August 15, 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, AUGUST 22, 2024, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.** (V*isit* **SalinasValleyHealth.com/virtualboardmeeting** *for Public Access Information*).

Allen Radner, MD
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, AUGUST 22, 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*
2. CLOSED SESSION *(See Attached Closed Session Sheet Information)*	*Victor Rey*
3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION *(Estimated time 4:30 pm)*	*Victor Rey*
4. AWARDS & RECOGNITION	*Allen Radner, MD*
5. PUBLIC COMMENT 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.	*Victor Rey*
6. BOARD MEMBER COMMENTS AND REFERRALS	*Board Members*
7. CONSENT AGENDA - GENERAL BUSINESS	*Victor Rey*

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

A. Minutes of the Regular Meeting of the Board of Directors July 25, 2024
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
   1. Infection Prevention Program Plan
   2. Patient Safety Program Plan
   3. Quality Assessment and Performance Improvement Plan

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

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

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

Catherine Carson

Minutes of the August 12, 2024 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair.

1. Star Reports Center for Medicare and Medicaid Services

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Catherine Carson

Minutes of the August 12, 2024 Personnel, Pension and Investment Committee meeting have been provided to the Board for their review. The following recommendation has been made to the Board.

1. Consider Recommendation for Board Approval to remove the Transamerica Guaranteed Investment Account and transfer assets to the Vanguard Federal Money Market fund for SVMHS's 403 (b) Plan and 457 Plan, pending final fee negotiations and legal review.
   - 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 August 19, 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 Board of Directors to Award a Construction Contract to McLaughlin Painting & Waterproofing for the Medical Center Campus Exterior Repainting Project.
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
2. Consider Recommendation for Board of Directors Approval of Project Budget for the Salinas Valley Health X-Ray Rooms 1 and 2 Replacement Project, and Award of Contract to Philips for the X-Ray Equipment System and Service Agreement.
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

3. Consider Recommendation for Board Approval of Capital funding for the replacement of the medical center based cardiac Nuclear Medicine Camera (D-SPECT) and Five (5) year service agreement and equipment purchase with Spectrum Dynamics Medical
    - Questions to Committee Chair/Staff
    - Motion/Second
    - Public Comment
    - Board Discussion/Deliberation
    - Action by Board/Roll Call Vote

D. **COMMUNITY ADVOCACY** — *Rolando Cabrera, MD*

Minutes of the August 14, 2024 Community Advocacy Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF AUGUST 8, 2024, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING: — *Rakesh Singh, MD*

A. Reports
1. Credentials Committee Report
2. Interdisciplinary Practice Committee Report (Including the following)
    - Amniotic Fluid Rupture Membrane Nursing Standardized Procedure
    - OB Medical Screen Examination Nursing Standardized Procedure

B. Policies/Procedures/Plans:
1. Influenza (Respiratory Virus) Pandemic Plan
2. Sedation Guidelines
3. Bioterrorism Readiness Plan

C. Bylaws Amendments (Approved by a vote of the General Medical Staff)

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

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

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

12. ADJOURNMENT — *Victor Rey*

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, September 26, 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
AUGUST 22, 2024

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. Medical Executive Committee
   - Report of the Medical Staff Executive Committee (With Comments)
2. Report of the Medical Staff Quality and Safety Committee to Quality and Efficient Practices
   - Commission on Cancer Report
   - BETA OB Quest for Zero Report
   - Quality and Safety Committee Consent Agenda
     - Environment of Care Full Report
     - Pt safety/ Risk Full Report
     - Accreditation and Regulatory Full Report
     - Pharmacy and Therapeutics/Infection Prevention Full Report

CONFERENCE WITH LABOR NEGOTIATOR

(Government Code §54957.6)

Agency designated representative: (Specify name of designated representatives attending the closed session): Allen Radner, MD

Employee organization: (Specify name of organization representing employee or employees in question): California Nurses Association, or

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

REPORT INVOLVING TRADE SECRET

(Government Code §37606 & Health and Safety Code § 32106)

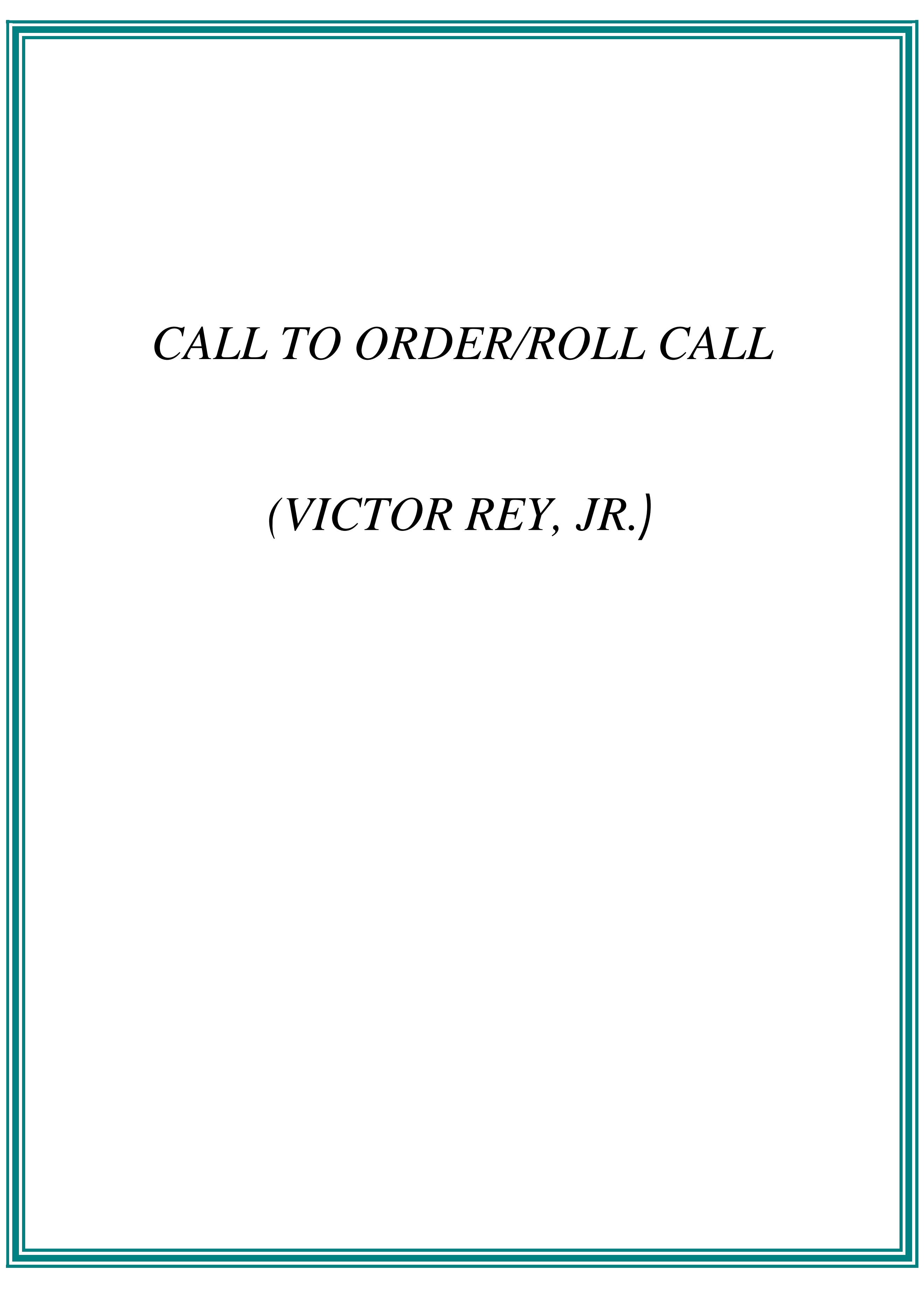
Discussion will concern: (Specify whether discussion will concern proposed new service, program, or facility): Trade Secret, Strategic Planning, Proposed New Programs and Services

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

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

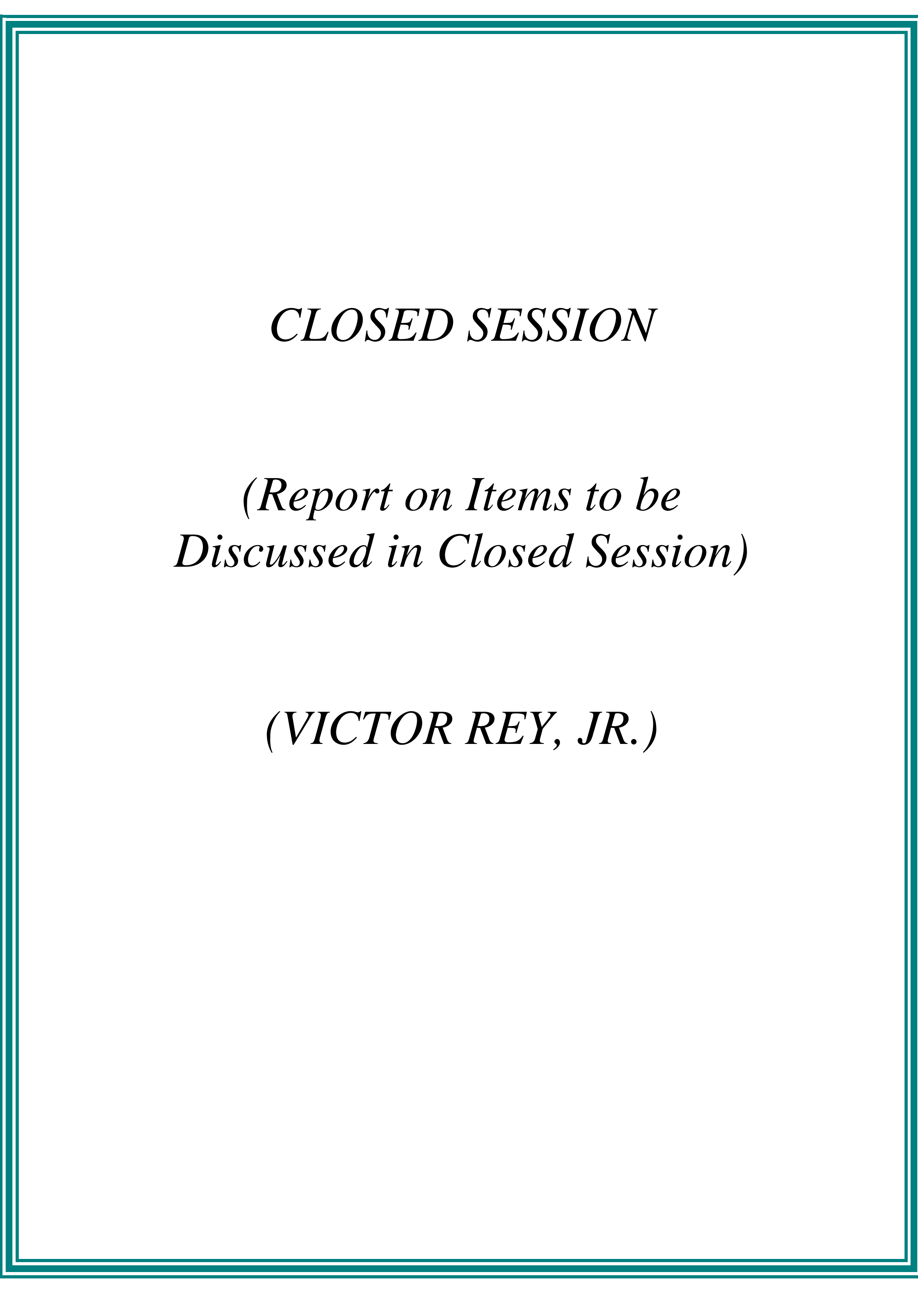
Name of case: (Specify by reference to claimant's name, names of parties, case or claim numbers):
Araujo et al vs. Salinas Valley Memorial Healthcare System

ADJOURN TO OPEN SESSION



CALL TO ORDER/ROLL CALL

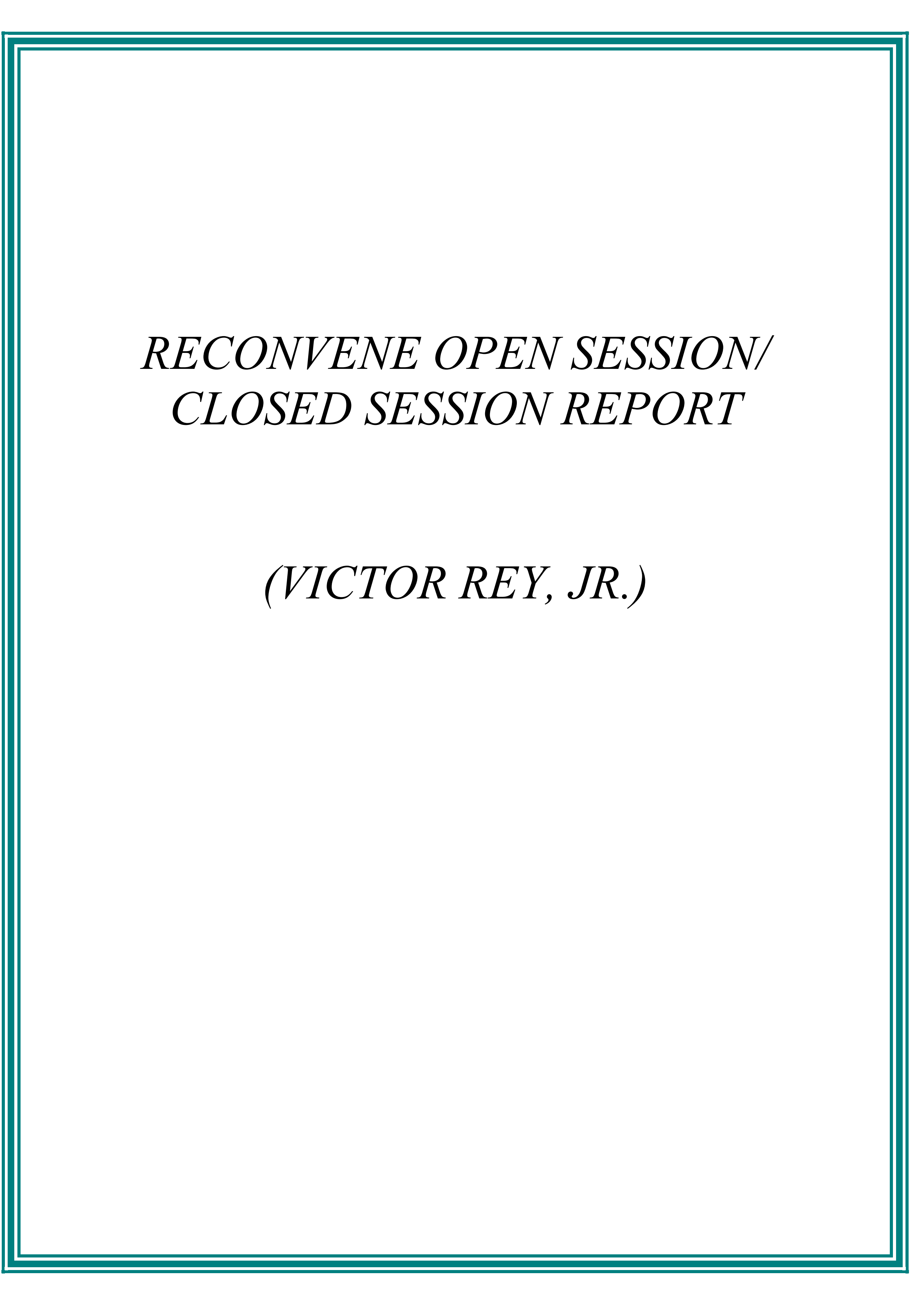
(VICTOR REY, JR.)



CLOSED SESSION

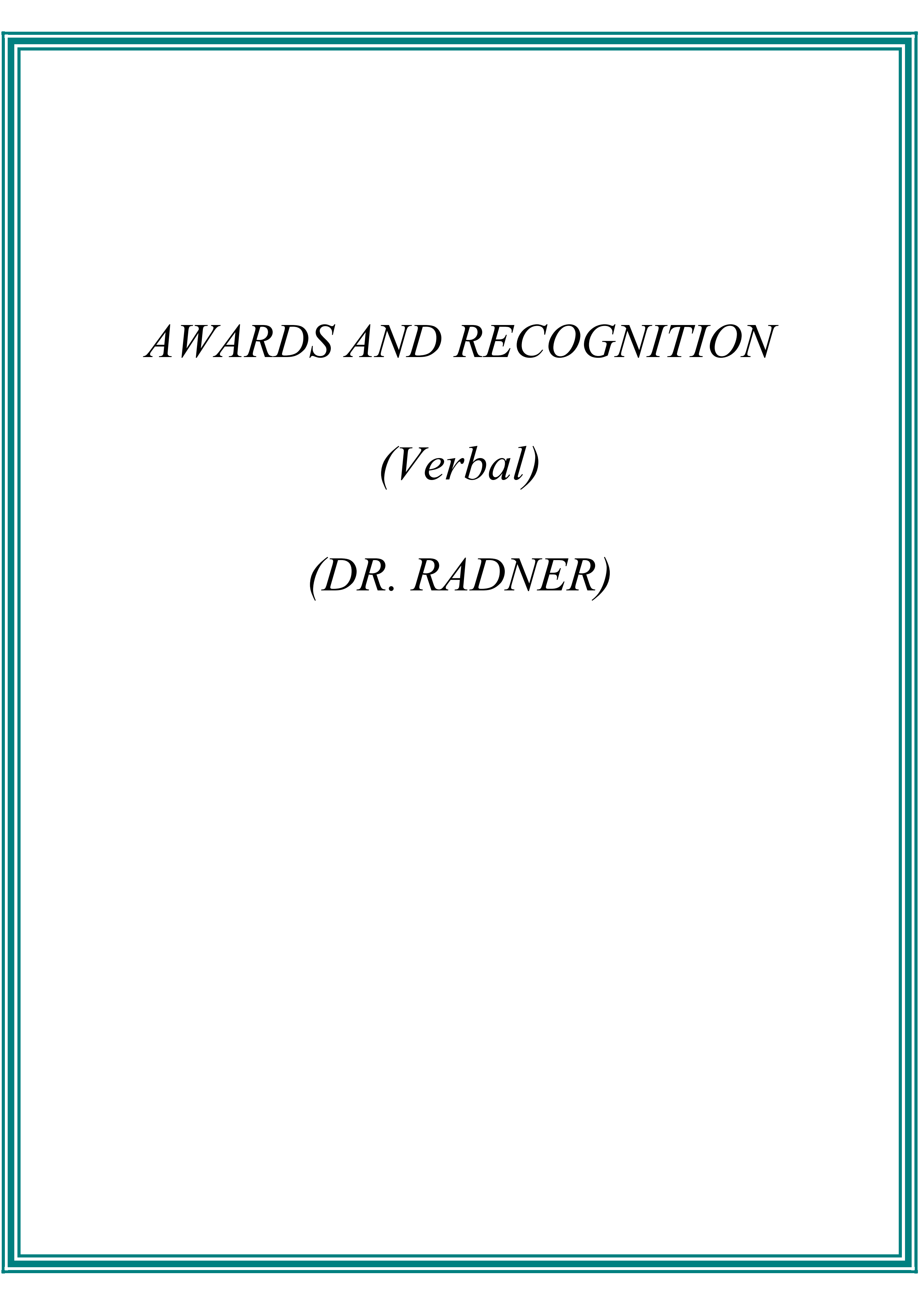
(Report on Items to be Discussed in Closed Session)

(VICTOR REY, JR.)



RECONVENE OPEN SESSION/ CLOSED SESSION REPORT

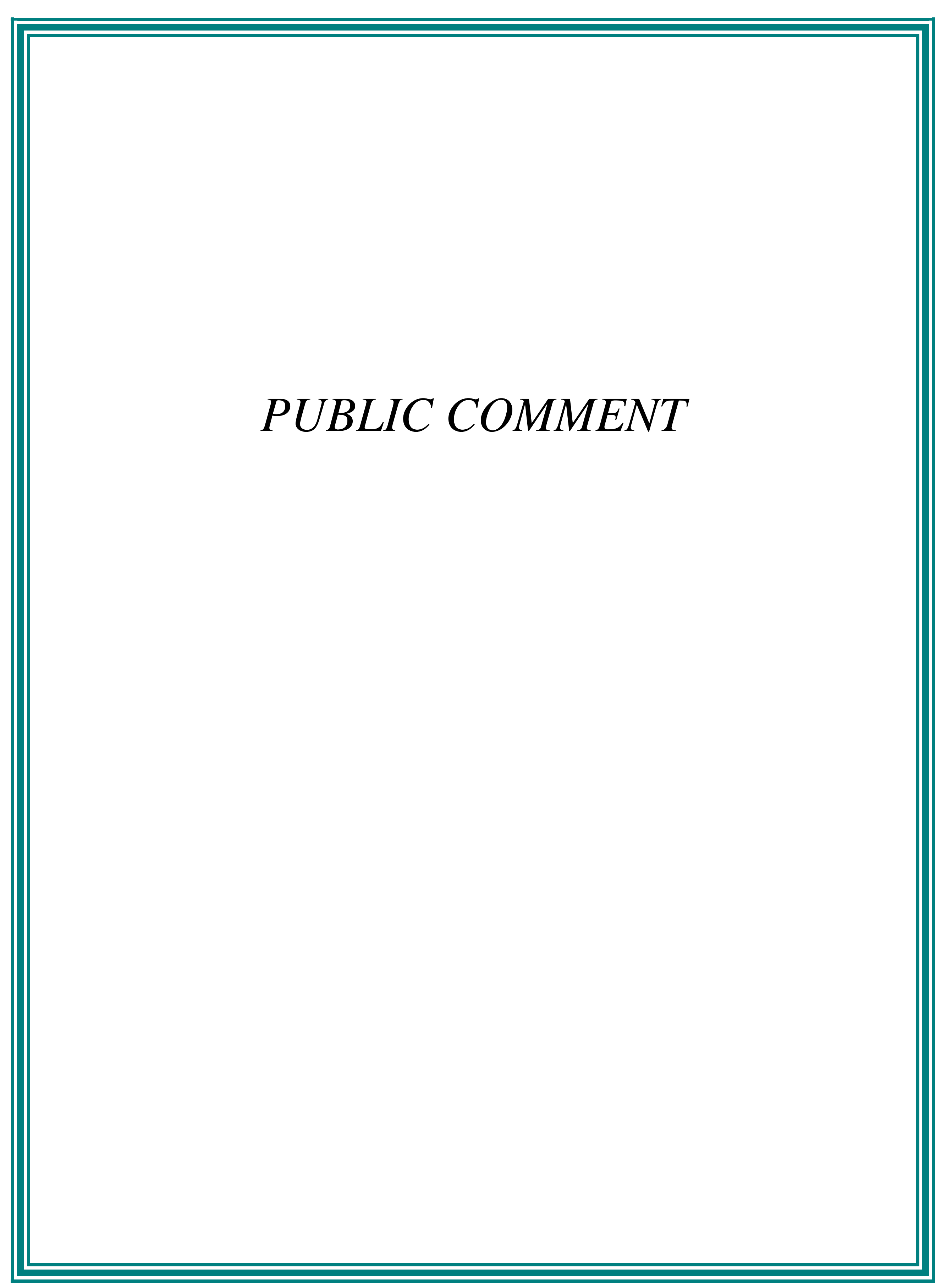
(VICTOR REY, JR.)

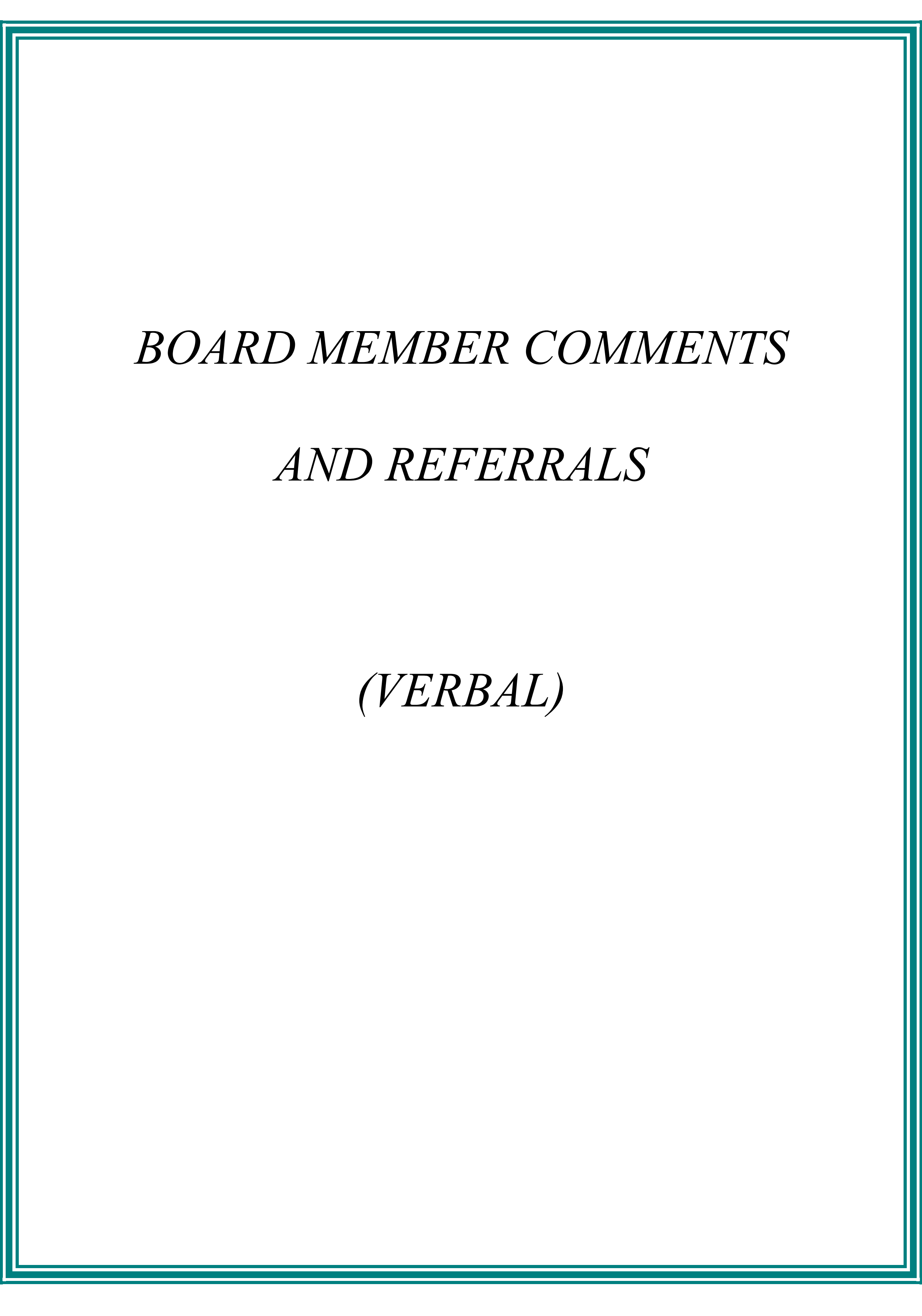


AWARDS AND RECOGNITION

(Verbal)

(DR. RADNER)


PUBLIC COMMENT



BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

Status Pending PolicyStat ID 15668446

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

Salinas Valley HEALTH

Infection Prevention Program Plan

I. PURPOSE

This plan describes the infection control program of Salinas Valley Health Medical Center (SVHMC) and Out-patient clinics, which is designed to provide for the coordination of all infection surveillance prevention activities and to deliver safe, cost-effective care to our patients, staff, visitors, and others in the healthcare environment (with emphasis on populations at high risk of infection). The program is designed to prevent and reduce hospital-associated infections and provide information and support to all staff regarding the principles and practices of Infection Prevention (IP) to support the development of a safe environment for all who enter the facility. The Infection Prevention Plan will be reviewed annually to determine its effectiveness in meeting the program's goals.

The plan provides oversight to the:

- Completion and evaluation of the Infection Prevention Risk Assessment
- Establishment of Infection Prevention Goals
- Identification of Surveillance Activities
- Review of Infection Prevention Data
- Preparation of emergency management activities to deal with the surge of agents/individuals
- Education of all staff to ensure a broad understanding of Infection Prevention strategies and individual requirements

The Plan guides all components of the hospital governing board, medical staff, administration, management, and staff, including clinical and non-clinical services, obtaining excellent patient outcomes that reduce the impact of healthcare-associated infections.

II. INFECTION CONTROL SCOPE OF SERVICES/ PROCESSES/STRUCTURE

Geographic location and community environment

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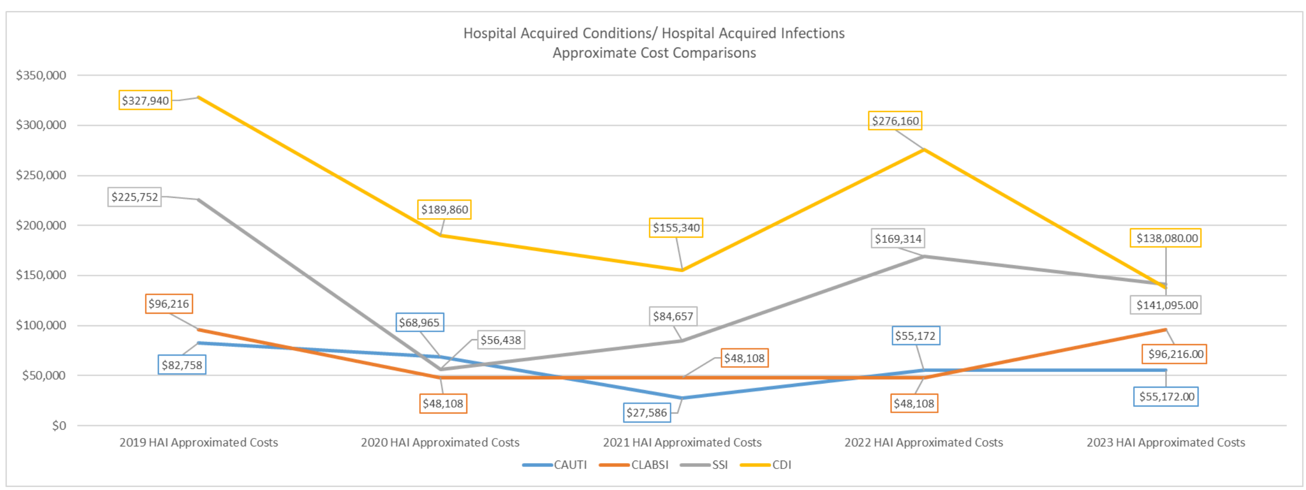
SVHMC is part of Salinas Valley Health. The healthcare system is an integrated network of healthcare programs and services, and at the core is a level 2 public district hospital with 263 beds, which employs approximately 1600 full-time employees, located in the town of Salinas, the county of Monterey on the central coast of the state of California. Salinas Valley Health has specialty clinics throughout the region, most centrally located near the hospital. Specialized programs include the Comprehensive Community Cancer Program, Joint Replacement Center, Regional Spine Center, Women and Children Center, Salinas Valley Health Clinic, Stroke Center, Taylor Farms Family Health and Wellness Center in Gonzales, Outpatient Infusion Center and the Regional Wound Healing Center. In addition, the hospital has a Level III neonatal Intensive Care Unit (NICU) and an expanded Level II Emergency Department. In 2023, there were 18,004 hospital admissions, with 43,736 patient days. The total number of Emergency service visits for 2023 was 63,955. OR surgical services performed 2,028 cases in 2023, averaging 5.6 cases daily.

Infection Prevention Financial Data Summary is based on the Agency for Healthcare Research and Quality (AHRQ) National Scorecard Report 2017. AHRQ summary of meta-analysis additional cost estimates for Hospital-Aquired Conditions (HACs) or Hospital Acquired Infections (HAIs) Estimated costs (95% confidence interval) per HAI ranging per event. Salinas Valley Health Medical Center had an approximate cost loss in 2019 for Catheter-Associated Urinary Tract Infection (CAUTI): $82,758, then in 2023, $55,172. Central-line Associated Bloodstream Infections (CLABSI) approximate cost loss in 2019 was $96,216, and in 2023, $96,216. Surgical Site Infections (SSI) approximate cost losses for 2019 are $225,752; for 2023, they are $141,095. Lastly, the approximate cost loss for C. difficile infections (CDI) for 2019 is $327,940, and $138,080 in 2023. (See below graph) In summary, HAC/HAI costs have reduced from 2019 in comparison to 2023. Salinas Valley Health Medical Center performance improvement measures for HAC/HAIs have made positive strides in preventing hospital-acquired infections and improving patient outcomes.



SVHMC serves Monterey County communities, which include Salinas, Seaside, Monterey, Soledad, Marina, Prunedale, Greenfield, Pacific Grove, King City, Gonzalez, and all other surrounding communities. SVHMC serves adjacent communities, such as Watsonville, Santa Cruz, San José, Big Sur, and Aptos. Monterey County area is surrounded by hills, mountains, streams, and the Pacific Ocean 15 miles to the west. The economy is primarily based on tourism and agriculture in the coastal regions of the Salinas River Valley. Most of the county's people live near the northern coast and Salinas Valley, while the southern coast and inland mountain regions are sparsely populated. Per the 2022 updated California Census data, the county's population was 432,858; 263,285 are Hispanic. The county seat and largest city is Salinas. The City of Salinas's population in 2017 was 157,596, with a population decrease since 2000 by -0.01%. The Patient

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population mix consists of African American 2.5%, American Indian 0.2%, Asian 5.6%, Hispanic 57.9%, and White 30.6%, which includes residents, people experiencing homelessness, and immigrants and seasonal farm workers. Per the 2020 National Census, 91.3% of Monterey County residents speak Spanish; 2.1% speak Tagalog. The estimated median household income from the 2020 Census Bureau for Monterey County residents is $128,227 annually; updated 2022 data shows a decrease in annual revenue to $91,043

Reported by Monterey County Public Health, 2022 Community Health Assessment, and additional Communicable Diseases reports that SVHMC that would potentially impact SVHMC:

- Specific diseases or conditions that showed a statistically significant increase in incidence rates were chlamydia, with an incidence rate of 500.6 (CA value 484.7), fall/winter respiratory viral illnesses (RSV, Influenza, and COVID-19), and syphilis.
- Although coccidioidomycosis rates have decreased in the last several years (per 100,000 population), from 56.6 in 2018 to 8.7 in 2023, SVHMC still sees a significant number of active cases in infectious disease clinics and in-patient hospitalizations. The populations affected the most are individuals 50 and older, mainly in Monterey's South County. The racial and ethnic groups most affected are African Americans.
- The most commonly reported enteric illnesses were campylobacteriosis, salmonellosis, and shigellosis. Affected population groups differed between these enteric pathogens, but incidence rates were generally highest among children under 15.
- Reported by Monterey County Public Health, 2012 Epidemiological Impact of Communicable Diseases, Sexually transmitted infections (STIs) represented the most significant portion of diseases reported in Monterey County. Individuals aged 15 to 24 accounted for the majority of reported chlamydia and gonorrhea cases. African Americans and Others (comprised of individuals of Native American/Alaskan Native, Multiracial, and Other racial groups) were disproportionally affected by chlamydia and gonorrhea. Men who have sex with men (MSM) were disproportionately affected by syphilis.
- MCPHD outbreaks of Syphilis in pregnant women and women of childbearing age, April 2019.Then again, in 2022, with increased incidence in mothers with congenital disease with increased transmission to infants. Syphilis incidence rate increased from 7.0 to 11.1 in 2022.
- MCPHD increased in Tuberculosis cases in 2023; the populations affected the most are those 50 years and older. The racial and ethnic groups most affected are African Americans and Hispanics.
- CDPH/MCPHD alerts to infectious disease outbreaks either nationally, state , or locally in the last year:
    - RSV and other respiratory virus activity continue to evolve, and new evidence emerges; the California Department of Public Health (CDPH) will collaborate with local health departments to assess and provide additional updates as they become available. CDPH provides brief guidance regarding vaccination, testing, treatment, and other preventive measures for respiratory viruses, January 2023
    - All Facilities Letter (AFL) notifying all hospitals about recommendations from the Centers for Disease Control and Prevention (CDC) regarding Ebola virus disease (EVD) preparedness, January 2023
    - Emergence of Candida auris in Healthcare Facilities in Northern California, February 2023
    - Shigella XDR (nationally), March 2023
    - CAHAN Alert, Potential Risk for New Monkeypox Cases. May 15, 2023

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- All Facility Letter (AFL) 22-09.1: Coronavirus Disease 2019 (COVID-19) Vaccine and Booster Recommendations for Clinically Eligible Individuals (This AFL supersedes AFL 22-23.1)
- AFL 22-23.2: Guidance for Response to Surge in Respiratory Viruses among Pediatric Patients (This AFL supersedes AFL 22.09)
- All Facilities Letter (AFL) 21-20.2 Coronavirus Disease 2019 (COVID-19) Vaccine Recommendations for Eligible Individuals Prior to Discharge (This AFL supersedes AFL 21-20.1)
- AFL 22-33.1 Guidance for Response to Surge in Respiratory Viruses Among Adult Patients (This AFL supersedes AFL 22-33)
- June, 2023:
    - CDC status of the ongoing fungal meningitis outbreak and highlights interim recommendations for diagnosis and treatment.
    - CDC/CDPH Preventing a Resurgence of Mpox Cases in California
    - CDC Bicillin® L-A (Benzathine Penicillin G) Shortage
    - CDC Health Advisory 493 - Guidance on Measles during the Summer Travel Season
    - CDC Health Alert Network (HAN) Health Advisory: Locally Acquired Malaria Cases Identified
    - CDPH News Release: Record Rainfall Raises Risk of Mosquito-borne Diseases
    - CDPH News Release: Potential Increased Risk for Valley Fever Expected
- CDC Health Alert Network (HAN) Health Advisory: Increased Respiratory Syncytial Virus (RSV) Activity in Parts of the Southeastern United States: New Prevention Tools Available to Protect Patients, September 2023.
- •09/06/23: CAHAN Disease Notification - CDC Health Alert Network (HAN) Health Advisory: Increased Respiratory Syncytial Virus (RSV) Activity in Parts of the Southeastern United States: New Prevention Tools Available to Protect Patients
- October 2023:
    - CAHAN All Facilities Letter – AFL 23-30 Guidance for Response to Anticipated Adult and Pediatric Surges in Respiratory Virus Transmission
    - CAHAN Disease Notification - CDPH Health Advisory: Preparation for Respiratory Virus Season (COVID-19, Influenza and RSV)
    - CAHAN Disease Notification - CDPH Health Advisory: Early Respiratory Syncytial Virus (RSV) Activity and Use of RSV Prevention Products
    - CAHAN Disease Notification - CDPH Health Advisory: Increase in Mpox Cases in California: Updates on Identification, Laboratory Testing, Management and Treatment, and Vaccination for Mpox
- •CAHAN All Facilities Letter – AFL 23-33: Coronavirus Disease 2019 COVID-19) Vaccine Recommendations for Eligible Individuals Prior to Discharge (This AFL supersedes AFL 21-20.2), November 2023.
- Increase in respiratory illnesses globally: The CDC is monitoring respiratory illnesses around the world. Some countries have reported elevated levels of respiratory illness

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activity. Respiratory illnesses are monitored by the CDC around the world. Some countries have reported elevated levels of respiratory illness activity. Circulating respiratory illnesses include influenza, COVID-19, respiratory syncytial virus (RSV) infection, and Mycoplasma pneumoniae infection, December 2023.

The hospital has identified the Infection Prevention Manager as the individual with clinical authority over the infection prevention program. The Infection Preventionist (IP) is a qualified individual who manages the ongoing infection prevention program. Qualifications include appropriate education and training and obtaining & maintaining certification (CIC) in infection control.

The Infection Preventionist 's role is ongoing with regular over-site and collaborative efforts in surveillance, specific environmental monitoring, continuous quality improvement, consultation, committee involvement, outbreak and isolation management, and regulatory compliance and education.

The infection prevention function reports to the Senior Administrative Director of Quality & Safety, who reports to the Chief Medical Officer and the SVHMC Administration. Responsibilities of the infection Preventionist include, but are not limited to:

- Managing the Infection Prevention Program under the direction of the Pharmacy & Therapeutics/ Infection Prevention Committee.
- Collecting and coordinating data collection, tabulation, and reporting of healthcare-associated and communicable infections
- Facilitating the ongoing monitoring of the effectiveness of prevention/control activities and interventions
- Educating selected patients, families, and hospital staff about infection prevention principles
- Serving as a consultant to patients, employees, physicians and other licensed independent practitioners, contract service workers, volunteers, students, visitors, and community agencies
- Taking action on recommendations of the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee
- Surveillance Rounds in clinical areas
- Active Participation in the Antimicrobial Stewardship Program

The Medical Staff Committee is a multidisciplinary team that sanctions the Pharmacy & Therapeutics/ Infection Prevention Committee. The Medical Director for Infection Prevention is an Infectious Disease Physician and Committee member. The IP Medical Director works collaboratively with the infection preventionist to administer and manage the infection control program. The committee membership is responsible for developing and implementing strategies for components/functions of the Infection Prevention Program. It includes representation from the Medical Staff, Administration, Nursing Service, Safety, Physician Office Practices, Laboratory, Performance Improvement, EVS, Operating Room, Pharmacy, and Community Health. Determining the effectiveness of the key processes for preventing infections is an ongoing function of the Committee. Pharmacy & Therapeutics/Infection Prevention Committee meeting minutes are reported to the Medical Staff Committee, then to SVHMC Administration and Board of Directors to assess the adequacy of resources allocated to support infection prevention activities.

III. AUTHORITY

A. Integration of Hospital Components and Functions into Infection, Prevention Activities

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Infection prevention is integrated into clinical departments. Clinical departments identify department-specific infection prevention concerns. Department-specific infection prevention policies are developed from the concerns. Each department's specific infection prevention policies are reviewed/ revised every three years. The department director/manager or designee and infection preventionist discuss proposed revisions before submitting them to the Pharmacy & Therapeutics/Infection Prevention Committee for approval. After approval, the policies are reviewed and approved by the Medical Staff, the SVHMC Administration, and the Board of Directors. Once final approval is obtained, the infection preventionist communicates decisions to the department director/manager. Before implementation, major policy revisions or changes are discussed at the Pharmacy & Therapeutics/Infection Prevention Committee and Quality Interdisciplinary Committee.

Infection Prevention Policies are developed to guide the practice and provide consistency in applying principles throughout the organization. These policies are available on the SVHMC Intranet called the "STAR net" and are communicated to staff upon hire, yearly, during safety and leadership meetings, and as updates or changes occur.

IV. DEFINITIONS

N/A

V. STRATEGIES

A. RISK ASSESSMENT

An annual assessment/reassessment is conducted to determine the presence and changing needs of the organization and surrounding community to assist in the design and development of appropriate facility-specific strategies to address the unique and emerging characteristics of the hospital environment. The hospital evaluates risk for the transmission and acquisition of infectious agents throughout the hospital and is based on the collection of the following information:

- Identify risks for transmission of infectious diseases based on patient/community demographics, medical services provided, and epidemiological trends.
- The characteristics of the population served
- The results of the hospital's infection prevention data

The Risk Assessment is completed on at least an annual basis or whenever significant changes are noted to occur in any of the above-stated criteria.

Once the risks are identified, the organization prioritizes those of epidemiological significance.

The tool was revised to precisely capture the risk of acquiring or transmitting central line bloodstream infections, multi-drug resistant organisms and surgical site infections, and catheter-associated urinary tract infections.

B. STRATEGIES TO ADDRESS THE PRIORITIZED RISKS

Specific strategies are developed and implemented to address the prioritized risks. These strategies may include policy and procedure establishment, surveillance and monitoring activities,

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education and training programs, environmental and engineering controls, or combinations thereof.

General Scope and Activities of the Infection Control Program

1. Maintenance of a sanitary physical environment, including but not limited to high and low-level disinfection
2. Management of staff, physicians, and other personnel, including but not limited to screening for exposure and immunity to infectious diseases
3. Mitigation of risk associated with patient infections present on admission
4. Mitigation of risks contributing to healthcare-associated infections
5. Active surveillance
6. Communication/coordination with outside agencies
7. Pandemic Management

C. ACTIVE SURVEILLANCE

The Infection Preventionist is responsible for facilitating hospital-wide surveillance and processes to prevent infections. Surveillance methods include daily nursing unit rounding, review of positive lab culture reports, review of newly admitted patients, and referrals from Nursing, Case Management, and Physicians.

Based on the population served, the following indicators were chosen for 2023-2024 to guide infection control surveillance activities:

- All Healthcare Onset Central line Bloodstream Infections
- All healthcare-onset catheter-associated Urinary Tract Infections
- Central Line Insertion Practices (CLIP) & Compliance
- All Healthcare Onset Multi-Drug Resistant Organisms (MDRO), including:
    - Clostridium difficile Surveillance Facility-wide,
    - MRSA Bloodstream Infections Facility-wide
    - VRE Bloodstream Infections Facility-wide
- Infections such as multi-drug resistant organisms (MDRO), including admission & discharge screening and surveillance of MRSA per California Senate Bill 1058
- All Surgical Site Infections designated by CDPH & CMS via NHSN
- CMS requirements for reporting Healthcare Worker Vaccination data for SARS-COV-2 into NHSN
- CDPH and Cal OSHA requirements for reporting SARS-COV-2 outbreaks in healthcare workers
- CPDH Reportable Diseases, including Seasonal Influenza and Active Tuberculosis patients
- Environment of Care Surveillance Rounds
- Hand Hygiene

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The CDC/NHSN definitions are used to determine the presence of nosocomial infection. The comprehensive data collection process is based on current scientific knowledge, accepted practice guidelines, and all applicable laws and regulations. NHSN is the database where all events (infections) are credited and conferred rights to all mandated agencies (i.e., CDPH, CMS, etc.)

D. REGULATORY AGENCIES AND GUIDELINES

In addition, administrative involvement and the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee facilitate the committee's/function's role as a compliance body, assuring guidelines and standards of regulatory and accreditation organizations are applied consistently throughout the organization. Guidelines and standards of the Occupational Safety and Health Administration (OSHA), The Joint Commission, the Center for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), National Healthcare Safety Network (NHSN), The Association for Practitioners in Infection Control and Epidemiology (APIC), and California Department of Public Health (CDPH), state and federal laws are integrated into the organization's infection prevention policies as they are developed and compliance is monitored ongoing.

E. ROLE OF THE INFECTION PREVENTIONIST:

- Surveillance and evaluation identified clusters of infection
- Reduce the incidence of preventable infection.
- Maintain formal and informal systems to identify trends in infection occurrence.
- Investigate and recommend action to resolve identified Infection Prevention concerns.
- Communication of significant problems to administration and medical staff through designated channels promptly.
- Institutional policies and procedures for the surveillance and prevention of infection:
    - Develop and maintain Infection Prevention Plan.
    - Define the activities of the Infection Prevention Department.
- Consultative services to departmental Infection Prevention Programs:
    - Assist departments to develop and implement department-specific procedures.
    - Assist departments in defining their role and scope in surveillance and prevention of infection.
    - Assist departments with compliance with the requirements of regulatory and accrediting agencies.
    - Facilitate cost containment and revenue preservation.
- Collaborates with the SVHMC Employee Health Department:
    - Consults on processes/procedures to minimize and manage risks of infection to staff.
    - Receives reports, evaluates, documents, and reports diseases of epidemiologic significance in employees, defined as any infectious disease.
- Education in Infection Prevention is provided to hospital staff, including hospital employees, physicians, volunteers, and students.

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- Liaison between the State and Local Public Health Department and SVHMC.

F. OUTBREAK MANAGEMENT

Outbreaks may be identified during surveillance activities. The infection control practitioner is authorized to take immediate action to control any outbreak utilizing sound epidemiologic principles in investigating its origin and root cause analysis. See policy OUTBREAKINVESTIGATION.

G. DEFINITIONS USED IN IDENTIFYING HEALTHCARE-ASSOCIATED INFECTIONS

The CDC/NHSN provides definitions for healthcare-associated infections to create statistics that are as comparable as possible to statistics cited in the literature. The CDC/NHSN updates the definitions bi-annually. It must be noted that the CDC/NHSN definitions are statistical, NOT clinical. Therefore, a clinical situation that warrants treatment may not always meet the CDC/NHSN definition of HAI definition.

H. INTEGRATION OF THE INFECTION CONTROL PROGRAM INTO SVHMC'S PERFORMANCE IMPROVEMENT PROGRAM

The infection prevention program is fully integrated with the hospital's overall process for assessing and improving organizational performance. Risks, rates, and trends in healthcare-associated infections are tracked over time. This information is used to strengthen prevention activities and to reduce nosocomial infection rates to the lowest possible levels. The infection prevention program works collaboratively with the employee health program to reduce the transmission of infections, including vaccine-preventable infections, from patients to staff and staff to patients. Employee health data is also aggregated, tracked, and trended over time to identify opportunities for improvement.

Management systems, including staff and data systems, assist in achieving these objectives. Such systems support activities, including data collection, analysis, interpretation, and presentation of findings using statistical tools. Findings from the Pharmacy & Therapeutics/Infection Prevention Committee are provided to the Quality & Safety Committee, Medical Staff Committee, the SVHMC Administration and Board of Directors

The following infection prevention information is currently reported at least quarterly through the organization's performance improvement (PI) activities:

- CPDH Reportable Diseases, including Seasonal Influenza and Active Tuberculosis patients
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Bloodstream Infections (CLABSI)
- Central Line Insertion Practices (CLIP) & Compliance
- Multi-Drug Resistant Organisms (MDRO) rates :
    - Clostridium difficile Surveillance Facility-wide,
    - MRSA Bloodstream Infections Facility-wide
    - VRE Bloodstream Infections Facility-wide
- Hand Hygiene Facility-wide
- Surgical Site Infections (per NHSN guidelines) on Cardiac (CBGB/CBGC), Caesarian

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Sections, Total Hip, Total Knee, Colectomy, Hysterectomy

- See Attachments: Risk Assessment Grid and Correlating Performance Improvement Plan

I. GOALS

Based on the Risk Assessment, SVHMC establishes goals on an annual basis to reflect the current trends and environmental factors of the hospital and community. The following goals are established yearly, and additional goals are established as needed based on the ongoing assessments, surveillance, circumstance, and data trends, which shall include:

- Decrease CAUTI hospital-wide from SIR 0.173 in 2022 to 0.381 in 2023. *SIR Goal: HHS Goal = below 0.75*
- Decrease CLABSI hospital-wide SIR from 0.563 in 2022 to 0.559 in 2023. SIR Goal: HHS Goal = below 0.5
- Decrease Utilization of Central Lines and Foley Catheters.
- Clostridium difficile: There will be an ongoing reduction facility-wide SIR of 0.631 in 2022 to 0.299 in 2023. *HHS Goal= below 0.70*
- Sustain Hand Hygiene compliance rate >80%.
- Surgical Site Infection (SSI) hospital-wide SIR from 0695 in 2022 to 0.607 in 2023. SIR Goal: HHS Goal = below 0.5
- Surgical Site Infection (SSI) reduction by implementing an SSI prevention bundle.
- Decrease the possible transmission of infection on portable equipment, reusable equipment, etc., by evaluating EVS standards of practice and implementing tools to aid in improving EVS processes.
- Evaluating and monitoring High and Low-Level Disinfection processes hospital-wide.
- Environment of Care Surveillance

J. EMERGENCY PREPAREDNESS AND MANAGEMENT

Infection Preventionist(s) participate in the hospital-wide emergency plan via the Hospital Incident Command System (HICS). In the HICS system, a Biological / Infectious Disease Medical Specialist will be called in as needed by the Incident Commander.

Multiple established resources exist in the event of an influx of potentially infectious patients. The hospital is part of the Monterey County Emergency Response System and has an Emergency Manual for all the regional hospitals listing resources regarding infectious patients, including bioterrorism. The Infection Prevention Department works collaboratively with the local and state health departments that serve as resources.

The infection prevention department regularly receives updates from the local and state health departments regarding emerging infections in the community and state, as well as surge capacity and syndrome surveillance. The syndromes monitored are asthma, diarrhea, gastroenteritis, vomiting, fever, rash, sepsis / septic shock, and chicken pox.

The hospital communicates this information to licensed independent practitioners and staff if

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patterns are identified. Medical Staff would be notified and communicate the information to the medical providers via the staff structure. The nursing staff also has a similar structure; the Chief Nursing Officer would be notified, and information would be communicated to nursing directors and unit managers for communication to staff. The hospital has an education department that can assist, if needed, in staff education.

The hospital has developed a process that details the hospital's planned response to an influx of infectious patients. The plan addresses infectious control practices for patients, post-exposure management, management of large-scale exposures, post-incident debriefing, laboratory support, and CDC information if needed. If needed, the hospital has a nurse-staffing plan that can be implemented to care for patients over an extended period.

Supporting documents:

- EMERGING INFECTIOUS DISEASES INFECTION PREVENTION PANDEMIC PLAN
- ISOLATION - STANDARD AND TRANSMISSION-BASED PRECAUTIONS
- EMPLOYEES EXPOSURES & PREVENTION PLANS: SPECIFIC DISEASE EXPOSURES AND WORK RESTRICTIONS
- EMERGENCY OPERATIONS PLAN
- INFLUENZA PANDEMIC PLAN
- Aerosol Transmitted Diseases Exposure Control Plan
- INFECTION PREVENTION AUTHORITY STATEMENT

VI. ORIENTATION AND EDUCATION

A. Orientation, education, and training is provided on an as-needed basis.

VII. DOCUMENTATION

A. ANNUAL EVALUATION OF PLAN

The Infection Prevention Performance Improvement Report is updated/reviewed quarterly at Pharmacy & Therapeutics/Infection Prevention Committee meetings. New risks or changes in priorities are identified throughout the year. At the end of each year, the outcomes of each identified goal are determined and considered for inclusion in next year's plan. The revised Plan is taken to the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee for final revisions and approval.

VIII. REFERENCES

A. The Joint Commission Infection Prevention and Control

B. Title 22 Infection Control Program 70739

C. APIC Text of Epidemiology and Infection Control and Epidemiology, Association for Professionals in Infection Control and Epidemiology (APIC), Inc., 2023

D. National Healthcare Safety Network (NHSN) Patient Safety Component Manual January 2023: https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf

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E. California Department of Public Health, Communicable Disease Data. https://www.cdph.ca.gov/data/statistics/Pages/CDdata.aspx.

F. Monterey County Health Department: https://datasharemontereycounty.org

G. Monterey County Health Department, Communicable Diseases Report: Salinas, California: Public Health Bureau, Communicable Disease Unit. https://www.co.monterey.ca.us/government/departments-a-h/health/public-health/communicable-disease-unit

H. US Census Bureau, https://www.census.gov/data/tables/2020/dec/2020-apportionment-data.html

I. ***NHSN Reports***, the webpage contains reports organized by the year of data included in the report. The annual reports include the Antimicrobial Resistance Reports, National and State-specific Healthcare-Associated Infections Progress Reports, and additional NHSN reports and resources; 2004 to 2020. https://www.cdc.gov/nhsn/datastat/index.html.

J. The NHSN Standardized Infection Ratio (SIR), A Guide to the SIR. Updated 02/2021. https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

K. Estimating the Additional Hospital Inpatient Cost and Mortality Associated With Selected Hospital-Acquired Conditions, 2017. https://www.ahrq.gov/hai/pfp/haccost2017-results.html

Attachments

2024_2025 IP Risk Assessment Analysis.pdf

2024_2025 Risk Assessment PI Plan.doc

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	08/2024
P&T Committee	Genevieve delos Santos: Director Pharmacy	08/2024
Quality Improvement Committee	Aniko Kukla: Director Quality & Patient Safety	08/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2024
Policy Owner	Melissa Deen: Manager Infection Prevention	04/2024

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Standards

No standards are associated with this document

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DRAFT SALINAS VALLEY HEALTH[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
JULY 25, 2024

Board Members Present: President Victor Rey, Jr., appearing via teleconference pursuant to Government Code Section 54952.7(b)(1), Vice-President Joel Hernandez Laguna, Juan Cabrera, Rolando Cabrera, MD and Catherine Carson;

Absent: None.

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

Victor Rey arrived (via videoconference) at 4:09 p.m. during Closed Session.
Victor Rey left (via videoconference) at 5:14 p.m.

1. CALL TO ORDER/ROLL CALL

A quorum was present and Vice-President Hernandez Laguna called the meeting to order at 4:02 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. CLOSED SESSION

Vice-President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports, (2) Conference with Labor Negotiator-National Union of Healthcare Workers, California Nurses Association, Local 39, ESC Local 20, (3) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, (4) Conference with Legal Counsel Existing Litigation,* and *(5) Conference with Legal Counsel Anticipated Litigation*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:04 p.m. The Board completed its business of the Closed Session at 4:40 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:46 p.m. Vice-President Hernandez Laguna reported that in Closed Session, the Board discussed *(1) Hearings and Reports, (2) Conference with Labor Negotiator-National Union of Healthcare Workers, California Nurses Association, Local 39, ESC Local 20, and (3) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services.* The Board received and accepted the reports listed on the Closed Session agenda.

Vice-President Hernandez Laguna announced there is a need for an extended closed session. The items to be discussed in Extended Closed Session will be *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, and (2) Conference with Legal Counsel Existing Litigation,* and *(3) Conference with Legal Counsel Anticipated Litigation*.

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

4. AWARDS AND RECOGNITION

Dr. Radner announced it was his pleasure to open the Awards and Recognition portion of the Board of Directors. The following was presented:

- **STAR Award Holly Lombardi**: Clement Miller, COO, introduced Holly Lombardi, Breast Ultrasonographer/Mammography Center. A patient nominated Holly who wrote: "Holly is fabulous! She made the very scary feeling of getting a biopsy melt away. She was professional, knowledgeable & encouraging. We were able to connect on a personal level and laugh together. Which made a bad situation bearable. I felt loved and well cared for. I joked that I had fun with her but never actually wanted to see her ever again (given the circumstances). However, I truly felt like I left that office with yet another person to add to my cheer corner. Holly is well deserving of any and all recognition." Holly commented she has worked here for over a decade. She comes to work with the fullest heart and leaves with an even fuller heart. She works with cancer patients; loves our patients, and loves what she does. She thanked the Board for having the opportunity to work at Salinas Valley Health (SVH) and feels blessed to work here.
- Julie Vasher, Director/Women and Children's Services, reported SVH has received the following awards based on quality, safety and patient experience:
  - **High Performing Hospital/Maternity by US News and World Report** which is based on newborn complications, early elective deliveries, episiotomy rates, routine VBAC option, excluding breastfeeding rates, birthing-friendly practices ensuring equity in the delivery of care, reviewing outcome data with a lens to race and ethnicity to detect potential disparities
  - **The Joint Commission Healthy People 2030 NTSV Award** for exceeding the target of less than 23.6 Nulliparous Term Singleton Vertex (NTSV) Cesarean birth rate, that measures the number of live babies born by cesarean section to women in their first pregnancy. A multidisciplinary team of nurses, management and physicians worked together to develop criteria for patient care. In our last quarter our rate was 18.8% NTSV which is outstanding.
  - **BETA Healthcare Award/Quest for Zero**: SVH received its 14th Consecutive award. The criteria are now a part of our culture.

  BOARD MEMBER DISCUSSION: Director Carson reported that perinatal performance is tracked in the quality dashboard and is consistently high. She has never seen a NTSV rate of 18; the rate is usually around 30%. She also stated that some insurance companies will not allow a client to deliver at a hospital not meeting the benchmark. The team is doing a great job.
- Clement Miller, COO, reported SVH has received the following awards:
  - **2024 Platinum Performance Achievement Award: Chest Pain – MI Registry:** This is the highest designation. A hospital becomes eligible to receive this designation after 8 consecutive quarters (2 years) of data is submitted and shows the highest quality of care rendered for acute myocardial infarction patients. Congratulations was given to the team for their dedicated work in support of our cardiac patients that

resulted in their tribute to “Top level performance.” The team includes the entire hospital from the ER, cath lab, and floors; they have done an amazing job.

  - **American Heart Association Gold Plus Get with the Guidelines Award for Stroke:** This is the highest recognition of all of the stroke awards for Primary Stroke Centers. This award includes targets of Stroke Honor Roll Elite and Type 2 Diabetes Honor Roll.
  - **American Heart Association Gold Award for Coronary Artery Disease NSTEMI:** This award includes the target of Type 2 Diabetes Honor Roll.

- **US News & World Report BEST Regional Hospital and High Performing Hospital:** Aniko Kukla, Director/Quality and Patient Safety, reported nearly 5,000 U.S. hospitals were evaluated. SVH is among only 11% that earned a numerical ranking. Not only did we receive the *Best Regional Hospital* award, we also earned a medallion for *Best Regional Hospitals for Equitable Access*. US News evaluated 418 hospitals in California. 70 met the standards for recognition as Best Regional Hospital in California. SVH was previously ranked as 44th in the state, we have moved up to being tied at 50th out of 317 California hospitals. *U.S. News* ranked SVH as high performing in 10 out of 20 procedures and conditions for spinal fusion, congestive heart failure, heart attack, lymphoma and myeloma, pneumonia and stroke, kidney failure, diabetes, hip fracture, leukemia and maternity care.
- **2024 California Opioid Honor Roll from CalCompare Excellent Recognition:** Aniko Kukla, Director/Quality and Patient Safety, reported that 157 hospitals participated in the program (out of the 347 California adult, acute care hospitals). There are 3 levels of recognition: Superior, Excellent and a participant award. SVH is one of 39 hospitals that met the ‘Excellent’ recognition. The Opioid Honor Roll is rebranding into Substance Use Disease (SUD) Care Honor Roll to include other substance use disorders. Considerable work was already done at SVH for all SUDs.
- **Nine Epic Gold Stars:** Josh Rivera, Director/Enterprise Informatics, reported that SVH has achieved an outstanding feat. We've been awarded nine Gold Stars by Epic, surpassing industry averages. With an impressive 86% completion rate of Gold Stars items is a direct reflection of the exceptional proficiency of our team and our staff's ongoing dedication to optimizing patient care. This achievement reflects our dedication to optimizing patient care through advanced system features and Epic best practice. Less than 15% of hospitals using Epic receive this recognition. The Epic Team has done a tremendous amount of great collaborative work. This is a significant award for the organization. Almost the entire team was present to be recognized.

5. PUBLIC COMMENT:

None

6. BOARD MEMBER COMMENTS AND REFERRALS

Vice President Joel Hernandez Laguna: Director Hernandez Laguna and Director Dr. Cabrera went on a tour of the ED provided by Ms. Spencer and Dr. Radner. Additionally, Dr. Radner and he attended the Gonzalez City Council meeting to provide an update regarding SVH.

Director Juan Cabrera: Director Cabrera stated he recently had a family member in the hospital. The care was excellent, and everyone was nice and attentive. He thanked staff, doctors, nurses for their care, and Aniko Kukla for her attention to quality. It takes everybody to make the hospital function well and he thanked the care team for taking care of his relative.

Director Rolando Cabrera, MD: None

Director Catherine Carson: Congratulation everyone recognized tonight, including physicians, nurses and staff.

President Victor Rey, Jr.: None

7. CONSENT AGENDA – GENERAL BUSINESS

Recommend Board Approval of the Following:

A. Minutes of the Regular Meeting of the Board of Directors June 27, 2024
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
   1. Fecal Management System in the ICU Nursing Standardized Procedure
   2. Hyperbilirubinemia-Infant Management & Treatment
   3. Nipple Shields
E. Approved Projects
   1. Budget Augmentation for Nuclear Medicine Equipment Replacement Project.
   2. Budget Augmentation for CT Equipment Replacement Project.

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION: Director Carson stated the policies are done really well. The financial report at the Finance Committee demonstrates the outstanding work being done by the CEO, the finance team and the Finance Committee. The teamwork shows.

MOTION:

Upon motion by Director Dr. Cabrera, second by Director J. Cabrera, the Board of Directors approved the Consent Agenda, Items (A) through (E), as listed above.

ROLL CALL VOTE:

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

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 minutes were provided for Board review. There was a presentation by the Professional Development Council, including their work on improving the BSN rate, improving specialty certification,

retention, resulting in low turnover. There was also a report by the Opioid Committee. A lot of work is being done in the area led by Erica Locke, MD, addressing the crisis to provide services and help patients. The following recommendation was made.

1. Consider Recommendation for Board approval of providing harm reduction services and education to hospitalized patients who use illicit substances in Monterey County and ensure the availability of equitable, safer drug-use supplies upon discharge.

PUBLIC COMMENT: Dr. Locke thanked the Board for spearheading change in practice to save people's lives.

BOARD MEMBER DISCUSSION:
None.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director J. Cabrera, the Board of Directors approves providing harm reduction services and education to hospitalized patients who use illicit substances in Monterey County and ensure the availability of equitable, safer drug-use supplies upon discharge.

ROLL CALL VOTE:

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

Motion Carried

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE

A report was received from Director Juan Cabrera regarding the Personnel, Pension and Investment Committee. The following recommendation was made.

1. Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Jamil Matthews, MD, (ii) Contract Terms for Dr. Matthews' Recruitment Agreement, and (iii) Contract Terms for Dr. Matthews' Vascular Surgery Professional Services Agreement.

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION: Thanks was extended to the physician recruitment team.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Carson, the Board of Directors makes the following findings and approves the recommendations as follows:

(i) The Findings Supporting Recruitment of Jamil Matthews, MD;

- That the recruitment of a vascular 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;

(ii) The Contract Terms of the Recruitment Agreement for Dr. Matthews; and

(iii) The Contract Terms of the Vascular Surgery Professional Services Agreement for Dr. Matthews.

ROLL CALL VOTE:

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

Motion Carried

C. FINANCE COMMITTEE

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

1. Consider Recommendation to the Board of Directors for Approval of the of the Workday Financial and Supply Chain Management Solutions as Sole Source and Contract Award

MOTION:

Upon motion by Director Carson, and seconded by Director Dr. Cabrera, the Board of Directors approves the Workday Enterprise Resource Planning project as sole source and contract award with a total budget over six years estimated at $10,011,108 (after offsets of $1,791,245), and approval of a six (6) year contract with Workday, Inc., in the amount of $4,899,800 for software subscription, training and implementation services subject to final legal review.

PUBLIC COMMENT:
None.

BOARD DISCUSSION: Staff is doing a wonderful job with the economic situation. This system integrates with the Epic system.

ROLL CALL VOTE:

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

Motion Carried

2. Consider Recommendation for Board of Directors approval of the Lease Agreement Between Salinas Valley Memorial Healthcare System (SVMHS) and Mobile Modular Management Corporation for the Installation and Lease of Two (2) Modular Units.

MOTION:

Upon motion by Director Dr. Cabrera, and seconded by Director Carson, the Board of Directors approves the Lease Agreement between Salinas Valley Memorial Healthcare System (SVMHS) and Mobile

Modular Management Corporation for the construction and lease of two (2) modular units, pending final contract negotiations and legal counsel approval.

PUBLIC COMMENT:
None.

BOARD DISCUSSION: Approval will expedite this project to help get the modular units installed as soon as possible. Thank you for moving this along to facilitate moving away from the tents. This is an important project for our patients.

ROLL CALL VOTE:

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

Motion Carried

D. TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE

A report was received from Director Dr. Cabrera regarding the Transformation, Strategic Planning and Governance Committee. There was a great presentation on the Levine Act Rules and will help Board Members remain compliant while conducting business and navigating the election process. The minutes were provided for Board review.

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON JULY 11, 2024, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING:

Allen Radner, MD, President/CEO, reviewed the reports of the Medical Executive Committee (MEC) meeting of July 11, 2024, and Policies/Procedures/Plans revisions. Proposed Medical Staff Bylaws Amendments were included in the packet for review. Bylaw revision has been a long process. The Bylaws will be presented for approval to the medical staff at the next Annual Medical Staff Meeting. The full Bylaws will then be referred to the Board of Directors for final approval. 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. Care of the Patient with an IRRAflow Irrigation Catheter
   2. Medical Cannabis for the Terminally Ill Patient
   3. Medication Use
   4. Restraints

PUBLIC COMMENT:
None.

BOARD DISCUSSION: Dr. Singh stated it is exciting to increase physicians for Taylor Farms Health and Wellness Clinic. There has been a lot of work done surrounding Ryan's law which provides medical cannabis for the terminally ill patient. Well done.

MOTION:

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

A. Reports
   1. Credentials Committee Report (Including the following)
      - Anesthesiology Clinical Privileges Delineation Revision
      - Robotic Surgery Clinical Privileges Delineation Revision
   2. Interdisciplinary Practice Committee Report (Including the following)
      - Abdominal Pain Nursing Standardized Procedure
      - HCG Recheck Nursing Standardized Procedure
      - Intraosseous Infusion Nursing Standardized Procedure
      - Nausea and Vomiting Nursing Standardized Procedure
      - SEPSIS Management Nursing Standardized Procedure
      - Urinary Tract Infection Nursing Standardized Procedure
      - Vaginal Bleeding Nursing Standardized Procedure
      - APP Rules and Regulations
      - CRNA Clinical Privilege Delineation – New

B. Policies/Procedures/Plans:
   1. Care of the Patient with an IRRAflow Irrigation Catheter
   2. Medical Cannabis for the Terminally Ill Patient
   3. Medication Use
   4. Restraints

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

Motion Carried

10. EXTENDED CLOSED SESSION

Vice-President Hernandez Laguna 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) Conference with Legal Counsel Existing Litigation,* and *(3) Conference with Legal Counsel Anticipated Litigation*. The meeting recessed into Closed Session under the Closed Session Protocol at 6:15 p.m. The Board completed its business of the Closed Session at 7:00 p.m.

11. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 7:05 p.m. Vice-President Hernandez Laguna 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) Conference with Legal Counsel Existing Litigation,* and *(3) Conference with Legal Counsel Anticipated Litigation*.

No action was taken.

12. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, August 22, 2024, at 4:00 p.m.** There being no further business, the meeting was adjourned at 7:06 p.m.

____

Rolando Cabrera, MD
Secretary, Board of Directors

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
July 31, 2024

	Month of July,		One months ended July 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 50,449,190	$ 49,290,716	$ 50,449,190	$ 49,290,716
Other operating revenue	1,187,180	1,041,862	1,187,180	1,041,862
Total operating revenue	51,636,370	50,332,578	51,636,370	50,332,578
Total operating expenses	46,907,586	47,015,796	46,907,586	47,015,796
Total non-operating income	1,222,522	(786,603)	1,222,522	(786,603)
Operating and non-operating income	$ 5,951,307	$ 2,530,179	$ 5,951,307	$ 2,530,179

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
July 31, 2024

	Current year	Prior year
ASSETS:		
Current assets	$ 401,367,503	$ 440,118,325
Assets whose use is limited or restricted by board	168,797,833	158,603,034
Capital assets	248,796,850	245,617,710
Other assets	303,209,529	191,771,068
Deferred pension outflows	88,274,589	116,911,125
	$ 1,210,446,304	$ 1,153,021,262
LIABILITIES AND EQUITY:		
Current liabilities	93,878,605	86,794,178
Long term liabilities	20,971,301	22,722,645
Lease deferred inflows	2,027,900	2,856,606
Pension liability	93,403,946	118,792,064
Net assets	1,000,164,552	921,855,769
	$ 1,210,446,304	$ 1,153,021,262

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
July 31, 2024

	Month of July,		One months ended July 31,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,801	1,862	1,801	1,862
Medi-Cal	968	1,026	968	1,026
Commercial insurance	531	691	531	691
Other patient	85	111	85	111
Total patient days	3,385	3,690	3,385	3,690
Gross revenue:				
Medicare	$ 125,586,541	$ 110,980,965	$ 125,586,541	$ 110,980,965
Medi-Cal	79,105,569	60,807,708	79,105,569	60,807,708
Commercial insurance	54,631,570	50,069,566	54,631,570	50,069,566
Other patient	9,488,283	9,118,585	9,488,283	9,118,585
Gross revenue	268,811,963	230,976,824	268,811,963	230,976,824
Deductions from revenue:				
Administrative adjustment	360,469	344,863	360,469	344,863
Charity care	771,905	651,415	771,905	651,415
Contractual adjustments:				
Medicare outpatient	40,946,735	34,154,645	40,946,735	34,154,645
Medicare inpatient	50,630,527	48,282,003	50,630,527	48,282,003
Medi-Cal traditional outpatient	1,523,198	2,365,238	1,523,198	2,365,238
Medi-Cal traditional inpatient	4,553,235	5,746,550	4,553,235	5,746,550
Medi-Cal managed care outpatient	39,752,792	26,214,788	39,752,792	26,214,788
Medi-Cal managed care inpatient	26,787,598	19,745,496	26,787,598	19,745,496
Commercial insurance outpatient	25,663,502	19,564,566	25,663,502	19,564,566
Commercial insurance inpatient	21,732,373	19,180,324	21,732,373	19,180,324
Uncollectible accounts expense	5,091,829	4,071,764	5,091,829	4,071,764
Other payors	548,610	1,364,455	548,610	1,364,455
Deductions from revenue	218,362,773	181,686,108	218,362,773	181,686,108
Net patient revenue	$ 50,449,190	$ 49,290,716	$ 50,449,190	$ 49,290,716
Gross billed charges by patient type:				
Inpatient	$ 129,469,463	$ 119,461,977	$ 129,469,463	$ 119,461,977
Outpatient	106,986,747	81,911,981	106,986,747	81,911,981
Emergency room	32,355,753	29,602,866	32,355,753	29,602,866
Total	$ 268,811,963	$ 230,976,824	$ 268,811,963	$ 230,976,824

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
July 31, 2024

	Month of July,		One months ended July 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 50,449,190	$ 49,290,716	$ 50,449,190	$ 49,290,716
Other operating revenue	1,187,180	1,041,862	1,187,180	1,041,862
Total operating revenue	51,636,370	50,332,578	51,636,370	50,332,578
Operating expenses:				
Salaries and wages	16,672,047	16,175,545	16,672,047	16,175,545
Compensated absences	3,577,020	3,048,106	3,577,020	3,048,106
Employee benefits	7,710,583	8,687,225	7,710,583	8,687,225
Supplies, food, and linen	7,772,212	6,607,489	7,772,212	6,607,489
Purchased department functions	3,266,362	3,962,609	3,266,362	3,962,609
Medical fees	2,214,807	2,126,284	2,214,807	2,126,284
Other fees	1,331,595	2,888,597	1,331,595	2,888,597
Depreciation	2,475,811	1,806,499	2,475,811	1,806,499
All other expense	1,887,149	1,713,442	1,887,149	1,713,442
Total operating expenses	46,907,586	47,015,796	46,907,586	47,015,796
Income from operations	4,728,784	3,316,782	4,728,784	3,316,782
Non-operating income:				
Donations	5,400	(21,180)	5,400	(21,180)
Property taxes	476,714	333,333	476,714	333,333
Investment income	5,850,454	2,544,661	5,850,454	2,544,661
Taxes and licenses	0	0	0	0
Income from subsidiaries	(5,110,046)	(3,643,417)	(5,110,046)	(3,643,417)
Total non-operating income	1,222,522	(786,603)	1,222,522	(786,603)
Operating and non-operating income	5,951,307	2,530,179	5,951,307	2,530,179
Net assets to begin	994,213,245	919,325,590	994,213,245	919,325,590
Net assets to end	$ 1,000,164,552	$ 921,855,769	$ 1,000,164,552	$ 921,855,769
Net income excluding non-recurring items	$ 5,951,307	$ 2,530,179	$ 5,951,307	$ 2,530,179
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	$ 5,951,307	$ 2,530,179	$ 5,951,307	$ 2,530,179

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
July 31, 2024

	Month of July,		One months ended July 31,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (213,523)	$ (177,364)	$ (213,523)	$ (177,364)
Neurological Clinic	(60,955)	(79,165)	(60,955)	(79,165)
Palliative Care Clinic	(133,084)	(84,521)	(133,084)	(84,521)
Surgery Clinic	(262,520)	(226,390)	(262,520)	(226,390)
Infectious Disease Clinic	(31,154)	(34,483)	(31,154)	(34,483)
Endocrinology Clinic	(251,585)	(209,267)	(251,585)	(209,267)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(519,836)	(526,532)	(519,836)	(526,532)
OB/GYN Clinic	(372,219)	(319,797)	(372,219)	(319,797)
PrimeCare Medical Group	(906,595)	(734,034)	(906,595)	(734,034)
Oncology Clinic	(482,554)	(293,778)	(482,554)	(293,778)
Cardiac Surgery	(316,251)	(222,875)	(316,251)	(222,875)
Sleep Center	(91,498)	(37,209)	(91,498)	(37,209)
Rheumatology	(91,901)	(63,574)	(91,901)	(63,574)
Precision Ortho MDs	(390,954)	(406,363)	(390,954)	(406,363)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(97,117)	(63,332)	(97,117)	(63,332)
Vaccine Clinic	0	0	0	0
Dermatology	(48,240)	(1,642)	(48,240)	(1,642)
Hospitalists	0	0	0	0
Behavioral Health	(54,231)	(36,842)	(54,231)	(36,842)
Pediatric Diabetes	(63,782)	(51,607)	(63,782)	(51,607)
Neurosurgery	(128,310)	(30,526)	(128,310)	(30,526)
Multi-Specialty-RR	7,920	7,633	7,920	7,633
Radiology	(530,695)	23,793	(530,695)	23,793
Salinas Family Practice	(119,475)	(116,979)	(119,475)	(116,979)
Urology	(212,284)	(146,575)	(212,284)	(146,575)
Total SVHC	(5,370,843)	(3,831,429)	(5,370,843)	(3,831,429)
Doctors on Duty	20,875	33,869	20,875	33,869
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	151,541	110,651	151,541	110,651
Coastal	33,381	22,893	33,381	22,893
Apex	0	0	0	0
21st Century Oncology	0	(16,412)	0	(16,412)
Monterey Bay Endoscopy Center	54,999	37,011	54,999	37,011
Total	$ (5,110,046)	$ (3,643,417)	$ (5,110,046)	$ (3,643,417)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
July 31, 2024

		Current year		Prior year
A S S E T S				
Current assets:				
Cash and cash equivalents	$	266,936,928	$	330,930,358
Patient accounts receivable, net of estimated uncollectibles of $43,363,463		112,945,542		87,141,496
Supplies inventory at cost		8,673,126		8,048,689
Current portion of lease receivable		1,621,407		1,921,803
Other current assets		11,190,500		12,075,978
Total current assets		401,367,503		440,118,325
Assets whose use is limited or restricted by board		168,797,833		158,603,034
Capital assets:				
Land and construction in process		43,163,809		60,334,728
Other capital assets, net of depreciation		205,633,041		185,282,982
Total capital assets		248,796,850		245,617,710
Other assets:				
Right of use assets, net of amortization		7,066,009		5,681,859
Long term lease receivable		435,661		1,115,546
Subscription assets, net of amortization		9,736,690		10,754,599
Investment in Securities		260,112,491		146,194,103
Investment in SVMC		1,994,494		9,696,941
Investment in Coastal		1,910,752		1,704,534
Investment in other affiliates		21,682,327		17,411,763
Net pension asset		271,105		(788,277)
Total other assets		303,209,529		191,771,068
Deferred pension outflows		88,274,589		116,911,125
	$	1,210,446,304	$	1,153,021,262
L I A B I L I T I E S A N D N E T A S S E T S				
Current liabilities:				
Accounts payable and accrued expenses	$	64,324,257	$	57,659,157
Due to third party payers		3,679,405		5,404,186
Current portion of self-insurance liability		19,248,183		17,205,482
Current subscription liability		4,005,767		4,630,742
Current portion of lease liability		2,620,993		1,894,611
Total current liabilities		93,878,605		86,794,178
Long term portion of workers comp liability		12,752,056		13,027,333
Long term portion of lease liability		4,904,742		3,980,405
Long term subscription liability		3,314,503		5,714,907
Total liabilities		114,849,906		109,516,823
Lease deferred inflows		2,027,900		2,856,606
Pension liability		93,403,946		118,792,064
Net assets:				
Invested in capital assets, net of related debt		248,796,850		245,617,710
Unrestricted		751,367,702		676,238,059
Total net assets		1,000,164,552		921,855,769
	$	1,210,446,304	$	1,153,021,262

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
July 31, 2024

	Month of July,				One months ended July 31,			
	Actual	**Budget**	**Variance**	**% Var**	**Actual**	**Budget**	**Variance**	**% Var**
Operating revenue:								
Gross billed charges	$ 268,811,963	$ 257,912,588	10,899,375	4.23%	$ 268,811,963	$ 257,912,588	10,899,375	4.23%
Dedutions from revenue	218,362,773	206,659,967	11,702,806	5.66%	218,362,773	206,659,967	11,702,806	5.66%
Net patient revenue	50,449,190	51,252,620	(803,430)	-1.57%	50,449,190	51,252,620	(803,430)	-1.57%
Other operating revenue	1,187,180	1,452,669	(265,489)	-18.28%	1,187,180	1,452,669	(265,489)	-18.28%
Total operating revenue	**51,636,370**	**52,705,289**	**(1,068,919)**	**-2.03%**	**51,636,370**	**52,705,289**	**(1,068,919)**	**-2.03%**
Operating expenses:								
Salaries and wages	16,672,047	16,995,758	(323,711)	-1.90%	16,672,047	16,995,758	(323,711)	-1.90%
Compensated absences	3,577,020	3,605,706	(28,686)	-0.80%	3,577,020	3,605,706	(28,686)	-0.80%
Employee benefits	7,710,583	8,052,004	(341,421)	-4.24%	7,710,583	8,052,004	(341,421)	-4.24%
Supplies, food, and linen	7,772,212	7,302,276	469,936	6.44%	7,772,212	7,302,276	469,936	6.44%
Purchased department functions	3,266,362	3,825,284	(558,922)	-14.61%	3,266,362	3,825,284	(558,922)	-14.61%
Medical fees	2,214,807	2,485,637	(270,830)	-10.90%	2,214,807	2,485,637	(270,830)	-10.90%
Other fees	1,331,595	1,756,428	(424,833)	-24.19%	1,331,595	1,756,428	(424,833)	-24.19%
Depreciation	2,475,811	2,359,059	116,752	4.95%	2,475,811	2,359,059	116,752	4.95%
All other expense	1,887,149	2,008,333	(121,184)	-6.03%	1,887,149	2,008,333	(121,184)	-6.03%
Total operating expenses	**46,907,586**	**48,390,486**	**(1,482,900)**	**-3.06%**	**46,907,586**	**48,390,486**	**(1,482,900)**	**-3.06%**
Income from operations	**4,728,784**	**4,314,804**	**413,980**	**9.59%**	**4,728,784**	**4,314,804**	**413,980**	**9.59%**
Non-operating income:								
Donations	5,400	208,333	(202,933)	-97.41%	5,400	208,333	(202,933)	-97.41%
Property taxes	476,714	476,714	(0)	0.00%	476,714	476,714	(0)	0.00%
Investment income	5,850,454	1,891,173	3,959,281	209.36%	5,850,454	1,891,173	3,959,281	209.36%
Income from subsidiaries	(5,110,046)	(5,123,222)	13,176	-0.26%	(5,110,046)	(5,123,222)	13,176	-0.26%
Total non-operating income	**1,222,522**	**(2,547,001)**	**3,769,524**	**-148.00%**	**1,222,522**	**(2,547,001)**	**3,769,524**	**-148.00%**
Operating and non-operating income	**$ 5,951,306**	**$ 1,767,802**	**4,183,504**	**236.65%**	**$ 5,951,306**	**$ 1,767,802**	**4,183,504**	**236.65%**

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

	Month of July		One months to date		
	2023	2024	2023-24	2024-25	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	31	31	31	31	0
Other Admissions	82	76	82	76	(6)
Total Admissions	113	107	113	107	(6)
Medi-Cal Patient Days	51	120	51	120	69
Other Patient Days	130	54	130	54	(76)
Total Patient Days of Care	181	174	181	174	(7)
Average Daily Census	5.8	5.6	5.8	5.6	(0.2)
Medi-Cal Average Days	1.8	3.9	1.8	3.9	2.1
Other Average Days	1.6	0.7	1.6	0.7	(0.9)
Total Average Days Stay	1.7	1.6	1.7	1.6	(0.0)
ADULTS & PEDIATRICS					
Medicare Admissions	387	391	387	391	4
Medi-Cal Admissions	267	280	236	280	44
Other Admissions	384	303	302	303	1
Total Admissions	1,038	974	925	974	49
Medicare Patient Days	1,630	1,496	1,630	1,496	(134)
Medi-Cal Patient Days	1,058	981	1,058	981	(77)
Other Patient Days	932	714	932	714	(218)
Total Patient Days of Care	3,620	3,191	3,620	3,191	(429)
Average Daily Census	116.8	102.9	116.8	102.9	(13.8)
Medicare Average Length of Stay	4.3	3.8	4.3	3.8	(0.6)
Medi-Cal AverageLength of Stay	3.7	3.2	3.7	3.2	(0.6)
Other Average Length of Stay	2.5	1.9	2.5	1.9	(0.7)
Total Average Length of Stay	3.5	2.9	3.5	2.9	(0.6)
Deaths	25	37	25	37	12
Total Patient Days	3,801	3,365	3,801	3,365	(436)
Medi-Cal Administrative Days	3	0	3	0	(3)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	3	0	3	0	(3)
Percent Non-Acute	0.08%	0.00%	0.08%	0.00%	-0.08%

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

	Month of July		One months to date		
	2023	**2024**	**2023-24**	**2024-25**	**Variance**
PATIENT DAYS BY LOCATION					
Level I	223	271	223	271	48
Heart Center	329	313	329	313	(16)
Monitored Beds	625	570	625	570	(55)
Single Room Maternity/Obstetrics	313	303	313	303	(10)
Med/Surg - Cardiovascular	891	820	891	820	(71)
Med/Surg - Oncology	293	271	293	271	(22)
Med/Surg - Rehab	467	469	467	469	2
Pediatrics	95	98	95	98	3
Nursery	181	174	181	174	(7)
Neonatal Intensive Care	122	76	122	76	(46)
PERCENTAGE OF OCCUPANCY					
Level I	55.33%	67.25%	55.33%	67.25%	
Heart Center	70.75%	67.31%	70.75%	67.31%	
Monitored Beds	74.67%	68.10%	74.67%	68.10%	
Single Room Maternity/Obstetrics	27.29%	26.42%	27.29%	26.42%	
Med/Surg - Cardiovascular	63.87%	58.78%	63.87%	58.78%	
Med/Surg - Oncology	72.70%	67.25%	72.70%	67.25%	
Med/Surg - Rehab	57.94%	58.19%	57.94%	58.19%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	17.03%	17.56%	17.03%	17.56%	
Nursery	35.39%	34.02%	17.69%	17.01%	
Neonatal Intensive Care	35.78%	22.29%	35.78%	22.29%	

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

	Month of July		One months to date		
	2023	2024	2023-24	2024-25	Variance
DELIVERY ROOM					
Total deliveries	111	123	111	123	12
C-Section deliveries	32	31	32	31	(1)
Percent of C-section deliveries	28.83%	25.20%	28.83%	25.20%	-3.63%
OPERATING ROOM					
In-Patient Operating Minutes	16,247	20,885	16,247	20,885	4,638
Out-Patient Operating Minutes	28,629	29,584	28,629	29,584	955
Total	44,876	50,469	44,876	50,469	5,593
Open Heart Surgeries	9	12	9	12	3
In-Patient Cases	118	134	118	134	16
Out-Patient Cases	273	301	273	301	28
EMERGENCY ROOM					
Immediate Life Saving	37	31	37	31	(6)
High Risk	699	838	699	838	139
More Than One Resource	2,767	2,736	2,767	2,736	(31)
One Resource	1,634	1,672	1,634	1,672	38
No Resources	115	62	115	62	(53)
Total	5,252	5,339	5,252	5,339	87

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

	Month of July		One months to date		
	2023	2024	2023-24	2024-25	Variance
CENTRAL SUPPLY					
In-patient requisitions	14,091	12,872	14,091	12,872	-1,219
Out-patient requisitions	10,154	10,476	10,154	10,476	322
Emergency room requisitions	613	827	613	827	214
Interdepartmental requisitions	6,343	6,497	6,343	6,497	154
Total requisitions	31,201	30,672	31,201	30,672	-529
LABORATORY					
In-patient procedures	35,996	35,911	35,996	35,911	-85
Out-patient procedures	10,695	44,179	10,695	44,179	33,484
Emergency room procedures	12,162	12,352	12,162	12,352	190
Total patient procedures	58,853	92,442	58,853	92,442	33,589
BLOOD BANK					
Units processed	300	231	300	231	-69
ELECTROCARDIOLOGY					
In-patient procedures	1,077	1,106	1,077	1,106	29
Out-patient procedures	396	347	396	347	-49
Emergency room procedures	1,210	1,249	1,210	1,249	39
Total procedures	2,683	2,702	2,683	2,702	19
CATH LAB					
In-patient procedures	115	125	115	125	10
Out-patient procedures	90	119	90	119	29
Emergency room procedures	0	0	0	0	0
Total procedures	205	244	205	244	39
ECHO-CARDIOLOGY					
In-patient studies	330	448	330	448	118
Out-patient studies	248	357	248	357	109
Emergency room studies	0	2	0	2	2
Total studies	578	807	578	807	229
NEURODIAGNOSTIC					
In-patient procedures	118	124	118	124	6
Out-patient procedures	20	14	20	14	-6
Emergency room procedures	0	0	0	0	0
Total procedures	138	138	138	138	0

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

	Month of July		One months to date		
	2023	2024	2023-24	2024-25	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	0	0
Out-patient procedures	189	270	189	270	81
Emergency room procedures	0	0	0	0	0
Total procedures	189	270	189	270	81
RADIOLOGY					
In-patient procedures	1,254	1,365	1,254	1,365	111
Out-patient procedures	407	444	407	444	37
Emergency room procedures	1,421	1,551	1,421	1,551	130
Total patient procedures	3,082	3,360	3,082	3,360	278
MAGNETIC RESONANCE IMAGING					
In-patient procedures	152	208	152	208	56
Out-patient procedures	133	111	133	111	-22
Emergency room procedures	9	6	9	6	-3
Total procedures	294	325	294	325	31
MAMMOGRAPHY CENTER					
In-patient procedures	3,643	3,248	3,643	3,248	-395
Out-patient procedures	3,608	3,236	3,608	3,236	-372
Emergency room procedures	0	1	0	1	1
Total procedures	7,251	6,485	7,251	6,485	-766
NUCLEAR MEDICINE					
In-patient procedures	21	26	21	26	5
Out-patient procedures	110	116	110	116	6
Emergency room procedures	0	0	0	0	0
Total procedures	131	142	131	142	11
PHARMACY					
In-patient prescriptions	81,796	82,755	81,796	82,755	959
Out-patient prescriptions	15,349	15,988	15,349	15,988	639
Emergency room prescriptions	8,771	9,317	8,771	9,317	546
Total prescriptions	105,916	108,060	105,916	108,060	2,144
RESPIRATORY THERAPY					
In-patient treatments	12,529	15,247	12,529	15,247	2,718
Out-patient treatments	1,179	651	1,179	651	-528
Emergency room treatments	322	360	322	360	38
Total patient treatments	14,030	16,258	14,030	16,258	2,228
PHYSICAL THERAPY					
In-patient treatments	2,446	2,198	2,446	2,198	-248
Out-patient treatments	263	269	263	269	6
Emergency room treatments	0	0	0	0	0
Total treatments	2,709	2,467	2,709	2,467	-242

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

	Month of July		One months to date		
	2023	2024	2023-24	2024-25	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,418	1,597	1,418	1,597	179
Out-patient procedures	259	233	259	233	-26
Emergency room procedures	0	0	0	0	0
Total procedures	1,677	1,830	1,677	1,830	153
SPEECH THERAPY					
In-patient treatments	481	475	481	475	-6
Out-patient treatments	24	23	24	23	-1
Emergency room treatments	0	0	0	0	0
Total treatments	505	498	505	498	-7
CARDIAC REHABILITATION					
In-patient treatments	2	1	2	1	-1
Out-patient treatments	499	672	499	672	173
Emergency room treatments	0	0	0	0	0
Total treatments	501	673	501	673	172
CRITICAL DECISION UNIT					
Observation hours	372	306	372	306	-66
ENDOSCOPY					
In-patient procedures	60	72	60	72	12
Out-patient procedures	46	44	46	44	-2
Emergency room procedures	0	0	0	0	0
Total procedures	106	116	106	116	10
C.T. SCAN					
In-patient procedures	722	788	722	788	66
Out-patient procedures	471	416	471	416	-55
Emergency room procedures	753	753	753	753	0
Total procedures	1,946	1,957	1,946	1,957	11
DIETARY					
Routine patient diets	21,298	14,942	21,298	14,942	-6,356
Meals to personnel	27,945	35,476	27,945	35,476	7,531
Total diets and meals	49,243	50,418	49,243	50,418	1,175
LAUNDRY AND LINEN					
Total pounds laundered	98,051	93,665	98,051	93,665	-4,386

Memorandum

To: Board of Directors
From: Clement Miller, COO
Date: August 16, 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 Exec
1.	Infection Prevention Program Plan	Approved by MEC 4-13-2024. Minor Changes.	Allen Radner, MD
2.	Patient Safety Program Plan	Approved by MEC 4-13-2024. Minor Changes.	Allen Radner, MD
3.	Quality Assessment and Performance Improvement Plan	Approved by MEC 5-9-2024. Minor Changes.	Allen Radner, MD

Status **Pending** PolicyStat ID **15668446**

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

Infection Prevention Program Plan

I. PURPOSE

This plan describes the infection control program of Salinas Valley Health Medical Center (SVHMC) and Out-patient clinics, which is designed to provide for the coordination of all infection surveillance prevention activities and to deliver safe, cost-effective care to our patients, staff, visitors, and others in the healthcare environment (with emphasis on populations at high risk of infection). The program is designed to prevent and reduce hospital-associated infections and provide information and support to all staff regarding the principles and practices of Infection Prevention (IP) to support the development of a safe environment for all who enter the facility. The Infection Prevention Plan will be reviewed annually to determine its effectiveness in meeting the program's goals.

The plan provides oversight to the:

- Completion and evaluation of the Infection Prevention Risk Assessment
- Establishment of Infection Prevention Goals
- Identification of Surveillance Activities
- Review of Infection Prevention Data
- Preparation of emergency management activities to deal with the surge of agents/individuals
- Education of all staff to ensure a broad understanding of Infection Prevention strategies and individual requirements

The Plan guides all components of the hospital governing board, medical staff, administration, management, and staff, including clinical and non-clinical services, obtaining excellent patient outcomes that reduce the impact of healthcare-associated infections.

II. INFECTION CONTROL SCOPE OF SERVICES/ PROCESSES/STRUCTURE

Geographic location and community environment

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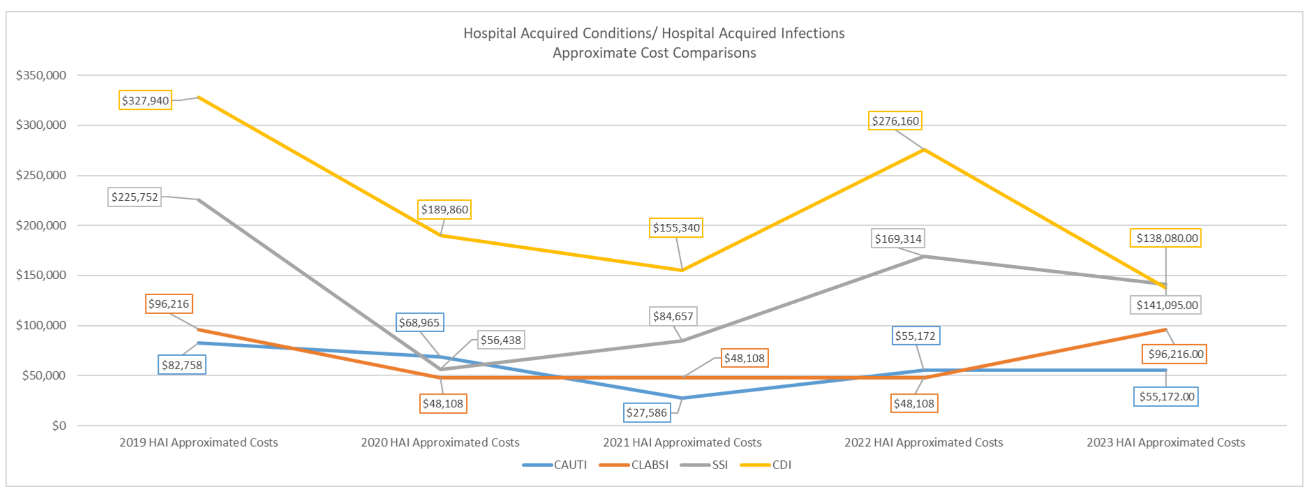
SVHMC is part of Salinas Valley Health. The healthcare system is an integrated network of healthcare programs and services, and at the core is a level 2 public district hospital with 263 beds, which employs approximately 1600 full-time employees, located in the town of Salinas, the county of Monterey on the central coast of the state of California. Salinas Valley Health has specialty clinics throughout the region, most centrally located near the hospital. Specialized programs include the Comprehensive Community Cancer Program, Joint Replacement Center, Regional Spine Center, Women and Children Center, Salinas Valley Health Clinic, Stroke Center, Taylor Farms Family Health and Wellness Center in Gonzales, Outpatient Infusion Center and the Regional Wound Healing Center. In addition, the hospital has a Level III neonatal Intensive Care Unit (NICU) and an expanded Level II Emergency Department. In 2023, there were 18,004 hospital admissions, with 43,736 patient days. The total number of Emergency service visits for 2023 was 63,955. OR surgical services performed 2,028 cases in 2023, averaging 5.6 cases daily.

Infection Prevention Financial Data Summary is based on the Agency for Healthcare Research and Quality (AHRQ) National Scorecard Report 2017. AHRQ summary of meta-analysis additional cost estimates for Hospital-Aquired Conditions (HACs) or Hospital Acquired Infections (HAIs) Estimated costs (95% confidence interval) per HAI ranging per event. Salinas Valley Health Medical Center had an approximate cost loss in 2019 for Catheter-Associated Urinary Tract Infection (CAUTI): $82,758, then in 2023, $55,172. Central-line Associated Bloodstream Infections (CLABSI) approximate cost loss in 2019 was $96,216, and in 2023, $96,216. Surgical Site Infections (SSI) approximate cost losses for 2019 are $225,752; for 2023, they are $141,095. Lastly, the approximate cost loss for C. difficile infections (CDI) for 2019 is $327,940, and $138,080 in 2023. (See below graph) In summary, HAC/HAI costs have reduced from 2019 in comparison to 2023. Salinas Valley Health Medical Center performance improvement measures for HAC/HAIs have made positive strides in preventing hospital-acquired infections and improving patient outcomes.



SVHMC serves Monterey County communities, which include Salinas, Seaside, Monterey, Soledad, Marina, Prunedale, Greenfield, Pacific Grove, King City, Gonzalez, and all other surrounding communities. SVHMC serves adjacent communities, such as Watsonville, Santa Cruz, San José, Big Sur, and Aptos. Monterey County area is surrounded by hills, mountains, streams, and the Pacific Ocean 15 miles to the west. The economy is primarily based on tourism and agriculture in the coastal regions of the Salinas River Valley. Most of the county's people live near the northern coast and Salinas Valley, while the southern coast and inland mountain regions are sparsely populated. Per the 2022 updated California Census data, the county's population was 432,858; 263,285 are Hispanic. The county seat and largest city is Salinas. The City of Salinas's population in 2017 was 157,596, with a population decrease since 2000 by -0.01%. The Patient

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population mix consists of African American 2.5%, American Indian 0.2%, Asian 5.6%, Hispanic 57.9%, and White 30.6%, which includes residents, people experiencing homelessness, and immigrants and seasonal farm workers. Per the 2020 National Census, 91.3% of Monterey County residents speak Spanish; 2.1% speak Tagalog. The estimated median household income from the 2020 Census Bureau for Monterey County residents is $128,227 annually; updated 2022 data shows a decrease in annual revenue to $91,043

Reported by Monterey County Public Health, 2022 Community Health Assessment, and additional Communicable Diseases reports that SVHMC that would potentially impact SVHMC:

- Specific diseases or conditions that showed a statistically significant increase in incidence rates were chlamydia, with an incidence rate of 500.6 (CA value 484.7), fall/winter respiratory viral illnesses (RSV, Influenza, and COVID-19), and syphilis.
- Although coccidioidomycosis rates have decreased in the last several years (per 100,000 population), from 56.6 in 2018 to 8.7 in 2023, SVHMC still sees a significant number of active cases in infectious disease clinics and in-patient hospitalizations. The populations affected the most are individuals 50 and older, mainly in Monterey's South County. The racial and ethnic groups most affected are African Americans.
- The most commonly reported enteric illnesses were campylobacteriosis, salmonellosis, and shigellosis. Affected population groups differed between these enteric pathogens, but incidence rates were generally highest among children under 15.
- Reported by Monterey County Public Health, 2012 Epidemiological Impact of Communicable Diseases, Sexually transmitted infections (STIs) represented the most significant portion of diseases reported in Monterey County. Individuals aged 15 to 24 accounted for the majority of reported chlamydia and gonorrhea cases. African Americans and Others (comprised of individuals of Native American/Alaskan Native, Multiracial, and Other racial groups) were disproportionally affected by chlamydia and gonorrhea. Men who have sex with men (MSM) were disproportionately affected by syphilis.
- MCPHD outbreaks of Syphilis in pregnant women and women of childbearing age, April 2019.Then again, in 2022, with increased incidence in mothers with congenital disease with increased transmission to infants. Syphilis incidence rate increased from 7.0 to 11.1 in 2022.
- MCPHD increased in Tuberculosis cases in 2023; the populations affected the most are those 50 years and older. The racial and ethnic groups most affected are African Americans and Hispanics.
- <u>CDPH/MCPHD alerts to infectious disease outbreaks either nationally, state , or locally in the last year</u>:
    - RSV and other respiratory virus activity continue to evolve, and new evidence emerges; the California Department of Public Health (CDPH) will collaborate with local health departments to assess and provide additional updates as they become available. CDPH provides brief guidance regarding vaccination, testing, treatment, and other preventive measures for respiratory viruses, January 2023
    - All Facilities Letter (AFL) notifying all hospitals about recommendations from the Centers for Disease Control and Prevention (CDC) regarding Ebola virus disease (EVD) preparedness, January 2023
    - Emergence of Candida auris in Healthcare Facilities in Northern California, February 2023
    - Shigella XDR (nationally), March 2023
    - CAHAN Alert, Potential Risk for New Monkeypox Cases. May 15, 2023

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- All Facility Letter (AFL) 22-09.1: Coronavirus Disease 2019 (COVID-19) Vaccine and Booster Recommendations for Clinically Eligible Individuals (This AFL supersedes AFL 22-23.1)
- AFL 22-23.2: Guidance for Response to Surge in Respiratory Viruses among Pediatric Patients (This AFL supersedes AFL 22.09)
- All Facilities Letter (AFL) 21-20.2 Coronavirus Disease 2019 (COVID-19) Vaccine Recommendations for Eligible Individuals Prior to Discharge (This AFL supersedes AFL 21-20.1)
- AFL 22-33.1 Guidance for Response to Surge in Respiratory Viruses Among Adult Patients (This AFL supersedes AFL 22-33)
- June, 2023:
    - CDC status of the ongoing fungal meningitis outbreak and highlights interim recommendations for diagnosis and treatment.
    - CDC/CDPH Preventing a Resurgence of Mpox Cases in California
    - CDC Bicillin® L-A (Benzathine Penicillin G) Shortage
    - CDC Health Advisory 493 - Guidance on Measles during the Summer Travel Season
    - CDC Health Alert Network (HAN) Health Advisory: Locally Acquired Malaria Cases Identified
    - CDPH News Release: Record Rainfall Raises Risk of Mosquito-borne Diseases
    - CDPH News Release: Potential Increased Risk for Valley Fever Expected
- CDC Health Alert Network (HAN) Health Advisory: Increased Respiratory Syncytial Virus (RSV) Activity in Parts of the Southeastern United States: New Prevention Tools Available to Protect Patients, September 2023.
- •09/06/23: CAHAN Disease Notification - CDC Health Alert Network (HAN) Health Advisory: Increased Respiratory Syncytial Virus (RSV) Activity in Parts of the Southeastern United States: New Prevention Tools Available to Protect Patients
- October 2023:
    - CAHAN All Facilities Letter – AFL 23-30 Guidance for Response to Anticipated Adult and Pediatric Surges in Respiratory Virus Transmission
    - CAHAN Disease Notification - CDPH Health Advisory: Preparation for Respiratory Virus Season (COVID-19, Influenza and RSV)
    - CAHAN Disease Notification - CDPH Health Advisory: Early Respiratory Syncytial Virus (RSV) Activity and Use of RSV Prevention Products
    - CAHAN Disease Notification - CDPH Health Advisory: Increase in Mpox Cases in California: Updates on Identification, Laboratory Testing, Management and Treatment, and Vaccination for Mpox
- •CAHAN All Facilities Letter – AFL 23-33: Coronavirus Disease 2019 COVID-19) Vaccine Recommendations for Eligible Individuals Prior to Discharge (This AFL supersedes AFL 21-20.2), November 2023.
- Increase in respiratory illnesses globally: The CDC is monitoring respiratory illnesses around the world. Some countries have reported elevated levels of respiratory illness

activity. Respiratory illnesses are monitored by the CDC around the world. Some countries have reported elevated levels of respiratory illness activity. Circulating respiratory illnesses include influenza, COVID-19, respiratory syncytial virus (RSV) infection, and Mycoplasma pneumoniae infection, December 2023.

The hospital has identified the Infection Prevention Manager as the individual with clinical authority over the infection prevention program. The Infection Preventionist (IP) is a qualified individual who manages the ongoing infection prevention program. Qualifications include appropriate education and training and obtaining & maintaining certification (CIC) in infection control.

The Infection Preventionist 's role is ongoing with regular over-site and collaborative efforts in surveillance, specific environmental monitoring, continuous quality improvement, consultation, committee involvement, outbreak and isolation management, and regulatory compliance and education.

The infection prevention function reports to the Senior Administrative Director of Quality & Safety, who reports to the Chief Medical Officer and the SVHMC Administration. Responsibilities of the infection Preventionist include, but are not limited to:

- Managing the Infection Prevention Program under the direction of the Pharmacy & Therapeutics/ Infection Prevention Committee.
- Collecting and coordinating data collection, tabulation, and reporting of healthcare-associated and communicable infections
- Facilitating the ongoing monitoring of the effectiveness of prevention/control activities and interventions
- Educating selected patients, families, and hospital staff about infection prevention principles
- Serving as a consultant to patients, employees, physicians and other licensed independent practitioners, contract service workers, volunteers, students, visitors, and community agencies
- Taking action on recommendations of the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee
- Surveillance Rounds in clinical areas
- Active Participation in the Antimicrobial Stewardship Program

The Medical Staff Committee is a multidisciplinary team that sanctions the Pharmacy & Therapeutics/ Infection Prevention Committee. The Medical Director for Infection Prevention is an Infectious Disease Physician and Committee member. The IP Medical Director works collaboratively with the infection preventionist to administer and manage the infection control program. The committee membership is responsible for developing and implementing strategies for components/functions of the Infection Prevention Program. It includes representation from the Medical Staff, Administration, Nursing Service, Safety, Physician Office Practices, Laboratory, Performance Improvement, EVS, Operating Room, Pharmacy, and Community Health. Determining the effectiveness of the key processes for preventing infections is an ongoing function of the Committee. Pharmacy & Therapeutics/Infection Prevention Committee meeting minutes are reported to the Medical Staff Committee, then to SVHMC Administration and Board of Directors to assess the adequacy of resources allocated to support infection prevention activities.

III. AUTHORITY

A. Integration of Hospital Components and Functions into Infection, Prevention Activities

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Infection prevention is integrated into clinical departments. Clinical departments identify department-specific infection prevention concerns. Department-specific infection prevention policies are developed from the concerns. Each department's specific infection prevention policies are reviewed/ revised every three years. The department director/manager or designee and infection preventionist discuss proposed revisions before submitting them to the Pharmacy & Therapeutics/Infection Prevention Committee for approval. After approval, the policies are reviewed and approved by the Medical Staff, the SVHMC Administration, and the Board of Directors. Once final approval is obtained, the infection preventionist communicates decisions to the department director/manager. Before implementation, major policy revisions or changes are discussed at the Pharmacy & Therapeutics/Infection Prevention Committee and Quality Interdisciplinary Committee.

Infection Prevention Policies are developed to guide the practice and provide consistency in applying principles throughout the organization. These policies are available on the SVHMC Intranet called the "STAR net" and are communicated to staff upon hire, yearly, during safety and leadership meetings, and as updates or changes occur.

IV. DEFINITIONS

N/A

V. STRATEGIES

A. RISK ASSESSMENT

An annual assessment/reassessment is conducted to determine the presence and changing needs of the organization and surrounding community to assist in the design and development of appropriate facility-specific strategies to address the unique and emerging characteristics of the hospital environment. The hospital evaluates risk for the transmission and acquisition of infectious agents throughout the hospital and is based on the collection of the following information:

- Identify risks for transmission of infectious diseases based on patient/community demographics, medical services provided, and epidemiological trends.
- The characteristics of the population served
- The results of the hospital's infection prevention data

The Risk Assessment is completed on at least an annual basis or whenever significant changes are noted to occur in any of the above-stated criteria.

Once the risks are identified, the organization prioritizes those of epidemiological significance.

The tool was revised to precisely capture the risk of acquiring or transmitting central line bloodstream infections, multi-drug resistant organisms and surgical site infections, and catheter-associated urinary tract infections.

B. STRATEGIES TO ADDRESS THE PRIORITIZED RISKS

Specific strategies are developed and implemented to address the prioritized risks. These strategies may include policy and procedure establishment, surveillance and monitoring activities,

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education and training programs, environmental and engineering controls, or combinations thereof.

General Scope and Activities of the Infection Control Program

1. Maintenance of a sanitary physical environment, including but not limited to high and low-level disinfection
2. Management of staff, physicians, and other personnel, including but not limited to screening for exposure and immunity to infectious diseases
3. Mitigation of risk associated with patient infections present on admission
4. Mitigation of risks contributing to healthcare-associated infections
5. Active surveillance
6. Communication/coordination with outside agencies
7. Pandemic Management

C. ACTIVE SURVEILLANCE

The Infection Preventionist is responsible for facilitating hospital-wide surveillance and processes to prevent infections. Surveillance methods include daily nursing unit rounding, review of positive lab culture reports, review of newly admitted patients, and referrals from Nursing, Case Management, and Physicians.

Based on the population served, the following indicators were chosen for 2023-2024 to guide infection control surveillance activities:

- All Healthcare Onset Central line Bloodstream Infections
- All healthcare-onset catheter-associated Urinary Tract Infections
- Central Line Insertion Practices (CLIP) & Compliance
- All Healthcare Onset Multi-Drug Resistant Organisms (MDRO), including:
    - Clostridium difficile Surveillance Facility-wide,
    - MRSA Bloodstream Infections Facility-wide
    - VRE Bloodstream Infections Facility-wide
- Infections such as multi-drug resistant organisms (MDRO), including admission & discharge screening and surveillance of MRSA per California Senate Bill 1058
- All Surgical Site Infections designated by CDPH & CMS via NHSN
- CMS requirements for reporting Healthcare Worker Vaccination data for SARS-COV-2 into NHSN
- CDPH and Cal OSHA requirements for reporting SARS-COV-2 outbreaks in healthcare workers
- CPDH Reportable Diseases, including Seasonal Influenza and Active Tuberculosis patients
- Environment of Care Surveillance Rounds
- Hand Hygiene

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The CDC/NHSN definitions are used to determine the presence of nosocomial infection. The comprehensive data collection process is based on current scientific knowledge, accepted practice guidelines, and all applicable laws and regulations. NHSN is the database where all events (infections) are credited and conferred rights to all mandated agencies (i.e., CDPH, CMS, etc.)

D. REGULATORY AGENCIES AND GUIDELINES

In addition, administrative involvement and the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee facilitate the committee's/function's role as a compliance body, assuring guidelines and standards of regulatory and accreditation organizations are applied consistently throughout the organization. Guidelines and standards of the Occupational Safety and Health Administration (OSHA), The Joint Commission, the Center for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), National Healthcare Safety Network (NHSN), The Association for Practitioners in Infection Control and Epidemiology (APIC), and California Department of Public Health (CDPH), state and federal laws are integrated into the organization's infection prevention policies as they are developed and compliance is monitored ongoing.

E. ROLE OF THE INFECTION PREVENTIONIST:

- Surveillance and evaluation identified clusters of infection
- Reduce the incidence of preventable infection.
- Maintain formal and informal systems to identify trends in infection occurrence.
- Investigate and recommend action to resolve identified Infection Prevention concerns.
- Communication of significant problems to administration and medical staff through designated channels promptly.
- Institutional policies and procedures for the surveillance and prevention of infection:
    - Develop and maintain Infection Prevention Plan.
    - Define the activities of the Infection Prevention Department.
- Consultative services to departmental Infection Prevention Programs:
    - Assist departments to develop and implement department-specific procedures.
    - Assist departments in defining their role and scope in surveillance and prevention of infection.
    - Assist departments with compliance with the requirements of regulatory and accrediting agencies.
    - Facilitate cost containment and revenue preservation.
- Collaborates with the SVHMC Employee Health Department:
    - Consults on processes/procedures to minimize and manage risks of infection to staff.
    - Receives reports, evaluates, documents, and reports diseases of epidemiologic significance in employees, defined as any infectious disease.
- Education in Infection Prevention is provided to hospital staff, including hospital employees, physicians, volunteers, and students.

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- Liaison between the State and Local Public Health Department and SVHMC.

F. OUTBREAK MANAGEMENT

Outbreaks may be identified during surveillance activities. The infection control practitioner is authorized to take immediate action to control any outbreak utilizing sound epidemiologic principles in investigating its origin and root cause analysis. See policy OUTBREAKINVESTIGATION.

G. DEFINITIONS USED IN IDENTIFYING HEALTHCARE-ASSOCIATED INFECTIONS

The CDC/NHSN provides definitions for healthcare-associated infections to create statistics that are as comparable as possible to statistics cited in the literature. The CDC/NHSN updates the definitions bi-annually. It must be noted that the CDC/NHSN definitions are statistical, NOT clinical. Therefore, a clinical situation that warrants treatment may not always meet the CDC/NHSN definition of HAI definition.

H. INTEGRATION OF THE INFECTION CONTROL PROGRAM INTO SVHMC'S PERFORMANCE IMPROVEMENT PROGRAM

The infection prevention program is fully integrated with the hospital's overall process for assessing and improving organizational performance. Risks, rates, and trends in healthcare-associated infections are tracked over time. This information is used to strengthen prevention activities and to reduce nosocomial infection rates to the lowest possible levels. The infection prevention program works collaboratively with the employee health program to reduce the transmission of infections, including vaccine-preventable infections, from patients to staff and staff to patients. Employee health data is also aggregated, tracked, and trended over time to identify opportunities for improvement.

Management systems, including staff and data systems, assist in achieving these objectives. Such systems support activities, including data collection, analysis, interpretation, and presentation of findings using statistical tools. Findings from the Pharmacy & Therapeutics/Infection Prevention Committee are provided to the Quality & Safety Committee, Medical Staff Committee, the SVHMC Administration and Board of Directors

The following infection prevention information is currently reported at least quarterly through the organization's performance improvement (PI) activities:

- CPDH Reportable Diseases, including Seasonal Influenza and Active Tuberculosis patients
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Bloodstream Infections (CLABSI)
- Central Line Insertion Practices (CLIP) & Compliance
- Multi-Drug Resistant Organisms (MDRO) rates :
  - Clostridium difficile Surveillance Facility-wide,
  - MRSA Bloodstream Infections Facility-wide
  - VRE Bloodstream Infections Facility-wide
- Hand Hygiene Facility-wide
- Surgical Site Infections (per NHSN guidelines) on Cardiac (CBGB/CBGC), Caesarian

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Sections, Total Hip, Total Knee, Colectomy, Hysterectomy

- See Attachments: Risk Assessment Grid and Correlating Performance Improvement Plan

I. GOALS

Based on the Risk Assessment, SVHMC establishes goals on an annual basis to reflect the current trends and environmental factors of the hospital and community. The following goals are established yearly, and additional goals are established as needed based on the ongoing assessments, surveillance, circumstance, and data trends, which shall include:

- Decrease CAUTI hospital-wide from SIR 0.173 in 2022 to 0.381 in 2023. *SIR Goal: HHS Goal = below 0.75*
- Decrease CLABSI hospital-wide SIR from 0.563 in 2022 to 0.559 in 2023. SIR Goal: HHS Goal = below 0.5
- Decrease Utilization of Central Lines and Foley Catheters.
- Clostridium difficile: There will be an ongoing reduction facility-wide SIR of 0.631 in 2022 to 0.299 in 2023. *HHS Goal= below 0.70*
- Sustain Hand Hygiene compliance rate >80%.
- Surgical Site Infection (SSI) hospital-wide SIR from 0695 in 2022 to 0.607 in 2023. SIR Goal: HHS Goal = below 0.5
- Surgical Site Infection (SSI) reduction by implementing an SSI prevention bundle.
- Decrease the possible transmission of infection on portable equipment, reusable equipment, etc., by evaluating EVS standards of practice and implementing tools to aid in improving EVS processes.
- Evaluating and monitoring High and Low-Level Disinfection processes hospital-wide.
- Environment of Care Surveillance

J. EMERGENCY PREPAREDNESS AND MANAGEMENT

Infection Preventionist(s) participate in the hospital-wide emergency plan via the Hospital Incident Command System (HICS). In the HICS system, a Biological / Infectious Disease Medical Specialist will be called in as needed by the Incident Commander.

Multiple established resources exist in the event of an influx of potentially infectious patients. The hospital is part of the Monterey County Emergency Response System and has an Emergency Manual for all the regional hospitals listing resources regarding infectious patients, including bioterrorism. The Infection Prevention Department works collaboratively with the local and state health departments that serve as resources.

The infection prevention department regularly receives updates from the local and state health departments regarding emerging infections in the community and state, as well as surge capacity and syndrome surveillance. The syndromes monitored are asthma, diarrhea, gastroenteritis, vomiting, fever, rash, sepsis / septic shock, and chicken pox.

The hospital communicates this information to licensed independent practitioners and staff if

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patterns are identified. Medical Staff would be notified and communicate the information to the medical providers via the staff structure. The nursing staff also has a similar structure; the Chief Nursing Officer would be notified, and information would be communicated to nursing directors and unit managers for communication to staff. The hospital has an education department that can assist, if needed, in staff education.

The hospital has developed a process that details the hospital's planned response to an influx of infectious patients. The plan addresses infectious control practices for patients, post-exposure management, management of large-scale exposures, post-incident debriefing, laboratory support, and CDC information if needed. If needed, the hospital has a nurse-staffing plan that can be implemented to care for patients over an extended period.

Supporting documents:

- EMERGING INFECTIOUS DISEASES INFECTION PREVENTION PANDEMIC PLAN
- ISOLATION - STANDARD AND TRANSMISSION-BASED PRECAUTIONS
- EMPLOYEES EXPOSURES & PREVENTION PLANS: SPECIFIC DISEASE EXPOSURES AND WORK RESTRICTIONS
- EMERGENCY OPERATIONS PLAN
- INFLUENZA PANDEMIC PLAN
- Aerosol Transmitted Diseases Exposure Control Plan
- INFECTION PREVENTION AUTHORITY STATEMENT

VI. ORIENTATION AND EDUCATION

A. Orientation, education, and training is provided on an as-needed basis.

VII. DOCUMENTATION

A. ANNUAL EVALUATION OF PLAN

The Infection Prevention Performance Improvement Report is updated/reviewed quarterly at Pharmacy & Therapeutics/Infection Prevention Committee meetings. New risks or changes in priorities are identified throughout the year. At the end of each year, the outcomes of each identified goal are determined and considered for inclusion in next year's plan. The revised Plan is taken to the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee for final revisions and approval.

VIII. REFERENCES

A. The Joint Commission Infection Prevention and Control

B. Title 22 Infection Control Program 70739

C. APIC Text of Epidemiology and Infection Control and Epidemiology, Association for Professionals in Infection Control and Epidemiology (APIC), Inc., 2023

D. National Healthcare Safety Network (NHSN) Patient Safety Component Manual January 2023: https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf

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E. California Department of Public Health, Communicable Disease Data. https://www.cdph.ca.gov/data/statistics/Pages/CDdata.aspx.

F. Monterey County Health Department: https://datasharemontereycounty.org

G. Monterey County Health Department, Communicable Diseases Report: Salinas, California: Public Health Bureau, Communicable Disease Unit. https://www.co.monterey.ca.us/government/departments-a-h/health/public-health/communicable-disease-unit

H. US Census Bureau, https://www.census.gov/data/tables/2020/dec/2020-apportionment-data.html

I. ***NHSN Reports***, the webpage contains reports organized by the year of data included in the report. The annual reports include the Antimicrobial Resistance Reports, National and State-specific Healthcare-Associated Infections Progress Reports, and additional NHSN reports and resources; 2004 to 2020. https://www.cdc.gov/nhsn/datastat/index.html.

J. The NHSN Standardized Infection Ratio (SIR), A Guide to the SIR. Updated 02/2021. https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

K. Estimating the Additional Hospital Inpatient Cost and Mortality Associated With Selected Hospital-Acquired Conditions, 2017. https://www.ahrq.gov/hai/pfp/haccost2017-results.html

Attachments

2024_2025 IP Risk Assessment Analysis.pdf

2024_2025 Risk Assessment PI Plan.doc

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	08/2024
P&T Committee	Genevieve delos Santos: Director Pharmacy	08/2024
Quality Improvement Committee	Aniko Kukla: Director Quality & Patient Safety	08/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2024
Policy Owner	Melissa Deen: Manager Infection Prevention	04/2024

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Standards

No standards are associated with this document

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Status Pending PolicyStat ID 15587214

Salinas Valley HEALTH

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

Patient Safety Program Plan

I. PURPOSE

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

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

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

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

II. PATIENT SAFETY PROGRAM SCOPE AND PURPOSE

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

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

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

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

D. The purpose of the Patient Safety Program is:

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

objectives relative to the quality and safety of patient care.

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

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

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

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

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

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

communication among caregivers.

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

III. PATIENT SAFETY PLAN ANNUAL GOALS/ OBJECTIVES

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

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

9. Evaluate and identify opportunities for improvement regarding medication management and patient safety.
10. Participate in Beta Healthcare Pro-Active Risk Assessments and Initiatives.
11. Partner with California Healthcare Patient Safety Organization (CHPSO), National Patient Safety Foundation and the Emergency Care Research Institute (ECRI) to eliminate preventable harm and improving the quality and safety of health care delivery at SVHMC.

IV. PATIENT SAFETY PROGRAM ORGANIZATIONAL STRUCTURES/ RESPONSIBILITIES

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

   1. **Board of Directors**

      - The SVHMC Board of Directors, through the approval of this document, authorizes the establishment of a planned and systematic approach to preventing and addressing patient safety. The Board delegates the implementation and oversight of this program to the Patient Safety Officer. It is the ultimate responsibility of the SVHMC Board of Directors to ensure quality and safe patient care throughout the organization. Key responsibilities of the Board of Directors regarding Patient Safety are seen in activities such as:

         a. Critically examines SVHMC and medical staff processes to assure high standards.
         b. Monitors the adequacy and appropriateness of the Medical Staff processes.
         c. Delegates' oversight of medical care to the Medical Staff per California law.
         d. Approves the Patient Safety Program Plan.
         e. Reviews SVHMC performance on key quality and safety indicators including sentinel/never events, and holds senior leadership, physician leadership, mid-level management, and frontline caregivers directly accountable for results.

2. **Patient Safety Officer**
    - The Patient Safety Officer is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Patient Safety Officer will establish the structures and processes necessary to accomplish this objective.
    - The Patient Safety Office will review, and in collaboration with relevant leaders, identify and implement actions as necessary for all critical events within 5 days of the event. The Patient Safety Officer or designee will review non critical incidents for trends / patterns or concerns and share with appropriate leaders, Quality Management and/or medical staff as necessary.
    - The Patient Safety Officer communicates and collaborates with Administration and department leaders and others in an effort to ensure coordination in reduction of harm and promote safe practices as well as a safe culture of reporting.
    - Oversees the Culture of Safety survey as defined by the organization.
    - Meets routinely with leaders and staff on the Patient safety Program goals, objectives and outcomes.
    - Is available to all persons under SVHMC when questions or concerns are raised concerning the safety of patients. Collaborates with the Environmental Health and Safety Officer for other safety concerns.
3. **Medical Executive Committees (MEC)**
    - As delegated by the SVHMC Board of Directors and consistent with its bylaws, policies and rules and regulations, the Medical Executive Committee is responsible for the day-to-day implementation and evaluation of the processes and activities noted in this program. These Patient Safety responsibilities include but are not limited to:
        a. Reviewing Patient Safety initiatives and activities.
        b. Approving the Patient Safety Program Plan and providing subsequent recommendations for approval to the Board.
        c. Identifying opportunities to improve patient care, patient safety, and SVHMC's performance. This responsibility is shared with Quality and Safety Committees of SVHMC.
4. **Senior Leadership Team**
    - As delegated by the SVHMC Board of Directors, the Senior Leadership Team responsibilities include:
        a. Incorporating Patient Safety function into the Strategic Plan.
        b. Reviewing and approving the Patient Safety Program Plan.
        c. Ensuring that processes are in place for communicating relevant Patient Safety information throughout SVHMC and identifying opportunities to improve Patient Safety. Allocating sufficient

resources needed to improve Patient Safety.

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

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

5. **Quality and Safety Committees**
   - The Quality and Safety Committee's responsibilities for patient safety include:
     a. Overseeing all Patient Safety activities, which include approving, prioritizing and facilitating operationalization of the Plan.
     b. Reviewing and evaluating the Patient Safety Plan and provides its subsequent recommendations for approval to medical staff, Senior Leadership and the Board.
     c. Reviewing Patient Safety reports and identifying opportunities to improve Patient Safety. This responsibility is shared with medical staff and Leadership.
     d. Reviewing action plans resulting from teams for intensive assessment of adverse events.
     e. Reviewing and evaluating reports regarding the progress and effectiveness of Patient Safety initiatives and improvement activities.
     f. Ensuring that Patient Safety is incorporated in the design of processes, functions and services.
     g. Oversees the committee for the Safety and Reliability Council

6. **Patient Safety Advisory Team (PSAT)**
   - This ad-hoc committee is comprised of key representatives from leadership to:
     a. Evaluate reported events related to patient safety and quality care that occur within SVHMC to determine whether the event is treated as a sentinel event and/or is reportable according to state and regulatory requirements.
     b. The Regulatory and Accreditation team oversees the PSAT process and collaborates with the Quality and Risk Departments for evaluation of events as necessary.

7. **Medical Staff**
   - The Medical Staff supports Patient Safety through the following:

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

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

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

8. **Staff**

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

V. PATIENT SAFETY PROGRAM ELEMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. Educating the Patient on Error Prevention - The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

    1. The Patient Safety Program includes a survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to

patients and requests suggestions for improving patient safety.

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

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

VI. PATIENT SAFETY PLAN MANAGEMENT

A. **Patient Safety Program Resources**

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

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

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

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

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

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

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

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

VII. REFERENCES

A. Center for Medicare Services (CMS) Conditions of Participation
B. Joint Commission Sentinel Event Policy
C. The Joint Commission Standards.
D. To ERR is Human: Building a Safer Health System
E. Crossing the Quality Chasm: A New Health System for the 21st Century
F. OIG Report on Medical Error 12-00
G. HSC §442.5, HSC §1254.4, HSC §1255.8, HSC §1279.6, HSC §1279.7, HSC §1288.6, HSC §1288.7, HSC §1288.8, HSC §1288.9, HSC §1288.95
H. National Patient Safety Foundation
I. The Just Culture Community, www.justculture.org
J. California Senate Bill 1058, (Infection Control and Prevention)
K. California Senate Bill 444 (Patient Safety Plan)
L. Healthcare Performance Improvement (2011) The HPI SEC & SSER Patient Safety Measurement System for Healthcare. https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0008/569537/Known-Complications-HPI-White-Paper.pdf

Attachments

BETA 4.0 JC Algorithm-rv1.pdf

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	08/2024
QSC	Aniko Kukla: Director Quality & Patient Safety	08/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024

Policy Owner	Aniko Kukla: Director Quality & Patient Safety	08/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16424980**

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

Quality Assessment and Performance Improvement Plan

I. SCOPE

A. The purpose of the Organizational Quality Assessment and Performance Improvement (QAPI) Program Plan at Salinas Valley Health Medical Center (SVHMC), under the Salinas Valley Health is to ensure that the Governing Body, medical staff and professional services staff demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risk. Furthermore, the QAPI Plan is used as a mechanism to develop, implement, and maintain an effective, ongoing, organization-wide, data-driven quality assessment and performance improvement program through a planned, systematic, and interdisciplinary approach to improving the care, treatment and services provided. This is an organization-wide plan. It applies to all inpatient, outpatient departments and ambulatory outpatient services, licensed under SVHMC including those services furnished under contract or arrangement.

B. The QAPI Program is designed to promote an environment where patient care and services are continually improved, where professional performance and employee competence are maximized, and in which operational systems are efficient. Through an interdisciplinary and integrated process, patient care and the processes that affect patient care are measured and assessed to provide optimal outcomes. The Board of Directors, Medical Staff, organizational leaders and all personnel assume appropriate accountability for the quality of care and services provided at SVHMC. The QAPI Program is designed to align with and support the organizational MISSION, VISION, AND GOALS STATEMENT.

C. In concert with the organizational QAPI Program, professional nursing practice care at Salinas Valley Health Medical Center is guided by a Professional Practice Model, developed by the nursing staff. The nursing mission is to heal, protect, empower and teach. The nursing vision is to be an innovative leader in nursing excellence - a place where patients choose to come and nurses want to practice. Other components of the Professional Practice Model include shared governance, respectful, collaborative professional relationships, recognition and reward for professional nursing development and a care delivery model which embraces a relationship-based, collaborative approach emphasizing partnerships with our colleagues, patients, families and the community. Clinical Nurses, ancillary staff, support staff and medical staff

participate in quality committees to make interprofessional decisions at the organizational level to improve processes and quality of care. These decision making committees include committees in Administrative Quality; Safety and Reliability; Shared Governance and ad hoc subcommittees where nursing sensitive measures and nursing practice initiatives are incorporated into the overall organizational performance improvement.

II. OBJECTIVES/GOALS

A. **Objectives**

1. The organizational QAPI program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided and on patient safety practices conducted throughout the organization. The program encompasses elements of the mission, vision, goals and organizational strategic objectives and consists of performance improvement, patient safety and quality control activities. Indicators are objective, measurable, based on current knowledge and experience, and are structured to produce statistically valid, data driven measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time when appropriate.
2. The QAPI Plan includes data collection, data aggregation and analysis, analysis of undesirable patterns or trends, identifying and managing sentinel events, improving performance, patient safety and reducing risk of adverse / sentinel events, and conducting proactive risk reduction activities, including processes that involve the Medical Staff as well as clinical and support services. The QAPI program is implemented in conjunction with the organizational PATIENT SAFETY PROGRAM PLAN **and the** RISK MANAGEMENT PLAN

B. **Goals**

1. The goals for the QAPI Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance monitoring and environmental monitoring.
2. Annually the organization defines at least one improvement priority. In collaboration with organizational strategic objectives, the following priorities have been established for 2023:
   - Annual Quality and Safety Pillar Strategic Initiatives
   - Patient Perception of Care, Services and Treatment
   - Patient Flow Initiatives
   - Regulatory Reporting Requirements, including Value Based Purchasing
   - Adherence to National Patient Safety Goals
   - Maintenance of Disease Specific Care Certification Designations
   - Pain Management and Opioid Reduction Strategies
   - Safety and Reliability Improvement Initiatives
   - Magnet Recognition/Nurse Sensitive Indicators

- Health Equity
- Diagnostic Excellence and Error Prevention
- Early Recovery After Surgery
- Age Friendly Initiative

III. DEFINITIONS

A. CMS	Centers for Medicare and Medicaid Services
B. MEC	Medical Executive Committee
C. PIT	Process Improvement Team
D. QAPI	Quality Assessment and Performance Improvement
E. QSC	Quality and Safety Committee

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. **Measuring Performance**

a. Data Collection
The Board of Directors, in collaboration with medical staff and hospital administrative leaders, establish priorities for data collection as well as the frequency for collection. Data collected for high priority processes are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement, or sustain improvement. The Program is expected to show improvement in measures for which there is evidence that patient outcomes will be improved and medical errors will be reduced. Data are collected and analyzed for the following (not a comprehensive list):

- Performance improvement priorities identified by leaders
- Operative or other procedures that place patients at risk of disability or death
- All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- Adverse patient events
- Adverse events related to using moderate or deep sedation or anesthesia
- Blood management
- The results of resuscitation / Effectiveness of its response to change or deterioration in a patient's condition
- Medication errors
- Adverse drug reactions

- Patient perception of the safety and the quality of care, treatment or services
- Processes that improve patient outcomes such as fall reduction activities including assessment, interventions and education
- National Patient Safety Goals
- Processes as defined in the organizations Infection Control Program, Environment of Care Program, and Patient Safety Program
- Organ Procurement Organization processes
- Staff opinions and needs, staff perceptions of risk to individuals, staff suggestions for improving patient safety, and willingness to report adverse events
- Core measure data and other required Centers for Medicare and Medicaid Services (CMS) measures
- Patient flow processes
- Contracted services
- Emergency Management
- Other areas as outlined in the Quality Oversight structure

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on selected populations. A reporting calendar has been defined for department and operational reporting. This is a dynamic document and may change throughout the year based on priorities and/or metric outcome trends.

Relevant information developed from the following activities is integrated into performance improvement initiatives as required:

- Patient safety
- Clinical outcomes
- Key financial/utilization indicators including length of stay
- Risk management
- Quality control
- Infection control surveillance and reporting
- Research when applicable
- Autopsies
- Other relevant data as required or identified

2. **Assessing Performance**

a. **Data Compilation and Analysis**
Data aggregation and analysis transforms data into information. Data are systematically aggregated and analyzed in order to monitor the effectiveness and safety of services and quality of care, and assess performance levels, patterns, or trends.

  i. Data aggregation is performed at the frequency appropriate to the activity or process.
  ii. Statistical tools and techniques are used to display and analyze data whenever possible.
  iii. Data are analyzed and compared internally over time and externally with other sources of information when available.
  iv. When available, comparative data are used to determine if there is excessive variability or unacceptable levels of performance.
  v. Results of data analysis are used to identify improvement opportunities.

3. **Improving Performance**
   a. Information from data analysis is used to make changes that improve performance and safety. The Board of Directors, in collaboration with medical staff and hospital leaders, establish priorities for improvement opportunities and requests action be taken on those priorities.
      - Information from data analysis including data from new or modified services is used to identify and implement changes that will improve performance and patient safety.
      - Improvement strategies are evaluated to confirm that they have resulted in improvement, and are tracked to ensure that improvements are sustained.
      - Additional actions are taken when the improvements do not achieve or sustain the desired outcomes.
      - Changes that will reduce the risk of sentinel events are identified and implemented.
4. **Identifying and Managing Adverse or Unexpected Occurrences**
   a. Processes for identifying and managing sentinel events are defined in the organization wide ADVERSE EVENTS - REPORTABLE.
5. **Proactive Risk Reduction Program**
   a. Salinas Valley Health Medical Center has dedicated a consistent effort to reduce potential harm to patients and prevent unanticipated adverse events by remaining proactive in approaches to performance improvement. Periodically, a systematic proactive evaluation method is completed on a process to evaluate and identify how it might fail and determine the relative impact a failure might have. This process assists to identify the key parts in a process that require change.

6. **Priority Patient Population**
    a. The priority patient populations are based on high-risk, high volume, high risk/low volume and/or problem prone areas with consideration of the incidence, prevalence and severity of problems in those areas which may affect patient outcomes, safety and quality of care.
7. **Analysis of Staffing**
    a. When undesirable patterns, trends or variations in performance related to the safety or quality of care are identified from data analysis or a single undesirable event, the adequacy of staffing (number, skill mix, competency), including nurse staffing is analyzed for possible cause. Additionally, processes related to work flow, competency assessment, credentialing, supervision of staff, orientation, training and education may also be analyzed.
    b. When analysis reveals a problem with the adequacy of staffing, the QSC is informed of the results of the analysis and actions taken to resolve the identified problem(s).

B. **Plan Management**
1. **Performance/Process Improvement Model**
    a. Salinas Valley Health Medical Center utilizes a wide range of systematic and structured problem-solving approaches to plan, design, measure, assess and improve organizational performance/processes. Methodologies include Lean for Healthcare, F O C U S – P D C A and Rapid Cycle Improvement.
        - F O C U S – P D C A.
          F – Find a process to improve.
          O – Organize a team that understands the process.
          C – Clarify how the current process works.
          U – Understand the causes of process variation, the "root cause".
          S – Select changes that will improve the process.

          P – Plan how the changes will be implemented.
          D – Do/implement the plan.
          C – Check the results of the improvement plan by collecting post-implementation data.
          A – Act on the findings of post-implementation data by standardizing the process or testing another change.
        - Systems Redesign
          Utilizes concepts such as eliminating waste, process mapping, one piece flow; just in time, standardization, and workload leveling.
        - Rapid Cycle Improvement / Kaizen
          When appropriate, the *rapid cycle improvement* process may be

utilized. The advantages of the rapid cycle improvement process include:

- Using a small sample to test a proposed change idea quickly.
- Testing ideas side by side with existing processes.
- Testing many ideas quickly.
- Providing opportunities for failures without impacting performance.
- Minimizing resistance to successful change.

2. **Performance/Process Improvement Teams**
   a. A performance/process improvement team is defined as a group of knowledgeable people, who are close to the process, that cooperate to achieve a common goal. Teams are composed of individuals with expertise in the process(es) that require(s) improvement.
3. **Performance/Process Improvement Team Request**
   a. A request for approval for a formal performance/process improvement team (PIT) may be presented to the Quality Interdisciplinary or Safety and Reliability Committee for consideration of a performance improvement team. PITs will be considered when interdisciplinary and/or interdepartmental processes require improvement that cannot be accomplished by an individual or by the individual department(s) or discipline(s). In order to prioritize and coordinate organizational improvement processes and resources, interdisciplinary / interdepartmental teams may be approved by the Quality and Safety Committee. NOTE: Individual departments may charter teams for the purpose of improving processes specific to their departments.

C. **Plan Responsibility**

1. Performance / Process Improvement Structure
   a. The Quality Oversite Structure outlines the quality and performance improvement structure and processes. A calendar for reporting is defined annually and changes made ongoing as the needs of the organization changes. The Quality Management Department, in collaboration with facility leaders, staff and medical staff, facilitates the implementation of the QAPI Program.
   b. **Governing Board**
      i. Responsibility for performance improvement rests with every employee of Salinas Valley Health Medical Center. Overall responsibility rests with the Board of Directors. The Board of Directors requires review and evaluation of patient care activities by the Quality and Efficient Practices Board Committee to measure and improve the quality and efficiency of patient care

and services in the organization. While maintaining overall responsibility, the Board delegates operational authority to the Medical Staff and Hospital Leadership.

ii. In exercising its supervising responsibility, the Board:

1. Reviews and approves the QAPI, Risk Management and Patient Safety Program Plans.
2. Reviews periodic reports on findings, actions, and results of program activities, including input from the populations served via results of patient experience data.
3. Reviews reports on the following: all system or process failures; the number and type of sentinel events; whether the patients and the families were informed of the event; results of analyses related to adequacy of staffing; all actions taken to improve safety, both proactively and in response to actual occurrences.
4. Assesses the QAPI, Risk Management and Patient Safety Programs' effectiveness and efficiency and required modification, as necessary.
5. Provides resources and support for performance improvement, change management, patient safety and risk management functions related to the quality and safety of patient care, including sufficient staff, access to information and training throughout the hospital.

c. **Medical Executive Committee**

i. MEC authorizes the establishment of an interdisciplinary Quality and Safety Committee to implement the QAPI program.

ii. Medical Executive Committee (MEC) is accountable to the Board of Directors for the oversight of performance improvement activities to ensure that one level of care is rendered to all patients.

iii. The Medical Staff participates in developing measures to evaluate care systematically. Their participation may be in individual departments, medical staff committees, or on interdepartmental or interdisciplinary process/performance improvement teams.

iv. The medical staff departments review and evaluate the results of ongoing measures that include the medical staff review functions as well as risk management, patient safety, infection control, case management, and organizational planning.

d. **Organizational Leaders**

i. Set expectations for performance/process improvement.
ii. Develop plans for performance/process improvement.
iii. Manage processes to improve hospital performance.
iv. Review results from key financial indicators in order to ensure overall financial stability.
v. Monitor contracted services by establishing expectations for the performance of the contracted services.
vi. Participate in performance/process improvement activities when appropriate.
vii. Ensure participation from appropriate individuals in organization wide performance/process improvement activities.
viii. Ensure that new or modified processes or services incorporate the following:
    - Needs and/or expectations of patients, staff and others.
    - Results of performance improvement activities, when available.
    - Information about potential risk to patients, when available.
    - Current knowledge, when available and relevant.
    - Information about sentinel events, when available and relevant.
    - Testing and analysis to determine whether the proposed design or redesign is an improvement.
    - Collaboration with staff and appropriate stakeholders to design services.
ix. Ensure that an integrated patient safety program is implemented throughout the organization.
x. Establish and maintain operational linkages between risk management activities related to patient care and safety, and performance improvement activities.
xi. Ensure compliance with state and federal laws, and the Joint Commission regulations/standards.

e. **Support Service Departments/Department Directors**
   i. The Department leaders are accountable to the Organizational Leaders, QSC and the Board of Directors for the quality of care/services and performance of their staff and departments. Departments participate in the systematic measurement and assessment of the quality of care/services they provide. The Department Directors:

ii. Promote the development of standards of care and measures to assess the quality of care/services rendered in their departments.

iii. Monitor the processes in their areas, which affect patient safety, care, outcomes and the patient's perception of care received.

iv. Promote the integration of their department's performance improvement activities with those of other support services and the Medical Staff through participation in performance improvement teams.

v. Report the results of applicable performance improvement activities in accordance with the established Quality Oversight Structure (see Appendix A).

D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of the QAPI Program Plan. Performance measures have been established to measure important aspects of care. Leaders are responsible to determine what measures will be evaluated at least every 2 year. These measures are updated / revised ongoing as compliance is sustained.
2. To ensure that the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities on the basis of assessment; and maintaining achieved improvements, the organizational QAPI program is evaluated for effectiveness at least annually and revised as necessary.
3. **Confidentiality**
   a. All information related to performance improvement and patient safety activities performed by the Medical Staff or hospital personnel in accordance with this plan are confidential and protected under the Patient Safety Work Product and California Evidence Code 1157.
   b. Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a "need to know" as approved by the Medical Executive Committee, Organizational Leaders, and/or the Governing Body.
   c. HIPAA regulations will be followed.

E. **Orientation and Education**

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

V. REFERENCES

A. The Joint Commission

B. Title 22 (CDPH)

C. CMS

Attachments

Appendix A- Quality Oversight 2024 SVHMC-1.pdf

Approval Signatures

Step Description	Approver	Date
Policy Owner	Aniko Kukla: Director Quality & Patient Safety	Pending

Standards

No standards are associated with this document

QUALITY AND EFFICIENT PRACTICES COMMITTEE

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

(CATHERINE CARSON)

Star Reports

Center for Medicare and Medicaid Services

Announced July 31st, 2024

Aniko Kukla DNP, RN,
Director of Quality and Patient Safety
Patient Safety Officer

Congratulations

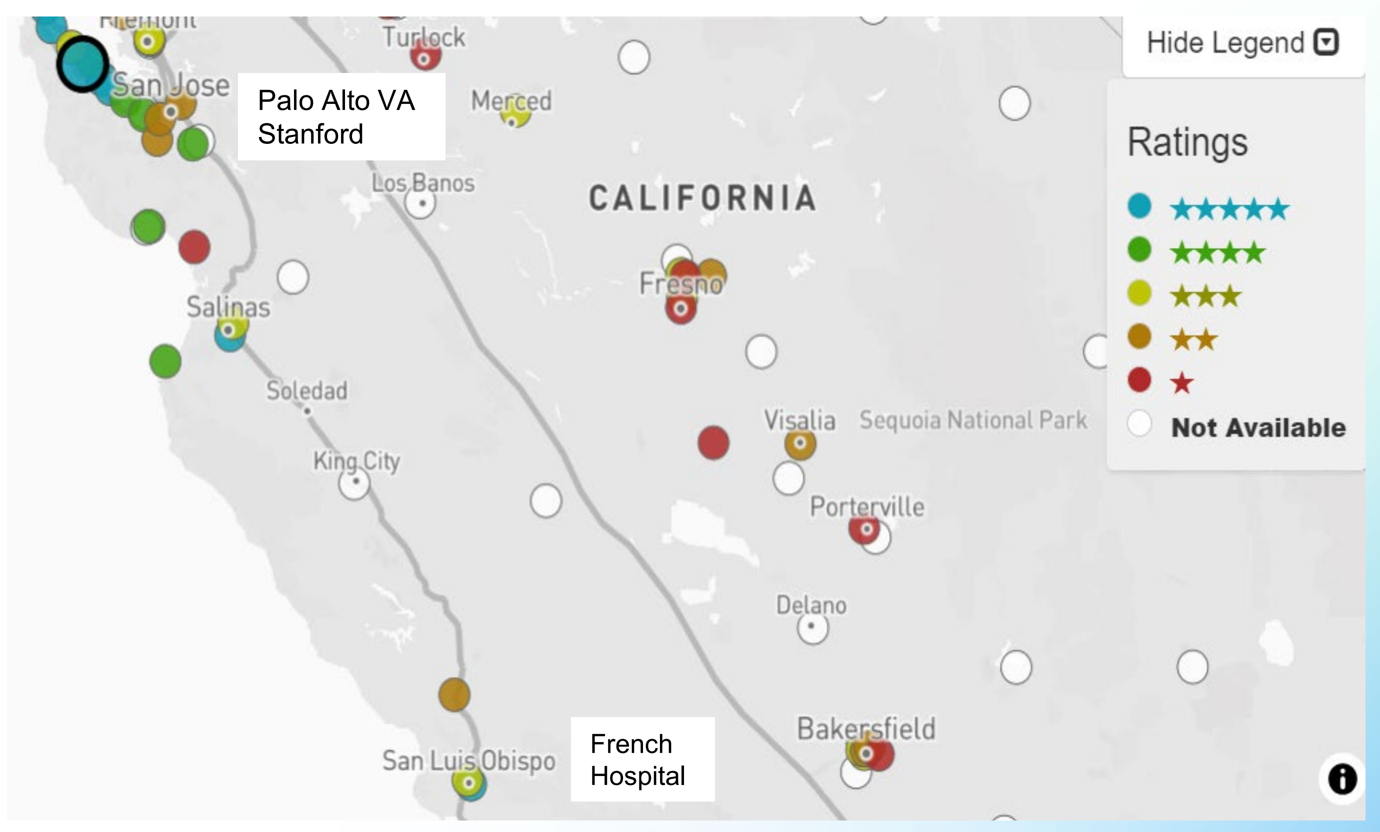
Salinas Valley Medical Center

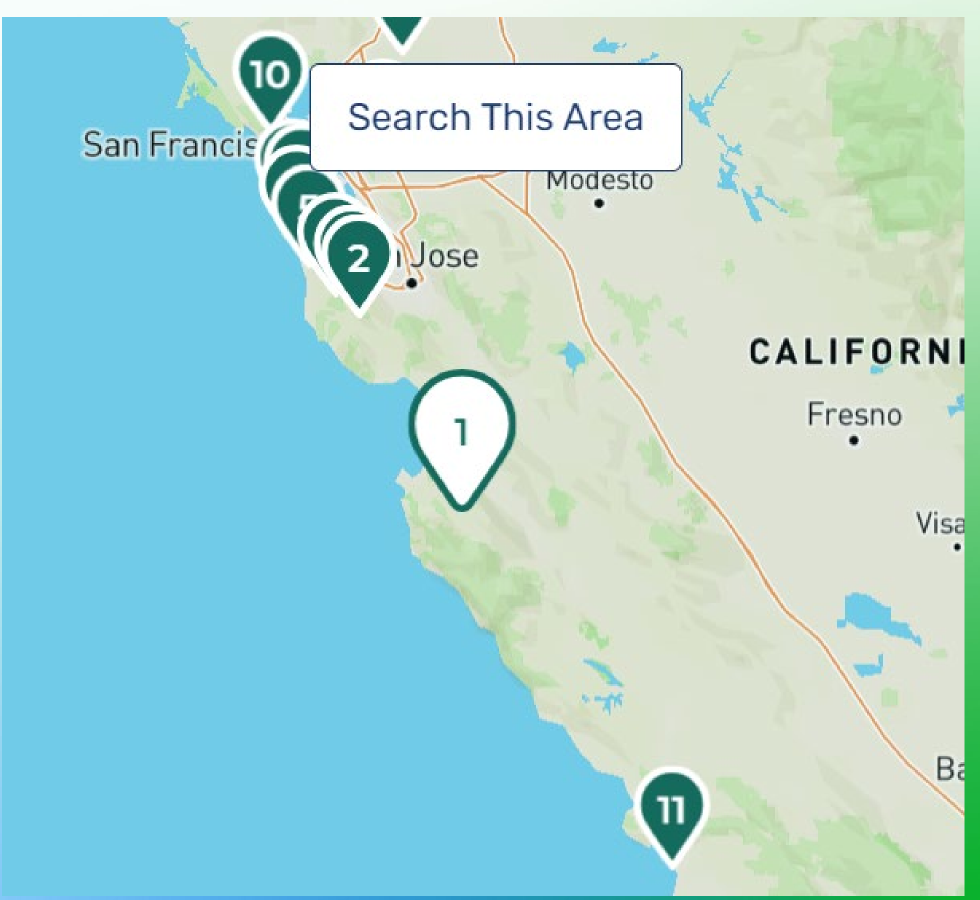
for the 5 Star Recognition on the

CMS Hospital Compare Ratings

Salinas Valley HEALTH

Map of CMS Star Ratings- California





CMS Star Ratings Measures and Star Distribution Hospitals

46 measures reported and grouped into 5 categories

Measure group	Weight used in calculation
Mortality	22%
Safety	22%
Readmission	22%
Patient Experience	22%
Timely & Effective Care	12%

Overall rating	Number of hospitals (N=4,658, %)
1 star	277 (5.9%)
2 stars	595 (12.8%)
3 stars	828 (17.8%)
4 stars	766 (16.4%)
5 stars	381 (8.2%)
N/A	1811 (38.9%)

Salinas Valley Health Medical Center joins the top 8.2% of the hospitals that have earned five stars.

	Salinas Valley Memorial Hospital 450 East Romie Lane Salinas, CA 93901 5☆	Stanford Health Care 300 Pasteur Drive Stanford, CA 94305 5☆	UCSF Medical Center 505 Parnassus Ave, Box 0296 San Francisco, CA 94143 5☆
Percentage of patients who received appropriate care for severe sepsis and/or septic shock *Higher percentages are better* National average: 61% [25,26] CA average: 66% [25,26]	**60%** [2] of 210 patients	**49%** [2] of 214 patients	**38%** [2] of 128 patients
Percentage of patients who left the emergency department before being seen *Lower percentages are better* National average: 3% [25,26] CA average: 3% [25,26]	**2%** of 66795 patients	**3%** of 82987 patients	**6%** of 60020 patients

	Salinas Valley Memorial Hospital 450 East Romie Lane Salinas, CA 93901 5 ☆	Stanford Health Care 300 Pasteur Drive Stanford, CA 94305 5 ☆	UCSF Medical Center 505 Parnassus Ave, Box 0296 San Francisco, CA 94143 5 ☆
Emergency department volume	**Very High** 60,000+ patients annually	**Very High** 60,000+ patients annually	**Very High** 60,000+ patients annually
Average (median) time patients spent in the emergency department before leaving from the visit *A lower number of minutes is better*	**175 minutes** Other Very High volume hospitals: Nation: 196 minutes [25,26] California: 208 minutes [25,26] Number of included patients: 387	**250 minutes** Other Very High volume hospitals: Nation: 196 minutes [25,26] California: 208 minutes [25,26] Number of included patients: 383	**258 minutes** Other Very High volume hospitals: Nation: 196 minutes [25,26] California: 208 minutes [25,26] Number of included patients: 338

	Salinas Valley Memorial Hospital 450 East Romie Lane Salinas, CA 93901 5☆	Stanford Health Care 300 Pasteur Drive Stanford, CA 94305 5☆	UCSF Medical Center 505 Parnassus Ave, Box 0296 San Francisco, CA 94143 5☆
Serious complications National result: 1.00	**0.78** No different than the national value	**1.01** No different than the national value	**0.83** Better than the national value
Deaths among patients with serious treatable complications after surgery National result: 167.87	**168.32** No different than the national rate	**147.81** No different than the national rate	**115.22** Better than the national rate
Infections			
Central line-associated bloodstream infections (CLABSI) in ICUs and select wards	**0.365** No different than national benchmark	**0.835** No different than national benchmark	**0.983** No different than national benchmark
Clostridium difficile (C.diff.) intestinal infections 🡇 *Lower numbers are better* National benchmark: 1.000	**0.373** Better than the national benchmark	**0.627** Better than the national benchmark	**0.738** Better than the national benchmark

Back to T

	Salinas Valley Memorial Hospital 450 East Romie Lane Salinas, CA 93901 5☆	Stanford Health Care 300 Pasteur Drive Stanford, CA 94305 5☆	UCSF Medical Center 505 Parnassus Ave, Box 0296 San Francisco, CA 94143 5☆
Hospital return days for heart attack patients National result: Not applicable	**-1.1 days** Average days per 100 discharges Number of included patients: 194	**-6.7 days** Average days per 100 discharges Number of included patients: 263	**15.3 days** Average days per 100 discharges Number of included patients: 144
Rate of readmission for heart failure patients National result: 19.8%	**19%** No different than the national rate Number of included patients: 682	**21%** No different than the national rate Number of included patients: 827	**17.2%** Better than the national rate Number of included patients: 582
Hospital return days for heart failure patients National result: Not applicable	**-21.2 days** Fewer days than average per 100 discharges Number of included patients: 538	**20.2 days** More days than average per 100 discharges Number of included patients: 676	**-16 days** Average days per 100 discharges Number of included patients: 473

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*

(CATHERINE CARSON)

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

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 Board of Directors to Award a Construction Contract to McLaughlin Painting & Waterproofing for the Medical Center Campus Exterior Repainting Project
Executive Sponsor:	Clement Miller, Chief Operating Officer Dave Sullivan, Facilities Management & Construction
Date:	August 5,2024

Executive Summary

Salinas Valley Health implemented a comprehensive re-branding campaign, rolling out new logo and signage installations. Concurrently, leadership requested the development of a fresh color scheme consistent with re-branding goals and characteristics that will result in a new visual presentation of campus structures to the community. Several different color schemes were proposed, one was selected by the Executive Leadership Alignment Committee and subsequently approved by the Board in September of 2023.

WRD Architects prepared detailed plans and specifications. The City of Salinas reviewed the project and issued a minor modification to the Conditional Use Permit to allow execution of the project. Salinas Valley Health publicly advertised a request for contractor bids to complete the construction services required for the project. The advertisement was circulated in the Californian and Central Coast Builder's Exchange. At the close of bid period, on July 31 2024, eleven bids from painting contractors were received and publicly opened (Attachment 1). After staff review of the bid packages submitted, Facilities Management identified McLaughlin Painting & Waterproofing as the lowest responsible, responsive bidder. The project is expected to be implemented in 8 phases on a building-by-building basis, completing one building before moving to the next building. Project duration is anticipated to take up to 10 months, dependent upon the weather.

Timeline/Review Process

July 2024	Contractor Bidding
August 2024	Contract Award & Project Commencement
June 2025	Anticipated Project Completion

Pillar/Goal Alignment

☐ Service ☐ People X Quality ☐ Finance ☐ Growth X Community

Financial/Quality/Safety/Regulatory Implications

Key Contract Terms	Vendor: Avila Construction Company
1. Proposed effective date	Issuance of Notice to Proceed anticipated on August 26, 2024
2. Term of agreement	300 calendar days
3. Renewal terms	Not Applicable
4. Termination provision(s)	Provided in Bid Specifications Part 12 of General Conditions
5. Payment Terms	Lump Sum, with monthly payment applications based upon % complete
6. Annual cost	Contract Sum of $669,580.00
7. Cost over life of agreement	Not Applicable
8. Budgeted (indicate y/n)	Yes

Recommendation

Consider recommendation to the Board to award McLaughlin Painting & Waterproofing the contract for SVH Medical Center Campus Exterior Building Repainting at 450 E. Romie Lane in the amount of $669,580.00.

Attachments

- Attachment 1: Bid Results July 31, 2024

SALINAS VALLEY HEALTH
PROJECT: Campus Building Exterior Repainting
BID OPENING: 7/31/2024 @ 2:00 PM

BID OPENING LOCATION: 535 E. Romie, Suite 6, Salinas CA 93901
SIGN IN SHEET

	PRINTED NAME	COMPANY	BASE BID LUMP SUM	PHONE NUMBER	LIC. Number/Class	Pre Walk	Add A	Add B	Sub Lst	Dqual Ltr	Ins Rqt	Bid Bond	Non Colus	Bid Ltr
1	Jose Canchola	McLaughlin Paint & WC	**$669,580.00**	(408) 920-6119		x	x	x	x	x	x	x	x	x
2	Cesar Arroyo	Primal Paint	$1,043,000.00	(408) 373-9822		x	x	x	x	x	x	x	x	x
3	Carlos Zarate	Perfection Paint	$1,061,000.00	(661) 234-1957		x	x	x	x	x	x	x	x	x
4	Jinn Lee	Aiden's Quality Paint	no bid	(408) 314-1830		x								
5	Steve Saleh	Saleh Painting	$778,754.00	(831) 384-1552		x	x	x	x	x	x	x	x	x
6	Vincent Rodgriguez	R-Bros	$1,000,838.00	(408) 291-6820		x	x	x	x	x	x	x	x	x
7	Dimitar Mitev	Color New	$1,017,000.00	(818) 884-0845		x	x	x	x	x	x	x	x	x
8	Mike Dovgan	ProEx Const	$1,372,000.00	(916) 970-0097		x	x	x	x	x	x	x	x	x
9	Alan Murdoch	George E Masker	$1,625,000.00	(510) 568-1206		x	x	x	x	x	x	x	x	x
10	Diego Rodriguez	Simplify Painting	no bid	(831) 241-1636		x								
11	Manolis Koutantos	Fresh Start Painting Co.	$888,900.00	(650) 222-7766		x	x	x	x	x	x	x	x	x
12	Mike Cabe	CMA Painting, Inc.	$862,000.00	(530) 216-0691		x	x	x	x	x	x	x	x	x
13	Pete Trevino	Applied Finishes	$1,618,198.00	(209) 625-6625		x	x	x	x	x	x	x	x	x

■ attended bid opening (shaded box: rows 1, 2, 5, 11, 12, 13)

Board Paper: Finance Committee

Agenda Item: Consider Recommendation for Board of Directors Approval of Project Budget for the Salinas Valley Health X-Ray Rooms 1 and 2 Replacement Project and Award of Contract to Philips for the X-Ray Equipment System and Service Agreement

Executive Sponsor: Clement Miller, Chief Operating Officer
John Kazel, Director Diagnostic Imaging

Date: August 8, 2024

Executive Summary

Salinas Valley Health is pursuing x-ray equipment replacements to upgrade the hospital systems' capabilities to the latest standards in radiography. The Imaging department currently relies on two Siemens X-ray rooms, each surpassing 20 years of age. These systems are now considered outdated due to their antiquated computer processing, software, radiation dose efficiency, and image quality. The vendor no longer provides new parts or hardware/software updates, necessitating repairs with third-party refurbished parts, which are increasingly scarce. The aging systems also operate on an obsolete third-party Digital Radiography (DR) conversion system, heightening the risk of irreparable failures.

A number of planning and review sessions involving the Diagnostic Imaging evaluation team were held weighing solutions from multiple vendors including Samsung and Philips. The Philips equipment package earned the most consideration for overall equipment and service features over time with of state-of-the-art DR X-ray systems promising significant enhancements including:

- **Advanced Technology:** The new systems feature fixed DR plates in both the table and upright stands, as well as one portable DR plate. This eliminates the need for technologists to manage and move plates, reducing the risk of costly damage.
- **Improved Patient Care:** Larger DR plates (17x17) facilitate imaging of bariatric patients in fewer exposures, thereby decreasing radiation exposure. Larger field-of-view coverage reduces the number of image retakes. Table weight capacity of 825lbs, and exam tables can be lowered to near ground level to easily support seating and transfers and reducing fall risk.
- **Innovative Features:** The systems incorporate cutting-edge technologies for image stitching, image filtering, lung nodule detection and upcoming 3D imaging capabilities.
- **Operational Efficiency:** Robotic equipment movements minimize manual handling of equipment, thereby reducing the risk of workplace injuries among technologists.
- **Enhanced Workflow:** Integrated AI features streamline the exam workflow, improve image quality, and expedite image processing times.

The replacement of the antiquated Siemens X-ray rooms with Philips' advanced systems will not only enhance diagnostic capabilities but also improve patient safety and operational efficiency. These upgrades align with our commitment to providing top-tier medical care and maintaining a leading edge in medical imaging technology.

Background/Situation/Rationale

These projects will upgrade and modernize Salinas Valley Health's Diagnostic Imaging capabilities, remove barriers to accessibility, and comply with current rules and regulations enforced by all agencies having jurisdiction including HCAI. Ancillary improvements necessary to implement the project include repairs and upgrades to fire life safety, architectural, structural, electrical, mechanical, and plumbing building elements, and enhancements to building management systems, while also bringing the suites into compliance with current building codes. Salinas Valley Health will be responsible for securing the HCAI approvals necessary to execute the work.

Replacement/Construction of these rooms will be staggered to ensure only one x-ray room is down at a time. One of the two rooms being replaced will remain operational with X-ray room 3 serving as a backup.

Strategic Plan Alignment

To provide high quality x-ray services and improved throughput while reducing radiation dose to our patients.

Pillar/Goal Alignment

✓ **Service** ✓ **People** ✓ **Quality** ✓ **Finance** ✓ **Growth** ✓ **Community**

Financial Implications

The terms of the proposed Contract with the X-Ray equipment supplier include:

Key Contract Terms	Philips Healthcare
1. Proposed effective date	Procurement anticipated in August/September 2024
2. Term of agreement	Eighteen months (Initial system warranty)
3. Renewal terms	The term of the Service Coverage may be extended for a total of 120 months after warranty expiration
4. Cost	Reference Below
5. Budgeted	Yes, Partial spends in Fiscal Years 2025 and 2026

Budget Projections

	X-ray 1	X-ray 2	X-ray 1 & 2	FY25	FY26	FY27-37
Philips Equipment	$282,834	$231,126	$513,960	$411,168	$102,792	
Philips Estimated Tax & Shipping	$26,655	$22,001	$48,656	$48,656		
Direct & Indirect	$1,218,692	$1,218,692	$2,437,384	$1,218,692	$1,218,692	
Capital Total*	**$1,528,181**	**$1,471,820**	**$3,000,000**	$1,678,516	$1,321,484	
Philips Service Agreement	$372,502	$372,502	$745,004			$745,004

*Includes a total of $155,293 in project contingency which shall be reserved for use by Salinas Valley Health.

Schedule: Fall 2024 – Commence procurement of onsite equipment, and development of HCAI permitting documents for permanent equipment.
Winter 2024 - 2025 – Commission procurement of interim onsite equipment
Summer 2025 – Commence construction of permanent onsite renovations

Budget: As currently programmed, the x-ray equipment replacement project cost estimate is $3,000,000. The project cost estimate includes design and engineering fees, permitting, project contingency, design-assistance from Philips, program management, and construction services required to complete the project.

Procurement: Salinas Valley Health solicited for product agreement services to qualified medical equipment suppliers. Various proposals were received with multiple arrangements and pricing. Each of the responses was reviewed by Diagnostic Imaging, Materials Management and Facilities Management to compare initial capital construction costs and product supply agreement arrangements. After evaluating all proposals, Salinas Valley Health determined that Philips Healthcare provided the most effective solution.

Recommendation

Consider recommendation for Board of Directors to approve (i) the total estimated project cost for the Salinas Valley Health X-Ray Rooms 1 and 2 Equipment Replacement projects in the budgeted amount of $1,528,181 and $1,471,820 respectively, and (ii) award equipment supply to Philips in the amount of $562,616 and (iii) approve service agreement with Philips Healthcare in the amount of $745,004.

Attachments

- Attachment 1: Estimated Project Budgets
- Attachment 2: Quote for Philips X-Ray equipment (Closed Session)
- Attachment 3: Philips Service Agreement (Closed Session)
- Attachment 4: ECRI Reports for Philips X-Ray

Attachment 1. Part 1

Salinas Valley Health (10348)

Project Cost Summary: X-Ray Room 1 Equipment Replacement

Architect: SKA

Subject: Budget Version Predesign July 2024

Date Printed: *8/9/2024*

Version 1

Prepared by: Bogard Team

Line Item		Description	A
Line Item		**Description**	**Original Budget**
	1	**Construction**	
0101		Construction Contract	$448,678
0102		Owner Construction Contingency	$211,730
0103		Contractor Contingency	
0104		Owner Direct Purchases	
	2	**Design**	
0200		Professional Fees - Fixed	$114,500
0201		Professional Fees - Time and Materials	
0202		Reimbursables	
	3	**Inspections and Consultation**	
0300		Inspector of Record	$76,440
0301		Special Inspections	$35,000
0302		Other Inspection Consultants	
0303		Environmental / Abatement Testing	
	4	**AHJ Fees**	
0400		OSHPD	$19,698
0401		City Fees	
0402		County Fees	
0403		APCD	$10,000
0404		Other Fees	
	5	Soft Costs	
0500		Department Relocation	
0501		Temporary Services	
0502		Construction Management	$207,000
0503		Abatement	
	6	**Site Work**	
0600		Landscaping	
0601		Sitework	
	7	**FF&E**	
0700		Radiology Equipment	$282,834
		Radiology Equipment Tax & Shipping	$26,655
0701		Other Medical Equipment	
0702		Non-Medical Equipment	
0703		Data and Phone Equipment	
0704		Furnishings	
0705		Furniture	$16,000
0706		Signage	$2,000
	8	**Insurance**	
0800		Insurance Claims	
	9	**Utilities**	
0900		PGE	
0901		Water	
0902		Sewer	
	99	**Contingency**	
9900		Contingency	$77,646
9901		Unbudgeted Items	
Totals			$1,528,181

Attachment 1. Part 2`

Salinas Valley Health (10348)

Project Cost Summary: X-Ray Room 2 Equipment Replacement
Architect: SKA
Subject: Budget Version Predesign July 2024

Date Printed: 8/9/2024
Version 1
Prepared by: Bogard Team

Budget Summary - Opinion of Probable Cost			
			A
Line Item		Description	Original Budget
	1	**Construction**	
0101		Construction Contract	$448,678
0102		Owner Construction Contingency	$211,730
0103		Contractor Contingency	
0104		Owner Direct Purchases	
	2	**Design**	
0200		Professional Fees - Fixed	$114,500
0201		Professional Fees - Time and Materials	
0202		Reimbursables	
	3	**Inspections and Consultation**	
0300		Inspector of Record	$76,440
0301		Special Inspections	$35,000
0302		Other Inspection Consultants	
0303		Environmental / Abatement Testing	
	4	**AHJ Fees**	
0400		OSHPD	$19,698
0401		City Fees	
0402		County Fees	
0403		APCD	$10,000
0404		Other Fees	
	5	Soft Costs	
0500		Department Relocation	
0501		Temporary Services	
0502		Construction Management	$207,000
0503		Abatement	
	6	**Site Work**	
0600		Landscaping	
0601		Sitework	
	7	**FF&E**	
0700		Radiology Equipment	$231,126
		Radiology Equipment Tax & Shipping	$22,001
0701		Other Medical Equipment	
0702		Non-Medical Equipment	
0703		Data and Phone Equipment	
0704		Furnishings	
0705		Furniture	$16,000
0706		Signage	$2,000
	8	**Insurance**	
0800		Insurance Claims	
	9	**Utilities**	
0900		PGE	
0901		Water	
0902		Sewer	
	99	**Contingency**	
9900		Contingency	$77,646
9901		Unbudgeted Items	
Totals			**$1,471,820**

Capital Guide

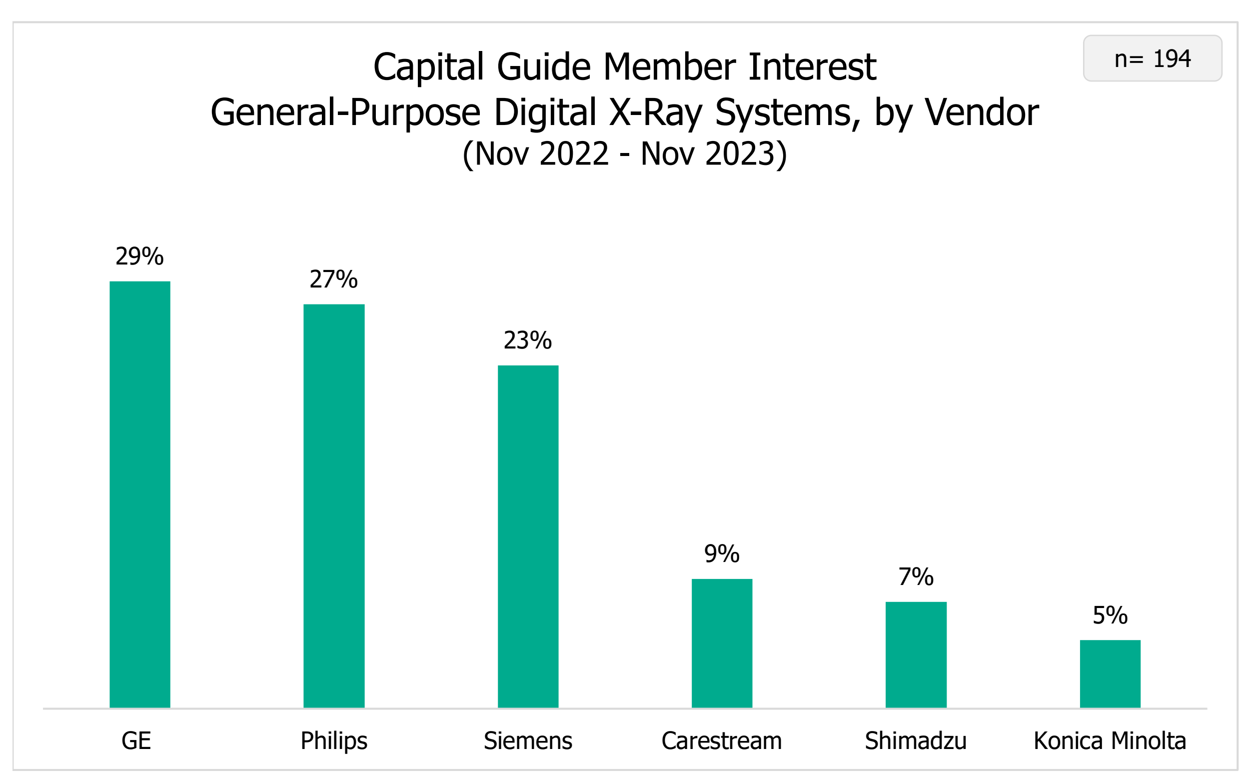
Market Intelligence Report

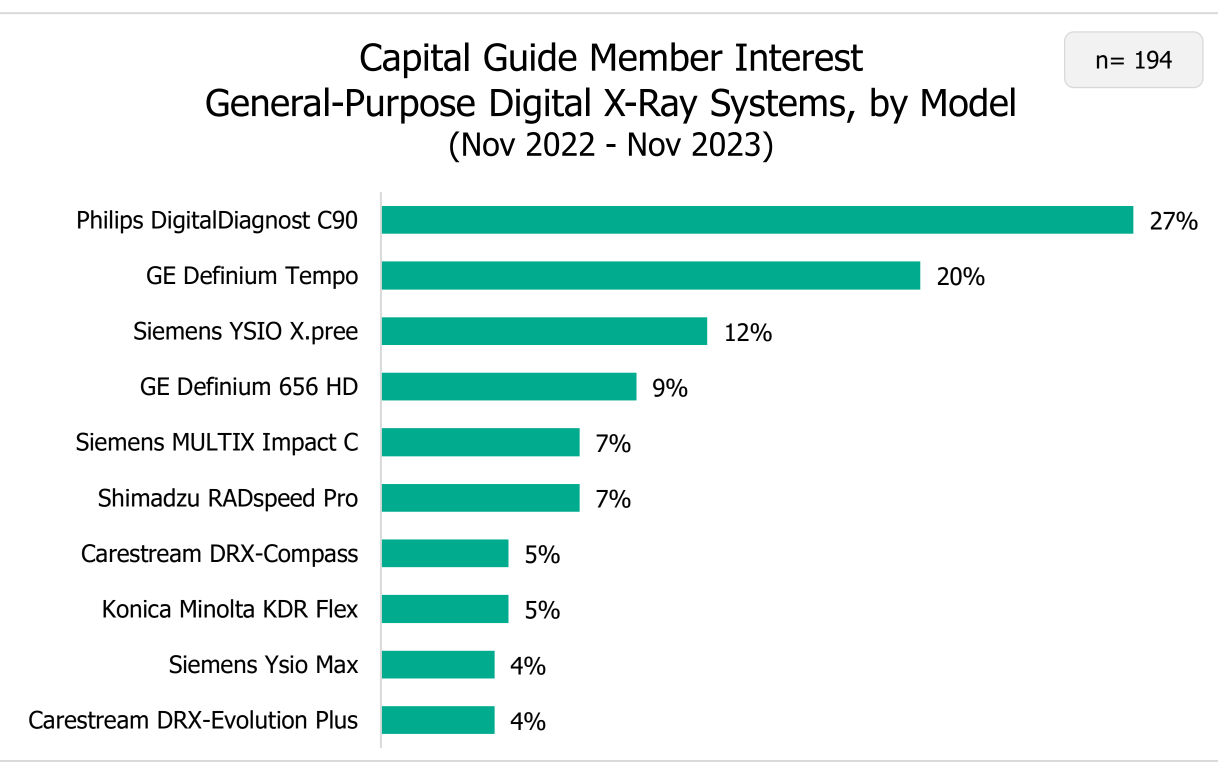
General-Purpose Digital X-Ray Systems

Description

General-Purpose Digital X-Ray Systems are used to perform routine diagnostic x-ray procedures in hospitals, clinics, physician offices, and urgent care centers. The most basic systems produce individual still images which allow for the examination and differentiation of internal organs and tissue structures. They may also offer Bucky, cross-table, horizontal, off-table, and other techniques. Some units can be enhanced with optional modular components for fluoroscopy and linear tomography.

Popular Vendors and Models





Key Considerations

- **Components** of a general-purpose film or digital radiographic system **normally include** the table unit, the Bucky film tray and grid system, the film or digital detector, the x-ray generator, the x-ray tube and suspension system, and the collimator.
- The table unit **should have** an **electromagnetic locking system** and a **weight capacity** of at least 440 lbs. Most tabletops are moved electro-mechanically (float-top) in two or four directions; some can **tilt and move** in as many as six or eight directions.
- For better **resolution**, a maximum detector **pixel size of 150 µm is recommended**.
- To optimize workflow, **automatic positioning** of the detector and x-ray tube, and positioning controls directly on the x-ray tube are recommended.
- **Digital radiographic (DR)** systems use **various methods to acquire** electronic x-ray images, which are digitized for viewing, storage, or hard-copy printing. Digital images are available almost immediately for viewing on a monitor. These images can be manipulated electronically to enhance the region of interest and can be transmitted digitally to other locations.
- Another major consideration in acquiring a DR system is the system's **integration into picture archiving and communication systems (PACS)** already in use in the facility. All digital systems **should be compliant** with Digital Imaging and Communications in Medicine (**DICOM**) 3.0 and integrating the Healthcare Enterprise (**IHE**) integration profiles.

Feature Comparison for Popular Models

General-Purpose Digital X-Ray Systems	Carestream DRX-Compass	Carestream DRX-Evolution Plus	GE Definium 656 HD	GE Definium Tempo	Konica Minolta KDR Flex	Philips DigitalDiagnost C90	Shimadzu RADspeed Pro	Siemens MULTIX Impact C	Siemens Ysio Max	Siemens YSIO X.pree
Table Top Length, in	85	94.5	94	34.5	86.8	94.5	92.5	91.7	94.5	94.5
Table Top Width, in	35.4	Not Specified	37	92.5	34.2	29.5	32	31.5	31.5	31.5
Patient Weight Capacity, lb	650	600 (optional 705)	882 static 705 dynamic	771 dynamic	771.6	826	650	661	660	992 static 660 dynamic
Generator Strength, kW	50, 65, 80	65, 80	50, 65, 85	50, 65, 80	50, 65, 80	65, 80	65, 80	55, 65, or 80	65, 80	65, 80
Tube Heat Capacity, kHU	300 or 400	400 or 600	350	350	600	300	400	1,350	820	820
Tube Cooling Rate, HU/min	667 or 1,664 (anode)	120,000	60,000, blower operating	60,000, blower operating	Not specified	105,300	135,000	97,000	170,000	170,000
Tube Suspension	Floor or Ceiling	Overhead	Overhead	Overhead	Overhead	Overhead	Overhead	Overhead	Overhead	Overhead
Detector Material	CsI	Dependent on detector	Amorphous silicon detector with CsI	a-Si/CsI	CsI	Digital CsI (Cesium Iodide) flat	GOS or CsI	a-Si with CsI scintillator	CsI scintillator; a-Si flat panel	CsI scintillator; a-Si flat panel
Detector Pixel Size, µm	Dependent on detector	Dependent on detector	100	100	100	148	Dependent on detector	148 µm MAX wi-D, 139 µm Core XL	148	148
Image Preview Wait Time, sec	<3	<3	≤1	≤1	>2	3 to 4	3	<2 MAX wi-D, <3 Core XL	<3.5 static, <2 wireless, <1.5 mini	<3.5 static, <2 wireless, <1.5 mini
Wireless Detector, cm (in)	Yes	Yes	Yes	Yes	Yes	Yes, 43 x 43 (17 x 17), optional 35 x 43 (14 x 17)	Yes	Not Specified	Yes, 43 x 43 (17 x 17) or 35 x 43 (14 x 17)	Yes, 43 x 43 (17 x 17) or 35 x 43 (14 x 17)
Dual-Energy Subtraction	Bone Suppression Software	Yes, or Bone Suppression Software	Yes	Yes	No	No	Pro EDGE configuration only	No	No	No
Digital Tomosynthesis	N/A	Optional	Yes	No	No	No	Pro EDGE configuration only	No	N/A	N/A

Other Considerations

More than 60% of all radiographs taken for routine examinations of the skull, respiratory organs, and skeletal system are produced by general-purpose table systems.

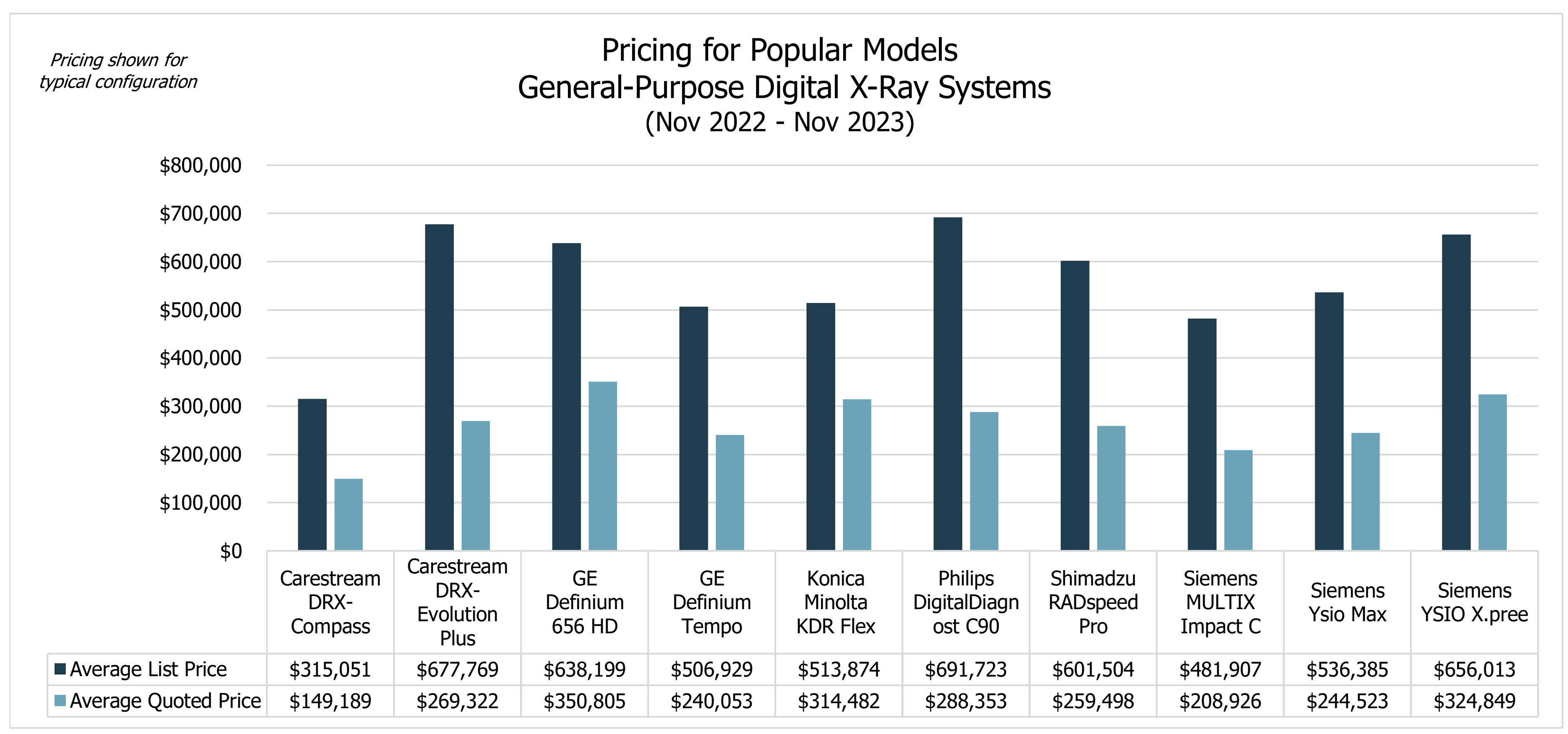
The number and types of procedures to be performed will influence the selection of features for the system. Smaller focal-spot sizes provide better spatial resolution on the image receptor for certain studies, and options such as, tomography and table tilt can increase the system's overall procedural capabilities.

Elevating tables allow easier patient access and are especially beneficial to departments handling trauma and emergency cases because the table height can be adjusted to facilitate patient transfer from a mobile stretcher or wheelchair. Generator options should also be considered; high-frequency generators require less space and often eliminate the need for high-voltage cables.

Digital Radiography (DR) offers many potential advantages over film-based radiography, including storage space reduction, enhanced image processing, and off-site diagnostic capabilities. Some technologists say that exams can be completed three to four times faster with DR than Computed Radiography (CR) systems.

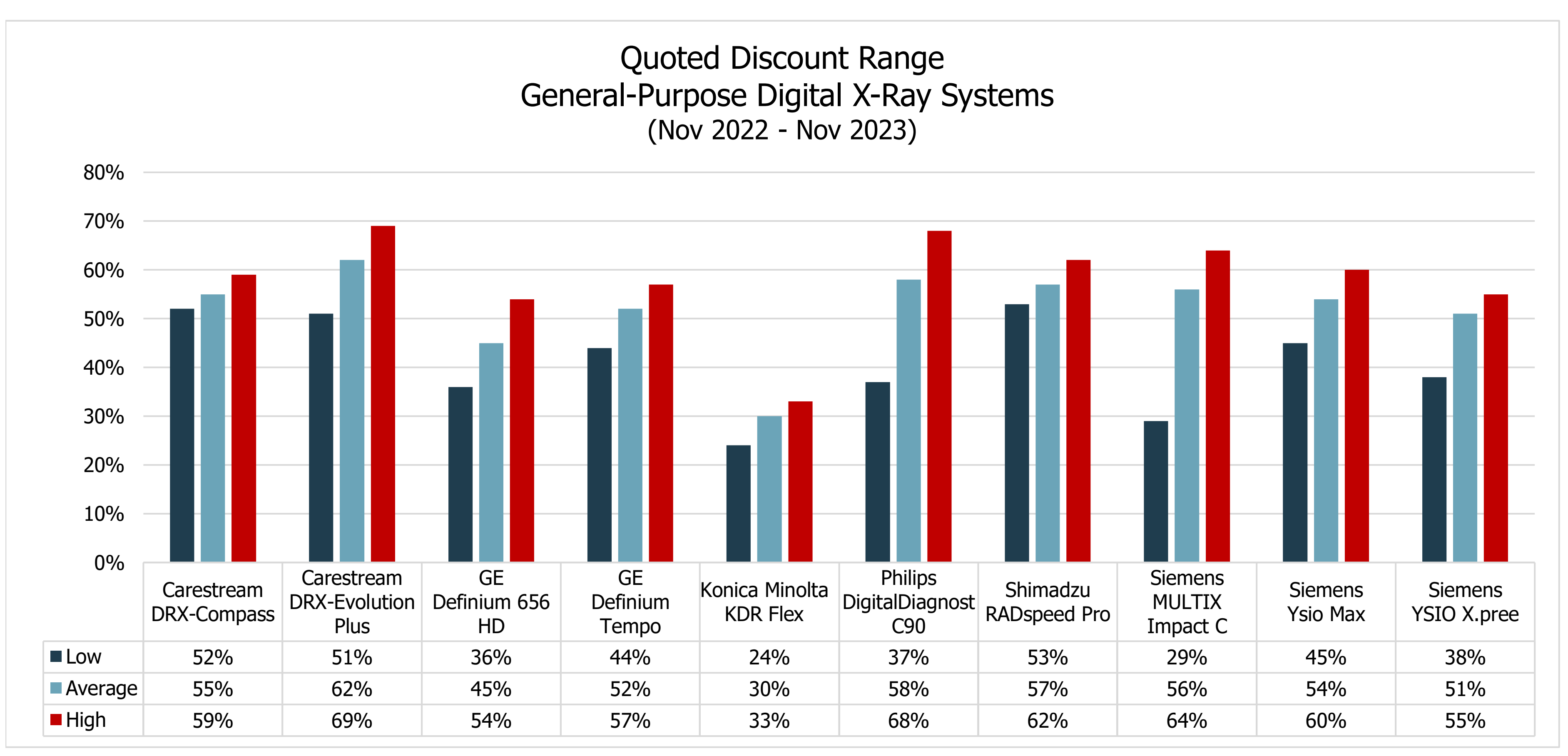
Purchasing a wireless detector can be the least expensive way to attain DR benefits with film-based or CR equipment; most vendors offer digital upgrades or retrofits to their older, film-based systems. Wireless detectors can be integrated with their respective vendor's systems and occasionally with other vendors' systems. Numerous models fit into a standard cassette holder and therefore can be used with any standard radiographic table.

Pricing Information



	Carestream DRX-Compass	Carestream DRX-Evolution Plus	GE Definium 656 HD	GE Definium Tempo	Konica Minolta KDR Flex	Philips DigitalDiagnost C90	Shimadzu RADspeed Pro	Siemens MULTIX Impact C	Siemens Ysio Max	Siemens YSIO X.pree
Average List Price	$315,051	$677,769	$638,199	$506,929	$513,874	$691,723	$601,504	$481,907	$536,385	$656,013
Average Quoted Price	$149,189	$269,322	$350,805	$240,053	$314,482	$288,353	$259,498	$208,926	$244,523	$324,849

Typical Discounts Seen by Capital Guide Members



	Carestream DRX-Compass	Carestream DRX-Evolution Plus	GE Definium 656 HD	GE Definium Tempo	Konica Minolta KDR Flex	Philips DigitalDiagnost C90	Shimadzu RADspeed Pro	Siemens MULTIX Impact C	Siemens Ysio Max	Siemens YSIO X.pree
Low	52%	51%	36%	44%	24%	37%	53%	29%	45%	38%
Average	55%	62%	45%	52%	30%	58%	57%	56%	54%	51%
High	59%	69%	54%	57%	33%	68%	62%	64%	60%	55%

Service and Support Information

Digital X-Ray Systems

- **Estimated Service Life: 10 Years**

Model	Warranty	Est. Annual Service Cost
Carestream DRX-Compass	1 Year	$11,184
Carestream DRX-Evolution Plus	1 Year	$16,902
GE Definium 656 HD	1 Year	$24,521
GE Definium Tempo	1 Year	$18,176
Konica Minolta KDR Flex	1 Year	$11,000
Philips DigitalDiagnost C90	1 Year	$36,646
Shimadzu RADspeed Pro	1 Year	$19,620
Siemens MULTIX Impact C	1 Year	$31,804
Siemens Ysio Max	1 Year	$38,468
Siemens YSIO X.pree	1 Year	$22,093

Total Estimated Cost

Total Estimated 10-Year Cost of Equipment and Service
General-Purpose Digital X-Ray Systems
(Nov 2022 - Nov 2023)

System	Capital Equipment Cost (Typical Configuration)	Service Cost (Excluding Warranty Period)	Total Estimated Cost (Capital Equip + Service)
Carestream DRX-Compass	$149,189	$100,656	$249,845
Carestream DRX-Evolution Plus	$269,322	$169,020	$438,342
GE Definium 656 HD	$350,805	$220,689	$571,494
GE Definium Tempo	$240,053	$163,584	$403,637
Konica Minolta KDR Flex	$314,482	$99,000	$413,482
Philips DigitalDiagnost C90	$288,353	$329,814	$618,167
Shimadzu RADspeed Pro	$259,498	$176,580	$436,078
Siemens MULTIX Impact C	$208,926	$286,236	$495,162
Siemens Ysio Max	$244,523	$346,212	$590,735
Siemens YSIO X.pree	$324,849	$198,837	$523,686

Additional Information

For updated information on Pricing, Vendor Discounts, Equipment Specifications, or to request a Custom Report on this technology, Click Here: CapitalGuide@ecri.org

Want to know more? Go to Digital Radiography: The Essentials to access Product Ratings, Selection and Use Guidance, and other vital information on this technology.

Disclaimer

Market interest charts are based solely upon quotations submitted to ECRI by members of the Capital Guide advisory service. This data is not validated market share and is time sensitive.

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Board Paper: Finance Committee

Agenda Item:	Consider Recommendation for Board Approval of Capital funding for the replacement of the medical center based cardiac Nuclear Medicine Camera (D-SPECT) and Five (5) year service agreement and equipment purchase with Spectrum Dynamics Medical
Executive Sponsor:	Clement Miller, Chief Operating Officer John Kazel, Director Diagnostic Imaging
Date:	August 12, 2024

Executive Summary

The Nuclear Medicine department at Salinas Valley Health operates two cameras to conduct all necessary imaging exams. One camera is dedicated to inpatient cardiac nuclear medicine imaging, while the other supports non-cardiac nuclear medicine studies. The dedicated cardiac imaging camera requires replacement due to its age, sun-setting service support, lack of available parts, and increasing downtime. Consequently, Salinas Valley Health is pursuing the replacement of this essential piece of imaging equipment.

Background/Situation

The current cardiac nuclear medicine camera (D-SPECT), installed in May 2012, has exceeded its planned useful life by two years. This system performs an average of four inpatient cardiac stress test exams daily, Monday through Friday. As of August 31, 2024, the equipment vendor, Spectrum Dynamics Medical, will no longer support this model, resulting in unavailability of OEM parts and the inability to renew the service contract.

In the past six months (February 2024 through July 2024), the system experienced 14 significant downtimes, totaling approximately one month of non-operational periods. While the project scope is limited, replacing the nuclear medicine camera will involve project management, architectural design, and minimal construction, necessitating HCAI engagement for permitting. The associated costs have been comprehensively scoped in the proposed project plan and included in the total project budget.

The *project/construction cost of $221,140.00 is a non-budgeted expense not captured in initial project scoping of the approved 2025 capital request. This delta of non-budgeted capital expense will be identified within the approved 2025 capital plan and applied to this capital project to cover this unplanned project/construction expense.

Component	Amount
Equipment cost (including tax)	$435,773.00
*Project permit &construction cost	$221,140.00
Total Capital Cost	**$656,913.00**
Service agreement (5 years beginning after year 1)	$195,505.00
Total Project Cost	**$852,418.00**

Strategic Plan Alignment:

This Nuclear Medicine camera is essential for providing high quality diagnostic cardiac imaging in support timely patient disposition, treatment, and discharge of patients presenting to the hospital cardiac concerns and symptoms.

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

Financial/Quality/Safety/Regulatory Implications:

Key Contract Terms	**Vendor: Spectrum Dynamics Medical**
1. Proposed effective date	September 1, 2024
2. Term of agreement	5 Years
3. Renewal terms	Auto Renewal unless prior notification of non-renewal provided prior to expiration anniversary.
4. Termination provision(s)	Breach Only
5. Payment Terms	Net 30 days
6. Annual cost	$656,913 Total Capital Cost $39,101.00 (Yr 2) (Service) $39,101.00 (Yr 3) (Service) $39,101.00 (Yr 4) (Service) $39,101.00 (Yr 5) (Service) $39,101.00 (Yr 6) (Service)
7. Cost over life of agreement	$656,913 (Capital) $195,505.00 (Service Agreement (5yrs)) - Effective immediately following 1yr Warranty) ========= $852,418 (Total Commitment)
8. Budgeted (indicate y/n)	Equipment expense of $435,773.00 was budgeted in 2025 capital. Associated construction/project cost of $221,140.00 was not budgeted.

Recommendation

Consider recommendation for Board approval of (i) capital funding in the amount of $852,418.00 for the replacement of the medical center based D-SPECT Nuclear Medicine camera to include associated project/construction costs and (ii) equipment purchase in the amount of $435,773 from Spectrum Dynamics Medical and (iii) the five (5) year service agreement in the amount of $195,505.00 with Spectrum Dynamics Medical.

Attachments

(1) Project Budget (Bogard Const.)
(2) Equipment Quote (Spectrum Dynamics Medical) – Closed Session
(3) Equipment Service Quote (Spectrum Dynamics Medical) – Closed Session

Salinas Valley Health Medical Center

Project Cost Model: D-Spect Cardio Camera Replacement

Architect/Engineer: TBD

Subject: Budget prepared during predesign

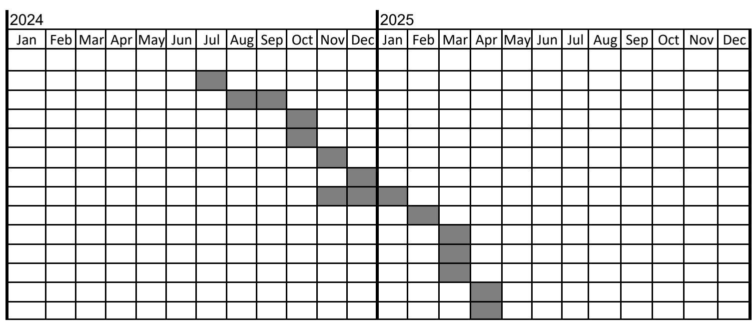
Date Printed:	*8/12/2024*
Budget Amount:	**$0**
Budget Approved Date:	*FY 2025*
Version 1	
Anticipated Completion:	**3/1/2025**

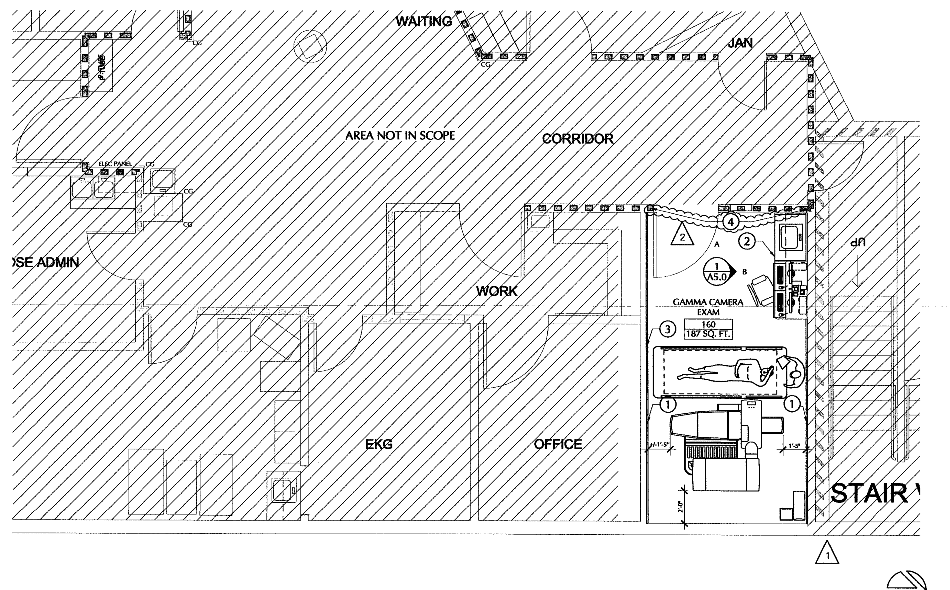
Prepared by: DS, Checked by SL 081224

Budget Summary				
			A	B
Line Item		Description	Target Values	Comments
	1	**Construction**		
100		Equipment-related construction on-site	$58,140	ICRA, Finishes, MEPT, Structural Anchorage
	2	**Design**		
200		Design Professionals	$75,000	Arch, Structural, MEPT
	3	**Inspections & Consultations**		
300		Inspector of Record	$8,000	
301		Physicist	$14,000	Lead Lining Certification
303		Hazmat Survey	$6,000	
	4	**Permits & Fees**		
400		HCAi	$5,000	
	5	**Soft Costs**		
502		Construction Management	$50,000	
	7	**FF&E**		
702		Imaging Equipment	$435,773	Price perJ Kazel Board Paper Quote
	9			
9900		Project Contingency	$5,000	
Totals			**$656,913**	

Cardio D-Spect Camera Replacement

Executive Notice to Pursue Project
Engage Design Team
Design Option Development
Staff Review & Refinement of Equipment Configuration
SVH Board Action to Approve Project and Equipment
Execute Purchase Order for Equipment
Architect/EngineeringHCAi Package Submittal
HCAi Plancheck & Permit Issuance
Removal of Existing Equipment
Construction
Equipment install, facility activation
Licensing & Commissioning
First Patient Visit





1 PARTIAL BASEMENT FLOOR PLAN

SCALE: 1/4"=1'-0" NORTH

Figure 1-1 D-SPECT® Cardiac Scanner

Justification for Sole Source Form

To: Contract Review Committee

From: John Kazel, Nuclear Medicine

Type of Purchase: (Check One)

☐Non-Medical, Non-Surgical Equipment/Supplies >= $25,000
☐Data Processing/Telecommunication Goods >= $25,000
× Medical/Surgical – Supplies/Equipment >= $25,000
☐Purchased Services >= $350,000

Total Cost $:	$435,773.63 (Includes sales tax)
Vendor Name:	Spectrum Dynamics Medical Inc.
Agenda Item:	

Statement of Need: My department's recommendation for sole source is based upon an objective review of the product/service required and appears to be in the best interest of SVMHS. The procurement of the Spectrum Dynamics D-Spect camera gives us the ability to quickly switch out the camera with a newer model of the same equipment allowing for efficiency in construction and staff training, effectively minimizing downtime. The procurements proposed for acquisition through sole source are the only ones that can meet the district's need. I know of no conflict of interest on my part or personal involvement in any way with this request. No gratuities, favors or compromising action have taken place. Neither has my personal familiarity with particular brands, types of equipment, materials or firms been a deciding influence on my request to sole source this purchase when there are other known suppliers to exist.

Describe how this selection results in the best value to SVMHS. See typical examples below.

× Licensed or patented product or service. No other vendor provides this. Warranty or defect correction service obligations of the consultant. **Describe.**

☐Existing SVMHS equipment, inventory, custom-built information system, custom built data inventory system, or similar products or programs. **Describe.**

☐Uniqueness of the service. **Describe.**

☐SVMHS has established a standard for this manufacturer, supplier or provider and there is only one vendor. **Describe.**

☐Factory-authorized warranty service available from only this single dealer. Sole availability at the location required. **Describe.**

☐Used item with bargain price (describe what a new item would cost). **Describe.**

☐Other -The above reasons are the most common and established causes for an eligible sole source. If you have a different reason, please **describe**:

By signing below, I am attesting to the accuracy and completeness of this form.

Submitter Signature *John Kazel* Date: 8/15/24

COMMUNITY ADVOCACY COMMITTEE

Minutes of the
Community Advocacy Committee
will be distributed at the Board Meeting

(ROLANDO CABRERA, MD)

Medical Executive Committee Summary – August 8, 2024

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Healy, Mark, MD	Surgical Oncology	Surgery	General Surgery
Kowalczyk, Katie, MD	Neurology	Medicine	Tele-Neurology
Overall, Trenton, MD	Neurology	Medicine	Tele-Neurology
Rasi, Annette, MD	Radiology	Surgery	Salinas Valley Health Nancy Ausonio Breast Health Center: Mammography Salinas Valley Imaging: Diagnostic Radiology Salinas Valley Health Advanced Imaging - Non-Cardiac Diagnostic Radiology Privileges

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Allen, Chad, DDS	Oral Maxillofacial Surgery	Surgery	Oral & Maxillofacial Surgery
Arreola, Guadalupe, MD	Family Medicine	Family Medicine	Salinas Valley Health Taylor Farms Family Health & Wellness Center
Atcha, Muneera, MD	Rheumatology	Medicine	Rheumatology General Internal Medicine
Brunet, Russell, DO	Family Medicine	Family Medicine	Family Medicine – Adult Pediatric and Well Newborn Category I and II Obstetrics
Carlson, Steven, MD	Pathology	Surgery	Pathology
Chaudhry, Monika, MD	Psychiatry	Medicine	Tele-Psychiatry
Chowdhury, Nagib, MD	Psychiatry	Medicine	Tele-Psychiatry
Colorado, Rene, MD	Neurology	Medicine	Neurology
Fowler, Martin, MD	Neurology	Medicine	Tele-Neurology.
Freeman, Heidi, MD	Ob/Gyn	Ob/Gyn	OB Hospitalist Obstetrics & Gynecology
Hessler, Christine, MD	Neurology	Medicine	Tele-Neurology
Horvath, Susanna, MD	Neurology	Medicine	Tele-Neurology
Iqbal, Arshad, MD	Neurology	Medicine	Tele-Neurology
Penalver, Alberto, MD	Psychiatry	Medicine	Tele-Psychiatry
Prizivalli-Rolfe, Brigitte, MD	Neurology	Medicine	Tele-Neurology
Shah, Panna, MD	Neurology	Medicine	Tele-Neurology
Singer, Paul, MD	Neurology	Medicine	Tele-Neurology
Stahl, Mark, MD	Neurology	Medicine	Tele-Neurology
Tung, Christie, MD	Neurology	Medicine	Tele-Neurology
Windham, Charles, MD	Psychiatry	Medicine	Tele-Psychiatry

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE
Bonano, John, MD	Orthopedic Surgery	Add: Robot Assisted Surgery using ROSA and Mako Robots
Hay, Sunthara, DO	Ob/Gyn – Hospitalist	Add: D&C for spontaneous abortion, less than 14 weeks and I&D of Bartholin cyst or perineal abscess
Macedo, Joseph, MD	Ob/Gyn - Hospitalist	Add: D&C for spontaneous abortion, less than 14 weeks.

Staff Status Modifications:

NAME	SPECIALTY	RECOMMENDATION
Bonano, John, MD	Orthopedic Surgery	Recommend advancement to Active Staff.
Erlichman, Oren, MD	Anesthesiology	Recommend advancement to Active Staff.
Kadakia, Rikin, MD	Interventional Cardiology	Recommend advancement to Active Staff.
Lee, Sherry, DO	Pediatrics	Recommend advancement to Active Staff.
Logono, Alex, MD	Family Medicine	Recommend advancement to Active Staff.
Wang, Aileen, MD	Endocrinology	Recommend advancement to Active Staff.
Winter, Amy, MD	Pediatrics	Requesting a Leave of Absence Effective 9/4/2024 – 12/24/2024.
Adams, Rebecca, MD	Family Medicine	Resignation effective 8/31/2024
Chaudhari, Amit MD	Neurology	Resignation effective 7/24/2024
Gasper, Mason, DO	Neurology	Resignation effective 7/20/2024
Gokaldar, Reshma, MD	Neurology	Resignation effective 8/01/2024
Ippolito, Mark, MD	Neurology	Resignation effective 7/22/2024
Romero, Eloy, MD	Family Medicine	Resignation effective 8/15/2024.
Vegesna, Neelima, MD	Ob/Gyn	Resignation effective 7/31/2024

Temporary/Locum Tenens Privileges:

NAME	SPECIALTY	DATES	RECOMMENDATION
Chandrasoma, Shahin, MD	Urology	8/7/2024-8/14/2024	Locum tenens for Leonard Renfer, MD.
Gootnick, Susan MD	Radiology	7/19/2024-7/25/2024	Requested temporary privileges while awaiting August Board approval.
Toyota, Brian, MD	Neurosurgery	7/18/2024 – 7/21/2024	Locum tenens for Dragan Dimitrov, MD.

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

ITEM	RECOMMENDATION
Family Medicine Active Community – Clinical Privileges Delineation – Administrative Corrections	Recommend approval
Obstetrics & Gynecology – Clinical Privileges Delineation – Revisions to Gynecologic Oncology and Robotic Assisted Surgery	Recommend approval
Pathology – Clinical Privileges Delineation – Administrative Corrections	Recommend approval
Robotic Surgery – Clinical Privileges Delineation – Revision	Recommend approval
Taylor Farms Family Health Wellness Center – Clinical Privileges Delineation – Revision	Recommend approval
Vascular Surgery – Clinical Privileges Delineation – Revision	Recommend approval
Administrative Correction of Telemedicine Physician Reappointment Dates to Correspond with Distant Site	Chamsuddin, Abbas, MD 01/31/2025 Mrelashville, David, MD 11/30/2025 Sanghi, Amit, DO 12/31/2024 Erickson, Jay, MD 06/30/2026 Gootnick, Susan, MD 06/30/2026 Jafrey, Syed, MD 06/30/2026 Kerwin, Lewis, MD 06/30/2026 Korenis, Panagiota, MD 06/30/2026 Kulik, Tobias, MD 06/30/2026 Mahendrarajah, Sulahshan, MD 06/30/2026 Morvarid, Babak, MD 06/30/2026 Rainville, Christopher, MD 06/30/2026 Sachar, Pawani, MD 06/30/2026 Tanoura, Tad, MD 06/30/2026 Zolyan, Anna, MD 06/30/2026

Interdisciplinary Practice Committee

Applicants:

APPLICANT	PRIVILEGES	DEPT	COLLBAORATING/SUPERVISING PHYSICIAN(S)
Baez, Ivan PA-C	Thoracic Surgery	Surgery	Andreas Sakopoulos, MD Vincent DeFilippi, MD
Campbell, Colleen, PA-C	Neurosurgery	Surgery	Gurvinder, Kaur, MD
Shay, Deidre NP	Cardiology	Medicine	Rikin Kadakia, MD

Reappointments:

APPLICANT	PRIVILEGES	RECOMMENDATION
Ludema, Helia, PA-C	Surgery	Resignation effective 8/23/2024
Strobridge, Michael PA-C	Emergency	Resignation effective 8/31/2024

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

Amniotic Fluid Rupture Membrane Nursing Standardized Procedure	Recommend approval
OB Medical Screen Examination Nursing Standardized Procedure	Recommend approval

Policies/Plans and Privilege Forms Recommended for Approval: ***(Attached)***

1. Influenza (Respiratory Virus) Pandemic Plan
2. Sedation Guidelines
3. Bioterrorism Readiness Plan

Bylaws Amendments – Approved by a vote of the General Medical Staff ***(Attached)***

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Quality and Safety Committee Reports:
   - Commission Cancer
   - Accreditation & Regulatory Update
   - Perinatal Services – BETA OB Quest for Zero
   - Pharmacy & Therapeutics/Infection Prevention Committee
     - Antibiotic Stewardship Committee
     - Medication Safety Committee
     - Medication Reconciliation
     - CLABSI, CAUTI, CDI, Hand Hygiene, MRSA
     - Avian Influenza Update
   - Environment of Care
   - Workplace Violence Prevention Program

II. Order Sets:

1	Approved	Acute Colonic Pseudo Obstruction
2	Approved	Alcohol Withdrawal
3	Approved	Anticoag Dabigatran (Pradaxa)
4	Approved	Bronchoscopy Pre Procedure
5	Approved	Card Cath PreProc InPt Tomorrow
6	Approved	Card Cath PreProc OutPt
7	Approved	Chronic Obst Pulmonary Disease
8	Approved	ENT T&A Pediatric PostOp
9	Approved	PVAD Impella with DWS
10	Approved	Tile Table Test
11	Retired	Hypothermia Rewarming TTM (Ganzhorn)
12	Retired	Hypothermia Post Arrest Lab (Ganzhorn)
13	Retired	Hypothermia Post Arrest TTM (Klimberg)

III. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings
c. Medical Staff Treasury Report August 2, 2024
d. Medical Staff Statistics Year to Date
e. Health Information Management (HIM) Update
f. Budget/Financial Update
g. HCAHPS Update August 1, 2024
h. Annual Medical Library Report

Clinical Privileges Delineation
Family Medicine – Active Community

Applicant Name: ______________________________

Qualifications:

ACTIVE COMMUNITY MEDICINE PRIVILEGES:
To be eligible to apply for Active Community privileges in Family Medicine, the applicant must meet the following qualifications:

> Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in family medicine.

These privileges are available only for those applicants who qualify and apply for Active Community Status membership.

ACTIVE COMMUNITY PRIVILEGES
Active Community privileges are reserved for physicians with office based practices who do not routinely provide care in the acute hospital setting.

Active Community Privilege: Applicant please check box next to privilege you are requesting.

☐ **Concurrent review of hospitalized patients – excludes documentation in the medical record, inpatient orders and any activity construed to direct patient care.**
(No volume associated proctoring or reappointment criteria associated with this privilege)

☐ **Ordering of outpatient diagnostic tests**
(No volume associated proctoring or reappointment criteria associated with this privilege)

Special Procedures/Privileges

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

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

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Surgical Assisting Only *(Designation as Co-Surgeon is not allowed)*	• Successful completion of an approved surgical or surgical associated residency training program **AND** • Applicant must be able to document that he or she has assisted in at least 12 surgical procedures as first assistant or primary surgeon within the past 24 months.	**1**	Applicant must provide reasonable evidence of current ability to perform requested privileges And document the performance of at least 6 surgical procedures as first assistant within the past 24 months

Acknowledgment of practitioner
I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Health Medical Center. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

_______________________________ _______________

Applicant Signature Date

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

_______________________________ _______________

Department Chair Signature Date

Salinas Valley Health Medical Center

Clinical Privileges Delineation
Obstetrics & Gynecology

Applicant Name: ______________________________

Scope: Obstetrics & Gynecology, Female Pelvic Medicine and Reconstructive Surgery (Urogynecology), Gynecologic Oncology, and Maternal Fetal Medicine: New applicants for all privileges will be required to provide documentation of the number and types of hospital cases within the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming board certified; **OR** demonstrate ongoing cancer-related education by documenting 12 CME hours annually.

General Privileges Statement:
Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat, and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

OBSTETRICS: To be eligible to apply for core privileges in obstetrics, the applicant must meet the following qualifications:

Initial Appointment:

• Current certification or board eligibility in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology.
AND

• Documentation of at least 100 deliveries, including at least 20 C-Sections or 25 C-Section assists, in the past 24 months or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship within the past 24 months.
AND

- Completion of an American College of Obstetricians and Gynecologists (ACOG) endorsed fetal monitoring strip interpretation course that includes NICHD nomenclature within three months of appointment

Reappointment Criteria for Core Obstetrical Privileges:

- Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 deliveries; 10 of which must be C-Sections or C-Section assists.
AND
- Current certification or board eligibility in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology.
AND
- Participation in the annual assessment of EFM (electronic fetal monitoring) principles (assessed at the time of reappointment).

Obstetrics Core Privileges (*check box if requested*)

☐ **Requested**

Admit, evaluate, diagnose, treat and provide consultation to pregnant patients and/or provide medical and surgical care of the female reproductive system, including major medical diseases that are complicating factors in pregnancy. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

GYNECOLOGY: To be eligible to apply for core privileges in gynecology, the applicant must meet the following qualifications:

Initial Appointment:

- Current certification or board eligibility in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology.

AND

- Documentation of at least 50 gynecological surgical procedures in the past 24 months or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship within the past 24 months.

Reappointment Criteria for Core Gynecologic Privileges:

- Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 gynecologic procedures; 10 of which must be major procedures.

AND

- Current certification or board eligibility in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology.

Gynecology Core privileges (*check box if requested*)

☐ **Requested**

Admit, evaluate, diagnose, treat and provide consultation to pregnant patients; pre-, intra- and post-operative care necessary to correct or treat female patients presenting with injuries and disorders of the female reproductive system and the genitourinary system and non-surgically treat disorders and injuries of the mammary glands. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

GYNECOLOGIC ONCOLOGY: To be eligible to apply for core privileges in gynecologic oncology, the applicant must meet the following qualifications:

Initial Appointment:

- As for gynecology plus, current certification or board eligibility in gynecologic oncology by the American Board of Obstetrics and Gynecology or Special Qualifications in gynecologic oncology by the American Osteopathic Board of Obstetrics and Gynecology or alternative specialty training. The alternative specialty training for physicians without completion of an accredited fellowship program in gynecologic oncology must be evaluated on a case-by-case basis, looking specifically at the physician's relevant postgraduate continuing medical education and recent gynecologic oncological surgery experience.

AND

- Documentation of the performance of at least 25 gynecologic oncology procedures within the past 24 months.

AND

- Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming board certified; **OR** demonstrate ongoing cancer-related education by documenting 12 CME hours annually.

Reappointment Criteria for Core Gynecologic Oncology Privileges:

- Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 gynecologic oncology procedures.

AND

- Current certification or board eligibility in gynecologic oncology by the American Board of Obstetrics and Gynecology or Special Qualifications in gynecologic oncology by the American Osteopathic Board of Obstetrics and Gynecology or alternative specialty training. The alternative specialty training for physicians without completion of an accredited fellowship program in gynecologic oncology must be evaluated on a case-by-case basis, looking specifically at the physician's relevant postgraduate continuing medical education and recent gynecologic oncological surgery experience.

AND

- Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming board certified; **OR** demonstrate ongoing cancer-related education by documenting 12 CME hours annually.

Gynecologic Oncology Core privileges *(check box if requested)*

☐ **Requested**

Includes all core privileges for Gynecology plus, admit, evaluate, diagnose, treat, provide consultation and surgical and therapeutic treatment to female patients with gynecologic cancer and complications resulting therefrom, including carcinomas of the cervix, ovary and fallopian tubes, uterus, vulva, pelvis, and vagina. Also included within this core set of privileges are microsurgery, chemotherapy, radical hysterectomy, vulvectomy, pelvic exenteration and staging by lymphadenectomy, and the performance of procedures on the bowel, liver, ureters, omentum, bladder, and other abdominal structures as indicated. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

UROGYNECOLOGY: To be eligible to apply for core privileges in urogynecology, the applicant must meet the following qualifications:

Initial Appointment:

•The same as for gynecology

AND

•Successful completion of an ABOG-approved fellowship in female pelvic medicine and reconstructive surgery/urogynecology or AOA–approved fellowship in female pelvic medicine and reconstructive surgery.

As for gynecology plus, current certification or board eligibility in FPMRS by the American Board of Obstetrics and Gynecology or Special Qualifications in gynecologic FPMRS by the American Osteopathic Board of Obstetrics and Gynecology or alternative specialty training. The alternative specialty training for physicians without completion of an accredited fellowship program in FPMRS must be evaluated on a case-by-case basis, looking specifically at the physician's relevant postgraduate continuing medical education and urogynecologic surgery experience.

•***Required current experience:*** At least 25 female pelvic medicine and reconstructive surgical procedures, reflective of the scope of privileges requested, within the past 24 months.

Reappointment Criteria for Core Urogynecology Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 successful Urogynecology procedures.

Female Pelvic Medicine and Reconstructive Surgery (Urogynecology) Core privileges: *(check box if requested)*

☐ **Requested**

Includes all core privileges for Gynecology plus, admit, evaluate, diagnose, treat, and provide consultation and the pre-, intra-, and postoperative care necessary to correct or treat female patients

presenting with injuries and disorders of the genitourinary system. Includes diagnosis and management of genitourinary and rectovaginal fistulae, urethral diverticula, injuries to the genitourinary tract, congenital anomalies (excluding the kidney and/or bladder), infectious and noninfectious irritative conditions of the lower urinary tract and pelvic floor, and the management of genitourinary complications of spinal cord injuries. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills.

MATERNAL FETAL MEDICINE: To be eligible to apply for core privileges in <u>maternal and fetal medicine</u>, the applicant must meet the following qualifications:

Initial Appointment:

- As for obstetrics plus, current certification or board eligibility in maternal-fetal medicine by the American Board of Obstetrics and gynecology or Special Qualifications in maternal-fetal medicine by the American Osteopathic Board of Obstetrics and Gynecology or alternative specialty pathway. The alternative specialty training for physicians without completion of an accredited fellowship program in maternal-fetal medicine must be evaluated on a case-by-case basis, looking specifically at the physician's relevant postgraduate continuing medical education and recent maternal-fetal medicine experience

And

Applicants must demonstrate that they provided MFM inpatient or consultative services for at least 50 patients in the past 12 months.

Reappointment Criteria for Core Maternal Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges, at a minimum this shall include documentation of 25 maternal fetal medicine inpatient consultations.

Maternal-Fetal Medicine Core Privileges*(check box if requested)*

☐ **Requested**

Admit, evaluate, diagnose, treat and provide consultation to female patients with medical and surgical complications of pregnancy such as maternal cardiac, pulmonary, metabolic, connective tissue disorders, and fetal malformations, conditions, or disease. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills: 2nd trimester amniocentesis, level 2 & 3 obstetrical ultrasound, chorionic villus sampling, and transvaginal and intra-abdominal cerclage placement.

Core Proctoring Requirements: Core proctoring requirements include direct observation or concurrent and/or retrospective review as per proctoring policy contained in the Medical Staff General Rules and Regulations. At least one laparoscopic procedure must be proctored as part of core requirements.

<u>OBSTETRICAL PROCTORING REQUIREMENTS FOR DELIVERIES</u>

A minimum of 3 proctored deliveries - 2 of which must be C-Sections if C-Section privileges are requested (remaining delivery may be demonstrated by vaginal delivery or C-Section.

Special Procedures/Privileges

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

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

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

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

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	1	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months

ADVANCED LAPAROSCOPY CRITERIA:

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Laparoscopic Burch (Laparoscopic Urethropexy)	Unrestricted "Operative laparoscopy" privileges **AND** Residency training in the advanced privilege requested <u>or</u> an approved, recognized hands-on course in the advanced procedure when such a course exists **AND** Privileges in the same procedure by laparotomy. Applicant much submit documentation of having assisted on or performed at least four (4) cases within the past 24 months for each procedure requested.	1 case proctored by a staff member with unrestricted laparoscopic burch privileges.	Documentation of successful performance of at least two (2) cases within the past 24 months
				Laparoscopic Lymph Node Biopsy or Excision	Unrestricted "Operative laparoscopy" privileges **AND** Residency training in the advanced privilege requested <u>or</u> an approved, recognized hands-on course in the advanced procedure when such a course exists **AND** Privileges in the same procedure by laparotomy. Applicant much submit documentation of having assisted on or performed at least four (4) cases within the past 24 months for each procedure requested.	1 case proctored by a staff member with unrestricted laparoscopic lymph node biopsy or excision privileges.	Documentation of successful performance of at least four (4) cases within the past 24 months
				Laparoscopic Uterosacral Nerve Excision or Ablation	Unrestricted "Operative laparoscopy" privileges **AND** Residency training in the advanced privilege requested <u>or</u> an approved, recognized hands-on course in the advanced procedure when such a course exists **AND** Privileges in the same procedure by laparotomy. Applicant much submit documentation of having assisted on or performed at least four (4) cases in the past 2 years for each procedure requested.	1 case proctored by a staff member with unrestricted laparoscopic uterosacral nerve excision or ablation privileges.	Documentation of successful performance of at least four (4) cases within the past 24 months

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Sacral Nerve Stimulation	The applicant must be able to demonstrate 1. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) / AOA Accredited training program in FPMRS (Female Pelvic Medicine & Reconstructive Surgery) that included training in SNS **OR** 2. Completion of ACGME or AOA accredited residency in OB/GYN or urology and Completion of a training course in Sacral Nerve Stimulation **AND** Demonstrate that they have performed at least six (6) sacral nerve stimulation simulator tests and implant procedures within the past 12 months	1 case	Documentation of successful performance of at least six (6) cases within the past 24 months
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	N/A	Current California State X-Ray S&O Fluoroscopy Certification

Salinas Valley Memorial Healthcare System

Core Procedure List: The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Vice President of Medical Affairs and/or the Chief of Staff.

Obstetrics

1. Amnio infusion
2. Amniotomy
3. Amniocentesis, 3rd trimester
4. Induction of labor
5. Application of internal fetal and uterine monitors
6. Augmentation and induction of labor by use of Oxytocin
7. Caesarean hysterectomy
8. Caesarean section
9. Cervical biopsy or conization of cervix in pregnancy
10. D&C for spontaneous abortion, less than 14 weeks
11. D&C for termination of pregnancy (greater than 14 weeks) – D&E
12. External cephalic version
13. Hypogastric artery ligation
14. Manual removal of placenta
15. Obstetrical ultrasound (limited)
16. Operative vaginal delivery (including forceps, vacuum extraction, breech extraction)
17. Postpartum D&C
18. Pudendal and paracervical blocks
19. Repair of fourth-degree perineal lacerations
20. Repair of cervical, vaginal or vulvar lacerations

Gynecology *(Procedures marked with an asterisk are considered "major" procedures)*

1. *Adnexal surgery(including ovarian cystectomy, oophorectomy, salpingectomy, and conservative procedures for treatment of ectopic pregnancy)
2. *Anterior and posterior colporrhaphy and perineorrhaphy
3. ***Basic Operative laparoscopy:**
    a. Diagnostic Laparoscopy
    b. Tubal Sterilization
    c. Management of ectopic pregnancy
    d. Simple ovarian cysts
    e. Adhesiolysis
    f. Excision of and/or fulguration of endometriosis
    g. Oophorectomy and/or salpingectomy
4. Cervical biopsy
5. *Closure or repair of enterocele
6. *Colpoplasty
7. Colposcopy
8. Cystoscopy as part of gynecological procedure
9. D&C
10. Endometrial ablation
11. *Exploratory laparotomy for pelvic disorders
12. *Hysterectomy:
    a. Abdominal
    b. Vaginal
    c. Laparoscopic Assisted Vaginal (LAVH)

d. Total Laparoscopic
e. Laparoscopic Suprecervical

13. Hysteroscopy
14. I&D of bartholin cyst or perineal abscess
15. *I&D of pelvic abscess
16. Incidental appendectomy
17. Marsupialization or excision of bartholin cyst
18. *Metroplasty
19. *Myomectomy
20. Operations for sterilization (tubal ligation)
21. *Repair of rectocele, enterocele, cystocele, or pelvic prolapse (to include sphincteroplasty)
22. Treatment/Management of ectopic pregnancy
23. Umbilical hernia repair
24. *Vaginal hysterectomy
25. Vulvar biopsy
26. Vulvectomy, simple

Gynecologic Oncology:

1. Chemotherpy for GYN malignancies; central venous vascular and intraperitoneal access port insertion
2. *Cystoscopy with or without biopsy and/or ureteral stenting; sigmoidoscopy; hysteroscopy*
3. Hysteroscopy

~~3.~~4. Gynecologic ultrasound
~~4.~~5. Myocutaneous flaps, skin grafting
~~5.~~6. Para aortic and pelvic lymph node dissection
~~6.~~7. Pelvic exenteration
~~7.~~8. Radical hysterectomy, vulvectomy and staging by lymphadenectomy
~~8.~~9. Radical surgery for treatment of gynecological malignancy (to include procedures on bowel, ureter, bladder, as indicated)
~~9.~~10. Treatment of invasive carcinoma of the vagina by radical vaginectomy (and other related surgery)
~~10.~~11. Treatment of invasive carcinoma of vulva by radical vulvectomy (with groin dissection)
~~11.~~12. Treatment of malignant disease with chemotherapy (to include gestational trophoblastic disease)

Urogynecology: Female pelvic medicine and reconstructive surgery:

Continence procedures for genuine stress incontinence

1. Long-needle procedures (e.g., Pereyra, Raz, Stamey, Gittes, Muzsnai)
2. Periurethral bulk injections
3. Sling procedures (e.g., fascia lata, rectus fascia, heterologous materials, vaginal wall)
4. Synthetic mid-urethral slings
5. Vaginal urethropexy (e.g., bladder neck placation, vaginal paravaginal defect repair)

Procedures for overflow incontinence due to anatomic obstruction following continence surgery

1. Cutting of one or more suspending sutures
2. Retropubic urethrolysis with or without repeat bladder neck suspension
3. Revision, removal, or release of a suburethral sling

Other surgical procedures for treating urinary incontinence

1. Sacral nerve stimulator implantation
2. Urethral closure and suprapubic cystotomy
3. Cystoscopic botox injection
4. Sacrospinous fixation

Genital prolapse procedures

1. Abdominal or Laparoscopic (closure or repair of enterocele, paravaginal repair, uterosacral ligament suspension)
2. Vaginal (transvaginal hysterectomy with or without colporrhaphy, anterior and posterior colporrhaphy and perineorrhaphy, paravaginal repair, Manchester operation, enterocele repair, vagina vault suspension, colpocleisis, retrorectal levator plasty and postanal repair)
3. Placement of transvaginal mesh for prolapse
4. Sacrocolpopexy (laparoscopic or open)
5. Anal incontinence procedures:
    a. Anal sphincteroplasty
    b. Sacral nerve stimulator implantation
6. Colpoceleisis
7. Sacrosphous Ligament Fixation
8. Paravaginal Repair (vaginal, open or laparoscopic)
9. Revision or removal of vaginal mesh

Diagnostic Procedures and other

1. Ureteral stenting
2. Retrograde pyelogram
3. Closure of cystotomy (vaginal, laparoscopic or open), or urethrotomy
4. Urethral diverticulectomy
5. Surgical repair of rectovaginal and genitourinary fistulas

Treatment of pelvic and bladder pain

1. Cystoscopy with:
    a. Biopsy
    b. Intravesical botox injection
    c. Hydrodistention
    d. Fulguration or ijection of lesion
2. Vaginal mesh excision
3. Injection of botox into muscles of pelvic floor

Performance and interpretation of diagnostic tests for urinary incontinence and lower urinary tract dysfunction, fecal incontinence, and pelvic organ prolapse

Maternal Fetal Medicine

Management of high-risk pregnancy inclusive of such conditions as preeclampsia, post-datism, third trimester bleeding, intrauterine growth retardation, premature rupture of membranes, premature labor, and multiple gestation
Management of patients with/without medical surgical or obstetrical complications for normal labor, including mild toxemia, threatened abortion, normal puerperal patient, normal antepartum and postpartum care, postpartum complications, and fetal demise

Treatment of medical complications of pregnancy, including pregnancy-induced hypertension, chronic hypertension, diabetes mellitus, renal disease, coagulopathies, cardiac disease, anemias and hemoglobinopathies, thyroid disease, sexually transmitted disease, pulmonary disease, thromboembolic disorders, infectious diseases.

Procedures:

Amniocentesis
Targeted obstetric ultrasound

Applicant: Complete this section only if you do not wish to apply for any of the specific core procedures listed above:

Please indicate any privilege on this list you would like to ***delete or change*** by writing them in the space provided below. Requests for deletions or changes will be reviewed and considered by the Department Chair, Credentials Committee and Medical Executive Committee. Deletion of any specific core procedure does not preclude mandatory requirement for Emergency Room call.

____________________________________ ________________________________

____________________________________ ________________________________

____________________________________ ________________________________

Applicant Signature: Date:

Acknowledgment of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Health Medical Center. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

______________________________ ________________________

Applicant Signature Date

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

______________________________ ________________________

Department Chair Signature Date

Clinical Privileges Delineation
Robotic Surgery
Primary Surgeon

Definition:

~~Computerized~~ Robotic assisted surgery using advanced technology coupled with high resolution imaging to remotely control surgical arms. Surgical intervention is accomplished by manipulation of the device under 3-D imaging which reproduces motions that affect patient tissue.

Approved Specialties (check those being requested)

- ☐ Cardiovascular Surgery
- ☐ Colon and Rectal Surgery
- ☐ General Surgery
- ☐ Gynecology
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Thoracic Surgery
- ☐ Urogynecology
- ☐ Urology

Robot Type (check those being requested)

- ☐ daVinci ☐
- ROSA
  - ☐ Knee
  - Other (please specify): ______________________
- Mako
  - ☐ Partial Knee
  - ☐ Total Knee
  - ☐ Total Hip

Other (please specify):

____

Initial Appointment Criteria for Primary Surgeon:

Current unrestricted privileges in one of the approved specialties at Salinas Valley Health Medical Center.

Experienced Non Residency/Fellowship Trained Applicants

Documentation of current privileges to perform both open and laparoscopic or endoscopic surgery

AND

Documentation of successful completion of the ~~"Intuitive"~~manufacurer's training course ~~(A hands-on training practicum in the use of the daVinci Surgical Platform of at least eight (8) hours duration with experience in a laboratory setting which included a minimum of three (3) hours of personal time on the system using animal or cadaver models.)~~

AND

Documentation of the successful proctoring of two cases conducted by a certified ~~"Intuitive"~~ proctor at the institution where cases were performed

AND

Documentation of the successful completion of twenty (20) cases as primary operator for robotic surgery within the past two (2) years.

Experienced Residency/Fellowship Trained Applicants

Documentation of appropriate training from their Residency/Fellowship program director
AND
Documentation of the successful completion of twenty (20) cases as primary operator for robotic surgery during training

Newly Trained Applicants

Documentation of current privileges to perform both open and laparoscopic or endoscopic surgery
AND
Documentation of successful completion of the ~~"Intuitive"~~manufacturer's training course ~~(A hands-on training practicum in the use of the daVinci Surgical Platform of at least eight (8) hours duration with experience in a laboratory setting which included a minimum of three (3) hours of personal time on the system using animal or cadaver models.)~~
AND
Documentation of the successful proctoring of two cases conducted by a certified ~~"Intuitive"~~ proctor at the institution where cases were performed.

For a newly trained robotic surgeon, the first three cases must be proctored by an Expert Proctor ~~from Intuitive Surgical, Inc~~provided by the manufacturer. The proctor will be approved by the Chair of the applicant's Department prior to scheduling. The need for additional proctoring, if any, to be recommended by the proctor or corresponding Department Chair.

Reappointment Criteria:
Documentation of the successful completion of at least twenty (20) robotic procedures during the past 24 months.

Proctoring: All applicants will be required to have the first three (3) cases proctored regardless of experience. It is the responsibility of the applicant to arrange proctorship by another practitioner within the primary practicing specialty. Written documentation must be received from the proctor stating requirements have been met and proctored surgeon is competent to perform the requested robotic assisted procedures before full privileges are granted.

Proctor Qualifications: Proctoring physician must practice in the primary specialty and have minimum experience of twenty (20) cases as a primary surgeon.

Proctor Expectations: Proctor must be present in the OR for positioning and procedure. Completion of proctoring form based on objective assessment of physician skills and insuring proctor form is forwarded to the Medical Staff Services Department.

Performance Review:
Outcomes for each surgeon will be monitored and reviewed on an ongoing process. These include but are not limited to: OR time, blood loss, conversion to open, complications, length of stay.

Salinas Valley Health Medical Center
Taylor Farms Family Health & Wellness Center (TFFHWC)
Active Community Delineation of Privileges

Applicant Name: ______________________________

CORE PRIVILEGES

Criteria:

- Board Certification or qualified for certification by the American Board of Family Medicine, Pediatrics or Internal Medicine; **OR**
- Successful completion of an ACGME or AOA approved Internal Medicine, Pediatrics or Family Medicine training program; **AND**
- Evidence of current BLS certification (at minimum); **AND**
- Evidence of current competency in the management of 100 patients in an outpatient setting over the previous two years.

Proctoring Requirements: In accordance with the Medical Staff Bylaws/General Rules & Regulations.

General Privilege Statement

Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to evaluate, diagnose, treat and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

Appropriate consultation will be obtained when the patient's condition exceeds the scope of training of the treatment practitioner.

Requested	Approved	Denied	Core Procedure
			Includes the outpatient management and coordination of care, treatment and services, including prescribing medication and outpatient medical history and physical examinations. See Core Procedure list for Taylor Farms Family Health & Wellness Center below.

MOONLIGHTING PRIVILEGES

Requested

To be eligible to apply for moonlighting privileges at TFFHWC, the applicant must meet the following qualifications:

Current PGY3 or PGY4 Resident in good standing at a hospital affiliated formalized Family Medicine or Internal Medicine Residency program

AND

• Documentation from the Residency Program Director of current competence to perform requested privileges as well as approval to moonlight

Moonlighting does not replace any part of the clinical experience that is integral to the Resident's training program. Residents with a J-1 Visa are excluded from moonlighting in accordance with Federal regulations.

TFFHWC Moonlighting Privileges

Under the supervision of a fully credentialed physician member of the Medical Staff, assess, work up, and provide outpatient treatment to patients who present at TFFHWC with any illness or injury, condition, or symptom.

Special Procedures/Privileges

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

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

Renewal of Privileges at Reappointment: In the event a physician has not performed a requested special procedure privilege during the reappointment period, the physician will be required to have that procedure observed and approved prior to granting without restriction. If a physician has not performed a procedure during two appointment periods (4 years), that privilege will not be granted.

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

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

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Newborn Circumcision	Documentation of successful completion of at least five (5) within the past 24 months	1	Documentation of successful completion of at least two (2) procedures within the past 24 months
				~~Low Risk~~ **Obstetrical Care:** Evaluate, diagnose, treat and provide consultation to ~~low risk~~ obstetrical patients ~~See Attachment~~	Documentation of successful completion of a 6-month rotation on an obstetric unit during training **OR** Documentation of the care of 20 outpatient obstetrical patients within the past 24 months	1	Documentation of appropriate outpatient care of at least ten (10) obstetrical patients within the past 24 months.

Taylor Farms Family Health and Wellness Center (TFFHWC)

Low Risk: Defined as patients who are anticipated to have a normal prenatal course and subsequent delivery.

The SVHS OB Hospitalist Program will admit and deliver these low-risk patients unless arrangements have been made with the patient to deliver with another provider with inpatient obstetrical privileges.

High Risk: Including but not limited to hypertensive disorders, twin pregnancies and other multiples, patients with pre-existing diabetes or diabetes that is uncovered during pregnancy, systemic lupus erythematosus and pre-existing renal insufficiency.

Patients who are identified to be high risk, either before or during pregnancy, will be referred to the appropriate obstetrical provider when that determination is made. Salinas Valley Medical Clinic Healthcare for Women as agreed to accept referral of these high risk patients unless arrangements have been made with another provider with inpatient obstetrical privileges.

Clinical Privileges Delineation
Vascular Surgery

Applicant Name: ______________________________

Qualifications:

To be eligible to apply for core privileges in Vascular Surgery, the applicant must meet the following qualifications:

Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in vascular surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 7 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two years out of Residency training must provide documentation of the performance of ~~at least~~ 50 vascular surgery procedures ~~(excluding percutaneous or catheter access and >50% of which must be non-cardiac)~~ within the past 12 months, the majority being of a reconstructive nature excluding cardiac surgery.

New applicants will be required to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the ~~Hospital~~ Medical Staff for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

General Privileges Statement:
Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat, and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

Vascular Surgery Core Privileges

Admit, evaluate, diagnose, provide consultation and treat patients with diseases/disorders of the arterial, venous, and lymphatic circulatory systems, excluding the intracranial vessels or the heart. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

Peripheral Endovascular Core Privileges

All candidates for interventional privileges must qualify for vascular interventions based on fellowship or experience. The candidate shall have spent a minimum of twelve months of full time experience in invasive laboratory and have performed a minimum of diagnostic peripheral angiographic studies and/or peripheral intervention cases listed below in the capacity of primary operator. The candidate must provide the Credentials Committee with documentation of specific procedure and patient for each case. For documentation purposes, the Credentials Committee will consider only the number of procedures, not the number of lesions, as counting toward the candidate's eligibility. The fellowship must also include intensive training in all aspects of a body of knowledge

Peripheral Endovascular

Requested

The core privileges in this specialty include the procedure on the attached list and such other procedure that are extension of the same techniques and skills

Cardiologists: Documentation of a successful completion of a (3) three year fellowship which included peripheral angiography training with peripheral intervention training as part of a fourth year fellowship.

Radiologists: Documentation of the inclusion of angiographic training during a residency program with the addition of peripheral intervention training during a minimum (1) one year fellowship.

Vascular Surgeons: Documentation of the successful completion of a vascular fellowship of at least (1) one year in duration with catheter directed techniques as part of the fellowship.

Core Proctoring Requirements:

Core proctoring requirements include direct observation or concurrent and/or retrospective review as per proctoring policy contained in the Medical Staff General Rules and Regulations.

Reappointment Criteria for Core Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges; 50 vascular surgery procedures ~~(excluding percutaneous and catheter access)~~ within the past 24 months, the majority being of a reconstructive nature excluding cardiac surgery.

AND

Be Board Certified. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period ~~shall~~ may result in ~~automatic~~ suspension of Medical Staff privileges.

Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.

Status **Pending** PolicyStat ID **15608450**

Last Approved	N/A	Owner	Daniela Jago: Clinical Manager
Next Review	3 years after approval	Area	Nursing Standardized Procedures

Amniotic Fluid Ruptured Membrane Testing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Director of Nursing – Nursing Director responsible for a nursing unit or cluster of units.

B. RN – Registered Nurse employed by SVHMC

C. SP – Standardized Procedure

III. PROCEDURE

A. Function (s)

1. To provide guidance to the registered nurse in administration and assessment of amniotic fluid ruptured membrane testing

B. Circumstances

1. Setting

a. Labor and Delivery unit

b. Supervision

i. No physician supervision is required. Positive findings will be communicated to physician. Negative findings will be reported to physician if relevant to patient condition and/or treatment

ii. Patient Conditions

a. This test will be for pregnant women who have signs and/or symptoms of ruptured amniotic fluid

membranes

b. This test should not be performed if clinical confirmation of ruptured amniotic fluid membranes can be achieved. For example, if amniotic fluid is easily visualized and identified, further testing would be unnecessary.

C. Database

- Subjective
  1. Report leaking of fluid that may be related to ruptured amniotic membranes.
- Objective
  1. Signs of ruptured membranes may include a wet peri-pad or underwear, pooling of fluid, and/or intermittent or continuous leaking of fluid from the vagina.

D. Diagnosis

- Pegnancy with fluid leakage

E. Plan

- Treatment
  1. The treatment plan will vary dependent on patient condition, gestational age, and labor status.
  2. Collect specimen and perform testing within 30 minutes of collection.
     a. Kit Storage and Stability:
        i. Store the kit in a dry place at 4-24C. Do not freeze.
        ii. When stored in the foil pouch at the recommended temperature, the test is stable until the "Use By" date on the foil pouch.
        AmniSure® Test should be used within six (6) hours after removing from foil pouch.
        Kits are obtained from the Laboratory.
     b. Procedure for AmniSure® specimen collection:
        i. Take the solvent vial by its cap and shake well to make sure all liquid in the vial has dropped on the bottom. Open the solvent vial and put it in a vertical position.
        ii. To collect a sample from the surface of the vagina use the sterile polyester swab provided. Remove the sterile swab from its package per instructions on the package. The polyester tip should not touch anything prior to its insertion into vagina. Hold the swab in the middle of the stick and, while the patient is lying on her back, carefully insert the polyester tip of the swab

into the vagina until the fingers contact the skin no more than 2-3 inches (5-7 cm) deep. Withdraw the swab from the vagina after **one minute**.

   iii. Place the polyester tip into the vial and rinse the swab in the solvent by rotating for **one minute**.

   iv. Express fluid from swab as you remove and dispose of the swab.

   v. Label specimen per LABELING OF SPECIMENS policy

   vi. Enter order into electronic order system "per policy"

c. Procedure for Testing:

   i. Tear open the foil pouch at the tear notches and remove the AmniSure® test strip.

   ii. Dip the white end of the test strip (marked with arrows) into the vial with solvent. Strong leakage of amniotic fluid may make the results visible early (within 5 minutes), while a very small leak will take the full 10 minutes.

   iii. **Remove the test strip if two stripes are clearly visible in the vial or after 10 minutes sharp.** AmniSure test results can be read if two stripes are clearly visible in the vial or 10 minutes sharp after the Test strip is dipped into the vial.

   iv. **Do not read or interpret the results after 15 minutes have passed since dipping the test strip into the vial.** After the results become visible (lines appeared in the test region), they remain stable for at least 5 min. This kind of stability is observed when PAMG-1 concentration is very small (5-10 nG/ml). When the concentration is higher the lines remain stable for hours. In using the AmniSure®, it is recommended that the results not be read or interpreted after 15 minutes are passed after the Test strip is dipped into the vial.

   v. Read the results by placing the test on a clean, dry, flat surface and interpret as follows:

      a. One line present: Negative - NO MEMBRANES RUPTURE

      b. Two lines present: Positive - THERE IS A RUPTURE

      c. No lines: **INVALID** - Perform another test with a new specimen collection. Either the specimen or strip is defective.

d. NOTE: The darkness of the stripes may vary. The test is valid even if the lines are faint or uneven. Do not try to interpret the result based on the darkness of the stripes

d. Precautions and Warnings:

i. *A false-negative test may result in an inadequate level of care for newborns less than 37 weeks gestation if device is used in institutions other than those equipped to care for preterm infants (e.g. Level II-III nurseries).*

ii. *F*alse negative results can delay the diagnosis of rupture of membranes and can increase the risk of chorioamnionitis, oligohydramnios and fetal umbilical cord accident. Negative results alone may not rule-out membrane rupture.

iii. The performance of the AmniSure® Test has not been established in the presence of meconium in the amniotic fluid.

iv. Read and follow exactly the directions for use. Failure to do so may result in inaccurate results.

v. Do not bend or fold the test strip or the aluminum foil pouch with the Test strip in it.

vi. Interrupted leakage with minimal residual fluid can lead to false negative result.
Until the diagnosis of membrane rupture is excluded, avoid digital cervical examination to prevent infection and shorten the latency period.

e. Interference Studies:

i. Vaginal infections and urine do not interfere with the results of the AmniSureTest.

ii. Detailed analysis showed that PAMG-1 concentration in vaginal exudates during infections never exceeds the level of 3 ng/mL. The PAMG-1 sensitivity of Amnisure is 5 ng/mL. Urine samples were also examined for presence of PAMG-1and all were negative.

- Patient conditions requiring consultation/reportable conditions
    1. Positive findings will be communicated to physician. Negative findings will be reported to physician if relevant to patient condition and/or treatment
- Education-Patient/Family
    1. Patient education related to findings will be included in documentation and the plan of care related to anticipated treatment will also be discussed

- Follow-up
    1. Monitor fetal and maternal response
- Documentation of Patient Treatment
    1. Results of testing, communication with the OB provider and patient/family, and patient teaching will be documented in the electronic health record.

F. Record Keeping

- The facility will retain the patients' record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education and Training

- In accordance with the SVHMC RN job description.

B. Training

- RNs will be trained during the unit orientation process.

C. Experience

- In accordance with the established SVHMC job description. Completion of L&D orientation.

D. Evaluation

- Initial: During the initial orientation process RNs are educated to this SP and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this SP two (2) times prior to be deemed competent.
- Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
- During the annual RN performance appraisal process any areas of this SP not meeting requirements will be reviewed with the RN and a plan will be defined if necessary

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule

- Every 3 years or when practice changes are made.

B. Approval

- The electronic policy and procedure system maintains tracking of initiation, review

and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

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 / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. California Board of Registered Nursing,

B. Title 16, California Code of Regulations Section 1474

C. Medical Board of California. Title 16, Code of Regulations Section 1379

D. Qiagen. (2021) Amnisure Test Procedure. Retrieved from https://www.qiagen.com/us/resources/resourcedetail?id=37dd72ae-62f9-465a-92dc-2db77834d07d&lang=en

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	08/2024
IDPC	Katherine DeSalvo: Director Medical Staff Services	08/2024
OB Dept.	Katherine DeSalvo: Director Medical Staff Services	07/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2024
Policy Owner	Daniela Jago: Clinical Manager	07/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14931262**

Last Approved	N/A	Owner	Daniela Jago: Clinical Manager
Next Review	3 years after approval	Area	Nursing Standardized Procedures

OB Medical Screen Examination Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Director of Nursing – Nursing Director responsible for a nursing unit or cluster of units.

B. RN – Registered Nurse employed by Salinas Valley Health Medical Center (SVHMC).

C. SP – Standardized Procedure

D. **EMC – Emergency Medical Condition:**

1. A medical condition manifested by acute symptoms of sufficient severity (including severe pain, disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
    a. Placing the health of the individual, including an unborn child, in serious jeopardy; or
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any bodily organ or part
2. With respect to a pregnant woman who is having contractions:
    a. There is inadequate time to effect a safe transfer to another hospital before delivery; or
    b. Transfer may pose a threat to the health or safety of the woman or the unborn child.

E. **Labor:**

1. The process of childbirth beginning with the latent or early phase of labor and

continuing on to the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time in observation, the woman is in false labor.

F. MFTI - Maternal Fetal Triage Index

III. PROCEDURE

A. Function (s)

1. It is the intent of this document to authorize registered nurses in Perinatal Services at Salinas Valley Health Medical Center (SVHMC) to implement the Standardized Procedure without the immediate supervision of a physician. It is not the intent to have the registered nurses independently manage all patient conditions that may be encountered while performing the MSE. This standardized procedure is not designed to be implemented with individuals presenting for (a) routine testing; (b) direct admission to the hospital; or (c) without prior prenatal care.
2. The medical screen exam will be provided for patients who present for a non-scheduled complaint. Scheduled, outpatient antepartum procedural patients do not require a medical screen. Patients will be triaged according to their level of acuity and care will be provided without regard to patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services.THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

B. Circumstances

1. Setting
    a. Labor and delivery unit at SVHMC
2. Supervision
    a. The registered nurse is authorized to implement the Standardized Procedure in this document without the direct or immediate observation or supervision of the physician, except as may be specified in the Medical Screening Examination policy. Physician consultation is available at all times, either on site or by telephone
3. Patient Conditions
    a. **Consultation**
        i. The registered nurse (RN) performs medical screening exams as outlined in this document. In general, communication with a physician will be sought for all the following situations and any others deemed appropriate.
            a. For certification of false labor prior to discharge home.
            b. For discharge home after screening/evaluation.
        ii. Whenever a physician is consulted, a notation to that effect,

including the physician's name should be made in the patient record.

C. Database

1. Subjective

   a. Perform physical assessment appropriate for presenting complaint. If pregnancy related, determine whether the patient perceives or complains any of the following:

      i. Uterine contractions – potential sign of labor

      ii. Abdominal pain

      iii. Menstrual like cramps – potential symptom of preterm labor or urinary tract infection (UTI)

      iv. Dull lower backaches/flank pain – potential preterm labor or pyelonephritis

      v. Pelvic pressure – potential symptom of preterm labor

      vi. Intestinal cramps – potential symptom of preterm labor, viral or bacterial illness with risk of dehydration

      vii. Increase or change in vaginal discharge – potential sign of preterm labor, vaginal infection

      viii. Vaginal bleeding – potential for placental abruption or previa

      ix. A general feeling that something is "not right" – potential symptom of anxiety or illness

2. Objective

   a. Check vital signs – Blood pressure, respiratory rate, heart rate and temperature

   b. Complete MFTI classification

   c. Observe level of consciousness

   d. Obtain patient's prenatal record

      i. Review prenatal and medical/surgical history

      ii. Note gravid (G), Term, Pre-term, Abortions, Live (TPAL), estimated date of delivery (EDD) by dates and/or ultrasound if available, and last menstrual period (LMP)

   e. If patient is an unregistered OB patient (patients who are not under the care of a physician with privileges at SVHMC)

      i. Obtain prenatal records as soon as possible (ASAP)

      ii. Obtain prenatal lab results ASAP

   f. Apply external fetal monitor (EFM) and assess fetal heart rate pattern (FHR)

i. In the presence of Category II or Category III tracing or active maternal bleeding, notify physician and initiate MANAGEMENT OF CATEGORY II (WITH HEIGHTENED CONCERN) OR CATEGORY III FETAL HEART TRACINGS IN OB TRIAGE STANDARDIZED PROCEDURE

D. Plan

1. Treatment

a. Notify physician of the screening evaluation

b. The physician will determine, based on the RN Medical Screen Exam evaluation, whether the patient has:

i. EMC

ii. Potential EMC

iii. Non-emergent condition

iv. False labor

v. Active labor

vi. May require transfer to another facility

c. The physician will determine the level of care required to be provided based on the patient's medical condition

d. Obtain Obstetrical, Medical, Surgical and Psychosocial history and determine the chief complaint.

e. Assess for preterm labor:

i. Uterine contractions > 4 per hour

ii. Obtain Fetal fibronectin FETAL FIBRONECTIN VAGINAL SPECIMEN CLINICAL PROCEDURE prior to any cervical exam (< 34 weeks gestation)and send to laboratory per physician order

iii. Cervical change based on last known exam or advanced cervical ripening/dilation for gestational age

f. Assess for early latent phase of labor, prodromal labor, false labor

i. Fetal well being

ii. Vaginal exam

iii. May allow patient to walk for one hour

iv. Recheck cervical status

g. For patients presenting with complaints of rupture of membranes:

i. Evaluate utilizing OB AMNIOTIC FLUID RUPTURED MEMBRANE TESTING STANDARDIZED PROCEDURE

ii. If questionable preterm rupture, consult with physician regarding further assessment.

2. Patient may be discharged home with appropriate discharge instructions following consultation with physician and receipt of physician discharge order. Patients are eligible for discharge if:
    a. Fetal heart rate demonstrates reactivity and/or fetal well being
    b. Patient is not in labor
    c. Patient does not have an EMC
    d. Patient does not require further evaluation or care
3. For patients who are potentially in false labor, the physician will determine how much longer the patient will be observed.
4. For patients potentially requiring transfer to another facility, please refer to MATERNAL TRANSPORT-TERTIARY CARE AND TRANSFER OF PATIENT policy
5. For patients declining outpatient assessment/treatment or threatening to leave AMA prior to evaluation:
    a. Notify physician immediately; encourage communication between physician and patient to discuss risks, alternatives, and potential consequences to signing out AMA.

       Patient Refusal
       An individual retains the right to refuse necessary stabilizing treatment and further medical examination, as well as a transfer to another facility.

       Refusal of medical screening examination. If an individual leaves the Hospital before receiving a medical screening examination, either with or without notice to staff of his/her departure, staff should document the circumstances and reasons (if known) for the individual's departure and the time of departure.
       Refusal of further examination or stabilizing treatment. If an individual who has received a medical screening examination refuses to consent to further examination or stabilizing treatment, the Hospital must offer the examination and treatment to the individual, inform the individual of the risks and benefits of the examination and treatment and request that the individual sign a form that he/she has refused further examination or treatment.
       Refusal of transfer. If an individual refuses to consent to a transfer, the Hospital must inform the individual of the risks and benefits to the individual of the transfer and request that the individual sign a form that he/she refused the transfer.

       Patients to be examined by physician prior to determination of disposition
        i. Any unexplained physical examination or historical finding
        ii. Whenever patient conditions fail to respond to the management

plan in an appropriate time

   iii. In the event that a patient transfer to another facility might be indicated.
   iv. All emergency situations after initial stabilizing care has been started.
   v. Whenever situations arise which go beyond the intent of the Standardized Procedure or the competence, scope of practice of the registered nurse.

6. Education-Patient/Family
   a. Patient receives education from the RN regarding:
      i. The purpose of the Medical Screening examination process
      ii. The nature and appropriate care of their condition
   b. Follow up
      i. The availability of additional health care resources in the community (as applicable)
      ii. The need for follow-up care
7. Documentation of Patient Treatment
   1. Document the following in the electronic health record:
      i. Patient complaint
      ii. Maternal Assessment
      iii. Fetal assessment, reassessment
      iv. MFTI classification
      v. Procedures
      vi. Laboratory findings
      vii. Communication with physician
      viii. Timing of calls
      ix. Negative/positive findings
      x. Written and/or oral discharge instructions
   2. Prior to discharge assessment and documentation:
      i. Fetal well being
         i. Category I tracing, or reactive NST
      ii. If patient discharged and not in labor, it is imperative that the discharge note clearly states the rationale for deciding that the woman is not in active labor
   3. Perinatal Services will maintain a central log of all patients presenting and disposition out of the unit. The log contains the following information:

i. Date and time of visit
ii. Patient's name
iii. Date of birth and Medical record number
iv. Attending physician
v. Chief complaint
vi. Disposition
vii. If patient refused treatment

E. **Record Keeping**
  1. The facility will retain the patients' record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education/Training
  1. In accordance with the SVHMC RN job description.
  2. Orientation and education will be provided by a registered nurse who has shown competency in assessment and documentation of the Medical Screen Exam. The orientation schedule will be coordinated between assistant head nurse, clinical nurse specialist, and precepting RN.

B. Experience
  1. A minimum of twelve months documented labor and delivery experience after orientation period is complete for new grads.
  2. Newly hired experienced RNs will participate in OB Medical Screen Examination based on evaluation by LD Clinical Manager and /or Perinatal Nurse Educator

C. Initial Evaluation
  1. Initial evaluation completed by Clinical Nurse Educator or their designee through random chart review after orientation is complete.

D. Ongoing Evaluation will occur as needed.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule
  1. Every 3 years or when practice changes are made.

B. Signatures of Authorized Personnel Approving the Standardized Procedure and Dates
  1. The electronic policy and procedure system maintains tracking of initiation, review and approval of this SP including the Interdisciplinary Practice Committee, Medical

Executive Committee and the Board of Directors.

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 / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. American Academy of Pediatrics & American College of Obstetricians and Gynecologists (2017). *Guidelines for Perinatal Care.*(8th ed). https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx

B. Association of Women's Health, Obstetric and Neonatal Nurses. (2022). *Maternal Fetal Triage Index*, MFTI Education course.

C. California Board of Registered Nursing. (n.d.) Standards of competent performance. California code of regulations. Title 16, section 1443.

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
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Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	08/2024
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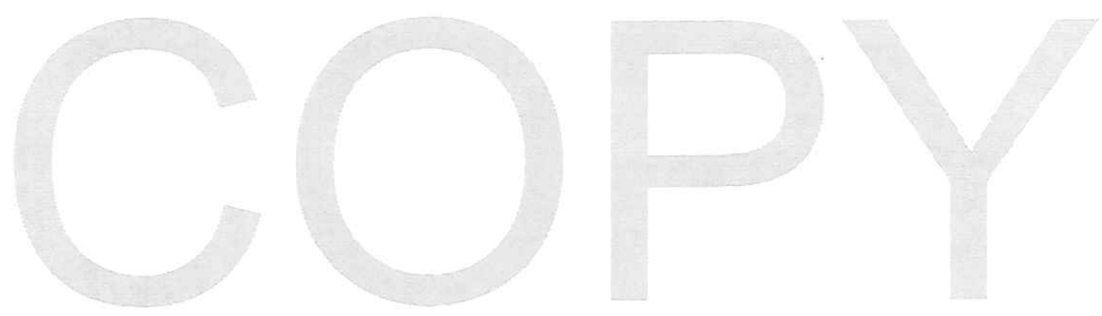
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Daniela Jago: Clinical Manager	07/2024

Standards

No standards are associated with this document



Status **Pending** PolicyStat ID **16172189**

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

Respiratory Virus (Influenza) Pandemic Plan

I. SCOPE

A. To prevent the spread of influenza (and/or other aerosolizing infectious diseases) by: vaccination, early detection and treatment with antiviral medications and the use of infection control measures to prevent transmission during patient care.

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

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

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

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

II. OBJECTIVES/GOALS

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

1. vaccination of patients and healthcare personnel;
2. early detection of respiratory viral cases in a facility;
3. use of antiviral medications to treat ill persons and, if recommended, as prophylaxis;
4. isolation of infectious patients in private rooms or cohort units;
5. Barrier precautions during patient care, as recommended for identified respiratory viruses, as Standard, Droplet, Contact, or Airborne Precautions.

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6. Administrative measures include restricting visitors, educating patients and staff, and cohorting healthcare workers assigned to an outbreak unit.

B. Salinas Valley Health Medical Center (SVHMC) (will follow the guidelines established by the Center for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH), and Cal OSHA for detection, treatment to minimize the transmission and treatment of influenza any other unknown communicable respiratory condition.

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

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

III. DEFINITIONS

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

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

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

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

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

D. ***Airborne transmission*** - Airborne transmission occurs by dissemination of either airborne droplet nuclei or small particles in the respirable size range containing the infectious agent.

Microorganisms carried in this manner—such as M. tuberculosis— may be dispersed over long distances by air currents and inhaled by susceptible individuals who have not had face-to-face contact with (or been in the same room with) the infectious individual.

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

E. ***Pathogenesis of influenza and implications for infection control*** - The cellular pathogenesis of human influenza or any other unknown communicable respiratory condition indicates that infection principally occurs within the respiratory tract. Following respiratory transmission, the virus attaches to and penetrates respiratory epithelial cells in the trachea and bronchi. Pathogenic mechanisms of viral disease include (1) implantation of virus at the portal of entry, (2) local replication, (3) spread to target organs (disease sites), and (4) spread to sites of shedding of virus into the environment. This information suggests that preventing direct and indirect inoculation of the respiratory tract is paramount for preventing person-to-person transmission when caring for infectious patients.

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. ***Control of transmission in healthcare facilities*** - These are the primary infection control measures recommended in this plan. They will be updated, as necessary, based on the observed characteristics of the pandemic influenza / emerging communicable disease such as new or Novel virus, SARS etc).
2. ***Recommendations for Infection Control in Healthcare Settings*** - The recommendations for infection control described below are generally applicable throughout the different pandemic phases. In some cases, as indicated, recommendations may be modified as the situation progresses from limited cases to widespread community illness.
    a. Basic infection control principles for preventing the spread of pandemic influenza or any other unknown communicable respiratory condition in healthcare settings. The following infection control principles apply in any setting where persons with pandemic influenza or viral respiratory illness might seek and receive healthcare services (e.g. hospitals, emergency departments, out-patient facilities, residential care facilities, homes).
    b. Limit contact between infected and non-infected persons
        i. Isolate infected persons (i.e., confine patients to a defined area appropriate for the healthcare setting).
        ii. Limit contact between nonessential personnel and other persons (e.g., social visitors) and patients who are ill with pandemic influenza or any other unknown communicable respiratory condition.
        iii. Promote spatial separation in common areas (i.e., sit or stand as far away as possible, at least 6 feet from potentially infectious persons) to limit contact between symptomatic and non-symptomatic persons.
    c. Protect persons caring for influenza patients or other respiratory viral illnesses in healthcare settings from contact with the virus. Persons who must be in contact should:
        i. Wear a surgical or procedure mask for close contact with infectious patients. Wear gloves (gown if necessary) for contact with respiratory secretions. Other unknown communicable respiratory conditions may require Airborne precautions with the use of an N95 respirator or PAPR, possibly with Contact (gown & gloves) and eye protection based on current guidelines from CDC, CDPH, or Cal OSHA.
        ii. Perform hand hygiene before and after contact with infectious patients
            a. Contain infectious respiratory secretions:
                i. Instruct persons who have "flu-like" symptoms (see below) to use respiratory hygiene/cough etiquette (See Box 2).
                ii. Promote the use of masks by symptomatic

persons (including visitors) or when transported (e.g., transfers between departments).

3. ***Symptoms of influenza and other respiratory viral illnesses*** include fever, headache, myalgia, prostration, coryza, sore throat, and cough. Otitis media, nausea, diarrhea, and vomiting are also commonly reported among children and adults over 65. Typical influenza or viral symptoms, such as fever, may not always be present in elderly patients, young children, patients in long-term care facilities, or persons with underlying chronic illnesses (see Supplement 5, Box 2).

B. **Plan Management**

1. ***Management of infectious patients***

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

   b. The impact of covering sneezes and coughs and/or placing a mask on a coughing patient on the containment of respiratory secretions or on the transmission of respiratory infections. Masks block aerosols produced during coughs and exhalations ("source control"). Masks also slow and deflect cough and exhalation airflows, which changes the dispersion of aerosols. Factors such as the directions in which people are facing (orientation) and separation distance also affect aerosol dispersion. In theory, any measure that limits the dispersal of respiratory droplets should reduce the opportunity for transmission. ***Masking should be encouraged with patients and visitors who are actively coughing*** but may be difficult in some settings, e.g., pediatrics, where the emphasis will be on cough hygiene.

   c. The elements of respiratory hygiene/cough etiquette include:

      i. Healthcare facility staff, patients, and visitors should be educated on the importance of containing respiratory secretions to help prevent the transmission of influenza and other respiratory viruses with masking.

      ii. Posted signs in languages appropriate to the populations served with instructions to patients and accompanying family members or friends to report symptoms of a respiratory infection as directed immediately

      iii. Source control measures (e.g., using masks on the coughing person when they can be tolerated and are appropriate)

      iv. Hand hygiene before and after contact with respiratory secretions and

      v. When possible, persons with respiratory infections should be separated spatially, ideally by more than 6 feet, in common

waiting areas.

2. ***Droplet precautions and patient placement***

    a. Patients with known or suspected pandemic influenza or other respiratory viral illnesses should be placed on appropriate precautions (Droplet or Airborne) based on SVHMC's current policy and/or current guidelines from CDC, CDPH, and Cal OSHA. Immunocompromised patients may shed the viruses for extended periods, and they may be placed on precautions for the duration of their illness. Healthcare personnel should wear appropriate PPE (see S4-IV.C). The placement of patients will vary depending on the healthcare setting (see setting-specific guidance). If the pandemic virus is associated with diarrhea, contact precautions (i.e., gowns and gloves for all patient contact) should be added. CDC, CDPH, and Cal OSHA will update these recommendations if changes occur in the anticipated pattern of transmission.

    b. Patients suspected of H1N1 influenza will be placed on Droplet Precautions for at least 7 days. They should remain in Droplet precautions until clearance to discontinue Precautions has been obtained from an infectious disease physician, a pulmonologist, or consultation with Infection Prevention.

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

    a. Infection control practices for pandemic influenza or other respiratory viral illnesses primarily involve the application of standard and droplet precautions (Box 1) during patient care in healthcare settings (e.g., hospitals, nursing homes, outpatient offices, emergency transport vehicles). Some respiratory viruses, such as Novel Influenzas or other types of SARS, will require *airborne isolation* with contact precautions and possible eye protection based on current guidance from the CDC, CDPH, or Cal OSHA. This guidance also applies to healthcare personnel entering patients' homes.

    b. Infection control practices for H1N1 influenza require *Droplet Precautions* and the use of a regular "ear loop" face mask.

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

        i. **Personal Protective Equipment -** PPE is used to prevent direct contact with the pandemic influenza virus or other respiratory

viruses. PPE that may be used to provide care includes surgical or procedure masks, as recommended for droplet precautions, and gloves and gowns, as recommended for standard precautions (Box 1). Additional precautions may be indicated during the performance of aerosol-generating procedures or per guidelines from CDC, CDPH, or Cal OSHA (see below).

ii. **Masks ("Ear-loop")/ Respirators (N95 or PAPR)**

a. Wear a mask "ear loop" when entering a patient's room. A mask should be worn once and then discarded. If pandemic influenza patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between patients and hand hygiene performed.

b. Respirators (N95 or PAPRs) may be required in place of "ear-loop" masks if required by CDC, CDPH, and/or Cal OSHA if the respiratory virus is identified as "Novel" or "SARS," etc.

c. Change masks "ear loop"/respirators "N95s" when they become moist.

d. Do not leave masks dangling around the neck.

e. Upon touching or discarding a used mask, perform hand hygiene.

iii. **Gloves**

a. A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care and handling soiled tissues). Gloves made of latex, vinyl, nitrile, or other synthetic materials are appropriate for this purpose; if possible, latex-free gloves should be available for healthcare workers with latex allergies.

b. Gloves should fit comfortably on the wearer's hands.

c. Remove and dispose of gloves after use on a patient; do not wash gloves for subsequent reuse.

d. Perform hand hygiene after glove removal.

e. If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive patient or

environmental contact with blood or body fluids, including during suctioning.

iv. **Gowns**

a. Wear an isolation gown if soiling personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated. Most patient interactions do not necessitate the use of gowns. However, procedures such as intubation and activities that involve holding the patient close (e.g., in pediatric settings) are examples of when a gown may be needed when caring for pandemic influenza patients. Additionally, gowns may be required during a pandemic or for other respiratory viral illnesses.

b. A disposable gown made of synthetic fiber or a washable cloth gown may be used.

c. Ensure that gowns are of the appropriate size to fully cover the area to be protected.

d. Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.

e. If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are required can reduce the volume used. Alternatively, other coverings (e.g., patient gowns) could be used.

v. **Goggles or face shield**

a. In general, wearing goggles or a face shield for routine contact with patients with H1N1 influenza is not necessary. Respiratory viral illnesses like "Novel" influenza or "SARS" may require eye protection; follow current SVHMC policy for isolation, including CDC/CDPH or Cal OSHA guidance.

b. However, if sprays or splatters of infectious material are likely, goggles or a face shield should be worn as recommended for standard precautions.

vi. References:

a. Aerosol Transmitted Diseases Exposure Control Plan

b. Isolation - Standard and Transmission Based Precautions

Box 2. Respiratory Hygiene/Cough Etiquette	
To contain respiratory secretions, all persons with signs and symptoms of a respiratory infection, regardless of presumed cause, should be instructed to:	A. Cover the nose/mouth when coughing or sneezing. Encourage the use of masks for any persons with an active cough. B. Use masks, such as "ear loop" masks, to contain respiratory secretions. C. Dispose of tissues in the nearest waste receptacle after use. D. Perform hand hygiene after contact with respiratory secretions and contaminated objects/materials.
Healthcare facilities should ensure the availability of materials for adhering to respiratory hygiene/cough etiquette in waiting areas for patients and visitors:	A. Provide ear loop masks, tissues, and no-touch receptacles for used mask/tissue disposal. B. Provide conveniently-located dispensers of alcohol-based hand rub. C. Provide soap and disposable towels for handwashing where sinks are available.
Masking and separation of persons with symptoms of respiratory infection:	A. During periods of increased respiratory infection in the community, persons who are coughing should be offered either a procedure mask (i.e., with ear loops) or a surgical mask (i.e., with ties) to contain respiratory secretions. Coughing persons should be encouraged to sit as far away as possible (at least 6 feet) from others in common waiting areas. Some facilities may wish to institute this recommendation year-round.

C. **Plan Responsibility**

1. ***PPE for special circumstances***

a. **PPE for aerosol-generating procedures**

During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a Powered Air Purifier (PAPr) or other appropriate particulate respirators. Respirators should be used within a respiratory protection program that includes fit testing, medical clearance, and training. If possible and when practical, the use of an airborne isolation room may be considered when conducting aerosol-generating procedures.

b. **PPE for managing pandemic influenza or other respiratory viral illness with increased transmissibility**
The addition of airborne precautions, including respiratory protection (an N95 respirator or other appropriate particulate respirator), may be considered for strains of influenza or respiratory viruses exhibiting increased transmissibility during the initial stages of an outbreak of an emerging or novel strain of influenza, and as determined by other factors such as vaccination/immune status of personnel and availability of antivirals. As the epidemiologic characteristics of the pandemic virus are more clearly defined, CDC/CDPH/CalOSHA will provide updated infection control guidance, as needed.

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

2. ***Caring for patients with pandemic viral illness*** - Healthcare personnel should be particularly vigilant to avoid:
    a. Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and the risk of self-contamination during use. Careful removal of PPE is also important, with good hand hygiene after removal.
    b. Contaminating environmental surfaces that are not directly related to patient care (e.g., door knobs, light switches)

3. **Hand hygiene -** Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings and is an essential element of standard precautions. The term "hand hygiene" includes both hand washing with either plain or antimicrobial soap and water and the use of alcohol-based products (gels, rinses, foams) containing an emollient that does not require the use of water.
    a. If hands are visibly soiled or contaminated with respiratory secretions, wash hands with soap and water.

b. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over soap and water because of their superior micro-biocidal activity, reduced drying of the skin, and convenience.

c. Always perform hand hygiene between patient contacts and after removing PPE.

d. Ensure that resources to facilitate hand washing (e.g., sinks with warm and cold running water, soap, disposable paper towels) and hand disinfection (e.g., alcohol-based products) are readily accessible in areas where patient care is provided.

e. For additional guidance on hand hygiene, see: Clinical Safety: Hand Hygiene for Healthcare Workers

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

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

   b. Discard as routine waste used patient-care supplies that are not likely to be contaminated (e.g., paper wrappers).

   c. Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

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

   a. Place soiled linen into a laundry bag in the patient's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area.

   b. Wear gloves and gown when handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.

   c. Wear gloves to transport bagged linen and laundry.

   d. Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.

   e. Wash and dry linen according to routine standards and procedures.

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

   a. Wash reusable dishes and utensils in a dishwasher at the recommended

water temperature.

b. Disposable dishes and utensils (e.g., those used in an alternative care site set up for large numbers of patients) should be discarded with other general waste.

c. Wear gloves when handling patient trays, dishes, and utensils.

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

    a. Wear gloves when handling and transporting used patient-care equipment.

    b. Wipe heavily soiled equipment with a hospital-approved disinfectant before removing it from the patient's room. Follow current recommendations for cleaning and disinfecting or sterilizing reusable patient-care equipment.

    c. Upon removal from the patient's room, wipe the external surfaces of portable equipment used for X-rays and other procedures with a hospital-approved disinfectant.

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

9. ***Cleaning and disinfection of patient-occupied rooms***:

    a. Wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with droplet precautions. Gowns are not necessary for routine cleaning of an influenza patient's room.

    b. Keep areas around the patient free of unnecessary supplies and equipment to facilitate daily cleaning.

    c. Use any hospital-approved detergent-disinfectant. Follow the manufacturer's recommendations for use-dilution (i.e., concentration), contact time, and care in handling.

    d. Follow facility procedures for regular cleaning of patient-occupied rooms. Give special attention to frequently touched surfaces (e.g., bed-rails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes, ventilator surfaces) in addition to floors and other horizontal surfaces.

    e. Clean and disinfect spills of blood and body fluids in accordance with current recommendations for Isolation Precautions. Cleaning and disinfection after patient discharge or transfer

    f. Follow standard facility procedures for post-discharge cleaning of an isolation room.

        i. Clean and disinfect all surfaces that were in contact with the patient or might have become contaminated during patient care.

No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.

ii. Do not spray (i.e., fog) occupied or unoccupied rooms with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

iii. Utilization of UV light disinfection will be incorporated into the discharge cleaning process during a pandemic and/or when guidelines from CDC, CDPH , or Cal OSHA are recommended.

10. ***Postmortem care***

    a. Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids. For H1N1 patients, use gown, gloves, regular face mask, and eye protection at a minimum. Other respiratory viruses may require specific handling and PPE, following current SVHMC policy or current guidance from CDC, CDPH, and Cal OSHA.

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

    a. Aerosol Transmissible Pathogens - Pathology

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

    a. Implement a system to educate personnel about occupational health issues related to pandemic influenza.

    b. Screen all personnel for symptoms before they come on duty. Symptomatic personnel should be sent home until they are physically ready to return to duty. Also, the current SVHMC processes for staff screening and return-to-work policies related to respiratory viral illness or pandemic should be followed. CDC, CDPH, and/or Cal OSHA may require additional screening and return-to-work guidance based on the viral disease or pandemic.

    c. Personnel who are at high risk for complications of pandemic viral illness (e.g., pregnant women, immunocompromised persons) should be informed about their medical risk and offered an alternate work assignment, away from pandemic patient care if possible or considered for administrative leave until the pandemic has abated in the community. During an identified pandemic, follow SVMHC's current Human Resources policies related to assignments, etc.

    d. Reducing the exposure of persons at high risk for complications during a pandemic - Persons who are well but at high risk for respiratory viral illness or its complications (e.g., persons with underlying diseases) should be instructed to avoid unnecessary contact with healthcare facilities caring

for pandemic patients (i.e., do not visit patients, postpone nonessential medical care).

13. ***Hospitals*** - Detection of persons entering the facility who may have pandemic influenza or other respiratory viral illness - Post visual alerts (in appropriate languages) at the entrance to hospital outpatient facilities (e.g., emergency departments, outpatient clinics) instructing persons with respiratory symptoms (e.g., patients, persons who accompany them) to:
    a. Inform reception and healthcare personnel when they first register for care and
    b. Practice respiratory hygiene/cough etiquette and encourage "ear-loop" masks for all patients and visitors
    c. Triage patients calling for medical appointments for symptoms
    d. Discourage unnecessary visits to medical facilities.
    e. Instruct symptomatic patients on infection control measures to limit transmission in the home and when traveling to necessary medical appointments.
    f. As the scope of the pandemic escalates locally, consider setting up a separate triage area for persons presenting with symptoms of respiratory infection. Because not every patient presenting with symptoms will have the pandemic virus, infection control measures will be important in preventing further spread.
    g. During the peak of the pandemic, emergency departments and outpatient offices may be overwhelmed with patients seeking care. A "triage officer" may be useful for managing patient flow.
    h. Designate separate waiting areas for patients with influenza-like symptoms. If this is not feasible, the waiting area should be set up so that patients with respiratory symptoms can sit as far away as possible (at least 6 feet) from other patients.
14. "Source control" measures to limit dissemination of respiratory virus from respiratory secretions - Post signs that promote respiratory hygiene/cough etiquette in common areas (e.g., elevators, waiting areas, cafeterias, lavatories) where they can serve as reminders to all persons in the healthcare facility. Signs should instruct persons to:
    a. Cover the nose/mouth when coughing or sneezing.
    b. Use ear-loop masks to contain respiratory secretions.
    c. Dispose of mask/tissues in the nearest waste receptacle after use.
    d. Perform hand hygiene after contact with respiratory secretions.
    e. Facilitate adherence to respiratory hygiene/cough etiquette by ensuring the availability of materials in waiting areas for patients and visitors.
    f. Provide masks/tissues and no-touch receptacles (e.g., waste containers with pedal-operated lids or uncovered waste containers) for used tissue disposal.

g. Provide conveniently-located dispensers of alcohol-based hand rub.
h. Provide soap and disposable towels for handwashing where sinks are available.
i. Promote the use of masks and spatial separation by persons with symptoms of respiratory viral illness.
j. Offer and encourage the use of either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties or elastic) by symptomatic persons to limit the dispersal of respiratory droplets.
k. Encourage coughing persons to sit as far away as possible (at least 6 feet) from other persons in common waiting areas.

15. ***Hospitalization of pandemic patients***
    a. Patient Placement
        i. Limit admission of pandemic patients to those with severe complications who cannot be cared for outside the hospital setting.
            a. Admit patients to either a single-patient room or an area designated for cohorts of patients with the same identified viral illness.
    b. Cohorting
        i. Designated units or areas of a facility should be used for cohorting patients with pandemic illness. During a pandemic, other respiratory viruses (e.g., non-pandemic influenza, respiratory syncytial virus, parainfluenza virus) may be circulating concurrently in a community. Therefore, to prevent cross-transmission of respiratory viruses, assign only patients with the same confirmed virus to the same room whenever possible. At the height of a pandemic, laboratory testing to confirm viral pandemic is likely to be limited, in which case cohorting should be based on having symptoms consistent with identified viral pandemic.
        ii. Personnel (clinical and non-clinical) assigned to cohorted patient care units for viral pandemic patients should not "float" or otherwise be assigned to other patient care areas. The number of personnel entering the cohorted area should be limited to those necessary for patient care and support.
        iii. Personnel assigned to cohorted patient care units should be aware that patients with viral pandemic may be concurrently infected or colonized with other pathogenic organisms (e.g., Staphylococcus aureus, Clostridium difficile) and should adhere to infection control practices (e.g., hand hygiene, changing gloves between patient contact) used routinely, and as part of standard precautions, to prevent nosocomial transmission.

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

c. Patient transport

i. Limit patient movement and transport outside the isolation area to medically necessary purposes.

ii. Consider having portable x-ray equipment available in areas designated for cohorting pandemic patients.

iii. If transport or movement is necessary, ensure the patient wears an "ear-loop" mask. If a mask cannot be tolerated (e.g., due to the patient's age or deteriorating respiratory status), apply the most practical measures to contain respiratory secretions. Patients should perform hand hygiene before leaving the room.

iv. During a pandemic, additional transfer guidelines will be implemented based on guidelines from the CDC, CDPH, and CalOSHA. Check for current SVHMC policies for the transfer of a pandemic patient and or current SVHMC isolation policy.

d. Visitors

i. Screen visitors for signs and symptoms of viral illness before entry into the facility and exclude persons who are symptomatic.

ii. Family members accompanying patients with viral symptoms to the hospital are assumed to have been exposed to the virus and should wear "ear-loop" masks.

iii. Limit visitors to persons necessary for the patient's emotional well-being and care.

iv. Instruct visitors to wear "ear-loop" masks while in the patient's room.

v. Instruct visitors on hand hygiene practices.

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

a. Cohorting of patients and staff on affected units

b. Restriction of new admissions (except for other pandemic patients) to the affected unit(s)

c. Restriction of visitors to the affected unit(s) to those who are essential for patient care and support

d. If widespread nosocomial transmission occurs, controls may need to be

implemented hospital-wide and might include:

i. Restricting all nonessential persons

ii. Stopping admissions not related to the pandemic virus and stopping elective surgeries

17. ***Care of pandemic viral patients at alternative sites*** - If a viral pandemic results in severe illness that overwhelms the capacity of existing healthcare resources, it may become necessary to provide care at alternative sites (e.g., schools, auditoriums, conference centers, hotels). Existing "all-hazard" plans have likely identified designated sites for this purpose. The same principles of infection control apply in these settings as in other healthcare settings. Careful planning is necessary to ensure that resources are available and procedures are in place to adhere to the fundamental principles of infection control. These sites would be managed in collaboration with local county, state, and federal authorities under Emergency Management.

D. **Performance Measurement**

1. The performance measurement process is one part of evaluating the effectiveness of the Influenza (Respiratory Virus) Pandemic Plan. Performance measures have been established to measure at least one important aspect of the plan.
2. The Pharmacy, Therapeutics, and Infection Prevention Committee evaluates the plan's scope, objectives, performance, and effectiveness on an annual basis to manage risks to the staff, visitors, and patients at SVHMC.

E. **Orientation and Education**

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

V. REFERENCES

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

B. CDC: Pandemic Influenza

C. CDC: National Pandemic Strategy

D. CDC: Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017

E. CDC: Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings

F. CDC: Conserving Supplies of Personal Protective Equipment in Healthcare Facilities during Shortages

G. CDC: CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings

H. CDC: Environmental Infection Control Guidelines

I. SVHMC Plans and Polices:

1. Aerosol Transmitted Diseases Exposure Control Plan

2. Aerosol Transmissible Pathogens - Pathology
3. Isolation - Standard and Transmission Based Precautions
4. Patient Room Cleaning - Discharge/Transfer
5. Medical Equipment Care, Cleaning and Maintenance
6. Outbreak Investigation
7. Emergency Management Program Plan
8. Infection Prevention Pandemic Plan Emerging Infectious Diseases
9. Employees Exposures & Prevention Plans: Specific Disease Exposures and Work Restrictions

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	08/2024
P&T/IP Committee	Genevieve delos Santos: Director Pharmacy	08/2024
Emergency Management	Sophia Sanchez: Emergency Preparedness Coordinator	07/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2024
Policy Owner	Melissa Deen: Manager Infection Prevention	07/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14931203**

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

Sedation Guidelines

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide guidelines to administer, monitor, recover, and discharge patients undergoing procedural sedation.

B. To define competency standards for those providing minimal, moderate, and deep sedation.

III. DEFINITIONS

A. Because the level of sedation is defined by the patient's psychologic and physiologic state, and the ability to maintain a patent airway and spontaneous ventilation, this guideline does not delineate the levels of sedation based solely on the route, doses or specific drug used. Therefore, providers are directed to the definitions for use in determining when the intended plan for sedation/analgesia can be expected to render a patient sedated at the minimal sedation (anxiolysis), moderate sedation, or deep level sedation.

B. Minimal Sedation (Anxiolysis) - With minimal sedation patients respond normally to verbal commands, their cognitive function and coordination may be impaired and/or their respiratory and cardiovascular functions remain unaffected.

C. Moderate Sedation (Conscious Sedation) - With moderate sedation patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate and cardiovascular function is usually maintained.

D. Deep Sedation (Analgesia)-With deep sedation patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Their ability to independently maintain respiratory functions may be impaired. They may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate and cardiovascular function is usually

maintained.

E. General Anesthesia (A drug-induced loss of consciousness) - With general anesthesia patients are not arousable, even by painful stimulation. Their ability to independently maintain respiratory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure may be required and cardiovascular function may be impaired.

IV. GENERAL INFORMATION

A. All Salinas Valley Health Medical Center (SVHMC) patients who receive sedation for a procedure will be provided a safe and comparable level of care consistent with, or in excess of, the minimum recognized standards for such procedures.

B. SVHMC respects the diverse cultural needs, preferences, and expectations of the patients and families it serves to the extent reasonably possible while appropriately managing available resources and without compromising the quality of health care delivered.

C. Guidelines are general and cannot take into account all of the circumstances of a particular patient. Judgment regarding the propriety of using any specific procedure with a particular patient remains with the patient's physician, nurse, or other health care professional, taking into account the individual circumstances presented by the patient.

D. Oversight Responsibility:

    1. The Department of Anesthesia in collaboration with the Director, Perioperative Services is responsible for the development of practice standards for sedation care.

E. General Anesthesia can only be provided by an Anesthesiologist.

F. Physicians must be physically present during the administration of all medications.

G. Exclusions:

    1. Patients undergoing mechanical ventilation in critical care settings
    2. Perioperative patients undergoing anesthesia
    3. Patients undergoing care for alcohol or drug withdrawal protocols
    4. End-of-Life Sedation
    5. Local and topical Anesthesia
    6. Pain control
    7. Treatment of Seizures
    8. Anxiety management

H. Documentation:

    1. Documentation should follow the guidelines set forth for the specific level of sedation used for procedure.
    2. Documentation flow sheet may be used.
    3. Documentation in the electronic medical records or in the paper chart following downtime procedures.
    4. Department Specific Electronic Sedation Record

a. Cardiac Catheterization Lab
b. Radiology Department
c. Endoscopy

I. Refer to guidelines for Personnel/Staffing required for types of sedation
1. Minimal Sedation - Attachment C
2. Moderate Sedation - Attachment D
3. Deep Sedation - Attachment E

V. PROCEDURE

A. Obtain Informed Consent
1. Each patient, parent, or guardian must receive an explanation regarding the risks and alternatives of moderate sedation.
2. Obtain informed consent for procedure / sedation from the patient, parent, or legal guardian and document on the procedural form before the procedure. This consent may or may not be part of the procedure itself. This does not apply to emergency situations. Refer to the policy CONSENT TO SURGERY OR SPECIAL THERAPEUTIC OR DIAGNOSTIC PROCEDURE(S) .

B. Equipment for sedation and resuscitation must be present during the procedure. This includes but is not limited to:
1. Advanced Airway equipment (oral and nasal airways, LMA's, intubation equipment)
2. Crash Cart
3. Suction catheters/suction apparatus (e.g., Yankauer-type suction)
4. Oxygen – supply and flow meter/other devices (e.g. Ambu bag face mask, nasal cannula, extension tubing, and connectors)
5. Sedation, reversal and resuscitative medications
6. Monitors: pulse oximeter, non-invasive blood pressure, EKG monitor,
7. End tidal Co2 monitor required for moderate and deep sedation
8. Temperature monitoring equipment for children under warming lights or for infants weighing less than 5 kg

C. Dietary Precautions:
1. Sedation may reduce airway protective reflexes, thus allowing pulmonary aspiration of gastric contents in the event of emesis. The use of sedation will be preceded by an evaluation of food and fluid intake.
2. For non-elective sedation when proper fasting has not been assured, the increased risks of sedation will be weighed against its benefits. If possible, such patients may benefit from delaying the procedure and administering appropriate pharmacologic treatment to reduce gastric volume and increase gastric pH. These patients may require protection of the airway before sedation or anesthesia consultation. Certain

radiological procedures require the administration of oral fluids in conjunction with sedation and analgesia. Risk of aspiration during these procedures must be weighed against the benefits of sedation and analgesia.

D. Minimal Sedation

1. Pre-Procedural Assessment to Include:
    a. Focused History including NPO status (Attachment A) and allergies
    b. Baseline vitals: Blood Pressure, Heart Rate, Respiratory Rate, Oxygen Saturation
    c. Intra-procedural monitoring/documentation of BP, HR, RR and O2 Saturation every 5 minutes
    d. Post-procedural documentation that the patient is be able to respond to questions and/or ambulate with stable vitals for at least 15 minutes
    e. Repeat dosing of anxiolytic agents may require monitoring appropriate for moderate sedation.

E. Moderate and Deep Level Sedation (Minimal Sedation is exempt from the following):

Pre-Procedural:

1. Obtain airway and sedation assessment to determine Mallampati score and Determine ASA classification. (Attachment B)
2. Determine if the patient requires consultation and/or medical management from a member of the Department of Anesthesiology. For procedures performed under moderate and deep sedation in the endoscopy suite, an anesthesiologist or critical care physician should be present or an anesthesia consult should be obtained for patients with the following conditions:
    a. Severe cardiac disease, (NYHA Class IV Congestive Heart Failure, symptomatic arrhythmias, unstable angina, moderate-severe or severe valvular heart disease.)
    b. Pulmonary disease requiring oxygen at baseline.
    c. Hemodynamic instability.
    d. ASA IV
    e. Morbid Obesity with BMI > 40.
    f. Pregnancy
    g. Age under 16
    h. ERCP procedures.
3. Perform a medical history and physical exam within 30 days of the procedure which should include the following:
    a. Health history including allergies, current medications, current health problems, previous hospitalizations, previous sedation/anesthesia history including adverse reactions, known pregnancy status, smoking, alcohol

and illicit drug use

   b. Height and Weight*
   c. Mental Status* (Aldrete Score) (Attachment B)
   d. Focused physical examination including vital signs, airway evaluation and auscultation of heart and lungs.
   e. NPO status
   f. Pulmonary Status
   g. Cardiovascular Status

4. If the History and Physical examination were completed greater than 24 hours prior to the procedure an Interval History and Physical must be completed.
5. A Plan of Care for sedation will be developed by the appropriately privileged member of the medical staff based on the assessment, assignment of the ASA physical status, airway assessment, pulmonary and cardiovascular assessments, and risk and benefits of planned level of sedation.
6. Provide appropriate instructions to patient, and parent, family or accompanying adult including NPO status, dietary restrictions, drug information, post-procedure transportation information
7. Obtain and document (baseline) Pre-Procedural Vital signs no greater than 15 minutes prior to start of procedure:
   a. Blood pressure, Heart rate, Respiratory Rate, Oxygen saturation which will serve as the immediate re-evaluation prior to beginning sedation
   b. Aldrete Score
8. Obtain and maintain vascular access if IV medications are planned/used.
9. Prior to the start of sedation applicable components of Universal Protocol are to be completed.
10. Items with a (*) may be delegated by the appropriately privileged member of the medical staff or their designee, or to a clinical staff member who has demonstrated competency in pre-sedation assessment when the pre-sedation assessment is not also serving as the H & P. The appropriately privileged member of the medical staff is responsible to review all of the items before ordering sedation.

Intra-Procedural Guidelines:

1. Document Start time
2. Monitor and document vital signs every 5 minutes or more as indicated
   a. Blood pressure, Heart rate, and Respiratory rate shall be monitored and documented every 5 minutes.
   b. Oxygen Saturation, capnography, and cardiac rhythm shall be monitored continuously and should be documented every 5 minutes.

3. Monitor and document level of sedation every 5 minutes during procedure

   SEDATION RATING SCALE
   0 = No sedation; awake
   S = sleepy; normal to arouse
   1 = mild sedation; occasionally sleepy, easy to arouse, responds to verbal stimuli
   2 = moderate sedation; frequently drowsy, responds to gentle shake
   3 = severe or deep; somnolent, difficult to arouse, responds to sternal rub
   4 = unresponsive

4. For exposed children under warming lights, continuously monitor skin temperature using skin probe.
   a. For Infants weighing less than 5 kg, monitor temperature at the beginning and the end of the procedure and use interventions as needed to maintain neutral thermal temperature (i.e., warm blanket, Bair Hugger, plastic wrap).

Post-Procedural Guidelines:

1. Document End time
2. Each patient's post-procedure status is assessed on discharge
3. Each patient is discharged from the post-sedation or post-anesthesia recovery area by a qualified licensed independent practitioner or according to criteria approved by the medical staff.
4. For patients receiving deep sedation a post anesthesia evaluation must be completed and documented by an individual qualified to administer deep sedation, no later than 48 hours after the procedure. The qualified individual performing the post anesthesia evaluation need not be the same individual who administered the sedation.

   The elements of an adequate post anesthesia evaluation should be clearly documented and include:
   a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation
   b. Cardiovascular function, including pulse rate and blood pressure
   c. Mental status
   d. Temperature
   e. Pain
   f. Nausea and vomiting
   g. Post procedure hydration
5. In the absence of specific orders, routine nursing recovery care will include but not be limited to:
   a. Initial post procedure Aldrete Score

b. Blood pressure and respiratory rate documented every 15 minutes

c. Cardiac rhythm, heart rate, oxygen saturation and level of consciousness monitored continuously and documented every 15 minutes

d. Monitoring should continue until patient reaches discharge criteria.

6. Any abrupt deterioration of the patient's condition will be reported to the responsible physician immediately. These include but are not limited to:
   a. Respiratory rate greater than 20 or less than 12
   b. Oxygen saturation less than 94% or less than pre-procedure levels
   c. Stridor, wheezing and/or croup symptoms
   d. Shallow or inadequate tidal volumes
   e. Sudden onset of cyanosis
   f. Respiratory obstruction
   g. Blood pressure less than 90 systolic or 80% of preoperative value
   h. Blood pressure greater than 160 systolic or more than 20% of preoperative value
   i. Pulse greater than 100 or less than 50
   j. Any cardiac dysrhythmia
   k. Any change in mental status
7. While current practice dictates that patients receiving moderate sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, a post anesthesia evaluation performed by someone qualified to administer anesthesia as specified in § 482.52 9(a) is NOT required under this regulation. (71 FR 68691)

F. Discharge Criteria:

1. Patients can only be Transferred or Discharged after examination and/or written order by an LIP that directs staff to follow approved discharge protocol.
2. Patients who have received procedural sedation may be discharged from the recovery area when the following criteria are met:
   a. Discharge order from physician
   b. Vital signs to within +/- 20% of pre-procedure level
   c. Aldrete score of 8 or a score equivalent to pre-procedure levels for thirty minutes
   d. No use of reversal agents (Naloxone, Flumazenil) for one hour (see Attachment F)
   e. Return of baseline motor function
   f. Pain is minimal / manageable
   g. Oxygen saturation maintained at 94% or greater, or is at pre-procedural

level

h. Discharge oxygen saturation less than admission, with physician approval
i. Patients who received reversal agents need to remain in the procedure area for at least one hour after the last dose of reversal agent.

3. Patients being discharged to home will meet the following additional criteria:
   a. Able to ambulate without assistance and without dizziness (if applicable)
   b. Able to tolerate oral fluids (unless contraindicated by procedure)

4. Discharge instructions
   a. Patient and family education, and discharge planning will be done and validation that learning took place should be documented. Patient and family / significant others should receive written aftercare instructions covering the following:
      1. Limitations of activity (to include operating a motor vehicle and machinery)
      2. Dietary precautions
      3. Medications
      4. Signs and symptoms of complications and course of action to take, if any complication develops
      5. Name and phone number of attending physician
      6. Follow-up appointment
      7. Name and phone number of secondary source of information in case patient develops complication
      8. Written post-procedure instructions reviewed with the patient and / or responsible adult
      9. Transportation home shall be by a responsible adult
   b. Attending physician, if applicable, may provide procedure specific discharge instructions, which may include showering, dressing and wound care.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. American Society of Anesthesiologists, Inc. (ASA)
B. The Joint Commission Centers for Medicare and Medical, Conditions of Participation, Anesthesia Services
C. Recommended practices for the patient receiving moderate sedation. Association of

Perioperative Nurses. Denver, CO.

D. American Association of Nurse Anesthetists.

E. Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to health Patients Undergoing Elective Procedures, Anesthesiology 2011;114;495-511

F. Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018: A Report by the American Society of Anesthesiologists Task Force on Moderate Procedural Sedation and Analgesia, the American Association of Oral and Maxillofacial Surgeons, American College of Radiology, American Dental Association, American Society of Dentist Anesthesiologists, and Society of Interventional Radiology, Anesthesiology 2018; 128; 437-479.

G. California board of registered nursing – Conscious sedation

H. Note: § 482.52 9(a) is NOT required under this regulation. (71 FR 68691)

Attachments

A: NPO Status

B: Mallampati, ASA and Aldrete Scoring

C: Minimal Sedation

D: Moderate Sedation

E: Deep Sedation

F: Emergency Resuscitation Medications

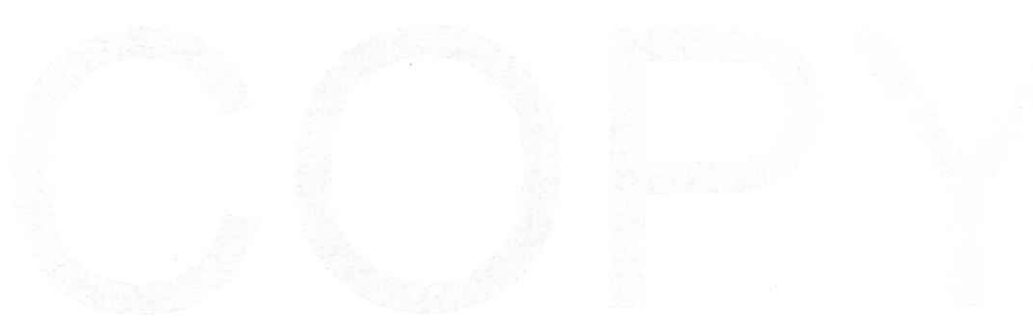
Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	08/2024
Perioperative Medical Director	Christina Hinz: PHYSICIAN	08/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024

Policy Owner	Carla Knight: Director Perioperative Services	07/2024

Standards

No standards are associated with this document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Status **Pending** PolicySat ID **16172365**

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

Salinas Valley HEALTH

Bioterrorism Readiness Plan

I. SCOPE

A. Four major agents/diseases potentially encountered in the event of bioterrorism are anthrax, botulism, plague, and smallpox. Additional agents/diseases may include tularemia, brucellosis, Q fever, viral hemorrhagic fevers, viral encephalitis, and staphylococcal enterotoxin B. With the exception of smallpox, these agents are generally not transmitted from person to person, and re-aerosolization of the agents is unlikely.

B. For Pathology department procedures related to the Laboratory Response Network and recognizing possible bioterrorism agents, see BIOTERRORISM PREPAREDNESS – PATHOLOGY.

C. Support Policies/Plans:

1. AEROSOL TRANSMITTED DISEASES EXPOSURE CONTROL PLAN
2. AEROSOL TRANSMISSIBLE PATHOGENS – PATHOLOGY
3. ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS
4. INFECTIOUS DISEASE REPORTING - PATHOLOGY

II. OBJECTIVES/GOALS

A. **Objectives**

1. To guide the staff in the event Salinas Valley Health Medical Center (SVHMC) provides care/treatment to individuals with illnesses related to suspected or known exposure to bioterrorism agents.

B. **Goals**

1. Summary of the goals for the bioterrorism plan at Salinas Valley Health Medical Center (SVHMC):
   a. Develop a comprehensive bioterrorism response plan and ensure staff are

trained.

b. Enhance surveillance for and rapid diagnosis of bioterrorism-related illnesses.
c. Respond quickly and appropriately to suspected or confirmed cases, including isolating patients and administering treatment.
d. Communicate effectively and collaborate with public health authorities.
e. Minimize the spread of disease within the facility.
f. Have a plan for returning to normal operations after an event and update the response plan based on lessons learned.

III. DEFINITIONS

A. Association of Professionals in Infection Control and Epidemiology (APIC)
B. Centers for Disease Control and Prevention (CDC)
C. Hospital Infection Control Practices Advisory Committee (HICPAC)
D. California Department of Public Health (CDPH)

IV. PLAN MANAGEMENT

A. Plan Elements

1. Reporting Requirements and Contact Information (see Table 1 in Attachments)
    a. Internal Contacts - Immediately notify the following persons:
        i. Infection Prevention: (831) 759-1858 SVHMC Operator has after-hours contact information.
        ii. After hours, contact Administrative Supervisor/ Hospital Operator
    b. External Contacts
        i. Monterey County Health Department:(831) 755-4521, after hours: (831) 755-5100
        ii. State Health Department, defers to local County Public Health; see contact information above
    c. FBI Field Office (San Francisco): (415) 553-7400
    d. Bioterrorism Emergency Number, CDC Emergency Response Office: (770) 488-7100
    e. CDC Hotline 800-232-4636
    f. California Poison Control Centers: (800) 222-1222
    g. *Note: Phone numbers listed above were last verified on 02/24/2024*
2. Detection of Outbreaks Caused by Agents of Bioterrorism: Bioterrorism is generally committed as a covert act and persons are unknowingly exposed. An outbreak may

only be recognized if unusual disease clusters or symptoms are recognized. Rapid response is required if bioterrorism related illness is suspected to prevent progression to illness and potential dissemination of these agents through secondary spread of infection.

a. Recognition of Illness: "Diseases Associated with Bioterrorism" lists the four most common diseases caused by these agents and their characteristic features. These are not easily identified in the absence of an outbreak.

b. Epidemiologic Criteria for Recognition of Outbreaks: Features that may represent early symptoms of exposure to a bioterrorism agent include:

   i. A rapidly progressing incidence of disease in a normally healthy population.

   ii. An epidemic curve that rises and falls during a short period of time.

   iii. An unusual increase in the number of people seeking care, especially with fever, respiratory, or gastrointestinal complaints.

   iv. An endemic disease rapidly emerging at an uncharacteristic time or in an unusual pattern.

   v. Lower attack rates among people who had been indoors, especially in areas with filtered air or closed ventilation systems, compared with people who had been outdoors.

   vi. Clusters of patients arriving from a single locale.

   vii. Large numbers of rapidly fatal cases.

   viii. Any patient presenting with a disease that is relatively uncommon and has bioterrorism potential (e.g., pulmonary anthrax, tularemia, or plague).

3. Surveillance

a. Reporting & Analysis of Disease – the following may be considered for detection of Bioterrorism-related diseases.

   i. Laboratory – Laboratories must immediately report cases to the local Health Department. Including SVHMC Infection Prevention and / or Chief Medical Officer/Infectious Disease Medical Director.

   ii. Radiology Departments – Most cases will not initially be recognized by radiological findings; however, in the presence of an outbreak, Radiologists should be alerted to report suspect findings immediately.

   iii. Analysis of trends

      a. Clusters

      b. Epidemic curves

iv. Sources of information
    a. Medical record access
    b. Coding
    c. Hospital Information Systems
    d. Pharmacy records (e.g., high use of amantadine may indicate influenza or other pulmonary illness)

4. Community-wide Surveillance—The Health Department, CDC, and the local chapter of the Association of Professionals in Infection Control and Epidemiology (APIC) will alert infection preventionists in Monterey County.
5. **Infection Prevention Practices for Patient Management** (See CDC Links in References)
    a. **Isolation Precautions**:
        i. Standard Precautions – Agents of bioterrorism are generally not transmitted from person to person. Standard Precautions are recommended for all patients regardless of their diagnosis or presumed infection status.
        ii. Transmission-Based Precautions
            a. Suspected or confirmed smallpox - Airborne & Contact Precautions - using a negative pressure room with an anteroom.
            b. Suspected or confirmed pneumonic plague – Droplet Precautions
            c. ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS
    b. **Patient Placement**:
        i. Routine patient placement for Standard or Transmission-based Precautions is generally adequate for small-scale events.
        ii. If a large-scale event occurs, and existing in-patient facilities are insufficient for the number of patients admitted, the Infection Control Committee will work with the Incident Commander.
        iii. Patients with similar syndromes may be directly triaged to alternate sites such as a designated clinic, emergency department area, or a designated ward, floor, or separate building, and cohorted and negative air ventilation may be required. Non-emergency services and procedures may need to be canceled.
    c. **Patient Transport**: Patient movement should be limited. Patients in Airborne Precautions must have procedures done in negative pressure rooms. Transportation outside the facility must be coordinated with the Monterey County Emergency Operations Center.

d. Cleaning, disinfection, laboratory testing, and sterilization of equipment and environment: Notify Pathology/laboratory and the Medical Examiner of potentially infectious cases during an outbreak before submitting specimens for examination, testing, or disposal.

B. Plan Management

1. Post-exposure Management:

a. Decontamination is not necessary and should only be considered in instances of gross contamination.

b. Employee Health and Pharmacy will identify sources of vaccines, immune globulin, antibiotics, and botulinum anti-toxin (with assistance from the local health departments). Current antibiotic prophylaxis for Plague (*Yersinia pestis*) and Anthrax (*Bacillus anthracis*) should be referenced by CDC standards, and the Infectious Disease Medical Director should be consulted.

c. All in-patients will be evaluated for discharge potential and discharged as early as possible.

d. Patients treated for a biological event-induced illness and their families will receive discharge instructions applicable to their illness.

e. The hospital will attempt to reduce the psychological impact of bioterrorism by using on-site clergy, counselors, social workers, and volunteers. Public inquiries will be referred to the Public Information Officer.

C. Plan Responsibility

1. This plan will be utilized by staff as a support document during a bioterrorism event through the facility's HICS System and Incident Command Structure, as outlined in the EMERGENCY MANAGEMENT PROGRAM PLAN.

D. Plan Performance

1. The performance measurement process is one part of evaluating the effectiveness of the Bioterrorism Readiness Plan. Performance measures have been established to measure at least one crucial plan aspect.

2. On an annual basis, the PT/IC Committee evaluates the plan's scope, objectives, performance, and effectiveness to manage risks to the staff, visitors, and patients at SVHMC.

E. Orientation and Education

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

2. Education is provided during general or departmental-specific orientation and periodically as practice or policy changes.

V. REFERENCES

A. Preparation and Planning for Bioterrorism Emergencies.

https://emergency.cdc.gov/bioterrorism/prep.asp

B. Public Health Emergency Response Guide for state, local, and tribal public health directors. Version 2.0, April 2011. https://emergency.cdc.gov/planning/pdf/cdcresponseguide.pdf

    1. See also in Attachments

C. Laboratory Information for Bioterrorism Emergencies. https://emergency.cdc.gov/bioterrorism/lab.asp

D. CDC Emergency Preparedness and Response, Bioterrorism Agents/Diseases. https://emergency.cdc.gov/agent/agentlist.asp

E. **DISEASES ASSOCIATED WITH BIOTERRORISM & Preventable measures:**

    1. Anthrax: Anthrax | CDC
    2. Botulism: Botulism | Botulism | CDC
    3. Ebola: Ebola (Ebola Virus Disease) | CDC
    4. Plague: CDC Plague Information | Emergency Preparedness & Response
    5. Smallpox: Smallpox | CDC
    6. Tularemia: CDC Tularemia | Emergency Preparedness & Response

F. Infectious Disease Disasters: Bioterrorism, Emerging Infections and Pandemics. APIC Text of Infection Control and Epidemiology, updated 2024.

COPY

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	08/2024
P&T/IP Committee	Genevieve delos Santos: Director Pharmacy	08/2024
Emergency Management	Sophia Sanchez: Emergency Preparedness Coordinator	07/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2024
Policy Owner	Melissa Deen: Manager Infection Prevention	07/2024

Standards

No standards are associated with this document

Medical Staff Bylaws

Presented for Board Ratification:

August 22, 2024

BYLAWS OF THE MEDICAL STAFF

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BYLAWS OF THE MEDICAL STAFF
OF SALINAS VALLEY HEALTH MEDICAL CENTER

PREAMBLE

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Board of Directors of Salinas Valley Health Medical Center in protecting the quality of medical care provided in the Hospital and assuring the competency of the Hospital's Medical Staff and Advanced Practice Providers. The Bylaws provide for the organization of the Medical Staff of , provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants, members of the Medical Staff, others who exercise clinical privileges, and Advanced Practice Providers.

The Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges and to enforce those criteria and standards. The Bylaws establish clinical criteria and standards for the oversight and management of quality assurance, utilization review, and other Medical Staff activities, including, but not limited to, periodic meetings of the Medical Staff, its committees, and departments and review and analysis of patient medical records. The Bylaws also describe the standards and procedures for selecting and removing Medical Staff Officers, and they address the respective rights and responsibilities of the Medical Staff and the Board of Directors.

DEFINITIONS

1. "ADVANCED PRACTICE PROVIDER" means the organization of those limited licensed practitioners and dependent practitioners who are not members of the Medical Staff but either hold clinical privileges or provide patient care services pursuant to practice prerogatives.

2. "AUTHORIZED REPRESENTATIVE" means the individual designated by the Hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

3. "BOARD OF DIRECTORS" means the Board of Directors of the Hospital.

4. "CHIEF EXECUTIVE OFFICER" means the administrator appointed by the Board of Directors to act on its behalf in the overall management of the Hospital.

5. "CHIEF OF STAFF" means the Chief Officer of the Medical Staff elected by members of the Medical Staff.

6. "CLINICAL PRIVILEGES" or "PRIVILEGES" means the permission granted to provide patient care services and includes access to those Hospital resources, including equipment, facilities and Hospital personnel which are necessary to effectively exercise those privileges. All privileges are limited as appropriate by licensure and legal restrictions on the licensed independent practitioner's scope of practice.

7. "CLOSED MEETING" means any meeting, or portion of any meeting, of any department, or committee of the Medical Staff at which privileged and/or confidential information regarding

quality assessment and improvement and/or peer review information is presented or discussed. Non-voting members are excused.

8. "DEPENDENT PRACTITIONER" means an appropriately licensed or certified health care practitioner whose licensure or certification does not permit, and/or the Hospital does not authorize the independent exercise of clinical privileges. Dependent practitioners may only provide patient care services pursuant to individually designed practice prerogatives as defined in the dependent practitioner's job description. Dependent practitioners may become members of the Advanced Practice Provider Staff at the Hospital.

9. "EX OFFICIO" means by virtue of an office or position held. Ex officio members on committees have no voting rights unless otherwise specified in these Bylaws.

10. "FEDERAL HEALTH CARE PROGRAM" means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly in whole or in part by the United States government or a state health program (with the exception of the Federal Employees Health Benefits program).

11. "FOCUSED REVIEW OF PRACTITIONER PERFORMANCE" means monitoring, analyzing, and understanding those special circumstances of a practitioner's performance, as defined by the organized Medical Staff, which require further evaluation.

12. "FOCUSED PROFESSIONAL PRACTICE EVALUATION" (FPPE) means establishing current competency for new medical staff members, new privileges and/or concerns from the Ongoing Professional Practice Evaluation. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances.

13. "HOSPITAL" means Salinas Valley Health Medical Center including all locations of the Hospital, on and off-site, operating under the Hospital's license.

14. "INELIGIBLE PERSON" means any person who:

    a. Is currently excluded, suspended, debarred, or ineligible to participate in any federal health care program, or

    b. Has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a federal health care program after a period of exclusion, suspension, debarment, or ineligibility.

15. "INVESTIGATION" means a process specifically initiated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a member of the Medical Staff or others holding clinical privileges, and does not include activity by the Medical Staff Practitioner Health and Well-Being Committee.

16. "LOCUM TENENS" means a practitioner who temporarily replaces another practitioner member on the Medical Staff. A locum tenens cannot be used as additional help, such as opening another operating room or lending an extra hand to deliver a baby. A locum tenens *must always be used as a replacement* who substitutes for one physician.

17. "LIMITED LICENSED PRACTITIONER (LLP)" means a practitioner whose licensure or certification permits, and the Hospital authorizes, the independent provision of patient care services without direction or supervision and within the scope of individually delineated clinical privileges. Limited licensed practitioners may qualify to become members of the Medical Staff or may qualify to become members of the Advanced Practice Provider Staff.

18. "MEDICAL EXECUTIVE COMMITTEE" means the committee of the Medical Staff that shall constitute the Board of Directors of the Medical Staff as described in these Bylaws.

19. "MEDICAL STAFF" means the organization of those Doctors of Medicine ("M.D."), Doctors of Osteopathic Medicine ("D.O."), Doctors of Podiatric Medicine ("D.P.M."), Doctors of Dental Surgery ("D.D.S.") or Clinical Psychologists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

20. "MEDICAL STAFF YEAR" means the period from October 1 to September 30.

21. "MEMBER", unless otherwise expressly limited, means any M.D., D.O., D.P.M., D.D.S or Clinical Psychologist holding a current license to practice within the scope of their licensure who is a member of the Medical Staff.

22. "MONTHLY", when referring to meetings, means at least ten (10) times per year.

23. "ONGOING PROFESSIONAL PRACTICE EVALUATION" (OPPE) means the routine monitoring and evaluation of current competency for current medical staff. These activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment. The Code of Conduct policy addresses the process by which professional interactions and behavior of the medical staff are addressed. Reportable events and actions will be submitted and aggregated as part of the OPPE monitoring and evaluation of competency.

24. "ORGANIZED MEDICAL STAFF" means the governance structure of the Medical Staff, including these Medical Staff Bylaws, rules and regulations, and policy and procedure to which the Medical Staff is subject. This structure is approved by the Board of Directors.

25. "PATIENT CONTACT" means a documented admission, procedure, rounding or consultation. For the specialties of Diagnostic Imaging and Pathology, a diagnostic interpretation shall be considered a patient contact.

26. "PERFORMANCE IMPROVEMENT" means the continuous study and adaptation of the Hospital and Medical Staff functions and processes to increase the probability of achieving desired outcomes and to better meet the needs and expectations of individuals and other users of services.

27. "PHYSICIAN" means a doctor of medicine or osteopathy, a doctor of dental surgery or of dental medicine, a doctor of podiatric medicine, a doctor of optometry or, a clinical psychologist who is legally authorized to practice by the State of California within the scope of their license.

28. "PRACTITIONER" means those individuals who are members of either the Medical Staff or Advanced Practice Provider Staff of Salinas Valley Health Medical Center.

29. “RESPONSIVE ACTION” means an action taken by the Medical Executive Committee as a result of investigation including, but not limited to, corrective actions which may create a right to a hearing pursuant to the terms of these Bylaws.

30. “TELEMEDICINE” is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications.

31. “VOTE” means the casting of a ballot by either an Active Status Medical Staff Member or another individual granted voting rights via Medical Staff processes.

32. “LIP” means licensed independent practitioner.

33. “HOUSE STAFF” means students, residents and fellows who are associated with an Accreditation Council for Graduate Medical Education (ACGME) accredited post-graduate medical education program approved by SVH Board of Directors.

ARTICLE I
NAME, PURPOSE AND RESPONSIBILITIES

1.1 NAME

The name of the organization shall be the "MEDICAL STAFF OF SALINAS VALLEY HEALTH MEDICAL CENTER."

1.2 PURPOSE AND RESPONSIBILITIES

The Medical Staff's purpose and responsibilities are:

1.2.1 To assure that all patients admitted or treated in any of the Hospital services receive care at a uniform level of quality and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances;

1.2.2 To provide for a uniform level of professional performance that is consistent with generally accepted standards attainable within the Hospital's means and circumstances;

1.2.3 To organize and support professional education and community health education and support services;

1.2.4 To initiate and maintain rules and regulations and policy and procedure for the Medical Staff to carry out its responsibilities for the professional work performed in the Hospital;

1.2.5 To provide a means for the Medical Staff, Board of Directors and Administration to discuss issues of mutual concern;

1.2.6 To provide for accountability of the Medical Staff to the Board of Directors;

1.2.7 To establish and enforce, subject to the Board of Directors approval, professional standards related to the delivery of health care within the Hospital;

1.2.8 To establish and amend from time to time as needed Medical Staff Bylaws, rules and policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws;

1.2.9 To select and remove Medical Staff Officers;

1.2.10 To assess Medical Staff dues and utilize Medical Staff dues as appropriate for the purposes of the Medical Staff; and

1.2.11 To exercise its rights and responsibilities in a manner that does not jeopardize the Hospital's license, Medicare and Medi-Cal provider status, accreditation, or status as a California district Hospital.

ARTICLE II
MEDICAL STAFF MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff and/or clinical privileges may be extended to and maintained by only those professionally competent M.D.s, D.O.s, D.P.M.s, D.D.S.s, D.M.D.s or Clinical Psychologists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the rules and regulations. A practitioner, including one who has a contract with the Hospital to provide medical-administrative services, may admit or provide services to patients in the Hospital only if the practitioner is a member of the Medical Staff and has been granted privileges in accordance with these Bylaws and the rules.

Appointment to the Medical Staff shall permit the exercise of only those specifically delineated clinical privileges that are established by the Medical Staff and granted by the Board of Directors in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2.1 GENERAL QUALIFICATIONS

Only those M.D.s, D.O.s, D.P.M.s, D.D.S.s or Clinical Psychologists who:

a. Document their current licensure, adequate experience, education and training, current professional competence in the exercise of the privileges which they seek, good judgment, and current adequate physical and mental health status relative to the privileges requested, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally competent and ethically sound and that patients treated by them can reasonably expect to receive quality medical care;

b. Except for the Emeritus Staff category, meet the criteria for membership in at least one department of the Medical Staff and hold clinical privileges in at least one department of the Medical Staff although exceptions to this requirement may be made by the Medical Executive Committee for good cause;

c. Are determined:

   (1) To adhere to the ethics of their respective professions;

   (2) To be able to work cooperatively with others so as not to adversely affect patient care;

   (3) To keep as confidential, as required by law, all information or records received through the physician-patient relationship;

   (4) To be willing to participate in and properly discharge those responsibilities determined by the Medical Staff; and

   (5) To be willing to keep confidential and discuss only within established Medical Staff Committees the proceedings of such Medical Staff activities related to Performance Improvement, Quality Assessment Focused Review of Practitioner Performance and Peer Review activities.

d. Maintain in force professional liability insurance covering the exercise of all requested privileges, in not less than amounts that may be determined from time to time upon recommendation of the Medical Executive Committee and approval by the Board. Professional liability insurance must be held with an insurance carrier approved by the State Insurance Commissioner to conduct business in the State of California, or the practitioner may demonstrate membership in a physician's cooperative with the same minimum amounts of coverage as determined by the Medical Executive Committee and the Board of Directors.

   (1) Each member of the Medical Staff, or applicant thereto, shall certify in writing at the time of application, and provide ongoing documentation as required by the Medical Executive Committee, that they possess professional liability insurance in the amount determined appropriate by the Medical Staff and Board of Directors, including either prior acts (nose coverage) or an extended reporting enhancement (tail coverage). Such certification shall include the name of the carrier, the period of coverage, assurance that the coverage can be reduced or canceled only after notification to the Hospital and, if requested by the Medical Executive Committee, a certified or photo copy of the face sheet of their policy evidencing such coverage, or the entire policy if requested;

   (2) Each member or applicant shall promptly report in writing to the Medical Executive Committee any reductions, restrictions, cancellation or termination of the required professional liability coverage, or change in insurance carrier; and

   (3) Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic relinquishment of a member's Medical Staff membership and clinical privileges and shall result in a written warning of delinquency to the member. If the member does not provide evidence of required professional liability insurance to the Medical Executive Committee within thirty (30) days after the date of the warning of delinquency, the member's Medical Staff membership and clinical privileges shall be automatically relinquished. Automatic relinquishment of Medical Staff membership and privileges pursuant to this section is not grounds for a fair hearing or appeal and the procedures set forth in Article VII of these Bylaws shall not apply.

e. Are eligible to participate in federal health care programs. The practitioner may not currently be an ineligible person and shall not become an ineligible person during any term of membership.

f. Have never been convicted of, or entered a plea of guilty or no contest to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence or any felony.

g. Document adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that they are sufficiently healthy and professionally competent and ethically sound so that patients can reasonably expect to receive the generally recognized professional level of quality and safety of care for this community. Without limiting the foregoing, with respect to communicable diseases, practitioners are expected to know their own health status, to take such precautionary measures as may be warranted under the circumstances to protect patients and others present in the Hospital, and to comply with all reasonable precautions established by Hospital and/or Medical Staff policy respecting safe provision of care and services in the Hospital. Individuals must be able to document compliance with immunization and health screening requirements (e.g., TB testing, mandatory vaccines and infectious agent exposures).

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2.2.2 PARTICULAR QUALIFICATIONS

a. Physicians. An applicant for physician membership on the Medical Staff, except for the Emeritus Staff, must hold an M.D., D.O., D.P.M, D.D.S. or D.M.D. degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the State of California. For the purpose of this section "or their equivalent" shall mean any degree (i.e., foreign) recognized by the State of California.

b. Clinical Psychologists. A Clinical Psychology applicant for membership on the Medical Staff, except for the Emeritus Staff, must hold a Ph.D. or equivalent degree and a valid and unsuspended certificate to practice clinical psychology issued by the State of California.

2.2-3 WAIVER OF QUALIFICATIONS

Insofar as is consistent with applicable laws, the Board of Directors has the discretion to deem a practitioner to have satisfied a qualification, after consulting with the Medical Executive Committee, if it determines that the practitioner has demonstrated they have substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the Hospital. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. A practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff or to exercise any clinical privilege merely because that person holds a certain degree, is licensed to practice in California or any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at any health care facility.

2.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of age, sex (to include discrimination based on "gender identity" and "sex stereotyping), race, creed, color, sexual orientation, handicap unrelated to the ability to fulfill patient care and required staff obligations, national origin or on the basis of any criteria unrelated to the delivery of quality patient care in the Hospital, to professional qualifications, to the Hospital's purposes, needs, and capabilities or to community need.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

2.5.1 The ongoing responsibilities of each member of the Medical Staff include:

a. Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital;

b. Abiding by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital administrative policies,

c. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

d. Preparing and completing in a timely fashion, medical records for all the patients to whom the member provides care in the Hospital;

e. Utilizing the Hospital electronic medical record pursuant to Medical Staff Rules & Regulations and policies.

f. Abiding by the lawful ethical principles of professional and specialty associations, as applicable;

g. Participating in any Medical Staff approved educational programs for medical students, interns, resident physicians and resident dentists, although members who choose not to participate in professional graduate education programs shall not be subject to denial or limitation of privileges for that reason alone;

h. Actively participating in and regularly cooperating with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, performance improvement, focused review of practitioner performance, utilization management, quality evaluation, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time. This shall include mandatory participation, if requested by Medical Staff leadership, in an investigation and/or Root Cause Analysis (RCA) involving the individual Medical Staff member's patient;

i. Working cooperatively with members, nurses, Hospital administration and others so as not to adversely affect patient care;

j. Providing continuing coverage for their patients and making appropriate arrangements for coverage when not available. This includes coverage for the member's patients who may come to the Hospital for emergency services;

k. Refusing to engage in fee splitting or in improper inducements for patient referral;

l. Participating in continuing education programs as determined by the Medical Staff;

m. Communicating with appropriate department Officers and/or Medical Staff Officers when they obtain credible information that a fellow Medical Staff member or Advanced Practice Provider may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperating as reasonably necessary toward the appropriate resolution of any such matter;

n. Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;

o. Responding in a timely manner to all notices or requests made by a peer review body of the Medical Staff. Such requests may include requests for information, clarification of information or a request for personal appearance by the practitioner at a specific meeting;

p. Participating in any emergency services "on call" panel or consultation panel as may be required by the Medical Executive Committee; and

q. Participating in patient and family education activities, as determined by the department, Medical Staff Rules, or the Medical Executive Committee.

r. Notifying the Medical Staff Services Department in writing (no later than fourteen (14) days) following any action taken regarding the member's license, DEA registration, privileges at other facilities, changes in liability insurance coverage, , changes in alternate coverage, office and/or home address, or any other action that could affect their Medical Staff and/or clinical privileges at the Hospital.

s. Acquire a patient's informed consent for all procedures and treatments identified in the Bylaws, Section 15.1-5, and abide by the procedures for obtaining such informed consent.

t. Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee. This shall include, but is not limited to, mandatory health or psychiatric evaluation and mandatory drug and/or alcohol testing, the results of which shall be reportable to the Medical Executive Committee.

u. The Medical Staff recognizes that electronic communication, when appropriately implemented, is the most efficient and convenient mechanism to expedite communication between the Medical Staff, Advanced Practice Providers and Hospital staff. To this end, it is a basic responsibility of all individuals with clinical privileges to utilize the electronic medical record, electronic call schedule and HIPAA-compliant communication platforms implemented by SVH. This includes the use of smart phones and other electronic devices.

v. Communicating with the appropriate Medical Staff leadership in a timely manner when there has been a significant change in their health status that may impact their ability to safely carry out their clinical privileges.

w. The burden of producing clinical, medical, and psychological information rests with any practitioner required to produce information as part of an authorized Medical Staff peer review activity.

x. Members of the Medical Staff and Advanced Practice Provider Staff are expected to actively and cooperatively participate in a variety of peer review, Ongoing Practitioner Performance Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) activities to measure, assess, and improve performance of their peers in the Hospital. These activities are outlined in detail in the General Medical Staff Rules and Regulations.

2.5.2 Each practitioner who is not a member of the Medical Staff but who exercises any clinical privilege shall be obligated to meet each of the responsibilities set forth in Section 2.5.1 above and other provisions of Article II.

2.6 BEHAVIOR

Members of the Medical Staff and others holding clinical privileges shall adhere to the Medical Staff Code of Conduct Policy and demonstrate a willingness and capability based on current behavior and evidence of performance:

2.6.1 To work with and relate to other staff members, members of other health disciplines, Hospital management and employees, visitors and the community in general in a cooperative, professional, non-disruptive manner that is essential for maintaining a Hospital environment appropriate to quality and efficient patient care; and

2.6.2 To discharge the basic obligations of Medical Staff membership and to participate equitably in the discharge of staff obligations appropriate to staff membership category.

Failure of a member to demonstrate behavior as described in Section 2.6.1 and 2.6.2 of this Section may result in action by the Medical Staff which may include, but is not limited to, disciplinary action as described in Article VII.

2.7 HARASSMENT PROHIBITED

2.7.1 HARASSMENT

a. Harassment of any kind by a Medical Staff member against any individual (i.e., against another Medical Staff member, Hospital employee, patient, vendor or visitor) on the basis of race, religion, color, national origin, ancestry, age, physical or mental disability, medical condition, marital status, sex, gender, or sexual orientation will not be tolerated.

b. "Harassment" is verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of race, religion, color, national origin, ancestry, age, physical or mental disability, medical condition, marital status, sex, gender, or sexual orientation, or that of their relatives, friends or associates, and that has the purpose or effect of (i) creating an intimidating, hostile or offensive work environment; (ii) unreasonably interfering with an individual's work performance; or (iii) otherwise adversely affecting an individual's employment opportunities.

c. Harassing conduct includes (i) epithets, slurs, negative stereotyping, or threatening, intimidating or hostile acts that relate to race, religion, color, national origin, ancestry, age, physical or mental disability, medical condition, marital status, sex, gender, or sexual orientation; and (ii) written or graphic material that denigrates or shows hostility or aversion toward an individual or group because of race, religion, color, national origin, ancestry, age, physical or mental disability, medical condition, marital status, sex, gender, or sexual orientation, and that is placed on walls, bulletin boards, or elsewhere on the Hospital's premises, or circulated in the work place.

2.7.2 SEXUAL HARASSMENT

a. "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault or interference with movement or work), and visual harassment (such as the display or derogatory cartoons, drawings, or posters).

b. Sexual harassment includes unwelcome advances, requests for sexual favors or any other verbal, visual or physical conduct of a sexual nature when submission to, or rejection of, this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, benefits or other aspects of employment training and education or training and educational opportunities, medical treatment, referrals, purchases, etc. It also includes such conduct when the conduct interferes with the individual's employment or education/training, or creates an intimidating, hostile or offensive environment for work, education or treatment.

2.7.3 ALLEGATIONS OF HARASSMENT

All allegations of harassment shall be investigated as per the Medical Staff Code of Conduct Policy and, if confirmed, will result in appropriate responsive action by the Medical Executive Committee including, but not limited to, reprimands, suspension, restriction or revocation of all or any part of Medical Staff membership and/or clinical privileges.

2.8 ADVANCED PRACTICE PROVIDER STAFF

2.8.1 The Advanced Practice Provider Staff shall include those licensed or certified practitioners who do not qualify for membership on the Medical Staff but provide clinical services to Hospital patients. Allied health professionals who apply to practice in the Hospital cannot apply for medical staff appointment and are not entitled to the rights, privileges or prerogatives of medical staff appointment.

2.8.2 The qualifications, responsibilities, prerogatives, mechanisms for termination of privileges or practice prerogatives, hearing rights and appeals process, and other issues germane to Advanced Practice Providers are defined in the Advanced Practice Provider Rules and Regulations.

2.8.3 Nothing in these Medical Staff Bylaws or the Advanced Practice Provider Rules and Regulations shall be interpreted to entitle an Advanced Practice Provider to the provisions of Articles VI and VII of these Bylaws, unless required under California Business and Professions code sections 805 and 809.

ARTICLE III
CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Active Community, Consulting, Provisional, Emeritus, and Temporary. At the time of appointment and each reappointment, the member's staff category shall be determined.

3.2 ACTIVE STAFF

3.2.1 QUALIFICATIONS

The Active Staff shall consist of members who:

a. Meet the general qualifications for membership set forth in Section 2.2;

b. Have offices and residences that, in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide appropriate continuity of quality care; and

c. Have satisfactorily completed their designated term in the Provisional Staff category as set forth in Section 3.5.

Members in good standing on the Active Staff, over age sixty-two (62) and with ten (10) years on the Active Staff, or Medical Staff members with twenty-five (25) years of service to Hospital, may apply for **Senior Active** staff status.

3.2.2 PREROGATIVES

Except as otherwise provided, an Active Staff member may:

a. Apply for admitting and attending privileges and exercise other clinical privileges which are granted to the member pursuant to Article V;

b. Attend and vote on matters within the scope of the member's licensure and privilege which are presented at general and special meetings of the Medical Staff or any meeting of any service, department, or committee of which they are a member;

c. Hold any staff or department office for which the member is qualified; and

d. Serve as a voting member on any committee to which they are duly appointed or elected.

Members of the **Senior Active** staff shall have all privileges and obligations of Active Staff membership, with the exception of obligatory committee assignment, meeting attendance, and emergency call requirements.

Members who qualify for Senior Active staff may request removal from the emergency call schedule and other rotational obligations. The Department Chair will recommend to the Medical Executive Committee whether to grant such a request based on patient care need and the effect on others who

serve on the call roster for that specialty. The Medical Executive Committee's recommendation will be subject to final action by the Board. Denial of change to Senior Active staff is not subject to hearing rights, however, the applicant may appeal the decision to the Medical Executive Committee in writing.

Voluntary removal from the emergency call panel under the above circumstances shall be for a minimum of one year after which the Senior Active staff member shall have to reapply to participate in the emergency call schedule. Recommendation for reinstatement to the call schedule shall come from the Department Chair and must be approved by the Medical Executive Committee.

Senior Active candidates may request limited participation in the unassigned emergency call schedule. Such requests must be in writing and approved by the Department Chair and Medical Executive Committee. Once approved, inclusion in the call schedule will not be guaranteed and will be based on need as determined by the author of the call schedule.

This amendment shall be applicable to Senior Active requests for removal from the call schedule after March 28, 2013.

3.2.3 RELINQUISHMENT OF ACTIVE STAFF STATUS

The failure of an Active Staff member to meet the objective requirements of Section 3.2.1(a-c) shall be deemed a voluntary relinquishment of Active Staff status and the member shall automatically be transferred to the appropriate staff category, if any, for which the member is eligible. In the event that the member is not eligible for any other category, their Medical Staff membership shall automatically terminate at the end of their current term of appointment. No such transfer or termination shall be subject to the provisions of Article VII.

3.3 ACTIVE COMMUNITY STAFF

3.3.1 QUALIFICATIONS

The Active Community Staff shall consist of members who:

a. Meet the general qualifications for membership set forth in Section 3.2.1(a) and (b);

b. Have satisfactorily completed their designated term in the Provisional Staff category as set forth in Section 3.5 (applies to applicants for inpatient privileges only); and

c. Are non-voting members of the Medical Staff.

3.3.2 PREROGATIVES

Except as otherwise provided, an Active Community Staff member may:

a. Apply for admitting and attending privileges and exercise those clinical privileges which are granted pursuant to Article V;

b. Attend, in a nonvoting capacity, general and special meetings of the Medical Staff and open committee meetings and educational programs of any department of which they are a member;

c. Be appointed as voting or nonvoting members on any Medical Staff committee and shall be eligible to hold any Medical Staff or department office upon Medical Executive Committee Approval;

d. Clinical Privileges for Active Community Status members shall be limited to Active Community Core Privileges; and

e. Do not participate in Unassigned Emergency Room Call.

3.3.3 RELINQUISHMENT OF ACTIVE COMMUNITY STAFF STATUS

The failure of an Active Community Staff member to meet the objective requirements of Section 3.3.1 (a-c) shall be deemed a voluntarily relinquishment of Active Community Staff status and the member shall automatically be transferred to the appropriate staff category, if any, for which the member is eligible. In the event the member is not eligible for any other category, their Medical Staff membership shall automatically terminate at the end of their current term of appointment, unless otherwise specified in these Bylaws. No such transfer or termination shall be subject to the provisions of Article VII.

3.4 CONSULTING STAFF

3.4.1 QUALIFICATIONS

The Consulting Staff shall consist of physicians who are of outstanding reputation who excel in a given field and preferably have a medical school or recognized teaching institution faculty appointment.

3.4.2 PREROGATIVES

Except as otherwise provided, a Consulting Medical Staff member:

a. Shall neither admit nor provide primary care to patients as an attending practitioner but may otherwise exercise such clinical privileges as are granted pursuant to Article V;

b. May attend, in a nonvoting capacity, general and special meetings of the Medical Staff and open committee meetings and educational programs of any department of which they are a member; and

c. May be appointed as voting or nonvoting members on any Medical Staff committee.

3.4.3 RELINQUISHMENT OF CONSULTING STAFF STATUS

Consulting Staff members who do not meet the objective requirements of Section 3.4.1shall be deemed to have voluntarily relinquished Consulting Staff status and shall be automatically transferred to the appropriate staff category, if any, for which the member is eligible. In the event the member is not eligible for any other category, their Medical Staff membership shall automatically terminate at the end of their current term of appointment, unless otherwise specified in these Bylaws. No such transfer or termination shall be subject to the provisions of Article VII.

3.5 PROVISIONAL STAFF

3.5.1 QUALIFICATIONS

All applications to the Medical Staff requesting initial clinical privileges, except those requesting temporary privileges, shall be appointed to the Provisional Staff. The Provisional Staff shall consist of members who:

a. Meet the general Medical Staff membership qualifications set forth in Section 2.2;

b. Meet the requirements set forth in either Section 3.2.1(b), Section 3.3.1(c) or Section 3.4.1; and

c. Meet the requirements of Section 3.2.1(b) if they are applying for admitting or attending privileges.

3.5.2 PREROGATIVES

Except as otherwise provided, a Provisional Staff member may:

a. Exercise such clinical privileges as are granted pursuant to Article V;

b. Attend, in a nonvoting capacity, general and special meetings of the Medical Staff, committee meetings and educational programs of any department of which they are a member; and

c. May serve on committees and may be granted voting rights on specific committees by the Medical Executive Committee, but shall not be eligible to hold any Medical Staff or department office.

3.5.3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each Provisional Staff member shall undergo a period of observation, evaluation and proctoring by designated proctors as may be established by the Medical Executive Committee and as described the Medical Staff Focused Professional Practice Evaluation Policy. The proctor shall evaluate the member's proficiency and competency in the exercise of clinical privileges initially granted and overall eligibility for continued staff membership and advancement within staff categories. This policy shall follow a process established by the Medical Executive Committee.

3.5.4 CONCLUSION OF PROVISIONAL STAFF STATUS

All new members of the Medical Staff requesting clinical privileges, except those requesting temporary privileges, will initially be appointed to the Provisional Staff and shall remain in the Provisional Staff category for a period of one (1) year but no longer unless the provisional status is extended for an additional period of up to one (1) year by the Medical Executive Committee for good cause. Recommendations for advancement from Provisional Staff shall be made in accordance with the Medical Staff Focused Professional Practice Evaluation Policy.

3.6 EMERITUS STAFF

3.6.1 QUALIFICATIONS

The Emeritus Staff shall consist of M.D.s, D.O.s, D.P.M.s, D.D.S.'s or Clinical Psychologists who have been members of the Active Medical Staff for no less than ten (10) years, do not actively practice at the Hospital, and continue to adhere to appropriate professional and ethical standards.

3.6.2 PREROGATIVES

The Emeritus Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or to vote or hold office, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend general and special Medical Staff meetings, open committee meetings and educational programs. Emeritus Staff members may change categories of membership only through the application and credentialing process as established in these Bylaws.

3.7 TEMPORARY STAFF

3.7.1 QUALIFICATIONS

The Temporary Staff shall consist of M.D.s, D.O.s, D.P.M.s, D.D.S.s or Clinical Psychologists who either:

a. Do not actively practice at the Hospital but are important resource individuals for Medical Staff quality assessment and peer review. Such persons shall be qualified to perform the quality assessment and peer review functions for which they are made temporary members of the staff; or

b. Hold temporary privileges pursuant to Article V Section 5.5.

3.7.2 PREROGATIVES

Except as otherwise provided, Temporary Staff members shall be afforded the following prerogatives:

a. Temporary Staff members appointed to engage in specific quality assessment and peer review activities shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assessment and peer review functions. They shall have no privileges to perform clinical services in the Hospital. They may not admit patients to the Hospital or hold office in the Medical Staff organization. They may attend other Medical Staff meetings only upon invitation.

b. Temporary Medical Staff members who hold temporary privileges pursuant to Article V, Section 5.5 shall perform such clinical services as are defined pursuant to the practitioner's delineated clinical privileges. Such practitioners may not vote or hold office in the Medical Staff organization. They may serve on designated committees at the discretion of the Medical Executive Committee. They may attend other Medical Staff meetings only upon invitation.

3.7.3 APPOINTMENT

Recommendation for appointment to the Temporary Medical Staff for the purpose of quality assessment and peer review shall be made by the Chief of Staff or designee and approved by the Chief Executive Officer or designee acting on behalf of the Board of Directors. Appointment to the Temporary Medical Staff shall occur automatically with the granting of temporary privileges pursuant to Article V, Section 5.5.

3.7.4 TERM

Membership on the Temporary Medical Staff shall be time limited and the exact duration of membership shall be specified at the time of appointment to the Temporary Medical Staff. For practitioners holding temporary privileges pursuant to Article V, Section 5.5, the duration of Temporary Medical Staff membership shall coincide with the duration of temporary privileges.

3.8 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation and special conditions attached to a particular member, by other sections of these Bylaws, the Medical Staff Rules and Regulations, or the Medical Executive Committee.

3.9 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership, members shall only exercise those privileges and shall only have the right to vote on those matters within the scope of their licensure. In the event of a dispute over voting rights, the issue shall be determined by the Chair of the meeting, subject to final decision by the Medical Executive Committee.

3.10 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, or upon direction of the Board of Directors as set forth in Section 6.1.8, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

3.11 HOUSE STAFF

The House Staff shall consist of those graduates of approved medical or osteopathic schools who are participating a graduate training program that is formally approved by the Hospital as well as an official accrediting agency. House Staff include graduates of medical or osteopathic schools who meet eligibility requirements for State licensure and who are authorized by the State to perform medical services in hospitals.

3.11.1 SUPERVISION

All medical care, including the writing of orders provided by the House Staff, is under the supervision of a practitioner with appropriate clinical privileges.

3.11-2 STATUS AND PROCEDURAL RIGHTS

The members of the House Staff are not members of the Medical Staff, nor do they comprise an organized body. Nothing herein shall create any vested rights to any members of the House Staff to receive or maintain any clinical privileges. Anyone entitled to impose a summary suspension has the authority to summarily suspend a House Staff member. A House Staff member who has been suspended or terminated shall not be entitled to any of the provisions of Article VIII. Any corrective action taken against a licensed practitioner for a medical disciplinary cause or reason shall be reported to the appropriate licensing board as required by law.

3.11-3 APPOINTMENT AND TERMINATION OF HOUSE STAFF

Appointment and termination of House Staff shall be made in accordance with the rules of the residency program.

3.12 STUDENTS

Students shall be enrolled in appropriately accredited health professional school which grants M.D., D.O., or other health professional degrees and which have an affiliation agreement or other appropriate documentation on file with the Hospital. The Hospital shall maintain, for each current Student, a letter issued by the Dean of such Student's school stating that the Student is in good standing. Students shall complete all necessary paperwork prior to participating in any clinical training or patient care activities.

3.12-1 SUPERVISION

All medical care provided by Students is under the supervision of a practitioner with appropriate clinical privileges.

3.12-2 STATUS AND PROCEDURAL RIGHTS

Students are not members of the Medical Staff, nor do they comprise an organized body. Nothing herein shall create any vested rights to any Student to receive any clinical privilege, and Students are not entitled to any of the provisions of Article VIII of these Bylaws.

ARTICLE IV
APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL PROVISIONS AND APPLICATION OF ARTICLE

No person shall exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is otherwise granted privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment, applying for clinical privileges (or, in the case of members of the Emeritus Staff, by accepting an appointment to the category), the applicant acknowledges responsibility to review the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital administrative policies and agrees that throughout any period of membership they will comply with the responsibilities of Medical Staff membership and with the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital administrative policies as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws. For the purpose of this Article, the term "member" shall include Medical Staff and Advanced Practice Provider Staff members and applicants as applicable under the circumstances, unless otherwise stated.

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every individual specifically agrees that any significant misstatement in, or omission from, the application is grounds for the Hospital to stop processing the application.

The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the Medical Executive Committee. The Medical Executive Committee will recommend to the Board whether the application should be processed further.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing sufficient information of clinical and professional performance to permit an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, to resolve any reasonable doubts about these matters, and to satisfy any request for such information. The information required to be submitted may also include a complete history and physical examination that may include blood or other chemical analysis and/or a psychological examination as deemed appropriate by the Medical Executive Committee. Any such examination shall be at the applicant's expense and shall be performed by an M.D., D.O., D.P.M., D.D.S. or Clinical Psychologists approved by the Medical Executive Committee. The applicant's failure to produce any required information shall render the application incomplete and it shall not be acted upon. Failure of a practitioner to produce required information related to an authorized Medical Staff peer review, quality assessment, performance improvement, or credentialing activities in a timely manner shall result in automatic suspension of all clinical privileges until such time as the required information has been provided. An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete thirty (30) days after the individual has been notified of the information required shall be deemed to be withdrawn. An incomplete application will not be processed.

4.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws only after there has been a final recommendation from the Medical Executive Committee and decision by the Board of Directors.

4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments and reappointments to the Medical Staff and/or renewal of clinical privileges shall be for a period of up to two (2) years.

4.5 REQUEST FOR APPLICATION:

An individual requesting membership and clinical privileges at this Hospital shall be sent a letter that: (i) outlines the general qualifications for appointment and clinical privileges as set forth in these Bylaws; (ii) explains the review process; and (iii) outlines the general qualifications for clinical privileges.

Requests from individuals who demonstrate that they meet the threshold criteria for consideration for appointment to the Medical Staff and clinical privileges shall proceed to the application process. Requests that fail to meet the threshold criteria shall not be processed. The requestor shall be deemed not qualified to apply and shall be so notified.

4.6 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.6.1 MEDICAL STAFF APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

a. Each Medical Staff application shall be submitted via the Hospital credentialing software with all provisions completed, or accompanied by an explanation of why answers are unavailable, and electronically signed by the applicant. It is the applicant's obligation to assure that the information contained in the application is accurate and complete.

b. Each Medical Staff application shall include components to be completed by initial applicants for Medical Staff membership and/or privileges and by those individuals seeking reappointment to the Medical Staff and/or renewal or revision of clinical privileges.

c. A nonrefundable application fee, as determined by the Medical Executive Committee, must accompany the application.

e. Any significant misrepresentation or omission of information on the Medical Staff application or temporary privilege request form shall be grounds for immediate denial or automatic relinquishment of the applicant's Medical Staff membership and clinical privileges.

f. Each Medical Staff application shall be considered a confidential peer review document of the Medical Staff. As a peer review evaluation document and official record of the Medical Executive Committee, the Medical Staff application forms are afforded protection pursuant to California Evidence Code Section 1157. These forms shall require detailed information which shall include, but not be limited to, information concerning:

(1) Postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended and names of practitioners responsible for the applicant's performance;

(2) Specialty or subspecialty board certification, recertification and eligibility;

(3) The applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, special certifications, where appropriate and as specified in Medical Staff policy and continuing medical education information related to the clinical privileges requested by the applicant;

(4) The membership staff category the applicant wishes to apply for and the clinical privileges sought by the applicant;

(5) Health impairments, if any, affecting the applicant's ability in terms of skill, attitude or judgment to perform professional and Medical Staff duties fully and including information regarding the ability to perform all procedures and other privileges requested with or without reasonable accommodations, according to accepted standards of professional performance without posing a threat to patients;

(6) For initial applicants, peer references from individuals familiar with the applicant's professional competence and ethical character, who have had recent reasonable experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's present professional competence and character. These references may not be from individuals associated or about to be associated with the applicant in professional practice or personally related to the applicant. The names and addresses of at least three (3) peer references shall be required at initial appointment. At least one (1) of the three (3) references shall be from the same specialty area as the applicant when possible;

(7) The practitioner's professional liability insurance coverage for the clinical privileges sought to be exercised. This information shall include the name of the insurance company, the amount and classification of such coverage, and whether said insurance coverage covers the clinical privileges requested;

(8) The existence and circumstances of any professional liability complaint, claim or other cause of action that has been lodged against the practitioner, the substance of the allegations, the status or outcome of each such matter, including all unexpired notices of intent to sue, as well as any final judgments and/or settlements involving the practitioner, and any additional information the Credentials and Medical Executive Committees or the Board of Directors may deem appropriate;

(9) The existence and circumstances of any past or pending professional disciplinary action or investigation involving the practitioner including the status or outcome of each such matter;

(10) Any voluntary or involuntary termination or denial of Medical Staff membership or voluntary or involuntary limitation, suspension, subject to probationary or other conditions, restriction, withdrawal, reduction, relinquishment, or other loss of clinical privilege at any other Hospital or health care facility;

(11) Any prior or pending government agency or third party proceeding or litigation challenging or sanctioning the practitioner's admission, treatment, discharge, billing, collection, or utilization practices, including but not limited to Medicare and Medicaid fraud and abuse proceedings, convictions, and or settlements;

(12) Any prior or pending challenge to any licensure or registration, or the voluntary or involuntary relinquishment of any such licensure or registration and the status or outcome of each such matter;

(13) Information as to any current or pending sanctions affecting participation in any federal health care program or any action which might cause the practitioner to become an ineligible person, as well as any sanctions from a professional review organization;

(14) Information as to whether the applicant has ever been a defendant or subject to criminal conviction or whether any such action is pending;

(15) The names and complete addresses of each clinical department or service of any and all Hospitals or other health care institutions at which the applicant has worked, trained and/or practiced. If the number of Hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular Hospital, the Credentials and Medical Executive Committees and the Board of Directors may take into consideration such factors;

(16) A complete chronological listing of the applicant's professional and educational appointments, employment, or positions;

(17) Information on the citizenship or visa status of the applicant;

(18) The applicant's signature; and

(19) Any such other information as the Medical Executive Committee and Board of Directors may require.

(20) Authorization and Release to Obtain/Release Information:
By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the following conditions, whether or not appointment or clinical privileges are granted, throughout the term of any appointment or reappointment and as applicable to third party inquiries received following the conclusion of any appointment term.

(a) Release:
To the fullest extent permitted by law, the individual releases from any and all liability, the Hospital, any member of the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information:
The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on their qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. The individual also agrees to sign any necessary authorizations to permit a consumer reporting agency to conduct a criminal background check.

(c) Authorization to Release Information:
The individual also authorizes Hospital representatives to release information to other Hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate their professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter

4.6.2 EFFECT OF APPLICATION

In addition to the matters set forth in Sections 4.1 and 4.2, by applying for appointment to the Medical Staff each applicant:

a. Signifies willingness to appear for interviews in regard to the application;
b. Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
c. Consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
d. Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
e. Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
f. Consents to the disclosure to other Hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;
g. If a requirement then exists for Medical Staff dues or other fees, acknowledges responsibility for timely payment;
h. Pledges to provide continuous quality care for patients;
i. Pledges to maintain an ethical practice, including refraining from illegal inducements for patient

referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, and refraining from delegating patient care responsibility to non-qualified or inadequately
supervised practitioners;

j. Pledges to be bound by the Medical Staff Bylaws, Rules and Regulations, and Hospital policies;
k. Acknowledges that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, result in no further processing of the application. If appointment or reappointment has been granted prior to discovery of such misrepresentation, misstatement or omission, such discovery may result in automatic relinquishment of all clinical privileges and Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal; and;
l. Acknowledges that the hearing and appeal procedures set forth in this policy shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital.

4.6.3 DEPARTMENT AND CREDENTIALS COMMITTEE ACTION

a. Upon receipt of the completed Medical Staff application and payment of any applicable Medical Staff fees, the Medical Staff Services Department shall review and verify, using primary source verification, the information on the application and all supporting documentation. Verification of previous Hospital affiliations, with the exception of training programs, will be limited to the previous 4 years. After reviewing and verifying the application information, the Medical Staff Services Department shall forward the application and supporting documentation to the appropriate department Chair or their designee.

b. In Departments comprised of multiple specialties, the Chair may choose to delegate review of credentials to an appropriate designee. The designee must have Active Status with education, skills and training similar to the applicant.

b. The department Chair shall review the application and supporting documentation, and may conduct a personal interview with the applicant at their discretion. The Chair shall evaluate all matters deemed relevant to the recommendation, including information concerning the applicant's patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice, provision of services within the scope of privileges requested, the individual's clinical and/or technical skill as indicated by the results of quality assessment and performance improvement activities, and shall submit to the Credentials Committee Chair their recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached.

c. At its next regular meeting after receipt of the Department Chair's recommendation, the Credentials Committee shall consider the recommendation of the Department Chair and other relevant information. The Credentials Committee may request additional information and/or return the matter to the Department Chair for further review and evaluation. The Credentials Committee shall submit to the Medical Executive Committee a recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions attached to the appointment.

4.6.4 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting following recommendation by the Credentials Committee, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the Credentials Committee recommendation and any other relevant information. The Medical Executive Committee may defer action on the application, request additional information, return the matter to the Credentials Committee or Department Chair for further investigation, elect to interview the applicant, or make a recommendation regarding the appointment. The Medical Executive Committee shall forward to the Board of Directors a report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any conditions to be attached to the appointment, including but not limited to consultation, monitoring and/or proctoring requirements.

4.6.5 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

a. When the Medical Executive Committee recommends appointment and the granting of all requested privileges, the recommendation shall be promptly forwarded, together with any necessary supporting documentation, to the Board of Directors.

b. When the Medical Executive Committee recommends denial of appointment for reasons related to the applicant's professional competence or conduct, the Chief Executive Officer shall be promptly informed. The applicant shall be informed of the denial by the Chief of staff and notified regarding procedural rights provided in Article VII.

c. When the Medical Executive Committee recommends appointment, but recommends denial of one or more requested privileges based on the applicant's professional competence or conduct, the Chief Executive Officer shall be promptly informed. The applicant shall be so informed by the Chief of Staff and entitled to the procedural rights provided in Article VII with respect to the portion of the recommendation that is unfavorable. The remainder of the recommendation shall be transmitted to the Board of Directors for action.

d. When the Medical Executive Committee recommends denial of appointment or denial of a requested privilege for reasons other than the applicant's professional competence or conduct, the Board of Directors and the applicant shall be promptly informed by written notice, but the procedural rights provided in Article VII shall not apply.

4.6.6 ACTION ON THE APPLICATION

a. If the Medical Executive Committee recommendation is favorable to the applicant, the Board of Directors may:

   (1) Approve the appointment and clinical privileges as recommended by the Medical Executive Committee; or

   (2) Return the application to the Medical Executive Committee (or the Credentials Committee or clinical Department Chair) for clarification or further review and evaluation of any aspect of the application that is unclear or of concern to the Board of Directors; or

(3) Reject or modify the recommendation stating its reason for its disagreement with the Medical Executive Committee's recommendation. Before the Board of Directors rejects a favorable recommendation of the Medical Executive Committee, the Board of Directors should meet with the Credentials Committee Chair and Chief of Staff to discuss the application and the Board of Directors' preliminary decision. If, after that meeting, the Board's decision continues to be adverse, that decision will be forwarded to the Chief Executive Officer to notify the applicant of the recommendation and of the right to request a hearing before the Board of Directors takes final action.

b. If the Medical Executive Committee fails to render a recommendation within the required time, the Board of Directors may, after notice to the Medical Executive Committee, take action of its own initiative. If the Board of Directors proposes to deny appointment or any requested privilege, the Board of Directors shall take final action only after the applicant has exhausted or waived their procedural rights as established by Article VII.

c. If the Medical Executive Committee recommends denial of appointment or denial of any requested privilege, and

(1) The applicant waives procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Board of Directors for final action.

(2) The applicant requests a hearing following an adverse Medical Executive Committee recommendation or an adverse Board of Directors tentative final action, the Board of Directors shall take final action only after the applicant has exhausted or waived their procedural rights as established by Article VII.

d. The Board of Directors' final action shall give great weight to the recommendations of the Medical Executive Committee. The Board of Directors shall not act in an arbitrary or capricious manner, but shall act in keeping with its legal responsibilities to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital.

4.6.7 NOTICE OF FINAL DECISION

a. Notice of the final decision shall be given to the Chief Executive Officer, the Chief of Staff, the Medical Executive Committee, and the Chair of each department concerned. The applicant shall be notified electronically and by mail.

b. A decision and notice to appoint or reappoint shall include, if applicable (1) the staff category to which the applicant is appointed; (2) the department and to which they are assigned; (3) the clinical privileges granted; and (4) any conditions attached to the appointment.

4.6.8 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment, reappointment or termination of Medical Staff Membership based on professional competence or conduct shall not be eligible to reapply to the Medical Staff for a period of three (3) years. Any such reapplication shall be processed as an initial application, and the applicant shall have the burden to submit information as set forth in Section 4.2, including such information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.6.9 TIMELY PROCESSING OF APPLICATIONS

Applications for staff appointments shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following maximum time periods provide a guideline for routine processing of applications:

a. Evaluation, review and verification of application and all supporting documentation by the Medical Staff Services Department: thirty (30) days after receipt of a completed application and all necessary supporting documentation.

b. Review and recommendations by Department Chair: forty-five (45) days after receipt of all necessary documentation from the Medical Staff Services Department.

c. Review and recommendation by the Credentials Committee: thirty (30) days after receiving of all necessary documentation from the Department Chair.

d. Review and recommendation by the Medical Executive Committee: thirty (30) days after receipt of all necessary documents from the Credentials Committee.

e. Final action: one hundred and forty (140) days after receipt of a completed application and verification of all supporting documentation by the Medical Staff Services Department or fourteen (14) days after conclusion of all hearings.

4.7 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.7.1 APPLICATION

a. In the year of expiration, at least ninety (90) days prior to the expiration of Medical Staff membership and/or clinical privileges excluding temporary privileges, an application for reappointment, consistent with Section 4.5, shall be sent to the member. If an application for reappointment and a non-refundable fee, determined by the Medical Executive Committee, are not received at least ninety (60) days prior the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. The applicant shall then have fourteen (14) days to submit the completed application and fees, otherwise their membership and clinical privileges will lapse at the end of their current term without any hearing rights under Article VII. The member shall bear the burden of submitting additional information as set forth in Section 4.2.

b. A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time, except that such application may not be filed within one (1) year of the time a similar request has been denied, absent a showing of good cause.

4.7.2 PROCESSING OF REAPPOINTMENTS AND REQUESTS FOR MODIFICATION OF STAFF STATUS OR PRIVILEGES

The processing of an application for reappointment or modification of staff status or privileges is the same as that set forth in Sections 4.6.1 through 4.6.8.

4.7.3 STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits the first application for reappointment, and every two years thereafter, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Section 4.6. In each such instance, the member's eligibility for Medical Staff membership as set forth in Article II, and the member's eligibility for assignment to a category of the Medical Staff as set forth in Article III, shall be re-determined, considering the member's adherence to Medical Staff membership requirements, Medical Staff and Hospital policies, and where appropriate, comparisons to aggregate information about performance, judgment, and clinical or technical skills. Where applicable, the results of focused review of practitioner performance shall also be considered. If sufficient review data are unavailable, peer recommendations may be used instead; however, any member who has failed to engage in at least one (1) patient care activity at the Hospital for the preceding two (2) years shall be ineligible to apply for renewal of clinical privileges and the procedures set forth in Article VII shall not apply. Exceptions to this activity requirement may be made by the Medical Executive Committee for good cause.

4.7.4 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure to file a completed application for reappointment within forty-five (45) days of the expiration of the member's current appointment and/or provide required documentation may result in the automatic expiration of Medical Staff membership and/or privileges at the end of the current staff appointment, unless an exception is made for good cause as determined by the Medical Executive Committee and approved by the Board of Directors. In the event membership and/or privileges expire as set forth herein, the procedures set forth in Article VII shall not apply.

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5.05-5 LEAVE OF ABSENCE

LEAVE STATUS

(a) Request. An individual appointed to the Medical Staff or granted clinical privileges may request a leave of absence by submitting a written request to the relevant department chief, through the Medical Staff Services Department. Whenever possible, members and privilege holders are expected to submit this request at least 30 days prior to the anticipated start of the leave in order to permit the individual to make adequate coverage arrangements necessary for patient care and assure adequate coverage of any administrative activities. The request must state the beginning and ending dates of the leave and the reasons for the leave.

(b) Approval. The Chief of Staff will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the Chief of Staff will consult with the relevant department chief. The granting of a leave of absence may be conditioned upon the individual's completion of all medical records. Leaves of absence are matters of courtesy, not of right, and where a request for leave is not

granted, the determination shall be final, with no right to a hearing or appeal under Article VIII.

(c) Privileges. During the leave of absence, the individual shall not exercise any clinical privileges, but may continue to access the electronic medical record as appropriate to complete medical records and/or respond to peer review inquiries. In addition, the individual will be excused from certain Medical Staff responsibilities (e.g., meeting attendance, committee service, and any applicable emergency service call obligations) during this period.

(d) Duration. Except for military leave of absence, a leave of absence may not exceed two (2) years. A leave of absence exceeding two years will be deemed a voluntary resignation from the Medical Staff and will result in automatic termination of membership, privileges and prerogatives. A member or privilege holder whose membership or privileges are automatically terminated is not be entitled to the procedural rights provided in Article VIII, unless required by law.

(e) Expiration of Term of Appointment. If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, otherwise appointment and clinical privileges will lapse at the end of the current appointment period.

MEDICAL LEAVE OF ABSENCE

Except for parental leaves, members of the Medical Staff and privilege holders must report to the Medical Staff Services Department any time if (a) they are away from Medical Staff and/or patient care responsibilities for longer than 30 days; and (b) the reason for such absence is related to their physical or mental health or their ability to care for patients safely and competently ("Medical Leave"). Upon receipt of credible information that these criteria are met (a and b above), the Chief of Staff may invoke a medical leave of absence without a request from the Medical Staff member or privilege holder.

MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Chief of Staff. Military Leaves may exceed two (2) years. Reactivation of membership and clinical privileges previously held shall be granted notwithstanding the provisions of Sections 5.05-5 (b)-(e) and 5.05-8(a), but may be granted subject to monitoring and/or FPPE as determined by the applicable Department.

REINSTATEMENT

(a) Request. Individuals seeking reinstatement from a leave of absence must submit a written request at least 30 days before the end of the leave, accompanied by a summary of their professional activities during the leave. Requests for reinstatement will be reviewed by the relevant department chair and the Chief of Staff and these individuals may request additional information and/or documentation relevant to the request for reinstatement. If these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the hospital. If either individual reviewing the request has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the Credentials Committee and the Medical Executive Committee for review and recommendation, and the recommendation forwarded to the Board for action. If a member's request for reinstatement is not granted for reasons related to clinical

competence or professional conduct, the individual will be entitled to procedural rights under Article VIII. An AHP whose request for reinstatement is not granted for reasons related to clinical competence or professional conduct will be entitled to the procedural rights set forth in Section.

(b) Medical Clearance. If the leave of absence was for health reasons (except for parental leave), the request for reinstatement must be accompanied by a report from the treating physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. The Department Chief (or designee) in consultation with the Chief of Staff (or designee) shall determine the sufficiency of the report and may request additional information. If additional information is needed, the Medical Staff member or privilege holder must sign authorizations to enable the release of sufficient information to determine whether the individual is able to safely provide care to patients.

5.05-9 FAILURE TO REQUEST REINSTATEMENT

Failure, to timely request reinstatement will be deemed a voluntary resignation from the Medical Staff and will result in automatic termination of membership, privileges and prerogatives at the end of the approved leave. A member whose membership is automatically terminated will not be entitled to the procedural rights provided in Article VIII, unless required by law.

4.9 NOTIFICATION AND UPDATE TO THE MEDICAL STAFF

Each applicant agrees to notify the Medical Staff promptly and no later than fourteen (14) calendar days from the occurrence of any event representing a change or modification of information required as a condition of appointment and/or reappointment as described in Article IV. Such information includes but is not limited to:

4.9.1 Receipt of written notice of any adverse action by the Medical Board of California (or other applicable licensing board) taken or pending including but not limited to an accusation filed, temporary restraining order, or imposition of any interim suspension, probation, or limitations affecting license to practice medicine or the practitioner's designated profession.

4.9.2 Any action taken by any health care organization which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank.

4.9.3 The denial, revocation, suspension, reduction, limitation on renewal, or voluntary relinquishment by resignation of Medical Staff membership or clinical privileges at any health care organization.

4.9.4 Any material reduction in professional liability coverage including changes in the scope of coverage.

4.9.6 Conviction of any crime excluding minor traffic violations.

4.9.7 Receipt of any proposed or actual exclusion or adverse action under Medicare or Medicaid programs or any other federally funded or state health care programs including but not limited to fraud and abuse proceedings or convictions.

4.9.8 Imposition of a performance improvement plan or undertaking of a formal investigation by any health care organization.

4.9.9 Any change in practice including but not limited to practice location and alternate coverage.

ARTICLE V
CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

A practitioner shall be entitled to exercise only those clinical privileges or practice prerogatives specifically granted. Said privileges or practice prerogatives must be Hospital and setting specific and within the scope of the person's license, certificate or other legal credential authorizing practice in this State. Clinical privileges and practice prerogatives shall be exercised pursuant to these Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policy, and subject to the authority of the Department Chair, the Medical Executive Committee, and the Board of Directors.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2.1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for specific clinical privileges. Limited licensed practitioners who seek to exercise independent clinical privileges must specifically delineate the privileges desired.

5.2.2 BASIS FOR PRIVILEGE DETERMINATIONS

a. Not all clinical privileges are exercised at this Hospital (and not all Hospital privileges may be exercised in all settings of the Hospital). Requests for privileges not exercised at this Hospital may be denied solely on that ground. Any such denial shall not be subject to the provisions of Article VII. Privileges that are specified for certain Hospital settings may only be exercised in those specific settings.

b. Requests for clinical privileges shall be evaluated on the basis of the member's licensure, education, training, experience, demonstrated professional competence and judgment, clinical performance (as confirmed by peers knowledgeable of the applicant's professional performance), health status, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

c. The burden of providing sufficient information to evaluate a request for privileges rests with the applicant. The provisions of Section 4.2 apply to requests for privileges.

d. The decision to grant or deny a privilege and/or to renew an existing privilege is an objective evidence-based process involving review of physician specific information pertaining to

patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and evidence of systems based practice.

5.2.3 PRACTITIONERS IN DEPARTMENTS SUBJECT TO EXCLUSIVE CONTRACTS

In order to exercise clinical privileges in any service or department that is subject to an exclusive contract with the District, a practitioner must be a member of the Medical Staff (with the exception of Advanced Practice Providers and physicians working in a locums capacity for the contracted entity), hold the applicable clinical privileges, and be an employee, partner, contractor, or associate (hereinafter "affiliate") of the group, individual, or entity that holds the exclusive contract (hereinafter "contracted entity"). Upon (1) the departure of the affiliate from the contracted entity, (2) notice from the contracted entity that a practitioner will no longer provide services at the District, or (3) the termination of the exclusive contract with the District, whichever occurs first, when all of the affiliate's clinical privileges are encompassed by the exclusive contract, the affiliate shall be deemed to have voluntarily resigned from the Medical Staff and to have voluntarily relinquished their clinical privileges, except when an affiliate qualifies for Honorary Staff under Section ___ of the Bylaws and the Medical Executive Committee, in its discretion, approves a transfer to that category. Such a resignation and relinquishment shall not entitle the practitioner to the procedural rights described in Article VII of the Bylaws. To the extent the practitioner holds clinical privileges beyond those encompassed by the exclusive contract, their departure from the contracted entity or the termination of the exclusive contract will not result in the practitioner's voluntary resignation from the Medical Staff and the practitioner's remaining clinical privileges will remain intact.

5.3 PROCTORING

The FPPE (Focused Professional Practice Evaluation) Proctoring process is outlined in policy contained in the General Rules and Regulations of the Medical Staff.

5.4 LIMITATIONS ON PRIVILEGES OR PRACTICE PREROGATIVES OF DENTISTS AND PODIATRISTS

5.4.1 GENERAL PROVISIONS APPLYING TO DENTISTS

a. Admitting and other clinical privileges of dentists may not exceed the scope of their licensure.

b. The scope and extent of surgical procedures that a dentist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

c. Surgical procedures performed by dentists shall be under the overall supervision of the Chair of the Department of Surgery. A medical history and physical examination of the patient shall be performed and recorded by an M.D. or D.O. who holds an appointment to the Medical Staff before dental surgery may be performed. A designated M.D. or D.O. shall be responsible for the medical care of the patient throughout the period of Hospitalization.

d. Oral/Maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Medical Staff and Board of Directors privileging process. Oral/Maxillofacial surgeon shall mean licensed

dentists who have successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.

e. The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Medical Staff rules and regulations, and in compliance with the Hospital and Medical Staff Bylaws.

5.4.2 GENERAL PROVISIONS APPLYING TO PODIATRISTS

a. Admitting and other clinical privileges of podiatrists may not exceed the scope of their licensure.

b. The scope and extent of podiatric procedures that a podiatrist may perform in this Hospital shall be delineated and recommended in the same manner as other clinical privileges and in accordance with the policies governing such practitioners as may be adopted by the Medical Executive Committee and Board of Directors from time to time.

c. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chair of the Department of Surgery. Podiatrists who admit patients may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Medical Staff and Board of Directors privileging process.

d. The podiatrist shall be responsible for the podiatric care of the patient, including the history and physical examination as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license, consistent with the Medical Staff rules and regulations, and in compliance with Hospital and Medical Staff Bylaws.

5.4.3 CARE DISPUTES BETWEEN PHYSICIANS AND A DENTIST OR PODIATRIST

The Department Chair must promptly resolve any dispute between a dentist or podiatrist and a physician member regarding proposed treatment.

5.5 TEMPORARY CLINICAL PRIVILEGES

5.5.1 REQUIREMENT OF NEED AND DEFINITION OF CIRCUMSTANCES

a. Temporary privileges may only be granted on a case by case basis when:

(1) There is need to fulfill an important patient care, treatment, or service that mandates an immediate authorization to practice for a limited period of time; or

(2) When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board of Directors.

b. Temporary privileges may be granted in the following circumstances:

(1) Care of a Specific Patient: Temporary privileges may be granted for a specified period not to exceed sixty (60) consecutive days to M.D.s, D.O.s, D.P.M.s, D.D.S.'s or

Clinical Psychologists for the care of a specific patient. No individual shall be granted such privileges on more than two (2) occasions per 12 month period.

(2) Locum Tenens: Temporary privileges may be granted for a specified period not to exceed sixty (60) consecutive days, to a person serving as a locum tenens for a current member of the Medical Staff. Such privileges may be granted or renewed up to one (1) time in a twelve (12) month period.

(3) Pending Completion of the Credentialing Process: Temporary privileges may be granted for a specified period, not to exceed thirty (30) consecutive days, to an applicant for Medical Staff membership whose services are required to maintain or enhance the quality of care of the Hospital. Such privileges may be renewed up to three (3) times (i.e., not to exceed 120 days).

5.5.2 APPLICATION AND REVIEW

a. Upon completion of a temporary privilege application related to 5.5.1(b)(1) or upon completion of an application as described in section 4.6.1 f, to the medical staff related to 5.5.1 (b)(2), and all required fees and supporting documentation, including responses to all requests for information, from an M.D., D.O., D.P.M., D.D.S., or Clinical Psychologist who is authorized to practice in California, and who meets one of the requirements for need as described in Section 5.5.1, the Board of Directors through the Chief Executive Officer or administrative designee may grant temporary privileges to an individual who appears to have qualifications, ability and judgment consistent with Article II, but only after:

(1) The passage of a minimum of seven (7) days to permit verification of information, although exceptions may be made for good cause;

(2) Primary source verification of licensure status, current competence relevant to the privileges requested, and insurance status is obtained;

(3) A National Practitioner Data Bank and Medical Board of California query;

(4) An Office of the Inspector General (OIG) and Government Services Administration (GSA) sanction query to ensure that applicant is not an excluded provider;

(5) Review of information and written or verbal recommendation has been obtained from the Chair or designee of each department from which the applicant is requesting privileges;

(6) The applicant's file, including the recommendation of the Department Chair or designee is reviewed on behalf of the Medical Executive Committee by the Chief of Staff or designee; and

(7) The Chief of Staff or designee recommends and the Board of Directors, through the Chief Executive Officer, concurs in the granting of temporary privileges.

All practitioners requesting temporary privileges pursuant to Section 5.5.1(b)(1) and (2) must demonstrate Active Staff membership at a Hospital accredited by The Joint Commission, although exceptions may be made by the Chief of Staff or designee for good cause.

In the event of a disagreement between the Board of Directors and the Medical Executive Committee regarding the granting of temporary clinical privileges, the matter shall be referred to the Joint Conference Committee for resolution.

b. Temporary privileges may also be granted by the Chief Executive Officer, after consultation with the Department Chair and/or the Chief of Staff, when an applicant for initial appointment:

(1) Has completed an application to the Medical Staff and the relevant supporting documentation is available for review,

(2) Is awaiting review by the Medical Executive Committee and the Board, following a favorable recommendation of the Credentials Committee and a favorable report from the applicable clinical Department Chair;

(3) Has no current or previously successful challenges to their licensure or registration; and

(4) Has not been subject to involuntary termination of medical staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.

The Medical Staff Services Department, Department Chair(s) and Credentials Committee shall verify appropriate information regarding the individual's licensure, DEA registration, current clinical competence and judgment, character, ethical standing, behavior, ability to safely and competently exercise the privileges requested, lack of Medicare or other governmental exclusions/sanctions, and professional liability insurance coverage and shall query the National Practitioner Data Bank before a final decision to grant temporary privileges is made by the Chief Executive Officer.

c. The omission of any information, response, or recommendation specified in this section shall preclude the granting of temporary privileges.

d. Temporary appointment and clinical privileges shall be terminated automatically at such time as the Medical Executive Committee recommends unfavorably with respect to the applicant's appointment to the staff and clinical privileges. At the Medical Executive Committee's discretion, temporary clinical privileges shall be modified to conform to the recommendation of the Medical Executive Committee that the applicant be granted different permanent privileges from the temporary privileges.

5.5.3 GENERAL CONDITIONS

a. Temporary privileges shall be exercised under the supervision of the Chair of each Department to which the applicant has been assigned. The applicant shall ensure that the Chair, or the Chair's designee, is kept closely informed as to the applicant's activities within the Hospital.

b. All temporary privileges are time limited and shall automatically terminate at the end of the designated period. The provisions of Article VII shall not apply to such termination.

c. Requirements for proctoring shall be imposed on all individuals granted temporary privileges at the discretion of the Chief of Staff or designee. The requirements shall be determined by the Chief of Staff or designee after consultation with the Chair of any Department to which the applicant is assigned. Temporary appointment and clinical privileges shall be immediately terminated by the Chief Executive Officer upon written notice of any failure by the individual to comply with any proctorship requirements or other special conditions.

d. All persons requesting or receiving temporary privileges shall be bound by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies.

5.6 EMERGENCY PRIVILEGES

5.6.1 In the case of an emergency, any M.D., D.O., D.P.M., D.D.S. or Clinical Psychologist, to the degree permitted by their license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The M.D., D.O., D.P.M, D.D.S., or Clinical Psychologist shall make every reasonable effort to communicate promptly with the appropriate Department Chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the Department Chair with respect to further care of the patient.

5.6.2 In the event of an emergency, any non-physician shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such non-physicians shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available.

5.7 DISASTER PRIVILEGES

The President/Chief Executive Officer, or designee, or Chief of Staff or their designee(s) may grant disaster privileges after establishing the qualifications of a practitioner upon presentation of a valid government issued identification and at least any one (1) of the following:

5.7.1 A current Hospital picture identification card from a licensed Hospital in the United States of America that clearly identifies professional designation;

5.7.2 A current license to practice;

5.7.3 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or Federal organizations or group;

5.7.4 Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a Federal, state, or municipal entity); or

5.7.5 Identification by current Hospital or Medical Staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

Those practitioners granted disaster privileges shall wear an identification badge indicating their name, professional degree, and specialty. Practitioners with such disaster privileges serve under the supervision and direction of the Chief of Staff or their designee.

The Chief of Staff and the Medical Staff Services Department shall begin the primary source verification of the practitioner's license or certification as soon the immediate situation is under control or at minimum and within seventy-two (72) hours from the time the provider begins providing services at the hospital.

The Medical Staff oversees the performance and professional practice, care, treatment and services provided by the volunteer LIP/APP through direct observation, monitoring and clinical record review.

5.9 TRANSPORT AND ORGAN HARVEST TEAM PRIVILEGES

Properly licensed practitioners who individually, or as members of a group or entity, have contracted with the Hospital to participate in transplant and/or organ harvesting activities may exercise clinical privileges within the scope of their agreement with the Hospital.

5.10 CLINICAL PRIVILEGES FOR NEW PROCEDURES

5.10.1 Whenever a Medical Staff member requests clinical privileges to perform a procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the request will not be processed until:

a. A determination has been made regarding whether the technique/procedure or service will be offered by the Hospital; and

b. Threshold criteria have been established defining the qualifications that an individual must possess to be eligible to request the clinical privileges in question.

5.10.2 The Credentials and Medical Executive Committees shall make a preliminary recommendation following the Medical Staff and Hospital Policy as to whether the new technique/procedure or service should be offered to patients, considering such factors as the Hospital's capabilities, including support services, space and equipment to perform the technique/ procedure or service. After reviewing the recommendations of the Credentials and Medical Executive Committees, the Board or its designee shall determine whether the new technique/procedure or service shall be offered.

5.10.3 The Credentials Committee shall forward its recommendation to the Medical Executive Committee, which shall review the matter and forward its recommendation to the Board of Directors or its designee for final action.

5.10.4 Once the threshold qualifications are approved, specific requests from eligible Medical Staff members may be processed.

5.11 CLINICAL PRIVILEGES THAT CROSS SPECIALTY LINES

5.11.1 Whenever a Medical Staff member requests clinical privileges that have traditionally been exercised only by individuals from another specialty, the request will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the staff member's eligibility to request the clinical privileges in question.

5.11.2 The Credentials Committee shall conduct research and may consult with experts, including those on the Hospital's Medical Staff (appropriate clinical committee Chairs or individuals on the Medical Staff with special interest and/or expertise in the privileges in question) or those outside the Hospital, including but not limited to, other Hospitals, residency training programs and specialty societies.

5.11.3 The Credentials Committee shall then develop recommendations regarding:

a. Minimum education, training, and experience necessary to perform the clinical privileges in question; and

b. Extent of monitoring and supervision that should be required.

5.11.4 These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendation to the Board or its designee for final action.

5.11.5 Once threshold qualifications are approved, specific requests from eligible Medical Staff members may be processed.

5.12 TELEMEDICINE PRIVILEGES

5.12.1 The Board of Directors will determine the clinical services to be provided through Telemedicine after considering the recommendations of the appropriate Department Chair, Credentials Committee, and the Medical Executive Committee.

5.12.2 Individuals applying for Telemedicine privileges must meet the qualifications for Medical Staff appointment outlined in these Bylaws, except for those requirements relating to geographic location of office/residence, coverage arrangements, and emergency call responsibilities.

5.12.3 Qualified applicants may be granted Telemedicine privileges but will not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement will be incidental to and coterminous with the agreement.

5.12.4 Applications for Telemedicine privileges will be processed in accordance with the provisions of these Bylaws and the Telemedicine Credentialing Policy.

5.12.5 Telemedicine privileges are granted for a period of not more than two (2) years.

5.12.6 Individuals granted Telemedicine privileges shall be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities.

ARTICLE VI
CORRECTIVE ACTION

6.1 CRITERIA FOR INITIATION OF FORMAL CORRECTIVE ACTION

6.1.1Generally, formal corrective action should not be initiated unless reasonable attempts at informal resolution have failed; however, this is not a mandatory condition, and formal corrective action may be initiated whenever circumstances reasonably appear to warrant formal action. Any recommendation of formal corrective action must be based on evaluation of applicant-specific information.

6.1.2Any person may provide information to the Medical Executive Committee about the conduct, performance, or competence of a Medical Staff member or Advanced Practice Provider. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws, Rules and Regulations, or Medical Staff and Hospital policy, or; (4) below applicable professional standards, a request for an investigation of such member may be initiated by the Chief of Staff, a Department Chair, the Hospital’s Chief Executive Officer, the Hospital’s Chief Medical Officer, or the Medical Executive Committee.

6.1.3 INITIATION

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate record of the reasons for the request.

6.1.4 INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The investigation shall be considered to have been initiated upon approval by the Medical Executive Committee. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff Officer, Medical Staff Department Chair, or standing or ad hoc committee of the Medical Staff. The parties involved in the investigation shall not include partners, associates, relatives or any individual who is in direct economic competition or who has a conflict of interest with the individual being investigated. The Medical Executive Committee in its discretion may appoint practitioners, review consultants, or agencies who are not members of the Medical Staff as temporary members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee conducting an investigation. An outside practitioner, review consultant, or agency may be used whenever a determination is made by the Medical Executive Committee that:

a. Clinical expertise needed to conduct the review is not available on the Medical Staff; or

b. Individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

c. Individuals with the necessary clinical expertise would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded; or

d. Medical Staff members are unwilling to serve as members of an Investigating committee.

If the investigation is delegated to an Officer, Department Chair, or committee other than the Medical Executive Committee, such Officer, Department Chair, or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.1.5 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action that may include but is not limited to:

a. Determining no corrective action be taken and if the Medical Executive Committee determines there was no credible evidence for the complaint, the Medical Executive Committee shall document in the member's credential file, or other file created for this purpose, the investigation of the complaint and the exoneration of the member;

b. Deferring action for a reasonable time where circumstances warrant;

c. Issuing letters of admonition, censure, reprimand, or warning ("Letter of Reprimand"). In the event a Letter of Reprimand is issued, the affected member may make a written response that shall be placed in the member's file pursuant to Section 14.8. Nothing herein shall be deemed to preclude a Department Chair, committee Chair, or the Medical Executive Committee from issuing informal written or oral warnings outside of the mechanism for issuance of a Letter of Reprimand as described in these Bylaws;

d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

e. Recommending reduction, modification, suspension or revocation of clinical privileges. Such actions affecting clinical privileges may be time limited;

f. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care. Such actions affecting membership may be

time limited. Should the time limitation exceed 14 calendar days the terms and conditions of section 7.2 shall apply;

g. Recommending suspension, revocation or probation of membership. Such actions affecting membership may be time limited. Should the time limitation exceed 14 calendar days the terms and conditions of section 7.2 shall apply; and

h. Taking other actions deemed appropriate under the circumstances.

6.1.6 SUBSEQUENT ACTION

a. If corrective action as set forth in Section 7.2(a)-(k) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Directors.

c. Following a fair procedure, so long as the recommendation of the Medical Executive Committee is supported by substantial evidence, such recommendation shall be adopted by the Board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VII of the Bylaws.

6.1.7 INITIATION BY BOARD OF DIRECTORS

a. The Medical Staff acknowledges that, in the event that the Medical Staff fails in any of its substantive duties or responsibilities, the Board of Directors must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible governance of the Hospital.

b. If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Directors may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The Board's request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the Medical Executive Committee fails to take action in response to that Board of Directors direction, the Board of Directors may, in furtherance of the Board of Directors' ultimate responsibilities and fiduciary duties, initiate corrective action after written notice to the Medical Executive Committee, but this corrective action must comply with Articles VI and VII of these Medical Staff Bylaws.

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2.1 CRITERIA FOR INITIATION

Whenever a member's conduct is such that a failure to take action may result in an imminent danger to the health of any individual, the Chief of Staff or designee, Chief Medical Officer, the Medical Executive Committee, or the Chair of the Department or designee in which the member holds privileges may summarily restrict or suspend the membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the Board of Directors, the Medical Executive Committee and the Chief Executive Officer or designee. In addition, the affected member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 6.2.2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the Department Chair, the Chief Medical Officer or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member. If summary suspension is imposed by the Board of Directors or their designee, including the Chief Executive Officer, said suspension shall be automatically lifted in 2 days unless ratified by the Medical Executive Committee.

6.2.2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within two (2) working days of imposition of a summary suspension, the affected member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3.1.

6.2.3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within ten (10) days after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two (2) working days of the meeting.

6.2.4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article VII of these Bylaws.

6.2.5 INITIATION BY BOARD OF DIRECTORS

a. If the Chief of Staff, members of the Medical Executive Committee and the Department Chair or designee in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the Board of Directors through the Chief Executive Officer or designee may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the Board of Directors or designee made reasonable attempts to contact the Chief of Staff or designee, members of the Medical Executive Committee and the Department Chair or designee before the suspension.

b. Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.2 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the

Medical Executive Committee for purposes of compliance with notice and hearing requirements.

6.3 AUTOMATIC AND VOLUNTARY RELINQUISHMENT

In the following instances, the member's membership or privileges may be limited as described below. A practitioner whose membership and/or privileges have been voluntarily or automatically relinquished pursuant to a voluntary or automatic relinquishment shall not be entitled to procedural rights of a fair hearing or appeal afforded by Article VII of these Bylaws. The practitioner shall be only entitled to a limited review of the instance resulting in the relinquishment which shall consist only of presenting information to the Medical Executive Committee solely on the issue of whether the act or event generated a voluntary or automatic relinquishment.

6.3.1 ELIGIBILITY CRITERIA

When such time as a member fails to continuously satisfy any of the Qualification Criteria outlined in Article 2.2 it may result in the automatic relinquishment of membership and privileges.

6.3.2 LICENSURE

a. Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, membership and clinical privileges shall be automatically relinquished as of the date such action becomes effective.

b. Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

6.3.3 CONTROLLED SUBSTANCES

a. Whenever a member's DEA certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.3.4 MEDICAL RECORDS

a. Members of the Medical Staff and Advanced Practice Providers are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee.

b. A limited relinquishment in the form of withdrawal of admitting and other related privileges until medical records are completed will be imposed by the Chief of Staff or designee after notice of delinquency for failure to complete medical records within such period.

d. For the purpose of this Section, "related privileges" means scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. In the case of automatic relinquishment of privileges for the purpose of this Section, the staff member shall remain responsible for their emergency on-call coverage obligations as scheduled.

d. Bona fide vacation or illness may constitute an excuse subject to the current Medical Staff delinquency and automatic relinquishment policy.

e. Members whose privileges have been relinquished for delinquent records may admit patients only in life-threatening situations pursuant to the current Medical Staff delinquency and relinquishment policy.

f. The relinquishment shall continue until lifted by the Chief of Staff or their designee.

6.3.5 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments, as required under Section 14.2, shall be ground for automatic relinquishment of a member's clinical privileges.

6.3.6 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic relinquishment of a member's Medical Staff membership and clinical privileges and shall result in a written warning of delinquency to the member. If the member does not provide evidence of required professional liability insurance (including such nose or tail coverage as may be necessary to assure no gaps in coverage during any period the member exercised privileges in the Hospital) to the Medical Executive Committee within thirty (30) days after the date of the warning of delinquency, the member's Medical Staff membership and clinical privileges shall be automatically relinquished. Automatic relinquishment of Medical Staff membership and privileges pursuant to this section is not grounds for a fair hearing or appeal and the procedures set forth in Article VII of these Bylaws shall not apply.

6.3.7 FAILURE TO PROVIDE INFORMATION OR SATISFY SPECIAL ATTENDANCE REQUIREMENTS

Failure of a practitioner to provide information or appear when requested by a Medical Staff committee as discussed in Sections 4.2 and 12.8 shall result in automatic relinquishment of all privileges. The automatic relinquishment shall remain in effect until the practitioner has provided requested information and/or satisfied the special attendance requirement which has been made by the Medical Staff committee. Failure to respond to such a request within thirty (30) days of the request may result in the automatic resignation of Medical Staff membership and relinquishment of all clinical privileges. For purposes of this section, "information" means:

a. Physical or mental examination reports as specified elsewhere in these Bylaws;

b. Information necessary to explain an investigation, peer review action, or resignation from another health care facility, or action by third party payer or government agency;

c. Information from an individual's private office that is necessary to resolve questions that have arisen during a peer review activity; or

d. Information pertaining to professional liability coverage and/or actions.

e. Failure of a practitioner to produce required information related to an authorized Medical Staff peer review, quality assessment, performance improvement, or credentialing activities in a timely manner.

6.3.8 EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM

Whenever a practitioner is excluded from any federal health care program and becomes ineligible person, the event shall result in immediate automatic relinquishment of practicing in the Hospital and automatic relinquishment of Medical Staff membership.

6.3.8 CRIMINAL ACTIVITY

Conviction of any felony or of any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, Medicare, Medicaid, or insurance fraud or abuse, or a plea of guilty or *nolo contendere* to charges pertaining to the same shall result in automatic relinquishment of Medical Staff membership and privileges.

6.3.9 FAILURE TO PROVIDE CALL COVERAGE AS SCHEDULED

In the absence of extenuating circumstances, failure to fulfill emergency call obligations as scheduled shall result in automatic relinquishment of the individual's clinical privileges and resignation from the Medical Staff.

6.4 AUTOMATIC RELINQUISHMENT OR LIMITATION

6.4.1 Upon automatic relinquishment or limitation of Medical Staff membership and/or privileges, the practitioner shall be notified in writing by the Medical Executive Committee or its designee of the effective date of the automatic relinquishment or limitation of Medical Staff membership and/or privileges.

6.4.2 MEDICAL EXECUTIVE COMMITTEE DELIBERATION FOLLOWING AUTOMATIC RELINQUISHMENT OR LIMITATION

a. After action is taken or warranted as described in Section 6.3.1, 6.3.2, 6.3.5, 6.3.6, or 6.3.7, the Medical Executive Committee shall review and consider the facts and may recommend further corrective action as it may deem appropriate.

b. Practitioner shall not be entitled the procedural rights of a fair hearing or appeal afforded by Article VII of these Bylaws for automatic relinquishment or limitation of Medical Staff membership and/or privileges pursuant to Section 6.3 of these Bylaws.

ARTICLE VII
HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners, and at the same time to protect the peer review participants from liability. The Medical Staff, their Officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

7.1.1 EXHAUSTION OF REMEDIES

If adverse action described in Section 7.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.1.2 APPLICATION OF ARTICLE

For purposes of this Article, the term "member" may include "applicant," as it may be applicable under the circumstances, unless otherwise stated. In addition to Medical Staff members and applicants, clinical psychologists who are providing or applying to provide professional services in the Hospital as a licensed independent practitioner, but are not members of the Medical Staff, are entitled to the hearing rights specified in this article.

7.1.3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

7.1.4 FINAL ACTION

Recommended adverse actions described in Section 7.2 shall become final actions only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Directors.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing if the final action would require a report to the Medical Board of California (Section 805 Report) or to the National Practitioner Data Bank:

a. Denial of membership;

b. Denial of requested advancement in staff membership status, or category;

c. Denial of reappointment;

d. Demotion to lower Medical Staff category or membership status;

e. Suspension of staff membership for greater than fourteen (14) days;

f. Revocation of membership;

g. Denial of requested clinical privileges;

h. Involuntary reduction of current clinical privileges;
i. Suspension of clinical privileges for greater than fourteen (14) days;

j. Termination of all clinical privileges; or

k. Involuntary imposition of mandatory concurring consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 5.3).

7.3 REQUESTS FOR HEARING

7.3.1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the Chief of Staff or designee on behalf of the Medical Executive Committee shall give the member prompt written notice of the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank if required; the reasons for the proposed action including the acts or omissions with which the member is charged; the right to request a hearing pursuant to Section 7.3.2, and that such hearing must be requested within 30 days; and a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws.

7.3.2 REQUEST FOR HEARING

The member shall have 30 days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Board of Directors. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3.3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and, within fifteen (15) days give notice to the member of the time, place and date of the hearing. Unless extended by the Judicial Review Committee, the date of the commencement of the hearing shall be not less than thirty (30) days from the date of notice, nor more than sixty (60) days from the date of receipt of the request by the Medical Executive Committee for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, so long as the member has at least thirty (30) days from the date of notice to prepare for the hearing or waives this right. The hearing is deemed to have commenced when Judicial Review Committee members undergo voir dire questioning.

7.3.4 NOTICE OF HEARING

Together with the notice stating the place, time and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice unless waived by a member under summary

suspension, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged, a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 7.4.1.

7.3.5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Medical Executive Committee shall appoint a Judicial Review Committee. The Judicial Review Committee shall be composed of not less than three (3) members of the Medical Staff. The Judicial Review Committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. In the event that it is not feasible to appoint a Judicial Review Committee from the active Medical Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the chair. Membership on a Judicial Review Committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member. All other members shall have MD or DO degrees or their equivalent as defined in Section 2.2.2.

7.3.6 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3.7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Officer on a showing of good cause, or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4.1 PRE-HEARING PROCEDURE

a. If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The member shall also have the right to receive at least thirty (30) days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the Hospital or Medical Staff. The member and the Medical Executive Committee shall have the right to receive all evidence which will be made available to the Judicial Review Committee. Failure to disclose

the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

b. At the discretion of the Medical Executive Committee, all hearing sessions may be conducted by virtual videoconference platform instead of in person. In that circumstance, all hearing participants, including the parties and their legal counsel, if any, the Hearing Officer, the Judicial Review Committee members, the witnesses, and the court reporter, may attend the hearing sessions remotely, so long as all participants can see each other, can hear and be heard during the proceedings, and have access to all evidence admitted at the hearing, either by electronic means or hard copies. The Hearing Officer has authority and discretion to rule on questions regarding the implementation of the virtual proceedings.

b. The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member possesses or controls as soon as practicable after receiving the request.

c. The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

d. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the Hearing Officer shall consider:

(1) Whether the information sought may be introduced to support or defend the charges;

(2) The exculpatory or inculpatory nature of the information sought, if any;

(3) The burden imposed on the party in possession of the information sought, if access is granted; and

(4) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

e. The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the Hearing Officer. Challenges to the impartiality of any Judicial Review Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

f. It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

7.4.2 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character.

The member shall be entitled to representation by legal counsel in any phase of the hearing, if the member so chooses, and shall receive notice of the right to obtain representation by an attorney at law. A member's legal representation costs shall be the member's financial responsibility. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the state of California who is not also an attorney at law, and the Medical Executive Committee shall appoint a representative who is not an attorney to present its action or recommendation and the materials in support thereof, to examine witnesses, and to respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney at law if the member is not so represented.

7.4.3 THE HEARING OFFICER

The Medical Executive Committee shall recommend a Hearing Officer to the Board of Directors to preside at the hearing. The Board of Directors shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within five (5) days. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the Hospital, the Medical Staff or the involved Medical Staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as Officer. The Hearing Officer shall gain no direct financial benefit from the outcome (i.e., the Hearing Officer's remuneration shall not be dependent upon or vary depending upon the outcome of the hearing), and must not act as a prosecuting Officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances. If requested by the Judicial Review Committee, the Hearing Officer may participate in the deliberations of such committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote. The Hearing Officer may recommend, but may not unilaterally terminate, a hearing. A termination order must be at the direction of the Judicial Review Committee, must be in writing and must include documentation as to the reasons for termination. Appeal of the termination is limited to 10-days from receipt of the written request by the Board of Directors. If Board of Directors find termination unwarranted, they will remand the Judicial Review Committee to complete the hearing.

7.4.4 RECORD OF THE HEARING

A stenographer or court reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

7.4.5 RIGHTS OF THE PARTIES

Within reasonable limitations, both parties may call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents; cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available by the other party to the Judicial Review Committee; and submit a written statement, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the body whose decision prompted the hearing or the Judicial Review Committee and examined as if under cross-examination. The Judicial Review Committee may question witnesses or call additional witnesses if it deems such action appropriate. The hearing officer shall also have the discretion to ask questions of witnesses if he or she deems it appropriate for purposes of clarification or efficiency.

7.4.6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the Hearing Officer issues a written decision that the member or the Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.

7.4.7 BURDENS OF PRESENTING EVIDENCE AND PROOF

a. At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

b. An applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

c. Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

7.4.8 ADJOURNMENT AND CONCLUSION

After consultation with the chair of the Judicial Review Committee, the Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the

hearing. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4.9 BASIS FOR DECISION

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these Bylaws, but shall otherwise be affirmed by the Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

7.4.10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the administrator, the Board of Directors, and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these Bylaws, but shall otherwise be affirmed by the Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

7.5 APPEAL

7.5.1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the Judicial Review Committee, either the member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the President/Chief Executive Officer, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

7.5.2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

a. Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; or

b. The decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5.5.

7.5.3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the appeal board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) days or more than sixty (60) days from the date of such notice; provided, however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

7.5.4 APPEAL BOARD

The Board of Directors may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than three (3) members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Board of Directors shall be neither the attorney firm that represented either party at the hearing before the Judicial Review Committee nor the attorney who assisted the Judicial Review Committee or served as Hearing Officer.

7.5.5 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision consistent with the standard set forth in Section 7.5.6, or remand the matter to the Judicial Review Committee for further review and decision.

7.5.6 DECISION

a. Except as provided in Section 7.5.6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure.

b. Should the Board of Directors determine that the Judicial Review Committee decision is not supported by substantial evidence, the Board may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review

and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the Board of Directors and the Judicial Review Committee.

c. The decision shall be in writing and shall specify the reasons for the action taken.

7.5.7 RIGHT TO ONE HEARING

Except in circumstances where a new hearing is ordered by the Board of Directors or a court because of procedural irregularities or otherwise for reasons not the fault of the member, no member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

7.6. AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

Except as otherwise stated in Section 6.3, any automatic suspension or limitation initiated pursuant to Section 6.3 does not invoke hearing rights as described in these Bylaws.

7.7 DEPARTMENT FORMATION OR ELIMINATION

A Medical Staff Department can only be formed or eliminated following a review and recommendation by the Medical Executive Committee regarding the appropriateness of the department elimination or formation. The Board of Directors shall consider the recommendations of the Medical Executive Committee prior to making a final determination regarding formation or elimination.

The member(s) whose privileges may be adversely affected by Department formation or elimination are not afforded hearing rights pursuant to Article VII.

7.8 EXPUNCTION OF DISCIPLINARY ACTION

Upon petition by the affected practitioner, the Medical Executive Committee, in its sole discretion, may seal or expunge from the credential file references related to previous disciplinary action upon a showing of good cause or rehabilitation provided at least three years have passed since the described action was taken.

7.9 NATIONAL PRACTITIONER DATA BANK REPORTING

Except as may be required to timely report summary restriction or suspension actions, the authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

7.10 SUBSTANTIAL COMPLIANCE

Technical, insignificant or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

ARTICLE VIII
OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1.1 IDENTIFICATION

The Officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Associate Chief of Staff, Secretary/Treasurer, and two (2) Members at Large of the Medical Executive Committee.

8.1.2 QUALIFICATIONS

All Medical Staff Officers shall:

a. Be Active Status members of the Medical Staff at the time of their nomination and election, and must remain Active Status members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

b. Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns.

c. Understand and be willing to work toward attaining the Hospital's lawful and reasonable policies and requirements.

d. Have administrative ability as applicable to the respective office.

e. Be available to Chair and attend required Medical Staff and Hospital meetings and able to work with and motivate others to achieve the objectives of the Medical Staff and Hospital

f. Demonstrate clinical competence in their field of practice.

g. Not have any significant conflict of interest.

All nominees for election or appointment to Medical Staff office including those nominated by petition of the Medical Staff must, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware or that could foresee ably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of their conflict shall be disclosed in writing and circulated with the ballot.

8.1.3 NOMINATIONS

a. A Nominating Committee shall be appointed by the Chief of Staff and approved by the Medical Executive Committee at least seventy-five (75) days prior to the annual meeting of the Medical Staff. The Nominating Committee, if possible, will include three (3) past Chiefs of Staff of the Medical Staff. The Nominating Committee shall submit to the Medical Executive Committee one or more nominations for each elected office at least forty-five (45) days prior to the annual meeting. The nominations and a ballot shall be sent to each voting Medical Staff

member at least twenty (20) days prior to the meeting. The Nominating Committee will remain in existence until a new nominating committee is appointed. It may make recommendations to the Medical Executive Committee regarding training and experience requirements for elected staff Officers and perform such other duties as may be assigned to it by the Medical Executive Committee. It shall meet as often as is necessary.

b. Nominations for elected office may also be made by petition provided that a petition designating the nominee and containing the nominee's approval is signed by no less than fifteen percent (15%) of the members of the voting Medical Staff and is submitted to the Medical Staff Services Department at least forty-five (45) days prior to the election. Any nominations made by the petition procedure shall be added to the ballot and sent to each voting Staff member along with the nominations received from the Nominating Committee.

c. Nominations from the floor at the annual meeting will not be accepted.

8.1.4 ELECTION

Election of Officers shall be by majority vote of those eligible Staff members who have submitted a ballot.

8.1.5 INSTALLATION OF OFFICERS

All elected and appointed Officers, Department Chairs, committee Chairs and committee members shall assume their duties and responsibilities on the first day of October following the annual meeting.

8.1.6 TERM OF ELECTED OFFICE

The Chief of Staff, Vice Chief of Staff, and Associate Chief of Staff shall serve two (2) year terms, not to exceed two consecutive terms, commencing on the first day of the Medical Staff year following their election. The Secretary/Treasurer and the two (2) Members at Large of the Medical Executive Committee shall serve two (2) year terms. Each Officer shall serve in each office until the end of their term, or until a successor is elected, unless they shall sooner resign or be removed from office.

8.1.7 REMOVAL OF OFFICERS

Removal of an Officer may be initiated for failure to carry out the duties and responsibilities of the office as set forth in Article VIII. Except as otherwise provided, removal of a Medical Staff Officer may be initiated by the Medical Executive Committee, or by a petition signed by at least one-third of the members of the Active Medical Staff. Removal shall be considered at a special Medical Staff meeting called for that purpose. Recall shall require a two-thirds (2/3) vote of the Active Medical Staff members via electronic ballot prior to the special meeting.

8.1.8 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the Officer, or the Officer's loss of membership in the Active Medical Staff. Vacancies, other than that of Chief of Staff, shall be filled by appointment by the Medical Executive Committee until an election is approved by the Medical Executive Committee. If there is a vacancy in the office of Chief of Staff, the then Vice Chief of Staff shall serve out the remaining term. The Medical Executive Committee would then appoint a Vice Chief of Staff to serve until the next regular election.

8.2 DUTIES OF THE OFFICERS

8.2.1 CHIEF OF STAFF

The Chief of Staff shall serve as the Chief Officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

a. Enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards;

b. Calling, presiding at, and being responsible for the agenda of all General Staff meetings of the Medical Staff;

c. Serving as Chair of the Medical Executive Committee;

d. Serving as an ex-officio member of all other staff committees without vote, unless their membership in a particular committee is required by these Bylaws;

e. Interacting with the Chief Executive Officer and Board of Directors in all matters of mutual concern within the Hospital;

f. Appointing, with the Medical Executive Committee approval, committee members for all standing and special Medical Staff, liaison, or interdisciplinary practice committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the Chair of those committees;

g. Representing the views and policies of the Medical Staff to the Board of Directors and to the Chief Executive Officer;

h. Being a spokesperson for the Medical Staff in external professional and public relations;

i. Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the Medical Executive Committee;

j. Serving on liaison committees (including the Joint Conference Committee) with the Board of Directors and Administration; and

k. Serving as the Medical Staff's liaison to outside licensing or accreditation agencies.

l. In the interim between Medical Executive Committee meetings, performing those responsibilities of the committee that, in their reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee.

m. Officers shall verbally disclose all actual or potential conflicts of interest in the course of each medical staff meeting or other event where such a disclosure may be relevant. Any potential conflicts so disclosed shall be resolved as set form in the Medical Staff Conflict of Interest Policy.

8.2.2 VICE CHIEF OF STAFF

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall also perform other duties as would ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or the Medical Executive Committee.

The Vice Chief of Staff shall serve as Chair of the Quality and Safety Committee and a member of the Joint Conference Committee and Medical Executive Committee.

8.2.3 SECRETARY/TREASURER

The Secretary/Treasurer shall serve as a member of the Medical Executive Committee and keep or cause to be kept minutes of all proceedings of the Medical Staff and the Medical Executive Committee and shall maintain a roll of attendance, answer correspondence, collect, disperse and account for Medical Staff funds, and perform other such studies as pertinent to the office or as may be assigned by the Chief of Staff or the Medical Executive Committee.

8.2.4 ASSOCIATE CHIEF OF STAFF

The Associate Chief of Staff shall serve on the Medical Executive Committee, Executive Operations Committee of the Medical Executive Committee and Quality and Safety Committee.

8.2.5 MEMBERS AT LARGE OF THE MEDICAL EXECUTIVE COMMITTEE

The Members at Large of the Medical Executive Committee shall serve on the Medical Executive Committee and shall perform such duties as may be assigned by the Chief of Staff or the Medical Executive Committee. They shall also serve on the Quality and Safety Committee.

ARTICLE IX
CLINICAL DEPARTMENTS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chair selected and entrusted with the authority, duties and responsibilities specified in Section 9.6.5. The Medical Executive Committee may recommend to the Board of Directors the creation, elimination, modification, or combination of departments.

9.2 DEPARTMENTS OF THE MEDICAL STAFF

9.2.1 CURRENT DEPARTMENTS

a. Anesthesiology
b. Emergency Medicine
c. Family Medicine/Pediatrics
d. Medicine
e. Obstetrics and Gynecology
f. Surgery

9.3 ASSIGNMENTS TO DEPARTMENTS

Each member shall be assigned membership to one department but may also be granted clinical privileges in other departments.

9.4 DUTIES OF DEPARTMENTS

9.4.1 Serve as a forum for the exchange of clinical information regarding services provided by department members.

9.4.2 Develop educational programs to meet the needs of department members.

9.4.3 Provide information and/or recommendations when requested by the Department Chair and/or Medical Executive Committee related to:

a. Medical Staff policies and procedures.

b. Issues of standard of practice and/or clinical competence.

c. Criteria for clinical privileges.

9.4.4 Receive reports related to relevant Medical Staff and/or organizational quality assessment and performance improvement activities.

9.4.5 Medical Staff departments will meet as often as necessary. Departmental meetings may be combined with other departments and held concurrently with any general Medical Staff meeting.

9.5 DEPARTMENT CHAIR

9.5.1 QUALIFICATIONS

a. Each Chair shall be a physician member of the Active Medical Staff qualified by training, experience and demonstrated ability for the position.

b. Each Chair shall be certified by an appropriate specialty board, or shall affirmatively establish through the privilege delineation process that they possesses comparable competence.

9.5.2 SELECTION

The Department Chair and Department Vice Chair shall be elected from the membership of the involved department. The membership shall nominate at least one (1) member to be Chair. The names of the nominee(s) for department Chair shall be placed on a ballot and sent to all Active Medical Staff members in the respective department. Each department member shall cast one (1) vote for Department Chair. Write-in nominations will be accepted. In order for a vote to be counted, it must be returned to the Medical Staff Office within seven (7) days. The candidate receiving the highest number of votes shall be the department Chair.

9.5.3 TERM OF OFFICE

Each Department Chair and Vice Chair shall serve a two (2) year term which coincides with the term of office of the Medical Staff Officers unless they shall sooner resign or be removed from office or lose Medical Staff membership or clinical privileges in that department. Department Chairs may succeed themselves.

9.5.4 REMOVAL

The removal of a Department Chair may be initiated for failure to carry out the duties and responsibilities as set forth in Section 9.6.5. Removal of a Department Chair requires a two-thirds majority vote of Active Medical Staff members in the department. The vote may be held at a regular or special meeting of the department and votes may be submitted in person or through written ballot.

9.5.5 DUTIES OF THE DEPARTMENT CHAIR

The Department Chair shall perform the following duties:

a. Provide information and recommendations to the Credentials, Interdisciplinary Practice (IDPC) and/or Medical Executive Committees regarding the qualifications of applicants seeking appointment and/or reappointment and/or clinical privileges in the Department.

b. Recommend to the IDPC, Credentials and/or Medical Executive Committees specific clinical privileges for each Medical Staff member holding or requesting clinical privileges in the department both at the time of appointment and reappointment.

c. Review and evaluate adherence of Medical Staff members and Advanced Practice Providers to the Medical Staff Bylaws, Rules and Regulations and policies, and make recommendations regarding such adherence to the appropriate Medical Staff committee and/or Medical Executive Committee.

d. Recommend to the IDPC, Credentials Committee and Medical Executive Committee proctoring programs to be utilized at the time of appointment or when practitioners are requesting new privileges in the department.

e. Make recommendations to the Medical Executive Committee regarding policies necessary for the proper discharge of department responsibilities as it relates to the provision of care, treatment, and services.

f. Direct and supervise all administrative (unless otherwise specified) and clinical activities within the department and report on such activities as necessary to the appropriate Medical Staff committees and/or Medical Executive Committee.

h. Recommend to the Medical Executive Committee the criteria for clinical privileges related to the department.

i. Transmit to the Medical Executive Committee any recommendations regarding a request for investigation or recommendations for corrective action regarding any person holding clinical privileges in the department.

j. Provide programs to assure the continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department.

k. Serve as a member on the Medical Executive Committee.

l. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

m. Coordinate and integrate interdepartmental and intradepartmental services.

o. Integrate the department or service into the primary functions of the organization.

p. Recommend a sufficient number of qualified and competent persons to provide care, treatment, and service in the department.

q. Recommend the qualifications and competence of department or service personnel who are not LIPs and who provide patient care, treatment, and services.

r. Recommend the space and other resources needed by the department.

s. Maintain quality control programs, as appropriate.

t. Recommend the qualifications and competence of department or service personnel who are not LIPs and who provide patient care, treatment, and services. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

u. Involvement in the development and implementation of policies and procedures that guide and support the provision of care, treatment and services.

9.5.6 VACANCIES

If the position of Department Chair becomes vacant, the vacancy shall be filled by the Department Vice Chair.

9.6 DEPARTMENT VICE CHAIR

9.6.1 QUALIFICATIONS

The qualifications of the Department Vice Chair shall be the same as those of the Department Chair as set forth in Section 9.5.1.

9.6.2 SELECTION

The selection of the Department Vice Chair shall occur pursuant to Section 9.5.2.

9.6.3 TERM OF OFFICE

The term of office for the Department Vice Chair shall be the same as that of the Department Chair as set forth in Section 9.5.3.

9.6.4 REMOVAL

The removal of the Department Vice Chair shall occur in the same manner as set forth for removal of the Department Chair, as described in Section 9.5.4.

9.6.5 DUTIES

The Department Vice Chair shall assume all duties and authority of the Department Chair in the absence of the Department Chair and shall perform other duties as assigned by the Department Chair, delegated by the Bylaws, Rules and Regulations, Policies and Procedures, or as directed by the Medical Executive Committee.

9.6.6 VACANCIES

If the position of Department Vice Chair becomes vacant, the vacancy shall be filled for the remainder of the current term by Medical Executive Committee appointment.

ARTICLE X
COMMITTEES OF THE MEDICAL STAFF

10.1 DESIGNATION

Medical Staff committees shall include, but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of Departments, meetings of committees established under this Article, and meetings of special or ad hoc committees. The committees described in this Article shall be the standing committees of the Medical Staff.

Unless otherwise specified, the Chair and members of all standing committees shall be appointed by the Chief of Staff, subject to approval by the Medical Executive Committee. Ad Hoc Medical Staff Committee members may be appointed to any Medical Staff committee by the committee Chair or by the Chief of Staff.

Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members; Advanced Practice Providers, representatives from Hospital departments such as administration, nursing services, or health information services, representatives of the community; and persons with special expertise, depending upon the functions to be discharged. The Chief Executive Officer or their designee, in consultation with the Chief of Staff, shall appoint any non-Medical Staff members who serve in non-ex officio capacities. The committee Chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.

Each committee chair shall appoint a Vice Chair to fulfill the duties of the Chair in their absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

An Ad Hoc Medical Staff Committee may be established and members may be appointed by any Medical Staff committee Chair, the Chief of Staff, or the Medical Executive Committee. All ad hoc committees shall report to the Chair of the committee which appointed the ad hoc committee or to the Chief of Staff. All ad hoc committees will ultimately report to the Medical Executive Committee.

The purpose of Medical Staff committees shall be to monitor and improve the quality of patient care services and perform other functions relative to the needs of the facility, the regulations of the state and federal government and the standards of The Joint Commission.

Unless otherwise specified in these Bylaws, all non-Medical Staff members appointed to the Medical Staff committees shall be nonvoting. When non-physician members have been granted a vote on a Medical Staff committee, such voting rights shall only be exercised relative to the practitioner's area of clinical expertise and restricted by the practitioner's scope of licensure. The Chief of Staff and Medical Chief Medical Officer shall be a nonvoting, ex officio member on all committees to which they are not otherwise specifically assigned.

10.2 GENERAL PROVISIONS

10.2.1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members of the standing Medical Staff committees shall be appointed for a term of two (2) years corresponding with the terms of the at-large Medical Staff Officers.

10.2.2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by a majority vote of the Medical Executive Committee.

The process for removal of non-voting members shall consist of the current administrative process as outlined in Hospital policy.

10.2.3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

10.2.4 ATTENDANCE BY NON MEMBERS

Any Medical Staff member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that practitioner. The committee chair shall have the discretion to grant or deny the request and shall grant the request only if the member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Bylaws and rules applicable to that committee.

10.2.5 EXECUTIVE SESSION

The Chair of any standing, special, or ad hoc committee of the Medical Staff, including departments, may call an executive session meeting. Only members of the Active Medical Staff holding voting privileges on the committee shall attend the executive session meeting. The Chair, at their discretion, may request other individuals to attend the meeting in an informational capacity.

10.2.6 ADDITION, DELETION, OR MODIFICATION OF STANDING COMMITTEES OF THE MEDICAL STAFF

The Medical Executive Committee may recommend to the Board of Directors the addition, deletion, or modification of any standing committee of the Medical Staff as may be described in these Bylaws, or as has otherwise been appointed, with the exception of the Medical Executive Committee. Modification of the Medical Executive Committee requires vote of the General Medical Staff pursuant to Bylaws modification requirements.

10.3 STANDING MEDICAL STAFF COMMITTEES

The current standing committees of the Medical Staff are:

10.3.1 MEDICAL EXECUTIVE COMMITTEE

10.3.2 CREDENTIALS COMMITTEE

10.3.3 INTERDISCIPLINARY PRACTICE COMMITTEE

10.3.4 JOINT CONFERENCE COMMITTEE

10.3.5 PRACTITIONER HEALTH AND WELLNESS COMMITTEE

10.3.7 QUALITY & SAFETY COMMITTEE

10.3.9 INFECTION PREVENTION/PHARMACY & THERAPEUTICS COMMITTEE

10.3.10 CRITICAL CARE COMMITTEE

10.3.11 MEDICAL STAFF EXCELLENCE COMMITTEE

10.3.12 EXECUTIVE OPERATIONS COMMITTEE (OF THE MEC)

10.4 QUORUM MEETING/REPORTS

Except as is otherwise provided for by a particular committee, three or more voting Medical Staff members of the committee present shall constitute a quorum at any meeting of that committee. The action of the majority of the committee members present and voting at any meeting shall be considered the act of the committee. All committees of the Medical Staff shall report to the Medical Executive Committee. Written reports shall be submitted to the Medical Executive Committee at periodic intervals as established by the Medical Executive Committee.

10.5 MEDICAL EXECUTIVE COMMITTEE

10.5.1 COMPOSITION

The Medical Staff Executive Committee will include the Chief of Staff, the Vice Chief of Staff, the Associate Chief of Staff, the Secretary/Treasurer of the Medical Staff, the Chair of each department, two (2) at-large members of the Active Staff, and the Medical Director of the Adult Hospitalist Program. The Chair of the Credentials Committee, Chair of the Medical Staff Excellence Committee, Chief Medical Officer or designee, the Hospital President/Chief Executive Officer or designee, the Hospital Chief Nursing Officer or designee, and the Director of Medical Staff Services shall attend without vote. No member of the Active Medical Staff is ineligible for membership on the Medical Executive Committee solely because of their professional discipline or specialty. A minimum of fifty percent (50%) of the Medical Staff Executive Committee membership shall be comprised of MDs/DOs.

10.5.2 MEC DUTIES

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. With the assistance of the Chief of Staff, and without limiting this broad delegation of authority, the Medical Executive Committee shall perform in good faith the duties listed below.

a. Supervise the performance of all Medical Staff functions, which shall include:

1. Requiring regular reports and recommendations from the departments, committees and Officers of the Medical Staff concerning discharge of assigned functions;

2. Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

3. Following up to assure implementation of all directives.

b. Coordinate the activities of the committees and departments.

c. Assure that the Medical Staff adopts Bylaws and Rules establishing the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures.

d. Based on input and reports from the departments, assure that the Medical Staff adopts Bylaws, Rules, or Regulations establishing criteria and standards, consistent with California law, for Medical Staff membership and privileges (including, but not limited to, any privileges that may be appropriately performed via telemedicine), and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members.

e. Assure that the Medical Staff adopt Bylaws, Rules, or Regulations establishing clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

f. Evaluate the performance of practitioners exercising clinical privileges whenever there is doubt about an applicant's, member's, or Advanced Practice Provider's ability to perform requested privileges.

g. Based upon input from the departments and Credentials Committee, make recommendations regarding all applications for Medical Staff appointment, reappointment and privileges.

h. When indicated, initiate Focused Professional Practice Evaluations and/or pursue disciplinary or corrective actions affecting Medical Staff members.

i. With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:

1. The Medical Staff Bylaws, Rules, and policies;

2. The Hospital's Bylaws, Rules, and policies;

3. State and federal laws and regulations; and

4. The Joint Commission accreditation requirements.

j. Oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of all such policies.

k. Implement, as it relates to the Medical Staff, the approved policies of the Hospital.

l. With the Department Chairs set departmental objectives for establishing, maintaining and enforcing professional standards within the Hospital and for the continuing improvement of the quality of care rendered in the Hospital; assist in developing programs to achieve these objectives including, but not limited to, Ongoing Professional Practice Evaluations, as further described at Bylaws, Article 7, Performance Evaluation and Monitoring.

m. Regularly report to the Board of Directors through the Chief of Staff and the Chief Executive Officer on at least the following:

1. The outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Board of Directors that quality of care is consistent with professional standards; and

2. The general status of any Medical Staff disciplinary or corrective actions in progress.

n. Review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee shall assist the Hospital in reviewing and advising on sources of clinical services provided by consultation, contractual arrangements or other agreements, in evaluating the levels of safety and quality of services provided via consultation, contractual arrangements, or other agreements, and in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

o. Prioritize and assure that Hospital-sponsored educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.

p. Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee.

q. Establish the date, place, time and program of the regular meetings of the Medical Staff.

r. Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.

s. Take such other actions as may reasonably be deemed necessary in the best interests of the Medical Staff and the Hospital.

t. Enforce the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital Policy and Procedure in the best interest of patient care and of the Hospital with regard to all persons who hold appointment to the Medical Staff or the Advanced Practice Provider Staff.

The authority delegated pursuant to this Section 9.3-2 may be removed by amendment of these Bylaws, or by Resolution of the Medical Staff, approved by a 2/3 vote of the voting Medical Staff, taken at a general or special meeting noticed to include the specific purpose of removing specifically-described authority of the Medical Executive Committee.

10.5.3 MEETINGS

The Medical Staff Executive Committee should meet monthly but at least ten (10) times annually and maintain a permanent record of its proceedings and actions. Special meetings of the Medical Staff Executive Committee may be called at any time by the Chief of Staff.

Recommendations of the Medical Executive Committee shall be forwarded in writing to the Board of Directors with a copy to the Chief Executive Officer. The Chief of Staff shall be available to meet with the Board of Directors or its applicable committee or designee on any recommendation that the Medical Executive Committee may make.

10.7 CREDENTIALS COMMITTEE

10.7.1 COMPOSITION

The Credentials Committee shall consist of the Chair who is appointed by the Chief of Staff, the Vice Chief of Staff, the immediate past chair of each department or their designee, the Hospital President/CEO or designee and the Director of Medical Staff Services. The Hospital President/CEO and Director of Medical Staff Services shall be ex officio members.

10.7.2 DUTIES

The duties of the Credentials Committee shall be:

a. To review and evaluate the qualifications of each practitioner applying for initial appointment and consider recommendations of the appropriate Department Chair;

b. To submit required reports and information to the Medical Executive Committee regarding the qualifications of each practitioner applying for membership or particular clinical privileges, including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions;

a. To investigate, review, and report on matters referred by the Chief of Staff, Medical Executive Committee or Department Chairs regarding the qualifications, conduct, professional character or competence of any applicant or Medical Staff Members;

b. To assist the Medical Staff departments and Medical Executive Committee in the evaluation of new technologies and the development credentialing criteria for the granting of new clinical privileges when applicable;

c. To assist the Medical Staff departments and the Medical Executive Committee in the development of credentialing criteria for procedures which are performed by more than one clinical discipline.

f. To assure that recommendations for appointment, reappointment and clinical privileges, are based on evaluations of each applicant or member, as well as (with respect to reappointments) the results of any Medical Staff quality assessment and performance improvement activities.

10.7.3 MEETINGS

The Credentials Committee shall meet as often as necessary but at least quarterly.

10.8 INTERDISCIPLINARY PRACTICE COMMITTEE

10.8.1 COMPOSITION

The committee shall consist of, at a minimum, the Chief Medical Officer, the Chief Nursing Officer, and other nurses appointed by the Chief Nursing Officer, the Chief Executive Officer or their designee, and an equal number of physicians. Licensed or certified health practitioners other than registered nurses who are credentialed by the Interdisciplinary Practice Committee and who perform functions requiring standardized procedures and/or protocols shall also be represented on this committee. The chair of the committee shall be an M.D., D.O., D.P.M., or Clinical Psychologist. A quorum for conducting business shall consist of two (2) Physicians, two (2) registered nurses and one (1) person from Administration.

10.8.2 DUTIES

The duties of this committee shall be:

a. To develop and review standardized procedures that apply to nurses or Advanced Practice Providers, identify functions that are appropriate for standardized procedures and initiate such procedures to include Medical Screening Examinations (MSE) when appropriate, and review and approve standardized procedures. Standardized procedures may be approved only after consultation with the Medical Staff department involved and by an affirmative vote of the committee representatives from Administration, a majority of physician members, and a majority of nurse members;

b. To recommend practice prerogatives, treatment protocols, or job descriptions for assessing, planning and directing the patients' diagnostic and therapeutic care;

c. To review Advanced Practice Providers' applications and requests for privileges and forward its recommendations and the applications on to the appropriate clinical department;

d. To receive the conclusions of Advanced Practice Provider specific departmental peer review and quality improvement information for assessment of Advanced Practice Provider competency at the time of reappointment. The Medical Executive Committee shall be responsible for the initiation of corrective action when indicated for Advanced Practice Providers in accordance with the Medical Staff Bylaws and the Rules and Regulations governing Advanced Practice Providers.

e. To assure that appropriate ongoing educational programs are developed and implemented addressing issues of interest to the Advanced Practice Provider Staff;

f. To serve as liaison between Advanced Practice Providers and the Medical Staff.

10.8.3 MEETINGS

The Interdisciplinary Practice Committee shall meet as often as necessary, but at least quarterly.

10.9 JOINT CONFERENCE COMMITTEE

10.9.1 COMPOSITION

The Joint Conference Committee shall consist of the Chief of Staff, Vice Chief of Staff, Associate Chief of Staff, Chief Medical Officer, Chief Nursing Officer, two (2) members of the Hospital Board appointed by the Chair of the Board, and the Hospital Chief Executive Officer.

The Chief of Staff shall serve as the Chair.

10.9.2 DUTIES

The duties of the Joint Conference Committee shall be:

a. To provide a forum for discussion of matters of mutual concern to the Medical Staff, Board, and Administration;

b. To address existing or potential conflicts of interest involving licensed independent practitioners and/or staff and how these issues will be addressed.

10.9.3 MEETINGS

The Joint Conference Committee shall meet on an ad hoc basis, keeping a record of its proceedings, which are reported to both the Board of Directors and the Medical Executive Committee.

10.10 QUALITY AND SAFETY COMMITTEE

10.10.1 COMPOSITION

The Quality and Safety Committee is composed of voting members of the Medical Staff including the Chief of Staff, Vice Chief of Staff, Associate Chief of Staff, and the Chief Medical Officer, the two (2) members at large of the Medical Executive Committee, the Chair of the Medical Staff Excellence Committee, and others as chosen by the Chief of Staff. Non-physician voting members shall include a member of the Board of Directors, the President/Chief Executive Officer, Chief Operations Officer, and Chief Nursing Officer. Non-voting members include a representative from Risk Management, Regulatory and Accreditation, Quality Management, and other ex-officio members as needed. The Vice Chief of Staff shall serve as Chair of the Quality and Safety Committee. All other appointments of the Quality and Safety Committee are made by virtue of title or position.

10.10.2 DUTIES

<u>Performance Improvement Structure</u>

The Quality and Safety Committee (QSC) is an interdisciplinary medical staff committee that oversees all aspects of performance improvement and patient safety throughout the hospital.

10.10.2.1 The <u>key functions</u> of the Quality and Safety Committee are:

- Setting guidelines for hospital wide performance improvement activities.
- Setting performance improvement and patient safety priorities.
- Addressing patient safety issues.

- Allocating adequate resources for measuring, assessing and improving the organization's performance and patient safety, including:
    - Sufficient staff to conduct PI and patient safety activities;
    - Adequate time for staff to participate in PI activities;
    - Adequate information systems to support PI activities; and
    - Training staff in PI approaches and methods.

Additional functions include:

- Overseeing the implementation process for performance improvement and patient safety activities which include approving, prioritizing and the Performance Improvement and Patient Safety Plan.
- Measuring and assessing the effectiveness of the performance improvement and patient safety activities.
- Reviewing recommendations from all sources regarding performance improvement and patient safety opportunities.
- Acting on recommendations for implementing new processes for patient safety and/or process/performance improvement.
- Evaluating and prioritizing problem/process referrals related to patient safety issues.
- Responding to a sentinel event as defined in the Sentinel Event Policy. Reviewing action plans resulting from teams for intensive assessment of adverse events and/or root cause analysis.
- Identifying criteria to guide the selection and implementation of the guidelines if/when clinical practice guidelines are utilized;
    - Evaluate the outcomes related to use of clinical practice guidelines and determine steps to improve processes.
    - When used, monitor and review clinical practice guidelines for effectiveness and modify as necessary.
- Fostering communication among all departments, Medical Staff, and hospital committees as deemed appropriate.
- Having direct oversight for the improvement of organizational performance and leadership functions.
- Reviewing reports based on the approved quality oversight structure.
- Reviewing key financial indicators related to utilization management.

10.10.3 MEETINGS

The Quality and Safety Committee shall meet as often as necessary, but at least quarterly.

10.13 CRITICAL CARE COMMITTEE

10.13.1 COMPOSITION

The Critical Care Committee shall consist of the Medical Director(s) of the Hospital's special care units, and at least three (3) other members of the Medical Staff who regularly use one or more of the Hospital's special care units all of whom shall be voting members of the committee. In addition, at least one (1) registered nurse having managerial responsibilities for one or more of the special care units, the Chief Medical Officer, and a representative of Hospital Administration shall be voting ex officio members.

10.13.2 DUTIES

The duties of the Critical Care Committee shall be:

a. To evaluate and improve the quality of care provided to special care unit patients;

b. To oversee quality measures and other performance improvement activities as may be necessary to monitor and improve the processes and outcomes of care related to the special care unit patient;

c. To review and recommend to the Medical Executive Committee relevant policies, procedures, and protocols that may be necessary for the operation of the special care units;

d. and

e. To monitor the effectiveness and efficiency of patient flow between the Emergency Department, Surgery, Critical Care Units, Transitional Care Unit and the non-critical care patient areas.

10.13.3 MEETINGS

The Critical Care Committee shall meet as often as necessary, but at least quarterly.

10.14 PHARMACY AND THERAPEUTICS/INFECTION PREVENTION COMMITTEE

10.14.1 COMPOSITION

The Pharmacy and Therapeutics/Infection Prevention Committee shall consist of at least eight (8) members of the Active Medical Staff as well as representative from Microbiology, Employee Health, Pharmacy, Nutrition Services, Nursing Services, Perioperative Services, Administration, an Infection Control Practitioner, and Quality Management representation. It may include ad hoc non-voting persons from relevant Hospital services such as Environmental Services, Sterile Processing, Facilities, and Information Technology.

10.14.2 DUTIES

The duties of the Pharmacy and Therapeutics/Infection Prevention Committee shall include:

a. Formulating professional practices and policies regarding the on-going evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to medications in the Hospital, including antibiotic usage;

b. Periodically developing and reviewing a formulary or drug list for use in the Hospital;

c. Supporting relevant components of prevention and control of acquisition and transmission of Healthcare Associated Infections (HAIs) in patients, healthcare workers, volunteers, students, licensed independent practitioners, and visitors by:

   (1) Bringing clinical, administrative, epidemiological and pharmaceutical expertise to the committee;

(2) Participating in annual risk analysis and prioritizing strategies to minimize, reduce or eliminate the risks;

(3) Previewing and approving policies and procedures;

(4) Providing direction and strength to the clinical aspects of the program by participation, discussion, decision making, and education;

(5) Assessing the adequacy of the human, information, physical, and financial resources allocated to the program annually or whenever significant changes occur;

(6) Evaluating key processes for the prevention and control of infection.

a. Coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;

b. Acting upon recommendations from the Chief of Staff, the Medical Executive Committee and referrals from Hospital departments and other Medical Staff committees;

c. Reviewing sensitivities of organisms specific to the facility;

d. Assuring that appropriate the results of studies and reviews are incorporated into the Medical Staff and Hospital educational programs as well as quality assessment and performance improvement activities;

e. Making recommendations concerning medications to be stocked in patient care areas including:

(1) Annual review of the formulary for use in patient care areas;

(2) Evaluating clinical data concerning new medications or preparations requested for use in patient care areas;

(3) Establishing standards concerning the use and control of investigational medications and of research in the use of recognized medications;

(4) Advising the Medical Staff and the Pharmacy Service on matters pertaining to the choice of available medications.

f. Maintaining a record of all activities relating to pharmacy, therapeutics, and infection control and submitting periodic reports and recommendations to the Medical Executive Committee and other departments as necessary concerning those activities;

g. Reviewing untoward drug reactions.

10.14.3 MEETINGS

The committee shall meet as often as necessary at the discretion of its Chair, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations through the Quality and Safety Committee to the Medical Executive Committee and the Board of Directors as needed but at least quarterly.

10.15 RESEARCH OVERSIGHT COMMITTEE (ROC):
The ROC is a subcommittee of the Pharmacy and Therapeutics/Infection Control Committee.

10.15.1 COMPOSITION

The ROC shall consist of seven (7) voting members of which four (4) are members of the Active Medical Staff: ROC Physician Chair, Chief of Staff, Chief Medical Officer and past Oncology Medical Director; plus three (3) voting members representing Clinical Research, Health Information Management/Privacy and Medical Staff Services. In addition, the ROC may include ad hoc non-voting persons from relevant Hospital services such as Pharmacy.

10.16 MEDICAL STAFF EXCELLENCE COMMITTEE (See Charter contained in General Rules and Regulations of the Medical Staff

10.17 EXECUTIVE OPERATIONS COMMITTEE (EOC):

10.17.1COMPOSITION:

The EOC shall consist of the Chief of Staff, Vice Chief Staff, Associate Chief of Staff, and the Chief Medical Officer as an ex-officio member.

10.17.2DUTIES:

The EOC shall serve as a working group to address daily operational issues and develop projects prior to presentation to the Departments or MEC. The EOC may meet with stakeholders to accomplish information/data gathering in order for the Departments and MEC to function more efficiently and expeditiously. The EOC shall review incidents and issues prior to review by the full MEC. Additional obligations of the committee include on-call and code of conduct issues. The EOC is a working group. All matters of policy shall come forward to the MEC for action. The EOC shall send forward a summary of their weekly meetings to the MEC.

The EOC shall serve as the Bylaws Committee. It shall conduct ongoing review of the Medical Staff Bylaws, and Rules and Regulations.

Recommendations will be submitted to the Medical Executive Committee.

10.17.3MEETINGS: The EOC shall meet as often as needed, but at least monthly.

10.18 PRACTITIONER HEALTH AND WELLNESS COMMITTEE

10.18.1 Composition

The Practitioner Health and Wellness Committee shall be composed of at least three (3) members of the Medical Staff, a representative from the Advanced Practice Provider staff and the Chief Medical Officer. The committee shall not have any disciplinary function with respect to a practitioner's staff

membership or privileges and shall not be responsible for any investigation leading to disciplinary action against staff membership or privileges.

10.18.2 DUTIES

The Practitioner Health and Wellness Committee shall perform the following duties:

a. Provide education about Practitioner health, addressing prevention of physical, psychiatric, or emotional illness;

b. Facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from potentially impairing conditions;

c. Aid the Practitioner in regaining or retaining optimal professional function consistent with protection of patients;

d. Educate the Medical Staff and other organizational staff about illness and impairment recognition issue-specific to practitioners;

e. Welcome self-referral or referral by other staff;

f. Refer affected practitioners to appropriate professional internal or external resources for diagnosis and treatment of physical, emotional, or drug dependency related conditions;

g. Maintain the confidentiality of the practitioner seeking referral or referred for assistance except as limited by law, ethical obligation, or when the safety of a patient is threatened;

h. Evaluate the credibility of any complaint, allegation, or concern regarding the physical or emotional health of a practitioner;

i. Provide support for and accountability to practitioners during programs of treatment and rehabilitation; and

j. Monitor compliance with any mandatory drug treatment programs if needed.

k. If the Committee identifies a Medical Staff or Advanced Practice Provider who is or may be providing unsafe treatment, it shall report the details of concern, including the practitioner's identity, to the Chief of staff, or designee, for appropriate action.

l. Organize events to enrich peer support and social/emotional wellness.

m. Provide support, when requested, around life changes/stressors to include but not limited to: parental time, elder care, medical malpractice cases, and regulations for aging physicians.

10.18.3 MEETINGS

The Practitioner Health and Wellness Committee shall meet as often as necessary, but at least annually. It shall maintain only such records of its proceedings as it deems advisable.

ARTICLE XI
MEDICAL STAFF MEETINGS

11.1 REGULAR MEETINGS

The Medical Staff shall meet at least two (2) times per year.

11.2 SPECIAL MEETINGS

11.2.1 The Chief of Staff may give notice of a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within fifteen (15) days after receipt of a written request stating the purpose of such meeting from either the Medical Executive Committee or not less than twenty percent (20%) of the Active Medical Staff. The Chief of Staff shall designate the time and place for any special Medical Staff meeting.

11.2.2 A notice stating the date, place, hour, and nature of business to be conducted for any special Medical Staff meeting shall be emailed to each member of the Active Staff not less than seven (7) calendar days before the date of such meeting. No other business shall be transacted at any special meeting except that which is stated in the meeting notice.

11.3 QUORUM

For actions to be taken at a regular or special Medical Staff meeting, a quorum shall be those members present.

11.4 MANNER OF ACTION

11.4.1 The Medical Executive Committee shall determine if any action to be taken at a regular or special Medical Staff meeting shall be subject to electronic ballot. Electronic ballots will always be permitted relevant to the election of Officers and amendment of Bylaws. If the Medical Executive Committee determines that electronic ballots are appropriate for other actions to be taken at a Medical Staff meeting, the Medical Executive Committee shall prepare a summary of the issue(s) to be voted upon and a written summary of the issue(s), along with an electronic ballot, will be sent to each member of the voting Medical Staff at least seven calendar (7) days before the date of such meeting pursuant to the process described in Section 11.2.2.

11.4.2 Except as otherwise specified, the action of a majority of the members voting in person or by electronic ballot at a Medical Staff meeting at which a quorum is present pursuant to Section 11.3 shall be the action of the Medical Staff.

11.5 ATTENDANCE REQUIREMENTS

Members of the Active Medical Staff are encouraged to attend at least fifty percent (50%) of the regular and special meetings of the Medical Staff, of the department to which they are assigned, and committees to which they are assigned or elected.

11.6 AGENDA

11.6.1 The agenda at any regular Medical Staff meeting may include:

a. Call to order;

a. Acceptance of the minutes of the last regular and of all special meetings;

c. Unfinished business;

d. Communications/Reports;

e. Report from the Chief of Staff;

f. Reports of the Chief Executive Officer of the Hospital;

g. New business (including elections, where appropriate);

h. Educational presentations;

i. Adjournment.

11.6.2 The agenda of special meetings shall be:

a. Reading of the notice calling the meeting;

b. Transaction of business for which the meeting was called;

c. Adjournment.

11.6.3 Agenda items for Medical Staff meetings may be added by the Medical Executive Committee or a petition presented to the Chief of Staff by ten percent (10%) of the Active Medical Staff members not less than twenty (20) days before the scheduled regular meeting.

11.6.4 Only items listed on the agenda may be subject to action during the meeting.

11.7 MINUTES

Minutes of Medical Staff meetings shall be prepared and retained. They shall include, at a minimum, a record of attendance and votes taken on significant matters. Minutes shall be reviewed and accepted at the next scheduled meeting.

11.8 CONDUCT OF MEETINGS

11.8.1 Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

11.8.2 Tape recording of meetings shall not be allowed by any party for any purpose.

ARTICLE XII
DEPARTMENT AND COMMITTEE MEETINGS

12.1 REGULAR MEETINGS

12.1.1 DEPARTMENTS

Departments shall meet on an as needed basis to review and discuss patient care activities and to fulfill other departmental responsibilities.

12.1.2 COMMITTEES

Committees shall meet regularly in accordance with these Bylaws or as called by the Committee Chair.

12.2 SPECIAL MEETINGS

A special meeting of any department or committee may be called by the Chair, by the Chief of Staff, or by one-third (1/3) of the group's voting members, but not less than two (2) members.

12.3 NOTICE OF SPECIAL MEETINGS

Written/Electronic notice stating the date, place, and hour of any special meeting shall be given by the person or persons calling the meeting to each member of the department or committee but not less than five (5) days before the day of such meeting..

12.4 QUORUM

12.4.1 DEPARTMENTS

A quorum for any Medical Staff department shall consist of those members present (at minimum 2 voting members).

12.4.2 COMMITTEES

A quorum for any Medical Staff Committee meeting shall consist of three (3) or more voting members.

12.5 MANNER OF ACTION

The action of a majority of the voting members present at a meeting shall be the action of the department or committee. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting or such greater number as may be required by these Bylaws. Committee action may be conducted by electronic conference, which shall be deemed to constitute a meeting for the matters discussed in that conference. The meeting chair shall refrain from voting except when necessary to break a tie.

12.6 RIGHTS OF AD HOC COMMITTEE MEMBERS

Persons serving as ad hoc members of a committee shall have all rights and privileges of regular committee members except they shall not be counted in determining the existence of a quorum and shall not vote unless voting rights are otherwise granted by this document.

12.7 MINUTES

Minutes of all meetings shall include a record of the attendance of members and the vote taken on each matter. Minutes shall be reviewed and accepted at the next scheduled meeting and a record of the actions and recommendations forwarded to the Medical Executive Committee. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery, as provided by California law.

12.8 ATTENDANCE REQUIREMENTS

12.8.1 Medical Staff members shall attend at least 50% of committees to which they are assigned or elected. Attendance is encouraged for all Department, regular, and special meetings of the Medical Staff.

12.8.2 Members of the Medical Executive Committee are required to attend at least fifty percent (50%) of all regular Medical Executive Committee meetings. Failure of a Medical Executive Committee member to attend fifty percent (50%) of regularly scheduled Medical Executive Committee meetings in any twelve (12) month period shall constitute a voluntary resignation of Medical Executive Committee membership and voluntary resignation from any Medical Staff position which afforded the member a seat on the Medical Executive Committee. Any vacancies created by such a voluntary resignation will be filled by the Medical Executive Committee for the remainder of the current term except for the position of Chief of Staff, which would be filled by the Vice Chief of Staff. Exceptions to this requirement may be made by the Medical Executive Committee for cause.

12.8.3 The Chair of any Medical Staff committee may give notice to a practitioner that their attendance at a meeting is mandatory to discuss clinical competence, behavior, conduct, or any other quality or performance improvement issue is mandatory.

a. A practitioner's failure to attend any meeting with respect to which they were given notice that attendance was mandatory, unless excused by the Medical Executive Committee upon a showing of good cause, shall result in an automatic suspension of all of the practitioner's clinical privileges. Such automatic suspension shall remain in effect until the practitioner's mandatory attendance requirement has been met.

b. If the practitioner makes a timely request for postponement of mandatory meeting attendance supported by an adequate showing that their absence will be unavoidable, their attendance may be postponed to the next regular or special meeting of the committee by the Chair or by the Medical Executive Committee.

c. If the committee Chair is the practitioner involved, such a postponement may only be granted by the Medical Executive Committee.

d. This requirement shall not preclude any committee from reviewing the competence or conduct of any practitioner in their absence.

e. Automatic suspension of clinical privileges pursuant to this service shall not constitute grounds for hearing rights.

12.9 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

ARTICLE XIII
CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

By applying for and/or exercising clinical privileges within this Hospital, an individual:

13.1.1 Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the individual's professional ability and qualifications;

13.1.2 Authorizes persons and organizations to provide information concerning the individual to the Medical Staff;

13.1.3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of this article to the fullest extent permitted by law;

13.1.4 Acknowledges that the provisions of this Article are express conditions to the granting of Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

13.2 CONFIDENTIALITY OF INFORMATION

13.2.1 GENERAL

Medical Staff, department or committee minutes, files, and records, including information regarding any applicant, member, or other individual exercising clinical privileges, shall be considered Medical Staff minutes or records and, to the fullest extent permitted by law, shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157. Dissemination of such information and records shall only be made where expressly required by law, or pursuant to these Bylaws or officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee.

13.2.2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff applicants, members, and other individuals exercising clinical privileges to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments or committees, except in conjunction with other Hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred pursuant to the actions of a committee member, the Medical Executive Committee may undertake such responsive action as it deems appropriate.

13.2.3 MEDICAL STAFF RECORDS

Access to Medical Staff records shall be limited to duly appointed Officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained. Further details can be found in the Medical Staff General Rules and Regulations.

13.2.4 BOARD OF DIRECTORS INFORMATION

Medical Staff information or records which are disclosed to the Board of Directors of the Hospital or its appointed representatives, in order that the Board of Directors may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential.

13.3 IMMUNITY FROM LIABILITY

13.3.1 FOR ACTION TAKEN

Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant, member, or other individual exercising clinical privileges, and for damages or other relief for any action taken or statements or recommendations made within the scope of their duties as a representative of the Medical Staff or Hospital.

13.3.2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to any applicant, member, or other individual exercising clinical privileges, and from damages or other relief by reason of providing any information concerning such person in connection with any evaluation of their competence or conduct.

13.4 ACTIVITIES AND INFORMATION COVERED

13.4.1 ACTIVITIES

The confidentiality and immunity protections provided by Evidence Code section 1157 shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility or organizational activities concerning, but not limited to:

a. Applications for appointment, reappointment, or clinical privileges;

b. Responsive action;

c. Hearings and appellate reviews;

d. Utilization reviews;

e. Department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

f. The actions of peer review organizations, medical boards and other entities which engage in the monitoring or evaluation of professional competence or conduct.

13.5 RELEASES

Each applicant and each member or other individual exercising clinical privileges, shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent, of this Article. Execution of such releases, however, shall not be deemed a prerequisite to the effectiveness of this Article.

13.6 INDEMNIFICATION

The Hospital shall indemnify, defend, and hold harmless the Medical Staff and its individual members from and against losses and expenses (including attorney's fees, judgments, settlements and all other costs, direct or indirect) incurred or suffered by reason or based upon any threatened, pending, or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment and improvement activities including, but not limited to:

a. Serving as a member of or witness for a Medical Staff department, committee, orJudicial Review Committee;

b. Servings as a member or witness for the Hospital Board or any Hospital task force group or committee; and

c. Providing information to any Medical Staff or Hospital group, Officer, Board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant.

The Medical Staff member may seek indemnification and representation by a qualified attorney (approved by the Board of Directors, whose approval shall not be unreasonably withheld) under this Bylaw provision so long as the Medical Staff member has acted in good faith and upon reasonable belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or performance improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws. In no event will the Hospital be responsible to indemnify for acts or omissions taken in bad faith or in pursuit of the member's personal economic or private interests.

13.7 CUMULATIVE EFFECT

Provisions in these Bylaws and in Medical Staff applications relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE XIV
GENERAL PROVISIONS

14.1 RULES AND REGULATIONS AND MEDICAL STAFF POLICIES AND PROCEDURES

Medical Staff Rules & Regulations/Policies:

The Medical Staff shall initiate and adopt such Rules & Regulations/Policies as it may deem necessary and shall periodically review and revise its Rules & Regulations/Policies to comply with current Medical Staff practice. New Policies, Rules or changes to the Rules (proposed Rules) or Policies may emanate from any responsible committee, department, medical staff officer, or by petition

signed by at least two thirds of the voting members of the Medical Staff. Additionally, Hospital administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on Hospital operations and feasibility. Proposed Rules shall be submitted to the Medical Executive Committee for review and action, as follows:

a. Except as provided at Section 14.1-2(d), below, with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. This review and comment opportunity may be accomplished by posting proposed Rules on the Medical Staff website at least fifteen days prior to the scheduled Medical Executive Committee meeting, together with instructions how interested members may communicate comments. A comment period of at least fifteen days shall be afforded, and all comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed Rule.

b. Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least two thirds of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.1-6:

   1. If conflict management is not invoked within ten days, it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1-2(b)(3), the proposed Rule shall be forwarded to the Board of Directors for action. The Medical Executive Committee may forward comments to the Board of Directors regarding the reasons it declined to approve the proposed Rule.

   2. If conflict management is invoked, the proposed Rule shall not be voted upon or forwarded to the Board of Directors until the conflict management process has been completed and the results of the conflict management process shall be communicated to the Board of Directors.

   3. With respect to proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the voting Medical Staff members voting on the matter by electronic ballot, provided at least 14 days advance notice, accompanied by the proposed Rule, has been given.

c. Following approval by the Medical Executive Committee or favorable vote of the Medical Staff as described above, a proposed Rule shall be forwarded to the Board of Directors for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the Board of Directors or automatically within 60 days if no action is taken by the Board of Directors.

Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Rule and forward it to the Board of Directors for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described at Section 14.1-2(a)), the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least two thirds of the voting members of the Medical Staff, require the Rule to be submitted for possible recall; . However, the approved Rule shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 14.1-2.

14.1.2 ADOPTION BY THE BOARD OF DIRECTORS

Following Medical Executive Committee approval of Medical Staff General Rules and Regulations, departmental Rules and Regulations, or Medical Staff policies as noted above, such Rules and Regulations or policies shall become effective following approval by the Board of Directors. Board of Directors approval shall not be withheld unreasonably.

14.1.3 ADHERENCE TO MEDICAL STAFF RULES AND REGULATIONS, MEDICAL STAFF POLICIES, AND HOSPITAL ADMINISTRATIVE POLICIES

Applicants and members of the Medical Staff and others holding clinical privileges or exercising practice prerogatives shall be governed by all applicable Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital administrative policies which have been appropriately approved by the Medical Executive Committee and Board of Directors.

14.1.4 Conflict Management

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least two thirds (2/3) of the voting members of the Medical Staff) regarding a proposed or adopted Rule or policy or other issue of significance to the Medical Staff, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five (5) members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives. Unresolved differences shall be submitted to the Board of Directors for its consideration in making its final decision with respect to the proposed Rule, policy, or issue.

14.1.5 CONFLICT OF INTEREST

a. In accordance with the Medical Staff Conflict of Interest Policy, in any instance where a Medical Staff Officer or committee Chair has or reasonably could be perceived to have a conflict of interest or bias in any matter involving another Medical Staff member, such individual or member with a conflict shall disclose the conflict, and if determined by the chair of the committee, shall not participate in the discussion or voting on the matter and may be excused from any meeting during that time. However, that individual or committee member with a conflict may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the Chair of that committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias.

b. Any committee member with knowledge of the matter may call the existence of a potential conflict of interest or bias on the part of any committee member to the attention of the committee Chair.

c. A clinical committee Chair shall have a duty to delegate review of applications for appointment, reappointment, or clinical privileges, or questions that may arise to a vice Chair or other member of the committee if the Chair has a conflict of interest with the individual under review or could be reasonably perceived to be biased.

d. If the recusal of an Officer or committee member affects the quorum necessary to transact business or applicable functions, the Chief of Staff shall appoint an Active Staff member without a conflict to act on the matter(s) as a temporary replacement for the recused individual.

14.2 DUES OR ASSESSMENTS

a. The Medical Executive Committee shall have the power to establish the amount of dues, if any, for each category of Medical Staff and Advanced Practice Provider, and to determine the manner of expenditure of such funds received, provided that the expenditures are consistent with the purposes of the Medical Staff and shall not jeopardize the Hospital's status as a California Public District Hospital.

b. The Medical Executive Committee shall also have the power to recommend the amount of the application fee for each category of Medical Staff and Advanced Practice Provider, subject to the approval of the Board of Directors which shall not be unreasonably withheld. Except as otherwise approved by the Board of Directors, application fees are intended to defray the costs of Medical Staff credentialing functions.

14.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws.

14.4 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such responsive action as the Medical Executive Committee may deem appropriate.

14.5 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

14.6 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, or requests shall be in writing. An alternative delivery mechanism may be used if it is reliable, expeditious, and if evidence of its use is documented.

14.7 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, State, and national Hospital Medical Staff services shall be filled by such selection process as may be adopted by the Medical Executive Committee.

14.8 MEDICAL STAFF CREDENTIALS FILES

14.8.1 INSERTION OF LETTER OF REPRIMAND

The Medical Executive Committee may issue of a letter of admonition, censure, reprimand, or warning ("Letter of Reprimand") to any member of the Medical or Advanced Practice Provider Staff. Nothing herein shall be deemed to preclude a department Chair, committee Chair, or the Medical Executive Committee from issuing informal written or oral warning outside of the mechanism for issuance of a Letter of Reprimand as described in these Bylaws. The following provisions apply to issuance of a Letter of Reprimand:

a. Only the Medical Executive Committee shall have the authority to issue a Letter of Reprimand and place the Letter of Reprimand into the practitioner's credential file.

b. If the Medical Executive Committee authorizes the issuance of a Letter of Reprimand and insertion of a Letter of Reprimand into the practitioner's credential file, the practitioner shall be notified of this action and may respond in accordance with Section 14.8.2.

c. Notice to the practitioner shall include a copy of the Letter of Reprimand which will be inserted into the practitioner's credential file.

14.8.2 OPPORTUNITY TO REQUEST CORRECTION/DELETION OF INFORMATION CONTAINED IN A LETTER OF REPRIMAND AND/OR MAKE AN ADDITION OF INFORMATION TO THE CREDENTIAL FILE

a. When an individual has received notice of insertion of a Letter of Reprimand into their credential file, the practitioner may address to the Medical Executive Committee a written request for correction or deletion of information contained in the Letter of Reprimand. Such request shall include a statement of the basis for the action requested.

b. The Medical Executive Committee shall review such a request within a reasonable time and determine after such review whether or not to make the correction or deletion requested by the practitioner.

c. The member shall be notified in writing of the decision of the Medical Executive Committee in this matter.

d. In any case, the practitioner shall have the right to add to their own credential file, upon written request to the Medical Executive Committee, a statement responding to the information contained in the Letter of Reprimand.

14.9 CONFIDENTIALITY OF THE CREDENTIAL FILE

Medical Staff members or other individuals exercising clinical privileges shall be granted access to their own credentials file, subject to the following provisions:

14.9.1 A request for access must be submitted in writing to the Chief of Staff;

14.9.2 The individual may review, and receive a copy of, only those documents provided by or addressed personally to the individual.

14.9.3 The review by the individual shall be scheduled in advance at a mutually agreeable date and time and take place in the Medical Staff Services Department during normal work hours. An Officer or designee of the Medical Staff shall be present.

14.10 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

14.10.1 The Medical Executive Committee shall make recommendations to the Board of Directors regarding all quality of care issues related to exclusive arrangements for physician and/or medical professional services prior to action by the Board of Directors. Such arrangements include:

a. Execution of an exclusive contract in a previously open department or service;

b. Renewal or modification of an exclusive contract in a department or service;

d. Termination of an exclusive contract in a department or service.

14.10.2 The Medical Executive Committee shall conduct the review using an appropriate mechanism and may elect to conduct a notice and comment hearing to assess the quality of care issues related to such arrangements. The results of the Medical Executive Committee assessment shall be reported to the Chief Executive Officer and to the Board of Directors.

14.10.3 The Board of Directors shall consider the recommendations of the Medical Executive Committee related to quality of care issues prior to making a decision regarding an exclusive arrangement for physician and/or medical professional services.

14.10.4 Notwithstanding any other provision of these Bylaws, a member of the Medical Staff, whose Medical Staff Membership and/or clinical privileges are impacted as a result of the implementation or termination of an exclusive agreement between the Hospital and the member, another practitioner, or an entity, shall not be entitled to procedural rights of a fair hearing or appeal afforded by Article VII of these Bylaws.

14.11 FORMS

Application documents and any other prescribed forms required by these Bylaws for use in connection with Medical Staff and Advanced Practice Provider appointments, reappointments, delineation of privileges, responsive action, notices, recommendations, reports, and other matters shall be approved by the Medical Executive Committee and the Board of Directors. Upon adoption, they shall be deemed part of the Medical Staff Rules. Substantive amendments shall require approval of the Medical Executive Committee and the Board of Directors.

14.12 LEGAL COUSEL

The Medical Staff may retain and be represented by independent legal counsel.

ARTICLE XV
HEALTH INFORMATION PRIVACY AND CONFIDENTIALITY

15.1 PROTECTED HEALTH INFORMATION

Federal, State and local laws and regulations, including, but not limited to, the California Confidentiality of Medical Information Act, Cal. Civ. Code §56 *et seq*., California Privacy Laws, Cal. Health & Safe. Code §1280.15, and the Federal Health Insurance Portability and Accountability Act of 1996, and regulations from time to time promulgated thereunder, 42 C.F.R. §164.500 *et. seq*. (HIPAA), ("collectively "Privacy Regulations"), require providers to implement policies and procedures to protect the privacy and security of individually identifiable patient information ("protected health information" or "PHI") and to afford individuals certain rights with regard to their health information. PHI includes any health related information that identifies or could be used to identify an individual, including patient medical and billing records. These Privacy Regulations apply to the Hospital, including its employees, and to the physicians and other independent health care practitioners who practice at the Hospital.

15.1.1 The Hospital and the physicians and other independent practitioners practicing at the Hospital constitute a clinically integrated care setting and as such qualify as an "Organized Health Care Arrangement" under the Privacy Regulations. This allows the Hospital and its physicians and other practitioners to meet their obligations under the Privacy Regulations by adopting joint privacy practices for the use and disclosure of PHI for Hospital patients.

15.1.2 The Hospital has adopted policies and procedures for the use and disclosure of PHI. These uses and disclosures are summarized in the Hospital's Notice of Privacy Practices, which is furnished to patients and posted at the Hospital's facilities.

15.1.3 The Notice of Privacy Practices applies to all PHI created or received in the course of providing health care or conducting business operations at any location of the Hospital. It is given jointly on behalf of the Hospital and its independent practitioners, including the members of the Medical and Advanced Practice Provider Staff, who provide health care services at any Hospital location. It does not, however, apply to patient health information at locations not operated by the Hospital, such as a Medical Staff member's private office.

15.1.4 Each member of the Medical and Advanced Practice Provider Staff must comply with the Hospital's policies and procedures for health information privacy and security, which may be amended from time to time, including the terms of the Hospital's Notice of Privacy Practices. No member of the Medical or Advanced Practice Provider Staff may adopt or distribute a different notice of privacy practices relating to health information for Hospital patients. Medical and Advanced Practice Staff members must, however, adopt their own privacy practices at locations not operated by the Hospital, such as their private offices.

15.2 ACCESS, USE AND DISCLOSURE OF HEALTH INFORMAITON

15.2.1 As members of an Organized Health Care Arrangement with the Hospital, members of the Medical and Advanced Practice Provider Staff may have access to patient health information as necessary for them to perform any Medical Staff or Hospital related administrative functions. These include department and committee peer review and quality assurance activities as well as medical direction and other administrative services, whether or not they are performed pursuant to contract. The Hospital has adopted policies concerning the access, use and disclosure of health information by Medical Staff members in the course of providing administrative services. Each member of the Medical and Advanced Practice Provider Staff

providing administrative services on behalf of the Hospital or the Medical Staff must comply with these policies, as amended from time to time.

ARTICLE XVI
MEDICAL RECORDS

16.1 HISTORY AND PHYSICALS

A History and Physical ("H&P") must be completed and documented for each patient no more than thirty (30) days prior to or twenty four (24) hours after Hospital admission or registration, but prior to surgery or a procedure requiring anesthesia services. The H&P may be written or transcribed, but always must be placed in the patient's medical record within twenty four (24) hours of admission or registration, or prior to surgery or a procedure requiring anesthesia, whichever comes first. Detailed requirements for completion and updating of admission and surgical histories and physicals are outlined in Article 8.8.2.2 of the Medical Staff General Rules and Regulations.

ARTICLE XVII
ADOPTION AND AMENDMENTS OF BYLAWS

17. Medical Staff Responsibility and Authority

17.1-1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Board of Directors, which approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Board of Directors. Additionally, Hospital administration may develop and recommend proposed Bylaws, and in any case should be consulted as to the impact of any proposed Bylaws on Hospital operations and feasibility.

17.1-2 Proposed amendments shall be submitted to the Board of Directors for comments at least 30 days before they are distributed to the Medical Staff for a vote. The Board of Directors has the right to have its comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

17.1-3 Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least two thirds of the voting Medical Staff members. Amendments submitted upon petition of the voting Medical Staff members shall be provided to the Medical Executive Committee at least 30 days before they are submitted to the Board of Directors for review and comment as described in Section 17.1-2. The Medical Executive Committee has the right to have its comments regarding the proposed amendments circulated to the Board of Directors when the proposed amendments are submitted to the Board of Directors for comments, and to have its comments circulated to the Medical Staff with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

17.2 Methodology

17.2-1 Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:

a. The affirmative vote of a majority of the Medical Staff members voting on the matter by electronic ballot, provided at least 14-days advance notice, accompanied by the proposed Bylaws and/or alterations, has been given; and

b. The approval of the Board of Directors, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing, and shall be forwarded to the Chief of Staff and the Medical Executive Committee.

17.2-2 In recognition of the ultimate legal and fiduciary responsibility of the Board of Directors, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Board of Directors to such effect, including a reasonable period of time for response, that the Board of Directors may impose conditions on the Medical Staff that are required for continued state licensure, approval by accrediting bodies, or to comply with law or a court order. In such event, Medical Staff recommendations and views shall be carefully considered by the Board of Directors in its actions.

17.2-3 Technical and Editorial Corrections

The Medical Executive Committee shall have the power to approve technical corrections, such as reorganization or renumbering of the Bylaws, or to correct punctuation, spelling, or other errors of grammar expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the Board of Directors. Such corrections are effective upon adoption by the Medical Executive Committee. However, they may be rescinded by vote of the Medical Staff or the Board of Directors within 120 days of the date of adoption by the Medical Executive Committee. (For purposes of this Section, "vote of the Medical Staff" shall mean a majority of the votes cast, provided at least 25 percent of the voting members of the Medical Staff cast ballots.)

17.3 APPROVAL

Bylaws changes adopted by the Medical Staff shall become effective following approval of the Board of Directors, which approval shall not be withheld unreasonably. Neither the Board of Directors nor the Medical Staff may unilaterally amend or cancel the Medical Staff Bylaws. If approval by the Board of Directors is withheld, the reason for doing so shall be specified by the Board of Directors in writing and shall be forwarded to the Chief of Staff and the Medical Executive Committee. Changes in the Bylaws adopted at any regular or special meeting of the Medical Staff shall, upon approval of the Board of Directors, replace any previous Bylaws.

17.4 EXCLUSIVE MECHANISM

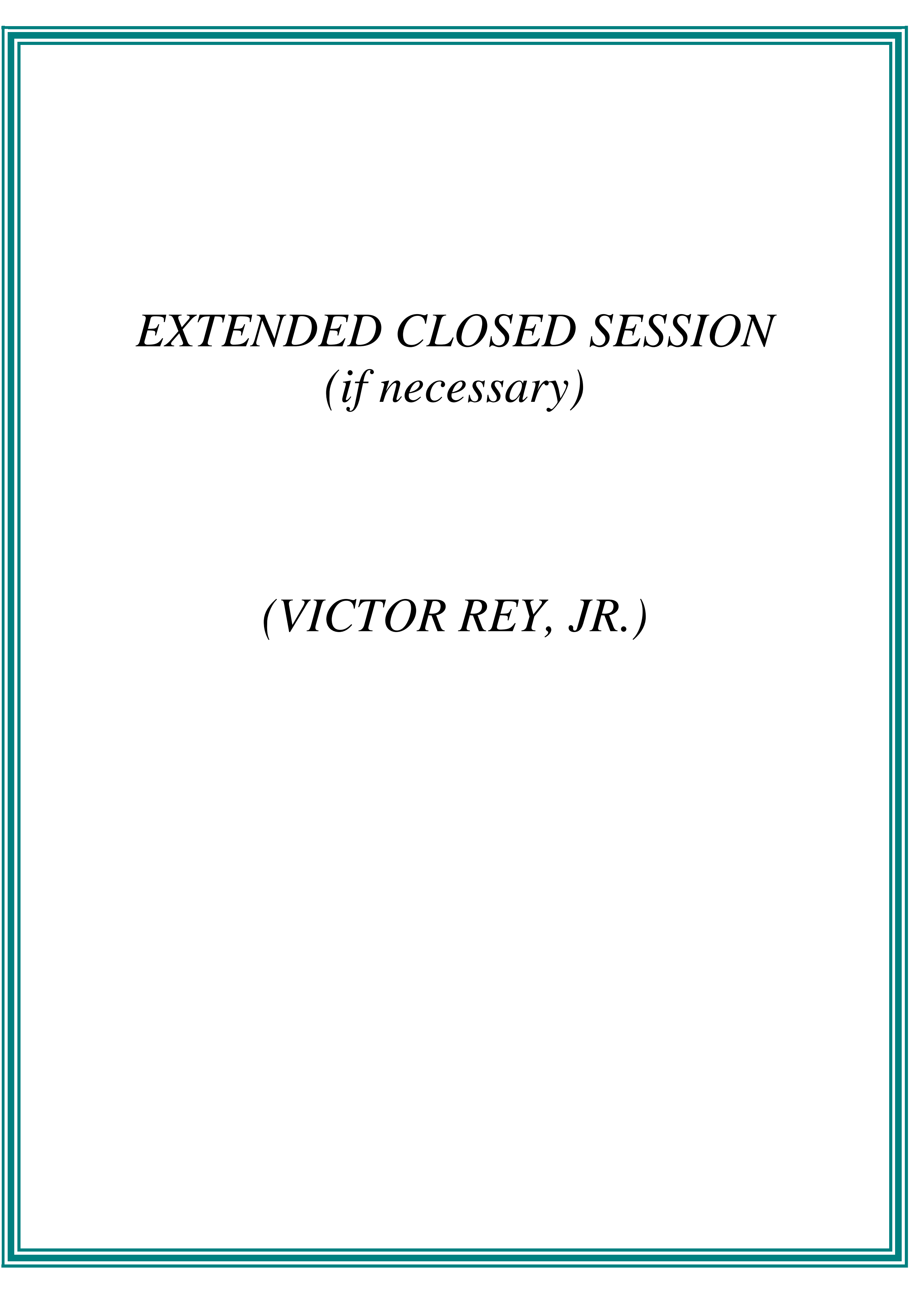
The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

17.5 DOCUMENT RESOLUTION

If there is a conflict between the Bylaws and Medical Staff Rules and Regulations, the Bylaws shall prevail. If there is a conflict between the Department Rules and Regulations and the Medical Staff Rules and Regulations, the Medical Staff Rules and Regulations shall prevail. If there is a conflict between Medical Staff Rules and Regulations and Medical Staff Policies and Procedures, the document which has most recently been reviewed and approved by the Medical Executive Committee shall prevail.

17.6 SUCCESSOR IN INTEREST

These Bylaws and the membership privileges accorded under these Bylaws will be binding upon the Medical Staff, the Advanced Practice Provider Staff, and the Board of Directors. To the extent that any future merger, acquisition, or other affiliation requires a merger of this Medical Staff with another, or the reconstitution of this Medical Staff, these Bylaws will remain in full force and effect until such time as new Bylaws or Bylaw revisions are properly drafted, adopted, and approved. Any accounts under the title of Medical Staff Funds, irrespective of the tax identification number under which they are maintained, shall remain the property of the medical staff for use as outlined in Article 14.2.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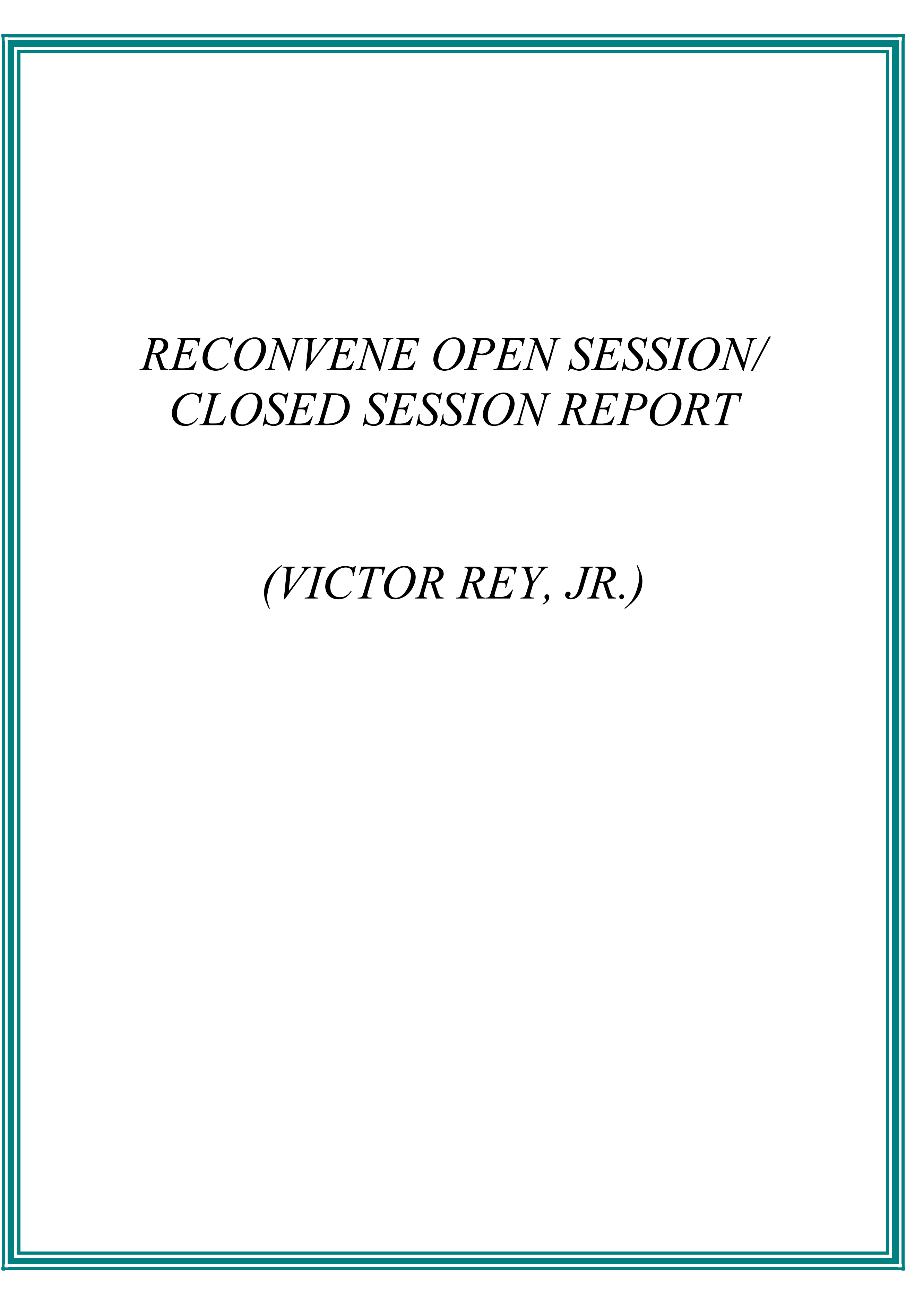
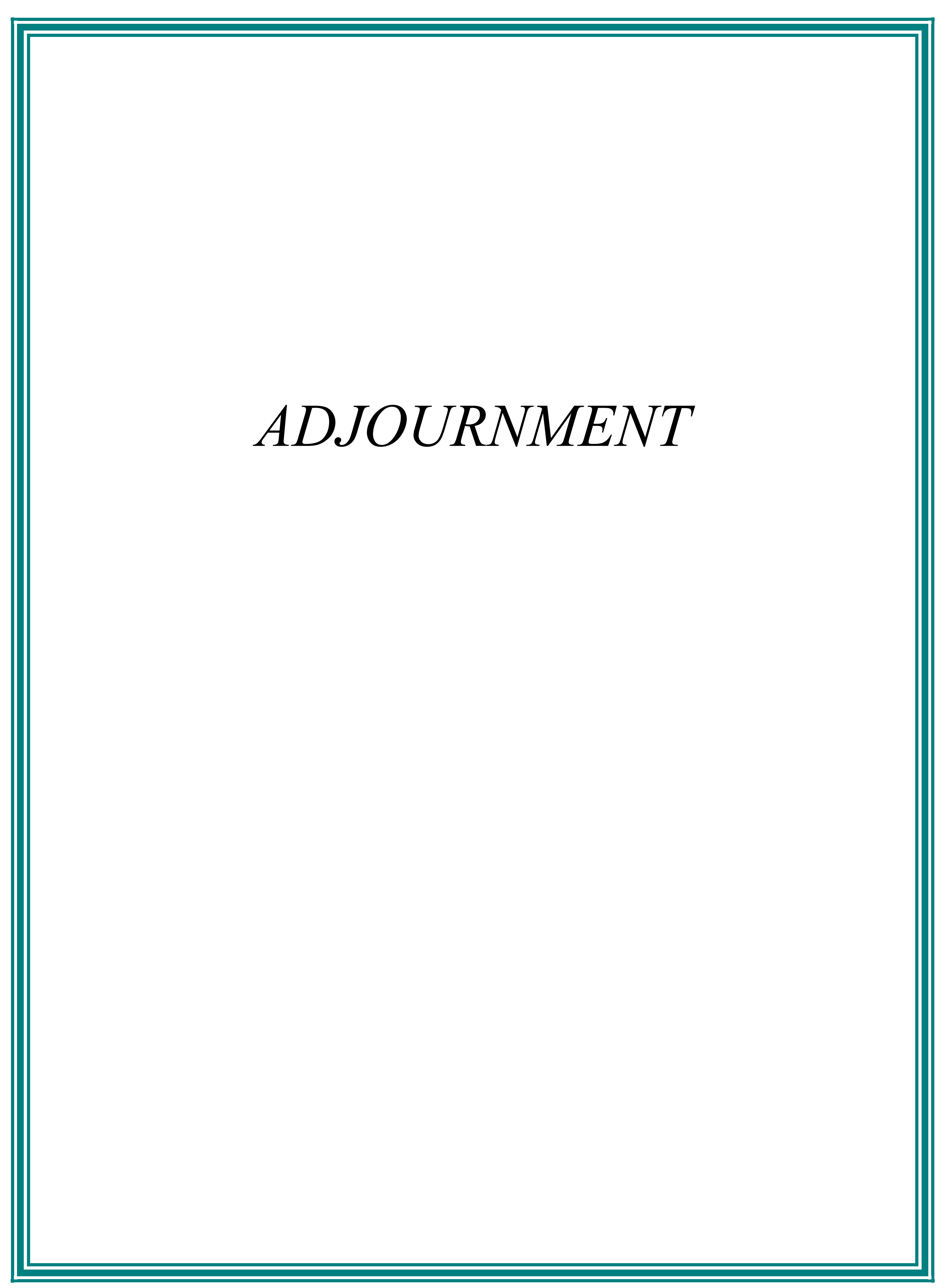


RECONVENE OPEN SESSION/
CLOSED SESSION REPORT

(VICTOR REY, JR.)



ADJOURNMENT