IMPERIAL VALLEY
HEALTHCARE DISTRICT

BOARD OF DIRECTORS
Katherine Burnworth, President | Laura Goodsell, Vice-President | James Garcia, Treasurer | Arturo Proctor, Secretary | Enola Berker, Director | Rodolfo Valdez, Director

AGENDA
REGULAR MEETING OF THE BOARD OF DIRECTORS
THURSDAY, September 11, 2025, 6:00 P.M.

601 Heber Ave. Calexico, Ca 92231

Join Microsoft Teams
Meeting ID: 230 908 957 739 2
Passcode: VY6r5ie7

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 Merger Strategic Planning 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 August 28, 2025

9. **Items for Discussion and/or Board Action:**
   a. Approval of Resolution No. 2025-0911, Resolution of the Imperial Valley Healthcare District Board of Directors Declaring Vacancy on the Board of Directors

   b. Approval of Shared Services Agreement between Imperial Valley Healthcare District and El Centro Regional Medical Center

   c. Action Item: Policy and Procedure: Executive Leadership Car Allowance Program

   d. Action Item: Policy and Procedure: Breastfeeding

   e. Action Item: Policy and Procedure: Organizational Performance Improvement Plan

   f. Action Item: Policy and Procedure: Quality Review Report

   g. Action Item: Patient Safety Program

   h. Action Item: Safety Management Plan

   i. Staff Recommends Action to Authorize: Agreement between MTC Medical, LLC and Imperial Valley Healthcare District.
   Presented by: Carol Bojorquez, CNO
   Contract Value: Dependent of volume of cases sent to us for services.
   MTC agrees to pay the following fees:
   - Victim Sexual Assault Exam $2250
   - Suspect Sexual Assault Exam $1150
   - Response Fee/no exam $300

   Contract Term: 2 Years

Budgeted: Yes
Budgeted Classification: Clinical Services, SART program

j. Staff Recommends Action to Authorize: Agreement between Touro University, Nevada and Imperial Valley Healthcare District.
Presented by: Carol Bojorquez, CNO
Contract Value: No cost associated with agreement
Contract Term: 2 Years
Budgeted: No
Budgeted Classification: N/A

k. Staff Recommends Action to Authorize: Agreement between Point Loma Nazarene University and Imperial Valley Healthcare District.
Presented by: Carol Bojorquez, CNO
Contract Value: No cost associated with agreement
Contract Term: 3 Years
Budgeted: No
Budgeted Classification: N/A

l. Discussion and Action Regarding Future El Centro Facility Naming/Branding

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. Closed Session

a. CONFERNECE WITH LEGAL COUNSEL – EXISTING LITIGATION (Gov. Code 54956.9(d)(1))
Name of Case: Arleen Fernandez v. Pioneers Memorial Healthcare District
Claim Number: 24-00131

13. Adjournment

a. The next regular meeting of the Board will be held on October 9, 2025, at 6:00 p.m.

POSTING STATEMENT

A copy of the agenda was posted September 5, 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
August 28, 2025
REGULAR BOARD MEETING

THE IMPERIAL VALLEY HEALTHCARE DISTRICT MET IN REGULAR SESSION ON THE 28th OF AUGUST AT 1271 ROSS AVENUE 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 6:02 pm by Katie Burnworth.

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

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

ABSENT:
Donald W. Medart Jr. – Treasurer
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:**
Director Proctor had some questions for item 9E Policy and Procedure: Executive Leadership Care Allowance Program and since Chris is the author of this policy and he is not here he would like to remove and table this item.

Motion was made by Director Proctor and second by Director Berker to pull item 9E Policy and Procedure: Executive Leadership Car Allowance Program and approve the agenda for August 28, 2025, Motion passed by the following vote wit:

AYES: Burnworth, Goodsell, Proctor, Berker, Valdez, Garica
NOES: None

6. **PUBLIC COMMENT TIME:**
None

7. **BOARD COMMENTS:**

a. Brief reports by Directors on meetings and events attended.

Director Burnworth reported she and Director Berker attended the MEC meeting.

b. Schedule of upcoming Board meetings and events.

None

c. Report of Merger Strategic Planning Ad-Hoc Committee

Attorney Adriana reported that the Strategic Planning Ad-Hoc Committee has had two meetings since the last board meeting. One internally to discuss progress with UCSD and a second one with larger team including Pablo and UCSD folks to talk about continued progress in the strategic planning process. We do think that we will be ready for a more robust and larger presentation for the full board in he next month or so. We are still working through some of those items, but we've got BRG meeting as far as I understand weekly with ECRMC folks to finalize the financial models.

8. **CONSENT CALENDAR:**

Motion was made by Director Berker and second by Director Garcia to approve the consent calendar for August 14, 2025, and approve and file PMH Expenses/Financial Report July 2025. Motion passed by the following vote wit:

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

9. **ACTION ITEMS:**

a. Fourth Amendment to Professional Services Agreement between Imperial Valley Healthcare District and Berkeley Research Group, LLP for Financial Strategist Services.

Motion was made by Director Goodsell and second by Director Garcia to approve the Fourth Amendment to Professional Services Agreement between Imperial Valley Healthcare District and Berkeley Research Group, LLP for Financial Strategist Services with the additional cap increase of $250 thousand dollars and also request that we have an addition of scope of work for the new work that's being done and with direction to council to work with Pablo regarding the deliverables. Motion passed by the following vote wit:

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

b. Discussion and Appointment of IVHD Board Treasurer Position.

President Burnworth reported that Director Medart Jr. turned a letter to resign as his position of Treasurer.

President Burnworth nominated Director James Garcia as Treasurer.

Motion was made by Director Burnworth and second by Director Proctor to approve

Appointing James Garcia as IVHD Board Treasurer. Motion passed by the following wit:

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

c. Discussion and Appointment of IVHD Standing Committees:

President Burnworth appointed the Directors to following Committees:

- Finance & Budget
  Garcia, Berker, Goodsell

- Hospital Operations & Integration
  Burnworth, Proctor, Goodsell

- Governance
  Goodsell, Proctor, Garcia

- Quality Audit, Compliance & Ethics
  Berker, Valdez, Proctor

- Advocacy & Outreach
  Burnworth, Valdez, Berker

Motion was made by Director Berker and second by Director Valez to approve the slate as presented. Motion passed by the following wit:

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

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

Motion was made by Director Berker and second by Director Garcia to approve 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 wit:

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

e. Action Item: Policy and Procedure: Executive Leadership Car Allowance Program.

Item tabled for the next meeting.

f. Action Item: Appointment of Dr. Michael Krutzik, M.D., as Medical Director, Cardiopulmonary Department.

Motion was made by Director Goodsell and second by Director Proctor to approve

Appointment of Dr. Michael Krutzik, M.D., as Medical Director, Cardiopulmonary Department. Motion passed by the following vote wit:

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

g. Action Item: Appointment of Dr. Michael Krutzik, M.D., as Medical Executive Committee Chair of Department of Medicine.

Motion was made by Director Goodsell and second by Director Proctor to approve Appointment of Dr. Michael Krutzik, M.D., as Medical Executive Committee Chair of Department of Medicine. Motion passed by the following vote wit:

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

h. Action Item: Authorization to approve seventh amendment to the Professional Service Agreement for Rady's Children's Specialist of San Diego.

Motion was made by Director Berker and second by Director Proctor to approve the Authorization to approve seventh amendment to the Professional Service Agreement for Rady's Children's Specialist of San Diego. Motion passed by the following vote wit:

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

i. Staff Recommends Action to Authorize: Purchase of six (6) GE HealthCare Panda iRes Warmer Beds with upgraded technology for the Neonatal Intensive Care Unit (NICU).
Presented by: Carol Bojorquez, CNO, Christopher R. Bjornberg CEO
Contract Value: $104,418.92 (grant-funded; no additional District cost anticipated).
Contract Term: Grant period July 1, 2025 - June 30, 2026.
Budgeted: Yes- fully funded by First 5 Imperial grant award.
Budgeted Classification: Equipment Purchases (per approved FY 2025–2026 project budget, Exhibit E).

Motion was made by Director Goodsell and second by Director Garcia to approve the Staff Recommendation of the Purchase of six (6) GE HealthCare Panda iRes Warmer Beds with upgraded technology for the Neonatal Intensive Care Unit (NICU). Motion passed by the

following vote wit:

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

j. Staff Recommends Action to Authorize: Cannon CT Replacement
Presented by: Sean Beckham
Contract Value: $702,640.00

Contract Term: Approximately 4 months for completion

Attorney Adriana did not have a chance to review the staff report and is a little concerned that this potential approval of the proposal might not comply with the procurement policy. She has not had a chance to connect with Chris or Carly about the bidding process because there has to be an evaluation and then notice of lowest responsive and responsible bidder determinations and sounds like maybe this was that but has not had the opportunity to confirm. But if the board wanted to move on it today, she wants to make sure to review the agreement to ensure prevailing wage language is in there because when it comes to installation, construction type work there has to be language about prevailing wage for public projects, which this would be the for the public project.

Carly will request the offer to extend for the September 11th meeting.

Item will be tabled for the next meeting.

10. MANAGEMENT REPORTS:

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

Carly went over the July 2025 financial report.

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

Carol went over the CNO report.

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

None

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

Tomas reported that the Urgent Care numbers are low, which is normal during the summer, but the numbers are beginning to pick up for back to school. Chris and he will be bringing back some final payments from the constructor and the construction company probably at the next meeting.

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

None

f. Legal: Adriana Ochoa – General Counsel

Adrana reported that Doug and she have standing Monday morning meetings to discuss compliances and other issues with regards to both hospitals and best approaches for emerging. They had a great contract review meeting las Friday with the contract review group to go over the entirety of the contracts between the two hospitals and to make sure the counterparts are checking in with each other and selecting one of the other contracts. She circulated some proposed language and understood ECRMC has been using it or something similar on contracts we have for vendors. She reported they have another

follow-up contract review working group meeting next Friday, September 5th and will keep meeting every two weeks so we go through every single contract between hospitals to make us understand what the outcome as to are we terminating or renewing it and keep going for the merge hospital system. Doug sent her yesterday a shared services agreement which hopefully the board will see at the next board meeting.

11. ITEMS FOR FUTURE AGENDA:

Cannon CT Replacement
Policy and Procedure: Executive Leadership Car Allowance Program

12. ADJOURNMENT:

With no future business to discuss, Motion was made unanimously to adjourn meeting at 7:09 p.m.

RESOLUTION NO 2025 - 0911

RESOLUTION OF THE IMPERIAL VALLEY HEALTHCARE DISTRICT BOARD OF DIRECTORS DECLARING VACANCY ON THE BOARD OF DIRECTORS

WHEREAS, Mr. Donald Medart Jr. was appointed to the Imperial Valley Healthcare District ("**IVHD**") Board of Directors by the Quechan tribe pursuant to Health & Safety Code 32499.6(a)(1)(E) and was duly sworn-in to the position on February 2, 2024;

WHEREAS, the IVHD Board of Directors received a letter of voluntary resignation from Mr. Medart Jr. with an effective resignation date of September 11, 2025;

WHEREAS, Section 6 of IVHD's Amended and Restated Bylaws, dated August 14, 2025, states that a voluntary resignation from any member of the Board of Directors is effective immediately upon receipt or any such later time specified therein;

WHEREAS, Mr. Medart was absent from more than three consecutive regular meetings of the IVHD Board of Directors, which meetings were held on July 10, 2025; July 24, 2025; August 14, 2025; and August 28, 2025.

WHEREAS, Section 7 of IVHD's Amended and Restated Bylaws and Health and Safety Code § 32100.2 each provide that the term of any member of the board of directors shall expire if he or she is absent from three consecutive regular meetings, or from three of any five consecutive meetings of the board and the board by resolution declares that a vacancy exists on the board;

NOW THEREFORE, this Board of Directors of IVHD does hereby find, resolve, and order the following:

SECTION 1. Mr. Medart Jr.'s seat on the IVHD Board of Directors is hereby declared vacant effective September 11, 2025.

SECTION 2. The remaining members of the IVHD Board of Directors intend to fill the vacancy by appointment within 60 days pursuant to Government Code § 1780(d).

SECTION 3. IVHD shall notify the county elections official of the vacancy no later than 15 days from the date of this Resolution, and shall a post a notice of the vacancy in three or more conspicuous places in the District at least 15 days before the District Board makes the appointment pursuant to Government Code § 1780(b)&(d).

SECTION 4. The person appointed to fill the vacancy shall hold office until the person who is elected to fill the vacancy at the next general District election (November 2026) has been qualified pursuant to Government Code § 1780(d)(2). The person elected to fill the vacancy shall hold office for the unexpired balance of the term of office, or until the November 2028 election, consistent with IVHD Resolution No. 2024-01.

SECTION 5. This resolution shall take effect immediately upon its adoption.

IT IS SO RESOLVED, PASSED AND ADOPTED AND SIGNED ON THIS 11th DATE OF SEPTEMBER 2025.

SECRETARY'S CERTIFCIATE

I, Arturo Proctor, Secretary of the Board of Directors if Imperial Valley Healthcare District, a California healthcare district, County of Imperial, California, certify as follows:

The attached is a full, true, and correct copy of Resolution 2025-0911, duly adopted at the meeting of the Board of Directors of Imperial Valley Healthcare District, which was duly held September 11, 2025, at which meeting a quorum of the members of the Board of Directors were present; and at such meeting such resolution was adopted by the following vote:

YES:
NO:
ABSTAIN:
ABSENT:

I have carefully compared the same with the original minutes of such meeting on file and of record in my office; the attached resolution is a full, true and correct copy of the original resolution adopted at such meeting and entered in such minutes; and such resolution has not been amended, modified, or rescinded since the date of its adoption, and the same is now in full force and effect.

WITNESS my hand this 11th day of September 2025

_____
Secretary
Imperial Valley Healthcare District

Approved as to Form:

_____
Adriana R. Ochoa
Legal Counsel for Imperial Valley Healthcare District

IMPERIAL VALLEY HEALTHCARE DISTRICT

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

September 11, 2025

VIA EMAIL AND U.S. MAIL

Linsey J. Dale, Registrar of Voters
940 W. Main Street, Suite 206
El Centro, CA 92243
linseydale@co.imperial.ca.us

Dear Ms. Dale:

I am writing to inform you of a vacancy on the Imperial Valley Healthcare District ("IVHD") Board of Directors (the "Board") pursuant to California Government Code § 1780(b).

IVHD's Board Director Donald Medart Jr. voluntarily resigned effective September 11, 2025. IVHD declared the position vacant on September 11, 2025.

IVHD will fill the vacancy by appointment on or before November 10, 2025 pursuant to California Government Code § 1780(d).

Sincerely,

Kathrine Burnworth
IVHD Board President/Chair

IMPERIAL VALLEY HEALTHCARE DISTRICT

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

IMPERIAL VALLEY HEALTHCARE DISTRICT
BOARD OF DIRECTORS

NOTICE OF VACANCY
AND
CALL FOR APPLICATIONS

The Imperial Valley Healthcare District ("**IVHD**") Board of Directors hereby provides notice that a vacancy has been declared on the IVHD Board of Directors.

The Board will fill the vacancy by appointment. The individual appointed will serve as an IVHD Board Director until the person who is elected to fill the vacancy at the next general District election (November 2026) has been qualified.

The Board is seeking applications to fill the vacant Board Director position. Each applicant must be a registered voter and a resident of the District. Applicants should submit a resume and a statement of interest to arochoa@swlaw.com **by no later than 5:00 p.m. PST on September 26, 2025.**

For information about the IVHD, see https://imperialvalleyhealth.com/.

SHARED SERVICES AGREEMENT

This Shared Services Agreement ("Agreement") is made and entered into effective as of August 1, 2025 (the "Effective Date") by and between **Imperial Valley Healthcare District**, a California healthcare district ("IVHD") and **El Centro Regional Medical Center** a separate public agency and enterprise operation of the City of El Centro organized and operating as a municipal hospital ("ECRMC") (collectively referred to as the "Parties" and each a "Party").

RECITALS

WHEREAS, effective August 1, 2025 IVHD, ECRMC and the City of El Centro ("City") entered into an Asset Transfer Agreement ("ATA") whereby ECRMC and the City have agreed to transfer the assets and liabilities of ECRMC to IVHD in accordance with the provisions of AB 918, Health & Safety Code §32499.5 *et. seq*.; and

WHEREAS, IVHD owns and operates Pioneer Memorial Hospital and ECRMC operates El Centro Regional Medical Center (collectively, the "Hospitals"); and

WHEREAS, the Parties intend that such Hospitals shall be combined into an integrated healthcare system upon the closing of the transaction contemplated in the ATA; and

WHEREAS, the Parties have determined that upon closing of the transaction contemplated by the ATA, the management team of ECRMC will be substantially integrated with the management team of IVHD, and such combined managers shall serve post-closing as the management team for the Hospitals, subject to the governance of the IVHD Board of Trustees; and

WHEREAS, the Parties have further determined that prior to closing the transaction contemplated in the ATA, various functions and services associated with the operation of the Hospitals are required to be significantly integrated and/or preparations made to substantially integrate such functions upon closing.

NOW, THEREFORE, in consideration of the mutual covenants set forth herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. SHARED SERVICES

1.1 Shared Services. Prior to closing of the transaction, both IVHD and ECRMC shall mutually cooperate by providing shared services between the IVHD and ECRMC management teams to manage and integrate clinical and operational services that are set forth in Exhibit A ("Shared Services").

1.2 Access to Information. IVHD and ECRMC shall both provide to designated management personnel providing the Shared Services full and complete access to information,

records and systems necessary for the provision of such Shared Services and to effect substantial integration of the Hospitals effective at closing.

1.3 Changes to Shared Services. Notwithstanding the Shared Services identified in Exhibit A, the Parties agree to consider in good faith any reasonable request for the provision of additional Shared Services that are necessary for the integration of operations of the Hospitals that are not included in the Exhibit as of the Effective Date of this Agreement. In the event the Parties agree, in their discretion, to provide such additional Shared Services, the Parties shall amend this Agreement and the respective Shared Services exhibit, which shall be included in Exhibit A with respect to such additional Shared Services. Any such additional Shared Services provided hereunder shall constitute Shared Services and shall be subject in all respect to the provisions of this Agreement as if fully set forth on Exhibit A as of the Effective Date.

1.4 Termination of Shared Services. The Parties acknowledge and agree that either Party may determine from time to time that it does not require or no longer intends to provide or receive all the Shared Services set forth in Exhibit A. Accordingly, notwithstanding anything in this Agreement to the contrary, either Party may terminate any Shared Service that it provides or that it receives upon thirty (30) days written notice to the other Party, with a corresponding amendment to the respective Shared Services exhibit.

1.5 Asset Transfer Agreement. The Parties agree that this Agreement is at all times subject to the terms and conditions set forth in the ATA, and shall be considered as necessary to the fulfillment of the obligations and duties of each Party for concluding and closing the transaction contemplated under the ATA.

2. ACCESS TO PREMISES.

2.1 Access to the Hospitals. The Parties shall each provide, at no cost to the other Party and without barrier or pre-condition, access to the Hospitals, facilities, and books and records in all cases to the extent reasonably necessary to comply with the terms of this Agreement and to provide the Shared Services. Further, either Party shall be entitled to make copies, either paper or electronic, of such books and records as necessary to effect this Agreement. Both Parties agree that in providing such Shared Services, it and its employees shall conform to all applicable policies and procedures of the other Party concerning health, safety and security of which they have been notified in writing in advance.

2.2 Confidential Information and Privacy. The Parties have previously entered into a Confidentiality and Non-Disclosure Agreement ("NDA") dated April 1, 2024 that is still in full force and effect and the provision of such Shared Services shall be fully subject to the confidentiality requirements of that NDA. Further, to the extent that the Parties are required to access patient identifiable information to perform the Shared Services contemplated by this Agreement, they shall enter into a Business Associate Agreement ("BAA") in accordance with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") in a form as set forth and attached as Exhibit B of this Agreement.

3. ELIGIBILITY FOR GOVERNMENT PROGRAMS.

3.1 Eligibility Status. Each Party represents it has not been convicted of a criminal offense related to health care, and it is not, nor are any of its employees or agents performing services under this Agreement, currently listed on the List of Excluded Individuals and Entities ("LEIE") by the Office of Inspector General of the Department of Health and Human Services or by any other Federal or State of California agency or department (including the General Services Administration) as debarred, excluded or otherwise ineligible for participation in federal or state programs and/or federally funded health care programs including Medicare and Medicaid (collectively, "Excluded"). Each Party further represents that, to the best of its knowledge, neither it nor its employees/agents are under investigation or otherwise aware of any circumstances which may result in such Party or its employees/agents being Excluded.

3.2 Continuing Duty. Each Party shall (i) regularly verify the continued accuracy of the eligibility status representation (as described in Section 3.1); (ii) immediately terminate its relationship with any individual, agent or entity upon discovering such individual, agent or entity is Excluded; and (iii) notify the other Parties immediately, in writing, of any change in circumstances related to its representations made in this Section 3).

4. TERM.

4.1 Term. Unless earlier terminated as provided in Section 5, the initial term of this Agreement (the "Initial Term") shall commence as of the Effective Date and shall remain in effect for one (1) year or until the transaction contemplated by the ATA has closed, whichever is earlier.

5. TERMINATION OF AGREEMENT.

5.1 No Cause Termination. Either Party may, without stated cause, provide to the other Party thirty (30) days written notice of termination of this Agreement.

6. NO PAYMENT FOR SERVICES.

6.1 No Fee for Shared Services. The Parties agree that there shall be no payment of fees and/or costs to be paid by either Party for the provision of Shared Services pursuant to this Agreement.

6.2 Responsibility for Wages and Fees. During the Term of this Agreement, and while any employee of a Party is engaged in providing Shared Services pursuant to this Agreement: (i) such employees will remain employees of the respective Party or its affiliate, as applicable, and shall not be deemed to be employees of the other Party for any purposes; and (ii) each Party or its affiliate, as applicable, shall be solely responsible for the payment and provision of all wages,

bonuses and commissions, employee benefits, including severance and worker's compensation, and the withholding and payment of applicable taxes relating to such employment.

7. INDEMNIFICATION.

7.1 Mutual Indemnity. Each Party agrees that it shall defend, indemnify and hold harmless (the "Indemnifying Party") the other Party, their permitted successors and assigns and their respective directors, officers, and employees (collectively, the "Indemnified Parties") from and against any and all Losses incurred by such Indemnified Parties arising from or out of any claim for any injury to or death of any Person or loss or damage to property of any Person to the extent such claims and/or Losses arise out of any breach of this Agreement or negligence or willful misconduct by the Indemnifying Party, except and to the extent that such Loss is due to the negligence or willful misconduct of the Indemnified Party.

7.2 Prompt Notice Required. As a condition precedent to any indemnity owed by the Indemnifying Party hereunder, the Indemnified Parties must provide prompt and timely written notice to the Indemnifying Party of such Losses.

8. ACCESS TO RECORDS; CONFIDENTIALITY; STATUTORY EMPLOYER

8.1 Access to Records and Record Retention. The Parties shall retain this Agreement (including all amendments and agreements hereto) and any of their books, documents, and records that may serve to verify the costs of this Agreement for a period of ten (10) years after the services contemplated herein have been performed. All Parties agree to allow the Secretary of the Department of Health and Human Services and the Comptroller General access to the Agreement, books, documents, and records in the event that such access is requested in writing and is made in accordance with applicable federal regulations and requirements. Furthermore, a Party's auditors or compliance team shall have the right upon reasonable written notice to inspect and audit, during a Party's regular business hours and at no expense to such Party, the books and records of a Party, in order to verify compliance with this Agreement.

9. MISCELLANEOUS PROVISIONS

9.1 Parties Bound. This Agreement shall bind and shall inure to the benefit of the Parties and their respective successors and permitted assigns.

9.2 Governing Law. This Agreement has been executed and shall be governed by and construed in accordance with the laws of the State of California without regard to conflict of laws principles that would require the application of any other law.

9.3 Independent Contractors. The relationship between the Parties is that of independent contractors. Neither Party is an agent of the other, and neither has any right or authority to assume or create any obligation or responsibility on behalf of the other, except as otherwise provided in this Agreement.

9.4 Jurisdiction, Venue and Service of Process. The exclusive venue for any lawsuit filed by any Party to this Agreement is the County of Imperial, State of California. The Parties agree that any of them may file a copy of this Section with any court as written evidence of the knowing, voluntary, and bargained agreement between the Parties irrevocably to waive any objections to venue or to convenience of forum as set forth hereinabove. Process in any lawsuit referred to in the first sentence of this Section may be served on any party anywhere in the world.

9.5 Rule of Construction. The Parties acknowledge and agree that this is a negotiated agreement, in which all Parties have received the assistance and advice of competent legal counsel; and accordingly that the rule of construction that any ambiguities are to be construed against the drafting Party shall not apply.

9.6 Severability. If any term, provision, covenant or condition of this Agreement is held unenforceable or invalid for any reason and not susceptible to reformation due to a change in applicable legal requirements, the remaining portions or provisions shall continue in full force and effect, unless the effect of such severance would be to substantially alter this Agreement or obligations of the Parties, in which case the Agreement may be immediately terminated.

9.7 Integration. This Agreement constitutes the entire agreement of the Parties with respect to the subject matter hereof. This Agreement cancels and supersedes all prior shared services agreements and understandings, oral or written, among the Parties.

9.8 Non-Waiver. No waiver of any breach or default hereunder shall be considered valid, unless in writing and signed by the Party giving such waiver. No such waiver shall be deemed a waiver of any subsequent breach or default of a similar nature.

9.9 Notices. All notices, demands and other communications to be given or delivered pursuant to or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given and received (i) if by hand or electronic delivery, when delivered; (ii) if given by nationally recognized and reputable overnight delivery service, the business day on which the notice is actually received by the Party; (iii) if given by certified mail, return receipt requested, postage prepaid, three (3) business days after posted with the United States Postal Service. Notices, demands and communications to Manager shall, unless another address is specified in writing, be sent to the addresses indicated below:

If to IVHD:
Imperial Valley Healthcare District
207 West Legion Road
Brawley, CA 92227
Attention: Christopher Bjornberg, CEO
Email: cbjornberg@iv-hd.org

With a Copy to:

Snell & Wilmer LLP
12230 El Camino Real

Suite 300
San Diego, CA 92130
Attention: Adriana Ochoa
Email: arochoa@swlaw.com

If to ECRMC:
El Centro Regional Medical Center
1415 Ross Avenue
El Centro, CA 92243
Attention: Pablo Velez, CEO
Email: pablo.velez@ecrmc.org

With a Copy to:

El Centro Regional Medical Center
1415 Ross Avenue
El Centro, CA 92243
Attention: Douglas Habig, General Counsel
Email: douglas.habig@ecrmc.org

9.10 Authorized Representative. Except as may be provided more specifically herein, if approvals, authorizations, or notices are required hereunder, they shall be given on behalf of ECRMC by the Chief Executive Officer of ECRMC and on behalf of IVHD by the Chief Executive Officer of IVHD.

9.11 Form of the Agreement. All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine or neuter, single or plural, as the identity of the person(s) or thing(s) may require. Article and Section headings are included for convenience of reference only and shall not define, limit, extent or otherwise affect the interpretation of this Agreement or any of its provisions.

9.12 Amendment. This Agreement may be amended or modified only in writing signed by the Parties.

9.13 Further Cooperation. In order to confirm this Agreement or carry out its provisions or purposes, each Party shall cooperate with the other and shall take such further action and execute and deliver such further documents as the other may reasonably request.

9.14 Assignability. Neither Party may assign its rights or delegate its duties (by subcontract or otherwise) under this Agreement without the prior written consent of the other Party.

9.15 No Third Party Beneficiaries. Nothing in this Agreement shall be construed as conferring any benefit, either directly or indirectly, on any person or entity not a Party to this Agreement.

9.16 Referrals. The Parties acknowledge that none of the benefits granted ECRMC or the IVHD hereunder are conditioned on any requirement that any physician make referrals to, be in a position to make, or influence referrals to, or otherwise generate business for, the Hospitals.

9.17 Force Majeure. The obligations of the Parties under this Agreement with respect to any Shared Services shall be suspended during the period and to the extent that the Parties are prevented or hindered from providing such Shared Services, or the Parties are prevented or hindered from receiving such Shared Services, due to any of the following events (collectively, "Force Majeure Events"): acts of God, civil or military acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, national or regional emergency, shortage of adequate power, failure of transportation, strikes or other work interruptions by either Party's employees, or any similar or dissimilar cause beyond the reasonable control of either Party. The Party suffering a Force Majeure Event shall give notice of suspension as soon as reasonably practicable to the other Party stating the date and extent of such suspension and the cause thereof. The Party suffering the Force Majeure Event shall resume the performance of its obligations as soon as reasonably practicable after the removal of the cause. Neither Party shall be liable for any failure, inability or delay to perform hereunder, if such failure, inability or delay is due to a Force Majeure Event and beyond the reasonable control of the party so failing, and due diligence is used in curing such cause and in resuming performance.

9.18 Additional Instruments. Each of the Parties shall, from time to time, at the request of any other Party, execute, acknowledge and deliver to the other Parties any and all further instruments that may be reasonably required to give full force and effect to the provisions of this Agreement.

9.19 Headings. All section and part headings are inserted for convenience. Such headings shall not affect the construction or interpretation of this Agreement.

9.20 Multiple Counterparts. Provided all Parties execute an identical copy of this Agreement, including Exhibits, the Parties acknowledge and agree that these multiple counterparts will be considered fully executed originals.

9.21 Time Periods. Time periods expressed by a specified number of days shall be based on calendar days.

9.22 Execution Warranty. Each person signing this agreement on behalf of a Party represents that the execution of this Agreement has been duly authorized by the Party for which representative is signing, and that no restrictions or restrictive agreements exist that prevent either the execution or the carrying out of this Agreement by such Party.

10. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

10.1 Non-Discrimination and Affirmative Action. The Parties agree to abide by the requirements of the following as applicable: Title VI of the Civil Rights Act of 1964 and Title VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972, Federal Executive Order 11246 as amended,1 the Rehabilitation Act of 1973, as amended,

the Vietnam Era Veteran's Readjustment Assistance Act of 1974, Title IX of the Education Amendments of 1972, the Age Discrimination Act of l 975, the Fair Housing Act of l 968 as amended. The Parties also agree to abide by the requirements of the Americans with Disabilities Act of 1990. The Parties agree not to discriminate in employment practices, and will render services under this Agreement without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities.

10.2 Compliance with Federal Law. The Parties and their respective officers, directors, employees and agents (including, as to ECRMC, the HSC-S Faculty) shall comply with the applicable provisions of the Federal Criminal False Claims Act (18 U.S.C. § 287 et seq.), the Federal Civil False Claims Act (31 U.S.C. § 3729 et seq.), the Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)), the Federal Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), the Federal Physician Self-Referral Law (42 U.S.C. § 1395rm) ("Stark II"), the California Medical Assistance Programs Integrity Law (La. R.S. 46:437.1 et seq.) and other applicable Federal and California statutes and regulations relating to health care.

IN WITNESS WHEREOF, the Parties have executed this Shared Services Agreement on the dates written below, to be effective as of the Effective Date.

Imperial Valley Healthcare District

By: _____
Christopher R. Bjornberg, Chief Executive Officer

El Centro Regional Medical Center

By: _____
Pablo Velez, Chief Executive Officer

EXHIBIT A

SHARED SERVICES

The Shared Services to be provided to and collaborated on by the Parties are as follows:

1. Finance – The Parties shall collaborate on the finance services, including but not limited to staffing and leadership, operational issues, systems and processes, policies and procedures, contract services with third parties and all other matters pertaining to finance services for the combined organization.

2. Human Resources – The Parties shall collaborate on human resources services, including but not limited to staffing and leadership, operational issues, systems and processes, policies and procedures, contract services with third parties and all other matters pertaining to human resources services for the combined organization.

3. Quality and Education – The Parties shall collaborate on quality and education services, including but not limited to staffing and leadership, operational issues, systems and processes, policies and procedures, contract services by third parties and all other matters pertaining to quality and education services for the combined organization. Further, as necessary the Quality Director for ECRMC shall serve in the capacity as Quality Director for IVHD and ECRMC's Quality Incentive Program ("QIP") staff shall provide services to evaluate, improve and implement changes to IVHD's QIP.

4. Pharmacy – The Parties shall collaborate on pharmacy services, including but not limited to staffing and leadership, operational issues, systems and processes, policies and procedures, contract services by third parties and all other matters pertaining to pharmacy services for the combined organization. As necessary, IVHD shall provide their Pharmacist in Charge (PIC) to support and direct the ECRMC pharmacy. Likewise, ECRMC shall provide IVHD with compounding medications and services.

5. Laboratory – The Parties shall collaborate on laboratory services, including but not limited to staffing and leadership, operational issues, systems and processes, policies and procedures, contract services by third parties and all other matters pertaining to laboratory services for the combined organization. As necessary, the parties will provide clinical laboratory scientists (CLS) to the other party for staffing purposes.

6. Hospital Clinical Services – The Parties shall collaborate on hospital clinical services, both inpatient and outpatient, including but not limited to staffing and leadership, operational issues, systems and processes, policies and procedures, contract services by

third parties and all other matters pertaining to hospital clinical services for the combined organization.

7. Outpatient Clinics – The Parties shall collaborate on outpatient clinics, including but not limited to staffing and leadership, operational issues, systems and processes, policies and procedures, contract services by third parties, leases and facilities and all other matters pertaining to outpatient clinics for the combined organization.

8. Information and Technology – The Parties shall collaborate on information and technology services, including but not limited to staffing and leadership, operational issues, systems and processes, policies and procedures, contract services by third parties and all other matters pertaining to information and technology services for the combined organization.

9. Facilities and Construction – The Parties shall collaborate on facilities and construction services, including but not limited to staffing and leadership, operational issues, systems and processes, leases, construction plans, policies and procedures, contract services by third parties and all other matters pertaining to facilities and construction services for the combined organization.

10. Medical Equipment – The Parties shall collaborate on medical equipment services, including but not limited to staffing and leadership, operational issues, systems and processes, policies and procedures, contract services by third parties and all other matters pertaining to medical equipment services for the combined organization. Further, both ECRMC and IVHD shall exchange and share medical equipment and services based on need of either organization.

11. Medical Staff – The Parties shall collaborate on medical staff issues, including but not limited to staffing and leadership, operational issues, systems and processes, bylaws, policies and procedures, contract services by third parties and all other matters pertaining to medical staff for the combined organization.

12. Compliance and Risk Management – The Parties shall collaborate on compliance and risk management issues, including but not limited to staffing and leadership, systems and processes, policies and procedures, contract services by third parties and all other matters pertaining to compliance and risk management for the combined organization.

13. Marketing and Patient Experience – The Parties shall collaborate on marketing and patient experience issues, including but not limited to staffing and leadership, systems and processes, policies and procedures, contract services by third parties and all other matters pertaining to marketing and patient experience for the combined organization.

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

Preamble

In order to comply with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 42 U.S.C. §§ 1320d through 1320d-8) as amended, ("HIPAA"), Title XIII of the American Recovery and Reinvestment Act of 2009 (20 Public Law 111-5, 123 Stat. 115) ("ARRA"), which is the Health Information Technology for Economic and Clinical Health Act, including without limitation 42 U.S.C.A. § 300jj-17 as amended ("HITECH"), and its implementing regulations, the Privacy, Security, Breach Notification, and Enforcement Rules at 45 Code of Federal Regulations ("C.F.R.") Parts 160 and 164 as amended ("HIPAA Rules"), **IMPERIAL COUNTY HEALTHCARE DISTRICT**, a local health care district formed under California Health & Safety Code §§ 32000 *et. seq.* ("Covered Entity") and **EL CENTRO REGIONAL MEDICAL CENTER** ("Business Associate"), enter into this Business Associate Agreement ("BA Agreement"), effective as of the date identified on the signature page ("Effective Date") and agree as set forth below. Business Associate and Covered Entity may be referred to as "Party" or "Parties" in this BA Agreement.

1. DEFINITIONS

a. Administrative Safeguards: "Administrative Safeguards" shall mean administrative actions and policies and procedures used to manage the selection, development, implementation, and maintenance of security measures to protect Electronic Protected Health Information and to manage the conduct of the Business Associate's workforce in relation to the protection of that information, as is more particularly set forth in 45 C.F.R. § 164.308 as amended.

b. Breach: "Breach" shall mean the acquisition, access, use, or disclosure of Protected Health Information not permitted by HIPAA Rules which compromises the security or privacy of Protected Health Information as defined in 45 C.F.R. § 164.402 as amended.

c. Business Associate: Business Associate shall have the same meaning as that term as defined in the HIPAA Rules, 45 C.F.R. § 160.103 as amended**.** In order for Business Associate to perform its obligations, Covered Entity must disclose certain Protected Health Information that is subject to protection under HIPAA Rules. For purposes of this BA Agreement, "Business Associate" is identified in the Preamble.

d. Catch-all Definition: Terms used, but not otherwise defined, in this BA Agreement shall have the same meaning as those terms in HIPAA, HIPAA Rules, ARRA, HITECH, and applicable laws and regulations, as amended.

e. Covered Entity: Covered Entity is defined by law as persons, organizations, and agencies that meet the definition of a "covered entity" in 45 C.F.R. § 160.103 as amended. For purposes of this BA Agreement, "Covered Entity" is identified in the Preamble.

f. Designated Record Set: "Designated Record Set" shall mean a group of records maintained by or for the Covered Entity that is the medical records and billing records about Individuals maintained by or for the Covered Entity or used, in whole or in part, by or for the Covered Entity to make decisions about Individuals, as defined in 45 C.F.R. § 164.501 as amended.

g. Electronic Protected Health Information: "Electronic Protected Health Information" shall mean Protected Health Information that is transmitted or maintained in electronic media or format, as defined in 45 C.F.R. § 160.103 as amended.

h. Encryption: "Encrypt" or "Encryption" shall mean the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key, as defined in 45 C.F.R. § 164.304 as amended.

i. Individual: "Individual" shall mean "individual" as defined in 45 C.F.R. § 160.103 as amended and shall include a person who qualifies as a Personal Representative in accordance with 45 C.F.R. § 164.502(g) as amended.

j. Physical Safeguards: "Physical Safeguards" shall mean the physical measures, policies and procedures used to protect Business Associate's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion, as is more particularly set forth in 45 C.F.R.§ 164.310 as amended.

k. Privacy Rule: "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information in 45 C.F.R. parts 160 and 164 as amended.

l. Protected Health Information: Protected Health Information ("PHI") shall mean Individually Identifiable Health Information that is (i) transmitted by electronic media; (ii) maintained in any medium constituting electronic media, or (iii) transmitted or maintained in any other form or medium. For example, PHI includes information contained in a patient's medical and billing records, as defined in 45 C.F.R. § 160.103 as amended.

m. Required by Law: "Required by Law" shall have the same meaning as the term "required by law" defined in 45 C.F.R. § 164.103 as amended.

n. Secretary: "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or his or her designee.

o. Security Incident: "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, as defined into 45 C.F.R. § 164.304 as amended.

p. Security Rule: "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information in 45 C.F.R. parts 160 and 164 as amended.

q. Technical Safeguards: "Technical Safeguards" shall mean the technology and the policy and procedures for its use that protect Electronic Protected Health Information and control access to it, as is more particularly set forth in 45 C.F.R.§ 164.312 as amended.

r. Underlying Contract: "Underlying Contract" shall mean the contract for services (including where applicable, related products) between Covered Entity and Business Associate that constitutes the main agreement between the Parties to which this BA Agreement is attached.

s. Unsecured Protected Health Information: "Unsecured Protected Health Information" shall mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary, as defined in 45 C.F.R. § 164.402 as amended.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

a. Business Associate shall not use or disclose PHI other than as permitted in this BA Agreement or as Required by Law.

b. Business Associate shall use reasonable and appropriate administrative, technical, and physical safeguards to protect the confidentiality, integrity, and availability of PHI other than as provided for in this BA Agreement and to comply with the Security Rule with respect to Electronic Protected Health Information that the Business Associate creates, receives, maintains, or transmits on the Covered Entity's behalf.

c. Business Associate will comply with the standards, requirements, and implementation specifications adopted under the Privacy Rule that apply to the Business Associate with respect to the PHI of the Covered Entity. To the extent the Business Associate is to carry out one or more of Covered Entity's obligations under the Privacy Rule, Business Associate must comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligations.

d. Business Associate shall mitigate, to the extent practicable, and will act in good faith with Covered Entity, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this BA Agreement.

e. Business Associate shall report in writing to the Covered Entity, in accordance with Section 3(d)(1)–(4) of this BA Agreement, promptly and no later than three (3) business days after discovery, any use or disclosure of PHI not provided for by this BA Agreement of which it becomes aware in accordance with 45 CFR § 164.504(e)(2)(ii)(C) as amended, including Breaches of Unsecured Protected Health Information as required at 45 CFR § 164.410 as amended, and any Security Incident of which it becomes aware in accordance with 45 CFR § 164.314(a)(2)(i)(C) as amended.

f. Business Associate shall not disclose PHI to any subcontractor without the prior written consent of Covered Entity. In accordance with 45 CFR § 164.502(e)(1)(ii) and 164.308(b)(2), as amended, and if Covered Entity provides written consent, Business Associate shall ensure that any agent, including any subcontractors, that create, receive, maintain, or

transmit PHI on behalf of Business Associate, agree to the same restrictions and conditions, in writing, that apply through this BA Agreement to Business Associate with respect to such PHI. Business Associate ensures that any subcontractors, including any agents of the Business Associate that create, receive, maintain, or transmit Electronic Protected Health Information on behalf of the Business Associate agree, in writing, to comply with the Security Rule.

g. Unless prohibited by the attorney-client or other applicable legal privileges, Business Associate shall make its internal practices, books, and records including policies and procedures relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity, available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a prompt and timely manner as designated by the Secretary, for purposes of determining Covered Entity's compliance and Business Associate's compliance with HIPAA Rules.

h. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an Accounting of Disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528 as amended.

i. Business Associate and its agents or subcontractors shall, ***w***ithin thirty (30) days of notice by Covered Entity of a request for an accounting of disclosures of PHI, make available to Covered Entity the information required to provide an accounting of disclosures to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.528 as amended, and its obligations under HITECH, including but not limited to 42 U.S.C. § 17935(c) as amended, as determined by Covered Entity. The provisions of this Subparagraph 2.i shall survive the termination of this BA Agreement.

j. Business Associate shall make available PHI maintained by Business Associate or its agents or subcontractors in a Designated Record Set to the Covered Entity for inspection and copying within fifteen (15) days of a request by Covered Entity to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524 as amended. If Business Associate maintains an Electronic Health Record, Business Associate shall provide such information in electronic format to enable Covered Entity to fulfill its obligations under HITECH, including, but not limited to, 42 U.S.C. § 17935(e) and 45 CFR § 164.524, as amended.

k. Business Associate, or its agents or subcontractors, shall within thirty (30) days of receipt of a request from the Covered Entity or an individual for an amendment of PHI or a record about an individual contained in a Designated Record Set make any amendments of PHI that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 as amended. This provision applies only to PHI received or created by Business Associate pursuant to this BA Agreement, if Business Associate possesses such PHI.

l. Business Associate may provide data aggregation services, as requested by the Covered Entity, relating to the Health Care Operations of the Covered Entity, and to the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under

HIPAA Rules, comply with the requirements of HIPAA Rules that apply to the Covered Entity in the performance of such obligation(s).

m. Business Associate shall not make or cause to be made any communication about a product or service that is prohibited by 45 CFR §§ 164.501 and 164.508(a)(3), as amended.

n. Business Associate shall not make or cause to be made any written fundraising communication that is prohibited by 45 CFR § 164.514(f) as amended.

o. Business Associate shall take all necessary steps, at the request of Covered Entity, to comply with requests by Individuals not to send PHI to a Health Plan in accordance with 45 CFR § 164.522(a) as amended.

3. HIPAA SECURITY RULE REQUIREMENTS

BUSINESS ASSOCIATE shall:

a. Secure all Electronic Protected Health Information through the use of encryption and/or destruction as provided by HITECH, the HITECH Omnibus Rule (published at 78 Fed. Reg. 5566 on Jan. 25, 2013 as amended) and HIPAA Rules, including without limitation 45 C.F.R. § 164.312. Business Associate shall so encrypt and/or destroy all Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity through all methods of data transmission, including secure email and on portable devices and removable media. If Business Associate elects destruction of PHI, then Business Associate shall comply with those provisions regarding destruction as contained in Section 8(e) of this BA Agreement. The Business Associate shall, however, encrypt Electronic Protected Health Information transmitted by the Business Associate to the Covered Entity over a public network.

b. Implement and document, as set forth in 45 C.F.R. § 164.316 as amended, Administrative Safeguards, Physical Safeguards and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, as required by 45 C.F.R. Part 164 as amended, and specifically, but not exclusively, including the following:

(1) Ensure the confidentiality, integrity, and availability of all Electronic Protected Health Information the Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity;

(2) Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;

(3) Protect against any reasonably anticipated uses or disclosures of such information that are not permitted under this Agreement or required under HIPAA Rules; and

(4) Ensure compliance with these sections by its Workforce.

c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement and document reasonable and appropriate Administrative Safeguards, Physical Safeguards, and Technical Safeguards, in the same manner as such

requirements apply to contracts or other arrangements between a Covered Entity and a Business Associate.

d. Report to the Covered Entity, in writing, within three (3) business days of becoming aware of or discovering any: (i) Breach; (ii) Security Incident; (iii) incident that involves an unauthorized acquisition, access, use or disclosure of PHI, even if Business Associate believes the incident will not rise to the level of a Breach; (iv) use or disclosure of PHI not permitted by this BA Agreement by the Business Associate, its contractors and agents. Creation of this report is necessary in order to comply with HIPAA Rules and specifically, 45 C.F.R. § 164.410 beginning as of its effective date of 45 C.F.R. Part 164. The content of such a written report of the Business Associate to the Covered Entity shall include, without limitation:

(1) A brief description of what happened and how the Breach occurred, including date of the Breach or Security Incident(s) or other inappropriate or impermissible or unlawful use or disclosure of PHI, if known, and the date of discovery of the Breach;

(2) A description of the types of PHI that were involved (e.g. SSN, name, DOB, home address, account number or disability code)

(3) identification and the contact information for the individuals who were or who may have been affected by the Breach (*e.g*., first and last name, mailing address, street address, phone number, email address) to mitigate harm to the individuals and to protect against further breach; and

(4) A brief description of what the Business Associate has done or is doing to investigate the Breach and to mitigate harm to the individuals affected by the Breach. Business Associate shall pay the actual, reasonable costs of Covered Entity to provide required notifications. Business Associate shall also pay the costs of conducting an investigation of any incident required to be reported under this Section 3(d).

e. assist the Covered Entity and act in good faith and to assist, and mitigate potential or actual harms or losses including but not limited to any actual monetary costs due to the Business Associate or its agent(s) or contractor(s) fault or liability and to assist and protect PHI, if appropriate, and to further protect any known suspected or actual Breaches, Security Incidents, or known inappropriate or unlawful use or disclosure of PHI;

f. make its policies and procedures, and documentation required by Section 3 of this Agreement relating to such safeguards, available to the Secretary and to the Covered Entity for purposes of determining the Business Associate's compliance with Section 3 of this BA Agreement and with the Privacy Rule in general; and

g. authorize termination of the relationship with Covered Entity if Covered Entity notifies the Business Associate of a pattern of an activity or practice of the Business Associate that constitutes a material breach or violation of the Business Associate's obligation under this Agreement and the Business Associate has failed to cure the breach or end the violation in accordance with Section 8(d) of this BA Agreement.

4. HITECH PROVISIONS

a. Without limiting any uses or disclosures expressly permitted in the BA Agreement, Business Associate shall not sell, or receive remuneration for, either directly or indirectly, PHI created or received for or from Covered Entity or use or disclose PHI for purposes of marketing or fundraising, as defined and proscribed in HIPAA Rules.

b. Effective upon the compliance date applicable to the Covered Entity, Business Associate shall record all disclosures by Business Associate of PHI required to be recorded by regulations promulgated by the Secretary pursuant to ARRA with respect to the Accounting obligation.

c. Business Associate shall limit its uses and disclosures of, and requests for, PHI (i) when practical, to the information making up a Limited Data Set, and (ii) in all other cases subject to the requirements of 45 C.F.R. § 164.502(b) as amended, to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

d. In the event Business Associate breaches the BA Agreement and termination of the Service Agreement(s) between the Parties is not feasible, the Business Associate shall report the breach to the Covered Entity and to the Secretary, if applicable, consistent with 45 C.F.R. § 164.504(e)(1)(i) as amended and HIPAA Rules.

e. To the extent Business Associate is acting as a Business Associate of Covered Entity, Business Associate may be subject to the penalty provisions specified in § 13404 of ARRA as amended and HIPAA Rules.

f. Nothing in the BA Agreement shall be construed to create an agency relationship between the Parties.

5. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

Except as otherwise limited in this BA Agreement and as necessary to perform the services set forth in the Underlying Contract, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in this BA Agreement and as necessary to perform the services set forth in the Underlying Contract, provided that such use or disclosure would not violate HIPAA Rules if done by Covered Entity. Business Associate may use PHI (i) for the proper management and administration of the Business Associate, (ii) to carry out the legal responsibilities of the Business Associate, or (iii) for Data Aggregation purposes for the Health Care Operations of the Covered Entity. Business Associate will make no other Disclosures of PHI, whether written or oral, to any third-party, without Covered Entity's express advance written consent or an order from a judge specifically authorizing disclosure of the PHI.

6. SPECIFIC USE AND DISCLOSURE PROVISIONS

Except as otherwise limited in this BA Agreement, Business Associate may use PHI for: (i) the proper management and administration of the Business Associate; (ii) to carry out the legal responsibilities of the Business Associate; (iii) as Required by Law; or (iv) for Data Aggregation purposes for the Health Care Operations of the Covered Entity. If Business Associate discloses PHI to a third-party, Business Associate must obtain, prior to making any

such disclosure, (i) Covered Entity's express advance written consent or an order from a judge specifically authorizing disclosure of the PHI, (ii) reasonable written assurances from such third-party that PHI will be held confidential as provided pursuant to this BA Agreement and only disclosed as Required by Law or for the purposes for which it was disclosed to such third-party, and (iii) a written agreement from such third-party to immediately notify Business Associate of any breaches of confidentiality of PHI, to the extent it has obtained knowledge of such breach.

7. OBLIGATIONS OF COVERED ENTITY

a. Covered Entity shall make available to Business Associate a copy of and shall notify Business Associate of any limitations in its Notice of Privacy Practices that Covered Entity produces in accordance with 45 C.F.R. § 164.520 as amended, as well as any changes to such notice.

b. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

c. Covered Entity shall notify Business Associate in writing of any restriction to the use or disclosure of PHI that Covered Entity has agreed to if such restriction affects Business Associate's permitted or required uses and disclosures in accordance with 45 C.F.R. § 164.522 as amended. Effective September 23, 2013, Business Associate shall, upon receipt of written notification, not Disclose PHI that pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full to any health plan for purposes of carrying out payment or health care operations.

d. Covered Entity shall obtain any consent, authorization, or permission that may be required by HIPAA Rules or applicable state laws and/or regulations prior to furnishing Business Associate the Protected Health Information pertaining to the Individual.

e. Covered Entity shall not request Business Associate to Use or Disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

8. TERM AND TERMINATION

a. Term: The Term of this BA Agreement shall be effective as of the Effective Date, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of Section 8 of this BA Agreement.

b. Material Breach by Business Associate: A breach by Business Associate of any provision of this BA Agreement, as determined by Covered Entity, shall constitute a material breach of the Underlying Contract and shall provide grounds for termination of the Underlying Contract, any provision in the Underlying Contract to the contrary notwithstanding, with or without an opportunity to cure the breach. If termination of the Underlying Contract is not feasible, Covered Entity will report the problem to the Secretary.

c. Material Breach by Covered Entity: Pursuant to 42 U.S.C. § 17934(b) as amended, if Business Associate knows of a pattern of activity or practice of Covered Entity that constitutes a material breach or violation of the Covered Entity's obligations under the Underlying Contract or BA Agreement or other arrangement, the Business Associate must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Business Associate must terminate the Underlying Contract or other arrangement if feasible, or if termination is not feasible, report the problem to the Secretary.

d. Termination for Cause: Upon Covered Entity's knowledge of a material breach of this BA Agreement by Business Associate, Covered Entity may either i) provide an opportunity for Business Associate to cure the breach or end the violation and terminate this BA Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, but not less than thirty (30) days, or ii) immediately terminate this BA Agreement and the Underlying Agreement if Business Associate has breached a material term of this BA Agreement and cure is not possible**.** Covered Entity may, at its discretion, require Business Associate to submit reports to demonstrate that the breach has been cured or the violation has ended.

e. Effect Upon Termination: Except as provided in paragraph (d) of Section 8 of this BA Agreement, upon termination of this BA Agreement, for any reason, Business Associate shall return or destroy all PHI pursuant to 45 C.F.R. §164.504(e)(2)(J) and C.F.R. §164.504(e)(5), as amended, in any form that is received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity**.** If Covered Entity elects destruction of PHI, then Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of PHI. In the event that Business Associate determines that returning or destroying PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this BA Agreement, particularly with respect to Sections 2 and 3 of this BA Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

9. MISCELLANEOUS

a. Regulatory References: A reference in this BA Agreement to a section in HIPAA Rules (e.g., Privacy Rule, HIPAA Security Rule, HITECH, and Notification in the case of Breach of Unsecured Protected Health Information Rule) means the section as in effect or as amended, and for which compliance is required.

b. Amendment:

(i) The Parties agree to take such action as is necessary to amend this BA Agreement from time to time as is necessary for Covered Entity and Business Associate in order to comply with the requirements of HIPAA Rules, HIPAA HITECH, applicable regulations, and other applicable laws.

(ii) This BA Agreement may be amended only by the signed mutual written consent of the Parties. The Parties agree to negotiate in good faith any modification to this BA Agreement that may be necessary or required to ensure consistency with amendments to and changes in applicable federal and state laws and regulations, including without limitation regulations promulgated pursuant to HIPAA, HIPAA Rules, or HITECH, court decisions or relevant government publication and/or interpretive policy affecting the use or disclosure of PHI. Covered Entity may terminate the Underlying Contract upon thirty (30) days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend the Underlying Contract or BA Agreement when requested by Covered Entity pursuant to Section 9(b) or (ii) Business Associate does not enter into an amendment to the Underlying Contract or BA Agreement providing assurances regarding the safeguarding of PHI that Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

c. Survival: The respective rights and obligations of Business Associate under Section 8(e) of this BA Agreement shall survive the termination of this BA Agreement until all PHI received from Covered Entity has been returned or destroyed.

d. Construction of Terms and Interpretation: The terms of this BA Agreement shall be construed in light of any applicable interpretation or guidance on HIPAA, HIPAA Rules, HITECH Act, or any other applicable provisions of ARRA issued by the U. S. Department of Health and Human Services ("HHS") or the Office for Civil Rights and the Center for Medicare and Medicaid Services at HHS and the U.S. Federal Trade Commission. Any ambiguity in this BA Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with HIPAA, HIPAA Rules, HITECH, and applicable laws and regulations.

e. Contradictory Terms: Any provision of the Underlying Contract that is directly contradictory to one or more terms of this BA Agreement ("Contradictory Term") shall be superseded by the terms of this BA Agreement as of the Effective Date of this BA Agreement: to the extent and only to the extent of any such Contradictory Term, solely for the purpose of the Covered Entity's compliance with HIPAA, HIPAA Rules, HITECH, and applicable laws and regulations and only to the extent that it is reasonably impossible to comply with both the Contradictory Term and the terms of this BA Agreement. This BA Agreement and the Underlying Contract shall be interpreted as broadly as necessary to implement and comply with HIPAA, HITECH, and HIPAA Rules, including the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this BA Agreement shall be resolved in favor of a meaning that permits Business Associate and Covered Entity to comply with the HIPAA Rules and applicable state laws. Except as specifically required to implement the purposes of this BA Agreement, all other terms of the Underlying Contract shall remain in force and effect.

f. Ownership of PHI: The PHI to which Business Associate, or any agent or contractor, or subcontractor of Business Associate has access under this BA Agreement shall be and remain the property of Covered Entity.

g. Notices: Any notice, demand, or communication required or permitted to be given by any provision of this BA Agreement shall be in writing and will be deemed to have been given when actually delivered (by whatever means) to an authorized agent of the Party designated to receive such notice, or if by an overnight-courier service, then the next business

day after delivery, as long as an authorized signature is obtained, or on the fifth (5th) business day after the same is sent by certified United States mail, postage and charges prepaid, directed to the address(es) noted below, or to such other or additional address as any Party timely designates by written notice to the other Party.

h. Severability: If any provision of this BA Agreement is rendered invalid or unenforceable by the decision of any court of competent jurisdiction, then any such invalid or unenforceable provision shall be severed from this BA Agreement, and all other provisions of this BA Agreement shall remain in full force and effect if such can reasonably be done in conjunction with the original intent of this BA Agreement.

i. Assignment: No assignment of the rights or obligations of either Party under this BA Agreement shall be made without the express written consent of the other Party, which consent shall not be unreasonably withheld.

j. Successors and Assigns: This BA Agreement shall be binding upon, and shall inure to the benefit of, the Parties, their respective successors and permitted assignees.

k. Waiver of Breach: Waiver of breach of any provision of this BA Agreement shall not be deemed a waiver of any other breach of the same or different provision.

l. Indemnification; Limitation of Liability: To the maximum extent permitted by law, Business Associate shall indemnify, defend and hold harmless Covered Entity, its directors and employees from any and all liability, claim, lawsuit, injury, loss, expense or damage, including attorneys' and consultants' fees resulting from or relating to: (i) any negligent or fraudulent act or omission of Business Associate (including its employees, agents, delegatees, representatives, or subcontractors); (ii) a violation of HIPAA by Business Associate (including its employees, agents, delegatees, representatives, or subcontractors); (iii) a breach of this BA Agreement by Business Associate (including its employees, agents, delegatees, representatives, or subcontractors); or (iv) or any other acts or omissions of Business Associate (including its employees, agents, delegates, representatives, or subcontractors) in connection with the representations, duties, and obligations of Business Associate under this BA Agreement. Any limitation of liability contained in the Underlying Contract shall not apply to the indemnification requirement of this provision. This provision, 9-l, shall survive the termination of the BA Agreement.

m. Assistance in Litigation: Business Associate shall make itself and any employees, agents, delegatees, representatives, or subcontractors assisting Business Associate in the performance of its obligations under the Underlying Contract (or Addendum) available to Covered Entity, at no cost to Covered Entity, to testify as witnesses, or otherwise assist in the defense, in the event of litigation or administrative proceedings brought against Covered Entity, its directors, officers, agents, or employees based upon a claim of violation of HIPAA, HITECH, HIPAA Rules, including the Privacy Rule and the Security Rule, or other laws related to PHI security and privacy, except where Business Associate or its employee, agent, delegate, representative, or subcontractor is named as a party adverse to Covered Entity.

n. No Third-Party Beneficiaries: Nothing express or implied in the Underlying Contract or this BA Agreement is intended to confer, nor shall anything herein confer upon any

person other than Covered Entity, Business Associate (and their respective successors or assigns), any rights, remedies, obligations or liabilities whatsoever. This provision, 9-n, shall survive the termination of the BA Agreement.

o. Headings: The headings or captions provided throughout this BA Agreement are for reference purposes only and shall not in any way affect the meaning or interpretation of this BA Agreement.

p. Governing Law, Jurisdiction, and Venue: These Terms and Conditions shall be governed by, construed and enforced in accordance with the laws of the State of California regardless of the choice-of-law rules of any jurisdiction. Each Party irrevocably agrees that the courts of the State of California located in Imperial County shall have the sole and exclusive jurisdiction with respect to any action or proceeding at law or in equity arising out of or relating to these Terms and Conditions. Each Party hereby submits to the personal jurisdiction of, and venue in, such forum, and expressly waives any claim of lack of jurisdiction, improper venue, or that such venue constitutes an inconvenient forum. This provision, 9-p, shall survive the termination the BA Agreement.

q. HIPAA Compliance: Business Associate will comply with all current and future applicable provisions of HIPAA, HIPAA Rules, HITECH, to, and applicable laws and regulations.

r. Covered Entity's Name and Logo: Business Associate shall not use the Covered Entity's name, trade-name, trade-mark, service marks, brands, or logos except upon the prior written consent of the Covered Entity by a duly authorized signatory.

s. Entire Agreement of the Parties: With the exception of the Underlying Contract, this BA Agreement supersedes any and all prior and contemporaneous business associate agreements or addenda between the Parties, and constitutes the final and entire agreement between the Parties hereto with respect to the subject matter hereof. With the exception of the Underlying Contract, no other agreement, statement, or promise, with respect to the subject matter of this BA Agreement, not contained in this BA Agreement, shall be valid or binding.

t. Identity Theft Program Compliance: To the extent that Covered Entity is required to comply with the final rule entitled "Identity Theft Red Flags and Address Discrepancies under the Fair and Accurate Credit Transactions Act of 2003," as promulgated and enforced by the Federal Trade Commission (16 C.F.R. Part 681 as amended ; "Red Flags Rule"), and to the extent that Business Associate is performing an activity in connection with one or more "covered accounts," as that term is defined in the Red Flags Rule, pursuant to the Underlying Contract, Business Associate shall establish, and comply with, its own reasonable policies and procedures designed to detect, prevent, and mitigate the risk of identity theft, which shall be consistent with and no less stringent than those required under the Red Flags Rule or the policies and procedures of Covered Entity's Red Flags Program. Business Associate shall provide its services pursuant to the Underlying Contract in accordance with such policies and procedures. Business Associate shall report any detected "red flags" (as that term is defined in the Red Flags Rule) to Covered Entity and shall cooperate with Covered Entity to take appropriate steps to prevent and mitigate identity theft.

u. Independent Contractor Relationship: The parties acknowledge and agree that Business Associate is an independent contractor and not an employee of Covered Entity, and nothing contained herein shall be construed by the parties or any third person to create the relationship of partners, joint venture, principal and agent, employer and employee or any association other than contracting parties to this BA Agreement. Business Associate shall have the right to operate its business as it chooses, and Covered Entity does not have the right or ability to control Business Associate as to the specific means or manner in which Business Associate discharges its duties hereunder.

IN WITNESS WHEREOF, the Parties hereto have duly executed this Business Associate Agreement effective as of August 1, 2025

COVERED ENTITY

IMPERIAL VALLEY HEALTHCARE DISTRICT

By: _____
Christopher Bjornberg, CEO

BUSINESS ASSOCIATE

EL CENTRO REGIONAL MEDICAL CENTER

By: _____
Pablo Velez, CEO

NOTICE:

If to Covered Entity:

Imperial Valley Healthcare District
207 West Legion Road
Brawley, CA 9227
Attn: Christopher Bjornberg, CEO
cbjornberg@iv-hd.org

If to Business Associate:

El Centro Regional Medical Center
1415 Ross Avenue

El Centro, CA 92243
Attention: Pablo Velez, CEO
Email: pablo.velez@ecrmc.org

Imperial Valley Healthcare District

Title: **Executive Leadership Car Allowance Program**	Policy No. ADM-00185 Page 1 of 2
Current Author: Christopher Bjornberg	Effective:
Latest Review/Revision Date: June 17, 2025	Manual: Administration

Collaborating Departments: None		Keywords:	
Approval Route: List all required approval			
MARCC x	PSQC	Other:	
Clinical Service _____	MSQC	MEC	BOD x

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 policy and procedures for providing a car allowance reimbursement to members of the Executive Leadership Team who are required to travel between facilities within the same health district and to other locations as part of their official job responsibilities in fulfilling executive responsibilities.

2.0 Scope:

2.1 This policy applies to the Chief Executive Officer's designated Executive Leadership Team members and the like, whose job duties include regular inter-facility travel.

3.0 Policy:

3.1 Eligible executives will be provided with a monthly car allowance. This allowance is provided to offset the cost of personal vehicle use for work-related travel and does not apply to commuting between home and primary work location.

3.1.1 Eligibility

3.1.1.1 Applies to Executive Leadership Team members who are required to travel between facilities within the health district or other locations as a regular part of their job duties.

3.1.1.2 Must have a valid driver's license and personal auto insurance.

3.1.2 Monthly Allowance:

3.1.2.1 Executives may receive a fixed monthly car allowance as compensation for regular travel of $250 per month.

3.1.3 Conditions:

3.1.3.1 Executives must be available to travel to any facility within the district at any time.

3.1.3.2 Executives must maintain a personal vehicle in good working condition and meet all insurance requirements.

4.0 Definitions:

4.1 NA

5.0 Procedure:

5.1 Eligible Executives may complete Car Allowance Acknowledgment Form subject to the Chief Executive Officer's approval.

5.2 After approval, payroll shall disburse a monthly allowance payment consistent with this policy on the first day of the month following approval, and each subsequent pay period thereafter.

5.3 Legal and Finance shall perform an annual review of eligibility and amount to be reimbursed.

5.4 This policy shall take effect on the first day of the month after adoption. No retroactive payment of car allowances shall be permitted.

6.0 References: Not Applicable

7.0 Attachment List:

7.1 Attachment A: Car Allowance Acknowledgment Form.

8.0 Summary of Revisions: New Policy

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Car Allowance Reimbursement Acknowledgment Form

Executive Information

Name: _____

Title/Position: _____

Primary Work Location: _____

Acknowledgment of Car Allowance Policy

I acknowledge that I have read and understood the **Car Allowance Reimbursement Policy** and agree to the following:

- I am a member of the Executive Leadership Team, or the like as designated by the Chief Executive Officer.
- I am required, as part of my regular job duties, to travel between facilities within the health district and/or to other locations for official business.
- I possess a valid driver's license and carry active personal automobile insurance that meets California state requirements.
- I will maintain a personal vehicle in good working condition and be available to travel to any facility within the district as needed.
- I understand that the car allowance of **$250 per month** is intended to offset the cost of work-related travel and does not apply to commuting between my home and primary work location.
- I understand that no retroactive payments will be made, and the allowance will begin on the first day of the month following CEO approval.
- I agree to inform Human Resources and my supervisor immediately if I become ineligible for this allowance for any reason (e.g., change in job duties, license/insurance status).

Executive Signature

Signature

Printed Name

Date

Approval

Chief Executive Officer

Signature

Printed Name

Date

Routing Instructions:

- Completed and signed forms must be submitted to Human Resources for processing and retained in the employee file.
- A copy will be sent to Payroll to initiate the monthly allowance.

Imperial Valley Healthcare District

Title: **Breastfeeding**	Policy No. CLN-02501
	Page 1 of 12
Current Author: Sandra Taylor, RNC-NIC, BSN	Effective: 1/25/2010
Latest Review/Revision Date: 05/21/2025	Manual: Clinical / OB

Collaborating Departments: Perinatal, Neonatal, Dr Alshareef, NICU Manager	Keywords: Baby Friendly Initiative, Breastfeeding/NICU

Approval Route: List all required approval			
PSQC	Other:		
Clinical Service Pediatrics OB 7/2025	MSQC 8/2025	MEC 8/2025	BOD

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 This policy will be a resource guide as a model for the nursing staff of Pioneers Memorial Hospital Perinatal/Neonatal Unit, to assist the mother who would like to breastfeed or provide breast milk to her infant(s).

1.2 To promote a philosophy of maternal/infant care which advocates breastfeeding and supports the mother/infant couplet in attaining the goal of successful breastfeeding and enhance the bonding experience

2.0 Scope:

2.1 Perinatal and Neonatal Nurses

2.2 Lactation Consultants (LC's or IBCLC)/Educators(CLEC)

2.3 MD's and PA's from L&D

3.0 Policy:

3.1 To promote a philosophy of maternal infant care that advocates breastfeeding and supports the normal physiological functions involved in the establishment of this maternal infant process, PMH Perinatal Department will implement this policy based on the recommendations from the most recent breastfeeding policy statements published by the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the World Health Organization, the Association of Women's Health Obstetric and Neonatal Nurses, and the UNICEF/WHO evidence-based "Ten Steps to Successful Breastfeeding"

3.2 The Perinatal Director, Perinatal Clinical Managers or their Designees will be responsible for implementing this policy.

3.3 The policy recommendations include:

3.3.1 Exclusive breastfeeding for approximately the first six months and support for breastfeeding for the first year and beyond as long as mutually desired by mother and child.

3.3.2 Mother and infant should sleep in proximity to each other to facilitate breastfeeding.

3.3.3 Self-examination of mother's breasts is recommended throughout lactation, not just after weaning.

3.3.4 Pediatricians should counsel adoptive mothers on the benefits of induced lactation through hormonal therapy or mechanical stimulation.

3.3.5 Recognize and work with cultural diversity in breastfeeding practices.

3.3.6 A Pediatrician or other knowledgeable and experienced health care professional should evaluate a newborn breastfed infant at 1 to 3 days of age and again at 2 to 3 weeks of age to be sure the infant is feeding and growing well.

3.4 A written breastfeeding policy will be in place and communicated to all health care staff. The policy will be reviewed and updated annually using current research as an evidence-based guide

4.0 Definitions:

4.1 LC – Lactation Consultant
4.2 IBCLC – International Board Certified Lactation Consultant
4.3 CLEC – Certified Lactation Educator
4.4 PMH -Pioneers Memorial Hospital

5.0 Procedure:

5.1 Pioneers Memorial Hospital staff will actively support breastfeeding as the preferred method of providing nutrition to infants. A multidisciplinary, culturally appropriate team comprising physician and nursing staff, lactation consultants and specialists, and other appropriate staff shall be established and maintained to identify and eliminate institutional barriers to breastfeeding. On a yearly basis, this group will compile and evaluate data relevant to breastfeeding support services and formulate, along with administration, a plan of action to implement needed changes.

5.2 The Perinatal Manager, in collaboration with the Lactation Consultant, is responsible for implementing and assuring all perinatal staff is trained in breastfeeding and lactation management.

5.2.1 All Perinatal staff will receive 8 hours of education in breastfeeding and lactation management. The curriculum for this education will cover the sessions identified by UNICEF/WHO and include 3 hours of supervised clinical training.

5.2.2 Staff competency in the critical areas identified in the Baby-Friendly Guidelines and Criteria for Evaluation will be verified upon hire and annually.

5.2.3 All staff will be trained within 6 months of hire and this education will be documented in the employee education file.

5.2.4 Training acquired prior to hire at this facility will be assessed for verification of inclusion of the lessons recommended by UNICEF/WHO.

5.2.4.1 If the prior training does not meet recommendations, the new hire will be required to participate in the facility breastfeeding and lactation management training program.

5.2.4.2 For all new hires, competency will be verified during orientation.

5.3 Lactation Consultant, International Board Certified Lactation Consultant or Certified Lactation Educator Counselors are available as an advanced breastfeeding resource for all patients, families and staff.

5.4 Lactation consults designated for the NICU:

5.4.1 Special needs infants, (i.e., Premature, Late Preterm, Cardiac, Down’s syndrome)

5.4.2 Hyperbilirubinemia

5.4.3 Failure to Thrive
5.4.4 Maternal medications/drugs
5.4.5 Maternal Illness
5.4.6 Pump rentals and referrals

5.5 Lactation consultations will be performed within 5 days of order.

5.6 A formal lactation consult will include an assessment of both the mother and the infant.
- 5.6.1 Assessment of the mother includes:
  - 5.6.1.1 Previous nursing history
  - 5.6.1.2 General health
  - 5.6.1.3 Diet
  - 5.6.1.4 Medications
  - 5.6.1.5 Exam of breasts/nipples
- 5.6.2 Assessment of baby includes:
  - 5.6.2.1 Gestation age
  - 5.6.2.2 Health issues
  - 5.6.2.3 Weight – both birth and current
  - 5.6.2.4 Exam of oral anatomy and suck/swallow
- 5.6.3 Feeding observation when assessed includes:
  - 5.6.3.1 Rooting reflex
  - 5.6.3.2 Proper latch
  - 5.6.3.3 Sucking and swallowing
  - 5.6.3.4 Behavior at the breast
- 5.6.4 Other:
  - 5.6.4.1 Feeding frequency
  - 5.6.4.2 Feeding duration
- 5.6.5 Once the evaluation has been completed and the problem identified, appropriate recommendations should be given. A printed copy of the appropriate handouts will be provided to the mother for her reference. English and Spanish handouts are available.

5.7 The woman's desire to breastfeed will be documented in her medical record. All pregnant women and their support people, as appropriate, will be provided with information on breastfeeding and counseled on the benefits of breastfeeding, contraindications to breastfeeding, and risk of formula feeding. "Getting Your Baby Off to a Healthy Start" handouts are available in English and Spanish

5.8 Mothers will be encouraged to exclusively breastfeed unless medically contraindicated. The method of feeding will be documented in the medical record of every infant. Exclusive breastfeeding is defined as providing breast milk as the sole source of nutrition. Exclusively breastfed babies receive no other liquids.

5.9 Health care professionals should recommend human milk for all infants in whom breastfeeding is not specifically contraindicated and provide parents with complete, current information on the benefits and techniques of breastfeeding to ensure that their feeding decision is a fully informed one.

5.10 When direct breastfeeding is not possible, expressed human milk should be provided. (See Breast Milk Collection and Storage policy)

5.11 To facilitate the greatest success, the healthy infants should be placed and remain in direct skin-to-skin contact with their mother immediately after delivery until the first feeding is accomplished

5.11.1 Skin-to-skin contact involves placing the naked (with diaper and hat) baby prone on the mother's bare chest. Mother/infant couples will be given the opportunity to initiate breastfeeding within one hour of birth. Post C-section babies will be encouraged to breastfeed as soon as possible.

5.11.1.1 Unless mother and/or infant are medically unstable, all infants will be placed skin-to-skin with their mothers as soon as physically possible, regardless of feeding choice.

5.11.1.2 The nursing staff present immediately after delivery will encourage and support immediate and continuous skin-to-skin contact for mother and infant. The nurses will teach the mother to look for signs of feeding readiness and support self-attachment of the infant. "Infant Hunger Cues" handouts are available in English and Spanish

5.11.1.3 When a delay of initial skin-to-skin contact has occurred (post cesarean birth babies), staff will ensure that mother and infant receive skin-to-skin care as soon as medically possible and encouraged to breastfeed as soon as possible

5.11.1.4 When it is necessary for an infant to be admitted to the special care nursery, the nursing staff will educate the mother regarding the importance of skin-to-skin care for her infant and support the implementation of skin-to-skin care as soon as medically possible.

5.11.1.5 Documentation of skin-to-skin time will be recorded in the maternal/neonatal record.

5.11.1.6 The alert, healthy newborn infant is capable of latching on to a breast within the first hour after birth.

5.11.1.7 Dry the infant, assign Apgar scores, and perform the initial physical assessment while the infant is with the mother. (The mother is an optimal heat source for the infant)

5.11.1.8 Delay weighing, measuring, bathing, needle-sticks, and eye prophylaxis until after the first feeding is completed to allow uninterrupted mother-infant contact and breastfeeding.

5.11.2 Infants affected by maternal medications may require assistance for effective latching.

5.11.3 Except under unusual circumstances, the newborn should remain with the mother throughout the recovery period.

5.12 Breastfeeding assessment, teaching, and documentation will be done on each shift by the Neonatal/Perinatal nursing staff. After each feeding, Neonatal/Perinatal staff will document information about the feeding in the infant's medical record. This documentation may include the latch, position, and any problems encountered. For feedings not directly observed, a maternal report may be used. Every shift, a direct observation of the baby's latch and position should be observed and documented.

5.13 Prior to discharge, the breastfeeding mother will be instructed about breastfeeding and

the skills reviewed before release. Documentation will be logged in the Maternal and/or Infant chart.

5.13.1 Proper positioning and latch on
5.13.2 Nutritive suckling and swallowing
5.13.3 Milk production and release
5.13.4 Frequency of feeding/feeding cues
5.13.5 Expression of breast milk (including manual expression) and use of a pump if indicated
5.13.6 How to assess if infant is getting adequate nutrition
5.13.7 Reasons to contact the lactation specialist

5.14 Parents will be taught that breastfeeding infant, including C-sections infant, should be put to the breast at least 8-12 times in 24 hours. Infant feeding cues (such as increased alertness or activity, mouthing, or rooting) will be used as indicators of the infant's readiness for feeding.

5.15 Time limits for breastfeeding on each side will be avoided. Infant can be offered both breasts at each feeding but may be interested in feeding only on one side at a feeding.

5.16 No formula will be given unless medically indicated or by the mother's documented and informed request. Prior to non–medically indicated supplementation, mothers will be informed of the risks of supplementing. Bottles will not be placed in a breastfeeding infant's bassinet. Breastfeeding mothers who request artificial nipples and infant feeding bottles will receive education on the possible negative consequences regarding breastfeeding.

5.17 Most breastfed infants will not require any supplementary feedings.

5.18 Supplementation is <u>NOT</u> appropriate in the following instances:

5.18.1 To let the mother rest or sleep
5.18.2 To try to prevent weight loss
5.18.3 To try to prevent hypoglycemia
5.18.4 To try to prevent hyperbilirubinemia
5.18.5 To quiet a fussy baby
5.18.6 To try to prevent sore nipples from a baby on the breast "too long"
5.18.7 To teach a baby to take a bottle "for later"

5.19 The primary goals of supplementation are to:

5.19.1 Provide appropriate nutrition and hydration
5.19.2 Avoid feeding-related morbidities for the infant
5.19.3 Avoid loss of milk supply for the mother

5.20 Medical Indications for Supplementation

5.20.1 Infant Indications

5.20.1.1 Hypoglycemia (Refer to Hypoglycemia Policy)
5.20.1.2 Weight loss of > 10%
5.20.1.3 Delayed bowel movements or dark stools at day 3
5.20.1.4 Poor urine output (<1 wet diaper for each day of life)
5.20.1.5 Inadequate milk transfer despite an adequate milk supply (e.g., borderline premature, sleepy infant, or sucking problems)
5.20.1.6 Breastfeeding jaundice related to poor intake after breastfeeding

evaluation and management has occurred and infant is unable to sustain feedings at the breast

5.20.1.7 Late Preterm/IUGR with mother unavailable or unable to express sufficient quantities for the baby's immediate needs

5.20.1.8 Hyperbilirubinemia due to inadequate intake, significant enough to require phototherapy or continued hospitalization

5.20.1.9 No effective latch to the breast by 18-24 hours of age for all babies on the well-baby unit

5.20.1.9.1 Effective latch defined by:

5.20.1.9.1.1 Infant's mouth latched deeply unto the nipple/areola for a minimum of 5 minutes

5.20.1.9.1.2 To unlatch the infant, a finger must be used to break the suction

5.20.1.9.1.3 The mother feels a strong tug with suckling, but no pain

5.20.2 Maternal Indications

5.20.2.1 Delayed lactogenesis (day 5 or later) and inadequate intake by infant

5.20.2.2 Delayed lactogenesis and inconsolably hungry infant

5.20.2.3 Intolerable pain during feedings

5.20.2.4 Unavailability of mother due to severe illness or geographic separation

5.20.2.5 Primary glandular insufficiency (primary lactation failure), as evidenced by poor breast growth during pregnancy and minimal indications of lactogenesis

5.20.2.6 Retained placenta causing delayed lactogenesis (lactogenesis probably will occur after placenta fragments are removed)

5.20.2.7 Sheenhan syndrome (postpartum hemorrhage followed by absence of lactogenesis)

5.21 Supplementation is appropriate:

5.21.1 When the infant is 18-24 hours of age and has never maintained an effective latch

5.21.2 When requested by the mother after appropriate information has been given. (See Parental Information Sheet: Supplementation for Late Preterm and Term Breastfed Infants)

5.21.3 As per Lactation Consultant direction

5.21.4 Prior to supplementing the infant, the staff will discuss with the mother the feeding options available. When a decision has been made as to the choice of alternative feeding device to be utilized, the mother will be taught how to safely administer a feeding with the device. This information will be documented in the mothers' and/or infants' chart. Staff will avoid the use of artificial nipples if possible.

5.21.4.1 Modes of supplemental feeding devices utilized at this facility include:

5.21.4.1.1 Pre-filled formula bottles

5.21.4.1.2 Finger feeding

5.21.4.1.3 Cupping

5.21.4.1.4 Supplemental Nursing System (SNS)
5.21.4.1.5 Per N/G tube

5.22 Before 24 hours of life, if the infant has not latched on or fed effectively, the mother will be instructed to begin breast massage and hand expression of colostrum into the baby's mouth during feeding attempts. Skin-to-skin contact will be encouraged. Parents will be instructed to watch closely for feeding cues and whenever these are seen, to awaken and feed infant. If the baby continues to feed poorly, pumping with skilled hand expression or an electric breast pump will be initiated and maintained approximately every 3 hours or a minimum of 8 times per day. Any expressed colostrum or mother's milk will be fed to the baby by an alternative method. The mother will be reminded that she may not obtain much milk or even any milk the first few times she pumps her breasts. Until the mother's milk is available, a collaborative decision should be made among the mother, nurse and clinician regarding the need to supplement the baby.

5.22.1 When an infant has been admitted to the Special Care Nursery, their mother will be encouraged to begin breast milk expression within the first 6 hours or as soon as medically possible.

5.23 Each day clinicians will be consulted regarding the volume and type of the supplement. In cases of problems feeding, the lactation consultant or specialist will be consulted.

5.24 See Breastfeeding Management Flow Chart for further decision making information (attachment)

5.25 Infants that are not latching on or feeding well should not be discharged home.

5.26 All babies should be seen for follow-up within the first few days after discharge. This visit should be with a pediatrician or other qualified health care practitioner for a formal evaluation of breastfeeding performance, a weigh check, assessment of jaundice and age appropriate elimination.

5.27 Pacifier use is best avoided during the initiation of breastfeeding and used only after breastfeeding is well established. Pacifiers will not be given by the staff to breastfeeding babies. If the mother requests a pacifier, the nursing staff will explore the reasons for this request, address the mother's concerns and educate her on problems associated with pacifier use and the effects on breastfeeding. This education will be documented

5.27.1 Pacifiers may be used for the breastfeeding infant during painful and/or therapeutic medical procedures. Discard the pacifier after the procedure.

5.28 Soft pliable nipple shields may be initiated by nursing to cover a mother's nipple to treat latch-on problems or manage sore or cracked nipples, or when mother has flat or inverted nipples. Nipple shield use will be followed by a lactation consultation.

5.29 During the early weeks of breastfeeding, mothers should be encouraged to have 8 to 12 feedings at the breast every 24 hours.

5.29.1 Instruct the mother to offer the breast whenever the infant shows early signs of hunger such as increased alertness, physical activity, mouthing or rooting

5.29.2 Crying is a late indicator of hunger.

5.29.3 Appropriate initiation of breastfeeding by continuous rooming-in throughout the day and night

5.29.4 The mother should offer both breasts at each feeding for as long a period as the infant remains at the breast. May alternate breast every feeding if the infant does

not nurse from both breasts at one feeding

5.29.5 In the early weeks after birth, non-demanding infant should be aroused to feed if 4 hours have elapsed since the beginning of the last feeding.

5.30 Care of the breast should be discussed with each nursing mother and will include:

5.30.1 Instruct the mother that the breasts should be cleansed with water only, every day, during a shower.

5.30.2 No soap should be used on the nipple/areola area

5.30.3 Not to wipe of the milk after the feeding is completed.

5.30.4 To observe the nipples for cracks, fissures and/or bleeding and to apply colostrum/breast milk to the nipples as necessary

5.30.5 Allow the nipples to air-dry after feedings are completed. Instruct the mother to wear nursing bras for her comfort and support of the breasts

5.30.6 Instruct the mother in the prevention and relief of breast engorgement.

5.31 After breastfeeding is well established, the frequency of feeding may decline to approximately 8 times per 24 hours, but the infant may increase the frequency again with growth spurts or when an increase in milk volume is desired.

5.32 Encourage the mother to record the time and duration of each breastfeeding, as well as urine and stool output during the hospital stay and the first weeks at home. This helps facilitate the evaluation process.

5.33 Formal evaluation of breastfeeding, including observation of position, latch, milk transfer, status of the nipples/breasts should be made by the neonatal/Perinatal staff at least twice a day and documented in the infants' record at least once every day.

5.33.1 Lactation consultants and/or educators should be available to the client's daily.

5.33.2 Mothers that have had previous breast surgery, nipple protractility or breast pathology should be referred to the lactation consultant. An assessment may be provided prior to delivery.

5.33.3 Information regarding follow-up services and support groups will be provided prior to discharge

5.34 Should hospitalization of the breastfeeding mother or infant be necessary, every effort should be made to maintain breastfeeding, preferably directly, or pumping the breasts and feeding expressed milk of necessary.

5.35 It is recommended that mothers and infant be allowed rooming-in regardless of the infant feeding choice as health conditions of mother/baby permit.

5.35.1 Rooming should be facilitated within the first 2-6 hours to allow c-section recovery time and infant transition

5.35.2 The maximum time for separation of the normal newborn from the mother is 2 hours within a 24 hour period.

5.35.3 As is appropriate, all routine newborn procedures may be performed at the mother's bedside

5.35.4 Any interruption of rooming in will be documented in the infant's chart and include the reason for the interruption, the location of the infant during the separation and the time when the separation began, as well as the time when the infant was returned to the mother's room.

5.35.5 When a mother requests that her baby be cared for in the nursery, the nursing

staff should explore the reasons for the request and should encourage and educate the mother about the advantages of having her infant(s) stay with her in the same room 24 hours a day.

5.35.5.1 If the mother still requests that the baby be cared for in the nursery, the baby will be brought to the mother for feedings whenever the infant shows feeding cues. Interruption of rooming-in will be documented as per protocol

5.36 Mothers who are separated from their sick or premature infants will be seen by the lactation consultant/educator before maternal discharge and given proper education in pumping and storage.

5.37 Fortification of expressed human milk is indicated for many low birth weight infants. The Neonatologist/Pediatrician will order the amount to be added for each feeding on an individual basis.

5.38 Breast pumps and private lactation areas are available for all breastfeeding mothers (patients and staff) in the newborn nursery.

5.39 Lactation consultant will be responsible to maintain communications with local breastfeeding resources available (i.e., WIC clinics, breastfeeding specialists, lay support groups and breastfeeding rental companies) so patients can be referred appropriately.

5.40 Lactation consultant will be a resource person for staff and provide education as the need arises.

5.41 At discharge, the mother should be supplied with information regarding community resources available to assist in the continuum of care and promote success in breastfeeding when at home.

5.41.1 Transient breastfeeding difficulties can often be resolved with reassurance and support from an experienced care provider.

5.42 Before leaving the hospital, breastfeeding mothers should be able to:

5.42.1 Position the infant correctly at the breast with no pain during the feeding

5.42.2 Latch the infant to the breast properly

5.42.3 State when the baby is swallowing milk

5.42.4 State that the baby should be nursed approximately 8 to 12 times every 24 hours

5.42.5 States age appropriate elimination patterns (at least 6 urinations per 24 hours and 3-4 stools per 24 hours by the fourth day of life)

5.42.6 List indications for calling a clinician

5.43 Pioneers Memorial Hospital does not accept free formula or free breast milk substitutes. Discharge bags are sometimes given, but are non-commercial

5.44 All formula and other bottle feeding supplies are to be purchased in the same manner as it purchases all other supplies. Additionally, we will not give infant formula samples, literature or other items bearing the name of an infant formula product to breastfeeding mothers.

5.45 Pioneers Memorial Hospital Perinatal nursing staff will attend educational sessions on lactation management and breastfeeding promotion to ensure that correct, current and consistent information is provided to all mothers wishing to breastfeed

5.46 Breast Engorgement: Prevention and Treatment

5.46.1 Prevention:
- 5.46.1.1 Encourage mother to breastfeed frequently, 8-12 time in 24 hours.
- 5.46.1.2 Avoiding supplementation for the first 3-4 weeks
- 5.46.1.3 Express the milk if any feedings are missed
- 5.46.1.4 Wean over a gradual period of time.

5.46.2 Treatment
- 5.46.2.1 Have mother apply hot moist towel, or disposable diaper to the breasts for 2-5 minutes, or take a hot shower before nursing the infant.
- 5.46.2.2 If the breasts are severely swollen and engorged, try applying icy cold compresses or cold cabbage leaves prior to nursing
- 5.46.2.3 Hand express some milk to soften the areola after using moist heat. This makes it easier for the baby to attach to the breast
- 5.46.2.4 Use gentle breast massage before and during breastfeeding or pumping
- 5.46.2.5 Try applying cold compresses to the breast after nursing to relieve the discomfort and decrease swelling
- 5.46.2.6 If the baby takes only one breast, have the mother use an electric breast pump or hand expression to express the milk from the other breast during the engorgement period.
- 5.46.2.7 If the baby cannot latch on or the nipples are flat, using a breast pump or hand expression for 5 minutes may help to soften the areola. Use moist heat and breast massage before pumping. Encourage mother to pump every 2 hours, 15 minutes per side until the baby can latch on.

5.47 Contraindications to Breastfeeding
- 5.47.1 Mothers who have active untreated tuberculosis
- 5.47.2 Mothers who are using drugs of abuse (street drugs)
- 5.47.3 Mothers who have herpes simplex lesions on a breast (infants may feed from the other breast if clear of lesions)
- 5.47.4 Mothers who are infected with human immunodeficiency virus (HIV)
- 5.47.5 Mothers who are receiving diagnostic or therapeutic radioactive isotopes or have had exposure to radioactive materials (for as long as there is radioactivity in the milk)
- 5.47.6 Mothers who are receiving antimetabolites or chemotherapeutic agents
- 5.47.7 Infants with classic galactosemia
- 5.47.8 Mothers who have varicella that is determined to be infectious to the infant
- 5.47.9 Mothers who have HTLV1 (human T-cell leukemia virus type 1)
- 5.47.10 If there are questions regarding any medication that the mother is receiving, the lactation consultant may be contacted or the information may be found in the book "*Medications and Mother's Milk"* 2023*,* by Thomas Hale, found in the Nursery.
- 5.47.11 For mothers who insist on breastfeeding when breastfeeding is contraindicated, the Multidisciplinary group consisting of at least the attending physician, the charge RN and the MSW will discuss the plan of care

5.48 Formula feeding option

5.48.1 When a mother chooses to feed her infant formula:
- 5.48.1.1 The mother will be taught the proper mixing, storage and handling procedures. Handouts available in English and Spanish
- 5.48.1.2 Staff will verify understanding by asking mother for return demonstration of the procedure
- 5.48.1.3 The education given regarding formula feeding and preparation will be documented in the mother's chart
- 5.48.1.4 Mothers who are formula feeding well be taught "baby-led" feeding.

5.49 The Ten Steps to Successful Breastfeeding
- 5.49.1 Have a written breastfeeding policy that is routinely communicated to all health care staff
- 5.49.2 Train all health care staff in skills necessary to implement this policy.
- 5.49.3 Inform all pregnant women about the benefits and management of breastfeeding.
- 5.49.4 Help mothers initiate breastfeeding within 1 hour of birth.
- 5.49.5 Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants
- 5.49.6 Give newborn infants no food or drink other than breast milk, unless medically indicated. (A hospital must pay fair market price for all formula and infant feeding supplies that it uses and cannot accept free or heavily discounted formula and supplies)
- 5.49.7 Practice rooming-in – allow mothers and infants to remain together – 24 hours a day.
- 5.49.8 Encourage breastfeeding on demand.
- 5.49.9 Give no artificial teats or pacifiers to breastfeeding infants.
- 5.49.10 Foster the establishment of breastfeeding support groups and refer mothers to them, on discharge from the hospital.

5.50 Compliance with the International Code of Marketing of Breast Milk Substitutes
- 5.50.1 Employees of manufacturers or distributers of breastmilk substitutes, bottles, nipples, and pacifiers have no direct communication with pregnant women and mothers at PMH
- 5.50.2 PMH does not receive free gifts, non-scientific literature, materials, equipment, money, or support for breastfeeding education or events from manufacturers of breastmilk substitutes, bottles, nipples, and pacifiers
- 5.50.3 No pregnant women, mothers, or families are given marketing materials, or samples or gift packs by the facility that consists of breastmilk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for the above items at PMH
- 5.50.4 Any educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drinks other that breastmilk at PMH

6.0 References:

6.1 American Academy of Pediatrics Policy Statement; Breastfeeding and the Use of Human Milk (July 2022)

https://publications.aap.org/pediatrics/article/150/1/e2022057988/188347/Policy-Statement-Breastfeeding-and-the-Use-of?autologincheck=redirected

6.2 American Academy of Pediatrics: Newborn and Infant Breastfeeding (May 2022) https://www.aap.org/en/patient-care/newborn-and-infant-nutrition/newborn-and-infant-breastfeeding/

6.3 Hale, T., Rowe, H., (2023). *Medications & Mother's Milk*, 20th Ed. Hale Publishing

6.4 The Ten Steps to Successful Breastfeeding, Baby Friendly USA, (2024) https://www.babyfriendlyusa.org/for-facilities/practice-guidelines/10-steps-and-international-code/

6.5 Exclusive Breastfeeding, (2024), World Health Organization https://www.who.int/health-topics/breastfeeding#tab=tab_1

6.6 The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies (2013) https://www.cdc.gov/breastfeeding/pdf/bf-guide-508.pdf

6.7 Breastfeeding Initiative: Breastfeeding Model Hospital Policy Recommendations, Fourth Edition, (2022) https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/Hospital-Policy-Recommendations.aspx

6.8 Providing Breastfeeding Support: Model Hospital Policy Recommendations, 4th Ed (2022) https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/CDPH%20Document%20Library/Breastfeeding-Model-Hospital-Policy-Recommendations.pdf

7.0 Attachment list:

7.1 Attachment A – Parent Information Sheet – Supplementation for Late Preterm and Term Breastfed Infants – English

7.2 Attachment B – Parent Information Sheet – Supplementation for Late Preterm and Term Breastfed Infants –Spanish

7.3 Attachment C – Breastfeeding Management Flow Chart for Term Infants

8.0 Summary of Revisions:

8.1 Removed "for lumps" in 3.3.3

8.2 Changed "20 hours of education to 8 hours" and "5 hours to 3 hours" in 5.2.1

8.3 Removed "5 days of order" and changed to first day (24 hours) of order in 5.5

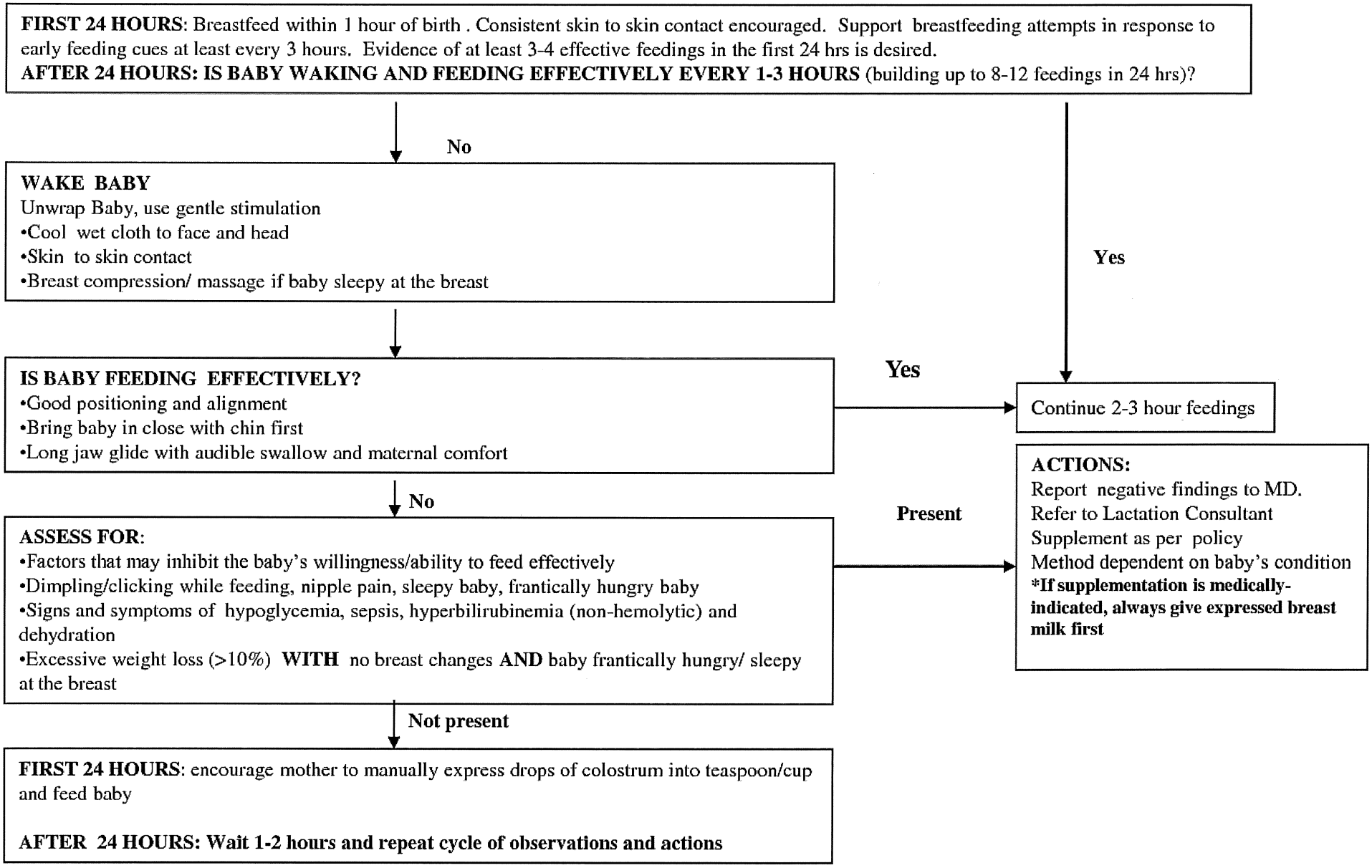
8.4 Changed "infant will be placed skin to skin as soon as the mother is stable enough to respond to the infant" and removed "as soon as possible in 5.11.1

8.5 Added "by the nurse initiating skin to skin" in 5.11.1.5

8.6 Removed "supplemental water, glucose water" in 5.16

8.7 Updated references

BREASTFEEDING MANAGEMENT FLOW CHART FOR TERM INFANTS FOR FIRST 3 DAYS POSTPARTUM (NO MATERNAL RISK FACTORS)



Parent Information Sheet
Supplementation for Late Preterm and Term Breastfed Infants

At Pioneers Memorial Hospital, we do not routinely give breastfed babies any water, sugar water, or formula. We support and educate parents on breastfeeding.

What is supplementation?

- Feedings given in place of, or with, breastfeeding (which may include expressed breast milk, formula, or water).
- Methods of supplementation include:
    - Using a syringe or dropper at the breast
    - Using a syringe with a feeding tube at the breast
    - Feeding with a spoon
    - Feeding with a cup
    - Feeding with a dropper
    - Finger-feeding with a dropper or a syringe with a feeding tube
    - Using a nipple with a wide base and slow flow

Does my baby need supplementation?

- Healthy term newborns rarely need supplementation.
- The American Academy of Pediatrics recommends that breastfed babies should not be given anything except breast milk for at least 6 months unless medically indicated.
- Breastfed babies are only offered supplements when medically needed. (for example, low blood sugar, premature babies, excessive weight loss, or jaundice due to poor feeding.)

What if my baby gets formula or water that is not medically needed?

- Giving any formula changes the kind of bacteria in your baby's intestines.
- The suck on a bottle is different from the suck on a breast. If your baby is fed bottles in the first days of life, a breastfed baby may have problems later latching onto the breast.
- Formula takes longer to digest than human milk. It empties from the stomach slower than breast milk. This increases the time between breast feedings. If your breasts are not emptied often your milk production will go down.

- Research studies have shown feeding a healthy term baby often without supplements encourages early milk production. This will decrease the change of jaundice and provide better weight gain for your infant.
- Early use of formula may increase the risk of allergies.
- While any amount of breastfeeding is better than none, some benefits of breastfeeding are associated with exclusive breastfeeding.
- Exclusive breastfeeding means solely giving your baby breast milk for the first months of life.
- Most breastfed infants will not require any supplementary feedings, but if you have any questions about supplementation, please ask your nurse, lactation consultant, or your baby's physician.

Información Para Pádres

Suplementación para prematuros y recién nacidos sános

En el hospital de Pioneers Memorial Hospital, no subtituimos la lactancia materna por fórmula ó água. Nosotros apoyamos y educamos a los pádres en la maravillosa decisíon de amamantamiento y cercania con su bebé.

¿Qué es la suplementación?

- La suplementacion es reemplasar ó alimentar al bebé con leche maternal, fórmulam ó agua.
- Métodos para la suplementación incluyen:

    - El uso de uan jeringa ó gotero al seno
    - El uso de una jeringa con un tubo de alimentación al seno
    - Alimentación con cuchara
    - Alimentación con una taza
    - Alimentación con un gotero
    - Alimentación del dedo con un gotero o jeringa utilizando un tubo de alimentación
    - Utilizando un pezón de base ancha y flujo lento (pezónera)

¿Mi bebé necesitara suplementación?

- Recién nacidos sános raramente necesitan suplementación
- Es recomendado por La Asociación Americana de Pediatría que los recién nacidos sean alimentados únicamente con leche materna por lo menos seis meses (al menos que sea indicado medicamente)
- A los recién nacidos recibiendo lactancia materna se les ofrece suplementacion únicamente cuando se indique medicamente. (Ejenplo: azúcar baja, prematuro, pérdida de peso excesivo, ó ictericia causada por falta de alimentación).

¿Qué si mi bebé recibe fórmula ó agua sin indicación medica?

- La alimentación con fórmula cambia el tipo de bacterias en los intestinos de su bebé.
- Succionar ó alimentar con botella ó biberon con mamila en los primeros dias de vida, le puede ocacionar problemas al prenderce al seno. La fórmula se queda en el estómago mas tiempo que la leche maternal aumentando al tiempo entre comidas. Si sus sénos no son vaciados, su producción de leche disminurá.

- Estudios de investigación han comprobado que la alimentacion de un recién nacido sáno sin suplementación promueve la produccion de la leche materna. También disminuye la posibilidad de ictericia y proporciona mejor aumento de peso para su recién nacido.
- El uso temprano de fórmula puede aumentar el riesgo de alergias.
- Aunque cualquier cantidad de leche materna es mejor que nada, los beneficios de la lactancia materna son mayores cuando se amamanta exclusivamente.
- La lactancia materna exclusiva significa dar únicamente leche materna por los primeros meses de vida.
- La mayoria de los bebes alimentados con leche materna no requieren suplementación alimenticia . Si tiene alguna pregunta sobre la suplementación, por favor pregúntele a su enfermera, consultora de lactancia, ó a su pediatria.

Imperial Valley Healthcare District

Title: **Organizational Performance Improvement Plan**	Policy No. ADM-00058
	Page 1 of 7
Current Author: Biké Enwezoh	Effective: 12/28/2005
Latest Review/Revision Date: 11/4/2024	Manual: Administrative / Quality

Collaborating Departments: Dr. Su, Dr. Nelson, Administration	Keywords: PI, PDCA, rapid cycle, Quality Plan, QMS, ISO, Quality Management System		
Approval Route: List all required approval			
PSQC 12/2024	Other:		
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 This policy establishes a structured approach to identifying, addressing, and resolving threats to patient outcomes by providing a formal ongoing process by which the organization and stakeholders utilize objective measures to monitor and evaluate quality of service, patient safety and risk reduction strategies. Our hospital commits to the outcomes of safety, quality, good experience, and reasonable efficiency

1.2 To serve as the authorizing document for ISO quality management system by:

- 1.2.1 Identifying policies and objectives related to the quality of products and services provided to patients/customers.
- 1.2.2 Identifies the management representatives' assigned authority and responsibility for implementing and maintaining the policies and objectives
- 1.2.3 Authorizes the procedures which defines plans and process to be established and maintained in support of these policies and procedures
- 1.2.4 Identifies exclusions to ISO 9001-2015

2.0 Scope: District wide

3.0 Policy:

3.1 IVHD will implement an organizational-wide quality assessment and performance improvement efforts to address priorities for improved quality of care, patient safety and risk reduction by ensuring corrective and preventative actions are implemented and evaluated for effectiveness.

3.2 The Organizational Performance Improvement Plan will serve as the Quality Manual for addressing performance improvement, patient safety and risk reduction, IVHD selects projects or similar activities that focus attention on various processes, functions, and areas of the organization.

- 3.2.1 The number and scope of these projects will be prioritized and determined at least annually by the Board with Senior Leadership, as well as the Patient Safety and Quality Committee (PSQC)
- 3.2.2 These projects will be documented to include the rationale for selection and measureable progress achieved.
- 3.2.3 Improvement opportunities may be based on, but not limited to:
  - 3.2.3.1 IVHD's mission, vision, and strategic goals
  - 3.2.3.2 Sentinel Event Activities
  - 3.2.3.3 Root Cause Analysis outcomes

3.2.3.4 Failure, Modes, Effects, and Analysis results
3.2.3.5 Risk Management and insurer's recommendations to minimize risk
3.2.3.6 Direction adjustment in response to unusual or urgent events, including identification and management of sentinel events
3.2.3.7 Internal Audit findings
3.2.3.8 Quality Measures
3.2.3.8.1 The PSQC may request a formal PI project for any measures that are trending negatively, or that have not shown improvement for 3 consecutive quarters.
3.2.3.8.2 Results of study/project will be reported to PSQC until consistent improvement is observed and monitored monthly at the QAPI meetings (sub-committee of PSQC).
3.2.3.8.3 Decision to request a formal PI project will be considered based on feasibility of project, resources and strategic goals priorities.

3.2.4 IVHD Board of Directors and Senior Leadership are accountable and responsible for establishing a culture of continual improvement by dedicating adequate resources for measuring, assessing, improving and sustaining organizational quality, safety, and risk reduction.

3.1 Design and Development (§8.3) of the ISO 9001-2015 standards will be *excluded* from the QMS as IVHD does not design or develop any products or processes for use in the healthcare industry.

3.2 The following documented procedures have been established in accordance to ISO 9001-20015 standards.
3.2.1 Policy *ADM-00074*; *Control of Documents*; §7.5.3.1
3.2.2 Policy *ADM-00073*; *Control of Records*; §7.5.3.2
3.2.3 Policy *ADM-00060; Internal Audits*; §9.2.2
3.2.4 Policy *ADM-00059*; *Control of Nonconforming Product or Service*; §8.7
3.2.5 Policy *ADM-00075*; *Non-Conformity and Corrective Action*; §10.2
3.2.6 Policy *ADM-00076*; *Preventive Action*; §8.5.1

3.3 IVHD Senior Leadership has appointed the Quality Director as the management representative with the responsibilities and authority that include:
3.3.1 Provide staff support to the Organizational Performance Improvement Plan
3.3.2 Assist in coordinating the collection of information needed by the Performance Improvement Program
3.3.3 Uses efficient data gathering procedures, methods and systems that avoid duplication of effort and generation of useless data
3.3.4 Prepares, arranges and displays performance improvement data in meaningful and useful formats for those who must analyze and use the data
3.3.5 Provides guidance and instruction on data availability, gathering procedures, evaluation techniques and external requirement to the Board of Directors, Medical Staff, organizational leadership, and other personnel involved in the Performance Improvement (PI)
3.3.6 Documents the performance improvement activities and prepares complete, timely and reliable reports

3.3.7 Shares reports with Board of Directors, Medical Staff leadership and organizational leadership in an effort to avoid duplication of PI activities

3.4 IVHD Senior Leadership reviews the organizational performance initiatives, at least annually, to ensure its continuing suitability, adequacy and effectiveness

3.4.1 The review assesses opportunities for improvement and the need for changes to the organizational priorities, including quality policies and objectives

3.4.2 Records of Management Review are maintained by the Quality Resource Department.

3.5 Medical Staff Quality Council (MSQC), a multidisciplinary medical staff committee functions to provide feedback regarding prioritization of quality, patient safety and risk reduction initiatives for PI activities.

3.5.1 Hospital wide PI reports are submitted by the Patient Safety Quality Council (PSQC) quarterly for review.

3.6 Patient Safety Quality Council (PSQC), a multidisciplinary committee with representatives of the organization's leadership and medical staff functions to:

3.6.1 Oversee all Performance Improvement (PI) activities in a continual, systematic, and collaborative manner.

3.6.2 Set expectations of organizational PI projects and other measures as delineated by Regulatory Agencies (i.e. AHRQ), the California Department of Public Health (CDPH), Centers for Medicare and Medicaid Services (CMS), and accrediting body based on adopted criteria.

3.6.3 Receive PI reports, assist in analysis or plans of action as necessary, and submit reports to Board of Directors at least annually.

3.6.4 Charter hospital wide PI team projects and Failure Mode Effects Analysis (FMEA), at least annually.

3.6.5 Determine the education and training needs of the organization related to PI and Patient Safety.

3.6.6 Evaluate the effectiveness of PI activities by annually weighing the importance in relation to the mission, risk, volume, problem prone, cost benefit, and regulatory obligations.

3.6.7 Assure credible and thorough root cause analyses (RCA) are performed, action plans implemented; and assessment(s) are completed and reported as scheduled.

3.6.8 Ensure PI reports submitted to Quality Resource Department based on the QAPI Cadance schedule (see Attachment C) at least monthly with quarterly and annual summary-reports due the last day of the month of the following quarter.

3.7 Pioneers Rehabilitation and Wellness Center Quality Management System

3.7.1 The quality management program for this location will be the responsibility of the Pioneers Rehabilitation and Wellness Center Administrator.

3.7.2 The Administrator or designee will be responsible for communicating quality management efforts to IVHD's overall QMS program.

3.7.3 Pioneers Rehabilitation and Wellness Center Administrator will be represented at the PSQC committee.

3.8 Risk Management functions to:

3.8.1 Contribute to PI through risk identification, evaluation, control and education.
3.8.2 Submit reports to Safety Committee and PSQC quarterly and annually.
3.9 Departments and staff functions include:
3.9.1 Submitting PI plan at least annually for priority areas (*Attachment A – Performance Improvement Project Plan*).
3.9.2 Collecting data and documenting activities.
3.9.3 Submitting PI reports to Quality Resource Department at least quarterly with an annual summary (*Attachment B – Performance Improvement Project Report*) reports due on the last day of the month of the following quarter.
3.9.4 Communicating PI activities and results to staff.
3.10 Quality Resource Department functions to:
3.10.1 Provide training and education on Performance Improvement.
3.10.2 Facilitate and centralize the facility's PI efforts.
3.10.3 Assist PI team leaders and members to create PI reports.
3.10.4 Maintain Hospital-wide PI documentation.
3.10.5 Facilitate Monthly Hospital Wide Quality Assurance and Performance Improvement (QAPI) meeting (see Attachment C).
3.11 Compliance Office functions to:
3.11.1 Coordinate IVHD activities related to regulatory compliance
3.11.2 Assist management in the development and implementation of a formal Compliance Program through work with the Compliance Committee and the Board of Directors
3.11.3 Serve as a resource to IVHD areas related to regulatory compliance issues

4.0 Definitions: Not applicable

5.0 Procedure:
5.1 Plan Do Check Act (PDCA) is the organization's systematic method for process improvement.
5.2 The PDCA model looks at how a process is currently performing to meet customer needs and expectations, as well as to plan changes for improvement (see Table 1 on page 5).
5.3 Rapid Cycle PDCA
5.3.1 Uses the PDCA model, on a smaller, more frequent scale, i.e. multiple cycles in rapid succession.
5.3.2 Uses small data samples to test change in rapid succession – "What can we do by next Tuesday?"
5.3.3 Tests ideas side by side with existing processes or sequentially.
5.3.4 Guidelines for Rapid Cycle PDCA use:
5.3.4.1 When a quick change is needed
5.3.4.2 When baseline measurements already exist
5.3.4.3 When there are multiple ideas to test
5.3.4.4 When change ideas are not expensive, invasive, or hard to reverse
5.4 PI Measures

5.4.1 Data and Data Collection
- 5.4.1.1 Data and monitoring performance is the foundation of PI activities.
- 5.4.1.2 Data provides information for informed decisions, identifying opportunities or need to redesign.
- 5.4.1.3 Data parameters and criteria for measurement are explicitly defined.
- 5.4.1.4 Data criteria are periodically reviewed and evaluated against internal aggregate information, external benchmarks, and organizational objectives.
- 5.4.1.5 Data collection, when possible, should be incorporated into daily work processes.

5.4.2 Aggregate and Analyze Data
- 5.4.2.1 Data obtained is interpreted in order to measure performance, analyze variation, and determine a course of action when indicated.
- 5.4.2.2 Analytical statistical techniques and tools are used appropriately in the assessment process.
- 5.4.2.3 Analysis process incorporates four basic comparisons:
  - 5.4.2.3.1 Performance over time internally run charts or longitudinal study
  - 5.4.2.3.2 Comparable organizations with similar processes-benchmarks
  - 5.4.2.3.3 Standards – CDPH, CMS, etc.
  - 5.4.2.3.4 Best practices-evidence based research

5.4.3 Performance Measures or Indicators can arise from multiple areas including but not limited to:
- 5.4.3.1 PSQC recommendations and Quality or Organization Strategic Plan
- 5.4.3.2 Patient Satisfaction surveys or physician and employee satisfaction reports
- 5.4.3.3 Medical record review and monitoring
- 5.4.3.4 Regulatory standards and Hospital Quality/Core Measures
- 5.4.3.5 Outcome management and case management performance
- 5.4.3.6 Peer Review or Medical Staff indicators
- 5.4.3.7 Accreditation Survey findings
- 5.4.3.8 Current processes-high risk, high-volume, problem prone and trigger tools if applicable
- 5.4.3.9 Patient and Environmental Safety rounds
- 5.4.3.10 Risk Management findings
- 5.4.3.11 Compliance auditing & monitoring activities

5.4.4 The Systematic Process PI Methodology
- 5.4.4.1 Define the Opportunity
- 5.4.4.2 Analyze Current State
- 5.4.4.3 Identify Root Causes
- 5.4.4.4 Design Future State
- 5.4.4.5 Improve and Sustain: Improvement and design/redesign methods include Lean Six-Sigma, RCA, Data Analysis, Organizational Development, Change Acceleration Process.

5.5 Program Evaluation

5.5.1 The Performance Improvement Plan is reviewed and approved by the PSQC and Board of Directors annually.

5.5.2 The effectiveness of PI activities and special teams is evaluated by PSQC annually.

5.6 Training and Education

5.6.1 Process Improvement education will be provided during annual orientation and as needed before the start of a PI project.

5.7 Confidentiality of Information

5.7.1 Appropriate safeguards restrict access to highly sensitive and confidential PI information protected against disclosure and discoverability through California Evidence Code Sections1145 and 1157, and HIPAA.

Table 1

Plan	• Identify a problem or opportunity to improve and the dimension of performance affected • Prioritize with consideration of high volume, risk, cost and problem prone opportunities • Establish baseline data and determine methods for data collection • Set a goal or establish a target or benchmark • Determine individuals or teams to be involved • Develop an implementation plan
Do	• Implement the change • Carry out a test (see rapid cycle) • Document procedures and observations • Gather data to track progress
Check	• Analyze data and compare to target or benchmark • Evaluate the impact of the change by plotting data over time; i.e. run chart or longitudinal data • Determine if improvement has occurred • If results are not as expected, skip ACT and return to PLAN
Act	• Adopt or maintain the change • Determine what changes must be permanent • Identify the support structures necessary to complete or maintain the gains • If necessary to abandon the change, return to PLAN

6.0 References:

6.1 DNV-NIAHIO Standard QM.1, QM.3, QM.6, QM.7 and QM.8

6.2 American National Standard ANSI/ISO/ASQ Q9001-2015

6.3 California Evidence Code §1145

6.4 California Evidence Code §1157

7.0 Attachment List:

7.1 Attachment A – Performance Improvement Project Plan

7.2 Attachment B – Performance Improvement Project Report
7.3 Attachment C – Quality Assurance and Performance Improvement (QAPI) Cadance
7.4 Attachment D – QAPI Reporting Template
7.5 Attachment E - PDCA Cycle Diagram
7.6 Attachment F – Lean Six Sigma Methodology Diagram

8.0 Summary of Revisions:

8.1 Updated Current Author
8.2 Updated Revision Date
8.3 Updated 3.2.3.8.2
8.4 Updated 3.6.2 and 3.6.8
8.5 Deleted 3.8
8.6 Added 3.11.5
8.7 Added 5.4.3.11
8.8 Added 5.4.4 (new) and its sub bullets
8.9 Updated 5.6.1
8.10 Added attachments C, D, E, F
8.11 Updated 1.1

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Performance Improvement Project Title - Year

Department:

Goals/Description:

Why it is important: (regulatory, strategic, financial, pt. safety, etc.)

Team Leader:

Team Members:

Data Source:

Data Abstractor:

Frequency of review/reporting:

Key Processes (steps/elements to improve or required elements)	**Description** (how are you going to do this)	**Target/Goal**

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Title of your project

Reporting Period (mm/dd/yyyy through mm/dd/yyyy)

Goal:
Type what did you wanted to accomplish here

Why it is important:
type your reason for selecting this project (strategic, financial, patient safety, regulatory, etc.)

Analysis:
type your analysis – what does the data say/show?

True Cause:
Type your root cause of why you did not meet your defined goal/goals

Actions:
type your actions here – what did you do according to the data you captured, what actions did you take to improve or continue your improvement?

Paste or type your graph title here (delete of none)

Paste your graph here

Submitted by:
Date:

PIONEERS MEMORIAL HEALTHCARE DISTRICT

QAPI - 2025

Quality Improvement Activities				JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Cardiology	PI/DNV	PIC	Catalina Holt	x			x			x			x		
Respiratory Therapy	PI/DNV	PIC	Catalina Holt	x			x			x			x		
Work Place Violence	OSHA/CDC	PIC	Jorge Mendoza	x			x			x			x		
Environment of Care	OSHA/CMS	PIC	Jorge Mendoza	x			x			x			x		
FANS (food & nutrition srvcs)	PI/DNV/CMS	PIC	Jenna Middleton	x			x			x			x		
Imaging Services /Nuc.Med./MRI/CT	PI/DNV	PIC	Derek Tapia/AndresGarcia	x			x			x			x		
Bio-Med	PI/DNV	PIC	Mario Garcia	x			x			x			x		
Therapy Services	PI/DNV	PIC	Mimi Viray	x			x			x			x		
Risk - Complaints & Events Analysis	System Initiative/CMS	PIC	Merlina Esparza	x			x			x			x		
Medication Diversion (errors)/Narcotic	DNV/CMS	PIC	Liz Reyes/Pharmacy	x			x			x			x		
Antimicrobial Stewardship (P&T)	DNV/CMS	PIC	John Teague	x			x			x			x		
Patient Safety Reports/Teams				**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
Sepsis	System Initiative/CMS	PIC	Jeanine Mora		x			x			x			x	
Perinatal	CMS/CMQCC	PIC	Alexis Garcia		x			x			x			x	
Suicide Prevention/Risk (IP) - pending	CMS		Gerry Ibarra		x			x			x			x	
Anticoagulant (Nursing-Heparin)	DNV/CMS	PIC	Gerrry Ibarra		x			x			x			x	
Dialysis	DNV/CMS	PIC	Vendor/Gerry Ibarra		x			x			x			x	
ED - Suicide Risk/Behavorial Restraints,	DNV/CMS	PIC	Osman Valencia		x			x			x			x	
Resuscitation Outcomes	DNV/CMS	PIC	Osman Valencia		x			x			x			x	
Stroke	DNV/CMS	PIC	Osman Valencia		x			x			x			x	
Procedural Areas/High Level Disinfection	DNV/CMS	PIC	Erika Arias/Michael Cajigas		x			x			x			x	
Medication Reconcilliation	DNV/CMS	PIC	Nursing/Med Staff		x			x			x			x	
Med. Staff Monitoring Functions		**Reports to**	**Leader**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
Communication /Patient Identification	CMS/JC	PIC	Annabel Limentang			x			x			x			x
Blood & Blood Component/Tissue	CMS/JC	PIC	Annabel Limentang			x			x			x			x
Organ Procurement	CMS	PIC	Vendor/Gerry Ibarra			x			x			x			x
IP Restraints	DNV	PIC	Gerrry Ibarra			x			x			x			x
Utilization Management	CMS	PIC	Ashraf Malik			x			x			x			x
Infection Control Metrics/EVS	System Initiative/CMS	PIC	Angela McElvaney			x			x			x			x
HIM Metrics	CMS	PIC	Lorena Santana			x			x			x			x
Pediatrics/NICU	CPQCC/AHRQ	PIC	Fidelita Cortes			x			x			x			x
Security	OSHA/CMS	PIC	Jorge Mendoza			x			x			x			x
Health Equity	System Initiative/CMS	PIC	CEO?			x			x			x			x
Pioneers 2024 Quality SPlan & Board Goals				**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
Patient Experience (HCAHPS)	System Initiative/CMS	PIC	Carol Bojorquez / Biké Enwezoh	x	x	x	x	x	x	x	x	x	x	x	x
Fall Prevention (Progressive Mobility)	System Initiative/CMS	PIC	Gerry Ibarra	x	x	x	x	x	x	x	x	x	x	x	x
Pressure Ulcer Prevention (HAPU)/Wound Care	System Initiative/CMS	PIC	Gerry Ibarra	x	x	x	x	x	x	x	x	x	x	x	x
Through-put/Patient Flow (IP/ED)	System Initiative/CMS	PIC	Osman Valencia	x	x	x	x	x	x	x	x	x	x	x	x
CMS/DNV Metrics/PI				**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
EKG Timeliness	DNV	PIC	Osman Valencia	x	x	x	x	x	x	x	x	x	x	x	x
Transfers ED	DNV	PIC	Osman Valencia	x	x	x	x	x	x	x	x	x	x	x	x
Pain Management/Reassesment	DNV	PIC	Gerrry Ibarra	x	x	x	x	x	x	x	x	x	x	x	x
HR/Employee Health	DNV	PIC	Charity Dale / Lizbette Cordova	x	x	x	x	x	x	x	x	x	x	x	x
Chart Prep for QIP	System Initiative	PIC	Laura Green/Israel Samaniego	x	x	x	x	x	x	x	x	x	x	x	x

PIONEERS MEMORIAL HEALTHCARE DISTRICT
QAPI - 2025

Department: Emergency Department (SR/Restraints)																			
Metric/Indicator (Rationale - Regulatory)	Baseline (CY 2023)	Jan	Feb	Mar	Q1	April	May	June	Q2	July	Aug	Sept	Q3	Oct	Nov	Dec	Q4	Year End 2024	Target
ED SUICIDE RISK																			
C-SSRS tool	New																		95%
Reassessments Q 15 minutes	New																		95%
ED BEHAVIOURAL RESTRAINTS																			
Behavioral Restraints Overall	New																		90%
Q15mins	New																		90%

PDCA				
	Q1 Analysis	Q2 Analysis	Q3 Analysis	Q4 and Year End Analysis
Plan: Establish Plan of Action & Measure, Goals/Success Criteria (identify baseline & target goal) - what are some of the barriers & challenges. Plan to get better metrics (maybe change in existing process),				
Do: Implement Program/Project (test pilot) - Progress (what are the highlights from the past 30 days?). Doing to meet goal (do small test run)				
Check: Measure Actual Outcomes Against Planned . Check/Study – analyze result and see if close to goal				
Act: Next Steps:Suggest Improvements (either adjust, adopt or abandon). Act – based on lesson learned, plan for next step or keep as std. (sustainment)				

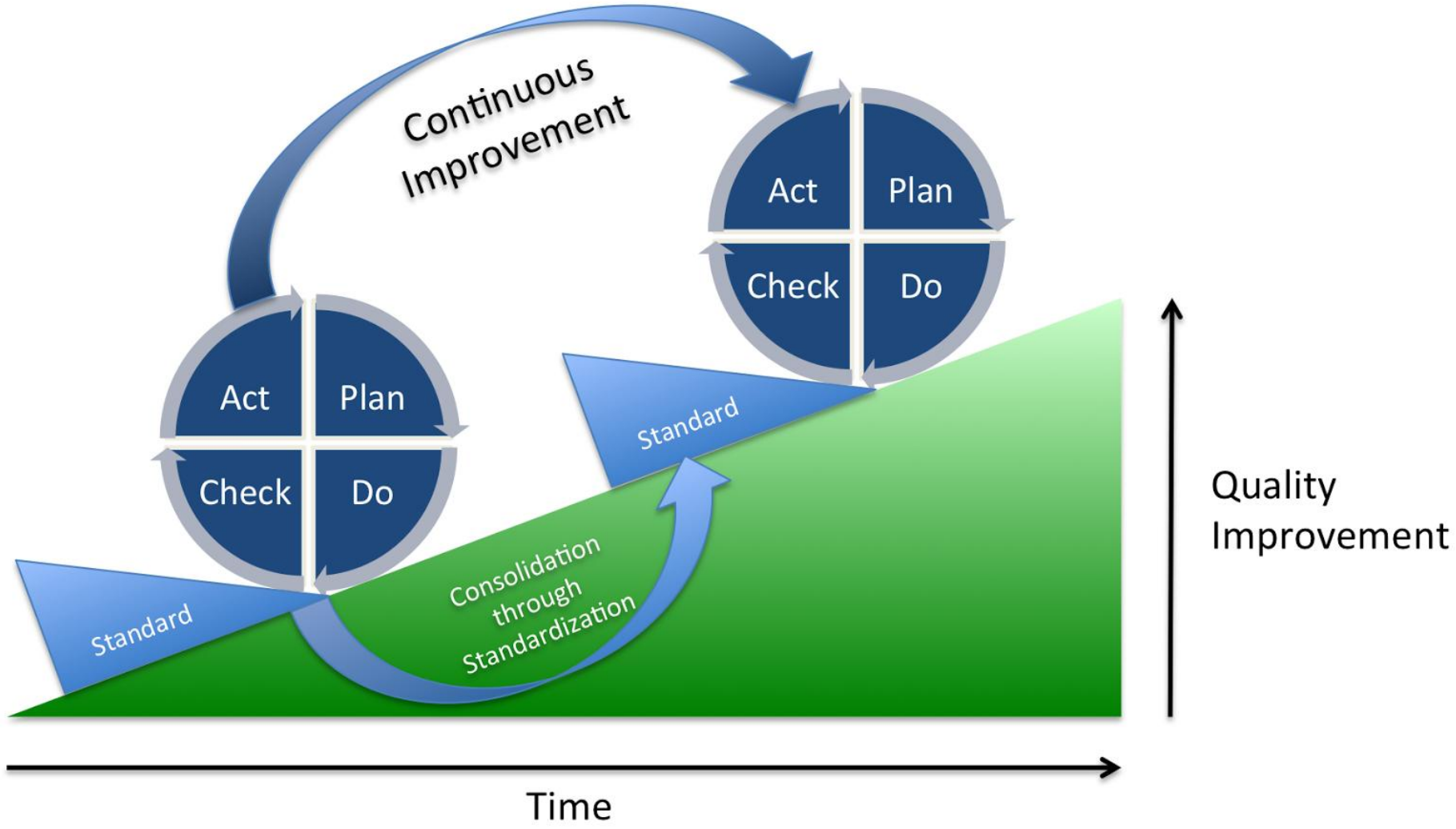
PDCA Cycle

Plan Phase:
Establish Plan of Action & Measure, Goals/Success Criteria (identify baseline & target goal)

Do Phase:
Implement Program/Project (test pilot)

Check Phase:
Measure Actual Outcomes Against Planned

Act Phase:
Suggest Improvements (either adjust, adopt or abandon)



Lean Six Sigma Methodology

DMAIC

Establish problem statement, governance and team, Voice of customer, scope, stakeholders

Identify current performance baseline, validate measurement system, define capability and stability

Identify root causes validate with data, hypothesis testing

Identify improvements based on analyse phase, pilot run PDSA cycles, implement solutions, confirm improvement

Ensure systems and process are in place to sustain new performance

Imperial Valley Healthcare District

Title: **Quality Review Report**	Policy No. ADM-00481
	Page 1 of 4
Current Author/Reviewer: Bike Enwezoh and Merlina Esparza	Effective: 12/02/1998
Latest Review/Revision Date: 9/24/2024	Manual: Administrative

Collaborating Departments: Dr. Su, Dr. Nelson Quality Resource	Keywords: QRR, incident report, variance report		
Approval Route: List all required approval			
PSQC 12/2024	Other:		
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 provide a mechanism for communicating incidents or adverse events, including near misses that potentially or actually affect the quality of patient care, patient safety and/or safety in general

1.2 To aggregate data from Quality Review Reports (QRR) for identifying trends and/or significant quality of care issues, that can lead to performance improvement activities.

2.0 Scope: District Wide

3.0 Policy:

3.1 QRR data is a source of quality measurement provided to the Medical Staff committees, Patient Safety Quality Council and the Board of Directors.

3.2 QRRs will be completed via Remote Data Entry (Attachment A: Remote Data Entry-QRR)

3.2.1 In the event QRR submission is not available electronically, paper QRRs may be completed.

3.2.2 Paper QRR forms are located in the Quality/Risk Department and on clinical units in computer downtime folders.

3.3 A QRR should be completed within 24 hours by a hospital employee or medical staff member who was directly involved or discovered the occurrence.

3.4 Information documented in the report must be factual and objective, inappropriate comments that place blame or establish negligence shall be avoided.

3.5 Once a QRR is submitted an email notification will be sent to the location director/designee.

3.6 QRRs will be entered under patients' name when care is affected

3.7 The location director/designee will investigate and document findings, as well as plan of correction if warranted.

3.8 All QRRs will be visible to the Quality/Risk Department via the electronic database.

3.9 Sentinel Events, Never Events or incidents causing patient harm must be reported via phone IMMEDIATELY to Administration and Quality/Risk Department in addition to completing a QRR (See policy #ADM-00480, Sentinel Event Policy).

3.10 An incident or adverse event reported on a QRR that has the potential to become a claim against the organization will be marked on the QRR as "potential litigation", examples include but are not limited to:

3.10.1 Falls resulting in any type of injury
3.10.2 Medication Errors resulting in any type of reactions or injury regardless of the severity
3.10.3 Injuries resulting from restraints
3.10.4 Any patient, visitor or physician injuries while on the organizations premises
3.10.5 Any provision of care or procedures resulting injury or harm
3.10.6 Incorrect diagnosis, diagnostic readings or interpretations resulting in injury or harm
3.10.7 Blood component transfusion reactions
3.10.8 Any instance resulting in injury to a person on the hospital premises
3.10.9 Any instance were a threat of suit is verbally voiced
3.10.10 Disruptive behavior by physician or employee
3.10.11 Allegations of harassment of any type which may potentially lead to legal action
3.10.12 Inappropriate documentation by physician or employee
3.10.13 Sentinel Events and Never 28 events.

3.11 The organizations liability carrier (Beta Healthcare Group) will be notified of any potential risk for litigation (See policy # ADM-00477, Claims Management).

3.12 QRRs are not used in lieu of workers compensation claim for reporting an employee injury.

3.13 QRRs prepared by employees and medical staff will be protected from discovery by California Evidence Code 1157.
3.13.1 The privilege of confidentiality may be waived, if the report is disclosed to anyone other than hospital personnel or members of the medical staff or if subpoenaed.

3.14 The QRR is intended to be protected by attorney-client privilege and must not be disclosed to anyone outside the administrative/risk management department.

3.15 To ensure confidentiality, QRRs must NOT be:
3.15.1 Completed by or shared with a patient or visitor
3.15.2 Disclosed to a patient or visitor upon initiation or completion
3.15.3 Made reference to in the medical record
3.15.4 Made reference to in the employee's personnel record
3.15.5 Openly displayed, e.g., left out on a nursing unit desk, left open on computer screen
3.15.6 Removed from the premises
3.15.7 Copied, duplicated or printed in any way

3.16 The Quality/Risk Department will oversee the reporting process to ensure appropriate documentation and referral, including incidences requiring medical staff peer review.

3.17 The Quality/Risk Department will trend QRR data and report to Patient Safety Quality Council and Medical Staff Committees to facilitate continual improvement in patient safety and quality care.

3.18 QRRs will be addressed timely by the Department Director or Designee.
3.18.1 Initial acknowledgment/investigation will occur within 2 business days.
3.18.2 Final Resolution will occur within 14 days

3.18.2.1 Quality/ Risk Management may extend 14-day time frame to up to 30 days, due to extenuating circumstances.

4.0 Definitions:

4.1 Adverse Event – A negative result stemming from medical intervention

4.2 Sentinel Event – An unexpected occurrence, not related to the normal course of illness or condition, involving death or serious physical or psychological harm or the risk thereof (any process variation for which a reoccurrence would carry a significant chance of a serious adverse outcome). Serious injury specifically includes loss of limb or function.

4.3 Never Event – An adverse event or series of events that cause the death or serious disability of a patient, personnel or visitor.

4.4 Near Miss – A process variation which did not affect an outcome, but a reoccurrence carries a significant change of serious adverse outcome.

4.5 Human Error – Inadvertent action; lapse, mistake

4.6 At Risk Behavior – A choice: risk not recognized or believed justified.

4.7 Reckless Behavior – Conscious disregard of unreasonable risk (Note: Repetitive at-risk behaviors may become reckless but manager must rule out system's contribution to the repetitive behaviors)

5.0 Procedure:

5.1 Access the Quality Review Report (QRR) via the hospital's intranet (See Attachment-Remote Data Entry (RDE)-QRR (Risk Event).

5.1.1 After 20 minutes the program will close and information will not be saved and the process will need to be restarted.

5.2 Complete all required information in the designated spaces, required areas will be identified by **bold text.**

5.3 Select the risk category that is most applicable to the incident.

5.4 Enter the event date, may use calendar on the right.

5.5 Select patient or non-patient.

5.5.1 If the incident potentially or actually affects a patient enter the patient name not the name of employee who provided or failed to provide care.

5.5.2 If the incident involves a visitor, volunteer, physician or other, choose non-patient, write in the person's name or department, and identifying type.

5.5.3 If entering for equipment, enter the name of the equipment and the identification number is applicable.

5.6 Enter time of occurrence using military time.

5.7 Enter location of occurrence.

5.7.1 May click magnifying glass on the right-hand side of the screen and choose the location from the drop down menu.

5.8 Complete patient/family information if applicable.

5.9 Enter employee and non-employee witnesses in the assigned areas.

5.9.1 The person reporting and/or witnessing the incident should be listed.

5.10 Comments are to be typed in the designated area and must include all pertinent facts.
5.11 Do not assign blame or establish negligence.
5.12 When reporting medication errors the name of the drug must be documented.
5.13 Once submitted, the director/designee, or Risk Manager will select the severity of outcome after the incident is investigated, if it is not immediately known.
5.14 As part of the investigation process the Director will also conduct an investigation and determine the type of behavior that led to the event objectively using the three classifications of behaviors: Human Error, At Risk Behavior, and Reckless Behavior. If it is applicable to the event.

6.0 References:

6.1 Policy # ADM-00480 Sentinel Event Policy
6.2 Policy # ADM-00477 Claims Management
6.3 California Senate Bill 1301
6.4 California Evidence Code 1157

7.0 Attachment List:

7.1 Attachment A – Remote Data Entry (RDE)-QRR (Risk Events)
7.2 Attachment B – Quality Review Report: Investigation, Documentation & Corrective Action

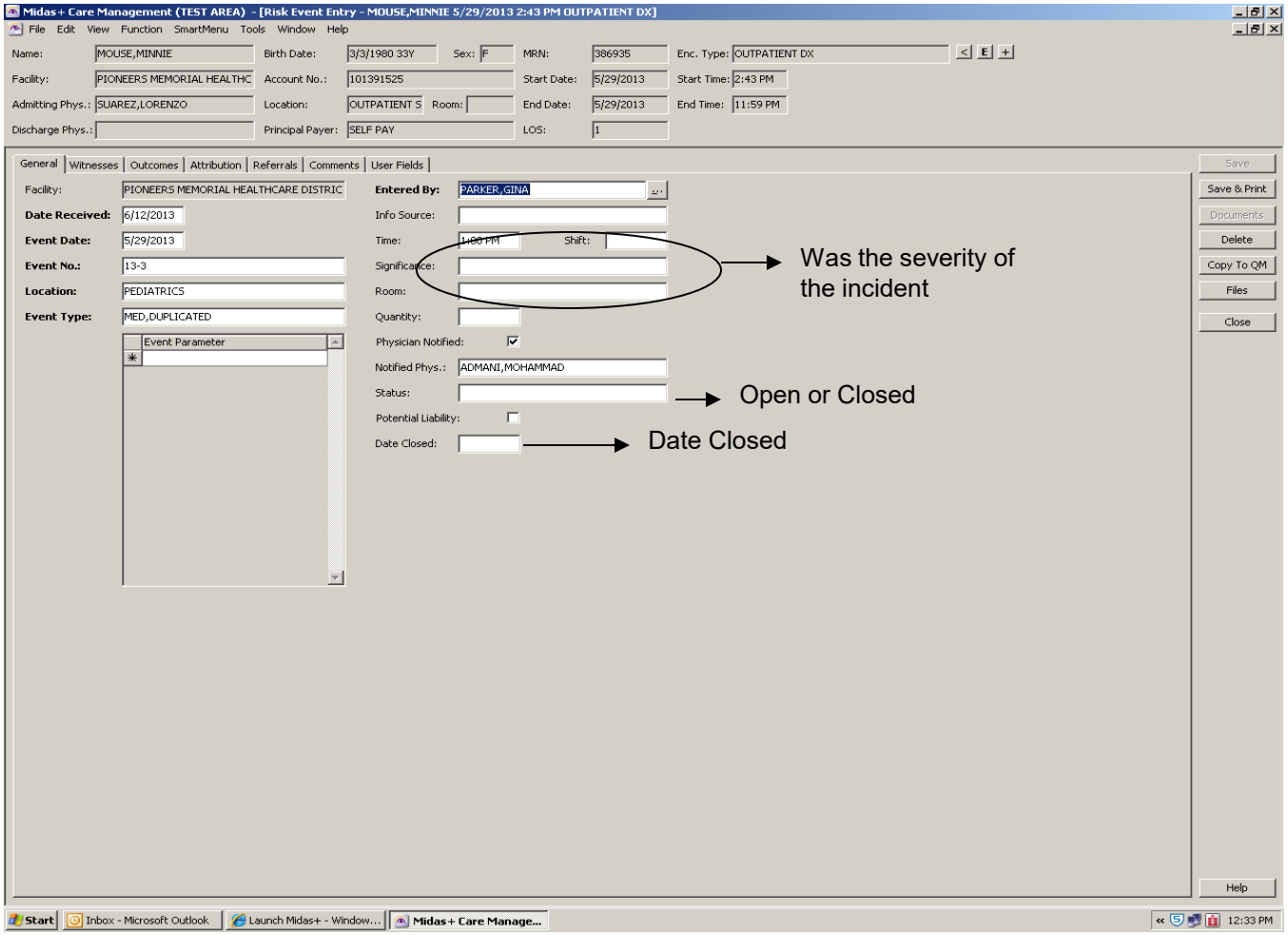
8.0 Summary of Revisions:

8.1 Updated Current Author/Reviewer
8.2 Updated date of latest review

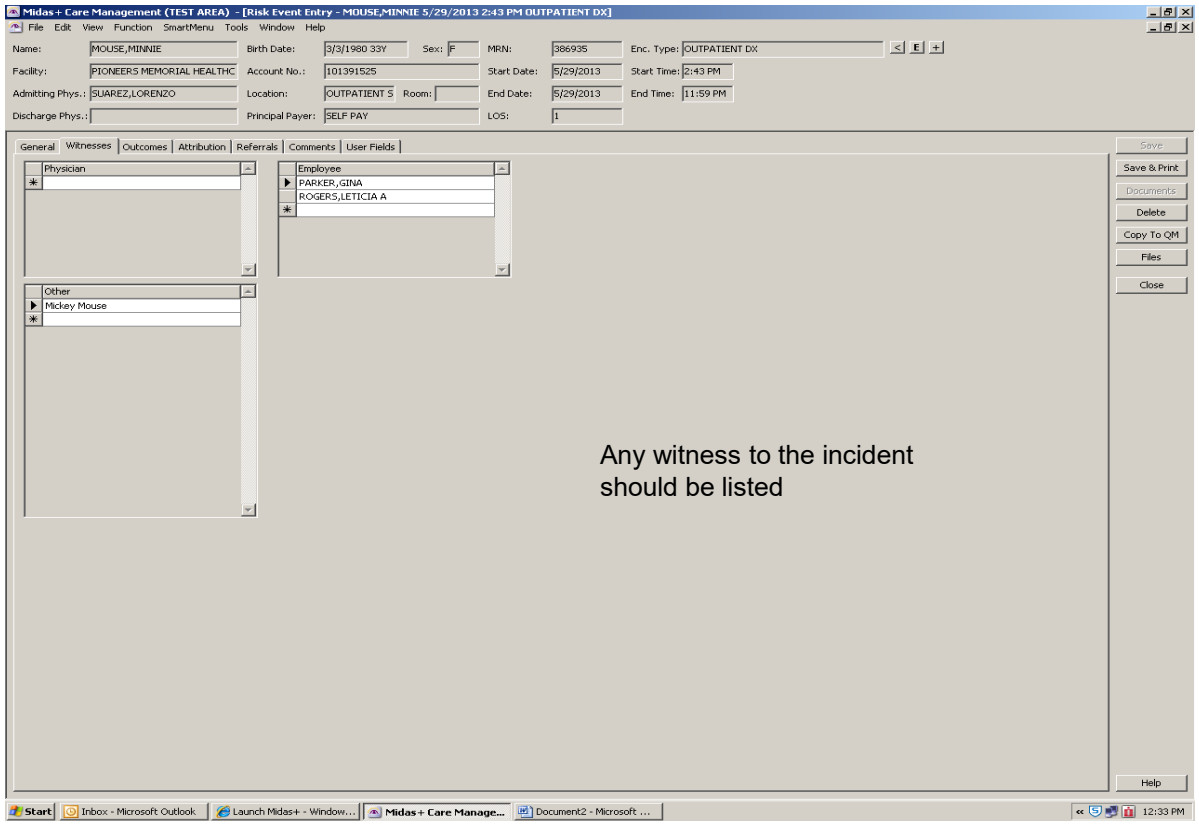
Quality Review Report: Investigation, Documentation and Corrective Action

2013

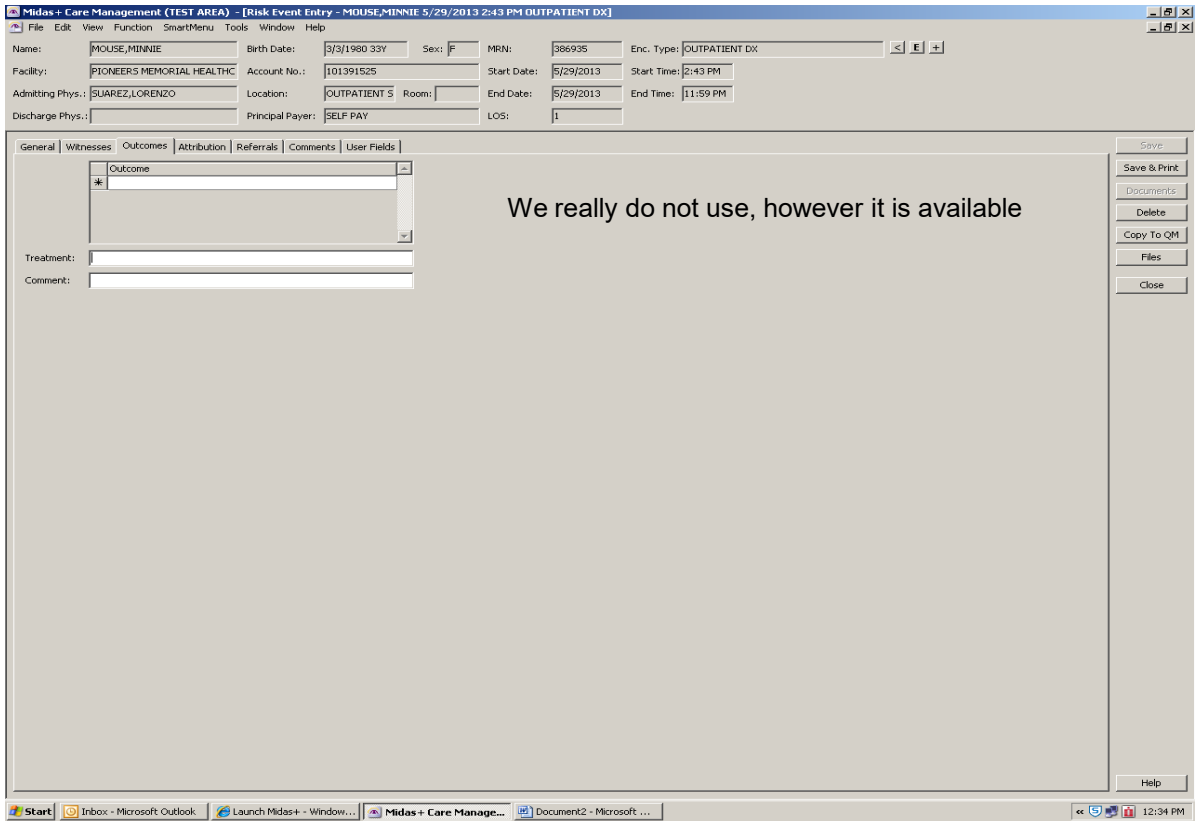
General Tab


Midas+ Care Management (TEST AREA) - [Risk Event Entry - MOUSE,MINNIE 5/29/2013 2:43 PM OUTPATIENT DX]
File Edit View Function SmartMenu Tools Window Help
Name: MOUSE,MINNIE
Birth Date: 3/3/1980 33Y
Sex: F
MRN: 386935
Enc. Type: OUTPATIENT DX
Facility: PIONEERS MEMORIAL HEALTHC
Account No.: 101391525
Start Date: 5/29/2013
Start Time: 2:43 PM
Admitting Phys.: SUAREZ,LORENZO
Location: OUTPATIENT S
Room:
End Date: 5/29/2013
End Time: 11:59 PM
Discharge Phys.:
Principal Payer: SELF PAY
LOS: 1
General
Witnesses
Outcomes
Attribution
Referrals
Comments
User Fields
Facility: PIONEERS MEMORIAL HEALTHCARE DISTRIC
Date Received: 6/12/2013
Event Date: 5/29/2013
Event No.: 13-3
Location: PEDIATRICS
Event Type: MED,DUPLICATED
Event Parameter
Entered By: PARKER,GINA
Info Source:
Time: 1:00 PM
Shift:
Significance:
Room:
Quantity:
Physician Notified:
Notified Phys.: ADMANI,MOHAMMAD
Status:
Potential Liability:
Date Closed:
Was the severity of the incident
Open or Closed
Date Closed
Save
Save & Print
Documents
Delete
Copy To QM
Files
Close
Help
Start
Inbox - Microsoft Outlook
Launch Midas+ - Window...
Midas+ Care Manage...
12:33 PM

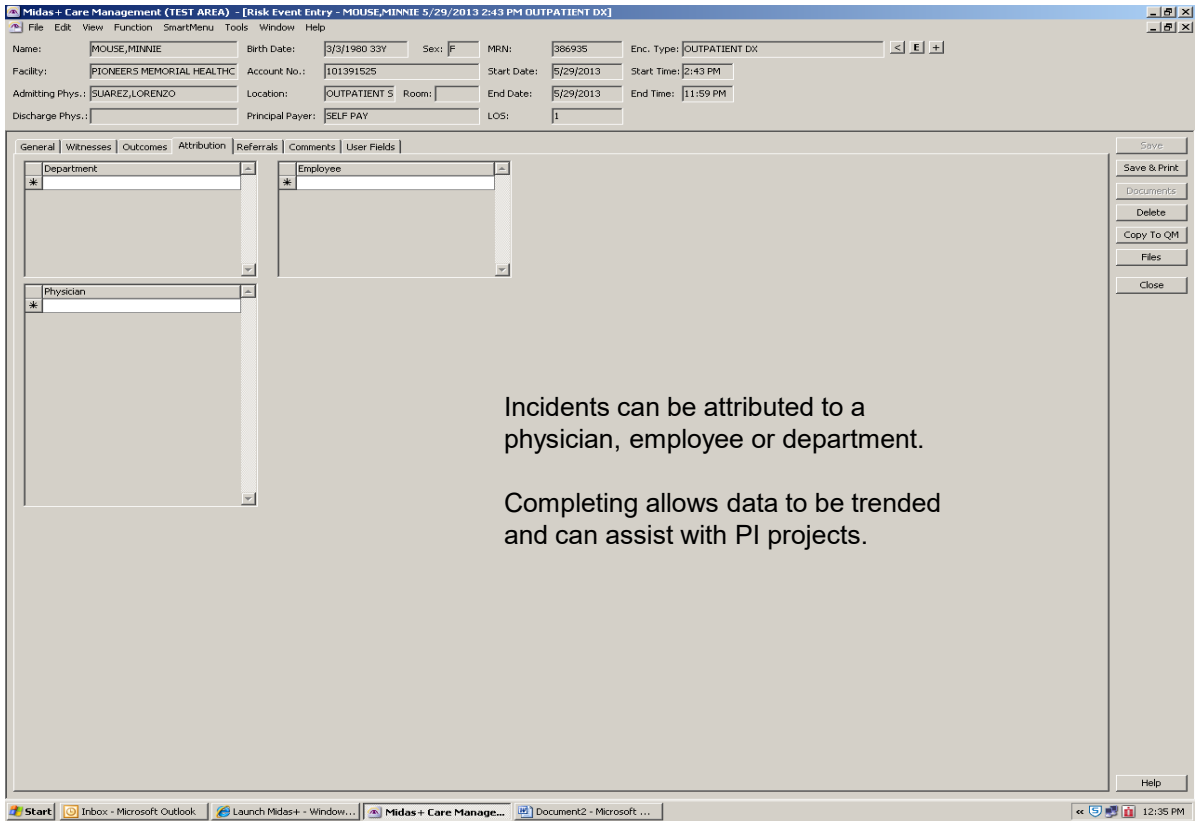
Witnesses Tab



Outcomes Tab



Attribution



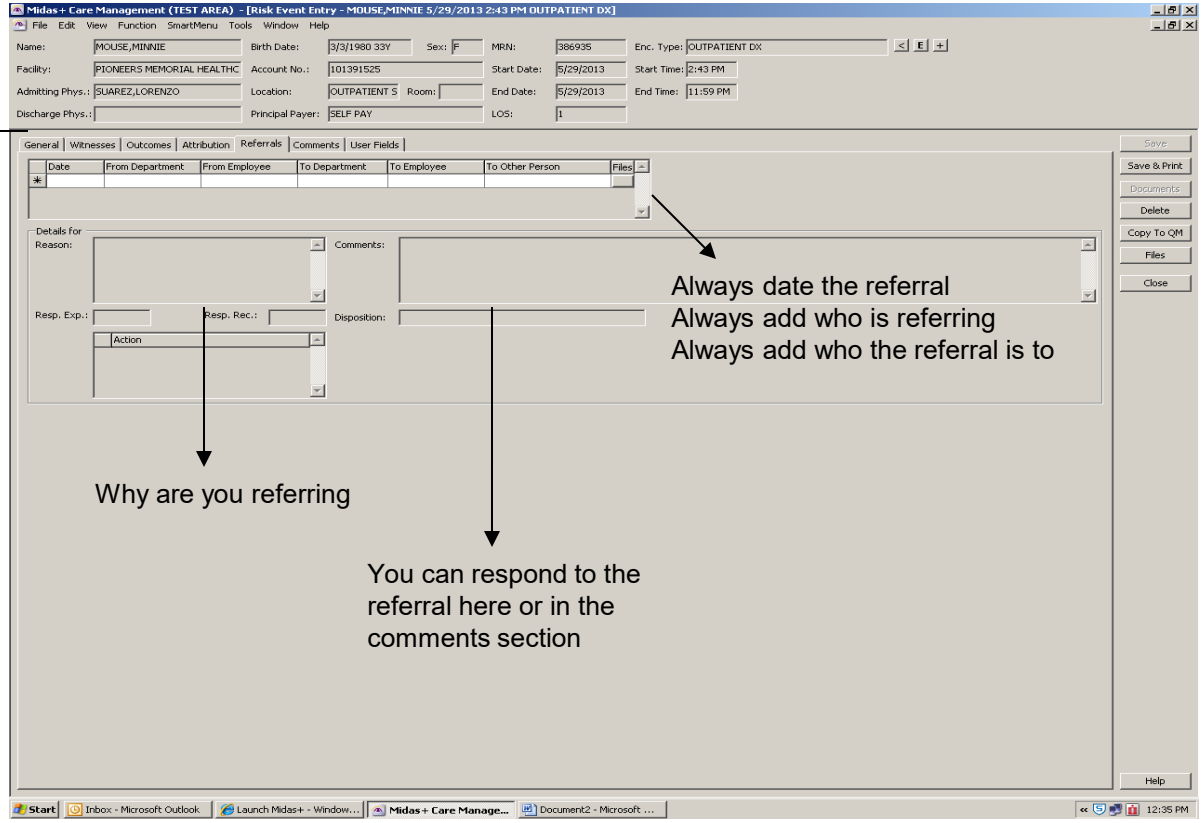
Incidents can be attributed to a physician, employee or department.

Completing allows data to be trended and can assist with PI projects.

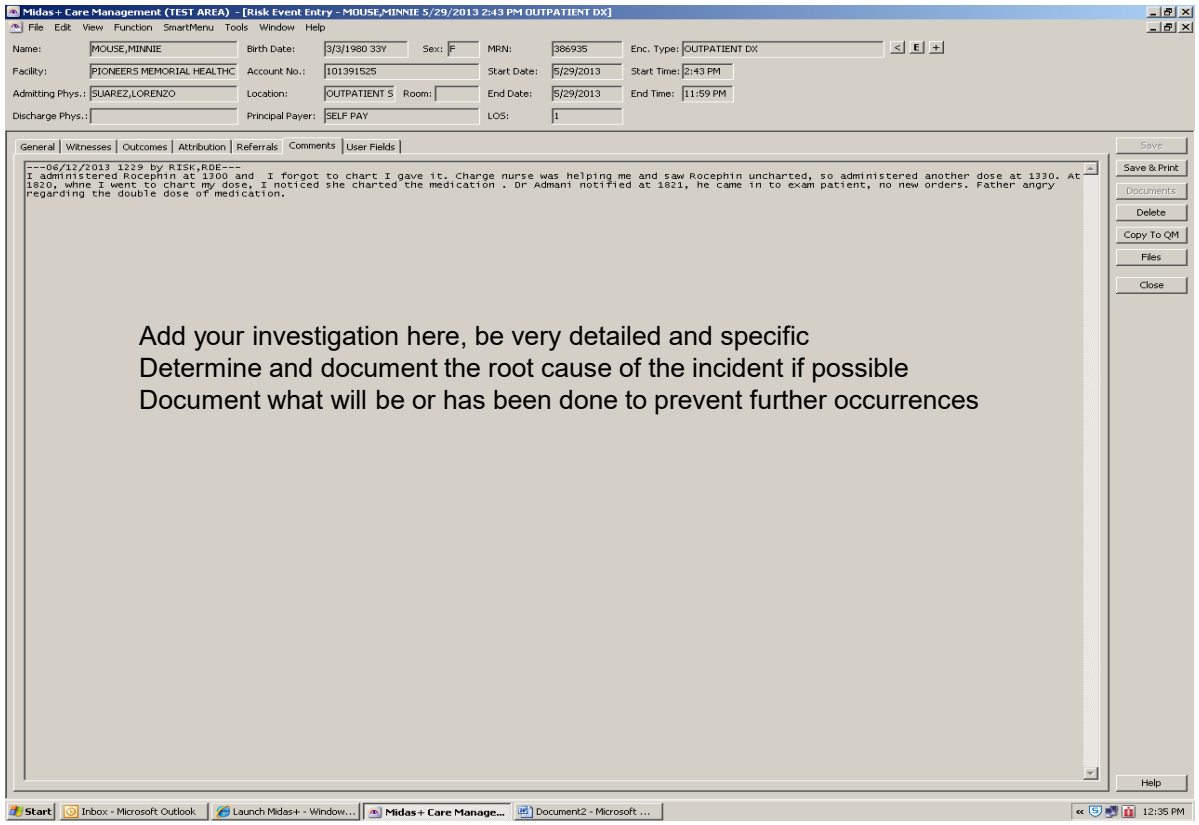
Referrals Tab (my personal favorite)

Never refer to a department

Click on the arrow for “Details for Reason” and “Comments”



Comments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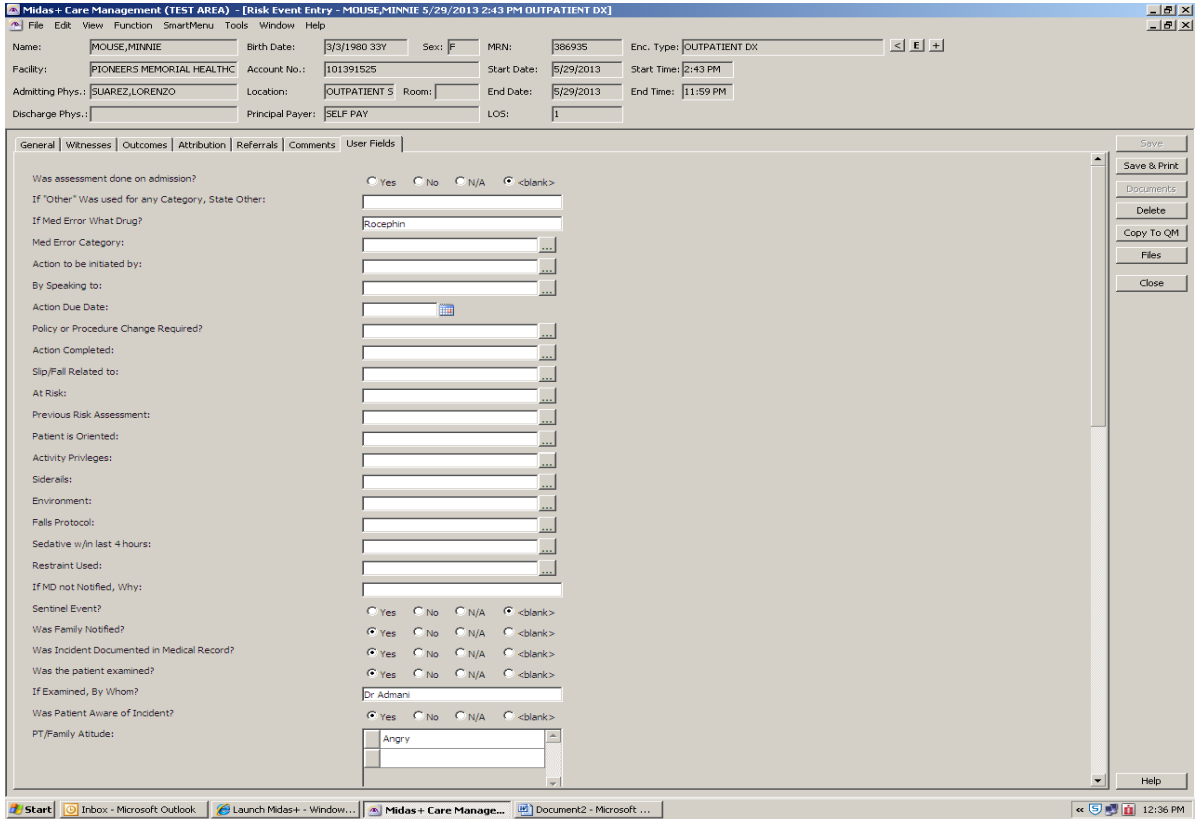
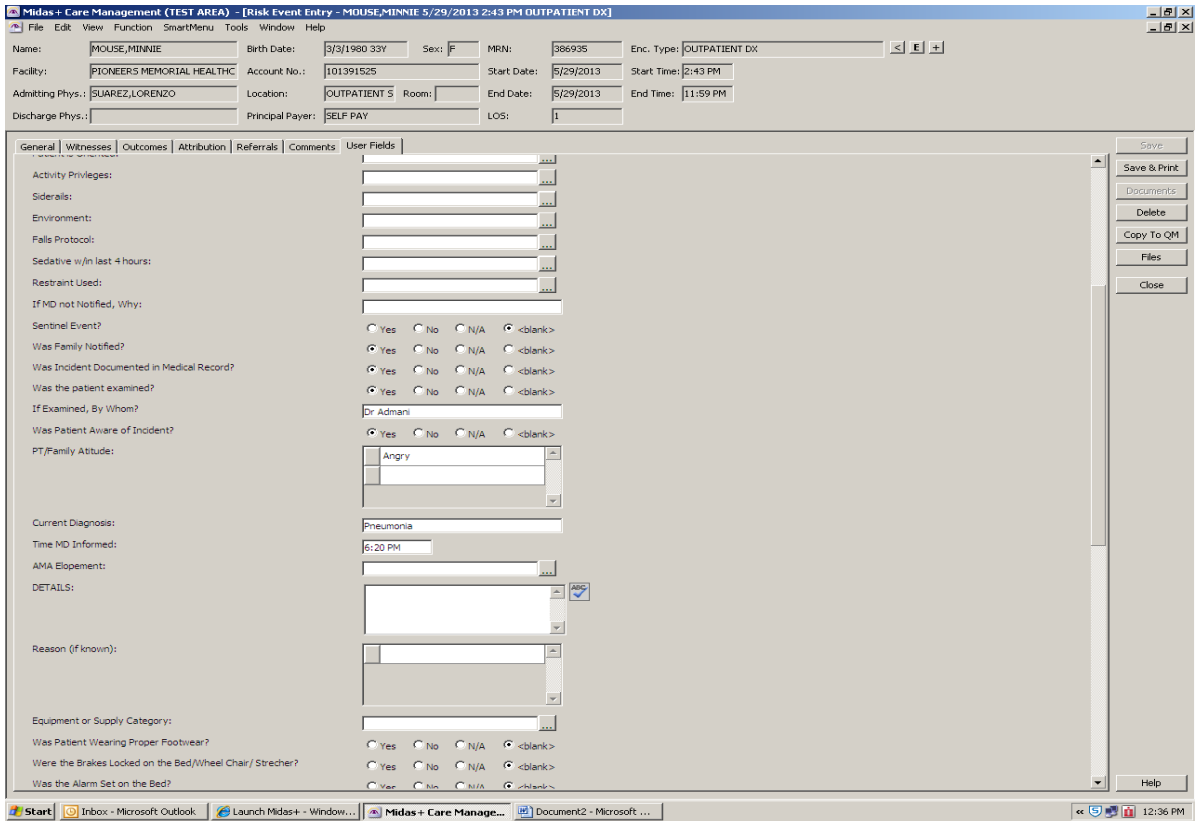
End Time: 11:59 PM
Discharge Phys.:
Principal Payer: SELF PAY
LOS: 1
General Witnesses Outcomes Attribution Referrals Comments User Fields
---06/12/2013 1229 by RISK,RDE---
I administered Rocephin at 1300 and I forgot to chart I gave it. Charge nurse was helping me and saw Rocephin uncharted, so administered another dose at 1330. At 1820, whne I went to chart my dose, I noticed she charted the medication . Dr Admani notified at 1821, he came in to exam patient, no new orders. Father angry regarding the double dose of medication.
Save
Save & Print
Documents
Delete
Copy To QM
Files
Close
Help
Add your investigation here, be very detailed and specific
Determine and document the root cause of the incident if possible
Document what will be or has been done to prevent further occurrences
Start
Inbox - Microsoft Outlook
Launch Midas+ - Window...
Midas+ Care Manage...
Document2 - Microsoft ...
12:35 PM

User Fields


Midas+ Care Management (TEST AREA) - [Risk Event Entry - MOUSE,MINNIE 5/29/2013 2:43 PM OUTPATIENT DX]
File Edit View Function SmartMenu Tools Window Help
Name: MOUSE,MINNIE
Birth Date: 3/3/1980 33Y
Sex: F
MRN: 386935
Enc. Type: OUTPATIENT DX
Facility: PIONEERS MEMORIAL HEALTHC
Account No.: 101391525
Start Date: 5/29/2013
Start Time: 2:43 PM
Admitting Phys.: SUAREZ,LORENZO
Location: OUTPATIENT S
Room:
End Date: 5/29/2013
End Time: 11:59 PM
Discharge Phys.:
Principal Payer: SELF PAY
LOS: 1
General Witnesses Outcomes Attribution Referrals Comments User Fields
Was assessment done on admission? Yes No N/A <blank>
If "Other" Was used for any Category, State Other:
If Med Error What Drug? Rocephin
Med Error Category:
Action to be initiated by:
By Speaking to:
Action Due Date:
Policy or Procedure Change Required?
Action Completed:
Slip/Fall Related to:
At Risk:
Previous Risk Assessment:
Patient is Oriented:
Activity Privileges:
Siderails:
Environment:
Falls Protocol:
Sedative w/in last 4 hours:
Restraint Used:
If MD not Notified, Why:
Sentinel Event? Yes No N/A <blank>
Was Family Notified? Yes No N/A <blank>
Was Incident Documented in Medical Record? Yes No N/A <blank>
Was the patient examined? Yes No N/A <blank>
If Examined, By Whom? Dr Admani
Was Patient Aware of Incident? Yes No N/A <blank>
PT/Family Atitude: Angry
Save
Save & Print
Documents
Delete
Copy To QM
Files
Close
Help
Start
Inbox - Microsoft Outlook
Launch Midas+ - Window...
Midas+ Care Manage...
Document2 - Microsoft ...
12:36 PM

User Fields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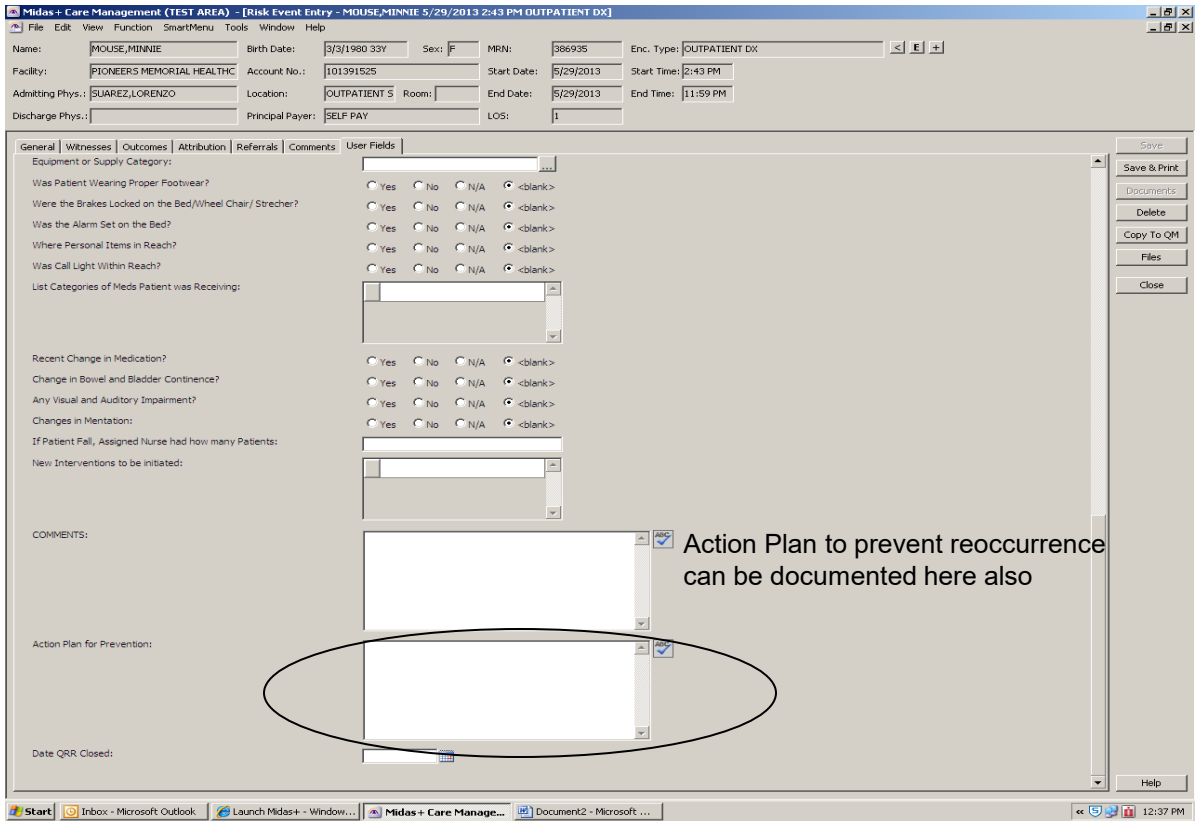
Sedative w/in last 4 hours:
Restraint Used:
If MD not Notified, Why:
Sentinel Event?
Was Family Notified?
Was Incident Documented in Medical Record?
Was the patient examined?
If Examined, By Whom?
Dr Admani
Was Patient Aware of Incident?
PT/Family Atitude:
Angry
Current Diagnosis:
Pneumonia
Time MD Informed:
6:20 PM
AMA Elopement:
DETAILS:
Reason (if known):
Equipment or Supply Category:
Was Patient Wearing Proper Footwear?
Were the Brakes Locked on the Bed/Wheel Chair/ Strecher?
Was the Alarm Set on the Bed?
Yes No N/A <blank>
Save
Save & Print
Documents
Delete
Copy To QM
Files
Close
Help
Start
Inbox - Microsoft Outlook
Launch Midas+ - Window...
Midas+ Care Manage...
Document2 - Microsoft ...
12:36 PM

User Fields



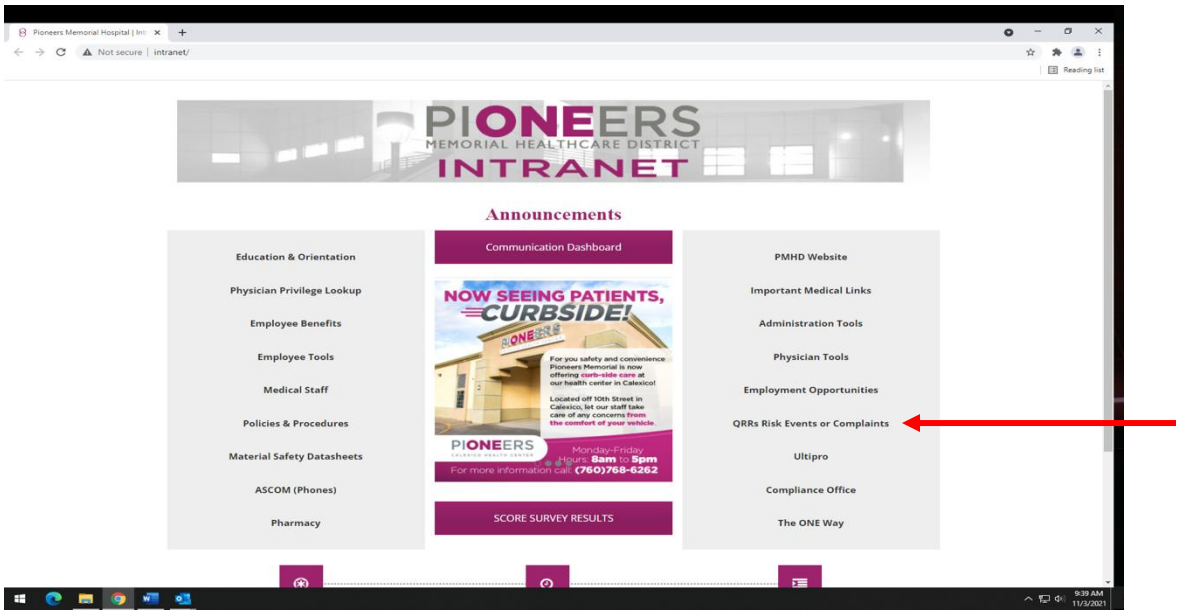
Action Plan to prevent reoccurrence can be documented here also

Reminders

- Do not document a QRR was completed in the medical record
- Investigate, document and initiate a corrective action as quickly as possible
  - If you add documentation 30 days later the QRR will reappear on everyone's work list
- Complete all areas of the QRR before they are closed
- Encourage reporting

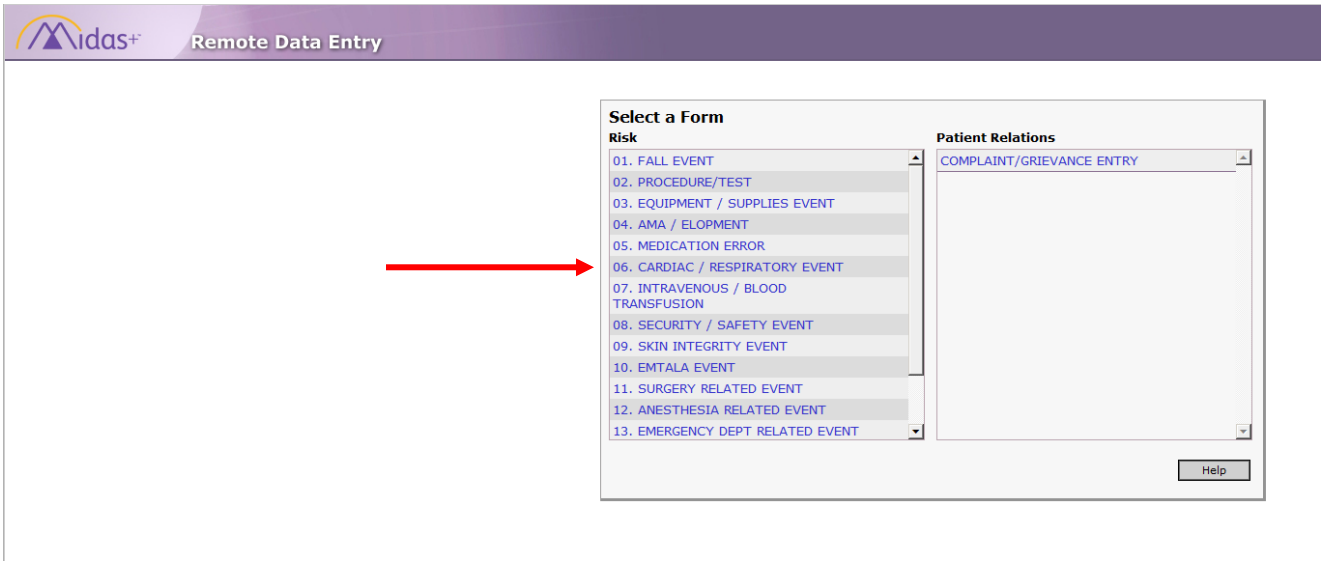
ON-LINE INCIDENT REPORTING THROUGH MIDAS+
REMOTE DATA ENTRY (RDE) – QRR (Risk Events)

To report any incidents that you used to report on a QRR form, you will need to access a hospital computer. You will not need a password, but will simply "click" on the Intranet Page Icon on the desktop to take you to the following screen. Select the ***QRRs Risk Events or Complaint*** button.



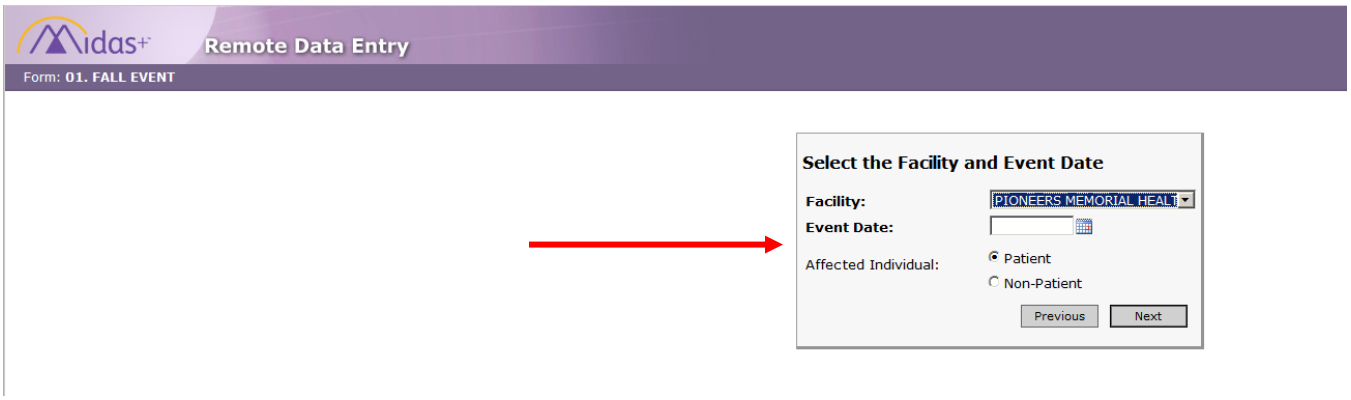
Once you click on this, select a **Risk Form**, this will bring up a list of the forms. Select the specific form for the type of incident you are reporting. (Fall, medication, etc.)

*All ***patient*** complaint related issues need to be entered in ***Complaint*** button.



Enter the date the incident occurred.
Select Patient or Non-Patient

- Always tie incident to a patient when possible
- Choose Non-Patient for visitor, volunteer, equipment not used on patient only when applicable

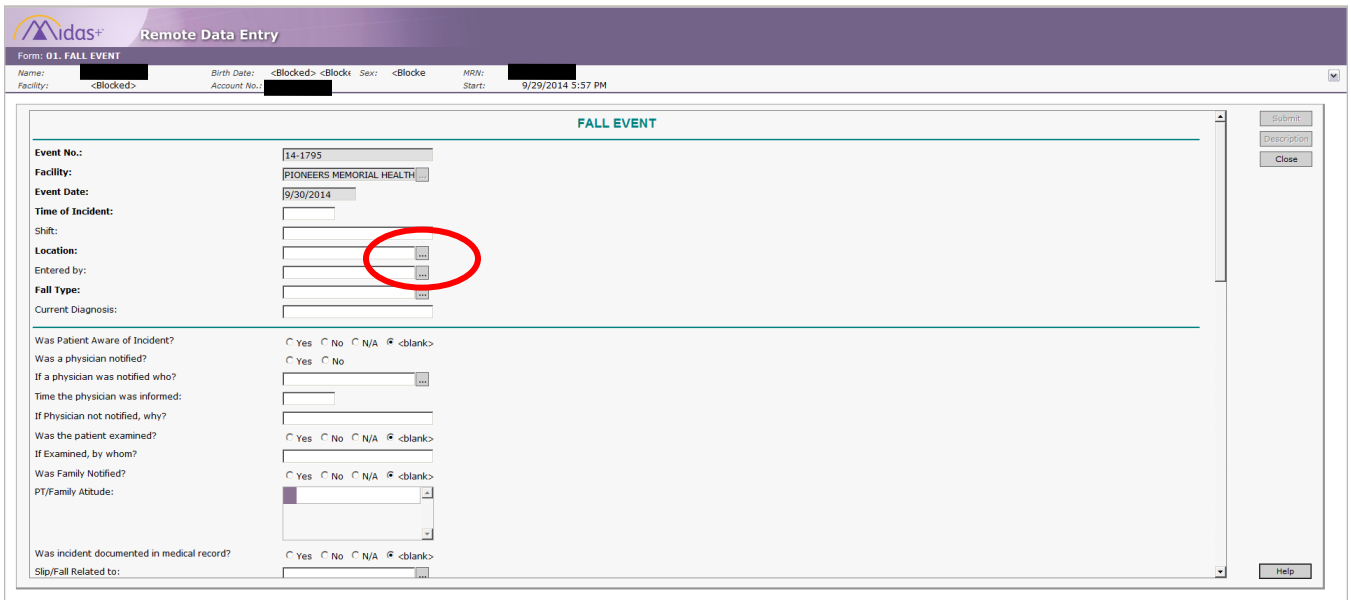


If you choose patient, you will be taken to another screen to identify the patient by name or medical record number.

- A list of patients who were at your facility on the date selected with the name or number you have entered will be brought up.
- Once you identify that this is the patient you wish to report on, you can click on the patient's name to continue.
- You will only be able to enter data on a patient that has had an encounter with the facility for the date the incident occurred.

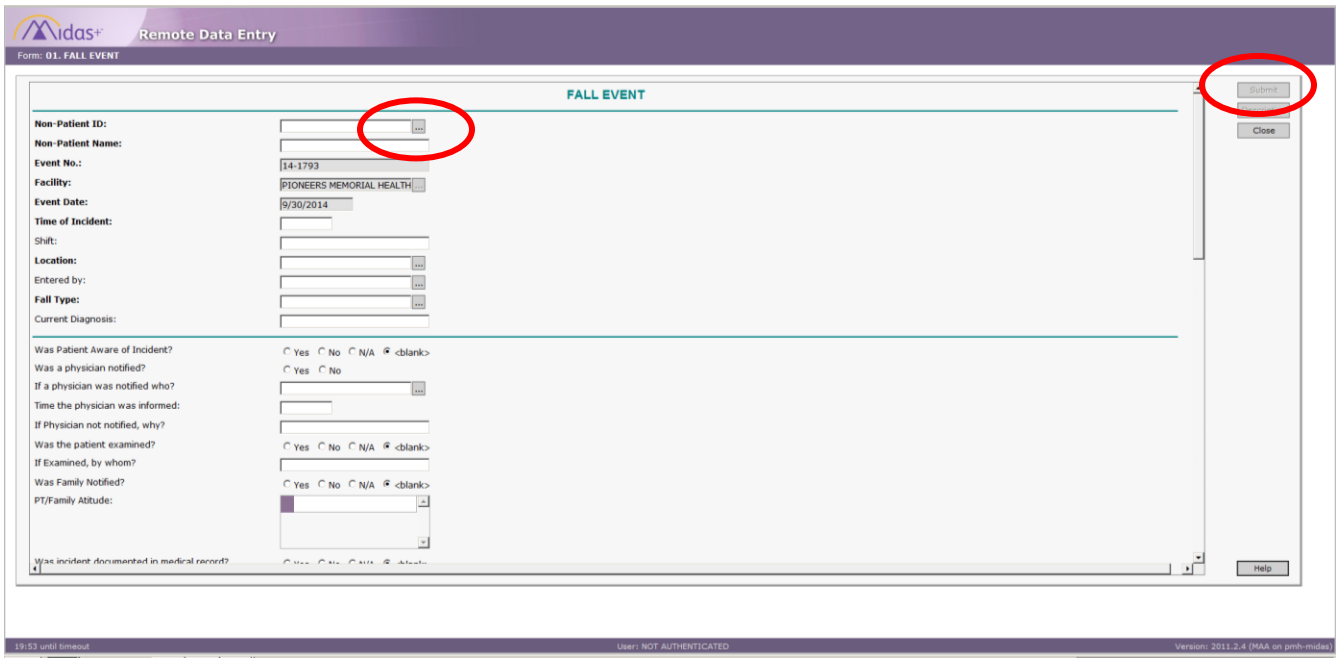
Event Screen for patient

- All bold text area are mandatory to complete
- Click drop downs for options



If you choose non- patient, you will be taken to event entry screen

- Identify the Non Patient type
- If the Non-Patient is a person enter his/her name under Non-Patient Name
- Click drop downs for options
- All bold text area are mandatory to complete



Once you have entered all required fields, and entered all information as completely and accurately as possible, click on the Save button. The incident information will be automatically forwarded to the location leader and the Risk Management Department.

Imperial Valley Healthcare District

Title: **Patient Safety Program**	Policy No. ADM-00055
	Page 1 of 4
Current Author/Reviewer: Bike Enwezoh	Effective: 7/23/2001
Latest Review/Revision Date: 9/26/2024	Manual: Administrative / Quality

Collaborating Departments: Dr. Su, Dr. Papp, Dr. Nelson, Nursing, Ancillary, Administration	Keywords: error, reporting		
Approval Route: List all required approval			
PSQC 12/2024	Other:		
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 The purpose of the Patient Safety Program is to establish an organizational approach to patient safety, risk reduction and medical error prevention and reporting.

2.0 Scope: District wide

3.0 Policy:

3.1 Patient Safety Quality Council (PSQC) is responsible for the development, implementation and revision of the Patient Safety Program.

3.1.1 The membership is multidisciplinary and includes representatives of Administration, Medical Staff, Nursing and support managers, and others.

3.2 The Patient Safety Program is approved by administration, medical staff and the Board of Directors.

3.3 Leaders of IVHD provide adequate resources, human, material, and capital to measure, assess and improve patient safety

4.0 Definitions:

4.1 Patient Safety – Care and intervention practices that reduce actual and potential risks contributing to patient injury or unintended adverse patient outcomes

4.2 Near Miss or Good Catch – any process variation that did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome

4.3 No Harm Error – unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in an action or potential negative outcome

4.4 Error – unintended acts either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate adverse outcome

4.4.1 Mild Outcome – may include error that require additional monitoring, but no harm

4.4.2 Moderate Outcome – may include adverse drug reactions, blood transfusion reactions, or require intervention or treatment causing temporary harm

4.5 Hazardous Condition – Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome. The error occurred may result in initial or prolonged hospitalization and temporary patient harm

4.6 Sentinel Event – An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, not related to the natural course of the patients illness or underlying condition. *<Refer to policy ADM-00480; Sentinel Event>*

4.7 Medication Errors – Shall be categorized utilizing the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index
4.8 Failure Mode and Effects Analysis (FMEA) – Examination of the high-risk or high vulnerability safety process for proactive risk assessment
4.9 Quality Review Report (QRR) – Internal form for reporting medical errors, incidents, or complaints
4.10 Patient Safety Hotline (extension 4555): – Staff can call extension 4555 to report safety and quality concerns anonymously

5.0 Procedure:

5.1 Patient Safety Program Activities
5.1.1 Data related to variances in patient safety and quality are measured, monitored and analyzed in the following categories including but not limited to:
5.1.1.1 Threats to patient safety (i.e. falls, pt. identification, injuries)
5.1.1.2 Medication therapy/medication use; to include medication reconciliation, look alike / sound alike medications and the use of dangerous abbreviations
5.1.1.3 Operative and invasive procedures; to include wrong site/wrong patient/wrong procedure surgery
5.1.1.4 Anesthesia/moderate sedation
5.1.1.5 Blood and blood components
5.1.1.6 Restraint use/seclusion
5.1.1.7 Effectiveness of pain management system
5.1.1.8 Infection control system, including hospital acquired infections (HAI)
5.1.1.9 Utilization Management System
5.1.1.10 Patient flow issues, to include reporting of patients held in the Emergency Department or the PACU for extended periods of time (as defined by the organization)
5.1.1.11 Customer satisfaction, both clinical and support areas
5.1.1.12 Discrepant pathology reports
5.1.1.13 Unanticipated deaths, adverse and/or sentinel events
5.1.1.14 Near misses
5.1.1.15 Other adverse events
5.1.1.16 Critical and/or pertinent processes, both clinical and supportive
5.1.1.17 Medical record delinquency
5.1.1.18 Physical Environment Management Systems
5.1.2 Education
5.1.2.1 New staff is introduced to patient safety and quality during the orientation process.
5.1.2.2 Existing staff are re-educated throughout the year with recurring in-service/training via multiple media.
5.1.2.3 Each employee is required to complete at least six hours of in-service/training specific to patient safety annually.
5.1.2.4 Training is provided through in-person sessions, e-learning, and

departmental meetings.

5.1.3 Patient and Family Involvement
- 5.1.3.1 Patients and their families/representatives are encouraged to be actively involved in their care and patient safety.
- 5.1.3.2 The admission packet contains information regarding patient rights and patient safety.

5.1.4 Proactive Assessment of Patient Safety
- 5.1.4.1 At least annually, staff is surveyed to assess safety culture and reporting attitudes, and suggestions for improving patient safety.
- 5.1.4.2 Annually, leadership with the Patient Safety Quality Council select at least one high-risk or high vulnerability safety process for proactive risk assessment, typically in the form of an FMEA.
  - 5.1.4.2.1 The process selected is determined through the use of internal and external data
    - 5.1.4.2.1.1 Internal data may include QRRs, internal audits and staff suggestions.
    - 5.1.4.2.1.2 External data may include, occurrence reporting from regulatory sources and literature.

5.1.5 Reporting Errors and Near Misses/Good Catches
- 5.1.5.1 Medical/healthcare errors are reported in a systematic non-punitive manner.
  - 5.1.5.1.1 Individuals should report without fear of discipline or retaliation from employer.
  - 5.1.5.1.2 The organization can provide support for staff who is involved in any significant occurrence, including personal counseling via Employee Assistance Program.
  - 5.1.5.1.3 Errors will be viewed from a process, not person, stand point when possible.
- 5.1.5.2 Internal reporting is processed through completion of QRRs *<Refer to policy ADM-00481; Quality Review Reporting>* and/or anonymously by calling the Patient Safety Hotline at extension 4555.
  - 5.1.5.2.1 Errors to report via QRR include but not limited to near misses/good catches, error causing any harm, error not causing harm, hazardous conditions, and sentinel events.
- 5.1.5.3 External reporting is performed in accordance with state, federal, and other regulatory organizations.

5.1.6 Disclosing Medical/Healthcare Errors
- 5.1.6.1 If the patient has experienced a significant error, the patient, and when appropriate, the family (support persons) shall be informed.
- 5.1.6.2 The attending physician, pharmacist or appropriate qualified designee informs the patient and family (support persons). *<Refer to policy ADM-00134; Communication with the Patient / Family after a Harm Event>*

5.1.7 Responsibility for reporting actual or potential errors are addressed as follows:

5.1.7.1 All staff and managers are responsible for
5.1.7.1.1 Immediately notifying his/her manager of any actual error
5.1.7.1.2 Documenting occurrence on a QRR

5.2 Oversight and Evaluation of the Patient Safety Program
5.2.1 PSQC provides oversight and evaluation of the Patient Safety Program by:
5.2.1.1 Reviewing aggregated and benchmarked data and reports regarding patient safety
5.2.1.2 Prioritizing patient safety activities based on, but not limited to, high risk processes, results of patient satisfaction survey, and incident reporting and staff perception of patient safety survey.
5.2.1.3 Submitting patient safety reports to the Board of Directors at least annually and to the Medical Executive Committee as appropriate
5.2.2 The Governing Board has the final authority and responsibility for:
5.2.2.1 Reviewing aggregated and benchmarked data and reports regarding patient safety
5.2.2.2 Empowering IVHD leadership with the responsibility for implementing improvement strategies
5.2.2.3 Reviewing administration's recommendations in planning and goals for patient safety

6.0 References:
6.1 NIAHO Accreditation Requirements (Revision 24-0), QM.3 Quality Outline/Plan
6.2 NIAHO Accreditation Requirements (Revision 24-0), QM 7 Measurement, Monitoring, Analysis
6.3 IVHD policy ADM-00134; Communication with the Patient / Family after a Harm Event
6.4 IVHD policy ADM-00480; Sentinel Event
6.5 IVHD policy ADM-00481; Quality Review Reporting

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:
8.1 Updated 6.1 and 6.2
8.2 Added patient rights to 5.1.3.2
8.3 Updated current Author/Reviewer
8.4 Updated Review date
8.5 Added 5.1.2.4
8.6 Updated 5.1.4.1

Title: **Safety Management Plan**	Policy No. EOC-00054
	Page 1 of 6
Current Author: Jorge Mendoza	Effective: 12/1/1995
Latest Review/Revision Date: 06/2025	Manual: EOC / Safety Management

Collaborating Departments: Risk; HR; EMS Manager; Infection Control		Keywords:		
Approval Route: List all required approval				
	PSQC 6/2024	Other: Safety Committee		
Clinical Service _____		MSQC 7/2024	MEC 7/2024	BOD 7/2024

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 The District establishes the safety program by creating and implementing policy and procedures, by establishing and maintaining the supporting activities, and by evaluating, and when appropriate, improving the program's performance. The focus for many of the program's functions is the Safety Committee, and many of the program activities are described by Injury and Illness Prevention Program Policy.

2.0 Scope: District wide

3.0 Policy:

3.1 The Safety Management Program at Pioneers Memorial Hospital is a plan that describes the responsibilities, functions entities and the mechanisms by which the hospital carries out its commitment to a safe and healthful environment for everyone that enters the District's facilities.

3.1.1 Constituent and Overlapping Programs and Functions

- 3.1.1.1 Injury and Illness Prevention Program
- 3.1.1.2 Safety Committee
- 3.1.1.3 Safety Committee Statement of Authority
- 3.1.1.4 Risk Management Program
- 3.1.1.5 Incident Reporting
- 3.1.1.6 Infection Control Program
- 3.1.1.7 Employee Orientation Program
- 3.1.1.8 Department Specific Safety Policies
- 3.1.1.9 Reporting of Unsafe Condition or Hazard
- 3.1.1.10 Medical Device Reporting
- 3.1.1.11 Medical Device and Product Recall
- 3.1.1.12 Maintaining Grounds and Equipment

3.1.2 Key Roles

- 3.1.2.1 Risk Manager – responsible for the Risk Management Program; member of the Safety Committee, Patient Safety Quality Council Committee
- 3.1.2.2 Safety Officer – 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
- 3.1.2.3 Director of Human Resources – Responsible for investigation of

employee accidents, coordination with the compensation program and the Employee Orientation Program

3.1.2.4 Infection Control Practitioner – Responsible for the hospital-wide Infection Control Program, Coordination with the Infection Control Committee

3.1.2.5 Safety Committee Members – The members carry out the duties of the committee including the safety inspections 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

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

3.1.2.7 Employees – Responsible to work safely and maintain a safe and healthful hospital by learning and following Pioneers Memorial Hospital Safety Program

4.0 Definitions:

4.1 District – Pioneers Memorial Hospital Imperial Valley HealthCare District.

5.0 Procedure:

5.1 The overall scope of the District's Safety Management Program shall include provisions for the following:

5.1.1 Laboratory, Oncology, Radiology, Pharmacy and Facilities Services will maintain their own specific Safety Management Plan on handling and disposal of hazardous waste.

5.1.2 Ongoing hazard surveillance program including response to product safety recalls shall be maintained and reported through the Safety Committee.

5.1.3 Safety Committee shall review all reports of accidents or injuries to patients, visitors and/or personnel monthly. Summary reports of incidents shall include evaluation of the incident, conclusions, recommendations and actions taken.

5.1.4 All safety orientation and continuing education of employees shall be directed by the Safety Committee in an effort to respond to identifiable incidents and trends that may compromise the safety of patients, visitors, and/or staff in the facility or grounds.

5.1.5 Conduct fire drills, and provide regular testing and preventative maintenance of the fire prevention systems.

5.1.6 Monitor equipment and utility preventative maintenance and inspection procedures as well as education and training of users to protect against failure or user error, in compliance with the Utility Management Plan.

5.1.7 The Safety Program will be evaluated annually for its effectiveness. Evaluation shall include all areas of safety management including hazardous materials and waste management, emergency preparedness and life safety management.

5.2 Responsibilities of the Safety Committee:

5.2.1 The Safety Committee shall include representation from Administration and supervisory personnel from clinical and support services. Non-supervisory employees are encouraged to participate in the activities of the Safety Committee, but may not be members. All members of the Safety Committee are appointed by the Chief Executive Officer of the District.

5.2.2 Regular compliance with the safety objectives shall be observed. Written records of inspection shall be maintained and corrective actions documented for identified risks.

5.2.3 Safety surveys conducted by qualified safety engineers such as those employed by various hospital insurers, shall be reported to the Safety Committee, with follow-up actions documented.

5.2.4 The Safety Committee shall develop a valid audit procedure and carry out periodic audits of institutional performance against the Safety Plan.

5.2.5 The Safety Committee will establish an incident reporting program:

5.2.5.1 For investigating and evaluating all incidents reported

5.2.5.2 For documenting review of all such reports and actions taken

5.2.6 The Safety Committee will provide liaison with Infection Control Practitioner and Employee Health Representative.

5.2.7 The Safety Committee will provide safety related information through:

5.2.7.1 Orientation of all new employees

5.2.7.2 Continuing education of all hospital employees

5.2.7.3 Safety information bulletin boards

5.2.7.4 By developing a reference library of pertinent documents and publications dealing with all facets of hospital safety

5.2.7.5 By recommending purchase of safety equipment and suggest any necessary physical changes to improve safety conditions.

5.2.8 The Safety Committee shall coordinate District wide educational activities in order to effect improvements in the safety of patients, visitors and staff. Educational programs shall be based on industry standards and literature review and are continually adapted to reflect organizational experience and evaluation of effectiveness of training programs.

5.2.8.1 Chairperson

5.2.8.1.1 The duty of the chairperson shall be to convene the Safety Committee, assure the maintenance of appropriate records, assure timely follow-up of actions and business of the Safety Committee, supervise inspection, survey activity and report recommendations and actions to the Chief Executive Officer, and act as liaison with the Fire Department and other agencies as needed on matters relative to safety.

5.2.8.2 Safety Officer

5.2.8.2.1 The Safety Officer has the authority and responsibility to act when hazardous conditions exist which could result in personal injury to individuals or damage to equipment or buildings.

5.2.8.2.1.1 The Safety Committee and its members, jointly and

separately, shall meet monthly and make every reasonable, enlightened effort to identify risks to patients, visitors and employees, determine their acuity and priority and work toward their abatement.

5.2.8.2.1.2 The Safety Committee shall inform itself of standards for safety incorporated in the American National Standards Institute (ANSI); General Acute Care Hospital Regulation of the State Department of Health; Code of Federal Regulations Title 29; Occupational Safety and Health Act (OSHA); plus the minimum consensus standards and optimum achievable standards of the Det Norske Veritas (DNV). It shall thoroughly acquaint itself with the functioning and mechanizations of the District, its employees, agents, environs, and sphere of responsibility. It shall apply reasonable interpretations of standards in recognizing and recommending abatement of hazards.

5.2.8.2.1.3 The Safety Committee will develop written policies and procedures to enhance safety with the District and its grounds.

5.2.8.2.1.4 The Safety Committee will report in writing pertinent findings and recommendations to the governing board, administration, medical and nursing staff, and all departments and services involved.

5.2.8.2.1.5 The Safety Committee shall coordinate and cooperate in the development of department/service safety rules and practices. Special focus programs shall be developed and implemented related to need. All departmental safety policy revisions shall be reviewed every two years by the committee.

5.2.8.2.1.6 The Safety Committee shall identify and review contemporary research reports pertaining to the full scope of responsibility of the Safety Program.

5.2.8.2.1.7 The Safety Committee shall assure the maintenance, review and reporting of such records as are consistent with its goals.

5.2.8.2.1.8 The Safety Committee shall undertake periodic inspections of the hospital premises and spheres of influence including construction sites for the purpose of assuring compliance with safety policies.

5.2.8.2.1.9 The Safety Committee shall:

- Meet monthly and shall record its activities. Summaries of all activities shall be posted on the

bulletin boards, forwarded to administration, quality department, risk management, and all department directors.
- Identify risks, recommending their abatement
- Conduct inspections
- Educate and communicate safety awareness.

5.2.8.3 Administration

5.2.8.3.1 Toward fulfillment of the general and specific safety goals of the District, the Chief Executive Officer shall:

5.2.8.3.1.1 Assure the formation and development of the Safety Committee.

5.2.8.3.1.2 Appoint a chairperson who is qualified and among the members of the Safety Committee.

5.2.8.3.1.3 Provide administration representation on the Safety Committee.

5.2.8.3.1.4 Ensure the participation and representation on the Safety Committee.

5.2.8.3.1.5 Approve the budget for the Safety Programs.

5.2.8.4 Department Directors

5.2.8.4.1 The role of the department directors in our Safety Program is vitally important. The Safety Committee through verbal and/or Departmental Action Reporting Forms shall alert departments or services of safety issues that require intervention.

5.2.8.4.2 The following responsibilities lie with the department directors:

5.2.8.4.2.1 Plan and organize department activities.

5.2.8.4.2.2 Develop techniques and procedures for specific operations.

5.2.8.4.2.3 Select and train employees.
- Each department director is responsible for the degree to which his/her employees have gained knowledge and skills necessary to perform safely and effectively in their particular position.
- It is the responsibility of the Safety Committee to see that department directors have a thorough knowledge and apply on-the-job instructions for all employees.

5.2.8.4.2.4 Supervise and evaluate employee performance.

5.2.8.4.2.5 Stimulate and promote employee interest and participation in the District's Safety Program.

5.2.8.4.2.6 Eliminate all unsafe conditions and unsafe acts within department.
- Safe Work Rules – Individual departments, with the assistance of the Safety Committee, will

establish and publish safe work rules which reduce accident probability. Development of these rules should involve:
- A review of all work methods and practices
- A review of all past accident experiences
- Recommendations by supervisory personnel
- Recommendations by employees

5.2.8.4.2.7 Investigate employee injuries within the department.

5.2.8.4.2.8 Cooperate with the Safety Committee in the promotion of its activities.

5.2.8.4.2.9 Assist in monitoring safety recommendations as outlined by the Safety Officer.

6.0 References:

6.1 OSHA 29 CFR – Occupational Safety Regulations
6.2 NIAHO – PE.3, SR.2, SR.3, SR.4, SR.5, SR.6, SR.7
6.3 NFPA 101 Life Safety Code
6.4 NFPA 99 Health Care Facilities

7.0 Attachment List: Not applicable

8.0 Summary of Revisions:

8.1 Revised the header.
8.2 Changed Pioneers Memorial HealthCare District to Pioneers Memorial Hospital.
8.3 Changed definition section 4.1 from Pioneers Memorial HealthCare District to Pioneers Memorial Hospital Imperial Valley HealthCare District.
8.4 Reviewed with no further changes.

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: September 11, 2025

SUBJECT: Agreement between MTC Medical, LLC and Imperial Valley Healthcare District.

BACKGROUND:

MTC Medical operates the medical unit within the Imperial Regional Facility in Calexico.

They refer victims or suspects of sexual assault to our SART team for sexual assault examinations.

KEY ISSUES:

None

CONTRACT VALUE: Dependent of volume of cases sent to us for services.

MDT agrees to pay the following fees:

- Victim Sexual Assault Exam $2250
- Suspect Sexual Assault Exam $1150
- Response Fee/no exam $300

CONTRACT TERM: 2 years

BUDGETED: Yes

BUDGET CLASSIFICATION: Clinical Services, SART program

RESPONSIBLE ADMINISTRATOR: Carol Bojorquez, CNO

DATE SUBMITTED TO LEGAL: 9/4/2025 **REVIEWED BY LEGAL:** [x] Yes [ ] No

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

RECOMMENDED ACTION:
That the Board authorize the agreement between MTC Medical, LLC and Imperial Valley Healthcare District.

AMENDMENT NO. 5
TO THE MEMORANDUM OF AGREEMENT
BETWEEN
MTC MEDICAL, LLC
AND
IMPERIAL VALLEY HEALTHCARE DISTRICT
(previously PIONEERS MEMORIAL HEALTHCARE DISTRICT)

THIS AMENDMENT to the Agreement dated March 1, 2015 between **MTC Medical, LLC** (hereinafter called "MTC Medical") and **Imperial Valley Healthcare District** (previously Pioneers Memorial Healthcare District) (hereinafter called "Provider") is made and entered into effective as of August 1, 2025.

Pursuant to the terms of Article V Section 18 of the Agreement, the Agreement is amended as follows:

> The term of this Agreement shall extend for an additional two-year period, as referenced in Article IV Section 15, beginning on the date of August 1, 2025.
>
> Pioneers Memorial Healthcare District has been dissolved and absorbed into Imperial Valley Healthcare District. All references in the original agreement and any prior amendments thereto to Provider shall now refer to Imperial Valley Healthcare District as of the effective date.

Except for the changes set forth herein, the Agreement as amended remains unchanged.

IN WITNESS WHEREOF, the parties have executed this Amendment in their official capacities with legal authority to do so.

MTC Medical, LLC	Imperial Valley Healthcare District
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	_____
Title	Title
_____	_____
Date	Date

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: September 11, 2025

SUBJECT: Agreement between Touro University, Nevada and Imperial Valley Healthcare District.

BACKGROUND: IVHD provides clinical experience for students of Touro University Physician Assistant Program which requires clinical experiences for students enrolled in the program.

KEY ISSUES: None

CONTRACT VALUE: No cost associated with agreement.

CONTRACT TERM: 2 years

BUDGETED: NO

BUDGET CLASSIFICATION: NA

RESPONSIBLE ADMINISTRATOR: Carol Bojorquez, CNO

DATE SUBMITTED TO LEGAL: 9/4/2025 **REVIEWED BY LEGAL:** [x] Yes [ ] No

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

RECOMMENDED ACTION:

That the Board authorizes the agreement between Touro University and Imperial Valley Healthcare District.

Affiliation Agreement for Clinical Experience

This Affiliation Agreement for Clinical Experience (the "**Agreement**") is entered into this 1st day of May, 2025 (the "**Effective Date**") by and between IMPERIAL VALLEY HEALTHCARE DISTRICT, a local health care district formed under California Health & Safety Code §§ 32000 et. seq. ("**IVHDIVHD**"), located at 601 Heber Ave, Calexico, CA 92231, and TOURO UNIVERSITY NEVADA ("**Affiliate**"), located at 874 American Pacific Dr., Henderson, NV 89014. IVHDIVHD and Affiliate may also be individually referred to as a "Party" and collectively referred to as the "Parties".

RECITALS

A. Affiliate is an accredited university;

B. Affiliate offers approved Physician Assistant program which requires clinical experiences for students enrolled in the program ("Affiliate Students");

C. IVHD recognizes the need for and desires to aid in the professional development of Affiliate Students, has facilities suitable for the clinical experiences required for Affiliate Students, and is willing to make its employees and premises available for such purposes;

D. Both Affiliate and IVHD agree it is to the benefit of both Affiliate and IVHD that Affiliate Students have opportunities for clinical experience to enhance their capabilities as health practitioners;

NOW, THEREFORE, in consideration of the mutual agreements and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which hereby are acknowledged Affiliate and IVHD agree as follows:

AGREEMENT

1. Term.

a. The term of this Agreement shall commence on the Effective date and continue for two (2) years unless terminated earlier pursuant to Paragraph 4 below. This Agreement may be extended or renewed only in writing and signed by authorized representatives of Affiliate and IVHD.

2. Affiliate Responsibilities.

a. Affiliate shall remain responsible for the education of its students, for the curriculum, and for the design, delivery and quality of its programs. Affiliate shall provide IVHD with current information, in writing, about its curriculum and clinical education goals.

b. Affiliate shall have the responsibility for planning and determining the adequacy of the educational experience of the Affiliate Students in theoretical background, basic skill, professional ethics, attitude, and behavior.

c. c. Affiliate will determine the eligibility of its students to participate in the clinical experience with IVHD established under this Agreement, including any certifications or licensure in California and satisfactory completion of any prerequisite theoretical and clinical portions of the Affiliate's curriculum.

d. Affiliate will assign students to IVHD in such numbers as are mutually agreed upon by the parties.

e. Affiliate shall designate a faculty member to coordinate with a designee of IVHD regarding the clinical experience for each Affiliate Student assigned to IVHD.

f. Affiliate will monitor and evaluate the progress of each Affiliate Student assigned to IVHD and Affiliate will maintain all academic records of Affiliate students participating in the clinical experience.

g. Affiliate will determine the number of credits provided to each Affiliate student as a result of participation in the clinical experience described under this Agreement.

h. Affiliate will inform Affiliate Students assigned to IVHD that all information concerning IVHD's business, employees, and patients is confidential and not to be released to any person without the prior written approval of IVHD. Both Affiliate Students and onsite faculty shall complete Health Insurance Portability and Accountability Act ("HIPAA") training through Affiliate and abide by all rules and regulations pertaining to the confidentiality of patient information as set forth by HIPAA.

i. If required by IVHD, Affiliate will require all participating students to complete an appropriate criminal background check and to submit documentation of appropriate immunizations. Affiliate will inform the student of his/her responsibility to provide evidence to IVHD of any required criminal background checks or immunizations, when requested. IVHD will notify Affiliate of its background check and immunization requirements. Affiliate also will inform Affiliate Students that they may be required to undergo a chug test or other similar screening test pursuant to IVHD's policies and practices. The cost of any background check, immunization or other screen will be paid for by Affiliate Student if it is not paid for by IVHD.

j. Affiliate will inform Affiliate Student that they are required to comply with IVHD's policies, rules and procedures.

k. Affiliate shall forward to IVHD the name, mailing address, phone number, and email address of each Affiliate Student at least one (1) week prior to the clinical experience.

l. Affiliate will inform Affiliate Student that they are required to comply with IVHD's policies, rules and procedures.

m. If any part of the IVHD program requires patient contact (close contact via observation or touching of the patient), the Affiliate Student will not initiate such patient contact until submission of proof of HBV vaccination or declination forms, proof of a negative tuberculin skin test ("PPD") within one (1) year of patient contact, evidence of MMR vaccination; demonstration of varicella immunization/vaccination, and completion of blood borne pathogen safety training required under current regulations of the Occupational Safety and Health Administration ("OSHA").

n. Affiliate Student shall not participate in patient care unless the Affiliate Coordinator (or delegate) provides direct supervision of the Affiliate Student and the patient consents to the Affiliate Student assisting the Affiliate Coordinator or delegate in performing the health care task.

3. IVHD Responsibilities.

a. IVHD will maintain a positive, respectful, and adequately resourced learning environment so that sound educational experiences can occur for Affiliate Students. IVHD will provide clinical learning experiences that are planned, organized and administered by qualified staff. The clinical assignments provided by IVHD shall be designed to facilitate the Affiliate Student's professional growth.

b. IVHD will retain full authority and responsibility for patient care and quality standards and will maintain a level of care which meets generally accepted standards conducive to satisfactory instruction. While in IVHD's facilities, Affiliate Students will have the status of trainees and will not replace IVHD staff and are not to render unsupervised patient care and/or services.

c. IVHD will provide for the orientation of Affiliate Students and Affiliate faculty members as to IVHD's applicable policies, rules and procedures.

d. IVHD will assign one or more of its employees to supervise and instruct each Affiliate Student assigned to IVHD.

e. Upon request by Affiliate, IVHD will assist Affiliate in the evaluation of the learning and performance of participating Affiliate students by completing evaluation forms provided by Affiliate.

f. IVHD may refuse to accept any Affiliate Student assigned to it. Similarly, IVHD may request that an Affiliate Student assigned to it be withdrawn from the clinical experience at any time. IVHD will notify Affiliate in writing of a decision not to accept an Affiliate Student or to request that an Affiliate Student be withdrawn from the clinical experience. IVHD agrees to work in good faith with Affiliate to address any resolvable issues. Nevertheless, IVHD may accept or deny any Affiliate Student, for any reason except an unlawful reason, in IVHD's sole discretion.

g. IVHD will ensure that Affiliate Students do not replace or substitute for any IVHD employee, and that Affiliate Students do not perform any of the duties normally performed by an employee for IVHD, except those duties that are part of the clinical experience and training performed by Affiliate Students under the supervision of an IVHD employee.

4. Termination.

a. Either patty shall have the right to terminate this Agreement at any time and for any reason with thirty (30) days' advance written notice to the other party. Notwithstanding the foregoing, the parties agree that any Affiliate Student participating in a clinical experience at IVHD shall be permitted to complete the applicable calendar year term during which such termination of Agreement occurs.

5. HIPAA.

a. Students participating in clinical training pursuant to this Agreement are members of IVHD' s workforce for purposes of the Health Insurance Portability and Accountability Act (HIPAA) within the definition of "health care operations" and therefore may have access to patient medical information as provided for in HIPAA's Privacy Rule. This provision applies only to HIPAA regulations applicable to IVHD and does not establish an employment relationship between IVHD and the participating students. Both Affiliate Students and onsite faculty shall complete HIPAA training through Affiliate and abide by all rules and regulations pertaining to the confidentiality of patient information as set forth by HIPAA.

6. Commitment to Non-Discrimination.

a. Affiliate and IVHD shall not discriminate in the selection of, acceptance of, or participation by any Affiliate Student in any program or services offered under this Agreement on the basis of the student's race, color, national origin, religion, sex, sexual orientation, disability, or any other characteristic protected by federal, state or local law. Each party shall notify the other party of any internal or external allegations or reports of misconduct pertaining to an Affiliate Student's experience during the course of the clinical experience, including but not limited to sexual harassment complaints and ethics investigations. The parties agree to meet and confer regarding any investigations pertaining to any Affiliate Student, preceptors, agents, or employees of IVHD participating in the clinical experience.

7. Indemnification.

a. IVHD agrees to defend, indemnify and hold Affiliate and its employees and agents harmless from any and all liability, claims, demands, suits, costs, charges and expenses, including without limitation attorneys' fees, arising out of the negligence or willful misconduct of IVHD or IVHD's employees or agents in connection with the performance of this Agreement.

b. Affiliate agrees to defend, indemnify and hold IVHD and its employees and agents

harmless from any and all liability, claims, demands, suits, costs, charges and expenses, including without limitation attorneys' fees, arising out of the negligence or willful misconduct of Affiliate or Affiliate's employees or agents in connection with the performance of this Agreement.

8. Insurance.

a. At all times during the term of this Agreement, IVHD will maintain the following types and levels of insurance for its employees and agents who perform any services to fulfill IVHD's responsibilities under this Agreement: Commercial general liability insurance, workers' compensation insurance, and professional liability insurance, each with a limit in an amount not less than $1,000,000 per occurrence and $3,000,000,000 in aggregate.

b. At all times during the term of this Agreement, Affiliate will maintain the following types and levels of insurance for its employees and agents who perform any services to fulfill IVHD's responsibilities under this Agreement: Commercial general liability insurance, workers' compensation insurance, and professional liability insurance, each with a limit in an amount not less than $1,000,000 per occurrence and $3,000,000,000 in aggregate.

c. Affiliate will maintain accident insurance coverage that will cover up to $25,000 for injuries or accidents sustained by any Affiliate Students (subject to applicable limitations and exclusions contained in the statement of insurance) for the entire Term of this Agreement.

d. Affiliate will ensure that ensure that all students maintain adequate health insurance coverage for the entire Term of this Agreement.

e. Proof of the required insurance under this Agreement shall be provided by one party to the other party upon request. Either party will provide the other with at least thirty (30) days' advance written notice before cancellation or any reduction or material change in coverage.

9. Use of Trademarks and Logos.

a. Neither IVHD nor Affiliate shall use trademarks, logos or insignia, or othe1wise identify the other party in any form of publicity, disclosure or sale without the advance written permission.

10. No Agency Relationship Between the Parties.

a. This Agreement does not constitute and shall not be construed as constituting an agency, employment, partnership, joint venture association, fiduciary or other similar relationship between parties. Neither party shall have the right to obligate or bind the other in any manner whatsoever with respect to a third party, and nothing herein contained shall give or is intended to give any right to a third party. In no event will either party be liable for the debts or obligations of the other party, except as specifically provided herein.

11. Employment Disclaimer.

a. The Affiliate Students participating in the clinical experience will not be considered employees or agents of IVHD or Affiliate for any purpose.

12. Entire Agreement.

a. The parties declare and represent that no promise, inducement or agreement not herein expressed has been made to them and that this Agreement contains the full and entire agreement between and among the parties relating to the subject matter herein, and that the terms of this Agreement are contractual and not a mere recital.

13. Amendment/Severability.

a. This Agreement may not be amended, except through a writing signed by authorized representatives of Affiliate and IVHD. If any provision of this Agreement, or part thereof, is held invalid, void or voidable as against public policy or otherwise, the invalidity shall not affect other provisions, or parts thereof, which may be given effect without the invalid provision or part. To this extent, the provisions, and parts thereof, of this Agreement are severable.

14. Assignment and Subletting.

a. The rights and responsibilities granted in this Agreement are not assignable.

15. Dispute Resolution.

a. This Agreement shall be governed by the laws of the State of California. The venue for any litigation or dispute resolution shall be in Imperial County, California. Each patty shall be responsible for its own costs and attorneys' fees incurred in connection with any such dispute.

16. No Third Party Beneficiaries.

a. This Agreement shall be binding upon and inure to the benefit of and be enforceable only by the parties to this Agreement. No third party shall be a beneficia1y of or have any right to enforce the te1ms of this Agreement.

17. Authority.

a. By signing below, the representative from each party represents that he/she is duly authorized to sign the Agreement on behalf of either Affiliate or IVHD.

18. Execution of Agreement.

a. This Agreement may be executed in counterparts, each of which shall be deemed to be an original and all of which, taken together, shall constitute a single agreement binding

on the patties. This Agreement will be considered executed by a party when the signature. of such party is delivered physically, by email or facsimile transmission to the other party. The parties agree that any signature delivered by email or facsimile transmission shall have the same force and effect as an original signature.

19. Notices.

a. Any notice, demand, or communication required or pe1mitted to be given by any provision of this Agreement shall be in writing and will be deemed to have been given when actually delivered (by whatever means) to an authorized agent of the Party designated to receive such notice, or if by an overnight-courier service, then the next business day after delivery, as long as an authorized signature is obtained, or on the fifth (5th) business day after the same is sent by certified United States mail, postage and charges prepaid, directed to the address(es) noted below the signature for each Party, or to such other or additional address as any Party timely designates by written notice to the other Party.

The Parties below have executed this Agreement and it shall be effective upon approval by both parties as of the signature date of the last Party to sign.

IMPERIAL VALLEY HEALTHCARE DISTRICT

By: _____ Date: _____

TOURO UNIVERSITY NEVADA

By: _____ Date: April 28, 2025

Andrew Priest, Ed.D., PT
Provost and Interim Dean,
College of Health and Human Services

IMPERIAL VALLEY HEALTHCARE DISTRICT

BOARD MEETING DATE: September 11, 2025

SUBJECT: Agreement between Point Loma Nazarene University and Imperial Valley Healthcare District.

BACKGROUND: IVHD provides clinical experience for students of Point Loma Nazarene University's Physician Assistant Program which requires clinical experiences for students enrolled in the program.

KEY ISSUES: None

CONTRACT VALUE: No cost associated with agreement.

CONTRACT TERM: 3 years

BUDGETED: NO

BUDGET CLASSIFICATION: NA

RESPONSIBLE ADMINISTRATOR: Carol Bojorquez, CNO

DATE SUBMITTED TO LEGAL: 7/23/2025 **REVIEWED BY LEGAL:** [x] Yes [ ] No

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

RECOMMENDED ACTION:

That the Board authorizes the agreement between Touro University and Imperial Valley Healthcare District.

FIRST AMENDMENT TO CLINICAL EXPERIENCE AGREEMENT

RECITALS

WHEREAS, Imperial Valley Healthcare District ("PMHD") entered into a Clinical Experience Agreement ("Original Agreement") with Point Loma Nazarene University ("University") on July 1, 2020 with an expiration date of September 1, 2025;

WHEREAS, PMHD dissolved effective Jan 21, 2025, and Imperial Valley Healthcare District ("Clinical Site") is the successor agency which by operation of law has taken on all the rights and obligations of PMHD under the Original Agreement;

WHEREAS, the parties desire to amend the Original Agreement to extend the term of the Original Agreement for an additional three (3) years;

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

Clinical Site and University enter into this First Amendment to Clinical Experience Agreement ("First Amendment") as of August 30, 2025.

Clinical Site and University agree to amend the Original Agreement to extend the term of the Original Agreement for an additional three (3) years. Upon execution of this First Amendment to the Clinical Experience Agreement, the new expiration date of the Agreement will be August 30, 2028.

All other terms and conditions of the Agreement remain in full force and effect.

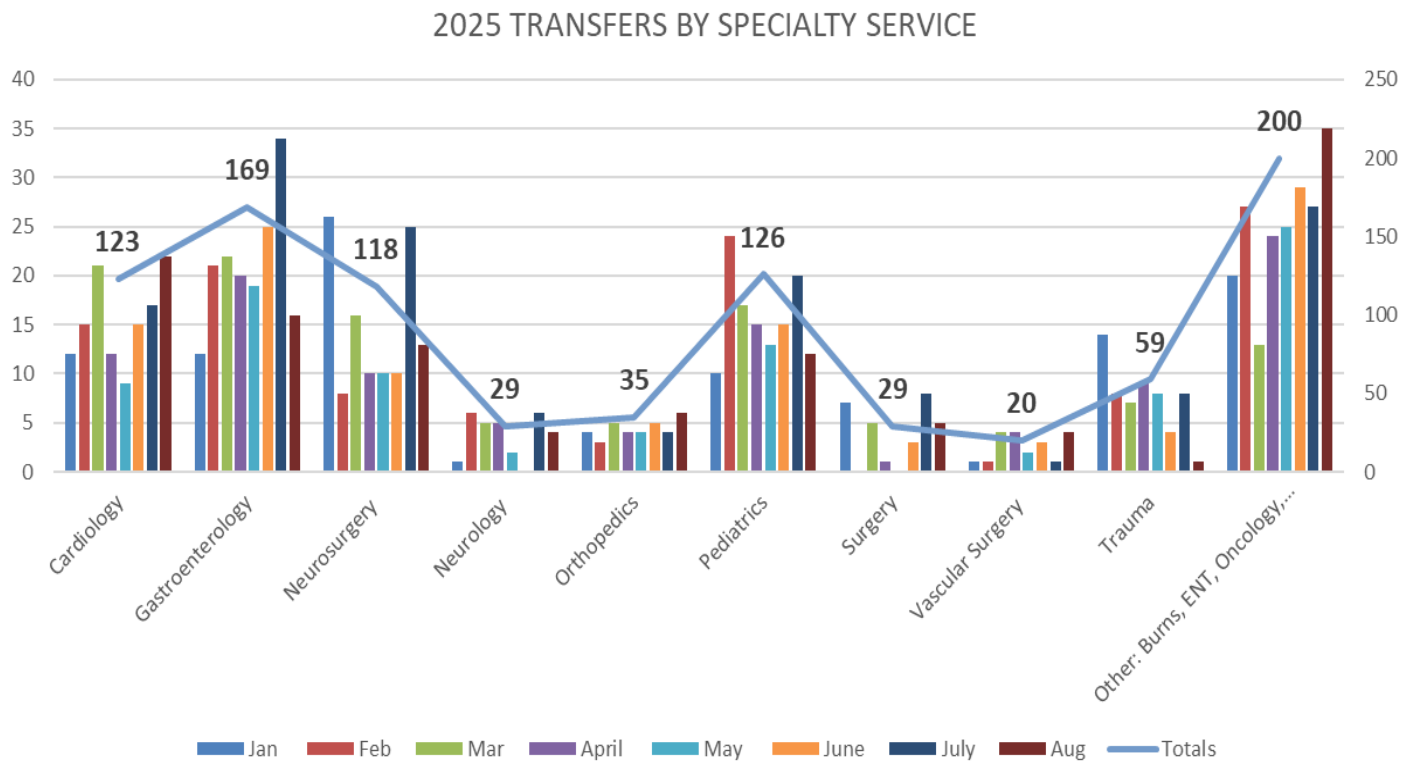
The parties execute this First Amendment as of the date first written above.

Point Loma Nazarene University	Imperial Valley Healthcare District
By: _____	By: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

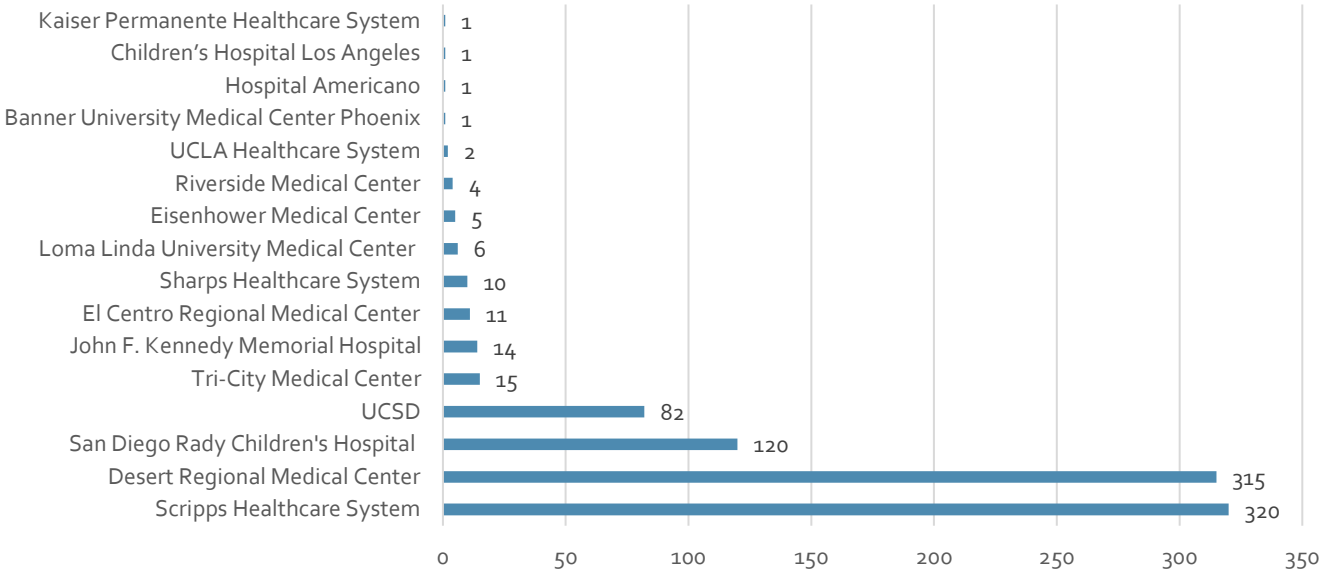
Board of Directors Meeting – Chief Nursing Officer Report

September 2025



Specialty	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	Totals
Cardiology	12	15	21	12	9	15	17	22	123
Gastroenterology	12	21	22	20	19	25	34	16	169
Neurosurgery	26	8	16	10	10	10	25	13	118
Neurology	1	6	5	5	2	0	6	4	29
Orthopedic	4	3	5	4	4	5	4	6	35
Pediatrics	10	24	17	15	13	15	20	12	126
Surgery	7	0	5	1	0	3	8	5	29
Vascular Surgery	1	1	4	4	2	3	1	4	20
Trauma	14	8	7	9	8	4	8	1	59
Other: Burns, ENT, Oncology, Ophthalmology, Podiatry, Urology	20	27	13	24	25	29	27	35	200
January through April 2025	**107**	**113**	**115**	**104**	**92**	**109**	**150**	**118**	**908**

TRANSFERS BY ACCEPTING FACILITY
JANUARY THROUGH AUGUST 2025



Accepting Facilities	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	Total
Scripps Healthcare System	40	42	37	42	39	59	46	15	320
Desert Regional Medical Center	38	27	51	36	30	23	56	54	315
San Diego Rady Children's Hospital	10	22	15	14	12	15	20	12	120
UCSD	5	6	4	8	7	7	17	28	82
Tri-City Medical Center	6	1	3	0	0	3	1	1	15
John F. Kennedy Memorial Hospital	1	4	2	1	3	0	1	2	14
Loma Linda University Medical Center	0	3	2	1	0	0	0	0	6
El Centro Regional Medical Center	2	3	0	0	0	1	2	3	11
Sharps Healthcare System	1	2	1	0	0	0	3	3	10
Eisenhower Medical Center	0	3	0	0	0	1	1	0	5
Riverside Medical Center	3	0	0	0	0	0	1	0	4
Banner University Medical Center Phoenix	1	0	0	0	0	0	0	0	1
Hospital Americano	0	0	0	1	0	0	0	0	1
UCLA Healthcare System	0	0	0	1	0	0	1	0	2
Children's Hospital Los Angeles	0	0	0	0	1	0	0	0	1
Kaiser Permanente Healthcare System	0	0	0	0	0	0	1	0	1
Totals	**107**	**113**	**115**	**104**	**92**	**109**	**150**	**118**	**908**

From January through August, there were a total of 30,543 Emergency Department visits. Of these, 908 visits (2.97%) resulted in transfers to other facilities. The most commonly transferred specialties were Gastroenterology, Cardiology, and Pediatrics.

- **Gastroenterology transfers** were primarily due to the need for definitive GI intervention/management and intervention, often involving critically ill patients requiring specialized care. We will be increasing on-call GI coverage in the immediate future.
- **Cardiology transfers** were mainly for emergent catheterizations or other invasive cardiac procedures.
- **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).

In August 2025, we received 2 incoming transfer requests from ECRMC. These included one obstetrics case and one pediatric case.

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Board of Directors Meeting – Chief Nursing Officer Report
September 2025

Staffing:

	New Hires	In Orientation	FT to PD status	Resignations	Open Positions
Medical Surgical	4	4	0	0	2
Intensive Care Unit	0	0	0	2	3
Pediatrics	1	1	0	0	0
Emergency Department	0	7	0	0	4
Perioperative Services	2 (EVS, SCT)	3 (1PACU RN ,2 Circulator RNs)	0	1	3
Perinatal Services	2	4	1	0	3
NICU	3	3	0	0	0
Cardiopulmonary Services	1 RCP	1RCP	0	0	2 RCP
Case Management	0	0	0	0	0
Totals	**13**	**23**	**1**	**3**	**17**

Travelers:

- (2) Labor and Delivery Nurses: 2-day shift (1 more will return on 9/8)
- (1) 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	July 2025	Aug 2025
89.11%	83.70%	88.63%	90.71%	91.88%	91.4%	91.73%	92.58%	93.22%

Patient Experience – Q3 2025

HCAHPS								
	AUG 2025	JULY 2025	2Q2025	1Q2025	4Q2024	3Q2024	2Q2024	1Q2024
Overall	74.60	71.79%	62.80%	66.7%	69.5%	69.7%	84.6%	73.7%
Communication With Nurses	86.06	80.66%	82.80%	80%	76.7%	78.2%	76.3%	79.6%
Communication With Doctors	88.22	83.57%	83.44%	81%	80.2%	73.1%	82.8%	81.8%

- Implementation of Press Ganey iRounding
- Increasing Service Recovery
- Implemented hourly rounding
- Reinforcing Quiet time

Nurse Residency Program

	Total	Key Points
Nurse Residency Program	**45**	• **17 Winter 25' cohort/28 Summer 25' cohort** ○ **Cohort A (ADN)** = 20 with 100% NCLEX pass rate ○ **Cohort B (BSN)** = 8 pending clearances from BRN to schedule NCLEX test. • Nurse Residency Classes are every 2nd Wednesday of the month and are for all Nurse Residency Participants
Student Nurse Interns	**20**	**9** SDSU /**11** IVC
20/40 Program students	**5**	**3** ED/ **1** OB/ **1** PT
Newly Hired Novice Nurses (RNIP)	**14**	

High Fidelity Simulations:

- Mock Codes and Skills fairs have been scheduled through November.
- Victoria Birthing Simulator is on loan- we have OB Skills Fair and Mock Codes scheduled through the end of September.
- Cardiopulmonary team will be hosting high-level respiratory education for nurse residents in September.
- NICU/OB/RT mega Code Scheduled for 9/19/25

Emergency Department:

ED Throughput Metrics						
INDICATOR	GOAL	1ST QUARTER	MAY	JUNE	JUL	AUG
Average Daily Visits	>125 Patients	137 Patients	130 Patients	123 Patients	119 Patients	119 Patients
Median Time to Triage	<10 minutes	10 minutes	8 minutes	7 minutes	8 minutes	6 minutes
Average Length of Stay for Discharged Patients	<180 minutes	190 minutes	187 minutes	183 minutes	183 minutes	176 minutes
Average Length of Stay for all Patients	<160 minutes	205 minutes	210 minutes	198 minutes	203 minutes	191 minutes
Average Length of Stay for all Transfers	<160 minutes	511 minutes	446 minutes	515 minutes	473 minutes	499 minutes

Medical Surgical Department:

Inpatient Throughput									
INDICATOR	GOAL	1Q2024	1Q2025	MAR 2025	APR 2025	MAY 2025	JUN 2025	JUL 2025	AUG 2025
Time of Orders Written to Head in Bed	90 min	372 min	220 min	130 min	111 min	123 min	185 min	152 min	145 min

Perioperative Services:

	Goal	JAN 2025	FEB 2025	MAR 2025	APR 2025	MAY 2025	JUNE 2025	JULY 2025
First Case On-Time Starts (%)	≥ 90%	65.9	70.8	59.7	69.1	67.6	65.6	59
Day Of Surgery Cancellation Rate (%)	≤ 5%	3.2	2.5	2	4.1	3	2.2	2.4
Time-Out Compliance (%)	100%	98	98	98	99	98.21	94.52	98.27
Case Volumes Including Robotics	YTD-1578	497	348	385	348	477	373	418
Robotics	YTD-70	19	11	11	17	17	19	38
IUSS	0%	0	0	0	0	0	0	0

PIONEERS
IMPERIAL VALLEY
HEALTHCARE DISTRICT

Board of Directors Meeting – Chief Nursing Officer Report

September 2025

Case Management:

Indicator		Goal	Jan	Feb	Mar	Apr	May	June	July	Aug	Average / Total
	Average Daily Census		57	46	44	46	50	54	54	NA	50
Acute LOS	GMLOS (Expected)		3.62	3.49	*3.53*	*3.5*	*3.37*	*3.62*	*3.46*	*3.38*	*3.50*
	ALOS (Actual)	<4.50	3.75	2.93	*2.65*	*2.56*	*2.76*	*3.16*	*2.88*	*2.84*	*2.94*
Case Mix Index	Acute: Case Mix Index (CMI)	>1.40	1.473	1.41	1.28	*1.33*	*1.29*	*1.353*	*1.257*	*1.34*	*1.34*
	Acute: Medicare CMI	>1.55	1.59	1.54	1.48	*1.47*	*1.62*	*1.357*	*1.438*	*1.51*	*1.50*
Medicare	Medicare One-Day Stay Count		8	13	12	11	16	10	13	15	11.88
	% Medicare 1-day Stays		7	10	12	15	14	11	11	14	11.70
Observation	Total Observation Cases		33	24	39	17	38	37	37	33	32.25
	Observation to IP Converted		23	5	15	4	18	21	15	19	15.00
	Observation % Conversion Rate		69.7	20.8	38.5	23.5	47.4	56.8	40.5	57.6	44.35
Readmissions	All-Cause Hospital-Wide Readmissions (HWR)	<10	3.86	6.16	3.62	4.05	2.93	5.23	3.57	4.68	4.26

*N/A= not available at time of report

Case Management:

- Increasing Clinical documentation efforts to improve CMI.

Perinatal Department:

- August Deliveries: 150 (104 vaginal, 21 primary C-Section, 25 secondary C-Section)
- June Non-Stress Tests conducted: 205
- June OB checks: 294

Neonatal Intensive Care Unit:

- NICU will start the Neonatal Stabilization project funded by First 5. Recently approved by the Board of Directors to purchase the 6 Panda Beds.

Pediatrics:

- Pediatrics is on the planning stage, collaborating with Cardiopulmonary for the Asthma Prevention & Management Program, as part of the First 5 Grant.
- On 9/4/2025 the Pediatric Team launched a Backpack Project wherein the unit provided backpacks with school supplies for the PMH Day Care students.

Medical Surgical Unit:

- Implemented hourly rounding, promoting quiet time and improving discharge education and communication regarding plan of care.

Cardio-Pulmonary:

- Five Asthma Mini-Grant: Teaming up with the NICU Director to roll out the TRACK framework and improve discharge planning for asthma patients 0-5 years old, admitted with a diagnosis of asthma. This includes post discharge referrals to the Asthma Wellness Program at ECRMC which is part of the Enhanced Care Management Asthma Remediation Program.

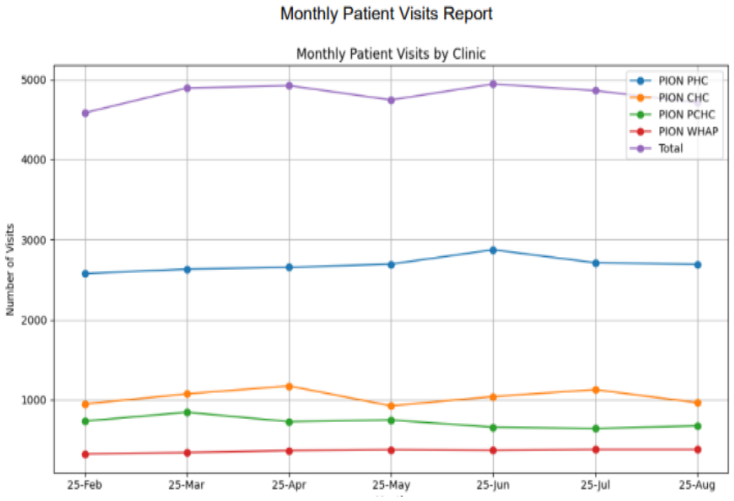
REPORT DATE	MONTHLY STATUS REPORT	PREPARED BY
Date: August 2025 Activity	Chief of Clinic Operations	Carly Zamora, MSN, RN

2025 IVHD/PMH AMBULATORY DIVISION RHC ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
IVHD Transition	Ongoing	N/A	Weekly Meetings. On-Site Clinic Site Visit scheduled 9/11/25 with ECRMC
Staffing:	Ongoing	N/A	1-PD LVN
Reviewing Expansion of RHC	Early Stages	N/A	On-HOLD
Provider Additions	100%	N/A	Behavioral Health tentative October 2025.
Quality Measures	Pending	N/A	CHPIV Medical Record Audit 9/10/25 CHPIV Site Review 9/15/25
Stats			

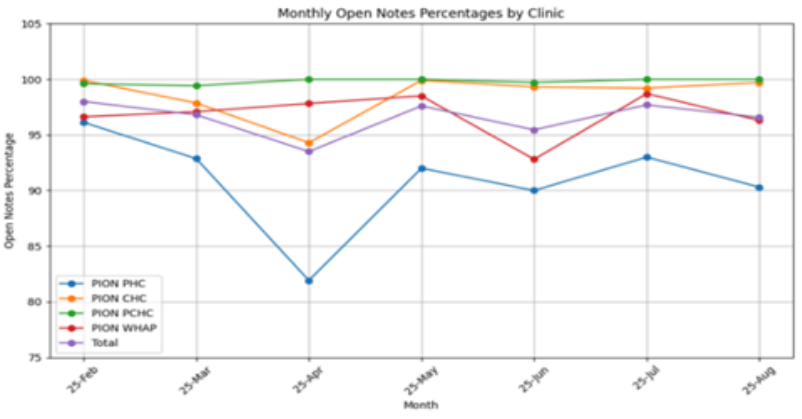
Patient Visits

Clinic	25-Jul	25-Aug	Variance
PHC	2712	2693	-19
CHC	1127	965	-162
PCHC	643	675	32
WHAP	379	379	0
Total	**4861**	**4944**	

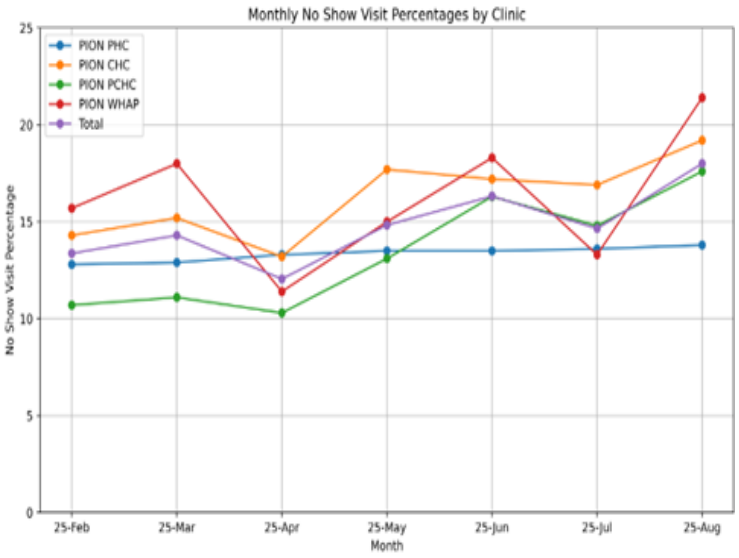


Locked Notes

Clinic	25-Jul	25-Aug	Variance
PHC	93.00%	90.30%	-2.70%
CHC	99.20%	99.70%	0.50%
PCHC	100.00%	100.00%	0.00%
WHAP	98.70%	96.30%	-2.40%
Total	**97.70%**	**96.57%**	



No Show Visits			
Clinic	**25-Jul**	**25-Aug**	**Variance**
PHC	13.60%	13.80%	-0.20%
CHC	16.90%	19.20%	-2.30%
PCHC	14.80%	17.60%	-2.80%
WHAP	13.30%	21.40%	-8.10%
Total	**14.65%**	**18.00%**	



2025 IVHD/PMH AMBULATORY DIVISION OPD SPECIALITY CLINIC ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
IVHD Transition	Ongoing	N/A	Weekly Meetings. On-Site Clinic Site Visits scheduled 9/11/25 with ECRMC
GI	Ongoing	None	Streamlining staffing due to added Provider starting August 25th, 2025, increase in Volumes.. Dr. Idrees Suliman started 8/25/25.
Staffing ECM	Ongoing	TBD	Met with ECM Team regarding Merger, Met with ECRMC team.
Staffing	Ongoing	N/A	1 FT Positions open in GI, currently interviewing.
Infusion	Ongoing	N/A	Met with Team regarding Merger
Stats			See below:

Specialty Clinic Dashboard

Total Visits	Average No Show Rate	Total Locked Notes	Average Pt Satisfaction
1,310	10.4%	93%	Q4 - 73.51 %

Patient Visits

Clinic	Last Month	This Month	Variance
Ambulatiory Infusion	191	198	4%
Center for Digestive & Liver Disease	125	68	-46%
Comprehensive Women's Health	486	442	-9%
Surgical Health	61	38	-38%
Surgical Health - Urology	359	283	-21%
Wound Clinic	291	281	-3%

No Show Rate

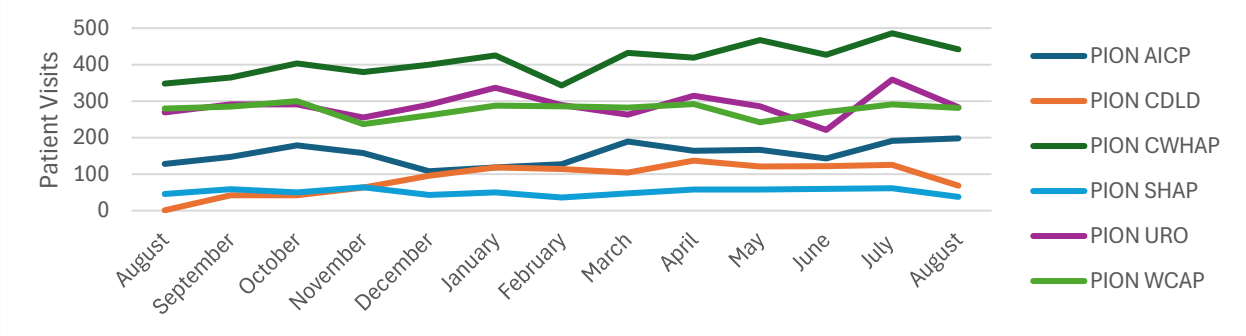
Clinic	Last Month	This Month	Variance
Ambulatory Infusion	6.6%	5.9%	-10.6%
Center for Digestive & Liver Disease	17.8%	12.6%	-29.2%
Comprehensive Women's Health	9.5%	11.5%	21.1%
Surgical Health	3.2%	3.6%	12.5%
Surgical Health - Urology	10.7%	11.8%	10.3%
Wound Clinic	8.1%	9.3%	14.8%

Closed Notes

Clinic	Last Month	This Month	Variance
Ambulatiory Infusion	100%	100%	0%
Center for Digestive & Liver Disease	98%	100%	2%
Comprehensive Women's Health	91%	88%	-4%
Surgical Health	98%	92%	-6%
Surgical Health - Urology	76%	79%	4%
Wound Clinic	100%	97%	-3%

Patient Satisfaction - Top Box Score

Clinic	FY25 Q3	FY25 Q4	FY26 Q1
Ambulatiory Infusion	No Data	No Data	Pending
Center for Digestive & Liver Disease	No Data	69.14%	Pending
Comprehensive Women's Health	No Data	74.17%	Pending
Surgical Health	No Data	95.45%	Pending
Surgical Health - Urology	No Data	55.26%	Pending
Wound Clinic	No Data	No Data	Pending



2025 IVHD/PMH AMBULATORY DIVISION PHYSICAL THERAPY ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
IVHD Transition	Ongoing	N/A	Meet and greet to be Scheduled month of September
Staffing	Ongoing	N/A	1 PT Physical Therapy Assistant.
Cerner on-going	Ongoing	N/A	Working with patient accounting on Cerner Reviews and Reporting-Tickets Placed
Inpatient/Outpatient Review	Meetings Ongoing with Nursing	N/A	OP Volumes Consistent

2025 IVHD/PMH RADIOLOGY ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
IVHD Transition	Ongoing	N/A	Meetings being held Bi-weekly. Working Collaboratively on IR Procedures.
Canon CT Project	Early Stages	. Payments will occur once the scanner is installed and operational	Currently in the early stages, Plans/Proposals being reviewed for general contracting.
PACS System	Ongoing	None	Working on the PACS Back Up Server
Staffing	Ongoing	None	RN/LVN FT (Onboarding, Nuclear Medicine FT Position Opening (traveler extended additional 13 weeks) MRI FT position filled 1 PD MRI filled and 1 PD opening, currently interviewing.
Radiology Monthly Meeting Schedule	100%	None	Meeting continues to be held to discuss Radiology orders and workflow with departments, goals set (protocols).
Stats:			

	24-AUG	YTD-24	25-AUG	YTD-25
Nuclear Med	53	291	45	324
DIAGNOSTIC	2,697	22,711	2,865	25,261
DEXA	56	465	106	576
Mammo	228	1,774	225	1,890
MRI	160	1,404	204	1,694
US	1,482	12,996	1,484	12,117
CT	1,816	14,088	2,021	16,863

2025 IVHD/PMH LABRATORY ACTIVITIES/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
IVHD Transition	Ongoing	N/A	Meetings being held weekly. Meet and greet to be scheduled with ECRMC
Staffing	Ongoing	Contracting	2 FT Clinical Laboratory Scientist Positions open
Process Improvement	Ongoing	N/A	Reporting in October Q3
Annual Health Fair	Scheduled		Employee TB & FLU Vaccinations starts 9/9/25.

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	Ongoing	N/A	Meetings being held weekly. Meet and greet to be scheduled with ECRMC
Policy Updates-IVHD PMHD	Ongoing	N/A	Policies and procedures are being reviewed and updated to reflect the IVHD PMH name change. This includes pharmacy operations, compliance documentation, and clinical protocols.
Clean Room/Compounding Trailer/Pharmacy Space	Review Stages	N/A	July met reviewed space needs. Exploring move of the main Pharmacy, to a more usable space and keeping compound rooms in their current locations.
Provider Collaboration	Ongoing	N/A	Ongoing work with providers to update policies and protocols. Formulary requests are being reviewed for drug efficiency and cost. Pharmacy attending Medical Staff Meetings.
Pharmacy & Therapeutics (P&T) Committee	Scheduled	N/A	Meeting August 21st. The committee oversees evaluation and approval of medications, formulary management, and clinical guidelines to ensure safe and effective patient care.

2025 IVHD/PMH CHIEF OF CLINIC OPERATIONS/UPDATES

PROJECT/ISSUE	PERCENT COMPLETE	EXPENSE TO DATE	ACTION/NOTES
Physician Updates	Ongoing	N/A	Recruitment ongoing- 4 pending Provider Contracts (September-November Board Meeting) PD-Pediatric GI Physician-start 2025-New Provider Urologist Renewal in Review Wound Care Renewals in Review General Surgery Renewal in Review Psychiatrist in Review with Medical Staff Call Contract Meetings to be held
Contracts	Ongoing	N/A	Contract Review ongoing monthly
Locums	Ongoing	N/A	No Current Locums and pending Gaps in OB Call October-December. Gaps in Peds Call starting September
Projects:			
Centralized Scheduling	Ongoing	N/A	Meetings Held in August with Managers, Directors and Consulting Group. Innova initiating Review and Process Changes.
Ring Central (New Call Center Software)	Ongoing	Monthly Expense	Ring Central Productivity being monitored and reviewed, team members added to nurse line, Reviewing Prompts
Expansion of OP Infusion	Early Stages	N/A	On HOLD
Notable	Ongoing	N/A	49% utilization within all departments

Grants	Ongoing	N/A	Reviewing New Grants for Submission Path Cited Grant Submitted 5/2/2025 waiting notification if awarded.
IVHD Transition	Ongoing	N/A	Meet weekly- Meet and Greets being Scheduled 9/3/25: QIP Teams 9/4/25: Radiology 9/10/25: Meeting with CNO 9/11/25: OP Centers