SUBJECT:	SECTION:
PROFESSIONAL PRACTICE COUNCIL NURSING PEER REVIEW	*Leadership (LD)* **Page 1 of 5**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure that the hospital, through the activities of its nursing staff, assesses the performance of individuals (employee or contractor) and uses the results of such assessments to improve care.

AFFECTED AREAS/PERSONNEL:

NURSING SERVICES; PERFORMANCE IMPROVEMENT

GOALS:

1. Improve the quality of care provided by individual nurses
2. Monitor nurses' performance
3. Identify opportunities for performance improvement
4. Identify system process issues
5. Monitor significant trends by analyzing aggregate data
6. Ensure that the process for peer review is clearly defined, fair, defensible, timely, and useful

DEFINITIONS

Peer review:

Peer review is the evaluation of an individual nurse's professional performance and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual nurse's performance, rather than appraising the quality of care rendered by a group of professionals or a system.

Peer review is conducted using multiple sources of information, including:

1. The review of individual cases;
2. The review of aggregate data for compliance with general rules of the nursing staff; and
3. Clinical standards and use of rates in comparison with established benchmarks or norms.

The individual's evaluation is based on generally recognized standards of care. Through this process, nurses receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

Peer:

A peer is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a nurse's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general nursing care, a nurse may review the care of another nurse (RN to RN). For specialty-specific clinical issues, such as evaluating the technique of a specialized procedure, a peer is an individual who is well trained and competent in that specialty.

The degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital will be determined by the ***Professional Practice Council*** unless otherwise designated for specific circumstances by nursing leadership.

Conflict of interest:

A conflict of interest exists if a member of the nursing staff is not able to render an unbiased opinion. Automatic conflict of interests would result if the nurse on the ***Professional Practice Council*** is the nurse under review. Relative conflicts of interest are due to the reviewer either being involved in the patient's care or having a familial relationship with the nurse involved, and similar situations.

It is the obligation of the individual reviewer to disclose to the peer review committee the potential conflict. The responsibility of the peer review body is to determine whether the conflict would prevent the individual from participating or the extent of the individual's participation. Individuals determined to have a conflict may not be present during peer review body discussions or decisions other than to provide information if requested.

Collaboration with Organized Medical Staff

The organized Medical Staff and Nursing Division of Sierra View Local Healthcare District (Sierra View Medical Center) support an environment of collegial relationships. To sustain this environment of continuous improvement for the quality of care offered patients at Sierra View Local Healthcare District, the V.P. of Patient Care Services will serve as chair of the Nursing Professional Practice Council. To facilitate Council meetings and Nursing Peer Review, the Chair may delegate an RN to chair the meeting. The VP of Patient Care Services will be responsible for reporting the outcomes of Nursing Peer Review activities at the Performance Improvement Committee In the event the results of the peer review require "Letters of Education", system issue identification or other corrective action, the VP of Patient Care Services will maintain responsibility for initiation and follow-up with the identified member of the Nursing Division.

Issues referred to the Nursing Professional Practice council for review from the Departments of the organized Medical Staff will be reported back to that Department through the organization's Performance Improvement Department when Nursing Peer Review is completed

POLICY:

1. All peer review information is privileged and confidential in accordance with nursing and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

2. The involved nurse will receive specific feedback on a case-by-case basis.

3. The hospital will use the nurse-specific peer review results in its annual evaluation process, and as appropriate, in its performance improvement activities. This also meets the standards established by the Leap Frog organization.

4. The hospital will keep nurse-specific peer review and other quality information concerning a nurse in a secure, locked file archived or in a secure digital file within the Performance Improvement Department. The peer review and quality information will be kept separate from the employment file. Nurse-specific peer review information consists of information related to Performance data for all dimensions of performance measured for that individual nurse.

    a. The individual nurse's role in sentinel events, significant incidents, or near misses; and or

    b. Correspondence to the nurse regarding commendations, comments regarding practice performance, or corrective action.

5. Peer review information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a nursing leader or hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to nurse-specific peer review information and only for purposes of quality improvement:

    a. Vice President, Nursing Division

    b. Vice President, Performance Improvement

    c. Department Director(s) to include Risk Management

    d. Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., The Joint Commission or state/federal regulatory bodies)

    e. Individuals with a legitimate purpose for access as determined by the Hospital CEO or designee

6. No copies of peer review documents will be created and distributed unless authorized by Vice President, Nursing Division, or per hospital policy.

CIRCUMSTANCES REQUIRING PEER REVIEW

Peer review is conducted on an ongoing basis and reported for review and action. The procedure for conducting peer review is described in the "Process and time frames" document. Evaluation of a case will be conducted through the following means:

- Through reporting processes such as occurrence reports

- When there is a sentinel event or "near miss" identified during concurrent or retrospective review
- When there is an unusual individual case or clinical pattern of care identified during a quality review

CIRCUMSTANCES REQUIRING EXTERNAL PEER REVIEW:

The ***Professional Practice Council*** will make recommendations on the need for external peer review to Nursing Leadership. External peer review will take place under the following circumstances if deemed appropriate by Nursing Leadership or by the Board of Directors. A nurse cannot require the hospital to obtain external peer review if it is not deemed appropriate by the Nursing Leadership or Board of Directors.

Circumstances requiring external peer review include:

- Litigation—when dealing with the potential for a lawsuit.
- Ambiguity—when dealing with vague or conflicting recommendations from internal reviewers and conclusions from this review will directly affect a nurse's employment.
- Lack of internal expertise—when no one on the nursing staff has adequate expertise in the specialty under review, or when the only nurse with that expertise is determined to have a conflict of interest regarding the nurse under review as described above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by nursing leadership.
- Miscellaneous issues—when the nursing staff needs an expert for purposes of establishing nursing standards.

PARTICIPANTS IN THE REVIEW PROCESS:

Participants in the review process will be selected according to the nursing policies and procedures. Medical staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities the ***Professional Practice Council*** will consider and record the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual, as long as the individual responds in the time frame outlined.

In the event of a conflict of interest or circumstances that would suggest a biased review, the ***Professional Practice Council*** and Nursing Leadership will determine who will participate in the process. Participants with a conflict of interest may not be present.

THRESHOLDS FOR INTENSIVE REVIEW:

If the results of individual case reviews for a nurse exceed thresholds established by the nursing staff (described below), the ***Professional Practice Council*** will review the findings to determine whether further intensive review is needed to identify a potential pattern of care.
Thresholds:

1. Any single egregious case;

2. Within any 12-month period of time, any one of the following criteria:

   a. Three cases rated "care inappropriate"

   b. Five cases rated either care controversial or inappropriate

   c. Five cases rated as having documentation issues regardless of care rating

PEER REVIEW FOR SPECIFIC CIRCUMSTANCES:

A request for nurse peer review can come through several sources to the Chief Nurse Executive. The Chief Nurse Executive has ultimate authority to engage and start the nursing peer review process.

PEER REVIEW TIME FRAMES:

Peer review will be conducted by the ***Professional Practice Council*** in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the PI coordinator and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability.

STATUTORY AUTHORITY:

The above policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, *et seq*. and California State SB 1157 .

ATTACHMENT A: Nursing Peer Review Case Rating Form

SUBJECT:	SECTION:
SPONSORSHIPS AND DONATIONS	***Leadership: Marketing/Community Relations***
	Page 1 of 1

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish the guidelines for hospital donations and sponsorships for community-related events, fundraisers, publications, or other similar occurrences.

POLICY AND PROCEDURE:

As a leader in the community and one of the largest employers in the area, Sierra View Medical Center is often solicited by area organizations to participate as a sponsor or donor in various community-related events, publications and/or causes.

All donations and sponsorships shall be made primarily for a public purpose, consistent with the Hospital's statutory purpose, mission statement or vision statement, and not be otherwise expressly prohibited by law. Any private benefit shall be incidental to the primary public purpose.

All donations and sponsorships should only be directed toward entities and events that are consistent with developing collaborative relationships and improving the health status and quality of life in our community. Where appropriate the hospitals name and logo should be prominently displayed by those events, publications or causes that the hospital selects for donations and sponsorships.

All requests will be directed to the Director of Marketing & Community Relations and the Chief Executive Officer for approval. The Director of Marketing & Community Relations will have the authority to approve requests up to $5,000.00; the President/CEO will have the authority to approve all other requests exceeding $5,000.00 as well as those under $5,000.00 if the Director of Marketing & Community Relations is not available for approval.

Annual sponsorships and donations will be incorporated into the budget process.

AFFECTED PERSONNEL: *ALL EMPLOYEES*

SUBJECT: **VOLUNTARY DISCLOSURE OF VIOLATIONS (REPORTABLE EVENTS)**	SECTION: **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish a process and guidelines to address potential violations of law, and to report to appropriate governmental authorities reportable events requiring the return of overpayments.

POLICY:

Sierra View Medical Center (SVMC) will report to appropriate governmental authorities any reportable events or misconduct that violates criminal, civil or administrative law, including the return of overpayments or refunds to any governmental health care program. Reporting should be within a reasonable period, but not more than sixty (60) days after determining credible evidence of a violation. Prompt reporting demonstrates SVMC's good faith and willingness to work with governmental authorities to correct and remedy problems. A reportable event may be the result of an isolated event or a series of occurrences. For guidelines that address the correction of routine processing errors, refer to the Correction of Errors Related to Government Reimbursement Policy.

DEFINITIONS:

"Reportable Events" shall mean anything that involves: (1) a substantial overpayment relating to any government health care program, or (2) a matter that any reasonable person would consider a potential violation of criminal, civil or administrative laws applicable to any governmental health care program.

"Governmental Authority" shall mean any federal, state, or local governmental authority, including but not limited to the Office of the Inspector General of the U.S. Department of Health and Human Services; the Office for Civil Rights of the U.S. Department of Health and Human Services; the U.S. Department of Justice, including the U.S. Attorney's Office; the Federal Bureau of Investigation; the Centers for Medicare and Medicaid Services; any Medicare or Medi-Cal carrier or fiscal intermediary; the California Attorney General's Office; and a State Medicaid Fraud Control Unit.

"**Governmental Health Care Program**" shall mean any health care program funded or sponsored by a governmental authority, including the Medicare program and the Medi-Cal program.

"**Law**" shall mean any statute or other law, rule, regulation, or interpretation of any governmental authority.

"**Overpayment**" shall mean the amount of money received by SVMC in excess of the proper amount due and payable under the provisions of the applicable governmental health care program.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

1. Anyone with knowledge of a potential violation of any law or requirement of a governmental health care program shall immediately report the potential violation to the Compliance Office. Such report shall include as much detail as possible, including:

   a. A description of the relevant facts, including the time, place, and persons involved; the health care program implicated, and the dollar amount, if any, involved;

   b. A description of actions taken in identifying the potential violation and any actions taken or planned to correct the potential violation.

2. The Compliance Office or designee shall be responsible for making an initial assessment of such reports. If the initial assessment of the Compliance Office indicates that there is a credible basis that the conduct or event reported may constitute a violation of law or a requirement of a governmental health care program, or may adversely affect any governmental health care program, the Compliance Officer (CO) or designee shall promptly:

   a. Inform the Chief Financial Officer (CFO), the Chief Executive Officer (CEO) and/or Board of Directors, and

   b. Coordinate an investigation of the matter, using such internal and/or external resources as the CO or designee and/or the CFO, the CEO or Board of Directors deem necessary. Such resources may include management designated by the CO and/or legal counsel or other health care experts.

3. The CO or designee and/or legal counsel will determine whether a violation occurred and, if so, whether the information relating to the violation appears to be within the scope of an on-going investigation by a governmental authority.

4. If it is determined that the violation falls within the scope of an on-going investigation, the CO or designee and /or legal counsel shall present to the investigating governmental authority relevant information pertaining to the violation. Such information shall be provided to the governmental authority without payment of any amount due as a result of the violation in anticipation that any payment due will be included in negotiations regarding the resolution of the investigation.

5. If the CO or designee and/or legal counsel determine that a violation occurred that does not appear to be within the scope of an ongoing investigation, the CO or designee shall report such violation to the appropriate governmental authority and pay the governmental authority any amount due as a result of the violation.

6. If it is determined that SVMC has received an overpayment from a governmental health care program and/or SVMC may have violated a law or requirement of a governmental health care

program, then SVMC shall promptly take all necessary steps to correct the problem to prevent recurrence.

The CFO, the CEO or Administrator and the CO are responsible for the implementation of this policy.

REFERENCES:

- Federal Register / Vol. 63, No. 35 / Friday, October 30, 1998, https://www.govinfo.gov/content/pkg/FR-1998-02-23/pdf/98-4399.pdf

CROSS REFERENCES:

- CORRECTION OF ERRORS RELATED TO GOVERNMENT REIMBURSEMENT

SUBJECT: **WAIVER OF MEDICARE CO-PAYMENTS AND DEDUCTIBLES/OFFERINGS BENEFITS**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish specific guidelines for employees when considering authorizing the waiver of Medicare co-payments and/or deductibles.

POLICY:

Sierra View Medical Center (SVMC) recognizes that there are limited circumstances under which it may be appropriate to waive Medicare co-payments and/or deductibles. However, routine waivers of Medicare co-payments and/or deductibles, or providing other inappropriate benefits to Medicare beneficiaries, could violate federal and/or state health care laws, as well as federal and/or state anti-kickback laws and regulations. As a result of the complexities of these laws and regulations, the following policy is enacted to provide employees with guidance on this subject.

Waivers of Medicare co-payments and/or deductibles as well as other benefits provided to Medicare beneficiaries are prohibited unless provided in accordance with policies outlined below, or as otherwise approved by legal counsel and the Compliance Officer (CO). Routine waivers could subject SVMC to serious legal liability, and under no circumstances will SVMC or its employees engage in any of the following activities with respect to the wavier of Medicare coinsurance and deductibles:

- Use financial hardship as a means to avoid charging Medicare patients co-payment obligations without ascertaining the patient's qualifications for such a waiver.
- Collect co-payment and deductibles only where the beneficiary has Medicare supplemental insurance coverage.
- Charge Medicare beneficiaries higher amounts than those charged to other persons for similar services (e.g., to offset the waiver of co-payment and deductible amounts).
- Fail to collect co-payment and deductibles from selected Medicare patients, such as those serviced by certain doctors, for reasons unrelated to indigence or managed care contracting.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

WAIVER OF MEDICARE CO-PAYMENTS & DEDUCTIBLES

1. Any routine or blanket waivers of Medicare co-payments and/or deductibles must receive prior approval by the Chief Financial Officer (CFO), CO and legal counsel.

2. Non-routine waiver of co-payments or deductibles on a case-by-case basis is allowed if the following criteria is met:

a. The waiver is not advertised or marketed

b. The waiver is not routinely offered

c. The waiver is made following an individualized, good faith assessment of financial need

OFFERING BENEFITS TO MEDICARE BENEFICIARIES

The following benefits for special community and affiliated groups are permissible:

1. Providing free preventative health fairs offered for the purpose of promoting community health.

2. Providing periodic social and educational sessions that include a lecture or presentation promoting preventative healthcare.

The following benefits to any group or individual are PROHIBITED:

1. Financial or monetary credits given for each inpatient or outpatient admission that can be applied as a credit toward out-of-pocket patient or organization expense;

2. A cash rebate paid to any patient for the provision or furnishing of any medical service or item;

3. Waiver or reduction of Medicare co-payment or deductible amounts in violation of this policy;

4. Waiver or reduction of Medicare co-payment or deductible amounts made as part of a price reduction agreement between the organization and a third-party payor.

REFERENCES:

- 42 U.S.C. sec. 1320A – 7(B) 2 (b), https://www.law.cornell.edu/uscode/text/42/1320a-7
- 41 C.F.R sec. 1001.952(k)(1), https://www.law.cornell.edu/cfr/text/42/1001.952
- 59 Fed. Reg. Special Fraud Alert (December 1994), https://www.govinfo.gov/content/pkg/FR-1994-12-19/html/94-31157.htm

Sierra View Medical Center

ANNUAL EVALUATION FOR THE EFFECTIVENESS OF THE ENVIRONMENT OF CARE (EC), EMERGENCY OPERATIONS PLAN (EOP) & LIFE SAFETY (LS) MANAGEMENT PROGRAMS

January 1, 2021 – December 31, 2021

This annual evaluation of the objectives, scope, performance and effectiveness of Sierra View Medical Center's Environment of Care, Life Safety and Emergency Management programs applies to Sierra View Medical Center and all affiliated properties and all locations where patient care is provided.
Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. The database provides Sierra View Medical Center with comparative data in 86 areas of performance within the Environment of Care. Sierra View Medical Center was within the national target results in 81 of those areas, the Medical Center was rated above the national target results in 3 areas with only 2 areas being rated below national target results.

I. SAFETY MANAGEMENT

A. Objective:

The objective of the Safety Management Plan is to describe processes and mechanisms by which the organization strives to provide a physical environment free of hazards and manage staff activities to reduce the risk of injuries.

B. Scope:

The Safety Management Plan and related policies and procedures extend to the Sierra View Medical Center, Wound Healing Center, Ambulatory Surgery Department, Cancer Treatment Center, Urology Clinic, Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory and Patient Accounting). The scope of the Safety Management Plan is current and appropriate.

C. Performance and Effectiveness:

The Safety Committee at Sierra View Medical Center includes members from various hospital departments including Nursing, Clinical Services, Medical Staff, Human Resources, Risk Management, Administration and Support Services. The Environment of Care/Safety and Security Manager chair the meetings. The Safety Committee meets at least on a quarterly basis.

A standard agenda is used at Committee meetings and the agenda includes reports from each of the chapters of the Environment of Care (EC). Safety Policies and Procedures are reviewed at least every three years.

All new employees attend hospital orientation, which includes Environment of Care education and training.

Environmental tours are performed routinely. The committee meets at least every quarter to review the findings of the Environmental tours. Patient care areas are inspected every six months and non-patient care areas are inspected every twelve months. The Accreditation & Regulatory Affairs Coordinator coordinates the inspections through the Huron Rounding program. Follow-up actions are taken as needed by Facilities, Environmental Services, and/or Nursing Unit and Department Directors. Documented follow-up action is maintained and stored in the Huron Rounding program

Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. 14 performance monitors were within control limits in 2021 (i.e., within one standard deviation of the database mean). 1 area rated below target results, Visitor Slips and Falls/1000 Inpatient Days. The current set of performance monitors will continue to be monitored in 2022.

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Fourteen areas of Safety performance are benchmarked. The fourteen areas focus on both patient safety and worker safety.

Significant issues addressed during 2021 in the Safety Management Program via the Safety Committee are listed below:

- Commonly cited deficiencies identified during Environmental tours include:

  a. Corridor clutter and high storage.
  b. Stained ceiling tiles.
  c. Expired supplies.

- A revised Safety Management Plan was approved and adopted in 2021. The revised plan addresses the changes within the 2021 EC Standards of The Joint Commission.

The Safety Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring Data and Benchmarking Results
- Environmental Tour Results
- Response and Tracking of recalled products and medications
- Training and Education Results
- Safety Committee Activity

D. Review of 2021 Goals:

Work to lower Patient Slips and Falls Resulting in Class IV Injuries (Major Injuries). *The facility saw a drop from the 92nd percentile to the 83rd percentile which meets National Target Results; as a result, a new goal has been added for this year.*

E. Goals for 2022:

- Work to lower Visitor Slips and Falls/1000 Inpatient Days. The current rate is the 93rd percentile. *Review and assess with Risk Management.*

II SECURITY MANAGEMENT

A. Objective:

The objective of the Security Management Plan is to establish and maintain an environment, which protects property and all staff, patients and visitors from harm.

B. Scope:

The Security Management Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, and Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Security Management Plan is current and appropriate.

C. Performance and Effectiveness:

The Security Department investigates security incidents involving patients, visitors, personnel or property. Security personnel patrol the facility on a 24 hour / 7 day per week basis. Through a risk assessment, the Environmental Safety/Security Officer has identified sensitive areas of the facility and recommended enhanced measures to increase security of those areas. An excellent working relationship is maintained with the Porterville Police Department. The Security Supervisor participates in new employee orientation with assistance from security leadership to make new staff aware of the facility and ways to avoid potential incidents.

The Safety Committee using the Osborne Engineering, Inc. Environment of Care Benchmarking database tracks performance-monitoring data. Sierra View Medical Center's security staffing level exceeded control limits (i.e., w/i one standard deviation of the database mean). Security staffing for 2021 averaged 4.47 FTE's per 100,000 square feet of buildings including parking which placed the facility at the 86th percentile.

The benchmarking database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the

Environment of Care. Thirteen areas of Security performance are benchmarked.

Significant issues addressed during 2021 in the Security Management Program via the Safety Committee are listed below:

- Review all security incident rates and statistics

- Review results of all Code Gray (Violent Patient/Visitor) and Code Strong (Hospital Lockdown) and Code Green (Missing Patient) incidents
- Revised Security Management Plan adopted to comply with the 2021 Joint Commission Standards

The Security Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring Data and Benchmarking Results
- Security Vulnerability Analysis Review
- Security Incident Reports
- Training and Education Results
- Safety Committee review of incidents
- Revised Security Management Plan adopted

D. Review of 2021 Goals:

- Work to reduce Automobile Thefts to the 50th percentile in the Osborne Engineering benchmarking database. The current rate is at the 86th percentile. *The facility not only met but exceeded this goal with no automobile thefts reported during 2021.*

E. Goals for 2022:

- Work to reduce Assault and Batteries Against Patients, Employees and Visitors to the 50th percentile in the Osborne Engineering benchmarking database. The current rate is at the 91ST percentile.
  Meet with On-Site Security to assess the current situation.
  Work with staff on to ensure they are aware of the proper time to call a Code Gray. Continue to offer Nonviolent Crisis Intervention (CPI) training to staff.

III HAZARDOUS MATERIALS AND WASTE MANAGEMENT

A. Objective:

The objective of the Hazardous Materials and Hazardous Waste Management Program is to establish and maintain the safe control of hazardous materials and to reduce the incidence of occupational illness and injury related to hazardous materials and wastes.

B. Scope:

The Hazardous Materials and Hazardous Wastes Management Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, and Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Hazardous Materials and Hazardous Wastes Management Plan remains current and appropriate.

C. Performance and Effectiveness:

Safety Data Sheets (SDS) are available on the hospital intranet in all areas of the hospital. A vendor disposes medical waste off-site and no problems were noted.

Performance monitoring data is tracked using the Osborne Engineering, Inc. Environment of Care Benchmarking database. All 12 Hazardous Materials and Hazardous Wastes performance data results were within control limits (i.e., w/i one standard deviation of the database mean)

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Eleven areas of Hazardous Materials and Wastes performance are benchmarked.

Significant issues addressed during 2021 in the Hazardous Materials and Hazardous Wastes Management Program via the Safety Committee listed below:

- Revised Hazardous Materials and Hazardous Waste Management Plan adopted
- Tulare County EH&S inspected and reviewed hazardous materials business plan and hazardous materials inventory, no violations
- Hazardous materials disposed of in 2021 maintained required manifests.

The Hazardous Materials and Wastes Management Program have been deemed effective based on the following data and criteria:

- Performance Monitoring and Benchmarking Data Results
- Training and Education Results
- Revised Hazardous Materials and Hazardous Wastes Management plan adopted
- Safety Committee Activity

D. Review of 2021 Goals:

- Work with staff to reduce the cost of Non-Hazardous (Non RCRA) Pharmaceutical Waste to the 50th percentile within the Osborne Engineering benchmark database. *The Facility was able to drop from the 77th percentile to the 51st percentile and is within the National Target Results.*

E. Goals for 2022:

Work with staff to reduce the cost of Medical Waste Disposal/Adjusted Patient Day/Quarter. The current rate is in the 64th percentile. *Meet with the Director of Environmental Services to develop a plan to reduce cost.*

IV EMERGENCY MANAGEMENT PROGRAM / EMERGENCY OPERATIONS PLAN

A. Objective:

The objective of the Sierra View Medical Center Emergency Management Program is to establish and maintain an effective response to emergencies within the organization or in the community that would suddenly and significantly affect the need for Sierra View's services, or its ability to provide these services for extended periods, up to ninety-six hours.

B. Scope:

The Emergency Operations Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, and Cardiac Cath Lab, Sierra View Community Health Center (SVCHC),

Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Emergency Management Program and Emergency Operations Plan (EOP) remains current and appropriate.

C. Performance and Effectiveness:

Real world events and performance data were reviewed and monitored for improvements in the Hospital's Emergency Management Program.

The Central California Healthcare Coalition met virtually to review and revise the Hazard Vulnerability Analysis to identify events that by scoring matrix have a potential to occur in July 2021. Representatives from Tulare County, Fresno County, Kings County, Sierra View Medical Center, Adventist Tulare Medical Center, Kaweah Health, Porterville Developmental Center, Tulare County Sheriff's Office, Red Cross and local Religious Leaders participated in the process.

Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. All Emergency Management performance data results were within control limits (i.e., w/i one standard deviation of the database mean) or exceeded database performance. In particular, Sierra View has exceptional on-site storage of potable water for use during disasters and on site food supplies.

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Nine areas of Emergency Management performance are benchmarked.

Significant issues addressed during 2021 in the Emergency Management Program via the Safety Committee are listed below:

- Emergency Management COVID 19/implementation requirements
- Hazard Vulnerability Analysis was affirmed with changes
- Participation in disaster planning with the County of Tulare Emergency Preparedness program
- California Health Alert Network (CAHAN) participation

The Emergency Management Program is deemed effective based on the following data and criteria:

BA

- Continued HRSA Grant Compliance.
- Performance Monitoring of HVA and Benchmarking Data Results
- Emergency Management Actual Events
- Training and Education Results
- Disaster Equipment owned and maintained by organization
- Hazard Vulnerability Analysis revised with changes

D. Review of 2021 Goals:

- Work to replenish the Hospital's Emergency Management supplies to ensure that items such as masks, gloves, face shields, etc. will be readily available when needed. *The facility was able to procure large amounts of these items from our Local, State and Federal partners.*

E. Goals for 2022:

- Begin working with Tulare County Public Health/Emergency Services on performing drills now that Covid is winding down

V. LIFE SAFETY MANAGEMENT

A. Objective:

The objective of the Life Safety Management Plan is for the organization to establish and maintain programs and facilities which provide a fire safe environment.

B. Scope:

The Life Safety Management Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Life Safety Management Plan is current and appropriate.

C. Performance and Effectiveness:

As per the NFPA 101 Life Safety Code, the facility is designed to protect people and property from fire and other products of combustion. This is accomplished through a variety of programs.

As part of new employee orientation, general fire safety principles and techniques are covered. This includes proper use of emergency codes, telephone numbers, fire extinguishing techniques and evacuation procedures. Emergency procedures are in place which addresses specific roles and responsibilities of personnel at and away from a fire's point of origin and building compartmentalization procedures.

Fire drills are conducted at least once per shift per quarter in all buildings. Fire drills are conducted as required and drills were unannounced. In addition, staff is interviewed during fire drills for proper response.

Annual fire safety training is provided to employees in addition to training which is provided during fire drills, employee orientation and annual training. It is noted that staff training regarding fire response is deemed effective based on the results of fire drills, annual training, and new employee orientation.

In compliance with LS.02.01.03, regular inspection and testing of fire protection and life safety systems are done by qualified individuals.

The Facilities Department is responsible for all life safety systems inspection testing and maintenance. All inspection and testing documents are located in the Environment of Care/Safety & Security Managers office.

Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. All Life Safety Management performance data results were within control limits (i.e., w/i one standard deviation of the database mean).

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Ten areas of Life Safety Management performance are benchmarked.

Additional noteworthy actions taken during 2021 include the following:

- Environment of Care Committee worked on reducing hallway clutter
- Life Safety Management Plan was revised and adopted
- All life safety systems inspected and tested as required in 2021
- Hot Work Permit Program continues to be utilized and successful.
- Interim Life Safety Measures (ILSM)

The Life Safety Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring Data Results
- Review of Fire Drills completed
- Training and Education Results
- Safety Committee Activity
- Building Inspection for Life Safety Code Compliance
- Inspection, Testing and Maintenance Results of Life Safety Systems

D. Review of 2021 Goals:

- Develop and updated Fire Drill Calendar that will note preferred times and dates so drill will vary from the previous month on the calendar. *This goal was met.*

E. Goals for 2022:

- Work with Engineering to provide access to all Fire/Smoke Dampers so that Signature Services can test all on the system.

VI. MEDICAL EQUIPMENT MANAGEMENT

A. Objective:

The objective of the Medical Equipment Management Plan is to promote the safe and effective use of medical equipment and to properly maintain and inspect such equipment on a regular basis.

B. Scope:

The Medical Equipment Management Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Medical Equipment Management Plan is current and appropriate.

C. Performance and Effectiveness:

Sierra View utilizes a contractual management arrangement with Renovo Solutions Inc. to provide ongoing biomedical services, ensure preventive maintenance and recommend program improvements.

This contracted biomedical service applies to the hospital as well as diagnostic equipment. Biomedical or engineering personnel for basic electrical safety and correct operating performance as per manufacturer's specifications inspect equipment entering the facility. The Biomedical vendor utilizes an inventory with sticker program to ensure preventive maintenance (P.M.) and inspections are done as scheduled.

A representative from Renovo Solutions Inc. makes presentations to the Safety Committee and reports Preventive Maintenance compliance and any user errors on a regular basis. If required, in services are scheduled for appropriate staff.

Performance monitoring data is tracked using the Osborne Engineering, Inc. Environment of Care Benchmarking database. All Medical Equipment Management performance data results were within control limits (i.e., w/i one standard deviation of the database mean).

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Eleven areas of Medical Equipment performance are benchmarked.

Additional noteworthy actions taken during 2021 include the following:

- Monitoring preventative maintenance results

- Keeping track of and responding to medical equipment recalls and notifications
- Incoming equipment inspections
- Medical Equipment Management Plan revised and adopted

The Medical Equipment Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring and Benchmarking Data Results
- Training and Education Results
- Safety Committee Activity
- Inspection, Testing and Maintenance Results of Medical Equipment

D. Review of 2021 Goals:

- Work with Renovo to get a current inventory of Medical Equipment inside the facility so that we can track lost/missing equipment. *This goal was met.*

E. Goals for 2022:

- Work with Renovo to ensure that the Preventative Maintenance Rate for Non-Life Support Equipment stays at 100%. The current rate is at 99.8%.

VII. UTILITIES MANAGEMENT

A. Objective:

The objective of the Utilities Management Plan is to establish and maintain reliable utility systems to provide an effective environment for patients, visitors and staff.

B. Scope:

The Utility Systems Management Plan and related policies and procedures extend to the Sierra View Medical Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Utility Systems Management Plan is current and appropriate.

C. Performance and Effectiveness:

Preventative maintenance is provided on an on-going basis to all utility systems including, but not limited to, the following:

1. Electrical Distribution
2. Emergency Power
3. Heating, Ventilating and Air Conditioning
4. Plumbing
5. Boiler and Steam
6. Piped Medical Gases and Vacuum Systems
7. Elevators

Preventative maintenance (P.M.) is provided as detailed in the hospital's Utilities Management Program. At least a 95% Preventive Maintenance (PM) completion rate was maintained (currently at 98.3%). All PM records are located in the facility's Engineering Department.

The Engineering Department continues to work with Infection Control on all construction projects to ensure adequate infection control measures are in place. An infection control risk assessment program is in place to minimize the risk of facility-acquired illnesses for patients.

No problems occurred during the past year regarding pathogenic biological agents such as Legionella or airborne contaminants such as Aspergillus. An on-going management program as described in the Utility Systems Management plan is in place to minimize the risk of Legionella and Aspergillus by identifying needs for procedures and controls to minimize the potential for the spread of infections through the utility systems.

Performance monitoring data is tracked using the Osborne Engineering, Inc. Environment of Care Benchmarking database. All Utility Systems performance data results were within control limits (i.e., w/i one standard deviation of the database mean)
The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Fifteen areas of Utility Systems performance are benchmarked.

Additional noteworthy actions taken during 2021 include the following:

- Preventive Maintenance completion rates maintained above 95% bench mark

The Utility Systems Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring and Benchmarking Data Results
- Training and Education Results
- Safety Committee Activity
- Inspection, Testing and Maintenance Results of Utility Systems
- Utility Management Plan revised and adopted
- Utility 96 Hour Disruption Matrix implemented

D. <u>Review of 2021 Goals</u>:

- Work with Precept Environmental to implement our Water Safety Plan. *This goal was met.*

F. <u>Goals for 2022</u>:

- Work with Engineering to update our Equipment/ Asset inventory.

Respectfully Submitted,

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David Whittington, Environment of Care/Safety and Security Manager

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MINUTES OF A REGULAR MEETING OF THE BOARD OF DIRECTORS OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The regular meeting of the Board of Directors of Sierra View Local Health Care District was held **February 28, 2023 at 4:30 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 4:34 p.m.

Directors Present: REDDY, LOMELI, MARTINEZ, PANDYA, KASHYAP

Others Present: Blazar, Dan, Patient Experience Officer, Canales, Tracy, VP of Human Resources, Marketing and Public Relations, Dorwart, Stephanie, Altius, Gomez, Cindy, Director of Compliance, Dickson, Doug, Chief Financial Officer, Espinoza, Alexis, Porterville Recorder, Franer, Julie, Admin Director Patient Financial Services, Hefner, Donna, President/Chief Executive Officer, Hirte, Todd, Contracts Administration, Hudson, Jeffery, VP Patient Care Services, CNO and DIO, Martinez, Atalia, Community Member, Pryor-DeShazo, Kimberley, Director of Marketing and Public Relations, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, Chief of Staff, Sousa, Kelvin, Community Member, Themm, Eric, Zephyr Healthcare Advisors, Tiller, Joni, Altius, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment, Wilbur, Gary, Admin Director of General Services

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ, and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 4:34 p.m. to discuss the following items:

A. Pursuant to Evidence Code Section 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation- Quality of Care/Peer Review/Credentials

2. Quality Division Update

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – April 2024

Closed Session Items B.3, and D – G were deferred to the conclusion of Open Session as there was not time for discussion prior to Open Session.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:17 p.m., reconvening in Open Session at 5:18 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff Sandhu. Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review. Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA, and carried to approve the Quality Division Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Discussion Regarding Trade Secrets. Information only; no action taken.

IV. Public Comments

None.

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Director PANDYA, seconded by Vice Chair LOMELI, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Vice Chairman LOMELI and seconded by Director MARTINEZ to approve the January 24, 2023 Minutes of the Regular Meeting of the Board of Directors as presented. The motioned carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. Hospital CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View:

In the District:

- COVID State of Emergency Declaration expires today
- SVMC Digital Newsletter – subscribe at sierra-view.com and wait for the pop up prompt
- Porterville Little Library installed
- SCOR Survey

VIII. Business Action Items

A. Approval of Bylaws of the Board of Directors Section 5.2.1 Time Change

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve changing the start time for the Board Meeting to 5:00 p.m. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

B. January 2023 Financials

Doug Dickson, CFO presented the Financials for January 2023. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $13,178,365. Supplemental Funds were $1,077,210. Total Operating Expenses were $14,557,308. Loss from operations were $1,378,943.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve the January 2023 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Investment Report

Doug Dickson, CFO presented the Investment Report.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve the Investment Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

D. Capital Budget Report

Alex Jimenez, Project Manager presented the Capital Budget Report.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director KASHYAP and carried to approve Capital Budget Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

E. Annual Institutional Report for Graduate Medical Education

Jeffery Hudson-Covolo, VP Patient Care Services, CNO and Chief Academic Officer presented a verbal report.

Information only; no action taken.

F. Board Self Evaluation and Goals

Information only; no action taken.

IX. Closed Session: Board adjourned Open Session at 6:24 p.m. and went into Closed Session at 6:30 p.m. to discuss the following items:

B. Pursuant to Evidence Code Section 1156 and 1157.7:

3. Compliance Report – Quarter 2

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – February 2026

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – December 2023

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – June 2024

G. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1 Item)

X. Open Session: Board adjourned Closed Session at 7:58 p.m. and went into Open Session at 7:58 p.m. to discuss the following items:

B. Pursuant to Evidence Code Section 1156 and 1157.7:

3. Evaluation – the Quality of Care/Peer Review. Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

D. Trade Secret. Information only; no action taken.

E. Trade Secret. Information only; no action taken.

F. Trade Secret. Information only; no action taken.

G. Conference with Legal Counsel. Information only; no action taken.

XII. Announcements:

A. Regular Board of Directors Meeting – February 28, 2023 at 4:30 p.m.

The meeting was adjourned 7:59 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors
AM: ww