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

Closed Meeting Agenda

Wednesday, June 28, 2023-5:00 pm

Kathleen King Community Room - 85 Nielson Street, Watsonville

https://zoom.us/j/93443061917

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

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: PVHCDHC.ORG. To view online, visit the Board's website at: **PVHCDHC.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. on the day of the meeting and before the end of the meeting will be included in the official 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

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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.

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@pvhcd.orgpara solicitar interpretación.

Pajaro Valley Health Care District Hospital Corporation
Closed Meeting Agenda- Wednesday, June 28, 2023

Call to Order

Roll Call

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 the Board will be noted in the minutes and may be scheduled for discussion at a future meeting or referred to staff for clarification and a report.

Public Comment on Matters on the Agenda

Adjourn to Closed Session

1. **Conference with Labor Negotiators** (Government Code 54957.6)
   Agency Negotiator: Allyson Hauck; California Nurses Association (CNA)
   Contact: Allyson Hauck, Chief Human Resources Officer

2. **Public Employee Recruitment Update** (Government Code 54957(b)(1))
   Conference with Labor Negotiators (Gov't Code 54957.6)
   Title-Chief Executive Officer
   Contact: Allyson Hauck, Chief Human Resources Officer

3. **Hearings/Reports** (Health and Safety Code HSC § 1461 and 32155)
   Reports of Patient Safety and Quality Committee, Medical Staff Credentials Committee, Medical Staff Interdisciplinary Practice Committee and Quality Dashboard.
   Contact: Executive Sponsor-Dr. Angel, Chief of Staff

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.

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

Wednesday, June 28, 2023-5:00 pm

(This meeting will begin after Closed Session)

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

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

Kathleen King Community Room - 85 Nielson Street, Watsonville

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Pajaro Valley Health Care District Hospital Corporation
Regular Meeting Agenda- Wednesday, June 28, 2023

Call to Order

Roll Call

Closed Session Report

Agenda Modification Consideration

Public Comment on Matters Not on the Agenda

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Comments from Board Members

Consent

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. **Minute Approval: May 31, 2023**
   Recommendation: Pass a **Motion** approving the minutes of the May 31, 2023.
   Contact: Dawn Bullwinkel, Consultant Clerk of the Board, dbullwinkel@watsonvillehospital.com

2. **Policies/Policy Summary Approval: June 2023**
   Recommendation: Pass a **Motion** approving the Policies/Policy Summary.
   Contact: Sherri Torres, Chief Nursing Officer, Sherri_StoutTorres@Watsonvillehospital.com

3. **Employee Engagement (EE) Committee Member Appointments**
   Recommendation: Pass a **Motion** approving:1) Senior Executive, Allyson Hauck, Chief Human Resources Officer; 2) Senior Executive, June Ponce, Foundation Executive Director 3) Hospital Director/Manager – Anna Anton, Director of Acute Care; 4) Hospital Director/Manager – Yvonne Combs, Director of Rehab Services; 5) Staff – Elizabeth Smolanovich, Staff Nurse II Telemetry; 6) Staff – Carole Kulik, Nursing Supervisor; 7) Staff/Other – Leticia Suarez, Central Scheduler; 8) Staff/Other –Kelly Strickling, Lead Lab Technician 9) Provider – TBD; and 10) Provider – TBD to serve on the EE Committee.
   Contact: Allyson Hauck, Chief Human Resources Officer

4. **Quality and Patient Safety (QPS) Committee Member Appointments**
   Recommendation: Pass a **Motion** approving Hospital Director/Manager, Tracy Trail-Mahan-Quality and Risk; 2) Hospital Director/Manager, Jennifer Gavin-Director of Pharmacy; 3) Hospital Director/Manager, Sherri Stout-Torre-Chief Nursing Officer; 4) Matko Vranjes-Interim CEO; 5) Provider, Dr. Clay Angel-Chief of Staff and 6) Provider, Dr. Janelle Rasi-Vice Chief of Staff to serve on the QPS Committee.
   Contact: Sherri Stout-Torre-Chief Nursing Officer

5. **Medical Executive Committees Report June 2023**
   Recommendation: Pass a **Motion** approving 1) the Medical Executive Committee (MEC) Report, the Credentials Report and the Interdisciplinary Practice Credentials Report of June 2023 and 2) OPPE templates for Anesthesia Physicians, Pathology Physicians, Emergency Medicine Physicians, Emergency Medicine AHP.
   Contact: Executive Sponsor-Dr. Angel, Chief of Staff, Medical Executive Committee

Discussion

6. **Chief Executive Officer Matko Vranjes Oral Report on Operational Hospital Activities**
   Recommendation: Receive and file.
   Contact: Matko Vranjes, Chief Executive Officer

7. **Chief Financial Officer Monthly Financial Performance**
   Recommendation: Receive and file.
   Contact: Julie Peterson, Chief Financial Officer

8. **Nurse Staffing Levels Update**
   Recommendation: Receive and file.
   Contact: Allyson Hauck, Chief Human Resources Officer

9. **Pipeline Rx Agreement Amendment**
   Recommendation: Pass a **Motion** approving the First Amendment to the Master License and Service Agreement with Pipeline Health Holdings LLC ("Pipeline Rx").
   Contact: Matko Vranjes, Interim Chief Executive Officer

10. **Philips Picture Archival and Communications System (PACS) Service Agreement for Medical Imaging Technology**
    Recommendation: Pass a **Motion** approving the renewal of the PACS service agreement with Philips Healthcare for medical imaging technology with the inclusion of the standard agreement termination language.
    Contact: Sergio Nell-IT Director

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.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023
Report Type: Consent

Title: Minutes Approval: May 31, 2023

Recommendation: Pass a Motion approving the minutes for May 31, 2023

Contact: Dawn Bullwinkel, Consultant Board Clerk

Analysis

After each Board meeting, the Board Clerk composes the DRAFT minutes noting the action taken by the board. Those DRAFT minutes are presented to the Board Members for their approval as a permanent record of the meeting actions.

Financial Impact: None

Attachments:

A. May 31, 2023-Closed
B. May 31,2023-Regular

Pajaro Valley Health Care District Hospital Corporation
Closed Session Meeting Minutes- Wednesday, May 31, 2023

Call to Order at 5:02 pm.

Roll Call:
Present: Directors Cox, Nunez, Pimentel and Chair Friel
Absent: Director Gallagher

Agenda Modification Consideration-None

Public Comment on Matters on the Agenda

a) CEO Recruitment in support of Matko Vranjes leadership:
   i. Jennifer Ura Gavin
   ii. Eddie Wade
   iii. Robin Cosby

Adjourn to Closed Session

1. **Conference with Labor Negotiators** (Government Code 54957.6)
   Agency Negotiator: Allyson Hauck; California Nurses Association (CNA)
   Contact: Allyson Hauck, Chief Human Resources Officer

2. **Public Employee Recruitment Update** (Government Code 54957(b)(1))
   Conference with Labor Negotiators (Gov't Code 54957.6)
   Title: Chief Executive Officer
   Contact: Allyson Hauck, Chief Human Resources Officer

3. **Hearings/Reports** (Health and Safety Code HSC § 1461 and 32155)
   Reports of Patient Safety and Quality Committee, Medical Staff Credentials Committee, Medical Staff Interdisciplinary Practice Committee and Quality Dashboard.
   Contact: Executive Sponsor-Dr. Angel, Chief of Staff

Adjourned to Close Session: 5:12 pm.

Pajaro Valley Health Care District Hospital Corporation
Regular Meeting Minutes - Wednesday, May 31, 2023

Call to Order at 5:43 pm.

Roll Call:
Present: Directors Cox, Nunez, Pimentel and Chair Friel
Absent: Director Gallagher

Closed Session Report: None

Agenda Modification Consideration:
Moved/Seconded: Pimentel/Nunez
Yes: Directors Cox, Nunez, Pimentel and Chair Friel
Absent: Gallagher

Action: Reorder the discussion calendar to have item 5: Line of Credit heard as the last item.

Public Comment on Matters Not on the Agenda: None

Comments from Board Members-None

Consent

All items listed under the Consent Calendar are considered and acted upon by one Motion.

Moved/Seconded: Pimentel/Cox
Yes: Directors Cox, Nunez, Pimentel and Chair Friel
Absent: Gallagher

1. **Minute Approval: April 26, 2023**
   Action: Passed **Motion No. 29-2023** approving the minutes of the April 26, 2023.
   Contact: Dawn Bullwinkel, Consultant Clerk of the Board, dbullwinkel@watsonvillehospital.com

2. **Policies/Policy Summary Approval: May 2023**
   Action: Passed **Motion No. 30-2023** approving the Policies/Policy Summary except for the Peer Review Policy to be heard at a future date.
   Contact: Sherri Torres, Chief Nursing Officer, Sherri_StoutTorres@Watsonvillehospital.com

Discussion

3. **Chief Executive Officer Matko Vranjes Oral Report on Operational Hospital Activities**
   Action: Received and filed.
   Contact: Matko Vranjes, Chief Executive Officer

4. **Chief Financial Officer Monthly Financial Performance**
   Action: Received and filed.
   Contact: Julie Peterson, Chief Financial Officer

5. **Line of Credit**
   Director Cox recused herself at 6:25 pm.
   Action: Received information regarding $5,000,000 Commercial Revolving Line of Credit, secured by external agency(s) funding presenting the opportunity for the Pajaro Valley Health Care District Hospital Corporation Board of Directors to provide the Hospital with short-term working capital.
   Contact: Julie Peterson, Chief Financial Officer

6. **Medical Executive Committees Reports Report May 2023**
   Moved/Seconded: Nunez/Cox
   Yes: Directors Cox, Nunez, Pimentel and Chair Friel
   Absent: Gallagher

   Action: Passed **Motion 031-2023** approving 1) the Medical Executive Committee (MEC) Report, the Credentials Report and the Interdisciplinary Practice Credentials Report of May 2023.
   Contact: Executive Sponsor-Dr. Angel, Chief of Staff, Medical Executive Committee

Adjourn at 6:36 pm.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023
Report Type: Consent

Title: Policy/Summaries June 2023

Recommendation: Pass a **Motion** approving the Policies and Summary Report of June 2023.

Contact: Sherri Torres, Chief Nursing Officer, Sherri_StoutTorres@Watsonvillehospital.com

Analysis
As required under Title, 22, CMS and The Joint Commission (TJC), a list of regulatory required policies with a summary of changes are provided for your approval.

Financial Impact: None.

Attachment A:
Reports

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

POLICY APPROVAL SUMMARY REPORT

Committee: BOD

Reporting Period: June 28, 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
Infection Prevention				
Infection Prevention & Control Plan 2023	IPC2020	The changes were primarily grammatical and not related of the report	Regulary Scheduled Review	Author: IP Director 05/2023 CNO:05/2023 PTIC: 05/2023 QPSC:05/17/2023 PTIC: 05/2023 VP/Sr. Leader/CEO: MEC: 06/20/2023 BOD:
NURSING (NUR)				
Color-Coded Wristbands	NURXXXX	New policy, Colored codedwrist band policy-New policy allows standard arm bands	New Policy	Author: Chief Nursing Officer/ED 04/2023 QPSC: 05/17/2023 CNO:05/2023 VP/Sr. Leaders/CEO: MEC: 06/20/2023 BOD:
Fall Prevention	NUR1681	Updates to current policy, update post-fall documentation and ensure MD, Family notification, references new Post Fall Toolkit in WCH intranet	Regulary Scheduled Review	Author: Nursing ADM QPSC: 05/17/2023 CNO: 05/2023 VP/Sr. Leader/CEO: MEC: 06/20/2023 BOT:
Emergency Department (ED)				

WATSONVILLE COMMUNITY HOSPITAL

Watsonville Community Hospital

POLICY APPROVAL SUMMARY REPORT

Committee: BOD

Reporting Period: June 28, 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
Hand-Held Metal Detectors for Use in Concealed Weapon and Contraband Detection	NURXXXX	NEW Policy: This is a new policy to enhance the safety of staff and patients ED has acquired a metal detector. The metal detector will allow for scanning of patients and belongings for hidden sharps or weapons.	New Policy	Author: ED Director 04/19/2023 CNO: 04/2023 QPSC: 05/17/2023 VP/Sr/Leader/CEO: MEC: 06/20/2023 BOD:
Puncture Resistant Glove Use in Concealed Weapon and Contraband Detection	NURXXXX	New Policy:	New Policy	Author: ED Director 04/19/2023 CNO: 04/2023 QPSC: 05/17/2023 VP/Sr/Leader/CEO: MEC: 06/20/2023 BOD:
Rehabilitiation (REHAB)				
Care Process	REHAB1925	No Changes	Regulary Scheduled Review	Author: Rehabilitation Director 04/2023 CNO: 04/2023 QPSC: 05/17/2023 VP/Sr. Leader/CEO: 06/19/2023 MEC: 06/20/2023 BOD:
Medical Staff (MS)				
Medical Staff Policy Regarding Peer Review, Ongoing Professional Practice Evaluation (OPPE & (FPPE)	MS2842	Remove language on sharing external peer review reports and replace with wording that meets and protects confidentiality.	Updated to maintain compliance with California Evidence Code Section 1157	Author: Medical Staff MEC: 5/16/2023 BOD:

Infection Prevention & Control Plan 2023

2022 Analysis
2023 Performance Improvement Plan

Prepared By: Gloria Przelenski, Director of Infection Prevention & Control	
Reviewed By: Tracy Trail-Mahan, Directory, Quality & Safety Sherri StoutTorres, Chief Nursing Officer Li Kong, MD, Infectious Disease Lead	
Approved By: Infection Prevention & Control Committee	

Table of Contents

Abbreviations

CDPH	California Department of Public Health
CIC	Certification in Infection Control
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
HAI	Healthcare Associated Infections
IP	Infection Preventionist
IP&C	Infection Prevention & Control
IP&CC	Infection Prevention & Control Committee
IP&CP	Infection Prevention & Control Program
NHSN	National Healthcare Safety Network
OPIM	Other Potentially Infectious Material
PVHDP	Pajaro Valley Healthcare District Project (PVHDP)
WCH	Watsonville Community Hospital

Section 1

Infection Prevention and Control Program Executive Summary

PANDEMIC YEAR 2022:

SARS-CoV-2 and new Emerging Infectious Communicable Disease (Monkeypox):

Synopsis of Year's Highlights:

COVID Pandemic 2022

COVID continued to be prevalent in 2022

CDPH requirements relative to COVID began to lessen in 2022:

1) Updates to COVID vaccination and what CDPH considered up-to-date vaccination (i.e., vaccinations that were required).
2) 12/29/2021, new cases in the U.S. soared to the highest level on record and was driven largely by the contagious COVID Omicron variant.
3) 03/09/2022 the 7-day positivity rate in California for the first time decreased to 1.8%; this was after setting records in January, 2022, for positivity rates that were 21.4%, 21.3% and 20.4%.
4) 05/13/2022, the California death toll from COVID was at 90,000
5) 06/21/2022 Vaccines for babies and children less than 5 years of age
6) 06/18/2022 The CDC opened vaccinations for children as young as 6 months
7) 07/06/2022 California topped 9.5 M Coronavirus cases
8) 09/01/2022 CDC signed off on the new Booster shot that targeted the Omicron variant, as well as the original SARS-CoV-2 virus.
9) 09/02/2022 The government ended its program for free coronavirus tests after funding was no longer available, and after distributing more than 600 M tests.
10) 9/2022: Testing of employees was limited to outbreaks; prior to this guidance, no staff could enter WCH without having their temperature checked.
    a) At WCH there was one outbreak in our Medical/Surgical Unit. It was tracked down to a patient who had tested negative upon admission and then tested positive after reviewing information from staff. This outbreak was attributed to the patient and no other outbreaks in this unit occurred. Testing of employees prior to each shift was conducted and stopped once we had no staff member testing positive. As required, the IP communicated with Santa Cruz County Public Health Department. The County gave the approval when the outbreak was considered to be cleared.
11) 10/12/2022 The FDA authorized and the CDC signed off on the updated COVID booster vaccination for children as young as 5 years old.
12) 10/17/2022 The State of Emergency enacted in California for the pandemic was designated to end 2/28/2023, this had been in place since 3/14/2020.
13) In the fall of 2022, Omicron BA.5 was the variant that was most prominent in California.
14) Requirements in the State of California for visitors changed (in particular, face covering), within the community, however, visitors and healthcare workers in Acute Care Hospitals masking remain unchanged.

15) Monkeypox was the latest emerging infectious communicable disease that arrived in the U.S. around June and July, 2022. CDPH prioritized the inventory of vaccines (JYNNEOS) smallpox and Mpox vaccine. CDPH recommended 2nd doses at 28 day interval. Six patients were tested during a visit to our Emergency Department with only two positive through Santa Clara Public Health Department Laboratory.

Healthcare Associated Infections (HAI's) SUMMARY:

All mandated HAI reportables (C. diff, CLABSI, CAUTI, MRSA, SSI) are Compared to other hospitals of WCH's demographics nationwide. The rating is based upon the Sandardized Infection Raio (SIR). The SIR is a summary measure used to track HAIs nationwide based upon aggregate data from specific timeline (i.e., we are currently measuring data based upon the 2015 Rebaseline Data). It adjusts for various facility and or patient level factors that contribute to an HAI risk within each facility.

Standardized Infection Ratio (SIR)
Currently using the 2015 Rebaseline Data

1) **SIR of 1.000 would make WCH comparable to all hospitals our size throughout the U.S.**
2) **SIR Above 1.000 would make WCH perform worse and**
3) **SIR Below 1.000 would have WCH performing better than all average best performers of hospitals our size nationwide. The calculations are tabulated by using the CDC's 2015 Baseline Data.**
4) **SIR Nationwide goal is 1.0 or less.**

HAND Hygiene **not rated under NHSN: This is the goal both Nursing and Leadership management agreed upon to obtain Leapfrog's Letter Grade A for best performance.**

(Met Goal) All units met their Total Number of Hand Hygiene Opportunities to be considered for the Letter "Grade A" from Leapfrog for the last 6 months of 2022.

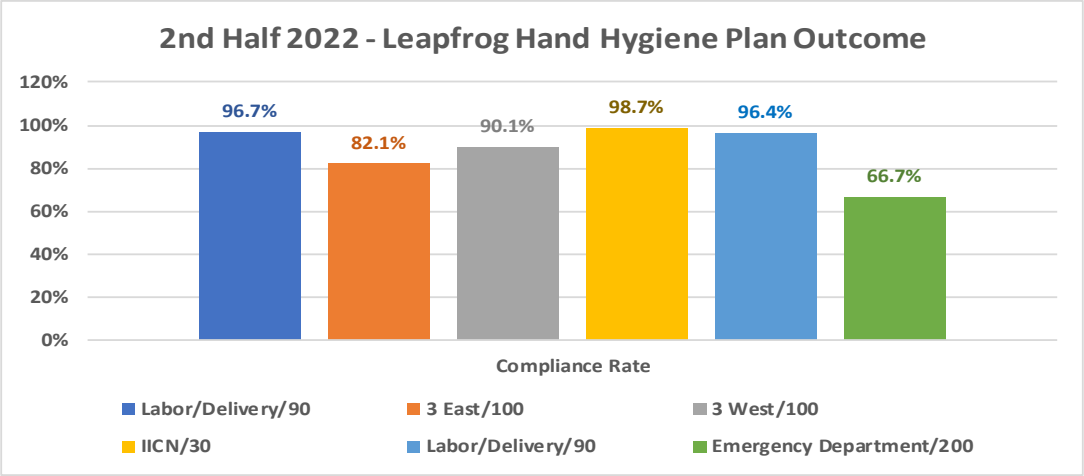
A hand hygiene business plan was written, approved, and implemented in 2022. The Hand Hygiene Business Plan draft was presented to Management and Leadership for approval. The goal was to achieve a letter grade A from Leapfrog. The plan was approved in January, 2022. The plan did not officially begin until March of 2022. During the 2nd half of 2022, all units met the total number of hand hygiene opportunities observed to meet their goal. All units met their goal established through Leapfrog's Hand Hygiene calculations dependent upon patient days in a unit and/or number of patient's seen (such as ED).

During the time period following the Hand Hygiene Business Plan approved in 2022:

1) There were a total of 5,540 hand hygiene opportunities observed utilizing the 2022 approved business plan for hand hygiene opportunities. In previous years, the total number of hand hygiene observations was less than 1,000.

2) Overall, the Hand Hygiene cumulative compliance rate facility-wide since March, 2022, was 79.4%
3) CCU had the highest hand hygiene compliance rate at 96.7%, whereas the Emergency Department had the lowest hand hygiene compliance rate at 66.7%
4) Hand Hygiene is observed 24-hours day on all shifts
5) Each unit is responsible for collecting their own unit's hand hygiene observations. Primarily, the audit tool application "Speedy Audit" is used for collection and recording hand hygiene audits. Once completed the spreadsheet from Speedy Audit is submitted to the Infection Preventionist. Some are also collected from a paper audit form.
6) There have been Champions for hand hygiene from other departments (Facilities, Education, Infection Prevention & Control, and Managers of smaller units helping other larger units reach their goal. All worked from a collaborative approach to help meet WCH's hand hygiene performance goals for 2022.)
7) Hand Hygiene was observed primarily for appropriate washing or rubbing prior to entry to a room/zone and/or immediately after exiting a patient's room/zone. Entry into a room is one opportunity, exiting a room is a separate opportunity.
8) Hand Hygiene is considered the #1 prevention measure for prevention of Healthcare Associated Infection, and in particular multi-drug resistant organisms (MDROs).

Leapfrog Data – 2nd Half of 2022 Compliance Rates



Total # HH Oppr/Month 2nd Half 2022 Leapfrog Submission Report	Compliance Rate
Labor/Delivery/90	96.7%
3 East/100	82.1%
3 West/100	90.1%
IICN/30	98.7%
Labor/Delivery/90	96.4%
Emergency Department/200	66.7%

HEALTHCARE ASSOCIATED INFECTIONS (HAIs):

Reportable to National Healthcare Safety Network (NHSN)
California (CDPH) and CMS mandated

CDC reported on the 2020 Annual National and State Healthcare-Associated Infections (HAI) Progress Report for select HAIs (from nationwide hospital data submitted to the National Healthcare Safety Network (NHSN). The report compared reportable data results on healthcare associated infections from 2019 through 2020. This review was done to determine the impact of the coronavirus disease (COVID-19) pandemic on HAI reporting. This was published in the Infection Control & Hospital Epidemiology journal in September, 2021. The results from those published results have set a nationwide goal (from CMS) for all hospitals to re-establish performance improvement measures back to previous ratios so that all hospitals nationwide go back to the improvement established during the pre-pandemic years.

The comparison study showed significant increases among hospitals nationwide. Standardized Infection Ratios (SIRS) for CLABSI, CAUTI, VAE, and MRSA bacteremia were reportedly higher in 2020. The largest increase was observed for CLABSI with significant increases in VAE incidence and ventilator utilization were seen across all four quarters of 2020.

Watsonville Community Hospital HAI hospital Comparison to the CDC report of September, 2021

Clostridioides difficile (C. diff)

(Did not Meet GOAL) WCH increased from the previous year rather than decreasing the Ratio and total number of HAI per quarter.

(2021 SIR = 1.565) and increased in (2022 SIR = 1.623

For WCH, Clostridioides difficile (C. diff) has been an ongoing issue. A multidisciplinary, collaborative group meets monthly to review trends from C. diff laboratory results. The group includes participants from Infection Prevention & Control (includes Infectious Disease Physician and Infection Preventionist), Pharmacist, Laboratory Director, Microbiologist, Quality & Safety Director and Medical Surgical Manager. The group has identified collection problems, as well as a confusing number of order sets established within WCH's EMR that physician's use.

Prior prevention measures were already in place and continue:

1) nurse driven protocols to facilitate rapid isolation of patients (no issues);
2) patient to remain on isolation precautions until discharge (no issues);

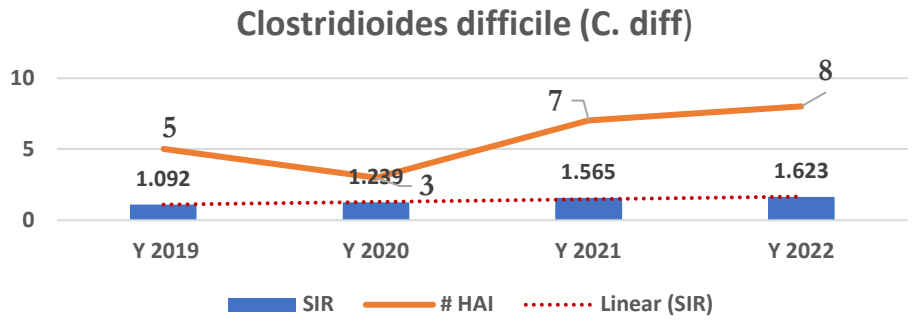
3) recommended hand hygiene practices (soap and water after caring for a C. diff patient) (no issues);
4) intradepartmental communication to other units and/or outside facilities when patient is transferred for testing or new location (nothing glaring but could use some improvement work), and.
5) terminal clean of patient rooms after discharge (no issues).
6) testing of C. diff specimen (needs improvement)
7) collection of specimen (needs improvement)
8) use of Bristol Stool Chart (needs to be implemented

Please see WCH's C. diff HAI chart below which outlines the Standardized Infection Ratio (SIR) beginning with year 2019. The team's main goal is to decrease the total number of C. diff HAIs through nursing and physician collaboration. Not only did the C. diff SIR increase, but the total number of HAIs also increased in each quarter of 2022. 1st Qtr = 5; 2nd Qtr decreased to 3, 3rd Qtr. increased to 7, and 4th Qtr. increased to 8. Work needs to be done to meet the definition of stool samples as noted by the experts. The biggest problem facing C. diff today is the colonization that has been identified and noted below, whereby patients are asymptomatic, but have diarrhea and can test positive for C. diff. This creates problems when treating colonization with antibiotics.

A C. diff HAI is defined as diarrhea that was collected from a symptomatic patient who had three or greater loose stools in a 24-hour period on or after the patient's fourth hospital day (with day one being the day of admission). WCH has a trending for stool collection happening on the patient's 4th day; as noted by the IP's review of each of the patient's chart, it was noted that each of these patients were Community Onset (CO) as opposed to an HAI, however, the CDC only categorizes C. diff HAI by admission date and collection date only. Work continues to be needed in this area.

Currently, literature has shown that high rates of C. diff colonization (asymptomatic) is now prevalent in hospitalized patients. Over-testing among patients without signs and symptoms of C. diff infection can lead to false positive results.

From the literature: it is advised to only test patients who are symptomatic with 1) greater than or equal to 3 loose stools within a 24-hour period and 2) who have not been exposed to laxatives within 48 hours. The literature advises against retesting within 7 days of a negative test as it is usually not clinically indicated, and do not test for cure. The graph below shows the data for WCH only. Our SIR increased from 2021 from 1.565 to 1.623 in 2022.



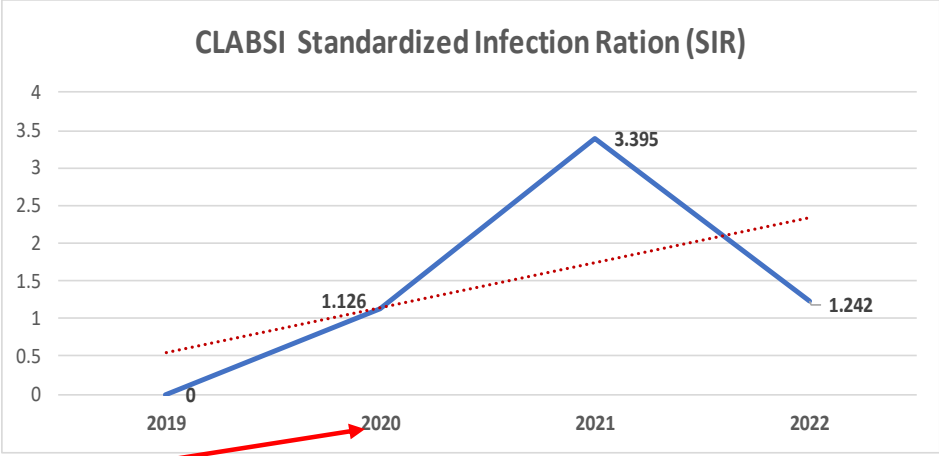
Central Line Associated Bloodstream Infection (CLABSI)

(MET an Improvement GOAL) decreased SIR from previous year, but still not comparable to NHSN goal of a SIR of 1.

(2021 SIR = 3.395) and decreased in (2022 SIR = 1.242)

1) In 2021, CLABSI SIR was 3.395 (height of the COVID pandemic) and decreased to 1.242 in 2021. A dramatic decrease and some of it is due to the decrease in the total number of patients in our Intensive Care Unit no longer requiring ventilation and central lines, in combination with shorter length of stays.
2) Reviewed and revised Prevention of Central Line Associated Bloodstream Infection policy with the collaboration of the Intensive Care Unit Nurses and nursing management on the policy and standards known to prevent CLABSI.
3) The graph below outlines the dramatic CLABSI SIR rate that began during the initial phase of COVID and spiked in 20222.
4) During the COVID pandemic our Standardized Utilization Ratio (SUR) of both foley usage and central lines increased. This increased our risk for CLABSIs and CAUTIs. The increase was as the result of an increased number of critical patients due to COVID in the Intensive Care Unit and on the Medical Surgical Unit with higher risks from illness acuity.

Central Line Associated Bloodstream Infection (CLABSI) and Standardized Infection Ratio



Coronavirus (SARS-CoV-2), the cause of COVID-19, a fatal disease emerged from Wuhan, a large city in the Chinese province of Hubei in December, 2019. The first confirmed case in the USA was January 18, 2020, taken from samples in Washington State. On that same day, the CDC activated its Emergency Operations Center (EOC) to respond to the emerging outbreaks. It was during this time that Watsonville Community Hospital activated it COVID Task Force. All hospitals nationwide have had an increase in their healthcare associated infection ratios following the pandemic. All governmental agencies have pushed for all hospitals to get back to pre-pandemic levels.

Central Line Associated Bloodstream Infection CLABSI Standardized Infection Ratio (SIR) and Standardized Utilization Ratio (SUR)					
Year	# HAIs	Unit	Predicted	SIR	SUR
2019	0	N/A	0.981	0.000	18.534
2020	1	CCU	0.888	1.126	17.215
2021	4	CCU	1.177	3.398	1.190
2022	1	CCU	0.805	1.242	1.031

The boxes in red show where on a yearly basis WCH failed to meet the SIR of 1, which meant that we had more HAIs than predicted from CDC's 2015 Rebaseline Data. The good news with both SIR and SUR is that we are trending downward and that needs to continue on into 2023 and beyond.

The Standardized Utilization Ratio is the SUR assigned to the number of days for invasive device usage on patients (primarily central line and foley catheters). The Standard is for all hospitals to have a nurse driven protocol whereby the nurse has a daily discussion with the physician on the continued need for an invasive line. Continuation of any invasive line increases the patient's risk for an infection.

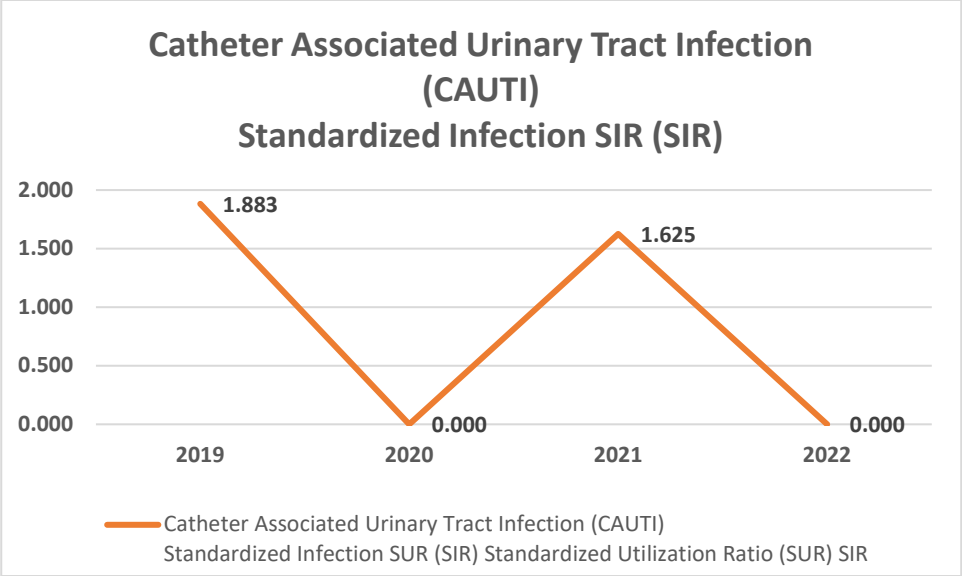
Catheter-Associated Urinary Tract Infection (CAUTI)

(MET GOAL) by decreasing the SIR in 2022 from the SIR of 2021

2021 SIR = 1.625 2022 SIR = 0.000

1) WCH has vacillated from year to year with CAUTIs. 2 CAUTI HAIs in 2019, 0 HAIs in 2020; 2 in 2021, and 0 HAIs for 2022. Most of the CAUTIs are in the Medical/Surgical Unit.
2) There were no HAI CAUTIs in 2022 as compared to 2021. The SIR in 2021 was 1.625 with a SUR below 1.0 (0.779). This was an improvement from the previous year, but sustainability and consistency in our Standard of Care must be improved.
3) Both SUR and SIR ratios for foley catheters must be improve and sustained.

Catheter Associated Urinary Tract Infection (CAUTI) Standardized Infection SUR (SIR) Standardized Utilization Ratio (SUR)			
Year	# HAI	SIR	SUR
2019	2	1.883	1.026
2020	0	0.000	1.413
2021	2	1.625	0.779
2022	0	0.000	0.627



Methicillin-resistant Bloodstream Infection (MRSA)
(Did Not Meet Goal in 2022)

1) WCH had one MRSA BSI which calculated to a SIR of 1.992. for all other years 2019, 2020, and 2021 there were no MRSA BSIs.
2) This was one of the first multi-drug resistant organisms that CDPH mandated all California hospitals with guidance to decrease the numbers of MRSA HAIs and prevent transmission of colonization among patients.
3) With the onset of the COVID pandemic, higher level MDROs have surfaced and currently all hospitals in the State of California are monitoring for Carbapenem-resistant Enterobacters, as well as Candida auris.

MRSA Bloodstream Infection HAI	
Year	**SIR**
2019	**0.000**
2020	**0.000**
2021	**0.000**
2022	**1.992**

Surgical Site Infections
(MET GOAL)

1) Both Adult Complex and Pediatric Complex procedures met goal.
2) There were several cases that were NOT calculated in the SIR, however, there are exceptions when a procedure falls out of the infection range as there could have been an infection already related to the case prior to the start of surgery. If a surgical case has an infectious process prior to the operation then it is based upon a higher risk rate for infection and is rated at a much higher risk level.
3) WCH was working on the risk factor of the Wound Classification in 2020 and 2021. There has been an improvement with identifying and classifying wound classifications to be more in alignment with the definitions of NHSN. There is now a process whereby the physician and nursing staff have a timeout at the end of the case to review the wound classification to ensure the correct assignment has been made.
4) Prior to the current Anesthesiologists, there were many times when the height and weight in previous years were not recorded. Many of these procedures did not make it into the calculations as the case patient's height/weight are two of the risk factors calculated into the risk of the procedure. Since there has been a change in the Anesthesiology group, there has been an improvement in the height/weight designation, thereby fewer cases are not being dropped by NHSN.
5) There were no SSIs in 2021, **met goal with a "0" SIR**
6) There was a decrease in SSIs from 2018, and 2020
7) There were fewer procedures compared to 2018, however, we were in the Pandemic from 2020 onward; and elective services were initially stopped and then hospitals gradually opened the surgical arena, but with specific requirement (testing) prior to procedures to identify any possible instances which could impact an outbreak for both patients and staff.

Standardized Infection Ratio (SIR) Surgical Site Infections (SSI) Adult Complex Procedures				
Year	**# Procedures**	**# Infections**	**Procedures with Infections**	**SIR**
2019	434	3	Laminectomy (SIP) Exploratory Lap (2) (SIP x's 2) Colon (IAB) Appy (DIP)	0.630
2020	275	2	C. Section (SIP) Colon (2) (SIP	0.726
2021	309	0	0	0
2022	133	0	Appy (DIP) Colon (IAB)	0

Standardized Infection Ratio (SIR) Surgical Site Infections (SSI) Pediatric Complex Procedures				
Year	**# Procedures**	**# Infections**	**Procedures with Infections**	
2019	41	1		
2020	24	0	0.000	
2021	29	0	0.000	
2022	14	0	0.000	

Under adult complex above for the year 2022. It does show that we identified 2 SSIs, however, since both of these cases had an infectious process internally prior to surgery, both of the cases were listed on the exempt list.

A. Overview

Key Terms

- **Hazard** is any source of potential damage, harm, or other adverse health effects on something or someone (e.g., patients, HCWs, or community members visiting the health care facility) under certain conditions. For example, blood and body fluids are hazards that can cause infection from bloodborne pathogens (the harm) or insertion of a urinary catheter without following recommended aseptic precautions is a hazard that can cause urinary tract infections (the harm). In general, the types of hazards include: biological, chemical, ergonomic, physical, and safety.

- **Hazard identification** is a process of finding, listing, and characterizing hazards.

- **Infection Prevention and Control Committee (IP&CC)** is a formally established, multidisciplinary group of healthcare facility staff appointed to oversee implementation of the Infection Prevention & Control Program (IP&CP) according to the national Infection Prevention & Control (IP&C) policy and guidelines to minimize the risk of infections for patients and employees.

- **Infection Prevention and Control (IP&C) task force** is a temporary group of healthcare facility staff created under one leader for the purpose of accomplishing a definitive objective, e.g., improve compliance with hand hygiene, or improve the quality of instrument processing at the hospital.

- **Infection Preventionist (IP)** is a professional who makes sure healthcare workers and patients are doing all the things they should to prevent infections. Most IPs are nurses, epidemiologists, public health professionals, microbiologists, doctors, or other health professional who work to prevent germs from spreading within healthcare facilities. They look for patterns of infection within the facility; observe practices; educate healthcare teams; advise hospital leaders and other professionals; compile infection data; develop policies and procedures; and coordinate with local and national public health agencies.

- **Risk** is the chance or probability that a person will be harmed or experience an adverse health effect if exposed to a hazard. For example, if blood and body fluids are the hazard and infection with bloodborne pathogens is the harm, the chance of harm occurring is the risk.

- **Risk assessment**, from the IP&C perspective, is the process of identifying infection hazards, and
    - analyzing and evaluating the risk associated with these hazards with the goal of determining
    - appropriate ways to eliminate or control them. Risk assessment for IP&C is conducted periodically and allows the IP&C team to make decisions regarding the focus of the IP&C program at the health care facility.

- **Quality** is the degree to which health services increase the likelihood of desired health outcomes for individuals and populations and are consistent with current knowledge. In simpler terms, it means, at all times, providing patient care according to the standards of care. According to the Institute of Medicine (1999), high-quality health care is safe, effective, patient centered, timely, efficient, and equitable.

Program Policy

The Leadership at Watsonville Community Hospital (WCH) supports an Infection Prevention & Control Program **(IP&CP)** designed to ensure the safety of patients, visitors, and all healthcare workers within its environment by:

1) Reducing the risks of patients acquiring a healthcare-associated infection (HAI) through evidence-based prevention strategies.
2) Focusing on the safety of WCH staff and other healthcare workers at WCH utilizing State and National programs like the Federal Ryan White HIV/AIRDS Program Legislation.
3) Emphasizing the importance of early identification for prevention measures to prevent exposures from communicable diseases, as soon as possible. (i.e., infections that could possibly be brought into the hospital environment by visitors either through the Emergency Department and or main entrance to the hospital). By following the Centers for Disease Control's **(CDC)**. Standard Precautions, prevention measures have been implemented with a Respiratory Hygiene / Cough Etiquette protocol to everyone who enters the facility.
4) Implementation of prevention bundles and performance improvement initiatives based upon published standard guidelines from:

(CDC)	Centers for Disease Control and other professional societies
(APIC)	Association for Professionals in Infection Control,
(IDSA)	Infectious Disease Society of America,
(AORN)	Association of Operating Room Nurses,
(AAMI)	Association for the Advancement of Medical Instrumentation;
(TJC)	The Joint Commission.

The Infection Prevention & Control (**IP&C**) Program maintains a culture of safety that promotes zero tolerance for both the occurrence of preventable HAIs and for noncompliance with established IP&C practices. The IP&C plan is updated, reviewed, and approved at least annually by the Infection Prevention & Control Committee **(IP&CC)**, Infectious Disease physician and the Infection Preventionist to maintain consistency with new recommendations and changes within the institution.

Program Authority

The IP&CP has the authority to institute any surveillance or prevention and control measures, when there is reason to believe that others may be at risk of contracting or transmitting an infectious communicable disease within the hospital environment. This authority and responsibility include:

- Develop and implement a preventive and corrective program(s) designed to minimize infection hazards,
- Review and approve all policies and procedures related to infection surveillance, prevention, and control activities in all departments/services,
- Collaborate with the organization leadership to institute emergency measures to prevent infections such as closure of units, transfer of patients, halting construction, and other measures,
- Promote the application of organizational and departmental policies relating to infection prevention and control involving, but not limited to, isolation procedures and techniques, sterilization procedures, prevention of cross-infection through equipment use, and the safe disposal of biohazardous or contaminated wastes,
- Provide proposals and information that facilitate general infection prevention & control program activities defined by program components and specific activities that support disease prevention, data collection, and reporting.

Program Scope

This plan is implemented to protect all Watsonville Hospital patients (inpatients and outpatients), employees, and visitors, including medical staff and allied health affiliates. This plan is an organization-wide plan that interfaces with all departments and services of the organization and all national and state regulatory agencies concerning infection prevention & control.

The IP&C Program at Watsonville Community Hospital is based upon the facility's problems or needs, prioritizing activities, and using available resources effectively. Resources are always limited, so careful planning, implementation, and evaluation of IP&C activities are essential, whether in the outpatient clinics or the acute care units. An IP&C program is not only the most cost-effective prevention option, but also the best strategy available to protect patients.

Structure and Authority

1. Multi-disciplinary voting members that comprise the Infection Prevention & Control Committee **(IP&CC)**,
2. Medical director or lead Infectious Disease physician, and
3. Director of Infection Prevention & Control

The Committee is responsible for overview of the program and makes recommendations to the Medical Staff and other hospital committees on infection control issues. The Committee is comprised of representatives from the medical staff, administrative representatives, and appropriate hospital departmental leadership. The IP&CC meets at least quarterly or as often as necessary and has the responsibility to approve Infection Prevention Program Policies and Procedures.

The Committee Chairperson is responsible for presiding over the Committee.
The Infectious Disease medical leader guides the group with knowledge and expertise in the area(s) of clinical microbiology, infectious diseases, infection control, or epidemiology.

Lead Infection Prevention & Control Professional

The IP&C professional consists of a trained infection preventionist who engages and educates staff in all areas to prevent healthcare-associated infections (HAI) or transmission of communicable diseases within the hospital and/or community and serves as the infection control lead for emergency preparedness. Primary responsibility for the activities of the infection prevention program belongs to the Infection Preventionist. The Infection Preventionist reports to the Director of Quality & Safety. The Director of Infection Prevention & Control has advanced training in healthcare infection prevention and control, including knowledge of prevention, surveillance, and epidemiologic methods. The standard of knowledge required is reflected by the designation of the Director's Certification in Infection Control (CIC) status. Staffing level for infection prevention professionals are within the boundaries to ensure adequate resources are available for the program consistent with regulatory requirements and professional society guidelines.

Continuing education in Infection Control is required and supported by leadership at WCH. This includes active participation through the Association of Professionals in Infection Control (APIC) at the state, regional and national levels, as well as participation in other related organizations that promote infectious disease prevention & education. Currently, the IP has certificates for APIC 101, 102, and the Advanced infection prevention series.

The Infection Preventionist provides general infection prevention & control orientation for all newly hired staff. Other infection control education (especially, Just in Time education) is conducted when necessary. All employees who work in the direct care of patients and could incur potential exposure to "other potentially infectious material" (OPIM) are targeted annually for competency education. In addition, staff members who are part of the Tuberculosis **(TB)** screening program receive information on tuberculosis annually. The IP Professional provides "just in time" spontaneous training and other prepared education in various formats as needed throughout all department settings.

Medical Lead for Infectious Diseases

The medical lead for the IP&CP is a physician with training in hospital epidemiology and infection prevention & control as demonstrated by completion of a fellowship in Infectious Diseases with either additional work experience in Hospital Epidemiology and that person's completion of the SHEA/CDC Course in Healthcare Epidemiology. The medical lead for the IP&CP provides consultative expertise.

IP&C Risk Assessment

A risk assessment is performed to identify key internal and external infection vulnerabilities that can inhibit efforts to prevent and control infections throughout the organization. This risk assessment evaluates possible infectious risks specific to Watsonville Hospital and its community. It helps to establish infection prevention priorities, goals, and objectives. The Infection Preventionist and Infectious Diseases Medical Lead with input from the IP&CC members assess risks on an ongoing basis either through trending that might occur through the Laboratory and/or alerts received from CDC and/or CDPH. There is a re-evaluation of the risk assessment document annually and as needed.

Patients may be susceptible to infections due to their immune status, underlying disease, procedures performed, or treatments given. A very complex mix of patients is seen within WCH. All departments within the hospital that have an impact on patient or employee IP&C issues are included in the IP&CP. This includes Food & Nutrition Service, Environmental Services, all patient care sites, diagnostic, surgical & treatment areas, and environment of care.

Evaluation of Effectiveness

The IP&CC evaluates the effectiveness of the infection control interventions and, as necessary, redesigns the infection prevention and control interventions throughout the year as needed. This evaluation and revision:

- Occurs formally (at least annually) and whenever risks significantly change before the annual review,
- Addresses changes in the scope of the IP&C program, such as new services or new sites,
- Addresses new risks to be added to the Risk Assessment,
- Addresses emerging and re-emerging healthcare issues in the community,
- Assesses the success or failure of the interventions for preventing and controlling infection, and
- Whenever changes are made to currently acceptable practice standards.

Reporting Structure:

The Director of IP&CP provides information regarding its program and activities to Hospital Administration, Leadership Team, and Risk and Quality Management on a regular basis. Appropriate reports of surveillance data are sent to the department directors to share with staff. IP&CC minutes and reports go to Quality & Safety Committee and then to the Infection Preventionist consults regularly with the Infectious Diseases Medical Lead and engages with staff and managers in all clinical and non-clinical departments, as well as to the Nursing Division Directors.

Goals and Functions

To have an effective infection prevention & control program, healthcare administrators, directors, managers, and staff at all levels must be committed to support recommended IP&C guidelines. The IP&C practices follow all evidence-based guidelines for the prevention and control of infectious and communicable diseases.

The two primary goals for the IP&C program are to:

1. Protect patients, healthcare workers, visitors, and others in the healthcare environment, and
2. Achieve this protection in the most cost-effective manner within the constraints of available resources, while at the same time following all latest Infection Prevention standards of practice.

The primary objective of the IP&CP is to protect patients by reducing the risk of acquiring healthcare-associated infections (HAI). The activities involved to achieve this goal can be divided into three main functions:

1. Prevention,
2. Surveillance, and 3)Control.

Resources

1. Sentri7 Infection Prevention and Antimicrobial Stewardship application
2. Computer with various processing tools (Microsoft Powerpoint, Excel, and Word)
3. Collaboration with Microbiology, Laboratory, and Pharmacy
4. Collaboration with clinical and allied health departments
5. Collaboration with senior management
6. On-line references pertaining to Infection Prevention & Control
   a. Infusion Nurses Society (INS)
   b. Association for Professionals in Infection Control (APIC)
   c. Association for Operating Room Nurses (AORN)
   d. State of California Department of Public Health
   e. Santa Cruz and Monterey County Department of Public Health
   f. American Association of Medical Instrumentation (AAMI)
   g. Centers for Disease Control (CDC)
   h. Centers for Medicaid/Medical Services (CMS)
   i. Any and all research articles relating to infection prevention & control (online search)
7. Staffing sufficient to mee the demands of the mandated infection reporting into the national database.

The Role of the IP&C Professional

To serve as an expert in a support role to the day-to-day functions, acting as a consultant, educator, role model, researcher, and change agent.

Responsibilities:

- Prepare and implement the yearly IP&CP Plan in comparison to the previous years' summary
- Organize and conduct surveillance for HAIs
- Investigate and address outbreaks and provide expert advice, analysis, and leadership in outbreak investigation and prevent further occurrences
- Oversee the implementation of and compliance with IP&C practices
- Serve as a member on the Products Committee for product and material evaluations
- Review and audit methods of disinfection and sterilization and the effectiveness of systems developed to improve hospital cleanliness
- New hire orientation education on the basics of infection prevention & control principles
- Participate in program initiatives to promote judicious antimicrobial use
- Ensure that patient care practices are appropriate to the level of patient risk
- Participate in development and implementation of teaching programs for medical, nursing, and allied health staff, as well as all other categories of HCWs
- All mandated reporting to the State, CDC, CMS, and the local public health department relative to Infection Prevention & Control.

The Role of the Facility Staff

Follow recommended IP&C practices according to IP&C standards as noted in Infection Prevention & Control Policies and Procedures.

Responsibilities:

- Uses evidence-based practices or bundles when providing direct patient care to lower the risk of healthcare associated infections,
- Understands and follows recommended IP&C practices,
- Supports the IP&C team,
- Serves on or participates in IP&C task forces and programs,
- Notifies the IP about communicable diseases that have the potential to spread after initiating immediate containment measures.

ADDITIONAL ACTIVITIES of the Infection Preventionist

Collaboration with Employee Health Services

The Infection Preventionist collaborates with the Employee Health Coordinator regarding federal/state vaccination reporting, staff exposures to communicable infectious diseases, outbreak monitoring and reporting, and policies and procedures which have an impact on infection control.

Collaboration with Safety and Quality Programs

The Infection Preventionist is a member of the Hospital Safety Committee. Actively participates in the Environment of Care rounding audits and patient safety risk assessments. As part of the pre-construction or building renovation efforts, the Infection Preventionist completes the Infection Control Risk Assessments (ICRA) to ensure associated infection control risks have been identified and addressed prior to the start of any construction or work that requires more in-depth work into current facility structures. The Infection Preventionist will also participate in construction team meetings with input on negative pressure rooms and other possible infection control construction-related issues from any source (Infection Prevention education and assessment for possible contamination risks from water, air, building material, dust and dirt, and worker access route to and from work site, as well as communicable disease health (as noted by required vaccination and/or annual testing, etc.)).

Liaison Role with Local Public Health Departments

The Infection Preventionist is responsible for notifying the Local Public Health Department's (LPHD) Communicable Disease section for reportable diseases mandated by the State of California. The extent of this role could include chart reviews, as necessary, for the health department and gathering epidemiological information, in addition to the submission of reports within the State's timelines. Other events such as outbreaks and any unusual occurrence such as high level MDROs are reported to the County by the IP with dissemination of instructions and guidance to staff, physicians, and management for each specific event. Any patient worked up for Tuberculosis is also reported to the LPHD.

Mandated Reporting

State of California and CMS have mandated reporting of healthcare associated infections into the National Healthcare Safety Network (NHSN/CDC). The State of California requires this within a specified timeframe. The primary goal is to obtain the statistics required to complete the data into the national database (National Healthcare Safety Network / NHSN) and ensure the completion is accurate and up-to-date. NHSN reports on specific healthcare associated infections from all hospitals nationally with a calculated ratio that helps to determine how well a hospital is performing in comparison to other like hospitals nationwide (size, geography, etc.).

There is also mandated reporting according to State requirements on communicable diseases within a specified timeline to the Local Public Health Department.

SECTION II

Watsonville Population

(Source: Applied Geographic Solutions 2021 and noted in Watsonville Economic Development Department Website)

Watsonville is a city in Santa Cruz County, California. The population as noted in City of Watsonville.org website listed as 51,663.

Ethnicity Distribution:

- White (non-Hispanic) 5,933;
- Hispanic 75.4% of the total population

The city is 100% urban and 0% rural. It is located on the central coast of California, the economy centers predominately around farming and food processing. A river forms a boundary of the city, and also divides Santa Cruz County from Monterey County. Land area covers 6.7 square miles, and Water at 0.1 square miles and is at an elevation of 29 feet.

25.06% of Watsonville residents speak only English, while 74.94% speak other languages. The non-English language spoken by the largest group is Spanish, which is spoken by 71.0% of the population. (Source: worldpopulationreview.com/us-cities/Watsonville-ca-population). A large population within WCH speak Mixtec, Mixtec is an ancient language, unrelated to Spanish, dating back to pre-Columbian times. There are anywhere from 30-50 variations of the language.

12.9% of the Watsonville population is below the poverty level.

The total number of natural disasters in Santa Cruz County (27) is greater than the US average of 15 (floods, fires, earthquake). Watsonville-area's historical earthquake activity is significantly above California State average. Since 1906 there have been six earthquakes with an average magnitude of 7.3 on the Richter Scale.

The type of industries in Watsonville include:

- Agriculture – Total Businesses = 23; Employees 1,570
- Arts/Entertainment – Total Businesses = 10; Employees 27
- Biotech/Biosciences – Total Businesses = 22; Employees 1,330
- Food Processing – Total Businesses = 10; Employees 646
- Healthcare – Total Businesses = 13; Employees 802
- High Tech Manufacturing – Total Businesses = 4; Employees 34
- Logistics – Total Businesses = 13; Employees 247

Hospitals and medical centers in Watsonville:

- Watsonville Community Hospital
- Country Villa Watsonville West Nursing and Rehab Center
- Valley Convalescent Hospital / Skilled Nursing Facility (SNF)

- Satellite Dialysis

Airports and heliports located in Watsonville:

- Watsonville Municipal Airport (WVI)
- Alta Vista Heliport (CA65)
- Watsonville Community Hospital Heliport (CL99)

Train Stations

- Amtrak Station – bus station

Colleges/Universities with over 2000 students nearest Watsonville

- Cabrillo College (11 miles in Aptos with full time enrollment 7,729)
- Gavilan College (12 miles in Gilroy with full time enrollment 3,327)
- University of California-Santa Cruz (18 miles; full time enrollment 17,751)
- Hartnell College (18 miles; Salinas, CA with full time enrollment 5,506)
- California State University-Monterey Bay (19 miles; Seaside; full time enrollment 5,125)
- Naval Postgraduate School (24 miles; Monterey; full time enrollment 4,951)
- Monterey Peninsula College (24 miles; Monterey; full time enrollment 4,588)

City of Watsonville Statistics

Data Topic	Data Information
Information from City of Watsonville.org on 3/27/2023	Population 51,663
	US Citizens 61.6%
	Non-US Born Citizens 14.1%
Largest Ethnic Group in Watsonville	
	Hispanic 75.4%
% Population Living at Poverty Level Source: DataShare - Santa Cruz County Data for Action	
	Person's in Poverty 12.9% (Watsonville) Measurement Period 2017-2021
	Santa Cruz 18.7%
Veterans Watsonville City - US Census Bureau QuickFacts 2017-2021	953
	from: Vietnam Gulf War World War II
Main Industries	
	Construction
	Agriculture
	Manufacturing
Common Trade Partners Data USA: Economy 2019	
	Texas Arizona Washington

SECTION III
SURVEILLANCE

The goal of surveillance is to develop and implement a system for surveillance of infections with a focus on high-volume, high risk and problem-prone procedures to include:

- Identifying baseline information about the frequency and type of healthcare-associated infections
- Recognizing clusters or significant deviations from endemic levels
- Developing a system for identifying, reporting, and analyzing the incidence and causes of healthcare-associated infections.
- Performing a risk assessment of the needs for the institution on at least a yearly basis
- Preparing staff and physicians to identify and report clusters of patients with similar symptoms to the IP Professional.

The IP Professional conducts surveillance for many reasons, including to establish prevalence rates of healthcare-associated infections (HAI), to detect time/space clustering (i.e., outbreaks), to generate hypotheses concerning risk factors for acquiring HAIs, to assess the impact of infection prevention & control measures, and to reduce of HAI rates. In general, established criteria from the Centers for Disease Control (CDC) are used to define healthcare-associated infections. The infection must meet the specific criteria noted in the National Healthcare Safety Network (NHSN) guidelines when submitting data into NHSN database. This is a requirement of the CDC, as well as California Department of Public Health (CDPH).

The IP&CC on an annual basis determines the type and scope of the surveillance completed at Watsonville Community Hospital. A targeted surveillance method is utilized to focus resources. In addition to targeted surveillance, single occurrences and/or outbreaks of HAIs related to any unusual or virulent pathogenic organism are evaluated.

Data produced from the surveillance process are presented to the IP&CC to facilitate decisions concerning prevention and control activities and resource allocation within the IP&CP. Infection rates are established using recognized statistical methodology and/or NHSN to identify trends. If established "action thresholds" are met or exceeded, a team will be established to review the case(s) and determine actions to eliminate possible causes and improve or create interventions. Process control charts are utilized when feasible to enhance the identification of infection trends and variances. Surveillance data is maintained in NHSN and/or other WCH spreadsheet databases and managed by the IP Professional.

WCH Licensure

Watsonville Community Hospital is licensed by the State of California Department of Public Health for 106 General Acute Care beds under an older licensure, however, as of February 23, 2022, a bankruptcy judge approved the sale of Watsonville Community Hospital to the Pajaro Valley Healthcare District. The same licensure exists but under new ownership as a not-for-profit with the goal of becoming more community focused.

The goal of the current owners is to ensure the people of Pajaro Valley have access to high quality, sustainable healthcare services. Watsonville Community Hospital has been providing critical services

to its community for more than a century. Previous to the bankruptcy (from 1998), the hospital has been owned by private entities.
A breakdown on the type beds from the old licensure is:

1. 18 Perinatal
2. 10 Intensive Care Newborn Nursery
3. 3 Coronary Care
4. 3 Intensive Care
5. 72 Unspecified Acute Care

6. Other approved services:
    a. Basic Emergency Medical
    b. Cardiac Catheterization Laboratory Services (not open as of yet)
    c. Nuclear Medicine
    d. Occupational Therapy
    e. Physical Therapy
    f. Respiratory Care Services
    g. Social Services
    h. Speech Pathology

Hemodialysis Equipment and Healthcare Associated Infections:

Other Procedural Monitoring (Hemodialysis Water cultures, Dialysate cultures and LAL cultures are performed monthly on hemodialysis equipment).

Summary of Culture Testing and Disinfection of Dialysis Machines.

1. A change with the contracted hemodialysis group occurred after the 1st quarter 2021.
2. Quality and Infection Prevention & Control participate in the dialysis Quarterly meetings with the contracted group.
3. No outliers of concern for dialysate or water cultures were identified in 2022.
4. Assisted with the contracted group throughout the year with administrative concerns and establishing safe work environment for contracted group and dialysis patients.

Seasonal Influenza Summary: Over the previous three years there has been a decline in the total number of staff and other healthcare workers with an unknown vaccination status. The goal established by The Joint Commission was set at 90% vaccination rate for 2020. That goal was met during the 2019-2020 influenza season. Due to the pandemic the criteria if a person has not received the flu vaccine is to wear a mask. However, during the pandemic, a mask was worn at all times by all healthcare workers and visitors entering the facility. There were many factors contributing and most of it stemmed nationwide, especially with COVID pandemic vaccinations refusing to get vaccinated.

Seasonal Influenza Vaccination Rate The Joint Commission (TJC) had set a goal of 95% by 2020					
Influenza Year	**Employees**	**Licensed Independent Practitioners**	**Student/ Volunteers**	**Contractors**	**Total Vaccination Compliance**
2022/2023	**56%**	**56%**	**100%**	**59%**	**57%**
2021/2022	35%	61%	Closed	19%	39%
2020/2021	75%	70%	Closed	Closed	74%
2019/2020	89%	91%	100%	100%	90%
2018/2019	87%	85%	92%	88%	87%
2017/2018	88%	31%	100%	92%	77%

*Closed due to pandemics to specified workers

(Occupational Safety and Health Administration) OSHA Requirements for Respiratory Protection Program

1. All employees are given a particular month with an annual review for fit testing with an annual education on the use and maintenance of the PAPRs. (Positive Air Pressure Respirators). For 2022 there is a 100% compliance rate for fit testing

2. Any employee who fails to be fit tested during their scheduled time is removed from schedule until the fit testing is completed.

Tuberculosis Risk Assessment for WCH 2023

Facility Name: Watsonville Community Hospital	**Date Completed:** 03/27/2023
Completed By: Gloria Przelenski, RN, BSN, MA, CIC	

Assessment completed for:

- ☒ Entire Facility
- ☐ Area of Facility (specify) _____
- ☐ Occupational Group (specify)_____

Time Interval (month & year) for conducting the TB Risk Assessment. This is usually done for the previous calendar year (i.e., January – December). January 1, 2022 to January 1, 2023

Background Information:

Number of TB cases in the community (calculated by compiling the TB county data for the counties in which the facility staff and residents resided during the time-period being assessed).

Counties included in risk assessment: Santa Cruz and Monterey Counties

Facility size/type:

Inpatient facility: ☒ < 200 beds

☐ ≥ 200 beds

☐ Outpatient or non-traditional setting

If evidence suggests person to person transmission of TB has occurred in the setting during the previous year; answer yes or no to the following:

- Clusters of TST* or BAMT** conversions (NO)
- HCW*** with confirmed TB disease (NO)
- Increase rates of TST or BAMT conversions (NO)
- Recognition of an identical strain of M. tuberculosis patients or HCWs with TB disease identified by DNA fingerprinting (NO)

If "no" is answered to these 5 questions:

LOW RISK

Inpatient facility < 200 beds = < 3 cases
Inpatient facility ≥ 200 beds = < 6 cases
Outpatient or non-traditional setting = < 3 cases

MEDIUM RISK

Inpatient facility < 200 beds = ≥ 3 cases
Inpatient facility ≥ 200 beds = ≥ 6 cases
Outpatient or non-traditional setting = ≥ 3 cases

If "yes" is answered to any of the above, the facility may be ranked as POTENTIAL ONGOING TRANSMISSION. Follow the CDC risk assessment guidelines to re-assess the facility. Seek professional assistance if necessary. The potential ongoing transmission ranking is considered a temporary classification while the facility investigates the problem. Once interventions have been implemented and proven to work, the facility should assess to an appropriate lower ranking.

Please refer to the CDC document Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities, 2005 for recommendations regarding the risk assessment process, whether annual TB skin testing is recommended as well as additional TB recommendations (pages 9-16 and Appendix C on page 134).

* TST: TB skin test
** BAMT: Blood assay for Mycobacterium tuberculosis
*** HCW: Health care worker

Select Applicable Risk Category: ☐ Low Risk ☒ Medium Risk ☐ POTENTIAL ONGOING TRANSMISSION

State of California: Goal over the next 5 years

A Plan to Eliminate TB CDPH, in collaboration with the California TB Elimination Advisory Committee and the California TB Controllers Association, developed a TB Elimination Plan which outlines actions over 5 years to make progress toward eliminating TB from California. The plan is supported by diverse stakeholders across the state. The plan calls for making TB prevention a routine part of medical care by finding and testing Californians who are at risk for TB, optimizing treatment for LTBI, monitoring and evaluating LTBI testing and treatment, and ensuring that patients, clinicians, and public health programs have the tools and resources they need to prevent TB

Update on Tuberculosis following COVID-19

U.S. Tuberculosis cases are nearing pre-pandemic levels, CDC data shows. TB increased slightly last year after a substantial 20.2% decline in 2020 and a 9.8% increase in 2021, according to the data published in the CDC's Morbidity and Mortality Weekly Report. This was reported just a day ahead of the World Tuberculosis Day. CDC researchers wrote: "the incidence appears to be returning to pre-pandemic levels among U.S. born and non-U.S. born populations." Much of this has been attributed to the

In the first couple of months alone at Watsonville Community Hospital, there have been five cases that have come into WCH as a patient and were ruled out for TB. This is already higher for WCH in comparison to the last four years. "Major factors that fueled the U.S. TB resurgence were the emergence of human immunodeficiency virus (HIV), the spread of multi-drug-resistant (MDR) TB (a problem first noted in 1978), and reductions in resources for U.S. TB control programs." (National Institute of Health (.gov): https://www.ncbi.nim.nih.gov).

For the reason noted above in the current updates on Tuberculosis, IP&C has updated our risk to a medium level.

Section IV
Emergency Management and Planning

WCH IP&C's objectives during an emergency disaster are:

1. Understand the impact of any infectious diseases during a disaster.
2. Implement interventions for infection prevention during a disaster.
3. Assess the organization's response relative to infection prevention and control.

To help address the objectives of an infectious emergency disaster, any of the following is assessed in a systematic manner to implement appropriate preventive measures. The Infection Preventionist collaborates with the disaster Emergency Committee to monitor and follow communication from the State and Local Health Department and the Centers for Disease Control on the known attributes of the infectious event or novel infectious agent and help implement strategic prevention measures as quickly as possible.

- The current predicted risks relative to infectious diseases is bioterrorism, bird flu, and emerging infectious diseases. Diseases travel globally and more are currently predicted.

- The environment plays a role in infection transmission. Ongoing screening and triage at the point of entry are implemented as best practices to prevent rapid transmission before an outbreak is detected.

- Personal Protective Equipment (PPE) are needed in adequate amounts during a disaster, especially for an infectious event. Staff will need to be taught how to use PPE safely. Following the current pandemic of 2020, the State of California set up a plan for all facilities to have at least 90 days of stockpile going forward (equivalent to the highest usage month in 2019).

- In any emergency, it is possible that facilities might not get the supplies needed and the Infection Preventionist and Emergency Committee will have to adopt ways of extending the use or reuse of respirators and other personal protective equipment within safety guidelines. The IP will monitor all national emergency organizations for the emergency Instructions for Use (IFU) for all equipment used at WCH.

- Linen Management is a problem dependent upon its infectious nature. Considerations and adjustments will have to be made with disposition and handling of linen (this is especially true during Ebola). Ongoing education is key during any disaster or emerging infectious event.

- The Infection Preventionist will help with vaccine administration if one is needed to counter a novel infectious respiratory disease.

- The Infection Preventionist will play a major role on the Emergency Management team helping to design ways to assess patients but limit exposure to others. Designing ways to control exposures such as drive through testing and vaccine administration.

- The Infection Preventionist will educate both the staff in the healthcare facility and local population – especially in promoting vaccine administration to help develop herd immunity.

- Infection Prevention & Control will collaborate closely with Employee Health to ensure healthcare workers do not acquire and/or spread the disease.

- Following the COVID-19 pandemic, CDPH has alerted all hospitals of the increase in Carbapenamase-resistant Enterobacteriaceae and Candida auris (both multi-drug resistant organisms / CRE is on the highest level). Both are reportable to CDPH and stringent prevention measures must be instituted to prevent transmission to other patients. Although there has been a trend in California (especially for CRE), WCH has not seen much activity within the hospital. However, just recently, two patients from the Wound Care Center were found to have CRE and all measures were put forth to terminally clean the unit and IP&C went around to the nursing staff to educate on CRE.

Section V
2023 Infection Prevention & Control Risk Assessment

Potential Risks/Problems	Probability of Performance Failure				Risk/Impact (Health, Financial, Legal, Regulatory)				Infection Prevention System Preparedness				
Year 2023	High	Medium	Low	Never	High	Moderate	Minimal	None	Poor	Fair	Good	Excellent	
	3	2	1	0	3	2	1	0	3	2	1	0	TOTAL
HEALTHCARE ASSOCIATED INFECTIONS (HAIs)													
Surgical Site Infections (SSIs)		2			3					2			7
Methicillin-resistant Staphylococcus aureus (MRSA)			1				1					0	2
Clostridioides difficule	3				3					2			8
Vancomycin-resistant Enterobacter (VRE)			1				1					0	2
Extended Spectrum Beta Lactamase (ESBL)		2					2				1		5
Carbapenem-resistant Enterobacteriaceae (CRE)			1		3					2			6
PREVENTION ACTIVITIES													
Hand Hygiene Compliance		2				2						0	4
Antibiotic Stewardship Program			1				1					0	2
Surveillance activity for performance improvement plans		2				2				2			6
Initial screening of patients at point of entry for communicable disease		2				2				2			6
Spatial separation of patients with viral communicable disease			1			2				2			5
Disease prevention through vaccination			1				1				1		3
ISOLATION ACTIVITIES													
Failure to implement standard precautions on all patients all the time		2					1					0	3
Failure to initiate appropriate isolation precautions early on		2				2						0	4
EQUIPMENT RELATED RISKS													
Inadequate or improper disinfection / sterilization of medical devices			1		3						1		5
Cleaning/disinfection of reusable equipment after each patient use		2				2						0	4
POLICES & PROCEDURES													
Failure of staff to follow evidence-based guidelines for infection prevention			1		3						1		5
Policies with outdated evidence-based guidelines for infection prevention			1		3						1		5

EMPLOYEE HEALTH RELATED RISKS													
Bloodborne Pathogen Exposures			1			2						0	3
Annual Fit Testing program for competency and fit			1			2						0	3
Exposure to COVID pandemic		2				2					1		5
PPE stockpile for future community events and/or pandemic			1		3						1		5
INTERNAL ENVIRONMENTAL RISKS													
Construction or renovation projects			1		3						1		5
Legionella from water source			1		3						1		5
Medical waste mishandling			1			2					1		4
Dirty or contaminated laundry mishandling			1			2					1		4
Water intrusion/disruption			1		3						1		5
Environmental mold			1		3						1		5
Ineffective cleaning of the OR and patient care rooms			1		3						1		5
Ice Machine: improper maintenance			1			2					1		4
Safe Food Handling			1		3						1		
Contaminated dialysis water and/or LAL			1				1					0	2
Infection from Inadequate Sterilization			1				1					0	2
Infection from Inadequate Air Handling			1				1					0	2
Contamination - infection from Pharmacy enironment			1				1					0	2

The goal of this IP&C Risk Assessment is to identify the highest level of risks as noted on by the TOTALs in the right hand column. The lowest risk is at a "1" and the highest is at an "8". The Infection Prevention & Control Department will work on all risks and concerns that have been assigned beginning with #5 and going through #8.

The **Infection Prevention & Control RISK ASSESSMENT for 2023 on pages 33 and 34 is an ongoing continual process.** If an outbreak or unexpected risk should occur with a high level of risk associated to it, it will take precedence over the IC Plan.

Zero- Process has been going well
Low or 1- Processes are initiated and being followed
Med or 2- The processes in place are working well and the outcomes are improving and sustaining
High or 3- Training or education sessions may need to be scheduled

2023 Performance Improvement Plan

GOAL	EVALUATION	IMPROVEMENT PLAN
Prevent transmission of MDROs to other patients within WCH	Following the COVID pandemic, WCH has not had any event related to transmission of MDROs interfacility from patient to patient. Exposures have occurred due to COVID-19, but it is not an MDRO and prevention measures are in place and fairly effective.	1) Monitor closely for CRE and Candida auris and report findings to LPHD per protocol and implement all prevention measures and education to staff as needed. 2) Continue to work on improving HAI rate of Clostridioides difficile by working with Antimicrobial Stewardship Task Force. More consistent measures need to be implemented between both nursing staff and physicians. 3) One incidence of MRSA BSI, which is a rare event following the measures placed by CDPH mandates in early 2000. Monitor closely. 4) SSIs: monitor early on and report to Surgical Department on any outliers relative to risk assignment and/or infections that occur following a surgical procedure.
Routine prevention activities that are ongoing	Continue with hand hygiene program implemented in 2022 and move toward more involvement with staff as Champions of Hand Hygiene.	1) Implement a more aggressive surveillance activity in the inpatient unit; with unit staff having more accountability with standards and the outcomes as noted by surveillance. Continue to monitor assessment of patients upon immediate entry into hospital to stop infections at the Point of Entry. 2) Monitor closely during viral seasons that spatial separation is set up to prevent the spread of viral infections from close encounters.
Procedural equipment related risks	Monitor and audit all cleaning/disinfection from Point of Care to Processing areas to ensure all IFUs are followed.	1) Routinely set up review with department management to ensure that all standards relative to cleaning/disinfection is followed.
Policy and Procedures	Infection Prevention & Control policies following COVID-19 have had changes made as a result of the research conducted during COVID-19.	1) IP&C to assess each policy for any changes to standards that were made as the result of the pandemic; review, revise and/or update. 2) This will be a major focus in 2023 for Infection Prevention & Control.
Employee health related risks	a) BBPE policy not completed in 2022 b) Reviewed the annual testing for TB – will remain as is for now c) Good system in place for COVID-19 exposures d) PPE stockpile per CDPH requirements have been me t	1) Continue working on the BBPE policy that is efficient and does not create chaos during policy implementation among various groups: a) First Responders; b) staff; c) physicians and other contracted employees.

Infection Prevention & Control Activities 2022

1. Monthly Clostridioides - Clostridium difficile (C. diff) Task Force Meeting with Infectious Disease physician; Microbiology, Director of Laboratory, Pharmacist, Quality & Safety Director, Infection Prevention & Control Director, and Medical/Surgical Manager.
2. Infection Preventionist CIC (Certification of Infection Control) was reissued in late 2022.
3. Combined Pharmacy & Therapeutics and Infection Prevention & Control Committee Meetings
4. COVID Task Force Meetings
5. Respiratory Staff Meeting to go over Infection Prevention & Control Issues
6. Emerging Infections Newsletter collaboration
7. Committee member of Quality & Safety
8. New Hire Orientation Education
9. Member of Product Evaluation Committee
10. CDPH Regional Conference Calls
11. Environment of Care Rounding
12. Policy Review and revisions
13. Hand Hygiene Implementation and follow through for Leapfrog goal
14. Collaborated on Bloodborne Pathogen Exposure Policy
15. Educated and collaborated with staff and management on changes throughout the year with COVID-19 and Monkeypox.

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Color-Coded Wristbands	Policy #	NURXXXX
Responsible	Chief Nursing Officer	Revised/Reviewed	04/2023

I. PURPOSE

Have a standardized process to visually identify and communicate patient specific risk factors, or special needs, by standardizing the use of color-coded wristbands based upon the patient's assessments, screenings, and medical status.

II. POLICY

A. All inpatient, perioperative, and emergency department patients will have identification wristbands, and appropriate color-coded wristbands that communicate patient safety risks or special needs.

   1. Colorless patient ID wristbands may be applied by non-clinical staff.
   2. Color-coded wristbands are applied, or removed, per this policy, by or at the direction of, a nurse or licensed staff person conducting an assessment and/or screening.
   3. A solid red band is applied by a phlebotomist or nurse at the time of sample collection for identification and banding of potential transfusion recipients.

B. Preprinted written descriptive text is used on color-coded wristbands.

C. The purple DNR (Do Not Resuscitate) color-coded wristband serves as an alert and does not take the place of a DNR order.

D. If labels, stickers, magnets, or other color-coded visual cues are used to communicate safety risk factors or special needs, the cues should use the same corresponding color to the colored band.

E. Patient and family education should be provided for explanation of the color-coded wristbands and associated risk.

III. DEFINITIONS

Table shows the definition of each color-coded band.

Table 1. Color-coded Wristbands

Color-coded Wristbands	Communicates
Red	Allergy
Yellow	Fall Risk
Purple	DNR
Pink	Restricted Extremity

Green	Latex Allergy

IV. PROCEDURE

A. During assessments and/or screenings, risk factors associated with allergies, fall risks, DNR, restricted extremities, and latex allergies are identified.

B. Efforts are made to place the color-coded wristband on the same extremity as the patient ID wristband, except the pink restricted extremity wristband. It will be placed on the extremity that is restricted.

C. The application of the color-coded wristband(s) is documented in the chart by the nurse.

Commented [KH1]: Need to update shift assessment to include color-coded bands with existing band check. Add check box for patient refusal, risk/benefit explained, and text box.

Commented [KH2R1]: This has been completed.

D. Upon application of a color-coded wristband, the nurse should instruct the patient and their family member(s) (if present) that the wristband is not to be removed.

E. In the event that any color-coded wristband(s) have to be removed for a treatment or procedure, a nurse will remove the wristbands. Upon completion of the treatment or procedure, new wristbands will be obtained, risks reconfirmed, and replaced immediately by, or at the direction of, the nurse.

F. The nurse will reconfirm color-coded wristbands before invasive procedures and with transfers.

G. Color-coded wristbands are not removed at discharge.
   - For home discharges, the patient is advised to remove the wristband at home.
   - For discharges to another facility, the wristbands are left intact as a safety alert during transfer. Receiving facilities should following their policy and procedure for the banding process.

H. If a patient refuses to wear a color-coded wristband the nurse will complete the following:
   - An explanation of the risks will be provided to the patient/family.
   - The nurse will reinforce that the wristbands are intended to prevent patient errors.
   - The nurse will document in the medical record patient refusals, and the explanation provided by the patient or their family member.
   - The patient may be requested to sign an acknowledgement of refusal by the completion of a refusal to permit medical treatment form.
   - Correlating wristband signage will be placed at the head-of-bed with risks indicated.

V. REFERENCES

Cizek, K. E., Estrada, N., Allen, J., & Elsholz, T. (2010). A crystal-clear call to standardize color-coded wristbands. *Nursing2022*, *40*(5), 57-59.

Ran, D. (2009). The Color of safety: hospitals join together on wrist band standards.

Traynor, K. (2009). Most Wisconsin hospitals adopt standardized color alerts.

VI. STAKEHOLDERS

N/A

WATSONVILLE COMMUNITY HOSPITAL

Policy Title	Fall Prevention	Policy #	NUR1681
Responsible	Nursing Administration	Revised/Reviewed	~~12/2021~~05/2023

I. PURPOSE

Creating a safe environment for patients by reducing falls and eliminating serious injuries from falls.

The scope of this policy will include:

A. Definition of a Fall
B. Assessing fall risk and applying evidence-based interventions.
C. Identify and effectively communicate patients that are 'At Risk' to fall.
D. Reduce patient falls and eliminate falls resulting in ~~serious~~ injury.
E. Address repeat falls with a post-fall assessment and change in interventions.
F. Educate staff related to fall prevention and interventions that ~~eliminate serious~~reduce injuries from falls.
G. Educate patient, family and others on the fall prevention program.

II. POLICY

This Fall Prevention policy applies to all inpatient/outpatient/~~resident care settings~~ and populations.

III. RESPONSIBILITIES

A. Executive leadership team (CEO, COO, CNO, and CFO or designee) is responsible for ensuring that fall prevention is a high priority at the facility by promoting a culture of safety for patients and staff.
B. Nurse Directors and Managers:
   a) Hold staff accountable and re-enforce compliance with fall prevention interventions.
   b) Verify that all nursing staff receives education and are competent in the fall prevention program.
C. Charge Nurses
   1. Lead Post Fall Huddles
   2. Share learnings from post fall huddles during safety huddles
   3. Ensure the completion of the EMR post fall assessment
   4. Ensure submission of event in incident reporting system
   5. Ensure appropriate fall prevention interventions are implemented including visual alerts (e.g., yellow arm band, yellow socks, fall risk door marker)

~~C.~~D. RN/Licensed staff (within scope of practice to perform a fall evaluation):
   a) To complete the fall-risk ~~evaluation~~ assessment in conjunction with the initial assessment.
   b) Notifying the charge nurse of new patients assessed as "High Risk" for falls.
   c) Following and implementing the fall interventions for 'At Risk' patients at time of admission.

~~D.~~E. Staff Nurses (including RN, ~~LPNs~~, ~~Nurse Technicians~~, ~~CNAs~~ and Contract Nursing Staff):
   a) Implementation and compliance with fall prevention and interventions that ~~eliminate~~ reduce ~~serious~~ injuries from falls.
   b) Complete fall-risk (re)assessments when:

- Patient transfers from one unit to another
- With every shift assessment
- Following a change in patient status/condition
- Following a fall

c) Ensuring interventions for patients 'At Risk' to fall are implemented, documented, and communicated during bedside shift report and during unit safety huddles.

d) During hourly rounds; assure the fall prevention interventions are implemented.

~~E.~~F. It is the responsibility of all employees to observe, monitor and intervene when necessary, with patients identified 'At Risk' for falls to prevent a fall and eliminate serious injuries from falls.

IV. DEFINITIONS

A. For the purpose of consistent interpretation, a fall is defined as:

~~1.~~ a sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., a trash can). When a patient rolls off a low bed or on a mat or is found on a surface where you would not expect to find a patient, this is considered a fall. If a patient who is attempting to stand or sit falls back on to a bed, chair or commode, this is only counted as a fall if the patient is injured. ~~Unintentionally coming to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g., patient pushes another patient)~~

~~2. Any unobserved or witnessed fall reported by a patient/ family or staff.~~

~~3. Unless there is evidence suggesting otherwise, when a patient is found on the floor, a fall is considered to have occurred.~~

~~4. Rolls or slides off bed or chair onto the floor.~~

~~5. Falling off of or out of equipment (including apparatus used for therapy or transfers).~~

~~6. An episode where a patient lost his/her balance and would have fallen, if not for staff intervention.~~

B. **Types of Falls**: Based on the immediate cause, the type of fall is determined by the following: ~~Accidental, Anticipated Physiological, Unanticipated Physiological and Intentional (Behavioral Fall)~~

1. **Non-Physiological Fall (Accidental Fall)** ~~**Accidental Falls**~~: A fall attributed to an external cause (e.g., wet floor) and cannot be attributed to a physiological factor.~~Fall that occurs due to extrinsic environmental risk factors or hazards: spills on the floor (such as water or urine), tripping on clutter, tubing / cords on the floor, or errors in judgment, such as not paying attention or leaning against a curtain or unlocked furniture.~~

2. Physiological Falls: A fall attributed to one or more intrinsic, physiological factors. Physiological falls include anticipated and unanticipated physiological falls.

   ~~2.~~a. **Anticipated Physiological Falls**: Factors associated with known fall risks as indicated on the ~~Morse Fall Scale that are predictive of a fall occurring: loss of balance, impaired gait or mobility, impaired cognition/confusion, impaired vision. Falls that we anticipate will occur due to the patient's existing physiological status, history of falls, and decreased mobility upon assessment.~~fall risk assessment. e.g related to high risk meds, hypotension, impaired gait, dementia, etc.

~~3.~~b. **Unanticipated Physiological Falls**: Factors associated with unknown fall risks that were not predicted (cannot be predicted) on a fall risk assessment. ~~scale~~: e.g related to heart attack, seizure, stroke, dysrhythmia ~~unexpected orthostatic; extreme hypoglycemia; stroke; heart attack; seizure, etc.~~

3. **Suspected Intentional (Behavioral) ~~(Intentional)~~ Fall**: An intentional fall event occurs when patient age 5 years or older falls on purpose of falsely claims to have fallen. Patients may fall intentionally or falsely claim to have fallen for various reasons, including seeking attention or obtaining pain medication.~~Patient who has behavioral issues and voluntarily positions his/her body from a higher level to a lower level.~~
4. **Assisted Fall:** A fall in which any staff member (whether a nursing service employee or not) was with the patient and attempted to minimize the impact of the fall by slowing the patient's descent.
5. **Unassisted Fall:** Any fall/slip in which a person comes to rest unintentionally on the floor or some object and no one intervenes during the fall
6. **Baby/Child Drop:** A fall in which a newborn, infant, or child being held or carried by a healthcare professional, patient, family member or visitor falls or slips from that person's hands, arms, lap, etc. This can occur when a child is being transferred from one person to another. The fall is counted regardless of the surface on which the child lands (e.g. bed, chair, or floor).

~~4.~~7. **Developmental Fall**: falls common to infant, toddler, or preschooler learning to stand, walk, run, or pivot as part of the developmental process of acquiring these skills.

~~**Note:** The last two categories of falls may not be preventable. Fall research indicates that the majority of falls are accidental or anticipated physiological falls.~~

C. Fall Interventions are defined as Preventive and Protective. Interventions are sorted by the categories as they are scored on the Morse Fall Scale (MFS). Preventive measures are to ensure a safer environment in preventing accidental falls and optimize the patient's physical status and safe ambulation. Protective measures are implemented to protect the patient from falling and injury.

D. **PREVENTIVE** Interventions are implemented for no/ low risk patients with scores of 44 or less for the Morse Fall Scale (MFS) assessments. **PROTECTIVE** Interventions are implemented for all high-risk patients with scores of 45 or greater for the Morse Fall Scale assessments.

V. PROCEDURE

A. The RN/Licensed Staff (within scope of practice to perform a fall evaluation) will assess the patient's risk to fall using an evidence-based, valid and reliable Fall Risk Assessment Scoring Tool. ~~Two (2) evidence-based fall assessment tools that have been studied, reliable and valid measure of fall risk are: 1) Morse Fall Risk Assessment* or 2) Hendrich II Fall~~

Risk Assessments.

A. ~~*~~Watsonville Community Hospital will use Morse Fall Risk Assessment (Attachment A) for inpatients.

B. Other evidence-based fall Risk assessments tools Watsonville Community Hospital may use specific to certain patient populations and care settings include the **Memorial Emergency Department Fall Risk Assessment Tool** and **Obstetric Falls Risk Assessment System (OFRAS),** and the **Little Schmidty Fall Risk Assessment** for age specific pediatric patients.

~~B.~~C. The assignment of a Fall Risk category is based on the risk criteria including the nursing assessment of psychological, physiological and environmental factors as defined in the~~a~~ Fall Risk Assessment Tool. The nurse will assess the patient's risk for falls using the patient's self-report as a primary source, current medical status, past medical history, information reported from family and by direct observation of the patient.

~~C.~~D. An RN/Licensed Staff (within scope of practice to perform a fall evaluation) will assess risk factors that may impact the patient's risk to fall and assign appropriate risk score and add them to determine the total score. The RN/Licensed Staff (within scope of practice to perform a fall evaluation) will then assign an appropriate Fall Risk category based on the calculation of the total score.

~~D.~~E. **The Morse Fall Risk Assessment Tool** ~~**(Emprint Form # NS-1330HMS)**~~ The Morse Fall scale (MFS) is a rapid and simple method of assessing a patient's likelihood of falling. It consists of 6 variables that are quick and easy to score. This tool has been shown to have predictive validity and reliable.

Morse Fall Risk Assessment		
Risk Factor	Scale	Score
History of Falls	No	0
	Yes	25
Secondary Diagnosis	No	0
	Yes	15
Ambulatory Aid	None/Bed Rest/Wheel Chair/Nurse assists	0
	Crutches / Cane / Walker	15
	Furniture	30
IV / Heparin Lock	No	0
	Yes	20
Gait / Transferring	Normal, on bed rest, immobile	0
	Weak (uses touch for balance)	10
	Impaired (unsteady, difficulty rising to stand)	20
Mental Status	Oriented to own ability	0
	Forgets Limitations	15

Morse Fall Risk Category	
High Risk	45 or greater
No/Low Risk	0 - 44

~~E.~~F. Scoring the Morse Fall Scale: Items in the scale are scored as indicated in the following subsections:

a) History of Falling: Score = 25 if the patient has fallen during the present hospitalization admission or if there was an immediate history of physiological falls such as falls from seizures or an impaired gait prior to admission. If the patient has not fallen or a history of falling; score = 0. Note: if a patient falls for the first time, then his/her score immediately increases to 25.

b) Secondary Diagnosis: Score = 15 if more than one medical diagnosis is listed on the patient chart; if not, the score = 0.

c) Ambulatory Aids: Score = 0 if patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on bed rest. If patient uses crutches, cane or a walker score = 15; if the patient ambulates clutching onto furniture for support score = 30.

d) Intravenous Therapy: Score = 20 if the patient has an intravenous line or a heparin lock; if not, score = 0.

e) Gait: Score = 0 if patient has a normal gait; characterized by the patient walking with head erect and arms swinging freely. Score = 10 if gait is weak; characterized by the

patient is stooped but is able to lift his/her head while walking without losing balance. Score = 20 if gait is impaired; characterized by the patient having difficulty rising from a chair, poor balance and grasps onto furniture for support or can't walk without assistance. Patient takes short steps and shuffles. If patient is in a wheelchair, the patient is scored according to the gait he/she used when transferring from wheelchair to the bed.

f) Mental Status: Mental status is measured by checking the patient's own self-assessment of his/her ability to ambulate. Ask the patient "Are you able to go to the bathroom alone or do you need assistance"? If the patient's reply is consistent with the ambulatory orders; the patient is rated as normal and score = 0. If the response is not consistent with the ambulatory orders or if the patient's assessment is unrealistic; then the patient is considered to be overestimating his/her ability and to be forgetful of limitations and score = 15.

VI. INTERVENTIONS TO PREVENT FALLS AND SERIOUS INJURIES FROM FALLS

Based on the assessed Fall Risk Category; the following Interdisciplinary Interventions will be implemented and documented:

Description	Interdisciplinary PREVENTIVE Interventions - May Include (but are not limited to):
No or Low Risk to Fall **(Final risk score:** ≤44 using the Morse Fall Score)	▪ Thorough orientation to immediate surroundings/use of patient communication board(white board) to indicate fall risk. ▪ Remove unnecessary furniture from patient's room, i.e. IV poles, BSC, etc. as appropriate. ▪ Keep call light within reach and have the patient 'teach back' call light use. ▪ Bed/stretcher in lowest position/brakes locked. ▪ Side rail position (up, down, half) as assessment indicates; document in nursing notes. ▪ Non-slip footwear while ambulating. ▪ Provide assistance with elimination (as indicated by nursing assessment or orders). ▪ Regularly check on patients receiving diuretics or laxatives. ▪ Provide a safe environment (remove spills, objects obstructing walkway, unstable furniture, and adequate lighting). ▪ Instruct patient to make frequent position changes and do so slowly. ▪ Instruct patient to call for assistance after procedures and/or new medications to assess stability ▪ Teach male patients prone to dizziness to void while sitting. ▪ Evaluate patient response to medications (especially analgesics, anesthetics, anti-anxiety/tranquilizers, anti-hypertensive, anticonvulsants, benzodiazepines, diuretics, hypnotics, laxatives, antidepressants, antipsychotic and mood stabilizers, skeletal muscle relaxants and antispasmodics, GI antispasmodics, opioids/narcotics, and sedative-hypnotics), and their effects. ▪ Document on patient education in medical record. ▪ Give patient and family education material for Fall Prevention; reinforce teaching as needed.
Description	**Interdisciplinary PROTECTIVE Interventions - May Include (but are not limited to):**
High Risk to Fall: **(Final risk score:** ≥ 45 using Morse Fall Score)	**Includes Low Risk to Fall Interventions above, plus:** ▪ Apply High Risk to Fall ~~< state color>~~yellow armband. ▪ Apply High Risk to Fall ~~<describe>~~yellow magnet on door rim. ▪ Place High Risk to Fall ~~<describe>~~yellowidentification on the appropriate location for visual alerts and nursing station patient location/assignment board. ▪ Bed alarms to alert staff when patient is attempting to get up and activate the use of chair alarms when patient is sitting up. ▪ Bedside floor mats for patients at risk of injury from a fall by using the mnemonic **("ABCS"):** o **A**ge over 85 o **B**one disorders (e.g. osteoporosis, metastasis) o **C**oagulation disorders (e.g. bleeding, anticoagulant use) o **S**urgery (e.g. recent surgery involving limbs, hips, abdominal, thoracic) ▪ Arms reach attendance while in bathroom or on bedside commode; do not leave patient unattended.

	▪ Instruct patient/caregiver/family to ask for assistance for any activities such as getting out of bed. ▪ Medication review conducted with physician and/or pharmacist. ▪ Use assistive devices as appropriate to patient needs. (Gait belt, walker, cane) ▪ Evaluate need for a sitter. ▪ Ensure bed is in lowest position it will go when care is completed. ▪ Reinforce teaching with patient and family as needed; including activity limits. ▪ Keep needed items within reach such as glasses, urinals, and call light devices. ▪ Evaluate patient need to move closer to nurses' station. ▪ Reorient to environment frequently when performing hourly rounding ▪ Siderails up at all times (half or x3 as patient assessment indicates). ▪ Nightlight in use as appropriate for dark bathrooms or walkways. ▪ Elimination needs assessed and attended to during hourly rounding. ▪ Consider Physical therapy/occupational therapy consult to improve mobility/flexibility and/or appropriate use of aids, gait training. ▪ Encourage family members to stay with patient, educate the family to notify the nursing staff prior to leaving patient unattended. Provide Education Information regarding Fall Risks to family/caregiver. ▪ Other nursing interventions applicable to the patient that may reduce fall risk. ▪ Also consider bedside mats for patients with a history of stroke or frequent falls.

VII. INTERDISCIPLINARY AND INTERDEPARTMENTAL FALL PREVENTION PROGRAM

The Fall Prevention Program is a hospital-wide effort for all employees to assist in providing a safe environment for all patients.

A. **Fall Risk Assessment for Outpatients:**
   1. Fall Risk assessment will be conducted on all outpatients who require a nursing or therapy initial assessment.
   2. The primary care nurse or therapist will perform an initial fall risk screening and re-screening with significant changes in condition. Fall risk interventions will be implemented relative to the fall risk score of the patient.

B. **Education:**
   1. Staff will receive orientation and training to achieve competency in assessing 'At Risk' to fall patients including prevention and intervention strategies.
   2. Provide patient and family education on Fall Prevention and document education given.

C. **Hand Off Communication/Documentation of 'At Risk' for falls patients:**
   - Communicate fall risk with a verbal handoff report to other procedural areas such as when a patient is leaving the floor to go for an x-ray and/or provide a communication tool such as a 'ticket to ride' to transporters indicating the patient's fall risk status and need for special observation.
   - Discuss fall risk and patient specific interventions when giving report to nurses and unlicensed assistant personnel at change of shift as well as a change to unit or procedural area.
   - If patient is considered to be ' At Risk' to fall and/or 'At Risk' for Injury from falls (ABCS); the risk and interventions will be reported in all hand-off communications (e.g. department to department, bedside shift report, discipline to discipline, transfer or discharge to other facility or service).
   - Remind and prompt staff of patients 'At Risk' to fall and the planned interventions (e.g. bed alarm,

   bed to be in lowest position it will go, bedside floor mats and do not leave unattended in bathroom) during unit-based daily safety huddle.
   - Document falls by completing a Fall Event Report in the incident reporting ~~ERS~~ system; the post fall assessment in the electronic medical record, and if indicated a Root Cause Analysis (RCA) may be conducted for falls classified as Serious Safety Events (SSE). Document hand off communication.

D. **Review of 'At Risk' for falls Patients in Procedural Areas:**

- Procedural area staff should review patient for risk and provide precautions and education to patient and family concerning the new environment.
- All patients' wearing a High Risk for fall armband must be assisted when ambulating or when standing alone for a procedure/exam in order to protect patient from falling.
- Implement safety precautions such as safety straps, supportive devices to protect patients from falls during procedures.

E. **Fall Risk Interventions for Imaging Area/Interventional Radiology:**

- Don't stand patients for examinations who are 'At Risk' to fall.
- Any patient receiving contrast or moderate sedation during the procedure have a higher risk to fall therefore ensure the use of 'safety straps' when patient is on the examination table.
- Include 'at risk' for fall patients in hand off communication.
- All patients should be assisted on/off examination table and use long handed foot stools when patients are stepping up or down from the examination table.
- Keep ambulatory assisted device close to patient when possible.
- Do not allow patients to sit on rolling stools.
- Assist 'At Risk' patient for falls with re-dressing.
- Do not leave a fall risk patient unattended on a stretcher or examination table.

F. **All Staff Preventive Measures:**

- Patients identified as 'At Risk' to fall will have a distinctive fall prevention magnet/symbol or sign placed on the door outside of the patient's room to identify a patient with a fall risk. When passing by a room and the ~~**<Change to accurately reflect the type of door magnet utilized, i.e. star, dot >**~~ magnet/symbol or sign ~~magnet~~ is seen, look in the room to make sure the patient is i~~n bed~~, not trying to get out of bed or recliner alone, and/or is not already out without assistance. Get help if needed. The emergency bell in the bathroom is a quick access for emergency help. ~~A distinctive color placed on the chart and/or nurses communication board to notify nurses/ancillaries that the patient is prone to falls.~~
- Transporting 'At Risk' to fall patients off of the nursing unit to other areas of the facility should only be done after the nursing staff is notified and the patient should not be left unattended while away from the unit.
- If the patient starts to fall while ambulating, do the following:
  1. Grasp the gait belt or put both arms around the patient's waist.
  2. Stand with feet apart to provide a broad base of support.
  3. Extend one leg forward and let the patient slide against it to the floor. Avoid hyperextending the knee to avoid injury.
  4. Bend the knees and lower body as the patient slides to the floor.
- ~~Consistency in using the same color for magnet, dot and armband is an important intervention in order to provide clear understanding of the fall prevention program being implemented.~~

VIII. POST-FALL

If a patient does fall nursing staff may refer to the WCH Post F~~f~~all ~~Critical Event Checklist (Emprint Form #NS4-701)~~Toolkit located on the WCH intranet. ~~for how to care for a patient's immediate clinical needs post fall.~~

A. Follow Post Fall Event Checklist (attachment B) **:**

- Assess patient for injury
- Notify MD
- Notify family
- Update preventive measures

- Communicate during handoffs and transfer

B. **Conduct Post Fall Huddle utilizing WCH Post-Fall Huddle Form (Attachment C)**
: A post fall huddle should be led by the charge nurse or designee and should:

- Convene as soon as possible after the fall
- Be brief
- Involve staff caring for the patient and/or present at the time of the fall
- Involve the patient and family whenever possible
- Utilize a spirit of inquiry to discover fall type and preventability
- Identify actions to prevent reoccurrence
- Identify patient specific fall and injury prevention interventions

Findings from the post fall huddle should be shared at change of shift and at safety huddles.

- ~~occur as soon as possible after a fall. During the Post Fall Huddle determine the immediate cause of the fall by leading front-line staff and patient/family in a conversation to determine why a patient fell and what can be done to prevent future falls. Refer to Post Fall Huddle Form (RM-1301).~~

IX. REFERENCES

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Attachment A

MORSE FALL ASSESSMENT SCALE

To be completed by nurse along with Date and Time – check ALL that apply

CHOOSE HIGHEST APPLICABLE SCORE FROM EACH CATEGORY		Scale	DATE and TIME /	/	/
HISTORY OF FALLING	No	0			
	Yes	25			
SECONDARY DIAGNOSIS *(more than one diagnosis)*	No	0			
	Yes	15			
AMBULATORY AID	None, bed rest, uses W/C, or nurse assists	0			
	Crutches, cane(s), walker	15			
	Furniture	30			
IV/HEPARIN LOCK OR SALINE	No	0			
	Yes	20			
GAIT/TRANSFERRING	Normal, on bed rest, immobile	0			
	Weak (uses touch for balance)	10			
	Impaired (unsteady, difficulty rising to stand)	20			
MENTAL STATUS	Oriented to own ability	0			
	Forgets limitation	15			
Total Morse Fall Scale score at the time of fall (High Risk greater than or equal to 45)		Total Score			

Risk Level	Morse Fall Scale Score	Actions
No/Low Risk	0-44	Implement NO/LOW Risk fall preventive interventions
High Risk	45 or greater	Implement HIGH Risk fall protective interventions plus No/Low Risk preventive interventions

If High Risk for fall, Complete this Section. Check ALL that apply to identify patients at risk of injury from a fall. Patient is at risk for injury from a fall if any one or more of the ABCS apply.	DATE and TIME /	/	/
Age over 85			
Bone disorder (osteoporosis, Metastasis)			
Coagulation (bleeding, anticoagulant use)			
Surgery (recent surgery of abdominal, limb, thoracic)			

Signature	Title	Date	Time
Signature	Title	Date	Time
Signature	Title	Date	Time

Morse Fall Assessment Tool
NS-1330HMS 09/15 Page 1 of 2

Patient Label

WATSONVILLE COMMUNITY HOSPITAL

WCH Post Fall Event Checklist

Step	Intervention	Completed
Witnessed or unwitnessed post fall response		
Utilize the Nursing Process to assess and identify immediate dangers	✓ Assess ABCs ✓ Assess vital signs ✓ Assess for injuries, including c-spine ✓ Glascow Coma Score (for unwitnessed fall or if patient hit head) ✓ Observe for neurological changes indicating stroke ✓ Note Factual Events	
Implement necessary notifications and treatments	✓ Notify MD ✓ Consider notifying case management for home assessment ✓ Obtain order for PT eval, if not already done ✓ Clean and dress any wounds ✓ Provide analgesia if required and not contraindicated ✓ Arrange further tests as indicated (i.e., blood sugar, x-ray) ✓ Unwitnessed or head injury fall: vital signs and neuro check hourly x 4, then every 4 hours x 24 hours OR as ordered by MD ✓ Witness and no head injury fall: Monitor patient condition every 4 hours x 24 hours OR as ordered by MD	
Notify the charge nurse of need to conduct post fall huddle.	✓ Include multidisciplinary team whenever possible • Primary RN • CNA • Provider • Pharmacist • Physical Therapy	
Conduct the Post Fall Huddle	✓ Convene as soon as possible after the fall ✓ Keep huddle brief ✓ Involve staff present at time of fall ✓ Involve the patient and family whenever possible ✓ Utilize a spirit of inquiry to discover fall type and preventability ✓ Identify actions to prevent reoccurrence ✓ Identify patient specific fall and injury prevention interventions	
Notify family and document the notification	✓ **Adult patient:** Notify family member or primary contact ✓ **Pediatric patient:** Parent(s) or guardian must be notified	
Complete documentation in electronic medical record	✓ Complete Post Fall Assessment ✓ Fall Risk Assessment ✓ Glascow Coma Scale if indicated ✓ Update patient specific fall prevention interventions as indicated	
Complete documentation in incident reporting system	✓ Primary RN complete Verge report	
Communicate during handoffs and upon transfer to another unit	✓ Fall Risk Assessment Score ✓ Fall prevention interventions in place ✓ Fall history	

WATSONVILLE
COMMUNITY HOSPITAL

WATSONVILLE COMMUNITY HOSPITAL

Post Fall Huddle Tool

Date:_____ **Patient Name**_____ **MRN** _____

GOAL: Ensure quality care and patient safety by implementing immediate changes to Patient's plan of care to prevent further falls or falls with injury.

Complete huddle for ALL falls (assisted/unassisted) after providing appropriate patient care.

Participants	1. Designated post-fall huddle facilitator for the shift (charge nurse or in absence, designee) 2. Healthcare professionals who directly care for the patient (E.g., primary RN, CNA) 3. Other members of the patient care team as available (E.g., PT, OT, pharmacy, physician)

Facilitator Role: Guide frontline staff in a conversation to determine why a patient fell, what can be done to prevent future falls or injury, and to identify immediate changes to the plan of care.

	Ask these questions:	**Handwritten notes**
Step 1	**Did we know this patient was at high fall risk?** ☐ **Yes** ☐ **No** **Was there a hx of falls prior to admission?** ☐ **Yes** ☐ **No** **Was there a hx of falls during this admission?** ☐ **Yes** ☐ **No**	
	Describe what the patient/resident was doing when he/she fell? (E.g., transferring to chair, standing from bedside chair without walker, toileting without assistance)	
	Describe what staff caring for this patient were doing when the patient fell? (E.g., waiting for bathroom call light, caring for another patient, charting)	
	What was different this time as compared to other times the patient was engaged in the same activity for the same reason?	
	How could we have prevented this fall? (E.g., physical/occupational therapy consult, pharmacy consult/medication review, remaining with patient during toileting)	
	What immediate changes will we make in this patient's plan of care to decrease the risk of future falls of falls with injury?	

	Identify Fall Type (Choose ONE)		**Actions taken to prevent reoccurrence for this patient.**
Step 2	☐**Non-Physiological - Accidental** E.g., Trip over tubing or furniture, slip on floor. Environmental cause.	Possibly Preventable	
	☐**Physiological fall - Anticipated** E.g., Hypotension, impaired gait, confusion, loss of balance, centrally acting medication. Previously known factor.	Possibly Preventable	
	☐**Physiological fall - Unanticipated** E.g., Heart attack, seizure, stroke. Unknown sudden condition that cannot be anticipated before event.	Unpreventable	

Facilitator – Turn this form into your manager. Answers may be helpful for primary RN EMR documentation and Verge report.
Primary RN- Complete EMR documentation (post fall assessment, fall risk assessment) and submit Verge report by the end of your shift.

Post Fall Huddle Form adapted from the University of Nebraska Huddle Form.

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Hand-Held Metal Detectors for Use in Concealed Weapon and Contraband Detection	Policy #	NURXXXX
Responsible	Emergency Department Director	Revised/Reviewed	04/19/2023

I. PURPOSE

1. The purpose of this policy is to provide operating instructions to use the handheld metal detector to search patients and their belongings for weapons for the safety of patients and staff.
2. From the manufacturers operating instructions:

The metal detector is an active handheld metal detector with very high sensitivity to all metals, including ferrous, non-ferrous and stainless steel. Detection and alarming takes place when the instrument is passed in close proximity to metal objects.

Detection range is dependent upon the size and conductivity of the metal object. The larger the object, the greater the detection distance.

The detector is factory preset to nominal sensitivity with no operator adjustments required. This ensures that the detector will be used at the proper operating level established for the particular security need.

Should nearby, stationary metal objects (floor rebar, metal walls or cell bars) cause interference to the scanning process, an interference elimination button is available to momentarily reduce sensitivity so as to ignore the interfering nearby metal and permit precise scanning of the individual or object being scanned.

When metal objects are encountered, the red LED is activated along with an audible or vibrating alarm (depending upon user setting). An optional earphone may be used by the operator. Further convenient LEDs include green for power on status and amber for low battery indication.

II. POLICY

xx

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Turn the detector on.
   a. The detector has a 3 way power switch
   b. When the switch is forward the detector will give audio and visual alarms
   c. When the switch is backward the detector will vibrate and audio is muted
   d. When the switch is in the middle position the detector is off
2. While the detector is ON it will only detect metal when the wand is in motion.

3. Move the instrument within approximately one inch from the object or person being screened
4. Vibration or audio alarms (depending on the setting selected) indicate a metallic object under the area being scanned and warrants further investigation.

Trouble Shooting

1. The detector is battery operated. Replace the batteries by sliding back the battery cover and tilting the battery out. Replace it with a fresh battery.
2. There is an operation manual available on the INTRANET AT (place manual there)

V. REFERENCES

GARRETT HANDHELD METAL DETECTOR Operating Instructions
https://manuals.plus/m/ea9b9f6370a35bbe9141ba5039b8f11f6738a23ebee43ec82eee9333959d9c6d_optim.pdf

Hand-Held Metal Detectors for Use in Concealed Weapon and Contraband Detection

https://www.ojp.gov/pdffiles1/nij/200330.pdf

VI. STAKEHOLDERS

Emergency Department
Facility Department

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Puncture Resistant Glove Use in Concealed Weapon and Contraband Detection	Policy #	NURXXXX
Responsible	Emergency Department Director	Revised/Reviewed	04/19/2023

I. PURPOSE

The purpose of this policy is to provide instructions for use of puncture resistant gloves during patient personal searches and/or searches within their belongings for weapons, sharps or contraband for the safety of staff and patients.

Employers shall select and require employees to use appropriate hand protection when employees' hands are exposed to hazards such as those from skin absorption of harmful substances; severe cuts or lacerations; severe abrasions; punctures. (OSHA 1910.138(a)

1. From the manufacturer's instructions:
   a. Glove life varies depending on the application, environment, and amount of use. Take note of areas that have begun to wear down, such as loose Velcro® or a worn-down name tag. If you see holes in the synthetic leather or TP-X® material on the palm of your glove, this is an indication that its protective qualities may be compromised, putting you at risk of injury. (Do not use or put gloves back into circulation if you encounter a pair of gloves that are compromised).
   b. Lingering moisture or a strong odor are also signs that your gloves may need to be replaced.
   c. Gloves should be stored in clean, dry conditions, away from direct sunlight and extreme temperatures.

2. Use Safety
   a. Remove gloves from circulation if holes, cuts, odor or excessive wear noted and return worn/damaged product to unit manager for replacement.
   b. Return visibly soiled gloves to manager for laundry.

II. POLICY

xx

III. DEFINITIONS

N/A

IV. PROCEDURE

1. Perform hand hygiene
2. Don nitrile gloves
3. Select puncture resistant glove closest to your glove size
4. Don puncture resistant glove over nitrile glove.
5. Perform search (belongings and/or patient)
6. Wash hands with puncture resistant gloves still on with soap and water.
7. Remove puncture resistant gloves and hang puncture resistant gloves to dry
8. Remove nitrile gloves and discard in trash container

9. Perform hand hygiene

V. REFERENCES

1. 1910.138 - Hand protection. | Occupational Safety and Health Administration (osha.gov)
2. PointGuard® Ultra 9032 Spec Sheet
3. PointGuard® Ultra 9032 CE Certificate

VI. STAKEHOLDERS

Emergency Department
Facility Department

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Care Process	Policy #	REHAB1925
Responsible	Director of Rehabilitation Services	Revised/Reviewed	04/17/2023

I. PURPOSE

1. To ensure patient care is provided according to physicians' orders, and compliant with Federal and State laws and regulations.
2. To coordinate the care, treatment, and services of rehabilitation.

II. POLICY

1. Each Outpatient Rehabilitation Services patient will have a medical record of care and treatment, which includes subsequent referrals, copies of progress notes and treatment plans. Documentation of Inpatient Rehabilitation Services will be contained in the patient's medical record.
2. Rehabilitation therapists will obtain orders and provide care in accordance with physician's orders that are established prior to initiating patient care and reviewed/revised by the physician per hospital policy.
3. An initial evaluation of every patient will be performed by a licensed Rehabilitation Therapist to determine a treatment plan that is based upon the prescription of the referring physician and the specific individual needs of the patient.
4. The patient's assigned Rehabilitation Therapist has responsibility of determining the overall effectiveness of the established treatment plan and determine if implementation of care and services is consistent with the actions and time frames identified in the Treatment/Care Planning process, including specified visit frequency.
5. All assessments and evaluations must be performed and signed by a licensed therapist. If written home instructions are necessary, a copy will be filed in the patient's medical record.
6. The interdisciplinary treatment approach will be used in the planning of care by communicating essential information about patient care to the appropriate individuals using approved facility mechanisms of communication (documentation, verbal communication, meetings).
7. All patient visits will be documented in the patient's record. Proper documentation of communications with the referring physician will be maintained in the patient's medical record and will include the physician's signature.

III. DEFINITIONS

Medical Record Documentation: Rehabilitation Therapists record their initial assessments and treatment notes on the MedHost electronic medical record. A physical chart also exists in the outpatient with all appropriate documentation for each patient.

IV. PROCEDURE

1. Each patient will be assessed, and observations recorded. The data collected in the initial assessment will be utilized to establish a Treatment Care Plan for the patient. An individualized Treatment Care Plan will be developed for each patient considering the patient's preference regarding:
   a. Medical intervention.
   b. Treatment choices.
   c. Family involvement.
   d. End of life decision, if appropriate.

2. The Treatment Care Plan is developed by the evaluating therapist. The licensed therapist initiates the Treatment Care Plan for care and for therapist assistant's care provided as an extension of services.
3. The Treatment Care Plan is individualized and based on the initial assessment and evaluation of the patient's physical, cognitive, communicative, educational, emotional, daily activity needs and social status. A therapy treatment plan will be developed in collaboration with the physician and documented in the patient's medical record.
4. The Treatment Care Plan may include:
   a. Treatment modalities.
   b. Identification of adaptive equipment and devices.
   c. Functional limitations and status including barriers or facilitators to achievement of the treatment goals.
   d. Activities permitted.
   e. Nutritional requirements.
   f. Medications.
   g. Pain assessment and treatment required.
   h. Community resources identified and utilized.
   i. Safety measures to protect the patient from injury.
   j. Patient skill and support requirements for functioning with optimal independence and choice.
   k. Potential discharge needs.
   l. Type, frequency, duration of rehabilitative services.
   m. Diagnosis.
   n. Anticipated goals.
5. Every patient will be monitored for response to care or services and adapted as necessary. Quality service should be provided for every patient.
6. The patient's current clinical condition will be noted in each assessment, including a functional or rehabilitation service diagnosis. A summary of the patient's current clinical condition will be included with all presenting problems that directly relate to the patient's primary dysfunction (functional diagnosis) which is identified by the therapist. This list of problems will determine the choice of appropriate treatment procedures to be utilized and dictate the short-term goals of the patient's individualized treatment program.
7. Individual treatment goals will be based on pertinent diagnoses, problems and needs, strengths, limitations, patient goals, condition, preferences, and ability to respond to care or services. Changes to or modification of goals will be performed only by the treating therapist.
8. Patients will participate in establishing their own goals for treatment. If a patient has unreasonably high expectations, the evaluating therapist is required to explain and clarify what is a reasonable expectation or the limitations of rehabilitation therapy. Appropriate documentation of this conversation should also be made in the patient's medical record.
9. Short-term goals are achievable within a matter of days or weeks, depending on the patient's current clinical condition. Long-term goals are achievable as the final functional outcome.
10. When short term goals are achieved, either the list will be reduced, or new short-term goals will be established. Additionally, if short-term goals are not attained within the desired time frame, the treatment plan must be reassessed by the therapist to determine if changes or modifications are necessary. The therapist will indicate the reason goals were not met.
11. Progress is evaluated on the deficits noted, response to treatment given, and progress toward the goals established at the time of the initial evaluation. The plan of care is periodically modified by a licensed therapist based on progress toward the goals of treatment.
12. Each treatment will be documented appropriately. Documentation will include all treatment provided, subjective comments or complaints, response to treatment, and patient progress. Only individuals authorized to document in the patient's medical record, according to state law, will document in the record.
13. Documentation for treatment may include, but is not limited to, the following information:
    a. Date of treatment.
    b. Area of treatment.
    c. Pain level at beginning and end of session and how therapist address pain.
    d. Treatment given, including length of time for each procedure and intensities.

   e. All formal or informal education.
   f. Review of or instruction in home exercise/care programs, including any instruction provided to the patient/patient's family or primary caregiver. Include a statement of the patient's demonstration of the covered aspects of the program(s) and understanding of the covered aspects.
   g. Subjective comments or complaints made by the patient.
   h. Objective findings.
   i. Positioning of patient during treatment.
   j. Patient response to treatment.
   k. Patient progress or lack of progress.
   l. Plan for continuation or discontinuation of treatment.
   m. Signature of therapist and professional designation.
14. Progress Reports will be prepared to reflect changes in patient status since the start of treatment and changes since the previous Summary Progress Report.
15. Progress or changes documented in the Summary Progress Report will be stated in behavioral, objective, and measurable terms (i.e., level of assistance, range of motion, strength, gait, etc.). Any changes in the treatment plan will be made by the treating therapist based on objective findings and in consideration of any necessary medical direction.
16. Each Progress Report will include:
   a. Comparison of all objective data (range of motion, strength, special testing, etc.) to initial findings.
   b. Comparison of all subjective data.
   c. Objectives and current patient progress, including goals met.
   d. Necessity to modify initial goals.
   e. Necessity to modify the treatment plan.
   f. Frequency and anticipated duration of treatment yet needed.
   g. Signature of therapist and professional designation.
17. The licensed professional is to contact the physician for input and possible orders when:
   a. Initial assessment is completed.
   b. Change in patient's condition occurs.
   c. Ordered care is ineffective.
   d. Pertinent patient information to communicate.
   e. Desired goals are not being achieved.
   f. Patient failure to participate.
18. Documentation must include:
   a. Response to treatment.
   b. Any cancellations or missed appointments including the reason for the missed treatment, if known.
   c. The removal and reapplication of restraints (if in use) during the treatment session. Since most patients who are being restrained are confused or exhibit other similar symptoms, it should be documented that a staff member was in attendance during the entire treatment session.
19. The patient will be discharged from Rehabilitation Services when:
   a. Established objectives and goals were accomplished to the satisfaction of the patient, physician, and rehabilitation therapist.
   b. Patient has reached maximum benefit from treatment, with further treatment determined to be of no real improvement to level of functioning.
   c. Patient non-compliance.
   d. Patient relocation out of the area.
   e. Intercurrent illness.
   f. Patient refusal of treatment.
   g. Termination of treatment recommended and ordered by physician.
   h. The patient's level of function is sufficiently high that skilled therapy services are not indicated.

20. Discharging a patient
    a. Outpatient: Send a discharge note to the attending physician summarizing the course of therapy for the patient. In the progress notes, write that the patient is being discharged from your specific therapy, Physical Therapy, Occupational Therapy, or Speech Therapy.
    b. Inpatient: Document discharge from services in the treatment notes.
21. Outpatient Discharge Summary should include:
    a. Total length of time in active rehabilitation services care.
    b. Comparison of all objective data (range of motion, strength, special testing) to initial findings.
    c. Comparison of all subjective data and/or patient complaints.
    d. Goals and achievement of those goals, or lack thereof.
    e. Treatment provided to the patient during the course of care.
    f. Rehabilitation services care.
    g. Patient's current clinical condition and status as discharged from active rehabilitation services care.
    h. Discharge plans and instructions provided.
    i. Reason(s) for discharge.
    j. Progress toward goal achievement.
    k. Final outcome status.
    l. Any special discharge care needs (discussions with other members of the healthcare team).
    m. Date of discharge.
    n. Signature of therapist and professional designation.
    o. If the duration of therapy services is so short that the above information is not available, an amended brief discharge summary will be completed.

V. REFERENCES

Professional Practice Acts from Physical Therapy (APTA), Occupational Therapy (AOTA) and Speech Language Pathology (ASHA).

VI. STAKEHOLDERS

Occupational Therapists, Physical Therapists, Physical Therapy Assistants, Speech Language Pathologists

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Medical Staff Policy Regarding Peer Review, Ongoing Professional Practice Evaluation (OPPE) & (FPPE)	Policy #	MS2842
Responsible	Medical Staff , Quality Management Director	Revised/Reviewed	01/17/2023

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.

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

Ongoing Professional Practice Evaluation:
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.

Focused Professional Practice Evaluation:

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.

Peer Review

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.

Practitioner Proctoring:

Please Refer to Proctoring Policy (#0158)

Focused Professional Practice Evaluation (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
d. 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
   iv. Professionalism
   v. 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. Reviewer Selection & 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. Reviewer Disqualification & 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~~ **summary** of the review. ~~Comments and/or opinions made by the reviewer may be included; however, the~~ **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 **will** 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. ~~**The Practitioner will be given a copy of their external peer review findings.**~~

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. Review Form Summary

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

DOCUMENTATION OF PEER REVIEW ACTIVITIES:

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 Bylaw.

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

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.

I. REFERENCES

N/A

II. STAKEHOLDERS

MEC

WATSONVILLE COMMUNITY HOSPITAL

PEER REVIEW WORKSHEET

☐ **MQRC** ☐ **SQRC** ☐ **B&T**

MEDICAL STAFF BUSINESS NOT TO BE INCLUDED IN PATIENT CHART

Physician #	Account #	Medical Record #	*INPATIENT*		Outpt./ER Date	Review Date
	3050562		Admission Date	Discharge 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:

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)*

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

Case Review Scoring		
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

Case Review Scoring			
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's Final Score	☐ 1 – Treatment appropriate, outcome good and any adverse impact on the patient was minimal. ☐ 2 – Treatment appropriate, but in spite of that the patient sustained a significant adverse outcome. ☐ 3 – Treatment inappropriate, but the adverse impact on the patient was minimal. ☐ 4 – Treatment inappropriate and the patient sustained a significant adverse outcome.		
Additional Committee Recommendations:			

DISPOSITION

QRC Action: ☐ Score Upheld ☐ Score Modified _____

☐ Refer to _____ Department / SQRC / MQRC / MEC / QCC/CNO ☐ External Peer Review

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

Chairperson Signature _____ Date _____

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023

Report Type: Discussion

Title: Employee Engagement (EE) Committee Member Appointments

Recommendation: Pass a **Motion** approving:1) Senior Executive, Allyson Hauck, Chief Human Resources Officer; 2) Senior Executive, June Ponce, Foundation Executive Director 3) Hospital Director/Manager – Anna Anton, Director of Acute Care; 4) Hospital Director/Manager – Yvonne Combs, Director of Rehab Services; 5) Staff – Elizabeth Smolanovich, Staff Nurse II Telemetry; 6) Staff – Carole Kulik, Nursing Supervisor; 7) Staff/Other – Leticia Suarez, Central Scheduler; 8) Staff/Other –Kelly Strickling, Lead Lab Technician 9) Provider – TBD; and 10) Provider – TBD to serve on the EE Committee.

Contact: Allyson Hauck, Chief Human Resources Officer

Background

The Pajaro Valley Health Care District Hospital Corporation amended and restated bylaws were approved on 01/25/2023 clarifying the composition of the established Standing Committees.

Section 6.5 (c) Employee Engagement Committee specifies the following:
The Employee Engagement Committee shall consist of minimum of two (2) Board members, with a total minimum of at least twelve (12) persons including, two (2) senior executives; two (2) hospital directors or managers, two (2) providers with medical staff privileges at Watsonville Community Hospital i.e. physicians or advanced practice providers and two (2) hospital front line staff.

Since its initial March 8, 2023 meeting, the EE Committee has continued to outreach to those who might be interested in serving on the Committee.

Financial Impact: None.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023

Report Type: Discussion

Title: Quality and Patient Safety Committee Member Appointments

Recommendation: Pass a **Motion** approving Hospital Director/Manager Tracy Trail-Mahan-Quality and Risk; 2) Hospital Director/Manager Jennifer Gavin-Director of Pharmacy; 3) Hospital Director/Manager Sherri Stout-Torre-Chief Nursing Officer; 4) Hospital Director Matko Vranjes Interim CEO; 5) Provider, Dr. Clay Angel-Chief of Staff and 6) Provider, Dr. Janelle Rasi-Vice Chief of Staff to serve on the QPS Committee.

Contact: Sherri Stout-Torre-Chief Nursing Officer

Background

The Pajaro Valley Health Care District Hospital Corporation amended and restated bylaws were approved 01/25/2023.

Section 6.5 (d) Quality Patient Safety Committee specifies the following:

The Quality and Patient Safety Committee shall consist of a minimum of two (2) Board members, with a total minimum of at least ten (10) persons, including, two (2) senior executives; two (2) hospital directors or managers, two (2) providers with medical staff privileges at Watsonville Community Hospital i.e. physicians or advanced practice providers 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.

Since its initial February 15, 2023 meeting, the QPS Committee continues to outreach to those who might be interested in serving on the Committee.

Financial Impact: None.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023

Report Type: Discussion

Title: Medical Executive Committees Reports June 2023

Recommendation: Pass a **Motion** approving 1) the Medical Executive Committee (MEC) Report, the Credentials Report and the Interdisciplinary Practice Credentials Report of June 2023 and 2) OPPE templates for Anesthesia Physicians, Pathology Physicians, Emergency Medicine Physicians, Emergency Medicine AHP.

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

Analysis

At each board meeting the board receives reports from the Medical Executive Committee including the Credentials Report and the Interdisciplinary Practice Credentials Report.

Financial Impact: None.

Attachments:

A-Medical Executive Committee Reports
B-OPPE Templates
- Anesthesia Physicians
- Pathology Physicians
- Emergency Medicine Physicians
- Emergency Medicine, AHP

WATSONVILLE COMMUNITY HOSPITAL

Medical Executive Committee Summary – June 20, 2023
ITEMS FOR BOARD APPROVAL

Credentials Committee

INITIAL APPOINTMENTS: (10)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Alexander, Charlotte, MD	Obstetrics / Provisional	OBGYN	Obstetrics	06/29/2023 – 05/31/2025
Bi, Luke, MD	Gastroenterology / Provisional	Medicine	Gastroenterology, Sedation, Fluoroscopy	06/29/2023 – 05/31/2025
Bownds, Shannon, MD	Teleradiology / Provisional	Medicine	Teleradiology	06/29/2023 – 05/31/2025
El-Akkad, Samih, MD	Teleradiology / Provisional	Medicine	Teleradiology	06/29/2023 – 05/31/2025
Hazrati, Ehsan, MD	Internal Medicine Hospitalist / Provisional	Medicine	Internal Medicine, Critical Care	06/29/2023 – 05/31/2025
Klein, Michael, MD	Teleradiology / Provisional	Medicine	Teleradiology	06/29/2023 – 05/31/2025
Nalaboff, Kenneth, MD	Teleradiology / Provisional	Medicine	Teleradiology	06/29/2023 – 05/31/2025
Simpson, Dustin, MD	Teleradiology / Provisional	Medicine	Teleradiology	06/29/2023 – 05/31/2025
Strauchler, Daniel, MD	Teleradiology / Provisional	Medicine	Teleradiology	06/29/2023 – 05/31/2025
Wang, Eileen, MD	Pain Medicine / Provisional	Surgery	Pain Medicine, Sedation, Fluoroscopy	06/29/2023 – 05/31/2025

REAPPOINTMENTS: (4)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Follmar, Keith, MD	Plastic & Reconstructive Surgery / Active	Surgery	Plastic Surgery	07/01/2023-06/30/2025
Hasan, Mohamed, MD	Pediatrics / Active	Pediatric	Pediatrics	07/01/2023-06/30/2025
Hwang, Stanley, MD	Cardiovascular Disease / Active	Medicine	Cardiovascular Disease	07/01/2023-06/30/2025
Powell, Carmin, MD	Pediatrics / Active	Pediatrics	Pediatric	07/01/2023-06/30/2025

MODIFICATION / ADDITION OF PRIVILEGES:

NAME	SPECIALTY	Privileges
None		

STAFF STATUS MODIFICATIONS:

NAME	SPECIALTY / DEPARTMENT	RECOMMENDATION
Nguyen, Tea, DPM	Podiatry / Surgery	Voluntary Resignation

TEMPORARY PRIVILEGES:

NAME	SPECIALTY / DEPARTMENT	DATES
Alexander, Charlotte, MD	Obstetrics / OBGYN	06/21/2023 – 06/29/2023
Bi, Luke, MD	Gastroenterology / Medicine	06/01/2023 – 06/28/2023
Hazrati, Ehsan, MD	Internal Medicine Hospitalist / Medicine	06/05/2023 – 06/29/2023

INTERDISCIPLINARY PRACTICE COMMITTEE

Initial Appointment: (2)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Castellanos-Jimenez, Cristina, PA-C	Physician Assistant / Allied Health Provider	Surgery	Physician Assistant, Surgery	06/29/2023 – 05/31/2025
Duffy, Erin, PA-C	Physician Assistant / Allied Health Provider	Emergency Medicine	Physician Assistant, Emergency Medicine	06/29/2023 – 05/31/2025

REAPPOINTMENT: (1)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Nguyen, Tran, PA-C	Physician Assistant / Allied Health Provider	Surgery	Physician Assistant, Surgery	06/29/2023 – 05/31/2025

Temporary Privileges: (1)

NAME	SPECIALTY / DEPARTMENT	DATES
Nguyen, Tran, PA-C	Physician Assistant / Surgery	06/24/2023 – 06/28/2023

WATSONVILLE COMMUNITY HOSPITAL

ANESTHESIA PHYSICIAN OPPE REPORT TEMPLATE 2023

Metrics	Source / Triggers	Physician Name			
Assessment					
~~Current medical/clinical knowledge~~	~~100%~~				
~~Appropriate clinical judgment~~	~~100%~~				
~~Good technical skills and proficiency~~	~~100%~~				
~~Accurate and timely medical record documentation~~	~~100%~~				
~~Appropriate management of multiple complex problems~~	~~100%~~				
~~Effective communication with other members of the health care team~~	~~100%~~				
~~Professionalism with patients, families and other members of the health care team~~	~~100%~~				
~~Efficient and effective utilization of hospital resources~~	~~100%~~				
~~Compliance with applicable clinical protocols and guidelines~~	~~100%~~				
~~Core Measures – SCIP – Antibiotics; timing, selection~~	~~100%~~				
~~Surgery cancelled after induction~~	~~2 incidents in a 6 month time period~~				
~~MI pre-op/Post-op (w/in 24 hrs)~~	~~2 incidents in a 6 month time period~~				
~~Unexplained change in patient condition in PACU (prolonged nausea/vomiting, aspiration)~~	~~2 incidents in a 6 month time period~~				
Dental injuries to patient during intubation	**3 incidents in a 12 month time period**				
Re-intubation in the recovery room	**3 incidents in a 12 month time period**				
Medical Record Delinquencies (suspensions)	**Trend**				
Peer Review Cases: Rated 3 or 4, PI Plan or FPPE	**2 level 4 or 4 level 3 & 4 in 24 months**				
~~Validated Patient Complaints~~	~~2 incidents in 6 months~~				
Validated SIGNIFICANT Disruptive Physician Complaints	**3 incidents in 12 months**				

☐ No issues identified; continue unrestricted current privileges

- ☐ Track and trend for pattern analysis
- ☐ Refer to SQRC for possible FPPE
- ☐ Other _____

_____

Department Chair: Date

Pathology Physicians OPPE Summary Report
TEMPLATE 2023

PATHOLOGY OPPE 2023

Indicator		Physician #					Physician #					Physician #					Physician #				
Peer Congruence:		**# of Cases**	**1**	**2**	**3**	**4**	**# of Cases**	**1**	**2**	**3**	**4**	**# of Cases**	**1**	**2**	**3**	**4**	**# of Cases**	**1**	**2**	**3**	**4**
Internal/External																					
Blind Overread																					
Frozen Section/ Histology Correlation	100%																				
External Consultations	N/A																				
Routine Report STAT (avg)	<72hrs																				

1 = No difference in interpretation

2 = Difference in interpretation with no potential impact

3 = Difference in interpretation with minimal potential impact

4 = Difference in interpretation with significant potential for altering plan of care

WATSONVILLE COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT PHYSICIAN OPPE REPORT TEMPLATE

Metrics	Source/ Triggers	Physician Name			
ED returns within 48 hours who are admitted with adverse outcomes/events	**MedHost ≥ 1.0% in 8 months**				
Procedural sedation adverse events or requiring interventions of administering reversal agents or invasive procedures (exclude brief bagging/O2 administration)	**MedHost 3 incidents in 8 months**				
Compliance with Central Line Placement Bundle Elements	**MedHost 100%**				
Medical Record Delinquencies (suspensions)	**HIM Trend**				
Peer Review Cases: Rated 3 or 4, PI Plan or FPPE	**2 level 4 or 4 level 3 & 4 in 24 months**				
Validated Disruptive Physician Complaints	**3 significant incidents in 12 months**				

☐ No issues identified; continue unrestricted current privileges

☐ Track and trend for pattern analysis

☐ Refer to M/SQRC for possible FPPE

☐ Other _____

_____

Department Chair: David Claypool, MD Date

Moderate Sedation Adverse Outcomes:

- Unplanned admission
- SaO2 of < 90% for 2 consecutive time periods
- Recovery time > 90 minutes
- Vomiting with potential aspiration
- Narcan given
- Sedation failure with inability to proceed with procedure
- Romazicon given
- Loss of protective reflexes
- Intubation required during or after procedure
- Non-corrected hemodynamic instability requiring intervention
- Procedure cancelled after patient had sedation
- Cardio-Respiratory arrest/ROSC

WATSONVILLE COMMUNITY HOSPITAL

EMERGENCY DEPARTMENT PRACTITIONER OPPE TEMPLATE REPORT

Metrics	Source/ Triggers	Practitioner Name			
Ordering Ultrasound for OB	**ED DATA / MedHost 90%**				
Otitis Externa–Avoidance of Systemic Antibiotics	**ED DATA / MedHost 90%**				
Medical Record Delinquencies (suspensions)	**HIM Trend**				
Peer Review Cases: Rated 3 or 4, PI Plan or FPPE	**2 level 4 or 4 level 3 & 4 in 24 months**				
Validated Disruptive Practitioner Complaints	**3 Significant incidents in 12 months**				

☐ No issues identified; continue unrestricted current privileges

☐ Track and trend for pattern analysis

☐ Refer to M/SQRC for possible FPPE

☐ Other _____

_____

Department Chair: David Claypool, MD Date

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023
Report Type: Discussion

Title: Update by Interim Chief Executive Officer (CEO)

Recommendation: Receive and file update from Matko Vranjes, Interim CEO

Contact: Matko Vranjes, Interim CEO

Analysis
At each board meeting the CEO provides the board and the public an oral update on various matters.

Financial Impact: None

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023

Report Type: Discussion

Title: Update by Chief Financial Officer (CFO)

Recommendation: Receive and file update from Julie Peterson, Chief Financial Officer

Contact: Julie Peterson, Chief Financial Officer

Analysis

At each board meeting the CFO provides the board and the public an update on Financial Performance.

Financial Impact: See attached report.

Attachments

A: Financial Performance Report

B: Presentation

Watsonville Community Hospital
Consolidated Income Statement
For The Month of May, 31, 2023

CURRENT PERIOD					YTD			
May-23	BUDGET	VARIANCE	% VARIANCE		ACTUAL	BUDGET	VARIANCE	% VARIANCE
				Operating Revenues				
26,275,584	36,380,933	(10,105,349)	-27.8%	Inpatient Revenue	146,106,960	175,829,405	(29,722,445)	-16.9%
59,153,198	51,060,742	8,092,456	15.8%	Outpatient Revenue	261,379,730	236,964,510	24,415,220	10.3%
85,428,782	**87,441,675**	**(2,012,893)**	**-2.3%**	**Total gross patient revenue**	**407,486,690**	**412,793,915**	**(5,307,225)**	**-1.3%**
				Deductions From Revenue:				
73,856,026	75,464,565	(1,608,539)	-2.1%	Contractual Allowances	359,104,336	358,217,206	887,130	0.2%
(1,599,179)	(1,599,179)		0.0%	QAF	(7,995,896)	(7,995,896)		0.0%
(128,059)	(128,059)		0.0%	Disproportionate Share DSH	(640,293)	(640,293)		0.0%
72,128,788	**73,737,327**	**(1,608,539)**	**-2.2%**	**Total Deductions From Rev**	**350,468,147**	**349,581,017**	**887,130**	**0.3%**
13,299,994	**13,704,348**	**(404,354)**	**-3.0%**	**Net Revenue**	**57,018,543**	**63,212,897**	**(6,194,354)**	**-9.8%**
970,343	116,834	853,509	730.5%	Provision for Bad Dbt	(530,267)	539,051	(1,069,318)	-198.4%
12,329,651	**13,587,514**	**(1,257,863)**	**-9.3%**	**Collectible Patient Revenue**	**57,548,810**	**62,673,847**	**(5,125,037)**	**-8.2%**
416,743	136,542	280,201	205.2%	Other Revenue	3,310,012	665,094	2,644,918	397.7%
12,746,394	**13,724,057**	**(977,663)**	**-7.1%**	**Total Net Operational Revenue**	**60,858,822**	**63,338,941**	**(2,480,119)**	**-3.9%**
				Operating Expenses				
6,044,479	6,241,118	(196,639)	-3.2%	Salaries & Wages	29,439,126	28,678,953	760,173	2.7%
1,815,585	2,102,725	(287,140)	-13.7%	Benefits	8,189,820	10,251,678	(2,061,858)	-20.1%
563,116	535,000	28,116	5.3%	Contract Labor	2,837,739	2,850,000	(12,261)	-0.4%
8,423,180	**8,878,843**	**(455,663)**	**-5.1%**	**Subtotal Salaries Wages & Benefits**	**40,466,685**	**41,780,631**	**(1,313,946)**	**-3.1%**
686,414	849,534	(163,120)	-19.2%	Medical Spec Fees	3,364,705	4,193,377	(828,672)	-19.8%
920,253	979,231	(58,978)	-6.0%	Supplies	4,796,878	4,497,006	299,872	6.7%
86,297	104,310	(18,013)	-17.3%	Repairs & Maintenance	499,145	508,091	(8,946)	-1.8%
151,206	166,678	(15,472)	-9.3%	Utilities	1,203,790	812,985	390,805	48.1%
1,168,611	1,278,654	(110,043)	-8.6%	Purchased Services	6,304,447	7,515,892	(1,211,445)	-16.1%
157,828	213,393	(55,565)	-26.0%	Lease Cost and Rent	791,922	1,044,189	(252,267)	-24.2%
191,762	280,606	(88,844)	-31.7%	Prop Taxes & Ins	915,303	1,366,015	(450,712)	-33.0%
500	4,167			Marketing	2,194	20,833		
641,407	996,437	(355,030)	-35.6%	Other Operating Exp	3,262,000	4,995,894	(1,733,894)	-34.7%
12,427,458	**13,751,853**	**(1,324,395)**	**-9.6%**	**Total Operating Exp**	**61,607,069**	**66,734,914**	**(5,127,845)**	**-7.7%**
318,936	**(27,796)**	**346,732**	**-1247.4%**	**EBITDA**	**(748,247)**	**(3,395,974)**	**2,647,727**	**-78.0%**
82,502	96,850	(14,348)	-14.8%	Depreciation and Amortization	452,159	481,728	(29,569)	-6.1%
386,429	405,337	(18,908)	-4.7%	Interest	1,940,441	2,008,626	(68,185)	-3.4%
468,931	**502,186**	**(33,255)**	-6.6%	**Total Other Expenses**	**2,392,600**	**2,490,354**	**(97,754)**	-3.9%
(149,995)	**(529,983)**	**379,988**	-71.7%	**Net Income/Loss from Operations**	**(3,140,847)**	**(5,886,327)**	**2,745,480**	-46.6%

Watsonville Community Hospital
Income Statement
For The Month of May, 31, 2023

CURRENT PERIOD					YTD			
May-23	BUDGET	VARIANCE	% VARIANCE		ACTUAL	BUDGET	VARIANCE	% VARIANCE
				Operating Revenues				
6,671,202	9,846,834	(3,175,632)	-32.3%	Inpatient Routine	36,165,735	46,734,457	(10,568,722)	-22.6%
19,604,382	26,534,099	(6,929,717)	-26.1%	Inpatient Ancillary	109,941,225	129,094,948	(19,153,723)	-14.8%
58,629,948	50,567,843	8,062,105	15.9%	Outpatient	258,822,427	234,593,350	24,229,077	10.3%
26,275,584	36,380,933	(10,105,349)	-27.8%	Inpatient Revenue	146,106,960	175,829,405	(29,722,445)	-16.9%
58,629,948	50,567,843	8,062,105	15.9%	Outpatient Revenue	258,822,427	234,593,350	24,229,077	10.3%
84,905,532	**86,948,777**	**(2,043,245)**	**-2.3%**	**Total gross patient revenue**	**404,929,387**	**410,422,755**	**(5,493,368)**	**-1.3%**
				Deductions From Revenue:				
73,532,379	75,187,931	(1,655,552)	-2.2%	Contractual Allowances	357,529,486	356,893,256	636,230	0.2%
(1,599,179)	(1,599,179)		0.0%	QAF	(7,995,896)	(7,995,896)		0.0%
(128,059)	(128,059)		0.0%	Disproportionate Share DSH	(640,293)	(640,293)		0.0%
71,805,141	**73,460,693**	**(1,655,552)**	**-2.3%**	**Total Deductions From Rev**	**348,893,297**	**348,257,067**	**636,230**	**0.2%**
13,100,391	**13,488,083**	**(387,692)**	**-2.9%**	**Net Revenue**	**56,036,090**	**62,165,688**	**(6,129,598)**	**-9.9%**
971,231	114,388	856,843	749.1%	Provision for Bad Dbt	(520,691)	527,207	(1,047,898)	-198.8%
12,129,160	**13,373,695**	**(1,244,535)**	**-9.3%**	**Collectible Patient Revenue**	**56,556,781**	**61,638,481**	**(5,081,700)**	**-8.2%**
345,154	116,792	228,362	195.5%	Other Revenue	2,960,760	568,888	2,391,872	420.4%
12,474,314	**13,490,487**	**(1,016,173)**	**-7.5%**	**Total Net Operational Revenue**	**59,517,541**	**62,207,369**	**(2,689,828)**	**-4.3%**
				Operating Expenses				
5,786,923	5,946,166	(159,243)	-2.7%	Salaries & Wages	28,182,697	27,303,922	878,775	3.2%
1,770,168	2,037,256	(267,088)	-13.1%	Benefits	7,953,942	9,923,407	(1,969,465)	-19.8%
563,116	535,000	28,116	5.3%	Contract Labor	2,837,739	2,850,000	(12,261)	-0.4%
8,120,207	**8,518,422**	**(398,215)**	**-4.7%**	**Subtotal Salaries Wages & Benefits**	**38,974,378**	**40,077,329**	**(1,102,951)**	**-2.8%**
679,539	843,983	(164,444)	-19.5%	Medical Spec Fees	3,336,663	4,111,014	(774,351)	-18.8%
911,897	972,573	(60,676)	-6.2%	Supplies	4,764,087	4,465,915	298,172	6.7%
86,297	104,189	(17,892)	-17.2%	Repairs & Maintenance	499,034	507,503	(8,469)	-1.7%
150,388	165,741	(15,353)	-9.3%	Utilities	1,197,160	807,318	389,842	48.3%
1,187,669	1,244,319	(56,650)	-4.6%	Purchased Services	6,111,228	7,347,356	(1,236,128)	-16.8%
133,769	196,296	(62,527)	-31.9%	Lease Cost and Rent	670,586	956,151	(285,565)	-29.9%
183,885	272,329	(88,444)	-32.5%	Prop Taxes & Ins	879,823	1,326,506	(446,683)	-33.7%
500	-	500		Marketing	2,194	-	2,194	
-	-			Management Fees	-	150,000	(150,000)	-100.0%
643,394	994,156	(350,762)	-35.3%	Other Operating Exp	3,251,525	4,829,609	(1,578,084)	-32.7%
12,097,545	**13,312,008**	**(1,214,463)**	**-9.1%**	**Total Operating Exp**	**59,686,678**	**64,578,701**	**(4,892,023)**	**-7.6%**
376,769	**178,478**	**198,291**	**111.1%**	**EBITDA**	**(169,137)**	**(2,371,332)**	**2,202,195**	**-92.9%**
-	-			Depreciation and Amortization	-	-		
7,927	18,878	(10,951)	-58.0%	Interest	114,334	76,333	38,001	49.8%
7,927	**18,878**	**(10,951)**	-58.0%	**Total Other Expenses**	**114,334**	**76,333**	**38,001**	49.8%
368,842	**159,600**	**209,242**	131.1%	**Net Income/Loss from Operations**	**(283,471)**	**(2,447,665)**	**2,164,194**	-88.4%

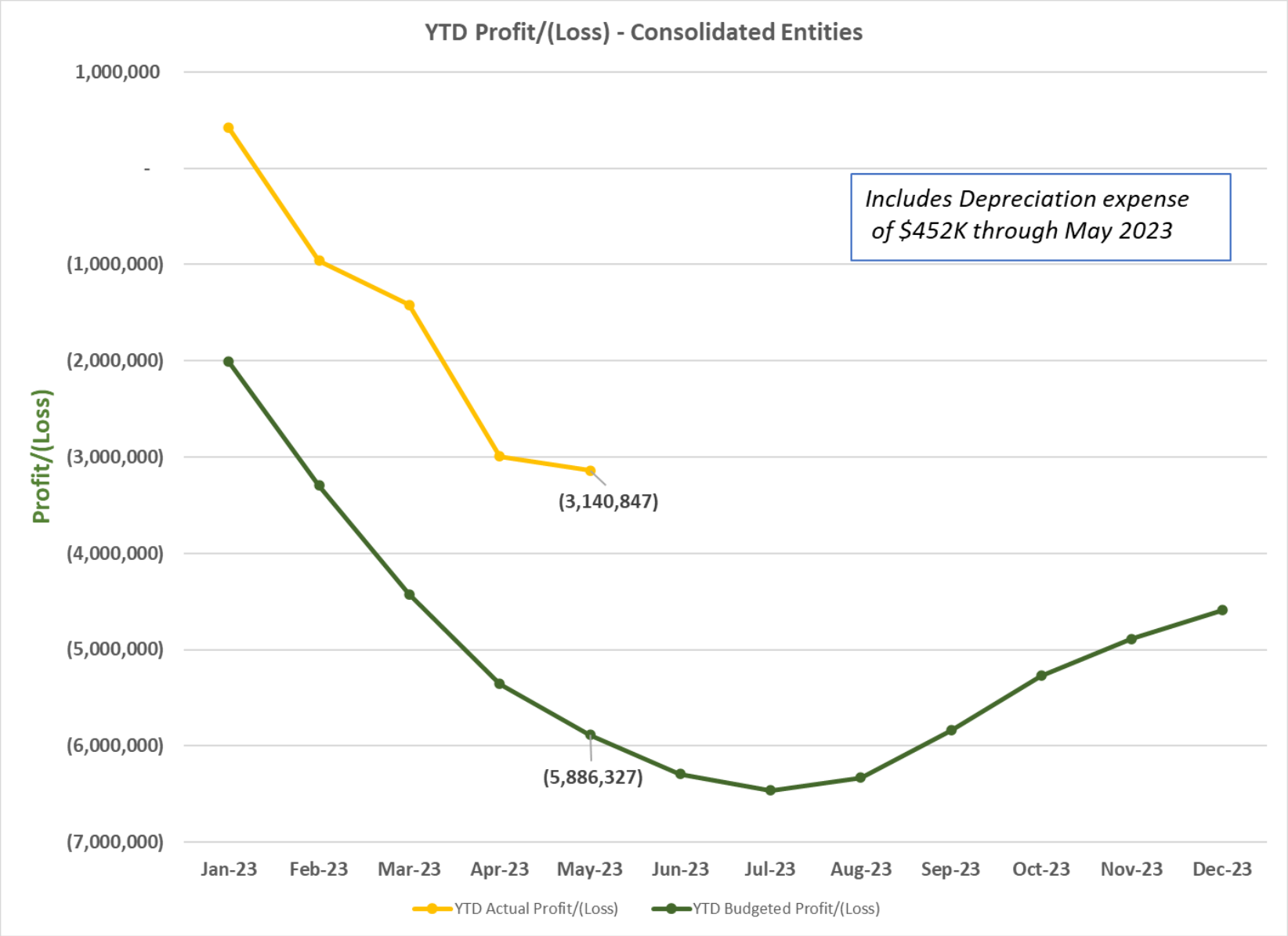
WATSONVILLE COMMUNITY HOSPITAL
2023 CONSOLIDATED TRENDED BALANCE SHEET
($ in 000's)

	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Assets					
Cash	$ 5,982	$ 6,078	$ 1,916	$ 3,958	$ 3,576
A/R	43,166	43,452	42,474	39,084	39,504
Less: Allowance for BD	(8,134)	(7,325)	(6,587)	(6,365)	(7,298)
Prior yr Cost Report Settlement					
Supplies	2,079	2,073	2,118	2,069	2,058
Prepaid Expenses	1,185	1,209	1,104	1,096	1,028
Other Current Assets	722	1,195	2,551	2,271	2,217
Total Current Assets	$ 45,000	$ 46,682	$ 43,576	$ 42,113	$ 41,085
Net PP&E	35,245	35,168	35,150	35,074	34,999
Operating Lease ROU, Net	1,676	1,634	1,491	1,449	1,408
Notes Receivable					
Deposits	5	5	5	5	5
Unamortized Loan Costs	50	50	50	50	50
Physician Recruitment Costs	-	-	-	-	-
Deferred MIS Charges	698	631	562	496	431
Goodwill (Placeholder)	(20,666)	(20,551)	(20,963)	(20,963)	(20,963)
Total Other Assets	$ (18,237)	$ (18,231)	$ (18,855)	$ (18,963)	$ (19,069)
Total Assets	$ 62,008	$ 63,619	$ 59,871	$ 58,224	$ 57,015
Liabilities and Equity					
Current maturities of LTD	$ (47)	$ (57)	$ (68)	$ (79)	$ (90)
Accounts Payable	6,622	7,194	7,009	7,361	6,855
Accrued Emp. Comp.	9,401	10,052	7,793	8,535	8,112
Operating Lease - Current	30	20	319	324	307
Other Accrued Liabilities	5,844	7,716	7,006	5,955	6,073
Total Current Liabilities	$ 21,850	$ 24,925	$ 22,059	$ 22,096	$ 21,257
Deferred Credits	6,935	6,880	6,405	6,318	6,133
Operating Lease Liabilities	1,693	1,655	1,194	1,159	1,124
Long Term Debt	39,836	39,847	40,358	40,369	40,379
Total Liabilities	$ 70,314	$ 73,307	$ 70,016	$ 69,942	$ 68,893
Stockholders' Equity	(8,306)	(9,688)	(10,145)	(11,718)	(11,878)
Total Liabilities and Equity	$ 62,008	$ 63,619	$ 59,871	$ 58,224	$ 57,015

Financial Performance May 2023

WATSONVILLE COMMUNITY HOSPITAL

Consolidated YTD Profit/(Loss)



WATSONVILLE COMMUNITY HOSPITAL

Consolidated YTD Budget vs Actual

Account	Actual	Budget	Variance
Net Operating Revenue	60,858,822	63,338,941	(2,480,119)
Labor (SWB & Registry)	40,466,685	41,780,631	(1,313,946)
Pro Fees Medical	3,364,705	4,193,377	(828,672)
Supplies	4,796,878	4,497,006	299,872
Purchased Services	6,304,447	7,515,892	(1,211,445)
Plant (Utilities, R&M, Tax & Insurance)	2,618,238	2,687,092	(68,854)
Other (Rent, Mgmt Fees, Other)	4,056,116	6,060,917	(2,004,801)
Total Operating Expense	61,607,069	66,734,914	(5,127,845)
EBITDA	**(748,247)**	**(3,395,974)**	**2,647,727**
Lease	1,940,441	2,008,626	(68,185)
Net Cash Gain/(Shortfall)*	(2,688,688)	(5,404,599)	2,715,911

** Excludes Depreciation*

WATSONVILLE COMMUNITY HOSPITAL

Consolidated 3 Month Trend

Account	Mar-23	Apr-23	May-23
Net Operating Revenue	12,488,037	11,008,160	12,746,394
Labor (SWB & Registry)	8,151,089	7,985,788	8,423,180
Pro Fees Medical	581,672	710,036	686,414
Supplies	910,085	911,733	920,253
Purchased Services	1,659,286	1,033,045	1,168,611
Plant (Utilities, R&M, Tax & Insurance)	437,112	493,186	429,265
Other (Equip Lease, Mgmt Fees, Other)	730,695	972,330	799,735
Total Operating Expense	12,469,939	12,106,118	12,427,458
EBITDA	**18,098**	**(1,097,958)**	**318,936**
MPT Lease	381,242	390,722	386,429
Net Cash Gain/(Shortfall)*	(363,144)	(1,488,680)	(67,493)

** Excludes Depreciation*

WATSONVILLE COMMUNITY HOSPITAL

IP Statistics

IP Statistics	May-23	May-23 Budget	Variance to Budget	May-22	Variance to Prior Year
Admissions	276	379	(103)	363	(87)
Discharges	271	373	(102)	357	(86)
Patient Days	1,086	1,395	(309)	1,320	(234)
Average Daily Census	35.0	45.0	(10.0)	42.6	(7.5)
Acute Length of Stay	3.93	3.68	0.25	3.70	0.24
Acute Case Mix Index	1.47	1.36	0.11	1.38	0.09
Deliveries	71	69	2	69	2
IP Surgeries	60	76	(16)	62	(2)

- YTD Admissions and Discharges are 17% (~300) less than May 2022 YTD
- Length of Stay decreased while case mix remained constant.
- IP Surgeries were down and Deliveries remained strong
- YTD IP Surgeries and Deliveries per day are down slightly

WATSONVILLE COMMUNITY HOSPITAL

OP Statistics

OP Statistics	May-23	May-23 Budget	Variance to Budget	May-22	Variance to Prior Year
OP Visits – Hospital Only (Non ER)	2,946	3,161	(215)	3,252	(306)
ER Visits	3,106	2,656	450	2,498	608
OP Surgeries	100	118	(18)	87	13

- Non ER OP Visits are down about 12 per day from 2022
- ER Visits are up about 9 per day over 2022
- May YTD averages 88 ER visits per day
- OP Surgeries 3.4 per day as compared to 2.9 per day in 2022
- CHP Clinic visits are up 14.6% YTD compared to 2022
- May YTD average 35 clinic visits per day

WATSONVILLE COMMUNITY HOSPITAL

Turn-around Plan Updates

Revenue Initiatives	Budget
Charge Master Updates	250,000
Renegotiate Payer Contracts	11,945,975
DaVinci Robot	909,504
Revenue Cycle Improvements	5,000,000
Cath Lab*	73,028
Total Revenue Initiatives	18,178,507

** Not yet implemented*

- May YTD Collectible Patient Revenue is $5.1M below budget, however Total Net Revenue is only $2.5M under budget due to an unbudgeted PRF payment in January.
- The implementation of the DaVinci Robot in March and the delayed implementation of the Cath Lab (~Q4 2023) accounts for $2.3M in unrealized revenue
- Contract implementation delays and Revenue Cycle improvements in Billing, Collections and Denials Management represent $2.8M in opportunity through May.

WATSONVILLE COMMUNITY HOSPITAL

Turn-around Plan Updates

Expense Initiatives	Budget
Labor Efficiencies	445,709
Sales Tax Exemption*	520,000
GPO Savings*	750,000
Physician Subsidies/Contracts*	(511,000)
Eliminate Transition Costs	10,437,438
Total Expense Initiatives	11,642,147

** Not yet implemented*

- Total operating expense is $5.1M favorable to budget through May.
- Salary expenses are $748K unfavorable, offset by improvements in premium pay & contract staffing utilization.
- Intensivist contract not yet implemented, saving the additional expense.
- GPO contract implementation & recovery of sales tax exemption to occur in Q3 & Q4
- Favorable variances in the reduction of transition costs and other expense categories

WATSONVILLE COMMUNITY HOSPITAL

Turn-Around Dollars & Reasons

Net Revenue Variances	Estimated Amount	Reason
Robot	(797,017)	Three month delay and ramp up period
Cath lab	(1,487,706)	Not yet implemented
Rev Cycle & Contract Implementation	(2,840,315)	Staggered contract implementations and ramp up on other initiatives
Expense Variances	**Estimated Amount**	**Reason**
GPO Contract	(301,919)	Not yet implemented
Sales Tax Exemption	(209,330)	Awaiting 501(c)3 designation
Intensivist Contract	205,707	Not yet implemented
Labor (Salaries & Benefits)	(1,313,946)	Volumes & benefits variance to budget
Transition/Other Expenses	(3,508,357)	Significant reduction in legal & consulting; some timing

Other Updates

- $2.6M Letter of Credit renegotiated payment agreement is fully executed – first payment by June 30, 2023.
- $5.0M Line of Credit work still in progress with Santa Cruz County Bank and external partners.
- Distressed Hospital Loan program application process started – Due July 31, 2023.
- Medi-Cal payments on hold due by State until July – carefully monitoring impact on cashflow.

Questions?

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023

Report Type: Discussion

Title: Nursing Staff Levels Update

Recommendation: Receive and file.

Contact: Allyson Hauck, Chief Human Resources Officer

Summary

Earlier this month, The Lookout and The Pajaronian published articles with statements from individuals related to nurse staffing at the hospital. There were multiple statements that 42 nurses had left employment due to the transition of offering more full-time nurse positions. Further, additional statements implied that the hospital does not maintain appropriate nurse staffing levels. Staff wanted the opportunity to provide the Board with an update on nurse staffing since our records do not support these statements.

Background

- **Only five (5) nurses have left employment that were part-time prior to the transition, and were offered full-time positions.**

Since the transition, twenty-nine (29) nurses have left employment. Of the nurses that left, only five (5) of those nurses held part-time positions prior to transition, and were offered full-time positions. (See Exhibit A). The other nurses that left employment did not have a change in their part-time or full-time status following the transition.

- **The hospital has not experienced an increase rate of resignations since the transition**

In the first nine months since the transition (September 1, 2022 – May 31, 2023), the following count of nurses left employment:

- 29 Regular Nurses (Benefitted FT and PT)
- 28 Per Diem Nurses (Non-Benefitted)

In this same period, the hospital has hired twenty-five (25) Regular Nurses and twenty-six (26) Per Diem nurses

The rate of nurses leaving employment since the transition is consistent with *the two preceding nine-month periods* prior to the transition.

From December 1, 2021 to August 31, 2022, the following count of nurses left employment:

- 35 Regular Nurses (Benefitted FT and PT)
- 22 Per Diem Nurses (Non-Benefitted)

From March 1, 2021 to November 30, 2021, the following count of nurses left employment:

- 28 Regular Nurses (Benefitted FT and PT)
- 27 Per Diem Nurses (Non-Benefitted)

➢ **At the current staffing levels, the hospital has 494 hours more per week of patient care coverage by a regular nurse than prior to the transition**

The hospital follows Title 22 of the California Code of Regulations for staffing nurse-to-patient ratios based on patient acuity and census and employs a staffing model of regular full-time/part-time nurses, per diem nurses, and registry nurses.

Just prior to the transition, the hospital employed 192 regular nurses that encompassed 151.65 FTE (1.0 FTE = 40 hrs/week), with nurses working an average of 30 hours per week. As of the end of May WCH employs 183 regular nurses that encompass 164 FTE, with nurses working an average of 36 hours per week. Therefore, WCH employs nine fewer regular nurses, but those nurses provide 494 more hours per week in patient care coverage.

Prior to the transition, these additional hours that regular nurses now cover would have been covered by per diem staff, registry nurses, or regular nurses working for premium pay. Per diem nurses work on an intermittent basis, working based on their availability and the needs of the hospital. Typically, the hospital would utilize per diem employees to fill regular nurses scheduled time off or during a position vacancy. Per Diem employees, depending on level and shift, are only required, at most, to provide availability for six weekday shifts and two weekend shifts per month. Registry nurses are employed by outside agencies at a high hourly rate and are here on a temporary basis. Although per diem and registry nurses are invaluable and an integral part of hospital operations, the nature of the intermittent and temporary employment does not provide the same continuity of patient care as does a regularly scheduled benefitted nurse.

Recruitment Efforts

As of June 1, of the 251 nursing positions (Regular FT/PT and Per Diem) providing patient care, the hospital had 39 vacancies (28 Regular FT/PT, 11 Per Diem). This is a vacancy rate of 15.5%. While we aim for a lower vacancy rate, this is consistent with the national vacancy rate of 15.7% for RN positions, as reported by the NSI National Health Care Retention and RN Staffing Report. We are, however, expecting a lower vacancy rate by month's end.

In the past few weeks, nurses have accepted offers of employment in the following positions and will start employment at the hospital:

- Five (5) Regular FT Nurses (Four (4) in ED night shift and One (1) in Telemetry day shift)
- Nine (9) per diem nurses in Emergency, Med/Surg, PACU, and Wound Care

In addition to strong recruitment efforts, staff are looking to improve retention by various methods – this includes expansion of training, education, and employment engagement efforts. This should be an exciting time for recruitment – with the hospital transitioning to a non-profit model owned and operated by a public district. We look forward to collaborative efforts on recruitment and retention solutions to ensure exceptional and sustainable patient care for our community.

Attachments:

A- Nurse Resignation Since Transition -Table

Exhibit A: Nurse Resignation Since Transition

Count	Department Description	Job Title Description	Termination Date	FTE Offer of Employment at Transition	FTE Prior to Transition
1	Labor & Delivery	Staff Nurse II - 12 HR	June 2023	36 hrs/wk	36 hrs/wk
2	Telemetry	Staff Nurse II - 12 HR	May 2023	36 hrs/wk	30 hrs/wk
3	Emergency Services	Staff Nurse II - 12 HR	May 2023	36 hrs/wk	24 hrs/wk
4	Telemetry	Staff Nurse II - 12 HR	April 2023	36 hrs/wk	36 hrs/wk
5	Emergency Services	Staff Nurse II - 12 HR	March 2023	36 hrs/wk	36 hrs/wk
6	Operating Room	Staff Nurse II - 12 HR	March 2023	36 hrs/wk	Hired after the transition (resignation during probationary period)
7	Telemetry	Staff Nurse II - 12 HR	February 2023	36 hrs/wk	36 hrs/wk
8	Case Management	Case Manager RN - 10 HR	February 2023	40 hrs/wk	Hired after the transition (resignation during probationary period)
9	Emergency Services	Staff Nurse II - 12 HR	February 2023	36 hrs/wk	Hired after the transition (resignation during probationary period)
10	Intensive Care Unit	Staff Nurse I - 12 HR	February 2023	36 hrs/wk	Hired after the transition (resignation during probationary period)
11	Med/Surg unit/floor 1	Staff Nurse II - 12 HR	January 2023	36 hrs/wk	36 hrs/wk
12	Med/Surg unit/floor 1	Staff Nurse II	January 2023	32 hrs/wk	32 hrs/wk
13	Med/Surg unit/floor 1	Staff Nurse II - 12 HR	January 2023	36 hrs/wk	Hired after the transition
14	Emergency Services	Charge Nurse - 12 HR	December 2022	36 hrs/wk	24 hrs/wk
15	Emergency Services	Staff Nurse II - 12 HR	December 2022	36 hrs/wk	36 hrs/wk
16	Med/Surg unit/floor 1	Charge Nurse - 12 HR	November 2022	36 hrs/wk	36 hrs/wk
17	Med/Surg unit/floor 1	Staff Nurse II - 12 HR	November 2022	36 hrs/wk	36 hrs/wk
18	Recovery Room	Staff Nurse II	November 2022	40 hrs/wk	24 hrs/wk
19	Labor & Delivery	Staff Nurse I - 12 HR	October 2022	36 hrs/wk	30 hrs/wk
20	Med/Surg unit/floor 1	Staff Nurse II - 12 HR	October 2022	N/A	Did not start employment
21	Telemetry	Staff Nurse I - 12 HR	October 2022	36 hrs/wk	Hired after the transition
22	Telemetry	Staff Nurse II - 12 HR	October 2022	36 hrs/wk	36 hrs/wk
23	Labor & Delivery	Staff Nurse II - 12 HR	October 2022	36 hrs/wk	36 hrs/wk
24	Recovery Room	Staff Nurse II	September 2022	36 hrs/wk	24 hrs/wk (Personnel related resignation)
25	Operating Room	Charge Nurse	September 2022	40 hrs/wk	40 hrs/wk
26	Med/Surg unit/floor 1	Staff Nurse II - 12 HR	September 2022	36 hrs/wk	36 hrs/wk
27	Case Management	Case Manager RN - 10 HR	September 2022	40 hrs/wk	40 hrs/wk
28	Med/Surg unit/floor 1	Staff Nurse II - 12 HR	September 2022	36 hrs/wk	36 hrs/wk
29	Operating Room	Staff Nurse II	September 2022	N/A	32 hrs/wk (Personnel related resignation)

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023

Report Type: Discussion

Title: Pipeline Rx Agreement Amendment

Recommendation: Pass a **Motion** approving the First Amendment to the Master License and Service Agreement with Pipeline Health Holdings LLC ("Pipeline Rx").

Contact: Matko Vranjes, Interim Chief Executive Officer

Summary

Amendment to current Master License and Service Agreement will result in overall decrease in monthly cost. Increase in length of agreement from 3 to 5 years.

Background/Situation/Rationale

Watsonville Community Hospital is currently operating under a 3-year agreement with Pipeline Rx to provide remote order entry validation by pharmacist (telepharmacy) during hours of 2000 to 0700.

Minimum order lines for original agreement is greater than usual daily lines per day. Agreement has been adjusted to facility's current "usual daily lines" use per day.

Financial Impact: Annual Savings

Key Contract Terms	
1. Proposed effective date	August 1, 2023
2. Term of agreement	5 years (60 months)
3. Renewal terms	Auto renew 1-year terms
4. Termination provision(s)	120-day notice prior to expiration of Term MSA
5. Payment terms	Net 30

Key Contract Terms	
6. Annual cost	Cost per line with defined minimum PLUS technology fee of $1329.98 per month: Current: $2.93 / line w/ 8500 line minimum = $24,905 + $1329.98 = $26,234.98 Proposed: $3.10 / line w/ 3600 line minimum = $11,160 + $1329.98 = $12,489.98
7. Cost over life of agreement	$669,600
8. Budgeted (indicate Yes/No)	Yes

Attachments:

A- Invoices 08-2022 thru 05-2023
B- Master Service Agreement
C- Amendment
D- Business Associates Agreement

APHOSP	APVEND	VENDOR	APDESC	INV#	AMOUNT	DATE
153	PH10	Pipeline Holding	AUG-22 TELEPHARMACY + FEE	29840	12,446.40	8/31/2022
153	PH10	Pipeline Holding	SEPT22 TELEPHARMACY + FEES	30076	10,618.08	9/30/2022
153	PH10	Pipeline Holding	OCT-22 TELEPHARMACY + FEE	30312	11,209.94	10/31/2022
153	PH10	Pipeline Holding	NOV-22 TELEPHARMACY+FEES	30546	11,400.39	11/30/2022
153	PH10	Pipeline Holding	DEC-22 TELEPHARMACY+FEES	30783	12,756.98	12/31/2022
153	PH10	Pipeline Holding	JAN23 TELEPHARMACY + FEES	31022	12,845.52	1/31/2023
153	PH10	Pipeline Holding	FEB23 TELEPHARMACY + FEES	31260	11,583.16	2/26/2023
153	PH10	Pipeline Holding	MAR23 TELEPHARMACY + FEES	31501	10,855.34	3/31/2023
153	PH10	Pipeline Holding	APRIL23 TELEPHARMACY+FEES	31758	11,205.66	4/30/2023
153	PH10	Pipeline Holding	MAY23 TELEPHARMACY+FEES	32010	11,936.50	5/31/2023
					116,857.97	total
					11,685.80	per month

MASTER LICENSE AND SERVICES AGREEMENT

This Master License and Services Agreement ("***Agreement***") is entered into as of September 1st, 2022 (the "***Effective Date***") between PIPELINE HEALTH HOLDINGS LLC, a Delaware limited liability company doing business as PipelineRx ("***PipelineRx***") Pajaro Valley HealthCare District Hospital Corporation (PVHCDHC), dba Watsonville Community Hospital ("***Customer***"). Capitalized terms not defined herein shall have the meanings set forth in Exhibit A hereto.

WHEREAS, Customer desires to license from PipelineRx, and PipelineRx desires to license to Customer, the PipelineRx software as services platform "PowerGridRx" to process and verify prescriptions internally or through the PipelineRx network.

WHEREAS, if requested by Customer in an Order Form entered into pursuant to this Agreement, PipelineRx will also make available to Customer the services of PipelineRx remote pharmacists.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the parties agree as follows:

SECTION 1: PIPELINERX SOFTWARE SERVICES

1.1 Grant of License. PipelineRx hereby grants Customer a limited, non-transferable license to use the PipelineRx Software Services during the Term to provide pharmacist services to the client hospitals of Customer located in the United States (the "***Customer Hospitals***") on the terms and conditions set forth herein and in the applicable Order Form. PipelineRx will host the PipelineRx Software Services made available to Customer and Customer Hospitals on a segmented basis.

1.2. Order Forms. For each Customer Hospital, the Parties shall complete an order form ("***Order Form***") in the form of Exhibit B hereto identifying the Customer Hospital and the Services to be provided to the Customer Hospital(s). Each Order Form shall be governed by and form part of this Agreement. The use of the Services by each Customer Hospital shall be subject to the terms of this Agreement. Customer shall require each Customer Hospital to agree to the terms of use of the PipelineRx Software Services set forth herein and shall be responsible for the compliance of the Customer Hospital(s) with the terms of this Agreement. If required by PipelineRx, the Customer Hospital shall enter into an agreement directly with PipelineRx with respect to any applicable Services.

1.3 License Fees. Customer shall pay the license fees for the PipelineRx Software Services (the "***License Fees***") set forth on the applicable Order Form. Any additional fees payable by Customer or a Customer Hospital shall be as specified in the applicable Order Form.

1.4 License Restrictions.

(a) Copying and Modification. Customer shall not copy or modify any aspect the PipelineRx Software Services, except as expressly permitted in this Agreement. Customer will not alter any trademark, copyright notice, or other proprietary notice on the PipelineRx Software Services or Documentation.

(b) Permitted Users; Customer Hospitals. The PipelineRx Software Services may only be used by Permitted Users of the Customer Hospitals identified in the applicable Order Forms.

(c) Ownership of PipelineRx Software Services; Derivative Works. PipelineRx is and shall remain the sole and exclusive owner of the PipelineRx Software Services, including all Upgrades and Enhancements, and all intellectual property rights therein, and Customer shall have only the license and right to use the PipelineRx Software Services on the terms set forth herein.

(d) Other Restrictions. Customer shall not, and shall not allow any Customer Hospital to: (i) materially alter any part of the PipelineRx Software Services; (ii) reverse assemble or reverse compile the PipelineRx Software Services; (iii) create any derivative works from or enhancements to the PipelineRx Software Services (and any such derivative works or enhancements shall be owned by PipelineRx); or (iv) use the PipelineRx Software Services to provide service bureau or other similar services.

1.5 Warranty. PipelineRx warrants that (a) the PipelineRx Software Services will perform in all material respects in accordance with the applicable functional specifications set forth in the Documentation, and (b) PipelineRx has the authority to license use of PipelineRx Software Services.

THE WARRANTIES IN THIS SECTION 1.5 ARE IN LIEU OF ALL OTHER WARRANTIES, EXPRESS AND IMPLIED, INCLUDING, BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, WHICH WARRANTIES ARE HEREBY SPECIFICALLY DISCLAIMED. PIPELINERX DOES NOT WARRANT THAT THE PRODUCTS OR SERVICES WILL YIELD ANY PARTICULAR BUSINESS OR FINANCIAL RESULT OR THAT THE SERVICES WILL BE PERFORMED WITHOUT ERROR OR INTERRUPTION. CUSTOMER'S SOLE AND EXCLUSIVE REMEDY FOR PIPELINERX'S BREACH OF ANY WARRANTY WILL BE THE REPAIR, REPLACEMENT, OR RE-PERFORMANCE BY PIPELINERX OF THE NONCONFORMING PRODUCT OR SERVICE. IF PIPELINERX FAILS TO DELIVER THIS REMEDY, THEN CUSTOMER MAY PURSUE ANY OTHER REMEDY THAT IS OTHERWISE PERMITTED UNDER THIS LICENSE.

SECTION 2: REMOTE PHARMACIST AND OTHER SERVICES.

2.1 Remote Pharmacist Services. If an Order Form specifies the provision of remote pharmacist services provided by PipelineRx personnel, such services will be subject to the Pharmacist Services Terms and Conditions set forth in Exhibit C hereto.

2.2 Implementation Services. Subject to payment of applicable fees, if any, and as set forth in an Order Form, Implementation Services will be provided by PipelineRx and highlight any and all Customer obligations. For the Initial Term, fees for Implementation Services are included in the License Fees set forth on Schedule 1 hereto.

2.3 Other Services. Any additional Services required by Customer shall be as set forth in the applicable Order Form.

SECTION 3: TERM

The initial term of this Agreement ("***Initial Term***") commences on the applicable solution activation date (see Exhibit B, Order Form) and continues for a period of Three (3) years, unless earlier terminated as set forth in Section 5.6. This Agreement shall automatically renew for successive one (1) year periods (each a "***Subsequent Term***"), unless terminated by a Party in accordance with Section 5.6. "***Term***" refers collectively to the Initial Term and any Subsequent Term. The terms and conditions of this Agreement shall continue to apply to any Services that remain to be provided under any Order Form after expiration or termination of the Term.

SECTION 4: PAYMENT

4.1 Invoicing Terms. Customer will pay all fees and other charges in U.S. dollars within thirty (30) days after invoice date. Invoices may be issued by PipelineRx or any PipelineRx Affiliates.

4.2 Taxes. All amounts payable under this Agreement are exclusive of sales, use, value-added, withholding, and other taxes and duties (except for taxes payable on PipelineRx's net income). Customer will promptly pay, and indemnify PipelineRx against, all such taxes and duties, unless Customer provides PipelineRx satisfactory evidence of an applicable tax exemption prior to the Order Form Effective Date.

4.3 Late Payments. PipelineRx may charge Customer interest on any undisputed overdue fees, charges, or expenses at a rate equal to the lesser of one and a half percent (1.5%) per month or the highest rate permitted by law. Customer will reimburse PipelineRx for all reasonable costs and expenses incurred (including reasonable attorney's fees) in collecting any undisputed overdue amounts. If Customer does not pay undisputed fees, charges, or expenses when due, then PipelineRx may require reasonable advance payments as a condition to providing Services.

4.4 Audit. Upon reasonable advance notice and no more than twice per year, PipelineRx may conduct an audit to ensure that Customer is in compliance with this Agreement. Such audit will be conducted during regular business hours, and Customer will provide PipelineRx with reasonable access to all relevant equipment and records. If an audit reveals that Customer's use of any Services during the period being audited exceeds the use identified in the applicable Order Form, then PipelineRx may invoice Customer for all such excess use based on PipelineRx's prevailing rates in effect at the time the audit is completed, and Customer will pay any such invoice. If such excess use exceeds five percent (5%) of the licensed use, then Customer will also pay PipelineRx's reasonable costs of conducting the audit.

4.5 Fees. Except as otherwise set forth in an Order Form, Pipeline may increase its fees for Services, including License Fees at the start of each calendar year. The amount of such increase will not exceed the lesser of 1) five percent (5%) per annum or 2) the annual percentage change in the Consumer Price Index, Hospital and Related Services. The next price increase will go into effect as of January 1, 2023 and for future years will be effective on January 1st of every year.

4.6 Suspension of Services. PipelineRx reserves the right to suspend provision of any Services (a) ten (10) days after notice to Customer of nonpayment of undisputed sums owed to PipelineRx that are thirty (30) days or more past due, where such breach remains uncured, or (b) if such suspension is necessary to comply with any applicable law or order of any governmental authority.

SECTION 5: GENERAL TERMS

5.1 Confidentiality and Proprietary Rights.

(a) Use and Disclosure of Confidential Information. Each Party may disclose to the other Party Confidential Information. Except as expressly permitted by this Agreement, neither Party will: (a) disclose the other party's Confidential Information except (i) to its employees or contractors who have a need to know and are bound by confidentiality terms no less restrictive than those contained in this Section 5.1, or (ii) to the extent required by law following prompt notice of such obligation to the other Party, or (iii) use the other party's Confidential Information for any purpose other than performing its obligations under this Agreement, except as set forth herein. Each Party will use all reasonable care and handling and securing the other Party's Confidential Information and will employ all security measures used for its own proprietary information of similar nature. Following the expiration or earlier termination of this Agreement, each Party will, upon written request, return or destroy all of the other Party's tangible Confidential Information in its possession and will promptly certify in writing to the other Party that it has done so.

(b) Period of Confidentiality. The restrictions on use, disclosure and reproduction of Confidential Information set forth in Section 5.1 will, with respect Confidential Information that constitutes a "trade secret" (as that term is defined under applicable law), be extended, and will, with respect to other Confidential Information, remain in full force and effect following the termination of this Agreement.

(c) Injunctive Relief. The parties agree that the breach, or threatened breach, of any provision of this Section 5.1 may cause irreparable harm without adequate remedy at law. Upon any such breach or threatened breach, a Party will be entitled to injunctive relief to prevent the other Party from commencing or continuing any action constituting such breach, without having to post a bond or other security and without having to prove the inadequacy of other available remedies. Nothing in this Section 5.1(c) will limit any other remedy available to either party.

(d) Retained Rights. Customer's rights and the Services will be limited to those expressly granted in this Agreement. PipelineRx and its suppliers reserve all intellectual property rights not expressly granted to Customer. All changes, modifications, improvements or new modules made or developed with regard to the Services, whether or not (a) made or developed at Customer's request, (b) made or developed in cooperation with Customer, or (c) made or developed by Customer, will be solely owned by PipelineRx or its suppliers.

(e) Aggregated Hospital Data. Notwithstanding anything to the contrary set forth herein, PipelineRx shall be entitled to use aggregated data of Customer Hospital pharmacies for its own business purposes, provided such use (i) complies with all applicable laws, and (ii) in no way identifies any patient or hospital, directly or indirectly.

5.2 Intellectual Property Infringement.

(a) Duty to Defend. PipelineRx will defend, indemnify, and hold Customer harmless from any action or other proceeding brought against Customer to the extent that it is based on a claim that (a) the use of any PipelineRx Software Services delivered under this Agreement infringes any U.S. copyright or U.S. patent or (b) the PipelineRx Software Services incorporates any misappropriated trade secrets. PipelineRx will pay costs and damages finally awarded against Customer as a result thereof; provided, that Customer (i) notifies PipelineRx of the claim within ten (10) business days, (ii) provides PipelineRx with all reasonably requested cooperation, information and assistance, and (iii) gives PipelineRx sole authority to defend and settle the claim.

(b) Exclusions. PipelineRx will have no obligations under Section 5.2(a) with respect to claims arising from: (i) PipelineRx Software Services modifications that were not performed by PipelineRx or authorized by PipelineRx in writing, (ii) custom interfaces, file conversions, or other programming for which PipelineRx does not exclusively develop the specifications or instructions, (iii) use of any PipelineRx Software Services in combination with products or services not provided by PipelineRx, if use of the PipelineRx Software Services alone would not result in liability under Section 5.2(a), or (iv) any use of the PipelineRx Software Services not authorized by this Agreement.

(c) Infringement Remedies. If a claim of infringement or misappropriation for which Customer is entitled to be indemnified under Section 5.2(a) arises, then PipelineRx may, at its sole option and expense: (i) obtain for Customer the right to continue using such PipelineRx Software Services, (ii) replace or modify such PipelineRx Software Services to avoid such a claim, provided that the replaced or modified PipelineRx Software Services are substantially equivalent in function to the affected PipelineRx Software Services, or (iii) terminate Customer's rights and PipelineRx's obligations under this Agreement with respect to such PipelineRx Software Services. Upon any such termination, PipelineRx will refund to Customer a prorated portion of the fees paid for that PipelineRx Software Services

(d) Exclusive Remedy. THE FOREGOING ARE PIPELINERX'S SOLE AND EXCLUSIVE OBLIGATIONS, AND CUSTOMER'S SOLE AND EXCLUSIVE REMEDIES, WITH RESPECT TO INTELLECTUAL PROPERTY INFRINGEMENT OR TRADE SECRET MISAPPROPRIATION.

5.3 Limitation of Liability.

(a) Total Damages. PIPELINERX'S TOTAL CUMULATIVE LIABILITY UNDER, IN CONNECTION WITH, OR RELATED TO THIS AGREEMENT WILL BE LIMITED TO THE TOTAL FEES PAID (LESS ANY REFUNDS OR CREDITS) BY CUSTOMER TO PIPELINERX UNDER THE APPLICABLE ORDER FORM FOR THE SERVICE GIVING RISE TO THE CLAIM DURING THE 12-MONTH PERIOD PRECEDING THE DATE OF THE CLAIM, AS APPLICABLE, WHETHER BASED ON BREACH OF CONTRACT, WARRANTY, TORT, PRODUCT LIABILITY, OR OTHERWISE.

(b) Exclusion of Damages. IN NO EVENT WILL PIPELINERX BE LIABLE TO CUSTOMER UNDER, IN CONNECTION WITH, OR RELATED TO THIS AGREEMENT FOR ANY SPECIAL,

INCIDENTAL, INDIRECT, OR CONSEQUENTIAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS OR LOSS OF GOODWILL, WHETHER BASED ON BREACH OF CONTRACT, WARRANTY, TORT, PRODUCT LIABILITY, OR OTHERWISE, AND WHETHER OR NOT PIPELINERX HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGE.

(c) Material Consideration. THE PARTIES ACKNOWLEDGE THAT THE FOREGOING LIMITATIONS ARE A MATERIAL CONDITION FOR THEIR ENTRY INTO THIS AGREEMENT.

5.4 Professional Responsibility and Clinical Content Disclaimer. CUSTOMER ACKNOWLEDGES AND AGREES THAT ANY CLINICAL CONTENT FURNISHED BY PIPELINERX HEREUNDER (WHETHER SEPARATELY OR INCLUDED WITH ANY PRODUCT) IS AN INFORMATION MANAGEMENT AND DIAGNOSTIC TOOL ONLY AND THAT ITS' USE CONTEMPLATES AND REQUIRES THE INVOLVEMENT OF TRAINED INDIVIDUALS. CUSTOMER FURTHER ACKNOWLEDGES AND AGREES THAT PIPELINERX HAS NOT REPRESENTED ITS SERVICES AS HAVING THE ABILITY TO DIAGNOSE DISEASE, PRESCRIBE TREATMENT, OR PERFORM ANY OTHER TASKS THAT CONSTITUTE THE PRACTICE OF MEDICINE. THE PARTIES AGREE THAT, AS BETWEEN CUSTOMER AND PIPELINERX, CUSTOMER IS RESPONSIBLE FOR THE ACCURACY AND QUALITY OF CUSTOMER DATA AS INPUT INTO THE PRODUCTS. CUSTOMER ACKNOWLEDGES THAT PIPELINERX: (A) HAS NO CONTROL OF OR RESPONSIBILITY FOR THE CUSTOMER'S USE OF THE CLINICAL CONTENT, AND (B) HAS NO KNOWLEDGE OF THE SPECIFIC OR UNIQUE CIRCUMSTANCES UNDER WHICH THE CLINICAL CONTENT PROVIDED MAY BE USED BY THE CUSTOMER. THE PARTIES AGREE THAT PIPELINERX DOES NOT PROVIDE MEDICAL SERVICES TO PATIENTS AND IS NOT ENGAGED IN THE PRACTICE OF MEDICINE, AND THAT THE CUSTOMER'S USE OF THE PRODUCTS JUST ABSOLVE THE CUSTOMER OF ITS' OBLIGATION TO EXERCISE INDEPENDENT MEDICAL JUDGMENT IN RENDERING HEALTHCARE SERVICES TO PATIENTS. CUSTOMER ACKNOWLEDGES THAT THE PROFESSIONAL DUTY TO THE PATIENT AND PROVIDING HEALTHCARE SERVICES IS SOLELY WITH THE HEALTHCARE PROFESSIONAL PROVIDING THE SERVICES. PIPELINERX MAKES NO WARRANTY AS TO THE NATURE OR QUALITY OF THE CONTENT OF RESULTS, MESSAGES OR INFORMATION SENT BY THE CUSTOMER, OR ANY THIRD-PARTY USERS OF THE SUBSCRIPTION SERVICES.

5.5 Internet Disclaimer. CERTAIN PRODUCTS AND SERVICES PROVIDED BY PIPELINERX UTILIZE THE INTERNET. PIPELINERX DOES NOT WARRANT THAT SUCH SERVICES WILL BE UNINTERRUPTED, ERROR – FREE, OR COMPLETELY SECURE. PIPELINERX DOES NOT AND CANNOT CONTROL THE FLOW OF DATA TO OR FROM PIPELINERX'S CUSTOMER'S NETWORK AND OTHER PORTIONS OF THE INTERNET. SUCH FLOW DEPENDS IN LARGE PART ON THE INTERNET SERVICES PROVIDED OR CONTROLLED BY THIRD PARTIES. ACTIONS OR INACTIONS OF SUCH THIRD PARTIES CAN IMPAIR OR DISRUPT CUSTOMER'S CONNECTIONS TO THE INTERNET (OR PORTIONS THEREOF). ACCORDINGLY, PIPELINERX DISCLAIMS ANY AND ALL LIABILITY RESULTING FROM OR RELATED TO THE ABOVE EVENTS.

5.6 Termination.

(a) Termination After Initial Term. Following the Initial Term, either Party may terminate this Agreement effective as of the end of the Subsequent Term then in effect by written notice given at least one hundred twenty (120) days prior to the end of such Subsequent Term. This Agreement shall continue to apply to any Order Form that by its terms remains in effect following such termination.

(b) Termination for Cause. A Party may terminate this Agreement or any Order Form immediately upon notice to the other Party if the other Party: (i) materially breaches this Agreement or such Order Form and fails to remedy, or fails to commence reasonable efforts to remedy, such breach within thirty (30) days after receiving notice of the breach from the terminating Party, (ii) infringes the terminating Party's intellectual property rights and fails to remedy, or fails to commence reasonable efforts to remedy, such breach within ten (10) days after receiving notice of the breach from the terminating Party, (iii) materially breaches this Agreement or such Order Form in a manner that cannot be remedied, or (iv) commences dissolution proceedings or ceases to operate in the ordinary course of business. The right to terminate an Order Form shall otherwise be as set forth in the Order Form.

(c) Orderly Transition. Except in the event of termination relating to Customer's material breach of this Agreement, for a period of up to six (6) months following termination or expiration this Agreement: (a) the license granted hereunder with respect to the PipelineRx Software Services will continue, together with Customer's obligation to pay License Fees, with respect to mutually agreed upon Customer Hospitals, (b) PipelineRx will cooperate with Customer in an orderly transition, and (c) Customer will pay PipelineRx fees for any Services that PipelineRx performs for Customer during such period at the Prevailing Rate(s). Except as expressly set forth in this Section 5.6(c), PipelineRx is relieved of its obligation to provide Services to Customer immediately upon termination or expiration of an Order Form.

(d) Obligations upon Termination or Expiration. At the end of any transition period under Section 5.6(c), or the termination or expiration of this Agreement or an Order Form if no transition period applies, Customer and the Customer Hospitals will promptly lose access to using all PipelineRx Software Services and Clinical Content.

(e) Survival of Provisions. Those provisions of this Agreement that, by their nature, are intended to survive termination or expiration of this Agreement will remain in full force and effect, including, without limitation, the following Sections of this Agreement: 4 (Payment), 5.1 (Confidentiality and Proprietary Rights), 5.2 (Intellectual Property Infringement), 5.3 (Limitation of Liability), 5.6 (Termination), 5.7 (Books and Records), 5.9 (Discount Reporting) and 5.11-5.25 (general terms).

5.7 Books and Records. If required by Section 952 Of the Omnibus Reconciliation Act of 1980, 42 U.S.C. Section 1395x(l)(i)(ii), for a period of four (4) years after the Services are furnished, the parties agree to make available, upon the written request of the Secretary of Health and Human Services, the Comptroller General, or their representatives, this Agreement and such books, documents, and records as may be necessary to verify the nature and extent of the Services with a value or cost of $10,000 or more over a twelve month period.

5.8 Business Associate. The parties will enter into a mutually acceptable Business Associate Agreement ("***BAA***")**.**

5.9 Discount Reporting. The transactions covered by an Order Form may involve a discount, rebate or other price reduction on the items covered by the Order Form. Customer may have an obligation to report such price reduction or the net cost and its cost reports or in another appropriate manner in order to meet the requirements of applicable federal and state anti-kickback laws, including 42 U.S.C. Sec. 1320a-7b(b)(3)(A) and the regulations found at 42 C.F.R. Sec. 1001.952(g) and (h). Customer will be responsible for reporting, disclosing, and maintaining appropriate records with respect to such a price reduction or net cost and making those records available under Medicare, Medicaid, or other applicable government healthcare programs.

5.10 Governing Law. This Agreement is governed by and will be construed in accordance with the laws of the State of California, exclusive of its rules governing choice of law and conflict of laws and any version of the Uniform Commercial Code. Each party agrees that exclusive venue for all actions, relating in any manner to this Agreement will be in federal or state court of competent jurisdiction located in San Francisco County, California.

5.11 Statute of Limitations. Any action relating to this Agreement, other than collection of outstanding payments, must be commenced within one year after the date upon which the cause of action accrued.

5.12 Assignment and Subcontracts. Customer will not assign this Agreement without the prior written consent of PipelineRx, which will not be unreasonably withheld. PipelineRx may, upon notice to Customer, assign this Agreement to any affiliate or to any entity resulting from the transfer of all or substantially all of PipelineRx's assets or capital stock or from any other corporate reorganization or merger. PipelineRx may subcontract its obligations under this Agreement.

5.13 Severability. If any part of a provision of this MA is found illegal or unenforceable, it will be enforced to the maximum extent permissible, and the legality and enforceability of the remainder of that provision and all other provisions of this Agreement will not be affected.

5.14 Notices. All notices and other communications given or made pursuant to this Agreement shall be in writing and shall be deemed effectively given upon the earlier of actual receipt or: (a) personal delivery to the party to be notified, (b) when sent, if sent by electronic mail or facsimile during normal business hours of the recipient, and if not sent during normal business hours, then on the recipient's next business day, (c) five (5) days after having been sent by registered or certified mail, return receipt requested, postage prepaid, or (d) one (1) business day after deposit with a nationally recognized overnight courier, freight prepaid, specifying next business day delivery, with written verification of receipt. All communications shall be sent to the respective parties at their address as set forth on the signature page, or to such e-mail address, facsimile number or address as subsequently modified by written notice given in accordance with this Section 5.14. If notice is given to PipelineRx, a copy shall also be sent to Viewpoint Law Group, 100 Pine Street, Suite 1250, San Francisco, California 94111, attn. Paul J. Neibergs, paul@viewpointlg.com.

5.15. Waiver. Failure to exercise or enforce any right under this Agreement will not act as a waiver of such right.

5.16 Force Majeure. Except for the obligation to pay money, a party will not be liable to the other party for any failure or delay caused by a Force Majeure Event, whether or not such matters were foreseeable, and such failure or delay will not constitute a material breach of this Agreement.

5.17 Amendment. This Agreement may be modified, or any rights under it waived, only by a written document executed by the authorized representatives of both parties.

5.18 No Third Party Beneficiaries. Except as specifically set forth in and Order Form, nothing in this Agreement will convert any right, remedy, or obligation upon anyone other than Customer and PipelineRx.

5.19 Relationship of Parties. Each party is an independent contractor of the other party. This Agreement will not be construed as constituting a relationship of employment, agency, partnership, joint venture or any other form of legal association. Neither Party has any power to bind the other Party or to assume or to create any obligation or responsibility on behalf of the other Party or any other Party's name.

5.20 Non-solicitation of Employees. Neither Party will directly or indirectly solicit for employment any employee of the other Party during the Term of this Agreement and for a period of one (1) year thereafter without the written consent of the other Party. This prohibition will not apply if an employee answers a party's notice of a job listing or opening, advertisement or similar general publication of a job search or availability for employment.

5.21 Publicity. The Parties may publicly announce that they have entered into this Agreement and describe their relationship in general terms, excluding financial terms. Neither Party will make any other public announcement or press release regarding this Agreement nor any activities performed hereunder without the prior written consent of the other Party.

5.22 Construction of Agreement. This Agreement will not be presumptively construed for or against either Party. Section titles are for convenience only. As used in this Agreement, "will" means "shall," and "include" means "Includes without limitation."

5.24 Counterparts. This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one instrument. Counterparts may be delivered via facsimile, electronic mail (including pdf or any electronic signature complying with the U.S. Federal ESIGN Act of 2000) or other transmission.

5.25 Entire Agreement. The Agreement, including the Exhibits and the Order Forms entered into hereunder, and documents incorporated by reference, represent the complete and exclusive agreement between the Parties with respect to the subject matter hereof, superseding and replacing all the prior agreements, communications and understandings (written and oral) regarding its subject matter.

[Signature Page Follows]

IN WITNESS WHEREOF, the parties have entered into this Master License and Services Agreement as of the date first written above.

PIPELINE HEALTH HOLDINGS LLC	**Pajaro Valley HealthCare District Hospital Corporation (PVHCD), dba Watsonville Community Hospital** **75 Nielson St, Watsonville, CA 95076**
By: Kevin L Jones	DocuSigned by: By: 041697AE557E4B3...
Name: Kevin Jones	Name: Monica Morales
Title: SVP, Telepharmacy	Title: Interim Administrative Staff
Address: 88 Kearny Street, 21st Floor, #2103 San Francisco, CA 94108 Email:	Address: 75 Nielson Street Watsonville, California 95076 Email:

EXHIBIT A
DEFINITIONS

"***Clinical Content***" means medical, clinical, or billing and coding information such as terminology, vocabularies, rolls, alerts, drug interaction knowledge, care pathway knowledge, standard ranges of normal or expected result values, and any other clinical content or rules provided to Customer under and Order Form together with any related Documentation and Upgrades. Depending on the intended usage, Clinical Content may be provided in either paper or electronic formats. Clinical Content may be either (a) owned by PipelineRx or (b) Third-Party Clinical Content.

"***Confidential Information***" means non-public information, including technical, marketing, financial, personnel, planning, and other information that is marked confidential or which the receiving party should reasonably know to be confidential, and will also include the terms of this Agreement. Confidential Information will not include: (a) information lawfully obtained or created by the receiving party independently of the disclosing party's Confidential Information without breach of any obligation of confidence, (b) information that enters the public domain without breach of any obligation or confidence, or (c) Protected Health Information or PHI (as defined in Exhibit B), the protection of which will be governed by Exhibit C.

"***Documentation***" means user guides or operating manuals containing the functional specifications for the Services that PipelineRx provides to Customer, as may be reasonably modified from time to time by PipelineRx.

"***Effective Date***" means the Effective Date as defined in the Master Agreement.

"***Enhancements***" means enhancements or new releases of the PipelineRx Software Services, Documentation, Clinical Content, or Services providing new or different functionality that are separately priced and marketed by PipelineRx.

"***Force Majeure Event***" means any cause beyond the reasonable control of the party that could not, by reasonable diligence, be avoided, including ask of God, acts of war, terrorism, riots, embargoes, acts of civil or military authorities, denial of or delays in processing of export license applications, fire, flood, earthquakes, accidents, or strikes.

"***Generally Available***" means available as a non-development product, licensed by PipelineRx in the general commercial marketplace.

"***Implementation Services***" means the implementation services, training and education listed in an Order Form to be performed by PipelineRx, which may include PipelineRx Software Services loading, data conversion, interface services, PipelineRx Software Services testing assistance, equipment installation, services setup, and training.

"***Initial Term***" has the meaning specified in Section 1.

"***Live Date***" means PipelineRx Software Services Installation Date.

"***Maintenance Services***" means support services for the PipelineRx Software Services consisting of telephone support, problem resolution, and Upgrades delivered by PipelineRx. Maintenance Services do not include: (a) development of custom code or customizations for any PipelineRx Software Services, (b) support of PipelineRx Software Services modifications generated by anyone other than PipelineRx, (c) services to implement Upgrades, (d) services to correct improper Installation or integration of the PipelineRx Software Services that was not performed by PipelineRx-authorized personnel, (e) system administrator functions, (f) Enhancements.

"***PipelineRx Affiliates***" means any U.S. entities that, now or in the future, are controlled by or under common control with PipelineRx.

"***PipelineRx Software Services Installation Date***" or "***System Installation Date***" or "***Services Installation Date***" means the earlier of (a) the date when the PipelineRx Software Services are first available for Productive Use, or (b) the date specified in the applicable implementation plan when the PipelineRx Software Services are intended to be available for Productive Use.

"***PipelineRx Software Services***" means the proprietary software and related services made available by PipelineRx on a software-as-services basis through the cloud that interfaces with hospital information systems to allow Customer pharmacists to provide pharmacy services to hospital clients. An Order Form may specify particular modules covered by the Order Form.

"***Customer Hospital***" has the meaning specified in Section 2.1.

"***Order Form***" has the meaning specified in Section 2.2.

"***Order Form Effective Date***" means the effective date of an Order Form, as set forth therein.

"***Permitted User***" means any individual, whether on-site at a Customer Hospital or from a remote location, (a) Customer employee, (b) consultant or independent contractor who has need to use of the Services based upon a contractual relationship with Customer, so long as (i) such consultant or independent contractor is not a PipelineRx competitor, (ii) Customer remains responsible for use of the Services by such consultant for independent contractor, and (iii) such consultant or independent contractor is subject to confidentiality and use restrictions at least as strict as those contained in this Agreement, (c) physician with admitting privileges at a Customer Hospital, (d) employee of such physician, and (e) medical professional authorized to perform services at a Customer Hospital.

"***Prevailing Rate***" means the PipelineRx standard fee(s) in effect for the applicable PipelineRx Software Services, Clinical Content or other Services, on the date that the PipelineRx Software Services, Clinical Content, or Services are to be provided.

"***Professional Services***" means any consulting, programming or other professional services that PipelineRx provides to Customer or a Customer Hospital pursuant to an Order Form.

"***Provider***" means Physicians or Non-physician professionals who are employed by, or under contract,

to provide health care services for Customer or its affiliates, whether full or part-time. "**Physician**" means an individual legally licensed to provide healthcare services to patients and includes a medical or dental doctor, optometrist, certified consulting psychologist, osteopath and chiropractor. "**Non-physician professional**" means an individual, who is licensed, certified or otherwise designated to assist physicians and providing healthcare services to patients and includes a nurse practitioner, physician assistant, therapist, technician and social worker.

"***Customer***" has the meaning set forth in the preamble to the Collaboration Agreement.

"***Customer Hospitals***" has the meaning specified in Section 2.1.

"***Services***" means the PipelineRx Software Services, the Implementation Services, the Maintenance Services, the Pharmacist Services, and any other services provided to Customer or Customer Hospitals by PipelineRx as specified in an Order Form.

"***Subsequent Term***" has the meaning specified in Section 1.

"***Third Party Clinical Content***" means any Clinical Content that is owned by a third party and sublicensed to Customer under an Order Form.

"***Third Party Software Services***" means any portion PipelineRx Software Services that is owned by a third party and sublicensed to Customer under and Order Form.

"***Third Party Terms***" means any additional terms and conditions that are applicable to Third Party PipelineRx Software Services, including those referenced in or attached to an Order Form.

"***Third Party Vendor***" means a vendor other than PipelineRx from whom PipelineRx or Customer (with Prior written approval from PipelineRx) obtained Third Party Product, Third Party Software Services.

"***Term***" has the meaning set forth in Section 1.

"***Transition Date***" has the meaning set forth in the Collaboration Agreement.

"***Upgrades***" mean corrections, modifications, improvements, updates or releases of the PipelineRx Software Services designated by PipelineRx as "**Upgrades**", which are Generally Available and generally provided to Customers as part of the Maintenance Services. Upgrades do not include Enhancements.

EXHIBIT B
ORDER FORM

This Order Form ("***Order Form***") is entered pursuant to and is governed by the Master License and Services Agreement (the "***Master Agreement***") dated as of _____, 202____ between PIPELINE HEALTH HOLDINGS LLC, a Delaware limited liability company doing business as PipelineRx ("***PipelineRx***") and [CUSTOMER NAME], a [TYPE OF CUSTOMER] ("***Customer***"). Capitalized terms not defined herein shall have the meanings set forth in Exhibit A to the Master Agreement. In the event of a conflict between this Order and the Master Agreement, the Master Agreement shall govern, unless the Order Form expressly states that it will govern over the Master Agreement and identifies the applicable provision of the Master Agreement to be superseded by the Order Form.

Order Form Effective Date (OFED): _____

Customer Hospital(s) Address **Principal Contact:**	[Attached Schedule if necessary]		
PipelineRx Solutions Included	**Fees***	**Payment Terms**	**Term**
[Specify module(s) or service(s) as applicable]	[Specify applicable Tier from Schedule 1]	[Specify cost and frequency, include any minimums]	[Specify #months]
Implementation Services			
Transaction Cost(s)			

* *Fees will be due and payable 90 days from OFED or go-live, whichever is first, unless otherwise noted above.*

* *Fees are subject to annual cost of living adjustments as defined in the Master License and Services agreement*

VALUE ADDED OPTIONAL SERVICES

PipelineRx is pleased to offer additional services to the Hospital. These services will be billed on a monthly basis as requested by the Hospital. These services are in addition to the Pharmacy Services as outlined in Schedule 1.

- **Emergency Staffing (Less than 3 days' notice) - $130.00 per hour**
- **On-Demand Short Term Coverage**
    1. **3 – 14 days' notice –** 200% of contracted rate
    2. **14 – 30 days' notice** – 175% of contracted rate
    3. **30 – 60 days' notice** – 150% of contracted rate
    4. **60 – 90 days' notice** – 125% of contracted rate
- **EMR systems conversion, System Cut-over, system enhancement – $7,500**

[Signature Page Follows]

PIPELINE HEALTH HOLDINGS LLC	Pajaro Valley HealthCare District Hospital Corporation (PVHCDHC), dba Watsonville Community Hospital
By: Kevin Jones	DocuSigned by: By: 041697AE557E4B3...
Name: Kevin Jones	Name: Monica Morales
Title: SVP, Telepharmacy	Title: Interim Administrative Staff
Date: June 12, 2022	Date: August 26, 2022

EXHIBIT C
PHARMACIST SERVICES TERMS AND CONDITIONS

These Pharmacist Services Terms and Conditions shall apply if Pharmacist Services are included in Customer's Order Form entered into pursuant to the Master License and Services Agreement entered into between Customer and PipelineRx (the "***Master Agreement***"). In the event of a conflict between these Pharmacist Terms and Conditions and the Master Agreement, these Pharmacist Terms and Conditions shall govern as to the Pharmacist Services.

ARTICLE 1. PIPELINERX'S OBLIGATIONS

1.1 Remote Pharmacy Services. PipelineRx shall use commercially reasonable efforts to provide the Pharmacist Services described on Schedule 1 hereto ("***Pharmacist Services***") to the pharmacies of the hospitals listed on the applicable Order Form (as such Order Form may be updated from time to time by the parties, the "***Hospitals***" and the "***Hospital Pharmacies***"). Pharmacy Services shall be performed by licensed pharmacists (the "***PipelineRx Pharmacists***") in accordance with the requirements of these terms and conditions**.** The fees for the Pharmacist Services will be as set forth in the applicable Order Form. If included in the applicable Order Form, Pipeline**R**x will also provide the value-added services listed on Schedule 2 hereto.

1.2 PipelineRx Pharmacists. PipelineRx represents and warrants that the PipelineRx Pharmacists are properly licensed to perform the Pharmacy Services. PipelineRx shall immediately discontinue the provision of Pharmacy Services by any PipelineRx Pharmacist who: (a) has any disciplinary action taken against him or her, including but not limited to, revocation, suspension, or any limitation imposed on his or her pharmacists license in state applicable to service provided under this agreement; (b) has been excluded from participation in any state or federal health care program, including but not limited to, Medicare or Medicaid; (c) has been convicted of any criminal offense involving controlled substances; or (d) fails to observe the data security and password protection procedures implemented by Hospital of which PipelineRx and the PipelineRx Pharmacist have notice. PipelineRx shall immediately notify Hospital concerning the occurrence of any of the events described in this Section 1.2.

1.3 Employer Responsibilities. PipelineRx shall be solely responsible for the satisfaction of any and all obligations, including employment obligations, with respect to any PipelineRx Pharmacist that it employs to assist in its performance of this Agreement.

1.4 Compliance with Hospital Policies and Applicable Laws and Standards.

1.4.a PipelineRx shall ensure that all PipelineRx Pharmacists comply with Hospital's applicable pharmacy policies and procedures, which shall be furnished to PipelineRx upon execution of this Agreement. In the event of changes or updates to the Hospital's policies and procedures, it is the responsibility of the hospital to provide this information to PipelineRx. It is then PipelineRx's responsibility to ensure that all PipelineRx Pharmacists are aware and act in accordance with these new or changed policies.

1.4.b PipelineRx Pharmacists shall provide all Pharmacy Services in conformance with applicable laws, rules and regulations. PipelineRx shall provide assistance as reasonably requested by Hospital in order for Hospital to comply with applicable accrediting bodies as well as federal, local, and

state laws and regulations, including the requirements relating to participation in the Medicare and Medicaid programs and applicable standards of Hospital's accreditation organization (i.e., "The Joint Commission"). PipelineRx shall not differentiate or discriminate in the employment or engagement of PipelineRx Pharmacists or the provision of Pharmacy Services on any basis in violation of any applicable state, federal or local law or regulation or Hospital policy of which PipelineRx has notice. PipelineRx shall cooperate with Hospital in meeting or exceeding the standards of The Joint Commission or other regulatory agencies.

ARTICLE 2. HOSPITAL'S OBLIGATIONS

2.1 Access; Policies and Procedures; Additional Competency Assessment. Hospital shall provide PipelineRx with unique user identification and password-protected access to the hospital information system and electronic health record system for each PipelineRx Pharmacist. Hospital shall provide PipelineRx with applicable Hospital policies, procedures and guidelines pertaining to the performance of Pharmacy Services and shall be responsible for orienting each PipelineRx Pharmacist in such policies and procedures, including without limitation HIPAA and other corporate compliance policies. Hospital shall designate an individual who shall be responsible for coordinating review and feedback to PipelineRx on the Pharmacy Services and shall serve as the Hospital contact person for PipelineRx. If the Hospital requires a PipelineRx pharmacy staff member to complete additional competency assessment or clinical training programs above and beyond the standard PipelineRx programs, the hospital will be charged an hourly fee to complete these programs.

2.2 Recruitment Restrictions. Hospital acknowledges that PipelineRx has incurred substantial recruitment, screening, and marketing expenses with respect to PipelineRx Pharmacists, and that the identity, address, work history, and any other personal information of the PipelineRx Pharmacists constitute trade secrets of PipelineRx. During the two (2) year period after either the presentation of PipelineRx Pharmacist to Hospital or the completion of the PipelineRx Pharmacist's assignment to Hospital, whichever occurs later (the "Non-Solicitation Period"), Hospital agrees not to solicit, employ, or engage such PipelineRx Pharmacist's services, either directly or through any non-employee direct or indirect contractor, subcontractor, or staffing firm relationship, other than through PipelineRx, unless PipelineRx and Hospital arrive at mutually agreeable terms for any such employment or engagement sought by Hospital, including a recruiting fee payable to PipelineRx.

ARTICLE 3. INSURANCE

3.1 **PipelineRx Insurance.** Throughout the period during which Pipeline is providing Pharmacist Services, PipelineRx shall maintain professional liability coverage for PipelineRx Pharmacists with an aggregate limit of not less than $3 million, and per occurrence limits of not less than $1 million. PipelineRx shall also provide general liability coverage for the provision of Pharmacy Services, with an aggregate limit of not less than $3 million, and per occurrence limits of not less than $1 million. PipelineRx will provide Workers' Compensation insurance coverage for PipelineRx Pharmacists in accordance with applicable state laws.

3.2 **Hospital Pharmacy Insurance.** Throughout the period during which Pipeline is providing Pharmacist Services, Hospital shall maintain general and professional liability coverage for Hospital Pharmacy and its staff and all activities, with aggregate limits of not less than $3 million, and per occurrence limits of not less than $1 million.

SCHEDULE 1

DESCRIPTION OF REMOTE PHARMACIST SERVICES

Basic TelePharmacy Services will be defined as the following: 1.) Medication orders will be transmitted to PipelineRx by Hospital. The Hospital will provide PipelineRx with the required system access necessary to review medication orders transmitted to PipelineRx. 2.) Review of medication orders for appropriateness. 3.) Entry or verification of medication orders into Hospital pharmacy computer systems. 4.) Follow up with appropriate members of the Hospital nursing, pharmacy or other medical staff to clarify any issues with the medication orders. 5.) Drug information provided to medical staff or other members of the healthcare team at Hospital.

Pipeline's Premium Remote Order Verification Service includes for each patient: 1.) Medication profile review. 2.) Drug-allergy and drug-drug interaction review. 3.) Medication order entry and verification. 4.) Clinically appropriate interventions with RN/MD. 5.) Documentation of verified orders and intervention within Pipeline's proprietary software system, PowerGridRx. 6.) Providing drug information to providers as needed. 7.) Completion of initial dosing calculations. 8.) End-of-shift handoff to Hospital's on-site pharmacy staff. 9.) Completion of Pharmacy-to-Dose orders according to Hospital's policies. 10.) The following of Hospital's specific dosing policies. 11.) Documentation within Hospital's EHR or other systems. 12.) Entry of lab orders. 13.) Follow-up lab review. 14.) Comparison of Med Rec orders to home and inpatient medications.

A Medication Order Line is defined as any single pharmacist action in reference to an individual drug therapy transmitted to PipelineRx which shall include but is not limited to: medication orders received, reviewed, entered, or verified; modification in orders; or discontinuation of a therapy. Line items may also include time change requests, duplicate orders, and patient demographic changes/additions that may or may not involve a physician order form. Furthermore, requirement for PipelineRx Pharmacist to create duplicate documentation of pharmacist clinical activity or interventions in the hospital information system will result in an additional line order charge to the hospital. There are no additional charges or line order charges for the following pharmacist activities when associated with the initial review of an individual medication order as described above:

- calls to/from nursing/hospital staff for clarification of order information;
- therapeutic substitution or other formulary initiatives;
- IV to PO conversions;
- or other clinical initiatives; review of labs, allergy, renal dosing, drug/drug interactions
- and other interventions
- other clinical initiatives.

Retrospective review of patient drug therapy after the initial review of a medication order (e.g. IV to PO conversion program, renal dosing program, antimicrobial stewardship program, etc.) are not included as part of the basic telepharmacy service.

FEES

Item	Price
Price Per Order (Labor)	$2.93 / line with a minimum of 8,500 medication order lines per month
Technology fee (PowergridRx Essentials)	$1,329.98 / month
Implementation Cost	Waived

Telepharmacy/remote medication order entry review and verification with the following hours:

Monday-Friday	2000-0700 PST (11 Hours)
Saturday and Sunday	2000-0700 PST (11 Hours)
Holidays (6)	2000-0700 PST (11 Hours)

1. Holidays
    a. PipelineRx holidays are the following: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day, unless specified in this contract.
    b. All coverage during the specified holidays is billed at twice the normal rate specified in Exhibit C.
    c. All coverage of holidays not specified in the contract are billed at the emergency staffing/on-demand rate as described in Exhibit D.
2. Scheduled downtime and outages
    a. Any scheduled system downtime or outage in which PipelineRx remote pharmacist services will not be required must be communicated to PipelineRx in writing no less than thirty (30) days in advance to avoid billing during these hours.
    b. In the event that thirty (30) days' notice is not given, PipelineRx staff will be available for phone support to the Hospital and the hours will be billed at the normal rate.

PipelineRx, as a clinical services company will provide the following information about PipelineRx pharmacists upon request to our Customers in order to receive access codes to their Hospitals' information system(s):

1. Full name of staff, including maiden name or previous name, if changed
2. Date of birth
3. PipelineRx employee number
4. A list of all States in which staff hold a license
5. A copy of these licenses

6. City and State of residence
7. PipelineRx telephone number
8. PipelineRx job description

In addition to the above information, PipelineRx will provide a signed attestation verifying the following has been checked and the staff has met or exceeded PipelineRx's requirements for employment:
1. OIG check
2. EPLS check
3. 9 panel drug screen
4. Clinical Competency test
5. Background Check

On an annual basis, PipelineRx will provide upon request confirmation that the following has been successfully completed:
1. Annual OIG check
2. Annual EPLS check
3. Annual Clinical Competency test

FIRST AMENDMENT TO THE MASTER LICENSE AND SERVICES AGREEMENT

This is the First Amendment to the Master License and Services Agreement ("Agreement") between **Pajaro Valley HealthCare District Hospital Corporation (PVHCDHC), dba Watsonville Community Hospital** ("Hospital") and **Pipeline Health Holdings LLC** ("Pipeline") dated 1st day of September, 2022.

A. Hospital and Pipeline are parties to that certain remote pharmacist services Agreement which provides in Paragraph 5.17 thereof, that the Agreement may not be amended or modified except by mutual written agreement.
B. The parties now desire to amend the Agreement, upon the terms and conditions set forth herein.

Now, therefore, in consideration of the foregoing premises and for valuable consideration the receipt of which is acknowledged by the parties, Hospital and Pipeline agree to amend the Agreement as follows:

1) The following language in **SECTION 3: TERM**

> The initial term of this Agreement ("Initial Term") commences on the applicable solution activation date (see Exhibit B, Order Form) and continues for a period of Three (3) years, unless earlier terminated as set forth in Section 5.6.

Is replaced with:

> The initial term of this Agreement ("Initial Term") commences on the applicable solution activation date (see Exhibit B, Order Form) and continues for a period of Five (5) years, unless earlier terminated as set forth in Section 5.6.

2) **The Following in SCHEDULE 1: FEES**

Item	Price
Price Per Order (Labor)	$2.93 / line with a minimum of 8,500 medication order lines per month
Technology fee (PowergridRx Essentials)	$1,329.98 / month
Implementation Cost	Waived

is replaced with

Item	Price
Price Per Order (Labor)	$3.10 / line with a minimum of 3600 medication order lines per month
Technology fee (PowergridRx Essentials)	$1,329.98 / month
Implementation Cost	waived

3) **Entire Agreement; Modification.** Except as expressly provided herein above, all other terms, covenants and conditions of the Agreement shall apply and remain in full force and effect. In the event of any conflict between the terms of the Agreement and the Terms of this Amendment, this Amendment will be deemed to have superseded those of the Agreement and exclusively will govern the matter in question. This Agreement may not be amended or modified except by mutual written agreement.

IN WITNESS WHEREOF, the parties have signed this Amendment for Remote Pharmacist Services of the date last signed below, to be **effective as of the latest date executed below.**

HOSPITAL:

Pajaro Valley HealthCare District Hospital Corporation (PVHCDHC)

dba Watsonville Community Hospital

By: _____

Name: _____

Title: _____

Date: _____

PIPELINE:

Pipeline Health Holdings, LLC

By: _____

Name: _____

Title: _____

Date: _____

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between Pipeline Health Holdings LLC ("Business Associate") and Pajaro Valley HealthCare District Hospital Corporation (PVHCD), dba Watsonville Community Hospital ("Covered Entity").

1. Purpose and Intent

Business Associate has agreed to perform certain services for or on behalf of the Covered Entity pursuant to the terms of certain agreements executed concurrently herewith or hereafter (collectively, the "Services Agreements"), which services may involve the use or disclosure of the Protected Health Information ("PHI") within the meaning of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulation") and Security Standards for the Protection of Electronic Protected Health Information (the "Security Regulation") at 45 C.F.R. Parts 160 and 164 (together, "Privacy and Security Regulations"). . This Agreement supplements the Services Agreements and is intended to satisfy the requirements for Business Associate Contracts as set forth in the Privacy Regulation, including 45 C.F.R. § 164.504 (e). Business Associate hereby agrees to comply with applicable provisions of the Privacy and Security Regulations and to assist Covered Entity its compliance as set forth below.

2. Definitions

Designated Record Set means (1) medical records about individuals maintained by or for Covered Entity; and (2) other records used by or for Covered Entity to make decisions about Individuals. See 45 C.F.R. § 164.501.

Individual means the person who is the subject of PHI, and any person who qualifies as a personal representative of such person in accordance with 45 C.F.R. 164.502(g).

Protected Health Information ("PHI") means information that is created or received by the Business Associate from or on behalf of Covered Entity, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of an Individual, or the provision of health care to an Individual, and which identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Secretary shall mean the Secretary of the Department of Health and Human Services or his/her designee.

Terms used but not otherwise defined in this agreement shall be defined as set forth in 45 C.F.R. 160.103 or Part 164, Subparts A, C and E.

3. Obligations and Activities of Business Associate

a. Business Associate agrees to not use or disclose the PHI other than as permitted or required by the Services Agreements or this Agreement or as required by law.

b. Business Associate agrees to use appropriate safeguards or to prevent use or disclosure of the PHI other than as provided for by this Agreement.

c. Business Associate agrees to mitigate, to extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to immediately report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware, including any Security Incident. For purposes of this Agreement, "Security Incident" means the attempted or successful unauthorized access, use or disclosure, modification, or destruction of information or interference with the system operations in an information system containing Covered Entity's PHI.

e. Business Associate shall report to Covered Entity, within 60 days following discovery, any acquisition, access, use or disclosure of PHI that is not permitted under the Privacy Regulation and which poses a significant risk of financial, reputational or other harm to the Individual(s) whose PHI is involved, if the subject PHI is "Unsecured," i.e., has not been rendered unusable, unreadable or indecipherable to unauthorized persons. Such report shall include the following information:

(1) To the extent possible, the identification of each individual whose Unsecured PHI is reasonably believed to have been accessed, acquired, used or disclosed;

(2) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

(3) A description of the types of Unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved); and

(4) A brief description of what Business Associate is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches.

f. Business Associate agrees to ensure that any agent to whom it provides PHI, including a subcontractor, agrees to the same restriction and conditions concerning the PHI that apply through this Agreement to Business Associate. Business may comply with this section by entering into a contract with such agent of subcontractor, which contract requires the agent or subcontractor to comply with the terms of this Agreement.

g. Upon a request by Covered Entity, Business Associate agrees to provide access to PHI maintained in a Designated Record Set in Business Associate's possession to Covered Entity, or as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. Business Associate shall provide access to the PHI in the time and manner reasonably designated by Covered Entity.

h. Upon request by Covered Entity or an Individual and at Covered Entity's direction or agreement, Business Associate agrees to make any amendment(s) to PHI maintained in a Designated Record Set in Business Associate's possession in order to meet the requirements under 45 C.F.R. § 164.526. Business Associate shall act on the amendments in the time and manner reasonably designated by Covered Entity.

i. Business Associate agrees to make internal practices, books, and record (including policies and procedures and PHI) relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity, available to Covered Entity or to the Secretary for purpose of the Secretary's determining Covered Entity's compliance with the Privacy Regulation. Business Associate shall make the documents available in the time available in the time and manner designated by Covered Entity or the Secretary.

j. Business Associates agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

k. Business Associate agrees to provide to Covered Entity, or as instructed by Covered Entity, to an Individual, information collected in accordance with the subsection 3(j) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F. R. § 164. 528. Business Associate shall act in the time and manner reasonably designated by Covered Entity.

l. Business Associate agrees that, to the extent Business Associate requests Covered Entity to disclose PHI to Business Associate, such request shall be for only the minimum necessary PHI for the accomplishment of Business Associate's purpose and, where practicable for the intended purpose, only the Limited Data Set.

m. Business Associate agrees that it will use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted by this Agreement and will require any agent or subcontractor to whom Business Associate discloses PHI to use such appropriate safeguards as well. Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of Covered Entity.

4. Permitted Uses and Disclosures by Business Associate

a. General Use and Disclosure Provisions. Except as otherwise limited in this agreement, Business Associate may use or disclose PHI on behalf of, or to provide services to, Covered Entity if such use or disclosure of PHI would not violate (1) The Privacy and Security Regulations if done by Covered Entity or (2) Covered Entity's policies and procedures of which Business Associate is made aware.

b. Specific Use and Disclosure Provisions

(1) Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate, or to carry out the legal responsibilities of the Business Associate.

(2) Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are required by law or Business Associate obtains reasonable assurance from the person to who the information is disclosed that it will remain confidential and used or disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is ware in which the confidentiality of the information has been breached

(3) Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. 164.504(e)(2), (i)(B).

(4) Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

5. Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any limitations(s) in Covered Entity's notice of privacy practices in accordance with 45.C.F.R. § 164.520, to the extent that such limitation may affect aBusiness Associate's use or disclosure.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI to which Covered Entity has agreed in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

d. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy and Security Regulations if done by Customer, unless the requested use or disclosure is specifically permitted by this Agreement.

6. Term and Termination

a. Term. The Term of this Agreement shall be effective as of the Effective Date identified below and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, subject to subsection (c) of this Section 6.

b. Termination for Cause. Upon Covered Entity's knowledge of a material breach of the Agreement by Business Associate, Covered Entity shall either:

(1) Provide an opportunity for Business Associate to cure the breach or end the violation and, if Business Associate fails to cure the breach or end the violation within the time reasonably specified by Covered Entity, Covered Entity shall terminate this Agreement and all related agreements for Business Associate's services involving the use of disclosure of PHI:

(2) Immediately terminate this Agreement together with any related agreement for Business Associate's services involving the use or disclosure of PHI if Business Associate has breached a material term of this Agreement and cure is not possible; or

(3) If neither termination or cure is feasible, Covered Entity shall report the violation to the Secretary.

c. Effect of Termination. Except as further provided in this subsection (c), upon termination of this Agreement for any reason, Business Associate shall return of destroy all PHI received from Covered Entity, or created or received by the Business Associate on behalf of the Covered Entity. This provision shall apply to PHI that is in the possession of the subcontractors or agents of Business Associate. Business Associate shall retain copies of the PHI solely to the extent required for compliance with applicable licensing regulations, and in any event no longer than five years. In the event that Business Associates determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's agreement that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to the purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as necessary for Covered Entity to copy with the requirements of the Privacy Rule and HIPAA.

c. Interpretation. Any ambiguity in this Agreement shall be resolved in such a manner as to permit the parties to comply with the Privacy and Security Regulations.

8. Effective Date

The effective date of this Agreement shall be the date of last signature.

Business Associate:	Covered Entity:
Pipeline Health Holdings LLC	Pajaro Valley HealthCare District Hospital Corporation (PVHCD), dba Watsonville Community Hospital
BY: Kevin Jones	BY: [signature]
Printed name: Kevin Jones	Printed name: Matko Vranjes
Title: SVP, Telepharmacy	Title: Interim CEO
Date: June 17, 2023	Date: June 16, 2023

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: June 28, 2023

Report Type: Discussion

Title: Philips Picture Archiving and Communication System (PACS) Service Agreement for Medical Imaging Technology

Recommendation: Pass a **Motion** approving the renewal of the PACS service agreement with Philips Healthcare for medical imaging technology with the inclusion of the standard agreement termination language.

Contact: Sergio Nell-IT Director

Summary

The PACS (Picture Archiving and Communication System) system is a medical imaging technology that allows healthcare providers to store, retrieve, and share digital images. Renewing the PACS Service Agreement will result in support and maintenance of the PACS system for 3 years.

Background/Situation/Rationale

Maintaining and supporting our Philips PACS system is essential to ensure that we continue to provide high-quality patient care. Regular maintenance will help us avoid unexpected downtime and ensure that the system is always up to date with the latest security patches and software updates. This will help us maintain compliance with regulatory requirements and ensure that our patient data is always secure. In addition, having access to support services will help us quickly resolve any issues that may arise and minimize the impact on patient care.

Financial Impact: Annual Savings

Key Contract Terms	
1. Proposed effective date	July 1, 2023
2. Term of agreement	3 years

Key Contract Terms	
3. Renewal terms	Auto renew 1-year terms
4. Termination provision(s)	Standard WCH Termination Language
5. Payment terms	Net 30
6. Annual cost	89,447.00
7. Cost over life of agreement	268,341.00
8. Budgeted (indicate Yes/No)	Yes

Attachments:

A- Pricing Quote and Terms And Conditions

A Pricing Quote for:
Watsonville Community Hospital 75 Nielson Street
Watsonville, CA 95076

CONFIDENTIAL
QUOTE NO. 46394
QUOTE DATE: 06/13/2023
QUOTE EXPIRATION DATE: 09/10/2023

To Provide:
Year Service Agreement
An Image and Information Management Service

Quotation No.: 46394

Software Maintenance Agreement

Watsonville Community Hospital
75 Nielson Street
Watsonville, CA 95076

Philips Healthcare, a division of Philips North America LLC
222 Jacobs Street, 3rd Fl
Cambridge, MA 02141

Important Notice : A signed copy of this agreement for the services and prices quoted herein, is Customers acceptance that the Terms and Conditions attached to this quotation are the sole terms applicable to the services quoted. The acceptance of this quotation is not binding upon Philips until further review by Philips Contract Administration.

As required by 42 CFR 1001.952(g) and (h), Customer must, where applicable, fully and accurately report any discounts or credits or other financial concessions related to this agreement in the applicable cost reporting mechanism or claim for payment filed with U.S. Department of Health and Human Services (“DHHS”) or a state agency, and, upon request from the applicable agency, must provide the information contained in this agreement regarding any discounts, credits, or other financial concessions to DHHS or th t t

Customer Agreement as Quoted

Upon customer signing and an authorized Philips representative accepting, this quotation constitutes a contract and Customer is bound by accordance with the following terms set forth herein. Philips by its acceptance hereof, agrees to provide maintenance services for the equipment listed above in all terms and conditions hereof.

Authorized Signature

Authorized Signature

Printed Name

Title/Date

Title / Date _____

Customer PO # _____
(Please attach copy of original PO)

Philips Healthcare
1875 Buckhorn Gate, 5th Floor
Mississauga, Ontario L4W 5P1
Contact Name: Henry Adams
Phone Number: (650) 438-5059 Fax Number: (650) 293-2302 Email: henry.b.adams@philips.com

PHILIPS CONFIDENTIAL
QUOTE NO. 46394
QUOTE DATE: 6/13/2023
QUOTE EXPIRATION DATE: 9/10/2023
Not valid without a quote number

A Pricing Quote for: ***Watsonville Community Hospital***
3 Year Service Agreement

Pajaro Valley Health Care District Hospital Corporation (PVHCDHC)

Included Service Offerings:

- Service Desk access
- Remote support

Service Maintenance Agreement	Coverage Dates	Annual Amount
Service Maintenance Agreement - Year 1	12/27/2023 - 12/26/2024	$ 89,447.00
Service Maintenance Agreement - Year 2	12/27/2024 - 12/26/2025	$ 89,447.00
Service Maintenance Agreement - Year 3	12/27/2025 - 12/26/2026	$ 89,447.00
GRAND TOTAL		**$ 268,341.00**

Billing Terms:

○
○ Qua
○ A Monthly

Defaults to monthly payments if not checked by customer above

Payment Terms:

All payments under this Agreement are due thirty (30) days from the date of Philips' invoice. Taxes may be added, if applicable

1875 Buckhorn Gate, 5th Floor
Mississauga, Ontario L4W 5P1
Contact Name: Henry Adams
Phone Number: (650) 438-5059
Fax Number: (650) 293-2302
Email: henry.b.adams@philips.com

QUOTE EXPIRATION DATE: 09/10/2023
Not valid without a quote number

A Pricing Quote for:
Watsonville Community Hospital
3 Year Service Agreement

Below are included in the offering:

Description:	Tech ID/K#:	Product:	Qty:	Coverage Dates:
3D BASE PKG UNLIMITED < 15K	43204422	FHC1131	1	12/27/2023 - 12/26/2024
CARDIAC CT UNLMTD LIC < 15K	43204422	FHC1158	1	12/27/2023 - 12/26/2024
DBT F/UNLMTD MAMMO LIC < 15K	43204422	FHC1185	1	12/27/2023 - 12/26/2024
POWERVIEWER SITE LIC LESS 50K	43204422	FHC0426	1	12/27/2023 - 12/26/2024
POWERVIEWER SITE LIC ADD 10K E	43204422	FHC0428	1	12/27/2023 - 12/26/2024
STREAMING SITE LIC ADD 25K	43204422	FHC0172	1	12/27/2023 - 12/26/2024
STREAMING SITE LIC < 50K	43204422	FHC0170	1	12/27/2023 - 12/26/2024
VESSEL ANALYS UNLMITED < 15K	43204422	FHC8004	1	12/27/2023 - 12/26/2024
VIRT MAMMO STANDALONE	43204422	FHC1114	3	12/27/2023 - 12/26/2024
VTL SITE LICENSE < 50K	43204422	FHC0180	1	12/27/2023 - 12/26/2024
VTL SITE LICENSE ADD 25K EX/YR	43204422	FHC0182	1	12/27/2023 - 12/26/2024
UNLIMITED READING LIC < 50K	43204422	FHC0406	1	12/27/2023 - 12/26/2024
CD DIRECT SOFTWARE	58011163	FHC0386	1	12/27/2023 - 12/26/2024
SDBR F/ SWFM, TEST WFM OR RSF	58011163	FHC0141	1	12/27/2023 - 12/26/2024
SDBR WFM/VNA+CS/CLSTR EXP <80K	58011185	FHC0161	1	12/27/2023 - 12/26/2024
PACS BCKUP WFM SW < 50K	58011185	FHC0044	1	12/27/2023 - 12/26/2024
PACS BCKUP WFM SW ADD 10K	58011185	FHC0046	1	12/27/2023 - 12/26/2024
BASE WFM SW < 25K	58011185	FHC0070	1	12/27/2023 - 12/26/2024
BASE WFM SW ADD 25K	58011185	FHC0074	2	12/27/2023 - 12/26/2024
PACS CRITICAL RESULTS SOFTWARE	58011186	FHC0219	1	12/27/2023 - 12/26/2024
SDBR WFM / VNA < 80K EX/YR	58011186	FHC0143	1	12/27/2023 - 12/26/2024
VUE MOTION DISTR < 50K	58011187	FHC0090	1	12/27/2023 - 12/26/2024
VUE MOTION UNLMTD ADD 50	58011187	FHC0091	1	12/27/2023 - 12/26/2024
VR OPTION-CONCURRENT NO CHARGE LIC	58011188	989606800308	1	12/27/2023 - 12/26/2024
VOICE REC CONCURRENT USER / SAMER	58011188	989606800314	1	12/27/2023 - 12/26/2024

VUE REPORTING < 50K EX/YR	58011188	FHC0204	1	12/27/2023 - 12/26/2024
EIS SW < 75K Ex/Yr	58011190	FHC5171	1	12/27/2023 - 12/26/2024
VIRTUAL READING BASIC SW WORKGROUP	SP00601	SP00601	4	12/27/2023 - 12/26/2024