EL CENTRO REGIONAL MEDICAL CENTER
BOARD OF TRUSTEES – REGULAR MEETING

TUESDAY, MAY 30, 2023 **MOB CONFERENCE ROOM 1&2**
5:30 PM **1271 ROSS AVENUE, EL CENTRO, CA**

PRESIDENT: Tomas Oliva
MEMBERS: Sylvia Marroquin; Martha Cardenas-Singh; Edgard Garcia; Sonia Carter; Patty Maysent-CEO, UCSD Health; Christian Tomaszewski-M.D.-CMO, UCSD; Pablo Velez-CEO ECRMC

***CLERK**: Belen Gonzalez* ***ATTORNEY**: Elizabeth Martyn, City Attorney*

This is a public meeting. If you are attending in person, and there is an item on the agenda on which you wish to be heard, please come forward to the microphone. Address yourself to the president. You may be asked to complete a speaker slip; while persons wishing to address the Board are not required to identify themselves (Gov't. Code § 54953.3), this information assists the Board by ensuring that all persons wishing to address the Board are recognized and it assists the Board Executive Secretary in preparing the Board meeting minutes. The president reserves the right to place a time limit on each person asking to be heard. If you wish to address the board concerning any other matter within the board's jurisdiction, you may do so during the public comment portion of the agenda.

BOARD MEMBERS, STAFF AND THE PUBLIC MAY ATTEND VIA ZOOM.
To participate and make a public comment in person, via Zoom or telephone, please raise your hand, speak up and introduce yourself.

Join Zoom Meeting: https://ecrmc.zoom.us/j/81175459312?pwd=VSs4QnVoY2J4ZXNpamJUM2VYOWlvdz09
Optional dial-in number: (669) 444-9171
Meeting ID: 811 7545 9312 Passcode: 799114
Public comments via zoom are subject to the same time limits as those in person.

OPEN SESSION AGENDA

ROLL CALL:

PLEDGE OF ALLEGIANCE:

PUBLIC COMMENTS: Any member of the public wishing to address the Board concerning matters within its jurisdiction may do so at this time. Three minutes is allowed per speaker with a cumulative total of 15 minutes per group, which time may be extended by the President. Additional information regarding the format for public comments may be provided at the meeting.

BOARD MEMBER COMMENTS:

CONSENT AGENDA: *(Item 1-3)*
All items appearing here will be acted upon for approval by one motion, without discussion. Should any Board member or other person request that any item be considered separately, that item will be taken up at a time as determined by the President.

1. Review and Approval of Board of Trustees Minutes of Regular Meeting of April, 24, 2023.

2. Review and Approval of Triennial Policy: ECRMC's Holiday Pay and Work Schedules.

3. Review and Approval of the Triennial Policy: Moderate Sedation (Conscious Sedation).

FINANCE and OPERATIONAL UPDATE

4. Presentation of Financial Statements for Month and Year-to-Date as of April 2023—**Informational**

5. Presentation of Current Weekly Cash Budget—**Informational**

6. Review and Approval of Resolution No. ECRMC 23-02 to open new account with First Foundation Bank
   RESOLUTION **NO. ECRMC 23-02** OF THE BOARD OF TRUSTEES OF ECRMC AUTHORIZING THE OPENING OF NEW ACCOUNT WITH FIRST FOUNDATION BANK

7. Review and Approval of Project Construction fees

CHIEF EXECUTIVE OFFICER UPDATE

8. Verbal Report from the CEO to the Board of Trustees—**Informational**

9. Manager Update—Patty Maysent—**Informational**

RECESS TO CLOSED SESSION:

A. **LABOR NEGOTIATIONS.** The Hospital Board will recess to closed session pursuant to Government Code 54957.6 **Agency Negotiator**: Chief Executive Officer. **Employee organization**: Teamsters Union Local 542

B. **HEARING/DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES.** The Hospital Board will recess to closed session pursuant to Government Code Section 37624.3 for a hearing and/or deliberations concerning reports of the ___ hospital medical audit committee, or _X_ quality assurance committees, or _X_ staff privileges.

C. **TRADE SECRETS.** The Hospital Board will recess to closed session pursuant to Govt. Code Section 37606(b) for the purpose of discussion and/or deliberation of reports involving hospital trade secret(s) as defined in subdivision (d) of Section 3426.1 of the Civil Code and which is necessary, and would, if prematurely disclosed create a substantial probability of depriving the hospital of a substantial economic benefit:

Discussion of:	Number of Items:
_X_ hospital service;	2
_X_ program;	2
_X_ hospital facility	1

D. **CONFERENCE WITH LEGAL COUNSEL—**The Hospital Board will recess to closed session pursuant to Government Code Section 54956.9(d)(4)

RECONVENE TO OPEN SESSION – BOARD PRESIDENT

ANNOUNCEMENT OF CLOSED SESSION ACTIONS, IF ANY – GENERAL COUNSEL

10. Approval of Report of Medical Executive Committee's Credentials Recommendations Report for Appointments, Reappointments, Resignations and Other Credentialing/Privileging Actions of Medical Staff and/or AHP Staff *(Approved in Closed Session)*

ADJOURNMENT: Adjourn. (Time:) Subject to additions, deletions, or changes.

El Centro Regional Medical Center
BOARD OF TRUSTEES – REGULAR MINUTES
OPEN SESSION MINUTES
MOB CONFERENCE ROOMS 1 & 2
1271 Ross Avenue, El Centro, CA 92243
Zoom Meeting link: https://ecrmc.zoom.us/j/81947726314?pwd=WGdXb05ma2hmcmlHSXFoTlJlcHM2UT09

Monday, April 24, 2023

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
ROLL CALL	**PRESENT**: Oliva; Marroquin; Cardenas-Singh; Garcia; Carter; Maysent; Jenusaitis; Morita; Tomaszewski; and Executive Board Secretary Belen Gonzalez Via Zoom: Outside General Counsel Hope Levy-Biehl; **ABSENT**: **ALSO PRESENT:** Sunny Richley, M.D., Chief of Staff Interim City of El Centro Manager Cedric Ceseña; Veronica Marsich, UCSD Legal Counsel;	
CALL TO ORDER		The Board of Trustees convened in open session at 5:32 p.m. Board President Oliva called the meeting to order.
OPENING CEREMONY	The Pledge of Allegiance was recited in unison.	None
NOTICE OF MEETING	Notice of meeting was posted and mailed consistent with legal requirements.	None
PUBLIC COMMENTS	None	None

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
BOARD MEMBER COMMENTS	The Board of Trustees welcomed Pablo Velez, new ECRMC CEO to his first Board of Trustees Meeting.	None
CONSENT AGENDA: *(Items 1-2)* **Item 1. Review and Approval of Board of Trustees Minutes of Special Joint Meeting with Pioneers Memorial Health District and Heffernan Memorial Health District of March 22, 2023.** **Item 2. Review and Approval of Board of Trustees Minutes of Regular Meeting of March 28, 2023.**	All items appearing here were acted upon for approval by one motion (or as to information reports, acknowledged receipt by the Board and directed to be appropriately filed) ***Item 1. Review and Approval of Board of Trustees Minutes of Special Joint Meeting with Pioneers Memorial Health District and Heffernan Memorial Health District of March 22, 2023.*** An error was identified in the minute attendees; change is suggested as follows: • In the Pioneers Memorial Health District attendee list, Aguirre was listed as attended. Aguirre was not present at the meeting.	MOTION: by Cardenas-Singh, seconded by Marroquin and carried to approve the Consent Agenda with the suggested change. All present in favor; none opposed.
FINANCE and OPERATIONAL UPDATE—Informational **Item 3. Presentation of Financial Statements for Month and Year-to-Date as of March 2023—Informational** **Item 3a. FYE 2022 Audit Report—Wipfli, LLP** *(auditors presentation in-person)* **Item 3b. Financial Update—P&L, CF forecast, Expenditures>$100K**	Lenin Valdes provided an overview and summary of the Financial Statements for Month and Year-to-Date as of March 2023. The presentation included: • Balance Sheet vs. Prior Month comparison • Operating Statement vs. Budget comparison • Monthly Cash Flow (Fiscal Year to Date) • **Item 3a. FYE 2022 Audit Report—Wipfli, LLP** *(auditors presentation in-person)* Jeff Johnson, Partner, Wipfli, LLP and Wes Thew, Senior Manager, Wipfli, LLP provided an overview of the 2022	Informational

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
Item 3c. Construction Project Funding—update as to completion, authorization of funding	Audit results. Discussed the financial statement reviews, financial analysis, and answered questions. **Item 3b. Financial Update—P&L, CF forecast, Expenditures>$100K** Tammy Morita and Lenin Valdes provided a summary of the financial update. **Item 3c. Construction Project Funding—update as to completion, authorization of funding** Tammy Morita provided an update on the Construction Project and discussed payment disbursements that were previously delayed and the intents of catching up on payments.	
Item 4. Presentation of Current Weekly Cash Budget—Informational	Tammy Morita provided an update on current cash budget and answered question regarding payments to vendors.	Informational
Item 5. Update on Construction Project—Informational	Tammy Morita provided a verbal report on the Construction Project and answered questions.	Informational
CHIEF EXECUTIVE OFFICER UPDATE		
Item 6. Verbal Report form the CEO to the Board of Trustees—Informational	Pablo Velez provided a verbal update on introductory meetings with staff and physicians.	Informational
Item 7. Manager Update—Patty Maysent—Informational	Patty Maysent provided an overview of issues similar to those of ECRMC.	Informational

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
RECESS TO CLOSED SESSION		MOTION: by Marroquin, seconded by Maysent and carried to recess to Closed Session at 6:49 p.m. for LABOR NEGOTIATIONS, HEARING/ DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES, TRADE SECRETS, and CONFERENCE WITH LEGAL COUNSEL. All present in favor to recess to Closed Session. None opposed.
RECONVENE TO OPEN SESSION		The Board of Trustees reconvened to Open Session at 08:46 p.m.
ANNOUNCEMENT OF CLOSED SESSION ACTIONS		[**B. HEARING/DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES—GOVERNMENT CODE SECTION 37624.3**] MOTION: by Cardenas-Singh, seconded by Garcia and carried to approve the Report of Medical Executive Committee's Credentials Recommendations Report for Appointments, Reappointments, Resignations and Other Credentialing/Privileging Actions of Medical Staff and/or AHP Staff. All present in favor; none opposed

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
ADJOURNMENT		There being no further business, meeting was adjourned at approximately 8:47 p.m.

BELEN GONZALEZ, BOARD EXECUTIVE SECRETARY

APPROVED BY

TOMAS OLIVA, PRESIDENT

TO: ECRMC BOARD MEMBERS

FROM: Luis Castro, Chief Operations Officer

DATE: May 30, 2023

COMMITTEE: Board of Trustees

RECOMMENDED ACTION/MOTION: Move to approve the triennial review of ECRMC's Holiday Pay and Work Schedules policy.

SUBJECT: Holiday Pay and Work Schedules

DESCRIPTION OF ISSUE: To ensure adequate staffing is in place for patient care and provide incentive for employees to work shifts on major holidays, El Centro Regional Medical Center (ECRMC) provides holiday pay to non-exempt employees for time worked on designated major holidays.

OPTION(S): (1) Approve (2) Do not approve

IMPLEMENTATION PLAN:

BUDGET IMPACT: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___ Yes ___ No
B. If yes, what is the impact amount: _____

SUPPORTING DOCUMENT LIST:

- Holiday Pay and Work Schedules Policy

Approved for agenda, Pablo Velez, CEO

Date and Signature: Pablo Velez /BZ

LEGAL REVIEW:

A. Legal Review Necessary ___ Yes _X_ No
B. If Legal Review Necessary, has legal review been completed with legal concerns satisfied? ___ Yes ___ No
C. Item reviewed by Pablo Velez, Chief Executive Officer, and recommendations made have been incorporated.
D. Seeking Board Approval pending final legal review. ___ Yes ___ No

		Department: Human Resources	
		Document Owner/Author: Chief Operations Officer (COO)	
		Category: Hospital Wide	**Approval Type:** Triennial
Date Created 06/06/2011	**Date Board Approved:** 01/09/2017	**Date Last Review:** 05/22/2023	**Date of Next Review:** Triennial
Policy Name: Holiday Pay and Work Schedules			

Purpose

To ensure adequate staffing is in place for patient care and provide incentive for employees to work shifts on major holidays, El Centro Regional Medical Center (ECRMC) provides holiday pay to non-exempt employees for time worked on designated major holidays.

Responsibilities

Person/Title	Responsibilities
Human Resources Division	• Review and update policy • Policy Implementation

Procedure/Plan

Holiday pay will be paid to non-exempt employees who work the actual designated major holiday during the period described below.

Holiday pay is provided to those non-exempt employees who work between 1900 hours (7:00pm) on the eve of the holiday and 2400 hours (12 midnight) when the majority of their hours fall on the actual date of the following holidays:

New Year's Day (January 1)
Memorial Day (last Monday in May)
Independence Day (July 4)
Labor Day (1st Monday in September)
Thanksgiving Day (4th Thursday in November)
Christmas Day (December 25)

The holiday pay rate is one and one-half (1.5) the employee's base rate of pay. The holiday is paid for all hours worked in the designed period for the holiday.

Under no circumstance is the overlapping or stacking of holiday pay or any other premium rate permitted.

All non-exempt employees (regular full-time, regular part-time, pay in lieu full-time, pay in lieu part-time and casual per diem) are eligible for Holiday Pay. Exempt employees are not eligible to receive holiday pay.

Exempt employees may be required to work hours on holidays due to patient care and or business necessity.

Exempt employees may use eight (8) hours of PTO to be paid for a major holiday, with the provision that exempt employees cannot be paid in excess of eighty (80) hours in any pay period.

The following holidays are considered minor holidays and are not designated for holiday pay:

Martin Luther King Jr. Day (3rd Monday in January)
President's Day (3rd Monday in February)
Juneteenth (June 19)
Veteran's Day (2nd Monday in November)
Day after Thanksgiving (4th Friday in November)
Christmas Eve (December 24)
New Year's Eve (December 31)

The Department Manager will attempt not to schedule an employee for the same major holiday on consecutive calendar years. The Department Manager will build rotational holiday schedules.

Business departments and business support departments will generally be closed on major Holidays. A list of closed departments is distributed through Administration the week prior to the holiday.

Definitions

Term	Definition

Associated Policies/Plans/Protocols/Procedures/Forms

Title	Number	Location *(Hyperlink)*

TO: ECRMC BOARD MEMBERS

FROM: Erika Rodriguez, Clinical Nurse Specialist

DATE: May 30, 2023

COMMITTEE: Board of Trustees

RECOMMENDED ACTION/MOTION: Move to approve the triennial review of ECRMC's Moderate Sedation (Conscious Sedation) Policy.

SUBJECT: Moderate Sedation (Conscious Sedation).

DESCRIPTION OF ISSUE: ECRMC medical staff members and employees will follow the policies and procedures provided for the safe administration of sedation. These policies and procedures will be followed wherever and whenever sedation is administered.
The following policy sets uniform requirements and minimum standards for the use of moderate sedation for therapeutic, diagnostic, or surgical procedures performed at ECRMC.

OPTION(S): (1) Approve (2) Do not approve

IMPLEMENTATION PLAN:

BUDGET IMPACT: _X_Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No
B. If yes, what is the impact amount: _____

SUPPORTING DOCUMENT LIST:

- Moderate Sedation (Conscious Sedation) Policy

Approved for agenda, Pablo Velez, CEO

Date and Signature: Pablo Velez | BG

LEGAL REVIEW:

A. Legal Review Necessary ___ Yes _X_ No
B. If Legal Review Necessary, has legal review been completed with legal concerns satisfied? ___ Yes ___ No
C. Item reviewed by Pablo Velez, Chief Executive Officer, and recommendations made have been incorporated.
D. Seeking Board Approval pending final legal review. ___ Yes ___ No

		Department: Clinical Process- Hospital Wide	
ECRMC El Centro Regional Medical Center An Agency Of The City Of El Centro		Document Owner/Author: Clinical Nurse Specialist / Clinical Educator	
		Category: Departmental	Approval Type: Triennial
Date Created 11/05/2001	**Date Board Approved:** 07/26/2016	**Date Last Review:** 04/12/2023	**Date of Next Review:** Triennial
Policy Name: Moderate Sedation (Conscious Sedation)			

Purpose

ECRMC medical staff members and employees will follow the policies and procedures provided for the safe administration of sedation. These policies and procedures will be followed wherever and whenever sedation is administered.

Sedation practices and outcomes shall be monitored and evaluated by the Department of Anesthesia on a regular basis. Identified concerns will be referred to the appropriate medical staff or administrative committee to assure that processes related to the use sedation are continuously monitored and improved.

Scope

The sedation guidelines apply to all locations in the hospital where sedation is administered. These locations include:

1. Endoscopy Room
2. Intensive Care Unit
3. Emergency Department
4. Radiology- Special Procedures
5. Operating Room and PACU

Policy Statement

The following policy sets uniform requirements and minimum standards for the use of moderate sedation for therapeutic, diagnostic, or surgical procedures performed at ECRMC.
All ECRMC patients who receive moderate sedation for a procedure will be provided a safe and comparable level of care consistent with, or in excess of, the minimum recognized standards for such procedures.

ECRMC respects the diverse cultural needs, preferences, and expectations of the patients and families it serves to the extent reasonably possible while appropriately managing available resources and without compromising the quality of health care delivered.
This policy is applicable to all cases of moderate or deep sedation. In this policy moderate and deep sedation/analgesia will be sometimes discussed together and collectively referred to as sedation.

Deleted: /anesthesia

Deleted: This policy does not apply to minimal sedation, anxiolysis or anesthesia

This policy does not apply to medications used for the management of pain control, seizures, anxiolysis, pre-operative mediations, or medication given to an intubated patient on a ventilator.

Exclusions

A. This policy applies to the use of moderate sedation in all healthcare areas except as stated below.
   1. This policy does not apply to :
      a) Sedation provided by an anesthesiologist/Certified Registered Nurse Anesthetists (CRNC)
      b) Mechanically ventilated patients in the Intensive Care Unit (ICU), ER, or Post Anesthesia Care Unit (PACU) with ECG, B/P and SaO2 monitoring; or
      c) Administration of anxiolytic or analgesic agents when administered routinely to alleviate pain and agitation (e.g., sedation for treatment of insomnia, pre-or post-operative analgesia)

B. Anesthetic Agents Ketamine, Propofol, Etomidate and Methohexital: Refer to Pharmacy Policy for additional requirements for use of anesthetic agents for sedation.

C. The use of these agents for non-procedural sedation by continuous drip is addressed in Pharmacy Policy.

Responsibilities

Person/Title	Responsibilities
Anesthesiologist	Privileged to provide all levels of sedation, including moderate sedation with no additional requirements.
CRNA	Privileged to provide all levels of sedation, including moderate sedation with no additional requirements.
Emergency Department Physicians	Privileged to provide procedural sedation; must complete and pass test.

Procedure/Plan

Equipment needed for moderate sedation includes:

1. Cardiac Monitor
2. Pulse Oximeter
3. ETC02
4. Noninvasive Blood Pressure Monitor
5. O2 and suction at bedside
6. Emergency crash cart with defibrillator and including all approved emergency drugs
7. Ambu bag and mask ventilation apparatus
8. Appropriate oral and nasal airways
9. Reversal agents including: Naloxone and Flumazenil
10. Intubation tray
11. IV supplies and equipment
12. Electrical outlet with emergency power

13. Telephone

Personnel Requirements:

1. All sedation must be administered under the supervision of a licensed independent practitioner who holds clinical privileges for the level of sedation which is being administered, either intentionally or unintentionally.
2. A qualified registered nurse or qualified physician must have the primary responsibility for medication administration and monitoring the patient's vital signs and level of consciousness during sedation.
3. The registered nurse administering medication, monitoring and recovering the sedation patient must demonstrate current competence in sedation and advanced cardiac life support (ACLS or PALS).
4. If a procedure is being performed with the administration of sedation, a sufficient number of qualified personnel shall participate in sedation in addition to the practitioner performing the procedure. Qualified personnel shall be present during the procedure using sedation to appropriately evaluate and monitor the patient during the procedure and recover and discharge the patient from the post-sedation recovery area. The registered nurse assigned to monitoring the patient during sedation shall not also act as an assistant to the practitioner performing the procedure.

Competency

1. All sedation will be ordered and supervised by a credentialed practitioner holding current privileges to administer sedation. Specific credentialing criteria for both moderate and deep will be utilized as approved by the Medical Executive Committee. Credentialing criteria developed by the Medical Executive Committee shall include verification of competency in both evaluating patients prior to performing sedation and methods and techniques required to rescue those patients who unavoidably or unintentionally slip into deeper than desired levels of sedation or analgesia.
2. **Moderate sedation** - Practitioners who have appropriate credentials and are permitted to administer moderate sedation are qualified to rescue patients from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation.
3. **Deep sedation** - Practitioners who are appropriately credentialed and are permitted to administer deep sedation are qualified to rescue patients from deep sedation and are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.

The registered nurse responsible for managing the care of the patient receiving sedation will hold current ACLS provider card and maintain sedation competency in the following areas:

1. Airway Management
2. Cardiac Monitoring and arrhythmia recognition
3. Use of sedation and reversal agents
4. Oxygen therapy
5. The ability to intervene in the event of complications
6. Sedation Policy and Procedure
7. Current PALS or NALS certification is required for RN's performing pediatric sedation.

Deleted: general anesthesia

NPO Status

1. The following NPO guidelines apply for otherwise healthy patients. Variations in these guidelines may be indicated because of the patient's clinical presentation.
2. Patients - may take clear liquids up to 2 hours before procedure and may take solids up to 6 to 8 hours before procedure.
3. Breast milk 4 hours, cow's milk 6 hours.
4. Patient greater than 2 to 8 years old - may take clear liquids up to 2 hours before procedure and may take solid up to 6-8 hours before procedure.

Deep sedation/analgesia:

1. Depending on the dosage utilized, medications identified in the attached medication grid may be utilized for deep sedation. A practitioner must be specifically credentialed to administer medications identified for deep sedation in dosages to effect deep sedation and also to administer any of the anesthetic agents listed below.
2. Etomidate IV*Restrict to administration by an anesthesiologist or credentialed ED physician only. Rapid Sequence Intubation (RSI) to receive Etomidate for intubation are excluded from this policy; with credentialed MD at bedside.
3. Ketamine IV/IM*Restrict to administration by an anesthesiologist or credentialed ED physician only.
4. Propofol IV *Restrict to administration by an anesthesiologist or credentialed ED physician only. Patients on mechanical ventilators are excluded from this policy.
5. Methohexital IV*Restrict to administration by an anesthesiologist or credentialed ED physician only.
6. Monitoring for deep sedation will follow the same guidelines as for moderate sedation.
7. A Registered Nurse cannot administer deep sedation. Deep sedation will only be administered in Surgical Services, ER or ICU.
8. A credentialed MD will remain at the bedside after the administration of deep sedation agent until the patient achieves an ALDRETE Score of 6 or better.

PROCEDURE

Pre-sedation Patient Evaluation

1. Except in emergency situations, an appropriate patient assessment must be performed by a credentialed practitioner prior to the administration of sedation. The pre- sedation assessment must include:
    a. Patient interview
    b. Relevant history including past sedation/anesthetic history, current medications, allergies, cardiopulmonary problems and any other pertinent diagnosis
    c. Physical assessment including an assessment of at least airway, heart and lung
    d. Review of the results of relevant diagnostic testing
    e. ASA risk classification (Attachment B)
    f. Choice of sedation agents to be utilized
    g. Sedation plan/choice of sedation agents to be utilized
    h. Informed consent for sedation

2. If a practitioner is also performing a procedure, then informed consent for the procedure must also be obtained.
3. The patient must be re-evaluated by an appropriately credentialed practitioner immediately before sedation use to ensure that the patient is still a suitable candidate for the sedation plan that has been proposed.

Pre-sedation assessment to be performed by the registered nurse shall include:

1. Baselines vital signs including heart rate, cardiac rhythm, blood pressure, respiratory rate and 0_2 saturation
2. Level of consciousness
3. Mental status
4. NPO status
5. Pregnancy status
6. Baseline Aldrete score (Attachment A)
7. Verification of the procedure to be performed
8. Current medications
9. Medical problems
10. Admitting diagnosis
11. Pain perception

1. All patients must have a signed informed consent for any procedures to be performed unless there is documentation that an emergency exists. Informed consent for the sedation/analgesia may be documented by the physician in the medical record.
2. Intravenous access should be secured in all adult patients and all pediatric patients receiving intravenous medications. For pediatric patients receiving sedation through routes other than intravenously, the patient's physician may determine if intravenous access is necessary. If it is determined that intravenous access is not necessary, then skilled personnel and equipment necessary to start and intravenous line should be immediately available.

Sedation Treatment, Monitoring and Documentation

1. Supplemental oxygen if oxygen saturation < 90%.
2. Monitoring of the patient is to be continuous throughout the procedure and will include documentation of the following:
3. Continuous Pulse Oximetry and heart rate with recording every 5 minutes.
4. Respirations, blood pressure and level of consciousness recorded every 5 minutes.
5. Continuous EKG monitoring for patients with significant cardiovascular disease or when dysrhythmias are detected or anticipated.
6. Responsiveness to verbal and physical stimuli assessed and recorded 5 minutes after administration of any agent and every 15 minutes thereafter.

Sedation Documentation should also include:

1. Procedure performed
2. Start time/end time
3. Personnel involved

4. Monitoring equipment used
5. Name and dose of all drugs used including oxygen (time, route, and patient response)
6. Type and amount of IV fluids administered
7. Record of all vital signs
8. Patient status at the end of the procedure
9. Post-procedure diagnosis
10. Unusual events or interventions
11. Significant changes to be reported immediately by the registered nurse to the attending practitioner:
12. Heart rate < 60 or > 100 beats per minute
13. Oxygen saturation changes:
14. Adult – 10% drop or saturation < 90
15. Pediatric – 5% drop or saturation < 90
16. Level of consciousness changes:
17. Change in which the patient cannot communicate verbally or appropriately for age
18. Richmond Agitation Sedation Scale (RASS) (Attachment B)
19. Tissue perfusion changes with cyanosis, mottled skin or clamminess
20. Sedation medication given, pain level and patient's response to medication

Post-sedation Monitoring and Recovery

1. Vital signs including blood pressure, pulse, respirations, and oxygen saturation recorded upon arrival in the recovery area and at least every 15 minutes until discharge criteria met. EKG monitoring for patients with significant cardiac disease or when dysrhythmias are detected or anticipated until discharge criteria met.
2. Pain medication given, pain level and patient's response to medication
3. Patients with an Aldrete score of less than 8 will be evaluated by the physician for possible transfer to PACU for further monitoring and recovery.(Does not apply to ED patients)
4. Level of consciousness recorded every 15 minutes until discharge criteria met.
5. A written record to be maintained which describes the following:
6. IV fluids administered and time IV discontinued
7. Name and dosage of all drugs used including oxygen (time, route, patient response and administered by whom)
8. PO fluids or nourishment's
9. Unusual events
10. Record of Vital Signs
11. Disposition of patient
12. Mode of transportation
13. Discharge instructions
14. Person responsible for patient at discharge
15. Protocol to continue until patient meets criteria that allows for discontinuing moderate sedation protocol.
16. O2 saturation to be done on admission to the unit and prior to discontinuing moderate sedation protocol.

17. Patient Recovery Locations
18. ICU, ED, or patient's undergoing uncomplicated, uneventful procedures may return to ICU, ED for recovery.
19. All other patients will be recovered at the site where the procedure was performed or in a post-anesthetic care unit.

Discontinuation of Monitoring Protocol and Transfer Criteria – for Transfer to another Hospital Unit

1. O_2 saturation of 95% or > or return to pre-procedure level
2. Last dose of antagonist (naloxone) or Benzodiazepine antagonist (flumazenil) at least 30 minutes prior to transfer.
3. Aldrete scoring of at least 8
4. Activity score of at least 2
5. Respiratory score of at least 2
6. C/V score of at least 1
7. Color score of at least 2
8. Consciousness score of at least 1
9. Minimum post-consciousness sedation observation time of 30 minutes

Discharge Criteria – for Discharge from the Hospital

1. If a patient is to be discharged from the hospital following sedation, then the patient must be discharged following evaluation by a physician or the patient may be discharged by a nurse following the sedation standardized procedure.
2. Prior to the administration of any sedation or any other mind-altering medication, arrangements must be made to have a responsible adult take the patient home upon discharge.
3. In addition to the transfer criteria described above, if a patient is to be discharged by a registered nurse following the standardized procedure then the following criteria must be met:
    a. Last dose of depressant drug administered at least 45 minutes prior to discontinuing protocol or discharge from the hospital if IV and 30 minutes if IM.
    b. Last dose of Benzodiazepine administered at least 45 minutes prior to discontinuing protocol or discharge from hospital.
    c. Last dose of Valium given at least 45 minutes prior to discontinuing protocol or discharge from hospital.
    d. Last dose of narcotic antagonist (naloxone) or Benzodiazepine antagonist (flumazenil) administered at least 60 minutes prior to discontinuing protocol or discharge from hospital.
    e. Patients receiving moderate sedation or anesthesia must be discharged with an accompanying responsible adult.
    f. A discharge instruction given to patient and/or patient's family.

PI REPORTING REQUIREMENTS:

1. Cases in which Narcan or Flumazenil is administered.
2. Cases requiring assisted ventilation.
3. Unanticipated hospital admissions related to moderate sedation
4. Cases in which the SaO2 is less than 90% for more than five (5) minutes, or if the SaO2 is 80% at any time.
5. Cases in which there is hemodynamic instability defined as a 20% change from baseline in blood pressure or heart rate and/or the occurrence of new atrial or ventricular arrhythmias.
6. Deaths related to sedation.
7. Occurrences of non-compliance to the sedation policy.

Definitions

Term	Definition
General anesthesia	A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory support could be impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. For example, a patient undergoing major abdominal surgery involving the removal of a portion or all of an organ would require general anesthesia in order to tolerate such an extensive surgical procedure. General anesthesia is used for those procedures when loss of consciousness and analgesia is required for the safe and effective delivery of surgical procedure.
Regional anesthesia	The delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks, is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required. Given the potential for the conversion and extension of regional to general anesthesia in certain procedures, it is necessary that the administration of regional and general anesthesia be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).
Monitored anesthesia care (MAC)	Anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia as defined by the regulations at §482.52(a). Indications for MAC depend on the nature of the procedure, the patient's clinical condition, and/or the potential need to convert to a general

Deleted: is often

Deleted: services;

	or regional anesthetic. Deep sedation/analgesia is included in MAC.
Deep sedation/analgesia	A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Because of the potential for the inadvertent progression to general anesthesia in certain procedures, it is necessary that the administration of deep sedation/analgesia be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).
Moderate sedation/analgesia	A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. CMS, consistent with ASA guidelines, does not define moderate or conscious sedation as anesthesia (71 FR 68690-1).
Minimal sedation	a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. This is also not anesthesia.
Topical or local anesthesia	The application or injection of a drug or combination of drugs to stop or prevent a painful sensation to a circumscribed area of the body where a painful procedure is to be performed. There are generally no systemic effects of these medications, which also are not anesthesia, despite the name.

Associated Policies/Plans/Protocols/Procedures/Forms/Links

Title	**Number**	**Location** *(Hyperlink)*
Dynamic Health- Using the Richmond Agitation Sedation Scale in Adults		https://www.dynahealth.com/nursing-skills/using-the-richmond-agitation-sedation-scale-in-adults

Dynamic Health-Monitoring Moderate Sedation in Pediatric Patients		https://www.dynahealth.com/nursing-skills/monitoring-moderate-sedation-in-pediatric-patients
Dynamic Health-Monitoring Moderate Sedation in Adults		https://www.dynahealth.com/nursing-skills/monitoring-moderate-sedation-in-adults

ATTACHMENTS:

Attachment A – Discharge/Transfer Assessment-Aldrete Score
Attachment B – ASA Physical Status Classification System and Richmond Agitation Sedation Scale (RASS)
Attachment C – Medical Staff Credentialing Criteria for Moderate sedation
Attachment D – Adult & Pediatric Moderate and deep Sedation Drugs
Attachment E – Short Form History & Physical Examination and Sedation Pre-Sedation Assessment

References

CMS Conditions of Participation for Hospitals, Anesthesia Services: Appendix A CFR482.52
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R74SOMA.pdf

Joint Commission Provision of Care, Treatment, and Services PC.03.01.01 , PC.03.01.03, PC.03.01.05, PC.03.01.07, PC.01.01.01 EP 5, and Record of Care RC.02.01.03

Attachment A

Discharge/Transfer Assessment

Aldrete Post Anesthesia Recovery Scoring	
Criteria	**Definitions**
Activity	2 - Able to move 4 extremities 1 - Able to move 2 extremities 0 - Able to move 0 extremities
Respiration	2 - Able to deep breath/cough 1 - Dyspnea or limited breathing 0 - Apneic
Cardiovascular	2 - BP ± 20% pre-anesthetic level 1 - BP ± 20-50% pre-anesthetic level 0 - BP ± 50% pre-anesthetic level
Color	2 - Pink or normal 1 - Pale or dusky 0 - Cyanotic
Consciousness	2 - fully awake 1 - arousable on calling 0 - not responding For children under 12 months of age: 2- fully awake / strong cry 1- Arousable / weak cry 0- Not Responding

Attachment B

The ASA Physical Status Classification System	
ASA Classification	**DISEASE STATE**
ASA CLASS I	**A normal healthy patient. No organic, physiologic, biochemical, or psychiatric disturbance.** **Nurse may monitor**
ASA CLASS II	**A patient with mild to moderate systemic disease.** **1. None or only slightly limited organic heart disease** **2. Mild diabetes controlled with oral medication** **3. Essential hypertension controlled with medication** **4. Anemia** **5. Chronic bronchitis** **Nurse may monitor after evaluation precludes the necessity of anesthesia**
ASA CLASS III	**A patient with severe systemic disease.** **1. Diabetes, well controlled with insulin or whom restoration of normal diet will aid in diabetic control** **2. Immunosuppressed** **3. Moderate degree of pulmonary insufficiency** **4. Stable coronary artery disease** **5. Asthma under treatment** **6. Extreme obesity** **Nurse may monitor after evaluation precludes the necessity of anesthesia**
ASA CLASS IV	**A patient with severe systemic disease that is a constant threat to life.** **1. Organic heart disease showing marked signs of cardiac insufficiency.** **2. Persistent angina syndrome** **3.Active myocarditis** **4. Advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency** **Shall be monitored by anesthesia**
ASA CLASS V	**A moribund patient who is not expected to survive for 24 hours with or without the operation** **Shall be monitored by anesthesia**

Score		Description
+4	Combative	Overtly combative, violent, immediate danger to staff
+3	Very Agitated	Pulls or removes tube(s) or catheter(s); aggressive
+2	Agitated	Frequent non-purposeful movement, fights ventilator
+1	Restless	Anxious but movements not aggressive vigorous
0	Alert and Calm	
-1	Drowsy	Not fully alert, but has sustained awakening (eyeopening/eye contact) to (voice ≥10 seconds)
-2	Light Sedation	Briefly awakens with eye contact to voice (<10 seconds)
-3	Moderate Sedation	Movement or eye opening to voice (but no eye contact)
-4	Deep Sedation	No response to voice, but movement or eye opening to physical stimulation
-5	Unarousable	No response to voice or physical stimulation **If RASS is -4 or -5 STOP sedation and notify MD**

Attachment C

a.

Deleted: **MEDICAL STAFF CREDENTIALING CRITERIA FOR SEDATION¶**
Sedation or Analgesia¶
¶
Moderate Sedation¶
¶
Separate privileges to be granted for the categories of adult and pediatric (< 15 years) moderate sedation or analgesia based on documentation of current competency.¶
Documentation of review of the current medical staff moderate sedation policy;¶
Documentation of training, experience and current competence related to the use of moderate sedation or analgesia, and successful performance of at least four (4) moderate sedation/analgesia cases in the last two (2) years for each category of moderate sedation or analgesia applied for;¶
Documentation of relevant training and experience, and the following criteria has been met:¶
Attendance at an El Centro Regional Medical Center-sponsored or CME program on moderate sedation/analgesia or review of the videotape of such conference and achievement of a score of 85% or higher on the moderate sedation/analgesia post-test, and;

Deleted: <#>Documentation of successful completion of a total of four (4) moderate sedation/analgesia cases for each category under the direct supervision of an El Centro Regional Medical Center practitioner holding appropriate clinical privileges in moderate sedation. If applying for both categories of moderate sedation/analgesia, a total of six (6) cases will satisfy this requirement.¶

Deleted: ***Deep Sedation or Analgesia¶***
¶
Separate privileges to be granted for the categories of adult and pediatric (< 15 years) deep sedation or analgesia based on documentation of current competency;¶
Current ACLS provider card *(PALS or NALS as appropriate)*; or Board Certified or fully trained in an ABMS approved residency in Emergency Medicine, Anesthesiology or Critical Care Medicine;¶
Documentation of review of the current medical staff moderate sedation policy;¶
Documentation of training, experience and current competence related to use of deep sedation/analgesia, and successful performance of at least four (4) deep sedation/analgesia cases in the last two (2) years for each category of deep sedation or analgesia applied for, **or**; ¶
Documentation of relevant training and experience, and the following criteria has been met:¶
Attendance at an El Centro Regional Medical Center - sponsored or CME program on deep sedation/analgesia or review of the videotape of such conference and achievement of the score of 85% or higher on the deep sedation/analgesia post-test, and;¶
Documentation of successful completion of four (4) deep sedation/analgesia cases in each category applied for under the direct supervision of an El Centro Regional Medical ...

ADULT MODERATE SEDATION MEDICATIONS

Dosage Guidelines – Actual drug dosages to be determined by the practitioner ordering the drug and titrated to effect. **(Rev 03/23)**

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations
Diazepam IV (Valium®)	2 mg-5 mg q 5 min.; (usual maximum dose of 10mg) [Vial conc. = 5 mg/ml]	2-5 min	10-30 min	2-6 hours	-Slowly over 1-2 min/ each 5mg. Repeat q 5-10 min. -Maximum dose: 10mg -Administer slow IV push (undiluted); may flush with 5ml N.S.	- Drowsiness, rash, thrombosis & phlebitis @ IV site, slurred speech, nausea, bradycardia, hypotension, resp. depression, blurred vision - Additive effects may be seen if other sedative meds (e.g. narcotics) are given. - *Reversal agent* = Flumazenil (Romazicon®).	- To reduce reactions (burning, pain) at the IV site, give slowly (5mg/1-2min). Avoid small veins. Solution is unstable; do not mix with any other drugs. Admin. undiluted, IV solution flowing in IV line. - Rarely used now for moderate sedation procedures. - Elderly patients may require reduced dosages.
Etomidate IV (Amidate®)	*Procedural* sedation dose: 0.15 mg/kg. May repeat 0.05 mg/kg every 3-5 min. *General anesthesia:* 0.3 mg/kg (usual dose) decrease for elderly. Maximum usual dose 20mg. [Vial conc. = 2 mg/ml]	30 – 60 sec.	~ 1 min.	3 – 5 min.	-No problem identified with single dose. -Excellent hemodynamic stability. -Administer slow IV push over 30 sec. – 1 minute. Rapid acting hypnotic medication.	- GI: nausea and vomiting, - Neuromuscular: local pain at injection site (> 30%), transient skeletal movements, muscle spasms, myoclonus in 33%	- Hypnotic drug used for induction agent (procedures) or to intubate patients (RSI), often with rocuronium. - Less cardiovascular depression.
Fentanyl IV (Sublimaze®)	Loading (initial) dose 50 – 100	0.5-1 min	1-1.5 min	30-60 min	- Slowly over 1 minute into infusing line (max. rate of	- Resp. depression, apnea, rigidity, bradycardia, hypotension, dizziness,	- Rapid IV administration may cause seizures, apnea, skeletal and chest wall muscle rigidity.

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations
	mcg or up to 0.5-1 mcg/kg; then 12.5mcg - 50 mcg q 5-10 min. (usual dose) [Vial conc. = 50 mcg/ml]				25mcg-50mcg /minute). Usual maximum: 100 mcg initial, then 50 mcg each dose PRN pain. - Never more than 100mcg per each dose. Max. total dosage of 200mcg in 1 hr.	drowsiness, blurred vision, n & v, laryngospasm and diaphoresis. - Doses of > 50mcg IV may cause adverse effects as listed above. - *Reversal agent* = Naloxone (Narcan®).	- Should be given with caution to patients with neuromuscular diseases, myasthenia gravis, etc. - Short-acting analgesic, less sedation activity.
Ketamine IV (Ketalar®)	**Refer dosing guidelines for Moderate and Deep Sedation Procedures to the Table below: Adult Deep Sedation Medications.**						
Midazolam IV (Versed®)	Loading (initial) dose 2 – 4 mg. Less for elderly: 1 mg -2 mg. Repeat q 2-5 minutes (up to 7 mg total usual dosage) [Vial conc. = 1 mg/ml]	1-5 min.	10-15 min	1-2.5 hours	-Titrate to patient response. -Never administer in bolus. Administer dose over 1-2 min into infusing line with IV solution flowing. Wait 2 min. to evaluate effects. - Maximum individual initial dose generally 4 mg, often less. Administer undiluted at 1mg/minute IV rate.	- Fluctuation in vital signs, apnea, decreased respirations, hypotension, hiccoughs, N&V, coughing, oversedation, headaches, drowsiness, confusion, retrograde amnesia, restlessness, nightmares, excessive salivation, warm or cold feeling at injection site. - ***Monitor pt. constantly*** for early signs of resp. distress during procedure and recovery phases. - *Reversal agent* = Flumazenil (Romazicon®).	- Hypotension may be more common when patient has also received a narcotic. * Elderly and debilitated clients require lower doses and are more prone to side effects. (AORN recommends decreased doses for those over age 60). - Use with caution when severe electrolyte disturbances are present. Additive effects may be seen if other sedative meds (e.g. narcotics) are given.
Morphine IV	1 mg - 4 mg q 5-15 min. (usual dose 2 – 4 mg)	1-2.5 min	10-20 min	1-2 hours	-Slowly at 1mg/minute into infusing IV line. May repeat every	- Nausea and vomiting, drowsiness, dizziness, injection site pain or mild burning, agitation, headache, flushing,	- Rapid administration increases the risk of adverse effects.

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations
	[Vial conc. = 2 or 4 mg/ml]				15 minutes. -Maximum: generally 10 mg in 60 minutes.	hot flashes, itching, paresthesia, constipation, abnormal vision, fatigue. - *Reversal agent* = Naloxone (Narcan®).	- Elderly and debilitated clients require lower doses and are more prone to side effects. - Additive effects seen if other sedative meds are given. Analgesic effect mainly. - Rarely used now for procedural sedation/analgesia.

ADULT DEEP SEDATION MEDICATIONS

Dosage Guidelines – Actual drug dosages to be determined by the practitioner ordering the drug and titrated to effect. (Rev 03/23)

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations
Ketamine IV (Ketalar®)	IV: initial: **1-2 mg/kg over 1-2 minutes.** May repeat **0.5 – 1.5 mg/kg every 5-10 minutes PRN sedation. Usual max. dose = 2mg/kg, or Usual max. rose = 50mg. Older patients = additional doses to be** 1/3 **to ½ of the initial dose.** **- Note:** If other sedative meds are given,	30 Sec.	IV: 1-5 min. IM: 5-30 min. Intra-nasal: 10-15 min.	5-15 min.	- Do not admin. IV rate faster than 1 min., or rate max. of 0.5mg/kg/min. May prefer admin. over 2 minutes. - May give undiluted through an IV line with flowing IV solution. - Resuscitative equipment must be available for use.	-Emergence reactions : prolonged emergence from anesthesia (12%), delirium, dreaming, vocalizing, hallucinations, akathisia, nightmares, anxiety. - Too rapid IV administration may result in respiratory depression. -Hypertension, Tachycardia - Hypnotic, "glassy look" seen -Hypotension (Catecholamine depleted)	- To decrease the emergence reactions (although rare), may consider premedication with a benzodiazepine (ex. Midazolam). - Apnea may be seen with large doses or rapid administration. - Used for procedures involving stitches or sutures. - MUST be administered (IV route) only by physicians with hospital approved/ proven competency.

	dosage may need to use lower doses (additive effect). [Vial conc. = 10 mg/ml]					-Potentiates other sedatives, hypnotics, and opioids. -Increases ICP, IOP -Increases airway secretions -Heightens laryngeal reflexes -Diplopia, nystagmus GI: anorexia, nausea, vomiting	
Ketamine IM	3 – 9 mg/kg 4 – 5 mg/kg Ped. [Vial conc. = 50 mg/ml]	3-4 min	5-20 min.	12-25 min	- Inject deep IM into a large muscle mass.	- See above reactions.	If IV site not available. - MUST be administered only by physicians with hospital approved/ proven competency.
Propofol IV (Diprivan®)	**- Initial (usual):** 20-50 mg IV push over 20-30 seconds. May repeat dose every 2-3 minutes PRN deep sedation. - *Or:* 0.5-1 mg/kg IV push (less for elderly). **- Total max dose (usual):** 200mg.	30 sec.	45-60 sec.	3-10 min. (dose-dependent	**- Initial (usual):** 20-50 mg IV push over 20-30 seconds. - Can be titrated for moderate-deep sedation with lower-doses (along with opiates and/or benzodiazepines). - MUST be administered only by physicians with hospital approved/ proven competency.	- Propofol may induce respiratory depression quickly. - This can frequently produce compromises in cardiovascular function. - May cause hypotension, apnea (lasting 30-60 sec), bradycardia, dystonic movements. - IV irritation common (may add lidocaine 1% 1 ml to syringe to reduce this). - No reversal agent for propofol overdose. Treatment is	- MUST have resuscitative equipment readily available, and be ready to mechanically ventilate and suction patient if needed. Propofol creates an hypnotic, anesthesia, sedative state. Fast-acting. - MUST have licensed staff readily available to assist patient. - Patient MUST have cardiac monitor and O2 sat. during procedure. - Coughing noted after intubation. - Use IV fat emulsion tubing. - Recovery time may be quicker (15-20 min.). - MUST be administered only by physicians with hospital approved/ proven competency.

	[Vial conc. = 10 mg/ml]					symptomatic and supportive.	

PEDIATRIC MODERATE SEDATION MEDICATIONS

Dosage Guidelines – Actual drug dosages to be determined by the practitioner ordering the drug and titrated to effect. (Rev 03/23)

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations
Diazepam IV (Valium®)	**Moderate sedation dose:** *** Oral:** 0.2-0.3mg/kg (max. 10mg) 45-60 min. prior to procedure. *** IV:** 0.25mg/kg; may repeat q 15-30 min. (max. total dose = 0.75mg/kg, or 5-10mg), depending on patient age/wt. [Vial conc. = 5 mg/ml]	3-5 min	10-30 min	2-6 hours	-Slowly over 1-3 min. Do not exceed 5mg/min. -Rapid IV push may cause sudden resp. depression, apnea, or hypotension. Do not use small veins. Admin. slow IV push (undiluted); may flush with 5ml N.S. - If given with narcotic reduce narcotic dose.	-Drowsiness, rash, thrombosis & phlebitis @site, slurred speech, nausea, bradycardia, hypotension resp. depression, blurred vision. -Additive effects may be seen if other sedative meds (e.g. narcotics) are given. - *Reversal agent =* Flumazenil (Romazicon®).	-To reduce reactions at the IV site (burning, pain), give slowly (1-3 min). -Administer undiluted, IV solution flowing in IV line. - Solution is unstable; do not mix with any other drug. - Diazepam is not used much any longer for sedation procedures, due to other mediations available.
Etomidate IV (Amidate®)	***Procedural* sedation dose:** 0.1-0.3 mg/kg. usual initial dose 0.2 mg/kg. May repeat 0.1-0.2 mg/kg every 3-5 min.	30 – 60 sec.	~ 1 min.	3 – 5 min.	-No problem identified with single dose. -Excellent hemodynamic stability. -Administer slow IV push over 1 minute. Rapid acting hypnotic medication.	- GI: nausea and vomiting, - Neuromuscular: local pain at injection site (> 30%), transient skeletal movements, muscle spasms, myoclonus in 33%	- Hypnotic drug used for induction agent (procedures) or to intubate patients (RSI), often with rocuronium. - Less cardiovascular depression. - MUST be administered by the physician.

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations
	General anesthesia: 0.2-0.4 mg/kg (usual dose), Maximum usual dose 20mg. [Vial conc. = 2 mg/ml]						
Fentanyl IV (Sublimaze®)	Loading dose up to 1-2 mcg/kg. Then 12.5-50 mcg or 0.5-1 mcg/kg every 5-10 minutes PRN pain. Usual max. dose 50 mcg. [Vial conc. = 50 mcg/1 ml]	0.5-1 min	1-1.5 min	30-60 min	- Slowly IV over 1-3 minutes into infusing line (max. rate of 25 mcg-50 mcg / minute). Usual maximum: 50 mcg initial, then may repeat ½ initial dose every 3-5 min. PRN pain control.	- Resp. depression, apnea, rigidity, nausea, vomiting, anorexia, bradycardia, hypotension, dizziness, drowsiness, blurred vision, laryngospasm and diaphoresis. - Doses of > 50mcg IV may cause adverse effects as listed above. - *Reversal agent =* Naloxone (Narcan).	- Rapid IV administration may cause seizures, apnea, skeletal and chest wall muscle rigidity. - Should be given with caution to patients with severe bowel obstruction. - Short-acting analgesic, less sedation activity.
Ketamine	***Procedural* sedation dose: IV:** 1-1.5 mg/kg usual dose. May repeat dose of 0.5-1 mg/kg every 5-15 min. PRN	IV: 30 sec. to < 1 min. IM: 3-4 min. Intra-nasal:	1-5 min.	IV: 5-10 min. IM: 12-25 min.	- Administer max. IV rate of 0.5 mg/kg/min. Usual rate 2-3 min. - Too rapid IV administration may result in respiratory depression - Additional may repeat	- Too rapid IV administration may result in respiratory depression. – CNS (12%): Dizziness, feeling of unreality, mood	- Contraindicated for children < 3 months of age. Caution in child < 2 years age. - MUST be administered (IV route) by the physician.

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations
	sedation. Max dose of 2 mg/kg. **IM:** 4-5 mg/kg; may repeat dose of 2-4 mg/kg IM 10 min. later PRN sedation.	5-8 min.			doses of 0.5-1 mg/kg/dose IV PRN sedation.	changes, dreamlike state, agitation. GI: anorexia, nausea, vomiting. Respiratory depression, apnea.	
Morphine IV	***Procedural* sedation / analgesic dose:** 0.05-0.1 mg/kg 5 min. before procedure. May repeat 0.05-0.2mg/kg/dose every 15 min. PRN pain. (usual max. dose = 2 mg), depending on patient age/weight.	1-3 min.	10-20 min	3-5 hours	- Administer slowly at 1 mg/ min. (max. rate) into infusing IV line. - Push slowly into infusing IV line. May repeat every 15 minutes.	- Nausea and vomiting, drowsiness, dizziness, injection site pain or mild burning, agitation, euphoria, headache, flushing, hot flashes, itching, paresthesia, emotional liability, hypotension, abnormal vision, fatigue.	- Rapid administration increases the risk of adverse effects. Debilitated patients require lower doses and are more prone to side effects. - Additive effects seen if other sedative meds are given. - Rarely used now for procedural sedation/analgesia.
Midazolam (Versed®)	***Procedural sedation*: Oral:** 0.3-0.5mg/ kg PO (max dose 15mg) **IV:** 0.05 - 0.1mg/kg I.V. (usual max. 2mg each	10-30 min. 1-5 min.	1 hour 5-10 min.	2 hours 20-30 min	-Titrate to patient response. Administer dose over 2 min into infusing line with IV solution flowing. Wait 2 min. to evaluate effects. - Max. each dose generally 2mg.	-Apnea, oversedation, syncope. Depression of hypoxic ventilatory response, decreased respirations. - Anxiety or restlessness may be seen after oral dosing.	- Monitor patient constantly for early signs of resp. distress during procedure and recovery phases. - Additive effects seen if other sedative or opiate meds are given.

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations
	dose); (up to 7mg usual <u>total</u> dose), depending on patient age/weight. [Vial conc. = 1 mg/ml]				Administer undiluted at 1mg/minute IV rate.	- *Reversal agent =* Flumazenil (Romazicon®]).	
Propofol IV (Diprivan®)	***Repeated IV bolus method:*** Usual initial dose: 1 mg/kg (range 1-2 mg/kg). Follow initial dose with 0.5 mg/kg every 3-5 min. PRN adequate level of sedation. [Vial conc. = 10 mg/ml]	< 1 min.	1 min.	5-15 min.	- To reduce pain associated with propofol injection, use larger veins and add 1 ml of lidocaine 1% to the preparation. - Administer slow IV push undiluted, over 20 – 30 seconds. - Do not use filter needle.	- May cause decrease in blood pressure, respiratory depression, injection site pain.	- Avoid in patients with egg or soy allergies. Highly lipophilic. - MUST be administered by the physician. - Hypnotic / anesthesia effect.

REVERSAL AGENTS – MODERATE SEDATION

Dosage Guidelines – Actual drug dosages to be determined by the practitioner ordering the drug and titrated to effect. (Rev 03/23)

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations

Naloxone (Narcan®)	**Adult:** -Initial dose: **0.2mg-1mg IV; may be repeated at 2-3 min. intervals PRN oversedation or decreased resp.** - **Pediatric: Initial dose:** 0.01 mg/kg IV (approx. 0.1-0.4mg dose); then repeat every 2-3 min. PRN. [Vial conc. = 0.4 mg/ml or 1mg/ml] [Syringe: 2 mg/2ml]	IV: 2 min.	5-15 min.	20-60 minutes -Since the duration of opiates is longer than naloxone, the dose of reversal agent often may have to be repeated.	- May administer undiluted IV push at a rate of 0.4 mg over 15 seconds for narcotic OD. - For the acute narcotic OD admin. 1-2mg IV push over 30 sec. - Not recommended for use in neonates. **Note:** 0.2-0.4 mg dose = partial reversal of opiate medication; a 1-2 mg dose = complete reversal of opiate. - The SC or IM route may be used if IV not available.	- Nausea and vomiting, sweating, hypertension, tremors, sweating due to reversal of narcotic depression. - If used post-operatively, excessive doses may cause v-tach. and or v-fib. arrhythmias, hypo- or hypertension, pulmonary edema and seizures. (Infrequent). **- Note:** excessive dose of naloxone (1 mg or more) will cause complete reversal of narcotic medication. This may cause patient to be in pain again.	***- The duration of the effects of the narcotic may exceed the effects of naloxone.*** May need to re-administer med. - More than one dose may be necessary to counteract the effects of the narcotic (decreased respirations and/or oversedation, etc). - Observe client closely - May cause narcotic withdrawal symptoms in chronic narcotic users. - Excess naloxone dosage may cause post-op pain to reappear (due to opiate med reversal). ***-Reversal agent (antidote) for:*** **narcotic analgesics** (Fentanyl, hydromorphone, Meperidine, morphine).

Medication	Dose & Frequency	Onset	Peak	Duration	Admin. Techniques	Potential Adverse Reactions	Special Prescriber / Nursing Considerations
Flumazenil (Romazicon®)	**- Adults: initial dose** 0.2 mg given IV over 15 seconds. May be repeated after 45-60 sec.; usual total max. dose = 0.6-1 mg. May give 0.5mg/dose in acute benzodiazepine O.D. (over 30 sec). **Pediatric: initial dose** 0.01mg/kg given over 15 sec. (max. each dose of 0.2mg). May be repeated after 45-60 sec. [Vial conc. = 0.1 mg/ml]	1-2 minutes	6-10 min.	-The duration is usually less than 1 hour; and is related to the plasma levels of the benzodiaz meds given. The dose of reversal agent often may have to be repeated.	- May administer 0.2mg slow IV push (undiluted) over 15 sec. - The 1-min wait between doses may be too short for high-risk pts., as it takes 6-10 min. for single dose to reach full effects. Thus, slow rate in high-risk as either dose of long action or large dose of short acting benzodiazepines may exceed that of Flumazenil. - Repeat dose at 20 min. intervals as necessary. Give through "free running" large IV to decrease pain at site. - Doses larger than a total of 3mg do not produce additional effects.	- The dose of flumazenil should be reduced to 40%-60% of normal in clients with severe hepatic dysfunction. - May cause pain at injection site. Admin. into an IV line with flowing IV solution. - Fatigue, dizziness, anxiety, agitation, and headache may occur. - Chronic Benzodiazepine users may experience withdrawal symptoms. - Seizures may occur in pts on anti-seizure meds and also may occur at random. - The 0.2 mg dose is a "partial reversal" dose (adults). - Complete and total reversal may require larger or additional doses (0.5-3 mg total).	***- The duration of the effects of the benzodiazepine may exceed the effects of flumazenil.*** - The use of flumazenil has been associated with the occurrence of seizures. Most frequent with patients on benzodiazepines long term. - More than one dose may be necessary to counteract the effects of the benzodiazepine (decreased respirations and/or oversedation, etc.). - Excess flumazenil dosage may cause anxiety or agitation to reappear (due to benzo. med reversal). - Stable only of 24 hours when mixed with NSS, LR or D5W. ***- Reversal agent (antidote) for:*** **benzodiazepine sedatives** (diazepam, lorazepam, midazolam).

Medical References:

1. Alameda County Medical Center, Moderate Sedation Policy, 1999
2. American Pharmaceutical Association, Drug Information Handbook 14th Ed., 2006-2007, Lexi-Comp.

3. EM Daily, Back to Basics: Procedural Sedation Cheat Sheet, Jan. 2018. www.emdaily.cooperhealth.org/content/back-basics-precedural-sedation-cheat-sheet
4. Lexi-Comp Drug Information 2022, www.lexi-comp.com.
5. Gahart, B., Nazareno, A., Intravenous Medications, 27th Ed., 2011
6. Medscape Drug Information, 2015, www.reference.medscape.com/drug343099.
7. Taming the SRU, Procedural Sedation and Analgesia, Jan. 2017, www.tamingthesru.com/proceduralsedation
8. Texas Children's Hospital, Medications for Procedural Sedation, May 2014.
https://www.texaschildrens.org/sites/default/files/uploads/documents/outcomes/standards/Procedural%20Sedation%20Guidelines

PHYSICIAN SEDATION AND H&P FORM

Pre-Procedure Diagnosis: | **Indication(s):**

Procedure Planned:

PRE-PROCEDURE MEDICAL ASSESSMENT

Prior Sedation/Anesthetic History: ❑ No ❑ Yes, Explain:_____

❑ Current/Past Cardio/Pulmonary Problems:_____

❑ CABG ❑ COPD ❑ Diabetes ❑ Hypertension ❑ Neuro Impairment

❑ Asthma ❑ Bleeding History ❑ Depression/Anxiety ❑ Sleep Apnea

ASA: ❑ 1-Normal Healthy ❑ 2-Mild Systemic Disease ❑ 3-Severe systemic Disease ❑ 4-Incapacitating Disease ❑ 5-Moribund

Airway Assessment: CLASS ❑ I ❑ II ❑ III ❑ IV *(SEE DIAGRAM ON BACK PAGE)* ➠

Pre-Sedation Assessment:

Time: B/P: HR: RR: O2Sat:

❑ Medication Reconciliation Form Reviewed Allergies: ❑ NKA

❑ Results of Pertinent Diagnostic Testing Reviewed

Heart: ❑ WNL Other:

Lungs: ❑ WNL Other:

Abdomen: ❑ WNL Other:

NPO Status: ❑ NPO – 8 hours for solids, 4 hours for clear liquids

NPO Status: ❑ Other:_____

❑ Procedure Risks, Indications, Alternatives and sedation discussed with patient

Physician Sedation Plan: ❑ Demerol ❑ Fentanyl ❑ Morphine ❑ Versed ❑ Valium ❑ Other

❑ Re-evaluation of Patient Immediately Prior to Sedation/Analgesia Completed

I have examined the patient prior to induction and the patient remains a candidate for the sedation planned. Immediate sedation re-assessment was completed including a review of the vital signs and airway update. Patient response to any pre-medications noted as applicable.

Physician's Signature:

Date: **Time:**

POST PROCEDURE DATA SUMMARY

Principal Diagnosis: | **Additional Diagnosis:**

Procedure Performed:

Complication(s): ❑ None

Discharged/Transferred to: ❑ SDS ❑ PACU ❑ ICU ❑ Floor ❑ Home

Condition upon Discharge: ❑ Hemodynamically Stable ❑ Procedure Tolerated Well ❑ Other

Physician's Signature:

Date: **Time:**

ECRMC

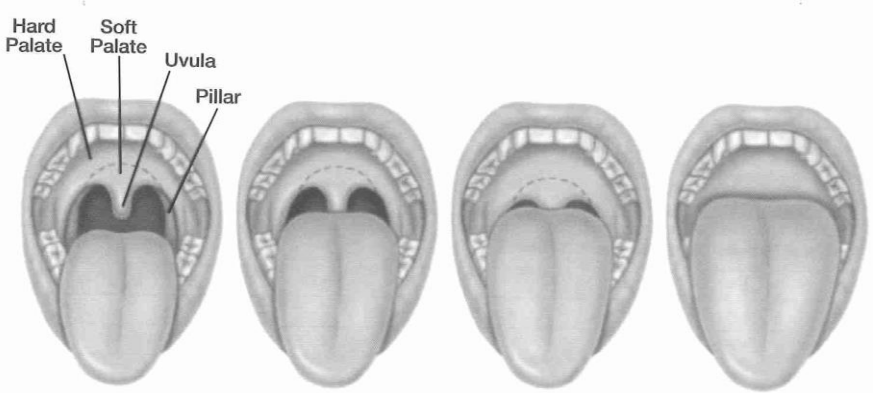
PHYSICIAN SEDATION AND H&P FORM
FORM 3405 EN
(Rev 5/15)

PATIENT INFORMATION

HP0030

PHYSICIAN SEDATION AND H&P FORM

MALLAMPATI AIRWAY ASSESSMENT



Class I **Class II** **Class III** **Class IV**

ECRMC
El Centro Regional Medical Center
An Agency Of The City Of El Centro

TO: HOSPITAL BOARD MEMBERS

FROM: Tammy Morita, Interim Chief Financial Officer

DATE: May 30, 2023

MEETING: Board of Trustees

SUBJECT: April 2023 Month and Year-to-Date Financial Statements

BUDGET IMPACT: _X_Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No

B. If yes, what is the impact amount: _____

BACKGROUND: The month of April 2023 resulted in an excess of expenses over revenues of <$1,091,087>, a negative margin of -7.9%. For YTD fiscal year 2023, the excess of expenses over revenues is <$24,467,611> or a negative margin of -19.2%.

DISCUSSION: For a more detailed description of financial performance, please see the attached Financial Report.

RECOMMENDATION: Informational

ATTACHMENT(S):

- Financial Packet for April 2023

Approved for agenda, Pablo Velez, CEO

Date and Signature: Pablo Velez | BG

April 2023 Financial Report

May 30, 2023

To: Finance Committee

From: Tammy Morita, Interim Chief Financial Officer

The following package contains:

- Balance Sheet vs. Prior Month comparison
- Operating Statement vs. Budget comparison
- Monthly Cash Flow (Fiscal Year to Date)

Balance Sheet:

a) Cash balance decreases due to the low patient collection registered during the month with the lowest since January 2021 ($8.4 million).
b) Our Third party net receivables increase since our Medicare Advance balance was paid off during the month ($639K).
c) Our Accounts payables increased 3% versus prior month since we slow down payment considering our low cash collections.
d) Days Cash on Hand decreased to 26.99 from 33.58.
e) Days in A/R decreased to 54.10 from 56.02 days. The goal is 50 days.
f) Accounts payable days are 68.89 vs. 64.42 days from previous month.
g) Current Ratio remained is 1.00.

Income Statement – Current Month Actual to Budget Comparison:

a) Our Inpatient Revenue is -11% under MTD budget due to low admissions in MedSurg and ICU (budget also includes L&D admissions).
b) Outpatient Revenues meeting MTD and YTD budget due to high Oncology volumes (ER, Calexico and El Centro clinics are 16% below MTD budget).
c) Charity and Bad debt expense with a good month for a total of $670K (our monthly average is $1.1 million so far this FY 2023).
d) Salaries and Registry (*Registered Nurses travelers*) expense lines showing savings v. MTD budget for three consecutive months.
e) Non-Medical Prof Fee expense exceeding our MTD budget mainly due to unbudgeted contracted CNO and Attorneys fees.
f) Medical supplies is 12% over MTD budget mainly due to a large urolift implants order ($171K) during the month.
g) April 2023 is becoming our best month since July 2022, ending with a Net loss of -$1.1 million (*$660K positive EBIDA*) after averaging -$2.6 million per month in prior months this Fiscal Year (High operation cost versus low volumes/patient collection and insufficient Medi-Cal supplemental payments).

Definitions:

- **EBIDA** - Earnings Before Interest, Depreciation, and Amortization.
- **Contribution Margin** – Total Revenue minus Expenses (excluding functional areas of IT, Finance, HR, and management assessments/restructuring costs).
- **EBIDA Margin** – EBIDA/Total Revenue.
- **Operating Expenses Per Day** – Total Expenses less Depreciation divided by Days.
- **Operating Revenue Per Day** – Operating Income/Days.
- **Days Cash on Hand** – Cash/Operating Expenses per Day.
- **Days Revenue in A/R** – Accounts Receivable/Operating Revenue per Day.
- **Current Ratio** – Current Assets/Current Liabilities.
- **Equity Financing Ratio** – Total Capital/Total Debt.

ECRMC BALANCE SHEET COMPARED TO PRIOR MONTH

	April 30, 2023	March 31, 2023	Variance ($)	Variance (%)
Assets				
Current Assets:				
Cash and Cash Equivalents	$ 12,821,570	$ 15,167,397	$ (2,345,827)	-15%
Net Patient Accounts Receivable	16,156,828	16,039,261	117,567	1%
Other Receivables	125,471	118,369	7,102	6%
Due from Third-Party Payors	8,410,764	6,675,023	1,735,741	26%
Inventories	3,417,718	3,415,549	2,168	0%
Prepaid Expenses & Other	4,056,267	3,513,938	542,329	15%
Total Current Assets	44,988,619	44,929,538	59,081	0%
Assets Limited as to Use				
Restricted Building Capital Fund	2,150,442	2,128,593	21,849	1%
Funds Held by Trustee for Debt Service	12,295,829	11,658,742	637,087	5%
Restricted Programs	11,497	11,497	-	0%
Total Assets Limited as to Use	14,457,768	13,798,832	658,937	5%
Property, Plant, and Equipment: Net	140,668,689	140,256,929	411,760	0%
Other Assets	262,595	262,595	-	0%
Total Assets	200,377,671	199,247,894	1,129,777	1%
Deferred Outflows of Resources				
Deferred Outflows of Resources - Pension	4,050,911	4,838,107	(787,196)	-16%
Total Deferred Outflows of Resources	4,050,911	4,838,107	(787,196)	-16%
Total Assets and Deferred Outflows of Resources	$ 204,428,582	$ 204,086,002	$ 342,581	0%
Liabilities				
Current Liabilities:				
Current Portion of Bonds	881,250	1,271,250	(390,000)	-31%
Current Portion of Capital Lease Obligations	2,022,288	2,081,820	(59,531)	-3%
Accounts Payable and Accrued Expenses	23,262,367	22,621,651	640,716	3%
Accrued Compensation and Benefits	7,980,300	6,708,404	1,271,896	19%
Due to Third-Party Payors	10,815,454	10,894,604	(79,150)	-1%
Total Current Liabilities	44,961,659	43,577,729	1,383,930	3%
Long-Term Bond Payable, Less Current Portion	113,176,065	112,867,749	308,316	0%
Capital Lease Obligations, Less Current Portion	4,069,730	4,328,307	(258,578)	-6%
Net Pension Liability	39,119,000	39,119,000	-	0%
Total Liabilities	201,326,454	199,892,786	1,433,668	1%
Deferred Inflows of Resources	7,448,200	7,448,200	-	0%
Deferred Inflows of Resources - Pension	7,448,200	7,448,200	-	0%
Total Deferred Inflows of Resources				
Net Position				
Restricted Fund Balance	17,238	17,238	-	0%
Fund Balance	(4,363,310)	(3,272,223)	(1,091,087)	33%
Total Net Position	(4,346,071)	(3,254,984)	(1,091,087)	34%
Total Liabilities, Deferred Inflows of Resources and Net Position	$ 204,428,582	$ 204,086,002	$ 342,581	0%
Days Cash on Hand	26.99	33.58		
Days Revenue in A/R	54.10	56.02		
Days in A/P	68.89	64.42		
Current Ratio	1.00	1.03		
Debt Service Coverage Ratio	(1.91)	(1.88)		

STATEMENTS OF OPERATIONS COMPARISON TO BUDGET

MTD April 30, 2023	MTD Budget	Budget Variance	% Variance Favorable/ (Unfavorable)		YTD April 30, 2023	YTD Budget	Budget Variance	% Variance Favorable/ (Unfavorable)
				OPERATING REVENUE				
$ 13,744,718	$ 24,225,693	$ (10,480,975)	-43.26%	I/P Revenue	$ 170,734,249	$ 251,682,021	$ (80,947,772)	-32.16%
42,110,131	41,407,644	702,487	1.70%	O/P Revenue	430,942,532	416,349,983	14,592,549	3.50%
55,854,849	65,633,337	(9,778,488)	-14.90%	Gross Patient Revenues	601,676,781	668,032,005	(66,355,223)	-9.93%
516,613	538,100	(21,487)	-3.99%	Other Operating Revenue	4,095,786	5,195,908	(1,100,123)	-21.17%
56,371,462	66,171,437	(9,799,975)	-14.81%	Total Operating Revenue	605,772,567	673,227,913	(67,455,346)	-10.02%
				Contractuals				
11,317,562	18,482,498	7,164,936	38.77%	IP Contractuals	132,927,836	191,933,545	59,005,709	30.74%
34,282,071	33,585,188	(696,883)	-2.07%	OP Contractuals	351,879,396	337,689,167	(14,190,229)	-4.20%
467,910	442,624	(25,286)	-5.71%	Charity	7,247,608	4,505,138	(2,742,470)	-60.87%
201,879	713,240	511,361	71.70%	Provision for Bad Debts	3,780,193	7,259,526	3,479,333	47.93%
(2,719,594)	(1,080,444)	1,639,150	151.71%	Other Third Party Programs	(15,160,539)	(10,804,436)	4,356,103	40.32%
(912,379)	(189,917)	722,462	380.41%	M/Cal Disproportionate Share	(2,639,101)	(1,899,167)	739,934	38.96%
42,637,449	51,953,189	9,315,740	17.93%	Total Deductions	478,035,392	528,683,774	50,648,382	9.58%
13,734,013	14,218,247	(484,235)	-3.41%	Total Net Revenues	127,737,175	144,544,139	(16,806,964)	-11.63%
				EXPENSES				
4,726,402	5,548,141	821,739	14.81%	Salaries & Wages	53,161,874	57,009,484	3,847,610	6.75%
227,343	536,250	308,907	57.61%	Registry	8,370,393	5,696,048	(2,674,345)	-46.95%
2,262,672	1,353,056	(909,616)	-67.23%	Employee Benefits	13,796,280	13,530,557	(265,722)	-1.96%
426,085	(36,419)	(462,504)	1269.94%	Employee Benefits - Pension GASB 68	3,362,830	(364,194)	(3,727,024)	1023.36%
1,223,459	1,152,955	(70,504)	-6.12%	Professional Fees - Medical	13,911,011	11,459,764	(2,451,247)	-21.39%
314,274	193,033	(121,241)	-62.81%	Professional Fees - Non-Med	3,213,884	2,112,774	(1,101,110)	-52.12%
2,358,782	2,515,800	157,018	6.24%	Supplies - Medical	22,936,110	25,500,357	2,564,247	10.06%
148,512	250,028	101,516	40.60%	Supplies - Non-Medical	1,893,083	2,500,280	607,197	24.29%
67,785	91,882	24,097	26.23%	Food	834,987	918,822	83,835	9.12%
712,006	719,545	7,539	1.05%	Repairs and Maintenance	7,107,058	7,205,195	98,138	1.36%
596,449	747,942	151,493	20.25%	Other Fees	6,654,474	7,479,070	824,596	11.03%
63,342	67,218	3,876	5.77%	Lease and Rental	682,102	670,538	(11,563)	-1.72%
156,491	201,297	44,806	22.26%	Utilities	1,901,625	2,012,970	111,345	5.53%
704,525	754,645	50,119	6.64%	Depreciation and Amortization	6,928,267	7,088,924	160,657	2.27%
186,364	246,898	60,534	24.52%	Insurance	2,074,040	2,468,984	394,944	16.00%
75,805	147,164	71,359	48.49%	Other Expenses	1,340,227	1,442,485	102,258	7.09%
14,250,296	14,489,436	239,139	1.65%	Total Operating Expenses	148,168,245	146,732,061	(1,436,184)	-0.98%
(516,283)	(271,188)	(245,095)	90.38%	Operating Income	(20,431,070)	(2,187,922)	(18,243,149)	833.81%
-3.8%	-1.9%			Operating Margin %	-16.0%	-1.5%		
				Non-Operating Revenue and Expenses				
31,350	(42,529)	73,879	-173.71%	Investment Income	453,110	(211,619)	664,729	-314.12%
13,649	180,864	(167,215)	-92.45%	Grants and Contributions Revenue	612,883	1,854,639	(1,241,757)	-66.95%
750	236,791	(236,041)	-99.68%	Non Operating Revenue/(Expense)	1,122,200	2,367,911	(1,245,711)	-52.61%
(620,553)	(588,838)	(31,716)	-5.39%	Interest Expense	(6,224,733)	(5,887,653)	(337,080)	-5.73%
(574,804)	(213,711)	(361,092)	-168.96%	Total Non-Operating Rev. and Expenses	(4,036,540)	(1,876,722)	(2,159,818)	-115.08%
$ (1,091,087)	$ (484,900)	$ (606,188)	-125.01%	(Deficit)/Excess Rev. Over Exp.	$ (24,467,611)	$ (4,064,644)	$ (20,402,967)	-501.96%
-7.9%	-3.4%			(Deficit)/Excess Rev. Over Exp. %	-19.2%	-2.8%		
660,076	822,163	(162,087)	-19.71%	EBIDA	(7,951,780)	8,547,740	(16,499,520)	-193.03%
4.8%	5.8%			EBIDA %	-6.2%	5.9%		

El Centro Regional Medical Center

Monthly Cash Flow

Unaudited

	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023	April 2023	Year-to-Date 2023
Cash Flow From Operating Activities											
Net Income/(Loss)	$ 156,662	$ (2,197,317)	$ (4,027,726)	$ (3,660,849)	$ (3,764,219)	$ (2,893,234)	$ (3,787,152)	$ (1,840,895)	$ (1,361,794)	$ (1,091,087)	**$ (24,467,611)**
Adjustments to reconcile net income to net cash:											
Add: Depreciation	713,569	700,147	673,369	689,612	664,873	686,394	498,399	943,829	653,550	704,525	**$ 6,928,267**
Capital Lease Interest	14,782	14,777	14,225	13,682	13,141	15,010	14,804	31,948	15,493	15,841	**$ 163,705**
Bond Interest	592,686	592,686	592,686	592,686	592,686	592,686	592,686	592,686	592,686	592,686	**$ 5,926,857**
Accounts Receivable	(2,682,761)	(979,897)	(120,054)	529,302	1,769,695	(828,416)	3,757,456	1,017,432	1,492,438	(117,567)	**$ 3,837,629**
Other Receivables	(9,724)	(12,725)	21,125	(9,193)	10,500	97	(87,187)	43,230	54,863	(7,102)	**$ 3,884**
Inventory	(32,807)	(34,588)	(30,322)	52,561	11,247	(7,239)	26,216	32,888	(4,673)	(2,168)	**$ 11,116**
Prepaid Expenses/Other Assets	(1,217,325)	63,881	103,606	(55,641)	458,711	2,039,336	247,822	(1,203,637)	139,833	(542,329)	**$ 34,259**
Accounts Payable and Accrued Expenses	362,817	1,320,217	1,499,005	3,282,337	1,014,647	1,690,818	1,086,288	313,284	(3,132,539)	(90,523)	**$ 7,346,350**
Accrued Compensation and Benefits	654,732	(1,203,861)	(520,172)	590,450	403,831	626,689	(51,938)	198,961	(1,805,451)	1,328,765	**$ 222,005**
Third-Party Liabilities	(2,543,212)	(2,855,401)	(2,949,857)	(2,150,584)	(1,272,922)	5,473,990	(1,212,664)	8,482,591	(1,735,518)	(1,814,892)	**$ (2,578,469)**
Net Pension Obligation	80,248	72,658	705,071	601,231	285,660	48,379	513,897	513,897	342,752	787,196	**$ 3,950,989**
Net Cash From Operating Activities	$ (3,910,334)	$ (4,519,423)	$ (4,039,043)	$ 475,593	$ 187,850	$ 7,444,510	$ 1,598,627	$ 9,126,215	$ (4,748,359)	$ (236,655)	**$ 1,378,980**
Cash Flow From Investing Activities											
Fixed Assets - Gross	$ (416,524)	$ (715,671)	$ (1,002,075)	$ (867,113)	$ (773,857)	$ (631,785)	$ (199,850)	$ (1,097,486)	$ (419,816)	$ (1,116,285)	**$ (7,240,462)**
Intangible Assets - Gross	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Restricted Assets	5,159,432	(67,804)	(189,066)	192,514	(653,990)	(658,057)	3,610,540	(653,131)	4,142	(658,937)	**$ 6,085,644**
Net Cash From Investing Activities	$ 4,742,908	$ (783,475)	$ (1,191,140)	$ (674,599)	$ (1,427,848)	$ (1,289,842)	$ 3,410,690	$ (1,750,617)	$ (415,674)	$ (1,775,221)	**$ (1,154,818)**
Cash Flow From Financing Activities											
Bond Payable	$ (4,632,656)	$ -	$ -	$ -	$ -	$ -	$ (3,431,219)	$ -	$ -	$ -	**$ (8,063,875)**
Capital Leases	(199,835)	(289,175.18)	(282,800)	(372,230)	(96,424)	116,743	(348,043)	290,559	(362,740)	(333,950)	**$ (1,877,896)**
Notes Payable	-	-	-	-	-	-	-	-	-	-	**$ -**
Net Cash From Financing Activites	$ (4,832,491)	$ (289,175)	$ (282,800)	$ (372,230)	$ (96,424)	$ 116,743	$ (3,779,262)	$ 290,559	$ (362,740)	$ (333,950)	**$ (9,941,771)**
Total Change In FY 2023 Cash	$ (3,999,917)	$ (5,592,074)	$ (5,512,984)	$ (571,236)	$ (1,336,422)	$ 6,271,411	$ 1,230,055	$ 7,666,157	$ (5,526,774)	$ (2,345,827)	**$ (9,717,609)**
Cash & Cash Equivalents, Beginning Balance	22,539,180	18,539,263	12,947,188	7,434,205	6,862,968	5,526,547	11,797,958	13,028,013	20,694,170	15,167,397	**22,539,180**
Cash & Cash Equivalents, Ending Balance	**$ 18,539,263**	**$ 12,947,189**	**$ 7,434,205**	**$ 6,862,968**	**$ 5,526,547**	**$ 11,797,958**	**$ 13,028,013**	**$ 20,694,170**	**$ 15,167,397**	**$ 12,821,570**	**12,821,570**

TO: HOSPITAL BOARD MEMBERS

FROM: Tammy Morita, Interim Chief Financial Officer

DATE: May 30, 2023

MEETING: Board of Trustees

SUBJECT: 2023 Fiscal Year Cash Flow Projection (Informational)

BUDGET IMPACT: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No
B. If yes, what is the impact amount: _____

BACKGROUND:

Due to major economic considerations the Hospital has been dealing with (Medi-Cal's Supplemental payment delays, Inflation, COVID-19 State regulations, new EHR implementation, Building constructions, Operational mishaps, etc.), the Medical Center Administration has the necessity to anticipate more than ever before the cash inflows and outflows for coming months to appropriately plan ahead the operation and the decision making of the Management and the Board.

The Cash Flow forecast attached to this motion sheet has the main intention of tracking our monthly cash position to implement immediate actions that will help us reduce our cash deficits foreseen in the near future.

DISCUSSION: N/A

RECOMMENDATION: N/A

ATTACHMENT(S):

- Cash Flow Forecast –CY2023

Approved for agenda, Chief Executive Officer

Date and Signature: Pablo Vela / BG

El Centro Regional Medical Center

Cash Flow Forecast dated: May 20, 2023

Actual/Projection	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Projection	Projection	Projection	Projection	Projection	Projection	Projection	Projection
Month	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Beginning Wells Fargo cash balance	**1,384**	**2,800**	**1,878**	**11,202**	**10,377**	**18,253**	**13,909**	**13,413**	**8,644**	**5,631**	**649**	**(5,805)**	**(17,373)**	**(24,530)**	**(33,145)**
Cash receipts															
Patient receipts	4,368	9,721	15,495	10,917	10,414	9,956	13,612	9,497	9,477	11,847	9,477	11,847	9,477	9,477	11,847
Cerner Implementation - AR Slowdown	-	-	-	-	-	-	-	-	-	-	-	-	(2,500)	(4,000)	(6,000)
Pharmacy receipts	20	81	57	44	69	71	54	83	60	75	60	75	60	60	75
Collector deposits	41	116	116	106	119	132	150	97	110	137	110	137	110	110	137
Rent collection	-	8	8	8	8	8	8	10	7	9	7	9	7	7	9
Cafeteria receipts	3	7	7	5	5	5	6	5	5	7	5	7	5	5	7
Other receipts	3	44	11	61	19	11	5	12	21	26	21	26	21	21	26
Total operating receipts	**4,436**	**9,977**	**15,694**	**11,141**	**10,634**	**10,183**	**13,835**	**9,703**	**9,680**	**12,100**	**9,680**	**12,100**	**7,180**	**5,680**	**6,100**
Total operating disbursements	**(5,202)**	**(12,414)**	**(12,178)**	**(11,966)**	**(11,973)**	**(14,719)**	**(17,869)**	**(13,840)**	**(14,423)**	**(17,067)**	**(14,423)**	**(18,991)**	**(14,423)**	**(14,423)**	**(17,102)**
Cash flow from operations	**(766)**	**(2,437)**	**3,516**	**(826)**	**(1,340)**	**(4,536)**	**(4,034)**	**(4,136)**	**(4,743)**	**(4,966)**	**(4,743)**	**(6,891)**	**(7,243)**	**(8,743)**	**(11,002)**
Supplemental receipts	-	-	6,167	-	9,910	1,558	1,413	-	2,757	1,085	(600)	-	1,234	1,190	384
Capital expenditures	(144)	(797)	-	(856)	-	(658)	-	(954)	(227)	(284)	(336)	(3,868)	(372)	(287)	(323)
Bond payments	-	(637)	(1,274)	-	(637)	(637)	(1,274)	(637)	(637)	(637)	(637)	(637)	(637)	(637)	(637)
Other loan payments	(16)	(51)	(36)	(35)	(57)	(69)	(53)	(63)	(18)	(23)	(18)	(23)	(18)	(18)	(23)
Transfers (to)/from bond funds	843	-	-	893	-	-	658	1,059	-	-	-	-	-	-	-
Transfers (to)/from UBS	1,500	3,000	1,200	-	-	-	2,794	-	-	-	-	-	-	-	-
Restructuring Cost	-	-	(250)	-	-	(2)	(0)	(37)	(145)	(156)	(120)	(150)	(120)	(120)	(150)
Net non-operating cash flows	**2,182**	**1,515**	**5,807**	**2**	**9,215**	**192**	**3,538**	**(632)**	**1,729**	**(15)**	**(1,711)**	**(4,677)**	**86**	**128**	**(749)**
Net cash flow excl. sweep transfers	**1,416**	**(922)**	**9,323**	**(824)**	**7,876**	**(4,344)**	**(496)**	**(4,769)**	**(3,014)**	**(4,981)**	**(6,454)**	**(11,568)**	**(7,157)**	**(8,615)**	**(11,751)**
Beginning unrestricted cash	**9,880**	**9,796**	**5,874**	**13,997**	**13,173**	**21,049**	**16,705**	**13,415**	**8,646**	**5,632**	**651**	**(5,803)**	**(17,371)**	**(24,528)**	**(33,143)**
Total net cash flow	(84)	(3,922)	8,123	(824)	7,876	(4,344)	(3,290)	(4,769)	(3,014)	(4,981)	(6,454)	(11,568)	(7,157)	(8,615)	(11,751)
Ending unrestricted cash	**9,796**	**5,874**	**13,997**	**13,173**	**21,049**	**16,705**	**13,415**	**8,646**	**5,632**	**651**	**(5,803)**	**(17,371)**	**(24,528)**	**(33,143)**	**(44,894)**
	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Key Assumptions:

Vendor payments managed week to week to ensure cash balances sufficient to meet critical payments like, payroll, bond payments, other governmental transfer requirements.

Expecting increase in operating disbursement with delayed service agreements, pending formal approvals.

Electronic health record system (EHR) implementation - additional resources to re-engage.

Executive leadership projected in April 2023

RESOLUTION NO. ECRMC 23-02

RESOLUTION OF THE BOARD OF TRUSTEES OF EL CENTRO REGIONAL MEDICAL CENTER AUTHORIZING THE OPENING OF NEW ACCOUNT WITH FIRST FOUNDATION BANK

WHEREAS, El Centro Regional Medical Center ("Hospital") has the need to open a bank account for certain funds previously deposited into Wells Fargo bank; and

WHEREAS, after research by staff, it has been determined that First Foundation bank provides the best terms for such an account.

THEREFORE, THE BOARD OF TRUSTEES OF EL CENTRO REGIONAL MEDICAL CENTER DOES HEREBY RESOLVES AND ORDERS AS FOLLOWS:

1. That the recitals set out above are true and correct.
2. That the Board of Trustees authorizes the Hospital to establish a banking resolution with First Foundation Bank.
3. That the Hospital has the authority to transact business, including but not limited to the maintenance of savings, checking and other accounts, by named officers authorized to so act on behalf of the Hospital.

PASSED AND ADOPTED at a regular meeting of the Board of Trustees of El Centro Regional Medical Center held on the 30th day of May, 2023.

EL CENTRO REGIONAL MEDICAL CENTER

By:_____
Tomas Oliva, President

ATTEST:

By: _____
Sylvia Marroquin, Vice-President

APPROVED:

By: _____
Cedric Cesena, Interim City Treasurer

STATE OF CALIFORNIA)
COUNTY OF IMPERIAL) ss
CITY OF EL CENTRO)

I, Belen Gonzalez, Board Executive Secretary of El Centro Regional Medical Center, El Centro, California, do hereby certify that the foregoing Resolution No. ECRMC 23-01 was duly and regularly adopted at a regular meeting of the El Centro Regional Medical Center, held on the 30th day of May, 2023 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAINED:

By: _____
Belen Gonzalez, Board Executive Secretary

$125,000,000
El Centro Financing Authority
Hospital Revenue Refunding Bonds
(El Centro Regional Medical Center Project)
Series 2018

REQUISITION NO. 74

U.S. Bank, N.A.

Re: Series 2018 Project Account ("Project Account") held pursuant to the Trust Agreement (defined below) relating to the El Centro Financing Authority Hospital Revenue Refunding Bonds (El Centro Regional Medical Center Project), Series 2018

The undersigned hereby states and certifies:

1. That I am the duly qualified [Authorized Medical Center Representative] of the EL CENTRO REGIONAL MEDICAL CENTER, a municipal hospital and agency of the City of El Centro duly organized and existing under and by virtue of the laws of the State of California (the "Medical Center"), and as such, am familiar with the facts herein certified and am authorized and qualified to execute and deliver this requisition.

2. I, on behalf of the Medical Center, hereby request U.S. Bank, N.A. (the "Trustee"), pursuant to that certain Trust Agreement, dated as of April 1, 2018, (the "Trust Agreement"), between the El Centro Financing Authority and the Trustee, to pay from the moneys in the Project Account established pursuant to the Trust Agreement, the amounts provided below to the payee identified below.

Payee	**Purpose for Payment**	**Amount**
El Centro Regional Medical Center	Reimbursement of project costs	$ 324,466.85

3. That the obligations in the amounts stated above have been incurred by the Medical Center and are presently due and payable and that each item thereof is a proper charge against the Project Account and has not been previously paid therefrom.

4. That there has not been filed with or served upon the City of El Centro or the Medical Center notice of any lien, right to lien or attachment upon, or claim affecting the right to receive payment of, any of the amounts payable to any of the persons named in this requisition, which has not been released or will not be released simultaneously with the payment of such obligation, other than materialmen's or mechanics' liens accruing by mere operation of law.

5. That such payments shall be made by check or wire transfer in accordance with the payment instructions set forth below and the Trustee shall rely on such payment instructions as though given by the Medical Center with no duty to investigate or inquire as to the authenticity of the payment instructions or the authority under which they were given.

Payment Instructions:

Wells Fargo Bank
297 West Main Street
Brawley, CA 92227

Routing Number – 121000248
Account Number – 4159-801596
Account Name – El Centro Regional Medical Center General Fund

Capitalized terms used and not defined herein shall have the meaning ascribed to such terms in the Trust Agreement.

Date: May 30, 2023

EL CENTRO REGIONAL MEDICAL CENTER

By: _____
Authorized Medical Center Representative

Payee	Purpose of Payment		ORIGINAL COST	VENDOR NAME	INVOICE NO.
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	ANCILLARY SERVICES BUILDING	$ 7,860.00	ATLAS ENGINEERING	3231
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 3,372.40	ATLAS ENGINEERING	3240
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 146,206.44	ETC BUILDING & DESIGN INC	APPLICATION #21 4/23
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	ANCILLARY SERVICES BUILDING	$ 152,074.06	NIELSEN CONSTRUCTION	2018-209-60
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 250.00	OSHPD	331442
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	BOILER, MEDICAL AIR & VACUUM UPGRADES	$ 250.00	OSHPD	331443
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 250.00	OSHPD	333173
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 250.00	OSHPD	333197
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 250.00	OSHPD	333198
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 250.00	OSHPD	333201
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 250.00	OSHPD	333202
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 134.65	OSHPD	333847
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 134.65	OSHPD	333849
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 134.65	OSHPD	333850
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	SPC-4D UPGRADE	$ 6,000.00	LYN INSPECTION SERVICES	17
EL CENTRO REGIONAL MEDICAL CENTER	REIMBUSEMENT FOR	ANCILLARY SERVICES BUILDING	$ 6,800.00	LYN INSPECTION SERVICES	65

SUB-TOTAL: $ 324,466.85

REIMBURSEMENT REQUEST TOTAL: $ 324,466.85