March 22, 2024

TO: Legal Counsel

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

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, MARCH 28, 2024, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** (*visit* **SalinasValleyHealth.com/virtualboardmeeting** *for Public Access Information*).

Allen Radner, MD
Interim President/Chief Executive Officer

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

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

THURSDAY, MARCH 28, 2024, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C

Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California

(Visit salinasvalleyhealth.com/virtualboardmeeting for Public Access Information)

AGENDA

Presented By

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

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

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION — *Victor Rey, Jr.*

(Estimated time 4:30 pm)

4. PUBLIC COMMENT — *Victor Rey, Jr.*

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

5. AWARDS & RECOGNITION — *Allen Radner, MD*

- Star award: Landen Mucha, RCS
- Daisy award: Chanthary Pich, BSN, RN
- Spotlight recognition:
  - Patient Safety Fair
  - Certified Nurses Day

6. BOARD MEMBER COMMENTS AND REFERRALS — *Board Members*

7. CONSENT AGENDA - GENERAL BUSINESS — *Victor Rey, Jr.*

(Board Member may pull an item from the Consent Agenda for discussion.)

A. Minutes of February 22, 2024, Regular Meeting of the Board of Directors
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
   1. Bloodborne Pathogen Exposure Control Plan
   2. Cervical Ripening Balloon
   3. Scheduling: Caridac Cath Lab
   4. Tissue Acquisition, Storage, and Implant Tracking
   5. Utilities Management Plan
E. Board Policy on Reporting and Settlement of Claims

- Board President Report
- Questions to Board President/Staff
- Public Comment

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

- Board Discussion/Deliberation
- Motion/Second
- Action by Board/Roll Call Vote

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

Catherine Carson

Minutes of the March 15, 2024 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Juan Cabrera

Minutes of the March 15, 2024 Personnel, Pension and Investment Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Mario Roldan, DO, (ii) Contract Terms for Dr. Roldan's Recruitment Agreement, and (iii) Contract Terms for Dr. Roldan's General Surgery Professional Services Agreement.

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

2. Consider Recommendation for Board Approval of the proposed investment asset allocation for the Salinas Valley Memorial Healthcare District Employee Pension Plan assets.

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

C. FINANCE COMMITTEE

Joel Hernandez Laguna

Minutes of the March 25, 2024 Finance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. Consider recommendation to the SVH Board of Directors to approve (i) the purchase of an additional 5.9143 units of Voting Membership Interests in Monterey Peninsula Surgery Center, and (ii) the execution of the MPSC Subscription Agreement by the Interim President/CEO, as presented.

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

2. Consider Recommendation for Board Approval of contract for perfusion services with Prime Perfusion Inc.

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

D. **CORPORATE COMPLIANCE & AUDIT COMMITTEE** *Juan Cabrera*

The March Corporate Compliance & Audit Committee Meeting is scheduled for Friday, March 29, 2024. Additional Report from Committee Chair, if any.

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF MARCH 14, 2024, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING: *Rakesh Singh, MD*

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

B. Policies/Procedures/Plans:
   1. Abdominal Pain Nursing Standardized Procedure
   2. Medical Record Addenda Documentation Policy

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

11. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION *Victor Rey, Jr.*

12. ADJOURNMENT *Victor Rey, Jr.*

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, April 25, 2024, at 4:00 p.m.**

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

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

SALINAS VALLEY HEALTH BOARD OF DIRECTORS
AGENDA FOR CLOSED SESSION

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

CLOSED SESSION AGENDA ITEMS

HEARINGS/REPORTS

(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

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

1. Report from Quality and Efficient Practices

   A. Report of the Medical Staff Quality and Safety Committee to Quality & Efficient Practices Committee
      - Cardiothoracic Surgery/ STS Program Review Presentation
      - Update on TJC/CMS Survey action plans

   B. Quality and Safety Board Dashboard Review (KUKLA)

   C. Consent Agenda:
      - Rehabilitation Services: OT, PT, Speech therapy
      - Opioid Safety/Pain Management
      - Service Excellence
      - Perioperative Services
      - Respiratory Care
      - Cardiology, Cardiac Wellness, CDOC, Cath Lab
      - Nutrition Services
      - Patient Financial Services
      - Clinical Research
      - Pathology Tissue Review 3Q 2023
      - Pharmacy and Therapeutics/Infection Control Committee
        (Includes Antibiotic Stewardship reports and Infection Prevention)Consent Agenda:

2. Medical Executive Committee
   - Report of the Medical Staff Credentials Committee (With Comments)
   - Report of the Medical Staff Interdisciplinary Practice Committee (With Comments)

CONFERENCE WITH LEGAL COUNSEL-EXISTING LITIGATION

(Government Code §54956.9(d)(1))

Name of case: (Specify by reference to claimant's name, names of parties, case or claim numbers):
Araujo et al vs. Salinas Valley Memorial Healthcare System, 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): one

Additional information required pursuant to Section 54956.9(e): Communications with Department of Justice

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

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): 1067 N. Davis Road, Salinas, California; 341 Abbott Street, Salinas, California.
Agency negotiator: (Specify names of negotiators attending the closed session): Dr. Allen Radner

Negotiating parties: (Specify name of party (not agent): Farmers Daughter L;, Uni-Kool Partners

Under negotiation: (Specify whether instruction to negotiator will concern price, terms of payment, or both): Price and Terms

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

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

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

PUBLIC EMPLOYMENT
(Government Code §54957)

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

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

(VICTOR REY, JR.)

PUBLIC COMMENT

Awards & Recognition

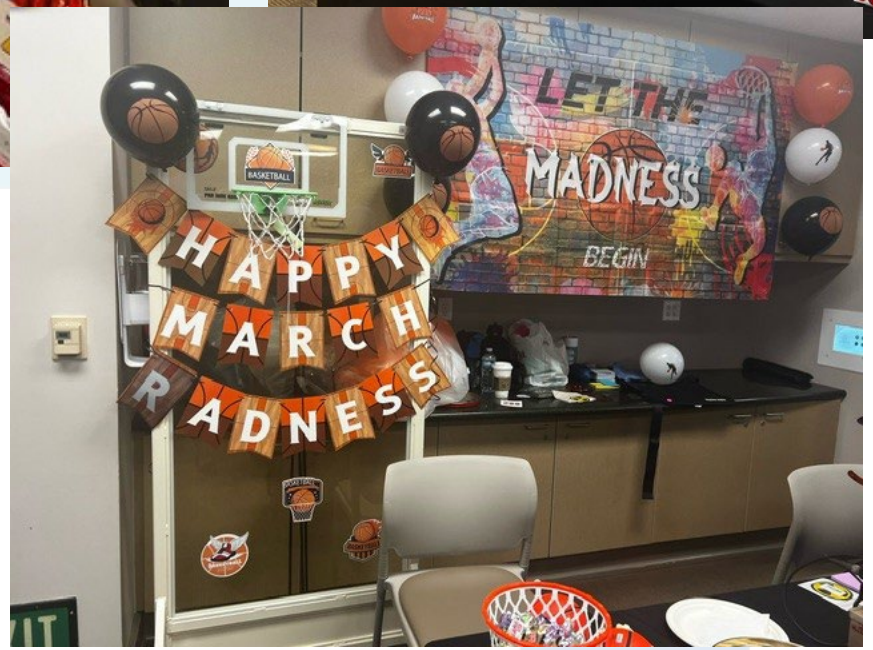
Board of Directors Meeting

March 28, 2024

Salinas Valley HEALTH

January STAR Award
Landen Mucha, RCS

January DAISY Award
Chanthary Pich, BSN, RN



Patient Safety Week
Safer Together Faire March 13

Certified Nurses Day
March 19

Awards & Recognition

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

DRAFT SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
FEBRUARY 22, 2024

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

Also Present:
Allen Radner, MD, Interim President/Chief Executive Officer
Rakesh Singh, MD, Chief of Staff
Matthew Ottone, Esq., District Legal Counsel
Kathie Haines, Executive Support

Director Juan Cabrera joined the meeting at 4:23 p.m.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Victor Rey, Jr., called the meeting to order at 4:03 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. CLOSED SESSION

President Rey announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports, (2) Conference with Legal Counsel-Existing Litigation, (3) Public Appointment: Interim President/Chief Executive Officer, and (4) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:06 p.m. The Board completed its business of the Closed Session at 4:46 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:50 p.m. President Rey reported that in Closed Session, the Board discussed *(1) Hearings and Reports System, (2) Conference with Legal Counsel-Existing Litigation-Araujo et al vs. Salinas Valley Memorial Healthcare, and (3) Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services*. The Board received and accepted the reports listed on the Closed Session agenda.

President Rey announced there is a need for an extended closed session. The items to be discussed in Extended Closed Session will be *Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services* and *Public Appointment: Interim President/Chief Executive Officer.*

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

ADDITIONS AND CHANGES

President Rey reported that in order to ensure that the restructuring of Board Standing Committees to effect for the March Committee meetings, it is requested that the Board place the following items onto the Consent Agenda pursuant to Government Code Section 54954.2(b)(2):

Consideration for Approval of Revised Committee Charters for the following Standing Committees of the Board:

- *Finance Committee*
- *Personnel, Pension, and Investment Committee*
- *Transformation, Strategic Planning and Governance Committee*
- *Quality and Efficient Practices Committee*
- *Corporate Compliance and Audit Committee*
- *Community Advocacy Committee*

This requires approval of two thirds of the members of the Board and a finding that these Revised Charters came to the attention of the Board after the posting of the Board's agenda.

PUBLIC COMMENT:
None.

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Hernandez Laguna, the Board of Directors made the finding that the item came to the attention of the Board subsequent to the posting of the agenda, and approved the addition to the Board of Directors consent agenda.

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

Motion Carried

4. PUBLIC COMMENT
None.

5. AWARDS AND RECOGNITION

Dr. Radner introduced Carla A. Spencer, MSN, RN, NEA-BC, Associate Chief Nursing Officer, to recognize the following awards:

- December STAR Award recipients Guillermo Rodriguez, MSW, CADC II (present at the meeting) and Lauren Stroud, MS, LCSW (unable to attend) both from Case Management, were honored. Troy Scott, Director Case Management, reported that several years ago Case Management imbedded social workers into ED to address needs of patients with complicated social determinants to enable safe discharge; including issues with mental health and addiction. Both Guillermo and Lauren have made a positive impact on this initiative. **BOARD MEMBER DISCUSSION:** When asked what brought him to this role, Guillermo

reported he has been at SVH for 3 years and loves working here. His own journey is one of addiction and he walks the path of recovery every day. It is personal for him to help those patients and complimented the physicians and nursing staff as it is a very collaborative effort. Rakesh Singh, MD, Chief of Staff and Emergency Physician personally thanked Guillermo for his contribution. Director Dr. Cabrera thanked Guillermo for his service and asked how we can help to meet the needs of the initiative? Guillermo indicated more agencies are needed; more open beds. He encouraged SVH to collaborate to overcome some of the housing barriers. Director Rey stated SVH is lucky to have Guillermo here.

- December DAISY Award recipient Brittnee Sandoval, RN, BSN, CMSRN, a Med/Surg 3M Nurse was introduced and honored. Of note, Brittnee was one of the nurses who went to the fields to educate field workers regarding COVID. Cathy Gomez, RN, Clinical Manager Med Surg reported Brittnee was nominated by Patient Experience and that Med/Surg is fortunate to have her. **BOARD MEMBER DISCUSSION:** Director Carson reported that med/surg nurses have a very diverse patient population and are some of the most highly educated nurses. Director Dr. Cabrera thanked Britnee for her service and involvement, stating nurses are our back bone.
- ICU/CCU Units received the American Association of Critical Care Nurses Beacon Award for Excellence. Kelly Flower, RN, Clinical Manager ICU/CCU, Laurel Black, RN, SNIII, Stephanie Fierro, RN, SNIII, and Jean Marll, RN, SNIII were present to represent the ICU/CCU team; though many staff were in the audience. It was reported the Beacon Award is based on patient outcomes, a healthy work environment and nursing workforce. Application is a rigorous process which was a five-year effort and submission of a 55-page document. Salinas Valley Health ICU/CCU has earned a prestigious silver-level award. **BOARD MEMBER DISCUSSION:** The ICU/CCU team was congratulated for their dedication to their patients.

6. BOARD MEMBER COMMENTS AND REFERRALS

Vice President Joel Hernandez Laguna: Director Hernandez Laguna attended the Salinas Valley Leadership Group and spoke to a few former patients; everyone had great things to say about the exceptional work of physicians and nurses. He will also be attending Chamber Legislative Breakfast representing the hospital.

Director Rolando Cabrera, MD: Director Dr. Cabrera stated he appreciates Director Carson's passion for the element of safety in the hospital and thanked her for her service.

Director Juan Cabrera: Director Cabrera stated the hospital continues to do a great job.

Director Catherine Carson: Director Carson congratulated the entire staff for their participation in the TJC survey; preparation was evident.

President Victor Rey, Jr.: No additional comments.

7. CONSENT AGENDA – GENERAL BUSINESS

A. Minutes of January 25, 2024, Regular Meeting of the Board of Directors
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
   1. Absence of President/Chief Executive Officer
   2. California Paid Sick Leave

3. Extravasation Management – Clinical
4. Healthcare Worker Immunizations & Immunity
5. Interpreter/Translator Communication
6. Medication Box: ED Surge Tent
7. Non-Compliance Reporting and Response
8. Nutritional Care Manual
9. Scope of Service: Health Information Management
10. Scope of Service: Health Promotion
11. Student Affiliations
12. Utilities Management Plan

E. Approval of Quote Q-78647-1 by TigerConnect, Inc., Under the Enterprise Master Subscriber Agreement for the period of March 24, 2024 to March 23, 2025

F. Approval of Revisions to Standing Board Committee Charters

1. Finance Committee
2. Personnel, Pension, and Investment Committee
3. Transformation, Strategic Planning and Governance Committee
4. Quality and Efficient Practices Committee
5. Corporate Compliance and Audit Committee
6. Community Advocacy Committee

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

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION: None**.**

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Hernandez Laguna, the Board of Directors approved the Consent Agenda, Items (A) through (F), as presented.

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

Motion Carried

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Catherine Carson regarding the Quality and Efficient Practices Committee. The Critical Care Unit Practice Council reported initiatives on open-heart education, alarm fatigue and early mobilization in the ICU. Early mobilization in the ICU can reduce length of stay and

anesthesia-induced dementia. The minutes were provided for Board review. There were no recommendations.

B. PERSONNEL, PENSION, AND INVESTMENT COMMITTEE

A report was received from Director Cabrera regarding the Personnel, Pension, and Investment Committee. The minutes were provided for Board review. There were no recommendations.

C. FINANCE COMMITTEE

A report was received from Director Joel Hernandez Laguna regarding the Finance Committee. The minutes were provided for Board review. The following recommendations were made:

1. Consider Recommendation for Board Approval of the Exercise of a Five (5) Year Lease Option in the Existing and Approved Lease for Space Located at 928 E. Blanco Road, #215 (Information Technology Department).

MOTION:

Upon motion by Director Cabrera, and seconded by Director Hernandez Laguna, Board of Directors approves exercise of a five (5) year lease option in the existing and approved lease for space located at 928 E. Blanco Road, #215, in the estimated amount of $999,832.

PUBLIC COMMENT:
None.

BOARD DISCUSSION: None.

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

Motion Carried

2. Consider Recommendation for Board Approval of awarding the contract for construction to FTG Builders, Inc. for the Permanent Bulk Oxygen Supply Replacement Project, for the terms and conditions in the proposed agreement in the total amount of $856,820.

MOTION:

Upon motion by Director Carson, and seconded by Director Dr. Cabrera, the Board of Directors awards the contract for construction to FTG Builders, Inc., the terms and conditions in the proposed agreement for the permanent bulk oxygen supply replacement project, in the total amount of $856,820.

PUBLIC COMMENT:
None.

BOARD DISCUSSION: None.

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

Abstentions: None;
Absent: None.

Motion Carried

3. Consider Recommendation for Board Approval of HSS Security, LLC (HSS) Amendment No. 4 to renew Security and Valet Service Agreement for one year in the amount of $1,997,142.

MOTION:

Upon motion by Director Cabrera, and seconded by Director Carson, the Board of Directors approves HSS Security, LLC (HSS) Amendment No. 4 to renew Security and Valet Service Agreement for one year in the amount of $1,997,142.

PUBLIC COMMENT:
None.

BOARD DISCUSSION: Director Hernandez Laguna reported the valet services HSS offers is needed to alleviate the ongoing parking burden imposed on hospital patients/visitors to help improve the Salinas Valley Health patient experience. HSS has notified our organization that the service line is no longer sustainable for their business and intends to terminate the valet line of business effective no later than June 1, 2024, giving Salinas Valley Health the opportunity to obtain a suitable provider.

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

Motion Carried

4. Consider Recommendation for Board Approval of the Alliance HealthCare Services (Alliance), Inc., MRI Service Contract Addendum

MOTION:

Upon motion by Director Cabrera, and seconded by Director Carson, the Board of Directors approves the Alliance Healthcare Services, Inc. MRI contract Addendum "C" for the maximum amount of $2,295,000 over the course of the contract.

PUBLIC COMMENT:
None.

BOARD DISCUSSION: None.

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

Motion Carried

D. COMMUNITY ADVOCACY COMMITTEE

A report was received from Director Rolando Cabrera, MD, regarding the Community Advocacy Committee. Dr. Cabrera reported all Board members were present for the meeting and thanked them. Reports were received on the Community funding process and policy, the Blue Zones Project (stating the contract terminates 9/30/2025), the Services League (noting there are currently about 160 volunteers), and a Foundation update. The minutes were provided for Board review. There were no recommendations.

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON FEBRUARY 8, 2024, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING

Rakesh Singh, MD, Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of February 8, 2024, and Policies/Procedures/Plans revisions. Dr. Singh noted the Blood-borne Pathogen Exposure Control Plan has been removed for consideration; more work is needed on that policy. A full report was provided in the Board packet.

Recommend Board Approval of the Following:

a. Reports
    1. Credentials Committee Report
    2. Interdisciplinary Practice Committee Report
b. Policies/Procedures/Plans:
    1. Clinical Privilege Delineation Form Nurse Practitioner
    2. Clinical Privileges Practice Agreement/ Physician Assistant-Cardiology Ambulatory Care
    3. Physician Assistant-Clinical Privileges/ Practice Agreement

PUBLIC COMMENT:
None.

BOARD DISCUSSION:
None.

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Hernandez Laguna, the Board of Directors receives and approves the Medical Executive Committee Credentials Committee Report, the Interdisciplinary Practice Committee Report, and the Policies, Procedures, Plans, as follows:

a. Reports
    1. Credentials Committee Report
    2. Interdisciplinary Practice Committee Report
b. Policies/Procedures/Plans:
    1. Clinical Privilege Delineation Form Nurse Practitioner
    2. Clinical Privileges Practice Agreement/ Physician Assistant-Cardiology Ambulatory Care
    3. Physician Assistant-Clinical Privileges/ Practice Agreement

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

Motion Carried

10. EXTENDED CLOSED SESSION

President Rey announced items to be discussed in Extended Closed Session are (1) *Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services* and *(2) Public Appointment: Interim President/Chief Executive Officer.* The meeting recessed into Closed Session under the Closed Session Protocol at 5:26 p.m. The Board completed its business of the Closed Session at 7:05 p.m.

11. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 7:06 p.m. President Rey reported that in Extended Closed Session, the Board discussed *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services* and *(2) Public Appointment: Interim President/Chief Executive Officer,* conducting a performance review on the Interim CEO. No action was taken on either item.

14. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, March 28, 2024, at 4:00 p.m.** There being no further business, the meeting was adjourned at 7:08 p.m.

_____

Rolando Cabrera, MD
Secretary, Board of Directors

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
February 29, 2024

	Month of February,		Eight months ended February 29,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 51,203,565	$ 47,827,772	$ 402,589,544	$ 416,392,643
Other operating revenue	1,165,959	1,073,440	8,741,193	6,350,941
Total operating revenue	52,369,524	48,901,212	411,330,737	422,743,584
Total operating expenses	47,158,694	46,085,915	382,673,348	377,050,095
Total non-operating income	(5,076,526)	(4,267,617)	(11,894,106)	(19,381,923)
Operating and non-operating income	$ 134,304	$ (1,452,320)	$ 16,763,282	$ 26,311,567

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
February 29, 2024

	Current year	Prior year
ASSETS:		
Current assets	$ 351,193,614	$ 406,744,270
Assets whose use is limited or restricted by board	164,215,685	155,924,593
Capital assets	249,951,875	242,692,401
Other assets	286,832,533	180,537,005
Deferred pension outflows	116,911,125	95,857,027
	$ 1,169,104,832	$ 1,081,755,296
LIABILITIES AND EQUITY:		
Current liabilities	91,968,802	101,740,270
Long term liabilities	20,638,874	17,159,971
Lease deferred inflows	1,616,220	1,642,999
Pension liability	118,792,064	79,111,485
Net assets	936,088,872	882,100,571
	$ 1,169,104,832	$ 1,081,755,296

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
February 29, 2024

	Month of February,		Eight months ended February 29,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,766	1,992	14,368	16,449
Medi-Cal	1,102	1,111	8,413	9,295
Commercial insurance	409	583	4,576	6,305
Other patient	38	134	821	925
Total patient days	3,315	3,820	28,178	32,974
Gross revenue:				
Medicare	$ 119,729,091	$ 109,225,210	$ 905,779,115	$ 829,004,548
Medi-Cal	74,556,691	71,669,232	557,562,508	551,625,097
Commercial insurance	47,886,002	42,965,147	417,279,578	417,414,062
Other patient	7,451,292	8,587,981	71,011,282	67,448,306
Gross revenue	249,623,076	232,447,571	1,951,632,483	1,865,492,013
Deductions from revenue:				
Administrative adjustment	283,914	328,993	2,513,879	2,140,954
Charity care	353,174	539,958	5,538,719	5,045,935
Contractual adjustments:				
Medicare outpatient	39,018,520	30,717,055	281,089,336	235,865,245
Medicare inpatient	48,184,519	48,499,812	375,545,528	374,249,244
Medi-Cal traditional outpatient	1,789,602	3,866,048	21,967,387	27,414,661
Medi-Cal traditional inpatient	4,897,607	5,825,631	38,029,780	41,108,507
Medi-Cal managed care outpatient	33,576,493	29,462,793	243,969,887	217,911,458
Medi-Cal managed care inpatient	26,646,831	25,375,324	201,180,676	204,948,373
Commercial insurance outpatient	21,391,288	17,862,847	174,394,469	141,718,600
Commercial insurance inpatient	17,829,397	16,970,454	161,393,693	158,192,224
Uncollectible accounts expense	4,350,530	3,573,522	33,909,165	30,628,593
Other payors	97,636	1,597,361	9,510,420	9,875,576
Deductions from revenue	198,419,511	184,619,798	1,549,042,939	1,449,099,370
Net patient revenue	$ 51,203,565	$ 47,827,772	$ 402,589,544	$ 416,392,643
Gross billed charges by patient type:				
Inpatient	$ 120,101,071	$ 124,316,641	$ 992,014,802	$ 1,011,769,841
Outpatient	100,349,331	79,573,085	725,267,074	624,255,406
Emergency room	29,172,674	28,557,845	234,350,607	229,466,766
Total	$ 249,623,076	$ 232,447,571	$ 1,951,632,483	$ 1,865,492,013

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
February 29, 2024

	Month of February,		Eight months ended February 29,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 51,203,565	$ 47,827,772	$ 402,589,544	$ 416,392,643
Other operating revenue	1,165,959	1,073,440	8,741,193	6,350,941
Total operating revenue	52,369,524	48,901,212	411,330,737	422,743,584
Operating expenses:				
Salaries and wages	15,832,796	15,822,205	132,969,018	137,480,441
Compensated absences	2,754,652	2,656,136	23,918,846	22,591,885
Employee benefits	9,170,977	8,045,868	67,930,024	61,624,924
Supplies, food, and linen	7,328,460	6,602,666	57,804,224	54,095,864
Purchased department functions	3,168,633	3,958,519	28,850,148	33,065,884
Medical fees	2,510,986	2,858,452	19,909,093	16,358,470
Other fees	2,060,984	2,619,399	18,283,364	23,461,278
Depreciation	2,387,765	1,885,276	19,163,609	16,628,323
All other expense	1,943,441	1,637,394	13,845,022	11,743,026
Total operating expenses	47,158,694	46,085,915	382,673,348	377,050,095
Income from operations	5,210,830	2,815,297	28,657,389	45,693,489
Non-operating income:				
Donations	0	556,767	2,333,567	5,592,903
Property taxes	333,333	333,333	2,666,667	2,666,667
Investment income	15,606	(628,362)	19,989,251	241,476
Taxes and licenses	0	0	0	0
Income from subsidiaries	(5,425,465)	(4,529,355)	(36,883,591)	(27,882,969)
Total non-operating income	(5,076,526)	(4,267,617)	(11,894,106)	(19,381,923)
Operating and non-operating income	134,304	(1,452,320)	16,763,282	26,311,567
Net assets to begin	935,954,568	883,552,890	919,325,589	855,789,004
Net assets to end	$ 936,088,872	$ 882,100,571	$ 936,088,872	$ 882,100,571
Net income excluding non-recurring items	$ 134,304	$ (1,452,320)	$ 16,763,282	$ 26,311,567
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	0
Operating and non-operating income	$ 134,304	$ (1,452,320)	$ 16,763,282	$ 26,311,567

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
February 29, 2024

	Month of February,		Eight months ended February 29,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (200,426)	$ (77,102)	$ (1,623,660)	$ (1,253,586)
Neurological Clinic	(62,439)	(96,065)	(581,097)	(496,867)
Palliative Care Clinic	(96,434)	(66,814)	(711,893)	(557,296)
Surgery Clinic	(180,392)	(120,613)	(1,478,113)	(1,079,367)
Infectious Disease Clinic	(48,474)	(51,420)	(301,486)	(249,392)
Endocrinology Clinic	(260,673)	(207,091)	(1,865,536)	(1,303,695)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(674,109)	(717,322)	(4,730,434)	(3,467,790)
OB/GYN Clinic	(561,826)	(334,487)	(3,309,726)	(2,377,814)
PrimeCare Medical Group	(965,779)	(1,226,055)	(7,026,706)	(4,860,402)
Oncology Clinic	(415,138)	(542,898)	(2,713,947)	(2,223,406)
Cardiac Surgery	(383,426)	(441,392)	(2,477,945)	(2,305,473)
Sleep Center	(88,613)	(55,670)	(432,257)	(246,973)
Rheumatology	(87,897)	(75,103)	(580,444)	(466,939)
Precision Ortho MDs	(530,556)	(372,636)	(3,881,821)	(2,678,212)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(65,157)	(33,081)	(378,799)	(284,139)
Vaccine Clinic	0	0	16	(683)
Dermatology	(38,272)	(65,507)	(325,157)	(182,370)
Hospitalists	0	0	0	0
Behavioral Health	(84,335)	(20,498)	(398,834)	(254,583)
Pediatric Diabetes	(46,863)	(35,286)	(368,411)	(361,811)
Neurosurgery	(84,279)	(36,937)	(325,643)	(246,256)
Multi-Specialty-RR	1,385	2,188	21,251	79,872
Radiology	(386,300)	(190,446)	(2,630,147)	(1,644,629)
Salinas Family Practice	(152,751)	(199,360)	(1,118,913)	(810,434)
Urology	(176,095)	(112,152)	(1,382,222)	(792,937)
Total SVHC	(5,588,849)	(5,075,747)	(38,621,924)	(28,065,182)
Doctors on Duty	(45,956)	380,280	325,865	164,268
Vantage Surgery Center	0	0	0	0
LPCH NICU JV	0	0	0	(1,387,567)
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	99,780	163,153	1,049,041	1,287,983
Coastal	29,073	89,203	47,409	(37,696)
Apex	0	0	0	0
21st Century Oncology	50,331	(112,906)	3,223	(152,706)
Monterey Bay Endoscopy Center	30,156	26,662	312,795	307,931
Total	$ (5,425,465)	$ (4,529,355)	$ (36,883,591)	$ (27,882,969)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
February 29, 2024

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 221,537,903	$ 291,608,376
Patient accounts receivable, net of estimated uncollectibles of $45,696,646	102,081,358	87,322,824
Supplies inventory at cost	7,718,586	7,600,078
Current portion of lease receivable	1,131,104	546,861
Other current assets	18,724,663	19,666,131
Total current assets	351,193,614	406,744,270
Assets whose use is limited or restricted by board	164,215,685	155,924,593
Capital assets:		
Land and construction in process	75,825,405	51,473,148
Other capital assets, net of depreciation	174,126,470	191,219,252
Total capital assets	249,951,875	242,692,401
Other assets:		
Right of use assets, net of amortization	6,714,217	5,622,496
Long term lease receivable	608,766	1,186,426
Subscription assets, net of amortization	7,722,471	0
Investment in Securities	252,399,372	143,623,006
Investment in SVMC	5,373,835	9,300,282
Investment in Coastal	1,729,050	1,606,005
Investment in other affiliates	20,921,934	21,663,233
Net pension asset	(8,637,112)	(2,464,443)
Total other assets	286,832,533	180,537,005
Deferred pension outflows	116,911,125	95,857,027
	$ 1,169,104,832	$ 1,081,755,296
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	$ 62,009,649	$ 62,983,799
Due to third party payers	4,336,365	17,467,801
Current portion of self-insurance liability	18,839,225	18,517,715
Current subscription liability	4,299,728	0
Current portion of lease liability	2,483,835	2,770,954
Total current liabilities	91,968,802	101,740,270
Long term portion of workers comp liability	13,027,333	14,058,922
Long term portion of lease liability	4,449,212	3,101,049
Long term subscription liability	3,162,329	0
Total liabilities	112,607,676	118,900,241
Lease deferred inflows	1,616,220	1,642,999
Pension liability	118,792,064	79,111,485
Net assets:		
Invested in capital assets, net of related debt	249,951,875	242,692,401
Unrestricted	686,136,997	639,408,170
Total net assets	936,088,872	882,100,571
	$ 1,169,104,832	$ 1,081,755,296

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
February 29, 2024

	Month of February,				Eight months ended February 29,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 249,623,076	$ 227,145,113	22,477,963	9.90%	$ 1,951,632,483	$ 1,869,191,940	82,440,543	4.41%
Dedutions from revenue	198,419,511	178,785,255	19,634,256	10.98%	1,549,042,939	1,472,126,764	76,916,175	5.22%
Net patient revenue	51,203,565	48,359,858	2,843,707	5.88%	402,589,544	397,065,176	5,524,368	1.39%
Other operating revenue	1,165,959	1,332,540	(166,581)	-12.50%	8,741,193	10,660,320	(1,919,127)	-18.00%
Total operating revenue	**52,369,524**	**49,692,398**	**2,677,126**	**5.39%**	**411,330,737**	**407,725,496**	**3,605,241**	**0.88%**
Operating expenses:								
Salaries and wages	15,832,796	17,179,058	(1,346,262)	-7.84%	132,969,018	135,846,758	(2,877,740)	-2.12%
Compensated absences	2,754,652	1,966,116	788,536	40.11%	23,918,846	24,119,619	(200,773)	-0.83%
Employee benefits	9,170,977	8,023,332	1,147,645	14.30%	67,930,024	62,856,641	5,073,383	8.07%
Supplies, food, and linen	7,328,460	6,461,789	866,671	13.41%	57,804,224	54,317,521	3,486,703	6.42%
Purchased department functions	3,168,633	3,539,227	(370,594)	-10.47%	28,850,148	28,313,833	536,315	1.89%
Medical fees	2,510,986	2,359,060	151,926	6.44%	19,909,093	18,872,481	1,036,612	5.49%
Other fees	2,060,984	2,194,967	(133,983)	-6.10%	18,283,364	17,988,238	295,126	1.64%
Depreciation	2,387,765	2,190,779	196,986	8.99%	19,163,609	17,050,593	2,113,016	12.39%
All other expense	1,943,441	1,762,396	181,045	10.27%	13,845,022	14,572,773	(727,751)	-4.99%
Total operating expenses	**47,158,694**	**45,676,726**	**1,481,968**	**3.24%**	**382,673,348**	**373,938,457**	**8,734,891**	**2.34%**
Income from operations	**5,210,830**	**4,015,673**	**1,195,157**	**29.76%**	**28,657,389**	**33,787,039**	**(5,129,650)**	**-15.18%**
Non-operating income:								
Donations	0	166,667	(166,667)	-100.00%	2,333,567	1,333,333	1,000,234	75.02%
Property taxes	333,333	333,333	(0)	0.00%	2,666,667	2,666,667	0	0.00%
Investment income	15,606	1,185,806	(1,170,199)	-98.68%	19,989,251	9,486,444	10,502,806	110.71%
Income from subsidiaries	(5,425,465)	(3,966,452)	(1,459,013)	36.78%	(36,883,591)	(31,749,440)	(5,134,152)	16.17%
Total non-operating income	**(5,076,526)**	**(2,280,646)**	**(2,795,879)**	**122.59%**	**(11,894,106)**	**(18,262,995)**	**6,368,889**	**-34.87%**
Operating and non-operating income	**$ 134,304**	**$ 1,735,026**	**(1,600,722)**	**-92.26%**	**$ 16,763,283**	**$ 15,524,044**	**1,239,238**	**7.98%**

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

	Month of Feb		Eight months to date		
	2023	2024	2022-23	2023-24	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	37	33	296	278	(18)
Other Admissions	83	71	690	643	(47)
Total Admissions	120	104	986	921	(65)
Medi-Cal Patient Days	57	52	472	445	(27)
Other Patient Days	136	111	1,158	1,065	(93)
Total Patient Days of Care	193	163	1,630	1,510	(120)
Average Daily Census	6.7	5.6	6.7	6.2	(0.5)
Medi-Cal Average Days	1.6	1.6	1.7	1.7	0.0
Other Average Days	0.8	1.6	1.7	1.7	(0.0)
Total Average Days Stay	1.7	1.6	1.7	1.7	0.0
ADULTS & PEDIATRICS					
Medicare Admissions	367	354	3,219	3,001	(218)
Medi-Cal Admissions	334	263	2,362	2,114	(248)
Other Admissions	360	278	2,530	2,353	(177)
Total Admissions	1,061	895	8,111	7,468	(643)
Medicare Patient Days	1,658	1,490	13,865	12,223	(1,642)
Medi-Cal Patient Days	1,132	1,090	9,585	8,610	(975)
Other Patient Days	935	490	8,417	5,680	(2,737)
Total Patient Days of Care	3,725	3,070	31,867	26,513	(5,354)
Average Daily Census	128.4	105.9	130.6	108.7	(21.9)
Medicare Average Length of Stay	4.4	4.3	4.3	4.1	(0.2)
Medi-Cal AverageLength of Stay	3.5	3.6	3.5	3.5	0.0
Other Average Length of Stay	2.5	1.5	2.7	1.9	(0.8)
Total Average Length of Stay	3.5	3.1	3.5	3.2	(0.3)
Deaths	23	20	197	205	8
Total Patient Days	3,918	3,233	33,497	28,023	(5,474)
Medi-Cal Administrative Days	25	0	81	5	(76)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	25	0	81	5	(76)
Percent Non-Acute	0.64%	0.00%	0.24%	0.02%	-0.22%

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

	Month of Feb		Eight months to date		
	2023	2024	2022-23	2023-24	Variance
PATIENT DAYS BY LOCATION					
Level I	261	214	2,396	1,950	(446)
Heart Center	318	317	2,799	2,621	(178)
Monitored Beds	655	594	5,419	4,947	(472)
Single Room Maternity/Obstetrics	312	267	2,711	2,457	(254)
Med/Surg - Cardiovascular	919	829	7,539	6,655	(884)
Med/Surg - Oncology	269	264	2,212	2,229	17
Med/Surg - Rehab	492	423	4,261	3,674	(587)
Pediatrics	99	114	1,056	1,058	2
Nursery	193	163	1,630	1,510	(120)
Neonatal Intensive Care	103	48	1,128	922	(206)
PERCENTAGE OF OCCUPANCY					
Level I	71.70%	56.76%	75.85%	61.73%	
Heart Center	75.71%	72.87%	76.79%	71.91%	
Monitored Beds	86.64%	75.86%	82.59%	75.40%	
Single Room Maternity/Obstetrics	30.12%	24.88%	30.15%	27.33%	
Med/Surg - Cardiovascular	72.94%	63.52%	68.94%	60.86%	
Med/Surg - Oncology	73.90%	70.03%	70.02%	70.56%	
Med/Surg - Rehab	67.58%	56.10%	67.44%	58.15%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	19.64%	21.84%	24.14%	24.19%	
Nursery	41.77%	34.06%	20.33%	18.83%	
Neonatal Intensive Care	33.44%	15.05%	42.20%	34.49%	

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

	Month of Feb		Eight months to date		
	2023	2024	2022-23	2023-24	Variance
DELIVERY ROOM					
Total deliveries	115	100	952	853	(99)
C-Section deliveries	45	24	312	273	(39)
Percent of C-section deliveries	39.13%	24.00%	32.77%	32.00%	-0.77%
OPERATING ROOM					
In-Patient Operating Minutes	19,069	12,783	163,432	125,698	(37,734)
Out-Patient Operating Minutes	23,189	29,168	212,100	233,891	21,791
Total	42,258	41,951	375,532	359,589	(15,943)
Open Heart Surgeries	14	6	115	86	(29)
In-Patient Cases	133	96	1,115	905	(210)
Out-Patient Cases	255	278	2,169	2,314	145
EMERGENCY ROOM					
Immediate Life Saving	36	44	246	288	42
High Risk	604	811	4,591	6,015	1,424
More Than One Resource	2,821	2,445	23,684	22,253	(1,431)
One Resource	1,635	1,624	17,018	15,158	(1,860)
No Resources	73	51	722	699	(23)
Total	5,169	4,975	46,261	44,413	(1,848)

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

	Month of Feb		Eight months to date		
	2023	2024	2022-23	2023-24	Variance
CENTRAL SUPPLY					
In-patient requisitions	14,957	11,388	122,336	103,405	-18,931
Out-patient requisitions	8,581	10,467	74,251	82,498	8,247
Emergency room requisitions	1,376	648	5,759	5,780	21
Interdepartmental requisitions	6,353	6,270	56,653	52,749	-3,904
Total requisitions	31,267	28,773	258,999	244,432	-14,567
LABORATORY					
In-patient procedures	35,864	33,969	319,832	292,671	-27,161
Out-patient procedures	10,031	39,448	82,107	207,188	125,081
Emergency room procedures	11,576	12,208	103,841	103,021	-820
Total patient procedures	57,471	85,625	505,780	602,880	97,100
BLOOD BANK					
Units processed	274	230	2,533	2,333	-200
ELECTROCARDIOLOGY					
In-patient procedures	1,076	1,103	8,970	8,788	-182
Out-patient procedures	369	382	2,737	3,142	405
Emergency room procedures	1,197	1,297	8,998	9,740	742
Total procedures	2,642	2,782	20,705	21,670	965
CATH LAB					
In-patient procedures	103	132	768	973	205
Out-patient procedures	84	140	640	946	306
Emergency room procedures	0	0	1	0	-1
Total procedures	187	272	1,409	1,919	510
ECHO-CARDIOLOGY					
In-patient studies	351	366	3,113	3,032	-81
Out-patient studies	242	305	1,849	2,242	393
Emergency room studies	2	1	11	8	-3
Total studies	595	672	4,973	5,282	309
NEURODIAGNOSTIC					
In-patient procedures	125	116	1,126	1,026	-100
Out-patient procedures	29	23	152	151	-1
Emergency room procedures	0	0	0	0	0
Total procedures	154	139	1,278	1,177	-101

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

	Month of Feb		Eight months to date		
	2023	2024	2022-23	2023-24	Variance
SLEEP CENTER					
In-patient procedures	0	0	1	0	-1
Out-patient procedures	109	244	1,074	1,882	808
Emergency room procedures	0	0	1	0	-1
Total procedures	109	244	1,076	1,882	806
RADIOLOGY					
In-patient procedures	1,320	1,218	11,587	10,486	-1,101
Out-patient procedures	417	428	2,927	3,209	282
Emergency room procedures	1,367	1,419	12,213	11,819	-394
Total patient procedures	3,104	3,065	26,727	25,514	-1,213
MAGNETIC RESONANCE IMAGING					
In-patient procedures	128	139	1,193	1,121	-72
Out-patient procedures	123	99	792	895	103
Emergency room procedures	7	1	47	50	3
Total procedures	258	239	2,032	2,066	34
MAMMOGRAPHY CENTER					
In-patient procedures	3,651	3,665	31,564	32,661	1,097
Out-patient procedures	3,618	3,617	31,276	32,268	992
Emergency room procedures	0	0	7	9	2
Total procedures	7,269	7,282	62,847	64,938	2,091
NUCLEAR MEDICINE					
In-patient procedures	14	24	153	163	10
Out-patient procedures	85	147	713	891	178
Emergency room procedures	0	0	2	2	0
Total procedures	99	171	868	1,056	188
PHARMACY					
In-patient prescriptions	86,629	78,997	776,491	674,873	-101,618
Out-patient prescriptions	14,273	15,685	116,746	125,734	8,988
Emergency room prescriptions	7,820	9,066	69,794	73,911	4,117
Total prescriptions	108,722	103,748	963,031	874,518	-88,513
RESPIRATORY THERAPY					
In-patient treatments	17,703	13,289	143,530	129,802	-13,728
Out-patient treatments	1,258	1,159	8,813	8,751	-62
Emergency room treatments	367	493	3,289	4,080	791
Total patient treatments	19,328	14,941	155,632	142,633	-12,999
PHYSICAL THERAPY					
In-patient treatments	2,534	2,186	20,742	19,868	-874
Out-patient treatments	177	297	1,377	2,139	762
Emergency room treatments	0	0	2	0	-2
Total treatments	2,711	2,483	22,121	22,007	-114

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

	Month of Feb		Eight months to date		
	2023	2024	2022-23	2023-24	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,700	1,420	12,900	11,403	-1,497
Out-patient procedures	145	262	1,221	1,949	728
Emergency room procedures	0	0	0	0	0
Total procedures	1,845	1,682	14,121	13,352	-769
SPEECH THERAPY					
In-patient treatments	461	508	3,590	4,090	500
Out-patient treatments	38	46	202	318	116
Emergency room treatments	0	0	0	0	0
Total treatments	499	554	3,792	4,408	616
CARDIAC REHABILITATION					
In-patient treatments	0	1	1	11	10
Out-patient treatments	506	581	3,934	4,118	184
Emergency room treatments	0	0	0	0	0
Total treatments	506	582	3,935	4,129	194
CRITICAL DECISION UNIT					
Observation hours	400	319	3,424	2,540	-884
ENDOSCOPY					
In-patient procedures	80	83	689	605	-84
Out-patient procedures	59	47	488	444	-44
Emergency room procedures	0	0	0	0	0
Total procedures	139	130	1,177	1,049	-128
C.T. SCAN					
In-patient procedures	671	702	5,856	5,739	-117
Out-patient procedures	365	325	3,129	2,811	-318
Emergency room procedures	645	684	5,378	5,797	419
Total procedures	1,681	1,711	14,363	14,347	-16
DIETARY					
Routine patient diets	20,660	20,648	194,349	138,745	-55,604
Meals to personnel	22,564	26,488	199,667	225,902	26,235
Total diets and meals	43,224	47,136	394,016	364,647	-29,369
LAUNDRY AND LINEN					
Total pounds laundered	99,718	91,546	812,115	774,597	-37,518

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: March 14, 2024

Re: Policies Requiring Approval

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

	Policy Title	Summary of Changes	Responsible VP
1.	Bloodborne Pathogen Exposure Control Plan	Updated attachments. Template corrections. Goals removed.	Dr. Gilbert, CMO
2.	Cervical Ripening Balloon	Updated references, added Outpatient Cervical Ripening, removed prior hysterotomy as a contraindication.	Lisa Paulo, CNO
3.	Scheduling: Cardiac Cath Lab	Changed block drop to 72 hours. Less than 60% block usage in one month may lose block.	Lisa Paulo, CNO
4.	Tissue Acquisition, Storage, and Implant Tracking	Updated tissue tracking to current practices and documentation. References updated. Attachments deleted.	Clement Miller, COO
5.	Utilities Management Plan	Edited to reflect prepublication requirements that go into effect January 1, 2024. Removes points that distinguish between OEM and AEM as well as removes required completion rates for non-high-risk items on the inventory.	Clement Miller, COO

Status **Pending** PolicyStat ID **14161455**

Last Approved	N/A	Owner	Melissa Deen: Manager Infection Prevention
Last Revised	02/2024		
Next Review	1 year after approval	Area	Plans and Program

Bloodborne Pathogen Exposure Control Plan

~~I. Objective~~

~~The objective of the Salinas Valley Health Medical Center (SVHMC) Bloodborne Pathogen Exposure Control Plan is to comply with the Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard, 29 CFR 1910.1030, and to eliminate or minimize employee occupational exposure to blood, certain *other* bodily fluids, or other potentially infectious materials as defined below:~~

II. SCOPE

A. (Write out the introduction and/or purpose of the Plan.)

B. (Why is the plan needed? Regulatory requirement is not a reason why)

III. OBJECTIVES/GOALS

A. ~~Blood means human blood, human blood components, and products made from human blood.~~

B. ~~Bodily fluids means semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.~~Objectives

1. The objective of the Salinas Valley Health Medical Center (SVHMC) Bloodborne Pathogen Exposure Control Plan is to comply with the Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard, 29 CFR 1910.1030, and to eliminate or minimize employee occupational exposure to blood, certain *other* bodily fluids, or other potentially infectious materials as defined below:
    a. Blood means human blood, human blood components, and products made from human blood.
    b. Bodily fluids means semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid,

saliva in dental procedures, body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

c. Other potentially infectious materials mean any unfixed tissue or organ (other than intact skin) from a human (living or dead), and human immunodeficiency virus (HIV)-containing cell or tissue cultures, organ cultures, and HIV- or hepatitis B virus (HBV)-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV. **Note: see--BLOOD BORNE PATHOGEN EXPOSURE GUIDELINES: EMPLOYEES, FIRST RESPONDERS, PATIENTS & VISITORS**

C. ~~Other potentially infectious materials mean any unfixed tissue or organ (other than intact skin) from a human (living or dead), and human immunodeficiency virus (HIV)-containing cell or tissue cultures, organ cultures, and HIV- or hepatitis B virus (HBV)-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.~~

~~**Note: see--BLOOD BORNE PATHOGEN EXPOSURE GUIDELINES: EMPLOYEES, FIRST RESPONDERS, PATIENTS & VISITORS**~~

IV. Background

OSHA requires employers to identify situations and job classifications in which employees may be exposed to blood or other potentially infectious materials, and to provide protection to these employees in the form of engineering controls, personal protective equipment, training, and risk reduction.

V. Assignment Of Responsibility

A. **Program Administrator**

Infection Prevention in collaboration with Employee Health Services shall manage the Bloodborne Pathogen Exposure Control Plan for SVHMC and maintain all records pertaining to the plan.

B. **Management**

SVHMC will provide adequate controls and equipment that, when used properly, will minimize or eliminate risk of occupational exposure to blood or other potentially infectious materials. These shall be provided at no cost to the employees. SVHMC management will ensure proper adherence to this plan through periodic audits.

C. **Supervisors**

Supervisors shall themselves follow and ensure that their employees are trained in *and* use of proper work practices, standard precautions, the use of personal protective equipment, and proper cleanup and disposal techniques.

D. **Employees**

Employees are responsible for employing proper work practices, standard precautions, and personal protective equipment and cleanup/disposal techniques as described in this plan. Employees are also responsible for reporting all exposure outlined in this plan to their direct supervisor and EHS immediately. If this is off hours and /or the direct supervisor / EHS is unavailable, then reporting is to the Administrative Supervisor.

E. **Contractors**

Contract employees such as, but not limited to medical staff members, travelers, security personnel, etc., are responsible for complying with this plan, and shall be provided the training described herein during orientation.

VI. Exposure Determination

All job classifications and locations in which employees may be expected to incur occupational exposure to blood or other potentially infections materials, based on the nature of the job or collateral duties, regardless of frequency, shall be identified and evaluated by Infection Prevention & Control / EHS. This list shall be updated as job classifications or work situations change. Exposure determination shall be made without regard to the use of personal protective equipment.

A. Category I

Job classifications in which employees are exposed to blood or other potentially infectious materials on a regular basis, and in which such exposures are considered normal course of work, fall into Category I. Outlined in this plan is a list of the types of jobs and the locations in which the work will be performed (see Attachment A).

B. Category II

Job classifications in which employees may have an occasional exposure to blood or other potentially infectious materials, and in which such exposures occur only during certain tasks or procedures that are collateral to the normal job duties, fall into Category II. Outlined in this plan is a list of the types of jobs and the locations in which the work may be performed (see Attachment B).

VII. Implementation Schedule And Methodology

A. Compliance Methods

1. Standard precautions

   Standard precautions (formally "universal precautions") shall be used at SVHMC to prevent contact with blood or other potentially infectious materials. All blood or other potentially infectious materials shall be considered infectious, regardless of the perceived status of the source individual.

2. Engineering Controls

   The engineering and work practice controls listed below shall be used to minimize or

eliminate exposure to employees at SVHMC.

a. Sharps containers, bio-safety cabinets, safety needles, needleless systems, gowns, gloves, eye protection, etc. are to be used in accordance with training and policy as a first line of protection.

The following schedule shall be followed to review the effectiveness of the engineering controls:

a. Engineering controls that assist in the prevention of exposure will be reviewed during policy review and /or earlier as needed or required by regulatory guideline changes.

Where occupational exposure remains after SVHMC institution of these controls, personal protective equipment shall also be used.

3. Needles

Except as noted below, contaminated needles and other sharps shall not be bent, recapped, removed, sheared, or purposely broken. Contaminated sharps shall be placed immediately, or as soon as possible, after use into appropriate sharps containers. All disposable sharps containers shall be puncture resistant, labeled with a biohazard label, and leak-proof.

4. Containers for Reusable Sharps

Contaminated sharps that are reusable shall be placed immediately, or as soon as possible, after use into appropriate sharps containers. All reusable sharps containers shall be puncture resistant, labeled with a biohazard label, and leak-proof.

a. Sharps containers are readily available in all clinical areas at SVHMC. Environmental Service (EVS) is responsible for the removal and replacement of sharps containers. Sharps containers are to be replaced when ¾ full.

5. Sharps Injury Log

A needle stick or sharps injury log shall be maintained by EHS and will reflect the standards of 29 CFR 1910.1030(h)(5) and will include the following information for each incident:

a. date of incident
b. type and brand of device involved
c. department or area of incident occurred
d. explanation of how of the incident occurred

The log shall be retained for the period required by 29 CFR 1904.33, which at the time of this review is (5) years following the end of the calendar year that these

records cover.

6. Hand Washing Facilities

   Hand washing facilities are made available and are readily accessible to all HCW who may incur exposure to blood or other potentially infectious materials. Where hand washing facilities are not feasible, SVHMC will provide an antiseptic alcohol based cleanser in conjunction with clean cloth/paper towels. Such areas include:

   a. Engineering office / areas, waste management disposal areas, non-clinical areas, buildings and unit are provided with SVHMC approved alcohol based hand sanitizer**.**

   When these alternatives are used, employees shall wash their hands with soap and running water as soon as feasible.

7. Work Area Restrictions

   In work areas where there is a reasonable risk of exposure to blood or other potentially infectious materials, employees shall NOT have food, water containers without leak proof/sealed lids (examples not to be used: no disposable paper coffee cups with open lids or drink containers with straws), apply cosmetics or lip balm, or handle contact lenses. All drink containers MUST be spill proof, and each department MUST determine a location for hydration stations. Drinks are NOT allowed on equipment, including WOWs. NO Food and beverages shall be kept in refrigerators, freezers, shelves, cabinets, or on counter tops or bench tops where blood or other potentially infectious materials may be present.

   Mouth pipetting or suctioning of blood or other potentially infectious materials is *strictly prohibited.*

   All processes and procedures shall be conducted in a matter that will minimize splashing, spraying, splattering, and generation of droplets of blood or other potentially infectious materials.

   a. Covers will be used on centrifuges'; eye protection will be utilized when exposure to splashes is expected/anticipated to occur.

8. Specimens

   Each specimen of blood or other potentially infectious material shall be placed in a container that will prevent leakage during the collection, handling, processing, storage, and transport of the specimen.

   Specimen containers shall be labeled or color-coded in accordance with the requirements of the OSHA standard and per SVHMC applicable policies.

   Any specimens that could puncture a primary container shall be placed within a secondary puncture-resistant container. If outside contamination of the primary container occurs, the primary container shall be placed within a secondary container

that will prevent leakage during handling, processing, storage, transport, or shipping of the specimen.

9. Contaminated Equipment

   Bio-medical services, Engineering, Materials Management and Sterile Processing shall ensure that equipment that has become contaminated with blood or other potentially infectious materials is examined prior to servicing or shipping. Contaminated equipment shall be decontaminated, unless decontamination is not feasible. Contaminated equipment shall be tagged and labeled as such.

10. Personal Protective Equipment (PPE)

    a. PPE Provision

       Personal protective equipment shall be chosen based on the anticipated exposure to blood or other potentially infectious materials. Protective equipment shall be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach an employees' clothing, skin, eyes, mouth, or other mucous membranes under normal and proper conditions of use and for the duration of time that the equipment will be used.

       Follow AAMI levels as noted:
       https://wwwn.cdc.gov/PPEInfo/Standards/Info/ANSI/AAMIPB70Class3

       A list of personal protective equipment and associated tasks for SVHMC can be found in **Attachment B** of this plan.

    b. PPE Use

       Infection Prevention, EHS, Directors, Managers and supervisors shall ensure that employees use appropriate PPE. In cases where an employee temporarily and briefly declines to use PPE because, in the employee's professional judgment, its use may prevent delivery of healthcare or pose an increased hazard to the safety of the worker or co-worker, then the Director shall investigate and document the situation and work with EHS and IP to determine whether changes can be instituted to prevent such occurrences in the future.

    c. PPE Accessibility

       SVHMC shall ensure that appropriate PPE in the necessary sizes is readily accessible at the work site or is issued at no cost to employees. Hypoallergenic gloves, glove liners, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

    d. PPE Cleaning, Laundering and Disposal

       All garments non-disposable PPE, penetrated by blood or other potentially

infectious materials shall be removed immediately or as soon as feasible. All PPE will be removed before leaving the work area. When PPE is removed, it will be placed in appropriately designated areas or containers for storage, washing, decontamination, or disposal.

All PPE will be cleaned, laundered, and disposed of by SVHMC / contracted laundry vendor, at no cost to the employees.

e. Types of PPE

i. Gloves

Disposable gloves are not to be washed or decontaminated for re-sue, and are to be replaced as soon as possible when they become contaminated, or directly after use. Gloves that become torn or punctured (or their ability to function as a barrier is otherwise compromised) shall be replaced immediately or as soon as feasible.

Utility gloves may be decontaminated for re-use if the integrity of the glove is uncompromised. Utility gloves shall be disposed of properly if they are cracked; peeling, torn, punctured, or they exhibit other signs of deterioration or inability to function as a barrier without compromise.

ii. Eye and Face Protection

Masks worn in combination with eye protection devices (such as goggles or glasses with solid side shield, or chin-length face shields) are required when the occurrence of splashes, splatters, or droplets of blood or other potentially infectious materials can reasonably be anticipated to contaminate an employee's eye, nose, or mouth. Situations at SVHMC where eye and face protection is required include:

a. Any area during procedures that may expose the HCW to Blood borne pathogen to include ancillary depts. such as laboratory, diagnostic Imaging, etc.

iii. Other PPE

Additional protective clothing (such as lab coats, gowns, aprons, clinic jackets, or similar outer garments) shall be worn in instances when gross contamination can reasonably be expected. The following situations require additional protective clothing:

a. Central sterile, Laboratory, Pathology / Histology, Endoscopy, Surgery

B. Housekeeping

This facility shall be cleaned and decontaminated regularly, as needed in the event of a gross contamination and per Environmental Services dept. process / policy. All contaminated work surfaces; bins, pails, cans, and similar receptacles shall be inspected and decontaminated regularly as described in Appendix A.

Any potentially contaminated glassware shall not be picked up directly with the hands. Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where sharps are placed.

C. Regulated / Biological Waste Disposal

Disposal of all regulated /biological waste shall be in accordance with applicable federal, state, and local regulations.

1. Sharps

   Contaminated sharps shall have safety device engaged by user and discarded immediately or as soon as feasible in containers that are ~~closable~~close-able, puncture resistant, leak proof on sides and bottom, and labeled or color-coded.

   During use, containers for contaminated sharps shall remain upright throughout use, shall be easily accessible to employees, and shall be located as close as feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (including laundry areas).

   When moving sharps containers from the area of use, the containers shall be closed /locked immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping. Sharps containers shall be placed in a secondary container if leakage of the primary container is possible. The second container shall be ~~closeable~~close-able, constructed to contain all contents, and shall prevent leakage during handling, storage, transport, or shipping. The secondary container shall be labeled or color-coded to identify its contents.

   Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner that would expose employees to the risk of percutaneous injury.

2. Other Regulated Waste

   Other regulated waste shall be placed in containers that are closeable, constructed to contain all contents, and will prevent leakage of fluids during handling, storage, transportation, or shipping.

   All waste containers shall be labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

D. Laundry

Laundry contaminated with blood or other potentially infectious materials shall be handled as little as possible. Contaminated laundry shall not be sorted or rinsed in the area of contamination and is to be placed into dirty linen. All laundry is to be considered potentially contaminated and standard precautions are to be utilized. Example: wear gloves if visibly soiled, hold laundry away from body, and place into soiled linen container.

The designated laundry facility utilizes standard precautions for blood / body fluid contamination. The facility is visited by EVS and /or Infection Prevention every year or more as indicated to assure all applicable regulatory standards are met.

VIII. Hepatitis B Vaccines and Post-Exposure Evaluation and Follow Up

A. General

SVHMC will make the Hepatitis B vaccine available to all employees who have the occupational exposure, as well as post-exposure follow up to employees who have experienced an exposure incident.

SVHMC shall ensure that all medical evaluations and procedures involved in the Hepatitis B vaccine and post-exposure follow up, including prophylaxis are:

1. made available at no cost to the employee;
2. made available to the employee at a reasonable time and place;
3. performed by or under the supervision of a licensed physician or other licensed healthcare professional; and
4. Provided in accordance with the recommendations of the United States Public Health Service, and in accordance with California Public Health guidelines. Ensure laboratory tests are conducted by an accredited laboratory at no charge to the employee.

B. Hepatitis B Vaccination

EHS, in collaboration with Infection Prevention, shall manage the Hepatitis B vaccination program.

1. Category I Employees

   The Hepatitis B vaccination shall be made available to an affected Category I employee after he or she has received training in occupational exposure and within 10 working days of initial assignment to job duties that involve exposure. Exceptions to the administration of the Hepatitis B vaccination include situations where an employee has previously received the complete Hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons or the employee documents declination.

Participation in a pre-screening program shall not be a prerequisite for an affected employee to receive the Hepatitis B vaccination. If an employee initially declines the Hepatitis B vaccination, but later decides to accept the vaccination and is still covered under the OSHA standard, the vaccination shall then be made available.

All employees who decline the Hepatitis B vaccination shall sign a waiver indicating their refusal as required by OSHA. SVHMC will follow guidelines for Hepatitis B vaccination imposed by the United States Public Health Service and /or the California Department of Public Health.

2. Category II Employees

The Hepatitis B vaccination series shall be made available and administered to Category II employees as per CDC and OSHA guidelines. All employees who decline the Hepatitis B vaccination shall sign a waiver indicating their refusal.

C. Post-Exposure Evaluation and Follow Up

Employees must report all exposure incidents to their immediate supervisor and EHS immediately or as soon as possible but within 1 hour of incident. If the exposure occurs off hours/ holiday/weekend, then the employee is to notify Administrative Supervisor immediately if EHS is unavailable. The Administrative Supervisor will investigate and document each exposure incident for follow up by EHS. Following a report of an exposure incident, the exposed employee shall immediately receive a confidential post-exposure evaluation and follow up, to be provided by EHS and /or SVHMC Emergency Department. The post-exposure evaluation and follow up shall include the following elements, at a minimum:

1. Documentation of the route of exposure, and the circumstances under which the exposure occurred.
2. Identification and documentation of the source individual, unless it can be established that identification is infeasible or prohibited by state or local law.
3. The source individual's blood shall be tested and documented as soon as feasible in order to determine Hepatitis B, Hepatitis C and HIV status.
4. When the source individual is already known to be infected with the Hepatitis B virus (HBV), Hepatitis C virus, (HCV) or human immunodeficiency virus (HIV), testing for the source individual's known HBV or HIV status need not be repeated. Hepatitis C virus testing may be indicated to determine viral load of patient at time of exposure.
5. Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.
6. The exposed employee's blood and source patient blood shall be collected as soon as feasible and rapid tested for HIV prior to administration of prophylaxis exposure medications.

Employees that contract HIV or Hepatitis shall be de-identified as a "confidentiality case" on the OSHA 300 log this information will be maintained in the employee's file as confidential.

Conversion rates will be reported in IC Committee and Environment of Care.

D. Information Provided to the Healthcare Professional

After an exposure incident involving an employee, EHS, shall ensure that the employee's post-exposure evaluation is completed, and referral initiated to an MD if patient and /or source has positive results. The following is to be provided to the treating provider:

1. a copy of 29 CFR 1910.1030, OSHA's Bloodborne Pathogen Standard, with emphasis on the confidentially requirements contained therein;
2. a written description of the exposed employee's duties as they relate to the exposure incident;
3. written documentation of the route of exposure and circumstances under which the exposure occurred;
4. results of the source individual's blood testing, if available
5. All medical records relevant to the appropriate treatment of the employee, including vaccination status.

E. Healthcare Professional's Written Opinion

EHS shall obtain and provide the exposed employee a copy of the evaluating healthcare professional's written opinion within 15 days of completion of the evaluation.

The healthcare professional's written opinion for HBV vaccination shall be limited to whether HBV vaccination is indicated for the employees, and if the employee has received said vaccination.

The healthcare professional's written opinion for post-exposure follow up shall be limited to ONLY the following information:

1. Documentation that the employee has been informed of the results of the evaluation; and
2. Documentation that the employee has been informed of any medical conditions resulting from exposure to blood or other potentially infectious materials that require further evaluation or treatment.

Other findings or diagnosis resulting from the post-exposure follow up shall remain confidential and shall not be included in the written report.

IX. Labels and Signs

Environmental Services shall ensure that biohazard labels are affixed to containers of regulated waste, refrigerators, and freezers containing blood or other potentially infectious materials. Labels shall also be affixed to any other containers used to store, transport, or ship blood or other potentially infectious materials.

The labels shall be fluorescent orange or orange-red, and shall include the universal biohazard symbol.

Red bags or containers with the universal biohazard symbol may be substituted for labels. However, regulated wastes must be handled in accordance with the rules and regulations of the entity with jurisdiction. Blood products that have been released for transfusion or other clinical use are exempted from these labeling requirements.

X. Training

SVHMC shall ensure that training is provided to all new healthcare workers at new employee orientation. Training is provided by Infection Prevention. Training is repeated annually, or when there are any changes to tasks or procedures affecting an employee's occupational exposure. Training is interactive and shall include:

1. available copy of 29 CFR 1910.1030, OSHA's Bloodborne Pathogen Standard;
2. a discussion of the epidemiology and symptoms of Bloodborne diseases; an explanation of the modes of transmission of Bloodborne pathogens;
3. an explanation of SVHMC Bloodborne Pathogen Exposure Control Plan, and how employees can obtain a copy of the plan;
4. a description and recognition of tasks that may involve exposure;
5. an explanation of the use and limitations of the methods employed by SVHMC healthcare workers to reduce exposure (such as engineering controls, work practices, and personal protective equipment);
6. information about the types, use, location, removal, handling, decontamination, and disposal of personal protective equipment;
7. an explanation of the basis of selection of personal protective equipment;
8. information about the Hepatitis B vaccination (including efficacy, safety, method of administration, and benefits), as well as an explanation that the vaccination will be provided at no charge to the employee;
9. instruction on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;
10. an explanation of the procedures to follow if an exposure incident occurs, including the method of reporting and medical follow up;
11. information on the post-incident evaluation and follow up required for all exposure incidents; and
12. An explanation of signs, labels, and color-coding systems.

The person conducting the training shall be knowledgeable in the subject matter.

~~XI. Recordkeeping~~

XII. Record Keeping

A. Medical Records

EHS shall maintain medical records as required by 29 CFR 1910.1020. All records shall be kept confidential and shall be retained for at least the duration of employment plus 30 years.

Medical records shall include:

1. name of the employee;
2. a copy of the employee's HBV vaccination status, including the dates of vaccination; and any other pertinent information related to ability to receive the HBV.
3. a copy of all results of examinations, medical testing, and follow-up procedures; and
4. a copy of the information provided to the healthcare professional, including a description of the employee's duties as they relate to an exposure incident, and documentation of the routes and circumstances of an exposure.
5. Training Records

SVHMC Human Resource Department / Education Department shall maintain training records for three years from the date of training. Records shall be kept in SVHMC HR Department and shall include:

- dates of the training sessions;
- contents or summary of the training;
- names and qualifications of persons conducting the training; and
- Names and job titles of all persons attending the training sessions.

B. Availability of Records

Whenever an employee (or designated representative) requests access to a record, EHS shall provide access to said employee's records in a reasonable time, place, and manner in accordance with 29 CFR 1910.1020(e). An employee (or designated representative) will only be given access to his or her own records.

C. Evaluation and Review

The Infection Prevention and Employee Health shall review this Bloodborne Exposure Control Plan for effectiveness at least annually and as needed to incorporate changes to the standard or changes in the work place.

XIII. References

Bill Text - AB-2537 Personal protective equipment: health care employees.

CA SB 275 refers to 90 emergency supply of PPE, but does state the below:

Bill Text - SB-275 Health Care and Essential Workers: personal protective equipment.

"(5) "Personal protective equipment" or "PPE" means protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, including, but not limited to, N95 and other filtering facepiece respirators, elastomeric air-purifying respirators with

appropriate particulate filters or cartridges, powered air purifying respirators, disinfecting and sterilizing devices and supplies, medical gowns and apparel, face masks, surgical masks, face shields, gloves, shoe coverings, and the equipment identified by or otherwise necessary to comply with Section 5199 of Title 8 of the California Code of Regulations."

Appendix A:

Cleaning and Decontamination Schedule Work Area/Equipment	Cleaning and Decontamination Frequency	Type of Cleaners or Supplies to be Used	Responsible Person
Trash containers	Disinfect all prior to returning to building	Hospital approved disinfectant	EVS
Red Containers	Disinfect all prior to returning to building	Hospital approved disinfectant	EVS
Large blue Recycle Containers	Disinfect when visibly dirty	Hospital approved disinfectant	EVS

Attachments

BLOODBORNE (12561)_Attachment_1390_Attachment B_Bloodborne Pathogens_Matrix of Department related Tasks_proced_2.pdf

BLOODBORNE PATHOGEN EXPOSURE CONT (12561)_Attachment_1389_Attachment A_BBP Job Titles_2021 (4).pdf

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	02/2024
P&T Committee	Genevieve delos Santos: Director Pharmacy	12/2023
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
EH Director	Jill Crowley: Manager Clinical Nutrition	08/2023

Policy Owner	Melissa Deen: Infection Prevention Manager	08/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14186838**

Last Approved	N/A	Owner	Daniela Jago: Clinical Manager
Last Revised	10/2023	Area	Women's and Children's Services
Next Review	3 years after approval		

Cervical Ripening Balloon

I. POLICY STATEMENT

~~A. The cervical ripening balloon will be placed using sterile technique by the MD with RN assistance.~~

~~B. The placement of the balloon should be timed so that it is in place no longer than 12 hours before active labor is induced.~~

~~C. Placental location should be documented prior to cervical ripening balloon placement.~~

A. N/A

II. PURPOSE

A. To guide the nurse in the care provided to the patient who is undergoing cervical ripening with a cervical ripening balloon.

III. DEFINITIONS

~~A. N/A~~

A. ***MFTI*** - Maternal fetal triage index

B. ***EFM - E***xternal fetal monitor

IV. GENERAL INFORMATION

~~A. N/A~~

A. The cervical ripening balloon will be placed using sterile technique by the MD with RN assistance.

B. The placement of the balloon should be timed so that it is in place no longer than 12 hours before active labor is induced.

C. Placental location should be documented prior to cervical ripening balloon placement.

V. PROCEDURE

A. Indications for the initiation of cervical ripening balloon include, but are not limited to:
    1. Term pregnancy
    2. Singleton pregnancy
    3. Vertex presentation
    4. Intact membranes
    5. Lack of persistent uterine contractions
    6. Evaluate fetal and uterine status prior to insertion for a minimum of 20 minutes.
    7. Normal fetal heart rate (Category I), or Category II with OB consideration

B. Informed consent

C. Contraindications to the initiation of a cervical ripening balloon include, but are not limited to:
    1. Ruptured membranes
    2. Labor, defined as regular contractions of 3 or more in 10 minutes
    3. Prior ~~hysterotomy,~~ classic uterine incision~~,~~ or myomectomy~~, or any other full thickness uterine incision~~
    4. Prolapsed umbilical cord
    5. Pelvic structural abnormality
    6. Active genital herpes infection
    7. Invasive cervical cancer
    8. Abnormal fetal heart rate pattern
    9. Multiple gestational pregnancy
    10. Low lying placenta
    11. Maternal heart disease
    12. Multiple gestational pregnancy
    13. Polyhydramnios
    14. Presenting part above the pelvic inlet
    15. Severe maternal hypertension
    16. Any contraindication to labor induction

D. May be used concurrently with an oxytocin infusion per order/policy

E. May be used concurrently with Misoprostol 25 mcg per vagina Q4h

F. Provide 16 Fr Foley catheter to physician or double balloon per physician preference
    1. Explain procedure to patient

2. Position patient in the lithotomy position
3. Monitor patient for 30 minutes following balloon insertion; if Category I status, patient may ambulate and assessment will follow for latent labor until active labor begins
4. Catheter should be removed when: (may be removed by RN)
    a. No spontaneous extrusion occurs after 12 hours
    b. Excessive or unexplained bleeding occurs
    c. Abnormal fetal heart rate tracing
    d. Spontaneous rupture of membranes
    e. Maternal temp > 100.5 F.

G. **Outpatient Cervical Ripening**

1. Perform MFTI upon patient arrival for scheduled procedure
2. Verify physician order for "Outpatient Testing/Treatment Order"
3. Place patient on EFM, monitor for 30 minutes prior to balloon placement
4. Explain procedure to patient
5. Position patient in the lithotomy position
6. Physician inserts balloon (can be Foley catheter or double balloon per physician preference)
7. Monitor maternal and fetal response for one hour minimum post insertion
8. Confirm patient is scheduled for induction of labor 12 hours from appointment for cervical ripening balloon placement
9. Discharge patient with preprinted "Outpatient Cervical Ripening: Patient education and instructions" handout

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

~~A. Cook Medical Incorporated. (2014). *Cervical ripening balloon: Instructions for use.* Retrieved from https://www.cookmedical.com/data/IFU_PDF/T_J-CCRB_REV2.PDF~~

~~B. Levine, L., Downs, K., Elovitz, M., Parry, S., et al. (2016). Mechanical and pharmacologic methods for labor induction. *Obstetrics &Gynecology*, 128:6, 1357-1364.~~

A. American College of Obstetricians and Gynecologists. (2019). Vaginal birth after cesarean section. (Practice Bulletin No. 205).

B. Cook Medical Incorporated. (2021). *Cervical ripening balloon with stylet: A nonpharmaceutical option for preinduction dilation.* Retrieved from https://cdnnamsseuspwsprod.azureedge.net/data/resources/RH-D63251-EN-F_M3_1645193893859.pdf

Attachments

A: Guidelines for Use of Cervical Ripening Balloon

B: Guidelines for Use with Urinary Catheter Balloon for Cervical Ripening

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Obstetrics Committee	Katherine DeSalvo: Director Medical Staff Services	02/2024
Director of WCS	Julie Vasher: Director Women's & Children's Services	01/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2024
Policy Owner	Daniela Jago: Clinical Manager	12/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15060759**

Last Approved	N/A
Last Revised	03/2024
Next Review	3 years after approval
Owner	Megan Giovanetti: Manager Cath Lab
Area	Cardiology Departments

Scheduling: Cardiac Cath Lab

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To define the scheduling protocols which will provide optimal patient care while taking into account efficient operation of the Cardiac Cath Lab, the wellbeing of the Cardiac Cath Lab personnel, and whenever possible, the individual needs and preferences of the participating physicians.

III. DEFINITIONS

A. N/A

IV. PROCEDURE

A. General Information

- **Required Patient Data**

1. To schedule a procedure in the Cardiac Cath Lab, the physician operator or his representative will call the Cath Lab Office or request an appointment through the Sharepoint e-portal. All requests will include the following:
    a. Patient's name
    b. Social Security number
    c. Diagnosis
    d. Date of birth
    e. Insurance carrier and Authorization number if available at the time of request
        i. Authorization MUST be received before the date of procedure
    f. Date and type of admission

g. Home phone number

h. The anticipated procedure to be performed

i. Any Vendors, Anesthesia or special equipment needed for the procedure

B. Scheduling

- Scheduling of procedures requiring Cardiac Cath Lab resources will be coordinated with the Cath lab Office during normal business hours. The Cath Lab is open 0730 to 1600, Monday – Friday, excluding official National Holidays.

1. Requests to perform procedures outside of these hours will be referred initially to the Senior Administrative Director/Cardiovascular Services and/or the Cath Lab Manager or Chair of the Department of Cardiology or Cath Lab Medical Director. The decision to perform studies outside the confines of the regular working day will be made with consideration toward staffing availability, clinical status of the patient and availability of alternative schedule possibilities. Provisions of laboratory time for the performance of urgent and emergency procedures are detailed below.
2. The elective schedule for the next business day will be finalized at 1300, Monday – Friday. All cases scheduled after 1300 for the current or next business day must be urgent or emergent, and scheduled with Cardiac Cath Lab clerical staff during working hours or the Senior Administrative Director (or designee when the Cath Lab is not staffed)

- Clinical Privileges to Schedule Cases

1. Only those cardiologists/physicians who have clinical privileges to perform procedures may schedule cases in the Cath Lab
   a. The physician may delegate to their office staff to schedule, cancel or amend surgical procedures.
   b. The physician is responsible for ensuring accuracy, as well as monitoring quality assurance with respect to these designees.
2. Privileges for the Cath Lab are obtained by following the procedures as stated in the Medical Staff Bylaws.
3. If there are any questions about a physician's privileges, the Medical Staff ~~Office~~Services must be notified for clarification.

C. ~~Physicians identified on the "Suspended List" per Medical Staff Bylaws will not be permitted to schedule and perform procedures.~~

D. Case Duration

- Physician and procedure specific case duration will be estimated at the time of scheduling. Case duration is based on the Olympic mean (historical case time of last ten cases performed less the longest and shortest case time) as databased within the hemodynamic information system or historical case length by procedure type.

1. Case duration is based on case time (patient in room time – patient out of room plus the current practice turnover time by procedure.
2. When a physician's request for a case duration differs from the estimate provided by the hemodynamic information system:
   a. The Scheduler will document the clinical indications for the request. The

request will be reviewed by the Senior Administrative Director and or Cath Lab Manager.

E. On-Time Start Performance

- Procedures are expected to start on time.
    1. The first case of the day will be at 0800 (stick time) unless other arrangements have been made and approved by the management team of the Cardiac Cath Lab. Requests to begin earlier or later than this time will be considered on an individual basis.
- The posted start time is defined as physician scrubbed in and time out has been performed
- The physician is to arrive in Cath Lab 10 minutes prior to the scheduled start time.
- Delays in the schedule will occur in spite of prior planning and effective facilitation of the schedule.
    1. Examples of acceptable delays include:
        a. Emergencies
        b. Patient has taken liquids or nourishment while NPO
        c. Last minute cancellations
        d. No show ambulatory patient
    2. Examples of inappropriate or unacceptable delays include:
        a. Tardiness on the part of the physician, anesthesia or Cath Lab staff
        b. Unavailable or malfunctioning equipment
        c. Lack of planning or preparations by the medical or Cath Lab staff
- First case on-time start performance will be monitored monthly and late starts will be categorized by delay reason by the Cath Lab Director or Cath Lab Manager.

F. Modified Block Scheduling

- In an effort to maximize Cath Lab efficiency through consecutive utilization of personnel and equipment, the elective case scheduling methodology is a modified block scheduling system.
    1. Available resource hours for elective cases are defined as 0730 – 1600 Monday – Friday.
    2. Staffing resources will be matched to demand.
    3. Available weekday resource hours of Cath Lab time will be reserved for a physician, service or a group practice of physicians in blocks of time.
        a. Within a defined cut off period, this is time into which only the given physician, service or group practice of physicians may schedule.
        b. Block time cannot be exchanged or traded with another physician, group practice or service.
    4. Open time will be maintained on a first-come first-served basis for those physicians who:
        a. Prefer scheduling on first come, first served basis
        b. Need additional Cath Lab time once their allocated block time is filled.

c. Emergency and urgent case accommodation

G. Block Time Allocation

- The ~~Chairman of the Department~~Medical Director of Cardiology , Cath Lab Medical Director and the Senior Administrative Director of Cardiopulmonary Services has the sole authority to collaboratively allocate block time.
- Physicians are expected to petition for block time.
    1. The petition must be submitted in writing to the ~~Chairman of the Department~~Medical Director of Cardiology and the Senior Administrative Director of Cardiopulmonary Services. The request is to be for no less than 4 hours of block time per week.
    2. Block time requests will be evaluated based on whether there is block available on the day requested, evidence of the historical case volume of the requesting physician, the impact allocation of the block will have on inpatient and outpatient bed utilization and overall Cath lab utilization.
        a. An attempt will be made by the ~~Chairman of the Department~~Medical Director of Cardiology and the Senior Administrative Director of Cardiopulmonary Services to allocate blocks in such a manner that the schedule will be smoothed throughout the week.
    3. The ~~Chairman of the Department~~Medical Director of Cardiology and the Senior Administrative Director of Cardiopulmonary Services will formally document a response to the petitioning physician request within 30 days of the physician's request.
    4. A temporary block may be approved for 60 days, subject to utilization review.
    5. Blocks are based on a two-week cycle.
        a. Thus, a block may be allocated to a physician, group practice or specialty every other week rather than every week.
    6. Blocks will be granted as half day blocks.
        a. On designated late start days, early unused block time will be used for add-on cases and/or urgent and emergent cases.
        b. Physicians must first demonstrate that they can adequately utilize one half-day block prior to being granted a second half day block during the week. Preference for adjusting blocks will be given to those physicians who already occupy and have demonstrated they can utilize half-day blocks.
    7. Total procedure time scheduled in block time will generally not exceed allocated block time. Exceptions will be made with the approval of the Senior Administrative Director.

H. Block Time Release

- Block time is held until one (~~1~~3) business day prior to the scheduled day at 1:00pm and then released for general use if not utilized by the block physician.

Day of week Block	Monday	Tuesday	Wednesday	Thursday	Friday	

Release Day 1:00 pm	Wednesday	Thursday	Friday	Monday	Tuesday	~~Wednesday~~	~~Thursday~~

- Block time is released to first-come first served scheduling as follows:
    1. Eligibility to schedule elective cases in released block time extended to:
        a. Any physician who has not been allocated a block, Any physician who does not have block time on the scheduled day, or any physician who has completely filled his or her own block time on the scheduled day.
        b. Accommodation of urgent and emergent cases
    2. Physicians who elect to add cases after the release of block time are not guaranteed to follow themselves.
    3. In the event a case cancels after the release time and was scheduled during the allotted block time, the physician can substitute a case of equal or less duration for the canceled case if said case does not cause a resource conflict.
    4. Only case minutes performed within allocated block time will be considered in calculation of block utilization.
        a. Total allocated block time will include released block time when calculating block utilization.
    5. Physicians are responsible for notifying the Cath Lab of cancellation of block time for upcoming vacations and continuing medical education conferences.
        a. Notice is to be given in writing to the Cath Lab Director.
        b. Canceled block time will not be considered in the calculation of the physician's block time utilization when a signed and dated notice of cancellation of block time is received by the Heart Program Office greater than14 days prior to the block time.
        c. Failure to give notice of canceled block time will result in re-evaluation of block time eligibility.

I. Block Utilization Monitoring
    1. The ~~Chairman of the Department~~Medical Director of Cardiology and the Senior Administrative Director of Cardiopulmonary Services have responsibility and authority for block utilization monitoring and adjustment.
        a. Decisions to adjust block time will be based on block time utilization over a rolling three-month period.
        b. Blocks will be adjusted in full block increments (i.e., half-day blocks).
    2. Daily and overall block time will be monitored monthly and reported quarterly at the Cardiovascular Service line Meeting.
        a. The Cath Lab Manager or Senior Administrative Director of Cardiopulmonary Services will collect and analyze the utilization data.
        b. Greater than 75% utilization averaged over a rolling 3-month period is required to maintain block time.
        c. Block utilization is measured by the following definition: Elective procedure

minutes performed in an allocated block plus the current practice turnover minutes/Allocated block minutes (including released minutes).

d. Less than ~~30~~60% utilization in any given month may result in the immediate loss of block time.

e. Elective procedure minutes that occur outside the block will be tracked monthly and considered when a physician petitions for additional block time.

f. Evening, Weekend and Holiday minutes that occur outside block time will be tracked monthly to identify trends.

J. Bumping Protocol

- The physician who is to perform an emergency procedure contacts the Cath Lab Clerical staff when the emergency occurs during weekday resource hours.
- The physician who is to perform an emergency procedure contacts the Administrative Supervisor when the emergency occurs outside weekday resource hours.
- If it is identified that the procedure cannot be delayed and staff coverage is available within a timeframe that will not jeopardize patient safety, then the case will be placed in an empty and available Cath Lab.
- If it is identified that the procedure cannot be delayed and the existing Cath Lab schedule does not allow for it to be immediately scheduled in an empty and available Lab, a scheduled procedure in a blocked or open room will be bumped. Employing the following order:
    1. If the physician has block time at the time of the bump, he will bump himself.
    2. If the physician does not have block time, the first available room will be bumped.
    3. When a physician bumps a case on his block day and the bump causes the delay of a scheduled case beyond the allocated block time, the scheduled case will be sequenced as an add-on case.
- The Senior Administrative Director, Charge RN or Cath Lab Manager will review the scheduled procedures to determine which room and procedure will be bumped.
- Direct physician-to-physician communication is mandatory for a case to be bumped
    1. The bumping physician has the authority to bump a case based on his clinical knowledge of the patient's condition.
    2. Disputes over appropriateness of the bump will be directed to the ~~Chairman of the Department~~Medical Director of Cardiology for resolution.

K. Publishing the Next Day's Schedule

- The schedule will be reviewed by the management team of the Cardiac Cath Lab on the last working day prior to the anticipated procedures and the order of cases will be established. The schedule will then be posted and distributed to the hospital departments and physicians involved through the Meditech Community-Wide Scheduling Module.

L. Scheduling of Urgent Cases

- An urgent case will be defined as one in which clinical criteria indicate a need for performance of angiography or PTCA within the current hospitalization.
    1. Not elective status.
    2. Not emergency status.

3. Procedure required without delay during same hospitalization in order to minimize chance of further clinical deterioration.
4. Worsening, sudden chest pain, CHF, acute myocardial infarction (AMI), high risk coronary anatomy, IABP, unstable angina (USA) on intravenous (IV) nitroglycerin (NTG) or rest angina (in a stabilized patient) are examples of some such cases.

- Patients called into Admitting as urgent transfers from another facility will be given priority over scheduled/elective outpatients.
- All patients admitted or transferred from another facility to the hospital with a designation of "urgent" or "emergent" are expected to have a procedure completed within 24 hours of admission.
- These cases will ordinarily be performed at the end of the current working day. However, if the physician wishes to perform the test earlier in the day, that may be arranged with the consent of all physicians affected by the schedule change.
- The ~~Chair of the Department~~Medical Director of Cardiology or Cath Lab Medical Director may prospectively review any case designated as urgent in order to determine the authenticity of that designation. If the case does not appear to merit urgent performance, it will be scheduled according to guidelines indicated above.

M. Emergency Cases

- An emergent case is defined as one in which undue delay in performing diagnostic or interventional studies is the Cardiac Cath Lab is likely to result in an adverse outcome for the patient (e.g., excess morbidity or mortality). Emergent cases must meet at least one of the following conditions:
    1. Ischemic dysfunction (any of the following):
        a. Evidence of ongoing ischemia including but not limited to, rest angina (despite maximal medical therapy and/or IABP);
        b. Evolving Acute Myocardial Infarction within 24 hours of Cardiac Cath Lab Procedure; or
        c. Pulmonary edema requiring intubation;
    2. Mechanical dysfunction :
        a. Shock with or without circulatory support
- This designation is the responsibility of the physician performing the study and the Cardiac Cath Lab staff or ~~the Chair of the Department~~theMedical Director of Cardiology will not question the validity of that description prospectively. The appropriate use of the emergency designation may be reviewed retrospectively by the ~~Department~~Medical Director of Cardiology ~~or its Chair~~ and appropriate corrective measures instituted if this option is used inappropriately.
- An emergency case will be transported to the Cardiac Cath Lab as soon as possible. During the working hours, the case in progress in the Cardiac Cath Lab should be completed as quickly as possible allowing for timely transport of the emergency case. During non-operating hours, the Cardiac Cath Lab on-call team will be notified by the administrative supervisor of the need for provision of emergency services.

N. Case cancellations

- In the event a case needs to be canceled, the physician or designee will contact the Cath Lab

Charge RN, department secretary or Manager during working hours to have the case removed from the schedule. After hours cancellations must be communicated to the Cath Lab charge RN. It is the responsibility of the Cath Lab charge RN to notify the Administrative Supervisor and any other caregivers/units of the cancellation.

V. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VI. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Lisa Paulo: Chief Nursing Officer	03/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2024
Policy Owner	Megan Giovanetti: Manager Cath Lab	03/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14675174**

Last Approved	N/A	Owner	Carla Knight: Director Perioperative Services
Last Revised	02/2024		
Next Review	3 years after approval	Area	Patient Care

Tissue Acquisition, Storage, and Implant Tracking

I. POLICY

A. "It is the policy of Salinas Valley Health CTB00080837 that no tissues shall be transferred into the body of another person by means of transplantation unless the donor of the tissues has been screened and found nonreactive by laboratory tests for evidence of infection with human immunodeficiency virus (HIV), agents of viral hepatitis (HBV and HCV), and syphilis. For tissues that are rich in viable leukocytes, the tissue shall be tested for evidence of infection with human T lymphotrophic virus (HTLV) and found nonreactive." (Reference: California Health and Safety Code §1644.5(a)) Salinas Valley Health acknowledges that donor testing information of tissue received at this facility can be obtained from the tissue vendor.

II. PURPOSE

A. To direct staff in maintaining tissue products by standardizing the process for approving the source and on site management, which includes maintaining pertinent records of receiving, storage, ultimate disposition of each implant, and adverse patient events.

~~III. POLICY~~

~~A. It is the policy of Salinas Valley Memorial Healthcare System that no tissue shall be transferred into the body of another person by means of transplantation, unless the donor of the tissues has been screened and found nonreactive by laboratory tests for evidence of infection with HIV, agents of viral hepatitis (HBV and HCV), human T lymphotrophic virus-1 (HTLV-1), and syphilis (Reference: California Health and Safety Code §1644.5(a).~~

~~B. Salinas Valley Healthcare System maintains/stores non-frozen tissues for transplantation. In compliance with California DHS regulations, a tissue bank license is maintained for tissue storage. For patient safety, tissues are ordered exclusively from licensed tissue bank sources that have screened the donors as described in paragraph A.~~

~~C. Hospital departments follow standard ordering procedures for ordering tissue implants through Materials Management Department and use only sources/suppliers, which have~~

provided copies of FDA registration and California licensure. Refer to attachments, Tissue Temp Range Table for current approved sources. Arriving tissues are checked in through Materials Management and have a Tissue Tracking Form upon arrival at the requesting unit.

D. Oversight of the implantable tissue program/processes is shared with the Assistant Director of Surgical Services, the Director of Resources Management and the Director of the department ordering the tissue in order to maintain a standardized process.

The Director of Resources Management, may delegate to the Senior Buyer and/or Senior Healthcare Allocation Specialist, the responsibility for utilization of the Tissue Tracking and Temperature Range Forms to confirm the tissue and source are approved for use at SVMH and the tissue is tracked according to regulatory standards.

E. The director of the department requesting tissue appoints Tissue Coordinators with ongoing responsibility for coordination, ordering, storage, implantation, and maintenance of implant related records, e.g. in Surgery, the Nurse Specialist for the specialty utilizing the implants.

F. The source/suppliers recommendations for temperature maintenance, storage, and preparation are maintained by the departments requesting tissue.

G. Daily temperature monitoring is accomplished with a continuous recording device with alarm capabilities and back-up for power failure.

H. Implantation of tissue is recorded in the procedure record and on the Tissue Tracking Form by the circulator.

I. The hospital maintains tissue records for 10 years as required by state and federal laws.

J. The department directors ensure that the hospital wide tissue management system, as described in this policy, is maintained in order to trace tissues from the patient to the source/supplier and donor or to trace recalls from the source/supplier to the patient should a recall or adverse event occur. The hospital's system supports the source/supplier's record keeping system in order to expedite a recall and/or investigation.

K. In the event of a recall due to transmissible infection, the Director of Resources Management notifies the Director of Infection Prevention and Control and the director of the department implanting tissue who notifies the patient and the physician of the recall in order to provide the physician the opportunity to discuss risks with the patient and explore treatment options.

L. The director of each department implanting tissue ensures infections of implanted tissues are reported to the Director of Infection Prevention and Control and the source/supplier.

M. Frozen tissue may be used by ordering it for the day of the procedure and maintaining it in the supplier's container with dry ice or sealed in the liquid nitrogen canister. The hospital does not maintain a tissue freezer.

IV. DEFINITIONS

A. FDA: Food and Drug Administration.

B. Circulator: ~~nurse~~RN responsible for supplying materials/tissue, attending to the patient, and documenting the procedure and tissue.

C. Source/Supplier: vendor of cellular tissue for implantation.

D. ~~Senior Healthcare Allocations Specialist (SHAS)~~Materials Supply Technician: an employee in Materials Management who is responsible for receiving tissue and other products.

E. Inventory Control Specialist (ICC): Materials Management employee who coordinated specialty supplies for departments.

F. Senior Buyer: an employee in Materials Management who is responsible for oversight of the receiving and transfer of tissue.

G. Tissue Coordinator/Specialist: the person in the ordering unit who is responsible for tissue oversight, e.g. in Surgery, the Nurse Specialist for the specialty utilizing the implants or in the Wound Healing Center, the clinical ~~manager~~leader or designee.

H. Tissue. For the application of this policy and compliance with The Joint Commission standards, tissue is defined as **human and non-human cellular -based** implantable and transplantable products, for example..

- Bone, cornea, skin, heart valves, tendons, fascia, dura, bone marrow, veins, arteries, cartilage, sperm, embryos, eggs, stem cells, cord blood, synthetic tissue (artificially prepared human and non-human products, other cellular -based products, i.e., synthetic tissue made ~~form~~from coral).
- Additional clarification of tissue for this policy application is provided in the 2010 TJC Hospital Accreditation Standards Manual: Examples of Tissues and Cell Products~~,~~; refer to attachment.
- For California, the law expands the above definition of tissue to include products derived from human tissue that are no longer cellular in nature, e.g. acellular dermis (clarified by Jan Otey, examiner, CDPH laboratory field services, 2010).

I. Non-Tissue is defined by The Joint Commission Standards Interpretation Group, Megan Sawchuk.

- Collagen.
- Bovine albumen or acellular products impregnated with bovine albumen e.g. Thrombin, Tisseal, Floseal, and Paritex mesh.

J. Tissue Bank as defined by the State of California: Any place, establishment, or institution that collects, processes, **stores**, or distributes tissue for transplantation into human beings.

- California Tissue Bank License requirements identified.
    1. California Health and Safety Code, section 1639-1641.1: human tissue for transplantation into humans.
    2. Exclusions (CA Health and Safety Code, section 1635-1635.2):
        a. Tissue collected by a physician for re-implantation into the same patient.
        b. Solid organs for implantation.
        c. Freeze -dried bone.
        d. Other exemptions: "human blood, collection of tissue for autopsy …or education, where transplantation is not intended; processing and storage of semen obtained by a physician from

a licensed tissue bank; processing, storage, or distribution of fetal ….or embryonic tissue…"; organ procurement organization"…activities."

K. WHC: Wound Healing Center

V. GENERAL INFORMATION

A. Salinas Valley Health System maintains/stores non-frozen tissues for transplantation. In compliance with California DHS regulations, a tissue bank license is maintained for tissue storage. For patient safety, tissues are ordered exclusively from licensed tissue bank sources that have screened the donors, as described in paragraph A.

B. Hospital departments follow standard ordering procedures for ordering tissue implants through the Materials Management Department and use only sources/suppliers that have provided copies of FDA registration and California tissue bank license. Arriving tissues are checked in through Materials Management, where the tissue is entered into the Tissue tracking software , and a tracking bar-code label is generated and applied prior to arrival at the requesting unit.

C. Oversight of the implantable tissue program/processes is shared with the Director of Surgical Services, the Director of Materials Management, and the Director of the department ordering the tissue in order to maintain a standardized process.

The Director of Materials Management may delegate to the Inventory Control Coordinator (ICC) the responsibility for utilization of the Tissue Tracking software and Temperature Range Forms to confirm the tissue and source are approved for use at Salinas Valley Health, and that the tissue is tracked according to regulatory standards.

D. The director of the department requesting tissue appoints Tissue Coordinators with ongoing responsibility for coordination, ordering, storage, implantation, and maintenance of implant-related records, e.g., in Surgery, the Nurse Specialist for the specialty utilizing the implants.

E. Tissue tracking software is the source for tissue temperature, preporation, and storage requirements.

F. Daily temperature monitoring is accomplished with a continuous recording device with alarm capabilities and backup for power failure.

G. Implantation of tissue is recorded in the procedure record and on the tissue tracking software by the nurse.

H. The hospital maintains tissue records for 10 years as required by state and federal laws.

I. The department directors ensure that the hospital-wide tissue management system, as described in this policy, is maintained in order to trace tissues from the patient to the source/supplier and donor or to trace recalls from the source/supplier to the patient should a recall or adverse event occur. The hospital's system supports the source/supplier's record-keeping system in order to expedite a recall and/or investigation.

J. In the event of a recall due to transmissible infection, the Director of Materials Management notifies the Manager of Infection Prevention and Control and the director of the department implanting tissue, who notifies the patient and the physician of the recall in order to provide the

physician the opportunity to discuss risks with the patient and explore treatment options.

K. The director of each department implanting tissue ensures infections of implanted tissues are reported to the Manager of Infection Prevention and Control and the source/supplier.

L. Frozen tissue may be used by ordering it for the day of the procedure and maintaining it in the supplier's container with dry ice or sealed in the liquid nitrogen canister. The hospital does not maintain a tissue freezer.

VI. PROCEDURE

A. Tissue Coordinators/Specialists are responsible for the oversight of the tissues used by their area of specialization. Those responsibilities include the following:

- Confirmation of qualifications of source/supplier (FDA registration and for human tissue, California license) prior to ordering tissue for the first time and annual reconfirmation. Documentation of current status is maintained on each unit that uses tissue.
- Acquisition and maintenance of records of source/supplier instructions for storage and preparation for use.
- Requesting tissue.
- Documentation of unique tissue and patient identifiers and implantation, which includes staff involved in the procedure, the scrub person who prepared the tissue, storage temperature, and ongoing tissue preparation.
- Confirmation of records maintenance for tissue storage temperature and ongoing monitoring.
- Maintenance of records for tissue transfers and final disposition.
- Resolution of problems related to tissue acquisition, storage, and implantation.
- Communication of adverse tissue events.
- Maintenance of the above -described records for a minimum of 10 years as required by state and federal regulations.

B. The Tissue Coordinator/Specialists maintain the source/supplier ~~reference binder/ file~~references in the tissue tracking software, which contains documentation of the following:

- Current FDA registration.
- Current California license (required for human tissue only).
- Tissue storage temperature recommendations.
- Tissue preparation instructions~~, which~~ are added to the nurses' procedure record at the time of implantation.
- Source/supplier declaration that temperature parameters are preserved during shipping.

C. New tissue or sources/suppliers are reviewed and confirmed to have supplied the required documentation~~,~~ by the Tissue Coordinator/Specialist ~~and Senior Buyer~~or Inventory control coordinator, after which the following occurs.

- ~~The Senior Buyer adds tissues to the Materials Management item file.~~
- ~~The Tissue Coordinator/Specialist adds sources/suppliers to the source/supplier reference binder/file.~~
- ~~The source/supplier recommended tissue/temp range table is updated by the OR Educator or the Tissue Coordinator/Specialist, for Materials Management and unit staff to use as a reference when confirming the source/supplier has been accepted at SVMH and during temperature checks.~~
- The Inventory control coordinator adds tissues to the Materials Management Item Master.
- The Tissue Coordinator/Specialist or Inventory Control Coordinator adds sources/suppliers to the Vendor file in the tissue tracking software

D. Tissues are stored in temperature -controlled areas. **Wound care is not currently monitored...**

- The temperature in storage areas is maintained within a range~~, which~~ that meets the requirements specified by the source/supplier for the tissues stored in each area. Those ranges are provided to Engineering by the Tissue Coordinator/Specialists for entry into the computerized temperature monitoring system.
- The temperature recording system is equipped with alarms and battery power ~~back-up~~backup.
- Alarms are responded to by an Engineer who coordinates problem resolution with the charge person and the Tissue Coordinator/Specialist and records the action taken in the computerized system.
- ~~Communication of refrigerator alarm status is emailed by Engineering to the director of the affected department, and for Surgery, the OR Educator, who are responsible for confirming the tissue is safe to use.~~
- ~~Quarterly, Engineering sends the history of alarms and corrective actions report to the Director of Surgery and the Director of the Wound Healing Center.~~
- Temperature records are maintained for 10 years.

E. Tissues stocked for Surgery and the WHC are ordered by the Senior Buyers following a department -specific process.

- ~~For Surgery, the RN who used the tissue places the empty tissue containers in the re-order receptacle.~~
    1. ~~The Tissue Coordinator/Specialist provides the Buyer with a list of tissues implanted the previous day.~~
    2. ~~If the list is not provided by Surgery, the Buyer has the capability to print the implant list.~~
    3. ~~The Buyers correlate the implant list with the empty containers and then generate an order which is recorded in Meditech.~~

  For Surgery, the RN who used the tissue records the usage in the patient's surgical record and completes all of the required information in the tissue tracking software

    1. The Buyer prints the implant report.

2. The Buyers then generate an order, which is recorded in Meditech.

- For special order tissues, the surgeon notifies the ~~Tissue Coordinator~~tissue coordinator/~~Specialist~~specialist, who ~~completes a PO~~coordinates with the senior buyer to obtain the tissue ~~information~~, application date, and patient~~'s~~ identifiers.
- For the WHC
    1. Following a Physician's order, the ~~RN~~Nurse completes a pre-printed Purchase Order (PO) and adds the following: the ~~quantity~~number of units, application date, and the physician's name.
    2. ~~The RN FAXes the PO to the Director for signature and the Director FAXes the finalized PO to Materials Management.~~
    3. The Nurse obtains clinical leader approval and sends the finalized PO to the Senior Buyer.
    4. PAR level stock of Tissues stored in WHC will be restocked when Senior Buyers receives notification of usage from WHC staff.

F. ~~As tissues arrive in Materials, the receiving information is recorded in the Materials Receiving section of the Tissue Tracking form (refer to attachments) by the Senior Healthcare Allocations Specialist (SHAS).~~

- ~~Date and time of arrival.~~
- ~~Product and source/supplier description.~~
- ~~Numbers: catalogue, serial, and donor (when printed on package).~~
- ~~Expiration date.~~
- ~~For two tissues, the shipping date is not on the package exterior and tissue specific tracking forms were developed to meet those and other unique product needs.~~
    1. ~~The Apligraf tracking form requires notation of the shipping date and contains the warning product expires in 10 days. The actual date is on the inner polybag, which is only accessed by WHC staff.~~
    2. ~~Genzyme's tracking form (refer to attachments) requires notation of the "return by" date.~~
- ~~Tissue temperature within suppliers recommended range. Exceptions are~~
    1. ~~Genzyme Carticel, which is shipped cooled in a validated shipping container and no temperature monitoring is suggested by the source.~~
    2. ~~Organogenesis' Apligraf, which can only be confirmed by receiving unit staff.~~
- ~~Condition of package on arrival.~~
- ~~Name of receiver who is recording data on the Tissue Tracking form and verifying the data with the purchase order in Meditech.~~
- ~~For Apligraf, multiple units are sometimes ordered for a procedure and one Apligraf Tissue Tracking form (refer to attachments) is generated for each unit of Apligraf indicated on the packing slip.~~

As tissues arrive in Materials, the receiving information is recorded in the Materials Receiving section of the Tissue Tracking software by the Materials Supply Tech.

- Date and time of arrival.
- Product and source/supplier description.
- Numbers: catalog and serial.
- Expiration date.
- Condition of the package on arrival.
- The receiver records data on the Tissue Tracking software and verifies the data with the purchase order in Meditech.

G. Interventions for unacceptable tissue e.g. expired or damaged package, or temperature ~~or pH~~ in excess of source/supplier recommended range.

- ~~The SHAS refers the tissue to the Senior Buyer.~~
- ~~The Senior Buyer notifies the Tissue Coordinator/Specialist and the source and returns the tissue to the source.~~
- ~~The Senior Buyer's interventions are recorded in the Final Disposition section of the Tissue Tracking form and the form is sent to the department billing clerk for filing.~~
- The material supply tech refers the tissue to the Senior Buyer.
- The senior Buyer returns the tissue to the source.

H. After arriving tissue is checked in by the ~~SHAS~~Materials Management Supply Tech, it is transferred to the ordering unit by the ~~Senior Buyer~~ICC who records the following in the Materials Transfer section of the Tissue Tracking ~~form and retains a copy for Materials Management~~software.

- Date and time of transfer.

  For Surgery

  1. Storage unit/area. Inventory is rotated to promote use prior to expiration.
  2. Bin #, if applicable.
  3. ~~Tissue Temperature.~~
  4. Transferor's ~~initials~~name

I. ~~Apligraf checks upon arrival in the WHC~~

- ~~The WHC receiver opens the package for the first time.~~
- ~~The following is noted on the Apligraf Tracking Form: date and time of arrival, box unopened on arrival, polybag integrity (intact or not), expiration date, and unit lot number.~~
- ~~Temperature is within range, 68-73ºF.~~
- ~~pH displayed on the polybag is within acceptable range on color chart, 6.8 to 7.7.~~
- ~~After the checks are recorded, the polybag is returned to its box and placed in~~

~~storage. The printed name of the person completing the form is added to the form.~~

J. ~~Tissue is issued for the procedure based on the physician's request and transferred to the procedure room by the SSPT3, scrub technician, LVN, or RN, who completes the Interim Transfer section of the Tissue Tracking form.~~

- ~~Date and time of transfer.~~
- ~~Procedure room #.~~
- ~~Tissue temperature, except Genzyme and Organogenesis.~~
- ~~Transferor's printed name.~~

K. ~~Tissue not used during the procedure may be returned to storage or to the Senior Buyer for return to the supplier, by the SSPT3, scrub technician, or RN as long as the packaging remains intact and temperature remains within acceptable range. The Return to Storage or final disposition section of the Tissue Tracking form is completed.~~

- ~~Date and time of return.~~
- ~~Tissue temperature, except Genzyme and Organogenesis, which are not removed from the outer container until the physician is certain the tissue will be used.~~
- ~~Returner's printed name.~~

L. Tissue is issued for the procedure based on the physician's request and transferred to the procedure room by the RN only when the surgeon requests the tissue to be placed on the sterile field. The RN will then complete the tracking software.

- Date and time of implantation
- anatomic site of implant
- package integrity
- Documentor's name.

M. The final disposition of the tissue is documented in the Final ~~disposition of the tissue is documented in the Final~~ Disposition section of the Tissue Tracking ~~form~~software.

- ~~For implanted tissue the circulator (OR RN or WHC RN/LVN)~~
  1. ~~Notes the date, time, temperature when applicable, and his/her printed name.~~
  2. ~~Attaches a patient ID sticker to the printer generated patient record.~~
  3. ~~Attaches the Tissue Tracking form to the billing sheets for billing staff to file.~~

  For implanted tissue, the nurse records implanted or wasted tissues.
- For expired tissue, the Tissue Coordinator/Specialist records the date, time, disposition (return to source or discard)~~, and his/her printed name.~~
- For tissue implanted and removed, the ~~circulator (OR RN or WHC RN/LVN)~~nurse records the date, time, and reason for removal (comments section)~~, and his/her printed name~~. If the removal date is after the date of implantation, the Tissue Tracking ~~form will~~software may be ~~requested from the billing staff's file~~used to

retrieve implant tracking information.

- ~~Completed~~ Tissue Tracking ~~forms are~~information is retained for 10 years in the tissue tracking software. This includes all tissue implanted ~~and removed~~, returned, or expired.
- Tissue temperatures are determined by use of a temperature sensing device attached to packaging or implants with an ambient temperature range, which are checked upon receipt and monitored through engineering temperature monitoring.

N. ~~Tissue temperatures are determined, using the same type of temperature sensing device for continuity, by Materials Management and the ordering department.~~

- ~~The tissue package is held in midair and the sensor gun is held 4-6 inches from the package to prevent underlying cold or hot surfaces from influencing the sensed temperature.~~
- ~~The person shooting the temperature compares the value displayed on the gun to the recommended range on the Tissue Temperature Range form.~~
- ~~The current temperature sensing gun uses a **Laser aiming beam,** which **must not be directed at a person's face. The Laser can cause permanent eye damage.**~~

O. **Frozen** tissues are occasionally ordered for specific ~~date~~dates/~~time,~~times and patient procedures. ~~**For Genzyme cooled tissue, there are special handling requirements; refer to the next section.**~~

- The physician communicates the tissue request to the Tissue Coordinator/ Specialist, who alerts the Senior Buyer or the ~~Purchasing~~Materials Manager of the need.
- The Senior Buyer orders the tissue and coordinates the arrival with the source, shipper, ~~SHAS~~Material Supply Tech, and the procedure schedule. After 1030 hrs is the preferred time for scheduling the procedure to avoid shipping and schedule problems.
- ~~The senior Buyer arranges for dry ice to be on hand for the date and time of arrival.~~
- The Tissue tracking ~~form~~software is completed in the same manner as other ~~tissue~~tissues with the addition of the notations about dry ice and shipping container's expiration date, both of which are completed by the ~~SHAS.~~Materials Management Supply Tech
- The Senior Buyer notifies the ~~Tissue Coordinator/Specialist or when the specialist is unavailable the~~ charge person~~,~~ about the impending transfer to the unit.
- The frozen tissue is transferred to the ordering unit in the shipping container by the ~~Senior Buyer~~Inventory Control Coordinator.
- The person receiving the frozen tissue on the ordering unit (Tissue Coordinator/ Specialist or charge person) confirms ~~the temperature noted on the receiving section of~~that the container is not opened in order to prevent premature thawing until the tissue ~~tracking form~~ is ~~within acceptable range and the container is not opened for checks, in order to prevent premature thawing, until the tissue is~~ transferred to the procedure room.

- To prevent unnecessary opening of the shipping container, the Tissue Coordinator/ Specialist or charge person may
    1. ~~Tape the lid on the container.~~
    2. ~~Note on the tape the date, time, and temperature.~~
    3. ~~Secure the tissue in the designated area.~~
    1. Secure the tissue in the designated area.
        - Prior to breaking the seal on the shipping container in Surgery
            1. The patient is cleared to enter the OR/procedure room by the circulating nurse.

P. ~~Genzyme Carticel, cooled autologous tissue (Surgery only).~~
- ~~The physician communicates the tissue request to the Tissue Coordinator/Specialist who alerts the Senior Buyer or the Purchasing Manager of the need.~~
- ~~The Purchasing Manager confirms the shipping date and time with the Genzyme representative and notifies the Tissue Coordinator/Specialist, the senior Buyer, and the SHAS.~~
- ~~The tissue is delivered in a validated shipping container to Materials Management by courier the day of surgery.~~
- ~~The Senior Buyer confirms the package is intact, completes the special Genzyme Tissue Tracking form and delivers the form and shipping **container intact and unopened** to the Tissue Coordinator/Specialist or charge person.~~
    1. ~~The tissue identification, delivery date and time, and 24-72 hour expiration, can be found in the envelope attached to the shipping carton exterior. That envelope may be opened upon arrival in Materials.~~
    2. ~~**The shipping carton must not be opened for temperature checks.**~~
    3. ~~The shipping carton may not cross the red line in Surgery.~~
- ~~Prior to breaking the seal on the shipping container in Surgery~~
    1. ~~The patient is cleared to enter the OR/procedure room by the circulating nurse.~~

Q. ~~Apligraf tissue has unique characteristics and requirements, which are summarized as follows:~~
- ~~The tissue is ordered for each patient procedure as the need arises.~~
- ~~The physician communicates the tissue request to the Tissue Coordinator/ Specialist/Director who alerts the Senior Buyer or the Purchasing Manager of the need.~~
- ~~The Senior Buyer orders the tissue and coordinates the arrival with the source, shipper, SHAS, and the procedure schedule. After 1030 hrs is the preferred time for scheduling the procedure to avoid shipping and scheduling problems.~~
- ~~The tissue is shipped in a cool pack container with an expiration date approximately 10 days from ship date.~~

- ~~Upon arrival in Materials, the Apligraf shipping container is **not opened.** The inner container is only a polybag, which is sandwiched between cool packs.~~
- ~~The Apligraf specific Tissue Tracking form is completed by the Senior Buyer or SHAS and the package is transported promptly to the ordering department.~~
- ~~The person receiving the tissue on the ordering unit opens the package to determine the temperature and the pH is within limits indicated on the poly bag and records those results on the Apligraf Tissue Tracking form.~~
- ~~If the tissue is not used for the scheduled patient and there is need for this tissue prior to its expiration date, which is posted on the polybag, the tissue is returned to the unit storage. If the unused tissue will not be needed, the Tissue Coordinator/ Specialist communicates with the Senior Buyer to arrange return to the source without delay.~~

R. For Surgery Department, an emergency order for tissue may be necessary for an emergency procedure. When that tissue will arrive on a holiday or Sunday, the following process is implemented.

- The Tissue Coordinator/Specialist notifies the Senior Buyer and the house supervisor of the expected date and time of arrival.
- When the implant arrives, ~~the~~The tissue must be received and entered into the tissue tracking software system, and a tracking label must be generated by the materials supply tech. The house supervisor calls an RN from the on-call team and secures the implant.
- ~~Upon arrival the on-call person initiates the Tissue Tracking form/process with the additional notation of the time the implant arrived and the name of the receiving supervisor. (The response time for the OR on-call team members is 20 minutes regardless of the procedure.)~~

S. **Tissue preparation** for use during the procedure complies with the source/supplier's recommendations and is documented by the ~~RN circulator~~nurse in the Case/Procedure record.

- Tissue preparation solution notations include type~~, lot #,~~ and expiration date.
- Medications added to the preparation solution are noted, including name and concentration, ~~lot #,~~ and expiration date.
- The name of the scrub person ~~who completes the preparation~~ is noted.

T. **Tissue implantation** is documented by the ~~circulator (OR RN or WHC RN/LVN)~~nurse in

- The Implant section of the Case/Procedure Record where the following is noted: Implant identification, which includes source/supplier, description, ~~catalogue~~catalog #, serial/lot#, quantity, and site of implantation.
- The ~~Tissue Tracking form on~~tissue tracking software which the final disposition date~~,~~ and time~~, and temperature~~ are recorded.
- The patient source documents~~, which~~ (If supplied) will be placed on the patient's chart until the patient is able to take possession.
- ~~The source/supplier implant card, which upon completion is attached to the billing sheets by the RN circulator for the billing staff to return to the source.~~

1. ~~The implant cards are shipped weekly by FedEx to each source/supplier.~~
2. ~~The billing clerk places the implant card in the FedEx envelope identified with the source/supplier name.~~
3. ~~The billing clerk places the FedEx tracking number on the bottom of the Tissue Tracking form to confirm the implant card was sent and to allow for tracing the card disposition.~~
4. ~~The Senior Buyer picks up the FedEx envelopes and replaces them once weekly as needed.~~
5. ~~Apligraf and Carticel are exceptions. The sources, Organogenesis and Genzyme, do not supply implant cards and do not desire mailed documentation at the time of implantation.~~

The source/supplier implant card, which, upon completion of tissue tracking software documentation by the nurse, will be sent electronically to the source.

U. The data recorded in the Case/Procedure Record is retrievable by printing the Implant Log.

V. **Source/supplier** notification of **recalls or infections** are received by the Senior Buyer and communicated to the Tissue Coordinator/Specialist~~,~~ and Risk Management and infections are reported to the ~~Director~~Manager of Infection Prevention and Control.

- The Tissue Coordinator/specialist retrieves the ~~Tissue Tracking form and~~tissue tracking information in the software and, when applicable, the Case/Procedure Record and completes an occurrence report.
- For **recalled tissue in inventory**, the implants are removed from inventory by the Tissue Coordinator/Specialist, marked as recalled and sent to the Inventory Control Coordinator, ~~and sent to the Senior Buyer~~ who follows the source's instructions for disposition. The final disposition is recorded on the ~~Tissue Tracking form, which is sent to the billing staff for filing~~tissue tracking software.
- For **recalled infected tissue in inventory**, the tissue is removed from inventory and quarantined by the Tissue Coordinator/Specialist until collaboration with the source and the ~~Director~~Manager of Infection Prevention and Control results in a mutually acceptable plan. The final disposition is recorded on the Tissue Tracking ~~form, which is then sent to the billing staff for filing~~software.
- ~~For **recalled implanted tissue**, the Tissue Coordinator/Specialist notifies the physician and the unit director, who notifies the patient,~~
    1. ~~The notification is recorded by the Tissue Coordinator/Specialist in the Case/Procedure Record and the Tissue Tracking form in the "final disposition" comments section.~~
    2. ~~The Tissue Coordinator/Specialist confers with the implanting physician to determine the final tissue disposition and communicates the disposition/outcome to the source.~~
    3. ~~The Tissue Tracking Form is returned to the billing staff for filing.~~

For **recalled implanted tissue**, the Tissue Coordinator or implanting surgeon may receive notification from the vendor. The physician and the unit director, who notifies

the patient,

- For **recalled implanted infected tissue**, the physician, ~~Tissue Coordinator/Specialist, Director~~the Manager of Infection Prevention and Control, and the Epidemiologist collaborate to produce the best outcome for the patient.
    1. The patient (TJC 2010, TS 03.03.01, EP 5), physician, and epidemiologist are notified by the unit director
    2. ~~The notification is recorded by the Tissue Coordinator/Specialist in the Case/Procedure Record and on the Tissue Tracking form in the "final disposition" comments section.~~
    3. ~~The final tissue disposition is communicated to the source.~~
- Materials Management maintains documentation of recalls in the Vendor Recall spreadsheet, which includes to whom the printed recall notice was provided and what action was taken.

W. Tissue -related adverse events are primarily wound infections. Examples of other adverse reactions may include graft failure, immune response, development of HIV/HTLV, and viral hepatitis.

X. Patients who return for **tissue ~~explant~~ex-plant** procedures **secondary to acquired implant site infections or other adverse events** are reported:

- To the Tissue Coordinator/Specialist and the ~~Director~~manager of Infection Prevention and Control, who receive their notice by the ~~RN circulator~~nurse completing an occurrence report~~,~~ and an email.
- To the Department Director by the Tissue Coordinator/Specialist.
- To the source by the Tissue Coordinator/Specialist.
- For Surgery, a secondary reporting mechanism is placed into action by:
    1. The ~~RN circulator~~nurse completing the Pre-op/Anesthesia section of the Case Record, which requires a field entry for "previous implant at the surgical site: Y/N."~~.~~
    2. The ~~RN circulator~~nurse completing the Culture section of the Case Record, which requires field entries for "previously implanted tissue/bone ~~explanted~~ex-planted: Y/N" and ~~Explanted~~ex-planted Tissue cultured: Y/N
    3. The incorporation of the above entries into a report, which is then available for the ~~Director~~Manager of Infection Prevention and Control and Tissue Coordinator/Specialist to print for use in the investigation of an event.

Y. ~~Tissue related events are reported to the OR Educator who maintains a log of those events.~~

Z. A reconciliation of tissues ordered, tracked, stored, implanted, and returned to source/supplier or discarded is conducted by the Tissue/Coordinator specialists. An annual summary is prepared for California tissue bank license renewal.

VII. EDUCATION

~~A. Staff with responsibilities related to implantable cellular tissue, receive education during~~

~~orientation and when policy or procedure modifications occur.~~

~~B. Clerks are oriented to noting the FedX routing # for the implant cards on the Tissue Tracking form, coordinating pick-up and delivery of FedX envelopes, and filing the Tissue Tracking form.~~

~~C. The Tissue Coordinator/Nurse Specialists are educated, at the time of promotion or hire, regarding temperature monitoring, tissue tracking standards, inventory par levels, ordering procedures, and tissue source/supplier confirmation.~~

~~D. Materials Management Staff are instructed how to place orders and participate in tissue tracking during orientation.~~

~~E. The Director of Infection Prevention and Control is introduced, during orientation, to the tissue tracking process and to which reports to monitor for compliance or implant related infection.~~

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

VIII. DOCUMENTATION

A. Tissue Tracking Form.

B. Patient procedure record, e.g., in Surgery, the Case Record, and in the Wound Healing Center~~,~~ ~~Wound Expert~~ documentation system.

C. Patient Billing documents.

D. Source/supplier implant documents/card and labels with tissue/bone ID number and product code.

E. Temperature monitoring: computerized record.

F. Surgical Implant Log.

G. On file, source/supplier state licenses and FDA approval stored in tissue tracking system.

IX. ~~EVIDENCE BASED~~ REFERENCES

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Approval Signatures

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

CNO	Lisa Paulo: Chief Nursing Officer	02/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2024
Policy Owner	Carla Knight: Director Perioperative Services	02/2024

Standards

No standards are associated with this document

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Last Approved	N/A	Owner	Earl Strotman: Director Facilities Management & Construction
Last Revised	12/2023	Area	Plans and Program
Next Review	1 year after approval		

Utilities Management Plan

I. SCOPE

A. The Utility Systems Program provides a process for the proper design, installation and maintenance of appropriate utility systems and equipment to support a safe patient care and treatment environment at Salinas Valley Health Medical Center (SVHMC).

B. The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the utility systems, and manage risks associated with the operation and maintenance of utility systems. Finally, the Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education, and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at SVHMC.

II. OBJECTIVES/GOALS

A. Objectives

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

III. DEFINITIONS

A. EOC: Environment of Care Committee

B. AEM: Alternate Equipment Maintenance

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. Patient care providers are trained to understand how utility systems support patient

care, limitations of system performance, safe operating conditions, safe work practices, and emergency clinical interventions during interruptions.

2. Hospital utility systems are highly complex. When upgrades and new installations are proposed, a multidisciplinary group approach is used to ensure that patient care needs, regulatory requirements and industry standards are met.
3. Utility systems are maintained to ensure proper operation and reduce potential for failures.
4. Emergency response procedures are required to manage utility system failures or service disruptions.

B. **Plan Management**

1. **Processes of Managing Utility System Risks**

a. **Management Plan**

i. The organization develops and maintains the Utility Systems Management Plan to effectively manage the utility system risks to the staff, visitors, and patients at SVHMC.

b. **Design and Maintenance of Utility Systems**

i. The Director of Facilities and Construction, Plant Operations is responsible for managing the planning, design, construction, and commissioning of utility systems to meet the patient care and the operational needs of SVHMC. The construction and commissioning programs are designed to assure compliance with codes and standards, and to meet the specific needs of the occupants throughout the facility. The Director of Facilities and Construction, Plant Operations is responsible for setting maintenance standards and implementing a program of planned maintenance and customer service to ensure a safe comfortable environment.

c. **Utility Inventory**

i. SVHMC maintains an inventory of all operating components of the utility systems. These are categorized by potential impact to the safety of patients, staff and visitors in the event of failure. The Director, or designee, assesses systems and components to identify the appropriate maintenance strategies based on risk and impact. Added expectations of leaders and notifications to affected departments written criteria are used to identify risks associated with utility systems. Some of the risks include infections, occupant needs, and systems critical to patient care needs, including life support systems. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of the utility systems. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.

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

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

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

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

i. The Director of Facilities and Construction, Plant Operations identifies in writing the activities used for maintaining, inspecting, and testing all of the operational components of the utility systems in the inventory to assure safety and equipment longevity. The determination of the appropriate activity is made as part of the initial evaluation of equipment, as well as failure trends and equipment history.

ii. Potential activities may be selected to ensure reliable performance including:

a. Preventive maintenance based on manufacturer's recommendations

b. Reliability-centered maintenance based on equipment history

c. Interval-based inspections, tests, inspections, and preventive maintenance activity

d. Corrective maintenance based on direct observation of deficiency or failure of designated testing protocol

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

iii. The results of assessment are used to identify appropriate maintenance strategies, and to identify which equipment may be included in preventive maintenance program.

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

f. **Maintenance, Inspection, and Testing Frequencies**

i. The organization identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all

applicable operating components of utility systems on the inventory. ~~These activities and associated frequencies are in accordance with manufacturers' recommendations or follow an Alternative Equipment Maintenance (AEM) program.~~

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

a. Preventive maintenance based on manufacturer's recommendations

b. Reliability-centered maintenance based on equipment history

c. Interval-based inspections

d. Corrective maintenance based on direct observation of deficiency or failure of designated testing protocol

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

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

iv. A computerized maintenance management system is used to schedule and track timely completion of preventive maintenance activities. Added expectations of leaders and notifications to affected departments

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

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

ii. Reports of the completion rate of scheduled inspection and maintenance are presented to the EC Committee each quarter. If the rate of completion falls below 100%, there will be an analysis to determine the cause of the problem and ~~make recommendations for~~ corrective actions taken.

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

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

activities are documented.

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

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

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

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

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

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

Testing Non-High Risk Components of the Utility System

i. All Non-high-risk utility system components on the inventory are tested, maintained, and inspected. The completion date and the results of the activities are documented.

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

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

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

b. New operating components with insufficient maintenance history to support the use of alternative maintenances strategies.

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

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

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

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

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

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

d. Incident history of identical or similar equipment

e. Maintenance requirements of the equipment

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

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

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

m. **Labeling Controls for Emergency Shutdown**

i. The Director of Facilities and Construction, Plant Operations, or designee is responsible for labeling the locations of critical or emergency controls for a partial or complete shutdown of the utility systems. Critical or emergency operating components of utility systems are identified on historical documents or

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

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

   i. SVHMC has identified and implemented procedures for responding to utility system disruptions or failures. These procedures are developed to include the criteria for implementing a utility response plan. The staff is responsible for making the decisions; activities and resources used to mitigate the emergency (e. g., an emergency power system to mitigate external power failure); and preparation for the failure (e. g., flashlights, staff training about how to respond to a power failure). The response plans are also included in a quick chart which is widely distributed and posted in a number of locations throughout the facility. The recovery plans focus on return to normal conditions, and the resetting and recovery of emergency equipment and supplies.

   ii. The Utility Systems include the following:

      a. Electrical Distribution
      b. Emergency Power
      c. Medical Gas
      d. HVAC
      e. Boiler & Steam
      f. Plumbing
      g. Vertical & Horizontal Transport
      h. Vacuum Systems
      i. Communication Systems

o. **Emergency Clinical Interventions**

   i. SVHMC has identified and implemented emergency procedures for responding to utility system disruptions or failures that require emergency clinical interventions. This is focused on clinical staff and support staff as well. The Environment of Care Committee will assist in obtaining the necessary procedures for those utility systems that could impact on the life support equipment. The clinical staff will be trained on the proper response to the disruption of life support utility services and the method of notifying the appropriate group. The response plans

are also included in a quick chart which is widely distributed and posted in a number of locations throughout the facility.

p. **Emergency Repair Services**

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

q. **Management of Waterborne Pathogenic Agents**

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

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

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

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

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

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

ii. The air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by the Plant Operations

/ Engineering Department. The schedule of regular inspection of filter performance monitoring equipment, air pressure sensing equipment, and air flow rate sensors is managed by the Engineering staff.

iii. A qualified service provider is engaged to verify volume flow rates (air exchange rates, and positive or negative pressure rates) and pressure relationships as part of the commissioning of all new building projects and major space renovations. In addition, the air volume flow rates and pressure relationships are tested periodically throughout the hospital including investigation of complaints related to indoor air quality. The results of testing are used to adjust the performance of air handling systems by changing control software parameters and mechanical or electrical controls.

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

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

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

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

t. **Mapping Utility Systems**

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

ii. Hard copies of the documentation are maintained in Facility Management. Documents that are available in electronic format

are maintained in the Facility Department server and are available to work stations throughout the organization.

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

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

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

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

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

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

2. **PROCESSES MANAGING ELECTRICAL SYSTEMS**

a. **Providing Essential Electrical Circuitry**

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

automatic transfer switch. The transfer of power and operation of the automatic transfer switch are tested regularly.

b. **Electrical Distribution in the organization**

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

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

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

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

c. **Electrical Receptacles**

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

d. **Power Strips**

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

e. **Extension Cords**

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

f. **Wet Procedure Locations**

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

g. **Testing Line Isolation Monitors**

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

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

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

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

b. With the EPS running at rated load, ventilation airflow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer.

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

d. With the EPS running at rated load, ventilation air flow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer.

e. Ventilation air supply shall be from outdoors or from a source outside of the building by an exterior wall opening or from a source outside the building by a 2-hour fire-rated air transfer system.

f. Ventilation air shall be provided to supply and discharge cooling air for radiator cooling of the EPS when running at rated load.

3. **MANAGING EMERGENCY POWER SYSTEMS**

    a. The Director of Facilities and Construction, Plant Operations is responsible for managing a program of inspection, maintenance, and testing of the following essential electrical systems.

    b. **Emergency Electrical Power Systems**

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

            a. Alarm systems, as required by the Life Safety Code

            b. Exit route and exit sign illumination, as required by the Life Safety Code

            c. Emergency communication systems, as required by the Life Safety Code

            d. Equipment that could cause patient harm when it fails, including life support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems

            e. Areas in which loss of power could result in patient harm, including operating rooms, recovery rooms, obstetrical delivery rooms and nurseries

            f. Emergency lighting at emergency generator locations with a remote manual stop station with identifying label to prevent inadvertent or unintentional operation and a remote annunciator (powered by storage battery) located outside the generators location.

            g. Elevators (at least one for non-ambulatory patients)

    c. **Energizing Equipment by Emergency Power**

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

    d. **Battery and Flashlight Availability**

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

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

        i. The Director of Facilities and Construction, Plant Operations, or designee, is responsible for identifying all battery-powered lights installed to provide exit path illumination or for illumination of offsite patient care services.

        ii. The organization performs a functional test of emergency lighting systems and EXIT signs required for egress and task

lighting for a minimum duration of 30 seconds, along with a visual inspection of other EXIT signs. The test results and completion dates are documented.

iii. Every 12 months, the organization performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 ½ hours. The results and completion dates are documented.

iv. The annual test meets the requirements of applicable codes and standards and manufacturer recommendations. An alternate process for some systems is the annual replacement of batteries with random testing of 10% of all batteries for 1-1/2 hours. The date of the testing is recorded.

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

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

g. **Inspecting Emergency Generator Systems**

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

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

i. The Director of Facilities and Construction, Plant Operations or designee, tests emergency generators twelve times a year at intervals not less than 20 days or more than 40 days for at least 30 continuous minutes. The tests are conducted with a dynamic load of at least 30% of the nameplate rating of the generator or meet the recommendations of the manufacturers for prime mover of gas temperature. The completion date of the test is documented.

ii. Appropriate notice of each test run is forwarded to departments throughout the organization. Tests will be delayed if a critical medical procedure is underway and unanticipated failure of the essential electrical system would result in immediate life threatening conditions, but testing is conducted within the defined time frames.

iii. Testing is conducted for at least 30 minutes under full connected load at operating temperature. The test begins with a cold start, and the cool down period is not part of the 30 continuous minutes. Testing time starts when the generator reaches defined operating conditions, generally full operating

temperature of either the exhaust system, or coolant water. Appropriate testing parameters are recorded and evaluated by the Director of Facilities and Construction, Plant Operations, or designee. Any indication of performance below code requirements or expectations is immediately evaluated to determine the source of the problem and rectified.

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

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

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

j. **Monthly Automatic Transfer Switch Test**

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

k. **Testing Generator Fuel Quality**

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

4. **MANAGING THE MEDICAL GAS & VACUUM SYSTEM**

a. The Director of Facilities and Construction, Plant Operations, or designee, is responsible for managing a program of inspection, maintenance, and testing of the following essential medical gas systems.

b. Plant Operations / Engineering Department conduct a preventive maintenance (PM) program on the system at an annual frequency. The maintenance program includes inspecting, testing, and maintaining the critical components of the piped medical gas systems. Components that are maintained include the master signal panels (i. e., high and low

pressure, transfer from normal to reserve indicators), area medical gas alarms, automatic pressure switches (high and low pressure), zone and main shutoff valves, flexible connectors (where installed), and medical gas outlets.

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

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

    i. **Designation of Medical Gas Systems**

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

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

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

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

    ii. **Alarm Systems**

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

    iii. **Storage Room Requirements**

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

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

            ii. Storage is planned so cylinders are used in

order of which they are received from the supplier. Only gas cylinders and reusable shipping containers and their accessories are permitted to be stored in rooms containing central supply systems or gas cylinders.

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

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

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

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

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

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

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

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

a. SVHMC uses certified contractors, or specially trained

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

vii. **Labeling Main Supply Valves**

a. The organization makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (see NFPA 99-2012: Table 5.1.11), and operating pressure if other than standard. Labels are at intervals of 20 feet or less and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency.

viii. **Handling and Transporting Gas Cylinders**

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

ix. **Transfilling Gas Cylinders**

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

with sections NFPA 99-2012

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

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

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

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

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

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

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

gauge HgV.

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

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

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

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

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

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

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

C. **Plan Responsibility**

1. The Chief Engineer works under the general direction of the Director of Facilities and Construction, Plant Operations. They are responsible for operation and maintenance of the utility systems and management of contractors working on the utility systems.

D. **Performance Measurement**

1. **EVALUATING THE MANAGEMENT PLAN**
    a. On an annual basis, the EOC Committee evaluate the scope, objectives, performance, and effectiveness of the Plan to manage the utility system risks to the staff, visitors, and patients at SVHMC.
2. **PERFORMANCE STANDARDS**
    a. The performance measurement process is one part of the evaluation of the effectiveness of the Utility Systems Program. Performance measures are established to measure at least one important aspect of the Utility Systems Program and are meant to focus on areas that need improvement or affect the overall safety of patient, staff, or visitors.

E. **Orientation and Education**

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

V. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	02/2024
Environment of Care Committee	James Hively: Manager Environmental Health & Safety	02/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2024
Policy Owner	Earl Strotman: Director Facilities Management & Construction	12/2023

Standards

No standards are associated with this document

Policy on Reporting and Settlement of Litigation and Claims

Adopted _____ __, 2024

Salinas Valley Memorial Healthcare System is a California local health care district operating as Salinas Valley Health, governed by an elected Board of Directors and subject to requirements for the filing of claims against public entities as provided by Government Code Section 910.

Salinas Valley Health participates as a member in the BETA Risk Management Authority, a California Joint Powers Authority that permits local health care districts to self-insure their liability claims and losses by pooling risk among similar healthcare facilities. As such, BETA acts as Salinas Valley Health's insurer.

Salinas Valley Health has adopted the following Policy on Reporting and Settlement of Litigation and Claims for Salinas Valley Health Medical Center, establishing the authority of the Board of Directors, General Counsel and the Chief Executive Officer (CEO) and requirements with respect to reporting of settlements under healthcare liability claims by department of Risk Management.

1. As used in this Policy, the following terms shall have the meaning specified:

    a. "Claim" shall refer to any demand for payment from an entity or individual presented to the district under the California Tort Claims Act.

    b. "Request for Write-Offs or Reimbursements" for such things as loss items or other items not presented as formal claims can be decided upon by the CEO.

    c. "Litigation" shall refer to legal proceedings in the form of a lawsuit, arbitration proceeding, or internal or external administrative proceeding.

    d. "Consideration" shall refer to a monetary commitment.

2. Settlement Authority of the CEO.

The Board of Directors delegates to the CEO with authority to execute a "Consent to Settle" authorizing BETA Risk Management Authority on behalf of Salinas Valley Health to settle existing claims or litigation up to maximum amount of the policy limits of the insurance provided by BETA Risk Management Authority. Settlement of claims or litigation that requires payment of consideration exceeding the BETA insurance policy limits shall require the concurrence of the CEO, General Counsel, and the approval of the Board of Directors.

3. Reporting on Pending Claims, Litigation and Settlements

    a. Bi-Annually, the Risk Management Department shall provide the CEO, General Counsel, and the Board of Directors a report of all pending claims, litigation and settlements which BETA Healthcare Group determines to have a value in excess of $100,000 per claim. Said report shall be presented in the Closed Session portion of a Regular Meeting of the Board of Directors.

    b. All settlement proposals which require approval by the Board of Directors as provided herein, shall be accompanied by a recommendation from BETA Healthcare Group and/or a recommendation from legal counsel retained by the District, and a statement of the applicable fund source.

QUALITY AND EFFICIENT PRACTICES COMMITTEE

Minutes of the Quality and Efficient Practices Committee will be distributed at the Board Meeting

(CATHERINE CARSON)

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

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

Background information supporting the
proposed recommendation from the
Committee is included in the Board Packet

(JUAN CABRERA)

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

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Mario Roldan, DO, (ii) Contract Terms for Dr. Roldan's Recruitment Agreement, and (iii) Contract Terms for Dr. Roldan's General Surgery Professional Services Agreement**

Executive Sponsor: Allen Radner, MD, Interim President/CEO, Salinas Valley Health
Gary Ray, Chief Legal Officer, Salinas Valley Health

Date: March 11, 2024

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of a physician specializing in **general surgery** as a recruiting priority for the medical center's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, the specialty of general surgery is recommended as a top priority for recruitment. In addition, two general surgeons currently on SVH Medical Staff will become eligible to discontinue their general surgery call requirement. Adding another general surgeon is necessary for continuing coverage of the service.

The recommended physician, **Mario Roldan, DO**, received his Doctor of Osteopathic Medicine Degree in 2016 at A.T. Still University in Mesa Arizona. Dr. Roldan completed his general surgery residency at Oklahoma State University Medical Center in 2021. After completing his training, Dr. Roldan provided general surgery services at St. Joseph's Medical Center in Stockton, CA. Dr. Roldan has immediate family in Salinas and is fluent in Spanish. He plans to join SVH Clinics this June.

Terms and Conditions of Agreements

The proposed physician recruitment requires the execution of two types of agreements:

1. **Professional Services Agreement**. Essential Terms and Conditions:
   - Professional Services Agreement (PSA). Contracted physician under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics. Pursuant to California law, physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
   - Term: PSA is for a term of two years, with annual compensation reported on an IRS W-2 Form.
   - Base Compensation: $450,000 per year.
   - Productivity Compensation: To the extent it exceeds the base salary, physician is eligible for work Relative Value Units (wRVU) productivity compensation at a $74.00 wRVU conversion factor.
   - Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
     - Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
     - Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403(b) plan that vests after three years. This contribution is capped at the limits set by Federal law.
     - Four weeks (20 days) of time off each calendar year.
     - Continuing Medical Education (CME) annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income.
   - Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.
2. **Recruitment Agreement** that provides a recruitment incentive of $50,000, which is structured as forgivable loan over two years of service.

Meeting our Mission, Vision, Goals
Strategic Plan Alignment:

The recruitment of Dr. Roldan is aligned with our strategic priorities for the growth and finance pillars. We continue to develop Salinas Valley Health Clinics infrastructure that engages our physicians in a meaningful way, promotes efficiencies in care delivery and creates opportunities for expansion of services. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by improving access to care regardless of insurance coverage or ability to pay for services.

Pillar/Goal Alignment:

☒ **Service** ☐ **People** ☒ **Quality** ☐ **Finance** ☒ **Growth** ☐ **Community**

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Roldan to SVH Clinics has been identified as a need for recruitment while also providing additional resources and coverage for SVH PrimeCare.

The compensation proposed in these agreements have been reviewed against published industry benchmarks to confirm that the terms contemplated are fair market value and commercially reasonable.

Recommendation

Salinas Valley Health Administration requests that the Personnel, Pension and Investment Committee recommend to the Salinas Valley Health Board of Directors approval of the following:

1. **The Findings Supporting Recruitment of Mario Roldan, DO;**
   - That the recruitment of a general surgeon to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
   - That the recruitment benefits and incentives the District proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;
2. **The Contract Terms of the Recruitment Agreement for Dr. Roldan; and**
3. **The Contract Terms of the General Surgery Professional Services Agreement for Dr. Roldan.**

Attachments

- Curriculum Vitae for Mario Roldan, DO

Mario Roldan, DO

Profile

An experienced and accomplished, results driven surgeon, navy veteran, and recent graduate of Oklahoma State University's general surgery residency program, currently working as an attending surgeon at St. Joseph's Medical Center in Stockton, California. I bring a proactive approach to rendering care in order to achieve the best possible clinical outcome for my patients. I have sought experience in the management of critically ill patients having completed 6 months of trauma/critical care at Saint Francis hospital in Tulsa, Oklahoma and have further augmented my surgical training by moonlighting as an emergency room physician during my time in residency.

Experience

09/2021 - PRESENT; ATTENDING SURGEON - ST. JOSEPH'S MEDICAL CENTER; STOCKTON, CA

During my two years here at St. Joseph's, I did communicate and collaborate with patients and other medical professionals to create a treatment plan that includes preoperative preparations, surgical protocols, and postoperative care in order to produce the best clinical outcome possible. Furthermore I have had the opportunity approximately 225 robotic surgery cases on the Da Vinci Xi platform as well as perform various surgical procedures while taking acute care surgical call and assisting colleagues during gynecologic oncology and foregut surgical cases. I prepare reports and other forms of documentation to keep patient charts updated during pre- and post-surgical hospital stays, and participate in post graduate surgical education by providing mentorship and instruction to the surgery residents of the San Joaquin general surgery residency program, as well as rotating third year medical students from Touro School of Medicine.

07/2016 – 06/2021; SURGERY RESIDENT (CHIEF 2020-2021) – OKLAHOMA STATE UNIVERSITY MEDICAL CENTER; TULSA, OKLAHOMA

While working as a resident, I did acquired thorough experience with the evaluation and management of surgical patients. I completed six months of training in trauma and critical care which has augmented my skills in the management of this patient population. I have had over four years of experience with management of general surgical, and critical care as well as extensive exposure to both upper and lower endoscopy and its requisite endoscopic management of various forms of pathology, as well as wound care management including extensive wound care management. As a resident in the OSU surgical program, we did undergo extensive exposure to robotics and I augmented this area of my training by seeking out further elective rotations with robotic surgical exposure. As we are associated with the Oklahoma State University School of Medicine, a portion fair portion of our training is centered on the teaching of medical students during their third year surgical rotations and hosting their associated educational/instructional events.

- 10/30/2019 - Sole instructor to over 70 medical students on thoracostomy tube insertion, and central line placement.
- 11/19/2019 – Served as an instructor/presenter to the republican senate members on the events of 'Operation Orange', an outreach program sponsored by Oklahoma State University School of Medicine which aims to engage high school students throughout the

state of Oklahoma and provide exposure to careers in medicine
- 10/30/2020 – Served as sole instructor to 70 medical students on placement of thoracostomy tubes, as well as central line placement.

09/2009 – 06/2010: CLINICA TEPATI CLINICAL INTAKER, UNIVERSITY OF CALIFORNIA, DAVIS; DAVIS, CALIFORNIA

While a member of Clinica Tepati, a student run clinic functioning under the auspices of the University of California at Davis, I performed initial assessment of patients by taking patient vital signs and preparing initial paperwork for the medical student's follow up assessment. I further functioned as a translator for Spanish speaking patients and as the head of the clinic's information technology committee, I effectively maintained and updated the clinic website as well as directed the implementation of a clinic staff website and the training of two committee members.

10/1997 – 10/2002: HOSPITAL CORPSMAN, UNITED STATES NAVY

As a hospital corpsman, I functioned as both a field medic and pharmacy technician who trained in rendering aided both Marines and Sailors in everything from first aid to preventive care education. I oversaw the training of 25 platoon Marines in basic lifesaving skills and I.V. administration. I did gain additional training as a pharmacy technician at the Naval School of Heath Sciences in Portsmouth, Virginia and worked in this role for the remainder of my enlistment concluding in Point Loma, CA where I spearheaded the implementation of more efficient prescription handling that resulted in a decrease of approximately 35% in patient wait time and the ability to process some 20,000 monthly prescriptions. This resulted in the awarding of a Naval achievement medal while stationed at the Recruit Training Center command in Point Loma, Ca.

Education

OKLAHOMA STATE UNIVERSITY MEDICAL CENTER, TULSA OKLAHOMA – GENERAL SURGERY; 07/2016 - 06/2021

A.T. STILL UNIVERSITY – SCHOOL OF OSTEOPATHIC MEDICINE, MESA, ARIZONA – DOCTOR OF OSTEOPATHIC MEDICINE; 09/2012 - 05/2016

UNIVERSITY OF CALIFORNIA, DAVIS – B.S. NEUROBIOLOGY, PHYSIOLOGY, AND BEHAVIOR; 09/2007 – 06/2010

Certifications

Doctor of Osteopathic Medicine (D.O.)

Intuitive certified Da Vinci Console Surgeon (9/2022)

BLS, PALS, ACLS

Skills/Interest/Miscellaneous

Fluent in written and spoken Spanish

I enjoy woodworking, Celtics basketball, the films of Quentin Tarantino, and spending time with my wife and three children.

SVMHS Defined Benefit Pension Plan Performance

As of 12/31/2023

Creative Planning Retirement Services

CREATIVE PLANNING®
RETIREMENT SERVICES

SVMHS Pension Plan
Executive Summary: Committee Objectives

- Original objectives articulated by Personnel Pension and Investment Committee in May, 2016
  - Primary Objective
    - Improve the plan's funded ratio
    - Reduce the assumed discount rate used to calculate the plan's liability
  - Manage the Plan Contribution Volatility for budget purposes
  - Long Term view of plan investments
    - Equity investing has risk and Committee will accept some risk
    - Liabilities are long term and investment posture should reflect long term obligations of District
    - Accept a Moderate level of investment risk and volatility
  - Invest in both actively managed and passively managed investments
  - Established investment allocation of 60% equities/40% fixed income

- These objectives were confirmed in September, 2021 and May, 2023 by the Committee with the following change:
  - Asset allocation of 65% equities/35% fixed income with "guard rails" of +/- 5%

SVMHS Pension Plan
Executive Summary: Update Objectives

- Proposal to Committee to update objectives
  - Primary Objective Retained
    - Improve the plan's funded ratio
    - Monitor the assumed discount rate used to calculate the plan's liability
  - Retain the current asset allocation
    - 65% equities/35% fixed income
    - Maintain the "guard rails" of +/- 5%
  - Utilize only passive management strategies
  - Proposed asset allocation
    - Short Term Bonds Index/ Money Market 5%
    - Total Market Bond Index 30%
    - Total Market Stock Index 60%
    - Real Estate Index 5%
  - No allocation to International Equities

Executive Summary:
Proposed Passive Asset Allocation

Proposed Fund	Ticker	Asset Allocation
Vanguard Short Term Bond Index I	VBITX	5%
Vanguard Total Bond Market Index I	VBTIX	30%
Vanguard Total Stock Market Index I	VITSX	60%
Vanguard Real Estate Index I	VSNGX	5%

Proposed Asset Allocation Hypothetical Performance

	One Year Performance January 1, 2023-December 31, 2023	Three Year Performance January 1, 2021-December 31, 2023	Five Year Performance January 1, 2019-December 31, 2023	Inception Performance February 17, 2016-December 31, 2023
Current SVMHS Pension Investment Portfolio	15.47%	2.08%	7.46%	7.43%
Hypothetical Index Based Portfolio	17.94%	4.41%	10.04%	9.49%

Source: Morningstar. Data as of 12/31/2023.

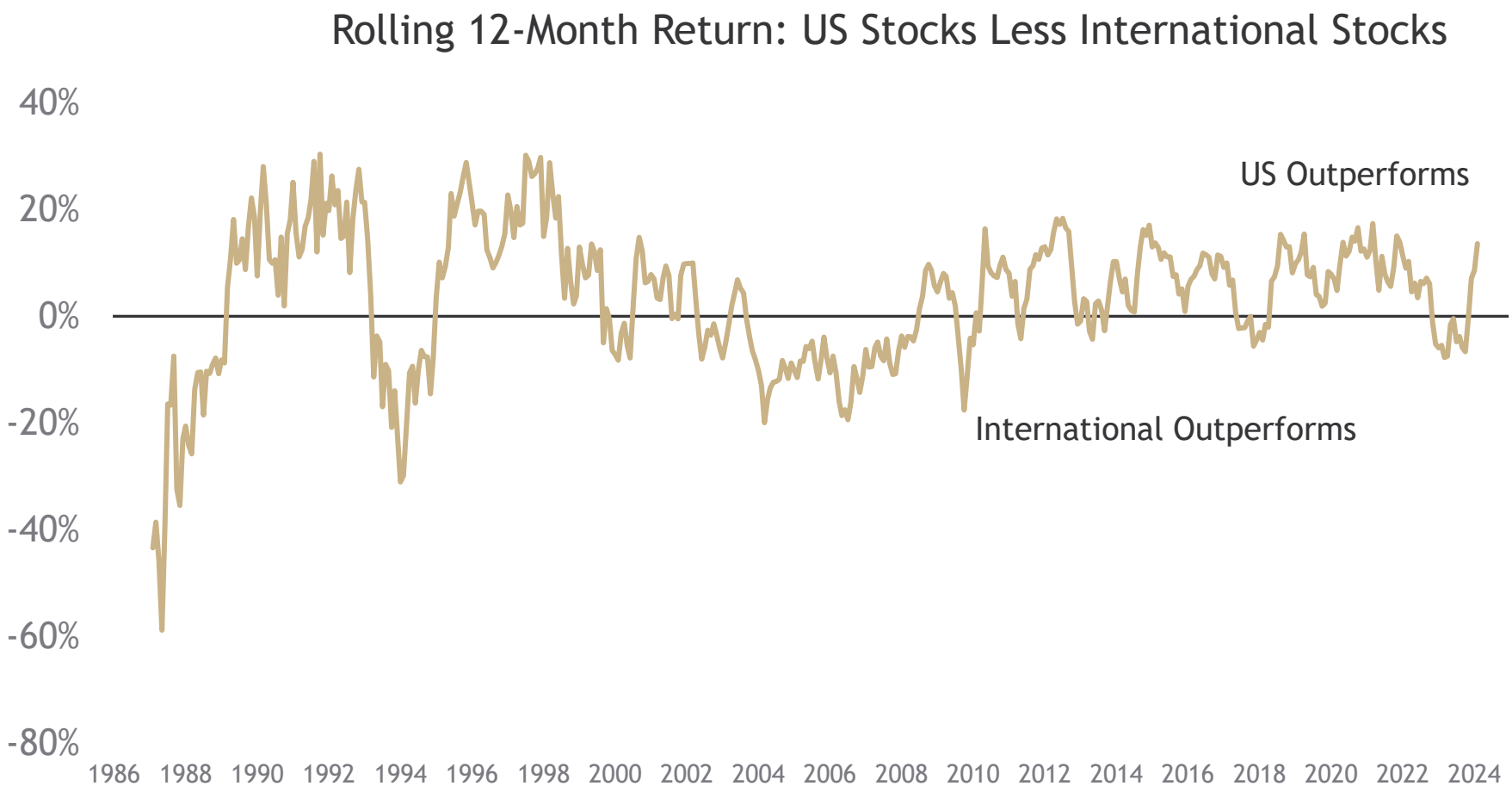
Inception date: 2/17/2016

Performance is net of investment expenses

SVMHS Pension Plan
Executive Summary: Hypothetical Lineup

- Comments
  - Advantages
    - Index based investing will provide the plan a “market” return
    - Committee will focus on asset allocation and not on specific strategies or investment returns
    - Reduction in investment management expenses
  - Considerations
    - Investment volatility cannot be managed to something other than market risk
    - International equities will not be part of asset allocation. This reduces the diversification of the plan assets

US vs International Stocks



Source: Morningstar, monthly returns. Period shown: 3/31/1986 - 2/29/2024. US Stocks represented by the Russell 3000 TR Index, International Stocks represented by the MSCI EAFE GR USD Index.

Employees Pension Plan
Defined Benefit Plan Investment Performance

Investment Performance as of December 31, 2023

One Year January 1, 2023 to December 31, 2023		Three Year January 1, 2021 to December 31, 2023		Five Year January 1, 2019 to December 31, 2023	
Actual	15.47%	Actual	2.08%	Actual	7.46%
Benchmark	15.23%	Benchmark	2.92%	Benchmark	7.81%

Inception performance from February 17, 2016 to December 31, 2023 is 7.43% annualized.
Performance Information obtained from Trust Reports prepared by Transamerica

Performance is actual performance for time period listed and returns are net of investment management fees

Benchmark is custom benchmark for Plan and does not include any investment management fees

Overview of Plan Assets and Investment Return

Date	Assets	One Year Return as of December 31
February 17, 2016	$180,194,217	n/a
December 31, 2016	$215,805,774	n/a
December 31, 2017	$268,172,043	14.63%
December 31, 2018	$263,007,573	-7.38%
December 31, 2019	$331,115,464	19.61%
December 31, 2020	$386,005,926	12.63%
December 31, 2021	$442,374,774	12.06%
December 31, 2022	$403,719,515	-17.70%
December 31, 2023	$459,538,694	15.47

Trust Accounting Overview
January 1, 2022 – December 31, 2023

	January 1, 2022 to December 31, 2022	January 1, 2023 to December 31, 2023
Plan Assets Beginning of Time Period	$442,374,774	$403,719,515
Plan Contributions	$64,157,097	$13,776,419
Benefit Credits	$138,591	$208,015
Benefit Payments	($18,960,982)	($19,961,806)
Transamerica Administration Expenses	($105,554)	($96,394)
Investment Performance	($83,884,411)	$61,892,945
Plan Assets End of Time Period	$403,719,515	$459,538,694

SVMHS Defined Benefit Pension Plan Appendix

As of 12/31/2023

Creative Planning Retirement Services

CREATIVE PLANNING®
RETIREMENT SERVICES

SVMHS Pension Plan
Committee Investment Objectives

- Developed by Personnel Pension and Investment Committee with consulting from Lockton Retirement Services in May, 2016
  - The Pension Plan was established in 1966
- Objectives
  - The PPI Committee's long-term goal is to improve the plan's funded ratio and reduce the discount rate used to calculate the plan's liability
    - Discount rate and funded ratio over time
      - 2014 8.0% with a funded ratio of 77%
      - 2016 7.5% with a funded ratio of 75%
      - Current 6.5% with a funded ratio of 88%
- Contribution Volatility
  - The District wants to limit the annual contribution volatility required to fund the pension plan. This is designed to assist with the District's budgeting process
- Investment Risk and Long-Term Focus
  - The Committee recognized that exposure to equity return risk was necessary to improve funded ratio
  - The Pension Plan is an active plan with liabilities that will extend for decades. A long-term approach to investments will be maintained

SVMHS Pension Plan Investment Objectives

- Asset Allocation
  - At the inception of the relationship with Lockton Retirement Services, the PPI Committee evaluated asset allocations that attempted to balance Equities/Fixed Income including
    - 60% equity, 40% fixed income
    - 70% equity, 30% fixed income
    - 80% equity, 20% fixed income
    - The Committee selected 60% equity, 40% fixed income as an appropriate asset allocation and instructed Lockton Retirement Services to invest according to this allocation
- The PPI Committee has evaluated the Asset Allocation several times over the past 7+ years
  - In general, the PPI Committee has confirmed the initial asset allocation
  - ***In September, 2021, the Committee approved a change to the asset allocation to 65% equities 35% fixed income with guardrails of +/- 5%***
  - ***This allocation was confirmed in May, 2023***

SVMHS Performance Benchmarking vs. Balanced Funds

			Portfolio Composition				Standardized Performance			
Investment	Ticker	Exp Ratio	US Equity	Non-US Equity	Fixed Income	Cash/ Other	1 Year	3 Year	5 Year	Since Inception
SVMHS Defined Benefit Plan	-	0.43	44%	21%	35%	0%	15.47	2.08	7.46	7.43
Fidelity Balanced	FBALX	0.51	58%	4%	37%	1%	21.60	5.58	12.37	11.10
Vanguard Balanced	VBIAX	0.07	61%	0%	38%	1%	17.58	3.73	9.61	9.10
Vanguard STAR	VGSTX	0.31	40%	20%	36%	4%	17.11	1.74	9.34	8.95

Source: Morningstar. Data as of 12/31/2023.
Inception date: 2/17/2016
Performance is net of investment expenses

SVMHS Performance Benchmarking vs. Global Allocation Funds

			Portfolio Composition				Standardized Performance			
	Ticker	Exp Ratio	US Equity	Non-US Equity	Fixed Income	Cash/ Other	1 Year	3 Year	5 Year	Since Inception
SVMHS Defined Benefit Plan	-	0.43	44.0	21.0	35.0	0.0	15.47	2.08	7.46	7.43
Vanguard LifeStrategy Mod Growth	VSMGX	0.13	35.4	23.6	39.0	2.0	15.49	2.21	7.68	7.56
American Funds Global Balanced	RGBGX	0.48	32.9	29.0	30.6	7.4	14.10	2.43	6.99	6.74
Fidelity Advisor Asset Manager 60% Z	FIQAX	0.62	38.8	24.8	36.4	0.1	14.82	2.54	8.61	8.23
SPDR SSgA Global Allocation ETF	GAL	0.35	40.9	24.7	27.3	7.1	13.32	3.27	7.56	7.05
Allspring Asset Allocation Inst	EAAIX	0.80	44.3	18.2	34.0	3.5	14.63	3.24	8.56	7.22
T. Rowe Price Balanced	RBAIX	0.47	44.1	21.3	32.7	1.9	18.10	3.57	9.03	8.84

Source: Morningstar. Data as of 12/31/2023.
Inception date: 2/17/2016
Performance is net of investment expenses

Asset Allocation by Investment Fund
SVMHS Pension Plan vs. Vanguard STAR

SVMHS Pension Investments	Ticker	Asset Allocation	Asset Class	Vanguard STAR (VGSTX) Investments	Ticker	Asset Allocation
Goldman Sachs FS Government Instl	FGTXX	2.00	Money Market-Taxable			
Vanguard Short Term Invest Grade I	VFSIX	3.00	Short-Term Bond	Vanguard Short Term Invest Grade Inv	VFSTX	12.30
iShares US Aggregate Bond Index K	WFBIX	14.00	Intermediate Core Bond (Index)			
PGIM Total Return Bond R6	PTRQX	6.00	Intermediate Core-Plus Bond			
Western Asset Core Plus Bond IS	WAPSX	6.00	Intermediate Core-Plus Bond			
PIMCO Income Instl	PIMIX	4.00	Multisector Bond			
			Long Term Inv Grade Bond	Vanguard Long Term Invest Grade Inv	VWESX	12.70
			Intermediate Government Bond	Vanguard GNMA	VFIIX	12.40
American Century Equity Income R6	AEUDX	7.00	Large Value	Vanguard Windsor	VWNDX	7.70
iShares Total US Stock Market Idx K	BKTSX	7.00	Large Blend (Index)			
PIMCO StocksPLUS® Absolute Return I	PSPTX	8.00	Large Blend	Vanguard Windsor II	VWNFX	14.40
Principal LargeCap Growth I R6	PLCGX	7.00	Large Growth	Vanguard US Growth Investor	VWUSX	12.10
			Large Growth	Vanguard PRIMECAP	VPMCX	6.10
JPMorgan Mid Cap Value L	FLMVX	2.00	Mid-Cap Value			
MassMutual Mid Cap Growth I	MEFZX	2.00	Mid-Cap Growth			
American Beacon Small Cp Val R5	AVFIX	2.00	Small Value			
PIMCO StocksPLUS® Small Institutional	PSCSX	2.00	Small Blend			
Janus Henderson Triton N	JGMNX	2.00	Small Growth	Vanguard Explorer	VEXPX	3.70
			Foreign Large Value	Vanguard International Value	VTRIX	9.40
iShares MSCI Total Intl Idx K	BDOKX	7.00	Foreign Large Blend (Index)			
PIMCO StocksPLUS® Intl (Unhedged) Inst	PSKIX	7.00	Foreign Large Blend			
American Funds Europacific Growth R6	RERGX	7.00	Foreign Large Growth	Vanguard International Growth	VWIGX	9.20
Principal Real Estate Securities Fd R-6	PFRSX	5.00	Real Estate			

Measuring Risk: Standard Deviation Benchmarking as of January 31, 2024

		Standard Deviation
	Ticker	Since Inception
SVMHS Defined Benefit Plan	-	12.79
Vanguard LifeStrategy Moderate Growth	VSMGX	12.63
American Funds Global Balanced	RGBGX	12.90
Fidelity Advisor Asset Manager 60% Z	FIQAX	13.36
SPDR SSgA Global Allocation ETF	GAL	14.47
Allspring Asset Allocation Inst	EAAIX	13.79
T. Rowe Price Balanced	RBAIX	14.31
Fidelity Balanced	FBALX	15.86
Vanguard Balanced	VBIAX	13.75
Vanguard STAR	VGSTX	14.55

Source: Morningstar. Data as of 1/31/2024.
Inception date: 2/17/2016
Performance is net of investment expenses

Fiduciary Committee Action Alternatives
Asset Allocation Strategy

- The Personnel, Pension and Compensation Committee is responsible for determining the asset allocation utilized for the investment of plan assets in the Pension Plan. The Committee directs Creative Planning Retirement Services to invest the assets according to the approved strategy

- Committee Approved Asset Allocation Strategy

Time Period	Asset Allocation	
Inception to September 2021	Equities (including Real Estate) Fixed Income	60% 40%
September 2021 to Current	Equities (including Real Estate) Fixed Income	65% 35%

Fiduciary Committee Action Alternatives Rebalancing Strategy

- The Personnel, Pension and Compensation Committee is responsible for determining the frequency for the rebalancing of investments in the Pension Plan

- Committee Approved Rebalancing Strategy

Strategy	Comments
Current Strategy: Committee permits variance to strategy of +/- 5%	Permits some flexibility in Asset Allocation in attempt to take advantage of market conditions

- Today's Action

Action Item	Comments
Confirm Current Strategy	Allows variance relative to target to attempt to capture return manage risk according to market conditions
Confirm a specific strategy that will reallocate assets to target at the beginning of each calendar quarter	Will provide specific reallocation instructions. This will align return more closely with benchmark but will not allow any variance due to anticipated market conditions

Fiduciary Committee Action Alternatives
Investment Alternative Strategy

- The Personnel, Pension and Compensation Committee is responsible for determining the investment alternatives considered by Creative Planning Retirement Services for the investment of Pension Plan assets

- Investment Alternative Strategies

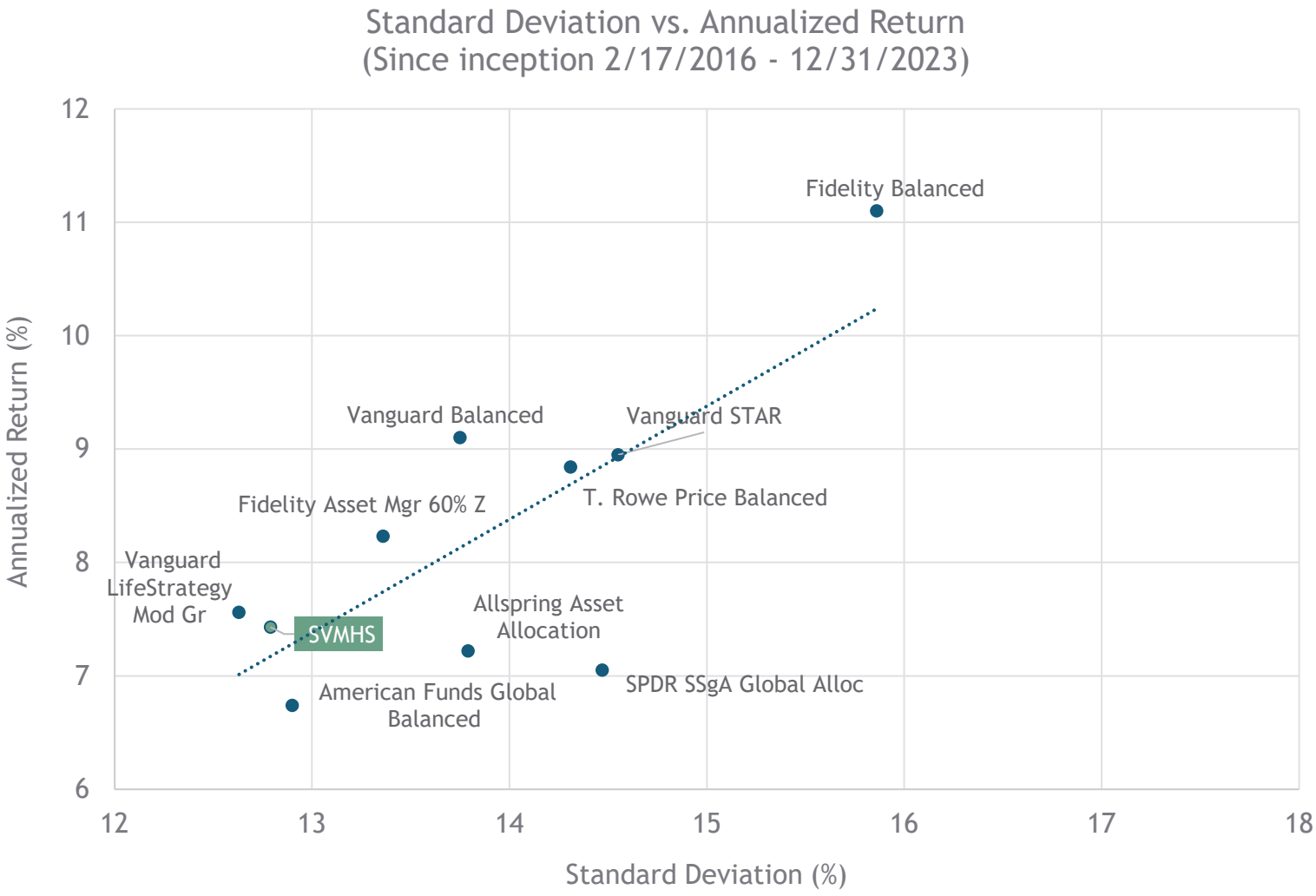
Strategies	Comments
Hybrid: invests in both actively managed and passively managed alternatives	Combines risk management investing in actively managed investments with low cost, benchmark based investments
Passive: invests in passively managed investments that approximate a benchmark	Lowest cost portfolio that will obtain a benchmark rate of return. Risk management of portfolio is more difficult to achieve
Active: invests in actively managed alternatives based on managers analysis	Best for risk management of portfolio but will increase investment management cost

Additional Slides

Current vs. Proposed Allocation

Asset Class	SVMHS Pension Investments	Asset Allocation	Proposed Investments	Asset Allocation
Fixed Income		**35%**		**35%**
Money Market-Taxable	Goldman Sachs FS Government Instl	2%	Goldman Sachs FS Government Instl	5%
Short-Term Bond	Vanguard Short Term Invest Grade I	3%		
Intermediate Core Bond (Index)	iShares US Aggregate Bond Index K	14%	Vanguard Total Bond Market Index	30%
Intermediate Core-Plus Bond	PGIM Total Return Bond R6	6%		
Intermediate Core-Plus Bond	Western Asset Core Plus Bond IS	6%		
Multisector Bond	PIMCO Income Instl	4%		
US Stocks		**39%**		**60%**
Large Value	American Century Equity Income R6	7%		
Large Blend (Index)	iShares Total US Stock Market Idx K	7%	Vanguard Total Stock Market Index Inst	60%
Large Blend	PIMCO StocksPLUS® Absolute Return I	8%		
Large Growth	Principal LargeCap Growth I R6	7%		
Mid-Cap Value	JPMorgan Mid Cap Value L	2%		
Mid-Cap Growth	MassMutual Mid Cap Growth I	2%		
Small Value	American Beacon Small Cp Val R5	2%		
Small Blend	PIMCO StocksPLUS® Small Institutional	2%		
Small Growth	Janus Henderson Triton N	2%		
International Stocks		**21%**		**0%**
Foreign Large Blend (Index)	iShares MSCI Total Intl Idx K	7%		
Foreign Large Blend	PIMCO StocksPLUS® Intl (Unhedged) Inst	7%		
Foreign Large Growth	American Funds Europacific Growth R6	7%		
Real Estate		**5%**		**5%**
Real Estate	Principal Real Estate Securities Fd R-6	5%	Vanguard Real Estate Index	5%

SVMHS Historical Risk/Return Benchmarking vs. Other Allocation Funds



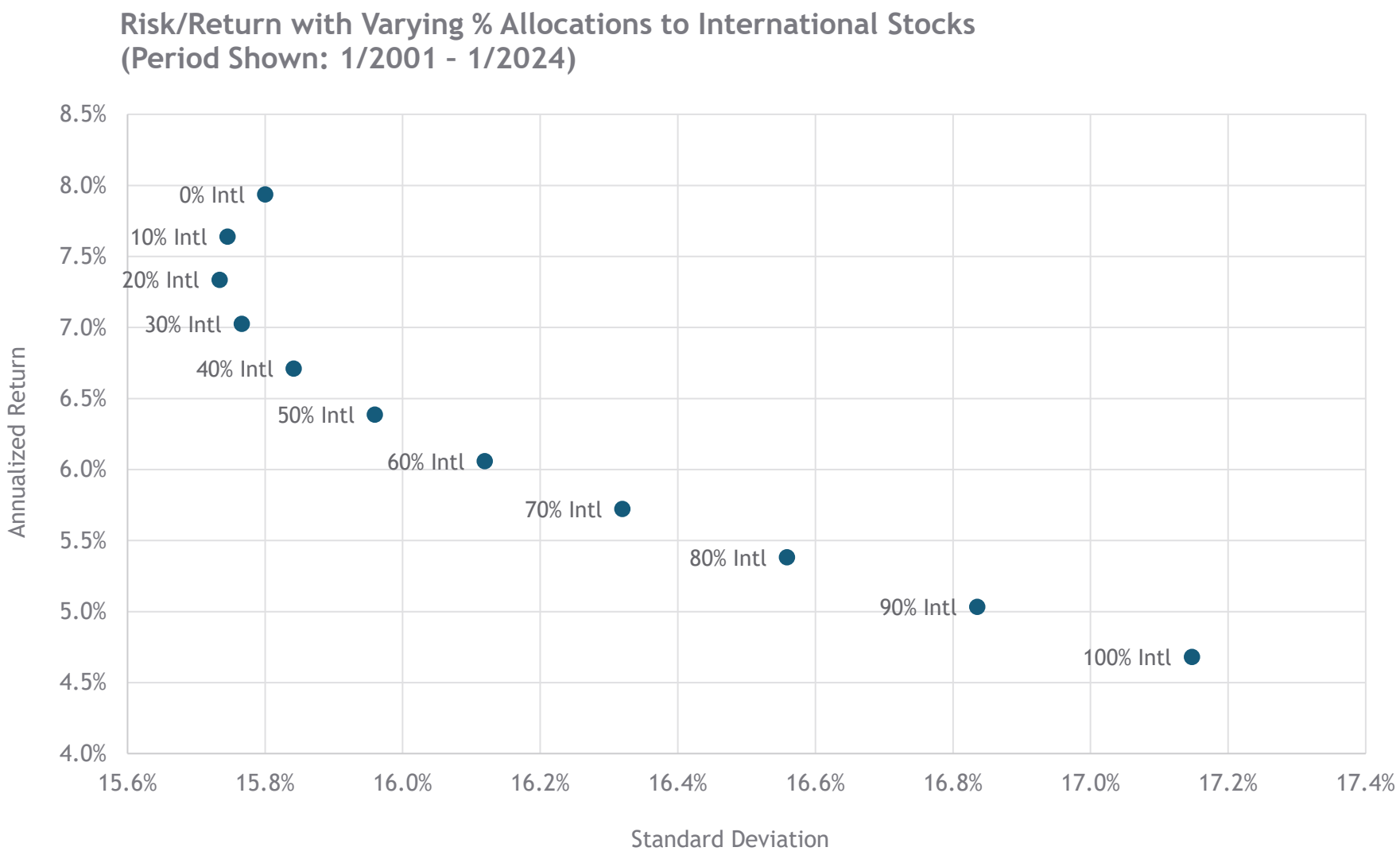
Capital Market Assumptions

	US Stocks	ex-US Stocks
5 year expected return	4.00%	8.80%
10 year expected return	4.80%	8.60%
20 year expected return	6.10%	8.10%
Volatility	17.40%	17.00%

This information is not intended as a recommendation to invest in any particular asset class or strategy or as a promise - or even estimate - of future performance.

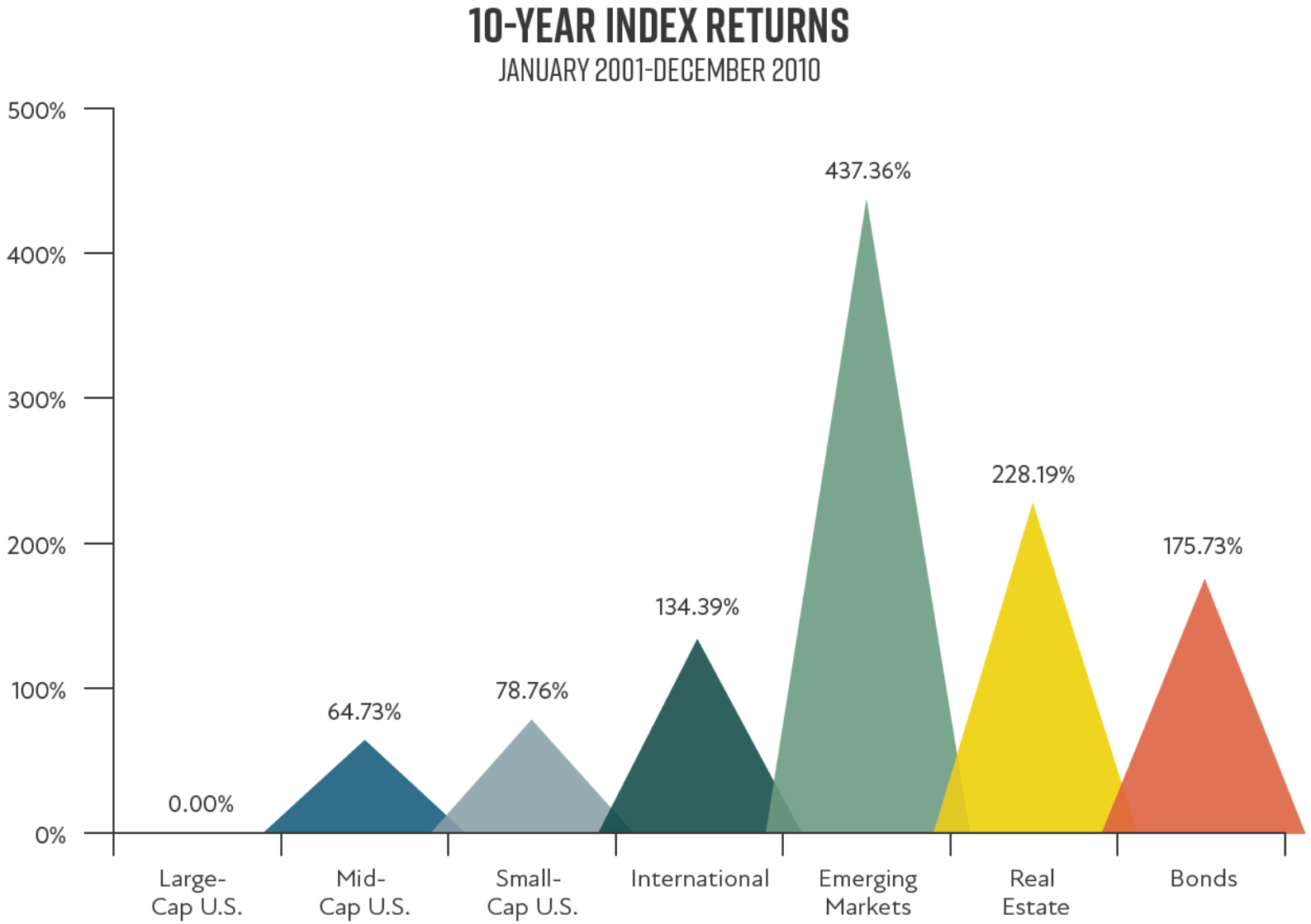
Source: BlackRock Investment Institute, February 2024. Data as of 29 December 2023.

International Exposure



Source: Morningstar, monthly return data. US Stocks represented by the Russell 3000 TR Index. International stocks represented by the MSCI ACWI ex USA Index.

Why Not Just Invest in the S&P 500?



Source: Standard & Poors, MSCI, Barclay's Capital, Google Finance, Dow Jones. Benchmark indexes such as the S&P 500 Index are unmanaged, broadly based indexes. It's not possible to invest directly in a benchmark index.

Sally Johnson

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Sally serves as a Managing Director for Creative Planning Retirement Services. She has spent her entire career of 20+ years, in the retirement plan industry. Previously she held positions at Wealth Plan Advisors, Inc., and Principal Financial Group. Her specialization is in helping plan sponsors build programs to truly get the most out of their retirement plans and carefully navigate their role as Fiduciaries.

Sally and her team have broad experience across all types of retirement plan solutions including ESOPs, Defined Benefit, Defined Contribution, and Executive Benefits. Her clients value how she helps them protect their businesses and provide security for their employees through comprehensive advice, a disciplined process and consistent delivery of results.

Sally received her Bachelor of Arts degree from Simpson College. She is a proud Member of the National Association of Plan Advisors and serves as Co-Chair to Women in Leadership. In her spare time Sally also serves with Girl Scouts of America and Women in Mentoring for the Phoenix Business Journal.

In 2021 Sally earned an award as a Top Women Advisor All Star with the National Association of Plan Advisors.

*Disclosures: Rankings and/or recognition by unaffiliated rating services and/or publications should not be construed by a client or prospective client as a guarantee that he/she will experience a certain level of results if the Wealth Advisor is engaged, or continues to be engaged, to provide investment advisory services, nor should it be construed as a current or past endorsement of the Wealth Advisor by any of his/her clients. Rankings published by magazines, and others, generally base their selections exclusively on information prepared and/or submitted by the recognized Wealth Advisor. Rankings are generally limited to participating advisors. The Wealth Advisor does not pay a fee to be considered for any ranking or recognition but may purchase plaques or reprints to publicize rankings.

National Association of Plan Advisors Top Women Advisor award, as with other NAPA Net industry lists (Top DC Wholesalers, Top Retirement Plan Advisors Under 40), we began by asking NAPA Firm Partners to nominate candidates for this recognition. Nominees were asked to respond to a series of questions, both quantitative and qualitative, about their experience and practice. Those anonymized questionnaires were then reviewed by a blue-ribbon panel of judges who, over the course of several weeks, selected the women honored in three categories: **Captains**: All-stars who happen to be principals, owners or team captains of their organizations; **All-Stars**: Top producers who have their own practice. **Rising Stars**: Top producers who have less than five years of experience with retirement plans as a Financial Advisor (some have been working with plans longer, but not as a plan advisor).

Andrew Scalia

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Andrew is a Consultant for Creative Planning Retirement Services. He has over 25 years of industry experience working with defined contribution, defined benefit, and nonqualified retirement plans. He has a broad range of experience in the areas of relationship management, plan conversions and plan administration. He assists his clients with investment advisory duties, fiduciary risk profiles, plan design, compliance reviews, audit preparation, fee benchmarking, and plan marketing and provider oversight.

Andrew received his Bachelor of Arts degree in Business Administration and Finance from the University of St. Thomas, St. Paul, MN. Previously, Andrew was employed with Lockton Companies and Wells Fargo.

Dan Lennington, FSA, EA, FCA, MAAA

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Dan Lennington has over 20 years of experience as a retirement actuary, consulting on both qualified and nonqualified pension plans. Prior to joining Creative Planning Retirement Services as the Director of Defined Benefits Advisory, Dan was a Senior Consulting Actuary at Willis Towers Watson where he began his career in 2000.

Dan is experienced in consulting on both large and small defined benefit plans ranging in asset size from $10 million to greater than $12 billion, specializing in strategic consulting on de-risking plan design and pensions. His experience includes pension funding and accounting actuarial valuations; retiree medical accounting valuations; defined benefit legislative and regulatory analysis; consulting on mergers, acquisitions and divestitures; plan compliance and government form filings; employee communications; experience studies and plan assumption reviews; consulting on the Pension Protection Act; consulting on executive pension benefits; defined benefit plan design changes and implementation; defined contribution plan design; consulting on defined benefit financial risk implications and strategy; and consulting on pension risk transfer and plan termination solutions.

Dan's focus at Creative Planning Retirement Services is centered on helping companies manage balance sheet and income statement risk associated with pension plan obligations, developing plan design, and funding strategies, and providing investment management glidepath consulting. Dan partners with his clients to develop de-risking strategies, as well as provide full plan termination and annuity purchase consulting.

Dan received his Bachelor of Science, Actuarial Science degree from the University of Manitoba.

Dan is a Fellow of the Society of Actuaries (FSA) as designated by Society of Actuaries, an Enrolled Actuary (EA) as designated by the Internal Revenue Service, a Fellow of the Conference of Consulting Actuaries (FCA) as designated by Conference of Consulting Actuaries, and a Member of the American Academy of Actuaries (MAAA) as designated by American Academy of Actuaries.

Sean Grzyb, CFA®

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Sean Grzyb is a Director of Investments for Creative Planning Retirement Services. Sean is responsible for managing investment research and analysis for investment recommendations. Sean works closely with the national investment to provide research and analytical tools to Creative Planning Retirement Services advisors and clients.

Sean's focus includes quarterly investment reviews, investment selection and monitoring, investment product research and investment thought leadership. Sean regularly meets with investment managers and performs new product reviews.

Sean received his B.S. Magna Cum Laude in Finance from DePaul University.

COMMITTEE RECOMMENDATION

Consider recommendation for Board of Directors approval of the proposed investment asset allocation for the Salinas Valley Memorial Healthcare District Employee Pension Plan assets to allocate future plan investments in passively managed investments (index funds) and minimal or no investment in international equities.

FINANCE COMMITTEE

Minutes of the Finance Committee
will be distributed at the Board Meeting

Background information supporting the
proposed recommendations from the
Committee is included in the Board Packet

(JOEL HERNANDEZ LAGUNA)

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

Board Paper—Finance Committee

Agenda Item: **Consider recommendation to the SVH Board of Directors to approve (i) the purchase of an additional 5.9143 units of Voting Membership Interests in Monterey Peninsula Surgery Center for the amount of $196,500.00, and (ii) the execution of the MPSC Subscription Agreement by the Interim President/CEO**

Executive Sponsor: Allen Radner, MD, Interim President/CEO
Gary Ray, Chief Legal Officer

Date: March 20, 2024

Executive Summary

A key strategic objective for Salinas Valley Health is to develop and expand partnerships that drive value for our patients. Recognizing the importance of providing a low cost, high quality option for surgical services needed by our residents, Salinas Valley Health has pursued greater investment in our partnership with Monterey Peninsula Surgery Center (MPSC). SVH presently owns slightly more than 13.5% of MPSC, which operates surgery centers in Salinas, Monterey, and Santa Cruz.

MPSC has notified SVH that there are additional shares available for purchase and MPSC's board has approved the sale of an additional member interest to SVH. The company valuation of MPSC was most recently appraised at six hundred fifty-five thousand dollars ($655,000) per one percent (1%) for voting units. The proposed transaction is the acquisition of **5.9143 voting membership interests** at a purchase price of **one hundred ninety-six thousand five hundred dollars ($196,500.00)**. This additional investment will increase SVH's total ownership interest in MPSC to just under fourteen percent (13.8206%). Estimated MPSC market value attached.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment

The increase in our investment in MPSC is aligned with the further develop of population health management capabilities and the development of a sustainable cost structure. Population health management requires expansion of services beyond the walls of SVH. As a high quality, lower cost option for some surgical services, MPSC represents a significant value to our patients. Additionally, MPSC is a well-managed business that has generated a historically stable return on investment for SVH.

Pillar/Goal Alignment: ☐ Service ☐ People ☐ Quality ☑ **Finance** ☑ **Growth** ☐ Community

Financial/Quality/Safety/Regulatory Implications

This investment represents an expansion of our current ownership interest in MPSC at fair market value as determined by the most recent independent appraisal of MPSC and as such, there is no quality, safety or regulatory implications related to this transaction. MPSC Subscription Agreement attached.

1. MPSC Valuation	$655,000 per one percent (1%) voting interest
2. Additional MPSC Interest Offered	5.9143 units of voting membership interest
3. Additional Investment Amount	One hundred ninety-six thousand five hundred dollars ($196,500.00)
4. Documentation	Subscription Agreement for Purchase of Voting Membership Interests

Recommendation

Administration requests that the Finance Committee recommends to the SVH Board of Directors to approve (i) the purchase of an additional 5.9143 units of Voting Membership Interests in Monterey Peninsula Surgery Center for the amount of $196,500.00, and (ii) the execution of the MPSC Subscription Agreement by the Interim President/CEO

Estimated Market Value of MPSC Ownership
Salinas Valley Health

MPSC, Inc.	Salinas Valley Health	
	As of February 1, 2024	*As of April 1, 2024*
Ownership Shares	246	246
Total Outstanding Shares	5829.103	5829.103
% Ownership in MPSC, Inc.	4.22%	4.22%
MPSC, Inc.'s % Ownership in MPSC, LLC	16.10%	16.10%
Company Valuation per 1%	$655,000	$655,000
MPSC, Inc.'s Ownership Value MPSC, LLC	$10,545,693	$10,545,693
Ownership Value in MPSC, Inc.	**$445,049.69**	**$445,049.69**

MPSC, LLC	Salinas Valley Health	
	As of February 1, 2024	*As of April 1, 2024*
Ownership Shares	257.3690	263.2833
Total Outstanding Shares	2003.511	2003.511
% Ownership in MPSC, LLC	12.84590%	13.14110%
Company Valuation per 1%	$655,000	$655,000
	$8,414,064.50	**$8,607,420.50**

Total Combined Ownership % (Inc. & LLC)	13.5254%	13.8206%
Total Combined Ownership Value (Inc. & LLC)	**$8,859,114.19**	**$9,052,470.19**

Current Cost of Investment in MPSC

$2,515,927
$230,498
$2,629,777
$281,228
$387,656
$525,538
$262,000
$6,832,625

Cost of Additional Shares: **$196,500.00**

Cost of Investment for 13.8206% Interest is MPSC
$7,029,125

Distributions from MPSC

Fiscal Year	Amount
FY2013	$452,781
FY2014	$751,960
FY2015	$836,794
FY2016	$761,298
FY2017	$1,078,405
FY2018	$1,537,425
FY2019	$1,644,718
FY2020	$1,624,692
FY2021	$1,409,648
FY2022	$2,131,431
FY2023	$1,560,619
FY2024	$1,023,132
Total	**$14,812,902**

SUBSCRIPTION AGREEMENT FOR PURCHASE OF 5.9143 UNITS OF VOTING MEMBERSHIP INTERESTS OF MONTEREY PENINSULA SURGERY CENTER, LLC, A CALIFORNIA LIMITED LIABILITY COMPANY AND REPRESENTATIONS OF PURCHASER
April 1, 2024

The undersigned entity ("Purchaser") hereby agrees to purchase five point nine one four three (5.9143) units of Voting Membership Interests ("Voting Membership Units") of Monterey Peninsula Surgery Center, LLC, a California limited liability company ("MPSC") for the sum of One Hundred Ninety Six Thousand Five Hundred Dollars ($196,500.00) payable April 1, 2024 ("Subscription Agreement") pursuant to the terms and conditions set forth herein as follows:

1. The Purchaser is an existing holder of Voting Membership Units and a Member of MPSC having previously acquired Voting Membership Units. In consideration of the Purchaser's obligations set forth herein, MPSC consents to issuance of additional Voting Membership Units to the Purchaser.

2. The Purchaser hereby agrees that the Voting Membership Units acquired herein are governed by the terms and conditions of the Fourth Amended and Restated Operating Agreement for Monterey Peninsula Surgery Center, LLC, a California limited liability company dated as of January 18, 2012 and as amended from time to time prior to the date hereof (herein "Governing Document").

3. The Purchaser acknowledges and confirms its agreement to all terms and conditions of the above referenced Governing Document, and by its signature hereunder agrees to be bound by all representations and warranties made by it in any previous Subscription Agreement executed by it, with respect to the Voting Membership Units acquired pursuant hereto, including, but not limited to, **restrictions on transfer as set forth in the Governing Document and the provisions regarding noncompetition as set forth in Article 9 of the Governing Document.**

4. The Purchaser confirms that the Purchaser has relied solely upon its own and its advisors' investigation and review of information with respect to the purchase made herein and has relied in accepting this offer to purchase on no promise or representation of MPSC or any agent or representative on behalf of MPSC. The Purchaser confirms that it is not represented in this transaction by the firm of Horan Lloyd A Professional Corporation or any attorney associated with said law firm and has been advised to review the terms hereof with independent counsel and has had an opportunity to do so.

5. The Purchaser agrees to execute such other and further documents as shall be necessary to affirm and constitute the Purchaser's acceptance and agreement to the terms and conditions of this Subscription Agreement and the Governing Document.

This Subscription Agreement, when signed by the Purchaser, shall constitute a binding agreement for purchase of Voting Membership Units pursuant to the terms set forth above and its agreement to be bound to all terms and provisions of the Governing Document.

PURCHASER SIGNATURE:

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

By: _____
_____, _____

6. MPSC hereby accepts this Subscription Agreement and has authorized the undersigned officer of MPSC to execute this Subscription Agreement on MPSC's behalf.

Monterey Peninsula Surgery Center, LLC, a California limited liability company

By: _____
David Awerbuck, M.D., President

Board Paper: Finance Committee

Agenda Item:	Consider Recommendation for Board Approval of contract for perfusion services with Prime Perfusion Inc.
Executive Sponsor:	Carla Knight, Perioperative Services Director Clement Miller COO
Date:	March 25, 2024

Executive Summary

The perioperative services department is seeking approval to enter into a Perfusion Services Agreement between Salinas Valley Memorial Healthcare System (SVMHS) and Prime Perfusion, Inc. for a two (2) year term through March 2026. Approval of this contract will allow the Cardiac Service line to transition to a new provider of perfusion services, following the completion of the required RFP process. This transition is a 27% increase over our current provider, increasing our monthly expense from $54,337.50 to $69,000.00, but was the lowest bidder of the three proposals received.

Background/Situation/Rationale

The current demand for perfusionists is exceedingly high, with staffing shortages in hospitals throughout the country. At most, there are 120-150 new perfusion graduates in a year in the United States.

Perfusionists are certified medical technicians responsible for extracorporeal oxygenation of the blood during open-heart surgery and for the operation and maintenance of the equipment (such as a heart-lung machine) controlling it. Perfusionists are vital members of the cardiovascular surgical team because they are responsible for operating the heart-lung (cardiopulmonary bypass) machine. The heart-lung machine diverts blood away from the heart and lungs, adds oxygen to the blood, then returns the blood to the body—all without the blood having to go through the heart. During surgery, perfusionists use the heart-lung machine to maintain blood flow to the body's tissues and regulate levels of oxygen and carbon dioxide in the blood. Perfusionists are also responsible for measuring selected laboratory values (such as blood cell count) and monitoring circulation.

The low rate of available perfusionists coupled with the increased demand for their services has dramatically increased the rate required to secure a team that can effectively support our cardiac surgery and structural heart programs 24 hours a day, 7 days a week. In addition to Prime, our team reached out to an additional three perfusion service providers to assess the availability and cost of potentially transitioning to a new provider. The outcome of the inquiry confirmed that transitioning to a relationship with Prime Perfusion Inc is the best option for Salinas Valley Health, due to availability of services in our area, the overall cost of the contract, and the team's commitment to our organizations cardiac program.

Timeline/Review Process to Date:

[1/2024] Perfusion Services RFP Initiated

[3/2024] Contract Finalized with Prime Perfusion Inc

[4/1/2024] Current Perfusion Services Agreement Expiration Date

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

Approval of this contract will allow our organization to continue to provide high quality cardiac surgical services and maintain our growing structural heart program.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

Key Contract Terms	Vendor: Prime Perfusion Inc.
1. Proposed effective date	4/1/2024
2. Term of agreement	2 years
3. Renewal terms	Every two years
4. Termination provision(s)	Without cause with 60 day notice, immediate with cause
5. Payment Terms	Monthly @ $69,000/month
6. Annual cost	$828,000
7. Cost over life of agreement	$1,656,000
8. Budgeted (indicate y/n)	Y

Recommendation

Consider Recommendation for Board Approval for the Two (2) year Perfusion Services Agreement with Prime Perfusion, Inc for total cost of $1,656,000.

Attachments

(1) Perfusion Services Agreement Proposal

(2) RFP

PERFUSION SERVICES AGREEMENT

THIS PERFUSION SERVICES AGREEMENT ("Agreement") is made and entered into as of April 2, 2024 ("Effective Date"), by and between Salinas Valley Memorial Healthcare System, a local health care district organized and operating pursuant to Division 23 of the California Health and Safety Code, operating as Salinas Valley Health ("Hospital") and Prime Perfusion Inc., an Oregon corporation ("Company").

RECITALS

A. Hospital owns and operates an acute care facility located at 450 East Romie Lane, Salinas, California ("Facility") and is in need of qualified perfusion services in order to assist in the performance of extracorporeal bypass cardiac surgery and autotransfusion at Hospital ("Services");

B. Company employs or otherwise contracts with clinical perfusionists (individually "Perfusionist", collectively "Perfusionists") who are duly certified and/or licensed in the State of California ("State"), and qualified to perform such Services;

In consideration of the recitals above and the mutual covenants and conditions contained herein, Hospital and Company agree as follows:

1. RESPONSIBILITIES AND OBLIGATIONS.

a. Services. While this Agreement is in effect, Company shall provide Perfusionists to perform those Services set forth at Exhibit A, attached hereto and as described in this Section 1. The Services are for coverage of one (1) operating room at a time, with such coverage being provided either through a Perfusionist at a regularly scheduled procedure or by a Perfusionist being "on call." This Agreement does not obligate Company to provide more than one Perfusionist to be present at the Facility or to be otherwise "on call" at any one time. The Hospital may, as set forth below, request more than one Perfusionist at one time, but the Company is not obligated to provide more than one.

b. Emergency Back-Up Services. If there is an emergency requiring a second Perfusionist at the Facility, the Hospital may request that the Company provide a second Perfusionist on an emergent basis. Company has no obligation to do so, as there may not be a second Perfusionist available. If a second Perfusionist is available, then the provision of such additional Perfusionist is included within the Services provided under this Agreement. Hospital releases and shall indemnify and hold Company harmless from and against any and all claims, damages, liabilities, costs, suits, actions, or other expenses (including but not limited to attorney fees) arising from or related to any failure to provide such emergency back-up Services.

c. Applicable Standards. Company and each Perfusionist agree that all Services provided pursuant to this Agreement shall be performed in compliance with all applicable standards set forth by law or ordinance or established by the rules and regulations of any federal, state or local agency, department, commission, association or other pertinent governing, accrediting, or advisory body, including The Joint Commission, having authority to set standards for health care facilities. Also, each Perfusionist shall perform all Services in accordance with all applicable Hospital rules, regulations, procedures, policies and bylaws.

d. Compliance Program. Company shall comply with the Hospital's Corporate Compliance Program ("Program"), as applicable to the Services provided under this Agreement. Hospital represents that it has provided Company with all of the Program in writing prior to the Effective Date of this Agreement. Company agrees to comply with any Program policies and procedures duly adopted by the Hospital that are provided to Company at least thirty (30) days in advance of implementation. In the event that any changes to the Program are detrimental to the Company, Company may elect to terminate this Agreement prior to the date that such Program changes are implemented.

e. Records and Reports. Each Perfusionist shall promptly document all treatments and procedures performed pursuant to this Agreement. Each Perfusionist shall use the medical records and report forms, whether paper or electronic, as provided by Hospital Operating Room ("OR") to document treatments

and procedures. Company and each Perfusionist agree that all records and reports required by this Subparagraph shall be the exclusive property of Hospital. Hospital agrees to provide Company access to any records to the extent required by applicable law.

f. Professional Qualifications. Company shall ensure that each Perfusionist providing Services hereunder shall at all times:

(1) Possess certification, or is Board Eligible, as a Perfusionist in the State of California; and

(2) Register and remain fully current with Hospital's vendor credentialing and tracking mechanism and requirements ("Vendor Credentialing").

g. Representations and Warranties. Company represents and warrants to Hospital upon execution and while this Agreement is in effect, as follows:

(1) Neither Company nor any Perfusionist is bound by any agreement or arrangement which would preclude Company or any Perfusionist from entering into, or from fully performing the Services required under, this Agreement;

(2) To Company's knowledge, no Perfusionist's license /certification to practice in the State or in any other jurisdiction has ever been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way;

(3) To Company's knowledge, no Perfusionist's privileges or permission to perform services at any health care facility have ever been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction;

(4) Each Perfusionist has, and shall maintain throughout this Agreement, an unrestricted license/certification to practice as a Perfusionist in the State and current status with Vendor Credentialing as necessary to perform the Services; and

(5) Company warrants that, to its knowledge, neither Company nor its employees/agents performing services under this Agreement have been excluded from participation in federal or state healthcare programs. If an employee/agent performing services under this Agreement is excluded, Company will promptly replace that employee/agent. If Company is excluded, Hospital may terminate this agreement, without penalty, upon written notice to Company.

h. Use of Hospital Facilities. Any facilities, equipment, supplies, or personnel provided by Hospital shall be used by Company and each Perfusionist solely to provide Services under this Agreement and shall not be used for any other purpose whatsoever. This Agreement shall not be construed as a lease to Company or any Perfusionist of any portion of Hospital's facilities; insofar as each Perfusionist may use a portion of Hospital's facilities, each Perfusionist does so as a licensee only, and Hospital shall at all times have full and free access to the same.

i. Quality Measures. Company will submit the following measures to Hospital on a quarterly basis:

Metric Name	Measurement System	Frequency of Review	Target
Minimum SvO2 of 65% maintained during cardiopulmonary bypass	Provided by Company	Quarterly	90%
All ACT's before and during cardiopulmonary bypass should by >400 seconds	Provided by Company	Quarterly	90%
Maintain proper Potassium (K+) level during cardiopulmonary bypass	Provided by Company	Quarterly	80%
HMS electronic QC performed and documented as required	Record on Machine, in log	Quarterly	100%

2. RESPONSIBILITIES OF HOSPITAL.

a. Equipment, Facilities, Supplies, Utilities and Services. Hospital shall, at no cost to Company, provide all equipment, facilities, supplies, utilities, including in-house telephone service, and other services, including laundry, linen and janitorial services, as the Hospital shall, in its sole discretion, determine from time to time to be necessary for the performance of the Services. Perfusionists shall have access to the physician's lounge at the Hospital. If Company determines that such items are insufficient to perform the Services, then the Company may upon ten (10) days' notice to the Hospital elect to terminate this Agreement. The parties expressly agree that all items supplied by Hospital pursuant to this Subparagraph shall remain the exclusive personal property of Hospital. Notwithstanding the foregoing, Hospital may request assistance from Company in securing quotes for supplies from vendors.

b. Personnel. Company shall employ or contract for such personnel as Company deems necessary for the proper performance of the Services or any other Company obligation set forth in this Agreement. The parties hereby agree that all such personnel shall be subject to the direction and control of Company or Perfusionists in its or their performance of professional services to patients.

3. COMPENSATION.

a. Monthly Payments. For the Services rendered by Company to include two Perfusionists, Hospital shall pay Company the amount of Sixty-Nine Thousand Dollars ($69,000.00) per month for the first twelve-month period. Thereafter, fees will be increased annually to no less than one percent (1%) and no more than three- and one-half percent (3.5%) based on the increase on each anniversary of the Effective Date in the US Bureau of Labor Statistics Consumer Price Index for All Urban Consumers (CPI-U). Should Hospital in its sole discretion elect to add additional Perfusionist(s) to provide/cover on-going Services at Hospital, Hospital shall increase the compensation to Company for the Services by Thirty-Two Thousand Dollars ($32,000.00) per month. Hospital agrees to provide sixty (60) days prior notice when requesting the Services of any additional Perfusionist. The Monthly Payments will be NET Forty- five Days (45). Any amounts unpaid when due accrue interest at the rate of one percent per month.

b. Vacation Relief. It is understood by Hospital that at various times during the contract period, that vacation will be taken by a Perfusionist. Vacation will be taken by only one (1) Perfusionist at a time and during this time the Hospital will have one (1) Perfusionist to cover all necessary work, call and caseload. For up to twelve (12) weeks per year, Company may provide coverage during times of vacation from another Perfusionist from Company. This additional Perfusionist shall cost Hospital a daily rate of One Thousand Two Hundred Dollars ($1,200.00) per day plus expenses actually incurred.

c. Locums Tenens. If at any time the Company does not have a full-time employee as one (or more) of the Perfusionists, the Company may provide a locums tenens or temporary Perfusionist instead (a "Traveler").

(1) During the first six (6) months following the Effective Date of this Agreement ("Initiation Period"): There is no additional charge to Hospital for the first twenty-one (21) days of a calendar month for services from a Traveler. For each day thereafter in a calendar month, Hospital shall pay Company One Thousand Two Hundred Dollars ($1,200.00) per day plus expenses actually incurred. Company shall make reasonable efforts to try and schedule Travelers for as few days each month as possible, while meeting the vacation relief, on-call schedule, and Hospital requirements.

(2) After the first six (6) months following the Effective Date of this Agreement ("Initiation Period"): There is no additional charge to Hospital for services from a Traveler. Company shall make reasonable efforts to try and schedule Travelers for as few days each month as possible, while meeting the vacation relief, on-call schedule, and Hospital requirements.

d. Expenses Actually Incurred. Hospital shall additionally reimburse Company for actual airfare (economy, coach, or other similar class of fare only), automobile mileage for private automobile (at the then-current Internal Revenue Service rate), rental car expense (limited to $75 per day of rental), hotel charges

(limited to $275 per night), and credentialing fees and expenses. All charges for a Traveler for vacation relief are due regardless of whether any procedures are performed and include all weekends, holidays, and travel days. The expense reimbursement described under this Section shall only be available for expenses actually incurred in connection with a Traveler for locums tenens coverage during the first six (6) months following the Effective Date of this Agreement. After the first six (6) months following the Effective Date of this Agreement, there shall be no expense reimbursement under this Section for locums tenens. For the sake of clarity, expense reimbursements described in this Section for a Traveler for vacation relief are not limited to the first six (6) months following the Effective Date.

e. Perfusion Disposable Fees. Company will attempt to help Hospital by securing quotes for products below current market price. Hospital will have the final decision on what products Hospital will purchase.

f. Billing and Collection. It is understood by the parties that the compensation specified herein shall be Company's sole and exclusive compensation for perfusion services performed pursuant to this Agreement, and that Company shall not bill, charge or otherwise attempt to collect any additional compensation for services provided to Hospital's patients pursuant to this Agreement.

4. TERM OF AGREEMENT.

a. Term. The term of this Agreement shall be two (2) years commencing on the Effective Date, unless terminated earlier as provided herein.

b. Termination.

(1) Termination Without Cause. Either party may terminate this Agreement at any time with or without stating cause or reason and without penalty, upon not less than sixty (60) days written notice to the other party.

(2) Termination for Breach. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided such breach continues for fifteen (15) days after receipt by the breaching party of written notice of such breach from the non-breaching party.

(3) Immediate Termination by Hospital. Hospital may terminate this Agreement immediately by written notice to Company upon the occurrence of any of the following events:

(1) the denial, suspension, revocation, termination, restriction, lapse, or voluntary relinquishment (under threat of disciplinary action) of any Perfusionist's Allied Health Professional privileges at Hospital or Perfusionist's' s failure to maintain clearance with Vendor Credentialing, or Perfusionist's license/certification to provide the Services in the State;

(2) the failure of Company to make a timely disclosure required pursuant to Paragraph 10 hereof;

(3) conduct by any Perfusionist which, in the sole discretion of Hospital, could affect the quality of professional care provided to Hospital's patients or the reasonable performance of duties required hereunder, or be prejudicial or adverse to the best interest and welfare of Hospital or its patients;

(4) breach by any Perfusionist of any of the confidentiality provisions hereto;

(5) Company's failure to maintain professional liability insurance as required in Paragraph 7 hereof; or

(6) any Perfusionist becomes involved in a pending criminal action or proposed debarment, exclusion, or other sanctioning action related to any Federal or State healthcare program.

(4) Immediate Termination by Company. Company may terminate this Agreement Hospital is insolvent, files for bankruptcy or receivership, or is subject to an involuntary bankruptcy or receivership not dismissed within ninety (90) days.

(5) Effect of Termination. As of the effective date of termination of this Agreement, neither party shall have any further rights or obligations hereunder except: (a) as otherwise provided herein; (b) for rights and obligations accruing prior to such effective date of termination; or (c) arising as a result of any breach of this Agreement. Hospital shall make all payments after termination for Services performed prior to termination.

5. WITHDRAWAL OF PERFUSIONISTS. All Perfusionist performing Services under this Agreement shall be subject to initial and continuing approval of the cardiac surgeons and Hospital. At all times while this Agreement is in effect, either Hospital's President/Chief Executive Officer ("CEO") or Hospital's Chief Medical Officer ("CMO") shall have the right to request removal of any such Perfusionist if, in the CEO's or CMO's best judgment, such removal is in the best interests of Hospital. Company hereby agrees to remove any such Perfusionist upon receipt of the CEO's or CMO's request.

6. COMPANY'S STATUS. Company and each Perfusionist providing Services under this Agreement shall act at all times as independent contractors in relation to Hospital. The parties agree that Hospital shall not have and shall not exercise control or direction over the manner or method by which Company or Perfusionist provide the Services. However, Company and each Perfusionist shall perform at all times in accordance with currently approved methods and standards of practice for Services in the medical community. The provisions of this Paragraph shall survive expiration or other termination of this Agreement, regardless of the cause of such termination. Company agrees that it shall be solely responsible for payment of state, local and federal taxes, withholding payments, penalties, fees, fringe benefits, insurance premiums, contributions to insurance and pension or other deferred compensation plan, including but not limited to social security obligations and the filing of all necessary documents, forms and returns required for or pertinent to all of the foregoing. Company shall indemnify, reimburse and hold Hospital harmless against any and all claims for the payment or filing of any of the foregoing payments or documents, withholdings, contributions, taxes, documents and returns, including but not limited to, employee benefit programs, social security taxes and income withholding taxes.

7. **INSURANCE.** Company shall maintain at all times throughout this Agreement professional liability insurance for itself and each Perfusionist providing Services hereunder in the minimum amounts of $1,000,000 per occurrence/$3,000,000 annual aggregate from an insurance company acceptable to Hospital. Company shall also maintain general liability in the miniumum amount of $1,000,000. If such insurance is on a "claims-made" basis, and such coverage is later terminated, or converted to an "occurrence" coverage (or vice versa), Company shall provide evidence to Hospital that it has in force or has procured "prior acts" or "tail" coverage (as applicable), in the above amounts, covering all periods that this Agreement is or has been in force. Company shall provide Hospital with written evidence of such insurance prior to the execution of this Agreement and after any change is made in any insurance policy that would alter the information on the certificate then on file.

8. ACCESS TO BOOKS AND RECORDS.

a. If the value or cost of Services rendered to Hospital pursuant to this Agreement is Ten Thousand Dollars ($10,000.00) or more over a twelve-month period, Company agrees as follows:

(1) Until the expiration of four (4) years after the furnishing of such Services, Company shall, upon written request, make available to the Secretary of the Department of Health and Human Services (the "Secretary"), the Secretary's duly-authorized representative, the Comptroller General, or the Comptroller General's duly-authorized representative, such books, documents, and records as may be necessary to certify the nature and extent of the cost of such Services; and

b. If any such Services are performed by way of subcontract with another organization and the value or cost of such subcontracted Services is Ten Thousand Dollars ($10,000.00) or more over a twelve-month period, such subcontract shall contain, and Company shall enforce, a clause ID the same effect as Subparagraph 8.a.(l) immediately above. The availability of Company's books, documents, and records shall be subject at all times to all applicable legal requirements, including without limitation, such criteria and procedures for seeking and obtaining access that may be promulgated by the Secretary by regulation. The provisions of

Subparagraphs 8.a. and 8.b. shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

9. CONFIDENTIALITY.

a. Hospital Information. Company recognizes and acknowledges that, by virtue of entering into this Agreement and providing services to Hospital hereunder, Company and each Perfusionist may have access to certain information of Hospital that is confidential and constitutes valuable, special and unique property of Hospital. Such information is limited to information that is not available to the public (such information being "Hospital Information"). Company agrees that neither it nor any Perfusionist will at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without Hospital's express prior written consent, except pursuant to his duties hereunder, any confidential or proprietary information of Hospital, including, but not limited to, information which concerns the costs or treatment methods developed by Hospital, and which is not otherwise available to the public.

b. Terms of this Agreement. Except for disclosure to Company's or any Perfusionist's legal counsel, accountant or financial advisors (none of whom shall be associated or affiliated in any way with Hospital or any of its affiliates), neither Company nor any Perfusionist shall disclose the terms of this Agreement to any person or entity, unless disclosure thereof is required by law or otherwise authorized by this Agreement or consented to by Hospital.

c. Disclosure of Hospital Information and Terms of Agreement. Either Company or Hospital may disclose this Agreement and Company may disclose Hospital Information to enforce the terms of this Agreement, to defend itself with respect to any claim, or to any current or prospective owner, investor, or lender who has an obligation of confidentiality and with notice to the Hospital. Unauthorized disclosure of the terms of this Agreement shall be a material breach of this Agreement and shall provide Hospital or Company with the option of pursuing remedies for breach or immediate termination of this Agreement in accordance with Subparagraph 4.b. hereof.

d. Patient Information. Neither Company nor any Perfusionist shall disclose to any third party, except where permitted or required by law or where such disclosure is expressly approved by Hospital in writing, any patient or medical record information regarding Hospital patients ("Patient Information"), and Company and each Perfusionist shall comply with all federal and state laws and regulations, and all rules, regulations, and policies of Hospital, regarding the confidentiality of such information, including, but not limited to, the Federal Health Insurance Portability and Accountability Act of l996, Public Law 104-191 ("HIPAA"), Subtitle D of the Federal HITECH Act ("HITECH Act,"42 U.S.C. § 17921 et seq.), and the regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations," 45 C.F.R. Part 160, et. seq.), and the Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 C.F.R. Part2), as amended from time to time.

e. Remedy. Unauthorized disclosure of Patient Information or Hospital Information shall be a material breach of this Agreement and in the event of such unauthorized disclosure; Hospital shall have the option of pursuing remedies for breach, or, notwithstanding any other provision of this Agreement, immediately terminating this Agreement upon written notice to Company. Notwithstanding any other remedy that may be available in law or equity, the parties stipulate and agree that the aggrieved party may obtain preliminary or permanent injunctive relief to prevent disclosures of confidential information or further disclosures, along with such mandatory relief as may be appropriate to limit the effect of any prior disclosure, without the need of showing irreparable harm, as it may be difficult or impossible to establish an imminent threat of irreparable harm.

f. Survival. The provisions of this Paragraph 9 shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

10. REQUIRED DISCLOSURES. Company shall notify Hospital in writing within three (3) days after Company is aware of any of the following events occurs:

a. Any Perfusionist's license/certification to practice in the State or any other jurisdiction lapses

or is denied, suspended, revoked, terminated, relinquished or made subject to terms of probation or other restriction;

b. Any Perfusionist's clear status with Vendor Credentialing or privileges at any health care facility are denied, suspended, revoked, terminated, voluntarily relinquished (under threat of disciplinary action), or made subject to terms of probation or other restriction; or

c. Company or any Perfusionist becomes the subject of an investigatory, disciplinary, or other proceeding before any governmental, professional, licensing board, medical staff, or peer review body;

11. ARBITRATION. Any dispute or controversy arising under, out of or in connection with, or in relation to this Agreement, or any amendment hereof, or the breach hereof shall be determined and settled by arbitration in Monterey County, California, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration and applying the laws of the State. Any award rendered by the arbitrator shall be final and binding upon each of the parties, and judgment thereon may be entered in any court having jurisdiction thereof. The costs shall be borne equally by both parties. During the pendency of any such arbitration and until final judgment thereon has been entered, this Agreement shall remain in full force and effect unless otherwise terminated as provided hereunder. The provisions of this Paragraph shall survive expiration or other termination of this Agreement regardless of the cause of such termination.

12. ENTIRE AGREEMENT MODIFICATION. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

13. GOVERNING LAW. This Agreement shall be construed in accordance with the laws of the State of California. The provisions of this Paragraph shall survive expiration or other termination of this Agreement regardless of the cause of such termination. Venue shall be in Monterey County.

14. COUNTERPARTS. This Agreement may be executed in one or more counterparts, all of which together shall constitute only one Agreement. This Agreement may be signed and delivered electronically.

15. NOTICES. All notices hereunder shall be in writing, delivered personally, by certified or registered mail, return receipt requested, by overnight courier, or via electronic mail with confirmation of or evidence of receipt, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier, addressed as follows:

If to Hospital:

Salinas Valley Memorial Healthcare System
Attn: President/CEO
450 E. Romie Lane
Salinas, CA 93901

If to Company:

Prime Perfusion Inc.
PO Box 251
Canby, OR 97013
Email: morgan@primeperfusioninc.com

or to such other persons or places as either party may from time to time designate by notice pursuant to this Paragraph.

16. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute

a waiver of any subsequent breach or failure.

17. CAPTIONS. The captions contained herein are used solely for convenience and shall not be deemed to define or limit the provisions of this Agreement.

18. ASSIGNMENT, BINDING EFFECT. Company shall not assign or transfer, in whole or in part, this Agreement or any of Company's rights, duties or obligations under this Agreement without the prior written consent of Hospital, and any assignment or transfer by Company without such consent shall be null and void; notwithstanding the foregoing, the Company may with notice to the Hospital transfer or assign this Agreement at the same time and to the same buyer of all or substantially all of its assets. Company may engage independent contractors to be Perfusionists. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns. Hospital shall not assign or transfer, in whole or in part, this Agreement or any of Hospital 's rights, duties or obligations under this Agreement without the prior written consent of Company, and any assignment or transfer by Hospital without such consent shall be null and void, except that the Hospital may with notice to the Company transfer or assign this Agreement at the same time and to the same buyer of all or substantially all of its assets.

19. FINANCIAL OBLIGATION. Neither Company nor any Perfusionist shall incur any financial obligation on behalf of Hospital without the prior written approval of Hospital.

20. EXCLUSIVE AGREEMENT. Hospital agrees that during the term of this agreement, and any extension thereof, Company shall be the exclusive provider of perfusion/autotransfusion services to Hospital, and Hospital will not schedule itself to provide nor enter into any agreement with a third party to provide such services to Hospital. Other hospital employees such as nurses, physician assistants or technicians, will not perform perfusionist services and duties.

21. NON-DISCRIMINATION. It is understood that neither Hospital nor Company nor any Perfusionist shall discriminate against any person on the basis of race, color, religion, age, sex, national origin, disability, sexual orientation or any other legally protected status.

22. INDEMNIFICATION BY COMPANY. Company shall indemnify, defend and hold harmless Hospital, its officers, trustees, agents, and employees from and against the following:

a. All third-party claims and liabilities for compensation (together with related expenses, including but not limited to damages, costs and attorneys' fees) on account of Company's failure to pay for any work, services, materials, or supplies furnished or supplied by such third parties to or for either the Company or Company's subcontractors in connection with the performance of this Agreement; and

b. Any and all claims, liabilities, and losses (together with any expenses related thereto, including but not limited to damages, court costs, and attorneys' fees) occurring or resulting to any person, firm, or corporation for damage, injury, or death, to the extent that such claims, liabilities, or losses arise out of, are alleged to arise out of, or are connected with the wrongful, willful or negligent act or omission of the Company, its officers, employees, agents, or subcontractors in the performance of this Agreement.

23. INDEMNIFICATION BY HOSPITAL. Hospital shall indemnify, defend and hold harmless Company, its officers, Perfusionists, agents, and employees from and against any and all claims, liabilities, and losses (together with any expenses related thereto, including but not limited to damages, court costs, and attorneys' fees) occurring or resulting to any person, firm, or corporation for damage, injury, or death, to the extent that such claims, liabilities, or losses arise out of, are alleged to arise out of, or are connected with the wrongful, willful or negligent act or omission of the Hospital, its officers, employees, agents, or subcontractors in the performance of this Agreement or the failure of any equipment or supplies provided by Hospital.

24. FORCE MAJEURE. No party is liable or responsible to the other party and is not in breach of this Agreement for any failure or delay in fulfilling or performing any term of this Agreement to the extent that the same is caused by or results from acts beyond the impacted party’s reasonable control, including without limitation for any flood, fire, earthquake, explosion, war, invasion, terrorist threat or act, civil unrest, government order, blockades, emergency, strikes, epidemic, pandemic, or influenza or bacterial infection, or other similar events.

Signatures

The parties hereby execute this Agreement as of the Effective Date set forth above.

HOSPITAL

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

By: _____ Date: _____
Allen Radner, MD
Interim President/CEO

COMPANY

PRIME PERFUSION INC.

By: _____ Date: _____
Morgan Leder, CCP, MPS
President

EXHIBIT A

Duties and Responsibilities

1. Cardiac Perfusion Services: Complete blood gas analysis, hemoconcentration, cardioplegia delivery, administration of pharmacological agents as necessary, cardiac autotransfusion, perfusion standby, anticoagulation regulation, insertion of: IABP, LVAD, RVAD, or BIVADS.

2. Coverage Services. Company shall provide Perfusionists to perform such services of extracorporeal perfusion and cardiac autotransfusion. Such coverage will include the following:

(a) Coverage of a Perfusionist for all elective cases requiring cardiopulmonary bypass; and

(b) Twenty-four (24) hours, seven (7) days per week, coverage for all services requiring a Perfusionist. Services include basic cardiopulmonary bypass, all minimally invasive cardiac procedures where a Perfusionist is needed either for standby or technical assistance or any other cardiac surgical procedure where the cardiac surgeon deems it necessary for a Perfusionist to be present, perfusion standby, and cardiac autotransfusion. Company shall ensure the availability of one (1) Perfusionist ("On-Call Perfusionist") at all times during off hours and weekends. In this regard, Company shall have the responsibility of providing Hospital with an accurate and up-to-date call schedule. If a Perfusionist is at the Hospital for a procedure, the Company is not obligated to provide a second Perfusionist to be on-call. For purposes of this Agreement, On-Call Perfusionist shall be at all times within thirty (30) minutes from Hospital, measured according to the speeding limit of any roadways, it being understood that the Company is released and not liable in the event that an On-Call Perfusionist takes longer than thirty (30) minutes to arrive at the Hospital for reasons other than such On-Call Perfusionist's gross negligence or intentional misconduct; and

(c) On elective cases, Company agrees to have a Perfusionist available in the operating room prior to and prepared for the starting time and agrees to have such Perfusionist remain on the case until excused by the surgeon in charge of the case.

3. Further Duties. Further duties shall include but not necessarily be limited to the following:

a. Responsibility for setting up heart-lung machine (HLM) on all cases, and for cleaning so that HLM is ready for subsequent cases;

b. Responsibility for notifying the Hospital of the need for ordering, purchasing and maintaining perfusion disposable inventory;

c. Assistance and cooperation in connection with the development of any and all studies undertaken by the cardiac surgeons;

d. Responsibility for a complete record of perfusion and/or autotransfusion: one copy to be placed in the patient's chart at the end of each case;

e. Responsibility for establishing and maintaining perfusion database for purposes of tracking and reporting volume and other statistics deemed necessary by Hospital;

f. Responsibility for operating other related equipment associated with circulatory support (i.e., ventricular support devices, portable perfusion equipment (CPS) and autotransfusion equipment);

g. Responsibility for submitting, at least annually, perfusion protocols to the Surgery and Anesthesia Departments for approval; and

h. Responsibility for undergoing annual clinical competency assessments commensurate with designated duties and responsibilities.

Perfusion Services RFP				
Category:	Total	Prime Score	FRP Score	CVP Score
Responsiveness & Completeness	25	25	17	20
Ability, history & references	25	25	22	17
User experience	25	25	25	20
Price & ROI	25	25	25	25
Results:	100	100	89	82

CORPORATE COMPLIANCE
AND AUDIT COMMITTEE

The Corporate Compliance and Audit Committee
Is Scheduled for Friday, March 29, 2024

(JUAN CABRERA)

Salinas Valley HEALTH

Medical Executive Committee Summary – March 14, 2024

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Becerra, Maura, MD	Family Medicine	Family Medicine	TFFH&WC: Moonlighting Core
Hawthorne, Kinji, MD	Infectious Disease	Medicine	Remote Infectious Disease: Core

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Ajoc, Jose, MD	Family Medicine	Medicine	Adult Hospitalist
Gerber, Richard, MD	Interventional Cardiology	Medicine	Cardiology Interventional Cardiology Cardiac Diagnostic Outpatient Center (CDOC) Center for Advanced Diagnostic Imaging (CADI) at Ryan Ranch
Ginsburg, Jerry, MD	Cardiology	Medicine	Cardiology:
Holcombe, Travis, MD	Plastic Surgery	Surgery	Plastic & Reconstructive Surgery
Joye, James, DO	Cardiology	Medicine	Cardiology Interventional Cardiology Peripheral Endovascular
Kim, Richard, MD	Ophthalmology	Surgery	Ophthalmology
Meyerhoff, Karen, MD	Anesthesiology	Anesthesiology	Anesthesiology Critical Care/Pulmonary Medicine
Mudge, Dawn, MD	Internal Medicine	Medicine	Adult Hospitalist
Ozoigbo, Guguamobi, MD	Anesthesiology	Anesthesiology	Anesthesiology
Panchal, Dhanu, MD	Physical Medicine & Rehabilitation	Medicine	Medicine – Active Community
Romero, Eloy, MD	Family Medicine	Medicine	Adult Hospitalist
Shawo, Alexandra, MD	Internal Medicine	Medicine	Adult Hospitalist:
Waddell, Adam, MD	Neurology	Medicine	TeleNeurology
Wong, Angela, MD	Family Medicine	Family Medicine	Adult Family Medicine
Lieberman, Marc, MD	Rheumatology	Medicine	Medicine Active Community
Wilson, Hugh, MD	Pathology	Surgery	Pathology

Privilege Modifications:

NAME	SPECIALTY	PRIVILEGE
Kaur, Gurvinder, MD	Neurosurgery	Use of Fluoroscopy
Semer, Nadine, MD	Hospice/Palliative Care	SVH Outpatient Infusion Center
Meisner, Nicole, MD	Obstetrics & Gynecology	Gynecology Core Procedure: Treatment/management of ectopic pregnancy

Staff Status Modifications:

NAME	SPECIALTY	STATUS	RECOMMENDATION
Bashtar, Reza MD	Internal Medicine	Provisional	Recommend advancement to Active staff.
Kaur, Gurvinder, MD	Neurosurgery	Provisional	Recommend advancement to Active staff.

Bradley, Cedrick, MD	Family Medicine	Active	Resignation effective 3/31/2024.
Chamberlain, Brittany, MD	Family Medicine	Active Community	Resignation effective 4/18/2024.
Zhang, Zachary, MD	Interventional Radiology	Leave of Absence	Resignation effective 3/31/2024. Did not request a return from LOA.

Other Items:

Dept. of Medicine – Clinical Privileges Delineation Hematology and Oncology – Revision	The Committee recommended approval of the removal of Special Privilege – Prescribing of Epoetin Alfa Procrit Epogen as it is now considered core.
Dept. of Medicine – Clinical Privileges Delineation Palliative Medicine – Revision	The Committee recommended approval of the revision to the clinical privilege delineation for Palliative Medicine adding SVH Outpatient Infusion Center Privileges.

Interdisciplinary Practice Committee

Initial Appointment:

NAME	SPECIALTY	DEPARTMENT	SUPERVISOR(S)
Benitez, Tanya, NP	Cancer Care	Medicine	Hong Zhao, MD
Frieben, Cody, NP	Cardiothoracic & Vascular Surgery	Surgery	Vincent DeFilippi, MD Andreas Sakopoulos, MD
Shimizu, Ellen PA-C	- Orthopedics	Surgery	Bert Tardieu, MD

Reappointment:

NAME	SPECIALTY	DEPARTMENT	SUPERVISOR(S)
Miller, David PA-C	Cardiology	Medicine	Steven Regwan, DO

Modification/Addition of Privileges/Status:

NAME	SPECIALTY	RECOMMENDATION
Davis, Chris, PA-C	Cardiovascular/Thoracic Surgery	Add insert arterial, and Central venous catheters as directed by cardiac surgeon
Carlquist, Jennifer PA-C	Cardiology	Resignation effective 3/5/2024

Other Items Recommended for Approval: ***(Attached)***

Abdominal Pain Standardized Procedure	Review and recommend approval of revisions.

Policies/Plans and Privilege Forms: ***(Attached)***

Medical Record Addenda Documentation - Revised

Attachments:

1. Abdominal Pain Nursing Standardized Procedure
2. Medical Record Addenda Documentation Policy

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Medical Staff Excellence Committee
d. Practitioner Health & Wellness – Post Heart of the Healer Retreat Update
e. Quality and Safety Committee Reports:
   - Cardiac Surgery Program
   - TJC Survey Findings
   - Opioid Safety and Pain Management Committee
   - Service Excellence
   - Pharmacy & Therapeutics and Infection Prevention
   - Perioperative Services
   - Respiratory Care
   - Cath Lab/Cardiac Rehab/CDOC
   - Nutrition Services
   - Patient Financial Services
   - Clinical Research

II. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings
c. Medical Staff Treasury Report
d. Medical Staff Statistics Year to Date
e. Health Information Management (HIM) Update
f. Financial Update
g. HCAHPS Update
h. TJC 2024 National Patient Safety Goals

III. Other Items Approved:

Order Sets:

- Latent TB Infection Treatment AMB Order
- Methylene Blue for Refractory Vasodilatory Shock
- Midazolam
- Poseidon Protocol

Status **Pending** PolicyStat ID **14740336**

Last Approved	N/A	Owner	David Thompson: Clinical Manager
Last Revised	03/2024	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Abdominal Pain Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. CBC : Complete Blood Count

B. CMP: Comprehensive Metabolic Panel

C. HCG: Quantitative Serum Pregnancy Test

D. Draw Extra: Extra serum tubes collected in anticipation of blood test being added on at a later time.

E. ED: Emergency Department

F. INT: Intravenous Therapy (saline lock) with intermittent flushes

G. UA: Urinalysis

H. ODT: Oral Disintegrating Tablet

III. PROCEDURE

A. Function

- To expedite care for patients who present to the Emergency Department with a chief complaint of abdominal pain

B. Circumstances

- Setting

1. Registered nurses in the ED may order the following labs for patient's thirteen years of age and over with a complaint of abdominal pain: CBC, CMP, POC I-stats as needed, serum HCG (non-menopause females only),

LIPASE, DRAW EXTRA, UA and culture if needed, and place INT. Zofran 4mg ODT (oral disintegrating tablet) x1 dose may be given to patients 13 yrs. and older for a complaint of nausea or vomiting.

- Supervision
    1. Registered Nurses who are qualified to perform this standardized procedure may independently order blood work and initiate IV therapy to patients who present with a chief complaint of abdominal pain, and for whom meet the criteria above. Physician supervision is not required.
- Patient Conditions
    1. Emergency Department patients who meet the following criteria:
        a. If the patient has not been seen in the ED within the previous 24 hours for the same complaint and/or the need for blood testing and IV therapy is questionable/concerning.
        b. Patients thirteen years of age and over
        c. Chief complaint of abdominal pain
        d. ~~Will not been seen by a physician within fifteen minutes~~ED physician not immediately available

C. Database

- Subjective:
    1. Prioritization and Severity of Illness
        a. Patients thirteen years of age and older with the chief complaint of abdominal pain will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)
        b. History of present illness/injury/chief complaint
        c. Have patient point with one finger to most painful location
        d. Consider conditions related to gastrointestinal, genitourinary, or reproductive systems.
            i. Female: determine last normal menstrual period
            ii. Male: assess for possible testicular torsion.
        e. History of abdominal surgeries/illnesses
        f. History of diarrhea, constipation, nausea, or vomiting
        g. Pain description
- Objective:
    1. Chief complaint of abdominal pain
        a. Signs of hypovolemia

b. Signs of peritoneal irritation
c. Inability to ambulate or sit
d. Color of skin/sclera
e. Odors
f. Objective signs of pain

D. Diagnosis
- Abdominal pain

E. Plan
- Treatment
  1. ~~The order must be placed under the name of the supervising ED physician. If a different provider is later assigned to the patient, the orders will be transferred to the provider assigned.~~In no ED provider has signed up for the patient then the order set should be placed under 'Physician, Emergency'
  2. The blood and urine specimens must be labeled accurately with the patient's name and account number. The accuracy of the label must be verified by using the hospital approved patient identification process (see PATIENT IDENTIFICATION POLICY). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE. (see PATIENT IDENTIFICATION POLICY)
  3. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag
  4. Specimens collected in the ED will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.
- Patient conditions requiring consultation/reportable conditions
  1. **Immediately notify an Emergency Department physician of the following:**
     a. Changes in airway, breathing, circulation or altered level of consciousness.
     b. Change in triage acuity.

     Note: if the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, suspected mesenteric ischemia, Ruptured appendix/peritonitis
- Education - Patient/Family
  1. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy
- Follow Up

1. As needed to maintain continuity of care

- Documentation of Patient Treatment
    1. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.
    2. The ED RN initiating the standardized procedure will document the following: "CBC, CMP, LIPASE, DRAW EXTRA, UA, ~~serum~~ HCG Qualitative, urine HCG (if appropriate) ordered per "standardized procedure" in the patient record
    3. Enters "supervising ED physician as ordering provider per policy.
    4. Navigates to ER Nursing Orders.
    5. Selects "ABD Pain-Standardized Procedure" order set.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education and Training

- The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge.

B. Experience

- Current California RN license and designated to work in ED

C. Evaluation

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

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

- Policy goes through the Emergency Department Physician Group every three (3) years.
- Policy goes through the interdepartmental policy committee (IDPC) upon creation of

policy and when changes are made.

- Chief Nursing Officer (Vice President of Patient Care Services) upon creation of policy and with significant changes.

B. Review schedule

- Review of policy occurs every three (3) years

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

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

1. Director of Emergency Department, Medical Director of Emergency Department, Chair of Interdisciplinary Practice Committee, and Chief Nursing Officer.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

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

VII. REFERENCES

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

B. Emergency Nurses Association: Emergency Nursing Core Curriculum (2007), 6th Edition- Emergency management involving assessment of the abdomen 47, 159-186

C. Marx, J., Hockberger, R.WS., & Walls, R. M. (Eds). (2002). Rosen's emergency medicine: Concepts and clinical practice (5th ed). St Louis, MO: Mosby

D. ~~TRIAGE ASSESSMENT~~

E. ~~PATIENT IDENTIFICATION POLICY~~

Approval Signatures

Step Description	Approver	Date
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Owner	David Thompson: Clinical Manager	03/2024

Standards

No standards are associated with this document

History

Comment by DeSalvo, Katherine: Director Medical Staff Services on 10/10/2023, 6:49PM EDT

> Nursing Standardized Procedures must be approved by the Interdisciplinary Practice Committee.

Draft saved by Thompson, David: Clinical Manager on 11/17/2023, 5:50PM EST

Edited by Thompson, David: Clinical Manager on 11/17/2023, 5:50PM EST

> Adding urine culture if needed to reflex urine culture is UA sample indicates. Changed the ordering physician to 'Physician, Emergency' when no provider has signed up for the patient yet.

Last Approved by Vaughan, Darlene: Director Nursing on 11/21/2023, 7:24PM EST

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 12/4/2023, 1:32PM EST

> Darlene & David are there more current references?

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 12/4/2023, 1:33PM EST

> Approval flow corrected

Rejected by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 12/4/2023, 1:35PM EST

> Approval flow corrected. Darlene please approve to move forward with corrected approval flow.

Last Approved by Vaughan, Darlene: Director Nursing on 12/4/2023, 3:03PM EST

Administrator override by Woodrow, Lea: Director Accreditation and Regulatory Compliance on 1/17/2024, 5:25PM EST

> Removed references to other P&Ps

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 2/1/2024, 3:19PM EST

> Policy Committee previously approved

Comment by DeSalvo, Katherine: Director Medical Staff Services on 2/1/2024, 3:52PM EST

> Every time there are changes this needs to be reviewed by the Department Chair, IDPC, MEC and the Board.
> Can you tell me why this is coming to me again?

Comment by Woodrow, Lea: Director Accreditation and Regulatory Compliance on 2/1/2024, 4PM EST

> We have not built all the flows into these SP. Looks like needs to go to ED then IDPC then MEC / Board right??This looks like is pending IDPC?? should we pull back to change flow?

Comment by DeSalvo, Katherine: Director Medical Staff Services on 2/1/2024, 6:31PM EST

> The was approved by IDPC, MEC and the Board this month. Have there been additional changes since January 4, 2023?

Responsibilities transferred to new account by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 2/23/2024, 1:56PM EST

> The previous owner's account (*Darlene Vaughan: Director Nursing*) was deactivated, so all of their responsibilities were transferred to *David Thompson: Clinical Manager*.

Comment by DeSalvo, Katherine: Director Medical Staff Services on 2/27/2024, 12:51PM EST

> I'm unclear as to whether there were changes since January 2024 needing additional approval or not. Please clarify. Thank you.

Draft saved by Thompson, David: Clinical Manager on 3/5/2024, 3:41PM EST

Edited by Thompson, David: Clinical Manager on 3/5/2024, 3:42PM EST

> Changed serum HCG to HCG Qualitative as requested.

Last Approved by Thompson, David: Clinical Manager on 3/5/2024, 3:42PM EST

Status **Pending** PolicyStat ID **14812485**

Last Approved	N/A	Owner	Philip Katzenberger: Director HIM/ Privacy Officer
Last Revised	02/2024		
Next Review	3 years after approval	Area	Health Information Management

Medical Record Addenda Documentation

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff ~~in~~on making ~~late entries~~documenting addendums into the medical record when a pertinent entry was missed ~~or not written in a timely manner~~.

III. DEFINITIONS

A. ~~Late Entry - A late entry provides additional information that was omitted from the original entry. It is added as soon as possible and is written only if the person documenting has total recall of the omitted information.~~

B. Addendum - An addendum is used to provide information that was not available at the time of the original entry. It is used to provide additional information in conjunction with a previous entry and includes the reason for the addition.

C. Correction - Corrections are made to erroneous entries in the medical record and to record the correct information.

D. Clarification - A clarification may be entered when the intent of an original order is unclear or there are duplicate orders.

E. Amendment - See USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) policy.

F. ELR - Electronic Legal Record

G. pDoc – Provider Documentation

H. EMR – Meditech electronic medical record

IV. GENERAL INFORMATION

A. Salinas Valley Health Medical Center (SVHMC) recognizes that any clinical provider of healthcare services may need to enter ~~a late~~an addendum entry into the medical record. ~~Late entries, addenda,~~Addenda or corrections to a medical record are legitimate occurrences in documentation of clinical services. ~~While late entries are discouraged, they should be entered if the information is relevant to or necessary for subsequent patient care.~~

B. SVHMC ensures a uniform procedure for handling additions, deletions, alterations, obliterations, mistaken entries, or omissions in all medical records, either paper or electronic maintained by the Hospital.

C. ~~A late~~An addendum or correction to the medical record bears the current date of that entry~~, addendum or correction to the medical record bears the current date of that entry~~ and is signed by the person making the addition or change.

V. PROCEDURE

A. The author of ~~a late entry into~~an addendum to the medical record must meet the following requirements:

1. ~~Late Entry:~~
    a. ~~Identify the new entry as a "late entry".~~
    b. ~~Identify or refer to the date and circumstance for which the late entry is written.~~
    c. ~~Enter the current date and time; do not attempt to give the appearance that the entry was made on a previous date or an earlier time.~~
    d. ~~Sign the late entry when it is entered.~~
    e. ~~Must be documented as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.~~

2. Addenda:
    a. ~~Write "Addendum" and state the reason for creating the addendum, referring back to the original entry.~~ Addenda will be added in chronological order.
    b. Document the date and time on which the addendum was made.
    c. Sign the entry when it is entered.
    d. Addenda to transcribed reports must be stated in the addendum dictation, so they can be properly added to the original report.
    e. An addendum should be completed as soon as possible after the original note.
    f. Addenda to electronic documentation may be created by printing the page to be corrected and following the same procedure for correction to paper-based documentation. This Addendum would then be scanned into the

ELR, maintaining both versions.

g. Only the original author can add an addendum to a pDoc report. The date and time of the addendum is located in the audit history of the report.

h. For a paper entry, write "Addendum", refer back to the original entry. (i.e. Addendum of progress note/Consultation created on 12/01/2022, adding content note).

B. Corrections (Paper documentation):

1. For corrections to paper-based documentation that is already scanned into the ELR, a print-out shall be obtained of the entry to be corrected.
2. Handwritten entries should be corrected by the author, however, in the case where the author is unavailable, a director/manager or designee, after review and when appropriate, can make a correction.
3. The authorized person shall line out the incorrect entry with a single line, leaving the original writing legible (never write over, erase or otherwise obliterate the original passage when an entry to a paper medical record is made in error).
4. The person shall note the reason for the correction (i.e. wrong patient) above the correction or in the margin, the date of striking, and sign the correction.
5. This corrected document will be re-scanned into the ELR, replacing the original version once correct information is added.
6. In the event that documentation has been scanned into the incorrect medical record, that documentation will be removed from the incorrect record and moved into the correct record. This may be done electronically, or the documents may be rescanned.
7. Omissions noted after 72 hours:
    a. An occurrence report should be completed by the person identifying the omission and sent to Risk Management.
    b. The immediate supervisor should be consulted for further instructions under consultation with Health Information Management.
8. Under no circumstances shall any correction be made to any entry in a patient's medical record after the record has been completed in final form.
9. For patient request for a change or amendment to the record – See USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) .

C. **Corrections to electronically-created source information (EMR) must be done by one of the following methods:**

- ~~The Department Director must approve any changes to information that is created in the EMR or a source system that interfaces with the EMR. If approved, the edit will cause the documentation to re-archive to the ELR, replacing the original version. Audit trails are maintained to determine when this documentation has been edited.~~

  A finalized document may only be returned to draft status within seventy (72) hours of finalization and when authorized by the Chief Medical Information Officer (CMIO)

or the Chief Medical Officer (CMO). If approved, the edit will cause the documentation to re-archive to the ELR, replacing the original version. Audit trails are maintained to determine when this documentation has been edited.

- Follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction.
- When a ~~hardcopy~~hard copy is generated from an electronic record, both paper and electronic records must reflect the correction.
- Corrected records must make clear the specific change made, the date of the change, and the identity of the person making the entry.

D. **Clarification**

- An order clarification must be written by a person authorized to make entries in the medical record and also designated to take verbal and telephone orders.
- The order clarification must be documented as such, and signed by the physician, either manually or electronically.

E. Documentation: N/A

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. CMS- Centers for Medicare and Medicaid Services

B. AHIMA- American Health Information Management Association

C. The Joint Commission of Hospital Accreditation

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2024
Policy Owner	Philip Katzenberger: Director HIM/Privacy Officer	02/2024

Standards

No standards are associated with this document

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

RECONVENE OPEN SESSION/
CLOSED SESSION REPORT

(VICTOR REY, JR.)

ADJOURNMENT