REGULAR MEETING OF THE BOARD OF DIRECTORS
SAN BENITO HEALTH CARE DISTRICT
911 SUNSET DRIVE, HOLLISTER, CALIFORNIA
THURSDAY, SEPTEMBER 28, 2023 – 5:00 P.M.
SUPPORT SERVICES BUILDING, 2ND-FLOOR, GREAT ROOM

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.

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.

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** (Pages 1 - 48) (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 – August 16, 2023

   B. Consider and Approve Minutes of the Regular and Special Meeting of the Board of Directors – August 23, 2023

C. Consider and Approve Risk Management & Patient Safety Plan 2023

D. Consider and Approve Plan for the Provision of Patient Care 2023 - 2024

E. Consider and Approve Policies

- New Employee Orientation Policy
- Dress Code Policy
- Drug-Free Workplace Policy
- Workplace Violence Prevention Policy
- Adverse Event Reporting Policy

F. Receive Officer/Director Written Reports - No action required. (Pages 49 - 60)

- Interim Chief Nursing Officer
- Provider Services & Clinic Operations
- Skilled Nursing Facilities Reports (Mabie Southside/Northside)
- Laboratory and Radiology
- Foundation Report
- Marketing/Public Relations

Recommended Action: Approval of Consent Agenda Item (A) through (F).

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

5. **Medical Executive Committee** (Pages 61 - 69) (Dr. Bogey)

A. Consider and Approve Medical Staff Credentials: September 20, 2023

Recommended Action: Approval of Credentials.

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

B. Consider and Approve Revised Radiology Rules & Regulations

Recommended Action: Approval of Rules & Regulations

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

C. Consider and Approve Revised Radiology Core Privileges

Recommended Action: Approval of Radiology Core Privileges

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

6. Receive Informational Reports (Pages 70 - 110)

A. Interim Chief Executive Officer (Casillas)

- ➢ Public Comment

B. Finance Committee

1. Finance Committee Meeting Minutes – September 21, 2023 (Robinson)

2. Review Financial Updates
   - Financial Statements – August 2023
   - Finance Dashboard – August 2023
   - Pension Plan Actuarial Funding Valuation Report

3. Public Comment

7. Action Items (Pages 111 - 132)

A. Consider Recommendation for Board Approval of the Professional Services Agreement Between the County of San Benito and Hazel Hawkins Memorial Hospital for County Eligibility Specialist Worker Effective July 1, 2023 through June 30, 2026 and Not to Exceed $90,000 Annually (Robinson)
Recommended Action: Approval of Professional Services Agreement

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

8. Closed Session
(See Attached Closed Session Sheet Information) (Johnson)

9. Reconvene Open Session / Closed Session Report (Johnson)

10. Adjournment (Johnson)

The next Regular Meeting of the Board of Directors is scheduled for Thursday, October 26, 2023 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
SEPTEMBER 28, 2023

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), or

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)

Agency designated representative:
Employee organization:
Unrepresented employee:

[ ] **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): **unknown**

[X] **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):

1. Report from Quality, Risk, and Compliance.

[ ] **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
WOMEN'S CENTER, 2ND-FLOOR, HORIZON ROOM

MONDAY, AUGUST 16, 2023
5:00 P.M.
Livestream via YouTube

MINUTES

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

Also, Present
Mary Casillas, Interim Chief Executive Officer
Mark Robinson, Chief Financial Officer
Heidi Quinn, District Legal Counsel
Robert Miller, Hooper, Lundy & Bookman, Special Counsel
Nicholas Koffroth, Fox Rothschild, Special Counsel
Suzie Mays, Executive Assistant

DRAFT

1. **Call to Order – Roll Call**

   Directors Hernandez, Johnson, Sanchez, and Shelton were present; attendance was taken by roll call. A quorum was present and the Special Meeting was called to order at 5:00 p.m. by Director Hernandez.

   Director Hernandez announced Director Pack as present at 5:06 p.m.

2. **Board Announcements**

   Directors Hernandez and Sanchez met with the community group CIIA to provide information and answer questions.

   Dr. Hernandez read a letter dated August 2, 2023 signed by ten members of the Medical Staff in support of Mary Casillas as Interim CEO, as well as the Administrative Team. The letter expressed appreciation for their leadership during this difficult time, including reaching an agreement with Anthem Blue Cross, filing Chapter 9 so the District could continue operations while renegotiating debts and contracts, and working to find a compatible partner.

3. **Board Education**

A. Introduction to American Advanced Management (AAM)

Ms. Casillas reported the District received a letter of intent from American Advanced Management (AAM). Members of the AAM Team attended to provide an overview of the company and answer any questions from the Board.

Additionally, public forums will be scheduled with AAM in the near future to provide information and answer questions from the public.

Ms. Casillas introduced Matthew Beehler, the Chief Strategic Officer for AAM.

B. American Advanced Management Presentation to Board

Members of the AAM Team were in attendance, including: Dr. Gurpreet Singh, President of AAM; Dr. Shamsher Bhullar, CEO of AAM; Matthew Beehler, CSO of AAM; Amy Micheli, Regional COO of AAM; Steve Stark, Regional CEO of AAM; and Ann Gors, CEO of Kentfield Hospital.

Mr. Beehler provided a PowerPoint presentation entitled *Introduction to American Advanced Management*, which was included in the Board packet. The following highlights were provided:

- 2012 – AAM originated with the opening of its pilot hospital, Central Valley Specialty, a general acute care specialty hospital in Modesto, California. The facility has grown to 96 beds.
- 2017 - AAM acquired Colusa Regional Medical Center, which had closed and was in bankruptcy.
- 2018 - Glenn Medical Center was saved from closure by AAM through a management service agreement. AAM took on all of the financial liability. Glenn now has a successful swing bed program and critical access designation.
- 2019 - Sonoma Specialty Hospital was reopened. Sonoma was a district hospital that had gone through bankruptcy several times. It was converted to an LTAC hospital and expanded to 54 beds in 2023.
- 2020 - Coalinga Regional Medical Center, a critical access hospital, was acquired through bankruptcy. The facility was reopened in 2021 during the COVID surge at the request of Governor Newsom.
- 2023 - Orchard Hospital, a critical access and non-profit hospital, is currently under a management contract and in the process of change of ownership.

Mr. Beehler provided an overview of the AAM portfolio, which includes fourteen rural health clinics and seven hospitals across northern and central California. He noted AAM has a track record for expanding clinics, i.e., Colusa Regional had no clinics when acquired and now has five rural health clinics. AAM is also in the process of bringing on two additional LTAC facilities, which will operate under one license.

DRAFT

The District Leadership Team was commended for the job done in stabilizing Hazel Hawkins and keeping it open during a difficult financial crisis. AAM is familiar with the critical access model, as well as rural health clinics and skilled nursing facilities, and believes the market is prime for growth at Hazel Hawkins. AAM utilizes a growth-based model, including physician and service growth, and noted cutting services, costs, and employees is not in alignment with the growth model. AAM has a large physician group of over sixty physicians and can offer multiple forms of employment for physicians.

AAM provided the following additional information in response to questions from the Board:

- AAM is in support of the direction District Leadership is taking to structure the union agreements so they are sustainable for the District. The negotiation process would likely reach a conclusion before a partnership with AAM would be finalized. AAM's intent would be to honor the agreements reached with the Leadership Team.

- AAM would provide the District the ability to better negotiate with insurance plans. The number of facilities AAM has and the number of communities and lives they serve is significant. AAM would provide leverage to represent a larger system.

- AAM's focus would be sustainability rather than profitability. Portions of the AAM portfolio are profitable, but the goal would be to help develop a sustainable model for the community.

- Dr. Singh noted some of the specialties included in the AAM Medical Group are internal medicine, primary care, gastroenterology, orthopedics, urology, nephrology, and critical care. The AAM Medical Group includes multiple specialties and over sixty physicians. The goal would be to work with and support local physicians to grow the Medical Staff and add new services.

- To support the growth-based strategy, AAM would work with the local Medical Staff and the hospital to understand what services are needed and current service volumes. Potential services identified for growth opportunity include cardiology and inpatient dialysis. Oncology services could also be considered if it is determined providers can be recruited and the volume is adequate.

- Given the size of San Benito County and that Hazel Hawkins is the sole provider, it would be appropriate to grow the facility to approximately 50 – 60 beds. It would be up to AAM to provide enough services to keep patients locally. It is the belief that Hazel Hawkins is in a position to grow relatively quickly with the right support, resources, and physicians in place.

- It is in the best interest of the District for a transaction to move expeditiously. A first of the year transition would make things very clean and be a good target.

- AAM is independent of the bankruptcy timeline and process. AAM is not involved with the bankruptcy, other than having interest in being part of the organization moving forward.

- AAM will collaborate with the District on specific terms related to bond funding.

- AAM believes moving forward the organization will need more employees, not less. In general, AAM can provide centralized services and additional expertise to support work in areas such as revenue cycle, documentation, and ability to work with payors.

DRAFT

- To grow the commercial base, AAM would work to provide services and build programs that attract employers of the community, as well as commercial payors.

- The possibility of a satellite / extension hospital for those traveling out of San Benito County to work could be considered. Relationships would need to be developed with insurance carriers and the data reviewed to determine need and feasibility.

- The development of an urgent care center in Hollister could be considered if data shows there is a need for the community.

- Dr. Singh noted the mission of AAM is to provide quality healthcare options to the community so that patients do not need to travel out of the community, especially when it is critical to receive care on a timely basis.

- AAM could assist patients with Kaiser Insurance by building up the physician network and specialties, as well as offering additional services. In this way, it would attract Kaiser to enter into a contract to serve members locally.

An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

C. Adjournment:

There being no further special business or actions, the meeting was adjourned at 6.22 p.m.

The next Regular Meeting of the Board of Directors is scheduled for Wednesday, August 23, 2023 at 5:00 p.m.

/tr

DRAFT

SPECIAL AND REGULAR MEETING OF THE BOARD OF DIRECTORS
SAN BENITO HEALTH CARE DISTRICT
SUPPORT SERVICES BUILDING, 2ND-FLOOR, GREAT ROOM

WEDNESDAY, AUGUST 23, 2023
5:00 P.M.
MINUTES

HAZEL HAWKINS MEMORIAL HOSPITAL

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

Also Present
Mary Casillas, Interim Chief Executive Officer
Mark Robinson, Chief Financial Officer
Michael Bogey, MD, Chief of Staff
Heidi A. Quinn, District Legal Counsel
Suzie Mays, Executive Assistant

1. **Call to Order**

   Directors Hernandez, Johnson, Pack, Sanchez, and Shelton were present; attendance was taken by roll call. A quorum was present and President Jeri Hernandez called the meeting to order at 5:00 p.m.

2. **Board Announcements**

   None.

3. **Public Comment**

   An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

4. **Consent Agenda - General Business**

   A. Approve Minutes of the Regular Meeting of the Board of Directors, July 27, 2023

   B. Approve Minutes of the Special Meeting of the Board of Directors, August 7, 2023

   C. Approve Crash Cart – Contents and Checks Policy

   D. Receive Officer/Director Written Reports – Written reports were included in the packet and no action required.
      1. Interim Chief Nursing Officer
      2. Provider Services & Clinic Operations
      3. Skilled Nursing Facilities Reports (Mabie Southside/Northside)
      4. Laboratory and Radiology
      5. Foundation Report

DRAFT

6. Marketing/Public Relations

Director Hernandez presented the consent agenda items before the Board for action. This information was included in the Board packet.

MOTION: By Director Hernandez to approve Consent Agenda – General Business, Items (A) through ((D), as presented; Second by Director Sanchez.

MOTION: Director Johnson moved to amend the previous motion and to approve Consent Agenda – General Business, with the exception of Item (C), Crash Cart – Contents and Checks Policy, which will be pulled from the Consent Agenda and moved to Item #7.D. under Action Items; Director Hernandez accepted and seconded the Amendment to the Motion.

Moved/Seconded/Unanimously Carried. Ayes: Directors Hernandez, Johnson, Pack, Sanchez, and Shelton. Approved 5-0 by roll call.

5. **Report from the Medical Executive Committee Meeting on August 16, 2023 and Recommendations for Board Approval of the following:**

A. Medical Staff Credentials Report: Dr. Bogey, Chief of Staff, provided a review of the Credentials Report from August 16, 2023. The full written report can be found in the Board Packet.

Item: Proposed Approval of the Credentials Report; six (6) New Appointments, one (1) Change of Status, one (1) Additional Privileges, one (1) Allied Health Reappointment, and four (4) Resignations/Retirements.

No public comment.

MOTION: By Director Sanchez to approve the Credentials Report as presented; Second by Director Hernandez. .

Moved/Seconded/and Unanimously Carried: Ayes: Directors Hernandez, Johnson, Pack, Sanchez, and Shelton. Approved 5-0 by roll call.

B. Approval Crash Cart – Contents and Checks Policy:

MOTION: Director Johnson to Reorder the Agenda to Consider Item #7.D at #5.B - Approval of the Crash Cart – Contents and Checks Policy in order to receive feedback from Dr. Bogey; Second by Director Sanchez.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Hernandez, Johnson, Pack, Sanchez, and Shelton. Approved 5-0 by roll call.

Dr. Bogey answered questions regarding the crash carts, noting additional crash carts are not being requested. The Crash Cart - Contents and Checks Policy has been updated and is being brought before the Board for consideration. Director Pack questioned the annual maintenance cost for the crash carts; Administration will research and provide additional information in response to this question.

MOTION: Director Johnson to Approve Crash Cart – Contents and Checks Policy, as presented; Second by Director Shelton.

DRAFT

Moved/Seconded/and Unanimously Carried: Ayes: Directors Hernandez, Johnson, Pack, Sanchez, and Shelton. Approved 5-0 by roll call.

6. **Receive Informational Reports**

A. Interim Chief Executive Officer

Ms. Casillas provided highlights of the Interim CEO Report, which can be found in the Board packet.

- The District continues due diligence with AAM and will conduct site visits to several acute care hospitals in the near future;
- AAM attended employee forums to provide information and answer questions. The questions and answers have also been included in an employee newsletter;
- AAM attended a meeting with approximately thirty physicians to provide information and answer questions. The questions and answers have also been included in a physician newsletter. Physicians are encouraged to share additional questions and AAM will attend weekly meetings with physicians to provide further information. The same process will occur with any other potential partners as additional Letters of Intent are received;
- An update was provided to Congresswoman Lofgren regarding Hazel Hawkins, including receipt of the Letter of Intent from AAM;
- Work continues with the professional team on due diligence for potential partners;
- Meetings continue weekly with Speaker Rivas's office, as well as Senator Caballero's office;
- Met with ACHD and other hospital CEOs regarding HCAI and seismic retrofitting. The District is on-track to complete the seismic evaluation, which is due in 2024. The District will continue to meet with HCAI regarding seismic retrofitting.
- Meetings continue with NUHW and CNA to discuss contracts.
- GI services ROI will be completed for the first two quarters and should be available at the next regular Board meeting.
- Staff has been meeting with the Ombudsman's office. The report is due mid-September to the Court. The scheduled Hearing is on track and information has been provided.
- Status of an advance of property taxes to the District has been tabled by the County. Mr. Robinson will reach out to the County to get an update on the status.

An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

Director Sanchez asked that it be noted for the record she did not attend dinner with AAM.

B. Financial Report

1. Review Finance Updates - Mr. Robinson provided an overview of the financial report for August 17, 2023, as well as the Financial Statements and Finance Dashboard for July 2023, included in the Board packet.

   Highlights include:

   - The District application has been approved for the AB112 Distressed Hospital Loan Program. The State is waiting to determine how much money will be allocated once all applications are received. The money has been increased to $300M instead of $150M. The approved hospitals will be rated according to need and those in most need will receive funding sooner. Funding for all should be completed by mid-September.

DRAFT

7. **Action Items**

A. Consider Recommendation for Board Approval of Christopher Verioti, D.O. Second Amendment to Orthopedic Surgery Coverage Agreement Effective 9/1/2023 for a One-Year Term and an Estimated Annual Cost of $462,000 and Reimbursement of Travel Expenses

Staff reviewed the proposed Second Amendment, which was included in the Board packet. There was a question of annual incremental travel cost for Dr. Verioti; Administration will research and provide additional information in response to this question.

An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

MOTION: By Director Hernandez to Approve Christopher Verioti, D.O. Second Amendment to Orthopedic Surgery Coverage Agreement Effective 9/1/2023 for a One Year Term and an Estimated Annual Cost of $462,000 and Reimbursement of Travel Expenses; Second by Director Johnson.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Hernandez, Johnson, Pack, Sanchez, and Shelton. Approved 5-0 by roll call vote.

B. Consider Recommendation for Board Approval of Hue Nguyen-Ngo, D.O. Professional Services Agreement Effective 8/30/2023 for a One Year Term and an Estimated Annual Cost of $113,100

Staff reviewed the professional services agreement, which was included in the Board packet, and answered questions.

An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

MOTION: By Director Pack to approve Hue Nguyen-Ngo, D.O., Professional Services Agreement Effective 8/30/2023 for a One Year Term and an Estimated Annual Cost of $113,100; Second by Director Sanchez.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Hernandez, Johnson, Pack, Sanchez, and Shelton. Approved 5-0 by roll call vote.

C. Consider Recommendation for Board Approval of FY 2024 Operating and Capital Budgets

An overview of the Operating and Capital Budgets for FY 2024 was included in the Board Packet.

Mr. Robinson noted the budgeted gross revenue is increasing due to an increase in patient volume, as well as a price increase. The inpatient and outpatient charges are being increased by 5%; however, the net patient revenue is affected by several factors, including Medicare and Medi-Cal reimbursement, as well as commercial insurance reimbursement. The net operating revenue is budgeted to decrease by $9.9M, mainly due to an $8.9M reduction in funding from the American Rescue Plan, a one-time true up for the Quality Incentive Program, and reduction in physician revenue collections due to the closure of the Primary Care Associate on June 1, 2023.

The proposed budget reflects the trend of a decreasing acute inpatient census due to the reduction in COVID-19 patients. The SNFs are on track to exceed the pre-COVID-19 average daily census. The District's Net Surplus (Loss) is budgeted to be $2.12M. The District is budgeted to meet the Cal-

DRAFT

Mortgage Bond requirements for FYE June 30, 2024. The District should remain a Critical Access Hospital to remain financially viable until an alternative source of revenue can be secured.

An opportunity was provided for public comment and individuals were given three minutes to address the Board Members and Administration.

MOTION: By Director Hernandez to Approve the FY2024 Operating and Capital Budgets; Second by Director Johnson.

Moved/Seconded/and Unanimously Carried: Ayes: Directors Hernandez, Johnson, Pack, Sanchez, and Shelton. Approved 5-0 by roll call vote.

An opportunity was provided for public comment on Item #6.B Financial Reports and individuals were given three minutes to address the Board Members and Administration.

8. **Adjournment:**

There being no further regular business or actions, the meeting was adjourned at 7:08 p.m.

The next Regular Meeting of the Board of Directors is scheduled for Thursday, September 28, 2023 at 5:00 p.m., and will be conducted in person.

/tr

DRAFT

PURPOSE

The Risk Management & Patient Safety Plan is designed to support the mission of Hazel Hawkins Memorial Hospital (HHMH). The purpose of this Plan is to improve delivery of safe patient care and ensure a safe environment for staff, physicians, and visitors.

GUIDING PRINCIPLES

This Risk Management and Patient Safety Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives and activities. The Plan is a tool designed to provide guidance and structure for the care and services that drive quality patient care while fostering high reliability processes.

The focus of this Plan is to provide an ongoing, comprehensive, and systematic approach to reducing medical errors, adverse events, potentially unsafe conditions, and near misses through proactive risk identification, investigation, analysis, and evaluation of options to select and implement the most appropriate actions to correct, manage, and minimize or eliminate risks.

This Plan supports the HHMH philosophy that patient safety and risk management is the responsibility of all members of the healthcare team including leadership, providers, and staff who are vital for an effective patient safety and risk management program. The Plan is applicable to all service locations and interfaces operationally with clinical and ancillary departments throughout the organization

HHMH supports a just culture that emphasizes implementation of evidence-based best practices and learning from errors in a blame-free environment. In a just culture, unsafe conditions are readily and proactively identified, errors are reported, mistakes are openly discussed, and suggestions for systemic improvements are supported.

AUTHORITY & RESPONSIBILITY

The success of the Risk Management & Patient Safety Plan requires Administrative commitment and support. The Board of Directors (BOD) is committed to promoting the safety of all patients and staff, and authorizes the adoption of this plan and delegates responsibility for this function to the Medical Executive Committee, Quality & Patient Safety (QAPI) Committee, and Hospital Administrators.

DEFINITIONS

Adverse Event: An undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services.

Claims Management: Activities to mitigate potential or filed claims against the organization and/or its providers. These activities include identifying potential claims early, notifying the organization's liability insurance carrier, evaluating exposure, mitigating potential damages, providing documents for interrogatories, and investigating adverse events.

Culture of Safety & High Reliability: The collective product of individual and group values, attitudes, beliefs, and systems that cultivate persistent mindfulness and relentless prioritization of patient safety. It is an environment that regards safety as its primary goal with freedom to discuss errors or near misses in a blame-free environment. A culture of safety is concerned with preventing errors, accidents, and adverse events in an environment that promotes collaboration and open communication.

Near miss: An event or situation that could have resulted in an accident or injury but did not, either by chance or through timely intervention. Near misses are opportunities for learning and development of preventative strategies and actions.

Patient Safety Event: Adverse event that results in harm to a patient. Some patient safety events are reportable as defined by the California Health and Safety Code - HSC 1279.1, and Title 22 § 70737.

Proactive Risk Assessment: (Previously known as Failure Mode and Effects Analysis) A method for evaluating a process to identify where and how it might fail and for assessing the relative impact of different failures in order to identify the parts of the process that are most in need of improvement.

Risk Identification: The process used to identify situations, policies, or practices that could result in the risk of patient harm. Sources of information include proactive risk assessments, closed claims data, event reports, past accreditation or licensing surveys, departmental reports, and insurance company claims.

Risk Management: Clinical and administrative activities undertaken to identify, evaluate, prevent, and control the risk of injury to patients, staff, and others as well as to reduce the risk of loss to the organization itself. Activities include the process of making and carrying out decisions that will prevent or minimize clinical, business, and operational risks.

Risk Management System: A computerized system used for data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of events.

Root Cause Analysis & Action (RCA2): A process for identifying causal factor(s) that underlie the occurrence of an adverse event and development of effective action plans to address identified opportunities.

Sentinel event: Defined by The Joint Commission as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse event.

PROGRAM GOALS AND OBJECTIVES

The Risk Management & Patient Safety goals and objectives are to:

- Continuously improve patient safety and minimize and/or prevent the occurrences, and system breakdowns that lead to patient harm through proactive and/or reactive risk management and patient safety initiatives.
- Establish an organization-wide patient safety culture.
- Improve the quality and safety of patient care through ongoing proactive assessments and the use of tools such as the occurrence reporting system, RCA2 etc.
- Minimize losses to the organization by proactively identifying and preventing potential clinical or operational failures.
- Facilitate compliance with regulatory and accrediting agency requirements.
- Protect human and intangible resources (e.g., reputation).

RISK MANAGEMENT PROGRAM FUNCTIONS

Risk Management functional responsibilities include:

- Developing policies and systems for reporting of adverse events, near misses, or unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory or governmental agencies.
- Ensuring the collection and analysis of data to monitor events that involve risk or that may result in serious adverse outcomes.
- Overseeing the organizational occurrence reporting system for data collection, processing, analysis, and generation of statistical trend reports of adverse events and other risk management metrics.
- Review sources for incident information that may include medical records, survey findings, quality improvement activities, patient complaints / grievances, legal notices, risk assessments, staff and physician input.
- Providing feedback to providers and staff; and using data to facilitate system improvements to reduce the probability of recurrence of similar events.
- Facilitating and ensuring the implementation of patient safety initiatives such as medication safety systems and falls prevention programs.
- Facilitating and ensuring provider and staff participation in educational programs to improve patient safety.
- Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and staff members can talk freely about safety problems and potential solutions without fear of retribution.
- Proactively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of patients, visitors, and staff.
- Reducing the probability of events that may result in losses to the physical plant and equipment (e.g., biomedical equipment maintenance, fire prevention).
- Decreasing the likelihood of claims and lawsuits through transparent communications and disclosures to patients and families when appropriate.
- Reporting claims and PCEs to the hospital insurance carrier.
- Supporting safety assessment and improvement programs throughout the organization.

ADMINISTRATIVE AND COMMITTEE STRUCTURE

The Patient Safety and Risk Management program is administered through the Quality/Risk Director who reports to the Chief Clinical Officer. The Quality/Risk Director interfaces with administration, staff, providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The Quality/Risk Director serves on the Quality and Patient Safety Committee. The committee meets monthly and includes representatives from all clinical and service areas. The composition of the Quality & Patient Safety Committee is designed to facilitate the sharing of quality and risk management knowledge, practices, and opportunities across disciplines to optimize the use of key findings from risk management activities in making recommendations to reduce the overall likelihood of adverse events and improve patient safety.

The Quality/Risk Director is responsible for overseeing day-to-day monitoring of patient safety and risk management activities and for investigating and reporting to the insurance carrier actual or potential clinical, operational, business claims, or lawsuits. The Quality/Risk Director serves as the primary contact between the organization and other external parties on all matters relative to risk identification, prevention, and control.

MONITORING AND CONTINUOUS IMPROVEMENT

The Quality & Patient Safety Committee reviews and approves the risk management plan annually. The Quality/Risk Director reports activities and outcomes (e.g., claims, risk and safety assessment results, event report summaries and trends) regularly to the Quality & Patient Safety Committee, Hospital and Medical Staff Leadership, and the Board. This report informs the governing board of efforts made to identify and reduce risks and the success of these activities, and communicates outstanding issues that need input and/or support for action or resolution.

2023 RISK MANAGEMENT & PATIENT SAFETY PROGRAM GOALS

- Develop trending report for Patient Safety incidents
- Work with Nursing to implement a Fall Reduction team
- Coordinate BETA Culture of Safety survey in early 2024

CONFIDENTIALITY

Any and all documents and records that are part of the patient safety and risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include attorney client privilege, attorney work product, and peer review protections from California Evidence Code 1157.

REFERENCES

- California Health and Safety Code: Section 1279
- Title 22 § 70737
- The Joint Commission

Plan for the Provision of Patient Care
San Benito Health Care District
Hollister, California
2023-2024

PURPOSE

The purpose of this Plan for the Provision of Patient Care is to provide the framework for the appropriate provision of health care services, as outlined by the California State Board of Nursing, California Department of Public Health, The Joint Commission, as well as other federal and state agencies as required. The Plan encompasses:

- Identifying existing and new patient care services
- Directing and integrating patient care and support services
- Implementing and coordinating services across departments and continuum of care
- Directing and supporting an equitable level of patient care

This plan outlines the organizational components integral in the provision of safe and effective patient care while considering:

- The areas of the organization in which care is provided
- The mechanisms used in each area to identify and address patient care needs
- The number and mix of staff members in each area to provide for patient needs
- The process used for assessing and acting on staffing variances
- The interdisciplinary plan for improving quality of care and services
- Compliance with regulatory standards including the National Patient Safety Goals

POLICY

The leadership of San Benito Health Care District (SBHCD) recognizes its role in providing the framework for planning, directing, coordinating, and improving health care services that are responsive to community and patient needs, which result in optimal patient care outcomes. The leadership further recognizes the complexity of the acute care hospital organization as composed of many professional disciplines, each of which brings a unique expertise to patient care. The coordination and integration of each of these disciplines is guided by the values of SBHCD and defined by the leadership for Hazel Hawkins Memorial Hospital (HHMH). This Plan is appropriate for the scope of service and the level of care required by the patients served.

Community

HHMH is located in San Benito County, California. Approximately 99% of San Benito County is unincorporated land, primarily used for agricultural purposes. San Benito County is home to two incorporated cities: Hollister and San Juan Bautista. San Benito County is 61% Hispanic and 30% Caucasian with a population of 65,000.

HHMH is the primary healthcare provider for San Benito County and the sole hospital in the county for over a century. HHMH is a 25-bed Critical Access Hospital, Level IV Trauma Center and is designated as a Rural Hospital by the State of California.

SBHCD currently offers inpatient, outpatient, emergency care and diagnostic/therapeutic programs. The SBHCD has created a system of eight clinics in various neighborhood locations. Six (6) clinics are Rural Health Clinics (RHC). Specialties available in addition to Primary Care include Pediatrics, Obstetrics, Gynecology, Cardiology, General Surgery and Orthopedic Surgery. Consultants that are available on a limited basis include: Pulmonology, Infectious Disease, Endocrinology, Nephrology, Neurology, and Gastroenterology.

Hospital statistics for FY 2023

- Total Employees: 745
- Active physicians: 41
- Babies Delivered: 444
- Admissions: 2,130
- Emergency Department Visits: 25,132
- Surgeries: 2,134
- Clinic Visits: 157,503
- Skilled Nursing Patient Days: 32,890

Mission

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

San Benito Healthcare District is committed to meeting community health care needs with quality care in a safe and compassionate environment.

Values

- Respect- We recognize the value of every employee's contribution to the mission of Hazel Hawkins Memorial Hospital, honoring our diversity and working together as an effective team in which each person understands his/her importance to the team.
- Integrity- Never compromise ethics
- Compassion- the feeling that arises when you are confronted with another's suffering and feel motivated to relieve that suffering.
- Innovation
- Teamwork
- Agility
- Connectedness

Patient Care Philosophy:

It is the philosophy of HHMH to create a system that supports safe and effective delivery of patient care, treatment and services, continuous improvement, and innovative leadership that recognizes the complexities presented by the current health care environment. Compliance with The Joint Commission (TJC), California Department of Public Health (CDPH), Centers for Medicaid and Medicare Services (CMS) regulations is fundamental to providing quality health care. Achieving compliance requires interdisciplinary teamwork involving all hospital departments and services. Our goals in the provision of patient care, treatment and services are as follows:

- Ethics, Rights, and Responsibilities:

  We will recognize and respect each patient in the provision of care, treatment, and services in accordance with fundamental human rights to improve patient outcomes. HHMH will function as patient advocates and participate in problem identification and resolution to ensure a high level of quality care. All relationships with patients and family members are conducted in an ethical manner.

- Provision of Care, Treatment, and Services:

  Nursing and other clinical leaders will create a culture that enables HHMH to fulfill its mission and meet the goals established by the administrative team. The leaders support the staff and instill in them a sense of ownership of their work processes. Leaders may delegate work to qualified staff, but the leaders are responsible for the care, treatment, and services provided in their areas.

  The nursing care will match the patient's ongoing needs to the appropriate level and type of care from admission through discharge and by coordination of post-hospitalization care.

  a. Providing patient care in an integrated system of settings, services, health care Providers and care levels.
  b. Maximizing coordination of interdisciplinary care to meet care needs through assessment of each patient's individual needs.
  c. Providing individualized and appropriate care in settings that support the patient's care and treatment.
  d. Incorporating population specific requirements into the plan of care including, but not limited to culture, ethnicity, religious/spiritual beliefs, gender, and age.

- Patient and Family Education:

  The patient and/or family receives education specific to the patient's assessed needs, abilities, readiness to learn, cultural and religious practices, emotional barriers, physical and cognitive limitations, language barriers, and financial considerations. Initial assessment and reassessments are performed by all patient care disciplines and include assessments of patient/family learning needs. The goal is to provide patients and families with the knowledge and skills to:

  a. Promote recovery and return optimal level of functioning.
  b. Involve patient and family in making health care decisions.

c. Understand health status and self care responsibilities.
d. Anticipate benefits of treatment as well as possible complications and costs.

Organizational Structure:

A management philosophy, which combines realistic delegation of authority with principles of participative management, has been adopted to carry out our mission and to fulfill our vision. This type of management is one in which employees at all levels are encouraged to contribute ideas towards identifying and setting goals, problem solving, and other decisions that may directly affect then. While senior management retains the final decision making authority, when participatory management is practiced, employees are encouraged to voice their opinions about their working conditions in a safe environment.

The Chief Clinical Officer (CCO) is a registered nurse in the State of California and is qualified by advanced education and experience. The CCO is ultimately accountable for the provision of patient care and is vested with the authority and responsibility to address the following functions:

- Create a strong vision, well-articulated patient care philosophy, care delivery model, and strategic and quality plans to lead patient care services.
- Develop and implement the nursing plan to ensure quality care and positive outcomes.
- Promote a healthy work environment that promotes the health and well-being of all employees.

The Clinical Directors are responsible to the Chief Clinical Officer and are available to staff for consultation, collaboration, interpretation of hospital and nursing policies, and management of untoward events.

The Nursing leadership provides Mission and Vision for Nursing philosophy, development, and advancement. HHMH nursing and clinical leaders are accountable for the quality and cost effectiveness of nursing/clinical services. The nursing leadership and clinical leaders serve as a catalyst for integration and collaboration of nursing with other professional disciplines and functional areas in the mutual achievement of patient-centered and organizational goals. Nursing leaders foster effective collaboration and professional communication in order to provide effective, compassionate, and efficient nursing care. Nursing leaders promote the identification and implementation of standards of nursing practice that are consistent with standards of professional organizations, statutes and regulations.

Planning for Services:

The planning process is collaborative and inclusive in order to allow input from all relevant levels of the organization, medical staff and community to address both patient care functions (access, treatment, patient rights, patient teaching, discharge planning, and assessment) and organizational support functions (information systems, safety, environment and performance assessment improvement). The planning process is guided by concurrent and retrospective assessment of the patient. The goal of the planning process is to ensure excellent patient care and compliance with regulatory standards and requirements. Consideration is given to ensuring configuration and allocation of all necessary resources, including space, equipment and other facilities to meet the specific needs of the patient population served by the hospital including age, ethnicity, physical disabilities, and other characteristics. The Chief Clinical Officer or designee exercises final authority over staff who provide nursing care, treatment and services. A Registered Nurse must supervise and evaluate the nursing care for each patient.

Directing Services:

The leadership team at HHMH continuously develops leaders at every level who help to fulfill the hospital's mission, vision, and values; accurately assesses the needs of patients; and develops an organizational culture that focuses on continuously improving performance to meet these needs. Leadership and staff share responsibility in developing consistent standards of practice and competency by ensuring uniform delivery of patient care services throughout the organization, communication of the hospital's values, mission and vision throughout the organization in order to guide the day to day activities of the staff, and interdepartmental collaboration on issues of mutual concern that require multidisciplinary input. The Directors have the authority and responsibility to direct and guide their assigned departments, foster staff involvement, and assure current standards of practice as described by the California Board of Nursing.

Participation in the Budget Process:

HHMH Leadership involvement in the budget process is in the early phases of development. The nursing leaders have input in their needed equipment and supply purchases. When new technologies are suggested, the nurse leaders would be expected to identify, investigate and budget with Senior Leadership those items which would be expected to improve the delivery of patient care services.

Patient Care Organizational Performance Improvement Activities:

As part of the organization planning process, the plan for providing patient care will be reviewed and revised as necessary. All departments are responsible for participating in ongoing performance improvement efforts. Changes in patient care needs or findings from performance improvement activities, risk management, infection control, safety and other internal assessments may also trigger a review and/or revision.

Integrating Patient Care and Support Services:

The organizational structure at HHMH supports an integrated approach to the delivery of patient care services. Clinical services/departments are aligned under the direction of the Chief Clinical Officer. Regular meetings are conducted for the purpose of interdisciplinary collaboration, planning and systems enhancement. Interdisciplinary relations are maintained to ensure continuity of patient care services through open communication. Examples of such collaboration include, but are not limited to:

- Informing physicians of changes in patients' condition, patient questions, needs or concerns.
- Clarifying orders of a confusing nature, or those which do not correlate with the clinical plan of care.
- Involving patients and family members in patient care including but not limited to, decisions regarding goals of care, treatment, and services offered, providing information necessary to make effective decisions and patient/family teaching.
- The discharge planning process and interdisciplinary communication with members of various disciplines such as nursing, medical staff, pharmacist, dietary, respiratory therapy and others.
- Conferring with environmental services for coordinating a safe and clean environment upon admission and throughout the hospitalization.
- Coordinating between the patient-care areas for appropriate patient placement.
- Committees, task forces, and performance improvement teams for departmental or

interdisciplinary problem solving.
- Interdepartmental consultations for expertise related to identified patient needs to assure the same level of care regardless of patient placement.
- Notification of Plant Operations/Facilities engineering regarding potentially unsafe equipment.
- Maintaining an interdisciplinary electronic medical record.
- Pharmacy consultation regarding medical orders, effects, usage, food/drug interaction, etc.
- Dietary consultation regarding nutritional assessment and intervention.
- Statistical tracking, trending, and analysis by finance, medical records, and quality management.

Communication and information management is essential with all productive and professional working relationships with all of the hospital services and departments. Communication occurs via staff meetings, individual conversations, telephone calls, emails, memos, performance improvement teams, or committee meetings, and various reports generated by departments within the facility.

Staffing for Patient Care:

Staffing plans for patient care service departments are developed based on the level and scope of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriate and competently provide the type of care needed. The average daily census is considered when developing monthly nursing schedules. Title 22 California Code of Regulations Division 5 requires established staffing ratios for hospitals.

Each department has a specific staffing plan that is reviewed no less than annually based on the assessment of patient needs, patient satisfaction, physician satisfaction, and performance improvement. Leaders meet daily with the staff and staffing for the upcoming shifts are done together.

To promote quality patient care, services including nursing care, are provided on a continuous basis to those patients requiring care and services. Nursing monitors each patient's status and coordinates the provision of patient care while assisting other professionals to implement their plan of care. To achieve this goal, the hospital provides a sufficient number of qualified nursing staff to:
- Assess the patient care needs.
- Plan and provide nursing care interventions.
- Prevent complications and promote improvement in the patients' comfort and well-being.
- Alert other care professionals to the patients' condition as appropriate.

The plan for staffing at Hazel Hawkins Memorial Hospital is dependent upon the assessment made by a Registered Nurse with consideration for patient requirements and provides shift-by-shift staffing based upon those requirements. Ongoing assessment and monitoring provides the patient/family with appropriate and timely interventions. An assessment is performed by a Registered Nurse who may delegate appropriate aspects of patient care to ancillary nursing personnel. Nursing personnel provides a safe and therapeutic environment for all patients. When patient care is provided by students or outside supplemental staff, patient care is the ultimate responsibility of the hospital.

Census and patient acuity are continually reassessed by the charge RN and/or Department Leaders. Staffing is adjusted in the following manner:

a. Understaffing may be corrected by:
    - Floating a staff person from another department that is on duty.

- Requesting a staff member to work additional hours.
- Utilizing the Charge RN or other available, qualified personnel or obtaining registry/traveler staff.

b. Overstaffing may be corrected by:
   - Floating a staff member to another area in need.
   - Flexing off personnel to meet low census needs.
   - Sending staff home before completion of the shift after appropriate reassessment.

When staff members float to another area, assignments are made based on knowledge and competency and are always under the direct supervision of the charge nurse and House Coordinators. All staff nurses have been verified regarding their basic/core competencies throughout the facility.

Staff schedules and daily staffing sheets are retained and are reflective of action taken to manage variance between required and actual staffing. Staffing levels within nursing are adequate to allow for the communication and continuity of patient care between shifts and among caregivers. Staffing plans are reviewed and revised as necessary at least annually by the Chief Clinical Officer and the Director of the department

The clinical information concerning patient care management presented at the shift report is designed to provide for continuity of nursing care and effective work patterns. The quality of communication in the change of shift report influences the quality of patient care and requires each nurse to summarize the patient's status concisely and accurately. Report may be completed through the use of any method which allows the communication to be transferred in a timely and effective manner including:

- Direct verbal communication between on coming and off going staff.
- Bedside rounding.
- Written summary using the Situation, Background, Assessment, Recommendation (SBAR) form. The SBAR form is recommended and promoted as the most effective means of communication.

Competency of Nursing Staff**:**

HHMH believes that quality patient care is provided by personnel who demonstrate knowledge, attitudes, skills, and behaviors that are indicative of meeting stated competencies required to fulfill their work obligations. Competency assessment and validation begins upon employment during the new employee Orientation and followed with Nursing and Unit Orientation. Nursing competency validation continues through the orientation period where each staff member will complete an orientation packet designed for the employee in terms of job title and unit assigned. The length of time on unit orientation differs based on the specifications of the unit where the new employee is assigned, and the amount of experience the new employee has in that field of nursing. Preceptors provide the best method for assessing, providing, and evaluating those competencies. The decision to come off orientation is made between the preceptor, the orientee and the Director. Nursing competency validation continues through education days designed to promote critical thinking skills particularly for the new graduate.

All competencies are documented and available in human resources and education as proof of eligibility to perform the required job performance skills. Topic selections are based on The Joint Commission regulations; California Department of Public Health recommendation; Centers for Medicare and Medicaid regulations; and any high risk/low volume/problem prone skills. Areas for improvement initiatives, patient satisfaction surveys, unit education needs assessments, or other avenues of data collection utilized within the hospital.

Mentoring of new employees is encouraged for all nursing personnel to provide an environment of respect, support, and learning to promote professional and personal growth. All employees have a responsibility to be open to learning opportunities provided by the hospital and the individual unit. New employees are ultimately responsible for expanding their knowledge and skills through their own initiative, attitudes and behaviors. All Registered Nurses must complete 30 hours of continuing education every two years as required by the California State Board of Nursing.

Staff development is supported by the Education Committee through a variety of educational offerings that meet the assessed needs hospital-wide or unit specific requirements. The education programs offered provide an environment conducive to retention, professional growth, and meeting regulatory requirements for nursing personnel. Directors support these programs by being on the nursing units and evaluating the nursing care directly and in present time. Ultimately, professional development is the responsibility of the individual nurse to utilize resources to meet their individual goals and needs.

Patient Care Services:

Patient Care Services at HHMH occur through an organized and systematic process designed to ensure the delivery of safe, effective and timely care, treatment, and services. Providing and delivering patient care, treatment and services requires specialized knowledge, judgment, and skills derived from the principles of biological, physical, behavioral, psychosocial and medical sciences. As such, patient care, treatment and services are planned, coordinated, provided, delegated and supervised by professional health care providers who recognize the unique physical, emotional and spiritual needs of patient/family teaching, patient advocacy and research. Under the auspices of HHMH, the medical staff, registered nurses, allied health care professionals, and support services function collaboratively as part of an interdisciplinary team to achieve optimal patient outcomes.

Departments (clinical) within the facility include:

- Emergency Department
- Intensive Care Unit
- Medical Surgical Unit (with and without Telemetry)
- Surgical Services including Ambulatory Surgery Center
- Recovery Room (PACU)
- Central Sterile Processing
- Respiratory Therapy
- Pharmacy
- Diagnostic Imaging Services
- Clinical Pathology and Laboratory Services
- Nutrition and Food Services
- Infection Prevention
- Nursing Administration
- Physical/Occupational/Speech Therapy
- Case Management/Social Services
- Clinical Informatics

Medical Staff:

Medical Staff is organized to coordinate, direct, and provide medical care to the hospital. The medical staff has established bylaws, rules, and regulations to govern their activities, the management of patient care, policy and procedure approval, quality improvement oversight, peer review, appointment, reappointment, and determination of clinical privileges.

Patient Support Services:

Patient Support Services assist the individuals providing direct patient care through their collaborations and interaction with direct patient care providers. Other hospital services are provided to ensure that direct patient care services are maintained in a continuous manner by coordinating organizational function such as leadership/ management, information systems, human resources, environment of care, infection prevention and organizational improvement. These services support the integration of patient services to ensure provision of safe and efficient patient care.

Non-Clinical Departments include:

- Registration/Business Office
- Finance/Accounting
- Biomedical Engineering
- Marketing
- Health Information Management
- Human Resources/Compliance
- Quality/Risk
- Employee Health
- Information Technology
- Medical Staff Services
- Facilities Management
- Purchasing
- Environmental Services

Functional and Organizational Relationships**:**

Accounting/Finance: The Finance department provides financial reporting, budgeting, accounts payable, payroll, and revenue management oversight for the facility; receives and processes all invoices for the facility.

*Business Office/Admitting**:*** This department is responsible for the management of the patient admission process for both inpatients and outpatients. They assist with insurance verification, financial counseling, receipt of payments, preparation of bills, and collection of patient accounts.

Case Management & Social Services: Works collaboratively with clinical care team to assess, plan, facilitate, and coordinate continuing care to safely meet patients' needs with consideration of available and/or appropriate community resources that will promote quality, cost-effective outcomes.

Central Sterile Processing: This department is a core department in which medical/surgical supplies and equipment, both sterile and non-sterile, are decontaminated, processed, sterilized, stored and used for patient care. The services in this department include decontamination procedures, preparation and packaging for sterilization, monitoring the process of steam, dry heat, and liquid chemical sterilization, maintaining product sterility through shelf-life/rotation, storage distribution, inspection and inventory control of supplies, instruments and equipment.

Diagnostic Imaging Services: Provides inpatient and outpatient diagnostic and screening services at the direction of members of the medical staff for the following areas: Computerized Tomography (CT), Ultrasound, Magnetic Resonance Imaging (MRI), Mammography, Ultrasound, Cardiac Sonography, Fluoroscopy, and General Radiology.

Emergency Department: The Emergency Department is open 24 hours/day, seven days a week, and accepts all patients who present to the facility for treatment. The department is a Level 4 Trauma Center, is capable of instituting essential lifesaving measures and implementing emergency procedures that will minimize further compromise of the condition of any infant, child, adolescent, adult, or geriatric patient. All presenting patients are triaged by a Registered Nurse for priority of care and medically screened by a physician. Any patients requiring a service not offered at Hazel Hawkins Memorial Hospital will be evaluated by a physician, treated, stabilized and transferred to an appropriate facility.

Engineering/Facilities/Biomedical: This department is responsible for the maintenance, repair, and proper operation of hospital equipment and utilities. The department is staffed by trained hospital engineers, versed in all aspects of facilities/biomedical engineering and maintenance. In addition, some equipment is maintained by utilizing outside contractor preventative maintenance/service agreements. Repairs for equipment and utilities are initiated during preventative maintenance cycles and/or by requests from users of the equipment. Fire, Life & Safety concerns receive priority and are completed as soon as possible.

Environmental Services: EVS is responsible for routine cleaning of the patient rooms and work areas, including the removal and replacement of sharps containers. Soiled linen and trash are collected at regular intervals. Biohazard waste is disposed differently from regular waste. Linen is delivered to each unit according to patient census.

Food and Nutrition Services: The Director of Clinical Dietetics, a Registered Dietitian, is responsible for providing all prescribed diets and medical nutrition products per physicians' orders. The Registered Dietitian collaborates with nursing to screen and assess the patient's nutritional needs, and in addition, the RD plans and implements nutritional care in collaboration with the attending physician and other health care professionals and provide nutrition education to inpatients and home health care patients.

Health Information Management: This department maintains all records and documentation of patient care provided by the health care team.

Human Resources/Compliance: Recruits and maintains documentation for all employees of the hospital. Human Resources coordinates the processing of employee actions and notifies the appropriate department Director of any related problems. Human Resources monitors all vacant positions and is responsible for advertising and recruiting efforts.

Infection Prevention: An experienced Infection Prevention RN coordinates the hospital wide program for infectious disease surveillance and ensures adherence to best practices for prevention of hospital-acquired infections and in all patient care and clinical support departments.

Information Technology: This department is responsible for the planning, implementation and maintenance of all information technology services throughout the facility. Responsible for the electronic medical record and all software / hardware updates.

Clinical Laboratory: The clinical laboratory provides diagnostic and monitoring services under the

direction of the CLIA Laboratory Director. Services in the areas of Chemistry, Coagulation, Hematology, Microbiology, Serology, Immunohematology, Clinical Microscopy and Point of Care Testing services are offered 24 hours a day.

Materials Management: Provides unit forms, office supplies, and patient care items which are obtained through purchase orders. All capital purchases will go through Materials Management for obtaining comparable costs.

Medical Staff Services: Supports the organized Medical Staff's functions and processes for credentialing and re-credentialing, as well as Medical Staff meeting management and the flow of information from the Medical Staff departments and committees through the Medical Executive Committee to the Board of Directors, and other services to ensure compliance with the appropriate accrediting and regulatory agencies.

Nursing Administration: The role of Nursing Administration is to provide oversight to the care of all patients based on the physical, psychosocial, cultural, and spiritual needs of the patients. The Chief Clinical Officer and the Clinical Directors cooperate with various disciplines in coordinating comprehensive care and services based on the individual needs of the patients.

Pharmacy: The Pharmacy Department provides clinical, distributive, and educational services. Clinical services include monitoring patient medication regimens, provision of drug information, adverse drug reaction and medication error investigation and follow up, drug use evaluation, formulary management, and pharmacokinetic service. Distributive services include intravenous admixture preparation, emergency and floor stock drug distribution, and distribution of controlled substances.

Physical/Occupational/Speech Therapy Services: The Rehab department provides a range of inpatient and outpatient services to address patients' injury, disability, illness, or other condition that may affect mobility, speech, swallowing, and activities of daily living.

Quality/Risk Management: Coordinates and oversees hospital wide quality assessment and performance improvement activities to ensure provision of safe, quality patient care and services. The staff also works with all hospital departments to establish safe practices, monitor improvement initiatives, and minimize patient occurrences.

Respiratory Care Services: Provides coverage to all inpatients and outpatients requiring respiratory care. Services include the performance of cardiopulmonary evaluation and assessment; screening and diagnosis; respiratory disease prevention; administration of respiratory therapy treatment techniques; and the ongoing education of the patient, family and significant others.

Surgical Services: Provides the facilities and personnel for invasive surgical procedures in-hospital 24 hours per day. Accommodates electively scheduled procedures as well as urgent and emergent surgical cases. Nursing staff is responsible for preparing patients for surgery, as well as their immediate recovery period following the procedure.

Scopes of Service:

The design of patient care services provided throughout the organization is specified in each department's scope of service. Each scope includes, but is not limited to the following information:

- Department description
- Hours of service
- Population served
- Services provided
    a) Conditions/Diagnosis of patients cared for in the department
    b) Treatments, interventions, and activities provided
    c) Utilization of technology
- Staffing
    a) Accountabilities, responsibilities, and scope of practice
    b) Competency validation and maintenance plan
    c) Staffing plan/matrix
- Goals of the department

Annual Review:

The Plan for Provision of Patient Care will be reviewed and revised as necessary at least every 2 years and will be approved by Hospital Leadership, QAPI, Medical Executive Committee, and Board of Directors.

New Employee Orientation

Disclaimer

PDF DISCLAIMER LEGAL NOTICE: This PDF was requested on 9/15/2023 and will be made available in the Lucidoc application until midnight on the requested day. PDFs should not be used as official documentation. Contents of official documents are subject to change without notice. Lucidoc makes no representation or warranty whatsoever regarding the completeness, accuracy, "up-to-dateness", or adequacy of the information or materials contained herein. Please refer to Lucidoc for the most up to date information.

CONFIDENTIALITY LEGAL NOTICE: This PDF may contain confidential information and is intended solely for the addressee. The information may also be legally privileged. This transmission is sent in trust, for the sole purpose of delivery to the intended recipient. If you have received this transmission in error, any use, reproduction, or dissemination of this transmission is strictly prohibited. If you are not the intended recipient, please immediately notify the sender and permanently delete this file.

Revision Insight

Document ID:	11810
Revision Number:	0
Owner:	Drew Tartala, HR Manager
Revision Official Date:	No revision official date

Revision Note:
Approved by P&P committee on

DocID: 11810
Revision: 0
Status: In preparation
Department: Human Resources
Manual(s):

Policy : New Employee Orientation

SCOPE

All San Benito Health Care District staff, travelers, and clinical contractors who provide direct and indirect patient care are required to attend New Employee Orientation (NEO).

PURPOSE

Welcoming new employees, travelers, and clinical contractors involves human resources (HR), department leaders, and other San Benito Healthcare District (SBHCD) teams. Preparing for new hires and providing appropriate guidance and information during the first several days at SBHCD can ensure success. This orientation process is not a replacement for ongoing training requirements for employees, travelers, and clinical contractors to their specific roles and department, which is a more detailed and longer process.

POLICY

New hires to be orientated within 30 days of employment or start of assignment.

PROCEDURE

Orientation will be held monthly.

Onboarding

Representatives from HR and Employee Health will meet with the new hire to complete health screenings,new-hire paperwork and review the orientation process.

Organizational Orientation

All newly hired employees, travelers, and clinical contractors will be scheduled to attend orientation. Employees, travelers, and clinical contractors who do not participate in the NEO within 30-days will be deactivated and cannot perform any duties until the orientation is complete. If the second orientation is missed, it will be considered job abandonment, and the employee, traveler or clinical contractor will be terminated.

A new hire checklist and agenda will be used to sign off that the employee, traveler or clinical contractor has successfully completed the orientation.

Document ID	11810	Document Status	In preparation
Department	Human Resources	Department Director	Quintana, Mario
Document Owner	Tartala, Drew	Next Review Date	
Keywords	onboarding, training		
Attachments: (REFERENCED BY THIS DOCUMENT)			
Other Documents: (WHICH REFERENCE THIS DOCUMENT)			

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at

https://www.lucidoc.com/cgi/doc-gw.pl?ref=hhmh:11810$0.

Dress Code Policy

Disclaimer

PDF DISCLAIMER LEGAL NOTICE: This PDF was requested on 9/19/2023 and will be made available in the Lucidoc application until midnight on the requested day. PDFs should not be used as official documentation. Contents of official documents are subject to change without notice. Lucidoc makes no representation or warranty whatsoever regarding the completeness, accuracy, "up-to-dateness", or adequacy of the information or materials contained herein. Please refer to Lucidoc for the most up to date information.

CONFIDENTIALITY LEGAL NOTICE: This PDF may contain confidential information and is intended solely for the addressee. The information may also be legally privileged. This transmission is sent in trust, for the sole purpose of delivery to the intended recipient. If you have received this transmission in error, any use, reproduction, or dissemination of this transmission is strictly prohibited. If you are not the intended recipient, please immediately notify the sender and permanently delete this file.

Revision Insight

Document ID:	11811
Revision Number:	0
Owner:	Drew Tartala, HR Manager
Revision Official Date:	No revision official date

Revision Note:
Approved by P&P committee on 09/14/23.

Policy : Dress Code Policy

PURPOSE

These guidelines define acceptable standards of dress and appearance for all hospital staff (including San Benito Health Care District (SBHCD) employees and non-employed volunteers, students, and agency/registry or contract staff) assigned to or working at HHMH. This policy is per the Hazel Hawkins Memorial Hospital Standards of Behavior: Appearance.

POLICY

Staff employed by SBHCD or assigned to work at SBHCD by another Department, Contractor, or Agency/Vendor ("All Staff") must follow the hospital's professional appearance guidelines. It is impossible to address every conceivable question of dress and grooming in these guidelines. The most effective control comes from using good judgment to meet our obligations to patient care and the public. Depending upon work assignments and involvement in patient care activities, some departments may need uniform and appearance guidelines. Any exception to the policy must be approved by the Human Resources Department or Chief Executive Officer (CEO). This dress code is to be adhered to ***at all times***.

GUIDELINES

- All staff is expected to be neat, clean, well-groomed, and professional in appearance when reporting for duty.
- Assigned hospital identification badges must be worn at all times, above the waist, with your name, photograph, and SBHCD logo easily visible.
- **Unacceptable items** include:
  - Apparel that is faded, wrinkled, in need of repair, soiled, torn, tight, revealing, or promoted by any organization other than HHMH is not considered professional or per this dress code policy.
  - T-shirts (except when worn for a sanctioned SBHCD event, of which a notice would be sent to staff in advance), tank tops, halter tops, bare midriffs (defined as any top which shows any portion of the torso from the bust to the hips when sitting, leaning forward, backward, or with the arms lifted above the head), tops or blouses showing excess cleavage, strapless or spaghetti strap dresses or tops.
  - Jewelry presents a safety hazard, i.e., long earrings, long chains, and multiple bangle bracelets. Jewelry must be simple.
  - Footwear prevents employees from safely performing their job. Any shoes with openings or holes (including Crocs) are prohibited in any clinical or patient care area. Leather shoes are preferable for safety in all clinical or patient care areas. Shoes must be secured onto feet (e.g., strap or buckle) and cover at least 50% of each foot. Flip-flops or thong sandals are not permitted at any time.
  - Bare legs or ankles are not allowed in clinical or patient care areas.
  - Shorts, skorts, jorts, or jean skirts are not permitted.
  - Sweat suits and other sportswear of any material (including yoga pants) are not permitted. Staff members, with the exception of the perioperative services areas and all direct care patient care areas, may wear a solid-colored shirt under their scrubs for warmth.
  - Hemlines exceeding two inches above the top of the kneecap are not permitted.
  - Leggings or tights of any material (e.g., "jeggings") unless worn with a dress or skirt no more than 2" above the knee are not permitted.
  - Hats or caps except in areas where Infection Control and/or safety require them are not permitted.
  - Slip-on winter boots (e.g., Ugg or a similar style/brand) are not permitted at any time.

UNIFORM GUIDELINES

- Uniform Guidelines for individual departments are set forth below:
  - Central Sterile, Operating Room, Radiology & Outpatient Surgical Services – scrub dresses or suits shall be worn on duty.
  - All clinical and patient care areas, except those mentioned above, must wear clean and professional scrub suits/uniforms when reporting for duty.
  - All ancillary departments may wear slacks and a collared shirt/blouse.
  - Engineering, Environmental Services, and Materials Management Departments may wear department-issued uniforms.
  - Dietary staff will wear any combination of black and white clothing; must wear non-slip sole shoes; hair (including beards) must be covered with a hair net or hair bonnet at all times. Jewelry on the face, ears, neck, or hands is not permissible. Staff assigned to the kitchen must always wear a department-supplied apron.

GUIDELINES FOR PERSONAL HYGIENE AND GROOMING

- Skin, hair, and body are to be clean and free from offensive odors. Scents and makeup may be used in moderation.
- Hair must be neat, clean, and controlled in all clinical and patient care areas. It must not hang loosely over thepatient.
- No flowers (natural or artificial) are to be worn on thehair.
- Facial hair should be clean and neatly trimmed.

- Fingernails may not be longer than ¼ inch for employees in clinical and patient care areas. Artificial nails or nail accessories (including gel or shellac-based nails or polish that cannot be removed with acetone) of any type are prohibited in clinical, patient care, or Food Services areas. Fingernails will be kept clean and trimmed. Nail polish should be neutral and non-chipped.
- Staff may not use scented products in clinical, patient care, and Food Services areas.

NON-COMPLIANCE

The Department Manager and designated Supervisor(s) ensure all staff members' appearances comply with these guidelines. Non-compliance with professional appearance guidelines will result in appropriate disciplinary action, including being sent home to change for the remainder of the day without pay (leave accruals cannot be utilized).

STAKEHOLDERS

Human Resources Department

Department Directors and Managers

All Employees

Document ID	11811	Document Status	In preparation
Department	Human Resources	Department Director	Quintana, Mario
Document Owner	Tartala, Drew	Next Review Date	
Attachments: (REFERENCED BY THIS DOCUMENT)			
Other Documents: (WHICH REFERENCE THIS DOCUMENT)			

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at

https://www.lucidoc.com/cgi/doc-gw.pl?ref=hhmh:11811$0.

Drug-Free Workplace Policy

Disclaimer

PDF DISCLAIMER LEGAL NOTICE: This PDF was requested on 9/18/2023 and will be made available in the Lucidoc application until midnight on the requested day. PDFs should not be used as official documentation. Contents of official documents are subject to change without notice. Lucidoc makes no representation or warranty whatsoever regarding the completeness, accuracy, "up-to-dateness", or adequacy of the information or materials contained herein. Please refer to Lucidoc for the most up to date information.

CONFIDENTIALITY LEGAL NOTICE: This PDF may contain confidential information and is intended solely for the addressee. The information may also be legally privileged. This transmission is sent in trust, for the sole purpose of delivery to the intended recipient. If you have received this transmission in error, any use, reproduction, or dissemination of this transmission is strictly prohibited. If you are not the intended recipient, please immediately notify the sender and permanently delete this file.

Revision Insight

Document ID:	11979
Revision Number:	0
Owner:	Drew Tartala, HR Manager
Revision Official Date:	No revision official date

Revision Note:
Approved by P&P committee on 09/14/2023.

Policy : Drug-Free Workplace Policy

PURPOSE

This policy describes SBHCD's expectations regarding the use and misuse of drugs and alcohol and outlines the options available to employees of SBHCD seeking assistance with drug and alcohol problems. Employees must abide by this policy as a condition of continued employment with SBHCD.

This policy is consistent with the Federal Drug-Free Workplace Act of 1988 requirements, applicable State Drug-free workplace requirements, and SBHCD's obligation to provide a safe work environment.

POLICY

San Benito Health Care District (SBHCD) is committed to protecting employees' and other individuals' safety, health, and well-being in the SBHCD workplace. It provides an environment that is free from the use of alcohol and drugs. SBHCD recognizes that alcohol use and drug use significantly threaten SBHCD goals.

SCOPE/COVERAGE

This policy applies to all staff working for San Benito Healthcare District. All organizations supplying temporary or registry personnel, students, volunteers, physicians, or trainees to SBHCD will be held accountable for providing personnel the same drug-free standard imposed by SBHCD. Volunteers and Contractors are also required to adhere to this drug-free policy. Violation of applicable provisions or refusal to cooperate in implementing this policy can result in contract personnel or volunteers being barred from company premises or from working in its operations.

DEFINITIONS

- **Alcohol** – means alcohol in any consumable form (e.g., ethanol or R1,3-Butanediol in beer, wine, liquor).
- **Being under the influence** – means an individual is impaired by alcohol or a drug, or the combination of alcohol and drugs, regardless of the level detected. Being "under the influence" can be determined by a professional opinion, a medically accepted drug or alcohol-screening test, and/or based on observations by supervisors, co-workers, or others.
- **Company premises** – includes parking lots, vehicles, and other facilities and property owned, leased, or operated by SBHCD, as well as off-site premises used for company-sponsored events.
- **Drug – means:**
  Any drug which is legally and not legally obtainable: any "illicit" drug or "controlled substance" for which the possession or use could result in arrest or other legal sanction according to state or federal statute. Examples include but are not limited to, marijuana, cocaine, crystal methamphetamines (ice), and hallucinogens. [NOTE: Although "medical marijuana" or marijuana use laws may exist in some states because marijuana is a Schedule I drug and possession or use of it is unlawful under federal law, marijuana is an illicit drug for all purposes under this policy.]; prescribed drugs not being used for specified purposes, at prescribed dosages, or by the person for whom the drug is prescribed; and/or any non-prescription substances that are used contrary to the manufacturer's recommendations.
- **Work Time** is when an employee is representing, performing, or conducting business for SBHCD, or is required or scheduled to be on duty.

PROCEDURE

Managers and/or House Supervisors suspecting an employee of drug and alcohol use should immediately contact Human Resources to report their concerns.

Any employee suspecting a co-worker of alcohol/and or drug use should notify their Department Director or House Supervisor immediately.

EMPLOYEE DRUG AND ALCOHOL TESTING

When Human Resources reasonably suspects that the employee possesses or is under the influence of drugs and/or alcohol, an alcohol and/or drug test may be ordered.

Requests for tests based upon reasonable suspicion will be based on reasonably contemporary observations of the individual's behavior or performance.

- When ordering a test, the request must be in the present and at the moment of reasonable suspicion.

Examples of what may trigger a request to submit to a reasonable suspicion test include, but are not limited to, one or more of the following:

- Observed suspected drug or alcohol use;
- Bizarre or erratic behavior (endangerment to self, fellow employees, SBHCD property, equipment, or services provided), or a pattern of conduct that indicates substance use may be a problem;
- Observed suspected possession of alcohol, drugs, or drug paraphernalia while working or on SBHCD premises (although it should be emphasized that control of these substances is prohibited and may lead to discipline even absent a test);
- A report of substance use in violation of this policy from a credible source (i.e., employee, manager, director, doctor, visitor, and patient) and/or
- A physical appearance, odor, or symptoms indicating drug or alcohol use.

The Director/Supervisor will be provided with information to assist them in recognizing the signs and symptoms of substance use, and the Department Director/Supervisor will document in writing the observations that formed the basis for any reasonable suspicion determination.

Human Resources or the Department Director/Supervisor, if Human Resources is unavailable, shall (1) inform the employee of the Hospital's Drug-Free Workplace Policy and (2) advise the employee of the reason(s) for the concern that the policy has been violated.\

TESTING PROCEDURE

If the employee admits to having a drug and/or alcohol dependency problem, the employee shall be referred to Human Resources and/or Employee Health Services. The employee will be offered the opportunity for possible participation in the Employee Assistance Program and any protected leaves in accordance with applicable law. Such referral does not necessarily shield the employee from disciplinary action.

If the employee denies being under the influence of drugs/alcohol or otherwise violating this policy, the following steps may be taken:

The employee will be asked immediately to voluntarily agree to a blood alcohol test or a drug screen. Any employee who decides to take a drug/ alcohol blood or urine test must sign an Employee Voluntary Consent and/ or Authorization for Release of Test Results. A copy of the Employee Voluntary Consent and of the Authorization for Release of Test Results shall be given to the employee. (Employee Voluntary Consent and Authorization For Release of Test Results) forms. These forms are located on the Intranet.

Any employee who does not consent to and cooperate fully with the drug and/or alcohol testing request is subject to discipline, up to and including termination. Human Resources or Administration shall relieve employees of their duties by placing them on Administrative Leave pending further investigation.

The Department Director/Supervisor or Human Resources shall notify the SBHCD laboratory that an employee will be in for testing, escort the employee to the SBHCD Laboratory, and wait for the results with the employee.

The SBHCD Laboratory will perform the required test(s) if the employee consents.

SBHCD will send the sample(s) to a Substance Use & Mental Health Services Administration (SAMSHA) approved laboratory for confirmation testing if the test is positive for any drug. Sample testing positive for only alcohol will not be sent for confirmation testing.

The employee will be placed on Administrative Leave pending investigation. All items belonging to SBHCD should be retrieved from the employee before the employee is sent home, i.e., pagers, badges, etc. The Human Resources representative will arrange for transportation for the employee. The Department Director/Supervisor and Human Resources will determine disciplinary action pending the results of an investigation, if applicable.

If the test results are ultimately reported as unfavorable, the employee shall be paid for all lost time while testing and the delivery of final test(s) results, if applicable, including any missed overtime and other benefits.

PROCEDURAL SAFEGUARDS FOR TESTING

SBHCD may test for the presence of the following substances or their metabolites: marijuana (THC, hemp), cocaine (coca tea, benzoylecgonine), opiates (including heroin, morphine, and codeine), amphetamines (including methamphetamine and non-prescribed illegal stimulants), barbiturates, benzodiazepines (Valium, Xanax), methadone, methaqualone (Quaaludes), phencyclidine (PCP or "angel dust"), fentanyl, meperidine (Demerol), tramadol, and alcohol.

DRUG TESTS

Drug tests may be conducted using urine, blood, hair, or oral fluids (saliva) samples. If there is a positive finding for the presence of drugs, the SBHCD laboratory shall send the sample(s) to a SAMSHA-approved laboratory for confirmation. The SAMSHA-approved laboratory shall test the sample by using the gas chromatography/mass spectrometry method.

Initial testing shall be done by the SBHCD laboratory, which is qualified to perform such tests.

The SBHCD laboratory shall always maintain an adequate chain of custody of blood, urine, hair, or oral fluids (saliva) samples in possession.

A portion of the blood or urine sample used by the SBHCD laboratory shall be maintained by the SBHCD laboratory in the event further testing is requested.

In the event of a positive finding from both labs, the individual shall be permitted to have a portion of the blood or urine sample tested by another laboratory of their choosing at the employee's expense. SBHCD will review the employee-requested laboratory report and provide results to the employee.

ALCOHOL TESTS

SBHCD may require alcohol tests on a reasonable suspicion basis. Breath, blood and/or saliva tests will be used to detect alcohol. An alcohol test will be considered positive if it shows .02 percent or more alcohol in a person's system. All initial tests will be confirmed by repeat testing.

PROVISIONS

PRE-EMPLOYMENT DRUG TESTING

Under *Pre-Employment Drug Testing*, SBHCD requires all individuals external to SBHCD who have been offered employment complete pre-employment drug testing demonstrating the absence of illegal or prohibited use of legal drugs.

POSITIVE TEST

If a candidate tests positive on an initial screening test, the test will be confirmed by further testing through an outside lab. The employment offer will be formally withdrawn upon receipt of the second positive confirmation test. The candidate will be provided with a copy of the test results and written notification why they are no longer being considered for employment.

EMPLOYEES WITH DRUG AND ALCOHOL PROBLEMS

SBHCD supports treatment and programs to address alcohol or drug use and will provide them when warranted by conditions and circumstances. However, SBHCD must balance respect and concern for individuals experiencing these problems with SBHCD's commitment to maintaining an alcohol and drug-free environment. SBHCD encourages employees to seek help with drug and alcohol problems voluntarily.

SBHCD encourages any employee covered by this policy experiencing alcohol or drug dependency to seek professional assistance, including using the SBHCD confidential Employee Assistance Program and/or utilizing SBHCD leave of absence options. Whenever practical, SBHCD will assist employees in overcoming drug, alcohol, and other problems that may affect employee job performance, provided such assistance is requested before violating this policy. SBHCD will provide information on the Employee Assistance Program, leave options, and other rehabilitative programs outside of the Hospital.

Employees' voluntary participation in chemical dependency recovery programs or rehabilitation services will be confidential. It will not affect their employment if they meet the program's terms and conditions. Both SBHCD policy and existing laws protect the confidentiality of persons seeking chemical dependency treatment.

Depending on the circumstances, an employee's return to work, reinstatement, and continued employment may be conditioned on the employee's successful participation in and/or completion of all evaluations, counseling, treatment, rehabilitation programs, or other appropriate conditions determined by SBHCD.

EMPLOYEES TAKING PRESCRIBED MEDICATION

The use of prescribed medication at prescribed dosages and for specified purposes under the direction of a physician or other appropriate licensed person on either a long-term or short-term basis may affect the safety of the employee, co-workers or members, the employee's job performance, or the safe or efficient delivery of services. Therefore, any employee who experiences an impairment of performance that could impact their work duties due to using such medication (e.g., vision impairment, lack of balance, loss of reflexes, impaired judgment) must report this to their supervisor, if such medication affects the safety of employees, co-workers, or members. In that case, the employee's job performance, or the safe or efficient delivery of services, may be required to be away from work temporarily using PTO, PSL, medical leave, personal leave, or other time off benefits.

PROHIBITED CONDUCT AND PENALTIES

It is a violation to use, possess, sell, purchase, trade, and/or offer for sale or to purchase drugs (as defined in this policy) during work or at any time on SBHCD premises. Being under the influence of a drug by any employee on SBHCD premises or during work time is prohibited.

Being under the influence of alcohol or drugs by any employee while on SBHCD premises or during work time is prohibited. The consumption, sale, purchase, or offer for sale or purchase of alcohol or drug on SBHCD premises is prohibited. Possession or transfer of an open container of alcohol on SBHCD premises violates this policy, except in circumstances in which consumption of alcohol is authorized explicitly at an SBHCD-sponsored or sanctioned function.

Being at work and failing to report to the supervisor that the prescribed medication is impairing the employee's motor functions violates this policy.

Theft, diversion, or unauthorized removal of drugs maintained or dispensed on SBHCD premises violates this policy.

It is a violation for employees to unlawfully manufacture, distribute, dispense, possess, sell, purchase, or use an illegal drug. Such violations include any off-duty conduct on or off the premises where the behavior adversely affects the employment relationship or SBHCD business interests.

Violation of this policy will subject employees to corrective/disciplinary action, up to and including termination of employment. It may result in a referral to law enforcement agencies for possible criminal prosecution.

NOTIFICATION OF CONVICTIONS

Any employee convicted of a criminal offense for all drug and alcohol violations must notify Human Resources within five days of that conviction as a condition of employment. Failure to provide timely notification will result in corrective/disciplinary action, including termination of employment.

Federal contracting agencies will be notified of employee convictions when appropriate.

REASONABLE SUSPICION OF PROHIBITED ALCOHOL OR DRUG USE

A supervisor may have a "reasonable suspicion" that an employee is under the influence based on observation of conduct and events. Factors that may establish reasonable suspicion include, but are not limited to:

- Sudden unexplained changes in behavior adversely impact work performance.
- Discovery or presence of alcohol or illegal drugs in an employee's possession or near the employee's workspace.
- The odor of alcohol and/or residual odor peculiar to alcohol or controlled substances.
- Personality changes or disorientation.
- Any violation of safety policies or involvement in an on-the-job or near-miss accident.

When reasonable suspicion has been established to indicate an employee is under the influence of alcohol or drugs, the employee will be asked to provide blood or urine specimens for laboratory testing. Employees are required to follow policies/procedures regarding drug and alcohol testing.

Where there is reasonable suspicion that employees possess or their personal effects (including vehicles, purses, briefcases, clothing, and personal containers) contain an illegal drug or an open container of alcohol, management may, with consent, search such individuals or their personal effects, refusal to consent to such searches may be considered insubordination. Illegal drugs which are confiscated will be turned over to local law enforcement agencies.

Before sending any employee for drug or alcohol testing due to reasonable suspicion, the **Drug Testing: Reasonable Suspicion Documentation** form must be completed—two members of management who have had a first-hand observation or conversation with the employee. In rare situations, a second member of leadership may not be available to witness the behavior. If the employee is in a safety-sensitive area, remove the employee from work immediately until a second observer can talk with the employee and decide whether testing is necessary.

When completing the document, list all observations noticed. Include names of employees/witnesses and when and where the behaviors occurred. Furthermore, include what the employee was doing then and any witnesses of these events. Include any observations or changes in the employee's appearance, smell, speech, movement, or actions. Some signs of impairment may include slurred speech, difficulty walking, clumsiness, dilated pupils, and watery and/or red eyes.

POST-ACCIDENT

Employees are subject to testing when involved in accidents that damage a vehicle, machinery, equipment, or property or injure themselves or another employee requiring medical attention. A circumstance that constitutes probable belief will be presumed to arise in any instance involving a work-related

accident or damage in which an employee operating a motorized vehicle is found to be responsible for causing the accident. In any of these instances, the investigation and subsequent testing must occur within two hours following the accident, if not sooner. Refusal by an employee will be treated as a positive test result and result in immediate termination of employment.

Under no circumstances will the employee be allowed to drive themselves to the testing facility (Hospital). A member of management must transport the employee or arrange for a cab for the employee to be transported home.\

NOTIFICATION AND MEDICAL REVIEW

Any individual who tests positive for drugs will be notified by a Human Resources Representative and allowed to explain in confidence any legitimate reasons they may have that would explain the positive drug test (such as information showing that the individual holds a prescription for the substance detected). Suppose the individual provides an explanation acceptable to Human Resources that the positive drug test result is due to factors other than the consumption of illegal drugs. In that case, the Employee Health Director (EHDIR) will order the positive test result to be disregarded and will report the test as unfavorable. Individuals may request or will be provided with a copy of their test results. An individual who tests positive for drugs may ask the EHDIR to have their sample sent to an independent certified laboratory for a second confirmatory test at the individual's expense, provided that the request is made within three business days of the date the EHDIR informed the individual of the positive test result. However, the Hospital may suspend, transfer, or take other appropriate employment action against the employee pending the results of any such re-test.

CONFIDENTIALITY

SBHCD recognizes the importance of maintaining confidentiality when current and former employees covered by this policy are suspected of alcohol or drug-related infractions. Every effort will be made to ensure suspected employees' privacy throughout investigatory and corrective/disciplinary action proceedings.

POLICY ATTESTATION

New employees must read the policy and sign the Drug-Free Workplace Acknowledgement at hire, which states that they acknowledge, understand, accept, and agree to comply with this policy. Failure to abide by this policy may result in corrective/disciplinary action up to and including termination.

STATE REQUIREMENTS

In addition to the federal requirements regarding a drug-free workplace, some states have related laws or statutes that SBHCD must comply with in applicable regions (see Addendum).

ADDITIONAL EMPLOYEE OBLIGATIONS AND RESPONSIBILITIES

Employees who use drugs and/or alcohol often affect other employees' performance. SBHCD cannot provide quality health care without the cooperation and assistance of all employees. Employees who observe activities prohibited by this policy are responsible for alerting their supervisors or whatever management is necessary to resolve the issues.

ADA – DRUGS AND ALCOHOL

Although alcoholism and drug addiction may both be disabilities under the Americans with Disabilities Act (ADA), they are, in some respects, treated differently. An alcoholic is generally a person with a disability under the ADA. In contrast, someone addicted to drugs is protected under the ADA only if they are not using illegal drugs.

According to the Equal Employment Opportunity Commission's (EEOC's) Technical Assistance Manual: Title I of the ADA, "A person who currently uses alcohol is not automatically denied protection simply because of the alcohol use. An alcoholic is a person with a disability under the ADA and may be entitled to consideration of accommodation if the employee is qualified to perform the essential functions of a job. However, an employer may discipline, discharge, or deny employment to an alcoholic whose use of alcohol adversely affects job performance or conduct to the extent that the employee is not 'qualified' ".

Current illegal drug use is not protected, but recovering addicts are protected under the ADA. According to the EEOC's manual, "Persons addicted to drugs, but who are no longer using drugs illegally and are receiving treatment for drug addiction or who have been rehabilitated successfully, are protected by the ADA from discrimination based on past drug addiction." However, a drug test that shows the employee is using an illicit substance qualifies as "illegal drug use" and bars them from ADA protections.

In both cases, SBHCD can hold the individuals to the performance standards applicable to their jobs, and SBHCD will prohibit the use of drugs and alcohol in the workplace and require that employees not be under the influence of alcohol or drugs in the workplace.

REFERENCES/APPENDICES

Addendum – Alcohol & Drug Rehabilitation for California Employees
Drug-Free Workplace – Employee Acknowledgement
Disciplinary Process
Pre-Employment Drug Testing
Employee Assistance Program
Federal Drug-Free Workplace Act of 1988
California Drug-Free Workplace Act of 1990
Society of Human Resources Management – ADA – Drugs and Alcohol
Cal Govt Code § 8355 et seq.
Drug Testing: Reasonable Suspicion Documentation Form- https://bit.ly/3OCo3Do

ADDENDUM

ALCOHOL & DRUG REHABILITATION LEAVE FOR CALIFORNIA EMPLOYEE

TIME OFF

Employees may take time off work to voluntarily enter and participate in an alcohol or drug rehabilitation program. The amount of time off must be reasonably applicable to the law and/or union contract and not create an undue hardship on SBHCD operations.

Nothing in this policy prohibits SBHCD from refusing to hire or discharge an employee due to current use of drugs or alcohol, inability to perform their duties due to drug or alcohol use, or failure to perform their duties without endangering the health or safety of the employee or others.

ELGIBILITY

Any employee who voluntarily enters and participates in an alcohol or drug rehabilitation program will be eligible.

NOTICE & DOCUMENTATION REQUIREMENTS

Time off for this will be granted if an employee provides reasonable notice of the request and a doctor's note to their manager. Alternatively, the employee may give information to their local Human Resources Representative.

PAID OR UNPAID TIME OFF

Employees must use available paid time off (sick leave, vacation, Paid Time Off) before taking leave without pay.

CONFIDENTIALITY

Any records and information regarding an employee's absence from participation in an alcohol or drug rehabilitation program will be maintained as confidential. Managers and supervisors will take all reasonable steps to safeguard an employee's privacy regarding participation in an alcohol or drug rehabilitation program.

Document ID	11979	**Document Status**	In preparation
Department	Human Resources	**Department Director**	Quintana, Mario
Document Owner	Tartala, Drew	**Next Review Date**	
Revised	[09/01/2019], [03/01/2021]		
Reviewed	[09/01/2009], [12/01/2012]		
Attachments: (REFERENCED BY THIS DOCUMENT)			
Other Documents: (WHICH REFERENCE THIS DOCUMENT)			

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at

https://www.lucidoc.com/cgi/doc-gw.pl?ref=hhmh:11979$0.

Workplace Violence Prevention Policy

Disclaimer

PDF DISCLAIMER LEGAL NOTICE: This PDF was requested on 9/18/2023 and will be made available in the Lucidoc application until midnight on the requested day. PDFs should not be used as official documentation. Contents of official documents are subject to change without notice. Lucidoc makes no representation or warranty whatsoever regarding the completeness, accuracy, "up-to-dateness", or adequacy of the information or materials contained herein. Please refer to Lucidoc for the most up to date information.

CONFIDENTIALITY LEGAL NOTICE: This PDF may contain confidential information and is intended solely for the addressee. The information may also be legally privileged. This transmission is sent in trust, for the sole purpose of delivery to the intended recipient. If you have received this transmission in error, any use, reproduction, or dissemination of this transmission is strictly prohibited. If you are not the intended recipient, please immediately notify the sender and permanently delete this file.

Revision Insight

Document ID:	11980
Revision Number:	0
Owner:	Drew Tartala, HR Manager
Revision Official Date:	No revision official date

Revision Note:
No revision note

Policy : Workplace Violence Prevention Policy

PURPOSE

To establish a policy prohibiting workplace violence (WPV) and the possession of weapons on Hospital premises to promote the safety of employees and non-employees. To provide guidance to staff in addressing various forms of WPV and how to report WPV incidents.

POLICY

Hazel Hawkins Memorial Hospital (HHMH) is committed to providing a safe workplace for all employees. In keeping with this commitment, HHMH has adopted a zero- level tolerance for all forms of violence in the workplace.

DEFINITIONS

Possession - To have on one's person, in one's personal effects, or otherwise under one's care, custody and/or control.

Premises - This Policy includes all property, facilities, buildings, structures, installations, work locations, work areas, private cars on the premises, and vehicles owned, operated, leased, or under the facility's control.

Weapons - Instruments designed or reasonably believed to be intended for inflicting injury to or intimidating another person, including, but not limited to, firearms, knives, ballistics, explosives, ammunition or other incendiary devices.

Workplace violence - Any act of violence or threat of violence that occurs at the work site. Workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence consists of the following:

1. The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
2. An incident involving the threat or use of a firearm or other dangerous weapon, including the use of ordinary objects as weapons, regardless of whether the employee sustains an injury.
3. Four workplace violent types:
   a. Type 1 violence means workplace violence committed by a person who has no legitimate business at the work site and includes violent acts by anyone who enters the workplace intending to commit a crime.
   b. Type 2 violence means workplace violence directed at employees by customers, clients, patients, students, inmates, visitors, or other individuals accompanying a patient.
   c. Type 3 violence means workplace violence against an employee by a present or former employee, supervisor, or manager.
   d. Type 4 violence means workplace violence committed by someone who does not work there but has or is known to have had a personal relationship with an employee.

VIOLENCE OR THREATS OF VIOLENCE

Any employee who engages in threatening behavior or acts of violence or who uses obscene, abusive, or threatening language or gestures will be subject to disciplinary action, up to and including immediate termination of employment. Furthermore, any acts or threats of violence by a non-employee on the premises are forbidden. They will immediately expel such a person from the premises unless such persons require emergent medical treatment – e.g., EMTALA.

WEAPONS

Weapons are not permitted on facility premises, in -HHMH owned vehicles, or in private vehicles on facility premises. Specifically excepted are those individuals acting in an official capacity who are licensed to possess a weapon to act in that capacity (e.g., law enforcement officer, deputy sheriff.) The facility will fully cooperate with any law enforcement officer or agency to enforce this policy. Any employee who possesses a weapon while otherwise engaged in business on behalf of, with, or for HHMH, will be subject to disciplinary action, up to and including termination. Any non-employee who possesses a weapon on facility premises violating this policy will be expelled unless such person requires medical treatment as EMTALA requires.

In enforcing this policy, every employee may be required, upon reasonable suspicion and a leader's request, to submit to an inspection of personal or facility property, including, but limited to, any pocket, package, purse, briefcase, lunchbox, or other container brought onto facility premises, or any desk, file cabinet, personal locker, or other container provided by the facility.

Failure to submit to an inspection may subject an employee to immediate discharge. Any non-employee who refuses to submit to an inspection with reasonable cause to believe that the non-employee may have a weapon(s) in his/her possession will not be allowed onto the Hospital or facility premises or will be expelled from such premises.

Employees should report any violation of this policy's prohibitions on violence, threatened violence, or possessing weapons to their supervisor, House Coordinator, Human Resources, or Administration. Upon such report, a thorough investigation will be conducted, and appropriate disciplinary action will be taken if warranted.

SECURITY

The hospital will establish security measures to ensure that the hospital's premises are safe and secure to the maximum extent possible and to deal correctly with access to the hospital facilities. The security measures are outlined in the "Environmental Safety & Security Management Plan".

PROCESS

Handling of incidents of violence in the workplace:

Incidents of violence in the workplace should be referred immediately to Security or through the PBX Operator, extension 1000. Security personnel are best equipped to evaluate the potential for violence and diffuse a situation involving a visitor. During the period while Security personnel are en-route to the scene of the incident, employees should not unnecessarily engage the aggressor, but should take all steps necessary to safeguard themselves and their patients.

Incidents of violence in the workplace involving patients are most often handled effectively by direct patient care providers without the intervention of Security personnel. Patient care providers should understand, however, that Security personnel are available at all times to assist in these matters.

Incidents arising between co-workers should be mediated by their direct supervisors, with the assistance of Human Resources. All employees should understand that engaging in violence in the workplace (which, as defined in this policy, includes threats of violence) is grounds for discipline, including immediate discharge. Once again, Security personnel are available to intervene in these incidents when necessary or appropriate.

Internal Reporting of Incidents of Violence in the Workplace

- Any employee who is a victim of an incident of violence in the workplace is required to report the incident immediately to his/her supervisor. No employee will be retaliated against for making a good faith report of an incident of violence in the workplace.
- Managers/Supervisors are required to ensure that the incident is immediately documented on the Hospital's Incident Report System and (if involved) the Security's report sheets. Managers/Supervisors are also required to refer the affected employee to Employee Health Department and assure the employee receives the appropriate injury packet for appropriate follow-up. Finally, Managers/Supervisors are required to report the incident to Human Resources.
- The Human Resources Department shall record information in the Workplace Violence Incident Log about every incident, post-incident response, and investigation performed. Information about each incident shall be based on information from the employees who experienced workplace violence. The employer shall omit any element of personal identifying information sufficient to allow identification of any person involved in a violent incident, such as the person's name, address, email address, telephone number, or other information that, alone or in combination with other publicly available information, reveals the person's identity.

The information recorded in the Log shall include, but not necessarily be limited to:

1. The date, time, specific location, of the incident;
2. A detailed description of the incident;
3. A classification of who committed the violence, including whether the perpetrator was a patient/client/customer, family/friend of a patient/client/customer, a stranger with criminal intent, coworker, supervisor/manager, partner/spouse, parent/relative, or another perpetrator;
4. A classification of circumstances at the time of the incident, including whether the employee was completing usual job duties, working in poorly lit areas, rushed, performing during a low staffing level, in a high crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances;
5. A classification of where the incident occurred, including whether it was in a patient or client room, emergency room or urgent care, hallway, waiting room, restroom or bathroom, parking lot or other area outside the building, personal residence, break room, cafeteria, or other area;
6. The type of incident, including whether it involved:
    - Physical attack, including biting, choking, grabbing, hair pulling, kicking, punching, slapping, pushing, pulling, scratching, or spitting;
    - Attack with a weapon or object, including a gun, knife, or other object;
    - Threat of physical force or threat of the use of a weapon or other object;
    - Sexual assault or threat, including rape/attempted rape, physical display, or unwanted verbal/physical sexual contact;
    - Other.
7. Consequences of the incident, including:
    - Whether medical treatment was provided to the employee;
    - Who, if anyone, provided the necessary assistance to conclude the incident;
    - Whether security and/or law enforcement was contacted;
    - Amount of lost time from work, if any;
    - Actions taken to protect employees from a continuing threat, if any.
8. Information about the person completing the Log includes their name, job title, phone number, email address, and completion date.

Training and Communication with Associates

- All new employees will be oriented to this policy during New Employee Orientation. This policy will be reviewed annually for all employees.
- Areas in the Hospital which are at significant risk for incidents of violence in the workplace (Emergency Services and Security Services) will receive annual in-service training regarding methods to prevent incidents and to minimize the potential for injury if an incident does occur. Any other area in the Hospital which requests training will receive it.
- Any questions regarding this policy should be directed to the Department Director, or Human Resources.

REPORTING REQUIREMENTS FOR GENERAL ACUTE CARE HOSPITALS TO CAL/OSHA

Every general acute care hospital and special hospital shall report to Cal/OSHA through OSHA's secure online system any incident involving either of the following:

1. The use of physical force against an employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

   Note: These reports do not relieve the employer of the requirements of Section 342 to immediately report serious injury, illness, or death to the Cal/OSHA Modesto District Office at 209-545-7310.

2. An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee/ non-employee sustains an injury.

   The report to Cal/OSHA shall be made within 24 hours, after the employer knows or with diligent inquiry would have known of the incident, if the incident results in injury, involves the use of a firearm or other dangerous weapon, or presents an urgent or emergent threat to the welfare, health, or safety of hospital personnel.

   For purposes of this reporting process:

   a. "Injury" means a fatality, an injury that requires inpatient hospitalization for a period in excess of 24 hours, or when an employee suffers a loss of any member of the body or sustains a serious degree of permanent disfigurement.
   b. An "urgent or emergent threat to the welfare, health, or safety of hospital personnel" means that hospital personnel are exposed to a realistic possibility of death or serious physical harm.

3. All other reports to Cal/OSHA be made within 72 hours.
4. Cal/OSHA reports shall include, at a minimum, the following items:
   a. Hospital name, site address, hospital representative, phone number, and email address, and the name, representative name, and contact information for any other employer of employees affected by the incident;
   b. Date, time, and specific location of the incident;
   c. A brief description of the incident, including but not limited to the type of attacker, the type of physical assault, the type of weapon or object used by the attacker, if any, working conditions at the time of the attack, and whether the assaulted employee was alone or isolated immediately before the incident;
   d. The number of employees injured and the types of injuries sustained;
   e. Whether security or law enforcement was contacted, and how a security or law enforcement assisted the employee(s);
   f. Whether there is a continuing threat, and if so, what measures are being taken to protect employees by engineering control modifications, work practice modifications, or other measures;
   g. A unique incident identifier;
   h. Whether the incident was reported to the nearest district office (Cal/OSHA Modesto District Office) as required.
   i. The report shall not include any employee or patient names. Employee names shall be furnished upon request to Cal/OSHA.
5. The employer shall provide supplemental information to the Cal/OSHA regarding the incident within 24 hours of any request.
6. Reports shall be provided through a specific online mechanism established by the Division for this purpose.

RECORD KEEPING

- Records of WPV hazard identification, evaluation, and correction shall be created and maintained in accordance with Cal/OSHA requirements.
- Training records shall be created and maintained for a minimum of one year and include training dates, contents or a summary of the training sessions, names and qualifications of persons conducting the training, and names and job titles of all persons attending the training session.
- Records of violent incidents, including but not limited to violent incident logs required by Cal/OSHA, and workplace violence injury investigations conducted pursuant to Cal/OSHA requirements, shall be maintained for a minimum of five years. These records shall not contain "medical information".
- All records required by this subsection shall be made available to Cal/OSHA upon request, for examination and copying. All records required by this policy shall be made available to employees and their representatives upon request for examination and copying.

REFERENCES

Title 8, CCR, Section 3342

TJC EC.02.01.01, EC.04.01.01, HR.01.05.03, LD.03.01.01

Document ID	11980	Document Status	In preparation
Department	Human Resources	Department Director	Quintana, Mario
Document Owner	Tartala, Drew	Next Review Date	
Attachments: (REFERENCED BY THIS DOCUMENT)			
Other Documents: (WHICH REFERENCE THIS DOCUMENT)			

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at

https://www.lucidoc.com/cgi/doc-gw.pl?ref=hhmh:11980$0.

Adverse Event Reporting

Disclaimer

PDF DISCLAIMER LEGAL NOTICE: This PDF was requested on 9/15/2023 and will be made available in the Lucidoc application until midnight on the requested day. PDFs should not be used as official documentation. Contents of official documents are subject to change without notice. Lucidoc makes no representation or warranty whatsoever regarding the completeness, accuracy, "up-to-dateness", or adequacy of the information or materials contained herein. Please refer to Lucidoc for the most up to date information.

CONFIDENTIALITY LEGAL NOTICE: This PDF may contain confidential information and is intended solely for the addressee. The information may also be legally privileged. This transmission is sent in trust, for the sole purpose of delivery to the intended recipient. If you have received this transmission in error, any use, reproduction, or dissemination of this transmission is strictly prohibited. If you are not the intended recipient, please immediately notify the sender and permanently delete this file.

Revision Insight

Document ID:	11978
Revision Number:	0
Owner:	Monica Hamilton, Clinical Quality Services Director
Revision Official Date:	No revision official date

Revision Note:
Approved by P&P Commitee on 09/14/23.

Policy : Adverse Event Reporting

PURPOSE

- To describe the process for reporting adverse events to governmental agencies when required.
- To improve patient care, reduce the occurrence of patient safety events, and encourage a culture of safety.

POLICY

Upon detection of a Reportable Adverse Event, Hazel Hawkins Memorial Hospital will file a report to the California Department of Public Health (CDPH).

DEFINITIONS

1. ADVERSE EVENT: US Department of Health and Human Services

   An event in which care resulted in an undesirable clinical outcome (not caused by underlying disease) that prolonged patient stay, caused permanent patient harm, required life-saving interventions, or contributed to death.
2. ADVERSE EVENT: Health and Safety Code (HSC) §1279.1 including the following:

   I. **SURGICAL EVENTS**
      - A. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
      - B. Surgery performed on the wrong patient.
      - C. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
      - D. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
      - E. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

   II. **DEVICE EVENTS**
      - A. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
      - B. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph,
      - C. “device” includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
      - D. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

   III. **PATIENT PROTECTION EVENTS**
      - A. An infant discharged to the wrong person.
      - B. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
      - C. A patient suicide or attempted suicide resulting in serious disability due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
      - D. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

   IV. **CARE MANAGEMENT EVENTS**
      - A. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
      - B. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluids embolism, acute fatty liver of pregnancy, or cardiomyopathy.
      - C. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
      - D. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. “Hyperbilirubinemia” means bilirubin levels greater than 30 milligrams per deciliter.

E. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

F. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

V. **ENVIRONMENTAL EVENTS**

A. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.

B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

C. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

D. A patient death associated with a fall.

E. A patient death or serious disability associated with the use of restraints or bedrails.

VI. **CRIMINAL EVENTS**

A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

B. The abduction of a patient of any age.

C. The sexual assault on a patient within or on the grounds of the facility.

D. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds.

VII. **ADVERSE EVENT or SERIES OF ADVERSE EVENTS that cause the death or serious disability of a patient, personnel, or visitor.**

A. The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.

B. “Serious disability” means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

C. Nothing in this section shall be interpreted to change or otherwise affect hospital reporting requirement regarding reportable disease or unusual occurrences, as provided in Section 70737 of Title 22 of the California Code of Regulations.

PROCEDURE

1. Adverse events that meet the HSC §1279.1 above will be reported to CDPH via email or secure online portal no later than five (5) calendar days of their detection (first business day on which an adverse event is known to the hospital).
2. Adverse events that meet the following criteria will be reported to CDPH within 24 hours.
   a. ongoing, urgent, or emergent event(s) that threaten the welfare, health or safety of patients, personnel, or visitors,
   b. detection or allegation of sexual assault against a patient
3. An intense analysis will be conducted for adverse events using an interdisciplinary team to identify causal factors and develop effective action plans to address identified learning opportunities and mitigate recurrence of the adverse event.
4. Adverse events will be reported to Quality Assessment & Patient Safety Committee, Medical Executive Committee, and Board of Directors.

RESOURCES & REFERENCES

- Health and Safety Code §1279.1, 1279.6
- Title 22, 70970 - 70974
- HHMH Policy Risk Management and Patient Safety Plan

Document ID	11978	Document Status	In preparation
Department	Quality	Department Director	Hamilton, Monica
Document Owner	Hamilton, Monica	Next Review Date	
Reviewed	[09/01/2009], [12/01/2012], [05/01/2015], [12/01/2017], [08/01/2018]		
Attachments: (REFERENCED BY THIS DOCUMENT)			
Other Documents: (WHICH REFERENCE THIS DOCUMENT)			

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at

https://www.lucidoc.com/cgi/doc-gw.pl?ref=hhmh:11978$0.

San Benito Health Care District
Board of Directors Meeting
August 2023
Chief Clinical Officer Report

- **Emergency Department**:
  - Visits: 2,032
  - Admitted: 97
  - Stroke: 1
  - Left Without being seen: 0.2
  - ELOPE: 0.6

- **Med / Surg**
  - ADC: 7.73

- **ICU**
  - ADC: 1.8

- **OB**
  - Deliveries: 32
  - Outpatients Visits: 67

- **OR**
  - Inpatient Cases: 28
  - Outpatient Cases: 14
  - Total ASC Cases: 138
  - GI Total: 94

To: San Benito Health Care District Board of Directors

From: Amy Breen-Lema, Director, Provider Services & Clinic Operations

Date: September 12, 2023

Re: All Clinics – August 2023

2023 Rural Health and Specialty clinics' visit volumes

Total visits in all outpatient clinics = 5,301

Clinic	Visits
Orthopedic Specialty	390
Multi-Specialty	694
Sunset Clinic	832
Surgery & Primary Care Clinic	182
San Juan Bautista	289
1st Street	801
4th Street	1429
Barragan	684

- **Kudos to our clinic providers**! I want to express our appreciation to our Physicians and Mid-Level providers who have been working with limited provider resources for the last few months. They have gone above & beyond to make sure that patient care has continued to be our top priority and offer more availability to all patients.

- The clinics welcomed full-time primary care physician assistant Mark Villegas, PA-C to our team! Mark has adapted very quickly and is developing a steady stream of patients.

Hazel Hawkins
MEMORIAL HOSPITAL

Mabie Southside / Mabie Northside SNFs
Board Report – September 2023

To: San Benito Health Care District Board of Directors

From: Sherry Hua, RN, MSN, Director of Nursing, Skilled Nursing Facility

1. Census Statistics: August 2023

Southside	2023	Northside	2023
Total Number of Admissions	10	Total Number of Admissions	3
Number of Transfers from HHH	10	Number of Transfers from HHH	1
Number of Transfers to HHH	4	Number of Transfers to HHH	1
Number of Deaths	0	Number of Deaths	0
Number of Discharges	10	Number of Discharges	7
Total Discharges	10	Total Discharges	7
Total Census Days	**1,492**	**Total Census Days**	**1,500**

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: August 2023

Southside	From	Payor	Northside	From	Payor
4	HHMH	Medicare	1	Good Sam	MA
1	HHMH	MC	1	SVMH	MA
1	HHMH	Medi-Cal	1	HHMH	MA
4	Re-Admissions	Medi-Cal			
10 Total			**11 Total**		

3. Total Discharges by Payor: August 2023

Southside	2023	Northside	2023
Medicare	3	Medicare	6

Medicare MC	1	Medicare MC	0
Medical	5	Medical	0
Medi-Cal MC	1	Medi-Cal MC	0
Private (self-pay)	0	Private (self-pay)	0
Commercial	0	Commercial	1
Total	**10**	**Total**	**7**

4. Total Patient Days by Payor: August 2023

Southside	2023	**Northside**	2023
Medicare	155	Medicare	169
Medicare MC	7	Medicare MC	0
Medical	1238	Medical	1219
Medi-Cal MC	7	Medi-Cal MC	0
Private (self-pay)	85	Private (self-pay)	62
Insurance	0	Commercial	45
Bed Hold / LOA	10	Bed Hold / LOA	5
Total	**1,502**	**Total**	**1,500**
Average Daily Census	**48.45**	**Average Daily Census**	**48.39**

To: San Benito Health Care District Board of Directors
From: Bernadette Enderez, Director of Diagnostic Services
Date: September 2023
Re: Laboratory and Diagnostic Imaging

Updates:

Laboratory

1. Service/Outreach
   - Sunnyslope Lab updated business hours starting October 2023:
     Mon-Friday 07:00am – 3:00 pm (closed for lunch 11:00-12:00)

2. Quality Assurance/Performance Improvement Activities
   - Submitted 2023 TJC lab survey corrective plan of action
   - Started validation on the new GeneXpert Cepheid analyzer; estimated completion date 10/2023

3. Laboratory Statistics
   - See attached report

Diagnostic Imaging

1. Service/Outreach
   - Due to staffing shortage, the Diagnostic Center next to Ortho clinic is still closed.

2. Quality Assurance/Performance Improvement Activities
   - Updated Diagnostic Imaging Requisition form as well as department specific procedure protocols

3. Diagnostic Imaging Statistics
   - See attached report

Radiology

	January	February	March	April	May	June	July	August	September	October	November	December
2021	1276	1311	1446	1529	1580	1662	1726	1797	1667	1647	1750	1750
2022	1586	1606	1990	1730	1791	1718	1737	1866	1688	1620	1632	1718
2023	1710	1640	1855	1737	1721	1638	1657	1776				

MAMMO Volumes

	January	February	March	April	May	June	July	August	September	October	November	December
2021	494	538	693	648	600	648	633	685	711	834	713	698
2022	480	594	804	546	718	777	643	569	591	752	772	629
2023	614	599	788	714	770	660	596	617				

CT Volumes

	January	February	March	April	May	June	July	August	September	October	November	December
2021	489	522	652	637	690	693	672	701	611	639	657	642
2022	603	653	668	736	777	811	845	1004	921	867	839	783
2023	932	845	1008	988	987	906	869	994				

MRI Volumes

	January	February	March	April	May	June	July	August	September	October	November	December
2021	77	104	134	132	113	151	147	173	162	162	146	181
2022	141	146	191	137	180	166	142	180	152	138	143	142
2023	158	144	211	148	170	138	165	179				

ECHO Volumes

	January	February	March	April	May	June	July	August	September	October	November	December
2021	63	67	92	105	71	95	93	100	90	94	79	114
2022	79	71	118	102	109	108	81	122	114	92	99	94
2023	105	90	146	107	94	100	70	115				

US Volumes

	January	February	March	April	May	June	July	August	September	October	November	December
2021	495	524	713	662	665	711	738	729	702	659	639	714
2022	616	617	781	756	736	767	728	809	650	617	646	607
2023	722	638	860	727	785	735	801	782				

LABORATORY STATISTICS

MAIN LABORATORY													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	891	739	1020	939	955	1058	1080	1272	1563	1504	1491	1584	14096
2022	2035	1336	1506	1323	1277	1165	1112	1252	1092	1257	1186	1209	15750
2023	1187	1236	1394	1125	1173	1112	1092	1197					9516

HHH EMPLOYEE HEALTH WEEKLY COVID TEST (INCLUDING SNF_NEW SNF LOCATION ONLY)													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	1888	1566	1443	1110	1031	1122	1045	1656	2143	1695	1842	2458	18999
2022	2987	2136	1915	1767	2219	2546	2244	2355	2066	1046	1144	1596	24021
2023	595	114	609	880	28	15	24	48					2313

MC CRAY LAB													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	1263	1274	1394	1125	1119	1193	1165	1248	1192	1187	1100	1099	14359
2022	1230	1044	1206	1069	1033	1025	1061	1130	866	975	810	752	12201
2023	1038	931	1167	975	1054	930	1009	1039					8143

SUNNYSLOPE LAB													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	699	601	624	590	479	636	553	613	580	574	462	487	6898
2022	536	511	632	521	467	488	495	558	423	402	368	186	5587
2023	511	486	551	418	516	458	427	490					3857

SJB AND 4TH STREET													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021					41	64	55	29	45	27	37	55	353
2022	63	54	82	72	63	58	23	61	82	82	63	53	756
2023	74	44	83	67	63	81	77	75					564

ER AND ASC													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	1628	1162	1126	1077	1083	1089	1174	1415	1272	1139	1059	1279	14503
2022	1434	839	1040	993	1328	1335	1111	1198	1231	1237	1614	1604	14964
2023	1268	1298	1453	1448	1482	1234	1256	1156					10595

TOTAL OUTPATIENT													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	6369	5342	5607	4841	4708	5162	5072	6233	6795	6126	5991	6962	69208
2022	8285	5920	6381	5745	6387	6617	6046	6554	5760	4999	5185	5400	73279
2023	4673	4109	5257	4913	4316	3830	3885	4005					34988

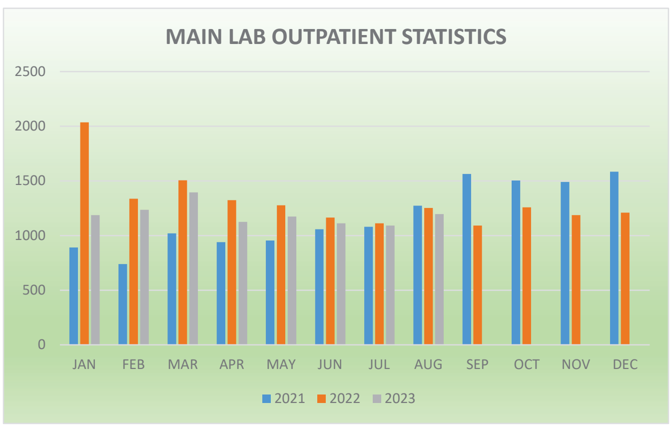
TOTAL INPATIENT (ICU,MEDSURG,OB,SNF)													
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2021	1116	1053	603	654	705	751	761	803	791	986	874	1301	10398
2022	1311	1102	945	678	963	1258	1321	1421	1145	973	1066	1205	13388
2023	816	603	950	710	591	347	214	353					4584

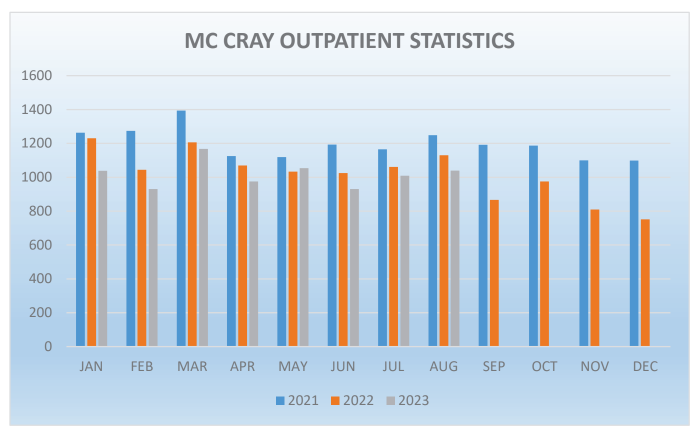
LABORATORY DEPARTMENT

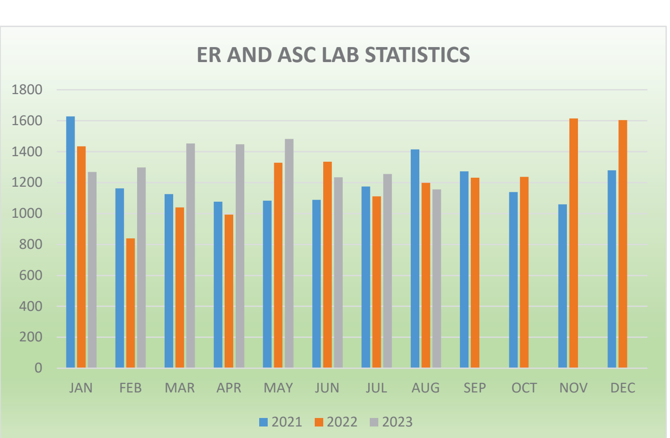
REQUISITION STATISTICS

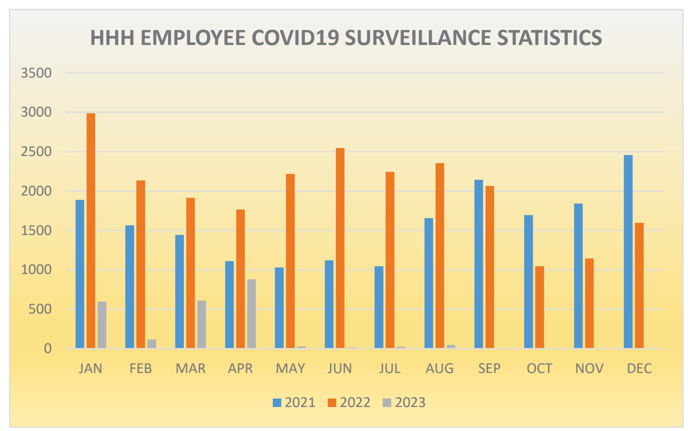
Bernadette Enderez
Director of Laboratory Services

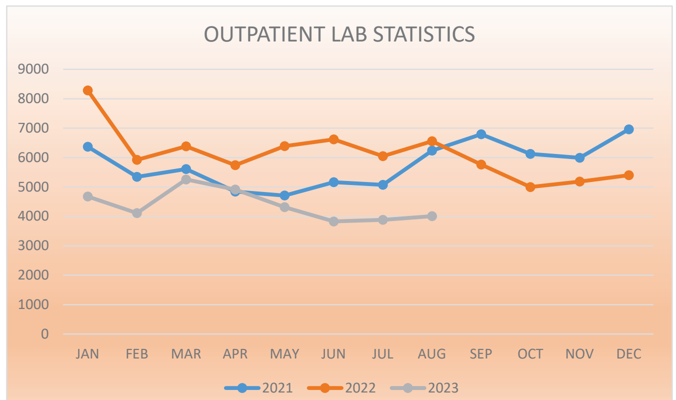
Michael McGinnis, M.D.
Medical Director

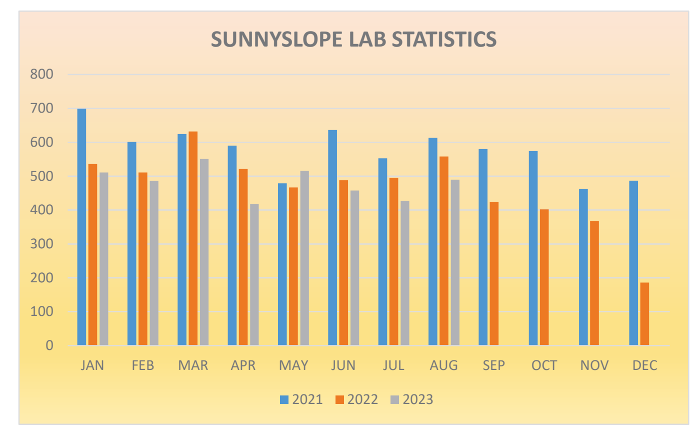


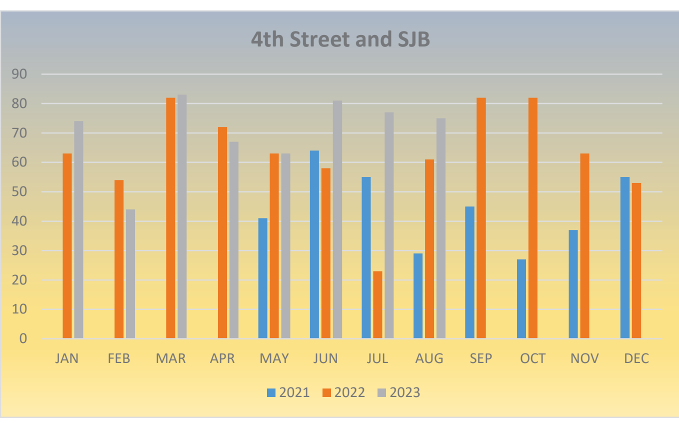












LABORATORY DEPARTMENT

OUTPATIENT STATISTICS

Bernadette Enderez
Director of Laboratory Services

Michael McGinnis, M.D.
Medical Director

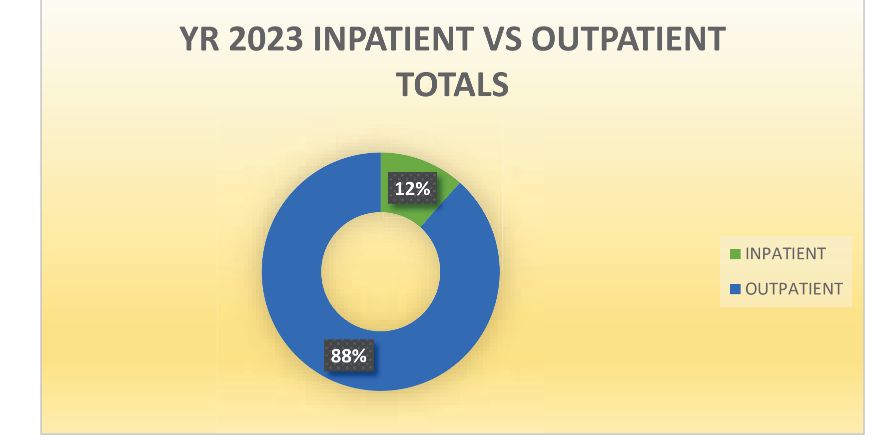
INPATIENT VS OUTPATIENT LABORATORY STATISTICS

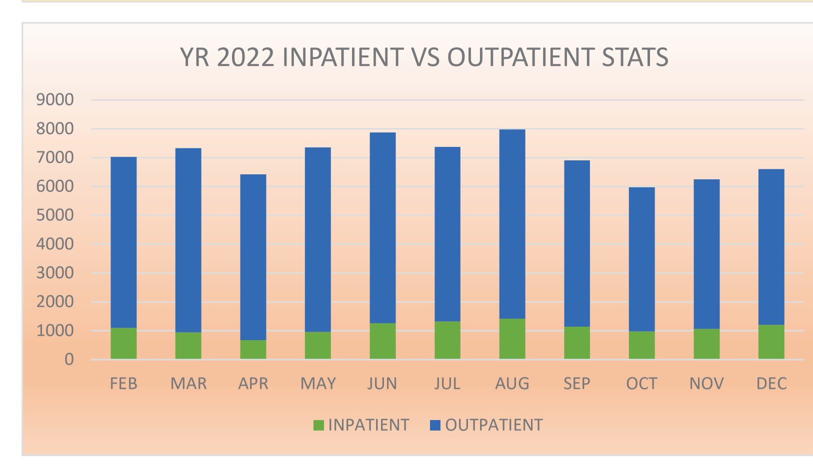
YR 2023														
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL	
INPATIENT	816	603	950	710	591	347	214	353					4584	INPATIENT
OUTPATIENT	4673	4109	5257	4913	4316	3830	3885	4005					34988	OUTPATIENT

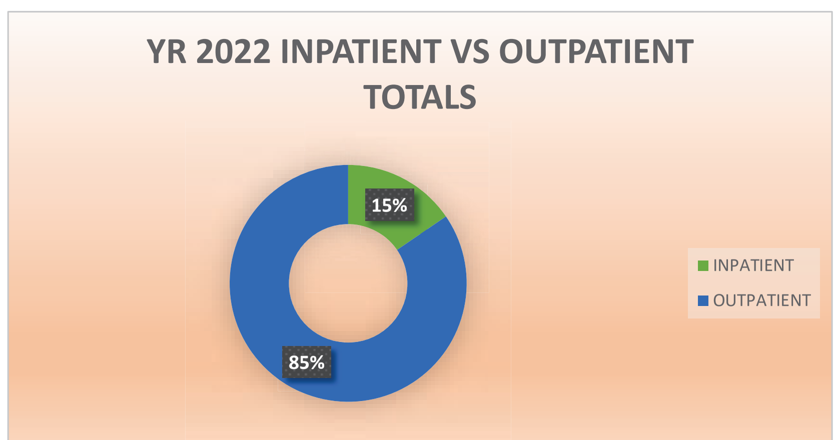
YR 2022														
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL	
INPATIENT	1311	1102	945	678	963	1258	1321	1421	1145	973	1066	1205	13388	INPATIENT
OUTPATIENT	8285	5920	6381	5745	6387	6617	6046	6554	5760	4999	5185	5400	73279	OUTPATIENT

YR 2023 INPATIENT VS OUTPATIENT STATS

INPATIENT OUTPATIENT







TO: San Benito Health Care District Board of Directors
FROM: Liz Sparling, Foundation Director
DATE: September 2023
RE: Foundation Report

The Hazel Hawkins Hospital Foundation Board of Trustees met on September 14. Bernadette V. Enderez, M.S., SBB(ASCP)CM, MT(ASCPi), HHMH Director of Diagnostic Services, Clinical Laboratory | Diagnostic Imaging presented the need for a new microscope in the Lab. She also gave an update on the status of the analyzer the Foundation purchased. The analyzer should be arriving in November.

Financial Report for August

1. Income $ 7,024.96
2. Expenses $ 650.00
3. New Donors 1
4. Total Donations 68

Allocations

1. $15,800 for a Microscope for the Lab Department

Directors Report

- We had a great effort and turn out for the Development Committee's Informational night at Ted and Irene Davis' house on Sept. 13. There were great questions by the attendees that cleared up some misconceptions about the Hospital at this time.
- The Dinner Dance date for this year's fundraiser is November 4th. The Committee met and selected **Bonnie & Alan Clark** for our donors of the year, the **Community Foundation** for the business donor of the year and **Dr. Barra** as our heart for hazel recipient. Sponsor letters went out last week and we already have $7,250 in sponsorships and with the letters going out I have had a couple donors thank me for keeping our format the same as last year.
- We have Board Members terming out at the end of the year and we need to start thinking of potential Board Members. Seth, Jill and Tisi are terming out and Nan will finish her first term. The nominating committee should meet before the next Foundation Board Meeting.
- Working on gathering all the information for our audit.
- We will be at the San Benito County Fair and have a portion of the Hospital Booth. The fair dates are September 29, 30 & Oct. 1.

Marketing

- **Social Media Posts**

Post	Post reach	Engagement
October is Breast Cancer Awareness Month HHH is offering reduced cost mammograms for uninsured or underinsured patients during the month of October. EARLY DETECTION SAVES LIVES! Mon, Sep 18	838	46
Join our community partners, San Benito County Office of Emergency Services on Saturday, September 16 from 10 - 2 at the old Kmart parking lot for an EMERGENCY PREPAREDNESS FAIR. Fri, Sep 15	221	8
On this day September 11, we honor and remember the lives that were lost and share our gratitude for all of the first responders. Thank you to our local first responders and veterans for this tribute today. Mon, Sep 11	577	92
Emergency Loan Explained Thu, Sep 7	921	117
HHMH Welcomes Brittney Slibsager to Medical Staff Services Brittney joins the HHMH team as the new Manager of Medical Staff Services in preparation for the retirement of Joan Rogers, our current Medical Staff Director. Brittney, a lifelong resident of Hollister, graduated with a Bachelor of Science degree in Health Service Administration. She... Thu, Sep 7	2,450	1,340
Yoga is back! Join us today at 4:30 pm in the Support Services building 2nd Floor Great Room Tue, Sep 5	1,200	25
Labor Day Holiday Hours for HHH Clinics and Outpatient Services Mon, Sep 4	321	4
Labor Day Holiday Hours for HHH Clinics and Outpatient Services Fri, Sep 1	533	39
We're hiring! Join our team of nursing professionals at our Mabie Skilled Nursing Facilities. Thu, Aug 31	640	47
Hazel Hawkins Memorial Hospital Receives $10M Loan through State of California Distressed Hospital Loan Program https://www.hazelhawkins.com/--/ https://hcai.ca.gov/california-announces-300-million-in-financial-support-for-community-hospitals-across-the-state/ The State Department of Health Care Access and Information announced... Fri, Aug 25	252	12
Celebrating World Breastfeeding Day at HHH. Fri, Aug 25	360	25
Many thanks to Jana Tomasini, our OB staff and physicians, our community partners, and the wonderful Mom's and families who came out to celebrate at our World Breastfeeding Celebration. Fri, Aug 25	966	458
Join us and our community partners tomorrow for our World Breastfeeding Celebration. Activities include: * Family/Newborn Wellness * Car Seat Safety * Drawings for Car Seats and Breast Pumps * Reading Developmental Milestones * Breastfeeding Information * World Breastfeeding Week Give-Aways * Dr. Armstrong's Famous... Wed, Aug 23	876	35
QiGong/Yoga is currently on a summer break. Sessions will resume on Tuesday, September 5. Tue, Aug 22	747	29
Thank you to our employees and community members that participated in our Blood Drive today and gave the gift of life. Many thanks to Diane Beck and CNA for coordinating our blood drives with Stanford Blood Center. Tue, Aug 22	844	424
The Leadership Team from American Advanced Management, Inc. (the group that presented our Board with a Letter of Intent) has been visiting HHH for the past two days touring our facilities and meeting our physicians and staff. They made presentations to our employees yesterday and at our Board meeting last night and today they met wit... Thu, Aug 17	809	482
Our special Board Meeting this evening will be live-streamed on YouTube beginning at 5:00 p.m. The SBHCD board will be introducing American Advanced Management, Inc., the company that presented a Letter of Intent at the beginning of the month. Wed, Aug 16	259	14

EMPLOYEE ENGAGEMENT

Employees:

- Hazel's Headlines
- Food Truck Friday

MEDIA

Public:
Working with Marcus Young from townKRYER PR agency on proactive PR:

- Answered media requests from Free Lance & BenitoLink
- Press Releases
  - HHMH Receives $10M Loan from State of California

COST SAVING MEASURES

- Working with departments to produce & print forms in-house

MEDICAL EXECUTIVE COMMITTEE
CREDENTIALS REPORT
SEPTEMBER 19, 2023

NEW APPOINTMENTS

PRACTITIONER	DEPT/SERVICE	STATUS REQUEST	PROCTOR ASSIGNED
Collins, Chris. MD	Medicine/Teleneurology	Telemedicine privileges	
Zamani, Parham, MD	Medicine/Teleneurology	Telemedicine privileges	
De'Prey, Justin, MD	Medicine/Teleneurology	Telemedicine privileges	

REAPPOINTMENTS

PRACTITIONER	DEPT/SERVICE	STATUS	TERM
Venigalla, Sridevi, MD	Perinatal/Teleneonatology	Affiliate	2 yrs
Malik, Zainab, MD	Medicine/Clinic Psychiatry	Active	2 yrs
Mitchell, S. Todd, MD	Medicine/Family Medicine	Active	2 yrs
Aharonian, Artin, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Amundson, Janet, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Anand, Neil, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Burns, Jason, DO	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Coll, Jonathan, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Frencher, James, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Furubayashi, Jill, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Heller, Howard, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Hermann, Matthew, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Hobart, Edward, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Hotchkiss, John, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Hwang, Janice, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Karachalos, Michael, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Kato, Kambre, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Klein, Michael, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Lotan, Roi, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Lucchesi, Archana, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Mischiu, Oana, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Morneau, Leonard, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Obembe, Olufolajimi, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Reuss, Peter, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Riad, Shareef, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Roeder, Zachary, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Schoellerman, Manal, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Shou, Jason, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Strauchler, Daniel, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Thomson, Matthew, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs
Yuh, Theresa, MD	Radiology/Teleradiology	Telemedicine privileges	2 yrs

CHANGE OF STATUS

PRACTITIONER	DEPT/SERVICE	CHANGE

ADDITIONAL PRIVILEGES - none

ALLIED HEALTH – NEW APPOINTMENT - none

ALLIED HEALTH – REAPPOINTMENTS - none

RESIGNATIONS/RETIREMENTS

PRACTITIONER	DEPT/SERVICE	CURRENT STATUS	COMMENT
Bi, Luke MD	Medicine/Gastroenterology	Courtesy	Voluntary resignation eff 8/31/23
Gustafson, G. Allen MD	Surgery/Orthopedic Srg	Active	Voluntary resignation eff 9/11/23
MacArthur, Robert MD	Surgery/Orthopedic Srg	Provisional	Voluntary resignation eff 8/31/23
Black, Evan, MD	Medicine/Teleneurology	Telemedicine privileges	Voluntary resignation eff 8/31/23
Borte, Bernadette, MD	Medicine/Teleneurology	Telemedicine privileges	Voluntary resignation eff 8/31/23
Nguyen, Hoang, DO	Medicine/Cardiology	Provisional	Voluntary resignation eff 9/1/23

RULES AND REGULATIONS OF THE DEPARTMENT OF RADIOLOGY

ARTICLE I - PREAMBLE

1.1 These rules & regulations shall conform to the Bylaws of the Medical Staff of San Benito Health Care District and shall be subordinate to those bylaws should conflict arise.

ARTICLE II – MEMBERSHIP/QUALIFICATIONS

The members of the Department of Radiology shall be those members of the Medical Staff who are engaged in the practice of Radiology, or as otherwise defined and assigned by the ***Medical*** Executive Committee. Members assigned to this department shall:

2.1 Meet the general and particular qualifications for Medical Staff membership as delineated in Article 3.2 of the Medical Staff Bylaws, and

2.2 Have completed a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association in Radiology.

2.3 Possess a current California Radiology Supervisor & Operator Certificate ***(not required for tele-radiology providers)***.

2.4 Current certification or active participation in the examination process leading to certification in Radiology by the American Board of Radiology or the American Osteopathic Board of Radiology.

ARTICLE III - OFFICERS

3.1 Officers of the Department shall include the Chairperson and Vice-Chairperson who shall be members of the Active staff and elected by voting members of the Department of Radiology. Each Chairperson shall be elected for a two-year term, and shall be eligible to succeed themselves.

3.2 Removal of a Chairperson shall be in accordance with the Medical Staff Bylaws Article 11.6.4.

3.3 The duties and responsibilities of the officers shall be those defined by the Medical Staff Bylaws Article 11.6.5.

ARTICLE IV - MEETINGS

4.1 The Department of Radiology shall meet at least three (3) times per year. Written minutes shall be kept at all meetings.

4.2 A quorum is in accordance with the Medical Staff Bylaws Article 13.3.2.2.

ARTICLE V - RESPONSIBILITIES/FUNCTIONS

In addition to the general functions outlined in the Medical Staff Bylaws Article 11.4, the functions of the Department of Radiology shall include, but not be limited to:

5.1 Providing recommendations regarding policies and procedures to other practitioner departments and services relevant to patient care and management as they relate to the practice of Radiology.

5.2 Assuring that the rules and regulations of this Department reflect current practices with respect to the hospital, and the medical staff organization, bylaws, and policies and the standard of medical care in the community.

5.3 Developing and implementing a planned, systematic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by this department which includes provisions for monitoring and evaluation of all individuals with clinical privileges in this department.

ARTICLE VI - PROCTORING

6.1 Proctoring shall be in accordance with Medical Staff Bylaws, Article 7.3.

6.2 The Department Chair will assign active staff member(s) in the Department of Radiology to serve as proctors for new staff members. Proctors should be qualified and credentialed to perform the procedures for which he/she is reviewing.

6.3 Physicians appointed to the Provisional Staff shall be proctored in the following manner:

6.3.1 Twenty - five (25) cases minimum, to be evaluated by retrospective chart review of the following types of cases:

5 – General Radiology
5 – Ultrasound
5 – MRI
5 – CT
5 - Mammography

6.4 Initial appointment to Provisional Staff is for one year, and may be continued for an additional year. At the conclusion of the observation/review period, the proctor will prepare a report indicating the number of cases reviewed, general quality of performance, specific cases in which care was questionable, and an overall recommendation to the department regarding staff status and whether proctoring should be continued or discontinued.

Proctoring may conclude prior to one year, however the new member will remain on Provisional Staff until the first year of membership has been completed and clinical and medical staff activity have been reviewed by the department, the Medical Executive Committee and approved by the Board of Directors.

ARTICLE VII - PATIENT CARE

7.1 Criteria for patient care are addressed in the Medical Staff Rules and Regulations.

Approvals:
Department of Radiology – February 25, 2008, revised 8/25/2023
Medical Executive Committee – March 18, 2008, revised 9/19, 2023

HAZEL HAWKINS MEMORIAL HOSPITAL
APPLICATION FOR CLINICAL PRIVILEGES

RADIOLOGY

Name of Applicant:____

In order to be eligible to request clinical privileges for both initial appointment and reappointment, a practitioner must meet the following minimum threshold criteria:

- Education: M.D. or D.O.
- Formal Training: The applicant must demonstrate successful completion of an ACGME or AOA approved post-graduate residency program in Radiology.
- Certification: Current certification or active participation in the examination process leading to certification in Radiology by the American Board of Radiology or the American Osteopathic Board of Radiology.
- Current valid California Radiology Supervisor & Operator Certificate.
- Required Clinical Experience: The applicant for **initial appointment or reappointment** must be able to demonstrate that he/she has satisfactorily performed and interpreted at least ***7,500*** ~~10,000~~ radiological tests or procedures during the past 24 months.

If the applicant meets the above criteria, he/she may request privileges as specified below.

I hereby request privileges as follows:

Radiology Core Privileges
Privileges include interpretation of plain x-rays (e.g. chest x-rays, abdominal series, extremities), ultrasound, IVP, CT, MRI, and fluoroscopic procedures. **NOTE**: If last 24-months experience does not meet requirements for core privileges listed above and still request privileges, please clarify below. ______________________________ ______________________________ ______________________________ **____Requested ____Approved**

Core privileges do not include any of the following **specific** privileges. For each, the applicant must demonstrate the minimum training and experience as defined below.

Radiology Specific Privileges				
PROCEDURE	TRAINING	EXPERIENCE INITIAL ` Approx. Number Performed in Last 24 Months	REQUESTED	APPROVED
Moderate sedation	Passing score on hospital exam			
Imaging ~~CT~~ guided biopsy	Completion of an approved residency with training in *imaging* ~~CT 10~~ guided biopsies or Other postgraduate training in a JCAHO accredited hospital with a minimum of 10 biopsies performed under the supervision of a credentialed physician.	For continuing privileges, 6 biopsies in the last 2 years.		
~~Ultrasound guided biopsy~~	~~Completion of an approved residency with training in ultrasound 10 guided biopsies or other postgraduate training in a JCAHO accredited hospital with a minimum of 10 biopsies performed under the supervision of a credentialed physician.~~	~~For continuing privileges, 10 biopsies in the last 2 years.~~		
Stereotactic breast biopsy	Successful completion of an approved residency with training in the stereotactic and ultrasound guided technique of breast biopsy, or successful completion of qualifications under the Mammography Quality Standards Act (MQSA) to be an interpreting physician **AND** Current Board Certification **AND** Successful completion of at least three hours of Category 1 continuing medical education in interventional mammography; and successful completion of at least 15 hours of continuing medical education in breast imaging, including benign and malignant breast disease; and Performance of either of the following: at least 12 stereotactic breast biopsies; or at least three hands-on procedures with a physician who is qualified to interpret mammography under the Mammography Quality Standards Act (MQSA) and has performed at least 24 procedures.	Performance of at least 6 stereotactic breast biopsies in the past 12 months; or requalification of those requirements specified under initial appointment and required previous experience.		
Mammography	Physician must meet or exceed the practitioner requirements defined by the American College of Radiology, *and provide the following documentation:* *Copy of Board Certification certificate from ABR, AOBR, or*	Physician must meet or exceed the practitioner requirements defined by the American College of Radiology		

	RCPSC *Letter from Mammo residency program confirming at least 3 months of mammography training, 60 Cat I CME hours in mammography (with 15 hrs in the past 3 years), and at least 240 mammo interpretations in any 6 months within the last 2 years of residency* *Documentation of at least 960 mammo interpretations within the preceding 24 months.*			

NOTE: If last 24-months experience does not meet requirements for privileges listed above and still request privileges, please clarify below.

____

____

____

ADDITIONAL AND SPECIFIC PRIVILEGES REQUESTED

PROCEDURE	REQUESTED	APPROVED
____________________	______	______
____________________	______	______
____________________	______	______
____________________	______	______

I certify that I have had the necessary training and experience to perform the procedures I have requested.

Name of Applicant:____________________ Date:____________________

Signature of Applicant:____________________

APPROVALS:
All privileges delineated have been individually considered and have been recommended based upon the physician's specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

Applicant may perform privileges as indicated.

Exceptions/Limitations: ❒ None ❒ Specify below

____

____

____ __________________
Radiology Department Chair Date

Approved Radiology Department:	*02/25/08, revised 10/25/12, revised 8/25/23*
Approved Medical Executive Committee:	*03/18/08, revised 05/15/13, revised 9/19/23*
Approved Board of Directors:	*03/27/08, revised 05/30/13*

Interim CEO Report
September 2023

Financial Emergency Update

- Site visits to AAM sites August 31, 2023.
- Hosted site visit for The County and SVMH September 13, 2023.
- Continue work with Ombudsman as they prepare to submit their report to the bankruptcy judge in September.

CEO Activities

- Attended HealthCare Ad Hoc Committee meeting August 28, 2023.
- Attended Foundation information night September 13, 2023.
- Continued weekly meetings with physicians to keep them up to date on the status of the hospital. Hosted AAM with the physician meetings.
- Work with Board Ad Hoc committee July 31. More meetings will be set with the new scope.
- Met with CHA to discuss issues with Rural Hospitals to join to advocate for improved pay.
- Met with Michael Schrader, CEO of Central California Alliance on Health, to discuss our transition to their program January 1, 2024. This was to discuss some logistics with the transition.
- Working with Hollister High School as they develop a Health Care work program for their students. Asked to be on the advisory board and will be kicking off this work soon.
- Participated on the Civic and Community Leaders listening session hosted by BenitoLink. This was an opportunity to voice our concerns and issues that we see in our community. A listening session specifically for healthcare workers will be taking place later in September. BenitoLink will be putting out a piece once they have finished all sessions.
- Conducted interviews for the CNO position, which we hope to fill in the next few weeks.
- Met with the County Behavioral Health team to discuss new programs that they have coming in January, as well as some of our barriers that we experience in getting patients to IP programs. Dr. Bogey and Shanell Kerkes also attended.
- Held a quarterly business review with USACS to go over Hospitalists and ER Physician quality and performance scores. Requested a plan to staff down or flex when we have lower volumes on Med Surg.

San Benito Health Care District
Finance Committee Minutes
September 21, 2023 - 4:30pm

Present: Rick Shelton, Board Treasurer
Mark Robinson, Chief Financial Officer
Amy Breen-Lema, Vice President, Clinic, Ambulatory & Physician Services
Lindsey Parnell, Controller

1. **CALL TO ORDER**

The meeting of the Finance Committee was called to order at 4:30pm.

2. **REVIEW FINANCIAL UPDATES**

A. August 2023 Financial Statements

The Financial Statements for August 2023 were presented for review. For the month ending August 31, 2023, the District's Net Surplus (Loss) is $299,998 compared to a budgeted Surplus (Loss) of $569,529. The District is under budget for the month by $269,531.

YTD as of August 31, 2023, the District's Net Surplus (Loss) is $634,714 compared to a budgeted Surplus (Loss) of $1,054,867. The District is under budget YTD by $420,153.

Acute discharges were 128 for the month, under budget by 93 discharges or 42%. The ADC was 11.45 compared to a budget of 19.95. The ALOS was 2.77. The acute I/P gross revenue was under budget by $4.9 million while O/P services gross revenue was $2.6 million or 11% over budget. ER I/P visits were 97 and ER O/P visits were under budget by 23 visits or 1%. The Rural Health Clinics treated 4,217 patients (includes 684 visits at the Diabetes Clinic) while other clinics treated 1,084 outpatients.

Other Operating revenue exceeded budget by $4,210. Other operating revenue includes a monthly $250,000 accrual for the PY6 QIP.

Operating Expenses were under budget by $454,862 due mainly to variances in: Salary and Wages being over budget by $53,217, Registry over budget by $83,451. However, these overages were offset by Employee Benefits being under budget by $352,139 to the increase in employee healthcare premiums and the new PTO accrual plan. In addition, Supplies expense was under by $244,951 due to the lower patient volume.

Non-operating Revenue was over budget by $30,857 due to the timing of the property tax accrual.

The SNFs ADC was 96.35 for the month. The Net Surplus (Loss) is $424,781 compared to a budget of $227,602. Effective May 10, 2023, the SNF Medi-Cal rate is $704.86 per day.

B. August 2023 Finance Dashboard

The Finance Dashboard was reviewed by the Committee in detail.

3. **CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF COUNTY ELIGIBILITY SPECIALIST WORKER MOU**
   The Professional Services Agreement between County of San Benito and Hazel Hawkins Memorial Hospital for the provision of eligibility services for Medi-Cal is effective from July 1, 2023 through June 26, 2026 with a 90-day termination clause. The Eligibility Staff maximum annual salary and benefits is not to exceed $92,000.

4. **CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF PENSION ACTUARIAL FUNDING VALUATION REPORT**
   Mark Robinson presented the January 1, 2023 Actuarial Funding Valuation Report prepared by Nicolay Consulting Group. The net pension liability for the measurement date of December 31, 2022 was $16,546,258 compared to $10,779,539 for the previous year. The majority of the increase can be attributed to asset returns below expectations. The plan was recently amended to freeze the accrual of any additional benefits effective July 3, 2023. PEPRA employee contributions also ceased on the same date. At January 1, 2023, there were a total of 576 participants and the plan was 68% funded.

5. **PUBLIC COMMENT**
   An opportunity was provided for public comment and no public comment was received.

6. **ADJOURNMENT**
   There being no further business, the Committee was adjourned at 4:43 pm.

Respectfully submitted,

Lindsey Parnell
Controller

MEMORIAL HOSPITAL
SKILLED NURSING FACILITIES
HOME HEALTH AGENCY

San Benito Health Care District
A Public Agency
911 Sunset Drive
Hollister, CA 95023-5695
(831) 637-5711

September 21, 2023

CFO Financial Summary for the District Board:

For the month ending August 31, 2023, the District's Net Surplus (Loss) is $299,998 compared to a budgeted Surplus (Loss) of $569,529. The District is under budget for the month by $269,531.

YTD as of August 31, 2023, the District's Net Surplus (Loss) is $634,714 compared to a budgeted Surplus (Loss) of $1,054,867. The District is under budget YTD by $420,153.

Acute discharges were 128 for the month, under budget by 93 discharges or 42%. The ADC was 11.45 compared to a budget of 19.95. The ALOS was 2.77. The acute I/P gross revenue was under budget by **$4.9 million** while O/P services gross revenue was **$2.6 million** or 11% over budget. ER I/P visits were 97 and ER O/P visits were under budget by 23 visits or 1%. The RHCs & Specialty Clinics treated 4,217 (includes 684 visits at the Diabetes Clinic) and 1,084 visits respectively.

Other Operating revenue exceeded budget by **$4,210.** Other operating revenue includes a monthly $250,000 accrual for the PY6 QIP.

Operating Expenses were under budget by **$454,862** due mainly to variances in: Salary and Wages being over budget by $53,217, Registry over budget by $83,451. However, these overages were offset by Employee Benefits being under budget by $352,139 to the increase in employee healthcare premiums and the new PTO accrual plan. In addition, Supplies expense was under by $244,951 due to the lower patient volume.

Non-operating Revenue was over budget by **$30,857** due to the timing of the property tax accrual.

The SNFs ADC was **96.35** for the month. The Net Surplus (Loss) is **$424,781** compared to a budget of $227,602. Effective May 10, 2023, the SNF Medi-Cal rate is **$704.86** per day.

HAZEL HAWKINS MEMORIAL HOSPITAL - COMBINED
HOLLISTER, CA 95023
FOR PERIOD 08/31/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22
GROSS PATIENT REVENUE:										
ACUTE ROUTINE REVENUE	2,671,109	5,156,735	(2,485,627)	(48)	4,645,914	5,422,411	9,519,799	(4,097,388)	(43)	8,595,521
SNF ROUTINE REVENUE	2,311,705	2,092,500	219,205	11	2,088,150	4,630,678	4,185,000	445,678	11	4,070,500
ANCILLARY INPATIENT REVENUE	3,568,790	5,860,862	(2,292,072)	(39)	5,856,332	7,176,518	11,110,766	(3,934,248)	(35)	10,961,254
HOSPITALIST\PEDS I\P REVENUE	114,863	190,826	(75,964)	(40)	209,159	252,752	381,661	(128,909)	(34)	408,689
TOTAL GROSS INPATIENT REVENUE	8,666,466	13,300,923	(4,634,457)	(35)	12,799,556	17,482,358	25,197,226	(7,714,868)	(31)	24,036,364
ANCILLARY OUTPATIENT REVENUE	27,757,876	25,106,491	2,651,385	11	23,435,712	53,461,629	51,385,376	2,076,253	4	44,629,778
HOSPITALIST\PEDS O\P REVENUE	52,421	61,398	(8,977)	(15)	59,145	106,319	122,803	(16,484)	(13)	132,342
TOTAL GROSS OUTPATIENT REVENUE	27,810,297	25,167,889	2,642,408	11	23,494,856	53,567,949	51,508,179	2,059,770	4	44,762,120
TOTAL GROSS PATIENT REVENUE	36,476,763	38,468,812	(1,992,050)	(5)	36,294,412	71,050,307	76,705,405	(5,655,098)	(7)	68,798,483
DEDUCTIONS FROM REVENUE:										
MEDICARE CONTRACTUAL ALLOWANCES	8,862,833	11,132,749	(2,269,916)	(20)	10,911,465	18,678,708	22,089,265	(3,410,557)	(15)	20,126,832
MEDI-CAL CONTRACTUAL ALLOWANCES	11,084,302	10,418,348	665,954	6	9,796,634	20,810,190	20,925,073	(114,883)	(1)	17,134,346
BAD DEBT EXPENSE	663,649	432,423	231,226	54	316,245	1,376,158	862,312	513,846	60	549,775
CHARITY CARE	26,414	40,452	(14,038)	(35)	35,989	70,633	80,661	(10,028)	(12)	71,596
OTHER CONTRACTUALS AND ADJUSTMENTS	4,506,455	4,340,369	166,086	4	3,023,796	8,531,241	8,721,753	(190,512)	(2)	7,134,535
HOSPITALIST\PEDS CONTRACTUAL ALLOW	(526)	13,403	(13,929)	(104)	25,569	(4,887)	26,726	(31,613)	(118)	55,844
TOTAL DEDUCTIONS FROM REVENUE	25,143,127	26,377,744	(1,234,617)	(5)	24,109,699	49,462,043	52,705,790	(3,243,747)	(6)	45,072,928
NET PATIENT REVENUE	11,333,636	12,091,068	(757,433)	(6)	12,184,713	21,588,263	23,999,615	(2,411,352)	(10)	23,725,555
OTHER OPERATING REVENUE	586,709	582,499	4,210	1	1,418,428	1,175,951	1,164,998	10,953	1	1,953,558
NET OPERATING REVENUE	11,920,345	12,673,567	(753,222)	(6)	13,603,141	22,764,214	25,164,613	(2,400,399)	(10)	25,679,113
OPERATING EXPENSES:										
SALARIES & WAGES	4,904,069	4,754,014	150,055	3	5,457,035	9,294,179	9,481,965	(187,786)	(2)	10,119,409
REGISTRY	286,746	200,000	86,746	43	609,686	462,794	400,000	62,794	16	1,190,710
EMPLOYEE BENEFITS	2,083,670	2,514,911	(431,241)	(17)	2,767,915	3,940,859	5,036,787	(1,095,928)	(22)	5,395,853
PROFESSIONAL FEES	1,570,790	1,652,446	(81,656)	(5)	1,574,223	3,103,123	3,304,892	(201,769)	(6)	2,941,189
SUPPLIES	1,029,790	1,268,355	(238,565)	(19)	1,269,836	1,884,353	2,457,486	(573,133)	(23)	2,520,485
PURCHASED SERVICES	1,174,276	1,093,674	80,602	7	1,287,362	2,257,910	2,187,353	70,557	3	2,499,557
RENTAL	128,801	131,560	(2,759)	(2)	165,255	243,190	263,111	(19,922)	(8)	328,066
DEPRECIATION & AMORT	326,161	320,777	5,384	2	320,867	651,817	641,554	10,263	2	634,714
INTEREST	24,073	25,417	(1,344)	(5)	2,780	51,070	50,834	236	1	12,656
OTHER	414,079	436,405	(22,326)	(5)	432,437	835,211	872,806	(37,595)	(4)	890,251
TOTAL EXPENSES	11,942,454	12,397,559	(455,105)	(4)	13,887,415	22,724,506	24,696,788	(1,972,282)	(8)	26,532,889
NET OPERATING INCOME (LOSS)	(22,110)	276,008	(298,118)	(108)	(284,274)	39,708	467,825	(428,117)	(92)	(653,776)

HAZEL HAWKINS MEMORIAL HOSPITAL - COMBINED
HOLLISTER, CA 95023
FOR PERIOD 08/31/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	1,691	5,000	(3,309)	(66)	89,759	1,133	10,000	(8,867)	(89)	129,342
PROPERTY TAX REVENUE	236,568	205,711	30,857	15	195,915	411,422	411,422	0	0	391,830
GO BOND PROP TAXES	170,388	170,388	0	0	164,964	340,776	340,776	(1)	0	329,928
GO BOND INT REVENUE\EXPENSE	(68,721)	(68,721)	0	0	(72,048)	(137,442)	(137,442)	0	0	(144,095)
OTHER NON-OPER REVENUE	14,924	13,843	1,081	8	9,241	43,510	27,686	15,824	57	28,365
OTHER NON-OPER EXPENSE	(32,742)	(32,700)	(42)	0	(37,700)	(65,442)	(65,400)	(42)	0	(76,485)
INVESTMENT INCOME	0	0	0	0	0	1,051	0	1,051		246
COLLABORATION CONTRIBUTIONS	0	0	0	0	0	0	0	0	0	0
TOTAL NON-OPERATING REVENUE/(EXPENSE)	322,108	293,521	28,587	10	350,132	595,006	587,042	7,964	1	659,133
NET SURPLUS (LOSS)	299,998	569,529	(269,531)	(47)	65,858	634,714	1,054,867	(420,153)	(40)	(194,643)
EBIDA	$ 557,235	$ 821,339	$ (264,104)	(32.15)%	$ 331,529	$ 1,148,640	$ 1,558,487	$ (409,847)	(26.29)%	$ 330,722
EBIDA MARGIN	4.67%	6.48%	(1.81)%	(27.86)%	2.44%	5.05%	6.19%	(1.15)%	(18.52)%	1.29%
OPERATING MARGIN	(0.19)%	2.18%	(2.36)%	(108.51)%	(2.09)%	0.17%	1.86%	(1.68)%	(90.61)%	(3.32)%
NET SURPLUS (LOSS) MARGIN	2.52%	4.49%	(1.98)%	(43.99)%	0.48%	2.79%	4.19%	(1.40)%	(33.48)%	(0.76)%

HAZEL HAWKINS MEMORIAL HOSPITAL - ACUTE FACILITY
HOLLISTER, CA 95023
FOR PERIOD 08/31/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22
GROSS PATIENT REVENUE:										
ROUTINE REVENUE	2,671,109	5,156,735	(2,485,627)	(48)	4,645,914	5,422,411	9,519,799	(4,097,388)	(43)	8,595,921
ANCILLARY INPATIENT REVENUE	3,153,720	5,471,312	(2,317,592)	(42)	5,322,855	6,383,989	10,349,491	(3,965,502)	(38)	10,161,516
HOSPITALIST I\P REVENUE	114,863	190,826	(75,964)	(40)	209,159	252,752	381,661	(128,909)	(34)	408,689
TOTAL GROSS INPATIENT REVENUE	5,939,693	10,818,873	(4,879,182)	(45)	10,177,929	12,059,152	20,250,951	(8,191,799)	(41)	19,166,126
ANCILLARY OUTPATIENT REVENUE	27,757,876	25,106,491	2,651,385	11	23,435,712	53,461,629	51,385,376	2,076,253	4	44,629,778
HOSPITALIST O\P REVENUE	52,421	61,398	(8,977)	(15)	59,145	106,319	122,803	(16,484)	(13)	132,342
TOTAL GROSS OUTPATIENT REVENUE	27,810,297	25,167,889	2,642,408	11	23,494,856	53,567,949	51,508,179	2,059,770	4	44,762,120
TOTAL GROSS ACUTE PATIENT REVENUE	33,749,987	35,986,762	(2,236,775)	(6)	33,672,785	65,627,100	71,759,130	(6,132,030)	(9)	63,928,245
DEDUCTIONS FROM REVENUE ACUTE:										
MEDICARE CONTRACTUAL ALLOWANCES	8,534,458	10,840,639	(2,306,182)	(21)	10,599,388	18,044,632	21,519,305	(3,474,673)	(16)	19,687,578
MEDI-CAL CONTRACTUAL ALLOWANCES	10,845,770	10,310,040	535,730	5	9,638,423	20,426,677	20,708,457	(281,780)	(1)	16,824,440
BAD DEBT EXPENSE	684,786	422,423	262,363	62	288,223	1,332,075	842,312	489,763	58	512,815
CHARITY CARE	26,414	40,452	(14,038)	(35)	35,989	70,633	80,661	(10,028)	(12)	71,596
OTHER CONTRACTUALS AND ADJUSTMENTS	4,527,058	4,273,409	253,649	6	2,925,303	8,475,049	8,587,833	(112,784)	(1)	6,966,049
HOSPITALIST\PEDS CONTRACTUAL ALLOW	(526)	13,403	(13,929)	(104)	25,569	(4,887)	26,726	(31,613)	(118)	55,844
TOTAL ACUTE DEDUCTIONS FROM REVENUE	24,617,959	25,900,366	(1,282,407)	(5)	23,512,895	48,344,180	51,765,294	(3,421,114)	(7)	44,118,321
NET ACUTE PATIENT REVENUE	9,132,028	10,086,396	(954,368)	(10)	10,159,890	17,282,920	19,993,836	(2,710,916)	(14)	19,809,924
OTHER OPERATING REVENUE	586,709	582,499	4,210	1	1,418,428	1,175,951	1,164,998	10,953	1	1,953,558
NET ACUTE OPERATING REVENUE	9,718,738	10,668,895	(950,157)	(9)	11,578,318	18,458,871	21,158,834	(2,699,963)	(13)	21,763,482
OPERATING EXPENSES:										
SALARIES & WAGES	3,867,444	3,814,227	53,217	1	4,466,719	7,342,352	7,602,393	(260,041)	(3)	8,223,306
REGISTRY	250,451	167,000	83,451	50	562,406	392,311	334,000	58,311	18	1,115,830
EMPLOYEE BENEFITS	1,632,779	1,984,917	(352,139)	(18)	2,183,059	3,064,557	3,976,550	(911,993)	(23)	4,257,664
PROFESSIONAL FEES	1,568,580	1,650,109	(81,529)	(5)	1,572,013	3,098,703	3,300,218	(201,515)	(6)	2,936,259
SUPPLIES	934,046	1,178,997	(244,951)	(21)	1,164,499	1,692,254	2,278,770	(586,516)	(26)	2,316,675
PURCHASED SERVICES	1,087,215	986,211	101,004	10	1,181,462	2,078,003	1,972,427	105,576	5	2,286,204
RENTAL	127,788	130,516	(2,728)	(2)	164,236	241,187	261,023	(19,836)	(8)	326,051
DEPRECIATION & AMORT	286,768	281,320	5,448	2	280,333	573,032	562,640	10,392	2	554,981
INTEREST	24,073	25,417	(1,344)	(5)	2,780	51,070	50,834	236	1	12,656
OTHER	362,914	378,206	(15,292)	(4)	382,434	742,311	756,408	(14,097)	(2)	739,336
TOTAL EXPENSES	10,142,059	10,596,920	(454,862)	(4)	11,959,939	19,275,779	21,095,263	(1,819,484)	(9)	22,768,960
NET OPERATING INCOME (LOSS)	(423,321)	71,975	(495,296)	(688)	(381,622)	(816,908)	63,571	(880,479)	(1,385)	(1,005,478)

HAZEL HAWKINS MEMORIAL HOSPITAL - ACUTE FACILITY
HOLLISTER, CA 95023
FOR PERIOD 08/31/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22
NON-OPERATING REVENUE\EXPENSE:										
DONATIONS	1,691	5,000	(3,309)	(66)	89,759	1,133	10,000	(8,867)	(89)	129,342
PROPERTY TAX REVENUE	205,711	174,854	30,857	18	166,528	349,708	349,708	0	0	333,056
GO BOND PROP TAXES	170,388	170,388	0	0	164,964	340,776	340,776	(1)	0	329,928
GO BOND INT REVENUE\EXPENSE	(68,721)	(68,721)	0	0	(72,048)	(137,442)	(137,442)	0	0	(144,095)
OTHER NON-OPER REVENUE	14,924	13,843	1,081	8	9,241	43,510	27,686	15,824	57	28,365
OTHER NON-OPER EXPENSE	(25,454)	(25,412)	(42)	0	(29,357)	(50,867)	(50,824)	(43)	0	(59,799)
INVESTMENT INCOME	0	0	0	0	0	1,051	0	1,051		246
COLLABORATION CONTRIBUTIONS	0	0	0	0	0	0	0	0	0	0
TOTAL NON-OPERATING REVENUE/(EXPENSE)	298,538	269,952	28,586	11	329,088	547,868	539,904	7,964	2	617,044
NET SURPLUS (LOSS)	(124,782)	341,927	(466,709)	(137)	(52,534)	(269,040)	603,475	(872,515)	(145)	(388,434)

Date: 09/19/23 @ 1119
User: LPARNELL

HAZEL HAWKINS SKILLED NURSING FACILITIES
HOLLISTER, CA
FOR PERIOD 08/31/23

	CURRENT MONTH					YEAR-TO-DATE				
	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22	ACTUAL 08/31/23	BUDGET 08/31/23	POS/NEG VARIANCE	PERCENT VARIANCE	PRIOR YR 08/31/22
GROSS SNF PATIENT REVENUE:										
ROUTINE SNF REVENUE	2,311,705	2,092,500	219,205	11	2,088,150	4,630,678	4,185,000	445,678	11	4,070,500
ANCILLARY SNF REVENUE	415,070	389,550	25,520	7	533,477	792,529	761,275	31,254	4	799,738
TOTAL GROSS SNF PATIENT REVENUE	2,726,775	2,482,050	244,725	10	2,621,627	5,423,206	4,946,275	476,931	10	4,870,238
DEDUCTIONS FROM REVENUE SNF:										
MEDICARE CONTRACTUAL ALLOWANCES	328,375	292,110	36,265	12	312,077	634,076	569,960	64,116	11	439,254
MEDI-CAL CONTRACTUAL ALLOWANCES	238,532	108,308	130,224	120	158,211	383,513	216,616	166,897	77	309,907
BAD DEBT EXPENSE	(21,137)	10,000	(31,137)	(311)	28,023	44,083	20,000	24,083	120	36,960
CHARITY CARE	0	0	0	0	0	0	0	0	0	0
OTHER CONTRACTUALS AND ADJUSTMENTS	(20,603)	66,960	(87,563)	(131)	98,493	56,192	133,920	(77,728)	(58)	168,486
TOTAL SNF DEDUCTIONS FROM REVENUE	525,168	477,378	47,790	10	596,803	1,117,863	940,496	177,367	19	954,607
NET SNF PATIENT REVENUE	2,201,607	2,004,672	196,935	10	2,024,823	4,305,343	4,005,779	299,564	8	3,915,631
OTHER OPERATING REVENUE	0	0	0	0	0	0	0	0	0	0
NET SNF OPERATING REVENUE	2,201,607	2,004,672	196,935	10	2,024,823	4,305,343	4,005,779	299,564	8	3,915,631
OPERATING EXPENSES:										
SALARIES & WAGES	1,036,624	939,787	96,837	10	990,316	1,951,827	1,879,572	72,255	4	1,896,104
REGISTRY	36,295	33,000	3,295	10	47,280	70,484	66,000	4,484	7	74,880
EMPLOYEE BENEFITS	450,892	529,994	(79,102)	(15)	584,857	876,302	1,060,237	(183,935)	(17)	1,138,189
PROFESSIONAL FEES	2,210	2,337	(127)	(5)	2,210	4,420	4,674	(254)	(5)	4,930
SUPPLIES	95,744	89,358	6,386	7	105,337	192,099	178,716	13,383	8	203,810
PURCHASED SERVICES	87,061	107,463	(20,402)	(19)	105,900	171,304	214,926	(43,622)	(20)	213,353
RENTAL	1,012	1,044	(32)	(3)	1,018	2,003	2,088	(85)	(4)	2,015
DEPRECIATION	39,393	39,457	(64)	0	40,555	78,785	78,914	(129)	0	79,733
INTEREST	0	0	0	0	0	0	0	0	0	0
OTHER	51,165	58,199	(7,034)	(12)	50,003	92,900	116,398	(23,498)	(20)	150,915
TOTAL EXPENSES	1,800,396	1,800,639	(243)	0	1,927,476	3,440,124	3,601,525	(161,401)	(5)	3,763,929
NET OPERATING INCOME (LOSS)	401,211	204,033	197,178	97	97,347	865,219	404,254	460,965	114	151,703
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	61,714	61,714	0	0	58,774
OTHER NON-OPER EXPENSE	(7,288)	(7,288)	0	0	(8,343)	(14,576)	(14,576)	1	0	(16,685)
TOTAL NON-OPERATING REVENUE/(EXPENSE)	23,569	23,569	0	0	21,044	47,139	47,138	1	0	42,089
NET SURPLUS (LOSS)	424,781	227,602	197,179	87	118,392	912,358	451,392	460,966	102	153,791

Date: 09/19/23 @ 1119
User: LPARNELL

HAZEL HAWKINS MEMORIAL HOSPITAL
HOLLISTER, CA
For the month ended 08/31/23

	CURR MONTH 08/31/23	PRIOR MONTH 07/31/23	POS/NEG VARIANCE	PERCENTAGE VARIANCE	PRIOR YR 06/30/23
CURRENT ASSETS					
CASH & CASH EQUIVALENT	15,017,859	14,680,916	336,944	2	14,441,825
PATIENT ACCOUNTS RECEIVABLE	56,838,808	54,833,203	2,005,605	4	51,674,982
BAD DEBT ALLOWANCE	(6,143,484)	(5,738,098)	(405,386)	7	(5,227,791)
CONTRACTUAL RESERVES	(33,762,665)	(32,822,738)	(939,927)	3	(30,266,699)
OTHER RECEIVABLES	6,636,534	6,498,368	138,166	2	5,934,176
INVENTORIES	4,054,906	4,061,474	(6,568)	0	4,057,813
PREPAID EXPENSES	2,833,976	2,633,524	200,452	8	2,222,227
DUE TO\FROM THIRD PARTIES	2,037,861	2,784,747	(746,886)	(27)	2,784,747
TOTAL CURRENT ASSETS	47,513,795	46,931,395	582,400	1	45,621,279
ASSETS WHOSE USE IS LIMITED					
BOARD DESIGNATED FUNDS	5,038,289	4,773,531	264,758	6	4,509,818
TOTAL LIMITED USE ASSETS	5,038,289	4,773,531	264,758	6	4,509,818
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	43,684,281	43,484,575	199,705	1	43,302,208
CONSTRUCTION IN PROGRESS	905,142	889,255	15,887	2	880,124
CAPITALIZED INTEREST	8,869	5,924	2,945	50	0
GROSS PROPERTY,PLANT, AND EQUIPMENT	148,067,140	147,848,602	218,538	0	147,651,180
ACCUMULATED DEPRECIATION	(91,043,489)	(90,702,745)	(340,744)	0	(90,362,507)
NET PROPERTY, PLANT, AND EQUIPMENT	57,023,651	57,145,857	(122,206)	0	57,288,673
OTHER ASSETS					
UNAMORTIZED LOAN COSTS	458,857	464,928	(6,071)	(1)	470,999
PENSION DEFERRED OUTFLOWS NET	3,797,637	3,797,637	0	0	3,797,637
TOTAL OTHER ASSETS	4,256,494	4,262,565	(6,071)	0	4,268,636
TOTAL UNRESTRICTED ASSETS	113,832,228	113,113,348	718,880	1	111,688,406
RESTRICTED ASSETS	125,571	125,518	53	0	125,193
TOTAL ASSETS	113,957,799	113,238,866	718,933	1	111,813,599

HAZEL HAWKINS MEMORIAL HOSPITAL
HOLLISTER, CA
For the month ended 08/31/23

	CURR MONTH 08/31/23	PRIOR MONTH 07/31/23	POS/NEG VARIANCE	PERCENTAGE VARIANCE	PRIOR YR 06/30/23
CURRENT LIABILITIES					
ACCOUNTS PAYABLE	5,240,865	5,164,451	(76,414)	2	4,647,330
ACCRUED PAYROLL	3,368,383	2,810,873	(557,510)	20	2,324,681
ACCRUED PAYROLL TAXES	2,188,750	2,167,396	(21,354)	1	2,123,227
ACCRUED BENEFITS	5,560,719	5,592,474	31,754	(1)	6,051,228
ACCRUED PENSION (CURRENT)	4,961,787	4,976,625	14,838	0	5,061,807
OTHER ACCRUED EXPENSES	74,985	71,127	(3,858)	5	63,664
PATIENT REFUNDS PAYABLE	1,136	961	(174)	18	961
DUE TO\FROM THIRD PARTIES	4,225,310	4,614,565	389,255	(8)	4,400,056
OTHER CURRENT LIABILITIES	3,998,326	3,767,729	(230,597)	6	3,361,223
TOTAL CURRENT LIABILITIES	29,620,260	29,166,202	(454,059)	2	28,034,176
LONG-TERM DEBT					
LEASES PAYABLE	6,017,962	6,024,619	6,656	0	6,037,899
BONDS PAYABLE	34,727,321	34,755,841	28,520	0	34,784,361
TOTAL LONG TERM DEBT	40,745,284	40,780,460	35,177	0	40,822,260
OTHER LONG-TERM LIABILITIES					
DEFERRED REVENUE	0	0	0	0	0
LONG-TERM PENSION LIABILITY	14,706,676	14,706,676	0	0	14,706,676
TOTAL OTHER LONG-TERM LIABILITIES	14,706,676	14,706,676	0	0	14,706,676
TOTAL LIABILITIES	85,072,220	84,653,338	(418,882)	1	83,563,112
NET ASSETS:					
UNRESTRICTED FUND BALANCE	28,085,294	28,085,294	0	0	28,085,294
RESTRICTED FUND BALANCE	165,571	165,518	(53)	0	165,193
NET REVENUE/(EXPENSES)	634,714	334,716	(299,998)	90	0
TOTAL NET ASSETS	28,885,579	28,585,528	(300,051)	1	28,250,487
TOTAL LIABILITIES AND NET ASSETS	113,957,799	113,238,866	(718,933)	1	111,813,599

Statement of Cash Flows

Hazel Hawkins Memorial Hospital
Hollister, CA
Two months ending August 31, 2023

	CASH FLOW		COMMENTS
	Current Month 8/31/2023	**Current Year-To-Date 8/31/2023**	
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net Income (Loss)	$299,998	$634,714	
Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities:			
Depreciation	340,746	680,986	
(Increase)/Decrease in Net Patient Accounts Receivable	(660,292)	(752,166)	
(Increase)/Decrease in Other Receivables	(138,166)	(702,358)	
(Increase)/Decrease in Inventories	6,568	2,907	
(Increase)/Decrease in Pre-Paid Expenses	(200,452)	(611,750)	
(Increase)/Decrease in Due From Third Parties	746,886	746,886	
Increase/(Decrease) in Accounts Payable	76,415	593,537	
Increase/(Decrease) in Notes and Loans Payable	0	0	
Increase/(Decrease) in Accrued Payroll and Benefits	532,267	518,692	
Increase/(Decrease) in Accrued Expenses	3,858	11,321	
Increase/(Decrease) in Patient Refunds Payable	174	174	
Increase/(Decrease) in Third Party Advances/Liabilities	(389,255)	(174,746)	
Increase/(Decrease) in Other Current Liabilities	230,597	637,103	Semi-Annual Interest - 2021 Insured Revenue Bonds
Net Cash Provided by Operating Activities:	**549,346**	**950,586**	
CASH FLOWS FROM INVESTING ACTIVITIES:			
Purchase of Property, Plant and Equipment	(218,538)	(415,961)	
(Increase)/Decrease in Limited Use Cash and Investments	0	0	
(Increase)/Decrease in Other Limited Use Assets	(264,758)	(528,471)	Bond Principal & Int Payment - 2014 & 2021 Bonds
(Increase)/Decrease in Other Assets	6,071	12,142	Amortization
Net Cash Used by Investing Activities	**(477,225)**	**(932,290)**	
CASH FLOWS FROM FINANCING ACTIVITIES:			
Increase/(Decrease) in Bond/Mortgage Debt	(6,656)	(19,936)	Refinancing of 2013 Bonds with 2021 Bonds
Increase/(Decrease) in Capital Lease Debt	(28,520)	(57,040)	
Increase/(Decrease) in Other Long Term Liabilities	0	0	
Net Cash Used for Financing Activities	**(35,176)**	**(76,976)**	
(INCREASE)/DECREASE IN RESTRICTED ASSETS	**0**	**0**	
Net Increase/(Decrease) in Cash	**336,943**	**576,034**	
Cash, Beginning of Period	14,680,916	14,441,825	
Cash, End of Period	**$15,017,859**	**$15,017,859**	$0

Cost per day to run the District	**$356,539**
Operational Days Cash on Hand	42.12

San Benito Health Care District
Hazel Hawkins Memorial Hospital
AUGUST 2023

Description	Target	MTD Actual	YTD Actual	YTD Target
Average Daily Census - Acute	19.95	11.45	12.00	19.08
Average Daily Census - SNF	90.00	96.35	95.37	90.00
Acute Length of Stay	2.80	2.77	2.85	2.66
ER Visits:				
Inpatient	196	97	200	305
Outpatient	1,958	1,935	3,868	3,821
Total	2,154	2,032	4,068	4,126
Days in Accounts Receivable	45.0	50.7	50.7	45.0
Productive Full-Time Equivalents	500.90	482.39	467.28	500.90
Net Patient Revenue	12,091,068	11,393,636	21,583,263	23,999,615
Payment-to-Charge Ratio	31.4%	31.1%	30.4%	31.3%
Medicare Traditional Payor Mix	30.48%	26.91%	26.70%	30.44%
Commercial Payor Mix	21.46%	23.69%	23.29%	21.66%
Bad Debt % of Gross Revenue	1.12%	1.83%	1.95%	1.12%
EBIDA	821,339	557,235	1,148,640	1,558,487
EBIDA %	6.48%	4.67%	5.05%	6.19%
Operating Margin	2.18%	-0.19%	0.17%	1.86%
Salaries, Wages, Registry & Benefits %:				
by Net Operating Revenue	58.93%	61.03%	60.17%	59.28%
by Total Operating Expense	60.25%	60.91%	60.28%	60.41%
Bond Covenants:				
Debt Service Ratio	1.25	3.68	3.68	1.25
Current Ratio	1.50	1.60	1.60	1.50
Days Cash on hand	30.00	42.12	42.12	30.00

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

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	-	-	-	-	-	-	-	-	-	-	70,691,236
Actual Bad Debt Expense	712,509	663,649	-	-	-	-	-	-	-	-	-	-	1,376,158
BD Exp as a percent of Gross Revenue	2.07%	1.83%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	1.95%
Budgeted YTD BD Exp	862,312	1.12%											
Actual YTD BD Exp	1,376,158	1.95%											
Amount under (over) budget	(513,846)	-0.82%											
Prior Year percent of Gross Revenue	1.15%												
Percent of Decrease (Inc) from Prior Year	-69.3%												

YTD Charity Exp Budget	80,661
YTD Charity Exp Actual	70,633
Amt under (over) budget	10,028
Charity Exp % of Gross Rev	0.10%

San Benito Healthcare District

Pension Plan

January 1, 2023 Funding Valuation Report

September 2023

www.nicolayconsulting.com

©2023 Nicolay Consulting Group

At the request of San Benito Healthcare District (the "District"), the plan sponsor, we have prepared this report to summarize the results of the January 1, 20223 actuarial funding valuation completed by Nicolay Consulting Group. The purpose of this report is to communicate:

- The current funded position of the plan,
- The actuarially determined contribution, and
- The determination of the PEPRA employee contribution rate as required by California statute

The results included in this report may not be appropriate for other purposes and should not be relied on for any other purposes without first contacting Nicolay Consulting Group. This report should not be disclosed to other parties without prior consent from Nicolay Consulting Group. When shared, this report should be shared in its entirety.

This report has been prepared in accordance with applicable Federal and State laws.

Our calculations were based on financial data furnished by Principal Bank and on the employee data furnished by the District as of December 31, 2022. We have reviewed the data provided for reasonableness compared to prior data collections, however, we have not audited the data. Where data was missing, we have made assumptions we believe to be reasonable given the purpose of the measurement. In general, we have relied on the data as provided. Any errors or omissions in the provided data will cause the results of our report to differ.

Actuarial assumptions were selected by the plan sponsor. Nicolay Consulting Group has not completed a thorough experience study to validate assumptions. Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following:

- Plan experience differing from that anticipated by the economic or demographic assumptions;

- Changes in economic or demographic assumptions;

- Increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period);

- Changes in plan provisions or applicable law.

We did not perform an analysis of the potential range of future measurements due to the limited scope of our engagement.

The valuation was based on results generated in ProVal, a third-party valuation system. Use of this software required us to code the plan provisions, assumptions, and methods outlined in this report. We reviewed the outputs for reasonableness at a high level and also reviewed sample calculations in detail. We are not aware of any material weaknesses or limitations in the software or its parameterization. We certify that the amounts presented in the accompanying report have been appropriately determined according to the actuarial assumptions stated herein.

We would be pleased to answer any questions on the material contained in this report or to provide explanation or further detail as may be appropriate.

The undersigned actuaries are members of the American Academy of Actuaries, Society of Actuaries and/or Conference of Consulting Actuaries and have met the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein. To the best of our knowledge, the information supplied in the actuarial valuation is complete and accurate. In our opinion, assumptions as approved by the plan sponsor are reasonably related to the experience of and expectations for the Plan. We do not have any relationship with the plan sponsor that could impact our objectivity in preparing this report.

Respectfully submitted,

Nicolay Consulting Group

Earlene L. Young MAAA, FCA
Consulting Actuary
Enrolled Actuary No. 23-04437

Sue Simon, ASA, MAAA, FCA
Vice President
Enrolled Actuary No. 23-06211

Table of Contents

			Page(s)
SECTION	I	- Summary	1 – 4
SECTION	II	- Funding	5 – 8
SECTION	III	- Assets	9 – 10
SECTION	IV	- PEPRA Employee Contribution Rate	11
SECTION	V	- Risk Analysis	12 – 14
SECTION	VI	- Census Data	15 – 16
SECTION	VII	- Assumptions and Methods	17 – 19
SECTION	VIII	- Plan Provisions	20 – 23

A. Highlights

	January 1, 2023	January 1, 2022
Annual Actuarially Determined Contribution (ADC [1]	$ 3,401,336	$ 3,154,060
Market Value of Assets as	$ 35,137,453	$41,223,881
Actuarial Accrued Liability	$ 51,683,711	$52,003,420
Unfunded Actuarial Accrued Liability	$ 16,546,258	$10,779,539
PEPRA Employee Contribution Rate during current year	4.00%	4.00%
PEPRA Employee Contribution Rate for following year[2]	NA	4.00%
Number of Participants:		
Retired participants	138	118
Terminated vested participants entitled to future benefits	137	132
Active participants	288	280
Active participants (frozen status)	13	22
Total participants	576	552

[1]Net of estimated employee contributions
[2] Contributions ceased 7/2/2023 due to an amendment to freeze the plan.

B. Valuation Summary

The San Benito Healthcare District Pension Plan (the "Plan") was established effective January 1, 2005. The Plan was amended effective January 1, 2016 to update the plan for legislative changes according to California Public employees' Pension Reform Act of 2013 (PEPRA). The plan was most recently amended to freeze the accrual of any additional benefits under the plan effective July 3, 2023. This valuation reflects the 2023 amendment.

This report presents the results of the January 1, 2023 actuarial valuation.

This section presents a summary of the valuation results and the funding status of the Plan at January 1, 2023:

1. Annual Contribution

The employer's Actuarially Determined Contribution (ADC) for the 2023 Plan Year is $ 3,401,336 (assuming contributions will be deposited throughout the Plan Year). In addition, PEPRA employees are expected to contribute 4.0% of their eligible pay to the plan.

2. Historical Annual Contribution

	2023	2022	2021
Actuarially Determined Contribution (ADC):	$ 3,401,336	$3,154,060	$3,438,240
Total Compensation[1]:	$ 26,658,478	$26,085,105	$28,460,305
Contribution as a Percentage of Total Compensation:	12.8%	12.1%	12.1%

[1]Includes compensation for frozen employees and employees over age 65.

3. Reconciliation of Funded Status

The funded status of the Plan decreased between January 1, 2022 and January 1, 2023. The primary reasons were asset returns below expectations (-$6.6M vs. $2.7M expected) and demographic experience losses. These losses were partially offset by liability gains from assumption and plan changes noted below.

4. Assumptions and Methods Changes from Prior Valuation

The salary increase assumption rates were updated from 5.5% for NUHW participants to 3.5%. All other participant salary increases were set to 3%.

5. Plan changes since Prior Valuation

The plan was most recently amended to freeze the accrual of any additional benefits under the plan effective July 3, 2023. PEPRA employee contributions also ceased on the same date.

6. Funded Status

A plan's "funded status" is measured by comparing the Plan's assets with the Plan's actuarial liability. A ratio in excess of 100% means that the Plan's assets exceed the actuarial liability.

The Plan's actuarial liability can be measured in a variety of ways. Some of the alternatives are described below:

- Entry Age Normal Accrued Liability:

  This actuarial liability represents the actuarial present value of the projected benefits of each individual included in the valuation. Cost of benefits accrued are spread over an individual's career such that, ignoring any experience or assumption change gains or losses, costs will be a level percent of pay each year. GASB 67/68 accounting requirements and PEPRA employee contribution rates mandate the use of Entry Age Normal liability measurements.

- Frozen/Terminated Plan Basis:

  This actuarial liability represents the actuarial present value of all benefits accrued as of the valuation date, based on service and salary at that date (traditional unit credit cost method).

- All Expected Future Plan Benefits:

  This actuarial liability represents the actuarial present value of all expected future benefits under the Plan as of the valuation date including benefits expected to be earned for future service based and future salary increases.

The Plan's funded status is described below, based on each of these measures of actuarial liability as of January 1, 2023, January 1, 2022 and January 1, 2021:

	January 1, 2023	January 1, 2022	January 1, 2021
Market Value of Assets	$ 35,137,453	$41,223,881	$35,138,016
Actuarial Liabilities:			
Entry Age Normal	$ 51,683,711	$52,003,420	$47,039,034
Frozen Plan Basis	$ 51,683,711	$46,252,348	$42,132,918
All Expected Future Plan Benefits	$ 51,683,711	$68,655,321	$65,071,337
Funded Status (Market Value of Assets):			
Entry Age Normal	67.99%	79.27%	74.70%
Frozen Plan Basis	67.99%	89.13%	83.40%
All Expected Future Plan Benefits	67.99%	60.04%	54.00%

C. Historical Summary

ANNUAL COSTS	2023	2022	2021
Actuarially Determined Contributions:	$ 3,401,336	$3,154,060	$3,438,240
Employer Contributed	N/A	$1,545,627	$2,738,385
EMPLOYEE CONTRIBUTIONS			
Dollar amount	$ 121,865 [1]	$ 310,498	$262,258
Annual Rate	4.00%	4.00%	4.00%
ACTUARIAL LIABILITIES AT BEGINNING OF PLAN YEAR			
Actuarial Accrued Liability (EAN)	$ 51,683,711	$52,003,420	$47,039,034
Entry Age Normal Cost	$ 1,759,962	$1,987,739	$2,135,348
Expected Employee Contributions	$ (121,865)	$ (219,819)	$ (140,692)
Net Employer Normal Cost	$1,638,097	$1,767,920	$ 1,994,656
ASSETS AT BEGINNING OF PLAN YEAR			
Market Value of Plan Assets	$ 35,137,453	$41,223,881	$ 35,138,016
UNFUNDED ACTUARIAL ACCRUED LIABILITY	$ 16,546,258	$ 10,779,539	$ 11,901,018
NUMBER OF PARTICIPANTS			
Retired	138	118	110
Terminated Vested	137	132	125
Active (include frozen)	301	302	315
Total	576	552	550
TOTAL COMPENSATION[2]	$ 25,765,287	$24,420,350	$ 25,294,720

[1]Estimated PEPRA employee contributions (see Section II(B) for details). Contributions ceased 7/2/2023 due to an amendment to freeze the plan.
[2] Includes salary for non-frozen, active participants who are under maximum assumed retirement age (age 65).

Section II
Funding

A. Normal Cost

The normal cost is the portion of the actuarial present value of benefits allocated to the current Plan year under the actuarial cost method.

	Classic	PEPRA	Total
Total Normal Cost	$ 1,653,300	$ 106,662	$ 1,759,962
Expected Employee Contribution	$0	$ 121,865	$ 243,729
Net Employer Normal Cost	$ 1,653,300	$ (15,203)	$ 1,516,233
Covered Payroll <age 65	$ 19,672,061	$ 6,093,226	$ 25,765,287
Total Normal Cost % of Payroll	8.40%	1.75%	6.83%

B. Development of the 2023 Estimated Employee Contribution

Under the California Public Employees' Pension Reform Act of 2013 (PEPRA), government employees participating in pension programs are required to share in the cost of funding the pension program. In general, employees hired on or after 1/1/2013 must contribute one-half of their normal cost during the year. Administratively, the employee contribution rate is typically established based on the results of the prior year's actuarial funding valuation.

(a)	Total Covered Payroll for PEPRA Participants	$ 6,093,226
(b)	Annual PEPRA contribution rate (From prior year valuation report)	4.00%
(c)	Expected contribution from PEPRA participants through 7/2/2023 = (a) × (b) *.5	$ 121,865
(d)	Expected Contribution from PEPRA Participants at Beginning of Year =(c)/(1+.065*.5)	$ 118,029

C. Development of the 2023 Employer Contribution

(a)	Normal cost at January 1, 2023	$ 1,759,962
(b)	Annual amortization of Actuarial Accrued Liability	1,652,339
(c)	Expected contribution from PEPRA participants (4.00%) [see B(d)]	118,029
(d)	Contribution for 2023 plan year, payable at the beginning of the year, not less than zero = (a) + (b) - (c)	3,294,272
(e)	Interest on (d) to mid-year at 6.50%	107,064
(f)	Contribution for 2022 plan year, payable at the mid-year	$3,401,336

D. Development of the Unfunded Actuarial Accrued Liability

The actuarial accrued liability is the actuarial present value of the accrued benefits attributable to service as of the valuation date under the actuarial cost method . The excess, if any, of the actuarial accrued liability over the actuarial value of assets is the unfunded actuarial accrued liability.

1. Entry Age Actuarial Accrued Liability at January 1, 2023 attributable to:			
	Classic	PEPRA	Total
(a) Active Participants	$ 24,346,432	$ 2,815,483	$ 27,161,915
(b) Inactive (Frozen) Participants	$ 690,022	$-	$ 690,022
(c) Terminated Vested Participants	$ 7,220,387	$ 274,016	$ 7,494,403
(d) Retirees	$ 15,770,600	$ 566,771	$ 16,337,371
(e) Total = (a) + (b) + (c) + (d) + (e)	$ 48,027,441	$ 3,656,270	$ 51,683,711
2. Actuarial value of Plan assets at January 1, 2022			$ 35,137,453
3. Unfunded Actuarial Accrued Liability at January 1, 2023 = (1)(e) - (2)			$ 16,546,258

E. Development of the Actuarial (Gain) Loss

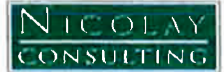
1.	Unfunded Actuarial Accrued Liability at January 1, 2022	$ 10,779,539
2.	Normal Cost due January 1, 2022	1,987,739
3.	Interest at 6.50% to the end of the Plan year on (1) + (2)	829,873
4.	Total contribution for the 2022 Plan year plus interest at 6.50%	1,916,449
5.	Expected Unfunded Actuarial Accrued Liability as of January 1, 2023 = (1) + (2) + (3) - (4), not less than zero	$ 11,680,702
6.	Actual Unfunded Actuarial Accrued Liability as of January 1, 2023 (before change in assumptions/plan)	21,934,091
7.	Actuarial (Gain) Loss at January 1, 2023= (6) - (5)	$ 10,253,389

F. Development of the (Gain) Loss for Change in Assumption

(a)	Actual Unfunded Actuarial Accrued Liability as of January 1, 2023 (before change in assumptions)	$ 21,934,091
(b)	Actual Unfunded Actuarial Accrued Liability as of January 1, 2023 (after change in assumptions)	22,568,309
(c)	Actuarial (Gain) Loss due to assumption change as of January 1, 2023 = (b) - (a)	$634,218

G. Development of the (Gain) Loss for Plan Amendment

(a)	Actual Unfunded Actuarial Accrued Liability as of January 1, 2023 (after change in assumptions)	$ 22,568,309
(b)	Actual Unfunded Actuarial Accrued Liability as of January 1, 2023 (after plan amendment)	16,546,258
(c)	Impact of Plan Amendment as of January 1, 2023 = (b) - (a)	($ 6,022,051)



H. Amortization Method Used in Development of 2023 Recommended Employer Contribution

(a)	Actual Unfunded Actuarial Accrued Liability as of January 1, 2023	$16,546,258
(b)	Amortization Factor (15-Years at 6.5%)	10.0138
(c)	Annual Amortization of Actuarial Accrued Liability as of January 1, 2023 = (a) / (b)	$1,652,339

The Unfunded Actuarial Accrued Liability will be amortized over a closed 15-year period effective January 1, 2023. Future gains and losses will not be separately amortized. Previously, the gains and losses arising each year were amortized over closed periods over varying length depending on the source of the new unfunded liability. A fresh start closed amortization period is more appropriate for a frozen plan.

Section III
Assets

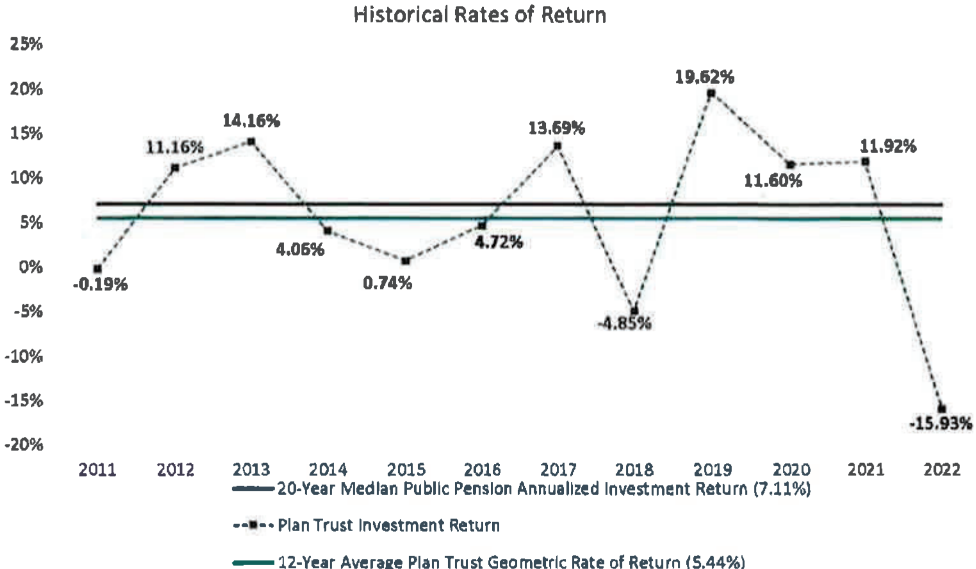
A. Statement of Plan Assets at January 1, 2023 and January 1, 2022

	2023	2022
Market Value of Assets at January 1:	$ 35,137,453	$41,223,881
Actuarial Value of Assets at January 1	$ 35,137,453	$41,223,881

B. Changes in Market Value of Assets during the 2022 and 2021 Plan Years

			2022		2021
1. Market Value of Assets at January 1st		$	41,223,881	$	35,138,016
2. Changes During the Year					
(a)	Credits				
(i)	Employer Contributions	$	1,545,627	$	2,738,385
(ii)	Employee Contributions		310,498		262,258
(iii)	Income (Interest, Dividend)		864,950		1,569,110
(iv)	Gain from Sale of Asset		1,307,231		2,162,883
(v)	Unrealized Gain/Loss		(8,768,858)		583,015
(vi)	Total Credits	$	(4,740,551)	$	7,315,651
(b)	Charges				
(i)	Benefit Payments	$	(1,323,008)	$	(1,207,348)
(ii)	Fees and Commissions		-		-
(iii)	Other Administrative Fees		(22,868)		(22,438)
(iv)	Investment Advisory and Management Fees		-		-
(v)	Total Charges	$	(1,345,876)	$	(1,229,786)
3. Market Value of Assets at December 31st = 1 + 2(a)(vi) + 2(b)(v)		$	35,137,453	$	41,223,881

C. Historical Asset Rates of Return:



Section IV
PEPRA Employee Contribution Rate

A. PEPRA Member Normal Cost

The normal cost is the actuarial present value of benefits allocated to the current Plan Year and is used to calculate the employee contribution rate for the next Plan Year. This table shows the normal cost for PEPRA employees only for select Plan Years. However, contributions will cease on July 3, 2023 due to an amendment freezing the plan.

Applicable Year[1]:	2017 (Last Adjustment)	2023	2024
(a) Normal Cost	$149,041	$458,286	N/A
(b) Covered Payroll	$1,832,105	$5,495,464	N/A
(c) Percent of Payroll	8.13%	8.34%	N/A

[1]Applicable Year is the year in which data shown will first be applicable to contributions made by PEPRA employees.

B. Development of the 2024 Estimated Employee Contribution Rate

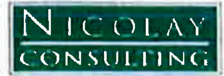
Effective January 1, 2013, the California Public Employees' Pension Reform Act (PEPRA) requires that a new participant must contribute at least 50% of the normal cost rate of the Plan and that employers not pay any of the required employee contribution [GC 7522.30(a)]. The normal cost rate means the annual actuarially determined normal cost for the Plan based on the actuarial assumptions used to determine the liabilities and costs as part of the annual actuarial valuation [GC 7522.30(b)].

New Plan participants shall have an initial contribution rate of at least 50 percent of the normal cost rate for the Plan, rounded to the nearest quarter of 1 percent, unless a greater contribution rate was adopted [GC 7522.30(c)].Once established, the employee contribution rate shall not be adjusted on account of a change to the normal cost rate unless the normal cost rate increases or decreases by more than 1 percent of payroll above or below the normal cost rate in effect at the time the employee contribution rate is first established. Or if later, the normal cost rate in effect at the time of the last adjustment to the employee contribution rate [GC 7522.30(d)].

Valuation Date:	January 1, 2016 w/ 12/31/16 Update	January 1, 2022	January 1, 2023
Applicable Year:	2017	2023	2024[2]
(a) Normal Cost	$149,041	$458,286	N/A
(b) Covered Payroll	$1,832,105	$5,495,464	N/A
(c) Normal Cost Rate	8.13%	8.34%	N/A
(d) 1 percent in/decrease?	N/A	No	N/A
(e) 50% of NC Rate	4.06%	4.17%	N/A
(f) Rounded to ¼ of 1%	4.00%[1]	4.00%[1]	0.00%

[1] Last Adjustment (2017) contribution rate for PEPRA participants.

[2] Contributions ceased 7/2/2023 due to an amendment to freeze the plan.



Section V
Risk Analysis

SUMMARY

While the valuation results are based on the actuary's best estimate, future costs will fluctuate due to actual experience being different than assumed. We have identified the following risks that could affect the plan's future funding condition:

Risk	Risk Description	Assessed Risk Level
1. Interest Rate Risk	Despite recent increases in interest rates and inflation, there is risk that investment return outlooks may remain low resulting in a need to lower the Plan's discount rate leading to higher measured liabilities.	Moderate
2. Investment Risk	There is risk that future investment returns will be volatile causing assets to be at a low point as of a valuation date, requiring higher contributions to make up the difference.	Moderate
3. Plan Maturity Risk	There is risk for plans with a high proportion of inactive/retired participants, where the plan cost is more volatile as inactive/retired liability changes are spread over active participant future service/payroll.	Moderate
4. Demographic Risk	There is risk that participants' turnover, retirements, mortality and salary increases will be different than expected, leading to higher costs.	Low

We discuss these risks in more detail on the following pages.

1) Interest Rate Risk

Plan liabilities are measured using a discount rate based on the expected long-term return on assets. The current discount rate is 6.5%. The table below shows the impact on Plan costs if this rate decreased by 50 bps:

	Current (6.50%)	-50 bps (6.00%)
1/1/2022 EAN Actuarial Accrued Liability	$ 51,683,711	$55,134,606
2023 Recommended Contribution Level	$ 3,401,336	$ 3,885,572
Funded Status %	67.99%	63.73%

2) Investment Risk

A measure of the plan's sensitivity to Investment Risk is a stress test where assets immediately drop 20% during a period that includes the valuation date. The effect on 2023 actuarially determined contribution levels and funding status of an immediate 20% asset loss would be as follows:

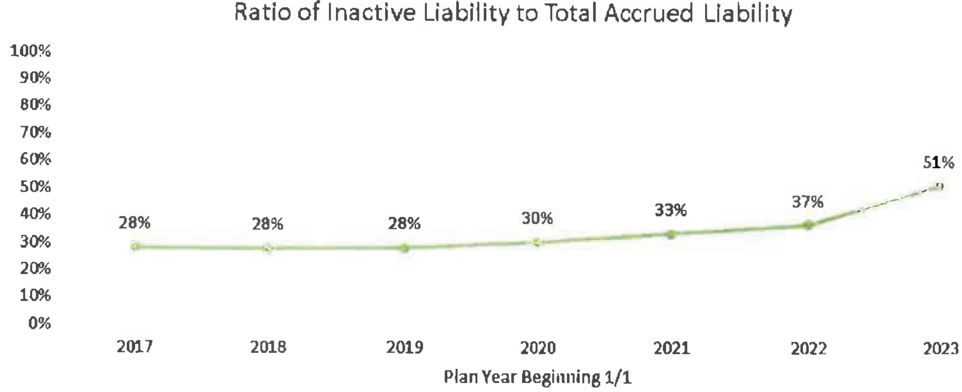
	Current Results	Revised Results if Assets Drop 20%
1/1/2023 Market Value of Assets	$ 35,137,453	$ 28,109,963
2023 Recommended Contribution Level	$ 3,401,336	$ 4,125,921
Funded Status %	67.99%	54.40%

3) Plan Maturity Risk

Plan Maturity is an additional type of risk inherent with plans that have a high proportion of liability for inactive participants. While mature plans are less sensitive to many potential shocks, they tend to have a harder time recovering from negative shocks as plan liabilities tend to be larger relative to future payroll/service of the active population. This means a mature plan's inactive liabilities may cause the plan cash costs to be more volatile than a non-mature plan.

The San Benito Healthcare District should consider how plan investments should be managed to account for the growing inactive liability percentage. Since the retired liability is a bond-like liability, the San Benito Healthcare District may want to reduce risk by matching fixed income securities with the retired liability where the fixed income securities generate income approximating the expected benefit payments. If the San Benito Healthcare District allocates a higher percentage to fixed income securities, the resulting yields may be less than expected resulting in actuarial losses. This effect would be more gradual than the 20% drop illustrated in Section 2).

The table below shows the plan's ratio of inactive and retired liability to accrued liability over time:



The chart indicates that the ratio of inactive liability to total accrued liability has increased over the last 5 years from 28% to 51%. There is no fixed measure of what constitutes a mature plan, but since the plan's inactive liability is more than 50% of total accrued liability, the plan would be considered by most to be a mature plan. The 2023 increase was impacted largely by the plan freeze.

2. Classification of Participants on January 1, 2023

		Total
1. Actives Participants accruing benefits :		
(a)	Under Normal Retirement Age	260
(b)	Over Normal Retirement Age	28
can	Total	288
2. Active Frozen Participants		13
3. Terminated Participants with deferred vested benefits		137
4. Retired Participants receiving benefit payments		138
5. Total = (1c) + (2) + (3) + (4)		576

B. Participant Data Reconciliation

The San Benito Health Care District Employees Pension Plan valuation data base included active and inactive participants, terminated participants with deferred vested rights, and retired participants. Set forth below is the reconciliation of the valuation database from the January 1, 2022 valuation to the January 1, 2023 valuation.

RETIRED PARTICIPANTS AND BENEFICIARIES

Retirees and Beneficiaries, January 1, 2022		**118**
Plus:	New retirements from actives	15
	New retirements from Vested Termination	6
	New beneficiary	1
Less:	Deaths	2
	Returned to active	0
	Data adjustments	0
Retirees and Beneficiaries, January 1, 2023		**138**

VESTED TERMINATED PARTICIPANTS

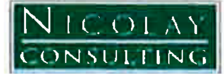
Vested Termination, January 1, 2022		**132**
Plus:	New Vested Termination with Deferred Benefits	14
	Leave of Absences	0
Less:	Deaths	0
	Retirements	6
	Returned to active	2
	Data adjustments	1
Vested Termination, January 1, 2023		**137**

ACTIVE AND INACTIVE PARTICIPANTS

	Active (Accruing)				Active Frozen			
	CNA1	NUHW	Non-Union	Total	CNA1	NUHW	Non-Union	Total
Active Participants, January 1, 2022	**76**	**132**	**72**	**280**	**10**	**7**	**5**	**22**
Plus: New Entrants	11	11	5	27				
Former non-vested returning								
Former vested returning		1		1	1			1
Former frozen returning	1	3	2	6	(1)	(3)	(2)	(6)
Former retired returning								
Less: Vested Terminations								
with Deferred Benefits	1	2	7	10	2		2	4
Non-Vested Terminations						1		1
Deaths								
Suspended	1	2		3	(1)	(2)		(3)
Retirements	5	6	2	13	1	1		2
Data Adjustments				0				
Plus: Union Code Changes	(2)	(1)	3					
Active Participants, January 1, 2023	**79**	**136**	**73**	**288**	**8**	**4**	**1**	**13**

1 CNA category includes participants with a Union code of LabTech, LVN, or RN.

Where current union code is missing, it is assumed union code is the same as in the prior year



Assumptions and Methods

A summary of the actuarial assumptions and methods used in the January 1, 2022 actuarial valuation of the Plan follows:

2. A. Actuarial Assumptions

Investment Return(CO): For 2023: 6.5% per annum, compounded annually (Net of Administrative Expenses).

The investment return assumption was set based on capital market projections by the investment consultant adjusted for administrative expenses paid from the trust.

Salary Scale(FE): For 2023:
3.5% per annum (NUHW);
3.0% per annum (all other participants).

These new Salary scale assumptions are based on union agreements finalized in 2022 and changes in future expected salary increases.

For 2022:
5.50% per annum (NUHW);
4.00% per annum (CNA);
5.25% per annum (Other Union);
5.00% per annum (all other participants).

Mortality(FE)*: The PubG-2010 Generational Mortality Tables for males and females and surviving spouses projected using scale MP-2021 improvement table.

Retirement Age(FE):* 100% at Normal Retirement Age.

Due to the early retirement provisions in the Plan and the number of active employees older than age 65 in the data, we recommend a study of recent experience be completed to validate this assumption.

Turnover(FE)* Based on T-4 Table, Sample Rates are:

Age	Rate
25	5.29%
35	4.70%
45	3.54%
55	0.94%

Disability (FE)*: None.

Assumptions and Methods

Marital Status(FE):	Percentage married: 80% of males and females are assumed to be married. Age difference: Females are assumed to be three years younger than males.
Inflation	2.25% per year for applicable plan limits

*NCG has not performed an experience study to select these assumptions.

Valuation Date	January 1, 2023
Actuarial Cost Method:	Entry Age Normal Cost Method This method was effective January 1, 2015. Under the Entry Age Normal Actuarial Cost Method, the actuarial value of the projected benefits of each individual included in the actuarial valuation is allocated on a level basis over the earnings of the individual between entry age and assumed exit age(s). The portion of this actuarial present value allocated to a valuation year is called the normal cost. The portion of this actuarial present value not provided for at a valuation date by the actuarial present value of future normal costs is called the Actuarial Accrued Liability.

Assumptions and Methods

Amortization Policy:

For 2023:

The total unfunded actuarial accrued liability is amortized over a closed 15 year period.

For 2022:

The unfunded actuarial accrued liability is amortized at the valuation interest rate over closed periods over varying length depending on the source of the new unfunded liability:

- 20 Years – Initial Unfunded
- 10 Years – Method Changes
- 10 Years – Liability Experience
- 10 Years – Asset Experience
- 15 Years – Assumption Changes
- 15 Years – Plan Amendments

When the Plan reaches full funding, all amortization bases are wiped out.

Contributions toward prior amortization bases are allocated prorata based on their outstanding unamortized balance. Each year prior bases are re-amortized over the remaining amortization period. In years where contributions to prior bases are less (greater) than recommended, this approach will increase (decrease) the annual amortization requirement of each prior base.

FE: Indicates an assumption is an estimate of future experience.
MD: Indicates an assumption is an estimate inherent in market data.
CO: Indicates an assumption is based on a combination of estimated future experience and estimates inherent in market data.

Section VIII
Plan Provisions

Effective Date:	January 1, 2005
Most Recent Restatement Date:	January 1, 2015
Most Recent Amendment Date:	July 3, 2023(Plan Freeze)
Plan Year:	January 1 to December 31

Classic Employee Provisions

Eligible Employee:	Benefited full-time or part-time employee. Hired prior to January 1, 2013.
Participation Entry Date:	January 1st following three years of consecutive employment (1,000 hours in each year) and attainment of age 21.
Normal Retirement Date:	First of month after reaching age 65 and completion of five Years of Service.
Deferred Retirement Date:	First of any month following actual retirement after a participant's Normal Retirement Age. An employee can work beyond his normal retirement date and continue to earn pension benefits.
Early Retirement Date:	First of any month after reaching age 50 and completing 10 Years of Service.
Normal Form of Payment For Unmarried Participants:	A retirement income payable monthly for life, with guaranteed payments for 120 months.
Normal Form of Payment For Married Participants:	A retirement income payable monthly for life, with guaranteed payments for 120 months; in addition, after the guaranteed period, in the event of the participant's death, the participant's spouse will receive a monthly pension equal to 50% of the participant's pension for the remainder of the spouse's lifetime.
Optional Forms of Distribution of Retirement Benefit:	No other options available.

Retirement Benefit Formula For Future Service:	Effective January 1, 2005: 1% of the participant's compensation in each calendar year. Effective January 1, 2007, the rate increases to 1.1% per year for future service of non-SEIU employees' future service after January 1, 2007, but prior to January 1, 2010. Effective January 1, 2010, the rate increases to 1.3% per year for non-SEIU employees' future service after January 1, 2010. Effective January 1, 2012, the benefit accrual rate increases to 1.3% of participant's compensation for all eligible employees' future service after January 1, 2012. Effective July 3, 2023, benefit accruals cease due to an amendment to freeze the plan.
Retirement Benefit Formula For Past Service as of January 1, 2005	1% of the participant's compensation in each consecutive calendar year in which the participant completed 1,000 hours as a benefited full-time or part-time employee during the period 1999 through 2004.
Early Retirement Benefit:	Accrued benefit earned to the date of early retirement with payments commencing on participant's normal retirement date. The participant may elect to receive an actuarlally reduced benefit starting after his or her early retirement date.
Deferred Retirement Benefit:	The greater of 1) the Accrued Benefit as of Normal Retirement Date and 2) The participants Accrued Benefit as of the Deferred Retirement Date.
Disability Benefit:	Accrued benefit earned to disability retirement date with payments commencing on participant's normal retirement date. The participant may elect to receive an actuarially reduced benefit starting after his or her early retirement date.
Death Benefits:	Larger of: (1) Present value of vested accrued benefits; (2) 25,000.
Vesting of Accrued Benefits:	The earlier of (i) the completion of five years of service (1,000 hour rate) in the Plan and (ii) a participant's Normal Retirement Date. This vested benefit would be in the form of a pension beginning at normal retirement date equal to the benefits accrued at time of termination, or for a reduced amount if an election is made to have payments commence before normal retirement date.

PEPRA Provisions

PEPRA Participant	"PEPRA Participant" means a participant who (i) was never a member of a California "public retirement system" as that term is defined in California Government Code section 7522.04(j), prior to January 1, 2013, (ii) was a member of a California public retirement system prior to January 1, 2013, other than the system through which this Plan is offered but was not subject to reciprocity under California Government Code section 7522.02(c), or (iii) was an active member in the system through which this Plan is offered but who returned to active membership in the system with a new employer after a break in service of more than six (6) months.
Classic Participant	Means a participant who is not a PEPRA Participant
Eligibility Requirements	Employees must be employed by the Employer in an eligible category of employment, attained age 21, and completed three years of service in order to be eligible to participate in the plan. An eligible employee will become a participant upon the later of January 1, 2016, completion of three years of services, or attainment of age 21. No employee will be allowed to enter or reenter the plan effective July 3, 2023.
Benefit Accrual Rates(PEPRA Participants)	Same as Retirement Benefit for Future Service
Normal Retirement:	Normal retirement age under the plan is the later of age 65 or the date an employee completes 5 years of service. Normal retirement date is the first day of the month after reaching normal retirement age.
Early Retirement:	The first day of the month following a Participant's attainment of age fifty (50) years and the completion of ten (10) Years of Service, or the first day of any subsequent month preceding the Participant's Normal Retirement Age; provided, however, that a Post-2012 Participant must have attained age fifty-two (52).
Maximum Benefit of PEPRA Participants	The Accrued Benefit of a PEPRA participant shall not exceed the amount defined in PEPRA and described in Appendix A of the plan document. The amount shall be determined by interpolating to the participant's nearest completed quarter of age at the date benefit are scheduled to commence, based on the rates shown opposite the participant's age in Appendix A of the plan document table. Based on Appendix A table, Sample rates are:

Age of retirement	Benefit Rate (Percentage of Final Base Pay)
52	1.000%
55	1.300%
60	1.800%
65	2.300%
67	2.500%

Final Base Pay

The highest average annual Pensionable Compensation earned by the Participant during a period of at least 36 consecutive months immediately preceding his retirement (or last separation from service, if earlier) Pay after 7/3/2023 will not be recognized.

Employee Contributions

PEPRA participants shall have an initial contribution rate of at least 50% of the normal cost rate as defined under the Employer PEPRA Contribution. Contributions cease on 7/3/2023.

Change in Plan Provisions

The plan was most recently amended to freeze the accrual of any additional benefits under the plan effective July 3, 2023. Employee contributions for PEPRA participants also ceased on that date.

PROFESSIONAL SERVICES AGREEMENT

BETWEEN

COUNTY OF SAN BENITO

AND

HAZEL HAWKINS MEMORIAL HOSPITAL

FOR THE PROVISION OF

ELIGIBILITY SERVICES FOR MEDI-CAL

This agreement is entered into by and between the County of San Benito, acting through the San Benito County Health and Human Services Agency hereinafter referred to as the "COUNTY" and Hazel Hawkins Memorial Hospital hereinafter referred to as the "CONTRACTOR"; for the purpose of providing one or more services.

WHEREAS, CONTRACTOR operates an acute care general hospital located at 911 Sunset Drive, Hollister, California 95023. In conjunction therewith CONTRACTOR needs the services of qualified personnel to determine eligibility of CONTRACTOR's patients for Medi-Cal and to assist patients with the application process for such program hereinafter referred to as the "Services".

WHEREAS, COUNTY employs or contracts with personnel who are duly qualified and experienced in furnishing the Services.

WHEREAS COUNTY AND CONTRACTOR agree that it is in the best interest of CONTRACTOR's ability to provide quality patient care in a cost-effective and efficient manner for CONTRACTOR to contract with an entity to provide the Services.

WHEREAS COUNTY shall retain all professional and administrative responsibility for the Services rendered pursuant to this Agreement to the extent required to comply with Title 22 of the California Code of Regulations, Section 70713.

NOW, THEREFORE, for and in consideration of the recitals above and the mutual covenants and conditions contained here, COUNTY and CONTRACTOR agree as follows:

A. Services:

1. County and Contractor shall perform all services as stipulated in Exhibit "A" which is incorporated by reference and made a part of this agreement.

2. In order for Scope of Work duties to be met County will provide Contractor hardware and specialized software which is to be used by the County's Eligibility Specialist in Contractor's facility in connection with the Californian Statewide Automated Welfare System (Cal-SAWS) automated eligibility system. The following is agreed to by all parties:

a. Use of Hardware & Software: During the term of this Agreement, County shall provide to Contractor, for use by each Eligibility staff, one (1) licensed Cal-SAWS hardware and software program and any updates to the hardware and software.

b. Upon termination of this Agreement, Cal-SAWS project staff shall remove all hardware, software and programs that are unique to Cal-SAWS.

c. Maintenance Costs: County is responsible for coordinating all system upgrades, maintenance, or repairs to the Cal-SAWS system. CONTRACTOR shall reimburse the COUNTY for the cost of the Cal-SAWS hardware and software maintenance throughout the term of this Agreement. The COUNTY will invoice the CONTRACTOR on an annual basis for the maintenance costs.

B. Term:

1. This agreement is effective from: **July 1, 2023 through June 30, 2026.**

C. Payments:

1. Total Amount:

In consideration of services provided by the County to the Contractor pursuant to this Agreement, the County shall be entitled to payment as specified in Exhibit "B" which is referenced and incorporated herein. An Eligibility staff maximum annual salary and benefits is not to exceed, **$92,000.00**.

2. Entire Compensation.

County shall have the sole responsibility to pay for its own employee payroll taxes, withholdings, social security, worker's compensation insurance, other post-employment benefits, disability insurance, unemployment insurance or other insurance and shall have no claim under this agreement or otherwise against Contractor for vacation pay, sick leave, retirement benefits or other benefits of any kind. County hereby agrees to indemnify and hold Contractor harmless from any and all claims, costs and/or liability suffered or incurred by Contractor in connection with any claims for compensation by County for services rendered hereunder. The indemnification obligations herein stated in this subparagraph shall survive the termination and/or expiration of this agreement.

3. Method and Rate of Payment:

In full consideration of services provided by County pursuant to this agreement, the County shall invoice Contractor quarterly, in the manner and rate described in Exhibit "B", attached hereto and by this reference incorporated herein.

4. Responsibility for Audit Exceptions:

It being understood by the parties hereto that the County's funding source herein is Federal, State, and County appropriation, and it being further understood that County is responsible for administering the program as described herein, County agrees to accept responsibility for receiving, replying to and/or complying with any audit exceptions by appropriate regulatory audit agencies occurring during the performance of this contract and through the retention of records required time frame. Contractor also agrees to pay to County the full amount of County's liability to the State Government resulting from said audit exceptions that result from a breach of contract.

D. General Provisions:

1. Right of Termination:

(a) **Without Cause.** This Agreement may be terminated by either party with or without cause at any time upon at least ninety (90) days written notice.

(b) **Mutual Agreement.** This Agreement may be terminated at any time upon written concurrence of the parties.

(c) **Immediate Termination.** This Agreement may be immediately terminated in the following circumstances:

(1) By either COUNTY or CONTRACTOR, if CONTRACTOR's license to operate as a general acute care hospital is revoked or suspended or if hospital is closed; or
(2) Failure of any party to maintain insurance pursuant to Section D-6 of this Agreement.

2. Effect of Termination:

As of the effective date of termination of this Agreement, neither party shall have any further rights nor obligations hereunder except: (a) as otherwise provided herein; or (b) for rights and obligations accruing prior to such effective date of termination.

3. Consideration on Termination

Upon termination of this Agreement CONTRACTOR shall be obligated to pay COUNTY for any services rendered up to the effective date of termination. Any advance payments received by COUNTY from CONTRACTOR which cover any period after the effective date of termination shall be pro-rated and refunded to CONTRACTOR.

4. Right to Monitor and Audit:

County, State and Federal Governments shall have the right to monitor all work performed under this agreement to assure that all-applicable State and Federal regulations are met. County, State and Federal Governments shall have the right to audit all work, records and procedures related to this agreement to determine the extent to which the program is achieving its purposes. County will notify Contractor within five (5) days of any potential Federal and/or State exception(s) discovered during such examination. Where such findings indicate that program requirements are not met, and Federal participation in this program may be imperiled, such written notification will constitute County's intent to terminate this contract in the event that corrections are not accomplished by Contractor within thirty (30) days.

5. Availability and Retention of Records:

Contractor shall maintain and preserve all records related to this agreement in its possession (or will assure the maintenance of such records in the possession of any third-party performing work related to this agreement) for a period of three (3) years from the effective date of this agreement, or until all State audits are complete, whichever is later. Upon request, Contractor shall make available copies of these records to County, State or Federal Governments' personnel, including the State Auditor General.

6. County Status.

County shall act at all times under this agreement as an independent contractor. The parties agree that Contractor shall not have and shall not exercise any control or direction over the manner or method by which County provides the services. However, Contractor may require County to perform at all times in accordance with currently approved methods and standards of practice for services in the community. The provisions of this paragraph shall survive expiration or other termination of this agreement, regardless of the cause of such termination.

7. Insurance.

Each party agrees to maintain insurance coverage for general liability, auto liability, worker's compensation and for personal injury as provided in Exhibit C, Standard Insurance Requirements which is incorporated by reference and made a part of this Agreement. Furthermore, each party will cause their insurance carrier to provide a certificate evidencing coverage and provide that the other party will receive thirty (30) days' notice in the event of any decrease in such coverage. It is understood by the parties that both parties are self-insured for most of their liability risk.

8. Indemnification.

Each party agrees to indemnify, defend, and save harmless the other party, its officers, agents, and employees from and against any and all claims and losses whatsoever accruing or resulting to any person, firm or corporation for damage, injury or death arising out of or connected with the other party's negligent performance of this agreement or intentional failure to perform hereunder.

9. Confidentiality:

a. Welfare and Institutions Code Compliance.

Contractor agrees to require his/her employees to comply with the provisions of Section 10850 of the Welfare and Institutions Code and Division 19-000 of the COSS Manual of Policies and Procedures to assure that:

1. All applications and records concerning any individual made or kept by any public officer or agency in connection with the administration of any provision of the Welfare and Institutions Code relating to any form of public social services for which grants-in-aid are received by this State from the Federal Government will be confidential and will not be open to examination for any purpose not directly connected with the administration of such public social services.

2. No person will publish or disclose or permit or cause to be published or disclosed any list of persons receiving public social services.

3. No person will publish, disclose, or use or permit, or cause to be published, disclosed, or used any confidential information pertaining to an applicant or recipient. Contractor agrees to inform all employees, agents, and partners on the above provisions and that any person knowingly and intentionally violating the provisions of this paragraph is guilty of a misdemeanor.

b. Contractor Information.

County recognizes and acknowledges that, by virtue of entering into this agreement and providing services to Contractor hereunder, County may have access to certain information of Contractor that is confidential and constitutes valuable, special, and unique property of Contractor. County agrees that at no time, either during or subsequent to the term of this agreement, will it disclose to others, use, copy or permit to be copies, without Contractor's express prior written consent, except pursuant to County's duties hereunder, any confidential or proprietary information of Contractor, including, but no limited to information which concerns Contractor's employees, patients, costs, or treatment methods developed by Contractor for the Contractor and which is not otherwise available to the public.

c. HIPAA Compliance.

County agrees to comply with the applicable provision of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, ad codified at 42 U.S.C. Section 1320d through d-8 ("HIPAA"), and the requirements of any regulations promulgated hereunder including without limitation the federal privacy regulations as contained in 45 CFR Part 164 (the "Federal Privacy Regulations") and the federal security standards as contained in 45 CFR Part 142 (the "Federal Security Regulations"). County agrees to comply with business associate provisions as substantially set forth in Exhibit D ("Business Associate Agreement Terms and Conditions") attached hereto and incorporated herein.

10. Hold Harmless:

The Contractor shall indemnify and save harmless the County, its officers, agents, employees and servants from all claims, suits or actions of every name, kind, and description, brought for, or on account of, injuries to or death of any person or damage to property resulting from the performance of any work required by this agreement of Contractor, its officers, agents, employees and/or servants.

The duty of the Contractor to indemnify and save harmless, as set forth herein, shall include the duty to defend as set forth in Section 2778 of the California Civil Code, provided, however, that nothing herein shall be construed to require the Contractor to indemnify the County, its officers, agents, employees and servants against any responsibility or liability in contravention of Section 2782 of the California Civil Code.

11. Non-Discrimination:

a. By signing this contract the CONTRACTOR certifies under the laws of the State of California that the CONTRACTOR and its contractors shall not unlawfully discriminate in the provision of services because of race, color, creed, national origin, sex, age, or physical or mental disability as provided by state and federal law and in accordance with Title VI of the Civil Rights Act of 1964 [42 USC 2000 (d)]; the Age Discrimination Act of 1975 (42 USC 6101); the Rehabilitation Act of 1973 (29 USE 794); The Education Amendments of 1972 (20 USC 1681); The Americans with Disabilities Act of 1990 (42 USC 12132), Title 45 Code of Federal Regulations, Part 84; the provisions of the Fair Employment and Housing Act (Gov. Code Sec. 12900 et seq.), and the regulations promulgated thereunder (Title 2, CCR sec. 7285.0 et seq.); Title 2, Division 3, Article 9.5 of the California Government Code, commencing with Section 11135; and Title 9, Division 4, Chapter 6 of the California Code of Regulations, commencing with Section 10800.

b. For the purpose of this contract, distinctions on the grounds of race, color, creed, national origin, sex, age or physical or mental disability include, but are not limited to, the following: denying a participant service or providing a benefit to a participant which is different, or is provided in a different manner or at a different time form that provided to other participants under this contract; subjecting a participant to segregation or separate treatment in any manner related to the receipt of any service; restricting a participant in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; treating a participant differently from others in determining whether the participant satisfied any admission, enrollment, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service or benefit.

c. The CONTRACTOR shall take affirmative action such as assessment and monitoring to ensure that beneficiaries and intended beneficiaries of service are provided services without regard to race, color, creed, national origin, sex, age, or physical or mental disability, and shall include nondiscrimination and compliance provisions in all subcontracts. The CONTRACTOR shall establish written procedures under which service participants are informed of their rights which shall include the right of appeal and the right to be free from sexual harassment and sexual contact by members of the treatment, recovery, advisory, or consultant staff.

d. The CONTRACTOR shall do a self-evaluation to assess access to services which relate to this contracted service.

e. The CONTRACTOR shall keep records to document compliance with the provisions referenced in Section D, Item 4, Subsections A through C and copies of the required Notice of Client's Rights. Upon request by the State and/or COUNTY, the CONTRACTOR shall provide such records to the COUNTY and/or State within fifteen (15) calendar days.

f. Noncompliance with Section D, Item 11, Subsections (a) through (e) may result in withholding of payments under this contract or termination of any part of Contractor's reimbursement.

g. "Affirmative Action" is used in a broad sense, not to imply that each and every line of the provisions of 45 CFR part 74, Appendix A, Section 1 (Equal Opportunity) is applicable to the nature of this particular contract. See CONTRACTOR'S employment policy.

12. <u>Liaison Personnel:</u>

The parties to this agreement agree that, unless otherwise indicated in writing, the following persons have primary responsibility for liaison and coordination of activities required to carry out this agreement:

For County: Tracey Belton, Director
Phone: 831-630-5146

E-mail: tbelton@cosb.us

For Contractor: Mark Robinson, Chief Financial Officer
Phone: 831-637-5711
E-mail: mrobinson@hazelhawkins.com

13. Addresses:

All correspondence, notices, claims, etc., will be addressed to the following parties unless otherwise specified in this agreement or may be otherwise specified in this agreement or may be otherwise agreed by the parties hereto:

To County: 1111 San Felipe Road, Suite 206
Hollister, CA. 95023

To Contractor: 911 Sunset Drive
Hollister, CA 95023

14. Licensing or Accreditation:

Where applicable, the Contractor shall maintain the appropriate license or accreditation through the life of this contract.

15. Assignability of Contract:

Without the written consent of the Contractor, this agreement is not assignable by County either in whole or in part.

16. Access to Information and Data:

Without infringing upon the rights of the client/Contractor's confidentially, the County will have access to any records that pertain to eligibility by the Contractor on any client receiving services in which eligibility is being determined and within the scope of this agreement for purposes of data gathering and analyzing the service given and the overall service results. In addition, in the event the Contractor loses its corporate standing or should decide to discontinue its program, copies of all files and records.

17. Subcontract:

Without the written consent of the Contractor, this agreement may not be subcontracted within whole or in part.

18. Alterations of Agreement:

No alteration or variation of the terms of this agreement shall be valid unless made in writing and signed by the parties hereto and no oral understanding or agreement not incorporated herein shall be binding on any of the parties hereto. All modifications are subject to prior approval of the County.

19. Time:

Time is the essence of this agreement.

20. Law Governing Contract:

This contract shall be governed and construed in accordance with all of the laws of the State of California in addition to any cited herein.

21. Equal Opportunity Clause:

The Contractor certifies compliance with Government Code Section 12990 and California Code of Regulations, Title II, Division 4, Chapter 5 in matters related to the development, implementation, and maintenance of a nondiscrimination program. The Contractor shall not discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, sex, age, or sexual orientation of any person. The Contractor shall take affirmative action to ensure that qualified applicants have equal opportunity for employment, and that qualified employees have equal opportunity during employment. Such action shall include, but not be limited to, the following: employment; upgrading; demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; career development opportunities and selection for training, including apprenticeship.

The Contractor requests that County again specifies that "Affirmative Action" is used in a broad sense, not to imply that each and every line of the provisions of 45 CFR Part 74, Appendix A, Section 1 (Equal Opportunity) is applicable to the nature of this particular contract. See Contractor's Equal Employment Opportunity Policy referenced and attached as Exhibit E and made a part of this contract.

22. Conflict of Interest:

a. Contractor and Contractor's employees shall have no interest, direct or indirect, which will conflict in any manner or degree with the performance of services required under this Agreement.

b. This provision does not run exclusively to County; but rather it expressly also runs to those persons receiving services provided for herein. In the event a potential conflict arises, Contractor shall immediately advise County so that the potential conflict can be eliminated or avoided.

c. This contract is entered into by County upon the express representation that Contractor has no other contracts in effect with County except as described on Exhibit "D".

IN WITNESS WHEREOF, the parties hereto, by their duly authorized representative, have affixed their hands on the day and year first above written.

Mark Robinson, Chief Financial Officer Hazel Hawkins Memorial Hospital	Date
Tracey Belton, Director Health and Human Services Agency	Date
Mindy Sotelo, Chair San Benito County Board of Supervisors	Date
San Benito County Counsel	Date

EXHIBIT A

DESCRIPTION OF SERVICES

County Responsibilities:

A. County agrees to assign a minimum half-time (20 hours per week) Eligibility Specialist up to the maximum of one Full Time Equivalent (FTE) Eligibility Specialist (hereinafter referred to as ES) to Contractor.

1. The assignment of the ES shall be the sole responsibility of County and shall be made in accordance with applicable employee rules and regulations as set forth in agreements with employee organizations. Such assignment shall be made in conformance with normal County hours of operation as specified in the County's contract with the Service Employees International Union (SEIU) Local 521 as follows:

   a. Normal County Hours of Operations: the normal work schedule is Monday through Friday, 8:00 a.m. to 5:00 p.m. each day of the year except Saturdays, Sundays, and Holidays, with a one-hour lunch break and a 15-minute rest break in the morning and afternoon daily.

   b. Holidays Defined: New Year's Day, Martin Luther King's Birthday, Presidents' Day, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day, Post-Thanksgiving Day, Christmas Day, and every day appointed by the President and/or Governor, and the Board, when the day is celebrated as a State or Federal Holiday. Days declared as permanent Federal holidays shall be observed as County holidays. When a holiday falls on a Saturday, it will be observed on the proceeding Friday. When a holiday falls on a Sunday, it will be observed on the following Monday.

   c. County/Human Services Agency Furlough Closure Days Defined: If the county opts to have mandatory furlough days for Health and Human Services Agency, the ES will be required to take these days as will all other Health and Human Services Agency staff.

2. The ES assigned to Contractor shall be qualified to perform the duties required. ES shall have training and experience to conduct intake interviews following County procedures for persons applying for Medi-Cal benefits.

3. The ES is prohibited from performing any work not related to Medi-cal eligibility determinations. This includes entering information into a provider's electronic systems and any other work not related to Medi-cal eligibility determinations.

B. County shall be the appointing authority and the employer of ES, responsible for his/her selection, hiring, training, and supervision. As appointing authority, County shall assume responsibility for any Worker's Compensation claims or other work-related liabilities.

C. County shall make a good faith effort to replace the ES during planned and unplanned absences. Good faith efforts will take into consideration operational needs at the main office.

D. County shall assign one bilingual Spanish/English ES to Contractor site.

E. County shall aide the Contractor's clerical staff in obtaining Medi-Cal Benefits Identification Cards (BIC) as required by law. These cards are the property of the applicant/recipient of the above-mentioned benefits.

F. ES assigned to Contractor shall conform to the reasonable rules and regulation of Contractor applicable to all contractor staff. A copy of these rules and regulations will be provided to the ES and to the ES Supervisor.

G. County shall use its best efforts to assure that case processing and final eligibility determination are accomplished within regulatory timeframes.

H. ES will be provided a primary point of contact (including a backup in times when primary is unavailable due to vacation or other leave time) in which all business matters will be conducted. ES will be made aware when the primary is unavailable.

I. Upon Request, the County will provide an update to Contractor on status of pending/approved/denied applications. As much detail as allowed by State and Federal regulations will be provided.

J. ES will attend County trainings and unit meetings as necessary and monthly at a minimum.

K. ES's working at the Contractor's site will adhere to the Contractor's rules of conduct and dress codes.

<u>County Scope of Work:</u>

A. The ES assigned to the Contractor site will conduct the following in the scope of work for an applicant that submit a SAWS 1 (Application for Cash Aid, Food Stamps, and/or Medi-Cal) through the Contractor:

   a. On receipt of the SAWS 1, the ES will research applicant for prior or on-going benefits.

   b. In cases where there isn't sufficient information to research applicant the ES will contact the primary point of contact for additional information if available.

   c. The ES will enter information into the Californian Statewide Automated Welfare System (Cal-SAWS) as required by County policy taking the application to a pending status.

d. **If the applicant is still hospitalized,** the ES will contact the applicant and complete the Medi-Cal informational packet which is required in order to determine eligibility.

e. The ES will then enter the required information into Cal-SAWS. The system will generate a verification list which will be provided in person or through the mail to the application. Verification will be due within 10 calendar days.

f. The ES will work with the primary point of contact to secure all verifications that have already been obtained by the Contractor. In addition, the Contractor can attempt to secure the required verifications however all must be received within the 10 calendar days.

g. If verifications are not received timely, the ES will notify the applicant in writing or verbally that the verifications are needed to move forward with the application. An additional 10 calendar days will be given for the additional information to be returned. This will be documented in the Cal-SAWS system.

h. The ES will review all verification documents, enter appropriate information into the Cal-SAWS system and determine eligibility as soon as administratively possible or as close to the 45-day processing standard as maintained by Federal and State regulations as possible. Standard performance for an ES is to process all applications within the set standard.

i. If verification documents are not received after the second 10 calendar day request the ES will enter appropriate information into the Cal-SAWS system and deny the application. This denial will take place at the end of the second request period which may be prior to the 45-day processing timeframe.

j. **If the applicant is not hospitalized** (this could happen over a weekend when the applicant was treated and released or never made in-patient) the Contractor will be responsible for collecting the SAWS 1 and ensuring it is given to the ES the next working day.

k. The ES will mail the Medi-Cal informational packet which is required in order to determine eligibility. A control will be set for the returned packet in 10 calendar days.

l. When the packet is returned, the ES will then enter the required information into the Cal-SAWS system. The system will generate a verification list which will be provided in person or through the mail to the application. Verification will be due within 10 calendar days.

m. If the packet is not returned within the first 10 days, the ES will notify the applicant in writing or verbally that the informational packet has not been received. An additional 10 calendar days will be given to provide the informational packet. A control will be set to have the packet returned within 10 calendar days.

n. When verifications are not received timely, the ES will notify the applicant in writing or verbally that the verifications are needed to move forward with the application. An additional 10 calendar days will be given for the additional information to be returned. This will be documented in the Cal-SAWS system.

o. When verifications are received, the ES will review all verification documents, enter appropriate information into the Cal-SAWS system and determine eligibility as soon as administratively possible or as close to the 45-day processing standard as maintained by Federal and State regulations.

p. If verification documents are not received after the second 10 calendar day request the ES will enter appropriate information into the Cal-SAWS system and deny the application. This denial will take place at the end of the second request period which may be prior to the 45-day processing timeframe.

8. **Reports:**

a. Upon request, the County will provide a report to the primary point of contact or designee on the status of applications taken or being processed at the Contractors site.

b. The report shall information that is allowable by regulation on the status of an application.

c. The report format is set by the Contract. The contractor will provide the following information:

- Patients Name, Date of Birth, Social Security Number, Admission Date, Discharge Date, and Total Charges. An additional column will be added to provide the ES a place to add the status of the case and additional comments.

d. The County comments will include but are not limited to:

- Application pending packet, Application pending verification, Pending processing. Application denied or Application approved,

C. Other Contractor Cases

a. All applicants that apply at the main Health and Human Services Agency office that are deemed Contractor applicants will be processed by the ES at the Contractors site.

b. All new Long-Term-Care cases will be processed by the ES assigned to the Contractor.

Contractor Responsibilities:

A. Contractor shall provide adequate office space that will protect the client's confidentiality. The office space should be lockable with access limited to the ES, the ES Supervisor, and Office Manager. Contractor shall provide a desk, locked

storage, chair, telephone, and sufficient filing cabinet space and appropriate clerical support for ES assigned to Contractor. Included in the provision of adequate office space, Contractor agrees to provide for reasonable accommodation with regard to special needs the ES might have.

B. Contractor shall notify the County no less than three weeks prior to moving the ES to a different office space, so that the County can arrange to move the DSL circuit.

C. Contractor agrees that County has a compliance requirement to provide adequate language translation services to clients as needed. Contractor agrees to make available personnel for interpreter services in order for ES to appropriately complete the intake process. Contractor further understands and agrees that County has an internal process for ensuring that language translation services are available for clients, and Contractor will work cooperatively with ES in order to provide services to clients.

D. Contractor agrees to provide orientation and training related to the Contractor site environment and special precautions related to infectious diseases to the ES.

E. Both parties agree to cooperate in providing information and documents required by regulatory agencies either party may be accountable to in a timely manner.

F. Contractor shall, within (10) days of the signing of this agreement, designate a liaison to work with County.

G. Contractor staff shall determine which hospital patients are to be referred to ES for Medi-Cal eligibility determination.

H. Medi-Cal applications will be processed in accordance with applicable statutes and regulations including, but not limited to, regulations concerning the processing of applications for comatose patients and patients who are minors.

I. Maximum amount to be received by County for the above-described services are not to exceed the amount as per Exhibit B.

END OF EXHIBIT A

EXHIBIT B

METHOD AND RATE OF PAYMENT

Contractor shall reimburse County for the cost of Eligibility staff assigned to them at a flat rate of $90.00 per hour. The rate is estimated cost of an Eligibility Specialist (ES) and administrative overhead and shall not exceed $92,000.00 annually. The cost is subject to any County annual cost of living increase, increase in wages agreed to by SEIU Local 521 and the County.

Eligibility Specialist

Contractor shall reimburse County on a quarterly basis. Fiscal Year quarters are as follows:

1st Quarter	July – September
2nd Quarter	October – December
3rd Quarter	January – March
4th Quarter	April - June

County shall bill Contractor by the forty-fifth (45) day following the end of each quarter for services rendered the preceding quarter. County billing shall be amended as adjusted by State Review process.

Reimbursement should be sent to:

San Benito County Health and Human Services Agency
Attn: Fiscal Division
1111 San Felipe Road, Suite 206
Hollister, CA 95023

END OF EXHIBIT B

EXHIBIT C

STANDARD INSURANCE REQUIEMENTS

Prior to County's rendering Services provided by the terms and conditions of this Agreement, each party or their subcontractor shall acquire and maintain during the term of this Agreement, insurance coverage, through a program of commercial insurance or self-insurance. The limits of insurance herein shall not limit the liability of either party hereunder.

1. Except for professional liability coverage said policies shall be in effect throughout the term of this Agreement and shall provide that they may not be canceled without first providing the other party with thirty (30) days' written notice of such intended cancellation. If either party fails to maintain the insurance provided herein, this Agreement will terminate immediately.

2. Minimum Scope of Insurance. Each party shall procure insurance covering general liability, automobile liability, and worker's compensation. Coverage shall be at least as broad as:

(a) Commercial General Liability through a program of commercial insurance or self-insurance.

(b) Insurance Services Office form number CA 0001 (Ed. 1/87) covering Automobile Liability, Code I "any auto" and Endorsement CA 0029.

(c) Workers' Compensation insurance as required by the Labor Code of the State of California and Employers Liability insurance.

3. Other Insurance Provisions. The policies are to contain, or be endorsed to contain, the following provisions:

(a) Either party's insurance coverage or self-insurance shall be primary insurance as respects the other party, its officials, employees and volunteers and any other insureds under this Agreement. Any insurance of self-insurance maintained by the either party, its officials, employees and volunteers or other insureds shall be excess of the other party's insurance and shall not contribute with it.

(b) Any failure to comply with reporting provisions of the policies shall not affect coverage provided to either party, its officials, employees and volunteers or other insureds under this contract.

(c) Coverage shall state that each party's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

(d) Workers' Compensation and Employers Liability Coverage.

(e) Professional Errors and Omissions Insurance: Each insurance policy

required by this clause shall be endorsed to state that coverage shall not be suspended, voided, canceled by either party, reduced in coverage or in limits except after thirty (30) days' prior written notice by certified mail, return receipt requested, has been given to the other party.

4. Minimum Limits of Insurance. Each party shall maintain limits no less than:

(a) Commercial General Liability: One Million Dollars ($1,000,000) combined single limit per occurrence for bodily injury, personal injury, and property damage with a general aggregate limit of $1,000,000.

(b) Automobile Liability: $1,000,000 combined single limit per accident for bodily injury or property damage.

(c) Workers' Compensation and Employers Liability: Workers' compensation limits as required by the Labor Code of the State of California and Employers Liability limits of One Million Dollars ($1,000,000) per accident.

(d) Professional Errors and Omissions Liability: Policy limits of not less than One Million Dollars ($1,000,000) per incident and One Million Dollars ($1,000,000) annual aggregate. Coverage may be made on a claims- made basis with "Retro Date" either prior to the date of this Agreement or the beginning of the County's provision of Services. If claims-made, coverage must extend to a minimum of twelve (12) months beyond expiration or termination of this Agreement. If coverage is canceled or non-renewed, and not replaced with another claims made policy form with a "Retro Date" prior to the effective date of this Agreement, the Hospital must purchase "extended reporting" coverage for a minimum of twelve (12) months after completion of Services.

5. Except as otherwise provided in this agreement, any deductibles or self-insured retentions must be declared to and approved by the County.

6. Contractor shall furnish the County with Certificate(s) of Insurance affecting coverage required by this clause as soon as reasonably practicable upon execution of this Agreement. The certificate(s) for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

7. If Contractor shall fail to procure and maintain said insurance, this Agreement will terminate immediately. The policies of insurance provided herein which are to be provided by Contractor shall be for a period of not less than one year, it being understood and agreed that thirty (30) days prior to the expiration of any policy of insurance, Contractor will deliver to County a renewal or new policy to take the place of the policy expiring.

END OF EXHIBIT C

EXHIBIT D

BUSINESS ASSOCIATE AGREEMENT TERMS AND CONDITIONS

To the extent County is a business associate as defined under the federal Health Insurance Portability and Accountability Act (HIPAA), County shall comply with the additional terms and conditions set forth in this Exhibit D. For purposes of this Exhibit D, use of the term "Individual" is intended to be used as defined in HIPAA and its associated regulations and amendments.

County has entered into a business relationship with Contractor that involves or may involve, the collection, transmission, retention, processing, or other use of individually identifiable protected health information ("PHI"). The purpose of this Exhibit D is to comply with HIPAA, including all its related regulations, directives, and subsequent amendments.

1. Except as otherwise provided in this agreement, County may use or disclose protected health information ("PHI") to perform functions, activities or services for or on behalf of the Contractor as specified in the Agreement and its Exhibits, provided that such use or disclosure would not violate HIPAA, 42 U.S.C. 1320d *et seq.*, and its implementing regulations and subsequent amendments, including but not limited to 45 C.F.R. Parts 142, 160, 162, and 164, also known as and referred to as the Privacy Rule. The uses and disclosures of PHI may not be more expansive than the limitations applicable to the Contractor under the regulations except as authorized for management, administrative or legal responsibilities of the County. See: 45 Code of Federal Regulations sections 164.502, 164.502(e), 164.504, 164.504(e)(2)(i)(A) and (B), 164.506, 164.508, 164.510, 164.512, 164.514, including any subsequent amendments or revisions. This Exhibit is not intended to authorize any disclosures or uses of PHI in violation of any other applicable state or federal law or regulation.

2. County shall not use or further disclose PHI other than as permitted or required by this Agreement, or as authorized or permitted by law.

3. County shall use appropriate safeguards to prevent use or disclosure of PHI, including Electronic PHI, other than as provided for by this Agreement. Such safeguards shall conform with the standards and implementation specifications required by the HIPAA Security Standards for the Protection of Electronic PHI.

4. County shall report to the Contractor any use or disclosure of the PHI, including Electronic PHI, not provided for by this Agreement or otherwise in violation of the Privacy Rule. County shall also promptly report in electronic form to the Security Officer of Contractor any Security Incident relating to Electronic PHI of which County becomes aware.

5. County shall ensure that any agent, including a subcontractor, to which County provides PHI received from, or created or received by the County on behalf of

the Contractor shall comply with the same restrictions and conditions that apply through this Agreement to the County with respect to such information.

6. County shall provide access, at the request of the Contractor, and in the time and manner designated by the Contractor to PHI in a Designated Record Set, to an Individual or the Contractor as defined by and in accord with the requirements of 45 C.F.R. section 164.524.

7. County shall make any amendment(s) to PHI in a Designated Record Set that the Contractor directs or at the request of the Contractor or Individual, and in the time and manner designated by the Contractor in accordance with 45 C.F.R. section 164.526.

8. County shall document such disclosures of PHI and information related to such disclosures as would be required for the Contractor to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. section 164.528.

9. County shall provide to the Contractor or an Individual, in time and manner designated by the Contractor, information collected in accordance with 45 C.F.R. section 164.528, to permit the Contractor to respond to a request by the Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. section 164.538.

10. County shall make internal records related to the use, disclosure, and privacy protection of PHI received from Contractor, or created or received by the County on behalf of the Contractor, available to the Contractor or to the Secretary of the United States Department of Health and Human Services for purposes of investigating or auditing the Contractor's compliance with the Privacy Rule requirements, in a time and manner designed by the Contractor or the Secretary.

11. Upon termination of this Agreement for any reason, unless otherwise directed by Contractor, County shall return all PHI received from Contractor, or created or received by County on behalf of Contractor, which PHI is required to be retained by the Privacy Rule. In addition, County shall return all other PHI not subject to the Privacy Rule which is received from Contractor, or created or received by County on behalf of Contractor. This provision shall apply to PHI in possession of subcontractors or agents of County. County, its agents, and subcontractors shall retain no copies of PHI associated with this Agreement.

12. The County shall mitigate, to the extent practicable, any harmful effect that is known to the County of a use or disclosure of PHI by the County in violation of the requirements of this Agreement.

13. The County shall comply with any and all other applicable provisions of HIPAA, its rules and regulations, and any subsequent amendments or modifications.

14. Contractor may immediately terminate this entire contract and all its exhibits in the event of a material breach of the terms and conditions of this Exhibit D which County fails to cure and/or mitigate.

15. In addition to any other indemnification and defense obligation under the Agreement, County has a separate and additional obligation to indemnify and defend Contractor against any claims or suits arising from County's breach of its obligations under the terms and conditions of this Exhibit D.

16. The Contractor and County agree that in the future, it may be necessary to amend this Agreement to allow either party to comply with Privacy Standards that have been promulgated or will be promulgated or will be promulgated by various state or federal regulations or statutes. Contractor and County agree that they will fully comply with all such standards and agree to amend this Agreement to incorporate any material amendment(s) and change(s) required by the various regulations.

17. This Agreement will remain in effect until changed or revoked in writing by an authorized representative of Contractor.

18. Paragraphs 2 through 16 of this Exhibit D shall survive the termination of the Agreement so long as PHI obtained or generated during the term of this Agreement is retained by County.

END OF EXHIBIT D

EXHIBIT E

Hazel Hawkins Memorial Hospital Equal
Employment Opportunity Policy

1. Hazel Hawkins Memorial Hospital is committed to a policy of equal employment opportunity for applicants and employees. The Hospital does not discriminate on the basis of race, color, sex, sexual orientation, pregnancy, religion, national origin, ancestry, age, physical or mental disability, or any other characteristic protected by applicable state and federal law.

2. We will recruit, hire, and promote for all job classifications without regard to race, color, sex, sexual orientation, religion, national origin, ancestry, age, physical or mental disability, except where age or sex is a bonafide occupational qualification.

3. We will base employment decisions solely upon an individual's abilities, interests, and skills as they are commensurate with their responsibilities.

4. All other personnel actions such as compensation, benefits, transfers, low census days, Hospital-sponsored training, tuition assistance, and any other such programs will be administered without regard to any protected characteristic as stated above.

5. The successful achievement of a nondiscriminatory employment program requires a maximum of cooperation between management and employees. In fulfilling its part in this cooperative effort, the Hospital is obliged to lead the way by establishing and implementing procedures and practices which will ensure our objective, equitable employment opportunity for all.

END OF EXHIBIT E