IMPERIAL VALLEY HEALTHCARE DISTRICT

AGENDA
REGULAR MEETING OF THE BOARD OF DIRECTORS
THURSDAY, July 10, 2025, 6:00 P.M.

Pioneers Memorial Hospital | PMH Auditorium
207 W. Legion Road, Brawley, CA92227

Join Microsoft Teams
Meeting ID: 237 740 019 538
Passcode: 5La9vz35

CLOSED SESSION

a. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION (Gov. 54956.9(d)(2))
   - One potential matter

OPEN SESSION

1. **Call to Order**

2. **Roll Call**

3. **Pledge of Allegiance**

4. **Approval of Request for Remote Appearance by Board Member(s)**, *if Applicable*

5. **Consider Approval of Agenda**
   In the case of an emergency, items may be added to the agenda by a majority vote of the Board of Directors. An emergency is defined as a work stoppage, a crippling disaster, or other activity that severely imperils public health, safety, or both. Items on the agenda may be taken out of sequential order as their priority is determined by the Board of Directors. The Board may take action on any item appearing on the agenda.

6. **Public Comments**
   At this time the Board will hear comments on any agenda item. If any person wishes to be heard, they shall stand; address the president, identify themself, and state the subject for comment. Time limit for each speaker is 3 minutes individually per item to address the Board. Individuals who wish to speak on multiple items will be allowed four (4) minutes in total. A total of 15 minutes shall be allocated for each item for all members of the public. The board may find it necessary to limit the total time allowable for all public comments on items not appearing on the agenda at anyone one meeting to one hour.

7. **Board Comments**
   Reports on meetings and events attended by Directors; Authorization for Director(s) attendance at upcoming meetings and/or events; Board of Directors comments.
   a. Brief reports by Directors on meetings and events attended
   b. Schedule of upcoming Board meetings and/or events
   c. Report by Education and Outreach Ad-Hoc Committee
   d. Report by AB 918 Negotiation Ad-Hoc Committee

8. **Consent Calendar**
   Any member of the Board may request that items for the Consent Calendar be removed for discussion. Items so removed shall be acted upon separately immediately following approval of items remaining on the Consent Calendar.

   a. Approve minutes for meetings of June 26, 2025

9. **Items for Discussion and/or Board Action:**
   a. Action Item: Policy and Procedure: Life Safety Management Control Plan

   b. Action Item: Policy and Procedure: Antimicrobial Stewardship Program

   c. Action Item: Policy and Procedure: Criteria for Case Referrals to Morbidity and Mortality Meetings - NICU

   d. Action Item: Policy and Procedure: Standardized Procedure for Registered Nurses: Hypoglycemia in the Newborn

   e. Action Item: Policy and Procedure: Neonatal Resuscitation Work Instruction

   f. Action Item: Policy and Procedure: Prevention of Surgical Site Infections

   g. Action Item: Policy and Procedure: Utilization Management Plan

h. Staff Recommends Action to Authorize: Purchase of one BD Fiber Dust Thulium Laser system
Presented by: Carol Bojorquez
Contract Value: $120,305.00
Contract Term: One time purchase
Budgeted: Yes
Budgeted Classification: Medical Equipment, Surgery Department

i. Staff Recommends Action to Authorize: Purchase of a De Soutter OrthoDrive Sagittal Saw Handpiece and Rotary Handpiece Power System.
Presented by: Carol Bojorquez
Contract Value: $ 55, 821.26
Contract Term: One time purchase
Budgeted: Yes
Budgeted Classification: Medical Equipment, Surgery Department

j. Staff Recommends Action to Authorize: Renewal of annual agreement between Dr. Terence Mulvany M.D. ("Dr. Mulvany") and Imperial Valley Healthcare District dba Pioneers Memorial Hospital ("IVHD"), whereby Dr. Mulvany will provide Occupational Medicine services to employees of IVHD.
Presented by: Christopher R. Bjornberg
Contract Value: $15,000 Estimated
Contract Term: Contract agreement- 1 year
Budgeted: Yes
Budgeted Classification: Professional Fees

k. Staff Recommends Action to Authorize: Authorization to approve Professional Service Agreement and Emergency On-call for Dr. Idrees Suliman, M.D.
Presented by: Carly Zamora
Contract Value: approximately $330,000 annually value varies depending on wRVU incentives and demands and on-call demands.
Contract Term: 3 years
Budgeted: No
Budgeted Classification: PSA/On-call

l. Staff Recommends Action to Authorize: Authorization to approve Professional Service Agreement and Emergency On-call for Dr. Rami Jirjis, MD.
Presented by: Carly Zamora
Contract Value: approximately $550,000 annually, value varies depending on wRVU incentives and demands and on-call demands. This does not include first year one-time payments of Sign on Bonus, Relocation and Buyout of approximately $130,000.

Contract Term: 3 years
Budgeted: No
Budgeted Classification: PSA/On-call

m. Staff Recommends Action to Authorize: ACHD-Association of California Healthcare District
Presented by: Christopher R. Bjornberg
Contract Value: Membership $24, 834.00
Contract Term: -7/01/2025-06/30/2026
Budgeted Classification: Membership fees

n. Staff Recommends Action to Authorize: Authorization to approve Professional Services Agreement with Property Management Advisors for Facility Master Planning Services
Presented by: Christopher R. Bjornberg and Adriana R. Ochoa

o. Appointment of Ad Hoc Bylaws Committee

10. Management Reports

a. Finance: Carly C. Loper, MAcc – Chief Financial Officer
b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer
c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations
d. Urgent Care: Tomas Virgen – Administrative Coordinator/ Support for AB 918
e. Executive: Christopher R. Bjornberg – Chief Executive Officer
f. Legal: Adriana Ochoa – General Counsel

11. Items for Future Agenda

This item is placed on the agenda to enable the Board to identify and schedule future items for discussion at upcoming meetings and/or identify press release opportunities.

12. Announcement of Closed Session Actions

13. Adjournment

a. The next regular meeting of the Board will be held on July 24, 2025, at 6:00 p.m.

POSTING STATEMENT

A copy of the agenda was posted July 3, 2025, at 601 Heber Avenue, Calexico, California 92231 at 10:30 p.m. and other locations throughout the IVHD pursuant to CA Government code 54957.5. Disclosable public records and writings related to an agenda item distributed to all or a majority of the Board, including such records and written distributed less than 72 hours prior to this meeting are available for public inspection at the District Administrative Office where the IVHD meeting will take place. The agenda package and material related to an agenda item submitted after the packets distribution to the Board is available for public review in the lobby of the office where the Board meeting will take place.

In compliance with the Americans with Disabilities Act, if any individuals request special accommodations to attend and/or participate in District Board meetings please contact the District at (760)970- 6046. Notification of 48 hours prior to the meeting will enable the District to make reasonable accommodation to ensure accessibility to this meeting [28 CFR 35.102-35.104 ADA title II].

MEETING MINUTES
June 26, 2025
REGULAR BOARD MEETING

THE IMPERIAL VALLEY HEALTHCARE DISTRICT MET IN REGULAR SESSION ON THE 26th OF JUNE AT 1275 MAIN STREET CITY OF EL CENTRO, CA. ON THE DATE, HOUR AND PLACE DULY ESTABLISHED OR THE HOLDING OF SAID MEETING.

1. **TO CALL ORDER:**
   The regular meeting was called to order in open session at 6:00 pm by Katie Burnworth.

2. **ROLL CALL-DETERMINATION OF QUORUM:**

President	Katherine Burnworth
Vice-President	Laura Goodsell
Secretary	Arturo Proctor
Trustee	Rodolfo Valdez
Trustee	James Garcia

ABSENT:
Donaldo Medart Jr. - Treasurer
Enola Berker - Trustee
Christopher R. Bjornberg - Chief Executive Officer

GUESTS:
Adriana Ochoa – Legal/Snell & Wilmer
Tomas Virgen - Support for IVHD (AB 918)

3. **PLEDGE OF ALLEGIANCE WAS LED BY DIRECTOR BURNWORTH.**

4. **APPROVAL OF REQUEST FOR REMOTE APPEARANCE BY BOARD MEMBER(S)**
   None

5. **CONSIDER APPROVAL OF AGENDA:**
   Motion was made by Director Goodsell and second by Director Proctor to approve moving it 9C up an public comments and then proceed with closed session on the agenda and approving the agenda with those changes for June 26, 2025. Motion passed by the following vote wit:

   AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
   NOES: None

6. **PUBLIC COMMENT TIME:**
   Flavio Grijalva from El Centro Regional Medical Center spoke on concerns on the contracts that are in place.

BOARD ENTERED INTO CLOSED SESSION AT 6:20PM

CLOSED SESSION:
   a. CONFERENCE WITH REAL PROPERTY NEGOTIATORS

Property: El Centro Regional Medical Center and Related Facilities
1415 Ross Ave, El Centro, CA 92243
Agency negotiators: AB 918 Ad Hoc Committee (Katherine Burnworth, James Garcia, Laura Goodsell), Christopher Bjornberg, Adriana Ochoa, Josh Schneiderman
Negotiating parties: City of El Centro
Under negotiation: Terms relating to acquisition of El Centro Regional Medical Center and related hospital facilities.

b. CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Property: All Valley Urgent Care Facility
400 Mary Ave., Calexico, CA 92231
Agency negotiators: Katherine Burnworth, Christopher Bjornberg, Tomas Virgen
Negotiating parties: City of El Centro
Under negotiation: Terms relating to potential lease of space and urgent care support.

BOARD RECONVENED INTO OPEN SESSION AT 8:00PM

No reportable action taken in closed session

7. **BOARD COMMENTS:**

a. Brief reports by Directors on meetings and events attended. Schedule of upcoming Board meetings and events.

Laura Goodsell reported that she attended the June 16th medical staff meeting and it was very informative. She also reported the Holtville City Council meeting on Monday and gave them a little update on to where we are and invited them to team in or attend our meetings.

Director Proctor reported that on Tuesday he attended the County Supervisors meeting. The presented us with a proclamation making Junes Men health award and received a nice plaque.

b. Report by Education and Outreach Ad-Hoc Committee

None

c. Report by AB 918 Ad Hoc Negotiation Committee re AB 918

None

8. **CONSENT CALENDAR:**

Motion was made by Director Goodsell and second by Director Proctor to approve the consent calendar. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
NOES: None

9. ACTION ITEMS:

a. Information Only: Presentation by Baker Tilly on 2025 Audit Planning

Aparna Venkateswaran and Kyle Rogers from Baker Tily gave a presentation on the 2025 Audit Planning.

b. MEDICAL STAFF REPORT – Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/ procedures/forms, or other related recommendations

Dr. Alshareef went over the all recommendations from the Medical Executive Committee.

Motion was made by Director Goodsell and second by Director Valdez to approve the Recommendations from the Medical Executive Committee for Medical Staff Membership and/or Clinical Privileges, policies/procedures/forms, or other related recommendations. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
NOES: None

c. Authorize: Discussion and possible action to approve the FY 2026 Budget
Presented by: Carly Loper

Carly gave review of the FY 2026 Budget.

Motion was made by Director Goodsell and second by Director Garcia to approve the FY 2026 Budget. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
NOES: None

d. Authorize: Discussion and possible action to approve Resolution 2025-0626, A Resolution of The Imperial Valley Board of Directors Approving the Asset Transfer Agreement by and among City of El Centro, El Centro Regional Medical Center, and Imperial Valley Healthcare District

Josh Schneiderman and Adriana Ochoa went over the Resolution 2025-0626.

Motion was made by Director Goodsell and second by Director Garcia to approve the Resolution 2025-0626 with recommendations to add a determination in section three for Hart-Scott-Rodino Antitrust Act purposes the aggregate fair market value of the acquired assets from ECRMC is less than $126,400,000, and renumber three to four and four to five. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
NOES: None

e. Discussion and Action: Discussion and possible action to reject all proposals in response

to RFP for Master Facility Planning Services

Staff Recommendation: Reject all proposals and direct staff to negotiate directly with solicited firms.

Motion was made by Director Garcia and second by Director Proctor to approve rejecting the current proposal that have been made and authorize Adriana, Chris and UCSD to solicit other proposals and make recommendations to the board. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
NOES: None

f. Authorize: Approval of Second Amendment to Standard Industrial/Commercial Single-Tenant Lease with Tyson Medical Inc.

Motion was made by Director Proctor and second by Director Valdez to approve the Second Amendment to Standard Industrial/Commercial Single-Tenant Lease with Tyson Medical Inc. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
NOES: None

g. Authorize: Approval of Social Media Policy

Motion was made by Director Garcia and second by Director Proctor to approve the Social Media Policy. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
NOES: None

h. Authorize: The execution of the Joint Powers Authority Agreement, the Application for Certificate of Consent to Self-Insure as a Public Agency Employer Self-Insurer and the Resolution to effectuate such application for Imperial Valley Healthcare District ("IVHD").
Presented by: Carly Loper
Classification: Workers' Compensation Insurance

Motion was made by Director Goodsell and second by Director Garcia to approve the execution of the Joint Powers Authority Agreement, the Application for Certificate of Consent to Self-Insure as a Public Agency Employer Self-Insurer and the Resolution to effectuate such application for Imperial Valley Healthcare District ("IVHD"). Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
NOES: None

i. Authorize: Resolution 2025-02 of the Imperial Valley Healthcare District Board of Directors Authorizing Execution and Delivery of the Application to the Directors of Industrial Relations, State of California, for a certificate of consent to self-insure worker's

compensation liabilities.

Motion was made by Director Garcia and second by Director Proctor to approve the Resolution 2025-02 of the Imperial Valley Healthcare District Board of Directors Authorizing Execution and Delivery of the Application to the Directors of Industrial Relations, State of California, for a certificate of consent to self-insure worker's compensation liabilities. Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Valdez, Garcia
NOES: None

j. Discussion and Direction Regarding IVHD Bylaws Revisions and Creation of Standing Committees

Board Members will send Adriana their thoughts on which committees they would like to set up in the immediate and those will be brought back to next meeting for discussion and action.

10. MANAGEMENT REPORTS:

a. Finance: Carly C. Loper, MAcc – Chief Financial Officer

None

b. Hospital Operations: Carol Bojorquez, MSN, RN – Chief Nursing Officer

None.

c. Clinics Operation: Carly Zamora MSN, RN – Chief of Clinic Operations

None.

d. Urgent Care: Tomas Virgen – Administrative Coordinator/ Support for AB 918

None.

e. Executive: Christopher R. Bjornberg – Chief Executive Officer

None

f. Legal: Adriana Ochoa – General Counsel

None

11. ITEMS FOR FUTURE AGENDA:

None

12. ADJOURNMENT:

With no future business to discuss, Motion was made unanimously to adjourn meeting at 9:25 p.m.

Imperial Valley Healthcare District **Reviewed Annually**

Title: **Life Safety Management Plan**	Policy No. EOC-00348
	Page 1 of 3
Current Author: Oscar Clemente	Effective: 12/95
Latest Review/Revision Date: 2/2025	Manual: EOC - Life Safety

Collaborating Departments: Human Resources, Nursing, Risk, Infection Control		Keywords:	
Approval Route: List all required approval			
	PSQC	Other: Safety Committee	
Clinical Service _____	MSQC	MEC	BOD 3/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 The IVHD Life Safety Management Plan describes responsibilities, functions, and mechanisms the hospital carries out to ensure a fire-safe environment of care for patients, staff, and visitors.

1.2 The Life Safety Management Plan is implemented by creating, maintaining, evaluation, and improving policies and procedures for managing fire protection. The process for creating these actions is the Safety Committee.

1.3 Life Safety Management Plan consists of these overlapping programs and functions:

1.3.1 Risk Management Program
1.3.2 Employee Orientation Program
1.3.3 Education Program
1.3.4 Safety Plan
1.3.5 Security Plan
1.3.6 Utility Systems Plan
1.3.7 Hazardous Material and Waste Plan
1.3.8 Space Plan
1.3.9 Emergency Preparedness Plan
1.3.10 Infection Control Plan

2.0 Scope: Hospital wide

3.0 Policy: Not applicable

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 Objectives:

5.1.1 To assure that all buildings, bedding, draperies, furnishings and decorations, at IVHD are in compliance with Life Safety Code
5.1.2 To establish a plan to identify life and safety problems due to construction and to take appropriate to steps to mitigate these problems. Assessment and implementation of Interim Life Safety Measures, when appropriate
5.1.3 To maintain buildings and grounds for safe use by patients, staff, and visitors
5.1.4 To assure the Emergency Department is easily identifiable and easily accessible to patients and emergency vehicles, including helicopter

5.1.5 To maintain adequate security to assure the safety of patients, visitors, and hospital staff

5.1.6 Maintains a Fire Safety Program including:

5.1.6.1 Identify and maintain all features of fire protection to Life Safety Code standards

5.1.6.2 Inspects, test, and maintain fire alarm system to include quarterly testing of all components of systems

5.1.6.3 Policy for placement, inspection, identification, and maintenance of portable fire extinguishers

5.1.6.4 Fire Plan to address staff response to an emergency, including training of all employees

5.1.6.5 To conduct fire drills to evaluate the fire alarm system and employee compliance with the fire plan to be completed a minimum one per shift per quarter.

5.1.6.6 Enforcement of hospital-wide smoke-free facility

5.1.6.7 The results of all drills and inspections will be reported to the Safety Committee for evaluations to be used in staff training

5.1.6.8 Test emergency lights annually for 90 minutes and monthly for 30 seconds

5.2 Key Roles:

5.2.1 Safety Committee Chairperson – Responsible for the functions and activities of the Safety Committee and delegated to act in an emergency to alleviate a condition that could result in immediate threat to life, health, and property, and a member of the Disaster Sub-Committee

5.2.2 Safety Manager – Responsible for providing security for patients, employees, visitors, and for protecting hospital buildings, assets and premises as assigned

5.2.3 Risk Manager – Responsible for Risk Management Program, member of the Safety Committee, and the Patient Safety Quality Council Committee

5.2.4 Safety Committee Members – The members carry out the duties of the committee including the safety inspection of the hospital physical plant, fire and disaster drills, staff education, and participate in the analysis of information and the formation of plans to improve safety when appropriate.

5.2.5 Department Directors – Responsible (with the help of the Safety Committee) for the formation and training, and practice of department specific safety policy and procedure

5.2.6 Facilities Services Director – Responsible for the Equipment Management Program including fire alarms, fire dampers, automatic Smoke compartments, closures and establishing policy and procedures maintaining records, aggregating and presenting the Safety Committee trends and incidents relating to safety hazards

5.2.7 Employees – Responsible to work safely and to maintain a safe and healthful hospital by learning and following hospital Safety Program

5.2.8 Physician – Responsible for advising the Administrator about the need to activate the Emergency Preparedness Plan and medical integrity of the plan

5.2.9 Administration – Responsible for the activation of the Emergency Preparedness Plan

5.3 Life Safety Management Plan consists of these overlapping programs and functions:
- 5.3.1 Risk Management Program
- 5.3.2 Employee Orientation Program
- 5.3.3 Education Program
- 5.3.4 Safety Plan
- 5.3.5 Security Plan
- 5.3.6 Utility Systems Plan
- 5.3.7 Hazardous Material and Waste Plan
- 5.3.8 Space Plan
- 5.3.9 Emergency Preparedness Plan
- 5.3.10 Fire Plan
- 5.3.11 Infection Control Plan

5.4 All components of the Life Safety Management Plan are evaluated on an annual basis for effectiveness and appropriateness.

6.0 References:

6.1 CMS 42 CFR 842.41 – Hospitals, Condition of Participation: Physical Environment
6.2 NFPA 101 Life Safety Code, 2015 Edition
6.3 NFPA 99 Health Care Facilities Code, 2012 Edition
6.4 NIAHO – PE.2 Life Safety

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 No additions and deletions
8.2 Updated the edition of the NFPA 101 Life Safety Code

Imperial Valley Healthcare District

Title: **Antimicrobial Stewardship Program**	Policy No. CLN-02971
	Page 1 of 11
Current Author: Edward Padilla	Effective: 3/25/2013
Latest Review/Revision Date: 03/13/2025	Manual: Clinical Pharmacy

Collaborating Departments: Pharmacy, Infection Control, Laboratory, Information Technology, Nursing, Leadership, P&T Medical Staff	Keywords: Infection Control; Antibiotics; Selection; Antibiogram; Clinical Activities; Infectious Disease

Approval Route: List all required approval		
MSQC:	MEC:	PSQC: N/A
P&T Committee:	BOD:	Other: N/A

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To improve antimicrobial use and treatment of infectious diseases by optimizing antimicrobial selection, and providing antimicrobial therapy at the appropriate dose, frequency, and duration according to indication

1.2 To achieve optimal clinical outcomes related to antimicrobial use (e.g. reduced morbidity, reduced mortality, and reduced length of hospital stay) while minimizing toxicity, adverse events, and the emergence of antimicrobial-resistant organisms

1.3 To reduce antimicrobial days of therapy (DOT) and reduce healthcare costs associated with treatment of infectious diseases without adversely impacting quality of care

2.0 Scope:

2.1 Medical Staff

2.2 Pharmacy

2.3 Microbiology and Laboratory

2.4 Infection Control

2.5 Information Technology

3.0 Policy:

3.1 The implementation of an antimicrobial stewardship program (ASP) can decrease the emergence and transmission of multi-drug resistant pathogens, and can decrease healthcare costs associated with treating infectious diseases without adversely impacting the quality of care.

3.1.1 The ASP initiatives, in conjunction with infection control and prevention, are designed to reduce or prevent the emergence and transmission of infections due to multidrug-resistant organisms (MDROs).

3.1.2 The Antimicrobial Stewardship Program (ASP) initiatives are consistent with evidence-based practices and regulatory requirements as outlined by the Infectious Disease Society of America (IDSA), California Department of Public Health (CDPH), and Centers for Disease Control and Prevention (CDC)

3.2 A multidisciplinary Antimicrobial Stewardship Team (AST) oversees the Antimicrobial Stewardship Program (ASP) and works collaboratively with the Infection Control Committee, the Pharmacy and Therapeutics Committee, hospital administration, and medical staff leadership.

3.3 Healthcare information technology (i.e., electronic medical records, computerized physician order entry, antibiogram/microbiology lab data and clinical decision support) is used to support and optimize ASP initiatives.

3.4 Metric, process, and outcome measures are used to assess the effectiveness of the Antimicrobial Stewardship Program initiatives and the overall impact on antimicrobial use and resistance patterns.

3.5 This policy will establish the Antimicrobial Stewardship Team at Imperial Valley Healthcare District-Pioneers Memorial Hospital (IVHD-PMH) to promote multidisciplinary collaboration for a successful antimicrobial stewardship program, and will provide procedures for implementing strategies using recommended interventions to optimize antimicrobial therapy and improve antimicrobial use at IVHD-PMH.

4.0 Definitions:

4.1 Antimicrobial stewardship refers to collaborative and coordinated interventions designed to improve and measure the appropriate use of antimicrobial agents by promoting the selection of the optimal antimicrobial regime including dosing, duration of therapy, and route of administration.

4.1.1 When used in conjunction with infection prevention and control, antimicrobial stewardship also prevents the transmission of antimicrobial-resistant pathogens.

4.2 Antimicrobial and antibiotic will be used interchangeably in this policy, and will both be pertaining to all anti-infective therapy

5.0 Procedure:

5.1 Antimicrobial Stewardship Team (AST)

5.1.1 The AST is responsible for oversight and implementation of the Antimicrobial Stewardship Program initiatives. The AST is also responsible for reporting findings and recommendations to licensed independent practitioners (LIP), the Infection Control Committee, and the Pharmacy and Therapeutics (P&T) Committee.

5.1.2 The core members of the IVHD-PMH multidisciplinary Antimicrobial Stewardship Team, at minimum, include an infectious disease physician and clinical pharmacist with antimicrobial stewardship training.

5.1.2.1 When an infectious disease physician is not available, a physician with antimicrobial stewardship training may fill the role.

5.1.2.2 Other members of the AST may include other practitioners, a microbiologist or lab representative, an information system specialist, and an infection control professional.

5.1.3 The AST will report to the P&T Committee. Meeting minutes will be forwarded to the Medical Executive Committee (MEC) for review by medical staff.

5.1.4 Computer Surveillance and Decision Support

5.1.4.1 Information technology (i.e., electronic medical records, computerized physician order entry, antibiogram/microbiology lab data, and clinical decision support) is utilized and optimized to support the ASP initiatives including, but not limited to:

5.1.4.1.1 Improving access to patient-specific information such as microbiology cultures and susceptibilities, hepatic/renal function, drug interactions, and allergies
5.1.4.1.2 Tracking resistance patterns
5.1.4.1.3 Identifying nosocomial infections
5.1.4.1.4 Facilitating and tracking interventions
5.1.4.1.5 Surveillance of adverse drug events (ADE)

5.1.5 Microbiology laboratory: the microbiology laboratory plays a critical role in antimicrobial stewardship by providing:
5.1.5.1 Patient-specific cultures and susceptibility data using suppression cascade reporting
5.1.5.2 Surveillance of resistant organisms
5.1.5.3 Antibiogram data development and maintenance.
5.1.5.4 Suppression Cascade Reporting
5.1.5.4.1 Implement cascade reporting of antibiotic susceptibilities for common pathogens (i.e., suppression of unnecessarily broad spectrum agents for bacteria that are susceptible to less broad spectrum agents).

5.1.6 Pharmacy
5.1.6.1 The infectious diseases pharmacist is responsible for overseeing the daily operation of the ASP, and daily implementation of the ASP initiatives, strategies, and interventions
5.1.6.2 The infectious diseases pharmacist or clinical pharmacist, as a member of the antimicrobial stewardship team, will utilize the interventions and strategies as appropriate listed in Section 5.2 and Section 5.3, and make recommendations to the LIPs; and as appropriate to the infectious disease physician, AST, and/or P&T committee on a daily basis, with the intention of optimizing antimicrobial therapy for patients receiving broad and/or extended spectrum antibiotics.
5.1.6.3 The infectious disease pharmacists may order (per protocol) per this policy the following laboratory tests required to manage patients receiving antimicrobial therapy:
5.1.6.3.1 Culture Nasal R/O MRSA (S)
5.1.6.3.2 MRSA, PCR (S)
5.1.6.3.3 Culture Respiratory (S)
5.1.6.3.4 Culture Urine (S)
5.1.6.3.5 Urinalysis, Complete (S)
5.1.6.3.6 Procalcitonin (PCT)
5.1.6.3.7 Meningitis/Encephalitis (ME) Panel, PCR (S)
5.1.6.3.8 Respiratory Panel, PCR (S)
5.1.6.3.9 CBC w/AutoDiff (S)
5.1.6.3.10 CDiff (Clostridium difficile Antigen and Toxin (S))

5.1.6.4 The infectious diseases pharmacist or clinical pharmacist will also be responsible for the following:

5.1.6.4.1 Vancomycin and aminoglycoside pharmacokinetic (PK) dosing per IVHD-PMH Policy CLN-02967(Pharmacy Vancomycin Management Policy) and IVHD-PMH Policy CLN-02868 (Pharmacy Aminoglycoside Management Policy)

5.1.6.4.2 Medication utilization evaluation (MUE) of at least one antimicrobial medication

5.1.6.4.3 Drug use criteria (DUC) development and implementation

5.1.6.4.4 Antibiogram development and maintenance, with monitoring of drug resistant pathogens

5.1.6.4.5 Ensuring proper documentation of ASP clinical interventions

5.1.7 Infection Control Team: the infection control team plays a critical role in antimicrobial stewardship by providing:

5.1.7.1 Surveillance, tracking, reporting, and prevention of multidrug-resistant organisms (MDRO): initiatives are developed to prevent infections due to MDROs including, but not limited to; methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococcus (VRE), vancomycin-resistant *Staphylococcus aureus* (VRSA), extended spectrum β-lactamase (ESBL) producing pathogens, and carbapenem-resistant enterobacteriaceae (CRE), and *Clostridium difficile*

5.1.7.2 Practices consistent with evidence-based standards of practice and regulatory requirements are developed and implemented to reduce the risk of *transmitting* multidrug-resistant organisms.

5.1.7.3 Risk assessments: conducted annually for multidrug-resistant organism acquisition and transmission.

5.1.7.3.1 Based on the risk assessment, a targeted or hospital-wide surveillance initiative is implemented.

5.1.7.3.2 As indicated by the risk assessment, a laboratory-based alert system is implemented to identify new patients and readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.

5.2 Strategies

5.2.1 Antimicrobial formulary review

5.2.1.1 Review costs associated with antimicrobials

5.2.1.2 Assess for duplicative and/or unnecessary agents

5.2.1.3 Ensure antimicrobials on formulary are aligned with hospital antibiogram

5.2.2 Formulary Restrictions and Preauthorization Requirements: guidelines for the usage of restricted antimicrobial agents are provided in Attachment C (Criteria-Based Restricted Antimicrobial Usage Guidelines). The following formulary restrictions and preauthorization requirements for antimicrobial use will be implemented:

5.2.2.1 *Formulary-Based Restriction (Closed Formulary)*

5.2.2.1.1 The antimicrobial formulary, including any formulary restriction on use, are reviewed and approved through the P&T Committee.

5.2.2.1.2 Formulary changes are communicated to the microbiology lab in order to update susceptibility testing protocols

5.2.2.2 *Criteria-Based Restriction*: medications with high resistance liability, excess utilization, serious adverse events, or elevated costs may be considered for criteria-based restrictions.

5.2.2.2.1 Criteria-based medications are not dispensed until the criteria are met. These medications include:

- Aztreonam (Azactam®)
- Ceftaroline (Teflaro®)
- Daptomycin (Cubicin®)
- Ertapenem (Invanz®)
- Linezolid (Zyvox®)
- Meropenem (Merrem®)
- Imipenem and Cilastatin (Primaxin®)
- Micafungin (Mycamine®)
- Voriconazole (Vfend®)
- Dalbavancin (Dalvance®)

5.2.2.2.2 Requests to override the restriction based on pre-defined criteria (see Attachment C: Criteria-Based Restricted Antimicrobial Usage Guidelines) are treated as a non-formulary medication, and require documentation of the reason for override at the time of order entry.

- Overrides are reviewed by the AST. Overrides of criteria-based restricted antimicrobials may require an order for an infectious diseases (ID) consultation which may be placed by a pharmacy member of the AST if deemed appropriate after review. Criteria-based restricted antimicrobials that meet the P&T-approved appropriate clinical criteria for use do not require an ID consult.

5.2.2.3 *Preauthorization-Based Restriction:* Select antibiotics are only prescribed with the preauthorization of an approved practitioner

5.2.2.3.1 The following medications must be approved for use by the infectious disease specialist as soon as possible, but no later than 72 hours. If the infectious disease specialist is not available, approval may be obtained from the critical care specialist:

- Colistin (colistimethate) (Coly-Mycin M®)
- Polymyxin B
- Tigecycline (Tygacil®)
- Ceftazidime and Avibactam (Avycaz®)
- Rifabutin (Mycobutin®)

5.2.2.4 *Non-Formulary-Based Restriction*: non-formulary antimicrobials are not routinely stocked in the pharmacy.

5.2.2.4.1 Non-formulary antimicrobials require completion of a non-formulary request and approval by infectious diseases via an ID consult.

5.2.2.4.2 These medications include:

- Fidaxomicin (Dificid®)
- Nitazoxanide (Alinia®)

5.2.3 Prospective audits with intervention and feedback

5.2.3.1 Conduct audits and review of antimicrobials at the time of order entry, and provide direct feedback to the prescriber using recommendations in Section 5.3.

5.2.3.1.1 Special consideration to be given to broad and extended-spectrum antibiotics, including antibiotics that provide coverage for hospital-acquired MRSA, ESBL-producing microorganisms, and *Pseudomonas aeruginosa*

5.2.3.2 Review patient charts daily for patients receiving antimicrobial therapy, and evaluate the appropriateness of therapy including dose, frequency, and duration based on indication, and assess for opportunities for streamlining/de-escalation/discontinuation of therapy using recommendations in Section 5.3.1

5.2.3.2.1 Special consideration to be given to extended-spectrum antibiotics, including antibiotics that provide coverage for hospital-acquired MRSA and *Pseudomonas aeruginosa*

5.2.3.3 Evaluate antimicrobial therapy for patients receiving extended-spectrum antibiotics (carbapenems, β-lactams with *Pseudomonas aeruginosa* coverage, and antibiotics with HA-MRSA coverage) at least every 3 days for possible opportunities to de-escalate or discontinue therapy

5.2.4 Antibiotic Time Out

5.2.4.1 A re-evaluation of all patients receiving antimicrobial therapy after 48 hours, but no later than 72 hours after initiation of antimicrobial therapy is recommended. This should be done by a clinical pharmacist, ASP team member, and/or the patient's practitioner

5.2.4.2 This "Time-Out" should evaluate the need for continuation of antimicrobial therapy and will assess the following:

- Presence of an infection including signs and symptom
- C&S report results
- Appropriate antimicrobial dose, frequency, and duration
- IV to PO conversion criteria

5.2.5 Documentation of interventions

5.2.5.1 Interventions and recommendations made by the AST will be documented in the electronic medical record (Cerner PowerChart).

5.2.6 Tracking and reporting: metrics, process and outcome measures are used to assess the effectiveness of the ASP initiatives and the overall impact on antimicrobial use and resistance patterns

5.2.6.1 The following antimicrobial stewardship program metrics, process and outcome measures will be reported to the P&T committee at each meeting:

5.2.6.1.1 Antimicrobial utilization measurement and evaluation: antimicrobial utilization will be estimated and reported in days of therapy (DOT) and/or Days of Therapy (DOT) per 1,000 Patient Days/Days at Risk/Days Present

5.2.6.1.2 At least one MUE related to antibiotics is conducted; goals are established with an accompanying action plan based on results

5.2.6.2 The following antimicrobial stewardship program metrics will be reported to the P&T Committee, Medical Executive Committee (MEC), or the Patient Safety Quality Council (PSQC) at least annually:

5.2.6.2.1 Hospital acquired infections that are required for reporting to the National Healthcare Safety Network (NHSN)

5.2.6.2.2 Infections due to multi-drug resistant organisms (MDRO) based on microbiology results: number and/or frequency of infections due to microorganisms such as *Pseudomonas aeruginosa* (*PsA*), methicillin-resistant *Staphylococcus aureus* (MRSA), and extended spectrum β-lactamase (ESBL) producing pathogens

5.2.6.2.3 Resistance: antimicrobial susceptibility and resistance data for the most common pathogens

5.2.6.3 Antibiogram: an antibiogram will be updated annually, and will be uploaded to the pharmacy's IVHD-PMH intranet site using the following recommendations from the Clinical and Laboratory Standards Institute (CLSI) guideline on antibiogram preparation:

5.2.6.3.1 Susceptibility data will be analyzed for accuracy

5.2.6.3.2 Report data for species with ≥ 30 isolates

- If reporting for species < 30 isolates, must indicate reduction of statistical validity of result

5.2.6.3.3 Include only diagnostic cultures

5.2.6.3.4 Include only the first isolate of a species per patient per analysis period, irrespective of site or antibiotic susceptibility profile

5.2.6.3.5 Include unsuppressed results

5.2.6.3.6 Include antibiotics routinely tested on hospital formulary

5.2.6.3.7 For *Streptococcus pneumoniae,* list the susceptibility using both meningitis and non-meningitis breakpoints for cefotaxime, ceftriaxone, and penicillin

5.2.6.3.8 For *Staphylococcus aureus*, list the susceptibility for both methicillin susceptible and methicillin resistant species

5.2.6.3.9 Procedures for developing the antibiogram outside of CLSI recommendations will be noted on the antibiogram

5.2.6.4 Interventions: number and proportion of accepted and/or rejected interventions, including individual prescriber data will be reported to the P&T Committee at least annually

5.2.7 Education: educate and promote ASP strategies and prescribing criteria
- 5.2.7.1 Pharmacists will receive antimicrobial stewardship education at least every 2 years, with additional infectious disease-related topics as needed
- 5.2.7.2 The AST will provide education material regarding antibiotic stewardship to prescribers. This may include, but not limited to pocket guides, memos, management guidelines, order sets, and newsletters.
- 5.2.7.3 Education may be provided to practitioners in conjunction with active intervention and antimicrobial oversight (e.g., prospective audit and feedback).

5.3 Interventions

5.3.1 Documentation of indication
- 5.3.1.1 The licensed independent practitioner (LIP) will be responsible for entering an indication for all antimicrobial orders at the time of order entry

5.3.2 Documentation of allergies: patient allergies should be identified and properly documented in Cerner

5.3.3 Appropriate empiric antimicrobial selection: appropriate antimicrobial therapy based on indication, hospital-specific susceptibility data, and patient specific parameters
- 5.3.3.1 IVHD-PMH's antimicrobial formulary, order sets, management recommendations, and treatment algorithms provided in this ASP policy, should be used to guide empiric antimicrobial therapy
- 5.3.3.2 Antimicrobial formulary: institutional antimicrobial formulary is provided in Attachment F
- 5.3.3.3 Evidence based order sets: evidence based order sets will be available to prescribers via hard-copy or electronically via Cerner at the time of LIP order entry.
  - 5.3.3.3.1 These order sets will be developed using the most current literature and practice guidelines, and using IVHD-PMH's most current antibiogram
- 5.3.3.4 Management recommendations including treatment algorithms and clinical pathways
  - Pneumonia: see Attachment G
  - Sepsis: see Attachment H
  - *Clostridioides difficile* Infection: see Attachment I
  - Asymptomatic Bacteriuria and Urinary Tract Infection: see Attachment J
  - Skin and Soft Tissue Infections and Bone Infections: see Attachment K

5.3.4 Appropriate Dose and Frequency
- 5.3.4.1 All antimicrobial orders will be evaluated for appropriate dose and frequency based on indication by a clinical pharmacist.
- 5.3.4.2 The clinical pharmacist will evaluate the creatinine clearance for all patients placed on antimicrobial therapy and adjust dose/frequency based on IVHD-PMH Policy CLN-02983 (Renal Dosing Pharmacy Protocol)

5.3.4.3 The clinical pharmacist will be responsible for monitoring and adjusting vancomycin and aminoglycoside therapy for all patients per IVHD-PMH Policy CLN-02967 (Pharmacy Vancomycin Management Policy) and IVHD-PMH Policy CLN-02868 (Pharmacy Aminoglycoside Management Policy)

5.3.5 Appropriate length of therapy

5.3.5.1 All administration of antimicrobial therapy should be restricted to the minimum duration required for maximum efficacy to avoid unnecessary prolonged antimicrobial exposure

5.3.5.2 Recommended durations of antimicrobial therapy are provided in Attachment A: Antibiotic Length of Therapy for Select Conditions

5.3.6 Appropriate use of combination therapy

5.3.6.1 A clinical pharmacist will evaluate all antimicrobial combination therapy for appropriate use and make necessary recommendations to the prescribing LIP

5.3.7 Culture and Susceptibility (C&S) Timing: relevant cultures need to be obtained prior to the initiation of antimicrobial therapy.

5.3.8 MRSA surveillance: identifying patients colonized with MRSA may be useful in guiding antibiotic streamlining/de-escalation

5.3.8.1 Patients presenting with signs/symptoms of infection and MRSA risk factors should be screened for MRSA colonization with a MRSA nasal swab.

5.3.9 Streamlining or De-escalation

5.3.9.1 Culture and susceptibility (C&S) reports will be evaluated daily for patients receiving broad-spectrum and extended-spectrum antimicrobial therapy

5.3.9.2 A clinical pharmacist or ASP team member/s will assess C&S for opportunities to de-escalate or streamline antimicrobial therapy, and make appropriate recommendations to the LIP based on their findings.

6.0 References:

6.1 Deresinski S, Holubar M. Antimicrobial stewardship in hospital settings. In: UpToDate, Hooper DC, UpToDate, Waltham, MA. August 19, 2024. (Accessed March 2025).

6.2 California Department of Public Health: The California Antimicrobial Stewardship Program Initiative. https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AntimicrobialStewardshipLandingPage.aspx. (Accessed March 2025).

6.3 Centers of Medicare and Medicaid Services (CMS) CoP §482.42 Condition of participation: Infection prevention and control and antibiotic stewardship programs.

6.4 DNV National Integrated Accreditation for Healthcare Organizations (NIAHO –DNV) IC.1 Infection Prevention and Control System

6.5 Butler J, Foltz C, et al. Taking an Antibiotic Time-out: Utilization and Usability of a Self-Stewardship Time-out Program for Renewal of Vancomycin and Piperacillin-Tazobactam. Hosp Pharm. 2015 Nov;50(11):1011-24. doi: 10.1310/hpj5011-1011. Epub 2015 Nov 24.

6.6 Davidson LE, Doron S. Antimicrobial Stewardship. Mayo Clin Proc. 2011 Nov;86(11):1113-23. doi: 10.4065/mcp.2011.0358.

6.7 Billeter M, Brennan PJ, et al. Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America guidelines for developing an institutional program to enhance antimicrobial stewardship. Clin Infect Dis. 2007 Jan 15;44(2):159-77. Epub 2006 Dec 13.

6.8 Masterton RG. Antibiotic De-Escalation. Crit Care Clin. 2011 Jan;27(1):149-62. doi: 10.1016/j.ccc.2010.09.009.

6.9 See IVHD-PMH related policy Antibiogram; CLN-03000

6.10 See IVHD-PMH related policy IV to PO Conversion; CLN-02801

6.11 See IVHD-PMH related policy Formulary Management; CLN-02823

6.12 See IVHD-PMH related policy Vancomycin Management; CLN-02967

6.13 See IVHD-PMH related policy Pharmacy Aminoglycoside Management; CLN-02868

6.14 CDC. Core Elements of Hospital Antibiotic Stewardship Programs. Atlanta, GA: US Department of Health and Human Services, CDC; 2019. Available at https://www.cdc.gov/antibiotic-use/healthcare/pdfs/hospital-core-elements-H.pdf.

6.15 National Quality Partner's antibiotic Stewardship Action Team. National Quality Partners Playbook: Antibiotic Stewardship in Acute Care. Washington, DC: National Quality Forum, NQF; 2016. Available at http://www.qualityforum.org/Publications/2016/05/National_Quality_Partners_Playbook__Antibiotic_Stewardship_in_Acute_Care.aspx?utm_source=internal&utm_medium=link&utm_term=ABX&utm_content=Playbook&utm_campaign=ABX.

6.16 Nebraska Medicine. Antimicrobial Stewardship Program. http://www.nebraskamed.com/careers/education-programs/asp.

6.17 UCLA Health. Antimicrobial Stewardship Program. https://asp.mednet.ucla.edu/pages/.

6.18 Beaumont JL, Peterson LR, et al. Prediction of Methicillin-Resistant Staphylococcus aureus Involvement in Disease Sites by Concomitant Nasal Sampling. J Clin Microbiol. 2008 Feb; 46(2): 588–592. Published online 2007 Dec 5. doi: 10.1128/JCM.01746-07.

6.19 Chung A, Dangerfield B, et al. Predictive Value of Methicillin-Resistant Staphylococcus aureus (MRSA) Nasal Swab PCR Assay for MRSA Pneumonia. Antimicrob Agents Chemother. 2014 Feb; 58(2): 859–864. doi: 10.1128/AAC.01805-13.

6.20 American Society of Health-System Pharmacists. A Hospital's Guide to Antimicrobial Stewardship Programs. www.ashpadvantage.com/docs/stewardship-white-paper.pdf. (Accessed January 2017).

6.21 Clinical and Laboratory Standards Institute. M100-S23: Performance Standards for Antimicrobial Susceptibility Testing, Twenty-Third Informational Supplement, January 2013. http://reflab.yums.ac.ir/uploads/clsi_m100-s23-2013.pdf (Accessed January 2017).

7.0 Attachment List:

7.1 Attachment A: Antibiotic Length of Therapy for Select Conditions

7.2 Attachment B: Guidelines for Antimicrobial Prophylaxis in Surgery

7.3 Attachment C: Criteria-Based Restricted Antimicrobial Usage Guidelines

7.4 Attachment D: Criteria-Based Restricted Antimicrobial Order Form

7.5 Attachment E: Procalcitonin (PCT) Guidance for Sepsis and Lower Respiratory Tract Infections

7.6 Attachment F: IVHD-PMH Antimicrobial Formulary

7.7 Attachment G: IVHD-PMH Pneumonia Management Recommendations

7.8 Attachment H: IVHD-PMH Antimicrobial Guidelines for Adults with Sepsis, Severe Sepsis, or Septic Shock
7.9 Attachment I: IVHD-PMH *Clostridioides difficile* Infection (CDI) Management Recommendations
7.10 Attachment J: IVHD-PMH Adult Inpatient Antimicrobial Guidelines for Urinary Tract Infections
7.11 Attachment K: IVHD-PMH Antimicrobial Guidelines for Adults with Skin & Soft Tissue Infections and Osteomyelitis
7.12 Attachment L: IVHD-PMH Statement of Leadership Commitment to Antimicrobial Stewardship

8.0 Summary of Revisions:

8.1 Revised Section 5.2.2
8.2 Revision of Attachments C, D, F, G, H, J, K, and L

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

IVHD-Pioneers Memorial Hospital
Antibiotic Length of Therapy for Select Conditions

This document is intended as a guide for determining appropriate length of therapy for antibiotics. In dynamic patients, length of therapy may be shorter or longer than those traditionally recommended. The principles of antibiotic stewardship encourage practitioners to limit antibiotic duration to the shortest possible days, which slows the development of antibiotic resistance and superinfections, such as *Clostridiodes difficile*. Some durations of antibiotic therapy have been based on randomized trials while others are based on tradition or calendar days. Each of the recommendations below is taken from disease state guidelines.

Infection		Length of Therapy
***Clostridium difficile*[1]**		
Initial episode, mild or moderate		10 days
Initial episode, severe		10 days
Initial episode, severe, fulminant		10-14 days
First recurrence		Extended tapered/pulse regimen
Second recurrence		Extended tapered/pulse regimen
Diabetic Foot Infection[2]		
Soft Tissue Only		7-14 days
Bone or Joint		6 weeks
Endocarditis[3]		
Streptococci, *S. bovus*	Native Valve	<u>PCN susceptible (MIC ≤ 0.12 mg/L)</u> 4 weeks: PCN **or** Ceftriaxone monotherapy* **OR** 2 weeks: PCN **or** Ceftriaxone **PLUS** Gentamicin
		<u>PCN intermediate (MIC >0.12 to ≤ 0.5 mg/L)</u> 4 weeks: PCN **or** Ceftriaxone* **PLUS** 2 weeks: Gentamicin
		<u>PCN resistant (MIC >0.5 mg/L)</u> Treat like Enterococcal Endocarditis
	Prosthetic Valve	<u>PCN susceptible (MIC ≤ 0.12 mg/L)</u> 6 weeks: PCN **or** Ceftriaxone* ± 2 weeks: Gentamicin
		<u>PCN intermediate/resistant (MIC > 0.12 mg/L)</u> 6 weeks: PCN **or** Ceftriaxone* **PLUS** Gentamicin
S. pneumoniae		<u>PCN susceptible (MIC ≤ 0.1 mg/L)</u> 4 weeks: PCN, Cefazolin, Ceftriaxone*
		<u>PCN intermediate to resistant (MIC >0.1 to ≥ 2 mg/L)</u> 4 weeks: high dose PCN **or** Ceftriaxone (without meningitis) 4 weeks with/meningitis: consider Vancomycin **PLUS** Rifampin

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

IVHD-Pioneers Memorial Hospital
Antibiotic Length of Therapy for Select Conditions

S. pyogenes		4 weeks: PCN G **or** Cefazolin **or** Ceftriaxone*
Groups B,C,G Streptococcus spp.		4-6 weeks: PCN **or** Cefazolin **or** Ceftriaxone ± 2 weeks: Gentamicin
Methicillin Sensitive Staphylococci	Native Valve	MSSA - 4-6 weeks: Nafcillin (Cefazolin for PCN non-anaphylactic allergy)
	Prosthetic Valve	MSSA – ≥ 6 weeks: Nafcillin **PLUS** rifampin **PLUS** 2 weeks: Gentamicin CoNS – 4-6 weeks: Nafcillin* **PLUS** rifampin **PLUS** 2 weeks: Gentamicin†
Methicillin Resistant Staphylococci	Native Valve	6 weeks: Vancomycin (Linezolid **or** TMP/SMX + Rifampin alternatives)
	Prosthetic Valve	MRSA – ≥ 6 weeks: Vancomycin **PLUS** rifampin **PLUS** 2 weeks: Gentamicin CoNS - 6 weeks: Vancomycin **PLUS** rifampin **PLUS** 2 weeks: Gentamicin†
Enterococcus – Native and Prosthetic Valves	PCN/AG/Vanc Sensitive	4-6 weeks: PCN (Ampicillin alt) **PLUS** 4-6 weeks: Gentamicin (TID dosing)*
	PCN/Vanc Sensitive, Gentamicin resistant	4-6 weeks: PCN (Ampicillin alt) **PLUS** 4-6 weeks: Streptomycin*
	Vanc/AG Sensitive, PCN resistant	6 weeks: Ampicillin.Sulbactam **or** Vancomycin **PLUS** Gentamicin (depending on β-lactamase activity)
	PCN/AMG/Vanc Resistant	*E. faecium* 8 weeks: Linezolid
		E. faecalis 8 weeks: Imipenem/cilastatin **or** Ceftriaxone **PLUS** Ampicillin
HACEK (*Haemophilus, Actinogacillus, Cardiobacterium, Eikenella, Kingella sp.*)	Native Valve	4 weeks: Ceftriaxone **or** Ampicillin/Sulbactam (FQ as alternative)
	Prosthetic Valve	6 weeks: Ceftriaxone **or** Ampicillin/Sulbactam (FQ as alternative)
Pseudomonas sp.		≥6 weeks: extended spectrum β-lactam **PLUS** Tobramycin (8 mg/kg)
Fungal		Induction: Ampho B (AmB) to clinical response, then life-long –azole suppression PLUS valve replacement surgery

*Vancomycin can be substituted for β-lactam antibiotic in case of severe allergy
†**or** susceptible AMG **or** FQ

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

IVHD-Pioneers Memorial Hospital
Antibiotic Length of Therapy for Select Conditions

Intra-Abdominal Infection[4]	
Complicated intra-abdominal infections	4-7 days: (> 7 days if unable to achieve adequate source control)
Acute stomach & proximal jejunum perforations	≤ 24 hours: assumes adequate source control (focus of inflammation or infection is completely eliminated surgically *and* no extension of infection beyond the organ in question) **and** antibiotic therapy within 1 hour prior to operation.
Bowel injuries (penetrating, blunt, or iatrogenic trauma)	≤ 24 hours: Repair ≤12 hours **and** antibiotics within 1 hour before operation) 4-7 days: Repair > 12 hours
Acute appendicitis (without perforation, abscess, or local peritonitis)	≤ 24 hours: Prophylactic therapy with narrow spectrum aerobic and facultative anaerobic coverage (administer within 1 hour before operation)
Cholecystitis, bowel obstruction and bowel infarction	≤ 24 hours: assumes adequate source control (focus of inflammation or infection is completely eliminated surgically *and* no extension of infection beyond the organ in question)
Severe necrotizing pancreatitis *prior* to the diagnosis of infection	No antibiotic therapy recommended
Meningitis[5]	
Neisseria meningitidis **and** *Haemophilus influenzae*	7 days
Streptococcus pneumoniae	10-14 days
Streptococcus agalactiae	14-21 days
Aerobic gram-negative bacilli	21 days
Listeria monocytogenes	≥ 21 days
Pneumonia[6,7]	
Community Acquired Pneumonia	5 days **PLUS** afebrile x48-72 hrs **and** clinically stable (*clinical instability defined by tachycardia, tachypnea, hypotension, O_2 desaturation, NPO status, and/or mental status changes from baseline)
	>5-7 days: initial therapy not active **or** complicated by extrapulmonary infection
Hospital Associated/Hospital Acquired/Ventilator Associated Pneumonia	7 days: initial antimicrobial selection correct **and** good clinical response
	1-3 weeks if no initial improvement and based on clinical response
Aspiration Pneumonia	7-10 days
Sepsis[8]	
Good source control	7-10 days with de-escalation between 3-5 days
Poor source control	>10-14 days: slow clinical response, undrainable foci, immunologic deficiency
Skin and skin structure infection[9]	
Cellulitis or Abscess	5-7 days; may be extended if no improvement
Necrotizing fasciitis	Treat until operative procedures no longer needed, obvious clinical improvement, and fever absent for 48-72 hours
Neutropenia	7-14 days
Impetigo	Topical: 5 days Oral/IV: 7 days for positive response, extend for up to 14 days for severe infection or slow response to therapy
Cutaneous anthrax	7-10 days
Cat scratch disease	5 days
Animal and Human bites, including closed fist injuries	3-5 days prophylaxis indicated for immunocompromised, asplenic, advanced liver disease, resultant edema of area, moderate to severe injuries (especially hands and face), injuries penetrate periosteum or joint capsule

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

IVHD-Pioneers Memorial Hospital
Antibiotic Length of Therapy for Select Conditions

Candidemia or candidiasis[10]	
Non-neutropenic and Neutropenic	2 weeks after documented clearance from the bloodstream and resolution of symptoms attributable to candidemia **PLUS** catheter removal strongly recommended
Osteomyelitis	6-12 months: fluconazole
Septic Arthritis	6 weeks: fluconazole
CNS Candidiasis	Until all signs and symptoms, CSF abnormalities have resolved
Endophthalmitis	4-6 weeks
Aspergillosis[11]	
Invasive Pulmonary *Aspergillosis*	Highly variable; minimum 6-12 weeks
Disseminated	Not well defined; treat until resolution of symptoms and all radiographic manifestations
Urinary tract infection[12]	
Uncomplicated cystitis	3-5 days
Pyelonephritis or Complicated Cystitis	7-14 days
Bacteremia[13,14,15,16]	
Gram-negative bacilli	7-14 days depending on clinical response, primary source and extent of infection; may be extended for complicated cases
Staphylococcus aureus	14 days from first negative blood culture; may be extended up to 4-6 weeks for complicated cases
Gram-positive *Staphylococcus/Streptococcus*	14 days; may be extended depending on source and clinical response to treatment CLABSI: 5-7 days if catheter removed, otherwise 10-14 days
Osteomyelitis[17]	
Hematogenous, Vertebral	6 weeks

Abx – antibiotics; BCx – blood culture; BSI – blood stream infection; CoNS – coagulase negative *Staphylococcus*
NEG – negative; PCN – penicillin; POS – positive; SIRS – severe inflammatory response syndrome
WBC – white blood cell

References:

1. Bakken JS, Carroll KC, et al. Clinical Practice Guidelines for Clostridium difficile Infection in Adults and Children: 2017 Update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA). Clinical Infectious Diseases. 2018 Feb 15, cix1085, https://doi.org/10.1093/cid/cix1085.
2. Lipsky BA, Berendt AR, Cornia PB, et al. 2012 Infectious Diseases Society of America clinical practice guideline for the diagnosis and treatment of diabetic foot infections. *Clin Infect Dis* 2012;54:132-173.
3. Baddour LM, Wilson WR, Bayer AS, et al. Infective endocarditis: diagnosis, antimicrobial therapy, and management of complications. *Circulation* 2005;111:e394-e433.
4. Solomkin JS, Mazuski JE, Bradley JS, et al. Diagnosis and management of complicated intra-abdominal infection in adults and children: guidelines by the Surgical Infection Society and the Infectious Diseases Society of America. *Clin Infect Dis* 2010;50:133-164.
5. Tunkel AR, Hartman BJ, Kaplan SL, et al. Practice guidelines for the management of bacterial meningitis. *Clin Infect Dis* 2004;39:1267-1284.
6. Mandell LA, Wunderink RG, Anzueto A, et al. Infectious Diseases Society of America/American Thoracic Society consensus guidelines on the management of community-acquired pneumonia in adults. *Clin Infect Dis* 2007;44:S27-72.
7. American Thoracic Society. Guidelines for the management of adults with hospital-acquired, ventilator-associated, and healthcare-associated pneumonia. *Am J Respir Crit Care Med* 2005;171:388-416.
8. Dellinger RP, Levy MM, Rhodes A, et al. Surviving sepsis campaign: international guidelines for management of severe sepsis and septic shock: 2012. *Crit Care Med* 2013;41:580-637.
9. Stevens DL, Bisno AL, Chambers HF, et al. Practice guidelines for the diagnosis and management of skin and soft tissue infections: 2014 update by the infectious diseases society of America. *Clin Infect Dis* 2014:59(2);e10-e52.
10. Pappas PG, Kauffman CA, Andes D, et al. Clinical practice guidelines for the management of candidiasis. *Clin Infect Dis* 2009;48:503-35.
11. Walsh TJ, Anaissie EJ, Denning DW, et al. Treatment of Aspergillosis: clinical practice guidelines of the Infectious Diseases Society of America. *Clin Infect Dis* 2008;46:327-352.
12. Gupta K, Hooten TM, Naber KG, et al. International clinical practice guidelines for the treatment of acute uncomplicated cystitis and pyelonephritis in women: a 2010 update by the Infectious Diseases Society of America and the European Society for Microbiology and Infectious Diseases. *Clin Infect Dis* 2011;52:e103-e120.
13. Anderson DJ, Moehring R. Gram-negative bacillary bacteremia in adults. In: UpToDate, Calderwood SB, UpToDate, Waltham, MA. (Accessed March 2025).

14. Fowler VG, Holland TL. Clinical approach to Staphylococcus aureus bacteremia in adults. In: UpToDate, Tong S. UpToDate, Waltham, MA. (Accessed March 2025).
15. Stevens DL. Invasive group A streptococcal infection and toxic shock syndrome: Treatment and prevention. In: UpToDate, Edwards MS, Wessels MR. UpToDate, Waltham, MA. (Accessed March 2025).
16. Kanj SS, Sexton DJ. Pseudomonas aeruginosa bacteremia and endocarditis. In: UpToDate, Calderwood SB, UpToDate, Waltham, MA. (Accessed March 2025).

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

IVHD-Pioneers Memorial Hospital
Guidelines for Antimicrobial Prophylaxis in Surgery

Table 1: Recommended Antimicrobial Agents for Surgical Prophylaxis

Procedure	Recommended Agent/s	Usual Adult Dose	Redose Interval
Cardiac/Thoracic			
Cardiac: coronary artery bypass, cardiac device insertion procedures (eg, pacemaker implantation), placement of ventricular assist devices **Thoracic**: lobectomy, pneumonectomy, lung resection, thoracotomy	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy AND/OR History of MRSA infection/colonization within previous year vancomycin	15 mg/kg IV (max 2 g)	N/A
Abdominal			
Gastroduodenal: Procedures involving entry into lumen of gastrointestinal tract **Small Intestine**: Nonobstructed	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
Gastroduodenal: [b]HIGH RISK procedures not involving entry into lumen of gastrointestinal tract (selective vagotomy, antireflux)	**Severe β-Lactam Allergy** aztreonam **PLUS** clindamycin	2 g IV 900 mg IV	4 hours 6 hours
Hernia Repair	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy clindamycin	900 mg IV	6 hours
Appendectomy	cefoxitin	2 g IV	2 hours
Biliary Tract Surgery: [d]HIGH RISK open procedure or laparoscopic procedure including pancreatic procedures **Small Intestine:** obstructed [e]**Colorectal** **Penetrating abdominal trauma**	**Severe β-Lactam Allergy** aztreonam **PLUS** clindamycin	2 g IV 900 mg IV	4 hours 6 hours

Genitourinary			
**Prophylaxis for genitourinary procedures involving entry into the urinary tract should be modified to cover common pathogens and any organism/s identified in the most recent urologic culture within the past year. If the most recent positive urologic culture is older than one year, standard prophylaxis should be utilized.*			
<u>Cystoscopy with risk factors for infection or significant manipulation</u> (biopsy, resection, dilation, stent placement, lithotripsy) **<u>Transurethral surgery</u>** (TURP, TURBT, ureteroscopy, cystouretoscopy)	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy gentamicin	5 mg /kg (dosing body weight) IV	N/A
<u>Clean procedures without entry into urinary tract</u> (nephrectomy, radical prostatectomy, prostate brachytherapy)	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy clindamycin	900 mg IV	6 hours
<u>Clean procedures with entry into urinary tract</u> (radical cystectomy, ileal conduit, cystoprostatectomy)	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy gentamicin **PLUS** clindamycin	5 mg /kg (dosing body weight) IV 900 mg IV	N/A 6 hours
<u>Clean contaminated procedures</u> (i.e. <u>prostate biopsy</u>)	cefoxitin	2 g IV	2 hours
	Severe β-Lactam Allergy gentamicin **PLUS** clindamycin	5 mg /kg (dosing body weight) IV 900 mg IV	N/A 6 hours
<u>Involvement of prosthetic material</u> **<u>Vaginal urologic surgery (urethral sling, fistula repair, etc…)</u>** **<u>Open or laparoscopic procedure involving entry into the urinary tract</u>** **<u>Inguinal and scrotal cases</u>**	cefazolin **PLUS** gentamicin	<120 kg: 2 g IV ≥120 kg: 3 g IV 5 mg/kg (dosing body weight) IV	4 hours N/A
	Severe β-Lactam Allergy AND/OR History of MRSA infection/colonization within previous year vancomycin **PLUS** aztreonam	15 mg/kg IV (max 2 g) 2 g IV	N/A 4 hours

Obstetric/Gynecologic			
Hysterectomy (abdominal, vaginal, laparoscopic, or robotic) **Urogynecology procedures** (including those involving mesh)	cefoxitin	2 g IV	2 hours
	Severe β-Lactam Allergy gentamicin **PLUS** clindamycin	5 mg /kg (dosing body weight) IV 900 mg IV	N/A 6 hours
Cesarean section (Elective**)**	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy AND GBS Screen Negative gentamicin **PLUS** clindamycin	 5 mg /kg (dosing body weight) IV 900 mg IV	 N/A 6 hours
	Severe β-Lactam Allergy AND GBS Screen Positive gentamicin **PLUS** vancomycin	 5 mg /kg (dosing body weight) IV 15 mg/kg IV (max 2 g)	 N/A N/A
Cesarean section (Non-Elective**)**	cefazolin **PLUS** azithromycin	<120 kg: 2 g IV ≥120 kg: 3 g IV 500 mg PO or IV	4 hours N/A
	Severe β-Lactam Allergy AND GBS Screen Negative gentamicin **PLUS** clindamycin **PLUS** azithromycin	 5 mg /kg (dosing body weight) IV 900 mg IV 500 mg PO or IV	 N/A 6 hours N/A
	Severe β-Lactam Allergy AND GBS Screen Positive gentamicin **PLUS** vancomycin **PLUS** azithromycin	 5 mg /kg (dosing body weight) IV 15 mg/kg IV (max 2 g) 500 mg PO or IV	 N/A N/A N/A

Uterine Evacuation (surgical abortion, suction D&C, and D&E)	doxycycline	100 mg IV or PO one hour before procedure and 200 mg PO after procedure	N/A
Breast & Axillary			
Axillary lymph node dissection (ALND) **Sentinel lymph node biopsy (SLNB)** **Axillary abscess drainage**	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy clindamycin	900 mg IV	6 hours
Head & Neck			
Clean	None		
Clean with placement of prosthesis (excludes tympanostomy tube placement)	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy clindamycin	900 mg IV	6 hours
Clean-contaminated (excluding tonsillectomy and functional endoscopic sinus procedures)	cefazolin **PLUS** metronidazole	<120 kg: 2 g IV ≥120 kg: 3 g IV 500 mg IV	4 hours N/A
	Severe β-Lactam Allergy gentamicin **PLUS** clindamycin	5 mg /kg (dosing body weight) IV 900 mg IV	N/A 6 hours
Neurosurgery			
Elective craniotomy **Cerebrospinal fluid shunting procedures** **Implantation of intrathecal pumps**	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy vancomycin	15 mg/kg IV (max 2 g)	N/A
Orthopedic			
Clean operation involving hand, knee, or foot with no implantation of foreign material	None		

Sports Medicine **Spinal procedures**	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
Hip fracture **Internal fixation** **Total joint replacement** **Removal of orthopedic hardware used for treatment of lower extremity fractures** **Laminectomy**	**Severe β-Lactam Allergy AND/OR History of MRSA infection/colonization within previous year** vancomycin	 15 mg/kg IV (max 2 g)	 N/A
Vascular			
Arterial surgery involving a prosthesis, the abdominal aorta, or a groin incision **Lower Limb Amputation**	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy AND/OR History of MRSA infection/colonization within previous year vancomycin	 15 mg/kg IV (max 2 g)	 N/A
Interventional Radiology			
Any arterial or venous intervention that involves the hepatobiliary or reproductive systems **Biliary Interventions** **Thermal ablation of the liver**	cefoxitin	2 g IV	2 hours
	Severe β-Lactam Allergy AND/OR History of MRSA infection/colonization within previous year aztreonam **PLUS** clindamycin	 2 g IV 900 mg IV	 4 hours 6 hours
Any arterial embolization involving the genitourinary system	**Prophylaxis for genitourinary procedures involving entry into the urinary tract should be modified to cover common pathogens and any organism/s identified in the most recent urologic culture within the past year. If the most recent positive urologic culture is older than one year, standard prophylaxis should be utilized.*		
Genitourinary Interventions	cefoxitin	2 g IV	2 hours
Thermal ablation of the kidney with treatment zone including the collecting system **Suprapubic tube placement**	**Severe β-Lactam Allergy** aztreonam **PLUS** clindamycin	 2 g IV 900 mg IV	 4 hours 6 hours

Renal arterial embolization with < 70% of the kidney expected to be embolized	**Prophylaxis usually not indicated; consider if patient is immunosuppressed or plan to leave sheath in place.*		
	cefoxitin	2 g IV	2 hours
	Severe β-Lactam Allergy aztreonam **PLUS** clindamycin	 2 g IV 900 mg IV	 4 hours 6 hours
Any arterial, venous, or dialysis angio or intervention with plan for covered stent placement, overnight lysis, or plan to leave sheath in place. **Lung Ablation** **PleurX Placement**	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy AND/OR History of MRSA infection/colonization within previous year vancomycin	 15 mg/kg IV (max 2 g)	 N/A
Any arterial, venous, or dialysis angio or intervention with NO plan for covered stent placement, NO plan for overnight lysis, or NO plan to leave sheath in place. **Line placements and exchanges** **Thermal ablations of bone or kidney (treatment zone cannot include the collecting system)** **Gastrostomy/gastrojejunostomy placement/exchange, Jejunostomy exchanges** **Paracentesis or Thoracentesis** **Pain interventions not requiring needle passage through bowel, liver, or kidneys.**	*Prophylaxis usually not indicated; consider if patient is immunosuppressed or plan to leave sheath in place.		
	cefazolin	<120 kg: 2 g IV ≥120 kg: 3 g IV	4 hours
	Severe β-Lactam Allergy AND/OR History of MRSA infection/colonization within previous year vancomycin	 15 mg/kg IV (max 2 g)	 N/A

a. Parenteral prophylactic antimicrobials can be given as a single IV dose begun within 60 minutes before the procedure. If vancomycin is used, the infusion should be started within 60 to 120 minutes before the initial incision to have adequate tissue levels at the time of incision and to minimize the possibility of an infusion reaction close to the time of induction of anesthesia.

b. Prophylaxis should be considered for patients at highest risk for postoperative gastroduodenal infections, such as those with increased gastric pH (e.g., those receiving histamine H2-receptor antagonists or proton-pump inhibitors), gastroduodenal perforation, decreased gastric motility, gastric outlet obstruction, gastric bleeding, morbid obesity, or cancer. Antimicrobial prophylaxis may not be needed when the lumen of the intestinal tract is not entered.

c. For prolonged procedures (>3 hours) or those with major blood loss or in patients with extensive burns, additional intraoperative doses should be given at intervals one to two times the half-life of the drug for the duration of the procedure in patients with normal renal function.

d. Factors that indicate a high risk of infectious complications in laparoscopic cholecystectomy include emergency procedures, diabetes, long procedure duration, intraoperative gallbladder rupture, age of >70 years, conversion from laparoscopic to open cholecystectomy, American Society of Anesthesiologists classification of 3 or greater, episode of colic within 30 days before the procedure, reintervention in less than one month for noninfectious complication, acute cholecystitis, bile spillage, jaundice, pregnancy, nonfunctioning gallbladder, immunosuppression, and insertion of prosthetic device. Because a number of these risk factors are not possible to determine before surgical intervention, it may be reasonable to give a single dose of antimicrobial prophylaxis to all patients undergoing laparoscopic cholecystectomy.

e. Optional: a mechanical bowel preparation combined with oral neomycin sulfate plus oral erythromycin base or with oral neomycin sulfate plus oral metronidazole may be given in addition to IV prophylaxis.

Antimicrobial Surgical Prophylaxis Recommendations:

- Common Pathogens
  - Antibiotics should cover the predominant flora of the operative site.
  - It is desirable to use the narrowest spectrum agent possible.
    - Staphylococcus aureus and Streptococcal (species common for most skin flora)
    - Coagulase-negative staphylococci (especially cardiac surgery and hardware associated surgeries)
    - Enterobacterales (GI/GU)
    - Anaerobes (GI)
- Recommended Agent/s by Procedure
  - Recommended antimicrobial agents according to surgical procedure are provided in Table 1
  - Endocarditis prophylaxis: Patients receiving pre-op antibiotics to prevent an SSI generally do NOT need additional antibiotics for endocarditis prophylaxis.
  - Existing orthopedic hardware: Most infectious disease clinicians do not recommend additional prophylaxis beyond what is recommended for the case.
  - Severe β-Lactam Allergy: Although IgE-mediated anaphylaxis is rare with advanced generation cephalosporins or carbapenems, any β-lactam should not be administered with a documented severe penicillin allergy (i.e. angioedema or anaphylaxis).
    - Patients reporting a non-severe penicillin allergy (i.e. itching or rash) can safely receive a cephalosporin if there is no documentation of a cephalosporin allergy
  - Obesity: Since the rate of SSI increases with relative under-dosing, recommendations for some drugs include body-weight dosing.
  - Existing renal or hepatic dysfunction: For single dose administration for surgical prophylaxis, no modifications are usually necessary.
  - For patients colonized with methicillin-resistant Staphyloccous aureus (MRSA), addition of a single dose of vancomycin may be reasonable
- Antibiotic Administration
  - Successful prophylaxis requires the delivery of the antimicrobial to the operative site before contamination occurs. Thus, the antimicrobial agent should be administered at such a time to provide serum and tissue concentrations exceeding the minimum inhibitory concentration for the probable organisms associated with the procedure at the time of incision and for the duration of the procedure.
  - It is recommended to administer the initial antimicrobial dose beginning within 60 minutes before surgical incision.
  - The administration of vancomycin and fluoroquinolones should begin within 120 minutes before surgical incision due to the prolonged infusion times required for these drugs. Additionally, because these drugs have long half-lives, this early administration should not compromise serum levels of these agents during most surgical procedures.
  - Do not split doses: Give the full dose at one time.
  - Patients currently receiving antimicrobial therapy
    - Patients who are currently receiving therapeutic antimicrobials for infections remote to the site of surgery also need surgical prophylaxis to ensure adequate tissue levels at time of surgery
    - If the spectrum of the current antibiotic regimen is appropriate for surgical prophylaxis based on the site of surgery:
      - Hold the usual dose until 1 hour prior to incision, then give within 60 minutes before surgical incision
      - If not able to hold dose or next dose is due after scheduled surgery time, an additional dose should be given within 60 minutes before surgical incision
      - Special attention must be paid to patients on dialysis or with renal failure who are receiving intermittent dosing of therapeutic antimicrobials such as vancomycin and aminoglycosides.

Depending on recent doses and drug levels, an additional pre-operative dose may not be necessary. Questions regarding the need for an additional pre-operative dose of these agents should be discussed with a pharmacist.

- Recommendations for Redosing
  - Recommended redosing intervals are provided in Table 1
  - Intraoperative redosing is needed to ensure adequate serum and tissue concentrations of the antimicrobial if the duration of the procedure exceeds two half-lives of the antimicrobial
  - Consider redosing if there are factors that shorten the half-life of the antimicrobial agent such as extensive burns or excessive blood loss (>1500 mL)
  - The redosing interval should be measured from the time of administration of the preoperative dose, not from the beginning of the procedure.
  - Readministration may not be warranted in patients in whom the half-life of the agent may be prolonged (e.g., patients with renal insufficiency or failure).
  - Redosing of vancomycin and gentamicin is generally only required in unusually long procedures
- Appropriate Duration of an Antimicrobial Agent for Surgical Prophylaxis
  - Postoperative prophylaxis is NOT recommended for most surgeries and procedures
  - In general, repeat antimicrobial dosing following wound closure is not necessary and may increase the risk for development of antimicrobial resistance and C. difficile infection (CDI) [14]. In a systematic review of randomized trials, there was no difference in the rate of SSI with single dose compared with multiple-dose regimens given for less than or more than 24 hours (combined odds ratio 1.04, 95% CI 0.86-1.25) [10].
  - The Centers for Disease Control and Prevention DO NOT recommend the administration of additional prophylactic antibiotics after surgical closure for ANY clean or clean-contaminated procedure
    - The Centers for Disease Control and Prevention have put forth the following category 1A recommendation: “In clean and clean-contaminated procedures, do not administer additional prophylactic antimicrobial agent doses after the surgical incision is closed in the operating room, even in the presence of a drain.”
  - Prevention of Maternal Peripartum Infections
    - World Health Organization (WHO) favors a single-dose antibiotic regimen prior to the initiation of cesarean section in the absence of clinical signs of infection rather than multiple-dose regimens
    - Current evidence suggests that single-dose regimens are as effective as multiple-dose regimens
    - American College of Obstetricians and Gynecologists (ACOG) recommends that prophylaxis should be administered within 60 minutes of the start of the cesarean delivery without mention of continuing prophylaxis after surgical closure
  - If antimicrobial prophylaxis is continued post-surgical closure, the duration of antimicrobial prophylaxis for most procedures should be less than 24 hours from surgery end time.
    - Exception: For cardiothoracic procedures, it may be reasonable to extend the duration to less than 48 hours from surgery end time.

References

1. Anderson DJ. Antimicrobial prophylaxis for prevention of surgical site infection in adults. In: UpToDate, Harris A (Ed), Wolters Kluwer. (Accessed on March 13, 2025.)
2. Sanford, J., Gilbert, D. N., & Moellering Jr, R. C. (Eds.). (2024). The Sanford Guide to Antimicrobial Therapy. Antimicrobial Therapy, Inc.
3. Surgical Antimicrobial Prophylaxis Recommendations. Michigan Medicine. Antimicrobial Stewardship Program. December 2024. (Accessed on March 13, 2025.).
4. Bratzler DW, Dellinger EP, Olson KM, et al. Clinical practice guidelines for antimicrobial prophylaxis in surgery. *Am J Health-Syst Pharm* 2013;70:195-283

5. American Society of Health-System Pharmacists. ASHP therapeutic guidelines on antimicrobial prophylaxis in surgery. *Am J Health-Syst Pharm.* 1999; 56:1839-88.
6. Allen G, Berbari EF, et al. Centers for Disease Control and Prevention Guideline for the Prevention of Surgical Site Infection, 2017. JAMA Surg. 2017 Aug 1;152(8):784-791. doi: 10.1001/jamasurg.2017.0904.
7. Committee opinion no. 465: antimicrobial prophylaxis for cesarean delivery: timing of administration. Obstet Gynecol. 2010 Sep;116(3):791-2. doi: 10.1097/AOG.0b013e3181f68086.
8. Chambers B, Costa ML, et al. WHO recommendations for prevention and treatment of maternal peripartum infections. Department of Reproductive Health and Research: World Health Organization 2015. Geneva, Switzerland. http://apps.who.int/iris/bitstream/10665/186171/1/9789241549363_eng.pdf
9. Abramovici A, Ambalavanan N, et al. Adjunctive Azithromycin Prophylaxis for Cesarean Delivery. N Engl J Med. 2016 Sep 29;375(13):1231-41. doi: 10.1056/NEJMoa1602044.
10. Abel RM, Akins C, et al. Cephalothin prophylaxis in cardiac valve surgery. A prospective, double-blind comparison of two-day and six-day regimens. J Thorac Cardiovasc Surg. 1977 Mar;73(3):470-9.
11. Forbes A, Grabsch E, et al. Single- versus multiple-dose antimicrobial prophylaxis for major surgery: a systematic review. Aust N Z J Surg. 1998 Jun;68(6):388-96.
12. Cohen SN, Conte JE Jr., et al. Antibiotic prophylaxis and cardiac surgery. A prospective double-blind comparison of single-dose versus multiple-dose regimens. Ann Intern Med. 1972 Jun;76(6):943-9.
13. Benson MK, Evans MJ, et al. Antibiotic prophylaxis in total hip replacement. Br Med J. 1979 Mar 17;1(6165):707-9.
14. Carmeli Y, Harbarth S, et al. Prolonged antibiotic prophylaxis after cardiovascular surgery and its effect on surgical site infections and antimicrobial resistance. Circulation. 2000 Jun 27;101(25):2916-21.
15. Anderson PA, Bernatz JT, et al. Antibiotic Overuse is a Major Risk Factor for Clostridium difficile Infection in Surgical Patients. Infect Control Hosp Epidemiol. 2017 Oct;38(10):1254-1257. doi: 10.1017/ice.2017.158. Epub 2017 Jul 31.
16. Surgical site infection-prevention. In DynaMed [database online], Ipswich MA: EBSCO. http://www.dynamed.com/topics/dmp~AN~T316886/Surgical-site-infection-prevention. (Accessed October 2023).

ANTIMICROBIAL STEWARDSHIP PROGRAM
IMPERIAL VALLEY HEALTHCARE DISTRICT
PIONEERS MEMORIAL HOSPITAL

Criteria-Based Restricted Antimicrobial Usage Guidelines

IVHD-Pioneers Memorial Hospital Antimicrobial Stewardship Program

The usage guidelines below have been drafted by the Antimicrobial Stewardship Team and approved by the Pharmacy & Therapeutics Committee at Pioneers Memorial Hospital. These guidelines represent generally well-accepted criteria for use, and take into account appropriate dosages, place in therapy, and monitoring parameters for these agents. Usage of these antimicrobials outside of the guidelines should prompt stewardship team review of the patient's medical record, and may necessitate discussion or recommendation for therapy modification with the prescriber. All overrides of criteria-based restricted antimicrobials require an order for an infectious diseases (ID) consultation.

Drug	Pioneers Memorial Hospital Antimicrobial Usage Guidelines

Aztreonam (Azactam®)

Appropriate Uses

- Empiric or definitive therapy of serious gram-negative infections ONLY in patients with significant (severe) IgE-mediated β-lactam allergy (i.e. anaphylaxis, tongue/throat swelling, shortness of breath - please note that GI upset or mild rash due to β-lactams are NOT considered significant allergies)

Inappropriate Uses

- Gram-positive or anaerobic infections
- Resistance is higher than 30% locally on antibiogram for the target pathogen

Dosage

	Creatinine Clearance (mL/min)		
	> 30	**10 - 30**	**< 10, Hemodialysis**
Serious Infections, Infections due to *Pseudomonas aeruginosa*	2 g IV q6-8h	Normal dose (ND) x 1, then 50% ND every 6-8 hours	ND x 1, then 25% ND every 6-8 hours HD supplemental dose: 12.5% post-HD
Mild to Moderate Infections	1 g IV q8-12h	ND x 1, then 50% ND every 8-12 hours	ND x 1, then 25% ND every 8-12 hours HD supplemental dose: 12.5% post-HD

References

- Prescribing information for Azactam (aztreonam for injection), San Diego, California: Elan Pharmaceuticals, Inc., 2007.

Micafungin
(Mycamine®)

Appropriate Uses

- Empiric therapy of suspected invasive candidiasis in patients with moderate to severe illness (i.e. hemodynamically unstable) AND recent azole use, neutropenia, or history of infection with fluconazole-resistant *Candida*
- Empiric therapy of suspected invasive candidiasis in patients with moderate to severe illness (i.e. hemodynamically unstable) AND if more than 2 of the following candidemia risk factors are present:
    - recent major abdominal surgery
    - necrotizing pancreatitis
    - receiving total parenteral nutrition
    - prolonged central venous catheterization
    - immunocompromised (solid organ transplant, hematologic malignancy with chemotherapy, bone marrow transplant, or taking ≥ 10 mg prednisone/day x 2 weeks)
    - Multisite colonization with Candida spp. within the past year
- Empiric therapy of suspected invasive fungal infection in patients with neutropenic fever unresponsive to adequate antimicrobial therapy
- Definitive therapy of invasive candidiasis due to organisms not susceptible to fluconazole (i.e. *C. glabrata, C. krusei*)
- Definitive therapy of invasive candidiasis in patients intolerant or unresponsive to fluconazole
- Treatment of invasive aspergillosis for patients intolerant of or refractory to azoles and polyenes

Inappropriate Uses

- Empiric therapy of invasive candidiasis in patients with mild illness (i.e. hemodynamically stable) and with no recent azole exposure.
- Definitive therapy of candidiasis due to fluconazole-susceptible organisms (i.e. *C. albicans, C. tropicalis, C. parapsilosis, C. lusitaniae,* etc.)
- Fungal urinary tract, central nervous system, or ocular infections due to minimal drug penetration into these sites.

Dosage (Micafungin)

- 100 mg IV q24h for invasive fungal infection
- 50 mg IV q24h for fungal prophylaxis
- 150 mg IV q24h for esophageal candidiasis

References

- Pappas PG, Kauffman CA, Andes D, et al. Clinical practice guidelines for the management of candidiasis: 2009 update by the Infectious Diseases Society of America. Clin Infect Dis 2009;48:503-35.
- Prescribing information for Cancidas for injection, Whitehouse Statoin, New Jersey: Merck & Co, Inc, 2008
- Walsh TJ, Anaissie EJ, Denning DW, et al. Treatment of aspergillosis: clinical practice guidelines of the Infectious Diseases Society of America. Clin Infect Dis 2008; 46:327-60.

Ceftaroline
(Teflaro®)

Appropriate Uses

- Skin and soft tissue infection (SSTI) due to MRSA that is refractory or resistant to vancomycin
- Community-acquired pneumonia due to MRSA that is refractory or resistant to vancomycin
- Skin and soft tissue infection (SSTI) due to MRSA and patient cannot tolerate vancomycin (i.e. vancomycin induced nephrotoxicity)
- Community-acquired pneumonia due to MRSA and patient cannot tolerate vancomycin (i.e. vancomycin induced nephrotoxicity)

Possible Uses

- Infections due to MRSA to avoid unnecessary use of linezolid, daptomycin, or tigecycline

Inappropriate Uses

- Substitute for vancomycin in patients with renal failure without contraindications to vancomycin therapy including pre-existing renal failure

Dosage

	Creatinine Clearance (mL/min)			
	>50	**>30 - 50**	**15 - 30**	**< 15 or Hemodialysis**
Ceftaroline	600 mg IV q12h	400 mg IV q12h	300 mg IV q12h	200 mg IV q12h, after dialysis

NOTE: For SSTI, ceftaroline was shown to be non-inferior to vancomycin plus aztreonam. For CAP, ceftaroline was shown to be non-inferior to ceftriaxone.

References

- Corey, GR, Wilcox M, Talbot, GH, et al. Integrated Analysis of CANVAS 1 and 2: Phase 3, Multicenter, Randomized, Double-Blind Studies to Evaluate the Safety and Efficacy of Ceftaroline versus Vancomycin plus Aztreonam in Complicated Skin and Skin Structure Infection. Clin Infect Des 2010:51(6):641
- Kaye, D. FDA Approved Ceftaroline Fosamil (Teflaro) for Bacterial Infections. Clin Infec Dis 2011:52 (Jan 15): i

Dalbavancin (Dalvance®)	**Appropriate Uses**
	• Treatment of culture-proven acute bacterial skin and skin structure infections (ABSSI) caused by susceptible gram-positive bacteria in the outpatient setting in patients meeting pre-defined criteria:
	  ○ At least 2 local signs of infection
	  ○ Presence of at least 1 systemic sign of infection
	  ○ Treatment failure or non-compliance with oral antibiotic therapy
	
	Inappropriate Uses
	• Hospitalized patients
	• Presence of any of the following: immunocompromised (solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, or taking ≥ 10 mg prednisone or equivalent per day x 2 weeks); new onset altered mental status with no other identifiable cause persisting following appropriate rehydration; unstable comorbidities requiring hospital admission; true anaphylaxis to vancomycin or other glycopeptides; catheter, prosthesis, or device related infection; diabetic foot infection with ulcer; abscess difficult to drain; suspected bone or joint involvement; perirectal abscess; hemodynamic instability or sepsis; facial, orbital, or periorbital cellulitis; ABSSI associated with a burn, bite, or water exposure; ulceration, vascular ulcers, or decubitis ulcers; petechiae or purpura; > 50% of limb or torso affected; concern for necrotizing fasciitis, bullae or skin sloughing
	
	Dosage
	• CrCl ≥ 30 mL/min or Hemodialysis: Dalvance® (dalbavancin) 1500 mg in D5W 250 mL IVPB x 1 over 30 minutes
	• CrCl < 30 mL/min: Dalvance® (dalbavancin) 1125 mg in D5W 250 mL IVPB x 1 over 30 minutes
	
	References
	• https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/021883s000lbl.pdf

Daptomycin (Cubicin®)	**Appropriate Uses (Outpatient Only)**
	• Infections caused by methicillin-susceptible staphylococci if patient has allergy or intolerance to ß-lactams AND vancomycin
	• Infections caused by methicillin-resistant staphylococci ONLY if patient meets one of the following:
	  ▪ allergy or intolerance to vancomycin (Note: Red Man's Syndrome is NOT considered an intolerance to vancomycin)
	  ▪ vancomycin treatment failure (i.e. no improvement or worsening clinical status despite documented adequate vancomycin steady state trough levels of 15-20 mg/L for serious infections) as failure with vancomycin therapy predicts failure to daptomycin therapy. Should explore other options, such as clindamycin, sulfamethoxazole/trimethoprim, doxycycline, and linezolid.
	  ▪ documented vancomycin-resistant *Staphylococcus aureus* infection (vancomycin MIC ≥ 2 mcg/mL). NOTE: recent data suggest that daptomycin may not be ideal for patients with documented vancomycin-intermediate *Staphylococcus aureus* (vancomycin MIC 4 mcg/mL) infection due to potential for cross-resistance secondary to thickened cell wall
	• Daptomycin is not currently approved for the treatment of VRE infections. However, daptomycin has in vitro activity against VRE and may be considered a treatment option (4-6 mg/kg q24h) if no alternatives exist with documented ampicillin resistance (ampicillin is the drug of choice, VRE can be susceptible to ampicillin)

Inappropriate Uses

- Empiric therapy (unless patient has allergy or intolerance to vancomycin and/or ß-lactams)
- Pneumonia - daptomycin is bound and inactivated by pulmonary surfactant and is therefore ineffective in treating pulmonary infections.
- Infections of the central nervous system – daptomycin does not cross the blood-brain barrier to a significant extent (~5%).
- VRE in stool.
- Vancomycin MIC of 2 based on automated test
- VRE UTI

Dosage - based on *actual body weight* (package insert says actual, but recent data indicated 60% increased AUC in obese patients. Vd is 0.1 L/kg, Several analyses show a need for adjusted body weight, ideal body with or without capped dosing.). Very high doses greater than 6 mg/kg are not recommended for routine use. These experimental doses are only useful in the presence of daptomycin failure with no other viable options.

Indication	Creatinine Clearance (mL/min)	
	≥ 30	< 30, Hemodialysis
Skin/skin structure infection	4 mg/kg IV q24h	4 mg/kg IV q48h
Bacteremia/Endocarditis	6-10 mg/kg IV q24h	6 mg/kg IV q48h
Osteomyelitis	6-8 mg/kg IV q24h	6 mg/kg IV q48h

NOTE: Myopathy, CPK elevations, and rhabdomyolysis have been described with daptomycin therapy. Patients receiving concomitant statin therapy may be at an increased risk for these effects. CPK levels should be monitored at baseline and weekly during therapy. Daptomycin therapy should be discontinued in patients with CPK elevation >5x upper limit of normal (ULN) with signs and symptoms of myopathy OR with CPK elevation >10x ULN without signs and symptoms of myopathy.

References

- Arbeit RD, Maki D, Tally FP, et al. The safety and efficacy of daptomycin for the treatment of complicated skin and skin-structure infections. Clin Infect Dis 2004;38:1673-81.
- Bookstaver PB, Bland CM, Qureshi ZP, et al. Safety and efficacy of daptomycin across a hospitalized obese population : results of a multicenter investigation in the Southeast United States. Pharmacotherapy 2013 Dec. 33(12) : 1322
- Cottagnoud P, Pfister M, Acosta F, et al. Daptomycin is highly efficacious against penicillin-resistant and penicillin- and quinolone-resistant pneumococci in experimental meningitis. Antimicrob Agents Chemother 2004;48:3928-33.
- Fowler VG, Boucher JW, Corey GR, et al. Daptomycin versus standard therapy for bacteremia and endocarditis caused by *Staphylococcus aureus*. N Eng J Med 2006;355:653-65.
- Liu C, Bayer A, Cosgrove SE, et al. Clinical practice guidelines by the infectious diseases society of America for the treatment of methicillin-resistant Staphylococcus aureus infections in adults and children: executive summary. Clin Infect Dis 2011 Feb 1;52(3): 282
- Jones T, Yeaman MR, Sakoulas G, et al. Failures in clinical treatment of Staphylococcus aureus infection with daptomycin are associated with alterations in surface charge membrane phospholipid asymmetry and drug binding. Antimicrobial Agents Chemotherapy 2008 Jan 52(1): 269
- Ng JK, Schulz LT, Rose WE, et al. Daptomycin dosing on ideal body weight versus actual body weight, comparison of clinical outcomes. Antiimicrobial Agents Chemotherapy 2014 Jan 58(1): 88
- Pai MP, Norenberg JP, Anderson T, et al. Influence of morbid obesity on the single-dose pharmacokinetics of daptomycin. Antimicrob Agents Chemother 2007;51:2741-7.
- Prescribing information for Cubicin (daptomycin for injection), Lexington, Massachusetts: Cubist Pharmaceuticals, 2008.
- Rybak M, Lomaestro B, Rotschafer JC, et al. Therapeutic monitoring of vancomycin in adult patients: a consensus review of the American Society of Health-System Pharmacists, the Infectious Diseases Society of America, and the Society of Infectious Diseases Pharmacists. Am J Health-Systm Pharm 2009;66:82-98.
- Silverman JA, Mortin LI, Vanpraagh AD, et al. Inhibition of daptomycin by pulmonary surfactant: in vitro modeling and clinical impact. J Infect Dis 2005;191:2149-52.

Ertapenem
(Invanz®)

Appropriate Uses

- Empiric therapy in patients with an infection AND a history of infection or colonization with ESBL-producing organism within the past year
- Culture-proven infection due to gram-negative organisms resistant to other antibiotics but susceptible to carbapenems
- Infections outside of the urinary tract: culture-proven infection due to extended-spectrum β-lactamase (ESBL)-producing organisms regardless of *in vitro* susceptibility to other agents

Inappropriate Uses

- Therapy in patients where infection due to *Acinetobacter* spp., *Pseudomonas* spp., or *Enterococcus* spp. is implicated. Ertapenem lacks reliable activity against these organisms.
- Surgical prophylaxis

Dosage

Creatinine Clearance (mL/min)	
> 30	**≤ 30, Hemodialysis**
1 gram IV q24h	500 mg IV q24h (after HD on dialysis days)

References

- Jacoby GA. AmpC β-lactamases. Clin Micro Rev 2009;22:161-182.
- Paterson DL and Bonomo RA. Extended-spectrum β-lactamases: a clinical update. Clin Micro Rev 2005;18:657-686.
- Prescribing information for Invanz (ertapenem for injection), Whitehouse Station, New Jersey: Merck & Co, Inc., 2008.
- Sexton DJ. Carbapenems for surgical prophylaxis? N Eng J Med 2006;355:2693-5.

Imipenem and Cilastatin
(Primaxin®)

Appropriate Uses

- Empiric therapy in patients with urinary tract infection or intra-abdominal infection, presence of severe disease (sepsis, hemodynamic instability, ventilator support, or ICU admission), and at risk for infection due to an extended-spectrum β-lactamase producing gram-negative pathogen. Risk factors include:
  - receipt of piperacillin-tazobactam (Zosyn®), cefepime, ceftazidime, aztreonam, fluoroquinolone, or other anti-*Pseudomonal* antibiotic for > 5 days within the past 90 days
  - presence of a percutaneous gastrostomy or jejunostomy tube
  - presence of a central venous or arterial catheter
  - presence of a urinary catheter
- Culture-proven infection due to extended-spectrum β-lactamase (ESBL)-producing organisms regardless of *in vitro* susceptibility to other agents (excluding urinary tract infection) AND concomitant culture-proven infection due to *Enterococcus faecalis* demonstrating susceptibility to ampicillin.
- Culture-proven infection due to extended-spectrum β-lactamase (ESBL)-producing organisms regardless of *in vitro* susceptibility to other agents (excluding urinary tract infection) AND organism demonstrating resistance to ertapenem and meropenem.

Inappropriate Uses

- Empiric therapy
- Surgical prophylaxis

Dosage

Imipenem Dosage Adjustments (Intermittent Infusion Method) for Altered Kidney Function			
CrCl (mL/min) ≥ 60	**500 mg q6h**	**1 g q8h**	**1 g q6h**
CrCl (mL/min) ≥ 30 to < 60	250 mg q6h **or** 500 mg q8h	500 mg q8h	500 mg q6h
CrCl (mL/min) ≥ 15 to < 30	250 mg q8h **or** 500 mg q12h	250 mg q8h **or** 500 mg q12h	250 mg q6h
CrCl (mL/min) < 15	Do not administer imipenem/cilastatin unless hemodialysis is instituted within 48 hours.		

References

- Paterson DL and Bonomo RA. Extended-spectrum β-lactamases: a clinical update. Clin Micro Rev 2005;18:657-686.
- Jacoby GA. AmpC β-lactamases. Clin Micro Rev 2009;22:161-182.
- Lexicomp. (2023). Imipenem and Cilastatin [Monograph]. In Drug Information Handbook. Wolters Kluwer. Retrieved from: https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7074?cesid=5eq2boyMjzR&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dimipenem%2Band%2Bcilastatin%26t%3Dname%26acs%3Dtrue%26acq%3Dimipenem.

Linezolid
(Zyvox®)

Appropriate Uses

- Documented infections caused by vancomycin-resistant enterococci (VRE) not susceptible to ampicillin
- Documented infections caused by vancomycin-resistant (VRSA), vancomycin-intermediate Staphylococcus aureus (VISA), or coagulase-negative *Staphylococci* resistant to vancomycin
- Infections caused by methicillin-susceptible staphylococci if patient has allergy or intolerance to ß-lactams AND vancomycin
- Infections caused by methicillin-resistant staphylococci ONLY if patient meets one of the following:
  - allergy or intolerance to vancomycin (Note: Red Man's Syndrome is NOT considered an intolerance to vancomycin)
  - vancomycin treatment failure (i.e. no improvement or worsening clinical status despite documented vancomycin AUC/MIC 400-600 mg*hr/L for serious infections with vancomycin MIC ≤ 1 mcg/mL)
  - documented MRSA infection with vancomycin MIC ≥ 2 mcg/mL

Possible Use

- VRE UTI (must first demonstrate failure/resistance to ampicillin, nitrofurantoin, and/or fosfomycin)

Inappropriate Uses

- Empiric therapy (unless patient has allergy or intolerance to vancomycin and/or ß-lactams)
- Treatmet of VRE in stool

Dosage

- 600 mg IV/PO q12h
- Dosage adjustment is NOT necessary for patients with renal dysfunction or on hemodialysis. One of the two daily doses should be held and administered after hemodialysis on hemodialysis days.
- Linezolid is ~100% bioavailable. Consider initiating with or switching to oral therapy when patient is able to tolerate oral medications.

NOTE: Caution should be used in prolonged courses of therapy. Linezolid can cause bone marrow suppression with short courses., and potentially irreversible mitochondrial toxicities (peripheral neuropathies, optic neuritis, lactic acidosis, etc.) with ≥ 4 weeks of use. Caution should be used in patients receiving concomitant therapy with selective serotonin reuptake inhibitors (SSRI), tricyclic antidepressants, serotonin 5-HT1 receptor agonists (triptans), meperidine, or buspirone due to potential for serotonin syndrome. Patients concomitantly using these agents with linezolid should be closely monitored for signs and symptoms of serotonin syndrome such as cognitive dysfunction, hyperpyrexia, hyperreflexia, and incoordination.

References

- Prescribing information for Zyvox (linezolid injection, tablets, an oral suspension), New York, New York: Pfizer, Inc, 2008.
- Raad I, Hachem R, Hanna H, et al. Prospective, randomized study comparing quinupristin-dalfopristin with linezolid in the treatment of vancomycin-resistant Enterococcus faecium infections. J Antimicrob Chemother 2004;53:646-9.
- Rubinstein E, Cammarata S, Oliphant T, et al. Linezolid (PNU-100766) versus vancomycin in the treatment of hospitalized patients with nosocomial pneumonia: a randomized double-blind, multicenter study. Clin Infect Dis 2001;32(3): 402-12.
- Rybak M, Lomaestro B, Rotschafer JC, et al. Therapeutic monitoring of vancomycin in adult patients: a consensus review of the American Society of Health-System Pharmacists, the Infectious Diseases Society of America, and the Society of Infectious Diseases Pharmacists. Am J Health-Systm Pharm 2009;66:82-98.
- Weigelt J, Itani K, Stevens D, et al. Linezolid versus vancomycin in the treatment of complicated skin and soft tissue infections. Antimicrob Agents Chemother 2005;49(6):2260-6.
- Wunderink RG, Cammarata SK, Oliphant TH, et al. Continuation of a randomized, double-blind, multicenter study of linezolid versus vancomycin in the treatment of phatients with nosocomial pneumonia. Clin Ther 2003;25(3):980-92.

Meropenem
(Merrem®)

Appropriate Uses

- Empiric therapy in patients with severe infections (hemodynamic instability, ventilator support, or ICU admission) at risk for infection due to an extended-spectrum β-lactamase producing gram-negative pathogen. Risk factors include:
  - receipt of piperacillin-tazobactam (Zosyn®), cefepime, ceftazidime, aztreonam, fluoroquinolone, or other anti-*Pseudomonal* antibiotic for > 5 days within the past 90 days
  - presence of a percutaneous gastrostomy or jejunostomy tube
  - presence of a central venous or arterial catheter
  - presence of a urinary catheter
- Empiric therapy in patients with an infection AND a history of infection or colonization with both an ESBL-producing organism and *Pseudomonas aeruginosa* within the past year
- Culture-proven infection due to gram-negative organisms resistant to other antibiotics but susceptible to meropenem
- Clinically unstable (new or persistent fever, increase in WBC, hemodynamic instability, etc…) and already receiving broad-spectrum gram-negative antibiotic with appropriate coverage of *Pseudomonas aeruginosa* (i.e. piperacillin-tazobactam or cefepime).

Inappropriate Uses

- Continued use when culture and susceptibility results demonstrate susceptibility to other agents (unless clinical scenario pertains to exceptions noted above). Therapy should be de-escalated pending susceptibility results.
- Doripenem may not be used in pneumonia due to increased mortality

Dosage (Meropenem):

Indication for Meropenem	Creatinine Clearance (mL/min)				
	>50	26 - 50	10 - 25	< 10	Hemodialysis
Most infections	0.5-1 g IV q8h	0.5-1 g IV q12h	250-500 mg IV q12h	250-500 mg IV q24h	500 mg IV q24h (post HD)
Meningitis	2 g IV q8h	2 g IV q12h	1 g IV q12h	1 g IV q24h	

Use of Imipenem

Imipenem can be used for similar indications in place of meropenem. Mechanisms of action of resistance to meropenem and imipenem are slightly different. Therefore, it is possible that an organism may be resistant to one agent and susceptible to another.

References

- Paterson DL and Bonomo RA. Extended-spectrum β-lactamases: a clinical update. Clin Micro Rev 2005;18:657-686.
- Jacoby GA. AmpC β-lactamases. Clin Micro Rev 2009;22:161-182.
- Prescribing information for Merrem (meropenem for injection), Wilmington, Delaware: AstraZeneca Pharmaceuticals LP., 2008.

Tigecycline
(Tygacil®)

Appropriate Uses

- Complicated skin and skin structure infections, complicated intra-abdominal infections and community-acquired bacterial pnuemonia ONLY if patient meets one of the following:
  - allergy or intolerance to all standard (standard may be too vague) alternative therapies
  - infection refractory to all standard alternative therapies
  - Many don't realize that minocycline is better and more cost effective for resistance Acinetobacter (Fishbain, CID 2010)
- Documented infection due to multidrug-resistant organisms showing susceptibility to tigecycline ONLY if no other options exist
- Should be noted that mortality is higher with Tigecycline with an accompanying FDA warning

Inappropriate Uses

- Empiric therapy
- Infections suspected or known to be caused by *Pseudomonas aeruginosa, Providencia* spp., *Proteus* spp., or *Morganella* spp. – tigecycline has poor activity against these organisms.
- Primary bloodstream infections and infections associated with bacteremia unless no other alternatives exist – caution should be exercised because there is a lack of clinical data showing efficacy, and emergence of resistance while receiving tigecycline for bloodstream infections has been reported.
  - Serum C_{max} = 0.63 mcg/mL, 71 - 89% protein bound → maximum serum concentration of unbound (active) drug = 0.07 - 0.18 mcg/mL
  - These serum levels are subtherapeutic with regard to the MICs of most gram-positive and gram-negative organisms. Exposure to subtherapeutic levels of tigecycline is likely to promote the emergence of resistance in these organisms.
- Urinary tract infections unless no alternatives exist - tigecycline achieves poor urinary concentrations that are likely to be subtherapeutic with regard to the MICs of most urinary pathogens.
- Complicated intra-abdominal infections secondary to intestinal perforation unless no alternatives exist
- Hospital-acquired pneumonia/ventilator-associated pneumonia unless no alternatives exist – caution should be exercised because lower cure rates (47.9% vs. 70.1%) and higher mortality rates (19.1% vs. 11.5%) were seen when patients with ventilator-associated pneumonia were treated with tigecycline.
  - Pharmacokinetic data indicate that, while tigecycline pulmonary concentrations appear adequate, the majority of the dose concentrates intracellularly within alveolar cells, rather than in epithelial lining fluid (ELF), where most pulmonary pathogens reside (ELF concentrations = 0.01 – 0.02 mcg/mL at all times).
- Children < 18 years of age - lack of experience; risk of tooth discoloration with tetracycline derivatives in pediatric patients
- Pregnant or breast-feeding women

Dosage

- 100 mg IV x1, then 50 mg IV q12h
- Dosage adjustment is NOT necessary in patients with renal dysfunction or on hemodialysis.
- Severe hepatic impairment (Child-Pugh Class C - i.e. > 9 points): 100 mg IV x 1, then 25 mg IV q12h

Child-Pugh Score Calculation			
Measure	**1 point**	**2 points**	**3 points**
Bilirubin (mg/dL)	< 2	2 - 3	> 3
Serum Albumin (g/dL)	> 3.5	2.8 - 3.5	< 2.8
INR	< 1.7	1.7 - 2.2	> 2.2
Ascites	None	Controlled w/meds	Refractory to meds
Hepatic Encephalopathy	None	Controlled w/meds	Refractory to meds

References

- Anthony KB, Fishman NO, Linkin DR, et al. Clinical and microbiological outcomes of serious infections with multidrug-resistant Gram-negative organisms treated with tigecycline. Clin Infect Dis 2008;46:567-70.
- Babinchak T, Ellis-Grosse E, Dartois N, et al. The efficacy and safety of tigecycline for the treatment of complicated intra-abdominal infections: analysis of pooled clinical trial data. Clin Infect Dis 2005;41(Suppl 5): S354-367.
- Burkhardt O, Rauch K, Kaever V, et al. Tigecycline possibly underdosed for the treatment of pneumonia: a pharmacokinetic viewpoint [letter]. Int J Antimicrob Agents 2009;34:101-2.
- Curcio D. Treatment of recurrent urosepsis with tigecycline: a pharmacological perspective. J Clin Micro 2008;46:1892-1893.
- Ellis-Grosse EJ, Babinchak T, Dartois N, et al. The efficacy and safety of tigecycline in the treatment of skin and skin-structure infections: results of 2 double-blind phase 3 comparison studies with vancomycin-aztreonam. Clin Infect Dis 2005; 41(Suppl 5): S341-53.
- Florescu I, Beuran M, Dimov R, et al. Efficacy and safety of tigecycline compared with vancomycin or linezolid for treatment of serious infections with methicillin-resistant Staphylococcus aureus or vancomycin-resistant enterococci: a Phase 3, multicentre, double-blind, randomized study. J Antimicrob Chemother 2008; 62(Suppl 1): i17-i28.
- Peleg AY, Potoski BA, Rea R, et al. Acinetobacter baumannii bloodstream infection while receiving tigecyclin: a cautionary report. J Antimicrob Chemother 2007;59:128-131.
- Prescribing information for Tygacil (tigecycline for injection), Philadelphia, Pennsylvania: Wyeth Pharmaceuticals, Inc., 2008.
- Tygacil Product Information Request (#1-14TEVR), US Medical Information. Pfizer, Inc. Accessed 1/11/10.

Voriconazole
(Vfend®)

Appropriate Uses

- Treatment of invasive *Aspergillosis*
- Treatment of proven invasive fungal infection susceptible to voriconazole AND resistant to fluconazole

Inappropriate Uses

- Candidiasis / Neutropenic fever
- Treatment of positive urine cultures due to resistant *Candida* spp.

Dosage

- LD: 6 mg/kg q12h for first 24 hours IV
- MD: 4 mg/kg q12h IV, or 100 mg q12h PO (< 40 kg) or 200 mg q12h PO (≥ 40 kg)
- Dosage adjustment is NOT necessary in patients with CrCl ≥ 50 mL/min
- AVOID IV formulation in patients with CrCl ≤ 50 mL/min due to accumulation of the IV vehicle (SBECD); use PO (no IV)
- Hepatic impairment:
    - Mild-Moderate (Child-Pugh Class A & B): Reduce Maintenance Dose by 50%
    - Severe (Child-Pugh Class C): Only use if benefits outweigh the risk

NOTE: MUST check for potential drug interactions when initiating Voriconazole or starting a new medication in patients already receiving voriconazole therapy.

References

- Vfend ® [package insert], New York, NY: Roerig, division of Pfizer Inc. 2015.

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

IVHD-Pioneers Memorial Hospital
Antimicrobial Formulary

Generic Name	Trade Name	Strength	Size	Form
Aminoglycosides				
Amikacin	Amikin®	250 mg/mL	2 mL	Injection Vial
Gentamicin	Garamycin®	10 mg/mL	2 mL	PF Injection Vial
		40 mg/mL	2 mL	Injection Vial
		40 mg/mL	20 mL	Injection Vial
Neomycin		500 mg		Tablet
Tobramycin		40 mg /mL	2 mL	Injection Vial
		40 mg /mL	20 mL	Injection Vial
Anthelmintic				
Albendazole	Albenza®	200 mg		Tablet
Ivermectin	Stromectol®	3 mg		Tablet
Antibiotic, Antiprotozoal				
Atovaquone	Mepron®	150 mg/mL	210 mL	Oral Solution
Metronidazole	Flagyl®	250 mg, 500 mg		Tablet
		500 mg in NS	100 mL	Premix IV
Glycopeptides				
***Dalbavancin**	Dalvance®	500 mg		Injection Vial
Vancomycin	Vancocin®	125 mg, 250 mg		Capsule
		500 mg, 750 mg		Injection Vial
		1 g, 1.25 g, 1.5 g		Injection Vial
		1250 mg in SWFI	250 mL	Premix IV
		1500 mg in SWFI	300 mL	Premix IV
		1750 mg in SWFI	350 mL	Premix IV
		2 g in SWFI	400 mL	Premix IV
Miscellaneous Antibiotics				
[a]**Aztreonam**	Azactam®	1 g, 2 g		Injection Vial
Clindamycin	Cleocin®	150 mg, 300 mg		Capsule
		75 mg/5 mL	100 mL	Oral Solution
		150 mg/mL	2 mL	Injection Vial
		150 mg/mL	4 mL	Injection Vial
		150 mg/mL	6 mL	Injection Vial
		300 mg in D5W	50 mL	Premix IV
		600 mg in D5W	50 mL	Premix IV
		900 mg in D5W	50 mL	Premix IV
[b]**Colistimethate**	Coly-Mycin M®	150 mg		Injection Vial
Dapsone	Aczone®	100 mg		Tablet
[a]**Daptomycin**	Cubicin®	500 mg		Injection Vial
[a]**Linezolid**	Zyvox®	600 mg		Tablet
		600 mg in D5W	300 mL	Premix IV

Generic Name	Trade Name	Strength	Size	Form
Nitrofurantoin Monohydrate Macrocrystals	Macrobid®	100 mg		Capsule
[b]Polymyxin B Sulfate		500,000 Unit		Injection Vial
Rifaximin	Xifaxan®	200 mg, 550 mg		Tablet
[b]Tigecycline	Tygacil®	50 mg		Injection Vial
Miscellaneous Antifungals				
Terbinafine	Lamasil®	250 mg		Tablet
Antimalarials				
Hydroxychloroquine	Plaquenil®	200 mg		Tablet
Antiretrovirals, Nucleoside Reverse Transcription Inhibitors (NRTI)				
Emtricitabine and Tenofovir disoproxil fumarate	Truvada®	200-300 mg		Tablet
Emtricitabine	Emtriva®	200 mg		Tablet
[b]Tenofovir alafenamide	Vemlidy®	25 mg		Tablet
Lamivudine	Epivir®	150 mg 10 mg/mL		Tablet Oral Solution
Tenofovir disoproxil fumarate	Viread®	300 mg		Tablet
Zidovudine	Retrovir®	10 mg/mL 50 mg5 mL	20 mL	Injection Vial Oral Syrup
Antiretrovirals, Non-nucleoside Reverse Transcription Inhibitors (NNRTI)				
Nevirapine		50 mg/mL		Oral Suspension
Antiretrovirals, Integrase Strand Transfer Inhibitors				
Dolutegravir	Tivicay	50 mg		Tablet
Antitubercular Agents				
Ethambutol	Myambutol®	400 mg		Tablet
Isoniazid	Nydrazid®	300 mg		Tablet
Pyrazinamide		500 mg		Tablet
[b]Rifabutin	Mycobutin®	150 mg		Capsule
Rifampin	Rifadin®	150 mg, 300 mg 10 mg/mL 600 mg	 120 mL	Capsule Oral Suspension Injection Vial

Generic Name	Trade Name	Strength	Size	Form
Azole Antifungals				
Fluconazole	Diflucan®	100 mg		Tablet
		150 mg		Tablet
		200 mg		Tablet
		10 mg/mL	35 mL	Oral Suspension
		100 mg in NS	50 mL	Premix IV
		200 mg in NS	100 mL	Premix IV
		400 mg in NS	200 mL	Premix IV
Itraconazole	Sporanox®	100 mg		Capsule
Ketoconazole	Nizoral®	200 mg		Tablet
[a]Voriconazole	Vfend®	200 mg		Tablet
		200 mg		Injection Vial
Carbapenems				
[a]Ertapenem	Invanz®	1 g		Injection Vial
[a]Imipenem and Cilastatin	Primaxin®	500 mg		Injection Vial
[a]Meropenem	Merrem®	1 g, 500 mg		Injection Vial
Cephalosporin, 1st Generation				
Cefazolin	Ancef®	1 g, 2 g		Injection Vial
Cephalexin	Keflex®	250 mg, 500 mg		Capsule
		250 mg/5 mL	100 mL	Oral Suspension
Cephalosporin, 2nd Generation				
Cefoxitin	Mefoxin®	1 g, 2 g		Injection Vial
Cephalosporin, 3rd Generation				
Ceftazidime	Fortaz®	1 g, 2 g		Injection Vial
[b]Ceftazidime and Avibactam	Avicaz®	2.5 g		Injection Vial
Cefotaxime	Claforan®	500 mg		Injection Vial
		1 g		Injection Vial
Ceftriaxone	Rocephin®	250 mg, 500 mg		Injection Vial
		1 g, 2 g		Injection Vial
Cephalosporin, 4th Generation				
Cefepime	Maxipime®	1 g, 2 g		Injection Vial
Cephalosporin, 5th Generation				
[a]Ceftaroline	Teflaro®	400 mg 600 mg		Injection Vial
Echinocandin Antifungal				
[a]Micafungin	Mycamine®	100 mg		Injection Vial
Macrolides				
Azithromycin	Zithromax®	250 mg, 500 mg		Tablet
		200 mg/5 mL	30 mL	Oral Suspension
		500 mg		Injection Vial
Clarithromycin	Biaxin®	500 mg		Tablet
		250 mg/5 mL	50 mL	Oral Suspension
Erythromycin Base	Ery-Tab®	250 mg		Film-Coated Tablet
		[c]333 mg		Film-Coated Tablet
		[c]500 mg		Film-Coated Tablet
Erythromycin Ethylsuccinate	E.E.S.	[c]400 mg		Tablet
		200 mg/5 mL	100 mL	Oral Suspension
Erythromycin Lactobionate	Erythrocin®	500 mg		Injection Vial

Generic Name	Trade Name	Strength	Size	Form
Neuraminidase Inhibitor				
Oseltamivir	Tamiflu®	30 mg, 45 mg		Capsule
		75 mg		Capsule
		6 mg/mL	60 mL	Oral Suspension
Antivirals				
Acyclovir	Zovirax®	200 mg, 400 mg		Capsule
		50 mg/mL	20 mL	Injection Vial
Famciclovir	Famvir®	500 mg		Tablet
Ganciclovir	Cytovene®	500 mg		Injection Vial
Valacyclovir	Valtrex®	500 mg		Tablet
Penicillins				
Amoxicillin	Amoxil®	250 mg, 500 mg		Capsule
		250 mg/5 mL	100 mL	Oral Suspension
Amoxicillin/Clavulanate	Augmentin®	500-125 mg		Tablet
		875-125 mg		Tablet
		125-31.25 mg/5 mL	100 mL	Oral Suspension
		200-28.5 mg/5 mL	50 mL	Oral Suspension
Ampicillin		500 mg		Capsule
		250 mg/5 mL	100 mL	Oral Suspension
		125 mg, 250 mg		Injection Vial
		500 mg		Injection Vial
		1 g, 2 g		Injection Vial
Ampicillin/Sulbactam	Unasyn®	1.5 g, 3 g		Injection Vial
Dicloxacillin	Dynapen®	250 mg		Capsule
Nafcillin	Nafcil®	1 g, 2 g		Injection Vial
Penicillin G Benzathine	Bicillin L-A®	1,200,000 Unit	2 mL	Injection Syringe
		2,400,000 Unit	4 mL	Injection Syringe
		600,000 Unit	1 mL	Injection Syringe
Penicillin G Benzathine and Penicillin G Procaine	Bicillin C-R®	1,200,000 Unit	2 mL	Injection Syringe
Penicillin G Potassium		2.5 MMU in NS	100 mL	IV Premix
		5 MMU		Injection Vial
Penicillin V Potassium		250 mg		Tablet
		500 mg		Tablet
Piperacillin/Tazobactam	Zosyn®	2.25 g		Injection Vial
		3.375 g		Injection Vial
		4.5 g		Injection Vial
Polyene Antifungal				
Amphotericin B Lipid Complex	Abelcet®	5 mg/mL	20 mL	Injection Vial
Liposomal Amphotericin B	AmBisome®	50 mg		Injection Vial
Quinolones				
Ciprofloxacin	Cipro®	250 mg, 500 mg		Tablet
		200 mg in D5W	100 mL	IV Premix
		400 mg in D5W	200 mL	IV Premix
Levofloxacin	Levaquin®	250 mg, 500 mg		Tablet
		250 mg in D5W	50 mL	IV Premix
		500 mg in D5W	100 mL	IV Premix
		750 mg in D5W	150 mL	IV Premix
Moxifloxacin	Avelox®	400 mg		Tablet
		400 mg in NS	250 mL	IV Premix

Generic Name	Trade Name	Strength	Size	Form
Sulfonamides				
Sulfamethoxazole/Trimethoprim	Septra®, Bactrim®	400-80 mg		Tablet
	Bactrim DS®	800-160 mg		Tablet
		200-40 mg/5 mL	20 mL	Oral Suspension
		80-16 mg/mL	10 mL	Injection Vial
Tetracyclines				
Doxycycline	Vibramycin®	100 mg		Tablet
		100 mg		Injection Vial
Minocycline	Minocin®	100 mg		Capsule
Tetracycline	Sumycin®	500 mg		Capsule

[a]Restricted, criteria-based
[b]Restricted, requires preauthorization by infectious diseases specialist
*Restricted, criteria-based and for outpatient use only

IVHD-Pioneers Memorial Hospital Antimicrobial Stewardship Program
Antimicrobial Guidelines for Adult Patients with Pneumonia

Table 1: Inpatient antimicrobial recommendations for adult patients with pneumonia

Empiric antimicrobial therapy for inpatients with pneumonia is dependent on disease severity and presence of risk factors for multi-drug resistant organisms (MDRO).

Indication	Empiric Antimicrobial Regimen
Mild-Moderate Community-Acquired Pneumonia (CAP) No risk factors for drug-resistant gram negative pathogens	Ceftriaxone 1 g IVPB q24h + [5]Azithromycin 500 mg IVPB/PO q24h +/- [1]Vancomycin per pharmacy protocol ***Severe Beta-Lactam Allergy*** Levofloxacin 750 mg IVPB q24h +/- [2]Aztreonam 2 g IVPB q8h +/- [1]Vancomycin per pharmacy protocol
Mild-Moderate Community-Acquired Pneumonia (CAP) If one of the following is present: • Infection or colonization with Pseudomonas aeruginosa within previous 12 months • Detection of gram-negative rods on a good-quality respiratory culture.	Cefepime 2 g IVPB q8h + [5]Azithromycin 500 mg IVPB/PO q24h +/- [1]Vancomycin per pharmacy protocol ***Severe Beta-Lactam Allergy*** Levofloxacin 750 mg IVPB q24h +/- [2]Aztreonam 2 g IVPB q8h +/- [1]Vancomycin per pharmacy protocol
Severe Community-Acquired Pneumonia (CAP) No risk factors for drug-resistant gram negative pathogens	Ceftriaxone 2 g IVPB q24h + [5]Azithromycin 500 mg IVPB q24h +/- [1,3]Vancomycin per pharmacy protocol ***Severe Beta-Lactam Allergy*** Levofloxacin 750 mg IVPB q24h +/- [2]Aztreonam 2 g IVPB q8h +/- [1,3]Vancomycin per pharmacy protocol
Severe Community-Acquired Pneumonia (CAP) If one of the following is present: • History of hospitalization for at least 48 hours with receipt of broad-spectrum antibiotics within previous 90 days • [4]Immunocompromised	Cefepime 2 g IVPB q8h + [5]Azithromycin 500 mg IVPB q24h **PLUS** Vancomycin per pharmacy protocol ***Severe Beta-Lactam Allergy*** Levofloxacin 750 mg IVPB q24h + Aztreonam 2 g IVPB q8h **PLUS** Vancomycin per pharmacy protocol

Severe Community-Acquired Pneumonia (CAP) If one of the following is present: • Infection or colonization *with Pseudomonas aeruginosa* within previous 12 months • Detection of gram-negative rods on a good-quality respiratory culture. • Severe COPD • Tracheostomy • Structural lung disease (i.e. bronchiectasis or cystic fibrosis) • Requires invasive respiratory and/or vasopressor support	Cefepime 2 g IVPB q8h + [5]Azithromycin 500 mg IVPB q24h **+/-** [1,3]Vancomycin per pharmacy protocol ***Severe Beta-Lactam Allergy*** Levofloxacin 750 mg IVPB q24h + Aztreonam 2 g IVPB q8h **+/-** [1,3]Vancomycin per pharmacy protocol
Hospital-Acquired Pneumonia (HAP) **Ventilator-Associated Pneumonia (VAP)**	Cefepime 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol

[1]History of MRSA infection or colonization within previous 12 months or detection of gram-positive cocci in clusters on a good-quality respiratory culture
[2]If patient is admitted to the ICU, add aztreonam to regimen
[3]Presence of risk-factors associated with MRSA-CAP: history of hospitalization for at least 48 hours with receipt of broad-spectrum antibiotics within previous 90 days, immunocompromised, recent influenza-like illness, necrotizing or cavitary pneumonia, lung abscess/empyema, or risk factors for MRSA colonization (end-stage kidney disease, crowded living conditions, injection drug use, contact sports participation, or men who have sex with men)
[4]Immunocompromised: solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, AIDS with CD4 < 200, or taking ≥ 10 mg prednisone or equivalent per day x 2 weeks
[5]May use Doxycycline 100 mg PO/IVPB q12h instead of azithromycin
*History of infection or colonization with other MDROs within previous 12 months: replace cefepime and/or vancomycin with appropriate agent (i.e. replace cefepime with meropenem 2 g IVPB q8h in patients with a history of infection or colonization with ESBL-producing enterobacterale)

Table 2: Outpatient antimicrobial recommendations for adult patients with pneumonia

Indication	Empiric Antimicrobial Regimen
Mild-Moderate Community-Acquired Pneumonia (CAP) No presence of co-morbidities	Amoxicillin 1 g PO TID x 5 days ***Severe Beta-Lactam Allergy*** Levofloxacin 750 mg PO q24h x 5 days
Mild-Moderate Community-Acquired Pneumonia (CAP) Presence of at least 1 co-morbidity: chronic heart disease, chronic lung disease, chronic liver disease, chronic renal disease, diabetes, alcohol use disorder, neoplastic disease, or asplenia	Amoxicillin/Clavulanate (Augmentin®) 875 mg/125 mg PO BID **PLUS** [1]Azithromycin 500 mg PO x 1 followed by 250 mg PO QID x 5 days ***Severe Beta-Lactam Allergy*** Levofloxacin 750 mg PO q24h x 5 days

[1]May use Doxycycline 100 mg PO BID x 5 days instead of azithromycin

Rationale:

Recommended antimicrobial regimens for pneumonia are provided in Table 1 and Table 2. Antibiotic selection for CAP is dependent on outpatient or inpatient management. If admitted to the hospital for treatment, empiric therapy is also dependent on disease severity and presence of risk factors for MDROs. Monotherapy with a macrolide antibiotic is not recommended since *Streptococcus pneumoniae* resistance exceeds 25% for isolates tested at PMHD.

Standard empiric therapy for CAP includes coverage of atypical organisms (i.e. *Mycoplasma pneumoniae, Chlamydia pneumoniae,* and *Legionella spp*.), *Streptococcus pneumonia,* and *Haemophilus influenza*. Broadening standard empiric therapy is dependent on the presence of risk factors for MDROs and disease severity:

- Mild-moderate CAP:
  - Empiric coverage for MRSA is recommended if any of the following are present:
    - Infection or colonization with MRSA within previous 12 months
    - Detection of gram-positive cocci in clusters on a good-quality respiratory culture.
  - Empiric coverage for *Pseudomonas aeruginosa* is recommended if any of the following are present:
    - Infection or colonization with *Pseudomonas aeruginosa* within previous 12 months
    - Detection of gram-negative rods on a good-quality respiratory culture.
  - Empiric coverage for other MDROs including ESBL-producing enterobacterales is recommended if there is a history of infection or colonization within previous 12 months
- Severe CAP
  - Empiric coverage for MRSA is recommended if any of the following are present:
    - Infection or colonization with MRSA within previous 12 months
    - Detection of gram-positive cocci in clusters on a good-quality respiratory culture.
    - Hospitalization for at least 48 hours with receipt of IV antibiotics within previous 90 days
    - Immunocompromise: solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, AIDS with CD4 < 200, or taking ≥ 10 mg prednisone or equivalent/day x 2 weeks
    - Recent influenza-like illness
    - Necrotizing or cavitary pneumonia
    - Lung abscess/empyema
    - Risk factors for MRSA colonization: end-stage kidney disease, crowded living conditions (e.g. incarceration), injection drug use, contact sports participation, men who have sex with men
  - Empiric coverage for *Pseudomonas aeruginosa* is recommended if any of the following are present:
    - Infection or colonization with *Pseudomonas aeruginosa* within previous 12 months
    - Detection of gram-negative rods on a good-quality respiratory culture.
    - Hospitalization for at least 48 hours with receipt of IV antibiotics within previous 90 days
    - Immunocompromise: solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, AIDS with CD4 < 200, or taking ≥ 10 mg prednisone or equivalent/day x 2 weeks
    - Severe COPD
    - Tracheostomy
    - Structural lung diseases such as bronchiectasis or cystic fibrosis
    - Requires invasive respiratory and/or vasopressor support
  - Empiric coverage for other MDROs including ESBL-producing enterobacterales is recommended if there is a history of infection or colonization within the previous 12 months

Due to safety profile, fluoroquinolones should be avoided if alternative treatment options are available. Zosyn® in combination with vancomycin should be avoided when alternative therapies are available due to increasing reports of a higher nephrotoxicity risk associated with this combination in patients at high risk for nephrotoxicity.

Suspected aspiration pneumonia: If aspiration pneumonia is suspected, the addition of anaerobic coverage is not recommended unless a lung abscess or empyema is suspected to be present. Antimicrobials with sufficient anaerobic coverage include Augmentin®, Unasyn®, clindamycin, meropenem, metronidazole, and Zosyn®.

Hospital-Acquired Pneumonia (HAP) and Ventilator-Associated Pneumonia (VAP)

Table 3 provides recommended antibiotics for the treatment of HAP/VAP. Use a two-drug combination including one antibiotic from column 1 and one antibiotic from column 2. Empiric antimicrobial therapy for patients with HAP/VAP should be designed to target both MRSA and multi-drug resistant gram-negative pathogens since MRSA prevalence exceeds 20% in both the ICU and medical-surgical ward here at Pioneers Memorial Hospital. Most recent HAP/VAP guidelines published by the IDSA and ATS suggest that a second anti-pseudomonal agent be added to the antimicrobial regimen in patients at high-risk for multi-drug resistant pneumonia, although evidence demonstrating a clinical benefit is lacking.

Suspected aspiration pneumonia: If aspiration pneumonia is suspected, the addition of anaerobic coverage is not recommended unless a lung abscess or empyema is suspected to be present. Antimicrobials with sufficient anaerobic coverage include Augmentin®, Unasyn®, clindamycin, meropenem, metronidazole, and Zosyn®.

Table 3: Recommended Antibiotic Therapy for HAP/VAP

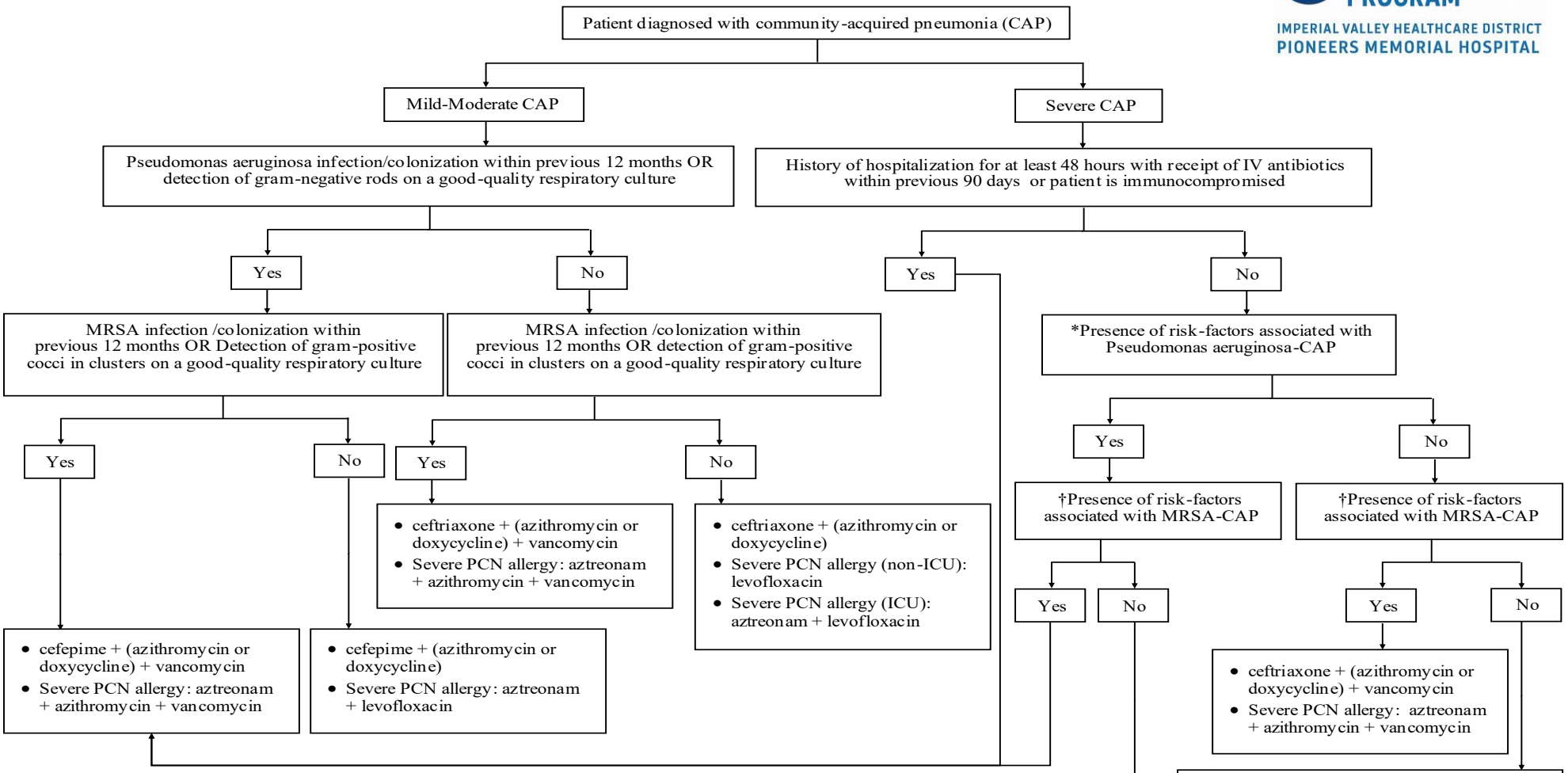
Column 1	Column 2	Column 3 (Optional)
Cefepime 2 g IVPB q8h OR *Meropenem 2 g IVPB q8h ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h	Vancomycin per pharmacy protocol OR Linezolid 600 mg IVPB q12h	Aminoglycoside per pharmacy protocol OR Levofloxacin 750 mg IV q24h

*Meropenem is restricted for patients with a history of infection or colonization with an ESBL-producing organism within the past year, or for the treatment of severe infections (hemodynamic instability, ventilator support, ICU admission) if patient received > 5 days of anti-*Pseudomonal* antibiotic therapy (Zosyn®, cefotaxime, ceftazadime, cefepime, aztreonam, levofloxacin, ciprofloxacin) or a carbapenem within the past 90 days.

Duration of Antimicrobial Therapy: Prolonged courses of antibiotic therapy increases the risk for colonization with multi-drug resistant organisms, increased risk for adverse drug events, and increased healthcare costs. Therefor the lowest recommended treatment duration should be applied. Patients diagnosed with CAP should be treated for a total of 5 days from source control if afebrile for at least 48 hours and clinically stable. Patients diagnosed with HCAP, HAP, or VAP should be treated for 7 days post-source control if clinical improvement is achieved within 72 hours of treatment, patient is afebrile for at least 48 hours and clinically stable. Patients with complicated or severe infection may require treatment for 7-21 days depending on clinical response. Patients should also be re-evaluated for alternative diagnosis if clinical improvement is not achieved by the minimum recommended treatment duration. Recommended treatment durations are provided in Figure 6.

Figure 1: Recommended INPATIENT antibiotic treatment for CAP

ANTIMICROBIAL STEWARDSHIP PROGRAM
IMPERIAL VALLEY HEALTHCARE DISTRICT
PIONEERS MEMORIAL HOSPITAL



MDRO Risk-Factors

**Pseudomonas aeruginosa*: infection/colonization with *Pseudomonas aeruginosa* within previous 12 months, detection of gram-negative rods on a good-quality respiratory culture, hospitalization for at least 48 hours with receipt of IV antibiotics within previous 90 days, immunocompromised, severe COPD, tracheostomy, structural lung diseases such as bronchiectasis or cystic fibrosis, or requires invasive respiratory and/or vasopressor support

†MRSA: infection or colonization with MRSA within previous 12 months, detection of gram-positive cocci in clusters on a good-quality respiratory culture, hospitalization for at least 48 hours with receipt of IV antibiotics within previous 90 days, immunocompromised, recent influenza-like illness, necrotizing or cavitary pneumonia, lung abscess/empyema, end-stage kidney disease, crowded living conditions (e.g. incarceration), injection drug use, contact sports participation, or men who have sex with men

**Infection/colonization with *other MDROs* within previous 12 months: replace cefepime and/or vancomycin with appropriate agent (i.e. replace cefepime with meropenem with a history of ESBL-producing enterobacterales or replace vancomycin with linezolid with a history of vancomycin-resistant *Enterococcus*)

Notes

- Immunocompromised: solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, AIDS with CD4 < 200, or taking ≥ 10 mg prednisone or equivalent/day x 2 weeks
- Severe disease includes patients that require invasive respiratory and/or vasopressor support (IRVS) or high clinical concern for needing ICU care

References:

1. Anzeueto A, Brozek J, et al. Diagnosis and Treatment of Adults with Community-acquired Pneumonia. An Official Clinical Practice Guideline of the American Thoracic Society and Infectious Diseases Society of America. Am J Respir Crit Care Med. 2019 Oct 1;200(7):e45-e67. doi:10.1164/rccm.201908-1581ST.
2. John Hopkins Medicine. Antibiotic Guidelines; online database. (Accessed March 2025).
3. Sanford Guide to Antimicrobial Therapy. Mobile application. Pneumonia, Community-acquired, Adult, Out-patient. Updated 08/23/2022. (Accessed March 2025).
4. Sanford Guide to Antimicrobial Therapy. Mobile application. Pneumonia, Community-acquired, Adult, In-patient. Updated 01/07/2025. (Accessed March 2025).
5. Sanford Guide to Antimicrobial Therapy. Mobile application. Pneumonia, Ventilator-Associated. Updated 01/17/2025. (Accessed March 2025).
6. Sanford Guide to Antimicrobial Therapy. Mobile application. Pneumonia, Anaerobic or Aspiration. Updated 01/05/2025. (Accessed March 2025).
7. Sanford Guide to Antimicrobial Therapy. Mobile application. Pneumonia, Hospital-Acquired. Updated 01/08/2025. (Accessed March 2025).
8. Mandell LA, Wunderink RG, Anzueto A, et al. Infectious Diseases Society of America/American Thoracic Society consensus guidelines on the management of community-acquired pneumonia in adults. Clin Infect Dis 2007; 44 Suppl 2:S27.
9. Kalil AC, Metersky ML, Klompas M, et al. Management of Adults With Hospital-acquired and Ventilator-associated Pneumonia: 2016 Clinical Practice Guidelines by the Infectious Diseases Society of America and the American Thoracic Society. Clin Infect Dis 2016; 63:e61.
10. Briel M, Chiappa V, Schuetz P. Procalcitonin Algorithms for Antibiotic Therapy Decisions: A Systematic Review of Randomized Controlled Trials and Recommendations for Clinical Algorithms. Arch Intern Med. 2011;171(15):1322-1331. doi:10.1001/archinternmed.2011.318.
11. Kanj SS. Principles of antimicrobial therapy of Pseudomonas aeruginosa infections. In: UpToDate, Calderwood SB, UpToDate Waltham, MA. October 30, 2024. (Accessed March 2025.)
12. Anderson DJ. Methicillin-resistant Staphylococcus aureus (MRSA) in adults: Epidemiology. In: UpToDate, Spelman D, UpToDate, Waltham, MA. November 20, 2024. (Accessed March 2025.)
13. File TM, Jr. Treatment of community-acquired pneumonia in adults who require hospitalization. In: UpToDate, Ramirez JA, UpToDate, Waltham, MA. April 13, 2023. (Accessed March 2025.)
14. Klompas M. Treatment of hospital-acquired and ventilator-associated pneumonia in adults. In: UpToDate, File TM, UpToDate, Waltham, MA. June 19, 2024. (Accessed March 2025.)
15. Antonelli M. Acute phase reactants. In: UpToDate, Hant FN, UpToDate, Waltham, MA. October 23, 2024. (Accessed March 2025.)
16. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. (Accessed March 2025.)
17. Aloush V, Cabili S, Carmeli Y, et al. Multidrug-resistant Pseudomonas aeruginosa: risk factors and clinical impact. Antimicrob Agents Chemother. 2006 Jan;50(1):43-8.
18. Akcam FZ, Ceylan T, Gonen I, et al. Risk factors for bacteremia due to extended-spectrum beta lactamase-producing *Escherichia* coli in a Turkish hospital. J Infect Dev Ctries 2013; 7(7):507-512. doi:10.3855/jidc.2788.
19. Jacoby GA, Munoz-Price LS. The New β-Lactamases. N Engl J Med. 2005 Jan 27;352(4):380-91.
20. Allez M, Denis B, Donay JL, et al. Prevalence, risk factors, and impact on clinical outcome of extended-spectrum beta-lactamase-producing Escherichia coli bacteremia: a five-year study. International Journal of Infectious Diseases, Volume 39, October 2015, Pages 1-6.
21. Liu C, Bayer A, Cosgrove SE, et al. Clinical practice guidelines by the infectious diseases society of america for the treatment of methicillin-resistant Staphylococcus aureus infections in adults and children. Clin Infect Dis 2011; 52:e18.

22. Anderson DJ, Carmeli Y, Giladi M, et al. Gram-Negative Bacteremia upon Hospital Admission: When Should Pseudomonas aeruginosa Be Suspected? Clin Infect Dis. (2009) 48 (5): 580-586. doi: 10.1086/596709.
23. File TM, Jr. Acute bronchitis in adults. In: UpToDate, Aronson MD, Sexton, DJ, UpToDate, Waltham, MA. January 17, 2025. (Accessed March 2025).
24. Murphy TF, Sethi S. Management of infection in exacerbations of chronic obstructive pulmonary disease. Ramirez JA, UpToDate, Waltham, MA. January 22, 2025. (Accessed March 2025.)
25. Andersson L, Melander E, et al. Risk factors for infections with extended-spectrum beta-lactamase-producing Escherichia coli in a county of Southern Sweden. Infect Drug Resist. 2013; 6: 93–97. Published online 2013 Sep 19. doi: 10.2147/IDR.S46290.

IVHD-Pioneers Memorial Hospital Antimicrobial Stewardship Program
Antimicrobial Guidelines for Adults with Sepsis, Severe Sepsis, or Septic Shock

Table 1: Empiric Antimicrobial Regimen for Sepsis and no MDRO Risk Factors
(Refer to Table 2 for severe sepsis or septic shock)

Associated Source of Infection	Empiric Antimicrobial Regimen
Unknown	Ceftriaxone 2 g IVPB q24 ***Severe Beta-Lactam Allergy*** Levofloxacin 750 mg IVPB q24h **PLUS** Aztreonam 2 g IVPB q8h
Pneumonia	Ceftriaxone 2 g IVPB q24 + Azithromycin 500 mg IVPB q24h ***Severe Beta-Lactam Allergy*** Levofloxacin 750 mg IVPB q24h **PLUS** Aztreonam 2 g IVPB q8h
Skin and Soft Tissue (Purulent or Non-Purulent Cellulitis)	Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Osteomyelitis	Ceftriaxone 2 g IVPB q24h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Diabetic Foot Infection	Ceftriaxone 2 g IVPB q24 **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Necrotizing Fasciitis or Gas Gangrene	Ceftriaxone 2 g IVPB q24 **PLUS** Clindamycin 900 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Clindamycin 900 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol

Meningitis	Ceftriaxone 2 g IVPB q12h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol **±** Ampicillin 2 g IVPB q4h (> 50 years of age only) ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol **±** Sulfamethoxazole/Trimethoprim 5 mg/kg TMP IVPB every 8 hours (> 50 years of age only)
Urinary Tract Infection	Ceftriaxone 2 g IVPB q24 ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h
Intra-Abdominal	Ceftriaxone 2 g IVPB q24 + Metronidazole 500 mg IVPB q8h **OR** Ciprofloxacin 400 mg IVPB q8h + Metronidazole 500 mg IVPB q8h ***Severe Beta-Lactam Allergy*** Ciprofloxacin 400 mg IVPB q8h + Metronidazole 500 mg IVPB q8h

Table 2: Empiric Antimicrobial Regimen for Severe Sepsis or Septic Shock, or Sepsis and Presence of Multi-Drug Resistant Organism (MDRO) Risk Factors†

Associated Source of Infection	Empiric Antimicrobial Regimen
Undifferentiated and/or Presence of Central Venous Catheter	*Zosyn® 4.5 g IVPB q6h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Community Acquired Pneumonia	*Cefepime 2 g IVPB q8h **PLUS** Azithromycin 500 mg IVPB q24h **OR** Doxycycline 100 mg IVPB q12h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Azithromycin 500 mg IVPB q24h **OR** Doxycycline 100 mg IVPB q12h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol

Nosocomial Pneumonia [includes hospital-acquired pneumonia (HAP) and ventilator-associated pneumonia (VAP)]	*Cefepime 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Skin and Soft Tissue (Purulent or Non-Purulent Cellulitis)	Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Osteomyelitis	*Cefepime 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Diabetic Foot Infection	*Zosyn® 4.5 g IVPB q6h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Necrotizing Fasciitis or Gas Gangrene	*Zosyn® 4.5 g IVPB q6h **PLUS** Clindamycin 900 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Clindamycin 900 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Meningitis	*Cefepime 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol **±** Ampicillin 2 g IVPB q4h (*> 50 years of age only*) ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol **±** Sulfamethoxazole/Trimethoprim 5 mg/kg TMP IVPB every 8 hours *(> 50 years of age only*)

Urinary Tract Infection	**Zosyn® 4.5 g IVPB q6h ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol
Intra-Abdominal	**Zosyn® 4.5 g IVPB q6h ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Levofloxacin 750 mg IVPB q24h **PLUS** Metronidazole 500 mg IVPB q8h

† MDRO risk factors: history of infection or colonization with MDRO within the previous 12 months, hospitalization for ≥ 48 hours in the past 90 days or current prolonged hospitalization ≥ 48 hours, exposure to broad-spectrum antibiotics in the past 90 days, residence in a long-term care facility or nursing home, immunocompromised (solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, AIDS with CD4 < 200, or taking ≥ 10 mg prednisone or equivalent/day x 2 weeks), severe COPD (respiratory source only), tracheostomy (respiratory source only), structural lung diseases such as bronchiectasis (respiratory source only), requires invasive respiratory and/or vasopressor support (ICU admission)
*Substitute with meropenem 1 g IVPB every 8 hours if ESBL risk factors are present. Meropenem is restricted for the treatment of septic shock if one or more of the following ESBL risk factors are present: history of infection or colonization with an ESBL-producing organism within the past year, presence of a percutaneous gastrostomy or jejunostomy tube, presence of a central venous or arterial catheter, presence of a urinary catheter, or received > 5 days anti-*Pseudomonal* antibiotic therapy (piperacillin-tazobactam, ceftazidime, cefepime, aztreonam, levofloxacin, ciprofloxacin) or a carbapenem within the past 90 days.
**Substitute with imipenem-cilastatin 500 mg IVPB every 6 hours if ESBL risk factors are present. Imipenem-cilastatin is restricted for the treatment of septic shock if one or more of the following ESBL risk factors are present: history of infection or colonization with an ESBL-producing organism within the past year, presence of a percutaneous gastrostomy or jejunostomy tube, presence of a central venous or arterial catheter, presence of a urinary catheter, or received > 5 days anti-*Pseudomonal* antibiotic therapy (piperacillin-tazobactam, ceftazidime, cefepime, aztreonam, levofloxacin, ciprofloxacin) or a carbapenem within the past 90 days.
***NOTE: Consider the addition of vancomycin to any regimen where vancomycin is not already recommended if any of the following: history of MRSA infection or colonization within the past year, hospitalization for ≥ 2 days in the past 90 days or current prolonged hospitalization ≥ 48 hours, immunocompromised (solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, AIDS with CD4 < 200, or taking ≥ 10 mg prednisone or equivalent/day x 2 weeks), or risk-factors for MRSA colonization (end-stage kidney disease, crowded living conditions (e.g. incarceration), injection drug use, contact sports participation, men who have sex with men)
****NOTE: Consider the addition of micafungin 100 mg IVPB q24h in sepsis or septic shock in neutropenic patients, patients with recent azole exposure, history of infection with fluconazole-resistant *Candida* within past 12 months, or if more than 2 of the following candidemia risk factors are present: recent major abdominal surgery, necrotizing pancreatitis, receiving total parenteral nutrition, prolonged central venous catheterization, or immunocompromised (solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, or taking ≥ 10 mg prednisone/day x 2 weeks)

References:

1. Mandel J, Schmidt GA, Bell TD. Evaluation and management of suspected sepsis and septic shock in adults. Zachrision KS, Ng Gong M, Sexton DJ, UpToDate, Waltham, MA. March 10, 2025. (Accessed March 2025.)
2. Neviere R. Sepsis syndromes in adults: Epidemiology, definitions, clinical presentation, diagnosis, and prognosis. Ng Gong M, UpToDate, Waltham, MA. March 14, 2025. (Accessed March 2025.)
3. Sanford Guide to Antimicrobial Therapy. Mobile application. Sepsis, Adult. Updated 01/27/2025. (Accessed March 2025).
4. Angus DC, Annane D, et al. Surviving sepsis campaign: international guidelines for management of severe sepsis and septic shock: 2012. Crit Care Med. 2013 Feb;41(2):580-637. doi: 10.1097/CCM.0b013e31827e83af.
5. Angus DC, Alhazzani W, et al. Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016. Critical Care Medicine: Post Author Corrections: January 17, 2017. doi: 10.1097/CCM.0000000000002255
6. Deutschman CS, Seymour CW, Singer M. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). JAMA. 2016;315(8):801-810. doi:10.1001/jama.2016.0287.
7. Gauer RL. Early recognition and management of sepsis in adults: the first six hours. Am Fam Physician. 2013 Jul 1;88(1):44-53.
8. Uslan D. Procalcitonin at UCLA. UCLA Health Antimicrobial Stewardship Program. June 2016.
9. Sepsis treatment in adults. In DynaMed [database online], Ipswich MA: EBSCO. https://www.dynamed.com/topics/dmp~AN~T316889/Sepsis-treatment-in-adults. (Accessed January 2017).
10. Sepsis in adults. In DynaMed [database online], Ipswich MA: EBSCO. https://www.dynamed.com/topics/dmp~AN~T316889/Sepsis-treatment-in-adults. (Accessed January 2017).
11. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. (Accessed March 2025.)
12. Aloush V, Cabili S, Carmeli Y, et al. Multidrug-resistant Pseudomonas aeruginosa: risk factors and clinical impact. Antimicrob Agents Chemother. 2006 Jan;50(1):43-8.
13. Akcam FZ, Ceylan T, Gonen I, et al. Risk factors for bacteremia due to extended-spectrum beta lactamase-producing *Escherichia* coli in a Turkish hospital. J Infect Dev Ctries 2013; 7(7):507-512. doi:10.3855/jidc.2788.
14. Jacoby GA, Munoz-Price LS. The New β-Lactamases. N Engl J Med. 2005 Jan 27;352(4):380-91.
15. Allez M, Denis B, Donay JL, et al. Prevalence, risk factors, and impact on clinical outcome of extended-spectrum beta-lactamase-producing Escherichia coli bacteremia: a five-year study. International Journal of Infectious Diseases, Volume 39, October 2015, Pages 1-6.
16. Povoa P. C-reactive protein: a valuable marker of sepsis. Intensive Care Med (2002) 28:235–243. DOI 10.1007/s00134-002-1209-6.
17. Liu C, Bayer A, Cosgrove SE, et al. Clinical practice guidelines by the infectious diseases society of america for the treatment of methicillin-resistant Staphylococcus aureus infections in adults and children. Clin Infect Dis 2011; 52:e18.
18. Anderson DJ, Carmeli Y, Giladi M, et al. Gram-Negative Bacteremia upon Hospital Admission: When Should Pseudomonas aeruginosa Be Suspected? Clin Infect Dis. (2009) 48 (5): 580-586. doi: 10.1086/596709.
19. Simpson SQ. New Sepsis Criteria: A Change We Should Not Make. Chest. 2016 May;149(5):1117-8. doi: 10.1016/j.chest.2016.02.653. Epub 2016 Feb 27.
20. Simpson SQ. Diagnosing sepsis: a step forward, and possibly a step back. Ann Transl Med. 2017 Feb;5(3):55. doi: 10.21037/atm.2017.01.06.
21. Rutter WC et al. Acute kidney injury in patients treated with vancomycin and piperacillin-tazobactam: A retrospective cohort analysis. J Hosp Med 2017 Feb; 12:77. (http://dx.doi.org/10.12788/jhm.2684)

IVHD-Pioneers Memorial Hospital Antimicrobial Stewardship Program
Clostridioides difficile (Clostridium difficile) Infection Management Recommendations

Purpose:

To provide evidence-based recommendations for the management of *Clostridioides difficile* (formerly *Clostridium difficile*) infections (CDI) in adult patients, and to improve outcomes by providing an organized mechanism to coordinate care for adult patients with CDI's.

Introduction:

Clostridioides difficile (*C. diff* or *C. difficile*) is an anaerobic, spore-forming, gram-positive bacillus that colonizes or infects the colon. It spreads via the fecal-oral route, often after antibiotic-induced disruption of gut flora. Toxins A (TcdA) and B (TcdB) cause inflammation and diarrhea. *C. difficile* is the leading cause of healthcare-associated infectious diarrhea, responsible for 20%-30% of antibiotic-associated diarrhea and nearly all antibiotic-related colitis. CDI is associated with increased morbidity, mortality, and healthcare costs in hospitalized patients.

Diagnosis:

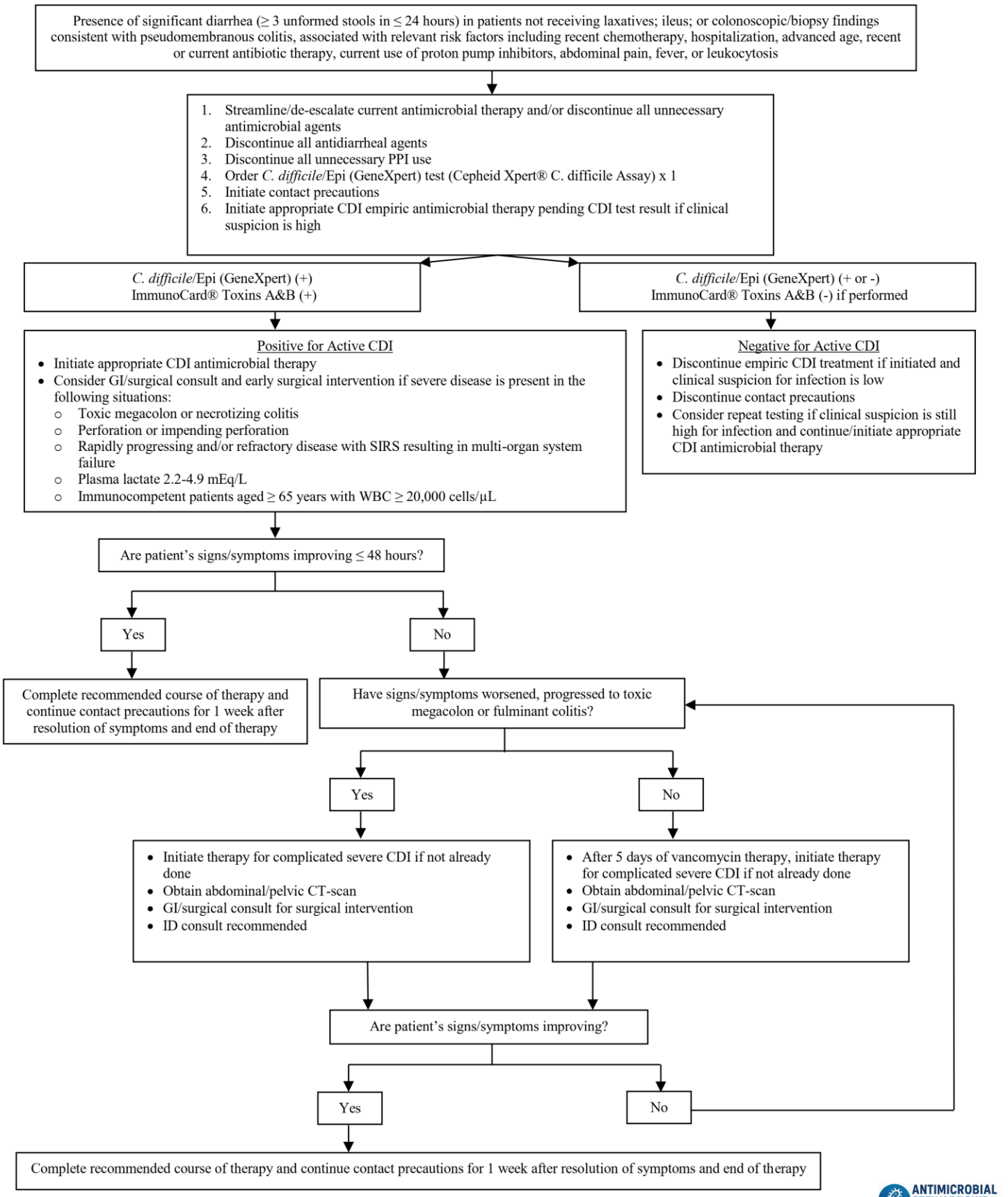
A diagnosis of CDI requires a two-step laboratory confirmation of toxigenic *Clostridioides difficile* in the stool of patients who exhibit significant diarrhea (≥ 3 unformed stools in ≤ 24 hours), ileus, or colonoscopy/biopsy findings consistent with pseudomembranous colitis. Diagnosis is also associated with relevant risk factors, including recent chemotherapy, hospitalization, advanced age, recent or current antibiotic therapy, use of proton pump inhibitors, abdominal pain, fever, or leukocytosis.

Management:

Overview: A clinical management pathway for CDI is provided in Figure 1. A patient presenting with significant diarrhea or ileus associated with relevant risk factors should have a liquid stool sample collected and tested for toxigenic *Clostridioides difficile*. Current antimicrobial therapy should be streamlined/de-escalated, and/or all unnecessary antimicrobial agents should be discontinued. If possible, it is best to avoid cephalosporins, clindamycin, and fluoroquinolones as these agents have been associated with the highest risk for CDI compared to other antibiotic agents.

Antidiarrheal agents including stool softeners and laxatives, and all unnecessary proton pump inhibitors (PPI's) should also be discontinued as data suggests that PPI's increased the risk for CDI. Cholestyramine should also be discontinued in patients receiving oral vancomycin since cholestyramine binds to vancomycin in the GI tract and decreases efficacy. Patients suspected of having a CDI should be placed on contact precautions plus isolation. Patients confirmed to be infected by toxigenic *Clostridioides difficile* by via laboratory stool testing should receive appropriate antimicrobial therapy immediately. Antimicrobial therapy targeting *Clostridioides difficile* is dependent on disease severity, PO status, and number of CDI episodes. Surgical intervention should be considered in specific cases.

Figure 1: CDI Clinical Management Pathway



ANTIMICROBIAL STEWARDSHIP PROGRAM
IMPERIAL VALLEY HEALTHCARE DISTRICT
PIONEERS MEMORIAL HOSPITAL

Testing: The laboratory at PMH utilizes a two-step testing method for *Clostridioides difficile* infection (CDI) using the Cepheid Xpert® *C. difficile* Assay followed by the ImmunoCard® Toxins A&B. The Cepheid Xpert® C. difficile Assay, used with the GeneXpert® Dx System, is a rapid in vitro diagnostic test that detects toxin B gene sequences in unformed stool samples from patients suspected of having *Clostridium difficile* infection (CDI). It uses automated real-time PCR to identify toxin-producing *C. difficile* and aids in diagnosing CDI. However, since PCR detects the gene rather than active toxin production, it can lead to false positives in colonized patients.

To improve diagnostic accuracy, a Toxin EIA (ImmunoCard® Toxins A&B) is performed if the PCR test is positive. Immunocard® Toxins A & B is a rapid, qualitative, horizontal-flow enzyme immunoassay (EIA) for detecting *Clostridium difficile* Toxins A and B in human stool. If both PCR and Toxin EIA are positive, CDI is confirmed. If PCR is positive but Toxin EIA is negative, the patient may be colonized rather than actively infected, and clinical correlation is required before treatment. If PCR is negative, CDI is ruled out. This method helps reduce overdiagnosis and unnecessary antibiotic use while ensuring true infections are identified and treated appropriately.

Antimicrobial therapy: Antimicrobial therapy targeting *Clostridioides difficile* is dependent on disease severity, PO status, and number of CDI episodes. Oral Vancomycin is recommended as first-line therapy in adults for all severity of disease. Recurrent episodes of CDI should be managed with a prolonged tapered and pulsed vancomycin regimen. Recurrent CDI is defined as the re-appearance of signs and/or symptoms of CDI within two months of the previous CDI episode for which signs and symptoms had resolved. IV vancomycin should be avoided as it is not effective for the treatment of CDI. Patients receiving antimicrobial therapy for treatment of an underlying infection should not receive prophylactic antibiotics for *Clostridioides difficile* as doing so may increase the risk for CDI. Asymptomatic patients also should not receive antibiotic therapy as this may promote relapsing disease. Table 1 provides the recommended antimicrobial therapy for CDI depending on disease severity.

Prevention:

Preventing CDI involves a combination of infection control practices, antibiotic stewardship, and environmental cleaning. Proper hand hygiene with soap and water is essential, as alcohol-based hand sanitizers are less effective at removing *C. difficile* spores. Contact precautions, including the use of gloves and gowns, should be implemented for patients with suspected or confirmed CDI to prevent the spread of. Antibiotic stewardship programs play a critical role in reducing CDI risk by minimizing unnecessary antibiotic use, which disrupts normal gut flora and increases susceptibility to infection. Additionally, thorough environmental cleaning with EPA-approved sporicidal disinfectants is necessary to eliminate *C. difficile* spores from contaminated surfaces. Educating healthcare workers and patients about CDI transmission and prevention further enhances efforts to reduce infection rates.

Probiotics may help prevent CDI, particularly in high-risk populations, but the evidence is mixed. Probiotics, such as *Lactobacillus* and *Saccharomyces boulardii*, work by restoring gut microbiota balance and preventing colonization by *C. difficile*. Several studies suggest that administering probiotics alongside antibiotics can reduce the risk of CDI, especially in hospitalized patients or those receiving broad-spectrum antibiotics. However, the effectiveness of probiotics may vary depending on the strain, dose, and timing of administration. While probiotics show promise in reducing CDI risk, they are not currently recommended as standard prevention due to inconsistent results and limited evidence in certain populations, such as immunocompromised patients. Probiotic therapy should be avoided in patients who are immunosuppressed, pregnant/nursing, patients with pancreatitis, or patients who have a prosthetic heart valve.

Table 1: Recommended Antibiotic Therapy for CDI

Clinical Definition	Supportive Clinical Data	Recommended Antibiotic Therapy
Asymptomatic (colonized)	Positive *C. difficile* DNA amplification test without diarrhea, ileus, or colitis	None
Initial episode (**non-fulminant**)	Significant, ileus, or colonoscopy/biopsy findings consistent with pseudomembranous colitis	Vancomycin 125 mg PO q6h for 10 days
Initial episode of **fulminant** disease	Presence of hypotension, shock, ileus, bowel obstruction, toxic megacolon, bowel perforation, or peritonitis	Metronidazole 500 mg IVPB q8h + vancomycin 500 mg PO q6h for 10-14 days
Initial episode of **complicated fulminant** disease	Complete ileus, bowel obstruction, or fecal diversion	Metronidazole 500 mg IVPB q8h + vancomycin 500 mg PO q6h + vancomycin 500 mg/NS 100 mL enema (retained for 1 hr) administered every 6 hours for 10-14 days
Recurrent CDI episode stratified by disease severity (mild-moderate, severe, or complicated severe)		ID consult recommended Vancomycin taper plus pulse dosing: 125 mg PO q6h x 10-14 days, followed by 125 mg PO q12h x 7 days, followed by 125 mg daily x 7 days, followed by 125 mg every 2-3 days for 2-8 weeks
Second or more recurrent CDI episode		ID consult strongly recommended; may require fidaxomicin (non-formulary and restricted to ID) Vancomycin taper plus pulse dosing: 125 mg PO q6h x 10-14 days, followed by 125 mg PO q12h x 7 days, followed by 125 mg daily x 7 days, followed by 125 mg every 2-3 days for 2-8 weeks OR Vancomycin 125 mg PO q6h for 10 days followed by rifaximin 400 mg TID for 20 days
Unable to take oral medications		Vancomycin 500 mg/NS 100 mL enema (retained for 1 hr) administered every 6 hours ± metronidazole 500 mg IVPB q8h for 10-14 days

References:

1. Bakken JS, Carroll KC, et al. Clinical Practice Guidelines for Clostridium difficile Infection in Adults and Children: 2017 Update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA). Clinical Infectious Diseases. 2018 Feb 15, cix1085, https://doi.org/10.1093/cid/cix1085.
2. Owens RC. *Clostridium difficile*-associated disease: an emerging threat to patient safety: insights from the Society of Infectious Diseases Pharmacists. Pharmacotherapy. 2006 Mar;26(3):299-311.
3. Nebraska Medicine. Antimicrobial Stewardship Program. Clinical Pathway for Clostridium difficile Infection (CDI). http://www.nebraskamed.com/careers/education-programs/asp.
4. Anderson SM, Auwaerter PG. John Hopkins Medicine. Clostridium difficile Infection (CDI). Antibiotic Guidelines. May 10, 2024. (Accessed March 2025.)
5. Kelly CP, Lamont JT. *Clostridioides difficile* infection in adults: Treatment and prevention. Calderwood SB, UpToDate, Waltham, MA. March 07, 2025. (Accessed March 2025.)

6. Kelly, CP, Bakken JS, Lamont JT. Clostridium difficile infection in adults: Clinical manifestations and diagnosis. Calderwood SB, UpToDate, Waltham, MA. February 03, 2025. (Accessed March 2025.)
7. Sunenshine RH, McDonald LC. Clostridium difficile-associated disease: new challenges from an established pathogen. Cleve Clin J Med. 2006 Feb;73(2):187-97. doi: 10.3949/ccjm.73.2.187. PMID: 16478043.
8. Bauer MP, Kujper EJ, et al. European Society of Clinical Microbiology and Infectious Diseases: update of the treatment guidance document for Clostridium difficile infection. Clin Microbiol Infect. 2014;20 Suppl 2:1.
9. Ancy K, Crawford CV, et al. Timely Use of Probiotics in Hospitalized Adults Prevents Clostridium difficile Infection: A Systematic Review With Meta-Regression Analysis. Gastroenterology. 2017 Jun;152(8):1889-1900.e9. doi: 10.1053/j.gastro.2017.02.003. Epub 2017 Feb 10.
10. Johnston BC, Ma SS, Goldenburg JZ, et al. Probiotics for the prevention of clostridium difficile-associated diarrhea: A systematic review and meta-analysis. Ann Int Med 2012. https://annals.org/article.aspx?articleid=1390418.
11. Dubberke, E. R., & Gerding, D. N. (2019). Prevention of Clostridioides difficile infection: Infection control and antimicrobial stewardship. Clinical Infectious Diseases, 68(9), 1456-1464.
12. Drekonja, D. M., Butler, M., MacDonald, R., et al. (2020). Antimicrobial stewardship programs: A systematic review. Infection Control & Hospital Epidemiology, 41(2), 137-144.
13. McDonald, L. C., Gerding, D. N., Johnson, S., et al. (2018). Clinical practice guidelines for Clostridium difficile infection in adults and children. Clinical Infectious Diseases, 66(7), e1-e48.
14. Rutala, W. A., & Weber, D. J. (2019). Disinfection and sterilization in healthcare facilities: An overview. American Journal of Infection Control, 47(Suppl 1), A3-A9.
15. Goldenberg, J. Z., Yap, C., Lytvyn, L., et al. (2017). Probiotics for the prevention of Clostridium difficile-associated diarrhea in adults and children. Cochrane Database of Systematic Reviews, 12(12), CD006095.
16. McFarland, L. V. (2016). Prevention of Clostridium difficile infection: Probiotics and fecal microbiota transplantation. Microbiology Spectrum, 4(4), 10.1128/microbiolspec.EI10-0010-2016.
17. Pillai, A., & Nelson, R. L. (2018). Probiotics for treatment of Clostridium difficile-associated colitis in adults. Cochrane Database of Systematic Reviews, 2018(3), CD004611.
18. Shen, N. T., Maw, A., Tmanova, L. L., et al. (2017). Timely use of probiotics in hospitalized adults prevents Clostridium difficile infection: A systematic review with meta-regression analysis. Gastroenterology, 152(8), 1889-1900.
19. Sanford Guide to Antimicrobial Therapy. Mobile application. *Clostridioides difficile, C. diff*. Updated January 05, 2025. (Accessed March 2025).

IVHD-Pioneers Memorial Hospital Antimicrobial Stewardship Program
Antimicrobial Guidelines for Adult Inpatients with Urinary Tract Infections

Diagnosis	Empiric Antimicrobial Therapy
Asymptomatic bacteriuria	-Do NOT treat unless: • Pregnant: treat for 7 days • Planned urologic procedure with a risk for mucosal bleeding -If treatment recommended, follow empiric antimicrobial therapy recommendations for uncomplicated cystitis using a β-lactam antibiotic
Cystitis (uncomplicated)	Nitrofurantoin (Macrobid®) 100 mg PO BID x 5 days (preferred) OR Cephalexin 500 mg PO BID x 7 days OR Cefazolin 1 g IV every 8 hours x 5 days ***Severe Beta-Lactam Allergy*** Nitrofurantoin (Macrobid®) 100 mg PO BID x 5 days OR Gentamicin 5 mg/kg IVPB x 1 dose
Complicated cystitis	Nitrofurantoin (Macrobid®) 100 mg PO BID x 7 days (preferred) OR Cephalexin 1000 mg PO TID x 7 days OR Cefazolin 2 g IV every 8 hours x 7 days ***Severe Beta-Lactam Allergy*** Nitrofurantoin (Macrobid®) 100 mg PO BID x 7 days OR Gentamicin 5 mg/kg IVPB x 1, then per pharmacy protocol x 7 days
Pyelonephritis (uncomplicated)	Ceftriaxone 2 g IV every 24 hours x 7 days ***Severe Beta-Lactam Allergy*** Gentamicin 5 mg/kg IVPB x 1, then per pharmacy protocol x 7 days
Pyelonephritis or complicated cystitis w/MDRO risk factor/s	Cefepime 2 g IV every 8 hours x 7 days ***Severe Beta-Lactam Allergy*** Tobramycin 7 mg/kg IVPB x 1, then per pharmacy protocol x 7 days
Pyelonephritis or complicated cystitis w/ESBL risk factor/s	Ertapenem 1 g IV every 24 hours x 7 days (RESTRICTED) ***Severe Beta-Lactam Allergy*** Tobramycin 7 mg/kg IVPB x 1, then per pharmacy protocol x 7 days
Complicated Urinary Tract Infection with Sepsis or Bacteremia, Complicated Pyelonephritis, Pyelonephritis in Pregnancy, or Perinephric Abscess	Piperacillin-Tazobactam 4.5 g IVPB every 6 hours x 7 days OR (if ESBL risk factor/s present) Imipenem-Cilastatin 500 mg IVPB every 6 hours x 7 days (RESTRICTED) ***Severe Beta-Lactam Allergy*** Aztreonam 2 g IVPB every 8 hours (RESTRICTED) PLUS Vancomycin 25 mg/kg IVPB x 1, then dosed per pharmacy protocol

*Empiric antimicrobial therapy should be modified to cover microorganisms present on urine cultures obtained within previous year
*Fluoroquinolones are not recommended as 1st line agents due to *Escherichia coli* resistance and risk of associated toxicities
*SMX-TMP is not recommended as 1st line agent due to *Escherichia coli* resistance
*β-lactam antibiotics and fluoroquinolones concentrate in the urine; may be clinically effective for cystitis when C&S results demonstrate intermediate susceptibility
*MDRO risk factors: history of UTI or colonization with MDRO within the previous 12 months, hospitalization for ≥ 48 hours with receipt of broad-spectrum antibiotics in the past 90 days, immunocompromised (solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, AIDS with CD4 < 200, or taking ≥ 10 mg prednisone or equivalent/day x 2 weeks), hemodynamic instability requiring ICU admission
*ESBL risk factors: infection or colonization with an ESBL-producing organism within the past 12 months, or for the treatment of severe infection (sepsis, hemodynamic instability, ICU admission) if urinary catheter present or patient received > 5 days anti-*Pseudomonal* antibiotic therapy (piperacillin-tazobactam, ceftazidime, cefepime, aztreonam, levofloxacin, ciprofloxacin) or a carbapenem within the past 90 days.

Empiric antimicrobial therapy for multi-drug resistant organisms (MDRO): Patients presenting with a complicated UTI or pyelonephritis with at least one risk factor for infection with a multi-drug resistant gram-negative organism should receive antimicrobial therapy that covers *Pseudomonas aeruginosa*. Risk factors for infection with a multi-drug resistant gram-negative organism include:

- History of UTI or colonization with MDRO within the previous 12 months
- Hospitalization for ≥ 48 hours with receipt of broad-spectrum antibiotics in the past 90 days
- Immunocompromise: solid organ transplant, splenectomy, hematologic malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, AIDS with CD4 < 200, or taking ≥ 10 mg prednisone or equivalent/day x 2 weeks
- Hemodynamic instability requiring ICU admission

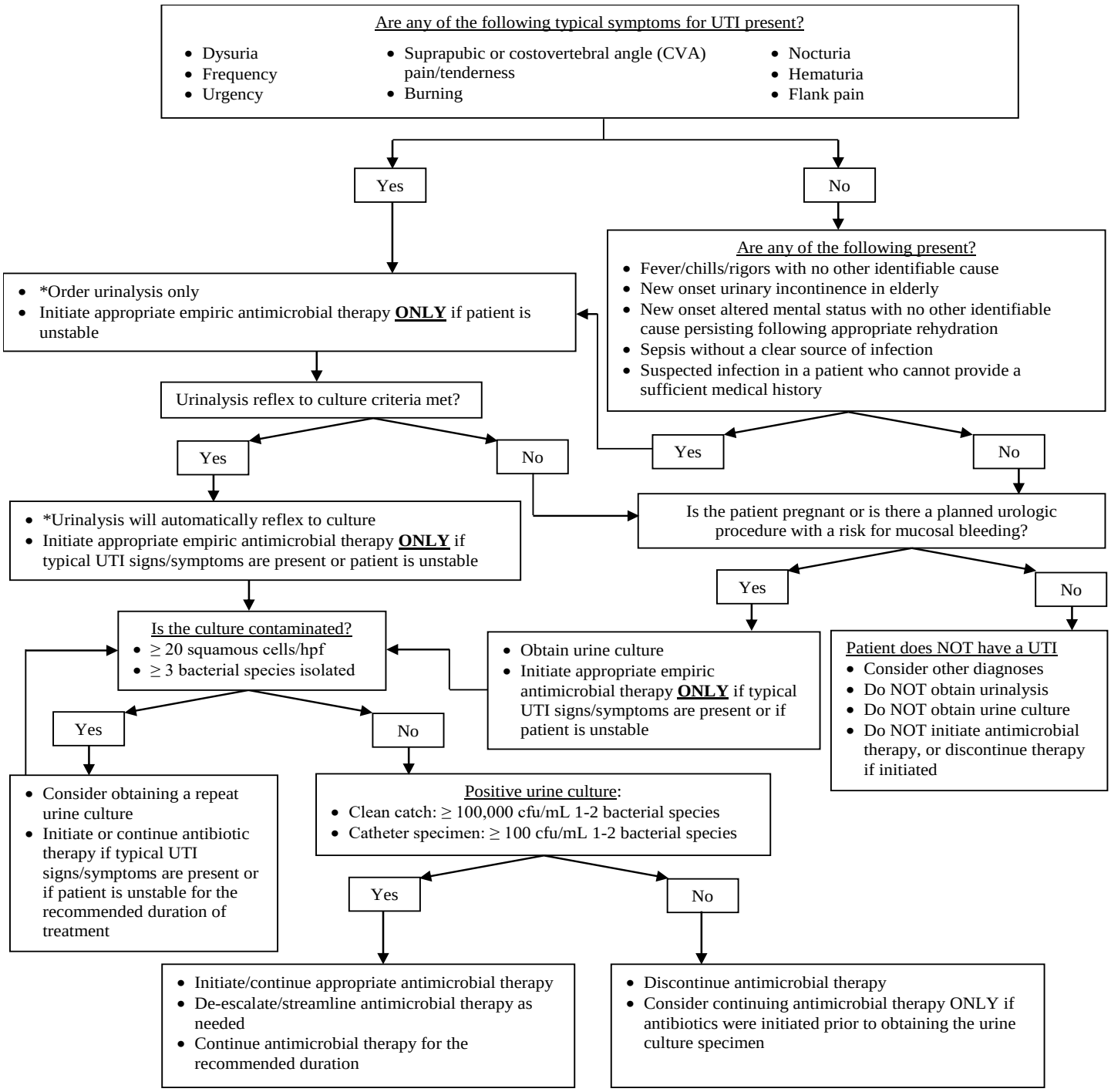
The addition of a second empiric antimicrobial agent to cover for multi-drug resistant gram-negative pathogens (combination therapy) is not recommended for the treatment of UTIs. Cefepime and tobramycin provide excellent coverage for *PsA*. Combination therapy including a fluoroquinolone with an aminoglycoside may not significantly increase the susceptibility rate in comparison to each individual agent.

Carbepenem restriction: Infection rates with carbapenem-resistant enterobacteriaceae (CRE) are on the rise, and the US Center for Disease Control and Prevention has recognized CRE infections as an urgent public health threat. Taking into consideration the high mortality rate associated with and limited options available to treat infections due to CRE, carbapenems (including meropenem) should be reserved for treating patients at high-risk for extended spectrum beta-lactamase (ESBL) producing gram-negative pathogens. Meropenem is recommended for empiric therapy in patients with a history of infection or colonization with an ESBL-producing organism within the past 12 months, or for the treatment of **severe infection (sepsis, hemodynamic instability, ICU admission)** if urinary catheter present or patient received > 5 days anti-Pseudomonal antibiotic therapy (piperacillin-tazobactam, ceftazidime, cefepime, aztreonam, levofloxacin, ciprofloxacin) or a carbapenem within the past 90 days.. To preserve the effectiveness of carbapenems, de-escalation of empiric carbapenem therapy based on culture and susceptibility results is of utmost importance and should occur no later than 72 hours after initiation.

Extended-spectrum beta-lactamase (ESBL) positive cases: The Infectious Diseases Society of America (IDSA) recommends numerous options outside of the carbapenem class of antibiotics to treat UTIs with laboratory confirmed ESBL producing enterobacterales when culture & susceptibility results demonstrate susceptibility. If a patient was started on a carbapenem empirically and susceptibility to one of these agents is demonstrated, patients should be transitioned to one of these agents to complete their treatment course to preserve carbapenem activity. The following treatment options are recommended when susceptible based on C&S results:

- Uncomplicated Cystitis
    - Nitrofurantoin (Macrobid®) 100 mg PO BID x 5 days (females) or 7 days (males)
    - Sulfamethoxazole-Trimethoprim 800 mg-160 mg IV/PO q12h x 3 days (females) or 7 days (males)
    - Alternatives
        - Tobramycin 5 mg/kg IVPB x 1 dose
        - Levofloxacin 750 mg IV/PO q24h x 3 days (females) or 7 days (males)
        - Ciprofloxacin 500 mg PO q12h x 3 days (females) or 7 days (males)
        - Ciprofloxacin 400 mg IV q12h x 3 days (females) or 7 days (males)
- Complicated Cystitis or Pyelonephritis
    - Sulfamethoxazole-Trimethoprim 800 mg-160 mg IV/PO q12h x 7-14 days
    - Levofloxacin 750 mg IV/PO q24h x 7-14 days
    - Ciprofloxacin 500 mg PO q12h x 7-14 days
    - Ciprofloxacin 400 mg IV q12h x 7-14 days
    - Tobramycin 7 mg/kg IVPB x1, then per pharmacy protocol x 7-14 days

Figure 1: Asymptomatic Bacteriuria and UTI Management Pathway



*All urinalyses that meet pre-defined reflex criteria that support a UTI diagnosis automatically reflex to culture at PMHD. There is no need to order a separate urine culture for adult patients unless patient is pregnant or patient has a planned urologic procedure.

PMHD Urinalysis to Urine Culture Reflex Criteria Urinalysis will automatically reflex to culture if one of the following is present:	
Clean-Catch Specimen	**Catheter Specimen**
• ≥ 6-10/hpf WBC • Few or more bacteria • Nitrite positive	• ≥ 3-5/hpf WBC • Rare or more bacteria • Nitrite positive

ANTIMICROBIAL STEWARDSHIP PROGRAM
IMPERIAL VALLEY HEALTHCARE DISTRICT
PIONEERS MEMORIAL HOSPITAL

References:

1. Hooton TM. Clinical practice. Uncomplicated urinary tract infection. N Engl J Med. 2012 Mar 15;366(11):1028-37, editorial can be found in N Engl J Med 2012 Mar 15;366(11):1028
2. Fihn SD. Clinical practice. Acute uncomplicated urinary tract infection in women. N Engl J Med. 2003 Jul 17;349(3):259-66, commentary can be found in N Engl J Med 2003 Oct 23;349(17):1674 full-text
3. Gupta K, Hooton TM, Naber KG, et al. International clinical practice guidelines for the treatment of acute uncomplicated cystitis and pyelonephritis in women: a 2010 update by the Infectious Diseases Society of America and the European Society for Microbiology and Infectious Diseases. Clin Infect Dis. 2011 Mar 1;52(5):e103-20 full-text, editorial can be found in Clin Infect Dis 2011 Mar 1;52(5):e103
4. Grabe M, Bartoletti R, Bjerklund-Johansen TE, et al. European Association of Urology (EAU). Guidelines on urological infections. EAU 2015 Mar PDF
5. Ramakrishnan K, Scheid DC. Diagnosis and management of acute pyelonephritis in adults. Am Fam Physician. 2005 Mar 1;71(5):933-42 full-text, correction in Am Fam Physician 2005 Dec 1;72(11):2182, commentary can be found in Am Fam Physician 2005 Dec 1;72(11):2180 full-text
6. Bradley SF, Cardenas DD, et al. Diagnosis, prevention, and treatment of catheter-associated urinary tract infection in adults: 2009 International Clinical Practice Guidelines from the Infectious Diseases Society of America. [published online March 21, 2019]. Clin Infect Dis. doi: 10.1093/cid/ciy1121.
7. Uncomplicated urinary tract infection (UTI) (pyelonephritis and cystitis). In DynaMed [database online], Ipswich MA: EBSCO. http://www.dynamed.com/topics/dmp~AN~T116894/Uncomplicated-urinary-tract-infection-UTI-pyelonephritis-and-cystitis. November 29, 2018. (Accessed March 2019).
8. Complicated urinary tract infection (UTI). In DynaMed [database online], Ipswich MA: EBSCO. http://www.dynamed.com/topics/dmp~AN~T114928/Complicated-urinary-tract-infection-UTI. March 26, 2019. (Accessed April 2019).
9. John Hopkins Medicine. Antibiotic Guidelines; online database. (Accessed April 2019).
10. Melia M. Sanford Guide to Antimicrobial Therapy. Mobile application. Bacterial Cystitis, Acute, Uncomplicated. October 15, 2022. (Accessed March 2025).
11. Melia M. Sanford Guide to Antimicrobial Therapy. Mobile application. Urinary Tract Infection, Complicated (UTI). November 4, 2023. (Accessed March 2025).
12. Melia M. Sanford Guide to Antimicrobial Therapy. Mobile application. Urinary Tract Infections in Pregnancy. August 3, 2016. (Accessed March 2025).
13. Melia M. Sanford Guide to Antimicrobial Therapy. Mobile application. Pyelonephritis, Acute, Uncomplicated. June 10, 2024. (Accessed March 2025).
14. Melia M. Sanford Guide to Antimicrobial Therapy. Mobile application. Pyelonephritis, Acute, Uncomplicated. June 10, 2024. (Accessed March 2025).
15. Sanford Guide to Antimicrobial Therapy. Mobile application. Perinephric Abscess. Updated August 26, 2024. (Accessed March 2025).
16. Sanford Guide to Antimicrobial Therapy. Mobile application. Pyelonephritis, Acute. Updated January 7, 2025. (Accessed March 2025).
17. Sanford Guide to Antimicrobial Therapy. Mobile application. UTI, Acute, Uncomplicated, Adult, Female. Updated September 10, 2024. (Accessed March 2025).
18. Sanford Guide to Antimicrobial Therapy. Mobile application. UTI, Complicated or Catheter-related. Updated January 7, 2025. (Accessed March 2025).
19. Sanford Guide to Antimicrobial Therapy. Mobile application. UTI, Adult, Male. Updated July 10, 2023. (Accessed March 2025).
20. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. (Accessed March 2025).

21. Bradley S, Colgan R, et al. Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America. [published online March 21, 2019]. Clin Infect Dis. doi: 10.1093/cid/ciy1121.
22. Tamma PD, Aitken SL, Bonomo RA, Mathers AJ, van Duin D, Clancy CJ. Infectious Diseases Society of America Antimicrobial-Resistant Treatment Guidance: Gram-Negative Bacterial Infections. Infectious Diseases Society of America 2022; Version 1.1. Available at https://www.idsociety.org/practice-guideline/amr-guidance/. Accessed December 15, 2023.
23. Aidan Yetsko, Heather M Draper, Kristen Eid, Andrew P Jameson, Lisa E Dumkow, Two Times Versus Four Times Daily Cephalexin Dosing for the Treatment of Uncomplicated Urinary Tract Infections in Females, Open Forum Infectious Diseases, Volume 10, Issue 9, September 2023, ofad430, https://doi.org/10.1093/ofid/ofad430.

IVHD-Pioneers Memorial Hospital Antimicrobial Stewardship Program
Antimicrobial Guidelines for Adults with Skin and Soft Tissue Infections and Osteomyelitis

Table 1: Empiric Antimicrobial Therapy and Duration for SSTIs and Osteomyelitis

- ***Purulent cellulitis*** *includes abscess, furuncle, carbuncle, or cellulitis with purulent drainage/exudate*
- ***Complicated infections*** *include any of the following: deep infection (e.g. pyomyositis, joint or graft infection), compartment syndrome, wound or injury (e.g. bite, pressure ulcer, puncture wound, burn wound), IV drug use, fresh water exposure, or involvement of the face, neck, hand, perineum, or genitalia*
- *For uncomplicated and/or mild-moderate infections, infections due to Pseudomonas aeruginosa are rare. Provide empiric therapy only if there was significant fresh water exposure or recent isolation (previous 12 months) of Pseudomonas aeruginosa.*

Infection	Mild-Moderate	[1]Severe
Purulent Cellulitis (Uncomplicated)	Bactrim DS® 1-2 tabs PO q12h **OR** Doxycycline 100 mg PO/IVPB q12h	Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol
Duration: 5-10 days		
Nonpurulent Cellulitis (Uncomplicated)	Cefadroxil 500 mg PO q12h **OR** Cefazolin 2 g IVPB q8h **± (if any [2]MRSA risk factor is present)** Doxycycline 100 mg PO/IVPB q12h OR Bactrim DS® 1 tab PO q12h ***Severe PCN Allergy*** Levofloxacin 750 mg PO/IVPB q24h **± (if any [2]MRSA risk factor is present)** Bactrim DS® 1 tab PO q12h OR Doxycycline 100 mg PO/IVPB q12h	Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol
Duration: 5-7 days for positive response, extend for up to 14 days for severe infection or slow response to therapy		
Complicated Cellulitis	Ceftriaxone 2 g IVPB q24h **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Doxycycline 100 mg IVPB q12h ***Severe PCN Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Doxycycline 100 mg IVPB q12h	Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Piperacillin-tazobactam 4.5 g IVPB q6h q24h ***Mild PCN Allergy*** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Cefepime 2 g IVPB q8h **PLUS** Metronidazole 500 mg IVPB q8h ***Severe PCN Allergy*** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Aztreonam 2 g IVPB q8h **PLUS** Metronidazole 500 mg IVPB q8h

Infection	Mild-Moderate	[1]Severe
Impetigo	Limited disease: Mupirocin ointment TID x 5-7 days Extensive tissue involvement: Cephalexin 500 mg PO q6h **OR** **± (if any [2]MRSA risk factor is present)** Bactrim DS® 1 tab PO q12h **OR** Doxycycline 100 mg PO q12h ***Severe PCN Allergy*** Levofloxacin 750 mg PO q24h **± (if any [2]MRSA risk factor is present)** Bactrim DS® 1 tab PO q12h OR Doxycycline 100 mg PO q12h	
Duration: 7 days		
Necrotizing Fasciitis or Clostridial myonecrosis (gas gangrene)	***Adjunct therapy only; prompt surgical debridement required*** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Piperacillin-tazobactam 4.5 g IVPB q6h **PLUS** Clindamycin 900 mg IVPB q8h ***Mild PCN Allergy*** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Cefepime 2 g IVPB q8h **PLUS** Clindamycin 900 mg IVPB q8h ***Severe PCN Allergy*** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Aztreonam 2 g IVPB q8h **PLUS** Clindamycin 900 mg IVPB q8h	
Duration: tailored to individual; continue until no further surgical debridement is necessary, clinical improvement achieved, and afebrile x 48 hours		
Osteomyelitis	Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Ceftriaxone 2 g IVPB q24h ***Severe PCN Allergy*** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Aztreonam 2 g IVPB q8h	Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Cefepime 2 g IVPB q8h ***Severe PCN Allergy*** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol **PLUS** Aztreonam 2 g IVPB q8h
Duration: tailored to individual; at least 6 weeks from last debridement, or 2-5 days for complete amputation and margins clear at surgery		

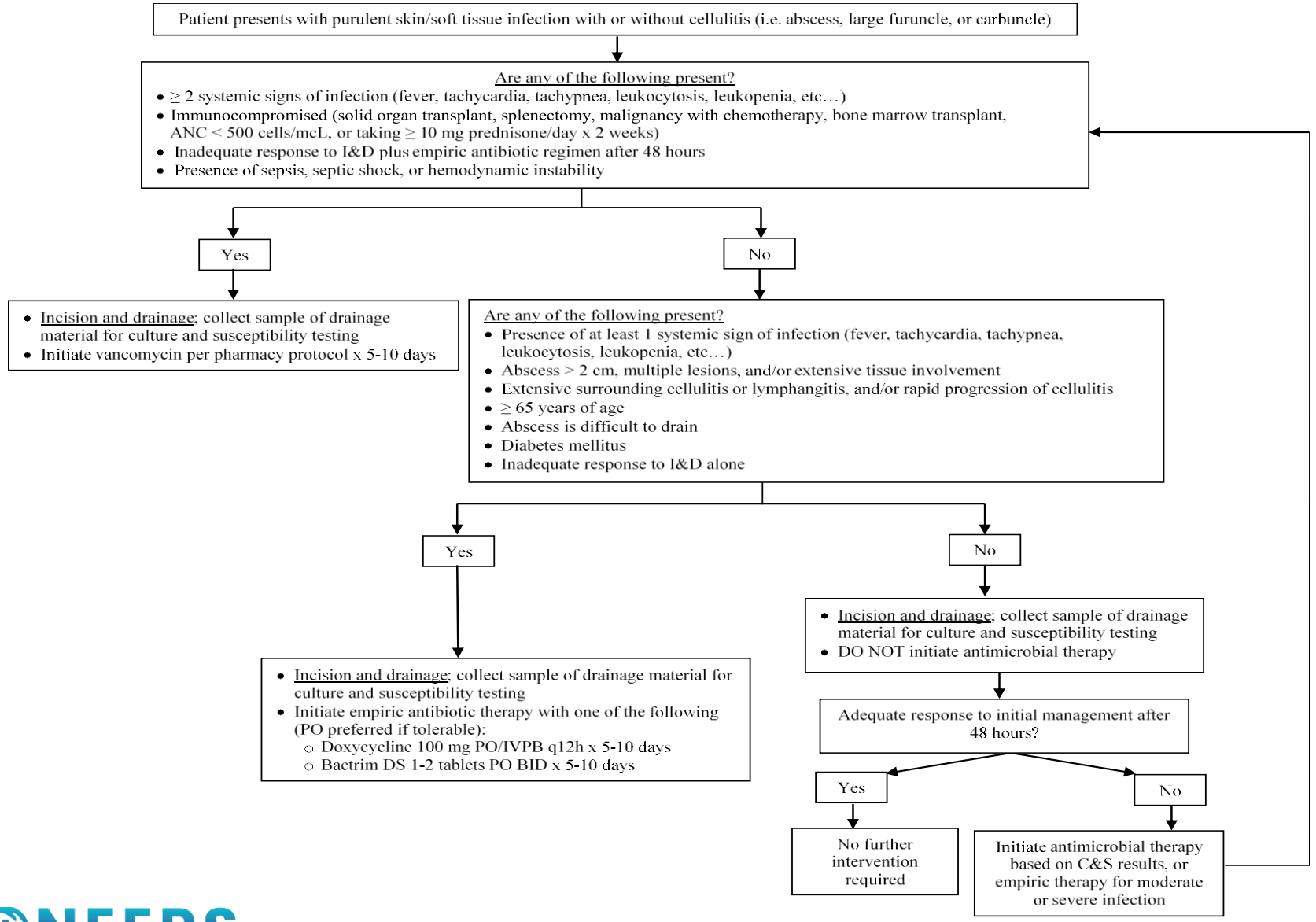
[1]Severe includes any of the following: ≥ 2 systemic signs/symptoms of toxicity (fever, tachycardia, tachypnea, leukocytosis, leukopenia, etc…), immunocompromised (solid organ transplant, splenectomy, malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, or taking ≥ 10 mg prednisone/day x 2 weeks), inadequate response to I&D and/or empiric antibiotic regimen after 48 hours, recent hospitalization for ≥ 48 hours within previous 90 days, received broad-spectrum antibiotics ≥ 7 days within previous 30 days, or presence of sepsis, septic shock, or hemodynamic instability
[2]MRSA risk factors: MRSA infection or colonization within previous 12 months, compromised immune system, recent hospitalization for ≥ 48 hours within previous 90 days, received broad-spectrum antibiotics ≥ 7 days within previous 30 days, hemodialysis, post-operative wound, swine farming, residence in a long-term healthcare facility, incarceration, current military service, injection drug use, contact sports participation, or men who have sex with men

Table 2: Empiric Antimicrobial Therapy and Duration for Diabetic Foot Infections

Mild	Moderate	[1]Severe
Cefadroxil 500 mg PO q12h **OR** Cefazolin 2 g IVPB q8h **± (if any [2]MRSA risk factor is present)** Bactrim DS® 1 tab PO q12h **OR** Doxycycline 100 mg PO/IVPB q12h	Ceftriaxone 2 g IVPB q24h **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol	Piperacillin-tazobactam 4.5 g IVPB q6h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol ***Mild PCN Allergy*** Cefepime 2 g IVPB q8h **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol
Severe PCN Allergy Levofloxacin 750 mg PO/IVPB q24h **± (if any [2]MRSA risk factor is present)** Bactrim DS® 1 tab PO q12h **OR** Doxycycline 100 mg PO/IVPB q12h	***Severe PCN Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol	***Severe PCN Allergy*** Aztreonam 2 g IVPB q8h **PLUS** Metronidazole 500 mg IVPB q8h **PLUS** Vancomycin 25 mg/kg IVPB x 1, then per pharmacy protocol
Duration: tailor to individual - mild infections: until no evidence of infection (1-2 weeks, but may take up to 4 weeks) - moderate-severe infections: until no evidence of infection (1-4 weeks, but may need to be extended up to 3 months if bone or joint involvement) - amputation: 1 week if entire infection is completely resected		

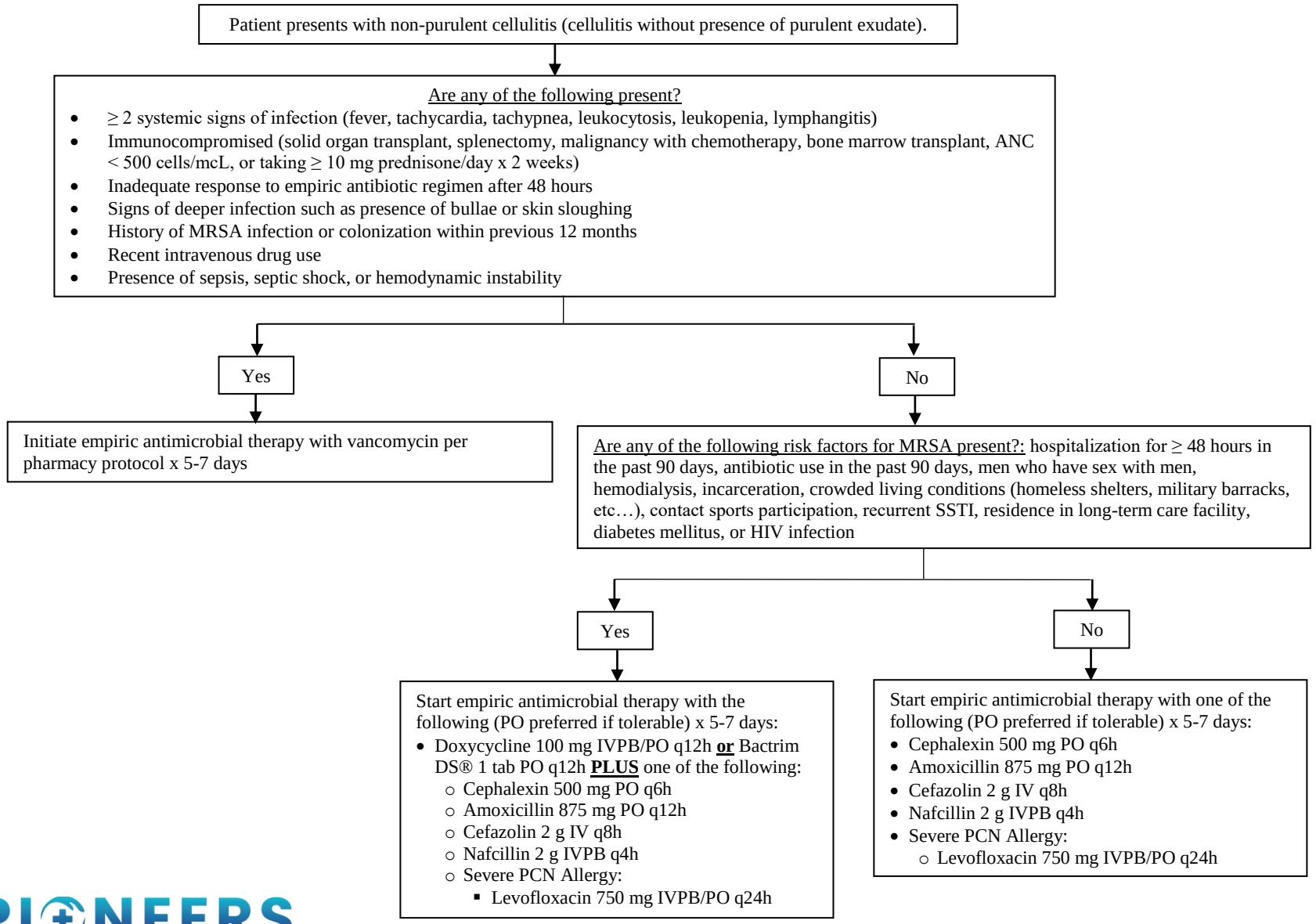
[1]Severe infections include presence of any of the following: ≥ 2 systemic signs/symptoms of toxicity (fever, tachycardia, tachypnea, leukocytosis, leukopenia, etc…), immunocompromised (solid organ transplant, splenectomy, malignancy with chemotherapy, bone marrow transplant, ANC < 500 cells/mcL, or taking ≥ 10 mg prednisone/day x 2 weeks), recent hospitalization for ≥ 48 hours within previous 90 days, received broad-spectrum antibiotics ≥ 7 days within previous 30 days, deep infection (e.g. pyomyositis, joint or graft infection), compartment syndrome, wound or injury (e.g. bite, pressure ulcer, puncture wound), IV drug use, fresh water exposure, or presence of sepsis, septic shock, or hemodynamic instability.
[2]MRSA risk factors: MRSA infection or colonization within previous 12 months, compromised immune system, recent hospitalization for ≥ 48 hours within previous 90 days, received broad-spectrum antibiotics ≥ 7 days within previous 30 days, hemodialysis, post-operative wound, swine farming, residence in a long-term healthcare facility, incarceration, current military service, injection drug use, contact sports participation, or men who have sex with men

Figure 1: Management Algorithm for Purulent Skin/Soft Tissue Infection (Uncomplicated)



PIONEERS IMPERIAL VALLEY HEALTHCARE DISTRICT

Figure 2: Management Algorithm for Nonpurulent Cellulitis (Uncomplicated)



PIONEERS IMPERIAL VALLEY HEALTHCARE DISTRICT

References:

1. Bisno AL, Chambers HF, et al. Practice guidelines for the diagnosis and management of skin and soft tissue infections: 2014 update by the Infectious Diseases Society of America. Clin Infect Dis. 2014 Jul 15;59(2):e10-52. doi: 10.1093/cid/ciu444.
2. Jackson JD. Infectious folliculitis. Rosen T, UpToDate, Waltham, MA. January 24, 2025, (Accessed March 2025).
3. Baddour LM, Spelman D. Cellulitis and skin abscess: Clinical manifestation and diagnosis. Kaplan SL, Sexton DJ, UpToDate. Waltham, MA. June 17, 2024. (Accessed December 2024).
4. Baddour LM, Spelman D. Acute cellulitis and erysipelas in adults: Treatment. Nelson S. UpToDate, Waltham, MA. December 12, 2024. (Accessed December 2024).
5. Baddour LM, Spelman D. Skin abscesses in adults: Treatment. Nelson S. UpToDate, Waltham, MA. November 27, 2024. (Accessed December 2024).
6. Baddour LM, Stevens DL. Necrotizing soft tissue infections. Edwards MS, Wessels MR. UpToDate, Waltham, MA. February 27, 2024. (Accessed December 2024).
7. Tande AJ. Osteomyelitis in the absence of hardware: Approach to treatment in adults. Nelson S. UpToDate, Waltham, MA. July 5, 2024. (Accessed December 2024).
8. Weintrob AC. Diabetic foot infections, including osteomyelitis: Treatment. Nelson S. UpToDate, Waltham, MA. July 2, 2024. (Accessed December 2024).
9. Skin abscesses, furuncles, and carbuncles. In DynaMed [database online], Ipswich MA: EBSCO. http://www.dynamed.com/topics/dmp~AN~T116747/Skin-abscesses-furuncles-and-carbuncles. (Accessed April 2019).
10. Nebraska Medicine. Antimicrobial Stewardship Program. Guidelines for Treatment of Skin and Soft Tissue Infections. http://www.nebraskamed.com/careers/education-programs/asp.
11. John Hopkins Medicine. Antibiotic Guidelines; online database. (Accessed December 2024).
12. Sanford Guide to Antimicrobial Therapy. Mobile application. (Accessed December 2024).
13. Necrotizing fasciitis. In DynaMed [database online], Ipswich MA: EBSCO. http://www.dynamed.com/topics/dmp~AN~T114375/Necrotizing-fasciitis. (Accessed December 2024).
14. Lipsky, B. A., et al. (2012). "2012 Infectious Diseases Society of America clinical practice guideline for the diagnosis and treatment of diabetic foot infections." Clinical Infectious Diseases 54(12): e132-173.
15. Sexton DJ, Weintrob AC. Clinical manifestations, diagnosis, and management of diabetic infections of the lower extremities. Calderwood SB, UpToDate, Waltham, MA. (Accessed December 2024).
16. Lalani T. Overview of osteomyelitis in adults. Sexton DJ, UpToDate, Waltham, MA. (Accessed December 2024).
17. Osteomyelitis. In DynaMed [database online], Ipswich MA: EBSCO. http://www.dynamed.com/topics/dmp~AN~T116047/Osteomyelitis. (Accessed April 2019).
18. Lalani T. Osteomyelitis in the absence of hardware: Approach to diagnosis in adults. Nelson S. UpToDate, Waltham, MA. November 19, 2024. (Accessed December 2024).

IVHD-Pioneers Memorial Hospital
Statement of Leadership Commitment to Antimicrobial Stewardship

The Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America estimate that 20%-50% of antimicrobial use is inappropriate, creating resistant bacteria that are susceptible to few, if any, antibiotic agents currently available. In response to this growing public health threat and as part of our commitment to provide the best quality of care to our patients, IVHD-Pioneers Memorial Hospital has developed and implemented an antimicrobial stewardship program (ASP). The ASP at IVHD-Pioneers Memorial Hospital is dedicated to improving antibiotic utilization and reducing the development of antibiotic resistance within our community

Our ASP team is committed to achieving optimal clinical outcomes related to antimicrobial use (e.g. reduced morbidity, reduced mortality, and reduced length of hospital stay) while minimizing toxicity, adverse events, and the emergence of antimicrobial-resistant organisms. The ASP team at IVHD-Pioneers Memorial Hospital will adhere to the Centers for Disease Control and Prevention's (CDC) Core Elements of Hospital Antibiotic Stewardship Programs by implementing interventions outlined in our Antimicrobial Stewardship Program policy including:

- optimizing antimicrobial selection, and providing antimicrobial therapy at the appropriate dose, frequency, and duration according to indication
- routinely reviewing the appropriateness of antibiotic therapy and making recommendations when necessary
- enforcing formulary restrictions and preauthorization requirements
- prospective audits with intervention and feedback
- tracking and reporting data on antimicrobial utilization and resistance

The hospital leadership team of IVHD-Pioneers Memorial Hospital understand that leadership support is critical to the success of the Antimicrobial Stewardship Program, and we are committed to providing dedicated personnel, financial, and information technology resources. We understand that ASP is an interdisciplinary program. In response we have dedicated a clinical pharmacist and physician champion to lead our ASP and oversee the implementation of the program. We will also provide dedicated time for our hospital's infection preventionist and microbiology clinical laboratory scientist to serve as members of the ASP. The ASP team will meet and report to hospital staff as part of the Pharmacy and Therapeutics committee. Improving antimicrobial utilization is a priority at our facility, and IVHD-Pioneers Memorial Hospital leadership is committed to supporting the efforts of the ASP team.

_____	_____
Chief Executive Officer Name/Signature	Date
_____	_____
Chief Medical Officer Name/Signature	Date
_____	_____
Chief Nursing Officer Name/Signature	Date
_____	_____
Director of Pharmacy Name/Signature	Date
_____	_____
Director of Information Systems Name/Signature	Date
_____	_____
Director of Laboratory Services Name/Signature	Date

Imperial Valley Healthcare District

Title: **Criteria for Case Referrals to Morbidity and Mortality Meetings - NICU**	Policy No. CLN-02528
	Page 1 of 2
Current Author: Sandra Taylor, RNC-NIC, BSN	Effective: 3/2023
Latest Review/Revision Date: 02/20/2025	Manual: Clinical / OB

Collaborating Departments: Neonatal; Medical Staff; Quality, Dr Alshareef, NICU Manager MSQC	Keywords: Morbidity, Mortality

Approval Route: List all required approval			
PSQC	Other:		
Clinical Service Pediatrics 4/2025	MSQC 5/2025	MEC 5/2025	BOD 6/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To establish criteria for the referral of cases related to infant death or unexpected adverse outcomes to Morbidity and Mortality (M&M) meetings

2.0 Scope: Neonatal and Perinatal Staff

3.0 Policy:

3.1 It is the policy of Pioneers Memorial Hospital to have a minimum of quarterly M&M reviews held within the Pediatric Committee Meetings.

3.2 Collaborative aims of M&M reviews are to improve the health of pregnant women, infants and children by collecting high quality information on perinatal outcomes and research utilization, which then allow for performance improvement and bench marking processes in perinatal care and neonatal intensive care units.

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 The attending physician in collaboration with the obstetrician identifies neonates that meet the criteria for the M&M meeting.

5.2 These criteria include, but are not limited to:

- 5.2.1 Death
- 5.2.2 Transfer out to another facility
- 5.2.3 Birth that requires extensive resuscitation, i.e., chest compressions, medications during resuscitation
- 5.2.4 Apgars less than 5 at 5 minutes of age
- 5.2.5 Major birth trauma (i.e., neonatal depression)
- 5.2.6 Infants with documented Grade III or Grade IV Intraventricular Hemorrhage
- 5.2.7 Complications from procedure resulting in the prolongation of hospital stay or disability
- 5.2.8 Major congenital abnormalities

5.3 The team will consist of all disciplines involved in the decision making and care for mom and baby, i.e., pediatrician, obstetricians, risk management, quality/performance improvement representative; and/or laboratory, pathologist, NICU and/or OB nurses, radiology, social worker.

5.4 The M&M meeting is held quarterly, at a minimum.

5.5 Infant morbidity and mortality data concerning birth weight, survival, transfer, incidence of certain conditions, and other information, as require, shall be compiled in a CCS-approved format and shall be submitted to the Chief, Children's Medical Services Branch/CCS program; 714 P Street, Room 350; PO Box 942732, Sacramento, Ca 94234-7320; annually and are due on the first day of June for the preceding calendar year

6.0 References:

6.1 California Children's Services Manual of Procedures, 3.25 Standards for Neonatal Intensive Care Units (NICUs). Chapter 3.25.3, section K, number 2, page 27 (1/1/99)

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Reviewed and submitted without change

Imperial Valley Healthcare District

Title: **Standardized Procedure for Registered Nurses: Hypoglycemia in the Newborn**	Policy No. CLN-02506
	Page 1 of 9
Current Author: Sandra Taylor, RNC-NIC, BSN	Effective: 2/1/1987
Last Review/Revision Date: 02/21/2025	Manual: Clinical / OB

Collaborating Departments: Perinatal/Neonatal; NICU Medical Director - Dr. Alshareef, NICU Manager	Keywords: hypoglycemia, glucose, blood glucose, Accu-check

Approval Route: List all required approval			
PSQC	Other:		
Clinical Service Pediatrics 4/2025	MSQC 5/2025	MEC 5/2025	BOD 5/2025

APPROVALS		
AUTHORITY	**SIGNATURE**	**DATE**
ADMINISTRATION		
CHIEF NURSING OFFICER		
PHYSICIAN DEPARTMENT CHAIR		
BOARD OF DIRECTORS		

NOTE: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

REVIEWED ANNUALLY

1.0 Purpose:

1.1 To provide guidelines for obtaining blood glucose in neonates at risk for developing hypoglycemia and to delineate the appropriate interventions for hypoglycemia in newborns in the Perinatal Couplet Care area and the Intermediate NICU.

2.0 Scope: Perinatal and Neonatal Staff

3.0 Policy:

3.1 Neonatal blood glucose testing and interventions will be initiated by competency validated RNs.

3.1.1 Circumstances under which RN may perform Standardized Procedure function(s):

3.1.2 Setting:

3.1.2.1 Competencies validated RN may perform neonatal blood glucose testing and intervention in any area of Pioneers Memorial Hospital providing care to the newborn

3.1.3 Scope of Supervision:

3.1.3.1 Neonatal blood glucose testing and intervention is done under the direct or indirect supervision of the physician.

3.2 Blood glucose concentration should only be measured in any infant who have clinical manifestations or who are known to be at risk.

3.2.1 Routine screening and monitoring of blood glucose concentrations is not needed in the healthy term newborn infant after a normal pregnancy and delivery

3.3 Newborns meeting one of the following criteria are to be observed for hypoglycemia and

bedside blood glucose monitoring and/or serum glucose testing will be implemented:

3.3.1 Within 1 hour of birth:
- 3.3.1.1 Large for gestational age (LGA) with birth weight greater than the 90TH percentile on the infant growth chart (Attachment D [male] or E [female], gender specific)
- 3.3.1.2 Small for gestational age (SGA) with birth weight less than the 10TH percentile in the infant growth chart (Attachment D [male] or E [female], gender specific)
- 3.3.1.3 Premature (37 weeks or less by examination)
- 3.3.1.4 Postmaturity (> 42 weeks gestation by examination)
- 3.3.1.5 Asphyxiated or hypoxic infant (Apgar $\leq$ 5 at 5 minutes of age)
- 3.3.1.6 Cold stressed infant (temperature less than 97.0°F at any time or less than 97.7°F after rewarming intervention
- 3.3.1.7 Admission to the Intermediate NICU
- 3.3.1.8 Respiratory distress including – tachypnea greater than or equal to 80 bpm with grunting, flaring, retracting and/or O_2 desaturation (<88% spo2) in the first hour of life

3.3.2 Within 30 minutes – 1 hour of life:
- 3.3.2.1 Infants of diabetic mothers (insulin dependent or gestational diabetes)

3.3.3 At 2 hours of life:
- 3.3.3.1 All infants with tachypnea greater than or equal to 70 bpm without other signs of distress
- 3.3.3.2 Any infant that met criteria as listed above in 3.3.1

3.3.4 At 6 hours, 12 hours and 24 hours of age:
- 3.3.4.1 All infants that were found to be LGA, SGA, <37 weeks, >42 weeks, Respiratory distress (as listed above in 3.3.1.8) or NICU admissions

3.3.5 At any time for infants exhibiting any of the following signs:
- 3.3.5.1 Apnea
- 3.3.5.2 Respiratory distress including – tachypnea greater than or equal to 70 bpm with grunting, flaring, retraction, and/or O_2 desaturation
- 3.3.5.3 Temperature instability – temperature less than 97.7°F after intervention
- 3.3.5.4 Hypotonia
- 3.3.5.5 Lethargy
- 3.3.5.6 Jitteriness
- 3.3.5.7 Seizure activity
- 3.3.5.8 Poor feeding – poor suck/swallow coordination for 2 consecutive feedings for infants greater than 12 hours of age

3.3.6 Note: If the infant is being fed, the test should be done prior to feeding

3.3.7 For any infant who is receiving IV therapy, testing should be done once every shift

3.4 The physician will be notified when point of care glucose value is:

3.4.1 Less than 25 mg/dl after intervention for infants less than 24 hours old

3.4.2 Less than 25 mg/dl at any time for infants equal to or greater than 24 hours of age
3.4.3 Less than 45 mg/dl with any of the following signs for infants less than 24 hours of age:
3.4.3.1 Apnea
3.4.3.2 Hypotonia
3.4.3.3 Lethargy
3.4.3.4 Seizure activity
3.4.3.5 Respiratory distress including: tachypnea greater than or equal to 80 bpm with grunting, flaring, retracting and/or O_2 desaturation
3.4.4 Less than 45 mg/dl with any signs and symptoms after intervention for infant less than 24 hours of age
3.4.5 Less than 50 mg/dl with any of the following signs for infants at or greater than 24 hours of age:
3.4.5.1 Apnea
3.4.5.2 Hypotonia
3.4.5.3 Lethargy
3.4.5.4 Seizure activity
3.4.5.5 Respiratory distress including: tachypnea greater than or equal to 80 bpm with grunting, flaring, retracting and/or O_2 desaturation
3.4.6 Less than 50 mg/dl after intervention for infants equal to or greater than 24 hours of age
3.4.7 Between 25-44 mg/dl after intervention with 2ND dose of glucose gel for infant less than 24 hours of age without signs
3.4.8 Between 25-44 mg/dl after intervention with 2nd dose of glucose gel for infants less than 24 hours of age with ONLY signs of jitteriness and/or tachypnea greater than or equal to 80 bpm
3.4.9 Between 25-49 mg/dl for infants equal to or greater than 24 hours old with ANY of the following signs ONLY:
3.4.9.1 Jitteriness
3.4.9.2 Temperature instability
3.4.9.3 Poor feeding
3.4.9.4 Poor suck/swallow coordination for 2 consecutive feedings

3.5 The physician will be notified for all infants at any time with rebound hypoglycemia
3.6 For frequency of testing aimed at infants receiving parenteral therapy <*Refer to policy CLN-02517; Intermediate NICU Standards of Practice*>
3.7 RN Requirements:
3.7.1 Education/Training/Experience:
3.7.1.1 RNs successfully oriented to units caring for neonates will perform neonatal blood glucose testing and intervention after successful completion of blood glucose point of care testing competency validation and neonatal blood glucose testing and intervention posttest
3.7.2 Initial and Ongoing Competency Evaluation:
3.7.2.1 Initial competency evaluation includes successful completion of:

3.7.2.1.1 Blood glucose point of care testing initial competency validation
3.7.2.1.2 Standardized Procedure: Blood Glucose in Neonates posttest with score of 100%
3.7.2.2 Annual competency evaluation includes successful completion of:
3.7.2.2.1 Blood glucose point of care testing annual competency validation
3.7.2.2.2 Validation of hypoglycemia management documentation on 1 patient/year, or if this opportunity is not possible, completes Standardized Procedure: Blood Glucose in Neonates posttest with score of 100%

3.8 RN authorized to perform standardized procedure function(s):
3.8.1 A written record of initial and annual competency will be maintained in the employee file in their respective unit. A roster of RNs competency validated to perform blood glucose testing and intervention will be sent to the Chief Nursing Officer and Lab Point of Care coordinator annually by the nursing unit manager.

4.0 Definitions:

4.1 PO – per os – oral
4.2 BPM – breaths per minute
4.3 AC – before feeding
4.4 mL – Milliliters
4.5 Glucose gel – 40% Dextrose oral gel for the treatment of hypoglycemia
4.6 Rebound hypoglycemia – a second episode of hypoglycemia following a previous hypoglycemia event that had resolved with appropriate treatment.
4.7 INICU – Intermediate Neonatal Intensive Care Unit

5.0 Procedure:

5.1 Treatment Pathways – Chose appropriate pathway based on infant's age, point of care blood glucose results and presenting symptoms (*See Attachments A, B and C*).

***NOTE**: must review the infants' history for any prior hypoglycemic events. If infant had any prior hypoglycemia, go directly to PATHWAY IV*

5.1.1 PATHWAY I
5.1.1.1 Infants less than 24 hours of age with point of care blood glucose less than 45 mg/dl without signs of hypoglycemia (*See Attachment A*)
5.1.1.1.1 Under direct supervision of the nurse, place the infant skin to skin with mother if possible to achieve physiologic stability
5.1.1.1.2 Administer glucose gel based on infant's birth weight

INFANT'S BIRTH WEIGHT IN KILOGRAMS	AMOUNT OF GLUCOSE GEL IN mL	DOSE OF 40% GLUCOSE GEL IN GRAMS
1.8 – 2.4 kg	1 mL	0.4 g
2.5 – 2.9 kg	1.25 mL	0.5 g
3 – 3.4 kg	1.5 mL	0.6 g

3.5 – 3.9 kg	1.75 mL	0.7 g
4 – 4.4 kg	2 mL	0.8 g
4.5 – 4.9 kg	2.25 mL	0.9 g
5 kg and above	2.5 mL	1 g

5.1.1.1.3 Feed Infant
- 5.1.1.1.3.1 If breastfeeding, attempt to breastfeed immediately
- 5.1.1.1.3.2 If bottle feeding, bottle feed 5-15 mLs

5.1.1.1.4 Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

5.1.1.1.5 If the repeat point of care glucose is:
- 5.1.1.1.5.1 Less than 45 mg/dl with any signs and symptoms or less than 25 mg/dl, proceed to PATHWAY IV
- 5.1.1.1.5.2 Between 25-39 mg/dl, without signs, administer glucose gel again and immediately breastfeed or bottle feed 5-15 mLs

5.1.1.1.6 Repeat point of care glucose 30 minutes after intervention

5.1.1.1.7 If the point of care glucose remains 25-39 mg/dl, obtain STAT serum glucose and notify the physician immediately for further orders

5.1.1.1.8 If not physician response to notification within 20 minutes, call physician on call for the INICU

5.1.1.1.9 Once the point of care glucose is greater than or equal to 45 mg/dl, obtain AC (before feeding) point of care glucose two times
- 5.1.1.1.9.1 If one of the AC points of care glucose values is less than 45 mg/dl and infant is otherwise asymptomatic, call physician for further orders
- 5.1.1.1.9.2 If either AC point of care glucose is less than 45 mg/dl with any signs and symptoms or less than 25 mg/dl, proceed to PATHWAY IV

5.1.2 <u>PATHWAY II</u>

5.1.2.1 Infants less than 24 hours of age, point of are blood glucose less than 45 mg/dl with only signs of jitteriness and/or tachypnea greater than or equal to 70 bpm without other signs of distress (*See Attachment A*)

5.1.2.1.1 Under direct supervision of the nurse, place the infant skin to skin with mother if possible to achieve physiologic stability

5.1.2.1.2 Administer glucose gel based on infant's birth weight

INFANT'S BIRTH WEIGHT IN KILOGRAMS	AMOUNT OF GLUCOSE GEL IN mL	DOSE OF 40% GLUCOSE GEL IN GRAMS
1.8 – 2.4 kg	1 mL	0.4 g
2.5 – 2.9 kg	1.25 mL	0.5 g

3 – 3.4 kg	1.5 mL	0.6 g
3.5 – 3.9 kg	1.75 mL	0.7 g
4 – 4.4 kg	2 mL	0.8 g
4.5 – 4.9 kg	2.25 mL	0.9 g
5 kg and above	2.5 mL	1 g

5.1.2.1.3 Feed Infant
- 5.1.2.1.3.1 If breastfeeding, attempt to breastfeed immediately
- 5.1.2.1.3.2 If bottle feeding, bottle feed 5-15 mLs. Bottle feed only if respiratory rate is less than 70 bpm. If respiratory rate is greater than or equal to 70 bpm, notify the physician

5.1.2.1.4 Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

5.1.2.1.5 If the repeat point of care glucose is:
- 5.1.2.1.5.1 Less than 45 mg/dl with an signs and symptoms other than jitteriness and/or tachypnea greater than or equal to 70 bpm, OR less than 25 mg/dl, proceed to PATHWAY IV
- 5.1.2.1.5.2 Between 25-44 mg/dl, and the infant is asymptomatic or shows ONLY signs of jitteriness and/or tachypnea greater than or equal to 70 bpm without other signs of distress, administer glucose gel again and immediately breastfeed or bottle feed 5-15 mLs. Bottle feed ONLY if respiratory rate is less than 70 bpm

5.1.2.1.6 Repeat point of care glucose 30 minutes after intervention

5.1.2.1.7 If point of care glucose remains 25-44 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders

5.1.2.1.8 If no physician response to notification within 20 minutes, call physician on call for the INICU

5.1.2.1.9 Once the point of care glucose value is greater than or equal to 45 mg/dl, obtain AC point of care glucose two times
- 5.1.2.1.9.1 If one of the AC points of care glucose values is less than 45 mg/dl and infant is otherwise asymptomatic, call physician for further orders
- 5.1.2.1.9.2 If either AC point of care glucose is less than 45 mg/dl with any signs and symptoms or less than 25 mg/dl, proceed to PATHWAY IV

5.1.3 <u>PATHWAY III</u>

5.1.3.1 Infants equal to or greater than 24 hours of age with point of care glucose 25-49 mg/dl with ANY of the following signs ONLY (*See Attachment B*)

5.1.3.1.1 Jitteriness
5.1.3.1.2 Temperature instability
5.1.3.1.3 Poor feeding – poor suck/swallow coordination for 2 consecutive feedings

5.1.3.2 Notify the physician STAT

5.1.3.3 Under direct supervision of the nurse, place the infant skin to skin with mother of baby if possible to achieve physiologic stability. If cold stressed (temperature less than 97.0°F), infant needs to be taken to Intermediate NICU for assessment and placed in open bed with radiant warmer for warmth and observation

5.1.3.4 Administer glucose gel based on infant's birth weight

Infant's Birth Weight in Kilograms	Amount of Glucose Gel in mL	Dose of 40% Glucose Gel in Grams
1.8 – 2.4 kg	1 mL	0.4 g
2.5 – 2.9 kg	1.25 mL	0.5 g
3 – 3.4 kg	1.5 mL	0.6 g
3.5 – 3.9 kg	1.75 mL	0.7 g
4 – 4.4 kg	2 mL	0.8 g
4.5 – 4.9 kg	2.25 mL	0.9 g
5 kg and above	2.5 mL	1 g

5.1.3.5 Feed Infant:
5.1.3.5.1 If breastfeeding, attempt to breastfeed immediately
5.1.3.5.2 If bottle feeding, bottle feed 5-15 mLs. Bottle feed only if respiratory rate is less than 70 bpm

5.1.3.6 Repeat the point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

5.1.3.7 If the repeat point of care glucose remains less than 50 mg/dl, obtain STAT serum glucose and notify the physician immediately for further orders

5.1.3.8 If no physician response to notification within 20 minutes, call the physician on call for the INICU

5.1.3.9 If repeat point of care glucose value is greater than or equal to 50 mg/dl, obtain AC point of care glucose two times
5.1.3.9.1 If either one of these values is less than 50 mg/dl, obtain STAT serum glucose and call the physician immediately for further orders
5.1.3.9.2 If no physician response to notification within 20 minutes, call physician on call for the INICU

5.1.4 PATHWAY IV

5.1.4.1 Infant less than 24 hours of age with a point of care glucose less than 45 mg/dl OR infants greater than or equal to 24 hours of age with a point of care glucose less than 50 mg/dl with any of the following signs (*See Attachment A or B*)

5.1.4.1.1 Apnea
5.1.4.1.2 Respiratory distress including: tachypnea greater than or equal to 70 bpm with grunting, flaring, retracting and/or O_2 desaturation
5.1.4.1.3 Hypotonia
5.1.4.1.4 Lethargy
5.1.4.1.5 Seizure activity

5.1.4.2 Infants equal to or greater than 24 hours of age with point of care glucose less than 25 mg/dl at any time
5.1.4.3 As indicated in PATHWAY I and II
5.1.4.4 Infants with rebound hypoglycemia
***NOTE**: Review history for previous hypoglycemia event*
5.1.4.4.1 Do Not feed or gavage infant
5.1.4.4.2 If the infant is not already in the INICU, contact the INICU to transfer the infant into the INICU immediately
5.1.4.4.3 Notify the physician of the transfer. If no response within 20 minutes, call the physician on call for the INICU
5.1.4.4.4 Obtain a STAT serum glucose
5.1.4.4.5 Administer IV glucose (*Physician response should not delay the IV glucose administration*)
5.1.4.4.5.1 Glucose dose for bolus administration is 2 mL/kg of D10W given over 15 minutes
5.1.4.4.6 Repeat the point of care glucose 30 minutes after completion of the IV bolus
5.1.4.4.7 Notify the physician for further orders
5.1.4.4.8 Once the point of care glucose is 45 mg/dl or greater, obtain a point of care glucose every 2-3 hours two time
5.1.4.4.9 Maximal concentration of glucose in peripheral IV is D12.5W
5.1.4.4.10 If infant requires IV dextrose concentrations of >12.5%, insert an umbilical venous catheter

5.2 Documentation in the Electronic Medical Record:
5.2.1 Point of Care Glucose values
5.2.2 Laboratory Glucose values
5.2.3 Signs of hypoglycemia
5.2.4 Interventions
5.2.5 Response to interventions
5.2.6 Physician notification, as applicable

6.0 References:

6.1 New Intrauterine Growth Curves Based on US data – Pediatrics, Volume 125, pages e214-e244 (2010) American Academy of Pediatrics https://pediatrics.aappublications.org/content/125/2/e214
6.2 Postnatal Glucose Homeostasis in Late-Preterm and Term Infants – Clinical Report form American Academy of Pediatrics. Pediatrics Vol 127 No 3 March 1, 2011. Pp 575-

579. http://pediatrics.aappublications.org/content/127/3/575.full

6.3 Fanaroff, A.A>, & Martin, R.J. (2020). Neonatal-Perinatal Medicine (11th ed.) St Louis: Elsevier/Mosby

6.4 Intensive Care Nursery House Staff Manual. (2004). Neonatal Hypoglycemia. pg. 154-154. The Regents of the University of California http://www.ucsfbenioffchildrens.org/pdf/manuals/52_Hypoglycemia.pdf

6.5 Adamkin, D.H., et al. (2011) "Clinical Report – Postnatal glucose homeostasis in late-preterm and term infants" Pediatrics; 127. pg. 575-579

6.6 Thompson-Branch, A., (2017) AAP Sets Guidelines for Neonatal Hypoglycemia https://pedsinreview.aappublications.org/content/38/4/147

6.7 Huntsman, R.J., et al (2008) Nonepileptic motor phenomena in the Neonate http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2606074/

6.8 Sharp Hospital San Diego Policy & Procedure 47621.99 "Standardized Procedure – Blood Glucose in Neonates – Criteria for Obtaining & Interventions for Hypoglycemia" (2016)

6.9 Giouleka, S. et al (2023) "Diagnosis and Management of Neonatal Hypoglycemia: A Comprehensive Review of Guidelines" https://pmc.ncbi.nlm.nih.gov/articles/PMC10378472/

7.0 Attachment:

7.1 Attachment A – Interventions for Hypoglycemia for infants less than 24 hours of age

7.2 Attachment B– Interventions for Hypoglycemia for infants greater than 24 hours of age

7.3 Attachment C – Blood Glucose in Neonates – Criteria for Obtaining and Interventions for Hypoglycemia

7.4 Attachment D – Intrauterine Growth Curves (2 sided) – Male

7.5 Attachment E – Intrauterine Growth Curves (2 sided) - Female

8.0 Summary of Revisions:

8.1 Changed all values from 40 mg/dl to 45 mg/dl throughout the body of the policy, including attachments A & B

8.2 Changed all references of respiratory rate of 80 bpm to 70 bpm

8.3 Added a time for giving the bolus in 5.1.4.4.5.1

8.4 Updated References

Pathway I (less than 24 hours)
BG less than 45mg/dl without signs/symptoms

Under direct supervision of the nurse, place infant skin to skin with mother of baby if possible to achieve physiologic stability.

Administer glucose gel per dosing guidelines

Breastfeed immediately OR bottle feed 5- 15 mLs

Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

BG less than 45 mg/dl **with** any s/s **OR** less than 25 mg/dl, **proceed to Pathway IV.**

See Pathway IV

If BG is 25-44 mg/dl **without signs**, administer glucose gel **again** and immediately breastfeeding OR bottle feed 5-15 mLs

Repeat BG 30 minutes after administering 2nd dose of glucose gel

If BG remains 25-44 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders.

If BG is 45 mg/dl or greater, obtain BG 2 more times. If one of these values is less than 40 mg/dl and infant is asymptomatic, call physician for further orders.

If either point of care blood glucose is less than 45 mg/dl **with** any signs and symptoms **OR** less than 25mg/dl **proceed to Pathway IV**

Attachment A CLN-02506, Interventions for Hypoglycemia
For infants less than 24 hours of age

Pathway II (Less than 24 hours)

BG less than 45 mg/dl with ONLY signs of jitteriness and/or tachypnea greater than or equal to 80

Under direct supervision of the nurse, place infant skin to skin with mother of baby if possible to achieve physiologic stability.

Administer glucose gel per dosing guidelines

Attempt to breastfeed immediately OR bottle feed 5-15 mLs. Bottle feed **ONLY** if RR less than 80. **(If RR is 80 or greater, NOTIFY PHYSICIAN).**

Repeat point of care glucose 30 minutes after initiating breastfeeding or completion of bottle feeding

BG less than 45 mg/dl **with** any s/s **OR** less than 25 mg/dl, **proceed to Pathway IV.**

If BG is 25-44 mg/dl **without new or additional s/s**, administer glucose gel **again** and immediately breastfeeding OR bottle feed 5-15 mLs. Bottle feed **ONLY** if RR less than 80.

See Pathway IV

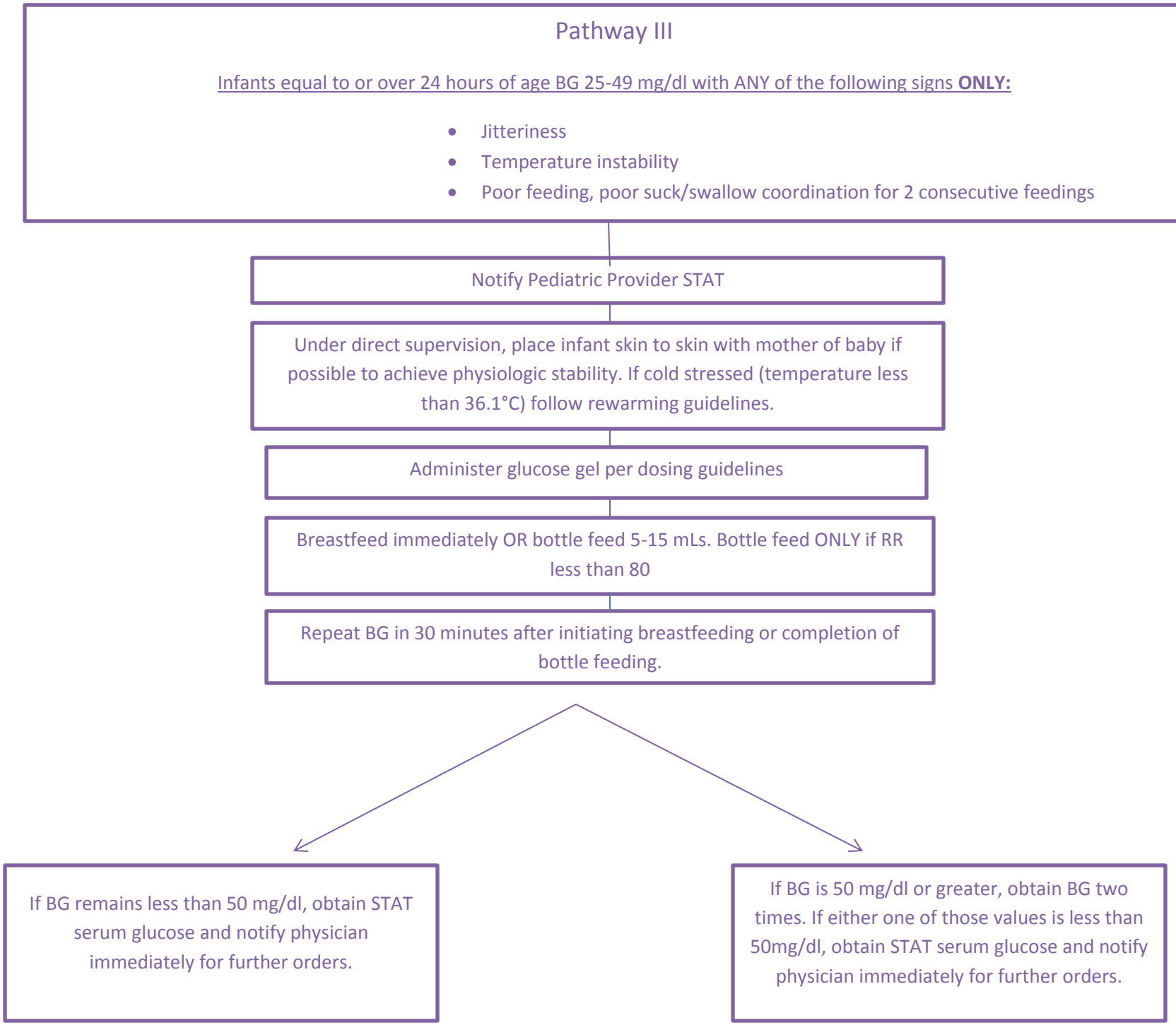
Repeat BG 30 minutes after administering 2nd dose of glucose gel

If BG remains 25-=44 mg/dl, obtain STAT serum glucose and notify physician immediately for further orders.

If BG is 45 mg/dl or greater, obtain BG two more times. If one of these values is less than 40 mg/dl and infant is asymptomatic, call physician for further orders.

If either point of care blood glucose is less than 45 mg/dl **with** any signs and symptoms **OR** less than 25mg/dl **proceed to Pathway IV**

Attachment B CLN-02506 Interventions for Hypoglycemia
For infants greater than 24 hours of age



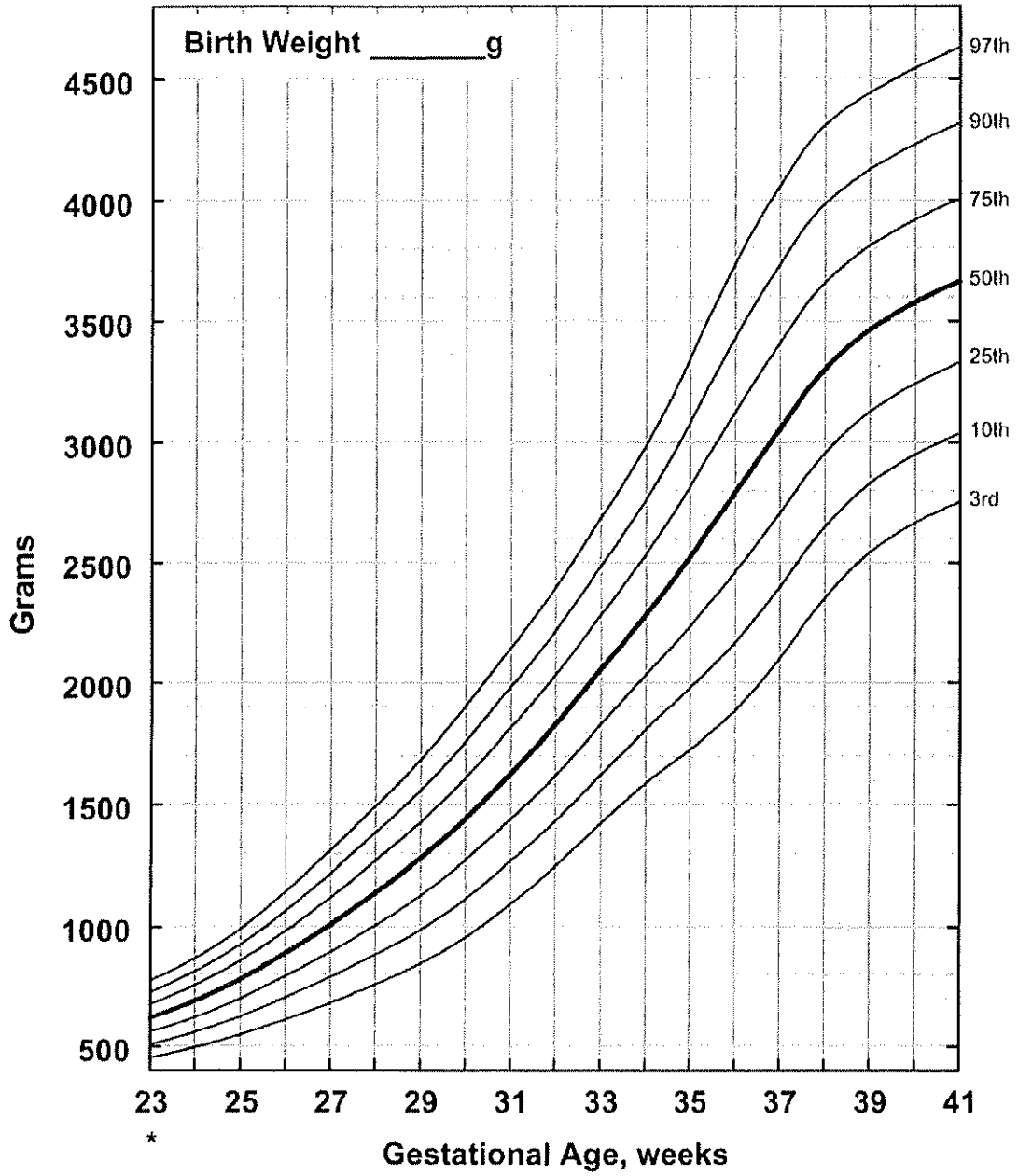
Attachment C CLN-02506 Blood Glucose in Neonates, Criteria for Obtaining and Interventions for Hypoglycemia

Intrauterine Growth Curves

Name _____

Record # _____

MALES



BIRTH SIZE ASSESSMENT:

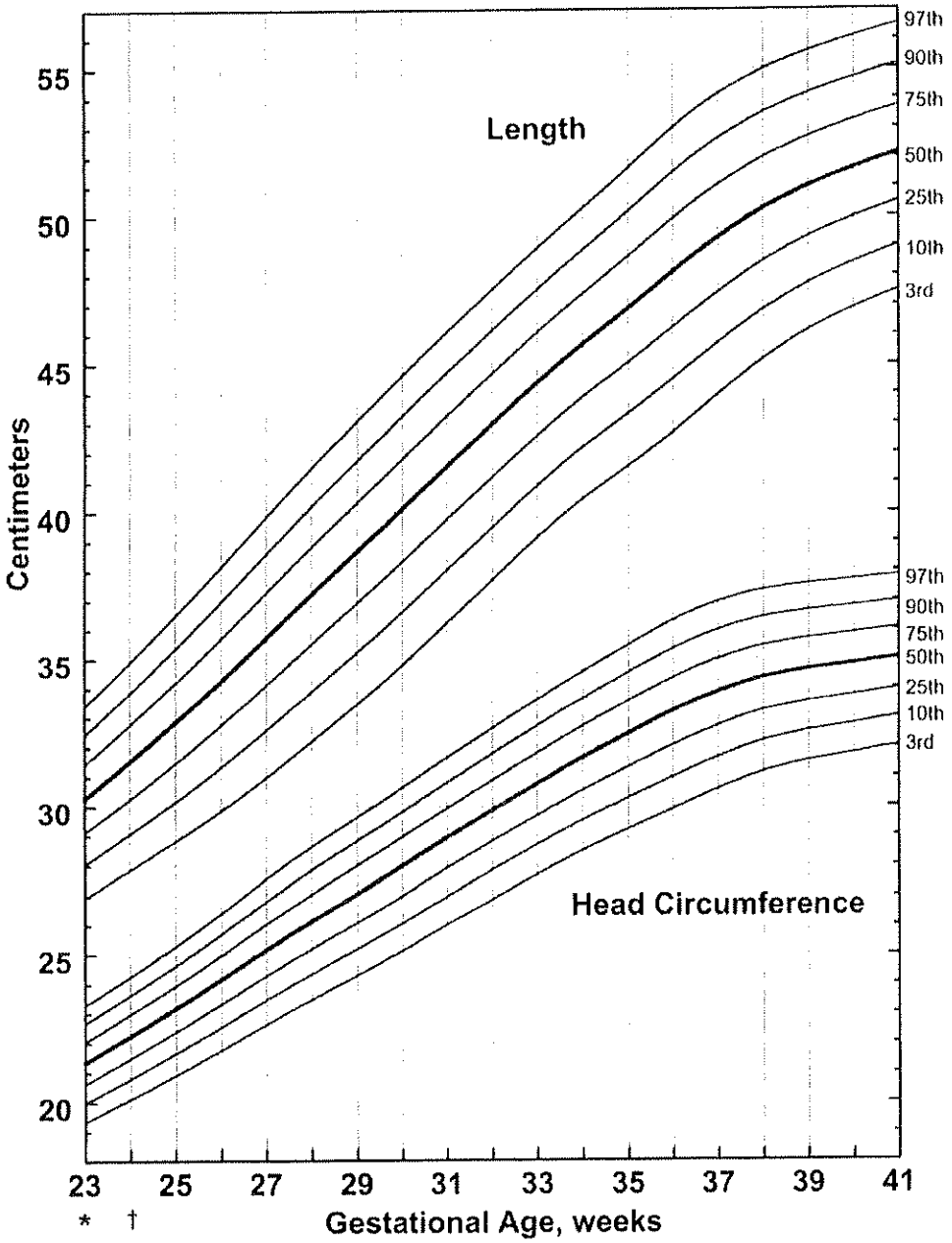
Date of birth: / / (wks GA)	Select one
Large-for-gestational age (LGA) >90th percentile	☐
Appropriate-for-gestational age (AGA) 10-90th percentile	☐
Small-for-gestational age (SGA) <10th percentile	☐

* 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.

Name _____

Record # _____

MALES



Date																		
GA (wks)																		
WT (g)																		
L (cm)																		
HC (cm)																		

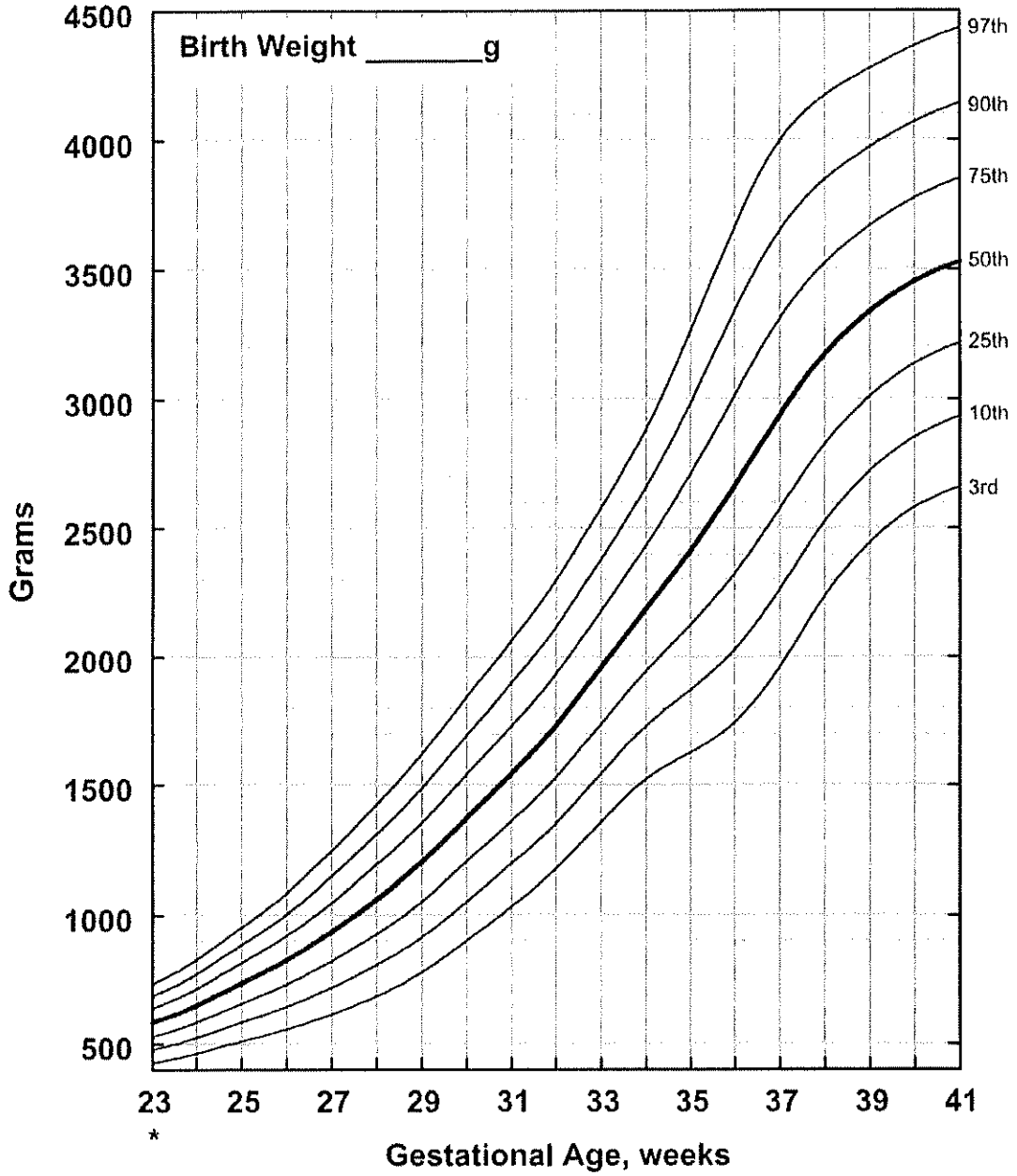
* 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.
† Male head circumference curve at 24 weeks all percentiles should be interpreted cautiously as the distribution of data is skewed left.

Intrauterine Growth Curves

Name _____

Record # _____

FEMALES



BIRTH SIZE ASSESSMENT

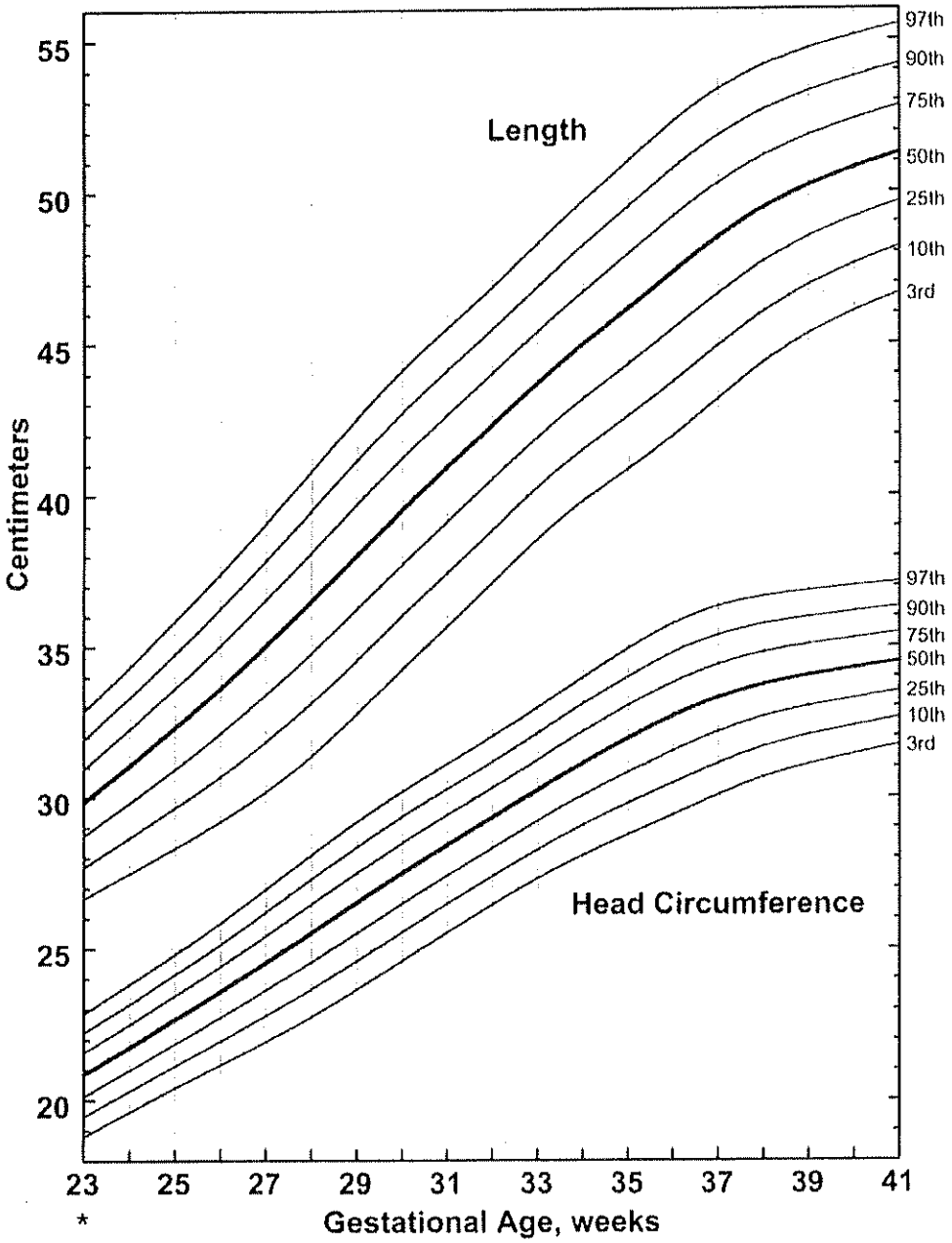
Date of birth: / / (wks GA)	Select one
Large-for-gestational age (LGA) >90th percentile	☐
Appropriate-for-gestational age (AGA) 10-90th percentile	☐
Small-for-gestational age (SGA) <10th percentile	☐

* 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.

Name _____

Record # _____

FEMALES



Date																		
GA (wks)																		
WT (g)																		
L (cm)																		
HC (cm)																		

* 3rd and 97th percentiles on all curves for 23 weeks should be interpreted cautiously given the small sample size.

Imperial Valley Healthcare District

Title: **Neonatal Resuscitation Work Instruction**	Policy No. CLN-00250
	Page 1 of 8
Current Author: Sandra Taylor, RNC-NIC, BSN	Effective: 10/1/2001
Latest Review/Revision Date: 03/26/2025	Manual: Clinical / OB

Collaborating Departments: Perinatal, Neonatal, ED Dr Alshareef, NICU Manager	Keywords: Resuscitation of Newborn		
Approval Route: List all required approval			
PSQC	Other:		
Clinical Service Credentials; OB/Pediatrics 04/2025	MSQC 05/2025	MEC 05/2025	BOD 06/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To outline the procedure for neonatal resuscitation in the delivery room, the emergency department or the neonatal nursery of Pioneers Memorial Hospital.

1.2 The purpose of resuscitation is to provide full oxygenation, ventilation and support of the circulation, using cardiac massage and, as necessary, intravascular medications.

2.0 Scope:

2.1 Neonatal RNs

2.2 Perinatal RNs

2.3 Neonatal ALS RNs

2.4 Pediatricians/attending physician

3.0 Policy:

3.1 All Perinatal/Neonatal RNs will maintain certification in the Neonatal Resuscitation Program (NRP) per the requirement set forth by the American Academy of Pediatrics (AAP).

3.1.1 The AAP requires NRP Provider Card renewal every 2 years.

3.1.1.1 These cards are delineated as either Essential or Advanced provider.

3.1.2 PMHD requires that all RN staff have current NRP Provider Cards to work in the Perinatal/Neonatal Departments.

3.1.2.1 All NICU employees will hold an Advanced Provider Card

3.1.2.2 All Perinatal Employees and Respiratory Care Practitioners will hold an Essential Card

3.2 For all deliveries, at least 1 person should be present who is skilled in neonatal resuscitation and is responsible only for the infant. This person must be skilled in the initiation of resuscitation, the use of bag-mask ventilation.

3.3 Additional personnel should be available to assist in tasks that may be required as part of resuscitation, including all aspects of neonatal resuscitation. If the delivery is identified as high-risk, 2 or more skilled individuals should be assigned to the infant at delivery.

3.4 Advanced NRP RN will be called for all neonatal resuscitations in the Perinatal Unit. *<See policy CLN-00208; High-Risk Delivery, Criteria for Attendance by Neonatal Staff>*

3.5 The Advanced RN nurse may perform all aspects of the procedure listed in this policy.

3.5.1 The Essentials NRP certified RN is to utilize the bag and mask component of this

policy only.

3.6 Circumstances under which the Advanced NRP RN may perform the procedure in:
- 3.6.1 Setting – The competency validated Advanced NRP RN may perform the procedure in:
  - 3.6.1.1 The Perinatal Unit of PMH
  - 3.6.1.2 The Neonatal Nursery of PMH
  - 3.6.1.3 The Pediatric Unit
  - 3.6.1.4 The Emergency Department of PMH

3.7 If a resuscitation requires more personnel, a Code Neo should be called by dialing **4444** from any place within the facility.

3.8 Scope of Supervision:
- 3.8.1 The competency validated Advanced NRP RN will receive indirect supervision by the attending physician
- 3.8.2 A pediatrician/attending physician will be available at all times for consultation.
- 3.8.3 Under all circumstances the Advanced NRP RN will carry out urgent delivery room and neonatal resuscitation according to the procedure or until a physician arrives.
- 3.8.4 In the event that this procedure is altered via a physician's written or verbal order, the Advanced NRP RN will inform the physician that he/she is not certified to carry out the altered plan and must either adhere to the procedure or relinquish responsibility to the physician.
- 3.8.5 Patient condition to notify the physician:
  - 3.8.5.1 The Advanced NRP RN or designee will immediately notify the attending pediatrician/physician whenever advanced life support (beyond simple stimulation or initial bag and mask support) is being initiated.
  - 3.8.5.2 The Advanced NRP RN will notify the pediatrician/physician whenever the delivery of an extremely small or complicated infant is anticipated so the pediatrician/physician may attend.
  - 3.8.5.3 Issues involving viability of life
  - 3.8.5.4 Any unsuccessful resuscitation

3.9 RN requirements
- 3.9.1 Education/Training/Experience
  - 3.9.1.1 The Advanced NRP RN will keep current with the requirement of recertification per AAP guidelines (every 2 years with RQI NRP)
  - 3.9.1.2 Essentials NRP providers will have completed an online NRP class and remain current on their certification with hands on demonstration for completion of certification
  - 3.9.1.3 Annual competency validation assessments will be performed during manual skills (Mock Codes) biannually (January and July) by the NICU Clinical Educator
  - 3.9.1.4 In conjunction with the Mock codes, written tests covering Normal Newborn care, NICU care and math calculations will be completed with $\geq$80% pass rate.

3.9.1.5 Remediation will be done if unsuccessful with either manual skills or written tests.

4.0 Definitions:

4.1 Neonate – Defined as an infant <30 days of age
4.2 PPV – Positive pressure ventilation
4.3 PIP – Peak inspiratory pressure
4.4 SpO^2 –
4.5 CPR – Cardiopulmonary resuscitation
4.6 ETT – Endotracheal tube
4.7 LMA – Laryngeal mask airway
4.8 NRP – Neonatal Resuscitation Program as provided by the American Academy of Pediatrics = Evidence Based Approach to care of the newborn at birth
4.9 Advanced NRP RN – Advanced Neonatal Resuscitation Certified Registered Nurse
4.10 Essentials NRP RN – Essentials Neonatal Resuscitation Certified Registered Nurse
4.11 AAP – American Academy of Pediatrics
4.12 RQI – Resuscitation Quality Improvement
4.13 PMH – Pioneers Memorial Hospital

5.0 Procedure:

5.1 Database:
- 5.1.1 Subjective:
  - 5.1.1.1 Historical information relevant to present illness
  - 5.1.1.2 History including reactions/allergies to medications
- 5.1.2 Objective:
  - 5.1.2.1 Physical exam with focus on pulmonary and cardiovascular systems
  - 5.1.2.2 Assessment: Decision for emergency medication administration will be based upon subjective and objective data and in collaboration with attending physician when not an emergent lifesaving maneuver
- 5.1.3 Plan:
  - 5.1.3.1 Patients and families will be provided with the appropriate information on emergency medication as soon as possible after administration.
  - 5.1.3.2 The Advanced NRP RN will notify the pediatrician or neonatologist to be present whenever the delivery of an extremely small or complicated infant is anticipated.
  - 5.1.3.3 In all emergencies, the primary physician will be notified as soon as practical while advanced life support is being initiated. Under all circumstances, the Advanced NRP RN will perform urgent delivery room and/or nursery resuscitation and emergency medication administration according to the procedure or until a physician arrives.

5.2 Informed consent is required prior to the procedure unless it is deemed an emergency and parental or guardian consent cannot be obtained.
5.3 A “Time Out” procedure is required to be performed according to policy.
5.4 Indications:

- 5.4.1 Cardiopulmonary arrest
- 5.4.2 Severe and rapid deterioration in patient's condition

5.5 Precautions:

- 5.5.1 Know the infant's weight
  - 5.5.1.1 If the infant's weight is not available, an estimate of the infant's weight is made for calculation of medication dosages until a time when an accurate weight can be measured.

5.6 Equipment:

- 5.6.1 Radiant warmer
- 5.6.2 Pulse oximeter
- 5.6.3 Endotracheal tubes
  - 5.6.3.1 2.5
  - 5.6.3.2 3.0
  - 5.6.3.3 3.5
  - 5.6.3.4 4.0
- 5.6.4 Stylet of appropriate size
- 5.6.5 Resuscitation bag connected to an oxygen source, able to provide 100% FiO^2
- 5.6.6 Infant oxygen masks
  - 5.6.6.1 Pre-term
  - 5.6.6.2 Term
- 5.6.7 Oxygen blender
- 5.6.8 Manometer
- 5.6.9 Suction apparatus
- 5.6.10 Suction Catheters
  - 5.6.10.1 5-6 Fr
  - 5.6.10.2 8 Fr
  - 5.6.10.3 10 Fr
  - 5.6.10.4 14 Fr
- 5.6.11 Bulb syringe
- 5.6.12 Laryngoscope handle
- 5.6.13 Laryngoscope blades
  - 5.6.13.1 0 Miller
  - 5.6.13.2 1 Miller
- 5.6.14 Meconium aspirator
- 5.6.15 Emergency medications with appropriate size syringes
  - 5.6.15.1 Epinephrine 1:10,000
  - 5.6.15.2 Normal Saline for volume replacement
- 5.6.16 Stethoscope
- 5.6.17 Adhesive tape
- 5.6.18 Umbilical catheter tray
- 5.6.19 Umbilical tape
- 5.6.20 Umbilical catheters
  - 5.6.20.1 3.5 Fr
  - 5.6.20.2 5.0 Fr

5.6.21 Three way stopcocks
5.6.22 NG tubes
5.6.22.1 5 Fr
5.6.22.2 8 Fr

5.7 Steps in the procedure – The following are steps of a maximum effort. They may be suspended at any time if the infant responds appropriately. The infant will then be monitored according to its acuity.
5.7.1 All delivery room equipment will be checked for function and availability at the beginning of every shift.
5.7.2 The Advanced NRP RN is responsible for checking and reviewing appropriate antepartum and intrapartum history to help identify those at risk for delivering a depressed or sick infant. It is important to be forewarned for impending deliveries of ill newborns. Perinatal RN should inform the Neonatal RN regarding any concerns prior to delivery, if known.
5.7.3 Be aware that the parents may hear and remember what is said in the delivery room.

5.8 Action Steps:
5.8.1 Turn on the radiant warmer
5.8.2 As the infant is being delivered, observe:
5.8.2.1 Whether the oropharynx was suctioned well
5.8.2.2 When infant had spontaneous activity and cry
5.8.2.3 Any reflex tone or activity
5.8.3 Place the infant under the radiant heat source
5.8.4 Position the head and neck so the airway is open
5.8.4.1 Place infant supine with the head and neck neutral or slightly extended in the “sniffing” position
5.8.4.2 A shoulder roll may be placed under the infant’s shoulders and is useful if the infant has a large occiput from molding, edema or prematurity
5.8.5 Clearing secretions if needed
5.8.5.1 If infant is not breathing, is gasping, has poor tone or secretions are obstructing the airway
5.8.5.2 Secretions may be removed from the upper airway by suctioning gently with the bulb syringe.
5.8.5.3 Brief gentle suction is usually adequate to removed secretions. Suction the mouth before the nose.
5.8.5.4 Be careful not to suction vigorously or deeply. Vigorous suction may injure tissues.
5.8.5.5 Stimulation of the posterior pharynx during the first minutes after birth can produce a vagal response leading to bradycardia or apnea.
5.8.5.6 Is using a suction catheter, the suction control should be set so that the negative pressure reads approximately 80 to 100 mm Hg when the tubing is occluded.
5.8.5.7 If secretions are thick enough to completely obstruct the airway,

directly suction the trachea with a meconium aspirator attached to an endotracheal tube.

5.8.5.7.1 Using 80-100 mm Hg, connect to suction tubing to the meconium aspirator and attach directly to the endotracheal tube connector. Gradually withdraw the tube to removed secretions from the trachea and posterior pharynx before reinserting a new endotracheal tube for ventilation.

5.8.6 Dry infant and remove wet blanket

5.8.6.1 Drying is not necessary for very preterm infant's less than 32 weeks' gestation. They should be covered immediately in polyethylene plastic. This intervention will reduce heat loss.

5.8.7 Provide gentle tactile stimulation, if needed

5.8.7.1 Positioning, clearing secretions and drying the infant will frequently provide enough stimulation to initiate breathing. If the infant does not have adequate respirations, brief additional tactile stimulation may stimulate breathing.

5.8.7.2 Gently rub the infant's back, trunk or extremities.

5.8.7.3 Overly vigorous stimulation is not helpful and can cause injury.

5.8.8 If the infant has persistent central cyanosis, place pulse oximeter probe on infant. The preferred site will be the right hand. This is the pre-ductal site. The targeted pre-ductal Spo2 after birth:

5.8.8.1 1 minute = 60% – 65%

5.8.8.2 2 minutes = 65% – 75%

5.8.8.3 3 minutes = 70% – 75%

5.8.8.4 4 minutes = 75% – 80%

5.8.8.5 5 minutes = 80% – 85%

5.8.8.6 10 minutes = 85% – 95%

5.8.9 If the infant is apneic or has ineffective respirations to keep the heart rate >100, start positive pressure ventilation (PPV) with a bag and mask.

5.8.10 Use pressure sufficient to move the infant's chest (PIP between 20-25 cm H_2O)

5.8.10.1 Higher pressures may be needed during the first several breaths and in infants with decreased lung compliance (PIP between 30-40 cm H_2O)

5.8.11 PPV should be done at a rate of 40-60 breaths per minute with 21% – 100% FiO^2

5.8.11.1 Begin with 21% FiO^2 and increase or decrease FiO^2 as needed

5.8.12 Check the heart rate by auscultating the apical pulse or palpate the umbilical cord.

5.8.13 Chest compressions are indicated if after 30 seconds of PPV, the heart rate is below 60. (Do not proceed to chest compressions until you have established an open airway and ventilation that inflates the lungs).

5.8.13.1 Chest compressions are given at a ratio of 3 compressions and 1 breath. These should be 90 compressions and 30 breaths in a 1 minute cycle.

5.8.13.2 Chest compressions are given to a depth of one-third of the diameter

of the chest and are coordinated with ventilations.

5.8.14 Continue with chest compressions with ventilator assistance until the heart rate is 80 or greater, or instructed to discontinue CPR by a physician assuming responsibility for the neonate's care.

5.8.15 Notify the pediatrician/attending physician that resuscitation is in progress.

5.8.16 If after 1-2 minutes of cardiac massage and PPV with bag and mask, and the infant are not responding appropriately, the infant should be intubated with the appropriate size ETT or a size 1 LMA. The intubation/LMA steps may be considered at any time the infant is not responding to PPV with the bag and mask.

5.8.17 If endotracheal intubation is needed, follow the procedure outlined in policy CLN-00236; Endotracheal Intubation – Standardized Procedure.

5.8.18 If the infant is intubated or has LMA and chest compressions continue and the heart rate is <60 after 30 additional seconds of chest compressions and ventilation, medications should be given.

5.8.19 If vascular access is needed, follow the procedure outlined in policy CLN-00258; Neonatal Umbilical Vessel Catheterization – Standardized Procedure

5.8.20 Epinephrine 1:10,000, is indicated if the heart rate is <60 beats per minute

- 5.8.20.1 Should be given intravenously – 0.1 to 0.3 mL/kg
- 5.8.20.2 May be given endotracheally – 0.5 to 1.0 mL/kg
- 5.8.20.3 Epinephrine may be repeated every 3-5 minutes

5.8.21 Volume expansion with normal saline is indicated when there is evidence of acute bleeding or signs of hypovolemia.

- 5.8.21.1 Normal Saline, 10 mL/kg is given IV over 5-10 minutes, repeat 1-2 times as needed.

5.8.22 O Rh-negative packed red blood cells should be considered as part of the volume replacement when severe fetal anemia is documented or expected.

- 5.8.22.1 10 mL/kg over 5-10 minutes

5.8.23 Continue with NRP procedure until a pediatrician or attending physician arrives. The decision to stop resides with the physician.

5.8.24 The infant should be stabilized as much as possible and then transported to the Intermediated NICU for further evaluation and treatment.

5.9 Documentation:

5.9.1 The Advanced NRP RN will document attendance at the delivery and associated interventions.

5.9.2 Document time of spontaneous respirations

5.9.3 Time and length of bag and mask ventilation

5.9.4 Intubation time and number of attempts

5.9.5 If need for chest compressions, time started and duration

5.9.6 Any medications given, time and response

5.9.7 Disposition of infant

6.0 References:

6.1 American Academy of Pediatrics, American Heart Association, *Textbook of Neonatal*

Resuscitation, 8th Ed (2021)

6.2 Rady Children's Hospital, San Diego, "Neonatal Resuscitation in the Delivery Area, Nursery or on Transport" SP 2-07 (2016)

6.3 March of Dimes "The STABLE program 7th ed. (2024)

6.4 Verklan, MT, et al, *Core Curriculum for Neonatal intensive Care Nursing,* 6th ed (2021*)*

6.5 Gardner, Carter, et al, *Merenstein & Gardner's Handbook of Neonatal Intensive Care,* 9th ed (2021)

7.0 Attachment List:

7.1 Algorithm for 8th ed Neonatal Resuscitation Program Guidelines

8.0 Summary of Revisions:

8.1 Updated References

8.2 Updated Education requirements in 3.9

8.3 Changed policy from a Standardized Procedure to Work Instruction

8.4 Updated Definitions

8.5 Added attachment A

Guidelines for Activation of "Code Neo"

1. The Code Neo Team consists of an NICU based intra-disciplinary team that responds to all neonatal emergencies within Pioneers Memorial Hospital
2. Coverage is 24/7
3. The appropriate team is activated by the NICU Charge Nurse
4. The Code Neo Team includes: NICU Charge Nurse (NRP RN), Respiratory Therapy, Pediatrician
5. In the event of simultaneous emergencies, the Emergency Department with Respiratory Therapy will be called
6. In the event an infant is subject to a Code Neo call, the infant will be transferred to the NICU for monitoring and evaluation by the attending pediatrician, if this has not occurred yet
7. For an infant born precipitously in the Emergency Department, the NICU Team will transport the required equipment to the location of the infant.
8. The infant will be transported to the NICU via the infant transport isolette or an open bed once the infant is stabilized to move to the NICU
9. The neonatal attending physician will assume the role of the code team leader when present. Otherwise any Advanced NRP credentialed clinician may assume the role of the code team leader to organize the resuscitative efforts of the newborn
10. All clinicians are responsible for documenting assessment and interventions in the neonates EMR
11. Designate the team members of their roles as soon as possible
    a. Team Leader (Charge NRP RN or Pediatrician/Neonatologist)
    b. Personnel responsible for airway management
    c. Personnel responsible for assisting/chest compressions
    d. Personnel responsible for medication set up and administration
    e. Personnel responsible for documenting events/treatments/communication with others and family
    f. Personnel responsible for gathering extra supplies and running lab work to lab
12. Criteria for Code Neo
    a. Any infant that requires NRP resuscitation that includes advanced airways, chest compressions or medications
    b. Apnea persisting past 1 minute of positive pressure ventilation(PPV) with bag and mask
    c. Bradycardia not responding to PPV (Heart rate persistently <80 bpm)
    d. Central cyanosis that persists > 5minutes
    e. Cyanosis (Circumoral, unresponsive to blow by oxygen administration of 100% Fio2)
    f. "Floppy baby" (absent muscle tone/lack of respiratory effort = stunned infant requiring resuscitation)
    g. Persistent oxygen saturation less than 85% (>10 minutes of life)
    h. Seizure like activity, change in behavior/lethargy
    i. Decreased muscle tone

j. Respiratory rate persistently >70 bpm at 10 minutes of life
k. Grunting/flaring/retractions
l. HR persisting >200 bpm
m. Any incident where infant is dropped of has a fall
n. Initial presentation after home birth
o. Uncontrolled bleeding of the infant
p. Unexplained pain
q. Unresolved parental concern
r. Any Staff concerns

13. How to activate a Code Neo Response
    a. Call 4444
14. Any staff member from any department call the NICU to request help must use the G.I.R.L. acronym to state the following:
    a. Gestational Age of the infant
    b. Indications for call (reason for impending birth or Code Neo Response)
    c. Relevant information for the NICU Team
    d. Location of the infant

Imperial Valley Healthcare District

Title: **Prevention of Surgical Site Infections**	Policy No. CLN-02340 Page 1 of 5
Current Author: Angela McElvany	Effective: 1/28/2002
Latest Review/Revision Date: 1/10/2025 R2	Manual: Clinical / Infection Control

Collaborating Departments: Dr. Al Jasim, Surgery	Keywords: SSI, surgical scrub		
Approval Route: List all required approval			
PSQC	Other:		
Clinical Service 7/2024, 10/2024	MSQC 11/2024	MEC 11/2024	BOD 11/2024

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To establish guidelines for the prevention of surgical site infections

2.0 Scope:

2.1 Hospital wide

3.0 Policy:

3.1 It is the policy of Pioneers Memorial Hospital to implement practices consistent with evidence-based standards of care to reduce the risk of surgical site infections.

3.2 All surgical instruments shall be sterilized in accordance with published guidelines, and standard of care. IUUS should be performed only for patient care items that will be used immediately (e.g., to reprocess an inadvertently dropped instrument). Flash sterilization should not be used for reasons of convenience, as an alternative to proper sterilization.

4.0 Definitions:

4.1 EPA – Environmental Protection Agency

4.2 CDC – Centers for Disease Control

4.3 IUUS – Immediate Use Steam Sterilization

5.0 Procedure:

5.1 Practices include but are not limited to, the following:

5.1.1 Education of Physicians & Staff

5.1.1.1 Staff involved in surgical procedures will be educated upon hire and on an annual basis thereafter about health care associated infections, surgical site infections, and the importance of prevention. Education will also occur when involvement in surgical procedures is added to an individual's job responsibilities

5.1.2 Education of Patients and Family

5.1.2.1 When possible – consistent with the patient's clinical condition and emergent need of the procedure – the patient and/or family will be educated about surgical site infection prevention.

5.1.3 Periodic Risk Assessments

5.1.3.1 Risk assessments will be conducted on at least an annual basis – and more frequently if indicated – to identify those surgical procedures that carry a significant risk of surgical site infection. These risk

assessments may be part of the overall infection control program risk assessment process or conducted as an adjunct or stand-alone activity. The results of the risk assessment shall form the basis for determining which surgical procedures shall be targeted for surveillance monitoring

5.1.4 Practice Guidelines

5.1.4.1 The organization shall implement practices aimed at reducing the risk of surgical site infections that meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

5.1.4.2 Any patient who is admitted and is scheduled to have a surgical procedure will receive a 2% CHG bath prior to the procedure and any patient scheduled for prosthetic joint replacement (Policy# CLN-01118)

5.1.5 Measurement of Surgical Site Infection (SSI)

5.1.5.1 The organization will measure the incidence of site infection for those surgical procedures targeted as a result of the aforementioned risk assessment. Measurement strategies shall follow evidence-based guidelines, and surgical site infection rates targeted as a result of the risk assessment and shall be defined and measured according to current NHSN guidelines and definitions.

5.2 Evidence Based Practice Guidelines

5.2.1 Preparation of the Patient

5.2.1.1 Whenever possible, infections remote to the surgical site should be identified and treated before elective procedures. Elective procedures should be postponed, if necessary, until the remote infection has resolved.

5.2.1.2 Consideration should be given to having patients shower or bathe with a chlorhexidine solution the night before surgery. Hair should not be removed preoperatively unless the hair at or around the incision site will interfere with the operation. If hair must be removed, it should occur immediately before the operation by a method that is cited in scientific literature or endorsed by professional organizations.

5.2.1.3 The area around the intended incision site should be thoroughly washed and cleaned to remove gross contamination before performing antiseptic skin preparation. Alcohol-based, chlorhexidine-based, and iodine-base are acceptable for use as antiseptics. When an antiseptic agent is applied, the prepared area must be large enough to extend the incision or create new incisions or drain sites, if necessary.

5.2.2 Administration of Prophylaxis Antimicrobial Therapy

5.2.2.1 Prophylactic antimicrobial agents should be administered only when indicated, and selected based on its efficacy against the most common pathogens causing SSI for a specific operation and published

recommendations

5.2.2.2 If an antimicrobial agent for prophylaxis is used for a particular surgical procedure or disease, it shall be administered according to evidence based best practices methods cited in scientific literature or endorsed by professional organizations. See policy CLN-02971 Attachment B-Guidelines for Antimicrobial Prophylaxis in Surgery.

5.2.3 Antisepsis for Operative Personnel

5.2.3.1 Nails should be kept short. Artificial nails should not be worn. There are two options for the first scrub of the day. Option 1) Hospital approved surgical hand antiseptic such as Avagard (see attachment A for instructions). Option 2) Personnel should perform a preoperative surgical scrub for at least 2 to 5 minutes using an appropriate antiseptic. Hands and forearms should be scrubbed up to the elbows. After performing the surgical scrub, hands should be kept up and away from the body (elbows in flexed position) so that water runs from the tips of the fingers toward the elbows. Hands should be dried with a sterile towel and staff should then don a sterile gown and gloves.

5.2.4 Ventilation of Operating Rooms

5.2.4.1 Positive-pressure ventilation should be maintained in the operating room with respect to the corridors and adjacent areas. A minimum of 15 air changes per hour, of which at least 3 should be fresh air, should be maintained. All air, recirculated and fresh, should be filtered through appropriate filters per the American Institute of Architects' recommendations. Air should be introduced at the ceiling, and exhausted near the floor. Operating room doors should be kept closed except as needed for passage of equipment, personnel, and the patient.

5.2.5 Cleaning & Disinfection of Environmental Surfaces

5.2.5.1 An EPA-approved hospital disinfectant should be used to clean the affected areas before the next operation, when visible soiling or contamination with blood or other body fluids of surfaces or equipment occurs. Manufacturer instructions relative to soak and drying times of the disinfectant shall be followed.

5.2.5.2 Tru-D SmartUVC will be used in un-occupied operating suites and procedure areas at end of each day (Policy# EOC-00114)

5.2.6 Sterilization of Instrumentation

5.2.6.1 All instruments should be prepared, packaged, sterilized and stored according to the device manufacturer's recommendations.

5.2.6.2 IUUS should be used only in selected clinical situations and in a controlled manner.

5.2.6.3 Adequate quantities of equipment and instrumentation should be available to avoid the use of IUUS as a routine sterilization method.

5.2.7 Surgical Attire and Drapes

5.2.7.1 A surgical mask that fully covers the mouth and nose must be worn when entering the operating room if an operation is about to begin or already under way, or if sterile instruments are exposed. The mask is to be worn throughout the operation. A cap or hood to fully cover hair on the head and face must be worn when entering the operating room. Sterile gloves must be worn by all scrubbed surgical team members. Surgical gowns and drapes that are effective barriers when wet (i.e., materials that resist liquid penetration) should be used. Scrub suits that are visibly soiled, contaminated, and/or penetrated by blood or other potentially infectious materials should be changed out.

5.2.8 Asepsis and Surgical Technique

5.2.8.1 Principles of asepsis should be adhered to when placing intravascular devices (e.g., central venous catheters), spinal or epidural anesthesia catheters, or when dispensing and administering intravenous drugs. Tissue should be handled gently, maintain effective hemostasis, minimize devitalized tissue and foreign bodies (i.e., sutures, charred tissues, necrotic debris), and eradicate dead space at the surgical site. A delayed primary skin closure should be used or leave an incision open to heal by secondary intention if the surgeon considers the surgical site to be heavily contaminated (e.g., Class III and Class IV).If drainage is necessary; a closed suction drain should be used. The drain should be placed through a separate incision distant from the operative incision and removed as soon as possible.

5.2.9 Postoperative Incision Care

5.2.9.1 For an incision that has been closed primarily, the site should be protected with a sterile dressing for 24 to 48 hours postoperatively. When a dressing must be changed, sterile technique should be deployed. Staff should follow appropriate hand hygiene practices when checking or changing dressings.

6.0 References:

6.1 CDC, (2017) Guideline for the Prevention of Surgical Site Infections, JAMA Surgery, Vol. 152, Number 8.

6.2 Institute for Healthcare Improvement, *Preventing Surgical Site Infections: How to Guide,* October 2008

6.3 Joint Commission NPSG 07.05.01

6.4 Association for the Advancement of Medical Instrumentation, *ST79*, 2006

6.5 Association of Perioperative Nurses, *Recommended Practices*, 2011

7.0 Attachment List:

7.1 Attachment A- Avagard Instructions

8.0 Summary of Revisions:

8.1 Updated CDC reference**.**
8.2 Added Hospital approved surgical hand antiseptic such as Avagard to 5.2.3.1
8.3 Attachment A- Avagard Instructions
8.4 Added - See policy CLN-02971 Attachment B-Guidelines for Antimicrobial Prophylaxis in Surgery.

3M Science. Applied to Life.™

3M™ Avagard™

(Chlorhexidine Gluconate 1% Solution and Ethyl Alcohol 61% w/w)

Surgical and Healthcare Personnel Hand Antiseptic with Moisturizers

Application Instructions for Surgical Hand Antisepsis

FDA approved* surgical hand antiseptic. **Avagard can be used for the first scrub of the day and every scrub of the day.**

Apply to clean, dry hands

First application of the day

Clean under nails with a 3M™ Avagard™ Nail Cleaner. No prescrub required.

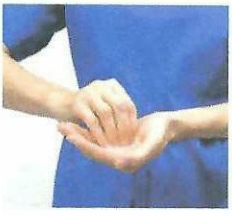
Three pump application

Pump 1

Dispense one pump (2 ml) into the palm of one hand. Dip fingertips of the opposite hand into the hand prep and work under fingernails. Spread remaining hand prep over the hand and up to just above the elbow.

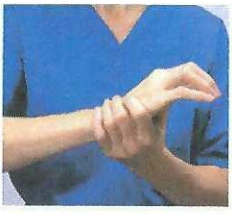
Pump 2

Dispense one pump (2 ml) and repeat procedure with opposite hand.



Pump 3

Dispense final pump (2 ml) of hand prep into either hand and reapply to all aspects of both hands up to the wrists. Allow to dry.
Do not use towels!



Tips to remember

- Use with care in premature infants or infants under 2 months of age. These products may cause irritation or chemical burns.
- Per OSHA Bloodborne Pathogen Rule, wash hands with soap and water after the surgical procedure.

Questions? Call the 3M Customer Helpline at 1-800-228-3957.

*Approved NDA 21-074 June 7, 2001

WARNINGS

Flammable, keep away from fire or flame. For external use only.

Do not use if you are allergic to chlorhexidine gluconate or any other ingredient in this preparation.

When using this product, do not touch the eye with hands that have been treated with this preparation. Keep out of eyes, ears and mouth. May cause serious and permanent eye injury if permitted to enter and remain in the eye. If contact occurs, rinse with cold water right away. Do not use routinely if you have wounds which involve more than the superficial layers of the skin.

Stop use and ask a doctor if irritation, sensitization or allergic reaction occurs. These may be signs of a serious condition.

Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away.

3M Science. Applied to Life.™

3M™ Avagard™

(Chlorhexidine Gluconate 1% Solution and Ethyl Alcohol 61% w/w)

Surgical and Healthcare Personnel Hand Antiseptic with Moisturizers

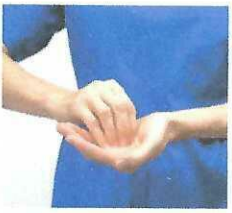
Application Instructions for Healthcare Personnel Antisepsis

Apply to clean, dry hands

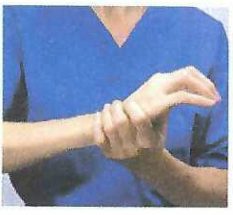
Application

Dispense one pump (2 ml) into the palm of one hand.

Apply the hand prep evenly to cover both hands up to the wrists, paying particular attention to the spaces between the fingers and under the fingernails.



Rub hand prep briskly into hands until completely dry.



Tips to remember

- Use with care in premature infants or infants under 2 months of age. These products may cause irritation or chemical burns.

Questions? Call the 3M Customer Helpline at 1-800-228-3957.

*FDA NDA-approved 21-074 June 7, 2001

WARNINGS

Flammable, keep away from fire or flame. For external use only.

Do not use if you are allergic to chlorhexidine gluconate or any other ingredient in this preparation.

When using this product, do not touch the eye with hands that have been treated with this preparation. Keep out of eyes, ears and mouth. May cause serious and permanent eye injury if permitted to enter and remain in the eye. If contact occurs, rinse with cold water right away. Do not use routinely if you have wounds which involve more than the superficial layers of the skin.

Stop use and ask a doctor if irritation, sensitization or allergic reaction occurs. These may be signs of a serious condition.

Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away.

Imperial Valley Healthcare District

Title: **Utilization Management Plan**	Policy No. ADM-00029
	Page 1 of 6
Current Author: Ashraf Malik RN CCM	Effective: 02/26/90
Latest Review/Revision Date: 8/2024	Manual: Administrative

Collaborating Departments: Administration		Keywords: Case Management, Discharge Plan	
Approval Route: List all required approval			
PSQC 4/2025	Other: UM Committee 8/2024		
Clinical Service _____	**MSQC** 4/2025	MEC 4/2025	BOD 4/2025

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To develop and maintain in effect a utilization management (UM) plan that provides for review of services furnished by the organization and by members of the medical staff to all patients including beneficiaries entitled to benefits under the Medicare and Medicaid programs.

1.1.1 support high quality patient care;

1.1.2 To promote effective and efficient use of hospital resources;

1.1.3 To provide oversight and support to staff responsible for evaluating medical necessity for admissions and continued stay reviews; and

1.1.4 To support and facilitate safe, appropriate, timely, and effective discharge planning.

2.0 Scope: Hospital Wide

3.0 Policy:

3.1 It shall be the policy of Pioneers Memorial Hospital (PMH) to adhere to Conditions of Participation (COP), Accreditation Standards, and California Code of Regulations (CCR) AND other State and Federal rules and regulations as it relates to medical necessity reviews, discharge planning, social services, and Clinical Documentation Improvement (CDI).

3.2 Medical Necessity Reviews (COP 482.30)

3.2.1 Admissions to the hospital;

3.2.2 Duration of stays; and

3.2.3 The professional services.

4.0 Definitions:

4.1 Admission Review is Initial (First Medical Necessity Review)

4.2 Duration of Stays is review conducted after Initial (Admission) Review

4.3 Professional Services: Services Rendered by Professional Staff (Attending, specialists, OT, PT, Speech)

4.4 Governing Body: Hospital Board of Directors

5.0 Procedure:

5.1 Establishment of UM Committee (UMC)

5.2 UM Committee Structures:

5.2.1 The Governing Body (The Board) has the ultimate authority for the Utilization Management.

5.3 Composition of the Utilization management Committee (UMC):

5.3.1 Membership will consist of at least two (2) physicians, including physicians in the major specialties as deemed necessary by the Medical Staff.

5.3.1.1 No physician member of the UMC shall have review responsibility for any case in which he/she was, is or anticipates being professionally involved or if he has covering duties for the case being reviewed.

5.3.1.2 No member of the UMC shall have direct financial interest, as defined by CMS in the hospital or any agency owned by the hospital.

5.3.2 Chief Nursing Officer

5.3.3 Director of Case Management

5.3.4 Direct Patient Care Nursing Director

5.3.5 Compliance Officer

5.3.6 Director of Quality

5.3.7 Director of Business Office/Finance

5.3.8 Other key staff as needed

5.4 Scope and Frequency of review:

5.4.1 The UMC will provide the review for all patients with respect to the medical necessity of-

5.4.1.1 Admissions to the hospital;

5.4.1.1.1 Review of admissions may be performed before, at, or after hospitalization.

5.4.1.2 Duration of stays;

5.4.1.2.1 Cases with a length of stay of 7 days or greater are assumed to be outlier cases with extended length of stay; cases that are reasonably assumed to be outlier cases based on extraordinarily high costs are also considered outlier cases.

5.4.1.3 Medical necessity of professional services, including medications.

5.4.1.3.1 Cases that are reasonably assumed to be outlier cases based on extraordinarily high costs are also reviewed at weekly interdisciplinary meeting.

5.4.1.3.2 Drugs and biologicals are reviewed at the Pharmacy and Therapeutics Committee (P&T). The Director of Case Management attends this meeting.

5.5 Medical Necessity Determination regarding admissions or continue stays.

5.5.1 Develop and approve screening criteria for inpatient admissions and observation placements using criteria that are evidence based and compliant with regulatory guidelines.

5.5.2 Establish and carry out a program that includes preadmission screening and review, admission screening and review, and continued stay reviews. Provide oversight to the screening process, including the appropriate processes of escalation of cases that fail screening criteria (Eg MCG, InterQual) to the physician advisors. This review process occurs both concurrently and retrospectively.

5.5.3 Optimize medical management of cases to reduce admissions without medical necessity and to minimize hospital stays by reducing non-acute days.

5.5.4 Recommend strategies and process changes to enhance the quality and efficiency of patient care while controlling cost.

5.5.5 Provide physician advisor oversight and support for the Case Management staff and any non-physician related screening activities.

5.5.6 Initiate and support the issuance of provider denial notices as indicated in the guidelines for Medicare, Medicaid, and as appropriate for third party payers.

5.5.7 Provide support and input to the medical staff regarding educational programs for physicians and other health professionals on utilization management topics.

5.5.8 Evaluate, report, and update at least annually the Utilization Management Plan to the MEC and Board of Directors.

5.6 Utilization Management Data Analysis:

5.6.1 Analyze data and information compiled on utilization management indicators. Identify case-related and quality assessment problems, including:

5.6.1.1 Medical Necessity of Short Stays <2 Midnights

5.6.1.2 Length of Stay (LOS) for inpatients greater than 7 days and observations greater than 24 hours

5.6.1.3 Avoidable Days/Delays by type, department, physician

5.6.1.4 Readmission rates by DRG and physician

5.6.1.5 Denials by payer, physician, and reason

5.6.1.6 Recovery Audit Contractor (RAC) denials and status of appeals

5.6.1.7 Number of Physician Advisor referrals to include reason, trends and any recommended follow up actions

5.6.2 Focused reviews on professional services such as targeted therapeutics, pharmaceuticals, and use of biologicals are reviewed at the Pharmacy and Therapeutics meeting.

5.6.3 Select high utilization indicators as identified by the committee

5.7 Review Processes

5.7.1 Pre-admission and admission screening is done by the Case Management (CM) department or other appropriately trained personnel.

5.7.1.1 Medical records are the source documents for conducting case reviews. Physician progress notes will be of sufficient frequency and quality to permit the staff to perform the review.

5.7.1.2 Staff will use criteria approved by the medical staff for initial screening reviews. Screening reviews will address, as appropriate, intensity of service, severity of illness and discharge criteria. Admit and discharge decisions will be made solely by a licensed independent practitioner. Screenings that do not meet criteria will be presented to physician advisors as described in this plan.

5.7.2 Procedure for Admission Reviews:

5.7.2.1 Admission reviews will be conducted, ideally, within 24 hours of admission/placement.

5.7.2.2 If the admission/placement does not meet established criteria, the case will first be discussed with the attending physician. If the attending physician is not able to provide additional information that ensures the patient meets criteria and there is not an alternate level of care order provided, the case is referred to the Physician Advisor.

5.7.3 Procedure for Continued Stay Reviews:

5.7.3.1 Although continued stay reviews are incorporated into the daily care coordination process, documentation of this review will be completed for inpatients based upon the expected LOS for the working Diagnostic Related Group (DRG) per Medicare for each particular patient. The continued stay reviews for observation patients will be done daily.

5.7.3.2 Extended stay cases are reviewed every 3 days by Case Manager. Extended stay review meetings will be conducted weekly focusing on those patients with a LOS of 7 days or greater. If, after this review, the Physician Advisor feels that medical necessity has not been established, he will give the attending physician an opportunity to present his views. If there is still disagreement, a second Physician Advisor will review the case. If he agrees with the first PA, that will be considered the final decision of the UMC. Once the decision is made that the admission, observation placement, or continued stay is not medically necessary, written notification is given after the determination, to the attending physician responsible for the care of the patient per Medicare guidelines. If the second P-A agrees with the attending physician, no further action is necessary.

5.8 Physician Advisors

5.8.1 The Physician Advisors are delegated authority as stated in the UMP, to provide final medical necessity determination of referred cases. Responsibilities of both internal and external Physician Advisors may include, but are not limited to:

5.8.1.1 Addresses quality of care concerns of referred cases.

5.8.1.2 Provides secondary medical necessity determination of referred cases.

5.8.1.3 Reviewing individual cases meeting outlier status (cost, LOS, etc.) upon request.

5.8.1.4 Collaborating with attending physicians and specialists regarding over utilization and underutilization of services.

5.8.1.5 Provide education to peers as related to current trends in utilization of clini9cal resources

5.8.1.6 Provides education and training to ancillary staff pertaining to UM / DC planning issues.

5.8.1.7 Reviews and signs appeal correspondence related to medical necessity denials.

5.8.1.8 Documenting activities appropriately

5.9 Hospital Staff

5.9.1 The appropriate hospital staff will conduct admission initial review of all patients being placed into acute settings using screening criteria (MCG, Interqual) approved by the medical staff . If a patient fails to clearly meet the initial screen, the staff will escalate the case for further review by the UMC and/or its designee Physician Advisor.

5.9.2 The appropriate staff will conduct continued stay and discharge reviews using screening criteria approved by the medical staff. If it is unclear whether the patient meets continued stay criteria, the case will be escalated for further review by the UMC and/or its designee Physician Advisor.

5.9.3 Individual cases that meet outlier cost (according to Medicare definition for outlier payments) and LOS thresholds (currently identified as greater than 7 days for inpatients and greater than 24 hours for observation patients), will also be escalated for further review. The LOS cases will be reviewed at least every week.

5.10 Conflict of Interest and Confidentiality

5.10.1 All persons involved in case management activities will comply with the Conflict of Interest stipulated in the code of Conduct of PMH.

5.10.2 All medical information and/or records incident to the Utilization Program shall be considered confidential having been prepared for hospital department functioning primarily to review adequacy or quality of professional services and are privileged.

6.0 References:

6.1 Centers for Medicare and Medicaid Services (COPs 42 CFR Part 482.30, 482.43), 412.3

6.2 Title 22

6.3 DNV

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Major Overhaul of UMP 8/2024

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: July 10, 2025

SUBJECT: Purchase of one BD Fiber Dust Thulium Laser system.

BACKGROUND:

The BD Fiber Dust Thulium Laser is an advanced medical laser system used primarily in urology for lithotripsy (stone ablation) and soft tissue treatments. Multiple laser systems including platforms from Karl Storz, Olympus and BD were trialed. The BD was the preferred system based on reliability, support services and performance.

KEY ISSUES:

1. Clinical Advantages:
    - Provides highly precise ablation with minimal thermal injury, leading to improved patient outcomes.
    - Enables shorter procedure times due to higher ablation efficiency.
2. Financial Impact:
    - Reduction in OR time and equipment usage per case.
    - Decrease in ancillary equipment needs (fewer retrieval baskets).
    - Enables increased case volume and potential for higher revenue.
3. Quality and Safety:
    - Reduced thermal damage risk improves patient safety and recovery.
    - Enables more precise treatments across a range of stone sizes and compositions.

The purchase includes two years of service coverage. After this period, we may choose to purchase an additional three years of coverage for $12,000.

CONTRACT VALUE: $ 120,305.00

CONTRACT TERM: One time purchase

BUDGETED: Yes

BUDGET CLASSIFICATION: Medical Equipment, Surgery Department

RESPONSIBLE ADMINISTRATOR: Carol Bojorquez, CNO

DATE SUBMITTED TO LEGAL: 7/2/2025 **REVIEWED BY LEGAL:** [x] Yes [ ] No

FIRST OR SECOND SUBMITTAL: [x] 1st [ ] 2nd

RECOMMENDED ACTION:

That the Board authorizes the purchase of the BD Fiber Dust Thulium Laser System and associated equipment and service agreement.

Cash Quote Proposal For:

Pioneers Memorial Hospital

(AKA Imperial Valley Healthcare District)

Fiber Dust Thulium Laser

Prepared by Territory Manager:

Name: Mary Ralston

Email: mary.ralston@bd.com

Phone: 310-307-6383

Date: June 19, 2025

Quote 06144064

Cash Quote

Customer Name	Pioneers Memorial Hospital (AKA Imperial Valley Healthcare District)
Customer Address	207 W Legion Rd
City, State, Zip	Brawley, CA 92227
Account Number	10163590

QTY	ITEM #	DESCRIPTION		LINE TOTAL
1	PFMS00005	Fiber Dust Thulium Laser		$120,000.00
2	DGM001484	User Manual Fiber Dust		INC
2	Warning Sign	Laser Warning Sign		INC
1	0BM003603	Google Protection > 1300, 2u, c02NM		INC
1	EAM001441	QS Removable Power Cord		INC
1	KBM00100	Case Salsa 1650 Brand for Lith/Cyber		INC
1	AGM00080	Ceramic Cutter With Slip Case		INC
1	OAM002112	Optical Blast shield for TFL EXT-access (1) blast shield located inside the laser		INC
1	OBM001079	Fiber stripper Optical Fibers 300-1000UM		INC
1	OBM001080	Fiber stripper Optical Fibers 300-400UM		INC
1	EAM000045	Interlock Connector		INC
1	Set of Keys	Two-Key Set		INC
1	EBM000473	Pedal MKF 2 1W/1W-MED GP212 With Niro Brace s/n #04638		INC
			Shipping charges	$305.00
			Subtotal	$120,305.00
			Tax	To be added at time of purchase
			Total	$120,305.00

This quote is good until August 18, 2025
Invoice will be applied at time of delivery; payment is expected within 30 days.
This quote is subject to the attached terms and conditions.

TERMS AND CONDITIONS OF SALE
INSTITUTION PRICING

Effective as of June 1, 2020

The following terms and conditions of sale constitute an integral part of this Becton, Dickinson and Company, ("BD") product price list (the "Price List") and apply to all products listed in the Price List other than brachytherapy seed implants and devices into which such implants are loaded by or on behalf of BD ("Products"). All prices and terms are subject to change.

I. Payment Terms

Payment is due no later than 30 days from the date of the invoice. Past due invoices will bear interest at the lesser of 1.5% per month or the maximum rate permitted by law.

II. Acceptance of Purchase Orders

All purchase orders are subject to acceptance at BD's Covington, Georgia facility and will be deemed accepted only when confirmed in writing or upon BD's commencement of performance. For convenience, customers may place purchase orders or make inquiries (between the hours of 8:30 a.m. – 6:30 p.m. Eastern Time) by calling toll free 1-800-526-4455 or by toll free fax at 800-852-1339.

Mail purchase orders to: Becton Dickinson,
8195 Industrial Blvd.
Covington, Georgia 30014
Attn: Customer Service

III. Additional Charges

All applicable excise, sales and other taxes will be invoiced to customer and are not included in Product prices.

IV. Shipments

All Product(s) will be shipped CIF destination customer facility. Delivery of any order hereunder shall be deemed to occur upon delivery of the Products to such destination. Ground transportation takes from 2-10 business days, depending upon shipping and receiving location.

<u>Expedited Shipments</u>

Customers requiring expedited delivery will be invoiced for the charge associated with the expedited delivery.

Shipping Damage

Although BD takes special care in the packaging of its Products, damage may occur in transit. All Products should, therefore, be inspected and any damage noted on the freight bill and reported to the carrier, upon receipt of Product. Although BD's responsibility for damage will cease when the carrier's agent accepts shipments, BD may extend assistance in helping customer settle damage claims.

V. Returns Under the Warranty

Should it be necessary to return Products for repair, replacement, refund or credit under the Warranty in Section VI., customer must obtain return authorization number from BD or a BD account representative prior to the Products return. With regard to those Products for which customer has obtained a return authorization number, BD will accept returns of such products if they are determined by BD to be defective and returned within the applicable warranty period. All Authorized Return Products must be returned freight prepaid by authorized customer. Any Authorized Return Product returned freight collect will be refused by BD and returned to customer at its expense. BD will, at is option, refund or credit customer for all freight charges incurred in connection with returning to BD any Authorized Return Product.

VI. Warranty; Disclaimer; Limitation of Liability

BD warrants to the original purchaser (i) the Products will meet the product specifications applicable thereto from delivery at customer location and for a period of one (1) year thereafter; and (ii) any services, if ordered, shall be executed in a workmanlike manner by competent personnel, in accordance with industry standards. If a Product proves to be so defective, such Product may be returned to BD for repair, replacement, refund or credit, at BD's option, in accordance with BD's return goods and allowance policy. The liability of BD under this limited warranty does not extend to abuse, misuse alteration, further manufacture, packaging or processing of a Product or its adjustment or repair by any person or entity other than BD or a person or entity authorized in writing by BD representative.

THIS LIMITED PRODUCT WARRANTY IS IN LIEU OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING WITHOUT LIMITATION, ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. THE LIABILITY AND REMEDY STATED IN THIS LIMITED PRODUCT WARRANY WILL BE THE SOLE LIABILITY OF BD AND REMEDY AVAILABLE TO CUSTOMER FOR BD PRODUCTS WHETHER IN CONTRACT, TORT (INCLUDING NEGLIGENCE) OR OTHERWISE, AND BD WILL NOT BE LIABLE TO CUSTOMER FOR ANY INDIRECT, SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES ARISING OUT OF HANDLING OR USE OF BD PRODUCTS EVEN IF BD HAS BEEN ADVISED OF THE POSSIBILITY OR LIKELIHOOD OF SUCH DAMAGES. IN NO EVENT WILL BD'S LIABILITY UNDER THIS WARRANTY WITH RESPECT TO ANY PRODUCT EXCEED THE PURCHASE PRICE PAID TO BD BY CUSTOMER FOR SUCH PRODUCT.

VII. Product Changes

All Products and Product specifications identified in this Price List are based upon the information available to BD at the time of publication. BD reserves the right to discontinue any of the Products or to change any specification without notice.

VIII. Force Majeure

BD will not be liable for its failure to perform or a delay in performance of any order due to strikes, fire, explosion, flood, riot, lock out, injunction, interruption of transportation, unavoidable accidents, acts of government or a public enemy, terrorism, inability to obtain supplies at reasonable prices or other causes beyond its control.

IX. Termination

Any customer purchase order may be terminated by BD as follows: (1) upon 30 days prior written notice to customer; (2) effective immediately, if customer commits a material breach of any provision of the purchase order or these terms and conditions and such breach continues for a period of 30 days following written notice from BD; or (3) effective immediately, if the customer files, or has filed against it, a petition for voluntary or involuntary bankruptcy or pursuant to any other insolvency law or makes or seeks to make a general assignment for the benefit of its creditors or applies for or consents to the appointment of a trustee, receiver or custodian for its or a substantial part of its property.

X. Choice of Law.

All transactions under these terms and conditions shall be governed by and construed in accordance with the laws of the State of Georgia as applicable to contracts made and to be performed in that state, without regard to conflicts of laws principles.

XI. General

NONE OF THE FOREGOING TERMS AND CONDITIONS MAY BE MODIFIED EXCEPT UPON BD'S EXPRESS WRITTEN CONSENT STATING THAT IT IS AN AMENDMENT OR MODIFICATION THERETO.
In the event of any inconsistency between these terms and conditions of sale and those contained in any purchase order, the terms and conditions set forth above shall prevail.

The parties understand and agree that the terms and conditions of this Agreement shall control over any additional or different terms contained in any purchase order, confirmation, invoice or similar document, even if accepted in writing by both parties.

Pioneers Memorial Hospital

Signed by _____

Title _____

Date _____

BD

Signed by _____

Title _____

Date _____

International Medical Lasers ("IML") is the exclusive US distributor of Quanta and Deka laser brands. IML has a robust network of Quanta Certified Field Service Engineers IML Field Service Engineers across the United States. As a sub-distributor in the IML network, BD has access to these IML Field Service Engineers and can facilitate efficient repair related to Warranty, Preventative Maintenance, and ad-hoc service needs. IML Terms and Conditions of Sale (U.S) Maintenance Service Agreements – Specific Terms for IML.

ELIGIBILITY: Eligibility for this Agreement is subject to the condition that you are the end user. In addition, if you opt to perform preventive maintenance on your purchased equipment, you must have an IML trained technician who holds a valid IML Training Certificate for the Equipment (as defined hereinafter) during the Term of this Agreement; if you do not have an IML Technician who meets this requirement, an IML Field Service Engineer must complete any repairs and/ or preventative maintenance work in order to maintain the manufacturer warranty..

EQUIPMENT COVERED: IML will provide specified services for the support of the Equipment during the Term of the Agreement. Other equipment may be added to this Agreement via an amendment, with the prior written consent of IML and upon payment of appropriate additional charges. Addition of equipment must be confirmed in writing by IML.

a. To be included, the equipment must be on the list of products approved for this Agreement, have been sold by IML, and must remain in Customers possession and control. IML may exclude equipment from this agreement if it is not and will not be in active use, becomes unserviceable, is sold by the Customer, or is not equipment for which IML currently provides service.
b. Equipment rented, loaned, or leased to you by a third party will be excluded. Customer agrees that the listed Equipment is in your facility or affiliated facilities and will be serviced only by IML or the Customer under this Agreement. The Customer will not permit any person or organization not authorized by IML to service the Equipment.
c. CONDITION OF EQUIPMENT: Equipment is either covered under an IML service agreement of similar coverage to this Agreement or covered under the original manufacturer's warranty and is assumed to be in good operating condition and repair. It is further assumed that the Equipment meets original specifications. Customer agrees to immediately advise IML of any condition to the contrary.
d. For other eligible Quanta or DEKA assets not covered under any IML service agreement or original manufacturer's warranty on the day prior to the first date of coverages on this Agreement, for which service is requested, Customer agrees to pay for any labor, parts, and travel-related expenses deemed necessary by IML to bring the Equipment to full proper operating condition. Any charges shall be at the current IML list price when service is performed. Normally, assessment of equipment condition and any necessary repairs will be affected at the time of initial training.

TRAINING; CERTIFICATION: Customer agrees that: only personnel trained and currently certified by Quanta will work on Equipment; Customer will perform work only to the level certified; and only on the products for which certified. Customer agrees that Quanta-Certified personnel will not allow certification to lapse during the term of this Agreement. Customer agrees to not attempt to perform repairs that exceed first-level services, in accordance with the Quanta-certified technician's training, as detailed below, without first consulting IML technical support. If it is determined by IML technical support that the repair is beyond the scope of the Customer's current technical capability, Customer will request IML on-site services for such repairs or replacements.

Manufacturer Warranty and Responsibility

- Quanta System S.p.A. will disclaim any responsibility for any misuse of the system.
- IML is not responsible for any damage or failure deriving from incorrect use of the device.
    - Correct use consists of:
        - Following the instructions described in this manual
        - Following a proper maintenance program of the system
        - Complying with international safety standards
- **The device is warranted against any defect in material and workmanship for a period of one (1) full year from its delivery ("Warranty")**
- **Repairs needed in case of natural disasters, accidents, electrical circuit failures, negligence, improper use or misuse of the device, or repairs or servicing carried out by persons not authorized by Quanta System S.p.A. or IML are not covered by Warranty.**
- **Quanta System S.p.A or IML staff must be allowed free access to the device.**
- **Any repair which cannot be carried out on-site will be performed in IML facilities.**
- Warranty and responsibility of the Manufacturer and Distributor will also expire for any of the following reasons:
    - Use of the device is not in accordance with the procedures and instructions reported in the user manual.
    - Incorrect installation and maintenance.
    - Use of an out-of-order, not correctly installed, or damaged safety system.
    - Noncompliance with the user manual instructions regarding transportation, storage, installation, or maintenance.
    - Arbitrary alteration of the device.
    - Incorrect repairs.
    - Accidents caused by external elements.

    - The goggles for operator and patients are not used while operating the device, while the device is in any mode.
- In no case the customer can be entitled to claim compensation for any damage resulting from the machine being out of operation.
- On demand, the manufacturer will provide all technical information including electrical drawings, list of components, and suggested application protocols.

Repairs and modifications of the device

- Only authorized service personnel can execute repairs and maintenance.
    - It is recommended that the authorized service personnel follow the standard maintenance program.
    - It is recommended that the authorized service personnel replace all damaged components.
- Use only original spare parts.
- Constructive modifications are not permitted.

LEVELS OF SERVICE AVAILABLE:

Warranty Service:

- New lasers include an initial preventative maintenance ("PM") and 12-month manufacturer's warranty backed by Quanta/Deka and facilitated through IML.
- End of warranty PM is included at no charge, prior to warranty expiration, and will be valid for 12 months.
- During warranty, guaranteed uptime applies if the laser goes down and cannot be fixed within one week.

Post Warranty Service:

- Ad-hoc service calls and/or PMs
    - Price to the Customer is $2,400 per visit plus the cost of any parts.
    - *It is not typical for the laser to need parts during routine maintenance*.
- Extended Warranty Service Agreement:
    - $12,000 per laser per year
    - 12-month initial term with optional 4 successive renewal terms
    - Includes 1 PM per year and unlimited service calls.
    - Includes parts*
    - Lasers that are less than 3 years from install date are eligible to enter extended warranty service.
    - *Footswitches, Blast Shields, Wheels, and physical and/or cosmetic damage are not covered.*

Alternates to Post Warranty Service:

- End-User / Customer Service teams can be trained to provide First Level Service by Quanta Certified Service Engineers.
    - Includes a 2-day training taking place at an IML facility.
    - Customer cost is $1,500 per person, per asset model.
    - First Level Service Certification includes preventive maintenance, basic troubleshooting, and maintenance needed to guarantee functionality.
- Second and Third Levels of Service Provided by IML.
    - Second Level Service includes advanced troubleshooting, backup technical knowledge, parts, and application (clinical/surgical) support.
    - Third Level Support includes access to R&D personnel and engineering resolution for problems that cannot be resolved otherwise or corrective action that requires product design changes, either of which will be provided to the extent and in the time and manner IML deems appropriate.

Items Included in the PM:

- Equipment inspection:
    - Paint / Panels Condition
    - Casters Condition
    - Touch / Screen Operation
    - Bench Alignment
    - Detector Calibration
    - Fluid Levels
    - Hose Connections

    - Filters
    - RFID Function
- Electrical Inspection:
    - Normal Polarity
    - Ground Resistance
    - Input Voltage
    - Connections
    - Power Cord
- Accessory Inspection:
    - Footswitch
    - Interlock
    - Blast Shield
- Output inspection:
    - Verification that output of the laser is within acceptable range of settings indicated on the laser

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: July 10, 2025

SUBJECT: Purchase of a De Soutter OrthoDrive Sagittal Saw Handpiece and Rotary Handpiece Power System.

BACKGROUND:

Our orthopedic service line utilizes the De Soutter OrthoDrive system, including sagittal saw and rotary handpieces, as essential tools for bone cutting and drilling during surgical procedures. This equipment is known for its precision, reliability, and ease of use in the operating room.

Currently, the facility maintains a limited supply of these handpieces and associated power systems. While these units are in good working order, the growing volume of orthopedic cases has created strain on our inventory. Sterile Processing Department (SPD) staff are routinely required to rapidly turn over and reprocess these devices within the same surgical day to meet demand, which increases operational pressure and heightens the risk of procedural delays.

KEY ISSUES:

1. Support growing case volume: Our orthopedic caseload has increased, and an additional sagittal saw handpiece and rotary handpiece power system will ensure we have adequate equipment to support current and projected demand.
2. Reduce intra-day reprocessing strain: Adding to our inventory will lessen the burden on SPD to perform rapid turnovers, improving efficiency and reducing risk of delays or reprocessing errors.
3. Improve OR workflow reliability: Ensures availability of sterile, ready-to-use equipment for all scheduled procedures without reliance on same-day turnover.
4. Extend equipment lifespan: By distributing use across more handpieces and systems, we reduce wear and extend the operational life of each unit.

CONTRACT VALUE: $ 55, 821.26

CONTRACT TERM: One time purchase

BUDGETED: Yes

BUDGET CLASSIFICATION: Medical Equipment, Surgery Department

RESPONSIBLE ADMINISTRATOR: Carol Bojorquez, CNO

DATE SUBMITTED TO LEGAL: 7/2/2025 **REVIEWED BY LEGAL:** [x] Yes [ ] No

FIRST OR SECOND SUBMITTAL: [x] 1st [ ] 2nd

RECOMMENDED ACTION:
That the Board authorizes the purchase of the purchase of the De Soutter OrthoDrive

power system and its components.


orthodrive®
dedicated battery saws

PRODUCT QUOTATION

PIONEERS MEMORIAL HEALTHCARE DIST
207 W LEGION RD BRAWLEY CA 92227
BRAWLEY
CA 92227
United States

De Soutter Medical Usa, Inc
224 Rolling Hill Road Suite 12A
Mooresville
NC 28117
USA

tel: (704) 655-9040
fax: (704) 987-2035
email: usa@de-soutter.com

web: www.de-soutter.com

DATE	QUOTATION NUMBER	AMENDMENT
01/10/2025	00121547	3

QUANTITY	PART NUMBER	DESCRIPTION	NET PRICE
1	1290004	DBK-701 ORTHODRIVE SAGITTAL SAW HANDPIECE - S89	$10,800.40
2	1289884	MBQ-701 ORTHODRIVE ROTARY HANDPIECE - TWIN TRIGGER	$21,600.80
1	17860	PQ-701 PIN DRIVER 1.8 - 3.2mm	$3,379.20
1	17940	WQ-701 WIRE DRIVER 0.6 - 2.0mm	$3,379.20
1	15390	CHUCK - Q-SERIES TO 7.4MM KEYLESS CHUCK OUTPUT	$1,878.84
1	15370	CHUCK - Q-SERIES TO 7.4MM KEYED CHUCK OUTPUT	$1,878.84
1	15490	CHUCK - Q-SERIES TO A.O. SYNTHES/PROTEK OUTPUT	$1,823.58
2	15480	CHUCK - Q-SERIES TO A.O. SYNTHES DRILL OUTPUT	$3,757.68
1	15530	CHUCK - Q-SERIES TO HUDSON OUTPUT	$1,823.58
1	15460	CHUCK - Q-SERIES TO ZIMMER OUTPUT	$1,878.84
1	16250	STD SIZE STERI-CASE & TRAY - 3 x MBQ-700 - STERILE	$1,620.30
1	991W	4 Year Warranty On Power Equipment Included Free Of Charge, Warranty Includes Repairs, Loaners, and Service.	$0.00

DELIVERY TO:

NET VALUE $53,821.26

TOTAL $53,821.26

Please visit www.de-soutter.com for details of the equipment offered and available accessories.

Notes:
Above quotation valid for **45** days.
Payment by credit card will be charged a 3% processing fee.
De Soutter Medical Terms and Conditions of Sale apply to all shipped orders and are subject to change without prior notice.
Consumables: All saw blades, drills, burs, k-wires and pump kits are sold in boxes of 5. Prices shown are per item.

TERMS & CONDITIONS OF SALE

1. **GUARANTEE** – All goods actually manufactured by DeSoutter Medical are guaranteed for the period of twelve months, unless otherwise specified, commencing from the date of purchase from DeSoutter Medical or our agents against defective workmanship and materials, and goods proved to be defective during this period in these respects will be replaced or repaired free of charge. In the case of goods supplied by but not manufactured by DeSoutter Medical we merely pass on the benefit of any guarantees, conditions, and warranties received by DeSoutter Medical in respect of such goods. None of the previous statements in this paragraph affect customers' statutory rights and such statements are in addition to such rights.

2. **DELIVERY** - Every effort will be made to keep to the delivery dates, but no liability can be accepted for loss caused through delay for reasons beyond our control or by industrial dispute of any kind (whether involving any of our employees or not) or by any failure to obtain materials goods or equipment from a supplier through no fault of our own in due time to observe delivery dates. The right is reserved to suspend delivery as long as any payment for goods previously invoiced is in arrears.

3. **PRICES** - In view of the fluctuations in raw material costs, etc., the prices quoted are subject to alteration without prior notice. Goods will be invoiced at prices ruling at date of dispatch notwithstanding any quotation or prior acceptance of order.

4. **PAYMENT** - Payment terms are NET 30 and must be made in full within 30 days of invoice date unless other arrangements are settled.

5. **PROPERTY** - All goods will remain the property of DeSoutter Medical until such time that the full invoice value has been paid.

6. **RETURN OF EQUIPMENT** - Equipment may not be returned to DeSoutter Medical DeSoutter Medical for credit without obtaining our prior written authorization. All returned goods will be subject to a re-stocking charge.

7. **SHIPPING** - All goods shall be shipped FOB Origin. Risk of loss or damage shall pass to the Customer upon delivery of goods to Carrier.

8. **CARRIAGE, PACKING & FREIGHT CHARGES** - Freight charges shall be prepaid by DeSoutter Medical and invoiced to the customer unless otherwise agreed upon in writing.

9. **LAW** - The applicable law shall be the law of the state of North Carolina.

10. **HEALTH & SAFETY AT WORK ACT** - Whilst every reasonable care is taken to ensure that our products are safe, you are requested to pay particular attention to applying the proper health and safety precautions in the use of our products and where instruction manuals are issued, that the instructions therein are scrupulously observed.

11. **CUSTOMER CONDITIONS NOT TO APPLY** - The above terms and conditions shall apply notwithstanding customers' terms and conditions and anything which may be stated or implied to the contrary in correspondence or other conditions.

12. **CLAIMS FOR SHORTAGES OR DAMAGED GOODS** - Claims for shortages must be submitted in writing within 10 days from receipt of goods.

13. **RESTOCKING CHARGE** - Goods returned for credit with seller's prior agreement will be subject to a standard re-stocking charge of 20% of the net invoiced value.

Imperial Valley Healthcare District

BOARD MEETING DATE: July 10, 2025

SUBJECT: Renewal of annual agreement between Dr. Terence Mulvany M.D. ("Dr. Mulvany") and Imperial Valley Healthcare District dba Pioneers Memorial Hospital ("IVHD"), whereby Dr. Mulvany will provide Occupational Medicine services to employees of IVHD.

BACKGROUND: Agreement to continue existing arrangements whereby Dr. Mulvany (Imperial Valley Occupational Medicine) will provide medical services and treat work-related injuries and illnesses of IVHD employees.

KEY ISSUES: None

CONTRACT VALUE: $15,000 Estimated

CONTRACT TERM: Contract agreement- 1 year

BUDGETED: Yes

BUDGET CLASSIFICATION: Professional Fees

RESPONSIBLE ADMINISTRATOR: Christopher R. Bjornberg

DATE SUBMITTED TO LEGAL: 07/02/2025 **REVIEWED BY LEGAL:** [X] Yes [ ] No

FIRST OR SECOND SUBMITTAL: [X] 1st [ ] 2nd

RECOMMENDED ACTION:

Comp-01, Compliance Officer 3/2023

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

207 West Legion Road, Brawley, CA 92227 voice 760.351.3250 ~ fax 760.351.4489

June 26, 2025

Dr. Terence Mulvany, M.D.

1850 W. Main St., Ste E

El Centro, CA 92243

Re: Occupational Medicine Services

Effective August 15, 2025, I, Dr. Terence Mulvany, M.D. ("Dr. Mulvany") and Imperial Valley Healthcare District dba Pioneers Memorial Hospital ("IVHD") have agreed to continue the existing arrangement whereby Dr. Mulvany will provide Occupational Medicine services to employees of IVHD under the District's employee health program.

Dr. Mulvany agrees to bill IVHD for those services in accordance to the Official Medical Fee Schedule (OMFS) promulgated by the Division of Workers' Compensation ("DWC") administrative director under Labor Code section 5307.1. This fee schedule can be found in sections 9789.10 et seq. of Title 8, California Code of Regulations. Such fee schedule is used for payment of medical services required to treat work related injuries and illnesses in the State of California.

IVHD will remit payment to Imperial Valley Occupational Medicine for all approved invoices within 30 days of the invoice date.

Either party may terminate this agreement with Thirty (30) days of advanced notice in writing.

Agreed to:

Imperial Valley Healthcare District,
dba Pioneers Memorial Hospital

By:_____

_Christopher R. Bjornberg_____
Print Name

_Chief Executive Officer_____
Title

_____
Date

Dr. Terence Mulvany, MD

By:_____

_Terence Mulvany_____
Print Name

__MD_____
Title

_____
Date

cc: Carly Loper, Chief Financial Officer Estella Chavarin HR Manager

Imperial Valley Healthcare District

BOARD MEETING DATE: 7/10/2025.

SUBJECT: Authorization to approve Professional Service Agreement and Emergency On-call for Dr. Idrees Suliman, M.D.

BACKGROUND: This agreement is for Gastroenterology Services and Emergency On-call services for Imperial Valley Healthcare District.

KEY ISSUES: Physician shall provide a minimum of (8 hours) per day, two days per week of Gastroenterology services in the Hospital, clinics, endoscopy center and or operating rooms. Physician shall be compensated as follows:

- Base Compensation $269,482.00 per year base compensation and $75.00 per wRVU incentive bonus after 3,580 wRVU's in excess annually.
- Sign-on Bonus of $10,000 to be paid within one week of signing.
- **Emergency On-Call Coverage Services:**
- 3 days included in PSA compensation.
- Additional coverage
    - Weekdays at ($500) for each 24-hour period
    - Weekends at ($1000) for each 24-hour period

CONTRACT VALUE: approximately $330,000 annually value varies depending on wRVU incentives and demands and on-call demands.

CONTRACT TERM: 3 years.

BUDGETED: No

BUDGET CLASSIFICATION: PSA/On-call

RESPONSIBLE ADMINISTRATOR: Carly Zamora/Christopher Bjornberg

DATE SUBMITTED TO LEGAL: 6/2025 **REVIEWED BY LEGAL:** [X] Yes [ ] No

FIRST OR SECOND SUBMITTAL: [X] 1st [ ] 2nd

RECOMMENDED ACTION: Authorization to approve Professional Service Agreement and Emergency On-call for Dr. IdreesSuliman, M.D

PROFESSIONAL SERVICES AGREEMENT
(Gastroenterology)

THIS PROFESSIONAL SERVICES AGREEMENT ("**Agreement**") is entered into and executed as of _____ ("**Effective Date**"), by and between Imperial Valley Healthcare District dba Pioneers Memorial Hospital a Local Healthcare District, organized and existing in the State of California pursuant to the California Health and Safety Code, §§32000 *et seq.* ("**Hospital**"), and Idrees Suliman, M.D., a physician licensed to provide medical services in the State of California, ("**Practitioner**"). Practitioner and Hospital are sometimes individually referred to hereafter as a "Party," and collectively as "Parties."

This Professional Services Agreement is entered into with respect to the following facts:

R E C I T A L S

A. Hospital owns and operates a general acute care hospital located in Brawley, California and rural health clinics ("**Clinics**"), in Calexico and Brawley, California, and by the start date, may also own and operate a second general acute hospital located in El Centro, California.

B. Practitioner is duly licensed and qualified to practice medicine, including surgery, under the laws of the State of California and is experienced and qualified to provide specialty medical services in the field of gastroenterology ("**Specialty**").

C. Hospital has determined that entering into an agreement with the Practitioner is an appropriate way to assure the availability of such Specialty services for its patients and to maintain a high quality of patient care. The Parties furthermore acknowledge that many of the patients of the Hospital and Clinics will be referred there by outside physicians.

D. The Parties desire to enter into this Agreement to set forth their respective responsibilities in connection with Hospital's and Practitioner's provision of Services for treating patients during the term of this Agreement beginning upon a mutually agreed date ("**Start Date**").

NOW, THEREFORE, the Parties agree as follows:

A G R E E M E N T

1. DUTIES OF PRACTITIONER

a. **Professional Medical Services.** Practitioner shall provide all professional medical

services ("**Professional Services**") as set forth in ***Exhibit A***, as reasonably required for coverage and patient care. Practitioner shall provide the Professional Services during regular hours of operation, as mutually agreed upon by the parties, and as more specifically set forth in ***Exhibit B*** ("**Practitioner Coverage**").

b. **Qualifications of Practitioner**. Practitioner shall be: (a) duly licensed by the State of California (b) have levels of competence, experience and skill comparable to those prevailing in the community; (c) are not excluded from any governmental healthcare program, (d) is a member in good standing of the Medical Staff of Hospital, and, within one (1) year following commencement of provision of services in the Agreement, become board certified in Specialty.

c. **Applicable Standards**. Practitioner shall perform all Specialty services under this Agreement in compliance with all applicable standards set forth by law or ordinance or established by the rules and regulations of any federal, state or local agency, department, commission, association or other pertinent governing, accrediting or advisory body, including compliance with the accreditation requirements of Det Norske Veritas (DNV), having authority to set standards for health care facilities, and in accordance with all Hospital and Medical Staff bylaws, rules, regulations, policies and procedures.

d. **Records and Documentation**; For each patient receiving Services, Practitioner shall promptly complete and finalize for Hospital all of the medical record and report documentation required to accurately record the visit in the Hospital's electronic medical record (EMR) system or on the forms provided by the Hospital. Subject to applicable restrictions on disclosure, Practitioner shall have reasonable access, including the right to make copies, during business hours of all such medical records and reports as they may need from time to time for patient care or responding to any legal, judicial or third party administrative/investigative inquiries.

e. **Use of Premises.** Practitioner shall not use, or knowingly permit any other person who is under Practitioner's direction to use, any part of the Hospital's premises for (i) the private practice of medicine – except for incidental telephonic communications – via voice, voicemail, text and/or e-mail – relating to external clinical work-practice, or (ii) any purpose other than the performance of the services required hereunder.

f. **Non-Discrimination.** During the performance of this Agreement, Practitioner (including employees and subcontractors) shall not unlawfully discriminate, harass or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, or family care leave. Practitioner and shall ensure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. Practitioner shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990(a-f), set forth in California Code of Regulations, Title 2, Chapter 5, Division 4 are incorporated into this contract by reference as if duly set forth herein. Practitioner shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Practitioner

shall include the nondiscrimination and compliance provisions of this Agreement in all subcontracts to perform work under this Agreement.

2. REPRESENTATIONS AND WARRANTIES OF PRACTITIONER. Practitioner hereby warrants and represents as follows:

a. Review of Compliance Requirements. Practitioner acknowledges that Hospital has a commitment to full compliance with all laws, regulations and guidance relating to its participation in the federal and state healthcare programs, and, as a result, has implemented a compliance program including, without limitation, mandatory requirements related to ongoing compliance training and education programs for its workforce, medical staff and persons/entities that conduct healthcare business with the Hospital. As a condition to this Agreement, Practitioner shall provide written acknowledgement that Practitioner and Practitioner's principal, employees, subcontractors and/or agents who are engaged/authorized by Practitioner to act under or in relation to this Agreement, have received (or have been provided with electronic or other access to), read and understood, and agree they will comply with all pertinent provisions of, Hospital's compliance program materials and "Code of Conduct of Medical Staff."

b. Practitioner Is Not Restricted. Practitioner is not bound by any agreement or arrangement which would preclude Practitioner from entering into, or from fully performing the services required under, this Agreement.

c. Practitioner is Qualified. Practitioner's license to practice medicine in the State of California, or in any other jurisdiction, has not ever been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way. Additionally, Practitioner's medical staff privileges at any health care facility have not ever been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction.

d. Prohibition from Program Participation. Practitioner, including employees, has not been (a) excluded, suspended or debarred from, or otherwise ineligible for, participation in any federal or state health care program including, without limitation, Medicare or Medi-Cal (Medicaid), nor (b) convicted of a criminal offense related to conduct that would or could trigger an exclusion from any federal or state health care program including, without limitation, Medicare or Medi-Cal (Medicaid);

e. Notification of Threatened Exclusion From Program Participation. Practitioner shall notify Hospital immediately in writing if Practitioner becomes the subject of (a) any threatened, proposed or actual exclusion, suspension or debarment, (b) any conviction of a criminal offense related to conduct that would or could trigger an exclusion, of it or any of its agents or employees from any federal or state health care program, (c) any investigatory, disciplinary, or other proceeding by any governmental, professional, licensing board, medical staff, or peer review body, or (d) any event that substantially interrupts all or a portion of Practitioner's professional practice or that materially adversely affects Practitioner's ability to perform Practitioner's obligations hereunder.

f. **Third-party Payment, Managed Care Programs, and Charity Care**. Practitioner shall participate in all third-party payment or managed care programs in which Hospital participates, render services to patients covered by such programs, and accept the payment amounts for services rendered by Practitioner under these programs as payment in full for services of the Practitioner to Clinic patients. Hospital will provide to Practitioner timely notification of new contract negotiations. Hospital will also pay, or provide, for the Practitioner's credentialing with third-party payment or managed care programs. Practitioner shall participate in Hospital's Financial Assistance Program including Full Charity Care and Discount Partial Charity Care. Hospital will provide Practitioner with a copy of its Financial Assistance Program and any amendments thereto.

3. COMPENSATION FOR PRACTITIONER

a. **Compensation.** Hospital shall pay Practitioner according to the compensation schedule set forth in ***Exhibit C*** ("**Compensation**"). Hospital shall pay the compensation owed on or before the fifteenth (15th) day of each calendar month, for services provided by Practitioner during the immediately preceding calendar month; provided that Practitioner has delivered a visit record to Hospital in the form attached hereto as ***Exhibit D*** ("**Time Log**") on or before the fifth (5th) day of each calendar month for the immediately preceding calendar month.

b. **Taxation of Income**. The Parties understand that the Hospital will bill, collect and retain the proceeds from all charges for medical services, and may use the Practitioner's Principal's Billing Provider number for such purposes. Practitioner understands and agrees that Hospital will issue Practitioner an IRS Form 1099 at the end of each calendar year for compensation paid by Hospital to Practitioner under this Agreement. Practitioner understands and agrees that the payment of all taxes due and owing on Practitioner's behalf with respect to any payments made to the Practitioner are Practitioner's sole responsibility, along with any fines, penalties, or costs associated with Practitioner's failure to pay taxes due and owing on Practitioner's behalf with respect to any payments made to Practitioner pursuant to this Agreement. Practitioner shall be fully and solely responsible for Practitioner's own self-employment tax payments, as well as Social Security (FICA), Medicare, and other required tax payments, if any. Practitioner will be fully responsible for Practitioner's own worker's compensation insurance coverage, health insurance coverage, disability insurance coverage, life insurance coverage, and retirement plan, if any. Hospital will not withhold or pay on behalf of the Practitioner any taxes such as state and local or payroll taxes and those listed herein. Accordingly, it is anticipated, and Practitioner agrees, that Practitioner will deduct from Practitioner's compensation all required deductions and report on Practitioner's income tax return all compensation earned by Practitioner hereunder.

c. **Compliance with Health & Safety Code.** Any compensation received by Practitioner pursuant to this Agreement shall be issued in compliance with the provisions of California Health and Safety Code Section 32129. Hospital has the obligation and right to adjust compensation to be in compliance with any and all laws and regulations.

4. DUTIES AND OBLIGATIONS OF THE HOSPITAL

a. **Duties**. Hospital agrees to furnish, at its own cost and expense, for adequate

provision of professional services pursuant to this Agreement, the following:

i. Space. Space as reasonably necessary to provide service to patients.

ii. Equipment. Equipment as may be reasonably required as mutually agreed by the Hospital and Practitioner, subject to any applicable Hospital budget limitations. Practitioner acknowledges that existing equipment is adequate for Practitioner's purposes.

iii. Services and Supplies. Maintenance, repair and replacement of equipment as reasonably required; all utilities, including telephone, power, light, gas and water; all supplies (including, without limitation, film, laundry services and linen); transcription services, and any necessary housekeeping and in-house messenger service that may be reasonably required to provide services.

iv. Non-Physician Personnel. Hospital personnel with appropriate education, training and experience which are required to adequately assist Practitioner in performance of the services contemplated herein, as determined according to Hospital's discretion. Hospital shall have the sole right and responsibility for the hiring, discipline and termination of such Hospital employees.

b. Eligibility. At all times during the term of this Agreement, Hospital shall remain eligible to participate in the Medicare, Medi-Cal, and TriCare/CHAMPUS programs.

5. BILLING FOR MEDICAL SERVICES

a. Billing Records Availability. Each Party~~,~~ shall, on a monthly basis, make available to the other Party, records and data accurately reflecting a) total billed services in connection with the Services; b) payments received from all sources for medical services provided by the Practitioner, and c) all expenses paid by Hospital or Practitioner in connection with the operation of the Services or the services rendered therein.

b. Accurate Medical Records and Charts. Practitioner shall promptly prepare and submit complete and accurate medical records, medical chart notes, and related back-up documentation, and respond and provide such assistance and information as Hospital may reasonably request to facilitate billing and collection of charges for patient services, including, but not limited to, assigning appropriate procedure and diagnosis codes for billing purposes, and dictating or completing appropriate descriptions and notations to be made on the patient chart to support the appropriate billing code, in accordance with the requirements of the Centers for Medicare and Medicaid Services. Practitioner shall be responsible (and Hospital shall not be responsible except with respect to joint and several liability required by law) for errors or liabilities, if any, which may arise from Practitioner's fraudulent designation of inappropriate billing, procedure or diagnosis codes or for the negligent failure of Practitioner to prepare medical chart notes or dictation which corresponds to the services rendered.

c. Charges for Medical Services. Hospital shall be responsible for, and solely entitled to, billing and collection of all charges for all medical services (ancillary and professional); (ii) Practitioner hereby reassigns Practitioner's respective rights to bill such Professional Services

to Hospital.

d. **Schedule of Charges.** On an annual basis, Hospital may provide to Practitioner the schedule of charges for the professional component of the medical services provided for Practitioner's review and input. Practitioner may request changes to the schedule of charges as circumstances may warrant. Hospital, in its sole and absolute discretion, shall decide upon changes to the schedule of charges.

e. **Forwarding Billing to Hospital.** Practitioner shall provide Hospital, on a daily basis, with all information reasonably requested by Hospital to enable Hospital to (i) properly bill for the Professional Services provided by Practitioner to patients. It is understood and agreed that Hospital shall handle at its expense all the administrative work of this billing. All Professional Services shall be billed in Practitioner's, its Principal's or its Medical Group's name with all payments forwarded by payors (including, without limitation, Medicare and Medi-Cal) to a "lockbox" account in Practitioner's or Medical Group's name ("Account") established at Wells Fargo bank in Brawley, California. ("Bank"). Upon establishment of the Account, Practitioner shall direct the Bank, in writing, that during the term of this Agreement, on the last day of each calendar month, the Bank shall transfer all funds in the Account on each such day to an account in Hospital's name as designated by Hospital in writing to the Bank.

f. **Billing Third-Party Payors**. Practitioner shall not bill, nor cause to be billed, Medicare patients or Medicare (Part B) carriers in violation of 42 C.F.R. §405.550(d)(3), nor any other patients or payors, for administrative, supervisory, medical director or similar services.

g. **Rates for Service**. In the event that Practitioner is responsible for establishing rates charged to patients for any Professional Services rendered pursuant to this Agreement, Practitioner must ensure that such rates are reasonable and customary. In the event that Hospital determines Practitioner's rates are unreasonable, Hospital reserves the right to approve modify rates charged by Practitioner for Services.

6. TERM AND TERMINATION

a. **Term.** The term of this Agreement shall be three (3) years commencing on the Start Date, unless terminated earlier as provided herein.

b. **Termination Without Cause**. Either party shall have the right to terminate this Agreement without penalty or cause by providing ninety (90) days written notice to the other party.

c. **Termination for Cause.** Either Party may terminate this Agreement upon breach by the other Party of any material provision of this Agreement, provided such breach continues for fifteen (15) days after receipt by the breaching Party of written notice of such breach from the non-breaching Party, except where such breach requires immediate termination as enumerated below.

d. **Immediate Termination.** This Agreement may be terminated immediately and without notice for serious and incurable events, including but not limited to:

i. Breach. Hospital or Practitioner is in breach of any material term or

condition of this Agreement and such breach has not been cured within thirty (30) days following notice of such breach;

ii. Sale or Transfer. Hospital or Practitioner has sold or otherwise transferred all or substantially all of its assets, has merged with another entity or has dissolved.

iii. Insolvency or Bankruptcy. Hospital or Practitioner becomes insolvent or declares bankruptcy.

iv. Practitioner's License Suspension. The denial, suspension, revocation, termination, restriction, lapse, or voluntary relinquishment under threat of disciplinary action, of Practitioner's medical staff membership or privileges at Hospital or any other healthcare facility located in the State of California, or of Practitioner's license/Practitioner's Principal's license to practice medicine in the State of California.

v. (a) Either Party's exclusion, suspension, debarment from, or ineligibility for, participation in any federal or state health care program, or (b) conviction of a criminal offense related to conduct that would or could trigger an exclusion from any federal or state health care program.

vi. Cancellation of Insurance. Either Party fails to carry or reinstate the insurance required in Section 7 hereof or such coverage is cancelled or revoked within ten (10) days following notice thereof from its insurance carrier.

vii. Conduct Jeopardizing Licensure or Other Reimbursements. The performance by either Party of this Agreement which jeopardizes the licensure of Hospital, Hospital's participation in Medicare, Medi-Cal or other reimbursement or payment program, or Hospital's full accreditation by The Joint Commission or any other state or nationally recognized accreditation organization, or the tax-exempt status of Hospital's bonds, or if for any other reason such performance violates any statute, ordinance, or is otherwise deemed illegal, or is deemed unethical by any recognized body, agency, or association in the medical or hospital fields, and the jeopardy or violation has not been or cannot be cured within sixty (60) days from the date notice of such jeopardy or violation has been received by the parties.

viii. Misrepresentations. Any Party's representation or warranty that is false or was false at the time it was originally made, or any Party becomes the subject of any threatened, proposed or actual exclusion, suspension or debarment from, or is otherwise ineligible for participation in, any federal or state health care program including without limitation, Medicare or Medi-Cal, or is the subject of any threatened, proposed or actual criminal prosecution for, or is convicted of, any criminal offense related to conduct that would or could trigger an exclusion from any federal or state health care program.

e. One Year Prohibition on New Agreement. If this Agreement is terminated prior to expiration of the initial year of the term hereof, the Parties shall not enter into any new agreement or arrangement during the remainder of such year.

7. INDEPENDENT CONTRACTOR. Practitioner is engaged in an independent contractor

relationship with the Hospital in performing all work, duties and obligations hereunder. Hospital shall not have nor exercise any control or direction over the methods by which Practitioner performs work and functions, except that Practitioner shall perform at all times in strict accordance with then currently approved methods and practices of the professional Specialty services. Hospital's sole interest is to ensure that Practitioner performs and renders services in a competent, efficient and satisfactory manner in accordance with high medical standards. The Parties expressly agree that no work, act, commission or omission of Practitioner in connection with the terms and conditions of this Agreement shall be construed to make or render Practitioner, the agent, employee or servant of Hospital. Practitioner shall not be entitled to receive from Hospital vacation pay, sick leave, retirement benefits, Social Security, workers' compensation, disability or unemployment insurance benefits or any other employee benefit of any kind. The provisions of this Section shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

8. PROFESSIONAL LIABILITY INSURANCE COVERAGE. Practitioner shall secure and maintain at all times during the term, at Practitioner's sole expense, professional liability insurance covering Practitioner, with an admitted carrier (licensed to do business in the State of California) having at least an "A" BEST rating, with limits of one million ($1,000,000) per claim/and three million ($3,000,000) for annual aggregate claims. Such insurance shall not be cancelable except upon thirty (30) days' prior written notice to Hospital, and shall be primary and non-contributory. Annually, Practitioner shall provide Hospital with a certificate of insurance evidencing such coverages and coverage extensions upon request by the Hospital. If the coverage is on a claims-made basis, Practitioner hereby agrees that not less than thirty (30) days prior to the effective date of termination of Practitioner's current insurance coverage or termination of this Agreement, Practitioner shall either purchase unlimited tail coverage or provide proof of continuous coverage in the above stated amounts for all claims arising out of incidents occurring prior to termination of Practitioner's current coverage or prior to termination of this Agreement, as applicable, and provide Hospital a certificate of insurance evidencing such coverage.

9. OWNERSHIP OF FILMS AND RECORDS. Unless agreed upon in writing, all records of patients seen at any Hospital facilities shall be maintained by Hospital and shall be the property of the Hospital. Practitioner shall have the right to access such films and records during normal business hours.

10. NOTICES. Any notice to be given to any party hereunder shall be deposited in the United States Mail, duly registered or certified, with return receipt requested, with postage thereon paid, and addressed to the party for which intended, at the following addresses, or to such other address or addresses as the parties may hereafter designate in writing to each other.

Hospital:	Practitioner:
Chief Executive Officer Imperial Valley Healthcare District West 207 Legion Road Brawley, CA 92227	Idrees Suliman, M.D. _____ _____ _____

11. CONFIDENTIALITY

a. Confidential Information Belongs to its Respective Owner. Each Party recognizes and acknowledges that, by virtue of entering into this Agreement and providing services to the other hereunder, Practitioner and Hospital may have access to certain information of the other Party that is confidential and constitutes valuable, special and unique property. Each Party agrees that it will not at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without the other Party's express prior written consent, except pursuant to Practitioner's duties hereunder, any confidential or proprietary information of either Party, including, but not limited to, information which concerns Hospital's patients, costs, or treatment methods developed by Hospital for the Hospital, and which is not otherwise available to the public.

b. This Agreement is Confidential. Except for disclosure to Practitioner's legal counsel, accountant or financial advisors (none of whom shall be associated or affiliated in any way with Hospital or any of its affiliates), Practitioner shall not disclose the terms of this Agreement to any person who is not a party or signatory to this Agreement, unless disclosure thereof is required by law or otherwise authorized by this Agreement or consented to by Hospital. Unauthorized disclosure of the terms of this Agreement shall be a material breach of this Agreement. Except for disclosure to Hospital's legal counsel, accountant or financial advisors, its Board of Directors and/or any committee concerned with this Agreement, Hospital and its officers, directors, employees, and agents shall not disclose the terms of this Agreement to any person who is not a party or signatory to this Agreement, unless disclosure thereof is required by law or otherwise authorized by this Agreement or consented to by Practitioner. Unauthorized disclosure of the terms of this Agreement shall be a material breach of this Agreement. Upon the termination or expiration of this Agreement, all records of the patients seen or treated by Practitioner shall be the property of Hospital. However, upon Hospital's receipt of appropriately executed written request of any such patient therefor, Hospital will provide copies of the requesting patient's records to Practitioner, in paper or electronic form and the delivery of such records shall be in compliance with federal and state law.

c. Medical Records Are Confidential. Neither Party shall disclose to any third party, except where permitted or required by law or where such disclosure is expressly approved by the other Party in writing, any patient or medical record information regarding Hospital patients, and the Parties shall comply with all federal and state laws and regulations, and all bylaws, rules, regulations, and policies of Hospital, and Hospital's Medical Staff, regarding the confidentiality of such information. Practitioner acknowledges that in receiving or otherwise dealing with any records or information from Hospital about Hospital's patients receiving treatment for alcohol or drug abuse, Practitioner is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2, as amended from time to time).

d. HIPAA Compliance is Required. Each Party agrees to comply with the applicable provisions of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the requirements of any regulations promulgated thereunder including without limitation the federal privacy regulations (the "Federal Privacy Regulations") and the federal security standards (the "Federal Security Regulations").

12. AGREEMENT INTERPRETATION AND DISPUTE RESOLUTION

a. **Entire Agreement; Amendment**. This Agreement, its exhibits, and all documents referred to herein constitute the entire agreement between the parties pertaining to the subject matter contained herein. This Agreement supersedes all prior and contemporaneous agreements, representations and understandings of the parties which relate to the subject matter of this Agreement. No supplement, amendment or modification of this Agreement shall be binding unless executed in writing by all of the Parties.

b. **Subject Headings.** The subject headings of the Articles and Sections of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of the provisions of this Agreement.

c. **Parties.** Nothing in this Agreement, whether express or implied, is intended to confer any rights or remedies on any person other than the Parties to it and their respective successors and assigns; nor is anything in this Agreement intended to relieve or discharge the obligation or liability of any third persons to any Party to this Agreement; nor shall any provision give any third person any right of subrogation or action over or against any party to this Agreement.

d. **No Assignment**. This Agreement shall be binding upon and shall inure to the benefit of the Parties to it and their respective legal representatives, successors and permitted assigns. No Party may assign this Agreement or any rights hereunder, nor may they delegate any of the duties to be performed hereunder without the prior written consent of the other party.

e. **Governing Law and Waiver of Trial.** This Agreement shall be governed by, construed and enforced in accordance with the laws of the State of California. All disputes of any nature, including those for injunctive relief, relating to, or arising out of, this Agreement shall be subject to Arbitration.

f. **Counterparts.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute the same instrument.

g. **Attorneys' Fees.** In the event of any legal action between the Parties to interpret or enforce the terms of this Agreement, the prevailing party shall be entitled to recover its costs of suit, including reasonable attorneys' fees, from the unsuccessful Party.

h. **Arbitration**. Any dispute or controversy arising under, out of or in connection with, or in relation to this Agreement, or any amendment hereof, or the breach hereof shall be determined and resolved by arbitration before a single arbitrator in Imperial County, California, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration and applying the laws of the State of California. Any award rendered by the arbitrator shall be final and binding upon each of the Parties, and judgment thereon may be entered in any court having jurisdiction thereof. The costs shall be borne equally by both Parties. The prevailing Party in any such arbitration shall be entitled to recover its reasonable attorneys' fees. During the pendency of any such arbitration and until final judgment

thereon has been entered, this Agreement shall remain in full force and effect unless otherwise terminated as provided hereunder. The provisions of this Section shall survive expiration or other termination of this Agreement.

i. **Exhibits**. The attached exhibits, inclusive, constitute a material part of this Agreement and are to be construed as incorporated into this Agreement in full and are made a part hereof.

j. **No Waiver**. No waiver of any of the provisions of this Agreement shall be deemed, or shall constitute, a waiver of any other provision, whether or not similar, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in writing by the Party making the waiver.

k. **Enforceability**. In the event that any of the terms and provisions of this Agreement are determined by a court of competent jurisdiction to be illegal, invalid, or unenforceable under the laws, regulations, ordinances, or other guidelines of the federal government or of any state or local government to which this Agreement is subject, such terms or provisions shall remain severed from this Agreement and the remaining terms and provisions shall remain unaffected thereby. If the term of this Agreement cannot be severed without materially affecting the operation of this Agreement, then this Agreement shall automatically terminate as of the date in which the term is held unenforceable.

13. GENERAL PROVISIONS

a. **Effect of Exclusion.** Notwithstanding any other provision of this Agreement to the contrary if Practitioner or any of Practitioner's agents or employees is (a) excluded, suspended, debarred from, or otherwise becomes ineligible for, participation in any federal or state health care program, or (b) convicted of a criminal offense related to conduct that would or could trigger an exclusion from any federal or state health care program, at any time during the term of this Agreement, or if at any time after the Effective Date hereof, any Party determines that the other Party has made a false representation or is in violation or breach of this Section, this Agreement shall terminate as of the effective date of such exclusion, suspension, debarment from, or ineligibility for, any federal or state health care program or of such conviction of a criminal offense related to conduct that would or could trigger an exclusion from any federal or state health care program, or as of the date of the breach of such Section.

b. **Section 952 of Omnibus Budget Reconciliation Act of 1980.** In accordance with Section 952 of the Omnibus Reconciliation Act of 1980 (PL 96-499), Practitioner agrees that the books and records of Practitioner will be available to the Secretary of Health and Human Services and the Comptroller General of the United States, or their duly authorized representatives, for four (4) years after termination of this Agreement. In the event that any of the services to be performed under this Agreement are performed by any subcontractor of Practitioner at a value or cost of $10,000 or more over a twelve (12) month period, Practitioner shall comply and assure that such subcontractor complies with the provisions of Section 952 of the Omnibus Reconciliation Act of 1980. If regulations are issued at a later time which would determine that Section 952 of PL 96-499 is not applicable to this Agreement, this paragraph shall automatically be repealed.

c. Access to Books and Records. To the extent required by Section 1395(x)(V)(1) of Title 42 of the United States Code, until the expiration of ten (10) years after the termination of this Agreement, Practitioner shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States Department of Health and Human Services, or any of their duly authorized representatives, a copy of this Agreement and such books and documents and records as are necessary to certify the nature and extent of the costs of the services provided by Practitioner under this Agreement. Practitioner further agrees that in the event Practitioner carries out any of Practitioner's duties under this Agreement through a subcontractor, with a value or cost of ten thousand dollars ($10,000.00) or more over a twelve (12) month period, with a related organization, such contract shall contain a clause to the effect that until the expiration of ten (10) years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of such subcontract and such books, documents and records of such organization as are necessary to verify the nature and extent of such costs. The provisions of this Section shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

d. Mutual Indemnity. Practitioner and Hospital shall indemnify and hold harmless each other, including officers, directors, shareholders, members, employees, agents and representatives from any and all liabilities, loses, damages, claims and expenses of any kind, including costs and attorneys' fees, which result from or relate to the indemnifying party's performance or failure to perform under this Agreement. The provisions of this Section shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

e. Jeopardy. Notwithstanding anything to the contrary hereinabove contained, in the event that the performance by either Party hereto of any term, covenant, condition or provision of this Agreement should jeopardize the licensure of either Party, its participation in Medicare, Medi-Cal, TriCare or other major reimbursement or payment programs, or its full accreditation by DNV, or any other state or nationally recognized physician accreditation organization, or the tax-exempt status of interest earned on any of its bonds or other financial obligations, or if for any other reason such performance should be in violation of any statute, ordinance, or be otherwise deemed illegal, or be deemed unethical by any recognized body, agency, or association in the medical or hospital fields (collectively, the "Adverse Action"), then the Parties shall in good faith negotiate amendments to this Agreement necessary or appropriate to resolve the Adverse Action. If after a reasonable period of time, not to exceed sixty (60) calendar days, the Parties are unable to agree on an amendment necessary or appropriate to resolve the Adverse Action, then either Party may terminate this Agreement on ninety (90) days' prior written notice to the other Party.

f. No Financial Obligation. Practitioner shall not incur any financial obligation on behalf of Hospital without the prior written approval of Hospital.

g. Assistance in Litigation. Each Party shall provide information and testimony and otherwise assist the other in defending against litigation brought against the other, its directors, officers or employees based upon a claim of negligence, malpractice or any other cause of action,

arising under this Agreement, except where such Party is a named adverse Party.

h. **Retention of Professional and Administrative Responsibility**. Hospital shall retain professional and administrative responsibility for the services rendered as outlined in this Agreement.

i. **Other Agreements Between Practitioner and Hospital**. Hospital and Practitioner may enter, or may have entered, into other agreements for services such as Emergency Room On-Call, Directorship, or Supervisory Services agreements. Such agreements are maintained in an online contracts management system, MediTract, and will be made available to any State or Federal entity that require access to such contracts.

[*Signature Page Follows*.]

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date first set forth above.

HOSPITAL	**PRACTITIONER**
Imperial Valley Healthcare District	Idrees Suliman, M.D.
_____	_____
Christopher R. Bjornberg Chief Executive Officer	Idrees Suliman, M. D
Date _____	Date _____

EXHIBIT A
Professional Services

Gastroenterology services for patients as deemed to be medically necessary by Practitioner using Practitioner's sole professional medical judgment, all of which shall be provided without regard to the patients' payor classification or ability to pay. Such services shall be provided in accordance with privileges as requested by Practitioner and granted by the Imperial Valley Healthcare District Medical Staff and Board of Directors.

EXHIBIT B
Practitioner Coverage

Gastroenterology Coverage. Practitioner shall provide regularly scheduled gastroenterology services for the Hospital. Practitioner should provide a minimum of (8) hours per day, two (2) days per week of GI services in the Hospital Clinics, endoscopy centers and/or operating rooms.

The specific locations and schedule for Practitioner's services shall be mutually agreed upon by Practitioner and Hospital, including arrangements for block time in any of Hospital's endoscopy suites.

Emergency On-Call Coverage. The practitioner shall provide a minimum of three (3) days per calendar month of emergency on-call services. Practitioner shall provide a monthly schedule of on-call emergency coverage availability in the Hospital to the Emergency Room Director and the Hospital's Medical Staff Director at least 30 days prior to the commencement of the month for which the schedule applies.

EXHIBIT C
Compensation

Initial One-Time Payment ("Loans")

Sign-on Bonus. The practitioner shall be paid a one-time sign-on bonus incentive of ten thousand dollars ($10,000) within one week of signing.

Sign-on Bonus shall be considered a loan that will be forgiven if certain conditions are satisfied. For the Sign-on bonus to be forgiven, Practitioner must compete two (2) full years of the Agreement from the Start Date. If repayment of the loan is required, Practitioner shall also be responsible to pay Hospital Interest on the full amount of accrued interest from the date funds were advanced by Hospital to Practitioner until paid at the rate of prime plus two percent (2%), not to exceed ten percent (10%) per annum simple interest or the maximum rate permitted by law, whichever is less. Payment of the loan plus interest is due within thirty (30) days of termination of the Agreement.

Loan Forgiveness. If this Agreement is terminated early for any reason, Practitioner shall reimburse funds advanced to him by Hospital prorated by the number of months the Agreement was in place divided by Twenty-four (24) months. By way of example, if this Agreement is terminated after twelve months, Practitioner shall reimburse Hospital five thousand dollars ($5,000) plus interest.

Compensation

Base Compensation. The practitioner shall be compensated at a rate of two hundred sixty-nine thousand four hundred eighty-two dollars ($269,482.00) per year, payable monthly in accordance with the Hospital's usual payroll practices. Practitioner is expected to work a minimum of 47 non-consecutive work weeks per year, commencing on the start date. In other words, Practitioner shall be entitled to a noncumulative time of four (4) work weeks (total of eight (8) days) for time off per year, plus an additional one (1) work week (total of two (2) days) of time off for Continuing Medical Education (CME), for a total of five (5) work weeks of time off per year. A "work week" for this Agreement is defined as (2) weekdays. Practitioner's base compensation shall not be withheld or reduced for the equivalent of these five (5) work weeks of time off per year, irrespective of whether Practitioner actually takes time off or not. Practitioner shall not be entitled to additional compensation if they work more than 47 work weeks per year, and unused time off shall not "roll over" into subsequent work years. Requests for additional time off beyond the five (5) work weeks described above must be submitted to Hospital writing at least one (1) month in advance of Practitioner's requested absence. Requests for additional time off beyond the five (5) weeks contemplated by this Agreement will only be granted at Hospital's discretion and Practitioner will not be entitled to compensation during the additional time off if granted.

Additional wRVU Incentive Payments. Practitioner may earn additional incentive compensation based upon quarterly wRVU Productivity. The incentive payment will be based on the Practitioner Work RVU's as defined in the Medical Group Management Association (MGMA) compensation and production survey.

Practitioner shall be paid seventy-five dollars ($75.00) for each billable wRVU in excess of the expected annual production of 3,580 wRVU's.

Only completed and locked charts will count towards physician-generated wRVU productivity for additional incentive compensation calculations.

On-Call Compensation

A. First three (3) days of Call Coverage in a calendar month. Practitioner will not be entitled to any additional compensation for the first three (3) days of call coverage under this Agreement.

B. Additional On Call Coverage. The practitioner will be entitled to compensation for any additional call coverage provided after the first three (3) days at a rate of five hundred dollars ($500) for each twenty-four (24) hour on-call during a weekday and one thousand dollars ($1,000) for each twenty-four (24) hour on-call period during a weekend. The practitioner shall be compensated a pro-rated amount for coverage provided that is less than 24 hours.

C. For purposes of on-call coverage: a "weekday" falls between Monday at 7:01 am and Friday at 7:00 am. A "weekend" falls between Friday at 7:01 am and Monday at 7:00 am.

Annual Reimbursements

Continuing Medical Education Reimbursement. Hospital shall reimburse Practitioner for up to three thousand dollars ($3,000) per year in expenses incurred for completing required Continuing Medical Education. Practitioner must present receipts and invoices to Hospital to receive such reimbursement.

No Benefits

Hospital shall not provide, and Practitioner shall not receive any benefits from Hospital including by not limited to health insurance, professional liability insurance, disability insurance, retirement plan benefits, workers compensation insurance, sick leave etc.

EXHIBIT D
Time Log

Imperial Valley Healthcare District
207 West Legion Road
Brawley, California 92227

PRACTITIONER - TIME AND ACTIVITY LOG

Physician's Name: _____

Hospital Department: _____

Month: _____

Date	Services Performed	Time

I certify that I have performed the services set forth above and understand that this Time and Activity Log may be made available to law enforcement or other regulatory agencies to confirm compliance with applicable state and federal law if so requested.

Practitioner's Signature: _____ Date: _____

Imperial Valley Healthcare District

BOARD MEETING DATE: 7/10/2025.

SUBJECT: Authorization to approve Professional Service Agreement and Emergency On-call for Dr. Rami Jirjis, MD

BACKGROUND: This agreement is for Urology Services and Emergency On-call services for Imperial Valley Healthcare District.

KEY ISSUES: Physician shall provide a minimum of (8 hours) per day, four (4) days per week of Urology services in the Hospital, clinics, and or operating rooms. Physician shall be compensated as follows:

- **Year 1 & 2**: $495,200.00 per year base compensation and $75.25 per wRVU incentive bonus after 6,581 wRVU's annually paid quarterly.
- **Year** 3 Pure wRVU compensation and will review at least 30 days prior to the start of year 3.
- **Sign-on Bonus**: $50,000 to be paid within one week of signing.
- **Relocation Expenses**: $40,000 to be paid for expenses related to relocation expenses with receipts.
- **Buyout**: Up to $40,000 to facilitate early termination of existing employment agreement with current employer. Must provide sufficient documentation prior to buyout payment.
- **Emergency On-Call Coverage Services:**
  Practitioner shall provide (4) days per calendar month, included in PSA compensation.

CONTRACT VALUE: approximately $550,000 annually, value varies depending on wRVU incentives and demands and on-call demands. This does not include first year one-time payments of Sign on Bonus, Relocation and Buyout of approximately $130,000.

CONTRACT TERM: 3 years.

BUDGETED: No

BUDGET CLASSIFICATION: PSA/On-call

RESPONSIBLE ADMINISTRATOR: Carly Zamora/Christopher Bjornberg

DATE SUBMITTED TO LEGAL: 6/2025 **REVIEWED BY LEGAL:** [X] Yes [ ] No

FIRST OR SECOND SUBMITTAL: [X] 1st [ ] 2nd

RECOMMENDED ACTION: Authorization to approve Professional Service Agreement and Emergency On-call for Dr. Rami Jirjis, M.D.

PROFESSIONAL SERVICES AGREEMENT
(Urology Services)

THIS PROFESSIONAL SERVICES AGREEMENT ("**Agreement**") is entered into and executed as of _____ ("**Effective Date**"), by and between Imperial Valley Healthcare District dba Pioneers Memorial Hospital, a Local Healthcare District, organized and existing in the State of California pursuant to the California Health and Safety Code, §§32000 *et seq.* ("**Hospital**"), and Rami Jirjis, M.D., a physician licensed to provide medical services in the State of California ("**Practitioner**"). Practitioner and Hospital are sometimes individually referred to hereafter as a "Party," and collectively as "Parties."

This Professional Services Agreement is entered into with respect to the following facts:

R E C I T A L S

A. Hospital owns and operates a general acute care hospital located in Brawley, California and rural health clinics ("**Clinics**"), in Calexico, California and Brawley, California, and by the start date, may also own and operate a second general acute hospital located in El Centro, California.

B. Practitioner is duly licensed and qualified to practice medicine under the laws of the State of California and is experienced and qualified to provide Urology Services ("**Specialty**").

C. Hospital has determined that entering into an agreement with the Practitioner is an appropriate way to assure the availability of such Specialty services for its patients and to maintain a high quality of patient care. The Parties furthermore acknowledge that many of the patients of the Hospital and Clinics will be referred there by outside physicians.

D. The Parties desire to enter into this Agreement to set forth their respective responsibilities in connection with Hospital's and Practitioner's provision of Services for treating patients during the term of this Agreement.

NOW, THEREFORE, the Parties agree as follows:

A G R E E M E N T

1. DUTIES OF PRACTITIONER

a. **Professional Medical Services**. Practitioner shall provide all professional medical services ("**Professional Services**") as set forth in ***Exhibit A***, as reasonably required for coverage

and patient care. Practitioner shall provide the Professional Services during regular hours of operation, as mutually agreed upon by the parties, and as more specifically set forth in ***Exhibit B*** ("**Practitioner Coverage**").

b. **Qualifications of Practitioner**. Practitioner shall be: (a) duly licensed by the State of California and have a California DEA license; (b) have levels of competence, experience and skill comparable to those prevailing in the community; (c) not excluded from any governmental healthcare program; (d) a member in good standing of the Medical Staff of Hospital; and, (e) within one (1) year following the Effective Date of this Agreement, become board certified in Specialty.

c. **Applicable Standards**. Practitioner shall perform all Specialty services under this Agreement in compliance with all applicable standards set forth by law or ordinance or established by the rules and regulations of any federal, state or local agency, department, commission, association or other pertinent governing, accrediting or advisory body, including compliance with the requirements of Det Norske Veritas (DNV), having authority to set standards for health care facilities, and in accordance with all Hospital and Medical Staff bylaws, rules, regulations, policies and procedures.

d. **Records and Documentation**; For each patient receiving Services, Practitioner shall promptly complete and finalize within twenty-four (24) hours for Hospital all of the medical record and report documentation required to accurately record the visit in the Hospital's electronic medical record (EMR) system or on the forms provided by the Hospital. Subject to applicable restrictions on disclosure, Practitioner shall have reasonable access, including the right to make copies, during business hours of all such medical records and reports as they may need from time to time for patient care or responding to any legal, judicial or third party administrative/investigative inquiries.

e. **Use of Premises.** Practitioners shall not use or knowingly permit any other person who is under the Practitioner's direction to use, any part of the Hospital's premises for (i) the private practice of medicine, or (ii) any purpose other than the performance of the services required hereunder.

f. **Non-Discrimination.** Practitioner shall not differentiate or discriminate in the provision of medical services to patients on the basis of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, genetics, insurability or claims history, or family care leave, in violation of any applicable state and federal Laws or Hospital policies including without limitation, The Age Discrimination Act of 1975, the Americans with Disability Act and all regulations issued pursuant thereto and as may be amended from time to time. Practitioner shall be in full compliance with Section 504 of the Rehabilitation Act of 1973, Titles VI and VII or the 1964 Civil Rights Act, and all regulations issued pursuant thereto and as may be amended from time to time.

2. REPRESENTATIONS AND WARRANTIES OF PRACTITIONER. Practitioner hereby warrants and represents as follows:

a. **Review of Compliance Requirements**. Practitioners acknowledge that Hospital has a commitment to full compliance with all laws, regulations and guidance relating to its participation in the federal and state healthcare programs, and as a result has implemented a compliance program including, without limitation, mandatory requirements related to ongoing compliance training and education programs for its workforce, medical staff and persons/entities that conduct healthcare business with the Hospital. As a condition to this Agreement, Practitioner shall provide written acknowledgement that Practitioner has received (or been provided with electronic or other access to), read and understood and will comply with Hospital's compliance program materials and Code of Conduct of Medical Staff and further agrees to comply with all pertinent provisions.

b. **Practitioner Is Not Restricted.** Practitioner is not bound by any agreement or arrangement which would preclude Practitioner from entering into, or from fully performing the services required under, this Agreement.

c. **Practitioner is Qualified.** Practitioner's license to practice medicine in the State of California, or in any other jurisdiction has not ever been denied, disciplined, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way. Additionally, Practitioner's medical staff privileges at any health care facility have not ever been denied, suspended, revoked, terminated, limited, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction.

d. **Prohibition from Program Participation**. Practitioner has not been (a) excluded, suspended or debarred from, or otherwise ineligible for, participation in any federal or state health care program including, without limitation, Medicare or Medi-Cal (Medicaid), nor (b) charged or convicted of a criminal offense related to conduct that would or could trigger an exclusion from any federal or state health care program including, without limitation, Medicare or Medi-Cal (Medicaid);

e. **Notification of Threatened Exclusion From Program Participation.** Practitioner shall notify Hospital immediately in writing if Practitioner becomes the subject of (a) any threatened, proposed or actual exclusion, suspension or debarment, (b) any charge or conviction of a criminal offense related to conduct that would or could trigger an exclusion from any federal or state health care program, (c) any investigatory, disciplinary, or other proceeding by any governmental, professional, licensing board, health insurer, medical staff, or peer review body, or (d) any event that substantially interrupts all or a portion of Practitioner's professional practice or that materially adversely affects Practitioner's ability to perform Practitioner's obligations hereunder.

f. **Non-Solicitation of Hospital Employees.** During the term of this Agreement, Practitioner shall not solicit the services of or employ or procure on behalf of another the employment of, any individual currently employed by Hospital or under a service contract with Hospital; nor shall Practitioner engage in any other activity which would be in conflict with Practitioner's obligations hereunder.

g. **Third-party Payment, Managed Care Programs, and Charity Care**. Practitioner shall participate in all third-party payment or managed care programs in which

Hospital participates, render services to patients covered by such programs, and accept the payment amounts for services rendered by Practitioner under these programs as payment in full for services of the Practitioner to Clinic and Hospital patients. The hospital will provide to Practitioner with timely notification of new contract negotiations. Hospital will also pay, or provide, for the Physician's credentialing with third-party payment or managed care programs. Practitioner shall participate in the Hospital's Financial Assistance Program including Full Charity Care and Discount Partial Charity Care. Hospital will provide Practitioner with a copy of its Financial Assistance Program and any amendments thereto.

3. COMPENSATION FOR PRACTITIONER

a. **Compensation.** Hospital shall pay Practitioner according to the compensation schedule set forth in ***Exhibit C*** ("**Compensation**"). Hospital shall pay the compensation owed on or before the fifteenth (15th) day of each calendar month, for services provided by Practitioner during the immediately preceding calendar month; provided that Practitioner has delivered a visit record to Hospital in the form attached hereto as ***Exhibit D*** ("**Time Log**") on or before the fifth (5th) day of each calendar month for the immediately preceding calendar month.

b. **Taxation of Income**. The Parties understand that the Hospital will bill, collect, and retain the proceeds from all charges for medical services, and may use the Practitioner's Billing Provider number for such purposes. Practitioner shall be fully and solely responsible for Practitioner's own self-employment tax payments, as well as Social Security (FICA) and other required tax payments, if any. Practitioner will be fully responsible for Practitioner's own worker's compensation insurance coverage, health insurance coverage, disability insurance coverage, life insurance coverage, and retirement plan, if any. Hospital will not withhold or pay on behalf of the Practitioner any taxes such as state and local or payroll taxes and those listed herein. Hospital shall provide o Practitioner with an IRC Form 1099 annually for the monies paid for such services.

c. **Compliance with Health & Safety Code.** Any compensation received by the Practitioner pursuant to this agreement shall be in compliance with the provisions of California Health and Safety Code Section 32129. Hospital has the obligation and right to adjust compensation to be in compliance with any and all laws and regulations.

4. DUTIES AND OBLIGATIONS OF THE HOSPITAL

a. **Duties**. Hospital agrees to furnish, at its own cost and expense, for adequate provision of professional services pursuant to this Agreement, the following:

i. Space. Space as reasonably necessary to provide service to patients.

ii. Equipment. Equipment as may be reasonably required as mutually agreed by the Hospital and Practitioner, subject to any applicable Hospital budget limitations. Practitioner acknowledges that existing equipment is adequate for Practitioner's purposes.

iii. Services and Supplies. Maintenance, repair and replacement of equipment as reasonably required; all utilities, including telephone, power, light, gas and water; all supplies

(including, without limitation, film, laundry services and linen); transcription services, and any necessary housekeeping and in-house messenger service that may be reasonably required to provide services.

iv. Non-Physician Personnel. Hospital personnel with appropriate education, training and experience which are required to adequately assist Practitioner in performance of the services contemplated herein, as determined according to Hospital's discretion. Hospitals shall have the sole right and responsibility for the hiring, discipline and termination of such Hospital employees.

b. Eligibility. At all times during the term of this Agreement, Hospital shall remain eligible to participate in the Medicare, Medi-Cal, and TriCare/CHAMPUS programs.

5. BILLING FOR MEDICAL SERVICES

a. Billing Records Availability. Each Party shall, on a monthly basis, make available to the other Party, records and data accurately reflecting a) total billed services in connection with the Services; b) payments received from all sources for medical services provided by the Practitioner, and c) all expenses paid by Hospital or Practitioner in connection with the operation of the Services or the services rendered therein.

b. Accurate Medical Records and Charts. Practitioner shall promptly prepare and submit complete and accurate medical records, medical chart notes, and related back-up documentation, and respond and provide such assistance and information as District may reasonably request to facilitate billing and collection of charges for patient services, including, but not limited to, assigning appropriate procedure and diagnosis codes for billing purposes, and dictating or completing appropriate descriptions and notations to be made on the patient chart to support the appropriate billing code, in accordance with the requirements of the Centers for Medicare and Medicaid Services. Practitioner shall be responsible (and Hospital shall not be responsible except with respect to joint and several liability required by law) for errors or liabilities, if any, which may arise from Practitioner's fraudulent designation of inappropriate billing, procedure or diagnosis codes or for the negligent failure of Practitioner to prepare medical chart notes or dictation which corresponds to the services rendered.

c. Charges for Medical Services. Hospital shall be responsible for, and solely entitled to, the billing and collection of all charges for all medical services (ancillary and professional). (Practitioner hereby assigns to Hospital all of Practitioner's respective rights to bill and receive payment for any payor for providing Professional Services to Hospital. Practitioner understands and agrees that Practitioner is hereby precluded from billing any payor for Services under this Agreement unless required by a payor, in which event Practitioner shall bill such services with the understanding that all fees generated from such billings belong to Hospital.

d. Schedule of Charges. On an annual basis, Hospital may provide to Practitioner the schedule of charges for the professional component of the medical services provided for Practitioner's review and input. Practitioner may request changes to the schedule of charges as circumstances may warrant. Hospital, in its sole and absolute discretion, shall decide upon changes to the schedule of charges.

e. **Forwarding Billing to Hospital.** Practitioner shall provide the Hospital, on a daily basis, with all information reasonably requested by the Hospital to enable Hospital to (i) properly bill for the Professional Services provided by the Practitioner to patients. It is understood and agreed that Hospital shall handle at its expense all the administrative work of this billing. All Professional Services shall be billed by Hospital on behalf of Practitioner as the rendering provider.

f. **Rates for Service**. In the event that the Practitioner is responsible for establishing rates charged to patients for any Professional Services rendered pursuant to this Agreement, Practitioner must ensure that such rates are reasonable and customary. In the event that Hospital determines Practitioner's rates are unreasonable, Hospital reserves the right to approve modify rates charged by Practitioner for Services.

6. TERM AND TERMINATION

a. **Term.** The term of this Agreement shall begin no later than July 1st, 2026 (the "Start Date") and shall continue for four (4) years after the first day that Practitioner is present and able to provide services in accordance with this agreement (hereinafter the "Start Date"), unless terminated earlier as provided herein.

b. **Termination Without Cause**. Either party shall have the right to terminate this Agreement at any time without penalty or cause by providing ninety (90) days advance written notice to the other party.

c. **Termination Sale or Transfer**. If Hospital has sold or otherwise transferred all or substantially all of its assets, has merged with another entity or has dissolved, Hospital shall provide Practitioner with ninety (90) days advance written notice.

d. **Termination for Cause.** Either Party may terminate this Agreement upon breach by the other Party of any material provision of this Agreement, provided such breach continues for fifteen (15) days after receipt by the breaching Party of written notice of such breach from the non-breaching Party, except where such breach requires immediate termination as enumerated below.

i. Breach. Hospital or Practitioner is in breach of any material term or condition of this Agreement and such breach has not been cured within fifteen (15) days following notice of such breach;

ii. Insolvency or Bankruptcy. Hospital or Practitioner becomes insolvent or declares bankruptcy.

iii. Adverse Action on Practitioner's License. Denial, suspension, revocation, termination, restriction, lapse, or voluntary relinquishment under threat of disciplinary action, of Practitioner's medical staff membership or privileges at Hospital or any other healthcare facility, or of Practitioner's DEA license or license to practice medicine in the State of California or any other jurisdiction.

iv. Cancellation of Insurance. Practitioner fails to carry or maintain the

insurance required by this Agreement.

v. Conduct Jeopardizing Licensure or Reimbursements. Conduct by the Practitioner that jeopardizes the licensure of Hospital, Hospital's participation in Medicare, Medi-Cal or other reimbursement or payment program, or Hospital's full accreditation by The Joint Commission or any other state or nationally recognized accreditation organization, or the tax-exempt status of Hospital's bonds, or if for any other reason such performance violates any statute, ordinance, or is otherwise deemed illegal, or is deemed unethical by any recognized body, agency, or association in the medical or hospital fields, and the jeopardy or violation has not been or cannot be cured within fifteen (15) days from the date notice of such jeopardy or violation has been received by the parties.

vi. Death of Practitioner.

vii. Mental or Physical Disability. If the Practitioner is determined in the reasonable and good faith of the Hospital to have a mental or physical disability for more than ninety (90) days in any one hundred eighty (180) day period.

e. One Year Prohibition on New Agreement. If this Agreement is terminated prior to expiration of the initial year of the term hereof, the Parties shall not enter into any new agreement or arrangement during the remainder of such year.

f. New Agreement. The parties agree to initiate discussions for a new agreement after this Agreement has been in effect for three (3) years, six (6) months.

7. INDEPENDENT CONTRACTOR. Practitioner is engaged in an independent contractor relationship with the Hospital in performing all work, duties and obligations hereunder. Hospital shall not have nor exercise any control or direction over the methods by which Practitioner performs work and functions, except that Practitioner shall perform at all times in strict accordance with then currently approved methods and practices of the professional Specialty services. Hospital's sole interest is to ensure that Practitioner performs and renders services in a competent, efficient and satisfactory manner in accordance with high medical standards. The Parties expressly agree that no work, act, commission or omission of Practitioner in connection with the terms and conditions of this Agreement shall be construed to make or render Practitioner, the agent, employee or servant of Hospital. Practitioner shall not be entitled to receive from Hospital vacation pay, sick leave, retirement benefits, Social Security, workers' compensation, disability or unemployment insurance benefits or any other employee benefit of any kind. The provisions of this Section shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

8. PROFESSIONAL LIABILITY INSURANCE COVERAGE. Practitioner shall secure and maintain at all times during the term, at Practitioner's sole expense, professional liability insurance covering Practitioner, with an admitted carrier (licensed to do business in the State of California) having at least an "A" BEST rating, with limits of one million ($1,000,000) per claim/and three million ($3,000,000) for annual aggregate claims. Such insurance shall not be cancelable except upon thirty (30) days' prior written notice to Hospital and shall be primary and non-contributory. Annually, Practitioner shall provide Hospital with a certificate of insurance

evidencing such coverage and coverage extensions upon request by the Hospital. If the coverage is on a claims-made basis, Practitioner hereby agrees that not less than thirty (30) days prior to the effective date of termination of Practitioner's current insurance coverage or termination of this Agreement, Practitioner shall either purchase unlimited tail coverage or provide proof of continuous coverage in the above stated amounts for all claims arising out of incidents occurring prior to termination of Practitioner's current coverage or prior to termination of this Agreement, as applicable, and provide Hospital a certificate of insurance evidencing such coverage. If Practitioner fails to provide written confirmation of the coverage required, Hospital may, in its sole discretion, purchase such coverage and offset the costs against any amounts owed by Hospital to Practitioner, in addition to any other remedies Hospital may have against Practitioner.

9. OWNERSHIP OF MEDICAL RECORDS., All records of patients seen at any Hospital facilities shall be maintained by Hospital and shall be the property of the Hospital. Practitioner shall have the right to access images and records during normal business hours.

10. NOTICES. Any notice to be given to any party hereunder shall be deposited in the United States Mail, duly registered or certified, with return receipt requested, with postage thereon paid, and addressed to the party for which intended, at the following addresses, or to such other address or addresses as the parties may hereafter designate in writing to each other.

Hospital:	Practitioner:
Chief Executive Officer Imperial Valley Healthcare District West 207 Legion Road Brawley, CA 92227	Rami Jirjis, M.D. _____ _____

11. CONFIDENTIALITY

a. <u>Confidential Information Belongs to its Respective Owner.</u> Each Party recognizes and acknowledges that, by virtue of entering into this Agreement and providing services to the other hereunder, Practitioner and Hospital may have access to certain information of the other Party that is confidential and constitutes valuable, special and unique property. Each Party agrees that it will not at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without the other Party's express prior written consent, except pursuant to Practitioner's duties hereunder, any confidential or proprietary information of either Party, including, but not limited to, information which concerns Hospital's patients, costs, or treatment methods developed by Hospital for the Hospital, and which is not otherwise available to the public.

b. <u>This Agreement is Confidential</u>. Except for disclosure to Practitioner's legal counsel, accountant or financial advisors (none of whom shall be associated or affiliated in any way with Hospital or any of its affiliates), Practitioner shall not disclose the terms of this Agreement to any person who is not a party or signatory to this Agreement, unless disclosure thereof is required by law or otherwise authorized by this Agreement or consented to by Hospital. Unauthorized disclosure of the terms of this Agreement shall be a <u>material breach</u> of this

Agreement. Except for disclosure to Hospital's legal counsel, accountant or financial advisors, its Board of Directors and/or any committee concerned with this Agreement, Hospital and its officers, directors, employees, and agents shall not disclose the terms of this Agreement to any person who is not a party or signatory to this Agreement, unless disclosure thereof is required by law or otherwise authorized by this Agreement or consented to by Practitioner. Unauthorized disclosure of the terms of this Agreement shall be a material breach of this Agreement. Upon the termination or expiration of this Agreement, Hospital all records of the patients seen or treated by Practitioner shall be the property of Hospital. However, upon Hospital's receipt of appropriately executed written request of any such patient therefor, Hospital will provide copies of the requesting patient's records to Practitioner, in paper or electronic form and the delivery of such records shall be in compliance with federal and state law.

c. **Medical Records Are Confidential**. Neither Party shall disclose to any third party, except where permitted or required by law or where such disclosure is expressly approved by the other Party in writing, any patient or medical record information regarding Hospital patients, and the Parties shall comply with all federal and state laws and regulations, and all bylaws, rules, regulations, and policies of Hospital, and Hospital's Medical Staff, regarding the confidentiality of such information. Practitioner acknowledges that in receiving or otherwise dealing with any records or information from Hospital about Hospital's patients receiving treatment for alcohol or drug abuse, Practitioner is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2, as amended from time to time).

d. **HIPAA Compliance is Required.** Each Party agrees to comply with the applicable provisions of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the requirements of any regulations promulgated thereunder including without limitation the federal privacy regulations (the "Federal Privacy Regulations") and the federal security standards (the "Federal Security Regulations").

e. **Business Associate Agreement.** If requested by Hospital, Practitioner shall execute Hospital's Business Associate Agreement.

12. AGREEMENT INTERPRETATION AND DISPUTE RESOLUTION

a. **Entire Agreement; Amendment**. This Agreement, its exhibits, and all documents referred to herein constitute the entire agreement between the parties pertaining to the subject matter contained herein. This Agreement supersedes all prior and contemporaneous agreements, representations and understandings of the parties which relate to the subject matter of this Agreement. No supplement, amendment or modification of this Agreement shall be binding unless executed in writing by all of the Parties.

b. **Subject Headings.** The subject headings of the Articles and Sections of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of the provisions of this Agreement.

c. **Parties.** Nothing in this Agreement, whether express or implied, is intended to confer any rights or remedies on any person other than the Parties to it and their respective

successors and assigns; nor is anything in this Agreement intended to relieve or discharge the obligation or liability of any third persons to any Party to this Agreement; nor shall any provision give any third person any right of subrogation or action over or against any party to this Agreement.

d. **No Assignment**. This Agreement shall be binding upon and shall inure to the benefit of the Parties to it and their respective legal representatives, successors and permitted assigns. No Party may assign this Agreement or any rights hereunder, nor may they delegate any of the duties to be performed hereunder without the prior written consent of the other party.

e. **Governing Law and Waiver of Jury Trial.** This Agreement shall be governed by, construed and enforced in accordance with the laws of the State of California. Any and all disputes shall be resolved by arbitration, including claims for injunctive relief. The parties expressly waive their right to trial of any issue or claim by judge or jury.

f. **Counterparts.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute the same instrument.

g. **Arbitration**. Any dispute or controversy arising under, out of or in connection with, or in relation to this Agreement, or any amendment hereof, or the breach hereof or claim for injunctive relief shall be finally determined and resolved by arbitration before a single arbitrator in Imperial County, California, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration and applying the laws of the State of California. Any award rendered by the arbitrator shall be final and binding upon each of the Parties, and judgment thereon may be entered in any court having jurisdiction thereof. The costs shall be borne equally by both Parties. The prevailing Party in any such arbitration shall be entitled to recover its reasonable attorneys' fees. During the pendency of any such arbitration and until final judgment thereon has been entered, this Agreement shall remain in full force and effect unless otherwise terminated as provided hereunder. The provisions of this Section shall survive expiration or other termination of this Agreement.

h. **Exhibits**. The attached exhibits, inclusive, constitute a material part of this Agreement and are to be construed as incorporated into this Agreement in full and are made a part hereof.

i. **No Waiver**. No waiver of any of the provisions of this Agreement shall be deemed, or shall constitute, a waiver of any other provision, whether or not similar, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in writing by the Party making the waiver.

j. **Enforceability/Severability**. In the event that any of the terms and provisions of this Agreement are determined by an arbitrator to be illegal, invalid, or unenforceable under the laws, regulations, ordinances, or other guidelines of the federal government or of any state or local government to which this Agreement is subject, such terms or provisions shall remain severed from this Agreement and the remaining terms and provisions shall remain unaffected thereby. If the term of this Agreement cannot be severed without materially affecting the operation of this Agreement, then this Agreement shall automatically terminate as of the date in which the term is held unenforceable.

13. GENERAL PROVISIONS

a. **Effect of Exclusion.** Notwithstanding any other provision of this Agreement to the contrary if Practitioner or any of Practitioner's agents or employees is (a) excluded, suspended, debarred from, or otherwise becomes ineligible for, participation in any federal or state health care program, or (b) convicted of a criminal offense related to conduct that would or could trigger an exclusion from any federal or state health care program, at any time during the term of this Agreement, or if at any time after the Effective Date hereof, any Party determines that the other Party has made a false representation or is in violation or breach of this Section, this Agreement shall terminate as of the effective date of such exclusion, suspension, debarment from, or ineligibility for, any federal or state health care program or of such conviction of a criminal offense related to conduct that would or could trigger an exclusion from any federal or state health care program, or as of the date of the breach of such Section.

b. **Section 952 of Omnibus Budget Reconciliation Act of 1980.** In accordance with Section 952 of the Omnibus Reconciliation Act of 1980 (PL 96-499), Practitioner agrees that the books and records of Practitioner will be available to the Secretary of Health and Human Services and the Comptroller General of the United States, or their duly authorized representatives, for four (4) years after termination of this Agreement. In the event that any of the services to be performed under this Agreement are performed by any subcontractor of Practitioner at a value or cost of $10,000 or more over a twelve (12) month period, Practitioner shall comply and assure that such subcontractor complies with the provisions of Section 952 of the Omnibus Reconciliation Act of 1980. If regulations are issued at a later time which would determine that Section 952 of PL 96-499 is not applicable to this Agreement, this paragraph shall automatically be repealed.

c. **Access to Books and Records.** To the extent required by Section 1395x(v)(1) of Title 42 of the United States Code, until the expiration of ten (10) years after the termination of this Agreement, Practitioner shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States Department of Health and Human Services, or any of their duly authorized representatives, a copy of this Agreement and such books and documents and records as are necessary to certify the nature and extent of the costs of the services provided by Practitioner under this Agreement. Practitioner further agrees that in the event Practitioner carries out any of Practitioner's duties under this Agreement through a subcontractor, with a value or cost of ten thousand dollars ($10,000.00) or more over a twelve (12) month period, with a related organization, such contract shall contain a clause to the effect that until the expiration of ten (10) years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of such subcontract and such books, documents and records of such organization as are necessary to verify the nature and extent of such costs. The provisions of this Section shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

d. **Mutual Indemnity**. Practitioner and Hospital shall indemnify and hold harmless each other, including officers, directors, shareholders, members, employees, agents and representatives from any and all liabilities, loses, damages, claims and expenses of any kind,

including costs and attorneys' fees, which result from or relate to the indemnifying party's performance or failure to perform under this Agreement. The provisions of this Section shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

e. **Jeopardy**. Notwithstanding anything to the contrary hereinabove contained, in the event that the performance by either Party hereto of any term, covenant, condition or provision of this Agreement should jeopardize the licensure of either Party, its participation in Medicare, Medi-Cal, Blue Cross or other major reimbursement or payment programs, or its full accreditation by DNV, or any other state or nationally recognized Practitioner accreditation organization, or the tax-exempt status of interest earned on any of its bonds or other financial obligations, or if for any other reason such performance should be in violation of any statute, ordinance, or be otherwise deemed illegal, or be deemed unethical by any recognized body, agency, or association in the medical or hospital fields (collectively, the "Adverse Action"), then the Parties shall in good faith negotiate amendments to this Agreement necessary or appropriate to resolve the Adverse Action. If after a reasonable period of time, not to exceed sixty (60) calendar days, the Parties are unable to agree on an amendment necessary or appropriate to resolve the Adverse Action, then either Party may terminate this Agreement on ninety (90) days' prior written notice to the other Party.

f. **No Financial Obligation**. Practitioner shall not incur any financial obligation on behalf of Hospital without the prior written approval of Hospital.

g. **Assistance in Litigation**. Each Party shall provide information and testimony and otherwise assist the other in defending against litigation brought against the other, its directors, officers or employees based upon a claim of negligence, malpractice or any other cause of action, arising under this Agreement, except where such Party is a named adverse Party.

h. **Retention of Professional and Administrative Responsibility**. Except as otherwise provided in this Agreement Hospital shall retain professional and administrative responsibility for the services rendered as outlined in this Agreement.

i. **Other Agreements Between Practitioner and Hospital**. Hospital and Practitioner may enter, or may have entered, into other agreements for services such as Emergency Room On-Call, Directorship, or Supervisory Services agreements. Such agreements are maintained in an online contracts management system, Medi Tract, and will be made available to any State or Federal entity that require access to such contracts.

[*Signature Page Follows*.]

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date first set forth above.

Imperial Valley Healthcare District	Practitioner
_____	_____
Christopher R. Bjornberg Chief Executive Officer	Rami Jirjis, M.D.
Date _____	Date _____

EXHIBIT A
Professional Services

Provide urology specialty services for patients at Hospital and rural health clinics, as requested by Hospital, as deemed to be medically necessary by Practitioner using Practitioner's sole professional medical judgment, all of which shall be provided without regard to the patients' payor classification or ability to pay. Such services shall be provided in accordance with medical ethics, the standard of care, and medical staff privileges as requested by Practitioner and granted by the Hospital Medical Staff and Board of Directors.

EXHIBIT B
Practitioner Coverage

Urology Specialty Coverage. Practitioner shall provide a minimum of eight (8) hours per day, four (4) days per week of urology specialty care services in the Hospital and Clinics. In addition, Practitioner shall also provide the extra time necessary for charting and keeping medical records timely, current and accurate.

The specific locations and schedule for urology specialty care services shall be mutually agreed upon by Practitioner and Hospital.

Emergency Department Coverage. Practitioner shall provide a minimum of four (4) days of on-call emergency department coverage per month. One "day" of emergency department on-call coverage is a period of 24 hours, typically beginning 7am one day and ending 7am the following day. Practitioner shall provide a monthly schedule of his availability for on-call emergency coverage in the Hospital to the Emergency Department Director and the Hospital's Medical Staff Director at least 30 days prior to the commencement of the month for which the schedule applies.

EXHIBIT C
Compensation

Initial One-time Payments ("Loans")

Sign-on Bonus. Practitioner shall be paid a one-time sign-on bonus incentive of fifty thousand dollars ($50,000) within one week of the start date.

Moving Expenses. During the twelve (12) month period beginning on the Start Date, Hospital will provide Practitioner with reimbursement of the actual, reasonable costs incurred by Practitioner for any relocation expenses ("Relocation Expenses"), including such things as travel, lodging, house hunting, the cost of temporary housing for up to six (6) months, closing costs on the sale of Practitioner's primary home, and the cost of professional movers, incurred in moving Practitioner and Practitioner's immediate family, up to the amount of forty thousand dollars ($40,000). Practitioner must present receipts and invoices to Hospital in order to receive such reimbursement.

Sign-on Bonus and moving expenses shall be considered loans that will be forgiven if certain conditions are satisfied. For the Sign-on bonus to be forgiven, Practitioner must compete two (2) full years of the Agreement from the Start Date. For the Moving Expenses to be forgiven, Practitioner must complete two (2) years of this Agreement from the Start Date. If repayment of the loan(s) is required, Practitioner shall also be responsible to pay Hospital Interest on the full amount of accrued interest from the date funds were advanced by Hospital to Practitioner until paid at the rate of prime plus two percent (2%), not to exceed ten percent (10%) per annum simple interest or the maximum rate permitted by law, whichever is less. Full payment of the loan(s) is due within thirty (30) days of termination of the Agreement.

If this Agreement is terminated early for any reason, Practitioner shall reimburse funds advanced to him by District prorated by the number of months the Agreement was in place divided by Twenty-four (24) months, plus

Buyout. Hospital agrees to pay Practitioner up to Forty thousand dollars ($40,000) (Buyout payment) to facilitate the early termination of his existing professional services/employment agreement with his current employer. The payment is intended to resolve any contractual obligation or penalties required to expedite Practitioner's transition to Hospital Practitioner shall provide Hospital with sufficient documentation to concerning the amount of and legal requirement for the buyout.

Repayment and/or Forgiveness of Loans

Sign-on Bonus, Moving Expenses, and Buyout shall be considered loans (collectively "Loans") that will be forgiven if certain conditions are satisfied. For the Loans to be forgiven, Practitioner must compete two (2) full years of the Agreement from the Start Date.

If repayment of the Loans is required, Practitioner shall also be responsible to pay Hospital interest on the full amount of the loan plus accrued interest from the date funds were advanced by Hospital to Practitioner until paid at the rate of prime plus two percent (2%), not to exceed ten percent

(10%) per annum simple interest or the maximum rate permitted by law, whichever is less. Full payment of the loan(s) is due within thirty (30) days of termination of the Agreement.

Malpractice Insurance Premiums

Hospital will financially assist Practitioner in paying annual malpractice insurance premiums in an amount not to exceed $15,000 annually. The premium support will be provided by Hospital to Practitioner in quarterly payments.

Year 1 and Year 2 Compensation

Base Compensation. For the first two (2) years commencing on the Start Date, Practitioner shall be compensated at a rate of four hundred ninety-five thousand two hundred dollars ($495,200.00) per year, payable monthly in accordance with the Hospital's usual payroll practices. In exchange for this annual compensation, Practitioner is expected to work a minimum of 47 non-consecutive work weeks per year, commencing on the Start Date. In other words, Practitioner is entitled to take (4) non-consecutive work weeks of time off per year, plus one (1) work week of time off for Continuing Medical Education, cumulatively five (5) work weeks of time off per year. A "work week" is defined as five (5) consecutive days. Practitioner's base compensation shall not be withheld or reduced for the equivalent of these five (5) work weeks of time off per year, irrespective of whether Practitioner actually takes time off or not. Practitioner shall not be entitled to additional compensation if they work more than 47 work weeks per year, and unused time off shall not "roll over" into subsequent work years. Requests for additional time off beyond the five (5) work weeks described above must be submitted to Hospital writing at least one (1) month in advance of Practitioner's requested absence. Requests for additional time off beyond the five (5) weeks contemplated by this Agreement will only be granted at Hospital's discretion and Practitioner will not be entitled to compensation during the additional time off if granted.

Additional wRVU Incentive Payments. For the first two (2) years of this Agreement, Practitioner may earn additional incentive compensation based upon quarterly wRVU Productivity. The incentive payment will be based on the Practitioner Work RVU's as defined in the Medical Group Management Association (MGMA) compensation and production survey.

In each quarter (3 months) after the Start Date, if, Practitioner generates wRVU's in excess of 1,645.4 per quarter, the difference will be paid to the Practitioner at the rate of seventy-five dollars and twenty-five cents ($75.25) per wRVU. For the avoidance of doubt, the production payments may be only earned beginning with wRVUs in excess 1,645.4.

Only completed and locked charts will count towards physician-generated wRVU productivity for additional incentive compensation calculations.

Year 3 Compensation

Pure wRVU-based Compensation. Beginning on the third anniversary of the Start Date, Practitioner shall no longer receive any base compensation and shall only be compensated on a pure wRVU basis. At that time and for each successive year, the wRVU rate shall be based on the MGMA compensation and production survey and may change year to year. Hospital shall provide Practitioner with annual wRVU rates at least 30 days prior to commencement of the wRVU-based compensation model.

Only completed and locked charts will count towards physician-generated wRVU productivity.

Annual Reimbursements

Continuing Medical Education Reimbursement. Hospital shall reimburse Practitioner for up to three thousand dollars ($3,000) per year in expenses incurred for completing required Continuing Medical Education). Practitioner must present receipts and invoices to Hospital to receive such reimbursement.

On-Call Compensation

First Four (4) days of Call Coverage in a calendar month. Practitioner will not be entitled to any additional compensation for the first four (4) twenty-four-hour periods of call coverage for the first two years of service under this Agreement.

No Benefits

Hospital shall not provide, and Practitioner shall not receive any benefits from Hospital including by not limited to health insurance, professional liability insurance, disability insurance, retirement plan benefits, workers compensation insurance, sick leave etc.

EXHIBIT D
Time Log

Imperial Valley Healthcare District
207 West Legion Road
Brawley, California 92227

PRACTITIONER - TIME AND ACTIVITY LOG

Physician's Name: _____

Hospital Department: _____

Month: _____

Date	Services Performed	Time

I certify that I have performed the services set forth above and understand that this Time and Activity Log may be made available to law enforcement or other regulatory agencies to confirm compliance with applicable state and federal law if so requested.

Practitioner's Signature: _____ Date: _____

Imperial Valley Healthcare District

BOARD MEETING DATE: July 10th, 2025!

SUBJECT: ACHD-Association of California Healthcare District

BACKGROUND: ACHD works with numerous state and local entities to promote the profound role Healthcare Districts play in responding to the specialized health needs of tens of millions of Californians while also having direct accountability to the communities that Districts serve.

KEY ISSUES: ACHD ensure healthcare districts remain well represented in the legislature, advocating on issues such as access to care, community health, hospital infrastructure, governance, Brown act, Labor relations, workers compensation and more. ACHD plays a critical role in the legislature to ensure your voice is heard.

CONTRACT VALUE: Membership $24,834.00

CONTRACT TERM: 7/1/2025-6/30/2026.

BUDGETED:

BUDGET CLASSIFICATION: Membership dues

RESPONSIBLE ADMINISTRATOR: Christopher Bjornberg

DATE SUBMITTED TO LEGAL: _____ **REVIEWED BY LEGAL:** ☐ Yes ☒ No

FIRST OR SECOND SUBMITTAL: ☒ 1st ☐ 2nd

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

May 28, 2025

Imperial Valley Health District
Attn: Chris Bjornberg

Dear Chris:

ACHD is very grateful that IVHD joined the Association in 2025. We feel strongly that we can be helpful as the new district evolves. Our fiscal year is July 1 – June 30 and so I'm reaching out today with the 2025-26 Dues Notice. I hope we can keep IVHD in the ACHD family. I'm happy to come meet with your board at a time that works best for you, just let me know.

At ACHD, we are incredibly proud of our commitment to education and advocacy, two pillars that we believe are essential to the success of healthcare districts. As a member of ACHD, you have access to essential legislative and educational resources, including our monthly newsletter, The Advocate, Call to Action page, educational webinars, and much more. We offer a free governance toolkit designed to assist your district's growth in areas such as best practices and strategic planning. ACHD hosts CEO and board clerk roundtables to further support your district, providing a platform for connecting and brainstorming critical issues. Moreover, ACHD subsidizes the cost of annual board self-assessments and CEO evaluations to assist members in identifying strengths and creating high-performing teams.

At ACHD, we ensure healthcare districts remain well represented in the legislature, advocating on issues such as access to care, community health, hospital infrastructure, governance, Brown Act, labor relations, workers' compensation, and more. ACHD plays a critical role in the legislature to ensure your voice is heard.

In 2019, the ACHD Board of Directors adopted the position that all members should share in the costs of networking, legislative representation, and educational opportunities. The ACHD Board evaluated how membership dues were being assessed and spent time evaluating and discerning an equitable method for all districts to participate in the sharing of ACHD's annual costs.

The board determined and approved a formula for a membership dues rate as follows:

- .001% of the lower of the district's three-year average of revenue or expenses.
- The formulary worked based on numbers reported through https://www.bythenumbers.sco.ca.gov/

When the COVID-19 pandemic hit, this structure was put on hold and dues have remained at 2017 levels through today.

The dues structure approved by the Board of Directors in February 2023 uses the same model but also puts a maximum and minimum on dues increases and decreases. No member will experience an increase greater than 30% (phased in over three years). In addition, no member will receive a decrease in dues greater than 10%.

In addition, the Board approved a policy that no one member should pay more than one share, or no less than 1/20th of one share. For your district, I also used the Pioneers Memorial Healthcare District 2021-23 data, since IVHD does not currently have data.

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Invoice

Invoice No.	**2025-0701**
Date	07/01/2025
Terms	30 Days

Imperial Valley Healthcare District
ATTN Accounts Payable

Qty.	Description	Rate	Amount
1	Member Dues Covering 7/1/25-6/30/26	24,834.00	24,834.00
		Total	**$24,834.00**

Association of California Healthcare Districts
by check:
1127 11th St., #905
Sacramento, CA 95814

By wire:
Wells Fargo Bank
Account #: 4121-229975
ABA/Routing #: 121000248

ACHD

ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

MEMBERSHIP DRIVES CHANGE

JOIN ACHD

ACHD serves the diverse needs of healthcare districts by enhancing public awareness, training, and educating its members as well as advocating for legislative and regulatory policies that allow healthcare districts to deliver the best possible health services to their communities.

12 VIRTUAL TRAININGS	**16** CERTIFIED HEALTHCARE DISTRICTS	**375** TOTAL INDIVIDUALS EDUCATED
350 TOTAL TRACKED BILLS	**30** ACTIVE BILL POSITIONS	**30** KEY COALITIONS

CONNECT WITH LOCAL HEALTHCARE LEADERS

At ACHD, we champion the vital work of healthcare districts by providing the advocacy, education, and tools you need to thrive. Joining our association means your district has a stronger voice in shaping policies that directly impact the health of your community.

Cathy Martin

Chief Executive Officer

VALUABLE TOOLS

GOVERNANCE TOOLKIT
A free resource to support district growth in areas like community engagement and strategic planning.

CEO & BOARD EVALUATIONS
Subsidized annual assessments to identify strengths and build high-performing teams.

CEO ROUNDTABLE
Monthly meetings for member district CEOs to connect and address district issues.

BOARD CLERK ROUNDTABLE
Meetings for Board clerks to discuss challenges, needs, and share solutions.

COMMUNICATIONS
Members receive key legislative and educational updates, The Advocate, and our Calls to Action.

ADVOCACY

ACHD ensures healthcare districts are represented in the legislature on issues including access to care, community health, healthcare infrastructure and land use, governance & Brown Act, labor relations, public works, workers' compensation and more.

Through robust advocacy ACHD was able to stop **AB 810** in Assembly Appropriations, for the year. The bill would have required all special districts to move all websites they maintain to a ".gov" or ".ca.gov".

ACHD was the **lead supporter** in the efforts to pass **AB 869**, which was signed by the Governor, and provides relief for small, rural and district hospitals with regard to complying with the 2030 seismic mandate.

In 2025, ACHD is sponsoring **AB 533**, which would re-establish the authority for healthcare districts to use the design-build process for hospital and clinic construction projects.

ACHD secured amendments to **AB 2975** to allow for handheld wand use instead of metal detectors for small and rural hospitals. In addition, ACHD is working with the Commission on State Mandates to file a test claim stating that this bill, which was signed by the Governor, imposes an unfunded state mandate.

EDUCATION

CERTIFIED HEALTHCARE DISTRICT PROGRAM
Free for members, this three-year certification highlights compliance with governance, accountability, transparency, and California's legal and best practice standards.

ACHD ANNUAL MEETING
Join leaders and experts to gain fresh strategies, share best practices, and focus on governance during this premier health care event.

WEBINAR EDUCATION SERIES
Members enjoy free, specially curated, on-demand webinars on critical healthcare district topics, ensuring ongoing education and insight.

JOIN US

ACHD.ORG
INFO@ACHD.ORG
916.266.5200

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

EL CENTRO REGIONAL MEDICAL CENTER

BYLAWS OF THE BOARD OF TRUSTEES

(rev. July 2022)

TABLE OF CONTENTS

EL CENTRO REGIONAL MEDICAL CENTER
BYLAWS OF THE BOARD OF TRUSTEES

ARTICLE I

GENERAL

Section 1.01 Name. The name of this Hospital is El Centro Community Hospital, doing business as, El Centro Regional Medical Center.

Section 1.02 Principal and Business Offices. The principal and business offices of the Hospital are located at 1415 Ross Avenue, in the City of El Centro, County of Imperial, State of California.

Section 1.03 Statutory Reference. This Hospital is organized under Articles 7 and 8, Chapter 5, Part 2, Division 3, Title 4 of the California Government Code, commencing with Section 37600, dealing with municipal hospitals (hereafter referred to as "Municipal Hospital Law") and Article III, Chapter 13 of the El Centro City Code (hereafter referred to as the "Hospital Ordinance"). The Hospital is an agency of the City of El Centro, California.

ARTICLE II

PURPOSES

Section 2.01 Purposes. The object and purposes of this Hospital shall be:

Section 2.01-1 To do all acts necessary for the proper maintenance and administration of a charitable, nonprofit, governmental hospital or other health care facilities or programs, and to effect all acts necessary to accomplish the purpose of such efficient administration.

Section 2.01-2 To carry on educational activities relating to the rendering of care to the sick, injured, infirm, aged, and the general public which, in the opinion of the Hospital, may be justified by its facilities, personnel, funds and other factors; to promote and carry on research related to the care of the sick, injured, infirm, aged, and the general public insofar as research can be carried on in or in connection with the Hospital; to establish educational programs in accord with curricula consistent with the standards of local, state and national educational organizations and societies.

Section 2.01-3 To participate as far as circumstances may permit, in the opinion of the Hospital, in any activities designed and carried on to promote the general health, rehabilitation, and social needs of the community served by the Hospital.

Section 2.01-4 To do all things permitted by the Municipal Hospital Law and the Hospital Ordinance, as either or both may be revised and amended, which can be done and performed by municipal hospitals in California.

Section 2.01-5 To provide quality health care, without discrimination, to all regardless of their race, national origin, creed, citizenship or ability to pay. (Adopted by Resolution No.

ECRMC 91-6, adopted February 27, 1991, Amended by Resolution No. ECRMC 94-4, Adopted April 27, 1994.)

ARTICLE III

BOARD OF TRUSTEES

Section 3.01 Powers and Duties. The business and affairs of the Hospital shall be managed by the Board of Trustees. The Board of Trustees shall manage the activities of the Hospital in a manner consistent and in compliance with the purposes, objectives, philosophy, and limitations set forth in the Municipal Hospital Law, the Hospital Ordinance, these Bylaws and as otherwise required by law. The Board of Trustees is a public agency separate and apart from the city council of the City of El Centro, and neither is responsible for the debts or liabilities of the other nor are the employees of the Hospital employees of the City of El Centro. The Board of Trustees shall have the following powers and duties:
(Amended by Resolution No. ECRMC 22-05, adopted July 25, 2022)

Section 3.01-1 The formulation and development of overall policies of the Hospital for the purpose of accomplishing the purposes and objectives of the Hospital.

Section 3.01-2 The election or appointment of officers of the Hospital in accord with the procedures set forth herein.

Section 3.01-3 The development and approval of such budgets and reports, including an annual operating budget, as may be necessary or appropriate or as may be required by the Hospital Ordinance.

Section 3.01-4 The approval of Bylaws, Rules, and Regulations of all organizations affiliated with the Hospital.

Section 3.01-5 The delegation of the duties and responsibilities of any officer or Trustee of the Hospital in the event of the absence or disability of such officer or trustee until the absence or disability has terminated, in the absence of any other provision in these Bylaws.

Section 3.01-6 The removal of officers from office as set forth in Section 5.04, with or without cause.

Section 3.01-7 The making, adopting, and modifying as necessary and appropriate, from time to time, rules and regulations governing the activities and programs of the Hospital, including its educational and medical activities and programs; the organization of services; choice of staff; appointment of physicians and other health care professionals; admission or exclusion of patients; and, in general, the governing of all internal activities at the Hospital and its activities and programs.

Section 3.01-8 The approval of Bylaws, Rules, and Regulations governing the conduct of the Medical Staff and medical administration of the Hospital. It shall be the policy of the Hospital that every patient be under the care of an appropriately licensed physician, or such other practitioner as may qualify to supervise a hospital admission under state law or Medicare Conditions of Participation. Patients shall be admitted to the Hospital only on the recommendation of a physician.

Section 3.01-9 The appointment to, termination of, or modification of, membership on the Medical Staff and the approval, withdrawal or other modification of clinical privileges, in accord with the Bylaws of the Medical Staff of the Hospital and to formulate and/or approve procedures to limit members of the Medical Staff and all other practitioners granted clinical privileges to practice only within the scope of the privileges granted by the Board of Trustees.

Section 3.01-10 The Board of Trustees shall require a process or processes designed to assure that all individuals responsible for the assessment, treatment, or care of patients are competent in the following, as appropriate to the ages of the patients served:

a. The ability to obtain information and interpret information in terms of the patient's needs.

b. A knowledge of growth and development.

c. An understanding of the range of treatment needed by these patients.

These individuals shall be reviewed and evaluated as part of the Hospital's overall review and evaluation of the quality and efficiency of patient care services. (Adopted by Resolution No. ECRMC 92-31, adopted December 21, 1992).

Section 3.01-11 The coordination of the activities and general policies of the various hospital departments and the special committees established by the Board of Trustees of the Hospital.

Section 3.01-12 To receive from the Medical Staff written committee reports and recommendations based upon medical staff credentialing, peer review and quality improvement activities and review of the results of the quality evaluation studies conducted by the other health care professionals and take appropriate action thereon. (Formerly Section 6.08-2, Professional Services Committee, whose functions and responsibilities transferred directly to the Board by Resolution No. ECRMC 99 - 12, adopted October 27, 1999).

Section 3.01-13 The Board will regularly review the Governing Board Bylaws, Hospital Organization Chart, Administrative and Personnel Policies, and the Quality Improvement, Utilization, and Risk Management and other appropriate Plans and Programs and based on this review, take appropriate action. (Amended by Resolution No. ECRMC 92-31, adopted December 21, 1992, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Renumbered by Resolution No. ECRMC 99 - 12, adopted October 27, 1999).

The foregoing listing (Section 3.01 through 3.01-13) shall not be deemed to limit any authority granted by law to the Board of Trustees not otherwise restricted by these Bylaws, the Municipal Hospital Law, or the Hospital Ordinance. In furtherance of the foregoing, the Board of Trustees may delegate the management of any one or more activities of the Hospital to any person or persons, manager or committee however composed, provided that the activities and affairs of the Hospital shall be managed and all powers shall be exercised under the ultimate direction of the Board of Trustees. (Amended by Resolution No. 15-13, adopted November 12, 2015).

Section 3.01-14 Board Self-Evaluation. The Board shall annually conduct a Board self-evaluation. (Adopted by Resolution No. ECRMC 92-31, adopted December 21, 1992; this

Section was formerly numbered Section 3.01-13, Renumbered by Resolution No. ECRMC 99 - 12, adopted October 27, 1999).

Section 3.01-15 Board Evaluation of Chief Executive Officer. The Board shall annually conduct an evaluation of the Chief Executive Officer. (Adopted by Resolution No. ECRMC 92-31, adopted December 21, 1992; this Section was formerly numbered Section 3.01-14, Renumbered by Resolution No. ECRMC 99 - 12, adopted October 27, 1999).

Section 3.01-16 One Level of Care. There shall be an annual report which may be incorporated into the Compliance Report to the Board demonstrating that there is one level of care as defined by Leadership Standard in Joint Commission on Accreditation of Healthcare Organizations (JCAHO), in the hospital. (Adopted by Resolution No. ECRMC 92-31, adopted December 21, 1992; this Section was formerly numbered Section 3.01-15, Renumbered by Resolution No. ECRMC 99 -12, adopted October 27, 1999; Amended by Resolution No. ECRMC 10-02, adopted March 23, 2010).

Section 3.02 Board Membership/Medical Staff Eligibility; Voting Status.

a. Number.: (1) In General; Two Voting Members of the City Council; Four Voting Members of the Public (Medical Staff Eligible to be Voting Member of the Public on Board); Three Voting Members of Management (Chief Executive Officer, Chief Medical Officer, and one representative appointed by the Manager). During all periods where there is a management agreement and appointment of a manager in place for the Hospital, The Board of Trustees of the Hospital will be comprised of nine (9) Hospital Trustees who may be residents or non-residents of the City, as follows: four (4) members of the Board of Trustees shall be members of the public, three (3) members of the Board of Trustees shall be members of the Hospital management (the Hospital's Chief Executive Officer, the Hospital's Chief Medical Officer, and a management representative appointed by the manager), and two (2) members of the Board of Trustees shall be members of the City Council. (Amended by Resolution No. ECRMC 05-04, adopted June 22, 2005; Amended by Resolution , adopted November 12, 2015; Amended by Resolution No. ECRMC 22-05, adopted July 25, 2022).

(2) [INTENTIONALL LEFT BLANK] (Added by Resolution No. ECRMC, 05-04, adopted June 22, 2005; Amended by Resolution, adopted November 12, 2015; Amended by Resolution No. ECRMC 22-05, adopted July 25, 2022).

(3) Selection of Management Representative Trustees. During all periods in which there is a management agreement in place and appointment of a manager for the Hospital, the manager shall nominate for appointment to the Hospital Board one (1) management representative Trustee who: (a) is employed by the manager, (b) has at least five (5) years of experience in either Hospital administration or the practice of medicine and (c) serves in a leadership role within the manager. If the individual nominated by the manager meets this criteria, then the Mayor shall appoint to the Board of Trustees the nominee presented by the manager. (Added by Resolution, adopted November 12, 2015).

(4) [INTENTIONALLY LEFT BLANK] (Added by Resolution, adopted November 12, 2015; Amended by Resolution No. ECRMC 22-05, adopted July 25, 2022).

b. Medical Staff Representation; Honorary Trustee without Vote. The Executive

Committee of the Medical Staff may exercise its discretion to elect an active member in good standing of the Hospital's Medical Staff, who is in compliance with applicable state laws and regulations regarding conflicts of interest, to serve as an honorary, non-voting Trustee and who attends open session of the Board meetings and closed session of the Board meetings in order to present the Medical Staff report, and, upon invitation of the Board, the entirety of closed session of the Board meetings. The term of office of said honorary Trustee shall be one year and coincident with the terms of office of the Medical Staff officers. In the event a vacancy should occur in said office, the Executive Committee of the Medical Staff may exercise its discretion in accord with relevant provisions in its bylaws. In no event, however, shall the Medical Staff Executive Committee's action in accord with its bylaws constitute a relinquishment of its ability to subsequently elect a qualifying Medical Staff member to serve as the honorary, non-voting Trustee for the remainder of a one (1) year term or for a new one (1) year term as applicable. (Amended by Resolution No. ECRMC 92-31, adopted December 21, 1992, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Amended by Resolution No. ECRMC 03- 13, adopted November 20, 2003; Amended by Resolution, adopted November 12, 2015; Amended by Resolution No. ECRMC 22-05, adopted July 25, 2022).

c. Board Composition if the Management Agreement is Terminated. If the management agreement and the appointment of the manager are terminated, then the management Trustees appointed by the manager shall resign from the Board of Trustees concurrently with the termination of the management agreement. If the Hospital continues to employ or contract with a chief medical officer and/or chief executive officer, then the chief medical officer and/or chief executive officer shall remain as non-voting members of the Board of Trustees. The city council and the public trustees on the Board of Trustees at that time shall remain on the Board until the expiration of their terms, and the City Mayor shall make necessary additional non-management appointments in order to constitute a board of nine (9) trustees or such other number as allowed by law. (Added by Resolution, adopted November 12, 2015; Amended by Resolution No. ECRMC 22-05, adopted July 25, 2022).

Section 3.03 Board Orientation/Continuing Education.

a. There shall be an organized and timely orientation of new Board members per the Board policy.

b. All members of the Board of Trustees shall participate, on a regular basis, in continuing education programs relative to the operation of the Hospital and the role and responsibilities of Board members, as required by the appropriate accrediting and licensing bodies. Records of such continuing education shall be kept and maintained in the office of the Chief Executive Officer. (Amended by Resolution No. ECRMC 92-31, adopted December 21, 1992; Amended by Resolution No. ECRMC 15-13; adopted November 12, 2015).

Section 3.04 Appointment/Tenure. Trustees from the City Council and the public shall be appointed by the Mayor with the consent of the City Council.

a. There is no limit to the number of terms that may be served by a City Council Trustee as long as the council member remains in office and is reappointed to the Board of Trustees. The term of office of any City Council Trustee shall end at such time as the council member no longer holds office or that council member is not reappointed to the Board of Trustees.

b. Trustees from the public shall hold office for a term of three (3) years commencing on June 30 of the year of their appointment. Vacancies shall be filled by appointment for the unexpired term. No public trustee shall serve more than four (4) terms, whether consecutive or non-consecutive. Each public trustee shall serve until their term expires or that trustee resigns or is removed from the Board. A public trustee serves at the pleasure of the City Council and may be removed by the City Council with or without cause in the same manner as he or she was appointed, and as provided in these Bylaws.

c. There is no limit to the number of terms that may be served by any management Trustees. The term of office for Trustees who are the Hospital's Chief Executive Officer and Chief Medical Officer shall be coterminous with such person's term of service in such position.

d. All Trustees serve without compensation, except that the City Council may by resolution provide for compensation to the public Trustees and City Council Trustees from hospital revenues in an amount not to exceed one hundred dollars ($100.00)/month per board meeting, and not to exceed five (5) meetings per month or as otherwise allowed by law. (Amended by Resolution No. ECRMC 92-31, adopted December 21, 1992, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Amended by Resolution No. ECRMC 99- 12, adopted October 27, 1999; Amended by Resolution No. ECRMC 03 - 13, adopted November 20, 2003; Amended by Resolution No. ECRMC 22-05, adopted July 25, 2022).

Section 3.05 Vacancies. A vacancy on the Board of Trustees occurring during the term of a Trustee shall be filled by appointment by the Mayor and, in the case of any non-management Trustees, with the consent of the City Council. A vacancy created by the death, resignation, or removal of a management Trustee shall be filled by appointment by the Mayor based on the nomination of the manager pursuant to Section 3.02(a)(3) of these Bylaws. Each Trustee appointed to fill a vacancy shall hold office for the unexpired term of the Trustee he or she succeeds, which unexpired term shall not be counted for purposes of applying any term limits. During any vacancy, the remaining Trustees shall continue to act with the power and authority of the full Board of Trustees. (Amended by Resolution No. ECRMC 99- 12, adopted October 27, 1999; Amended by Resolution, adopted November 12, 2015; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 3.05-1 Vacancies Due To Absence From Board Meetings. The term of any member of the Board of Trustees shall expire if he or she is absent from three (3) consecutive regular meetings, or from three (3) of any five (5) consecutive meetings of the Board and the City Council by resolution declares that a vacancy exists on the Board. (Added by Resolution No. ECRMC 99 - 12, adopted October 27, 1999).

Section 3.05-2 Vacancies Due to Absence From Committee Meetings. The term of any member of the Board of Trustees shall expire if he or she is absent from three (3) consecutive regular committee meetings, or from three (3) of any five (5) consecutive committee meetings during their tenure on a committee and the Board recommends that the City Council by resolution declare that a vacancy exists on the Board. (Added by Resolution No. ECRMC 10-16, adopted December 20, 2010.)

Section 3.06 Expense Reimbursement, Annual Physical Examination, and Health Insurance For Board Members.

Section 3.06-1 Each Trustee shall be entitled to receive reimbursement for reasonable expenses incurred in connection with his or her performance of the affairs of the Hospital. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989).

Section 3.06-2 Each voting member of the Board, except management Trustees, shall be entitled to an annual physical examination paid for by the Hospital. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 3.06-3 Each voting member of the Board, except management Trustees, shall be eligible to receive the same medical and health care insurance benefits provided to Hospital employees. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 10-02, adopted March 23, 2010; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 3.07 Term Life Insurance for Board of Trustees. The Hospital shall maintain term life insurance for each voting Board member, except management Trustees, in the amount of Fifty Thousand Dollars No Cents ($50,000.00). (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 99 - 12, adopted October 27, 1999; Amended by Resolution No. ECRMC 10-02, adopted March 23, 2010; Amended by Resolution No. ECRMC 11-10, adopted April 26, 2011; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

ARTICLE IV

MEETINGS OF THE BOARD OF TRUSTEES

Section 4.01 Regular and Special Meetings. The Board by resolution shall establish a regular meeting date which shall be at least monthly. Special meetings of the Board of Trustees may be called by the President of the Board of Trustees or at the written request of a quorum of the Board of Trustees. (Amended by Resolution No. ECRMC 91-4, adopted January 23, 1991).

Section 4.02 Place. All regular meetings of the Board of Trustees shall be held at least on a monthly basis on the Hospital Campus on day(s) and time(s) established by resolution of the Board of Trustees. Such other meetings of the Board shall be held at such time and place designated by the Board President, Vice-President (in the absence of the Board President, a majority of the Board or the Board Secretary or the Secretary's designee (as permitted by the California Public Meeting law). (Amended by Resolution No. ECRMC 91-5 adopted February 2, 1991; Amended by Resolution No. ECRMC 98-7 adopted May 27, 1998; Amended by Resolution No. 07-08 adopted July 25, 2007; Amended by Resolution No. 08 - 01 adopted January 23, 2008).

Section 4.03 Notice of Meetings.

Section 4.03-1 The Secretary of the Board of Trustees shall give, or cause to be given, notice of all meetings to the members of the Board of Trustees. The notice for regular meetings shall be deemed complied with when the agendas for such meetings are delivered to the officers described herein. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989).

Section 4.03-2 Notice of special meeting of the Board of Trustees shall be delivered personally or by mail and shall be received at least twenty-four (24) hours before the time of such meeting as specified in the notice. The call and notice shall specify the time and place of the

special meeting and the business to be transacted. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989).

Section 4.03-3 Such written notice to the members of the Board of Trustees may be dispensed with as to any member who at or prior to the time the meeting convenes files with the Secretary of the Board a written waiver of notice. Such waiver may be given by telegram. The written notice may also be dispensed with as to any member who is actually present at the time the special meeting convenes. Notice of the special meeting is required as provided herein regardless of whether any action is taken at the meeting. (California Government Code Section 54956). (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989).

Section 4.04 Agendas of Meeting of the Board of Trustees; Contents, Publication, Distribution.

Section 4.04-1 The Chief Executive Officer shall prepare an agenda for all meetings of the Board of Trustees. The agenda shall reasonably define the items to be considered at the meeting. All documents to be utilized by the Board at its public meeting shall be distributed at the time the agenda is published. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989).

Section 4.04-2 A copy of the agenda, including all such documents referenced in Section 4.04-1 above, shall be promptly transmitted to the offices of the City Clerk and City Attorney, but in no event later than seventy-two (72) hours before the regular meeting. (Renumbered by Resolution ECRMC No. 89-1, adopted January 25, 1989; Amended by Resolution, adopted November 12, 2015).

Section 4.04-3 Except in the case of special meetings, the Secretary shall distribute the agenda and documents to the members of the Board no later than seventy-two (72) hours prior to the Board meeting. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 4.05 Quorum. Except as otherwise provided by law or by these Bylaws, a majority of the number of trustees then in office shall constitute a quorum for the transaction of business at any meeting of the Board of Trustees, but if less than such quorum is present at a meeting, a majority of the Trustees present may adjourn to a specified time and place without further notice. If no Trustees are present at the time of such meeting, the Clerk to the Board may so adjourn the meeting.

Section 4.06 Voting. Each Trustee shall be entitled to cast one (1) vote on each matter submitted to a vote at any meeting of the Board of Trustees. Voting by proxy shall not be permitted.

Section 4.07 Conduct of Meetings. The President of the Board of Trustees or, in his or her absence, the Vice-President of the Board of Trustees or, in his or her absence, any Trustee chosen by the Trustees present shall call meetings of the Board of Trustees to order and shall act as the chair of the meeting. The Secretary of the Board of Trustees shall act as secretary of all meetings of the Board, but, in the absence of the Secretary, the presiding officer may appoint an assistant secretary, a Trustee, or any other person present to act as secretary of the meeting. (Amended by Resolution No. ECRMC 88-1, adopted January 27, 1988; Amended by Resolution No. ECRMC 89-1, adopted January 25, 1989).

Section 4.08 Rules. The Board of Trustees may adopt rules governing its conduct and procedures at meetings, not inconsistent with the Hospital Law, Hospital Ordinance, applicable law, and these Bylaws. Such rules may be amended by the Board of Trustees at any meeting, without notice.

Section 4.09 Attendance. Trustees are expected to attend all meetings of the Board of Trustees and of any committees on which they serve.

ARTICLE V

OFFICERS

Section 5.01 Number and Designation. The officers of the Hospital shall be the President of the Board of Trustees, the Vice-President of the Board of Trustees, the Secretary of the Board of Trustees, the City Treasurer, and the Chief Executive Officer. With the exception of the City Treasurer, who is the City Manager of the City of El Centro, these officers shall be appointed or elected by the Board of Trustees. Such other officers and assistant officers of the Hospital as are deemed necessary and appropriate by the Board of Trustees may be elected or appointed by the Board of Trustees. (Amended by Resolution No. ECRMC 88-1, adopted January 27, 1988; Amended by Resolution No. ECRMC 13-03 adopted March 26, 2013).

Section 5.02 Union of Offices. Any two (2) or more offices may be held by the same person, except the offices of President of the Board of Trustees and Vice-President, Chief Executive Officer and any other officer position to the Board, or Trustee and City Treasurer. (Amended by Resolution No. ECRMC 22-05 adopted July 25, 2022)

Section 5.03 Election and Tenure. Except for the Chief Executive Officer, the officers of the Board of Trustees shall be elected by the Board of Trustees at its regular meeting in July of each year. The term of office for each officer of the Hospital shall be one (1) year and each officer shall hold office until the next regular meeting of the Board of Trustees in July of the following year or until a successor has been duly elected and qualified, or until his or her prior death, resignation, or removal. (Amended by Resolution No. ECRMC 09-09, adopted July 22, 2009; Amended by Resolution No. ECRMC 22-05 adopted July 25, 2022).

Section 5.04 Resignation and/or Removal. A Board member may resign at any time by submitting a written resignation to the City Clerk of the City of El Centro, California. A manager may remove a management Trustee from office, with or without cause, by delivery of written notice to the City Clerk of the City of El Centro, California. An officer of the Board of Trustees may resign from their office as President, Vice-President or Secretary at any time by submitting a written resignation to the Executive Secretary of the Board of Trustees. With the exception of the City Treasurer who is an appointed employee of the City of El Centro, and except as may be otherwise provided by the Board as to the Chief Executive Officer, an officer of the Board may be removed from such office by a majority of the Board's current membership. Such removal may be with or without cause. (Amended by Resolution No. ECRMC 09-09, adopted July 22, 2009; Amended by Resolution ECRMC No. 13-03, adopted March 26th, 2013; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 5.05 Vacancies. A vacancy on the Board of Trustees because of death, resignation, removal, disqualification or otherwise, shall be filled for the unexpired portion of the term by appointment of the Mayor and, in the case on non-management Trustees, with the consent

of the City Council, all as provided in Section 3.05. A vacancy in the offices of President, Vice-President and Secretary shall be filled by the Board of Trustees at the next regular meeting of the Board of Trustees after the vacancy occurs. The newly appointed officer to a vacant office shall hold the office for the remainder of the unexpired portion of the term of office in accord with Section 5.03. (Amended by Resolution No. ECRMC 09-09, adopted July 22, 2009; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 5.06 Duties of Officers of the Board. Officers of the Board of Trustees shall have the following duties:

Section 5.06-1 President of the Board of Trustees. The President of the Board shall preside at all meetings of the Board of Trustees. The President shall appoint all members of committees with the consent of the Board. The President may determine the order of business at meetings of the Board of Trustees. In general, the President of the Board shall perform all duties incident to the office of the presiding officer of a governmental agency and such other duties as may be prescribed by the Board of Trustees, from time to time. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989).

Section 5.06-2 Vice-President. In the absence of the President of the Board of Trustees or in the event of death, inability or refusal to act, or in the event for any reason it shall be impracticable for the President of the Board to act personally, the Vice-President shall perform the duties of the President of the Board of Trustees and when so acting shall have all the powers of and be subject to all of the restrictions upon the President of the Board of Trustees.

Section 5.06-3 Chief Executive Officer. The Chief Executive Officer (CEO) shall be the chief administrative officer of the Hospital and, subject to the oversight and direction of the Board of Trustees, shall supervise and control the business and affairs of the Hospital. The CEO shall be qualified by such education, training, and experience as required by all applicable laws, regulations, and accrediting agencies, and shall be selected by the Board of Trustees. The CEO shall attend all meetings of the Board of Trustees. The CEO shall have the authority and responsibility to direct and administer all activities, departments, and programs of the Hospital subject to such policies as may be adopted by the Board of Trustees or any committee or manager to which the Board of Trustees has delegated authority and responsibility for such policy. The CEO shall, unless otherwise expressly provided, be an ex-officio member without vote of all Board committees and shall act as the duly authorized representative of the Board in all matters except those in which the Board has formally designated some other person or group to act. (Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015; Amended by Resolution No. ECRMC 22-05 adopted July 25, 2022).

The CEO shall, subject to the oversight and direction of the Board of Trustees and subject to any delegation of authority to a manager of the Hospital:

a. Be responsible for the implementation of all policies established by the Board of Trustees or any manager of the Hospital;

b. Establish, in coordination with any manager, a plan of organization for the personnel of the Hospital, which plan will be submitted to the Board of Trustees for approval and/or modification;

c. Be responsible, except as otherwise provided or delegated by the Board or in these

Bylaws, for selecting, employing, controlling, and discharging employees, and for developing and maintaining personnel policies and practices for the Hospital;

d. Assist the Board and any manager in annually reviewing and updating the long term capital outlay budget and preparing an annual operating budget showing the expected receipts and expenditures of the Hospital, and supervise the business affairs of the Hospital so that funds are expended to good advantage (the budgets described shall be prepared in accordance with hospital industry standards for a local public agency hospital);

e. Be responsible for the maintenance of the physical properties of the Hospital in good repair and in good operating condition;

f. Be responsible for maintenance of insurance on all such physical properties of the Hospital;

g. Submit regular periodic reports to the Board of Trustees, its authorized committees, any manager and the Medical Staff, on the overall activities of the Hospital, as well as on appropriate federal, state and local developments that affect the operation of the Hospital;

h. Serve as liaison between the Board of Trustees and the Medical Staff, attend or send a designate to all quarterly staff meetings of the Medical Staff (and such other Medical Staff meetings as warranted) and to the departments of the Hospital, and take necessary steps to ensure quality patient care at the Hospital. The CEO shall coordinate physician recruitment activities under the direction of the Board and any manager with consultation by the Medical Staff;

i. In coordination with any manager, provide the Hospital's professional staffs with the administrative support and personnel reasonably required to carry out their quality maintenance and improvement activities;

j. In coordination with any manager, organize the administrative functions of the Hospital, delegate duties, and establish formal means of accountability on the part of subordinates;

k. In coordination with any manager, establish such Hospital administrative departments as are necessary, provide for departmental and interdepartmental meetings, and attend or be represented at such meetings;

l. In coordination with any manager, designate, in writing, other individuals by name or position who are, in order of succession, authorized to act for the CEO during any period of his absence from the Hospital with Board approval;

m. Represent the Hospital in its relationship with other health agencies;

n. Assist the Board of Trustees and any manager in the development of good community relations;

o. Avail himself or herself, at Hospital expense and within reasonable limits of sound judgment, of available continuing educational opportunities which would contribute to his or her effectiveness and ability in the execution of the responsibilities and duties as CEO of the Hospital;

p. Develop, encourage, and otherwise promote continuing education of all

professional and non-professional staff members in their particular fields and in subjects relating to their responsibilities within the Hospital;

q. Provide the Hospital's professional staffs with the administrative support and personnel reasonably required to carry out their review and evaluation activities;

r. Establish and maintain on behalf of the Board of Trustees comprehensive liability insurance coverage for the members of the Board of Trustees;

s. Timely prepare and publish as prescribed by these Bylaws, agenda for all Board meetings in consultation with the President of the Board which agenda shall reasonably define the items to be considered at the meeting. All documents to be utilized by the Board at its public meeting shall be distributed at the time the agenda is published;

t. Be responsible for maintaining proper licensing and accreditation for the Hospital from all applicable agencies including the Joint Commission on Accreditation of Healthcare Organizations;

u. Assist the Board and any manager in preparation, review, and adoption by the Board of a strategic plan for the Hospital. The strategic plan shall be submitted to the City Council when the Hospital's annual audit is filed with the City Council;

v. Perform any other duty within the express or implicit terms of the duties hereunder or as set forth in Administrator's Employment Agreement that may be necessary for the best interest of the Hospital;

w. Be responsible for maintaining a current written schedule of rates and charges for all Hospital services;

x. Be responsible for assuring that satisfactory physical arrangements are made for all Board meetings; and

y. Be responsible for the development and maintenance of methods for the protection and care of Hospital patients and others at the time of internal and external disaster in cooperation with the Chairman of the Emergency Room Department or his designee. In furtherance of the foregoing, the CEO shall:

1. Propose for adoption and periodically review a written plan to safeguard patients at the time of an internal disaster, particularly fire, and shall assure that all key personnel rehearse fire drills at least quarterly; and

2. Adopt and periodically review a written plan for the care, reception, and evacuation of mass casualties and assure that such plan is coordinated with the inpatient and outpatient services of the Hospital, that it adequately reflect developments in the Hospital community and the anticipated role of the Hospital in the event of disasters in nearby communities, and that the plan is rehearsed by key personnel at least twice yearly. (Amended by Resolution No. ECRMC 88-1, adopted January 27, 1988; Amended and renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 91-4, adopted January 23, 1991; Amended by Resolution No. ECRMC 92-31, adopted December 21, 1992; Amended by

Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 5.06-4 Chief Medical Officer. The Chief Medical Officer ("CMO") shall, subject to the oversight and direction of the Board of Trustees, be responsible for overseeing the medical services provided to patients at the Hospital. The CMO shall be qualified by such education, training and experience as required by all applicable laws, regulations, and accrediting agencies, and shall be appointed by the manager upon the implementation of a management agreement, or if there is no management agreement in place, shall be appointed by the Board of Trustees. (Added by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 5.06-5 Secretary.

a. The Secretary shall:

1. Keep or arrange for the keeping of the minutes of the meetings of the Board of Trustees in one or more books provided for that purpose (such minutes shall be prepared and distributed prior to the next Board meeting).

2. See that all notices are duly given in accordance with the provisions of these Bylaws or as required by law.

3. Be custodian of the Hospital records.

4. Cause the proceedings of the Board to be recorded by tape recording device.

5. Maintain the records of the Board's proceedings including Board Committee meetings, in a manner approved by the Board of Trustees with the consent of the City Council.

6. Promptly file in the office of the El Centro City Clerk copies of all Hospital rules, regulations, minutes of the Board, personnel rules, contracts, leases and all other material transactions of the Hospital.

7. Keep or arrange for the keeping of a register of the post office address of each Board member.

b. The Secretary may delegate to the Board Executive Secretary all or any portion of the Secretary's responsibilities set forth in Subparagraph (a) of this Section. At the time of the Board's annual reorganization, the Secretary shall make such delegation, subject to the Board's approval, for purposes of carrying out any or all of the Secretary's responsibilities set forth in Subparagraph (a) hereof. (Amended by Resolution No. ECRMC 05-01, adopted January 26, 2005; Amended by Resolution No. ECRMC 07-09, adopted July 25, 2007; Amended by Resolution No. ECRMC 08-01, adopted January 23, 2008; Renumbered by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 5.06-6 City Treasurer.

a. The Treasurer shall:

1. Have charge and custody of and be responsible for all funds and securities

of the Hospital as established by Board policy.

2. Receive and give receipts for monies due and payable to the Hospital from any source whatsoever, and deposit all such monies in the name of the Hospital in such banks, trust companies or other depositories as shall be selected in accordance with applicable law.

3. In general, perform all of the duties incident to the office of City Treasurer as it relates to the operation of a municipal hospital and have such other duties and exercise such other authority as from time to time may be delegated or assigned by the Board of Trustees.

b. The City Treasurer shall be bonded for the faithful discharge of his or her duties in such sum and with such surety or sureties as established by the City Council. (Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Renumbered by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 5.06-7 City Clerk. The City Clerk shall perform those functions set forth in the Hospital Ordinance and specifically Sections 13-39 and 13-40 (Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Amended by Resolution No. ECRMC 07-10 adopted July 25, 2007; Amended by Resolution No. ECRMC 08 – 01, adopted January 23, 2008; Renumbered by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 5.07 Additional Officers. Such additional officers or assistant officers may be elected by the Board of Trustees as the Board may, from time to time, deem necessary.

Section 5.08 Compensation. With the exception of the members of the Board of Trustees, the compensation of the officers of the Hospital, if any, shall be fixed, from time to time, by the Board of Trustees.

ARTICLE VI

COMMITTEES

Section 6.01 Standing Committees and Standing Sub-Committees. (Amended by Resolution No. ECRMC 98-7 adopted May 27, 1998).

Section 6.01-1 Standing Committees – Creation. The standing committees of the Hospital shall be: the Finance Committee, the Governance Effectiveness and Bylaws Committee, the Board Quality and Experience Committee, and the Strategic Planning and Public Relations Committee. (Amended by Resolution No. ECRMC 04-13, adopted July 28, 2004; Amended by Resolution No. ECRMC 04-16, adopted November 18, 2004; Amended by Resolution No. ECRMC 16-09, adopted February 28, 2017).

Section 6.01-2 Standing Subcommittees – Creation.

a. Creation. The Board of Trustees may create standing subcommittees of the Board Committees. When the Board has created a standing subcommittee, such fact shall be reflected in the Board Bylaws. Standing subcommittees of the Board committees shall consist of at least two (2) Board members, at least one being a member of the full committee.

b. Designation. The standing subcommittees of the committees of the Board are: for the Finance Committee, the Pension Program Subcommittee; for the Governance Effectiveness

and Bylaws Committee, the Ethics and Compliance Subcommittee; for the Board Quality Committee, the Joint Conference Subcommittee. (Amended by Resolution No. ECRMC 98-7, adopted May 27, 1998; Amended by Resolution No. ECRMC 10-17, adopted December 20, 2010).

Section 6.02 Finance Committee.

Section 6.02-1 Composition. The Finance Committee shall consist of three (3) members of the Board of Trustees (including at least one (1) management Trustee) and a member of the Medical Staff who has been nominated by the President in consultation with the Chief of Staff and the consent of the Board. The City Treasurer, or his designee, shall be a member of the Committee, ex-officio and without vote. Notwithstanding any provision in these Bylaws to the contrary, the presence of two (2) Board members shall be sufficient to constitute a quorum of the Committee for the purpose of conducting business. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 98-7, adopted May 27, 1998; Amended by Resolution No. ECRMC 06-11, adopted September 27, 2006; Amended by Resolution No. ECRMC 07-11 adopted July 25, 2007; Amended by Resolution No. ECRMC 08-01, adopted January 23, 2008; Amended by Resolution No. ECRMC 10-02, adopted March 23, 2010; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 6.02-2 Functions. The Finance Committee shall, in coordination with any manager, shall:

a. Review the monthly financial statements of the Hospital and appraise its performance;

b. Make recommendation to the Board of Trustees concerning fiscal affairs and financial performance of the Hospital;

c. Review and make recommendations to the Board regarding the proposed capital and annual operating budgets of the Hospital which has been prepared by the CEO and any manager;

d. Evaluate the financial feasibility of projected activities, departments, programs, and undertakings as requested by the Board of Trustees and make recommendation thereon to the Board of Trustees;

e. Evaluate and recommend plans for securing necessary capital and operating funds for the Hospital as requested by the Board of Trustees;

f. Engage in such other activities relating to financial matters as are assigned from time to time by the Board of Trustees;

g. Review the account of all funds of the Hospital;

h. Review the depositing, safekeeping and investing of all Hospital Funds;

i. Make recommendations to the Board concerning the selection of an institution auditor and concerning the general fiscal affairs of the institution;

j. Arrange an annual audit of the institution's financial operation and services by an

independent firm with a national presence in the health care industry (the firm recommended by the Finance Committee shall be subject to final approval and employment by the Board of Trustees);

k. Receive, review, and evaluate the findings and final reports of the auditors and, based thereon, make recommendations to the Board concerning the financial operation of, and services required by and provided to, the institution;

l. Determine with the County of Imperial, the manner in which reimbursement shall be made to the Hospital for the care of medically indigent patients of the County and medically indigent patients outside the County.

m. In coordination with any manager, oversee and make any necessary reports to the Board regarding the Hospital's Personnel System and its administration, including the Hospital's Pension Program.

n. In coordination with any manager, review, consider, and make recommendations to the Board regarding any proposed changes to the Hospital's Personnel Rules and Regulations, to the Hospital's employee relations program, employee's compensation plan, benefit plan, and to any applicable memorandum of understanding adopted pursuant to the Meyers-Milias-Brown Act (California Government Code Section 3500, et seq.). (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015; Amended by Resolution No. ECRMC 16-09, adopted February 28, 2017).

Section 6.02-3 Pension Program Subcommittee.

a. Composition. The Pension Program Subcommittee of the Finance Committee shall consist of at least one (1) member of the Board of Trustees who is a member of the Personnel Committee and one (1) member of the Board of Trustees who is a member of the Finance Committee.

b. Functions. The Pension Program Subcommittee of the Finance Committee shall review, consider, and make recommendations to the Finance Committee and the Board regarding the Hospital's pension program including, without limitation, the administration thereof and the management and investment of the pension fund assets. The Subcommittee shall make reports to the Finance Committee and the Board at least semi-annually. In conducting its responsibilities, the subcommittee may be assisted by professional advisors, the administration and representatives of the Hospital employees. (Added by Resolution No. ECRMC 10-02, adopted March 23, 2010.)

Section 6.03 Board Quality and Experience Committee. (Amended by Resolution No. ECRMC 04-13, adopted July 28, 2004; amended by Resolution No. ECRMC 16-09; adopted Feb. 28, 2017).

Section 6.03-1 Composition. The Committee shall consist of three (3) members from the Hospital Board (including at least one (1) management Trustee), and the Chief of Staff, the Chief of Medicine, and the Chief of Surgery. The Vice Chief of Staff shall be an ex-officio Committee member without vote. The Vice Chief of Staff shall be the alternate to the Chief of Staff. The Vice Chief of Medicine shall be the alternate to the Chief of Medicine. The Vice Chief of Surgery shall be the alternate to the Chief of Surgery. When either the Chief of Staff, the Chief of Medicine, or

the Chief of Surgery is absent from a Committee, then the alternate to that Chief shall sit in the absent Chief's seat and participate and vote as a voting member at that meeting. Notwithstanding any provision in these Bylaws to the contrary, the presence of two (2) Board members shall be sufficient to constitute a quorum of the Committee for the purpose of conducting business. (Amended by Resolution No. ECRMC 04-13, adopted July 28, 2004; Amended by Resolution No. ECRMC 05 – 01, adopted January 26, 2005; Amended by Resolution No. ECRMC 10-06, adopted June 22, 2010; Amended by Resolution No. 15-13, adopted November 12, 2015; Amended by Resolution No. ECRMC 16-09, adopted February 28, 2017).

Section 6.03-2 Functions. The Board Quality and Experience Committee, in coordination with any manager, shall:

a. Review, refine and recommend Board approval of:

1. Reports and updates of progress toward the achievement of strategic goals as they relate to quality,

2. Measures and metrics to use as benchmarks for improvement of quality in all Hospital operations,

3. Performance improvement plans and the Hospital's annual Quality plan.

b. Ensure that Administration and medical staff structures are established and functioning to support the achievement of quality goals.

c. Monitor and evaluate the performance of Hospital in comparison to national and local quality standards for clinical outcomes and customer satisfaction.

d. Oversee institutional accrediting and licensing efforts.

e. Review and recommend to the Board of Trustees recommendations of the medical staff with respect to quality management/assurance and improvement reports.

f. Review and recommend to the Board of Trustees recommendations of the medical staff with respect to the granting and/or renewing of medical staff membership status and clinical privileges as well as medical staff recommendations regarding each application by an Allied Health Professional ("AHP") for specific services, department affiliation, and modification in services such AHP may perform.

g. In coordination with any manager, review, consider, and make recommendations to the Board regarding any proposed changes to the Hospital's Policies and Procedures related to patient care.

h. Provide oversight of the Hospital's risk mitigation and safety programs, including a regular review of incident reports.

i. Perform an annual review of personnel vacancies, turn-over, and discharges.

j. Review all medical staff disciplinary actions and medical staff bylaws violations. (Added by Resolution No. ECRMC 05-04, adopted June 22, 2005; Amended by Resolution No.

ECRMC 15-13, adopted November 12, 2015; Amended by Resolution 16-09, adopted February 28, 2017).

Section 6.03-3 Meetings. The Board Quality and Experience Committee shall meet at least quarterly. (Amended by Resolution No. ECRMC 04 -13, adopted July 28, 2004; Amended by Resolution No. ECRMC 16-09; Amended by Resolution 16-09, adopted February 28, 2017).

Section 6.03-4 Joint Conference Subcommittee.

a. Composition. The Joint Conference Subcommittee shall consist of the Chair of the Board Quality and Experience Committee and one (1) member of the Board of Trustees who is a member of the Board Quality and Experience Committee, the Chief of Staff of the Medical Staff and one (1) member of the Medical Staff appointed by the Chief of Staff. The CEO of the Hospital shall be a member of the Subcommittee, Ex-officio and without vote, unless otherwise provided under these Bylaws. The Subcommittee Chair shall alternate every six (6) months between the Chairperson of the Board Quality and Experience Committee, and the Chief of Staff of the Medical Staff. (Amended by Resolution 22-059, adopted July 25, 2022)

b. Functions. The Joint Conference Subcommittee shall constitute a forum for collaboration of positive outcomes related to quality of care and concerns of the Medical Staff and the Board of Trustees which are referred to the Subcommittee by the Board of Trustees or the Medical Executive Committee.

c. Meetings. The Joint Conference Subcommittee shall meet quarterly and shall transmit written reports of its activities to the Medical Executive Committee and to the Board Quality and Experience Committee. Meetings may be called by the Chair or any two (2) members. (Added by Resolution No. ECRMC 10-17, adopted December 20, 2010; Amended by Resolution No. ECRMC 16-09, adopted February 28, 2017).

Section 6.03-5 Expedited Credentialing Subcommittee. (Added by Resolution 16-09, adopted February 28, 2017).

a. Composition. The Expedited Credentialing Subcommittee shall consist of any three members of the Board of Trustees available to attend a meeting of the Expedited Credentialing Committee on short notice, and two such Board members constitute a quorum of the Committee for the purpose of conducting business.

b. Functions. The Expedited Credentialing Subcommittee shall review and determine whether or not to approve certain applications for appointment, reappointment, or modification of privileges following review and recommendation by the Medical Staff Executive Committee.

c. Meetings. The Expedited Credentialing Subcommittee shall meet as necessary in order to timely review the recommendations of the Medical Staff Executive Committee. Meetings may be called by any member of the Board of Trustees.

Section 6.04 Strategic Planning and Public Relations Committee. (Amended by Resolution No. ECRMC 16-09, adopted February 28, 2017).

Section 6.04-1 Composition. The Strategic Planning and Public Relations Committee shall consist of three (3) members, at least one (1) of whom shall be a management Trustee. The CEO

and Director of Nursing, or his/her designee, shall be ex-officio members and shall serve without voting privileges. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 92-31, adopted December 21, 1992; Amended by Resolution No. ECRMC 98-7, adopted May 27, 1998; Amended by Resolution No. ECRMC 04-16, adopted November 18, 2004; Amended by Resolution No. 07-12 adopted July 25, 2007; Amended by Resolution No. 08 -01, adopted January 23, 2008; Amended by Resolution No. ECRMC 10-02, adopted March 23, 2010; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015; Amended by Resolution No. ECRMC 16-09, adopted February 28, 2017).

a. Strategic Planning Functions.

1. Make recommendations to the Board of Directors related to the Hospital's mission, vision, strategic initiatives, major programs, and services, and provide input regarding trends in the healthcare field that may influence the growth and development of the Hospital.

2. Ensure Hospital Administration has established an effective strategic planning process, including development of a three to five year strategic plan with measurable goals and time targets, to assure that the total Hospital program is attuned to meeting the health needs of the community. The strategic plan should coordinate the Hospital services with those of other health care facilities and related community resources.

3. Identify critical strategic issues facing the Hospital, assist Hospital Administration to analyze the availability of physician and personnel resources, assess alternative strategic options when required, and make recommendations thereon to the Board of Trustees.

4. Review opportunities to improve the scope, cost effectiveness, and quality of services.

5. Conduct an annual review of the performance of contractors providing patient care-related services.

6. Be informed on a periodic basis of the condition and needs of the Hospital's physical plant and its compliance with all local, state, and federal requirements, codes, and standards. Advise the Board of Trustees on any renovation, repair, and maintenance of the physical plant and recommend funds for these purposes.

7. Periodically review the mission, vision, and strategic plan of the Hospital, and make recommendations thereon to the Board of Trustees.

b. Public Relations Functions.

Inform the community served by the Hospital regarding the services offered by the Hospital and develop a mutual understanding, good will and respect between the Hospital and its constituency. (Amended and Renumbered by Resolution No. ECRMC 04–16 adopted November 18, 2004; Amended by Resolution No. ECRMC 16-09, adopted February 28, 2017).

Section 6.05 Governance Effectiveness and Bylaws Committee. (Amended by Resolution No. ECRMC 04-13, adopted July 29, 2004; Renumbered by Resolution No. ECRMC 04-16, adopted November 18, 2004).

Section 6.05-1 Composition/Meetings. The Governance Effectiveness and Bylaws Committee shall consist of three (3) Board members, including the Board president and including at least one (1) management Trustee. The current Board president will chair the committee. The committee shall meet quarterly and as called by the Chair or majority of the committee members or as otherwise prescribed in Section 6.10 of these Bylaws. Notwithstanding any provision in these Bylaws to the contrary, the presence of two (2) Board members shall be sufficient to constitute a quorum of the Committee for the purpose of conducting business. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Amended by Resolution No. ECRMC 98-7, adopted May 27, 1998; Amended by Resolution No. ECRMC 04-13, adopted July 28, 2004; Amended by Resolution No. ECRMC 10-02, adopted March 23, 2010; Amended by Resolution No. 15-13, adopted November 12, 2015).

a. Governance Effectiveness Functions. (Amended by Resolution No. ECRMC 04-13, adopted July 28, 2004; Renumbered by Resolution 04-16, adopted November 19, 2004; Amended by Resolution No. ECRMC 05-04, adopted June 22, 2005).

1. Plan Board members' development including recruitment, orientation, education and evaluation of Board members and their effectiveness.

2. Review and update Board policies and procedures.

3. Review the activity of Board members prior to reappointment.

4. When requested by the Mayor, pursuant to Section 13-34 of the Hospital Ordinance, review designated candidate(s) for appointment to those seats on the Board of Trustees which have not otherwise been designated by the City Code to be filled by member(s) of the City Council (13-34(a) and (b)) or any non-voting member appointed by the medical staff (13-34(c)). The Committee's recommendation relating to said candidate(s) shall be forwarded to the full Board for Board recommendation to the Mayor. The recommendation shall be limited to whether, in the opinion of the Board, the referred candidate(s) is/are highly qualified, qualified, or not qualified to serve effectively on the Board.

5. Identify and select candidates for committees of the Board using criteria for Board services as a guide.

6. Plan for orientation and education of Board members and non-Board members of Board committees.

7. Develop an evaluation instrument and conduct Board self-evaluation and make recommendations to the Board.

8. Review hospital's conflict of interest policy and code and make recommendations thereon to the Board.

9. Conduct annual evaluation of the Hospital's Chief Executive Officer.

10. Review Manager reports provided pursuant to the Management Agreement.

11. Review bargaining unit contracts and any labor union negotiation process.

12. Review goals and objectives of the Board of Trustees annually. (Amended by Resolution No. ECRMC 05-04, approved June 22, 2005; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015; Amended by Resolution 16-09, adopted February 28, 2017).

b. Bylaws Functions.

1. The Bylaws Committee shall review, consider, and make recommendations to the Board regarding any proposed changes to the Governing Board Bylaws.

2. The Bylaws Committee shall periodically review the Governing Board Bylaws.

3. Whenever it deems it appropriate or immediately necessary to reflect changes in the operation of the Hospital, the Bylaws Committee may submit recommendations to the Board for amendments to the Board Bylaws, Board organization, and Board policies. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Amended by Resolution No. ECRMC 04 -13, adopted July 28, 2004; Renumbered by Resolution No. ECRMC 04-16 adopted November 18, 2004).

Section 6.05-2 Ethics and Compliance Subcommittee.

a. Composition. The Ethics and Compliance Subcommittee of the Governance Effectiveness and Bylaws Committee shall consist of at least two (2) members of the Governance Effectiveness and Bylaws Committee of the Board of Trustees.

b. Functions. The Ethics and Compliance Subcommittee of the Governance Effectiveness and Bylaws Committee shall be responsible for monitoring the Hospital's Compliance Program and periodically reporting to the Hospital Board regarding the status of same. The subcommittee shall be concerned with, among other things, monitoring and receiving updates regarding compliance training and education in the Hospital, and receiving summary reports regarding: Key financial indicators used as monitoring tools; Results of audits completed since prior meeting and planned action; Hotline calls received and action taken; Proposed changes to compliance policies and procedures. (Approval is typically required for these changes); Non-compliant issues and actions being taken; and New initiatives being undertaken by authorities. (Added by Resolution No. ECRMC 06-13, adopted September 27, 2006).

Section 6.05-3 Claims Review Subcommittee.

a. Composition. The Claims Review Subcommittee shall consist of any three members of the Board of Trustees available to attend a meeting of the Claims Review Subcommittee on short notice, and two such Board members constitute a quorum of the Committee for the purposes of conducting business.

b. Functions. The Claims Review Subcommittee shall review and take action in relation to a claim submitted by a third party against El Centro Regional Medical Center pursuant to the California Tort Claims Act.

c. Meetings. The Claims Review Subcommittee shall meet as necessary in order to timely review and take action in relation to a third party claim to ensure that a response is sent to the claimant within 45 days of receipt of the claim. (Added by Resolution No. ECRMC 18-03, adopted October 23, 2018).

Section 6.06 Personnel and Policy Committee. (Amended by Resolution No. ECRMC 04-13, adopted July 28, 2004; Deleted by Resolution No. ECRMC 16-09, adopted February 28, 2017).

Section 6.06-1 Pension Program Subcommittee. (Deleted by Resolution No. ECRMC 10-02, adopted March 23, 2010).

Section 6.07 Membership and Chairs. Members of all committees shall be appointed by the President of the Board of Trustees with the consent of the Board. To the extent possible, the President is encouraged to appoint as one member of each committee that member of the Board of Trustees who was the chair of the committee during the previous year. Except as otherwise provided in Section 6.03 herein, and Section 6.05-1 herein, one (1) member of each committee, who shall be a Trustee, shall be appointed chair by the President of the Board of Trustees. Except as otherwise provided, membership on committees may include persons other than trustees such as administrative staff members, members of the Medical Staff, professional advisors, and other interested persons. The Chief of Staff of the Medical Staff shall be consulted prior to appointment of any members of the Medical Staff of the Hospital to committees. All voting members of the standing committees shall be considered alternates to any such committees. Replacement members of any committee shall be appointed or elected, as the case may be, in the same manner as committee members are elected. (Amended by Resolution No. ECRMC 89-1, adopted January 25, 1989; The former Section 6.08 was repealed. See now new Subsection 3.01-12 of Section 3.01, Board of Trustees Powers and Duties whereby the functions and responsibilities of the former Professional Services Committee of the Board were transferred directly to the Board by Resolution No. ECRMC 99 – 12, adopted October 27, 1999; Amended by Resolution No. ECRMC 04-13, adopted July 28, 2004; Renumbered by Resolution No. ECRMC 04 – 16, adopted November 18, 2004; Amended by Resolution No. ECRMC 06-12, adopted September 27, 2006; Amended by Resolution No. 07-13, adopted July 25, 2007; Amended by Resolution No. 08 – 01, adopted January 23, 2008).

Section 6.08 Tenure. A member of a committee shall serve until the regular meeting of the Board of Trustees which occurs in July or until his or her successor is appointed, unless the committee shall be sooner dissolved or unless he or she is removed from such committee or unless the individual ceases to qualify as a member of such committee. (Renumbered by Resolution No. ECRMC 88-1, adopted January 27, 1988; Renumbered by Resolution No. ECRMC 04 – 16, adopted November 18, 2004; Amended by Resolution No. ECRMC 09-09, adopted July 22, 2009).

Section 6.09 Meetings and Notice. Meetings of standing committees and special committees may be called by the President of the Board of Trustees, the CEO or the chair of the committee. Except as otherwise provided in these Bylaws, each committee shall meet as often as necessary and appropriate to perform its duties. Notice of the date, time, and place of a meeting shall be given at such time and in such manner as to provide reasonable notice to committee members of the meeting. To the extent permitted by the California Public Meeting Law, the

Municipal Hospital Enabling Law, and related laws, all committee meetings shall be conducted in closed session unless the committee votes to conduct a particular meeting or portion thereof in open session. Each committee shall keep minutes of its proceedings and shall record and file them in the Hospital minute book. (Renumbered by Resolution No. ECRMC 88-1, adopted January 27, 1988; Amended and Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 91-4, adopted January 23, 1991, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Renumbered by Resolution No. ECRMC 04 – 16, adopted November 18, 2004).

Section 6.10 Quorum. Except as otherwise provided in these Bylaws, or in the resolution of the Board of Trustees creating a committee, a majority of the full committee shall constitute a quorum and the act of the majority of the committee members present at a meeting at which a quorum is present shall be the act of the committee. (Renumbered by Resolution ECRMC No. 88-1, adopted January 27, 1988; Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Renumbered by Resolution No. ECRMC 04 – 16, adopted November 18, 2004; Amended by Resolution No. 07-14 adopted July 25, 2007; Amended by Resolution No. 08 – 01, adopted January 23, 2008).

Section 6.11 Resignations and Removals. A member of a committee may resign at any time by submitting a written resignation to the chair of the committee, the President of the Board of Trustees or the CEO. Subject to the composition requirements set forth in these Bylaws for each committee, any member of any committee may be removed by the Board of Trustees whenever, in its judgment, the best interests of the Hospital would be served thereby; provided, however, that a management Trustee may be removed only with the prior written approval of the manager. (Renumbered by Resolution ECRMC No. 88-1, adopted January 27, 1988; Amended by Resolution No. ECRMC 89-1, adopted January 25, 1989; Renumbered by Resolution No. ECRMC 04 -16, adopted November 18, 2004; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 6.12 Vacancies. A vacancy on a committee shall be filled for the unexpired portion of the term in the same manner in which the selection of the previous committee member was made. During any vacancy, the remaining members may continue to act with the power and authority of the full committee. (Renumbered by Resolution No. ECRMC 88-1, adopted January 27, 1988; Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Renumbered by Resolution No. ECRMC 04 – 16, adopted November 18, 2004).

Section 6.12-1 Vacancies Due to Absence from Committee Meetings. The term of any member of a committee shall expire if he or she is absent from three (3) consecutive regular committee meetings, or from three (3) of any five (5) consecutive committee meetings during their tenure on a committee and the Board by motion declares that a vacancy exists on the committee. (Added by Resolution No. ECRMC 10-16, adopted December 20, 2010.)

Section 6.13 Rules. Each committee may adopt rules as necessary for its government, not inconsistent with these Bylaws or rules adopted by the Board of Trustees. (Renumbered by Resolution ECRMC No. 88-1, adopted January 27, 1988; Renumbered by Resolution No. ECRMC. 89-1, adopted January 25, 1989; Renumbered by Resolution No. ECRMC 04 – 16, adopted November 18, 2004).

Section 6.14 Proceedings. Unless otherwise required by law, the proceedings and documents of the committees are confidential. All participants at committee meetings, including committee members, administration, staff members, medical staff representatives, Hospital employees, and consultants shall maintain confidentiality as to the committee proceedings and documents and at the time of their initial appointment, reappointment, or affiliation with the committee shall sign a written promise to abide by this confidentiality agreement. (Adopted by Resolution No. ECRMC 91-4, adopted January 23, 1991, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996.; Amended by Resolution No. ECRMC 02- 02, adopted February 15, 2002; Renumbered by Resolution No. ECRMC 04 – 16, adopted November 18, 2004).

ARTICLE VII

ADMINISTRATION

Section 7.01 Administrative Officers. The principal administrative officers of the Hospital shall be a Chief Executive Officer, appointed by the Board of Trustees of the Hospital, and a Chief Medical Officer, appointed by the manager or if there is no management agreement in place, appointed by the Board of Trustees. (Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015)

Section 7.02 Chief Executive Officer. The Chief Executive Officer, as provided in Article V, Section 5.06.3, in particular, shall be the Chief Executive Officer (CEO) of the Hospital and, subject to the oversight and direction of the Board of Trustees, and in coordination with any manager, shall supervise and control the business and affairs of the Hospital. The duties of the Chief Executive Officer shall be as set forth in Section 5.06.3 herein. (Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 7.03 Chief Medical Officer. The Chief Medical Officer, as provided in Article V, Section 5.06-4, shall be the Chief Medical Officer (CMO) of the Hospital and, subject to the oversight and direction of the Board of Trustees, and in coordination with any manager, shall oversee the medical services provided to patients at the Hospital and fulfill such other responsibilities as are within the purview of a Chief Medical Officer. (Added by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 7.04 Assistant Administrative Officers. There may be such assistant administrative officers as the Board of Trustees may authorize from time to time. The assistant administrative officers shall perform such duties and have such authority as shall be delegated or assigned to them from time to time by the CEO, the manager, or the Board of Trustees. (Amended by Resolution No. ECRMC 98-7, adopted May 27, 1998; Amended by Resolution No. ECRMC 99 -12, adopted October 27, 1999; Amended by Resolution No. ECRMC 02-02, adopted February 15, 2002; Amended by Resolution No. ECRMC 02-15, adopted November 19, 2002; Amended and Renumbered by Resolution No. ECRMC 15-13, adopted November 12, 2015).

ARTICLE VIII

MEDICAL STAFF

Section 8.01 Organization. The Board of Trustees shall cause to be created a medical staff organization, to be known as the Medical Staff of the El Centro Regional Medical Center,

composed of such physicians and other licensed independently practicing health professionals who are appointed to membership and granted privileges to provide care, diagnosis, treatment and rehabilitation to patients in the Hospital by action of the Board. Appointment to this Medical Staff shall be a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. Recommendations from the Medical Staff to the Board of Trustees called for herein shall be presented to the Board Quality Committee and then to the Chief Executive Officer or the Chief of Staff of the Medical Staff. (Amended by Resolution No. ECRMC 15-01, adopted January 27, 2015).

Section 8.02 Responsibilities.

Section 8.02-1 Quality Review. The Board of Trustees shall delegate to the Medical Staff the responsibility and authority to evaluate, under the direction and supervision of the Chief of Staff of the Medical Staff, the quality of medical care provided by the Hospital. In fulfilling this responsibility, the Medical Staff, through its committees and departments, shall conduct necessary retrospective and continuing review of the quality of performance and clinical practice of the members of the Medical Staff and make evaluations relating thereto. The Medical Staff and departmental staff shall review and revise all departmental policies and procedures when warranted. The period between reviews shall not exceed three (3) years. The Medical Staff, under the direction and supervision of the Chief of Staff of the Medical Staff, shall conduct patient care evaluations. (Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996).

Section 8.02-2 Evaluation of Health Care Professionals. The Board of Trustees shall delegate to the Medical Staff the responsibility to investigate and evaluate, under the direction and supervision of the CEO and the Chief of Staff of the Medical Staff, all matters relating to Medical Staff membership status, clinical privileges, and corrective action; and the Medical Staff Executive Committee shall make written recommendations to the Board of Trustees relating thereto.

Section 8.02-3 Compliance with Ethical and Professional Standards. The Medical Staff shall seek to achieve compliance with all ethical principles and standards of professional medical practice. There shall be an appropriately licensed physician responsible for the care and treatment of each patient at the Hospital at all times unless the physician has made specific arrangements to meet this responsibility in a manner consistent with applicable Medical Staff and Hospital Rules. Patients shall be admitted to the Hospital only by a physician with admitting privileges, and a physician shall be on duty or on call at all times. The Board of Trustees shall provide appropriate procedures to enable it to be regularly and fully apprised of matters of concern to and the viewpoints of the Medical Staff.

Section 8.03 Bylaws, Rules, and Regulations. The Medical Staff organization shall formulate and adopt Bylaws, Rules, and Regulations for its internal governance, and amendments thereto, and shall review same from time to time but not to exceed three (3) years from the last such review, and the Chief of Staff shall present said Bylaws, Rules, and Regulations and including amendments thereto to the Board of Trustees. Such shall be effective only when approved by the Board of Trustees. These Bylaws, Rules, and Regulations shall create an administrative organization to discharge the functions and responsibilities assigned to the Medical Staff by the Board of Trustees. The Bylaws, Rules, and Regulations shall state the purposes, functions and organization of the Medical Staff and shall set forth the policies by which the Medical Staff

exercises and accounts for its delegated authority and responsibilities. The Medical Staff Bylaws shall provide for a due process mechanism for the proper review, when requested, of situations in which membership on the staff or privileges of members of the Medical Staff are denied, reduced, altered or otherwise modified.

If the Medical Staff Bylaws are or become non-compliant with the requirements imposed by law, regulation, order of a court or administrative body of competent jurisdiction, including applicable licensing requirements, tax laws and regulations, or it becomes reasonably necessary therefor, the Board of Trustees may request appropriate amendment thereto. The Medical Staff shall take action on the proposed amendment at its next regular meeting, following requisite notice, unless sanctions will be imposed upon the Hospital in the absence of amendment prior to the next regular meeting, in which case a special meeting of the Medical Staff shall be called within a reasonable time to act thereon. Such amendment as is proposed by the Board of Trustees that is necessary to comply with law, regulation, order of a court of law or licensing authority shall be deemed adopted by the medical staff in at least 180 days, unless the Medical Staff takes action that amends the Medical Staff Bylaws to conform to such requirements. (Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Amended by Resolution NO. ECRMC 02-02, adopted February 15, 2002; Amended by Resolution No. ECRMC 02-15, adopted November 19, 2002.)

Section 8.04 Membership and Clinical Privileges.

a. The Medical Staff of the Hospital shall be composed of qualified physicians and such other licensed independently practicing health professionals who are licensed to practice in the State of California. Membership on the Medical Staff shall be a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. All appointments and reappointments to the Medical Staff shall be for two (2) years only, with eligibility for reappointment during the month of the member's birthday. All appointments and reappointments to the Medical Staff are subject to recall for just cause. Appointments and reappointments may be made contingent upon the Hospital's subsequent receipt of renewed DEA licensing within a defined period and a satisfactory report from the National Data Bank. (Amended by Resolution No. ECRMC 91-4, adopted January 23, 1991; Amended by Resolution No. ECRMC 92-31, adopted December 21, 1992).

b. In the case of reappraisal for reappointment to the Medical Staff or renewal/revision of clinical privileges, recommendations from the Medical Staff to the Board shall include information concerning the individual's professional performance, the individual's judgment, and the individual's clinical and/or technical skills, as indicated in part by the results of quality assessment and improvement activities. (Adopted by Resolution No. ECRMC 92-31, adopted December 21, 1992, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996).

Section 8.04-1 Recommendation to Board of Trustees. The Medical Staff, under the direction and supervision of the CEO and the Chief of Staff of the Medical Staff, shall investigate and evaluate matters relating to Medical Staff membership status, clinical privileges, and corrective action, and the Medical Staff Executive Committee shall make recommendations to the Board of Trustees thereon. The CEO shall promptly forward to the Board such recommendation together with a certification by the Chief of Staff that the applicant either satisfies or does not satisfy all requirements established by the Medical Staff and the Board. Final action on all matters

relating to Medical Staff status, clinical privileges, and adverse action as defined in the Medical Staff Bylaws shall be taken by the Board of Trustees after considering the recommendations of the Medical Staff Executive Committee, provided that the Board of Trustees shall act in any event if the Medical Staff Executive Committee fails to submit any such recommendation within the time periods required by the Medical Staff Bylaws. Any such Board of Trustees' action without the recommendation of the Medical Staff Executive Committee shall be based on the same kind of documented investigation and evaluation of current ability, judgment, and character as is required for recommendations of the Medical Staff. Notwithstanding the foregoing, in those months in which the Board does not hold a regular meeting, the Board President may designate any three (3) members of the Board of Trustees to unanimously approve on behalf of the Board of Trustees the Medical Staff's credentialing report and recommendation regarding an application for Medical Staff status and clinical privileges. Such action by the President's designees shall be reported to the Board at its next regular meeting for ratification. (Amended by Resolution No. ECRMC 05-04, adopted June 22, 2005).

Section 8.04-2 Medico-Administrative Positions. For any physician or dentist whose engagement by the Hospital in a medico-administrative capacity requires membership on the Medical Staff, the termination of such contract or employment shall constitute a resignation of such member's privileges if the contract or employment agreement covered all such clinical privileges. Such resignation shall not be subject to the review process set forth in the Fair Hearing Plan.

Section 8.04-3 Procedure for Appointment. Except as otherwise provided herein, the procedure to be followed by the Medical Staff and the Board of Trustees in acting on matters of membership status, clinical privileges, and corrective action shall be specified in the Medical Staff Bylaws. (Amended by Resolution No. ECRMC 91-4, adopted January 23, 1991).

Section 8.04-4 Application for Appointment. All applications for appointment to the Medical Staff shall be in writing and addressed to the CEO. Applications shall contain full information as required by the Medical Staff Bylaws. This information shall be verified by the Medical Staff pursuant to its credentials function.

Section 8.04-5 Selection Criteria. In acting on matters of Medical Staff membership status, the Board of Trustees shall consider the recommendations of the Medical Staff Executive Committee and Hospital Administration, the needs of the Hospital and community, and such other criteria as are set forth in the Medical Staff Bylaws. In granting and defining the scope of clinical privileges that is to be exercised by each professional providing health care services at the Hospital, the Board of Trustees shall consider the recommendation of the Medical Staff Executive Committee, the supporting information on which it is based, and such criteria as are set forth in the Medical Staff Bylaws. Important criteria for Medical Staff membership and clinical privileges, among others, are professional ability, judgment, rapport, community needs, Hospital needs and capacity to provide support, and ability to provide good patient care at the Hospital. Notwithstanding the above, for a physician or other licensed independently practicing health professional to be favorably considered for Medical Staff membership, it will be necessary to assure compatibility with the purposes, objectives, philosophies, programs, and staff of the Hospital.

Section 8.04-6 Malpractice Insurance. Unless otherwise provided by contract approved by the Board, all members of the Medical Staff as a precondition to obtaining and/or maintaining privileges at the Hospital shall maintain malpractice insurance in the amount set by resolution of the Board, but in no event less than Two Hundred Fifty Thousand Dollars/Five Hundred Thousand Dollars No Cents ($250,000.00/$500,000.00). Prior to amending these limits, the Board shall consult with and give due consideration to the Medical Staff's recommendation thereon. (Amended by Resolution No. ECRMC 92-31, adopted December 21, 1992).

Section 8.04-7 No Unlawful Discrimination. No aspect of membership status nor specific clinical privileges shall be limited or denied to a physician or dentist on the basis of sex, age, race, religious creed, mental or physical disability (except as permitted by law), medical condition, color, national origin, ancestry, pregnancy, childbirth, marital status or sexual orientation. (Amended by Resolution No. ECRMC 10-02, adopted March 23, 2010).

Section 8.05 Appointment of Department Chairs. The Board of Trustees shall receive a written report from the Executive Committee relating to each appointment of Department chairs made by the Medical Staff. Department Chairs shall serve for terms and carry out functions as provided in the Medical Staff Bylaws. (Amended by Resolution No. ECRMC 89-1, adopted January 25, 1989, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996).

Section 8.06 Fair Hearing. The Board of Trustees shall require that any action taken concerning a member of the Medical Staff, the effect of which is to deny, revoke, suspend or reduce a member's staff appointment, reappointment, staff category, admitting prerogatives or clinical privileges, shall, except under circumstances where a specific provision is made in the Medical Staff Bylaws, be accomplished in accordance with procedures and in a manner designed to assure fair treatment and afford opportunity for the presentation of all pertinent information. These procedures shall be stated in the Medical Staff Bylaws Fair Hearing Section.

Section 8.07 Allied Health Professionals. The Board shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate each application by an Allied Health Professional ("AHP") for specific services, department affiliation, and modification in the services such AHP may perform and shall require that the staff make recommendations to it or to its designee thereon. In this regard, the Medical Staff shall develop a written protocol for the exercise of the responsibilities delegated to it by this Section.

Section 8.08 Creation of Miscellaneous Medical Staff Committees; Quality Assurance; Peer Review; National Practitioner Data Bank. To assist the Medical Staff in achieving the goals and objectives prescribed in this Article VIII, the Medical Staff may, subject to the procedures set forth in Section 8.04-5 hereof, adopt appropriate bylaws and/or amendments thereto providing for the creation of a Medical Staff Aid Committee, a Bioethics Committee, and such other committees and/or programs and procedures necessary to keep the Hospital in compliance with applicable laws and regulations relating to quality assurance, peer review, including, without limitation, the Health Care Quality Improvement Act of 1986, 42USC 11101 et seq., and the regulations adopted to implement the Act, 54 Fed. Reg. 42722 (October 17, 1989) as made applicable by Chapter 336 of Statutes of the State of California for 1989. (SB 1211). (Adopted by Resolution No. ECRMC 90-3, adopted February 28, 1990; Amended by Resolution No. ECRMC 91-4, adopted January 23, 1991).

ARTICLE IX

CONTRACTS, LOANS, CHECKS AND DEPOSITS; SPECIAL CORPORATE ACTS

Section 9.01 Contracts. The Board of Trustees may authorize any officer or officers, manager, agent or agents, to enter into any contract or execute or deliver any instrument in the name of and on behalf of the Hospital, and such authorization may be general or confined to specific instances, consistent with the Hospital Decision-Making Guidelines. In the absence of other designation and to the extent permitted or required by law, all deeds, mortgages, and instruments of assignment or pledge made and approved by the Hospital Board of Trustees shall be executed in the name of the Hospital by the President of the Board of Trustees, and the City Clerk shall affix the City's seal thereto; and when so executed no other party to such instrument or any third party shall be required to make any inquiry into the authority of the signing officer or officers. (Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Amended by Resolution No. ECRMC 15-13, adopted on November 12, 2015; Amended by Resolution No. ECRMC 16-09, adopted February 28, 2017).

Section 9.02 Loans. No indebtedness for borrowed money shall be contracted on behalf of the Hospital and no evidences of such indebtedness shall be issued in its name unless authorized by or under the authority of a resolution of the Board of Trustees and, to the extent required by the Municipal Hospital Enabling Law (or other applicable law), by a resolution of the City Council. Such authorization may be general or confined to specific instances. (Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996).

Section 9.03 Checks, Drafts, etc. All checks, drafts, or other orders for the payment of money, notes or other evidences of indebtedness issued in the name of the Hospital, shall be signed by such officer or officers, manager, agent or agents of the Hospital and in such manner as shall from time to time be determined by or under the authority of a resolution of the Board of Trustees in conjunction with the City Treasurer. (Amended by Resolution No. ECRMC 15-13, adopted on November 12, 2015).

Section 9.04 Deposits.

All funds of the Hospital not otherwise employed shall be deposited from time to time to the credit of the Hospital in such banks, trust companies or other depositories as may be selected by and under the authority of the City Treasurer and approved by the Board of Trustees. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996).

Section 9.04-2 No portion of the Hospital fund shall be invested, deposited, transferred to, used as collateral for any loan, lease or financial arrangement with any bank, savings and loan institution, or other financial institution which has an officer, employee, representative, agent, or holder of more than one percent (1%) of the common stock of said institution a Trustee or officer of the Hospital. (See Hospital Ordinance Section 13-54(b). Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996).

ARTICLE X

OFFICERS AND TRUSTEES; LIABILITY AND INDEMNITY; TRANSACTIONS WITH CORPORATION

Section 10.01 Liability of Trustees and Officers. No person shall be liable to the Hospital for any loss or damage suffered by it on account of any action taken or omitted to be taken by him or her as a Trustee or officer or manager of the Hospital, or of any other corporation or entity which he or she serves as a member, Trustee or officer at the request of the Hospital, in good faith, if such a person (a) exercised and used the same degree of care and skill as a prudent person would have exercised or used under the circumstances in the conduct of his or her own affairs, or (b) took or omitted to take such action in reliance upon advice of counsel for the Hospital or such statements made or information furnished by officers or employees of the Hospital which he or she had reasonable grounds to believe to be true. The foregoing shall not be exclusive of other rights and defenses to which he may be entitled as a matter of law. (Amended by Resolution No. ECRMC 89-1, adopted January 25, 1989; (Amended by Resolution No. ECRMC 15-13, adopted on November 12, 2015).

Section 10.02 Indemnification of Trustees and Officers. Every person who is or was a Trustee or officer of the Hospital, and any member of the Medical Staff performing duties required of him or her by the Medical Staff Bylaws and Rules and Regulations, shall together with the heirs, executors, and administrators of such person, be indemnified by the Hospital against all costs, damages and expenses asserted against, incurred by or imposed upon him or her in connection with or resulting from any claim, action, suit or proceedings, including criminal proceedings, to which he or she is made or threatened to be made a party by reason of his or her being or having been such Trustee or officer, except in relation to matters as to which he or she should be adjudged in such action, suit, or proceeding to be liable for negligence or misconduct in the performance of his or her duty to the Hospital. This indemnity shall include reimbursement of amounts and expenses reasonably incurred and paid in settling any such claim, action, suit or proceeding.

The Hospital, by its Board of Trustees, may indemnify in like manner, or with any limitations, any current or former employee of this Hospital with respect to any action taken or not taken in his or her capacity as such employee.

The foregoing rights of indemnification shall be in addition to all rights to which trustees, officers, or employees may be entitled as a matter of law. (Amended by Resolution No. ECRMC 89-1, adopted January 25, 1989).

The Hospital and its Trustees, officers, employees, and agents shall not be liable to anyone for making any determination as to the existence or absence of liability, nor for making or refusing to make any payment hereunder on the basis of said determination, nor for taking or omitting to take any other action hereunder, in reliance upon the advice of counsel.

Section 10.03 Conflict of Interest.

Section 10.03-1 Incompatible Employment. No Trustee, Hospital official or Hospital employee shall engage in or accept private employment or render services for private interests when such employment or service is incompatible with the proper discharge of his/her

official duties or would tend to impair his/her independent judgment or action in the performance of his/her official duties. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989).

Section 10.03-2 Employment of Management Trustees by Manager. Notwithstanding the foregoing provisions of Bylaws Section 10.03-1, nothing contained in this section shall limit or restrict the employment by the manager of any management Trustee, nor shall such management Trustee's employment or position with the manager or any compensation paid to such management Trustee by the manager constitute a conflict of interest under this section. (Added by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 10.03-3 Gifts and Favors. No Trustee, Hospital official or Hospital employee shall accept any valuable gift, whether in the form of service, loan, discount, rebate, thing of value, or promise, from any person, firm, or corporation which to his/her knowledge is interested directly or indirectly in any manner whatsoever in business dealings with the City; nor shall any such Trustee, Hospital official or Hospital employee accept any gift, favor, discount, rebate, or thing of value from any one which may tend to influence him in the discharge of his duties; nor shall any such Trustee, Hospital official, or Hospital employee grant in the discharge of his/her duties any improper favor, service, or thing of value. Notwithstanding this section 10.03-3, nothing contained in this section shall limit or restrict the employment by the manager of any management Trustee, nor shall such management Trustee's employment or position with the manager or any compensation paid to such management Trustee by the manager constitute a conflict of interest under this section. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended and Renumbered by Resolution No. ECRMC 15-13, adopted on November 12, 2015).

Section 10.03-4 Contracts with the Hospital or Other Agencies. No Trustee, Hospital official (including any person who is a member of a committee established by the Board of Trustees or upon which any Board Member sits) or Hospital employee shall have a financial interest in any business transaction or contract with the Hospital or any agency of agency affiliated, regulated or created, or implemented by Hospital action, except as permitted in the conflict of interest statutes of the State. Notwithstanding this section 10.03-4, nothing contained in this section shall limit or restrict the employment by the manager of any management Trustee, nor shall such management Trustee's employment or position with the manager or any compensation paid to such management Trustee by the manager constitute a conflict of interest under this section. (Amended and Renumbered by Resolution No. ECRMC 15-13, adopted on November 12, 2015).

Section 10.04 Appearance of Impropriety. Trustees, Hospital officials and Hospital employees, whether appointed or elected, full-time or part-time, paid or unpaid, should conduct their official and private affairs so as not to give a reasonable basis for the impression that any such official or employee can be improperly influenced in the performance of his/her public duties. Such officials or employees should so conduct themselves as to maintain public confidence in their performance of the public trust in the government they represent. They should not be a source of embarrassment to that government and should avoid even the appearance of conflict between their public duties and private interests. Notwithstanding this section 10.04, nothing contained in this section shall limit or restrict the employment by the manager of any management Trustee, nor shall such management Trustee's employment or position with the manager or any compensation paid

to such management Trustee by the manager constitute an appearance of impropriety under this section. (Amended by Resolution No. ECRMC 15-13, adopted on November 12, 2015).

Section 10.05 Disqualification from Participation in Decision-Making Process. No Trustee, Hospital official or Hospital employee shall participate in any decision-making process or in any manner attempt to influence such decision-making process when such Trustee, Hospital official or Hospital employee possesses a conflict of interest as defined by applicable federal, state, city, Hospital local agency law, ordinance, resolution, rule, regulation or policy or possesses a discloseable interest as defined by such applicable federal, state, city, hospital, or local agency law, ordinance, rule, regulation or policy. Management Trustees shall recuse themselves from any actions to be taken by the Hospital Board with respect to or under the management agreement. (Amended by Resolution No. ECRMC 15-13, adopted on November 12, 2015).

ARTICLE XI

AMENDMENTS

Section 11.01 Amendments. These Bylaws may be altered, amended, or repealed, and new Bylaws may be adopted only by the affirmative vote of a majority of the members of the Board of Trustees present at any annual, regular, or special meeting of the Board of Trustees duly called for such purpose at which a quorum is present; provided that such majority includes at least one (1) management Trustee if the proposed alteration, amendment or repeal of these Bylaws or the adoption of new Bylaws would have any of the following effects:

a. Alter the composition of the Board or any committee thereof or the provisions governing the selection, removal or term of office of any management Trustee;

b. Alter the rights or obligations of the manager or the Hospital under any management agreement;

c. Adversely affect the Hospital's ability to perform its obligations under any management agreement; or

d. Alter the provisions in Section 10.03 (Conflict of Interest) or Section 10.04 (Appearance of Impropriety) in any manner that would restrict the manager's employment of (or compensation to) any management Trustee. (Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 11.02 Periodic Review. These Bylaws shall be reviewed periodically (not to exceed three (3) years) by the Board of Trustees, and the Hospital minutes shall reflect that such review was made. (Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996; Amended by Resolution No. ECRMC 02- 02 adopted February 15, 2002).

ARTICLE XII

GENERAL PROVISIONS

Section 12.01 Annual Report to the Board. Within a reasonable period of time after the end of each fiscal year of the Hospital, the CEO shall, in coordination with any manager, submit an annual report to the Board of Trustees which shall contain:

Section 12.01-1 Organizational chart, including persons serving as officers and members of committees;

Section 12.01-2 All contracts, agreements, conveyances of interests in real property, leases, association memberships, and other agreements of the Hospital existing and/or incurred during the time from the last report or as required by the Board;

Section 12.01-3 Financial statements for the immediately preceding fiscal year;

Section 12.01-4 Capital budget and operating budget forthe current fiscal year; and

Section 12.01-5 Summary of the Hospital's compliance with the laws and regulations of federal, state and local governmental agencies and with the standards, rules, and regulations of the various accrediting and approval agencies. (Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 12.02 Report to City Council/Hospital Annual Report.

Section 12.02-1 Annual Reports to the City Council. On or before October 31 in each year, the Board or its delegated manager shall report to the City Council the condition of the Hospital on June 30th preceding, with a statement of its proceedings for the year. (Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 02- 02, adopted February 15, 2002; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015).

Section 12.02-2 Hospital Financial Information.

a. An annual audit of the Hospital shall be conducted by a certified public accounting firm with a national or regional reputation in health care. A copy of the final audit report, including management letter, shall be presented to the City Council by the end of November of each year. (Amended by Resolution No. ECRMC 02 - 02, adopted February 15, 2002).

b. There shall be a semi-annual review of the Hospital's financial condition by an independent certified public accountancy firm employed by the Board with a copy of the report thereon being presented to the City Council within seventy-five (75) days from the end of the quarters ending June 30 and December 31 of the fiscal year. (See Hospital Ord. Section 13-53; Renumbered by Resolution No. ECRMC 89-1, adopted January 25, 1989, Amended by Resolution No. ECRMC 96-1 adopted February 28, 1996).

Section 12.03 Affiliated Organization. The Board of Trustees may authorize and direct the formation of other organizations, such as an auxiliary or advisory Board, to assist in fulfilling the purposes, objectives, and philosophies of the Hospital. Each such affiliated organization shall have Bylaws, Rules, and Regulations for the governance of its activities which are consistent with the Bylaws of this Hospital. All such bylaws and/or amendments shall be approved by the Board and be on file with the Hospital. Any such affiliated organizations shall serve at the pleasure of the Board of Trustees and the Bylaws, Rules, and Regulations and any amendments thereto shall become effective only upon the approval of the Board of Trustees of the Hospital. (Amended by Resolution No. ECRMC 89-1, adopted January 25, 1989).

Section 12.04 Fiscal Year. The fiscal year of the Hospital shall begin on the first day of July and end on the last day of June of each year.

Section 12.05 No Corporate Seal. The Hospital shall not have a Corporate Seal.

Section 12.06 Gender. Any word or reference contained in these Bylaws which implies one gender shall be applied to the other gender whenever appropriate.

Section 12.07 Waiver of Notice. Whenever any notice is required to be given under the provisions of the Public Meeting Law (Government Code Section 54950, et seq.) or these Bylaws, a waiver thereof in writing signed by the person entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice where such waiver shall be filed with the corporate records, or be made a part of the minutes of the relevant meeting.

Section 12.08 Glossary/Definitions. Wherever used in these Bylaws, the following words and terms shall have the meaning ascribed to them below.

a. HOSPITAL means EL CENTRO COMMUNITY HOSPITAL, dba, EL CENTRO REGIONAL MEDICAL CENTER, an agency of the City of El Centro, California.

b. BOARD OF TRUSTEES or BOARD means the Governing Body of the HOSPITAL.

c. CHIEF EXECUTIVE OFFICER means the individual appointed by the BOARD to act on its behalf in the overall administrative management of the HOSPITAL.

d. DECISION-MAKING GUIDELINES means the parameters for what contracting decisions can be made by HOSPITAL Administration, the BOARD, and the MANAGER.

e. MEDICAL STAFF or STAFF means the formal organization of all licensed physicians dentists, podiatrists, and clinical psychologists who are privileged to attend patients in the HOSPITAL.

f. MEDICAL STAFF MEMBERSHIP STATUS or MEMBERSHIP STATUS means all matters relating to MEDICAL STAFF appointments and reappointments to department affiliations and to staff category assignments.

g. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric, psychological, or surgical services.

h. PHYSICIAN means an individual with an M.D. or D.O. Degree who is fully licensed to practice medicine in all its phases.

i. PRACTITIONER means, unless otherwise expressly limited, any physician, psychologist, dentist or podiatrist applying for or exercising clinical privileges in this HOSPITAL.

j. ALLIED HEALTH PROFESSIONAL or AHP means an individual other than a licensed practitioner who exercises independent judgment within the areas of his professional competence and who is qualified to render direct or indirect medical, dental, podiatric or surgical care under the supervision of a practitioner who has been accorded privileges to provide such care in the HOSPITAL. Such AHPs shall include, without limitation, bacteriologists, chemists, clinical pharmacologists, dental auxiliaries, nurse clinicians/practitioners, other doctoral scientists, physician assistants, physiologists and qualified therapists (e.g., occupational, physical, respiratory).

k. EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

l. THIS STATE means the STATE OF CALIFORNIA, unless otherwise expressly provided.

m. THIS COUNTY means IMPERIAL COUNTY, unless otherwise expressly provided.

n. MANAGEMENT AGREEMENT shall mean an agreement executed by the City of El Centro and a single entity pursuant to which that entity has been appointed as the sole and exclusive manager of the operations and business functions of HOSPITAL.

o. MANAGEMENT TRUSTEES shall mean the representatives of the manager and the HOSPITAL'S chief executive officer and chief medical officer that are appointed to the HOSPITAL'S BOARD OF TRUSTEES. (Amended by Resolution ECRMC No. 22-05, adopted July 25, 2022)

p. MANAGER shall mean the single entity that has been appointed as the sole and exclusive manager of the operations and business functions of HOSPITAL pursuant to the MANAGEMENT AGREEMENT.

q. NON-MANAGEMENT TRUSTEES shall mean the two (2) members of the City Council and the four (4) members of the public appointed to the HOSPITAL'S BOARD OF TRUSTEES. (Amended and renumbered by Resolution Nos. ECRMC 96-1 and 96-2 adopted February 28, 1996; Amended by Resolution No. ECRMC 15-13, adopted November 12, 2015; Amended by Resolution No. ECRMC 16-09, adopted February 28, 2017; Amended by Resolution ECRMC No. 22-05, adopted July 25, 2022).

THESE BYLAWS were duly adopted by the affirmative vote of a majority of the members of the Board of Trustees of the Hospital at a duly called meeting of the Board of Trustees at which there was a quorum held on the 25th day of July, 2022, pursuant to due notice.

ATTEST:

By_____
Seung Gwon, M.D., Secretary

EL CENTRO REGIONAL MEDICAL CENTER

By_____
Joe Picazo, President
ECRMC Board of Trustees

APPROVED AS TO FORM:

By_____
Long X. Do, Esq.
Outside General Counsel

These codified Bylaws of the Board of Trustees of the El Centro Regional Medical Center were first adopted September 4, 1986; Amended by Resolution No. ECRMC 87-6, dated May 27, 1987; Amended by Resolution No. ECRMC 88-1, dated January 27, 1988; Amended by Resolution No. ECRMC 89-1, adopted January 25, 1989; Amended by Resolution No. ECRMC 89-7, adopted May 24, 1989; Amended by Resolution No. ECRMC 90-3, adopted February 28, 1990; Amended by Resolution No. ECRMC 91-4, adopted January 23, 1991; Amended by Resolution No. ECRMC 91-5, adopted February 2, 1991; Amended by Resolution No. ECRMC 91-6, adopted February 27, 1991; Amended by Resolution No. ECRMC 92-31, adopted December 21, 1992; Amended by Resolution Nos. ECRMC 94-3 and ECRMC 94-4, adopted April 27, 1994; Amended by Resolution Nos. ECRMC 96-1 and ECRMC 96-2, adopted February 28, 1996; Reviewed by Board Bylaws Committee on February 26, 1997; Amended by Resolution No. ECRMC 98-7, adopted May 27, 1998; Amended by Resolution No. ECRMC 99-12, adopted October 27, 1999; Amended by Resolution No. ECRMC 01-22, adopted November 28, 2001; Amended by Resolution No. ECRMC 02-02, adopted February 15, 2002; Amended by Resolution No. ECRMC 02-15, adopted November 19, 2002; Amended by Resolution No. ECRMC 03-13, adopted November 20, 2003; Amended by Resolution No. ECRMC 04-13, adopted July 28, 2004; Amended by Resolution ECRMC No. 04-16, adopted November 18, 2004; Amended by Resolution ECRMC No. 05-01, adopted January 26, 2005; Amended by Resolution No. ECRMC 05-04, adopted June 22, 2005; Amended by Resolution Nos. ECRMC 06-11, ECRMC 06-12 and ECRMC 06-13 adopted September 27, 2006; Amended by Resolution Nos. ECRMC 07-08, ECRMC 07-09, ECRMC 07-10, ECRMC 07-11, ECRMC 07-12, ECRMC 07-13 and ECRMC 07-14 adopted July 25, 2007; Amended by Resolution No. ECRMC 09-09, adopted July 22, 2009; Amended by Resolution No. ECRMC 10-02, adopted March 23, 2010; amended by Resolution No. ECRMC 10-06 adopted June 22, 2010; Amended by Resolution Nos. ECRMC 10-16 and ECRMC 10-17 adopted December 20, 2010; Amended by Resolution No. ECRMC 11-10, adopted April 26, 2011; Reviewed by Governance Effectiveness & Bylaws Committee on January 8, 2013; Amended by Resolution No. ECRMC 13-03, adopted March 26, 2013; Reviewed by Governance Effectiveness & Bylaws Committee on January 13, 2015; Amended by Resolution No. ECRMC 16-01, adopted January 26, 2016; Amended by Resolution No. ECRMC 17-01, adopted February 28, 2017; Reviewed by Governance Effectiveness & Bylaws Committee on January 10, 2019; Amended by Resolution No. ECRMC 19-01, adopted January 22, 2019; Amended by Resolution ECRMC No. 22-05, adopted July 25, 2022.

The codified bylaws were prepared and transcribed by ECRMC Outside General Counsel, Reviewed by ECRMC Administration.

Options for California Healthcare District Committees

Governance Committee: Responsible for matters related to board member appointments, bylaws review, and policies and procedures. Assess and update bylaws, policies, and procedures to ensure they are current and aligned with best practices. Ensures the governing board is up to date with ethics, orientations, and governance training and fulfilling fiduciary responsibilities. May develop and implement educational programs for board members to enhance their understanding of governance, healthcare regulations, strategic planning, and best practices in healthcare district management. This might involve workshops, conferences, webinars, or materials focusing on board self-assessments, legal requirements (like the Brown Act), and specific needs based on the district's strategic plans.

Advocacy & Outreach Committee: Focuses on legislative, regulatory, and grassroots activities related to healthcare districts. These committees work to ensure that districts can effectively provide healthcare services to their communities by influencing policy decisions at the local, state, and potentially federal levels. The committee may also mobilize local communities and stakeholders to support the healthcare district's advocacy efforts. This could involve public awareness campaigns, community forums, and calls to action to engage residents and demonstrate public support for the district's work. This committee may also foster collaboration among healthcare districts, other healthcare providers, and community organizations. This may involve joint initiatives, shared advocacy efforts, and partnerships to address common challenges and opportunities.

Executive compensation committee. The committee acts as an advisory body to the Board of Directors, making recommendations on executive compensation and performance-related matters to ensure the district effectively manages its leadership team and adheres to all relevant regulations and laws. [This one is probably unnecessary in light of the JPA?]

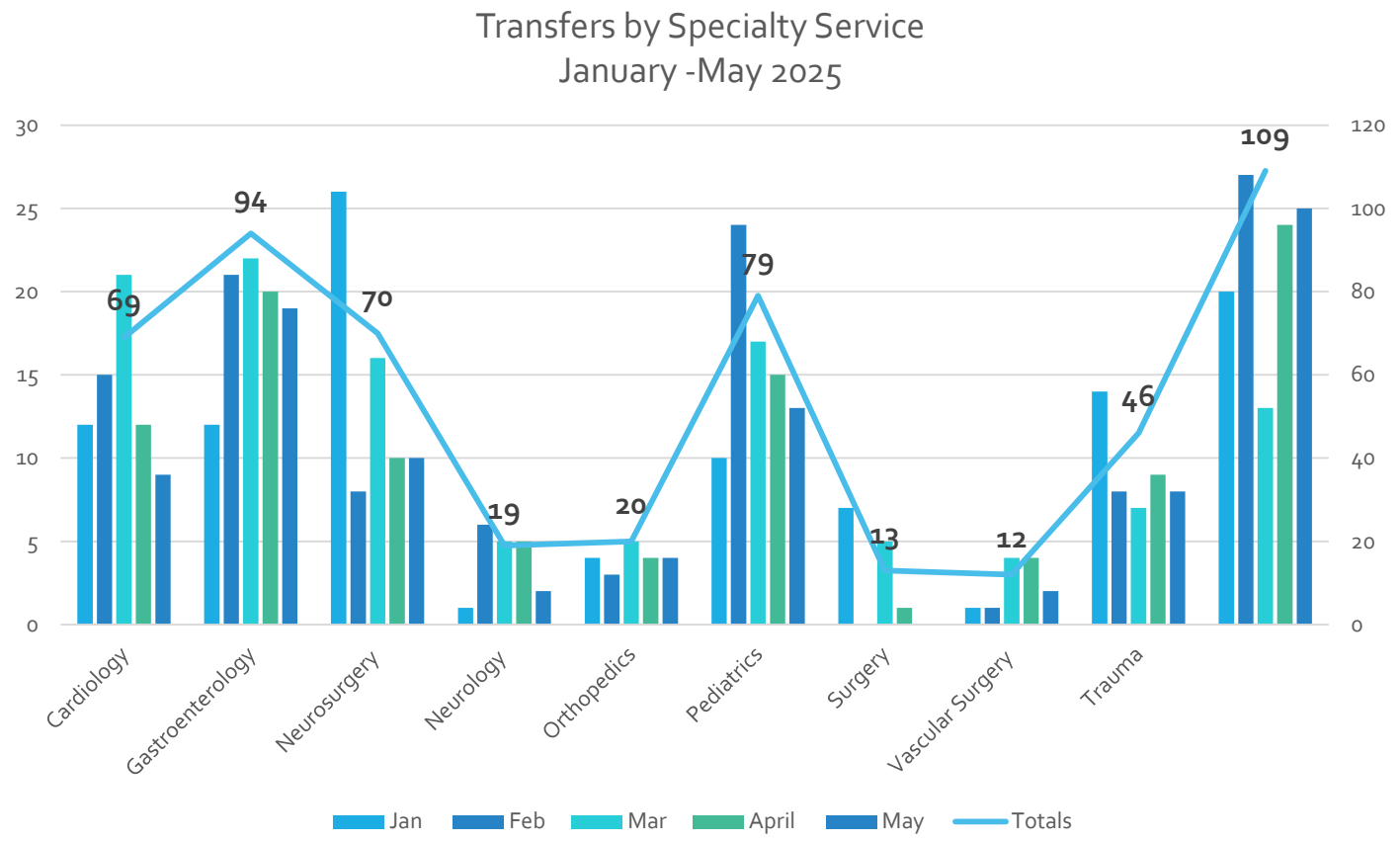
Strategic planning committee. Responsible for developing and recommending a strategic plan that guides the district's direction and ensures it effectively serves its community. This includes defining a vision, setting goals, and establishing principles for action planning. The committee also monitors progress and adjusts the plan as needed, often working with the board of directors, staff, and community stakeholders. The committee reports its findings and recommendations to the district's board of directors, who ultimately approve and oversee the implementation of the strategic plan.

Audit, Compliance & Ethics Committee (sometimes also called Safety & Quality committee). Oversees compliance with quality and safety related accreditation standards and regulations, like those set by the CDPH and the Joint Commission. Oversees audits. Help ensure a safe environment for patients and reduce preventable patient safety events. They receive and review reports of patient safety events, including adverse events and healthcare-associated infections. They monitor the implementation of corrective actions based on patient safety event reviews and make recommendations to eliminate future patient safety events. They monitor and review risk management activities and outcomes and report findings and recommendations to the board.

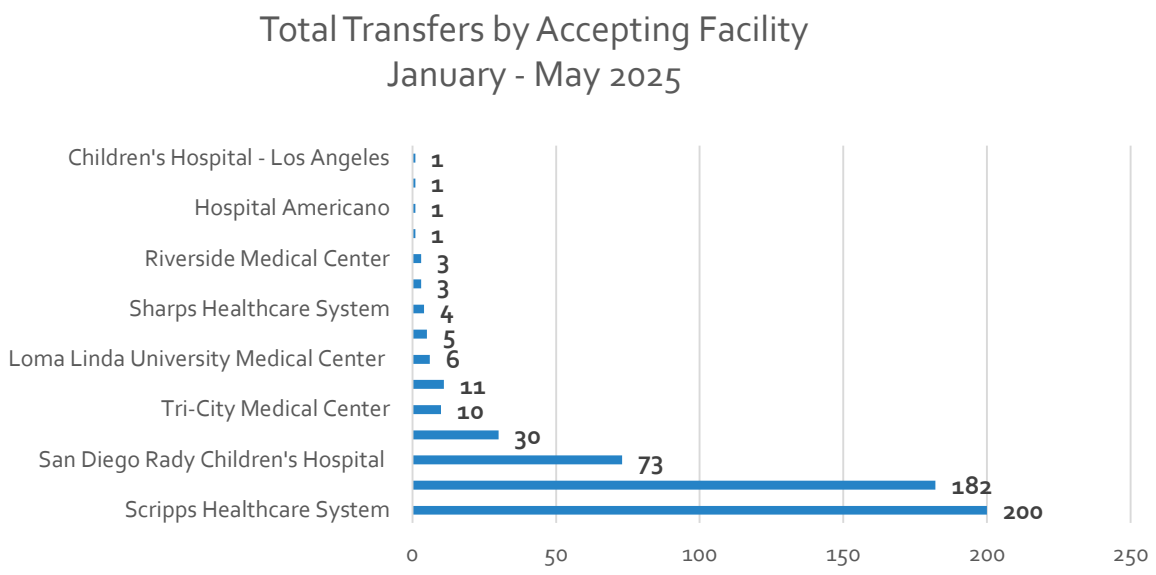
PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Board of Directors Meeting – Chief Nursing Officer Report

July 2025



Specialty	January	February	March	April	May	Totals
Cardiology	12	15	21	12	9	69
Gastroenterology	12	21	22	20	19	94
Neurosurgery	26	8	16	10	10	70
Neurology	1	6	5	5	2	19
Orthopedic	4	3	5	4	4	20
Pediatrics	10	24	17	15	13	79
Surgery	7	0	5	1	0	13
Vascular Surgery	1	1	4	4	2	12
Trauma	14	8	7	9	8	46
Other: Burns, ENT, Oncology, Ophthalmology, Podiatry, Urology	20	27	13	24	25	109
January through April 2025	**107**	**113**	**115**	**104**	**92**	**531**



Accepting Facilities	January	February	March	April	May	Total
Scripps Healthcare System	40	42	37	42	39	200
Desert Regional Medical Center	38	27	51	36	30	182
San Diego Rady Children's Hospital	10	22	15	14	12	73
UCSD	5	6	4	8	7	30
Tri-City Medical Center	6	1	3	0	0	10
John F. Kennedy Memorial Hospital	1	4	2	1	3	11
Loma Linda University Medical Center	0	3	2	1	0	6
El Centro Regional Medical Center	2	3	0	0	0	5
Sharps Healthcare System	1	2	1	0	0	4
Eisenhower Medical Center	0	3	0	0	0	3
Riverside Medical Center	3	0	0	0	0	3
Banner University Medical Center Phoenix	1	0	0	0	0	1
Hospital Americano	0	0	0	1	0	1
UCLA Healthcare System	0	0	0	1	0	1
Children's Hospital Los Angeles	0	0	0	0	1	1
Totals	**107**	**113**	**115**	**104**	**92**	**531**

The total number of Emergency Department visits from January through May was 19,822 with 531 visits (2.67%) resulting in transfers to other facilities. The top specialties for transfers were Neurology and Neurosurgery (89 combined), Pediatrics, Gastroenterology and Cardiology. PMH and ECRMC have started a review process for transfers. **PMH and ECRMC have initiated a formal review process for all transfer requests. Any case declined by either facility will be reviewed and escalated to the appropriate hospital administrators and medical staff leadership for further evaluation.**

- **Gastroenterology transfers** were primarily due to the need for definitive GI intervention/management and intervention, often involving critically ill patients requiring specialized care. The Scripps Affiliation committee reported expected gaps in their GI coverage during the summer.
- **Cardiology transfers** were mainly for emergent catheterizations or other invasive cardiac procedures. We hope to resume our diagnostic procedures at PMH soon.
- **Pediatric transfers** were typically required for higher-level care or pediatric specialty services not available at the current facility (i.e., genetic counseling, pediatric surgery, pediatric neurology, and pediatric critical care).

Between January and May of 2025, a total of 15 incoming transfer requests were received. These included 5 Obstetrics cases, 4 Pediatric cases, 2 ER-to-ER transfers, 1 General Surgery case, 2 Orthopedics case and 1 Gastroenterology case. Of these, 4 transfers were declined. One Orthopedics case was declined due to the patient requiring a higher level of care and Gastroenterology services. One Pediatric case was declined because the patient required Pediatric Hematology services, and another pediatric case was declined due to no bed availability. Additionally, one Obstetrics case from Blythe Hospital was declined based on the OB provider's recommendation that the patient be transferred to the nearest appropriate facility, which was Desert Regional Medical Center.

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Board of Directors Meeting – Chief Nursing Officer Report

July 2025

Staffing:

	New Hires	In Orientation	FT to PD status	Resignations	Open Positions
Medical Surgical	5	5	0	2	2
Intensive Care Unit	0	0	0	0	1
Pediatrics	0	0	0	0	1
Emergency Department	2	2	0	3	9
Perioperative Services	0	9 (6 ST & 3 RN)	0	1	2
Perinatal Services	4	3	0	0	2
NICU	1 (HUC)	0	0	0	1
Cardiopulmonary Services	0	1(RCP)	0	0	1(RCP)
Case Management	0	1	0	0	2
Totals	**12**	**21**	**0**	**6**	**21**

Travelers:

- (3) Labor and Delivery Nurses: 3 Day shift
- (2) Emergency Department - Night shift
- (1) Neonatal Intensive Care Unit - Night shift

Notable Updates:

Nursing Administration:

Barcode Medication Administration:

BCMA						
1Q2025	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025
87.68%	83.70%	88.63%	90.71%	91.88%	91.4%	91.73%

Patient Experience – Q2 2025

HCAHPS						
	2Q2025	1Q2025	4Q2024	3Q2024	2Q2024	1Q2024
Overall	62.80%	66.7%	69.5%	69.7%	84.6%	73.7%
Communication With Nurses	82.80%	80%	76.7%	78.2%	76.3%	79.6%
Communication With Doctors	83.44%	81%	80.2%	73.1%	82.8%	81.8%

Quality

- DNV Annual Survey Corrective Action Plan was submitted on June 25, 2025.
- Leapfrog Hospital Safety Survey to be submitted by September 1st.
- Risk Management in process of providing debriefing sessions for the 2025 Patient Safety and Employee Engagement Survey results. Goals for improvements will be implemented once debriefings are completed.

Nurse Residency Program

Student Nurse Interns	17
20/40 Program students	9
Newly Hired Novice Nurses (RNIP)	14

Emergency Department:

ED Throughput Metrics				
INDICATOR	GOAL	1ST QUARTER	MAY	JUNE
Average Daily Visits	>125 Patients	137 Patients	130 Patients	123 Patients
Median Time to Triage	<10 minutes	10 minutes	8 minutes	7 minutes
Average Length of Stay for Discharged Patients	<180 minutes	190 minutes	187 minutes	183 minutes
Average Length of Stay for all Patients	<160 minutes	205 minutes	210 minutes	198 minutes
Average Length of Stay for all Transfers	<160 minutes	511 minutes	446 minutes	515 minutes

Medical Surgical Department:

Inpatient Throughput							
INDICATOR	GOAL	1Q2024	1Q2025	MARCH 2025	APRIL 2025	MAY 2025	JUNE 2025
Time of Orders Written to Head in Bed	90 min	372 min	220 min	130 min	111 min	123 min	185 min

Case Management:

Indicator		Goal	Jan	Feb	Mar	Apr	May	June	Average / Total
	Average Daily Census		57	46	44	46	50	NA	48.6
Acute LOS	GMLOS (Expected)		3.62	3.49	*3.53*	*3.5*	*3.37*	*3.62*	*3.44*
	ALOS (Actual)	<4.50	3.75	2.93	*2.65*	*2.56*	*2.76*	*3.16*	*2.89*
Case Mix Index	Acute: Case Mix Index (CMI)	>1.40	1.473	1.41	1.28	*1.33*	*1.29*	*1.335*	*1.354*
	Acute: Medicare CMI	>1.55	1.59	1.54	1.48	*1.47*	*1.62*	*1.225*↑	*1.497*
Medicare	Medicare One-Day Stay Count		8	13	12	11	16	10	11.44
	% Medicare 1-day Stays		7	13	12	15	14	11	11.62
Observation	Total Observation Cases		33	24	39	17	38	37	33.38
	Observation to IP Converted		23	5	15	4	18	21	17.00
	Observation % Conversion Rate		69.7	20.8	38.5	23.5	47.4	56.8	48.01
Readmissions	All Cause Hospital Wide Readmissions (HWR)	<10	3.86	6.16	3.62	4.05	2.93	5.23	4.57

*N/A= not available at time of report

Perioperative Services:

	Goal	JAN 2025	FEB 2025	MARCH 2025	APRIL 2025	MAY 2025
First Case On-Time Starts (%)	≥ 90%	65.9	70.8	59.7	69.1	67.6
Day Of Surgery Cancellation Rate (%)	≤ 5%	3.2	2.5	2	4.1	3
Time-Out Compliance (%)	100%	98	98	98	99	98.21
Case Volumes Including Robotics	YTD-1578	497	348	385	348	477
Robotics	YTD-70	19	11	11	17	17
IUSS	0%	0	0	0	0	0

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Board of Directors Meeting – Chief Nursing Officer Report

July 2025

Perinatal Department:

- New 2025 CMS CoP guidelines for Emergency Services Readiness (482.55;485.618) – ED and Perinatal Services collaborating to meet guidelines.

Neonatal Intensive Care Unit:

- Neonatal Stabilization Training – Specialized education for staff to update CORE competencies in NICU. Part of the **First Five - Neonatal Stabilization Grant** –funding effective July 1, 2025.

Pediatrics:

- Unit awarded a grant for $15,000 on 6/5/25 from **First 5- Asthma Prevention & Management Grant**.
- Performance Improvement project to enhanced communication using SBAR increased from 95% in May to 100% in June.

Medical Surgical Unit:

- Hourly rounding has been implemented, and we are monitoring compliance to ensure everyone is performing their hourly rounding.

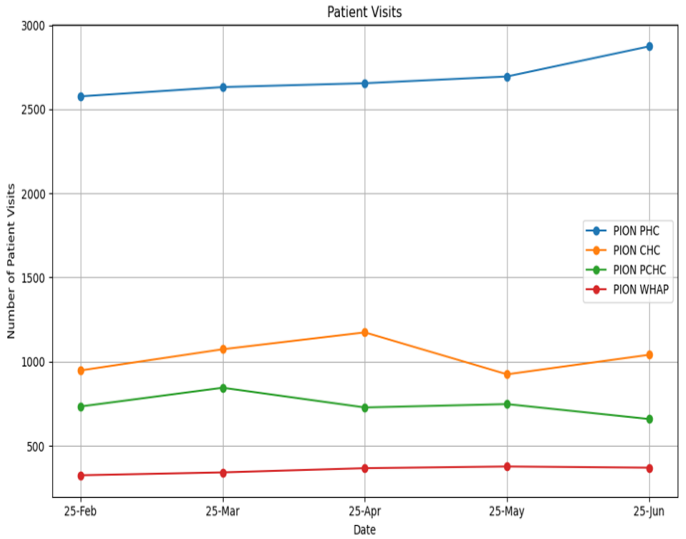
REPORT DATE	MONTHLY STATUS REPORT	PREPARED BY
Date: June 2025 Activity	Chief of Clinic Operations	Carly Zamora, MSN, RN

2025 IVHD/PMH AMBULATORY DIVISION RHC ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
Staffing:	Ongoing	N/A	PD LVN Position, currently reviewing applications
Reviewing Expansion of RHC	Early Stages	N/A	On-HOLD
Provider Additions	100%	N/A	Added Nephrology to the RHC
Stats			See below:

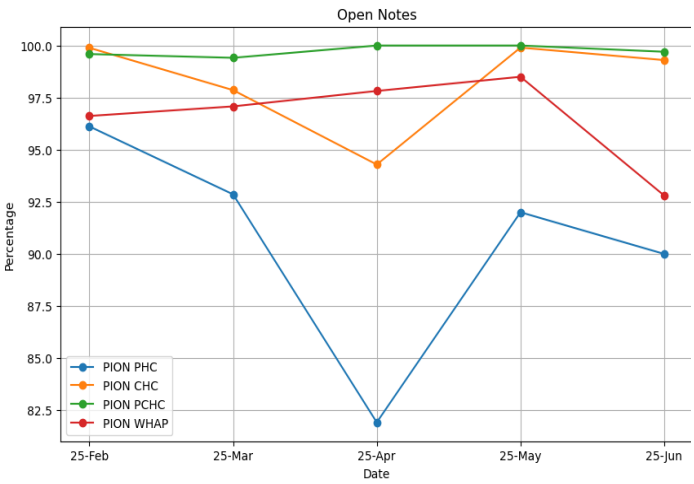
Patient Visits

Clinic	25-May	25-Jun	Variance
PHC	2695	2874	179
CHC	925	1041	116
PCHC	748	659	-89
WHAP	377	370	-7
Total	**4745**	**4944**	

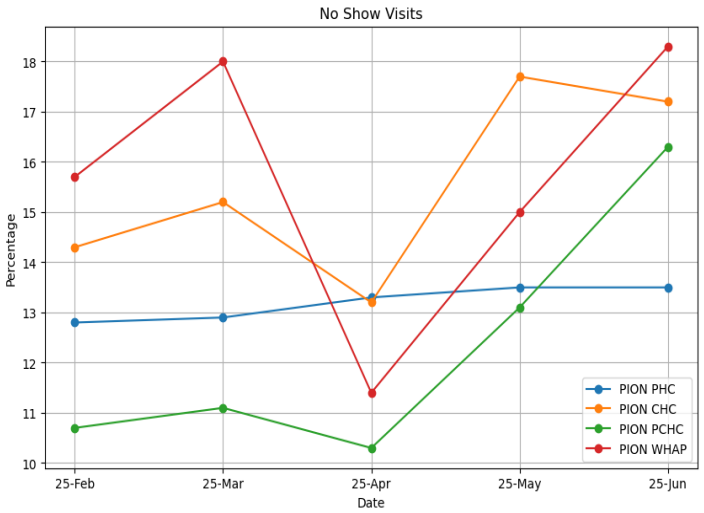


Open Notes

Clinic	25-May	25-Jun	Variance
PHC	92.00%	90.00%	-2.00%
CHC	99.90%	99.30%	-0.60%
PCHC	100.00%	99.70%	0.30%
WHAP	98.50%	92.80%	-5.70%
Total	**97.60%**	**95.45%**	



No Show Visits			
Clinic	**25-May**	**25-Jun**	**Variance**
PHC	13.50%	13.50%	0.0%
CHC	17.70%	17.20%	0.5%
PCHC	13.10%	16.30%	-3.20%
WHAP	15.00%	18.30%	-3.30%
Total	**14.83%**	**16.32%**	



2025 IVHD/PMH PHARMACY ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
Staffing	Ongoing	N/A	No Current Positions Open
IVHD Transition	Completed	N/A	Meetings being held weekly.
	Completed	N/A	Board of Pharmacy Licenses Received with updates, posted and site visit complete
	Ongoing	N/A	Reviewing and updating contracts to ensure compliance with the new name change to IVHD dba PMH.
Clean Room/Compounding Trailer/Pharmacy Space	Review Stages	N/A	Met in June to Review Spacing: Clean Room Expansion and Compounding Trailer needed reviewing Pharmacy space for possible relocation and reviewing budget.
Provider Collaboration	Ongoing	N/A	Working with providers on updating policies, protocols to better assist our clinical teams and patient care.

2025 IVHD/PMH CENTRALIZED SCHEDULING

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
Staffing	Ongoing	N/A	3 FT Temp positions posted, interviews held, job offers presented
Referral Process Review	Ongoing	N/A	Weekly Meetings with Admin- working on identifying accurate reporting and mapping
Call Center Review	Ongoing	N/A	Weekly Meetings with Admin

2025 IVHD/PMH AMBULATORY DIVISION OPD SPECIALITY CLINIC ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
GI	Ongoing	None	Reviewing Referrals and streamlining staffing due to added Provider and increase in Volumes
Staffing ECM	Ongoing	TBD	PT RN onboarding, Community Health Worker Opening
Staffing	Ongoing	N/A	1 FT LVN Position Opening Float (due to resignation), PT RN Infusion Center currently onboarding, PD medical assistant opening due to GI Provider onboarding.
Stats			See below:

Total Visits	Average No Show Rate	Total Locked Notes	Average Pt Satisfaction
1,243	9.9%	95%	Q3 - 82.3%

Patient Visits

Clinic	Last Month	This Month	Variance
Ambulatory Infusion	167	143	-14%
Center for Digestive & Liver Disease	121	122	1%
Comprehensive Women's Health	467	427	-9%
Surgical Health	58	60	3%
Surgical Health - Urology	286	221	-23%
Wound Clinic	242	270	12%

No Show Rate

Clinic	Last Month	This Month	Variance
Ambulatory Infusion	1.1%	5.1%	363.6%
Center for Digestive & Liver Disease	8.3%	12.3%	48.2%
Comprehensive Women's Health	7.4%	10.9%	47.3%
Surgical Health	5.7%	12.3%	115.8%
Surgical Health - Urology	8.3%	12.0%	44.6%
Wound Clinic	8.3%	6.8%	-18.1%

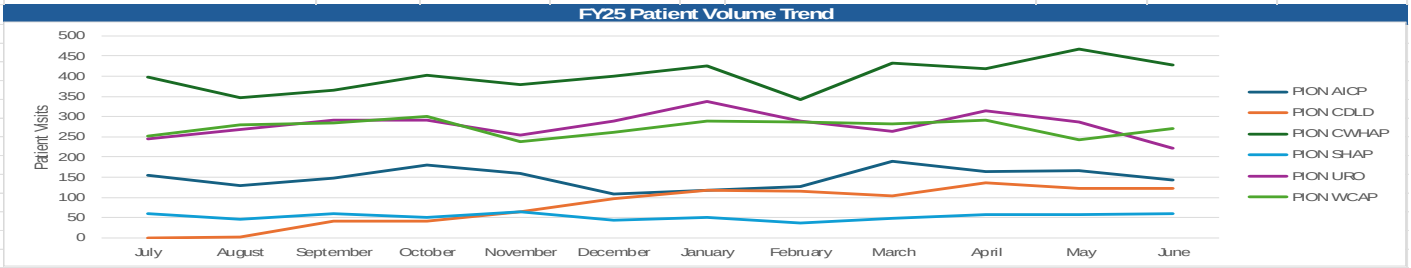
Closed Notes

Clinic	Last Month	This Month	Variance
Ambulatory Infusion	100%	100%	0%
Center for Digestive & Liver Disease	94%	96%	-2%
Comprehensive Women's Health	98%	98%	0%
Surgical Health	81%	88%	-9%
Surgical Health - Urology	84%	81%	4%
Wound Clinic	100%	100%	0%

Patient Satisfaction - Net Promoter Score

Clinic	FY25 Q2	FY25 Q3	FY25 Q4
Ambulatory Infusion	60	87.5	Pending
Center for Digestive & Liver Disease	80	83.3	Pending
Comprehensive Women's Health	68.2	73.2	Pending
Surgical Health	66.7	88.9	Pending
Surgical Health - Urology	93.9	78.6	Pending
Wound Clinic	No Data	No Data	Pending

FY25 Patient Volume Trend



2025 IVHD/PMH AMBULATORY DIVISION PHYSICAL THERAPY ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
DNV	Completed	N/A	Audited Physical Therapy, one finding addressed and implementation completed on finding.
Staffing	Ongoing	N/A	1 PT Physical Therapy Assistant opening due to 20/40-Pending
Cerner on-going	Ongoing	N/A	Working with patient accounting on Cerner Reviews and Reporting
Inpatient/Outpatient Review	Meetings Ongoing with Nursing	N/A	Skills Fair in the process of being implemented for inpatient. OP Volumes increasing

2025 IVHD/PMH RADIOLOGY ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
IVHD Transition	Ongoing	N/A	Licensing updated to IVHD- Meetings being held Bi-weekly
Canon CT Project	Early Stages	. Payments will occur once the scanner is installed and operational	Currently in the early stages, plans reviewed, meetings held in June 2025 on next stages. Plans submitted to HCAI and have been successfully submitted.
Creating a Centralized system	100%	None	Finalized with IT and Centralized Scheduling, Live with Notable (Self registering)6/4-Day 1-40% completed forms and Day 2- 50% had completed forms
Staffing	Ongoing	None	RN/LVN FT (New Hire), reviewing applications, interviews completed, Nuclear Medicine FT Position Opening
Radiology Monthly Meeting Schedule	100%	None	The meeting was held to discuss Radiology orders and workflow with departments, goals set.
Stats:			

	24-Jun	YTD-24	25-Jun	YTD-25
Nuclear Med	27	200	22	232
DIAGNOSTIC	2,627	17,360	2,892	19,362
DEXA	56	353	70	385
Mammo	218	1,317	252	1,401
MRI	178	1058	201	1,251
US	1,347	9,918	1,481	9,043
CT	1,803	10,515	1,995	12,680

2025 IVHD/PMH LABRATORY ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
IVHD Transition	Ongoing	N/A	New CDPH Registrations and Licenses ownership of all clinics and PMH Main Lab approved and now under IVHD. Meetings being held bi-weekly
Staffing	Ongoing	Contracting	3 FT Clinical Laboratory Scientist Position open- 1 Traveler CLS onboarded (6 months)
Process Improvement	Ongoing	N/A	Q1 25 Reports submitted; ED turnaround Times, blood utilization and Blood culture contamination monitoring.
QuantiFERON Gold Analyzer	100%	Decrease in Annual cost of outsourcing by expected 50k	Training and Validation completed; Ready for patient testing, awaiting Cerner interface completion.

Lab Indicators 2025	Target	1st QTR	2nd QTR	3rd QTR	4th QTR
Blood Culture Contamination Rates	<3%	2.37%			
Order to Results for Troponin and CMP	<60 Minutes				
Troponin		48%			
CMP		63%			

2025 IVHD/PMH CHIEF OF CLINIC OPERATIONS/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
Physician Updates	Ongoing	N/A	Recruitment ongoing- 6 pending Provider Contracts (July/August Board Meeting) PT-GI Physician-Start 2025 PD-Pediatric GI Physician-start 2025 FT-Urologist-Start 2025-2026 Pain Management Renewal Urologist Renewal Cardiology On-Call Renewals Call Contracts in Review
Contracts	Ongoing	N/A	Contract Review ongoing monthly
Locums	Ongoing	N/A	No Current Locums and pending gaps
Projects:			
IT Project (Notable)	Implemented final Phase	Monthly Expense	Implementation of Appointment Reminders, CO-PAYS, Pre-Registration within notable finalized in all Clinics, Radiology and Infusion Center.
AI (Provider)	Implemented	Monthly Expense	Implemented within the Clinic Settings, currently still onboarding providers, getting more participation- July Go Live for Referral and Order recommendations Pending Go live date
Centralized Scheduling	Ongoing	N/A	Working on Internal Review of Referrals, Orders and streamlining the process within all Clinics and Providers. Meetings Held in June with Managers, Directors and Providers.
Ring Central (New Call Center Software)	Ongoing	Monthly Expense	Implementation to all Clinics and Radiology completed. June has few setbacks with Ring Central Internal Connection Issues, now resolved, but continue to monitor.
Expansion of OP Infusion	Early Stages	N/A	On HOLD:
Grants	Ongoing	N/A	Health Net approved 15 K Grant, funding received. Health Net Approved Grant for Community Health Worker-Grant Funding Received for $55k Path Cited Grant Submitted 5/2/2025 Additional documentation requested and submitted, awaiting notification if awarded.
IVHD Transition	Ongoing	N/A	Meet weekly