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, November 29, 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.

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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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Pajaro Valley Health Care District Hospital Corporation
Special Closed Meeting Agenda - Wednesday, November 29, 2023

Call to Order

Roll Call

Public Comment on Matters on the Agenda

Adjourn to Closed Session

1. **Conference with Labor Negotiators** (Government Code 54957.6)
   CNA, SEIU UHW S&M and Professional's Unit, Teamsters, CalTech
   Agency Negotiator: Allyson Hauck;
   Contact: Allyson Hauck, Chief Human Resources Officer

2. **Medical Executive Committees Report November 2023** (California Health & Safety Codes 32155 (2022) and 1461)
   Contact: Executive Sponsor-Dr. Angel, Chief of Staff, Medical Executive Committee

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, November 29, 2023 - 5:15 pm

(Regular meeting immediately follows the PVHCDHC closed meeting.)

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

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

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Pajaro Valley Health Care District Hospital Corporation
Regular Meeting Agenda - Wednesday, November 29, 2023

Call to Order

Roll Call

Closed Session Report

Agenda Modification Consideration

Public Comment on Matters Not on the Agenda

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

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

No action or discussion shall be taken on any item presented except that any Board Member may respond to statements made or questions asked or may ask questions for clarification. All matters of an administrative nature will be referred to staff. All matters relating to 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.

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: October 25, 2023**
   Recommendation: Pass a **Motion** approving the minutes for October 25, 2023.
   Contact: Rosie Brown, Clerk of the Board

2. **Policies/Policy Summary Approval: November 2023**
   Recommendation: Pass a **Motion** approving the Policies/Policy Summary.
   Contact: Sherri Torres, Chief Nursing Officer

Discussion

3. **Medical Executive Committees Report November 2023**
   Recommendation: Pass a **Motion** approving the Medical Executive Committee (MEC) Report, the Credentials Report and the Interdisciplinary Practice Credentials Report of November 2023.
   Contact: Executive Sponsor-Dr. Angel, Chief of Staff, Medical Executive Committee

4. **Watsonville Community Hospital Quality Report November 2023**
   Recommendation: Receive and file.
   Contact: Tracy Trail-Mahan, Director of Quality, Risk and Patient Safety

5. **Chief Executive Officer Report**
   Recommendation: Receive and file.
   Contact: Stephen Gray, Chief Executive Officer

6. **Co-Tenancy Agreement between Pajaro Valley Health Care District (District) and Pajaro Valley Health Care District Hospital Corporation (Hospital Corporation)**
   Recommendation: Pass a **Resolution:** (1) consenting to the Hospital Corporation entering into the Co-Tenancy Agreement with the District as a co-tenant under the MPT Lease; and (2) authorizing the Chief Executive Officer, Stephen Gray, to execute and deliver the Co-Tenancy Agreement on behalf of the Hospital Corporation.
   Contact: Stephen Gray, Chief Executive Officer

Adjourn

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: November 29, 2023
Report Type: Consent

Title: Minute Approval: October 25, 2023

Recommendation: Pass a **Motion** approving the minutes for October 25, 2023.

Contact: Rosie Brown, Clerk of the Board

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: October 25, 2023 – Closed Meeting
B: October 25, 2023 – Regular Session

Pajaro Valley Health Care District Hospital Corporation
Special Closed Meeting Minutes - Wednesday, October 25, 2023

Call to Order at 5:00 pm.

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

Public Comment on Matters on the Agenda

a. Dr. Gavin regarding fund raising – Holiday of Hope @ $6k including a match from the hospital.
b. CNA Union Members – Carli Boitano, Mallory, Elise, Michael Hudson, Taylor, Laurie about the rising costs of their share of medical benefits coverage along with the quality of coverage, and concerns over patient safety.

Adjourned to Closed Session at 5:20 pm.

1. **Medical Executive Committees Report October 2023** (California Health & Safety Codes 32155 (2022) and 1461)
   Contact: Executive Sponsor-Dr. Angel, Chief of Staff, Medical Executive Committee

2. **Conference with Labor Negotiators** (Government Code 54957.6)
   CNA, SEIU UHW S&M, Teamsters, CalTech
   Agency Negotiator: Allyson Hauck
   Contact: Allyson Hauck, Chief Human Resources Officer

Adjournment at 6:10pm

Pajaro Valley Health Care District Hospital Corporation
Regular Meeting Minutes - Wednesday, October 25, 2023

Call to Order at 6:20 pm.

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

Closed Session Report - None

Agenda Modification Consideration - Hear audit item #10 at the beginning of the meeting.
Moved/Seconded: Pimental/Gallagher
Yes: Directors Cox, Gallagher, Nunez, Pimentel and Chair Friel

Public Comment on Matters Not on the Agenda
a. Welcome Finance Manager, Chad Yerrick
b. Welcome Clerk of the Board, Rosalie (Rosie) Brown
c. Jennifer Gavin-Thank you to Directors Friel and Pimentel for CEO Recruitment

Comments from Board Members
a. Great job on the audit - Chair Friel.

Consent

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

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

1. **Minute Approval: September 27, 2023**
   Action: Passed **Motion 055-2023** approving the minutes for September 27, 2023.
   Contact: Rosie Brown, Clerk of the Board

2. **Policies/Policy Summary Approval: October 2023**
   Action: Passed **Motion 056-2023** approving the Policies/Policy Summary.
   Contact: Sherri Torres, Chief Nursing Officer

3. **Short Term Loans Ratification**
   Action: Passed **Motion 057-2023** ratifying Julie Peterson, CFO and Matko Vranjes, Interim CEO securing the short term loan arrangement from external partners, including potentially Salud Para La Gente, not to exceed $1.5 million dollars.
   Contact: Julie Peterson, Chief Financial Officer

   Moved/Seconded: Pimental/Nunez
   Yes: Directors Gallagher, Nunez, Pimentel and Chair Friel
   Recused: Director Cox

4. **PVHCDHC Board and Committee Meeting Calendar Approval: 2024**
   Action: Passed **Motion 058-2023** approving the 2024 Calendar.
   Contact: Rosie Brown, Clerk of the Board

Discussion

5. **Medical Executive Committees Report October 2023**
   Moved/Seconded: Friel/Gallagher
   Yes: Directors Cox, Gallagher, Nunez, Pimentel and Chair Friel
   Action: Passed **Motion 059-2023** approving the Medical Executive Committee (MEC) Report, the Credentials Report and the Interdisciplinary Practice Credentials Report of October 2023.
   Contact: Executive Sponsor-Dr. Angel, Chief of Staff, Medical Executive Committee

6. **Watsonville Community Hospital (WCH) Food Market Pilot Program**
   Action: Received and filed update on the Second Harvest Foodbank in conjunction with WCH as is done throughout the state to partner with healthcare providers to work upstream in addressing the social determinants of health.
   Contact: Matko Vranjes, Interim Chief Executive Officer

7. **Santa Cruz County Pediatrics Crisis Stabilization**
   Action: Received and filed update with public comment Carmin Powell regarding the partnership with the County of Santa Cruz Health Services Agency Behavioral Health Services division (Santa Cruz BHD) to accept minors detained on a §5585 hold, under EMTALA, until a designated receiving facility is completed.
   Contact: Matko Vranjes, Interim Chief Executive Officer.

8. **Chief Executive Officer Report**
   Action: Received and filed.
   Contact: Matko Vranjes, Interim Chief Executive Officer

9. **Chief Financial Officer Monthly Financial Performance & Budget Update**
   Action: Received and filed.
   Contact: Julie Peterson, Chief Financial Officer

10. **Pajaro Valley Health Care District and Pajaro Valley Health Care District Hospital Corporation Consolidated Audit Report**
    Moved/Seconded: Pimental/Nunez
    Yes: Directors Cox, Gallagher, Nunez, Pimentel and Chair Friel
    Action: Passed **Motion 060-2023** approving the Pajaro Valley Health Care District Hospital Corporation and the Pajaro Valley Healthcare District audit findings for the period of September 01, 2022, through December 31, 2022.
    Contact: Julie Peterson, Chief Financial Officer

Adjourned at 7:23 pm.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: November 29, 2023

Report Type: Consent

Title: Policy/Summaries November 2023

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

Contact: Sherri Torres, Chief Nursing Officer

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.

Attachments:

A: Reports

Watsonville Community Hospital
POLICY APPROVAL SUMMARY REPORT

Committee: BOD
Reporting Period: 11/29/2023

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
Respiratory Therapy				
Non-Invasive Positive Pressure Ventilation (NPPV) (BiPAP/CPAP)	RESP112	policy overdue for review	Regulary Annual Review	Author: RT Director: 11/2023 CNO/VP Sr. Leader/CEO: 11/2023 IM Comm: 11/15/2023 MEC: 11/28/2023 BOD:
Respiratory Therapy Assess and Treat Protocol	RES102	policy overdue for review	Regulary Annual Review	Author: RT Director: 11/2023 CNO/VP Sr. Leader/CEO: 11/2023 IM Comm: 11/15/2023 MEC: 11/28/2023 BOD:
Nursing				
Perinatal Urine Toxicology Testing Policy	NUR0857	Remove: Illicit word, changed word: safe to unsafe	Previously approved with changes- removed the word illicit. Does not need to go back through committee. Provider request to remove this word from policy.	Author: Perinatal/WS Director: 07/2023 CNO: 08/24/2023 VP/Sr. Leader/CEO:08/2023 OB/GYN Comm:11/14/2023 MEC:11/28/2023 BOD:
TOLAC Trial of Labor after Cesarean Delivery	NUR0014	Added CRNAs, fixed formatting, updated references. Minor updates per Dr. Cox. Minor word change: attempting to undergoing.	Regular review.	Author: WS/Perinatal Director : 10/2023 CNO/VP/Sr. Leader/CEO:9/2023 OB/GYN: 11/14/2023 MEC:11/28/2023 BOD:

WATSONVILLE COMMUNITY HOSPITAL

Policy Title	Non-Invasive Positive Pressure Ventilation (NPPV) (BiPAP/CPAP)	Policy #	RESP112
Responsible	Respiratory Therapy Director	Revised/Reviewed	~~9/1/2020~~11/2023

I. PURPOSE

A. To establish responsibility and guidelines for the Respiratory Care Provider (RCP) in management of the NPPV equipment

B. To identify appropriate care settings for patients receiving NPPV

II. POLICY

A. BiPAP/CPAP requires a written order by a physician or licensed independent practitioner.

B. Respiratory Therapy staff will set up, initiate, adjust, monitor, and evaluate the effectiveness of BiPAP/CPAP systems.

C. CPAP for OSA (obstructive sleep apnea) may be ordered per "RT Assess and Treat" Protocol.

III. DEFINITIONS

A. NPPV – Non-invasive Positive Pressure Ventilation is utilized to improve arterial oxygenation, decrease work of breathing, decrease ventilation- perfusion mismatching, and increase tidal volume. Types of NPPV utilized at the facility include:

1. BiPAP ~~–~~(Bi-level positive airway pressure-~~BiPAP~~) is the application of a user selected level of IPAP (Inspiratory Positive Airway Pressure) and EPAP (Expiratory Positive Airway Pressure) to the patient's airway vial a nasal mask or a full face mask.
2. CPAP – continuous positive airway pressure
3. Pressure Support ~~– Pressure Support~~ is a method of assisting spontaneous breathing in a mechanically ventilated patient.

IV. PROCEDURE

A. CLINICAL INDICATIONS FOR USE:

1. BiPAP should not be considered a method of continuous ventilator support.
2. Patients who exhibit clinical evidence of ventilatory muscle fatigue that may be accompanied by CO2 retention, tachypnea, accessory respiratory muscle use, etc. i.e. COPD.
3. Heart failure patients who may benefit from positive pressure for afterload reduction and decrease work of breathing.
4. Recently extubated patients in order to help prevent re-intubation.
5. Treatment of Obstructive Sleep Apnea
6. Impending respiratory failure is an indication for BiPAP in a select group of patients whose acute cause of respiratory distress is of transient origin and who demonstrate a successful response to a trial of BiPAP.
7. Successful trial response to BiPAP should be apparent within 2 hours of initiation of treatment. Successful trial is defined as any of the following, provided the patient is able to tolerate the BiPAP.
   a. Improvement in gas exchange.
   b. Decrease in respiratory distress and improved cardiac function.

B. LOCATION OF CARE

1. ICU level of care is required for the following:

a. Rescue NPPV that may require intubation and the patient agrees to intubation.

2. Medical Surgical/Telemetry level of care is indicated for the following:
   a. Sleep apnea.
   b. Other conditions where the patient has chosen to forego intubation yet requires rescue NPPV for palliation or comfort.
   c. For any clinical condition that is not addressed above, decisions about level of care will be made in collaboration with the Pulmonary physician, Respiratory Therapist (RCP) and Nurse

C. **BiPAP orders** must include:
1. Mode of BiPAP
2. IPAP level
3. EPAP level
4. O_2 saturation goal
5. Specified O_2 flow rate or FIO_2 settings
6. Duration/circumstances of use
7. **A Respiratory Therapist (RCP) will evaluate the appropriateness of the request for the medical floor and will procure the necessary equipment.

D. PATIENT PREPARATION/EDUCATION

1. The Respiratory Therapist (RCP) should explain the device and its purpose, how the mask is applied, that the patient may or may not be able to speak, and the duration of use.
2. Patient understanding and acceptance is important for the success of this modality.
3. The Respiratory Therapist (RCP) should select the smallest mask possible for the patient's nasal or facial contour.
4. The nasal mask should fit from the superior bridge of the nose to just below the nares above the upper lip.
5. The facemask should cover the nose and mouth and extend from the superior bridge of the nose to beneath the lower lip.
6. The head strap should be snug enough to keep the mask in place without significant leaks.
7. Proper mask sizing is a crucial component of success. Mask comfort is often the limiting factor to success.
8. Moisture barrier cream should be applied to prevent any skin breakdown.
9. For patients that are on a BiPAP with a full face mask for >48 hours of continuous wear must be put on a mask that prevents pressure points.

E. **HAZARDS TO CONSIDER**

1. Patients incapable of maintaining life-sustaining ventilation with BiPAP including patients that may exhibit
   a. significant CO_2 retention,
   b. hypoxemia,
   c. new cardiac arrhythmia
   d. patients with the inability to protect their airway (i.e. comatose, obtunded, quadriplegic patients).
   e. Patients with respiratory rates >30 breaths per minute.

f. Patients in which the mask or headgear cannot be secured secondary to the extent of their injury, other interfering essential apparatus, or the patient's refusal or inability to cooperate.

g. Patients in which the air leak exceeds the BiPAP unit's ability to maintain desired pressures.

3. Risk of aspiration of gastric contents
4. Risks and benefits of usage should continually be assessed

F. MONITORING

1. The Respiratory Therapist (RCP) will assess the patient and system at least every 4 hours and provide documentation utilizing a ventilator flow sheet.
2. The RCP should note:
   a. Respiratory Rate- set
   b. Respiratory Rate- total
   c. Tidal Volume
   d. Heart Rate
   e. Respiratory Assessment (Breath sounds, RR, secretions, etc.)
   f. BiPAP Mode
   g. IPAP
   h. EPAP
   i. FIO_2 in Liter Flow
   j. Saturation
   k. ABG- if any
   l. The BiPAP circuit will be changed when soiled.
   m. Skin Integrity

G. Home CPAP/BIPAP

1. Doctors may order: Home CPAP/BIPAP units, belonging to patient, for use in-hospital.
   a. If "RT Assess and Treat" Protocol is ordered, RCP may place order for home CPAP/BiPAP, as above.
2. ~~They~~ Home CPAP/BiPAP units ~~have to~~shall be checked for safety, by authorized Bio-Med ~~Department 24/7,~~Engineer or RCP.
3. ~~if Bio-Med cannot~~If equipment does not pass safety check, approved hospital equipment ~~must be ordered~~shall be used.
4. Respiratory Therapists (RCP) can assist patients and/or family members to set up.
5. ~~However, Respiratory~~ RCP is not responsible for settings, changes to, or maintenance, repair.
6. It is the responsibility of the issuing: Vendor, Home Care Company, or Family Member, and/or Primary Care Physician, who originally ordered unit, for patient.
7. ~~Respiratory~~ RCP will monitor O_2 delivery, O_2 saturation, per O_2 protocol, if used with Home Unit.
8. ~~Respiratory~~ RCP will not alter any home equipment in any way, including filters.
9. If the home equipment is not providing adequate perfusion, ~~the physician must order~~ hospital equipment ~~to~~ shall be used.
10. ~~Respiratory~~ RCP cannot provide any pieces of equipment for patient discharge.

V. REFERENCES

N/A

VI. STAKEHOLDERS

N/A

WATSONVILLE COMMUNITY HOSPITAL

Policy Title	Respiratory Therapy Assess and Treat Protocol	Policy #	RESP102
Responsible	Respiratory Therapy Director	Revised/Reviewed	~~9/1/2020~~11/2023

I. PURPOSE

To provide standardized guidelines for the administration and titration of respiratory therapy (RT) including delivery of bronchodilators, secretion management, and expansion therapy.

II. POLICY

A. ~~The~~ "RT assess and treat protocol" may be initiated upon physician order for any of the following;

- Albuterol,
- Albuterol + Ipratropium (DuoNeb©),
- Ipratropium Bromide,
- Acetylcysteine (Mucomyst©),
- Med Neb (MN),
- Intermittent Positive Pressure Breathing (IPPB),
- Intrapulmonary Percussive Ventilation (IPV),
- Mucus Clearance Device,
- Incentive Spirometry,
- Chest Physiotherapy,
- Vest Airway Clearance System, ~~and~~
- Bronchodilator Protocol
- Home CPAP prescribed for obstructive sleep apnea (OSA)~~.~~
- Skin assessment

B. For patients not managed per "RT assess and treat protocol", the RCP (Respiratory Care Practitioner) will evaluate the patient, implement the physician order, and contact the physician for any indicated modification in the care plan. If the physician does not want the care plan managed under the "RT assess and treat protocol", the physician must enter an order for:

1. a specific therapy
2. frequency of any relevant medications
3. a statement that the "RT assess and treat protocol" is not to be initiated.

C. Patients UNDER 18 years of age~~s~~ will be excluded from this protocol.

D. The physician may terminate the "RT assess and treat protocol" at any time and enter orders as per above.

III. DEFINITIONS

N/A

IV. PROCEDURE

A. PERSONNEL:

1. May be performed by licensed Respiratory Care Practitioners (RCP) who have successfully completed performance competencies.

B. MONITORING and DOCUMENTATION:

- Upon verification of "RT assess and treat protocol" order, the RCP will review the patient's chart.
- RCP will perform patient assessment, review indications, and complete RT assessment/reassessment frequency grid form (see appendix A).
- Frequency and dosing will be adjusted to meet, at minimum, patient's home regimen.
- RCP will initiate appropriate modality (ies)~~, if any, as per #2 above~~. RCP will notify RN of plan of care.
- RCP completes the "RT assess and treat protocol" order in electronic medical record. "RT assess and treat protocol" order remains available for activation in electronic medical record at any time.
- RCP enters appropriate orders and documents assessment and therapy provided in electronic medical record.
  a. Bronchodilators per protocol score
  b. Secretion mobilization and clearance device
  c. Home CPAP
  d. NIV (non invasive) associated skin barrier
- Patients will be evaluated by RCP minimally every day for appropriateness of therapy.
- RCP will notify RN and physician if any acute deterioration in the patient's clinical condition.
- RCP will document all reassessments in electronic medical record along with any change in plan of care.

C. See individual policies for:

1. Vest Airway Clearance System
2. Mucus Clearance Device
3. Incentive spirometry (IS)
4. Intermittent Positive Pressure Breathing (IPPB)
5. Intrapulmonary Percussive Ventilation (IPV)
6. Bronchodilator Protocol
7. Chest Physiotherapy
8. ~~Patient own CPAP~~Non-Invasive Positive Pressure Ventilation (NPPV); BiPAP / CPAP

V. REFERENCES

N/A

VI. STAKEHOLDERS

N/A

Appendix A: Respiratory Care Assessment/Reassessment Frequency Grid

Severity	0	1	2	3	4	Points
Level of Consciousness	Alert-oriented, cooperative	Disoriented, sedated	Lethargic or uncooperative	Obtunded	Comatose	
Level of Activity	Ambulatory	Ambulatory with assistance	Non-ambulatory	Paraplegic	Quadriplegic	
Respiratory Pattern	Regular pattern RR 12-20	Increased RR 21-30	Dyspnea on exertion, or irregular pattern	Use of accessory muscles or prolonged expiration dyspnea RR 30-35	Severe dyspnea	
Breath Sounds	Clear	Diminished	Fine crackles, or slight wheezing	Coarse crackles, exp wheezing	Absent or severely diminished, Ins/exp wheezing	
Cough	Strong, non-productive	Strong, productive	Weak/ guarded dry	Weak, congested	Ineffective, none	
Respiratory History	No pulmonary history, non-smoker	Smoker or ex-smoker, unknown	Mild bronchitis, asthma	Chronic pulmonary disease	Severe end stage pulmonary	
Present Surgical History	None/general surgery not impairing pulmonary function	Lower abdominal	Upper abdominal	Thoracic	Thoracic with pulmonary history or chronic illness	
X-Ray	Clear	Unavailable or greater than 7 days	Minor atelectasis, pleural effusions	Infiltrates, acute changes, hyperinflation, atelectasis bilateral pleural effusions	Other multiple lung findings	

Score = _____

Point Value: **0-5** = no therapy or Q4 PRN

6-10 = BID & Q4 PRN

11-15 = TID or Q6 W/A & Q4 PRN

16-19 = QID or Q4 W/A & Q2 PRN

19-25 = Q4 & Q2 PRN

Greater than 25 = Q2, notify physician

WATSONVILLE COMMUNITY HOSPITAL

Policy Title	Perinatal Urine Toxicology Testing Policy	Policy #	NUR0857
Responsible	Director of perinatal and IICN Unit	Revised/Reviewed	~~07/2022~~07/05/2023

I. PURPOSE

1) To identify and care for birthing people and infants exposed to substances putting them at high risk for needing specific clinical interventions.
2) To minimize bias, discrimination, and punitive use of urine toxicology in caring for patients and families.
3) This policy is not intended to replace the clinical judgment of a substance use treatment team in using urine drug testing to monitor treatment. It is intended to guide screening outside the context of ongoing treatment.

II. POLICY

Indications for urine toxicology testing are based on needs for potential change in clinical management based on toxicology results. Urine toxicology testing is not to be used as a tool of determining fitness to parent. A positive toxicology screen at time of delivery is not, in and of itself, grounds to report to the State Department of Children's Services and a negative toxicology screen does not preclude a suspected child abuse report, if there are other risk factors present.

III. DEFINITIONS

N/A

IV. INDICATIONS

Universal verbal screening is the gold standard for assessing and identifying families affected by substance use disorder. If verbal disclosure is obtained and documented, perinatal urine toxicology is not indicated and risks creating a counterproductive lack of trust. If there is a physical symptom prompting evaluation for drug use, then verbal screening is indicated.

A. Birthing Person
   1. Acute mental status changes, altered level of consciousness not otherwise explained
   2. Unexplained disorientation, psychosis, manic symptoms, ataxia, hallucinations, internal preoccupation, severe psychomotor agitation, confusion, and/or somnolence where a toxicology test would dictate medical management
   3. If desired/requested by the birthing person (i.e.: to demonstrate recovery and/or safety of chest/breastfeeding.

B. Newborn Indications for urine toxicology of birthing person
   1. Newborn exhibits symptoms consistent with intoxication that are after neonatal evaluation and review of maternity medications are otherwise unexplained such as:
      i. Excessive tremors and/or seizures
      ii. Hypertonicity and hyperactivity (i.e.: frantic sucking of fists, hyperactive moro reflex)
      iii. Irritability and/or high-pitched cry
      iv. Unexplained lethargy
      v. Diaphoresis
      vi. Fever
      vii. Frequent yawning (>3-4 x/interval)

WATSONVILLE
COMMUNITY HOSPITAL

Policy Title	Perinatal Urine Toxicology Testing Policy	**Policy #**	NUR0857
Responsible	Director of perinatal and IICN Unit	**Revised/Reviewed**	~~07/2022~~07/05/2023

viii. Mottling
ix. Respiratory distress (e.g., tachypnea, nasal flaring, retractions)
x. Sneezing, nasal stuffiness
xi. Poor feeding and/or vomiting
xii. Loose or watery stools, diarrhea

2. If birthing person desires to chest/breastfeed and the following conditions exist:
    i. Report of substance use or positive urine toxicology screen during last trimester of pregnancy or within the last three months (excluding THC), AND
    ii. Birthing person is not engaging in substance use treatment or there is no negative toxicology screen subsequent to a positive toxicology screen ~~subsequent to a positive toxicology screen~~ then the birthing person will be asked for a urine toxicology testing result that is negative for stimulants prior to chest/breastfeeding or giving expressed breast milk. This applies to all ~~illicit~~ substances including opioids and others that might be considered unsafe~~safe~~ for chest/breastfeeding due to the possible contamination of street drugs with other substances. If there are no stimulants identified on this testing, the patient may chest/breastfeed.

C. Indications for Newborn toxicology testing
1. Infant demonstrates signs of intoxication or withdrawal or neonatal abstinence syndrome (as listed in Section III.B.1) that are otherwise not explained per clinical judgement.

D. Limited or no prenatal care: If a birthing parent had limited or no prenatal care and no known history of substance use, urine toxicology testing is not required. Verbal screening of the birthing parent for substance use using a validated verbal screen, e.g., NIDA, should be performed. Positive screens will prompt appropriate follow- up questions and assessments.

E. CONTRAINDICATIONS
1. Lack of consent in a patient who has capacity.

V. PROCEDURE

A. All labor patients will be verbally screened using NIDA upon admission to unit.
    1) A positive screen is not an indication for urine toxicology testing.

B. If the obstetric or pediatric care team deems urine toxicology is recommended as per indications above, care team will discuss indication, benefits, disadvantages and alternatives with the patient. If consent is given, sample will be collected and sent to lab. If consent is not given, the test can only be sent if the patient is deemed to not have capacity.

C. Signs of prenatal drug/alcohol exposure in the infant shall be documented in the infant's medical record. For neonatal abstinence syndrome/neonatal opiate withdrawal, refer to Eat-Sleep- Console Policy and Protocol for management (Policy #0693)

D. If pediatric team deems urine toxicology testing of newborn to be indicated, pediatric provider will review the rationale for recommendation with the birthing person and/or legal guardian prior to collecting and sending specimen. Though verbal consent is not legally required in this case, it is determined by this facility to be best practice. Testing will be performed on newborn urine.

E. In the case of a positive urine toxicology test, social worker will be notified. An interdisciplinary team including the on call obstetric provider, pediatric provider, social worker and RN will discuss case to review patient history, support team, strengths and challenges, and to determine if a referral to Child Protective Services is indicated as well as delineate additional plans of support for patient and family.

F. If it is determined by the care team that a referral to Child Protective Services is indicated:

1) The patient will be notified that a CPS report will be filed.
2) The Suspected Child Abuse and Neglect Forms must be completed and submitted within 36 hours of the phone report by Social Services
3) The Newborn Risk Assessment Form, relevant portions of the infant's medical record, including but not limited to the prenatal, labor and delivery records, and all other relevant documentation shall be provided to the Department of Children's Services worker investigating the report. (Information should be readily available as a court hearing may be scheduled within 72 hours.)
4) The form copies should be sent by Social Services to the Department of Health Services
5) Document the outcome of the referral in the infant's medical record.
6) Attending pediatrician/OBGYN/CNM will be notified if not already involved in decision making per Section IV F.

G. The discharge plan shall:
1) Be developed in conjunction with child protective services, when notified;
2) Identify services needed by the infant, parent or family and specify referrals;
3) Include referral of newborn for medical follow-up after discharge.

H. The Child Abuse Hotline is available for questions regarding child abuse reporting laws.
Monterey County 831-755-4661
Santa Cruz County 831-454-4222

F. All care referrals shall be documented in the nurses' notes. Copies of appropriate forms will be attached to the chart.

VI. REFERENCES

ACOG Committee Opinion, Opioid Use and Opioid Use Disorder in Pregnancy, August 2017

Mother and Baby Substance Exposure Toolkit, Best Practice No 1

Urine Toxicology Testing Policy, Zuckerburg San Francisco General Hospital

Finnegan LP, Connaughton JF, Dron RE, Emich JP. Neonatal abstinence syndrome: assessment and management. Addictive Diseases: An International Journal. 1975; 2 (1): 141-158.

NCPOEP. Neonatal Abstinence Syndrome Overview: 2018; 1-12.

Lucas K, Knobel RB. Implementing Practice Guidelines and Education to Improved Care of Infants with Neonatal Abstinence Syndrome. 2012. Advances in Neonatal Care. 12(1): 40-45.

Finnegan LP. Neonatal abstinence syndrome: assessment and pharmacotherapy. In : Nelson N, editor, Current therapy in neonatal-perinatal medicine. 2 ed. Ontario: BC Decker; 1990.

VII. STAKEHOLDERS

N/A

Policy Title	TOLAC Trial of Labor after Cesarean Delivery	Policy #	NUR0014
Responsible	Perinatal	Revised/Reviewed	~~11/11/2020~~09/2023

I. PURPOSE

To provide guidelines for managing a patient who is undergoing~~attempting~~ a Trial of Labor After Cesarean (TOLAC) while maintaining patient safety for both the mother and the fetus.

II. POLICY

The Perinatal Department will support the patient's decision to attempt a vaginal birth after cesarean section (C/S).

III. DEFINITIONS

Immediately available: On the main hospital campus, with rapid response time to patient evaluation, a clear communication method established and the ability to be contacted with a single phone call.

Active Labor: Cervical dilation equal to or greater than 6 cm in the presences of regular contractions of sufficient frequency, intensity and duration to bring about readily demonstrable effacement and dilation of the cervix.

Absolute Contraindications (to TOLAC):

1. Previous classical uterine incision
2. Previous "T" incision
3. Medical or obstetrical complication that is a contraindication for labor or vaginal delivery
4. Abnormal fetal presentation
5. Previous uterine rupture
6. Previous major uterine surgery (i.e. myomectomy with incision into the active segment of uterus)
7. Previous (one) cesarean delivery with an unknown scar type when there is a high clinical suspicion of previous classical uterine incision
8. Noncephalic presentation (External cephalic version for breech presentation is not contra-indicated in women with a prior low transverse incision who are at low risk for

adverse maternal or neonatal outcomes from external cephalic version and trial of labor after cesarean (TOLAC)

9. More than two previous cesarean sections

I. POLICY IN DETAIL

1. A TOLAC will only be considered if the following exists:
    a. No contraindications are identified.
    b. The patient consents to a TOLAC following informed consent by the attending physician.
    c. There is documentation in the medical record that the consent has been verified by the registered nurse.
    d. A signed consent form for a TOLAC and Cesarean Section is in the medical record.
    e. The patient is admitted to and under the care of the physician with privileges for management of TOLAC and able to perform an emergency cesarean section following admission of a patient undergoing a TOLAC.
    f. An obstetrician and midwife may co-manage a TOLAC and VBAC
    g. The attending physician, anesthesiologist/CRNA and OR team are immediately available to perform an emergency cesarean section of a patient undergoing a TOLAC who
    is in active labor.
    h. The hospital has the capability of beginning a cesarean section delivery within 30 minutes of the decision to operate.
    i. The hospital has the capability of providing one to one nursing care.
    j. Patient has intravenous access.
2. The physician/provider will be contacted within 60 minutes of the patient's arrival.
3. The nursing staff will inform the anesthesiologist/CRNA, obstetrician and the OR team when the patient is in active labor (6 cm) and this will be documented in the medical record.
4. If the patient refuses blood transfusion, informed declination will be given by the attending physician and the anesthesiologist will be notified.
5. If any of the following conditions are present at any time during the visit the MD must be contacted immediately:
    a. Frank bleeding
    b. Abnormal vital signs
    c. Signs and symptoms of uterine rupture, including but not limited to:
        i. Sudden increase in pain
        ii. Severe pain between contractions or at the incision site
        iii. Breakthrough pain in a patient with epidural analgesia
        iv. Sudden loss of uterine tone
        v. Change in fetal heart rate patterns
        vi. Maternal signs of shock
    d. Any other abnormal findings.
6. Labor induction or augmentation of a patient attempting TOLAC
    a. Obstetrician, anesthesiologist/CRNA, and OR team must be immediately available prior to beginning the induction or augmentation
    b. Prostaglandins may not be used in patients at term with a prior cesarean delivery or history of major uterine surgery.
    c. Prostaglandins may be considered in the case of preterm fetal demise or preterm inevitable fetal loss in patients with a prior cesarean delivery or major uterine surgery.

   d. Explicit informed consent regarding the increase risk for uterine rupture must be documented in the medical record
   e. Use of caution with Oxytocin, especially at higher doses.
   f. Cook balloon catheter may be used.
   g. Internal monitoring will be considered.
7. Terbutaline Sulfate:
   a. May be ordered for the patient who has hypertonus or tachysystole if no other contraindications present.

II. PROCEDURE

Nursing:

1. The Labor and Delivery staff will identify the patients who have had a previous cesarean section and wish to attempt TOLAC.
2. Review the prenatal records for pertinent information, including but not limited to:
   a. Informed consent and agreement for TOLAC and Cesarean Section if necessary.
   b. Contraindications listed in this policy
3. Perform initial assessment and fetal monitoring per unit standards of care
4. The attending physician/CNM will be contacted within 60 minutes or less and informed of the patient presence and desire TOLAC and orders will be obtained.
5. Admit patient per orders and unit standards of care.
6. Obtain hospital consent form for TOLAC and Cesarean Section.
7. IV will be started, as soon as possible, with 18G or greater IV catheter.
8. Ensure CBC with Type and Screen or Type and Cross Match for 2 units (if clinically indicated)
9. Continuous fetal monitoring and continuous uterine contraction monitoring.

Attending Physician:

1. Determine the appropriateness of the patient for TOLAC utilizing these guidelines, including availability of staff. The determination of appropriateness of the patient for TOLAC and whether a patient will be offered a trial of labor rests with the attending physician or his/her colleague on call at the time the patient is in active labor.
2. Confirm that a comprehensive history and physical is completed in the medical record.
3. Document that a thorough informed consent for a TOLAC was obtained from the patient, including the risks, benefits and alternatives. Patient is to sign a procedure consent for TOLAC and possible cesarean section. If the patient does not consent to possible transfusion, informed consent will be provided regarding additional risks of proceeding with TOLAC. Availability of additional volume expanders should be addressed.

4. Ensure anesthesiologist is aware of the patient in active labor attempting TOLAC and corresponding plan of care.
5. Communicate to the nursing staff his/her location during the entire period of labor and clarify method to reach him/her directly.
6. Communicate whether there is any change in his/her availability and who the back-up physician is as well as that person's location and direct contact information.

Anesthesiologist:

1. Review chart/prenatal record once patient is admitted to become familiar in case the need for immediate intervention arises.
2. Communicate to the nursing staff his/her location during the entire period of labor and clarify method to reach him/her directly.
3. Communicate whether there is any change in his/her availability and who the back-up physician is as well as that person's location and direct contact information.

~~1.~~
~~1.~~ Care Team:

~~2. 1:1 nursing care when in active labor~~
~~1.~~

1. 1:1 nursing care when in active labor

2. ~~3.~~ CNM/OBGYN co-management of patients undergoing TOLAC as appropriate per

3. WCH CNM Clinical Guidelines

4. ~~4.~~ The obstetrician of record or designated obstetrician will be on campus and immediately available during the active stage of labor (greater than 6 cm of dilation) and during the administration of Oxytocin.

5. ~~5.~~ The provider will notify the anesthesiologist/CRNA when patient is in active labor. The anesthesiologist/CRNA will be in-house and “immediately available” (~~i.e.~~i.e. ~~-~~not concurrently assigned to any scheduled surgical procedure) when he/she has a patient in active labor, and/or during administration of Oxytocin.

~~6.~~

6. ~~7.~~ The OB Charge RN will assure that an OR team including a scrub tech and RN Circulator are in house and immediately available when TOLAC patient is in active labor.

7. ~~8.~~ The OB Charge nurse will assure that the House Supervisor is aware that there is a TOLAC patient in the perinatal unit.

III. ~~IV.~~ **Documentation**

~~1.~~ Nursing:

1. ~~a.~~ All maternal and fetal assessments, plans, interventions, evaluations and teaching will be documented in the medical record.

2. b. All communications to physicians and other departments and staff will be documented in the medical record.

Policy Title	TOLAC Trial of Labor after Cesarean Delivery	Policy #	NUR0014

2. Physician:
    1. a. All maternal and fetal assessments, plans, interventions, evaluations, informed consent, communications and other pertinent information will be documented in the medical record.

III. REFERENCES

American College of Obstetricians and Gynecologists (ACOG). Vaginal birth after Cesarean Delivery. Washington (DC): American College of Obstetricians and Gynecologists (ACOG), ; February 2019.

Caughey, A., (2023, June 09). Vaginal Birth After Cesarean Delivery. Retrieved October 12, 2023 from https://emedicine.medscape.com/article/272187-overview#a1

Metz, T. Grobman, W. Barss, Vanessa. (2023, May 18). Choosing the route of delivery after cesarean birth. *UpToDate*. Retrieved October 12, 2023 from https://www.uptodate.com/contents/choosing-the-route-of-delivery-after-cesarean-birth/print

IV. STAKEHOLDERS

This policy applies to all hospital staff and includes guidelines and recommendations for nursing staff, midwives, physicians, anesthesiologists, CRNAs and other members of the staff of the hospital.

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: November 29, 2023

Report Type: Discussion

Title: Medical Committees Reports November 2023

Recommendation: Pass a **Motion** approving the Medical Executive Committee (MEC) Report, the Credentials Report and the Interdisciplinary Practice Credentials Report of November 2023

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 Report – November 2023 Credentials Report, Interdisciplinary Practice Credentials Report

WATSONVILLE COMMUNITY HOSPITAL

Medical Executive Committee Summary – November 29, 2023
ITEMS FOR BOARD APPROVAL

Credentials Committee

INITIAL APPOINTMENTS: (4)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
De Jesus-Alvelo, Indira, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	11/30/2023-10/31/2025
Jhamb, Neil G., MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	11/30/2023-10/31/2025
St. Clair-Brown, Tanen, DO	Family Medicine Hospitalist / Provisional	Medicine	Family Medicine, Critical Care, NonIntensivist	11/30/2023-10/31/2025
Thaker, Kuntal, MD	Gastroenterology / Provisional	Medicine	Gastroenterology, Sedation	11/30/2023-10/31/2025

REAPPOINTMENTS: (4)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Lindberg, Carl, DPM	Podiatry / Active	Surgery	Podiatry, Fluoroscopy, Wound Care	12/01/2023-11/30/2025
Van Ooy, Michelle, MD	OB/GYN / Active	OB/GYN	OB/GYN – Obstetrics and Minor GYN	12/01/2023 - 11/30/2025
Heywood, Christian, MD	Orthopedic Surgery / Active	Surgery	Orthopedics, Fluoroscopy	06/25/2022 – 05/31/2024 (Administrative Update to appointment date)
Khademi, Ali, DO	Gastroenterology / Active	Medicine	Gastroenterology, Sedation, Fluoroscopy	06/25/2022 – 05/31/2024 (Administrative Update to appointment date)

MODIFICATION / ADDITION OF PRIVILEGES: (0)

NAME	SPECIALTY / STATUS	Privileges
None		

STAFF STATUS MODIFICATIONS: (3)

NAME	SPECIALTY / DEPARTMENT	RECOMMENDATION
Furbayashi, Jill, MD	TeleRadiology / Medicine	Voluntary Resignation, 10/08/2023
Harbison, Anna, MD	Pediatric Cardiology / Pediatrics	Voluntary Resignation, 10/13/2023
Hawksley, Carlene, MD	Pathology / Surgery	Voluntary Resignation, 01/31/2023

TEMPORARY PRIVILEGES: (1)

NAME	SPECIALTY / DEPARTMENT	DATES
St. Clair-Brown, Tanen, DO	Family Medicine Hospitalist / Medicine	11/09/2023; 11/20/2023 – 11/30/2023 Privileges: Family Medicine, Nonintensivist Critical Care

INTERDISCIPLINARY PRACTICE CREDENTIALS REPORT

Initial Appointment: (1)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Treppendahl, Emily, CRNA	Nurse Anesthetist / Allied Health Professional	Surgery	Certified Registered Nurse Anesthetist, Adult, Pediatric, OB	11/30/2023 – 10/31/2025

REAPPOINTMENT: (4)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Berglund, Luke, PA-C	Physician Assistant / Allied Health Provider	Emergency Medicine	PA Emergency Medicine	11/30/2023 – 10/31/2025
Phillips, Charles, PA-C	Physician Assistant / Allied Health Provider	Emergency Medicine	PA Emergency Medicine	11/30/2023 – 10/31/2025
Sullivan, Malin, PA-C	Physician Assistant / Allied Health Provider	Emergency Medicine	PA Emergency Medicine	12/01/2023 - 11/30/2025
Villaverde, Raymond, PA-C	Physician Assistant Orthopedic / Allied Health Provider	Surgery	PA Orthopedics	12/01/2023 - 11/30/2025

Temporary Privileges: (3)

NAME	SPECIALTY / DEPARTMENT	DATES
Berglund, Luke, PA-C	Physician Assistant / Emergency Medicine	11/25/2023 - 11/30/2023
Phillips, Charles, PA-C	Physician Assistant / Emergency Medicine	11/25/2023 - 11/30/2023
Treppendahl, Emily CRNA	Nurse Anesthetist / Surgery	11/06/2023 - 11/30/2023

STAFF STATUS MODIFICATIONS: (2)

NAME	SPECIALTY / DEPARTMENT	RECOMMENDATION
Lamm, Zachary, PA-C	Physician Assistant / Surgery	Voluntary Resignation; 12/22/2023
Parker, Lindsay, PA-C	Physician Assistant / Surgery	Voluntary Resignation; 11/04/2023

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: November 29, 2023

Report Type: Discussion

Title: Watsonville Community Hospital Quality Report November 2023

Recommendation: Receive and file.

Contact: Tracy Trail-Mahan, Director of Quality, Risk and Patient Safety

Analysis:
At each board meeting the Director of Quality, Risk and Patient Safety provides a summary of quality and risk matters to the board and the public.

Financial Impact: None

Attachments:

A. Watsonville Community Hospital Quality Report

WATSONVILLE COMMUNITY HOSPITAL

Quality Report November 2023

Tracy Trail-Mahan MS RN PMGT-BC CPHQ
She/Her/Hers
Director of Quality, Risk & Patient Safety

Regulatory

- No regulatory activity
- KP Surgery, Quality and Infection Prevention visit November 29th 2p-4p

Quality

- New Risk Manager Kaylee Young start date October 23rd
- New Infection Prevention and Control Director Will Cardona RN start date November 15th

WATSONVILLE
COMMUNITY HOSPITAL

Readmissions (all cause)

HRRP	Baseline Rate Time Period: 01/01/2019 - 12/31/2019	Evaluation Rate Time Period: 6/1/2022 - 5/31/2023	Number Needed to Avert	Goal Rate
HRRP 5	16.73%	16.75%	9	16.89%

Jan 2023= 13.3%
Feb 2023=16.1%
Mar 2023= 23.5%
Q 1 2023= 19%
Apr 2023= 9.1%
May 2023=16.4%

HSAG HEALTH SERVICES ADVISORY GROUP

WATSONVILLE COMMUNITY HOSPITAL

Mortality (all cause)

HRRP	Baseline Rate Time Period: 01/01/2019 - 12/31/2019	Evaluation Rate Time Period: 7/1/2022 - 6/30/2023	Number Needed to Avert	Goal Rate
HRRP 5	8.83%	9.11%	12	8.04%

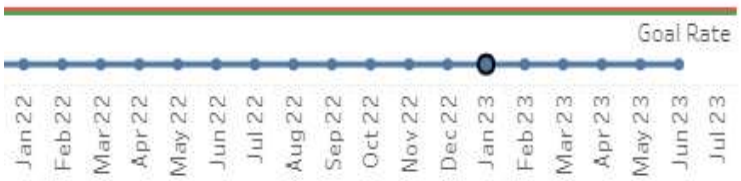
Jan 2023= 5.41%
Feb 2023= 4.55%
Mar 2023=8.12%
Apr 2023=7.59%
May 2023=9.59%
Jun 2023= 10.61%

HSAG HEALTH SERVICES ADVISORY GROUP

WATSONVILLE COMMUNITY HOSPITAL

CAUTI

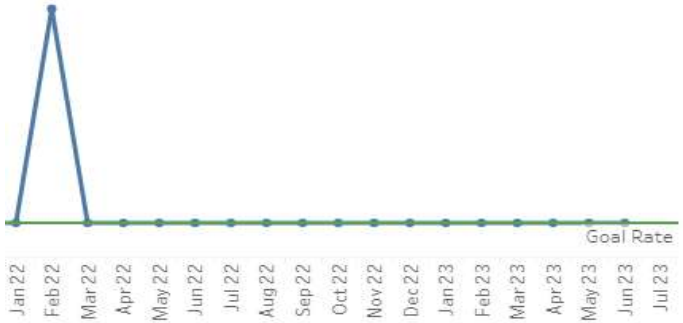
Baseline Rate Time Period: 01/01/2019 - 12/31/2019	Evaluation Rate Time Period: 8/1/2022 - 7/31/2023	Number Needed to Avert	Goal Rate
0.90	0.00	0	0.82



CLABSI

Baseline Rate Time Period: 01/01/2019 - 12/31/2019	Evaluation Rate Time Period: 8/1/2022 - 7/31/2023	Number Needed to Avert	Goal Rate
0.00	0.00	0	0.00

1



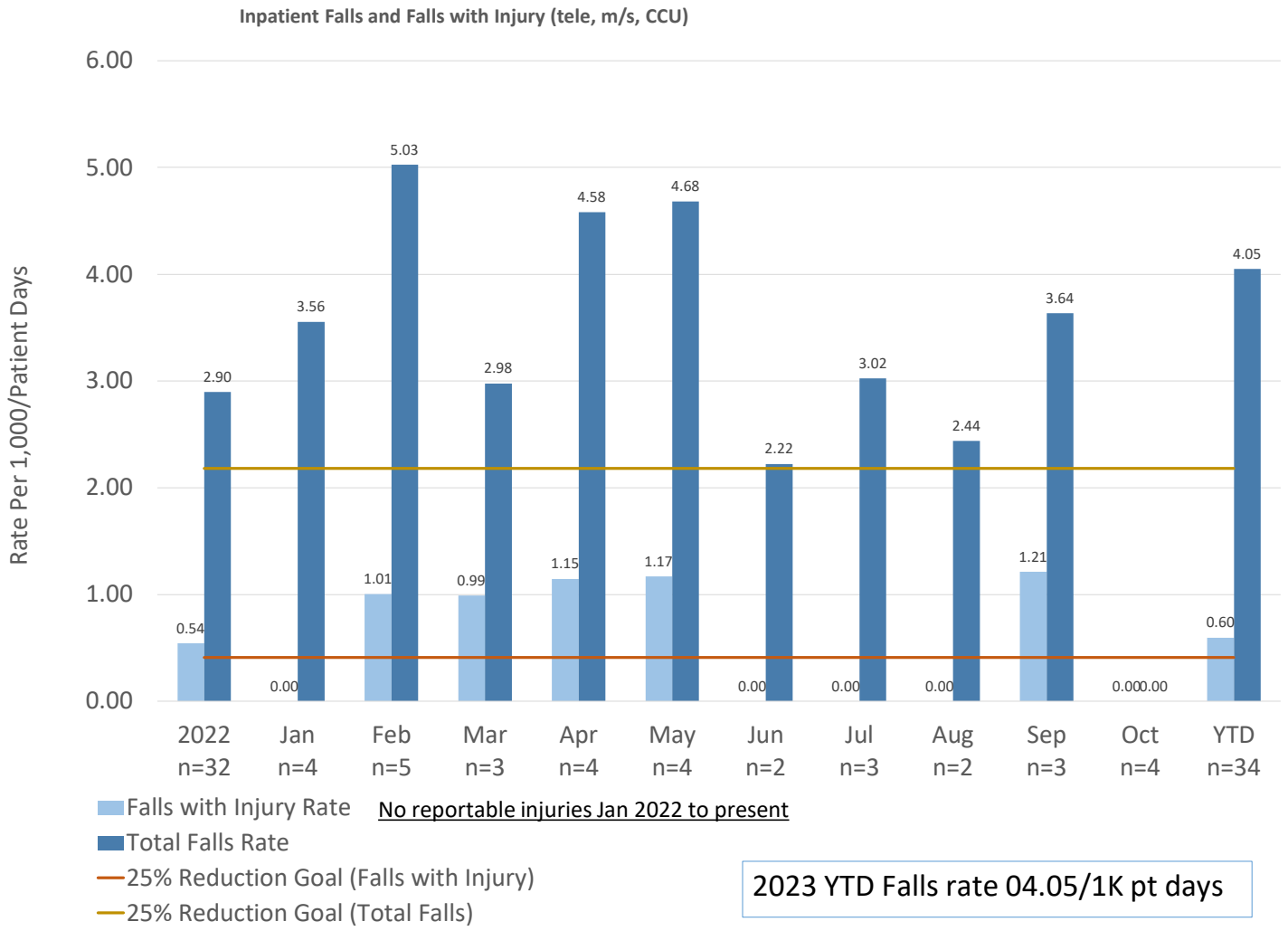
HSAG HEALTH SERVICES ADVISORY GROUP

WATSONVILLE COMMUNITY HOSPITAL

WATSONVILLE COMMUNITY HOSPITAL

National Benchmark
3.44 falls/1000 patient days*

2023 Goals
Total Falls 2.18
With Injury 0.41



2023 YTD Falls rate 04.05/1K pt days

Leapfrog Fall 2023 Safety Grade

Watsonville Community Hospital | Ratings | Leapfrog Group

THE LEAPFROG GROUP
Giant Leaps for Patient Safety

WATSONVILLE COMMUNITY HOSPITAL

Measure Domain	Measure	WCH Score Fall 2022	SPRING 2023	FALL 2023	Mean Fall 2023
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	70	70	100	90.56
	Bar Code Medication Administration (BCMA)	75	75	75	92.65
	ICU Physician Staffing (IPS)	5	5	50	62.23
	Safe Practice 1: Culture of Leadership Structures and Systems	92.31	92.31	110.77	117.46
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	120.00	120.00	110.00	115.71
	Total Nursing Care Hours per Patient Day	82.35	82.35	100	70.88
	Hand Hygiene	40	40	100	77.29
	H-COMP-1: Nurse Communication	87	87	88	89.55
	H-COMP-2: Doctor Communication	87	86	86	89.45
	H-COMP-3: Staff Responsiveness	79	80	79	80.97
	H-COMP-5: Communication about Medicines	71	70	70	73.85
	H-COMP-6: Discharge Information	86	86	83	84.80
Outcome Measures	Foreign Object Retained	0.000	0.000	0.000	0.014
	Air Embolism	0.000	0.000	0.000	0.001
	Falls and Trauma	0.598	1.321	0.906	0.430
	CLABSI	3.400	N/A	N/A	0.889
	CAUTI	1.640	N/A	N/A	0.734
	SSI: Colon	N/A	N/A	N/A	0.833
	MRSA	N/A	N/A	N/A	0.926
	C. Diff.	1.117	1.390	1.219	0.488
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	N/A	N/A	N/A	143.28
	CMS Medicare PSI 90: Patient safety and adverse events composite	1.06	1.06	1.06	0.98

Measure Domain	Measure	Reporting Period
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	2023
	Bar Code Medication Administration (BCMA)	2023
	ICU Physician Staffing (IPS)	2023
	Safe Practice 1: Culture of Leadership Structures and Systems	2023
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	2023
	Total Nursing Care Hours per Patient Day	2023
	Hand Hygiene	2023
	H-COMP-1: Nurse Communication	10/01/2021 - 09/30/2022
	H-COMP-2: Doctor Communication	10/01/2021 - 09/30/2022
	H-COMP-3: Staff Responsiveness	10/01/2021 - 09/30/2022
	H-COMP-5: Communication about Medicines	10/01/2021 - 09/30/2022
	H-COMP-6: Discharge Information	10/01/2021 - 09/30/2022
Outcome Measures	Foreign Object Retained	07/01/2020 - 06/30/2022
	Air Embolism	07/01/2020 - 06/30/2022
	Falls and Trauma	07/01/2020 - 06/30/2022
	CLABSI	01/01/2022 - 12/31/2022
	CAUTI	01/01/2022 - 12/31/2022
	SSI: Colon	01/01/2022 - 12/31/2022
	MRSA	01/01/2022 - 12/31/2022
	C. Diff.	01/01/2022 - 12/31/2022
	PSI 4: Death Rate among Surgical Inpatients with Serious Treatable Conditions	07/01/2019 - 12/31/2019 AND 07/01/2020 - 06/30/2021
	CMS Medicare PSI 90: Patient safety and adverse events composite	07/01/2019 - 12/31/2019 AND 07/01/2020 - 06/30/2021

C. Diff

- data reporting period July 2020-June 2022
- SIR 1.0 old standard, new Leapfrog benchmark 0. 49
- WCH C. Diff Collaborative June 2023
  - New process for early identification and testing
  - Policy Update
  - Nursing Education
  - MD education
  - EMR enhancements
    - Added Bristol Stool chart
    - Order enhancements, only Micro orders PCR after hospital day 3

Summary

Look for Leapfrog Monthly PI meetings coming 2024

Bright Spots

- CPOE
- Safe Practice 1: Culture of Leadership Structures and Systems
- Nursing Care hours
- RFO, Air Emboli
- CLABSI, CAUTI

Opportunity Areas

- ICU Physician Staffing (IPS)
- Safe Practice 2: Culture Measurement, Feedback, & Intervention
- HCAHPS
- C. Diff
- PSI 90

Leapfrog Resources

- Hospital Ratings and Reports | Leapfrog (leapfroggroup.org)
- Survey Materials | Leapfrog (leapfroggroup.org)

Questions?

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: November 29, 2023

Report Type: Discussion

Title: Update by Chief Executive Officer (CEO)

Recommendation: Receive and file update from Stephen Gray, CEO

Contact: Stephen Gray, CEO

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

Financial Impact: None

PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Board Report

Meeting Date: November 29, 2023

Report Type: Discussion

Title: Co-Tenancy Agreement between Pajaro Valley Health Care District (District) and Pajaro Valley Health Care District Hospital Corporation (Hospital Corporation)

Recommendation: Pass a **Resolution:** (1) consenting to the Hospital Corporation entering into the Co-Tenancy Agreement with the District as a co-tenant under the MPT Lease; and (2) authorizing the Chief Executive Officer, Stephen Gray, to execute and deliver the Co-Tenancy Agreement on behalf of the Hospital Corporation.

Contact: Stephen Gray, Chief Executive Officer

Analysis:

In order to consummate the purchase of Watsonville Community Hospital, as contemplated and approved by the District and Hospital Corporation boards in August of 2022, the District and the Hospital Corporation were required to enter into an Amendment to the MPT Lease Agreement with MPT of Watsonville, LLC, the landlord for the leased property described below, pursuant to which certain changes were to be made to the MPT Lease Agreement to reflect purchase of the hospital. The landlord required, as a condition to entering into Amendment to the MPT Lease Agreement, that both the District and the Hospital Corporation agree to be the lessees under the MPT Lease Agreement, jointly and severally as co-tenants.

In connection therewith, the District and the Hospital Corporation wish to enter into the attached Co-Tenancy Agreement, to set forth their respective roles and responsibilities as co-tenants under the MPT Lease Agreement. Under the Co-Tenancy Agreement, the Hospital Corporation has agreed to fund the payment of all rental expenses which may be due and owing under the MPT Lease Agreement. In addition, each of the District and the Hospital Corporation have agreed to regularly consult with one another to manage the sharing of their occupancy and use of the leased property.

Financial Impact:

The rental expenses for the leased premises are already a joint and several obligation of the District and the Hospital Corporation under the Amendment to the MPT Lease Agreement. No additional costs will be incurred by the parties in connection with the Co-Tenancy Agreement (with the exception of the Hospital Corporation's agreement to fund the payment of all rental expenses under the MPT Lease Agreement).

Leased Property:

The Leased Property consists of the land and the leased improvements located at the addresses below:

- 45 Nielson Street, Watsonville, California, 95076
- 65 Nielson Street, Watsonville, California, 95076
- 75 Nielson Street, Watsonville, California, 95076
- 85 Nielson Street, Watsonville, California, 95076

The District currently occupies the following portion of the Leased Property for the operation of the District's Clinics:

- 65 Nielson Street, Suite 125, Watsonville, California, 95076. The District has engaged Coastal Health Partners, PC ("CHP"), to provide general, vascular and thoracic surgery services at this location.
- 65 Nielson Street, Suite 102, Watsonville, California, 95076. The District has engaged CHP to provide nephrology and cardiology services at this location.

The Hospital Corporation currently occupies the following portion of the Leased Property for the operation of the Hospital:

- 75 Nielson Street, Watsonville, California, 95076

The District also currently occupies a portion of the premises located at 1820 Main Street, Watsonville, California, 95076 for the operation of the District's 1206(b) clinics. The District has engaged CHP to provide urology, orthopaedics and spine services at this location. Such premises are not part of the leased property.

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

RESOLUTION NO. ___

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

RESOLUTION APPROVING THE CO-TENANCY AGREEMENT

The Board of Directors (the "**Board**") of the **PAJARO VALLEY HEALTH CARE DISTRICT HOSPITAL CORPORATION**, a California nonprofit public benefit corporation (the "**Corporation**"), required to approve the matters set forth herein, does hereby consent to the adoption of the following resolutions.

I. Background

WHEREAS, Pajaro Valley Health Care District (the "**District**") was formed pursuant to the California Local Health Care District Law and California Senate Bill No. 418, approved by the Governor of California on February 4, 2022, for purposes that include without limitation the acquisition of the Watsonville Community Hospital (the "**Hospital**"); and

WHEREAS, the District caused the formation of the Corporation on April 29, 2022, for purposes that include without limitation the operation of the Hospital.

II. Co-Tenancy Agreement

WHEREAS, on August 31, 2022, the Corporation acquired Watsonville Community Hospital (the "**Hospital**");

WHEREAS, the acquired assets included, among other things, that certain Lease Agreement, dated as of September 30, 2019, by and between MPT of Watsonville, LLC ("**MPT Lessor**"), as lessor, and Watsonville Hospital Corporation, as lessee (as amended, the "**MPT Lease**"), as modified by that certain Lease Amendment, dated as of August 31, 2022, by and between MPT Lessor, as lessor, on the one hand, and the District and the Corporation, collectively, and jointly and severally, as lessees, on the other hand;

WHEREAS, in connection therewith, the Corporation and the District wish to enter into that certain Co-Tenancy Agreement, in substantially the form attached hereto as **Exhibit A** (the "**Co-Tenancy Agreement**"), to set forth their respective rights and obligations as joint and several lessees under the MPT Lease;

WHEREAS, the Board has reviewed and considered the terms of the Co-Tenancy Agreement, and such other agreements, instruments, or documents contemplated therein, in the forms previously submitted to the Board; and

WHEREAS, the Board deems it fair, advisable and in the best interest of the Corporation to execute and deliver the Co-Tenancy Agreement and to complete the transactions contemplated thereby.

NOW, THEREFORE, BE IT RESOLVED, that the Board hereby authorizes, adopts and approves the form, terms and provisions and the execution and delivery by the Corporation of the Co-Tenancy Agreement, including all of the exhibits attached thereto.

FURTHER RESOLVED, that the Corporation be, and it hereby is, authorized to enter into the Co-Tenancy Agreement, and that any director or officer of the Corporation and his or her designees be, and each of them hereby is, authorized in the name and on behalf of the Corporation, to execute and deliver the Co-Tenancy Agreement, with such changes therein as may be deemed necessary, appropriate or advisable by the directors or officers executing the same, the execution thereof by such director or officer to be conclusive evidence of such approval; and that the Corporation be, and it hereby is, authorized and empowered to perform its obligations under the Co-Tenancy Agreement.

III. General Authorization and Ratification

RESOLVED, that the directors and officers of the Corporation be, and each of them hereby is, authorized and directed to do or cause to be done all such acts or things and to sign and deliver, or cause to be signed and delivered, in the name and on behalf of the Corporation, all such documents, instruments, and certificates (including, without limitation, all notices and certificates required or permitted to be given or made under the terms of the Co-Tenancy Agreement), as such director or officer may deem necessary or appropriate to carry out the purposes and intent of the foregoing resolutions and to perform the obligations of the Corporation under the Co-Tenancy Agreement or otherwise referred to in the foregoing resolutions.

FURTHER RESOLVED, that all actions taken by the directors and officers on behalf of the Corporation in connection with the matters described in the foregoing resolutions are hereby ratified and confirmed in all respects.

(*Remainder of page intentionally left blank*)

(*Signature page follows*)

PASSED AND ADOPTED by the Board of Directors of the Pajaro Valley Health Care District Hospital Corporation, this 29th day of November, 2023, by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____

John Friel, Chair, Board of Directors

ATTEST: _____

Rosalie Brown, Clerk of the Board

Exhibit A

Co-Tenancy Agreement

(Attached)

CO-TENANCY AGREEMENT

This Co-Tenancy Agreement ("**Agreement**") is entered into as of September 1, 2023 (the "**Effective Date**"), by and between Pajaro Valley Health Care District, a political subdivision of the State of California (the "**District**"), and Pajaro Valley Health Care District Hospital Corporation, a California nonprofit public benefit corporation (the "**Corporation**"). The District and the Corporation are sometimes referred to in this Agreement as a "**Party**" or collectively, as the "**Parties**." Capitalized terms are defined in this Agreement.

RECITALS

A. MPT of Watsonville, LLC, a Delaware limited liability company ("**Lessor**"), and Watsonville Hospital Corporation ("**WHC**") executed that certain Lease Agreement, dated as September 30, 2019 (as amended, the "**Lease**"), relating to certain land, improvements, and fixtures located in Watsonville, Santa Cruz County, California (including the improvements consisting of a healthcare facility), all as more particularly described in the Lease (the "**Leased Property**").

B. WHC was engaged in the business of providing healthcare services as a licensed general acute care hospital known as Watsonville Community Hospital (the "**Hospital**"), located at 75 Nielson, Watsonville, California.

C. On December 5, 2021, WHC filed voluntary petitions for relief under title 11 of the United States Code (the "**Bankruptcy Code**") in the United States Bankruptcy Court, Northern District of California, San Jose Division (the "**Bankruptcy Court**"), commencing cases under chapter 11 of the Bankruptcy Code on an administratively consolidated basis under Docket No. 21-51477 (the **"Bankruptcy Proceeding"**).

D. Pajaro Valley Healthcare District Project (the "**Project**") is a California nonprofit public benefit corporation organized for the specific purpose to raise funds for and take all necessary steps to acquire the Hospital out of bankruptcy directly or through a health care district formed for the benefit of the County of Santa Cruz pursuant to California Health and Safety Code (the "**H&S Code**") sections 32000 through 32499.4 (the "**California Local Health Care District Law**").

E. The Project entered into that certain Asset Purchase Agreement, dated as of December 27, 2021, and amended by that certain First Amendment to Asset Purchase Agreement, dated as of February 18, 2022 (the "**Asset Purchase Agreement**"), as the "Buyer" described therein (the "**Buyer**"), with Halsen Healthcare LLC, Watsonville Hospital Holdings, Inc., Watsonville Healthcare Management, LLC, and Watsonville Hospital Corporation, as the "Sellers" described therein (each, a "**Seller**" and together the "**Sellers**"), pursuant to which the Project (or its assignee) was to purchase the Acquired Assets and assume the Assumed Liabilities described therein, which comprise and relate to the operation of the business of the Hospital and include the Lease (collectively, the "**Sale Transaction**").

F. The District was formed pursuant to Chapter 9 of Division 23 of the H&S Code added by Senate Bill No. 418 on February 4, 2022 (H&S Code sections 32498.5 through 32498.8) for purposes that include without limitation the acquisition of the Hospital.

G. Section 9.7 of the Asset Purchase Agreement provided that the Project was permitted to assign or otherwise transfer the Asset Purchase Agreement or any of its rights thereunder to the District or any "Affiliate" (as defined in the Asset Purchase Agreement) of the District (including without limitation a nonprofit corporation) with the demonstrated financial wherewithal to close the transactions contemplated by the Asset Purchase Agreement satisfactory to each of the Sellers and the Lessor.

H. The District caused the formation of the Corporation on April 29, 2022, for purposes that include without limitation the operation of the Hospital. The District is the sole corporate member of the Corporation.

I. On February 23, 2022, the Bankruptcy Court entered the Sale Order (as defined in the Asset Purchase Agreement) approving the Sale Transaction.

J. On August 31, 2022, immediately prior to the consummation of the Sale Transaction, the Project and the Corporation entered into that certain Assignment and Assumption Agreement (the **"Assignment and Assumption Agreement"**), pursuant to which the Project assigned and transferred to the Corporation the Asset Purchase Agreement and all of the Project's rights and obligations as the Buyer thereunder, including without limitation the right to receive an assignment of the Lease.

K. In order to consummate the Sale Transaction as contemplated by the Assignment and Assumption Agreement, the Corporation was required to enter into that certain Amendment to Lease Agreement with the Lessor (the "**Lease Amendment"**), pursuant to which certain changes were to be made to the Lease to reflect the Sale Transaction. The Lessor required, as a condition to entering into the Lease Amendment, that both the District and the Corporation agree to be the lessees under the Lease, jointly and severally as co-tenants.

L. On August 31, 2022, the Corporation and WHC consummated the Sale Transaction.

M. On August 31, 2022, contemporaneously with the consummation of the Sale Transaction, the Parties entered into the Lease Amendment.

N. On August 31, 2022, immediately subsequent to the consummation of the Sale Transaction, the District and the Corporation entered into that certain Conveyance (the "**Conveyance**"), pursuant to which the Corporation conveyed, transferred and assigned the Conveyed Assets described therein, including the Corporation's interest in the Lease and any subleases entered into in connection with the Lease, to the District to accomplish the District's acquisition of the Hospital, as contemplated by Chapter 9 of Division 23 of the H&S Code added by Senate Bill No. 418, 2022 (H&S Code sections 32498.5 through 32498.8), and pursuant to which the Corporation operates the Hospital pursuant to the Reserved Rights and Powers described therein (the **"Reserved Rights and Powers"**).

O. On August 31, 2022, immediately subsequent to the consummation of the Sale Transaction, the District and the Corporation entered into that certain Support Agreement (the "**Support Agreement**"), pursuant to which the Corporation provides certain administrative and management services to the District, including, without limitation, non-physician staffing for the operation of the District's outpatient clinics which are exempt from licensure pursuant to Section 1206(b) of the H&S Code (the "**Clinics**").

P. On September 1, 2021, the California Department of Public Health issued a license to the Corporation to operate the Hospital.

Q. The Parties wish to enter into this Agreement to set forth their respective roles and responsibilities as co-tenants under the Lease.

In consideration of the foregoing recitals and the mutual covenants and agreements set forth in this Agreement, the Parties agree as follows:

AGREEMENT

1. **Incorporation of Recitals**. The Recitals to this Agreement are incorporated into and shall constitute a part of this Agreement.

2. **Capitalized Terms**. Capitalized terms used but not defined herein shall have the meanings ascribed thereto in the Lease.

3. **Co-Tenancy**. The Parties hereby acknowledge that each Party entered into the Lease Amendment, jointly and severally, as co-tenants, pursuant to which the Parties and the Lessor amended the Lease to make certain changes to reflect the Sale Transaction. The Parties hereby acknowledge that, as a condition to approving the assignment of the Lease to the District as part of the Sale Transaction, the Lessor required that the Corporation enter into the Lease with the District as a co-tenant, and that the Parties agreed to the co-tenancy arrangement for no other reason other than to satisfy the Lessor's requirements.

4. **Conveyed Assets**. Under the Conveyance, the Corporation conveyed, transferred and assigned its interest in the Lease and any subleases of the Leased Property to the District to accomplish the District's acquisition of the Hospital through the Bankruptcy Proceeding, as contemplated by Chapter 9 of Division 23 of the H&S Code added by Senate Bill No. 418, 2022 (H&S Code sections 32498.5 through 32498.8). The Parties hereby acknowledge and agree that, as between the District and the Corporation, the District shall be deemed to be the holder of the leasehold interest in the Leased Property, and that the Corporation shall occupy and use the Leased Property solely pursuant to the terms of the Reserved Rights and Powers.

5. **Payment of Rental Expenses under the Lease**.

(a) As part of its Administrative Support Obligations under the Support Agreement (and as described in Section 3 therein), the Corporation has agreed to fund the payment of all Base Rent, Additional Charges, Letter of Credit Obligations and Cash Deposits which may be due and owing under the Lease (collectively, the "**Rental Expenses**"). The Corporation hereby agrees to

pay on the District's behalf all Rental Expenses at its sole cost and expense. The District hereby agrees to waive any claim to any Cash Deposit remainder that the Lessor may refund.

(b) The Corporation and the District have exercised care and diligence in determining their respective roles and responsibilities under this Agreement. In consideration of the obligations of the District to acquire the Hospital and to provide for the healthcare needs of persons served by the District pursuant to the H&S Code sections 32000 et seq., the obligations of the Corporation to operate the Hospital for the benefit of the District pursuant to Section 32121(o) of the H&S Code, and the affiliation between the District and the Corporation in furtherance of the District's mission, the Parties have agreed that the Corporation shall be responsible for the payment on the District's behalf of all Rental Expenses as set forth above. In the event that the Corporation or the District reasonably concludes that this arrangement is likely to be in violation of any applicable law, the Corporation and the District shall use best efforts to develop an alternative arrangement that complies with law, which shall replace the current arrangement.

6. **Occupancy; Subleasing Arrangements**.

(a) The Parties hereby acknowledge that the District currently occupies those portions of the Leased Property set forth on Exhibit A for the operation of the District's Clinics, and the Hospital currently occupies certain portions of the Leased Property set forth on Exhibit A for the operation of the Hospital. In addition, one or both of the Parties currently sublease those portions of the Leased Property set forth on Exhibit A to third parties.

(b) The Parties hereby acknowledge that one or both of them may now or hereafter sublease or license the Leased Property as permitted under Article XXII of the Lease and in accordance with subsection (c) below.

(c) To the extent that the District now or hereafter subleases or licenses any portion of the Leased Property, the District hereby agrees to promptly remit to the Corporation all rental and related payments received by the District under such sublease or license. To the extent that any rental or related payments are received by the District under any sublease or license of a portion of the Leased Property (in the name of the District or the Corporation or both), the District shall promptly remit to the Corporation all such payments received.

(d) As the deemed holder of the leasehold interest in the Leased Property, and subject to the Corporation's Reserved Rights and Powers, the District may sublease or license its right to occupy or use a portion of the Leased Property to a third party as permitted under Article XXII of the Lease. The Corporation shall only sublease or license its right to occupy or use a portion of the Leased Property to a third party in accordance with its Reserved Rights and Powers and as permitted under Article XXII of the Lease.

(e) The Parties agree to meet and confer in accordance with Section 7 of this Agreement prior to requesting any approval from the Lessor to assign or sublease any portion of the Leased Property, or subleasing or licensing any portion of the Leased Property that do not require the Lessor's prior written consent.

(f) The Parties agree to amend or replace Exhibit A from time to time to reflect any changes to the leasing or subleasing arrangements set forth therein.

7. **Consultation; Meet and Confer**.

(a) The Parties shall regularly consult with one another to manage the sharing of their occupancy and use of the Leased Property. Any decisions made by either Party that will substantially affect the other Party's use of the Leased Property shall be subject to meet and confer provisions below.

(b) The Parties agree that they will meet and confer in good faith at reasonable times and places concerning this Agreement and its interpretation or any other matter of mutual concern relating to the Leased Property. The Parties further agree that any Party to this Agreement may request, in writing delivered to the other Party, that the Parties confer within fifteen (15) calendar days after the date of delivery of the request, which shall specify the matter to be discussed. District requests to meet and confer shall be directed to the Corporation's Board of Directors. Corporation requests to meet and confer shall be directed to the District's Board of Directors. The District and the Corporation may designate who their respective representatives shall be at the meet and confer sessions. The Parties recognize that the success of their co-tenancy arrangement depends upon mutual cooperation and frequent and effective communication between the Parties. The Parties shall employ their best efforts to resolve any dispute that may arise under or in connection with this Agreement.

8. **No Lease Modification; No Third Party Rights**. The Parties hereby acknowledge and agree that this Agreement in no way modifies the Lease, nor shall it have any effect upon the rights of any third parties arising under the Lease, including without limitation the Lessor. None of the provisions contained herein are intended by the Parties, nor shall they be deemed, to confer any benefit on any person not a party to this Agreement. This Agreement only defines the relationship between the Parties.

9. **Insurance**.

(a) Corporation Insurance. The Corporation shall, at its sole expense, obtain and maintain in full force during the term of this Agreement, the insurance coverages described on Exhibit B (Corporation's Insurance), and shall, as to the General and Professional Liability and Directors' and Officers' policies, name the District as an additional insured thereunder. If any insurance required by this Agreement is under a "claims-made" policy and is cancelled or terminated or the policy is changed, the Corporation shall purchase or otherwise ensure "tail" coverage for acts or occurrences occurring during the term of this Agreement, but as to which claims may be asserted after the cancellation, change or termination of the policy.

(b) District Insurance. The District shall obtain and maintain in full force during the term of this Agreement, the insurance coverages described on Exhibit C (District's Insurance). If any insurance required by this Agreement is under a "claims-made" policy and is cancelled or terminated or the policy is changed, the District shall purchase or otherwise ensure "tail" coverage for acts or occurrences occurring during the term of this Agreement, but as to which claims may be asserted after the cancellation, change or termination of the policy.

10. **No Referrals**. The Parties agree and represent that all matters related to this Agreement are to promote the long term enjoyment and use of the Leased Property and provide for the governance of the Parties' respective co-tenancy interests in the Leased Property. Neither Party shall receive or provide pursuant to this Agreement any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided, directly or indirectly, for the purpose of improperly obtaining or rewarding favorable treatment in connection to any economic business relationship or interaction of the Parties. The Parties expressly agree that nothing contained in this Agreement shall require either Party (or any physician providing services to either Party) to refer to or admit any patients to the other Party. Notwithstanding any unanticipated effect of any provision of this Agreement, neither Party will knowingly or intentionally conduct itself in such a manner as to violate any federal or state physician self-referral or anti-kickback laws.

11. **Term and Termination**.

(a) Term. This Agreement shall be effective as of the Effective Date and remain in effect until the expiration or earlier termination of the Lease, or the termination of the Period of Operation set forth in the Conveyance .

(b) Termination of the Period of Operation. In accordance with Section 3(c) of the Conveyance, upon the District's notice of termination of the Period of Operation, the Parties shall transfer the operations of the Hospital either to the District or to another party selected by the District in compliance with applicable laws and regulations.

12. **Rights Cumulative**. The various rights and remedies herein provided for shall be cumulative and in addition to any other rights and remedies the Parties may be entitled to pursue under the law. The exercise of one or more of such rights or remedies shall not impair the rights of either Party to exercise any other right or remedy at law or in equity.

13. **Assignment**. Except as otherwise described herein, no Party shall, without the prior written consent of the other Party, assign any rights or delegate any duties arising out of this Agreement.

14. **Indemnity**.

(a) Indemnification. To the fullest extent permitted by law, each Party (the "**Indemnifying Party**") shall, at the Indemnifying Party's sole expense and with counsel reasonably acceptable to the other Party (the "**Indemnified Party**"), indemnify, defend and hold harmless the Indemnified Party and its officers, directors, agents, employees, independent contractors, and advisors (collectively, the "**Indemnified Parties**"), from and against all Claims, as defined in subsection (b) below, that are incurred by the Indemnified Parties as a result of:

(i) The use or occupancy, or manner of use or occupancy, of the Leased Property by the Indemnifying Party;

(ii) Any act, error, omission, or negligence of the Indemnifying Party or of any invitee, guest, or licensee of the Indemnifying Party in, on, or about the Leased Property;

(iii) the Indemnifying Party's conducting of its business, wherever conducted;

(iv) Any alterations, additions or improvements to the Leased Property (including without limitation Capital Additions and Major Repairs), and activities, work, or things done, omitted, permitted, allowed, or suffered by the Indemnifying Party in, at, or about the Leased Property, including the actual, alleged or asserted violation of or failure to comply with any applicable Legal Requirements in existence on the Commencement Date or enacted, promulgated, or issued after the Commencement Date of the Lease; and

(v) Any breach or default in the performance of any obligation on the Indemnifying Party's part to be performed under this Agreement or the Lease, including obligations which survive expiration or earlier termination of the Lease under the terms of the Lease.

(b) Type of Injury or Loss. This indemnification extends to and includes any and all claims, actions, causes of action, controversies, charges, obligations, damages, demands, expenses, costs, fines, penalties, fees, and/or liabilities, including, without limitation, from loss, damage, or injury to or death of persons or property in any manner ("**Claims**") for:

(i) Injury to any persons (including death at any time resulting from that injury);

(ii) Loss of, injury or damage to, or destruction of property (including all loss of use resulting from that loss, injury, damage, or destruction); and

(iii) All economic losses and consequential or resulting damage of any kind.

(c) Active or Passive Negligence; Strict Liability. Except as provided in this subsection (c), the indemnification provided in this Section 14 shall apply regardless of the active or passive negligence of the Indemnified Parties and regardless of whether liability without fault or strict liability is imposed or sought to be imposed on the Indemnified Parties. The indemnification provided in this Section 14 shall not apply to the extent that a final judgment of a court of competent jurisdiction establishes that a Claim against one of the Indemnified Parties was proximately caused by the willful misconduct of that Indemnified Party. In that event, however, this indemnification shall remain valid for all other Indemnified Parties.

(d) Indemnification Independent of Insurance Obligations. The indemnification provided in this Section 14 may not be construed or interpreted as in any way restricting, limiting, or modifying the Indemnifying Party's insurance or other obligations under the Lease and is independent of the Indemnifying Party's insurance and other obligations. The Indemnifying Party's compliance with the insurance requirements and other obligations under the Lease shall not in any way restrict, limit or modify the Indemnifying Party's indemnification obligations under the Lease.

(e) Attorney's Fees. The prevailing party shall be entitled to recover its actual attorney fees and court costs incurred in enforcing the indemnification clauses set forth in this Section 14.

(f) Survival of Indemnification. All of the provisions of this Section 14 shall survive the expiration or earlier termination of the Lease until all claims against the Indemnified Parties involving any of the indemnified matters are fully, finally, and absolutely barred by the applicable statutes of limitations.

(g) Duty to Defend. The Indemnifying Party's duty to defend the Indemnified Parties is separate and independent of the Indemnifying Party's duty to indemnify the Indemnified Parties. The duty to defend includes Claims for which the Indemnified Parties may be liable without fault or strictly liable. The duty to defend applies regardless of whether the issues of negligence, liability, fault, default or other obligation on the part of the Indemnifying Party has been determined. The duty to defend applies immediately, regardless of whether the Indemnified Parties have paid any sums or incurred any detriment arising out of or relating (directly or indirectly) to any Claims. It is the express intention of the parties that the Indemnified Parties be entitled to obtain summary adjudication or summary judgment regarding the Indemnifying Party's duty to defend the Indemnified Parties at any stage of any claim or suit within the scope of this Section 14.

(h) Indemnification Procedures. If an event occurs for which the Indemnified Party asserts the Indemnifying Party must indemnify it, the Indemnified Party shall notify the Indemnifying Party promptly of such event and, if the event involves the claim of a third party, the Indemnifying Party shall have sole control over, and shall assume all expenses with respect to, the defense, settlement, adjustment or compromise of such claim; provided, however, that (a) the Indemnified Party may, if reasonably necessary to protect its interests, employ counsel of its own to assist in the handling of the claim, and (b) the Indemnifying Party shall obtain the prior written approval of the Indemnified Party, before entering into any settlement, adjustment, or compromise of such claim of ceasing to defend such claim, if pursuant thereto or as a result thereof there would be imposed injunctive or other similar relief against the Indemnified Party.

15. **Construction of Agreement**. This Agreement is subject to and shall be governed solely by the laws of the State of California. The Parties agree that the terms and provisions of this Agreement represent their mutual agreement and that they are not to be construed more liberally in favor of, or more strictly against, any Party hereto.

16. **Waiver of Breach**. Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of either the same or any different provision of this Agreement. No waiver shall be effective against either Party unless it is in writing, signed by that Party. No waiver of any breach of any term or covenant contained in this Agreement shall operate as a waiver of any subsequent breach thereof.

17. **Force Majeure**. Notwithstanding any other provisions contained herein, no Party shall be liable to another Party, and shall not be deemed to be in default hereunder, for the failure to perform or provide any of the supplies, services, personnel, or other obligations to be performed or provided pursuant to this Agreement if such failure is a result of a labor dispute, act of God, pandemic or any other event which is beyond the reasonable control of the Party.

18. **Notice**. Whenever, under the terms of this Agreement, written notice is required or permitted to be given by any Party to any other Party, such notice shall be deemed to have been

sufficiently given if personally delivered or deposited in the United States Mail, in a properly stamped envelope, certified or registered mail, return receipt requested, addressed to the Party to whom it is to be given, at the address hereinafter set forth. Either Party hereto may change its respective address by written notice in accordance with this paragraph. Such notice shall be deemed to have been received (a) when actually received, (b) on the delivery date indicated on the return receipt, or (c) within five (5) business days of being deposited with the United States Postal Service, whichever is earlier.

19. **Entirety**. This Agreement, the Support Agreement and the Conveyance Agreement referenced herein contain the sole and entire agreement between the Parties related to their co-tenancy arrangement and shall supersede all prior agreements between the Parties as of the Effective Date hereof. The Parties acknowledge and agree that neither of them has made any representations with respect to the subject matter of this Agreement, or any representation inducing the execution and delivery hereof except such representations as are specifically set forth herein, and each of the Parties hereto acknowledges that it has relied on its own judgment in entering into the same.

20. **Amendments**. This Agreement may not be amended except upon the mutual written consent of the Parties. The Parties agree to negotiate in good faith regarding amendments hereto that either Party, upon the advice of legal counsel, determines are necessary to comply with any applicable state or federal requirements.

21. **Parties in Interest**. Each and all of the covenants, terms, provisions, and agreements herein contained shall be binding upon and inure to the benefit of the heirs, executors, administrators, successors, and assigns of the respective Parties hereto.

22. **Exhibits.** All exhibits referred to herein are hereby incorporated herewith. In the event of a conflict between a provision of this Agreement and an Exhibit, the Exhibit shall control with respect to the subject matter of the Exhibit.

23. **Counterparts.** This Agreement may be executed in counterparts, each of which shall be deemed to be an original.

24. **Severability**. In the event any provision of this Agreement is rendered invalid or unenforceable by the enactment of any applicable statute or ordinance or by any regulation duly promulgated by officers of the United States, or of the State of California, acting in accordance with law, or is declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect.

25. **Effective Date**. This Agreement is effective as of the Effective Date, even though the Parties may have executed it after said date.

[Remainder of page left blank intentionally]

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date.

"District"	**"Corporation"**
Pajaro Valley Health Care District	**Pajaro Valley Health Care District Hospital Corporation**
By: _____	By: _____
Name: John Friel	Name: Stephen Gray
Title: Chair of the Board	Title: Chief Executive Officer

EXHIBIT A

OCCUPANCY; SUBLEASING ARRANGEMENTS

I. Leased Property

A. The Leased Property consists of the Land and the Leased Improvements located at the addresses below:

- 45 Nielson Street, Watsonville, California, 95076
- 65 Nielson Street, Watsonville, California, 95076
- 75 Nielson Street, Watsonville, California, 95076
- 85 Nielson Street, Watsonville, California, 95076

B. The District currently occupies the following portion of the Leased Property for the operation of the District's Clinics:[1]

- 65 Nielson Street, Suite 125, Watsonville, California, 95076. The District has engaged Coastal Health Partners, PC ("**CHP**"), to provide general, vascular and thoracic surgery services at this location.
- 65 Nielson Street, Suite 102, Watsonville, California, 95076. The District has engaged CHP to provide nephrology and cardiology services at this location.

C. The Corporation currently occupies the following portion of the Leased Property for the operation of the Hospital:

- 75 Nielson Street, Watsonville, California, 95076

[1] The District also currently occupies a portion of the premises located at 1820 Main Street, Watsonville, California, 95076 for the operation of the District's Clinics. The District has engaged CHP to provide urology, orthopaedics and spine services at this location. Such premises are not part of the Leased Property.

II. Subleased Property

One or both Parties, or their direct or indirect sublessee, currently sublease those portions of the Leased Property set forth below:

A. 45 Nielson Street

Sublessor	Sublessee	Sublease Title	Date of Sublease	Address
District and Corporation, as successor in interest to WHC, jointly and severally, as co-tenants	Salud Para La Gente, Inc.	Medical Office Space Lease	4/1/2016	45 Nielson Street
		First Amendment to Medical Office Space Lease	7/15/2016	
		Second Amendment to Medical Office Space Lease	9/20/2019	

B. 45/65 Nielson Street

Sublessor	Sublessee	Sublease Title	Date of Sublease	Address
District and Corporation, as successor in interest to WHC, jointly and severally, as co-tenants	Sanderling Renal Services - USA LLC	Medical Office Space Lease	4/15/2018	45/65 Nielson Street

C. 65 Nielson Street

Sublessor	Sublessee	Sublease Title	Date of Agreement	Address
District and Corporation, as successor in interest to WHC, jointly and severally, as co-tenants	Neven Development LLC	Master Lease Agreement	11/21/2003	65 Nielson Street
Neven Development LLC	CHP	Sublease Agreement	7/1/2015	65 Nielson Street, Suite 135
CHP	Golden State Heart and Vascular Associates, Inc.	Sublease Agreement	9/10/2020	
Neven Development LLC	District, as successor in interest to WHC	Sublease Agreement	3/25/2004	65 Nielson Street, Suite 125[2]
		Amendment #1	8/18/2004	
		Amendment Two (2) to the Sublease Agreement	11/17/2014	
		Amendment Three (3) to the Sublease Agreement	4/25/2018	
Neven Development LLC	CHP, as successor in interest to Barstow Healthcare Management, Inc.	Sublease Agreement	11/1/2013	65 Nielson Street, Suite 102[3]
		Amendment One (1) to the Sublease Agreement	11/28/2018	

[2] District Clinic premises.
[3] District Clinic premises (to be assigned to the District in connection herewith).

District and Corporation, as successor in interest to WHC, jointly and severally, as co-tenants	County of Santa Cruz	Lease of Storage Space	11/1/2017	65 Nielson Street (approximately 560 square feet)
District and Corporation, as successor in interest to WHC, jointly and severally, as co-tenants	Watsonville Hospital Federal Credit Union	Office Space Lease	10/17/2002	65 Nielson Street
		QHC Renewal Letter Summary	1/26/2018	

D. 75 Nielson Street

Sublessor	**Sublessee**	**Sublease Title**	**Date of Sublease**	**Address**
District and Corporation, as successor in interest to WHC, jointly and severally, as co-tenants	Surgical Associates of Monterey Bay Medical Corp.	Part-Time Lease	1/1/2018	75 Nielson Street, Suite B 1432
		First Amendment to Part-Time Lease	12/1/2018	
		Second Amendment to Part-Time Lease	12/1/2019	
		Third Amendment to Part-Time Lease	12/1/2020	
		Fourth Amendment to Part-Time Lease	8/1/2020	

E. 85 Nielson Street

Sublessor	Sublessee	Sublease Title	Date of Sublease	Address
District and Corporation, as successor in interest to WHC, jointly and severally, as co-tenants	Salud Para La Gente, Inc.	Medical Office Space Lease	2/1/2018	85 Nielson Street
		First Amendment to Medical Office Space Lease	10/31/2018	
		Second Amendment to Medical Office Space Lease	3/4/2019	
District and Corporation, as successor in interest to WHC, jointly and severally, as co-tenants	Pajaro Valley Community Health Trust, as successor in interest to WHC	Lease	9/8/1998	85 Nielson Street (approximately 1,000 square feet on the second floor of the cafeteria building)

EXHIBIT B

LIST OF CORPORATION INSURANCE

1. General and Professional Liability – with an aggregate coverage limit of at least $20,000,000 and deductible/self-insured retention not to exceed $500,000

2. Directors and Officers Liability – with an aggregate coverage limit of at least $10,000,000 and deductible/self-insured retention not to exceed $250,000

3. Employer's Practices Liability – with an aggregate coverage limit of at least $3,000,000 and deductible/self-insured retention not to exceed $250,000

4. Workers' Compensation in compliance with applicable laws/regulations

EXHIBIT C

LIST OF DISTRICT INSURANCE

1. General and Professional Liability – with an aggregate coverage limit of at least $20,000,000 and deductible/self-insured retention not to exceed $100,000

2. Directors and Officers Liability – with an aggregate coverage limit of at least $5,000,000 and deductible/self-insured retention not to exceed $200,000

3. Real Property Insurance – with an aggregate coverage limit of at least $100,000,000 and deductible/self-insured retention not to exceed $100,000