WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION

BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Hybrid

Please click the link below to join the webinar:

https://us06web.zoom.us/j/93443061917

Or One tap mobile :

US: +16694449171,,93443061917#

January 25, 2023
5:00 p.m.

Pursuant to PVHCDHC Resolutions adopted monthly, Assembly Bill 361, and guidance from the Santa Cruz County Health Department in response to concerns regarding COVID-19, Board Members of PVHCDHC are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

TRANSLATION SERVICES/SERVICIOS DE TRADUCCIÓN

Spanish language translation is available on an as needed basis. Please make advance arrangements at least three business days before the meeting at by calling at 831.763.6040 or by emailing at info@pvhcd.org

Las sesiones de la Mesa Directiva pueden ser traducidas del inglés al español y del español al inglés. Por favor llame por lo menos tres días hábiles antes de la junta al 831.763.6040 o envíe un correo electrónico a info@.orgpara solicitar interpretación.

ACCOMMODATIONS FOR PERSONS WITH DISABILITIES

The Pajaro Valley Health Care District Hospital Corporation does not discriminate on the basis of disability, and no person shall, by reason of a disability, be denied the benefits of its services, programs, or activities. If you are a person with a disability and wish to participate in the meeting and require special assistance in order to participate, please call 831.763.6040 or email info@pvhcd.org at least three business days in advance of the meeting to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format.

For Public Participation Guidelines, see last page(s) of the agenda.

1. **CALL TO ORDER/ROLL CALL**

2. **PUBLIC COMMENTS REGARDING THE CLOSED SESSION AGENDA WILL ONLY BE ACCEPTED BY THE BOARD AT THIS TIME.**

3. **CLOSED SESSION**

The Board will recess to Closed Session to discuss the matters that follow:

a) Hearings/Reports, Code 1461, 32155
   1. Report of Medical Executive Committee
   2. Report of Medical Staff Credentials Committee
   3. Report of Medical Staff Interdisciplinary Practice Committee
   4. Quality Dashboard – *staff report*

   (Executive Sponsor: Dr. Angel, COS)

b) PUBLIC EMPLOYEE EVALUATION (Government Code Section 54957(b)(1))
   Title: CEO Metrics Assessment Update

6:00 p.m. (Estimated Time)

5. **REPORT OUT OF CLOSED SESSION**

6. **CONSIDERATION OF LATE ADDITIONS TO THE AGENDA**

7. **PUBLIC COMMENT**
This time is set aside for members of the general public to address the Board on any item not on the Board Agenda (not to exceed two minutes), which is within the subject matter jurisdiction of the Board. No action or discussion shall be taken on any item presented except that any Board Member may respond to statements made or questions asked or may ask questions for clarification. All matters of an administrative nature will be referred to staff. All matters relating to Board will be noted in the minutes and may be scheduled for discussion at a future meeting or referred to staff for clarification and report.

8. **COMMENTS FROM BOARD MEMBERS**

9. **REPORT FROM CHIEF EXECUTIVE OFFICER SALYER**

10. **REPORT FROM CHIEF FINANCIAL OFFICER PETERSON**

11. **INFORMATIONAL ITEMS**

A) PRESENTATION BY STRATEGIC PLANNING PARTNER – THE CHARTIS GROUP

12. **CONSENT AGENDA**
Consent items include routine business that does not call for discussion. One roll call vote is taken for all items. Only a Board Member may pull items from Consent to Regular agenda.

Members of the public must request that a Board Member pull an item from the Consent Agenda prior to the start of the meeting.

ACTION ON CONSENT AGENDA

a) Board questions to staff
b) Public Comment
c) Motion to approve Consent Agenda
d) Action by Board/Roll Call Vote

A. RESOLUTION MAKING FINDINGS AND ORDERING THE USE OF TELECONFERENCE MEETINGS OF THE BOARD OF DIRECTORS DUE TO COVID-19, PURSUANT TO THE REQUIREMENTS OF ASSEMBLY BILL 361: AND DIRECT STAFF TO RETURN WITHIN 30 DAYS WITH A NEW RESOLUTION ADDRESSING THE NEED TO CONTINUE HOLDING TELECONFERENCE MEETINGS CONSISTENT WITH THE REQUIREMENTS OF ASSEMBLY BILL 361

B. MOTION APPROVING MINUTES OF DECEMBER 28, 2022

C. MOTION APPROVING QUALITY DASHBOARD – January 2023

D. MOTION APPROVING AGENDA FORMAT – January 2023

E. MOTION APPROVING POLICIES – Policy Summary, January 2023

13. REGULAR AGENDA

A. ELECTION OF OFFICERS

1) Oral Report
2) Board questions to staff
3) Public Comment
4) Nomination of Chair
5) Motion electing Chair
6) Nomination of Vice Chair
7) Election of Vice Chair
8) Nomination of Secretary
9) Motion electing Secretary
10) Nomination of Treasurer
11) Motion Electing Treasurer

B. REPORT ON BEHALF OF MEDICAL COMMITTEES ON THE FOLLOWING REPORTS – CREDENTIALS, IDP, JAN 2023

1) Board questions to staff
2) Public Comment
3) Motion approving MEC Report, Credentials Report of January 2023 & Interdisciplinary Practice Credentials Report of January 2023

C. CONSIDERATION OF CONTRACT AGREEMENT WITH GROUP PURCHASING ORGANIZATION, VIZIENT INC.

1) Oral Report by COO Vranjes
2) Board questions to staff
3) Public Comment
4) Motion approving staff recommendation to execute Agreement with Vizient, Inc.

D. CONSIDERATION OF AMENDED AND RESTATED BYLAWS OF HOSPITAL CORPORATION

1) Oral Report by CEO Salyer
2) Board questions to staff
3) Public Comment
4) Motion approving amended restated bylaws

E. CONSIDERATION OF PROPOSED ENGAGEMENT AGREEMENT WITH THE CHARTIS GROUP – STRATEGIC PLANNING

5) Discussion following Chartis Presentation
6) Board questions to staff
7) Public Comment
8) Motion approving proposed Engagement Agreement

14. ADJOURNMENT

Agenda documents are available for review in person at Watsonville Community Hospital, 75 Nielson Street, Hospital Main Lobby-Visitors Desk; and electronically on the Pajaro Valley Healthcare District's website, at: PVHCHC.ORG

To view online, visit the Board's website at: PVHCHC.ORG and select the meeting date to view the agenda and supporting documents.

This agenda was posted in accordance with the California Brown Act. Any materials related to an item on this Agenda submitted to the Board after distribution of the agenda packet will be made available to the public in accordance with Government Section 54957.5.

RELATED CORRESPONDENCE -

Written comments on agenda items may also be submitted to the Board by email or US Mail

Email: info@pvhcd.org

- Emailed documents may take up to 24 hours to be posted
- Please include the agenda item number

U.S. Mail:
PVHCD Board of Directors
75 Nielson Street

Watsonville, CA 95076

Comments received after 4 p.m. the day of the meeting and before the end of the meeting will be included with the minutes record.

For additional information, call 831.763.6040 or email info@pvhcd.org

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Public Participation Guidelines

PUBLIC COMMENT

Participating in Person:

The meeting space is open with limited capacity. Face coverings are highly recommended in the meeting space, regardless of vaccination status. To address the Board, please line up at the podium when the Board Chair calls for general public comment or calls for public comment on the regular agenda item to which you would like to speak. Please state your name clearly for the record before making your comment and limit your remarks to the allotted time.

Participating by Phone:

To address the Board, dial the telephone number provided and you will be prompted to enter the meeting ID number. After that, you will be able to listen to the meeting and speak during public comment as announced by the Chair. The Clerk will call on people by the last four digits of their phone number.

The following commands can be entered via DTMF tones using your phone's dial pad while in a Zoom meeting:

- ***6** - Toggle mute/unmute
- ***9** - Raise hand

Participating online via Zoom:

You may download the Zoom client or connect to the meeting in-browser. If using your browser, make sure you are using a current, up-to-date browser: Chrome 30+, Firefox 27+, Microsoft Edge 12+, Safari 7+. Certain functionality may be disabled in older browsers including Internet Explorer.

You will be asked to enter an email address and name. **Please identify yourself by any name** you choose (you are not required to state your real name to participate) as this appears online and is how we notify you when it is your turn to speak.

When the Board Chair calls for the item on which you wish to speak, click on "raise hand." The Clerk will activate and unmute speakers in turn. Speakers will be notified shortly before they are called to speak.

When called, please limit your remarks to the time allotted.

Watsonville Community Hospital
Consolidated Income Statement
For The Month of December 31, 2022

	Sep-22	Oct-22	Nov-22	Dec-22	Sep-Dec YTD	Dec v PM
Inpatient Revenue	32,985,779	30,531,597	27,355,169	32,334,156	123,206,701	4,978,987
Outpatient Revenue	51,111,993	52,131,349	52,238,996	49,439,769	204,922,107	(2,799,227)
QAF	1,686,268	1,686,268	1,686,268	1,686,268	6,745,070	-
Disproportionate Share DSH	108,462	108,462	108,462	108,462	433,847	-
Total Revenue	85,892,501	84,457,675	81,388,894	83,568,654	335,307,726	2,179,760
Deductions From Revenue:						
Contractual Allowances	73,961,016	71,101,042	70,788,379	72,878,907	288,729,346	2,090,528
Total Deductions From Rev	73,961,016	71,101,042	70,788,379	72,878,907	288,729,346	2,090,528
Net Revenue	11,931,485	13,356,633	10,600,515	10,689,747	46,578,380	89,232
Provision for Bad Debts	428,003	635,356	262,067	(211,708)	1,113,718	(473,775)
Collectible Patient Revenue	11,503,482	12,721,277	10,338,448	10,901,455	45,464,662	563,007
Other Revenue	115,757	91,107	61,210	96,831	364,905	35,621
Total Net Operational Revenue	11,619,239	12,812,384	10,399,658	10,998,286	45,829,567	598,628
Salaries & Wages	5,223,977	5,516,333	5,532,471	6,044,081	22,316,862	511,610
Employee Benefits	2,263,894	2,284,473	891,434	652,817	6,092,618	(238,617)
Registry	754,158	677,821	432,443	550,193	2,414,615	117,750
Labor Subtotal	8,242,029	8,478,627	6,856,348	7,247,091	30,824,095	390,743
Professional Fees Medical	737,060	765,919	654,876	718,204	2,876,059	63,328
Supplies	870,221	835,981	989,187	988,489	3,683,878	(698)
Repairs & Maintenance	89,300	45,704	105,305	74,932	315,241	(30,373)
Utilities	156,873	163,596	198,151	194,124	712,744	(4,027)
Purchased Services	1,247,768	1,274,674	1,676,050	1,361,661	5,560,153	(314,389)
Lease Cost and Rent	95,396	96,762	87,951	111,816	391,925	23,865
Property Taxes & Insurance	187,979	308,378	208,263	27,201	731,821	(181,062)
Other Expenses	633,703	625,548	636,707	663,295	2,559,253	26,588
Management Fees	57,139	75,000	75,000	75,000	282,139	-
Total Operating Exp	12,317,468	12,670,189	11,487,838	11,461,813	47,937,308	(26,025)
EBITDA	(698,229)	142,195	(1,088,180)	(463,527)	(2,107,741)	624,653
Depreciation & Amortization	96,239	96,248	96,182	96,117	384,786	(65)
Interest/ Grants	393,144	399,529	393,391	393,391	1,579,455	-
Total Other Expenses	489,383	495,777	489,573	489,508	1,964,241	(65)
Net Income/Loss from Operations	(1,187,612)	(353,582)	(1,577,753)	(953,035)	(4,071,982)	624,718

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

Board Memo

Executive Sponsor: Steven Salyer, CEO

Agenda Item: AB 361 Resolution Authorizing Teleconference Meetings

Meeting Date: January 25, 2023

Recommended Actions:
Resolution authorizing making findings and ordering the use of teleconference meetings of the Board of Directors due to COVID-19, pursuant to the requirements of Assembly Bill 361; and Direct Staff to return within 30 days with a new resolution addressing the need to continue holding teleconference meetings consistent with the requirements of Assembly Bill 361.

Executive Summary
As a result of the continuing impacts of the COVID-19 pandemic, many local agencies have been holding teleconference meetings under the modified rules authorized under Assembly Bill 361. This item asks the Board to adopt a resolution ordering the use of teleconference meetings under the modified rules. This will allow Hospital Board members to appear at meetings remotely if they choose to do so.

Background
On March 4, 2020, Governor Newsom issued a Proclamation of State of Emergency in response to the COVID-19 pandemic pursuant to Government Code section 8550 et seq., which remains in effect. Assembly Bill 361 ("AB 361") allows legislative bodies to hold teleconference meetings during declared emergencies as long as they follow designated rules, and the legislative body routinely reviews the need to continue holding such teleconference meetings.

On September 30, 2021, Santa Cruz County Public Health Officer Dr. Gail Newel issued a strong recommendation that legislative bodies in Santa Cruz County continue to engage in physical/social distancing by meeting via teleconference as allowed by AB 361 and confirmed that she will regularly review and reconsider this recommendation and notify the public when it is no longer recommended. Dr. Newel's recommendation remains in effect.

Analysis
Many local legislative bodies have recognized that COVID-19 presents a continuing threat to the Santa Cruz County community and that there is an important governmental interest in protecting the health, safety, and welfare of those who participate in public meetings. Requiring all members of legislative bodies to appear in-person at meetings presents greater risk to the health and safety of meeting participants, including reduced social distancing among people of different communities, increased exposure for those who are immunocompromised or unvaccinated, and challenges associated with fully ascertaining and ensuring compliance with vaccination, face coverings, and other safety measures at such public meetings.

Pursuant to AB 361, a legislative body can hold teleconference meetings under the modified AB 361 teleconferencing rules if a state of emergency remains active, or local officials have recommended measures to promote social distancing, as long as the legislative body reconsiders the circumstances of the state of emergency and determines either that the state of emergency continues to directly impact the ability of the members to meet safely in person or that local officials continue to recommend measures to promote social distancing.

The Governor's emergency proclamation has not been lifted and Dr. Newel's social distancing recommendation remains in effect. The dangers presented by returning to non-emergency meeting protocols remain. Staff recommends that the Board adopt the draft resolution accompanying this item, which contains the findings necessary to hold teleconference meetings under the modified Brown Act rules.

Financial Impact
There is no financial impact associated with this item.

Attachment(s)
1. Resolution AB361

BEFORE THE BOARD OF DIRECTORS
OF THE PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION

RESOLUTION NO._____

On the motion of Director
Duly seconded by Director
The following resolution is adopted.

RESOLUTION AUTHORIZING TELECONFERENCE MEETINGS UNDER ASSEMBLY BILL 361 AS A RESULT OF THE CONTINUING COVID-19 PANDEMIC STATE OF EMERGENCY AND HEALTH OFFICER RECOMMENDATION FOR SOCIAL DISTANCING

WHEREAS, on March 4, 2020, Governor Newsom issued a Proclamation of State of Emergency in response to the COVID-19 pandemic pursuant to California Government Code section 8550 et seq., which remains in effect; and

WHEREAS, on March 17, 2020, Governor Newsom issued Executive Order N-29-20 that suspended the teleconferencing rules set forth in the California Open Meeting law, known as the Ralph M. Brown Act, and codified in California Government Code section 54950 et seq., provided that certain requirements were met and followed; and

WHEREAS, on June 11, 2021, Governor Newsom issued Executive Order N-08-21 which further extended the suspension of the teleconferencing rules set forth in the Brown Act and clarified that the provisions issued in N-29-20 would remain in effect through September 30, 2021; and

WHEREAS, on September 16, 2021, Governor Newsom signed Assembly Bill 361 ("AB 361"), which amended Government Code section 54953 to permit legislative bodies subject to the Brown Act to continue to meet under modified teleconferencing rules provided that they comply with specific requirements set forth in the statute; and

WHEREAS, pursuant to AB 361, a legislative body may hold an initial teleconference meeting under the modified teleconferencing rules during a proclaimed state of emergency where local officials have imposed or recommended measures to promote social distancing; and

WHEREAS, on September 30, 2021, Santa Cruz County Public Health Officer Dr. Gail Newel strongly recommended that legislative bodies in Santa Cruz County continue to engage in physical/social distancing by meeting via teleconference as allowed by AB 361 and confirmed that she will regularly review and reconsider this recommendation and notify the public when it is no longer recommended; and

WHEREAS, after its initial AB 361 teleconference meeting, a legislative body can continue to hold such teleconference meetings if a state of emergency remains active, or local officials have recommended measures to promote social distancing, if the legislative body has reconsidered the circumstances of the state of emergency and determined either that the state of emergency continues to directly impact the ability of the members to meet safely in person or that local officials continue to recommend measures to promote social distancing; and

WHEREAS, the findings set forth in the paragraph immediately above must be made within 30 days of the date the legislative body first held a teleconferenced meeting pursuant to AB 361, and every 30 days thereafter, for as long as the legislative body wishes to hold such teleconference meetings; and

WHEREAS, the Hospital has an important governmental interest in protecting the health, safety, and welfare of those who participate in meetings of the Hospital Board of Directors; and

WHEREAS, this Board finds that there is a continuing threat of COVID-19 to the community and finds that requiring all Board members to appear in-person at meetings presents greater risk to the health and safety of meeting participants stemming from reduced social distancing among people of different communities, increased exposure for those who are immunocompromised or unvaccinated, and challenges associated with fully ascertaining and ensuring compliance with vaccination, face coverings, and other safety measures at such public meetings; and

WHEREAS, this Board meets in-person in a facility where other functions take place, such that increasing the number of people present may impair the safety of participants and members of the public; and

WHEREAS, as required by AB 361, this Board has considered the circumstances of the current state of emergency and finds that the COVID-19 pandemic continues to directly impact the ability of Board members to meet safely in person and further finds that the Santa Cruz County Public Health Officer continues to recommend measures to promote social distancing; and

WHEREAS, in the interest of public health and safety, due to the emergency caused by the spread of COVID-19 the Board of Directors deems it necessary to utilize the modified teleconferencing rules set forth in AB 361.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF THE PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION HEREBY RESOLVES AND ORDERS AS FOLLOWS:

Section 1. The foregoing recitals are adopted as findings of the Board of Directors as set forth within the body of this Resolution.

Section 2. Effective immediately, for the next 30 days the Board of Directors will meet using the modified teleconference rules authorized under AB 361 and Government Code section 54953(e)(3).

Section 3. Staff is directed to return no later than thirty (30) days after the adoption of this Resolution with an item requesting the Board to reconsider the circumstances of the COVID-19 state of emergency and, if necessary, consider adoption of a subsequent Resolution to continue using the modified teleconference rules for meetings in accordance with Government Code section 54953(e)(3).

Section 4. Staff is authorized and directed to take all such other necessary or appropriate actions to implement the intent and purposes of this Resolution.

PASSED AND ADOPTED by the Board of Directors of the Pajaro Valley Health Care District Hospital Corporation this _____day of _____, 2022, by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
Chair, Board of Directors

ATTEST:

_____
Clerk of the Board

APPROVED AS TO FORM:

_____
PVHCDHC Counsel

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION

BOARD OF DIRECTORS

REGULAR MEETING MINUTES

December 28, 2022

5:01 p.m.

Meeting was held in virtual format

ZOOM LINK https://zoom.us/j/93443061917

1. **CALL TO ORDER/ROLL CALL**
   Directors Gallagher, Pimentel, and Chair Friel were present.

2. **PUBLIC COMMENTS REGARDING THE CLOSED SESSION-None**

3. **CLOSED SESSION**
   Directors Gabriel-Cox and Nuñez arrived for Closed Session.

   The Board recessed to Closed Session at 5:04 p.m. to discuss the matters that follow:

   a) Hearings/Reports, Code 1461, 32155
      1. Report of Patient Safety and Quality Committee
      2. Report of Medical Staff Credentials Committee
      3. Report of Medical Staff Interdisciplinary Practice Committee
      4. Quality Dashboard – *staff report*

      (Executive Sponsor: Dr. Angel, COS)

6:03 p.m.

4. **REPORT OUT OF CLOSED SESSION**
   Chair Friel reported that the Board received reports.

5. **CONSIDERATION OF LATE ADDITIONS TO THE AGENDA-None**

6. **PUBLIC COMMENT-None**

7. **COMMENTS FROM BOARD MEMBERS-None**

8. REPORT FROM CHIEF EXECUTIVE OFFICER SALYER

CEO introduced Julie Peterson, new CFO for WCH. CEO Salyer gave an operational update of hospital activities.

June Ponce, Dir of Marketing, Growth & Outreach, gave a report on activities and events for Hospital staff.

CFO Peterson provided financial report and presented Income Statement for Sept – Nov 2022.

9. CONSENT AGENDA

ACTION ON CONSENT AGENDA

a) Board questions to staff
b) Public Comment-None
c) **MOTION:** Director Pimentel made a motion to approve the Consent Agenda, seconded by Director Gabriel-Cox, and carried by the following vote:
d) **Action by Board/Roll Call Vote**

AYES:	Gabriel-Cox, Gallagher, Nuñez, Pimentel, Friel
NOES:	None
ABSENT:	None

A. RESOLUTION NO. 17-2022
RESOLUTION MAKING FINDINGS AND ORDERING THE USE OF TELECONFERENCE MEETINGS OF THE BOARD OF DIRECTORS DUE TO COVID-19, PURSUANT TO THE REQUIREMENTS OF ASSEMBLY BILL 361: AND DIRECT STAFF TO RETURN WITHIN 30 DAYS WITH A NEW RESOLUTION ADDRESSING THE NEED TO CONTINUE HOLDING TELECONFERENCE MEETINGS CONSISTENT WITH THE REQUIREMENTS OF ASSEMBLY BILL 361

B. MOTION APPROVING MINUTES OF NOVEMBER 30, 2022

C. RESOLUTION APPROVING RESTATED & AMENDED 401(A) PLAN TO INCLUDE PHARMACISTS AND NURSING SUPERVISORS IN THE EMPLOYER CONTRIBUTION

D. MOTION APPROVING OF QUALITY DASHBOARD – December 2022

E. MOTION APPROVING POLICIES – Policy Summary, December 2022

10. REGULAR AGENDA

A. CONSIDERATION OF APPROVAL OF REPORT ON BEHALF OF MEDICAL COMMITTEES ON THE FOLLOWING REPORTS

1) Oral Report
2) Board questions to staff
3) Public Comment
4) Motion approving MEC Report, Credentials Report of December 2022 & Interdisciplinary Practice Credentials Report of December 2022

MOTION: Director Nuñez made a motion to approve the Interdisciplinary Practice Credentials Report and Credentials Report of December 2022. The motion was seconded by Director Gabriel-Cox and carried by the following vote:

AYES: Gabriel-Cox, Gallagher, Nuñez, Pimentel, Friel
NOES: None
ABSENT: None

B. CONSIDERATION OF APPROVAL OF 2023 BUDGET

1) Report by Julie Peterson, CFO
2) Board questions to staff
3) Public Comment
4) Motion to approve 2023 Budget
5) Action by Board/Roll Call Vote

MOTION: Director Nuñez made a motion to approve the Interdisciplinary Practice Credentials Report and Credentials Report of November 2022. The motion was seconded by Director Gabriel-Cox and carried by the following vote:

AYES: Gabriel-Cox, Gallagher, Nuñez, Pimentel, Friel
NOES: None
ABSENT: None

11. ADJOURNMENT

The meeting was adjourned at 6:46 p.m.

Approved: _____

John Friel, Chair

Attest: _____

Beatriz Vázquez Flores, Clerk of the Board

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

Board Memo

Executive Sponsor: Steven Salyer, CEO
Agenda Item: Revised Agenda Format
Meeting Date: January 23, 2023

Recommended Actions

a) Approve the use of the attached branding for documents related to the Pajaro Valley Health Care District Hospital Corporation.
b) Approve the use of the attached updated Agenda format for PVHCDHC board and subcommittee meetings, including the use of a Consent Agenda for non-controversial items that do not require individual staff presentations.
c) Approve the use of a separate Agenda for Closed Session.
d) Authorize the Chief Executive Officer in consultation with the Chair of the Board to change the agenda format if it is determined that a certain agenda requires a different order of business.

Executive Summary

Staff recommends that the Board approve the use of the revised attached PVHCDHC branding and Agenda format for PVHCDHC Board and Subcommittee meetings. The Board will retain discretion to change the format to suit its needs over time.

Background/Analysis

The Board has discretion on how it conducts business and organizes its agendas. The proposed agenda is based on industry best practices for meeting management and sound records management.

Listed below are the main revisions:

1. Revised branding to distinguish boards and help with clarity.
2. Action format agenda distinguishes activity requested and executive contact or sponsor, owner.
3. Using clear phraseology provides the board, staff and the public with consistency and transparent access to public information.

Financial Impact

There is no financial impact associated with this item.

Attachment

A. Branding

B. Agenda Format SAMPLE

Watsonville Community Hospital Monthly Quality Report

January 2023

Tracy Trail-Mahan MS RN PMGT-BC CPHQ
Director of Quality, Risk and Patient safety

WATSONVILLE COMMUNITY HOSPITAL

Regulatory Activity

- CDPH CHOW completed December 19, 2022
- CDPH CA00808745 self-report review HAPI device related injuries review November 29th =no findings

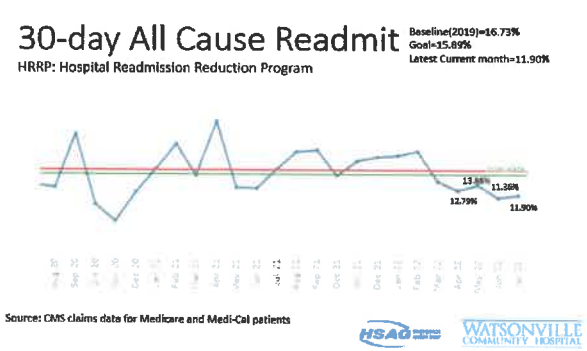
- TJC Lab Survey window opens April 23, 2023

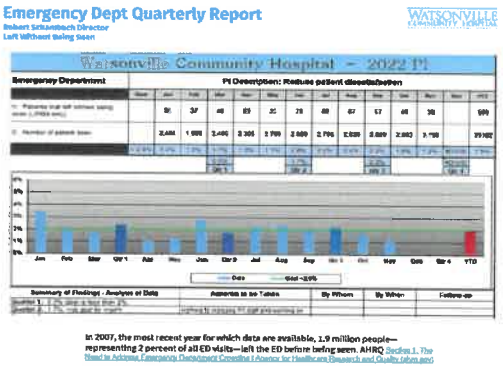
WATSONVILLE COMMUNITY HOSPITAL

PVHCD Monthly Quality Report

WATSONVILLE COMMUNITY HOSPITAL

Element	Source	Time lag
Payor Metrics(admits, discharges, ALOS, GMLOS, variance, CMI) Overall. Service line data reporting begin Jan 2023 (KP, USACS)	WCH Mei Luu reports (MedHost)	1 months October report reflective of Sept data **Defer to CFO**
All cause 30-day readmissions	HSAG (Medicare/Medi-Cal claims data)	6 month
All cause 30-day mortality	HSAG (Medicare/Medi-Cal claims data)	3 month
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Patient Satisfaction Data	Press Ganey Patient surveys	1 quarter
Fall rate per 1K/pt. days	WCH QA/Risk dept	current
HAPI rate per 1/pt. days	WCH QA/Risk dept (begin reporting Dec 2022)	current
ED LWBS	WCH ED	1 month
IP Dashboard HAIs, Hand hygiene	WCH IP/QA **(launch Q1 2023)**	





Item 12D

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Members

- John Friel (Chair)
- Dr. Katherine (Katie) Gabriel-Cox
- Dr. Joe Gallagher
- Jose A. (Tony) Nuñez
- Marcus Pimentel

Regular Meeting Agenda

Day, February XX, 2023

5:00 pm

Zoom: https://zoom.us/j/93443061917

Phone: +1 669 900 9128 WEBINAR ID: 934 4306 1917

Meeting Address

Pursuant to Pajaro Valley Health Care District Hospital Corporation (PVHCDHC) Resolutions adopted monthly, Assembly Bill 361, and guidance from the Santa Cruz County Health Department in response to concerns regarding COVID-19, Board Members of PVHCDHC are permitted to participate in this duly noticed public meeting via teleconference and certain requirements of The Brown Act are suspended.

TRANSLATION SERVICES/SERVICIOS DE TRADUCCIÓN
Spanish language translation is available on an as needed basis. Please make advance arrangements at least three business days before the meeting at by calling at (831) 763.6040 or by emailing at info@pvhcd.org

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The Pajaro Valley Health Care District Hospital Corporation does not discriminate on the basis of disability, and no person shall, by reason of a disability, be denied the benefits of its services, programs, or activities. If you are a person with a disability and wish to participate in the meeting and require special assistance in order to participate, please call (831)763-6040 or email info@pvhcd.org at least three business days in advance of the meeting to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format.

Agenda documents are available for review in person at Watsonville Community Hospital, 75 Nielson Street, Hospital Main Lobby-Visitors Desk; and electronically on the Pajaro Valley Healthcare District's website, at: PVHCHC.ORG.
To view online, visit the Board's website at: PVHCHC.ORG and select the meeting date to view the agenda and supporting documents. Written comments on agenda items may also be submitted to the Board by email or US Mail. Comments received after 4 p.m. the day of the meeting and before the end of the meeting will be included with the minutes record.

Email: info@pvhcd.org
- Emailed documents may take up to 24 hours to be posted
- Please include the agenda item number

U.S. Mail:
PVHCD Board of Directors
75 Nielson Street
Watsonville, CA 95076

For additional information, call 831.763.6040 or email info@pvhcd.org

Pajaro Valley Health Care District Hospital Corporation
Regular Meeting Agenda- Day, February XX, 2023

Call to Order/Roll Call

Closed Session Report

Agenda Modification Consideration

Public Comment on Matters Not on the Agenda

Time is set aside for members of the public to address the Board on any item not on the Board Agenda (not to exceed two minutes), which is within the subject matter jurisdiction of the Board.

Comments regarding items included on the Agenda will be heard before the item is discussed by the Board.

No action or discussion shall be taken on any item presented except that any Board Member may respond to statements made or questions asked or may ask questions for clarification. All matters of an administrative nature will be referred to staff. All matters relating to Board will be noted in the minutes and may be scheduled for discussion at a future meeting or referred to staff for clarification and report.

Comments From Chief Executive Officer Steven Salyer

Comments from Board Members

Consent Agenda

All items listed under the Consent Calendar are considered and acted upon by one Motion. Members of the public must request that a Board Member pull an item from the Consent Agenda for discussion prior to the start of the meeting.

1. **Assembly Bill 361 Approving the Use of Teleconference Meetings for Board of Directors**
   Recommendation: Pass a **Resolution** making findings and ordering the use of Teleconference Meetings of the Board of Directors due to Covid-19, pursuant to the requirements of Assembly Bill 36.
   Contact: Dawn Bullwinkel, Interim Board Clerk, dbullwinkel@watsonvillehospital.com

2. **Minute Approval: November 30, 2022**
   Recommendation: Pass a **Motion** approving the minutes of the November 30, 2022.
   Contact: Dawn Bullwinkel, Interim Board Clerk, dbullwinkel@watsonvillehospital.com

3. **Restated & Amended 401(a) Plan**
   Recommendation: Pass a **Resolution** approving the restated and amended 401 (a) Plan to include pharmacists and nursing supervisor in the Employer Contribution.
   Contact: Allyson Hauck, CHRO

4. **Watsonville Community Hospital Monthly Quality Report December 2022**
   Recommendation: Pass a **Resolution** approving the Watsonville Community Hospital Monthly Quality for December 2022.
   Contact: Tracy Trail-Mahan MS RN PMGT-BC CPHQ, Director of Quality, Risk and Patient Safety

5. **Policy Updates: December 28,2022**
   Recommendation: Pass a **Motion** approving policy updates for December 28, 2022 as required under Title, 22, CMS and the Joint Commission (TJC).
   Contact: Tracy Trail-Mahan MS RN PMGT-BC CPHQ Director of Quality, Risk and Patient safety

Discussion Agenda

6. **Medical Committees Reports Report December 2022**
   Recommendation: Pass a **Motion** approving the MEC Report, the Credentials Report and the Interdisciplinary Practice Credentials Report of December 2022.
   Contact: Clay Angel, M.D., Chief of Staff Chair, Medical Executive Committee

7. **2023 Budget to the Pajaro Valley Health Care District Hospital Corporation.**
   Recommendation: Pass a **Motion** approving the 2023 Budget to the Pajaro Valley Health Care District Hospital Corporation.
   Contact: Julie Peterson, CFO

Adjournment

This agenda was posted in accordance with the California Brown Act. Any materials related to an item on this Agenda submitted to the Board after distribution of the agenda packet will be made available to the public in accordance with Government Section 54957.5.

The Pajaro Valley Health Care District Hospital Corporation

Branding

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

POLICY APPROVAL SUMMARY REPORT

Committee: Board of Directors

Reporting Period: January 2023

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 request your approval.

Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Facility (FAC)				
Staffing Policy	PO1004	Template updated. Changed wording from 2 FTE on weekend to 1 FTE on weekends as is current in Department. Only minor changes	Regulary scheduled review	Author: Facility Director 11/2022 *12/2022 VP/Sr.Leader/CEO: 01/10/2023 MEC: N/A BOT:
Absenteeism and Tardiness Call-In Procedure Policy	PO1005	New Template, No changes	Regulary scheduled review	Author: Facility Director 11/2022 VP/Sr.Leader/CEO: 01/10/2023 MEC: N/A BOT:
Dress Code Policy	PO1006	New Template, No changes	Regulary scheduled review	Author: Facility Director :11/2022 *12-2022 VP/Sr.Leader/CEO: 01/10/2023 MEC: N/A BOT:
Overtime & Call Pay Policy	PO1009	New Template, No changes	Regulary scheduled review	Author: Facility Director :11/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Equipment Repair & Service Requests Policy	PO1010	New Template, minor changes, Plant Operations to Facilities	Regulary scheduled review	Author: Facility Director :11/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

POLICY APPROVAL SUMMARY REPORT

Committee: Board of Directors

Reporting Period: January 2023

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 request your approval.

Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Personal Phone Calls Policy	PO1012	New Template, updated wording to read Facilities Director instead of Director of Plant Operations. if this policy is redundant, please sunset	Regulary scheduled review	Author: Facility Director :11/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Use of Hospital Vehicles Policy	PO1015	New Template, changed wording to Facilities Director from Director of Plant Ops	Regulary scheduled review	Author: Facility Director :11/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Service Contracts Policy	PO1016	New Template, remove CHS from wording, change Director of Plant Ops. to Facilities Director, change CMMS to Work Order System	Regulary scheduled review	Author: Facility Director :11/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Emergency Operations Plan Policy	PO2001	New Template. updated Facilities Director from Director of Plant Ops. as well as TJC EM reference.	Regulary scheduled review	Author: Facility Director :11/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Floor Plan Policy	PO2002	New Template, changed Plant Operations Director to Facilities Director	Regulary scheduled review	Author: Facility Director :11/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

POLICY APPROVAL SUMMARY REPORT

Committee: Board of Directors

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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 request your approval.

Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Key and Access Management	PO2003	New Template, minor verbiage updated	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Environmental Maintenance Policy	PO2005	New Template, minor grammatical changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Environmental Maintenance Non Patient Care Area	PO2006	New Template. No Changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Environmental Maintenance Mechanical Area	PO2008	New Template. No Changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Maintenance and Inspection Fire Warning and Safety System	PO2010	New Template. No Changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

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Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Maintenance and Inspection Electrical Distribution System and Emergency Generator	PO2011	New Template. No Changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Emergency Generator Load Testing	PO2012	New Template, minor changes, updated tjc reference numbers.	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Maintenance and Inspection of HVAC System	PO2013	New Template, minor updates	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Maintenance and Inspection Water Distribution and Plumbing System	PO2014	New template, Minor changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Maintenance and Inspection Boiler Steam System	PO2015	New Template, minor updtaes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

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Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Maintenance and Inspection Medical Gas System	PO2016	New Template, No changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A
Maintenance and Inspection Medical Surgical Air and Vacuum System	PO2017	New Template, minor changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Domestic Water Temperature	PO2018	New Template. No Changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Scheduled Equipment Maintenance	PO2019	New Template, minor changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
New Equipment Inventory and Inspection Policy	PO2020	New template, some updates made including reference EC in body of policy	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

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Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Equipment & Problem Identification	PO2021	New Template. minor changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Renovation and Construction	PO2022	New Template, minor changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Regulations for Contractors	PO2023	New Template, minor changes and grammar updates	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Construction Smoking Policy	PO2024	New Template, minor changes	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Relocation of Equipment and Furniture	PO2025	New Template, minor	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

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Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Interior Furnishings, Finishes and Flooring Requirements	PO2026	New Template, minor updates	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Use of Personal Electronic Equipment	PO2028	New Template, minor changes	Regulary scheduled review	Author: Facility Director : 12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Vehicle Access and Parking Areas	PO2029	New Template, some updates made, employee parking lot one side always closed	Regulary scheduled review	Author: Facility Director :12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Utility System Failure Reporting	PO2030	New Template, minor changes	Regulary scheduled review	Author: Facility Director : 12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Use of Portable Air Conditioning Units	PO2031	New Template, minor update	Regulary scheduled review	Author: Facility Director : 12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

POLICY APPROVAL SUMMARY REPORT

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Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Operational Guideline for Water Treatment	PO2032	New Template, minor updates	Regulary scheduled review	Author: Facility Director :11/2022 **12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Use of Emergency Generators for Cogeneration	PO2033	New Template, minor updates , removed CHS references	Regulary scheduled review	Author: Facility Director : 12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Roof Replacement Projects	PO2034	New Template	Regulary scheduled review	Author: Facility Director : 12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Failure Air Conditioning System	PO3000	New Template, minor	Regulary scheduled review	Author: Facility Director : 12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Failure of Water Distribution System	PO3001	New Template, minor update	Regulary scheduled review	Author: Facility Director : 12/2022 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

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Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Failure of Plumbing System Flooding	PO3002	New Template, minor updates	Regulary scheduled review	Author: Facility Director : 12/2022***01/2023 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Failure of Boiler Steam Equipment	PO3003	New Template, minor updates	Regulary scheduled review	Author: Facility Director : 12/2022***01/2023 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Emergency Telephone List	PO3005	New Template, minor updates	Regulary scheduled review	Author: Facility Director : 12/2022***01/2023 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Mercury Spill Clean-up Policy	PO3006	New Template, minor updates	Regulary scheduled review	Author: Facility Director : 01/2023 VP/Sr.Leader/CEO: 01/17/2023 MEC: N/A BOT:
Pharmacy (PHARM)				
Pharmacy Quality Monitoring Activities and Medication Use Improvement Plan	PHARM1671	No changes	Regulary annual review	Author: Pharmacy Director 01/04/2023 PTIC: 01/04/2023 MEC: 01/17/2023 BOT:

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

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Committee: Board of Directors

Reporting Period: January 2023

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Policy Title	Policy Number	Summary of Changes	Rationale for Change	Approvals & Dates
Look A Like and Sound A Like Medication/Drugs	PHARM2019	No changes	Regulary annual review	Author: Pharmacy Director 01/04/2023 PTIC: 01/04/2023 MEC: 01/17/2023 BOT:
Medical Staff (MS)				
Medical Staff Office Policy Regarding Peer Review, Ongoing Profession Practice Evaluation (OPPE) & (FPPE)	MS2842	Updated	Redundant; process covered in Medical Staff Bylaws, Article 6 Corrective Action and Article 12 Confidentiality, Immunity and Releases	Author: Pharmacy Director MEC: 01/17/2023 BOT:

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Staffing Policy	Policy #	PO1004
Responsible	Facilities Director	Revised/Reviewed	11/1/22

I. PURPOSE

Define a policy the procedure for staffing the Plant Operations department.

II. POLICY

1. Staffing shall be flexed as required by senior management.
2. Staffing levels
    a. The budgeted staffing level for Watsonville Community Hospital Plant Operations department is 5 FTEs.
    b. Staffing levels for Monday-through Friday are 5 FTEs.
    c. Staffing levels for 2nd shift is 1 FTEs
    d. Staffing levels for 3rd shift is 0 FTEs.
    e. Staffing levels for weekends and holidays are 1 FTEs.
3. The Facility Director determines staffing needs per day and shift based on workload, available staff and hospital needs.
4. Any change to the required coverage for each shift shall be approved by the Facility Director.

III. DEFINITIONS

N/A

IV. PROCEDURE

I. REFERENCES

N/A

II. STAKEHOLDERS

N/A

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Absenteeism and Tardiness Call-In Procedure Policy	Policy #	PO1005
Responsible	Facilities	Revised/Reviewed	11/1/2022

I. PURPOSE

Define a policy and procedure for the Plant Operations department with regard to absenteeism.

II. POLICY

1. An employee who is ill or must be absent from work for personal reasons must contact their supervisor, or the Director of Facilities/Plant Operations before the beginning of their scheduled shift.
2. Providing advance notification of an absence does not automatically excuse the absence if sick leave has not been accrued or a request for time off has not been approved.
3. 3. If an employee reports to work late without prior notification and the supervisor has already contacted a replacement, the employee may be sent home.
4. Any employee who fails to report to work as scheduled and fails to report the intended absence may be subject to disciplinary action in accordance with the Human Resources Policy and Procedure manual.
5. Excessive absenteeism or tardiness, as outlined in the Human Resources Policy and Procedure manual will be cause for disciplinary action.

III. DEFINITIONS

IV. PROCEDURE

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Dress Code Policy	Policy #	PO1006
Responsible	Facilities	Revised/Reviewed	11/1/2022

I. PURPOSE

Define a policy to establish a standard for attire and grooming to support safe work practices in the Plant Operations department.

II. POLICY

1. **Clothing**
    a. Uniforms shall be worn by all Plant Operations personnel and shall be kept clean and in good repair by the employee.
2. Belts shall be dark brown or black.
3. The choice of personal clothing must always reflect consideration of the work environment, safety, practicality, in accordance with the Human Resources Policy and Procedure manual.
4. Specifically prohibited are shorts, cut-offs, see-through or low-cut tops
5. Personal clothing including shoes and belts shall be kept clean and in good repair at all times.
6. **Shoes**
    a. Plant Operations personnel shall wear heavy-soled, fully-enclosed shoes or boots of leather or other durable, protective material.
    b. Other personnel shall wear shoes appropriate to their work setting which demonstrate consideration of health and safety requirements. Specifically prohibited are backless shoes, sandals, or thongs.
7. Jewelry which presents a safety hazard to the wearer or interferes with work activity in any way shall not be worn.
8. Hair must be kept neat, clean, and protected from hazards inherent to the job.

III. DEFINITIONS

IV. PROCEDURE

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Overtime & Call Pay Policy	Policy #	PO1009
Responsible	Facilities	Revised/Reviewed	11/1/2022

I. PURPOSE

The purpose of this policy is to define expectations and procedures when Plant Operations employees are assigned to be on call. Plant Operations services are required twenty-four hours a day, seven days a week, to meet the needs for safe, quality, and comfortable patient care.

II. POLICY

NA

III. DEFINITIONS

NA

IV. PROCEDURE

1. In order to offer coverage beyond the normal work hours, one Plant Operations employees shall be assigned "on call" after outside of normal business hours.
2. Normal business hours are defined in policy PO-1004, Hours of Service.
3. Plant Operations employees may be eligible for on call pay situations based on the guidelines established in the Human Resources Policy and Procedure Manual.
4. Employees on call must be available at any time during that period.
5. Compensation for on call pay is as determined by labor agreement.
6. Plant Operations employees shall clock in and out when called in and shall enter the proper code on the time clock.
7. The Director of Facilities shall determine what a reasonable response time for employees reporting to work when on call.
8. The Director of Facilities shall review the reasons for on-call service requests to ensure the requests are patient care-related, or that emergency services are necessary.
9. Overtime will be assigned as outlined in the Human Resources Policy and Procedure Manual.

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Equipment Repair and Service Requests Policy	Policy #	PO1010
Responsible	Facilities	Revised/Reviewed	11/7/2022

I. PURPOSE

To describe the process by which requests for Plant Operations services will be processed and documented.

II. POLICY

1. All requests for services to the Plant Operations department are documented by requesters using the online maintenance work request system.
2. Requests for **emergency** services may be made to the Plant Operations department by calling 1277 or overhead page to Plant Operations.
3. Maintenance is performed in accordance with the request outlined in the work order. The Facilities Director or his designee is responsible for prioritizing work orders and determining the level of response required.
4. The assigned engineer shall document any pertinent observations on the work order (parts on order, unable to access area, etc.). If maintenance involves a tagged asset, the asset number is to be documented on the maintenance work order so that this becomes part of the equipment history.
5. The requestor is able to query for work orders submitted in work order system to view the status. In addition, sites may set-up an autoreply to requestor whenever there is an update in status entered into WO system.
6. Work orders that will require a large expenditure or labor, or which involve facility modifications, must be signed by the manager or director of the department making the request and referred to the Facilities Director for review and approval.
7. When maintenance and documentation is completed, the engineer dates and signs off that the maintenance was performed and returns the work order to the Facilities Director or his designee.
8. If maintenance is to be performed by an external vendor, the Facilities Department will contact the vendor and instruct the vendor to perform the maintenance. When maintenance and documentation is completed, the vendor dates and signs off that the maintenance was performed and returns the work order to the Facilities Director along with a copy of the vendor's inspection form.
9. If service requests cannot be completed within a normal expected time period, the department requesting service shall be contacted.
10. Open and closed work orders are managed by utilizing the Work Order system.

III. DEFINITIONS

N/A

IV. PROCEDURE

N/A

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Personal Phone Calls Policy	Policy #	PO1012
Responsible	Facilities	Revised/Reviewed	11/7/2022

I. PURPOSE

Define a policy for the employee the departmental expectations for making and receiving personal phone calls.

II. POLICY

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Personal phone calls should be limited while the employee is on duty to prevent productivity loss. The Facilities Director shall implement and manage this process.
2. Personal calls that continue to impact the productivity of employees shall be considered an infraction of policy as outlined in the Human Resources Policy and Procedures manual.
3. This policy includes hospital phones, personal cell phone calls, and personal cell phone text messages.

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Use of Hospital Vehicles Policy	Policy #	PO1015
Responsible	Facilities	Revised/Reviewed	11/7/2022

I. PURPOSE

To define the requirements for safe use and maintenance of hospital vehicles.

II. POLICY

III. DEFINITIONS

N/A

IV. PROCEDURE

1. The hospital will limit the use of hospital vehicles to those persons authorized to operate vehicles based on the requirements of the insurance carrier.
2. Hospital vehicles shall be operated in a safe, professional manner at all times. Unsafe or destructive operation of hospital vehicles will result in disciplinary action as outlined in the Human Resources Policy and Procedure manual.
3. Hospital vehicles shall be returned to the condition prior to use by cleaning out and refueling the vehicle as required by the Facilities Director.
4. Any problems noted while operating hospital vehicles shall be communicated to the Facilities Director immediately.
5. Any damage incurred to the hospital vehicle while operating shall be communicated to the Facilities Director immediately.

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Service Contracts Policy	Policy #	PO1016
Responsible	Facilities	Revised/Reviewed	11/7/2022

I. PURPOSE

To define the process for evaluating, obtaining or renewing service contracts under the responsibility of Facilities/Plant Operations.

II. POLICY

III. DEFINITIONS

N/A

IV. PROCEDURE

1. The service contract shall fully describe the scope of the services provided and exclusions.
2. The service contract shall indicate days and hours of service included in the contract.
3. Service contracts shall indicate the date of expiration.
    a. If the contract automatically renews, the contract shall indicate the minimum period in which cancellation of the contract must be communicated.
    b. Service contracts cancelled by Watsonville Community Hospital must be communicated to the vendor in writing.
4. Service contacts for required preventive maintenance shall include a PM schedule in the Work Order system.
5. A copy of the fully executed service contract shall be filed in the office of the Facilities Director. The original contract shall be filed in Administration.
6. Vendors considered for service contracts shall be approved as a corporate compliant vendor through the hospital's Director of Materials Management.
7. The evaluation of contract proposals for the purpose of renewing or obtaining a service contract under the responsibility of the Facilities Director shall be approved by the Senior Management.

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Emergency Operations Plan Policy	Policy #	PO2001
Responsible	Facilities	Revised/Reviewed	11/7/2022

I. PURPOSE

To identify and educate the employee required responsibility in the event of a disaster.

II. POLICY

Each employee will be familiar with the hospital Emergency Operation Plan and the Facilities/Plant Operations roles in the plan and will review the EOP annually.

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Read at least annually the Hospital Emergency Operation Plan.
2. 2. Review at least annually the Facilities/Plant Operations Department roles in the EOP.
3. 3. The Facilities Director will make known to each employee within ten days, of any changes made in the Emergency Operations Plan.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards,EM.02.01.01.2, EP's 2,7,15 Emergency Management Policy, EM.02.01.01.2 – Emergency Operations Plan. Standard EM.12.01.01: The hospital develops an emergency operations plan based on an all-hazards approach

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Floor Plans Policy	Policy #	PO2002
Responsible	Facilities	Revised/Reviewed	11/7/2022

I. PURPOSE

Define the responsibility for the use of and removal of floor plans or blueprints from the facility.

II. POLICY

1. Updated blueprints are maintained in the Facilities/Plant Operations Department. These blueprints are not permitted out of the department area unless approved by the Director of Facilities/Plant Operations, or Designee. If approval is given by the Director of Facilities/Plant Operations shall be made aware of the removal of the floor plans.
2. Floor plans removed from the facility shall be signed for by the receiving person or company with a scheduled date for their return.

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Floor plans are filed in the Facilities/Plant Operations Department.
2. Permission to use the plans must be received from the Facilities/Plant Operations Dept.
3. Request to remove the floor plans from the Facilities/Plant Operations Department should be made to the Facilities Director.
4. The removal authorization form for removal of blueprints should be signed before plans are removed.

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Key and Access Management Policy	Policy #	PO2003
Responsible	Facilities	Revised/Reviewed	11/7/2022

I. PURPOSE

To define the methods for issuing and receiving keys and the responsibility for key control locks within the hospital.

II. POLICY

The Security Department, in liaison with the Facilities Department, is responsible for key control.

1. The Facilities Director or department designee is responsible for the master key cabinet located in Plant Operations shop.
2. All key requests are initiated by the department head and forwarded to the Facilities Department for disposition.
3. The department head requesting the key, or in his/her absence, the employee receiving the key, signs for said key on the Key Request Form and thus is held responsible for the key. The Key Log is kept in Facilities/Plant Operations.
4. Requests presented for replacement or duplication of lost or misplaced keys is processed only after an investigation by Security Department/Facilities Department establishes that the lost or misplaced keys cannot be recovered and that the key system was not compromised.
5. Broken or damaged keys that cannot be used are turned in to the Facilities/Plant Operations Department. This key is accounted for in the log by the Facilities/Plant Operations Department.
6. Duplicate keys will be provided only by the Facilities/Plant Operations Department. No keys shall be duplicated while in the possession of the employee.
7. Master keys will open all doors in the facility, except pharmacy, accounting, and personnel files and are accounted for in the Key Log and are numbered by the Facilities/Plant Operations Department.
8. Personnel issued a master key are required to return this numbered key when he/she leaves Watsonville Community Hospital 's employment.
9. All master keys are issued only with the written permission of the Chief Executive Officer.
10. The following is a list of personnel who have access to a master key:

- Chief Executive Officer
- Assistant Chief Executive Officer/Chief Operating Officer
- Chief Nursing Officer
- Facilities/Plant Operations Director
- Security Officers
- Nursing Supervisor
- Plant Operations Staff

11. The table below or similar shall be used to document all keys issued to staff.

Key ID#	Employee Name	Issue Date

III. DEFINITIONS
N/A

IV. PROCEDURE
N/A

V. REFERENCES
The Joint Commission: EC.02.01.01

VI. STAKEHOLDERS
Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Environmental Maintenance Policy	Policy #	PO2005
Responsible	Facilities	Revised/Reviewed	11/7/2022

I. PURPOSE

To define the procedure for inspecting a non-flammable anesthetizing location and performing preventive and corrective maintenance as needed.

II. POLICY

Non-Flammable Anesthetizing Location is areas in which inhalant anesthetic agents are administered and which is so designated by hospital policy.

III. DEFINITIONS

N/A

IV. PROCEDURE

PROCEDURE (Semi-Annual)

1. Inspect the area for abnormal conditions or those which detract from the aesthetic appearance of the area, such as chipped or peeling paint or wall coverings, broken electrical or medical gas receptacle covers and burned-out lamps.
2. Check the integrity and function of minor mechanical and electrical equipment.
3. Lubricate and make minor adjustments to equipment, as needed.
4. Clean and vacuum equipment and those portions of the area not accessible to housekeeping personnel (e.g., electrical closets).
5. Check ground continuity of appropriate electrical equipment. (Refer to Electrical Safety Test No. 3, Maximum parameter: 0.15 OHM)
6. Test the polarity and tension of electrical receptacles. (Refer to Electrical Safety Test No. 1, Maintenance Manual, parameter: 8 oz or 225 g.)
7. Test warning devices of the line isolation monitor using an appropriate simulated fault load (2 or 5 MA). (Refer to Electrical Safety Test No. 7.)
8. Check the grounding environment of the anesthetizing room. (Refer to Electrical Safety Test No. 2, Maximum parameter: 40 Milliamperes or 0.15 OHM)
9. Prepare a Corrective Maintenance Order for any repair work which will take more than 30 minutes to perform or for which the necessary tools or parts are not Available.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards EC.02.01.01, EC02.06.01

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Environmental Maintenance Non Patient Care Area Policy	Policy #	PO2006
Responsible	Facilities	Revised/Reviewed	11/8/2022

I. PURPOSE

To define the procedure for inspecting a non-patient care area and performing preventive and corrective maintenance as needed.

II. POLICY

Non-Patient Care Area - Area in which patients are not normally cared for or treated, such as administrative offices, laboratories, nursing stations, storage areas or kitchens.

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Inspect the area for abnormal conditions or those which detract from the aesthetic appearance of the area, such as chipped or peeling paint or wall coverings, broken electrical receptacle covers and burned-out lamps.
2. Check the integrity and function of minor mechanical and electrical equipment.
3. Lubricate and make minor adjustments to equipment, as needed.
4. Clean and vacuum equipment and those portions of the area not accessible to housekeeping personnel (e.g., electrical closets).
5. Check ground continuity of appropriate electrical equipment. (Refer to Electrical Safety Test No. 3, Maximum parameter: 0.15 OHM)
6. Test the polarity and tension of electrical receptacles. (Refer to Electrical Safety Test No. 1, Minimum parameter: 8 oz or 225 g.)
7. Prepare a Corrective Maintenance Order for any repair work which will take more than 30 minutes to perform or for which the necessary tools or parts are not readily available.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards EC.02.01.01, EC02.06.01

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Environmental Maintenance Mechanical Area Policy	Policy #	PO2008
Responsible	Facilities	Revised/Reviewed	11/8/2022

I. PURPOSE

To define the procedure for inspecting a mechanical area and performing preventive and corrective maintenance as needed.

II. POLICY

Mechanical Area - Area of restricted access containing plant equipment.

III. DEFINITIONS

N/A

IV. PROCEDURE (semi-Annual)

1. Inspect the area for abnormal conditions or those which detract from the aesthetic appearance of the area, such as chipped or peeling paint or wall coverings, broken electrical receptacle covers, burned out lamps and signs of water leakage (discoloration).
2. Inspect all utility controls to ensure proper labeling.
3. Inspect all electrical conduit and piping insulation, hangers and supports. Make minor adjustments as needed.
4. Inspect and clear all vents and louvers. Change natural draft filters, if installed.
5. Inspect floor and floor drains. Clean as necessary.
6. Clean and vacuum the area.
7. Check electrical areas and move any combustibles or other equipment which have been stored within 3 feet of electrical panels, transformers, or switchgear.
8. Prepare a Corrective Maintenance Order for any repair work which will take more than 30 minutes to perform or for which the necessary tools or parts are not readily available.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards EC.02.01.01, EC.02.06.01

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Maintenance and Inspection Fire Warning and Safety System Policy	Policy #	PO2010
Responsible	Facilities	Revised/Reviewed	11/8/2022

I. PURPOSE

To describe the process by which the fire warning and safety system is maintained and inspected.

II. POLICY

META Check - A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.

TMS – A computerized information system used to facilitate the scheduling, monitoring, and documentation of equipment and environmental maintenance.

The facility will also maintain a comprehensive inventory of all device associated will the Fire Alarm and Sprinkler System.

III. DEFINITIONS

N/A

IV. PROCEDURE

A. The Statement of Conditions that describes the current condition of the buildings' structural features of fire protection is maintained by the Director of Facilities/Plant Operations and is kept in the Facilities/Plant Operations office.
B. The circuits of fire alarm and detection systems are inspected and periodically receive preventive maintenance, based on the table below. Records of inspections and maintenance are on file in the office of the Director of Facilities/Plant Operation / Safety Officer.
C. Fire pumps and sprinklers are inspected and tested based on the table below as required by the NFPA and The Joint Commission Accreditation standards. Records of inspections and testing are on file in the office of the Director of Facilities/Plant Operations.
D. All portable fire extinguishers are inspected monthly in-house and maintained annually by an outside contractor. Records of inspection and maintenance on file in the office of the Director of Facilities/Plant Operations.
E. All other fire protection equipment (dampers, valves, etc.) are tested and maintained in accordance with the table below

EC.01.01.01.6&EC.02.03.05 Inspection Requirements and Activities

Fire Alarm System	
1. Test all supervisory signal devices	Quarterly
2. Test all tamper switches & water flow devices	Quarterly
3. Test & maintain all elements of fire alarm system	Annually
Occupant Alarm Notification Devices	
Test & maintain all devices	Annually
Fire Department Alarm Transmission Verification	
Verification of transmission	Quarterly
Sprinkler System	
1. Perform fire pump no flow churn test	Weekly
2. Perform fire pump flow test	Annually

3. Perform main drain test	Quarterly if backflow prevented is upstream from main drain. Otherwise Annually
4. Inspection of fire department connections	Quarterly
5. Test water tank level alarms	Quarterly
6. Test water tank freeze alarms	Seasonal
7. Obstruction tests	5 years
8. Fire sprinkler gauges calibrated or replaced	5 years
Kitchen Hood Systems	
Inspection, maintenance, & cleaning	Semiannually
Other Automatic &/or Package Systems	
Inspection & maintenance	Annually
Portable fire Extinguishers	
1. Extinguisher inspection	Monthly
2. Extinguisher maintenance	Annually
3. Hydrostatic testing	5 years
Standpipe System	
1. Perform hydrostatic test on hoses	3 years
2. Perform standpipe flow test	5 years
Smoke & Fire Dampers	
Verify full closure of dampers	1 yr. after installation & every 6 years thereafter
HVAC Shut Down Services	
Operational test	annually
Rolling & Sliding Doors	
Operational test	Annually

V. REFERENCES

NFPA 10, 20, 25, and 72
The Joint Commission EC.01.01.01.6, and EC.02.03.05

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Maintenance and Inspection Electrical Distribution System and Emergency Generator Policy	**Policy #**	PO2011
Responsible	Facilities	**Revised/Reviewed**	11/9/2022

I. PURPOSE

To describe the process by which the electrical distribution system is maintained and inspected.

II. POLICY

It is the policy of Watsonville Community Hospital that the electrical distribution systems will be maintained and operated according to all applicable codes and agency regulations. In addition, there will be a scheduled maintenance system that is used to schedule, monitor, and document the testing and maintenance of the electrical distribution system at required intervals.

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Based on the outcome of the risk assessment all electrical receptacles in selected patient care areas will be checked by an engineer within the established time frame set for the maintenance of that environmental unit.
2. Work orders are generated for other components of the electrical distribution system on predetermined intervals.
3. The work orders are assigned by the Facilities Director or his designee.
4. The electrical distribution system is inspected and tested at predetermined intervals. The engineer will perform any preventative maintenance and corrective maintenance as necessary.
5. A corrective maintenance form is submitted for any repair work that exceeds 30 minutes to complete or for which tools or parts are not readily available.
6. A scheduled maintenance work order is completed by the engineer, indicating specific preventative or corrective maintenance actions taken. The date the scheduled maintenance was completed is entered on the form and it is submitted to the Facilities Director or his designee.
7. The Plant Operations/Facilities Management Department will inspect the generator and batteries weekly. A generator test will be performed (not under actual load) weekly. The tests are documented, and the test results are reviewed weekly by Plant Operations/Safety to assure the generator is starting and performing in a reliable manner.

V. REFERENCES

The Joint Commission Accreditation Standards EC 02.05.05
NFPA 110, and 99
TMS
Manufacturer Specifications

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Emergency Generator Load Testing Policy	Policy #	PO2012
Responsible	Facilities	Revised/Reviewed	11/9/2022

I. PURPOSE

Define a policy requiring proper load testing of emergency generators.

II. POLICY

In order to further ensure operational reliability, preventative maintenance will be conducted by a qualified team member or contractor at predetermined intervals.

Repairs or additional service as required will receive highest priority and will be completed only by qualified technicians. Responsibility for completion of immediate additional service is that of the Director of Plant Operations/Facilities Management.

III. DEFINITIONS

N/A

IV. PROCEDURE

The following services will be performed on each scheduled service call:

Items To Be Inspected Or Serviced:

1. All fluid levels will be checked to ensure they are within the correct operating range.
2. Inspect and clean air filter element. Replace if necessary.
3. Fuel tanks and lines (above ground and accessible) will be inspected for leaks and for determining if excessive sludge, water, or rust is collecting. All fuel filters and sediment bowels will be inspected, cleaned, and replaced as necessary.
4. All coolant hoses will be inspected for security, brittleness, leaking, cracking, and weakness.
5. The entire unit will be lubricated. Oil will be changed if the running time meter exceeds one hundred (100) hours of operation since the last oil change or once annually. Oil filters will be changed with each oil change.
6. All batteries will be cleaned, specific gravities checked, and load tested.
7. Jacket water heater will be checked for proper operation.
8. All belts will be inspected for proper tension and condition.
9. All brushes on generator will be checked for proper setting.
10. All instruments will be checked for proper operation.
11. Automatic transfer switch will be checked for proper operation if load transfer is possible.
12. All safety alarms and shutdowns will be checked for proper operation.
13. Battery charger will be checked for proper operation.
14. Personnel will be instructed on operating procedures and upkeep.
15. After all of the above has been completed, the engine will be run and driven equipment under load providing it is practical to run the test.
16. The Plant Operations/Facilities Management Department will inspect the generator (including batteries) and test it under actual load and operating temperature conditions for at least 30 minutes monthly.
17. The Plant Operations/Facilities Department will start the generator weekly to ensure reliable starts and to make general observations.
18. Generator tests are documented. The Director of Facilities, Safety or designee reviews tests weekly to assure generator is performing in a reliable manner. Refer to EC.02.05.07.4-7 "Generator Test Log".

V. REFERENCES

The Joint Commission Hospital Accreditation Standards EC 02.05.07
NFPA 110
TMS

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Interior Furnishings, Finishes and Flooring Requirements Policy	Policy #	PO2026
Responsible	Facilities	Revised/Reviewed	11/28/2022

I. PURPOSE

To outline the policy under which furnishings, finishes, and coverings (such as drapes, bedspreads, blankets, furniture, wall covering, and flooring) are selected regarding fire safety and use.

II. POLICY

Flame spread and smoke development criteria shall meet requirements of NFPA Life Safety Code 101, Section 6-5. Selection of wall covering, flooring, etc. will also be made on the basis of the ability to clean it, the safety and the appropriateness for the area being served.

III. DEFINITIONS

N/A

IV. PROCEDURE

Material Classification

Wall and Ceiling Finishes - Shall be classified as follows based on test results from NFPA 255 "Standard Method of Test of Surface Burning Characteristics of Building Materials"

Class A Flame Spread 0-25 Smoke 0-450
Class B Flame Spread 26-75 Smoke 0-450
Class C Flame Spread 76-200 Smoke 0-450

Floor Finishes - Shall be classified as follows based on test results from NFPA "Standard Method of Test for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source"

Class "A" Critical radiant flux, minimum of 0.45 watts per square centimeter.
Class "B" Critical radiant flux, minimum of 0.22 watts per square centimeter FIRE RETARDANT COATINGS: The required flame spread or smoke developed classification of surfaces may be secured by applying approved fire retardant coatings to surfaces having higher flame spread ratings than permitted.
Such treatments shall comply with the requirements of Chapter 3, NFPA 703. "Standard for Fire Retardant Impregnated Wood and fire-Retardant Coatings for Building Materials."

FURNISHINGS, DECORATIONS, AND TREATED FINISHES: Life Safety Code 101, 31-1.4.1. Draperies, curtains and other similar furnishings and decorations shall be flame resistant where required by the applicable provisions of the Chapter. These materials required to be tested shall be done so in accordance with NFPA 701, Standard Methods of Fire Test for Flame-Resistant Textiles and Films and shall comply with both the small and large-scale tests.

NOTE -- AUTOMATIC SPRINKLERS

Where a complete standard system of Automatic sprinklers is installed, CLASS "C" INTERIOR FINISH MATERIALS may be used in any location where Class B and Class A are normally specified (Unless specifically prohibited elsewhere in the code).

Therefore:

1. Interior wall and ceiling may be Class B
2. Interior floors may be Class II.
3. Furniture must meet standards set forth in NFPA 260B and 261.
4. The Joint Commission recommends that patient sleep rooms and exit corridors meet Class A and Class II requirements.

V. REFERENCES

TJC STANDARD: LS.02.01.30
NFPA 101, 261

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Maintenance and Inspection of HVAC System Policy	Policy #	PO2013
Responsible	Facilities	Revised/Reviewed	11/9/2022

I. PURPOSE

To describe the process by which the heat, air conditioning and ventilation system is maintained and inspected.

II. POLICY

1. Meta Check - A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
2. TMS- A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
3. A current, complete set of documents that indicate the distribution and controls for partial or complete shutdown of each HVAC system is on file.

III. DEFINITIONS

N/A

IV. PROCEDURE

1. A work order for preventive maintenance, inspection and/or testing of each component part of the HVAC system is produced on a pre-determined and pre-programmed schedule by the META Check/TMS.
2. The work is assigned by the Facilities Director or designee.
3. The engineer performs preventive maintenance (and corrective maintenance, if needed), inspects the system and conducts testing as specified in the META Check/TMS instruction set printed on the work order.
4. The engineer prepares and submits to the Engineering Department a Corrective Maintenance Form for any repair work which will take more than the normal required time to complete or for which he does not have tools or parts readily available.
5. The engineer completes the Scheduled Maintenance Work Order, indicating specific preventive or corrective actions he has taken and noting the date the scheduled maintenance was completed. He then submits the work order to the Facilities/Plant Operations Office for entry in the META Check/TMS.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards EC.02.01.01, EC.02.05.05
META Check
TMS
Manufacturers Specifications

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Maintenance and Inspection Water Distribution and Plumbing System Policy	**Policy #**	PO2014
Responsible	Facilities	**Revised/Reviewed**	11/10/2022

I. PURPOSE

To describe the process by which the water distribution/plumbing system is maintained and inspected.

II. POLICY

III. DEFINITIONS

1. META Check - A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
2. TMS- A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
3. A current valve chart is on file.

IV. PROCEDURE

1. A work order for preventive maintenance, inspection and/or testing of each component of the water distribution/plumbing system is produced on a pre-determined and pre-programmed schedule by the META Check/TMS.
2. The work is assigned by the Facilities Director or designee.
3. The engineer performs preventive maintenance (and corrective maintenance, if needed), inspects the system and conducts testing as specified in the META Check/TMS instruction set printed on the work order.
4. The engineer prepares and submits to the Engineering Department a Corrective Maintenance Form for any repair work which will take more than normal required time to complete or for which he does not have tools or parts readily available.
5. The engineer completes the Scheduled Maintenance Work Order, indicating specific preventive or corrective actions he has taken and noting the date the scheduled maintenance was completed, and submits the work order to the Facilities/Plant Operations Office for entry in the META Check.
6. Back flow protection devices are tested and maintained as required by AHJ, by an outside vendor under contract. Test results are kept in the Facilities/Plant Operations Office.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards EC.02.01.01, EC.02.05.05
META Check
TMS
Manufacturers' recommendations

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Maintenance and Inspection Boiler Steam System Policy	Policy #	PO2015
Responsible	Facilities	Revised/Reviewed	11/11/2022

I. PURPOSE

To describe the process by which the boiler/steam system are maintained and inspected.

II. POLICY

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Work orders are generated for each component of the boiler and steam system on a predetermined interval.
2. The boiler and steam system are inspected, tested, and preventative maintenance is completed at the above-predetermined level.
3. The work orders are assigned by the Facilities Director or designee.
4. The Facilities/Plant Operations Department personnel will perform preventative and corrective maintenance within their capabilities as needed. An outside contractor is used to perform periodic tune ups and major repairs. State inspection of the system is performed on an annual basis, with current permits and other documentation on site.
5. A corrective maintenance form is submitted for any repair work that exceeds 30 minutes to complete or for which tools or parts are not readily available.
6. A scheduled maintenance work order is completed by the engineer, indicating specific preventative or corrective actions taken. The date the scheduled maintenance was completed is entered on the form and it is submitted to the Facilities Director or his designee.
7. The Facilities/Plant Operations Department personnel inspects the alternative fuel supply at least quarterly and replenishes it when the level is at minimum level to maintain at least a 24-hour supply.
8. The Facilities/Plant Operation Department personnel conduct a daily water test and document their findings. Facilities/Plant Operations personnel adjust chemicals as required.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards EC.02.01.01, EC.02.05.05
META Check
TMS
Manufacturers recommendations

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Maintenance and Inspection Medical Gas System Policy	Policy #	PO2016
Responsible	Facilities	Revised/Reviewed	11/11/2022

I. PURPOSE

To describe the process by which the medical-gas system are maintained and inspected.

II. POLICY

III. DEFINITIONS

N/A

IV. PROCEDURE

1. An Engineering Tech checks the normal and reserve supplies of liquid oxygen once each day and documents the levels in the Plant Services Log. Oxygen is re-ordered when the level drops to 30 inches.
2. An Engineering Tech checks the normal and reserve supply of nitrous oxide once each day and documents the levels in the Plant Services Log. Nitrous oxide cylinder banks are replaced when the primary supply is exhausted and the secondary supply is activated. The watch engineer then shuts off the valve on the empty tanks to prevent back flow. Nitrous Oxide is reordered when the level drops to four cylinders.
3. An Engineering Tech observes the delivery and transfer of oxygen. Invoice copies indicating volumes and purity delivered are kept on file in the Facilities/Plant Operations Department
4. Following periods of construction or evidence (e.g. alarms) that the system has been breached, the medical-gas system will be tested by certified medical testing vendor to verify that the gases being delivered meet regulatory requirements. Documentation of such testing will be kept on file in Facilities/Plant Operations office.
5. In accordance with the META Check/TMS environmental maintenance procedures for non-flammable anesthetizing locations, critical care areas and general patient care areas, an engineer inspects the wall outlets and fittings for medical-gas delivery and makes repairs as necessary. He also verifies that zone and control valves are labeled appropriately
6. The Engineer tests the Medical Gas Alarm System low pressure alarm on the control panel once each month and documents such testing in the Plant Operations Log.
7. An annual test of the entire medical-gas system will be conducted in accordance with NFPA 99.
8. Deficiencies noted on inspection reports must be corrected in a timely manner and documentation of corrections must be on file in The Facilities/Plant Operations office.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards EC.02.01.01, EC.02.05.05
EC Policy: EC.02.05.04
NFPA 99
META Check
TMS
Manufacturer's recommendations

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Maintenance and Inspection Medical Surgical Air and Vacuum System	Policy #	PO2017
Responsible	Facilities	Revised/Reviewed	11/11/2022

I. PURPOSE

To describe the process by which the medical/surgical air and vacuum system are maintained and inspected.

II. POLICY

III. DEFINITIONS

N/A

IV. PROCEDURE

1. 1. A work order for preventive maintenance, inspection and/or testing of each component of the medical/surgical air and vacuum system is produced on a pre-determined and pre-programmed schedule by the META Check/TMS.
2. The work is assigned by the Facilities Director or designee.
3. The engineer performs preventive maintenance (and corrective maintenance, if needed), inspects the system and conducts testing as specified in the META Check/TMS instruction set printed on the work order.
4. The engineer prepares and submits to the Facilities/Plant Operations Department a Corrective Maintenance Form for any repair work which will take more than normal required time to complete or for which he does not have tools or parts readily available.
5. The engineer completes the Scheduled Maintenance Work Order, indicating specific preventive or corrective actions he has taken and noting the date the scheduled maintenance was completed and then submits the work order to the Facilities/Plant Operations Office for entry in the META Check/TMS.
6. Respiratory Therapy Department personnel check system flow rates before each procedure and report malfunctions to Facilities department.
7. An annual test of the entire system will be conducted in accordance with NFPA 99.
8. Deficiencies noted on inspection reports must be corrected in a timely manner and documentation of corrections must be on file in The Facilities Management/Plant Operations office.
9. Following repairs or modifications, the medical/surgical air and vacuum system will be tested by an approved company to verify that it has been connected properly and yields a sufficient volume of vacuum at each outlet. Documentation of such testing will be kept on file with the Facilities Director.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards EC.02.01.01, EC.02.05.05
NFPA 99
META Check
TMS
Manufacturers Recommendations

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Domestic Water Temperature Policy	Policy #	PO2018
Responsible	Facilities	Revised/Reviewed	11/11/2022

I. PURPOSE

The purpose of this policy is to inform associates of the maximum allowable hot water temperature in Watsonville Community Hospital.

II. POLICY

It is the policy of Watsonville Community Hospital to ensure the safety of patients and associates by regulating hot water temperature, in accordance with State Health Department regulations.

III. DEFINITIONS

N/A

IV. PROCEDURE

1. The temperature of hot water used by patients (domestic hot water) in Watsonville Community Hospital shall be maintained in accordance with state health department regulations (DOH). Absent state regulations, the following limits shall apply:
    a. 95-110 degrees Fahrenheit in residential treatment buildings/spaces (e.g., Nursing Homes and Long-Term Care Units).
    b. 105-120 degrees Fahrenheit in hospital buildings/spaces.
2. Food Services hot water temperature will be a minimum of 140 degrees in utensil dish wash area. Dishwasher final rinse temperature shall be 180 degrees unless alternative sanitization methods are used.
3. The temperature of domestic hot water is tested monthly as part of environmental maintenance checks.

V. REFERENCES

N/A

VI. STAKEHOLDERS

Facilities
Plant Operations
All Staff

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Scheduled Equipment Maintenance Policy	Policy #	PO2019
Responsible	Facilities	Revised/Reviewed	11/11/2022

I. PURPOSE

To define the procedure for inspection, maintenance, and repair of significant equipment and components of utilities systems deemed essential for normal medical center operations.

II. POLICY

III. DEFINITIONS

N/A

IV. PROCEDURE

Scheduled Maintenance - Includes, as appropriate, inspection, preventive and corrective maintenance, functional testing, performance testing and calibration and safety testing.

Equipment - (Specific Scheduled Maintenance), as used in this procedure, equipment shall mean those individually inventoried items of equipment which meet one or more of the following criteria:

1. Essential, directly, or indirectly, for supporting an ongoing normal hospital environment.
2. Associated with a higher-than-normal incident risk during routine operation.
3. Requires, by reason of its complexity, a more intensive maintenance schedule.
4. Supplied or maintained by an external vendor.

Environmental Scheduled Maintenance - Equipment and Utility System Components requiring equipment. Specific Scheduled Maintenance will be grouped into an Environmental Scheduled Maintenance Unit.

TMS OnSite Professional - A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.

Maintenance Data Table - A table listing all types of individually inventoried equipment and distinct environmental units or equipment groups, and including, for each, the appropriate maintenance procedure number and frequency of maintenance.

Equipment Listing by Location - A computerized list of all patient care and non-patient care equipment, powered and non-powered, in the facility, arranged by location of use.

Applied History - A computerized record of all scheduled and corrective maintenance performed on all patient care and non-patient care equipment in the facility.

V. REFERENCES

ENVIRONMENT OF CARE MANUAL
TJC STANDARD: EC.02.05.01.03, EC.02.05.01.4, EC.02.04.01.3.e, EC.02.04.01.4
TMS ON-SITE PROFESSIONAL

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	New Equipment Inventory and Inspection Policy	Policy #	PO2020
Responsible	Facilities	Revised/Reviewed	11/11/2022

I. PURPOSE

To outline the procedure by which new non-patient care equipment is inventoried and inspected before release for patient care or other use.

II. POLICY

1. All non-patient care equipment designated for use anywhere within the hospital shall be inspected and tested by the Facilities/Plant Operations Department before initial use.
2. New equipment which fails to pass the applicable electrical and mechanical safety tests will not be approved for use in the hospital until such deficiencies have been corrected.

III. DEFINITIONS

Environmental Unit - A space of manageable size in terms of square footage or work intensity classified by the principal activity which takes place within it.

Equipment Identification Number - A number assigned to a specific piece of equipment, grouping or environmental unit for the purposes of identification and maintenance scheduling.

IV. PROCEDURE

1. The receiving department (Materials Management) notifies the Engineering Department that new equipment has been received.
2. The Engineering Department will inspect the equipment.
3. The technician then performs a series of electrical and mechanical tests on the new equipment as outlined in the user manual and performs the required Electrical Safety Test.
4. If the equipment fails to pass the required tests or does not meet the standards specified by the hospital, the technician/engineer will return the equipment to the Material Management Department.
5. Once the equipment has been determined to meet the standards specified, the equipment will be evaluated following the procedure outline in the Utility Systems Inventory and Risks EC.02.05.01.2 to determine if it will be included in the utilities management program.
6. Following the inspection and evaluation, an individual asset number is to be assigned and the following information collected.
   Description: the equipment description is to be identified based on the Type, Category, Subcategory populated in CMMS.
   Building: Buildings that equipment will be housed in.
   Floor: This will be 1, 2, Basement, Ground, Roof, Outside, etc.
   Location: Use the room number, or area.
   Location Description: Give any useful information as to where the equipment is located within the room, such as by the window, etc. Be especially certain to include locations on the ceiling.
   Manufacture, Model #, Serial #, Purchase date: if available.

Once the above information is collected, the equipment should be entered into CMMS and the standard procedure shall be assigned with the appropriate maintenance intervals. Reference the User's Manual for instructions on adding new assets.

V. REFERENCES

TJC Standards: EC.02.05.01.03, EC.02.05.01.4, EC.02.04.01.3.e, EC.02.04.01.4

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Equipment & Problem Identification	Policy #	PO2021
Responsible	Facilities	Revised/Reviewed	11/15/2022

I. PURPOSE

To outline the procedure by which damaged or malfunctioning equipment will be repaired and problem identification will be managed. The Maintenance Management Program shall be used to identify and document equipment problems, failures and user errors that have or may have an adverse effect on patient safety and/or the quality of care.

II. POLICY

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Response from department personnel shall be in a reasonable time frame based on the nature of the problem. Response shall be courteous, reliable, and productive. Each request for service or repair received shall be answered within twenty-four hours. Requests affecting patient care, environmental safety and sanitation shall be corrected during the same workday. Failure to adhere to the required response and correction times must be approved by the Facilities Director or his designee. All completed requests will be turned into the Facilities Services Department, showing action taken and time and materials used for completion. Upon completion, the engineer signs the request as complete and returns it to the Service Coordinator.
2. When requesting repair and /or maintenance, each department will complete a maintenance request and send it to Facilities Department for action by the Facilities person scheduled to respond.
3. The request for repairs and/or maintenance will be the authorization for Facilities Services to complete the request unless the cost exceeds 25% of the value of the equipment or a total cost of $500.00 or more. In such cases, the department manager and the Controller will be contacted for approval before proceeding.
4. When more than twenty-four hours are required to obtain parts, service, or repairs; a response will be directed to the department manager by sending a "Maintenance Request Follow-Up".
5. Outside service vendors will check in with the Facilities Department and obtain a pass and a work order for the service to be rendered. When the work is completed, the service report will be signed by the department manager or their designee. The service vendor will then turn in the service report to the Service Coordinator who will attach a purchase order number for the charges.
6. Quality - It is essential that service and repairs be of the best quality. This is accomplished by the following:
    a. Institute a work order or maintenance request.
    b. When completed, work orders and maintenance requests are reviewed daily by the Chief engineer and facilities coordinator.
    c. Vender call backs are noted on the second work order/maintenance request.
    d. Call back is discussed with the responsible in-house service person or vendor.
    e. The equipment history is reviewed when reoccurring problems are suspected.

f. Repeat repairs are discussed with the department manager to assure the proper operations and care of equipment.
g. Each engineer/bio-med tech and the service Coordinator are expected to make known to the Director of Facilities/Materials repeat repairs or service.

7. Each engineer having incomplete service requests at the end of a shift will transfer information from the request to the "Incomplete Maintenance Request" form for follow up repair. Note: Incomplete service is any assignment not completed due to lack of time, parts not ordered, or outside service is required but not scheduled. If the repair work is performed, outside the facility, the assigned individual inspects or tests the equipment upon its return to make certain the repairs have been made properly and that the equipment meets appropriate electrical safety standards before returning it to the user department. (See Policy PO-2021)
8. If it is determined that the equipment cannot be repaired, the equipment is returned to the user department and communicates with the department manager about disposal by using the "Equipment Inventory Change" form.
9. In order to speed up repairs and maintenance on equipment, the responsible engineer does the following:
    a. Handling requests for service and repair.
    b. Orders all repair parts
    c. Follows up on service and repairs including changes, repeat repairs, parts delivery, and suppliers.
    d. Completes check requests when applicable.
    e. Finalizes paperwork with the request for purchase.
10. When closing each Corrective Maintenance Work Order the responsible engineer for facilities coordinator shall classify as to Work Order TYPE (USER ERROR, OR EQUIPMENT FAILURE).
11. Facilities coordinator shall run a monthly report from META Check of the type of equipment problems. Copies of this report shall be used to complete the monthly Equipment Service Order Evaluation.

V. REFERENCES

ENVIRONMENT OF CARE MANUAL
TJC STANDARD: EC.01.01.01.7, EC.01.01.01.8
META Check

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Renovation and Construction Policy	Policy #	PO2022
Responsible	Facilities	Revised/Reviewed	11/17/2022

I. PURPOSE

Define a policy for participation of the Facilities/Plant Operations department in renovations and construction.

II. POLICY

1. The Facilities/Plant Operations Department is staffed for building and equipment maintenance, minor repairs, and service to other departments. Other duties include the development, promotion, and performance of any and all duties relating to conformance with codes and standards of all regulatory authorities concerned.
2. Priorities
    a. Building and equipment preventive maintenance programs
    b. Codes and standards
    c. Service to other departments
    d. Service related to patient care
    e. Construction – The Facilities Director must be involved in all construction planning. Department participation should not be such that it will delay or exempt priorities A, B, C, and D.
3. All construction shall conform to the AIA guidelines for healthcare construction, the NFPA Life Safety code, the insurance carrier requirements, and state healthcare standards.
4. Fire protection, grounds and environmental safety shall be maintained at all times during construction. Interim life safety measures shall be documented, and the level of life safety shall never be diminished.

III. DEFINITIONS

N/A

IV. PROCEDURE

N/A

V. REFERENCES

Environment of Care Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Regulations for Contractors While Performing Construction	Policy #	PO2023
Responsible	Facilities	Revised/Reviewed	11/17/2022

I. PURPOSE

The purpose of this policy is to define expectations and procedures when Facilities/Plant Operations employees are assigned to be on call. Facilities/Plant Operations services are required twenty-four hours a day, seven days a week, to meet the needs for safe, quality, and comfortable patient care.

II. POLICY

1. General regulations for contractors:
    a. Contractors are expected to comply with normal hospital safety requirements of the areas in which they are working. This requires them to wear safety equipment and, where appropriate, follow pertinent procedures such as work permits and area safety rules.
    b. Contractors' employees are to confine their activities to their specific job areas.
    c. No equipment is to be operated without proper safety guards in place.
    d. Excavations and other hazardous work areas are to be provided with shoring, warning signs, ropes, guards, rails, or other adequate protection.
    e. The possession of intoxicants or illegal drugs on hospital grounds will not be permitted.
    f. No tobacco products permitted in or near work area.
    g. Horseplay and practical jokes are prohibited.

2. Special Hot Work Permits: (within occupied areas)
    a. Special Hot Work Permits will be required when welding, cutting, grinding or any open flame is to be performed. These permits will be issued through the Facilities Services Department during normal hours.
    b. Arcs, flashes, and sparks are to be shielded with flameproof curtains and/or floor coverings.
    c. A Fire Extinguisher is required within twenty-five (25) feet of all flames or arcs or any other hot work.

3. Location of Fire Alarm Equipment:
    a. The hospital representative should locate the nearest fire alarm box and explain how to turn on an alarm and what should be done when an alarm sounds. All burning and welding should stop when the alarm sounds.

4. Housekeeping:
    a. Good housekeeping must be maintained at all times. Special care must be taken not to block walkways, roadways or firefighting and safety equipment.
    b. All dirt and dust must be completely vacuumed at workday end.

5. Use of Hospital Equipment:
    a. Contractors must furnish their own tools and equipment.
    b. Electricity, steam, water, air, or fire lines are not to be used without permission of the hospital representative.
    c. Hospital personnel must place lock-outs on the main circuit breakers to insure that lines will not be energized or equipment operated while work is being performed on equipment.

6. Hospital Furnishings:

a. All ceiling tiles must be back in place by workday end. If job requires the same tile to be out the following day, special permission can be obtained from the Director of Facilities or his designee.
b. All carpet and flooring and walls must be maintained and kept in their original condition as it was at the start of construction.
c. All hospital furnishings and equipment shall be moved out of construction area and not be damaged in any way. All damages shall be reported to the Facilities Services Department for appropriate and immediate action.

7. Hazardous Materials:
   a. Contractors must be informed of the chemical hazards their employees may be exposed to during the period they work in the facility. While the contractor is responsible for the training of his personnel, it is required that they be informed of the criteria for safe behavior.
   b. SDS information will be made available to the contractor's management personnel.
   c. Contractors must demonstrate they are in compliance with state and local laws governing hazardous communication.
   d. Contractors must supply SDS information on all hazardous chemicals brought into workplace.

8. Letter of Transmittal:
   a. A signed acknowledgment form shall be attached with these regulations so that a record can be maintained that the regulations in this document were communicated.

III. DEFINITIONS
N/A

IV. PROCEDURE
N/A

V. REFERENCES
TJC STANDARD:
EC.02.06.05 1-6
EC.02.01.01.1
LS. 01.02.01
NFPA 99

VI. STAKEHOLDERS
Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Construction Smoking Policy	Policy #	PO2024
Responsible	Facilities	Revised/Reviewed	11/28/2022

I. PURPOSE

Define a policy to outline a designated smoking area for contractors during construction.

II. POLICY

Smoking and all other uses of tobacco products are prohibited at all times, under all circumstances, by all persons, in the interior and on the roofs of all Watsonville Community Hospital buildings. Smoking and other uses of tobacco products are discouraged throughout Watsonville Community Hospital grounds. Smoking is permitted only in specially designated smoking areas in accordance with hospital policy.

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Follow Watsonville Community Hospital smoking policy.
2. Smoking is only permitted in the designated areas determined by the CEO, the EOC Committee or Safety Officer.

V. REFERENCES

TJC STANDARD: EC.02.01.03.1,4,6

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Mercury Spill Clean-up Policy	Policy #	PO3006
Responsible	Facilities	Revised/Reviewed	1/3/2023

I. PURPOSE

It is the policy of the Watsonville Community Hospital to respond to spills of materials posing a threat to health or the environment in ways that protect staff, patients, visitors and the environment; and comply with applicable laws and regulations.

II. POLICY

III. DEFINITIONS

MERCURY: Mercury is a silver metallic liquid, which is easily vaporized under normal room temperatures. It is toxic by contact, by inhalation and should be handled with great care. Considering mercury's hazardous nature, toxicity, and readily available alternatives, it should be phased out of active hospital use.

SMALL MERCURY SPILL: A small spill, (less than 5 ml) in an area with hard surfaces, which allow the mercury to be accessed by an aspirator.

LARGE MERCURY SPILL: A spill of more than 5 ml, or a spill which occurs on a soft surface, such as carpet, furniture, which may not be completely cleaned.

IV. PROCEDURE

Mercury spills should only be handled by staff trained to work with the materials. Spills should never be handled with bare hands or with latex gloves, as they offer minimal protection against mercury's effects. Where possible, all spills should be covered by water, either in a puddle, or by wet towels or sheets, to minimize vaporization. (Mercury evaporates much more easily than water) All spills should be reported to Facilities/Plant Operations and the Safety Officer.

Handling of Mercury Spills and leaks

1. Spill Cleanup for Small Quantities (up to 5ml)
    a. The spill location should be closed and/or cordoned off, and all persons asked to leave the immediate area. If possible, close room doors to keep vapors in the room. If not in an enclosable room, cover with water-soaked cloth to minimize vapors and keep everyone away. Post staff at all doors or points of entry into the contaminated area to warn people who may be trying to enter.
    b. Notify Facilities/Plant Operations and the Safety Officer(via operator if needed).
    c. Obtain a mercury spill cleanup kit from Facilities/Plant Operations and follow the recommended procedures included in the kit.
    d. Put on the protective equipment located inside the clean-up kit including eyewear, gloves, mercury vapor respirator, etc. Disposable shoe covers and/or a jumpsuit may be obtained and worn if deemed necessary
    e. Spray ambient air in affected area with Mercon spray by starting at eye level and working down towards the floor including on the visible spill.

    CAUTION: After applying Mercon spray or water, the floor may become slippery.

f. Use mercury aspirator to pick up the mercury beads and deposit them into a closed container partly filled with water. Ensure the tip of the aspirator is below the water in the container (Note: Syringe with blunt canula may also be used).

NOTE: The closed container can be re-used, provided it is not more than ½ full

g. Wipe the contaminated surface clean with Mercon liquid or similar wipes to chemically decontaminate the surface.
h. Wipe shoes and other contaminated items with Mercon wipes or disposable towels saturated with Mercon. Dust mercury-indicating powder around the spill, with special attention to cracks, crevices, and other areas where mercury beads may have fallen into. If necessary, repeat steps (e) through (g) no mercury is present.
i. Label all contaminated items after placing them in Hazardous Waste bags (i.e., zipper lock bags). Larger items may be bagged in clear plastic and held for disposal.
j. Document and file the appropriate incident report.

2. Cleanup for Larger Spills: Any spill of a large amount of metallic mercury (more than 5 ml) or any spill on soft materials including carpeting, furniture and similar surfaces is considered a large spill.
   a. Isolate the location and relocate all persons in the area.
   b. Notify Facilities/Plant Operations and the Safety Officer.
   c. Where possible, HVAC systems shall be configured so that air from the contaminated area is exhausted to the outside. Otherwise, HVAC systems should be isolated in the affected area by closing dampers, covering air registers, and/or shutting down the air handling unit.
   d. Contact local fire department Haz-mat team and/or licensed chemical response company to remediate.
   e. Once sealed off, re-entry into the contaminated area is strongly discouraged. If re-entry is absolutely necessary, all persons entering shall wear mercury vapor respirators and other appropriate PPE as required by the specific situation. Only staff members that have been fit-tested and trained with the mercury vapor respirator will be permitted to enter contaminated areas.
3. Environmental Services is responsible for final cleaning after the area is released as safe.
4. Disposal of the spilled materials:
   a. All materials involved in the spill will be placed in an appropriate container and sealed. This container will be brought to the chemical waste storage room (or designated ventilated area) and held for removal by the licensed contractor.
   b. The Safety Officer or designee will notify the hazardous waste removal contractor to pick up the spilled materials as part of normal chemical waste removal.
5. The Safety Officer is responsible for ensuring that mercury spill clean-up kits are restocked and available for future use.
6. Injuries/Illness:
   a. Any employee or other person(s) who may be injured or become ill due to a mercury spill exposure will be transported to the Emergency Services Department for decontamination and medical treatment.
   b. Employees that are concerned about exposure to the vapors should contact Employee Health Services.
7. Staff Training:
   a. Selected Environmental Services and Facilities/Plant Operations Department employees are trained in Mercury spill clean-up procedures.
   b. Additionally, specific clean-up requirements and procedures are listed as part of the spill cleanup kit.
   c. All staff that are trained and expected to clean up minor mercury spills are fit tested for a mercury vapor mask. A mercury vapor mask will be worn during all cleanup operations.
8. Reporting
   a. All spills shall be documented and reported to the Environment of Care/Safety committee.

V. REFERENCES

The Joint Commission Hospital Accreditations Standards, EC.02.02.01, EP 3-4.
OSHA CFR 29 1910

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Relocation of Equipment and Furniture Policy	Policy #	PO2025
Responsible	Facilities	Revised/Reviewed	11/28/2022

I. PURPOSE

To define the means in which equipment, files and furniture are relocated within the facility or relocated off site.

II. POLICY

All equipment, files and furniture is the responsibility of the user department. When it becomes necessary to relocate an item that cannot be done by department staff, such moves will be pre-scheduled with Facilities/Plant Operations or the Environmental Services Department.

III. DEFINITIONS

IV. PROCEDURE

1. Relocation of furniture, files, or desks within the hospital proper shall be scheduled with Environmental Services.
2. Relocation of equipment requiring venting, plumbing or electrical changes shall be scheduled with Facilities/Plant Operations.
3. Relocation of an entire suite or office will be completed jointly by Facilities/Plant Operations and Environmental Services as scheduled with the Director of Facilities who will coordinate the move.

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Use of Personal Electronic Equipment	Policy #	PO2028
Responsible	Facilities	Revised/Reviewed	12/1/2022

I. PURPOSE

To define the restrictions and procedures by which personal electrical/electronic equipment may be used in the hospital.

II. POLICY

The hospital discourages the use of personal equipment in the facility such as personal radios, televisions, hair dryers, razors, etc. by the patient or employee. Exception: Equipment belonging to the patient may be waived if it is necessary to speed the patient's recovery, ordered by the physician, and approved by the Nurse Supervisor.

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Patient-owned equipment
    a. Requested by the physician.
    b. Biomedical Engineering; will inspect and approve such equipment if it has an approved UL Label and is safe for use.
2. Employee's personal equipment may be used if approved by the department manager, if it is UL approved and meets the hospital safety guidelines for equipment.
3. Medical equipment brought into the hospital for patient care shall be safety tested and conform to the standards maintained by the hospital for its own equipment. Proof of the test must be provided in writing to the department manager before use begins

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Vehicle Access and Parking Areas Policy	Policy #	PO2029
Responsible	Facilities	Revised/Reviewed	12/1/2022

I. PURPOSE

To define the means of entrance and exit of hospital services and to specify areas of designated parking.

II. POLICY

1. Emergency Entrance
    a. Emergency services shall be identified and easily assessable from any vehicle entrance on the grounds.
    b. Adequate parking for emergency vehicles shall be provided.
    c. The drive-thru (canopy) will be used for loading and unloading emergency patients only.
2. Main Hospital Lobby Entrance
    a. The front entrance shall be identified and easily assessable from any vehicle entrance to the grounds.
    b. The drive-thru (canopy) is for picking up or dropping off patients only.
3. Freight Entrance
    a. Only those drives identified for freight shall be used by delivery vehicles.
    b. Freight access is by way of Materials Mgmt. directions.
4. Parking Area Designations - See Attachment
    a. Front - Northwest - visitors and patients only
    b. Southwest side - as indicated by; for physicians, patients or emergency vehicles.
    c. Southeast or rear of hospital near Cobalt area - patients only (where indicated by signs) and employees.
    d. Southeast or rear of hospital off employee entrance door and area near power plant employees only.
    e. Handicap - Adequate parking shall be provided and clearly identified. Unauthorized vehicles will be ticketed.
5. Security of parking areas
    a. Parking areas will be observed by the Security personnel on duty during their scheduled shift.
    b. The employee parking lot will be closed off at one entrance. The employee parking lot will be continuously monitored by the security guard.
    c. At any time other than 2215 thru 2345 any employee may call or page the security guard to walk thru to their car or meet them in the lot to escort them into the hospital provided they are using the employee parking lot.

III. DEFINITIONS

N/A

IV. PROCEDURE

N/A

V. REFERENCES

Human Resources Policy and Procedure Manual

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Utility System Failure Reporting Policy	Policy #	PO2030
Responsible	Facilities	Revised/Reviewed	12/2/2022

I. PURPOSE

The purpose of this policy is to provide guidelines for repairs and a reporting mechanism for utility system failures. The processes outlined in this policy will serve to provide a root cause analysis for each internal failure in an effort to prevent such a failure in the future.

II. POLICY

III. DEFINITIONS

UTILITY SYSTEMS- CLASSIFICATIONS

Equipment in the Utility Systems Management Program shall be classified as one of the following systems:

1. Normal power distribution system
2. Emergency power distribution system
3. Boiler and steam system
4. Heating, ventilating and air conditioning system (HVAC)
5. Plumbing system
6. Medical gas system
7. Clinical air and vacuum systems
8. Vertical and horizontal transport systems

Equipment maintained by the Facilities/Plant Operations department but not classified as one of the utility systems named above shall not be required to be reported as a Utility System Failure. Examples of such equipment include but are not limited to OR blanket warmers, hospital beds, and kitchen equipment.

Utility Systems – Failure Level

All utility system failures shall be classified into one of the following levels:

1. Total Failure: A utility failure that affects the entire utility system, a single building, or a group of buildings.
2. Limited failure: A utility failure that affects a single department or multiple departments.
3. Affecting patient care: A utility failure that causes modification or interruption of patient care or medical center operations.
4. Minor/Nuisance: A utility failure that minimal impact on patient care or medical center operations.

IV. PROCEDURE

1. Upon a report of utility system failure, the craftsman shall inspect and evaluate repairs needed. The craftsman shall call for additional resources if necessary.
2. In the event the utility or major equipment must be removed from service, the craftsman shall notify the Facilities/Plant Operations lead or the Director of Facilities Management.
3. The craftsman shall notify the appropriate utility or Service Company if the equipment is under service contract or if special parts or procedures are necessary.

4. The craftsman shall notify management of the affected areas. For other than normal working hours, the Nursing Supervisor shall be notified.
5. Record all pertinent information in the daily log, such as diagnoses, problems and corrective actions taken.
6. Record all incidents on the Utility System Failure Report (see attachment PO-2031.1)

Reporting and Analysis

All utility failures shall be reviewed by the Director of Facilities Management and will be assessed to determine long-tern solutions to each internal failure. Procedural practices will be modified as needed to minimize future failures of each specific failure if necessary.

Utility system failures classified as "Total Failure, Limited failure or Affecting Patient Care" shall be forwarded and reviewed by the EOC Committee on a quarterly basis.

V. REFERENCES

N/A

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Use of Portable Air Conditioning Units Policy	Policy #	PO2031
Responsible	Facilities	Revised/Reviewed	12/5/2022

I. PURPOSE

The purpose of this policy is to ensure the safe use of portable air conditioning units, commonly referred to as "Spot Coolers" utilized in patient care areas.

II. POLICY

Spot coolers may be utilized in patient and non-patient care areas under emergency circumstances when the air conditioning system is compromised and under repair. It is important that processes be implemented to ensure safe installation, monitoring and maintenance are performed when these machines are in service.

III. DEFINITIONS

IV. PROCEDURE

1. A list shall be maintained by the Facilities/Plant Operations department indicating the date, time, and location for each Spot Cooler placed into service and when removed from service.
2. Upon receipt of the Spot Coolers, an initial safety inspection shall be performed by the Biomedical Engineering department. The equipment shall be tagged and shall be placed on the Spot Cooler to indicate it has been inspected.
3. A hospital-approved germicide cleaner shall be used to clean the units prior to placing into service.
4. The electrical circuits shall be assessed prior to the installation of the Spot Coolers. While in service, Plant Operations shall monitor the units for excessive power cord temperatures and circuit interruption.
5. Electrical power cords shall be routed away from the egress path to prevent trip hazards.
6. Plant Operations shall monitor the Spot Coolers routinely to ensure condensate pans do not overflow and are emptied as needed.
7. Filters shall be inspected prior to use and cleaned as needed.
8. Chlorine tablets shall be placed in Spot Cooler condensate pans to prevent the build-up of algae.
9. Spot coolers condensate pans shall be inspected every 24 hours for build-up of algae and cleaned as needed.
10. Spot Coolers shall be adequately exhausted from the building.

V. REFERENCES

N/A

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Operational Guideline for Water Treatment Policy	Policy #	PO2032
Responsible	Facilities	Revised/Reviewed	12/5/2022

I. PURPOSE

To establish operational guidelines for water treatment associated with HVAC equipment and systems.

II. POLICY

III. DEFINITIONS

IV. PROCEDURE

Cooling Towers and Condensers

1. **Water Testing & Inspections**

Performed or provided by water treatment supplier

A. Monthly visual inspection
B. Monthly standard water chemistry analysis including:
   - Specific conductivity
   - pH
   - P&M alkalinities
   - Chlorides
   - Total hardness as CaCO3
   - Inhibitor
C. Monthly biological testing
D. Monthly calibration of conductivity controller
E. Monthly prime check on all chemical feed pumps

Performed in-house

F. Weekly water chemistry analysis including:
   - Specific conductivity
   - Inhibitor

2. **Biocide Program**

Performed or provided by water treatment supplier

A. Water treatment supplier shall provide a biocide program consisting of two EPA registered products: one oxidizing and one non-oxidizing product
B. Water treatment supplier shall ensure these products are fed twice weekly and alternating weekly.
C. System volume shall be determined by water treatment supplier to insure legal EPA dosage.

3. **Corrosion Coupon Testing**

Performed or provided by water treatment supplier

A. Mild steel and copper coupons shall be evaluated by water treatment supplier annually, during start-up, or program changes with minimum limits of <0.5 mil/yr. for copper and <4.0 mil/yr. for mild steel. Recommended guidelines for corrosion rates are <0.1 mil/yr. for copper and <2.0 mil/yr. for Steel.
B. Water treatment supplier should check that flow through the coupon rack is 5 gpm and exposure periods should be 60-90 days.
C. Water treatment supplier should ensure that steel coupons should be installed upstream of copper coupons.

4. **Idle Condensers**

A. Idle or stand-by condensers should be properly stored. Call water treatment supplier.

Chilled and Hot closed loops

1. Water testing & Inspections
   Performed or provided by water treatment supplier
   A. Closed loop chemistry shall be tested quarterly. If leaks are present, testing interval should increase to monthly until leaks are located and repaired.
      - Conductivity
      - pH
      - Nitrite
   B. Check circulation pumps for leaks
   C. Check expansion tanks and makeup valves for leaks
   D. Check for proper operation of back flow preventers

Steam Boilers, feed-water tanks, and de-aerators

Performed or provided by water treatment supplier

1. De-aerators
   - Check steam plume monthly for proper venting of gases normally 12-24 inches in height. If height exceeds 24 inches check for faulty steam traps and/or leaking heat exchangers.
   - Check steam pressure and temperature following manufacturer's guidelines normally 212-224 F.
   - Ensure all chemicals are FDA and USDA compliant for food contact.
   - Perform monthly sulfite analysis.
2. Feed-water tanks & pre-heaters
   - Ensure all chemicals are FDA and USDA compliant for food contact.
   - Perform monthly sulfite analysis.
3. Steam Boiler
   - Conductivity
   - pH
   - Sulfite
   - Phosphate or Polymer
   - P&M and OH alkalinities

Performed in-house

- Perform boiler conductivity testing daily.
- Perform boiler low water blow-down daily.
- Perform boiler continuous blow-down and bottom blow-down based on in-house testing and/or instructions by water treatment vendor.
  - Automatic surface blow-down controllers are not a substitute for bottom and/or safety lower water blow-down valves.
- Do not exceed 10 second durations. Should feed-water pump come on during blow-down, cease blow-down until water level returns to normal state.
- Check boiler blow-down valve for leaks by carefully checking the drain for temperature.
- Idle or stand-by boiler shall be stored with **100-150 ppm sulfite and M alkalinity of 300** ppm by water treatment supplier.

4. **Idle Boilers**
   A. Idle or stand-by boilers shall be stored with **100-150 ppm sulfite and M alkalinity of 300 ppm**. Call water treatment supplier.

Water Softeners

1. **Water testing & inspections**

Performed or provided by water treatment supplier

A. Perform calcium hardness testing monthly.
B. Check brine tank for proper water level monthly.
C. Check resin level annually.
D. Elution studies to be performed by water treatment supplier on an as needed basis

Internal Inspections

A. Internal inspections of boilers, chillers and cooling towers shall be conducted by water treatment supplier in conjunction with regularly scheduled preventive maintenance. Hospital shall contact water treatment supplier at least one week in advance of scheduled preventive maintenance to coordinate inspections. Documentation of internal inspections shall be maintained in operations logbook.

Documentation

3. Operations Logbook
   A. Water treatment supplier shall furnish and maintain an operation logbook containing the following.
      - Water treatment policy
      - Water treatment suppliers contact information
      - SDS associated with water treatment
      - Test logs
      - Monthly reports
      - Vendor documentation of internal inspections
        - Boilers
        - Chillers
        - Cooling Tower

V. REFERENCES

N/A

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Use of Emergency Generators for Cogeneration Policy	Policy #	PO2033
Responsible	Facilities	Revised/Reviewed	12/6/2022

I. PURPOSE

To define the use of the emergency power supply system in an acute care or long-term care hospital.

II. POLICY

In the event a facility requests using the emergency generator(s) for cogeneration purposes, the following steps shall be followed:

1. The hospital, in coordination with the Facilities Director, shall receive written approval from the Chief Operations Officer.
2. All contracts for cogeneration shall require hospital administration approval.

III. DEFINITIONS

Cogeneration, for the purposes of utilizing emergency generators in hospitals is defined as the use of the emergency generator to supply electrical power to the utility grid during peak demand periods defined by the electrical utility. It is the intent of Watsonville Community Hospital to preserve the integrity of emergency generators. Emergency generators are provided to ensure power is available to Life Safety, Critical, and Equipment branch systems in the event of a loss of normal utility power. The emergency power supply system is not designed for any other purpose. Increased utilization of the emergency power system can result in undue wear on the engine, switchgear, and associated equipment. Other potential problems include an increase in carbon emissions, excessive noise to the surrounding community, increased fuel consumption, increased maintenance costs and poor power quality that could affect essential operations in the hospital. Generation of electric power with smaller diesel engines is typically not cost-effective in the long run.

IV. PROCEDURE

V. REFERENCES

N/A

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Roof Replacement Projects Policy	Policy #	PO2034
Responsible	Facilities	Revised/Reviewed	12/6/2022

I. PURPOSE

To ensure all roof replacement projects are reviewed and approved by current insurance underwriter to starting any project.

II. POLICY

1. Administration
    a. When the Facilities Department submits a Capital Expenditure Request (CER) to Administrative Team for approval, an acceptance Letter from insurance carrier must accompany the CER. Roof replacement CERs will not be processed without this letter.
    b. All roof related CERs shall include documentation to demonstrate that the roof(s) has been assessed for asbestos containing materials (ACM). Representative test samples shall be submitted with the CER as described below:
        - • (3) samples at perimeter flashing (i.e., random locations – collect core type samples down to substrate)
        - • (3) samples at main bulk of roof (i.e., random locations – collect core type samples down to substrate)
        - • (3) samples at roof penetrations (i.e., vent stacks, curbs, roof mounted equipment)
2. Managing the Project
    a. Facility personnel should closely supervise all contractors involved with this project whenever present in the facility.
    b. Contractors should be advised of all regulations on smoking, hot work, flammable liquids handling, and housekeeping, before the start of any work.
    c. Combustible rubbish should be disposed of promptly and safely.
    d. Strict rules and an adequate number of clean up personnel are essential to facilitate the removal of accumulations of paper wrappings, scrap lumber, and other construction rubbish. Prompt disposal is particularly needed for material subject to spontaneous ignition, such as oily waste and paint rags.
    e. An ample supply of fire extinguishers should be maintained on the roof at all times.
    f. Facility personnel should closely supervise any hot work required for this project. All basic precautions on the FM Global Hot Work Permit System should be completed before hot work is allowed to begin.

III. DEFINITIONS

N/A

IV. PROCEDURE

N/A

V. REFERENCES

N/A

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Failure Air Conditioning System Policy	Policy #	PO3000
Responsible	Facilities	Revised/Reviewed	12/7/2022

I. PURPOSE

It is the policy of Watsonville Community Hospital that in the event of failure of all or part of the air conditioning systems, the following steps and procedures will be taken.

II. POLICY

1. Possible reasons for failure of air conditioning system
    a. Chiller failure or malfunction
    b. Cooling tower failure
    c. Pump failure
    d. Other equipment failure
    e. Failure in electrical system
    f. Failure of pneumatic system
    g. Loss of water
    h. Fire/smoke damper malfunction
2. Warning signs or indicators of failure
    a. Audible alarm
    b. Call from one or more affected areas
3. Back-up mechanisms or reserves
    a. Emergency generators
    b. Emergency power docking station (if applicable)
    c. Portable chiller connection portal (if applicable)
    d. Underground water well
    e. Spot coolers
4. Areas which may be affected
    a. All areas

III. DEFINITIONS

IV. PROCEDURE

1. Chilled Water System Failure:
    a. Check chiller control panel(s) and/or building automation system for errors and/or alarms
    b. Check safety mechanisms for proper operation
    c. Verify cooling tower operation
    d. Verify water supply
    e. Verify operation of chilled water circulating pumps
    f. Verify operation of condenser water pumps
    g. Verify electrical source to equipment (check for tripped breakers)
    h. If Facilities/Plant Operations Department personnel are unable to identify the problem, notify the Director of Facilities or his designee and contact the preferred contractor/ vendor for emergency repair service
    i. Arrange for portable cooling equipment as necessary
2. Air handler and Distribution System Failure:
    a. Check building automation system for errors and/or alarms
    b. Verify supply and return fan operation and check belts
    c. Check safety mechanisms for proper operation (e.g., freezestat, static limit switch, fire alarm interface, etc.)
    d. Verify operation of variable frequency drives

e. Check for excessive filter loading
f. Verify electrical source to equipment (check for tripped breakers)
g. Check for malfunctioning fire/smoke dampers
h. Verify damper positions
i. Verify control of heating and cooling valves and verify positions
j. Verify exhaust systems
k. If Facilities/Plant Operations Department personnel are unable to identify the problem, notify the Director of Facilities or his designee and contact the preferred contractor/ vendor for emergency repair service
l. Arrange for portable cooling equipment as necessary

3. In the event of a long-term loss of air conditioning systems, notify the following:
   a. Administration
   b. Nursing Supervisor
   c. Surgical Services
   d. Radiology
   e. MRI
   f. Information Technology (IT)
   g. Laboratory

V. REFERENCES

The Joint Commission Hospital Accreditation Standards, EC.02.05.01.09-11, 13

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Failure of Water Distribution System Policy	Policy #	PO3001
Responsible	Facilities	Revised/Reviewed	12/7/2022

I. PURPOSE

It is the policy of Watsonville Community Hospital that in the event of a malfunction and/or failure of the water distribution system; the following procedure will be followed.

II. POLICY

1. Areas which would be impacted:
    a. All areas
2. Possible reasons for failure:
    a. Breakage or disruption of the main water line into the hospital.
    b. Breakage or disruption of the water line inside the hospital.
    c. Contamination of the outside water supply.
3. Warning signs or indicators of failure:
    a. Decreased flow of water at the delivery points.
    b. Change of water odor, taste, color, texture.
4. Automatic back-up mechanisms or reserves:
    a. Contractual supply from outside vendor
    b. Local fire department
    c. On site water well (if applicable)

III. DEFINITIONS

IV. PROCEDURE

1. If interruption of service is due to an external source, contact water supplier (e.g. city, county, etc.) and determine extent of interruption and estimated repair time.
2. Distribute reserve water supply.
3. Activate water conservation policies/practices and notify the following immediately:
    a. Nurse Supervisor
    b. Administration
    c. Dialysis Unit
    d. Surgical Services
    e. Central Sterile
    f. Dietary
    g. Environmental Services
    h. Materials Management
    i. PBX
4. Limit water usage to essential patient care. Use of sinks, showers, toilets and water fountains should be rationed according to plan.
5. Inventory emergency supplies and forward information to Nurse Supervisor and Materials Manager.
    a. Bottled water
    b. Bio-hazard bags/supplies
    c. Waterless hand-washing gels/foams
    d. Other related supplies
6. Notify local Fire Department to standby for support of water-based fire protection systems for all affected buildings. Arrange for tanker truck deliveries, pumps, hoses, bladder pools, etc. as required.
7. Notify property insurer if the duration of the water loss will be substantial.

8. Switch non-potable water systems (e.g. cooling towers, vacuum pumps, etc.) to alternate underground well source if applicable.
9. If water loss is due to internal source and/or breakage of water piping, determine cause and isolate damaged portion of system if possible. Begin repairs immediately and/or contact local plumbing repair contractor
10. Upon return to service, perform the following:
    a. Notify all departments
    b. Check all ice machines, dialysis equipment and sterilizers for contamination.
    c. Switch water-base systems back to primary water source (e.g. cooling towers, vacuum pumps, etc.)

EXTERNAL RESOURCES

The following external resources are available for shipment of various supplies and/or assistance.

a. Watsonville Fire Station #2 (831) 768 3200
b. Ready Refresh (800) 274 5282
c. The hospital has a means for an emergency water connection and is located at the Facilities area in the back of the hospital
d. D&G Sanitation LLC (831) 722 6066
e. Santa Cruz Health Services Agency (831) 454 4000

CONTAMINATION OF WATER SUPPLY:

1. Turn off the main domestic water valve(s) to all areas.
2. Using the hospital's public address system and/or any other required means, instruct all personnel and visitors to refrain from drinking or using water for any purposes until further notice.
3. Disconnect all ice machines/ice makers and empty storage bins.
4. Notify personnel/departments listed under procedure 3a through 3i above.
5. Contact House Supervisor and/or Administration to notify the Department of Health immediately.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards, EC.02.05.01.9-11, 13

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Failure of Plumbing System Flooding Policy	Policy #	PO3002
Responsible	Facilities	Revised/Reviewed	12/30/2022

I. PURPOSE

It is the policy of Watsonville Community Hospital that in the event of a failure in the plumbing system or related flooding occurs; the following procedure will be followed.

II. POLICY

III. DEFINITIONS

1. Areas which could be affected
    a. All areas
2. Possible reasons for failure
    a. Blockage of the main sewer line
    b. Blockage of internal waste lines
    c. Failure of sewage ejectors or sump pumps
3. Warning signs or indicators of failure
    a. Overflowing toilets
    b. Slow drainage or water back-up in sinks and over floor drains
4. Automatic back-up mechanisms or reserves
    a. Portable toilets
    b. Bio-hazardous waste bags
    c. Portable emergency sump pumps.

IV. PROCEDURE

In the event of failure of the external sewer main:

1. Notify the Administrator on call, who will in turn notify the Department of Health, if necessary.
2. Notify the Facilities/Plant Operations Department at: 1277
3. Notify all departments in the facility.
4. Limit available bathrooms for public and staff to one per floor. Post restriction signs or lock the other bathrooms if necessary. Environmental Services shall be directed to install red bag liners in the available bathrooms.
5. If failure results in flooding, Environmental Services will remove water with wet vacuums.
    a. For additional equipment and resources during severe flooding events, contact the local Fire Department and/or plumbing contractor.

In the event of failure to the internal plumbing lines:

1. Notify parts of the facility that are affected.
2. Identify point of blockage and correct the problem if possible. If Facilities/Plant Operations Department personnel are unable to resolve the problem, call in an outside contractor to perform the repairs.
3. Limit available bathrooms for public and staff to one per floor in the affected areas. Post restriction signs or lock the other bathrooms if necessary. Environmental Services shall be directed to install red bag liners in the available bathrooms.
4. If failure results in flooding, Environmental Services will remove water with wet vacuums.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards, EC.02.05.01.9-10

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Failure of Boiler Steam Equipment Policy	Policy #	PO3003
Responsible	Facilities	Revised/Reviewed	12/30/2022

I. PURPOSE

It is the policy of Watsonville Community Hospital that in the event of a malfunction and/or failure of the steam delivery boilers; the following procedure will be followed.

II. POLICY

III. DEFINITIONS

1. Possible reasons for a boiler failure
    a. Equipment failure
    b. Disruption of supply lines (fuel, water)
2. Warning signs or indicators of failure
    a. Audible alarms
    b. Pressure gauge readings
    c. Loss of water
3. Automatic back-up mechanisms or reserve
    a. Alternate fuel supply
4. Areas which may be affected
    a. All areas

IV. PROCEDURE

In the event of total loss of steam boilers, the following procedure will be followed:

1. Notify Director of Facilities/Plant Operations immediately.
2. Director of Facilities Management/Plant Operations will determine the length of down-time and notify the following:
    - ✓ Nurse Supervisor- After hours
    - ✓ Administration - Inform Doctors and coordinate
    - ✓ Surgery – For possible cancellations
    - ✓ Nursing - Restrict hot water use
    - ✓ Environmental Services - To supply extra blankets for patient comfort
    - ✓ Sterilization – Re-sterilize loads during failure/malfunction
    - ✓ Dietary - Restrict hot water use and use paper plates for food service
    - ✓ All other affected departments
3. Notify Central/Sterile and Surgery of the failure and the approximate time it occurred. Items that were in the sterilization process at or near the time when the failure occurred must be sterilized again.
4. The following items will be checked to determine the cause of the failure:
    - ✓ Operation of fuel supply valves
    - ✓ Boiler control panel
    - ✓ Boiler water level/water supply
    - ✓ Steam-line distribution system or valve closures for restriction and end user's equipment, if boiler is functioning, but steam is not being supplied
5. Make necessary repairs if possible. If Facilities/Plant Operations Department personnel cannot identify or resolve the problem, outside Vendor for 24-hour repairs with authorization of Facilities Director or designee.
6. The Facilities Director will notify all departments once systems have been restored.

V. REFERENCES

The Joint Commission Hospital Accreditation Standards, EC.02.05.01.9-10

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Emergency Telephone List Policy	Policy #	PO3005
Responsible	Facilities	Revised/Reviewed	12/3/2022

I. PURPOSE

To establish procedures on how to obtain emergency repair services.

II. POLICY

III. DEFINITIONS

IV. PROCEDURE

1. Plant Operations personnel shall respond immediately to all utility equipment and system failures.
   Common equipment/system failures or scenarios:
   a. Normal power systems
   b. Emergency power systems
   c. Elevators
   d. HVAC systems
   e. Boiler/Steam equipment
   f. Water distribution system
   g. Plumbing system
   h. Telecommunication systems
   i. Nurse call system
   j. Oxygen system
   k. Medical air system
   l. Medical vacuum system
   m. Nurse call system
   n. Fire alarm system
   o. Pneumatic tube system
   p. Roofing systems
   q. Hazmat
   r. Toxic External Atmosphere
   s. Other systems

*See respective policy and procedure for each of the above.

2. The numbers listed below will be utilized for emergency repair services and/or support. Emergency contact list shall be routinely reviewed for accuracy and updated at least annually.

Emergency Utility Contac	Vendor	Telephone Number
Fire Department		
Hazmat Team		
Police Department		
Police Department (Emergency)		
Natural Gas Co		
Natural Gas Co (Emergency)		
Water Department		

Elevator Repair Co		
Electric Co		
Emergency Generator		
Emergency Generator Fuel (diesel)		
Plumbing		
A?C & Refrigeration		
Fire Alarm Monitoring		
Fire Alarm System		
Fire Extinguisher Service (call & refill/replace when needed)		
Boilers		
Bulk Oxygen System/piped Med Gasses		
Telephone System (internal)		
Telephone System (external)		
Overhead Paging System		
Ambulance Radio		
Nurse Call System		
Alternate Water Supply		
Infant Abduction System		

V. REFERENCES

The Joint Commission Hospital Accreditation Standards, EC.02.05.01.12

VI. STAKEHOLDERS

Facilities

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Pharmacy Quality Monitoring Activities and Medication Use Improvement Plan	Policy #	PHARM1671
Responsible	Pharmacy Director	Revised/Reviewed	01/2023

I. PURPOSE

To ensure an on-going, criteria-based process for the hospital to evaluate its medication management system and identify areas to improve on the safe, effective, and appropriate use of medication.

II. POLICY

- Pharmacy staff shall participate in facility-wide quality improvement (QI) activities, and collaborate in planning, designing, measuring, assessing, and improving quality.
- Pharmacy staff shall participate in cross-departmental, cross-discipline, cooperative efforts to improve quality.
- Focus of medication use improvement process shall be to evaluate and improve on the safe, effective, and appropriate use of medication.
- Medication Use Evaluation (MUE) program shall be performed in collaboration with Pharmacy Department, Nursing Service, Medical Staff, Administration, and other departments, services and individuals, as required.

III. DEFINITIONS

N/A

IV. PROCEDURE

A. Design of Process:

1. The facility shall use a systematic, planned approach to improving quality. Pharmacy shall collaborate in the facility's quality improvement (QI) planning.
2. Pharmacy shall, as necessary, participate in the facility's process design activities.
3. Medication use improvement (quality improvement) activities will focus on improving processes that are important to the health and safety of patients.
   a. If specific drugs are targeted, medication use improvement activities may include the use of criteria against which drug use can be compared.
   b. Criteria may describe the presence or the absence of critical structures, processes, desirable outcomes, and undesirable outcomes.
4. Medication to be targeted – including, but not limited to medications which:
   a. Are used frequently (high volume)
   b. Are at risk for potentially serious consequences to patient if used inappropriately (high risk)
   c. Have a past demonstrated tendency to produce problems associated with use (problem-prone)
   d. Have known drug-drug interactions that may present significant health risk to patient.
   e. Have documented adverse and/or toxic effects or complications if not prescribed and monitored correctly.

f. Are used in treatment of patients who may be at high-risk for adverse drug reactions because of age, disability, or unique metabolic characteristics.
g. Are identified by Infection Control as possibly changing sensitivity patterns of pathogenic organisms due to suspected inappropriate prescribing.
h. Have potential for toxicity or increased effect in the presence of advance disease states.
i. Are identified or suspected by other monitoring and assessment activities as being inappropriate or incorrectly prescribed.
j. Have significant cost savings but no demonstrable clinical advantage.

5. Medication use shall be evaluated when important single events or variances occur and when patterns and trends signal opportunities to improve the quality of medication use.
   a. See policy *#1799: Medication Variance Monitoring and Reporting*
      1) Director of Pharmacy shall have access to medication error reports and work with Risk Manager to identify trends and opportunities for process improvements to improve safety of medication administration.

6. Emphasis shall be on the effective, appropriate, and safe use of drugs. Processes involved in medication administration to be targeted:
   a. Selection, procurement, and storage of medication
      1) e.g., ensuring integrity and security of medication
      2) The pharmacy shall monitor the selection/procurement/storage of drugs. The findings shall be recorded. Any form (e.g., a Pharmacy Intervention Log or similarly named form) may be used to record the findings. The pharmacy shall review the findings, identify problems to resolve or processes to improve, and work within the framework of the organization-wide quality improvement program to improve the processes.
   b. Ordering, prescribing medication
      1) e.g., improving the clarity of medication orders, preventing duplicate therapy, adjusting doses based on patient specific criteria (renal/hepatic function, pregnancy/lactation, age, other co-morbid states), ensuring appropriateness of route of administration to provide optimal patient outcomes
      2) The pharmacy shall monitor the ordering/prescribing of drugs. Then findings shall be recorded. Any form (e.g., a Pharmacy Intervention Log or similarly named form) may be used to record the findings. The pharmacy shall review these findings, identify problems, and work to resolve or improve processes while working within the framework of the organization-wide QI program.
   c. Dispensing, preparing medication
      1) e.g., reducing Pharmacy dispensing errors, ensuring timely delivery of medication
      2) The pharmacy shall monitor the preparation and dispensing of drugs and shall document dispensing errors (e.g., those related to accuracy and contraindications). The pharmacy shall review the findings, identify problems to resolve or processes to improve, and work within the framework of the organization-wide QI program to improve the preparation and dispensing of drugs.
   d. Administration of medication
      1) e.g., reducing medication administration errors, improving drug administration techniques
      2) The pharmacy shall cooperate with nursing service to monitor and document drug administration errors. The pharmacy shall participate, as necessary, in the review of drug administration errors to help identify problems to resolve and offer recommendations that improve drug administration procedures and safety. The Director of Pharmacy shall have access to medication error reports to identify trends and opportunities for process improvements to improve medication safety.

e. Monitoring the effects of medication on patients
   1) e.g., improving the detecting, reporting, and assessing of adverse drug reactions and less than optimal patient outcomes
   2) The pharmacy shall cooperate with the medical staff and nursing services to monitor the effects of drugs. The pharmacy shall participate in the facility's adverse drug reaction reporting program to help identify opportunities for improvement. Additional sources (e.g., patient laboratory data) may also be used to identify opportunities to improve monitoring the effectiveness of prescribed drugs.

B. Monitoring/measurement:
   1. The Pharmacy shall, when required, monitor objective, measurable indicators that measure the presence or absence of critical structures or processes, or define desirable or undesirable outcomes.
      a. Indicators shall be based on current knowledge and clinical experience.
   2. Pharmacy shall collaborate to select, collect, align, and integrate data and information for tracking daily operations and overall performance of medication management and safety with the intent to support appropriate decision making and innovation.
   3. Pharmacy shall monitor selection / procurement / storage of drugs, ordering / prescribing of drugs, preparation and dispensing of drugs, and administration of drugs.
      a. Pharmacy shall participate in review of medication variances, to identify problems, and resolve and/or improve on processes contributing to potentials for error.
      b. Findings shall be recorded.
   4. Data sources - including, but not limited to:
      a. Medical Records, including emergency and admitting records
      b. Pharmacy Profiles/Records
      c. Laboratory Records
      d. Medication Administration Records (MAR's)
      e. Infection Control Reports
      f. Statistical drug data
      g. Drug Usage Reports
      h. Adverse Drug Reaction Reports
      i. Medication Variance Reports
      j. Logs / inspection records
      k. Incident Reports
      l. Education Records
      m. Committee minutes
   5. Sampling:
      a. Either total population (e.g., all patients or units) or a representative sample may be monitored.
      b. When possible, the minimum sample size shall be the greater of at least 30 records or 5% of the total population.
   6. Monitoring frequency:
      a. Monitoring of data shall be ongoing, systematic, and sufficient to identify occurrences that may signal opportunities to improve processes.
      b. Frequency of monitoring may vary with the significance of the process and may range from continuous or daily monitoring to periodic screening (e.g., weekly, monthly, and quarterly)
   7. Collection of data:
      a. Pharmacist(s) shall be responsible for data collection activities.

b. Collection of data shall be performed from data sources pertinent to important aspects of drug use.

8. Patient Drug Monitoring:
   a. Pharmacy shall cooperate with Medical Staff and Nursing Service to monitor the effects of medication.
   b. Pharmacy shall participate in facility's adverse drug reaction reporting program to help identify opportunities for improvement.
      1) See policy *#1429: Adverse Drug Reaction*
   c. Additional sources (e.g., patient laboratory data) may also be used to identify opportunities to improve monitoring effectiveness of prescribed medication.

C. Assessment:
   1. The facility shall assess data for patterns and trends that signal opportunities to improve processes.
      a. The Pharmacy shall, as necessary, participate in the facility's assessment activities.
   2. Performance review findings shall be used to develop priorities for continuous improvement.

D. Improvement:
   1. The facility shall systematically work to improve its medication use processes.
      a. Highest priority shall be given to processes with the greatest potential for improving patient care and safety.
   2. Actions to improve medication use - including, but not limited to:
      a. Revising processes
      b. Providing educational programs
      c. Education of facility staff using newsletters and memoranda
      d. Developing, revising, and implementing policies and procedure that improve medication safety
      e. Establishing formulary and prescribing restrictions
      f. Developing standardized drug therapy protocols
      g. Implementing therapeutic substitution policies
      h. Requiring special order forms for selected drugs

E. Evaluation of effectiveness of action taken:
   1. The facility shall evaluate actions taken to ensure that it is effective and that any progress achieved is sustained.
   2. Time frame used for assessment or re-assessment may vary with the nature and severity of the area of concern.
   3. Pharmacy shall, as necessary, participate in the facility's evaluation of the effectiveness of actions taken.
   4. When possible, comparative data and information shall be obtained by benchmarking to ensure results represent best practices and performance for similar activities both within the facility and as it compares to like organizations.

F. Documentation:
   1. Documentation shall note any efforts to improve patient care – including, but not limited to the following:
      a. Findings (e.g., data, variances, and unjustified variances)
      b. Conclusions (e.g., problem identified, opportunities to improve medication use and patient care, causes of problems, usage patterns and trends)
      c. Recommendations (e.g., proposed action, what should be done)
      d. Action(s) taken (e.g., what has been done to date)

e. Effectiveness of results of actions taken (e.g., problems resolved and improvements in medication use)

2. Director of Pharmacy shall maintain records as required by the facility.

G. Reporting of data:

1. Communication of Medication Usage Evaluation (MUE) - including, but not limited to:
   a. Pharmacy and Therapeutics Committee
   b. Quality Coordinating Council
   c. Appropriate individuals and departments throughout facility
2. Reporting frequency shall be determined by facility's Director of Quality Management

I. REFERENCES

Joint Commission Standards: LD.03.04.01, EP 1,3,3,7; LD.03.05.01, EP 1,3,5,7; LD.04.04.05, EP 5; MS.05.01.01 ,EP 4; MM.02.01.01, EP 3; PI.02.01.01, EP 1-4; PI.03.01.01, EP 1-4

II. STAKEHOLDERS

N/A

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Look A Like and Sound A Like Medications / Drugs	Policy #	PHARM2019
Responsible	Pharmacy Director	Revised/Reviewed	01/2023

I. PURPOSE

To establish procedural guidelines for storage of look-a-like / sound-a-like medication.

II. POLICY

- Pharmacy will maintain a list of medications, which are considered to either look-a-like or sound-a-like.
- Since these identified medications are inherently more likely to cause a medication error, Pharmacy will put measures into place to differentiate particular medications from other medications that may look or sound similar.
- Hospital personnel should take precautions to ensure errors associated with look-a-like / sound-a-like medications are minimized.
- The Director of Pharmacy shall annually review the facilities' list of look-a-like / sound-a-like medication.

III. DEFINITIONS

N/A

IV. PROCEDURE

A. Definition:

1. Sound-a-like / look-a-like medication names include those names which possess similar spelling and/or similar phonetics.
2. A list of these medications may be obtained from the Institute for Safe Medication Practices (ISMP) at: http://www.ismp.org/Tools/confuseddrugnames.pdf.

B. Education:

1. Facility will provide education to all professionals who prescribe, stock, dispense, and administer medications to patients on the measures the facility has undertaken to minimize the potential for mistaken interchange of look-a-like / sound-a-like drugs.

C. List and Identification of Look-A-Like / Sound-A-Like Medications:

1. Facility will maintain a minimum list of 10 look-alike/sound-alike medication names.
2. Established organizations, which deal with medication safety, and health care professionals, such as Pharmacy and Nursing staffs, are the best sources to identify situations, where Look-A-Like and Sound-A-Like medications could potentially result in a medication error.
3. Organizations, such as the Institute for Safe Medical Practices (ISMP) and the USP Quality Review, are resources that may identify previously unidentified risk and will be periodically reviewed by the Director of Pharmacy.
4. Medications involved with a medication error or "close call" that are deemed to be related to Look-A-Like and Sound-A-Likes medications will be reviewed to identify ways to differentiate, if deemed necessary.

D. Strategies for differentiating Look-A-Like and Sound-A-Like Medications:

1. **Pharmacy Storage:**
   a. Medications that have similar appearances and/or names may be flagged with a Look-A-Like/Sound-A-Like warning sign, sticker, and/or bin.
   b. Segregation of similar products is recommended when the level of potential harm is high.
2. **Pyxis Storage:**
   a. Medications that have similar appearances may be segregated.
   b. Segregation may include loading Look-A-Like and Sound-A-Like medications in pockets that are NOT adjacent to each other.
   c. Segregation may also include loading medication into different drawers or unloading one of the medications, if both medications initially loaded into the same drawer.
   d. "Clinical Data Category" in Pyxis, that prompts User to validate medication prior to removal from MedStation, may be added to Look-A-Like / Sound-A-Like medication as an additional warning.
3. **Labeling:**
   a. Label with "Look-a-like and Sound-a-like" sticker
   b. Tallman lettering in HMS and Pyxis Systems
   c. Brand and generic names to appear in HMS and Pyxis Systems

I. REFERENCES

Joint Commission Standard: MM.01.02.01 EP 1 MM.04.01.01 EP 4

II. STAKEHOLDERS

N/A

List of Look-A-Like and Sound-A-Like medications:

1.	ePHEDrine	EPINEPHrine
2.	HYDROmorphone	morphine
3.	hydrOXYzine	hydrALAZINE
4.	Insulin products	
5.	metFORMIN	metroNIDAZOLE
6.	OxyCONTIN	oxyCODONE
7.	cloNIDine	KlonoPIN (Clonazepam)
8.	Mucinex	Mucomyst
9.	M.S. Contin	OxyCONTIN
10.	Solu-CORTEF	SOLU-Medrol
11.	OLANZapine (ZyPREXA)	Ondansetron (Zofran)
12.	HYDROcodone	oxyCODONE
13.	DOBUTamine	DOPamine
14.	RifAMPin	RifAXIMin
15.	SEROquel	Sertraline
16.	PrednisoLONE	predniSONE

Joint Commission – Medication Management Standards

Look-a-like and Sound-a-like List (MM.01.02.01)

ePHEDrine ... EPINEPHrine
HYDROmorphone ... morphine
hydrOXYzine ... hydrALAZINE
Insulin products
metFORMIN ... metroNIDAZOLE
OxyCONTIN ... oxyCODONE
cloNIDine ... KlonoPIN
Mucinex ... Mucomyst
M.S.Contin ... OxyCONTIN
Solu-CORTEF ... Solu-MEDROL
OLANZapine ... Ondansetron
HYDROcodone ... oxycodone
DOBUTamine ... DOPamine
Rifampin ... Rifaximin
SEROquel ... Sertraline
PrednisoLONE ... predniSONE

Hazardous Medication List (MM.01.01.03)

Handling:

- Please see updated list on Watsonville Community Hospital INTRANET / SharePoint site.
- Nursing Handling Categories (A/B/C) and Pharmacy Handling Categories (1/2/3/4/5) are built into both MediHost (eMAR) and Pyxis

Disposal:

- **Dispose of pourable remainder in Black Container** (Listed as BKC)
- **Dispose of remainder and PACKAGING in Black Compatible Container** (Listed as PBKC)
  COUMADIN NICOTINE
- **Send remainder back to Pharmacy for proper disposal** (Listed as SP / SPC / DW / SPLP / SPO)

High Alert Medication List (MM.01.01.03)

Aminoglycosides
Amiodarone
Anti-coagulants (eg. rivaroxaban, dabigatran)
Caffeine (Citrate)
Carbamazepine
Digoxin
Divalproex Sodium
Electrolytes
Enoxaparin
Epidural
Erythropoietin Stim. Agents
Fentanyl Transdermal Patch
Haloperiodol
Hazardous Drugs
Heparin
Immune Globulin
Insulin
Ketorolac
Magnesium Sulfate Injection
Methotrexate IM for ectopic pregnancy
Moderate Sedation medication (eg. fentanyl)
Neuraxial Local Anesthetics (eg, bupivacaine)
Neuromuscular Block. Agents (eg, vecuronium)
Oxycodone, immed & ext release
Parenteral Nutrition
PCA (patient controlled analgesia)
Pediatric doses
Phenytoin
Propofol
Radiocontrast Agents
Sodium Polystyrene Sulfonate
Warfarin

Updated 1-4-2023 AG

WATSONVILLE
COMMUNITY HOSPITAL

Policy/Procedure Title	Medical Staff Policy Regarding Peer Review, Ongoing Professional Practice Evaluation (OPPE) & (FPPE)	**Manual Location**		Medical Staff, Quality Management	
Policy/Procedure #	2842	**Effective**	9/12	**Page**	1 of 11
Department Generating Policy	Medical Staff , Quality Management	**Revised**	12/18		

I. SCOPE

Applies to all credentialed members of the Medical Staff and Allied Health Practitioners.

EXCEPTION:
No volume providers with medical staff membership and without clinical privileges per Joint Commission clarification are exempt from the Ongoing Professional Performance Evaluation and Focused Professional Practice Evaluation requirements contained within this document.

II. PURPOSE:

To assure that the Board of Trustees, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competence, practice, and the quality of patient care;

To define those circumstances in which an external review or focused review may be necessary

To address identified issues in an effective and consistent manner.

"Professional Practice Evaluation" is considered an element of the peer review process and the records and proceedings relating to this policy are confidential and privileged to the fullest extent permitted by applicable law.

III. DEFINITIONS

Peer:
For purposes of this policy, the term "Peer" refers to any practitioner who possesses the same or similar knowledge and training as the practitioner whose care is the subject of review.

IndividualCaseReview:
The process outlined for peer review of a particular case identified with a potential quality of care issue.

OngoingProfessionalPracticeEvaluation:

The ongoing process of data collection for the purpose of assessing a practitioner's clinical competence and professional behavior. Information gathered during this process is factored into decisions to maintain, revise, or revoke an existing privilege(s) prior to or at the time of the two-year membership and privilege renewal cycle.

FocusedProfessionalPracticeEvaluation:

The time-limited evaluation of practitioner competence in performing a specific privilege. The process is consistently implemented as a means to verify clinical competence for all initially requested privileges, for a newly requested privilege, and whenever a question arises regarding a practitioner's ability to provide safe, high-quality patient care. FPPE is not considered an investigation or corrective action as defined in the Medical Staff Bylaws and is not subject to the Bylaws provisions related to the corrective action process.

FPPE affects only the privileges for which a relevant concern has been raised and related privileges for which the same concern would apply. Other existing privileges in good standing should not be affected by the decision to initiate FPPE.

PeerReview

Peer Review is the process by which a practitioner, or committee of practitioners, examines the work of a peer and determines whether the practitioner under review has met accepted standards of care in rendering medical services. The professional or personal conduct of a physician or other healthcare professional may also be investigated. Individual Case Review, Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation are components of peer review.

PractitionerProctoring:
Please Refer to Proctoring Policy (#0158)

FocusedProfessionalPracticeEvaluation(FPPE)

A. Initiation of FPPE

FPPE will be initiated in the following instances:

- Upon initial appointment;
- When a new privilege is requested by an existing practitioner;
- When a question arises through the OPPE process, individual case review, or other peer review process regarding a currently privileged practitioner's ability to provide safe, high-quality patient care. For example, when a trigger is exceeded and preliminary review indicates a need for further evaluation.

A recommendation of FPPE may be made by:

- The Credentials Committee;
- A Department of the Medical Staff;
- The Chief of the Department;
- A special committee of the medical staff;
- The MEC

The FPPE monitoring plan for a new practitioner, or newly requested privilege(s) will be specific to the requested privileges or group of privileges as defined in the Medical Staff Proctoring policy.

FPPE is not considered an investigation as defined in the Medical Staff Bylaws and is not subject to the bylaws provisions related to investigations. If FPPE results in an action plan to perform an investigation, the process identified in the Medical Staff Bylaws would be followed.

B. Timeframe for Collection and Reporting

The period of FPPE must be time-limited. Time-limited may be defined by;
A specific period of time;
A specific volume (number of procedures/admissions)

The medical staff may take into account the practitioner's previous experience in determining the approach, extent, and time frame of FPPE needed to confirm current competence. The practitioner's experience may be individualized based upon one of the following experience/training examples:

1. Recent graduate from a training program at another facility, where the requested privileges were part of the training program (competence data is not available)
2. A practitioner with regular experience exercising the requested privilege of fewer than two to five years on another medical staff

FPPE shall begin with the applicant's first admission(s) or performance of the newly requested privilege. FPPE should optimally be completed within three months, or a suitable period based upon volume. The period of FPPE may be extended as necessary at the discretion of the medical staff but may not extend beyond the first biennial reappointment.

C. Methods for Conducting FPPE/Communication to the Practitioner

FPPE may be accomplished by:
1. Chart reviews, both concurrent and/or retrospective
2. Simulation
3. Discussion with the involved practitioner and/or other individuals involved in the care of the practitioner's patients
4. "Non-Mandatory" Direct observation/proctoring, i.e., observation/proctoring of a nature that does not restrict the physician's privileges or right to practice in the hospital, including the right to proceed with procedures or surgeries. Non-Mandatory observation/proctoring preserves the physician's right to proceed with a procedure or surgery regardless of the presence of an observer/proctor. Any requirement to the contrary is reserved solely for decision of the Medical Executive Committee, may implicate reports to the Board and Data Bank, and may require the grant of hearing rights under the Medical Staff Bylaws.
5. For dependent AHP's, FPPE methods may include review or proctoring by the sponsoring physician.
6. Internal or external peer review.

The terms of all FPPE shall be communicated in writing to the affected practitioner, including the following:
- The cause for the focused monitoring
- The anticipated duration
- The specific mechanism by which monitoring will occur (i.e. chart reviews, proctoring, peer observation, etc.)

D. Performance Monitoring Criteria and Triggers

Monitoring criteria, including specific performance elements to be monitored, as well as thresholds or triggers, are developed and approved by the medical staff or medical staff department/committee. The triggers are defined as potentially unacceptable levels of performance. Triggers to consider include, but are not limited to:
- A single egregious case or evidence of a practice trend
- Exceeding the predetermined thresholds established for OPPE
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations
- Elevated infection, mortality and/or complication rates
- Failure to follow approved clinical practice guidelines
- Unprofessional behavior or disruptive conduct

If the results for a practitioner exceed thresholds established by the Medical Staff, outliers may be forwarded for peer review after initial screening by the Quality Management Department.

Attachment B Performance Measures & Triggers

E. Conclusion of FPPE

At the conclusion of the initial FPPE, findings will be reviewed by the Medical Executive Committee or responsible Department, for decision and recommendation. Decisions may include moving forward with OPPE, extending the period of FPPE, development of a performance improvement plan, or recommending to limit or suspend the privilege. Such recommendations are reported to and approved by the Medical Executive Committee and Board of Trustees. For recommendations resulting in restriction, suspension, revocation of specific privileges or other limitation on privileges, the processes pursuant to the Medical Staff Bylaws Appendix A (Fair Hearing Plan) will apply.

Each practitioner will be notified of their performance and outcome(s) following FPPE. A letter is forwarded to the Medical Staff member including, but not limited to, the following:

- Findings and outcome of FPPE
- Specific actions, if any, that need to be taken by the Practitioner to address any quality concerns and the method for follow-up to ensure that the concerns have been addressed; and
- If the focused review is complete or will continue (duration will be specific if the focused review will continue)
- The period of initial FPPE is completed and the practitioner will move into OPPE
- The period of FPPE for a specific privilege is completed and the practitioner will continue with OPPE

At the end of the period of focused evaluation, in the event that the practitioner's activity/volume has not been sufficient to meet the requirements of FPPE:

- The practitioner may voluntarily resign the relevant privilege(s), or
- The practitioner may submit a written request for an extension of the period of focused evaluation, or
- If the practitioner has sufficient volume of the privileges in question at another local facility, external peer references specific to the privilege/procedure will be obtained.
- FPPE may be extended at the discretion of the responsible medical staff department or committee.

The practitioner is not entitled to a hearing or other procedural rights for any privilege that is voluntarily relinquished.

Results of FPPE are maintained in the Practitioner's Confidential Quality File.

F. Performance Improvement Plan

If FPPE outcomes identify the need for an improvement plan, the plan will be drafted by the responsible medical staff department, committee or chair. The written improvement plan and supporting FPPE outcomes should be presented to the Medical Executive Committee for approval. The involved Practitioner should also be offered the opportunity to address the Committee and respond to the findings before the improvement plan is finalized and implemented.

Methods identified to resolve performance issues shall be clearly defined. Examples of improvement methods may include:

- Necessary education
- Proctoring (but only as described under Section C.) and/or mentoring
- Counseling
- Practitioner Assistance Program
- Suspension or revocation of privilege, subject to the provisions of the Bylaws.

Following approval by the Medical Executive Committee (MEC), the Department or Committee Chair, or Chief of Staff will meet with the Practitioner to communicate the improvement plan. If the Practitioner agrees with the plan, the written document should be signed by the Practitioner and forwarded to the Quality Department. If the Practitioner does not agree with the plan and/or refuses to implement the improvement plan, the outcome will be reported to the responsible department chief and/or Medical Executive Committee for resolution.

ONGOING PROFESSIONAL PRACTICE EVALUATION

A. Timeframe for Collection and Reporting

OPPE will be initiated and reported on all providers with clinical privileges. Results of OPPE will be reported for review and/or action six months if possible, and in no event less frequently than every nine months.

B. Indicators for Review

1. The type of data to be collected and related thresholds, or triggers, is determined by individual medical staff committees/departments and approved by the Medical Staff. Indicators may change as deemed appropriate by the department and/or medical staff and should be reviewed and approved on an annual basis. Data collected should not be limited to negative/outlier trending data. Good performance data should also be considered.

    a. Each Medical Staff department will select three to five *specialty-specific* indicators based upon their clinical service. These indicators may be evidence-based, such as post-op infection rate, etc.
    b. The Medical Staff will select *general* indicators that apply to all credentialed practitioners.
    c. The Medical Staff may consider using the six areas of "General Competencies" developed by the Accreditation Council for Graduate Medical Education (ACGME). These include:
        i. Patient care
        ii. Medical/clinical knowledge
        iii. Practice-based learning and improvement
        iv. Interpersonal and communication skills
        v. Professionalism
        vi. Systems-based practice

2. Thresholds/triggers for performance must be defined for the selected indicators. Triggers are defined as unacceptable levels of performance within the established defined criteria and are used to identify those performance outcomes that could trigger FPPE. Triggers to consider include, but are not limited to:
    Defined number of events occurring
    Defined number of individual peer reviews with adverse determinations
    Elevated infection, mortality, and/or complication rates
    Sentinel events
    Small number of admissions/procedures over an extended period of time
    Increasing lengths of stay in comparison to peers
    Increasing number of returns to surgery
    Frequent unanticipated readmission for the same issue
    Patterns of unnecessary diagnostic testing/treatments
    Failure to follow approved clinical practice guideline

3. Two level 4 judgments within a rolling 24 month period
4. Any combination of four level 3 and 4 judgments within a rolling 24 month period
5. 3 incidents of significant disruptive behavior incidents (as judged by MEC) within a rolling 12 month period

C. Oversight and Reporting

The organized Medical Staff delegates the collection of the selected performance indicators to the appropriate hospital department. The overall process, data compilation and reporting is coordinated by the Quality Management Department.

The review of performance data and any recommendation(s) for action, if necessary, may be the responsibility of one of the following:

The Medical Executive Committee;
The specific Medical Staff Department;
The Chief of the Department;
The Medical and Surgical Quality Review Committees

D. Results and Reporting of Data Analysis

Data are analyzed and reported to determine whether to continue, limit, or revoke any existing privilege(s). The results of the individualized practitioner report are referenced in the MEC meeting minutes, maintained in the quality file and incorporated into the two-year reappointment process.

The outcome of the evaluation must be documented and maintained in the practitioner quality file.

During the course of OPPE, FPPE may be triggered by the following special circumstances:

A single egregious case or evidence of a practice trend
Exceeding the predetermined thresholds established for OPPE
Patient/staff complaints
Non-compliance with Medical Staff Bylaws, Rules and Regulations
Elevated infection, mortality and/or complication rates
Failure to follow approved clinical practice guidelines
Unprofessional behavior or disruptive conduct

If unprofessional behavior or disruptive conduct is identified as a possible concern, the Disruptive Practitioner Policy will be initiated as a component of the OPPE.

At the completion of the review period, the results of OPPE (the practitioner profile report) will be communicated to the individual practitioner. The original report will be maintained in the practitioner quality file.

RESPONSIBILITIES OF THE QUALITY MANAGEMENT DEPARTMENT:

1. The Quality Management Department will be responsible for compiling and reporting results of FPPE and OPPE to the Medical Staff Committee(s) every six months in no event less frequently than every nine months. A practitioner-specific profile will be utilized.

2. In order to facilitate FPPE for Allied Health Professionals, and/or those practitioners requesting a new privilege, the practitioner must notify the Quality Management Department of the first scheduled procedure or encounter. The practitioner must also provide the Quality Management Department with a patient listing or log until the specified patient volume or FPPE requirement is met.

3. The OPPE practitioner-specific profile that illustrates performance over the two-year reappointment cycle will be utilized at the time of reappointment.

4 The Quality Management Department will be responsible for working with each Medical Staff Committee on an annual basis to review the continued relevance of the selected indicators and triggers.

Individual Case Review Process

Cases identified with potential quality of care issues are referred to either the Medical Quality Review Committee or Surgical Quality Review Committee for review. The Quality Management Department is responsible for coordinating the Peer Review Process.

Cases may be identified through OPPE, FPPE, case management, risk management, audits, sentinel events, clinician referrals, allegations of suspected substance abuse or disruptive behavior and other sources. All cases should be initially screened by the Quality Management department utilizing medical staff approved screening criteria, prior to forwarding for physician review. If there are no potential quality of care issues identified following the quality management screening, the case is closed, the findings are documented and trending is performed in the Quality Department.

If potential quality of care issues are identified through Quality Management screening, the following process for peer review shall be implemented:

A. ReviewerSelection&Duties

Reviews are completed by the designated Medical Staff Quality Review Committee.

The Committee Chair shall determine the individual physician(s) to perform the initial review and shall designate a deadline within which the individual physician reviewers shall complete the review which shall not be greater than 60-days and at least 2 weeks prior to the next committee meeting. This will allow time for the involved Practitioner to respond prior to the meeting (see below Communication to Involved Practitioner).

The individual physician reviewer(s) shall perform the initial review, complete the Peer Review Form, including initial grade (see Review Form Summary below). The reviewer will report written findings and recommendations to the Committee at its next regularly scheduled meeting following the completion of the review period.

The designated reviewer may not review a case where he/she participated in the care.

B. ReviewerDisqualification&Replacement

If a reviewer does not feel he/she can adequately review a medical record due to a conflict of interest or believes he/she is not qualified to address a certain issue, the reviewer may discuss the issue with the Chairperson of the Committee, Department Chief or Chief of Staff. If the Chair concurs, the Chair shall reassign the record(s) to another reviewer. If a member has reviewed a record that needs to be presented but is unable to attend the meeting, the member shall report to the Chair so that the presentation may be reassigned to another Committee member or presented by the Chairperson. If the chairperson is the practitioner subject to review, the record review will be assigned to another Active Staff member by the Chief of Staff. Should the hospital have only one practitioner in a particular specialty, or the pool of eligible reviewers is otherwise conflicted or unable to serve, the MEC or the Board of Trustees may request external peer review by a practitioner who is Board certified within the same specialty.

C. Communication to Involved Practitioner

Any Practitioner who is the subject of a review receiving an assigned peer review score of 3 or greater, shall be notified in writing at least two weeks prior to the medical staff meeting where the outcome of review is reported. Communication shall include the case medical record number, admission/discharge date, reason and outcome of the review. Comments and/or opinions made by the reviewer may be included; however, the identity of the reviewer should be redacted.

The involved Practitioner is provided the opportunity to respond to the results of the review in writing in advance of the meeting where the outcome is reported. At the request of the Department Chief, or Chief of Staff, the Practitioner may be invited to attend the meeting to discuss the case.

D. Circumstances Requiring External Peer Review

If no practitioner on staff is qualified to conduct a review, the MEC, Chief of Staff, Department Chair or the Board of Trustees may request external peer review by a practitioner who is Board certified within the same specialty. External Peer Review may be necessary, but not limited to, the following circumstances:

The pool of eligible reviewers is unable to serve
There is no qualified practitioner on staff to conduct the review
Litigation risk
The facility has only a single practitioner in a particular specialty and no other practitioner has similar background, training or experience.

No practitioner may require the Hospital to obtain external peer review if it is not deemed necessary by the Chief of Staff, Executive Committee or Board of Trustees.

Where the body conducting the peer review seeks external or outside peer review by a qualified practitioner within the same specialty or discipline as the practitioner under review, it shall appoint such external or outside reviewer to be a member of the peer review committee, without vote. Any report generated by such external or outside reviewer shall be considered to be a report of the peer review committee and shall be utilized for the committee's purposes. Likewise, where the peer review committee in its discretion affords the practitioner under review the opportunity to respond to the report of an external or outside reviewer, the practitioner shall attend a peer review committee meeting to discuss such response, and any information submitted by the practitioner under review in response to such report shall be considered to have been acquired in connection with or in the course of the peer review committee proceeding. An external or outside reviewer who is appointed to the peer review committee shall attend peer review committee meetings personally or telephonically, as is appropriate under the circumstances, for the purpose of deliberations related to any report by such external or outside reviewer. All information pertaining to any external or outside review by a qualified practitioner who is appointed to the peer review committee shall be protected to the fullest extent permitted by state law. For purposes of this paragraph, "peer review committee" shall include, without limitation, any medical review committee, departmental peer review committee, and the Medical Executive Committee.[1]

E. ReviewFormSummary

Reviewing practitioners must complete the Peer Review Form, Attachment One, clearly and concisely. The reviewing practitioner must sign his/her name on the review form which shall grade the care and outcome based on the following schedule:

1 = Treatment appropriate, outcome good, and any patient impact was minimal
2 = Treatment appropriate but patient sustained significant adverse outcome
3 = Treatment inappropriate but adverse impact on patient was minimal
4 = Treatment inappropriate and patient sustained a significant adverse outcome

DOCUMENTATIONOFPEERREVIEWACTIVITIES:

Reports of OPPE and FPPE and individual case review findings and recommendations shall be presented to the MEC. The MEC may adopt the recommendations of the Medical Staff Quality Review Committees and/or make further recommendations, including recommendation for further investigation and/or Corrective Action in accord with the Medical Staff Bylaws.

WATSONVILLE COMMUNITY HOSPITAL

~~All recommendations of the MEC other than for further investigation or Corrective Action shall be delivered to the Board. The Board shall make a final determination concerning any actions warranted based on the findings and recommendations of the MEC.~~

Results of OPPE, FPPE and Peer Review outcomes shall be documented and maintained in the practitioner's quality file and referenced at reappointment.

~~PractitionerReviewofConfidentialQualityFile~~

~~A practitioner may review his quality file by making an appointment with the Director of Quality Management and Regulatory Compliance (QMRC)/Chief Quality Officer, and the Chief of Staff. No copies of the quality file may be made, nor may the practitioner remove any portion of the quality file from the Hospital. In the discretion of the CEO, in consultation with the Chief of Staff, personal information, such as the identity of external or internal peer reviewers, or the identity of patients or employees reporting quality issues, may be redacted before the practitioner may review the file.~~

IV. CONFIDENTIALITY OF REVIEW

All proceedings conducted as the result of this policy are subject to the California Evidence Code Section 1157 and The Health Care Quality Improvement Act of 1986 (HCQIA), 42 USC §11101.

Reviewed:	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date:	4/15/14	9/20/16			
By:	D Salvi	MEC			
Revised	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date:					
By:					

WORKSHEET

MEDICAL STAFF BUSINESS NOT TO BE INCLUDED IN PATIENT CHART

MQRC SQRC B&T

Physician #	Account #	Medical Record #	INPATIENT Admission Date	INPATIENT Discharge Date	Outpt./ER Date	Review Date

Referral Source:

- ☐ QRC-specific process audits or clinical practice guideline audits.
- ☐ QRC-specific clinical indicators or outcome measurements.
- ☐ Referrals from external agencies related to practitioner-specific issues.
- ☐ Sentinel events dealing with practitioner-specific issues.
- ☐ Specific patient complaints dealing with clinical and/or practitioner specific issues.
- ☐ Hospital-wide generic indicators.
- ☐ New legal cases identified by the organization, which may relate to physician performance.
- ☐ Staff concerns.
- ☐ Referrals from other medical staff or organizational committees or team related to practitioner specific issues.
- ☐ Event reports.

Case Summary: _____

Key Questions for Reviewer: 1) _____

2) _____

3) _____

Reviewer Findings/Conclusions: _____

Case Review Scoring		
RN	☐ Case reviewed by a RN outside of committee with no identified opportunity for improvement. ☐ Case referred to physician for review. RN Signature: _____	
Care by the Physician	☐ Treatment was appropriate and medically necessary. ☐ Treatment was not appropriate, either all or in part. *(See Practitioner Care Issues)* ☐ Treatment was not medically necessary. *(See Practitioner Care Issues)* ☐ Treatment was controversial, unproven, experimental or investigational. ☐ Treatment was not timely or not performed in the proper sequence. *(See Practitioner Care Issues)* ☐ Response time and/or ongoing assessment were not adequate. *(See Practitioner Care Issues)*	
Practitioner care Issues: *(Check all that apply)*	☐ Clinical Judgment/Decision-Making ☐ Diagnosis ☐ Knowledge ☐ Policy Compliance ☐ Technique/Skills	☐ Communication/Responsiveness ☐ Follow-up/Follow-through ☐ Planning ☐ Supervision (House Physician or AHP) ☐ Other: _____
Contributing Causes	☐ Judgment of the physician. ☐ Hospital systems/process issues. ☐ Failure by physician to comply with hospital/Medical Staff bylaws, Rules and Regulations. ☐ Issues identified with providers of care other than the physician under review. ☐ Inadequate documentation/not timely and/or poor interdisciplinary communication.	☐ Contributing cause not identified
	☐ Case reviewed by a physician outside of committee with no identified opportunity for improvement. ☐ Refer to QRC for Physician Concern or ☐ Refer to QCC for Process Problem	_____ Reviewer Signature

ADDITIONAL COMMENTS MAY BE WRITTEN ON THE BACK OF THIS FORM.

Committee Review	Is physician/provider response needed? ☐ Yes ☐ No (Care Appropriate, no issues or concerns) If yes, letter sent ☐ Yes ☐ No Date 1: _____ Date 2: _____
Practitioner Response	☐ Letter received and discussed ☐ No letter received
Committee Score	☐ 1 – Treatment appropriate, outcome good and any ☐ 2 – Treatment appropriate, but in spite of that the patient sustained a significant adverse outcome. ☐ 3 – Treatment inappropriate, but the adverse impa ☐ 4 – Treatment inappropriate and the patient sustained a significant adverse outcome.
Additional Committee Recommendations: _____	

DISPOSITION

QRC Act

☐ Refer to _____ ☐ External Peer Review

☐ Informational Letter to _____ ☐ Track and Trend ☐ Case Closed

Chairperson Signature _____ Date _____

Privileged and confidential per CA business and professions Code 1157.

WATSONVILLE COMMUNITY HOSPITAL

Memo

Item 13B

January 20, 2023

TO: Board of Trustees

FROM: Clay Angel, M.D., Chief of Staff
Chair, Medical Executive Committee

SUBJECT: Chief of Staff Report – January 17, 2023, MEC

ACTION ITEMS FOR APPROVAL

1. **Credentialing Actions:**
   - 1.1 Credentials Report: January 2023
   - 1.2 Interdisciplinary Practice Credentials Report: January 2023

WATSONVILLE COMMUNITY HOSPITAL

Medical Executive Committee Summary – January 17, 2023
ITEMS FOR BOARD APPROVAL

Credentials Committee

INITIAL APPOINTMENTS: (14)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Barminova, Anna, MD	Teleneurology Provisional	Medicine	Teleneurology Neurology	01/25/2023 – 12/31/2024
Boudreau, Michelle, DO	Teleneurology Provisional	Medicine	Teleneurology Neurology	01/25/2023 – 12/31/2024
Bradley, Nina, DO	Teleneurology Provisional	Medicine	Teleneurology Neurology	01/25/2023 – 12/31/2024
Nguyen, Jimmy, MD	Teleneurology Provisional y	Medicine	Teleneurology Neurology	01/25/2023 – 12/31/2024
Plancher, Joao, MD	Teleneurology Provisional	Medicine	Teleneurology Neurology	01/25/2023 – 12/31/2024
Redmond, Cintasha, MD	Teleneurology Provisional	Medicine	Teleneurology Neurology	01/25/2023 – 12/31/2024
Sabra, Mark, MD	Teleneurology Provisional	Medicine	Teleneurology Neurology	01/25/2023 – 12/31/2024
Suarez-Gonzalez, Vivian, MD	Teleneurology Provisional	Medicine	Teleneurology Neurology	01/25/2023 – 12/31/2024
Albright, Kristen, DPM	Podiatry Surgery Provisional	Surgery	Podiatry Fluoroscopy	01/25/2023 – 12/31/2024
Day, Eric J., MD	Internal Medicine Hospitalist Provisional	Medicine	Internal Medicine Critical Care, Non-Intensivist	01/25/2023 – 12/31/2024
Hotchkiss, John, MD	Teleradiology Provisional	Medicine	TeleRadiology Radiology	01/25/2023 – 12/31/2024
Lin, Jennifer, MD	Radiology Provisional	Medicine	Radiology, Diagnostic	01/25/2023 – 12/31/2024
Nandan, Raghu, MD	Plastic Surgery Provisional	Surgery	Plastic Surgery Wound Care	01/25/2023 – 12/31/2024
Ware, Paul, MD	Palliative care Provisional	Medicine	Palliative Care / Hospice Medicine	01/25/2023 – 12/31/2024

REAPPOINTMENTS: (8)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Abidi, Nicholas, MD	Orthopedics / Courtesy	Surgery	Orthopedic Surgery Fluoroscopy	02/01/2023-01/31/2025

Gonzalez, Gustavo, MD	Ophthalmology / Active	Surgery	Ophthalmology	02/01/2023-01/31/2025
Lopez-Bermejo, Melissa, MD	Critical Care Medicine, Pulmonary Disease / Active	Medicine	Critical Care, Intensivist Internal Medicine Moderate Sedation	02/01/2023-01/31/2025
Romo-Gritzewsky, Marylou, MD	Internal Medicine / Courtesy	Medicine	Internal Medicine	02/01/2023-01/31/2025
Simkin, Josefa, MD	Internal Medicine Hospitalist / Active	Medicine	Internal Medicine Critical Care, Non-Intensivist	02/01/2023-01/31/2025
Swamidurai, Rajeshwary, MD	Anesthesiology / Active	Surgery	Anesthesiology	02/01/2023-01/31/2025
Telefus, Phillip, MD	Pain Management / Active	Surgery	Pain Management Moderate Sedation Fluoscopy	01/28/2023-12/31/2024
Yousefi, Arian, MD	Internal Medicine Hospitalist / Active	Medicine	Internal Medicine Critical Care, Non-Intensivist	02/01/2023 – 07/31/2023

MODIFICATION / ADDITION OF PRIVILEGES:

NAME	SPECIALTY	Privileges
Nolan, Ryan, MD	General Surgery	Bariatric Surgery

STAFF STATUS MODIFICATIONS:

NAME	SPECIALTY / DEPARTMENT	RECOMMENDATION
Nolan, Ryan, MD	General Surgery / Active	Release from Wound Care proctoring; requirement met
Romo-Gritzewsky, Marylou, MD	Internal Medicine / Medicine	Move from Active to Courtesy
Telefus, Phillip, MD	Pain Management / Surgery	Advance from Provisional to Active Staff; proctoring completed
Yousefi, Arian, MD	Internal Medicine Hospitalist / Medicine	Release from Proctoring; Advance to Active Staff
Cole, Mario, MD	Pulmonary / Medicine	Resigned Effective 12/01/2022
Koostra, John, MD	Tele-ICU / Medicine	Resigned Effective 12/30/2022
Kundu, Nirvana, MD	Anesthesia / Surgery	Resigned Effective 07/27/2022
Rudnick, Nicholas, MD	Radiology / Medicine	Resigned Effective 12/23/2022
Sohal, Ravinder, MD	Teleradiology/ Medicine	Resigned Effective 12/06/2022
Suber, Ladouglas, MD	Anesthesia / Surgery	Resigned Effective 07/27/2022
Kalanithi, Suman, MD	Teleneurology / Medicine	Resigned Effective 12/16/2022
Prabhu, Divya, MD	Teleneurology / Medicine	Resigned Effective 12/16/2022
Ruff, Jeffry, MD	Teleneurology / Medicine	Resigned Effective 12/16/2022
Sajed, Mohammad, MD	Teleneurology / Medicine	Resigned Effective 12/16/2022

TEMPORARY PRIVILEGES:

NAME	SPECIALTY / DEPARTMENT	DATES
Albright, Kristin, DPM	Podiatry Surgery / Surgery	01/09/2023
Lin, Jennifer, MD	Radiology / Medicine	01/17/2023 – 02/01/2023

INTERDISCIPLINARY PRACTICE COMMITTEE

Initial Appointment: (0)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
None				

REAPPOINTMENT: (1)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Buraczynski, Mark, PA-C	Physician Assistant / Allied Health Professional	Emergency Medicine	Emergency Medicine Physician Assistant	02/01/2023-01/31/2025

STAFF STATUS MODIFICATIONS: (1)

NAME	SPECIALTY / DEPARTMENT	RECOMMENDATION
Brinton, Talia, PA-C	Physician Assistant / Emergency Department	Release from proctoring; requirement met

MEDICAL EXECUTIVE COMMITTEE, January 17, 2023, ACTION ITEMS FOR APPROVAL

1. Credentialing Actions:

1.1 Credentials Report: January 2023

1.2 Interdisciplinary Practice Credentials Report: January 2023

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

Board Memo – Group Purchasing Organization Agreement

Agenda Item: Consider Recommendation to Board of Directors for Approval of Master Services Agreement with Vizient, Inc.

Executive Sponsor: Matko Vranjes, COO

Date: January 25, 2022

Summary

Conversion of Group Purchasing Organization (GPO) from HealthTrust Purchasing Group to Vizient, Inc. GPO comparison along with Vizient Summary is included in the attached tables: GPO Comparison Summary, Vizient Summary

Background/Situation/Rationale

Watsonville Community Hospital is currently operating under a 1-year agreement extension with HealthTrust Purchasing Group (HPG). The Project had engaged FTI Consulting to perform a comparative analysis of GPOs using the hospital's 2021 supply spend. FTI compiled the market basket responses from Premier and Vizient and compared them to current pricing with HPG. Vizient provides more savings than Premier at every level. When comparing the prices line by line, Vizient and HPG have nearly the same quantity of "best" pricing relative to the other 2. However, the study indicates that Vizient still provides price savings.

Timeline/Process to date: The current agreement with HPG includes a 90-day termination notice requirement. The timeline for conversion to Vizient is estimated at 90-120 days after execution of the agreement.

Financial Impact: Annual savings

Key Contract Terms	
1. Proposed effective date	**May 1,2022**
2. Term of agreement	**36 months**
3. Renewal terms	**Auto renew 1-year terms**
4. Termination provision(s)	**180-day notice prior to expiration of Term MSA 90-day for SOW**
5. Payment terms	**Net 30**
6. Annual cost	**Fee Share Tiered, 2% up to 10M , 20% 10-12.5M**
7. Budgeted (indicate Yes/No)	**Yes**

Table 1. GPO Comparison Summary

Watsonville Community Hospital Top 80% Spend Analysis - Current (LPP) vs. Alternative GPO Pricing

	Premier		Vizient		
Outlier Exclusion Threshold (+/-)	Potential Savings Excl. Outliers	Total Line Count Excl. Outliers	Potential Savings Excl. Outliers	Total Line Count Excl. Outliers	
0%	$ 0	0	$ 0	0	
10%	$ (32,220)	99	$ (756)	103	148 items excluded due to 10% pricing variance
20%	$ (47,245)	148	$ (6,045)	137	
30%	$ (10,810)	179	$ 42,131	164	
40%	$ 22,048	200	$ 82,499	179	
50%	$ 42,090	213	$ 111,199	191	
60%	$ 121,200	227	$ 228,917	204	
70%	$ 225,792	236	$ 300,022	215	
80%	$ 355,049	250	$ 418,426	225	
90%	$ 335,445	251	$ 475,174	231	
100%	$ 366,121	253	$ 576,931	251	no items with 100% pricing variance
ALL ITEMS	$ 303,824	257	$ 576,931	251	

Match Type	Potential Savings	Total Line Count	Potential Savings	Total Line Count
N/A	N/A	30	N/A	36
Equivalent / Substitute	$ 7,176	22	$ 52,102	28
Exact / Match	$ 296,648	235	$ 524,829	223
TOTAL INCLUDED	$ 303,824	257	$ 576,931	251

Item Spend Detail Comparison Summary

Best Spend Estimate Offer	# of Items
Current	56
Vizient	49
Premier	15
Premier = Vizient	4
Current = Premier = Vizient	2
Items with <= 20% Outlier	126

Please note:
(1) Spend Analysis is based on top 80% of total Watsonville spend from 2021 Spend Report, excluding ~$3.3M of unlabeled spend items
(2) Items with >20% outlier for either Premier or Vizient were excluded
(3) Current spend is based on Last Paid Price (LPP)

Please note:
(1) Spend Analysis is based on top 80% of total Watsonville spend from 2021 Spend Report, excluding ~$3.3M of unlabeled spend items
(2) Last Paid Price (LPP) was used for all items
(3) Outlier % is based on variance between LPP and pricing GPO provided
(4) Item-specific assumptions detailed in *Comments* of subsequent Premier and Vizient summary tabs

Table 2. Vizient Summary

Watsonville Community Hospital Top 80% Spend Analysis - Current (LPP) vs. Vizient Pricing

DATA ANALYZED	LINE COUNT	% OF TOTAL LINES	Watsonville Invoice Qty	% OF TOTAL Invoice Qty	Total Invoice Spending based on LPP	% OF TOTAL Invoice Spending	Vizient Total Invoice Spending	% OF TOTAL Vizient Invoice Spend
Watsonville Community Top Spend Items Market Basket	287	100.0%	27,576	100.0%	3,392,235	100.0%	2,040,854	100.0%

SUMMARY BY MATCH TYPE	LINE COUNT	% OF TOTAL LINES	Watsonville Invoice Qty	% OF TOTAL Invoice Qty	Total Invoice Spending based on LPP	% OF TOTAL Invoice Spending	Vizient Total Invoice Spending	% OF TOTAL Vizient Invoice Spend	Potential Savings	Potential Savings %	Comments
NO EQUIVALENT	36	12.5%	6,737	24.4%	$ 774,450	22.8%	$ -	0.0%	N/A	N/A	
SUBSTITUTE	28	9.8%	1,081	3.9%	$ 117,836	3.5%	$ 65,734	3.2%	$ 52,102	44%	
MATCH	223	77.7%	19,758	71.6%	$ 2,499,950	73.7%	$ 1,975,120	96.8%	$ 524,829	21%	
Total excl. NO EQUIVALENT	*251*	*87.46%*	*20,839*	*75.57%*	*$ 2,617,785*	*77.17%*	*$ 2,040,854*	*100.0%*	*$ 576,931*	*22%*	

Please note:
Total Invoice Spending based on LPP = Last Price Paid (LPP) x Invoice Qty
Removed items without a description from analysis
Outlier % is based on difference in last paid price and pricing GPO provided

Match Type Definitions
MATCH - same supplier, same product category/contract description.
SUBSTITUTE- products deemed the same from a clinical performance perspective.
NO EQUIVALENT- includes products not on Vizient contracts.

Attachments:

Master Service Agreement
Statement of Work

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Master Services Agreement

This Master Services Agreement (this "Master Agreement") is entered into on February 1, 2023 (the "Effective Date"), by and between ***Vizient, Inc.,*** a Delaware corporation, on behalf of itself and its subsidiaries (collectively, "Vizient") and Pajaro Valley Health Care District Hospital Corporation ***d/b/a Watsonville Community Hospital***, a California not-for-profit corporation, ("Member") for itself and on behalf of its covered facilities ("Covered Facilities"), as specifically set forth in an applicable SOW (as defined below). Vizient and Member are sometimes referred to herein individually as a "Party" and collectively, as the "Parties."

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1. **Statement of Work**. For all services provided by Vizient under this Master Agreement (collectively, the "Services"), Vizient will issue a statement of work or order form (each, an "SOW") containing relevant terms and provisions which are fully incorporated herein, as an attachment to this Master Agreement, and made a part hereof. If applicable, the SOW will identify the Vizient subsidiary, if any, providing Services and any Covered Facilities receiving such Services. In the event of conflicting terms between this Master Agreement and any SOW executed hereunder, the terms set forth in the respective SOW will control.

2. **Service Fees and Invoicing**. Service fees for all Services ("Service Fees") will be specifically set forth in each SOW. Any obligation to reimburse Vizient for Services-related expenses, including, but not limited to, travel, meals, lodging, and other administrative costs, such as postage, copying, and overnight mailing (collectively, "Reimbursable Expenses"), are in addition to Service Fees and will be indicated in each applicable SOW. Except as otherwise set forth in an SOW, i) Vizient will invoice Service Fees and, if applicable, Reimbursable Expenses on a monthly basis; and ii) Member will remit payment net 30 days after the date of the invoice.

3. **Taxes**. Member hereby acknowledges and agrees Service Fees do not include foreign, federal, state, or local sales, use, or other similar taxes, however designated, levied on the Services, and Member will be responsible for such taxes. If Member is a tax-exempt organization, Member will provide Vizient with Member's current tax exemption certificate or a direct pay permit ("Certificate") and any updated Certificate, as may be requested by Vizient from time to time during the Term. The Parties presume all sales of tangible personal property or services are subject to tax unless Member provides a Certificate. **IF MEMBER FAILS TO PROVIDE A CERTIFICATE: i) MEMBER IS RESPONSIBLE FOR ALL TAXES CHARGED OR PAID EVEN IF LEGALLY EXEMPT FROM SUCH TAXES; ii) VIZIENT WILL REMIT ANY TAXES CHARGED AND COLLECTED TO THE TAXING AUTHORITIES AS IF A TAX WAS DUE; AND iii) VIZIENT WILL NOT RETURN OR REFUND SUCH TAXES TO MEMBER.**

4. **Data**. In order for Vizient to provide Services, Member will provide spend-related data to Vizient, including, but not limited to, purchase orders, item master information, vendor master information, receipts, invoices, and utilization data (individually and collectively referred to herein as "Spend Data"), in accordance with the submission requirements for requested Services.

   4.1. **Data Consent**. Vizient may use Spend Data provided by Member before the Effective Date and during the Term in de-identified form to populate benchmarking databases ("Databases") and to generate reports from such Databases ("Reports"), which Vizient solely owns and may use for any purpose. Vizient may also use Spend Data in de-identified form for any other purpose, including, but not limited to, contract development, research information, and for comparative analysis use for Vizient's customers. Vizient may disclose Spend Data on a line-item, identified basis to subcontractors and consultants under confidentiality agreements with Vizient for the purpose of assisting Vizient in providing services. Member represents it has the right to provide Vizient with Spend Data for the uses described in this provision.

   4.2. **Databases and Reports**. Vizient makes no warranties or representations with regard to the Databases and Reports, and Member is solely responsible for the results of its operational use of such Databases and Reports. Databases and Reports may sometimes include portions of Vizient's and its suppliers' confidential

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data, such as Vizient's group purchasing ("GPO") Member pricing data, supplier pricing data, and contract terms and conditions. Member must perpetually treat the Databases and Reports as Confidential Information of Vizient and its respective suppliers and will not use them for any purpose other than Member's internal use.

5. **Term and Termination**.

5.1. **Term**. The initial term of this Master Agreement will commence on the Effective Date and continue for a period of **36 months** ("Initial Term") and will automatically renew for additional 1-year terms (each, a "Renewal Term") unless either Party provides written notice of its intent not to renew to the other Party at least 180 days prior to the expiration of the then-current Term (the Initial Term and any Renewal Terms are collectively referred to herein as the "Term"). In the event the term of any SOW extends beyond the Term of this Master Agreement, the Term of this Master Agreement will automatically extend to the latest expiration or termination date of such SOW.

5.2. **Termination for Cause**. Either Party may terminate this Master Agreement or SOW effective immediately upon written notice to the other Party if the other Party is under default or breach of this Master Agreement or SOW and the breaching Party has not remedied such default or breach within 30 days after receipt of written notice from the non-breaching Party specifying the default or breach.

5.3. **Termination for Insolvency**. Either Party may terminate this Master Agreement and all attached SOWs immediately upon written notice to the other Party if the other party is adjudged insolvent or bankrupt; or upon the institution of any proceeding against the other Party seeking relief, reorganization, or arrangement under any laws relating to insolvency; or for the making of any assignment for the benefit of creditors; or upon the appointment of a receiver, liquidator, or trustee of any of the other Party's property or assets; or upon liquidation, dissolution, or winding up of the other Party's business.

6. **Grant of Limited Rights**. Vizient solely owns all work product, including, but not limited to, all materials, programs, documentation, concepts, methodologies, and aids related to the Services. Vizient grants to Member the limited right to use the Services for its internal use only during the Term of this Master Agreement or applicable SOW. Member will not, without Vizient's prior written consent, reproduce any of the materials, programs, documentation, or aids related to the Services for the purpose of disclosure or distribution to any other party, including any third-party legal, financial, or consulting advisors, unless such third party i) has a need to access the information for purposes of fulfilling Member's obligations under this Master Agreement, and ii) has entered into a confidentiality agreement with Vizient or has been approved by Vizient in writing.

7. **Intellectual Property**. Member will not, nor will it permit any third-party to: i) use any Vizient Database, Report, or Services, or any portion of the Vizient deliverables or work product, including, without limitation, information, design, specification, instruction, software, data, or material (collectively referred to as the "Vizient IP") for any unlawful purpose; ii) market, sublicense, publish, distribute, lend, transfer, or otherwise make Vizient IP, or any components or output therefrom, available to a third party; iii) alter, maintain, enhance, modify, or create derivatives of the Vizient IP; iv) remove any trademark, copyright, or proprietary notices; v) copy, decompile, disassemble, or otherwise reverse engineer the Vizient IP or perform any similar means or actions to discover the source code or trade secrets in the Vizient IP; vi) use the Vizient IP to provide service bureau, time sharing, or other computer services to third parties; vii) circumvent any technological measures that control access to the Vizient IP; viii) use the Vizient IP in any nuclear, aviation, mass transit, life support, or any other inherently dangerous manner; or ix) use the Vizient IP to benefit any party other than Member.

8. **Confidentiality**.

8.1. **General**. During the Term and for a period of 3 years after its expiration or termination, neither Party may publish, disseminate, or disclose to any third party any Confidential Information (as defined below) of the other Party without the other Party's prior written consent. A Party may disclose Confidential Information only to its

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employees who have a need to access the Confidential Information for purposes of fulfilling the Party's obligations under this Master Agreement.

8.2. **Confidential Information**. For purposes of this Master Agreement, "Confidential Information" includes: i) any information which refers or relates to this Master Agreement or any Vizient supplier agreement, including, but not limited to, any information relating to supplier pricing, supply contract terms, member data, customer lists, financial analyses, benchmarking and comparative reports of any kind prepared by the other Party, business processes or plans, sourcing and contracting methods, and "know-how"; ii) any information a Party marks as "Confidential," "Proprietary," or with a similar legend prior to disclosure; iii) any information which is orally identified as confidential at the time of disclosure and confirmed as confidential in writing within 10 business days following such disclosure; iv) any information which by its nature should reasonably be considered as confidential or proprietary; and v) all information generated by a Party that contains, reflects, or is derived from Confidential Information.

8.3. **Exclusions**. Confidentiality obligations will not apply to information that: i) is published by the disclosing Party or otherwise becomes available to the public other than by a breach of this Master Agreement; ii) is rightfully received by the recipient from a third party not under an obligation of confidentiality; iii) is known by or independently developed by the recipient prior to disclosure by the disclosing Party; or iv) is required to be disclosed pursuant to a lawful subpoena from a court of competent jurisdiction or in response to a valid request by a federal or state governmental agency. In the event of any required disclosure under law, the Party requesting disclosure of such Confidential Information will provide reasonable advance written notice to the non-disclosing Party so the non-disclosing Party may have an opportunity to object or seek to make such disclosure subject to a protective order or other appropriate remedy to preserve the confidentiality of the Confidential Information.

8.4. **Rights in the Confidential Information**. Except as expressly stated in this Master Agreement or an SOW, i) this Master Agreement does not confer any right, license, interest, or title in, to, or under the Confidential Information; and ii) no license is granted to the receiving Party, by estoppels or otherwise, under any patent, trademark, copyright, trade secret, or other proprietary rights.

8.5. **Equitable Relief**. The Parties acknowledge and agree that monetary damages are insufficient for any breach of the confidentiality provisions of this Master Agreement. As such, the nonbreaching Party may seek specific performance or injunctive relief, in addition to any other remedies available at law or in equity, upon the breach or threatened breach of this Confidentiality Section without posting bond and without proof of actual damages.

9. **Compliance**.

9.1. **Compliance with Applicable Laws**. The Parties agree to comply with all applicable federal, state, and local laws, including, but not limited to, the requirements of the federal fraud and abuse statute, codified at 42 U.S.C. 1320a-7b, as amended, and relevant regulations thereto.

9.2. **Discounts and Rebates**. To the extent Member receives discounts, rebates, distributions, or any other price reductions as a result of purchases or remuneration under this Master Agreement, an SOW, or any other group purchasing program agreement, Member may have an obligation under federal or state law to disclose such price reductions or remuneration to federal or state health care programs or other payors (as part of the cost reporting process or otherwise). Member and all Covered Facilities will comply with all such laws. Member will provide each of its applicable Covered Facilities, if any, rebate or other information (if any) necessary for the Covered Facility to comply with its obligations under this Section.

9.3. **Records**. Upon request of the Secretary of Health and Human Services, the Comptroller General of the United States, or any other duly authorized representative, Vizient will make available the contracts, books,

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documents, and records necessary to certify the nature and extent of the cost of any Services in excess of $10,000 per year until the expiration of 4 years from completion of any such Services provided under this Master Agreement.

10. **Professional Obligations**. Member acknowledges and agrees that the professional duty owed to patients seeking health care services lies solely with the health care professional providing health care services. As such, Member takes full responsibility for the use of information provided under this Master Agreement and all SOWs in patient care and acknowledges that the use of any and all Services is not intended to replace or substitute professional judgment. Vizient does not assume any responsibility for actions of Member that may result in liability or damages arising from malpractice, failure to warn, negligence, or any other basis, and Member agrees to indemnify, defend, and hold Vizient, the Vizient subsidiaries, and their respective employees, officers, and directors harmless from and against any and all liability or damages.

11. **Indemnification**.

11.1. **General Indemnification**. Each Party will indemnify and hold the other Party harmless from any and all damages, losses, liabilities, claims, or cost (including, without limitation, reasonable attorney's fees) arising out of any third-party claim for bodily injury or death, or damage to property, caused by any negligent act or omission or breach of this Master Agreement (or any SOW hereunder) by the indemnifying Party or its employees, officers, or agents. Vizient's indemnity and hold harmless obligation does not apply to any medical malpractice claim, damage, loss, or liability. Neither Party is responsible for losses incurred to the extent caused by the other Party's negligence or willful misconduct.

11.2. **Intellectual Property Indemnification**. Subject to the Indemnification Procedure Section below, Vizient will, at its sole expense, defend any third-party action brought against Member based on a claim that any Vizient IP that is proprietary to Vizient or licensed by Vizient and purchased pursuant to this Master Agreement infringes any United States copyright, patent, or trademark and will pay all reasonable costs and damages finally awarded against Member in any such action attributable to such claim.

A. **Limitation**. Vizient will have no liability to Member under Section 11.2 to the extent such infringement arises from the use of such: i) Vizient IP in combination with equipment, software, or services not supplied by Vizient; ii) Vizient IP in a manner other than in accordance with its product description and the terms of this Master Agreement, applicable SOW, or any end user license agreement that may be provided with such Vizient IP; or iii) modifications to Vizient IP made by persons other than Vizient personnel or Member's design or specifications.

B. **Modification by Vizient**. If any allegation of infringement with respect to any Vizient IP is made, or, in Vizient's opinion is likely to be made, then Vizient may, at its sole option and expense: i) procure for Member the right to continue using the Vizient IP; ii) modify the Vizient IP so as to avoid the infringement; iii) replace the Vizient IP with a functionally similar version and require Member to cease use of the Vizient IP in question; or iv) refund Service Fees paid to Vizient by Member for the use of such Vizient IP, less an amount for amortization based on a five-year, straight-line amortization schedule, in which case the Member must cease using the Vizient IP and return it to Vizient.

11.3. **Indemnification Procedure**. A Party's right to indemnification is conditioned upon the following: i) the indemnified Party must promptly notify the indemnifying Party of the claim (provided, however, that if the indemnified Party fails to provide prompt notice, the indemnifying Party will be relieved of its indemnification obligations only if and to the extent the indemnifying Party is materially prejudiced by such failure); ii) the indemnifying Party will have sole control of the defense and settlement of the claim (but the indemnifying Party must not agree to a consent decree or similar order binding the indemnified Party or to any settlement that specifically apportions fault or liability to the indemnified Party without the indemnified Party's prior written consent); iii) the indemnified Party will provide the indemnifying Party, at its expense, with assistance

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in the defense as the indemnifying Party may reasonably request; and iv) the indemnified Party must not incur any cost or expense for the indemnifying Party's account without its prior written consent.

THE PARTIES HEREBY ACKNOWLEDGE AND AGREE THE FOREGOING STATES VIZIENT'S ENTIRE LIABILITY UNDER THIS MASTER AGREEMENT OR OTHERWISE WITH RESPECT TO INFRINGEMENT OF INTELLECTUAL PROPERTY RIGHTS.

12. **Limitation of Liability**. EXCEPT FOR EACH PARTY'S INDEMNITY OBLIGATIONS SET FORTH HEREIN : i) IN NO EVENT WILL EITHER PARTY BE LIABLE, WHETHER IN CONTRACT OR IN TORT OR UNDER ANY OTHER LEGAL THEORY (INCLUDING STRICT LIABILITY AND NEGLIGENCE), FOR LOST PROFITS OR REVENUES, LOSS OR INTERRUPTION OF USE, LOST OR DAMAGED DATA, REPORTS, DOCUMENTATION, OR SECURITY, OR SIMILAR ECONOMIC LOSS, OR FOR ANY INDIRECT, EXEMPLARY, SPECIAL, INCIDENTAL, CONSEQUENTIAL, OR SIMILAR DAMAGES ARISING FROM OR RELATED TO THIS MASTER AGREEMENT, EVEN IF THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES; AND ii) EXCEPT FOR MEMBER'S FAILURE TO PAY FOR THE SERVICES, EACH PARTY'S MAXIMUM LIABILITY IS LIMITED TO THE ANNUAL SERVICE FEES AND REIMBURSABLE EXPENSES IN THE APPLICABLE SOW. ***THIS LIMITATION OF LIABILITY IS FUNDAMENTAL TO THIS MASTER AGREEMENT. THE PARTIES REVIEWED AND BARGAINED FOR THESE TERMS AND NEITHER PARTY WOULD BE WILLING TO ENTER INTO THIS MASTER AGREEMENT WITHOUT THIS LIMITATION.***

13. **Warranty and Remedies**.

    13.1. **Authority**. Each Party represents and warrants it is authorized to enter into and execute this Master Agreement and any and all applicable SOWs, if any, on behalf of itself and each of the applicable Vizient subsidiaries or Covered Facilities, respectively, as documented in any applicable SOW.

    13.2. **Vizient Warranty**. Vizient warrants it will perform the Services in a good and workmanlike manner in accordance with the requirements in each SOW. **EXCEPT AS SET FORTH IN THIS SECTION, THERE ARE NO OTHER WARRANTIES, EXPRESS OR IMPLIED, WITH RESPECT TO THE SERVICES INCLUDING, BUT NOT LIMITED TO, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.** MEMBER'S SOLE AND EXCLUSIVE REMEDY, AND VIZIENT'S SOLE AND EXCLUSIVE LIABILITY, FOR A BREACH OF THE WARRANTY IN THIS SECTION ARE: i) THE SPECIFIC SUPPORT SERVICES IN THE APPLICABLE SOW; ii) REPEATING OR REPROCESSING OF THE SERVICE(S) (IF POSSIBLE) BY VIZIENT AT NO ADDITIONAL CHARGE; OR iii) TERMINATION OF THE APPLICABLE SOW UPON 30 DAYS' PRIOR WRITTEN NOTICE TO VIZIENT.

    13.3. **Cooperation**. Each Party agrees to cooperate and respond to applicable requests for information in a timely manner. A Party's failure or delay is excused to the extent the other Party impedes or delays completion of the Services by: i) failing or delaying to provide necessary information, equipment, or access to facilities to Vizient; ii) failing to complete required tasks or perform its obligations under this Master Agreement or the applicable SOW for any reason; or iii) providing materially untrue or incorrect information.

14. **Protected Health Information**. One or more of the Services may involve the use and disclosure of Member's Protected Health Information ("PHI"). Each Party intends to protect the privacy, security, and integrity of any PHI exchanged under this Master Agreement in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and their implementing regulations, as each may be amended from time to time (collectively, "HIPAA"). The Parties further acknowledge Member is a Covered Entity (as defined under HIPAA) and Vizient may be a Business Associate (as defined under HIPAA) in the delivery of certain services through Member's participation in Vizient's national healthcare alliance. If Member engages Vizient to perform Services involving the use or disclosure of PHI, then the respective SOW will explicitly state the use or disclosure of PHI is required and Vizient and Member shall enter into a mutually agreeable business associate agreement for the protection of PHI in accordance with HIPAA requirements.

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15. **Government Program Participation**. Each Party represents and warrants it has never been excluded from participation in any federal health care program (as such term is defined in 42 U.S.C. § 1320a-7b(f)) ("Federal Health Care Program"), or been debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency. Each Party represents and warrants it has not been the subject of an actual, pending, or threatened formal adverse action, as that term is defined in 42 U.S.C. § 1320a-7e(g). Each Party will promptly notify the other Party in the event it is excluded from any Federal Health Care Program, or debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency, during the Term.

16. **General**.

16.1. **Entire Agreement**. This Master Agreement, including all SOWs executed hereunder, amendments, and exhibits, constitutes the entire agreement between Vizient and Member relating to the subject matter of this Master Agreement, and supersedes all prior understandings, agreements, proposals, and documentation relating to the subject matter of this Master Agreement.

16.2. **Amendment**. This Master Agreement may be amended only by a document signed by authorized representatives of both Parties.

16.3. **Assignment**. Member will not assign or transfer any rights or obligations under this Master Agreement or any SOW without Vizient's prior written consent. This Master Agreement will inure to the benefit of and be binding on the Parties and their respective assigns.

16.4. **Governing Law**. This Master Agreement will be governed by and interpreted in accordance with the laws of the State of Delaware, excluding its conflicts of law provisions.

16.5. **Independent Entities**. None of the provisions of this Master Agreement or any SOW will create any relationship between the Parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Master Agreement. Neither of the Parties, nor any of their employees, will be construed to be the agent, employer, employee, or representative of the other.

16.6. **Force Majeure**. Neither Party will be liable for delays in their performance to the extent and for the duration of time resulting from an event beyond the Party's reasonable control, such as acts of God (earthquake, hurricane), terrorism, national emergencies, or changes in government regulations.

16.7. **Severability**. In the event any provision of this Master Agreement is for any reason deemed to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability will not affect any other term or provision of this Master Agreement, and this Master Agreement will be construed by limiting or invalidating such provision to the minimum extent necessary to make such provision valid, legal, and enforceable.

16.8. **Waiver**. The waiver of any breach of any term or condition of this Master Agreement does not waive any other breach of that term or condition or of any other term or condition, unless agreed to in a writing signed by the Parties.

17. **Notices**. All notices related to this Master Agreement shall be in writing and shall be deemed to have been given when delivered personally, or at the time sent, if sent by registered or certified United States mail, return receipt requested, postage prepaid, or by FedEx or similar delivery service for overnight delivery, and addressed to the other Party as follows or at such address as such Party from time to time may indicate by written notice to the other Party:

If to Vizient:

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Vizient, Inc.
Attn: Membership/Sales Operations
290 East John Carpenter Freeway
Irving, Texas 75062

With a copy to:
Vizient, Inc.
Attn: Legal Department
290 East John Carpenter Freeway, 7th Floor
Irving, Texas 75062

If to Member:
Watsonville Community Hospital d/b/a Pajaro Health District
Attn:
75 Neilson St
Watsonville, CA 95076

18. **Equal Opportunity and Affirmative Action**. Vizient is an equal opportunity and affirmative action employer. Vizient abides by the requirements of 41 C.F.R. 60-1.4(a) (Executive Order 11246 Equal Opportunity Clause); 41 C.F.R. 60-250.5(a) (Equal Opportunity for Special Disabled Veterans, Veterans of the Vietnam Era, Recently Separated Veterans, and Other Protected Veterans); 41 C.F.R 60-300.5(a) (Equal Opportunity for Disabled Veterans, Recently Separated Veterans, Other Protected Veterans, and Armed Forces Service Medal Veterans); 41 C.F.R. 60-741.5 (a) (Equal Opportunity for Workers with Disabilities); FAR 52.222-21 (Prohibition of Segregated Facilities); and FAR 52.222-26 (Equal Opportunity). These regulations are incorporated herein by reference and prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities and prohibit discrimination against all individuals based on their race, color, religion, sex, or national origin.

19. **Counterparts**. All documents pertaining to this Master Agreement may be executed by the exchange of certified electronic signatures or copies delivered by electronic mail in Adobe Portable Document Format or similar format. Any signature transmitted by those shall be deemed an "original signature." All documents pertaining to this Master Agreement may be executed in two or more counterparts, but all of which, taken together, shall constitute one and the same instrument.

20. **Publicity/Use of Marks**. Except as otherwise agreed to by the Parties in writing, neither Party may: i) use each other's trademarks or service marks; or ii) make any press release or other public disclosure regarding this Master Agreement or the transactions contemplated by this Master Agreement without the other Party's prior written consent, except as required under applicable law or by any governmental agency, in which case the Party required to make the press release or public disclosure shall use commercially reasonable efforts to obtain the approval of the other Party as to the form, nature, and extent of the press release or public disclosure prior to issuing the press release or making the public disclosure.

21. **Survival**. The following provisions shall survive the expiration or any earlier termination of this Master Agreement for the number of years stated in the provision or, if none is stated, then perpetually: Grant of Limited Rights, Confidentiality, Discounts and Rebates, Records, Professional Obligations, Indemnification, the last sentence in Vizient Warranty regarding limitations of liability, General, and Notices.

[Signatures on next page]

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IN WITNESS WHEREOF, the Parties have caused this Master Agreement to be executed by their duly authorized representatives as of the Effective Date.

Vizient, Inc.	**Watsonville Community Hospital d/b/a Pajaro Health District**
By: _____	By: _____
Printed Name: _____	Printed Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Pajaro Health Care District Hospital Corporation d/b/a Watsonville Community Hospital– Group Purchasing Program
(MID# 2624064)

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Group Purchasing Program
Statement of Work

Vizient, Inc., a Delaware corporation, on behalf of itself and its subsidiaries (collectively, "Vizient"), will provide the services detailed in this ***Group Purchasing Program Statement of Work*** ("SOW") to ***Pajaro Health Care District Hospital Corporation d/b/a Watsonville Community Hospital***, a California not-for-profit corporation, ("Member"), and Member's Covered Facilities (defined below), for the Service Fees indicated below. This SOW is made pursuant to the terms and conditions set forth in the ***Master Services Agreement*** dated February 1, 2023, and any amendments or addendums thereto (collectively, the "Master Agreement"). As such, all capitalized terms used herein and not otherwise defined in this SOW will have the meanings ascribed to such terms in the Master Agreement. As of the Effective Date, this SOW shall supersede all previous agreements relating to the subject matter described herein. ***This SOW is effective as of May 1, 2023*** ("Effective Date"). Vizient and Member are sometimes referred to herein individually as a "Party" and collectively as the "Parties." Any reference to, or description of any right or obligation of, "Member" in this SOW will also include its Covered Facilities unless specifically delineated.

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1. **Services**. Vizient will provide Group Purchasing Program services to Member (collectively, the "Services"). Specifically, the Services include:

   1.1 **GPO Services and Agent Designation**. Vizient is a health care group purchasing organization ("GPO") that, on behalf of participating organizations, negotiates, directly and through its contracting subsidiaries, such as Vizient Supply, LLC ("Vizient Supply") and MedAssets Performance Management Solutions, Inc. ("MedAssets"), vendor and distributor ("Suppliers") agreements ("Supplier Agreements") for goods, services, or intangible items (collectively, "Covered Items") and offers supply chain and clinical improvement related services (collectively referred to as the "Group Purchasing Program"). Member designates, for itself and on behalf of its Covered Facilities, Vizient and its agents, including, but not limited to, Vizient Supply and MedAssets, to act as Member's exclusive GPO agent for purposes of negotiating and entering into Supplier Agreements under which Member may purchase as a third-party beneficiary and Member will not engage any competitor GPO to provide services substantially similar to the Services provided hereunder.

   1.2 **Ancillary Document Agent Designation**. Member appoints Vizient as its authorized agent for the limited purpose of entering into, executing, and submitting to Suppliers, on Member's behalf, purchase-level tier assignments, letters of participation, letters of commitment, or other relevant documentation, to the extent such documentation is required to provide Member with access to and benefit from Supplier Agreements.

   1.3 **Vizient Catalog**. Vizient will provide Member with access to Vizient's electronic contract management and catalog database ("Vizient Catalog") which provides access to: i) Supplier Agreements; ii) information regarding Vizient's products and services; iii) Administrative Fees Database (as defined below); and iv) Annual Disclosure Reports (as defined below).

   1.4 **Supplier Disputes**. Vizient will provide Member with reasonable assistance to resolve disputes with Suppliers related to Supplier Agreements; provided, however, Vizient will not provide legal analysis or legal counseling to Member or any dispute-resolution assistance requiring legal expertise.

2. **Covered Facilities**.

   2.1 **Covered Facility**. A "Covered Facility," or collectively, "Covered Facilities," are individual sites or facilities whereby Member represents and warrants Member: i) has managerial or operational responsibilities including, without limitation, primary control of each Covered Facility's procurement activities related to supply chain management; ii) has the authority to bind each Covered Facility to the terms and conditions of this SOW; and iii) is authorized to accept any applicable Fee Share, Discounts, or Rebates (as defined below) on behalf of

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Covered Facilities. The term "primary control" means Member has the power, directly or indirectly, whether through ownership or via a management agreement, to direct, oversee, manage, or implement policies as it relates to procurement activities or facility operations. Vizient reserves the right to require reasonable written documentation a Covered Facility meets the requirements of this section. Member agrees to indemnify Vizient against, and hold Vizient harmless from, any claim arising from the breach of this representation and warranty.

2.2 **Covered Facility Addition Form**. Upon execution of this SOW, Vizient will provide Member with an electronic form whereby Member can add Covered Facilities to Member's Group Purchasing Program membership ("Covered Facility Addition Form"). Thereafter, Member has 30 days to complete and return the Covered Facility Addition Form to Vizient at the email address described therein. Member may add a Covered Facility at any time by submitting a Covered Facility Addition Form which will take effect within 3 business days of receipt. Member may remove a Covered Facility by providing written notice to Vizient. Member is responsible for providing all information necessary to roster Covered Facilities under Member's Group Purchasing Program membership. Each Covered Facility must comply with the terms hereof and Vizient will have no obligation to provide Services or Fee Share to any site or facility not rostered as a Covered Facility in accordance with this SOW. Notwithstanding the foregoing, Vizient reserves the right to condition the addition of an existing Vizient GPO member as a Covered Facility hereunder on a mutually agreeable amendment to this SOW.

3. **Term and Termination**.

3.1 **Term**. The initial term of this SOW will commence on the Effective Date and continue for a period of **36 months** ("Initial Term"). Thereafter, the Initial Term will automatically renew for 1-year terms (each, a "Renewal Term") unless either Party provides 90 days' written notice of its intent not to renew prior to the expiration of the then-current Term. The Initial Term and any Renewal Terms are referred to herein collectively as the "Term."

3.2 **Termination for Convenience**. This SOW may not be terminated for convenience. If the Master Agreement expires or is terminated prior to the expiration of this SOW, the applicable terms and conditions of the Master Agreement survive for the limited purpose of governing this SOW for its remaining Term.

3.3 **Termination for Cause**. The Parties may terminate this SOW for material breach in accordance with the terms of the Master Agreement. Notwithstanding the foregoing, all notices to or from a Covered Facility relating to any material breach will require a simultaneous notice to the Member.

3.4 **Effect of Termination**. The termination of this SOW relative to a Covered Facility will not automatically result in the termination of this SOW as between Vizient and Member; provided, however, termination of this SOW relative to the Member will result in the automatic termination of this SOW as between Vizient, Member, and all Covered Facilities.

4. **Administrative Fees, Discounts and Rebates, and Supplier Agreement Obligations**.

4.1 **Administrative Fees**. Member acknowledges and agrees that, pursuant to the terms of Supplier Agreements, Vizient i) will receive administrative fees from Suppliers based on Member's purchases ("Administrative Fees") and ii) may furnish certain administrative and promotional services to such Suppliers.

4.2 **Administrative Fees Database**. Except as otherwise provided for in a Supplier Agreement, each Supplier Agreement provides for a fixed Administrative Fee of 3% or less of the purchase price for Covered Item(s). For Supplier Agreements that provide for an Administrative Fee greater than 3%, Member can access such Administrative Fee amounts ("Administrative Fees Database") via Vizient Catalog, which Vizient will update as necessary, and is incorporated herein by reference. This section is intended to maintain the Parties' compliance with the federal health care GPO anti-kickback statutory exception, 42 USC 1320a-7b(b)(3)(C), and regulatory safe harbor, 42 CFR 1001.952(j), as amended.

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4.3 Discounts and Rebates. Member acknowledges and agrees that, in addition to any Fee Share (defined below), Member: i) may receive discounts ("Discounts") or rebates ("Rebates") from Suppliers or Vizient that may be subject to 42 USC 1320-7b and thus Member may have an obligation under federal or state law to disclose such Fee Share, Discounts, or Rebates to federal or state health care programs or other payors part of the cost reporting process or otherwise; and ii) agrees to comply with all such laws. This section is intended to maintain the Parties' compliance with the federal health care discount anti-kickback statutory exception, 42 USC 1320a-7b(b)(3)(A) and discount safe harbor, 42 CFR 1001.952(h), as amended.

4.4 Impact Standardization Program. Vizient's Impact Standardization Program ("Impact Program") provides quarterly Rebates to those members who enroll and comply with the Impact Program's standardization purchasing requirements. Upon successful enrollment and compliance with the Impact Program's requirements, Member will receive all Impact Program Rebates paid to Vizient, on behalf of Member, during each calendar quarter. Vizient will pay all Rebates to Member within 120 days following the end of each calendar quarter.

4.5 Annual Disclosure Report. Vizient will provide Member, no less than annually and via Vizient Catalog, an annual report listing Member's purchases and respective Administrative Fees, Rebates, or Discounts received by Vizient based on such purchases ("Annual Disclosure Report"). Member acknowledges and agrees Vizient has no obligation to provide an Annual Disclosure Report to Covered Facilities. As such, Member represents and warrants it will provide Covered Facilities with any information relating to Administrative Fees necessary for Covered Facilities to comply with all relevant state and federal cost reporting or other laws and regulations. Member agrees to indemnify Vizient against, and hold Vizient harmless from, any claim arising from breach of this representation and warrant.

4.6 Supplier Agreement Obligations. Member is bound to the terms and conditions of each Supplier Agreement if Member: i) purchases Covered Items under that agreement; or ii) agrees to be bound to that agreement in an ancillary document (such as a Letter of Commitment or Letter of Participation). Member warrants that any purchase made under any Supplier Agreement will not cause Member to breach any third-party agreement or obligation. Vizient has no responsibility for interpreting, negotiating, or managing ancillary agreements Member enters into with an individual Supplier. Notwithstanding the foregoing, Member determines, in its sole discretion, whether and how much to purchase through Supplier Agreements.

4.7 Own Use. Member represents and warrants that all Covered Items purchased will be for Member's "own use," within the meaning of the Nonprofit Institutions Act as interpreted by the U.S. Supreme Court in Abbott Laboratories v. Portland Retail Druggists Association Inc., 425 U.S. 1 (1976), and its successor line of cases, and will comply with the Prescription Drug Marketing Act of 1987, as applicable and amended. Member will indemnify and hold Vizient harmless from any and all manner of liability including, but not limited to, any and all costs of defense resulting from any breach by Member of this section. Vizient will have the right to immediately terminate this SOW should Member breach the foregoing representation and warranty.

5. Service Fees, Committed Purchases Requirement, and Fee Share.

5.1 Service Fees. Vizient will provide the Services described herein to Member in consideration of the Administrative Fees retained by Vizient hereunder ("Service Fees"), and Member acknowledges and agrees the retained Administrative Fees represent the fair market value of such Services.

5.2 Committed Purchases Requirement. For each 12-month period, commencing on the Effective Date (each, a "Contract Year"), Member's aggregate purchases reported by Suppliers, not acting in the capacity of a distributor ("Manufacturer Purchases"), will equal or exceed the applicable spend amount (the "Committed Purchases Requirement" or "CPR"), as follows:

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Contract Year	Committed Purchases Requirement
January 1, 2023 – December 31, 2023	$9,000,000
January 1, 2024 – December 31, 2024	9,000,000
January 1, 2025 – December 31, 2025	$9,000,000

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In the event of a Renewal Term, the then-current CPR will increase by 3% for each Renewal Term. If Member fails to meet the Committed Purchases Requirement for any Contract Year, Member will pay Vizient two point six five percent (2.65%) of the difference between the Committed Purchases Requirement and total Manufacturer Purchases made during such Contract Year.

5.3 **Fee Share**. Vizient will pay Member a percentage ("Fee Share Percentage") of Administrative Fees based on Member's purchases reported by Suppliers ("Fee Share"), within 120 days following the end of the calendar quarter in which such purchases were reported. At the beginning of each Contract Year, the applicable Fee Share Percentage will equal 2% until total purchases through Supplier Agreements, as reported by Suppliers not acting in the capacity of a distributor, equal or exceed $10,000,000 ("Reported Purchases"). Thereafter, the Fee Share Percentage will increase in accordance with the tier table below. For any calendar quarter during a Contract Year in which Reported Purchases exceed a tier threshold, the higher Fee Share Percentage will apply from dollar one ($1) of all Administrative Fees reported during the applicable Contract Year. At the beginning of each Contract Year the Fee Share Percentage will reset to 2%.

Reported Purchases	Fee Share Percentage
$0 - $9,999,999	2%
$10,000,000 - $12,499,999	20%
$12,500,000 - $14,499,999	25%
$14,500,000 and above	30%

5.4 **Member Statement**. After the end of each calendar quarter, Vizient will provide Member with a summary account statement ("Member Statement") showing total Fee Share earned, other cash payments, and any other invoices offset for the respective calendar quarter. If the Member Statement reflects a total net due amount owed from Vizient to Member, Vizient will pay Member such amounts within 120 days after the last day of the applicable period. If the Member Statement reflects a total net amount due from Member to Vizient, Vizient will issue an invoice for such amounts and Member will pay all invoices within 30 days of receipt. Vizient reserves the right to offset any invoices for Service Fees, Reimbursable Expenses, or any other amounts owed under the Master Agreement, past due 90 days, against amounts due to Member as reflected in the Member Statement. The Member Statement will provide a summary of any invoices for Service Fees, Reimbursable Expenses, and other amounts offset by Vizient.

5.5 **No Obligation**. Notwithstanding anything to the contrary stated herein, Vizient will not be obligated to pay Fee Share to the extent: i) Member breaches a material term of the Master Agreement or this SOW that remains uncured; ii) Administrative Fees are received for which a Supplier has failed to provide sufficient detail to determine whether they are derived from purchases made by Member or a Covered Facility; iii) a Supplier fails to pay Administrative Fees owed to Vizient based on purchases made by Member or a Covered Facility; or iv) a change in law or regulation occurs which Vizient reasonably believes prohibits the sharing of such Administrative Fees with its members.

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5.6 Term Expiration. Following the expiration of the Term, Vizient will pay Member Fee Share for purchases i) made prior to the Term expiration date; and ii) reported to Vizient by a Supplier within 90 days of the Term expiration date. For purposes of clarification, Vizient will have no obligation to pay Fee Share for any purchases made by Member following the expiration of the Term or reported by a Supplier more than 90 days after the expiration of the Term. An early termination of this SOW, for any reason, will terminate Vizient's obligation to pay any Fee Share to Member after the effective date of such termination.

IN WITNESS WHEREOF, the Parties have caused this SOW to be executed by their duly authorized representatives as of the Effective Date.

Vizient, Inc.	Pajaro Health Care District Hospital Corporation d/b/a Watsonville Community Hospital,
By: _____	By: _____
Printed Name: _____	Printed Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

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Please sign, scan, and email to executedagreements@vizientinc.com. Vizient will provide a fully executed electronic copy to Member.

Hospital Board Memo

From: Steven Salyer, CEO

Subject: Approval of Amended and Restated Bylaws for Pajaro Valley Health Care District Hospital Corporation

Meeting Date: January 25, 2023

Recommended Actions

Consider the Approval of the Amended and Restated Bylaws for the Pajaro Valley Health Care District Hospital Corporation (PVHCDHC").

Executive Summary

On May 11, 2022, the Hospital Board approved the Bylaws for the PVHCDHC in order to establish the rules and regulations for the exercise of its powers and duties. The Bylaws were approved before the transition of the Hospital to ownership by the Pajaro Valley Health Care District and operation by PVHCDHC which occurred on August 31, 2022. After 4 months of operation, management is now recommending that the composition of the committees as set forth in the bylaws be modified somewhat to ensure a broader spectrum of representation on the committees. The committees will include board members, executives, directors, physicians and front line employees. In addition, since the entire board has responsibility for credentialing, the Board Credentialing Committee was removed as was the Audit Committee whose tasks will instead be performed on an ad hoc basis as needed. The Amended and Restated Bylaws will need final approval by the District, as the sole member of PVHCDHC.

Background/Analysis

The Hospital is operated by a nonprofit corporation which is governed by a set of bylaws which sets forth the responsibilities of the Board of Directors, the conduct of business, selection of officers, the establishment and composition of committees and a number of other topics. The Bylaws are largely based on those used by similar organizations that have a similar governance structure. The District, as the sole member of the nonprofit, has the right of final approval of any changes to the Bylaws. This document as presented could act as the final version of the Amended and Restated Bylaws if it meets with the Board's approval, or it could be subject to revision after discussion and direction to staff. Currently, staff recommends that the Board consider adoption of the attached Amended and Restated Bylaws. Once approved by the PVHCDHC Board, the Bylaws will need final approval by the District, as the sole member of PVHCDHC.

Financial Impact

There is no financial impact to the Hospital associated with the adoption of the Amended and Restated Bylaws.

Attachment:

A. Redline of Amended and Restated Bylaws of the Pajaro Valley Health Care District Hospital Corporation

AMENDED AND RESTATED BYLAWS

OF

Pajaro Valley Health Care District Hospital Corporation, a California nonprofit public benefit corporation

ARTICLE I
NAME AND PRINCIPAL OFFICE

1.1. Name. The name of the Corporation shall be as listed in the Articles of Incorporation, namely, Pajaro Valley Health Care District Hospital Corporation ("PVHCDH"), a nonprofit public benefit corporation organized under the laws of the State of California.

1.2. Principal Office and Place of Business. PVHCDH shall have and continuously maintain a registered office in Santa Cruz County and may have other offices within the State of California, as the Board may from time to time determine.

ARTICLE II
PURPOSES

PVHCDH was formed for the purposes set forth in its Articles of Incorporation. The property of PVHCDH is irrevocably dedicated to public, charitable, educational and hospital purposes which meet the requirements of Section 501(c)(3) of the Internal Revenue Code and Sections 23701 and 214 of the California Revenue and Taxation Code.

ARTICLE III
MEMBERSHIP

3.1. Member. There shall be one member of PVHCDH who shall be the Pajaro Valley Health Care District, a political subdivision of the State of California (the "Member"). The Member, and only the Member, shall be entitled to exercise fully all rights and privileges of members of nonprofit corporations under the California Nonprofit Public Benefit Corporation Law, and all other applicable laws. The rights and powers of the Member shall also include, without limitation, the following: the limitation on liabilities described in Section 3.3 of these Bylaws; the right to dissolve PVHCDH upon a majority vote in favor of dissolution; and the exercise of all of the rights set forth in Article X and XI of these Bylaws. The Member may not be expelled or suspended as the Member without its consent. Any reference in these Bylaws to the "member," "Member" or any similar such reference, shall mean the Pajaro Valley Health Care District, a political subdivision of the State of California.

3.2. Exercise of Membership Rights. The Member shall exercise its membership rights through its own Board of Directors. Subject to the provisions of the Member's own bylaws, and except as otherwise provided in these Bylaws, the Board of Directors of the Member may, by resolution, authorize a person or committee of persons to exercise its vote on any matter to come before the membership of PVHCDH. In addition, the Member may exercise its membership rights at any regular or special meeting of the Board of Directors of the Member. The functions required by law or by these Bylaws to be performed at the annual membership meeting or any regular or special meeting of the members of PVHCDH may be performed at any regular or special meeting of the Member's own Board of Directors.

3.3. Liabilities and Assessments. The Member shall not be liable for the debts of PVHCDH. The Board of PVHCDH shall have no power to levy and collect assessments on the Member. The provisions of this paragraph cannot be amended in any manner.

ARTICLE IV
BOARD OF DIRECTORS

4.1. Responsibility. Except as otherwise provided by the Articles of Incorporation or by these Bylaws, the management of the affairs of PVHCDH shall be vested in a Board of Directors (the "Board") composed of the persons described in Section 4.2 of these Bylaws (the "Directors" and each a "Director"). Specifically, the Board of Directors shall be empowered as follows:

(a) To control and be responsible for the overall governance of Watsonville Community Hospital, including the provision of management and planning.

(b) To implement Compliance Program oversight consistent with Watsonville Community Hospital wide compliance programs and procedures, including, responsibility for an effective Compliance Program and adoption of related policies, review of routine and special Compliance reports on a regular basis, appropriate delegation of implementation to senior management, and Board training on Compliance Program oversight and implementation.

(c) To appoint a Chief Executive Officer and to define the powers and duties of such appointee, and to delegate to such person overall responsibility for operations of the Watsonville Community Hospital, and affiliated entities, as specified herein and consistent with Board of Directors' Policies.

(d) To determine policies and approve procedures for the overall operation and affairs of Watsonville Community Hospital and its facilities according to the best interests of the public health and to assure the maintenance of quality patient care.

(e) To evaluate the performance of Watsonville Community Hospital in relation to its vision, mission and goals.

(f) To provide for coordination and integration among Watsonville Community Hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.

(g) To be ultimately accountable for the safety and quality of care, treatment and services at Watsonville Community Hospital.

(h) To review and approve annual operating and multi-year capital budgets.

(i) To assure through implementation of appropriate processes that all individuals who provide patient care services, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services, and receive reports of quality assurance information regarding competency of care providers not subject to the privilege delineation process.

(j) To oversee the Medical Staff and the quality of professional services as described in Article VII and Article VIII of these Bylaws.

(k) To establish, maintain and support, through the Chief Executive Officer and the Medical Staff and its designated committees, a comprehensive, hospital-wide program for quality assessment and improvement, to receive reports of performance improvement information on a regular basis from the Medical Staff, and to assure that all aspects of the program are performed appropriately and that administrative assistance is available to the Medical Staff.

(l) To oversee programs for continuing medical education for Medical Staff members, and appropriate in-service education programs for hospital employees, for the purpose of maintaining and improving clinical and employee performance.

(m) To make recommendations to the Chief Executive Officer regarding the kinds and quality of service to be made available at Watsonville Community Hospital.

(n) To review and consult with the Chief Executive Officer concerning the long-range plan for Watsonville Community Hospital.

(o) To consult directly with the Chief of Staff or his/her designee, or through a subcommittee by the Board to include the Chief of Staff, on no less than two occasions per year, on matters including but not limited to: the scope and complexity of hospital services offered, specific patient populations served by Watsonville Community Hospital and any issues of patient safety and quality of care; promptly addressing any urgent request for consultation presented by the Chief of Staff or his/her designee.

(p) To assist in the accreditation process, including participation in the summation conference, and assist in maintaining compliance with current accreditation standards

set by The Joint Commission, in conjunction with the Chief Executive Officer and the Medical Staff.

(q) To assist the Chief Executive Officer in establishing medical record policies respecting composition, retention, confidentiality and other aspects of recordkeeping, maintaining confidentiality with respect to the records and affairs of Watsonville Community Hospital, except as disclosure is authorized or required by law.

(r) To approve bylaws for Watsonville Community Hospital auxiliary organizations or for any other similar organizations.

(s) To conduct an annual evaluation of its own activities and performance and an annual evaluation of the Chief Executive Officer and to implement programs to improve such activities and performance.

(t) To perform any other functions designated in these Bylaws but not specifically referred to in this Section and to do any and all other act and things necessary to carry out the provisions of these Bylaws or of the provisions of the California Nonprofit Public Benefit Corporation Law.

All powers of the Board of Directors, which are not otherwise restricted by law, agreement, or herein, may be delegated by an employment agreement, policies, and by direction of the Board to the Chief Executive Officer or to others employed or engaged by or with responsibilities to PVHCDH, to be exercised in accordance with that delegation

4.2. Number, Designation, Term, Removal of Directors. The number of Directors shall be five (5) and shall be comprised of the five (5) publicly elected Directors of the Board of the Member. Directors who no longer serve on the Member's Board of Directors shall be automatically removed as Directors of PVHCDH.

4.3. Voting Rights. Each Director shall be entitled to one vote on all matters before the Board. There shall be no voting by proxy.

4.4. Organizational Meeting. As soon as reasonably possible after each January 1, the Board of Directors shall meet for the purposes of organizing the Board, the election of officers, and the transaction of such other business as may come before the meeting. The initial Board of Directors shall meet for such purposes as soon as reasonably possible after such Board is first constituted.

4.5. Regular Meetings. The Board shall hold meetings at least monthly at such time and place as the Board shall from time to time determine.

4.6. Special Meetings. Special meetings of the Board for any purpose or purposes shall be called by the Secretary upon the request of the Chair, the Chief Executive Officer or any two (2) Directors.

4.7. Notice and Conduct of Meetings; Brown Act. Notice of meetings and meeting agendas shall be in conformance with the California Ralph M. Brown Act, and meetings of the Board shall be conducted consistent with the Brown Act.

4.8. Quorum. A majority of the members of the Board then serving shall constitute a quorum at any meeting of the Board provided that the minimum number of members of the Board which may constitute a quorum shall be three (3). The act of a majority of the voting power present at any meeting at which a quorum is present shall be considered the act of the Board.

4.9. Place. The Board shall hold its meetings at the principal office of the Member, or such other place as the Chair or the Directors requesting the meeting may designate.

4.10. Telephonic Meetings. Members of the Board may participate in a meeting through use of a conference telephone or similar communications equipment, consistent with Brown Act requirements.

4.11. Interested Directors. Not more than forty-nine percent (49%) of the persons serving on the Board at any time may be interested persons. An "interested person" is (i) any person being compensated, directly or indirectly, by PVHCDH for services rendered to it within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or otherwise (excluding any reasonable compensation paid to a director for serving in such capacity); and (ii) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, mother-in-law, or father-in-law of any such person. However, any violation of the provisions of this paragraph shall not affect the validity or enforceability of any transaction entered into by PVHCDH.

4.12. Conflict of Interest Policy. The Board shall develop and adhere to a conflict of interest policy that incorporates the provisions of Section 5233 of the California Nonprofit Corporation Law. The initial Conflicts Policy shall be that adopted by the Member prior to adoption of these Bylaws. PVHCDH's Conflicts Policy shall be consistent with laws and regulations applicable to California special districts.

4.13. Self-Dealing. Prior to conducting a business session at a meeting of the Board, Board members shall disclose and discuss their individual conflicts or potential conflicts and that of other members of the Board. Actual conflicts shall be subject to resolution pursuant to the Conflicts Policy, applicable federal and state non-profit corporation laws and conflict of interest laws related to public agencies including, but not limited to, Gov't Code 1090 and the Political Reform Act. In the exercise of voting rights by members of the Board, no individual shall vote on any issue, motion or resolution which directly or indirectly inures to his or her benefit financially

or with respect to which he or she has any other conflict of interest, except that such individual may be counted in order to qualify a quorum and, except as the Board may otherwise direct, may participate in the discussion of such an issue, motion or resolution if he or she first discloses the nature of his or her interest and such discussion is allowed under conflict of interest laws applicable to public agencies. Board members shall adhere to the Conflict of Interest Policy enacted pursuant to section 4.12 of these Bylaws.

4.14. Access to Board Records and Reports. Upon request, officers of the Member shall have access to Watsonville Community Hospital documents for review (but not possession) that have been reviewed by the Board of Directors. Such review shall be subject to the officer executing an agreement to maintain the confidentiality (no disclosure beyond officers and Board members of the Member) of information reviewed. Documents that are protected by legal privileges and confidentiality (e.g., personnel, peer review, legal, vendor contractual confidentiality), those containing pending competitive business transaction information, and physician agreements, shall not be subject to review. Subject to the execution of an agreement to maintain confidentiality, Board member and Board selected candidate conflict disclosure filings shall be available for review at PVHCDH's offices only to the chief executive or designated legal counsel of the Member upon request.

4.15. Bylaws Review. Consistent with regulatory and industry standards, the Board shall periodically conduct a review of these Bylaws in order to update and improve them. At least every two (2) years, commencing in January 2024, the Board shall seek the input of the Member in connection with such a review.

ARTICLE V
OFFICERS

5.1. Officers of this Corporation. The officers of PVHCDH shall be a Chair, a Vice Chair, a Chief Executive Officer, a Secretary, and a Treasurer (which office shall be separate from PVHCDH's Chief Financial Officer). No officer may hold more than one office at a time, with the exception of cases in which there is a vacancy in the office due to death, resignation, removal, disqualification or otherwise of a director pursuant to Section 4.2 above in which case more than one office may be held by a single director until the vacancy on the Member Board had been filled.

5.2. Officers Elected by the Board. The Chair, Vice Chair, Treasurer, and Secretary shall be elected annually by the Board at its organizational meeting. Nominations shall be submitted in advance of the selection by a nominating committee appointed by the Board. Each officer elected by the Board shall hold office at the pleasure of the Board and until his or her successor shall be elected and qualified to serve. A vacancy in any office because of death, resignation, removal, disqualification or otherwise of a director, may be filled by the Board for the unexpired term at any meeting of the Board.

5.3. Resignation or Removal. Any officer of the Board may resign at any time or be removed by the vote of the Board.

5.4. Vacancies in Office. A vacancy in any office because of death, resignation, removal, or any other cause shall be filled in the manner prescribed in these Bylaws for regular appointments.

5.5. Chair. The Chair of the Board shall preside at all meetings of the Board. Unless the signature of the Chief Executive Officer is required by law, the Chair of the Board shall possess the same power as the Chief Executive Officer to sign all certificates, contracts, or other instruments of PVHCDH when he or she is so authorized by the Board. The Chair of the Board shall exercise and perform such other powers and duties as may be prescribed by the Board from time to time. The Chair of the Board shall serve as the Board's liaison to the Chief Executive Officer.

5.6. Vice Chair. In the absence of the Chair of the Board or in the event of the Chair's disability, inability, or refusal to act, the Vice Chair of the Board shall perform all of the duties of the Chair and in so acting shall have all of the powers of the Chair. The Vice Chair shall have such other powers and perform such other duties as may be prescribed from time to time by the Board or by the Chair.

5.7. Chief Executive Officer.

(a) Appointment and Removal. The Chief Executive Officer of PVHCDH shall be engaged by the Board and shall serve at the pleasure of the Board, which may terminate the services of the Chief Executive Officer of PVHCDH subject to any employment agreement.

(b) Responsibilities and Authority. The Chief Executive Officer shall be the general manager, administrator and Chief Executive Officer of PVHCDH. The Chief Executive Officer shall be given the necessary authority and responsibility to operate PVHCDH in all of its activities, including without limitation, quality of services, safety matters, cost effectiveness and economic performance, subject to the following: with respect to safety and quality of care, treatment and services, policy development, program planning, employee and community relations, the Chief Executive Officer shall be subject to such policies as may be adopted and such orders as may be issued by the Board of PVHCDH or by any of its committees to which the Board has delegated the power for such action; with respect to program execution and overall management performance, the Chief Executive Officer shall be subject to the authority of and shall report to the Board. The Chief Executive Officer shall act as the duly authorized representative of the Board of PVHCDH in all matters in which the Board has not formally designated some other person to so act.

5.8. Treasurer. The Treasurer of PVHCDH shall keep and maintain or cause to be kept and maintained adequate and correct account of the properties and business transactions of

PVHCDH, including accounts of its assets, liabilities, receipts, disbursements, gains and losses. The books of account shall at all times be open to inspection by any Board member. The Treasurer shall be charged with safeguarding the assets of PVHCDH and he or she shall sign financial documents on behalf of PVHCDH in accordance with the established policies of PVHCDH. He or she shall have such other powers and perform such other duties as may be prescribed by the Board from time-to-time. The Treasurer may fulfill these responsibilities and perform his or her duties through appropriate delegation, with Board oversight, to individuals or firms charged with the financial management of PVHCDH.

5.9. Secretary. The Secretary shall keep or cause to be kept a book of minutes at the principal office or at such other place as the Board may order of all meetings of the Board with the time and place of holding, whether regular or special, and if special how authorized, the notice thereof given, the names of those present at the Board meetings, and the proceedings thereof. The Secretary shall give or cause to be given notice of all the meetings of the Board required by these Bylaws or by law to be given, and the Secretary shall keep the seal of PVHCDH in safe custody and shall have such other powers and perform such other duties as may be prescribed by the Board from time to time.

ARTICLE VI
COMMITTEES

6.1. Establishment of Committees. PVHCDH shall have the standing committees set forth in Section 6.5 of these Bylaws, and such other standing committees or special committees as may be established by the Board from time to time in accordance with these Bylaws.

6.2. Composition of Committees. Unless otherwise stated, standing committees shall not be limited to members of the Board, but consistent with California Nonprofit Corporation Law shall include at least two (2) members of the Board. Special committees and any subcommittees of any standing committee or special committee that may be established from time to time shall not be limited to members of the Board but may, by direction of the Board, include any number of persons the majority of whom need not be Directors. The Chair of the Board shall recommend committee members and Chairs of the committees to the Board, subject to the approval of the Board. The Board shall create committees as deemed necessary. Member's interests in appointment to certain committees shall be considered by the Chair. The Board may appoint alternate members of any committee who shall act on behalf of any committee member who is absent from a committee meeting. The Board or the committee may select other persons, whether or not members of the Board, to attend meetings of the committee and to participate in the discussion and activities of the committee; provided, however, that such additional persons attending the committee meeting shall not be entitled to vote and shall participate only at the discretion of the committee.

6.3. Powers; Restrictions and Limitations.

(a) Standing Committees. Subject to the duty of the Board to exercise ultimate direction over the activities and affairs of PVHCDH, the Board may delegate to any standing committee the power, subject to applicable law, to manage or direct any activity of PVHCDH. In addition to powers so delegated and the general duties of the standing committees described in the provisions of these Bylaws, the standing committees shall undertake duties or specific tasks assigned by the Board, or the Chair of the Board of Directors, and shall consider matters requested by other committees or the Chief Executive Officer of PVHCDH.

(b) Special Committees. The Board may authorize any special committee to carry out certain specified functions or responsibilities, or to provide such advice and recommendation as the Board shall require, but no special committee shall have the authority to determine PVHCDH policy or otherwise exercise any powers of the Board with respect to the business and affairs of the PVHCDH. Internal conflicts concerning Medical Staff affairs shall be referred to a special committee created and appointed by the Chair of the Board on an as needed basis for resolution.

(c) Subcommittees. The Board or any standing or special committee may authorize any subcommittee to carry out certain specified functions or responsibilities, or to provide such advice and recommendation as the Board or any such committee shall require, but no subcommittee shall have the authority to determine PVHCDH policy or otherwise exercise any powers of the Board with respect to the business and affairs of PVHCDH.

6.4. Meetings and Actions of Committees.

(a) Meetings. Meetings and actions of any standing committee, special committee or subcommittee shall be governed by, and held and taken in accordance with, the provisions of these Bylaws concerning meetings of the Board, including, but not limited to Section 4.7, with such changes in the content of these Bylaws as are necessary to substitute the committee or subcommittee and its members for the Board and its members, except a quorum of a committee shall be a majority of the voting members of the committee. The time for regular meetings of any committee or subcommittee may be determined either by direction of the Board or by direction of such committee or subcommittee. Special meetings of any committee or subcommittee may also be called by direction of the Board. Notice of special meetings of any committee or subcommittee shall also be given to any and all alternate members, who shall have the right to attend such meetings, subject to the discretion of the committee or subcommittee. Minutes shall be kept of meetings of any committees and subcommittees and shall be filed with the corporate records. The Board may adopt rules for the governing of any committee or subcommittee not inconsistent with the provisions of these Bylaws.

(b) Subcommittee membership. Subject to Board approval, each standing or special committee may establish such subcommittees as it deems necessary, the members of which

need not be members of the Board. The Chair of the parent committee shall recommend to the Board formation of any subcommittee and shall nominate initial membership and the proposed chair of any new subcommittee to the Board for approval. Thereafter, the Chair of a subcommittee shall recommend to the Chair of the parent committee annual appointments or reappointments to the subcommittee, or recommend individuals to fill vacancies. The Chair of the parent committee shall have discretion to accept or reject such recommendations, and shall submit nominations for annual subcommittee membership (including appointment of the subcommittee chair), or nominations to fill vacancies on subcommittees, to the Board of Directors for approval.

6.5. Establishment of Standing Committees. Standing Committees of the Board of Directors as established and appointed pursuant to these Bylaws shall be as follows:

(a) Finance Committee. The Finance Committee shall consist of two (2) Board members, with up to ten (10) persons, including, the Board Treasurer, two (2) senior executives; two (2) hospital directors or managers, two (2) physicians with medical staff privileges at Watsonville Community Hospital and two (2) hospital front line staff. The Finance Committee shall oversee all financial matters for PVHCDH including operating and capital budgets, borrowings and capital planning, audits, material contracts and leases, business plan development and implementation, and facilities and equipment.

(b) Strategic Planning and Marketing Committee. The Strategic Planning and Marketing Committee shall consist of two (2) Board members, with up to ten (10) persons including two (2) senior executives; two (2) hospital directors or managers, two (2) physicians with medical staff privileges at Watsonville Community Hospital and two (2) hospital front line staff. The Strategic Planning and Marketing Committee shall oversee marketing and strategic planning, integration of PVHCDH operations and facilities, service changes or adjustments, physician development, facility planning, and strategic alliances and ventures. The Committee shall oversee development and implementation of PVHCDH's community benefit programs and shall seek input into its work from the Member. The Committee shall also facilitate coordination of its community benefit programs with similar programs undertaken by the Member.

(c) Employee Engagement Committee. The Employee Engagement Committee shall consist of two (2) Board members, with up to ten (10) persons, including, two (2) senior executives; two (2) hospital directors or managers, two (2) physicians with medical staff privileges at Watsonville Community Hospital and two (2) hospital front line staff. The Employee Engagement Committee shall consider human resource issues and policies as warranted and shall review and recommend for Board approval employee compensation, pension and benefits programs (other than executive officer level).

(d) Quality and Patient Safety Committee. The Quality and Patient Safety Committee shall consist of two (2) Board members with up to ten (10) persons, including, two (2) senior executives; two (2) hospital directors or managers, two (2) physicians with medical staff

privileges at Watsonville Community Hospital and two (2) hospital front line staff. The Committee will be assisted in its work by the Chief Executive Officer, the CNO (Chief Nursing Officer), the Safety Officer, and the Medical Staff as needed and requested by the Committee. The Quality and Patient Safety Committee shall oversee effective functioning of activities related to: provision of quality patient care, patient and staff safety, performance improvement, risk management, regulatory and accreditation standards, and strategic direction for quality expenditures. The Quality and Patient Safety Committee shall forward Quality Reports and recommendations to the Board of Directors. This Committee shall also be responsible for developing and implementing the Board's annual action plan for resolution of safety and quality issues. In addition, the Committee shall:

(1) Analyze data regarding safety and quality of care, treatment and services and establish priorities for performance improvement.

(2) Oversee the Medical Staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards.

(3) Ensure that recommendations from the Medical Executive Committee and Medical Staff are made in accordance with the standards and requirements of the Medical Staff Bylaws, Rules and Regulations with regard to:

(i) completed applications for initial staff appointment, initial staff category assignment, initial department/divisional affiliation, membership prerogatives and initial clinical privileges;

(ii) completed applications for reappointment of medical staff, staff category, clinical privileges;

(iii) establishment of categories of Allied Health Professionals permitted to practice at Watsonville Community Hospital, the appointment and reappointment of Allied Health Professionals and privileges granted to Allied Health Professionals.

(4) Provide a system for resolving conflicts that could adversely affect safety or quality of care among individuals working within the hospital environment.

(5) Ensure that adequate resources are allocated for maintaining safety and quality care, treatment and services.

(6) Analyze findings and recommendations from the Watsonville Community Hospital's administrative review and evaluation activities, including system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

(7) Assess the effectiveness and results of the quality review, utilization review, performance improvement, and risk management programs.

(8) Perform such other duties concerning safety and quality of care matters as may be necessary.

6.6. Ad Hoc Committees. Ad hoc committees may be appointed by the Chair with the approval of the Board of Directors for special limited projects for such specific tasks as circumstances warrant e.g. ad hoc audit committee. Ad hoc committees shall comply with the Brown Act and no ad hoc committee so appointed shall have any power or authority to commit the Board of Directors or Corporation in any manner, but may make recommendations to the Board of Directors.

6.7. Vacancies. Vacancies in any committee shall be filled for the unexpired portion of the term in the same manner as provided in the case of original appointment.

6.8. Expenditures. Except as expressly delegated, any expenditure of corporate funds by a committee or any commitment by a committee to expend corporate funds shall require prior approval of the Board.

ARTICLE VII
CREDENTIALED PRACTITIONERS

7.1. Medical Staff Appointments and Clinical Privileges

(a) The Board shall appoint a Medical Staff and see that they are organized into a responsible administrative unit and adopt such bylaws and rules and regulations for government of their practice in Watsonville Community Hospital as the Board deems to be to the greatest benefit of patients within Watsonville Community Hospital. In the case of the individual patients, those appointed to the Medical Staff shall have full authority and responsibility for the care of patients subject only to such limitations as the Board may formally impose and to the bylaws and rules and regulations for the Medical Staff as adopted by the Board. The Medical Staff shall adhere to the highest ethical principles of the medical profession.

(b) All applications for appointment to the Medical Staff shall be in writing and addressed to the Medical Staff Office in such form as determined by Watsonville Community Hospital and more specifically described in the Medical Staff Bylaws. The application shall be complete and with required information relating to education, licensure, practice, previous hospital experience, professional liability coverage and any history relative to licensure, malpractice experience and/or hospital privileges.

(c) At its next regular meeting after receipt of a completed application and a recommendation from the Medical Staff concerning an applicant for Medical Staff appointment, the Board shall act in the matter unless further investigation requires that action be postponed to a later meeting, as provided in the following paragraph.

(d) At any time in its consideration of such recommendation, the Board may, in its absolute discretion, defer final determination by referring the matter to a committee of its choice for further consideration (any such referral shall state the reasons therefor, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional meeting be conducted to clarify issues which are in doubt). At its next regular meeting after receipt of such subsequent recommendation, the Board shall act in the matter.

(e) Appointments to the Medical Staff shall not exceed two (2) years, renewable by the Board before the end of the appointment upon formal application.

(f) The Board shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff and AHP membership status, clinical privileges and corrective action, and shall require that the Medical Staff adopt and forward to it specific written recommendations with appropriate supporting documentation that will allow the Board to take informed action. Such delegation, however, does not relieve the Board of its responsibilities in appointing members of the Medical Staff and overseeing the appointment and delineation of functions, responsibilities and prerogatives of AHPs.

(g) Final action on all Medical Staff matters shall be taken by the Board after considering the Medical Staff recommendation, except that the Board shall act on its own initiative if the Medical Staff fails to adopt and submit recommendations within the time periods required by the Medical Staff Bylaws. Board action without a staff recommendation shall be based on the same kind of documented investigation and evaluation of current ability, judgment and character as is required for Medical Staff recommendations.

(h) The Chief Executive Officer shall make available to each applicant for staff membership a copy of the Medical Staff Bylaws, including the Medical Staff Rules and Regulations and Fair Hearing Plan. The applicant shall sign a statement on the application form declaring that he/she has received and reviewed those documents and that he/she specifically agrees:

(1) to obligate himself/herself, as an appointee to the Medical Staff, to provide continuous care and supervision as needed to all hospital patients for whom he/she has responsibility;

(2) to abide by all such bylaws, policies and directives of Watsonville Community Hospital and its Medical Staff as shall be in force during the time he/she is appointed to the Medical Staff of Watsonville Community Hospital; and

(3) to accept committee assignments and such other duties and responsibilities as shall be assigned to him/her by the Board and the Medical Staff.

No appointment or reappointment shall take effect until such a statement has been signedby the individual concerned.

(i) The terms and conditions of membership status and clinical privileges and the procedure to be followed in acting on same, shall be as specified in the Medical Staff Bylaws or as more specifically defined in the notice of individual appointment.

(j) The Board shall make final decisions on all requests for corrective action, and shall otherwise participate in the corrective action process as described in the Medical Staff Bylaws.

(k) No aspect of membership status nor specific clinical privileges shall be limited or denied to a practitioner on the basis of race, color, sex, national origin or disability, or on the basis of any other criterion unrelated to quality patient care at Watsonville Community Hospital, to professional qualifications, to the hospital's purposes, needs and capabilities, or to community needs. Members of the Medical Staff who also have hospital administrative responsibilities shall be required to meet the same requirements and qualifications for membership on the Medical Staff as do practitioners who do not have an administrative relationship to Watsonville Community Hospital.

(l) All administrative relationships with members of the Medical Staff and others who are not members of the Medical Staff shall be reduced to written agreement between the individual practitioner and Watsonville Community Hospital. These administrative relationships may be terminated by the CEO following the same procedures utilized for other hospital employees unless the written agreement provides another method of termination. Should the written agreement provision for termination conflict with the general procedures utilized for other employees, the written agreement shall control.

7.2. Medical Staff Governance

(a) The Board shall adopt bylaws and rules and regulations establishing the organization and government of the Medical Staff. The bylaws and rules and regulations shall be developed by the Medical Staff, but shall be effective only upon approval by the Board. The power of the Board to adopt or amend Medical Staff Bylaws and Rules and Regulations shall be conditioned upon the Medical Staff's failure to keep current, update or make

necessary modifications to its bylaws in a manner that will allow for the maximum possible achievement of the purposes and objectives of the Medical Staff.

(b) The Board retains the right to rescind any authority or procedures delegated to the Medical Staff, and to recommend amendment or replacement of the Medical Staff Bylaws as necessary for the operation of Watsonville Community Hospital.

(c) The Medical Staff shall review and revise all Medical Staff Rules and Regulations, and, as applicable, departmental policies and procedures, when warranted, provided that such review shall occur at least every two (2) years. The Medical Staff shall recommend changes in such policies and procedures for approval by the Board.

7.3. Categories of Staff Membership

The Medical Staff shall be organized into categories as outlined in the Medical Staff Bylaws. The prerogatives and responsibilities of each staff category shall be outlined in the Medical Staff Bylaws.

7.4. Allied Health Professionals ("AHP")

(a) The Board may approve specific clinical privileges for individuals who are not part of the Medical Staff, but who may render patient care services within Watsonville Community Hospital setting.

(b) Each member of the AHP shall be assigned and made accountable to the appropriate clinical section of the Medical Staff, although such assignment will not constitute membership on the Medical Staff.

(c) All applications for appointment to AHP status shall be in writing and addressed to the Chief Executive Officer on such forms as determined by Watsonville Community Hospital. The application shall be processed in the same manner as Medical Staff applications.

(d) The terms and conditions of AHP status, and of the exercise of clinical privileges, shall be as specified in the appropriate section of Medical Staff Bylaws or as more specifically defined in the notice of individual appointment. AHPs shall not be entitled to the procedures set forth in the Fair Hearing Plan. They shall, however, be entitled to an appearance before a Medical Staff committee designated within the Medical Staff Bylaws, as well as a written appeal to the Board in the event of an adverse action.

ARTICLE VIII
MEDICAL CARE EVALUATION

8.1. Board Responsibility for the Quality of Professional Services

After considering the recommendations of the Medical Staff and the other health care professionals providing patient care services, the Board shall implement specific review and evaluation activities to assess, preserve and improve the overall quality and efficiency of patient care in Watsonville Community Hospital. The Board, through the Chief Executive Officer, shall provide whatever administrative assistance is reasonably necessary to support and facilitate activities contributing to continuous quality assessment and improvement.

8.2. Medical Records

In order to facilitate the Medical Staff's review and appraisal of the quality and efficiency of the medical care rendered in Watsonville Community Hospital, the Board will assure that the Medical Staff will have access to the services of the Medical Records Department and to any other administrative or technical assistance deemed appropriate.

8.3. Professional Accountability to the Board

The Medical Staff and the other health care professional staff providing patient care services shall conduct, and be accountable to the Board for conducting, activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in Watsonville Community Hospital. These activities shall include these functions:

(a) Providing effective mechanisms to monitor and evaluate the quality of patient care and the clinical performance of individuals with delineated clinical privileges within Watsonville Community Hospital;

(b) Ongoing review, evaluation and monitoring of patient care practices through a systematic process of overall quality assessment and improvement;

(c) Delineation of clinical privileges for Medical Staff members, commensurate with individual credentials and demonstrated ability and judgment, and assignment of patient care responsibilities to other health care professionals consistent with individual qualification and demonstrated ability;

(d) Establishing a process designed to assure that all individuals responsible for the assessment, treatment, or care of patients are competent in the following, as appropriate to the ages of the patients served:

(1) the ability to obtain information and interpret information in terms of patient needs;

(2) a knowledge of cognitive, physical and emotional growth and development in theparticular age group treated; and

(3) an understanding of the range of treatment needed by the patients.

(e) Providing continuing professional education, shaped primarily by the needs identified through the review and evaluation activities;

(f) Reviewing utilization of the hospital's resources to provide for their allocation to patients in need of them;

(g) Reviewing the competency of care providers who are not subject to the Medical Staff privilege delineation process; and reporting to the governing body of findings with regardto such care providers;

(h) Establishing a process to support the efficient flow of patients, such as a plan concerning the care of admitted patients who are in temporary bed locations; and

(i) Such other measures as the Board may, after receiving and considering the advice of the Medical Staff, the other professional services, and the CEO, deem necessary for the preservation and improvement of the quality and efficiency of patient care.

8.4. Documentation

The Board shall consider and act upon the findings and recommendations from the required review, evaluation, and monitoring activities. All findings and recommendations shall be in writing, signed by the persons responsible for conducting the review activities, and supported and accompanied by documentation upon which the Board can take informed action.

ARTICLE IX
THE VOLUNTEER SERVICES

9.1. Organization. Auxiliary and other hospital service organizations may be formed in Watsonville Community Hospital. The formation, constitution, bylaws, and operating procedure of such organizations shall be subject to approval and control by the Board of Directors. Each such organization shall cooperate with the Board and Chief Executive Officer in the best interests of Watsonville Community Hospital and its patients. Periodic and annual reports shall be made to the Board covering its activities by each organization.

9.2. Funds and Fund Raising. No volunteer service organization may undertake any fund raising or other project in the name of or for the benefit of Watsonville Community Hospital which might impose a liability on Watsonville Community Hospital or any affiliated entity without prior approval of the Board, nor undertake any activity on Watsonville Community Hospital premises without the approval of the Chief Executive Officer.

Funds collected or otherwise acquired on behalf of Watsonville Community Hospital or by any activities purporting to assist Watsonville Community Hospital or its patients, shall be reported to and be subject to control by the Board. No funds, other than operating funds, shall be disbursed without prior approval of the Board.

ARTICLE X
RESERVED HOSPITAL BOARD AUTHORITY

No approvals granted and no assignment, referral, or delegation of authority by the Board of Directors to hospital management, the Medical Staff, volunteer service organizations, or anyone else shall preclude the Board from exercising the authority required to meet its responsibility for the conduct of Watsonville Community Hospital. The Board retains the right to rescind any such approval or delegation.

ARTICLE XI
ACTIONS REQUIRING MEMBER APPROVAL

11.1. Approval or Action Requirement. Notwithstanding anything in these Bylaws to the contrary, neither the Board nor any officer or employee of PVHCDH may take any of the following actions, or approve a subsidiary or an affiliate taking any of the following actions, without the prior approval of the Member:

(a) Any merger, consolidation, reorganization, or dissolution of PVHCDH that would change the Member's status as sole member or owner of the assets operated by PVHCDH.

(b) Any transfer by sale, lease, debt or encumbrance, or other disposition, of any of the assets of PVHCDH, real or personal, outside the ordinary course of Watsonville Community Hospital business.

(c) Any transaction that, on a proforma basis, would cause PVHCDH to be in violation of any financial loan or bond covenant, as they exist at the time of the transaction, or that would cause PVHCDH's Debt to Capitalization Ratio to exceed 50%.

(d) Any Watsonville Community Hospital campus development plan that restricts future land use options or requires regulatory changes to land use permits/designations.

(e) Any transaction that causes or is anticipated to cause a downgrade in Member or PVHCDH'S bond rating by a standard rating agency.

(f) Amendment or restatement of the Articles of Incorporation.

(g) Amendment or restatement of these Bylaws.

(h) Any changes to the Mission Statement of the Watsonville Community Hospital.

(i) Appointment of independent auditors.

11.2. Record of Approval or Disapproval. The Member's approval or disapproval of matters described in Section 11.1 of these Bylaws shall be recorded in or filed with the minutes of this Corporation.

ARTICLE XII
GENERAL PROVISIONS

12.1. Compensation of Board Members. The members of the Board shall receive no compensation as such, except that they may be reimbursed from time to time for all expenses incurred on behalf of PVHCDH.

12.2. Indemnification. PVHCDH shall indemnify any Director, officer, employee or agent of PVHCDH for liability incurred by such person in the exercise of his or her duties with respect to PVHCDH to the extent permitted by Section 5238 of the California Corporations Code or any successor statute.

12.3. Fiscal Year. The fiscal year of PVHCDH shall end on December 31 of each year.

12.4. Construction and Definitions. Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California Nonprofit Corporation Law shall govern the construction of these Bylaws. Without limiting the generality of the preceding sentence, the masculine gender includes the feminine and neuter, the singular number includes the plural, the plural number includes the singular and the term "person" includes both a legal entity and a natural person.

ARTICLE XIII
AMENDMENTS

These Bylaws may only be amended or restated by the Member.

SECRETARY'S CERTIFICATE

I certify that I am the Secretary of Pajaro Valley Health Care District Hospital Corporation, a California nonprofit public benefit corporation, and that the attached Bylaws of Pajaro Valley Health Care District Hospital Corporation are the current bylaws of this Corporation adopted by the Board of Directors of Pajaro Valley Health Care District Hospital Corporation, and approved by the Member, the Pajaro Valley Health Care District.

Dated: _____, 2022

_____

[_____], Secretary

AMENDED AND RESTATED BYLAWS

OF

Pajaro Valley Health Care District Hospital Corporation, a California nonprofit public benefit corporation

ARTICLE I
NAME AND PRINCIPAL OFFICE

1.1. Name. The name of the Corporation shall be as listed in the Articles of Incorporation, namely, Pajaro Valley Health Care District Hospital Corporation ("PVHCDH"), a nonprofit public benefit corporation organized under the laws of the State of California.

1.2. Principal Office and Place of Business. PVHCDH shall have and continuously maintain a registered office in Santa Cruz County and may have other offices within the State of California, as the Board may from time to time determine.

ARTICLE II
PURPOSES

PVHCDH was formed for the purposes set forth in its Articles of Incorporation. The property of PVHCDH is irrevocably dedicated to public, charitable, educational and hospital purposes which meet the requirements of Section 501(c)(3) of the Internal Revenue Code and Sections 23701 and 214 of the California Revenue and Taxation Code.

ARTICLE III
MEMBERSHIP

3.1. Member. There shall be one member of PVHCDH who shall be the Pajaro Valley Health Care District, a political subdivision of the State of California (the "Member"). The Member, and only the Member, shall be entitled to exercise fully all rights and privileges of members of nonprofit corporations under the California Nonprofit Public Benefit Corporation Law, and all other applicable laws. The rights and powers of the Member shall also include, without limitation, the following: the limitation on liabilities described in Section 3.3 of these Bylaws; the right to dissolve PVHCDH upon a majority vote in favor of dissolution; and the exercise of all of the rights set forth in Article X and XI of these Bylaws. The Member may not be expelled or suspended as the Member without its consent. Any reference in these Bylaws to the "member," "Member" or any similar such reference, shall mean the Pajaro Valley Health Care District, a political subdivision of the State of California.

3.2. Exercise of Membership Rights. The Member shall exercise its membership rights through its own Board of Directors. Subject to the provisions of the Member's own bylaws, and except as otherwise provided in these Bylaws, the Board of Directors of the Member may, by resolution, authorize a person or committee of persons to exercise its vote on any matter to come before the membership of PVHCDH. In addition, the Member may exercise its membership rights at any regular or special meeting of the Board of Directors of the Member. The functions required by law or by these Bylaws to be performed at the annual membership meeting or any regular or special meeting of the members of PVHCDH may be performed at any regular or special meeting of the Member's own Board of Directors.

3.3. Liabilities and Assessments. The Member shall not be liable for the debts of PVHCDH. The Board of PVHCDH shall have no power to levy and collect assessments on the Member. The provisions of this paragraph cannot be amended in any manner.

ARTICLE IV
BOARD OF DIRECTORS

4.1. Responsibility. Except as otherwise provided by the Articles of Incorporation or by these Bylaws, the management of the affairs of PVHCDH shall be vested in a Board of Directors (the "Board") composed of the persons described in Section 4.2 of these Bylaws (the "Directors" and each a "Director"). Specifically, the Board of Directors shall be empowered as follows:

(a) To control and be responsible for the overall governance of Watsonville Community Hospital, including the provision of management and planning.

(b) To implement Compliance Program oversight consistent with Watsonville Community Hospital wide compliance programs and procedures, including, responsibility for an effective Compliance Program and adoption of related policies, review of routine and special Compliance reports on a regular basis, appropriate delegation of implementation to senior management, and Board training on Compliance Program oversight and implementation.

(c) To appoint a Chief Executive Officer and to define the powers and duties of such appointee, and to delegate to such person overall responsibility for operations of the Watsonville Community Hospital, and affiliated entities, as specified herein and consistent with Board of Directors' Policies.

(d) To determine policies and approve procedures for the overall operation and affairs of Watsonville Community Hospital and its facilities according to the best interests of the public health and to assure the maintenance of quality patient care.

(e) To evaluate the performance of Watsonville Community Hospital in relation to its vision, mission and goals.

(f) To provide for coordination and integration among Watsonville Community Hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.

(g) To be ultimately accountable for the safety and quality of care, treatment and services at Watsonville Community Hospital.

(h) To review and approve annual operating and multi-year capital budgets.

(i) To assure through implementation of appropriate processes that all individuals who provide patient care services, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services, and receive reports of quality assurance information regarding competency of care providers not subject to the privilege delineation process.

(j) To oversee the Medical Staff and the quality of professional services as described in Article VII and Article VIII of these Bylaws.

(k) To establish, maintain and support, through the Chief Executive Officer and the Medical Staff and its designated committees, a comprehensive, hospital-wide program for quality assessment and improvement, to receive reports of performance improvement information on a regular basis from the Medical Staff, and to assure that all aspects of the program are performed appropriately and that administrative assistance is available to the Medical Staff.

(l) To oversee programs for continuing medical education for Medical Staff members, and appropriate in-service education programs for hospital employees, for the purpose of maintaining and improving clinical and employee performance.

(m) To make recommendations to the Chief Executive Officer regarding the kinds and quality of service to be made available at Watsonville Community Hospital.

(n) To review and consult with the Chief Executive Officer concerning the long-range plan for Watsonville Community Hospital.

(o) To consult directly with the Chief of Staff or his/her designee, or through a subcommittee by the Board to include the Chief of Staff, on no less than two occasions per year, on matters including but not limited to: the scope and complexity of hospital services offered, specific patient populations served by Watsonville Community Hospital and any issues of patient safety and quality of care; promptly addressing any urgent request for consultation presented by the Chief of Staff or his/her designee.

(p) To assist in the accreditation process, including participation in the summation conference, and assist in maintaining compliance with current accreditation standards

set by The Joint Commission, in conjunction with the Chief Executive Officer and the Medical Staff.

(q) To assist the Chief Executive Officer in establishing medical record policies respecting composition, retention, confidentiality and other aspects of recordkeeping, maintaining confidentiality with respect to the records and affairs of Watsonville Community Hospital, except as disclosure is authorized or required by law.

(r) To approve bylaws for Watsonville Community Hospital auxiliary organizations or for any other similar organizations.

(s) To conduct an annual evaluation of its own activities and performance and an annual evaluation of the Chief Executive Officer and to implement programs to improve such activities and performance.

(t) To perform any other functions designated in these Bylaws but not specifically referred to in this Section and to do any and all other act and things necessary to carry out the provisions of these Bylaws or of the provisions of the California Nonprofit Public Benefit Corporation Law.

All powers of the Board of Directors, which are not otherwise restricted by law, agreement, or herein, may be delegated by an employment agreement, policies, and by direction of the Board to the Chief Executive Officer or to others employed or engaged by or with responsibilities to PVHCDH, to be exercised in accordance with that delegation

4.2. Number, Designation, Term, Removal of Directors. The number of Directors shall be five (5) and shall be comprised of the five (5) publicly elected Directors of the Board of the Member. Directors who no longer serve on the Member's Board of Directors shall be automatically removed as Directors of PVHCDH.

4.3. Voting Rights. Each Director shall be entitled to one vote on all matters before the Board. There shall be no voting by proxy.

4.4. Organizational Meeting. As soon as reasonably possible after each January 1, the Board of Directors shall meet for the purposes of organizing the Board, the election of officers, and the transaction of such other business as may come before the meeting. The initial Board of Directors shall meet for such purposes as soon as reasonably possible after such Board is first constituted.

4.5. Regular Meetings. The Board shall hold meetings at least monthly at such time and place as the Board shall from time to time determine.

4.6. Special Meetings. Special meetings of the Board for any purpose or purposes shall be called by the Secretary upon the request of the Chair, the Chief Executive Officer or any two (2) Directors.

4.7. Notice and Conduct of Meetings; Brown Act. Notice of meetings and meeting agendas shall be in conformance with the California Ralph M. Brown Act, and meetings of the Board shall be conducted consistent with the Brown Act.

4.8. Quorum. A majority of the members of the Board then serving shall constitute a quorum at any meeting of the Board provided that the minimum number of members of the Board which may constitute a quorum shall be three (3). The act of a majority of the voting power present at any meeting at which a quorum is present shall be considered the act of the Board.

4.9. Place. The Board shall hold its meetings at the principal office of the Member, or such other place as the Chair or the Directors requesting the meeting may designate.

4.10. Telephonic Meetings. Members of the Board may participate in a meeting through use of a conference telephone or similar communications equipment, consistent with Brown Act requirements.

4.11. Interested Directors. Not more than forty-nine percent (49%) of the persons serving on the Board at any time may be interested persons. An "interested person" is (i) any person being compensated, directly or indirectly, by PVHCDH for services rendered to it within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or otherwise (excluding any reasonable compensation paid to a director for serving in such capacity); and (ii) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, mother-in-law, or father-in-law of any such person. However, any violation of the provisions of this paragraph shall not affect the validity or enforceability of any transaction entered into by PVHCDH.

4.12. Conflict of Interest Policy. The Board shall develop and adhere to a conflict of interest policy that incorporates the provisions of Section 5233 of the California Nonprofit Corporation Law. The initial Conflicts Policy shall be that adopted by the Member prior to adoption of these Bylaws. PVHCDH's Conflicts Policy shall be consistent with laws and regulations applicable to California special districts.

4.13. Self-Dealing. Prior to conducting a business session at a meeting of the Board, Board members shall disclose and discuss their individual conflicts or potential conflicts and that of other members of the Board. Actual conflicts shall be subject to resolution pursuant to the Conflicts Policy, applicable federal and state non-profit corporation laws and conflict of interest laws related to public agencies including, but not limited to, Gov't Code 1090 and the Political Reform Act. In the exercise of voting rights by members of the Board, no individual shall vote on any issue, motion or resolution which directly or indirectly inures to his or her benefit financially

or with respect to which he or she has any other conflict of interest, except that such individual may be counted in order to qualify a quorum and, except as the Board may otherwise direct, may participate in the discussion of such an issue, motion or resolution if he or she first discloses the nature of his or her interest and such discussion is allowed under conflict of interest laws applicable to public agencies. Board members shall adhere to the Conflict of Interest Policy enacted pursuant to section 4.12 of these Bylaws.

4.14. Access to Board Records and Reports. Upon request, officers of the Member shall have access to Watsonville Community Hospital documents for review (but not possession) that have been reviewed by the Board of Directors. Such review shall be subject to the officer executing an agreement to maintain the confidentiality (no disclosure beyond officers and Board members of the Member) of information reviewed. Documents that are protected by legal privileges and confidentiality (e.g., personnel, peer review, legal, vendor contractual confidentiality), those containing pending competitive business transaction information, and physician agreements, shall not be subject to review. Subject to the execution of an agreement to maintain confidentiality, Board member and Board selected candidate conflict disclosure filings shall be available for review at PVHCDH's offices only to the chief executive or designated legal counsel of the Member upon request.

4.15. Bylaws Review. Consistent with regulatory and industry standards, the Board shall periodically conduct a review of these Bylaws in order to update and improve them. At least every two (2) years, commencing in January 2024, the Board shall seek the input of the Member in connection with such a review.

ARTICLE V
OFFICERS

5.1. Officers of this Corporation. The officers of PVHCDH shall be a Chair, a Vice Chair, a Chief Executive Officer, a Secretary, and a Treasurer (which office shall be separate from PVHCDH's Chief Financial Officer). No officer may hold more than one office at a time, with the exception of cases in which there is a vacancy in the office due to death, resignation, removal, disqualification or otherwise of a director pursuant to Section 4.2 above in which case more than one office may be held by a single director until the vacancy on the Member Board had been filled.

5.2. Officers Elected by the Board. The Chair, Vice Chair, Treasurer, and Secretary shall be elected annually by the Board at its organizational meeting. Nominations shall be submitted in advance of the selection by a nominating committee appointed by the Board. Each officer elected by the Board shall hold office at the pleasure of the Board and until his or her successor shall be elected and qualified to serve. A vacancy in any office because of death, resignation, removal, disqualification or otherwise of a director, may be filled by the Board for the unexpired term at any meeting of the Board.

5.3. Resignation or Removal. Any officer of the Board may resign at any time or be removed by the vote of the Board.

5.4. Vacancies in Office. A vacancy in any office because of death, resignation, removal, or any other cause shall be filled in the manner prescribed in these Bylaws for regular appointments.

5.5. Chair. The Chair of the Board shall preside at all meetings of the Board. Unless the signature of the Chief Executive Officer is required by law, the Chair of the Board shall possess the same power as the Chief Executive Officer to sign all certificates, contracts, or other instruments of PVHCDH when he or she is so authorized by the Board. The Chair of the Board shall exercise and perform such other powers and duties as may be prescribed by the Board from time to time. The Chair of the Board shall serve as the Board's liaison to the Chief Executive Officer.

5.6. Vice Chair. In the absence of the Chair of the Board or in the event of the Chair's disability, inability, or refusal to act, the Vice Chair of the Board shall perform all of the duties of the Chair and in so acting shall have all of the powers of the Chair. The Vice Chair shall have such other powers and perform such other duties as may be prescribed from time to time by the Board or by the Chair.

5.7. Chief Executive Officer.

(a) Appointment and Removal. The Chief Executive Officer of PVHCDH shall be engaged by the Board and shall serve at the pleasure of the Board, which may terminate the services of the Chief Executive Officer of PVHCDH subject to any employment agreement.

(b) Responsibilities and Authority. The Chief Executive Officer shall be the general manager, administrator and Chief Executive Officer of PVHCDH. The Chief Executive Officer shall be given the necessary authority and responsibility to operate PVHCDH in all of its activities, including without limitation, quality of services, safety matters, cost effectiveness and economic performance, subject to the following: with respect to safety and quality of care, treatment and services, policy development, program planning, employee and community relations, the Chief Executive Officer shall be subject to such policies as may be adopted and such orders as may be issued by the Board of PVHCDH or by any of its committees to which the Board has delegated the power for such action; with respect to program execution and overall management performance, the Chief Executive Officer shall be subject to the authority of and shall report to the Board. The Chief Executive Officer shall act as the duly authorized representative of the Board of PVHCDH in all matters in which the Board has not formally designated some other person to so act.

5.8. Treasurer. The Treasurer of PVHCDH shall keep and maintain or cause to be kept and maintained adequate and correct account of the properties and business transactions of

PVHCDH, including accounts of its assets, liabilities, receipts, disbursements, gains and losses. The books of account shall at all times be open to inspection by any Board member. The Treasurer shall be charged with safeguarding the assets of PVHCDH and he or she shall sign financial documents on behalf of PVHCDH in accordance with the established policies of PVHCDH. He or she shall have such other powers and perform such other duties as may be prescribed by the Board from time-to-time. The Treasurer may fulfill these responsibilities and perform his or her duties through appropriate delegation, with Board oversight, to individuals or firms charged with the financial management of PVHCDH.

5.9. Secretary. The Secretary shall keep or cause to be kept a book of minutes at the principal office or at such other place as the Board may order of all meetings of the Board with the time and place of holding, whether regular or special, and if special how authorized, the notice thereof given, the names of those present at the Board meetings, and the proceedings thereof. The Secretary shall give or cause to be given notice of all the meetings of the Board required by these Bylaws or by law to be given, and the Secretary shall keep the seal of PVHCDH in safe custody and shall have such other powers and perform such other duties as may be prescribed by the Board from time to time.

ARTICLE VI
COMMITTEES

6.1. Establishment of Committees. PVHCDH shall have the standing committees set forth in Section 6.5 of these Bylaws, and such other standing committees or special committees as may be established by the Board from time to time in accordance with these Bylaws.

6.2. Composition of Committees. Unless otherwise stated, standing committees shall not be limited to members of the Board, but consistent with California Nonprofit Corporation Law shall include at least two (2) members of the Board. Special committees and any subcommittees of any standing committee or special committee that may be established from time to time shall not be limited to members of the Board but may, by direction of the Board, include any number of persons the majority of whom need not be Directors. The Chair of the Board shall recommend committee members and Chairs of the committees to the Board, subject to the approval of the Board. The Board shall create committees as deemed necessary. Member's interests in appointment to certain committees shall be considered by the Chair. The Board may appoint alternate members of any committee who shall act on behalf of any committee member who is absent from a committee meeting. The Board or the committee may select other persons, whether or not members of the Board, to attend meetings of the committee and to participate in the discussion and activities of the committee; provided, however, that such additional persons attending the committee meeting shall not be entitled to vote and shall participate only at the discretion of the committee. ~~The Chair and the Chief Executive Officer of PVHCDH shall each serve ex officio as voting members on each standing committee, unless specifically excluded or otherwise specifically made members of the committee by these Bylaws or by appointment.~~

6.3. Powers; Restrictions and Limitations.

(a) Standing Committees. Subject to the duty of the Board to exercise ultimate direction over the activities and affairs of PVHCDH, the Board may delegate to any standing committee the power, subject to applicable law, to manage or direct any activity of PVHCDH. In addition to powers so delegated and the general duties of the standing committees described in the provisions of these Bylaws, the standing committees shall undertake duties or specific tasks assigned by the Board, or the Chair~~, or the Executive Committee~~ of the Board of Directors, and shall consider matters requested by other committees or the Chief Executive Officer of PVHCDH.

(b) Special Committees. The Board may authorize any special committee to carry out certain specified functions or responsibilities, or to provide such advice and recommendation as the Board shall require, but no special committee shall have the authority to determine PVHCDH policy or otherwise exercise any powers of the Board with respect to the business and affairs of the PVHCDH. Internal conflicts concerning Medical Staff affairs shall be referred to a special committee created and appointed by the Chair of the Board on an as needed basis for resolution.

(c) Subcommittees. The Board or any standing or special committee may authorize any subcommittee to carry out certain specified functions or responsibilities, or to provide such advice and recommendation as the Board or any such committee shall require, but no subcommittee shall have the authority to determine PVHCDH policy or otherwise exercise any powers of the Board with respect to the business and affairs of PVHCDH.

6.4. Meetings and Actions of Committees.

(a) Meetings. Meetings and actions of any standing committee, special committee or subcommittee shall be governed by, and held and taken in accordance with, the provisions of these Bylaws concerning meetings of the Board, including, but not limited to Section 4.7, with such changes in the content of these Bylaws as are necessary to substitute the committee or subcommittee and its members for the Board and its members, except a quorum of a committee shall be a majority of the voting members of the committee. The time for regular meetings of any committee or subcommittee may be determined either by direction of the Board or by direction of such committee or subcommittee. Special meetings of any committee or subcommittee may also be called by direction of the Board. Notice of special meetings of any committee or subcommittee shall also be given to any and all alternate members, who shall have the right to attend such meetings, subject to the discretion of the committee or subcommittee. Minutes shall be kept of meetings of any committees and subcommittees and shall be filed with the corporate records. The Board may adopt rules for the governing of any committee or subcommittee not inconsistent with the provisions of these Bylaws.

(b) Subcommittee membership. Subject to Board approval, each standing or special committee may establish such subcommittees as it deems necessary, the members of which need not be members of the Board. The Chair of the parent committee shall recommend to the Board formation of any subcommittee and shall nominate initial membership and the proposed chair of any new subcommittee to the Board for approval. Thereafter, the Chair of a subcommittee shall recommend to the Chair of the parent committee annual appointments or reappointments to the subcommittee, or recommend individuals to fill vacancies. The Chair of the parent committee shall have discretion to accept or reject such recommendations, and shall submit nominations for annual subcommittee membership (including appointment of the subcommittee chair), or nominations to fill vacancies on subcommittees, to the Board of Directors for approval.

6.5. Establishment of Standing Committees. Standing Committees of the Board of Directors as established and appointed pursuant to these Bylaws shall be as follows:

(a) Finance Committee. The Finance Committee shall consist of ~~a minimum of~~ two (2) Board members, with up to ~~five~~ten (~~5~~10) persons, including, the Board Treasurer, two (2) senior executives; two (2) hospital directors or managers, two (2) physicians with medical staff privileges at Watsonville Community Hospital and two (2) hospital front line staff. The Finance Committee ~~shall include the Treasurer (if not otherwise appointed as a voting member of the Finance Committee). The Finance Committee~~ shall oversee all financial matters for PVHCDH including operating and capital budgets, borrowings and capital planning, audits, material contracts and leases, business plan development and implementation, and facilities and equipment.

(b) Strategic Planning and Marketing Committee. The Strategic Planning and Marketing Committee shall consist of ~~a minimum of~~ two (2) Board members, with up to ~~five~~ten (~~5~~10) persons~~. The Committee shall include at least one physician as a member.~~ including two (2) senior executives; two (2) hospital directors or managers, two (2) physicians with medical staff privileges at Watsonville Community Hospital and two (2) hospital front line staff. The Strategic Planning and Marketing Committee shall oversee marketing and strategic planning, integration of PVHCDH operations and facilities, service changes or adjustments, physician development, facility planning, and strategic alliances and ventures. The Committee shall oversee development and implementation of PVHCDH's community benefit programs and shall seek input into its work from the Member. The Committee shall also facilitate coordination of its community benefit programs with similar programs undertaken by the Member.

(c) ~~Human Resources~~Employee Engagement Committee. The ~~Human Resources~~Employee Engagement Committee shall consist of ~~a minimum of~~ two (2) Board members, with up to ~~four~~ten (~~4~~10) persons~~. The Human Resources~~, including, two (2) senior executives; two (2) hospital directors or managers, two (2) physicians with medical staff privileges at Watsonville Community Hospital and two (2) hospital front line staff. The Employee Engagement Committee shall consider human resource issues and policies as warranted and shall

review and recommend for Board approval employee compensation, pension and benefits programs (other than executive officer level).

(d) Quality and Patient Safety Committee. The Quality and Patient Safety Committee shall consist of ~~a minimum of~~ two (2) Board members~~,~~ with up to ~~nine~~ten (~~9~~10) persons~~.~~, including, two (2) senior executives; two (2) hospital directors or managers, two (2) physicians with medical staff privileges at Watsonville Community Hospital and two (2) hospital front line staff. The Committee will be assisted in its work by the Chief Executive Officer, the CNO (Chief Nursing Officer), the Safety Officer, and the Medical Staff as needed and requested by the Committee. The Quality and Patient Safety Committee ~~shall include at a minimum: two (2) physicians. Non-voting, ex officio members shall include: the Chief of Staff, Chief Medical Officer and the CNO. The Quality and Patient Safety Committee~~ shall oversee effective functioning of activities related to: provision of quality patient care, patient and staff safety, performance improvement, risk management, regulatory and accreditation standards, and strategic direction for quality expenditures. The Quality and Patient Safety Committee shall forward Quality Reports and recommendations to the Board of Directors. This Committee shall also be responsible for developing and implementing the Board's annual action plan for resolution of safety and quality issues. In addition, the Committee shall:

(1) Analyze data regarding safety and quality of care, treatment and services and establish priorities for performance improvement.

(2) Oversee the Medical Staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards.

~~(3) Review and recommend to the Board on its oversight of all applications for appointment and reappointment to the Medical Staff, including privileges to be granted (except applications for temporary appointments and privileges which have been granted by the Chief Executive Officer pursuant to applicable procedures).~~

(3) ~~(4)~~ Ensure that recommendations from the Medical Executive Committee and Medical Staff are made in accordance with the standards and requirements of the Medical Staff Bylaws, Rules and Regulations with regard to:

(i) completed applications for initial staff appointment, initial staff category assignment, initial department/divisional affiliation, membership prerogatives and initial clinical privileges;

(ii) completed applications for reappointment of medical staff, staff category, clinical privileges;

(iii) establishment of categories of Allied Health Professionals permitted to practice at Watsonville Community Hospital, the appointment and reappointment of Allied Health Professionals and privileges granted to Allied Health Professionals.

(4) ~~(5)~~ Provide a system for resolving conflicts that could adversely affect safety or quality of care among individuals working within the hospital environment.

(5) ~~(6)~~ Ensure that adequate resources are allocated for maintaining safety and quality care, treatment and services.

(6) ~~(7)~~ Analyze findings and recommendations from the Watsonville Community Hospital's administrative review and evaluation activities, including system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

(7) ~~(8)~~ Assess the effectiveness and results of the quality review, utilization review, performance improvement, and risk management programs.

(8) ~~(9)~~ Perform such other duties concerning safety and quality of care matters as may be necessary.

6.6. Ad Hoc Committees. Ad hoc committees may be appointed by the Chair with the approval of the Board of Directors for special limited projects for such specific tasks as circumstances warrant e.g. ad hoc audit committee. Ad hoc committees shall comply with the Brown Act and no ad hoc committee so appointed shall have any power or authority to commit the Board of Directors or Corporation in any manner, but may make recommendations to the Board of Directors.

~~(c) Audit Committee. This Committee shall consist of a minimum of two Board members and not more than five (5) members as determined by the Board. The Chief Executive Officer shall not be a member of this Committee. The Committee shall be guided by the Committee's Charter as approved or further amended by the Board of Directors.~~

~~This Committee shall oversee effective functioning of PVHCDH's financial auditors, including approving their engagement by the Member and fee, their qualifications and independence, adequacy of PVHCDH's internal control systems, and provide oversight of the integrity of financial statements and reports. The Committee shall further assume such powers and responsibilities as specifically assigned or delegated from time to time by the Board of Directors, either directly or through development or amendment of the Committee's Charter.~~

~~The Committee shall meet at least once during each fiscal quarter, or more frequently as circumstances dictate and as necessary to fulfill the Committee's responsibilities and duties.~~

(f) Board Credentialing Committee. Consistent with requirements of these Bylaws and applicable Watsonville Community Hospital policies and procedures, and consistent with procedures for the appointment and reappointment of Medical Staff members based on Joint Commission accreditation standards, the Board of Directors delegates authority to take action on behalf of the Board on such appointments or reappointments to a standing committee of the Board, designated the Board Credentialing Committee. The Committee shall consist only of Board members and have at least two (2) members of the Board who are also members of the Quality and Patient Safety Committee. The Chair and Vice Chair of the Committee shall be the Chair and Vice Chair of the Quality and Patient Safety Committee.

Applications for appointments, reappointments and the granting of clinical privileges are eligible for such review by the Committee, except that applications in the following circumstances are not eligible for expedited processing:

(1) incomplete applications (which shall not be processed in any event); and

(2) applications as to which the Medical Executive Committee has made a final recommendation that is adverse or has limitations.

Applications showing any of the following circumstances shall be evaluated on a case-by-case basis and may be processed on an expedited basis only where, in the judgment of the Board Credentialing Committee, they do not present facts indicating any potential threat to patient safety:

(1) a current challenge or successful past challenge to licensure or registration;

(2) an involuntary termination of medical staff membership at another hospital;

(3) an involuntary termination, limitation, reduction, denial, or loss of clinical privileges at any other hospital or other entity; or

(4) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

In assessing whether expedited processing is appropriate for applications presenting facts in conformance with Items 1 - 4 above, the Board Credentialing Committee may take into account the time that has elapsed since the circumstances occurred, the frequency of such circumstances, and the severity of such circumstances, as well as other relevant information. Applications not so eligible shall be reviewed by the full Board. Any decision reached by the Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

6.7. ~~6.6.~~ Vacancies. Vacancies in any committee shall be filled for the unexpired portion of the term in the same manner as provided in the case of original appointment.

6.8. ~~6.7.~~ Expenditures. Except as expressly delegated, any expenditure of corporate funds by a committee or any commitment by a committee to expend corporate funds shall require prior approval of the Board.

ARTICLE VII
CREDENTIALED PRACTITIONERS

7.1. Medical Staff Appointments and Clinical Privileges

(a) The Board shall appoint a Medical Staff and see that they are organized into a responsible administrative unit and adopt such bylaws and rules and regulations for government of their practice in Watsonville Community Hospital as the Board deems to be to the greatest benefit of patients within Watsonville Community Hospital. In the case of the individual patients, those appointed to the Medical Staff shall have full authority and responsibility for the care of patients subject only to such limitations as the Board may formally impose and to the bylaws and rules and regulations for the Medical Staff as adopted by the Board. The Medical Staff shall adhere to the highest ethical principles of the medical profession.

(b) All applications for appointment to the Medical Staff shall be in writing and addressed to the Medical Staff Office in such form as determined by Watsonville Community Hospital and more specifically described in the Medical Staff Bylaws. The application shall be complete and with required information relating to education, licensure, practice, previous hospital experience, professional liability coverage and any history relative to licensure, malpractice experience and/or hospital privileges.

(c) At its next regular meeting after receipt of a completed application and a recommendation from the Medical Staff concerning an applicant for Medical Staff appointment, the Board shall act in the matter unless further investigation requires that action be postponed to a later meeting, as provided in the following paragraph.

(d) At any time in its consideration of such recommendation, the Board may, in its absolute discretion, defer final determination by referring the matter to a committee of its choice for further consideration (any such referral shall state the reasons therefor, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional meeting be conducted to clarify issues which are in doubt). At its next regular meeting after receipt of such subsequent recommendation, the Board shall act in the matter.

(e) Appointments to the Medical Staff shall not exceed two (2) years, renewable by the Board before the end of the appointment upon formal application.

(f) The Board shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff and AHP membership status, clinical privileges and corrective action, and shall require that the Medical Staff adopt and forward to it specific written recommendations with appropriate supporting documentation that will allow the Board to take informed action. Such delegation, however, does not relieve the Board of its responsibilities in appointing members of the Medical Staff and overseeing the appointment and delineation of functions, responsibilities and prerogatives of AHPs.

(g) Final action on all Medical Staff matters shall be taken by the Board after considering the Medical Staff recommendation, except that the Board shall act on its own initiative if the Medical Staff fails to adopt and submit recommendations within the time periods required by the Medical Staff Bylaws. Board action without a staff recommendation shall be based on the same kind of documented investigation and evaluation of current ability, judgment and character as is required for Medical Staff recommendations.

(h) The Chief Executive Officer shall make available to each applicant for staff membership a copy of the Medical Staff Bylaws, including the Medical Staff Rules and Regulations and Fair Hearing Plan. The applicant shall sign a statement on the application form declaring that he/she has received and reviewed those documents and that he/she specifically agrees:

(1) to obligate himself/herself, as an appointee to the Medical Staff, to provide continuous care and supervision as needed to all hospital patients for whom he/she has responsibility;

(2) to abide by all such bylaws, policies and directives of Watsonville Community Hospital and its Medical Staff as shall be in force during the time he/she is appointed to the Medical Staff of Watsonville Community Hospital; and

(3) to accept committee assignments and such other duties and responsibilities as shall be assigned to him/her by the Board and the Medical Staff.

No appointment or reappointment shall take effect until such a statement has been signedby the individual concerned.

(i) The terms and conditions of membership status and clinical privileges and the procedure to be followed in acting on same, shall be as specified in the Medical Staff Bylaws or as more specifically defined in the notice of individual appointment.

(j) The Board shall make final decisions on all requests for corrective action, and shall otherwise participate in the corrective action process as described in the Medical Staff Bylaws.

(k) No aspect of membership status nor specific clinical privileges shall be limited or denied to a practitioner on the basis of race, color, sex, national origin or disability, or on the basis of any other criterion unrelated to quality patient care at Watsonville Community Hospital, to professional qualifications, to the hospital's purposes, needs and capabilities, or to community needs. Members of the Medical Staff who also have hospital administrative responsibilities shall be required to meet the same requirements and qualifications for membership on the Medical Staff as do practitioners who do not have an administrative relationship to Watsonville Community Hospital.

(l) All administrative relationships with members of the Medical Staff and others who are not members of the Medical Staff shall be reduced to written agreement between the individual practitioner and Watsonville Community Hospital. These administrative relationships may be terminated by the CEO following the same procedures utilized for other hospital employees unless the written agreement provides another method of termination. Should the written agreement provision for termination conflict with the general procedures utilized for other employees, the written agreement shall control.

7.2. Medical Staff Governance

(a) The Board shall adopt bylaws and rules and regulations establishing the organization and government of the Medical Staff. The bylaws and rules and regulations shall be developed by the Medical Staff, but shall be effective only upon approval by the Board. The power of the Board to adopt or amend Medical Staff Bylaws and Rules and Regulations shall be conditioned upon the Medical Staff's failure to keep current, update or make necessary modifications to its bylaws in a manner that will allow for the maximum possible achievement of the purposes and objectives of the Medical Staff.

(b) The Board retains the right to rescind any authority or procedures delegated to the Medical Staff, and to recommend amendment or replacement of the Medical Staff Bylaws as necessary for the operation of Watsonville Community Hospital.

(c) The Medical Staff shall review and revise all Medical Staff Rules and Regulations, and, as applicable, departmental policies and procedures, when warranted, provided that such review shall occur at least every two (2) years. The Medical Staff shall recommend changes in such policies and procedures for approval by the Board.

7.3. Categories of Staff Membership

The Medical Staff shall be organized into categories as outlined in the Medical Staff Bylaws. The prerogatives and responsibilities of each staff category shall be outlined in the Medical Staff Bylaws.

7.4. Allied Health Professionals ("AHP")

(a) The Board may approve specific clinical privileges for individuals who are not part of the Medical Staff, but who may render patient care services within Watsonville Community Hospital setting.

(b) Each member of the AHP shall be assigned and made accountable to the appropriate clinical section of the Medical Staff, although such assignment will not constitute membership on the Medical Staff.

(c) All applications for appointment to AHP status shall be in writing and addressed to the Chief Executive Officer on such forms as determined by Watsonville Community Hospital. The application shall be processed in the same manner as Medical Staff applications.

(d) The terms and conditions of AHP status, and of the exercise of clinical privileges, shall be as specified in the appropriate section of Medical Staff Bylaws or as more specifically defined in the notice of individual appointment. AHPs shall not be entitled to the procedures set forth in the Fair Hearing Plan. They shall, however, be entitled to an appearance before a Medical Staff committee designated within the Medical Staff Bylaws, as well as a written appeal to the Board in the event of an adverse action.

ARTICLE VIII
MEDICAL CARE EVALUATION

8.1. Board Responsibility for the Quality of Professional Services

After considering the recommendations of the Medical Staff and the other health care professionals providing patient care services, the Board shall implement specific review and evaluation activities to assess, preserve and improve the overall quality and efficiency of patient care in Watsonville Community Hospital. The Board, through the Chief Executive Officer, shall provide whatever administrative assistance is reasonably necessary to support and facilitate activities contributing to continuous quality assessment and improvement.

8.2. Medical Records

In order to facilitate the Medical Staff's review and appraisal of the quality and efficiency of the medical care rendered in Watsonville Community Hospital, the Board will assure that the Medical Staff will have access to the services of the Medical Records Department and to any other administrative or technical assistance deemed appropriate.

8.3. Professional Accountability to the Board

The Medical Staff and the other health care professional staff providing patient care services shall conduct, and be accountable to the Board for conducting, activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in Watsonville Community Hospital. These activities shall include these functions:

(a) Providing effective mechanisms to monitor and evaluate the quality of patient care and the clinical performance of individuals with delineated clinical privileges within Watsonville Community Hospital;

(b) Ongoing review, evaluation and monitoring of patient care practices through a systematic process of overall quality assessment and improvement;

(c) Delineation of clinical privileges for Medical Staff members, commensurate with individual credentials and demonstrated ability and judgment, and assignment of patient care responsibilities to other health care professionals consistent with individual qualification and demonstrated ability;

(d) Establishing a process designed to assure that all individuals responsible for the assessment, treatment, or care of patients are competent in the following, as appropriate to the ages of the patients served:

(1) the ability to obtain information and interpret information in terms of patient needs;

(2) a knowledge of cognitive, physical and emotional growth and development in theparticular age group treated; and

(3) an understanding of the range of treatment needed by the patients.

(e) Providing continuing professional education, shaped primarily by the needs identified through the review and evaluation activities;

(f) Reviewing utilization of the hospital's resources to provide for their allocation to patients in need of them;

(g) Reviewing the competency of care providers who are not subject to the Medical Staff privilege delineation process; and reporting to the governing body of findings with regardto such care providers;

(h) Establishing a process to support the efficient flow of patients, such as a plan concerning the care of admitted patients who are in temporary bed locations; and

(i) Such other measures as the Board may, after receiving and considering the advice of the Medical Staff, the other professional services, and the CEO, deem necessary for the preservation and improvement of the quality and efficiency of patient care.

8.4. Documentation

The Board shall consider and act upon the findings and recommendations from the required review, evaluation, and monitoring activities. All findings and recommendations shall be in writing, signed by the persons responsible for conducting the review activities, and supported and accompanied by documentation upon which the Board can take informed action.

ARTICLE IX
THE VOLUNTEER SERVICES

9.1. Organization. Auxiliary and other hospital service organizations may be formed in Watsonville Community Hospital. The formation, constitution, bylaws, and operating procedure of such organizations shall be subject to approval and control by the Board of Directors. Each such organization shall cooperate with the Board and Chief Executive Officer in the best interests of Watsonville Community Hospital and its patients. Periodic and annual reports shall be made to the Board covering its activities by each organization.

9.2. Funds and Fund Raising. No volunteer service organization may undertake any fund raising or other project in the name of or for the benefit of Watsonville Community Hospital which might impose a liability on Watsonville Community Hospital or any affiliated entity without prior approval of the Board, nor undertake any activity on Watsonville Community Hospital premises without the approval of the Chief Executive Officer.

Funds collected or otherwise acquired on behalf of Watsonville Community Hospital or by any activities purporting to assist Watsonville Community Hospital or its patients, shall be reported to and be subject to control by the Board. No funds, other than operating funds, shall be disbursed without prior approval of the Board.

ARTICLE X
RESERVED HOSPITAL BOARD AUTHORITY

No approvals granted and no assignment, referral, or delegation of authority by the Board of Directors to hospital management, the Medical Staff, volunteer service organizations, or anyone else shall preclude the Board from exercising the authority required to meet its responsibility for the conduct of Watsonville Community Hospital. The Board retains the right to rescind any such approval or delegation.

ARTICLE XI
ACTIONS REQUIRING MEMBER APPROVAL

11.1. Approval or Action Requirement. Notwithstanding anything in these Bylaws to the contrary, neither the Board nor any officer or employee of PVHCDH may take any of the following actions, or approve a subsidiary or an affiliate taking any of the following actions, without the prior approval of the Member:

(a) Any merger, consolidation, reorganization, or dissolution of PVHCDH that would change the Member's status as sole member or owner of the assets operated by PVHCDH.

(b) Any transfer by sale, lease, debt or encumbrance, or other disposition, of any of the assets of PVHCDH, real or personal, outside the ordinary course of Watsonville Community Hospital business.

(c) Any transaction that, on a proforma basis, would cause PVHCDH to be in violation of any financial loan or bond covenant, as they exist at the time of the transaction, or that would cause PVHCDH's Debt to Capitalization Ratio to exceed 50%.

(d) Any Watsonville Community Hospital campus development plan that restricts future land use options or requires regulatory changes to land use permits/designations.

(e) Any transaction that causes or is anticipated to cause a downgrade in Member or PVHCDH'S bond rating by a standard rating agency.

(f) Amendment or restatement of the Articles of Incorporation.

(g) Amendment or restatement of these Bylaws.

(h) Any changes to the Mission Statement of the Watsonville Community Hospital.

(i) Appointment of independent auditors.

11.2. Record of Approval or Disapproval. The Member's approval or disapproval of matters described in Section 11.1 of these Bylaws shall be recorded in or filed with the minutes of this Corporation.

ARTICLE XII
GENERAL PROVISIONS

12.1. Compensation of Board Members. The members of the Board shall receive no compensation as such, except that they may be reimbursed from time to time for all expenses incurred on behalf of PVHCDH.

12.2. Indemnification. PVHCDH shall indemnify any Director, officer, employee or agent of PVHCDH for liability incurred by such person in the exercise of his or her duties with respect to PVHCDH to the extent permitted by Section 5238 of the California Corporations Code or any successor statute.

12.3. Fiscal Year. The fiscal year of PVHCDH shall end on December 31 of each year.

12.4. Construction and Definitions. Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California Nonprofit Corporation Law shall govern the construction of these Bylaws. Without limiting the generality of the preceding sentence, the masculine gender includes the feminine and neuter, the singular number includes the plural, the plural number includes the singular and the term "person" includes both a legal entity and a natural person.

ARTICLE XIII
AMENDMENTS

These Bylaws may only be amended or restated by the Member.

SECRETARY'S CERTIFICATE

I certify that I am the Secretary of Pajaro Valley Health Care District Hospital Corporation, a California nonprofit public benefit corporation, and that the attached Bylaws of Pajaro Valley Health Care District Hospital Corporation are the current bylaws of this Corporation adopted by the Board of Directors of Pajaro Valley Health Care District Hospital Corporation, and approved by the Member, the Pajaro Valley Health Care District.

Dated: _____, 2022

_____

[_____], Secretary

Summary report: Litera Compare for Word 11.3.0.46 Document comparison done on 1/18/2023 12:55:20 PM	
Style name: Default Style	
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Original DMS: iw://bbklaw-mobility.imanage.work/IMANAGE/35026968/6	
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Add	30
~~Delete~~	56
~~Move From~~	0
Move To	0
Table Insert	0
~~Table Delete~~	0
Table moves to	0
~~Table moves from~~	0
Embedded Graphics (Visio, ChemDraw, Images etc.)	0
Embedded Excel	0
Format changes	0
Total Changes:	86

WATSONVILLE COMMUNITY HOSPITAL

PVHCDHC

Board Memo

Executive Sponsor: Steven Salyer

Agenda Item: Approval of Engagement Agreement with The Chartis Group – PVHCDHC Strategic Planning Consulting Services

Meeting Date: January 25, 2023

Recommended Action

Request the Board's approval to execute engagement agreement with The Chartis Group for strategic planning development of prioritized set of strategic imperatives, key tactics, and related measures.

Background/Situation/Rationale

The Board od Directors of PVHCD and WCH's Executive Team seek to embark on a strategic planning process that elevates the hospital and healthcare district's health equity impact and preserves access to quality services for the community under a financially sustainable trajectory. Primary deliverable from this project will be a 3 to 5 year strategic plan for WCH with the PVHCD's overall objectives and needs in mind. The strategic plan will include a clear articulation of organizational goals and metrics by which success will be defined.

Financial Impact: Anticipated expense for this proposed agreement will be $480,000.

Attachment:

A. The Chartis Group Strategic Planning Proposal

Approved: XYZA 00, 20 xx

CHARTIS

December 20, 2022

Steven Salyer
Chief Executive Officer
Watsonville Community Hospital
75 Nielson Street, Watsonville, CA 95076

Cecilia Montalvo
Interim Chief Financial Officer
Watsonville Community Hospital
75 Nielson Street, Watsonville, CA 95076

Re: Watsonville Community Hospital and Pajaro Valley Healthcare District Strategic Planning

Dear Steven and Cecilia,

Thank you for the opportunity for The Chartis Group (Chartis) to provide Watsonville Community Hospital (WCH) and the Pajaro Valley Healthcare District (PVHCD) with our proposal for strategic planning consulting services. Chartis has been privileged to work with community safety net hospitals like WCH and community health planning bodies like PHVCD to improve community health outcomes and economic sustainability. Our collective experience across many organizations provides us with a deep knowledge base, client network, and perspective on what it takes to create meaningful and sustainable change. As you review our proposal, please keep in mind the following attributes that we believe differentiate Chartis:

- **We have led transformative engagements resulting in material improvements to the health of underserved communities.** Through our work across communities such as Chicago's South Side, Southwest Houston, West Texas, New Jersey, and beyond, Chartis has supported strategy development and implementation for healthcare organizations tackling community health challenges and inequities in local contexts. This includes work supporting the creation of the South Side Health Community Organization, a nonprofit organization dedicated to transforming health outcomes on Chicago's South Side, that resulted in the creation of an unprecedented collaboration of Federally Qualified Health Centers (FQHCs), safety net hospitals, and health systems and that received $150 million in state funding.

- **We have extensive strategic and operational planning experience with community safety net hospitals.** Our work with safety net hospitals such as Kaweah Health in California, Lawrence General Hospital in Massachusetts, Cook County Health & Hospitals in Chicago, and more provides us with a grounding of the value that safety net hospitals provide to their communities, as well as with clarity about the financial and operational challenges and risks facing these essential institutions. Our work with these clients, which has spanned strategic planning, operations and access, and financial performance improvement, has resulted in demonstrably improved patient experience, operating margins, and service quality / scope, leading to better and more equitable care for vulnerable and underserved patient and community segments.
- **We have a deep regional understanding of the northern California market.** We have worked with many of the region's health systems, including UCSF Health, Stanford Medicine, John Muir Health, Providence Health, and El Camino Health. We understand the unique market, competitive, and partnership dynamics in which WCH will need to chart its future course.
- **We have significant community engagement and communications expertise through our partner Jarrard** - a top-10 strategic communications consulting firm. We have provided trusted strategic communications counsel to healthcare leaders guiding their organizations through high-stakes times of change, challenge, and opportunity. We have served more than 600 leading healthcare companies and health systems of all genres – notably, publicly-owned community and regional providers such as Singing River Health System, Broward Health, Erlanger Health System, Lee Health, and Anniston Health Care Authority.

This letter of engagement, based on our conversations over the past several weeks, outlines our understanding of your situation, our project approach, and associated staffing and professional fees to complete this critical endeavor. If any modifications are required to better meet your needs, we would be pleased to work collaboratively to make the necessary adjustments.

Sincerely,

Cindy Lee
Chief Strategy Officer and Director
415.254.7743
clee@chartis.com

Our Understanding and Engagement Objectives

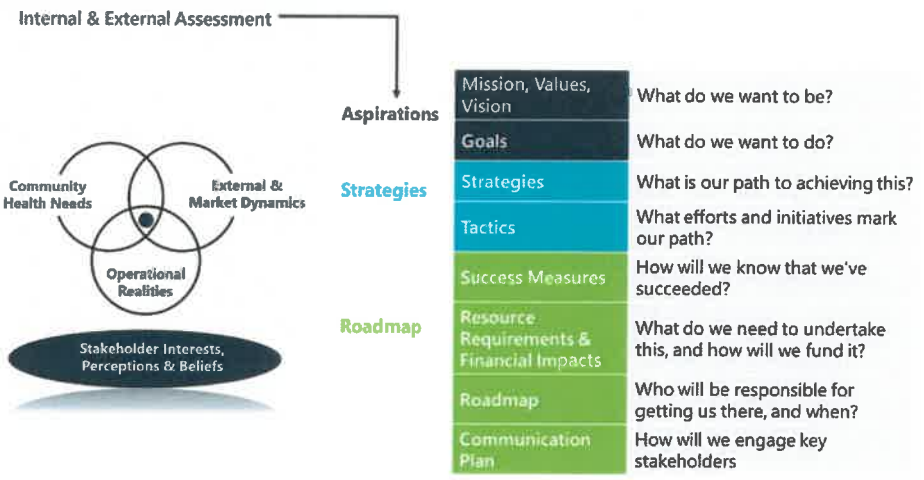
WCH is a 100-bed community hospital in Santa Cruz County that has operated under multiple for-profit owners for several decades. In December 2021, WCH filed for bankruptcy, creating the threat that the rural, under-resourced Watsonville community would be left without access to critical emergency, inpatient, and other hospital-based services. In response, a historic, grassroots effort of community advocacy and legislation led to the creation of a new public entity – the PHVCD – which went on to raise $66 million to acquire WCH and operational. This represented the largest public fundraising campaign in the history of Santa Cruz County – reflecting the community's conviction that the most meaningful way to address the region's health disparities is by preserving access to healthcare.

With the achievement of this historic milestone, the Board of Directors of PVHCD and WCH's Executive Team now seek to embark on a strategic planning process that elevates the hospital and healthcare district's health equity impact and preserves access to quality services for the community under a financially sustainable trajectory. This process will be grounded in the development of a shared mission, vision, values and guiding principles for the two entities, guided by internal and external stakeholders, including forums for diverse community input. The primary deliverable from this project will be a 3-to-5 year strategic plan for WCH with the PVHCD's overall objectives and needs in mind. The strategic plan will include a clear articulation of organizational goals and metrics by which success will be defined; supporting strategies and major tactics; a high-level roadmap with key milestones; and estimated financial projections building on the baseline financial assumptions in place today.

Our Approach

Our approach will ground WCH's strategic plan in a robust understanding of the internal and external environments, including an analytical and qualitative assessment of the community's healthcare needs and desires; external market dynamics (e.g., payers, providers, employers); and the operational realities in which WCH must operate. While our primary focus will be in the development of a robust strategic plan for WCH, we understand that this must include considerations for PVHCD's objectives. While we expect the "aspirations" or goals and mission/vision/values of these two entities to be similar and mutually reinforcing, there will be some differences. For example, PVHCD's broader focus will be to consider how to engage all of the capabilities available in the region to improve the health of the communities; whereas WCH's focus will be more centered on its specific role in improving the health of the communities it serves. We have highlighted the major components of the strategic planning framework as illustrated in Figure 1 below.

Figure 1: Strategic Planning Framework



The process for crafting WCH and PVHCD's aspirations, as well as WCH's strategies and roadmap, will rest on deep engagement from leadership and extensive input from clinicians, the broader workforce, and members of the Watsonville community. We will utilize interviews, workshops, community/employee listening sessions, and surveys to engage WCH's broad stakeholders and reflect the grassroots, public effort to keep the hospital open. In Figure 2 below, we have summarized the key phases and activities of the strategic planning effort.

Figure 2: Phases and Key Activities (12 Weeks Total)

Phase 1	Phase 2	Phase 3
Current State Assessment and Articulation of Aspirations	**Strategy and Tactics Development**	**Roadmap and Synthesized Plan**

Key Activities
• Conduct high level market / internal assessment
  ◦ 10-15 individual interviews, to be supplemented with listening sessions targeting up to 100 additional stakeholders
  ◦ Assessment of regional community need, health equity needs, and provider landscape, with community input to reflect needs
  ◦ Internal assessment (operating / quality / financial performance, service line mix, provider workforce)
• Work with internal & external stakeholders (including diverse community input) to initially articulate mission, vision, values, and strategic aims
  ◦ "Design & deliver" workshops to develop themes & ideas
  ◦ Comprehensive focus group listening sessions – 2 internal, 2 external, with up to 30 participants per session
• Determine 3-5 year goals
	Key Activities
	• Develop criteria to prioritize services for growth and focus vs. areas for deemphasis
	• Develop strategic imperatives and goals key priorities, e.g.,
	  ◦ Clinical services and network
	  ◦ Partnerships
	  ◦ Quality and outcomes
	  ◦ Access and experience
	• Finalize articulation of mission, vision, values
	  ◦ Continue comprehensive listening sessions
	  ◦ Launch community & employee online survey
	• Shape a comprehensive plan with imperatives, actions, key measures and timing
		Key Activities
		• Develop high level roadmap for execution, including key accountabilities and timelines, working closely with WCH leadership
		• Finalize high level financial impact analyses of key strategies
		• Finalize communications materials articulating the strategic plan for internal and external stakeholders

Deliverable Current state assessment; stakeholder engagement, and initial articulation of mission, vision, aims	**Deliverable** Prioritized set of strategic imperatives, actions, and measures; initial strategic plan	**Deliverable** High-level roadmap, financial projections, and strategic plan with communication for internal & external audiences

1. Current State Assessment and Articulation of Aspirations

Overview

The objective of Phase 1 is to craft a compelling vision for WCH and PHVCD that rests on a clear understanding of the internal and external current state, as well as of stakeholder engagement. To do so, Phase 1 is structured around information gathering, external market analysis, internal financial/operational performance assessment, interviews, and broader stakeholder engagement.

Tasks

- Conduct 10 – 15 individual interviews with executive leaders and members of the Board to understand to best understand strengths, needs, and opportunities, how they would like to see the organizations evolve, and what existing barriers may impact the success of this work; these interviews will be supplemented by broader listening sessions targeting up to 100 participants as detailed below
- Conduct "design" workshop with a small working group of internal executives, leaders and long-term employees to identify themes, sentiments, and ideas that would resonate most with WCH's internal and external audiences as we shape statements of mission, vision and values
- Conduct listening sessions, based on the themes identified in the "design" workshop, to capture critical feedback on potential mission, vision and values language from WCH's internal and external audiences
- Launch community and employee online survey to expand engagement beyond those able to participate in listening sessions
- Assess regional community need, health equity needs, employer landscape, payer landscape and provider landscape (inclusive of FQHCs)
- Review internal operating, quality, and financial performance
- Synthesize the current state and begin to form statements of mission, vision, values, and goals, with initial takeaways for internal and external communications

Deliverables

- Synthesized current state assessment of the community's healthcare needs broadly, from the PVHCD perspective
- Synthesized current state assessment of the community needs that WCH would be best positioned to meet (quantitative and qualitative)

- Initial articulation of mission, vision and values based on interviews, focus groups and online survey
- Initial identification of top 3 to 5 strategic goals for WCH and PVHCD (some goals may overlap)

2. Strategy and Tactics Development

Overview

Phase 2 will build on the emerging insights from Phase 1 to create actionable, measurable strategies and key tactics. Strategies will focus on identifying the core aspects of WCH's healthcare delivery model (e.g., service line priorities, provider and facility network, payer strategies, partnerships, quality and outcomes, and patient access). In doing so, we will keep in mind the broader community health aims of PVHCD (community health, social determinants of health, community-based partnerships). The result will be a set of prioritized strategic imperatives, related key tactics, and measures for WCH. In this phase, we will also begin to develop a financial model that will identify key requirements to achieve financial sustainability.

Tasks

- Develop criteria / guiding principles to evaluate strategies to pursue
- Develop strategic imperatives, key tactics, and goals around:
  - Clinical services
  - Provider/Facility network
  - Partnerships
  - Quality and outcomes
  - Access and experience
  - Others, to be determined
- Prioritize strategies to pursue
- For priority strategies, develop tactics and metrics for success
- Initiate financial modeling of key strategies to pursue

Deliverables

- Criteria / Guiding principles for prioritizing strategies
- Prioritized set of strategic imperatives, key tactics, and related measures

- Finalized mission/values/vision

3. Roadmap and Synthesized Plan

OVERVIEW

Phase 3 will support WCH in the transition from strategy to implementation. We will take the inputs from Phase 2 to develop high-level financial projections and sensitivities for WCH, deriving an estimate of resource requirements and financial performance under relevant scenarios. Additionally, we will develop a high-level roadmap that lays out key measures, the sequencing and phasing of strategies and key tactics, with assigned owners or points of responsibility, working closely with WCH leadership. In this phase, we will also identify key risks and key enablers necessary for successful execution.

Finally, we will develop communications materials that synthesize the strategic plan for internal and external audiences with engaging, accessible key visuals, bringing the strategic plan to life and ensuring early awareness, understanding, and adoption. Figure 3 provides an example of what such communications materials could look like.

Figure 3: Example Strategic Plan Visual

TASKS

- Develop high level implementation roadmap, working closely with WCH leadership
- Complete financial impact analysis related to prioritized strategies identified in Phase 2
- Develop materials articulating the strategic plan for internal and external audiences

DELIVERABLES

- High-level roadmap for implementing strategic plan
- High-level financial projections, building on existing assumptions
- Synthesized strategic plan with communication for internal & external audiences, including final mission/vision/values statements

Project Structure

Our approach to working with you will involve significant engagement with leaders, governance, employees, and stakeholders through interviews, community listening sessions, and surveys. The primary vehicle for developing the WCH strategy will be the Project Sponsor team that will include include Steven Salyer, Cecilia Montalvo as well as 1-2 additional leaders as desired. In addition to the Project Sponsor team, there will be two touchpoints with the Board of Directors of PVHCD / WCH. Figure 4 below illustrates this structure.

Figure 4: Project Structure

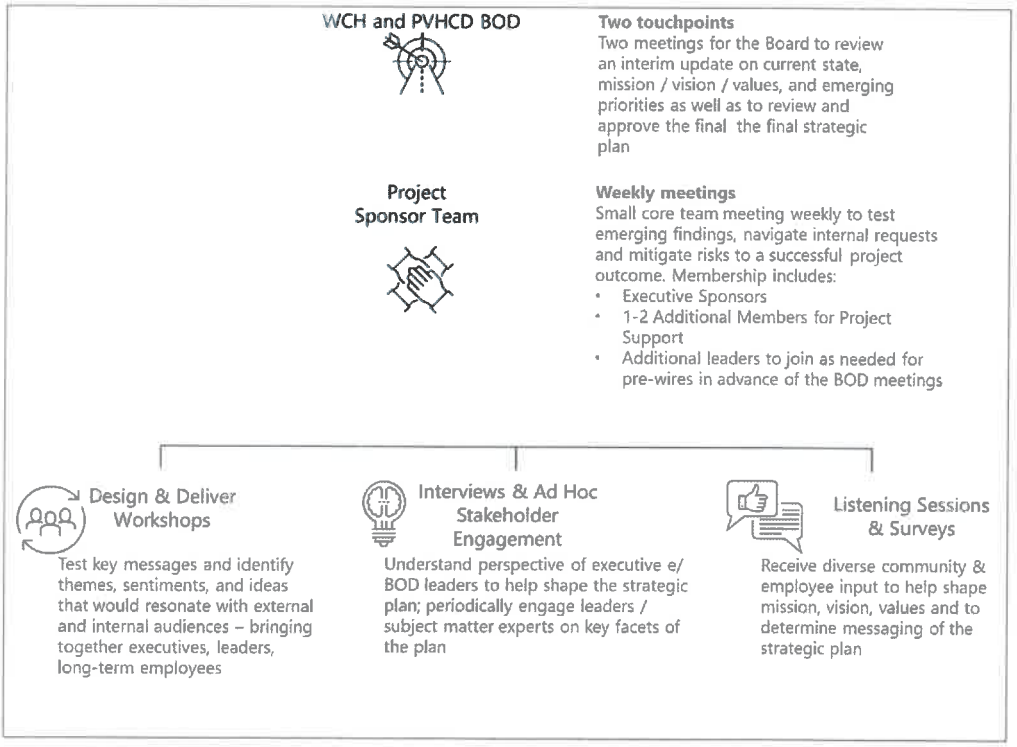
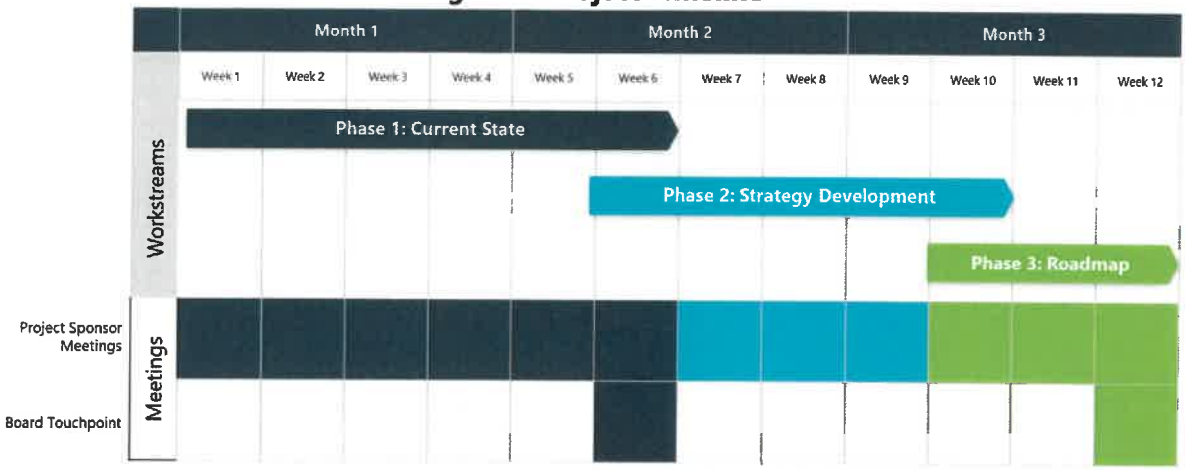


Figure 5 below captures the timeline for project phases and key touchpoints.

Figure 5: Project Timeline



Our Team

To support this engagement, we will staff an experienced project team of senior-level professionals with extensive healthcare consulting experience and requisite facilitation skills to garner consensus in a complex project such as this. An overview of our proposed project team is outlined in the table below. Please see Appendix C for detailed team member profiles.

Project Team Member	Project Role	Time Commitment
Cindy Lee *Chief Strategy Officer, Head of Strategy Practice*	Ensures the project is meeting all objectives and client expectations; provides oversight and senior input, participating in all key meetings	1 day per week
Amy Woodrum *Principal, Strategy Practice*	As the engagement leader, Amy will provide direction and thought leadership to the engagement and team on a day-to-day basis, as well as support and guidance in all key meetings	2-3 days per week
Letitia Fecher *Vice President (Jarrard), Public & Community Health System Practice Lead*	Leads the communications workstreams around mission, vision and values development and strategic plan communications	1 day per week

Project Team Member	Project Role	Time Commitment
Courtney Kelsey *Associate Vice President (Jarrard), Regional Health Systems Practice*	Supports Communications Team Lead and the mission, vision and values workstream strategy, execution and deliverables	As needed
Associate Consultant (To Be Assigned)	Will be responsible for developing and synthesizing analytics and content, day-to-day project management, financial modeling, and meeting materials	Full-time

Professional Fees and Expenses

Based on the description of the Proposed Services, our professional fees will be $480,000 for this 12-week project, which reflects a material discount off our commercial rates. In addition to our professional fees, we bill for direct expenses including travel to the client site and/or Chartis offices for team work sessions, lodging, meals and a 5% administrative fee for production and engagement support. Expenses generally do not exceed 15% of professional fees under normal travel circumstances and will be less with a reduced travel model. We will work closely with you to aggressively manage our expenses.

Key Assumptions for Project Success

- The following resources will be provided to support the project team:
  - A point of contact(s) that will act as the sponsor for this engagement.
  - Appropriate personnel from executive, clinical, operations and community leadership to participate as needed.
  - Access to staff and subject matter experts as needed.
  - Sufficient administrative support for document collection; scheduling interviews, project briefings, working sessions and conference calls; arranging special meetings; and other activities as needed.
- Appropriate workspace will be provided for Chartis consultants when onsite work is needed. Safety measures will be discussed with you in advance to ensure workspace and planned interactions between the Chartis team and client leaders/staff follow your and Chartis' policies/protocols.
- The following items will be managed in a timely manner. Delays in project work due to access or scheduling may result in project delays and additional fees, which will be discussed in advance.

- Scheduling of interviews and meetings.
- Response to data requests.
- Review and feedback of draft deliverables.
- Appropriate system and vendor access.

- This proposal is subject to and incorporates the Chartis Commercial Terms and Conditions attached to this proposal as Appendix _.

The parties have executed this proposal as of the date first set forth below.

Watsonville Community Hospital	The Chartis Group, LLC
Authorized Party	Cindy Lee Director
Date	Date
Name	
Title	

Please scan/email a copy of this signature page as your authorization to proceed.

The Chartis Group, LLC
220 W. Kinzie Street, 3rd Floor
Chicago, IL 60654
Email: finance@chartis.com
Telephone: 877.667.4700

APPENDICES

Appendix A: Relevant Experience

Chartis has been privileged to partner with clients across the nation on a broad range of engagements. All Chartis colleagues are committed to providing each client with excellent service and results such that the patients and communities served by our clients are better off in meaningful ways.

Below are examples of clients we have served in the areas of interest to WCH Additional information and project team member references are available upon request.

South Side Health Connected Care Platform Development

SOUTH SIDE HEALTHY COMMUNITY ORGANIZATION

For decades, the 900,000 residents of the South Side of Chicago have experienced health disparities ranging from materially higher disease incidence and comorbidities to significantly lower life expectancy, reflecting a history of racial inequities and underinvestment, and a fragmented healthcare delivery landscape with limited resources. In response to a new state initiative, a group of providers engaged Chartis to develop a proposal for transforming health outcomes. Upon successfully receiving a $150 million funding commitment from the state, Chartis supported the coalition through integrated implementation management.

Action	Results
The first phase of this work was focused on proposal development for the State of Illinois. Key actions included: • Grew the coalition from the 3 original sponsors to 13 community providers. • Engaged over 900 South Side providers, community/faith-based leaders, elected officials, and residents to develop a proposal shaped by deep community input. The second phase was focused on implementing the planned changes. This included: • Supported rapid stand up of a new governing board. • Took ownership of four workstreams: 1. Administration & Finance 2. Provider Operations & Deployment 3. Care Coordination Design & Care Team Recruitment 4. IT Design & Strategy	• The coalition submitted and successfully received a funding commitment of up to $150 million from the State of Illinois. With the support of this funding, the coalition launched the South Side Healthy Community Organization (SSHCO). Thus far, with project management support from Chartis, the SSHCO has selected care coordination partners, finalized criteria for provider deployment across coalition sites, approved an IT capabilities roadmap, and launched an RFP process to design a Connected Care Technology platform to enhance connectivity and reduce fragmentation of care.

- Organized, managed, and facilitated the work over 200 clinical, finance, operations, IT and care management leaders, supporting critical milestones and decision points across the above workstreams.
- Presented updates and recommendations to the new Board of Directors on a weekly basis.

Kaweah Health – Community Safety Net Operations

Kaweah Health is an $800M public health system in California. The Chartis group partnered with Kaweah Health to identify opportunities and initiatives to improve patient throughput starting in the Emergency Department through discharge, including transitions to post-acute care services.

Action	Results
• On-going areas for opportunity coalesce around the following themes: o Expand existing patient progression facilitation and inpatient throughput structure and augment active daily huddle participation with providers o Integrate CM, SW, RNs, and MD/APPs, etc. to create a robust and multidisciplinary care facilitation team o Optimize existing technology resources to enhance clinicians' efficiency	• Average length of stay (ALOS) was at 6.31 days during baseline period. Early results demonstrate improvement to ALOS of 6.03 days within 2 months post-implementation, ahead of benefit realization schedule, which has an overall ALOS goal of 5.64 days within 18 months. The corresponding potential bed availability is 29 beds with backfill volume opportunity represents $8.6M in annualized incremental contribution margin.

Memorial Hermann Southwest Community Impact-Based Hospital Strategy

MEMORIAL HERMANN

Memorial Hermann Southwest Hospital (MHSW) is a 543-bed hospital located in Southwest Houston serving as a vital anchor institution to a diverse and vibrant but also underserved community. It is part of the Memorial Hermann Health System (MH), a $5 billion health system in the Southeast Texas region with a network of 17 hospitals and over 250 care delivery sites.

While MHSW had made notable clinical quality achievements and financial performance improvements over the prior three years, it continued to face significant financial challenges, including a high uninsured/underinsured payor mix and regulatory uncertainties, as well as community health disparities.

Given these pressures, the client engaged Chartis to develop a strategy to elevate the health and community impact of MHSW while also enhancing its financial sustainability

Action

The engagement focused on three areas:

- **Service Mix**: What will be the healthcare service needs for the future-state Southwest Houston population and how should they be prioritized?
- **Community Impact**: How can MHSW best meet the health and wellbeing needs of Southwest Houston residents based on best practices and innovative models from across the country?
- **Financial Impact**: How can MH balance its mission to serve the community while addressing the financial challenges that MHSW faces? How can MH both meet the most pressing needs of the community and also achieve financial sustainability?

Chartis worked with the client to develop:

- Optimal service mix
- Community-based solutions
- Prioritized partnership list
- Strategic communications approach
- Financial model and implementation roadmap

Results

- Chartis delivered a prioritized list of 11 initiatives across four solution sets with financial impacts, key considerations, accountability, and timing of impact for each initiative

Appendix B: About Chartis

At Chartis, our mission is to materially improve healthcare in the world. The insights and services we provide support healthcare organizations in achieving their highest objectives.

We are at a moment of tremendous change and disruption in the healthcare industry. Today's healthcare needs, economics, and disparities demand the next set of solutions.

We're helping healthcare organizations navigate this new era to not just survive, but to thrive. We're guiding clients as they reimagine care delivery, redefine the patient journey, transform clinical and operating models for financial sustainability, and position for growth as new health ecosystems emerge.

Through bold thinking, incisive leadership, and powerful collaboration, we help our clients pivot to new strategies and operating models. We call this Next Intelligence, where leading-edge data, analytics, and technology meet human ingenuity and judgment. It's how we help our clients build a healthier world.

Uniquely Positioned to Serve

The Chartis Group is the nation's largest healthcare advisory firm, with a unique breadth and depth of capabilities to meet healthcare's most pressing issues. The Chartis Group comprises Chartis Consulting, The Greeley Company, and Jarrard Phillips Cate & Hancock. We operate under our unique brands in the market but share a singular focus on improving healthcare.

At Chartis, we draw upon our key areas of expertise to develop highly customized solutions to meet our clients' needs and deliver measurable, sustainable results. We deliver healthcare thought leadership and expertise across the following domains:

- Strategy
- Performance
- Informatics & Technology
- Revenue Cycle
- Oncology
- Digital Transformation
- Analytics
- Clinical Quality & Safety
- Strategic Communications & Change Management

Our Clients

The Chartis Group works with leading healthcare organizations across the country. We are continually moved and inspired by the clients we serve. Our clients include:

Mission and Values

Our mission: To materially improve the delivery of healthcare in the world.

We are lucky to have extraordinarily talented people working in our firm – all brought together around our unifying mission, a shared dedication to our core values, and the emphasis we place on creating an environment that enriches the experiences of our clients, our colleagues and our communities. In this way, we find that we are remarkably aligned with our clients. And that has made for achieving some truly great things.

The Chartis Group is guided by a simple set of core values that dictate our actions both as individuals and collectively as a firm:

Industry Recognition

For five consecutive years, Chartis has been recognized as one of ***Forbes*** **"America's Best Management Consulting Firms"** by our peers and clients.

In 2021, Chartis was recognized in the following categories:

- IT Strategy
- Organization
- Strategy

For more than a decade, Chartis has consistently been recognized as Best in KLAS by KLAS Research, a national healthcare IT data and insights company.

This year, Chartis was rated **#1 in four Best in KLAS categories** and was among the top 3 in two additional categories:

- Best Overall Healthcare Management
- #1 Digital Transformation Consulting
- #1 HIT Advisory Consulting
- #1 Financial Improvement Consulting
- #3 Clinical Optimization
- #3 Strategy, Growth, and Consolidation Consulting

This is the 12th year Chartis has ranked among the **Top 10 HIT Advisory Services Firms.**

Attracting colleagues passionate about healthcare and fostering a positive environment for top talent is something that also makes Chartis stand apart and has drawn attention from the industry. We are consistently recognized by Vault among its top-ranking consulting firms and have been ranked by Modern Healthcare among the top 20 "Best Places to Work in Healthcare" for nine consecutive years.*

**Note: Chartis Did not participate in 2020 due to the pandemic and the timing of the survey.*

Appendix C: Team Member Profiles

Cindy Lee

Chief Strategy Officer and Director, Strategy Practice

Cindy Lee is a Director with The Chartis Group. She serves as Chief Strategy Officer for the firm and Strategy Practice. Cindy advises healthcare leaders throughout the country in crafting their futures through scenario planning that considers how the healthcare environment is likely to evolve in the coming years and the transformation journey that may be required, including partnership formation, financial strength, value-based care strategies, and alignment/funds flow. She has worked with nationally leading academic health systems, children's hospitals, and healthcare focused companies over the last 20 years.

Cindy has been privileged to serve leading healthcare systems throughout California including several of the University of California Health Systems (UCSF Health, UC Davis Health, UC Irvine Health); Stanford Medicine including Stanford Children's Health, Stanford Health Care and Stanford School of Medicine; John Muir Health; and CHOC Children's.

In addition, Cindy has served healthcare companies throughout the U.S. in developing creative partnerships to improve community health, including a confidential partnership consideration between an academic health system in the Midwest and a district hospital; a confidential growth strategy for a national physician group focused on serving ex-urban and rural communities focused on innovative care models and community partnerships; and a confidential clinically integrated network development strategy in the West focused on physician and community center partnerships.

Before joining Chartis, Cindy was a partner at Stockamp & Associates, Inc. (now part of Huron Consulting), a national healthcare consulting firm focused on revenue improvement and patient flow solutions. Prior to that, she was a consultant at CSC Healthcare and its predecessor, APM Management Consultants.

Cindy has authored and been featured in numerous articles and webcasts including: "Beyond the Second Curve: Revisioning Value-Based Care"; "The New World of Partnerships: Technology Companies"; "Leading the Conversation: New Channels for Provider Contracting"; "Consortium Model Networks: Evaluating the Potential of Collaboration"; and "Delivering Value through Post-Acute Care."

Cindy holds a Bachelor of Science degree in journalism and economics from Northwestern University.

Amy Woodrum

Principal

Amy Woodrum is a Principal with The Chartis Group. Amy has over six years of healthcare consulting experience and over ten years of experience in the healthcare industry. At Chartis, her primary focus has been advising academic and community health systems on strategic planning initiatives and strategic advisory services to support health system partnerships. She has advised academic health systems, community hospitals, integrated delivery networks, and children's hospitals on service line planning, ambulatory network development, enterprise strategy, and physician alignment.

Amy's most recent engagements include enterprise strategic planning for nationally ranked academic health systems, partnership development between leading academic and community health systems, service line planning for nationally recognized children's hospitals and academic health systems, and physician alignment and medical group planning.

Amy has recent experience in California including advising multiple health systems in the Bay Area and an engagement with an independent community hospital on the Gold Coast.

Prior to her work with Chartis, Amy served as a Program Associate with the Robert Wood Johnson Foundation (RWJF), the largest foundation in the United States dedicated solely to health. At RWJF, she oversaw a portfolio of grants exceeding $2.5M, facilitated the organization's annual strategic assessment, and produced an annual impact scorecard.

Amy serves as a board member of the Yale Healthcare Conference.

Amy received her Master of Business Administration and her Master of Public Health, both from Yale University, and her Bachelor of Arts in Health & Society from the University of Pennsylvania.

Letitia Fecher

Vice President, Public & Community Health Systems Practice Lead, Jarrard

Letitia Fecher leads the Public & Community Health Systems practice for Jarrard. A seasoned communications strategist, she has significant expertise in messaging, branding and reputation management.

Letitia has played key roles in steering clients through mergers and integration; launching physician, employee and community engagement initiatives; spearheading public perception campaigns and creating branding and image strategies. She brings more than 15 years of marketing and strategic communications experience in the healthcare industry to Jarrard, including seven years of work as an in-hospital marketing and communications professional.

Prior to joining Jarrard in 2014, Letitia led the marketing and communications for an investor-backed, healthcare services start-up. There, she implemented an organization-wide employee engagement effort, oversaw relationship and business development with provider organizations and physician practices, and launched the company's brand, marketing and communications strategy. Additionally, she served as director of marketing for a Tenet-owned hospital and facilities in Atlanta; and marketing and customer relationship manager for a Catholic Health Partners nine-hospital system in Knoxville, Tenn.

Letitia earned a Bachelor of Arts in communications with a public relations specialization from Michigan State University and a Master of Business Administration from the University of Tennessee, Knoxville.

Courtney Kelsey

Associate Vice President, Jarrard

A strategic engagement and development expert, Courtney Kelsey uses her background in team optimization and people-focused change management to help healthcare leaders enhance the entire employee experience.

Since first joining the firm in 2016, Courtney has played a critical role in the expansion of its organizational development capabilities. Her issue navigation, experience design and strategic communications work has helped the firm's clients maintain trust through crises, accelerate their growth, improve engagement and retention of top performers and create marquee moments for leaders, teams and communities. Kelsey's approach is also informed by her extensive policy and public health training, which enables her to bring our clients a thorough understanding of their sociopolitical environments during times of significant change and opportunity.

Previously, Courtney served as a director of corporate communications at Baylor Scott & White Health, where she led HR, well-being, DEI and culture communications.

A Nashville native, Courtney is a former representative of public universities to the Tennessee Student Assistant Corporation. She earned a Bachelor of Arts in religious studies and political science from Rhodes College and a Master of Public Health in health policy and management from the University of Tennessee at Knoxville.

Appendix D: Chartis Commercial Terms & Conditions

1. **Performance of Services; Data Flow**

a) **Performance of Services.** The Chartis Group, LLC ("Chartis") will perform professional services for Watsonville Community Hospital ("Client") as described in the letter of engagement or proposal(s) to which these terms and conditions are attached ("Services") in compliance with such letter or engagement or proposal, these Chartis Commercial Terms & Conditions ("Terms & Conditions") and all applicable federal, state, and local laws. Such letter of engagement or proposal shall hereinafter be referred to as the "LOE."

b) **Data Flow**. Client shall give Chartis access to documents, data and information that are reasonably requested by Chartis and that (i) are necessary for the performance of the Services; and (ii) may lawfully be shared by Client with Chartis. Chartis will use such documents, data and information only to perform the Services, using commercially reasonable efforts to prevent underlying Confidential Information (as defined below) of Client from being used or disclosed to any third party in violation of these Terms & Conditions.

2. **Invoicing, Reimbursement of Expenses, Remittance, IRS Regulation, Legal Process.**

a) **Invoicing**. Client shall compensate Chartis for the performance of the Services in accordance with the LOE. At the end of each month during which Services are performed by Chartis, Chartis will submit an invoice to Client for its professional fees and reimbursable travel and business-related expenses (as set forth in Section 2.b. below) to the billing contact person for Client listed below. At the end of the final month in which Chartis performs Services, Chartis will submit an invoice for its final professional fees and its reimbursable travel and business-related expenses to Client. In the event that there are reimbursable travel and business-related expenses that are documented in the invoice submitted at the end of the final month in which Chartis performed Services, Chartis will provide Client with a reimbursable travel and business-related expense only invoice as soon as commercially practicable, but in any event, no more than two months after the completion of the Services.

Billing Contact Person for Client: Steven Salyer, Watsonville Community Hospital, 75 Nielson Street, Watsonville, CA 95076, Steven_Salyer@watsonvillehospital.com, 831.763.6040

b) **Travel and Business-Related Expense Reimbursement.** If Chartis is required to travel to perform the Services under the LOE, Client shall reimburse Chartis for all travel and business-related expenses reasonably incurred in connection with the performance of the Services, including the following expenses:

i. all air, auto, or other transit related travel expenses related to the Services;

ii. meal expenses;

iii. lodging expenses if the Services require overnight stays; and

iv. miscellaneous travel-related expenses (taxi, parking and tolls, etc.).

c) **Remittance**. Client shall pay Chartis the amount stated on each invoice for its professional fees and reimburse all travel and business-related expenses within thirty days of the date of the invoice. All payments due of amounts not reasonably disputed shall be made by check, bank wire transfer, or ACH transaction to a bank account designated by Chartis on the invoice. If Client in good faith, disputes the amount of an invoice issued by Chartis, Client shall pay Chartis the undisputed portion of the invoice within thirty (30) days of the date of the invoice, and provide Chartis with written notice of the portion of the invoice in dispute and the reasons for such dispute within fifteen (15) days of the date of the invoice. The parties shall use commercially reasonable efforts to reconcile the disputed amounts as soon as commercially practicable. If the parties agree that Client owes some or all of the disputed amount, then Client shall pay such amount within thirty (30) days from the date of the parties' agreement. All payments shall be made in U.S. dollars. Overdue amounts shall bear interest at an annual rate equal to 1.5% per month or the highest rate permitted by applicable law (whichever is lower) from thirty (30) days after the applicable due date until the date full payment is received by Chartis. In the event that the due date of any payment subject to this Section is a Saturday, Sunday or national holiday, such payment may be paid on the previous business day.

d) **IRS Regulation on Deduction Limitation for Meals and Entertainment.** In addition to Section 2.b. above, Client shall abide by the Internal Revenue Service regulations on reporting and deduction limitations set forth in Section 1.274-2, paragraphs (f)(2)(iv)(a) through (f)(2)(iv)(e) (the "IRS Regulations"). Client shall reimburse Chartis for 100% of the cost of meals and, if allowable under Client's travel and expense policy, entertainment expenses. Client agrees that they are responsible to account for the 50% deduction limitation on meals and the 100% deduction limitation on entertainment expenses as defined in the IRS Regulations. Chartis will provide the Client with adequate documentation to support the meals and, if allowable under Client's travel and expense policy, entertainment expenses subject to the limitation in the IRS Regulations.

e) **Legal Process.** If Chartis is requested by Client or any third-party, by subpoena, court order, investigation, or other legal or regulatory proceeding to produce documents or testimony pertaining to Client or the Services, and Chartis is not named as a party in the proceeding, Client will pay Chartis for its professional time, plus out-of-pocket expenses, costs, and fees, as well as reasonable attorney fees, incurred by Chartis in responding to such request.

3. **Client Delays**

In addition to the events described under Section 10.d below, there are two specific situations that are beyond Chartis' control and that may cause Chartis to spend more time and incur more expenses to perform of the Services. The two situations are:

a) **Insufficient resources**. Client provides insufficient personnel, information, and other resources to fulfill its obligations under the LOE. Chartis will notify Client as soon as reasonably possible upon Chartis becoming aware that it appears that the Client-provided resources are, or will be, below agreed upon levels.

b) **Unforeseen schedule slippage**. Client fails to stay within the timeline agreed to in the LOE. Chartis will notify Client as soon as reasonably possible upon Chartis becoming

aware that it appears that the Client is not keeping, or will not keep, pace with the agreed timeline.

The types of situations set forth above are not typically encountered during an engagement between Chartis and its clients. However, if such a situation arises, Chartis will notify and work with Client to determine if Chartis will be required to provide any additional time or resources as a result of a situation under Sections 3.a or 3.b above. In the event that the parties determine that Chartis will be required to provide additional time or resources, then upon written agreement between Chartis and Client, Client shall pay Chartis the amount agreed upon for such additional time or resources.

4. **Termination.**

a) **Completion of Services**. Unless earlier terminated under Section 4.b below, the LOE shall terminate upon the completion of the Services by Chartis in accordance with the LOE.

b) **Material Breach**. If either party (the "Non-Breaching Party") believes that the other party (the "Breaching Party") has materially breached one or more of its obligations under the LOE or these Terms & Conditions, then the Non-Breaching Party shall deliver written notice of such material breach to the Breaching Party specifying the nature of the alleged breach in reasonable detail (a "Default Notice"). The Non-Breaching Party shall have the right to terminate a LOE upon written notice to the Breaching Party if the breach set forth in the Default Notice has not been cured within thirty (30) days after Breaching Party receives the Default Notice. Notwithstanding the foregoing sentence, if such material breach, by its nature, cannot be remedied within such thirty (30) day cure period, but can be remedied over a longer period not expected to exceed sixty (60) days, then such thirty (30) day period shall be extended for up to an additional thirty (30) days, provided that the Breaching Party supplies the Non-Breaching Party with a reasonable written plan for curing the material breach and uses commercially reasonable efforts to cure the material breach in accordance with such written plan.

c) **Termination of the Services of a Member of the Team**. If Client judges the performance of the Services by a member of Chartis' team unsatisfactory for any reason other than reasons that violate applicable law, Client may request in writing the immediate removal of that member from the engagement, and Client shall not be liable for any fees for the performance of Services by that member after the date of such removal.

d) **Effect of Termination**. Upon termination of the LOE:

i. Client shall promptly pay Chartis for Services provided and reimburse for expenses incurred through the date of termination; and

ii. the Receiving Party will (a) return to the Disclosing Party all of the Disclosing Party's Confidential Information in its possession; or (b) destroy such Confidential Information; provided that the Receiving Party may retain one (1) copy of such Confidential Information solely for purposes of ensuring compliance with the terms of this Agreement. Notwithstanding the above, the Receiving Party may retain any of Disclosing Party's Confidential Information that is contained or embedded in Receiving Party's archived computer back-up systems in accordance with automated document retention, security, or disaster recovery

procedures, provided such Confidential Information shall remain subject to the terms of Section 8.a of these Terms and Conditions as long as it is retained by Receiving Party.

e) **Survival.** The provisions of Sections 2 (Invoicing, Reimbursement of Expenses, Remittance, IRS Regulation, Legal Process), 4.d (Effect of Termination), 4.e (Survival), 5 (Solicitation or Hiring of Employees), 6 (Indemnification and Insurance), 7 (Limitation of Liability), 8 (Confidentiality and Proprietary Information; Intellectual Property), 9 (Benchmarking) and 10 (Miscellaneous) of these Terms & Conditions will survive the expiration or termination of the LOE.

5. **Solicitation or Hiring of Employees.**

During the term of the LOE and for a period of twelve (12) months thereafter, neither party will knowingly employ or solicit for employment any employee, contractor or consultant of the other party who performed any of such party's obligations under the LOE without the prior written consent of the other party. This Section shall not restrict either party from offering employment or employing any employees, contractors or consultants of the other party who responds to any general advertisement or other general recruiting method used in the ordinary course of business.

6. **Indemnification and Insurance.**

Chartis shall indemnify, defend and hold harmless Client from and against any against any third-party claims, demands, actions, liabilities, damages, losses, costs and expenses (including reasonable attorney's fees) (each, a "Claim") arising from (a) the negligence or willful misconduct of Chartis in the performance of the Services, or (b) a violation of the LOE, Terms & Conditions or any applicable regulations or laws by Chartis.

Client shall indemnify, defend and hold harmless Chartis from and against any Claim arising from (a) the negligence or willful misconduct of Client, (b) a violation of the LOE, Terms & Conditions or any applicable regulations or laws by Client, or (c) Client's use of any Deliverables (as defined in Section 8.b).

Each party must notify the other party within thirty (30) days after learning of any Claim made for which the other party is obligated to provide indemnification as set forth above. The indemnifying party will have the sole right to defend, negotiate, and settle any such Claim. The indemnified party will be entitled to participate in the defense of such Claim and to employ counsel at its expense to assist in such defense; provided, however, that the indemnifying party will have final decision-making authority regarding all aspects of the defense of any Claim for which it is providing indemnification. The indemnified party will provide the indemnifying party with such information and assistance as the indemnifying party may reasonably request, at the expense of the indemnifying party. Neither party will be responsible or bound by any settlement of any Claim made without its prior written consent, which will not be unreasonably withheld or delayed. Further, the indemnifying party may not admit liability on the part of the indemnified party without the indemnified party's prior written consent, which shall not be unreasonably withheld or delayed.

Each party shall maintain sufficient insurance or a program of self-insurance to cover its indemnification obligations set forth above. Upon written request, each party will provide evidence of such insurance to the other party.

7. **Limitation of Liability.**

Excluding any liability resulting from a party's indemnification obligations under Section 6 of these Terms & Conditions or a party's breach of Section 8 of these Terms & Conditions, neither party shall be responsible or liable to the other party with respect to the subject matter of the LOE for any indirect, incidental, special or consequential damages, including, but not limited to, loss of profits, loss of revenues, or loss of business opportunity. With the exception of injunctive relief and specific performance, monetary damages shall be Client's exclusive remedy for any claims arising from the LOE and these Terms & Conditions. Chartis' liability to Client arising from the LOE and these Terms & Conditions shall be limited to actual damages and shall not exceed the total amount paid by Client to Chartis for the Services under which such liability arises.

8. **Confidentiality and Proprietary Information; Intellectual Property.**

a) **Confidential Information.** For purposes of these Terms & Conditions, "Confidential Information" means confidential or proprietary information furnished by a party ("Disclosing Party") to the other party ("Receiving Party") pursuant to the LOE, including, without limitation, such information relating to the Disclosing Party's business strategy, information systems, patients, software and hardware. The Receiving Party shall treat all Confidential Information of the Disclosing Party as proprietary and confidential and will use such Confidential Information only to perform its obligations under the LOE. The Receiving Party shall not disclose the Disclosing Party's Confidential Information to any third party except to (i) those third parties who have entered into confidentiality agreements that provide the same protection that disclosing party's Confidential Information has under these Terms & Conditions, and (ii) those employees and third parties that have a need to know disclosing party's Confidential Information in order to perform Receiving Party's obligations under the LOE. The obligations of confidentiality and non-use set forth herein shall not apply to any Confidential Information that:

i. at the time of disclosure or after disclosure is generally known by the public other than as a result of a breach of this Section 8.a by the Receiving Party;

ii. is generally known to Receiving Party prior to the disclosure hereunder as evidenced by Receiving Party's written records;

iii. is disclosed to Receiving Party by a third party having no obligation of confidentiality to the disclosing party;

iv. is developed by Receiving Party independent of the LOE or these Terms & Conditions and without any use of or reliance upon the Disclosing Party's Confidential Information; or

v. is approved in writing for disclosure by Disclosing Party.

In the event that the Receiving Party is required by applicable regulation or law to disclose any of the Disclosing Party's Confidential Information to a third party, the Receiving Party shall, if

legally permitted to do so, promptly notify the Disclosing Party in writing of such requirement. Upon the written request of the Disclosing Party, the Receiving Party shall cooperate in any lawful efforts by the Disclosing Party to seek a protective order or otherwise limit or prevent such disclosure, and if no such order or prevention is obtained, the Receiving Party shall only disclose such portion of the Disclosing Party's Confidential Information that it is legally required disclose.

The confidentiality obligations set forth above shall survive for five (5) years after the expiration or termination of the LOE.

If any of Client's Confidential Information is "Protected Health Information" as defined by the U.S. Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended from time to time, Chartis' duties and obligations relating to such information shall be governed by a separate business associate agreement entered into by Client and Chartis, and not the LOE and/or these Terms & Conditions.

Except for the immediately preceding paragraph, to the extent that these provisions conflict with the terms of any confidentiality agreement between the parties previously entered into in connection with the Services, these terms will govern.

b) **Deliverables.** All data, information and reports generated by Chartis solely in the performance of the Services in accordance with the LOE ("Deliverables") shall be owned by Client.

c) **Pre-Existing Property**. Notwithstanding any other provision of the LOE or these Terms & Conditions, Chartis' pre-existing solutions, methodologies, processes, tools, and materials ("Chartis Pre-Existing Property") are and shall remain the sole and exclusive property of Chartis. Chartis may use, for itself or others, without permission from Client, all pre-existing solutions, methodologies, processes, tools, and materials that may be included in, or be a basis for the Deliverables. Further, the Chartis Pre-Existing Property is proprietary to Chartis, and Client shall not disclose any Chartis Pre-Existing Property to any third party without Chartis' prior written consent. If Chartis uses any Chartis Pre-Existing Property in any of the Deliverables, Chartis agrees to grant to Client, as of the date Client receives such Deliverables from Chartis and Chartis receives payment for such Deliverables in accordance with the LOE and these Terms & Conditions, a non-exclusive, non-transferable license to use such Chartis Pre-Existing Property in the form included in the Deliverables in order to use such Deliverables for their intended purpose.

9. **Miscellaneous Provisions.**

a. **Modification or Amendment.** No modification or amendment of the LOE will be valid unless it is in writing and signed by the authorized representatives of both parties.

b. **Insurance.** Chartis shall carry, at its own cost and expense, commercial general liability insurance coverage in an amount of $1,000,000 per occurrence and $2,000,000 in the aggregate.

c. **Notices.** All notices, requests, demands, or other communications required or permitted by the applicable LOE or these Terms & Conditions will be given in writing and delivered to the respective party at the following addresses:

For The Chartis Group, LLC:
Attn: Cindy Lee
The Chartis Group, LLC
220 West Kinzie Street, 3rd floor
Chicago, IL 60654

For Client:
Watsonville Community Hospital
Attn: Steven Salyer, Chief Executive Officer
75 Nielson Street, Watsonville, CA 95076

or to such other address as either party may from time to time notify the other party in writing and will be deemed to be properly delivered (i) immediately upon being served personally, (ii) two days after being deposited with the postal service if served by registered mail, or (iii) the following day after being deposited with an overnight courier.

d. **Force Majeure.** Neither party shall be liable for any failure or delay in performing its obligations under this Agreement if such failure or delay is due to circumstances beyond its control, including but not limited to, governmental actions or restrictions, war, terrorism or insurrections, strikes, fires, floods, work stoppages, embargoes, pandemics, equipment, telecommunications, power, or electrical failures; provided that, if possible, the affected party promptly notifies the other party of the cause and its effects on the obligations to be performed hereunder by the affected party. The affected party shall use its reasonable efforts to mitigate the effect of the event of force majeure upon its performance of its obligations under the LOE. Upon conclusion of the event of force majeure the affected party shall as soon as reasonably practicable notify the other party of such conclusion and recommence the performance of its obligations under the LOE. In the event that the affected party fails to recommence the performance of its obligations under the LOE, the other party may terminate the LOE upon thirty (30) days written notice to the affected party.

e. **Independent Contractor.** Chartis will perform the Services in its capacity as an independent contractor for Client. Chartis and employees are not employees of Client and are not entitled to participate in health or disability insurance, retirement benefits, or pension benefits to which employees of Client may be entitled. Neither party will not hold itself out as a partner, agent, employee or joint venture partner of the other party.

f. **Entire Agreement.** The LOE, these Terms & Conditions and any attachments, as well as any separate business associate agreement between the parties, constitute the entire agreement between the parties regarding the Services and supersedes any prior and

contemporaneous agreements, representations and understandings of the parties regarding the Services.

g. **Governing Law and Jurisdiction.** The LOE and these Terms & Conditions will be governed by and interpreted in accordance with the laws of the State of Illinois, without regard to its conflict of laws rules. Chartis and Client specifically consent and agree that the courts of the State of Illinois and/or the federal courts located in Chicago, Illinois will have exclusive jurisdiction over each of the Parties in any proceedings arising from the LOE or these Terms & Conditions.

h. **Taxes**. Client shall pay all taxes relating to the LOE and the Services, including any sales or gross receipts taxes, but excluding any taxes measured by the income of Chartis and excluding any employment taxes relating to employees of Chartis. Notwithstanding the preceding sentence, if Client is a tax-exempt entity under Section 501(c)(3) of the Internal Revenue Code of the United States, as amended, Chartis shall take all reasonable actions to cause the provision of the Services under the LOE to be treated as a tax-exempt transaction. Upon written request, Client shall provide Chartis with certificates evidencing its tax-exempt status.

i. **Assignment; Binding Effect.** Neither party may assign any of its rights or delegate any of its respective obligations under the LOE or these Terms & Conditions without the prior written consent of the other party. A LOE and these terms and conditions shall be binding on and shall inure to the benefit of the parties hereto and their permitted successors and assignees.

j. **Section and Other Headings.** Section and other headings in the LOE and these Terms & Conditions are for reference purposes only and shall not be used in any way to govern, limit, modify, construe, or otherwise affect the LOE or these Terms & conditions.

k. **Counterparts; Delivery by Facsimile or Email.** The LOE and/or these Terms & Conditions may be executed in any number of counterparts with the same effect as if both parties had signed the same document. All counterparts shall be construed together and shall constitute one and the same agreement. The LOE and these Terms & Conditions and any amendments, to the extent signed and delivered by means of a facsimile machine or email, shall be treated in all manner and respects as an original agreement or instrument and shall be considered to have the same binding legal effect as if it were the original signed version delivered in person.

Signature Page

By signing below, both parties acknowledge that they have read, understood, and agree to these Terms & Conditions.

ACCEPTED AND AGREED TO:

The Chartis Group, LLC

By: _____

Printed Name: _____

Title: _____

Date: _____

ACCEPTED AND AGREED TO:

Watsonville Community Hospital

By: _____

Printed Name: _____

Title: _____

Date: _____

CHARTIS