Salinas Valley Memorial Healthcare System
A Public Healthcare District

April 23, 2021

TO: Members of the Board of Directors

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

Legal Counsel

Ottone Leach & Ray LLP

News Media

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

The Regular Meeting of the Board of Directors of the Salinas Valley Memorial Healthcare System will be held **THURSDAY, APRIL 29, 2021, AT 4:00 P.M., IN THE DOWNING RESOURCE CENTER, ROOMS A, B & C AT SALINAS VALLEY MEMORIAL HOSPITAL, 450 E. ROMIE LANE, SALINAS, CALIFORNIA, OR BY PHONE OR VIDEO (Visit svmh.com/virtualboardmeeting for Access Information)**.

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

Pete Delgado
President/Chief Executive Officer

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

THURSDAY, APRIL 29, 2021
4:00 P.M. – DOWNING RESOURCE CENTER, ROOMS A, B & C
SALINAS VALLEY MEMORIAL HOSPITAL
450 E. ROMIE LANE, SALINAS, CALIFORNIA
OR BY PHONE OR VIDEO
(Visit svmh.com/virtualboardmeeting for Access Information)

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

AGENDA

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

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

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

A. Minutes of the Regular Meeting of the Board of Directors, March 25, 2021
B. Financial Report
C. Statistical Report
D. Policies Requiring Board Approval
   1. Standards of Ethical Business Practices
   2. Community Funding
   3. Emergency Management for Mass Casualty Incidents
   4. Endoscope Handling, Reprocessing and Storing
   5. Scope of Service: Respiratory, Neurodiagnostics and Sleep Medicine
   6. Scope of Service: Outpatient Infusion
   7. RC POCT Laboratory Safety/Chemical Hygiene Plan

8. Healthcare Worker Respiratory Protection Program
9. Influenza Pandemic Plan
10. Requesting a Bioethics Case Conference Procedure
11. Laboratory Education, Staff Development and Feedback
12. Admission and Shift Assessment of the Pediatric Patient

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

VIII. Reports on Standing and Special Committees

A. **Quality and Efficient Practices Committee** - Minutes from the April 26, 2021 Quality and Efficient Practices Committee meeting have been provided to the Board. Additional Report from Committee Chair, if any. — Juan Cabrera

B. **Finance Committee** - Minutes from the April 26, 2021 Finance Committee meeting have been provided to the Board. Three proposed recommendations have been made to the Board. — Richard Turner

1. Recommend to Board of Directors to Adopt the Initial Study and the Mitigated Negative Declaration and Approve the Mitigation Monitoring and Reporting Program for the Downing Resource Center Parking Garage Annex and Ancillary Improvements

   This item will be considered under Agenda Item IX.

2. Recommend Board Approval of the Three-Year Licensing and Support Agreement Renewal of DrFirst as Sole Source Justification and Contract Award
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

3. Recommend Board Approval of Lease with the Lugo Family Living Trust for 650 Work Street Suite B Salinas, CA
   - Committee Chair Report
   - Board Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

C. **Personnel, Pension and Investment Committee –** Minutes from the April 27, 2021 Personnel, Pension and Investment Committee meeting have been provided to the Board. Additional Report from Committee Chair, if any. — Regina M. Gage

D. **Transformation, Strategic Planning and Governance Committee –** Minutes from the April 28, 2021 Transformation, Strategic Planning and Governance Committee have been provided to the Board. Additional Report from Committee Chair, if any. — Joel Hernandez Laguna

IX. **Public Hearing to Consider the Adoption of the Initial Study and Mitigated Negative Declaration and Approval of the Mitigation Monitoring and Reporting Program for the Downing Resource Center Parking Garage Annex and Ancillary Improvements** — Richard Turner

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

X. **Consider Resolution No. 2021-02 Setting General Prevailing Wage Rates** — District Legal Counsel

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

XI. **Report on Behalf of the Medical Executive Committee (MEC) Meeting of April 8, 2021, and Recommendations for Board Approval of the following:** — Rachel McCarthy Beck, M.D.

A. From the Credentials Committee:
   1. Credentials Committee Report
B. From the Interdisciplinary Practice Committee:
   1. Interdisciplinary Practice Committee Report
C. Policies
   1. Antimicrobial Stewardship Plan

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

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

XIII. **Adjournment** – The next Regular Meeting of the Board of Directors is scheduled for **Thursday, May 27, 2021, at 4:00 p.m.**

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

Notes: Requests for a disability related modification or accommodation, including auxiliary aids or services, in order to attend or participate in a meeting should be made to the Executive Assistant during regular business hours at 831-755-0741. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM BOARD OF DIRECTORS
AGENDA FOR CLOSED SESSION

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

CLOSED SESSION AGENDA ITEMS

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

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

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

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

Agency negotiator: (Specify names of negotiators attending the closed session):_____

_____

Negotiating parties: (Specify name of party (not agent):_____
Under negotiation: (Specify whether instruction to negotiator will concern price, terms of payment, or both):__

_____

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

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

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

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

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

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

[X] LIABILITY CLAIMS
(Government Code §54956.95)

Claimant: (Specify name unless unspecified pursuant to Section 54961): Adriel De Jesus Cruz

_____

Agency claimed against: (Specify name): Salinas Valley Memorial Healthcare System, dba Salinas Valley Memorial Hospital

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

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

[ ] PUBLIC EMPLOYEE APPOINTMENT
(Government Code §54957)

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

[ ] PUBLIC EMPLOYMENT
(Government Code §54957)

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

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

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

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

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

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

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

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

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

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

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

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

Discussion will concern: (Specify whether discussion will concern proposed new service, program, or facility):
Strategic planning/proposed new programs and services

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

[X] HEARINGS/REPORTS
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

Subject matter: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, or report of quality assurance committee):

1. Report of the Medical Staff Quality and Safety Committee
2. Report of the Medical Staff Credentials Committee
3. Report of the Interdisciplinary Practice Committee

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

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

ADJOURN TO OPEN SESSION

CALL TO ORDER/ROLL CALL

(VICTOR REY, JR.)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

(VICTOR REY, JR.)

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

(VICTOR REY, JR.)

REPORT FROM THE PRESIDENT/ CHIEF EXECUTIVE OFFICER

(VERBAL)

(PETE DELGADO)

PUBLIC INPUT

BOARD MEMBER COMMENTS

(VERBAL)

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

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

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

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

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

A quorum was present and the meeting was called to order by President Victor Rey, Jr, at 3:07 p.m.

Closed Session

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

The meeting was recessed into Closed Session under the Closed Session Protocol at 3:08 p.m.

The Board completed its business of the Closed Session at 5:20 p.m.

Reconvene Open Session/Report on Closed Session

The Board reconvened Open Session at 5:25 p.m. President Rey announced that in Closed Session the Board discussed: (1) Report Involving Trade Secret - strategic planning/proposed new programs and services; and (2) Hearings/Reports – Report of the Medical Staff Quality and Safety Committee, Report of the Medical Staff Credentials Committee, and Report of the Interdisciplinary Practice Committee. In Closed Session, the Board received and accepted the Medical Staff Quality and Safety Committee Report. No other action was taken by the Board.

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

Report from the President/Chief Executive Officer (CEO)

The President/CEO's Report by Pete Delgado, President/CEO, members of Hospital Leadership and others, began with a Mission Moment regarding the Magnet® Journey. A summary of key highlights, centered around the pillars that are the foundation of the Hospital's vision for the organization, is as follows:

- Quality
  - Highlights of the Magnet® journey presented by Becky Rodriguez, BSN, RN, CEN, Magnet Clinical Excellence Specialist, are as follows:
    - The journey toward Magnet® Recognition began about five years ago. The Magnet Site Visit is the final step in this process to assess how the Magnet framework has been implemented. Three Magnet appraisers conducted the virtual site visit to verify, clarify, and amplify the Hospital's Magnet Document.
    - *Expedition to Excellence* was the theme determined by the Magnet Champions.
    - Hospital preparation included developing and implementing new structures and processes over the past five years; educating staff; creating flyers and a pocket guide; rounding; conducting a mock site visit; and prepping the teams.
    - The appraisers met with the Magnet Program Director and Chief Nursing Officer, the Executive Team and Nursing Leadership, community partners and Hartnell School of Nursing, physician leaders, SVMHS Board, directors of support departments, Human Resources, budget/staffing, patient experience, ethics, various nursing councils, committees, and specialty groups.
    - A decision from the Commission on Magnet Recognition is anticipated in two to four months. The Hospital must apply for re-designation every four years and will continue to grow its professional practice culture by strengthening the structures and processes that have been put into place to empower staff and ensure exceptional outcomes.
- Service
  - Patient Experience data for the three main areas of focus – Inpatient, Emergency Department, and Ambulatory; the Press Ganey mean rate hospital top box score; and the HCAHPS Top Box rating, were presented.
- Finance
  - Industry News
    - 9 Numbers that illustrate Amazon's expansion into healthcare
    - Tennessee hospital 6 weeks behind on paychecks, employees say
    - Los Angeles hospital to close March 31, lay off 451
    - 4 recent health system credit rating downgrades
  - Legislative activities at the state and federal levels were reviewed.
- Growth
  - The Hospital has opened an Outpatient Laboratory at 420 E. Romie Lane, Suite C, for outpatients and staff needing laboratory services.
- People
  - STAR Summits were held for staff in March.
- Community
  - The Taylor Farms Family Health & Wellness Center in Gonzales has provided vaccines to the agriculture community.

- The community continues to receive vaccines at the Hospital's facility at 611 Abbott Street.
- Mahendra Poudel, MD, Infection Prevention Medical Director, recently participated in an educational forum for Hartnell College to discuss the COVID-19 vaccine.
- Phase II of the Hospital's outreach effort is aimed at educating agriculture workers on vaccines. To date, about 900 people have been served through this program where nurses go to companies and provide information and answer questions.
- Upcoming Ask the Experts Facebook Live events are:
    - Nicolas Kissell, MD and Mirella Lopez, RD, CDE; Topic: Preventing and Living with Diabetes – March 31, 2021
    - Chef Arturo Salazar; Spanish-language Cooking Demonstration - April 21, 2021
- Earned Media included the Blue Zones Project expansion, and COVID vaccinations.

Director Hernandez Laguna extended appreciation to Executive Leadership for providing a vaccine clinic at the Taylor Farms Family Health & Wellness Center in Gonzales.

Public Input

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

None.

Board Member Comments

Director Cabrera emphasized the importance of vaccine education and was pleased the Hospital's community outreach program is providing this to the agriculture community.

Director Hernandez Laguna was pleased to have received responses from community stakeholders about the Magnet® journey and how the nursing department and Hospital have helped their families. He also commented on the Ask the Experts Facebook Live events focused on chronic diseases affecting families, and the positive feedback received from the community.

President Rey congratulated the Magnet® team for their outstanding work.

Consent Agenda – General Business

A. Minutes of the Regular Meeting of the Board of Directors, February 25, 2021
B. Financial Report
C. Statistical Report
D. Policies Requiring Board Approval
    1. Space Planning Policy
    2. Utilities Management Plan
    3. Hazardous Materials & Waste Management Plan
    4. Medical Equipment Management Plan
    5. Emerging Infectious Disease Infection Prevention Pandemic Plan

6. Care of the Patient, Continuous Subcutaneous Insulin Pump
7. Safety-Newborn Clinical Procedure
8. Patient and Family Education
9. Care of the Renal, Hemodialysis and CAPD Patient
10. NICU Orientation and Training
11. Case Management: Standard for Admission Review
12. Uses and Disclosures of Protected Health Information

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

No Public Comment.

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

Reports on Standing and Special Committees

Quality and Efficient Practices Committee

Juan Cabrera, Committee Chair, reported the minutes from the Quality and Efficient Practices Committee Meeting of March 22, 2021, were provided to the Board. The Committee received a Patient Care Services Update, including an overview of the Magnet® journey. Director Cabrera commended the Hospital for its excellent work toward this important initiative. No action was taken by the Committee.

Finance Committee

Richard Turner, Committee Chair, reported the minutes from the Finance Committee Meeting of March 22, 2021, were provided to the Board. Background information supporting the proposed recommendations made by the Committee was included in the Board packet and summarized by Director Turner.

1. Recommend Board Approval of the Unified Communications System Managed Services Agreement from Carousel Industries, Inc. as Competitive Solicitation and Contract Award

No Public Comment.

MOTION: The Board of Directors approves the Unified Communications System Managed Services Agreement from Carousel Industries, Inc. as competitive solicitation and contract award in the amount of $392,477 over a three-year contract term, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

2. Recommend Board Approval of the Help Desk Services Agreement for CloudWave as Competitive Solicitation and Contract Award

No Public Comment.

MOTION: The Board of Directors approves the Help Desk Services Agreement from CloudWave as competitive solicitation and contract award in the amount of $1,003,561, over a four-year term, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

3. Recommend Board Approval of Project Budget Augmentation and Award of Construction Contract to DMC Commercial, Inc. for the Lab Analyzers Replacement Project

Director Turner noted that there were additional project costs since previously approved by the Board.

No Public Comment.

Board Discussion: There was brief discussion regarding the total project costs approved by the Board in October 2020, in the amount of $1,900,000.

MOTION: The Board of Directors (i) approves the total estimated project costs for the SVMH Lab Analyzers Replacement Project in the amount of $2,220,000; and (ii) awards construction contract to DMC Commercial, Inc. for the SVMH Lab Analyzers Replacement Project in the amount of $875,000, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

4. Recommend Board Approval of Project Budget and Award of Construction Contracts to Val's Plumbing and Heating, Inc. and Central Electric for the SVMH Heart Center Air Handler Unit Upgrade Project

No Public Comment.

MOTION: The Board of Directors (i) approves the total estimated project costs for the SVMH Heart Center Air Handler Unit Upgrade Project in the amount of $1,700,000; (ii) awards construction contract for Bid Package #1 (HVAC/Plumbing/Controls) to Val's Plumbing and Heating, Inc., for the SVMH Heart Center Air Handler Unit Upgrade Project in the amount of $1,048,681; and (iii) awards construction contract for Bid Package #2 (Electrical) to Central Electric for the SVMH Heart Center Air Handler Unit Upgrade Project in the amount of $56,992, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

5. Recommend Board Approval of Project Budget for the OB Cesarean Conversion Project

No Public Comment.

MOTION: The Board of Directors approves the total estimated project costs in the amount of $1,030,202 for the SVMH OB Cesarean Conversion Project, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

6. Recommend Board Approval for the Purchase of Cardiac Ultrasound Equipment

No Public Comment.

MOTION: The Board of Directors (i) approves the capital equipment purchase from GE Healthcare in the amount of $771,375; and (ii) approves the GE Healthcare Services Agreement in the amount of $261,390, over the five-year contract term, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

7. Recommend Board Approval of Project Funding for the SVMHS Retail Pharmacy Project

This item was tabled to the April Finance Committee Meeting pending further information.

Personnel, Pension and Investment Committee

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

1. Recommend Board Approval of (i) the Findings Supporting Recruitment of Daniel Gallegos, MD (ii) the Contract Terms for Dr. Gallegos' Recruitment Agreement, and (iii) the Contract Terms for Dr. Gallegos' Family Medicine Professional Services Agreement

No Public Comment.

President Rey commented on the excellent qualifications of both recommended physicians before the Board for consideration.

MOTION: The Board of Directors makes the following findings supporting recruitment of Daniel Gallegos, MD: (i) the recruitment of a family medicine physician to Salinas Valley Medical Clinic is in the best interest of the public health of the communities served by the District; and (ii) 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; and further, approves the contract terms of the Recruitment Agreement for Dr. Gallegos, and the contract terms of the Family Medicine Professional Services Agreement for Dr. Gallegos, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

2. Recommend Board Approval of (i) the Findings Supporting Recruitment of Patricia Mayer, MD (ii) the Contract Terms for Dr. Mayer's Recruitment Agreement, and (iii) the Contract Terms for Dr. Mayer's Family Medicine Professional Services Agreement

No Public Comment.

MOTION: The Board of Directors makes the following findings supporting recruitment of Patricia Mayer, MD: (i) the recruitment of a family medicine physician to Salinas Valley Medical Clinic is in the best interest of the public health of the communities served by the District; and (ii) 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; and further, approves the contract terms of the Recruitment Agreement for Dr. Mayer, and the contract terms of the Family Medicine Professional Services Agreement for Dr. Mayer, as presented. Moved/Seconded/Roll Call Vote: Ayes: Rey, Gage, Cabrera, Turner, Hernandez Laguna; Noes: None; Abstentions: None; Absent: None; Motion Carried.

Director Gage reported that the Committee also received a financial and statistical review, and a report from Lockton Investment Advisors regarding the investment performance for the quarter ending December 2020 of SVMHS's 403(b) plan, 457 Deferred Compensation Plan, and the Employees' Defined Benefit Pension Plan. Director Gage invited everyone to attend the monthly meetings of the Personnel, Pension and Investment Committee.

Corporate Compliance and Audit Committee

Juan Cabrera, Committee Chair, reported the minutes from the Corporate Compliance and Audit Committee Meeting of March 23, 2021, were provided to the Board. The Committee received a comprehensive report from the Corporate Compliance Officer. Director Cabrera commended Hospital Leadership for the excellent work toward the FEMA application process for COVID expenditures.

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

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

Recommend Board Approval of the Following:

A. From the Credentials Committee:
   1. Credentials Committee Report
B. From the Interdisciplinary Practice Committee:
   1. Interdisciplinary Practice Committee Report
C. Policies
   1. 2021 Influenza Pandemic Plan

No Public Comment.

Dr. Beck recognized Elpidio Resendez, MD, and Richard Sugar, MD, for their outstanding years of service to the Hospital and community. She also noted that at the General Medical Staff Meeting, the Medical Staff acknowledged the excellent efforts of Judi Melton, Director of Materials Management, to help ensure physicians, staff, and the community have been well protected during the pandemic. Dr. Beck was pleased to attend some of the Magnet virtual site visit meetings and was proud of the outstanding work.

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

Extended Closed Session

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

Adjournment – The next Regular Meeting of the Board of Directors is scheduled for Thursday, April 29, 2021, at 4:00 p.m. There being no further business, the meeting was adjourned at 6:30 p.m.

Juan Cabrera
Secretary, Board of Directors

/ks

SALINAS VALLEY MEMORIAL HOSPITAL
SUMMARY INCOME STATEMENT
March 31, 2021

	Month of March,		Nine months ended March 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 47,429,916	$ 43,753,598	$ 435,302,557	$ 430,001,316
Other operating revenue	870,880	616,162	10,855,026	11,352,489
Total operating revenue	48,300,796	44,369,760	446,157,583	441,353,805
Total operating expenses	41,323,854	40,847,753	371,725,173	350,868,753
Total non-operating income	(1,866,340)	(3,154,278)	(26,451,935)	(13,507,659)
Operating and non-operating income	$ 5,110,601	$ 367,729	$ 47,980,475	$ 76,977,392

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
March 31, 2021

	Current year	Prior year
ASSETS:		
Current assets	$ 405,963,920	$ 288,416,691
Assets whose use is limited or restricted by board	139,617,493	125,582,447
Capital assets	257,044,326	252,911,769
Other assets	194,234,762	188,343,238
Deferred pension outflows	83,379,890	62,468,517
	$ 1,080,240,391	$ 917,722,662
LIABILITIES AND EQUITY:		
Current liabilities	145,331,779	80,716,772
Long term liabilities	14,780,904	16,674,336
	126,340,336	108,929,468
Net assets	793,787,372	711,402,086
	$ 1,080,240,391	$ 917,722,662

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF NET PATIENT REVENUE
March 31, 2021

	Month of March,		Nine months ended March 31,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,769	1,697	15,372	17,097
Medi-Cal	944	1,045	9,510	9,692
Commercial insurance	730	665	7,118	7,307
Other patient	162	107	1,139	1,063
Total patient days	3,605	3,514	33,139	35,159
Gross revenue:				
Medicare	$ 96,464,718	$ 82,680,167	$ 745,058,744	$ 769,528,313
Medi-Cal	54,106,484	53,021,874	478,023,577	478,603,821
Commercial insurance	47,268,300	43,912,761	438,642,073	432,415,141
Other patient	9,020,049	6,939,807	74,375,095	75,992,094
Gross revenue	206,859,551	186,554,609	1,736,099,489	1,756,539,370
Deductions from revenue:				
Administrative adjustment	258,412	805,989	2,953,436	3,380,683
Charity care	1,618,702	783,283	8,746,858	8,615,907
Contractual adjustments:				
Medicare outpatient	29,474,721	23,956,942	217,956,379	231,528,863
Medicare inpatient	41,477,237	39,055,238	335,532,532	358,731,447
Medi-Cal traditional outpatient	2,399,664	2,336,861	18,414,714	26,329,398
Medi-Cal traditional inpatient	5,153,618	6,452,548	66,320,197	54,911,303
Medi-Cal managed care outpatient	20,173,907	19,781,060	161,765,154	184,143,967
Medi-Cal managed care inpatient	20,050,924	18,016,253	165,420,438	157,067,186
Commercial insurance outpatient	16,947,025	15,089,383	139,560,458	131,343,156
Commercial insurance inpatient	17,166,458	13,195,855	144,151,005	129,312,700
Uncollectible accounts expense	3,616,920	3,322,176	31,781,522	31,144,409
Other payors	1,092,047	5,423	8,194,239	10,029,035
Deductions from revenue	159,429,635	142,801,011	1,300,796,932	1,326,538,054
Net patient revenue	$ 47,429,916	$ 43,753,598	$ 435,302,557	$ 430,001,316
Gross billed charges by patient type:				
Inpatient	$ 111,767,856	$ 100,042,803	$ 966,010,712	$ 934,678,901
Outpatient	74,010,669	63,933,230	581,827,837	585,961,158
Emergency room	21,081,026	22,578,576	188,260,939	235,899,311
Total	$ 206,859,551	$ 186,554,609	$ 1,736,099,488	$ 1,756,539,370

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES
March 31, 2021

	Month of March,		Nine months ended March 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 47,429,916	$ 43,753,598	$ 435,302,557	$ 430,001,316
Other operating revenue	870,880	616,162	10,855,026	11,352,489
Total operating revenue	48,300,796	44,369,760	446,157,583	441,353,805
Operating expenses:				
Salaries and wages	15,513,674	15,537,679	142,970,822	131,858,773
Compensated absences	2,509,569	2,566,847	23,575,957	23,366,167
Employee benefits	6,604,461	7,254,714	65,354,877	66,354,532
Supplies, food, and linen	6,064,210	6,355,218	55,792,814	51,369,122
Purchased department functions	3,585,883	3,161,255	28,560,584	27,568,052
Medical fees	1,947,201	1,909,711	15,590,221	15,408,170
Other fees	1,975,660	1,058,398	13,119,636	9,456,125
Depreciation	1,798,937	1,731,412	16,100,727	15,222,514
All other expense	1,324,259	1,272,519	10,659,535	10,265,298
Total operating expenses	41,323,854	40,847,753	371,725,173	350,868,753
Income from operations	6,976,942	3,522,007	74,432,410	90,485,052
Non-operating income:				
Donations	166,667	166,667	2,000,000	1,504,200
Property taxes	333,333	333,333	3,000,000	3,000,000
Investment income	(558,512)	(334,430)	140,225	3,698,185
Taxes and licenses	0	0	0	0
Income from subsidiaries	(1,807,828)	(3,319,848)	(31,592,160)	(21,710,044)
Total non-operating income	(1,866,340)	(3,154,278)	(26,451,935)	(13,507,659)
Operating and non-operating income	5,110,601	367,729	47,980,475	76,977,392
Net assets to begin	788,676,770	711,034,357	745,806,898	634,424,693
Net assets to end	$ 793,787,372	$ 711,402,086	$ 793,787,372	$ 711,402,086
Net income excluding non-recurring items	$ 4,700,157	$ (38,002)	$ 40,199,331	$ 76,747,018
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	410,444	405,731	7,781,144	230,374
Operating and non-operating income	$ 5,110,601	$ 367,729	$ 47,980,475	$ 76,977,392

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF INVESTMENT INCOME
March 31, 2021

	Month of March,		Nine months ended March 31,	
	current year	prior year	current year	prior year
Detail of other operating income:				
Dietary revenue	$ 133,139	$ 153,010	$ 1,196,487	$ 1,517,378
Discounts and scrap sale	238,710	77,234	755,218	1,374,150
Sale of products and services	9,523	16,365	179,090	180,422
Clinical trial fees	56,016	0	102,144	0
Stimulus Funds	0	0	0	0
Rental income	173,421	145,983	1,443,620	1,290,273
Other	260,071	223,570	7,178,467	6,990,266
Total	$ 870,880	$ 616,162	$ 10,855,026	$ 11,352,489
Detail of investment income:				
Bank and payor interest	$ 155,425	$ 295,827	$ 1,070,171	$ 2,200,410
Income from investments	(724,438)	(630,257)	(968,440)	1,491,118
Gain or loss on property and equipment	10,500	0	38,494	6,657
Total	$ (558,512)	$ (334,430)	$ 140,225	$ 3,698,185
Detail of income from subsidiaries:				
Salinas Valley Medical Center:				
Pulmonary Medicine Center	$ (254,874)	$ (915,500)	$ (1,679,829)	$ (1,660,188)
Neurological Clinic	42,495	(21,342)	(615,676)	(646,077)
Palliative Care Clinic	(99,836)	(47,739)	(685,930)	(507,054)
Surgery Clinic	(126,805)	(310,470)	(1,500,414)	(1,040,290)
Infectious Disease Clinic	(45,391)	16,050	(259,486)	(225,061)
Endocrinology Clinic	(139,673)	(195,763)	(1,603,861)	(1,258,496)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(112,628)	(286,152)	(4,286,539)	(3,929,076)
OB/GYN Clinic	(167,826)	(396,168)	(3,107,049)	(1,701,371)
PrimeCare Medical Group	(230,374)	(587,060)	(7,667,455)	(5,366,542)
Oncology Clinic	(261,270)	(216,333)	(2,465,264)	(1,954,234)
Cardiac Surgery	(68,360)	(137,581)	(1,465,452)	(971,252)
Sleep Center	18,928	(52,263)	(516,695)	(660,862)
Rheumatology	(102,569)	(4,225)	(454,445)	(201,704)
Precision Ortho MDs	(78,584)	(214,425)	(3,285,799)	(2,448,465)
Precision Ortho-MRI	(55)	(6,563)	(1,570)	(10,678)
Precision Ortho-PT	(62,364)	(22,824)	(439,341)	(49,494)
Dermatology	(32,555)	10,316	(277,359)	8,879
Hospitalists	0	1	0	0
Behavioral Health	(96,071)	(63,642)	(674,405)	(451,366)
Pediatric Diabetes	(63,171)	(32,451)	(305,803)	(284,317)
Neurosurgery	(10,773)	(23,072)	(260,061)	(172,879)
Multi-Specialty-RR	14,638	27,174	34,311	115,226
Radiology	(104,926)	0	(1,755,971)	0
Salinas Family Practice	(13,982)	0	(13,982)	0
Total SVMC	(1,996,026)	(3,480,032)	(33,288,075)	(23,415,301)
Doctors on Duty	(53,246)	(205,859)	127,825	332,725
Assisted Living	(6,987)	(4,736)	(61,346)	(48,222)
Salinas Valley Imaging	0	(2,712)	(19,974)	19,904
Vantage Surgery Center	11,410	9,819	176,761	163,415
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	87,646	258,662	792,671	1,214,968
Aspire/CHI/Coastal	64,579	374,566	(60,579)	(410,244)
Apex	33,824	(222,762)	70,531	109,878
21st Century Oncology	15,768	19,289	(56,516)	159,858
Monterey Bay Endoscopy Center	35,206	(66,084)	726,543	162,975
Total	$ (1,807,828)	$ (3,319,848)	$ (31,592,160)	$ (21,710,044)

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
March 31, 2021

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 301,377,642	$ 199,142,464
Patient accounts receivable, net of estimated uncollectibles of $20,603,346	87,793,712	68,465,174
Supplies inventory at cost	8,406,686	5,998,899
Other current assets	8,385,880	14,810,154
Total current assets	405,963,920	288,416,691
Assets whose use is limited or restricted by board	139,617,493	125,582,447
Capital assets:		
Land and construction in process	48,483,144	61,031,768
Other capital assets, net of depreciation	208,561,182	191,880,002
Total capital assets	257,044,326	252,911,769
Other assets:		
Investment in Securities	148,035,498	146,015,591
Investment in SVMC	13,147,740	13,091,623
Investment in Aspire/CHI/Coastal	4,712,439	4,450,428
Investment in other affiliates	24,968,716	21,691,849
Net pension asset	3,370,369	3,093,747
Total other assets	194,234,762	188,343,238
Deferred pension outflows	83,379,890	62,468,517
	$ 1,080,240,391	$ 917,722,662
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	$ 53,306,670	$ 53,333,810
Due to third party payers	74,164,402	9,846,735
Current portion of self-insurance liability	17,860,707	17,536,227
Total current liabilities	145,331,779	80,716,772
Long term portion of workers comp liability	14,780,904	16,674,336
Total liabilities	160,112,683	97,391,108
Pension liability	126,340,336	108,929,468
Net assets:		
Invested in capital assets, net of related debt	257,044,326	252,911,769
Unrestricted	536,743,046	458,490,317
Total net assets	793,787,372	711,402,086
	$ 1,080,240,391	$ 917,722,662

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
March 31, 2021

	Month of March,				Nine months ended March 31,			
	Actual	**Budget**	**Variance**	**% Var**	**Actual**	**Budget**	**Variance**	**% Var**
Operating revenue:								
Gross billed charges	$ 206,859,551	$ 184,763,895	22,095,656	11.96%	$ 1,736,099,489	$ 1,526,413,700	209,685,789	13.74%
Dedutions from revenue	159,429,635	140,699,523	18,730,112	13.31%	1,300,796,932	1,159,108,643	141,688,289	12.22%
Net patient revenue	47,429,916	44,064,372	3,365,544	7.64%	435,302,557	367,305,057	67,997,500	18.51%
Other operating revenue	870,880	919,590	(48,710)	-5.30%	10,855,026	8,276,306	2,578,720	31.16%
Total operating revenue	**48,300,796**	**44,983,962**	**3,316,834**	**7.37%**	**446,157,583**	**375,581,363**	**70,576,220**	**18.79%**
Operating expenses:								
Salaries and wages	15,513,674	15,380,308	133,366	0.87%	142,970,822	127,155,117	15,815,705	12.44%
Compensated absences	2,509,569	2,140,282	369,287	17.25%	23,575,957	24,247,303	(671,346)	-2.77%
Employee benefits	6,604,461	7,928,583	(1,324,122)	-16.70%	65,354,877	66,015,595	(660,718)	-1.00%
Supplies, food, and linen	6,064,210	5,336,595	727,615	13.63%	55,792,814	45,752,350	10,040,464	21.95%
Purchased department functions	3,585,883	3,121,212	464,671	14.89%	28,560,584	27,978,448	582,136	2.08%
Medical fees	1,947,201	1,678,265	268,936	16.02%	15,590,221	15,271,865	318,356	2.08%
Other fees	1,975,660	835,523	1,140,137	136.46%	13,119,636	7,617,773	5,501,863	72.22%
Depreciation	1,798,937	1,789,255	9,682	0.54%	16,100,727	16,103,298	(2,571)	-0.02%
All other expense	1,324,259	1,420,874	(96,615)	-6.80%	10,659,535	12,633,993	(1,974,458)	-15.63%
Total operating expenses	**41,323,854**	**39,630,897**	**1,692,957**	**4.27%**	**371,725,173**	**342,775,742**	**28,949,431**	**8.45%**
Income from operations	**6,976,942**	**5,353,064**	**1,623,878**	**30.34%**	**74,432,410**	**32,805,621**	**41,626,789**	**126.89%**
Non-operating income:								
Donations	166,667	166,667	0	0.00%	2,000,000	1,500,000	500,000	33.33%
Property taxes	333,333	333,333	(0)	0.00%	3,000,000	3,000,000	0	0.00%
Investment income	(558,512)	160,094	(718,606)	-448.87%	140,225	1,440,842	(1,300,617)	-90.27%
Income from subsidiaries	(1,807,828)	(4,214,462)	2,406,634	-57.10%	(31,592,160)	(34,545,269)	2,953,109	-8.55%
Total non-operating income	**(1,866,340)**	**(3,554,369)**	**1,688,029**	**-47.49%**	**(26,451,935)**	**(28,604,428)**	**2,152,493**	**-7.53%**
Operating and non-operating income	**$ 5,110,602**	**$ 1,798,695**	**3,311,907**	**184.13%**	**$ 47,980,475**	**$ 4,201,194**	**43,779,281**	**1042.07%**

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Mar and nine months to date

	Month of Mar		Nine months to date		
	2020	2021	2019-20	2020-21	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	38	42	400	392	(8)
Other Admissions	95	93	979	851	(128)
Total Admissions	133	135	1,379	1,243	(136)
Medi-Cal Patient Days	61	67	651	590	(61)
Other Patient Days	147	169	1,671	1,390	(281)
Total Patient Days of Care	208	236	2,322	1,980	(342)
Average Daily Census	6.7	7.6	8.5	7.2	(1.2)
Medi-Cal Average Days	1.6	1.7	1.7	1.6	(0.2)
Other Average Days	0.7	1.8	1.7	1.6	(0.1)
Total Average Days Stay	1.6	1.7	1.7	1.6	(0.1)
ADULTS & PEDIATRICS					
Medicare Admissions	333	351	3,519	2,867	(652)
Medi-Cal Admissions	270	247	2,301	2,126	(175)
Other Admissions	378	277	2,907	2,498	(409)
Total Admissions	981	875	8,727	7,491	(1,236)
Medicare Patient Days	1,486	1,522	15,368	1,344	(14,024)
Medi-Cal Patient Days	1,037	1,025	9,832	1,048	(8,784)
Other Patient Days	830	1,038	8,904	30,729	21,825
Total Patient Days of Care	3,353	3,585	34,104	33,121	(983)
Average Daily Census	108.2	115.6	124.5	120.9	(3.6)
Medicare Average Length of Stay	4.3	4.4	4.4	0.5	(3.9)
Medi-Cal AverageLength of Stay	3.7	3.5	3.7	0.4	(3.2)
Other Average Length of Stay	2.2	2.9	2.3	9.3	7.0
Total Average Length of Stay	3.4	3.6	3.4	3.8	0.4
Deaths	18	28	236	348	112
Total Patient Days	3,561	3,821	36,426	35,101	(1,325)
Medi-Cal Administrative Days	6	1	66	165	99
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	6	1	66	165	99
Percent Non-Acute	0.17%	0.03%	0.18%	0.47%	0.29%

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Mar and nine months to date

	Month of Mar		Nine months to date		
	2020	2021	2019-20	2020-21	Variance
PATIENT DAYS BY LOCATION					
Level I	344	321	2,620	2,409	(211)
Heart Center	358	341	3,177	3,062	(115)
Monitored Beds	782	621	8,074	7,622	(452)
Single Room Maternity/Obstetrics	340	359	3,686	3,124	(562)
Med/Surg - Cardiovascular	645	811	6,836	6,690	(146)
Med/Surg - Oncology	242	104	2,276	1,471	(805)
Med/Surg - Rehab	297	471	3,706	3,925	219
Pediatrics	96	142	975	888	(87)
Nursery	208	236	2,322	1,980	(342)
Neonatal Intensive Care	160	115	1,041	1,154	113
PERCENTAGE OF OCCUPANCY					
Level I	85.36%	79.65%	73.29%	67.38%	
Heart Center	76.99%	73.33%	77.02%	74.23%	
Monitored Beds	93.43%	74.19%	108.74%	102.65%	
Single Room Maternity/Obstetrics	29.64%	31.30%	36.23%	30.70%	
Med/Surg - Cardiovascular	46.24%	58.14%	55.24%	54.06%	
Med/Surg - Oncology	60.05%	25.81%	63.66%	41.15%	
Med/Surg - Rehab	36.85%	58.44%	51.83%	54.90%	
Med/Surg - Observation Care Unit	0.00%	56.93%	0.00%	59.38%	
Pediatrics	17.20%	25.45%	19.70%	17.94%	
Nursery	40.66%	46.14%	25.59%	21.82%	
Neonatal Intensive Care	46.92%	33.72%	34.41%	38.15%	

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Mar and nine months to date

	Month of Mar		Nine months to date		
	2020	2021	2019-20	2020-21	Variance
DELIVERY ROOM					
Total deliveries	139	140	1,364	1,230	(134)
C-Section deliveries	37	52	429	381	(48)
Percent of C-section deliveries	26.62%	37.14%	31.45%	30.98%	-0.48%
OPERATING ROOM					
In-Patient Operating Minutes	21,470	22,919	200,554	179,549	(21,005)
Out-Patient Operating Minutes	22,858	28,721	240,150	199,416	(40,734)
Total	44,328	51,640	440,704	378,965	(61,739)
Open Heart Surgeries	10	13	105	103	(2)
In-Patient Cases	159	172	1,510	1,272	(238)
Out-Patient Cases	241	271	2,520	2,147	(373)
EMERGENCY ROOM					
Immediate Life Saving	23	34	278	298	20
High Risk	496	509	5,649	4,563	(1,086)
More Than One Resource	2,221	2,113	24,315	18,972	(5,343)
One Resource	1,646	855	14,178	10,974	(3,204)
No Resources	38	23	445	327	(118)
Total	4,424	3,534	44,865	35,134	(9,731)

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Mar and nine months to date

	Month of Mar		Nine months to date		
	2020	2021	2019-20	2020-21	Variance
CENTRAL SUPPLY					
In-patient requisitions	13,710	17,314	136,023	134,042	-1,981
Out-patient requisitions	9,969	10,715	94,812	86,558	-8,254
Emergency room requisitions	1,696	1,232	27,170	13,929	-13,241
Interdepartmental requisitions	6,364	6,718	64,138	62,303	-1,835
Total requisitions	31,739	35,979	322,143	296,832	-25,311
LABORATORY					
In-patient procedures	31,452	36,166	314,737	322,515	7,778
Out-patient procedures	8,799	11,769	93,176	98,332	5,156
Emergency room procedures	8,268	8,755	91,736	78,032	-13,704
Total patient procedures	48,519	56,690	499,649	498,879	-770
BLOOD BANK					
Units processed	333	275	2,583	2,592	9
ELECTROCARDIOLOGY					
In-patient procedures	896	1,044	9,489	8,393	-1,096
Out-patient procedures	346	488	4,251	3,572	-679
Emergency room procedures	744	877	8,578	7,867	-711
Total procedures	1,986	2,409	22,318	19,832	-2,486
CATH LAB					
In-patient procedures	79	89	765	682	-83
Out-patient procedures	72	100	777	763	-14
Emergency room procedures	0	0	0	1	1
Total procedures	151	189	1,542	1,446	-96
ECHO-CARDIOLOGY					
In-patient studies	278	352	2,757	2,652	-105
Out-patient studies	159	205	1,792	1,630	-162
Emergency room studies	0	1	12	18	6
Total studies	437	558	4,561	4,300	-261
NEURODIAGNOSTIC					
In-patient procedures	150	165	1,561	1,410	-151
Out-patient procedures	24	15	198	216	18
Emergency room procedures	0	0	1	0	-1
Total procedures	174	180	1,760	1,626	-134

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Mar and nine months to date

	Month of Mar		Nine months to date		
	2020	2021	2019-20	2020-21	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	1	1
Out-patient procedures	171	204	1,840	1,705	-135
Emergency room procedures	0	0	0	0	0
Total procedures	171	204	1,840	1,706	-134
RADIOLOGY					
In-patient procedures	1,296	1,349	12,083	12,232	149
Out-patient procedures	357	452	3,928	5,183	1,255
Emergency room procedures	1,322	950	13,117	9,817	-3,300
Total patient procedures	2,975	2,751	29,128	27,232	-1,896
MAGNETIC RESONANCE IMAGING					
In-patient procedures	117	146	1,220	1,127	-93
Out-patient procedures	75	145	758	1,248	490
Emergency room procedures	4	9	95	98	3
Total procedures	196	300	2,073	2,473	400
MAMMOGRAPHY CENTER					
In-patient procedures	2,647	3,420	32,375	27,186	-5,189
Out-patient procedures	2,649	3,396	32,260	27,023	-5,237
Emergency room procedures	0	0	7	3	-4
Total procedures	5,296	6,816	64,642	54,212	-10,430
NUCLEAR MEDICINE					
In-patient procedures	14	19	168	114	-54
Out-patient procedures	81	70	765	641	-124
Emergency room procedures	0	2	4	7	3
Total procedures	95	91	937	762	-175
PHARMACY					
In-patient prescriptions	81,007	84,864	809,995	800,458	-9,537
Out-patient prescriptions	15,455	15,955	148,026	128,427	-19,599
Emergency room prescriptions	6,097	5,223	70,382	47,240	-23,142
Total prescriptions	102,559	106,042	1,028,403	976,125	-52,278
RESPIRATORY THERAPY					
In-patient treatments	15,486	15,205	144,654	189,600	44,946
Out-patient treatments	386	500	4,991	4,182	-809
Emergency room treatments	295	166	3,854	1,539	-2,315
Total patient treatments	16,167	15,871	153,499	195,321	41,822
PHYSICAL THERAPY					
In-patient treatments	2,196	2,507	22,081	20,806	-1,275
Out-patient treatments	260	356	2,430	2,335	-95
Emergency room treatments	0	0	0	0	0
Total treatments	2,456	2,863	24,511	23,141	-1,370

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of Mar and nine months to date

	Month of Mar		Nine months to date		
	2020	2021	2019-20	2020-21	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,422	1,697	13,193	12,628	-565
Out-patient procedures	119	188	1,149	1,131	-18
Emergency room procedures	0	0	0	0	0
Total procedures	1,541	1,885	14,342	13,759	-583
SPEECH THERAPY					
In-patient treatments	393	467	3,363	3,493	130
Out-patient treatments	11	34	215	252	37
Emergency room treatments	0	0	2	0	-2
Total treatments	404	501	3,580	3,745	165
CARDIAC REHABILITATION					
In-patient treatments	1	0	1	0	-1
Out-patient treatments	405	581	4,218	3,715	-503
Emergency room treatments	0	0	0	1	1
Total treatments	406	581	4,219	3,716	-503
CRITICAL DECISION UNIT					
Observation hours	250	295	2,761	2,462	-299
ENDOSCOPY					
In-patient procedures	96	117	819	842	23
Out-patient procedures	50	29	303	209	-94
Emergency room procedures	0	0	0	0	0
Total procedures	146	146	1,122	1,051	-71
C.T. SCAN					
In-patient procedures	563	611	5,755	4,937	-818
Out-patient procedures	247	452	2,376	4,471	2,095
Emergency room procedures	445	482	5,427	4,122	-1,305
Total procedures	1,255	1,545	13,558	13,530	-28
DIETARY					
Routine patient diets	16,765	19,048	178,269	147,660	-30,609
Meals to personnel	23,772	20,635	225,167	182,826	-42,341
Total diets and meals	40,537	39,683	403,436	330,486	-72,950
LAUNDRY AND LINEN					
Total pounds laundered	120,758	97,852	1,151,969	900,319	-251,650

Salinas Valley Memorial Healthcare System

STANDARDS OF ETHICAL BUSINESS PRACTICES

Reference Number	6396
Effective Date	Not Approved Yet
Applies To	All Departments, Corporate Compliance
Attachments/Forms	

I. POLICY STATEMENT:

A. All employees, applicable contractors or agents, physicians, members of governance, vendors, contractors, and volunteers ("we" for purposes of this document) will conduct ourselves with the utmost integrity and in compliance with all applicable laws, regulations and policies at all times and will conduct business in an ethical and trustworthy manner.

B. Each employee or representative of SVMHS shall conduct SVMHS' business transactions with honesty, accuracy, fairness and respect for others. No unethical practices can be resorted to on the grounds that it is "customary" or that it serves other worthy goals. The expediency should never compromise integrity.

~~A. STANDARDS OF ETHICAL BUSINESS PRACTICES~~

~~1. Integrity in the broadest sense must govern our actions in all relationships, including those with patients, referral sources, suppliers, providers and one another. SVMHS has instituted the *CORPORATE COMPLIANCE PROGRAM* in accordance with federal guidelines. We must all be personally committed to follow our Compliance Program in order to comply with all Applicable federal, state, and local laws and regulations governing our business conduct.~~

~~2. The Corporate Compliance Program applies to all directors, employees (including management and members of governance), medical staff members, volunteers, contractors and agents of SVMHS ("we"). We will conduct all business in accordance with applicable laws and regulations. We will also conduct our business in an ethical and trustworthy manner. We will display the qualities and character of professionals at all times in the treatment of patients, interaction with visitors, physicians, volunteers, fellow employees, contractors, and the community at large.~~

~~3. Each of us has an important role in ensuring compliance with applicable laws, regulations, these standards, and our policies and procedures. We are encouraged to ask questions or seek clarification to better understand compliance responsibilities.~~

~~B. Compliance with these rules of ethics and business conduct can become very confusing. Common sense and sound judgment are our best guides in determining~~

the appropriateness of the behavior and necessary course of action. However, if we find ourselves in a situation where we are unsure of the ethical implications, we can ask ourselves a few simple questions.

1. Are my actions legal?

2. Am I being fair and honest?

3. Is this in the best interest of SVMHS and the patients we serve?

4. Will my actions stand the test of time?

5. How will I feel about myself afterward?

6. How will it look in the newspaper?

7. Will I sleep soundly tonight?

8. What would I tell my child to do?

C. If we are still in doubt or need clarification, there are numerous resources available to assist us in meeting the challenges of performing our duties and responsibilities. It is always a good idea to go to our supervisor first. If we believe that our concern needs further resolution, feel free to use the following resources:

1. Human Resources at (831) 755-0759

2. Director of Internal Audit and Compliance (Compliance Officer) at (831) 759-1958.

3. Reports concerning compliance issues may also be made anonymously and electronically through our Compliance Hotline, EthicsPoint at https://www.ethicspoint.com. You will be given a report number and may log in under that report number to follow-up.

4. SVMHS has a *NON-COMPLIANCE REPORTING AND RESPONSE AND NON-RETALIATION POLICY.* There will not be a penalty for good faith reports regarding compliance issues; however, self-reporting does not protect us from any consequences for engaging in inappropriate activities. If you feel you may have been retaliated against for a good faith report, you may call Human Resources at the number above.

II. **PURPOSE:**

A. SVMHS has adopted a *CORPORATE COMPLIANCE PROGRAM* that incorporates its policies and procedures for promoting compliance with the law and preventing and detecting violations. SVMHS has determined that the appropriate approach to compliance is to organize, centralize and formalize compliance policies and procedures. These Standards are part of that program.

~~A. The mission of Salinas Valley Memorial Healthcare System (SVMHS) recognizes that earning and maintaining a reputation for integrity encompasses more than compliance with law, regulations and contractual obligations.~~

~~B. The mission of SVMHS is to provide quality healthcare to our patients and to improve the health and well-being of our community. The vision of SVMHS is to be a center of excellence where an inspired team delivers compassionate and culturally sensitive care, outstanding quality, and an exceptional patient experience.~~

~~C. All employees, applicable contractors or agents, physicians, members of governance, vendors, contractors, and volunteers ("we" for purposes of this document) will conduct ourselves with the utmost integrity and in compliance with all applicable laws, regulations and policies at all times and will conduct business in an ethical and trustworthy manner.~~

~~D. It is each individual's responsibility to be familiar with and abide by the standards set forth. These standards cannot address every possible circumstance we may encounter in performing our duties. We are expected to use good judgement and may consult our supervisor or the Director of Internal Audit and Compliance (Compliance Officer) when appropriate.~~

~~E. Managers and above have an additional responsibility to instruct and advise those who report to them on legal policies and requirements applicable to their job functions.~~

~~F. SVMHS has adopted a *CORPORATE COMPLIANCE PROGRAM* that incorporates its policies and procedures for promoting compliance with the law and preventing and detecting violations. SVMHS has determined that the appropriate approach to compliance is to organize, centralize and formalize compliance policies and procedures. These Standards are part of that program.~~

~~G. Everyone who receives a copy of this policy is expected to comply with its requirements.~~

III. **DEFINITIONS:**

A. NA

IV. GENERAL INFORMATION:

A. The mission of Salinas Valley Memorial Healthcare System (SVMHS) recognizes that earning and maintaining a reputation for integrity encompasses more than compliance with law, regulations and contractual obligations.

B. The mission of SVMHS is to provide quality healthcare to our patients and to improve the health and well-being of our community. The vision of SVMHS is to be a center of excellence where an inspired team delivers compassionate and culturally sensitive care, outstanding quality, and an exceptional patient experience.

C. It is each individual's responsibility to be familiar with and abide by the standards set forth. These standards cannot address every possible circumstance we may encounter in performing our duties. We are expected to use good judgement and may consult our supervisor or the Director of Internal Audit and Compliance (Compliance Officer) when appropriate.

D. Managers and above have an additional responsibility to instruct and advise those who report to them on legal policies and requirements applicable to their job functions.

E. Everyone who receives a copy of this policy is expected to comply with its requirements.

~~A. **STANDARD: COMPLIANCE WITH LAWS AND REGULATIONS (Service Pillar)**~~

~~Healthcare is a highly regulated business that requires compliance with many federal and state laws and regulations. It is important to stay informed and be diligent about the work we perform.~~

~~1. As a California Public District Hospital we must comply with California Healthcare District Law. These laws are incorporated into our policies and procedures.~~

~~2. Following is a summary of certain federal and state laws related to fraud, waste, and abuse: (For further information, see *COMPLIANCE PLAN*.)~~

~~a. Anti-Kickback. The federal Anti-Kickback Statute is a criminal law that prohibits the exchange or offer of anything of value to induce or reward referrals of federal health care program business. Many states, including California, also have their own state anti-~~

kickback statutes that are similar to the federal Anti-Kickback Statute.

b. For example, the federal Anti-Kickback Statute prohibits any SVMHS employee from accepting or granting bribes or kickbacks (e.g., cash, in-kind contributions, subsidies in exchange for referrals of Medicare patients or Medicare business to SVMHS. For further information, please see GIFT, TICKET AND HONORARIA POLICY

c. False Claims Act (FCA). The federal FCA prohibits anyone from submitting claims they know, or should know, are false or misleading to the government. California also has a similar state false claims act provisions. It is important to completely, accurately, and clearly document all services rendered and only submit claims for which sufficient documentation is in the medical record. For further information, please see SVMHS' *FALSE CLAIMS ACT PROVISIONS POLICY.*

d. Examples of actions that may violate the federal or California False Claims Acts include:
   i. Billing for services not rendered in full or in part by a qualified medical professional
   i. Duplicate billing to the same payer
   ii. Billing more than one payer for the same service at the same time
   iii. Billing that does not reflect the actual items or services provided
   iv. Upcoding

e. Physician Self-Referral (Stark) Law. The Stark Law prohibits physicians from referring patients for "designated health services" to an entity with which the physician has a financial relationship unless a Stark Law exception applies. In addition, an entity (e.g., hospital) receiving the prohibited Stark Law referral is prohibiting from billing Medicare for any designated health service associated with that referral. The term "designated health services" includes inpatient and outpatient hospital services.

For example, the Stark Law would prohibit a physician from referring a patient to Salinas Valley Memorial Hospital (the "Hospital") for inpatient or outpatient hospital services, and prohibit the Hospital for billing Medicare for those services, if that

physician has a financial arrangement (e.g., a medical director agreement or on-call coverage agreement) with the Hospital that does not meet a Stark Law exception.

f. Antitrust. We must all comply with antitrust laws regulating competition. Antitrust laws are intended to prohibit an unfair competitive advantage.

B. STANDARD: QUALITY OF CARE (Quality Pillar)

We are committed to treating all patients equally and with dignity and respect regardless of their ability to pay and to provide a safe healthcare environment for all employees, patients, families, and visitors. Following are ways we can do that.

1. Administer and Record Healthcare Services Properly. Patient care must be appropriate, medically necessary, and well documented.

2. Emergency Medical Treatment and Active Labor Act (EMTALA). We will treat all patients who present to the Emergency Department regardless of their ability to pay. For further information, see the *CORPORATE COMPLIANCE PROGRAM*

3. Other ways we facilitate compliance with this standard include:

a. Care for patients as unique and important individuals.
a. Not discriminate in the admission and/or treatment of patients or the provisions of accommodations and services based on race, creed, disability, nation or origin, or any other legally protected class of individuals.
b. Make decisions to treat, admit, transfer, or discharge a patient within the limits of our capabilities to render are or service and in a manner that addresses the clinical needs of the patient.
c. Promote a caring, concerned, compassionate healthcare delivery system.
d. Develop and refine an integrated delivery system.
e. Represent ourselves in an honest, decent, and proper manner in all interactions with our customers and the community.
f. Protect the integrity of clinical decision making regardless of how providers of care are compensated or shared risk arrangements are structured.
g. Respect our patients' rights to be informed of the existence of business partnerships among our hospitals, educational institutions,

other healthcare providers, payers, or networks that may influence the patients' treatment and care.

h. Collaborate with educational institutions to enhance health education for the community, its patients, and employees.

C. STANDARD: WORKPLACE CONDUCT AND EMPLOYMENT PRACTICES (Quality, People Pillars)

Each of us has the right to work in an environment free of disruptive behavior, harassment, or discrimination. Patients, visitors, and guests have the right to receive care in a safe place.

1. Safe Workplace. We are strongly committed to health and safety and strive to provide a safe and healthful environment at SVMHS. Each of us is responsible for creating and maintaining a safe environment at SVMHS for all employees, patients, families, and visitors. The following plans have been developed to support our efforts. Each of us is responsible to comply with those plans:
   a. PATIENT SAFETY PROGRAM PLAN
   b. HAZARDOUS MATERIALS & WASTE MANAGEMENT PLAN

2. Harassment. No form of harassment will be permitted at SVMHS. Harassment includes verbal, non-verbal, or physical conduct intended to intimidate, or threaten another individual. For further information, see the *STANDARDS OF PROFESSIONAL BEHAVIOR* and *DISCRIMINATION/HARASSMENT POLICY*.)

3. Discrimination. We believe in the fair treatment in our internal and external business dealings. It is our policy to treat employees without regard to their race, color, religion, gender, ethnic origin, age, disability, sexual orientation, or any other classification prohibited by applicable law. We recruit, hire, train, promote, assign, transfer, layoff, recall, and terminate employees based on their ability, achievement, experience, and conduct. (For further information, see the *STANDARDS OF PROFESSIONAL BEHAVIOR* and *DISCRIMINATION/HARASSMENT POLICY*.)

4. Exemption from Job Responsibilities. An employee of SVMHS may be excluded from the performance of a job responsibility for reasons of religious of cultural beliefs. However, this excusal may only occur if it does not negatively affect the care, treatment, and/or services provided to any SVMHS patient.

D. STANDARD: PRIVACY AND CONFIDENTIALITY (Community Pillar)

The protection of the privacy and confidentiality of information created and/or obtained in the course of business is of the utmost importance. Each of us has the duty to use this information responsibly.

1. Protected Health Information. Due to the nature of our business, we have access to personal information about our patients' health. It is our responsibility to safeguard this information and to only access, use or disclose personal information in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended. (For further information, see the *CORPORATE COMPLIANCE PROGRAM* and the *USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)* .)

2. Personal information. We treat as confidential personal employee information including salary, benefits, and personnel file information. This should only be accessed and/or used when appropriate in the performance of our job responsibilities.

3. Property. We are also committed to use corporate property responsibly and for its intended use.

4. Security. We are all responsible for the appropriate use of the security measures at our disposal, including confidential login credentials, passwords, access badges, and keys. (For further information, see the *CORPORATE COMPLIANCE PROGRAM* and the *INFORMATION MANAGEMENT PLAN* .)

5. Social Media. Social media presents a special challenge for healthcare providers. We are expected to use social media responsibly and in compliance with our policies and procedures related to privacy, confidentiality, and security.

E. STANDARD: BUSINESS AND PERSONAL CONDUCT (People Pillar)

We are committed to conducting business in a professional and ethical manner and in the best interests of SVMHS. Following are values and standards that apply to that conduct.

1. Conflict of Interest. Each of us will avoid any relationship, influence, or activity that might impair our abilities to make objective and fair decisions

when performing our jobs. According to the *CONFLICT OF INTEREST* approved by the Monterey County Board of Supervisors, certain employees, contractors, and members of governance must disclose potential conflicts of interest. Even if we are not required to disclose, it is still important to let our supervisors know of any potential conflicts. (For further information, see the *CORPORATE COMPLIANCE PROGRAM*.) Examples include:

a. Becoming employed by a potential competitor, regardless of the nature of employment, while still working at SVMHS.
b. Owning or having substantial financial interest in a company that competes with or sells supplies to SVMHS.
c. Accepting of gifts, payments, or services from those seeking to do business with SVMHS.
d. Purchasing of goods or services for SVMHS from a firm owned or controlled by an employee or close relative of an SVMHS employee.
e. Acting as a consultant to SVMHS customers, competitors, or suppliers.

2. Gifts and Gratuities. We are prohibited from receiving or soliciting gifts or gratuities from patients and their families. Gifts and gratuities may include cash, gift cards, services, entertainment, or anything of value. A patient or patient's family member wishing to present a monetary gift should be referred to the Foundation. (For further information, see the *GIFT, TICKET AND HONORARIA POLICY*.)

F. STANDARD: BILLING, NEGOTIATIONS, AND FINANCIAL REPORTING (Financial Pillar)

1. Billing Practices. We will be fair and consistent with our mission and sound business practices. We will endeavor to provide an accurate, timely, understandable bill for services rendered and inform patients about the charges for which they are responsible. We will resolve expeditiously a question about a charge. Other responsibilities include:

a. Billing only for services provided and ordered by a physician.
b. Using accurate billing codes that reflect accurately the services furnished.
c. Refunding credit balances on a timely basis.
d. Not billing patients for contractual allowances.
e. Not billing patients or insurers for avoidable unexpected outcomes.

f. Not writing off or adjusting claims without documenting the reason and following applicable Business Office policies and procedures.

g. Not offering financial incentives to improperly code, charge, or bill a claim.

2. Purchase Negotiations. In the purchase of goods or services for SVMHS, we will treat all suppliers uniformly and fairly. In deciding among competing suppliers, we will weigh all facts and avoid favoritism. (For further information, see the *PROCUREMENT MANUAL*.)

3. Financial Reporting. Each of us is responsible to utilize SVMHS assets and resources in the most efficient and effective manner. SVMHS has established and maintains a standard of accuracy and completeness in its financial records. We will comply with the recording requirements of applicable laws, and generally acceptable accounting principles. (For further information, see the *CORPORATE COMPLIANCE PROGRAM*.)

G. STANDARD: COMMUNICATIONS (Quality, Financial Pillars)

1. Suppliers, vendors, trade and professional organizations, and others may seek endorsement or testimonial from SVMHS employees. Whether or not payment or consideration is offered in return for the endorsement or testimonial, no SVMHS employee may agree to an endorsement or testimonial without specific approval by the President/CEO or designee. Should this be approved, the approval will be in writing.

2. Required community disclosures will be transparent, accurate, and timely.

3. We will advertise using ethical and honest business practices and in compliance with applicable laws. We will also make clear in our marketing those services that are provided by an organization affiliated with SVMHS. Prohibited marketing practices include:

a. Providing bonuses, incentives, kickbacks, or bribes to induce or obtain referrals or admissions.

b. Inaccurate statements about the availability or quality of our services.

c. Untruthful allegations or assertions about other healthcare providers.

H. STANDARD: RESEARCH, INVESTIGATIONS, AND CLINICAL TRIALS (Growth, Quality Pillars)

~~1. SVMHS is engaged in clinical research involving human subjects. As such, we are required to adhere to rules promulgated by the Food and Drug Administration (FDA), Office for Civil Rights (OCR), Office of Inspector General (OIG), Medicare/CMS, as well as state laws and local standards for patient rights. The rights of these subjects are protected in accordance with national and international standards. (For further information, see *CORPORATE COMPLIANCE PROGRAM*.)~~

V. PROCEDURE:

~~A. **Each employee or representative of SVMHS shall conduct SVMHS' business transactions with honesty, accuracy, fairness and respect for others. No unethical practices can be resorted to on the grounds that it is "customary" or that it serves other worthy goals. The expediency should never compromise integrity.**~~

A. STANDARDS

~~B.~~

~~C.~~ I. **STANDARDS OF ETHICAL BUSINESS PRACTICES**

1. Integrity in the broadest sense must govern our actions in all relationships, including those with patients, referral sources, suppliers, providers and one another. SVMHS has instituted the *CORPORATE COMPLIANCE PROGRAM* in accordance with federal guidelines. We must all be personally committed to follow our Compliance Program in order to comply with all Applicable federal, state, and local laws and regulations governing our business conduct.

2. The Corporate Compliance Program applies to all directors, employees (including management and members of governance), medical staff members, volunteers, contractors and agents of SVMHS ("we"). We will conduct all business in accordance with applicable laws and regulations. We will also conduct our business in an ethical and trustworthy manner. We will display the qualities and character of professionals at all times in the treatment of patients, interaction with visitors, physicians, volunteers, fellow employees, contractors, and the community at large.

3. Each of us has an important role in ensuring compliance with applicable laws, regulations, these standards, and our policies and procedures. We are encouraged to ask questions or seek clarification to better understand compliance responsibilities.

~~D.~~B. Compliance with these rules of ethics and business conduct can become very confusing. Common sense and sound judgment are our best guides in determining the appropriateness of the behavior and necessary course of action. However, if we find ourselves in a situation where we are unsure of the ethical implications, we can ask ourselves a few simple questions.

1. Are my actions legal?
2. Am I being fair and honest?
3. Is this in the best interest of SVMHS and the patients we serve?
4. Will my actions stand the test of time?
5. How will I feel about myself afterward?
6. How will it look in the newspaper?
7. Will I sleep soundly tonight?
8. What would I tell my child to do?

~~E.~~C. If we are still in doubt or need clarification, there are numerous resources available to assist us in meeting the challenges of performing our duties and responsibilities. It is always a good idea to go to our supervisor first. If we believe that our concern needs further resolution, feel free to use the following resources:

1. Human Resources at (831) 755-0759
2. Director of Internal Audit and Compliance (Compliance Officer) at (831) 759-1958.
3. Reports concerning compliance issues may also be made anonymously and electronically through our Compliance Hotline, EthicsPoint at https://www.ethicspoint.com. You will be given a report number and may log in under that report number to follow-up.
4. SVMHS has a *NON-COMPLIANCE REPORTING AND RESPONSE AND NON-RETALIATION POLICY.* There will not be a penalty for good faith reports regarding compliance issues; however, self-reporting does not protect us from any consequences for engaging in inappropriate activities. If you feel you may have been retaliated against for a good faith report, you may call Human Resources at the number above.

~~F.~~ II. STANDARD: COMPLIANCE WITH LAWS AND REGULATIONS (Service Pillar)

Healthcare is a highly regulated business that requires compliance with many federal and state laws and regulations. It is important to stay informed and be diligent about the work we perform.

~~1.~~5. As a California Public District Hospital we must comply with California Healthcare District Law. These laws are incorporated into our policies and procedures.

~~2.~~6. Following is a summary of certain federal and state laws related to fraud, waste, and abuse: (For further information, see *COMPLIANCE PLAN*.)

~~g.~~a. Anti-Kickback. The federal Anti-Kickback Statute is a criminal law that prohibits the exchange or offer of anything of value to induce or reward referrals of federal health care program business. Many states, including California, also have their own state anti-kickback statutes that are similar to the federal Anti-Kickback Statute.

~~h.~~b. For example, the federal Anti-Kickback Statute prohibits any SVMHS employee from accepting or granting bribes or kickbacks (e.g., cash, in-kind contributions, subsidies in exchange for referrals of Medicare patients or Medicare business to SVMHS. For further information, please see GIFT, TICKET AND HONORARIA POLICY

~~i.~~c. False Claims Act (FCA). The federal FCA prohibits anyone from submitting claims they know, or should know, are false or misleading to the government. California also has a similar state false claims act provisions. It is important to completely, accurately, and clearly document all services rendered and only submit claims for which sufficient documentation is in the medical record. For further information, please see SVMHS' *FALSE CLAIMS ACT PROVISIONS POLICY.*

~~j.~~d. Examples of actions that may violate the federal or California False Claims Acts include:

~~v.~~i. Billing for services not rendered in full or in part by a qualified medical professional

~~vi.~~ii. Duplicate billing to the same payer

~~vii.~~iii. Billing more than one payer for the same service at the same time

~~viii.~~iv. Billing that does not reflect the actual items or services provided

~~ix.~~v. Up-coding

~~k.~~e. Physician Self-Referral (Stark) Law. The Stark Law prohibits physicians from referring patients for "designated health services" to an entity with which the physician has a financial relationship unless a Stark Law exception applies. In addition, an entity (e.g., hospital) receiving the prohibited Stark Law referral is prohibiting from billing Medicare for any designated health service associated with that referral. The term "designated health services" includes inpatient and outpatient hospital services.

For example, the Stark Law would prohibit a physician from referring a patient to Salinas Valley Memorial Hospital (the "Hospital") for inpatient or outpatient hospital services, and prohibit the Hospital for billing Medicare for those services, if that physician has a financial arrangement (e.g., a medical director agreement or on-call coverage agreement) with the Hospital that does not meet a Stark Law exception.

~~l.~~f. Antitrust. We must all comply with antitrust laws regulating competition. Antitrust laws are intended to prohibit an unfair competitive advantage.

~~C.~~ III. STANDARD: QUALITY OF CARE (Quality Pillar)

We are committed to treating all patients equally and with dignity and respect regardless of their ability to pay and to provide a safe healthcare environment for all employees, patients, families, and visitors. Following are ways we can do that.

~~1.~~7. Administer and Record Healthcare Services Properly. Patient care must be appropriate, medically necessary, and well documented.

~~2.~~8. Emergency Medical Treatment and Active Labor Act (EMTALA). We will treat all patients who present to the Emergency Department regardless of their ability to pay. For further information, see the *CORPORATE COMPLIANCE PROGRAM*

~~3.~~9. Other ways we facilitate compliance with this standard include:

~~i.~~a. Care for patients as unique and important individuals.

~~j.~~b. Not discriminate in the admission and/or treatment of patients or the provisions of accommodations and services based on race, creed, disability, nation or origin, or any other legally protected class of individuals.

~~k.~~c. Make decisions to treat, admit, transfer, or discharge a patient within the limits of our capabilities to render are or service and in a manner that addresses the clinical needs of the patient.

~~l.~~d. Promote a caring, concerned, compassionate healthcare delivery system.

~~m.~~e. Develop and refine an integrated delivery system.

~~n.~~f. Represent ourselves in an honest, decent, and proper manner in all interactions with our customers and the community.

~~o.~~g. Protect the integrity of clinical-decision making regardless of how providers of care are compensated or shared risk arrangements are structured.

~~p.~~h. Respect our patients' rights to be informed of the existence of business partnerships among our hospitals, educational institutions, other healthcare providers, payers, or networks that may influence the patients' treatment and care.

~~q.~~i. Collaborate with educational institutions to enhance health education for the community, its patients, and employees.

~~H.~~ IV. STANDARD: WORKPLACE CONDUCT AND EMPLOYMENT PRACTICES (Quality, People Pillars)

Each of us has the right to work in an environment free of disruptive behavior, harassment, or discrimination. Patients, visitors, and guests have the right to receive care in a safe place.

~~1.~~10. Safe Workplace. We are strongly committed to health and safety and strive to provide a safe and healthful environment at SVMHS. Each of us is responsible for creating and maintaining a safe environment at SVMHS for all employees, patients, families, and visitors. The following plans have been developed to support our efforts. Each of us is responsible to comply with those plans:

~~c.~~a. PATIENT SAFETY PROGRAM PLAN

~~d.~~b. HAZARDOUS MATERIALS & WASTE MANAGEMENT PLAN

~~2.~~11. Harassment. No form of harassment will be permitted at SVMHS. Harassment includes verbal, non-verbal, or physical conduct intended to intimidate, or threaten another individual. For further information, see the

STANDARDS OF PROFESSIONAL BEHAVIOR and *DISCRIMINATION/HARASSMENT POLICY*)

~~3.~~12. Discrimination. We believe in the fair treatment in our internal and external business dealings. It is our policy to treat employees without regard to their race, color, religion, gender, ethnic origin, age, disability, sexual orientation, or any other classification prohibited by applicable law. We recruit, hire, train, promote, assign, transfer, layoff, recall, and terminate employees based on their ability, achievement, experience, and conduct. (For further information, see the *STANDARDS OF PROFESSIONAL BEHAVIOR* and *DISCRIMINATION/HARASSMENT POLICY* .)

~~4.~~13. Exemption from Job Responsibilities. An employee of SVMHS may be excluded from the performance of a job responsibility for reasons of religious of cultural beliefs. However, this excusal may only occur if it does not negatively affect the care, treatment, and/or services provided to any SVMHS patient.

~~I.~~ V. STANDARD: PRIVACY AND CONFIDENTIALITY (Community Pillar)

The protection of the privacy and confidentiality of information created and/or obtained in the course of business is of the utmost importance. Each of us has the duty to use this information responsibly.

~~1.~~14. Protected Health Information. Due to the nature of our business, we have access to personal information about our patients' health. It is our responsibility to safeguard this information and to only access, use or disclose personal information in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended. (For further information, see the *CORPORATE COMPLIANCE PROGRAM* and the *USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) .)*

~~2.~~15. Personal information. We treat as confidential personal employee information including salary, benefits, and personnel file information. This should only be accessed and/or used when appropriate in the performance of our job responsibilities.

~~3.~~16. Property. We are also committed to use corporate property responsibly and for its intended use.

~~4.~~17. Security. We are all responsible for the appropriate use of the security measures at our disposal, including confidential login credentials, passwords, access badges, and keys. (For further information, see the *CORPORATE COMPLIANCE PROGRAM* and the *INFORMATION MANAGEMENT PLAN* .)

~~5.~~18. Social Media. Social media presents a special challenge for healthcare providers. We are expected to use social media responsibly and in compliance with our policies and procedures related to privacy, confidentiality, and security.

~~J.~~ VII. STANDARD: BUSINESS AND PERSONAL CONDUCT (People Pillar)

We are committed to conducting business in a professional and ethical manner and in the best interests of SVMHS. Following are values and standards that apply to that conduct.

~~1.~~19. Conflict of Interest. Each of us will avoid any relationship, influence, or activity that might impair our abilities to make objective and fair decisions when performing our jobs. According to the *CONFLICT OF INTEREST* approved by the Monterey County Board of Supervisors, certain employees, contractors, and members of governance must disclose potential conflicts of interest. Even if we are not required to disclose, it is still important to let our supervisors know of any potential conflicts. (For further information, see the *CORPORATE COMPLIANCE PROGRAM* .) Examples include:

a. Becoming employed by a potential competitor, regardless of the nature of employment, while still working at SVMHS.
b. Owning or having substantial financial interest in a company that competes with or sells supplies to SVMHS.
c. Accepting of gifts, payments, or services from those seeking to do business with SVMHS.
d. Purchasing of goods or services for SVMHS from a firm owned or controlled by an employee or close relative of an SVMHS employee.
e. Acting as a consultant to SVMHS customers, competitors, or suppliers.

~~2.~~20. Gifts and Gratuities. We are prohibited from receiving or soliciting gifts or gratuities from patients and their families. Gifts and gratuities may include cash, gift cards, services, entertainment, or anything of value. A patient or patient's family member wishing to present a monetary gift

should be referred to the Foundation. (For further information, see the *GIFT, TICKET AND HONORARIA POLICY* .)

~~K.~~ **VII. STANDARD: BILLING, NEGOTIATIONS, AND FINANCIAL REPORTING (Financial Pillar)**

~~1.~~21. Billing Practices. We will be fair and consistent with our mission and sound business practices. We will endeavor to provide an accurate, timely, understandable bill for services rendered and inform patients about the charges for which they are responsible. We will resolve expeditiously a question about a charge. Other responsibilities include:

a. Billing only for services provided and ordered by a physician.
b. Using accurate billing codes that reflect accurately the services furnished.
c. Refunding credit balances on a timely basis.
d. Not billing patients for contractual allowances.
e. Not billing patients or insurers for avoidable unexpected outcomes.
f. Not writing off or adjusting claims without documenting the reason and following applicable Business Office policies and procedures.
g. Not offering financial incentives to improperly code, charge, or bill a claim.

~~2.~~22. Purchase Negotiations. In the purchase of goods or services for SVMHS, we will treat all suppliers uniformly and fairly. In deciding among competing suppliers, we will weigh all facts and avoid favoritism. (For further information, see the *PROCUREMENT MANUAL* .)

~~3.~~23. Financial Reporting. Each of us is responsible to utilize SVMHS assets and resources in the most efficient and effective manner. SVMHS has established and maintains a standard of accuracy and completeness in its financial records. We will comply with the recording requirements of applicable laws, and generally acceptable accounting principles. (For further information, see the *CORPORATE COMPLIANCE PROGRAM* .)

~~L.~~ **VIII. STANDARD: COMMUNICATIONS (Quality, Financial Pillars)**

~~1.~~24. Suppliers, vendors, trade and professional organizations, and others may seek endorsement or testimonial from SVMHS employees. Whether or not payment or consideration is offered in return for the endorsement or testimonial, no SVMHS employee may agree to an endorsement or

testimonial without specific approval by the President/CEO or designee. Should this be approved, the approval will be in writing.

~~2.~~25. Required community disclosures will be transparent, accurate, and timely.

~~3.~~26. We will advertise using ethical and honest business practices and in compliance with applicable laws. We will also make clear in our marketing those services that are provided by an organization affiliated with SVMHS. Prohibited marketing practices include:

a. Providing bonuses, incentives, kickbacks, or bribes to induce or obtain referrals or admissions.
b. Inaccurate statements about the availability or quality of our services.
c. Untruthful allegations or assertions about other healthcare providers.

~~M.~~ **XI. STANDARD: RESEARCH, INVESTIGATIONS, AND CLINICAL TRIALS (Growth, Quality Pillars)**

~~1.~~27. SVMHS is engaged in clinical research involving human subjects. As such, we are required to adhere to rules promulgated by the Food and Drug Administration (FDA), Office for Civil Rights (OCR), Office of Inspector General (OIG), Medicare/CMS, as well as state laws and local standards for patient rights. The rights of these subjects are protected in accordance with national and international standards. (For further information, see *CORPORATE COMPLIANCE PROGRAM* .)

~~N.~~B. Documentation:

~~1.~~28. Attendance at educational sessions will be documented.
~~2.~~29. Completion of E-learning is monitored and reports are made available to all department managers /designees quarterly. Records are retained by the Education Department.
~~3.~~30. Attendance at New Employee Orientation will be documented.
~~4.~~31. Records are retained by the Education Department.

VI. **EDUCATION/TRAINING:**

A. Education and/or training is provided as needed.
~~A. New Employee Orientation~~
~~B. E-learning~~
~~C. Department meetings as needed.~~

VII. **REFERENCES:**

A. American Hospital Association (AHA) Guidelines for Corporate Compliance Programs

B. The Joint Commission , Human Resources, Leadership and Medical Staff ~~,~~

~~B.~~C. Title 22 Article 70701 – Governance Standards

~~C.~~D. Society of Corporate Compliance and Ethics, The Complete Compliance and Ethics Manual ~~2016~~ 2021

~~D.~~E. Department of Justice/Office of Inspector General Guidelines for Corporate Compliance Program

~~E.~~F. 2018~~0~~ Federal Sentencing Guidelines Manual Chapter 8, Part B2

~~F.~~G. United States Federal Register, Volume 63, No. 35, Monday, February 23, 1998 "Notices", pp. 8987-8993

~~G.~~H. United States Federal Register, Vol. 70, No. 19, Monday, January 31, 2005, "Notices", pp. 4874-4875

~~H.~~I. HCCA-OIG Compliance Effectiveness Roundtable "Measuring Compliance Program Effectiveness: A Resource Guide", January 17, 2017

~~I. SVMHS Organizational Policies, Procedures, and Plans~~

LEGAL REVIEW: 2/18

Salinas Valley Memorial Healthcare System

COMMUNITY FUNDING

Reference Number	5656
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	

I. POLICY STATEMENT:

~~A. It is the policy of SVMHS to ensure compliance with State law prohibitions on unlawful expenditures or gifts of public funds, including as specifically addressed in Sections 5 and 6 of Article XVI of the California Constitution, Government Code Section 8314, Code of Civil Procedure Section 526a and Penal Code Sections 424, et seq.~~

~~B.~~A. It is the policy of SVMHS to expend Agency resources only in furtherance of the Agency's statutory purposes and in the exercise of powers set forth or implied in SVMHS's enabling legislation (California Health and Safety Code Sections 32000, et seq.).

~~C. It is the policy of SVMHS to distribute all tickets/passes according to the Fair Political Practices Commission §18944.1. Gifts: Agency Provided Tickets or Passes.~~

~~D. More specifically, SVMHS will expend Agency resources only in the furtherance of its~~ MISSION, VISION, AND GOALS STATEMENT ~~related to improving the healthcare of our region and beyond.~~

~~E. It is further the policy of SVMHS to make expenditures related to community funding and marketing only after consideration pursuant to this Policy and an evaluation of the financial capacity of SVMHS to make such expenditures.~~

~~F. SVMHS will not provide Community Funding to support or oppose campaigns for or against political candidates or ballot measures.~~

~~G. SVMHS will not provide Community Funding to or in aid of any religious sect, church, creed, or sectarian purpose, or to help to support or sustain any school, college, university, hospital, or other institution controlled by any religious creed, church, or sectarian denomination.~~

~~H. SVMHS will not provide Community Funding for endowment funds. SVMHS will carefully consider support for individual endeavors and annual fund drives.~~

II. PURPOSE:

A. To ensure compliance with State law prohibitions on unlawful expenditures or gifts of public funds, including as specifically addressed in Sections 5 and 6 of Article XVI of the California Constitution, Government Code Section 8314, Code of Civil Procedure Section 526a and Penal Code Sections 424, et seq.

~~A.~~B. The purpose of this Community Funding Policy ("Policy") is to ensure that all funds and other resources of Salinas Valley Memorial Healthcare System ("SVMHS" or "Agency") are expended in furtherance of valid public purposes in full accordance with applicable laws and the rules in this Policy.

~~B. This Policy sets forth procedures and standards for consideration, approval and administration of potential expenditures of SVMHS resources in the areas of community benefit support and marketing.~~

III. **DEFINITIONS:**

A. "Community Funding" means SVMHS resources – including tax revenue or other funds, materials or in-kind support – given to or spent to support any individual, organization, or entity for the purpose of benefitting the healthcare of the region served by SVMHS, including the areas within and surrounding the SVMHS jurisdictional boundaries. Community Funding can include money or Materials/In-kind Benefits. There are two types of Community Funding: Community Benefit Support and Marketing Support

B. "Community Benefit Support" is resources given or spent for the purpose of improving the healthcare of the SVMHS community. Examples include contributions to community events at which individuals can benefit from health screenings or wellness screenings, community health education, and contributions to community health clinics.

C. "Marketing Support" means resources given or spent to promote the business, mission and goals of SVMHS and the services SVMHS provides. Examples include advertisements of SVMHS services at community events or in local organization publications. "Marketing Support" does not include advertising in, on or through newspaper, radio, television, social media or direct mail, except when such advertising is associated with a specific community event hosted by an entity other than SVMHS itself.

D. "Materials or In-kind Support" is resources other than money, including time and materials.

IV. **GENERAL INFORMATION:**

A. This Policy sets forth procedures and standards for consideration, approval and administration of potential expenditures of SVMHS resources in the areas of community benefit support and marketing.

B. SVMHS distributes all tickets/passes according to the Fair Political Practices Commission §18944.1. Gifts: Agency Provided Tickets or Passes.

C. SVMHS will expend Agency resources only in the furtherance of its MISSION, VISION, AND GOALS STATEMENT related to improving the healthcare of our region and beyond.

D. SVMHS makes expenditures related to community funding and marketing only after consideration pursuant to this Policy and an evaluation of the financial capacity of SVMHS to make such expenditures.

E. SVMHS will not provide Community Funding to support or oppose campaigns for or against political candidates or ballot measures.

F. SVMHS will not provide Community Funding to or in aid of any religious sect, church, creed, or sectarian purpose, or to help to support or sustain any school, college, university, hospital, or other institution controlled by any religious creed, church, or sectarian denomination.

G. SVMHS will not provide Community Funding for endowment funds. SVMHS will carefully consider support for individual endeavors and annual fund drives.

~~A. N/A~~

V. PROCEDURES:

A. Community Funding Committee ("Committee").

1. The Chief Executive Officer may create a Community Funding Committee to maintain the integrity of the procedures set forth in this Policy. In the absence of such a Committee, the duties and responsibilities assigned to the Committee in this Policy shall be carried out by the Executive Leadership Group ("ELG").

2. The Community Funding Committee will conduct the following activities:

   a. Review requests for Community Funding monthly or as pending either in person, online, or via telephone conference call and present recommendations on funding decisions to the President/CEO Review this Policy at least once every three years to ensure that implementation of this Policy remains consistent with the Policy's purpose and recommend needed changes to the ELG.

   b. By April of each year, evaluate the prior year's Community Funding activities for alignment with the SVMHS strategic plan and provide recommendations for the next year's Community Funding budget to the President/CEO. These recommendations will include planned community events, tentative line-item expenses and a total budget projection for the upcoming fiscal year.

   ~~b.~~c. On occasion, the President/Chief Executive Officer may choose to approve a community funding request without prior input from the committee.

B. Community Funding Requests and Decisions.

1. All decisions related to Community Funding will be made pursuant to the procedures set forth in this Policy.
2. All applicants for Community Funding, including SVMHS officers or employees, shall submit a Community Funding Request Form (see Attachment A as an example) to SVMHS Administration for Committee review. The Request Form can be accessed on the SVMHS website or by mail or in person through the office of the Chief Executive Officer.
3. Each event or endeavor requires submittal of a new Community Funding Request Form. Requests for support of annual events must be submitted annually.
4. The Committee will manage notification of request acceptance or denial.

C. Budgeting and Tracking of Community Funding Expenditures.

1. For budgeting and resource tracking purposes, Community Funding expenditures will be designated as follows: Community Benefit Support will be assigned to Administration 8610 and Marketing Support will be assigned to Administration 8630.

D. Policy Review.

1. Decisions made and actions taken pursuant to this Policy shall be reviewed at least once every three years to ensure compliance and alignment of Community Funding decisions with SVMHS's strategic plan and vision, mission and goals.

E. Tickets and Related Benefits.

1. If SVMHS receives event tickets or other benefits in response to the provision of Community Funding, such as in exchange for sponsorship of a community event, such benefits shall be managed according to the SVMHS GIFT, TICKET AND HONORARIA POLICY .

F. Documentation:

1. All applicants for Community Funding must complete and submit a Community Funding Request Form (Attachment A).
2. The Community Funding Committee will utilize the Community Funding Request Form (Attachment A) to consider and support recommendations to the President/CEO.
3. Applicants for Community Funding will be notified of the disposition of their request in writing.
4. The Committee shall maintain all documentation related to Community Funding requests, including completed Community Funding Request forms; records of Committee Community Funding Request evaluations and recommendations; and

notices of Community Funding awards or request denials, in compliance with the SVMHS record retention policy. (RECORDS RETENTION POLICY)

VI. DOCUMENTATION:

A. SVMHS Grants & Sponsorship Application (For consideration this form must be received 60 days prior to the event/activity.)

B. The Community Funding Committee will utilize the community funding Request Form to consider and support recommendations to the President/CEO.

C. Applicants for Community Funding will be notified of the disposition of their request in writing.

D. The Committee shall maintain all documentation related to Community Funding requests, including completed Community Funding request forms; records of Committee Community Funding Request evaluations and recommendations; and notices of Community Funding awards or request denials, in compliance with the SVMHS record retention policy. RECORDS RETENTION POLICY

~~VI.~~VII. EDUCATION/TRAINING:

A. Education and/or training is provided as needed.~~The Community Funding Committee, associated departments, ELG and others, as appropriate, will receive training on this Policy during the annual budget process and following any Policy revisions.~~

~~VII.~~VIII. REFERENCES:

A. Article XVI, Sections 5 and 6, California Constitution

B. California Government Code Section 8314

C. California Code of Civil Procedure Section 526a

D. California Penal Code Sections 424, et seq.

E. Fair Political Practices Commission §18944.1. Gifts: Agency Provided Tickets or Passes

Salinas Valley Memorial Healthcare System

EMERGENCY MANAGEMENT FOR MASS CASUALTY INCIDENTS

Reference Number	1102
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	

I. POLICY STATEMENT:

~~A. The Emergency Management Plan for Mass Casualty program is developed, approved and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts.~~

~~B. The program covers disasters occurring in the community and widespread disasters. It provides for at least the following: (1) Availability of adequate basic utilities and supplies, including gas, water, food and essential medial and supportive materials. (2) An efficient system of notifying and assigning personnel. (3) Unified medical command. (4) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care. (5) Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care. (6) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved. (7) Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy. (8) Maintaining security in order to keep relatives and curious persons out of the triage area. (9) Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information.~~

~~C. The program is in conformity with the California Emergency Plan of October 10, 1972 developed by the State Office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974 developed by the Office of Emergency Services, Department of Health.~~

~~D. This plan is reviewed at least annually and includes all areas of the Salinas Valley Memorial Hospital (SVMH) campus and surrounding buildings and offices, owned and not owned, where SVMH staff and/or services are present. A copy of the program is available on the premises for review by the California Department of Public Health (CDPH) and any other regulatory entity.~~

E. There is evidence in the personnel/education files, e.g., orientation checklist or elsewhere, indicating that all new employees have been oriented to the program and procedures within a reasonable time after commencement of their employment.

F.A. The disaster planEmergency Operations Plan (EOP) is rehearsed twice a year and a report andwith evaluation of all drills activations and exercises is kept in theapproved by the Emergency Management FilesCommittee and reviewed by the Environment of Care Committee. Management forof Mass Casualty Incidents follows the Salinas Valley Emergency Operations Program Plan.

II. **Effective Date: Not Approved Yet**

III.II. **PURPOSE:**

A. The Emergency Management Plan for Mass Casualty Incidents (MCI plan) is for events occurring inside and outside the hospital requiring additional staff, resources, communication, and preparation and/or extraordinary expansion of services.

IV.III. **DEFINITIONS:**

A.

V.IV. **GENERAL INFORMATION:**

A. The Emergency Management Plan for Mass Casualty program is developed, approved and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts.
B. The program covers disasters occurring in the community and widespread disasters. It provides for at least the following: (1) Availability of adequate basic utilities and supplies, including gas, water, food and essential medial and supportive materials. (2) An efficient system of notifying and assigning personnel. (3) Unified medical command. (4) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care. (5) Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care. (6) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved. (7) Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy. (8) Maintaining security in order to keep relatives and curious persons out of the triage area. (9) Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information.

C. The program is in conformity with the California Emergency Plan of October 10, 1972 developed by the State Office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974 developed by the Office of Emergency Services, Department of Health.

D. This plan is reviewed at least annually and includes all areas of the Salinas Valley Memorial Hospital (SVMH) campus and surrounding buildings and offices where SVMH staff and/or services are present.

E. There is evidence in the personnel/education files, e.g., orientation checklist or elsewhere, indicating that all new employees have been oriented to the program and procedures within a reasonable time after commencement of their employment.

~~A.~~

~~VI.~~V. PROCEDURE:

A. **Obtaining and relaying information**

1. Any employee who learns of an occurrence that might constitute a Mass Casualty Incident (MCI) should attempt to obtain the following information:
   - What was the occurrence?
   - What is the location of the occurrence?
   - How many casualties are estimated?
   - What type of injuries?
   - How many victims should the hospital expect and when?
   - The goal of Code Triage MCI is to be prepared to receive patients within 15 minutes.

2. An employee who learns of the occurrence must notify the Emergency Department at ext. 4355, Hospital Administration at ext. 1241 or during off hours and weekends the Administrative Supervisor on duty through the operator. After hours, it is the responsibility of the Administrative Supervisor to consult with the emergency department physician and charge nurse to determine if the event requires activation of the MCI plan. The following people have the authority to activate the MCI plan: Emergency Department physician, Emergency Department Director/Manager, Administrative Supervisor, Executive on site or on call. Any activation of the MCI plan should also call for an activation of the Hospital Incident Command System (HICS).

B. **Activation of the MCI plan**

1. Activation of the MCI plan should be done by overhead page as “Code Triage External, MCI.”
2. Activation of the MCI plan can be done in 3 levels depending on the nature and significance of the event.

Level 1: Unusual event, MCI with either mostly stable, low acuity victims or limited number of victims. Minimal to moderate response is needed. Portions of HICS may be activated.

Level 2: Large scale event or hospital emergency that will be involving multiple departments and will necessitate additional staff and resources. A level 2 event will likely involve multiple critical or unstable patients (or the potential for), and complicating factors such as decontamination. Moderate to full response is needed including partial to full activation of HICS.

Level 3: Major disaster that requires full activation of HICS and an "all hands on deck" response from the organization. A level 3 event will include an overwhelming number of patients, many of which will be traumas, critical, medically complicated, and worried well. It will likely include other complicating factors such as decontamination, alternate triage sites, and expanding treatment areas into other departments or outside. Assembly of tents in adjacent parking lots may also be necessary to accommodate the expansion of triage and treatment areas and staging areas. A level 3 event will likely include multiple outside agencies such as EMS, law enforcement, fire departments, media, etc. A Joint Incident Command may also be necessary in the Incident Command Center (ICC).

Phases: The MCI plan consists of three distinct phases:
Phase I: Alert of a possible event
Phase II: The actual event when parts, or all of the plan, is activated
Phase III: Demobilization

C. **MCI MANAGEMENT**

1. Once the MCI plan has been activated, the emergency notification system will be activated at the direction of the Incident Command Center (ICC). Each department will then activate their emergency response plans under administrative control of the ICC.

   a. The **Casualty Care Unit Leader** or appointee will remain in command of all available medical and surgical personnel and like resources during the event. The on duty Emergency Department physician will act as the Casualty Care Unit Leader until the ICC is operational.

   b. The **Administrative Supervisor** on duty will be responsible for establishing the ICC, assuming the role of incident commander, and initiating necessary protocols.
      - The Administrative Supervisor on duty shall remain in the ICC and remain in the role of the incident commander until relieved.
      - This role will include management of disaster operations as outlined in the Emergency Operations Plan (EOP) and Emergency Management Plan (EMP). This role shall not be superseded by an authority or directive from outside agencies involved with the event without consent from hospital administration.
      - The role of the incident commander may be assumed by the CEO or other Executive upon arrival to the hospital

c. **Decontamination**

Upon notification or suspicion that the event has a hazardous materials component and patients will need decontamination, the decontamination trailer will be utilized for all patient decontamination needs. The Liaison Officer or designee will contact the Monterey County EMS hazardous response team or other applicable agency to obtain the identity of the hazardous material involved, and attempt to obtain a copy of the Safety Data Sheet (SDS). If SDS has been received, or the material identified through other means, review with all SVMH responders before patient decontamination is initiated to ensure responding staff are aware of the potential hazards of the material involved, and have ensured they have donned the appropriate PPE to ensure their safety. The trailer should be opened and assembled on notification. Engineering will be notified to assist with infrastructure needs to support decontamination. Security will be notified for access control needs and patient belonging documentation. The Environmental Health and Safety Manager will coordinate waste water management in collaboration with the Monterey County Environmental Health and Safety Hazardous Materials Department and Monterey One. Patients contaminated with hazardous materials shall be decontaminated to the best of the hospital's ability and supplemented by one of Monterey County's EMS hazardous materials response teams if needed and available. At this time the responding agency must be represented in the ICC, if applicable, or a liaison from the ICC should be appointed to represent outside agencies under the Liaison Officer**.** At no time shall contaminated patients enter the Emergency Department until they have been decontaminated as this will compromise other patients, staff, and treatment areas inside. All contaminated patient belongings will be stored in the patient belonging bags, labeled, and secured in the locking storage box. Cleaning and return of patient belongings will be subject to the safety officer or designee discretion. If necessary, the decontamination certified Emergency Department team members can perform resuscitation efforts simultaneously with decontamination.

d. **Emergency Department MCI carts, Surge Kit and Triage Tags**

Upon activation of the MCI plan the MCI cart will be brought to the front entrance of the Emergency Department and immediately deployed. The MCI cart is located in the "MCI Response" storage shed near the front entrance of the Emergency Department. The MCI carts contain the Surge Kit (including treatment area equipment and assignments), Triage Ribbons and Tags.

Treatment Area Assignments
Red: MD, RN, RN, CA/Tech
Yellow: MD, RN, RN, CA/Tech
Green: PA, RN, CA/Tech

Emergency Department Surge Kit

- The Surge Kit contains the equipment for the pre-designated color coded treatment areas (Red, Yellow, Green, Black). It also contains specific duties and responsibilities to be accomplished immediately when the MCI plan is activated. Refer to the EOP for fatality management. Corresponding color coded vests and job action sheets are included for the following:

  Triage Unit Leader
  Casualty Care Unit Leader
  Transportation Unit Leader
  Immediate Treatment Manager
  Delayed Treatment Manager
  Minor Treatment Manager
  Expectant Manager
  Incident Commander
  Safety Officer
  Patient Registration Unit Leader
  Access Control Unit Leader
  Family Unification Unit Leader
  Patient Tracking Manager

Triage Tags and Ribbons

- Triage Ribbons are to given to the Triage Unit Leader to assign incoming patients to an acuity category based on the START/JumpSTART model.
- The Triage Tags are to be opened and given to assigned personnel in the designated treatment areas.
- The Triage Ribbons and Tags are to be deployed and ready at the time of notification and activation of the MCI plan, ideally before patients arrive to the emergency department.

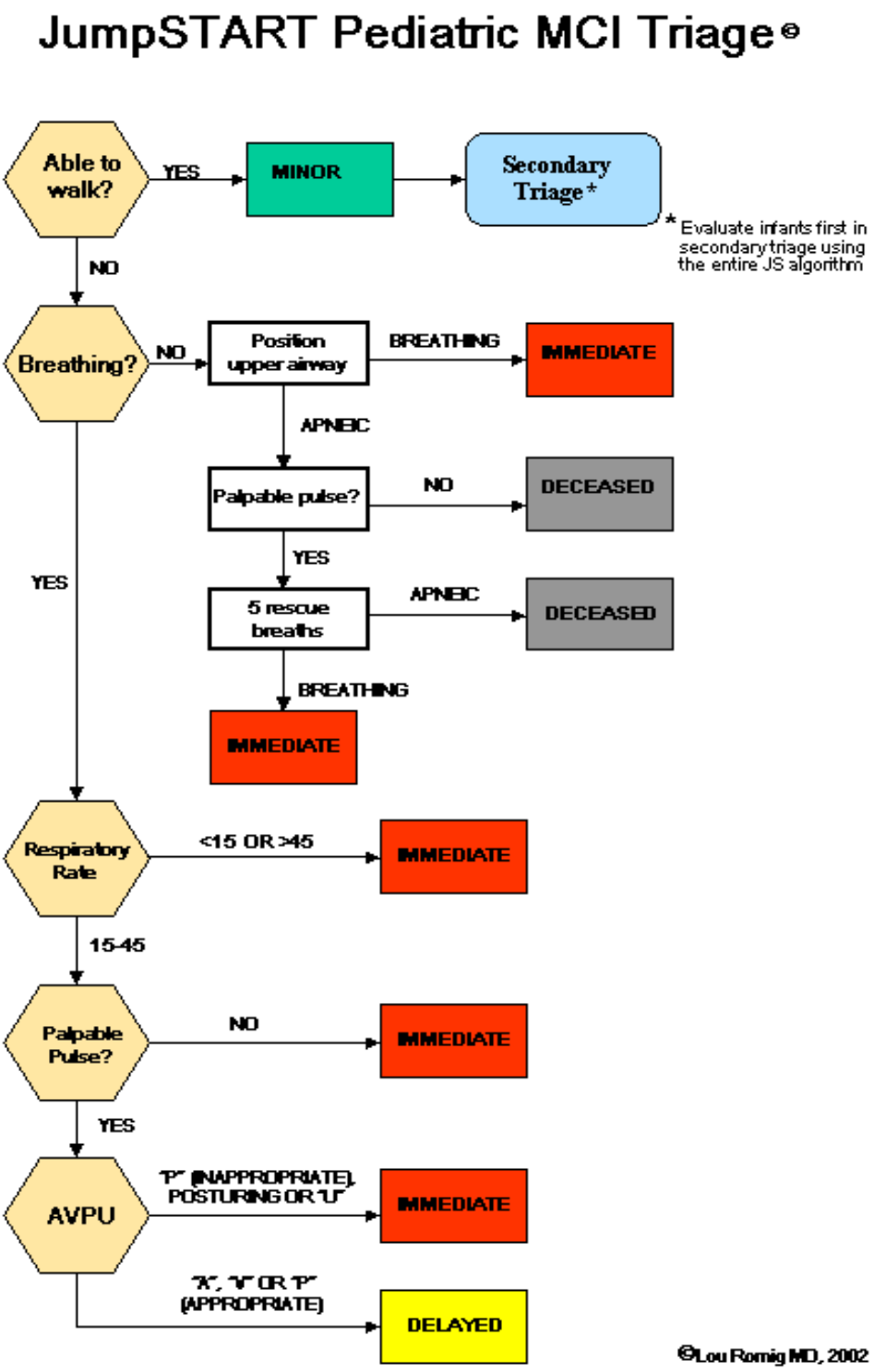
START and JumpSTART Triage

The Simple Triage And Rapid Treatment (START) and JumpSTART (pediatric version) models may be used. The Triage Unit Leader and team of triage nurses will assign patients on arrival to one of the standard four color categories and dispatched them accordingly:

- **Green:** minor injuries that can wait for appropriate treatment. "Green" patients will be placed in the minor treatment area.
- **Yellow:** significant injuries but relatively stable patients that can wait for medical attention. No life threatening conditions. "Yellow" patients will be placed in the delayed treatment area.
- **Red:** critical patients in need of immediate intervention and/or resuscitation. "Red" patients will be placed in the immediate treatment area.
- **Black:** deceased patients or those who have little to no chance of survival. "Black" patients will be taken to the morgue.

START Triage (adult)

Color	Acuity	Treatment	Description/Comments
Red	Emergent	Immediate	Threat to life, limb, or organ
Yellow	Urgent	Delayed	Significant injury or illness but can tolerate a delay
Green	Non-Urgent	Minimal/Non-urgent	Can safely wait for treatment
Black	Deceased or Expected	No treatment expected: Treat only if resourced available	Consider transport and care for expectant patients after “Reds” are cleared, if resources exist and does not delay care of “Yellows”*



Neurological Assessment

"A" =Alert

"V"= Responds to verbal stimuli

"P" =Responds to painful stimuli

"U" =Unresponsive to noxious stimuli

SVMH offers palliative care services and should be requested through the ICC or Medical Staff Office.

D. ROLES AND RESPONSIBILITIES

1. **Security**

   When the MCI plan is activated hospital security officers should secure the perimeter around the event. In the event of a hazardous material exposure this will help ensure safety of other patients, visitors and hospital personnel and avoid contamination of the treating facility. No passersby or media shall be allowed to enter the perimeter unless instructed by the ICC or unless someone is seeking medical attention. Anyone seeking medical attention shall be directed to the designated triage area. All entrances to the emergency department should be secured. All family and visitors seeking information or wishing to see loved ones should be directed to the Family Reunification Unit Leader. The ICC will assign a family reunification location and a liaison to provide information to family and visitors.

2. **Registration of Patients**

   During a declared MCI (activation of the MCI plan) patients involved in the MCI, regardless of their involvement, should not be registered on arrival in Meditech. Patients are sorted according to the START and JumpSTART model and tagged as appropriate with triage tags. They are to be tracked using the tracking log located in the surge kit. Patients that have been determined stable for discharge are to be discharged from the discharge area adjacent to the treatment areas. These patients should be fully registered then discharged in Meditech at this time. Patients that need ongoing complicated medical care should be moved into the Emergency Department and registered into Meditech.

3. **Nursing Services**

   An assigned Nursing director or, during off hours, an additional administrative supervisor or director, will be responsible for coordinating and dispatching nursing and support services to all routine and disaster care-related hospital areas, per the priorities established through the ICC. Specific initial duties include:

   - Conduct accurate bed count for available Med/Surg beds
   - Conduct accurate count of available ICU/Progressive Care/ Isolation beds
   - Contact the Director of Perioperative service to assess readiness of
   - OR and recovery rooms
   - Coordinate with inpatient services the evaluation of patients who can be rapidly discharged from inpatient services.
   - Ensure ED Charge nurse has needed staff and resources including transporters, interpreters, registration clerks, volunteers, etc.

   ~~**It is essential that inpatient nurses and nurses' aides**~~**aides' backfill** ~~**Emergency Department nurses at a ratio of at least 1:1 for every Emergency Department nurse that responds to the outside treatment areas. This**~~

~~**information is coordinated through the Medical Care Chief and Operations Chief in the Incident Command Center.**~~

4. **Support Services**
   The Incident Commander will be responsible to ensure the departmental disaster plans are activated and appropriate staff and supplies are brought to the ED, OR and other areas as needed.

   - **Materials Management:** Additional supplies will likely be needed to the ED. Assign dedicated Materials Management personnel to the ED to bring required supplies and equipment to the ED. An MCI supply cart is locate in SPD with supplies that can be deployed to outside staging areas.
   - **Blood Bank:** The Blood Bank is alerted to the MCI by the overhead paging system and will coordinate the distribution of blood and contact outside blood banks if necessary.
   - **Pharmacy:** Dispatches required personnel and medications to the ED. Also prepares for use of possible antidotes in Hazmat and Biohazard incidents.
   - **Radiology**: Dispatches two technicians to the ED with portable equipment if available. Also postpones non emergent diagnostic imaging requests to accommodate the MCI response. Ensures rapid availability of CT scanner, including the outside CT scanner, ultrasound and other diagnostic imaging services.
   - **Transport Services:** Bring all available gurneys and wheel chairs to ED.
   - **Respiratory:** A Respiratory Care Practitioner reports to the ED and the supervisor should compile a list of available ventilators, additional oxygen tanks and nebulizer sets and report this information to the ICC.
   - **Lab services:** Should be prepared to receive a large influx of requests and should deploy available phlebotomists to the treatment areas.

5. **Discharge Planning**
   A discharge staging area will be established adjacent to the Minor (Green) treatment area. Patients determined to be stable for discharge will be moved to this area and will be discharged by a discharge planner. Taxi vouchers and bus passes should be considered to decongest the area. A discharge planning kit is assembled and available in the MCI shed.

6. **Public Relations and News Media**
   At no time will the media be allowed unescorted through any patient care or treatment area. Hospital security will direct all media to the designated media area in the Downing Resource Center (DRC) or an alternate site will be designated by the ICC. If multiple agencies and/or facilities are involved a joint information center will likely need to be established at the Monterey County Office of Emergency Services.

7. **Volunteer and Labor Pool Management**

- Medical volunteers (physicians, surgeons, physician assistants) will be screened for emergency credentialing and coordinated through the medical staff office.
- All other clinical and ancillary volunteers will be screened for emergency credentialing and coordinated through Human Resources which is represented under the Operations section of the Hospitals Incident Command System.
- Refer to the Salinas Valley Memorial Hospital EMERGENCY OPERATIONS PLAN for more detailed labor pool management plans.

8. **De-escalation**
   The ICC will authorize telecommunications to give the "Code Triage, all clear" via the overhead paging system when the event has been declared over. It is the incident commander's responsibility to call for de-escalation and to deactivate the EOP and MCI plans. The Triage/Receiving area and MCI treatment areas will be deactivated at the direction of the ICC. This shall be done only after consultation with the ED physician and ED charge nurse.

9. **Recovery Phase**
   - Continue to assist employees and community with psychological needs
   - Assist employees with employee assistance programs through Human Resources department
   - Collect MCI documentation sheets and return to ICC
   - Perform debriefing (involve staff and outside agencies). This is the responsibility of the Incident Command team
   - Submit written evaluation of incident to Emergency Management Committee for review
   - Integrate improvements into the Emergency ~~Management~~Operations Plan and into departmental plans or procedures as needed.

~~VII.~~VI. REFERENCES:

A. Title 22 70413 and 70741 45

Salinas Valley Memorial Healthcare System

ENDOSCOPE HANDLING, REPROCESSING AND STORING

Reference [NBR1] ***Number***	2173
Effective Date	Not Approved Yet
Applies To	ENDO
Attachments/Forms	Attachment A: Scope Processing Procedure Log
Related Policies	ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS

I. POLICY STATEMENT:

A. N/A

~~A. SVMH uses the "SCOPE BUDDY" to flush endoscopes to ensure employee safety and scope flushing consistency by using an automated pump to flush endoscopes with the required volume of fluid.~~
~~B. SVMH will follow current manufacturer guidelines for utilization of SCOPE BUDDY.~~
~~C. SVMH will follow current manufacturer guidelines for use & maintenance of Automated Endoscope Repressor (AER).~~

II. PURPOSE:

A. To assure proper processing of endoscopes between patients.

III. DEFINITIONS:

A. e SCOPE BUDDY™ Endoscope Flushing Aid reduces the risk of repetitive motion injuries by providing continuous, hands-free channel flushing. With a simple one-touch operation, Scope Buddy quickly and quietly delivers fluids to endoscope channels.
B. AER – Automated Endoscope Reprocessor
C. ATP – Adenosine Triphosphate.
D. EPA – Environmental Protection Agency
E. IFU – Instructions for Use.
F. PPE – Personal Protective Equipment

IV. GENERAL INFORMATION:

A. SVMH uses the "SCOPE BUDDY" to flush endoscopes to ensure employee safety and scope flushing consistency by using an automated pump to flush endoscopes with the required volume of fluid.
B. SVMH will follow current manufacturer guidelines for utilization of SCOPE BUDDY.
C. SVMH will follow current manufacturer guidelines for use & maintenance of Automated Endoscope Repressor (AER).

~~A. N/A~~

~~II.~~V. **PROCEDURE:**

A. Personal Protective Equipment (PPE)

1. All Salinas Valley Memorial Hospital (SVMH) healthcare workers involved in the processing of endoscopes and ancillary equipment will wear gloves, fluid resistant gowns face protection and protective eyewear.

~~1.~~2. Hands will be washed just prior to donning and after doffing of PPE~~removing gloves~~.

B. Scope Cleaning

1. Decontamination of endoscopes begins at the end of procedure. The cleaning is done in accordance with the "Point of Use Decontamination" competency.

2. Immediately after use, the contaminated endoscope will have water with detergent suctioned through it until secretions and debris are no longer present in the water. The air water channel will be cleared by depressing the air/water valve. The exterior of the endoscope will be wiped down with a sponge soaked with hospital approved detergent per manufacturer's guidelines. Remove suction and biopsy valves from the scope.

~~2.~~3. An enzyme detergent will be utilized for cleaning all endoscopes and accessories, following the manufacturer's guidelines for use.

4. EPA-registered liquid sterilants/disinfectant solution and hospital approved high level disinfectant per manufacturer's recommendations for reprocessing of

endoscopes, will be utilized for all endoscopes and compatible accessories for high level disinfection[CP2].

~~a. Staff Education: All SVMH employees responsible for endoscope reprocessing will receive in-depth training on cleaning and processing endoscopes and accessories (per manufacturer guidelines) as part of the orientation to the department.~~

~~i. A company representative from the manufacturer(s) will be scheduled to come out annually and give an in-service on endoscope reprocessing for existing SVMH staff who require annual re-education.~~

5. All endoscopes and accessories will be thoroughly cleaned prior to application of any method of high-level disinfection and/or sterilization.

~~3.~~ All endoscopes and accessories will be inspected for damage and/or water leaks and will be removed from service if damage has occurred that renders the equipment inoperable or poses a threat to the well-being of patients.

C. Procedure for Decontamination of Endoscopes

1. **All endoscopes will be cleaned at termination of procedure using the hospital approved detergent/disinfectant per manufacturer's guidelines as described in the point of use competency.** DISINFECTION OF INSTRUMENTS/SCOPES **#586**

2. Manual Cleaning

a. The endoscopes will be cleaned in accordance to the endoscope manual cleaning competency. The manufacturers IFU are followed for each model of endoscope.

~~a.~~b. A "Scope Buddy" will be used per competency education/validation as part of leak testing during the manual cleaning process of endoscopes.

~~b.~~c. Add enzymatic cleaner to the designated sink, at the 7 gallon sink line (follow manufacturer guidelines of enzymatic cleaner for concentration, i.e. pumps per gallon).

~~c.~~d. Using the impregnated 4x4 gauze thoroughly wash the entire length of the endoscope tube, beginning with the area nearest the control body.

~~d.~~e. Utilizing a cleaning brush, clean the various orifices until clean. Insert the brush through the biopsy channel and brush the entire length of the channel.

When the brush protrudes from the distal end of the insertion tube, clean the brush in the cleaning solution and withdraw the brush. This process should be repeated at least twice or until no particulate matter is noted on the brush. Repeat the procedure for cord and the distance from the suction channel to the biopsy channel.

3. Test for cleaning efficacy

~~a.~~

~~b.~~a. The cleaning efficacy will be tested prior to placing endoscopes in the ~~automated endoscope reprocessor (~~AO~~ER.)~~

~~c.~~b. The Adenosine Triphosphate (ATP) testing is done using "Clean Trace." This procedure is done to test the cleaning efficacy of the exterior and the lumens of the endoscope.

~~d.~~c. The Test is done in accordance with the Clean Trace competency.

~~3.~~4. Use AER in accordance with manufacturer's IFU and AER competency to "high level" disinfect endoscopes.

D. Transport (pre and post procedure)

1. **PRE-PROCEDURE**

   a. Obtain a clean cart, transport bin, and a pack of scope liners (clear, green, and red).
   b. Perform hand hygiene procedure prior to donning gloves and PPE.
   c. Open the pack of scope liners and line the transport bin with the clear liner.
   d. Pick up the clean scope by its distal head and place it into the transport bin.
   e. Place the red liner into the transport bin, cover the bin by placing the green liner over the top, making sure that the bin is tightly sealed.
   f. Transport the scope using the clean cart to the procedure site.
   g. Re-perform hand hygiene procedure, don clean gloves and PPE, and attach suction and biopsy valves to the scopes prior to the procedure.

2. **POST-PROCEDURE**

   a. After procedure, please follow the "Point of Use" competency "~~B. Scope~~ Cleaning."
   b. Remove the red liner (to be used later to cover the bin).

c. Place dirty scope, including the suction and biopsy valves, into the transport bin.
d. Remove gloves and PPE and perform hand hygiene.
e. Cover the transport bin by placing the red biohazard marked red liner over the top of the bin, making sure a tight seal has been established.
f. Transport scope back into the Processing Room following the proper workflow for reprocessing.

E. Storage

1. Flexible endoscopes should be stored in a manner that protects the device from damage and minimizes microbial contamination.

   a. Flexible endoscopes should be stored in a closed cabinet with:
      - Venting that allows air circulation through lumens around the flexible endoscopes;
      - Internal surfaces composed of cleanable materials;
      - Adequate height to allow flexible endoscopes to hang without touching the bottom of the cabinet, and
      - Sufficient space for storage of multiple endoscopes without touching;
      - Hanging in a secure vertical position;
      - With all removable endoscopes components (e.g. valve mechanisms, biopsy valve covers, irrigation tubes) detached;
      - With all accessories removed; and
      - With scopes protectors applied if the protector does not interfere with the flexible endoscopes hanging straight or restrict the air movement around the channel openings.
   b. Flexible endoscopes should not be stored in the original shipment cases.
   c. Flexible endoscopes should be reprocessed before each use if unused for more than seven days.
   d. Flexible endoscopes should be reprocessed before use if evidence of improper drying exits (e.g. evidence of discoloration, wet spots, or stains, or soil in the storage cabinet) when the scope is removed from storage.
   e. Storage cabinets should be cleaned and disinfected with an EPA registered disinfectant when visibly soiled and on a weekly or monthly basis.

F. Documentation:

ENDOSCOPE HANDLING, REPROCESSING AND STORING

1. Daily checks and prior to use checks will be documented daily and kept readily available in room where cleaning & disinfection and scope buddy are being used.
2. A unit designated RN will check documentation daily and will do unannounced spot checks weekly.
3. All SVMH employees responsible for endoscope reprocessing will receive in-depth training on cleaning and processing endoscopes and accessories (per manufacturer guidelines) as part of the orientation to the department.
4. All SVMH employees responsible for endoscope reprocessing will have an annual competency skills review with a nurse competency tester.
5. A company representative from the manufacturer(s) may be scheduled to come out annually and give an in-service on endoscope reprocessing for existing SVMH staff who require annual re-education.

~~III. **POLICY**~~

~~D. SVMH uses the "SCOPE BUDDY" to flush endoscopes~~

~~A. Purpose~~

~~a. To ensure employee safety and scope flushing consistency by using an automated pump to flush endoscopes with the required volume of fluid.~~

~~B. Procedure~~

~~b. SVMH will follow current manufacturer guidelines for utilization of SCOPE BUDDY.~~

~~C. Use of the Endoscope Reprocessor~~

~~c. Will follow current manufacturer guidelines for use & maintenance of Endoscope Repressor.~~

ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS

VI. EDUCATION/TRAINING:

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

~~A. All SVMH employees responsible for endoscope reprocessing will receive in-depth training on cleaning and processing endoscopes and accessories (per manufacturer guidelines) as part of the orientation to the department.~~

~~All SVMH employees responsible for endoscope reprocessing will have an annual competency skills review with a nurse competency tester.~~

~~A company representative from the manufacturer(s) may be scheduled to come out annually and give an in-service on endoscope reprocessing for existing SVMH staff who require annual re-education.~~

VII. REFERENCES:

A. American Society of Gastroenterologist (AGA). "Multi-society guideline on reprocessing flexible gastrointestinal endoscopes: 2011"
B. Society of Gastroenterology Nurses and Associates, Inc. "Standards of Infection Control In Reprocessing of Flexible Gastrointestinal Endoscopes"
C. CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities ~~2008~~

https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

Salinas Valley Memorial Healthcare System

ENDOSCOPE HANDLING, REPROCESSING AND STORING

ATTACHMENT A
SCOPE REPROCESSING PROCEDURE LOG

Patient Name/MR#	Procedure date, time	Type of procedure	MD doing procedure	Type of Scope/model	Serial Number of scope	AER #	Signature of staff, date and time	AER strip

Salinas Valley Memorial Healthcare System

SCOPE OF SERVICE: RESPIRATORY, NEURODIAGNOSTICS AND SLEEP MEDICINE

Reference Number	6590
Effective Date	Not Approved Yet
Applies To	
Units	Respiratory, Neurodiagnostics and Sleep Medicine

I. SCOPE OF SERVICE

The Respiratory Care, Neurodiagnostics and Sleep Medicine Departments support the Mission, Vision, Values and Strategic Plan of Salinas Valley Memorial Healthcare System (SVMHS) and have designed services to meet the needs and expectations of patients, families and the community.

The purpose of the Respiratory Care, Neurodiagnostics and Sleep Medicine Departments is to enhance patient services and health programs that help Salinas Valley Memorial Healthcare System remain a leading provider of medical care. The goal of the Respiratory Care, Neurodiagnostics and Sleep Medicine Departments is to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible.

II. GOALS

In addition to the overall SVMHS goals and objectives, the Respiratory Care, Neurodiagnostics and Sleep Medicine Departments develop goals to direct short term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goals of Respiratory Care, Neurodiagnostics and Sleep Medicine Departments are:

1. To provide therapeutic, diagnostic and educational modalities to inpatients and outpatients of all acuity levels and all age groups.

2. To provide comprehensive diagnostic testing for Neurodiagnostic and Sleep Medicine Department inpatients and outpatients, in a manner that is both cost effective and patient care oriented.

3. To provide comprehensive diagnostic testing for Neurology, sleep disorder patients and newborn hearing screening, for inpatients and outpatients of all ages, in a manner that is both cost effective and patient care oriented.

Salinas Valley Memorial Healthcare System

SCOPE OF SERVICE: RESPIRATORY, NEURODIAGNOSTICS AND SLEEP MEDICINE

III. DEPARTMENT OBJECTIVES

A. To support Salinas Valley Memorial Healthcare System objectives.
B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.
C. To plan for the allocation of human/material resources.
D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.
E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
F. To evaluate staff performance on an ongoing basis.
G. To provide appropriate staff orientation and development.
H. To monitor Respiratory, Neurodiagnostics and Sleep Medicine Departments function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Respiratory Care provides services for the following departments:

1. All Acute Inpatient Services –including Emergency Department, Pulmonary Function Testing
2. All Outpatient Services provided under SVMH
3. Community Education
4. Pulmonary Rehabilitation

Neurodiagnostics and Sleep Medicine Departments provide care for the following patient population in the inpatient and outpatient setting.

1. Sleep Medicine- male and female patients 6-106 years of age.
2. Neurodiagnostics (AABR) newborns
3. Neurodiagnostics (EEG) male and female patients of all ages.

Respiratory Care provides care for infant, pediatric, adolescent, adult and geriatric patients (edit as necessary).

Salinas Valley Memorial Healthcare System

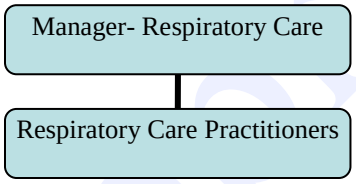
SCOPE OF SERVICE: RESPIRATORY, NEURODIAGNOSTICS AND SLEEP MEDICINE

Sleep Medicine patient population consists of male and female patients of all age groups (neonates through geriatrics). Services are provided to outpatients and inpatients of all acuity levels.

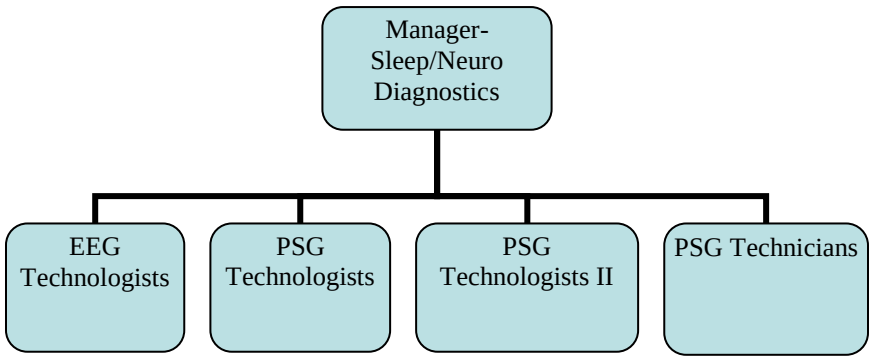
~~V.~~ ORGANIZATION OF THE DEPARTMENT ~~(include organizational chart)~~

A. Hours of Operation

1. The Respiratory Care Neurodiagnostics and Sleep Medicine Department provides services Twenty-four (24) hours/day; 365 days/year. The unit consists of one (1) pulmonary function lab and (2) offices and storage rooms. Community educational services provided include COPD (Chronic Obstructive Pulmonary Disease) and Asthma Programs. Most services are provided for inpatients at the bedside.



2. Neurodiagnostics-EEG operates nine (9) hours, five (5) days per week for both inpatients and outpatients.
3. EEG operates nine (9) hours, five (5) days per week for both inpatients and outpatients.
4. Sleep Disorder Dept. operates twelve (12) hours, seven (7) nights per week for testing and eight (8) hours, M-F for daily operations. Sleep Disorder Lab operate twelve (24) hours, seven (7) days per week for scheduled outpatient.
5. Newborn hearing screening operates 8 hours, seven (7) days per week as needed for both inpatients and outpatients
6. Neurodiagnostics- AABR (newborn hearing) operates eight (8) hours, seven (7) days per week as needed for inpatients and outpatients.



Salinas Valley Memorial Healthcare System

SCOPE OF SERVICE: RESPIRATORY, NEURODIAGNOSTICS AND SLEEP MEDICINE

B. Location of departments:

Inpatient EEG and newborn hearing testing is performed at patient bedside.
Outpatient EEG testing is performed at offsite sleep center
At 120 Wilgart Way Salinas, CA 93901

The off-site Sleep Center is a (10) bed center located at 120 Wilgart Way.

~~The in-house neurodiagnostic laboratory consists of one EEG room located in the CDU, room #522. The off-site Sleep Center is a seven (7) bed center located at 120 Wilgart Way. In-patient EEG's; out-patient EEG's, out-patient AABR and out-patient Evoked Potentials are performed in room #522.~~

C. Admission Discharge, Transfer Criteria (if applicable)

This is an Outpatient/Ambulatory department where patients have lifetime outpatient accounts. Patients receive treatment and are "arrived" for their appointment and "departed" after treatment. If the patient requires a higher level of care 911 is called and patient is transferred to the Emergency Department.

D. Major Services / Modalities of care include:

Respiratory Care Services are provided based upon patient assessments, plans of care and medical staff orders. Therapeutic, diagnostic, educational, palliative and lifesaving modalities provided include:

1. Medication Nebulizer Treatments
2. Medication Nebulizer/Heated Aerosol Treatments
3. Metered Dose Inhaler Administration
4. Metaneb Treatments
5. Oxygen Therapy
6. Humidity Therapy
7. Postural Drainage/Chest Percussion/IPV
8. Nasotracheal/Endotracheal Suctioning
9. Code Blue/CPR Services/ RRT (Rapid Response Team)
10. BiPAP
11. CPAP

SCOPE OF SERVICE: RESPIRATORY, NEURODIAGNOSTICS AND SLEEP MEDICINE

12. Pulmonary Function Studies (PFT Lab)
13. Pulmonary Function Screens (Bedside)
14. Stat ECG (after hours when ECG tech not in house)
15. Mechanical Ventilator Support / Management
16. Bedside Bronchscopy (Assist in ICU / CCU)
17. Transport Ventilator (Adults) Internal / External
18. Bronchial Hygiene
19. Patient and Community Education
20. COPD (Chronic Obstructive Pulmonary Disease) Education Program
21. Asthma Education Programs
22. Point-of-Care Testing/Arterial Blood Gas Collection and Analysis
23. Arterial catheterization
24. Intubation
25. Metabolic studies

Patient Education (In-House)

1. Asthma
2. Acute Bronchitis
3. COPD (Chronic Obstructive Pulmonary Disease)
4. Continuous Positive Airway Pressure (CPAP)
5. Metered Dose Inhaler
6. Peak Flow Meter
7. Smoking Cessation
8. Pulmonary Rehabilitation
9. Other Respiratory education as needed by patient

Level III NICU

1. Medication Nebulizer Treatments
2. Ventilatory Support / Management
3. Surfactant Therapy
4. Intubation
5. High Risk C-Sections
6. Oxygen Therapy
7. Chest Percussion
8. NICU Transport
9. Systems, services and patient care are evaluated to determine their timeliness, appropriateness, clinical necessity, and the extent to which the level of care or services provided meets the patients' needs through any one or all of the following quality improvement practices:

10. Multidisciplinary Performance Improvement Teams

Evaluation of Services:

1. EEG/Awake
2. EEG/Asleep
3. Evoked Potentials:, VEP
4. AABR, newborn hearing screening is performed to detect hearing losses in newborns so that follow-up hearing intervention can be performed
5. Attended PSG
6. Positive Airway Pressure Titration
7. Supplemental O2

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

A. The Respiratory Care unit consists of one (1) pulmonary function lab and (2) offices and storage rooms. The client population consists of male/female patients of all age groups (neonates through geriatric). Most services are provided to the patient at bedside. Services are provided to outpatients and inpatients. Community educational services provided include COPD (Chronic Obstructive Pulmonary Disease) and Asthma Programs.
B. The Respiratory Care treatment team is comprised of either registered or certified respiratory care practitioners licensed by the State of California, nursing staff, medical staff and support services according to the needs of the patient.
C. The Senior Administrative Director and Manager assume twenty-four (24) hour responsibility for respiratory care provided at SVMH. The leaders of this area are directly responsible to the Chief Operating Officer with oversight also provided by the Medical Director and Laboratory Director. It is the Senior Administrative Director's or their designee duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Manager. In the Manager's absence, the position is filled by the Senior Administrative Director or their designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.
D. The Neurodiagnostic Department provides diagnostic testing for epilepsy, head injuries, mental and maturation delay, spinal cord injuries, and neurology disorders/diseases. Portable EEG testing is performed at the bedside for suspected electrical cerebral silence diagnosis. Evoked potential studies test peripheral nerve conductivity, spinal nerve conductivity and cerebral cortex diseases and injuries.
E. The Sleep Disorders Center performs diagnostic testing for a variety of sleep disorders (obstructive sleep apnea, central sleep apnea, restless leg syndrome, hypersomnias, narcolepsy, and other diagnoses). The center also performs therapeutic

studies to treat obstructive sleep apnea, central apnea, and obesity-hypoventilation syndrome with positive pressure ventilation.

F. Sleep Medicine Outpatient Care is delivered by a multidisciplinary team comprised of medical staff and ancillary support according to the needs of the patients. The Sleep Medicine Center Manager assumes twenty-four hour responsibility for all personnel and care within the department. The Manager is directly responsible to the Senior Administrative Director of Cardiopulmonary services. It is the Manager's duty to attend all administrative and technical functions within the department. In the Manager's absence, the position is filled by the Senior Administrative Director of Cardiopulmonary services or designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.

G. AABR/EEG: A multidisciplinary team consisting of one (1) Neurodiagnostics Manager, two (2) EEG techs, and two (2) Neurodiagnostic Assistants.

H. POLYSOMNOGRAPHY: A multidisciplinary team consisting of one (1) Sleep Center Manager who is a Registered Sleep Tech, and/ Respiratory Care Practitioner, six (6) Registered Polysomnography Techs, and one (1) Certified Polysomnography Tech.1:1 patients: Certain patients will be flagged by management as 1:1 patients. This means that under normal circumstances, the tech assigned to this patient will only have this one patient. The patient populations most likely to be flagged in this manner are: Patients with severe developmental delay, patients under eight years old, patients with tracheotomies, patients with neuromuscular disorders, and certain types of non-ambulatory patients.
    - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged 1:1 that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions

I. High Acuity Patients: Certain patients will be flagged by management as high acuity patients. This means that under normal circumstances, it is preferable to not have the tech working alone on this particular shift. The types of patients most likely to be flagged as high acuity are from the patient populations listed above in the 1:1 section, as well as patients with severe mood disorders, patients with severe anxiety, and patients at high risk for coronary events. High acuity flagging differs from 1:1 flagging in that a tech assigned a high acuity patient will not necessarily have just one patient.
    - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged high acuity that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions.

Salinas Valley Memorial Healthcare System

SCOPE OF SERVICE: RESPIRATORY, NEURODIAGNOSTICS AND SLEEP MEDICINE

~~VII.~~VI. REQUIREMENTS FOR STAFF

All individuals who provide patient care services are licensed ~~or~~ AND registered (according to applicable state law and regulation) and have the appropriate/adequate training and competence including how to maintain a safe work environment.

A. Licensure / Certifications:

The basic requirements for ***Respiratory Care Practitioners*** include:

1. License by the State of California and
2. Certified or Registered through the NBRC (National Board of Respiratory Care)
3. Current BCLS
4. Current ACLS
5. Current NRP

The basic requirements ~~for ***Manager***~~for ***Manager*** include:

1. Current BLS
2. Registered Polysomnographic Technologist (RPSGT) and/or Registered Respiratory Therapist (RRT) Certification
3. Completion of competency based orientation
4. Completion of annual education

The basic requirements for ***Sleep Technologists*** include:

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

The basic requirements for ***Electroencephalography (EEG) Techs and Automated Auditory Brain Stem Response (AABR) Techs*** include:

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

Education and training of PSG technician II, RPSG Technologist II or Sleep Center Specialist is provided through department orientation and/or annual competencies. All sleep technicians and technologists are required to have a minimum of 10 continuing education hours a year, or 50 per 5 years. Any new technicians/technologists to the

center are required to reach 30 CE units in their first 3 years. CE units can be obtained ~~at our monthly physician lectures, or~~ from conferences sponsored by AASM, AAST, BRPT, RCB, or some other approved legislative body.

B. Competency

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

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from the conferences with other staff members at in-services. Additional teleconferences, 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-services evaluation forms, and in person.

D. Continuing Education

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

~~VIII.~~VII. STAFFING PLAN

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

General Staffing Plan:

The Respiratory Care Department flexes the staffing to meet the patient acuity level based on the number of respiratory care procedures. When respiratory care procedures exceeds the available staff, attempts are made to secure additional staffing. When necessary, overtime is used. If the variance in staffing continues, the prioritization policy will be utilized.

General Staffing Plan for Sleep Medicine Center and Neurodiagnostics

- An onsite staffing ratio of 2:1 is maintained during patient care hours.
- Flex Staffing a) ~~A~~a sleep technologists to patient ratio of 1:2 is the minimum for all sleep studies.
- Explanations: When units of service decrease, staff is canceled. When units of service increase, hours are rotated to cover testing. Outpatients can be rescheduled. Overtime is used only when necessary.
- AABR/EEG: A multidisciplinary team consisting of one (1) Neurodiagnostics Manager, two (2) EEG techs, and two (2) Neurodiagnostic Assistants.
- POLYSOMNOGRAPHY: A multidisciplinary team consisting of one (1) Sleep Center Manager who is a Registered Sleep Tech, and/ Respiratory Care

Practitioner, six (6) Registered Polysomnography Techs, and one (1) Certified Polysomnography Tech.1:1 patients: Certain patients will be flagged by management as 1:1 patients. This means that under normal circumstances, the tech assigned to this patient will only have this one patient. The patient populations most likely to be flagged in this manner are: Patients with severe developmental delay, patients under eight years old, patients with tracheotomies, patients with neuromuscular disorders, and certain types of non-ambulatory patients.

  - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged 1:1 that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions

- High Acuity Patients: Certain patients will be flagged by management as high acuity patients. This means that under normal circumstances, it is preferable to not have the tech working alone on this particular shift. The types of patients most likely to be flagged as high acuity are from the patient populations listed above in the 1:1 section, as well as patients with severe mood disorders, patients with severe anxiety, and patients at high risk for coronary events. High acuity flagging differs from 1:1 flagging in that a tech assigned a high acuity patient will not necessarily have just one patient.
  - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged high acuity that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions

The Neurodiagnostics and Sleep Center staff consists of a Manager, EEG technicians, PSG technologists, PSG Technologists II (possesses a Respiratory Care license) and PSG Technicians.

- A sleep technologists to patient ratio can be 1:1, 1:2 or 1:3 depending on prescreened acuity/age of patient. 1:2 is the minimum for all sleep studies.
- An onsite staffing ratio of 2:1 is maintained during patient care hours.
- Flex Staffing Explanations: When units of service decrease, staff is canceled. When units of service increase, hours are rotated to cover testing. Outpatients can be rescheduled. Overtime is used only when necessary.

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is: two technologists.

Salinas Valley Memorial Healthcare System

SCOPE OF SERVICE: RESPIRATORY, NEURODIAGNOSTICS AND SLEEP MEDICINE

~~IX.~~VIII. EVIDENCED BASED STANDARDS

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

~~X.~~IX. CONTRACTED SERVICES

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

~~XI.~~X. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Respiratory Care, Neurodiagnostics and Sleep Medicine support the SVMHS'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 Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure Respiratory Care, Neurodiagnostics and Sleep Medicine Departments will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

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

Salinas Valley Memorial Healthcare System

SCOPE OF SERVICE: OUTPATIENT INFUSION

Reference Number	6180
Effective Date	Not Approved Yet
Applies To	Nursing Administration
Unit	Outpatient Infusion

I. SCOPE OF SERVICE

The Outpatient Infusion Unit supports the Mission, Vision, Values and Strategic Plan of Salinas Valley Memorial Healthcare System (SVMHS) 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 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 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 goal~~(s)~~ s of Outpatient Infusion ~~is~~ are~~to~~:

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).
D. A Licensed Practitioner will be onsite during hours of operation.
E. Proper resuscitative and monitoring equipment is immediately available.

III. DEPARTMENT OBJECTIVES

A. To support Salinas Valley Memorial Healthcare System 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

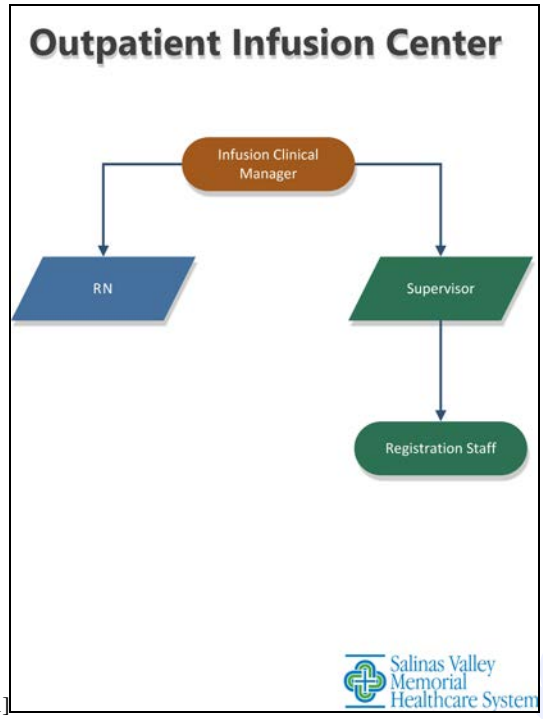
Clinical:

The Outpatient Infusion Unit provides care for ~~infant, pediatric, adolescent, adult and geriatric patients~~oncology/hematology adult outpatients.

V. ORGANIZATION OF THE DEPARTMENT ~~(include organizational chart)~~

SCOPE OF SERVICE: OUTPATIENT INFUSION

[TJ1]



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.

~~(s)~~

B. Admission, Discharge, Transfer Criteria (if applicable):

C. 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.

D. 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

~~V.~~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 Biotherapy Course
4. Current ONS Chemotherapy and Biotherapy 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
~~1.~~ 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.

~~VI.~~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. 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.

~~VII.~~IX. EVIDENCED BASED STANDARDS

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

~~VIII.~~X. CONTRACTED SERVICES

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

~~IX.~~XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Outpatient Infusion supports the SVMHS'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.

Salinas Valley Memorial Healthcare System

SCOPE OF SERVICE: OUTPATIENT INFUSION

In addition to the overall SVMHS Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, Outpatient Infusion ~~Department~~ 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.

Salinas Valley Memorial Healthcare System

RC POCT LABORATORY SAFETY/CHEMICAL

HYGIENE PLAN

2021

Table of Contents

I. SCOPE

A. SVMH is responsible for providing a safe place of employment and for furnishing safeguards, safety devices, and methods of operation to safeguard employees. In accordance with the SVMH Safety Plan and the Environment of Care Committee, the following is in place to protect respiratory care practitioners (RCP) from health/chemical hazards associated with performing arterial blood gas collection and analysis. It is designed to identify actual and potential employee exposure, as well as set forth responsibilities and activities to enhance employee safety. This policy, as well as the OSHA standard (1910.1450) requiring that this policy be implemented, shall be available to employees at all times.

B. All procedures (and use of chemicals and chemicals compounds) are listed, approved and reviewed in RC POCT ABG Policies: RC POCT LAB - BLOOD GAS ORDERING AND SPECIMEN COLLECTION ~~&~~ EPOC BLOOD ANALYSIS PROCEDURE

II. DEFINITIONS

A. N/A

III. PLAN MANAGEMENT

A. **Plan Elements**

1. **SAFETY EQUIPMENT/APPAREL:**
   a. Personal protective equipment is the last line of defense against injury. Lines of defense may include:
      i. Using proper technique, appropriate training, and methods
      ii. Using engineering controls such as those listed below:
         - EYEWASH – Located RC laboratory
         - Fire Extinguishers - extinguishers labeled ABC can be used for any kind of fire occurring in the Laboratory
         - Face Shields - located in par level areas
         - Gloves - Located throughout the hospital
         - Fire Alarm- Located throughout the hospital
         - Chemical Spill Kits – Located in engineering
   b. POCT Supervisor shall be responsible for assuring their personnel use the protective equipment and apparel and that they use it properly.
   c. The following personal protective equipment (PPE) rules shall apply to all Laboratory personnel:
      - Proper protective gloves and other protective clothing shall be worn when there is potential for contact with

corrosive or toxic materials or materials of unknown toxicity

- Gloves shall be selected on the basis of the materials being handled and the degree of hazard involved
- All personal protective equipment must be appropriately stored, cleaned and cared for on an ongoing basis. Cleaning is especially important after exposure to chemicals
- Prior to using any personal protective equipment, it should be thoroughly examined and inspected for unusual wear, deterioration, holes, cracks or other imperfections which could result in exposure of an employee.

2. **HOUSEKEEPING, MAINTENANCE AND INSPECTION:**
   a. Hospital Environmental Services perform general housekeeping. RCP personnel, however, will be responsible for keeping their respective work areas orderly and clean.
      - Waste materials shall be appropriately segregated in disposed of in appropriate receptacles.
      - Spilled chemicals must be cleaned up immediately in an approved manner. (See spill control section)

3. **WASTE HANDLING AND DISPOSAL COMPLIANCE:**
   a. Wastes will be handled and disposed of in a manner consistent with the hospital chemical and medical waste management program as well as Federal, State and Local regulations.
   b. The goal of the waste management program is to assure minimal harm to people, other organisms, and the environment as result from the disposal of waste laboratory chemicals.

4. **CHEMICAL WASTE PICK UP – ALL HAZARDOUS CHEMICALS:**
   a. Containers must be in good condition and wastes must be stored in compatible containers according to hazardous material disposal guidelines.
   b. Keep different types of wastes in separate containers.
   c. Unlabeled containers of chemicals and solutions should undergo prompt disposal. If partially used, they should not be opened.

5. **GENERAL GUIDELINES:**
   a. All RCPs shall familiarize themselves with all procedures associated with the use of chemicals.
   b. The application of safety rules and safe work procedures shall be considered as important as the quality and professionalism of work performance.

c. Supervisors at each management level shall be responsible for enforcing safety rules and safe work performance through regular performance evaluations and an application of the standard hospital disciplinary policy when infractions occur.

6. **GENERAL LABORATORY SAFETY:**

a. Smoking is prohibited in the technical work area.
b. Eating and drinking are prohibited in the technical work areas.
c. Cosmetic application is prohibited in the technical work areas.
d. Food is prohibited in technical refrigerators.
e. Face shields or eye protectors must be worn when handling caustic chemical or when pouring chemicals.
f. Shoes should be comfortable; rubber soled, and covers the entire foot.
g. Hair shall be secured back and off the shoulders in a manner as to prevent it from coming into contact with contaminated materials or surfaces and also to prevent shedding. Hair must be kept away from any machinery. Beards must be handled in the same manner.
h. All accidents shall be immediately reported to the immediate supervisor or lead regardless of injury severity; contact security at 2222.
i. Always wear appropriate protective gloves when handling hazardous chemicals and wash hands thoroughly afterwards.
j. Inspect gloves before use.
k. Flammable liquids should be kept away from sources of ignition.
l. Always know the exact location of all safety and emergency equipment.
m. Report any unusual odors, vapors or smoke at once to your immediate supervisor.
n. If you should happen to splash a caustic liquid on your skin or in your eyes, flush and/or wash the affected area immediately with copious amounts of water.
o. Never drink from a laboratory container.
p. Do not smell or taste chemicals.
q. Learn the uses and potential hazards of all equipment
r. Use equipment only for its intended purpose.
s. All containers shall be labeled & dated plainly to identify contents and provide warnings
t. Labels on original containers shall not be removed or defaced.
u. Never fill a container with a material other than that called for on the label.
v. Know the proper disposal method for chemical substances.
w. Always check with an SDS sheet when using chemical and procedures with which you are not familiar.
x. Become familiar with chemical incompatibilities. Chemicals which could react should not be stored together.

y. Refrigerators shall not be used for the storage of chemicals unless the refrigerator is specifically designed for the appropriate hazard (flammability, explosion proof lighting and electrical fixtures.)

7. **CHEMICAL PROCUREMENT, DISTRIBUTION AND STORAGE:**
   a. PROCUREMENT –All supplies are received in the central receiving area in the Materials Management (MM) Department. Refer to MM Procedures for receiving supplies.

8. **STOCKROOM/STOREROOM:**
   a. Hazardous substances should be clearly identified and segregated from other supplies or chemicals.
   b. Chemicals classified as highly toxic must be kept in rigid chemically resistant, secondary containers.
   c. Stored chemicals shall be examined annually.
   d. The store room shall not be used as a preparation area, repackaging area or chemical transfer area.
   e. All flammable liquids shall be stored in the flammable storage cabinet. The doors are to be kept closed at all times.

9. **LABORATORY STORAGE:**
   a. Amounts permitted should be as small as practical.
   b. Exposure to heat or direct sunlight should be avoided.

10. **EMPLOYEE MEDICAL SAFETY PROGRAM:**
   a. Medical surveillance shall be conducted in a manner consistent with federal OSHA requirements.
   b. Employees annually receive a health examination which consists of PPD and, if required, a chest X-ray. Abnormal results are referred to a physician by the Employee Health Nurse for review and comment. Every 2 years, employees are evaluated for ergonomic safety.
   c. In the event of over-exposure, exposure to a spill or leak or if an employee develops signs or symptoms associated with a hazardous chemical, they shall receive medical consultation and evaluation. This shall include follow-up medical examination thought to be necessary by the examining physician.
   d. First aid for exposure to toxic substance should be administered through the Employee Health Services. Some exposures may require immediate treatment (Employee taken directly to the Emergency Room). Listed below are some conditions which may require immediate treatment.
      - Thermal and chemical burns
      - Cuts and fracture wounds from glass or metal, including possible chemical contamination
      - Skin irritation by chemicals
      - Poisoning by ingestion, inhalation or skin absorption

- Asphyxiation (chemical or electrical)
- Injuries to the eyes from splashed chemicals

11. **SIGNS AND LABELS (SEE ALSO HAZARD COMMUNICATION PROCEDURES):**
    a. Emergency telephone numbers of emergency personnel, internal hospital codes and home phone numbers for key laboratory personnel available in multiple locations throughout the Lab.
    b. Original chemical containers must not have original labels removed or defaced. All containers must have identity labels showing the contents of the container as well as the associated hazard.
    c. Signs showing the location of the eyewash station and other safety and first aid equipment, exits, fire alarm and fire extinguishers. Signs are also posted where special or unusual hazards exist.
    d. Special hazards throughout the laboratory shall be clearly identified with symbols and working labels. Such signs and labels as listed below:
        - flammable liquid storage
        - biological waste receptacles
        - storage areas for strong alkalis or acids
    e. Safety equipment shall also be clearly marked and identifiable.

12. **CHEMICAL/ REAGENT LABELING:**
    a. Every container in the Laboratory should be labeled, regardless of size, with the following information:
        - name of chemical as it appears on the SDS sheet
        - the strength or concentration of the chemical
        - an appropriate warning where applicable
        - "Hazardous" warning label where applicable for hazardous chemicals
    b. Any new reagent/chemical acquisition must be approved by the RC POCT Director before ordering and must have SDS data sheet on file. New reagents/chemicals that are added to arterial blood gas program must be included in an appropriate training program for that chemical.

13. **SPILLS AND ACCIDENTS:**
    a. The Laboratory Department participates in the hospital wide internal and external disaster plans. Personnel shall:
        - Be familiar with exits and evacuation routes
        - Participate in both types and drills
        - Be familiar with alarms, hospital codes and know their responsibilities with respect to these alarms and codes.

14. **CHEMICAL SPILL PROCEDURE:**
    a. The following procedures shall be followed when a chemical spill occurs:

- Notify persons in the immediate area about the spill. Notify all lab personnel that a spill has occurred.
- Evacuate the spill area at once.
- Contain – Determine, if possible, the chemical spilled and estimate the quantity. Large spill clean-up should be carried out by Engineering. Immediately notify Engineering and the POCT Director to activate Code Orange
- If the spilled material is flammable, turn off ignition and heat sources, as well as ventilation systems.
- The individual or individuals working directly with the spill shall put on all appropriate personal protective equipment

b. Any of the following may be implemented as appropriate before Engineering arrives:
    - Attend to any person who has been contaminated or injured.
    - Persons with caustics on their skin or eyes shall immediately be assisted in utilizing an emergency shower or eye wash. Eyes should be washed for a minimum of 15 minutes. As soon as immediate eye wash is performed, take the employee to the emergency room to have their eyes flushed and examined.
    - Remove contaminated clothing immediately.
    - Any employee coming in contact with any chemical shall be evaluated immediately by the Employee Health who will determine if the employee needs to be seen by the Emergency Room Physician for evaluation and treatment.
    - Confine or contain the spill to a small area. Do not let it spread.
    - Carefully remove and clean any cartons or bottles that have been dropped. Do not attempt to pick up or move broken glass or other sharp objects. Use a broom and dust pan for handling these articles.
    - Sweep up moisture absorbent material or remove spill pillows and properly dispose of them in a clearly marked leak proof bag or other disposable container. (Caustics shall be neutralized before disposal. Additional precautions such as use of a vacuum cleaner equipped with a HEPA filter may be necessary in cleaning up spills of more highly toxic solids.) Broken glass should be placed in a sharps container or in the plastic container labeled broken glass.
    - Dispose of residues and adequately ventilate the area before allowing employees to return to the work area.

- Clean up safety equipment and return it to its designated storage place. Replace any disposable components.
- Documentation of the spill and the response will be handled by the Engineering Department.

15. **SPECIFIC HAZARDOUS CHEMICAL SPILL CONTROL INFORMATION for Common Laboratory Chemicals:**
    a. ALLERGENS: Wear suitable gloves to prevent hand contact with allergens or substances of unknown allergenic activity.

B. **Plan Responsibility**

1. The RC POCT Director is responsible for ensuring that the policies and procedures contained within the Chemical Hygiene plan are followed and that appropriate protective equipment is used.

    a. Responsibilities include:

        - Ensuring that workers know and follow the chemical hygiene rules and appropriate training has been provided.
        - Determining the required level of protective equipment, availability of equipment, and ensuring it is in working order
        - Provide regular inspections including routine inspections of emergency equipment.
        - The current legal requirements concerning regulated chemicals
        - Reporting lack of compliance to the RC POCT Director or RC POCT Supervisor for corrective actions.

2. No new chemical, chemical compound or laboratory procedure may be applied without the specific prior approval of the RC POCT Laboratory Director.

C. **Training and Information (See also Hazard Communication Procedures)**

1. All employees that perform analysis on bodily fluids are at risk must be informed about the work hazards on performing these types of analysis, the proper work procedures to follow to prevent exposures and accidents and what to do it an accident occurs. It is the intent of this department to make available as much information and literature as possible regarding the chemicals employees must work with. Personnel are encouraged to request information and utilize textbooks and reference materials to become as knowledgeable as possible regarding chemical hazards and appropriate precautions needed.

2. Textbooks and reference materials are available and are located on line using the SDS online library and/or the Hospital Library. This can be found on the organizational intranet: Safety & Survey Readiness, and Safety Data Sheet (SDS).
3. An inventory list of chemicals is found in the POCT Respiratory Safety Manual.
4. Other materials and information may also be found in the Laboratory Safety Manual or online. Materials found include:
    - The Laboratory Safety/Chemical Hygiene Plan
    - OSHA's Permissible Exposure Limits for Regulated Substances
    - OSHA's Laboratory Standard (CFR 1910.1450)
    - Signs and Symptoms Associated with Exposures
    - Material Safety Data Sheets/Safety Data Sheets in Lab and/or on STARnet.
5. Initial and ongoing training is provided and participation by department employees is required.
6. Information shall be provided at the time of an employee's initial assignment to a work area or prior to new exposure assignments.
7. Ongoing training will be provided as part of the Hospital's Corporate Compliance continuing Education program, Annual review of the RC Laboratory Safety/Chemical Hygiene Plan, and in person as needed, included but not limited to:
    - Methods and observations which may be used to detect the presence or release of a Hazardous chemical.
    - Physical and health hazards of chemicals in the work area.
    - Measures employees can take to protect themselves from these hazards.
    - Applicable details of the Laboratory Safety/Chemical Hygiene Plan.
    - Locate the potentially hazardous chemicals in the workplace.
    - Recognize the chemical labeling and its meaning. Discuss the major components of the facilities standard labeling system.
    - Understand how to read the SDS sheets and explain their use.
    - Identify the appropriate protective clothing and equipment for the area and demonstrate its use.
    - Demonstrate emergency procedures in case of a hazardous chemical spill.
    - Describe the environmental monitoring protocol.
    - Demonstrate knowledge of the waste disposal program and apply knowledge appropriately.

- Know and demonstrate the safe handling policies and procedures of arterial blood gas collection and analysis.

IV. REFERENCES

A. ~~T~~National Institute of Health (2018). Chemical Hygiene Plan Retrieved from: https://www.ors.od.nih.gov/sr/dohs/documents/nih%20chemical%20hygiene%20plan.pdf [PDF File].

B. Blumenfeld, J., Williams, M. (2020). 2019 California Hazardous Waste and Hazardous Substances Code Excerpts. Retrieved from: https://dtsc.ca.gov/wp-content/uploads/sites/31/2019/06/HSC-2018-Full-Doc.pdf [PDF File]

C. National Research Council (US) Committee on Prudent Practices in the Laboratory (2011). Prudent Practices in the Laboratory: Handling and Management of Chemical Hazards: Updated Version. Washington (DC): National Academies Press (US).

[CP1]

~~National Institute of Health (2018). Chemical Hygiene Plan Retrieved from:~~

~~https://www.ors.od.nih.gov/sr/dohs/documents/nih%20chemical%20hygiene%20plan.pdf [PDF File].~~

~~Blumenfeld, J., Williams, M. (2020). 2019 California Hazardous Waste and Hazardous Substances Code Excerpts. Retrieved from: https://dtsc.ca.gov/wp-content/uploads/sites/31/2019/06/HSC-2018-Full-Doc.pdf [PDF File]~~

~~National Research Council (US) Committee on Prudent Practices in the Laboratory (2011). Prudent Practices in the Laboratory: Handling and Management of Chemical Hazards: Updated Version. Washington (DC): National Academies Press (US).~~

HEALTHCARE WORKER RESPIRATORY

PROTECTION PROGRAM

2021

~~Effective Date: Not Approved Yet~~

TABLE OF CONTENTS

I. SCOPE

~~A.~~ The ~~following~~ Salinas Valley Memorial Hospital (SVMH) Respiratory Protection Program~~s~~ applies to all SVMH departments and~~,~~ healthcare workers ~~employees and temporary employees working~~ employed by or contracted with~~for~~ SVMH. While SVMH is not responsible for contractor employees or independent agents, all such individuals are required to adhere to ~~all of~~ SVMH safety program policies and procedures~~practices including the SVMH Respiratory Protection Program.~~

~~B.~~A. ~~The purpose of the Respiratory Protection Program (RPP) is to maximize the protection afforded by respirators when they must be used and:~~

1. ~~Establishes the procedures necessary to meet the regulatory requirements for use of respiratory protections~~
2. ~~Is compliant with Cal/OSHA regulations: Respiratory Protection Standard (Title 8 California Code of Regulations Section 5144) and the Aerosol Transmissible Disease Standard (8 CCR Section 5199).~~

~~C.~~ ~~This program applies to all employees and contractors who may need to wear respiratory protection due to the nature of the work they perform for Salinas Valley Memorial Healthcare Systems (SVMHS~~

~~D.~~B. The program ~~also~~ applies to use of all respirators including filtering disposable face pieces ~~or~~ (N-95) and establishes procedures for the voluntary use of filtering face pieces.

~~E.~~C. Respiratory protection is to be worn when engineering controls are not available ~~feasible~~ or when conditions are uncontrollable and represent a potential respiratory exposure.

~~SVMHS has certain clinics under its license and these clinics, while not operated by SVMHS, must also adhere to this policy.~~

~~F.~~D. The Respiratory Program Administrator (RPA) for SVMH is the Environmental Health and Safety Manager

~~This individual is knowledgable about the requirements of the Cal/OSHA Respiratory Protection Standard and all elements of the RPA that need to be implemented in order for it to me effective.~~

II. OBJECTIVES/GOALS

~~II.~~

~~(Define the goals for the overall plan. Do not state specific performance metrics)~~

A. **Objectives**

1. To ensure that employees who may be exposed to airborne infectious diseases and potentially harmful chemicals, gases, vapors, fumes and mists are provided with respiratory protection that meets the provisions of 8 CCR Section 5144
~~2.~~

B. **Goals**

1. The goals of the ~~SVMH for the Healthcare Worker~~ Respiratory Protection Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance monitoring and environmental tours. The goals for this Plan are:

   a. ~~XXX~~To maximize the protection afforded by respirators when[MD1][MD2] they must be used.
   ~~b. XXXX~~Establish procedures necessary to meet regulatory requirements for respiratory protection.
   b.

   ~~C. The purpose of the Respiratory Protection Program (RPP) is to maximize the protection afforded by respirators when they must be used and:~~
   ~~3. Establishes the procedures necessary to meet the regulatory requirements for use of respiratory protections~~
   ~~4. Is compliant with Cal/OSHA regulations: Respiratory Protection Standard (Title 8 California Code of Regulations Section 5144) and the Aerosol Transmissible Disease Standard (8 CCR Section 5199).~~

III. DEFINITIONS~~(LIST ANY DEFINITIONS HERE THAT ARE USED IN THE PLAN)~~

A. **AII:** Airborne Infection Isolation

B. **Air-purifying respirator**: respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through the air-purifying element. Example: N95, PAPR and cartridge type respirators.

C. **ANSI/AIHA -** American National Standards Institute Respiratory Protection/American Industrial Hygiene Association

D. **ATD:** – Aerosol Transmissible Disease. A disease for which droplet or airborne precautions are recommended.

E. **Atmosphere-supplying respirator:** respirator that supplies the respirator user with breathing air from a source independent of the ambient atmosphere, and includes supplied-air respirators (SARs) and self-contained breathing apparatus (SCBA) units.

F. **Cal-OSHA**: California Occupational Safety & Health Administration Standards Board

G. **Canister or cartridge:** a container with a filter, sorbent, or catalyst, or combination of these items, which removes specific contaminants from the air passed through the container.

H. **CDC:** Center for Disease Control and Prevention

I. **EHS:** Employee Health Services Department.

J. **Emergency situation:** any occurrence such as, but not limited to, equipment failure, rupture of containers, or failure of control equipment that may or does result in an uncontrolled significant release of an airborne contaminant.

~~K. **Employee exposure:** exposure to a concentration of an airborne contaminant that would occur if the Employee were not using respiratory protection.~~

~~L.~~K. **End-of-service-life indicator (ESLI):**a system that warns the respirator user of the approach of the end of adequate respiratory protection, for example, that the sorbent is approaching saturation or is no longer effective.

~~M.~~L. **Escape-only respirator:** a respirator intended to be used only for emergency exit.

~~N.~~M. **Filter or air purifying element:** a component used in respirators to remove solid or liquid aerosols from the inspired air.

~~O.~~N. **Filtering face piece (dust mask):** negative pressure particulate respirator with a filter as an integral part of the face piece or with the entire face piece composed of the filtering medium.

~~P.~~O. **Fit factor:** quantitative estimate of the fit of a particular respirator to a specific individual, and typically estimates the ratio of the concentration of a substance in ambient air to its concentration inside the respirator when worn.

~~Q.~~P. **Fit test:** use of a protocol to qualitatively or quantitatively evaluate the fit of a respirator on an individual. (See also Qualitative fit test QLFT and Quantitative fit test QNFT.)

~~R.~~Q. **HCW – Healthcare Worker** - staff that interact with patients directly or provide support to the patient care areas of the hospital. This includes employees, temporary employees / students, and medical staff~~, and volunteers~~.

~~S.~~R. **High efficiency particulate air (HEPA) filter:** a filter that is at least 99.97% efficient in removing mono-disperse particles of 0.3 micrometers in diameter. The equivalent NIOSH 42 CFR 84 particulate filters are the N100, R100, and P100 filters.

~~T.~~S. **Hood:** respiratory inlet covering that completely covers the head and neck and may also cover portions of the shoulders and torso.

~~U.~~T. **IP:** Infection Prevention.

~~V.~~U. **Immediately dangerous to life or health (IDLH):** atmosphere that poses an immediate threat to life, would cause irreversible adverse health effects, or would impair an individual's ability to escape from a dangerous atmosphere.

~~W.~~V. **Loose-fitting face piece:** respiratory inlet covering that is designed to form a partial seal with the face.

~~X.~~W. **Negative pressure respirator (tight fitting):** respirator in which the air pressure inside the face piece is negative during inhalation with respect to the ambient air pressure outside the respirator.

~~Y.~~X. **NIOSH -** National Institute of Safety and Health.

Y. **Oxygen deficient atmosphere:** atmosphere with oxygen content below 19.5% by volume.

~~Z.~~ **Permissible Exposure Limit (PEL)** ~~**the**~~ The maximum permitted 8-hour time-weighted average concentration of an airborne contaminant.

~~AA.~~Z. **Physician or other licensed health care professional or LIP (PLHCP or LIP):**individual whose legally permitted scope of practice (i.e., license, registration, or certification) allows him or her to independently provide, or be delegated the responsibility to provide, some or all of the health care services required by paragraph (e) of this section.

~~BB.~~AA. **Positive pressure respirator:** respirator in which the pressure inside the respiratory inlet covering exceeds the ambient air pressure outside the respirator.

~~CC.~~BB. **Powered air-purifying respirator (PAPR):** air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering.

~~DD.~~CC. **Pressure demand respirator:** positive pressure atmosphere-supplying respirator that admits breathing air to the face piece when the positive pressure is reduced inside the face piece by inhalation.

~~EE.~~DD. **Qualitative fit test (QLFT):** pass/fail fit test to assess the adequacy of respirator fit that relies on the individual's response to the test agent.

~~FF.~~EE. **Quantitative fit test (QNFT):** assessment of the adequacy of respirator fit by numerically measuring the amount of leakage into the respirator.

FF. **Respiratory inlet covering**: portion of a respirator that forms the protective barrier between the user's respiratory tract and an air-purifying device or breathing air source, or both. It may be a face piece, helmet, hood, suit, or a mouthpiece respirator with nose clamp.

RPA: The Respirator Program Administrator - Individual who is knowledgeable about the requirements of the Cal/OSHA Respiratory Protection Standard and all elements of the RPA that need to be implemented in order for it to be effective. The RPA for SVMH is the Environmental Health and Safety Manager.

GG. RPP - Respiratory Protection Program ~~(RPP)~~

~~GG. **Salinas Valley Memorial Hospital (SVMH)**~~

HH. **Self-contained breathing apparatus (SCBA):** atmosphere-supplying respirator for which the breathing air source is designed to be carried by the user.

II. **Service life:** the period of time that a respirator, filter or sorbent or other respiratory equipment provides adequate protection to the wearer.

~~II.~~JJ. **STEL Short Term Exposure Limit ~~(STEL)~~.** A 15-minute time-weighted average exposure which is not to be exceeded at any time during a workday even if the 8-hour time-weighted average is below the PEL

~~JJ.~~KK. **SSPD:** Sterile Surgical Processing Department

~~KK.~~LL. **Supplied-air respirator (SAR) or airline respirator:** atmosphere-supplying respirator for which the source of breathing air is not designed to be carried by the user.

~~LL.~~MM. **TB** – Tuberculosis

~~MM.~~NN. **Tight-fitting face piece:** respiratory inlet covering that forms a complete seal with the face.

~~NN.~~OO. **User seal check:** action conducted by the respirator user to determine proper fit for protection.

IV. PLAN MANAGEMENT

~~(What are the fundamental elements of the plan? How will the plan be managed?)~~

A. Plan Elements

1. Establishing engineering controls is the first and most desirable approach to controlling respiratory hazards. Engineering controls are considered where ~~-~~ever feasible and where they can be cost effectively utilized.

2. Respirators will be used to protect employees from air contaminants such as ~~which might include~~ dusts, mists, fumes, gases, smoke, sprays and/or vapors and otherwise generally described as ~~hazardous chemical exposure, dust or particulate exposure or~~ potential exposure to Aerosol Transmissible Disease (ATD).

~~3. Attachment A is a list of classifications that require fit testing and training in the use of N95 respirators.~~

~~4. Attachment B is a list of job classifications that may have a need to use a PAPR~~

~~5.~~3. ~~Stationary Engineers, Project Manager Assistant and Painter~~Designated Engineering staff ~~-~~will require fit testing and training in the use of tight fitting (cartridge type) respirators.

~~6.~~ Cartridge type respirators are required where personal dosimetry and/or air monitoring has been conducted by an industrial hygienist and is indicative of levels that require the use of a respirator and are greater than Cal/OSHA permissible exposure limit, or the STEL. ~~50% of the Threshold Limit Value (TLV) or Short Term Exposure Limit (STEL).~~

4. Only air filtering cartridges that have been approved by the Safety Office may be used with air filtering respirators to ensure that the proper cartridge has been provided to protect the wearer from the airborne contaminant.

~~7. In circumstances where levels of contaminant in air are below levels requiring the use of a respirator, the employee may voluntarily choose to use a respirator when the following apply:~~

~~a. He/she has passed medical evaluation, been assigned a respirator for the represented hazard, fit tested to that respirator and properly trained in the use of the respiratory protection for **Tight Fitting Respirators**.~~

~~b. The employee must be properly trained and may only use a filtering face piece for the protection of dusts, particulates and/or other contaminants for which the respirator is designed to filter. Attachment D – Employees using Respirators when not required under the standard must be trained and documentation maintained to illustrate full knowledge and understanding of voluntary respirator use.~~

~~8.~~5. It is the duty of each department manager to identify potential respiratory hazards and request Safety/EHS/~~Engineering~~/Infection Prevention assistance in determining the need for environmental sampling. Safety /EHS/ ~~Engineering~~/Infection Prevention will work with department to arrange for environmental sampling, analyze sampling reports and assign proper respiratory protective equipment when required.

~~9.~~6. Engineering and Safety Leadership should also evaluate the need for respirators when there are contaminates generated over short durations but create a concentrated breathing zone exposure and may be of significant nuisance to the employee. “Worse Case” Scenario should be considered.

~~10. xamples would be entering into the attic following building disruption such as an earthquake, welding, brazing or soldering in areas with low air flow, grinding, sanding or using other means that may increase concentrations of particulates in air.~~

~~11.~~7. ~~F~~Filtering respirators are not to be used in environments where oxygen concentrations are deficient (<19.5%) or into areas where the environmental conditions are unknown and may be Immediately ~~Hazardous~~ Dangerous to Life and/or ~~h~~Health (IDLH).

~~12.~~8. ~~Employees~~ Persons required to wear respirators must ~~ad hear~~adhere to all practices required to safely wear respirators including voluntary respiratory use. Practices include:

a. Absence of facial hair and/or physical condition that would interfere with the face to ~~facepiece~~face piece seal or valve function.

b. Will not wear contact lenses in conditions that involve potential chemical contamination and/or chemical environments

c. Corrective and/or protective eye wear, jewelry, clothing, etc. must not interfere with the ~~facepiece~~face piece seal or respirator function

d. When wearing a PAPR, check the motor, battery charge and condition before and after each use.

e. Proper cleaning, maintaining and storing practices for PAPR's and cartridge type respirators.

f. No sharing of respirators or related equipment.

g. Only use respiratory equipment for conditions where you understand the hazard and have been trained.

h. Successfully passed required medical evaluations, fit tests, etc.

i. Damaged or malfunctioning respirators must be turned into SSPD. SSPD will re-issue and properly discard damaged/malfunctioning respirators.

j. Respirators may not be removed from the premises and used for personal projects.

~~13.~~9. SVMH will provide all respirator users ~~(mandatory and voluntary)~~ with the appropriate respirator at no cost~~. to the employee~~ ~~SVMH employees~~Persons that fall under voluntary guidelines may not personally supply their own respirators.

~~14. Qualitative Fit Test (QLFT) is only acceptable where the OSHA-accepted fit factor is equal or less than 100 for negative pressure tight fitting respirators.~~

~~15.~~10. PAPR – Powered Air Purifying Respirator Use

a. PAPRs will be used when additional protection is warranted beyond that provided by an air purifying particulate respirator such as an N95 or when medical evaluation reveals that the individual is not fit for using negative pressure respirator but is for the use of a PAPR and the PAPR is sufficient for the respiratory exposure.

b. PAPRs will be used by staff performing ~~high risk~~high-risk procedures on confirmed or suspect patients with potential ATD. (see attached ATD list)

c. High Risk Procedures such as~~include~~:

   i. Bronchoscopy

   ii. Cardiopulmonary resuscitation

   iii. Open Suctioning

   iv. Intubation or extubation

d. All persons under this program plan will be provided i~~I~~nstruction in the use of PAPRs ~~will be provided by EHS and HealthStream~~ annually ~~(is this training provided for Engineers).~~

   i. An instruction and reference packet is available in the PAPR bag.

   ~~ii. PAPR units including hoods and hoses are ordered from SSPD via order entry~~

   ~~iii. The complete unit is returned to the soiled utility room for processing by SSPD.~~

   ~~iv. PAPR units are kept in the Emergency Room, ICU, EHS, SSPD and Endoscopy Departments. SSPD will maintain this equipment monthly and as needed by usage.~~

   ~~v. Storage for cartridge type tight fitting respirators will protect equipment against dust, sunlight, heat, extreme cold, excessive moisture, and damaging chemicals. NIOSH recommends that freshly cleaned respirators be placed in re-usable plastic bags until the respirators are used again. Face-pieces and exhalation valves should be kept in normal, upright position so that function is not impaired by distortion of the elastomeric (rubber gasket) border. Operating instructions should be kept with the respirator when placed in storage.~~

~~vi.~~ii. Respirators will be inspected for leaks or other defects before and after each use. The preferred time for inspection is during cleaning, when the respirator is disassembled and reassembled. Cal-OSHA requires inspection of:

1) All connections for tightness.

2) All valves and tubes and the face-piece.

3) Pliable parts for signs of deterioration.

~~vii.~~iii. Pliable parts will be periodically stretched/ turned/ massaged to keep them flexible during storage.

~~viii.~~iv. Maintenance and repairs should be performed by trained, qualified persons. Replacement parts must be those designed for the specific respirator. Any other replacement parts invalidate the NIOSH certification, meaning that their use would be in violation of Cal-OSHA requirements.

B. **Documentation and Recordkeeping:**

1. ~~Written information~~ Records regarding medical evaluations and~~,~~ fit ~~testing,~~testing ~~and the Respiratory Protection Program~~ are retained in the individual employee medical record. These materials are made available upon request to affected employees for examination and copying.

2. Medical Evaluation – Records of medical evaluations must be retained and made available in accordance with 8 CCR ~~5144~~ 3204 ~~for the duration of employment plus 30 years.~~

3. Fit Testing – Fit test records are retained for respirator users until the next fit test is administered, at least annually. The Fit test record includes:

    a. Name of the employee.
    b. Type of fit test performed.
    c. Specific make, model, style, and size of respirator.
    d. Date of test.

C. **Plan Management**

1. The RPP is managed by the RPA ~~(Environmental~~(Environmental Health and Safety Manager.

~~1.~~2.The Environment of Care Committee has the responsibility to oversee ~~oversight~~ this program plan.

Plan Responsibility ~~(Who is responsible for the plan and its components?)~~

~~EHS/Engineering/IP works with individual departments to identify the possible need for environmental sampling or personal dosimetry based upon review of SDS when applicable planned activities, frequency and duration of exposure.~~

~~EHS/Engineering/IP/Risk will involve interior and/or exterior subject matter expertise which may include any combination of safety and health specialists, independent consultants, insurance and/or insurance broker risk control or loss control consultants.~~

~~Employee Health Services and Infection Prevention Departments:~~

~~EHS completes the process that includes the following:~~

~~Reviews monitoring results when applicable~~

~~Includes affected employees in the respiratory protection program or voluntary use program as appropriate~~

~~Respirator selection based upon the hazard to which the worker may be exposed. Only NIOSH-certified respirators will be used. Initiates medical monitoring for affected employees. Those wearing tight fitting respirators must be medically qualified to wear such respirators regardless of voluntary or mandatory use.~~

~~Respirator selection and appropriate filtering cartridges where applicable, fit testing, respirator assignment and training.~~

~~Develops / implements new employee training / education, in addition to annual evaluation / education. Annually fit testing is preformed, and the employee is re-educated on proper use of selected respirators which include: N95 face piece, and powered air purifying respirators (PAPR).~~

~~Those that are identified as wearing tight fitting respirators (cartridge type respirators) will be trained and evaluated annually by an appropriate contract agency specializing in tight fitting respirators.~~

~~Employee Responsibilities:~~

~~If a respirator is required for potential chemical exposure, the employee is responsible to read the SDS (Safety Data Sheet) prior to using any chemical to determine the necessity and type of respiratory protection required.~~

~~Ensures that the assigned respirator is properly functioning via visual inspection prior to use and verifies that it is the appropriate type and utilizes the appropriate filtering media for the forthcoming exposure~~

~~Checks the respirator fit after each donning.~~

~~Uses the respirator as instructed.~~

~~Guards against damaging the respirator.~~

~~Immediately exits to a safe area if the respirator fails.~~

~~Reports any respirator malfunction to department director/manager or designee.~~

~~Reports to manager and EHS any difficulties (physical or emotional) associated with respirator use.~~

~~Clean and sanitizes re-useable respirator and return it to the designated storage area after each use.~~

~~Questions about the use of respirators are referred to Department Directors, EHS or Administrative House Supervisor.~~

~~Department Director/Manager or Designee Responsibility:~~

~~Audit safe practices" which include, donning and use, cleaning and proper storage of respirators, personal hygiene, etc. Monitor staff to ensure absence of facial hair that would interfere with the seal of N95 and respirator use.~~

~~Directs an employee to Employee Health Service if the employee reports medical signs or symptoms that are related to the ability to use a respirator.~~

~~Assess their department's potential exposure based on operations, procedures and possible exposures. Relevant potential employee exposures should be identified at this time.~~

~~Notify IP and EHS of the possible exposures and affected employees.~~

~~If respirators (PAPR) are used:~~

~~Provides a clean storage area that is large enough to store respirators in an upright position, without stacking them on one another. This avoids distortion of the face mask.~~

~~Questions about respirator use are referred to EHS or Administrative House Supervisor.~~

~~SSPD Responsibilities:~~

~~Cleaning, Storage, and Disinfection guidelines for Reusable Respirators.~~

~~Establishes procedures and assigns responsibilities for inspecting and cleaning respirators after each shift.~~

~~Assigns a person who is trained in these procedures to repair and maintain re-usable respirators and to order replacement parts.~~

~~Follow Manufacturer's recommendations for cleaning/disinfection, storage and repairs.~~

D. **Performance Measurement**

~~1. The performance measurement process is one part of the evaluation of the effectiveness of the Healthcare Worker Respiratory Protection Program. Performance measures have been established to measure at least one important aspect of the program.~~

~~2.~~1. Performance measures have been established to measure at least one important aspect of the program. On an annual basis, the Environment of Care Committee Safety Office ~~EHS, IC and Engineering to the 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. Evaluation includes consultation with respirator wearers, monitoring of hazards, and medical surveillance.

E. **Orientation and Education**

1. Training is provided at hire, prior to use as needed and/or annually thereafter. Training content will be outlined based upon Cal/OSHA specified content.
2. Training for cartridge type tight fitting respirators will consist of a formal classroom with practical illustration, video and/or other media. It is the responsibility of the department management to ensure that all employees that use respirators (voluntary or mandatory) use are trained as defined in this section.

V. REFERENCES

A. California Code of Regulations, ~~t~~Title 8 ~~(T8~~CCR~~)~~ Section 5144, Respiratory Protective Equipment ~~, Retrieved from: http://www.dir.ca.gov/title8/5144.html~~

B. The Joint Commission ~~(2013)~~ Hospital Accreditation Standards.

~~C. NIOSH TB Respiratory Protection Program in Health Care Facilities Guide, DHHS (NIOSH) Publication No. 99 – 143, September 1999 IS THERE A MORE CURRENT REFERENCE?. www.cdc.gov/niosh/docs/99-143~~

~~D.~~C. California ~~c~~Code o~~f~~ Regulations, Title 8, Aerosol Transmissible Disease, Section 5199~~, May 21, 2009 IS THIS HE MOST~~ [MD3]~~CURRENT. Retrieved from: http://www.dir.ca.gov/title8/5199.html~~

~~E. ANSI/AIHA Z88, Standard Practices for Respirator Protection, 1992, PULL CURRENT http://www.cdc.gov/niosh/respguid.html~~

~~The CDPH Guidance for Influenza Prevention in Health Care Settings and the~~

~~Cal/OSHA Guidance for the 2010-2011 GET MOST CURRENTInfluenza Season~~

~~Regarding the Application of the Aerosol Transmissible Diseases Standards are~~

posted at www.calhospital.org/Flu-prevention-guidance IS THIS THE WEBSITE??Q1QAAQ ATTACHMENT A NO

INFLUENZA PANDEMIC PLAN
2021

TABLE OF CONTENTS

I. SCOPE

A. To prevent the spread of influenza' by: vaccination, early detection and treatment with antiviral medications and the use of infection control measures to prevent transmission during patient care.

B. To limit transmission in healthcare settings by use of appropriate ~~of~~ infection control measures.

C. To minimize close contact of known or suspect patients with influenza. Transmission requires close exposure to large droplets (droplet transmission), direct contact (contact transmission), or near-range exposure to aerosols (airborne transmission)

D. To establish guidance based on our current knowledge of routes of influenza transmission (S4-II.A),, the pathogenesis of influenza (S4-II.B), and the effects of influenza control measures used during past pandemics.

E. Given some uncertainty about the characteristics of any new pandemic strain, all aspects of preparedness planning for pandemic influenza must allow for flexibility and real-time decision-making that take new information into account as the situation unfolds.

II. OBJECTIVES

A. Prevention and control of influenza or any other unknown communicable respiratory condition will be through a set of well-established strategies that include:

- vaccination of patients and healthcare personnel;
- early detection of influenza cases in a facility;
- use of antiviral medications to treat ill persons and, if recommended, as prophylaxis;
- isolation of infectious patients in private rooms or cohort units;
- Barrier precautions during patient care, as recommended for Standard and Droplet Precautions.
- Administrative measures, such as restricting visitors, educating patients and staff, and cohorting healthcare workers assigned to an outbreak unit.

B. Salinas Valley Memorial Healthcare System (will follow the guidelines established by the Center for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH), and Cal OSHA for detection, treatment to minimize the transmission and treatment of influenza

C. Salinas Valley Memorial will follow the recommendation of the Monterey Public Health Department in the event of untoward influx of patients identified as having a communicable disease

D. SVMHS will initiate surge capacity and activate additional components of the Emergency Management Plan as needed

III. DEFINITIONS

A. ***Modes of transmission of influenza*** - Epidemiologic pattern observed for seasonal influenza is generally consistent with spread through close contact (i.e., exposure to large respiratory droplets, direct contact, or near-range exposure to aerosols through small particle aerosols.

B. ***Droplet transmission*** - Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism.

- Droplets are generated from the source person primarily during coughing, sneezing, or talking and during the performance of certain procedures such as suctioning and bronchoscopy.
- Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances (about 3 – 6 feet) through the air. Because droplets do not remain suspended in the air, special air handling and ventilation are not required to prevent droplet transmission.

C. ***Contact transmission*** - Contact (direct) transmission involves skin-to-skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when personnel turn patients, bathe patients, or perform other patient-care activities that require physical contact.

- Direct-contact transmission also can occur between two patients (e.g., by hand contact), with one serving as the source of infectious microorganisms and the other as a susceptible host.
- Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the patient's environment.
- Contact transmission of influenza may occur through either direct skin-to-skin contact or through indirect contact with virus in the environment.
- Transmission via contaminated hands and fomite has been suggested as a contributing factor in some studies.

D. ***Airborne transmission*** - Airborne transmission occurs by dissemination of either airborne droplet nuclei or small particles in the respirable size range containing the infectious agent. Microorganisms carried in this manner—such as M. tuberculosis— may be dispersed over long distances by air currents and may be inhaled by susceptible individuals who have not had face-to-face contact with (or been in the same room with) the infectious individual.

- Organisms transmitted in this manner must be capable of sustaining infectivity, despite desiccation and environmental variation that generally limit survival in the airborne state.
- Preventing the spread of agents that are transmitted by the airborne route requires the use of special air handling and ventilation systems (e.g., negative pressure rooms).
- The relative contribution of airborne transmission to influenza outbreaks is uncertain. Evidence is limited and is principally derived from laboratory studies in animals and some observational studies of influenza outbreaks in humans, particularly on cruise ships and airplanes, where other mechanisms of transmission were also present. Additional information suggesting airborne transmission was reported in a Veterans Administration Hospital study that found lower rates of influenza in wards exposed to ultraviolet radiation (which inactivates influenza viruses) than in wards without UV radiation.
- Another study indicated that humidity can play a role in the infectivity of aerosolized influenza, although the influence of humidity on the formation of droplet nuclei was not evaluated.
- It is likely that some aerosol-generating procedures (e.g., endotracheal intubation, suctioning, nebulizer treatment, and bronchoscopy) could increase the potential for dissemination of droplet nuclei in the immediate vicinity of the patient. (Although transmission of SARS-CoV was reported in a Canadian hospital during an aerosol-generating procedure [intubation], it occurred in a situation involving environmental contamination with respiratory secretions.) Although this mode of transmission has not been evaluated for influenza, additional precautions for healthcare personnel who perform aerosol-generating procedures on influenza patients may be warranted. When these aerosol-generating procedures are performed on patients known or suspected of having an aerosol transmissible disease, healthcare workers will use a ~~of an N95 respirator. In September 2010, the minimum~~ standard ~~will be~~ will be a PAPR (powered air purifying respirator.)

E. ***Pathogenesis of influenza and implications for infection control*** - The cellular pathogenesis of human influenza indicates that infection principally takes place within the respiratory tract. While conjunctivitis is a common manifestation of systemic influenza infection, the ocular route of inoculation and infection has not been demonstrated for human influenza viruses. This may not be true with certain avian species of influenza (e.g., H7N7) that have been associated primarily with conjunctivitis in humans. This information suggests that preventing direct and indirect inoculation of the respiratory tract is of utmost importance for preventing person-to-person transmission when caring for infectious patients.

IV. PLAN MANAGEMENT

A. ***Control of transmission in healthcare facilities*** - These are the primary infection control measures recommended in this plan. They will be updated, as necessary, based on the observed characteristics of the pandemic influenza virus.

B. ***Recommendations for Infection Control in Healthcare Settings*** - The recommendations for infection control described below are generally applicable

throughout the different pandemic phases. In some cases, as indicated, recommendations may be modified as the situation progresses from limited cases to widespread community illness.

- Basic infection control principles for preventing the spread of pandemic influenza in healthcare settings. The following infection control principles apply in any setting where persons with pandemic influenza might seek and receive healthcare services (e.g. hospitals, emergency departments, out-patient facilities, residential care facilities, homes). Details
- Limit contact between infected and non-infected persons
    1. Isolate infected persons (i.e., confine patients to a defined area as appropriate for the healthcare setting).
    2. Limit contact between nonessential personnel and other persons (e.g., social visitors) and patients who are ill with pandemic influenza.
    3. Promote spatial separation in common areas (i.e., sit or stand as far away as possible—at least 3 feet—from potentially infectious persons) to limit contact between symptomatic and non-symptomatic persons.
- Protect persons caring for influenza patients in healthcare settings from contact with the pandemic influenza virus. Persons who must be in contact should:

~~1.~~ Wear a surgical or procedure mask for close contact with infectious patients. ~~For patients suspected of H1N1, use an N95 respirator.~~

~~2. Use contact and airborne precautions, including the use of N95 respirators, when appropriate [S4-IV.C]. For patients suspected of H1N1, use Enhanced Precautions.~~

a. Wear gloves (gown if necessary) for contact with respiratory secretions.

b. Perform hand hygiene after contact with infectious patients

1. Contain infectious respiratory secretions:

a. Instruct persons who have “flu-like” symptoms (see below) to use respiratory hygiene/cough etiquette (See Box 2).

b. Promote use of masks by symptomatic persons in common areas (e.g., waiting rooms in physician offices or emergency departments) or when being transported (e.g., in emergency vehicles).

C. ***Symptoms of influenza*** include fever, headache, myalgia, prostration, coryza, sore throat, and cough. Otitis media, nausea, and vomiting are also commonly reported among children. Typical influenza (or “flu-like”) symptoms, such as fever, may not always be present in elderly patients, young children, patients in long-term care facilities, or persons with underlying chronic illnesses (see Supplement 5, Box 2).

D. ***Management of infectious patients***

- ***Respiratory hygiene/cough etiquette*** - Respiratory hygiene/cough etiquette has been promoted as a strategy to contain respiratory viruses at the source and to limit their spread in areas where infectious patients might be awaiting medical care (e.g., physician offices, emergency departments) (see S4-IV.B.2).

- The impact of covering sneezes and coughs and/or placing a mask on a coughing patient on the containment of respiratory secretions or on the transmission of respiratory infections has not been systematically studied. In theory, however, any measure that limits the dispersal of respiratory droplets should reduce the opportunity for transmission. Masking may be difficult in some settings, e.g., pediatrics, in which case the emphasis will be on cough hygiene.
- The elements of respiratory hygiene/cough etiquette include:
    1. Education of healthcare facility staff, patients, and visitors on the importance of containing respiratory secretions to help prevent the transmission of influenza and other respiratory viruses
    2. Posted signs in languages appropriate to the populations served with instructions to patients and accompanying family members or friends to immediately report symptoms of a respiratory infection as directed
    3. Source control measures (e.g., covering the mouth/nose with a tissue when coughing and disposing of used tissues; using masks on the coughing person when they can be tolerated and are appropriate)
    4. Hand hygiene after contact with respiratory secretions, and
    5. Spatial separation, ideally >3 feet, of persons with respiratory infections in common waiting areas when possible.

E. ***Droplet precautions and patient placement***

- Patients with known or suspected pandemic influenza should be placed on droplet precautions for a minimum of ~~5~~7 days from the onset of symptoms. Because immunocompromised patients may shed virus for longer periods, they may be placed on droplet precautions for the duration of their illness. Healthcare personnel should wear appropriate PPE (see S4-IV.C). The placement of patients will vary depending on the healthcare setting (see setting-specific guidance). If the pandemic virus is associated with diarrhea, contact precautions (i.e., gowns and gloves for all patient contact) should be added. CDC will update these recommendations if changes occur in the anticipated pattern of transmission.
- For patients suspected of H1N1 influenza, the patient will be placed on Droplet~~Enhanced~~ Precautions for at least 7 days. Patients with suspected H1N1 influenza should remain i~~o~~n Droplet~~Enhanced~~ precautions until clearance to discontinue ~~Enhanced~~ Precautions has been obtained from an infectious disease physician, a pulmonologist, or consultation with Infection Prevention ~~and Control~~.

F. ***Infection control practices for healthcare personnel***

- Infection control practices for pandemic influenza are the same as for other human influenza viruses and primarily involve the application of standard and droplet precautions (Box 1) during patient care in healthcare settings (e.g., hospitals, nursing homes, outpatient offices, emergency transport vehicles). This guidance also applies to healthcare personnel going into the homes of patients.
- Infection control practices for H1N1 influenza require Droplet~~Enhanced~~ Precautions and use of a~~n~~ regular face mask~~N95 respirator at a minimum~~.

- During a pandemic, conditions that could affect infection prevention ~~control~~ may include shortages of antiviral drugs, decreased efficacy of the vaccine, increased virulence of the influenza strain, shortages of single-patient rooms, and shortages of personal protective equipment. These issues may necessitate changes in the standard recommended infection control practices for influenza. CDC will provide updated infection control guidance as circumstances dictate. Additional guidance is provided for family members providing home care (S4-IV.G) and for use in public settings (e.g., schools, workplace) where people with pandemic influenza may be encountered (S4-V and S4-VI).

1. **Personal Protective Equipment for standard and droplet precautions -** PPE is used to prevent direct contact with the pandemic influenza virus. PPE that may be used to provide care includes surgical or procedure masks, as recommended for droplet precautions, and gloves and gowns, as recommended for standard precautions (Box 1). Additional precautions may be indicated during the performance of aerosol-generating procedures (see below). Information on the selection and use of PPE is provided at www.cdc.gov/ncidod/dhqp/gl_isolation.html.
2. **Masks (surgical or procedure)**
   a. Wear a mask when entering a patient's room. A mask should be worn once and then discarded. If pandemic influenza patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between patients and hand hygiene performed.
   b. Change masks when they become moist.
   c. Do not leave masks dangling around the neck.
   d. Upon touching or discarding a used mask, perform hand hygiene.

~~3. **For H1N1 patients**, an N95 respirator will be used. The respirator may be re-used during shortages of respirators as outlined in the Practice Guideline, Re-use of N95 respirators.~~

~~4.~~3. **Gloves**
   a. A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of latex, vinyl, nitrile, or other synthetic materials are appropriate for this purpose; if possible, latex-free gloves should be available for healthcare workers who have latex allergy.
   b. Gloves should fit comfortably on the wearer's hands.
   c. Remove and dispose of gloves after use on a patient; do not wash gloves for subsequent reuse.
   d. Perform hand hygiene after glove removal.
   e. If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive patient or environmental contact with blood or body fluids, including during suctioning.
   ~~f. Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient's respiratory secretions (e.g., to~~

~~handle used tissues). Hand hygiene should be strongly reinforced in this situation.~~

~~5.~~4. **Gowns**

a. Wear an isolation gown, if soiling of personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated. Most patient interactions do not necessitate the use of gowns. However, procedures such as intubation and activities that involve holding the patient close (e.g., in pediatric settings) are examples of when a gown may be needed when caring for pandemic influenza patients.
b. A disposable gown made of synthetic fiber or a washable cloth gown may be used.
c. Ensure that gowns are of the appropriate size to fully cover the area to be protected.
d. Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.
e. If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., patient gowns) could be used. ~~It is doubtful that disposable aprons would provide the desired protection in the circumstances where gowns are needed to prevent contact with influenza virus, and therefore should be avoided. There are no data upon which to base a recommendation for reusing an isolation gown on the same patient. To avoid possible contamination, it is prudent to limit this practice.~~

~~6.~~5. **Goggles or face shield**

a. In general, wearing goggles or a face shield for routine contact with patients with pandemic influenza is not necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for standard precautions. Additional information related to the use of eye protection for infection control can be found at http://www.cdc.gov/niosh/topics/eye/eye-infectious.html.

G. ~~***B***~~***PPE for special circumstances***

- **PPE for aerosol-generating procedures**
During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a Powered Air Purifier (PAPr) ~~N95 respirator~~ or other appropriate particulate respirator. Respirators should be used within the context of a respiratory protection program that includes fit-testing, medical clearance, and training. If ~~possible,~~possible and when practical, use of an airborne isolation room may be considered when conducting aerosol-generating procedures.
- **PPE for managing pandemic influenza with increased transmissibility**
The addition of airborne precautions, including respiratory protection (an N95 filtering face piece respirator or other appropriate particulate respirator), may be considered for strains of influenza exhibiting increased transmissibility, during initial stages of an outbreak of an emerging or novel strain of influenza, and as

determined by other factors such as vaccination/immune status of personnel and availability of antivirals. As the epidemiologic characteristics of the pandemic virus are more clearly defined, CDC will provide updated infection control guidance, as needed.

- **Precautions for early stages of a pandemic**
  Early in a pandemic, it may not be clear that a patient with severe respiratory illness has pandemic influenza. Therefore precautions consistent with all possible etiologies, including a newly emerging infectious agent, should be implemented. This may involve the combined use of airborne and contact precautions, in addition to standard precautions, until a diagnosis is established.

H. ***Caring for patients with pandemic influenza*** - Healthcare personnel should be particularly vigilant to avoid:

- Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.
- Contaminating environmental surfaces that are not directly related to patient care (e.g., door knobs, light switches)

I. **Hand hygiene -** Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings (see http://www.cdc.gov/handhygiene/pressrelease.htm) and is an essential element of standard precautions. The term “hand hygiene” includes both hand washing with either plain or antimicrobial soap and water and use of alcohol-based products (gels, rinses, foams) containing an emollient that do not require the use of water.

- If hands are visibly soiled or contaminated with respiratory secretions, wash hands with soap (either non-antimicrobial or antimicrobial) and water.
- In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior micro-biocidal activity, reduced drying of the skin, and convenience.
- Always perform hand hygiene between patient contacts and after removing PPE.
- Ensure that resources to facilitate hand washing (i.e., sinks with warm and cold running water, plain or antimicrobial soap, disposable paper towels) and hand disinfection (i.e., alcohol-based products) are readily accessible in areas in which patient care is provided. For additional guidance on hand hygiene see http://www.cdc.gov/handhygiene/.

J. ***Disposal of solid waste*** **-** Standard precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with a pandemic influenza virus:

- Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of medical waste, including used needles and other sharps, and non-medical waste.

- Discard as routine waste used patient-care supplies that are not likely to be contaminated (e.g., paper wrappers).
- Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

K. ***Linen and laundry*** - Standard precautions are recommended for linen and laundry that might be contaminated with respiratory secretions from patients with pandemic influenza:

- Place soiled linen directly into a laundry bag in the patient's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area.
- Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
- Wear gloves for transporting bagged linen and laundry.
- Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
- Wash and dry linen according to routine standards and procedures (www.cdc.gov/ncidod/hip/enviro/guide.htm).

L. ***Dishes and eating utensils*** - Standard precautions are recommended for handling dishes and eating utensils used by a patient with known or possible pandemic influenza:

- Wash reusable dishes and utensils in a dishwasher with recommended water temperature (http://www.cdc.gov/ncidod/dhqp/gl_environinfection.html).
- Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of patients) should be discarded with other general waste.
- Wear gloves when handling patient trays, dishes, and utensils.

M. ***Patient-care equipment*** - Follow standard practices for handling and reprocessing used patient-care equipment, including medical devices:

- Wear gloves when handling and transporting used patient-care equipment.
- Wipe heavily soiled equipment with ~~an~~a ~~EPA-approved~~ hospital approved disinfectant before removing it from the patient's room. Follow current recommendations for cleaning and disinfection or sterilization of reusable patient-care equipment.
- Wipe external surfaces of portable equipment for performing x-rays and other procedures in the patient's room with ~~an~~a ~~EPA-approved~~ hospital approved disinfectant upon removal from the patient's room.

N. ***Environmental cleaning and disinfection*** - Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic influenza follow the same general principles used in healthcare settings.

O. ***Cleaning and disinfection of patient-occupied ~~rooms~~***
~~Wear~~rooms:

- Wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with droplet precautions. Gowns are not necessary for routine cleaning of an influenza patient's room.
- Keep areas around the patient free of unnecessary supplies and equipment to facilitate daily cleaning.
- Use any ~~EPA-registered~~ hospital approved detergent-disinfectant. Follow manufacturer's recommendations for use-dilution (i.e., concentration), contact time, and care in handling.
- Follow facility procedures for regular cleaning of patient-occupied rooms. Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes, ventilator surfaces) in addition to floors and other horizontal surfaces.
- ~~•~~Clean and disinfect spills of blood and body fluids in accordance with current recommendations for Isolation Precautions.
- ~~•~~
- Cleaning and disinfection after patient discharge or transfer
- Follow standard facility procedures for post-discharge cleaning of an isolation room.

1. Clean and disinfect all surfaces that were in contact with the patient or might have become contaminated during patient care. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.
2. Do not spray (i.e., fog) occupied or unoccupied rooms with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

~~O.~~P. ***Postmortem care***

1. Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids. For H1N1 patients, use gown, gloves, regular face mask~~N95 respirators~~, and eye protection at a minimum.

~~P.~~Q. ***Laboratory specimens and practices*** - Follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

~~Q.~~R. ***Occupational health issues*** - Healthcare personnel are at risk for pandemic influenza through community and healthcare-related exposures. Once pandemic influenza has reached a community, healthcare facilities must implement systems to monitor for illness in the facility workforce and manage those who are symptomatic or ill.

- Implement a system to educate personnel about occupational health issues related to pandemic influenza.
- Screen all personnel for influenza-like symptoms before they come on duty. Symptomatic personnel should be sent home until they are physically ready to return to duty.

- Healthcare personnel who have recovered from pandemic influenza should develop protective antibody against future infection with the same virus, and therefore should be prioritized for the care of patients with active pandemic influenza and its complications. These workers would also be well suited to care for patients who are at risk for serious complications from influenza (e.g., transplant patients and neonates).
- Personnel who are at high risk for complications of pandemic influenza (e.g., pregnant women, immunocompromised persons) should be informed about their medical risk and offered an alternate work assignment, away from influenza-patient care if possible, or considered for administrative leave until pandemic influenza has abated in the community.
- Reducing exposure of persons at high risk for complications of influenza - Persons who are well, but at high risk for influenza or its complications (e.g., persons with underlying diseases), should be instructed to avoid unnecessary contact with healthcare facilities caring for pandemic influenza patients (i.e., do not visit patients, postpone nonessential medical care).

~~R.~~S. ***Hospitals*** - Detection of persons entering the facility who may have pandemic influenza - Post visual alerts (in appropriate languages) at the entrance to hospital outpatient facilities (e.g., emergency departments, outpatient clinics) instructing persons with respiratory symptoms (e.g., patients, persons who accompany them) to:

- Inform reception and healthcare personnel when they first register for care, and
- Practice respiratory hygiene/cough etiquette (see http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm). Sample visual alerts are available on CDC's SARS website: http://www.cdc.gov/ncidod/hip/INFECT/RespiratoryPoster.pdf
- Triage patients calling for medical appointments for influenza symptoms
- Discourage unnecessary visits to medical facilities.
- Instruct symptomatic patients on infection control measures to limit transmission in the home and when traveling to necessary medical appointments.
- As the scope of the pandemic escalates locally, consider setting up a separate triage area for persons presenting with symptoms of respiratory infection. Because not every patient presenting with symptoms will have pandemic influenza, infection control measures will be important in preventing further spread.
- During the peak of a pandemic, emergency departments and outpatient offices may be overwhelmed with patients seeking care. A "triage officer" may be useful for managing patient flow, including deferral of patients who do not require emergency care.
- Designate separate waiting areas for patients with influenza-like symptoms. If this is not feasible, the waiting area should be set up to enable patients with respiratory symptoms to sit as far away as possible (at least 3 feet) from other patients.

~~S.~~T. "Source control" measures to limit dissemination of influenza virus from respiratory secretions - Post signs that promote respiratory hygiene/cough etiquette in common areas (e.g., elevators, waiting areas, cafeterias, lavatories) where they

can serve as reminders to all persons in the healthcare facility. Signs should instruct persons to:

- Cover the nose/mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions.
- Dispose of tissues in the nearest waste receptacle after use.
- Perform hand hygiene after contact with respiratory secretions.
- Facilitate adherence to respiratory hygiene/cough etiquette by ensuring the availability of materials in waiting areas for patients and visitors.
- Provide tissues and no-touch receptacles (e.g., waste containers with pedal-operated lid or uncovered waste container) for used tissue disposal.
- Provide conveniently located dispensers of alcohol-based hand rub.
- Provide soap and disposable towels for handwashing where sinks are available.
- Promote the use of masks and spatial separation by persons with symptoms of influenza.
- Offer and encourage the use of either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties or elastic) by symptomatic persons to limit dispersal of respiratory droplets.
- Encourage coughing persons to sit as far away as possible (at least 3 feet) from other persons in common waiting areas.

~~T.~~U. ***Hospitalization of pandemic influenza patients***

- Patient placement
  1. Limit admission of influenza patients to those with severe complications of influenza who cannot be cared for outside the hospital setting.
  2. Admit patients to either a single-patient room or an area designated for cohorting of patients with influenza.

- Cohorting
  1. Designated units or areas of a facility should be used for cohorting patients with pandemic influenza. During a pandemic, other respiratory viruses (e.g., non-pandemic influenza, respiratory syncytial virus, parainfluenza virus) may be circulating concurrently in a community. Therefore, to prevent cross-transmission of respiratory viruses, whenever possible assign only patients with confirmed pandemic influenza to the same room. At the height of a pandemic, laboratory testing to confirm pandemic influenza is likely to be limited, in which case cohorting should be based on having symptoms consistent with pandemic influenza.
  2. Personnel (clinical and non-clinical) assigned to cohorted patient care units for pandemic influenza patients should not “float” or otherwise be assigned to other patient care areas. The number of personnel entering the cohorted area should be limited to those necessary for patient care and support.
  3. Personnel assigned to cohorted patient care units should be aware that patients with pandemic influenza may be concurrently infected or colonized with other pathogenic organisms (e.g., Staphylococcus aureus, Clostridium difficile) and should adhere to infection control practices (e.g., hand hygiene, changing gloves between patient contact) used routinely, and as part of standard precautions, to prevent nosocomial transmission.

4. Because of the high patient volume anticipated during a pandemic, cohorting should be implemented early in the course of a local outbreak.

- Patient transport
  1. Limit patient movement and transport outside the isolation area to medically necessary purposes.
  2. Consider having portable x-ray equipment available in areas designated for cohorting influenza patients.
  3. If transport or movement is necessary, ensure that the patient wears a surgical or procedure mask. If a mask cannot be tolerated (e.g., due to the patient's age or deteriorating respiratory status), apply the most practical measures to contain respiratory secretions. Patients should perform hand hygiene before leaving the room.

- Visitors
  1. Screen visitors for signs and symptoms of influenza before entry into the facility and exclude persons who are symptomatic.
  2. Family members who accompany patients with influenza-like illness to the hospital are assumed to have been exposed to influenza and should wear masks.
  3. Limit visitors to persons who are necessary for the patient's emotional well-being and care.
  4. Instruct visitors to wear surgical or procedure masks while in the patient's room.
  5. Instruct visitors on hand-hygiene practices.

~~U.~~V. ***Control of healthcare acquired (nosocomial~~)~~pandemic~~)~~ pandemic influenza transmission*** - Once patients with pandemic influenza are admitted to the hospital, nosocomial surveillance should be heightened for evidence of transmission to other patients and healthcare personnel. (Once pandemic influenza is firmly established in a community this may not be feasible or necessary.) If limited nosocomial transmission is detected (e.g., has occurred on one or two patient care units), appropriate control measures should be implemented. These may include:

- Cohorting of patients and staff on affected units
- Restriction of new admissions (except for other pandemic influenza patients) to the affected unit(s)
- Restriction of visitors to the affected unit(s) to those who are essential for patient care and support
- If widespread nosocomial transmission occurs, controls may need to be implemented hospital wide and might include:
- Restricting all nonessential persons
- Stopping admissions not related to pandemic influenza and stopping elective surgeries

~~V.~~W. ***Care of pandemic influenza patients at alternative sites*** - If an influenza pandemic results in severe illness that overwhelms the capacity of existing

healthcare resources, it may become necessary to provide care at alternative sites (e.g., schools, auditoriums, conference centers, hotels). Existing "all-hazard" plans have likely identified designated sites for this purpose. The same principles of infection control apply in these settings as in other healthcare settings. Careful planning is necessary to ensure that resources are available and procedures are in place to adhere to the key principles of infection control.

V. PERFORMANCE STANDARDS

N/A

VI. DOCUMENTATION

N/A

VII. EVIDENCE-BASED REFERENCE

A. Reed C, Biggerstaff M, Finelli L, et al. Novel Framework for Assessing Epidemiologic Effects of Influenza Epidemics and Pandemics. *Emerging Infectious Diseases*. 2013;19(1):85-91. doi:10.3201/eid1901.120124.

B. Qualls N, Levitt A, Kanade N, et al. Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017. MMWR Recomm Rep 2017;66(No. RR-1):1–34. https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

C. Summary of Influenza Risk Assessment Tool (IRAT) Results. https://www.cdc.gov/flu/pandemic-resources/monitoring/irat-virus-summaries.htm

~~F. U.S Department of Health and Human Services (5/2007). Pandemic Planning Guidelines for Healthcare facilities.~~

~~G. CalOSHA Aerosol Transmissable Diseases Standard, Title 8, Chapter 4, 8/2009~~

~~H. CalOSHA Interim Enforcement Policy on H1N1 and Section 5199, 10/22/2009~~

~~I. CDC Updated Guidelines Regarding Infection ControlProcedures for H1N1, 10/14/2009~~

Table 1. - Summary of Infection Control Recommendations for Care of Patients with Pandemic Influenza

COMPONENT	RECOMMENDATIONS
	STANDARD PRECAUTIONS
Hand hygiene	Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items; after removing gloves; and between patient contacts. Hand hygiene includes both handwashing with either plain or antimicrobial soap and water or use of alcohol-based products (gels, rinses, foams) that contain an emollient and do not require the use of water. If hands are visibly soiled or contaminated with respiratory secretions, they should be washed with soap (either non-antimicrobial or antimicrobial) and water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbicidal activity, reduced drying of the skin, and convenience.
Personal protective equipment (PPE) • Gloves • Gown • Face/eye protection (e.g., surgical or procedure mask ~~or N95 for H1N1 patients~~ and goggles or a face shield	• For touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and non-intact skin • During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated • During procedures and patient care activities likely to generate splash or spray of blood, body fluids, secretions, excretions
Safe work practices	Avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces with contaminated gloves and other PPE that are not directly related to patient care (e.g., door knobs, keys, light switches).
Patient resuscitation	Avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions.
Soiled patient care equipment	Handle in a manner that prevents transfer of microorganisms to oneself, others, and environmental surfaces; wear gloves if visibly contaminated; perform hand hygiene after handling equipment.
Soiled linen and laundry	Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves (gown if necessary) when handling and transporting soiled linen and laundry; and perform hand hygiene.
Needles and other sharps	Use devices with safety features when available; do not recap, bend, break or hand-manipulate used needles; if recapping is necessary, use a one-handed scoop technique; place used sharps in a puncture-resistant container.
Environmental cleaning and disinfection	Use ~~EPA registered~~ hospital approved detergent-disinfectant; follow standard facility procedures for cleaning and disinfection of environmental surfaces; emphasize cleaning/disinfection of frequently touched surfaces (e.g., bed rails, phones, lavatory surfaces).
Disposal of solid waste	Contain and dispose of solid waste (medical and non-medical) in accordance with facility procedures and/or local or state regulations; wear gloves when handling waste; wear gloves when handling waste containers; perform hand hygiene.
Respiratory hygiene/cough etiquette Source control measures for persons with symptoms of a respiratory infection; implement at first point of	Cover the mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacles; perform hand hygiene after contact with respiratory secretions; wear a mask (procedure or surgical) if tolerated; sit or stand as far away as possible (more than 3 feet) from persons who are not ill.

encounter (e.g., triage/reception areas) within a healthcare setting.	
Droplet Precautions	http://www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html
Patient placement	Place patients with influenza in a private room or cohort with other patients with influenza.* Keep door closed ~~or slightly ajar~~; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet precautions to all persons in the room. *During the early stages of a pandemic, infection with influenza should be laboratory-confirmed, if possible. Personal protective equipment Wear a surgical or procedure mask for entry into patient room; wear other PPE as recommended for standard precautions.
Patient transport	Limit patient movement outside of room to medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.
Other	Follow standard precautions and facility procedures for handling linen and laundry and dishes and eating utensils, and for cleaning/disinfection of environmental surfaces and patient care equipment, disposal of solid waste, and postmortem care.
Aerosol-Generating Procedures	During procedures that may generate small particles of respiratory secretions (e.g., endotracheal intubation, bronchoscopy, nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 respirator or other appropriate particulate respirator.
COMPONENT	ENHANCED PRECAUTIONS FOR H1N1
Patient Placement	Place patients with H1N1 influenza in a private room or cohort with other patients with H1N1 influenza.* Keep door closed; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet ~~enhanced~~ precautions to all persons in the room. Personal protective equipment Wear a regular face mask ~~N95 respirator~~ for entry into patient room; wear other PPE as recommended for standard precautions.
Patient transport	Limit patient movement outside of room to medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.
Other	Follow standard precautions and facility procedures for handling linen and laundry and dishes and eating utensils, and for cleaning/disinfection of environmental surfaces and patient care equipment, disposal of solid waste, and postmortem care.
Aerosol-Generating Procedures	During procedures that may generate small particles of respiratory secretions (e.g., endotracheal intubation, bronchoscopy, nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 respirator or other appropriate particulate respirator.

Box 2. Respiratory Hygiene/Cough Etiquette

To contain respiratory secretions, all persons with signs and symptoms of a respiratory infection, regardless of presumed cause, should be instructed to:

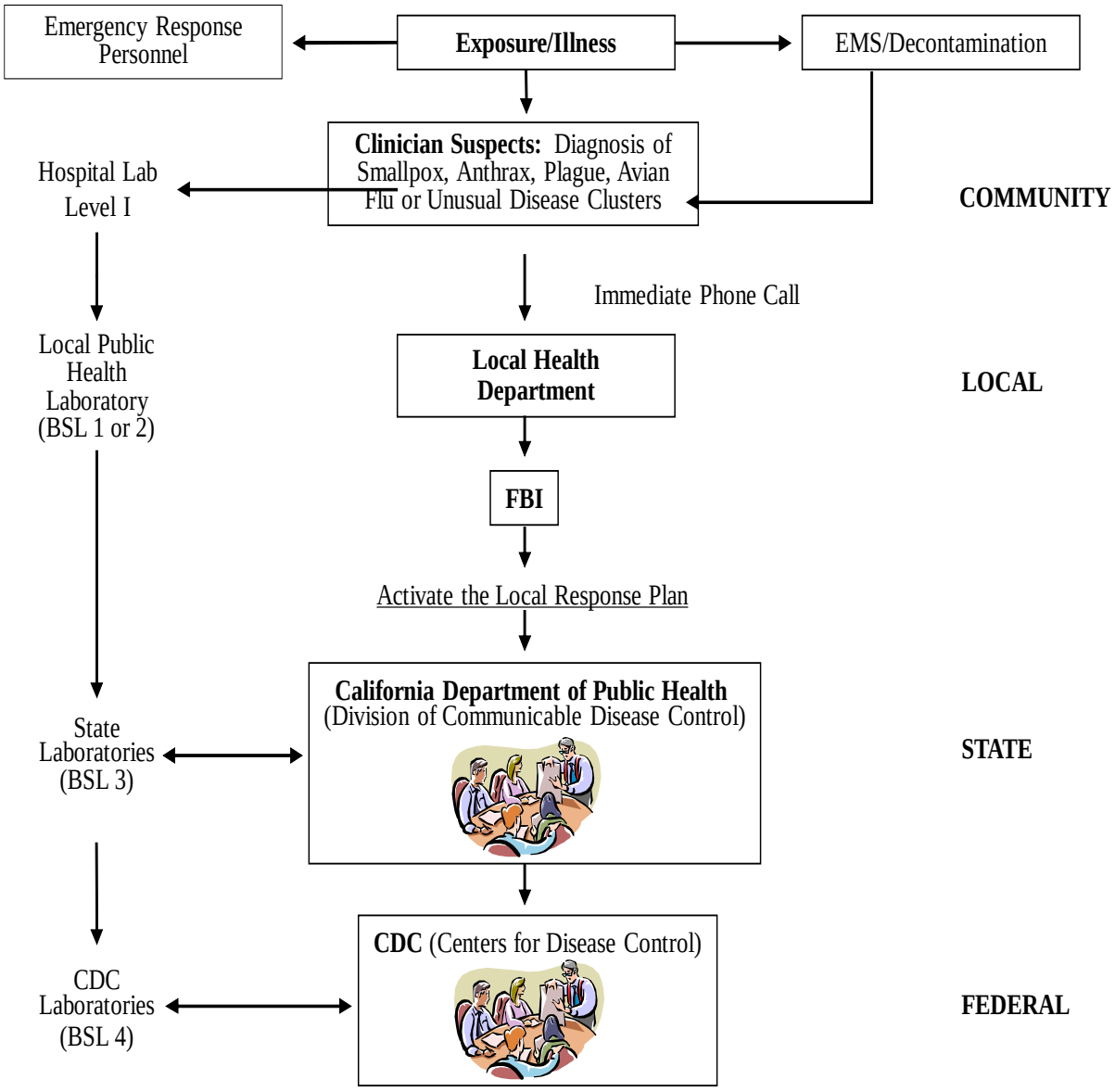
- Cover the nose/mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions.
- Dispose of tissues in the nearest waste receptacle after use.
- Perform hand hygiene after contact with respiratory secretions and contaminated objects/materials.

Healthcare facilities should ensure the availability of materials for adhering to respiratory hygiene/cough etiquette in waiting areas for patients and visitors:

- Provide tissues and no-touch receptacles for used tissue disposal.
- Provide conveniently located dispensers of alcohol-based hand rub.
- Provide soap and disposable towels for handwashing where sinks are available.

Masking and separation of persons with symptoms of respiratory infection:
During periods of increased respiratory infection in the community, persons who are coughing should be offered either a procedure mask (i.e., with ear loops) or a surgical mask (i.e., with ties) to contain respiratory secretions. Coughing persons should be encouraged to sit as far away as possible (at least 3 feet) from others in common waiting areas. Some facilities may wish to institute this recommendation year-round.

Reporting Influx of Communicable Illnesses



~~CALOSHA ATD.pdf~~

~~CDPH_NasopharyngealSwabCollection_042009.pdf~~

~~Enhanced_Precautions_Sign_-_English.pdf~~

~~Enhanced_Precautions_Sign_-_SPANISH.pdf~~

~~Executive Strategic Plan 9.9.09.xls~~

~~OSHA Instruction.pdf~~

~~Visitor and Family Members Guide to Enhanced Isolation.doc~~

~~Visitor and Family Members Guide to Enhanced Isolation - SPANISH.doc~~

Salinas Valley Memorial Healthcare System

REQUESTING A BIOETHICS CASE CONFERENCE PROCEDURE

Reference Number	6869
Effective Date	Not Approved Yet
Applies To	All Departments
Attachments/Forms	Attachment A

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To outline the process for requesting a bioethics case conference.

B. A request for consultation may come at any time from any individual who is concerned about an existing or potential ethical dilemma for a patient including family members.

III. DEFINITIONS:

A. Bioethics is the discipline that addresses ethical issues that arise in the health care setting, including those related to life and death, cure and comfort, truth telling and trust reflected in patient care and decision making. These are moral issues central to decision-making and the provision of patient care. The concerns of bioethics are the well-being and dignity of the patient; the rights, responsibilities and choices of the patient, family and care team; and matters of justice and access to care. In practice, bioethics includes behaviors that promote dignity, fairness, honesty, compassion and trust in all interactions between and among the health care team, patients and families.

IV. GENERAL INFORMATION:

A. N/A

V. PROCEDURE:

A. If there is a bioethical concern, the team member should discuss with the Attending Physician.

B. A Bioethics Consult can be entered through the Meditech order entry system.

C. The case will be reviewed to determine appropriateness for consultation.

D. If the case is determined to be appropriate:

1. A meeting will be arranged with appropriate stakeholders
2. Social Services will contact the family and:
    a. Provide the family with a copy of the brochure *BIOETHICS/BIOETICA* (directing their attention to the explanation of the purpose of the bioethics committee) and invite the family to the meeting.
    b. Alert Admitting if a translator will be needed.
    c. Ask the family if they wish to include their minister or counselor in the meeting as well.
3. The bioethics facilitator will conduct a chart review and bedside assessment as appropriate.

E. If the referral does not involve a medical ethics issue, the facilitator will direct the referring party to alternative resources.

F. The Case Conference Panel will encourage any individuals who have information about the case to participate in the Case Conference.

G. Documentation:

1. Documentation in the medical record will reflect that a consultation was held and recommendations and/or guidance was provided to the family and care team. Additional documentation regarding specific recommendations and findings will be made by the bioethics facilitator or team member as appropriate.
2. The attending physician will be alerted of the findings and recommendations by the bioethics facilitator.

VI. EDUCATION/TRAINING:

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

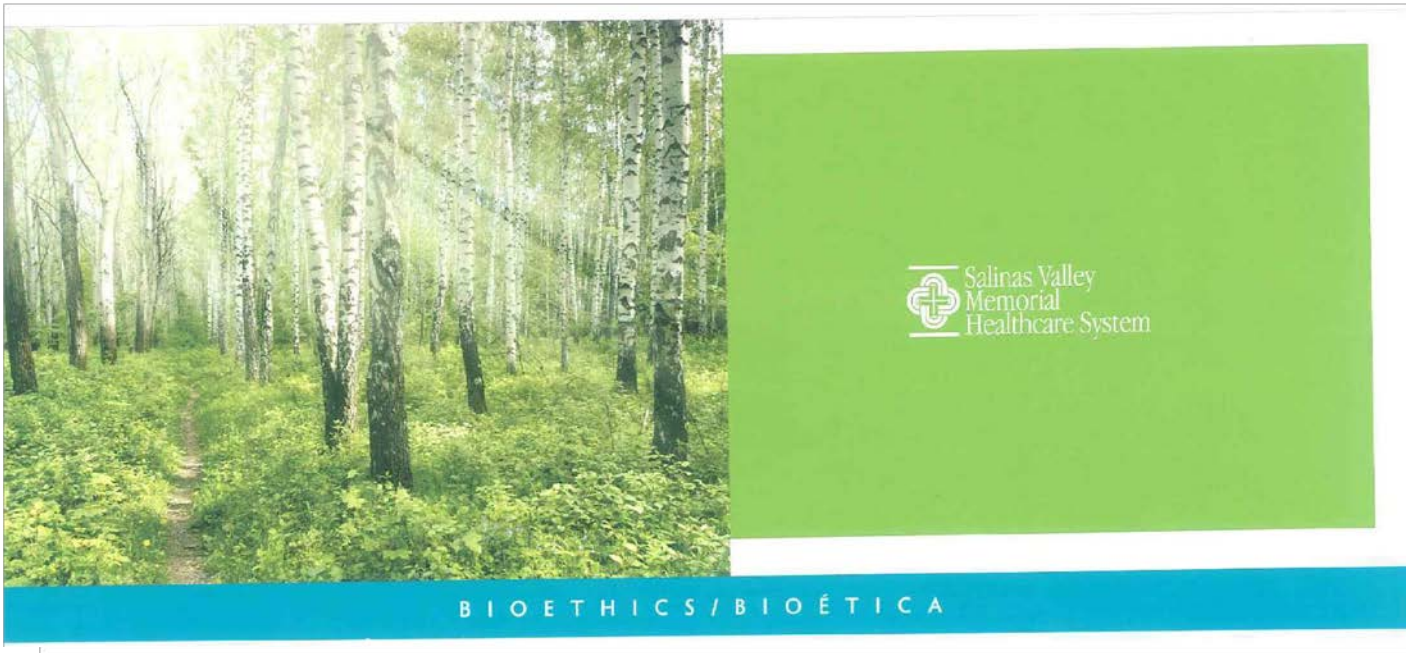
VIII. REFERENCES:

A. BIOETHICS/BIOETICA BROCHURE (2016)

REQUESTING A BIOETHICS CASE CONFERENCE PROCEDURE

ATTACHMENT A

BIOETHICS / BIOETICA BROCHURE



BIOETHICS COMMITTEE

Bioethics deals with the ethical and moral problems that occur in health care.

The Bioethics Committee at Salinas Valley Memorial Healthcare System offers support to patients, families, and staff who are facing difficult decisions in medical care.

The Committee consists of doctors, nurses, social workers, chaplains and community members.

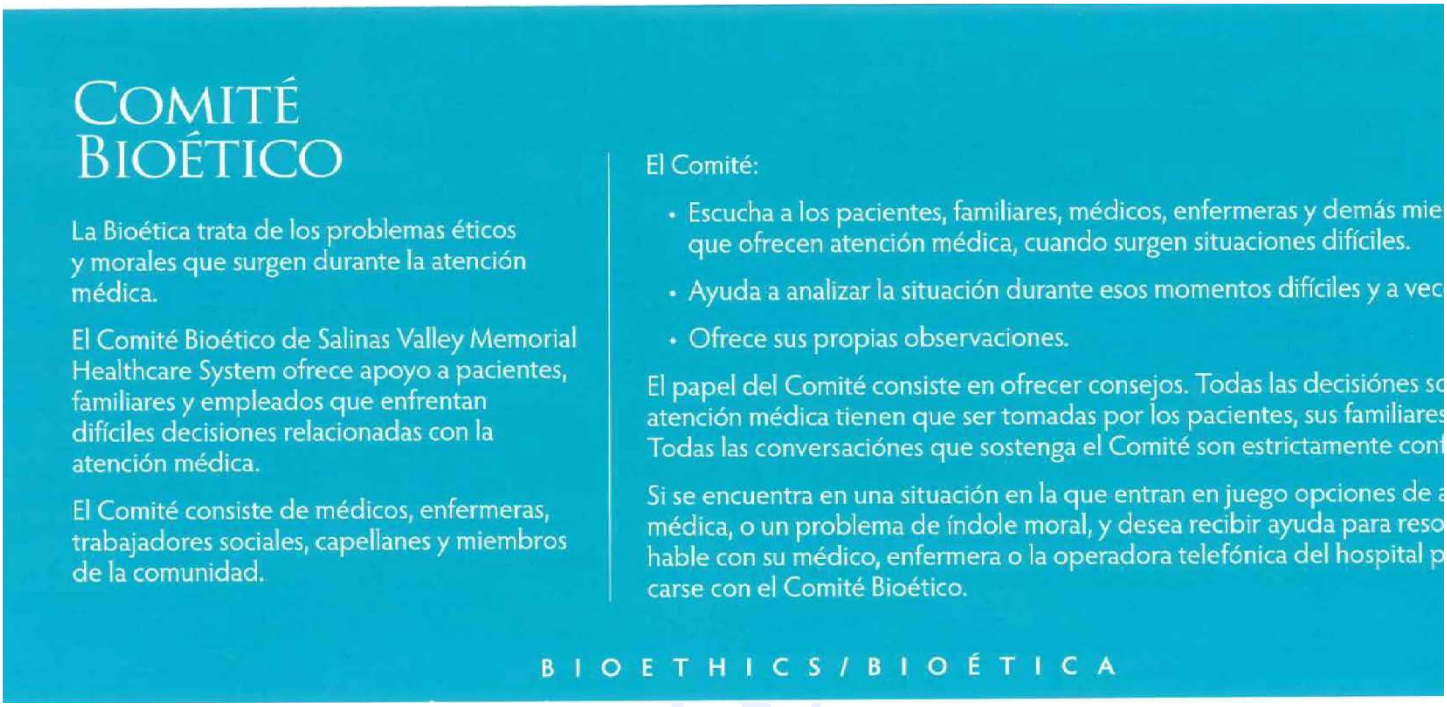
The committee:

- Listens to patients, families, doctors, nurses and other healthcare members involved in difficult situations.
- Helps thinking-through these difficult and sometimes confusing t
- Offers their own observations.

The Committee's role is to offer advice. All healthcare decisions must patients, families and their doctors. All discussions of the Committee confidential.

If you have a medical situation involving choices of medical care or a and would like some help in resolving your case, you may contact the Committee by speaking to your doctor, nurse, or the hospital telephe

REQUESTING A BIOETHICS CASE CONFERENCE PROCEDURE



COMITÉ BIOÉTICO

La Bioética trata de los problemas éticos y morales que surgen durante la atención médica.

El Comité Bioético de Salinas Valley Memorial Healthcare System ofrece apoyo a pacientes, familiares y empleados que enfrentan difíciles decisiones relacionadas con la atención médica.

El Comité consiste de médicos, enfermeras, trabajadores sociales, capellanes y miembros de la comunidad.

El Comité:

- Escucha a los pacientes, familiares, médicos, enfermeras y demás mie
que ofrecen atención médica, cuando surgen situaciones difíciles.
- Ayuda a analizar la situación durante esos momentos difíciles y a vec
- Ofrece sus propias observaciones.

El papel del Comité consiste en ofrecer consejos. Todas las decisiónes sc
atención médica tienen que ser tomadas por los pacientes, sus familiares
Todas las conversaciónes que sostenga el Comité son estrictamente con

Si se encuentra en una situación en la que entran en juego opciones de a
médica, o un problema de índole moral, y desea recibir ayuda para reso
hable con su médico, enfermera o la operadora telefónica del hospital p
carse con el Comité Bioético.

BIOETHICS / BIOÉTICA

ATTACHMENT A

BIOETHICS / BIOETICA BROCHURE (cont'd)

Salinas Valley Memorial Healthcare System

LABORATORY EDUCATION, STAFF DEVELOPMENT AND FEEDBACK

Reference Number	5669
Effective Date	Not Approved Yet
Applies To	Laboratory
Attachments/Forms	

I. POLICY STATEMENT:

A. N/A ~~All employees are required to:~~

~~1. Participate in hospital sponsored continuing education via e-learning, or in a classroom setting The content and duration are defined by the hospital/department needs and the individual needs, as determined by the initial employee needs assessment. Refer to hospital policy #866~~ EDUCATION AND STAFF DEVELOPMENT

~~2. Be knowledgeable of hospital and departmental policies via attending lab meetings or reviewing minutes from those meetings.~~

~~3. It is the responsibility of licensed staff to maintain the minimum number of continuing education unis required for re-licensure and to provide proof of current licensure and certification. Employees with expired licensure or certifications may not work until re-licensure documentation is obtained.~~

II. PURPOSE:

A. The Laboratory department provides ongoing education opportunities to keep staff members informed of changes in both the hospital, the department and in the laboratory profession. Technical personnel are required to complete ongoing continuing education as a requirement of licensure.

B. Staff receives ongoing feedback regarding issues of specimen quality and test performance through periodic discussions, emails from section supervisors/leads, department bulletin boards and work area postings.

C. Additionally, patients may also communicate concerns about quality and safety to management via an online survey as well and/or by filling out a suggestion card available in the laboratory.

III. DEFINITIONS:

A. N/A

IV. GENERAL INFORMATION:

~~B.~~A. All employees are required to:

1. Participate in hospital sponsored continuing education via e learning, or in a classroom setting The content and duration are defined by the hospital/department needs and the individual needs, as determined by the initial employee needs assessment. Refer to hospital policy #866 EDUCATION AND STAFF DEVELOPMENT
2. Be knowledgeable of hospital and departmental policies via attending lab meetings or reviewing minutes from those meetings.
3. It is the responsibility of licensed staff to maintain the minimum number of continuing education unis required for re-licensure and to provide proof of current licensure and certification. Employees with expired licensure or certifications may not work until re-licensure documentation is obtained.

V. **PROCEDURE:**

A. Any or all of the following may be used to update staff:

1. Staff Meetings/Supervisor, Lead Meetings – held monthly when possible. Additional meetings may be scheduled to address agenda items that cannot wait for the regularly scheduled meeting. Attendance is recorded and minutes sent out via email.
2. Agenda items can include:
    a. Communication issues
    b. Computer functionality
    c. New or changed policy and/or procedure
    d. Updates from Hospital Administration
    e. Updates from the Medical Director – including assessment of clinical needs of lab and strategic planning for laboratory operations
    f. Open agenda discussion items as needed
    g. 5-Minute Checkups – brief ongoing communication on various items. Checkup may also include items related to the Laboratory Quality Indicators and positive feedback to the staff. Minutes are sent to staff via email and kept electronically by the director.

B. New employee orientation – completed for each procedure/department before employee is scheduled to perform testing. New employees also attend a hospital orientation and complete a department orientation checklist.

C. Annual Employee Competency – completed for all technical personnel by department. Any employee not meeting standards is retrained and reassessed

D. Instrument updates or new analyzer in-services – completed in the individual departments as needed.

1. Trainings are documented by the department supervisor/lead or designee

E. Specimen collection/specimen quality feedback –

1. Employees who collect specimens are given feedback regarding their technique as part of their competency assessment. Other mechanisms to communicate specimen quality include feedback via staff meetings, email or in person on the following as appropriate:

    a. Blood culture contamination rates

    b. Order to Collect Turn Around Times

    c. Productivity by collector

    d. Other items are communicated as needed

    e. Mislabeled specimen tracking – mislabels are recorded and the director of the department notified via email upon discovery. The director then follows up with employee either with a coaching or disciplinary process based on the severity of the error. Data with follow-ups is reported at the QIC by invitation and uploaded to the Quality Dashboard located on the N drive.

F. CEU's – Staff have access to free CEU's through various instrument/product vendors or reagent manufacturers, as well as through the CAP website and other professional organizations. Upcoming CEU offerings are maintained in the various departments and communicated via email to the appropriate staff. On occasion, vendors may offer an on-site program that meets CEU requirements.

1. Technical staff may be assigned to training as part of new instrument acquisition and start up.

2. Technical staff may take time off to attend workshops or professional meetings- requests will be reviewed and approvals granted on a case by case basis.

—Written evaluations or formal presentations of in-services may be required of attendees.

3.

G. Pathologist Assessment of Laboratory Clinical Needs- the Pathologists are available for all staff members to ask questions, resolve technical problems or provide education as needed. Pathologists are on call if the problem is a critical patient care issue. The Medical Director and Pathologists evaluate the clinical needs of the laboratory and assess the necessity of implementing new testing or discontinuing testing based on the population being served as well as industry standards. These assessments are then discussed with Lab Leadership and staff and recorded in meeting minutes, emails and other forms of communication.

H. Laboratory Administrative Education – subscriptions to related journals and educational programs are reviewed on a case by case basis.

~~G.~~I. Employee Annual Reviews – Employee self-assessments are part of the employee annual review process. This time can be very effective in directing staff goals, empowering effective behaviors, encouraging educational development, and helping employees improve performance and overcome challenges. These items are all discussed with leadership during the Employee's Annual Review, and can be an excellent time for feedback and development. ~~et~~

~~H.~~J. Documentation:

1. Hospital wide education is documented in the Education Department e learning system
2. Department education is documented in each employee's file, both annual competency and new hire orientation
3. CEU Documentation is maintained by each employee according to the technical requirements for licensure. Employee verifies CEUs as part of annual competency assessment.

~~1.~~4. An annual Employee Engagement Survey is conducted by the organization.

   a. The results are published for the Department and discussed at staff meetings.

   b. Three areas are selected to improve upon. Action plans are discussed at staff meetings.

VI. EDUCATION/TRAINING:

A. Orientation and Department Specific Competency.

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

~~VII.~~ REFERENCES:

~~VIII.~~VII.

A. College of American Pathologists Laboratory Checklist

A. Pathologist Assessment of Laboratory Clinical Needs- the Pathologists are available - the Pathologists are available for all staff members to ask questions, resolve technical problems or provide education as needed. Pathologists are on call if the problem is a critical patient care issue. . The Medical Director and Pathologists evaluate the clinical needs of the laboratory and assess the necessity of implementing new testing or discontinuing testing based on the population being served as well as industry standards. These assessments are then discussed with Lab Leadership and staff and recorded in meeting minutes, emails and other forms of communication.

B. Laboratory Administrative Education – subscriptions to related journals and educational programs are reviewed on a case by case basis.

IX. **STAFF DOCUMENTATION :**

A. Hospital wide education is documented in the Education Department e learning system

B. Department education is documented in each employee's file, both annual competency and new hire orientation

C. CEU Documentation is maintained by each employee according to the technical requirements for licensure. Employee verifies CEUs as part of annual competency assessment.

D. An annual Employee Engagement Survey is conducted by the organization.

- The results are published for the Department and discussed at the monthly meetings.
- Three areas are selected to improve upon. Action plans are discussed at monthly meeting.

Signature on file Not Approved Yet
Johnny Hu, MD Date
Medical Director, Laboratory

Signature on file Not Approved Yet
Lynne McKeever, CLS Date
Laboratory Director

Salinas Valley Memorial Healthcare System

LABORATORY EDUCATION, STAFF DEVELOPMENT AND FEEDBACK

Salinas Valley Memorial Healthcare System

ADMISSION AND SHIFT ASSESSMENT OF THE PEDIATRIC PATIENT

Reference Number	233
Effective Date	Not Approved Yet
Applies To	PEDIATRICS
Attachments/Forms	Attachment A

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To guide the staff with providing age appropriate admission and shift assessment to the pediatric patient.

III. DEFINITIONS:

A. Neonate: Less than 28 days of age

B. Infant: 28 days of age to one (1) year of age

C. Toddler: One (1) year ~~to~~through ~~two~~ three (~~2~~3) years of age

D. Preschooler: Three (3) through~~to~~ five (5) years of age

E. School age: Six (6) through~~to~~ nine (9) years of age

F. Pre-teen: Ten (10) through~~to~~ twelve (12) years of age

G. Adolescent: Thirteen (13) through~~to~~ fifteen (15) years of age

~~IV. GENERAL INFORMATION:~~

~~A.~~

~~V.~~IV. GENERAL INFORMATION:

A. An Admission assessment and reassessment will be conducted per the ADMISSION HISTORY/ASSESSMENT & RE-ASSESSMENT OF THE PATIENT. The admission assessment will be completed by the Registered Nurse (RN).

B. Assessments and interventions will reflect patient's developmental stage.

C. Pediatric Standards of Care described below apply to patients 13 years of age and below. They are further categorized into neonate, infant, toddler, school age, pre- teen and adolescent.

D. Families are educated on the patient condition, hospital routines and anticipated treatments including pain management measures and are encouraged to participate in care. PARENT PARTICIPATION - PEDIATRICS CLINICAL PROCEDURE

E. Patients will be transferred to a higher level of care as condition warrants.

~~VI.~~V. **PROCEDURE:**

A. ***Assessments/Monitoring for admission and each shift:***

1. Height and weight Measurements:
2. *Patients from birth to 24 months:*
    a. Length (must be obtained in the supine position) in meters (m) or centimeters (cm). Weight obtained in kilograms (kg). Head circumference in centimeters. Date of birth and age in months will be automatically pulled from the electronic health record (EHR)
3. *Patients from 25 months to adult:*
    a. Stature or height in m or cm (i.e., standing height), weight in kg. Date of birth and age in months will be automatically pulled from the EHR.
4. Weight is measured daily for: PATIENT WEIGHTS CLINICAL PROCEDURE
    a. Patients admitted for failure to thrive, dehydration, cardiac disease, renal disease or on nutrition support.
    b. Patients under 1 year of age
    c. Or per physician's order
5. Vital signs including heart rate, respiration rate and temperature are taken every four (4) hours and as needed. Blood pressure is taken every twelve (12) hours and as needed.
6. Pain assessments include quality, duration, location and cause of pain if possible. Pain level should be reassessed within a reasonable time frame. Generally, IV/IM medications reach effectiveness within 30 min and PO medications within one hour. Involve parents/legal guardians in the assessment of pain in their child. For pain:
    a. Pre-medicate patient before any painful procedures as ordered.

b. Provide alternative comfort measures/therapies as appropriate PAIN MANAGEMENT

c. Instruct and provide informational booklet for Patient Controlled Analgesia (PCA) use as needed. Explain significance of PCA to parents/legal guardians PAIN MANAGEMENT BY PCA /CADD/ EPIDURAL

7. Respiratory assessment including lung sounds; respiratory patterns; and oxygen saturations as appropriate. Respiratory interventions include:

   a. Encourage deep breathing, coughing and ambulation unless contraindicated.

   b. Provide incentive spirometers or age appropriate alternatives for use.

   c. Elevate the head of the bed 30-45 degrees to facilitate respiratory exchange unless contraindicated.

   d. If emergency oxygen is necessary as indicated by cyanosis or oxygen desaturation, administer and immediately notify the physician to update patient's condition and ~~-~~obtain oxygen order.

8. If chest tubes are present refer to CHEST TUBE MANAGEMENT:

   a. Maintain chest tube patency; suction to 20 centimeters or as ordered; monitor type and amount of drainage; record volume after the first hour, then every four (4) hours as ordered/indicated; record presence of air leak or crepitus.

   b. Assess condition of dressing every four (4) hours and ~~,~~ensure that it is occlusive.

9. Cardiovascular assessment including regularity of apical pulse and heart tones for murmurs. It will also include assessment of capillary refill and peripheral pulses.

   a. PEDIATRIC CARDIO RESPIRATORY AND PULSE OXIMETRY MONITORING ~~It will also include capillary refill and peripheral pulse for quality and equality, and noting any present edema.~~

10. Neurological/musculoskeletal assessment including orientation and level of consciousness (LOC); developmentally appropriate speech; sensation and movement of all extremities; reflexes based on diagnosis as appropriate (See addendum A); and head circumference on admission for all children under the age of two (2) years.

    ~~11.~~a. For patients admitted with a convulsion or neurological injury and/or diagnosis the coma scale for children under two (2), should be used in conjunction with vital signs.

~~12.~~b. For seizure patients minimize stimulation. Set up suction at head of the bed. Have Oxygen mask and tubing set up at bedside. Place seizure pads on bed/crib as needed.

~~13.~~11. Integumentary assessment includ~~ing~~es skin and mucous membranes for color, temperature, integrity, turgor and moisture. For newborns, assess the condition of the umbilicus for discharge/drainage and evidence of herniation. Assess drains, wounds, dressings, and drainage characteristics every twelve (12) hours and as needed. See also SKIN ASSESSMENT, PRESSURE INJURY-IDENTIFICATION, PREVENTION AND TREATMENT CLINICAL PROCEDURE and WOUND MANAGEMENT

~~14.~~12. Calculate skin risk assessment on admission and each shift.

~~15.~~13. A pediatric IV may remain in place for as long as indicated if it is infusing well without pain or redness at site, and there is no evidence of infiltration or phlebitis. I.V. THERAPY - PERIPHERAL

a. A pediatric IV will be assessed for patency, site dressing and skin condition every two (2) hours.

~~16.~~14. Provide pericare daily and after incontinent episodes and as needed.

~~17.~~15. Gastrointestinal/Genitourinary assessment includes bladder condition, bowel sounds and abdominal distention. Bowel movements and voiding should be documented~~assessed~~. Weigh diapers (1 gram = 1 milliliter) for output.

a. Initiate routine bowel care as ordered. If patient has not had a bowel movement in three (3) days, notify physician.

b. It is recommended that stool and urine samples be collected within four (4) hours of time of order.

~~18.~~16. Nutrition assessment includes confirming tube-feeding placement every four hours and checking residuals as applicable; tolerance to diet; percent of meals eaten; frequency of feedings. Latch, suck, and position for breast or bottle feeding is assessed

a. Delivering intravenous (IV) fluids through use of an infusion pump to children 13 years of age and younger is recommended. It is recommended that children eight (8) years of age and younger have a macrobore extension set (filter) as well.

i. Pumps for patients eight and under are set to deliver two hours of fluid.

b. Consult ~~Provide~~ lactation services~~support~~ for the breast feeding mother. BREASTFEEDING THE NEWBORN

c. Provide storage for breast milk (See BREAST MILK, DONOR HUMAN MILK, CONCENTRATED HUMAN MILK FORTIFIER STORAGE, FREEZING AND DEFROSTING).

d. Monitor for signs and symptoms of hypoglycemia and hyperglycemia. ~~Insert hypoglycemia plic~~

e. Assist with baths daily and as needed.

f. Provide oral care after each meal, at bedtime and as needed.

~~19.~~17. Cultural and spiritual assessment should ensure patient needs are met in each area. Developmental assessment related to age as well as psychosocial assessment including parents/legal guardians/child interaction should also be incorporated. Signs of abuse are monitored and reported to the appropriate agencies (ABUSE AND ASSAULT REPORTING REQUIREMENTS)

~~20.~~a. Arrange for parent/legal guardian/family member to spend the night with child.

~~21.~~b. Use the treatment room for painful procedures.

~~22.~~c. Use distraction techniques and breathing techniques as appropriate to reduce anxiety.

~~23.~~d. Allow parents to stay with children during painful procedure as appropriate.

~~24.~~e. Arrange and coordinate schooling activities/tutor for stays greater than two (2) weeks with Social Services.

~~25.~~f. Encourage patient and parents/legal guardians/family to communicate feelings and concerns.

~~26.~~g. Offer spiritual consult as needed.

~~27.~~h. Modify care in accordance with patient's cultural beliefs.

~~28.~~i. Obtain an interpreter or use electronic interpreter as needed. INTERPRETER/TRANSLATOR COMMUNICATION POLICY

~~29.~~j. Provide age appropriate toys.

~~30.~~k. Refer to Bio-Ethics committee as warranted. ~~REQUESTING A BIOETHICS CASE CONFERENCE~~ [CP1]

~~31.~~18. Safety assessment includes identification bands; allergy bands, risk to fall; security sensor; availability of call lights; ability to turn self; age appropriate toys; side rails up (Four side rails on beds are considered a restraint and should not be up simultaneously); and age appropriate bed. It is recommended that children two and under sleep in a crib (complete crib release form as necessary). The need for isolation is assessed. Safety interventions include:

~~32.~~a. Initiate Pediatric Security system. (PEDIATRIC SECURITY STANDARDS)

~~33.~~b. Check patient's ID band and other wristbands such as for allergy, risk to fall and Do Not Resuscitate (DNR) status.

~~34.~~c. Place call light, phone, personal items, and bedside table within reach, as appropriate to age of patient.

~~35.~~d. Follow fall precautions as outlined in FALLS, MANAGEMENT OF THE PATIENT POLICY.

~~36.~~e. Ability to perform activities of daily living and risk assessment should be completed on admission and as needed.

~~37.~~f. Co-ordinate care to support infant/child sleep/wake states.

~~38.~~g. Cluster care to avoid unnecessary anxiety.

B. Clinical staff are responsible for the education of patients, and parents/legal guardians, as appropriate on:

1. The disease process and medical treatments.
2. Back to Sleep for infants who cannot turn over independently.
3. Sudden Infant Death Syndrome (SIDS) for parents/legal guardians of patients one (1) year of age and below.
4. Shaken Baby Syndrome for parents/legal guardians of patients four (4) years of age and below.
5. Orientation to Hospital and Unit
6. Age appropriate development.
7. Provide car seat information to parents/legal guardians for children younger than eight (8) years of age and/or at a height less than four (4) feet, nine (9) inches. (CAR SEAT CLINICAL PROCEDURE)
8. Encouraging parents/legal guardians to attend CPR and wellness/parenting classes.

C. The RN should observe parental/legal guardian knowledge base and provide literature or referral to appropriate resources.

D. Documentation:

1. Admission histories ~~are completed in the EHR and~~ should be initiated within 2 hours of admission or as patient condition warrants and completed in EHR. ADMISSION HISTORY/ASSESSMENT & RE-ASSESSMENT OF THE

PATIENT Emergency Drug Dosing Calculator ~~for CODE~~for CODE WHITE and CODE WHITE NEONATAL, are printed and placed in the patient's chart..

2. Shift assessments are charted per EHR by the end of the shift.
3. Pain assessment screens are to be completed in the EHR at least once a shift and with each episode of pain.
4. Parent/legal guardian/patient refusal for treatment or procedure is documented in a nursing note in the EHR.
5. Information pertinent to patient plan of care, assessment or health that is not documented in assessment screens or that requires elaboration is documented in a nursing note in the EHR.
6. In the event computer documenting software is not available, downtime forms are used. MEDITECH DOWNTIME PROCEDURE
7. Additional documentation is per the ADMISSION HISTORY/ASSESSMENT & RE-ASSESSMENT OF THE PATIENT

~~VII.~~VI. EDUCATION/TRAINING:

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

~~VIII.~~VII. REFERENCES:

A. Earhart, A., Jorgensent, J., & Kaminski, D. (2007). Assessing Pediatric Patients for Vascular Access and Sedation. Journal of Infusion Nursing 30(4) , 226-231.

B. Hockenberry, M. J., & Wilson, D. (2014). Wong's Nursing Care of Infants and Children, 10th Edition, Philadelphia: Mosby.

C. Neal, A., Frost, M., Kuhn, J., Green, A., Gance-Cleveland, B., & Kersten, R. (2007). Family Centered Care Within An Infant-Toddler Unit. Pediatric Nursing 33(6) , 481-486.

D. American Academy of Pediatrics; Red Book Atlas of Pediatric Infectious Diseases, 4th Ed -(201~~6~~9).

E. American Academy of Pediatrics; Pediatric Clinical Practice Guidelines and Policies. 20~~16~~th Edition (2020~~16~~).

ADMISSION AND SHIFT ASSESSMENT OF THE PEDIATRIC PATIENT

ATTACHMENT A

A. Babinski Reflex: Stroking the foot from heel to toe causes dorsiflexion of the big toe with fanning of the remaining toes. The reflex disappears at three (3) months of age.

B. Moro Reflex: Single most important reflex in determining central nervous system functioning in infants up to four (4) months of age. A sudden jarring or change in equilibrium causes sudden extension and abduction of extremities. The index and thumb form a "C" while the remainder of the fingers fan. This is followed by flexion and adduction. The reflex is seen until three (3) to four (4) months, and is strongest at two (2) months of age.

C. Motor Strength: While not a reflex, the ability to follow commands as well as determine motor strength is important in determining neurological status. Patients if able to stand can stand; hold up arms with palmar surface up to determine upper body strength. Weakness is indicated if arms drift downward or palmar surface turns downward. Lower body strength can be determined by having patients lift legs against resistance while lying in bed. Developmental consideration is used in assessing patient's ability to follow commands.

D. Palmar reflex: Pressure on palmar surface will stimulate grasp strong enough to raise infant by examiners fingers. The reflex will disappear by six (6) weeks to three (3) months of age.

E. Plantar reflex: When an object is placed on the plantar surface of the foot the toes will curl around it. The reflex disappears at eight (8) to nine (9) months of age.

F. Pupillary Reflex: Pupils are assessed to ensure they are equal, round, reactive to light (brisk or sluggishly) bilaterally. Pinpoint pupils can be indicative of drugs or pons damage. One dilated pupil is indicative of compressed Cranial Nerve III. Abnormal findings are reported to the physician. Used for patients of all ages.

G. Sucking reflex: Stimulated by touching baby's lips or placing an object in the mouth. Unstimulated, the reflex will disappear rapidly.

H. Symmetry: While not a reflex, symmetry of strength in extremities and facial features can be indicative of neurological status.

QUALITY AND EFFICIENT PRACTICES COMMITTEE

Minutes from the April 26, 2021 meeting of the Quality and Efficient Practices Committee will be distributed at the Board Meeting

(JUAN CABRERA)

FINANCE COMMITTEE

Minutes from the April 26, 2021 meeting of the Finance Committee will be distributed at the Board Meeting

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

(RICHARD TURNER)

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

THE PROPOSED RECOMMENDATION TO BOARD OF DIRECTORS TO ADOPT THE INITIAL STUDY AND THE MITIGATED NEGATIVE DECLARATION AND APPROVE THE MITIGATION MONITORING AND REPORTING PROGRAM FOR THE DOWNING RESOURCE CENTER PARKING GARAGE ANNEX AND ANCILLARY IMPROVEMENTS WILL BE CONSIDERED UNDER AGENDA ITEM IX.

Board Paper: Finance Committee

Request:	Consider Recommendation for Board Approval of the Three-Year Licensing and Support Agreement Renewal of DrFirst as Sole Source Justification and Contract Award
Executive Sponsor:	Augustine Lopez, CFO Audrey Parks, CIO David Kasting, MD, CMIO
Date:	April 6, 2021

Executive Summary

DrFirst is our platform for e-prescribing of all controlled and non-controlled substances. The software is directly embedded into the Meditech ecosystem. This provides physicians with a seamless experience in prescribing medications for their patients upon discharge from the hospital, completion of an outpatient procedure, or the conclusion of an outpatient clinic visit.

DrFirst collects an external medication history based on prior prescription activity for each patient. This information is compiled from multiple data sources: medication orders from participating retail pharmacies, and the nationwide e-prescribing network, Surescripts. This network electronically connects prescribers, pharmacies, and third party payers. The External Medication History is then verified with the patient upon admission and used for reconciliation of the home medications at that time.

Background/Situation/Rationale

DrFirst has developed two additional enhancements: My Benefit Check and Electronic Prior Authorization. My Benefit Check will provide information to the physician while in the prescribing process as to whether the drug being prescribed is covered under patients' formulary benefits. It will also offer up to three alternative drug treatments for consideration, guidance for alternative therapies, and patient out of pocket costs for each option.

Electronic Prior Authorization enables the physician to electronically initiate prior authorization for medications that require it. Both enhancements are being offered to us at no cost.

Sole source Justification is based on the fact that DrFirst is Meditech's only fully integrated e-prescribing software and has provided excellent service in ensuring our patients electronic prescriptions are managed safely and efficiently.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

The electronic process streamlines physician workflow and greatly expedites patients' access to medications needed for their treatment thereby enabling improved physician efficiency and promoting enhanced patient satisfaction.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications: Finance

Key Contract Terms	Vendor: DrFirst
1. Proposed effective date	March 23, 2021
2. Term of agreement	December 23, 2021 – December 22, 2024 (3-year term)
3. Renewal terms	One-year auto-renewal
4. Termination provision(s)	60 days' written notice
5. Payment Terms	Net 30
6. Annual cost(s)	$ 161,445
7. Cost over life of agreement	$ 484,335
8. Budgeted (indicate y/n)	Yes.
9. Contract	1001.1251

Recommendation

Request the Finance Committee to recommend to the Board of Directors the approval of the three-year licensing and support renewal of DrFirst as sole source justification and contract award in the amount of $484,335 over the three-year term.

Attachments:

1. Sole Source Justification
2. DrFirst Renewal Addendum

Justification for Sole Source Form

To: Proposal Evaluation Panel

From: David Kasting, MD, CMIO; Audrey Parks, CIO

Type of Purchase: (check one)

- ☐ Materials/Supplies
- ☒ Data Processing/Telecommunication Goods > $25,000
- ☐ Medical/Surgical – Supplies/Equipment > $25,000
- ☐ Purchased Services

Cost Estimate ($):	$484,335.
Vendor Name:	Dr First
Item Title:	Renewal Amendment to the Master Agreement of 2010

Statement of Need: My department's recommendation for sole source is based upon an objective review of the product/service required and appears to be in the best interest of the SVMHS. I know of no conflict of interest on my part or personal involvement in any way with this request. No gratuities, favors or compromising action have taken place. Neither has my personal familiarity with particular brands, types of equipment, materials or firms been a deciding influence on my request to sole source this purchase when there are other known suppliers to exist.

Describe how this selection results in the best value to SVMHS. See typical examples below.

- ☐ Licensed or patented product or service. No other vendor provides this. Warranty or defect correction service obligations of the consultant. **Describe why it is mandatory to use this licensed or patented product or service:**
- ☐ Existing SVMHS equipment, inventory, custom-built information system, custom built data inventory system, or similar products or programs. **Describe. If product is off-the-shelf, list efforts to find other vendors (i.e. web site search, contacting the manufacturer to see if other dealers are available to service this region, etc.).**
- ☒ Uniqueness of the service. **Describe.**

  We have been using DrFirst for e-Prescribing of controlled and non-controlled medications for over 10 years now. DrFirst is Meditech's vendor of choice for e-prescribing and the fact that it is embedded within Meditech streamlines physician workflow. Dr. First continues to be a great partner, always working to maximize our utilization of their product to improve efficiency and effectiveness of this important aspect of patient care.
- ☐ SVMHS has established a standard for this manufacturer, supplier or provider and there is only one vendor. **Attach documentation from manufacturer to confirm that only one dealer provides the product.**
- ☐ Factory-authorized warranty service available from only this single dealer. Sole availability at the location required. **Describe.**
- ☐ Used item with bargain price (describe what a new item would cost). **Describe.**
- ☐ Other -The above reasons are the most common and established causes for an eligible sole source. If you have a different reason, **Describe:**

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

Submitter Signature: David Kasting MD CMIO Date: 3/24/2021

David Kasting (Apr 8, 2021 10:02 PDT)

DrFirst
Unite the Healthiverse

AMENDMENT TO MASTER AGREEMENT

This Amendment (the "Amendment") is hereby made a part of a certain Master Agreement dated December 23, 2010 (the "Agreement"), by and between DrFirst.com, Inc., a Delaware corporation having its principal place of business at 9420 Key West Avenue, Suite 101, Rockville, Maryland 20850 ("DrFirst") and Salinas Valley Memorial Healthcare System, a corporation having its principal place of business at 450 East Romie Lane, Salinas, CA 93901("Company") (collectively, the "Parties").

WHEREAS the parties have a preexisting Agreement with Company to provide its services and products to certain MEDITECH partner hospitals within Company's healthcare system, the parties now desire and agree to modify said Agreement to extend the term; and

WHEREAS, the Parties agree to certain modifications to the terms and conditions of the Agreement as set forth below, and

NOW, THEREFORE, intending to be legally bound hereby, the Parties do hereby agree to, and do hereby, amend the Agreement, as follows:

1. The Parties agree to add Exhibit B-1 to the Agreement, attached hereto, which will memorialize the billing for Rcopia AC services from 2020 – 2023.

2. The Parties agree to modify Section 9.1 to extend the Agreement by an additional three (3) year term, therefore the new end date of the term of the Agreement will be December 22, 2023.

3. The Parties agree that all other terms and conditions of the Agreement shall remain unchanged and in force. The Company agrees to remain, and to cause all of its authorized End Users to remain, bound by any and all obligations and restrictions set forth in any Business Associate Agreement ("BAA"), Terms of Use ("TOU"), and Service License Agreement ("SLA") previously agreed to under the prior existing agreement between the Parties.

COMPANY: Salinas Valley Memorial Healthcare System	**DRFIRST.COM, INC.**
By:	**By:**
Printed Name:	**Printed Name:** Edward C. Lee
Title:	**Title:** Chief Administrative Officer
Date:	**Date:** Mar 23, 2021

DrFirst
Unite the Healthiverse

Exhibit B-1
Renewal Pricing Rcopia AC

1. **Pricing.**

9th Year License Fee	10th Year License Fee	11th Year License Fee
$161,445	$161,445	$161,445

2. **Payment.**

a. The initial payment of $161,445 will be invoiced on March 31, 2021 for the 9th year license fee. Company agrees to remit full payment of the invoice no later than thirty (30) days from the date the invoice is received. All other payment terms from the original Agreement shall remain in effect.

b. Annual Renewal: Company shall be invoiced $161,445 for the 10th and 11th year license fees at each anniversary of the 9th year invoice date. These invoices will cover the following services: Rcopia AC.

c. Should DrFirst's costs of obtaining Medication History increase by 5% or more during the term of this agreement, DrFirst shall have the right to increase the license fees.

DrFirst
Unite the Healthiverse

AMENDMENT TO THE RCOPIA AC SERVICE EXHIBIT

This Amendment to the Rcopia AC Service Exhibit (the "Amendment") is hereby made this Mar 23, 2021 ("Effective Date") a part of the Rcopia AC Service Exhibit ("RcopiaAC Exhibit") to the Master Agreement dated December 23, 2010 (the "Agreement") by and between DrFirst.com, Inc., a Delaware corporation having its principal place of business at 9420 Key West Avenue, Suite 101, Rockville, Maryland 20850 ("DrFirst") and Salinas Valley Memorial Healthcare System, a corporation having its principal place of business at 450 East Romie Lane, Salinas, CA 93901 ("Company").

RECITALS

WHEREAS, DrFirst and Company previously entered into the Agreement for e-prescribing and medication management services, including the RcopiaAC Exhibit thereto pursuant to which DrFirst integrated the Application into the Company Software; and

WHEREAS, Company wishes to add, and DrFirst agrees to integrate, DrFirst's Patient Engagement Services feature into the Application and Integrated Offering;

NOW, THEREFORE, the Parties agree as follows:

1. **Definitions.**
   A. "Notification" shall mean an SMS text message related to an e-prescribing event originating in the Company Software.

   B. "Patient Engagement Service" shall mean DrFirst's solution which, when integrated with the Company Software as part of the Integrated Offering, provides Notifications to patients of Authorized End Users.

   C. "Patient Engagement APIs" shall mean the application programming interfaces which allow for the connection to Patient Engagement Services.

2. **DrFirst Responsibilities.**
   A. DrFirst will integrate the Patient Engagement APIs with the Company Software so that Authorized End Users of the Integrated Offering are able to send Notifications to patients using Patient Engagement Services. Notifications will include a link to a secure website (URL) through which the patient may access cost savings, educational, and other information.
   B. Additionally, as part of the Patient Engagement Services, DrFirst may at DrFirst's discretion report to Company whether the prescription triggering the Notification was filled so that Company may use the information to manage and support the treatment of the patient. Any such reporting will be carried out by populating the fill information in the Company Software.

DrFirst
Unite the Healthiverse

3. **Company Representations and Warranties for use of Patient Engagement Services.**
   A. Company represents and warrants that Company meets all HIPAA and other applicable regulatory requirements related to sending Notifications using Patient Engagement Services, including, but not limited to, updating its Notification of Privacy Practices, as necessary, so that PHI may be used to send Notifications to Company's patients.
   B. Company acknowledges that it is solely responsible for ensuring that the phone numbers appearing in the Application and Integrated Offering are complete and accurate, and represents and warrants that Notifications will only be sent to those patients for whom Company has verified that the phone number is correct and which correspond to the patient for whom the Notification is intended.
   C. Company represents and warrants that Company shall obtain (and acknowledges that Company is solely responsible for obtaining) any and all consents, opt-ins, and authorizations (including but not limited to as required by the Telephone Consumer Protection Act of 1991) from patients required for the Integrated Offering to send Notifications to patients on behalf of the Authorized End Users.
   D. Company agrees to indemnify, defend, and hold DrFirst harmless for any claims, actions, or liabilities against DrFirst arising from a violation of this Section 3 by Company or its Authorized End Users.

4. **No Additional Changes.** Except as otherwise expressly provided in this Amendment, all terms and conditions of the Agreement and the RcopiaAC Exhibit remain unchanged and in full force and effect. Capitalized terms not otherwise defined in this Amendment will have the meanings ascribed to them in the Agreement or the RcopiaAC Exhibit, as applicable. The recitals are hereby incorporated into this Amendment by reference.

IN WITNESS WHEREOF, the undersigned Parties acting as duly authorized agents of their organizations intend to bind their organizations to the foregoing terms:

DrFirst.com, Inc.

By: _____

Name: Edward C. Lee

Title: Chief Administrative Officer

Date: Mar 23, 2021

Company: Salinas Valley Memorial Healthcare System

By: _____

Name: _____

Title: _____

Date: _____

DrFirst
Unite the Healthiverse

AMENDMENT TO THE RCOPIA AC SERVICE ADDENDUM

This Amendment to the Rcopia AC Service Exhibit (the "Amendment") is hereby made this Mar 23, 2021 ("Effective Date") a part of the Rcopia AC Services Exhibit within the Master Agreement dated December 23, 2010 (the "Agreement") by and between DrFirst.com, Inc., a Delaware corporation having its principal place of business at 9420 Key West Avenue, Suite 101, Rockville, Maryland 20850 ("DrFirst") and Salinas Valley Memorial Healthcare System, a corporation having its principal place of business at 450 East Romie Lane, Salinas, CA 93901 ("Company").

RECITALS

WHEREAS, DrFirst and Company previously entered into the Agreement for e-prescribing and medication management services, including the Rcopia Exhibit thereto pursuant to which DrFirst integrated the Application into the Company Software; and

WHEREAS, Company wishes to add, and DrFirst agrees to integrate DrFirst's my Benefit Check and Electronic Prior Authorization Services feature into the Application and Integrated Offering;

NOW, THEREFORE, the Parties agree as follows:

5. **Definitions.**
   A. "Electronic Prior Authorization" or "ePA" means DrFirst's service which enables the electronic transmission of information to determine and complete the applicable prior authorization(s).
   B. "myBenefitCheck" or "mBC" means DrFirst's services which enables real time price transparency and coverage information.
   C. Go-Live is defined as the initiation of myBenefitCheck inquiry transaction in production environment within MEDITECH.

6. **DrFirst Responsibilities.**
   A. Assist in the deployment, verification & rollout of the mBC and ePA services within the Rcopia AC.
   B. DrFirst agrees to provide Company with the required technical and implementation documentation for enabling the ePA and mBC services

7. **Company Responsibilities**
   A. Company agrees to follow all DrFirst technical and implementation documentation provided, and abide by the DrFirst requirements for the ePA and mBC implementation.
   B. Assist in the deployment, verification & rollout of the mBC and ePA services within Rcopia AC, activating the functionality in the MEDITECH platform.
   C. DrFirst shall be free to use, at its discretion, such Feedback for any purpose whatsoever, including but not limited to developing, and marketing, in DrFirst's sole discretion, products incorporating such ideas, concepts, or techniques.

D. Company agrees to connect to all pharmacy benefit managers and other sources of benefit information supported by the mBC Application.

8. **Pricing and Payment.** Pricing for the ePA and mBC services is specified in table 1.

Table 1

Service	Unit Price	Extended Price
ePA transaction services	Complimentary	Complimentary
mBC transaction services	Complimentary	Complimentary
ePA/mBC configuration	$15,000	Waived ($0)
ePA/mBC training services	$2,500/15 hours	Waived ($0)

9. **Term and Termination.** The services under this amendment require the utilization of the Rcopia AC services. Therefore, this amendment shall be subject to the termination provisions of the MSA, and is co-terminus with the Rcopia AC Services Exhibit.

10. **No Additional Changes**. Except as otherwise expressly provided in this Amendment, all terms and conditions of the Agreement and the Rcopia Exhibit remain unchanged and in full force and effect. Capitalized terms not otherwise defined in this Amendment will have the meanings ascribed to them in the Agreement or the Rcopia Exhibit, as applicable. The recitals are hereby incorporated into this Amendment by reference.

IN WITNESS WHEREOF, the undersigned Parties acting as duly-authorized agents of their organizations intend to bind their organizations to the foregoing terms:

DrFirst.com, Inc.

By: _____

Name: Edward C. Lee

Title: Chief Administrative Officer

Date: Mar 23, 2021

Company: Salinas Valley Memorial Healthcare System

By: _____

Name: _____

Title: _____

Date: _____

Salinas Valley Memorial Healthcare System

Agenda Item:	**Consider Recommendation for Board Approval of Lease with the Lugo Family Living Trust for 650 Work Street Suite B Salinas, CA**
Executive Sponsor:	Augustine Lopez, Chief Finanical Officer Judi Melton, Director Materials Management
Date:	April 19, 2021

Executive Summary

During an Emergency/Disaster/Pandemic, our system needs to be ready for the next crisis, this is not a financial decision, but rather a focus on caring for our caregivers and community.

The Legislative Assembly Bill #2537, Personal Protective Equipment bill – Beginning April 1, 2021, an employer shall maintain a stockpile of the following equipment in the amount equal to three months of normal consumption: N95 masks, PAPR, Surgical masks, Isolation gowns, Eye protection, and shoe coverings.

Our current storage spaces are at 7 different locations, the campus locations will not be available to us as we move forward with the Endoscopy (212 building) and Parking garage projects.

Along with the 96 Hour pandemic supply, and now the AB#2537, we need better/closer access to the Pandemic supply and equipment. The location is primary, as these supplies need weekly rotation for expiration date management.

Basis for recommendation: Life Safety Measures, Regulatory, hazard vulnerability analysis and operations impact.

The property includes 9,400 square feet of warehouse/mezzanine space and 2,000 square feet of administrative office space. The lease is proposed to be a five (5) year lease with option one (1) five (5) year option for renewal that requires one hundred twenty (120) days written notice and includes annual increases based on the Consumer Price Index and capped at 2.75% annually.

The SVMHS executive team has negotiated with the building owners to secure the terms as outlined below.

Timeline

April 26, 2021 – SVMHS Board Finance Committee Considers Recommendation for Approval
April 29, 2021 – SVMHS Board of Directors Consider Approval
May 1, 2021 – Lease Commencement Date

Strategic Plan Alignment:

This lease agreement is aligned with our goals for the community, quality and people pillars. This space will be utilized to support an Emergency/Disaster/Pandemic, as our system needs to be ready for the next crisis.

Pillar/Goal Alignment:
☐ Service ☒ People ☒ Quality ☐ Finance ☐ Growth ☒ Community

Financial/Quality/Safety/Regulatory Implications

1. Proposed Effective Date	May 1, 2021
2. Term of agreement	Five (5) Years
3. Renewal terms	Five (5) Year Option with 120 Days' Notice
4. Security Deposit	Waived
5. Termination provision(s)	None
6. Payment Terms	Monthly, in advance
7. Building Operating & Tax Expenses	Modified Gross Lease (Tenant Covers pro rata Gas/Water)
8. Annual Rent Cost	$201,000 ($1.47/psf/monthly/Modified Gross)
9. Cost Over Initial Five (5) Year Option	$1,061,816 (excluding CAM, including 2.75% increases)
10. Budgeted	No

Recommendation

Consider Recommendation for Board Approval of Lease with the Lugo Family Living Trust for 650 Work Street Suite B Salinas, CA

Attachments

- Lease between Salinas Valley Memorial Healthcare System and the Lugo Family Living Trust for 650 Work Street Suite B, Salinas, CA

LEASE

THIS LEASE, is made and entered into effective May 1, 2021 by and between KERRY R. LUGO and CHERYL A. LUGO, as Trustees of the LUGO FAMILY LIVING TRUST u/d/d October 5, 2006 (Landlord) and Salinas Valley Memorial Healthcare System, a California Public Health Care District (Tenant).

WITNESSETH:

1. **USE.** The Landlord hereby leases to Tenant and Tenant hereby hires from Landlord, the premises described below, for purposes of conducting thereon the following activities: storage of medical equipment and supplies.

Tenant represents to Landlord that prior to execution of this Lease, Tenant has determined what, if any, city or other governmental permits or other requirements are needed for Tenant to use the premises as herein indicated and has obtained or is obtaining any required permits and agrees to comply with such requirements, at its expense.

2. **PREMISES**. The premises leased to Tenant, together with appurtenances, are hereinafter referred to as the "premises" are a portion of the building commonly known as 650 Work Street, Suite B, Salinas, California, and are the premises outlined in red on the plot of the premises attached hereto as Exhibit A. Included in the premises are approximately 7,000 square feet of warehouse space, 2,000 square feet of office space, and 2,400 square feet of mezzanine. Tenants shall also have exclusive use of the parking spaces and parking areas as described in Paragraph 9.Tenant accepts responsibility for ensuring that the square footage is accurate and accept- able for its purposes and is not relying on any representation made by Landlord or Landlord's agents.

3. **TERM AND POSSESSION**. The term of this lease shall be for a period of five (5) years. The term of this lease, and Tenant's obligation to pay rent, shall commence on May 1, 2021 ("Commencement Date") and shall terminate on April 30, 2026 subject to options to renew, if any, as stated herein.

4. **RENTAL**.

A. Base Rent. Tenant shall pay to Landlord during the term of this lease as Base Rent for the premises the sum of sixteen thousand seven hundred fifty dollars ($16,750) per month due on the first day of each month, which sum shall be paid in lawful money of the United States of America and shall be paid without deduction or offset, prior to notice or demand, at the address designated for the Landlord herein. Any rent payment not paid within ten (10) days of its due date shall be subject to a six (6%) percent late charge.

B. Rent During Option Period. The rent for each year of the term of the Option shall be determined as follows: The rent paid for the prior year shall be increased as provided in subparagraph C "Base Rent Adjustment" of this section, which sum shall become the new Base Rent. Thereafter, the rent shall continue to be adjusted under such subparagraph each year of the option term.

C. Base Rent Adjustment. The Base Rent shall be adjusted two and three quarters percent (2.75%) annually on the first day of January, beginning on January 1, 2023. Tenant shall pay

the increased rent whether or not Tenant receives notice of the increase. This adjustment applies to the Base Rent only.

D. Security Deposit. Landlord agrees to waive the Security Deposit.

5. **DIRECT EXPENSES(CAM, ETC.)**.

In addition to Base Rent, Tenant shall pay to Landlord its share of water and gas which is common to the entire building. Tenant's share of water shall be 41%. Tenants share of gas shall be anything in excess of $1,638 per year. The water and gas expense may be billed annually, and shall be paid within 30 days of receipt of the billing.

6. **REAL ESTATE TAXES**. Landlord shall pay all annual real estate taxes and assessments levied upon the premises and the parking and common areas of the property. For purposes of this agreement "annual real estate taxes and assessments" means all federal, state, county, or local government or municipal taxes, fees, charges, or other impositions of every kind (whether general, special, ordinary or extraordinary) that are paid or incurred by Landlord because of or in connection with the ownership, leasing and operation of the Premises. These expenses include taxes, fees, and charges such as real property taxes, general and special assessments, transit taxes and fees, leasehold taxes (if any), and or taxes based on the receipt of rent.

7. **PERSONAL PROPERTY TAXES**. During the term hereof, Tenant shall pay, prior to delinquency, all taxes assessed against and levied upon fixtures, furnishings, equipment and all other personal property of tenant contained in the premises, and when possible Tenant shall cause said fixtures, furnishings, equipment and other personal property to be assessed and billed separately from the real property of Landlord. In the event any or all of the Tenant's fixtures, furnishings, equipment and other personal property shall be assessed and taxed with the Landlord's real property, the Tenant shall pay to Landlord its share of such taxes within ten (10) days after delivery to Tenant by Landlord of a statement in writing setting forth the amount of the taxes applicable to the Tenant's property.

8. **USE OF MEZZANINE.** Tenant agrees that Landlord, from time to time, may enter to premises in order to access Landlord's storage space that must be entered from the mezzanine in the premises and/or utility room located near restrooms. Landlord shall give Tenant prior notice of its intention to access and enter the premises and shall arrange a time with Tenant so as to not unduly disturb Tenant.

9. **PARKING AND COMMON FACILITIES**. Landlord covenants that 11 parking places in the front of the premises and all other parking places designated as Tenant's on Exhibit A shall be available for the exclusive use of Tenant during the full term of this lease or any extension of the term hereof. Tenant and its invitees shall not use any other parking areas on the property without obtaining the advance consent of Landlord. Landlord reserves the right to change the entrances, exits, traffic lanes and the boundaries and locations of such parking area or areas.

A. Landlord shall keep and maintain the parking and common areas that include the 11 parking spaces in front of the premises, driveway and gates and Tenant shall keep and maintain, at its cost and expense, the parking places designated for Tenant's exclusive use. The respective

responsible party shall keep or cause to be kept said parking and common areas in a neat, clean and orderly condition and shall repair any damage to the facilities thereof.

B. Tenant, for the use and benefit of Tenant, its agents, employees, customers, licensees and subtenants, shall have the non-exclusive right in common with Landlord, and other present and future owners, tenants and their agents, employees, customers, licensees and subtenants, to use the driveway during the entire term of this lease, or any extension thereof, for ingress and egress, and roadway purposes.

C. Tenant, in the use of any common driveways, agrees to comply with such reasonable rules and regulations as the Landlord may adopt from time to time for the orderly and proper operation of said common driveways.

D. Landlord shall permit Tenant reasonable access to Landlord's security camera footage, and permit Tenant's security personnel to patrol the area for purposes of monitoring the Premises. Tenant's security personnel shall not have access to any areas which are not part of the defined Premises.

10. **USES PROHIBITED**. Tenant shall not use, or permit said premises, or any part thereof, to be used for any purpose or purposes other than the purpose or purposes for which said premises are hereby leased and no use shall be made or permitted to be made of said premises, nor acts done, which will increase the existing rate of insurance upon the building in which said premises may be located once said rate is established or cause a cancellation of any insurance policy covering said building or any part thereof, nor shall Tenant sell or permit to be kept, used or sold in or about said premises, any article which may be prohibited by a standard form of fire insurance policies. Tenant shall, at his sole cost, comply with any and all requirements, pertaining to the use of said premises, of any insurance organization or company necessary for the maintenance of reasonable fire and public liability insurance, covering said building and appurtenances. In the event Tenant's use of the premises, as recited in Article 1 hereof, results in a rate increase for the building of which the premises are a part, Tenant shall pay annually on the anniversary date of this lease, as additional rent, a sum equal to that of the additional premium occasioned by said rate increase.

11. **ALTERATIONS AND FIXTURES**. Tenant shall not make, or suffer to be made, any alterations of the premises, or any part thereof, without the prior written consent of Landlord. Any additions to, or alterations of, said premises, except movable furniture, shall become at once a part of the realty and belong to Landlord, including trade fixtures. If Landlord agrees to allow Tenant to make any alterations, Tenant shall, at its sole cost and expense, prepare construction drawings, in accordance with all governmental requirements, which shall be submitted to Landlord for Landlord's written approval. If approved by the Landlord, Tenant shall obtain proper permits and other governmental approvals and shall install such improvements at Tenant's sole cost and expense. Landlord may require as a condition of approval that Landlord approve of the contractor hired to install the improvements. Tenant shall not cause any mechanic's or materialman's lien to be placed on the property and premises. Tenant shall indemnify, defend, and hold harmless Landlord from any such lien. Landlord shall have the right to post a notice of non-responsibility on the premises before or after the commencement of any work of improvement.

12. **MAINTENANCE AND REPAIR**. Tenant shall, subject to Landlord's obligations hereinafter provided, at all times during the term hereof, and at Tenant's sole cost and expense, keep, maintain and repair the premises in good and sanitary order and condition (except as

hereinafter provided) including without limitation, the maintenance and repair of any store front, doors, window casements, glazing, plumbing, pipes, electrical wiring and conduits. Tenant shall also at its sole cost and expense be responsible for any alterations or improvements to the premises necessitated as a result of the requirement of any municipal, state or federal authority due to Tenant's specific use of the premises. Tenant hereby waives all right to make repairs at the expense of Landlord. By entering into the premises Tenant shall be deemed to have accepted the premises as being in good and sanitary order, condition and repair and Tenant agrees on the last day of said term or any extensions or sooner termination of this lease to surrender the premises with appurtenances, in the same condition as when received, reasonable use and wear excepted.

Landlord shall maintain in good repair the exterior walls, roof and HVAC. Tenant agrees that it will not, nor will it authorize any person to access the roof of the building of which the premises are a part without the prior written consent of Landlord. Said consent will be given only upon Landlord's satisfaction that any repairs necessitated as a result of Tenant's action will be made by Tenant at Tenant's expense and will be made in such a manner so as not to invalidate any guarantee relating to said roof. Landlord shall not be required to make any repairs to the exterior walls, roof and HVAC unless and until Tenant has notified Landlord in writing of the need for such repairs and Landlord shall have had a reasonable period of time thereafter to commence and complete said repairs.

13. **COMPLIANCE WITH LAWS**. Tenant shall, at his sole cost and expense, comply with all of the requirements of all municipal, state and federal authorities now in force or which may hereafter be in force pertaining to the use of said premises, and shall faithfully observe in said use all municipal ordinances and state and federal statutes now in force or which shall hereinafter be in force. The judgment of any court of competent jurisdiction, or the admission of Tenant in any action or proceeding against Tenant, whether Landlord be a party thereto or not, that Tenant has violated any such order or statute in said use, shall be conclusive of that fact as between the Landlord and Tenant.

Tenant acknowledges and agrees that neither Landlord or Landlord's agents have made any representation to Tenant about what may be required by any governmental agency in order for Tenant to use the premises as Tenant desires. Tenant is responsible for determining whether zoning or other requirements are appropriate for Tenant's use and understands that past uses of the premises may no longer be allowed. Tenant assumes responsibility for paying for the cost of compliance for any governmental regulations required in order to use the premises as intended by Tenant.

Tenant shall not commit, or suffer to be committed, any waste upon the premises, or any nuisance or other act or thing which may disturb the quiet enjoyment of any other tenant in the building in which the premises may be located.

14. **INSURANCE**. Landlord shall maintain fire and extended coverage insurance throughout the term of this lease in an amount equal to at least ninety (90%) percent of the value of the building which includes the premises, together with such other insurance, including but not limited to, loss of rents, earthquake, flood insurance, all liability insurance, and such other insurance as Landlord deems necessary or that may be required by Landlord's lender or by any governmental agency. Tenant hereby waives any right of recovery from Landlord, its officers and employees, and Landlord hereby waives any right of recovery from Tenant, its officers or employees, for any loss or damage (including consequential loss) resulting from any of the perils insured against in the standard form fire insurance policy with extended coverage endorsement.

Tenant shall be billed its pro-rata share for such insurance as a Direct Expense.

15. **INDEMNIFICATION OF LANDLORD - LIABILITY INSURANCE BY TENANT**. Tenant, as a material part of the consideration to be rendered to Landlord under this lease, hereby waives all claims against Landlord for damage to personal property, goods, wares and merchandise, in, upon or about said premises and for injuries to persons in or about said premises, to the extent proximately caused by Tenant's occupation of the premises or caused by Tenant's agents, invitees, employees, licensees and contractors. Tenant will indemnify and hold Landlord and the property of Landlord exempt and harmless from any and all claims, liability, loss, expenses, damage or injury resulting from Tenant's use and occupation of the premises, including, but not limited to, any claim, liability, loss, or damage arising by reason of the death or injury of any person, the damage to or destruction of any property of any person, and any work performed on said premises or materials furnished to said premises at the instance or request of Tenant or its agents or employees.

During the entire term of this lease, the Tenant shall, at the Tenant's sole cost and expense, but for the mutual benefit of Landlord and Tenant, maintain general public liability and property damage insurance including contractual liability insurance against claims for personal injury, death, or property damage occurring in, upon or about the premises and on any sidewalks directly adjacent to the premises. The limitation of liability of such insurance shall be not less than Two million dollars ($2,000,000.00) in respect to any one occurrence, and to the limit of not less than Five hundred thousand dollars ($500,000.00) in respect to Property Damage.

All such policies of insurance shall be issued in the name of Tenant, with Landlord named as an additional insured, and such policies of insurance shall include a provision requiring that the insurer give Landlord at least ten (10) days written notice before any cancellation, decrease in coverage or other material change is effective. Copies of the policy or a certificate of Insurance thereof shall be delivered to the Landlord within fifteen (15) days after the rent commencement date of this lease and before each renewal date. If Tenant fails to deliver adequate proof that it has obtained and kept in force and effect the insurance required by this paragraph, Landlord shall have the right, at its option and after notice to Tenant, to effect such insurance and charge the cost of the premiums to Tenant's account.

16. **ABANDONMENT OF PERSONAL PROPERTY**. Tenant shall not vacate or abandon the premises at any time during the term of this lease; and if Tenant shall abandon, vacate or surrender the premises or be dispossessed by process of law, or otherwise, any personal property belonging to Tenant and left on the premises shall be deemed to be abandoned, at the option of Landlord, except such property as may be mortgaged to Landlord.

17. **SIGNS AND AUCTIONS**. Tenant shall not place or permit to be placed any sign upon the exterior or in the windows of the premises without Landlord's prior written consent, nor shall Tenant change the color or exterior appearance of the premises without Landlord's prior written consent. If Tenant seeks to install or modify its signs, Tenant shall, at its sole cost and expense, prepare sign construction drawings, in accordance with all governmental requirements, which shall be submitted to Landlord for Landlord's written approval. If approved by the Landlord, Tenant shall obtain proper permits and other governmental approvals and shall install such signs at Tenant's sole cost and expense. Landlord may require as a condition of approval that Landlord approve of the contractor who creates or installs the signs. Such signs shall become the property of the Landlord on expiration or earlier termination of this lease.

Tenant shall not without Landlord's prior written consent display or sell merchandise outside the defined exterior walls and permanent doorways of the premises. Tenant shall not conduct or permit to be conducted any sale by auction in, upon or from the premises, whether said auction be voluntary, involuntary, pursuant to any assignment for the payment of creditors or pursuant to any bankruptcy or other solvency proceeding.

18. **UTILITIES**. Landlord shall pay for water and sewer. Tenant shall pay before delinquency all charges for garbage, gas, heat, electricity, power, telephone service and all other services or utilities used in, upon, or about the premises by Tenant or any of its subtenants, licensees, or concessionaires during the term of this lease. Further, Tenant agrees that Landlord may use electricity for its 600 square foot of warehouse space retained by Landlord, without charge, until a sub-meter is installed by Landlord, so long as such use does not cause a significant increase in cost to Tenant.

19. **ENTRY AND INSPECTION**. Tenant shall permit Landlord and his agents to enter into and upon the premises at all reasonable times after notice, except in case of an emergency, for the purpose of inspecting the same or for the purpose of maintaining the building in which said premises are situated, or for the purpose of making repairs, alterations or additions to any other portion of said building, including the erection and maintenance of such scaffolding, canopy, fences and props as may be required, or for the purpose of posting notices of non-liability for alterations, additions or repairs, or for the purpose of placing upon the proper- ty in which the premises are located any usual or ordinary "For Sale" signs. Landlord shall be permitted to do any of the above without any rebate of rent and without any liability to Tenant for any loss of occupation or quiet enjoyment of the premises thereby occasioned. Tenant shall permit Landlord, at any time within thirty (30) days prior to the expiration of this lease, to place upon said premises any usual or ordinary "For Lease" signs and during such thirty (30) day period Landlord or his agents may, during normal business hours, enter upon said premises and exhibit same to prospective Tenants.

20. **DAMAGE AND DESTRUCTION OF PREMISES**. In the event of (a) partial destruction of said premises or the building containing same during the term of this lease or any extensions thereof, which requires repairs to either said premises or said building, or (b) said premises or said building being declared un- safe or unfit for occupancy by any authorized public authority for any reason other than Tenant's act, use or occupation, which declaration requires repairs to either said premises or said building, Landlord shall forthwith make said repairs provided Tenant gives to Landlord thirty (30) days written notice of the necessity therefor. No such partial destruction (including any destruction necessary in order to make repairs required by any declaration made by any public authority) shall in any way annul or void this lease except that Tenant shall be entitled to a proportionate reduction of minimum guaranteed rent while such repairs are being made, such proportionate reduction to be based upon the extent to which the making of such repairs shall interfere with the business carried on by Tenant in said premises. How- ever, if during the last four years of the term of this lease the building is damaged as a result of fire or any other insured casualty to an extent in excess of twenty- five (25%) percent of its then replacement cost (excluding foundation(s)), Landlord may, within thirty (30) days following the date such damage occurs, terminate this lease by written notice to Tenant. If Landlord, however, elects to make said repairs, and provided Landlord uses due diligence in making said repairs, this lease shall continue in full force and effect and the minimum guaranteed rent shall be proportionately reduced as provided above. If Landlord elects to terminate this lease all rents shall be prorated between Landlord and Tenant as of the date of such destruction.

The foregoing to the contrary notwithstanding, if the building is damaged or destroyed at any time during the term hereof to an extent of more than twenty- five (25%) percent of its then replacement cost (excluding foundation(s)) as a result of a casualty not insured against, Landlord may within thirty (30) days following the date of such destruction terminate this lease upon written notice to Ten- ant. If Landlord does not elect to so terminate because of said uninsured casualty, Landlord shall promptly rebuild and repair said premises and Tenant's rental obligation shall be proportionately reduced as provided above.

In respect to any partial destruction (including any destruction necessary in order to make repairs required by any authorized public authority) which Landlord is obligated to repair and may elect to repair under the terms of this Article, Tenant waives any statutory right it may have to cancel this lease as a result of such destruction.

21. **ASSIGNMENT AND SUBLETTING**. Tenant shall not assign this lease, or any interest therein , and shall not sublet the premises or any part thereof, or any right or privilege appurtenant thereto, or permit any other person (the agents and servants of Tenant excepted) to occupy or use the premises, or any portion thereof, without first obtaining the written consent of Landlord, which consent shall not be unreasonably withheld. Any transfer of twenty-five percent or more in interest in an entity that is a Tenant shall be considered an assignment subject to the terms of this section. Consent by Landlord to one assignment, subletting, occupation or use by another person shall not be deemed to be a consent to any subsequent assignment, subletting, occupation or use by another person. Consent to an assignment shall not release the original named Tenant from liability for the continued performance of the terms and provisions on the part of Tenant to be kept and performed, unless Landlord specifically releases the original named Tenant from said liability. Any assignment or subletting without the prior written consent of Landlord shall be void, and shall, at the option of Landlord, terminate this lease. Neither this lease nor any interest therein shall be assignable, as to the interest of Tenant, by operation of law, without the prior written consent of Landlord. Landlord may charge Tenant for any costs and fees it incurs related to the review of a proposed Assignment or sublet or preparation or review of any documents related to a proposed Assignment or sublet.

If Tenant proposes to assign the lease to any person or entity who shall have made a good faith offer to accept an assignment of this lease on terms acceptable to the Tenant, the notice of such proposed assignment, setting forth (a) the name and address of such person, (b) all the terms and conditions of such offer, and (c) the adequate assurance to be provided Landlord to assure such persons future performance under the lease, shall be given to Landlord by Tenant no later than ten (10) days after receipt by the Tenant. Landlord shall then have the right and option, to be exercised by a notice to Tenant given at any time prior to the effective date of such proposed assignment, to accept a different assignment of this lease on the same terms and conditions and for the same consideration, if any, as the offer made to the Tenant, less any brokerage commissions which may be payable out of the consideration to be paid to such person for the assignment of this lease. In the event any approved sublease provides for payment of rent or other consideration in excess of the rent payable hereunder, Landlord shall receive all such excess, upon receipt by Tenant.

22. **DEFAULT**. If Tenant fails to make any payment required by the provisions of this lease when due, or fails within thirty (30) days after written notice thereof to correct any breach or default of the other covenants, terms or conditions of this lease, or if Tenant breaches this lease and abandons the property before the end of the term, Landlord shall have the right at any time thereafter to elect to terminate said lease and Tenant's right to possession thereunder. Upon such termination, Landlord shall have the right to recover against Tenant:

A. The worth at the time of award of the unpaid rent which had been earned at the time of termination;

B. The worth at the time of award of the amount by which the unpaid rent which would have been earned after termination until the time of award exceeds the amount of such rental loss that the Tenant proves could have been reasonably avoided;

C. The worth at the time of award of the amount by which the unpaid rent for the balance of the term after the time of award exceeds the amount of such rental loss that the Tenant proves could be reasonably avoided; and

D. Any other amount necessary to compensate the Landlord for all the detriment proximately caused by Tenant's failure to perform its obligations under the lease or which in the ordinary course of things would be likely to result therefrom.

The "worth at the time of award" of the amounts referred to in subparagraphs A and B above shall be computed by allowing interest at ten (10%) percent per annum. The worth at the time of award of the amount referred to in subparagraph C shall be computed by discounting such amount at the discount rate of the Federal Reserve Bank of San Francisco at the time of award plus one (1%) percent.

Such efforts as Landlord may make to mitigate the damages caused by Tenant's breach of this lease do not constitute a waiver of Landlord's right to recover damages against Tenant hereunder, nor shall anything contained herein affect Landlord's right to indemnification against Tenant for any liability arising prior to termination of this lease for personal injuries or property damage, and Tenant hereby agrees to indemnify and hold Landlord harmless from any such injuries and damages, including all attorney's fees and costs incurred by Landlord in defending any action brought against Landlord for any recovery thereof, and in enforcing the terms and provisions of this indemnification provision against Tenant.

If Landlord elects to terminate this lease and gives Tenant notice of such termination, upon the giving of such notice, the term of this lease and the estate hereby granted shall expire and terminate on the effective date of the notice as fully and completely and with the same effect as if such date were the date herein fixed for the expiration of the term of this lease and all rights of Tenant shall hereunder expire and terminate, but Tenant shall remain liable as here before provided.

In the event Tenant abandons the premises, this lease shall terminate if the Landlord gives written notice of his belief of abandonment pursuant to Civil Code Sections 1951.2 and 1951.3.

Notwithstanding any of the following, the breach of this lease by Tenant, or an abandonment of the premises by Tenant, shall not constitute a termination of this lease, or of Tenant's right of possession hereunder, unless and until Landlord elects to do so, and until such time Landlord shall have the right to enforce all of its rights and remedies under this lease, including the right to recover rent, and all other payments to be made by Tenant hereunder, as it becomes due; provided, however, that until such time as Landlord elects to terminate this lease, and Tenant's right of possession hereunder, Tenant shall have the right to sublet the premises or to assign its interest in this lease, or both, subject to the written consent of Landlord, which consent shall not be unreasonably withheld.

As security for the performance by Tenant of all of its duties and obligations hereunder, Tenant does hereby assign to Landlord the right, power and authority, during the continuance of this lease, to collect the rents, issues and profits of the premises, reserving unto Tenant the right, prior to any breach or default by it hereunder, to collect and retain said rents, issues and profits as they become due and payable. Upon any such breach or default, Landlord shall have the right at any time thereafter, without notice except as provided for above, either in person, by agent or by a receiver to be appointed by a court, to enter and take possession of said premises and collect such rents, issues and profits, including those past due and unpaid, and apply the same, less costs and expenses of operation and collection, including reasonable attorney's fees, upon any indebtedness secured hereby, and in such order as Landlord may determine. The parties hereto agree that acts of maintenance or preservation or efforts to re-lease the premises, or the appointment of a receiver upon the initiative of the Landlord to protect its interests under this lease shall not constitute a termination of Tenant's right of possession for the purposes of this Article unless accompanied by a written notice from Landlord to Tenant of Landlord's election to so terminate. Nothing contained in this Article shall in any way diminish or be construed as waiving any of the Landlord's other remedies as provided elsewhere in this lease or by law or in equity.

23. **INSOLVENCY OF TENANT**. Tenant agrees that in the event all or substantially all of its assets be placed in the hands of a receiver or trustee, and in the event such receivership or trusteeship continues for a period of ten (10) days, or should Tenant make an assignment for the benefit of creditors, or be adjudicated a bankrupt, or should Tenant institute any proceedings under any state or federal bankruptcy act wherein Tenant seeks to be adjudicated a bankrupt, or seeks to be discharged of its debts, or should any involuntary proceeding be filed against such Tenant under such bankruptcy laws and Tenant consents thereto or acquiesces therein by pleading or default, then this lease or any interest in and to the premises shall not become an asset in any of such proceedings and, in any of such events and in addition to any and all rights or remedies of Landlord hereunder or as provided by law, it shall be lawful for Landlord at his option to declare the term hereof ended and to re-enter the premises and take possession thereof and remove all persons therefrom and Tenant shall have no further claim therein or hereunder.

24. **SURRENDER OF LEASE**. The voluntary or other surrender of this lease by Tenant, or a mutual cancellation thereof, shall not work a merger, and shall, at the option of Landlord, terminate all or any existing subleases or subtenancies, or may, at the option of the Landlord, operate as an assignment to him of any such subleases or subtenancies.

25. **OFFSET STATEMENT.** Tenant shall at any time and from time to time upon not less than ten (10) days prior written notice from Landlord execute, acknowledge and deliver to Landlord a statement in writing, (a) certifying that this Lease is unmodified and in full force and effect (or, if modified, stating the nature of such modification and certifying that this Lease as so modified, is in full force and effect), and the date to which the rental and other charges are paid in advance, if any, and (b) acknowledging that there are not, to Tenant's knowledge, any uncured defaults on the part of the Landlord hereunder, or specifying such de- faults if any are claimed. Any such statement may be relied upon by any prospective purchaser or encumbrancer of all or any portion or the real property of which the Premises are a part.

26. **WAIVER.** The waiver by Landlord and/or Tenant of any term, covenant or condition herein contained shall not be deemed to be a waiver of such term, covenant or condition on any subsequent breach of the same or any other term, covenant or condition herein contained. The subsequent acceptance of rent hereunder by Landlord shall not be deemed to be a waiver of any

preceding breach by Tenant of any term, covenant or condition of this Lease, other than the failure of the Tenant to pay the particular rental so accepted, regardless of Landlord's knowledge of such preceding breach at the time of the acceptance of such rent.

27. **NOTICES.** Wherever in this lease it shall be required or permitted that notice and demand be given or served by either party to this lease to or on the other, such notice or demand shall be given or served and shall not be deemed to have been duly given or served unless in writing and forwarded by certified mail, addressed as follows:

LANDLORD: 650 Work Street, Ste. A, Salinas, California 93901

TENANT: Salinas Valley Memorial Healthcare System
Attn: CEO/President, 450 East Romie Lane
Salinas, CA 93901

Either party may change such address by written notice by certified mail to the other.

28. **SUCCESSORS AND ASSIGNS.** The covenants and conditions herein contained, subject to the provisions as to assignment, apply to and bind their heirs, successors, executors, administrators and assigns of the parties hereto.

29. **RECORDATION.** Neither Landlord nor Tenant shall record this Lease or a short form memorandum hereof without the prior written consent of the other party.

30. **QUIET POSSESSION.** Upon Tenant paying the rent reserved here- under and observing and performing all of the covenants, conditions and provisions on Tenant's part to be observed and performed hereunder, Tenant has quiet possession of the Premises for the entire term hereof, subject to all the provisions of this Lease.

31. **PRIOR AGREEMENTS.** This Lease contains all of the agreements of the parties hereto with respect to any matter covered or mentioned in this Lease, and no prior agreements or understanding pertaining to any such matter shall be effective for any purpose. No provisions of this Lease may be amended or added to except by an agreement in writing signed by the parties hereto or their respective successors in interest. This Lease shall not be effective or binding on any party until fully executed by both parties hereto.

32. **INABILITY TO PERFORM.** This Lease and the obligations of the Tenant hereunder shall not be affected or impaired because the Landlord is unable to fulfill any of its obligations hereunder or is delayed in doing so, if such inability or delay is caused by reason of strike, labor troubles, acts of God, or any other cause beyond the reasonable control of the Landlord.

33. **ATTORNEY'S FEES.** In the event of any action or proceeding brought by either party against the other under this Lease, the prevailing party shall be entitled to recover all costs and expenses including the fees of its attorneys in such action or proceeding in such amount as the court may adjudge reasonable as attorney's fees. Landlord shall be entitled to recover all attorney's fees and costs of collection incurred by it due to Tenant's default, whether or not suit is brought.

34. **SALE OF PREMISES BY LANDLORD.** In the event of any sale of the Building,

Landlord shall be and is hereby entirely freed and relieved of all liability under any and all of its covenants and obligations contained in or derived from this Lease arising out of any act, occurrence or omission occurring after the consummation of such sale; and the purchaser, at such sale or any subsequent sale of the Premises shall be deemed, without further agreement between the parties or their successors in interest or between the parties and any such purchaser, to have assumed and agreed to carry out any and all of the covenants and obligations of the Landlord under this Lease. No sale of the Building by Landlord shall operate in any way to terminate this Lease, or Tenant's right to extend same pursuant to the option set forth in this Lease or to otherwise alter or modify the terms and provisions hereof, and Landlord shall not enter into any sale of the Building without giving the Buyer notice of this provision.

35. **SUBORDINATION, ATTORNMENT.** Upon request of the Landlord, Tenant will in writing subordinate its rights hereunder to the lien of any first mortgage, or first deed of trust to any bank, insurance company or other lending institution, now or hereafter in force against the land and Building of which the Premises are a part of, and upon any building hereafter placed upon the land of which the Premises are a part, and to all advances made or hereafter to be made upon the security thereof. In the event any proceedings are brought for foreclosure, or in the event of the exercise of the power of sale under any mortgage or deed of trust made by the Landlord covering the Premises, the Tenant shall attorn to the purchaser upon any such foreclosure or sale and recognize such purchaser as the Landlord under this Lease. The provisions of this Article to the contrary notwithstanding, so long as the Tenant is not in default hereunder, this Lease shall remain in full force and effect for the full term hereof.

36. **SEPARABILITY.** Any provision of this Lease which shall prove to invalid, void, or illegal shall in no way affect, impair, or invalidate any other part or provision hereof and such other provision shall remain in full force and effect.

37. **CHOICE OF LAW.** This Lease and all matters arising under the Lease or related to the parties relationship as Landlord and Tenant shall be governed by the laws of the State of California and venue for all legal actions shall be in Monterey County, California.

38. **HAZARDOUS MATERIALS.**

A. Landlord is not aware of any asbestos or any other hazardous material on, in or under the Premises or Building.

B. If Tenant knows or has reasonable cause to believe that any release of a hazardous substance has come or will come to be located on or beneath said Premises, Tenant shall, within a reasonable period of time, either prior to the release or following the discovery by the Tenant of the presence or believed presence of a hazardous substance release, give written notice of that condition to Landlord.

C. If Tenant has knowledge of the presence of a release of a material amount of a hazardous substance, or of a hazardous substance release, that is required to be reported to a state or local agency pursuant to law, on or under the Premises and knowingly and willfully fails to provide written notice to the Landlord, the failure is deemed to constitute a default, upon Landlord's written notice to Tenant.

D. Tenant may cure a default under this section by promptly commencing and completing the removal of, or taking other appropriate remedial action with respect to, the hazardous

substance release. Tenant shall conduct removal or remedial action in accordance with all applicable laws and regulations and in a manner which is reasonably acceptable to, and which is approved in writing by, Landlord. A cure does not relieve Tenant of any liability for actual damages or for any civil penalty for a violation of this provision.

E. "Hazardous waste" means a waste, or combination of wastes, which because of its quantity, concentration, or physical, chemical, or infectious characteristics may either cause, or significantly contribute to an increase in mortality or an increase in serious irreversible, or incapacitating reversible, illness or pose a substantial present or potential hazard to human health or environment when improperly treated, stored, transported, or disposed of, or otherwise managed. The term "hazardous waste" also includes "extremely hazardous waste" which means any hazardous or mixture of hazardous wastes which, if human exposure should occur, may likely result in death, disabling personal injury or serious illness because of its quantity, concentration, or chemical characteristics. The term "hazardous waste" shall include oil, lubricants, and similar wastes.

F. Tenant agrees to indemnify, defend and hold the Landlord harmless from any and all claims related to hazardous waste release and disposal.

39. **MOLD DISCLOSURES.** Landlord hereby represents that it does not know of any toxic, as defined by the California Health Department, mold present that affects the premises. Tenant acknowledges that it received and reviewed this disclosure prior to executing this Lease. If Tenant becomes aware that mold is present in the building, heating system, ventilating or air-conditioning system, or appurtenant structures, or that there is a condition of chronic water intrusion or flood, Tenant shall inform the landlord of this knowledge in writing within a reasonable period of time. Landlord shall be responsible for remediation if any toxic mold is determined to have existed at the date of this Lease or otherwise, Tenant is responsible. Tenant shall make the property available to the Landlord or its agents for appropriate assessment or remedial action as soon as is reasonably practicable after giving notice of the mold. The responsible party shall remediate the toxic mold as soon as practical after discovery.

40. **OPTION TO RENEW**. Should Tenant fully and faithfully perform all of the terms and conditions of this lease for the full term specified herein, Tenant shall have the option to renew this lease for one (1) consecutive five (5) year term after the expiration of the full terms specified herein. Tenant may extend this lease for the option term by giving Landlord written notice of Tenant's desire to do so at least one hundred twenty (120) days prior to the expiration of the term then in effect. Except for the change in amount of initial Base Rent and the option provision, all other terms and conditions of this lease shall continue in effect during each renewal term.

41. **JOINT AND SEVERAL LIABILITY.** Each Tenant or guarantor hereto agrees to be jointly and severally liable for any breaches hereunder.

42. **AUTHORITY OF THE PARTIES.** Tenant represents and warrants that it is a California public healthcare district, and that the individual executing this agreement has been authorized by Tenant's Board of Directors to enter into such agreement at a duly called public meeting of the District. .

43. **SIGNATURE BY COUNTERPARTS OR FACSIMILE.** This Lease may be executed in counterparts by the Parties. All counterparts shall be binding on all parties, notwithstanding that all Parties are not signatory to the original or same counterpart. The Parties

agree to accept signatures by facsimile or digital scan.

44. **CERTIFIED ACCESS SPECIALIST REPRESENTATION.** In accordance with Civil Code § 1938, Landlord represents that the premises have not undergone inspection by a Certified Access Specialist (CASp) and states the following as required by the Code: A Certified Access Specialist (CASp) can inspect the subject premises and determine whether the subject premises comply with all of the applicable construction-related accessibility standards under state law. Al- though state law does not require a CASp inspection of the subject premises, the commercial property owner or lessor may not prohibit the lessee or tenant from obtaining a CASp inspection of the subject premises for the occupancy or potential occupancy of the lessee or tenant, if requested by the lessee or tenant. The par- ties shall mutually agree on the arrangements for the time and manner of the CASp inspection, the payment of the fee for the CASp inspection, and the cost of making any repairs necessary to correct violations of construction-related accessibility standards within the premises.

45. **ACCESSIBILITY COMPLIANCE.** The parties agree that the expense of a CASp inspection and the cost of making any repairs necessary to correct violations of accessibility standards for the premises shall be borne by Tenant. Tenant understands and agrees that the premises leased hereunder are for private use and may not be ADA compliant.

EXECUTED in Monterey County, California.

Dated:_____

LANDLORD:

LUGO FAMILY LIVING TRUST

By:_____
Kerry R. Lugo, Trustee

By:_____
Cheryl A. Lugo, Trustee

Dated:_____

TENANT:

SALINAS VALLEY MEMORIAL HEALTH CARE SYSTEM

By:_____
Pete Delgado, President/CEO

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Minutes from the April 27, 2021 meeting of the Personnel, Pension and Investment Committee will be distributed at the Board Meeting

(REGINA M. GAGE)

TRANSFORMATION, STRATEGIC PLANNING, AND GOVERNANCE COMMITTEE

Minutes from the April 28, 2021 meeting of the Transformation, Strategic Planning, and Governance Committee will be distributed at the Board Meeting

(JOEL HERNANDEZ LAGUNA)

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation to Board of Directors to Adopt the Initial Study and the Mitigated Negative Declaration and Approve the Mitigation Monitoring and Reporting Program for the Downing Resource Center Parking Garage Annex and Ancillary Improvements**

Executive Sponsor: Pete Delgado, President / Chief Executive Officer
Earl Strotman, Director Facilities Management and Construction
Dave Sullivan, Facilities Management

Date: March 30, 2021

Executive Summary

As the lead agency for the construction project identified as the Downing Resource Center Parking Garage Annex and Ancillary Improvements ("DRC Annex"), SVMHS' Board of Directors is responsible for compliance with the California Environmental Quality Act (CEQA).

In compliance with the California Environmental Quality Act (CEQA), SVMHS has undertaken environmental review for the proposed Parking Garage Annex Project (Conditional Use Permit 2019-022). An Initial Study and Mitigated Negative Declaration (IS/MND) was prepared to identify the potential environmental effects of the project. While most environmental issues were found to be less than significant, the IS/MND identified mitigation measures for cultural and tribal resources (in the event of inadvertent discovery of resources), noise (to minimize sources of construction noise), and a requirement to secure additional offsite parking spaces during construction.

The IS/MND was circulated and made available for public review from April 8, 2020 to May 8, 2020 at the SVMHS Human Resources Department and the City of Salinas Community Development Department. The Notice of Intent to Adopt a Mitigated Negative Declaration (NOI) was published in the Salinas Californian, posted with the Monterey County Clerk, direct mailed to local agencies and organizations and made available on the SVMHS website. A project information flyer was also distributed throughout the immediate neighborhood.

At the end of the public review period, one request for consultation on the IS/MND was received by the Tribal Chairwoman of the Ohlone/Costanoan-Esselen Nation. Ms. Louise Miranda Ramirez has requested additional information pursuant to AB52/SB18 with the lead agency, SVMHS. SVMHS has requested a consultation to update the Tribal Chairwoman with project specific information relative to the current project plans.

Prior to taking action to approve the project, the Board of Directors must adopt the IS/MND and approve the Mitigation Monitoring and Reporting Program. Following action by the Board, the City of Salinas Planning Commission must also consider the adopted IS/MND prior to issuing planning approvals and permits.

CEQA Findings

The Initial Study identified potentially significant effects on the environment. However, this project has been mitigated (see mitigation measures of the MND which avoid or mitigate the effects) to a point where no significant effects would occur. There is no substantial evidence that the project may have a significant effect on the environment. The following reasons support these findings: 1. The proposal is a logical component of SVMHS campus, consistent with the objectives of the SVMHS Master Plan, and consistent with existing land uses of the immediate project area. 2. Identified adverse impacts are proposed to be mitigated by construction best practices, pre-construction surveys and other standard conditions as identified in the Initial Study. 3. The proposed project is consistent with the adopted goals, policies and land uses of the City of Salinas General Plan and Municipal Code. 4. With the application of mitigation measures, the proposed project will not have any significant impacts on the environment.

With respect to cultural and tribal cultural resources, implementation of mitigation measures would address inadvertently discovered resources by ceasing work, contacting tribal representatives and implementation of a mitigation plan specific to the resource. With respect to construction noise, equipment must be maintained and used to minimize unwanted noise and vibration at adjacent land uses. Regarding traffic, mitigation is provided to ensure that additional parking is provided during the construction phase of the parking structure.

Recommendation

The Finance Committee recommends that the SVMHS Board of Directors adopt the Initial Study and the Mitigated Negative Declaration and approve the Mitigation Monitoring and Reporting Program for the Downing Resource Center Parking Garage Annex and Ancillary Improvements.

Project Scope

The DRC Annex project calls for the design and construction of a new 4-level parking structure immediately adjacent to the existing Downing Resource Center parking structure ("DRC") which will serve as an extension, or annex to the DRC. The new garage will provide a net increase of 166 parking stalls and will connect to the existing structure's circulation system, functioning as a single larger garage. A new south entrance/exit will be provided from San Jose Street. New exterior stairways and pedestrian access will be provided to direct garage users to the main hospital entrance. Upon completion the annex would be the same height as the DRC, 37 feet above existing grade including a 5-foot parapet, and will be designed to have a consistent appearance. The lowest (basement) level will include 20,000 square feet of office and hospital support uses, connecting to the basement uses in the existing DRC structure.

Attachments

1. Mitigation Monitoring and Reporting Program
2. Hyperlink to the Initial Study and Mitigated Negative Declaration:
   https://www.svmh.com/betterparking

1 DRAFT MITIGATION MONITORING AND REPORTING PROGRAM

1.1 PUBLIC RESOURCES CODE

When approving projects that identify significant impacts, the California Environmental Quality Act (CEQA) requires public agencies to adopt monitoring and reporting programs or conditions of project approval to mitigate or avoid the identified significant effects (Public Resources Code Section 21081.6(a)(1)). A public agency adopting measures to mitigate or avoid the significant impacts of a proposed project is required to ensure that the measures are fully enforceable, through permit conditions, agreements, or other means (Public Resources Code Section 21081.6(b)). The program must be designed to ensure project compliance with mitigation measures during project implementation.

The Mitigation Monitoring and Reporting Program (MMRP) is organized in a table format (see **Table 1-1: Mitigation Monitoring and Reporting Program for the Downing Resource Center Parking Garage Annex and Ancillary Improvements [CUP 2019-022])**, keyed to each significant impact and each mitigation measure. Only mitigation measures adopted to address significant impacts are included in this program. Each mitigation measure is set out in full, followed by a tabular summary of monitoring requirements. The column headings in the tables are defined as follows:

- Mitigation Measures: This column presents the mitigation measure identified in the environmental document.
- Responsible Agency/Department: This column references any public agency/City Department with which coordination is required to satisfy the identified mitigation measure and/or confirm compliance. The agency or department listed is responsible for clearing the mitigation measure.
- Monitoring/Reporting Responsibility: This column contains an assignment of responsibility for the monitoring and reporting tasks will be implemented, which may include the project applicant, contractor, or responsible agency.
- Timing of Implementation: This column refers to when the measure is required to be implemented.
- Staff/Notes: This column will be used by the lead and/or responsible agency to document the person who verified the implementation of the mitigation measure and the date on which this verification occurred.

1.2 ENFORCEMENT

All mitigation measures for significant impacts must be carried out to fulfill the requirements of project approval. A number of the mitigation measures would be implemented during the course of the development review process. These measures would be checked on plans, in reports, and in the field prior to construction. Most of the remaining mitigation measures would be implemented during the construction, or project implementation phase.

Table 1-1: Mitigation Monitoring and Reporting Program for the Downing Resource Center Parking Garage Annex and Ancillary Improvements

Mitigation Number	Mitigation Measure	Responsible Agency/Department	Monitoring/Reporting Responsibility	Timing of Implementation	Staff Notes; Initials/Date when Completed
MM CUL-1	**Cultural and Tribal Resources.** During project construction, if any archeological, paleontological or tribal resources (e.g., evidence of past human habitation or fossils) are found, the project applicant and/or its contractor shall cease all work within 50 feet of the discovery and notify the City of Salinas Planning Division immediately. The project applicant and/or its contractor shall retain a qualified archaeologist, paleontologist and Native American representative to evaluate the finds and recommend appropriate mitigation measures for the inadvertently discovered resources. The City and the applicant shall consider the mitigation recommendations and agree on implementation of the measure(s) that are feasible and appropriate. Such measures may include avoidance, preservation in place, excavation, documentation, curation, or other appropriate measures. (Health and Safety Code Section 7050.5).	City of Salinas Planning Division	Project Applicant/Contractor	During construction	

Mitigation Number	Mitigation Measure	Responsible Agency/Department	Monitoring/Reporting Responsibility	Timing of Implementation	Staff Notes; Initials/Date when Completed
MM CUL-2	**Cultural and Tribal Resources**. If human remains or cultural resources associated with a burial (i.e. grave goods) are discovered during construction, the project applicant and/or its contractor shall cease all work within 50 feet of the find and notify the City of Salinas Planning Division and the County Coroner, according to California Health and Safety Code Section 7050.5. If the remains are determined to be Native American, the coroner shall notify the Native American Heritage Commission and shall follow the procedures outlined in CEQA Guidelines Section 15064.5(d) and (e) regarding treatment and disposition of recovered cultural items. The Commission will designate a Most Likely Descendant (MLD) who will be authorized to provide recommendations for management of the Native American human remains and any associated materials or objects (Public Resourced Code Section 5097.98 and Health and Safety Code Section 7050.5).	City of Salinas Planning Division	Project Applicant/Contractor, Monterey County Coroner	During construction	

Mitigation Number	Mitigation Measure	Responsible Agency/Department	Monitoring/Reporting Responsibility	Timing of Implementation	Staff Notes; Initials/Date when Completed
MM NOI-1	Prior to the initiation of construction, the City of Salinas City Engineer shall ensure that all project plans and specifications stipulate that: • All construction equipment, fixed or mobile, shall be equipped with properly operating and maintained mufflers; • The project shall implement construction noise reduction methods such as shutting off idling equipment, installing temporary acoustic barriers around stationary construction noise sources, maximizing the distance between construction equipment staging areas and occupied residential areas, and use of electric air compressors and similar power tools, rather than diesel equipment, shall be used where feasible; • During construction, stationary construction equipment shall be placed such that emitted noise is directed away from sensitive noise receivers;	City of Salinas Public Works Department	City of Salinas City Engineer; Contractor	Prior to the initiation of construction and during construction	

Mitigation Number	Mitigation Measure	Responsible Agency/Department	Monitoring/Reporting Responsibility	Timing of Implementation	Staff Notes; Initials/Date when Completed
	• During construction, stockpiling and vehicle staging areas shall be located as far as practical from noise sensitive receptors; and • Operate earthmoving equipment on the construction site, as far away from vibration sensitive sites as possible.				

RESOLUTION NO. 2021-02
OF THE BOARD OF DIRECTORS OF
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
SETTING GENERAL PREVAILING WAGE RATES

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

WHEREAS, the District is a political subdivision of the State of California as defined by Section 1721 of the California Labor Code;

WHEREAS, Section 1773 of California Labor Code provides various rules and regulations concerning contracts awarded by political subdivisions and requires political subdivisions to obtain prevailing wage rates from the Director of the Department of Industrial Relations;

WHEREAS, Section 1773.2 of California Labor Code requires political subdivisions to specify in bid documents, or maintain on file at its principal office, which shall be made available to any interested party on request, and post at each job site, such prevailing wage rates; and

WHEREAS, the general prevailing hourly wage rates are designated in the Schedules and Determinations provided by the Director of Industrial Relations pursuant to California Labor Code Sections 1770, 1773 and 1773.1 ("Wage Rates");

NOW THEREFORE IT IS HEREBY ORDERED AND DIRECTED THAT:

1. The District shall maintain a copy of the Wage Rates in the District's Principal office.

2. All calls for bids, bid specifications and contracts may specify the rates of pay, or contain a statement that said prevailing wages are available for review in the office of the President/Chief Executive Officer of the District and online from the Department of Industrial Relations website at https://www.dir.ca.gov/OPRL/DPreWageDetermination.htm.

3. A copy of the Wage Rates should be posted at each job site.

4. The President/Chief Executive Officer of the District is authorized and directed to execute any and all documents for and on behalf of the Board of Directors necessary to carry out the intent of this Resolution.

This Resolution was adopted at a duly noticed Regular Meeting of the Board of Directors of the District on April 29, 2021, by the following vote.

AYES:
NOES:
ABSTENTIONS:
ABSENT:

_____
Board Member
Salinas Valley Memorial Healthcare System

Medical Executive Committee Summary
April 8, 2021

The following items from the meeting of the Medical Executive Committee (MEC) are presented to the Board of Directors and recommended for approval or as informational as indicated:

Items for Board Approval:

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Burton, Elijah, MD	Radiology	Surgery	Remote Radiology
Klein, Michael, MD	Radiology	Surgery	Remote Radiology
Wright, Alexander, MD	Radiology	Surgery	Remote Radiology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Allen, Evan, MD	Neurology	Medicine	Tele-Neurology
Collins, Carlos, MD	Psychiatry	Medicine	Tele-Psychiatry
Dicus, Michael, MD	Nephrology	Medicine	Nephrology General Internal Medicine
Gasper, Mason, DO	Neurology	Medicine	Tele-Neurology
Hulkower, Jonathan, MD	Psychiatry	Medicine	Tele-Psychiatry
Johnson, Steven, MD	Gastroenterology	Medicine	Gastroenterology
Kalanithi, Suman, MD	Neurology	Medicine	Tele-Neurology
Kashif, Farheen, MD	Internal Medicine	Medicine	Adult Hospitalist
Lim, Jerrie, MD	Pediatrics	Pediatrics	Pediatrics
Martin, Sonya, MD	Psychiatry	Medicine	Tele-Psychiatry
Millan-Sanchez, Martha, MD	Psychiatry	Medicine	Tele-Psychiatry
Nezamabadi, Aryan, MD	Internal Medicine	Medicine	Adult Hospitalist
Nishimoto, Warren, DO	Family Medicine	Family Medicine	Family Medicine Active Community
Oppenheim, Peter, MD	Family Medicine	Family Medicine	Family Medicine Active Community
Radner, Allen, MD	Infectious Disease	Medicine	Infectious Disease General Internal Medicine Regional Wound Healing Center (RWHC)
Ramirez, Edward, MD	Gynecology	Ob/Gyn	Gynecology
Reddy, Sumana, MD	Family Medicine	Family Medicine	Family Medicine Active Community
Romans, Matthew, MD	Plastic Surgery	Surgery	Plastic & Reconstructive Surgery Regional Wound Healing Center (RWHC)
Rubin, Mitchell, MD	Neurology	Medicine	Tele-Neurology
Samuels, Todd, MD	Neurology	Medicine	Tele-Neurology
Shaikh, Faraz, MD	Internal Medicine	Medicine	Adult Hospitalist

Modification and/or Addition of Privileges:

NAME	SPECIALTY	RECOMMENDATION
Regwan, Steven, DO	Cardiology	Ambulatory, Cardiology core privileges at Taylor Farms Family Health & Wellness Clinic

Staff Status Modifications:

NAME	SPECIALTY	RECOMMENDATION
Barcelo, Lawrence, MD	Family Medicine	Senior Active to Emeritus effective 06/15/2021
Carlson, John, MD	Gastroenterology	Active to Senior Active effective 03/29/21
Anghelescu, Dan, MD	Interventional Radiology	Resignation effective 04/30/21
Edwards, Cheryl, MD	OB Hospitalist	Medical Leave of Absence 04/01/21 – 07/01/21
Khalsa, Hari, MD	Emergency Medicine	Resignation effective 04/04/21
Nielsen, Terrance, MD	Ob/Gyn	Resignation effective 03/15/21
Schachar, Ira, MD	Ophthalmology	Resignation effective 04/30/21
Sulak, Camilla, MD	Emergency Medicine	Leave of Absence effective 03/01/21
Ueda, Robert, MD	Interventional Radiology	Leave of Absence effective 02/28/21

Other Items:

ITEM	RECOMMENDATION
Kavitha Vemuri, MD	Recommend the processing of Dr. Vemuri's application be discontinued.
Department of Family Medicine: Clinical Privileges Delineation Forms ***(Attached)***	The Committee reviewed and recommended approval of the proposed reviews as presented. • Family Medicine - Revised • Family Medicine Active Community – No changes
FPPE/Proctor Form for Anesthesiology – New ***(Attached)***	The Committee reviewed and recommended approval of the new FPPE/Proctoring form for Anesthesiology.

Interdisciplinary Practice Committee

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Chen, Bryant, PA-C	Physician Assistant	Emergency Medicine	Physician Assistant – Clinical Privilege/Practice Agreement: Core with special privileges

Policies: Antimicrobial Stewardship Plan ***(Attached)***

Informational Items:

The following items were approved/accepted as appropriate:

I. Committee Reports:

a. Quality and Safety Committee
b. Medical Staff Excellence Committee

II. Other Reports:

a. Financial Performance Review – February 2021
b. Executive Update
c. Summary of Executive Operations Committee Meetings
d. Summary of Medical Staff Department/Committee Meetings
e. Health Information Management Update
f. Medical Staff Treasury
g. Medical Staff Statistics
h. SVMH Foundation Update
i. HCAHPS Data

III. Order Sets Approved:

DCD (Donation after Circulatory Death) Physician Order Request
Hypertriglyceridemia Pancreatitis
CALGB 10403 Interim Maintenance Capizzi Methotrexate (For Adolescent/Young Adult Acute Lymphoblastic Leukemia)
SCL28 Durvalumab + Etoposide + Cisplatin
Clinical Trial A021703

Clinical Privileges Delineation Form
Family Medicine

Applicant Name: _____

To be eligible to apply for core privileges in Family Medicine, the applicant must meet the following qualifications:

Qualifications for Adult Family Medicine Privileges:

A. Current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Practice OR Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in family medicine.

And

B. Documentation of the provision of inpatient care for at least 24 adult patients as the attending physician or senior resident during the past 24 months or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship.

Adult Family Medicine Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat patients at or above the age of 16 for common illnesses and injuries including disorders common to old age. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Pediatric and Well Newborn Family Medicine Privileges:

A. Meet ~~A~~all qualifications for Adult Family Medicine privileges under A above within the previous 24 months

~~**And**~~**OR**

B. Meet all qualification for Adult Family Medicine privileges under A above

AND

Document provision of inpatient care for at least 20 hospitalized pediatric/newborn patients during the past 24 months. Competency criteria requires that 5 of these patients be pediatric patients or, at a minimum, the applicant must have provided inpatient care for at least 3 pediatric patients in conjunction with documentation 5 hours of Category 1 CME on acute care pediatric medicine during the past 24 months

~~**OR**~~

~~B. Demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in the past 24 months.~~

Family Medicine Pediatric and Well Newborn Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat pediatric and well newborn patients with conditions of mild to moderate degree without immediate threat to life for patients up to the age of 21. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Well Newborn Family Medicine Privileges:

A. Meet All qualifications for Adult Family Medicine privileges under A above

And

B. Documentation of the provision of inpatient care for at least 20 hospitalized well newborn patients during the past 24 months or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in the past 24 months.

Family Medicine Well Newborn Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat well newborn patients.

Qualifications for Pediatric Family Medicine Privileges:

A. Meet All qualifications for Adult Family Medicine privileges under A above

And

B. Documentation of the provision of inpatient care for at least 24 hospitalized pediatric patients during the past 24 months or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in the past 24 months.

Family Medicine Pediatric Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat pediatric patients (with exceptions of newborns), with conditions of mild to moderate degree without immediate threat to life for patients up to the age of 21. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Family Medicine Category I Obstetrical Privileges:

A. All qualifications for Adult Family Medicine.

And

B. Documentation of successful completion of a six (6) month rotation on an obstetric unit during training with at least 100 vaginal deliveries under supervision during training

And

C. Documentation of at least 50 vaginal deliveries in the past 24 months.

And

D. Completion of an American Completion of an American College of Obstetricians and Gynecologists (ACOG) endorsed fetal monitoring strip interpretation course that includes NICHD nomenclature within three months of appointment

Family Medicine Category I Obstetrical Privileges ***(check box if requesting)***

☐ **Requested**

Core Procedures/Diagnoses: Admit, evaluate, diagnose, treat and provide consultation to obstetrical patients of all ages, to include management of normal pregnancy, labor and delivery, as well as expected complications or obstetrical emergencies.

Applicants without C-Section privileges are required to make arrangements for C-Section back-up for all deliveries in the event that a C-Section is needed.

Note: The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Family Medicine Category II Obstetrical Privileges

A. All qualifications for Adult Family Medicine and Category I Obstetrical Privileges
And

B. Documentation of successful completion of a full **1 year** exclusive experience on obstetric unit with at least **100 vaginal** deliveries with supervision and **30 abdominal** deliveries with supervision during training or practice within the past 24 months
And

C. Completion of an American Completion of an American College of Obstetricians and Gynecologists (ACOG) endorsed fetal monitoring strip interpretation course that includes NICHD nomenclature within three months of appointment

Family Medicine Category II Obstetrical Privileges *(check box if requesting)*

☐ **Requested**

Core Procedures/Diagnoses: Admit, evaluate, diagnose, treat and provide consultation to obstetrical patients of all ages, to include management of normal and complex pregnancy, labor and delivery, as well as expected complications or obstetrical emergencies. Applicants for this category are required to qualify for and request special procedure privileges for C-Sections.

Note: The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

New applicants will be required to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts. Terms are as defined by ACOG.

Core Proctoring Requirements:
Core proctoring requirements include direct observation or concurrent review of the first cases as follows:

Adult Family Medicine Core:	2 Adult Admissions
Pediatric & Well Newborn Core:	1 Pediatric Admission and 1 Well Newborn
Well Newborn Core:	1 Well Newborn
Family Medicine Pediatrics Core:	2 Pediatric Admissions
Family Medicine Obstetrics:	3 Deliveries – 2 of which must be C-sections if C-Section privileges are requested.

Reappointment Criteria for Core Privileges:
Applicant must provide documentation of the provision of the following within the past 24 months:

Adult Family Medicine Core:	20 hospitalized patients
Pediatric & Well Newborn Core:	20 hospitalized pediatric/newborn patients 5 of which must be pediatric or 3 and 5 hours Category 1 CME
Well Newborn Core:	20 hospitalized well newborn patients
Family Medicine Pediatrics Core:	24 hospitalized pediatric patients
Family Medicine Obstetrics I:	25 vaginal deliveries Participation in the annual assessment of EFM (electronic fetal monitoring) principles (assessed at the time of reappointment)
Family Medicine Obstetrics II:	25 vaginal deliveries w/10 C-sections Participation in the annual assessment of EFM (electronic fetal monitoring) principles (assessed at the time of reappointment)

Special Procedures/Privileges

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

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

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

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

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written conscious sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written conscious sedation exam with minimum 75% correct **AND** Performance of at least 2 Cases
				~~Rounding on Post-Partum Patients~~ ~~*Privileges may be held for a maximum of 4 years*~~	~~1. Meet criteria and be approved for Adult Family Medicine Privileges; **AND**~~ 2.1. ~~Hold full unrestricted Ob/GYN privileges for 5 consecutive years post completion of training in an accredited hospital within the past two years~~	~~**1**~~	~~1. Maintain Adult Family Medicine Privileges at SVMH.~~ 2.1. ~~Round on 100 post-partum patients during the previous 2 years without peer review referral for HIM delinquency~~

Gynecologic Special Procedure Privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Dilation and Curettage of the Uterus (Diagnostic)	Performance of at least 10 procedures during the previous 24 month period	**1**	Performance of at least 2 procedures during the previous 24 month period
				Dilation and Curettage of the Uterus for abortion <12 weeks (TAB, SAB)	Performance of at least 10 procedures during the previous 24 month period	**1**	Performance of at least 2 procedures during the previous 24 month period

Special Obstetrical Procedures

Qualifications:

Following completion of Family Practice residency and completion of a one year obstetric fellowship in an accredited Family Practice Obstetric Fellowship Training Program, and a letter of positive recommendation from the Chief of this program certifying training and competence to perform privileges requested

Other Requirements:

Deliveries with placenta previa require an assistant with unrestricted hysterectomy privileges

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Cesarean Section *Assistant Required*	Meet criteria for Category II Family Medicine Obstetrical Privileges AND Provide documentation of the successful completion of at least 30 C-sections within the past 24 months.	**2**	Performance of at least 10 procedures during the previous 24 month period
				Outlet and Low forceps delivery	Performance of at least 5 procedures during the previous 24 month period	**1**	Performance of at least 1 procedure during the previous 24 month period
				External Cephalic Version	Cesarean Section privileges are required	**1**	Maintenance of Cesarean Section privileges
				Amniocentesis-3rd Trimester	Performance of at least 5 procedures during the previous 24 month period	**1**	Performance of at least 1 procedure during the previous 24 month period
				~~Initiation of Q-Pump Pain Relief System~~	~~Review of "On-Q Pain Buster" educational materials~~	~~1 Retrospective Review~~	~~None~~

Applicant: Check box marked "R" to request privileges
Category 1 Pediatric Special Procedures – See Appendix for Description of Conditions in this Category

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Newborn Circumcision	Documentation of successful completion of at least 5 in the previous 24 months	**1**	Documentation of successful completion of at least 2 in the previous 2 years

Neonatal Intensive Care Special Procedure Privilege Qualifications: Applicant must

1. document 36-hours of continuing medical education in neonatal medicine every 3 years (Educational programs must meet the approval of the NICU Medical Director), and
2. maintain current Neonatal Resuscitation Program (NRP) certification, and
3. maintain current CCS Panel membership

R	A	C	N	Procedure/Condition	Initial Appointment	Proctoring	Reappointment
				R/O Sepsis Transient Tachypnea Prematurity 35-weeks and greater and/or weight greater than 2250 gm Hypoglycemia responding within 2-hours on IV C10 at maintenance rates	Documentation of 25 cases in the previous 24 months	**N/A**	Documentation of 12 cases in the previous 2 years

Acknowledgment of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Memorial Healthcare System. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

_____ _____

Applicant Signature Date

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

_____ _____

Department Chair Signature Date

Salinas Valley Memorial Healthcare System

Core Procedure List: The following procedures are considered to be included in the core privileges for this specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff

Family Medicine Adult

1. Assisting at Surgery
2. Arthrocentesis
3. I&D abscess
4. I&D hemorrhoids
5. Biopsy of superficial lymph nodes
6. Breast cyst aspiration
7. Burns, superficial and partial thickness
8. Excision of skin and subcutaneous lesions
9. Initial interpretation of electrocardiograms
10. Local anesthetic techniques
11. Lumbar puncture
12. Management of ICU and CCU patients with consultation
13. Manage uncomplicated minor closed fractures and uncomplicated dislocations
14. Paracentesis
15. Placement of anterior and posterior nasal hemostatic packing
16. Peripheral nerve blocks
17. Remove non-penetrating corneal foreign body, nasal foreign body
18. Repair of lacerations, including those requiring more than one layer of closure
19. Suprapubic bladder aspiration
20. Thoracentesis
21. Thrombolytic therapy for stroke
22. Vasectomy
23. Venous cut down

Family Medicine Pediatrics

1. Suture uncomplicated lacerations
2. I&D abscess
3. Perform simple skin biopsy or excision
4. Remove non-penetrating corneal foreign body
5. Manage uncomplicated minor closed fractures and uncomplicated dislocations
6. Lumbar puncture
7. Care of newborn infants above 2250 gm and >36 weeks
8. Ventilator management with consultation while awaiting transfer (not to exceed 12 hours after which care is automatically transferred to the Pulmonologist)

Family Medicine Obstetrics – Level I

1. Management of Uncomplicated Labor and cephalic delivery
2. Administration of fetal lung maturity inducers
3. Amnio infusion
4. Amniotomy
5. Application of internal fetal and uterine monitors
6. Management of pregnancy inclusive of such conditions as mild preeclampsia, third trimester bleeding, preterm premature rupture of membranes >32 weeks, premature labor >32 weeks, A-1 diabetes, and fetal demise with notification of backup physician when patient is admitted.
7. Manual removal of placenta
8. Outlet Vacuum Extraction
9. Gestational Diabetes – Non-insulin Dependent (A-1)
10. Hemorrhage ante/intra & post partum

11. Induction, augmentation, pharmacologic induction of labor
12. Pharmacologic treatment of preterm labor
13. Polyhdramnios
14. Repair 3rd degree perineal laceration
15. Ultrasound Exam for Placental location, presentation or Amniotic fluid only
16. Local and pudendal anesthesia
17. Amniotomy at 4cm and/or -1 station
18. Hyperemesis gravidarum
19. Episiotomy and Repair
20. Use of Oxytocic drug after the end of 3rd stage of labor
21. Treatment of medical complications of pregnancy – requires **notification of Maternal Fetal Medicine specialist**

Family Medicine Obstetrics – Level II

1. Postpartum surgical sterilization
2. Twins - Vaginal Vertex/Vertex
3. Twins - Other Presentation
4. Management of pregnancy induced hypertension/eclampsia on PIH < 34 weeks
5. Management of premature labor <32 weeks
6. C-section for previa at term must have assistant with hysterectomy privileges scrubbed in.
7. Repair of 4th degree perineal lacerations or cervical laceration
8. Management of pregnancy inclusive of such conditions as mild preeclampsia ,third trimester bleeding, premature rupture of membranes >32 weeks, A-1 diabetes, and fetal demise
9. Cephalic forceps Outlet
10. Treatment of medical complications of pregnancy – requires notification of the Maternal Fetal Medicine specialist.
11. Management of gestational diabetes A1 and A2, diet controlled and insulin requiring

Applicant: Complete this section only if you do not wish to apply for any of the specific core procedures listed above:

Please indicate any privilege on this list you would like to ***delete*** by writing them in the space provided below. Requests for deletions or changes will be reviewed and considered by the Department Chair, Credentials Committee and Medical Executive Committee. Deletion of any specific core procedure does not preclude mandatory requirement for Emergency Room call.

_____ _____

_____ _____

_____ _____

_____
Signature:

_____
Date

POLICY FOR LEVEL I FAMILY MEDICINE OBSTETRICAL PRIVILEGES
Back-Up, Consultation and Transfer

The following policy pertains to all Family Medicine physicians applying for Level I Obstetrical privileges.

DEFINITION OF BACK-UP PHYSICIAN:
The Back-up Physician can only be a Family Physician with Level II unrestricted Obstetrical privileges or an Obstetrician with unrestricted obstetrical privileges. Perinatologists are not eligible to be Back-up Physicians. The ED On-Call Physician for Obstetrics cannot be the back-up physician by default. Back-up coverage can only be made through prior arrangement with that physician.

1. **GENERAL POLICY**: As a prerequisite to obtaining Level I Family Medicine Obstetrical privileges, all Family Medicine applicants are required to have an Obstetrician or Family Physician with Level II Obstetrical privileges as Back-up who has agreed to provide obstetrical back up in the event the needs of the patient exceed their obstetrical privileges for the 2 year appointment periods. At no time should a Level I Family Medicine Physician continue in the practice of obstetrics without a designated Back-up Physician. If the reported Back-up Physician relationship changes at any point within the 2-year appointment period, a new Back-up Physician designate must be reported to the Medical Staff Services Department immediately.

    a. The Family Physician and Back-up Physician have mutually developed and agreed upon clear guidelines for consultation, co-management and transfer of care.

    b. The basic template for those guidelines is the Level I Obstetrical privileges for Family Physicians

    c. A Level I Family physician may have more than one designated Back-up Physician listed, however, a specific Back-up Physician must be designated and identified for each case.

    d. The Back-up Physician can designate an alternate Back-up Physician on a case by case basis only by mutual consent of the newly designated Back-up Physician and the Level I Family Physician.

    e. Because serving as a Back-up Physician is an assumption of risk and liability, the Back-up Physician CANNOT be assigned the task or designated the task by an Employer, Department Chair. Hospital Administrator, or Chief of Staff without the consent of the Physician providing these services.

2. **PRIVILEGING AND REAPPOINTMENT**: The Back-up Physician must be clearly identified and acknowledged at the time of application for and renewal of privileges with the Medical Staff Services Department.

    a. The Back-up Physician's name and contact information shall be included with the application. (see attached attestation form)

    b. The Back-up Physician must provide written acknowledgement of acceptance of this responsibility for the specific physician on the attestations form.

    c. Without cause, either the Level I Family Physician or Back-up Physician may terminate the agreement at any time. Should this occur, the Level I Family Physician and Back-up Physician must immediately report this termination to the Medical Staff Services Department (Mon-Fri, 8am – 4:30) or to the Nursing Supervisor outside of normal business hours..

3. **LABOR AND DELIVERY NURSING**: The Labor and Delivery Nursing station will access the names of all Family Physicians with Level I Obstetrical privileges and their corresponding back-up through the medical staff privileges in the Meditech system

4. **ADMISSION TO LABOR AND DELIVERY**:

   a. Upon admission of an Obstetrical patient to a Level I Family physician's service, the Back-up Physician will be clearly identified on the admission orders

   b. If the Back-up Physician is not available or declines to provide back-up, the Level I Physician must transfer care to a Level II Family physician, Obstetrician, or another Level I Physician with appropriate back-up; or the Chair of the Department of Family Medicine or Ob/Gyn must intervene to arrive at a safe and appropriate solution

5. CONSULTATION, TRANSFER AND CO-MANAGEMENT OF PATIENTS

   a. Any discussion with the Back-up Physician must be documented in the chart by the Level I Physician

   b. If the status of the patient exceeds Level I Family Medicine Obstetrical privileges, the care of the patient must be transferred to and accepted by the designated Back-up Physician.

   c. The Level I Physician must document transfer of care to the Back-up Physician by order and note in the chart

   d. The Back-up Physician must document acceptance of the transfer of care in the chart through either a dictated or handwritten consultation note

   e. The patient may be co-managed by the Back-up Physician and Level 1 Physician, if acceptable by the Back-up Physician.

6. VIOLATION OF POLICY

Violations of this policy will be reported to the Medical Staff Excellence Committee, the Chairs of the Family Medicine and Ob/Gyn Departments and to the Chief Medical Officer for review and action.

FAMILY MEDICINE
LEVEL I OBSTETRICS
BACK-UP ATTESTATION

The following physician has agreed to provide obstetrical back-up for hospitalized patients at Salinas Valley Memorial Hospital (SVMH) for the Family Medicine physician noted below.

Without cause, either the Level I Family Physician or Back-up Physician may terminate the agreement at any time. The Level I Family Physician and Back-up Physician but must immediately report this termination to the Medical Staff Services Department or to the Nursing Supervisor outside of normal business hours (Mon-Fri, 8am – 4:30).

Applicant Attestation:
I understand that I am required to have at least one back-up physician with Level II Family Medicine Obstetrical Privileges or full Obstetrical Privileges in order to qualify for Level I Family Medicine Obstetrical Privileges at SVMH. I understand that the back-up physician must be on staff in good standing with unrestricted privileges at SVMH. In the event that the needs of my hospitalized obstetrical patients exceed the privileges that I have been granted, the physician listed below has agreed to provide back up for me for the current reappointment period.

I understand that, should the status of any of these physicians change such that they would be unable to provide this back-up coverage, it is my responsibility to notify the Medical Staff Services Department immediately and to subsequently secure a replacement for that physician.

_____ _____
Physician's Signature Date

_____
Physician's Typed or Printed Name

Back Up Physician Attestation:
I have agreed to provide back-up coverage as outlined in the Medical Staff Back-Up, Consultation and Referral Policy for Family Medicine Physicians with Level 1 Obstetrical Privileges:

_____ _____
Physician's Signature Date

_____
Physician's Typed or Printed Name

_____
Physician's Contact Information

Clinical Privileges Delineation
Family Medicine – Active Community

Applicant Name: _____

Qualifications:

ACTIVE COMMUNITY MEDICINE PRIVILEGES:
To be eligible to apply for Active Community privileges in Family Medicine, the applicant must meet the following qualifications:

Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in family medicine.

These privileges are available only for those applicants who qualify and apply for Active Community Status membership.

ACTIVE COMMUNITY PRIVILEGES
Active Community privileges are reserved for physicians with office based practices who do not routinely provide care in the acute hospital setting.

Active Community Procedures List: Applicant please check box next to privilege you are requesting.

☐ **Concurrent review of hospitalized patients – excludes documentation in the medical record, inpatient orders and any activity construed to direct patient care.**
(No volume associated proctoring or reappointment criteria associated with this privilege)

☐ **Ordering of outpatient diagnostic tests**
(No volume associated proctoring or reappointment criteria associated with this privilege)

Special Procedures/Privileges

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
				Surgical Assisting	• Successful completion of an	**1**	Applicant must provide reasonable evidence of current ability to

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Only (*Designation as Co-Surgeon is not allowed*)	approved surgical or surgical associated residency training program **AND** • Applicant must be able to document that he or she has assisted in at least 12 surgical procedures as first assistant or primary surgeon within the past 24 months.		perform requested privileges And document the performance of at least 6 surgical procedures as first assistant within the past 24 months

Acknowledgment of practitioner
I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Memorial Healthcare System. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Applicant Signature Date

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

Department Chair Signature Date

Salinas Valley Memorial Healthcare System

Anesthesiology
FPPE/Proctoring Evaluation

Patient Information: (*patient information sticker acceptable for this section*)

Physician being Proctored: _____ Medical Record #_____

Surgical Procedure Performed: _____ Date of Surgery:_____

Type of Anesthesia:

Duration of Anesthesia: _____
ASA (circle): 1 2 3 4 5 E

- ☐ General
- ☐ Spinal/Epidural
- ☐ Regional/Local with MAC
- ☐ Sedation Adult
- ☐ Sedation Pediatric (15 years & under)
- ☐ *TEE (Special Privilege)

Please comment below for any "NO" responses.	**Yes**	**No**	**N/A**
Was the pre-operative patient assessment performed in a timely manner?			
Was the pre-operative patient assessment pertinent?			
Was the intra-operative technique, judgement, and documentation adequate?			
Was the post-anesthesia management timely and adequate?			
Was the post-anesthesia note documented prior to the patient leaving PACU			
Were there any anesthesia complications? If so, were the complications recognized and appropriately managed in a timely manner?			

Overall Performance	**Satisfactory**	**Unsatisfactory**
Anesthesia Type		
Special Privilege		
Patient Care		
Medical Knowledge		
Practice-Based Learning & Improvement		
Interpersonal & Communication Skills		
Professionalism		
Systems-Based Practice		

Comments: _____
_____

_____ _____
Proctor's Signature Date

_____
Print Proctor Name

_____ _____
Department Chair Signature Date

Peer Review Document – Not part of the Medical Record
Please return to Medical Staff Services

Salinas Valley Memorial Healthcare System

ANTIMICROBIAL STEWARDSHIP

Reference Number	6104
Effective Date	Not Approved Yet
Applies To	INFECTION CONTROL
Attachments/Forms	

I. **POLICY STATEMENT:**~~The Antimicrobial Stewardship Program (ASP) initiatives are consistent with evidence-based practices and regulatory requirement~~The ASP initiatives, in conjunction with infection prevention, are designed to reduce or prevent healthcare-associated infections due to multidrug-resistant organisms (MDROs).

A. A multidisciplinary Antimicrobial Stewardship Committee oversees the Antimicrobial Stewardship Program (ASP) and works collaboratively with the Infection Control Committee, the Pharmacy and Therapeutics Committee, hospital administration, and medical staff leadership.

~~Healthcare information technology (i.e., electronic medical records, computerized physician order entry, antibiogram/microbiology lab data and clinical decision support) is used to support and optimize ASP initiatives.~~

II. ~~Metric, process and outcome measures are used to assess the effectiveness of the Antimicrobial Stewardship Program initiatives and the overall impact on antimicrobial use and resistance patter~~All oral and intravenous antimicrobial agents require provider to specific indication for treatment: bloodstream, bone/joint, C. difficile, CNS/meningitis, Genitourinary tract, Endocarditis, Intra-abdominal, Sepsis, Pulmonary, Skin/soft tissue, surgical prophylaxis**PURPOSE:**

A. To achieve optimal clinical outcomes related to antimicrobial use while minimizing toxicity and other adverse events and the emergence of antimicrobial-resistant organisms.

III. **DEFINITIONS:**

A. Antimicrobial stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobial agents by promoting the selection of the optimal antimicrobial regime including dosing, duration of therapy, and route of administration. When used in conjunction with infection prevention and control, antimicrobial stewardship also prevents the transmission of antimicrobial-resistant pathogens.

B. MDROs refers to multidrug-resistant organisms.

IV. **GENERAL INFORMATION:**

A. The Antimicrobial Stewardship Program (ASP) initiatives are consistent with evidence-based practices and regulatory requirements.

B. The ASP initiatives, in conjunction with infection prevention, are designed to reduce or prevent healthcare-associated infections due to multidrug-resistant organisms (MDROs).

C. Healthcare information technology (i.e., electronic medical records, computerized physician order entry, antibiogram/microbiology lab data and clinical decision support) is used to support and optimize ASP initiatives.

D. Metric, process and outcome measures are used to assess the effectiveness of the Antimicrobial Stewardship Program initiatives and the overall impact on antimicrobial use and resistance patterns.

~~E.~~ All oral and intravenous antimicrobial agents require provider ~~to~~ specific indication for treatment: bloodstream, bone/joint, C. difficile, CNS/meningitis, Genitourinary tract, Endocarditis, Intra-abdominal, Sepsis, Pulmonary, Skin/soft tissue, surgical prophylaxis.

~~F.~~E. ~~N/A~~

V. **PROCEDURE:**

A. The Antimicrobial Stewardship Committee is responsible for oversight of the Antimicrobial Stewardship Program initiatives and reporting findings and recommendation to the Pharmacy and Therapeutics and Infection Control Committee.

B. The core members of a multidisciplinary Antimicrobial Stewardship Committee may include an infectious disease physician, a pharmacist with infectious disease training, a microbiologist or lab representative, an information system specialist, an infection prevention professional, a representative from nursing, and a hospital epidemiologist.

C. Interventions and Strategies

The Antimicrobial Stewardship Program, as developed by the Antimicrobial Stewardship Committee, may utilizes the following interventions and strategies, as appropriate.

1. Prospective Audits and Intervention
    a. Conduct prospective audits of antimicrobial use based on established criteria with direct feedback to the prescriber to include:
        i. Review of antimicrobials for appropriateness
        ii. Active auditing of prescribing practices
        iii. Patient-specific feedback
2. Approved mechanism and process of communication

3. Formulary restriction and preauthorization requirements. Antibiotic use may be limited by the following criteria:
    a. Formulary-based restriction
    b. Criteria-based restriction
    c. Preauthorization-based restriction
4. Education
    a. Educate and promote ASP strategies and prescribing criteria.
5. Guidelines, Clinical Pathways, and Antimicrobial Order Sets
    a. Develop evidence-based practice guidelines incorporating local microbiology and resistance patterns to improve antimicrobial utilization.
    b. Develop and implement the use of antimicrobial order forms or order sets to facilitate implementation of practice guidelines.
6. Streamlining or De-escalation
    a. Streamline or de-escalate empirical antimicrobial therapy on the basis of culture results to eliminate redundant combination therapy and more effectively target the causative pathogen, resulting in decreased antimicrobial exposure and potential cost savings.
7. Dose Optimization (Pharmacokinetics (PK), Renal Dosing, etc.)
    a. Optimize antimicrobial dosing based on individual patient characteristics, causative organism, site of infection, and pharmacokinetic and the pharmacodynamic characteristics of the medication.
8. IV to PO Conversion
    a. Develop and implement the use of clinical criteria and guidelines for the systematic conversion from parenteral to oral antimicrobials when the patient's condition allows.
9. Combination Therapy
    a. Utilize combination therapy where appropriate to minimize the emergence of resistance.
10. Suppression Cascade Reporting
    a. Implement cascade reporting of antibiotic susceptibilities for common pathogens. I.e., suppression of unnecessarily broad spectrum agents for bacteria that are susceptible to less broad spectrum agents.

D. Computer Surveillance and Decision Support

Information technology (i.e., electronic medical records, computerized physician order entry, antibiogram / microbiology lab data and clinical decision support) is utilized and optimized to support the ASP initiatives including, but not limited to:

1. Improving access to patient-specific information such as microbiology cultures and susceptibilities, hepatic/renal function, drug interactions, and allergies
2. Ensuring the effectiveness of drug regimens
3. Tracking resistance patterns
4. Identifying nosocomial infections
5. Facilitating and tracking interventions
6. Surveillance of adverse drug events (ADE)

E. Microbiology Laboratory

The microbiology laboratory plays a critical role in antimicrobial stewardship by providing:

1. Patient-specific cultures and susceptibility data using suppression cascade reporting
2. Surveillance of resistant organisms
3. Molecular epidemiologic investigation of outbreaks
4. Antibiogram data development and maintenance

F. Pharmacy

Pharmacy's role in the ASP includes active participation includes rounding twice weekly with Infectious Disease Specialist in the following:

1. Vancomycin and aminoglycoside pharmacokinetic (PK) dosing
2. Medication utilization evaluation (MUE) of antimicrobial medications
3. Antibiotic streamlining and de-escalation
4. Drug use criteria (DUE) development and implementation
5. IV to PO conversion
6. Documentation of clinical interventions in ~~[CP1]~~EMR Notes and Interventions sections and MedMined tracking tool
7. ~~Enforce -~~Infectious Disease use only restrictions are on specific antimicrobial agents such as but not limited to the following. Specific communication to the ordering physicians is as necessary. ~~Manage Infectious Disease use only restriction on specific antimicrobial agents below but not limited to and provide education tocommunication if necessary to ordering physician:~~

    - Amikacin
    - Daptomycin

- Linezolid
- Colistimethate
- Flucytosine
- Aztreonam
- Ertapenem
- Meropenem
- Imipenem/cilastin
- Tigecycline
- Minocycline (IV route)
- Ceftaroline
- Cefepime
- Fosfomycin

G. Surveillance and Prevention of Multidrug-Resistant Organisms

1. Initiatives are developed to prevent infections due to multiple drug-resistant organisms including, but not limited to, methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (CDI), Vancomycin-resistant Enterococci (VRE), and gram negative bacteria.

2. Practices consistent with evidence-based standards of practice and regulatory requirements are developed and implemented to reduce the risk of transmitting multidrug-resistant organisms.

3. Key opportunities to improve antibiotic use per Core Elements of ASP include:

   a. Community acquired pneumonia- avoid empiric use of antipseudomonal beta-lactams and/or MRSA agents unless clinically indicated. Guidelines suggest that in adults, most cases of uncomplicated pneumonia can be treated for 5 days when a patient has a timely clinical response.

   b. UTI- Avoid antibiotic therapy for asymptomatic bacteriuria except in certain clinical situations where treatment is indicated, such as pregnancy and those undergoing invasive genitourinary procedures. Use shortest duration of antibiotic therapy.

   c. Skin and soft tissue infection – avoid empiric use of antipseudomonal beta-lactams and/or anti-anaerobic agents. Limit use of treatment to 5 days.

~~2.~~4. MedMined surveillance platform for Intervention tracking of ASP related activities and opportunities for pharmacist interventions

~~H. Process and Outcome Measures~~

~~Processes and outcomes are measured and include:~~

- ~~Multidrug-resistant organism infection rates using evidence-based metrics~~
- ~~Compliance with evidence-based guidelines or best practices~~
- ~~Evaluation of the education programs for staff and licensed independent practitioners~~
- ~~Process and outcome data related to multidrug-resistant organisms are provided to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.~~

~~N.~~H. Metrics, Quality Assurance, and Performance Improvement

1. Metrics are developed and used to measure the prevalence of hospital-acquired infections caused by resistant organisms, antimicrobial susceptibilities of common pathogens obtained from antibiograms, antimicrobial use patterns, health care costs, and other variables related to hospital-acquired antibiotic-resistant infections.

~~2. Data collected using these metrics are analyzed to detect trends.~~

2. Metrics and process and outcome measures are used to assess the effectiveness of the Antimicrobial Stewardship Program initiatives and the overall impact on antimicrobial use and resistance patterns.

3. Processes and outcomes are measures may include:

   a. Multidrug-resistant organism infection rates using evidence-based metrics

   b. Compliance with evidence-based guidelines or best practices

   c. Evaluation of the education programs for staff and licensed independent practitioners

   d. Process and outcome data related to multidrug-resistant organisms are provided to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

~~O.~~I. Documentation:

1. Clinical interventions and monitoring activities will be documented in the electronic medical record.

VI. EDUCATION/TRAINING:

Education ~~is provided during general or department-specific orientation and periodically as practice or policy changes. Healthstream modules for Vancomycin~~

~~dosing per Pharmacy, Renal dosing of antibiotics, and Amingolycoside dosing per Pharmacy required for successful completion by all clinical pharmacists.~~

A. and/or training is provided as needed.

VII. REFERENCES:

A. Surgical antimicrobial guidelines: https://med.stanford.edu/bugsanddrugs/guidebook/_jcr_content/main/panel_builder_584648957/panel_0/download/file.res/SHC_SurgProphylaxisGuidelines.pdf

B. Clinical Practice Guidelines for Antimicrobial Prophylaxis in Surgery. https://www.ashp.org/-/media/assets/policy-guidelines/docs/therapeutic-guidelines/therapeutic-guidelines-antimicrobial-prophylaxis-surgery.ashp

C. Essential resources and strategies for antibiotic stewardship program in the acute care setting. https://www.ashp.org/-/media/assets/policy-guidelines/docs/therapeutic-guidelines/therapeutic-guidelines-antimicrobial-prophylaxis-surgery.ashx

~~A. CDC. Core Elements of Hospital Antibiotic Stewardship Programs. Atlanta, GA: US Department of Health and Human Services, CDC; 2014. http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html~~

D. https://www.cdc.gov/antibiotic-use/healthcare/pdfs/hospital-core-elements-H.pdf The Core Elements of Hospital Antibiotic Stewardship Programs 2019

~~B. Dellit TH, Owens RC, McGowan JE Jr., et al. Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America guidelines for developing an institutional program to enhance antimicrobial stewardship. Clin Infect Dis. 2007 Jan 15;44(2):159-77.~~

~~C.~~E. http://www.shea-online.org/PriorityTopics/AntimicrobialStewardship.aspx

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

ADJOURNMENT – THE NEXT REGULAR MEETING OF THE BOARD OF DIRECTORS IS SCHEDULED FOR THURSDAY, MAY 27, 2021, AT 4:00 P.M.