June 16, 2023

TO: Legal Counsel

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

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **WEDNESDAY, JUNE 21, 2023, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** or via **TELECONFERENCE** (*visit* **SalinasValleyHealth.com/virtualboardmeeting** *for Access Information*).

Pete Delgado
President/Chief Executive Officer

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

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

WEDNSDAY, JUNE 21, 2023, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C
SALINAS VALLEY HEALTH MEDICAL CENTER
450 E. ROMIE LANE, SALINAS, CALIFORNIA
or via TELECONFERENCE

(Visit salinasvalleyhealth.com/virtualboardmeeting for Access Information)

AGENDA

		Presented By
1.	**CALL TO ORDER / ROLL CALL**	*Victor Rey, Jr.*
2.	**CLOSED SESSION** *(See Attached Closed Session Sheet Information)*	*Victor Rey, Jr.*
3.	**RECONVENE OPEN SESSION/CLOSED SESSION REPORT** *(Estimated time 5:30 pm)*	*Victor Rey, Jr.*
4.	**EDUCATION PROGRAM – BOARD RESOURCES VIA VERALON (FORMERLY IPROTEAN)**	*Adrienne Laurent*
5.	**REPORT FROM THE PRESIDENT/CHIEF EXECUTIVE OFFICER**	*Pete Delgado*
6.	**PUBLIC INPUT** 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, Jr.*
7.	**BOARD MEMBER COMMENTS**	*Board Members*
8.	**CONSENT AGENDA - GENERAL BUSINESS** *(Board Member may pull an item from the Consent Agenda for discussion.)*	*Victor Rey, Jr.*

A. Minutes of May 25, 2023 Regular Meeting of the Board of Directors
B. Minutes of June 6, 2023 Special Meeting of the Board of Directors
C. Financial Report
D. Statistical Report
E. Policies Requiring Approval
   Mobile Phones & Digital Devices
   Fire Safety for Procedures
   Emergent Open Sternotomy (Assist)
   Nursing Excellence / Peer Review
   Operating Budget
F. Approval of Public Entity Banking Resolution for Mechanics Bank, N.A. identifying authorized signers for District deposit accounts

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

A.	**QUALITY AND EFFEICIENT PRACTICES COMMITTEE** Minutes of the June 19, 2023 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.	*Catherine Carson*

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

B. **FINANCE COMMITTEE** *Joel Hernandez Laguna*

Minutes of the June 19, 2023 Finance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board:

1. Consider Recommendation for Board of Directors Approval of the Fiscal Year 2024 (FY2024) Operating & Capital Budget as presented.

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

C. **COPORATE COMPLIANCE AND AUDIT COMMITTEE** *Juan Cabrera*

Minutes of the June 20, 2023 Corporate Compliance and Audit Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF JUNE 8, 2023, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING: *Theodore Kaczmar, Jr., MD*

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

B. Policies/Procedures/Plans:
   1. Appendix A – Quality Assessment and Performance Improvement Plan (QAPI) – 2023 Project List
   2. Appendix B – QAPI – 2023 Indicators and Scope
   3. Infection Prevention Program Plan
   4. Emergency Management Program Plan

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

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

12. ADJOURNMENT

The Regular Meeting of the Board of Directors is scheduled for **Thursday, July 27, 2023, at 4:00 p.m.**

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

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

SALINAS VALLEY HEALTH BOARD OF DIRECTORS

AGENDA FOR CLOSED SESSION

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

CLOSED SESSION AGENDA ITEMS

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

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

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

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

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

1. Report of the Medical Staff Credentials Committee
2. Report of the Medical Staff Interdisciplinary Practice Committee
3. Report of the Medical Staff Quality and Safety Committee
4. Report of the Quality and Efficient Practices Committee
    a. Report Risk Management/ Patient Safety and Accreditation and Regulatory Reports
    b. Report Dialysis Services Program
    c. Palliative and Spiritual Care
    d. Quality and Safety Board Dashboard Review
    e. Emergency Management Plan
    f. Receive and Accept Quality and Efficient Practices Committee Reports
        i. Environment of Care Committee
        ii. Accreditation and Regulatory Report
        iii. Clinical Alarm Safety
        iv. Diagnostic Discrepancies 3Q and 4Q 2022: Pathology report
        v. Pharmacy and Therapeutics Committee Report/Infection Prevention Program

ADJOURN TO OPEN SESSION

CALL TO ORDER/ROLL CALL

(VICTOR REY, JR.)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

(VICTOR REY, JR.)

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

(VICTOR REY, JR.)

EDUCATION PROGRAM -
BOARD RESOURCES VIA VERALON

(VERBAL)

(ADRIENNE LAURENT)

REPORT FROM THE PRESIDENT/ CHIEF EXECUTIVE OFFICER

(VERBAL)

(PETE DELGADO)

PUBLIC INPUT

BOARD MEMBER COMMENTS

(VERBAL)

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
May 25, 2023

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

Absent: Vice President Joel Hernandez Laguna

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

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Rey called the meeting to order at 4:07 p.m.

2. CLOSED SESSION

President Victor Rey, Jr. announced items to be discussed in Closed Session as listed on the posted Agenda are (1) *Report Involving Trade Secrets*, (2) *Conference with legal Counsel-Existing Litigation*, and (3) *Hearings/Reports*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:10 p.m. The Board completed its business of the Closed Session at 5:20 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 5:34 p.m. President Victor Rey, Jr. reported that in Closed Session, the Board discussed (1) *Report Involving Trade Secrets*, (2) *Conference with legal Counsel-Existing Litigation*, and (3) *Hearings/Reports*. The Board received the reports listed on the Closed Session Agenda. No additional actions were taken.

4. EDUCATION PROGRAM – LABORATORY SERVICES UPDATE

Received an update on Laboratory Services from Timothy Johnson, Lead Clinical Lab Scientist; Brandon Reed, Laboratory Technical Supervisor; Johnny Hu, Physician, and Frank Yu, Lead Clinical Laboratory Scientist

5. REPORT FROM THE PRESIDENT/CHIEF EXECUTIVE OFFICER

Received a report from President Pete Delgado. Aubree Collins, Staff Nurse III reported on the Collaborative Care Committee. Lisa Paulo, Chief Nursing Officer reported on the Quality Pillar, and Adrienne Laurent, Chief Communications Officer reported on the People Pillar.

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

6. PUBLIC INPUT

Public Comment received from Kati Bassler, President of Salinas Valley Federation of Teachers. Kati spoke about the Office of Health Care Affordability.

Public Comment received from Steve McDougall, Treasurer of Salinas Valley Federation of Teachers. Steve spoke about medical inflation rates.

7. BOARD MEMBER COMMENTS

Director Victor Rey congratulated staff on the Hospital's 70th-anniversary celebration event.

Director J. Cabrera no comment.

Director Carson congratulated staff on the Hospital's 70th-anniversary celebration event.

8. CONSENT AGENDA – GENERAL BUSINESS

- **a.** Minutes of April 20, 2023 Regular Meeting of the Board of Directors
- **b.** Financial Report
- **c.** Statistical Report
- **d.** Policies Requiring Approval
  Patient Safety Program Plan
  Scope of Service: Pharmacy
  Scope of Service Transport
  Scope of Service: Outpatient Infusion
  Tuition Assistance

PUBLIC COMMENT:
None

MOTION:
Upon motion by Director Carson, second by Director Cabrera, the Board of Directors approved the Consent Agenda, Items (a) through (d), as presented.

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

Motion Carried

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

a. Quality and Efficient Practices Committee

Received a report from Director Catherine Carson regarding the Quality and Efficient Practices Committee.

b. Finance Committee

Received a report from Director Joel Hernandez Laguna regarding the Finance Committee. The Finance Committee makes the following recommendations to the Board:

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

PUBLIC COMMENT:
None

MOTION:

Upon motion by Director Carson, second by Director Victor Rey Jr., the Board of Directors approves the three-year Microsoft Enterprise Agreement licensing renewal through CDW Government, a Supplier of Salinas Valley Health's group purchasing organization and contract award in the amount of $2,319,121.32.

BOARD DISCUSSION:

Director Victor Rey, Jr. commented to staff that this was a very thorough report.

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

Motion Carried

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

PUBLIC COMMENT:
None

MOTION:
Upon motion by Director Carson, second by Director Juan Cabrera, the Board of Directors approves engaging Guidehouse to conduct an organizational-wide Assessment and Strategy Plan (Phase 1) for Financial Performance Improvement in the amount of $2,319,121.32

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

Motion Carried

c. Personnel, Pension and Investment Committee

Received a report from Director Juan Cabrera regarding the Personnel, Pension, and Investment Committee.

d. Community Advocacy Committee

Director Victor Rey, Jr. received and accepted the minutes from the May 23, 2023, Community Advocacy Committee meeting.

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

Received a report from Matthew Ottone, District Legal Counsel regarding Resolution No. 2023-04.

PUBLIC COMMENT:
None

BOARD DISCUSSION:

Director Victor Rey, Jr. thanked Counsel for updating the Bylaws.

MOTION:

Upon motion by Director Carson, second by Director Juan Cabrera, the Board of Directors approves Resolution No. 2023-04 adopting amended and restated District Bylaws.

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

Motion Carried

11. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON MAY 11, 2023, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING

Received a report from Theodore Kaczmar, Jr., regarding the Medical Executive Committee meeting on May 11, 2023, and recommendations for Board approval.

Recommend Board Approval of the following:

a. Reports
    1. Credentials Committee Report
    2. Interdisciplinary Practice Committee Report
b. Policies/Procedures/Plans:
    1. Risk Management Plan
    2. Quality Assessment and Performance Improvement Plan

PUBLIC COMMENT:
None

MOTION:
Upon motion by Director Cabrera, second by Director Catherine Carson, the Board of Directors receives and approves the Medical and Executive Committee Reports and the Policies, Procedures, and Plans.

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

Motion Carried

12. EXTENDED CLOSED SESSION

An extended Closed Session was not required

13. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Wednesday, June 21 at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:45 p.m.

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Rolando Cabrera, MD
Secretary, Board of Directors

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM[1]
SPECIAL MEETING OF THE BOARD OF DIRECTORS – BUDGET WORKSHOP
MEETING MINUTES
JUNE 6, 2023

Committee Members Present:
In-person: President Victor Rey, Vice President Joel Hernandez, and Director Juan Cabrera
Via Teleconference: Director Catherine Carson
Committee Members Absent: Director Rolando Cabrera

Absent: None

Also Present:
Pete Delgado, President/Chief Executive Officer
Julian Lorenzana, Board Clerk

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Rey called the meeting to order at 5:07 p.m.

2. CLOSED SESSION

President Victor Rey, Jr. announced items to be discussed in Closed Session as listed on the posted Agenda (1) *Report Involving Trade Secrets*. The meeting recessed into Closed Session under the Closed Session Protocol at 5:08 p.m. The Board completed its business of the Closed Session at 6:55 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:55 p.m. President Victor Rey, Jr. reported that in Closed Session, the Board discussed (1) a *Report Involving Trade Secrets*. The Board received the reports listed on the Closed Session Agenda. No additional actions were taken.

4. PUBLIC INPUT

No public comment received

5. BOARD MEMBER COMMENTS

Director Juan Cabrera commented that he could tell that the staff have put a lot of work into the presentation and thanked the staff for their efforts.

Director Catherine Carson commented that a budget is just a guide and should be used as a framework. She appreciates that staff will be adjusting as things come up.

6. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Wednesday, June 21 at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:58 p.m.

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

_____
Rolando Cabrera, MD
Secretary, Board of Directors

SALINAS VALLEY MEMORIAL HOSPITAL
SUMMARY INCOME STATEMENT
May 31, 2023

	Month of May,		Eleven months ended May 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 52,684,616	$ 46,127,137	$ 577,006,658	$ 537,377,634
Other operating revenue	2,172,850	1,050,765	17,898,078	13,508,895
Total operating revenue	54,857,466	47,177,902	594,904,736	550,886,529
Total operating expenses	47,265,683	44,631,025	520,887,493	468,357,233
Total non-operating income	2,863,275	(3,993,614)	(16,728,110)	(38,705,769)
Operating and non-operating income	$ 10,455,059	$ (1,446,738)	$ 57,289,134	$ 43,823,527

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
May 31, 2023

	Current year	Prior year
ASSETS:		
Current assets	$ 443,660,407	$ 400,982,318
Assets whose use is limited or restricted by board	157,882,515	148,424,283
Capital assets	243,759,762	239,040,048
Other assets	173,318,052	228,689,616
Deferred pension outflows	95,857,027	50,119,236
	$ 1,114,477,763	$ 1,067,255,501
LIABILITIES AND EQUITY:		
Current liabilities	104,000,896	115,204,230
Long term liabilities	16,644,243	14,288,063
Lease deferred inflows	1,642,999	0
Pension liability	79,111,485	83,585,120
Net assets	913,078,140	854,178,089
	$ 1,114,477,763	$ 1,067,255,501

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF NET PATIENT REVENUE
May 31, 2023

	Month of May,		Eleven months ended May 31,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,749	1,897	21,870	19,388
Medi-Cal	1,138	999	12,890	10,789
Commercial insurance	596	710	8,061	8,160
Other patient	123	96	1,381	1,210
Total patient days	3,606	3,702	44,202	39,547
Gross revenue:				
Medicare	$ 108,533,041	$ 101,335,632	$ 1,158,444,536	$ 1,025,520,833
Medi-Cal	74,151,405	62,176,941	781,325,408	621,634,239
Commercial insurance	55,149,226	49,650,786	572,150,620	543,564,234
Other patient	9,652,934	7,721,389	96,843,918	88,989,539
Gross revenue	247,486,606	220,884,748	2,608,764,482	2,279,708,844
	73.8%	74.0%	74.4%	72.3%
Deductions from revenue:				
Administrative adjustment	558,645	279,149	3,014,033	3,287,908
Charity care	612,690	1,128,993	6,900,247	9,038,495
Contractual adjustments:				
Medicare outpatient	36,066,197	30,742,514	337,192,850	303,545,000
Medicare inpatient	40,549,698	45,163,802	510,450,299	451,421,745
Medi-Cal traditional outpatient	2,658,159	3,576,523	36,229,315	32,576,612
Medi-Cal traditional inpatient	5,196,564	6,512,438	58,540,773	66,025,585
Medi-Cal managed care outpatient	30,782,462	25,124,113	311,636,608	241,771,635
Medi-Cal managed care inpatient	27,787,607	21,702,601	284,545,963	211,133,445
Commercial insurance outpatient	22,503,497	18,767,795	203,510,164	182,951,789
Commercial insurance inpatient	21,888,807	17,626,357	220,023,944	190,345,758
Uncollectible accounts expense	4,530,415	3,963,591	43,134,124	41,573,189
Other payors	1,667,249	169,734	16,579,504	8,660,049
Deductions from revenue	194,801,990	174,757,611	2,031,757,824	1,742,331,211
Net patient revenue	$ 52,684,616	$ 46,127,137	$ 577,006,658	$ 537,377,634
	21.29%	20.88%	22.12%	23.57%
Gross billed charges by patient type:				
Inpatient	$ 123,611,612	$ 115,220,721	$ 1,399,986,371	$ 1,219,214,152
Outpatient	89,980,196	75,440,291	884,548,844	767,663,230
Emergency room	33,894,799	30,223,736	324,229,268	292,831,462
Total	$ 247,486,607	$ 220,884,748	$ 2,608,764,483	$ 2,279,708,844

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES
May 31, 2023

	Month of May,		Eleven months ended May 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 52,684,616	$ 46,127,137	$ 577,006,658	$ 537,377,634
Other operating revenue	2,172,850	1,050,765	17,898,078	13,508,895
Total operating revenue	54,857,466	47,177,902	594,904,736	550,886,529
Operating expenses:				
Salaries and wages	16,310,483	16,616,963	185,459,007	171,145,238
Compensated absences	2,942,162	3,036,554	31,798,016	30,170,963
Employee benefits	7,640,179	7,626,449	86,913,639	75,411,618
Supplies, food, and linen	6,821,514	6,306,021	75,291,499	69,701,677
Purchased department functions	3,957,066	3,776,831	45,271,053	38,004,670
Medical fees	3,208,301	1,444,422	24,111,704	20,110,148
Other fees	2,799,575	2,286,871	32,132,506	27,592,076
Depreciation	1,840,083	2,114,577	22,174,304	20,561,820
All other expense	1,746,320	1,422,337	17,735,765	15,659,023
Total operating expenses	47,265,683	44,631,025	520,887,493	468,357,233
Income from operations	7,591,783	2,546,877	74,017,243	82,529,296
Non-operating income:				
Donations	1,391,915	166,667	9,758,339	1,909,206
Property taxes	333,333	333,333	3,666,667	3,666,667
Investment income	786,758	832,106	6,846,700	(11,729,183)
Taxes and licenses	0	0	0	(29,074)
Income from subsidiaries	351,269	(5,325,720)	(36,999,816)	(32,523,385)
Total non-operating income	2,863,275	(3,993,614)	(16,728,110)	(38,705,769)
Operating and non-operating income	10,455,059	(1,446,738)	57,289,134	43,823,527
Net assets to begin	902,623,081	855,624,827	855,789,006	810,354,562
Net assets to end	$ 913,078,140	$ 854,178,089	$ 913,078,140	$ 854,178,089
Net income excluding non-recurring items	$ 10,455,059	$ (1,446,738)	$ 57,289,134	$ 37,531,151
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	6,292,376
Operating and non-operating income	$ 10,455,059	$ (1,446,738)	$ 57,289,134	$ 43,823,527

SALINAS VALLEY MEMORIAL HOSPITAL
SCHEDULES OF INVESTMENT INCOME
May 31, 2023

	Month of May,		Eleven months ended May 31,	
	current year	prior year	current year	prior year
Detail of other operating income:				
Dietary revenue	$ 178,866	$ 139,721	$ 1,803,683	$ 1,542,531
Discounts and scrap sale	293,535	283,031	1,214,491	1,334,564
Sale of products and services	62,458	33,874	419,360	714,471
Clinical trial fees	0	0	0	27,700
Stimulus Funds	0	0	0	0
Rental income	303,630	230,902	1,985,114	1,821,171
Other	1,334,361	363,237	12,475,430	8,068,458
Total	$ 2,172,850	$ 1,050,765	$ 17,898,078	$ 13,508,895
Detail of investment income:				
Bank and payor interest	$ 1,456,866	$ 107,460	$ 9,781,997	$ 967,327
Income from investments	(670,107)	671,989	(1,733,047)	(14,406,255)
Gain or loss on property and equipment	0	52,657	(1,202,250)	1,709,745
Total	$ 786,758	$ 832,106	$ 6,846,700	$ (11,729,183)
Detail of income from subsidiaries:				
Salinas Valley Medical Center:				
Pulmonary Medicine Center	$ (85,701)	$ (170,787)	$ (1,843,899)	$ (2,020,149)
Neurological Clinic	(28,018)	(62,178)	(712,287)	(609,252)
Palliative Care Clinic	(85,759)	(50,196)	(766,657)	(863,144)
Surgery Clinic	(135,980)	(147,789)	(1,578,081)	(1,397,208)
Infectious Disease Clinic	(29,324)	(35,534)	(338,379)	(287,491)
Endocrinology Clinic	(162,582)	(144,794)	(1,898,292)	(1,374,401)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(434,256)	(539,013)	(5,301,157)	(4,622,964)
OB/GYN Clinic	(354,036)	(223,298)	(3,633,241)	(3,646,003)
PrimeCare Medical Group	(526,078)	(1,123,783)	(7,304,234)	(5,566,811)
Oncology Clinic	(453,752)	(434,072)	(3,077,487)	(2,577,048)
Cardiac Surgery	(451,113)	(553,920)	(3,307,299)	(2,277,942)
Sleep Center	(51,899)	(66,917)	(415,586)	(366,893)
Rheumatology	(57,929)	(75,056)	(682,678)	(611,261)
Precision Ortho MDs	(286,885)	(567,107)	(4,211,239)	(3,242,423)
Precision Ortho-MRI	0	(190)	0	(190)
Precision Ortho-PT	(26,849)	(61,609)	(397,364)	(531,807)
Vaccine Clinic	0	(5,864)	(683)	(58,413)
Dermatology	(25,118)	(34,918)	(211,634)	(188,452)
Hospitalists	0	0	0	0
Behavioral Health	(43,545)	(35,112)	(378,380)	(684,937)
Pediatric Diabetes	(46,730)	(53,904)	(503,954)	(472,080)
Neurosurgery	(27,953)	(2,458)	(337,098)	(246,396)
Multi-Specialty-RR	9,594	(12,239)	80,734	89,264
Radiology	2,466,268	(247,386)	(497,495)	(2,549,826)
Salinas Family Practice	(107,603)	(135,868)	(1,145,286)	(1,068,887)
Urology	(13,004)	(69,540)	(975,553)	(240,135)
Total SVMC	(958,252)	(4,853,532)	(39,437,229)	(35,414,849)
Doctors on Duty	(191,556)	(522,839)	515,961	78,816
Vantage Surgery Center	0	(18,965)	0	222,007
LPCH NICU JV	1,387,567	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	142,323	2,873	1,590,881	2,239,637
Coastal	27,287	(23,219)	31,882	(275,270)
Apex	0	0	0	103,759
GenesisCare USA	(76,364)	55,096	(104,986)	119,984
Monterey Bay Endoscopy Center	20,263	34,866	403,674	402,531
Total	$ 351,269	$ (5,325,720)	$ (36,999,816)	$ (32,523,385)

SALINAS VALLEY MEMORIAL HOSPITAL
BALANCE SHEETS
May 31, 2023

	Current year	Prior year
Current assets:		
Cash and cash equivalents	$ 335,122,374	$ 286,918,297
Patient accounts receivable, net of estimated uncollectibles of $25,764,255	82,417,143	89,094,797
Supplies inventory at cost	7,966,981	7,775,688
Current portion of lease receivable	546,861	0
Other current assets	17,607,048	17,193,536
	443,660,407	400,982,318
Assets whose use is limited or restricted by board	157,882,515	148,424,283
Capital assets:		
Land and construction in process	57,215,843	39,224,682
Other capital assets, net of depreciation	186,543,919	199,815,367
	243,759,762	239,040,048
Other assets:		
Right of use assets, net of amortization	5,622,496	0
Long term lease receivable	1,186,426	0
Investment in securities	139,936,836	141,949,866
Investment in SVMC	6,404,238	8,793,387
Investment in Aspire/CHI/Coastal	1,675,583	1,712,098
Investment in other affiliates	22,858,662	21,133,374
Net pension asset	(4,366,189)	55,100,891
	173,318,052	228,689,616
Deferred pension outflows	95,857,027	50,119,236
	$ 1,114,477,763	$ 1,067,255,501
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	$ 64,216,959	$ 56,743,623
Due to third party payers	18,344,007	40,278,792
Current portion of notes payable	0	0
Current portion of self-insurance liability	18,668,976	18,181,815
Current portion of lease liability	2,770,954	0
	104,000,896	115,204,230
Long term portion of notes payable	0	0
Long term portion of workers comp liability	13,543,194	14,288,063
Long term portion of lease liability	3,101,049	0
	120,645,139	129,492,292
Lease deferred inflows	1,642,999	0
Pension liability	79,111,485	83,585,120
Net assets:		
Invested in capital assets, net of related debt	243,759,762	239,040,048
Unrestricted	669,318,378	615,138,041
	913,078,140	854,178,089
	$ 1,114,477,763	$ 1,067,255,501

SALINAS VALLEY MEMORIAL HOSPITAL
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
May 31, 2023

	Month of May,				Eleven months ended May 31,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 247,486,606	$ 215,925,569	31,561,037	14.62%	$ 2,608,764,482	$ 2,296,034,631	312,729,851	13.62%
Dedutions from revenue	194,801,990	167,478,169	27,323,821	16.31%	2,031,757,824	1,774,868,557	256,889,267	14.47%
Net patient revenue	52,684,616	48,447,400	4,237,216	8.75%	577,006,658	521,166,073	55,840,585	10.71%
Other operating revenue	2,172,850	1,374,687	798,163	58.06%	17,898,078	15,121,553	2,776,525	18.36%
Total operating revenue	**54,857,466**	**49,822,087**	**5,035,379**	**10.11%**	**594,904,736**	**536,287,626**	**58,617,110**	**10.93%**
Operating expenses:								
Salaries and wages	16,310,483	17,216,325	(905,842)	-5.26%	185,459,007	179,177,015	6,281,992	3.51%
Compensated absences	2,942,162	2,605,998	336,164	12.90%	31,798,016	31,336,036	461,980	1.47%
Employee benefits	7,640,179	7,480,050	160,129	2.14%	86,913,639	79,256,434	7,657,205	9.66%
Supplies, food, and linen	6,821,514	6,417,896	403,618	6.29%	75,291,499	69,367,941	5,923,558	8.54%
Purchased department functions	3,957,066	3,491,015	466,051	13.35%	45,271,053	38,401,042	6,870,011	17.89%
Medical fees	3,208,301	2,026,754	1,181,547	58.30%	24,111,704	22,294,297	1,817,407	8.15%
Other fees	2,799,575	1,872,390	927,185	49.52%	32,132,506	21,978,271	10,154,235	46.20%
Depreciation	1,840,083	1,941,518	(101,435)	-5.22%	22,174,304	21,183,336	990,968	4.68%
All other expense	1,746,320	1,767,161	(20,841)	-1.18%	17,735,765	19,228,797	(1,493,032)	-7.76%
Total operating expenses	**47,265,683**	**44,819,107**	**2,446,576**	**5.46%**	**520,887,493**	**482,223,169**	**38,664,324**	**8.02%**
Income from operations	**7,591,783**	**5,002,980**	**2,588,803**	**51.75%**	**74,017,243**	**54,064,457**	**19,952,786**	**36.91%**
Non-operating income:								
Donations	1,391,915	166,667	1,225,248	735.15%	9,758,339	1,833,333	7,925,006	432.27%
Property taxes	333,333	333,333	(0)	0.00%	3,666,667	3,666,667	0	0.00%
Investment income	786,758	129,915	656,843	505.59%	6,846,700	1,429,070	5,417,630	379.10%
Income from subsidiaries	351,269	(3,650,173)	4,001,442	-109.62%	(36,999,816)	(38,264,203)	1,264,387	-3.30%
Total non-operating income	**2,863,275**	**(3,020,258)**	**5,883,533**	**-194.80%**	**(16,728,110)**	**(31,335,133)**	**14,607,023**	**-46.62%**
Operating and non-operating income	**$ 10,455,058**	**$ 1,982,722**	**8,472,337**	**427.31%**	**$ 57,289,133**	**$ 22,729,324**	**34,559,809**	**152.05%**

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of May and eleven months to date

	Month of May		Eleven months to date		
	2022	2023	2021-22	2022-23	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	35	42	431	413	(18)
Other Admissions	95	83	1,052	937	(115)
Total Admissions	130	125	1,483	1,350	(133)
Medi-Cal Patient Days	56	67	671	671	0
Other Patient Days	153	141	1,721	1,580	(141)
Total Patient Days of Care	209	208	2,392	2,251	(141)
Average Daily Census	6.7	6.7	7.1	6.7	(0.4)
Medi-Cal Average Days	1.6	1.7	1.6	1.7	0.1
Other Average Days	0.7	1.6	1.6	1.7	0.1
Total Average Days Stay	1.6	1.7	1.6	1.7	0.1
ADULTS & PEDIATRICS					
Medicare Admissions	412	341	3,892	4,336	444
Medi-Cal Admissions	281	284	2,637	3,212	575
Other Admissions	405	288	3,337	3,394	57
Total Admissions	1,098	913	9,866	10,942	1,076
Medicare Patient Days	1,696	1,428	16,692	18,447	1,755
Medi-Cal Patient Days	1,000	1,188	11,125	13,273	2,148
Other Patient Days	1,398	1,053	12,217	12,700	483
Total Patient Days of Care	4,094	3,669	40,034	44,420	4,386
Average Daily Census	132.1	118.4	119.5	132.6	13.1
Medicare Average Length of Stay	4.1	4.0	4.3	4.2	(0.0)
Medi-Cal AverageLength of Stay	3.1	3.6	3.5	3.6	0.1
Other Average Length of Stay	3.6	2.9	2.8	3.0	0.2
Total Average Length of Stay	3.7	3.5	3.5	3.6	0.1
Deaths	23	11	308	267	(41)
Total Patient Days	4,303	3,877	42,426	46,671	4,245
Medi-Cal Administrative Days	0	8	212	93	(119)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	0	8	212	93	(119)
Percent Non-Acute	0.00%	0.21%	0.50%	0.20%	-0.30%

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of May and eleven months to date

	Month of May		Eleven months to date		
	2022	2023	2021-22	2022-23	Variance
PATIENT DAYS BY LOCATION					
Level I	256	301	3,034	3,306	272
Heart Center	419	351	3,369	3,849	480
Monitored Beds	745	628	8,228	7,360	(868)
Single Room Maternity/Obstetrics	370	305	3,939	3,654	(285)
Med/Surg - Cardiovascular	923	846	8,123	10,022	1,899
Med/Surg - Oncology	144	282	2,827	3,092	265
Med/Surg - Rehab	573	411	5,182	5,582	400
Pediatrics	151	85	1,156	1,326	170
Nursery	209	208	2,392	2,251	(141)
Neonatal Intensive Care	141	50	1,272	1,471	199
PERCENTAGE OF OCCUPANCY					
Level I	63.52%	74.69%	69.67%	75.91%	
Heart Center	90.11%	75.48%	67.04%	76.60%	
Monitored Beds	89.01%	75.03%	90.97%	81.37%	
Single Room Maternity/Obstetrics	32.26%	26.59%	31.78%	29.48%	
Med/Surg - Cardiovascular	66.16%	60.65%	53.88%	66.48%	
Med/Surg - Oncology	35.73%	69.98%	64.91%	71.00%	
Med/Surg - Rehab	71.09%	50.99%	59.49%	64.09%	
Med/Surg - Observation Care Unit	0.00%	77.80%	0.00%	83.55%	
Pediatrics	27.06%	15.23%	19.17%	21.99%	
Nursery	40.86%	40.66%	21.64%	20.36%	
Neonatal Intensive Care	41.35%	14.66%	34.52%	39.92%	

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of May and eleven months to date

	Month of May		Eleven months to date		
	2022	2023	2021-22	2022-23	Variance
DELIVERY ROOM					
Total deliveries	133	129	1,412	1,300	(112)
C-Section deliveries	44	29	459	412	(47)
Percent of C-section deliveries	33.08%	22.48%	32.51%	31.69%	-0.81%
OPERATING ROOM					
In-Patient Operating Minutes	22,055	17,328	214,205	216,919	2,714
Out-Patient Operating Minutes	26,790	30,538	277,037	302,542	25,505
Total	48,845	47,866	491,242	519,461	28,219
Open Heart Surgeries	16	14	131	154	23
In-Patient Cases	165	109	1,578	1,477	(101)
Out-Patient Cases	270	297	2,788	3,089	301
EMERGENCY ROOM					
Immediate Life Saving	30	28	355	361	6
High Risk	552	759	5,214	6,980	1,766
More Than One Resource	2,984	3,033	28,779	32,434	3,655
One Resource	1,941	2,013	18,340	22,623	4,283
No Resources	86	116	923	1,080	157
Total	5,593	5,949	53,611	63,478	9,867

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of May and eleven months to date

	Month of May		Eleven months to date		
	2022	2023	2021-22	2022-23	Variance
CENTRAL SUPPLY					
In-patient requisitions	14,953	13,813	165,851	166,782	931
Out-patient requisitions	9,744	10,628	102,481	105,783	3,302
Emergency room requisitions	650	667	10,800	8,280	-2,520
Interdepartmental requisitions	6,561	6,063	67,008	75,401	8,393
Total requisitions	31,908	31,171	346,140	356,246	10,106
LABORATORY					
In-patient procedures	35,748	35,562	384,141	432,858	48,717
Out-patient procedures	10,555	11,323	123,429	115,613	-7,816
Emergency room procedures	13,039	12,929	122,502	142,338	19,836
Total patient procedures	59,342	59,814	630,072	690,809	60,737
BLOOD BANK					
Units processed	343	344	3,368	3,435	67
ELECTROCARDIOLOGY					
In-patient procedures	1,096	1,112	10,918	12,424	1,506
Out-patient procedures	363	442	4,052	4,057	5
Emergency room procedures	1,206	1,294	11,463	12,753	1,290
Total procedures	2,665	2,848	26,433	29,234	2,801
CATH LAB					
In-patient procedures	98	117	997	1,124	127
Out-patient procedures	111	93	1,018	906	-112
Emergency room procedures	0	0	0	1	1
Total procedures	209	210	2,015	2,031	16
ECHO-CARDIOLOGY					
In-patient studies	453	412	4,002	4,385	383
Out-patient studies	189	230	2,358	2,659	301
Emergency room studies	1	3	9	15	6
Total studies	643	645	6,369	7,059	690
NEURODIAGNOSTIC					
In-patient procedures	155	143	1,673	1,544	-129
Out-patient procedures	16	23	271	220	-51
Emergency room procedures	0	0	0	0	0
Total procedures	171	166	1,944	1,764	-180

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of May and eleven months to date

	Month of May		Eleven months to date		
	2022	2023	2021-22	2022-23	Variance
SLEEP CENTER					
In-patient procedures	1	0	1	2	1
Out-patient procedures	133	186	1,858	1,587	-271
Emergency room procedures	0	0	0	1	1
Total procedures	134	186	1,859	1,590	-269
RADIOLOGY					
In-patient procedures	1,262	1,364	13,677	15,844	2,167
Out-patient procedures	359	507	4,403	4,443	40
Emergency room procedures	1,511	1,555	14,222	16,723	2,501
Total patient procedures	3,132	3,426	32,302	37,010	4,708
MAGNETIC RESONANCE IMAGING					
In-patient procedures	152	147	1,459	1,662	203
Out-patient procedures	115	144	1,202	1,167	-35
Emergency room procedures	8	7	79	66	-13
Total procedures	275	298	2,740	2,895	155
MAMMOGRAPHY CENTER					
In-patient procedures	3,726	3,906	39,647	43,624	3,977
Out-patient procedures	3,703	3,883	39,378	43,238	3,860
Emergency room procedures	0	0	12	9	-3
Total procedures	7,429	7,789	79,037	86,871	7,834
NUCLEAR MEDICINE					
In-patient procedures	16	24	170	215	45
Out-patient procedures	92	116	846	1,018	172
Emergency room procedures	0	0	5	2	-3
Total procedures	108	140	1,021	1,235	214
PHARMACY					
In-patient prescriptions	84,820	89,138	941,279	1,049,628	108,349
Out-patient prescriptions	15,114	17,227	163,522	167,312	3,790
Emergency room prescriptions	8,851	9,692	79,205	96,789	17,584
Total prescriptions	108,785	116,057	1,184,006	1,313,729	129,723
RESPIRATORY THERAPY					
In-patient treatments	15,938	16,020	196,695	197,577	882
Out-patient treatments	1,296	1,276	13,052	12,423	-629
Emergency room treatments	306	396	2,549	4,506	1,957
Total patient treatments	17,540	17,692	212,296	214,506	2,210
PHYSICAL THERAPY					
In-patient treatments	2,891	2,564	26,481	28,168	1,687
Out-patient treatments	350	278	3,318	2,265	-1,053
Emergency room treatments	0	0	0	2	2
Total treatments	3,241	2,842	29,799	30,435	636

SALINAS VALLEY MEMORIAL HOSPITAL
PATIENT STATISTICAL REPORT
For the month of May and eleven months to date

	Month of May		Eleven months to date		
	2022	2023	2021-22	2022-23	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,264	1,748	15,894	17,614	1,720
Out-patient procedures	138	225	1,674	1,900	226
Emergency room procedures	0	0	0	0	0
Total procedures	1,402	1,973	17,568	19,514	1,946
SPEECH THERAPY					
In-patient treatments	384	487	4,838	5,193	355
Out-patient treatments	37	31	315	282	-33
Emergency room treatments	0	0	0	0	0
Total treatments	421	518	5,153	5,475	322
CARDIAC REHABILITATION					
In-patient treatments	0	0	0	1	1
Out-patient treatments	481	678	6,020	5,888	-132
Emergency room treatments	0	0	1	0	-1
Total treatments	481	678	6,021	5,889	-132
CRITICAL DECISION UNIT					
Observation hours	376	390	3,687	4,649	962
ENDOSCOPY					
In-patient procedures	93	93	997	923	-74
Out-patient procedures	29	43	323	647	324
Emergency room procedures	0	0	0	0	0
Total procedures	122	136	1,320	1,570	250
C.T. SCAN					
In-patient procedures	585	682	6,508	8,072	1,564
Out-patient procedures	368	452	3,881	4,474	593
Emergency room procedures	711	770	6,828	7,568	740
Total procedures	1,664	1,904	17,217	20,114	2,897
DIETARY					
Routine patient diets	21,417	20,876	207,920	256,545	48,625
Meals to personnel	21,865	28,924	239,344	275,181	35,837
Total diets and meals	43,282	49,800	447,264	531,726	84,462
LAUNDRY AND LINEN					
Total pounds laundered	101,458	102,836	1,083,735	1,123,764	40,029

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: June 14, 2023

Re: Policies Requiring Approval

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

	Policy Title	Summary of Changes	Responsible VP
1.	Mobile Phones & Digital Devices	Template corrected to procedure. Updated to reflect reference to the Electronic Communication and Portable Audio/Video Listening Devices policy, email synch on one device, disallow re-provisioning by original recipient, and only use of SVH-approved messaging solutions. Name change updates.	Audrey Parks, CIO
2.	Fire Safety for Procedures	Added Section, Fire on or near Patient. Add links to Fire Response Lg on patient and Fire Response Sm on patient	Lisa Paulo, CNO
3.	Emergent Open Sternotomy (Assist)	updated version reflecting the new open heart cart/process	Lisa Paulo, CNO
4.	Nursing Excellence / Peer Review	Policy underwent major edits in collaboration with the NEC members.	Lisa Paulo, CNO
5.	Operating Budget	Minor edits and clarifications, updated titles, changed EPSi to Axiom	Augustine Lopez, CFO

Status Pending PolicyStat ID 12786256

Last Approved	N/A	Owner	Audrey Parks: Chief Information Officer
Last Revised	05/2023	Area	Information Technology
Next Review	3 years after approval		

Mobile Phones & Digital Devices

I. POLICY STATEMENT:

~~A. It is the policy of Salinas Valley Health Medical Center (SVHMC) to provide to its Executive Leadership Group members and other select Board Members, special committee members and other staff the tools necessary to complete the duties and responsibilities of their positions.~~

~~B. Executive Leadership Group members must often be available and accessible to Hospital employees and to members of the Board of Directors on an on-call basis.~~

~~C. SVHMC issued mobile phones and/or digital devices are for use by the employee, Board Member, special committee member, or other designated staff while employed by SVHMC. Such devices shall remain the sole property of SVHMC at all times.~~

A. N/A

II. PURPOSE:

A. To provide select Salinas Valley Health Medical Center (SVHMC) staff with smartphones and digital devices for use in accomplishing the duties and responsibilities of their positions.

III. DEFINITIONS:

A. N/A

IV. GENERAL INFORMATION:

~~A. N/A~~

A. SVHMC issued mobile phones and/or digital devices are for use by the employee, Board Member, special committee member, or other designated staff while employed by SVHMC. Such devices shall remain the sole property of SVHMC at all times.

V. PROCEDURE~~:~~

A. The recipient of an SVHMC issued ~~smartphone~~smart phone or other device agrees and acknowledges that any device provided by SVHMC remains the sole property of SVHMC. Upon termination of employment or their role with SVHMC, all devices issued pursuant to this policy remain the property of and shall be returned to SVHMC .

B. The designated Senior Administrative Team member issued a mobile phone or digital device understands and acknowledges that phone data, phone records, and/or other records and/or data contained on or related to the mobile phone or digital device is subject to review by SVHMC, and may be subject to public disclosure.

C. All mobile phones and digital devices distributed pursuant to this policy and procedure will be processed through ~~the~~ SVHMC Information Technology ~~Department~~(IT). Upon termination of employment, all devices issued under this policy shall be returned to the SVHMC Information Technology. The Department~~. The Department~~ shall maintain a log of all such devices which have been issued and/or returned.

D. Do not re-assign or allow others (staff, family, providers) to use or otherwise borrow SVHMC issued devices. The user of record (as documented by IT) is responsible for the asset(s).

E. Documentation:

1. The designated Senior Administrative Team member issued a mobile phone or digital device shall complete a form acknowledging receipt of the device and accepting responsibility for the device. ~~The~~ SVHMC Information Technology ~~Department shall maintain a record of these completed forms~~maintains records of request and fulfillment via their service management system.
2. Use of smart phones and electronic devices are subject to the Electronic Communication and Portable Audio/Video Listening Devices policy.

F. Only SVHMC -approved applications shall be used for text messaging of confidential or sensitive data.

G. Email synchronization with SVHMC email will only be allowed on one device. This is a licensing requirement and cost consideration.

VI. EDUCATION/TRAINING~~:~~

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

A. Education and/or training is provided as needed

VII. REFERENCES~~:~~

A. N/A

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Owner	Audrey Parks: Chief Information Officer	04/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **12773422**

Last Approved	N/A	Owner	Carla Knight: Director of Perioperative Services
Last Revised	05/2023	Area	Perioperative Services
Next Review	3 years after approval		

Fire Safety for Procedures

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To reduce the risk of fire during surgery and procedures and to promote effective interventions by staff members in the event of a fire.

B. To provide guidance to perioperative personnel for preventing fires during operative and other invasive procedures and responding appropriately if a fire should occur.

III. DEFINITIONS:

A. Ignition source: the heat energy necessary to start a fire. The following are examples:

1. Electrosurgical units (ESUs): devices used to deliver radio frequency energy for the purpose of cauterizing bleeding tissue. The most common ignition source at an estimated 70%.
2. Lasers: devices used to deliver a focused beam of light amplified by stimulated radiation for cauterization of bleeders, desiccation of tissue. The second most common ignition source at an estimated 10%.
3. Fiberoptic light cables: conduct high energy light beam from the source to a scope.
4. Hot wire cauterization, e.g. endoscopic biopsy loops.
5. Argon Beam Coagulator (ABC): electrosurgical unit using Argon gas to deliver the energy for coagulation.
6. High Speed burrs: power equipment used to grind bone.
7. Electrical system failures in medical devices e.g. equipment, instruments, and monitors.

8. Anesthesia delivery unit (anesthesia machines): ADU
9. Active electrodes: delivery devices for ESUs and ABCs.

B. Oxidizers: reactive agents that supply oxygen, which supports combustion and lowers the temperature and energy at which a fuel will ignite.
    1. Common oxidizers include (oxygen) O_2 and (Nitrous oxide) N_2O: both are present on the back side of each anesthesia delivery unit.
        a. O_2 and N_2O: result in a hotter, more vigorous fire.

C. Fuels: material capable of burning; found in abundance in the OR areas.
    1. Patient: gowns, hair, methane gas.
    2. Covering materials: OR table and patient; staff scrubs, masks, hats; and disposable packaging materials.
    3. Sterile drapes, sponges, gowns, and other disposable items used on the sterile field, ace bandages, stockinet.
    4. Dressings, gauze packing, cotton, ointments.
    5. Bone wax.
    6. Prepping agents: degreasers, alcohol based prep, tincture of benzoin.
    7. Monitoring devices, breathing circuits, endotracheal tubes, endoscopes.

D. RM: Risk Management Department.

E. Circulator: the primary care nurse who remains un-scrubbed and functions outside of the sterile field.

F. Scrub: the person who is scrubbed gowned, and gloved to assist the physician within the sterile field with sterile supplies.

G. Open oxygen delivery: utilizing a mask or cannula, vs. a closed system e.g. an endotracheal tube or laryngeal mask airway.

IV. GENERAL INFORMATION:

A. The expected outcome is that the patient is free from signs and symptoms of injury related to thermal sources, Ignition sources, oxidizers, and fuels are managed to reduce their associated risks: refer to control measures in the Procedure Section.
    1. In critical emergencies when drying time for alcohol based preps can't be observed (3 minutes for non-hairy areas and up to 60 minutes for hairy areas) the patient is **not** prepped with alcohol based prep solution.

B. Staff members are responsible for responding to a fire emergency and are provided education and the opportunity to participate in Fire Drills.

C. Staff members are responsible for maintaining access to fire exits, fire alarms, fire doors, and gas shut off valves.

D. Evacuation of a procedure room or the department may be necessary in limited situations.

1. Risks to patients and the surgical/procedure team are considered and if there is doubt concerning the team's ability to control the fire, they will initiate a Code Red and depart the room.
2. Relocation should be to another fire compartment area within the department whenever possible.
3. Evacuation of the department may be authorized by the person in charge of the hospital, or in an extreme emergency, the unit director, at the time of the incident.
4. The evacuation plan and exits are in the FIRE RESPONSE PLAN (CODE RED)

E. Post fire actions.

1. The primary care nurse/circulator in the area where the fire occurs is responsible for saving the materials and devices involved in the fire and completing an occurrence report in order to facilitate an investigation
2. Post-fire analysis is initiated by Risk Management.

V. PROCEDURE:

A. Measures implemented to reduce risks associated with ignition sources.

1. Prior to operation of devices that can be ignition sources, staff members are expected to demonstrate competence related to those devices, which includes fire safety: e.g. Lasers, ESUs.
2. Sterile saline and/or water should be available prior to the start of the procedure.
3. Electrosurgical Safety
    a. ESU ground and active electrode cords are inspected for integrity by the nurse as they are attached to the ESU.
    b. ESUs and Lasers are activated only when the active tip is visible and the tip is deactivated before it leaves the surgical/procedure site.
    c. When ESU active electrodes become contaminated, they should be disconnected by the circulator and scrub and not left hanging where activation could occur.
    d. Whenever open O_2 is used during head and neck procedures, bipolar ESUs should be used.
    e. Active ESU electrodes, not in use, are placed off the patient (Mayo stand, side table) or in a noncombustible container by the surgeon or scrub.
    f. When the bowel is distended with gas, the surgeon should avoid opening the bowel with the ESU.
4. Laser safety
    a. Lasers are placed in standby mode when not in use or the physician's attention is diverted.
    b. When CO_2 Lasers are used, the scrub provides ebonized or satin instruments and wet sponges to prevent ricochet of the beam and ignition

of surrounding materials.

c. The accuracy of the Laser aiming beam is confirmed prior to use.

5. Electrical safety
    a. The presence of Biomed and Engineering inspection stickers, and intact cords and plugs is confirmed by staff members.
    b. Electrical cords are protected by staff members from damage secondary to roll over by equipment, e.g. portable X-ray unit, gurney.
    c. Loaner, demonstration, and contracted units are inspected by Biomed prior to use.
    d. Placement of solution containers on electrical equipment is prohibited.
6. Fiberoptics: the light source is maintained in stand-by mode until the cable is connected to the light source.
7. High speed burs can become hot enough to ignite drapes by direct contact or sparking, which should be prevented by the scrub dripping saline over the active bur.

B. Measures to reduce risks associated with oxidizers (attachment #3).
1. Allow for adequate venting under drapes. The build-up of Oxygen (O_2) and Nitrogen (N_2O) beneath surgical drapes is minimized by suspension of drapes from IV poles or other similar devices, or otherwise arranging them to expedite dissipation of gases.
2. Oxygen (O_2) and Nitrogen (N_2O) should be shut off 3-5 minutes prior to use of ignition source.
3. For open delivery of gases, consideration is given to using air or ≤ 30% Oxygen (O_2). PVC ET tubes will not burn until 26% O_2 is achieved.
4. Suction is provided during airway procedures to prevent the build-up of volatile gases.
5. For a Laser procedure involving the airway, a Laser specific endotracheal tube and methylene blue to inflate the cuff are provided by the circulator; sponges used in proximity to the targeted lesion are moistened in their entirety by the scrub.
6. During airway procedures, including T&A, the scrub should maintain a bowl of saline and bulb syringe on the Mayo stand for fire suppression.
7. Medical gas tanks are limited in quantity and secured according to COMPRESSED GAS CYLINDER HANDLING, STORAGE AND TRANSPORT #6024

C. Measures to reduce risks associated with fuels.
1. Moist sponges including their strings are used in proximity to the ignition sources.
2. Hair near or in the procedure site should be removed or coated with **water based** lubricant.
3. Do not drape or use ignition source until solution is completely dry (minumum of 3 minutes on hairless skin, up to 1 hour in hair) or per manufacture requirement for flammable patient perioperative skin preparation.

4. Alcohol based preps
    a. The device for delivery of the prep solution is unit based/one time use only and control released when possible.
    b. Selection of the volume of the prep solution should match the size of the planned wound.
    c. Prep solution is dispensed judiciously as the circulator preps patient areas with creases and the umbilicus.
    d. Towels are placed to absorb runoff when prep solution may overflow onto linens and those towels are removed prior to draping, e.g. neck and groin areas.
    e. The prepped area is inspected by the scrub, physician, and circulator, for dryness before draping to prevent ignition of trapped vapors when the ESU/Laser is activated. **(Alcohol can burn unnoticed beneath the drapes.)**
    f. Whenever possible, the physician uses steridrapes for incision sites near anesthesia gases in order to isolate those gases from an ignition source, e.g. head and neck procedures and CABGs.
5. Flammable solutions, e.g. alcohol, spirits (of peppermint), and benzoin stock are maintained in a fire safe. One bottle of alcohol equal to or less than 16 ounces may be stored in a procedure room where anesthesia is administered.
6. Char buildup on the ESU active electrode serves as a fuel, which should be removed by the scrub.
7. Tissue desiccation can yield a flare of organic gas, which is prevented by the scrub providing suction for use at the site.
8. Warning: There is a common misperception that surgical drapes are fire retardant; none are made with fire retardant.

D. Procedure team's response to fires on /near patient Attachment/link to Small Fire & Large Fire)
    1. Activation CODE RED (pull arm, call 2222) per policy.
    2. Refer to attachments for Fire Response to Small or Large Fire on/or near patient.
    3. Requirement of 2 Water Sources on Side Table (Sterile Water and Sterile Saline)
    4. Dose Fire with Sterile Water.

E. Procedure team's response to fires
    1. Activation CODE RED (pull arm, call 2222) per policy.
    2. Refer to the attachments for role specific responses by fire site: airway, equipment, small fire on patient, and large fire on patient.
    3. **Responsibilities have been allocated for a fire that could occur when the only immediate responders are the on-call team. Team members' responsibilities in a fire may be delegated as help arrives.**
    4. Evacuation of the procedure room or department may be necessary in rare situations and is ordered by the person in charge. Refer to the EMERGENCY

OPERATIONS PLAN

5. Staff fighting the fire when the room has been evacuated.
    a. Before the room is entered:
        i. Gas shut-off is confirmed.
        ii. The door or window to the room is checked for heat and smoke. If the room is filled with smoke or engulfed in flames, the room is not entered.
    b. Fire extinguishers.
        i. For trash or drape fires, an ABC extinguisher is used.
        ii. For chemical and electrical fires, the B/C extinguishers are used.
    c. Using fire extinguishers - PASS:
        i. P-pull the pin.
        ii. A-aim at the base of the flames.
        iii. S-Squeeze the trigger.
        iv. S-sweep the base of the fire.

F. Documentation:
    1. Fire drill records.
    2. Annual validation of fire response competence.

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. Guideline for a safe environment of care. In: Guidelines for Perioperative Practice. Denver, CO: AORN, Inc.; 2018:246-254.

B. Guideline for safe use of energy-generating devices. In: Guidelines for Perioperative Practice. Denver, CO: AORN, Inc.; 2018:129-156.

C. Cowles, Jr., C.E., Lake, C., Ehrenwerth, J. (2020). Surgical fire prevention: a review. APSF Newsletter. 2020;

D. Anesthesia Patient Safety Foundation (APSF) free educational video and Supplemental Information (released April 2010). The 18 minute video is viewable on the Web (and order a free copy of the DVD) at: www.apsf.org/resources_video.php. **(confirmed 04/15/2021 as a current reference)**

E. AORN Fire Safety Tool Kit. Tools to promote fire prevention, plan effective response strategies, and develop department-specific evidence-based policies and protocols: https://test.aorn.org/guidelines/clinical-resources/tool-kits/fire-safety-tool-kit

F. Practice Advisory for the Prevention and Management of Operating Room Fires: An Updated

Report by the American Society of Anesthesiologists Task Force on Operating Room Fires Jeffrey L. Apfelbaum, M.D.; Robert A. Caplan, M.D.; Steven J. Barker, Ph.D., M.D.; Richard T. Connis, Ph.D.; Charles Cowles, M.D.; et al; Practice Parameter | February 2013

G. Cowles, C. E., & Chang, J. L. (2014, October). Flammable Surgical Preps Require Vigilance. *Abesthesia Patient Safety Foundation, 29*(2), 27-39. Retrieved from Anesthesia Patient Safeety Foundation: https://www.apsf.org/article/flammable-surgical-preps-require-vigilance/

Attachments

1: Surgical Fire Safety - Risk Assessment protocol

2: Surgical Fire Risk Assessment

3: American Society of Anesthesiologist Operating Room Fires Algorithm

Fire Drill Evaluation: Surgery and Procedure Areas

Fire Response: Airway Fire

Fire Response: Equipment Fire

Fire Response: Large Fire on a Patient

Fire Response: Small Fire on a Patient

Fire Safety for Surgery, L&D, and Procedure Areas

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
COO	Clement Miller: Chief Operating Officer	06/2023
EOCC	James Hively: Environmental Health & Safety Manager	05/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2023
Policy Owner	Carla Knight: Director of Perioperative Services	04/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13044457

Last Approved	N/A
Last Revised	05/2023
Next Review	3 years after approval
Owner	Carla Spencer: Director Critical Care Services
Area	Patient Care

Emergent Open Sternotomy (Assist)

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To guide ~~nursing~~the roles and responsibilities of staff ~~with the roles and responsibilities of nursing staff who will assist~~assisting the cardiac surgeon during an emergent open sternotomy.

III. DEFINITIONS:

~~A. N/A~~

A. VF - Ventricular Fibrillation

B. VT - Ventricular Tachycardia

IV. GENERAL INFORMATION:

A. Emergent open sternotomy is a priority when resuscitating the post-mediastinal cardiac surgery patient since sternal edges are not healed and external chest compressions may lacerate the heart.

B. Emergent open sternotomy is performed ~~by the~~after cardiac ~~surgeon~~surgery to identify and eliminate ~~areas of persistent hemorrhage, relieve pericardial tamponade and provide access for open chest massage and internal defibrillation.~~the following postoperative complications:

1. cardiac tamponade with imminent arrest
2. excessive bleeding
3. refractory VF/VT without improvement after standard treatments (provides access for open cardiac massage and internal defibrillation)

4. performed by the cardiac surgeon to identify and eliminate areas of persistent hemorrhage, relieve pericardial tamponade and provide access for open chest massage and internal defibrillation.

~~Open sternotomy is a priority in resuscitating a patient after mediastinal cardiac surgery. This procedure is important because the sternal edges are not healed and external CPR causes displacement of wires which may lacerate the heart.~~

~~This procedure performed by a Cardiac Surgeon on patients who have undergone medical sternotomy (usually first two weeks of cardiac surgery) with imminent cardiac arrest.~~

~~ICU/CCU RNs who have successfully completed the "Care of Post-Operative Cardiac Surgery Patient" can assist with this procedure.~~

C. ~~Signs~~Potential signs and symptoms of a cardiac ~~tamponade requiring~~emergency necessitating an emergent open sternotomy include:

1. ~~Excessive~~excessive chest drainage (> 400 ml for the first hour, 200 ml/hour ~~output~~continuous ouput)

   ~~Hypotension~~

2. sudden decrease or cessation of chest tube drainage
3. hypotension
4. ~~Altered~~altered mental status~~.~~
5. ~~Narrowing~~narrowing pulse pressure~~.~~
6. ~~Distended~~distended neck veins~~.~~
7. ~~Distant~~distant heart sounds~~.~~
8. ~~Equilibrium~~equilibrium of intracardiac pressures with right atrial, pulmonary capillary wedge~~, and~~ (if measured)~~,~~ and left atrial pressures being equal~~.~~
9. ~~Decreased~~decreased cardiac output and cardiac index~~.~~
10. Pulsus paradoxus - ~~A~~ marked ↓decrease in pulse amplitude during normal quiet inspiration or a ↓decrease in the systolic pressure by > 10 ~~mm Hg~~.mmHg

    ~~Sudden decrease or cessation of chest tube drainage.~~

V. PROCEDURE~~:~~

~~A. **Equipment**~~

1. ~~Open chest cart (See Attachment A for contents of open chest cart).~~
2. ~~Crash cart.~~
3. ~~Analgesia, sedation and/or paralytic agents per physician's preference.~~
4. ~~Blood products and IV solutions as prescribed.~~
5. ~~Chest tube drainage system.~~
6. ~~Additional equipment if needed:~~
   a. ~~Intra-aortic Balloon Pump (IABP)~~

b. Ventricular Assist Device (VAD)

B. Set-Up

1. The cardiac surgeon evaluates and assesses the need for emergent sternotomy. The cardiac surgical team is called to assist at the bedside. If a team is unavailable, trained ICU/CCU RNs may assume "assistant" roles.
2. Crash cart and open chest cart at bedside.
3. Prepare electro surgery unit for possible use: apply return electrode monitor (REM) pad to patient's skin and attach grounding and cautery cables to device. This device is used to terminate capillary oozing or bleeding. Available by request from the O.R. Department.
4. Set-up a new sterile suction system. This will be used to suction the mediastinum during the procedure.
5. Don caps, goggles, masks, sterile gowns and gloves for all members of the health care team involved with the procedure. **All personnel in the room must don mask and caps**
6. Remove old dressing and prepare skin for incision. Cleanse skin with antiseptic solution.
7. Assist with placement of sterile towels and drapes.
8. Assist as needed by supplying the wire cutters and aiding in the removal of cut wires from the surgical field.
9. Assist the physician with controlling bleeding, enhancing sternal retraction and provide suctioning and electrocautery as needed.
10. Assist with placement of IABP or mechanical assist devices if needed. Cardiac tamponade can conceal right and left ventricular dysfunction; mechanical assist may be necessary to improve cardiac output.
11. Assist patient transport to the operating room if necessary. The patient may need surgical repair of coronary artery bypass grafts, cardiac valves or the myocardium. If the patient does not need to return to OR, assist the physician with reinsertion of the sternal wires as needed.
12. Assist with skin closure.
13. Apply an occlusive dressing to the sternal incision, epicardial pacing wires, and chest tube sites. The patient may be left open and covered with a sterile occlusive surgical dressing if severe ventricular dysfunction exists.

C. Patient Monitoring and Care

1. Assess hemodynamic stability and volume status. Recurrent cardiac tamponade or persistent myocardial arterial depression may develop during and after sternotomy.
2. Monitor urine output closely.
3. Assess heart and lung sounds every two (2) hours as needed.
4. Monitor coagulation, hematologic and electrolyte laboratory results. Monitor chest tube drainage.

5. ~~Reportable conditions:~~

    a. ~~Decrease in cardiac output and cardiac index; abnormal pulmonary artery pressures; equalizing pulmonary pressures; mean arterial BP less than 60 mm Hg; and changes in HR.~~

    b. ~~Urine output less than 0.5ml/kg/hr.~~

    c. ~~Distant heart sounds or additional changes in heart and lung sounds.~~

    d. ~~Cessation or increase in chest tube drainage; clots in chest tube drainage system.~~

~~D. Documentation:~~

1. ~~Patient and family education. Teaching may be necessary after the procedure. If the emergent sternotomy is performed in the face of hemodynamic collapse, the education of the patient and family may be impossible until after the procedure is performed.~~

2. ~~Informed consent obtained.~~

3. ~~Estimated blood loss.~~

4. ~~Patient therapies and response: including hemodynamics, inotropic or vasopressor agents, ventilation and neurological status.~~

A. The cardiac surgeon states the need for an emergent open sternotomy at the ICU bedside.

B. Continue CPR (if needed) until the open chest supplies are ready, sterile field is prepared, and the surgeon is ready to perform the procedure.

C. ICU Charge RN

1. Notifies the Nursing Supervisor

2. Notifies the OR

    a. Requests the cardiac surgical team to assist at the ICU bedside. Until this team arrives, the ICU staff will assist the cardiac surgeon.

    b. Requests bottles of warmed saline and the electrocautery unit (Bovie). When no OR staff is available, assigns someone to retrieve these items from the OR.

D. Equipment is brought to the bedside (see Attachment A)

1. Crash Cart

2. Open Chest Cart

3. Bedside Tables

4. Rapid infuser (if needed)

E. Assignment of Roles

1. **Respiratory Therapy**

    a. Manages the ventilator/airway

    b. Location: towards the head of the bed

2. **Cardiac Surgeon**
    a. Opens the chest and repairs the issue
    b. Location: at the patient's side
3. **ICU Charge RN**
    a. Phone calls
    b. Assists with retrieving supplies
    c. Assists with documentation
    d. Location: nearby
4. **Nurse 1 (MEDICATION RN)**
    a. Preferably the patient's assigned RN.
    b. Manages IV medications, fluids, & blood
    c. Location: towards the head of the bed
5. **Nurse 2 (STERILE RN)**
    a. Assists the surgeon (may be replaced by the OR nurse upon arrival)
    b. Responsible for opening up sterile field and instruments
    c. Assists with suction and retractors
    d. Location: opposite of the bed from the surgeon
6. **Nurse 3 (NONSTERILE RN)**
    a. Handles nonsterile supplies
    b. Opens packages and drops them onto the sterile field
    c. Sets up suction
    d. Operates the defibrillator
    e. Location: bedside the STERILE RN by the patient's feet
7. **Nurse 4**
    a. Documents
    b. Runner for extra supplies
    c. Location: by the patient's feet

F. **STERILE PROCEDURE**
1. Everyone in the room must be wearing a mask and cap.
2. The SURGEON and STERILE RN will require a sterile gown, sterile gloves, cap, goggles, and masks.

G. While the SURGEON and STERILE RN are getting gowned:
1. Old dressing is removed - by another member of the team, using clean technique
2. Skin is cleansed - by another member of the team, by painting the entire chest with

betadine.

H. When the SURGEON and STERILE RN are ready/gowned:
    1. Sterile field is set up with included sterile drapes/towels
        a. Drapes and towels are handed by NONSTERILE RN to the STERILE RN.
    2. Sterile suction is set up.
        a. NONSTERILE RN drops sterile yaunker and sterile suction tubing onto the sterile field.
        b. STERILE RN attaches the sterile yaunker to sterile tubing and runs the sterile tubing off the sterile field (usually at the patient's head or feet).
        c. NONSTERILE RN connects the suction tubing to wall suction.
I. The SURGEON may have already requested and begun used the scalpel and staple remover.
J. A bedside table is prepared beside the STERILE RN.
    1. The open chest tray may be placed on this table, being careful to keep the contents sterile.
K. If the electrocautery unit (bovie) will be used, the grounding pad will be connected to the patient's thigh (being careful not to contaminate the sterile field). Grounding and cautery cables will be attached to the device.
L. The surgeon is assisted as needed.
M. The patient is transported to the surgical suite, if necessary.
N. **Documentation**:
    1. Patient and family education. Teaching may be necessary after the procedure. If the emergent sternotomy is performed in the face of hemodynamic collapse, the education of the patient and family may be impossible until after the procedure is performed.
    2. Informed consent obtained.
    3. Estimated blood loss.
    4. Patient therapies and response: including hemodynamics, inotropic or vasopressor agents, ventilation and neurological status.

VI. EDUCATION/TRAINING:

A. Education and/or training is provided as needed

VII. REFERENCES:

A. Shakenbach, L.: Emergent Open Sternotomy (Assist). In Wiegand, D., editor: *AACN Procedure Manual for Critical Care,* 7th edition, 2017.

B. AORN. (2020). Guidelines for perioperative practice: energy-generating devices; sterile technique; and surgical attire.

Attachments

Attachment A: Room Layout.docx

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Chief Nursing Officer	Lisa Paulo: Chief Nursing Officer	05/2023
Medical Director	Katherine DeSalvo: Director Medical Staff Services	05/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2023
Policy Owner	Carla Spencer: Nursing Director	02/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13165662**

Last Approved	N/A	Owner	Kirsten Wisner: Magnet Program Director
Last Revised	05/2023	Area	Administration
Next Review	3 years after approval		

Nursing Excellence / Peer Review

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. ~~To ensure that the hospital, through the activities of its nursing staff, assesses the performance of individuals (employee or contractor) and uses the results of such assessments to improve care.~~To ensure the highest quality care and identification of system-level opportunities to improve care.

B. Goals

1. Improve the quality of care and exemplary care recognition
2. Monitor ~~nurses'~~ performance
3. Identify opportunities for performance improvement
4. Identify system process issues
5. Monitor significant trends by analyzing aggregate data
6. Assure that the process for peer review is clearly defined, fair, defensible, timely

III. DEFINITIONS:

A. Peer Review

Nursing peer review is the process wherein registered nurses systematically evaluate the quality of nursing care provided at the individual and team level, measured against professional standards (Haag-Heitman & George, 2011).

Peer review is ~~the evaluation of an individual nurse's professional performance and includes the identification of opportunities to improve care as well as identification of exemplary care.~~

~~Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual nurse's performance, rather than appraising the quality of care rendered by a group of professionals or a system.~~

~~Peer review is~~ conducted using multiple sources of information, including:

1. The review of individual cases
2. The review of aggregate data for compliance with general rules of the nursing staff
3. Clinical standards and use of rates in comparison with established benchmarks or norms

~~The individual's evaluation~~Individual and team performance is evaluated against recognized, evidence-based ~~on generally recognized~~ standards of care. Through this process, ~~nurses~~system-level issues are identified and addressed and individuals and teams receive feedback ~~for personal~~to support improvement ~~or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care~~. For specialty-specific clinical issues, such as evaluating the technique of a specialized procedure, a peer is an individual who is well trained and competent in that specialty.

The degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital will be determined by the Nursing ~~Staff~~ Excellence Committee (~~NSEC~~NEC) ~~unless otherwise designated for specific circumstances by nursing leadership~~.

B. The American Nurses Association (ANA) principles for nursing peer review should be used when conducting peer review (Haag-Heitman & George, 2011)
    1. A peer is someone of the same rank.
    2. Peer review is practice-focused.
    3. Feedback is timely, routine, and a continuous expectation.
    4. Peer review fosters a continuous learning culture of patient safety and best practice.
    5. Feedback isn't anonymous.
    6. Feedback incorporates the nurse's developmental stage.

C. Conflict of Interest

A conflict of interest exists if a ~~member of the nursing staff~~nurse is not able to render an unbiased opinion. Automatic conflict of interests would result if the nurse on the ~~nursing staff excellence committee~~Nursing Excellence Committee (NEC) is ~~the nurse~~ under review. Relative conflicts of interest are due to the reviewer either being involved in the patient's care or having a familial relationship with the nurse involved, and similar situations.

It is the obligation of the individual reviewer to disclose to the ~~nursing staff excellence committee the~~NEC any potential ~~conflict~~conflicts. The ~~responsibility of the peer review body is~~

~~to determine~~NEC determines whether the conflict would prevent the individual from participating or the extent of the individual's participation. Individuals determined to have a conflict may not be present during peer review body discussions or decisions other than to provide information if requested.

IV. GENERAL INFORMATION:

A. All peer review information is privileged and confidential in accordance with nursing and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

B. The involved nurse and team will receive specific feedback on a case-by-case basis.

~~The hospital will use the nurse-specific peer review results in each nurse's annual evaluation process, and as appropriate, in its performance improvement activities.~~

C. The hospital will keep nurse-specific peer review and other quality information concerning a nurse in a secure area. The peer review and quality information will be kept separate from the employment file. Nurse- specific peer review information consists of information related to:

- Performance data for all dimensions of performance measured for that team or individual nurse
- The ~~individual~~ nurse's (or nurses') role in sentinel events, significant incidents, or near misses
- Correspondence to the ~~nurse~~involved stakeholders regarding commendations, comments regarding practice performance, or corrective action

D. Peer review information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a nursing leader or hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to nurse-specific peer review information and only for ~~purposes of quality~~ improvement efforts:

- The NEC
- Chief Nursing Officer (CNO)
- Nursing Director/Manager
- Quality Management Director
- Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., The Joint Commission or state/federal regulatory bodies)
- Individuals with a legitimate purpose for access as determined by the hospital board of directors

E. No copies of peer review documents will be created and distributed unless authorized by the CNO or per hospital policy.

V. PROCEDURE:

1. Circumstances requiring peer review:

Peer review is conducted on an ongoing basis and reported to the ~~NSEC~~NEC for review and action. The procedure for conducting peer review is described ~~in the "Process and time frames" document~~below. ~~Evaluation of a case will~~Triggers for peer review may be ~~conducted~~identified through ~~the following means~~:

- ~~Through reporting~~Reporting processes such as occurrence reports
- When there is an unusual individual case or clinical pattern of care identified during a quality review

~~Circumstances requiring external peer review:~~

~~The NSEC will make recommendations on the need for external peer review to nursing leadership. External peer review will take place under the following circumstances if deemed appropriate by nursing leadership or by the board of directors.~~

- ~~Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers and conclusions from this review will directly impact a practitioner's license.~~
- ~~When the only practitioners with that expertise are determined to have a conflict of interest regarding the practitioner under review and the conflict of interest cannot be appropriately resolved by the NSEC or nursing leadership.~~

A nurse cannot require the hospital to obtain external peer review if it is not deemed appropriate by the nursing leadership or board of directors.

2. Participants in the review process:
   - Unless otherwise specified, committee members shall be appointed for a term of ~~one~~two (~~1~~2) ~~year~~years. To maintain continuity, committee appointments will stagger to eliminate simultaneous replacement committee membership.
   - Participants in the review process will be selected according to the nursing policies and procedures. ~~Medical staff will participate in the review process if deemed appropriate.~~

     ~~Additional support staff will participate if such participation is included in their job responsibilities.~~

     ~~The Nursing Staff Excellence Committee (NSEC) will consider and record the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual, as long as the individual responds in the time frame outlined~~
   - The NEC will provide opportunities for feedback from nursing staff who can provide insight and clarification about the event under review. Nurses who are involved in the case will be invited to participate in the review, which may include email communications, attendance at the NEC case review or other meetings, and through informal conversations with NEC members.
   - In the event of a conflict of interest or circumstances that would suggest a biased review, the ~~NSEC~~NEC and nursing leadership will determine who will participate in the process. Participants with a conflict of interest may not be present.

~~Thresholds for Intensive Review~~

~~If the results of individual case reviews for a nurse exceed thresholds established by the nursing staff listed below, the department director will review the findings to determine whether further intensive review is needed to identify a potential pattern of care.~~

~~Thresholds:~~

- ~~Any single egregious case~~
- ~~Within any 12-month period of time, any one of the following criteria:~~
    1. ~~Three (3) cases rated Opportunity for Improvement~~
    2. ~~Four (4) cases rated Opportunity for Improvement~~
    3. ~~Four (4) cases rated as having documentation issues regardless of care rating~~

3. Peer ~~Review Time Frames~~

   ~~Peer~~ review will be conducted by the ~~nursing staff excellence committee~~NEC in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the Quality Management department and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability.
4. Statutory Authority

   The above policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. Sections 11101, et seq. and California Evidence Code Section 1157.

VI. EDUCATION/TRAINING~~:~~

~~A. Education is provided during committee orientation and periodically as practice or policy changes.~~

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

VII. REFERENCES~~:~~

~~A. N/A~~

A. Haag-Heitman, B. & George, V. (2011). *Peer review in nursing: Principles for successful practice.* Sudbury, MA: Jones and Bartlett.

B. George V. & Haag-Heitman B. (2015). Peer review in nursing: Essential components of a model supporting safety and quality. *JONA: Journal of Nursing Administration, 45*(7-8), 398-403.

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
CNO	Lisa Paulo: Chief Nursing Officer	05/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2023
Policy Owner	Kirsten Wisner: Magnet Program Director	03/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13432092**

Last Approved	N/A
Last Revised	05/2023
Next Review	3 years after approval
Owner	Rolf Norman: Director Financial Planning & Decision Support
Area	Administration

Operating Budget

I. POLICY STATEMENT:

A. Department Directors and Vice Presidents are responsible for planning for the operating needs of their departments. This planning is evident in the submission of their operating budget requests on an annual basis and reflects the hospital's goals and objectives.

B. The President/Chief Executive Officer of Salinas Valley Health and the Board of Directors must approve the operating budget through the annual Statement of Justification.

C. The annual operating budget is prepared according to accepted accounting principles.

D. An independent public accountant conducts an annual audit of the hospital's finances.

II. PURPOSE:

A. The purpose of this policy is to outline the steps that need to be followed to submit the annual operating budget (also known as the Statement of Justification).

III. DEFINITIONS:

A. **Operating Budget:** Detailed projection of all estimated net revenue (revenue less deductions) and expenses based on forecasted patient revenue for a period of one year. It consists of several sub-budgets, including the departmental operating expense budgets. The operating expenses consist of various accounts, which are defined in Attachment A.

1. Assets that cost more than $2,000 and have a useful life of over one year are considered capital and should not be included in operating expenses. Computer equipment and copy machines are also considered capital if their cost is greater than $1,000. Single purchases of like assets which cost $10,000 or more are also considered capital, even if individual items cost less than the limits above.

IV. GENERAL INFORMATION:

A. N/A

V. PROCEDURE:

A. **Submission of Departmental Operating Budgets:**

1. Each year, the ~~Vice President/Finance and~~CFO will set the calendar for budget submission. For the departmental operating budgets to be considered, they must be submitted by the submission date.
2. ~~EPSi – Budget Manager~~Axiom Financial Software will be utilized for the Operating Budget.
3. The Operating Budget consists of Departmental and Other revenue (if applicable), anticipated income, expenses and statistics (if applicable).
    a. Departmental revenue and statistics are not editable in ~~EPSi~~Axiom by Department Heads. Any proposed changes should be reviewed and discussed with the ~~Vice President~~CFO and/~~Finance and Budget~~or Director~~.~~ of Financial Planning
    b. Departmental expenses include salaries and wages and all other operating expenses. Salaries, wages and hours are prepared in the Payroll section of ~~EPSi~~Axiom. All other expenses are prepared in the Expenses section in ~~EPSi~~Axiom. Salaries and wages will crosswalk over from Payroll to Expenses. Hours will crosswalk from Payroll to Statistics.
4. ~~Vice President~~CFO must ~~sign off on all departmental~~approve the operating budgets.
    a. ~~The Statement of Justification~~Operating Budget is reviewed and approved at the May or June Board Meeting for use in the fiscal year starting July 1.
5. Department heads monitor the implementation of the budget~~.~~

~~Documentation:~~

~~1. Approved Statement of Justification~~

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. TJC Standards LD 01.07.01 and 04.01.03

B. CMS Standard 482.12 (d)

~~EPSi – Budget Manager and associated Help Guide~~

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2023
Policy Owner	Rolf Norman: Director Financial Planning & Decision Support	04/2023

Standards

No standards are associated with this document

Mechanics Bank

PUBLIC ENTITY BANKING RESOLUTION

I certify that I am the Treasurer of Salinas Valley Memorial Healthcare System, a Public Entity organized under the laws of the state of California ("Organization"). I also certify that at a meeting of the Organization's Board of Directors held on _____, at which a quorum was present and acting throughout, the following resolutions were adopted and are now in full effect.

AUTHORITY TO SIGN AND ACT FOR THE ORGANIZATION
(Cross out any of the below acts that the designated persons are not authorized to perform.)

It is resolved that the persons now or subsequently holding the positions named below are individually authorized in the name of and on behalf of the Organization to:

- Establish any banking accounts and services.
- Sign, or change in writing, any agreement with Bank regarding Organization's banking deposit relationship, including the use of automated teller services.
- Specify in writing to Bank the individuals who are authorized, in the name of and on behalf of Organization to:
  - Withdraw funds from any of Organization's banking accounts on Organization's checks or orders, subject to any multiple signature requirements, as set forth in a separate agreement between Organization and Bank.
  - Individually use an automated teller card to access any of Organization's deposit accounts, regardless of any multiple signature requirements otherwise applicable to the accounts.
  - Endorse and deliver to Bank, for any purpose, and in any amount, negotiable or non-negotiable commercial paper of any kind, owned by, held by, or payable to Organization.
  - Send, review, and/or authorize wire and electronic transfers of funds from Organization's deposit accounts. Such authority may be exercised by such authorized individuals acting alone, regardless of any multiple signature requirements otherwise applicable to the accounts.
  - Otherwise access Organization's deposit accounts.

This authority may be exercised at such time and on such terms as Organization's designated Representatives believe proper. This authority will remain in effect until Bank receives written notice of revocation at the Office where Organization's banking relationship is maintained.

I further certify that the following are true and correct specimen signatures of Organization's designated Representatives, who hold the titles stated below. **Please cross out any unused signature lines.**

Representative's Name (Typed or Clearly Printed)	Representative's Signature	Title (Typed or Clearly Printed)
Augustine Lopez		CFO
Pete Delgado		President and CEO
Victor Rey Jr.		Board President

Ratification of Prior Acts
The Organization ratifies and authorizes all acts of any of the Organization's designated Representative(s) performed in the name of Organization with respect to Organization's banking deposit relationship before the date of this authorization.

WITNESSED

Treasurer's Name (Typed or Clearly Printed)	Treasurer's Signature	Date

When the Treasurer is designated as the Organization's sole Representative, this Agreement should also be signed by a second officer.

Name and Title (Typed or Clearly Printed)	Signature	Date

Mechanics Bank

Instructions

PUBLIC ENTITY BANKING RESOLUTION

This form establishes the Organization's "Designated Representatives" and defines banking activities the Representatives are authorized to conduct in the name of and on behalf of the Organization. **This form may not be altered without prior agreement and consent from Bank.**

Please read/review the entire Public Entity Banking Resolution and complete as follows:

- In the top portion of the Resolution, indicate, where applicable:
  - The name of the Organization.
  - The name of the state under whose laws the Organization has been organized.
  - The date of the Organization's meeting that adopted the Resolutions.

- In the middle portion of the Resolution:
  - Type or clearly print the name of each authorized Representative.
  - Each authorized Representative must provide his or her signature specimen.
  - Type or clearly print the Title of each named authorized Representative. **Please cross out any unused signature lines.**

- In the bottom portion of the Resolution:
  - Type or clearly print the name of Organization's Treasurer.
  - The Treasurer must provide his or her signature specimen.
  - Type or clearly print the date the Resolution was executed. **The Witnessed section must be completed and signed by the Organization's Treasurer.**
  - **If the Treasurer is the only Designated Representative,** a second officer of the Organization should:
    - Type or clearly print his or her name.
    - Provide his or her signature specimen.
    - Type or clearly print the date the Resolution was executed.
  - If a second officer of the Organization is not available, **please cross out the unused signature line.**

QUALITY AND EFFICIENT PRACTICES COMMITTEE

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

(CATHERINE CARSON)

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*

“An Integrated Healthcare Delivery System”

Operating & Capital Budget
Fiscal Year 2024

Augustine Lopez

Chief Financial Officer

Salinas Valley Health Medical Center (SVHMC) Key Operating Budget Assumptions

- **Operating Margin % : 0.4%**

- **Budget FY 2024 – Incorporates patient volumes based on trends**

Statistic	FY 2024 Budget
ADC	127
Admissions	11,306
ALOS	4.1
IP Surgery	1,803
OP Surgery	2,956
OP Visits	131,198
Deliveries	1,446
ER Admissions	8,815
ER OP Visits	57,154
Total ER Admissions % of Admissions	86.0%

Consolidated FY 2024 Budget Compared to FY 2023 Projection

PL SUMMARY	FY 2024 Budget CONSOLIDATED TOTAL	FY 2023 Projection CONSOLIDATED TOTAL	CONSOLIDATED Variance	% Change
GROSS PATIENT REVENUE	3,031,451,266	3,041,449,549	(9,998,284)	-0.3%
NET PATIENT REVENUE	697,312,386	708,720,019	(11,407,634)	-1.6%
Yield	23.0%	23.3%	-0.3%	-1.3%
OTHER REVENUE	27,500,996	27,506,979	(5,983)	0.0%
TOTAL REVENUE	724,813,382	736,226,998	(11,413,617)	-1.6%
TOTAL OPERATING EXPENSES	721,734,945	708,879,702	(12,855,244)	-1.8%
OPERATING MARGIN	3,078,436	27,347,296	(24,268,860)	-88.7%
OPERATING MARGIN %	0.4%	3.7%	-3.3%	-88.6%
EBITDA	34,156,405	56,216,090	(22,059,686)	-39.2%
EBITDA %	4.7%	7.6%	-2.9%	-38.3%
OTHER NON OPERATING INCOME	22,919,607	22,220,959	698,648	3.1%
TOTAL MARGIN	25,998,043	49,568,255	(23,570,212)	-47.6%
TOTAL MARGIN %	3.6%	6.7%	-3.1%	-46.7%

SVH
Capital Budget
Fiscal Year 2024

Salinas Valley Health
Capital Budget Summary
FY 2024

FY2024 Capital Budget Summary		
Total Routine Capital (includes $1.7m from FY23 Budget from delayed CT/Nuc.Med)	$	19.9m
Total Strategic Capital (Including SVH Clinics)	$	9.7m
Master Facility Planning & Design *(Garage $36m Total, Done FY24)*	$	8.4m
Seismic Upgrade *($62.5m Preliminary Total, Done FY27)*	$	4.0m
Total Proposed Capital Budget For FY2024	**$**	**41.9m**

Salinas Valley Health
Routine Capital Budget Summary
FY 2024

Sources of Capital - Total Capital		
General Operating Funds	$	41.9m
Total Sources of Capital	**$**	**41.9m**

Proposed Uses Of Routine Capital

Carryover Projects Started in FY2023 or Prior		
1 CT Scanner ($4m total over FY23-24)	$	2.5m
2 Nuclear Medicine Camera ($3.3m total over FY23-24)	$	1.9m
3 Liquid Oxygen Tank Replacement ($2.8m FY23-24)	$	2.3m
4 High Speed elevator modernization ($2.8m total over FY22-25)	$	1.3m
5 Rebranding - Signage and Facilities ($2.2m over FY23-24)	$	0.9m
Subtotal Carryover Projects	**$**	**8.9m**

Salinas Valley Health
Routine Capital Budget Summary
FY 2024

New Capital Under Consideration			
Facilities/Construction			
1	Angio/Special Procedures Suite ($3.3m over FY24-25)	$	0.8m
2	Cath Lab 3 Replacement ($3.6m over FY24-26)	$	0.4m
3	X-ray Room 1 ($1.4m over FY24-26)	$	0.3m
4	X-ray Room 2 ($1.4m over FY24-25) *	$	0.3m
5	Other Projects < $200k	$	0.1m
	** X-Ray Room #3 remodel was completed in Feb. 2021*		
	Total New - Facilities/Construction	$	2.0m

Salinas Valley Health
Routine Capital Budget Summary
FY 2024

New Capital Under Consideration (Continued)

Equipment

1	Operating Room and Cath Lab Inventory Management Solution ($1.2m over FY24-25)	$	0.6m
2	Replace Stryker Orthopedic Instruments / Equipment	$	0.5m
3	IV Pump replacement (old pumps recalled, pending FDA approval on replacements)	$	0.4m
4	Dish Washing Machine/ Conveyor Belt replacment	$	0.3m
5	Replace NICU Bedside Monitors (11)	$	0.3m
6	HillRom Hospital Beds Project (113 beds over 3 years, FY24 22 Beds, Progressive Care and Med/Surg.)	$	0.3m
7	Replace Heart Lung Machine (We have 3 total, 2 end of life - one replaced in FY23, one in FY24	$	0.3m
8	Laboratory Air Handling Unit (AHU) ($1.6m over FY24-25)	$	0.3m
9	Replace Ultrasonic Aspirator System (Sonopet)	$	0.2m
10	Other Projects < $200k	$	2.0m
	Total New - Equipment	**$**	**5.1m**

Salinas Valley Health
Routine Capital Budget Summary
FY 2024

	Information Technology		
1	New Human Resources and Payroll System	$	1.0m
2	Server lifecycle replacement	$	0.6m
3	Hospital Desktop Computers/Lifecycle Replacement	$	0.4m
4	Replacement of obsolete Cisco 3850 series network switches	$	0.4m
5	Cardiology PACS Upgrade (Operations)	$	0.2m
6	Other Information Technology < $200k	$	1.3m
	Total New - Information Technology (Hospital Wide)	**$**	**4.0m**
	Total Fiscal Year 2024 Routine Capital	**$**	**19.9m**

Salinas Valley Health
Strategic Capital Budget Summary
FY 2024

Strategic Capital Under Consideration		
1 MRI Buildout Inside Hospital ($8m Total FY24-25)	$	4.0m
2 MRI Upgrades Clinics	$	3.0m
3 SVH Clinics Capital	$	1.1m
4 Vascular Clinic - Tenant Improvement 212 SJ Street	$	0.5m
5 Other	$	1.1m
Total Strategic Capital Requests	**$**	**9.7m**

Strategic Capital Targets:

Return on investment > 30%

Payback period of 4-5 years or less

QUESTIONS / COMMENTS

CORPORATE COMPLIANCE
AND AUDIT COMMITTEE

Minutes of the
Corporate Compliance and Audit Committee
will be distributed at the Board Meeting

(JUAN CABRERA)

Medical Executive Committee Summary – June 8, 2023

Items for Board Approval:

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Chadive, Deepika, MD	Neonatology	Pediatrics	Neonatology
Isom, Robert, MD	Nephrology	Medicine	Nephrology General Internal Medicine
Kironde, Tendo, MD	Pediatrics	Pediatrics	Pediatric

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Alexianu, Maria, MD	Tele-Neurology	Medicine	Tele-Neurology
Aziz, Shehzad, MD	Hematology/Oncology	Medicine	Hematology & Oncology
Breur, Tuvia, DO	Tele-Psychiatry	Medicine	Tele-Psychiatry
Iranmanesh, Reza, MD	Ophthalmology	Surgery	Ophthalmology
Janda, Herjap, MD	Internal Medicine	Medicine	Hospitalist – Adult
Le, Minh, MD	Critical Care/ Pulmonary Medicine	Medicine	Critical Care/Pulmonary Medicine
Leonard, Kristin, DO	Family Medicine	Medicine	Hospitalist – Adult
Marquez, Elida, MD	Ob/Gyn	Ob/Gyn	Obstetrics and Gynecology
Mayer, Patricia, MD	Family Medicine	Family Medicine	Family Medicine – Active Community
Revers, Robert, MD	Endocrinology	Medicine	Medicine – Active Community
Subbarao, Meena, MD	Pediatrics	Pediatrics	Pediatrics – Active Community
Whisler, Charles, MD	Ophthalmology	Surgery	Ophthalmology

Staff Status Modifications:

NAME	SPECIALTY	STATUS
Archibald-Seiffer, Noah, MD	Anesthesiology	Recommend advancement to Active Status
Cooper-Vaughn, Margaret, MD	Ob/Gyn	Leave of Absence effective 6/1/2023
Goodwein, Shelley, MD	Ob/Gyn	Leave of Absence effective 5/31/2023 at 5pm
Griggs, Ryan, DO	Urology	Recommend advancement to Active Status
Hu, Steve, MD	Gastroenterology	Recommend advancement to Active Status
Hunt, Madison, MD	Emergency Medicine	Recommend advancement to Active Status
Larsen, Melissa, MD	Ob/Gyn	Leave of Absence effective 5/31/2023 at 7am
Razzak, Anthony, MD	Gastroenterology	Recommend advancement to Active Status
Bou-Assaly, Wessam, MD	Radiology	Resignation effective May 23, 2023
Gregorious, Stephen, MD	Orthopedic Surgery	Resignation effective July 1, 2023
Lertdilok, Patrick, MD	Radiology	Resignation effective May 23, 2023
Serio, M. Kerala, MD	Cardiology	Resignation effective June 21, 2023

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE
Resendez, Elpidio, MD	Emergency Medicine	Moderate and Deep Sedation

Temporary/Locum Tenens Privileges:

NAME	SPECIALTY	DATES
Indudhara, Ramaiah, MD	Urology	6/7/2023-6/14/2023

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

Dept of Medicine – Clinical Privileges Delineation Adult Hospitalist	Revision of the clinical privilege delineation for Adult Hospitalist adding Telehealth to core procedures.
Dept of Family Medicine – Clinical Privileges Delineation	Revision of the clinical privilege delineation for Family Medicine with substantive changes to Family Medicine Obstetrical privileges. All changes were reviewed in concert with the OB/GYN Department Chair.

Interdisciplinary Practice Committee

Initial Appointment:

NAME	SUPERVISOR(S)	DEPARTMENT	PRIVILEGES
Gill, Shaminder, PA-C	Misty Navarro, MD Cristina Martinez, MD	Emergency Medicine	Physician Assistant- Emergency Medicine
Lo, Kevin, PA-C	Tarun Bajaj, MD	Surgery	Physician Assistant – Surgery

Reappointment:

NAME	SUPERVISOR(S)	DEPARTMENT	PRIVILEGES
Ramirez, Alberto, PA-C	Rakesh Singh, MD Cristina Martinez, MD	Emergency Medicine	Physician Assistant – Emergency Medicine

Staff Status Modifications:

NAME	SPECIALTY	STATUS
Cobb, Katie PA-C	Physician Assistant-Cardiology	Resignation effective May 2, 2023

Policies and Plans: *(Attached)*

I. Appendix 1 – Quality Assessment and Performance Improvement Plan – 2023 Indicators and Scope
II. Appendix 2 – Quality Assessment Performance Improvement Plan – 2023 Project List
III. Infection Prevention Program Plan
IV. Emergency Management Program Plan

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Medical Staff Excellence Committee
d. Quality and Safety Committee Reports:
    - Quality Assessment and Performance Improvement Plan Appendices
        - List of 2023 PI Projects for Approval
        - List of 2023 PI Measures for Approval
    - Risk Management & Patient Safety Reports
    - BETA Heart Validation Dashboard
    - Dialysis Service Program
    - Safety and Reliability Committee – Accreditation and Regulatory
    - Pharmacy & Therapeutics/Infection Preventions Committee – Summary Report
        - Antibiotic Stewardship
        - Medication Safety
        - Infection Prevention Program Data
    - Environment of Care Summary
    - Palliative Care
    - Diagnostic Discrepancies - Pathology

II. Other Reports:

a. Financial Performance Review April 2023
b. Operating and Capital Budget FY 2024
c. Summary of Executive Operations Committee Meetings
d. Summary of Medical Staff Department/Committee Meetings – May 2023
e. Medical Staff Excellence Committee – Annual Review of Peer Review Indicators
f. Medical Staff Treasury Report June 2, 2023
g. Medical Staff Statistics Year to Date
h. HCAHPS Update

Salinas Valley Health Medical Center

Clinical Privileges Delineation
Adult Hospitalist

Applicant Name: _____

Qualifications:

To be eligible to apply for core privileges as a Hospitalist, the applicant must meet the following qualifications:

- Current certification or active participation in the examination process leading to certification by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, the American Board of Family Medicine or the American Osteopathic Board of Family Practice.

Or

- Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in Internal Medicine or Family Medicine.

And

- Documentation of the provision of inpatient services to at least 40 hospitalized in-patients in the last 12 months or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship.
- New applicants will be required to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

General Privilege 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.

Hospitalist Core Privileges

Admit, evaluate, diagnose, treat and provide consultation to patients with common and complex illnesses, afflictions, diseases, and functional disorders of the circulatory, respiratory, digestive, endocrine, metabolic, musculoskeletal, hematopoietic, and eliminative systems of the human body. Core privileges also include Thrombolytic therapy for stroke with Neurology consultation/co-management and Management of ICU and CCU patients with consultation, as needed. 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.

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; those physicians who have fewer than 40 in-patient contacts per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify to reapply.

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
				Chest tube placement	Documentation of successful performance in the previous 2 years.	**1**	**2**
				Swan-Ganz Catheter Insertion	Documentation of successful performance in the previous 2 years	**1**	**1**

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Insertion and Management of Pulmonary Artery Catheter	Documented successful performance of at least 50 PACs during formal training, as the primary operator **OR** Successful completion of an accredited residency in another field; participation in a significant Category 1 accredited continuing medical education training program in pulmonary artery catheter insertion and management **AND** Successful insertion and subsequent management of pulmonary artery catheters in at least 100 patients during the past 36 months. **Required Previous Experience:** Documented successful performance (as primary operator) of at least 50 PACs during the past 24 months.	**1**	Documented successful performance of at least 15 PACs per year, as the primary operator

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Ventilator Management Complicated >48 hours	For complicated* ventilation cases, the applicant must demonstrate successful completion of an accredited fellowship that provided the necessary cognitive and technical skills for full ventilator management. *More than 48 hours, or for patients defined as those having any of the following ongoing characteristics or any other of a like or similar complexity: peak ventilator pressure is greater than 40cm H20,pH is less than 7.3, Fi02 is greater than 60^, status asthmaticus, ARDS, multi-organ failure, hemodynamic instability. **Required Previous Experience:** Successful management of at least 25 mechanical ventilation cases in the past 24 months.	**1**	Successful management of at least 25 mechanical ventilation cases within the past 24 months.
				Exercise Treadmill	Successful completion of at least 50 ETT in the previous 2 years **AND** current ACLS certification	**N/A**	Successful completion of 20 ETT procedures within the past 24 months **AND** current ACLS certification

Salinas Valley Memorial Healthcare System

Hospitalists: 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

- Arthrocentesis
- Arterial Line Placement – Percutaneous
- Central Venous Line Placement
- I & D abscess
- I&D hemorrhoids
- Biopsy of superficial lymph nodes
- Breast cyst aspiration
- Burns, superficial and partial thickness
- Excision of skin and subcutaneous lesions
- Excision of cutaneous and subcutaneous tumors and nodules
- Initial interpretation of electrocardiograms
- Local anesthetic techniques
- Lumbar puncture
- Manage uncomplicated minor closed fractures and uncomplicated dislocations
- Nasogastric tube placement
- Paracentesis
- Peripheral nerve blocks
- Placement of anterior and posterior nasal hemostatic packing
- Perform simple skin biopsy or excision
- Preliminary interpretation of electrocardiograms, own patient
- Remove non-penetrating corneal foreign body, nasal foreign body
- Repair of lacerations, including those requiring more than one layer of closure
- Suprapubic bladder aspiration
- Telehealth services
- Thoracentesis
- Ventilator Management Uncomplicated (<48 hours)
- Venous cutdown

Applicant:

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:

Salinas Valley Health Medical Center

Clinical Privileges Delineation Form
Family Medicine

Applicant Name: _____

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

Qualifications for Adult Family Medicine Privileges:

A. Current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Practice OR Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in family medicine.
AND

B. Documentation of the provision of inpatient care for at least 24 adult patients as the attending physician or senior resident during the past 24 months or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship.

General Privilege 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.

Adult Family Medicine Core Privileges

☐ **Requested**

Admit, evaluate, diagnose and treat patients for common illnesses and injuries including disorders common to old age. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Pediatric and Well Newborn Family Medicine Privileges:

A. Meet All qualifications for Adult Family Medicine privileges under A above
AND
Documentation of the provision of inpatient care for at least 20 hospitalized pediatric/newborn patients during the past 24 months. Competency criteria requires that 5 of these patients be pediatric patients or, at a minimum, the applicant must have provided inpatient care for at least 3 pediatric patients in conjunction with documentation 5 hours of Category 1 CME on acute care pediatric medicine during the past 24 months
OR

B. Demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in the past 24 months.

Family Medicine Pediatric and Well Newborn Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat pediatric and well newborn patients with conditions of mild to moderate degree without immediate threat to life. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Well Newborn Family Medicine Privileges:

A. Meet All qualifications for Adult Family Medicine privileges under A above
AND

B. Documentation of the provision of inpatient care for at least 20 hospitalized well newborn patients during the past 24 months or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in the past 24 months.

Family Medicine Well Newborn Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat well newborn patients.

Qualifications for Pediatric Family Medicine Privileges:

A. Meet All qualifications for Adult Family Medicine privileges under A above
And

B. Documentation of the provision of inpatient care for at least 24 hospitalized pediatric patients during the past 24 months or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in the past 24 months.

Family Medicine Pediatric Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat pediatric patients (with exceptions of newborns), with conditions of mild to moderate degree without immediate threat to life. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Family Medicine Category I Obstetrical Privileges:

A. All qualifications for Adult Family Medicine.
AND

B. Documentation of successful completion of a six (6) month rotation on an obstetric unit during training with at least 100 vaginal deliveries under supervision during training
AND

C. Documentation of at least 50 vaginal deliveries in the past 24 months.
AND

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

Family Medicine Category I Obstetrical Privileges ***(check box if requesting)***

☐ **Requested**

Core Procedures/Diagnoses: Admit, evaluate, diagnose, treat and provide consultation to obstetrical patients, to include management of normal pregnancy, labor and delivery, as well as expected complications or obstetrical emergencies.

Applicants without C-Section privileges are required to make arrangements for C-Section Back-Up for all deliveries in the event that a C-Section is needed.

Note: The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Family Medicine Category II Obstetrical Privileges

A. All qualifications for Adult Family Medicine and Category I Obstetrical Privileges
AND

B. Documentation of successful completion of a full **1 year** exclusive experience on obstetric unit with at least **100 vaginal** deliveries with supervision and **30 abdominal** deliveries with supervision during training or practice within the past 24 months
AND

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

Family Medicine Category II Obstetrical Privileges *(check box if requesting)*

☐ **Requested**

Core Procedures/Diagnoses: All core privileges under Category I as well as the following: Admit, evaluate, diagnose, treat and provide consultation to obstetrical patients, to include management of normal and complex pregnancy, labor and delivery, as well as expected complications or obstetrical emergencies. Applicants for this category are required to qualify for and request special procedure privileges for C-Sections.

Note: The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

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

Core Proctoring Requirements:
Core proctoring requirements include direct observation or concurrent review of the first cases as follows:

Adult Family Medicine Core:	~~2~~1 Adult Admission
Pediatric & Well Newborn Core:	1 Pediatric Admission and 1 Well Newborn
Well Newborn Core:	1 Well Newborn
Family Medicine Pediatrics Core:	1~~2~~ Pediatric Admission
Family Medicine Obstetrics:	2~~3~~ Deliveries – 1~~2~~ of which must be C-section if C-Section privileges are requested.

Reappointment Criteria for Core Privileges:
Applicant must provide documentation of the provision of the following within the past 24 months:

Adult Family Medicine Core:	20 hospitalized patients
Pediatric & Well Newborn Core:	20 hospitalized pediatric/newborn patients 5 of which must be pediatric or 3 and 5 hours Category 1 CME
Well Newborn Core:	20 hospitalized well newborn patients
Family Medicine Pediatrics Core:	24 hospitalized pediatric patients
Family Medicine Obstetrics I:	25 vaginal deliveries Participation in the annual assessment of EFM (electronic fetal monitoring) principles (assessed at the time of reappointment)
Family Medicine Obstetrics II:	25 vaginal deliveries w/10 C-sections Participation in the annual assessment of EFM (electronic fetal monitoring) principles (assessed at the time of reappointment)

Special Procedures/Privileges

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

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

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

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

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written conscious sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written conscious sedation exam with minimum 75% correct **AND** Performance of at least 2 Cases
				~~Rounding on Post-Partum Patients~~ ~~*Privileges may be held for a maximum of 4 years*~~	~~1. Meet criteria and be approved for Adult Family Medicine Privileges; **AND**~~ 2.1. ~~Hold full unrestricted Ob/GYN privileges for 5 consecutive years post completion of training in an accredited hospital within the past two years~~	~~**1**~~	~~1. Maintain Adult Family Medicine Privileges at SVMH.~~ 2.1. ~~Round on 100 post-partum patients during the previous 2 years without peer review referral for HIM delinquency~~

Gynecologic Special Procedure Privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Dilation and Curettage of the Uterus (Diagnostic)	Performance of at least 10 procedures during the previous 24 month period	**1**	Performance of at least 2 procedures during the previous 24 month period
				Dilation and Curettage of the Uterus for abortion <12 weeks (TAB, SAB)	Performance of at least 10 procedures during the previous 24 month period	**1**	Performance of at least 2 procedures during the previous 24 month period

Special Obstetrical Procedures

Qualifications:

Following completion of Family Practice residency and completion of a one year obstetric fellowship in an accredited Family Practice Obstetric Fellowship Training Program, and a letter of positive recommendation from the Chief of this program certifying training and competence to perform privileges requested

Other Requirements:

Deliveries with placenta previa require an assistant with unrestricted hysterectomy privileges

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Cesarean Section *Assistant Required*	Meet criteria for Category II Family Medicine Obstetrical Privileges **AND** Provide documentation of the successful completion of at least 30 C-sections within the past 24 months.	**2**	Performance of at least 10 procedures during the previous 24 month period
				Outlet and Low forceps delivery	Performance of at least 5 procedures during the previous 24 month period	**1**	Performance of at least 1 procedure during the previous 24 month period
				External Cephalic Version	Cesarean Section privileges are required	**1**	Maintenance of Cesarean Section privileges
				Amniocentesis-3rd Trimester	Performance of at least 5 procedures during the previous 24 month period	**1**	Performance of at least 1 procedure during the previous 24 month period
				~~Initiation of Q-Pump Pain Relief System~~	~~Review of "On-Q Pain Buster" educational materials~~	~~1 Retrospective Review~~	~~None~~

Applicant: Check box marked "R" to request privileges
Category 1 Pediatric Special Procedures – See Appendix for Description of Conditions in this Category

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Newborn Circumcision	Documentation of successful completion of at least 5 in the previous 24 months	**1**	Documentation of successful completion of at least 2 in the previous 2 years

~~**Neonatal Intensive Care Special Procedure Privilege Qualifications:** Applicant must~~
~~1. document 36 hours of continuing medical education in neonatal medicine every 3 years (Educational programs must meet the approval of the NICU Medical Director), and~~
~~2. maintain current Neonatal Resuscitation Program (NRP) certification, and~~
~~3. maintain current CCS Panel membership~~

R	A	C	~~N~~	~~**Procedure/Condition**~~	~~**Initial Appointment**~~	~~**Proctoring**~~	~~**Reappointment**~~
				~~R/O Sepsis~~ ~~Transient Tachypnea~~ ~~Prematurity~~ ~~35 weeks and greater and/or weight greater than 2250 gm~~ ~~Hypoglycemia responding within 2 hours on IV C10 at maintenance rates~~	~~Documentation of 25 cases in the previous 24 months~~	~~**N/A**~~	~~Documentation of 12 cases in the previous 2 years~~

Salinas Valley Memorial Healthcare System

Core Procedure List: The following procedures are considered to be included in the core privileges for this specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff

Family Medicine Adult

1. Assisting at Surgery
2. Arthrocentesis
3. I&D abscess
4. I&D hemorrhoids
5. Biopsy of superficial lymph nodes
6. Breast cyst aspiration
7. Burns, superficial and partial thickness
8. Excision of skin and subcutaneous lesions
9. Initial interpretation of electrocardiograms
10. Local anesthetic techniques
11. Lumbar puncture
12. Management of ICU and CCU patients with consultation
13. Manage uncomplicated minor closed fractures and uncomplicated dislocations
14. Paracentesis
15. Placement of anterior and posterior nasal hemostatic packing
16. Peripheral nerve blocks
17. Remove non-penetrating corneal foreign body, nasal foreign body
18. Repair of lacerations, including those requiring more than one layer of closure
19. Suprapubic bladder aspiration
20. Thoracentesis
21. Thrombolytic therapy for stroke
22. Vasectomy
23. Venous cut down

Family Medicine Pediatrics

1. Suture uncomplicated lacerations
2. I&D abscess
3. Perform simple skin biopsy or excision
4. Remove non-penetrating corneal foreign body
5. Manage uncomplicated minor closed fractures and uncomplicated dislocations
6. Lumbar puncture
7. Care of newborn infants above 2250 gm and >36 weeks
8. Ventilator management with consultation while awaiting transfer (not to exceed 12 hours after which care is automatically transferred to the Pulmonologist)

Family Medicine Obstetrics – Level I

1. Management of ~~Uncomplicated Labor~~labor and cephalic delivery
2. Administration of fetal lung maturity inducers
3. Amnio infusion
4. Amniotomy
5. Application of internal fetal and uterine monitors
6. Management of pregnancy inclusive of but not limited to such conditions as ~~mild~~ preeclampsia/pregnancy-induced hypertension >32 weeks, third trimester bleeding, preterm premature rupture of membranes >32 weeks, premature labor >32 weeks, ~~A-1 diabetes~~, gestational and preexisting diabetes, polyhydramnios, oligohydramnios, and fetal demise at any gestational age. ~~with notification of backup physician when patient is admitted.~~

~~6.~~7. Management of preterm premature rupture of membranes < 32 weeks, premature labor < 32 weeks, preeclampsia/pregnancy-induced hypertension < 32 weeks, and vaginal bleeding at any gestational age in consultation with a Maternal Fetal Medicine Specialist.

~~7.~~8. Manual removal of placenta

~~8.~~9. ~~Outlet~~ Vacuum Extraction

~~9. Gestational Diabetes – Non-insulin Dependent (A-1)~~

~~10.~~ 10Hemorrhage ante/intra & post partum

~~11.~~ 11Induction and~~,~~ augmentation~~, pharmacologic induction~~ of labor

~~12. Pharmacologic treatment of preterm labor~~

~~13. Polyhdramnios~~

~~14.~~ 12 Repair of vaginal 1st/2nd/3rd degree perineal, and cervical lacerations

~~15.~~ 13Ultrasound Exam for Placental location, presentation or Amniotic fluid ~~only~~

~~16.~~ 14Local and pudendal anesthesia

~~17. Amniotomy at 4cm and/or -1 station~~

~~18. Hyperemesis gravidarum~~

~~19.~~ 15Episiotomy and Repair

~~20. Use of Oxytocic drug after the end of 3rd stage of labor~~

~~21.~~ 16 Treatment of hyperemesis gravidarum ~~medical complications of pregnancy – requires **notification of Maternal Fetal Medicine specialist**~~

Family Medicine Obstetrics – Level II

~~1.~~ Postpartum surgical sterilization

~~2.~~ Twins - Vaginal Vertex/Vertex

~~3.~~ Twins - Other Presentation

~~4. Management of pregnancy induced hypertension/preeclampsia/pregnancy-induced hypertension <32 weeks, preterm premature rupture of membranes <32 weeks, premature labor <32weeks, and vaginal bleeding at any gestational age in consultation with Maternal Fetal Medicine Specialist. on PIH < 34 weeks~~

~~5.~~4. ~~Management of premature labor <32 weeks~~

~~6.~~5. ~~C-section for previa at term must have assistant with hysterectomy privileges scrubbed in.~~

~~7.~~ 5 Repair of 4th degree perineal lacerations ~~or cervical laceration~~

~~8. Management of pregnancy inclusive of such conditions as mild preeclampsia ,third trimester bleeding, premature rupture of membranes >32 weeks, A-1 diabetes, and fetal demise~~

~~9.~~ Cephalic forceps Outlet

~~10. Treatment of medical complications of pregnancy – requires notification of the Maternal Fetal Medicine specialist.~~

~~11. Management of gestational diabetes A1 and A2, diet controlled and insulin requiring~~

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

Please indicate any privilege on this list you would like to ***delete 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.

_____ _____

_____ _____

_____ _____

_____

Signature:

_____

Date

POLICY FOR LEVEL I FAMILY MEDICINE OBSTETRICAL PRIVILEGES
Back-Up, Consultation and Transfer

The following policy pertains to all Family Medicine physicians applying for Level I Obstetrical privileges.

DEFINITION OF BACK-UP PHYSICIAN:
The Back-Up Physician can only be a Family Physician with Level II unrestricted Obstetrical privileges or an Obstetrician with unrestricted obstetrical privileges. Perinatologists are not eligible to be Back-Up Physicians. The ED On-Call Physician for Obstetrics cannot be the Back-Up physician by default. Back-Up coverage can only be made through prior arrangement with that physician.

1. **GENERAL POLICY**: As a prerequisite to obtaining Level I Family Medicine Obstetrical privileges, all Family Medicine applicants are required to have an Obstetrician or Family Physician with Level II Obstetrical privileges as Back-Up who has agreed to provide obstetrical back up in the event the needs of the patient exceed their obstetrical privileges for the 2 year appointment periods. At no time should a Level I Family Medicine Physician continue in the practice of obstetrics without a designated Back-Up Physician. If the reported Back-Up Physician relationship changes at any point within the 2-year appointment period, a new Back-Up Physician designate must be reported to the Medical Staff Services Department immediately.

    a. The Family Physician and Back-Up Physician have mutually developed and agreed upon clear guidelines for consultation, co-management and transfer of care.

    b. The basic template for those guidelines is the Level I Obstetrical privileges for Family Physicians

    c. A Level I Family physician may have more than one designated Back-Up Physician listed, however, a specific Back-Up Physician must be designated and identified for each case.

    d. The Back-Up Physician can designate an alternate Back-Up Physician on a case by case basis only by mutual consent of the newly designated Back-Up Physician and the Level I Family Physician.

    e. Because serving as a Back-Up Physician is an assumption of risk and liability, the Back-Up Physician CANNOT be assigned the task or designated the task by an Employer, Department Chair. Hospital Administrator, or Chief of Staff without the consent of the Physician providing these services.

2. **PRIVILEGING AND REAPPOINTMENT**: The Back-Up Physician must be clearly identified and acknowledged at the time of application for and renewal of privileges with the Medical Staff Services Department.

    a. The Back-Up Physician's name and contact information shall be included with the application. (see attached attestation form)

    b. The Back-Up Physician must provide written acknowledgement of acceptance of this responsibility for the specific physician on the attestations form.

    c. Without cause, either the Level I Family Physician or Back-Up Physician may terminate the agreement at any time. Should this occur, the Level I Family Physician and Back-Up Physician

must immediately report this termination to the Medical Staff Services Department (Mon-Fri, 8am – 4:30) or to the Nursing Supervisor outside of normal business hours..

3. **LABOR AND DELIVERY NURSING**: The Labor and Delivery Nursing station will access the names of all Family Physicians with Level I Obstetrical privileges and their corresponding Back-Up through the medical staff privileges in the Meditech system

4. **ADMISSION TO LABOR AND DELIVERY**:

~~a. Upon admission of an Obstetrical patient to a Level I Family physician's service, the Back-Up Physician will be clearly identified on the admission orders~~

~~b.~~a. If the Back-Up Physician is not available or declines to provide Back-Up, the Level I Physician must transfer care to a Level II Family physician, Obstetrician, or another Level I Physician with appropriate Back-Up; or the Chair of the Department of Family Medicine or Ob/Gyn must intervene to arrive at a safe and appropriate solution

5. CONSULTATION, TRANSFER AND CO-MANAGEMENT OF PATIENTS

a. Any discussion with the Back-Up Physician must be documented in the chart by the Level I Physician

b. If the status of the patient exceeds Level I Family Medicine Obstetrical privileges, the care of the patient must be transferred to and accepted by the designated Back-Up Physician.

c. The Level I Physician must document transfer of care to the Back-Up Physician by order and note in the chart

d. The Back-Up Physician must document acceptance of the transfer of care in the chart through either a dictated or handwritten consultation note

e. The patient may be co-managed by the Back-Up Physician and Level 1 Physician, if acceptable by the Back-Up Physician.

6. VIOLATION OF POLICY

Violations of this policy will be reported to the Medical Staff Excellence Committee, the Chairs of the Family Medicine and Ob/Gyn Departments and to the Chief Medical Officer for review and action.

FAMILY MEDICINE
LEVEL I OBSTETRICS
BACK-UP ATTESTATION

The following physician has agreed to provide obstetrical Back-Up for hospitalized patients at Salinas Valley Memorial Hospital (SVMH) for the Family Medicine physician noted below.

Without cause, either the Level I Family Physician or Back-Up Physician may terminate the agreement at any time. The Level I Family Physician and Back-Up Physician but must immediately report this termination to the Medical Staff Services Department or to the Administrative Nursing Supervisor outside of normal business hours (Mon-Fri, 8am – 4:30).

Applicant Attestation:
I understand that I am required to have at least one Back-Up physician with Level II Family Medicine Obstetrical Privileges or full Obstetrical Privileges in order to qualify for Level I Family Medicine Obstetrical Privileges at SVMH. I understand that the Back-Up physician must be on staff in good standing with unrestricted privileges at SVMH. In the event that the needs of my hospitalized obstetrical patients exceed the privileges that I have been granted, the physician listed below has agreed to provide back up for me for the current reappointment period.

I understand that, should the status of any of these physicians change such that they would be unable to provide this Back-Up coverage, it is my responsibility to notify the Medical Staff Services Department immediately and to subsequently secure a replacement for that physician.

_____ _____
Physician's Signature Date

_____
Physician's Typed or Printed Name

Back Up Physician Attestation:

I have agreed to provide Back-Up coverage as outlined in the Medical Staff Back-Up, Consultation and Referral Policy for Family Medicine Physicians with Level 1 Obstetrical Privileges:

_____ _____
Physician's Signature Date

_____
Physician's Typed or Printed Name

_____
Physician's Contact Information

SCOPE OF QAPI PLAN 2023

No.	Indicator	Source	Services by CoP: Medical Staff	Nursing Services	Anesthesia	Surgical Services	Emergency	Outpatient	Pharmacy	Nutrition Services	Laboratory	Radiology	Nuclear Medicine	Respiratory Care	Rehabilitation	Physical Environment	Discharge Planning	Medical Record Services	Utilization Review	Organ, Tissue, and Eye Procurement	Infection Prevention and Control and Antibiotic Stewardship
	Total Indicators		31	31	18	18	21	10	14	7	19	14	10	10	10	15	5	12	1	8	12
1	Overall Mortality Index	Board Quality Dashboard	X	X	X	X	X		X					X				X		X	X
2	Risk adjusted all cause **sepsis** mortality index	Board Quality Dashboard	X	X	X	X	X		X									X		X	X
3	Never Events Reported CDPH Rate	Board Quality Dashboard	X	X	X	X	X	X	X	X	X	X	X	X	X	X				X	X
4	Medication Errors Rates (Reached Patient) WILL BE RELEASED ONCE DataRIX is implemented 07/2023	Board Quality Dashboard	X	X	X	X	X	X	X												
5	# of Incident Reports WILL BE RELEASED ONCE DataRIX is implemented 07/2023	Board Quality Dashboard	X	X	X	X	X	X	X	X	X	X	X	X	X	X				X	X
6	Employee Safety: Incidents Reported to Cal OSHA	Board Quality Dashboard	X	X	X	X	X	X	X	X	X	X	X	X	X	X				X	X
7	Patient Falls Reported to NDNQI (per 1000 pt days)	Board Quality Dashboard	X	X	X	X	X	X				X	X		X	X					
8	Falls with Injury	Board Quality Dashboard	X	X	X	X	X	X				X	X		X	X					
9	Stage 3, Stage 4, and Unstagable Hospital Acquired Pressure Injury (Reportable) Rate	Board Quality Dashboard	X	X	X	X	X								X	X		X			
10	Catheter Associated Urinary Tract Infection (CAUTI)	Board Quality Dashboard	X	X			X				X										X
11	Central Line Associated Blood Stream Infection (CLABSI)	Board Quality Dashboard	X	X			X				X										X
12	Clostridioides Difficile Infection (Cdiff)	Board Quality Dashboard	X	X			X				X										X
13	Surgical Site Infections	Board Quality Dashboard	X	X	X	X					X							X		X	X
14	Hand Hygiene Housewide Observation Data	Board Quality Dashboard	X	X	X	X	X			X	X	X	X	X	X						X
15	Hand Hygiene Housewide data validation (IP)	Board Quality Dashboard	X	X	X	X	X			X	X	X	X	X	X	X					X
16	30 Day Readmission Rate	Board Quality Dashboard	X	X			X	X	X					X	X		X	X	X		
17	PC-01: Elective Deliveries	Board Quality Dashboard	X	X	X	X												X			
18	PC-02: NTSV- Cesarean Section rates	Board Quality Dashboard	X	X	X	X												X			
19	PC-06: Unexpected Complications in Term Newborns	Board Quality Dashboard	X	X	X	X								X			X	X			X
20	Episiotomy Rates	Board Quality Dashboard	X	X														X			
21	Hypoglycemia e-CQM	Board Quality Dashboard	X	X					X	X	X							X			
22	Stroke (CVA): Door to needle time	Board Quality Dashboard	X	X			X	X	X		X							X			
23	MI: Door to PCI	Board Quality Dashboard	X	X			X	X	X		X							X			
24	OR Percentage of 1st Case on Time Starts	2023 Strategic Plan	X	X	X	X					X	X				X				X	
25	OR Turnover Time	2023 Strategic Plan	X	X	X	X					X	X				X				X	
26	ED Room Efficiencies: Median Length of Stay for non-admits (in min)	Board Quality Dashboard	X	X			X				X	X				X	X				
27	ED Room Efficiencies: Median Time from Admit Decision to Time of Admission to Nursing Unit (in min)	Board Quality Dashboard	X	X			X		X		X	X		X		X					
28	Average of Inpatient HCAHPS Scores	2023 Strategic Plan	X	X	X	X			X	X	X	X	X	X	X	X	X				
29	Average ED Press Ganey Score	2023 Strategic Plan	X	X			X		X		X	X	X			X	X				
30	Average Ambulary HCAHPS Scores	2023 Strategic Plan	X	X				X			X	X	X			X					

QAPI PI Project List 2023

Project Year	Status	Project Name	PI Measure with Baseline and Target	Key Change(s) Initiated	Current Project Phase	Prioritization Reason	Primary Effect	Project Leader	Project Sponsor	Clinical PI Specialist Support	Project Start Date	Project End Date
2023	In Progress	Hand Hygiene Improvement	Hand Hygiene Compliance, target 75%	Introduce validation rounding to observe staff protocols	4. Monitor and Control	High volume	Patient Safety	Melissa Dean	Lisa Paulo	Eva Tankesley	1/1/2023	12/31/2023
2023	In Progress	Pain/Opioid Improvement	Decrease the AMA rate among hospitalized inpatients with substance use disorder by 50% during calendar year 2023. Baseline 6%, target 3%, Decrease overdose rates for people recently-released from prison, increase rate of f/up care appts w/in 14 days of release	MAT for inpatients, CIWA protocol redesign, Initiate MAT before release from prison	3. Executing	High-risk	Health Outcomes	Aniko Kukla, Dr. Erica Locke	Dr. Allen Radner	Kathleen Fitzgerald	1/1/2023	12/31/2023
2023	In Progress	Health Equity Program	Health Equity measures collected in each care setting, percent of staff who completed cultural competency training	Define collection of required regulatory data elements, develop cultural competency training	2. Planning	High volume	Health Outcomes	Lilia M Gottfried	Pete Delgado	Toni Rodriguez	1/1/2023	12/31/2023

Status Active PolicyStat ID 13257369

Last Approved	04/2023	Owner	Melissa Deen: Infection Prevention Manager
Last Revised	04/2023	Area	Plans and Program
Next Review	04/2024		

Infection Prevention Program Plan

I. PURPOSE:

This plan describes the infection control program of Salinas Valley ~~Memorial Healthcare System~~Health Medical Center (~~SVMHS~~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) in order 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 goals of the program.

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 insure broad understanding of Infection Prevention strategies and individual requirements

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

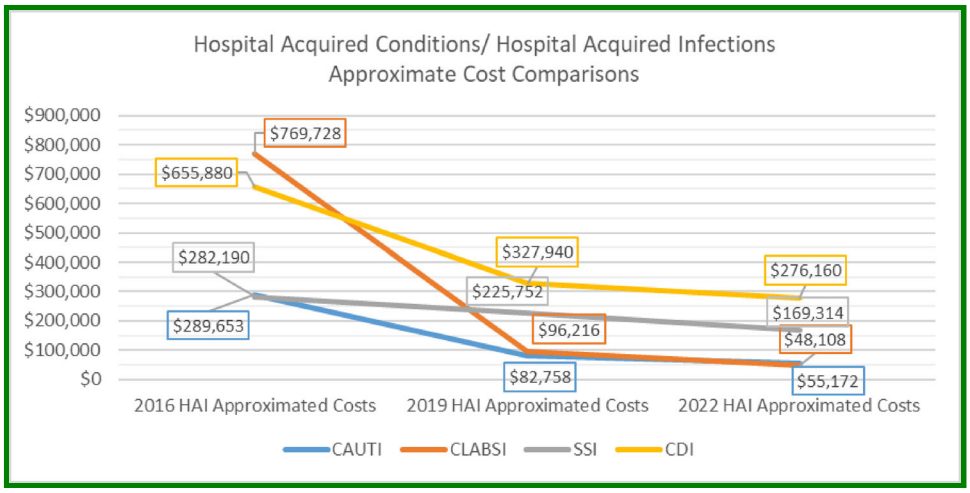
II. INFECTION CONTROL SCOPE OF SERVICES/

PROCESSES/STRUCTURE:

Geographic location and community environment

SVHMC is part of Salinas Valley ~~Memorial Hospital~~Health. The healthcare system is ~~part~~an integrated network of health care 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 ~~Memorial Healthcare System (SVMHS). The healthcare system is an integrated network of health care~~Health has specialty clinics located throughout the region, most which are centrally located next to the hospital. Specialized programs ~~and services and at the core is a level 2, public district~~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 ~~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. SVMHS~~ has ~~specialty clinics located throughout the region, most which are centrally located next to the hospital. Specialized programs include the Comprehensive Community Cancer Program, Joint Replacement Center, Regional Spine Center, Women and Children Center, Salinas Valley Medical 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 expanded Level II Emergency Department. In ~~2020,~~2022, there were ~~11,989~~18,191 hospital admissions, with, ~~46, 021~~42,422 patient days. Emergency service total visits~~: 49,271,~~ for 2022 was 65,740. OR surgical services preformed ~~4,821~~3,495 cases in ~~2020,~~2022, with average of ~~13.2~~9.6 cases per day.

Infection Prevention Financial Data Summary is based on Agency for Healthcare Research and Quality (AHRQ) National Scorecard Report from 2017. AHRQ summary of meta-analysis additional cost estimates for Hosiptal-Aquired Conditions (HAC's) or Hospital Acquired Infections (HAI's) Estimated costs (95% confidence interval) per HAI ranging per event. Salinas Valley Health Medical Center had an approximate cost loss in 2016 for Catheter Associated Urinary Tract Infection (CAUTI) $289,653, then in 2019 $82,758, then in 2022 $55,172. Central-line Associated Bloodstream Infections (CLABSI) approximate cost loss in 2016 $769,728, then 2019 $96,216, 2022 was $48,108. Surgical Site Infections (SSI) approximate cost losses for 2016 $282, 190, in 2019 $225,752, then 2022 $169,314. Lastly, C.difficile Infections (CDI) approximate cost loss for 2016 $655,880, in 2019 $327,940, to $276,160 in 2022. (See below graph) In summary, HAC/HAI costs have reduced from 2016 in comparison to 2022. Salinas Valley Health Medical Center performance improvement measures for HAC/HAI's have made positive strides in prevention hospital acquired infections and provided improvements in patient outcomes.



~~SVMHS~~SVHMC serves Monterey County communities, which includes 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 upon tourism in the coastal regions and agriculture in the Salinas ~~SVMHS 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 upon tourism in the coastal regions and agriculture in 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 2020 National Census, the county's population was 433,168, 257,721 of the population are Hispanic the county seat and largest city is Salinas. The City of Salinas population in 2017 157,596, with a population decrease since 2000 by -0.01% Patient population mix consists of African American 2.5%, American Indian 0.2%, Asian 5.6%, Hispanic 57.9%, and White 30.6%, which includes local residents, the homeless, and immigrants and seasonal farm workers.. Per 2020 census 91.3% of Monterey, county residents speak Spanish; 2.1% speak Tagalog. Estimated median household income from 2020 Census Bureau for Monterey County residents is $128,227 annually.

Reported by Monterey County Public Health ~~in~~, 2012~~,~~ Epidemiological Impact of Communicable Diseases that ~~SVMHS~~SVHMC that would potentially impact ~~SVMHS~~SVHMC:

- Specific diseases or conditions that showed a statistically significant increase in incidence rates were campylobacteriosis, chlamydia, coccidioidomycosis, E. coli non-O157 (STEC), chronic hepatitis C, pertussis, and early syphilis.
- The most commonly reported enteric illnesses were campylobacteriosis, salmonellosis, and shigellosis. Affected population groups differed between these enteric pathogens, but in general, incidence rates were highest among children less than 15 years old.
- Sexually transmitted infections (STIs) represented the largest portion of diseases reported in Monterey County. Individuals age 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~~disproportional affected by chlamydia and gonorrhea. Men who have sex with

men (MSM) were disproportionately affected by syphilis.

- Pertussis remained prevalent among Monterey County residents. Rates were highest among children less than 15 years of age, Hispanics, Asian/Pacific Islanders, and Whites. Asian/Pacific Islanders were disproportionately affected by chronic hepatitis B and tuberculosis (TB).
- Rates of newly reported chronic hepatitis C among non-correctional based community members have increased since 2003. Overall, rates were highest among males age 45 to 64 years old. African Americans were disproportionately affected. Incidence of coccidioidomycosis increased among Monterey County residents. Rates were highest among residents of South County, individual's ages 25 to 64 years, and African Americans.
- CDPH alerts for disseminated gonococcal infections November, 2020
- 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.
- MCPHD increases in Tuberculosis cases in 2019-2021
- ~~Based on September 2019 MCPHD Provider update (2019 vs 2018):~~
    - ~~Decrease in Hepatitis C, Chronic, Gonorrhea, Coccidioidomycosis, Syphilis, and HIV cases.~~
    - ~~Increases in Chlamydia, Campylobacteriosis, Pertussis, Shigellosis cases.~~

CDPH/MCPHD alerts to communicable disease outbreaks either nationally, state or local in the last year:

- SARS-CoV-2 Pandemic updates regarding status of the outbreak, healthcare workers vaccination guidelines and other CDPH guidelines and/or regulations
- Pediatric Hepatitis and Adenovirus infection, April 2022
- Highly Pathogenic Avian Influenza A(H5N1) Virus: Recommendations for Human Health Investigations and Response, April 2022
- Monkeypox Virus Infection alerts & updates, May 2022
- CDPH Healthcare Provider Monkeypox Health Advisory, June 23, 2022
- Human Parechovirus (PeV) in the United States - 2022
- Variant Influenza Virus Infections: Recommendations for Identification, Treatment, and Prevention for Summer and Fall 2022
- Severe Respiratory Illnesses Associated with Rhinoviruses and/or Enteroviruses Including EV-D68 – Multistate, September 2022
- CDPH Health Advisory: Early Respiratory Syncytial Virus Activity and Use of Palivizumab, October 2022
- Outbreak of Ebola virus disease (Sudan ebolavirus) in Central Uganda, October 2022
- Guidance for Response to Surge in Respiratory Viruses among Pediatric Patients, November 2022
- Early Respiratory Syncytial Virus and Seasonal Influenza Activity November 12, 2022
- Shigella XDR (nationally), March 2023
- Emergence of Candida auris in Healthcare Facilities in Northern California, February

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 that manages the ongoing infection prevention program. Qualifications include appropriate education and training, with a goal for 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 Chief Medical Officer and the ~~SVMHS~~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 Pharmacy & Therapeutics/Infection Prevention Committee sanctioned by the Medical Staff Committee and is a multidisciplinary team. The Medical Director for Infection Prevention is an Infectious Disease Physician and Committee member. The IP Medical Director works collaboratively with the infection preventionist for administration and management of the infection control program. The committee membership is responsible for the development and implementation of strategies for components/functions of the Infection Prevention Program and 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 ~~SVMHS~~SVHMC Administration and Board of Directors to include assessing the adequacy of resources allocated to support infection prevention activities.

III. AUTHORITY:

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

Infection prevention is integrated into clinical departments. Clinical departments identify department specific infection prevention concerns. From the concerns, department specific infection prevention policies are developed. Each department's specific infection prevention policies are reviewed/ revised every 3 years. The department director/manager or designee and infection preventionist discuss propose revisions before submitting to Pharmacy & Therapeutics/Infection Prevention Committee for approval. After approval, the policies are reviewed and approved by Medical Staff, then ~~SVMHS~~SVHMC Administration and the Board of Directors. Once final approval is obtained, the infection preventionist communicates decisions made to the department director/manager. Major policy revisions or changes are also discussed at the Pharmacy & Therapeutics/Infection Prevention Committee and Quality Interdisciplinary Committee before implementation.

Infection Prevention Policies are developed to guide the practice and provide consistency in application of principles throughout the organization. These policies are available on the ~~SVMHS Intranet~~SVHMC Intra-net called the "STARnet" and are communicated to staff upon hire, on a yearly basis, 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 risks that are of epidemiological significance.

The tool was revised to specifically 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 take the form of policy and procedure establishment, surveillance and monitoring activities, 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/or 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 for the prevention of 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 20212022 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

The CDC/NHSN definitions are used in determining the presence of nosocomial infection. The comprehensive data collection process is based on current scientific knowledge, accepted practice guidelines, an all applicable law and regulation. NHSN is utilized as the database where all events (infections) are imputed, Conferred Rights to all mandated agency's (i.e. CDPH, CMS, etc.)

D. REGULATORY AGENCIES AND GUIDELINES

In addition, administrative involvement and Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee facilitates 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 evaluate identified clusters of infection
- Reduce 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 in a timely manner.
- 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 to define their role and scope in the 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 ~~SVMHS~~SVHMC Employee Health Department:
        - Consults on processes/procedures to minimize and manage risks of infection to staff.
        - Receives reports, evaluates, and documents, and reports diseases of epidemiologic significance in employees, which are defined as any communicable disease.
    - Education in Infection Prevention provided to hospital staff, including hospital employees, physicians, volunteers, and students.
    - Liaison between the State and Local Public Health Department and ~~SVMHS~~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. ~~Seepolicy~~See policy OUTBREAKINVESTIGATION.

G. DEFINITIONS USED IN IDENTIFYING HEALTHCARE-ASSOCIATED INFECTIONS

The CDC/NHSN provides definitions for health-care associated infections for the purpose of creating 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 definitions, NOT clinical definitions. Therefore, a clinical situation that warrants treatment may not always meet the CDC/NHSN definition of a HAI definition.

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

The infection prevention program is fully integrated with the hospital's overall process for assessing and improving organization performance. Risks, rates, and trends in health care-associated infections are tracked and trended over time. This information is used to improve 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 from 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, data 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 ~~SVMHS~~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 Sections, Total Hip, Total Knee, Colectomy, Hysterectomy
- See Attachments ~~,~~: Risk Assessment Grid and Correlating Performance Improvement Plan

I. GOALS

Based on the Risk Assessment, ~~SVMHS~~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.~~543/0~~143 in 2021 to 0.~~568 (2015 baseline) in 2020~~173 in 2022. *SIR Goal : HHS Goal = below 0.75*
- Decrease CLABSI hospital-wide SIR 0.~~116/0~~264 in 2021 to 0.~~213 (2015 baseline) in 2020~~563 in 2022. SIR Goal : HHS Goal = below 0.5
- Decrease Utilization of Central Lines and Foley Catheters.
- Clostridium difficile, ongoing reduction facility-wide SIR 0.~~482/0.619 (2015 baseline) in 2020. HHS Goal by 2020 target goal with 30% reduction~~256 in 2021, to 0.~~70~~631 in 2022. *HHS Goal= below 0.70*
- Sustain Hand Hygiene compliance rate >80%.
- Surgical Site Infections Reduction with implementing SSI prevention bundle.
- Decrease possible transmission of infection on portable equipment, reusable equipment, etc. evaluating EVS standards of practice & implementing tools to aid in improving EVS processes.
- Evaluating and monitoring of High and Low Level Disinfection processes hospital-wide.
- Environment of Care Surveillance
  (IC 01.03.01 EP 4-5, IC 01.04.01 EP 1-5)

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, Biological / Infectious Disease Medical Specialist will be called in as needed by the Incident Commander.

In the event of an influx of potentially infectious patients, there are multiple established resources for use. The hospital is part of Monterey County Emergency Response System who has an Emergency Manual for all the hospitals in the region 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 receives updates from the local and state health departments regularly 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.

In the event that patterns are identified, the hospital communicates this information to licensed independent practitioners and staff. Medical Staff would be notified and would communicate the information to the medical providers via the medical staff structure. The nursing staff also has a similar structure and the Chief Nursing Officer would be notified and information communicated to Nursing Directors, Unit Mangers for communication to staff. The hospital has an education department that can be of assistance if needed in staff education.

The hospital has developed a process that details the hospitals 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 of time.

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/or 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 outcomes of each identified goal is 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., ~~2021~~2023

D. National Healthcare Safety Network (NHSN) Patient Safety Component Manual January ~~2021~~2023: https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf

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

F. 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

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

H. ***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.

I. 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

J. 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

2023_2024 IP Risk Assessment Analysis.pdf

2023_2024 Risk Assessment PI Plan.doc

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2023
MEC	Katherine DeSalvo: Director Medical Staff Services	04/2023
P&T Committee	Mark Danek: Director of Pharmacy	04/2023
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2023
Policy Owner	Melissa Deen: Infection Prevention Manager	03/2023

Standards

No standards are associated with this document

History

Edited by Deen, Melissa: Infection Prevention Manager on 3/6/2023, 5:50PM EST

> updated language and added content for CMS/JC requirements. Updated Risk Assessment and PI Plan with Strategic Plan summary

Last Approved by Deen, Melissa: Infection Prevention Manager on 3/6/2023, 5:50PM EST

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 3/9/2023, 5:31PM EST

> Template corrected

Rejected by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 3/9/2023, 5:31PM EST

> Sending back to start corrected approval workflow. Please accept to move through approval.

Last Approved by Deen, Melissa: Infection Prevention Manager on 3/9/2023, 5:43PM EST

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 3/9/2023, 5:50PM EST

> Policy Committee approved. Minor annual changes only.

Administrator override by PolicyStat Staff on 3/11/2023, 4:08PM EST

> PolicyStat performed system maintenance. One or more images have been converted to inserted image attachments. To learn more visit our article "Why were my images updated by System Maintenance?"

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/11/2023, 2:22PM EDT

> @DeSalvo, Katherine: Director Medical Staff Services Mark please push approve button TODAY as this needs MEC approval this week to go to Board next week before survey!

Comment by DeSalvo, Katherine: Director Medical Staff Services on 4/11/2023, 4:34PM EDT

> The plan needs to be reviewed by P&T/Infection Control Committee prior to MEC. MEC meets this Thursday and their agenda is already set.

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/11/2023, 4:46PM EDT

> @Woodrow, Lea: Director of Accreditation and Regulatory Compliance Kate, Lea said this already should have been approved at P&T. We need this to go to the Board next week so that we have an update for survey. Not sure why Mark has not approved yet?

Comment by Deen, Melissa: Infection Prevention Manager on 4/11/2023, 4:50PM EDT

> @Alaga, Rebecca: Regulatory/Accreditation Coordinator@Woodrow, Lea: Director of Accreditation and Regulatory Complianc@DeSalvo, Katherine: Director Medical Staff Services
>
> This was approved at last PT/IC on March 23rd.

Comment by DeSalvo, Katherine: Director Medical Staff Services on 4/11/2023, 5:01PM EDT

> Please check with Mark Danke or his Admin. I have no referral from P&T and it did not report to Quality and Safety in April.

Comment by Deen, Melissa: Infection Prevention Manager on 4/11/2023, 5:07PM EDT

> @Alaga, Rebecca: Regulatory/Accreditation Coordinator@Woodrow, Lea: Director of Accreditation and Regulatory Complianc@DeSalvo, Katherine: Director Medical Staff Services
>
> This was presented and approved in Quality & Safety at Thursdays meeting.

Draft saved by Danek, Mark: Director of Pharmacy on 4/11/2023, 5:56PM EDT

Last Approved by Danek, Mark: Director of Pharmacy on 4/11/2023, 5:57PM EDT

Draft discarded by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/13/2023, 5:56PM EDT

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Emergency Management Program Plan

I. SCOPE

~~A. The EOP is applicable to the Salinas Valley Health Medical Center (SVHMC) entities and their licensed off-site facilities or locations in the area. Consideration is given for specific variations supported by site-specific policy consistent with the EOP. Whenever there is a department, service, or site-specific variation, it will be supported by a department, service, or site-specific policy that is consistent with the EOP. The plan identifies the alert, notification, and activation of key Staff, the internal management structure and reporting relationships, as well as coordination with external agencies and the community.~~

The Emergency Management Program Plan ("plan") is applicable to the Salinas Valley Memorial Hospital (SVMH) entities and its licensed off-site facilities. Consideration is given for specific variations supported by site-specific policy consistent with the plan. Whenever there is a department, service, or site-specific variation, it will be supported by a department, service, or site-specific policy that is consistent with the plan. The plan identifies the leadership accountability, hazard identification, emergency operations plan, continuity of operations plan, disaster recovery plan, education and training program, testing the plans, and evaluating the plan.

II. OBJECTIVES/GOALS

~~A. The objective of the Salinas Valley Health Medical Center (SVHMC) Emergency Operations Plan (EOP) is to sufficiently educate employees, medical staff and other individuals providing services at the Salinas Valley Health Medical Center (SVHMC) entities and their licensed off-sites facilities, to provide safe, effective and timely response in the event of an internal, external, natural, technological, or man-made disaster (i.e. earthquake, loss of utilities, civil disturbance, act of terrorism, etc.) that could cause harm and/or disrupt the environment of care. The plan provides distinct policy direction, describes the roles and responsibilities of staff, and contains information and references to corresponding departmental mitigation, preparedness, response, and recovery procedures. Additionally, the EOP incorporates the local,~~

~~state, federal and professional codes, standards, and regulations as applicable.~~

The objective of the plan is to sufficiently educate employees, medical staff and other individuals providing services at the Salinas Valley Memorial Hospital (SVMH) and its licensed off-sites facilities, to provide safe, effective and timely response in the event of an internal, external, natural, technological, or man-made disaster (i.e. earthquake, loss of utilities, civil disturbance, act of terrorism, etc.) that could cause harm and/or disrupt the environment of care. The plan provides distinct policy direction, describes the roles and responsibilities of staff, and contains information and references to corresponding departmental mitigation, preparedness, response, and recovery procedures. Additionally, the plan incorporates the local, state, federal and professional codes, standards, and regulations as applicable.

III. DEFINITIONS

~~N/A~~

A. After Action Report (AAR): a detailed critical summary and analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement.
B. CAHAN: California Health Alert Network
C. CDC: Centers for Disease Control
D. EMC: Emergency Management Committee
E. EMS: Emergency Medical Services
F. EOC: Environment of Care Committee
G. EOP: Emergency Operations Plan
H. FEMA: Federal Emergency Management Agency
I. HICS: Hospital Incident Command System
J. J: HVA: Hazard Vulnerability Assessment
K. ICC: Incident Command Center
L. IC: Incident Commander
M. MHOAC: Monterey Health Operational Area Coordinator
N. OES: Office of Emergency Services

IV. PLAN MANAGEMENT

~~A. Salinas Valley Health Medical Center'S LEADERSHIP TEAM~~

B. SALINAS VALLEY MEMORIAL HOSPITAL LEADERSHIP TEAM

The SVMH leadership team provides the program vision, administration, support, and appropriate resources, which are embodied within and conveyed through the development and institutionalizing of business fundamentals relative to Emergency Management. The Environment of Care Committee (EOC) receives reports from the Emergency Management Committee (EMC) and examines the actions taken relative to the Emergency Operations Plan (EOP). Recommendations are given to and received by the EMC. The Board of Directors has authorized the EMC to update this plan and its processes as needed without formal Board approval.

~~The SVHMC leadership team provides the program vision, administration, support, and appropriate resources, which are embodied within and conveyed through the development and institutionalizing of business fundamentals relative to Emergency Management. The Environment of Care Committee (EOC) receives reports from the Emergency Management Committee and examines the actions taken relative to the EOP. Recommendations are given to and received by the Emergency Management Committee. The Board of Directors has authorized the chairperson of the Emergency Management Committee (EMC), to make addendums to the EOP as necessary. Addendums will be made only after the approval of the Emergency Management Committee.~~

- ***Board*** – Supports the plan through approval of the plan, evaluation of the quarterly summary reports of activities and annual Environment of Care Committee report with response as necessary.
- ~~***Administration*** - Supports the plan through approval of the plan by senior leadership. The Hospital administration participates on the Emergency Management Steering Committee, responds to regulatory issues, functions as Incident Commander when the plan is implemented, monitors quarterly summary reports of activities and evaluates the annual Environment of Care Committee report with response as necessary.~~***Senior Leadership***- Reviews the EOP as well as policies, training and education supporting the emergency management program. Participates on the EMC, responds to regulatory issues, often functions as Incident Commander when the plan is activated, reviews reports, activities, goals and evaluations of the program with response as necessary. Allocates resources for the emergency management program.
- ***Medical Staff*** - Supports the plan through participation in exercises and incidents. The Medical Executive Committee reviews and evaluates the Environment of Care Committee annual report with response as necessary.
- ***Department Managers*** - Support the plan through monitoring the compliance of the training and performance of staff with the plan, participates in exercises and incidents, event reporting

and initiation of corrective actions.

- ***Employees*** - Support the plan by following policies and procedures, participate in exercises and incidents, report deficiencies and problems promptly and participate in training and competency for emergency management.
- ***Safety Officer and Environment of Care Committee*** – Support the plan ~~through ongoing monitoring and formal review of~~by revieweing quarterly ~~report of activities and review of the Annual Emergency Operations Plan Performance Evaluation~~and annual reports, providing feedback as needed.
- ***Emergency Management Committee*** – ~~Is~~Multidisciplinary committee responsible for planning, design, measurement, assessment and improvement processes for the ~~EOP~~emergency management plan.

1. ~~The implementation of specific procedures in response to a variety of disasters is documented in the Hospital/EOP-General Plan and is reviewed with local and state entities and SVHMC as needed.~~
2. ~~The Hospital/EOP was developed as an "all hazards" approach that supports a level of preparedness enough to address a range of emergencies, regardless of the cause. Emergency Management principles such as mitigation, preparedness, response and recovery are addressed throughout the plan. By conducting an annual Hazard Vulnerability Analysis (HVA) SVHMC gains a realistic understanding of the vulnerabilities, which helps to focus resources and planning efforts.~~

~~C. PLANNING ACTIVITIES~~

~~Salinas Valley Health Medical Center (SVHMC) engages in planning activities prior to developing its written Emergency Operations Plan.~~

1. ~~**Leadership and Medical Staff**~~

   ~~SVHMC leaders, including leaders of the medical staff, participate in planning activities prior to developing an Emergency Operations Plan. Representation from leadership and the medical staff at SVHMC actively participate in emergency management planning by attending emergency management committee meetings and reviewing strategies set forth by the organization in response to emergencies.~~

2. ~~**Hazard Vulnerability Analysis (HVA)**~~

   ~~SVHMC conducts a hazard vulnerability analysis (HVA) to identify potential emergencies that could indirectly or directly affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events. The findings of this analysis are documented.~~

   ~~Risks associated with large scale emergency events are reviewed annually by the Emergency Management Committee in concert with leadership and the local geographic area (i.e. City of Salinas Police Department, Monterey County Sheriff's Department, Salinas Fire Department, Monterey County Office of Emergency Services, Monterey County EMS, Monterey County Healthcare Preparedness Coalition, and other neighboring healthcare organizations). When conducting the risk assessment for the organization the probability of the event happening, as~~

well as the severity of the impact of a potential event was taken into consideration. Included in the probability is a rating from one (being low) to three (of being high) that the likelihood this event will occur. Issues considered were known risk, historical data as well as past statistics. The organization's HVA is evaluated annually relative to its objectives, scope, performance, and effectiveness. This evaluation process is coordinated through the Emergency Management Committee under the guidance of the Emergency Management Program Chair. Revisions are shared with the Environment of Care Committee. Results of this evaluation process will form the basis for future performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives and HVA elements.

3. **Community Involvement**

SVHMC regularly collaborates with the healthcare partners and other local emergency management planners for prioritizing disaster preparedness efforts. Current and historical trends in preparedness planning are considered and applied to the HVA review and revision process.

4. **Communication with the Community Emergency Agencies**

SVHMC communicates its needs and vulnerabilities to community emergency response agencies and identifies the community's capability to meet its needs. This communication and identification occur at the time of the hospital's annual review of its Emergency Operations Plan and whenever its needs or vulnerabilities change.

SVHMC participates in state and communitywide emergency management programs, including, but not limited to, the Monterey County Healthcare Preparedness Coalition. Salinas Valley Health Medical Center's role in relation to these entities in the event of a disaster is discussed, planned, and drilled for accordingly.

SVHMC meets with local emergency response agencies and public health officials (Monterey County EMS, Monterey County Office of Emergency Services, Monterey County Healthcare Preparedness Coalition, and Monterey County Department of Public Health and communicates the hospital's needs and vulnerabilities based on analysis conducted as part of the Salinas Valley Health Medical Center Emergency Operations Plan and establishes expectations that the hospital will have from local response agencies in a disaster or an Emerging Infectious Disease (EID) event or Influenza Pandemic Event in terms of the local response agencies meeting the needs of the organization during EOP activation. SVHMC participates in the federally administered Hospital Preparedness Program administered through the MCDPH and reporting to the California Department of Public Health (CDPH). Salinas Valley Health Medical Center, in concert with the Monterey County Healthcare Preparedness Coalition and other healthcare and preparedness partners, actively participates in conducting drills and exercises, procuring disaster supplies, continuing education in emergency preparedness and disaster response. Because of the communication, collaboration with MCOES, MCDPH, CDPH, and participation in the Monterey County Healthcare Preparedness Coalition Salinas Valley Health Medical Center is eligible for federal grants administered through MCDPH.

5. **Use of HVA for Mitigation and Preparedness Activities**

SVHMC Emergency Operations Plan uses its hazard vulnerability analysis of all hazards, risks,

and vulnerabilities as a basis for defining mitigation activities (that is, activities designed to reduce the risk of and potential damage from an emergency). The disaster policies and procedures by way of the EOP are developed through the Emergency Management Program Chairperson in concert with the Emergency Management Committee, EOC Committee, executive leaders, and department leaders.

6. **Hospital Incident Command System**

SVHMC uses its hazard vulnerability analysis as a basis for defining the preparedness activities that will organize and mobilize essential resources.

Emergency management and communications functions within an Incident Command Center utilizing the Hospital Incident Command System (HICS), through the leadership of the Incident Commander, and are organized into various sections designed to optimize resources and skill.

The SVHMC HICS sections include:

- ***Incident Commander*** – The Incident Commander provides oversight and direction to the incident command staff team and the section chiefs. Within command staff positions are section the Liaison Officer has been designated as the representative to coordinate efforts with external agencies and the Public Information Officer will communicate with the media. The Medical/Technical Specialists provides oversight for all medical related operations or technical response modalities. The Safety Officer is responsible for overarching safety of the organization, the staff, and the patients. General Staff Section Chiefs make up the following section that may be expanded to include Branch Directors based on incident size and complexity.
- ***Logistics Section*** – Manages resources, means and methods.
- ***Planning Section*** – Collects intelligence, plans tactical responses and develops forecasts. Creates incident documentation.
- ***Finance Section*** - Addresses funding and reimbursement deliverables.
- ***Operations Section*** – Directs resource application and issue resolution for patient care activities and infrastructure support.
- ***Ancillary Section*** – Directs resource application and issue resolution for Ancillary Services.
- ***Human Resources Section*** – Addresses staff labor pool, patient, and visitor needs for personal care, including demobilization planning.

D. INCIDENT COMMAND CENTER (ICC)

1. **Command and Reporting**

Depending on the type of emergency occurring, the most qualified leader will assume the role of Incident Commander. During off hours, the Administrative Supervisor will assume the role of Incident Commander until relieved by the responding ICC team.
All section chiefs (Logistics, Operations, Planning, Medical, and Finance) report directly to the Incident Commander. In addition, the remaining ICC officers (Safety Officer, Liaison Officer,

Public Information Officer, and Medical Care Chief) report to the Incident Commander. SVHMC provides ongoing training for the organization's leaders who are most likely to assume a role in the HICS structure.

2. **Setting Up The Incident Command Center**

During the first fifteen minutes of an organizational emergency the responding command team must investigate and organize its resources to prepare for expected and unexpected problems. The Incident Command Center (ICC) is established for external or internal disasters or when deemed necessary by the Incident Commander (IC).

3. **Incident Command Center Location**

The ICC will be set up immediately upon notification of an event warranting the activation of HICS. The designated ICC is located in the Main Hospital Basement Nurse Admin Supervisors office. If the event needs to expand, CP4 will be utilized. The adjacent rooms and offices will be used as staging areas for the HICS sections that have been activated. In the event the primary Incident Command location is inaccessible or cannot be used as the ICC, the Incident Commander (IC) will designate an alternate location. In the event the hospital campus cannot support an ICC the Emergency Supply trailer located in the motor pool parking area across from the parking garage entrance is equipped to act as a mobile ICC so that the response can be coordinated from an offsite location.

4. **The ICC Is Staffed By:**
    - Administrator, Administrative Supervisor or designee – Incident Commander
    - Public Information Officer
    - Liaison Officer
    - Safety Officer
    - Security Officer
    - Medical Technical Specialist (as necessary)
    - Section Chiefs
    - Situation Status Unit Leader (as needed)
    - Coordinating Assistants and Scribes
    - Outside agencies (if needed)

5. **Responsibilities Of The Incident Commander**
    - Overall direction of response activities, including staff assignments, supply and equipment procurement.
    - Communication with Emergency Department (ED) or site affected.
    - Ensure all sections (Logistics, Planning, Operations, Medical, and Finance) report in regularly at predetermined intervals and all essential functions are assigned.
    - Designates a "Liaison Officer" to communicate with public agencies.
    - Public Information Officer (PIO):
        a. Concierge's services will be assigned to support the patient information

desk staff and assist the public in the family reunification and information center. This area is to be decided by the ICC team at the time of the event and based on the anticipated need.

b. Admitting will be responsible for collecting lists of patients, assuring all patients are registered appropriately and tracking their location.

c. A public information representative will be present at the scene and will be in charge of collecting information and communicating with the PIO in the ICC.

d. Volunteers and staff are not to release any information relating to the event unless specifically instructed.

6. **Description Of Duties**

Administrator, Administrative Supervisor, or designee, is the designated IC and coordinates the overall direction of response operations. The IC also ensures communication with the media, EMS agencies, Red Cross, and other outside organizations as necessary. The IC designates a Public Information Officer (PIO), Liaison Officer, Safety Officer, Medical Care Chief (as necessary), and all necessary Section Chiefs.

The ***Logistics Section Chief*** is responsible for the facility assessment and maintenance and/or restoration of essential services, such as telephone, electricity, steam, and structural assessment. This section also responds to any hazardous materials incidents and coordinates materials/supplies and nutritional needs. The logistics section chief is responsible for Resources and Assets and Utilities Management.

The ***Planning Section Chief*** is responsible for projecting the resources needed for possible long-term response effort. This section also maintains the Labor, Volunteer, and coordinates patient tracking/information activities. This section coordinates resources with off-site facilities. The planning section chief is responsible for communications.

The ***Operations Section Chief*** is responsible for all patient care activities including discharging of patients, morgue functions and ancillary services. This section also coordinates staff support functions. The operations section chief is responsible for clinical activities and staff responsibilities.

The ***Medical*** Technical Specialist is responsible for organizing, prioritizing, and assigning physicians to areas where medical care is being delivered. This section also advises the Incident Commander on issues related to the Medical Staff. Technical Specialists may also advise on information systems or critical infrastructure needs.

The ***Finance Section Chief*** is responsible for maintaining documentation of employee work hours and implements processes for payroll. It also completes and maintains documentation to submit to OES/FEMA and insurance companies for disaster financial claims.

The ***Safety Officer and Security Branch Director*** are responsible for ensuring the safety and security of patients, visitors and staff, ensuring that when a facility lockdown is ordered by the incident commander; the lockdown is executed in a safe and orderly fashion and all point of

~~entry / exits out of the buildings are monitored. Incident safety and security will be managed as needed to maintain safe and secure incident management.~~

7. ~~**Combining Hospital and Community Command Structures**~~

   ~~SVHMC's incident command structure is integrated into, and consistent with, its community's command structure. The use of the HICS model is in direct correlation with the Monterey County and State of California EOC, Fire Department ICS, Police Department ICS, as well as neighboring hospital HICS structures.~~

8. ~~**Resources and Assets Inventory**~~

   ~~SVHMC keeps a documented inventory of the resources and assets it has on site that may be needed during an emergency, including, but not limited to, personal protective equipment (PPE), water, fuel, and medical, surgical, and medication-related resources and assets. This inventory is updated on an ongoing basis, and full inventory assessment and review is completed at least annually. Through this assessment the organization can identify its capabilities to be self-sustaining if SVHMC cannot be supported by our local community for 96 hours. Once the plan is activated, supplies and equipment availability is closely monitored for depletion and replenishment. Supply conservation activities may be required, and this will be done at the direction of the Logistics Chief in collaboration with other members of the General and Command Staff. This inventory includes but is not strictly limited to PPE'S, water, fuel, staffing, medical/surgical supplies, pharmaceuticals and other back-up supplies listed in 96hr inventory binder located in the command center. Materials management maintains Infectious Disease related Personal Protective Equipment (PPE) per CAL OSHA AB 2537 and SB 275.~~

   ~~SVHMC has established a method for monitoring quantities of assets and resources during an emergency and keeps control of depletions of supplies to assess duration of sustainability for an extended emergency as part of the 96hr inventory and logistics section in HICS.~~

E. HAZARD VULNERABILITY ANALYSIS (HVA)

1. All- Hazards Approach

Annually, SVMH conducts a hazard vulnerability analysis (HVA) using an all-hazards approach to identify potential emergencies that could indirectly or directly affect demand for the hospital's services or its ability to provide those services. Considerations include hazards that are likely to impact the hospital's geographical region, community, facility and patient population. When available, community-based risk assessments (for example that may be developed by another organization or agency) will also be incorporated.

SVMH evaluates and prioritizes the findings of the HVA to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the hospital and its ability to provide services. SVMH then uses the prioritized hazards to identify and implement mitigation and preparedness actions to increase the resilience of the hospital and reduce disruption of essential services or functions. It is used to further develop the EOP.

See Attachment A: Hazard Vulnerability Analysis (Main Hospital Block)

See Attachment B: Hazard Vulerability Analysis (Taylor Farms Family Health & Wellness Center)

F. ~~EMERGENCY OPERATIONS PLAN~~ EMERGENCY OPERATIONS PLAN (EOP)

~~The SVHMC EOP is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patients clinical and support activities during an emergency. Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the Plan's response procedures address the prioritized emergencies, but are also adaptable to other emergencies that the organization may experience.~~

1. ~~**Leadership and Medical Staff Involvement**~~

   ~~The SVHMC leaders, including leaders of the medical staff, participate in the development of the Emergency Operations Plan through continued attendance in the emergency management committee and participation in post exercise critiques to seek opportunities for improving the EOP.~~

2. ~~**Maintaining a Written EOP**~~

   ~~SVHMC develops and maintains a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur.~~

   ~~SVHMC's Emergency Operations Plan is based upon the industry standard of HICS as a coordinated organizational response to a disaster. In addition to utilizing this industry standard, Salinas Valley Health Medical Center's disaster planning involves the incorporation of the principles of the plan into all levels of the organization. Specific policies and procedures are developed in collaboration with Salinas Valley Health Medical Center leadership, physicians, and front-line staff. The response procedures address the prioritized emergencies and is adapted to other emergencies as well that the hospital may experience.~~

3. ~~**Response**~~

   ~~The SVHMC Emergency Operations Plan identifies the hospital's capabilities and establishes response procedures for when the hospital cannot be supported by the local community in the hospital's efforts to provide communications, resources and assets, security and safety, staff, utilities, or patient care for at least 96 hours. The response procedures address the prioritized emergencies and is adapted to other emergencies as well that the hospital may experience. The response procedures include but are not limited to the following:~~

   - ~~Determination for maintaining and or expanding services during a disaster.~~
   - ~~Conservation of resources.~~
   - ~~Curtailment of services.~~
   - ~~Supplementing resources from outside the community.~~
   - ~~Suspension of services to new patients during disaster.~~

- Staged evacuation.
- Total evacuation is a last resort option for SVHMC due to its vital role in the community. SVHMC is committed to the community to defend in place and sustain services for at least 96 hours in the aftermath of a disaster as long as safe to do so.

The Emergency Management Committee (EMC) or EMC Chairperson, guides and directs the overall response, forecasting and strategic planning at the time of an incident in collaboration with the Incident Commander. As indicated or directed, all departments are expected to implement appropriate aspect of the plans including the following:

- Patient Triage, Treatment and Tracking
- Assess areas in need of support
- Incident Command System Activation
- Assignment of Staff and Identification
- Emergency supply
- Reduce ensuing or secondary events
- Initiate interim contingency plans to deal with system failures and shortfall
- Reassure others
- Communicate status, issues and needs to the ICC
- Follow IC/ICC directions
- Coordinate efforts with local agencies, as needed

4. **Recovery**

SVHMC develops and maintains a written Emergency Operations Plan that describes the recovery strategies and actions designed to help restore the systems that are critical to providing care, treatment, and services after an emergency.

This phase entails those efforts to quickly and effectively re-establish business, resume critical support functions, continue the provision of care, and ensure financial integrity.

The recovery aspects of the plan take the form of risk and vulnerability analysis that include contingency plans and interim measures that are predicated on relative risks, resources and systems operations, efforts to identify and quantify shortfall of damages and outlay for the purposes of reimbursements and governmental interventions, as indicated. Key considerations relative to recovery planning include, but are not limited to:

- Review of key business processes, information systems applications, equipment and interdependencies
- Review of risk analysis
- Secondary and tertiary measures to address failures
- Resources
- Reviewing the relevant terms of insurance policies

- Collecting documents, evidence, estimates, reports, etc. relative to the recovery of the physical structures and systems of the buildings and ensuing governmental reimbursement, as indicated.

In addition, each priority emergency has dedicated emergency preparedness procedures outlining the preparedness and response plans for that situation (i.e. earthquake, hazardous materials decontamination, biological emergency, and computer system failure etc.).

- The command structure utilized by the community is consistent with the command structure developed at Salinas Valley Health Medical Center and has been coordinated with local response agencies.
- The Business Continuity Plan (BCP) or Continuity of Operations Plan (COOP) can be found in the command center reference binder, command center external hard drive back up, or on the N drive Emergency Management folder:
- N:\EmergencyManagement\EM\EM Committee\EOP HVA\COOP

5. **Plan Activation/Initiation and Termination**

The Emergency Operations Plan describes the processes for initiating and terminating the hospital's response and recovery phases of an emergency, including under what circumstances these phases are activated.

To facilitate the orderly initiation of the response to an emergency, the following steps of the Emergency Operations and Management Plan will be initiated:

a. Information received by Salinas Valley Health Medical Center concerning an external emergency facing the community or an internal emergency involving the function of the organization will be passed directly to the Administrator on Duty, Administrative Supervisor, or designee.

b. When notified of a potential disaster, the Administrator on duty, Administrative Supervisor, Emergency Department (ED) Physician, and ED Charge Nurse will:

    i. Evaluate the issues such as location of incident (internal, external), the distance from the campus, the scope of the incident (single individual, mass casualty, or malicious attack), and weather conditions (seasonal and current)

    ii. Discuss the operations pertaining to the conversion of the organization to HICS activation.

    iii. Plan care of casualty and non-casualty patients arriving in the Emergency Department during a disaster.

    iv. Will evaluate the information concerning this emergency and determine if initiation of the Emergency Operations Plan (EOP) is warranted. Two of the three are required to initiate the EOP, unless deemed otherwise necessary by the onsite Incident Commander.

Once it has been determined to activate the EOP, the individual who takes the role of Incident

Commander will activate HICS, using the established mass notification system implemented by the organization.

6. **Authority to Activate the Response and/or Recovery**

The Emergency Operations Plan identifies the individual(s) who has the authority to activate the response and recovery phases of the emergency response. Refer to the persons listed in the Plan Activation/Initiation and Termination Section, the person who takes the role of Incident Commander will activate HICS and the EOP as deemed appropriate. The following are 3 levels of Activation outlined:

Level 1 Activation: – when notified by EMS and/or other sources of an incident with multiple casualties or a small incident with no casualties that occurred within the facility.

a. Situation that most likely can be managed with the staff already on duty.
b. Staff should remain on duty and review their department specific procedures to be prepared to respond to the next level if situation requires an upgrade.
c. The Administrative Supervisors and Charge Nurses will have a bed count and expected discharges ready to report.
d. The Hospital's Incident Command System (HICS) may be set up and only selected sections activated.

Level 2 Activation: – patients are received and some support from the Emergency Department will be required and/or the affected area may need some support.

a. Situation may require additional staff to be called into the hospital.
b. All staff will remain on duty and follow their procedures.
c. The HICS will be set up to coordinate response operations.

Level 3 Activation: – large numbers of patients are received and/or a significant response to the emergency will be necessary. A level 3 activation will most likely require a full activation of HICS.

a. The HICS will be set up to coordinate disaster operations.
b. The major event will require mobilization of most aspects of the Hospital Incident Command System in the EOP, including department callback procedure and planning for associate's relief over an extended period of time.

7. **Alternative Care Sites**

The Emergency Operations Plan identifies alternative sites for care, treatment, and services that meet the needs of the hospital's patients during emergencies.

In the unlikely event the facility is deemed unsuitable for continued occupancy or cannot support adequate patient care, communication will be coordinated through a collaborative effort between the EOC, Medical Care and Operations, Planning, and Logistics sections. The management of necessary patient materials, the transfer of medications, medical records,

medical equipment, as well as transportation arrangements and tracking patients to and from the alternative care site(s) is also a collaborative effort. Communications to the city and other healthcare facilities to find potential adequate outside facilities may be obtained through OES, EMS, MCHD and Monterey County Sheriff's Department.

Salinas Valley Health Medical Center has met with local schools and has reviewed plans and capabilities and has established these areas as potential alternate care sites. If these organizations are unable to provide an alternate site for patient placement or response and recovery efforts from Salinas Valley Health Medical Center during an emergency, the Incident Commander will work with local emergency management agencies to determine where patients can be relocated. SVHMC maintains 4 disaster tent Western Shelters in a mobile trailer. The tents are equipped with HVAC bio-containment negative pressure isolation capabilities. The tents can be deployed and configured as needed on or off hospital property.

Determination of the site to be used in any given situation will be made at the time by the incident commander(s) of the hospital(s) and the city leaders. Consideration will be given to clinical services required by the patients along with the nature of the emergency. Every effort will be made to provide the same quality of care at the alternate site chosen.

In the event of an overwhelming community disaster, Salinas Valley Health Medical Center would operate under the process for NDMS (National Disaster Management System).

The nurse assigned to each individual patient is responsible for packaging patient medications and obtaining the patient chart to ensure that these items are sent to the alternative site along with the patient. A list of inpatients to be evacuated will be generated by the Clinical Supervisor, Manager or Director and provided to the Incident Command team, who will note the medications, equipment, and records sent with the patient, along with the means of transportation and the designated evacuation site.

The individual assigned by the incident commander or designee will maintain patient tracking to and from the alternate care site.

8. **Implementing Response Procedures**

If SVHMC experiences an actual emergency, the hospital implements its response procedures related to care, treatment, and services for its patients. This phase focuses on tactical activities and actions taken to address a disaster event, to include the implementation of one or more component of the Emergency Operations Plan. The EMC or EMC Chairperson guides and directs the overall response, forecasting and strategic planning at the time of an incident in collaboration with the Incident Commander. As indicated or directed, all departments are expected to implement appropriate aspect of the plans including the following:

a. Patient Triage, treatment, and tracking
b. Assess areas in need of support
c. Incident Command System Activation
d. Assignment of Staff and Identification
e. Emergency supply carts

f. Reduce ensuing or secondary events

g. Initiate interim contingency plans to deal with system failures and shortfall

h. Reassure others

i. Communicate status, issues and needs to the EOC

j. Follow IC/ICC directions

k. Coordinate efforts with local agencies, as needed

G. COMMUNICATION

As part of its EOP, the hospital prepares for how they will communicate to staff, authorities, patients, family, the community, media, purveyors, other health care organizations, third parties, and alternative care sites during emergencies. If community communications infrastructure has failed and/or Salinas Valley Memorial facilities experience debilitation of communication pathways (electricity, satellite, network, or phone line failures), SVHMC has developed a plan to maintain communication pathways both within the hospital and to critical community resources.

1. **Notification and Communication with Staff**

   The Emergency Operations Plan describes the following: How staff will be notified that emergency response procedures have been initiated as well as the communication of information and instructions to its staff and licensed independent practitioners during an emergency. Everbridge mass notification system is in place and backed up by traditional communications capabilities overhead paging, email and phone trees etc.

   Ongoing communication and dissemination of information to Staff is of vital importance during a disaster. It enables better utilization of assets and resources. During a disaster all information and communications will be funneled through the section Chiefs to the Incident Commander then disseminated back to the section Chiefs for communicating to the Unit Leaders and individual department directors and managers and licensed independent practitioners.

   THE OPERATOR SHOULD NOT BE CALLED FOR INFORMATION.

2. **Notification and Communication with External Authorities**

   The Emergency Operations Plan describes the following: How the hospital will notify and communicate with external authorities that emergency response measures have been initiated as well as during the emergency.

   Salinas Valley Health Medical Center is active in Monterey County emergency and disaster planning and participates in community wide emergency management planning groups. This group of hospital and community emergency management planners has agreed to provide mutual aid to one another in the event of a disaster. Also included in the disaster planning is the sharing of the following information to improve communication and resource management when responding to a disaster:

   a. Essential elements of command structures and control centers for emergency

response.

b. Names, roles, and telephone numbers of individuals in their command structures.

c. Resources and assets that could potentially be shared or pooled in an emergency response.

d. Names of patients and deceased individuals brought to their organizations to facilitate identification and location of victims of the emergency.

Several local agencies may play a role in managing an emergency. Some of the key contacts include Police, Fire, EMS, OES, Department of Health, CDC and the Red Cross. Agencies are notified by the Incident Commander or a designee as soon as possible after an emergency response is initiated.

Communication with external agencies will depend on the given emergency.

When all normal communication channels (telephone, cell phones and emails) are operative, the normal means of voice / electronic communications is the first to be sought. When normal communication channels are not operative (due to internal or external infrastructure damage, loss of power or loss of communications links; wiring, satellite, microwave transmissions), the hospital will use all available means to communicate with external authorities including employment of OEM radios, walkie-talkie radios, runners, satellite telephone, Email, etc.

3. **Communication with Patients and Families**

The Emergency Operations Plan describes the following: How the hospital will communicate with patients and their families, including how it will notify families when patients are relocated to alternative care sites.

Staff will continually communicate with patients during a disaster for the accelerated activities they notice and be reassured. Customer Services, Social Services, Volunteers, and Administration will be made available to talk with patients as applicable. For patients whose family was not able to arrive at the hospital prior to an emergency in the community or the hospital, the information officer in conjunction with Social Services will contact family members to inform them of the conditions of their loved ones and the emergency response activities. If the hospital can no longer sustain operations and relocation of patients becomes necessary; the information officer will notify family members (those present at the hospital and those unable to get to the hospital due to the nature of the emergency in the community) that their loved ones are being relocated and provide the name of the facility where the patient is being relocated, provide name and telephone number of contact individual at the facility.

4. **Communication with the Community and the Media**

The Emergency Operations Plan describes the following: How the hospital will communicate with the community or the media during an emergency.

When the Emergency Operations Plan and the Hospital Incident Command Center (HICS) is activated, the hospital's communication with external agencies will depend on the given emergency. If multiple agencies and healthcare organizations are involved, all communication

and coordination of activities will go through the Emergency Operations Center (EOC) at the Office of Emergency Services (OES).

In a major event, members of the press/media will be escorted to Downing Resource Center Room A (DRC-A), or other designated area as needed, where a Public Information Center will be established. The designated Public Information Officer (PIO) will coordinate the collection and dissemination of information with the PIO at the Emergency Operations Center (EOC).

5. **Communication with Purveyors**

The Emergency Operations Plan describes the following: How the hospital will communicate with suppliers of essential services, equipment, and supplies during an emergency.

SVHMC has developed a list of purveyors, including vendors, contractors, and consultants that can provide specific services before, during, and after an emergency event. The list is maintained by the manager of the EOP and is kept in the incident command center and updated annually. Where appropriate, Memoranda of Understandings (MOU'S) are developed as needed to help facilitate services during the time of a community event.

Once emergency measures are initiated, the hospital utilizes its vendors list for essential supplies, services and equipment and notifies each vendor by telephone (or other means if the telephone system is not operational) to be on standby to respond to the hospital's needs should they arise.

6. **Communication with Other Health Care Organizations**

The Emergency Operations Plan describes the following: How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the essential elements of their respective command structures, including the names and roles of individuals in their command structures and their command center telephone numbers.

SVHMC has identified leaders in the organization who are most likely to assume the roles in the Hospital Incident Command System (HICS).

The healthcare organizations that are located within the geographical area to the facility have a working relationship with SVHMC before an event occurs. This occurred through a direct Mutual Aid agreement (MAA) with each individual hospital or town, borough, parish, county, and/or regional hospital group (NIMS Element 4). SVHMC actively participates in planning activities with the MCDPH Hospital Preparedness Program (HPP) and shares with its member's information that may have an impact on community wide planning and response.

The key information that is shared with the other healthcare organizations includes, but is not limited to:

- Command structures & other command centers information
- Names & roles of command center structure
- Resources & assets to be potentially shared
- Process for the dissemination of patient & deceased individual names for tracking

purposes

- Communication with third parties

For the other healthcare organizations to establish communications, they have existing systems in place for interoperability since an event may disable one or more communication methods, resulting in limited communication resources. The SVHMC Incident Command has established alternate communication methods to ensure that secondary communication is accessible during an event. This should ensure some interoperability with other organizations (NIMS Element 8).

The patient information that may be shared with the other healthcare organizations, local or state health departments, or other law enforcement authorities on the whereabouts on patients during an emergency may include patient's name and location. The information shared about the patients will be in accordance with applicable laws and regulations.

7. **Communicating the Resources and Assets of other Health Care Organizations**

The Emergency Operations Plan describes the following: How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the resources and assets that could be shared in an emergency response.

The logistics leader is responsible for assessing what resources and assets (such as staff, beds, transportation, linens, fuel, personal protective equipment, medical equipment and supplies) can potentially be shared with other local health care organizations, or with non-local health care organizations in the event of a regional or prolonged disaster. The decision to transfer resources and assets will be made by the incident commander, in coordination with the county's EOC, predicated on SVHMC's current and potential impact by a disaster or its escalating potential within the community.

A list of potential resources and assets that SVHMC may expect from other health care organizations and a list of resources and assets that they can share with other organizations has been compiled and communicated with all the organizations that are part of the disaster planning entity in the community and county.

8. **Communicating of Patients Names and the Deceased to a third Party**

The Emergency Operations Plan describes the following: How and under what circumstances the hospital will communicate the names of patients and the deceased with other health care organizations in its contiguous geographic area and to third parties (such as other health care organizations, the state health department, police, and the Federal Bureau of Investigation (FBI).

In a disaster, all patients brought to SVHMC are entered on a master patient triage roster that will be in the triage area and continually be submitted to the incident commander for updates to other health care organizations and/or the EMS Center in accordance with applicable law and regulation, when requested. The roster will include patient's names and deceased individuals brought to SVHMC.

The circumstances for communicating information about patients with community third parties will be any disaster event (of an internal or external nature) that impacts the community health and safety within the hospital environment and as required by laws and regulations.

9. **Communicating with Alternative Care Sites**

The Emergency Operations Plan describes the following: How the hospital will communicate with identified alternative care sites.

In the unlikely event the facility is deemed unsuitable for continued occupancy or cannot support adequate patient care,
communication will be coordinated through a collaborative effort between the Hospital Incident Command Center, Medical Care and Operations, Planning, and Logistics sections. The management of necessary patient materials, the transfer of medications, medical records, medical equipment, as well as transportation arrangements and tracking patients to and from the alternative care site(s) is also a collaborative effort. Communications to the OES and MCPHD and other healthcare facilities to find potential adequate outside facilities may be obtained through the Monterey County Office of Emergency Services.

10. **Back Up Communication**

The hospital establishes backup systems and technologies for the communication activities.

SVHMC's alternative communication systems include HAM Radios, handheld disaster radios, cellular phones, satellite phones, 800 MHz radio, MedNet radio, internet, e-mail, overhead paging, ReddiNet, Everbridge, and MCDPH HPP coalition notification process etc. It is the responsibility of the Incident Commander to ensure as many means of communication are utilized appropriately and when needed.

11. **Preparation to Support Communication**

The hospital implements the components of its Emergency Operations Plan that require advance preparation to support communications during an emergency.

H. RESOURCES AND ASSETS

As part of its Emergency Operations Plan, the hospital prepares for how it will manage resources and assets during emergencies. A solid understanding of the scope and availability of

SVHMC's resources and assets is perhaps more important during an emergency than during times of normal operation. Materials and supplies, vendor and community services, as well as state and federal programs, are some of the essential resources that SVHMC has established access to in times of crisis to ensure patient safety and sustain care, treatment, and services.

1. Authority to Activate the EOP

The Administrator on Duty, Nurse Administrative Supervisor, or designee may activate the EOP. In the event of a potential Mass Casualty Incident impacting the Emergency Department, the EOP may be

activated by the Nurse Administrative Supervisor together with the Emergency Department's Charge Nurse and on-duty Physician (See #1102 EMERGENCY MANAGEMENT FOR MASS CASUALTY INCIDENTS INCLUDING DECONTAMINATION)

a. When notified of a potential disaster, the person(s) having authority to activate the EOP will:

i. Evaluate the issues such as location of incident (internal, external), the distance from the campus, the scope of the incident (single individual, mass casualty, or malicious attack), and weather conditions (seasonal and current)

ii. Discuss the operations pertaining to the conversion of the organization to Hospital Incident Command System (HICS) activation.

iii. Plan care of casualty and non-casualty patients arriving in the Emergency Department during a disaster.

iv. Evaluate the information concerning this emergency and determine if initiation of the Emergency Operations Plan (EOP) is warranted. Two of the three are required to initiate the EOP, unless deemed otherwise necessary by the onsite Incident Commander.

b. Level 1 Activation:

When notified by Emergency Medical Services (EMS) and/or other sources of an incident with multiple casualties or a small incident with no casualties that occurred within the facility.

i. Situation that most likely can be managed with the staff already on duty.

ii. Staff should remain on duty and review their department specific procedures to be prepared to respond to the next level if situation requires an upgrade.

iii. The Administrative Supervisors and Charge Nurses will have a bed count and expected discharges ready to report.

iv. HICS may be set up and only selected sections activated.

c. Level 2 Activation:

Patients are received and some support from the Emergency Department will be required and/or the affected area may need some support.

i. Situation may require additional staff to be called into the hospital.

ii. All staff will remain on duty and follow their procedures.

iii. The HICS will be set up to coordinate response operations.

d. Level 3 Activation:

Large numbers of patients are received and/or a significant response to the emergency will be necessary. A level 3 activation will most likely require a full activation of HICS.

i. The HICS will be set up to coordinate disaster operations.

ii. The major event will require mobilization of most aspects of the Hospital Incident Command System in the EOP, including department callback procedure and planning for associate's relief

over an extended period of time.

2. Mobilizing Incident Command

Emergency management and communications functions within an Incident Command Center utilizing HICS, through the leadership of the Incident Commander. The HICS incident command team is organized into various sections designed to optimize resources and skill.

a. Incident Command Center (ICC)

The Incident Command Center (ICC) will be set up, at the discretion of the Incident Commander, immediately upon notification of an event warranting the activation of HICS.

b. Incident Command Center Location

The primary designated ICC is located in the Main Hospital Basement Nurse Admin Supervisors office. If the event needs to expand, CP4 may be utilized. The adjacent rooms and offices may be used as staging areas for the HICS sections that have been activated. Room HB175 contains emergency response supplies to support the incident command center.

The Incident Commander (IC) may designate an alternate location for the ICC, for example if the primary ICC location is inaccessible or cannot be used as the ICC. In the event the hospital campus cannot support an ICC, the Emergency Supply trailer may be used as a mobile ICC so that the response can be coordinated from an offsite location. The primary location of the trailer is the motor pool parking area across from the parking garage entrance, but it may change as needed. A virtual command center may also be established utilizing a web-based meeting platform, if available.

c. The Role of Incident Commander

Every incident will have an Incident Commander. The leader assuming this role establishes the goals of the response, appoints individuals to fill positions needed to meet the goals, and oversees the response. All command staff and section chiefs, below, report to the Incident Commander. SVMH maintains a list of leaders who are authorized to assume role of Incident Commander (or appoint a designee), which includes Nurse Administrative Supervisors and Administrators-on-call. During off hours, the Administrative Supervisor will assume the role of Incident Commander until relieved by the responding Incident Commander.

SVMH may participate in Joint Command with other authorities depending on the emergency.

d. The ICC is Staffed by the Incident Command Team:

Resource: California Hospital Association Hospital Incident Management Team Chart

i. Command Staff Positions:

- ***Liaison Officer*** - coordinates efforts with external agencies.
- ***Public Information Officer***- communicates with the media and the public, and is set up to communicate with internal stakeholders via mass notification system. May participate in Joint Information Office with other affected hospitals/organizations to deliver consistent coordinated messaging.

- ***Medical/Technical Specialist*** - provides oversight for all medical related operations or technical response (e.g. information technology, utilities) modalities.
- ***Safety Officer***- reviews and provides input to response plans to ensure safety of the organization, the staff, and the patients.

ii. General Staff Section Chiefs

Depending on the incident, section chiefs may need to expand their teams, and may appoint Branch Directors to lead separate initiatives. Branch directors report to their Section Chief, who in turn reports to the Incident Commander.

- ***Operations Section Chief*** develops and executes a plan (approved by IC) to resolve the incident while ensuring patient safety and the continuity of care. Depending on the incident response the Operations Section Chief may deploy one or several branches, appointing a Branch Director to each. Branch directors report to the Operations Section Chief, who then reports to Incident Commander. Following the California Hospital Association HICS model, Operations might include the following branches:
- Medical Care branch (e.g. inpatient, outpatient, casualty care, clinical support, patient registration)
- Infrastructure (e.g. power, water, HVAC, Facility assessment, medical gas)
- Security (Access control, crowd control, traffic control, law enforcement interface)
- HazMat (e.g. spill response, victim decontamination, facility decontamination)
- Business Continuity (e.g. IT systems, services continuity, records management)
- Patient Family Assistance (e.g. social services, family reunification)
- ***Logistics Section Chief*** is responsible for acquiring resources, assets and labor needed to support the incident command team and the response.
- ***Planning Section Chief*** is responsible for maintaining situation/status, coordinating periodic briefing meetings, updating the Incident Action Plan, and projecting the resources needed for possible long-term response effort. This section also performs patient tracking/information activities when needed. As the incident evolves, this section plans for demobilization and return/replenishment of resources and assets. This section collects incident documentation.
- ***Finance Section Chief*** is responsible for maintaining documentation of employee work hours and implements processes for payroll. It also completes and maintains documentation to submit to Office of Emergency Services (OES)/Federal Emergency Management Agency (FEMA) and insurance companies for disaster financial claims.

e. Collaborating with Community Partners

SVMH's incident command structure is integrated into, and consistent with, its community's command structure. The use of the HICS model aligns with the Monterey County and State of California Emergency Operations Center, Fire Department Incident Command System (ICS), Police Department ICS, as well as neighboring hospital HICS structures.

SVMH's IC may appoint a Liaison to communicate with community partners.

Collaboration with the Healthcare Coalition members may be accomplished using the ReddiNet

platform. This platform allows SVMH to send status alerts and send messages to community partners including healthcare coalition members, Monterey County EMS and Monterey County OES, and the Monterey County Medical/Health Operational Area Coordinator (MHOAC).

When outside resources are needed, the Monterey County Medical/Health Operational Area Coordinator (MHOAC) may be reached directly by calling Monterey County EMS Communications Center at 831-796-6444. For more information on this process see: Monterey County MHOAC Notification/ Activaction.

3. Communications Plan

a. Emergency Contacts

SVMH maintains one or more contact list(s) of individuals and entities that may be notified in response to an emergency. The type of emergency will determine which organizations and individuals need to be contacted to assist with the incident. Contacts include:

i. Staff
ii. Providers and other licensed practitioners
iii. Volunteers
iv. Other healthcare organizations
v. Entities providing services under arrangement, including suppliers of essential services, equipment and supplies
vi. Relevant community partners (fire, police, local incident command, public health departments)
vii. Relevant authorities (federal, state, tribal, regional and local emergency preparedness staff)
viii. Other sources of assistance (e.g. health care coalitions) as appropriate

b. Establishing & Maintaining Communication with Staff, Licensed Practitioners and Volunteers

Everbridge mass notification system is in place, backed up by other communications methods including overhead paging, email, phone trees, texting app, etc.

Ongoing communication and dissemination of information to staff, licensed practitioners and volunteers is of vital importance during a disaster. It enables better utilization of assets and resources. During a disaster all information and communications will be funneled through the section Chiefs to the Incident Commander then disseminated back to the section Chiefs for communicating to the Unit Leaders and individual department directors and managers and licensed independent practitioners.

THE OPERATOR SHOULD NOT BE CALLED FOR INFORMATION.

c. Establishing & Maintaining Communication with Patients and Families

Staff will continually communicate and reassure patients during a disaster. Patient Experience Team, Social Services, Volunteers, and Administration will be made available to talk with patients as applicable. If there are patients whose family was not able to arrive at the hospital prior to an emergency in the

community or the hospital, the Incident Command Team, under direction of the Incident Commander, will contact family members to inform them of the conditions of their loved ones and the emergency response activities.

If the hospital can no longer sustain operations and relocation of patients becomes necessary, the Incident Command Team will assign persons to notify family members (those present at the hospital and those unable to get to the hospital due to the nature of the emergency in the community) that their loved ones are being relocated and provide the name of the facility where the patient is being relocated, provide name and telephone number of contact individual at the facility. Augmentative and alternative communication may be used for those with difficulties communicating using speech.

d. Establishing & Maintaining Communication with Community Partners

Several local agencies may play a role in managing an emergency. Some of the key contacts include Police, Fire, EMS, OES, Department of Health, Center for Disease Control (CDC) and the Red Cross. Community partners are contacted by the Incident Commander or a designee as soon as possible after an emergency response is initiated.

Communication with community partners will depend on the given emergency.

When all primary communication channels (telephone, cell phones and emails) are operative, they will be used. When primary communication channels are not operative, the hospital will use any available means to communicate with community partners including employment of radios, runners, satellite telephone, etc.

Monterey County Emergency Medical Services (EMS) and public health department may also be reached via 880 MHz radio, and the ReddiNet application.

Depending on the incident, community partners may maintain communications via establishment of Joint Command, or Joint Information Center. These may be in person, or utilizing a web-based meeting platform such as Webex.

Community incident updates may be obtained via California Health Alert Network (CAHAN) alerts, Monterey County OES messaging (“Alert! Monterey”), and the Monterey County OES website (https://www.co.monterey.ca.us/government/departments-a-h/administrative-office/office-of-emergency-services/incidents).

e. Establishing & Maintaining Communication with Relevant Authorities

Authorities (whether federal, state, regional or local) are contacted by the Incident Commander or a designee as soon as possible after an emergency response is initiated.

Communication with the authority will depend on the given emergency, but as a general rule, begin with the most local authority.

When all primary communication channels (telephone, cell phones and emails) are operative, they will be used. When primary communication channels are not operative, the hospital will use any available means to communicate with the relevant authority including employment of radios, runners, satellite telephone, etc.

f. Establishing & Maintaining Communication with Media

When the EOP and HICS are activated, the hospital's communication with external agencies will depend on the given emergency. If multiple agencies and healthcare organizations are involved, all communication and coordination of activities will go through the Emergency Operations Center (EOC) at the OES.

In a major event, members of the press/media will be escorted to the Nancy Ausonio Mammography Center parking lot, or other designated area as needed, where a Public Information Center will be established. The designated Public Information Officer (PIO) will coordinate the collection and dissemination of information with the PIO at the Emergency Operations Center (EOC).

g. Communication with Vendors

SVMH maintains vendor contacts that may provide specific services before, during, and after an emergency event.

Once emergency measures are initiated, the hospital utilizes its vendors list for essential supplies, services and equipment and notifies each vendor by telephone (or other means if the telephone system is not operational) to be on standby to respond to the hospital's needs should they arise.

h. Reporting Organizational Needs, Occupancy & Capacity to Relevant Authorities

Organizational needs, such as personal protective equipment (PPE), staffing shortages, evacuation or transfer of patients and temporary loss of part or all organization function, can be communicated to the Monterey County Healthcare Coalition. The Monterey County Medical/Health Operational Area Coordinator (MHOAC) may be reached directly by calling Monterey County EMS Communications Center at 831-796-6444. Both admit capacity and diversion status may be reported to EMS and other community partners in the healthcare coalition via ReddiNet, or 880 MHz radio as a backup.

i. Warning and Notification Alerts

SVMH has established a number of codes specific to emergency and disaster events, and the procedures to follow when that emergency or disaster incident occurs. See #6304 EMERGENCY CODES FOR SVMH.

j. Sharing / Releasing Patient Information During an Emergency

During an emergency (such as a hospital evacuation, or mass casualty incident (MCI)), it may become necessary to share/release pertinent patient information with:

i. The patient's family, representative, or others involved in the care of the patient
ii. Disaster relief organizations and relevant authorities
iii. Other health care providers

Information shared may include the patient's location or medical records, for example. Sharing and releasing of patient information will be performed under the direction of the Incident Commander and will be consistent with 45 CFR 164.510 (b)(1)(ii) and (b)(4).

The method by which patient information is shared will depend on the type of incident. Patient & Family Reunification center may be established at the direction of the Incident Commander to provide location information and updates to family members. Medical records may be printed by unit nursing staff or with the support of Health Information Management department for patient transfer. During an MCI, patient information may be shared with community partners via ReddiNet to aid in community-wide patient/ family reunion efforts.

k. Primary vs. Alternate Communication Methods

The primary communication methods used by SVMH in an emergency include overhead page, phone calls, and text notification.

When these primary methods are insufficient, then the other communication methods, mentioned throughout this section, will be employed.

l. Compatibility of Communication Methods with Community Partners

The Monterey County Heatlhcare Coalition has established common communication pathways for use across the community which includes the ReddiNet application, 880 MHz Radio, CAHAN and Alert!Monterey.

m. Testing of Alternative Communication Equipment

SVMH's alternative communication equipment is tested for functionality on a periodic basis.

4. Staffing Plan

SVMH maintains a plan to manage staff and volunteers to meet patient care needs during the duration of an emergency, incident, or patient surge.

a. Methods for Contacting Off-Duty Staff, Physicians, Licensed Practitioners

Contact information, including off-duty phone numbers, is maintained by SVMH for its staff, physicians, and other licensed practitioners. If needed, an appointee (for example staffing office, HR, Medical Staff Services, or other, as appropriate) would reach out to individuals using their contact information.

b. Use of Volunteer Staffing

Staffing agencies, healthcare coalition support, and disaster medical assistance teams are all potential sources of volunteer staffing in an emergency.

c. Reporting Processes

On-duty staff report to their manager, director or immediate supervisor who will then be represented in the incident command center. Volunteers will be managed through the Labor Pool Unit under the direction of the Incident Commander.

d. Roles and Responsibilities for Essential Functions

Leaders who have been identified to assume a role in the HICS structure have received training for their roles. Ongoing education and training is also provided to staff through the exercises and activations

conducted each year.

e. Integrating Outside Staff / Teams Into Assigned Roles and Responsibilities

Outside staff from staffing agencies, volunteers staffing, or deployed medical assistance teams will be oriented to their roles and responsibilities as appropriate to the nature of the emergency.

f. Managing Licensed Practitioners

During disaster situations, members of the community may report to the facility wishing to provide volunteer assistance. Some volunteers may have specific licenses, skills, or qualifications that can be valuable to patient care. These could be physicians or other medical professionals. These volunteers will be directed to a Staging Area and their names provided to the Human Resources Department or in their absence, Nursing Staff Office to verify licensure. If licensure can be verified, the volunteers will be used as necessary in conjunction with hospital staff. If licensure cannot be verified, the volunteers can be used in roles that are not directly related to patient care.

SVMH's Medical Staff Bylaws maintains a plan to verify documents and identify of all volunteer licensed independent practitioners, perform primary source verification within 72 hours of the time the volunteer presents to the organization, and provide oversight of the care, treatment and services provided by volunteer licensed practitioners. The Bylaws also define the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners, and the process for granting these privileges.

g. Employee Assistance and Support

In the event of a disaster or extended emergency, it is likely that staff will need additional support in order to meet the increasing demands placed on them. These needs may include, but are not limited to housing, transportation, support with family care, or mental health and wellness.

Depending on the emergency, SVMH may provide its own resources or work with community organizations to provide the needed resource. Examples of providing SVMH resources include providing hospital conference rooms and meals to staff seeking wildfire shelter, or repurposing campus bus parking shuttles to transport staff to and from work. Examples of working with community organizations include working with hotels to house hospital staff exposed to a pandemic illness.

To help address mental health and wellness needs, SVMH provides the Employee Assistance Program which is available on-demand to all staff. SVMH also maintains a Care for the Caregiver program that provides peer support.

5. Patient Care and Clinical Support Plan

a. Maintaining Continuity of Care

SVMH cares for a number of patient populations including emergency care, adult ICU, Procedures (Cath Lab, Surgery, Diagnostic Imaging, Endoscopy) Progressive Care/Telemetry including a stroke unit, Medical/surgical including oncology and patients receiving dialysis, Mother/Child care including a Level II NICU, Labor & Delivery, post-partum, and pediatric general care.

Formal agreements are in place so that patients may be transferred to a facility that can provide adequate patient care when the environments at SVMH can no longer support care, treatment and services. The Liaison Officer will be responsible for inter facility communication between the hospital and the designated alternative care site, and a Patient Tracking team would also be deployed to document and retain records of which patients were transferred to and/or from the alternative care site(s).

The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If any hospital equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that the equipment may be retrieved during the recovery phase post emergency. The following resources may be utilized:

- Ambulance transfer of patients between facilities
- Licensed vendors providing van/bus transportation
- SVMH owned vehicles
- Vehicles arranged by Monterey County EMS

Additionally, SVMH maintains supporting procedures regarding patient transfers for certain patient populations. See:

- #399 MATERNAL TRANSPORT-TERTIARY CARE AND TRANSFER OF PATIENT.
- #2668 ACCEPTING INTERFACILITY TRANSFERS.
- #201 TRANSFER OF PEDIATRIC PATIENT TO HIGHER LEVEL OF CARE.
- #161 NICU: CONSULTATION & TRANSFER OF PATIENT TO & FROM NICU CLINICAL PROCEDURE.

b. Managing Visitors

During an emergency, the hospital may need to manage an influx of individuals that may present during a disaster that are not in need of medical care (such as visitors, or the "worried well"). Under the direction of the Incident Commander, SVMH Security Department Officers on duty will assume responsibility for traffic and crowd control. This may involve locking certain exits and entrances and controlling entrance to the emergency department or entrances, in order to maintain a safe and effective environment to perform patient care. Hospital staff are always required to wear ID badges. In the event volunteers from outside SVMH are assigned to duty, the Incident Command Team will employ a method to properly identify them. Only persons with proper identification will be admitted into the hospital during an emergency.

Traffic flow on the campus will be controlled by assigned security staff and law enforcement personnel only (Labor Pool may be utilized to help support efforts) allowing only authorized vehicles to enter the campus during emergencies.

At the direction of the Incident Commander, SVMH may set up a Patient Family Reunification center to provide support and updates to visitors.

c. Managing Influx of Unidentified or Deceased Patients

i. The mortality rate during emergency conditions may increase due to casualties brought into the hospital. The hospital is only equipped for handling a minimal number of mortality casualties due to limited morgue refrigeration units. The hospital will communicate with the county morgue and provide information relative to number of casualties that the county morgues will pick up from the hospital.

ii. The hospital would also contact the local medical examiner for the appropriate clearance and procedures. A refrigerated trailer may be requested for securing bodies not able to be contained in the hospital's existing morgue. The Medical Examiner's office will be notified when the refrigerated trailer is full, or the disaster has been cleared.

6. Safety and Security Plan

a. Coordinating with Community Security Agencies

SVMH may need to coordinate with community security agencies such as police, sheriff or National Guard. During an emergency, these entities will unite under the command of the highest-ranking law enforcement agency on site. Command of security inside the hospital's buildings will be under the hospital's Incident Commander unless the Incident Commander deems that law enforcement intervention is required inside the buildings, and then law enforcement, in conjunction with the director of hospital security, will assume command jointly.

b. Tracking On-Duty Staff and Patients

If all or part of SVMH is forced to shelter-in-place, relocate, or evacuate, the hospital will track the location of on-duty staff and patients. Depending on the nature of the emergency, this may be accomplished using printed schedules and patient census lists. Staff may also be polled via the Everbridge mass communication system. Tracking/head count activities may be performed periodically at intervals determined by the Incident Command Team, under the direction of the Incident Commander.

In the event of patient evacuation, SVMH will track the specific name and location of the receiving facility or evacuation location. For more information on evacuation procedures, see HOSPITAL EVACUATION PROCEDURE.

7. Resources and Assets Plan

a. Managing Hospital Resources and Assets

SVMH is aware of what resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency.

Inventory lists are maintained by the department who manages them, specifically:

Resource Type	Inventory Maintained by:
Medications & Related Supplies	Pharmacy
Medical/surgical supplies	Materials Management Sterile Supply

Medical gases including oxygen & supplies	RRT Engineering (bulk O2)
Potable or bottled water and nutrition	Nutrition Services
Laboratory equipment & supplies	Laboratory Blood Bank
Personal Protective Equipment	Materials Management
Fuel for operations	Engineering
Equipment and nonmedical supplies to sustain operations	Environmental Services

During an emergency or disaster incident the Logistics Section Chief, under direction of the Incident Commander, works with the responsible departments to track, monitor and locate resources as appropriate.

b. Acquiring Resources and Assets

In an emergency, SVMH may need to obtain, allocate, mobilize, replenish and/or conserve resources and assets. Depending on the emergency, SVMH may need to:

- Coordinate with local supply chains or vendors
- Coordinate with local, state, or federal agencies for additional resources
- Coordinate regional health care coalitions for additional resources
- Manage donations (such as food, water, equipment, materials)

High priority will be given to resources that are known to deplete quickly and are extremely competitive to receive and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications).

~~SVHMC maintains on-hand~~For those supplies with short shelf life and those that ~~may always be required for an extended emergency. For those supplies with short shelf life and those that~~ require continual replenishment, ~~SVHMC~~SVMH will contact supplier immediately upon suspecting the onset of an emergency and stock up for a minimum of 96 hours if possible.

~~The amounts, locations, and processes for obtaining and replenishing of medical and non-medical pharmaceutical supplies, including personal protective equipment, are established before an event. The process goes from mitigation to recovery stages. Medical supplies would include anything used in the care of patients. Non-medical supplies would include food, linen, water, fuel, and transportation vehicles.~~

~~The amounts and locations of current supplies have been evaluated to determine how many hours the facility can sustain before replenishing. This gives the facility a par level on supplies and aid in the projection of sustainability before terminating services or evacuating if supplies are unable to get to the facility. The inventory of resources and assets that were discussed earlier in the Planning Activities Section is the starting point of par levels. The processes for obtaining and replenishing those supplies once the par level has decreased have been identified. This includes a list of the vendors and contractors that deliver and manufacture the supplies.~~

1. **Pharmacy**

   The Emergency Operations Plan describes the following: How the hospital will obtain and replenish medications and related supplies that will be required throughout the response and recovery phases of an emergency, including access to and distribution of caches that may be stockpiled.

   The plan consists of continually monitoring inventories required for an extended emergency and the aftermath of an emergency during the recovery phase. SVHMC has memorandum of understanding with pharmaceutical suppliers to replenish pharmaceutical supplies and equipment. SVHMC also has access to local, city, state and federal stockpiles.

2. **Medical Supplies**

   The Emergency Operations Plan describes the following: How the hospital will obtain and replenish medical supplies that will be required throughout the response and recovery phases of an emergency, including personal protective equipment where required.

   The plan consists of continually monitoring inventories required for an extended emergency and the aftermath of an emergency during the recovery phase.

3. **Non-medical Supplies**

   The Emergency Operations Plan describes the following: How the hospital will obtain and replenish nonmedical supplies that will be required throughout the response and recovery phases of an emergency.

   SVHMC maintains on hand supplies that may always be required for an extended emergency for those supplies with a short shelf life and those that require continual replenishment. SVHMC will contact supplier immediately upon suspecting the onset of an emergency and stock up for a minimum of 96 hours.

   The plan also consists of continually monitoring inventories required for an extended emergency and the aftermath of an emergency during the recovery phase.

4. **Sharing Resources and Assets**

   The Emergency Operations Plan describes the following: How the hospital will share resources and assets with other health care organizations within the community and outside of the community, if necessary, in the event of a regional or prolonged disaster.
   The process of sharing resources with other healthcare organizations outside of the community during a regional event would go through the Monterey County Office of Emergency Services Emergency Operations Center (EOC). Those resources will be tracked by the Monterey County Office of Emergency Services Medical Health and Operational Area Coordinator (MHOAC). The EOC and MHOAC will be responsible for delivery of the needed resources.

5. **Inventory**

   The Emergency Operations Plan describes the following: How the hospital will monitor

quantities of its resources and assets during an emergency.
SVHMC has established a method for monitoring quantities of assets and resources during an emergency and keeps control of depletions of supplies to assess duration of sustainability for an extended emergency through the Logistics Section of HICS.

6. **Transportation of Patients and Staff**

The Emergency Operations Plan describes the following: The hospital's arrangements for transporting some or all patients, their medications, supplies, equipment, and staff to an alternative care site(s) when the environment cannot support care, treatment, and services.

Formal agreements and arrangements are in place so that patients may be transferred to a facility that can provide adequate patient care when the environments at SVHMC can no longer support care, treatment and services. The Liaison Officer will be responsible for inter facility communication between the hospital and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If any hospital equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that the equipment may be retrieved during the recovery phase post emergency. The following arrangements and agreements are in place for transporting patients to alternate care sites:

- Ambulance contract agreements for transfer of patient between facilities.
- Licensed vendors are contracted for providing van/bus transportation.
- Salinas Valley Health Medical Center owned vehicles are utilized.
- Salinas Valley Health Medical Center is provided with transportation vehicles arranged by the County Emergency Management Services (EMS).

7. **Transferring of Pertinent Information**

The Emergency Operations Plan describes the following: The hospital's arrangements for transferring pertinent information, including essential clinical and medication-related information, with patients moving to alternative care sites.

When the environment cannot support care, treatment and services, and the ICC has ordered evacuation of the hospital to an alternate care site, it will be necessary to transfer equipment, medications, essential clinical and medication-related information, and supplies to the alternate care site. This shall be coordinated through the ICC (See the section regarding Alternate Care Sites). The transfer of these components is made utilizing transportation agreements and arrangements and all transferred equipment, and records are entered into a transfer log for record keeping.

8. **Coordination of Government Assistance**

The hospital implements the components of its Emergency Operations Plan that require advance preparation to provide for resources and assets during an emergency.

I. SECURITY AND SAFETY

As part of its Emergency Operations Plan, the hospital prepares for how it will manage security and safety during an emergency. The safety and security of patients, staff and visitors are the prime responsibility of SVHMC during an emergency. As emergency situations develop and parameters of operability shift, SVHMC provides a safe and secure environment for their patients, visitors and staff. For example, the FACILITY LOCKDOWN policy #6405 describes situations and procedures for implementing heightened security at SVHMC.

1. **Internal Security**

   The Emergency Operations Plan describes the following: The hospital's arrangements for internal security and safety.

   Safety and security measures and monitoring activities are initiated and play a vital role during response and recovery phases of emergencies. When emergency measures are initiated, SVHMC's mode of operations for security shifts to operate under emergency conditions which are covered under policies and procedures in the Safety program.

2. **External Security Agencies**

   The Emergency Operations Plan describes the following: The roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency.

   SVHMC has established and communicated with community partners and law enforcement agencies that in the time of an emergency these entities will unite under the command of the highest-ranking law enforcement agency on site. Command of security inside the hospital's buildings will be under the hospital's Incident Commander unless the Incident Commander deems that law enforcement intervention is required inside the buildings, and then law enforcement, in conjunction with the director of hospital security, will assume command jointly.

3. **Joint Security**

   The Emergency Operations Plan describes the following: How the hospital will coordinate security activities with community security agencies (for example, police, sheriff, National Guard). See External Security Agencies.

4. **Hazardous Material Handling and Waste**

   The Emergency Operations Plan describes the following: How the hospital will manage hazardous materials and waste.

   It is recognized that once emergency measures are implemented, contracted hazardous waste haulers may not be able to get to the hospital to dispose of hazardous materials and medical wastes for days. Therefore, the hospital has set up a temporary secured storage area during emergencies. The regulated medical waste stream at SVHMC is secured and stored then hauled away by an approved vendor that meets all state and local regulations. The hospital's normal spill response policy will continue to be followed, in addition, storage of hazardous

materials and waste management will be temporarily placed in a designated overflow area until the emergency conditions have been lifted and vendors contracted for hauling are able to get to the hospital and remove materials from the overflow areas.

5. **HAZMAT Isolation and Decontamination**

The Emergency Operations Plan describes the following: How the hospital will provide for radioactive, biological, and chemical isolation and decontamination.

Facilities for decontamination are maintained and coordinated through the Engineering Department, Infection Control, and Emergency Management Committee. The effectiveness of the equipment and materials are periodically tested and evaluated.

SVHMC is equipped to manage decontamination with specified chemical agents, provided the agent and concentration is known. SVHMC staff can utilize the primary decontamination shower. Radiological emergencies are responded to in concert with the Radiation Safety Officer. Biological emergencies are responded to in concert with the Infection Control Director or Emergency Department physician. Chemical decontamination situations are responded to in concert with the Safety Officer.

The hospital has established a process for decontamination of patients that present to the hospital with hazardous material contamination. Appropriate staff are trained in the response to radiation or hazardous material contamination. A separate BIOTERRORISM READINESS PLAN #1789 has been developed, reviewed, and approved by the Emergency Management Committee.

Hazmat incidents including Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) incidents are handled based on SVHMC's ICC & Operations Section Hazmat / Decontamination procedures for the emergency department and support departments, the organization's biological response plan and in collaboration with the city and/or county Emergency Services & Hazmat team expertise including the Salinas Fire Department and the Office of Emergency Services (OES).

Pursuant to exposure conditions, SVHMC may establish a chemical HAZMAT decontamination triage setting external to Emergency Department per the EMERGENCY MANAGEMENT FOR MASS CASUALTY INCIDENTS (MCI), INCLUDING DECONTAMINATION Policy #1102. The Hospital has a trained and equipped a hazardous materials decontamination team following the hospital emergency response team (HERT) concept. When appropriate, and in unknown exposures defer to the local fire department HAZMAT team who has authority to command all emergency HAZMAT events.

Upon identification of a radiological HAZMAT event, SVHMC will establish an external HAZMAT triage and decontamination area and the Safety Officer may act as the SVHMC Liaison to coordinate activities with external HAZMAT/SFD entities. Upon identification of a biological event, all aspects of the BIOTERRORISM READINESS PLAN #1789 will be followed in consultation with Monterey County Health Department's Environmental Health division.

SVHMC has a limited number of isolation rooms and is not equipped to deal with mass

isolation which may be required under emergency conditions. Once it is determined that isolation of an area is required, security staff will be posted at all points of entry and exit from the area to ensure that the area remains confined as directed by the incident commander. The Engineering Department will respond to isolate recirculation of ventilation systems from the isolated area wherever possible or may initiate a HVAC shutdown in the area.

6. **Controlling Traffic of Individuals in and out of the entrance to the Facility**

   The Emergency Operations Plan describes the following: How the hospital will control entrance into and out of the health care facility during an emergency.

   At the time the Emergency Operations Plan is activated, the Security Department Officers on duty will be responsible for locking all exits and entrances except for the emergency department entrances. Hospital staff are always required to wear ID badges. Only persons with proper identification will be admitted to the hospital during an emergency.

7. **Controlling Traffic of Individuals within the Facility**

   The Emergency Operations Plan describes the following: How the hospital will control the movement of individuals within the health care facility during an emergency.

   During emergency conditions, when it becomes necessary to control the movement of visitors and staff horizontally and vertically to facilitate an effective environment during emergencies, movement within the hospital will be controlled by security through security check points, control of elevators, and control of doors. Staff that does not have a need to perform essential functions in specific areas, will not be allowed to pass through these check points.

8. **Controlling Vehicle Access**

   The Emergency Operations Plan describes the following: The hospital's arrangements for controlling vehicles that access the health care facility during an emergency.

   Signs will be posted throughout the hospital showing shelter locations, including instructions for taking shelter. Signs will also be posted on the hospital campus directing overflow emergency vehicles to locations for decontamination areas and parking for emergency vehicles.

   Traffic flow on the campus will be controlled by assigned security staff and law enforcement personnel only (Labor Pool may be utilized to help support efforts) allowing authorized vehicles to enter the campus during emergencies.

9. **Advanced Preparation for Security and Safety**

   The hospital implements the components of its Emergency Operations Plan that require advance preparation to support security and safety during an emergency.

J. STAFF

As part of its Emergency Operations Plan, the hospital prepares for how it will manage staff during an emergency. During an emergency, the probability that staff responsibilities will change is high. As new

risks develop along with changing conditions, staff will need to adapt their roles to meet new demands on their ability to care for patients. It cannot be anticipated how staff may be called upon to perform during an emergency, the likelihood of staffing sustainability increases during an emergency. From that standpoint, alternate roles and staff responsibilities has been developed to ensure that staff can adapt during an emergency and as an emergency escalates.

SVHMC has outlined for staff both general and specific guidelines for responding to emergencies. The Hospital Emergency Preparedness Procedures guidebook and the Hospital Incident Command System (HICS) provides specific response detail in the guidebooks, the HICS documents in the ICC includes job action sheets, tracking forms, and information sheets. This planning has also been provided to the hospital's vulnerable populations such as Women and Children's Services and Neonatal Intensive Care Unit.

1. **Roles and Responsibilities**

   The Emergency Operations Plan describes the following: The roles and responsibilities of staff for communications, resources and assets, safety and security, utilities, and patient management during an emergency.

   The Emergency Preparedness Procedures Guidebook in collaboration with this EOP provides specific detail about who is responsible for what and specific actions to take in the hospital identified vulnerabilities. At least 3 individuals have been identified for each position on the HICS chart at the section chief level and higher and have been trained as to their roles and responsibilities.

2. **Command Staff**

   The Emergency Operations Plan describes the following: The process for assigning staff to all essential staff functions.

   All staff who are hired at SVHMC have received training in emergency response protocols, including who they are to report to in the event of an emergency, and in what manner they are to do so. Staff members are generally instructed to report to their manager, director or immediate supervisor who will then be represented in the incident command center.

3. **General Staff**

   The Emergency Operations Plan identifies the individual(s) to whom staff report in the hospital's incident command structure per the HICS organizational chart, which is built based on incident needs.

4. **Managing Staff Support**

   The Emergency Operations Plan describes how the hospital will manage staff support needs (for example, housing, transportation, incident stress debriefing). In the event of a disaster or extended emergency, it is likely that staff will need additional support in order to meet the increasing demands placed on them. Hospital management has planned for such needs and is prepared to provide counseling and debriefing services to staff if necessary.

5. **Family Support Needs of the Staff**

   The Emergency Operations Plan describes how the hospital will manage the family support needs of staff (for example, child care, elder care, pet care, communication).

   It is also well understood that most staff have families to care for and that it is not realistic to expect staff to put the hospital's needs before their families. Therefore, childcare services, food, water, and shelter may be provided to staff if necessary.

6. **Training**

   The hospital trains staff for their assigned emergency response roles.

   Upon being hired all staff receives orientation to the hospital which includes the organizations disaster response protocols, the hospital incident command system (HICS), and their roles and expectations. All management staff, executive staff, or anyone likely to assume a role in the HICS structure has received training for their roles. Ongoing education and training is also provided to all staff through the exercises and activations conducted each year.

7. **Written Communication of Licensed Independent Practitioners' Roles**

   The hospital communicates, in writing, with each of its licensed independent practitioners regarding his or her role(s) in emergency response and to whom he or she reports during an emergency.

   Written communications regarding emergency response and to whom independent practitioners report is done in orientation upon granting of privileges and is tracked by the Medical Staff Services office, see Medical Staff By-Laws.

8. **Identification of Staff, Licensed Independent Practitioners, and Authorized Volunteers**

   The Emergency Operations Plan describes how the hospital will identify licensed independent practitioners, staff, and authorized volunteers during emergencies.

   SVHMC has developed a unique system to identify and track volunteers during emergencies and disasters. This system consists of simple color-coded badges that can quickly be made and given to volunteers. The color on the badge identifies that person as an independent practitioner or other authorized volunteer and aides in pairing them with established hospital staff. Please refer to Human Resources DISASTER PRIVILEGE POLICY AND PROCEDURE FOR CLINICAL VOLUNTEERS, SVHMC VOLUNTEERS, NON-CLINICAL VOLUNTEERS & NON SVHMC VOLUNTEERS Policy 860 and the Medical Staff Services emergency credentialing procedures.

9. **Advanced Preparation to Manage Staff**

   The hospital implements the components of its Emergency Operations Plan that require advance preparation to manage staff during an emergency.

   The hospital's Emergency Preparedness Procedures provide specific response detail for all hazard type events. All staff are required to take FEMA ICS courses based on job role in accordance with ASPR NIMS guidelines. The HICS command center resources include job

~~action sheets, tracking forms, and information sheets. All staff take annual emergency preparedness education via health stream.~~

~~SVHMC utilizes HICS as described in this EOP and department specific response plans for managing staff during emergencies. These plans are to be tested annually during drills and exercises.~~

~~K. UTILITIES MANAGEMENT~~

a. 96-Hour Plan

SVMH periodically assesses its inventory to see which on-hand resources can be expected to last 96 hours, and which resources require additional sustaining measures to remain self-sustaining. See Attachment C: 96 Hour Plan.

Note: Materials management maintains Infectious Disease related Personal Protective Equipment (PPE) per CAL OSHA AB 2537 and SB 275 PPE Stockpiling Requirement. This regulation stipulates that California hospitals keep a three-month stockpile of PPE based on normal consumption patterns.

8. Utilities Plan

a. Essential Utilities

~~As part~~SVMH is dependent on the uninterrupted function of its ~~Emergency Operations Plan,~~essential/ critical utilities during an emergency. Essential utilities include electrical distribution, emergency power, potable water, medical gas and vacuum, ventilation, fuel, plumbing, steam boilers, and network and communication systems. If disrupted, adverse events may occur as a result. SVMH has inventoried all its essential utilities based on calculated demand loads that may be affected under emergency conditions and is prepared to maintain effective operations of the hospital ~~prepares for how it will manage utilities during an emergency. SVHMC is dependent on the uninterrupted function of its critical utilities during an emergency. The supply of key utilities, such as power or potable water, medical gas and vacuum, ventilation, and fuel must not be disrupted, or adverse events may occur as a result. SVHMC has inventoried all its essential utilities based on calculated demand loads that may be affected in emergency conditions and is prepared to maintain effective operations of the hospital~~ for a period of 96 hours without reliance for replenishment of supplies associated with utilities at ~~SVHMC~~SVMH from external sources.

1. ~~**Alternative Means for Electricity**~~

   ~~As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Electricity.~~

   ~~SVHMC has built and tested an extensive power failure plan that includes a 2 MW generator.~~

2. ~~**Alternative means for Essential Care and Consumable Water**~~

   ~~As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Water needed for consumption and essential care activities.~~

Contracts and Memorandum's of Understanding have been established with vendors for fuel and other essential utilities to replenish supplies in the event of an extended emergency.

3. **Alternative Means for Equipment and Sanitary purpose Water**

   As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Water needed for equipment and sanitary purposes.

   Contracts and Memorandum's of Understanding have been established with vendors for fuel and other essential utilities to replenish supplies in the event of an extended emergency.

4. **Alternative Means for Fuel**

   As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Fuel required for building operations, generators, and essential transport services that the hospital would typically provide.

   SVHMC keeps on hand enough fuel to maintain essential functions for more than 96 hours. Refer to the 96 hour Inventory binder in command center or the N drive emergency management folder titled 96hr inventory.

5. **Alternative Means for Medical Gas/Vacuum Systems.**

   As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Medical gas/vacuum systems.

   Contracts and Memorandum's of Understanding have been established with vendors for fuel and other essential utilities to replenish supplies in the event of an extended emergency.

6. **Essential Utility Systems**

   As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following: Utility systems that the hospital defines as essential (for example, vertical and horizontal transport, heating and cooling systems, and steam for sterilization).

   Contracts and Memorandum's of Understanding have been established with vendors for fuel and other essential utilities to replenish supplies in the event of an extended emergency.

7. **Advanced Preparation for Utilities**

   The hospital implements the components of its Emergency Operations Plan that require advance preparation to provide for utilities during an emergency.

L. PATIENT MANAGEMENT

As part of its Emergency Operations Plan, the hospital prepares for how it will manage patients during emergencies. The clinical needs of patients during an emergency are of prime importance. SVHMC has a clear and reasonable plan in place to address the needs of patients during extreme conditions when the infrastructure and resources are taxed.

1. **Patient Triage**

The Emergency Operations Plan describes the following: How the hospital will manage the activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, and discharge.

Upon activation of the Emergency Operations Plan, normal admission requirements may be discontinued. Initially, admissions to the hospital may be limited to those whose survival depends upon services obtainable only through hospital treatment.

Outpatient care may be restricted to those whose lives may ultimately depend upon the present expenditure of medical supplies and human resources available at the time.

Elective admissions and procedures may be canceled, including elective surgery, non-emergency outpatient procedures and transferring patients who are stable to be discharged.

Patients may be transferred to other facilities so emergency patients may be accommodated. Individuals may be redirected or relocated for a Medical Screening Exam if the hospital's Emergency Operations plan is activated. (Section 1135(b) of the Social Security Act §489.24(a)(2)).

If the hospital's Emergency Operations Plan is activated, persons may be transferred prior to being stabilized if, based upon the circumstances of the emergency the hospital is unable to provide proper care, treatment or services. (Section 1135(b) of the Social Security Act §489.24(a)(2)).

2. **Floor to Floor Evacuation**

The Emergency Operations Plan describes the following: How the hospital will evacuate (from one section or floor to another within the building, or, completely outside the building) when the environment cannot support care, treatment, and services.

SVHMC has established an emergency evacuation plan to indicate evacuation of the hospital or unit within the hospital. In the unlikely event the hospital or a unit is deemed unsuitable for continued occupancy or cannot support adequate patient care, the FIRE RESPONSE PLAN (CODE RED) #618 will be initiated. Staff is educated on evacuating both horizontally and vertically. Staff is also trained to request assistance in evacuating non-ambulatory patients. Staff may also use the evacuation chairs and sleds for both horizontal and vertical evacuation.

The SVHMC's FIRE RESPONSE PLAN (CODE RED) #618 dictates that in the event of a fire emergency, the initial preferred evacuation method will be horizontal evacuation to an area of safe refuge/an adjoining smoke compartment. If evacuation from the facility becomes necessary due to a disaster situation where defending in place is not feasible and when the facility cannot continue to support care, treatment and services, the incident commander and the Salinas Fire Department may initiate and authorize a vertical evacuation of the facility.

3. **Increased Need for Clinical Services**

The Emergency Operations Plan describes the following: How the hospital will manage a

potential increase in demand for clinical services for vulnerable populations served by the hospital, such as patients who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions.

Clinical activities for vulnerable patient populations including pediatric, geriatric, disabled, or have serious chronic conditions (example; dialysis patients, respiratory patients, transplant unit patient, etc.) and psychiatric patients will be provided in the customary way but additional emphasis will be placed on security, safety, mobility in terms of evacuation should it become necessary during an emergency.

This planning has also been provided to the hospital's vulnerable populations such as Women and Children's Services and the Neonatal Intensive Care Unit.

Case Management and Social Services maintain a working document of community resources for patients needing resources beyond the organizations support system. SAM's Guide to Monterey County Family Resources can also be found at www.samsresources.com. This is a comprehensive guide to individuals who counsel families in need.

Clinical departments have specific policies and procedures that address clinical intervention for providing continued care in the event of total loss of commercial (PG&E) and generator power, the policies and procedures specifically address administration of medication to their vulnerable patient populations when electrically dependent bio medical equipment (example: IV pumps) cannot function due to loss of power.

4. **Patient Personal Hygiene and Sanitation**

The Emergency Operations Plan describes the following: How the hospital will manage the personal hygiene and sanitation needs of its patients.

Personal hygiene and sanitary needs of patients during emergencies will be provided in terms of assuring availability of water supply used for personal hygiene and sanitary water pumps. Also, when water intended for hand washing is not available the hospital utilizes waterless alcohol-based hand rub which is always maintained in ample supply at the hospital.

The alternative means to personal hygiene can be baby wipes, personal wipes, or alcohol-based rubs. The alternative means to sanitation, if toilets are inoperable, is kitty litter, bags in toilet, or bucket brigade. Other alternative means include limiting changes of bed linen to those patients who have gross soiling from draining wounds, catheters, etc. Environmental Services use of water will be curtailed to the extent of one change of water per day for mopping except in surgery, delivery rooms, and isolation areas.

The hospital may contact a water distribution vendor to provide water for personal hygiene and sanitary needs. When it is deemed that a disaster situation is imminent; the vendor is contacted and delivers tankers to the site.

5. **Patients' Mental Health Service Needs**

The Emergency Operations Plan describes the following: How the hospital will manage its patients' mental health service needs that occur during an emergency.

During an emergency, the organization will provide mental health services to the appropriate patient. Staff may use patient registration and triage information, and medical records to determine this population and the appropriate services required. The Behavioral Health Department may also assist in tracking these patients receiving these services during the emergency.

Any of these services provided to the organization's patients will be documented in the patient's records. The critique of the services will be reviewed by the Emergency Management Committee and appropriate medical associates before modifying the emergency services.

6. **Mortuary Services**

The Emergency Operations Plan describes the following: How the hospital will manage mortuary services.

The mortality rate during emergency conditions may increase due to casualties brought into the hospital. The hospital is only equipped for handling a minimal number of mortality casualties due to limited morgue refrigeration units. The hospital has an ample supply of body bags to temporarily store casualties. The hospital will communicate with the county morgue and provide information relative to number of casualties that the county morgues will pick up from the hospital.

In the event of emergency involving deceased patients, the organization will contact the local medical examiner for the appropriate clearance and procedures. If necessary, a refrigerated trailer should be requested for securing bodies not able to be contained in facility's existing morgue. The Medical Examiner's office will be notified when the refrigerated trailer is full, or the disaster has been cleared.

7. **Patient Information**

The Emergency Operations Plan describes the following: How the hospital will document and track patients' clinical information.

The hospital is equipped with back up data systems designed to be retrieved during emergencies and be utilized for documenting and tracking patients' clinical information. In addition, during emergency conditions, paper forms will also be utilized to document and track patients' clinical information.

For the departments that will be receiving disaster patients such as the Emergency Room and patient care units, they will have patient trackers assigned to track the patients entering and leaving the areas. That information will be given to the Patient Tracking Manager assigned through the command center who will track all the patients within the facility during disaster. The form to use for patient tracking is the SVHMC HICS Patient Tracking Form. Information will be maintained at SVHMC for the regional tracking of patient's transferred.

8. **Advanced Preparation for Patient Management**

The hospital implements the components of its Emergency Operations Plan that require

~~advance preparation to manage patients during an emergency.~~

b. Alternative Means for Providing Potable Water

See procedure #6009 FAILURE OF WATER DISTRIBUTION SYSTEM.

SVMH also maintains a memorandum of understanding (MOU) with at least one potable water distributor.

c. Alternative Means for Providing Emergency Generators

A 2MW generator supports SVMH's main hospital building. SVMH also maintains a second backup generator in the event of generator failure.

Relevant supporting procedure(s): #6004 EMERGENCY GENERATOR FAILURE.

d. Alternative Means for Providing Fuel

SVMH keeps on hand enough fuel to maintain essential functions for more than 96 hours. Refer to the 96-Hour Plan. Additionally, SVMH maintains a memorandum of understanding (MOU) with at least one local fuel distributor.

e. Alternative Means for Providing Emergency Power Supply Systems

SVMH has back up batteries at Taylor Farms Family Health & Wellness Center, and at the Outpatient Infusion clinic, which provide an additional 12 hours of power to medication refrigerators and freezers. If a power disruption lasts longer than 12 hours, the clinics and the main hospital pharmacy coordinate to relocate medications to the main hospital pharmacy (which is supported by generator power).

f. Alternate Source of Energy for Maintaining Safe Temperatures

SVMH relies on maintaining temperatures that protect patient health and safety and provide sanitary storage of provisions.

SVMH's generators support emergency lighting and fire detection, extinguishing and alarm systems. They support the HVAC system and patient medication and food refrigerators and freezers.

SVMH is fortunate to sit in a mild coastal climate and as such, patient care areas are not subject to temperature extremes. However, if the temperature of procedure areas or sterile supply areas could not be maintained within the regulated limits, SVMH would consider canceling non-emergent procedures or relocating supplies as appropriate to the situation.

If food refrigerators and freezers could not be powered, SVMH would rely on its disaster menu and inventory stockpile. If only off-campus clinics are affected, their food may be relocated to the main hospital building.

If medication refrigerators and freezers could not be powered, SVMH would look to sharing resources with the clinics within the SVMH/SVMC system, or healthcare coalition members. If only off-campus clinics are affected, their medications may be relocated to the main hospital building.

If steam boilers could not remain functional, SVMH may look to sharing resources with healthcare

coalition members, for example to share sterilization equipment.

Relevant supporting utilities procedure(s):

- #5999 FAILURE OF NATURAL GAS SUPPLY,
- #6008 FAILURE OF STEAM DELIVERY BOILERS
- #6005 FAILURE OF HVAC SYSTEM
- #6592 EMERGENCY PLAN FOR STERILIZATION FAILURE

g. Alternate Source of Energy for Emergency Lighting

SVMH's generators support emergency lighting in the main hospital building. If emergency lighting could not be maintained, SVMH may look to source emergency lighting from its own stockpiles of battery-powered lights, vendors, clinics or healthcare coalition members. As a last resort, SVMH may consider relocation of patients in a partial or full evacuation.

h. Alternate Source of Energy for Fire Detection, Suppression & Alarm Systems

SVMH's generators support emergency lighting in the main hospital building. If fire detection, extinguishing, and alarm systems could not be powered, SVMH would look to implement interim life safety measures.

Relevant supporting procedure(s):

- #624 INTEREIM LIFE SAFETY MEASURES
- #5995 FAILURE OF FIRE ALARM SYSTEM

i. Alternate Source of Energy for Sewage and Waste Disposal

See procedure #6007 FAILURE OF THE SANITARY SEWER SYSTEM.

In the event of the garbage compactor loses power, SVMH would coordinate with the hauler for more frequent pickups.

j. Additional Relevant Policies and Procedures

- #6001 FAILURE OF THE MEDICAL GAS OXYGEN SYSTEM
- #5998 FAILURE OF MEDICAL GAS SYSTEM NITROUS OXIDE
- #6002 FAILURE OF THE COMMUNICATIONS SYSTEM
- #6006 FAILURE OF NURSE CALL SYSTEM

9. Additional Procedures that Support the EOP

A. Facility Lockdown #6405
B. Fire Response Plan (Code Red) #610 (includes procedures for sheltering in place and horizontal relocation
C. Census Saturation #5886 defines the hospital surge plan

10. Hospital Role Under 1135 Waivers

In the event that the Secretary declares an 1135 waiver for a public health emergency, SVMH will review the waiver, what is covered in the blanket waiver, and applies for additional waivers if needed. This process is managed by the Regulatory & Accreditation department.

M. CONTINUITY OF OPERATIONS PLAN (COOP)

1. Leadership Participation

SVMH maintains a written continuity of operations plan (COOP) with the participation of key executive leaders, business and finance leaders, and other relevant department leaders. These key leaders have identified and prioritized the services and functions that are considered essential or critical for maintaining operations.

2. Purpose

The purpose of the COOP is to provide guidance on how SVMH will continue to perform its essential business functions to deliver essential or critical services. It identifies:

i. How and where it will continue to provide these essential business functions when the location of the service has been compromised due to an emergency or disaster incident.

ii. The order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties.

3. Essential Business Functions

SVMH's essential business functions include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption.

a. Administrative / Vital Records (Health Information Management, or "HIM")

i. HIM Functions That Can be Performed Remotely:

"Remotely" indicates there is capacity to perform the work from home or another computer/device connected to the internet.

Function	Resources Needed
Correspondence	Computer, Internet, SVMH remote access system, Access to Meditech software (web-based)
Coding / Abstracting	Computer, Internet, SVMH remote access system, Access to Clinical Documentation Integrity (CDI) software (web-based)
Transcription	Computer, Internet, SVMH remote access system,

	Access to Meditech software (web-based)

ii. HIM Succession Plan

In the event the directors of Health Information Management are unable to fulfill their function or perform their duties, the following role is authorized to assume this leadership role:

- Coding Manager

If above role(s) not available, Incident Command Team will designate another individual.

b. Information Technology (IT)

i. Information Technology has several policies and procedures articulating its continuity of operations plan:

1. Information Management Plan
2. Business Impact Analysis
3. Information Technology Standards and Best Practices
4. Data Backup Plan

ii. IT Succession Plan

1. In the event the Chief Information Officer is unable unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:
    a. IT Manager, followed by
    b. Network Engineering Manager
    c. If above role(s) not available, Incident Command Team will designate another individual

c. Financial Services

i. Financial Services Functions that can be Performed Remotely:

"Remotely" indicates there is capacity to perform the work from home or another computer/device connected to the internet.

Function	**Resources Needed**
Payroll: electronic deposits	Computer, Internet, SVMH remote access system
Accounts Payable: electronic vendor payments	Computer, Internet, SVMH remote access system
Billing	Computer, Internet, SVMH remote access system

ii. **Financial Services Functions to be Performed Onsite:**

"Onsite" indicates at an accessible part of the SVMH campus. In the event the Financial Services office is

unusable during an incident, the department will relocate to an available and appropriate alternate location. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

Function	Available Resources Needed
Patient financial counseling	Computer with internet, phone, printer
Receiving physical mail (invoices, payments)	Computer with internet, phone, printer Would connect with vendors to send invoices electronically. Most payments are received via a PO box and electronically credited to the hospital via a third-party organization. The remaining payments delivered to SVMH's onsite lockbox, if inaccessible, would be considered non-critical.

iii. Financial Services Succession Plan

In the event the Director of Patient Financial Services is unable unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

1. Assistant Director, Patient Financial Services, followed by
2. Manager, Patient Financial Services
3. If above role(s) not available, Incident Command Team will designate another individual

d. Security System

i. All Security Functions will be Performed Onsite

"Onsite" indicates at an accessible part of the SVMH campus. In the event the Security office is unusable during an incident, Security will relocate to an available and appropriate alternate location. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

Function	Needed Resources
Security rounding	Back up radios/batteries from EM supply
Monitor CCTV, Dispatch	Computer, internet, Vigilant software Security has 3 spare laptops for this use. Alternate location: PBX office has same capabilities

ii. Security Succession Plan

In the event the Security Manager is unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

1. HSS Facility Site Supervisor
2. Shift supervisors
3. If above role(s) not available, Incident Command Team will designate another individual

e. Telecommunications

i. All Telecommunications Functions will be Performed Onsite

"Onsite" indicates at an accessible part of the SVMH campus. In the event the Telecommunications office is unusable during an incident, Telecommunications will relocate to an available and appropriate alternate location. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

Function	Needed Resources
Operator	Phone reconfigured to Operator extension Computer, internet (to look up phone numbers)
Door Access Controls (override or lockdown procedures)	Computer, internet, Vigilant software Security has 3 spare laptops for this use, Alternate location: Security office has same capabilities
Managing Emergency Codes (x2222)	Dedicated phone reconfigured to ext. 2222 Computer, Internet Overhead page capability

Note: the Telephone Operator can be assigned another extension. However, both the dedicated line of 2222 and the overhead paging mechanism cannot be relocated due to current technology limitations. The alternate plan in this scenario is to communicate to all staff to call the regular Operator extension ("0") to report a code instead of 2222. To initiate codes, an alternate method of communication will be utilized. Some examples include: Everbridge notices, or via radio communication. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

ii. Telecommunications Succession Plan

In the event the Chief Information Officer is unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

1. Communications Engineering Manager
2. Network Engineering Manager
3. If above role(s) not available, Incident Command Team will designate another individual

f. CEO succession plan:

ABSENCE OF PRESIDENT/CHIEF EXECUTIVE OFFICER policy #1043

N. DISASTER ~~PRIVILEGES~~RECOVERY PLAN

~~During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners as well as those who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration.~~

~~SVHMC has a disaster privileges policy contained in the medical staff by laws and the DISASTER PRIVILEGE POLICY AND PROCEDURE FOR CLINICAL VOLUNTEERS, SVHMC VOLUNTEERS, NON-CLINICAL VOLUNTEERS & NON SVHMC VOLUNTEERS Policy #860.~~

~~Salinas Valley Health Medical Center has a policy and procedure for assigning disaster credentialing and responsibilities to volunteer practitioners. These policy and procedures are contained within the Medical Staff Department. See the Medical Staff Bylaws and or the Disaster Privileges Policy, for more detail regarding Emergency Credentialing of Physicians for the procedure for assigning emergency responsibilities to volunteer practitioners.~~

1. ~~**Granting Disaster Privileges**~~

   ~~The hospital grants disaster privileges to volunteer licensed independent and non-independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.~~

   ~~During disaster situations, members of the community may report to the facility wishing to provide volunteer assistance. Some volunteers may have specific licenses, skills, or qualifications that can be valuable to patient care. These could be physicians or other medical professionals. These volunteers will be directed to the Associates Staging Area and their names provided to the Human Resources Department or in their absence, Nursing Staff Office to verify licensure. If licensure can be verified, the volunteers will be used as necessary in conjunction with hospital staff. If licensure cannot be verified, the volunteers can be used in roles that are not directly related to patient care. Policies regarding emergency credentialing of non-licensed volunteers can be found in Human Resources Department DISASTER PRIVILEGE POLICY AND PROCEDURE FOR CLINICAL VOLUNTEERS, SVHMC VOLUNTEERS, NON-CLINICAL VOLUNTEERS & NON SVHMC VOLUNTEERS Policy 860.~~

2. ~~**Personnel Responsible for Granting these Privileges**~~

   ~~The medical staff identifies, in its bylaws, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.~~

   ~~See Human Resources Department DISASTER PRIVILEGE POLICY AND PROCEDURE FOR CLINICAL VOLUNTEERS, SVHMC VOLUNTEERS, NON-CLINICAL VOLUNTEERS & NON SVHMC VOLUNTEERS Policy 860.~~

3. ~~**Identifying Volunteers from Other Licensed Independent Practitioners**~~

   ~~The hospital determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners. See Human Resources Department DISASTER PRIVILEGE POLICY AND PROCEDURE FOR CLINICAL VOLUNTEERS, SVHMC VOLUNTEERS,~~

NON-CLINICAL VOLUNTEERS & NON SVHMC VOLUNTEERS Policy 860.

4. **Written Observation of Performance**

The medical staff describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, medical record review).

5. **Required Documentation to Verify a Volunteer Practitioner for Privileges**

Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license to practice
- Primary source verification of licensure
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster

6. **Performance Monitored by Staff**

During a disaster, the medical staff oversees the performance of each volunteer licensed independent practitioner.

7. **Determination of Continuation within 72 Hours**

Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.

8. **Verification to be completed in a timely manor**

Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival

- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
- Evidence of the hospital's attempt to perform primary source verification as soon as possible

9. **Extraordinary Circumstances, Verification to happen ASAP**

   If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.

O. EOP EVALUATION AND REVIEW

The hospital evaluates the effectiveness of its emergency management planning activities.

The Chair of the Emergency Management Committee is responsible for performing the annual evaluation of the Emergency Management Program.

The annual evaluation examines the objectives, scope, performance, and effectiveness of the Emergency Management Program. The annual evaluation uses a variety of information sources including the reports from internal policy and procedure review, incident report summaries, EOC Committee Meeting minutes, EOC Committee reports, and summaries of other activities. In addition, findings by outside agencies, such as accrediting or licensing bodies or qualified consultants, are used. The findings of the annual evaluation are presented in a narrative report supported by relevant data. The report provides a balanced summary of the Emergency Management Program's performance over the preceding 12 months. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer term future.

The annual evaluation is presented to the EOC Committee, Quality and Safety Committee, and Executive Leadership who reviews and approves the report. Once the review is finalized, the Emergency Management Committee Chair is responsible for implementing the recommendations in the report as part of the performance improvement process.

1. **Annual Review of the HVA**

   The hospital conducts an annual review of its risks, hazards, and potential emergencies as defined in its hazard vulnerability analysis (HVA). The findings of this review are documented.

   Annually prior to the end of the first quarter, SVHMC conducts an annual evaluation and review of the HVA to ascertain the following:

   - Identified potential emergencies that may inflict the hospital are still valid.
   - An identified potential emergency that may inflict the community is still valid.
   - Probability of occurrence.
   - Potential Risks.
   - Preparedness level.
   - New potential risks.

- ~~Priority level.~~
- ~~Appropriate mitigation, preparedness, response, and recovery strategies for the high risk potential emergencies.~~

2. ~~**Annual Review of the Objectives and Scope of the EOP**~~

   ~~The hospital conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.~~

   ~~Annually prior to the end of the first quarter, SVHMC conducts an annual evaluation and review to ascertain that the objectives and scope of the Emergency Operations Plan are appropriate and in line with the organization's EOP and priority emergencies in the HVA. The annual evaluation process is documented in an annual review report.~~

3. ~~**Annual Review of Inventory**~~

   ~~The hospital conducts an annual review of its inventory. The findings of this review are documented.~~

   ~~Annually prior to the end of the first quarter, SVHMC conducts and documents an annual evaluation and review of the disaster response inventory to ascertain the following:~~

   - ~~Required levels of inventory on hand.~~
   - ~~Potential newly required assets and resources.~~
   - ~~List of purveyors is current.~~
   - ~~Change in demand for fuel, water, food, PPE'S, medications, medical and surgical supplies.~~
   - ~~Review of methodology for inventory process.~~
   - ~~Review of expiration dates for supplies on hand.~~

4. ~~**Review Documentation sent to Senior Leadership for Review**~~

   ~~The annual emergency management planning reviews are forwarded to senior hospital leadership for review.~~

~~P. TRAINING, DRILLS AND EXERCISES~~

1. ~~The hospital evaluates the effectiveness of its Emergency Operations Plan through simulated exercises or actual events.~~
2. ~~**Activation of EOP**~~

   ~~As an emergency response exercise, the hospital activates its Emergency Operations Plan twice a year at each site included in the plan. Unless otherwise stipulated by wavier due to disaster declaration or state of emergency.~~

   ~~SVHMC tests the response phase of its emergency operations plan at least twice a year, either in response to an actual emergency or in planned drills. Actual events are documented in the~~

same manner as planned drills. Drills are planned to test various elements of the Emergency Operation Plan and to test the various Emergency Response Plans for specific priority emergencies. Where practical, drills are planned in conjunction with other hospitals and local Emergency Management agencies.

The main hospital offers emergency services and is a community disaster receiving center that receives patients in community wide disasters. At least one of the drills or events each year evaluates our readiness for such events and seeks to improve our patient care and the safety of victims and patients during such events.

Off-campus sites that are business occupancies participate in at least one drill each year, either as part of the system, or in response to events that would cause them to respond at their location. In addition, some events may call for their staff to be included in hospitals response.

3. **Exercise with and Influx of Patients**

   For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an influx of simulated patients.

4. **Emergency Response with No Community Support**

   For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an escalating event in which the local community is unable to support the hospital.

5. **Emergency Response Participating in a Community-wide Exercise**

   For each site of the hospital with a defined role in its community's response plan, at least one of the two emergency response exercises include participation in a community-wide exercise.

   SVHMC participates in at least one community wide exercise each year, relevant to emergency incidents identified in our hazard vulnerability analysis and the community plans appropriate to our role and designation in the community or regions plans. During each drill we assess the communication, logistics, and function of the organization plans in relation to the community's emergency command structures, and try to find methods to improve the communications, and effectiveness.

6. **Likely Disaster Scenarios for Evaluation of EOP Elements**

   Emergency response exercises incorporate likely disaster scenarios that allow the hospital to evaluate its handling of communications, resources and assets, security, staff, utilities, and patients.

   Exercises are designed to test the EOP and preparations for specific events predicted as high potential events by the HVA priorities and are as realistic as possible. The scenarios and objectives are designed to test the plans, and to objectively measure performance in key issues and activities against our expectations, and to focus improvements where the evidence indicates that are needed. Performance is and will be monitored in terms of timeliness and

effectiveness of staff notification of events, internal and external communications, availability and mobilization of resources, and effective and timely patient management as well as the six critical areas (Communication, Resources and assets, Safety and security, Staff responsibilities, Utilities management, Patient clinical and support activities). Where opportunities for improvement are identified, they will be developed and tested.

7. **Those Designated to Monitor, Document, and Evaluate Performance**

   The hospital designates an individual(s) whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.

   An individual who is not a participant in the exercise and whose sole responsibility is to monitor performance during exercises is assigned to each exercise. This individual is knowledgeable in the goals and expectations of the exercises and documents opportunities for improvements objectively.

8. **Efficacy of Communication**

   During emergency response exercises, the hospital monitors the effectiveness of internal communication and the effectiveness of communication with outside entities such as local government leadership, police, fire, public health officials, and other health care organizations.

   Effectiveness of communication is examined in the exercise critiques and data is aggregated to seek opportunities for improvements. An after-action report is then completed, and an action plan is developed to aid in the improvement process.

9. **Monitoring Resource Mobilization and Asset Allocation**

   During emergency response exercises, the hospital monitors resource mobilization and asset allocation, including equipment, supplies, personal protective equipment, and transportation.

   Effectiveness of resource and asset allocation is examined in the exercise critiques and data is aggregated to seek opportunities for improvements. An after-action report is then completed, and an action plan is developed to aid in the improvement process.

10. **Management of Safety and Security**

    During emergency response exercises, the hospital monitors its management of the following: Safety and security.

    Effectiveness of Safety and Security is examined in the exercise critiques and data is aggregated to seek opportunities for improvements. An after-action report is then completed, and an action plan is developed to aid in the improvement process.

11. **Management of Staff**

    During emergency response exercises, the hospital monitors its management of the following: Staff roles and responsibilities.

    Effectiveness of Staff Roles and Responsibilities is examined in the exercise critiques and data

is aggregated to seek opportunities for improvements. An after-action report is then completed, and an action plan is developed to aid in the improvement process.

12. **Management of Utility Systems**

During emergency response exercises, the hospital monitors its management of the following: Utility systems.

Effectiveness of the hospitals Utilities is examined in the exercise critiques and data is aggregated to seek opportunities for improvements. An after-action report is then completed, and an action plan is developed to aid in the improvement process.

13. **Management of Patient Care Activities**

During emergency response exercises, the hospital monitors its management of the following: Patient clinical and support care activities.

Effectiveness of Patient Clinical and Support Care Activities is examined in the exercise critiques and data is aggregated to seek opportunities for improvements. An after-action report is then completed, and an action plan is developed to aid in the improvement process.

14. **Process Evaluation of All Emergency Response Exercises**

Based on all monitoring activities and observations, including relevant input from all levels of staff affected, the hospital evaluates all emergency response exercises and all responses to actual emergencies using a multidisciplinary process (which includes licensed independent practitioners).

Critique data from the exercises, are also reviewed and critiqued again through the Emergency Management Committee members including representative from administration, clinical services, physicians and support staff. Actual emergencies are also responded to in accordance with the EOP and are documented and critiqued through a multi-disciplinary process.

15. **Deficiencies and Improvement Opportunities**

The evaluation of all emergency response exercises and all responses to actual emergencies includes the identification of deficiencies and opportunities for improvement. This evaluation is documented.
Each exercise is critiqued and identifies deficiencies and opportunities for improvement that are based on monitoring activities, observations and metrics utilized to gauge strengths and weaknesses and they identify deficiencies observed during exercises as well as define opportunities for improvement.

16. **Communication of Deficiencies and Improvement Opportunities to the Improvement Team and Senior Leadership**

The deficiencies and opportunities for improvement, identified in the evaluation of all emergency response exercises and all responses to actual emergencies, are communicated to the improvement team responsible for monitoring environment of care issues and to senior

hospital leadership. From aggregated data that precipitates from exercise critiques and metrics utilized to gauge the effectiveness of exercises, strengths and weaknesses that are identified during exercises are communicated to the EOC and Emergency Management committees.

17. **Modification of the EOP based on Evaluation**

The hospital modifies its Emergency Operations Plan based on its evaluation of emergency response exercises and responses to actual emergencies.

The strengths and weaknesses identified in exercise critiques are utilized to modify the emergency operations plan.

18. **Evaluation of Exercises after EOP Modifications**

Subsequent emergency response exercises reflect modifications and interim measures as described in the modified Emergency Operations Plan.

During exercises, an evaluation is conducted of the effectiveness of the improvements and interim measures that were made in response to critiques from previous exercises.

19. **Education, Performance, and Evaluation**

Education:

The education program provided, addresses new employee orientation and on-going and annual education for all employees (including licensed independent practitioners, who participate and implement the emergency management plan). This education provides information on general emergency management procedures that every employee needs to know in performing their work activities, emergency and event reporting, information related to changes in policies, and specific information related to identifying, reporting and managing emergency situations. Individual departments are responsible for identification and education related to specific department roles, how to recognize specific types of emergencies (possible agents used in chemical or bioterrorist attacks), skills required to perform assigned duties, backup communications and how supplies and equipment are obtained.

The Emergency Management Committee will be responsible for establishing emergency preparedness specific education and training requirements in addition to coordinating drills and exercises for SVHMC.

All employees: Upon hire, every employee will receive information regarding the Emergency Preparedness (EP) Program at hospital orientation and will annually be required to complete the Emergency Preparedness Module in the eLearning Health Stream system.

Management and Leadership Roles: In addition to the annual EP training required for all employees, those staff members in management and leadership roles must complete the following training

- Initial and refresher Hospital Incident Command System (HICS) training

- National Incident Management Systems (NIMS) training

HAZMAT Awareness Level Training: Clinical staff of ED and designated staff of Security and Plant Operations must complete HAZMAT Awareness Level Training and maintain annual competency thereafter.

Decontamination Training: Individuals identified as being part of the Decontamination Team are required to complete the following training:

- Initial Hospital Operations Training
- Annual Decontamination Team Refresher Training

The Education Department, Department Manager, and Emergency Management Committee will periodically revisit their training materials and modify, adjust and improve, as indicated, to reflect: the results of education and training needs assessments as determined through employee knowledge audits, disaster drill performance, organizational experiences, results of risk assessments, hazard surveillance rounds, changes in applicable regulations, and recommendations of the Emergency Management Committee members.

Performance:

Ongoing monitoring of performance regarding actual or potential risk related to one or more of the following:

- Staff knowledge and skills
- Level of staff participation
- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventive maintenance, and testing of equipment are achieved through the routine monitoring of all the activities of EM as well as any reported events or exercises. The Emergency Management Committee and/or its Sub-committees review results of monitoring, education tracking, exercises, and incident evaluations. Identified problems, corrective actions, and significant trends or patterns are communicated to the affected areas and reported to the Hospital Environment of Care Committee.

Evaluation:

Quarterly, a summary and activities reports are submitted to the Environment of Care Committee, Executive Council, and the Quality Management Committee of the Board. The Emergency Management Committee reviews the EOP and the organization's Hazard Vulnerability Analysis on an annual basis. The effectiveness of meeting the scope and functionality of the EOP, the effectiveness of the EOP goals/objectives, and performance improvement initiative(s) and the results are presented in an annual evaluation/report. This evaluation/report is conducted by the Emergency Management Manager and Emergency

~~Management Committee during the 4th quarter of each year and presented to the Environment of Care Committee. A report reflecting all seven Environment of Care areas is presented to the Medical Executive Committee, the Executive Council, and the Quality Management Committee of the Board in the annual Environment of Care Committee report during the following year.~~

1. Strategies for Disaster Recovery Stages

a. Conducting Organization Wide Damage Assessments

An emergency or disaster incident can, by definition, result in damage (to people, to physical infrastructure, utilities, network or communications, etc.). Assessing the damages will be a crucial task following an acute disruption or perhaps periodically throughout a prolonged incident (e.g. earthquake with aftershocks).

Assessing for damage will happen as soon as it is safe to do so, perhaps repeated at appropriate intervals, as determined by the Incident Management Team under the direction of the Incident Commander.

The persons conducting the assessment will be assigned by the Incident Command Team under the direction of the Incident Commander. These persons should have technical expertise in what needs assessing (for example, SVMH Engineers assessing utilities and infrastructure, IT staff assessing network and communications, etc.).

The results of the damage assessment will be used to establish a recovery plan.

Tools for Damage Assessments

i. Recovery Checklist for Hospitals After a Disaster

Referenced on the ASPR Tracie “Recovery Planning” webpage.

b. Restoring Critical Systems and Essential Services

This phase of activities includes the repair and restoration of services to the affected area or facility, in order to render the facility functional and allow the hospital to provide services to the community. Priority would be given to restoring essential services

Tools for Restoring Critical Systems and Essential Services

i. **Information Technology**

1. See #5961 Information Management Disaster Recovery. This documents a formal contingency plan that establishes guidelines for restoring software systems and data.

ii. **Utilities**

1. A number of SVMH procedures detail strategies for restoring critical utilities:
    a. #6004 EMERGENCY GENERATOR FAILURE
    b. #5995 FAILURE OF FIRE ALARM SYSTEM
    c. #6005 FAILURE OF HVAC SYSTEM

d. #5998 FAILURE OF MEDICAL GAS SYSTEM NITROUS OXIDE
e. #5999 FAILURE OF NATURAL GAS SUPPLY
f. #6006 FAILURE OF NURSE CALL SYSTEM
g. #6008 FAILURE OF STEAM DELIVERY BOILERS
h. #6002 FAILURE OF THE COMMUNICATIONS SYSTEM
i. #6001 FAILURE OF THE MEDICAL GAS OXYGEN SYSTEM
j. #6007 FAILURE OF THE SANITARY SEWER SYSTEM
k. #6009 FAILURE OF WATER DISTRIBUTION SYSTEM

iii. Financial Recovery

1. ASPR TRACIE Federal Recovery Programs Guide for Healthcare Organizations

c. Returning to Full Operations

This goal of this phase is to return to normal operations as a whole. The strategy for returning to full operations varies widely depending on the extent of the damage. SVMH could simply be back to full operations as soon as a damaged utility is recovered, for example. On the other hand, a full evacuation of the hospital due to an earthquake might require coordinating efforts with staff, community partners and transportation to return employees and patients to the facility. Returning to full operations might be further divided into stages for example beginning with providing critical access services.

Tools for Returning to Full Operations

- Hospital Repopulation After Evacuation Guidelines and Checklist
  - Source: California Hospital Association
- St. Louis Area Regional Hospital Re-Entry Plan
  - Source: ASPR Tracie “Recovery Planning” webpage

2. Family Reunification

In the event of an emergency or disaster incident, SVMH may need to assist with family reunification and coordinate with community partners to help locate and assist with the identification of adults and unaccompanied children.

Depending on the incident, some strategies SVMH is equipped to employ include:

a. Set up Family Reunification Center

A family reunification center may be set up by the Incident Management Team under the direction of the Incident Commander. The center may need to manage in-person visitors and family, or it may need to accommodate phone calls to family to notify them of patient status and location.

In-Person

- The conference room DRC A/B/C has been identified as a suitable location to manage in-person family and visitors because of its size, privacy, proximity to food, water and restrooms,

and it is well equipped with power outlets for family and visitors to keep phones charged.

- Staff would be deployed to support family and visitors, and collect information about who they are looking for. Ideally, this is accomplished with social workers, chaplain(s) and RNs.
    - **Supporting Resource:** Case Management and Social Services maintain a working document of community resources for patients needing resources beyond the organizations support system. SAM's Guide to Monterey County Family Resources can also be found at www.samsresources.com. A physical copy is also kept in the MCI shed. This is a comprehensive guide to individuals who counsel families in need.
- A Patient Tracking team may also be deployed to continuously update a documented list of SVMH patients and their descriptions (if unidentified), who will coordinate with the family reunification team to bring updates in care and, ultimately, reunify patients and families.

Phone-based

- Concierge's services may be assigned to support the patient information desk staff and assist the public in the family reunification and information center.
- Admitting may be best suited to provide updated lists of patients, assuring all patients are registered appropriately and tracking their location.
- A representative will be appointed to report updates to the Incident Command Team.
- Coordination with the PIO may be necessary to prevent inappropriate release of patient information.

b. Coordinate with the Community

Coordinating with community members may be necessary if, for example, the disaster is widespread, or if victims from an incident are taken to multiple hospitals in the area. The Incident Management Team would:

i. Confirm method of sharing information with the Healthcare Coalition. The ReddiNet Family Reunification module, phones, and even 880 MGH radio are all options.

ii. Appoint staff to be the liaison(s) to the Healthcare Coalition members. These person(s) will provide updated information from the Patient Tracking team.

Q. EDUCATION AND TRAINING PROGRAM

i. SVMH provides training based on its prioritized risks identified in the hazard vulnerability analysis, its emergency operations plan, communication plan, and applicable policies and procedures.

ii. SVMH provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, volunteers, physicians and other licensed practitioners that is consistent with their roles and responsibilities in an emergency. The initial education and training includes:

1. Activation and deactivation of the emergency operations plan
2. Communications plan

3. Emergency response policies and procedures
4. Evacuation, shelter-in place, lockdown and surge procedures
5. Where and how to obtain resources and supplies for emergencies (such as procedures or equipment)

iii. SVMH provides ongoing education and training to all staff, volunteers, physicians and other licensed practitioners that is consistent with their roles and responsibilities in an emergency:

1. At least every two years
2. When roles or responsibilities change
3. When there are significant revisions to the emergency operations plan, policies and/or procedures
4. When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training.

iv. SVMH trains its incident command staff to their specific duties and responsibilities in the incident command structure.

R. TESTING THE EMERGENCY OPERATIONS PLAN

i. SVMH tests its emergency operations plan annually via planned exercises. These exercises are based on the following:

1. Likely emergencies or disaster scenarios
2. Emergency operations plan and policies and procedures
3. After-action reports (AAR) and improvement plans
4. The six critical areas (communications, resources and assets, staffing, patient care activities, utilities, safety and security)
5. The exercise attempt to stress the limits of SVMH emergency response procedures in order to assess how prepared the hospital may be if a real event or disaster were to occur based on past experiences.

ii. SVMH conducts two exercises per year to test the emergency operations plan.

1. One of the exercises consists of an operations-based exercise as follows:
    a. Full-scale, community based exercise; or
    b. Functional, facility-based exercise with a community-based exercise is not possible
    c. The other annual exercise consists of either an operations-based or discussion-based exercise as follows:
        - Full-scale, community based exercise; or
        - Functions, facility-based exercise; or
        - Mock disaster drill; or
        - Tabletop, seminar, or workshop led by a facilitator and includes a

group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

iii. Exercises are documented with an AAR.

iv. Note: if SVMH experiences an actual emergency or disaster incident that is documented, its next operations-based exercise would be waived per regulations.

v. Each accredited freestanding outpatient care building that provides patient care, treatment and services also conducts at least one operations-based OR discussion-based exercise per year to test its emergency response procedures, if not conducted in conjunction with the hospital's emergency exercises.

S. EVALUATING THE PROGRAM AND PLANS

i. The multidisciplinary Emergency Management Committee reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews AARs, identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented.

ii. Review and evaluation addresses the effectiveness of response procedures, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients, as applicable.

iii. The AARs, identified opportunities for improvement, and recommended actions to improve the emergency management program are forwarded to senior hospital leadership for review.

iv. SVMH reviews and makes necessary updates based on AARs or opportunities for improvement to the following items annually:

1. Hazard vulnerability analysis
2. Emergency Management program
3. Emergency operations plan, policies and procedures
4. Communications plan
5. Continuity of operations plan
6. Education and training program
7. Testing program

V. ADDITIONAL RELEVANT POLICIES AND PROCEDURES

A. BIOTERRORISM READINESS PLAN #1789

B. EMERGENCY MANAGEMENT FOR MASS CASUALTY INCIDENTS (MCI), INCLUDING DECONTAMINATION Policy #1102

C. Nutrition Services Disaster Plan Policy #5866

D. Laboratory Disruption of Services/Disaster Plan Policy #2628

VI. REFERENCES

A. ~~The Joint Commission~~The Joint Commission, Emergency Management Chapter

~~Centers for Medicare & Medicaid Services~~

~~OSHA Best Practices for Hospital Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances~~

B. Department of Human Health Services ASPER TRACIE: Healthcare Emergency Preparedness Information Gateway: https://asprtracie.hhs.gov/

C. ASPR Tracie "Recovery Planning" webpage.

D. ~~Title 8 California Code of Regulations §5192(q) Hazardous Waste Operations and Emergency Response~~
Title 8 California Code of Regulations §5192(q) Hazardous Waste Operations and Emergency Response ~~https://www.caloes.ca.gov/CaliforniaSpecializedTraininginstituteSite/Documents/C-%A75192.pdf~~https://www.caloes.ca.gov/CaliforniaSpecializedTraininginstituteSite/Documents/C-%A75192.pdf

E. ~~National Incident Management System (NIMS)~~National Incident Management System (NIMS) https://www.fema.gov/emergency-managers/nims

F. CAL OSHA PPE Stockpiling Requirement (Assembly Bill No. 2537)

Attachments

Attachment A: Hazard and Vulnerability Analysis (Main Hospital Block)

Attachment B: Hazard Vulnerability Assessment (Taylor Farms Family Health and Wellness Center)

Attachment C: 96 Hour Plan

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
Environment of Care Committee	James Hively: Environmental Health & Safety Manager	03/2023

EM Committee	Laura Zerbe: Facilities Regulatory Compliance and Improvement S	03/2023
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2023
Policy Owner	Earl Strotman: Director Facilities Management & Construction	03/2023

Standards

No standards are associated with this document

History

Edited by Zerbe, Laura: Facilities Regulatory Compliance and Improvement S on 3/8/2023, 6:54PM EST

> Revised to reflect updated TJC emergency management chapter.

Last Approved by Strotman, Earl: Director Facilities Management & Construction on 3/9/2023, 12:16PM EST

> Approved by me. Name changes will come next round.

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 3/9/2023, 5:49PM EST

> Workflow updated

Rejected by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 3/14/2023, 3:16PM EDT

> Earl - Sending back to you to start the corrected approval workflow. Please approve to move forward. Thank you.

Sent for re-approval by Strotman, Earl: Director Facilities Management & Construction on 3/14/2023, 3:20PM EDT

> Approved by me. Name changes will occur next round.

Last Approved by Strotman, Earl: Director Facilities Management & Construction on 3/14/2023, 3:20PM EDT

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 3/15/2023, 12:39PM EDT

> Policy Committee previously approved

Last Approved by Zerbe, Laura: Facilities Regulatory Compliance and Improvement S on 3/23/2023, 4:37PM EDT

Last Approved by Hively, James: Environmental Health & Safety Manager on 3/31/2023, 1:38PM EDT

Comment by DeSalvo, Katherine: Director Medical Staff Services on 4/18/2023, 5:20PM EDT

> This plan should go to Quality and Safety Committee prior to MEC review. Please forward to Aniko Kukla. Thank you.

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/19/2023, 4:47PM EDT

> @Kukla, Aniko: Director Quality & Patient Safety please include in the next QCC agenda and then add a comment here when approved. Thank you.

Comment by DeSalvo, Katherine: Director Medical Staff Services on 5/2/2023, 6:18PM EDT

> This needs to be presented/reviewed and Quality and Safety prior to MEC review.

Comment by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 6:33PM EDT

> will be reviewed 06/01/2023

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 5/11/2023, 2:22PM EDT

> @Kukla, Aniko: Director Quality & Patient Safety can you please take this to QSC and add a comment that it was approved. If we add QSC to the approval flow now it will have to go all the way through one to approve again. Thanks

Comment by Kukla, Aniko: Director Quality & Patient Safety on 5/11/2023, 3:20PM EDT

> @ @Alaga, Rebecca: Regulatory/Accreditation Coordinator. We can approve at the next QSC meeting in June no problem. AK

QAPI PI Project List 2023

Project Year	Status	Project Name	PI Measure with Baseline and Target	Key Change(s) Initiated	Current Project Phase	Prioritization Reason	Primary Effect	Project Leader	Project Sponsor	Clinical PI Specialist Support	Project Start Date	Project End Date
2023	In Progress	Hand Hygiene Improvement	Hand Hygiene Compliance, target 75%	Introduce validation rounding to observe staff protocols	4. Monitor and Control	High volume	Patient Safety	Melissa Dean	Lisa Paulo	Eva Tankesley	1/1/2023	12/31/2023
2023	In Progress	Pain/Opioid Improvement	Decrease the AMA rate among hospitalized inpatients with substance use disorder by 50% during calendar year 2023. Baseline 6%, target 3%, Decrease overdose rates for people recently-released from prison, increase rate of f/up care appts w/in 14 days of release	MAT for inpatients, CIWA protocol redesign, Initiate MAT before release from prison	3. Executing	High-risk	Health Outcomes	Aniko Kukla, Dr. Erica Locke	Dr. Allen Radner	Kathleen Fitzgerald	1/1/2023	12/31/2023
2023	In Progress	Health Equity Program	Health Equity measures collected in each care setting, percent of staff who completed cultural competency training	Define collection of required regulatory data elements, develop cultural competency training	2. Planning	High volume	Health Outcomes	Lilia M Gottfried	Pete Delgado	Toni Rodriguez	1/1/2023	12/31/2023

SCOPE OF QAPI PLAN 2023

No.	Indicator	Source	Services by CoP: Medical Staff	Nursing Services	Anesthesia	Surgical Services	Emergency	Outpatient	Pharmacy	Nutrition Services	Laboratory	Radiology	Nuclear Medicine	Respiratory Care	Rehabilitation	Physical Environment	Discharge Planning	Medical Record Services	Utilization Review	Organ, Tissue, and Eye Procurement	Infection Prevention and Control and Antibiotic Stewardship
	Total Indicators		31	31	18	18	21	10	14	7	19	14	10	10	10	15	5	12	1	8	12
1	Overall Mortality Index	Board Quality Dashboard	X	X	X	X	X		X					X				X		X	X
2	Risk adjusted all cause **sepsis** mortality index	Board Quality Dashboard	X	X	X	X	X		X									X		X	X
3	Never Events Reported CDPH Rate	Board Quality Dashboard	X	X	X	X	X	X	X	X	X	X	X	X	X	X				X	X
4	Medication Errors Rates (Reached Patient) WILL BE RELEASED ONCE DataRIX is implemented 07/2023	Board Quality Dashboard	X	X	X	X	X	X	X												
5	# of Incident Reports WILL BE RELEASED ONCE DataRIX is implemented 07/2023	Board Quality Dashboard	X	X	X	X	X	X	X	X	X	X	X	X	X	X				X	X
6	Employee Safety: Incidents Reported to Cal OSHA	Board Quality Dashboard	X	X	X	X	X	X	X	X	X	X	X	X	X	X				X	X
7	Patient Falls Reported to NDNQI (per 1000 pt days)	Board Quality Dashboard	X	X	X	X	X	X				X	X		X	X					
8	Falls with Injury	Board Quality Dashboard	X	X	X	X	X	X				X	X		X	X					
9	Stage 3, Stage 4, and Unstagable Hospital Acquired Pressure Injury (Reportable) Rate	Board Quality Dashboard	X	X	X	X	X								X	X		X			
10	Catheter Associated Urinary Tract Infection (CAUTI)	Board Quality Dashboard	X	X			X				X										X
11	Central Line Associated Blood Stream Infection (CLABSI)	Board Quality Dashboard	X	X			X				X										X
12	Clostridioides Difficile Infection (Cdiff)	Board Quality Dashboard	X	X			X				X										X
13	Surgical Site Infections	Board Quality Dashboard	X	X	X	X					X							X		X	X
14	Hand Hygiene Housewide Observation Data	Board Quality Dashboard	X	X	X	X	X			X	X	X	X	X	X						X
15	Hand Hygiene Housewide data validation (IP)	Board Quality Dashboard	X	X	X	X	X			X	X	X	X	X	X	X					X
16	30 Day Readmission Rate	Board Quality Dashboard	X	X			X	X	X					X	X		X	X	X		
17	PC-01: Elective Deliveries	Board Quality Dashboard	X	X	X	X												X			
18	PC-02: NTSV- Cesarean Section rates	Board Quality Dashboard	X	X	X	X												X			
19	PC-06: Unexpected Complications in Term Newborns	Board Quality Dashboard	X	X	X	X								X			X	X			X
20	Episiotomy Rates	Board Quality Dashboard	X	X														X			
21	Hypoglycemia e-CQM	Board Quality Dashboard	X	X					X	X	X							X			
22	Stroke (CVA): Door to needle time	Board Quality Dashboard	X	X			X	X	X		X							X			
23	MI: Door to PCI	Board Quality Dashboard	X	X			X	X	X		X							X			
24	OR Percentage of 1st Case on Time Starts	2023 Strategic Plan	X	X	X	X					X	X				X				X	
25	OR Turnover Time	2023 Strategic Plan	X	X	X	X					X	X				X				X	
26	ED Room Efficiencies: Median Length of Stay for non-admits (in min)	Board Quality Dashboard	X	X			X				X	X				X	X				
27	ED Room Efficiencies: Median Time from Admit Decision to Time of Admission to Nursing Unit (in min)	Board Quality Dashboard	X	X			X		X		X	X		X		X					
28	Average of Inpatient HCAHPS Scores	2023 Strategic Plan	X	X	X	X			X	X	X	X	X	X	X	X	X				
29	Average ED Press Ganey Score	2023 Strategic Plan	X	X			X		X		X	X	X			X	X				
30	Average Ambulary HCAHPS Scores	2023 Strategic Plan	X	X				X			X	X	X			X					

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

ADJOURNMENT