient manner.

B. Ensure proper resuscitative and monitoring equipment is immediately available.

III. DEPARTMENT OBJECTIVES

A. To support ~~Salinas Valley Memorial Healthcare System~~SVHMC objectives.

B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.

C. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.

D. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.

E. To evaluate staff performance on an ongoing basis.

F. To provide appropriate staff orientation and development.

G. To monitor Transport Services function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

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

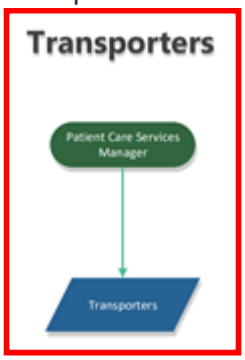
Non-Clinical: N/A

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

V. ORGANIZATION OF THE DEPARTMENT

A. Hours of Operation
The Department provides services seven days a week; ~~0600-2200~~0600-2300 weekdays and ~~0700-2200~~0700-2300 on weekends

B. Transport Services is a virtual department managed through nursing administration.



C. Major Services / Modalities of care may include:
Patient safety during transport in collaboration with nursing staff. Transporters are trained to provide groin and body preps for cardiac catheterization or surgical procedures.

VI. DEFINITION OF PRACTICE AND ROLE IN

MULTIDISCIPLINARY CARE /SERVICE

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

~~B. The Assistant Chief Nursing Officer (ACNO) assume twenty-four (24) hour responsibility for nursing care provided by the Department.~~

~~C. ACNO of the Department is directly responsible to the Chief Nursing Officer (CNO). It is the Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Director. In the Director's absence, the position is filled by their designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.~~

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

VII. REQUIREMENTS FOR STAFF

All individuals who provide patient care services are certified, licensed or registered (according to applicable state law and regulation) and have the appropriate training and competence. ~~Staff include:, Registered Nurses, and Unit Assistants.~~

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

A. Licensure / Certifications:

The basic requirements for ***Transporters*** include:

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

B. Competency

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

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements. Patient acuity level is

determined each shift to plan for staffing needs for the following shift. Patient assignments are made based upon staff skill level and total patient acuity.

General Staffing Plan:

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

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

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

IX. EVIDENCED BASED STANDARDS

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

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

In addition to the overall ~~SVMHS~~SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure Transport Services Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

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

Attachments

Image 1

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2023
Policy Owner	Marian Fox: Clinical Manager	04/2023

Standards

No standards are associated with this document

History

Edited by Fox, Marian: Clinical Manager on 4/25/2023, 1PM EDT

> removed reference to ACNO, adjusted service times

Last Approved by Fox, Marian: Clinical Manager on 4/25/2023, 1PM EDT

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/26/2023, 1:05PM EDT

> Hospital name change corrections

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/26/2023, 1:06PM EDT

> Policy Committee approved. Only very minor revisions.

Administrator override by Woodrow, Lea: Director of Accreditation and Regulatory Complianc on 5/8/2023, 12:56PM EDT

> rebrand typo

Status **Pending** PolicyStat ID **13370709**

Last Approved	N/A
Last Revised	04/2023
Next Review	1 year after approval
Owner	Caryn Liebowitz: Director Outpatient Oncology & Wound Services
Area	Scopes Of Service

Scope of Service: Outpatient Infusion

I. SCOPE OF SERVICE

The Outpatient Infusion Unit supports the Mission, Vision, Values and Strategic Plan of Salinas Valley ~~Memorial Healthcare System~~Health Medical Center (~~SVMHS~~SVHMC) and has designed services to meet the needs and expectations of patients, families and the community.

The purpose of the Outpatient Infusion Unit is to enhance patient services and health programs that help Salinas Valley ~~Memorial Healthcare System~~Health Medical Center remain a leading provider of medical care. The goal of the Outpatient Infusion Unit is to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible.

II. GOALS

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

The goals of Outpatient Infusion are:

A. To provide outpatient care services to patients who require infusions of chemotherapy, antibiotics, blood products or other therapies on an outpatient basis. All medical staff and non-medical staff can refer to the Outpatient Infusion Service.

B. To ensure that all patients treated will receive high quality care in the most expedient and professional manner possible.

C. There is sufficient equipment and supplies maintained to adequately perform the services that are offered to ~~Salinas Valley Memorial Hospital System (SVMHS)~~SVHMC.

D. A Licensed Practitioner will provide direct supervision onsite during patient treatment or via

direct contact at the medical oncology clinic.

E. Proper resuscitative and monitoring equipment is immediately available for interim management of emergent care until 911 system is activated and arrives on site. .

III. DEPARTMENT OBJECTIVES

A. To support Salinas Valley ~~Memorial Healthcare System~~Health Medical Center objectives.

B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.

C. To plan for the allocation of human/material resources.

D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.

E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.

F. To evaluate staff performance on an ongoing basis.

G. To provide appropriate staff orientation and development.

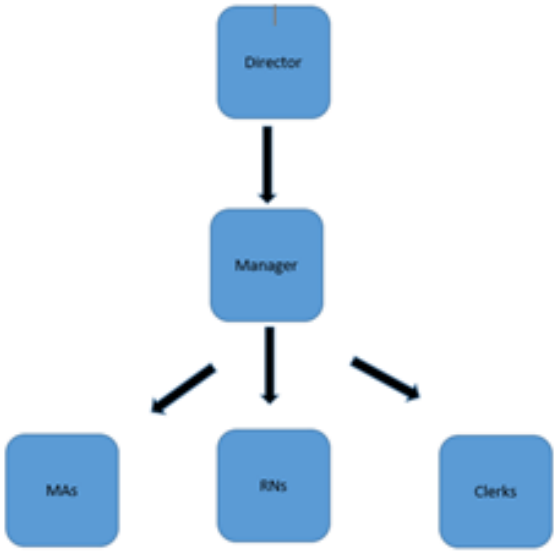
H. To monitor Outpatient Infusion Unit function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Clinical:

The Outpatient Infusion Unit provides care for adult outpatients to include but not limited to oncology/ hematology, rheumatology, nephrology, and neurology.

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation
The Infusion Care Unit provides services Monday- Friday, between the hours 0700-1730.

Location of department
The Infusion Care Unit is an outpatient department located at 515 E. Romie Lane in Salinas, Ca.

B. Admission, Discharge, Transfer Criteria (if applicable): This is an Outpatient/Ambulatory facility where patients have lifetime accounts. Patients receive treatment several times a week and are "arrived" for their appointment and "departed" after treatment. If the patient requires a

higher level of care 911 is called and patient is transferred to the Emergency Department.

C. Major Services / Modalities of care may include:
Outpatient Infusion provides care / services to patients with primary diagnoses, including but not limited to:

- Chemotherapy administration
- Antibiotic Therapy
- Blood and blood product transfusions
- Administrations of medications
- Injections
- Hydration therapy
- Maintenance of central lines such as PICCs and Vascular access port.
- Therapeutic Phlebotomy

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

A. Care in the Infusion Care Unit is delivered by a multidisciplinary team comprised of medical staff and registered nurses according to the needs of the patients.

B. The Director and Clinical Manager assume responsibility of day to day operations and reports up to the Chief Nursing Officer. It is the Director's duty to ensures administrative and technical functions within the department are carried out. All personnel within the department are under the guidance and direction of the Director.

C. The Director of Pharmacy will be responsible for the pharmacy services in the outpatient infusion center. This staff will be supported by the management team in the main hospital. The pharmacy team will include:

- One full time IT ONCO\EMR\Oncology specialty support position
- Three full time pharmacist
- Two full time technicians

VII. REQUIREMENTS FOR STAFF

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

The Unit follows guidelines of national, state and local regulatory bodies. Standards of practices are consistent with BLS, and Oncology Nursing Society (ONS).

A. Licensure / Certifications:

The basic requirements for ***Registered Nurses*** include:

1. Current state licensure

2. Current BLS
3. Completion of Oncology Nursing Society (ONS) Chemotherapy and Immunotherapy Course
4. Current ONS Chemotherapy and Immunotherapy provider card
5. Completion of competency-based orientation
6. Completion of annual competency

The basic requirements for *Outpatient Infusion Clerk* include:

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

The basic requirements for *Medical Assistants* include:

1. Current BLS
2. Current Phlebotomy Certification
3. **Completion of competency-based orientation**

Completion of annual competency

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input

- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements
- Needs assessment completed by Nursing Education

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

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

General Staffing Plan: ~~The RN to patient ratio is one RN to no greater than four patients at the same time.~~ Services are provided from 0700-1730. Staffing is based on patient volume ~~and acuity~~. Authorization of overtime will also be considered.

In the event of a severe emergency, cases will be prioritized to meet patient needs.

IX. EVIDENCED BASED STANDARDS

The ~~SVMHS~~SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient

assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2023
Policy Owner	Caryn Liebowitz: Director Outpatient Oncology & Wound Services	03/2023

Standards

No standards are associated with this document

History

Edited by Liebowitz, Caryn: Director Outpatient Oncology & Wound Services on 3/24/2023, 6:28PM EDT

> The staffing plan was revised. There is not a specific nurse: patient ratio which was stated in the document.

Last Approved by Liebowitz, Caryn: Director Outpatient Oncology & Wound Services on 3/24/2023, 6:28PM EDT

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/20/2023, 6:09PM EDT

> Name changes made.

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/21/2023, 1:08PM EDT

> Policy Committee approved

Status **Pending** PolicyStat ID **12853541**

Last Approved	N/A
Last Revised	05/2023
Next Review	3 years after approval
Owner	Michelle Barnhart Childs: Chief Human Resources Officer
Area	Human Resources

Tuition Assistance

I. POLICY STATEMENT:

~~A. Salinas Valley Memorial Hospital provides a tuition assistance for approved programs to facilitate regular full-time and part-time employee RNs to participate in advancement of nursing training for BSN or MSN degrees (Education, Clinical Nurse Leader, Clinical Informatics, Clinical Nurse Specialist, and Nursing Management).~~

~~B. The monies will be used exclusively for tuition.~~

~~C. Tuition will be reimbursed at the completion of each course/semester subject to the agreement and reimbursement processes.~~

A. Salinas Valley Health Medical Center (SVHMC) provides a tuition assistance for approved educational programs to facilitate regular full-time and part-time employees to participate in advancement opportunities within SVHMC.

II. PURPOSE:

A. The purpose of this policy is to set forth the process for requesting and receiving tuition assistance related to pursuit of ~~a Bachelor~~an Associate's ~~of Science in nursing~~, Bachelor's, or Master's. degree ~~(BSN) or Masters of Science in nursing degree (MSN)~~.

III. GENERAL INFORMATION:

~~A. N/A~~

A. The monies will be used exclusively for tuition.

B. Tuition will be reimbursed at the completion of each course/semester subject to the agreement and reimbursement processes.

IV. PROCEDURE:

A. Eligibility

1. Regular full-time and regular part-time ~~nurses with responsibility for bedside care~~employees are eligible for consideration.
2. Approval of request will be based on the following:
    a. Performance at satisfactory level as documented in the performance evaluation.
    b. No active disciplinary action in personnel file
        i. If an employee is approved for the tuition assistance program and receives disciplinary action during the course of the semester, tuition reimbursement will be declined for the period of time on active discipline.
3. If an employee terminates employment either voluntarily or involuntarily prior to completion of an approved course of study, the employee's eligibility for tuition reimbursement will terminate with the termination of his or her employment.

B. Application Agreement

1. Eligible employee must submit a completed Tuition Assistance Agreement to the Department Director prior to course start date. Incomplete applications will not be accepted.

C. Process for Application for ~~BSN and MSN~~ Tuition Reimbursement

1. ~~BSN and MSN tuition~~Tuition reimbursement limit is $4,000 per educational year based on a start date of semester/course with a total reimbursement limit of $10,000 during the course of employment. Eligible expenses: tuition expenses not covered by scholarships, military coverage or non-repayable grants. An itemized receipt for tuition expenses and payments must be submitted to Human Resources.
2. An official school transcript verifying course completion with a grade of "B" or higher must be submitted to Human Resources.
3. ~~BSN and MSN tuition~~Tuition reimbursements generally meet the requirements for exclusion from income as a Working Condition Fringe Benefit under IRC §132(d). As of January 2018, reimbursements under the policy will not be subject to payroll tax withholding, with some exceptions.

D. Documentation:

1. Appendix A: Agreement
2. Appendix B: Reimbursement Application Form

V. EDUCATION AND TRAINING:

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

VI. REFERENCES:

A. N/A

Attachments

Tuition Assistance Agreement.pdf

Tuition Assistance Reimbursement Application.pdf

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2023
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	04/2023

Standards

No standards are associated with this document

History

Edited by Andersen, Robert: Human Resources Manager on 12/19/2022, 5:55PM EST

> Updated policy to the new house wide program

Draft saved by Andersen, Robert: Human Resources Manager on 12/22/2022, 7:31PM EST

Sent for re-approval by Andersen, Robert: Human Resources Manager on 12/22/2022, 7:31PM EST

Comment by Barnhart Childs, Michelle: Chief Human Resources Officer on 1/9/2023, 2:06PM EST

> I thought we were updating the form so that the employees complete the financial piece rather than HR. I'm approving this, but would like to see the form updated.

Last Approved by Barnhart Childs, Michelle: Chief Human Resources Officer on 1/9/2023, 2:06PM EST

> see comments for update going forward

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 1/23/2023, 4:41PM EST

> Policy number removed

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 2/7/2023, 6:28PM EST

> @Barnhart Childs, Michelle: Chief Human Resources Officer and @Andersen, Robert: Human Resources Manager Forms are no longer included in policies. Please remove and place in your department page on StarNet.

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 2/7/2023, 6:31PM EST

> Policy Statement corrected.

Approval flow updated in place by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 2/7/2023, 6:32PM EST

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 2/7/2023, 6:33PM EST

> Approval flow corrected

Rejected by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 2/7/2023, 6:34PM EST

> Please approve so that can go through correct approval flow

Comment by Barnhart Childs, Michelle: Chief Human Resources Officer on 2/14/2023, 12:58PM EST

> @Andersen, Robert: Human Resources Manager Please work with Kayla to incorporate clarification of eligible education - relevant to SVMHS operations, and FAQ or other process for putting responsibility on employee for accurately completing the reimbursement form - net of "free" money - discounts, scholarships, pell grants, etc.

Last Approved by Barnhart Childs, Michelle: Chief Human Resources Officer on 4/3/2023, 1:20PM EDT

> Robert, is the reimbursement form updated to employee completion?

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/13/2023, 7:08PM EDT

> Previously approved at Policy Committee.

Administrator override by Woodrow, Lea: Director of Accreditation and Regulatory Complianc on 5/8/2023, 8:35AM EDT

> placed rebrand

QUALITY AND EFFICIENT PRACTICES COMMITTEE

Minutes of the May 22, 2023 Quality and Efficient Practices Committee will be distributed at the Board Meeting

(CATHERINE CARSON)

FINANCE COMMITTEE

Minutes from the May 22, 2023 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

(JOEL HERNANDEZ LAGUNA)

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

Board Paper: Review and Approval by Board

Agenda Item:	Consider Recommendation for Board Approval of Microsoft Enterprise Agreement Licensing Renewal Through CDW Government, a Supplier of Salinas Valley Health's Group Purchasing Organization and Contract Award
Executive Sponsor:	Augustine Lopez, Chief Financial Officer Audrey Parks, Chief Information Officer
Date:	May 19, 2023

Executive Summary

Microsoft Enterprise Agreement Renewal, 3-year term

Salinas Valley Health renews the Enterprise Microsoft Agreement for three-year terms per Microsoft licensing terms. Our current three-year agreement is up for renewal and includes essential licensing for our computing devices including Microsoft operating systems such as Windows 10 and Microsoft Office licensed products such as Microsoft Outlook and Microsoft Word. Licensing agreements come with support and software assurance, the right to update the software with applicable patches and upgrades.

This year's renewal reflects the following material changes.

1. Pricing includes discounts afforded government businesses through the Riverside County contract. These are among the deepest discounts available.
2. This enterprise agreement includes applicable Microsoft licensing for both Salinas Valley Health Medical Center and Salinas Valley Health Clinics.

VENDOR:	Microsoft, through CDW-Government, LLC
1. Proposed contract signing date	May 29, 2023
2. Term of agreement	June 28, 2023 – June 27, 2026
3. Renewal terms	Not auto-renewing
4. Termination provision(s)	None
5. Payment terms	Invoiced annually, net 30
6. Annual costs	$773,040.44

General Description	Qty	Unit cost	Extended
Core CAL	3061	$ 36.81	$ 112,673.48
Exchange	9	$ 260.95	$ 2,348.59
Office Professional	2132	$ 104.25	$ 222,261.00
Power BI	1	$ 90.76	$ 90.76
Project	57	$ 158.53	$ 9,036.24
SharePoint	3	$ 1,222.78	$ 3,668.34
SQL CAL	2569	$ 37.54	$ 96,440.26
SQL Server	94	$ 660.35	$ 62,072.56
System Center	946	$ 30.81	$ 29,141.98
Visio	190	$ 100.67	$ 19,127.62
Windows Enterprise	2569	$ 46.73	$ 120,039.24
Windows Remote Desktop	741	$ 39.71	$ 29,424.63
Windows Server	1272	$ 52.45	$ 66,715.74
		Year 1	**$ 773,040.44**
		Year 2	**$ 773,040.44**
		Year 3	**$ 773,040.44**
		Grand Total	**$ 2,319,121.32**

General descriptions have been consolidated for simplicity. See attached quote for details.

7. Cost over life of agreement	**$2,319,121.32** ($773,040.44 for each of the 3-years)
8. Budgeted (yes or no)	Yes, pending approval of the FY2024 operating budget by the Board of Directors
9. Contract	1001.2533

Recommendation

Consider recommendation for Board approval of the three-year Microsoft Enterprise Agreement licensing renewal through CDW Government, a Supplier of Salinas Valley Health's group purchasing organization and contract award in the amount of $2,319,121.32.

Attachments

- CDW quote dated April 26, 2023
- Vizient contract brief for CDW Government, LLC

CDW Government, LLC
Microsoft Enterprise 6.6 Agreement Pricing

Date 4/26/23
Account Manager Brian Sitter

Enterprise Quote
for

VSL Specialist Brent Cameron
Channel Price Sheet Month March

Salinas Valley Memorial Healthcare System (820A0388)

Unless otherwise noted, All Quotes expire upon current month's end

EA Renewal Quote

Customer to make three annual payments to CDW•G

				Year 1		Year 2		Year 3	
Microsoft Part #	Description	Level	Quantity	Price	Extended	Price	Extended	Price	Extended
W06-00021	Core CAL ALng SA DCAL	D	1256	$38.03	$ 47,765.68	$ 38.03	$ 47,765.68	$ 38.03	$ 47,765.68
W06-01069	Core CAL ALng SA Platform DCAL	D	1805	$35.96	$ 64,907.80	$ 35.96	$ 64,907.80	$ 35.96	$ 64,907.80
395-02504	Exchange Server Ent ALng SA	D	2	$728.64	$ 1,457.28	$ 728.64	$ 1,457.28	$ 728.64	$ 1,457.28
312-02257	Exchange Server Standard ALng SA	D	7	$127.33	$ 891.31	$ 127.33	$ 891.31	$ 127.33	$ 891.31
269-12442	Office Professional Plus ALng SA Platform	D	2132	$104.25	$ 222,261.00	$ 104.25	$ 222,261.00	$ 104.25	$ 222,261.00
NK4-00002	Power BI Pro Sub Per User	D	1	$90.76	$ 90.76	$ 90.76	$ 90.76	$ 90.76	$ 90.76
H30-00238	Project Professional ALng SA 1 Server CAL	D	21	$210.56	$ 4,421.76	$ 210.56	$ 4,421.76	$ 210.56	$ 4,421.76
076-01912	Project Standard ALng SA	D	36	$128.18	$ 4,614.48	$ 128.18	$ 4,614.48	$ 128.18	$ 4,614.48
H04-00268	SharePoint Server ALng SA	D	3	$1,222.78	$ 3,668.34	$ 1,222.78	$ 3,668.34	$ 1,222.78	$ 3,668.34
359-00792	SQL CAL ALng SA Device CAL	D	2569	$37.54	$ 96,440.26	$ 37.54	$ 96,440.26	$ 37.54	$ 96,440.26
810-04760	SQL Server Enterprise ALng SA	D	2	$1,545.36	$ 3,090.72	$ 1,545.36	$ 3,090.72	$ 1,545.36	$ 3,090.72
7JQ-00343	SQL Server Enterprise Core ALng SA 2L	D	17	$2,472.77	$ 42,037.09	$ 2,472.77	$ 42,037.09	$ 2,472.77	$ 42,037.09
228-04433	SQL Server Standard ALng SA	D	65	$161.47	$ 10,495.55	$ 161.47	$ 10,495.55	$ 161.47	$ 10,495.55
7NQ-00292	SQL Server Standard Core ALng SA 2L	D	10	$644.92	$ 6,449.20	$ 644.92	$ 6,449.20	$ 644.92	$ 6,449.20
9EP-00208	System Center DC Core ALng SA 2L	D	390	$49.09	$ 19,145.10	$ 49.09	$ 19,145.10	$ 49.09	$ 19,145.10
9EN-00198	System Center Standard Core ALng SA 2L	D	556	$17.98	$ 9,996.88	$ 17.98	$ 9,996.88	$ 17.98	$ 9,996.88
D87-01159	Visio Professional ALng SA	D	62	$109.96	$ 6,817.52	$ 109.96	$ 6,817.52	$ 109.96	$ 6,817.52
D86-01253	Visio Standard ALng SA	D	123	$56.50	$ 6,949.50	$ 56.50	$ 6,949.50	$ 56.50	$ 6,949.50
MX3-00117	Visual Studio Ent MSDN ALng SA	D	5	$1,072.12	$ 5,360.60	$ 1,072.12	$ 5,360.60	$ 1,072.12	$ 5,360.60
KV3-00368	Win Enterprise Device ALng SA	D	461	$48.72	$ 22,459.92	$ 48.72	$ 22,459.92	$ 48.72	$ 22,459.92
KV3-00353	Win Enterprise Device ALng SA Platform	D	2108	$46.29	$ 97,579.32	$ 46.29	$ 97,579.32	$ 46.29	$ 97,579.32
6VC-01254	Win Remote Desktop Services CAL ALng SA UCAL	D	735	$23.69	$ 17,412.15	$ 23.69	$ 17,412.15	$ 23.69	$ 17,412.15
6XC-00299	Win Remote Desktop Services Ext Con ALng SA	D	6	$2,002.08	$ 12,012.48	$ 2,002.08	$ 12,012.48	$ 2,002.08	$ 12,012.48
9EA-00278	Win Server DC Core ALng SA 2L	D	378	$125.87	$ 47,578.86	$ 125.87	$ 47,578.86	$ 125.87	$ 47,578.86
R39-00396	Win Server External Connector ALng SA	D	6	$330.12	$ 1,980.72	$ 330.12	$ 1,980.72	$ 330.12	$ 1,980.72
9EM-00270	Win Server Standard Core ALng SA 2L	D	888	$19.32	$ 17,156.16	$ 19.32	$ 17,156.16	$ 19.32	$ 17,156.16

Year 1 Total $ 773,040.44 **Year 2 Total $ 773,040.44** **Year 3 Total $ 773,040.44**

Three Year Total $ 2,319,121.32

Notes

No Tax Referenced
Riverside Contract: PSA-0001522
Current Enrollment# 65849611
Agreement End Date: 6/30/2023

Terms & Conditions

Terms and Conditions of sales and services projects are governed by the terms at:

http://www.cdwg.com/content/terms-conditions/product-sales.aspx

IT0031

CDW Government LLC

IT Hardware and Software Value Added Resellers

- Desktop/Workstations
- Notebooks/Laptops
- Tablets/eBook Readers
- Servers Storage and Memory products
- Displays & Projectors
- Networking Equipment
- Audio & Video
- Printers & Scanners Software Products
- IT Service

Effective dates: 01/01/2014 - 12/31/2023

Multi-source contract

OTHER CONTRACTS IN THIS CATEGORY IT0032 - Paragon Development Systems (PDS) IT VAR, IT0033 - PC Connection/MoreDirect/Gov Connection IT VAR, IT0034 - Insight Direct IT VAR

PREVIOUS CONTRACTS IN THIS CATEGORY IT132X - Eplus Technology, Inc., IT178X - CDW Government LLC, IT194X - Insight Public Sector, Inc., SVC1003X - Paragon Development Systems, U0919CX - PC Connection Information Tech Svcs, U0919GX - GovConnection Computer Services, U0919X - MoreDirect Information Tech Svcs

DISTRIBUTION Direct from the supplier

Agreement access

TO ACTIVATE CONTRACT TIERS - For those who have access to request tiers, click the purple "Activate Now" button on the catalog contract details page to launch the online activation process. Follow the prompts and provide all requested data until you reach the Submit stage. If requesting a different tier, click the purple "Request a New Tier" button and follow the same process.

ADDITIONAL FORM REQUIRED This contract requires an end user agreement or Supplier provided form. The form is completed as part of the online activation process described above.

Pricing and terms

PRICING Pricing detail is available from the Contract Documents area of the contract details page in Vizient Catalog.

PRICE TIERS Refer to Vizient Catalog for tier eligibility requirements. If you qualify for a different tier from the one your facility is currently on, click the "Request a New Tier" button on the Facility Status line to initiate a new tier request with the supplier. Follow the prompts and provide all requested data until you reach the Submit stage.

PRICE PROTECTION Firm Price, Entire Term of the agreement but may be subject to reduction due to market conditions.

CONTRACT TERM Initial term is effective through 12/31/2023; shall not automatically renew past 12/31 /2021 without mutual agreement of Parties.

CONTRACT AND PRODUCT UPDATES Product and price updates, promotions, supplier news and other changes that occur during the term of this contract are shared via Vizient Catalog. They can be viewed at the Contract News link on the contract details page.

Contract process and award rationale

COMPETITIVE CONTRACTING PROCESS Vizient awards product agreements to the suppliers that offer best overall value, as determined through a comprehensive contracting process that follows the principles of the American Bar Association's Model Procurement Code and involves participating member organizations to the greatest practical degree. The process uses member-driven criteria and a weighted award decision tool that considers financial and product specification/quality factors. This contract was awarded based solely on the results of this process.

Based solely upon the results of this process, Vizient awarded this category as described on page 1.

Request for proposal

Vizient issued a request for proposal in March 2013.

The RFP was issued to these suppliers: : CDW Government LLC, ePlus Technology Inc., Insight Direct USA Inc., Kyocera, Paragon Development Systems Inc., PC Connection/MoreDirect, Inc. /GovConnection, Inc. Inc. Presidio, Sentinel Technologies, SHI International Corp., System Design Advantage LLC, The Ergonomic Group Inc., Upstate Wholesale Supply, and Zones Inc..

Responses were received from these suppliers: CDW Government LLC, ePlus Technology Inc., Insight Direct USA Inc., Kyocera, Paragon Development Systems Inc., PC Connection/MoreDirect, Inc. /GovConnection, Inc. Inc. Presidio, Sentinel Technologies, SHI International Corp., System Design Advantage LLC, The Ergonomic Group Inc., Upstate Wholesale Supply, and Zones Inc. .

Proposal evaluation

In addition to financial value, the proposals were evaluated based on the following product specification /quality factors, which were developed and weighted by Vizient's Information Technology Council in February 2013:

- breadth and depth of offering, supplier capabilities/member value, member preference, and terms and conditions

Member input

A member preference survey was conducted in April 2013 in conjunction with the request for proposal to assess which suppliers' members find acceptable and prefer to use. Results were factored into the award recommendation.

Best-and-final offer

Based on the scoring results, CDW Government, Insight Direct, Paragon Development Systems, and PC Connection/MoreDirect/GovConnection were invited to submit their best-and-final pricing offer in October 2013.

Award validation

Based on the proposal scorecard results and the recommendation of the council, Vizient awarded this category as described above.

Vizient wishes to thank the members of the Information Technology Council for their valuable direction and input into this award decision.

Board/CEO – Packet Submission Checklist
Salinas Valley Health Microsoft Licensing: 2023 - 2026

The original of this completed/fully signed checklist and all required supporting documents are to be hand-delivered to Assistant to CFO by 4:00 p.m. on the Tuesday that falls three (3) weeks before Board week.

☒ **BOARD/CEO PAPER** – required for all submissions; see attached instructions/sample

☒ **KEY CONTRACT TERMS** – required for all submissions – see table in Board/CEO Paper

☒ **CONTRACT** – negotiated final with vendor signature #1001.2533

☒ **PROCUREMENT PROCESS DOCUMENTATION** – required for all submissions requiring Board review/approval per Procurement Management Policy (see policy for details; indicate which sub-category is applicable):

☒ If for **data processing/telecommunications goods/services** of more than $25,000, check applicable option and include documentation: CIO must review.
- ☒ RFP documentation *(see attached RFP responses and scorecard from 3 respondents)*
- ☐ If sole source – provide detailed justification (see attachment)
- ☐ If GPO, submit qualifying verification from Materials Management

☐ If for **professional/other services or medical/surgical equipment and supplies** more than $350,000, check applicable option and include documentation:
- ☐ RFP documentation
- ☐ If GPO, submit qualifying verification from Materials Management
- ☐ If emergency – as designated by Board

☐ If for **non-medical materials/supplies** more than $25,000, check applicable option and include documentation:
- ☐ Invitation for bids documentation
- ☐ If sole source – provide detailed justification (see Attachment 3B)
- ☐ If GPO, submit qualifying verification from Materials Management

Legal counsel/Contract Administrator reviewed: ☐ **No or** ☒ **Yes, By Whom: Natalie James,**

SUBMITTED BY DEPARTMENT DIRECTOR OR DEPARTMENT ADMINISTRATOR:

Signature	Title/Department	Date

REVIEWED BY:

CIO (if applicable): _____ Date: _____

Director of MM/Designee in lieu of Compliance: _____ Date: _____

12910035_1250

Board Paper: Finance Committee

Agenda Item: Consider Recommendation for Board of Directors Approval of Consulting Contract with Guidehouse Inc.

Executive Sponsor: Pete Delgado, Chief Executive Officer
Augustine Lopez, Chief Financial Officer

Date: May 22, 2023

Executive Summary

Salinas Valley Health is entering a system-wide examination of opportunities for reduced spending and increased revenue to ensure our sustainable success into the future. We are recommending the engagement of outside expertise to assist with an operational and strategic assessment of the organization.

Background/Situation/Rationale

Like healthcare systems across the country, we are experiencing a challenging environment. More than half of United States hospitals are seeing negative margins. A number of factors have contributed to this—the pandemic, staffing challenges, inflationary costs, payor challenges and more.

It is critical that we work to make healthcare affordable and accessible to the people of our community. To do this effectively, we propose engaging Guidehouse, a consulting firm with expertise in healthcare. Phase I of our journey with Guidehouse will include a comprehensive strategic and operational assessment of Salinas Valley Health over a 12-week period. During this time, Guidehouse will work with us to create a detailed assessment of our organization and opportunities, with a focus on prioritizing quick wins that will better position the organization for long-term growth.

The assessment will also include a high-level implementation plan and a projection of the required resourcing to support implementation and achievement of impact over a 12–18-month process.

Pillar/Goal Alignment:

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

Financial Implications

The essential terms of the proposed contract are as follows:

Key Contract Terms	Guidehouse Inc.
1. Proposed effective date	June 1, 2023
2. Term of agreement	Commencing June 1, 2023 ending August 30th, 2023
3. Renewal terms	None
4. Cost	• Flat Fee of $625,000 paid in 4 installments of $156,250 • Reimbursement for travel and transportations expenses, such as mileage (payable at Salinas Valley Health's standard IRS rates), tolls, parking, airfare, hotel accommodations, and meals). • Research Data and Technology Fee equal to five percent (5%) of fees (not to exceed $31,250
5. Budgeted (indicate y/n)	Funding for the July/August activity is included in the FY24 Budget

Recommendation

Consider recommendation for Board of Directors approval of consulting contract with Guidehouse Inc. for an operational and strategic assessment at the cost of $625,000 plus a data/technology fee (not to exceed $31,250) and expense reimbursement, subject to final legal review and negotiations on terms and conditions.

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Minutes of the May 23, 2023 Personnel, Pension and Investment Committee will be distributed at the Board Meeting

(JUAN CABRERA)

COMMUNITY ADVOCACY COMMITTEE

Minutes from the May 23, 2023 meeting
of the Community Advocacy Committee
will be distributed
at the Board Meeting

(Joel Hernandez Laguna)

Board Paper

Agenda Item: Amended and Restated District Bylaws
Executive Sponsor: Pete Delgado, President/CEO
Date: May 17, 2023

Executive Summary

Best practices in governance call for the regular review of organizational Bylaws. The Charter for the Transformation, Strategic Planning, and Governance Committee calls for this Committee to "Provide for a review of the Bylaws at least once every three years."

Background/Situation/Rationale

In an initial review, a few opportunities exist for updating in District Bylaws, as reflected in the attached document.

- Name change to reflect the new Salinas Valley Health rebrand.
- Updated Vision statement.
- Opportunity to have our board chair serve as an alternate committee member in the event that the board member assigned to a committee is absent.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

Salinas Valley Memorial Healthcare System's practice of excellence in governance allows us to meet our Mission, Vision and Goals.

Pillar/Goal Alignment:

☑ Service ☑ People ☑ Quality ☑ Finance ☑ Growth ☑ Community

Timeline

January 25: Transformation, Strategic Planning, and Governance Committee reviews proposed changes to District Bylaws.
January 26: Board of Directors formed a Special Committee to further review Bylaws.
May 25: Board of Directors considers approval of a Board resolution adopting the amended Bylaws, along with a vote to adopt the Bylaws.

Recommendation

Consider approval of Resolution No. 2023-04 of the Board of Directors of Salinas Valley Memorial Healthcare System Adopting Amended and Restated District Bylaws as presented and included in the Board packet.

RESOLUTION NO. 2023-04
OF THE BOARD OF DIRECTORS
OF SALINAS VALLEY MEMORIAL HEALTHCARE SYSYTEM

ADOPTING AMENDED AND RESTATED DISTRICT BYLAWS

WHEREAS, Salinas Valley Memorial Healthcare System is a local health care district organized and operated pursuant to Division 23 of the California Health and Safety Code ("District");

WHEREAS, the Board of Directors of the District have approved the rebranding of the Core Services and Facilities of the District to operate as Salinas Valley Health;

WHEREAS, the Board of Directors of the District from time to time reviews its Bylaws to ensure that the District Bylaws best reflect the organization, operation and strategic vision of the Board of Directors of the District;

WHEREAS, the Bylaws of the District require review of the Bylaws at least every two (2) years for revision as necessary;

WHEREAS, the Board of Directors of the District has reviewed the Amended and Restated Bylaws attached to this Resolution, and determined it is in the best interest of the District to adopt the attached Amended and Restated District Bylaws;

NOW THEREFORE, IT IS HEREBY ORDERED AND DIRECTED AS FOLLOWS:

1. The Board of Directors of the District does hereby approve and adopt the attached Amended and Restated Bylaws of Salinas Valley Memorial Healthcare System operating as Salinas Valley Health, dated May 25, 2023.

2. A copy of this Resolution shall be kept together with the Amended and Restated Bylaws of Salinas Valley Memorial Healthcare System operating as Salinas Valley Health and made available for inspection during reasonable business hours.

3. The President and Secretary of the Board of Directors and the President/CEO of the Salinas Valley Memorial Healthcare System operating as Salinas Valley Health are hereby authorized and directed to execute any and all documents and take any actions necessary to carry out the intent of this Resolution for and on behalf of this Board of Directors.

This Resolution was adopted at a Regular Meeting of the Board of Directors of the District on May 25, 2023, by the following vote.

AYES:
NOES:
ABSTENTIONS:
ABSENT:

_____
Dr. Rolando Cabrera, M.D., Secretary
Salinas Valley Memorial Healthcare System

AMENDED AND RESTATED

BYLAWS OF

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

OPERATING AS SALINAS VALLEY HEALTH

MONTEREY COUNTY, CALIFORNIA

ADOPTED BY

LOCAL HEALTH CARE DISTRICT BOARD OF DIRECTORS

May 25, 2023

DISTRICT BYLAWS TABLE OF CONTENTS

AMENDED AND RESTATED BYLAWS
of
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

Operating as Salinas Valley Heath

Monterey County, California

PREAMBLE

These Amended and Restated Bylaws are adopted by the Board of Directors (the "Board") of Salinas Valley Memorial Healthcare System, operating as Salinas Valley Health (sometimes referred to herein as "Salinas Valley Health" or(the "District"), a public health care district organized June 20, 1947, under the terms of the Local Health Care District Law (Health and Safety Code of the State of California, Division 23, Sections 32000-32492), pursuant to Section 32104 of the California Health and Safety Code. These Bylaws are adopted by the District Board for the purpose of establishing such rules and regulations, not inconsistent with governing laws and regulations, that in the opinion of the Board, are necessary for the exercise of the powers and duties of the Board imposed upon it by Local Health Care District Law and related statutes.

ARTICLE I. PURPOSE, AUTHORITY, OBLIGATIONS

1.1 **Purpose**. Salinas Valley Memorial Healthcare System, organized and operating pursuant to Division 23 of the California Health and Safety Code, is committed to serving the healthcare needs of its constituents. The purpose of the District, operating as Salinas Valley Health is to establish, maintain, operate and provide assistance in the operation of one or more health facilities (including Salinas Valley Health Medical Center, sometimes referred to herein as "the Hospital") or health services at any location inside or outside of the territorial limits of the District for the benefit of the District and the community served by the District; and to do or take any other actions necessary to carry out the provisions of these Bylaws and Local Health Care District Law. In addition, the District is committed to quality care in a family centered atmosphere.

1.2 **Mission**. The Mission of Salinas Valley Health is to provide quality healthcare to our patients and to improve the health and well-being of our community. In addition, it is the mission to coordinate services of the District with community agencies, both public and private within the boundaries of the District; to conduct educational and united research activities essential to the health and well-being of our community; and to develop health care and other related programs deemed appropriate and necessary as determined by the Board.

1.3 **Vision**. The Vision of Salinas Valley Heath is a community where good health grows through every action, in every place, for every person.

1.4 **Authority**. The authority of the Board arises from Division 23 of the California Health and Safety Code, Sections 32000 and following. The Board is required to comply with all federal and state laws and regulations.

1.4.1 Title to Property. The title, direction and control of property owned by Salinas Valley Health shall be vested in the Board. Purchases or sales of property and investment, transfer or other expenditures of trust funds shall be only upon the signature of the President and Treasurer of the Board, or their designees. Any officer of the Board or the President/CEO of District is authorized to execute any documents accepting and consenting to any deeds or grants conveying real property to the District.

1.4.2 Professional and Other Health Care Staff. The Medical Staff and other health care professionals providing patient care services in or under the auspices of Salinas Valley Heath are subject to the authority of the Board.

1.4.3 Disposition of Surplus Funds. In the event of a surplus of revenue over expenses, use of surplus funds shall be determined by the Board, within the limits of these Bylaws, Local Health Care District Law, and applicable California statutes and regulations.

1.5 **Obligations**. The business of Salinas Valley Health is conducted by the Board with due attention to relevant community interests and concerns. Obligations of the Board include, but are not necessarily limited to:

1.5.1 Ultimate accountability for the safety and quality of care, treatment, and services provided by Salinas Valley Health.

1.5.2 Retain fiduciary responsibility and legal authority for all aspects of operations for Salinas Valley Health, Salinas Valley Health Medical Center ("Medical Center") and Salinas Valley Health Medical Clinics ("Clinic"), including approval of the Medical Center's and Clinic's budgets;

1.5.3 Select a President/CEO for Salinas Valley Health;

1.5.4 Evaluate the performance of the President/CEO annually in accordance with preset criteria for that year, with a written evaluation conducted every other year;

1.5.5 Delegate certain specific responsibilities, subject to Board authority, to the Salinas Valley Health President/CEO;

1.5.6 Delegate certain specific responsibilities, subject to Board authority, to the Hospital Medical Staff;

1.5.7 Take action on the Bylaws, Rules and Regulations of affiliated organizations whose Bylaws are subject to Board approval;

1.5.8 Appoint and/or remove Medical Staff members and grant and/or limit specific clinical privileges, acting upon recommendations from the Medical Executive Committee;

1.5.9 Meet situations not specifically covered in these Bylaws through adoption of resolutions, and/or procedural descriptions in the policies and procedures of the Board; and

1.5.10 Account for Salinas Valley Health funds.

ARTICLE II. BOARD MEMBERS

2.1 **Number, Qualifications, District Zones, Election and Term**.

2.1.1 Number. The Board shall consist of five (5) elected board members.

2.1.2 Qualifications. Each member of the Board (i) shall be a registered voter; (ii) shall reside within the geographic boundaries of the District Zone where elected; and (iii) shall for the duration of the member's term continue to reside within the geographic boundaries of the District Zone where elected.

2.1.3 District Zones. The District shall consist of five (5) District Zones designated Zone 1, Zone 2, Zone 3, Zone 4 and Zone 5. Beginning with the General Election in November, 2012, and every four (4) years thereafter, the election of members to the Board shall take place in Zone 2 and Zone 3. Beginning with the General Election in November, 2014, and every four (4) years thereafter, the election of members to the Board shall take place in Zone 1, Zone 4 and Zone 5.

2.1.4 Election. Each member of the Board shall be elected by the eligible voters within the geographic boundaries of the District Zone represented by the Board member. Procedures of the election shall be governed by Local Health Care District Law and the Uniform District Election Law.

2.1.5 Term. Each Board member shall serve a term of four (4) years. Board members may succeed themselves indefinitely. In the event a member is appointed to a vacancy on the Board, such member will serve the balance of the unexpired term of office or will serve until the next consolidated election subsequent to the appointment, as provided in Section 1780 of the California Government Code.

2.1.6 Public Meeting Regulations. The District shall cause each Board member and any person elected to serve as a member of the Board who has not assumed the duties of office to receive a copy of California Government Code Sections 54950-54962 ("The Ralph M. Brown Act").

2.2 **Duties**. Duties of individual Board members include, but are not necessarily limited to:

2.2.1 Attend Board meetings;

2.2.2 Attend meetings of committees to which the member is assigned;

2.2.3 Relate community input to the Board;

2.2.4 Represent SVMHS in a positive and effective manner in public forums;

2.2.5 As appropriate, be politically active on behalf of Salinas Valley Health and its interests

and needs;

2.2.6 Learn enough details about hospital management and patient care services that the Board member can effectively question reports of both institutional managers and the professional staff, and evaluate the answers;

2.2.7 Accept and fulfill reasonable assignments from the President of the Board;

2.2.8 Participate in the performance evaluation of the Board members pursuant to the evaluation process established by the Board;

2.2.9 Participate in the orientation program for new Board members; and

2.2.10 Become familiar with the provisions of The Ralph M. Brown Act and Local Health Care District Law.

2.3 **Removal of Director**. In accordance with Health & Safety Code Section 32100.2, if a Board member is absent from three (3) consecutive regular meetings of the Board, or from three (3) of any five (5) consecutive meetings of the Board, the Board may, by resolution, declare that a vacancy on the Board exists.

2.4 **Filling Board Vacancies**. Board vacancies created by removal, resignation, death, or moving out of the boundaries of the District or Zone, shall be filled by the methods as provided in Government Code Section 1780 or any applicable successor statute.

2.5 **Compensation**. A member of the Board shall receive one hundred dollars ($100.00) per meeting, not to exceed five (5) meetings per month. Each member of the Board shall be allowed his or her actual necessary traveling and incidental expenses incurred in the performance of official business of Salinas Valley Health as assigned by the Board. "Meeting," as that term is used in this Section, shall mean regular and annual meetings held pursuant to Section 5.1 of these Bylaws, special meetings held pursuant to Section 5.3, standing committee meetings held pursuant to Section 4.2, ad hoc committee meetings held pursuant to Section 4.3, and meetings of the Medical Staff of the Hospital.

2.6 **Conflict of Interest**. No Board member shall realize economic gain from an action of the Board in which that Board member participated. Board members shall be required to follow the Conflict of Interest Code adopted by the Board.

ARTICLE III. OFFICERS

3.1 **List of Officers**. The Officers of the Board shall be:

- President
- Vice President
- Secretary
- Treasurer
- Assistant Treasurer

3.2 **Qualifications, Selection and Term**

3.2.1 Officers are elected by the Board at the annual meeting from among its own members. Election must be by no less than three (3) votes.

3.2.2 Officers are elected for a period of two (2) years and shall serve until a successor has been duly elected. No Board member shall serve more than six (6) consecutive years in the same office.

3.2.3 A Board member shall not simultaneously hold more than one (1) office.

3.3 **Duties of the President**. The President of the Board shall:

3.3.1 Preside at all meetings of the Board;

3.3.2 Execute contracts, correspondence, conveyances, and other written instruments as authorized by the Board; and

3.3.3 Appoint chairpersons and members of Board committees.

3.4 **Duties of the Vice President**. The Vice President shall:

3.4.1 In the absence of the President of the Board, assume the duties of the President of the Board; and

3.4.2 Perform such reasonable duties as may be required by the Board or by the President of the Board.

3.5 **Duties of the Secretary**. The Secretary shall:

3.5.1 Be responsible for maintaining minutes of Board meetings;

3.5.2 Be responsible for maintaining other documentation as may from time to time be required by the Board's activities; and

3.5.3 Perform such reasonable duties as may be required by the Board or by the President of the Board.

3.6 **Duties of the Treasurer**. The Treasurer shall:

3.6.1 Be responsible for the safekeeping, accounting for and disbursement of SVMHS funds, at the direction of the Board; and

3.6.2 Perform such reasonable duties as may be required by the Board or by the President of the Board.

3.7 **Duties of the Assistant Treasurer**. The Assistant Treasurer shall:

3.7.1 In the absence of the Treasurer, assume the duties of the Treasurer; and

3.7.2 Perform such reasonable duties as may be required by the Board or by the President of the Board.

3.8 **Removal of Officers and Vacancies**

3.8.1 Removal. Officers may be removed by vote of three (3) Board members for failure to perform the duties of the office, or for malfeasance in office.

3.8.2 Vacancies. Vacancy in any office shall be filled by Board election, as soon as is reasonably possible.

ARTICLE IV. COMMITTEES

4.1 **Appointment and Terms of Members of Board Committees**. The President of the Board shall appoint voting members of the Board committees. Appointments are for two (2) years.

4.2 **Standing Committees**. All meetings of the standing committees described in this Article, including without limitation regular, adjourned regular, and special meetings, shall be conducted in accordance with the provisions of The Ralph M. Brown Act. The Board of Directors shall adopt Committee Charters to include the purpose, authority, membership and scope of duties for the following standing committees of the Board:

4.2.1 Community Advocacy Committee

4.2.2 Corporate Compliance and Audit Committee

4.2.3 Finance Committee

4.2.4 Personnel, Pension and Investment Committee

4.2.5 Quality and Efficient Practices Committee

4.2.6 Transformation, Strategic Planning and Governance Committee

4.3 **Additional Committees**. Additional committees, permanent or temporary, can be established at any time and from time to time by the Board.

ARTICLE V. MEETINGS

5.1 **Regular Meetings and Annual Meeting**. The Board shall meet each month, and the December meeting is designated the annual meeting. Regular meetings and the annual meeting shall commence at 4:00 p.m., and shall be held at the Hospital or another SVMHS facility located within the District boundaries. If all members of the Board are absent from a regular meeting or

the annual meeting, the Secretary shall declare the meeting adjourned to a stated time and place. The Secretary shall cause a notice of adjournment to be posted within twenty-four (24) hours after the adjournment. The Secretary shall cause a written notice of adjournment to be mailed to each Board member at least twenty-four (24) hours before the time and date to which the meeting is adjourned.

5.2 **Agenda**. SVMHS shall post an agenda complying with Government Code Section 54954.2 at least seventy-two (72) hours before a regular meeting and before the annual meeting.

5.3 **Special Meetings**. Special meetings may be called at any time for a specific, announced purpose by the President of the Board, or on request of any three (3) Board members. SVMHS shall deliver written notice of a special meeting to all Board members at least twenty-four (24) hours before the time of the meeting as specified in the notice. SVMHS shall post the notice of the special meeting at least twenty-four (24) hours prior to the special meeting in a location that is freely accessible to members of the public.

This 24 hour notice requirement shall not apply in an "emergency situation" as defined in California Government Code Section 54956.5. If all members of the Board are absent from a special meeting, the Board secretary shall follow the same adjournment procedures set forth in Section 5.1 of these Bylaws.

5.4 **Quorum**. For regular and special meetings of the Board, a quorum shall be three (3) members. For committees, a quorum shall be a majority of the members of that committee, and shall include one (1) Board member.

5.5 **Majority Vote**. Actions of the Board shall be by a majority of three (3) members of the Board. No action shall be taken by the Board, however, by secret ballot, whether preliminary or final.

5.6 **Minutes**. A record of proceedings of all meetings of the Board and of all standing committees of the Board shall be kept on file.

5.7 **Public Meetings**. Except as otherwise provided in the California Government Code, all meetings of the Board shall be open and public, and all persons shall be permitted to attend any meeting, unless otherwise provided by law. Public testimony or comment on a particular issue shall be limited to a maximum of three (3) minutes for each individual speaker for each issue. The Board may, at its discretion, allow for more time if deemed appropriate or necessary.

ARTICLE VI. SVMHS PRESIDENT/CEO

6.1 **Employment of SVMHS President/Chief Executive Officer**. A qualified and competent President/CEO shall be employed by the Board and given responsibility for the day-to-day management of SVMHS, subject to Board policy. Such management shall include the selection and evaluation of key management staff.

6.2 **Duties of SVMHS President/CEO**. The duties of the President/CEO shall include but not be limited to the following:

6.2.1 The President/CEO, or the President/CEO's designee, shall make periodic reports to the Board regarding the operations of the Hospital.

6.2.2 The President/CEO shall be a member of all Board committees.

6.2.3 The President/CEO shall have the authority to sign temporary privileges and to sign Board approvals of Medical Staff membership and/or privileges for and on behalf of the Board.

6.3 **Evaluation of SVMHS President/CEO**. The President/CEO shall be evaluated annually in accordance with preset criteria for that year. A written evaluation of the President/CEO by the Board will be conducted every other year.

6.4 **CDPH Notification**. The California Department of Public Health shall be notified in writing if a new President/CEO is employed.

ARTICLE VII. MEDICAL STAFF

7.1 **Appointment and Duties**. The Board shall:

7.1.1 Determine which categories of practitioners are eligible for appointment to the Medical Staff.

7.1.2 Appoint a Medical Staff (see Medical Staff Bylaws approved by the Board for descriptions of qualifications for Medical Staff membership and clinical privileges). In appointing practitioners to the Staff, and in granting clinical privileges, the Board acts upon recommendations from the Medical Executive Committee, and shall ensure that the criteria for selection is the individual character, competence, training, experience and judgment of the practitioner;

7.1.3 Approve Medical Staff Bylaws by which the Medical Staff shall govern its affairs, subject to Board policy and to relevant statutes and legal precedents;

7.1.4 Ensure that the Medical Staff is accountable to the Board for the quality of care provided to patients.

7.1.5 Consider appointment and specific clinical privileges of each practitioner at least every two (2) years. The Board acts upon Medical Executive Committee recommendations regarding renewal and/or upgrading and/or restriction of Medical Staff membership and/or clinical privileges for each practitioner subject to the Medical Staff Bylaws;

7.1.6 Consult directly with the Chief of the Medical Staff regularly throughout the fiscal year and include discussion of matters related to the quality of medical care provided to patients at the Hospital.

7.1.7 Require that patient care services provided at the Hospital, or under the auspices of the

Hospital be within the scope of privileges granted by the Board;

7.1.8 Receive, question, and act upon regular reports of the clinical activities of Medical Staff members and of other practitioners actively engaged in providing clinical services in or under the auspices of the Hospital;

7.1.9 Provide adequate support personnel to assist the Medical Staff with organizational functions, including Medical Staff membership and clinical privileges (credentialing), physician performance evaluation (peer review), and collection and analysis of clinical data (quality assurance, utilization review, risk management); and

7.1.10 Review, revise and update as appropriate the Performance Improvement Plan for Medical Staff and Hospital activities.

7.2 **Termination and Due Process**. Membership on the Medical Staff and specific practice privileges are subject to denial, suspension, termination, or curtailment for cause by the Board. In such an event, due process shall be provided as described in the Medical Staff Bylaws.

ARTICLE VIII. CHIEF MEDICAL OFFICER

8.1 **Appointment and Duties**. The President/CEO, after consultation with the Board and with the Medical Executive Committee, may select a Chief Medical Officer who shall:

8.1.1 Be a non-voting member of the Medical Executive Committee;

8.1.2 Be responsible to the President/CEO (reporting relationship) and for working with and assisting the Chief of the Medical Staff, the Medical Executive Committee, and clinical department chiefs (functional relationship);

8.1.3 Be concerned, among other duties, with medico-administrative aspects of patient care provided in or under the auspices of the Hospital, and with coordination of organizational functions of the Medical Staff, working with and through the Chief of Staff, Medical Executive Committee, and department chiefs; and

8.1.4 Work with and through the Chief of Staff, Medical Executive Committee, and clinical department chiefs to invoke Article IX of Medical Staff Bylaws when and if necessary.

8.2 **Removal**. Removal of the Chief Medical Officer shall be by the President/CEO only after consultation with the Board and Medical Executive Committee.

8.3 **Responsiveness to the Medical Staff and Board**. The job description of the Chief Medical Officer and his evaluation by the President/CEO shall include reasonable responsiveness to the needs and concerns of Medical Staff officers and members, clinical department chiefs, and to the Board.

ARTICLE IX. QUALITY OF PROFESSIONAL SERVICES AND PERFORMANCE IMPROVEMENT

9.1 **Quality of Professional Services**. The Board is legally responsible for the conduct of the Hospital, and the Medical Staff shall be accountable to the Board for the quality of Professional Services provided to patients. To fulfill its responsibilities, the Board assures:

9.1.1 Every patient is under the care of a duly licensed doctor of medicine or osteopathy, doctor of podiatric medicine, doctor of dental medicine, or clinical psychologist; provided, however a doctor of medicine or osteopathy is responsible for the care of each patent with respect to any medical or psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or clinical psychologist.

9.1.2 Patients are admitted to the Hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital;

9.1.3. Services performed under a contract are provided in a safe and effective manner;

9.1.4 Financial oversight and provision of management and administrative assistance, as well as appropriate physical resources and personnel, to meet the needs of patients and support and facilitate the ongoing operations of the Hospital;

9.1.5 It participates in planning the health needs of the community served by the District;

9.1.6 All reasonable steps are taken to conform to all applicable federal, state and local laws and regulations, including those related to licensure, fire inspection and other safety measures;

9.1.7 Such other support as the Board deems necessary for the preservation and improvement of the quality, safety and efficiency of patient care.

9.2 **Performance Improvement Board Responsibilities**. The Board shall:

9.2.1 Require that the Medical Staff and District Staff implement and report on the activities and mechanism for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve patient care within the District.

9.2.2 Support the activities and mechanism as provided in Section 9.2.1.

9.2.3 Adopt a Performance Improvement Plan and Risk Management Plan for the District and shall provide the resources and support systems to ensure that the plans be carried out.

9.2.4 Require that a complete and accurate medical record be prepared and maintained for each patient; that the medical record of the patient shall be the basis for review and analysis of quality of care.

9.2.5 Ensure that the quality assurance mechanisms are provided for monitoring of patient care processes to assure that patients with the same health problem s receiving the same level of care within the District.

ARTICLE X. INDEMNIFICATION

10.1 **Indemnification of Directors and Officers**. Members of the Board and officers shall be indemnified to the full extent permitted by law against all claims, liabilities and expenses incurred as a result of an action by the Board, except in the instance of willful misconduct in the performance of duties as a director or officer.

ARTICLE XI. RULES AND PROCEDURES

11.1 **Board Policies and Procedures**. Agreed upon rules and procedures for implementation of these Bylaws may be contained in the policies and procedures of the Board.

XII. AMENDMENT, ADOPTION AND REVIEW

12.1 **Amendment**. These Bylaws may be amended at any properly noticed meeting of the Board by a majority of three (3) Board members.

12.2 **Adoption**. Adoption of Bylaws shall be by a majority of three (3) Board members, at any properly noticed meeting of the Board.

12.3 **Review**. These Bylaws will be reviewed at least every two (2) years for revision as necessary.

CERTIFICATE OF SECRETARY

I, the undersigned, the duly elected Secretary of the Board of Directors of Salinas Valley Memorial Healthcare System, do hereby certify:

That the foregoing Amended and Restated Bylaws were adopted as the Bylaws of Salinas Valley Memorial Healthcare System by Resolution 2023-04 of the Board of Directors of the Salinas Valley Memorial Healthcare System on May 25, 2023, and that the same do now constitute the Bylaws of Salinas Valley Memorial Healthcare System

Dated: May 25, 2023

Dr. Rolando Cabrera, M.D., Board Secretary
Salinas Valley Memorial Healthcare System

Medical Executive Committee Summary – May 11, 2023

Items for Board Approval:

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Bahia, Surinder, MD	Family Medicine	Medicine	Adult Hospitalist:
Cefala, Edward, MD	Radiology	Surgery	Mammography
Dar, Nabeel, MD	Radiology	Surgery	Remote Radiology
Ladd, Scott, DO	Internal Medicine	Medicine	Adult Hospitalist
Lin, Ethan, MD	Family Medicine	Medicine	Adult Hospitalist
Taylor, Collen, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Varma, Ross, MD	Radiology	Surgery	Remote Radiology and Mammography

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Beck, Rachel, MD	Ob/Gyn	Ob/Gyn	Obstetrics Gyn
Biehl, Kenneth, MD	Radiation Oncology	Medicine	Radiation Oncology
Bernstein, Jesse, MD	Physical Medicine and Rehabilitation	Medicine	Medicine-Active Community
Jalali, Maryam, MD	Pediatrics	Pediatrics	Pediatrics
Jones, Matthew, MD	Ophthalmology	Surgery	Ophthalmology
Kaur, Navneet, MD	Internal Medicine	Medicine	Adult Hospitalist
Lagana, Vittorio, DPM	Podiatric Surgery	Surgery	Podiatry
Paik, Aimee, MD	Dermatology	Medicine	Medicine – Active Community
Pruthi, Asit, MD	Ophthalmology	Surgery	Ophthalmology
Rohira, Ashish, MD	Internal Medicine	Medicine	Adult Hospitalist
Ryan, Martha, MD	Ophthalmology	Surgery	Ophthalmology
Varma, Geetha, MD	Hematology/ Oncology	Medicine	Hematology/Oncology General Internal Medicine
Zetterlund, Patrik, MD	Interventional Cardiology	Medicine	Cardiology Interventional Cardiology Peripheral Endovascular Cardiac Diagnostic Outpatient Center (CDOC) Center for Advanced Diagnostic Imaging (CADI)

Staff Status Modifications:

NAME	SPECIALTY	STATUS
Noel, Katherine, MD	Ob/Gyn	Leave of Absence
Goldberg, Steven, MD	Interventional Cardiology	Resignation effective May 25, 2023
Meigher, Stephen, MD	Emergency Medicine	Resignation effective March 26, 2023

Temporary/Locum Tenens Privileges:

NAME	SPECIALTY	DATES
Bahia, Surinder, MD	Family Medicine	4/17/2023-5/25/2023
Varma, Ross, MD	Radiology	4/7/2023-5/6/2023

Other Items: ***(Attached)***

Telemedicine Credentialing Policy	The Committee recommended approval of the revision to the Telemedicine Credentialing Policy regarding criminal background checks.
Dept of Medicine – Clinical Privileges Delineation Critical Care/Pulmonary Medicine – Revision	The Committee recommended approval of the revision to the clinical privilege delineation for Critical Care/ Pulmonary Medicine for the removal of Tube Thoracostomy as a special procedure since this is already listed as a core procedure.
Dept of Medicine – Clinical Privileges Delineation Interventional Cardiology – Revision	The Committee recommended approval of the revision to the clinical privilege delineation for Interventional Cardiology regarding reappointment criteria for Transcathter Aortic Valve Replacement (TAVR) as submitted.

Interdisciplinary Practice Committee

Initial Appointment:

NAME	SUPERVISOR	DEPARTMENT	PRIVILEGES
Candia, Julie (July), PA-C	Geetha Varma, MD	Medicine	Nurse Practitioner SVMHS Outpatient Infusion Center
DeMara, David, PA-C	Vincent DeFilippi, MD Andreas Sakopoulos, MD	Surgery	Physician Assistant
Hurst, Sharen, NP	Misty Navarro, MD Cristina Martinez, MD	Emergency Medicine	Nurse Practitioner
Shaw, Scott Eric, PA-C	Vincent DeFilippi, MD Andreas Sakopoulos, MD	Surgery	Physician Assistant

Reappointment:

NAME	SUPERVISOR	DEPARTMENT	PRIVILEGES
Klay, Amanda, PA	Bert Tardieu, MD Kelvin Lim, MD Allen Hershey, MD Willard Wong, MD David Roy, MD Matthew Griffin, MD Justin Swan, MD	Surgery	Physician Assistant APP – Taylor Farms Family Health & Wellness Center

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGES
Hein, Lance PA-C	Physician Assistant - Cardiac Surgery	Furnishing or Ordering of Schedule II-V Drugs

Staff Status Modifications:

NAME	SPECIALTY	STATUS
Fisher, Amanda PA-C	Physician Assistant-Emergency	Resignation effective February 2023.

Temporary/Locum Tenens Privileges:

PHYSICIAN	SPECIALTY	DATES
Shaw, Scott Eric PA-C	Physician Assistant – Surgical Assisting Cardiac Surgery	04/03/2023 – 4/30/2023 and extended; 05/01/2023 – 05/30/2023

Other Items: ***(Attached)***

Nursing Standardized Procedure Review	Neonatal Endotracheal Intubation Standardized Procedure approved as presented.

Policies and Plans: *(Attached)*

1. Risk Management Plan:
2. Quality Assessment and Performance Improvement Plan

Informational Items:

I. Bylaws, Rules and Regulations:

General Rules and Regulations Article 2.3-6 proposed change based on redundancy. Struck-out language represents proposed deletion. This item will be posted for General Medical Staff Review and comment prior to proposal to the Board of Director for approval:

2.3-6

All patients admitted to the hospital shall be seen by the attending provider or designee on each calendar day ~~including the day of discharge~~ and a daily progress note shall be recorded in the medical record.

II. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Medical Staff Excellence Committee
d. Quality and Safety Committee Reports:
    - Transitional Care
    - CMS Hospital Star Ratings
    - Health Equity and Social Determinants of Health
    - Resuscitation Committee
    - Critical Care Service Line
    - Med/Surg Cluster/Pediatrics, Inpatient Wound Care
    - Women's Services
    - Health Information Management
    - Nursing Administration/Transporters/Interpreter Services
    - Nursing Education
    - Taylor Farms Family Health and Wellness Center
    - Community/Volunteer Services
    - Nutrition Services
    - Respiratory Care
    - Rehabilitation Services (PT, OT, Speech)
    - Sleep Center
    - Risk Management Plan
    - Quality Assessment and Performance Improvement Plan

III. Other Reports:

a. Financial Performance Review March 2023
b. Summary of Executive Operations Committee Meetings
c. Summary of Medical Staff Department/Committee Meetings –April 2023
d. Medical Staff Excellence Committee – Annual Review of Peer Review Indicators
e. Medical Staff Treasury Report April 5, 2023
f. Medical Staff Statistics
g. HCAHPS Update May 1, 2023

IV. Order Sets/Treatment Plans:

V. Annual Review of Radiology/Nuclear Medicine Job Descriptions 2023

TJC Standards, MS.03.01.01 EP 16 - For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.

3. **PROCEDURE – INITIAL APPOINTMENT:**

A. No less than thirty (30) business days before the addition of any new Telemedicine provider, the distant site shall provide the following to SVMHS Medical Staff Services:

i. The distant site approved Delineation of Privileges;
ii. Evidence of current malpractice insurance coverage; and
iii. Demographic and licensure information as needed for Hospital systems.

B. Application Processing: Upon the receipt of the documentation referenced in section 5(A) above, the documents and information will be added to the SVMHS Medical Staff Credentialing Database.

C. Credentialing Review and Approval Process: Telemedicine applicants will be forwarded to the Department Chair and Credentials or Interdisciplinary Practice Committee. The remainder of the approval process shall take place in accordance with the SVMHS Medical Staff Bylaws.

D. SVMHS Medical Staff Services shall:

i. Update credentialing software as appropriate
ii. Notify the distant site of the appointment dates.
iii. SVMHS will be responsible for conducting inquiries into the NPDB, Medical Board of California, Office of the Inspector General, Government Services Administration, and State Medicaid program. A ~~and~~ criminal background check will also be conducted in the event the Distant site does not conduct background checks.

4. **PROCEDURE FOR REAPPOINTMENT**

A. The reappointment process shall follow the same process that applies to the granting of initial privileges. The distant site will also submit a quality profile for each practitioner for the previous 24 months.

B. Any outlying information will be reviewed by the SVMHS Credentials or Interdisciplinary Practice Committee and the department chair.

C. SVMHS will be responsible for conducting inquiries into the NPDB, Medical Board of California, Office of the Inspector General, Government Services Administration and State Medicaid program.

D. Completed Re-Credentialing Review and Approval Process:

Telemedicine applicants will be forwarded to the Department Chair and Credentials or Interdisciplinary Practice Committee. The remainder of the approval process shall take place in accordance with the SVMHS Medical Staff Bylaws.

Special Procedures/Privileges

Qualifications: To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth below.

Proctoring of Special Procedure Privileges: These special procedure-proctoring requirements must be met in addition to the core proctoring requirements described on page one of this privilege form.

Applicant: Place a check mark in the (R) column for each privilege requested. New applicants must provide documentation of the number and types of hospital cases during the past 24 months.

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended
Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months
				Deep Sedation	Unrestricted Moderate Sedation Privileges **AND** Completion of written deep sedation exam with minimum of 75% correct.	1	Completion of written deep sedation exam with minimum 75% correct **AND** Performance of at least two (2) deep sedation Cases within the past 24 months
				~~Tube Thoracostomy~~	~~**Documentation of 2 cases in the previous 24 months**~~	~~**N/A**~~	~~**N/A**~~
				Pulmonology Consultation at Taylor Family Farms Health and Wellness Center	Unrestricted Core Critical Care/Pulmonary Medicine privileges at SVMH **AND** Current BLS Certification (at minimum)	**N/A**	Maintenance of unrestricted Core Critical Care/Pulmonary Medicine Privileges at SVMH **AND** Current BLS Certification (at minimum)

Transcatheter Aortic Valve Replacement (TAVR)	1. Board eligible/certified in Interventional Cardiology or Cardiothoracic Surgery 2. Physician must provide documentation of product-specific vendor training within the last six (6) months; **AND** Documentation of one (1) observed case and two (2) completed simulations (done in training). **OR** 3. Applicants who have recently (within the past one (1) year) completed residency/ fellowship training must submit a letter from the residency/fellowship program director attesting to their competency to perform TAVR procedures as primary interventionalist/surgeon; **AND** Provide case logs documenting experience in 6 cases as primary interventionalist/ surgeon. **OR** 4. Documentation of current experience which must include six (6) cases as primary interventionalist/surgeon over the previous twelve (12) months **NOTES:** 1. The hospital TAVR program and clinical team members are subject to CMS TAVR requirements as outlined in "CMS National Coverage Decision Requirements". 2. Once granted supervised TAVR privileges, the first implant must be done at Salinas Valley Memorial Hospital within nine (9) months; otherwise, the physician must repeat the training outlined above or submit documentation of continuing experience at a level of six (6) cases over the previous twelve months.	The first five (5) Transfemoral TAVR cases must be concurrently supervised. (Additional proctored cases may be requested at the discretion of the proctor or department chair.) **Qualified supervisors include:** 1. Vendor-representative physician proctors 2. Vendor-sponsored physician proctors 1. Cardiovascular surgeons / interventional cardiologists on staff who have completed twenty (20) unsupervised TAVR procedures **AND** 2. Extensive experience in the recognition and management of intra-procedural complications and advanced troubleshooting skills 3. Other physicians with documented unsupervised TAVR privileges at another accredited facility.	1. Twelve (12) successful TAVR cases as primary or assistant interventionalist ~~at Salinas Valley Memorial Hospital~~ in the two (2) year period preceding reappointment; **OR** 2. Retraining within the last six (6) months with documented completion of at least one (1) observed case and two (2) simulations.

	3. Both a cardiovascular surgeon and an interventional cardiologist with TAVR privileges must be present at each case performed.		

Status **Pending** PolicyStat ID **12853586**

Last Approved	N/A
Last Revised	05/2023
Next Review	3 years after approval
Owner	Julie Vasher: Director of Women's & Children's Services
Area	Nursing Standardized Procedures

Neonatal Endotracheal Intubation Standardized Procedure

I. POLICY

A. Function (s)

1. To define an appropriate Standardized Procedure allowing the ~~registered~~Registered Nurse (RN)/Respiratory Care Practitioner (RCP) who has successfully completed a neonatal intubation ~~certification~~program to safely intubate neonates in accordance with an established procedure.
2. To provide airway and ventilator support to a compromised newborn.

B. Circumstances

Intubation of a neonate by a Registered Nurse (RN) or Respiratory Care Practitioner (RCP) who is certified in Neonatal Intubation Skills.

1. Setting
    a. Perinatal Services.
    b. A physician is notified and should be in route for all neonatal emergencies.
2. Supervision
    a. Oversight supervision is provided by the NICU Medical Director.
    b. The intubation certified RN or RCP may intubate infants without the presence of a physician under the following conditions:
3. Patient Conditions
    a. Respiratory insufficiency due to:
        i. Infant requiring assisted ventilation who is not being effectively

ventilated with bag valve mask.

ii. Infant's HR remains <100 and not increasing with PPV

a. Consider intubation or placement of laryngeal mask airway

b. Infant requiring chest compressions; intubation facilitates coordination of chest compressions and ventilation and maximizes the efficiency of each positive-pressure breath. Intubation is strongly recommended prior to beginning chest compressions. If intubation is not successful or not feasible, a laryngeal mask may be used.

c. Infant requiring endotracheal administration of epinephrine.

d. Infant requiring direct tracheal suctioning

e. Infant requiring surfactant administration (requires physician order).

f. Extreme prematurity.

g. Diaphragmatic Hernia.

~~Non-vigorous newborns with meconium-stained amniotic fluid do not require routine intubation and tracheal suctioning. Initial steps may be performed at the radiant warmer per the recommendations of the NRP.~~

II. DEFINITIONS

A. **Endotracheal intubation** is the insertion of an endotracheal tube into the trachea for emergency airway maintenance in conditions producing or resulting from respiratory insufficiency.

B. **Respiratory Insufficiency** is the failure to adequately provide oxygen to the cells of the body and to remove excess carbon dioxide from them.

III. PROTOCOL

A. Database

1. Subjective – The assessment data will be collected and documented to evaluate necessity to intubate neonate.

2. Objective

a. Positive pressure ventilation is not resulting in adequate clinical improvement.

b. Inadequate chest movement.

c. The need for positive pressure ventilation lasts beyond a few minutes.

d. The need to facilitate the coordination of chest compressions and ventilation .

e. Maximize the efficiency of each positive pressure breath.

f. The need to administer epinephrine via ETT.

g. Congenital anomaly.

B. Diagnosis

Respiratory Insufficiency.

C. Plan

1. Gather Equipment

a. Laryngoscope.

b. Blades: No. 1 (term newborn), No. 0 (preterm newborn), No. 00 (optional for extremely preterm newborn).

c. Endotracheal tubes with inside diameters of 2.5, 3.0, 3.5 and 4.0 mm.

d. Stylet (optional).

e. Carbon Dioxide (CO2) monitor or detector.

f. Suction setup with 10F or larger suction catheter, plus availability sizes 5F or 6F and 8F.

g. Endotracheal tube securing device.

h. Scissor.

i. Oral airway.

j. Meconium aspirator-/tracheal aspirator

k. Stethoscope (neonatal head preferred).

l. Positive-pressure device, pressure gauge and oxygen tubing. Self-inflating bag must have oxygen reservoir.

m. Blanket or towel for shoulder roll.

2. Treatment

a. Follow Neonatal Resuscitation Program Guidelines regarding steps for Intubating a Newborn.

b. Ventilation and oxygenation guidelines BEFORE ATTEMPTING INTUBATION.

i. Oxygenate/ventilate with resuscitation device and mask before beginning intubation and between repeated intubation attempts. Adjust FIO2 based on targeted pre-ductal SpO2 table (see attachment A).

ii. LIMIT ATTEMPTS TO 30 SECONDS.

c. REPEATED INTUBATION ATTEMPTS

i. Do not try to intubate for longer than approximately 30 seconds. If unable to visualize the glottis and insert the tube within 30 seconds, remove the laryngoscope and ventilate the baby with bag and mask. Administer oxygen based on targeted pre-ductal SpO2 table (see attachment A). Ensure that the baby is stable,

and then try again.

ii. If two (2) unsuccessful attempts (visualization **and** insertion) are made to intubate, abandon the procedure; attempt to maintain the infant's saturation within appropriate levels with bag and mask and ensure infant is breathing normally. If the infant still demonstrates respiratory insufficiency and another certified intubator is not available, consider placement of laryngeal mask airway. All NICU RN/RCP should be trained to insert neonatal laryngeal mask airways (LMAs).

d. Post Intubation Considerations/Assess for:

i. Improved vital signs (heart rate, color, and activity).

ii. Presence of exhaled CO2 as determined by a CO2 detector.

iii. Breath sounds over both lung fields but decreased or absent over the stomach.

iv. No gastric distention with endotracheal ventilation .

v. Vapor in the tube during exhalation.

vi. Chest movement with each breath.

vii. Tip-to-lip measurement: nasal-tragus length (NTL) +1cm or add 6 cm to newborn's weight in kilograms.

viii. Chest x-ray confirmation if the tube is to remain in place past initial resuscitation.

3. Patient conditions requiring consultation/reportable conditions:

a. The attending physician is consulted if any conditions outlined in Section I.B. 2 of this policy occur.

b. In the event that an RN/RCP intubator is not available for LD Unit, the LD staff is to call the On Call ~~Pediatrician~~ED Physician for emergency situations. The On-call Neonatologist should be the backup ~~for the On Call Pediatrician is the Neonatologist~~physician. ~~The Emergency Department physician responds to codes per policy.~~

4. Education-Patient/Family

a. Instruct parents/primary care takers regarding procedure/necessity for intubation.

5. Follow up

a. Re-assessment/re-evaluation of tube placement pre- and post-x-ray.

6. Documentation of Patient Treatment

a. The following information must be documented in the electronic medical record:

i. Patient condition warranting resuscitation.

ii. Resuscitative measures initiated.

iii. Blade number and tube size used.

iv. Resuscitation outcome and current patient condition.

b. Document any complications of procedure.

IV. REQUIREMENTS FOR THE ~~REGISTERED NURSE~~RN/RCP (See Attachment ~~B~~C)

~~Education~~

1. ~~Attend two and a half (2.5) hour class: Didactic Lecture/Workshop conducted by a neonatologist.~~
2. ~~Education and training for Nursing/Respiratory Care Practitioners will be provided through department orientation, skills lab, and/or annual competencies.~~

~~Training~~

1. ~~Perform one (1) successful intubation **without excessive time/need for coaching** while proctored by staff member certified for neonatal intubation.~~
2. ~~A previously certified intubator may also use an intubation for meconium as their required successful intubation for certification. Although, non-vigorous newborns with meconium-stained amniotic fluid do not require routine intubation and tracheal suctioning.~~

A. Education/Training

1. Successful completion of the RN/RCP Intubation Training Program (Attachement C)

B. Experience/Qualifications

RN:

- Six (6) months experience in Intensive Care Nursery.
- Current California RN licensure.
- Current Basic Life Support Certification.
- Current Neonatal Resuscitation Program Certification.

RCP:

- Current California RCP licensure.
- Current Basic Life Support Certification.
- Current Neonatal Resuscitation Program Certification.
- California Children's Services qualified.

C. Initial Evaluation

1. Competency will be verified and documented upon completion of ~~Education~~the

RN/RCP Intubation Training ~~in Section IV A. and B. Documentation maintained in the Intubator Binder on unit.~~Program (Attachment C)

2. Documentation maintained in the Intubator Binder on unit.

D. Ongoing Evaluation

1. Annual recertification shall be required.
2. Demonstration of clinical competency shall include a record of one (1) intubation every 18 months. The Director of the NICU and Director of the Respiratory Care review the records.
    a. Annual participation at an Intubation Simulation lab.
    b. In the event that the intubation procedure for recertification is not completed (as outlined in the second bullet above), the Nurse/Respiratory Intubator will attend an Intubation Lecture/Workshop every ~~6~~12 months until a successful proctored intubation has occurred.
    c. The ***Medical Director*** must approve yearly recertification.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

1. Review and approval every one (1) year.
2. Standardized Procedure reviewed by Chief Nursing Officer and the Interdisciplinary Practice Committee (IDPC) upon creation and when changes are made.

B. Review Schedule

a. Every one (1) year.

C. Signatures of Authorized Personnel Approving the Standardized Procedure and Dates

a. Nursing
    i. Clinical Nurse Educator/NICU.
b. Medicine
    i. Medical Director, NICU.
    ii. Chair, Interdisciplinary Practice Committee.
c. Administration
    i. Chief Nursing Officer.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

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

VII. REFERENCES

A. ~~Kattwinkel~~Weiner, G., Zaichkin, J~~.~~. (~~Ed.~~Eds). (~~2016~~2021). Textbook of Neonatal Resuscitation (**8**~~7~~th ed.). ~~Elkgrove Village~~Itasce, IL: American Heart Association and American Academy of Pediatrics.

~~MacDonald, M.G., Ramasethu, J., & Rais-Bahrami, K. (Eds.). (2013). Atlas of Procedures in Neonatology (5th ed.). Philadelphia: J.B. Lippincott Company.~~

B. Karlsen, Kristine. (2013). The S.T.A.B.L.E. Program. Pre-transport/Post-resuscitation Stabilization Care of Sick Infants. Guidelines for Neonatal Healthcare Providers (6th ed.). Utah, S.T.A.B.L.E., Inc.

Attachments

B: O2 Sats / Limits Guidelines

C: RN/RCP Intubation Training Program

Approval Signatures

Step Description	Approver	Date
Policy Owner	Julie Vasher: Director of Women's & Children's Services	Pending

Standards

No standards are associated with this document

History

Edited by Kessler, Karina: Clinical Nurse Educator w/Masters on 12/19/2022, 6:06PM EST

> Updated NRP reference, insertion measurement and included language related to possible need to intubate for direct tracheal suctioning.

Last Approved by Vasher, Julie: Director of Women's & Children's Services on 12/20/2022, 8:30AM EST

Rejected by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 1/23/2023, 5:53PM EST

> Please place on appropriate template. This looks like a combination of the policy template and the Nursing Standardized Procedure template. It is unclear which template and approval workflow you would like this to be.

Last Approved by Vasher, Julie: Director of Women's & Children's Services on 1/25/2023, 10:50AM EST

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 2/16/2023, 4PM EST

> Removed Policy number

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 2/16/2023, 4PM EST

> Policy Committee approved. Flow created.

Comment by DeSalvo, Katherine: Director Medical Staff Services on 2/16/2023, 4:55PM EST

> Julie - please have Dr. Castro review as the NICU Medical Director - then it can be forwarded to IDPC, MEC and the Board. Thank you, Kate

Comment by Vasher, Julie: Director of Women's & Children's Services on 2/16/2023, 4:59PM EST

> @Castro, Robert: PHYSICIAN - hi dr castro, please review this standardized procedure - thank you

Last Approved by DeSalvo, Katherine: Director Medical Staff Services on 3/10/2023, 12:44PM EST

> Approved by the Medical Director of NICU on 03/09/23

Draft saved by Kessler, Karina: Clinical Nurse Educator w/Masters on 3/14/2023, 12:03PM EDT

Edited by Kessler, Karina: Clinical Nurse Educator w/Masters on 3/14/2023, 12:10PM EDT

> 1.Updated the wording related to " No Intubator available" as per Dr. Castro's and groups recommendations
> 2. Added sentence related to LMA training for all NICU RN/RCP's
> 3. Corrected the education/training section to reference the RN/RCP Intubation Training Program (attachment C). Noted a discrepency in wording.

Last Approved by Vasher, Julie: Director of Women's & Children's Services on 3/14/2023, 12:13PM EDT

> Updated the language in regards to back up for neonatal intubation per Dr. Trieu request. Collaborated with all parties i.e. manager, educator and medical director.

Comment by Kessler, Karina: Clinical Nurse Educator w/Masters on 3/14/2023, 12:13PM EDT

> @Vasher, Julie: Director of Women's & Children's Services@Castro, Robert: PHYSICIAN @Villaneda Sr., Louis: NICU/Adult Educator/Supervisor Can you look at the updates made based on recent discussions?

Last Approved by Villaneda Sr., Louis: NICU/Adult Educator/Supervisor on 3/14/2023, 1:04PM EDT

> Hello Karina,
>
> This looks good as is.

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/12/2023, 5:55PM EDT

> Previously approved by Policy Committee

Comment by DeSalvo, Katherine: Director Medical Staff Services on 4/12/2023, 6:26PM EDT

> We will take this forward to IDPC. It will not go to MEC until May 11th through. April MEC is tomorrow.

Draft saved by Kessler, Karina: Clinical Nurse Educator w/Masters on 5/9/2023, 10:42AM EDT

Edited by Kessler, Karina: Clinical Nurse Educator w/Masters on 5/9/2023, 10:45AM EDT

> Added LMA use for non Increasing HR
> Removed the Pedaitric Hospitalist from the emergency response notification.

Status **Pending** PolicyStat ID **13233531**

Last Approved	N/A	Owner	Brenda Bailey: Risk Manager
Last Revised	04/2023	Area	Plans and Program
Next Review	1 year after approval		

Risk Management Plan

I. SCOPE

A. Enterprise Risk Management is a systematic process of identifying events, evaluating and reducing losses associated with patient, personnel or visitor injuries, property loss or damages and other sources of potential legal liability.

B. The Risk Management Program Plan is enacted to protect Salinas Valley Memorial Healthcare System (SVMHS) and all entities under their purview against the adverse consequences of accidental losses, regardless of source, effectively managing losses that may occur, and to enhance the continuous improvement of patient care services in a safe healthcare environment.

C. The CEO and Board of Directors have given the authority to the Risk Management Division to implement, monitor and track the elements of the Enterprise Risk Management Program under cover of this plan.

D. This enterprise risk management framework is geared to achieving the entity's objectives, set forth in four categories:

   i. *Strategic* – high-level goals, aligned with and supporting its mission

   ii. *Operations* – effective and efficient use of its resources

   iii. *Reporting* – reliability of reporting

   iv. *Compliance* – compliance with applicable laws and regulations.

E. The Risk Management Program Plan is organization wide and applies to all departments, programs and services at SVMHS. The scope of the program will encompass the patient population, employees, visitors, volunteers, students and other personnel providing services at SVMHS including medical staff. SVMHS has entities other than the acute care hospital under the Health System purview and these SVMHS entities adhere to this Risk Management Program Plan.

F. The Risk Management Program Plan establishes an approach to monitoring, evaluating, and managing risks throughout the organization. A risk is an uncertain event or condition that, if it

occurs, has a negative or positive effect on the organization.

G. Salinas Valley Health supports a Just Culture philosophy and approach to adverse event investigation and response and has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner.

II. OBJECTIVES/GOALS

A. In order to approach the process of Risk Management systematically, SVMHS utilizes the following four-step model for Risk Management
    1. The identification of risks
    2. The analysis of the risk identified
    3. The treatment of risks
    4. The evaluation of risk treatment strategies

B. This model assists in setting priorities for Risk Management activities and ensures a comprehensive Risk Management effort. Any single strategy or combination of the above Risk Management strategies may be employed to best manage a given situation.

C. **Risk Identification:**
    1. Risk Identification is the process whereby awareness of risks in the health care environment that constitute potential loss exposures for the facility is identified.
    2. The following information services may be utilized to identify potential risks:
        a. Identification of trends through the incident reporting system
        b. Patient, visitor, staff and physician complaint reports
        c. Performance improvement functions
        d. Peer review activities
        e. Informal discussions with management and staff members

D. **Risk Analysis:**
    1. Risk Analysis is the process of determining the potential severity of the loss associated with an identified risk and the probability that such a loss will occur. These factors establish the seriousness of a risk and will guide management in the selection of an appropriate risk treatment strategy.

E. **Risk Treatment:**
    1. Risk Treatment refers to the range of choices available to leadership in handling a given risk. Risk Treatment strategies include the following:
        a. Risk acceptance involves assuming the potential loss associated with a given risk and making plans to cover any financial consequence of such losses.
        b. Risk avoidance is a strategy utilized when a given risk poses a particularly serious threat that cannot be effectively reduced, and the conduct or service giving rise to the risk may perhaps be avoided.

c. Risk reduction or minimization involves various loss control strategies aimed at limiting the potential consequences or frequency of a given risk without totally accepting or avoiding the risk. Strategies may include system redesign, staff education, policy and procedure revision and other interventions aimed at controlling adverse occurrences without completely eliminating risk activities.

F. **Risk Management Evaluation:**

1. The final step in the Risk Management process is risk management evaluation. The effectiveness of the techniques employed to identify, analyze and treat risks are assessed and further action taken when warranted. If improvement and/or resolution of the risk are evident, additional follow-up will be done at predetermined intervals to evaluate continued improvement. This evaluation is in concert with the Salinas Valley Memorial Hospital Patient Safety Program Plan and Quality Assessment and Performance Improvement Plan.

III. DEFINITIONS

IV. PLAN MANAGEMENT

A. Plan Elements

1. The Risk Management Program is concerned with a variety of issues and situations that hold the potential for liability or losses for the hospital/organization. It addresses the following categories of risk:

Patient-Related Risks, including but not limited to:

- Patient Safety and all elements therein
- Policies and Procedures
- Licensing and Accreditation processes
- Confidentiality and appropriate release of patient medical information/protected health information (PHI)
- Patient Rights
- The securing of appropriate informed patient consent for medical treatment
- Nondiscriminatory treatment of patients, regardless of race, religion, national origin or payment status
- Protections of patient valuables from loss or damage

Medical Staff-Related Risks

- Medical Staff peer review and quality/performance improvement activities
- Confidentiality and protection of the data obtained
- Medical Staff credentialing, appointment and privileging processes

Employee -Related Risks

- Maintaining a safe work environment
- Reduction of the risk of occupational illnesses and injury
- Provision for the treatment and compensation of workers who suffer on-the-job injuries and work-related illnesses
- Ensuring nondiscrimination in recruitment, hiring and promotion of employees

Technology

- Maintaining Risk Management Information Systems (RMIS), Electronic Health Records (EHR)
- Meaningful Use, social networking and cyber liability.

Strategic

- Managed care relationships/partnerships
- Mergers, acquisitions, divestitures, joint ventures, affiliations and other business arrangements
- Contract administration

Financial

- **Access** to capital or external financial ratings through business relationships or the timing and recognition of revenue and expenses
- Costs associated with malpractice, litigation, and insurance, capital structure, credit and interest rate fluctuations, foreign exchange, growth in programs and facilities, capital equipment, corporate compliance (fraud and abuse), accounts receivable, days of cash on hand, capitation contracts, billing and collection

Legal/Regulatory

- The failure to identify, manage and monitor legal, regulatory, and statutory mandates on a local, state and federal level fraud and abuse, licensure, accreditation, product liability, management liability, Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) and Conditions for Coverage (CoC), as well as issues related to intellectual property.

Other Risks

- Ensuring mechanisms to prevent and reduce the risk of losses associated with fire, flood, severe weather and utilities malfunction
- Ensuring the development and implementation of emergency preparedness plans
- Ensuring that appropriate protocols are in place for hazardous materials/waste

management

- Maintaining a safe environment for patients and visitors
- Assisting Quality/Performances Improvement efforts to identify those areas which represent an opportunity to improve patient care and reduce risk.

2. Enterprise risk management consists of eight interrelated components. These are derived from the way management runs an enterprise and are integrated with the management process. Enterprise risk management is not strictly a serial process, where one component affects only the next. It is a multidirectional, iterative process in which almost any component can and does influence another. These components are:
    a. *Internal Environment* – The internal environment encompasses the tone of an organization, and sets the basis for how risk is viewed and addressed by the facility, people, including risk management philosophy and risk appetite, integrity and ethical values, and the environment in which we operate.
    b. *Objective Setting* – Objectives must exist before leaders can identify *potential* events affecting their achievement. Enterprise risk management ensures that management has in place a process to set objectives and that the chosen objectives support and align with our mission and are consistent with our risk appetite.
    c. *Event Identification* – Internal and external events affecting achievement of our objectives must be identified, distinguishing between risks and opportunities. Opportunities are channeled back to leaders strategy or objective-setting processes.
    d. *Risk Assessment* – Risks are analyzed, considering likelihood and impact, as a basis for determining how they should be managed. Risks are assessed on an inherent and a residual basis.
    e. *Risk Response* – Leadership selects risk responses – avoiding, accepting, reducing, or sharing risk – developing a set of actions to align risks with the entity's risk tolerances and risk appetite.
    f. *Control Activities* – Policies and procedures are established and implemented to help ensure the risk responses are effectively carried out.
    g. *Information and Communication* – Relevant information is identified, captured, and communicated in a form and timeframe that enable people to carry out their responsibilities. Effective communication also occurs in a broader sense, flowing down, across, and up the entity.
    h. *Monitoring* – The entirety of enterprise risk management is monitored and modifications made as necessary. Monitoring is accomplished through ongoing leadership activities, separate evaluations, or both.

B. Plan Management

1. The Plan Elements, although some may not be under the direct accountability /responsibility of the Risk Management Division, may be assured through, but not limited to the following tasks.
    a. Investigate adverse occurrences to assess and determine how similar occurrences might be averted, review patterns and trends, control the loss related to the adverse

occurrence, and identify areas for performance improvement.

b. Assess premise/property for potentially hazardous conditions which may present unnecessary risk to employees, patients, and visitors and make risk recommendations.

c. Review the performance of persons providing care to patients to identify practices which may present unnecessary risks to patients or deviate from acceptable standards.

d. Participate in policy and procedure review to update, amend, edit, and revise to reflect appropriate care, legislative requirements, and minimize or prevent liability ramifications.

e. Participate in response and management of regulatory investigations.

f. Organize educational programs on risk management topics to promote awareness of risk management and safe practices.

g. Report Effectiveness - Periodic reports are provided by the various areas previously described to assess the effectiveness of their monitoring. Outcome evaluations are conducted and reported annually as part of the Quality and Safety Committee.

h. Claims Management - Coordinate the management of claims against SVMHS in a timely, organized, manner. The Risk and Patient Safety Department, in concert with the Safety Officer investigates complaints, grievances, safety related events, incidents and actual or potential claims by a process protected from discovery. Safety events or Claims presenting serious exposure are reported immediately to the appropriate individuals. Issues concerning the hospital will be investigated and resolved with the assistance of Quality Management, affected departments, and staff, administration, physicians, and patient / family as needed. The results of the findings are provided to the appropriate individuals or committee. Matters involving care provided by the physician are forwarded to the Medical Staff Department for further review and response as indicated. See Attachment "B" Claims Process Map.

C. Plan Responsibility

1. Everyone in the organization has some responsibility for enterprise risk management. The Board of Directors provides important oversight to enterprise risk management, and is aware of and concurs with the risk appetite.
2. The Chief Executive Officer is ultimately responsible to assure the implementation of the Risk Management Program Plan.
3. The Risk and Patient Safety Division under the authority of the CMO is responsible for the implementation of the Risk Management Program Plan. The Risk Manager and Patient Safety Officer works in concert with other departments and leaders such as, Human Resources, Employee Health, Infection Prevention, Quality Management, Accreditation and Regulatory, Safety Officer, Medical Staff Services and others to assure full implementation of the Program Plan.
4. All leadership supports the risk management philosophy; promotes compliance with our risk appetite, and manages risks within their spheres of responsibility consistent with risk tolerances. These leaders are also responsible for executing enterprise risk management in

accordance with established directives, policies, procedures and protocols as outlined by SVMHS.

5. A number of external parties, such as customers, vendors, business partners, external auditors, regulators, and financial analysts often provide information useful in effecting enterprise risk management, but they are not responsible for the effectiveness of, nor are they a part of, this program plan.

   See Attachment "A" for Risk Management Program Structure

D. Confidentiality

1. Confidentiality shall be in effect for all Risk Management activities.
2. All communication and documentation generated as part of the Risk Management program are to be confidential and subject to the state and federal laws protecting such documents from discovery, including Attorney: Client Privileges and Patient Safety Work Product as applicable. It is the intent of this Risk Management Program Plan to apply all existing legal standards and state or federal statutes to provide protection to the documents, proceedings, and individuals involved in the program.
3. The medical staff Quality and Safety Committee is responsible for the oversight of the Risk Management Program. All information, data, reports, minutes, or memoranda relating to the implementation of this Risk Management Program Plan are solely for use in the course of internal quality control for the purpose of reducing morbidity and mortality and improving the environment of care.
4. Any and all documents and records that are part of the internal Risk Management program as well as the proceedings, reports and records from any of the involved committees shall be maintained in a confidential manner. Disclosure to any judicial or administrative proceedings will occur only under court order or legal mandate and in accordance with the Patient Safety Work Product protections.

E. Performance Measurement

1. The performance measurement process is one part of the evaluation of the effectiveness of the Risk Management Program. Performance measures may be established to measure at least one important aspect of the Risk Management Program.
2. On an annual basis, the Safety and Reliability Committee and Quality and Safety Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage risks to the staff, visitors, and patients at Salinas Valley Memorial Hospital.

F. Orientation and Education

1. Evaluation of the education and training needs of hospital staff and healthcare providers; participating in events annually to promote risk initiatives, making recommendations, coordinating and or conducting in-service programs, submitting information for medical staff physician education and issuing materials in the field of Risk Management is critical to the success of the Risk Management Program Plan.

V. REFERENCES

A. Risk Management Handbook for Healthcare Organizations
B. California Evidence Code 1157
C. Patient Safety and Quality Improvement Act of 2005; 42 U.S.C. 299b-21
D. American Society for Health Care Risk Management of the American Hospital Association
E. INFORMATION SECURITY RISK MANAGEMENT #1010

Attachments

A: Risk Management Program Structure

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	Pending
QSC	Aniko Kukla: Director Quality & Patient Safety	05/2023
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2023
Policy Owner	Brenda Bailey: Risk Manager	04/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13549799**

Last Approved	N/A
Last Revised	05/2023
Next Review	1 year after approval
Owner	Aniko Kukla: Director Quality & Patient Safety
Area	Plans and Program

Quality Assessment and Performance Improvement Plan

I. SCOPE

A. The purpose of the Organizational Quality Assessment and Performance Improvement (QAPI) Program Plan at Salinas Valley ~~Memorial Hospital~~Health Medical Center (~~SVMH~~SVHMC), under the Salinas Valley ~~Memorial Healthcare System (SVMHS)~~Health is to ensure that the Governing Body, medical staff and professional ~~service~~services staff demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risk. Furthermore, the QAPI Plan is used as a mechanism to develop, implement, and maintain an effective, ongoing, organization-wide, data-driven quality assessment and performance improvement program through a planned, systematic, and interdisciplinary approach to improving the care, treatment and services provided. This is an organization-wide plan. It applies to all inpatient, outpatient departments and ambulatory outpatient services, licensed under ~~SVMH~~SVHMC including those services furnished under contract or arrangement.

B. The QAPI Program is designed to promote an environment where patient care and services are continually improved, where professional performance and employee competence are maximized, and in which operational systems are efficient. Through an interdisciplinary and integrated process, patient care and the processes that affect patient care are measured and assessed to provide optimal outcomes. The Board of Directors, Medical Staff, organizational leaders and all personnel assume appropriate accountability for the quality of care and services provided at ~~SVMH~~SVHMC. The QAPI Program is designed to align with and support the organizational MISSION, VISION, AND GOALS STATEMENT.

C. In concert with the organizational QAPI Program, professional nursing practice care at Salinas Valley ~~Memorial Hospital~~Health Medical Center is guided by a Professional Practice Model, developed by the nursing staff. The nursing mission is to heal, protect, empower and teach. The nursing vision is to be an innovative leader in nursing excellence - a place where patients choose to come and nurses want to practice. Other components of the Professional Practice Model include shared governance, respectful, collaborative professional relationships, recognition and reward for professional nursing development and a care delivery model which embraces a relationship-based, collaborative approach emphasizing partnerships with our colleagues, patients, families and the community. Clinical Nurses, ancillary staff, support staff and medical staff participate in quality committees to make interprofessional decisions at the organizational level to improve processes and quality of care. These decision making committees include committees in Administrative

Quality; Safety and Reliability; Shared Governance and ad hoc subcommittees where nursing sensitive measures and nursing practice initiatives are incorporated into the overall organizational performance improvement.

II. OBJECTIVES/GOALS

A. **Objectives**

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

B. **Goals**

1. The goals for the QAPI Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance monitoring and environmental monitoring.
2. Annually the organization defines at least one improvement priority. In collaboration with organizational strategic objectives, the following priorities have been established for ~~2020~~2023:
    - Annual Quality and Safety Pillar Strategic Initiatives
    - Patient Perception of Care, Services and Treatment
    - Patient Flow Initiatives
    - Regulatory Reporting Requirements, including Value Based Purchasing
    - Adherence to National Patient Safety Goals
    - Maintenance of Disease Specific Care Certification Designations ~~Pain Management and Opioid reduction~~
    - Pain Management and Opioid Reduction Strategies
    - Safety and Reliability Improvement Initiatives
    - Magnet Recognition/Nurse Sensitive Indicators
    - Health Equity

III. DEFINITIONS

A. CMS	Centers for Medicare and Medicaid Services
B. MEC	Medical Executive Committee
C. PIT	Process Improvement ~~team~~Team
D. QAPI	Quality Assessment and Performance Improvement
E. QSC	Quality and Safety Committee

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. **Measuring Performance**

a. Data Collection
The Board of Directors, in collaboration with medical staff and hospital administrative leaders, establish priorities for data collection as well as the frequency for collection. Data collected for high priority processes are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement, or sustain improvement. The Program is expected to show improvement in measures for which there is evidence that patient outcomes will be improved and medical errors will be reduced. Data are collected and analyzed for the following ~~but~~ (not a comprehensive list):

- Performance improvement priorities identified by leaders
- Operative or other procedures that place patients at risk of disability or death
- All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- Adverse patient events
- Adverse events related to using moderate or deep sedation or anesthesia
- Blood management
- The results of resuscitation / Effectiveness of its response to change or deterioration in a patient's condition
- Medication errors
- Adverse drug reactions
- Patient perception of the safety and the quality of care, treatment or services
- Processes that improve patient outcomes such as fall reduction activities including assessment, interventions and education
- National Patient Safety Goals
- Processes as defined in the organizations Infection Control Program, Environment of Care Program, and Patient Safety Program

- Organ Procurement Organization processes
- Staff opinions and needs, staff perceptions of risk to individuals, staff suggestions for improving patient safety, and willingness to report adverse events
- Core measure data and other required Centers for Medicare and Medicaid Services (CMS) measures
- Patient flow processes
- Contracted services
- Emergency Management
- Other areas as outlined in the Quality Oversight structure

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on selected populations. A reporting calendar has been defined for department and operational reporting. This is a dynamic document and may change throughout the year based on priorities and/or ~~compliance to metrics~~metric outcome trends.

Relevant information developed from the following activities is integrated into performance improvement initiatives as required:

- Patient safety
- Clinical outcomes
- Key financial/utilization indicators including length of stay
- Risk management
- Quality control
- Infection control surveillance and reporting
- Research when applicable
- Autopsies
- Other relevant data as required or identified

2. **Assessing Performance**
    a. **Data Compilation and Analysis**
    Data aggregation and analysis transforms data into information. Data are systematically aggregated and analyzed in order to monitor the effectiveness and safety of services and quality of care, and assess performance levels, patterns, or trends.
        i. Data aggregation is performed at the frequency appropriate to the activity or process.
        ii. Statistical tools and techniques are used to display and analyze data whenever possible.
        iii. Data are analyzed and compared internally over time and externally with other sources of information when available.

iv. When available, comparative data are used to determine if there is excessive variability or unacceptable levels of performance.

v. Results of data analysis are used to identify improvement opportunities.

3. **Improving Performance**
    a. Information from data analysis is used to make changes that improve performance and safety. The Board of Directors, in collaboration with medical staff and hospital leaders, establish priorities for improvement opportunities and requests action be taken on those priorities.
        - Information from data analysis including data from new or modified services is used to identify and implement changes that will improve performance and patient safety.
        - Improvement strategies are evaluated to confirm that they have resulted in improvement, and are tracked to ensure that improvements are sustained.
        - Additional actions are taken when the improvements do not achieve or sustain the desired outcomes.
        - Changes that will reduce the risk of sentinel events are identified and implemented.

4. **Identifying and Managing Adverse or Unexpected Occurrences**
    a. Processes for identifying and managing sentinel events are defined in the organization wide ADVERSE EVENTS - REPORTABLE.

5. **Proactive Risk Reduction Program**
    a. Salinas Valley Memorial Hospital has dedicated a consistent effort to reduce potential harm to patients and prevent unanticipated adverse events by remaining proactive in approaches to performance improvement. Periodically, a systematic proactive evaluation method is completed on a process to evaluate and identify how it might fail and determine the relative impact a failure might have. This process assists to identify the key parts in a process that require change.

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

7. **Analysis of Staffing**
    a. When undesirable patterns, trends or variations in performance related to the safety or quality of care are identified from data analysis or a single undesirable event, the adequacy of staffing (number, skill mix, competency), including nurse staffing is analyzed for possible cause. Additionally, processes related to work flow, competency assessment, credentialing, supervision of staff, orientation, training and education may also be analyzed.

b. When analysis reveals a problem with the adequacy of staffing, the QSC is informed of the results of the analysis and actions taken to resolve the identified problem(s).

B. **Plan Management**

1. **Performance/Process Improvement Model**

a. Salinas Valley Memorial Hospital utilizes a wide range of systematic and structured problem-solving approaches to plan, design, measure, assess and improve organizational performance/processes. Methodologies include Lean for Healthcare, F O C U S – P D C A and Rapid Cycle Improvement.

- F O C U S – P D C A.
  F – Find a process to improve.
  O – Organize a team that understands the process.
  C – Clarify how the current process works.
  U – Understand the causes of process variation, the "root cause".
  S – Select changes that will improve the process.

  P – Plan how the changes will be implemented.
  D – Do/implement the plan.
  C – Check the results of the improvement plan by collecting post-implementation data.
  A – Act on the findings of post-implementation data by standardizing the process or testing another change.
- Systems Redesign
  Utilizes concepts such as eliminating waste, process mapping, one piece flow; just in time, standardization, and workload leveling.
- Rapid Cycle Improvement / Kaizen
  When appropriate, the *rapid cycle improvement* process may be utilized. The advantages of the rapid cycle improvement process include:
  - Using a small sample to test a proposed change idea quickly.
  - Testing ideas side by side with existing processes.
  - Testing many ideas quickly.
  - Providing opportunities for failures without impacting performance.
  - Minimizing resistance to successful change.

2. **Performance/Process Improvement Teams**

a. A performance/process improvement team is defined as a group of knowledgeable people, who are close to the process, that cooperate to achieve a common goal. Teams are composed of individuals with expertise in the process(es) that require(s) improvement.

3. **Performance/Process Improvement Team Request**

a. A request for approval for a formal performance/process improvement team

(PIT) may be presented to the Quality Interdisciplinary or Safety and Reliability Committee for consideration of a performance improvement team. PITs will be considered when interdisciplinary and/or interdepartmental processes require improvement that cannot be accomplished by an individual or by the individual department(s) or discipline(s). In order to prioritize and coordinate organizational improvement processes and resources, interdisciplinary / interdepartmental teams may be approved by the Quality and Safety Committee. NOTE: Individual departments may charter teams for the purpose of improving processes specific to their departments.

C. **Plan Responsibility**

1. Performance / Process Improvement Structure

    a. The Quality Oversite Structure outlines the quality and performance improvement structure and processes. A calendar for reporting is defined annually and changes made ongoing as the needs of the organization changes. The Quality Management Department, in collaboration with facility leaders, staff and medical staff, facilitates the implementation of the QAPI Program.

    b. **Governing Board**

        i. Responsibility for performance improvement rests with every employee of Salinas Valley Memorial Hospital. Overall responsibility rests with the Board of Directors. The Board of Directors requires review and evaluation of patient care activities to measure and improve the quality and efficiency of patient care and services in the organization. While maintaining overall responsibility, the Board delegates operational authority to the Medical Staff and Hospital Leadership. The MEC authorizes the establishment of an interdisciplinary Quality and Safety Committee to implement the QAPI Program.

        ii. In exercising its supervising responsibility, the Board:

            1. Reviews and approves the QAPI, Risk Management and Patient Safety Program Plans.
            2. Reviews periodic reports on findings, actions, and results of program activities, including input from the populations served via results of patient experience data.
            3. Reviews reports on the following: all system or process failures; the number and type of sentinel events; whether the patients and the families were informed of the event; results of analyses related to adequacy of staffing; all actions taken to improve safety, both proactively and in response to actual occurrences.
            4. Assesses the QAPI, Risk Management and Patient Safety Programs' effectiveness and efficiency and required modification, as necessary.
            5. Provides resources and support for performance improvement, change management, patient safety and risk

management functions related to the quality and safety of patient care, including sufficient staff, access to information and training throughout the hospital.

c. **Medical Executive Committee**

i. The Medical Executive Committee (MEC) is accountable to the Board of Directors for the oversight of performance improvement activities to ensure that one level of care is rendered to all patients.

ii. The Medical Staff participates in developing measures to evaluate care systematically. Their participation may be in individual departments, medical staff committees, or on interdepartmental or interdisciplinary process/performance improvement teams.

iii. The medical staff departments review and evaluate the results of ongoing measures that include the medical staff review functions as well as risk management, patient safety, infection control, case management, and organizational planning.

d. **Organizational Leaders**

i. Set expectations for performance/process improvement.

ii. Develop plans for performance/process improvement.

iii. Manage processes to improve hospital performance.

iv. Review results from key financial indicators in order to ensure overall financial stability.

v. Monitor contracted services by establishing expectations for the performance of the contracted services.

vi. Participate in performance/process improvement activities when appropriate.

vii. Ensure participation from appropriate individuals in organization wide performance/process improvement activities.

viii. Ensure that new or modified processes or services incorporate the following:

- Needs and/or expectations of patients, staff and others.
- Results of performance improvement activities, when available.
- Information about potential risk to patients, when available.
- Current knowledge, when available and relevant.
- Information about sentinel events, when available and relevant.
- Testing and analysis to determine whether the proposed design or redesign is an improvement.
- Collaboration with staff and appropriate stakeholders to design services.

ix. Ensure that an integrated patient safety program is implemented throughout the organization.

x. Establish and maintain operational linkages between risk management activities related to patient care and safety, and performance improvement activities.

xi. Ensure compliance with state and federal laws, and the Joint Commission regulations/standards.

e. **Support Service Departments/Department Directors**

i. The Department leaders are accountable to the Organizational Leaders, QSC and the Board of Directors for the quality of care/ services and performance of their staff and departments. Departments participate in the systematic measurement and assessment of the quality of care/services they provide. The Department Directors:

ii. Promote the development of standards of care and measures to assess the quality of care/services rendered in their departments.

iii. Monitor the processes in their areas, which affect patient safety, care, outcomes and the patient's perception of care received.

iv. Promote the integration of their department's performance improvement activities with those of other support services and the Medical Staff through participation in performance improvement teams.

v. Report the results of applicable performance improvement activities in accordance with the established Quality Oversight Structure

D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of the QAPI Program Plan. Performance measures have been established to measure important aspects of care. Leaders are responsible to determine what measures will be evaluated at least every 2 year. These measures are updated / revised ongoing as compliance is sustained.
2. To ensure that the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities on the basis of assessment; and maintaining achieved improvements, the organizational QAPI program is evaluated for effectiveness at least annually and revised as necessary.
3. **Confidentiality**

a. All information related to performance improvement and patient safety activities performed by the Medical Staff or hospital personnel in accordance with this plan are confidential and protected under the Patient Safety Work Product and California Evidence Code 1157.

b. Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a "need to know" as approved by the Medical Executive Committee, Organizational

Leaders, and/or the Governing Body.

c. HIPAA regulations will be followed.

E. **Orientation and Education**

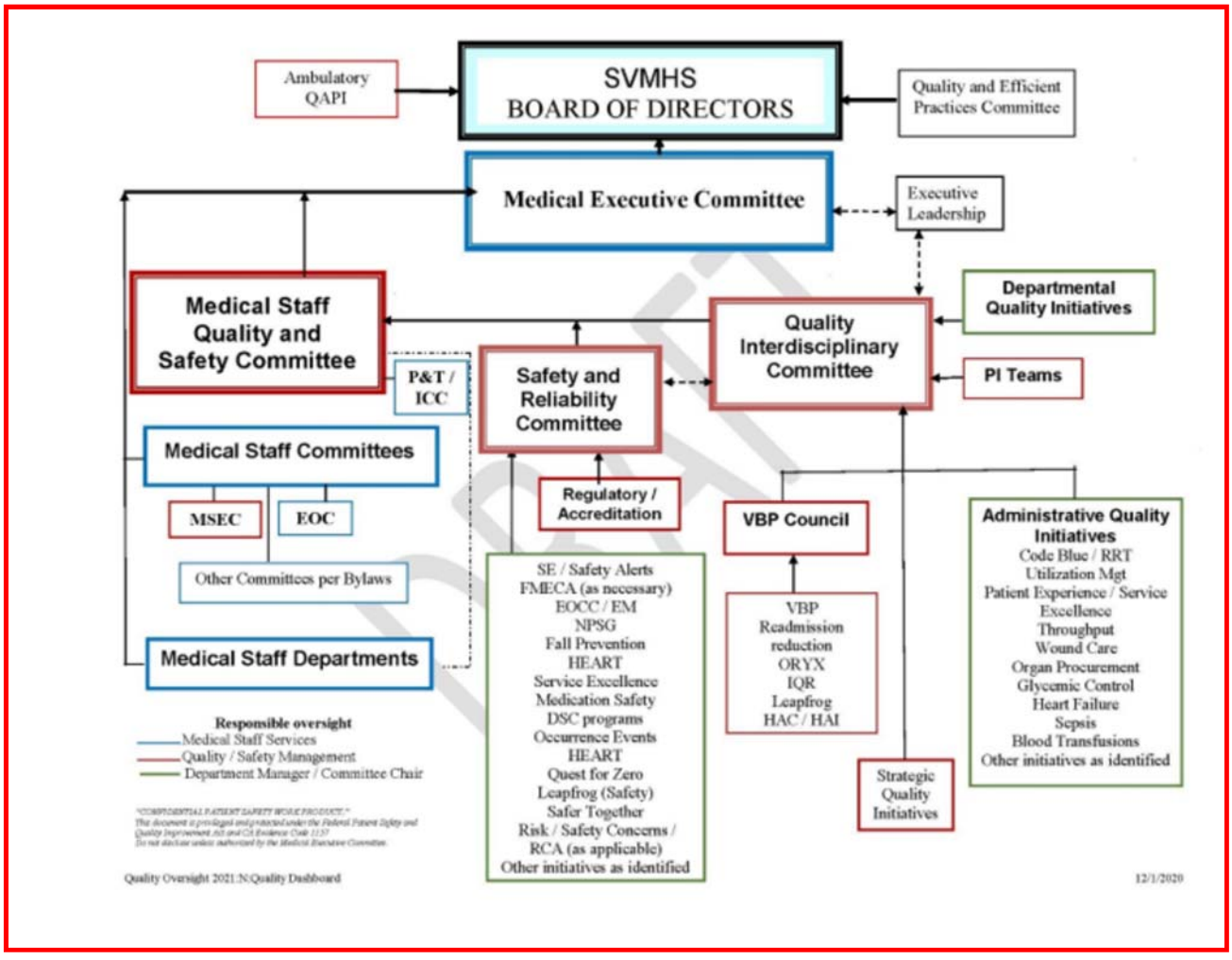
1. Orientation, education and/or training is provided on an as needed basis.

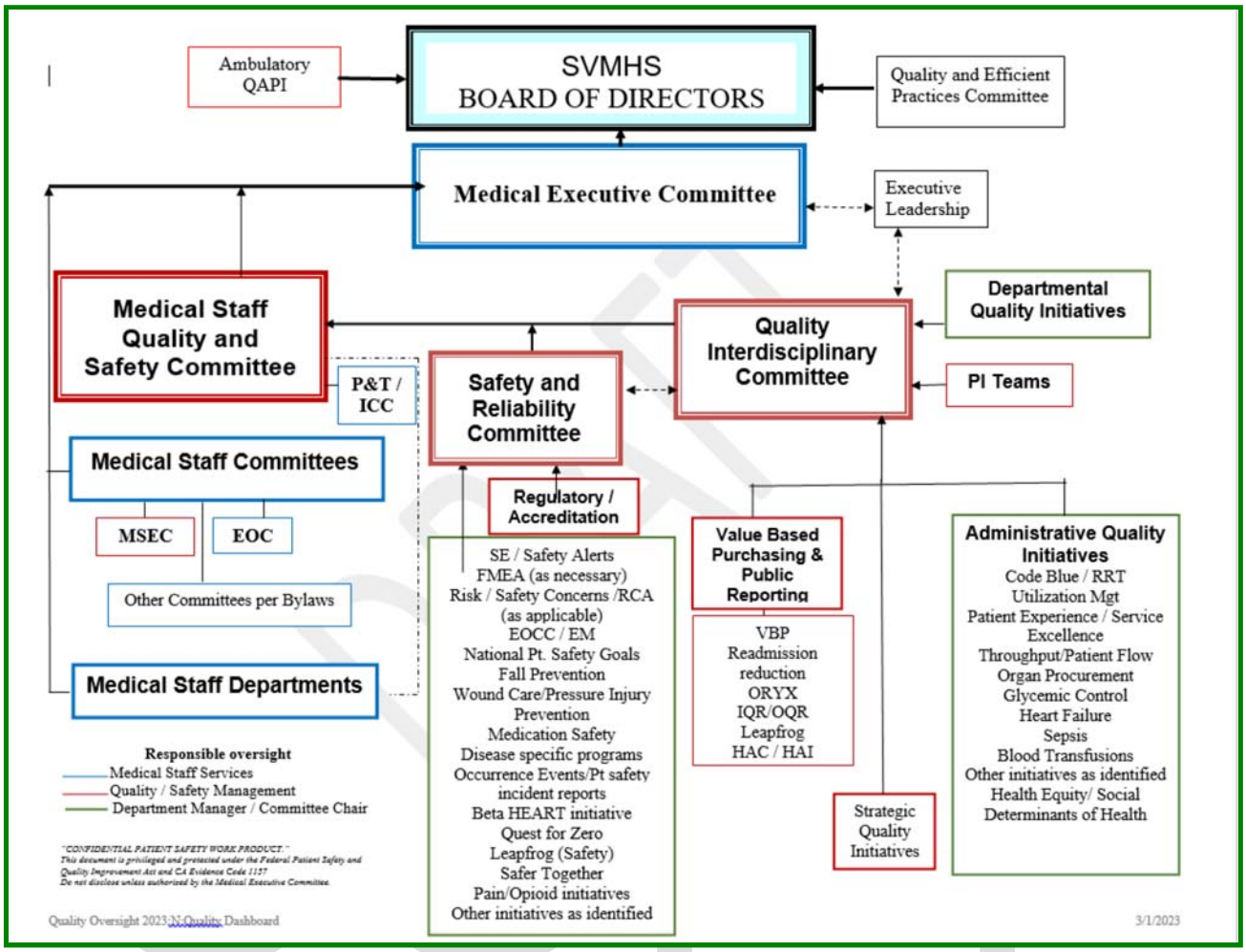
V. REFERENCES

A. The Joint Commission

B. Title 22 (CDPH)

C. CMS





Attachments

Image 1

Approval Signatures

Step Description	Approver	Date
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Owner	Aniko Kukla: Director Quality & Patient Safety	05/2023

Standards

No standards are associated with this document

History

Edited by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/25/2023, 6:19PM EDT

> Applied approval flow

Comment by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:48PM EDT

> The quality plan has been updated with the hospital new name and health equity was added as a focus

Comment by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:48PM EDT

> the quality structure has been updated too to reflect the current quality and safety structures

Draft saved by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:51PM EDT

Edited by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:52PM EDT

> Updated quality structure, changed hospital name and added health equity as a strategy

Last Approved by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:52PM EDT

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

ADJOURNMENT