Hazel Hawkins
MEMORIAL HOSPITAL

**REGULAR MEETING OF THE BOARD OF DIRECTORS**

**SAN BENITO HEALTH CARE DISTRICT**

**911 SUNSET DRIVE, HOLLISTER, CALIFORNIA**

**THURSDAY, APRIL 25, 2024 – 5:00 P.M.**

**SUPPORT SERVICES BUILDING, 2nd-FLOOR, GREAT ROOM**

**IN PERSON AND BY VIDEO CONFERENCE**

*Members of the public may participate remotely via zoom at the following link https://zoom.us/join with the following Webinar ID and Password:*

**Meeting ID 921 8501 9918**

**Security Passcode: 970928**

**Mission Statement -** The San Benito Health Care District is a public agency that serves as a responsive, comprehensive health care resource for its patients, physicians, and the health care consumers of the community.

**Vision Statement -** San Benito Health Care District is committed to meeting community health care needs with quality care in a safe and compassionate environment.

## AGENDA

**Presented By:**

1. **Call to Order / Roll Call** (Johnson)

2. **Board Announcements** (Johnson)

3. **Public Comment** (Johnson)
   This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on matters within the jurisdiction of this District Board, which are not otherwise covered under an item on this agenda. This is the appropriate place to comment on items on the Consent Agenda. Board Members may not deliberate or take action on an item not on the duly posted agenda. Written comments for the Board should be provided to the Board clerk for the official record. Whenever possible, written correspondence should be submitted to the Board in advance of the meeting to provide adequate time for its consideration. Speaker cards are available.

4. **Consent Agenda – General Business** (Johnson)
   The Consent Agenda deals with routine and non-controversial matters. The vote on the Consent Agenda shall apply to each item that has not been removed. A Board Member may pull an item from the Consent Agenda for discussion. One motion shall be made to adopt all non-removed items on the Consent Agenda.

**A.** Consider and Approve Minutes of the Special Meeting of the Board of Directors – March 21, 2024 (Pages 1-2)

**B.** Consider and Approve Minutes of the Special Meeting of the Board of Directors – March 25, 2024 (Pages 3-4)

**C.** Consider and Approve Minutes of the Regular Meeting of the Board of Directors – March 28, 2024

**D.** Consider and Approve Policies: (Pages 5-19)

- Universal Bilirubin Screening for Newborns at 35 Weeks or More of Gestation
- Identification and Reporting of Suspected Victims of Abuse and Domestic Violence
- Blanket-Solution Warmer

**E.** Receive Officer/Director Written Reports - No action required. (Pages 20-30)

- Provider Services & Clinic Operations
- Skilled Nursing Facilities Reports (Mabie Southside/Northside)
- Laboratory and Radiology
- Foundation Report
- Facilities Report
- PMO Project Summary Report

*Recommended Action: Approval of Consent Agenda Items (A) through (E).*

- ▶ Report
- ▶ Board Questions
- ▶ Motion/Second
- ▶ Action/Board Vote-Roll Call

**5.** **<u>Medical Executive Committee</u>** (Report Provided at Meeting) (Dr. Bogey)

***A.*** Consider and Approve Medical Staff Credentials: March 20, 2024
*Recommended Action: Approval of Credentials*

- ▶ Report
- ▶ Board Questions
- ▶ Public Comment
- ▶ Motion/Second
- ▶ Action/Board Vote-Roll Call

***B.*** Consider and Approve Revised OPPE Policy
*Recommended Action: Approval of Revised OPPE Policy*

- ▶ Report
- ▶ Board Questions
- ▶ Public Comment
- ▶ Motion/Second
- ▶ Action/Board Vote-Roll Call

**6. Receive Informational Reports** (Pages 31-50)

**A.** Board Education - Merger, Affiliation and Partnership; Risks and Benefits (Jeff Summer/Clare Kelley-Stroudwater Assoc.)

- ▶ Public Comment

**B.** Transaction Update (Peil/B.Riley)

- ▶ Public Comment

**C.** Chief Executive Officer (Casillas)

- ▶ Public Comment

**D.** Nurse Executive Consultant (Posey)

- ▶ Public Comment

**E.** Finance Committee (Robinson)

1. Finance Committee Meeting Minutes – April 18, 2024

2. Review Financial Updates
   - Financial Statements – March 2024
   - Finance Dashboard – March 2024
   - Supplemental Payments

   - ▶ Public Comment

**7. Action Item**

A. Consider Recommendation for Board Approval of Telemetry Services Agreement with Hicuity Health, Inc. for Three Years (Pages 51-71) (Robinson)

*Recommended Action: Approval of Telemetry Services Agreement*

- ▶ Report
- ▶ Board Questions
- ▶ Public Comment
- ▶ Motion/Second
- ▶ Action/Board Vote-Roll Call

**8. Public Comment**
This opportunity is provided for members to comment on the closed session topics, not to exceed three (3) minutes. (Johnson)

**9. Closed Session** (Johnson)
(See Attached Closed Session Sheet Information)

**10. Reconvene Open Session / Closed Session Report** (Johnson)

**11. <u>Adjournment</u>** (Johnson)

The next Regular Meeting of the Board of Directors is scheduled for Thursday, May 23, 2024 at 5:00 p.m., Great Room.

The complete Board packet including subsequently distributed materials and presentations is available at the Board Meeting, in the Administrative Offices of the District, and posted on the District's website at https://www.hazelhawkins.com/news/categories/meeting-agendas/. All items appearing on the agenda are subject to action by the Board. Staff and Committee recommendations are subject to change by the Board.

Any public record distributed to the Board less than 72 hours prior to this meeting in connection with any agenda item shall be made available for public inspection at the District office. Public records distributed during the meeting, if prepared by the District, will be available for public inspection at the meeting. If the public record is prepared by a third party and distributed at the meeting, it will be made available for public inspection following the meeting at the District office.

Notes: Requests for a disability-related modification or accommodation, including auxiliary aids or services, to attend or participate in a meeting should be made to District Administration during regular business hours at 831-636-2673. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

**SAN BENITO HEALTH CARE DISTRICT BOARD OF DIRECTORS**
**APRIL 25, 2024**

## AGENDA FOR CLOSED SESSION

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

## CLOSED SESSION AGENDA ITEMS

**[ ] LICENSE/PERMIT DETERMINATION**
(Government Code §54956.7)

**Applicant(s)**: (Specify number of applicants)_____

**[ ] CONFERENCE WITH REAL PROPERTY NEGOTIATORS**
(Government Code §54956.8)

**[X ] CONFERENCE WITH LEGAL COUNSEL-EXISTING LITIGATION**
(Government Code §54956.9(d)(1))

**Name of case:** (Specify by reference to claimant's name, names of parties, case or claim numbers):
San Benito Health Care District dba Hazel Hawkins Memorial Hospital, Case No. 23-50544 (United States Bankruptcy Court for the Northern District of California, San Jose Division)

**Case name unspecified:** (Specify whether disclosure would jeopardize service of process or existing settlement negotiations):_____

**[ ] CONFERENCE WITH LEGAL COUNSEL-ANTICIPATED LITIGATION**
(Government Code §54956.9)

Significant exposure to litigation pursuant to Section 54956.9(d)(2) or (3) (Number of potential cases):

Additional information required pursuant to Section 54956.9(e):_____

Initiation of litigation pursuant to Section 54956.9(d)(4) (Number of potential cases):____

**[ ] LIABILITY CLAIMS**
(Government Code §54956.95)

**Claimant:** (Specify name unless unspecified pursuant to Section 54961):
**Agency claimed against**: (Specify name):_____.

**[ ] THREAT TO PUBLIC SERVICES OR FACILITIES**
(Government Code §54957)

**Consultation with**: (Specify the name of law enforcement agency and title of officer):_____

**[ ] PUBLIC EMPLOYEE APPOINTMENT**
(Government Code §54957)

**Title**:

**[ ] PUBLIC EMPLOYMENT**
(Government Code §54957)

**Title:**

**[ ] PUBLIC EMPLOYEE PERFORMANCE EVALUATION**
(Government Code §54957)

**Title:** (Specify position title of the employee being reviewed):

**[ ] PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE**
(Government Code §54957)

(No additional information is required in connection with a closed session to consider discipline, dismissal, or release of a public employee. Discipline includes potential reduction of compensation.)

**[ ] CONFERENCE WITH LABOR NEGOTIATOR**
(Government Code §54957.6)

**[ ] CASE REVIEW/PLANNING**
(Government Code §54957.8)
(No additional information is required to consider case review or planning.)

**[ ] REPORT INVOLVING TRADE SECRET**
(Government Code §37606 & Health and Safety Code § 32106)

Discussion will concern: (Specify whether discussion will concern proposed new service, program, or facility):

1. Trade Secrets, Strategic Planning, Proposed New Programs, and Services.

**Estimated date of public disclosure**: (Specify month and year):

**[ ] HEARINGS/REPORTS**
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

**Subject matter**: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, or report of quality assurance committee):

**[ ] CHARGE OR COMPLAINT INVOLVING INFORMATION PROTECTED**

**BY FEDERAL LAW** (Government Code §54956.86)

(No additional information is required to discuss a charge or complaint pursuant to Section 54956.86.)

**ADJOURN TO OPEN SESSION**

# SPECIAL MEETING OF THE BOARD OF DIRECTORS
# SAN BENITO HEALTH CARE DISTRICT
# SUPPORT SERVICES BLDG., 2ND FLOOR - GREAT ROOM

**THURSDAY, MARCH 21, 2024**
**2:00 PM**

**MINUTES**
**IN PERSON AND BY ZOOM VIDEO CONFERENCE**

**MINUTES**

**Directors Present**
Jeri Hernandez, Board Member
Bill Johnson, Board Member
Devon Pack, Board Member
Rick Shelton, Board Member

**Absent**
Josie Sanchez, Board Member

**Also Present**
Mary Casillas, Chief Executive Officer
Mark Robinson, Chief Financial Officer
Amy Breen-Lema, VP Clinic, Ambulatory, & Phys. Services
Andrea Posey, Interim Chief Nursing Officer
Heidi Quinn, District Legal Counsel
Chela Brewer, Executive Assistant



1. **Call to Order- Roll Call**

   Directors Hernandez, Johnson, Pack, and Shelton were present; attendance was taken by roll call.

   Directors Josie Sanchez and Devon Pack were absent.

   A quorum was present and the Special Meeting was called to order at 2:00 p.m. by Director Hernandez.

   Director Pack arrived at 2:03 p.m.

2. **Update on Portal Transaction Partners**

   The District's consultant, Richard Peil of B.Riley provided an update to the Board.

   An opportunity was provided for public comment and individuals were given three minutes.

3. **Action Item**

**A**. Consider Temporary Advisory Committee's Recommendations Regarding County of San Benito's Letter of Intent for a Proposed Business Transaction with the District and Provide Authority to Negotiate

Ms. Mary Casillas, CEO, introduced Cecilia Montalvo, San Benito County's Consultant, and Supervisors Angela Curro, and Kollin Kosmicki with the San Benito County Board of Supervisors.

A PowerPoint presentation was provided to the Board, and is available online.

An opportunity was provided for public comment and individuals were given three minutes.

**Motion:** By Director Hernandez to Approve the Letter of Intent for a proposed business transaction with the County of San Benito and provide authority to negotiate.
Second by Director Johnson.

**Moved/Seconded/and Unanimously Carried:** Ayes: Directors Hernandez, Johnson, Pack and Shelton. Approved 4-0 by roll call, with Director Sanchez absent

4. **Adjournment:**

There being no further business or actions, the meeting was adjourned at 3:52 p.m.

The next Regular Meeting of the Board of Directors in scheduled for Thursday, March 28, 2024 at 5:00 p.m.

*Audio of the Special Board Meeting may be found at the District's website at* Healthcare Services Hollister, CA | Hazel Hawkins Memorial Hospital.

# SPECIAL MEETING OF THE BOARD OF DIRECTORS
# SAN BENITO HEALTH CARE DISTRICT
# SUPPORT SERVICES BLDG., 2ND FLOOR GREAT ROOM

**MONDAY, MARCH 25, 2024**
**2:00 PM**
**MINUTES**
**IN PERSON AND BY ZOOM VIDEO CONFERENCE**

**MINUTES**

**Directors Present**
Jeri Hernandez, Board Member
Bill Johnson, Board Member
Devon Pack, Board Member
Rick Shelton, Board Member

**Absent**
Josie Sanchez, Board Member

**Also Present**
Mary Casillas, Chief Executive Officer
Mark Robinson, Chief Financial Officer
Amy Breen-Lema, VP Clinic, Ambulatory, & Phys. Services
Andrea Posey, Interim Chief Nursing Officer
Heidi Quinn, District Legal Counsel
Chela Brewer, Executive Assistant



1. **Call to Order- Roll Call**

   Directors Hernandez, Johnson, Pack, and Shelton were present; attendance was taken by roll call.

   Director Josie Sanchez was absent.

   A quorum was present and the Special Meeting was called to order at 2:00 p.m. by Director Hernandez.

2. **Public Comment**

   An opportunity was provided for public comment and individuals were given three minutes.

## 3. Closed Session

President Hernandez announced the items to be discussed in Closed Session as listed on the posted Agenda:
(1) Conference with Legal Counsel-Existing Litigation, Government Code §54956.9(d)(1)
Name of case: San Benito Health Care District dba Hazel Hawkins Memorial Hospital, Case No. 23-50544 (United States Bankruptcy Court for the Northern District of California, San Jose Division). Full details are noted in the Agenda.

The meeting was recessed into Closed Session at 2:05 p.m.

The Board completed its business of the Closed Session at 4:00 p.m.

## 4. Reconvene Open Session/Closed Session Report

The Board of Directors reconvened into Open Session at 4:20 p.m. District Counsel Quinn reported that in Closed Session the Board discussed: (1) Conference with Legal Counsel-Existing Litigation, Government Code §54956.9(d)(1). An update was provided to the Board but no reportable action was taken.

## 5. Adjournment

There being no further business or actions, the meeting was adjourned at 4:00 p.m.

The next Regular Meeting of the Board of Directors in scheduled for Thursday, March 28, 2024 at 5:00 p.m.

*Audio of the Special Board Meeting may be found at* Healthcare Services Hollister, CA | Hazel Hawkins Memorial Hospital

Hazel Hawkins MEMORIAL HOSPITAL

# Universal Bilirubin Screening for Newborns at 35 Weeks or More of Gestation

## Disclaimer



## Revision Insight

| | |
|---|---|
| Document ID: | 12057 |
| Revision Number: | 0 |
| Owner: | Jacqueline Fernandez, |
| Revision Official Date: | No revision official date |

Revision Note:
Replacing biliflash policy.

# Policy : Universal Bilirubin Screening for Newborns at 35 Weeks or More of Gestation

## PURPOSE

To outline the universal bilirubin screening program so that newborns at risk for severe hyperbilirubinemia are identified, evaluated and treated, when necessary.

## POLICY

All newborns 35 weeks gestational age or greater are screened for hyperbilirubinemia prior to discharge using a transcutaneous bilirubinometer (TcB) or a total serum bilirubin (TSB). All bilirubin results will be interpreted based on the infant's age in hours. Nurses may obtain a bilirubin level using the TcB or draw blood for a total serum bilirubin without an order as warranted by the infant assessment.

## PROCEDURE

A. Assess every infant for the presence of jaundice during each physical assessment.

B. Assess for hyperbilirubinemia risk factors. Risk factors Include:
- Lower gestational age (i.e., risk increases with each additional week less than 40 weeks)
- Jaundice in the first 24 hours after birth
- Predischarge transcutaneous bilirubin (TcB) or total serum bilirubin (TSB) concentration close to the phototherapy threshold
- Hemolysis from any cause, if known or suspected based on a rapid rate of increase in the TSB or TcB of > 0.3 mg/dL per hour in the first 24 hours or > 0.2 mg/dL per hour thereafter
- Phototherapy before discharge
- Parent or sibling requiring phototherapy or exchange transfusion
- Family history or genetic ancestry suggestive of inherited red blood cell disorders, including glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Exclusive breastfeeding with suboptimal intake
- Scalp hematoma or significant bruising
- Down syndrome
- Macrosomic infant of a diabetic mother

C. Obtain a bilirubin level using a TcB, or send a blood sample to the lab for total serum bilirubin (TSB) on all infants at 24 hours of life (and on any infant appearing significantly jaundiced regardless of age) Obtain TCB every 24 hours of life or prior to discharge.

D. Use Bili tool to evaluate TCB/TSB. If TCB elevated, get TSB to confirm. Mark neurotoxicity risk factor in Bili tool if infant has the following risk factors:
- Gestational age <38 weeks and this risk increases with the degree of prematurity
- Albumin <3.0 g/dL
- Isoimmune hemolytic disease (i.e., positive direct antiglobulin test), G6PD deficiency, or other hemolytic conditions
- Sepsis
- Significant clinical instability in the previous 24 hours.

E. Notify pediatrician of bilirubin results and assess need for phototherapy.

F. For babies undergoing phototherapy, TcB should not be used, please get TSB.

G. For infants with elevated bilirubin, give the infant's parents or caregivers the infant's last bilirubin level, weight, follow-up plan, physicians name and phone number with other discharge instructions. Instruct parents to take this information to their first follow-up appointment scheduled in 48 to 72 hours.

H. Educate all parents about neonatal jaundice, and provide written education.

## REFERENCES

1. American Academy of Pediatrics. (2022). Management of hyperbilirubinemia in the newborn infant 35 or weeks of gestation (Clinical Practice Guideline). *Pediatrics, 114,* 297-316. Retrieved from: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;114/1/297
2. Association of Women's Health, Obstetric and Neonatal Nurses. (2010). Assessment and care of late preterm infant (Evidence-Based Clinical Guideline. Washington, D.C.: Author.
3. Association of Women's Health, Obstetric and Neonatal Nurses. (2009, Nov revised and reaffirmed). Universal screening for hyperbilirubinemia (Position Statement). Retrieved from www.awhonn.org

4. Centers for Disease Control and Prevention. (June, 2006). Jaundice alert: What every parent needs to know. Retrieved from http://www.cdc.gov/ncbddd/jaundice/documents/kernicterus_fs.pdf
5. Gennaro, S., Schwoebel, A., Hall, J.Y., & Bhutani, V.K. (2006). Hyperbilirubinemia: Identification and management in the healthy term and near-term infant (Practice Monograph). Washington, D.C.: AWHONN.
6. The Joint Commission. (August 31, 2004). Revised guidance to help prevent kernicterus (Sentinel Event Alert, Issue 31). From http://www.jointcommission.org/sentinel_event_alert_issue_31_revised_guidance_to_help_prevent_kernicterus/

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|---|---|---|---|
| **Document ID** | 12057 | **Document Status** | In preparation |
| **Department** | Obstetrics | **Department Director** | Fernandez, Jacqueline |
| **Document Owner** | Fernandez, Jacqueline | **Next Review Date** | |
| **Keywords** | hyperbilirubinemia, tcb, tsb, infant, jaundice, phototherapy, pediatrician | | |
| **Attachments: (REFERENCED BY THIS DOCUMENT)** | | | |
| **Other Documents: (WHICH REFERENCE THIS DOCUMENT)** | | | |

Hazel Hawkins MEMORIAL HOSPITAL

# Identification and Reporting of Suspected Victims of Abuse and Domestic Violence

## Disclaimer



## Revision Insight

| | |
|---|---|
| Document ID: | 10344 |
| Revision Number: | 1 |
| Owner: | Jacqueline Fernandez, |
| Revision Official Date: | No revision official date |

Revision Note:
Converting from Word to HTML format. Updated title from "Abuse - Identification and Reporting of Suspected Abuse" to "Identification and Reporting of Suspected Victims of Abuse and Domestic Violence"

# Policy : Identification and Reporting of Suspected Victims of Abuse and Domestic Violence

## PURPOSE

All Health care workers are mandated to identify, assess, evaluate, intervene, and report suspected victims of abuse to the appropriate authorities.

All patients over the age of fourteen (14) are to be screened for abuse at areas of entry to the facility.

## POLICY

It is Hazel Hawkins Memorial Hospital's policy to screen all patients upon entry to the facility for signs of abuse. All suspected and confirmed cases will be reported.

A. Early recognition and routine screening can significantly reduce the morbidity and mortality that results from violence. Routine screening is an effective way to identify patients who are being abused.

B. The following are the types of abuse that may be inflicted upon another individual and are reportable by law.
   1. Emotional Abuse
      a. Mental or emotional injury to the person that results in an observable and material impairment in growth, development or psychological functioning.
      b. Causing or permitting the person to be in a situation in which the person sustains a mental or emotional injury that results in an observable and material impairment in growth, development, or psychological functions.
   2. Physical Abuse
      a. Physical injury that results in substantial harm to the person or the genuine threat of substantial harm from physical injury to the person, including an injury that is at variance with the medical history or explanation given. This excludes an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the person to a substantial risk of harm.
      b. Failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the person.
   3. Sexual Abuse
      a. Sexual contact, sexual intercourse, sexual conduct, sexual penetration with a foreign object, incest, sexual assault or sodomy inflicted upon, shown to or intentionally practiced in the presence of a child or dependent adult, if the child or dependent adult is present only to arouse or gratify desires of any person.
      b. Failure to make a reasonable effort to prevent sexual contact, sexual intercourse, sexual conduct, sexual assault, or sodomy inflicted on, shown to or intentionally practiced in the presence of a child or dependent adult, if the child or dependent adult is present only to arouse or gratify desires of any person.
      c. Compelling or encouraging the person to engage in sexual conduct.
      d. Causing, permitting, encouraging or allowing the photographing, filming or depicting of the person if the person knew or should have known that the resulting photograph, film or depiction is obscene or pornographic.
   4. Domestic Violence

      Characterized as a pattern of coercive behaviors that may include repeated battery and injury, psychological abuse, sexual assault, progressive social isolation, deprivation and intimidation.
      a. All patients will be screened upon entry to the facility. This could be from the Emergency Department, Surgery Department, Direct Admission, the Clinic, or Skilled Nursing Facilities.
      b. All patients admitted for nursing services will be screened with the following question:

         “Are you being hurt/frightened/threatened by anyone?”

         This should be done:
         1. In a safe environment. No friends or relatives of the patients should be present during the screening and preferably no children over the age of two (2).
         2. Face to face, with assurance to the patient that the screening will be confidential. Use a non-threatening, non-judgmental manner.
         3. Using questions that are direct, specific and easy to understand in the patient’s primary language. Interpreters should be another healthcare provider. Do not use the patient’s family, friend, or children when asking questions about domestic violence.
      c. Document in the patient’s chart that domestic violence is or has been present, has not occurred, or is suspected even if the patient denies it. Complete Abuse/Domestic Violence Screening/Documentation Form

5. Financial Abuse

   Financial or material abuse is the misuse or stealing of money, assets, or belongings of another person for personal gain, sometimes by coercion, threats, or deception. Financial abuse may be experienced by a partner, child, and or caregiver who does the following: controls your money, steals from you and or refuses to contribute to the household expenses.

6. Digital Abuse

   Someone who engages in digital abuse exerts control using social media, texting, and other forms of technology. Digital abuse is most common in dating relationships and especially affects teenagers. Digital abuse may involve: Cyberbullying, demanding to know passwords, sexting (nonconsensual) and controlling social media use.

7. Abandonment

   The leaving of the person in a situation where they would be exposed to a substantial risk or harm without arranging for necessary care, and a demonstration of an intent not to return by a parent, guardian or managing possessory conservator.

8. Medical Neglect

   The failure to seek, obtain or follow through with medical care for a person, with the failure resulting in presenting a substantial risk of death, disfigurement or bodily injury, or with the failure resulting in an observable and material impairment to the growth, development and/or functioning of a person.

9. Physical Neglect

   The failure to provide the person with food, clothing, or shelter necessary to sustain life or health of the person, excluding failure caused primarily by financial inability unless relief services had been offered and refused.

C. The identification process is multidimensional and often complicated. The following criteria may be used to assist in identification of abuse.

1. Physical Abuse
   a. Scratches, cuts, bruises, burns.
   b. Welts, scalp injury, gag marks.
   c. Sprains, punctures, broken bones, bedsores.
   d. Confinement.
   e. Injuries inconsistent with explanation of occurrence.
2. Rape/Other Forms of Sexual Abuse
   a. Trauma to penis, vulva and/or anal region
   b. Sexual manipulation of penis, vulva and/or anal region with a foreign object
   c. Diagnosis of sexually transmitted disease in children and non-sexually-active adolescents
3. Neglect

   The failure to provide for one's self, the goods, or services, which are necessary to avoid physical harm, mental anguish, or mental illness, or the failure of a caretaker to provide such goods or services.
   a. Malnourishment, dehydration.
   b. Over/under medication.
   c. Lack of heat and or running water.
   d. Lack of medical care.
   e. Lack of personal hygiene and/or clothes.
4. Exploitation

   The illegal or improper act or process of using the resources of a child or an elderly or disabled person for monetary or personal benefit.
   a. Taking social security/SSI checks.
   b. Abusing joint checking account privileges.
   c. Taking property and/or other resources
5. Verbal and psychological abuse
6. In children under three (3)years of age
   a. The caregiver of an injured child reports a change in the child (such as decreased mobility) instead of reporting an accident.
   b. The extent of the injury is more severe that the reported cause would indicate.
   c. A child under one (1) year old suffers a fracture of the radius, ulna tibia/fibula, or femur.
7. In persons 65 years of age or older or in disabled persons:
   a. Contusions or lacerations are inconsistent with patients or caregiver's explanation of injury.
   b. Contusions or lacerations are found where people are not usually injured, such as inner thighs.
   c. Injuries from different causes which occurred at the same time: for example, stab wound and contusions.
   d. Symmetrical wounds or fractures are present.
   e. The patient has suffered a spiral long-bone fracture from a "direct blow".
   f. Multiple bruises appear to be in the same evolutionary state.
   g. The patient is wearing bloodstained undergarments.

h. The caregiver has provided improper levels of prescription medication.

i. The patient is dehydrated or malnourished.

j. Wounds or lesions are not properly attended.

- The rights and responsibilities of the individual
- The hospital will protect the patient from neglect, exploitation, and abuse while patient is receiving care, treatment and services at Hazel Hawkins Memorial Hospital.

D. Reporting

All suspected and confirmed cases of victim abuse will be reported to the appropriate follow-up and/or law enforcement agency. The shift coordinator and/or social services will be notified in the case of inpatients. Northside SNF, and Mabie SNF will follow their specific policy reporting guidelines.

1. Child Abuse/Neglect – Child Protective Services and Law Enforcement Agency

   See attached Appendix C. Follow instructions on form for completion and distribution. Yellow copy = chart copy.

2. Elder/Dependent Abuse/Neglect (age 65 years or older or 18-64 whose physical/mental limitations restrict their ability to care for themselves).

   Adult Protective Services and Law Enforcement agency (see attached Appendix A)

3. Domestic Violence – Law Enforcement agency
   a. The local law enforcement agency will be contacted where the incident of violence occurred, if known.

   b. A telephone report shall be made immediately. In all cases, a written report must be made within two (2) working days. Failure to report where required is a misdemeanor, punishable by fine of $1,000 and/or a jail term or six months (P.C. Sect 11162)

E. Documentation
1. Patient record

2. Appropriate reporting form

F. Patient Teaching

Hand out “Domestic Violence” (in English and Spanish) located in public and patient areas, including public restrooms.

## DESIGNEE

- MD/DO
- All SBHCD Healthcare Workers

## REFERENCES

- *California Penal Code: Sections 11160, 11161, 11166*
- *California Welfare and Institutions Code: Section 15630*
- *California Board of Registered Nursing: Nursing Practice Act*
- *APM Policy*
- *Child Sexual Assault Reporting Requirements (Appendix A)*
- *Mandated Reporting Simplified (Appendix B)*

## ATTACHMENTS

Appendix A – Child Sexual Assault Reporting Requirements (See below)

Appendix B - A Quick Reference Guide to Assault and Abuse Reporting Requirements (California Hospital Association - 03/15)

## Appendix A: Child Sexual Assault Reporting Requirements

| Activity | Report Required | Source |
|---|---|---|
| Minor under age 14: consensual sexual activity with minor partner under age 14 and of similar age, and additional facts do not suggest abuse.<br>This includes minors under age 14 who seek medical treatment for STDs, pregnancy, or abortion, where practitioners believe these conditions are the result of consensual sexual activity, and additional facts do not suggest abuse. | NO | *Planned Parenthood Affiliates of CA v. Van de Kamp*<br><br>*People v. Stockton Pregnancy Control Medical Clinic*<br><br>67 Ops. Atty. Gen. 235, 6-1-84 |
| Minor under age 14: Consensual sexual activity with partner age 14 or over, and additional facts do not suggest abuse | YES | Cal. Pen Code § 288(a)<br>Cal. Penal Code § 11165.1(a)<br>*In re Paul C.* |
| Minor age 14 or 15: Consensual sexual activity with partner at least 10 years older, and additional facts do not suggest abuse | YES | Cal. Pen Code § 288(a)<br>Cal. Penal Code § 11165.1(a) |
| Minor age 14 or over: consensual sexual activity with minor partner age 14 or over and of similar age, and additional facts do not suggest abuse. | NO | Imputed from lack of requirement for younger minors, legislative silence on the issue, and holding in *People v. Stockton* |
| Minor under age 16: consensual sexual intercourse (statutory rape) with partner age 21 or older, and additional facts do not suggest abuse. | YES | Cal. Pen Code § 261.5(d)<br>Cal. Penal Code § 11165.1(a) |
| Minors age 14 or over but younger than age 16: Consensual sexual activity with person under 21, and additional facts do not suggest abuse. | NO | Not specifically mandated by new reporting law |
| Minor age 16 or over: consensual sexual activity with adult of any age, and additional facts do not suggest abuse. | NO | Not specifically mandated by new reporting law |
| Other situations where provider knows or has a reasonable suspicion that there has been sexual assault, as defined in the statute. | YES | Cal. Penal Code § 11165.1(a) |

| | | | |
|---|---|---|---|
| **Document ID** | 10344 | **Document Status** | In preparation |
| **Department** | Nursing Administration | **Department Director** | Fernandez, Jacqueline |
| **Document Owner** | Fernandez, Jacqueline | **Next Review Date** | |
| **Original Effective Date** | 02/01/2010 | | |
| **Revised** | [05/01/2007], [09/01/2012], [04/20/2021 Rev. 0] | | |
| **Reviewed** | [02/01/2010], [12/01/2012], [03/01/2015], [06/01/2016], [01/01/2019] | | |
| **Keywords** | emotional, mental, injury, sexual, physical, threats, neglect, abandonment | | |
| **Attachments: (REFERENCED BY THIS DOCUMENT)** | A Quick Reference Guide to Assault and Abuse Reporting Requirements | | |
| **Other Documents: (WHICH REFERENCE THIS DOCUMENT)** | Assault and Abuse Reporting Policy/Guidelines | | |

*A Quick Reference Guide to*

# ASSAULT AND ABUSE REPORTING REQUIREMENTS

| | Child Abuse and Neglect | Elder/Dependent Adult Abuse | Injury by Firearm or Assaultive/ Abusive Conduct |
|---|---|---|---|
| **Reporting Trigger** | Mandated reporter has observed or has knowledge of a child whom he or she knows or reasonably suspects has been the victim of child abuse or neglect. May also report serious emotional damage or risk thereof (not required)<br><br>**Includes:** non-accidental physical injury that was not self-inflicted; sexual abuse; neglect; willful harm, injury or endangerment; unlawful corporal punishment or injury; abuse or neglect in out-of-home care<br><br>**Applies to:** minors under age 18<br><br>**Note:** reporting of a minor's sexual activity varies with age and circumstances | Mandated reporter has observed or has knowledge of (including being told by the elder/dependant adult) an incident that reasonably appears to be abuse<br><br>**Includes:** physical abuse, neglect, financial abuse, abandonment, isolation, abduction or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering<br><br>**Applies to:** elder persons age 65 or older; dependent adults ages 18 to 64 with physical or mental limitations; adult inpatients (age 18 to 64) in an acute care hospital or other 24-hour health facility | Health practitioner and physician providing medical services to a patient whom they reasonably suspect has a *physical* condition resulting from:<br>1. A wound or injury by a firearm (self-inflicted or by another person) or<br>2. A wound or injury resulting from assaultive or abusive conduct (as defined by Penal Code 11160(d))<br><br>**Includes:** murder, mayhem, assault, rape, battery, abuse of spouse or cohabitant and additional offenses as defined by Penal Code 11160(d)<br><br>Duty to report applies even if treating a condition not related to the assault, abuse or firearm injury |
| **To Whom to Report** | Local law enforcement, designated county probation department or county welfare department | Varies depending on where the suspected/alleged abuse occurred:<br>**1. Long-term care facility, physical abuse:** report to local ombudsman, local law enforcement, and corresponding licensing agency (CDPH or DSS)<br>**2. Long-term care facility, abuse other than physical:** report to local ombudsman or local law enforcement<br>**3. State mental health hospital or state development center:** report to designated investigators at California Department of State Hospitals, California Department of Developmental Services, and local law enforcement<br>**4. Anywhere other than the above:** report to adult protective services agency or local law enforcement | Local law enforcement |
| **Time Frame** | 1. Immediate telephone report<br>2. Follow up with written report by mail, fax or email within 36 hours | 1. Immediate report by telephone or confidential Internet reporting tool (if available)<br>2. If initially reported by phone, follow up with written report or Internet report within two working days<br>**NOTE:** If the abuse occurred in a long-term care facility, quicker reporting is required (sometimes within 2 hours of learning of the incident). See Welfare and Institutions Code Section 15630(b). | 1. Immediate telephone report<br>2. Follow up with written report within two working days |
| **Required Form** | "Suspected Child Abuse Report," Department of Justice, Form SS 8572. Obtain from local social services or child protective services agency or download at www.ccfmtc.org | "Report of Suspected Dependent Adult/Elder Abuse," California Department of Social Services, Form SOC 341, download at www.ccfmtc.org | "Suspicious Injury Report," Office of Emergency Services (OES), Form CalOES 2-920, download at www.ccfmtc.org |

**Sexual Assault/Rape** In addition to the above reporting requirements, each county must designate at least one general acute care hospital to perform forensic examinations on victims of sexual assault, including child molestation. Examination requires the consent of the patient. Local law enforcement must be notified by telephone prior to beginning the forensic examination. Forensic report forms may be downloaded at www.ccfmtc.org.

*See chapter 19, "Assault and Abuse Reporting Requirements," of CHA's* Consent Manual *for additional information.*



CALIFORNIA HOSPITAL ASSOCIATION
1215 K Street, Suite 800, Sacramento, CA 95814 • (916) 443-7401 • www.calhospital.org

Hazel Hawkins MEMORIAL HOSPITAL

# Blanket-Solution Warmer

## Disclaimer



## Revision Insight

| | |
|---|---|
| Document ID: | 12078 |
| Revision Number: | 0 |
| Owner: | Jacqueline Fernandez, |
| Revision Official Date: | No revision official date |

Revision Note:
No revision note

# Policy : Blanket-Solution Warmer

## PURPOSE

To maintain warm solutions/blankets for patient comfort in patient care areas.

## POLICY

A warming cabinet will be used to raise the temperature of Intravenous (IV) and irrigation solutions and/or blankets to an acceptable level for patient application.

## DESIGNEE

Patient Care Team

Sterile Processing Technicians

Transporter/Unit Clerk/Techs

Surgical Technician

Nurses/Licensed Vocational Nurses

Nursing Assistants

## EQUIPMENT

Warmer

Blanket-Solution Warmer Temperature Log

## PROCEDURE

1. The control dial for the blanket warmer chambers will be set at 125° Fahrenheit (F) for not to exceed 130°F. For solutions the chamber can be set for 101°F and not to exceed 104°F. Warming solution range can be from 86°F-104°F.
2. The temperature of the chambers will be verified and documented daily Monday – Friday and on weekends when staff is present. A Blanket-Solution Warmer Temperature Log will be used to capture temperature, if a temperature is out of range a work order will be placed for the Engineering department to follow up. In the instance where a temperature is found to be out of acceptable range, a member of the Engineering team will acknowledge and adjust accordingly. Close loop communication will be done with department lead or designee.
3. Temperature of solutions will be checked prior to use for safe patient use; pouring a sample or feeling the outside of an IV bag is an acceptable indicator. In the event temperature is found to be out of range, the following process will be implemented:

   Create a Work Order (WO) via the Hazel Hawkins Intranet, select **Eng Request** tab, fill out all required fields and Submit.
   The system will generate a WO ticket number. Record that number on the *Blanket-Solution Warmer Temperature Log*.
   If the solution warmer's temperature is above acceptable range, please contact pharmacy.
4. Shelving provided by the manufacturer will be used to support effective warming.
5. Solutions will be loaded in the unit to support a first in last out rotation; load from front left, front to back. Pull from right front. They will be dated as soon as stocked in the warmer, after 4 weeks, if unused, they will be discarded.
6. Blankets will be loaded in the unit to support patient care needs.
7. To reach desired temperature:
   - Solutions in bags-10-12 hours
   - Solutions in bottles-5-6 hours
   - Blankets –4 hours

## DOCUMENTATION

Blanket-Solution Warmer Temperature Log

## REFERENCES


AORN GUIDELINES

https://www.aorn.org/article/2021-12-03-Environment-of-Care

U.S. Pharmacopeia: Microsoft Word - m2773_c659.docx (uspnf.com) USP659

https://www.ecri.org/search-results/member-preview/hrc/pages/surgan23

| | | | |
|---|---|---|---|
| **Document ID** | 12078 | **Document Status** | In preparation |
| **Department** | Administration - Multidisciplinary | **Department Director** | Fernandez, Jacqueline |
| **Document Owner** | Fernandez, Jacqueline | **Next Review Date** | |
| **Attachments: (REFERENCED BY THIS DOCUMENT)** | | | |
| **Other Documents: (WHICH REFERENCE THIS DOCUMENT)** | | | |

To: San Benito Health Care District Board of Directors

From: Amy Breen-Lema, Vice President, Clinic, Ambulatory & Physician Services

Date: April 16, 2024

Re: All Clinics – March 2024

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## Rural Health and Specialty Clinics' visit volumes

| Clinic Location | Total visits current month |
|---|---|
| *Orthopedic Specialty* | 285 |
| *Multi-Specialty* | 669 |
| *Sunset* | 910 |
| *Surgery & Primary Care* | 143 |
| *San Juan Bautista* | 206 |
| *1st Street* | 815 |
| *4th Street* | 1,211 |
| *Barragan* | 638 |
| **Total** | **4,877** |

This month as part of **National Doctors' Day**, we honor our physicians for their unwavering dedication and invaluable contributions to patient care at all our health clinics.

- ***Zarin Amin DO, OB/Gyn***
- ***Ralph Armstrong DO, OB/Gyn***
- ***Aslam Barra MD, OB/GYN***
- ***Leticia Bradford MD, Orthopedic Surgery***
- ***Benedict Carota MD, Family Medicine***
- ***Raymond Carrillo MD, Nephrology***
- ***Dina Casparro DPM, Podiatry***
- ***Prathibha Chandrasekaran MD, Gastroenterology***
- ***Margaret Cooper Vaughn MD, OB/GYN***
- ***Russell Dedini MD, Orthopedic Surgery***
- ***Piyush Dhanuka MD, Gastroenterology***
- ***Joseph Fabry, DO, General Surgery***
- ***Taynet Febles MD, Infectious Disease***
- ***Nick Gabriel DO, General Surgery***
- ***Jerry Ginsburg MD, Cardiology***
- ***Michael Grecula, MD, Orthopedic Surgery***
- ***Vivek Jain MD, Neurology***
- ***Joseph Jiang MD, Cardiology***
- ***Joseph Klapper MD, Cardiology***
- ***Stefan Klein MD, Orthopedic Hand Surgery***
- ***Michael Koteles MD, Endocrinology***
- ***Zainab Malik, MD, Psychiatry***
- ***Carol Mei MD, Hematology/Oncology***
- ***Nicholas Namihas MD, Gastroenterology***
- ***Hue Nguyen DO, Pediatrics***
- ***Jullian Nguyen MD, Family Medicine***
- ***Dennis Phan MD, Nephrology***
- ***Barbara Rever MD, Nephrology***
- ***Jiwu Sun MD, Internal Medicine***
- ***Arminda Tolentino MD, Family Medicine***
- ***Anita Tolentino-Macaraeg MD, Pediatrics***
- ***Christopher Verioti DO, Orthopedic Surgery***

Hazel Hawkins
MEMORIAL HOSPITAL

Mabie Southside/Northside Skilled Nursing Facility
Board Report – APRIL 2024

To: San Benito Health Care District Board of Directors

From: Dee Cross, RN, MLS, Interim Director of Nursing, Skilled Nursing Facility

## 1. Census Statistics: March 2024

| Southside | 2024 | Northside | 2024 |
|---|---|---|---|
| Total Number of Admissions | 7 | Total Number of Admissions | 1 |
| Number of Transfers from HHH | 7 | Number of Transfers from HHH | 0 |
| Number of Transfers to HHH | 6 | Number of Transfers to HHH | 1 |
| Number of Deaths | 0 | Number of Deaths | 0 |
| Number of Discharges | 12 | Number of Discharges | 5 |
| Total Discharges | 12 | Total Discharges | 5 |
| **Total Census Days** | **1305** | **Total Census Days** | **1,312** |

Note: Transfers are included in the number of admissions and discharges. Deaths are included in the number of discharges. Total census excludes bed hold days.

## 2. Total Admissions: March 2024

| Southside | From | Payor | Northside | From | Payor |
|---|---|---|---|---|---|
| 4 | HHMH | Medicare | 0 | HHH | Medicare |
| 3 | HHMH/Re-Admit | Medicare | 0 | HHH/Re-Admit | CCA |
| | | | 1 | Salinas Valley | INS (Hospice) |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **Total: 7** | | | **Total: 3** | | |

## 3. Total Discharges by Payor: March 2024

| Southside | 2024 | Northside | 2024 |
|---|---|---|---|
| Medicare | 8 | Medicare | 2 |
| Medicare MC | 0 | Medicare MC | 0 |
| CCA | 4 | CCA | 2 |
| Medical | 0 | Medical | 1 |
| Medi-Cal MC | 0 | Medi-Cal MC | 0 |
| Hospice | 0 | Hospice | 0 |
| Private (self-pay) | 0 | Private (self ay) | 0 |
| Insurance | 0 | Insurance | 0 |
| **Total:** | **12** | **Total:** | **5** |

## 4. Total Patient Days by Payor: March 2024

| Southside | 2024 | Northside | 2024 |
|---|---|---|---|
| Medicare | 239 | Medicare | 3 |
| Medicare MC | 0 | Medicare MC | 0 |
| CCA | 973 | CCA | 1127 |
| Medical | 62 | Medical | 127 |
| Medi-Cal MC | 0 | Medi-Cal MC | 0 |
| Hospice | 0 | Hospice | 23 |
| Private (self-pay) | 31 | Private (self-pay) | 31 |
| Insurance | 0 | Insurance | 0 |
| Bed Hold / LOA | 19 | Bed Hold / LOA | 1 |
| **Total:** | **1324** | **Total:** | **1,312** |
| **Average Daily Census** | **42.71** | **Average Daily Census** | **42.32** |

To: San Benito Health Care District Board of Directors
From: Bernadette Enderez, Director of Diagnostic Services
Date: April 2024
Re: Laboratory and Diagnostic Imaging

Updates:

**Laboratory**

1. Service/Outreach
   - Providing specimen collection and labeling in-service to Provider offices.

2. Quality Assurance/Performance Improvement Activities
   - Currently working with Nursing departments on a process improvement for blood transfusion documentation.

3. Laboratory Statistics

| | March 2024 | YTD |
|---|---|---|
| Total Outpatient Volume | 4122 | 12086 |
| Main Laboratory | 1176 | 3553 |
| HHH Employee Covid Testing | 1 | 23 |
| Mc Cray Lab | 1348 | 3319 |
| Sunnyslope Lab | 391 | 1144 |
| SJB and 4th Street | 25 | 144 |
| ER and ASC | 1181 | 3903 |
| Total Inpatient Volume | 183 | 604 |

**Diagnostic Imaging**

1. Service/Outreach
   - Made modifications on scheduling radiology outpatient procedures to improve patient experience.

2. Quality Assurance/Performance Improvement Activities
   - TJC inspection preparation activities with staff

3. Diagnostic Imaging Statistics

| | March 2024 | YTD |
|---|---|---|
| Radiology | 1863 | 5257 |
| Mammography | 709 | 2155 |
| CT | 927 | 2650 |
| MRI | 158 | 449 |
| Echocardiography | 108 | 215 |
| Ultrasound | 796 | 2252 |

**BOARD OF DIRECTORS**
**DISTRICT FACILITIES & SERVICE DEVELOPMENT COMMITTEE**

**Thursday, April 18, 2024**
**4:00 P.M. – Great Room**

# MINUTES

## I. CALL TO ORDER/ROLL CALL:

The meeting of the District's Facilities & Service Development Committee was called to order by Jeri Hernandez at 4:00p.m.

**COMMITTEE MEMBERS:**

| | |
|---|---|
| Jeri Hernandez, Board President | In Attendance |
| Bill Johnson, Board Vice President | In Attendance |
| Mary Casillas, VP, Chief Executive Officer | |
| Mark Robinson, VP, Chief Finance Officer | In Attendance |
| Amy Breen-Lema, VP, Clinics, Ambulatory & Physicians Services | In Attendance |
| Andrea Posey, Consultant | In Attendance |
| Doug Mays, Senior Director, Support Services | |
| William Pollard, Plant Operations Manager | In Attendance |
| Tina Pulido, Plant Operations\Construction Coordinator | In Attendance |

## II. APPROVAL OF MINUTES:

The minutes of the District's Facilities & Service Development Committee of March 21, 2024 were approved with a motion by Bill J. and second by Jeri H.

## III. UPDATE ON CURRENT PROJECTS:

- HHH Autoclave Replacement (Will P.)
  Will P. reported that HCAI has reviewed the project and we received a few comments back on 4/12. The comments will be resolved this week and resubmitted next week.

- HHH Boiler Replacement (Will P.)
  Will P. reported that we have received the stamped approved drawings from HCAI.

- HHH Respiratory Therapy TJC POC Case Work (Will P.)
  Will P. reported that installation is currently scheduled for April 25th.

## IV. UPDATE ON PENDING PROJECTS:

- HHH Med Surg Double Door Replacement (Will P.)
  Will P. reported that we will replace the mag sensor and broken door mechanism instead of replacing the doors which should correct the issue with the door not closing completely when the fire alarm is activated.

## V. UPDATE ON MASTER PLAN:

- SPC-4d (Will P.)
  Will P. reported that we are currently working on the following:

  1) Small and Rural Hospital Relief Program Application (PIN 71)
     Will P. reported that our plan has been accepted by HCAI and we are currently awaiting notification of grant approval.

2) AB 1882/OSHPD PIN 75 Signage Requirements
Will P. reported that we should have a response from the AOR by the beginning of next week if HCAI has approved the verbiage needed to go on the signs.

**VI. PUBLIC COMMENT:**
There was no public comment.

**VII. OTHER BUSINESS:**
There was no other business.

**VII. ADJOURNMENT:**
There being no further business, the meeting was adjourned at 4:10 PM. The next Facilities Committee meeting is scheduled for May 16, 2024.

TO: San Benito Health Care District Board of Directors
FROM: Liz Sparling, Foundation Director
DATE: April 2024
RE: Foundation Report

The Hazel Hawkins Hospital Foundation Board of Trustees met on April 11 at Noon the in the Horizon Room. Our guest presenter was Kyle Sharp from Edward Jones Investments who gave a presentation on our Foundation accounts.

| **Financial Report** | **March** |
|---|---|
| 1. Income | $ 8,624.49 |
| 2. Expenses | $ 7,988.41 |
| 3. New Donors | 1 |
| 4. Total Donations | 165 |

**Allocations**

1. The Board allocated reserved funds from designated Edward Jones accounts to be placed into a CD.

**Directors Report**

- Our All for 1 Employee Giving Campaign started on April 1st. We have sent letters to all employees to participate. This year we have over $44,000 pledged! Thank you to all the employees that have participated! The campaign runs through April 30.
- I am currently on a Committee that is reorganizing a Leadership Program back into San Benito County. We are currently operating under the Community Foundation as the San Benito County Leadership Institute. The application for the fall class is now available. If you know anyone who would be interested, please let me know and I can get them more information.
- We continue to fundraise and meet with donors to inform them on what the latest news is at the Hospital.

**Dinner Dance Report:**

- The Committee met and had lunch at the Paicines Ranch on March 28th. We toured the venue and are excited about our in person Dinner Dance this year on **November 2nd**. Please mark your calendars!

**Scholarship Committee:**

- The Foundation is awarding Scholarships for students perusing their career in the medical field and the deadline to apply was April 1st. The Committee is currently reviewing all applications.

**PMO Project Summary Report**

**Date:** 4.18.24

Summary of current and completed projects managed by the Project Management Office (PMO). This is a high-level overview of the PMO's activity, highlighting key initiatives and their outcomes.

**Current Projects**

| Project Name | Project Description | Start Date | Target Completion Date | Current Status | Key Deliverables |
|---|---|---|---|---|---|
| Access eForms/Passport | Access Passport is a web-based forms solution that provides access to the functional elements you need to remove all paper from your forms processes—making them completely electronic from start to finish. | 4/29/24 | 11/30/24 | Waiting for servers | New registration forms and new hardware install |
| BD Anti Diversion & Pyxis Install | Install larger Pyxis in ICU. Current one will go to OB Surg. Install new in PACU and outside OR. Returning Anesthesia units. Implement pharmacy diversion software across all. | 2/9/24 | TBD | Waiting on vendor | • Install add'l units and move units<br>• Install diversion software on units<br>• Install data drops and electrical |
| EHR Project | Identify and demo EHR systems | 2/14/24 | TBD | Waiting on direction of other EHR's to include (if any) | Schedule and coordinate demos |
| Insight Due Diligence | Coordinate gathering of data and put in data room | 3/19/24 | 5/31/24 | Waiting on new data room and all of data to be sent | Set up data room and collate data |

| | | | | | |
|---|---|---|---|---|---|
| MD Staff | MD-Staff is a feature rich enterprise level credentialing system that is powerful, user friendly, and intuitive. | 3/18/24 | 20-30 Weeks | Waiting on current vendor for data export | • Provide Source Data to vendor<br>• Provide Merge Documents and priv forms<br>• Training<br>• Add users |
| MM Charge master | Ensure charge codes for RAD are entered and general cleanup of MM charge master | 4/5/24 | TBD | Waiting on additional instructions | Data validation |
| Promoting Interoperability | Meet and successfully attest to CMS regulations | 1/5/24 | Q4 – calendar year (Oct-Nov-Dec) | In process | Attest and report out successful completion of identified measures |

**Completed Projects**

| Project Name | Project Description | Start Date | Completion Date | Key Achievements | Lessons Learned |
|---|---|---|---|---|---|
| Insight Health Visit | Coordinate Insight community visit | 2/22/24 | 3/14/24 | Introductions, data sharing, community involvement | Over-communicate |
| Midas Risk Pharmacy | Edit worklists to change direction of med errors to go to Pharm first to ensure MERP | 4/1/24 | 4/4/24 | Regulatory compliance | Tiffany is awesome! (I kind of already knew this.) She learned a process from a 10 min training session |

| | | | | | |
|---|---|---|---|---|---|
| | regulatory information is entered | | | | |
| Statit | Schedule, coordinate and attend STATIT training for new Med staff director | 2/26/24 | 2/28/24 | Med staff department trained on software for OPPE | |
| Telephone Answering Service | Research and provide options to Mishel of other answering services | 3/27/24 | 4/8/24 | Options provided to management that afforded them information to make an informed decision | |
| TMS | Add district assets to the Eng WO system to allow coordinating and Prev Maint scheduling | 12/1/23 | 3/4/24 | Entering of this data increases reporting capabilities and tracking of assets | |

**Metrics and Reporting**

Surveys are being sent out to the project owners upon close of their project. We will utilize this feedback to improve our project management processes.

Hazel Hawkins
MEMORIAL HOSPITAL

# CEO Report
April 2024

**Financial Emergency Update**

- Met with representative from the County and their consultants to review their financial model.

**CEO Activities**

- Continue to participate in strategy for AB1423 with CHA. Financial analysis was performed through CHA and HHH appears to benefit from this proposed change.
- Testified at the State Senate Health Committee in Sacramento in favor of AB1423 on April 24, 2024.
- Met with Monterey section CEO's through the Hospital Council. Topics discussed included; Seismic legislation, Office of Healthcare Affordability, Insurer accountability, and workforce pipeline, retention and work place violence.

**HR**

- The overall turnover rate for the hospital has been consistent and is currently slightly over 4% for the year.

**PMO**

- The PMO completed a 3-day demo of Meditech Expanse, an upgrade to our current EMR. Staff, administration and Physicians attended the demos. All sessions were recorded to have those that could not attend see the demonstrations and give feedback. The PMO is currently collecting feedback from those who attended the demos and planning next steps.

**Physician Services**

- Dr. Klein and Dr. Dedini have started seeing patients in the orthopedic clinic. Dr. Kebelo will be starting in May. With the addition of these physicians, our orthopedic service line is more robust and diversified than has been in recent years.
- The team has interviewed and conducted site visits for Psychiatry providers.

## HUMAN RESOURCES DASHBOARD 2024

| DEPARTMENTAL METRICS | January | February | March | Q124 |
|---|---|---|---|---|
| # Employees | 667 | 676 | 679 | 674 |
| # New Hires | 15 | 17 | 10 | 42 |
| # Terminations | 7 | 11 | 10 | 28 |
| Overall Turnover | 1.0% | 1.6% | 1.5% | 4.2% |
| Nursing Turnover | 0.78% | 1.53% | 2.3% | 4.6% |

| Terms By Union | January | February | March | Q124 |
|---|---|---|---|---|
| The California Nurses Association (CNA) | 1 | 2 | 3 | 6 |
| National Union of Healthcare Workers (NUHW) | 4 | 8 | 7 | 19 |
| California License Vocational Nurses (CLVN) | 0 | 0 | 0 | 0 |
| Non-Union | 2 | 1 | 0 | 3 |

| Terms By Reason (V=Voluntary & IV= Involuntary) | January | February | March | Q124 |
|---|---|---|---|---|
| Personal (V) | 2 | 4 | 2 | 8 |
| Retirement (V) | 4 | 2 | 1 | 7 |
| Schedule (V) | 1 | 0 | 1 | 2 |
| Job Abandonment (V) | 0 | 2 | 0 | 2 |
| No Reason Given (V) | 0 | 2 | 2 | 4 |
| Relocating (V) | 0 | 0 | 1 | 1 |
| Performance (IV) | 1 | 1 | 3 | 5 |

CHA | California Hospital Association

# News Release

**FOR IMMEDIATE RELEASE**
**Contact:**
Jan Emerson-Shea
(916) 804-0663
jemerson-shea@calhospital.org
@jemersonshea – Twitter

## Legislators to Consider Bill to Preserve Rural Health Care Services

**SACRAMENTO (April 18, 2024) —** Nearly 2 million people live in California's rural communities, while many millions more visit these areas for relaxation and exploration. Yet, the lifesaving and life-changing hospital care residents and visitors alike count on is at risk of being lost.

California's smallest rural hospitals — the 37 critical access hospitals with fewer than 25 beds that serve communities at least 35 miles from another medical facility — are facing their gravest challenge in decades. They are losing money every day caring for patients. Nearly two-thirds of these hospitals are operating at a severe loss — with their operating margins dropping a frightening 8 percentage points from 2019 to 2023.

Senate Bill (SB) 1423 (Dahle, R-Bieber), which will be considered on April 24 by the Senate Health Committee, would help stabilize these vital, at-risk hospitals by creating a new financial model designed to cover the cost of providing services to Medi-Cal patients. SB 1423 would help ensure all Californians have access to the care they need and deserve.

"Health care that keeps families whole and healthy should be accessible to all — not just those living in urban or suburban areas with access to multiple providers," said Carmela Coyle, President & CEO of the California Hospital Association. "Rural and critical access hospitals are not only the backbone of care in isolated, underserved areas throughout the state, they are also essential partners in the state's broader health care delivery system. Without these hospitals, providers in more populated areas would struggle to meet all the health care needs of patients from more remote communities."

The challenges facing rural and critical access hospitals are a national problem. Between January 2013 and February 2020, more than 100 rural hospitals across the country closed — including Corcoran District Hospital and Madera Community Hospital, both in California's Central Valley. When a rural hospital closes, those in poor health, seniors, and people experiencing poverty suffer the

most (nationally, 13% of people living in an area affected by a closure are below the poverty line, compared to 9% overall). For Medicare beneficiaries, a closure means the travel distance to access inpatient services increases by 20 miles; for specialized services, like treatment for substance use disorders, it increases by almost 40 miles.

In those rural communities where hospitals currently remain open, health care services are dwindling. Since 2011, one-fifth of California's rural hospitals have had to close or reduce maternity care, and 40% have stopped providing cancer services so they can continue providing 24/7 emergency care for all.

"Even in this difficult budget year, California lawmakers have a responsibility to ensure that our state's most remote communities continue to have access to vital health care services," Coyle said. "SB 1423 is urgently needed to protect California's most vulnerable residents."

Nurse Executive Consultant Report

April 2024

**Nursing**

- Business Continuity Planning for disaster preparedness is continuing
- Quality Director and IP Director start in May 2023.
- Attended Meditech Expanse Demonstrations.

**Regulatory**

- Continuing through the Mock Survey findings, conducting system tracers.
- Collaborating with the Clinical Informatics to ensure documentation in the computer meets all the regulatory requirements.

**Utilization Management**

- Continue work with INNOVA on 3 projects- CDI, charge capture, and Business Continuity
- Met with Savista leadership to discuss coding processes.

# CNO Dashboard 2024

| Description | Target | Jan-24 | Feb-24 | YTD 2024 |
|---|---|---|---|---|
| ED Visits | 2370 | 2249 | 2093 | 4619 |
| Admission % | 10% | 6% | 6% | 6% |
| LWBS % | < 2.0% | 0.04% | 0.06% | 0.05% |
| Door to Provider | 10 min | 7 min | 7 min | 7min |
| MS admissions | 120 | 107 | 103 | 313 |
| ICU admissions | 22 | 22 | 28 | 50 |
| Deliveries | 39 | 32 | 28 | 78 |
| OR Inpatient | 40 | 24 | 40 | 64 |
| OR Outpatient | 12 | 8 | 7 | 22 |
| ASC | 141 | 104 | 130 | 364 |
| GI | 94 | 69 | 85 | 163 |

Hazel Hawkins
MEMORIAL HOSPITAL

**REGULAR AND SPECIAL MEETING OF THE FINANCE COMMITTEE**
**SAN BENITO HEALTH CARE DISTRICT**
**911 SUNSET DRIVE, HOLLISTER, CALIFORNIA**
**THURSDAY, APRIL 18, 2024 - 4:30 P.M.**
**SUPPORT SERVICES BUILDING, 2ND FLOOR – GREAT ROOM**

*San Benito Health Care District is a public agency that serves as a responsive, comprehensive health care resource for its patients, physicians and the community.*

1. Call to Order

2. Approve Minutes of the Finance Committee Meeting of March 21, 2024
   - Motion/Second

3. Review Financial Updates
   - Financial Statements – March 2024
   - Finance Dashboard – March 2024
   - Supplemental Payments

4. Consider Recommendation for Board Approval of Telemetry Services Agreement with Hicuity Health, Inc.
   - Report
   - Committee Questions
   - Motion/Second

5. Public Comment
   This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on matters within the jurisdiction of this District Board **Committee,** which are not on this agenda.

6. Adjournment

   The next Finance Committee meeting is scheduled for **Thursday, May 16, 2024** at **4:30 p.m.**

The complete Finance Committee packet including subsequently distributed materials and presentations is available at the Finance Committee meeting and in the Administrative Offices of the District. All items appearing on the agenda are subject to action by the Finance Committee. Staff and Committee recommendations are subject to change by the Finance Committee.

Hazel Hawkins
MEMORIAL HOSPITAL

Notes: Requests for a disability-related modification or accommodation, including auxiliary aids or services, to attend or participate in a meeting should be made to District Administration during regular business hours at 831-636-2673. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

Hazel Hawkins
MEMORIAL HOSPITAL

April 18, 2024

**CFO Financial Summary for the District Board:**

For the month ending March 31, 2024, the District's Net Surplus (Loss) is $1,522,945 compared to a budgeted Surplus (Loss) of ($77,920). The District exceeded its budget for the month by $1,600,865.

YTD as of March 31, 2024, the District's Net Surplus (Loss) is $10,347,594 compared to a budgeted Surplus (Loss) of $549,584. The District is exceeding its budget YTD by $9,798,010.

It is estimated that the annual cost of returning to the pre-bankruptcy benefits plan would be approximately **$7 million** for the first year.

Acute discharges were 186 for the month, slightly exceeding budget by 8 discharges or 5%. The ADC was 16.58 compared to a budget of 16.54. The ALOS was 2.76. The acute I/P gross revenue was under budget by **$168,943** while O/P services gross revenue was **$1.4 million** or 5% over budget. ER I/P visits were 140 and ER O/P visits were over budget by 173 visits or 9%. The RHCs & Specialty Clinics treated 3,923 (includes 638 visits at the Diabetes Clinic) and 954 visits respectively.

**Other Operating** revenue was over budget by **$119,726** due mainly to the Magellan Health Rx rebate being higher than budgeted.

**Operating Expenses** were under budget by **$344,396** due mainly to positive variances in: Employee Benefits of $263,142, Professional Fees of $269,702 and Supplies of $202,487 being offset with higher than budgeted expenses in Registry of $284,381 and Purchase Service of $140,889.

**Non-operating Revenue** exceeded budget by **$14,684** due mainly to higher than budgeted donations and other non-op revenue.

The SNFs ADC was **84.39** for the month. The Net Surplus (Loss) is **$213,138** compared to a budget of $221,041. YTD, the Net Surplus (Loss) is $3,129,760, exceeding its budget by $1,132,372.

HAZEL HAWKINS MEMORIAL HOSPITAL - COMBINED
HOLLISTER, CA 95023
FOR PERIOD 03/31/24

| | CURRENT MONTH | | | | | YEAR-TO-DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 |
| GROSS PATIENT REVENUE: | | | | | | | | | | |
| ACUTE ROUTINE REVENUE | 3,700,859 | 3,654,406 | 46,453 | 1 | 3,642,241 | 29,990,018 | 39,956,189 | (9,966,171) | (25) | 37,237,472 |
| SNF ROUTINE REVENUE | 1,967,580 | 2,092,500 | (124,920) | (6) | 2,142,850 | 19,180,768 | 18,562,500 | 618,268 | 3 | 18,373,200 |
| ANCILLARY INPATIENT REVENUE | 4,625,077 | 4,874,298 | (249,221) | (5) | 4,650,486 | 36,776,266 | 46,579,581 | (9,803,315) | (21) | 44,140,443 |
| HOSPITALIST\PEDS I\P REVENUE | 218,314 | 190,834 | 27,480 | 14 | 159,144 | 1,519,374 | 1,692,872 | (173,498) | (10) | 1,606,399 |
| TOTAL GROSS INPATIENT REVENUE | 10,511,830 | 10,812,038 | (300,208) | (3) | 10,594,722 | 87,466,426 | 106,791,142 | (19,324,716) | (18) | 101,357,514 |
| ANCILLARY OUTPATIENT REVENUE | 27,266,232 | 25,878,989 | 1,387,243 | 5 | 26,399,380 | 242,926,427 | 215,338,198 | 27,588,229 | 13 | 206,967,681 |
| HOSPITALIST\PEDS O\P REVENUE | 81,582 | 61,405 | 20,177 | 33 | 43,377 | 585,420 | 544,710 | 40,710 | 8 | 516,889 |
| TOTAL GROSS OUTPATIENT REVENUE | 27,347,814 | 25,940,394 | 1,407,420 | 5 | 26,442,757 | 243,511,847 | 215,882,908 | 27,628,939 | 13 | 207,484,570 |
| TOTAL GROSS PATIENT REVENUE | 37,859,644 | 36,752,432 | 1,107,212 | 3 | 37,037,479 | 330,978,273 | 322,674,050 | 8,304,223 | 3 | 308,842,084 |
| DEDUCTIONS FROM REVENUE: | | | | | | | | | | |
| MEDICARE CONTRACTUAL ALLOWANCES | 10,677,575 | 10,457,236 | 220,339 | 2 | 11,540,464 | 88,970,924 | 92,634,897 | (3,663,973) | (4) | 89,820,597 |
| MEDI-CAL CONTRACTUAL ALLOWANCES | 10,240,414 | 10,151,336 | 89,078 | 1 | 7,941,241 | 88,020,572 | 87,723,440 | 297,132 | 0 | 76,199,219 |
| BAD DEBT EXPENSE | 265,776 | 412,378 | (146,602) | (36) | 338,923 | 5,924,219 | 3,619,298 | 2,304,921 | 64 | 3,352,743 |
| CHARITY CARE | 19,783 | 38,534 | (18,751) | (49) | 25,823 | 350,230 | 337,973 | 12,257 | 4 | 299,400 |
| OTHER CONTRACTUALS AND ADJUSTMENTS | 4,180,786 | 4,236,200 | (55,414) | (1) | 4,288,164 | 39,471,384 | 36,574,687 | 2,896,697 | 8 | 33,591,476 |
| HOSPITALIST\PEDS CONTRACTUAL ALLOW | 24,622 | 12,771 | 11,851 | 93 | 15,999 | 78,936 | 112,029 | (33,093) | (30) | 72,724 |
| TOTAL DEDUCTIONS FROM REVENUE | 25,408,956 | 25,308,455 | 100,501 | 0 | 24,150,613 | 222,816,265 | 221,002,324 | 1,813,941 | 1 | 203,336,159 |
| NET PATIENT REVENUE | 12,450,688 | 11,443,977 | 1,006,711 | 9 | 12,886,866 | 108,162,008 | 101,671,726 | 6,490,282 | 6 | 105,505,925 |
| OTHER OPERATING REVENUE | 702,221 | 582,495 | 119,726 | 21 | 1,102,868 | 5,196,103 | 5,242,464 | (46,362) | (1) | 10,363,577 |
| NET OPERATING REVENUE | 13,152,909 | 12,026,472 | 1,126,437 | 9 | 13,989,734 | 113,358,111 | 106,914,190 | 6,443,921 | 6 | 115,869,502 |
| OPERATING EXPENSES: | | | | | | | | | | |
| SALARIES & WAGES | 4,669,668 | 4,772,360 | (102,692) | (2) | 4,765,086 | 42,040,419 | 42,111,276 | (70,857) | 0 | 42,927,645 |
| REGISTRY | 511,600 | 200,001 | 311,599 | 156 | 117,977 | 3,027,230 | 1,800,001 | 1,227,229 | 68 | 3,836,750 |
| EMPLOYEE BENEFITS | 2,208,614 | 2,543,535 | (334,921) | (13) | 3,441,277 | 18,707,595 | 21,982,699 | (3,275,104) | (15) | 25,423,433 |
| PROFESSIONAL FEES | 1,382,624 | 1,652,453 | (269,829) | (16) | 1,849,865 | 14,375,570 | 14,672,474 | (296,904) | (2) | 14,906,728 |
| SUPPLIES | 1,028,333 | 1,231,672 | (203,340) | (17) | 1,227,411 | 9,451,658 | 10,678,767 | (1,227,109) | (12) | 11,030,503 |
| PURCHASED SERVICES | 1,211,948 | 1,093,675 | 118,273 | 11 | 1,289,398 | 9,788,059 | 9,701,962 | 86,097 | 1 | 11,104,900 |
| RENTAL | 139,840 | 131,560 | 8,280 | 6 | 122,419 | 1,238,686 | 1,178,964 | 59,722 | 5 | 1,366,463 |
| DEPRECIATION & AMORT | 320,400 | 320,773 | (373) | 0 | 330,276 | 2,920,237 | 2,886,988 | 33,249 | 1 | 2,932,835 |
| INTEREST | 27,921 | 25,417 | 2,504 | 10 | 170,125 | 463,699 | 228,752 | 234,947 | 103 | 216,672 |
| OTHER | 447,154 | 436,401 | 10,753 | 3 | 473,848 | 3,866,793 | 3,874,343 | (7,550) | 0 | 3,968,606 |
| TOTAL EXPENSES | 11,948,103 | 12,407,847 | (459,745) | (4) | 13,787,682 | 105,879,945 | 109,116,226 | (3,236,281) | (3) | 117,714,534 |
| NET OPERATING INCOME (LOSS) | 1,204,806 | (381,375) | 1,586,181 | (416) | 202,052 | 7,478,166 | (2,202,036) | 9,680,202 | (440) | (1,845,032) |

HAZEL HAWKINS MEMORIAL HOSPITAL - COMBINED
HOLLISTER, CA 95023
FOR PERIOD 03/31/24

| | CURRENT MONTH | | | | | YEAR-TO-DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 |
| NON-OPERATING REVENUE\EXPENSE: | | | | | | | | | | |
| DONATIONS | 17,106 | 10,000 | 7,106 | 71 | 108,623 | 232,389 | 150,000 | 82,389 | 55 | 482,079 |
| PROPERTY TAX REVENUE | 205,711 | 205,711 | 0 | 0 | 195,915 | 1,851,399 | 1,851,396 | 3 | 0 | 1,763,235 |
| GO BOND PROP TAXES | 170,388 | 170,388 | 0 | 0 | 164,964 | 1,533,490 | 1,533,492 | (2) | 0 | 1,484,678 |
| GO BOND INT REVENUE\EXPENSE | (68,721) | (68,721) | 0 | 0 | (72,048) | (618,490) | (618,489) | (1) | 0 | (648,428) |
| OTHER NON-OPER REVENUE | 21,422 | 13,843 | 7,579 | 55 | 17,157 | 165,485 | 124,587 | 40,898 | 33 | 124,636 |
| OTHER NON-OPER EXPENSE | (27,767) | (27,766) | (1) | 0 | (37,647) | (290,636) | (289,366) | (1,270) | 0 | (372,565) |
| INVESTMENT INCOME | 0 | 0 | 0 | 0 | 0 | (4,209) | 0 | (4,209) | | 2,010 |
| COLLABORATION CONTRIBUTIONS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL NON-OPERATING REVENUE/(EXPENSE) | 318,139 | 303,455 | 14,684 | 5 | 376,965 | 2,869,429 | 2,751,620 | 117,809 | 4 | 2,835,644 |
| NET SURPLUS (LOSS) | 1,522,945 | (77,920) | 1,600,865 | (2,055) | 579,017 | 10,347,594 | 549,584 | 9,798,010 | 1,783 | 990,612 |
| EBIDA | $ 1,769,445 | $ 168,952 | $ 1,600,493 | 947.30% | $ 854,023 | $ 12,643,467 | $ 2,810,935 | $ 9,832,532 | 349.79% | $ 3,459,762 |
| EBIDA MARGIN | 13.45% | 1.40% | 12.05% | 857.63% | 6.10% | 11.15% | 2.63% | 8.52% | 324.21% | 2.99% |
| OPERATING MARGIN | 9.16% | (3.17)% | 12.33% | (388.85)% | 1.44% | 6.60% | (2.06)% | 8.66% | (420.30)% | (1.59)% |
| NET SURPLUS (LOSS) MARGIN | 11.58% | (0.65)% | 12.23% | (1,887.11)% | 4.14% | 9.13% | 0.51% | 8.61% | 1,675.91% | 0.85% |

HAZEL HAWKINS MEMORIAL HOSPITAL - ACUTE FACILITY
HOLLISTER, CA 95023
FOR PERIOD 03/31/24

| | CURRENT MONTH | | | | | YEAR-TO-DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 |
| GROSS PATIENT REVENUE: | | | | | | | | | | |
| ROUTINE REVENUE | 3,700,859 | 3,654,406 | 46,453 | 1 | 3,642,241 | 29,990,018 | 39,956,189 | (9,966,171) | (25) | 37,237,472 |
| ANCILLARY INPATIENT REVENUE | 4,262,532 | 4,505,408 | (242,876) | (5) | 4,271,987 | 33,952,348 | 43,263,351 | (9,311,003) | (22) | 40,584,419 |
| HOSPITALIST I\P REVENUE | 218,314 | 190,834 | 27,480 | 14 | 159,144 | 1,519,374 | 1,692,872 | (173,498) | (10) | 1,606,399 |
| TOTAL GROSS INPATIENT REVENUE | 8,181,706 | 8,350,648 | (168,943) | (2) | 8,073,372 | 65,461,741 | 84,912,412 | (19,450,671) | (23) | 79,428,290 |
| ANCILLARY OUTPATIENT REVENUE | 27,266,232 | 25,878,989 | 1,387,243 | 5 | 26,399,380 | 242,926,427 | 215,338,198 | 27,588,229 | 13 | 206,967,681 |
| HOSPITALIST O\P REVENUE | 81,582 | 61,405 | 20,177 | 33 | 43,377 | 585,420 | 544,710 | 40,710 | 8 | 516,889 |
| TOTAL GROSS OUTPATIENT REVENUE | 27,347,814 | 25,940,394 | 1,407,420 | 5 | 26,442,757 | 243,511,847 | 215,882,908 | 27,628,939 | 13 | 207,484,570 |
| TOTAL GROSS ACUTE PATIENT REVENUE | 35,529,520 | 34,291,042 | 1,238,478 | 4 | 34,516,129 | 308,973,587 | 300,795,320 | 8,178,267 | 3 | 286,912,859 |
| DEDUCTIONS FROM REVENUE ACUTE: | | | | | | | | | | |
| MEDICARE CONTRACTUAL ALLOWANCES | 10,367,592 | 10,181,656 | 185,936 | 2 | 11,282,655 | 86,937,576 | 90,155,163 | (3,217,587) | (4) | 87,512,061 |
| MEDI-CAL CONTRACTUAL ALLOWANCES | 10,091,784 | 10,043,028 | 48,756 | 1 | 8,810,578 | 86,615,372 | 86,762,638 | (147,266) | 0 | 75,833,678 |
| BAD DEBT EXPENSE | 282,772 | 402,378 | (119,606) | (30) | 378,311 | 6,024,237 | 3,529,298 | 2,494,939 | 71 | 3,329,226 |
| CHARITY CARE | 19,383 | 38,534 | (19,151) | (50) | 25,823 | 347,173 | 337,973 | 9,200 | 3 | 292,250 |
| OTHER CONTRACTUALS AND ADJUSTMENTS | 4,169,969 | 4,169,240 | 729 | 0 | 4,122,672 | 39,162,351 | 35,980,687 | 3,181,664 | 9 | 32,939,239 |
| HOSPITALIST\PEDS CONTRACTUAL ALLOW | 24,622 | 12,771 | 11,851 | 93 | 15,999 | 78,936 | 112,029 | (33,093) | (30) | 72,724 |
| TOTAL ACUTE DEDUCTIONS FROM REVENUE | 24,956,122 | 24,847,607 | 108,515 | 0 | 24,636,038 | 219,165,644 | 216,877,788 | 2,287,856 | 1 | 199,979,176 |
| NET ACUTE PATIENT REVENUE | 10,573,398 | 9,443,435 | 1,129,963 | 12 | 9,880,091 | 89,807,944 | 83,917,532 | 5,890,412 | 7 | 86,933,683 |
| OTHER OPERATING REVENUE | 702,221 | 582,495 | 119,726 | 21 | 1,102,868 | 5,196,103 | 5,242,464 | (46,362) | (1) | 10,363,577 |
| NET ACUTE OPERATING REVENUE | 11,275,618 | 10,025,930 | 1,249,688 | 13 | 10,982,959 | 95,004,046 | 89,159,996 | 5,844,050 | 7 | 97,297,259 |
| OPERATING EXPENSES: | | | | | | | | | | |
| SALARIES & WAGES | 3,774,029 | 3,832,575 | (58,546) | (2) | 3,857,994 | 33,560,046 | 33,769,023 | (208,977) | (1) | 34,744,231 |
| REGISTRY | 451,382 | 167,001 | 284,381 | 170 | 90,499 | 2,732,791 | 1,503,001 | 1,229,790 | 82 | 3,618,650 |
| EMPLOYEE BENEFITS | 1,746,862 | 2,010,004 | (263,142) | (13) | 2,691,113 | 14,518,091 | 17,307,064 | (2,788,973) | (16) | 20,063,087 |
| PROFESSIONAL FEES | 1,380,414 | 1,650,116 | (269,702) | (16) | 1,847,655 | 14,355,680 | 14,651,444 | (295,764) | (2) | 14,886,328 |
| SUPPLIES | 939,827 | 1,142,314 | (202,487) | (18) | 1,132,986 | 8,576,072 | 9,878,738 | (1,302,666) | (13) | 10,232,559 |
| PURCHASED SERVICES | 1,127,101 | 986,212 | 140,889 | 14 | 1,202,051 | 9,037,808 | 8,748,669 | 289,139 | 3 | 10,229,091 |
| RENTAL | 138,551 | 130,516 | 8,035 | 6 | 120,459 | 1,229,060 | 1,169,645 | 59,415 | 5 | 1,357,656 |
| DEPRECIATION & AMORT | 280,726 | 281,320 | (594) | 0 | 291,128 | 2,564,268 | 2,531,880 | 32,388 | 1 | 2,577,411 |
| INTEREST | 27,921 | 25,417 | 2,504 | 10 | 170,125 | 463,699 | 228,752 | 234,947 | 103 | 216,672 |
| OTHER | 392,469 | 378,202 | 14,267 | 4 | 422,096 | 3,404,905 | 3,357,986 | 46,919 | 1 | 3,452,708 |
| TOTAL EXPENSES | 10,259,281 | 10,603,677 | (344,396) | (3) | 11,826,104 | 90,442,418 | 93,146,202 | (2,703,784) | (3) | 101,378,391 |
| NET OPERATING INCOME (LOSS) | 1,016,337 | (577,747) | 1,594,084 | (276) | (843,145) | 4,561,628 | (3,986,206) | 8,547,834 | (214) | (4,081,132) |

HAZEL HAWKINS MEMORIAL HOSPITAL - ACUTE FACILITY
HOLLISTER, CA 95023
FOR PERIOD 03/31/24

| | CURRENT MONTH | | | | | YEAR-TO-DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 |
| NON-OPERATING REVENUE\EXPENSE: | | | | | | | | | | |
| DONATIONS | 17,106 | 10,000 | 7,106 | 71 | 108,623 | 232,389 | 150,000 | 82,389 | 55 | 482,079 |
| PROPERTY TAX REVENUE | 174,854 | 174,854 | 0 | 0 | 166,528 | 1,573,686 | 1,573,686 | 0 | 0 | 1,498,752 |
| GO BOND PROP TAXES | 170,388 | 170,388 | 0 | 0 | 164,964 | 1,533,490 | 1,533,492 | (2) | 0 | 1,484,678 |
| GO BOND INT REVENUE\EXPENSE | (68,721) | (68,721) | 0 | 0 | (72,048) | (618,490) | (618,489) | (1) | 0 | (648,428) |
| OTHER NON-OPER REVENUE | 21,422 | 13,843 | 7,579 | 55 | 17,157 | 165,485 | 124,587 | 40,898 | 33 | 124,636 |
| OTHER NON-OPER EXPENSE | (21,578) | (21,578) | 0 | 0 | (29,305) | (226,146) | (224,874) | (1,272) | 1 | (297,481) |
| INVESTMENT INCOME | 0 | 0 | 0 | 0 | 0 | (4,209) | 0 | (4,209) | | 2,010 |
| COLLABORATION CONTRIBUTIONS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL NON-OPERATING REVENUE/(EXPENSE) | 293,470 | 278,786 | 14,684 | 5 | 355,921 | 2,656,206 | 2,538,402 | 117,804 | 5 | 2,646,245 |
| NET SURPLUS (LOSS) | 1,309,808 | (298,961) | 1,608,769 | (538) | (487,224) | 7,217,834 | (1,447,804) | 8,665,638 | (599) | (1,434,888) |

**HAZEL HAWKINS SKILLED NURSING FACILITIES**
**HOLLISTER, CA**
**FOR PERIOD 03/31/24**

| | CURRENT MONTH | | | | | YEAR-TO-DATE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 | ACTUAL 03/31/24 | BUDGET 03/31/24 | POS/NEG VARIANCE | PERCENT VARIANCE | PRIOR YR 03/31/23 |
| GROSS SNF PATIENT REVENUE: | | | | | | | | | | |
| ROUTINE SNF REVENUE | 1,967,580 | 2,092,500 | (124,920) | (6) | 2,142,850 | 19,180,768 | 18,562,500 | 618,268 | 3 | 18,373,200 |
| ANCILLARY SNF REVENUE | 362,544 | 368,890 | (6,346) | (2) | 378,499 | 2,823,918 | 3,316,230 | (492,312) | (15) | 3,556,025 |
| TOTAL GROSS SNF PATIENT REVENUE | 2,330,124 | 2,461,390 | (131,266) | (5) | 2,521,349 | 22,004,686 | 21,878,730 | 125,956 | 1 | 21,929,225 |
| DEDUCTIONS FROM REVENUE SNF: | | | | | | | | | | |
| MEDICARE CONTRACTUAL ALLOWANCES | 309,982 | 275,580 | 34,402 | 13 | 257,809 | 2,033,348 | 2,479,734 | (446,386) | (18) | 2,308,537 |
| MEDI-CAL CONTRACTUAL ALLOWANCES | 148,630 | 108,308 | 40,322 | 37 | (869,337) | 1,405,201 | 960,802 | 444,399 | 46 | 365,541 |
| BAD DEBT EXPENSE | (16,996) | 10,000 | (26,996) | (270) | (39,388) | (100,018) | 90,000 | (190,018) | (211) | 23,518 |
| CHARITY CARE | 400 | 0 | 400 | | 0 | 3,057 | 0 | 3,057 | | 7,150 |
| OTHER CONTRACTUALS AND ADJUSTMENTS | 10,817 | 66,960 | (56,143) | (84) | 165,492 | 309,033 | 594,000 | (284,967) | (48) | 652,237 |
| TOTAL SNF DEDUCTIONS FROM REVENUE | 452,834 | 460,848 | (8,014) | (2) | (485,425) | 3,650,621 | 4,124,536 | (473,915) | (12) | 3,356,982 |
| NET SNF PATIENT REVENUE | 1,877,291 | 2,000,542 | (123,251) | (6) | 3,006,774 | 18,354,065 | 17,754,194 | 599,871 | 3 | 18,572,243 |
| OTHER OPERATING REVENUE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NET SNF OPERATING REVENUE | 1,877,291 | 2,000,542 | (123,251) | (6) | 3,006,774 | 18,354,065 | 17,754,194 | 599,871 | 3 | 18,572,243 |
| OPERATING EXPENSES: | | | | | | | | | | |
| SALARIES & WAGES | 895,639 | 939,785 | (44,146) | (5) | 907,093 | 8,480,374 | 8,342,253 | 138,121 | 2 | 8,183,414 |
| REGISTRY | 60,218 | 33,000 | 27,218 | 83 | 27,478 | 294,439 | 297,000 | (2,561) | (1) | 218,100 |
| EMPLOYEE BENEFITS | 461,752 | 533,531 | (71,779) | (14) | 750,164 | 4,189,504 | 4,675,635 | (486,131) | (10) | 5,360,346 |
| PROFESSIONAL FEES | 2,210 | 2,337 | (127) | (5) | 2,210 | 19,890 | 21,030 | (1,140) | (5) | 20,400 |
| SUPPLIES | 88,506 | 89,358 | (852) | (1) | 94,425 | 875,586 | 800,029 | 75,557 | 9 | 797,945 |
| PURCHASED SERVICES | 84,848 | 107,463 | (22,615) | (21) | 87,347 | 750,251 | 953,293 | (203,042) | (21) | 875,809 |
| RENTAL | 1,289 | 1,044 | 245 | 24 | 1,960 | 9,626 | 9,319 | 307 | 3 | 8,807 |
| DEPRECIATION | 39,675 | 39,453 | 222 | 1 | 39,148 | 355,969 | 355,108 | 861 | 0 | 355,424 |
| INTEREST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER | 54,685 | 58,199 | (3,514) | (6) | 51,752 | 461,888 | 516,357 | (54,469) | (11) | 515,898 |
| TOTAL EXPENSES | 1,688,822 | 1,804,170 | (115,348) | (6) | 1,961,578 | 15,437,527 | 15,970,024 | (532,497) | (3) | 16,336,142 |
| NET OPERATING INCOME (LOSS) | 188,469 | 196,372 | (7,903) | (4) | 1,045,197 | 2,916,538 | 1,784,170 | 1,132,368 | 64 | 2,236,100 |
| NON-OPERATING REVENUE\EXPENSE: | | | | | | | | | | |
| DONATIONS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PROPERTY TAX REVENUE | 30,857 | 30,857 | 0 | 0 | 29,387 | 277,713 | 277,710 | 3 | 0 | 264,483 |
| OTHER NON-OPER EXPENSE | (6,188) | (6,188) | 0 | 0 | (8,343) | (64,490) | (64,492) | 2 | 0 | (75,084) |
| TOTAL NON-OPERATING REVENUE/(EXPENSE) | 24,669 | 24,669 | 0 | 0 | 21,044 | 213,223 | 213,218 | 5 | 0 | 189,399 |
| NET SURPLUS (LOSS) | 213,138 | 221,041 | (7,903) | (4) | 1,066,241 | 3,129,760 | 1,997,388 | 1,132,372 | 57 | 2,425,500 |

**HAZEL HAWKINS MEMORIAL HOSPITAL**
**HOLLISTER, CA**
**For the month ended 03/31/24**

| | CURR MONTH 03/31/24 | PRIOR MONTH 02/29/24 | POS/NEG VARIANCE | PERCENTAGE VARIANCE | PRIOR YR 06/30/23 |
|---|---|---|---|---|---|
| CURRENT ASSETS | | | | | |
| CASH & CASH EQUIVALENT | 17,598,568 | 14,198,154 | 3,400,415 | 24 | 13,649,396 |
| PATIENT ACCOUNTS RECEIVABLE | 65,845,440 | 66,439,107 | (593,667) | (1) | 51,674,982 |
| BAD DEBT ALLOWANCE | (8,410,897) | (8,352,795) | (58,103) | 1 | (5,227,791) |
| CONTRACTUAL RESERVES | (41,761,372) | (41,902,265) | 140,893 | 0 | (32,708,039) |
| OTHER RECEIVABLES | 14,756,794 | 13,339,228 | 1,417,565 | 11 | 8,381,301 |
| INVENTORIES | 4,028,550 | 4,038,526 | (9,976) | 0 | 4,057,813 |
| PREPAID EXPENSES | 1,764,783 | 1,884,964 | (120,181) | (6) | 2,042,543 |
| DUE TO\FROM THIRD PARTIES | 1,978,192 | 1,978,192 | 0 | 0 | 2,784,747 |
| TOTAL CURRENT ASSETS | 55,800,058 | 51,623,111 | 4,176,946 | 8 | 44,654,951 |
| ASSETS WHOSE USE IS LIMITED | | | | | |
| BOARD DESIGNATED FUNDS | 5,230,367 | 6,635,662 | (1,405,295) | (21) | 3,825,798 |
| TOTAL LIMITED USE ASSETS | 5,230,367 | 6,635,662 | (1,405,295) | (21) | 3,825,798 |
| PROPERTY, PLANT, AND EQUIPMENT | | | | | |
| LAND & LAND IMPROVEMENTS | 3,370,474 | 3,370,474 | 0 | 0 | 3,370,474 |
| BLDGS & BLDG IMPROVEMENTS | 100,098,374 | 100,098,374 | 0 | 0 | 100,098,374 |
| EQUIPMENT | 44,046,824 | 43,953,011 | 93,814 | 0 | 43,302,208 |
| CONSTRUCTION IN PROGRESS | 1,013,589 | 977,711 | 35,879 | 4 | 880,124 |
| GROSS PROPERTY,PLANT, AND EQUIPMENT | 148,529,261 | 148,399,569 | 129,692 | 0 | 147,651,180 |
| ACCUMULATED DEPRECIATION | (93,408,707) | (93,073,724) | (334,983) | 0 | (90,362,507) |
| NET PROPERTY, PLANT, AND EQUIPMENT | 55,120,555 | 55,325,845 | (205,291) | 0 | 57,288,673 |
| OTHER ASSETS | | | | | |
| UNAMORTIZED LOAN COSTS | 416,360 | 422,431 | (6,071) | (1) | 470,999 |
| PENSION DEFERRED OUTFLOWS NET | 18,285,289 | 18,285,289 | 0 | 0 | 18,285,289 |
| TOTAL OTHER ASSETS | 18,701,649 | 18,707,720 | (6,071) | 0 | 18,756,288 |
| TOTAL UNRESTRICTED ASSETS | 134,852,628 | 132,292,339 | 2,560,290 | 2 | 124,525,709 |
| RESTRICTED ASSETS | 17,720 | 29,939 | (12,220) | (41) | 125,193 |
| TOTAL ASSETS | 134,870,348 | 132,322,278 | 2,548,070 | 2 | 124,650,902 |

**HAZEL HAWKINS MEMORIAL HOSPITAL**
**HOLLISTER, CA**
**For the month ended 03/31/24**

| | CURR MONTH 03/31/24 | PRIOR MONTH 02/29/24 | POS/NEG VARIANCE | PERCENTAGE VARIANCE | PRIOR YR 06/30/23 |
|---|---|---|---|---|---|
| CURRENT LIABILITIES | | | | | |
| ACCOUNTS PAYABLE | 5,513,208 | 5,873,237 | 360,029 | (6) | 4,938,613 |
| ACCRUED PAYROLL | 3,172,339 | 5,233,502 | 2,061,163 | (39) | 3,345,253 |
| ACCRUED PAYROLL TAXES | 2,231,817 | 1,584,217 | (647,600) | 41 | 1,497,221 |
| ACCRUED BENEFITS | 6,130,146 | 5,487,520 | (642,626) | 12 | 6,051,228 |
| ACCRUED PENSION (CURRENT) | 4,957,820 | 4,955,143 | (2,676) | 0 | 5,061,807 |
| OTHER ACCRUED EXPENSES | 93,949 | 86,486 | (7,463) | 9 | 84,460 |
| PATIENT REFUNDS PAYABLE | 1,310 | 1,310 | 0 | 0 | 961 |
| DUE TO\FROM THIRD PARTIES | 1,447,716 | (2,136,872) | (3,584,588) | (168) | 196,789 |
| OTHER CURRENT LIABILITIES | 2,507,709 | 2,418,872 | (88,838) | 4 | 3,132,834 |
| TOTAL CURRENT LIABILITIES | 26,056,014 | 23,503,415 | (2,552,599) | 11 | 24,309,166 |
| LONG-TERM DEBT | | | | | |
| LEASES PAYABLE | 5,462,661 | 5,469,395 | 6,735 | 0 | 5,529,504 |
| BONDS PAYABLE | 33,047,681 | 34,556,201 | 1,508,520 | (4) | 34,784,361 |
| TOTAL LONG TERM DEBT | 38,510,342 | 40,025,597 | 1,515,255 | (4) | 40,313,865 |
| OTHER LONG-TERM LIABILITIES | | | | | |
| DEFERRED REVENUE | 0 | 0 | 0 | 0 | 0 |
| LONG-TERM PENSION LIABILITY | 36,485,864 | 36,485,864 | 0 | 0 | 36,485,864 |
| TOTAL OTHER LONG-TERM LIABILITIES | 36,485,864 | 36,485,864 | 0 | 0 | 36,485,864 |
| TOTAL LIABILITIES | 101,052,220 | 100,014,875 | (1,037,344) | 1 | 101,108,895 |
| NET ASSETS: | | | | | |
| UNRESTRICTED FUND BALANCE | 23,376,814 | 23,376,814 | 0 | 0 | 23,376,814 |
| RESTRICTED FUND BALANCE | 93,720 | 105,939 | 12,220 | (12) | 165,193 |
| NET REVENUE/(EXPENSES) | 10,347,594 | 8,824,649 | (1,522,945) | 17 | 0 |
| TOTAL NET ASSETS | 33,818,128 | 32,307,402 | (1,510,726) | 5 | 23,542,007 |
| TOTAL LIABILITIES AND NET ASSETS | 134,870,348 | 132,322,278 | (2,548,070) | 2 | 124,650,902 |

Hazel Hawkins
MEMORIAL HOSPITAL

San Benito Health Care District
Hazel Hawkins Memorial Hospital
**MARCH 2024**

| Description | Target | MTD Actual | YTD Actual | YTD Target |
|---|---|---|---|---|
| Average Daily Census - Acute | 16.54 | 16.58 | 15.11 | 18.18 |
| Average Daily Census - SNF | 89.99 | 84.39 | 91.83 | 90.00 |
| Acute Length of Stay | 2.88 | 2.76 | 2.96 | 2.97 |
| ER Visits: | | | | |
| Inpatient | 170 | 140 | 1,076 | 1,479 |
| Outpatient | 1,926 | 2,099 | 18,470 | 17,679 |
| Total | 2,096 | 2,239 | 19,546 | 19,158 |
| Days in Accounts Receivable | 45.0 | 53.9 | 53.9 | 45.0 |
| Productive Full-Time Equivalents | 500.90 | 515.70 | 483.18 | 500.90 |
| Net Patient Revenue | 11,443,977 | 12,450,688 | 108,162,008 | 101,671,726 |
| Payment-to-Charge Ratio | 31.1% | 32.9% | 32.7% | 31.5% |
| Medicare Traditional Payor Mix | 30.18% | 28.96% | 27.10% | 30.36% |
| Commercial Payor Mix | 21.75% | 21.78% | 23.10% | 21.51% |
| Bad Debt % of Gross Revenue | 1.12% | 0.70% | 1.80% | 1.12% |
| EBIDA | 168,952 | 1,769,445 | 12,643,467 | 2,810,935 |
| EBIDA % | 1.40% | 13.45% | 11.15% | 2.63% |
| Operating Margin | -3.17% | 9.16% | 6.60% | -2.06% |
| Salaries, Wages, Registry & Benefits %: | | | | |
| by Net Operating Revenue | 62.49% | 56.18% | 56.26% | 61.63% |
| by Total Operating Expense | 60.57% | 61.85% | 60.23% | 60.39% |
| Bond Covenants: | | | | |
| Debt Service Ratio | 1.25 | 8.93 | 8.93 | 1.25 |
| Current Ratio | 1.50 | 2.14 | 2.14 | 1.50 |
| Days Cash on hand | 30.00 | 46.87 | 46.87 | 30.00 |

Met or Exceeded Target
Within 10% of Target
Not Within 10%

## Statement of Cash Flows
## Hazel Hawkins Memorial Hospital
## Hollister, CA
## Three months ending March 31, 2024

| | CASH FLOW | | COMMENTS |
|---|---|---|---|
| | Current Month 3/31/2024 | Current Year-To-Date 3/31/2024 | |
| CASH FLOWS FROM OPERATING ACTIVITIES: | | | |
| Net Income (Loss) | $1,522,945 | $10,347,594 | |
| Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities: | | | |
| Depreciation | 334,983 | 3,046,205 | |
| (Increase)/Decrease in Net Patient Accounts Receivable | 510,876 | (1,934,020) | |
| (Increase)/Decrease in Other Receivables | (1,417,565) | (6,380,493) | |
| (Increase)/Decrease in Inventories | 9,976 | 29,263 | |
| (Increase)/Decrease in Pre-Paid Expenses | 120,181 | 277,759 | |
| (Increase)/Decrease in Due From Third Parties | 0 | 806,555 | |
| Increase/(Decrease) in Accounts Payable | (360,029) | 574,599 | |
| Increase/(Decrease) in Notes and Loans Payable | 0 | 0 | |
| Increase/(Decrease) in Accrued Payroll and Benefits | (768,260) | 536,608 | |
| Increase/(Decrease) in Accrued Expenses | 7,463 | 9,487 | |
| Increase/(Decrease) in Patient Refunds Payable | 0 | 348 | |
| Increase/(Decrease) in Third Party Advances/Liabilities | 3,584,588 | 1,250,927 | |
| Increase/(Decrease) in Other Current Liabilities | 88,838 | (625,124) | Semi-Annual Interest - 2021 Insured Revenue Bonds |
| **Net Cash Provided by Operating Activities:** | **2,111,051** | **(2,407,886)** | |
| CASH FLOWS FROM INVESTING ACTIVITIES: | | | |
| Purchase of Property, Plant and Equipment | (129,692) | (878,083) | |
| (Increase)/Decrease in Limited Use Cash and Investments | 0 | 0 | |
| (Increase)/Decrease in Other Limited Use Assets | 1,405,295 | (1,404,569) | Bond Principal & Int Payment - 2014 & 2021 Bonds |
| (Increase)/Decrease in Other Assets | 6,071 | 54,639 | Amortization |
| **Net Cash Used by Investing Activities** | **1,281,674** | **(2,228,013)** | |
| CASH FLOWS FROM FINANCING ACTIVITIES: | | | |
| Increase/(Decrease) in Capital Lease Debt | (6,735) | (66,842) | |
| Increase/(Decrease) in Bond Mortgage Debt | (1,508,520) | (1,736,680) | Refinancing of 2013 Bonds with 2021 Bonds |
| Increase/(Decrease) in Other Long Term Liabilities | 0 | 0 | |
| **Net Cash Used for Financing Activities** | **(1,515,255)** | **(1,803,522)** | |
| (INCREASE)/DECREASE IN RESTRICTED ASSETS | **0** | **41,000** | |
| **Net Increase/(Decrease) in Cash** | **3,400,415** | **3,949,173** | |
| Cash, Beginning of Period | 14,198,154 | 13,649,396 | |
| **Cash, End of Period** | **$17,598,569** | **$17,598,569** | $0 |

| | |
|---|---|
| Cost per day to run the District | $375,451 |
| Operational Days Cash on Hand | 46.87 |

Hazel Hawkins Memorial Hospital
Bad Debt Expense
For the Year Ending June 30, 2024

| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Budgeted Gross Revenue | 38,236,593 | 38,468,812 | 35,049,053 | 34,999,737 | 35,870,267 | 36,385,781 | 34,851,365 | 32,060,010 | 36,752,432 | 35,946,200 | 39,112,090 | 38,876,681 | 436,609,021 |
| Budgeted Bad Debt Expense | 429,889 | 432,423 | 393,214 | 391,626 | 402,993 | 407,930 | 389,870 | 358,975 | 412,378 | 403,932 | 440,170 | 438,441 | 4,901,841 |
| BD Exp as a percent of Gross Revenue | 1.12% | 1.12% | 1.12% | 1.12% | 1.12% | 1.12% | 1.12% | 1.12% | 1.12% | 1.12% | 1.13% | 1.13% | 1.12% |
| Actual Gross Revenue | 34,381,757 | 36,309,479 | 36,251,934 | 37,061,367 | 36,004,686 | 37,198,238 | 37,873,381 | 36,232,889 | 37,559,748 | - | - | - | 328,873,479 |
| Actual Bad Debt Expense | 712,509 | 663,649 | 543,514 | 751,015 | 695,471 | 428,999 | 776,991 | 1,086,296 | 265,776 | - | - | - | 5,924,220 |
| BD Exp as a percent of Gross Revenue | 2.07% | 1.83% | 1.50% | 2.03% | 1.93% | 1.15% | 2.05% | 3.0% | 0.7% | #DIV/0! | #DIV/0! | #DIV/0! | 1.80% |
| Budgeted YTD BD Exp | 3,619,298 | 1.12% | | | | | | | | | | | |
| Actual YTD BD Exp | 5,924,220 | 1.80% | | | | | | | | | | | |
| Amount under (over)budget | (2,304,922) | -0.68% | | | | | | | | | | | |
| Prior Year percent of Gross Revenue | **1.15%** | | | | | | | | | | | | |
| Percent of Decrease (Inc)from Prior Year | -56.6% | | | | | | | | | | | | |

| | |
|---|---|
| YTD Charity Exp Budget | 337,973 |
| YTD Charity Exp Actual | 350,230 |
| Amt under (over)budget | (12,257) |
| Charity Exp % of Gross Rev | 0.11% |



13

Hazel Hawkins Memorial Hospital
Supplemental Payment Programs
As of March 31, 2024

| | Payor | FY 2024 | FY 2023 | Notes: |
|---|---|---|---|---|
| **Intergovernmental Transfer Programs:** | | | | **Requires District to fund program and wait for matching return.** |
| - AB 113 Non-Designated Public Hospital (NDPH) | | | | |
| SFY 2021/2022 True up for ACA | DHCS | - | 170,899 | Received in June 2023. |
| SFY 2022/2023 Interim | DHCS | - | 418,640 | Letter to participate sent by March 24, 2023 deadline. Rec'd 06/15/23. |
| SFY 2022/2023 Final Payment | DHCS | - | - | |
| SFY 2023/2024 Interim | DHCS | 434,472 | - | IGT by May 4, 2024 of $506,883.51, funds expected in May/June. |
| - SB 239 Hospital Quality Assurance Fund (HQAF) CY 2022 | Anthem | 2,405,548 | 2,277,244 | Net amount rec'd on November 1, 2023 check for CY 2022. |
| - SB 239 Hospital Quality Assurance Fund (HQAF) CY 2023 | Anthem | 2,432,278 | | IGT by March 22, 2024 of $1,257,738, funds expected in May/June. |
| - Rate Range Jan. 1, 2022 through Dec. 31, 2022 | Anthem | 910,699 | - | IGT by Feb. 23, 2024 of $472,508, funds expected in April/May. |
| - Rate Range Jan. 1, 2021 through Dec. 31, 2021 | Anthem | - | 1,180,145 | Funding of $347,021 sent by 02/17/2023. Rec'd in May 2023. |
| - QIP PY 5 Settlement | Anthem | 3,459,757 | - | IGT by Feb. 16, 2024 of $1,891,350.65, funds expected in April/May. |
| - QIP PY 4 **1st** Loan Repayment | District | (1,253,000) | | Paid on 02/26/2024. |
| - QIP PY 4 **2nd** Loan Repayment | District | (1,222,438) | | Paid on 04/08/2024. |
| - QIP PY 4 Settlement | Anthem | - | 3,713,527 | $ 1,044,187 funding sent by 02/17/2023. Plan returns May/June 2023. |
| - QIP PY 4 Final True-up | Anthem | - | 1,245,805 | Final True-up payment received on 06/02/2023. |
| **IGT sub-total** | | 7,167,316 | 9,006,259 | |
| **Non-Intergovernmental Transfer Programs:** | | | | **Direct Payments.** |
| - AB 915 | DHCS | 4,143,717 | 3,029,540 | Received on March 11, 2024. |
| - SB 239 Hospital Quality Assurance Fund (HQAF) | DHCS | 3,208,731 | 3,919,883 | Three of the four Qtrly payments should be received by June 30, 2024. |
| - SB 239 Hospital Quality Assurance Fund (HQAF) | DHCS | 1,069,577 | | 1st quarter rec'd on March 19, 2024. |
| - Distinct Part, Nursing Facility (DP/NF) | | - | - | Based on actual cost difference. |
| - Medi-Cal Disproportionate Share (DSH) | DHCS | 1,297,140 | 1,048,233 | Includes FY 2023 true-up $607,644 and Jul - December FY 2024. |
| - QIP PY 5 | CHFFA | - | 3,090,086 | Loan funds received 1st week of January. Due January 3, 2025. |
| **Non-IGT sub-total** | | 9,719,166 | 11,087,742 | |
| **CARES Act (COVID-19) Programs:** | | | | |
| - Cares Act Phase 4 | | - | - | Rec'd 12/16/2021. One-time funding. |
| - American Rescue Plan (ARP) | | - | - | Rec'd 11/23/2021. One-time funding. |
| - SHIP Grant | | - | 258,376 | Will be used for COVID expenses. |
| - Payroll Tax delay Pay dates 4/3 - 12/31/2020 | | - | (1,143,961) | Liability: 50% due 12/31/21 & 50% due 12/31/22. |
| **sub-total** | | - | (885,585) | |
| **Program Grand Totals** | | 16,886,482 | 19,208,416 | |
| Total Received | | 8,915,983 | 18,075,133 | |
| Total Pending | | 7,970,499 | 1,133,283 | |
| | | 16,886,482 | 19,208,416 | |

## TELEMETRY SERVICES AGREEMENT

THIS TELEMETRY SERVICES AGREEMENT (this "**Agreement**") is made and entered into between San Benito Health Care District, a local health care district organized and operating pursuant to Division 23 of California Health and Safety Code ("SBHCD"), owner and operator of Hazel Hawkins Memorial Hospital ("**Hospital**"), and **Hicuity Health, Inc.**, a Delaware corporation ("**HHI**"). Hospital and HHI are sometimes referred to in this Agreement as "**Party**" or "**Parties**". The "Effective Date" of this Agreement shall be the date of the last signature below.

### RECITALS:

A. Hospital owns and operates a hospital facility located at 911 Sunset Drive, Hollister, CA 95023, in which it has established or will establish telemetry care units (each a "**Unit**") that require telemetry monitoring by telemetry technicians.

B. HHI provides patient telemetry monitoring for clients of HHI.

C. Hospital desires to arrange with HHI for telemetry technicians to provide remote telemetry monitoring of patients in a Unit at Hospital, subject to and in accordance with the terms and conditions hereafter provided.

### AGREEMENT:

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

### ARTICLE I - REMOTE MONITORING AND OTHER SERVICES

1.1 HHI Services. HHI will provide the services described in this Section 1.1 (such services are collectively referred to as the "**HHI Services**").

(a) The "**Remote Telemetry Services**" means monitoring of telemetry messages sent from the patient monitor to the central station at the Hospital and remotely replicated at the HHI operations center, by telemetry technicians specifically trained in telemetry monitoring; interpretation of heart rhythms and other ancillary measurements; reporting and documentation of such monitoring of the patient; and communication with the local clinical staff at the Unit regarding telemetry messages. Prior to the commencement of services and within 30 days after execution of this Agreement, the parties shall meet to (i) cooperatively develop and define workflows, policies and procedures to facilitate the Remote Telemetry Services, (ii) provide a detailed statement of roles and responsibilities of Hospital and HHI staff, and (iii) discuss reporting obligations. During the term of this Agreement, HHI shall: (i) staff the Remote Telemetry Services with telemetry technicians that are exclusively dedicated to remote telemetry monitoring and have passed the EKG Technician Certification, (ii) staff the Remote Telemetry services in a manner adequate to ensure timely communication with Hospital, and (iii) provide its services in accordance with all applicable federal, state and local laws and regulations, prevailing professional standards in the community and the standards of any applicable accrediting or certifying body.

(b) Beginning on the Actual Launch Date (as hereafter defined), HHI shall arrange for telemetry technicians to perform the Remote Telemetry Services by remotely monitoring adult patients in Six (6) telemetry beds in the Units ("**Telemetry Beds**") using designated remote telemetry technology. Shall Hospital request Remote Telemetry Services on pediatric patients, the parties will enter into an amended Agreement. The Remote Telemetry Services shall be provided for twenty-four (24) hours per day, seven (7) days a week, except during periods of downtime due to scheduled or emergency maintenance or events such as natural disaster and other circumstances beyond the reasonable control of HHI. HHI will use best efforts to provide advance notice of scheduled downtime of the HHI Services hereunder. For purposes of this Agreement, the term "**Actual Launch Date**" means the date on which HHI's telemetry technicians first begin remote monitoring of patients in the Unit.

(c) HHI will provide Hospital with periodic reports during the term of this Agreement. The parties will collaboratively develop the content and reporting frequency of these reports.

(d) HHI will collaborate with Unit clinical staff to integrate the Remote Telemetry Services with the Hospital's existing clinical workflows.

(e) HHI does not warrant the accuracy of the information entered into, contained in or derived from equipment used by Hospital in the Remote Telemetry Services. Hospital acknowledges that the professional duty to the patient in providing health care services lies solely with the health care professionals providing patient care services. The clinical and other information contained in or derived from the Remote Telemetry Services is intended as a supplement to, and not a substitute for, the knowledge, expertise, skill, and judgment of physicians, nurses, pharmacists, or other health care professionals involved in patient care at the Hospital. HHI assumes no responsibility for actions of Hospital personnel which may result in any liability or damages due to malpractice, failure to warn, negligence or any other basis. Hospital likewise assumes no responsibility for actions of HHI personnel which may result in any liability or damages due to malpractice, failure to warn, negligence or any other basis.

(f) HHI shall own and be responsible for providing the KVM transmitter(s) and gateways to transmit data from the Hospital's patient monitoring system to HHI, as deemed necessary by HHI, and which will be located at the Hospital..

1.2 Implementation Plan and Proposed Launch Date. Within 30 days following execution of this Agreement, HHI and Hospital shall develop an implementation plan ("**Implementation Plan**") enabling the parties to fulfill their respective obligations. The final Implementation Plan will set forth resources, roles and responsibilities of the parties. The parties shall use all reasonable efforts to develop, comply with and abide by the Implementation Plan and timely execute their respective responsibilities. The Implementation Plan will set forth a "**Proposed Launch Date**", which is the expected date HHI's telemetry technicians begin monitoring of the Unit. The Proposed Launch Date shall be one hundred twenty (120) days from the Effective Date of this Agreement and is subject to modification only upon written agreement of the parties.

1.3 Hospital Operational Obligations. Hospital shall purchase, install and maintain, at its own cost, the required equipment and any additional hardware, software and connectivity as may be necessary to provide patient telemetry information to enable the delivery of the HHI Services. Furthermore, Hospital shall coordinate with any of its third-party vendors, including but not limited to telecommunications, hardware and software vendors, to support the Services on an ongoing basis and to facilitate the Implementation Plan and timelines as outlined in Section 1.3.

(a) Equipment, Hardware and Software. Hospital shall secure, equip, furnish and maintain, at its own cost, the Unit and Telemetry Beds so that HHI may provide the HHI Services contemplated herein. Hospital's costs and responsibilities for equipment include, but are not limited to, the following: (i) the initial costs associated with the purchase and installation of equipment, hardware and software to deliver telemetry messages used in the Remote Telemetry Services; (ii) any related third party software and components, including industry-acceptable technology security measures; and (iii) the ongoing operating costs, including: purchasing and installing third party software updates and upgrades; maintaining updated security applications; and arranging for local IT support of Hospital-owned equipment, hardware and software to deliver telemetry messages used for the Remote Telemetry Service. Prior to Hospital changing, upgrading or modifying its equipment used in the Remote Telemetry Services, Hospital must provide HHI with as much as possible, and at least 90 days', advanced notice of, any such change, upgrade or modification. If such change, upgrade or modification requires HHI to change, upgrade or modify its equipment in order to provide the Remote Telemetry Services, the parties will discuss and agree on responsibility for any such required expenses prior to Hospital proceeding with any equipment change, upgrade or modification. Hospital shall also assist HHI with the installation of the KVM transmitter.

(b) Connectivity. The parties will work together to arrange network connection through at least one MPLS (Multiprotocol Label Switching) or point-to-point connection to provide the Remote Telemetry Services, although Hospital acknowledges that HHI recommends two redundant and diverse connections that would be used as a primary and backup network connection for the Remote Telemetry Services. Should the Hospital desire to obtain and manage the network connections between Hospital and HHI's operations, such fees will be the responsibility of the Hospital. Hospital shall make its IT support team available 24/7 to HHI to help troubleshoot connectivity matters. Hospital shall also place a dedicated router, specified by HHI, on the network circuits for purposes of HHI managing the router and facilitating the troubleshooting process. If Hospital and HHI agree that HHI shall obtain and manage the network connections between Hospital and HHI's operations, then Hospital shall pay HHI in accordance with paragraph B.2(c) of **Exhibit B** for such services. Hospital and HHI will test the connection initially during the implementation period and on an ongoing basis during the term of this Agreement. If either party determines for any reason that the connection does not adequately address the needs of the Remote Telemetry Services, then the party making the determination shall notify the other party, in writing, of its determination. Within the forty-five (45) day period following the giving of such notice (or sooner if reasonably practicable), Hospital will implement an alternative connection between Hospital and HHI's operations center to assure HHI will be able to provide the Remote Telemetry Services as anticipated herein.

(c) Required Data. Hospital will provide (i) an ADT interface filtered to contain only data for patients with a telemetry order for the Remote Telemetry Services, and (ii) Alarm and Waveform data, which may be acquired via interface or a gateway, to HHI. Alternatively, the aforementioned ADT interface may be satisfied via an Order interface. The Parties will work together to implement and test the data integrations prior to commencement of HHI Services.

(d) Acknowledgment of Redundancy Recommendation. Hospital acknowledges and agrees HHI recommends two redundant and diverse MPLS network connections as described in Section 1.3(b) above. Should Hospital choose not to use the two redundant and diverse network connections, Hospital understands and agrees HHI disclaims any warranties related to the connectivity issues and limits its liability as further detailed in Section 1.3(d) below. Hospital also understands and agrees that should it choose not to use the two redundant and diverse network connections, the Remote Telemetry Services will be unavailable during scheduled and unscheduled downtimes.

(e) DISCLAIMER OF WARRANTIES AND LIMITATION OF LIABILITY. SHOULD HOSPITAL CHOOSE NOT TO ARRANGE A REDUNDANT NETWORK CONNECTIVITY METHOD:

(i) HHI MAKES NO WARRANTY OF ANY KIND, EITHER EXPRESS OR IMPLIED, INCLUDING BUT NOT LIMITED TO, A WARRANTY THAT THE OPERATION OR USE OF THE TELEMETRY NETWORK CONNECTIVITY EQUIPMENT WILL BE UNINTERRUPTED OR ERROR FREE, AND EXPRESSLY DISCLAIMS ANY WARRANTY OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE OR IMPLIED WARRANTY OF NON-INFRINGEMENT.

(ii) HHI STATES THE TOTAL LIABILITY, IF ANY OF HHI, FOR ALL DAMAGES AND BASED ON ALL CLAIMS, WHETHER ARISING FROM BREACH OF CONTRACT, BREACH OF WARRANTY, NEGLIGENCE, INDEMNITY, STRICT LIABILITY, OR TORT, OR OTHERWISE, ARISING FROM THE TELEMETRY NETWORK CONNECTIVITY EQUIPMENT OR ANY PART THEREOF SHALL NOT EXCEED THE UPFRONT FEE FOR TELEMETRY SERVICES CHARGED PURSUANT TO EXHIBIT B SECTION B.1 OF THIS AGREEMENT. IN NO EVENT SHALL HHI BE LIABLE FOR ANY INDIRECT, PUNITIVE, INCIDENTAL, CONSEQUENTIAL, OR SPECIAL DAMAGES, INCLUDING WITHOUT LIMITATION, LOST REVENUES, OR PROFITS, BUSINESS INTERRUPTION, LOSS OF DATA, OR THE COST OF SUBSTITUTE PRODUCTS WHETHER ARISING FROM BREACH OF CONTRACT, BREACH OF WARRANTY, NEGLIGENCE, INDEMNITY, STRICT LIABILITY OR OTHER TORT.

(f) Electronic Medical Record.

(i) No Access Required. HHI's telemetry technicians will not access Hospital's electronic medical record system. Hospital staff is responsible for all documentation in the patient medical record.

(ii) Timely Reports. During the term of this Agreement, Hospital staff shall prepare on a timely basis, in accordance with all applicable policies, complete and accurate medical and other records, reports, and supporting documents with respect to the patients in the Unit.

(iii) Ownership. The ownership and right of control of all reports, records, medical records and supporting documents prepared in connection with the HHI Services provided hereunder shall rest exclusively in Hospital; provided, however, HHI shall have the right to access such reports, records and supporting documentation as shall be permitted by law. Upon the expiration or termination of this Agreement for any reason, Hospital shall permit HHI and its employees or agents reasonable access to such records during business hours for any purpose, including to comply with applicable law or compulsory legal process, or to assert any right or defend against any claims or actions. The provisions of this Section 1.3(e)(iii) shall survive termination of this Agreement for any reason.

(g) Additional Obligations. During the term of this Agreement, Hospital shall: (i) staff the Unit in a manner adequate to ensure timely communication with HHI and timely care to patients; (ii) maintain back up procedures which shall allow for continuity of patient care should there be any technology disruptions that prohibit the delivery of Remote Telemetry Services; and (iii) provide its services in accordance with all applicable federal, state and local laws and regulations, prevailing professional standards in the community, and the standards of any applicable accrediting or certifying body.

## ARTICLE II - COMPENSATION

2.1 Fees. Hospital agrees to pay HHI for HHI Services provided under this Agreement as set forth on **Exhibit B** attached hereto.

2.2 Implementation Delays. If the Actual Launch Date is materially delayed by Hospital, or any of Hospital's third-party vendors, beyond the Proposed Launch Date, or as otherwise mutually agreed to in writing, then HHI reserves the right to initiate charging the expected service fees set forth in Exhibit B at the Proposed Launch Date milestone date or any other date agreed upon in writing by as set forth in Section 1.2 for such Hospital. Such service fee shall be based on the lesser of expected Patient Days as provided to HHI by Hospital, or 70% average daily occupancy of each Telemetry Bed.

2.2 Invoices. HHI shall submit monthly invoices to Hospital, who shall pay each invoice within thirty (30) days after receipt thereof. In the event Hospital has a bona fide good faith dispute related to an invoiced amount, Hospital shall notify HHI within thirty (30) calendar days of receipt of the disputed invoice and shall pay the remaining balance of the undisputed invoiced amount in accordance with this Section. The parties shall work diligently and in good faith to resolve any disputed invoiced amounts within thirty (30) days of notice of a dispute.

2.3 Interest Charge. Interest charges at one and one-half percent (1.5%) per month, or the maximum rate permitted by applicable law if less, may be charged on undisputed invoiced amounts past due.

## ARTICLE III - INSURANCE AND INDEMNIFICATION

3.1 HHI General Liability Insurance. HHI shall maintain comprehensive general liability insurance covering itself and its employees and agents providing services pursuant to this Agreement in the minimum amounts of one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) in the annual aggregate. Upon request, HHI will provide Hospital certificate(s) of insurance evidencing said coverage.

3.2 Professional Liability Insurance. HHI shall maintain professional liability coverage for the HHI Services provided under this Agreement in the amount of not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) in the annual aggregate. If HHI is unable to obtain occurrence-based coverage, HHI shall, in its sole determination, obtain appropriate tail coverage. Upon request, HHI will provide Hospital certificate(s) of insurance evidencing said coverage.

3.3 Internet and Network Security Insurance. HHI will maintain privacy, Internet and network security insurance covering itself and its employees and agents providing services pursuant to this Agreement in the minimum amounts of three million dollars ($3,000,000) per occurrence and in the annual aggregate. Upon request, HHI will provide Hospital certificate(s) of insurance evidencing said coverage.

3.4 Hospital Insurance. Hospital shall maintain general and professional liability insurance coverage in amounts of not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) in the annual aggregate. Hospital shall also maintain privacy, Internet and network security insurance covering itself and its employees and agents providing services pursuant to this Agreement in the minimum amounts of three million dollars ($3,000,000) per occurrence and in the annual aggregate. Upon request, Hospital will provide HHI certificate(s) of insurance evidencing said coverage.

3.5 Indemnification by Hospital. Hospital agrees to indemnify and hold HHI harmless from and against any and all claims, causes of action, liabilities, damages and expenses, including reasonable attorneys' fees and court costs, brought against or suffered or incurred by HHI, arising out of or resulting from any negligent or wrongful act or omission of Hospital or its agents or employees or the failure of Hospital to perform its duties and obligations under this Agreement. This Section 3.5 survives the termination of this Agreement for any reason.

3.6 Indemnification by HHI. HHI agrees to indemnify and hold Hospital harmless from and against any and all claims, causes of action, liabilities, damages and expenses, including reasonable attorneys' fees and court costs, brought against or suffered or incurred by Hospital, arising out of or resulting from any negligent or wrongful act or omission of HHI or its agents or employees or the failure of HHI to perform its duties and obligations under this Agreement. This Section 3.6 survives the termination of this Agreement for any reason.

## ARTICLE IV - TERM AND TERMINATION

4.1 Term and Renewal. The term of this Agreement will begin on the date first signed below and continues for a three (3) year period immediately following the Actual Launch Date. The Agreement will automatically renew on the same terms and conditions for successive one (1) year periods thereafter unless this Agreement is sooner terminated as provided within this Agreement or a party gives written notice of non-renewal to the other at least one hundred eighty (180) days prior to the expiration of the then current term.

4.2 Other Termination. This Agreement may be terminated upon written notice:

(a) by HHI if Hospital does not implement the stated number of Telemetry Beds as detailed (or within the timeframe indicated) in Section 1.1(b) and 1.2; or

(b) by the non-defaulting party if another party defaults in the performance of any material obligation under this Agreement and such default is not cured within thirty (30) days after written notice of such default (unless a longer cure period is permitted in writing by the non-defaulting party); or

(c) by a party if another party applies for or consents to the appointment of a receiver, trustee or liquidator of itself for all of or a substantial part of its assets, files a voluntary petition of bankruptcy or admits in writing its inability to pay its debts as they become due, makes a general assignment for the benefit of its creditors, files a petition or answer seeking reorganization or arrangement with creditors or seeking the benefits of any insolvency law.; or.

4.3 Effect of Termination.

(a) Within thirty (30) days following termination of this Agreement, each party shall return to the other party, such party's Confidential Information, or shall destroy such Confidential Information and certify in writing to the other party such destruction. Furthermore, any equipment provided by HHI shall be returned to HHI.

(b) Survival. Neither expiration, suspension nor termination of this Agreement shall terminate those obligations and rights of the parties pursuant to provisions of this Agreement which by their express terms are intended to survive and such provisions shall survive the expiration, suspension or termination of this Agreement. Without limiting the foregoing, the respective rights and obligations of the parties under Sections 1.3(e), 1.3(f)(iii), 3.5, 3.6, 4.3, Article II and V and Exhibit A shall survive the suspension, expiration or termination of this Agreement regardless of when such suspension, expiration or termination becomes effective.

## ARTICLE V - MISCELLANEOUS

5.1 Independent Contractors. The parties acknowledge that HHI is an independent contractor and nothing in this Agreement is intended, nor shall be construed to create, an employer-employee relationship, a joint venture relationship, an agency relationship or landlord tenant relationship between the parties.

5.2 Governmental Access. Pursuant to 42 U.S.C. Section 1395x(v)(1)(I) and 42 C.F.R. Sections 420.300-420.304, the parties agree to comply with the following.

(a) HHI shall, until the expiration of seven (7) years after the furnishing of the services pursuant to this Agreement, retain and make available, upon written request by the Secretary of the U.S. Department of Health and Human Services, or upon written request by the U.S. Comptroller General, or any of their duly authorized representatives, this Agreement and any books, documents and records of HHI that are necessary to verify the nature and extent of the costs of the services under this Agreement.

(b) If HHI carries out any of the duties of this Agreement through a subcontract with a value or cost of ten thousand dollars ($10,000) or more over a twelve (12) month period with a related organization, such subcontract shall contain a clause to the effect that the related organization shall abide by the same circumstances as detailed in section 5.2(a) above.

(c) In the event of a request for access, HHI agrees to notify Hospital immediately and to inform Hospital what response will be made to the request.

(d) This Section 5.2 survives the termination of this Agreement for whatever reason.

5.3 Notices. All notices, demands, requests or other communications which may be or are required to be given, served or sent by any party to any other party pursuant to this Agreement must be in writing and must be hand delivered, sent by recognized overnight delivery service, mailed by first-class, registered or certified mail, or sent by electronic mail to the addresses on the signature page of this Agreement or such other addresses as either party shall, in writing, inform the other in accordance with this Section 5.3. Each notice, demand, request, or communication that is delivered consistent with this Section 5.3 will be deemed sufficiently given or received for all purposes at such time as it is delivered to the addressee or at such time as delivery is refused by the addressee upon presentation.

5.4 Amendment. Except as otherwise provided herein, this Agreement may be amended only by mutual written agreement of the parties.

5.5 Entire Agreement. This Agreement, together with all exhibits and attachments, contains the entire agreement between the parties relating to the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no further force or effect.

5.6 Governing Law. This Agreement will be interpreted, construed and enforced in accordance with the laws of the State of California, and shall be binding upon the parties hereto and their successors.

5.7 Third Party Beneficiaries. Unless otherwise set forth herein, nothing express or implied in this Agreement is intended to confer, nor shall anything in this Agreement confer, upon anyone other than Hospital, HHI, and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

5.8 Cooperation. The parties will cooperate with each other to the fullest extent practicable in the execution of their obligations under this Agreement, and in obtaining all necessary licenses, consents and approvals. Upon the reasonable request of a party, the other party shall promptly provide any information relating to the services and obligations of the parties under this Agreement.

5.9 Confidentiality.

(a) Any information which a Party reasonably requests from another Party and which is necessary for the service contemplated in this Agreement shall be provided by the other party in a timely fashion and in a form reasonably specified. All information between the Parties shall be treated as "**Confidential Information**" unless otherwise identified.

(b) All Confidential Information provided by one party or its representatives or subcontractors (the "**Disclosing Party**") to the other party (the "**Receiving Party**"), whether in oral, written or other intangible or tangible media form or otherwise, or to which the Receiving Party acquires access during the term of this Agreement shall be treated with the same degree of care to protect the confidentiality of such information as the Receiving Party uses to protect the confidentiality of its own proprietary information (but in no event less than reasonable care) and shall only use it in respect of the proper operation of the transactions contemplated by this Agreement. All nonpublic information provided by a Party shall be treated as Confidential Information.

(c) The confidentiality obligations in this Section 5.9 shall continue for a period of three years (or such longer period as is required by applicable law) from the date of receipt but shall not apply to any of such information which: (i) is publicly available through no fault of the Receiving Party at any time during this Agreement; (ii) is already known by the Receiving Party prior to access; (iii) is independently developed by the Receiving Party; or (iv) is rightfully obtained by the Receiving Party from third parties without restriction.

(d) Each Party shall have the right to disclose Confidential Information to their respective affiliates, consultants, contractors and subcontractors as necessary to allow the Party to fulfill its obligations contemplated by this Agreement, subject to any such affiliates, consultants, contractors and subcontractors undertaking the same or reasonably similar confidentiality obligations as provided in this Section.

(e) HHI and Hospital shall each have the right to disclose Confidential Information referenced above if required by law, subpoena or governmental order, to the extent required by such law, provided that the Receiving Party shall promptly notify the Disclosing Party of such law, assert the confidentiality of such Confidential Information, and provide

the Disclosing Party with a reasonable opportunity to oppose such disclosure or obtain a protective order (including but not limited to "confidential treatment" pursuant to U.S. securities laws) reasonably satisfactory to the Receiving Party to maintain the confidentiality of such data, information or materials.

(f) The above confidentiality obligations shall not apply to Protected Health Information (as defined in the HIPAA Requirements; sometimes referred to hereafter as "**PHI**"), which shall be governed by the Business Associate Agreement attached hereto in **Exhibit A**.

(g) Notwithstanding any of the confidentiality obligations to the contrary within this Section, both parties may disclose this Agreement to an attorney, accountant, investor (current or potential), or other professional advisor for the limited purpose of reviewing this Agreement on behalf of the party, or to regulatory, licensure or accreditation body surveyors or other similar representatives who have a duty or right to review such agreements for accreditation or other clinically related purposes.

(h) Breach of Confidentiality Obligations. The parties acknowledge and agree that any breach of confidentiality pursuant to this Agreement will cause irreparable injury to the parties and therefore agree that the aggrieved party's remedies for such breach shall include, in addition to damages and other available remedies, injunctive relief including but not limited to temporary restraining orders, preliminary injunctions and permanent injunctions, without the necessity of posting bond or security which is waived by the relevant party or a cure period.

5.10 Force Majeure. A Force Majeure event is defined as any failure of performance under this Agreement if such failure results, whether directly or indirectly, from fire, explosion, strike, freight embargo, act of God or of the public enemy, war, terrorist act, civil disturbance, act of any government – de jure or de facto, or any agency or official thereof, labor shortage, transportation contingencies, unusually severe weather, default of manufacturer or supplier as a subcontractor, quarantine restriction, epidemic, pandemic outbreaks of infectious disease or any other public health crisis, or other causes beyond the control of said party. Hospital provides its equipment, information systems, and is responsible for ensuring its patient care environment is available to and accessible by HHI ("**Hospital Deliverables**"), and HHI provides the Remote Monitoring Services within that patient care environment ("**HHI Deliverables**"), as both sets of deliverables are further detailed in this Agreement.

If a Force Majeure event prevents or delays Hospital – and not HHI – from providing Hospital deliverables for more than sixty (60) calendar days at any time during the term, then HHI shall have the right to a) terminate the affected portion of the Agreement or the entire Agreement as of the date specified by HHI in a written notice of termination to Hospital, or b) HHI shall have the right to extend the term of the Agreement for a period of time equal to the length of Hospital's delay or inability to perform.

If a Force Majeure event prevents or delays HHI – and not Hospital – from providing HHI Deliverables for more than sixty (60) calendar days at any time during the term, then Hospital shall have the right to a) terminate the affected portion of the Agreement or the entire Agreement as of the date specified by Hospital in a written notice of termination to HHI, or b) Hospital shall have the right to extend the term of the Agreement for a period of time equal to the length of HHI's delay or inability to perform.

If a Force Majeure event concurrently prevents or delays both parties from providing their respective deliverables for more than sixty (60) calendar days at any time during the term, then the term of the Agreement will extend for a period of time equal to the length of the delay or inability to perform and is subject to modification only upon written agreement of the parties.

5.11 Compliance with Laws. During the term of this Agreement, each party shall abide by and comply with all state and federal laws and regulations applicable to it in connection with its duties and responsibilities under this Agreement.

5.12 Use of Name. Except as otherwise provided in this Section 5.12, no party shall use any other party's name, symbols, trademarks or service marks without the prior written consent of such other party, which consent will not be unreasonably withheld or delayed. Hospital agrees that HHI may identify Hospital on its client list, and each party agrees that the other party may use such party's name to the extent reasonably necessary or appropriate for such party to provide its services and fulfill its duties under this Agreement.

5.13 Interpretation. The parties each acknowledge and represent that they: have negotiated this Agreement over a period of time; have read and fully understand the terms of this Agreement and the attached Exhibits; have consulted with

and have been advised by independent legal counsel and other advisors regarding the Agreement; and that the Agreement shall not be construed against any party.

5.14 Waiver. Except as otherwise provided herein, no term or provision hereof shall be deemed waived and no breach excused unless such waiver or consent shall be in writing and signed by the party claimed to have waived or consented. Any consent by any party to, or waiver of, a breach by the other, whether expressed or implied, shall not constitute consent to, waiver of, or excuse for any other different or subsequent breach.

5.15 Severability. If a court or other tribunal of competent jurisdiction holds any term or provision, or portion thereof, of this Agreement to be invalid, void or unenforceable, the remaining provisions of the Agreement shall remain in full force and effect. It is the parties' intention that if a court or other tribunal holds any term or provision of this Agreement to be excessive in scope, such term or provision shall be adjusted rather than voided, if possible.

5.16 Delegation. HHI may delegate any of its obligations under this Agreement to any subcontractor(s). In such event, HHI will remain responsible to System for the work of such subcontractor and will ensure that such subcontractor be included within the provisions of the Business Associate Agreement attached as **Exhibit A**.

5.17 Assignment. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns. No party to this Agreement shall assign this Agreement or any rights or obligations hereunder without first obtaining the written consent of the other parties. Any attempt to otherwise assign or transfer any of the rights, duties or obligations of any party to this Agreement in the absence of such consent will be void. Notwithstanding the foregoing, an assignment by any party of this Agreement in consequence of a consolidation or merger with another person, the formation of a subsidiary or any other transaction whereby all or substantially all of the property or assets of such party become the property or assets of another entity shall not be considered to be an assignment for the purposes of this Section 5.17.

5.18 Referrals. The parties acknowledge that none of the benefits granted to any party hereunder are conditioned on any requirement that any party make referrals or be in a position to make or influence referrals to, or otherwise generate business for, the other parties.

5.19 Representations and Warranties.

(a) Each of the parties represent and warrant to each of the other parties that:

(i) it has the full right and legal authority to enter into and fully perform this Agreement in accordance with its terms;

(ii) the persons signing this Agreement on behalf of the party has the power and authority to execute this Agreement on behalf of such party;

(iii) this Agreement, when executed by all parties, will be a legal, valid and binding obligation enforceable against each party in accordance with its terms;

(iv) the execution and delivery of this Agreement have been duly authorized by the party, and such execution and delivery and the performance by the party of its respective obligations hereunder, do not and will not violate or cause a breach of any other agreement or obligation to which the party is obligated or bound, and no approval or other action by any governmental authority or agency is required in connection herewith; and

(v) in addition to being true as of the date first written above, each of the foregoing representations, warranties, and covenants shall be true at all times during the term hereof.

(b) Each of the representations, warranties and covenants set forth in Sections 5.19(a) above will be deemed to be material and to have been relied upon by the parties notwithstanding any investigation made by the parties.

5.20 HIPAA Requirements. HHI and Hospital shall comply with all laws applicable to their respective business concerning patient privacy and confidentiality. The parties have entered into the Business Associate Agreement in **Exhibit A**.

5.21 Employee Non-Solicitation. During the term of this Agreement and for one (1) year after the effective termination date of the Agreement, no party will solicit, directly or indirectly, a "Significant Employee" of any other party to this Agreement, without prior written approval of the chief executive officer of the employer of that Significant Employee. If a Significant Employee is hired (directly or indirectly) without prior written approval, then the hiring party will pay the other party (or parties) a sum equal to two (2) years of the Significant

Employee's salary. For purposes hereof, the term "Significant Employee" means any person employed by any party to this Agreement (including a party's affiliated professional corporations that employ a party's providers) in a professional, non-clerical and non-custodial position. This provision applies to any Significant Employee during the term of this agreement and for a 12-month period post-employment. This restriction shall not apply to any person employed by a party who seeks employment with the other party through media of general availability, such as newspapers or trade publication advertisements, internet listing or similar solicitations not targeted at specific employees, and to which individuals choose to respond.

5.22 Joint Commission Standard. HHI represents and warrants that the Services will be provided safely and effectively. In order to ensure compliance with this provision, HHI agrees to submit to an annual evaluation of the performance of the Services by means including, but not limited to, direct observation, audit of documentation, review of incident reports, review of periodic reports, collection of data, review of performance reports, review of staff and patient input, review of patient satisfaction studies, and/or review of results of risk management activities. Any such annual evaluation shall be conducted by Hospital upon reasonable advance written notice to HHI and shall be performed at the sole cost and expense of Hospital. The parties intend and agree that this provision and this Agreement are intended to comply with imposed Joint Commission Standard LD 04.03.09.

5.23 Dispute Resolution. In the event a dispute between the Parties arises out of or is related to this Agreement, the Parties shall make good faith efforts to settle the dispute by discussions prior to any other dispute resolution process. A Party shall provide notice of a dispute to the other Party and the Parties will assign the appropriate level of management who will initiate discussions to seek resolution of the dispute, consistent with the terms of this Agreement. Both Parties agree to make best efforts to reach a mutually agreeable resolution within a reasonable timeframe considering the nature of the dispute from the date of the original notice.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the dates set forth below.

**"Hospital"**
**Hazel Hawkins Memorial Hospital**

By: _____

Print Name: _____
Title: _____
Date: _____

Address:

Attention: _____
Fax: _____
Electronic Mail: _____

**"HHI"**
**Hicuity Health, Inc.**

By: _____

Print Name: Andrea Clegg
Title: Chief Financial Officer
Date: _____

Address: One CityPlace Drive, Suite 570
St. Louis, MO 63141
Attention: CFO
Fax: N/A
Electronic Mail: andrea.clegg@hicurityhealth.com

ATTACHMENTS:
Exhibit A – Business Associate Agreement
Exhibit B – Fees
Exhibit C – Clinical Roles, Responsibilities, and Metric Reporting

## EXHIBIT A – BUSINESS ASSOCIATE AGREEMENT

## EXHIBIT B – FEES

B.1 Upfront Fee. Hospital will pay an upfront fee of Five Thousand Dollars ($5,000) for one (1) central station. Such upfront Fee shall be paid upon execution of the Agreement. Should Hospital add future additional central stations, HHI shall invoice in accordance with the above terms.

B.2 Service Fees.

(a) Beginning on the Actual Launch Date and during the term of this Agreement, Hospital shall pay HHI a rate of Twenty-Six Dollars ($26.00) per Patient Day which HHI shall invoice to Hospital on a monthly basis. Such service fees shall be subject to a monthly minimum fee of Five Thousand Dollars ($5,000).

A "**Patient Day**" shall be defined as a unique patient occupying a Telemetry Bed for some portion of a single day (12:00am EST to 11:59pm EST), no matter how much of the day that patient occupies the Telemetry Bed. For clarification, a Telemetry Bed occupied by two different patients in a single day constitutes two patient days – one for each unique patient occupying the Telemetry Bed.

(b) The foregoing fees in Section B.2(a) are subject to annual increase on each anniversary of the Actual Launch Date based on the percentage increase over the most recent 12 month period in the Consumer Price Index (the "Index"), United States City Average, for "All Urban Consumers", published by the Bureau of Labor Statistics of the United States Department of Labor (or if the Index is no longer published or issued, any successor index).

(c) Network Connectivity. If Hospital elects for HHI to procure and manage the network connections supporting hardware between Hospital and HHI's operations center, Hospital shall pay HHI actual cost incurred, plus an administrative fee of twenty percent (20%) of the actual cost incurred for the implementation of such network connection in accordance with Article I of this Agreement. In addition, Hospital agrees to pay actual cost plus an administrative fee of twenty percent (20%) of the actual cost per month for the duration of the initial contract period and any subsequent renewal term for maintenance and support of the above referenced network connections.

B.3 Taxes. All prices exclude taxes, duties, shipping and handling. Any applicable taxes shall be the responsibility of Hospital. In the access and use provided hereunder, no tangible personal property is being sold, transferred or delivered to Hospital.

## EXHIBIT C – CLINICAL ROLES, RESPONSIBILITIES AND METRIC REPORTING

C.1 Metrics. During the term of this Agreement, the parties agree to work collaboratively to develop, monitor and report on specific clinical metrics, as may be possible.

C.2 Roles and Responsibilities of the Parties. The standard responsibilities of the telemetry service offering include:

- Baseline "strip" will be measured, annotated and sent to the Hospital one time per twelve hour shift per patient by HHI.
- Hospital is responsible for final strip interpretation and adding strips to the patient medical record as applicable.
- HHI will monitor cardiac waveforms and call on associated alarms as described in Exhibit D
- Hospital is responsible to answer HHI notifications and treat the patient as appropriate.
- Admit and discharge to monitoring stations will be the responsibility of the Hospital
- Silencing of alarms on the monitoring stations will be the responsibility of the Hospital
- The Parties' operational and clinical teams will meet at least one time per week during the implementation phase and initial eight weeks of service once launched
- The Parties' leadership teams will meet weekly during the implementation phase and monthly during the initial eight weeks of service
- The Parties agree to configure the Hospital monitoring central stations and other technology platforms to optimize the integrated workflows

Within 30 days following execution of this Agreement, the parties agree to cooperatively develop and define workflows, policies and procedures in advance of the Proposed Launch Date. It is anticipated that the parties will address the following:

- What is to be documented?
- When is something documented?
- Who documents it?
- Where is it documented?
- What is the protocol for contacting/alerting Hospital staff?
- How are "strips" documented and retained?
- What are downtime procedures?
- How is a patient admitted/discharged for Remote Telemetry Services?

**EXHIBIT D – STANDARD ALARMS**

| Alarm/Alert | Who is called? |
|---|---|
| Lead(s) Off-No interpretable rhythm | 1. Assigned Nurse<br>2. Charge Nurse<br>3. House Supervisor |
| No Signal | |
| Dead Battery | |
| Sustained Artifact/Inability to interpret rhythm > 2 min | |
| Low/Weak Battery | 1. Patient Care Tech<br>2. Assigned Nurse<br>3. Charge Nurse<br>4. House Supervisor |
| Lead(s) Off-Interpretable rhythm | |
| | |
| | |
| Idioventricular Rhythm | 1. Assigned Nurse<br>2. Charge Nurse<br>3. House Supervisor |
| Sustained VT | |
| VFib | |
| Asystole | |
| Rhythm Changes **which generate an alarm** | |
| Pause >2.5 sec | |
| Vtach (5 beats or more) | |
| High Limit >150 beats/min | |
| Low Limit <40 beats/min | |
| Vtach >100 beats/min | |

# Effect of Remote Cardiac Monitoring System Design on Response Time to Critical Arrhythmias



Noa Segall, PhD;

Jeffrey A. Joines, PhD;

Ron'Nisha D. Baldwin, BSN, MSN;

Diane Bresch, RN, BSN;

Lauren G. Coggins, RN, BA, BSc, BSN;

Suzanne Janzen, RN, BSN, MHS;

Jill R. Engel, DNP, ACNP, FNP, NEA-BC, FAANP;

Melanie C. Wright, PhD

**Introduction:** In many hospitals across the country, electrocardiograms of multiple at-risk patients are monitored remotely by telemetry monitor watchers in a central location. However, there is limited evidence regarding best practices for designing these cardiac monitoring systems to ensure prompt detection and response to life-threatening events. To identify factors that may affect monitoring efficiency, we simulated critical arrhythmias in inpatient units with different monitoring systems and compared their efficiency in communicating the arrhythmias to a first responder.

**Methods:** This was a multicenter cross-sectional in situ simulation study. Simulation participants were monitor watchers and first responders (usually nurses) in 2 inpatient units in each of 3 hospitals. Manipulated variables included: (1) number of communication nodes between monitor watchers and first responders; (2) central monitoring station location—on or off the patient care unit; (3) monitor watchers' workload; (4) nurses' workload; and (5) participants' experience.

**Results:** We performed 62 arrhythmia simulations to measure response times of monitor watchers and 128 arrhythmia simulations to measure response times in patient care units. We found that systems in which an intermediary between monitor watchers and nurses communicated critical events had faster response times to simulated arrhythmias than systems in which monitor watchers communicated directly with nurses. Responses were also faster in units colocated with central monitoring stations than in those located remotely. As the perceived workload of nurses increased, response latency also increased. Experience did not affect response times.

**Conclusions:** Although limited in our ability to isolate the effects of these factors from extraneous factors on central monitoring system efficiency, our study provides a roadmap for using in situ arrhythmia simulations to assess and improve monitoring performance.

(*Sim Healthcare* 17:112–119, 2022)

**Key Words:** Arrhythmia simulation, remote telemetry monitoring.

Every year more than 200,000 people are treated for in-hospital cardiac arrest in the United States.[1] Many of these patients have pulseless ventricular tachycardia (VT) or ventricular fibrillation (VF) and may be saved with timely treatment including cardioversion/defibrillation. The American Heart Association recommends defibrillation therapy within 2 minutes of recognizing a cardiac arrest. However, in 30% of patients, defibrillation is delayed more than 2 minutes from onset reducing their chances of survival to hospital discharge by half.[2]

Hospitals have implemented various solutions to ensure prompt detection and response to cardiac arrest and other critical patient events. Often, the electrocardiograms (ECGs) of multiple at-risk patients are monitored remotely by telemetry monitor watchers in a central location (Fig. 1). Although professional organizations do their best to provide evidence-based guidelines for central telemetry monitoring,[3] the standards are currently limited. Consequently, monitoring practices vary widely among hospitals, primarily driven by the available technologies, system constraints, and financial considerations. For example, continuous ECG telemetry monitoring can be implemented using local (on-unit) or remote (off-unit or even off-site) monitoring stations. Watchers may communicate a critical arrhythmia directly to the patient's nurse or through an intermediary such as a health unit clerk (HUC), and different communication technologies may be used for this purpose (eg, pagers, overhead speakers, landline and cell phones, or bidirectional voice communication badges). The watcher-to-patient ratio can also vary, with a single watcher monitoring between 16 and 72 patients at any given time.[4–6]

The effect of these practices on monitoring efficiency, that is, how quickly critical arrhythmias are detected and responded to, is largely unknown because such arrhythmias are rare and difficult to observe in clinical settings. To some extent, however, we can extend findings from studies on vigilance in simulated task performance to monitor watchers' work. Extensive research on vigilance—our ability to discern signals (eg, critical cardiac arrhythmias) from noise (eg, artifacts) over prolonged

From the Department of Anesthesiology (N.S.), Duke University School of Medicine, Durham; Textile Engineering, Chemistry, and Science (J.A.J.), North Carolina State University, Raleigh; Duke University Health System (R.D.B., J.R.E.); Duke Office of Clinical Research (D.B.), Duke University School of Medicine, Durham, NC; Rush University College of Nursing (L.G.C.), Chicago, IL; Saint Alphonsus Regional Medical Center (S.J.), Boise; and College of Pharmacy (M.C.W.), Idaho State University, Pocatello, ID.

Correspondence to: Noa Segall, PhD, Department of Anesthesiology, Duke University School of Medicine, Box 3094, Durham, NC 27710 (e-mail: noa.segall@duke.edu).

Supported by the Agency for Healthcare Research and Quality (Grant Number R01HS023387). The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.

N.S., J.J., R.D.B., D.B., L.G.C., S.J., and M.C.W. are or were supported by this grant. The other authors declare no conflict of interest.



DOI: 10.1097/SIH.0000000000000610

**FIGURE 1.** Central telemetry monitoring station.



periods—has demonstrated a decline in performance over time and identified factors that can affect this vigilance decrement. Among these are workload, false alarm rate, task duration, and environmental stressors such as noise.[7] High workload, for example, was shown to decrease performance, specifically response times and some types of errors, in simulated air traffic control and baggage screening tasks.[8–11] However, it is sometimes difficult to draw conclusions from performance in laboratory-based, simplified tasks to real-world performance,[12] where the consequences of poor performance may be catastrophic.

To study monitoring performance, we simulated cardiac arrhythmias in situ such that clinicians could not distinguish the simulated arrhythmia from an arrhythmia in a real patient.[13–15] Arrhythmia simulations in patient care settings provide an opportunity to measure responses to critical cardiac events without compromising patient safety and with a degree of control that is not feasible when studying real events. These simulations allow us to capture the critical—but often overlooked—time from arrhythmia onset to recognition, as well as the subsequent time to reach the patient. To the extent that this latency from arrhythmia onset to treatment can be minimized, patients' odds of surviving cardiac arrest can be improved.

The goal of our research was to use simulation to identify determinants of efficient cardiac monitoring systems. To this end, we compared the process of communicating a critical arrhythmia to a first responder, usually the patient's nurse, in 6 inpatient units with different monitoring systems, to determine the system that yields the fastest response time. Response times were defined as the time lapse between the beginning of a simulated critical arrhythmia and a first responder's arrival in the patient's room.

We hypothesized that response times to simulated critical arrhythmias positively correlate with the number of communication nodes between monitor watchers and first responders. This hypothesis is in line with our previous research, in which we validated in situ simulated cardiac events as a tool for measuring arrhythmia recognition and response performance. In that study, response times were shorter for patients monitored by their unit nurses than for patients monitored by remote watchers.[13] With respect to the other factors mentioned previously, we expected a faster response time when monitor watchers are located on the same unit as the monitored patient, rather than in a remote location. We based this hypothesis on qualitative research in which information timeliness and accuracy were perceived to be better when monitor watchers were colocated with the nursing unit than when they were in a different unit or hospital.[16] Based on our laboratory-based study on the effects of patient load on monitor watchers' response times to critical arrhythmias[17] and on the vigilance research described previously,[8–11] we also expected faster response times when the workload of monitor watchers and nurses is lighter. Finally, we hypothesized that more experienced clinicians and those who had previously participated in arrhythmia simulations would respond more quickly. (See Table 1 for a summary of study hypotheses.)

## MATERIALS AND METHODS

### Settings

This study involved 2 patient care units in each of 3 participating hospitals:

A. A large academic hospital in North Carolina (general surgery and mixed units),
B. A small community hospital in North Carolina (progressive care and medical/oncology units), and
C. A medium-sized community hospital in Idaho (telemetry and medical/oncology units).

Each hospital had a central monitoring station that served all of its noncritical cardiac telemetry patients, including those in the selected patient care units. In the large academic hospital (A), the monitoring station was located in a dedicated "war room" that was distant from the units. If a patient on one of the units experienced a critical arrhythmia or other urgent monitoring-related event, monitor watchers typically called an emergency (red) phone on that unit, while for less urgent issues, watchers called a regular unit phone. An HUC sitting in the unit's reception area was assigned to respond to these calls and then relayed the information to the patient's nurse via a call to the nurse's mobile phone, an overhead page, or a phone call to the nursing station (Fig. 2, top). In the small community hospital (B), the monitoring station was in a small room colocated with the progressive care unit. In this hospital, nurses carried phones, which a monitor watcher could call to inform them about patient arrhythmias (Fig. 2, bottom). Finally, in the medium-sized community hospital (C), the monitoring station was located in the nursing station of the telemetry unit. Similar to the small community hospital, monitor watchers could call nurses to inform them of problems but, in urgent situations, were also often observed verbally calling out to any nearby nurse in the telemetry unit (Fig. 2, bottom). Monitor watchers at the

**TABLE 1.** Study Hypotheses

| | Hypothesis | Dependent Variable(s) | Independent Variable |
|---|---|---|---|
| 1. | Fewer communication nodes lead to shorter unit RTs. | Unit RT | No. communication nodes (2 or 3) |
| 2a. | When patient units are colocated with central monitoring stations, monitor watcher RTs and unit RTs are shorter. | Monitor watcher RT<br>Unit RT | Central monitoring station location (on or off patient care unit) |
| 2b. | Monitor watchers who are monitoring fewer patients have shorter RTs. | Monitor watcher RT | No. patients monitored |
| 2c. | Monitor watchers with a lower perceived workload have shorter RTs. | Monitor watcher RT | Perceived workload (low, medium, or high) |
| 2d. | Nurses with a lower perceived workload have shorter RTs. | Unit RT | Perceived workload (low, medium, or high) |
| 2e. | Participants with more clinical experience have shorter RTs. | Monitor watcher RT<br>Unit RT | Clinical experience (<1 y or ≥1 y) |
| 2f. | Participants who have been previously exposed to arrhythmia simulations have shorter RTs. | Monitor watcher RT<br>Unit RT | Previous exposure to arrhythmia simulation (yes or no) |

RT, response time.



medium-sized community hospital were assigned additional, nonmonitoring tasks and were replaced by other staff, for example, the telemetry unit charge nurse, when they stepped away from the monitoring station. In all 3 hospitals, when a critical arrhythmia occurred (eg, VF for more than 5 seconds), monitor watchers were expected to urgently call a code response team before or while calling the patient's nurse. In practice, however, most watchers refrained from "calling a code" and only called the patient's nurse. Table 2 summarizes the characteristics and monitoring systems for each unit in the 3 hospitals.

### In Situ Arrhythmia Simulations

To test system response times to critical arrhythmias, we conducted in situ unannounced simulations of cardiac arrest at each hospital's central monitoring station and in the 6 patient care units. Shift lengths for monitor watchers, nurses, and HUCs in the 3 hospitals were typically 12 hours. Arrhythmia simulations were generally performed at least 30 minutes after the beginning of shifts, to allow time for participants to develop a vigilance decrement.[18] Simulation participants were informed of the research and the simulation procedures but were not told when a simulation would occur. The study was approved by the institutional review board of each participating hospital for research involving the use of human subjects.

#### Central Monitoring Stations

To measure response times of monitor watchers, a research nurse connected an ECG rhythm simulator from a patient room into the hospital's network such that the simulated signal appeared on the monitor watcher's display as a normal ECG would look for that patient. Using the simulator, the nurse mimicked the patient's baseline rhythm and then simulated a few premature ventricular contractions before initiating VT or VF (Fig. 3). During the simulation, the patient was monitored at the bedside by a nurse proficient in cardiac monitoring using a local monitor. Using a stopwatch, a confederate at the central monitoring station measured the time from the start of the simulated VT/VF until the monitor watcher called the nursing unit. If a call was not placed within 5 minutes, the simulation was stopped.

#### Patient Care Units

To measure response times in the nursing units, a confederate monitor watcher called the unit, that is, the HUC in the large academic hospital (A) or the patient's nurse in the small- and medium-sized community hospitals (B and C) and stated that a patient is in VT or VF. Using a stopwatch, we measured the time from the phone call until a first responder entered the patient's room. The response time was documented as 5 minutes if no clinician arrived in the patient's room within that timeframe, and the simulation was terminated.

After each arrhythmia simulation, a short debriefing was conducted with the participants—the monitor watcher, HUC, and/or first responder to the patient's room—to explain the study goals. They also completed a survey that asked for their

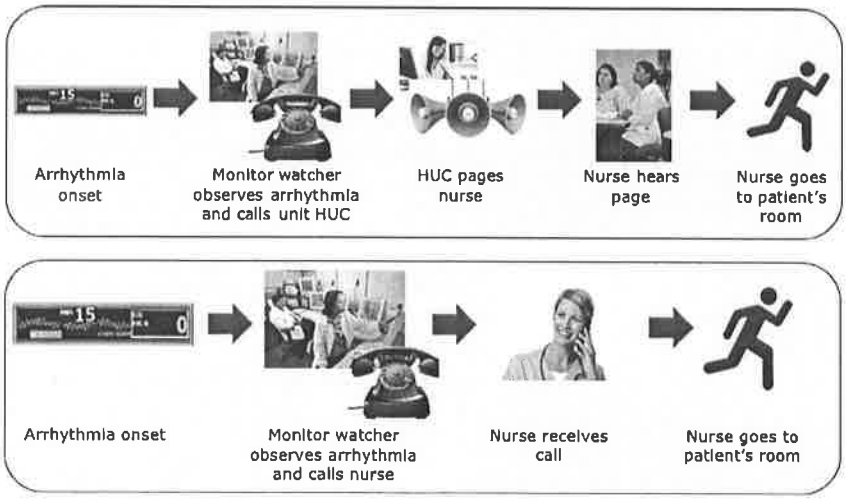


**FIGURE 2.** Response processes for a patient suffering a critical arrhythmia at the large academic hospital (A, top), small community hospital (B, bottom), and medium-sized community hospital (C, bottom).

**TABLE 2.** Participating Patient Care Units and Their Monitoring Systems

| Site | | Unit | No. Beds | Average Percent of Cardiac Telemetry Beds* | No. Communication Nodes (2, Watcher to Nurse; 3, Watcher to HUC to Nurse) | Monitor Watcher Location | Average (Min–Max) Patient Load for Monitor Watchers† |
|---|---|---|---|---|---|---|---|
| Large academic hospital (A) | 1 | General surgery | 32 | 13% | 3 | Remote | 27 (13–35) |
| | 2 | Urology, otology, ophthalmology, gynecology, plastic surgery (mixed) | 32 | 9% | 3 | Remote | |
| Small community hospital (B) | 3 | Progressive care | 33 | 56% | 2 | Local | 25 (11–35) |
| | 4 | General medicine/oncology | 45 | 22% | 2 | Remote | |
| Medium-sized community hospital (C) | 5 | Telemetry | 24 | 80% | 2 | Local | 33 (20–44) |
| | 6 | General medicine/oncology | 40 | 9% | 2 | Remote | |

*Data obtained through observations.
†Data obtained from postsimulation surveys.



demographic information, current patient load, clinical experience, and previous arrhythmia simulation experience and whether they perceived the simulation to be a real event. The participants received a gift card as compensation for their effort.

### Measures

The primary outcome measure was clinician response time, in seconds, to the simulated arrhythmia. *Monitor watcher response time* was defined as the time lapse from arrhythmia start until the watcher picked up the phone to call the nursing unit. *Unit response time* was defined as the time lapse from initiation of the phone call by the monitor watcher until a first responder arrived in the patient's room.

Based on our hypotheses, independent variables included: (1) number of communication nodes between monitor watchers and first responders (2 or 3 nodes, primary hypothesis); (2) monitor watchers' location—on or off the unit in which the simulated patient was located; (3) monitor watchers' workload, both actual (number of patients being monitored during the simulation) and perceived (self-scored as low, medium, or high); (4) nurses' perceived workload (self-scored as low, medium, or high); and (5) participants' clinical experience (<1 or 1 year or more) and experience with arrhythmia simulations. Study hypotheses are expressed in terms of these variables in Table 1.

### Statistical Analysis

We analyzed our data using a linear mixed-effects model, which removes variation because of both fixed and random effects and allows the handling of nonindependent data (eg, response times within a unit within a hospital). Fixed effects included (1) number of communication nodes, (2) monitor watchers' location, (3) patient load, (4) perceived workload, and (5) experience. We controlled for patient care units (nested within hospitals) as random effects.

A mixed model analysis of variance was used to assess the relationship between the dependent variable, response time, and the independent variables. A $P$ value of 0.05 was considered significant. A significant test result was followed up with a Steel-Dwass nonparametric multiple comparisons test,[19] where needed.

Based on data from a previous study comparing monitoring methods,[13] a sample size of 20 arrhythmia simulations in each central monitoring station and hospital unit was calculated to have 80% power to detect a significant difference in mean response times between units. Data analyses were performed using JMP Pro Version 15 (SAS Institute, Cary, NC).

## RESULTS

In all, 190 arrhythmia simulations (62 monitor watcher and 128 unit simulations) were performed. Simulation participant

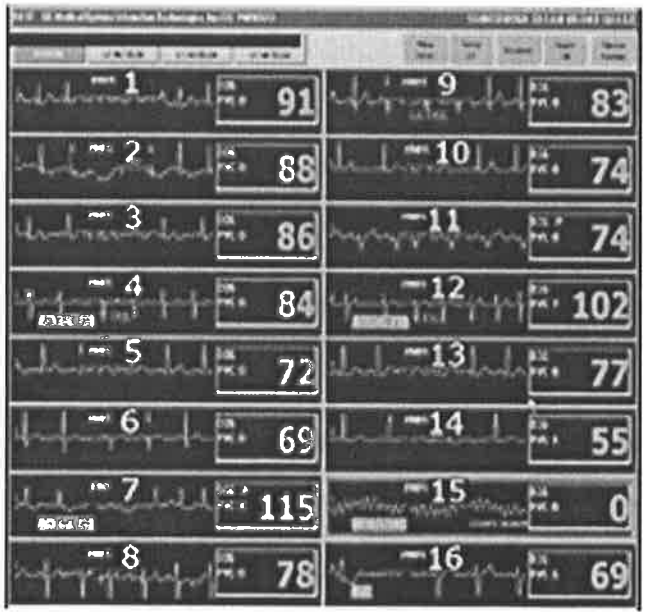


**FIGURE 3.** Simulated VF patient (number 15) on a monitor watcher's display.






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**TABLE 3.** Simulation Participant Characteristics

| Site | Unit | No. Simulations | Clinical Experience, Percent of Participants With <1 y of Experience | Average Patient Load During Simulation, No. Patients for Whom the Participant Was Caring | Average Perceived Patient Load During Simulation; 1 = Low, 3 = High | Percent of Participants Who Had Previously Been Exposed to a Simulation | Percent of Participants Who Perceived the Simulation as a Real Event |
|---|---|---|---|---|---|---|---|
| Large academic hospital (A) | General surgery | 20 | 13.3% | 3.6 | 1.9 | 53.3% | 93.3% |
| | Mixed | 19 | 26.7% | 4.2 | 1.9 | 26.7% | 86.7% |
| | Central monitoring station | 22 | 0% | 28.1 | 2.5 | 81.8% | 83.3% |
| Small community hospital (B) | Progressive care | 24 | 6.3% | 4.5 | 1.9 | 12.5% | 93.3% |
| | Medicine/oncology | 20 | 17.6% | 4.2 | 2.4 | 29.4% | 82.4% |
| | Central monitoring station | 20 | 33.3% | 27.8 | 2.2 | 94.7% | 94.7% |
| Medium-sized community hospital (C) | Telemetry | 21 | 11.1% | 3.9 | 1.9 | 83.3% | 89.5% |
| | Medicine/oncology | 24 | 19% | 4.5 | 2 | 68.1% | 100% |
| | Central monitoring station | 20 | 31.6% | 33.3 | 2.3 | 73.7% | 100% |



characteristics are summarized in Table 3. Response times for the central monitoring stations in the 3 hospitals are presented in Figure 4. A nonparametric analysis of variance found these response times to be significantly different across hospitals ($P = 0.0162$, $h_p^2$=0.157), with post hoc tests showing that response times at the medium-sized community hospital (C) were shorter than at the small community hospital (B). Response times for the 6 patient care units, shown in Figure 5, are significantly different across units ($P = 0.0059$, $h_p^2$=0.776). Post hoc tests showed that response times in the medicine/oncology units in hospitals B and C were significantly longer than in the mixed, progressive care, and telemetry units and that the response times in the general surgery unit were significantly longer than in the progressive care unit.

Hypothesis 1: *Fewer communication nodes lead to shorter unit response times.*

Our primary hypothesis was that unit response times decrease as the number of communication nodes between monitor watchers and first responders decrease. However, based on the linear mixed-effects model, while controlling for the random effects of unit, telemetry location, and hospital, this hypothesis was not supported. We found that response times were shorter in the large academic hospital (A) where monitor watchers called HUCs who then called unit nurses to report arrhythmias (mean = 39, SD = 40 seconds), compared with response times in the other hospitals (mean = 54, SD = 65 seconds) where monitor watchers called nurses directly (Fig. 5; $P = 0.035$, $h_p^2$=0.8681).

Hypothesis 2a: *When patient units are colocated with central monitoring stations, monitor watcher response times and unit response times are shorter.*

We also hypothesized that response times are shorter when monitor watchers are located on the same unit as the monitored patient, rather than in a remote location. Based on the linear mixed-effects model, while controlling for the random effects of unit and hospital, patient care unit response times were significantly affected by location ($P < 0.0047$, $h_p^2$=0.04), with shorter response times observed in units colocated with the monitoring

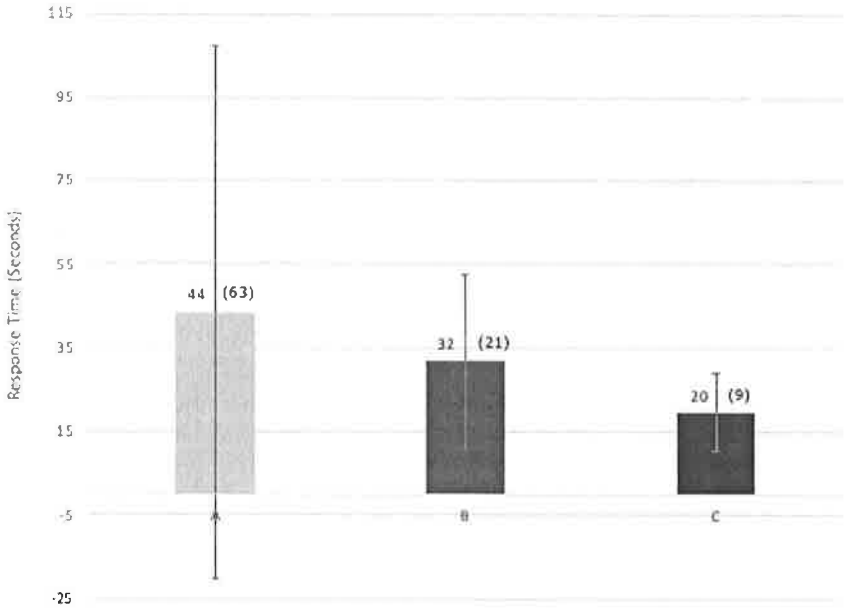


**FIGURE 4.** Central monitoring station response times to simulated arrhythmias (±1 standard deviation) by hospital. A, Large academic hospital; B, small community hospital; C, medium-sized community hospital.



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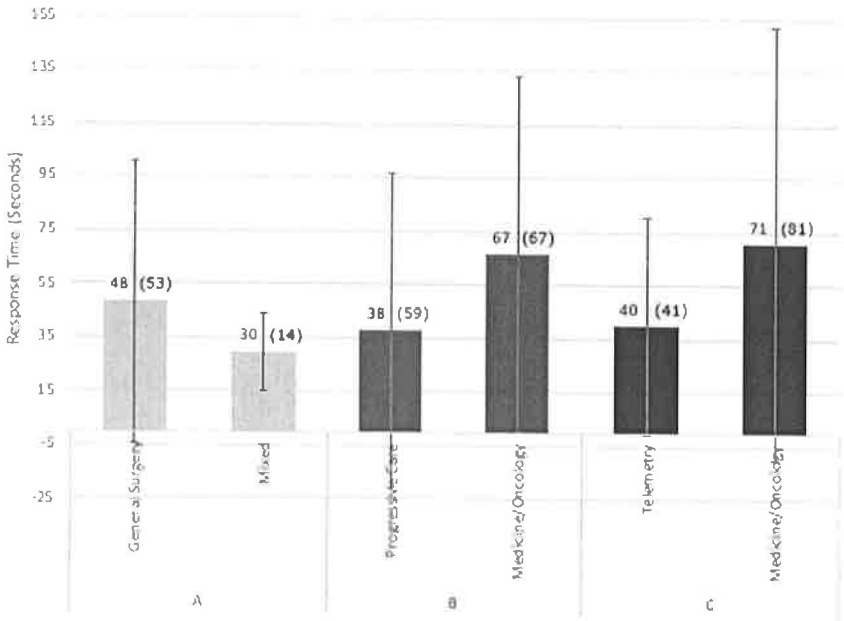


**FIGURE 5.** Patient care unit response times to simulated arrhythmias (±1 standard deviation) by hospital and unit. A, Large academic hospital; B, small community hospital; C, medium-sized community hospital.

stations (ie, progressive care and telemetry units; mean = 39, SD = 50 seconds vs. mean = 55, SD = 62 seconds in units remote from central monitoring stations). Central monitoring station response times were not, however, affected by location ($P = 0.63$), that is, monitor watchers responded as quickly to arrhythmias occurring in colocated units (progressive care and telemetry units) as to arrhythmias occurring in units located remotely (general surgery, mixed, and the 2 medicine/oncology units).

Hypothesis 2b: *Monitor watchers who are monitoring fewer patients have shorter response times.*

Hypothesis 2c: *Monitor watchers with a lower perceived workload have shorter response times.*

Hypothesis 2d: *Nurses with a lower perceived workload have shorter response times.*

Based on the linear mixed-effects model, while controlling for the random effects of hospital, unit, and telemetry location, monitor watchers' actual patient load did not affect central monitoring response times ($P = 0.36$). (We did not test patient load effects on unit response times because nurses' loads were relatively uniform, with an average of 4.2 patients and a median of 4 patients, while some responders were nursing assistants or charge nurses, with different patient loads and care roles.) Monitor watchers' response times were also not affected by perceived workload (scored by simulation participants as low, medium, or high; $P = 0.14$). However, unit response times were affected by perceived workload ($P = 0.0159$, $h_p^2 = 0.08$). Unit response time means were 71 seconds (SD = 82 seconds) when workload was high and 44 seconds (SD = 45 seconds) when workload was low or medium.

Hypothesis 2e: *Participants with more clinical experience have shorter response times.*

Hypothesis 2f: *Participants who have been previously exposed to arrhythmia simulations have shorter response times.*

Most participants were experienced—81.5% had more than 1 year of clinical experience—but experience did not affect unit or central monitoring station response times ($P = 0.15$ and 0.84, respectively). Finally, most participants—56% of unit responders and 70% of monitor watcher responders—had previous exposure to arrhythmia simulations. Nevertheless, 91.4% of responders perceived the arrhythmia to be real. In addition, neither unit response times ($P = 0.82$) nor central monitoring station response times ($P = 0.39$) were significantly affected by participants' previous experience with these types of simulations.

## DISCUSSION

Our findings have several implications for the design of in-hospital patient monitoring systems. First, nursing unit responses to critical arrhythmias were faster when monitor watchers called a unit's HUC who then contacted nurses, than when monitor watchers called the patient's nurse directly. There are several potential reasons for this finding. Health unit clerks were often observed calling the nursing station or using an overhead page, rather than page the patient's nurse. In these instances, the available nurse closest to the patient's room was typically the first to respond. Because the responder was the closest available nurse rather than the patient's assigned nurse, who may have been busy elsewhere, this practice could have contributed to shorter response times. Another contributor to the quick responses could be that monitor watchers always called the same phone numbers (the unit HUCs) and did not need to search for the name and phone number of specific nurses. Likewise, HUCs did not need to search for a specific nurse's number, which would have been another potential source of inefficiency. Finally, availability to respond to the unit phone remained a constant for HUCs, whereas the variable availability of the nurses could have contributed to longer response times.

It is important to note that other confounding factors may also have contributed to this finding. For example, units that had an HUC were part of hospital A, a large academic center with more complex and sicker patients than the 2 community hospitals (B and C). Therefore, patient acuity may have impacted

response time. Most likely, response times were driven by a combination of factors including HUC involvement, patient acuity, and additional factors that may distinguish the large academic hospital from the 2 community hospitals.

We also found that the location of the central monitoring station affected nurses' response times, with shorter response times in the 2 units colocated with the monitoring station rather than in remote locations. It is likely that monitor watchers' direct access to the nurses, and familiarity with them, contributed to the timeliness of communication. This setup is also perceived to improve communication accuracy and care coordination.[16] However, several confounding factors may also have contributed to this finding. For example, in the hospitals that we studied, monitoring stations were located within units that accommodate patients with more severe cardiac problems. In these units, nurses may experience a heightened sense of urgency in responding to critical arrhythmias[20] and may be better trained to recognize and address them. These units were also smaller and capacity than their remote counterparts (Table 2).

Similarly, we hypothesized that monitor watcher response times are shorter when they are calling a nurse in their colocated unit, because of proximity, rather than a nurse in a remotely located unit. Contrary to our expectations, however, monitor watcher response times were not affected by proximity to the patient care units. Monitor watcher communication methods varied by unit and hospital. In the 2 community hospitals (B and C), they were expected to call the nurse assigned to the patient experiencing an arrhythmia. In practice, in units colocated with the central monitoring station, they often verbally called out to the patient's assigned nurse or any nearby nurse. This did not, however, significantly reduce monitor watcher average response times. Directly calling the patient's nurse (community hospitals B and C) required monitor watchers to locate the name of the assigned nurse, then the nurse's phone number (and sometimes the name and number of the patient's backup nurse or charge nurse, if the patient's nurse was unable to respond). This task did not consume more time on average than calling a unit's HUC, the practice for watchers in the large academic hospital (A), many of whom had memorized these numbers. However, because the community hospitals also included units colocated with the monitoring stations, average response times may have been shorter in part because of the common practice of verbally calling out to nearby nurses. Thus, we cannot rule out the possibility that monitor watcher response times were affected by the time to locate the assigned nurse's name and phone number.

Based on our previous study,[17] we expected watchers who monitored a larger number of patients to have longer response times to arrhythmia alarms. Findings from the current study did not bear this out, in part because of missing data—of 62 arrhythmia simulations, monitor watchers only reported their patient load in 36 instances and their perceived workload in 41 instances. However, for nurses, as perceived workload increased, response latency also increased. This underscores the notion that workload is a function not only of the number of patients assigned to a clinician but also of the complexity of their care and other job responsibilities. One other confounding factor is that slower responders may have reported a higher workload to justify their longer response times.

A large majority of participants perceived the simulated arrhythmias to be real, and participants who had previously been exposed to an arrhythmia simulation responded as quickly as those for whom the simulation was a first experience. In addition, response times measured in this study are in line with those measured in other studies.[13,17,20] These findings provide evidence for the construct validity of arrhythmia simulations for measuring real arrhythmia recognition and response performance. It bears mentioning, however, that in situ arrhythmia simulations are not a simple, risk-free tool for assessing monitoring performance. Careful planning and control are required to protect patient safety and the professional reputation of participating clinicians.

Our hypothesis that more experienced clinicians have shorter response times was not upheld. Contrary to our expectations and to the findings of a recent study of nurse response times,[20] we did not find that clinical experience affected response latency, possibly because of the relatively small sample of clinicians with less than 1 year of experience (28 of 151 survey responders).

This study has several limitations. First, as previously mentioned, an important limitation is the multiple and often unknown factors that may have contributed to the arrhythmia response times we observed. For example, we do not know the extent to which differences between hospitals, nursing units, and health system safety cultures contributed to differences in response times. We were not able to isolate and control for the effects of such extraneous factors. Second, in light of the large variability in response times (Figs. 4, 5), our study may have been underpowered to detect differences between monitoring practices. Response times varied quite a bit. On 5 occasions, when a nurse was already in the room of the patient for whom an arrhythmia was simulated, the response time was recorded as 0 seconds. To minimize disruption to patient care, we also stopped simulated arrhythmias that received no response within 5 minutes. This happened once with a monitor watcher and 4 times with nurses. Although this time limit was appropriate when clinicians did not plan to respond to the arrhythmia at all (eg, a monitor watcher who perceived the arrhythmia to be artifact, or a nurse who mistakenly thought she was already in the room of the patient for whom the arrhythmia was called), it may not have sufficed for scenarios where clinicians were busy or unavailable to respond immediately (although hospital protocols required them to call for help in these situations).

## CONCLUSIONS

The practice of remote centralized cardiac monitoring is widespread,[21] despite scant evidence to support its use.[22] However, little is known about factors that contribute to or inhibit the performance of remote monitoring systems. In this study, we found that systems with an intermediary who acted between monitor watchers and nurses to communicate critical events were more efficient, that is, had shorter response times to simulated arrhythmias, than systems in which monitor watchers communicated directly with nurses. Responses were also faster in units colocated with the central monitoring stations than in those that were located remotely. The patient load of monitor watchers did not impact response times. However, as their perceived workload and nurses' perceived workload increased,

response latency also increased. Finally, response times were not affected by clinical experience or by previous exposure to arrhythmia simulations. Although limited in our ability to isolate the effects of these factors, our study provides initial insights into methods for improving central monitoring system efficiency. In addition, it provides a roadmap for using in situ arrhythmia simulations to assess and improve monitoring performance.



## ACKNOWLEDGMENTS

*The authors thank L. Kristin Newby, Michael Chrestensen, Tamara Mueller, Eric McClenny, Reid McCabe, Brandon King, Daniel Weikel, and the members of the Duke University Health System Cardiac Monitoring and Monitoring Oversight Committees for their support of this work.*

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