SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING ANNUAL MEETING
465 West Putnam Avenue, Porterville, CA – Board Room

AGENDA
January 23, 2024

OPEN SESSION (5:00 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:30 P.M. In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq.

Call to Order

I. **Approval of Agendas**
Recommended Action: Approve/Disapprove the Agenda as Presented/Amended

The Board Chairman may limit each presentation so that the matter may be concluded in the time allotted. Upon request of any Board member to extend the time for a matter, either a Board vote will be taken as to whether to extend the time allotted or the chair may extend the time on his own motion without a vote.

II. **Adjourn Open Session and go into Closed Session**

CLOSED SESSION (5:01 PM)

As provided in the Ralph M. Brown Act, Government Code Sections 54950 et seq., the Board of Directors may meet in closed session with members of the staff, district employees and its attorneys. These sessions are not open to the public and may not be attended by members of the public. The matters the Board will meet on in closed session are identified on the agenda or are those matters appropriately identified in open session as requiring immediate attention and arising after the posting of the agenda. Any public reports of action taken in the closed session will be made in accordance with Gov. Code Section 54957.1

III. **Closed Session Business**

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

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b):

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

2. Quality Division Update –Quality Report
Report deferred to February meeting

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

D. 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)

To the extent items on the Closed Session Agenda are not completed prior to the scheduled time for the Open Session to begin, the items will be deferred to the conclusion of the Open Session Agenda.

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

Pursuant to Gov. Code Section 54957.1; Action(s) to be taken Pursuant to Closed Session Discussion

A. Chief of Staff Report
Recommended Action: Information only; no action taken

B. Quality Review

1. Evaluation – Quality of Care/Peer Review/Credentials
Recommended Action: Approve/Disapprove Report as Given

2. Quality Division Update –Quality Report
Recommended Action: January Report deferred to February meeting

C. Discussion Regarding Trade Secret and Strategic Planning
Recommended Action: Information only; no action taken

D. Conference with Legal Counsel
Recommended Action: Information only; no action taken

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment. Written comments submitted to the Board prior to the Meeting will distributed to the Board at this time, but will not be read by the Board secretary during the public comment period.

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff and Hospital policies, and these items are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff and Hospital policies are normally approved by one motion. If discussion is requested by any Board member(s) or any member of the public on any item addressed during public comment, then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board.

VIII. Approval of Minutes

A. **December 19, 2023 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove December 19, 2023 Minutes of the Regular Meeting of the Board of Directors

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
January 23, 2024

IX. CEO Report

X. Business Items

A. **Sierra View Foundation Check Presentation**
Recommended Action: Information only; no action taken

B. **December 2023 Financials**
Recommended Action: Approve/Disapprove Report as Given

C. **Annual Appointments**
Recommended Action: Approve/Disapprove Report as Given

1. **Food and Dietetic Services Director**
Recommended Action: Approve Appointment

2. **Environmental Safety/Security Officer**
Recommended Action: Approve Appointment

3. **Patient Safety and Infection Control Officer**
Recommended Action: Approve Appointment

4. **Infection Control Officer**
Recommended Action: Approve Appointment

C. **SVLHCD Board of Directors Annual Self Evaluation to comply with SVLHCD Bylaw 4.2**
Recommended Action: Information only; no action taken

D. **Resolution 1.23.2024/01 Appointing Director Hans Kashyap to Treasurer of the Board**
Recommended Action: Appoint Director Hans Kashyap to Treasure of the Board

XI. Announcements:

A. Regular Board of Directors Meeting – February 27, 2024 at 5:00 p.m.

XII. Adjournment

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Mitchell, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 4:30 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

Materials related to an item on this agenda submitted to the Board after distribution of the agenda packet, as well as the agenda packet itself, are available for public inspection/copying during normal business hours at the Administration Office of Sierra View Medical Center, 465 W. Putnam Ave., Porterville, CA 93257. Privileged and confidential closed session materials are/will be excluded until the Board votes to disclose said materials.

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Senior Leadership Team	1/23/2024
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	1/23/2024

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
January 23, 2024
BOARD OF DIRECTOR'S APPROVAL

The following Polices/Procedures/Protocols/Plans have been reviewed by Senior Leadership Team and are being submitted to the Board of Director's for approval:

	Pages	Action
Policies:		Approve ↓
1. Business Associates Agreement	1-15	
2. Code of Conduct	16-36	
3. Disclosure of Protected Health Information During Disaster Relief Efforts	37-38	
4. Fire Response Plan	39-42	
5. Identification of Patient's Requests and Samples (Blood Bank)	43-45	
6. Injury Illness Prevention Program	46-51	
7. Medical Gases	52-55	
8. Medical Records to be Sent with Patient Transfers	56-57	
9. Physician and Non-Physician Practitioner Recruitment Policy	58-72	
10. Risk Management Plan	73-78	
Forms:		
1. Respiratory Syncytial Virus (RSV) Vaccine Consent	79-80	

SUBJECT: **BUSINESS ASSOCIATE AGREEMENT**	SECTION: *Compliance* **Page 1 of 15**

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

PURPOSE:

To ensure that Sierra View Medical Center (SVMC) is in compliance with the Health Information Portability and Accountability Act (HIPAA) Privacy Regulations and to establish guidelines for SVMC to identify those vendor/business relationships that meet the definition of "Business Associate" (BA) or subcontractor and provide direction in establishing formalized "Business Associate Agreements" (BAA). To define the permissible uses and disclosures that a BA may make regarding the protected health information (PHI) that it creates or receives in providing services to or on the behalf of SVMC as a covered entity (CE).

DEFINITIONS:

Protected Health Information (PHI): Any oral, written or electronic individually identifiable health information collected or stored by a facility. Individually identifiable health information includes demographic information and any information that relates to past, present or future physical or mental condition of an individual.

Business Associate (BA): A BA is not a member of SVMC's workforce and is a person or entity, who on behalf of SVMC:

- Performs or assists SVMC with a function or activity and reporting /accounting of disclosures regulated by HIPAA involving the creation, receipt, maintenance, use, disclosure, or transmittal of PHI. These activities include, but are not limited to: claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management or re-pricing;

- Provides any of the following functions or activities involving the use or disclosure of PHI to or for SVMC: e.g., legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services, where the provision of services involves the disclosure of individually identifiable health information from SVMC;

- Provides data transmission of PHI to SVMC, and requires access on a regular basis to such PHI;

- Stores, transmits, or maintains PHI physically within their facilities or electronically within the information systems.

Business Associate Agreement (BAA): An agreement entered into by SVMC and a third party that establishes permitted and required uses and disclosures of PHI requiring the BA to appropriately safeguard PHI, protect the privacy and provide for the security of PHI. (Exceptions to the Business Associate standard are found in the HIPAA Privacy Rule 45 CFR 164.502)

A BAA is NOT required in the following circumstances:

- Disclosures by SVMC to a health care provider concerning the treatment of an individual. Including, but not limited to, the PHI being disclosed for treatment purposes (e.g., primary/referring physician, contract physicians or specialists, x-ray technician, laboratory analysis, hospice care provider, contract nursing staff, contract rehab staff, ambulance, home health, dentist, etc.)

- Disclosures to a group health plan for payment purposes to the plan sponsor.

- Uses or disclosures by a health plan that is a government program providing public benefits, if eligibility for, or enrollment in, the health plan is determined by an agency other than the agency administering the health plan, or if the PHI used to determine enrollment or eligibility in the health plan is collected by an agency other than the agency administering the health plan.

AFFECTED AREAS/PERSONNEL: ADMINISTRATION, CONTRACT MANAGEMENT, COMPLIANCE, MATERIALS MANAGEMENT, VENDORS, DEPARTMENT LEADERSHIP

POLICY:

SVMC will not contract with a BA until satisfactory assurances are received that the BA will appropriately safeguard PHI, and they have met the requirements established by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the **HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "**HIPAA Regulations**") (collectively, "**HIPAA**") and other applicable laws.

- Under the Privacy Rule, SVMC cannot disclose PHI to its business associates without having a written contract in place that includes specific privacy protections. A written BAA is required (other than the contract) that documents these assurances.

- SVMC legal counsel has developed a standard HIPAA Business Associate template to be used in newly established business associate relationships or any contracts with existing relationships that are being renewed. (See attachment A HIPAA Business Associate Agreement). The BAA is generally an addendum to the main contract; however, it may be embedded into the main contract.

- Any BAA that is not the SVMC BAA template (ie; the Business Associate's version) when compared to the SVMC BAA is found to be materially different or material changes to the SVMC BAA template are requested by the Business Associate must be reviewed and approved by SVMC external legal counsel.

PROCEDURE:

Required Business Information:

When SVMC has determined that a BA relationship exists (or will exist for a new vendor/business relationship, the relevant Department Leader will contact SVMC's Contracts Administrator or designee to initiate a BAA. The following information will need to be provided:

- A description of the type of service(s) being provided by the BA, which should be consistent with the underlying service agreement (if applicable);
- Consistent with the service(s) being provided by the BA, list all permitted uses and disclosures of PHI;
- The date the BA will begin creating, receiving, maintaining or transmitting PHI should be simultaneous to the effective date of the service agreement;
- Point of contact information for the operational contacts of the BA. The individual(s) listed on a Point of Contact form should be able to represent the organization's interests and policies/practices pertaining to HIPAA compliance, and PHI breach notifications/investigations;
- Any additional BAA provisions requested by SVMC.

SVMC's Contracts Administrator or designee shall be responsible for overseeing the management of BA relationships and BAAs. SVMC department leaders are responsible for assessing existing and future vendor/business relationships to determine whether a BAA is required.

Contract Administrator or designee will:

- Evaluate the relationship and/or need for a BAA. If it is unclear, whether a relationship requires a BAA contact SVMC's Compliance/Privacy Officer or legal counsel;
- Determine the existence of a signed, current BAA by reviewing the contract management data base;
- If a BAA (or core contract addressing BAA requirements) is not on file, provide the Business Associate with the SVMC Business Associate Agreement. (Attachment A);
- If the Business Associate proposes edits or alterations to the BAA, or want to use their own BAA or indicate that negotiations are needed, it will need to be reviewed and approved by SVMC external legal counsel, if there are material differences with the SVMC BAA.

Term of BAA:

The BAA shall be effective for the length of the relationship between the BA and SVMC, unless otherwise terminated under the provisions outlined in the BAA.

Termination:

If SVMC or the BA chooses to terminate the main agreement, the BAA will be terminated as outlined in the BAA. Please note, HIPAA requires only that the BAA outline termination options for the CE. While mutual termination may be included in BAAs, this is not required under HIPAA.

REFERENCES:

- Health Insurance Portability and Accountability Act of 1996
- Health Information Technology for Economic and Clinical Health Act 2009
- 45 C.F.R. Section 160.103
- 2023 California Health Information Privacy Manual. 11 Business Associate Contracts (Vol. 9, PP 11.1-11.9.). Sacramento, CA: California Healthcare Association

CROSS REFERENCES:

- PATIENT PRIVACY-PROGRAM REQUIREMENTS
- ORGANIZED HEALTH CARE ARRANGEMENT

ATTACHMENT A

HIPAA BUSINESS ASSOCIATE AGREEMENT

This **HIPAA BUSINESS ASSOCIATE AGREEMENT** (this "**BA Agreement**") is made by and between **Sierra View Medical Center** ("**Sierra View**") and _____ ("**Business Associate**") and is effective as of _____ 1, 2023 ("**Effective Date**"). Capitalized terms used in this BA Agreement without definition shall have the respective meanings assigned to such terms by the administrative simplification section of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended by HITECH (as defined in Section 1.3 of this BA Agreement).

RECITALS

WHEREAS, Sierra View and Business Associate are parties to a Services Agreement that requires Business Associate to have access to Protected Health Information (the "**Services Agreement**"); and

WHEREAS, it is the intent of Sierra View and Business Associate to amend the Services Agreement, as described in this BA Agreement, for the parties to comply with HIPAA.

WHEREAS, Sierra View wishes to disclose certain information to Business Associate pursuant to the terms of this BA Agreement, some of which may constitute Protected Health Information ("**PHI**") (defined herein).

WHEREAS, Sierra View and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to this BA Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the **HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "**HIPAA Regulations**") (collectively, "**HIPAA**") and other applicable laws.

WHEREAS, as part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined herein) require Sierra View to enter into an agreement containing specific requirements with Business Associate prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(a) and (e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this BA Agreement.

NOW, THEREFORE, in consideration of the mutual premises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Sierra View and Business Associate agree as follows:

DEFINITIONS

a. **Breach** shall have the meaning given to such term under the HITECH Act and HIPAA Regulations at 42 U.S.C. Section 17921 and 45 C.F.R. Section 164.402.

b. **Breach Notification Rule** shall mean the HIPAA Regulation that is codified at C.F.R. Parts 160 and 164, Subparts A and D.

c. **Business Associate** shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

d. **Covered Entity** shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

e. **Data Aggregation** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

f. **Designated Record Set** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

g. **Electronic Protected Health Information** means PHI that is maintained in or transmitted by electronic media.

h. **Electronic Health Record** shall have the meaning given to such term under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

i. **Health Care Operations** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

j. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

k. **Protected Health Information or PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501. PHI includes Electronic Protected Health Information [45 C.F.R. Sections 160.103, 164.501].

l. **Protected Information** shall mean PHI provided by Sierra View to Business Associate or created, maintained, received or transmitted by Business Associate on Sierra View's behalf.

m. **Security Incident** shall have the meaning given to such term under the Security Rule, including, but not limited to, 45 C.F.R. Section 164.304.

n. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

o. **Unsecured PHI** shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

AGREEMENT

I. GENERAL PROVISIONS

Section 1.1. **Effect**. The provisions of this BA Agreement shall control with respect to PHI that Business Associate receives from or on behalf of Sierra View, and the terms and provisions of this BA Agreement shall supersede any conflicting or inconsistent terms and provisions of the Services Agreement, including all exhibits or other attachments thereto and all documents incorporated therein by reference, to the extent of such conflict or inconsistency. This BA Agreement shall not modify or supersede any other provision of the Services Agreement.

Section 1.2. **No Third Party Beneficiaries**. The parties have not created and do not intend to create by this BA Agreement any third party rights, including, but not limited to, third party rights for Sierra View's patients.

Section 1.3. **HIPAA Amendments**. Any future amendments to HIPAA affecting business associate agreements are hereby incorporated by reference into this BA Agreement as if set forth in this BA Agreement in their entirety effective on the later of the effective date of this BA Agreement or a subsequent date as may be specifiedby HIPAA.

Section 1.4. **Regulatory References**. A reference in this BA Agreement to a section in HIPAA means the section as it may be amended from time-to-time.

II. OBLIGATIONS OF BUSINESS ASSOCIATE

Section 2.1. **Use and Disclosure of Protected Health Information**. Business Associate may use and disclose PHI as permitted or required under this BA Agreement or as Required by Law, but shall not otherwise use or disclose any PHI. Business Associate shall assure that its employees, other agents and contractors do not use or disclose PHI received from Sierra View in any manner that would constitute a violation of HIPAA if so used or disclosed by Sierra View (except as set forth in Section 2.1(a) and (b) of this BA Agreement). To the extent Business Associate carries out any of Sierra View's obligations under HIPAA, Business Associate shall comply with the requirements of HIPAA that apply to Sierra View in the performance of such obligations. Without limiting the generality of the foregoing, Business Associate is permitted to use or disclose PHI as set forth below:

(a) Business Associate shall disclose Protected Information only for the purpose of performing Business Associate's obligations under the Services Agreement and as permitted or required under the BA Agreement, or as required by law.

(b) Business Associate shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by Sierra View. However, Business Associate may disclose Protected Information as necessary (i) for the proper management and administration of Business Associate; (ii) to carry out the legal responsibilities of Business Associate; (iii) as required by law; or (iv) for Data Aggregation purposes relating to Health Care Operation of Sierra View. If Business Associate discloses Protected Information to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BA Agreement and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify Business Associate of any breaches, suspected breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with Section 2.6 of this BA Agreement, to the extent it has obtained knowledge of such occurrences [42 U.S.C. Section 17932; 45 C.F.R. Section 164.504(e)].

(c) Business Associate shall not use or disclose PHI other than as permitted or required by the Services Agreement or this BA Agreement, or as required by law. Business Associate shall not use or disclose Protected Information for fundraising or marketing purposes. Business Associate shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates [42 U.S.C. Section 17935(a); 45 C.F.R. Section 164.522(a)(vi)]. Business Associate shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of Sierra View and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2) and the HIPAA regulations, 45 C.F.R. Section 164.502(a)(5)(ii); however, this prohibition shall not affect payment by Sierra View to Business Associate for services provided pursuant to the Services Agreement.

Section 2.2. **Safeguards**. Business Associate shall use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted or required by the Services Agreement or this BA Agreement. In addition, Business Associate shall implement Administrative Safeguards, Physical Safeguards and Technical Safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Section 164.308, 164.310 and 164.312, [45 C.F.R. Section 164.504(e)(2)(ii)(B); 164.308(b)] that reasonably and appropriately protect the Confidentiality, Integrity and Availability of Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of Sierra View. Business Associate shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316. [42 U.S.C. Section 17931]. Business Associate shall comply with the HIPAA Security Rule with respect to Electronic Protected Health Information.

Section 2.3. **Minimum Necessary Standard**. To the extent required by the "minimum necessary" requirements of HIPAA, Business Associate, its agents and subcontractors shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)]. To the extent practicable, Business Associate shall not request, use or disclose any Direct Identifiers (as defined in the limited data set standard of HIPAA) and comply with the minimum necessary guidance to be issued by the Secretary of the U.S. Department of Health and Human Services (the "***Secretary***") pursuant to HITECH.

Section 2.4. **Mitigation**. Business Associate shall take reasonable steps to mitigate, to the extent practicable, any harmful effect (that is known to Business Associate) of a use or disclosure of PHI by Business Associate in violation of this BA Agreement or HIPAA.

Section 2.5. **Subcontractors**. Business Associate shall enter into a written agreement meeting the requirements of 45 C.F.R. §§ 164.504(e) and 164.314(a)(2) with each Subcontractor (including, without limitation, a Subcontractor that is an agent under applicable law) that creates, receives, maintains or transmits PHI on behalf of Business Associate. Business Associate shall ensure that the written agreement with each Subcontractor obligates the Subcontractor to comply with restrictions and conditions that are at least as restrictive as the restrictions and conditions that apply to Business Associate under this BA Agreement and implement the safeguards required in Section 2.2 above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2)(ii)(D); 45 C.F.R. Section 164.308(b)]. Business Associate shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation [see 45 C.F.R. Section 164.530(f); and 164.530(e)(1)].

Section 2.6. **Reporting Requirements**.

(a) Business Associate shall notify Sierra View by reporting to the Compliance Officer at Sierra View, within twenty-four (24) hours of any suspected or actual breach of Protected Information; any use or disclosure of Protected Information not permitted by the Services Agreement or this BA Agreement; any Security Incident (i.e., any attempted or successful unauthorized, disclosure, modification, or destruction of information or interference with system operations in an information system) related to Protected Information, and any actual or suspected use or disclosure of data in violation of any applicable federal or state laws by Business Associate or its agents or subcontractors. The notification shall include, to the extent possible, the identification of each Individual whose unsecured Protected Information has been, or is reasonably believed by Business Associate to have been accessed, acquired, used, or disclosed, as well as any other available information that Sierra View is required to include in notification to the Individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including, but not limited, to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this section or promptly thereafter as information becomes available. Business Associate shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized

uses or disclosures required by applicable federal and state laws. [42 U.S.C. Section 17921; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)].

(b) Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504(e)(1)(ii), if the Business Associate knows of a pattern of activity or practice of an agent or subcontractor that constitutes a material breach or violation of the agent's or subcontractor's obligations under the Services Agreement or this BA Agreement or other agreement, the Business Associate must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Business Associate must terminate the Services Agreement or other arrangement if feasible. Business Associate shall provide written notice to Sierra View of any pattern of activity or practice of an agent or subcontractor that Business Associate believes constitutes a material breach or violation of the agent's or subcontractor's obligations under the Services Agreement or this BA Agreement or other agreement within five (5) days and shall meet with Sierra View to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

(c) Business Associate shall reimburse Sierra View for all costs, expenses (including reasonable attorneys fees), damages and other losses resulting from any breach of this BA Agreement, unauthorized use or disclosure, Security Incident or Breach involving PHI maintained by Business Associate, including, without limitation: fines or settlement amounts owed to a state of federal government agency; the cost of any notifications to Individuals or government agencies; credit monitoring for affected Individuals; or other mitigation steps taken by Sierra View to comply with HIPAA or state law. This reimbursement obligation shall survive the expiration or earlier termination of the Services Agreement and this BA Agreement.

Section 2.7. **Access to Protected Health Information**. Within five (5) business days of a request by Sierra View for access to PHI about an Individual contained in any Designated Record Set of Sierra View maintained by Business Associate or its agents or subcontractors, Business Associate shall make available to Sierra View such PHI for so long as Business Associate maintains such information in the Designated Record Set. Timely access will be provided to enable Sierra View to fulfill its obligations under state law [Health and Safety Code Section 123110] and the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 C.F.R. Section 164.504(e)(2)(ii)(E)]. If Business Associate maintains Protected Information in electronic format, Business Associate shall provide such information in electronic format as necessary to enable Sierra View to fulfill its obligations under the HITECH Act and HIPAA Regulations, including, but not limited to, 42 U.S.C. Section 17935(e) and 45 C.F.R. Section 164.524. If Business Associate receives a request for access to PHI directly from an Individual, Business Associate shall forward such request to Sierra View within (5) five business days. Sierra View will be responsible for making all determinations regarding the granting or denial of an Individual's request for PHI and Business Associate will make no such determination. Only Sierra View will release PHI to the Individual pursuant to such a request.

Section 2.8. **Availability of Protected Health Information for Amendment**. Within ten (10) business days of receipt of a request from Sierra View for the amendment of an Individual's

PHI contained in any Designated Record Set of Sierra View maintained by Business Associate or its agents or subcontractors, Business Associate shall provide such PHI to Sierra View for amendment and incorporate any such amendments in the PHI (for so long as Business Associate maintains such information in the Designated Record Set) as required by 45 C.F.R. § 164.526. If Business Associate receives a request for amendment to PHI directly from an Individual, Business Associate shall forward such request to Sierra View within five (5) business days. Sierra View will be responsible for making all determination regarding amendments to PHI and Business Associate will make no such determinations.

Section 2.9. Accounting of Disclosures. Within ten (10) business days of notice by Sierra View to Business Associate that it has received a request for an accounting of disclosures of PHI (other than disclosures to which an exception to the accounting requirement applies), Business Associate or its agents or subcontractors shall make available to Sierra View such information as is in Business Associate's possession and is required for Sierra View to make the accounting required by 45 C.F.R. § 164.528 and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17935(c) as determined by Sierra View. Business Associate agrees to implement a process that allows for an accounting to be collected and maintained by Business Associate and its agents and subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that Business Associate maintains an Electronic Health Record.

(a) Disclosure Records. Business Associate will keep a record of any disclosure made to its agents, subcontractors or other third parties for purposes other than:

(1) Disclosures to health care providers to assist in the treatment of patients;

(2) Disclosures to others to assist Sierra View in obtaining payment; and

(3) Disclosures to others to assist Sierra View in conducting its health care operations as defined in 45 C.F.R. § 164.501.

Business Associate will maintain this disclosure record for the term of the BA Agreement and for six (6) years from the effective date of termination of this BA Agreement.

(b) Data Regarding Disclosures. For each disclosure for which Business Associate must maintain documentation under Section 2.9.a, Business Associate will record and maintain the following information:

(1) The date of disclosure;

(2) The name of the entity or person who received the PHI, and, the address of such entity or person, if known;

(3) A description of the PHI disclosed; and

(4) A brief statement of the purpose of the disclosure that reasonably informs the Individual of the basis for the disclosure, or a copy of the Individual's authorization, or a copy of the written request for disclosure.

Section 2.10. **Availability of Books and Records**. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Sierra View available to the Secretary for purposes of determining Sierra View's and Business Associate's compliance with HIPAA [45 C.F.R. Section 164.504(e)(2)(ii)(I)].

Section 2.11. **Restrictions; Limitations in Notice of Privacy Practices**. Business Associate shall comply with any reasonable limitation in Sierra View's notice of privacy practices to the extent that such limitation may affect Business Associate's use or disclosure of PHI. Business Associate shall comply with any reasonable restriction on the use or disclosure of PHI that Sierra View has agreed to or is required to abide by under 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

Section 2.12. **Audits, Inspection and Enforcement**. Within ten (10) days of a request by Sierra View, Business Associate and its agents and subcontractors shall allow Sierra View or its agents or subcontractors to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use and disclosure of Protected Information pursuant to this BA Agreement for the purpose of determining whether Business Associate has complied with this BA Agreement or maintains adequate security safeguards; provided, however, that (i) Business Associate and Sierra View shall mutually agree in advance upon the scope, timing and location of such inspection, (ii) Sierra View shall protect the confidentiality of all confidential and proprietary information of Business Associate to which Sierra View has access during the course of such inspection; and (iii) Sierra View shall execute a nondisclosure agreement, upon terms mutually agreed upon by the parties, if requested by Business Associate. The fact that Sierra View inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Business Associate of its responsibility to comply with this BA Agreement, nor does Sierra View's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of Sierra View's enforcement rights under the Services Agreement or this BA Agreement. Business Associate shall notify Sierra View within five (5) days of learning that Business Associate has become the subject of an audit, compliance review, or compliant investigation by the Office of Civil Rights or other state or federal government entity.

III. TERMINATION OF AGREEMENT

Section 3.1. **Termination Upon Breach of this BA Agreement**. Any other provision of the Services Agreement notwithstanding, Sierra View may terminate the Services Agreement and this BA Agreement upon thirty (30) days advance written notice to Business Associate in the event that Business Associate breaches this BA Agreement in any material respect and such breach is not

cured within such thirty (30) day period. If termination of the Services Agreement and this BA Agreement is not feasible, Sierra View may report the breach to the Secretary.

Section 3.2. Return or Destruction of Protected Health Information upon Termination. Upon expiration or earlier termination of the Services Agreement, Business Associate shall, at the option of Sierra View, either return or destroy all PHI received from Sierra View or received by Business Associate and its agents and subcontractors on behalf of Sierra View and which Business Associate still maintains in any form and shall retain no copies. Notwithstanding the foregoing, to the extent that Sierra View reasonably determines that it is not feasible to return or destroy such PHI, the terms and provisions of this BA Agreement shall survive termination of the Services Agreement and Business Associate shall continue to extend the protections and satisfy the obligations of Article II of this BA Agreement to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible [45 C.F.R. Section 164.504(e)(2)(ii)(J)]. If Sierra View elects destruction of the PHI, Business Associate shall certify in writing to Sierra View that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.

IV. DISCLAIMER

Sierra View makes no warranty or representation that compliance by Business Associate with this BA Agreement, HIPAA, the HITECH Act, or the HIPAA Regulations will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

V. AMENDMENT TO COMPLY WITH LAWS

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Services Agreement or this BA Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA Regulations and other applicable state or federal laws relating to the security or confidentiality of PHI. The parties understand and agree that Sierra View must receive satisfactory written assurance from Business Associate that Business Associate will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BA Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA Regulations or other applicable laws. Sierra View may terminate the Services Agreement upon thirty (30) days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend the Services Agreement or this BA Agreement when requested by Sierra View pursuant to this section or (ii) Business Associate does not enter into an amendment to the Services Agreement or this BA Agreement providing assurances regarding the safeguarding of PHI that Sierra View, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

VI. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

Business Associate shall notify Sierra View within forty-eight (48) hours of any litigation or administrative proceedings commenced against Business Associate or its agents or subcontractors. In addition, Business Associate shall make itself, and any subcontractors, employees and agents assisting Business Associate in the performance of its obligations under the Services Agreement or this BA Agreement, available to Sierra View, at no cost to Sierra View, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Sierra View, its directors, officers or employees based upon a claimed violation of HIPAA, the HITECH Act, the HIPAA Regulations or other state or federal laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

VII. NO THIRD-PARTY BENEFICIARIES

Nothing express or implied in the Services Agreement or this BA Agreement is intended to confer, nor shall anything herein confer, upon any person other than Sierra View, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

VIII. EFFECT ON CONTRACT

Except as specifically required to implement the purposes of this BA Agreement, or to the extent inconsistent with this BA Agreement, all other terms of the Services Agreement shall remain in force and effect.

IX. INTERPRETATION

The provisions of this BA Agreement shall prevail over any provisions in the Services Agreement that may conflict or appear inconsistent with any provision of this BA Agreement. This BA Agreement and the Services Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA Regulations and other state and federal laws related to security and privacy. The parties agree that any ambiguity in this BA Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the HIPAA Regulations and other state and federal laws related to security and privacy.

X. COUNTERPARTS

This BA Agreement may be executed in two counterparts, each of which shall be deemed an original but both of which together shall constitute one and the same instrument. Copies of signatures sent by facsimile transmission or scanned and sent by email are deemed to be originals for purposes of execution and proof of this Amendment.

XI. NOTICES

Any notices required under this BA Agreement will be sent to the parties at the following addresses by first class mail, fax or hand delivery:

Sierra View:
Sierra View Medical Center
465 West Putnam Avenue
Porterville, CA 93257
Attn: Compliance Officer

Business Associate:

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have duly executed this BA Agreement.

COVERED ENTITY:

Sierra View Medical Center

By: _____

Name: _____

Title: _____

Date: _____

BUSINESS ASSOCIATE:

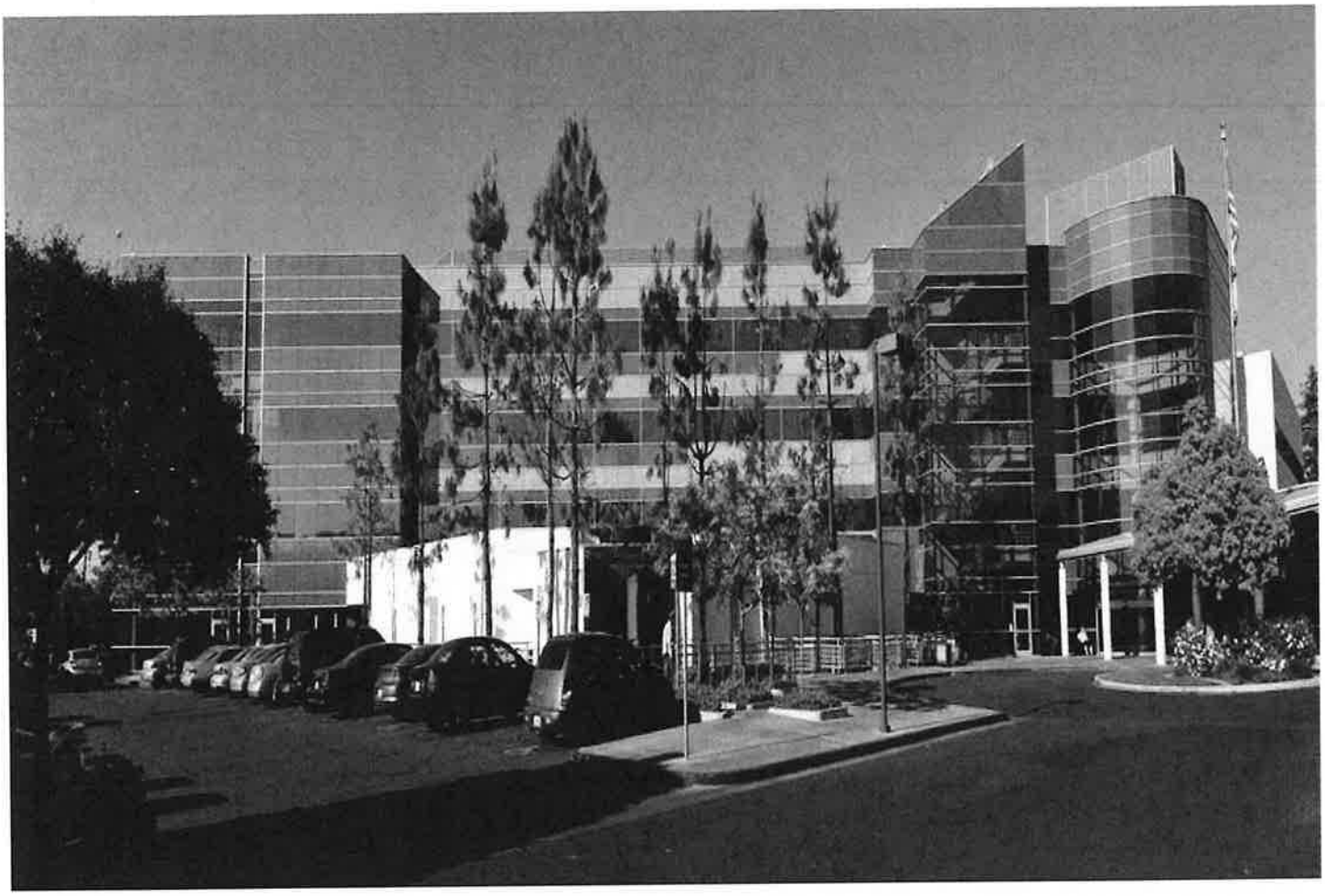
_____

By: _____

Name: _____

Title: _____

Date: _____



Sierra View Medical Center

Code of Conduct

PURPOSE:

To ensure Sierra View Medical Center (SVMC) fulfills its ethical responsibility to patients, staff, Medical Staff, contingent work force, third party payors, subcontractors, independent contractors, vendors, consultants, students, volunteers, one another and the community. This Code of Conduct was developed to meet our ethical standards and comply with applicable laws and regulations.

DEFINITIONS:

SVMC: For the purposes of this Code of Conduct, SVMC refers to Sierra View Medical Center, which includes all Medical Center departments, services, and clinics maintained and supported under the California Department of Public Health hospital license.

SVMC Staff: For the purposes of this Code of Conduct, SVMC Staff refers to SVMC employees.

SVMC Contingent Work Force: For the purposes of this Code of Conduct, SVMC Contingent Work Force refers to; Travelers, registry, contractors and subcontractors.

SVMC Medical Staff: For the purposes of this Code of Conduct, SVMC Medical Staff refers to Physicians and credentialed allied health practitioners.

SVMC Board of Directors: For the purposes of this Code of Conduct, the Board of Directors refers to the SVMC Governing Board.

POLICY:

It is the responsibility of every SVMC staff member, contingent work force member, Medical Staff member and Board member to act in a manner that is consistent with SVMC's policies and procedures, Values, and this Code of Conduct. Additionally, SVMC Medical Staff are governed by specific conduct rules outlined in their Bylaws.

MISSION, VISION AND VALUES STATEMENT:

Sierra View Medical Center is committed to upholding the highest standards of ethical behavior in improving the quality of life and health of our community. We are driven by our Mission and Vision.

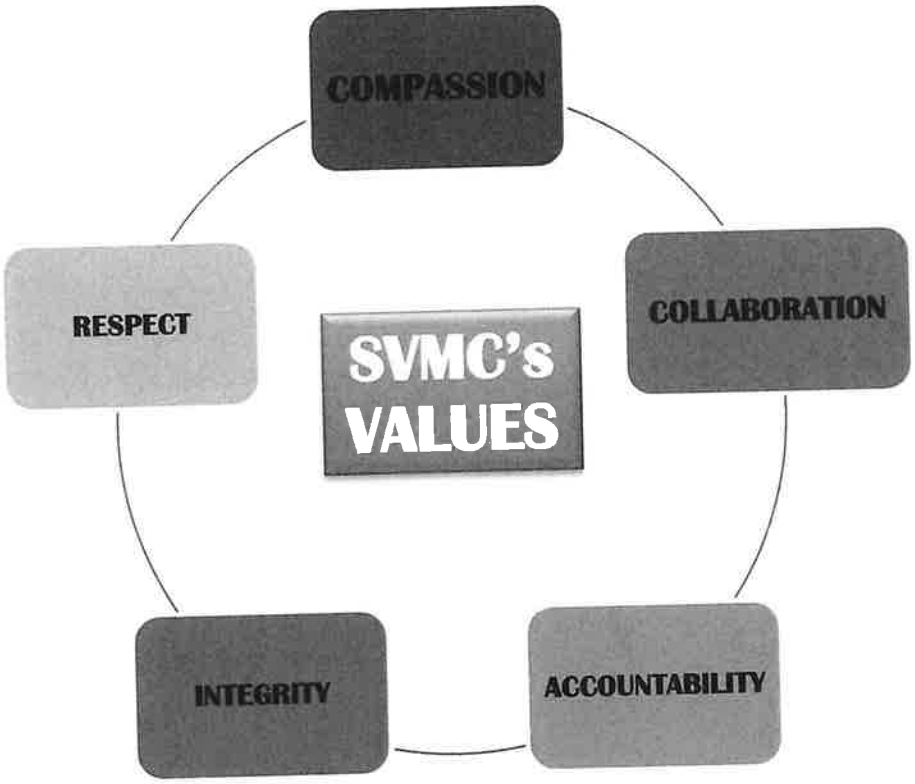
Our Mission:
SVMC promotes health and ensures access to high quality healthcare services. This will be achieved:

- Through partnerships and collaborations
- By being a good steward of resources to ensure that we can continue to meet the health needs of the community.

Our Vision:
Strengthen the quality of life through the delivery of integrated health care programs and services that promotes access, care coordination, and patient care experience.

Our Values:
SVMC is committed to our core values:

- **Compassion:** Caring from the heart
- **Collaboration:** Partnering for a common purpose
- **Accountability:** Accepting ownership of our actions
- **Integrity:** Inspiring trust and honesty
- **Respect:** Embracing and appreciating others



A MESSAGE FROM THE CEO

Dear Sierra View Medical Center Colleagues,

We are committed to providing quality health care in an environment that promotes compliance with applicable laws, regulations, and ethical standards. To assist in fulfilling this commitment, Sierra View Medical Center (SVMC) is supported by a Compliance Program managed by the Compliance/Privacy Officer and assisted by the Compliance Committee, which includes directors and members of senior leadership.

Our Code of Conduct is our most important policy, presented as a basic set of guidelines which reflects SVMC's culture, ethics, mission, vision and values. It defines our organizational and individual responsibilities and describes SVMC's expectations regarding your conduct, and the conduct of all employees, ranging from Senior Leadership to entry level positions. The Code of Conduct also combines with our individual judgment and personal accountability in forming the foundation of our professional behavior.

If you believe you have witnessed a potential or suspected violation of SVMC's Code of Conduct, SVMC policy or applicable law(s) or violation(s), please follow the reporting instructions on page 8 of this Code of Conduct, which includes details on our anonymous Compliance Reporting Hotline at (559) 791-4777 or ext. 4777. Retaliation against any employee, whom in good faith reports potential or suspected violations, will not be tolerated.

I appreciate your commitment to our mission, vision and values, and thank you for serving our patients, colleagues and hospital with integrity and for truly making a difference.

Sincerely,

Donna J. Hefner
President and Chief Executive Officer

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PURPOSE OF OUR CODE OF CONDUCT:

The Code of Conduct is a primary component of the Sierra View Medical Center (SVMC) Compliance Program, and has been developed to assist SVMC in complying with federal, state and local law, and to promote ethical conduct consistent with the mission, vision and strategic goals of SVMC.

The Code of Conduct is intended to:

- Describe the basic legal and ethical responsibilities expected of SVMC Staff, Contingent Work Force, Medical Staff, Students, Volunteers, Independent Contractors and Vendors.
- Inform SVMC Staff, Contingent Work Force, Medical Staff, Students, Volunteers, Independent Contractors and Vendors about existing SVMC policies and procedures.
- Explain the duty to report instances of suspected misconduct.
- Explain how to report suspected misconduct without fear of retaliation.

SVMC's expectation is that you follow the Code of Conduct and Values, as well comply with all other applicable laws, regulations, and SVMC policies and procedures, whether or not specifically addressed in this Code of Conduct.

Everyone at SVMC shall receive the Code of Conduct upon initial orientation and when significant updates occur. Staff shall acknowledge receipt of the Code of Conduct by electronic signature through the online Learning Management System or by signing and submitting an Attestation form to Human Resources.

Our ability to succeed depends on integrity, knowledge, diversity, respect and teamwork. While it is impossible to portray every situation one might encounter, or every detail of the policies, the Code of Conduct should serve as a guide for how we are expected to conduct ourselves while performing our professional duties on behalf of SVMC. Additional information and specific guidance on many of the topics covered in this Code of Conduct can be found in our Policy Library via the SVMC Intranet (http://home/).

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PERSONAL CONDUCT:

SVMC's reputation for the highest standards of conduct is reliant on the high level of mutual trust and responsibility that exists between Staff and the Organization. You, as an individual, are essential to the Organization's success. SVMC's integrity and reputation are in your hands and validated by those who exercise good judgment and act in accordance with this Code of Conduct and the law.

This means you are held accountable for:

- Reading the Code of Conduct and understanding how it applies to you.
- Referring to the Code of Conduct and SVMC policies to guide your daily work activities.
- Asking questions when you need clarification or help.
- Reporting all suspected misconduct to the appropriate SVMC personnel.
- Completion of assigned training.

If you have questions or concerns not fully addressed in the Code of Conduct or found in a SVMC policy, your next step should be to discuss the issue with your Manager. Other resources are also available, such as Compliance, Human Resources, Security, Employee Health, Information Technology, Health Information Management, and Financial Services. For current contact information, refer to the most recent phone directory located on the SVMC intranet home page.

DUTY TO REPORT:

There may come a time when you are made aware of a known or suspected violation of law, the Code of Conduct, or a SVMC policy. If you become aware of any questionable activities made by staff, contingent work force, Medical Staff, students, volunteers, independent contractors or vendors that appear to violate applicable laws, rules, regulations, conditions of participation,

policy, or this Code of Conduct, you have a duty to report the incident. You should always report suspicious or questionable behavior even if you are not sure there is a problem. Failure to report a violation is a serious violation in itself and may result in disciplinary action.
You can report incidents via:

- Your Supervisor
- The Compliance/Privacy Officer at (559)791-3838, ext. 3838 or Compliance Analyst at (559)791-3917
- Human Resources
- The Compliance Hotline **(see Compliance Hotline below)**
- A Compliance Incident Report form (Found on the Compliance page on the Intranet and submit in the lock box in SVMC's mail room)
- Email to ComplianceOfficeinbox@sierra-view.com
- The electronic event reporting program

COMPLIANCE HOTLINE (559)791-4777 or ext. 4777:

The Hotline is a confidential means of reporting ethical and compliance violations or concerns, or to ask Compliance-related questions. The Hotline is answered during normal business hours by Compliance staff and after hours by a recorded greeting which prompts you to leave a message. When reporting a concern, you can remain anonymous, although you are encouraged to identify yourself as it increases the exchange of vital communication and the ability to request additional information related to the incident being reported, should the need arise. If you disclose your name, but request confidentiality, the Compliance/Privacy Officer will keep this information confidential to the extent permitted by law. See the *Compliance Hotline policy*.

INTERNAL INVESTIGATIONS:

Violations of the Code of Conduct, failure to comply with applicable federal or state laws, and other types of misconduct threaten SVMC's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger SVMC's business and reputation, and can lead to serious sanctions against the Medical Center. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the Compliance/Privacy Officer to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred.

You are strongly encouraged to cooperate with investigations into potential misconduct. Any attempt to obstruct an investigation or the reporting of misconduct is subject to disciplinary

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action, up to and including, termination of employment.

If such a violation has occurred, prompt steps will be taken to correct the problem, taking into account the root cause of the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or submission of any overpayments. The specific steps that are appropriate in any given case will be determined after consultation with legal counsel.

Depending upon the nature of the alleged violations, the Compliance/Privacy Officer or designee will conduct a thorough and complete internal investigation, which could include interviews with relevant personnel and a review of relevant documents and may enlist experts from external resources, such as legal counsel, auditors or health care experts.

All interactions and information related to the investigation is kept confidential to the extent possible. To help ensure integrity of the investigation process, staff is also asked to practice discretion by refraining from discussing the information of the Compliance/Privacy Office consultation with colleagues or coworkers.

RETALIATION:

SVMC strives to uphold a culture where you feel comfortable in your work environment and can report known or suspected inappropriate conduct, activities or unethical behavior without fear of retaliation. All levels of leadership have a responsibility to create an atmosphere that facilitates open and honest discussion around issues that may negatively impact the organization. Retaliation against someone who files such a report will not be tolerated. Employees who participate in retaliation will be subject to disciplinary action.

Retaliation is defined as any action, statement, or behavior that is designed to punish an individual for filing a compliance report, cooperating with a compliance investigation, seeking guidance regarding a compliance concern or to deter one from taking such action. Retaliation includes, but is not limited to intimidation, adverse action against an employee regarding the terms and conditions of employment, such as termination, demotion, or suspension.

Protection is extended to *anyone* filing a Compliance report or inquiry or providing information in relation to an investigation. If you or others have been retaliated against, report this behavior to your supervisor, Compliance or Human Resources. All reports made in "good faith" are protected from retaliation, retribution, or harassment.

Good faith is defined as reasonably believing or perceiving the information reported to be true.

Please note that SVMC reserves the right to discipline employees who knowingly make a false accusation, provide false information to the Organization or have acted improperly.

For further information on Retaliation, see SVMC *Non-Retaliation-Compliance Issue Reporting and Harassment* policies.

WORK ENVIRONMENT:

SVMC strives to provide a safe and productive work environment. The work environment must be free from discrimination and harassment based on race, color, religion, sex, sexual orientation, age, national origin, disability, veteran status, medical condition, marital status or registered domestic status or other factors that are unrelated to the organization's legitimate business interests. SVMC does not tolerate sexual advances, actions, comments or any other conduct in the workplace that creates an intimidating or otherwise offensive environment. Similarly, the use of racial or religious slurs — or any other remarks, jokes or conduct that encourages or permits an offensive work environment — will not be tolerated.

If you believe that you are subject to such conduct, bring such activity to the attention of the Organization, either by informing your supervisor, Compliance or Human Resources. SVMC considers all complaints of such conduct to be serious matters, and all complaints will be investigated promptly.

Some other activities that are prohibited because they clearly are not appropriate are:

- Threats;
- Violent behavior;
- The possession of weapons of any type;
- The distribution of offensive jokes or other offensive materials via e-mail or any other manner; and
- The use, distribution, sale or possession of illegal drugs or any other controlled substance, except to the extent permitted by law for approved medical purposes.

In addition, staff, contingent work force, Medical Staff, students, volunteers, independent contractors, and vendors may not be on the premises or in SVMC work environment if under the influence of or affected by illegal drugs, alcohol or controlled substances used other than as prescribed. Please refer to SVMC policy: *Drugs and Alcohol in the Workplace* for additional information and further guidance on using medications in the workplace.

EMPLOYEE PRIVACY:

SVMC collects and maintains personal information that relates to staff's employment, including medical and benefit information. Access to personal information is restricted solely to people with a business need to know this information. Personal information is released outside the Medical Center or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are provided access to such information must ensure that the information is not disclosed in violation of the organization's *Employee's Right to Privacy* policy or other applicable laws or regulations.

PATIENT'S RIGHTS (HIPAA) & SAFETY:

SVMC is committed to providing safe and compassionate treatment and care where patients and their families understand his/her individual condition or illness, as well as the recovery process. Collectively with Medical Staff we will provide the patient or patient's representative with information regarding the diagnosis and anticipated treatment plan. We will provide a clear explanation of the right to refuse or accept care and to make an advance directive, and the risks and benefits associated with available treatment options, organ donation or procurement, as well as financial and insurance information. Discharge planning begins at the time of admission and continues throughout the admission. The patient, the patient's representative or guardian, designated family members, and the clinical team will be involved in the discharge planning process.

SVMC provides each patient with a written statement of patient rights and a notice of privacy practices. These statements conform to all applicable state and federal laws, including but not limited to the Health Insurance Portability and Accountability act of 1996 (hereinafter referred to as HIPAA). Each patient has the right to copy and inspect much of the PHI that we retain on their behalf. All requests for access to PHI must be submitted in writing and signed by the patient or the patient's representative. If a patient believes that the PHI we maintain on their behalf is incorrect or incomplete, they have the right to request in writing that their PHI be amended or corrected. SVMC is not obligated to make all requested amendments, but will give each request careful consideration. Patients have the right to submit written request restrictions of our uses and disclosures of their PHI for treatment, payment, or health care operations.

SVMC supports and facilitates patients' rights to access guardianship, advocacy, conservatorship, child and/or adult protective services by providing information as requested and referrals. The Social Services Department is responsible for ensuring that the proper protective agencies are notified as required by county, state and federal laws.

SVMC treats all patients with compassion and respect. SVMC makes no distinction in the availability of services; the admission, transfer or discharge of patients; or in the care we provide based on age, race, sex, economic status, educational background, color, religion, ancestry, national origin, sexual orientation, gender identity/expression, disability, medical condition, marital status, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by Federal Law). SVMC recognizes and respects the diverse backgrounds and cultures of its patients and makes every effort to equip its caregivers with the knowledge and resources to respect each patient's cultural heritage and needs.
SVMC maintains an ongoing, proactive patient safety program for the identification of risk to patient safety and the prevention, reporting and reduction of healthcare errors. The hospital addresses the resolution of grievances from patients and their families through a formal process which includes informing patients of whom to contact regarding the grievance resolution. Please refer to the following SVMC policies for further guidance related to Patient Safety and Patient's Rights: *Patient's Right to Privacy*, *Patient's Rights and Responsibility*, *Patient Safety Plan*, and *Reporting Suspected Child Abuse & Neglect* All policies are located in the policy library via the Intranet.

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PATIENT INFORMATION:

SVMC is committed to ensuring confidentiality of records and related information for all patients. In the course of providing care, SVMC may collect information about a patient's medical condition, financial information, and family or medication history. SVMC will be sensitive to the personal nature of this information, and will maintain its confidentiality at all times. Patient information will not be released or discussed unless it is necessary to serve the patient or required by law.

In accordance with SVMC privacy and security policies and procedures, which reflect HIPAA requirements, no SVMC Staff has a right to any patient information other than that necessary to perform his or her job or responsibilities. Any breach of confidentiality represents a failure to meet the professional and ethical standards expected, and constitutes a violation of this Code of Conduct. A full confidentiality statement is received and accepted by each employee as part of the Employee New Hire process. SVMC also expects its vendors involved in patient care to perform and provide services consistent with all applicable HIPAA laws.

Policies for reference include the following: *Patient Identity Theft Prevention, Detection, And Mitigation Program (Red Flags Rule), Patient Privacy – Program Requirements, Patient Privacy– Patient's Right to Access, Release of Patient Information, and Confidentiality.*

REGULATORY COMPLIANCE:

SVMC provides many types of healthcare services. These services are provided pursuant to appropriate federal, state, and local laws and regulations, and federal conditions of participation. Such laws, regulations, and conditions of participation may include, but are not limited to, subjects such as certificates of need, licenses, permits, accreditations, access to treatment, consent to treatment, medical record-keeping, access to medical records and confidentiality, patients' rights, clinical research, end of life care decision making, and Medicare and Medicaid program requirements. The organization is subject to other numerous laws in addition to these healthcare laws, regulations, and the conditions of participation.

SVMC has developed policies and procedures to address many legal, accreditation, certification and regulatory requirements. However, it is impractical to develop policies and procedures that encompass the full body of applicable law, standards, conditions and regulations. Such laws, standards, conditions and regulations not covered in organizational policies and procedures must still be followed. There is a range of expertise within SVMC, including operations counsel and numerous functional experts, who should be consulted for advice concerning human resources, legal regulations and statutes, established standards and applicable conditions of participation.

Accreditation and Surveys:

From time to time, government agencies and other entities conduct surveys at SVMC. Accreditation or external agency surveys are extremely significant and broader than the scope of this Code of Conduct. In preparation for, during and after surveys, SVMC staff must comply with all accrediting and external agency surveyors in a direct, open and honest manner and with accurate information.

In preparation for, or during a survey or inspection, SVMC staff must never conceal, destroy, or alter any documents, lie; or make misleading statements to the agency representative. Also, SVMC staff must never attempt to cause another staff member to fail to provide accurate information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of law. No action should ever be taken, directly or indirectly, to mislead the accrediting or external agency survey teams.

EMTALA:

SVMC complies with the Emergency Medical Treatment and Active Labor Act (EMTALA) in providing emergency medical screening examination and necessary stabilization to all patients – including pregnant women and their unborn children – regardless of their ability to pay. A Medical Screening Exam (MSE) shall be performed on all patients presenting to the SVMC Emergency Department with a medical emergency or requesting treatment for an emergency medical condition. If a patient elsewhere on hospital grounds requests treatment for an emergency medical condition, SVMC will expedite that patient to the Emergency Department for care. If, based on a MSE, it is determined the patient suffers from an emergency medical condition, SVMC is obligated to provide services within its capabilities to stabilize the patient. This must all be accomplished prior to requesting financial information from the patient.

SVMC does not admit, discharge, or transfer a patient with an emergency medical condition simply based on their ability or inability to pay or any other discriminatory factor. A patient with an emergency medical condition is only transferred to another facility at the patient's request or if the patient's medical needs cannot be met at SVMC and appropriate care is knowingly available at another facility. Patients are only transferred in strict compliance with state and federal EMTALA regulatory and statutory requirements.
Please refer to the *Intra-facility Transfers* and *EMTALA – Inter-facility Transfers, MSE, Emergency Care and Stabilization* policies.

MEDICAL STAFF:

Healthcare services like those owned and operated by SVMC are a collaboration between Hospital Staff and Medical Staff members. As in any collaboration, each party has important roles and responsibilities that they must adhere to. SVMC is committed to providing an excellent work environment for our Medical Staff employees and contingent workforce

The Identification and Management of Disruptive Behavior policy establishes that SVMC has an environment that requires all individuals, employees, physicians, allied health practitioners and other independent practitioners to conduct themselves in a professional and cooperative manner within the facility and to define the behaviors that:

- Interfere with high quality patient care.
- Disrupt the orderly administration of Sierra View Medical Center
- Disrupt the orderly administration of the independent Medical Staff
- Affects the abilities of others to do their jobs.
- Creates a hostile work environment for Hospital or Medical Staff members.
- Adversely affects or impacts the community's confidence in the Hospital's ability to provide exemplary patient care

SVMC requires Medical Staff members to be familiar with this Code of Conduct, in addition to the Bylaws governed by the Medical Staff Rules and Regulations.

Interactions with Physicians:

Federal and state laws and regulations govern the relationship between hospitals and physicians who may refer patients to SVMC. The applicable federal laws include the Anti-Kickback Law and the Stark Law. It is important that SVMC Staff who interact with physicians (particularly those SVMC Staff who make payments to physicians for services rendered, provide space or services to physicians, recruit physicians to the community, and/or arrange for physicians to serve in leadership positions in the organization) are aware of the requirements of the laws, regulations, and policies that address relationships between SVMC and physicians. If relationships with physicians are properly structured, but not diligently administered, a failure to administer the arrangements as agreed results in a violation of the law. Any arrangement with a physician must be structured to ensure compliance with legal requirements. Most arrangements must be in writing and reviewed by the Compliance Department. Failure to meet all requirements of these laws and regulations can result in serious consequences for SVMC.

Patient Referrals:

The Stark Law is a strict liability law prohibiting physicians from making referrals of Medicare patients to an entity that furnishes "designated health services" if the physician has a financial relationship with the entity, unless an exception applies. Further, Medicare will not pay for claims improperly referred and the entity has a duty to refund, as well as be liable for Civil Monetary Penalties for knowingly presenting or causing another to present an improper claim, the potential of exclusion and False Claims Act liability. SVMC accepts patient referrals and admissions based solely on the patient's medical needs and our ability to render the needed services.

No SVMC staff member or other person acting on behalf of SVMC is permitted to pay or offer to pay anyone, solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. Similarly, when making patient referrals to another healthcare provider, we do not take into account the volume or value of referrals that the provider has made to Sierra View.

Business Courtesies/Tokens of Appreciation:

Any entertainment, gift or token of appreciation involving physicians or other persons who are in a position to refer patients to SVMC must be undertaken in accordance with the Non-Monetary Compensation and Medical Staff Incidental Benefits policies. This policy was developed to be in compliance with federal laws, regulations, and rules regarding these practices. Staff must consult

SVMC policies or our Compliance Department prior to extending any business courtesy or token of appreciation to a potential referral source. See SVMC policy: *Non-Monetary Compensation and Medical Staff Incidental Benefits*

FEDERAL AND STATE FALSE CLAIMS ACTS (FCA):

Federal and State False Claims Acts prohibit any person or entity from, among other things, knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval, or knowingly making or using, or causing to made or used, a false record or statement to get a false or fraudulent claim paid or approved.

The penalties for violating the Federal or State False Claims Act include:

- Civil monetary penalties of up to $20,000 for each false claim submitted;
- Up to three times the amount of damages the government sustains because of the false claim; and,
- The costs of the legal action brought to recover for the false claim.

A private citizen may file suit under the Federal and State False Claims Acts on behalf of the government if the citizen has direct and independent knowledge of the submission of a false claim. The government will then decide whether to intervene and take over the case, dismiss or settle the case, or let the private individual pursue the case on his or her own. In either case, the person who initially filed the case may receive a portion of the amount recovered in either litigation or settlement of the claim.

WHISTLEBLOWER PROTECTIONS:

Both the Federal and State False Claims Acts prohibit employers from retaliating or discriminating against an employee who, acting in good faith, investigates, reports or assists in uncovering a false claim or statement.

An employee who suffers discrimination or retaliation based on protected activities has the right to sue under the both the Federal and State False Claims Act. If the employee can prove that his or her employer retaliated against him or her for engaging in protected activity, the employee is entitled to be "made whole." The remedies may include:

- Reinstatement of the employee to his or her position;
- Two times the amount of back pay;
- Interest on the back pay; and,
- Compensation for any special damages (including litigation costs and reasonable attorneys' fees).

As noted above, it is the policy of Sierra View Medical Center that no employee shall be punished solely on the basis that he or she reported what he or she reasonably believed to be an act of wrongdoing or a violation of the SVMC Compliance Program.

Please see the *False Claims And Whistleblower Protection* policy.

BUSINESS AND FINANCIAL INFORMATION:

Accuracy, Retention, and Disposal of Documents and Records:

SVMC is committed to keeping accurate and complete records in accordance with applicable federal and state laws and regulations and SVMC policies and procedures.

Each SVMC staff member is responsible for the integrity and accuracy of our organization's documents and records, not only to comply with regulatory and legal requirements, but also to ensure that records are available to support SVMC's business practices and actions. No one may alter or falsify information on any record or document. Records must never be destroyed in an effort to deny governmental authorities information that may be relevant to a government investigation.

Medical and business documents and records are retained in accordance with the law and SVMC record retention policy. Medical and business documents include paper documents such as letters and memos, computer-based information such as e-mail or computer files on disk or tape, and any other medium that contains information about the organization or its business activities. It is important to retain and destroy records only according with our policy. SVMC Staff must not tamper with records. No one may remove or destroy records prior to the specified date without first obtaining permission as outlined in the SVMC records management policy.

To ensure the integrity of its records, SVMC shall maintain a comprehensive document system with policies and procedures covering the following with respect to all documents including information maintained in computer files: (a) creation, (b) distribution, (c) retention, (d) storage and retrieval, and (e) destruction.

Please refer to the *Records Management* policy in the policy library for additional details.

Coding and Billing for Services:

SVMC communicates its billing policies to all of its patients prior to, or, at the time of service or admission. SVMC bills its patients for services rendered and provides itemized bills free of charge upon request. The patient financial services office responds to patient questions in a timely and courteous manner. Adjustments are made to correct any over or under billings.

SVMC has implemented policies, procedures and systems to facilitate accurate billing to government payers, commercial insurance payers, and patients. These policies, procedures, and systems conform to pertinent federal and state laws and regulations. SVMC prohibits any SVMC Staff member from knowingly presenting or causing to be presented claims for payment or approval that are false, fictitious, or fraudulent.

In support of accurate billing, medical records must provide reliable documentation of the services SVMC provided. It is important that all individuals who contribute to the medical record provide accurate information and do not destroy any information considered part of the official medical record. Accurate and timely documentation also depends on the diligence and attention of Medical

Staff members who treat patients in our facilities. Medical Staff Members are expected to provide SVMC with complete and accurate information in a timely manner.

Confidential Information:

You are prohibited from using any information about SVMC for your personal benefit. Business information should be disclosed only as required in the performance of your job duties or as authorized by SVMC management. Employees may be held personally liable for any benefit gained from improper use of this information or damages resulting from its disclosure. Employees who violate this policy may also face disciplinary action, up to and including termination.

All SVMC communication systems, including phone systems, voice mail, portable electronic devices, Internet and Intranet access and e-mail, are company property and are to be used for business purposes. Reasonable and limited personal use of these resources is permitted; however, these communications may be monitored. You should assume that your personal communications on company-owned or maintained systems are not private. Patient and confidential information should not be sent through any communication system unless it is sent through a secure system which complies with HIPAA. Anyone who abuses SVMC information systems or uses them excessively for non-business purposes will be subject to discipline.

You are all responsible for using company resources and assets wisely, including time, materials, equipment, supplies and information. These resources are to be maintained and used for business purposes only. The occasional use of items that are negligible in cost, such as telephones and insignificant copying, is permitted. The use of company assets for personal financial gain unrelated to the organization is not allowed. All employees must obtain prior written approval from their supervisor to use company assets for charitable reasons.
Please see: *Email* policy; *Information Security* ***policy***; *Workstation Use and Security and Internet* policy.

Q&A Computer Security

QUESTION: *I am out of town and need confidential information from my office computer. I call the office and ask my assistant to get the information for me. To do so, I must tell him my computer security password. Have I violated SVMC policy?*

ANSWER: *Yes. You may forward emails to your assistant or other designee to be read while you are away, but it is a violation of IT Security policies to disclose computer passwords. You are responsible for protecting your password, and for the use or misuse of the same.*

Charity Care:

SVMC is a not for profit organization, which provides hospital services to the community of Porterville and the greater area of Southeastern Tulare County. SVMC is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or

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underinsured. As part of fulfilling this commitment, SVMC provides medically necessary services, without cost or at a reduced cost, to patients who qualify in accordance with program requirements. Please see the *Financial Assistance - Full Charity Care and Partial Discount policy*

Conflict of Interest:

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise your integrity in business judgment, delivery of patient care, or ability to perform your job or responsibilities. A conflict of interest may arise if you engage in any activities to advance your personal interests at the expense of SVMC.

An actual or potential conflict of interest occurs when any person in a position to influence a decision which could result in personal gain for that individual, a relative or a friend as a result of the SVMC's business dealings. A relative is any person who is related by blood or marriage, or whose relationship with the person is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the person's household. You have a duty to disclose to their supervisor and the Compliance/Privacy Officer if you believe that you have a financial interest which could put you in a conflict of interest situation.

Political Activity: SVMC and its employees are prohibited from expending public funds to promote a candidate in an election campaign. This means no SVMC employee shall partake in any form of support for a political candidate while on company time. Such an infraction could jeopardize SVMC's status as a not-for profit entity. Nor are employees permitted to endorse any candidate or political entity as a representative of SVMC. Such an infraction could jeopardize SVMC's status as a not-for-profit entity. Please see *Compliance - Conflict of Interest policy in the policy library for more information.*

Q&A Political Contributions or Activities

QUESTION: *I work for the committee to re-elect a local political candidate. Can I distribute campaign brochures to other SVMC employees? Can I wear a candidate button?*

ANSWER: *No. You may not distribute campaign material on SVMC property, or otherwise campaign for the candidate while on duty. You are, however, free to distribute this material after hours in non-work areas and off campus*

Gifts and Business Courtesies:

SVMC mandates limitations and conditions concerning the exchange of gifts and business courtesies from outside sources to SVMC employees and associates. It is not permitted to accept any amount of cash or cash equivalent (check, money order, credit card, or gift card/gift certificate during the course of your duties as an agent, employee, volunteer or contractor of SVMC, from

any person or entity. Acceptance of gifts (tangible items) or favors during the course of your duties from any person or entity, with a value in excess of $50.00, is not permitted.

Patients may donate to the Sierra View Foundation or other charitable organization in the name of the SVMC employee or employees they wish to recognize

Promotional items from vendors may be accepted as long as they are nominal in value ($10.00 or less). Promotional items include, but are not limited to pens, notepads, mugs, binders or similar items which are pre-printed or embossed with the logo of a vendor or product name. Any gifts that are embossed or preprinted with the logo of a vendor or product name that exceed the $10.00 value are unacceptable even if they do not reach the $50.00 limit.

It is the responsibility of the Department leadership to monitor the value of all gifts received, and to contact the Compliance Department should there be a question as whether a gift is appropriate or not. Please see policy: *Compliance, Gifts and Business Courtesies, Exchange of*

Q&A Accepting Gifts

QUESTION: *I work on a unit in the hospital. Upon being discharged, a grateful patient offered me $20 in cash to thank me for the care they received. May I keep the cash?*

ANSWER: *No. You may not accept any amount of money in the form of cash, check, or pre-paid credit card from anyone in relation to your position or job performance at SVMC.*

Outside Employment and Business Interests:

SVMC recognizes that some employees may hold additional jobs outside their employment with SVMC. In accordance with California Government Code section 1126, employees of SVMC are permitted to engage in outside work or hold other jobs to certain restrictions based on reasonable business concerns. EXEMPT EMPLOYEES ONLY: Outside employment for exempt employees requires prior written approval from your respective vice-president.

You are not permitted to work on any personal business venture on the SVMC premises or while working on SVMC time. In addition, employees are not permitted to use SVMC equipment, telephones, computers, materials, resources or proprietary information for any outside work. You must abstain from any decision or discussion affecting SVMC when serving as a member of an outside organization or board or in public office, except when specific permission to participate has been granted by the SVMC's Compliance Officer. Please see: *Outside Employment policy* in the policy library for more information.

Contracting with SVMC:

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You may not contract with SVMC to be a supplier, to represent a supplier to SVMC, or to work for a supplier to SVMC while you are an employee of SVMC. In addition, you may not accept money or benefits, of any kind, for any advice or services you may provide to a supplier in connection with its business with SVMC. Please see *Compliance - Conflict of Interest policy* in the policy library for more information.

Government Investigations:

It is SVMC's policy to comply fully with all state and federal laws and regulations. SVMC will cooperate with any reasonable request for information from any governmental entity. In doing so, however, it is essential that our employees' legal rights and the legal rights of the company are protected. It is also important that government requests for information be responded to in an accurate, complete and timely manner. Notify your supervisor, Vice-President and/or Compliance/Privacy Officer immediately if you receive a subpoena, search warrant or other legal document from a government agency regarding SVMC's business, whether at home or in the workplace.

SVMC encourages employees to cooperate with governmental authorities conducting an investigation; no adverse action will be taken against you for any lawful cooperation. Be aware that the law guarantees each person the right to be represented by legal counsel during any investigation or inquiry by any governmental agency. In such a scenario, SVMC will likely also be represented, and you should be aware of the opportunity for such representation. You are not legally required to notify SVMC of your cooperation with governmental authorities in an investigation; however, we would appreciate such notification.

For more information on government search warrants or unannounced visits by auditors/ investigators, please refer to the *Government Search Warrants and Unannounced Visits* policies located in the policy library.

Exclusion List:

SVMC will not employ or conduct business with an individual or entity listed on a government exclusion list. Medical treatment provided to government insured patients (Medicare, Medicaid, TRICARE, etc.) cannot legally be billed for reimbursement if a person or entity on an exclusion list had any part in the care of that patient, whether direct or indirect, including the provision of equipment or supplies involved in the patient's treatment. Nor can an excluded person or entity have any part in the billing process for the care of a government insured patient. In addition, any service ordered or directed by an excluded physician is excluded from coverage under the Federal healthcare programs. For a hospital violating this law (by knowingly or in some cases even unknowingly employing or doing business with a person or entity on an exclusion list), penalties can be severe. By signing the attestation, you agree that you will immediately self-report to management and the Compliance/Privacy Officer if you receive notification of being excluded from participation in federal and/or state health care programs, including Medicare and MediCal or any government reimbursement program.

Please see *Compliance - Sanctions Screening* policy in the policy library.

SUBJECT:	SECTION:
DISCLOSURE OF PROTECTED HEALTH INFORMATION DURING DISASTER RELIEF EFFORTS	**Page 1 of 2**

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

POLICY:

1. Providers and healthcare plans covered by the HIPAA Privacy Rule may share patient protected health information to assist in disaster relief efforts and to assist patients in receiving the care they need. Information relevant to the following areas may be shared:

   a. Treatment

   b. Notification

   c. Imminent danger

   d. Hospital directory

PROCEDURE:

1. Treatment:

   a. Healthcare providers may share patient protected health information as necessary to provide treatment.

      - Treatment includes:

        – Sharing information with other providers (including hospitals and clinics)

        – Referring patients for treatment (including linking patients with available providers in areas where the patients have relocated)

        – Coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate healthcare services)

   b. Providers may share patient protected health information to the extent necessary to seek payment for these healthcare services.

2. Notification:

   a. Healthcare providers can share patient protected health information as necessary to identify, locate and notify family members, guardians or anyone else responsible for the individual's care or the individual's location, general condition or death.

   b. The healthcare provider should get verbal permission from individuals, when possible; but, if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.

c. When necessary, the hospital may notify the police, the news media or the public at large to the extent necessary to help locate, identify or otherwise notify family members and others as to the location and general condition of their loved ones.

d. When a healthcare provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information, if doing so would interfere with the organization's ability to respond to the emergency.

3. Imminent Danger:

a. Providers can share patient protected health information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, consistent with applicable law and the provider's standards of ethical conduct.

4. Hospital Directory:

a. Healthcare facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the hospital, his/her location in the hospital and general condition.

REFERENCE:

- The Joint Commission (2023. Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **FIRE RESPONSE PLAN**	SECTION: *Life Safety Management* **Page 1 of 4**

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

PURPOSE:

In order to assure the safety of patients, visitors, and staff, a standard response to fire, or to the potential of fire, defined plans are required. This fire plan describes the standard responses for all Staff, Volunteers, and Licensed Independent Practitioners within the Sierra View Medical Center inpatient and outpatient buildings to an activation of the Fire Alarm or to conditions that indicate the presence of a fire in the area.

POLICY:

In the event of a fire, the Staff, Volunteers, and Licensed Independent Practitioners will follow the basic plan for the building in which they are located. They will use the same plans for fire drills as they do in actual events. Fire drills will be observed to measure the effectiveness of staff response, as well as to measure the response of building fire systems.

AFFECTED PERSONNEL/AREAS: *GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, LICENSED INDEPENDENT PRACTICIONERS, SIERRA VIEW COMMUNITY HEALTH CENTER (SVCHC)*

PROCEDURE:

1. Code Red In Your Work Area

   Hospital:

   a. An alarm will sound throughout the building and where the pull station was activated or where the automatic sensors have detected smoke or heat.

   b. An overhead page will follow, indicating the location of the fire.

   c. If you discover smoke, fire, or the alarm system is activated in your immediate area, the appropriate response will best be remembered by using the acronym R.A.C.E.:

R- Rescue ***Remove people***

- Remove anyone in immediate danger to a safe area. This may be a patient, visitor, or employee.
- Do Not Use Elevators.

A- Alarm ***Sound the Alarm***

- Go to the nearest pull station and activate. This notifies the Fire Department and mobilizes the Hospital Fire Response Team (Engineering & Security).

- Call 55 to notify the operator of the location of the fire. The operator will then overhead page **"CODE RED, Building, Area, and Location"** three times at 5 minute intervals until ALL CLEAR.

C- Confine ***Secure the Area***

- Close all doors and windows
- Remove all items from the corridors
- The Safety Officer will assess if oxygen supply to the affected area should be discontinued. Only the Safety Officer or his/her designee and the fire marshal are authorized to order a supply valve closed.

E- Extinguish ***Attempt to extinguish fire***

- Fight the fire only if you are not placing yourself in danger.
- Personnel in the immediate department area should take an extinguisher and proceed to the fire.

All Clear ***Situation is under control***

The Fire Department Incident Commander at the scene verifies that the situation has been resolved. The Incident Commander will notify the switchboard operator and "CODE **RED IS ALL CLEAR"** will be paged overhead.

2. General Responsibilities for Fire Alarm Activation *Above, Below or Adjacent* to the Code Area

If your area is above, below, or adjacent to the point of origin, the following procedures should be taken:

i. Close all doors
ii. Remove items from the corridors
iii. Have patients return to their rooms
iv. Remind patients and visitors not to use elevators
v. Listen for overhead pages for status of situation
vi.

3. General Responsibilities for Fire Alarm Activation *Remote* from Your Work Area

If your area is away from the point of origin (not within your immediate area or above, below or adjacent to that area), the following procedures will need to be implemented:

i. Be ready to accept patients from the point of origin
ii. Remind patients and visitors not to use elevators
iii. Listen for overhead pages for status of situation

4. Evacuation

a. Evacuation will not take place until directed by the Incident Commander and/or Fire Department. At any time, when several patients are in immediate danger, moving them to a safer area can be done without these approvals. Administrator/Administrator-on-Call, Nursing Supervisor, and/or Safety Officer evaluates the situation and determines the need to activate the Emergency Operations Plan.

b. Do Not Use Elevators

c. There are several types of evacuations:

   i. Stage I-Horizontal-move into an adjacent smoke compartment.

   ii. Stage II- Vertical- move one floor down, taking the exit stairs.

   iii. Stage III- Building- all patients and visitors will be moved from the building to alternate care sites.

d. Incident Commander in conjunction with the Porterville Fire Department will determine the need for evacuation beyond horizontal evacuation to an adjacent smoke compartment.

5. Fire Response Team

The fire response team is made up of Facilities/Engineering Department, Security and the Safety Officer. They are responsible for responding to the area when a code red is initiated. The Safety Officer or designee will direct the fire response team once they arrive on the scene.

6. FIRE EXTINGUISHERS

a. Location of Fire Extinguishers:

All Staff, Volunteers, and Licensed Independent Practitioners should be oriented to the location of the fire extinguishers in their respective work area/department. Storage or equipment should never block fire extinguishers. The Facilities/ Engineering Department visually inspects extinguishers every month.

b. Use of Fire Extinguishers:

Select the proper fire extinguisher for the fire. Position yourself as close to the fire as safely possible. Remember to leave a way out.

Use the **PASS** method to extinguish the fire:

Pull	the pin on the extinguisher.
Aim	the extinguisher nozzle at the base of the flames.
Squeeze	the handle to discharge the extinguisher. Squeeze the handle as the contents are under pressure.

Sweep from side to side at the base of the fire. Remember that the extinguisher will empty quickly. Do not waste the extinguishing agent.

DO NOT ATTEMPT TO EXTINGUISH THE FIRE IF IT IS TOO LARGE OR DANGEROUS. CLOSE THE DOOR, LEAVE THE AREA AND AWAIT ARRIVAL OF THE FIRE DEPARTMENT.

7. Fire Drills Will:

- Be conducted a minimum of once per quarter per shift.
- Be evaluated for performance of fire safety equipment and staff.
- Be reviewed by the Safety Committee on a regular basis.
- Simulate real-life possibilities.
- Be scheduled at varied times.
- Be conducted by the Facilities/Engineering Department.
- Be observed from varied locations.

Evaluation of staff knowledge will include:

- Compartmentalization and containment
- Areas of refuge
- Fire extinguishment
- Fire response duties
- Vertical and horizontal evacuation

Staff response will be observed at the drill location and:

- Adjacent compartment(s).
- The compartment above and below the drill location.

REFERENCES:

- The Joint Commission (2023). EC.02.03.01 EP9 Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **IDENTIFICATION OF PATIENT'S REQUESTS AND SAMPLES (BLOOD BANK)**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide instructions on how to identify specimens for blood bank laboratory orders.

POLICY:

A. Request Forms: Done in order entry on the hospital computer system.

1. The electronic requisitions requesting blood bank (BBK) studies contain the following information to ensure positive identification of the patient and accurate processing of the blood bank orders in adherence to the Association for the Advancement of Blood & Biotherapies (AABB) Standards and TJC Accreditation Requirements.

NOTE: All patients will be issued an ID wristband, which will include a unique BBK (Blood Bank) number for positive ID.

a. Patient's first and last name

b. Patient's medical record number

c. Patient's account number

d. Patient's date of birth (DOB)

e. Physician of record

f. Patient's location

g. Test(s) required

h. Blood products requested, if any

i. Date/time specimen draw

j. Two initials required on blood tubes labeled at bedside to validate witnessed phlebotomy with correct ID and correct BBK#.

(For Inpatient and Emergency Department (ED), any combination of phlebotomist, nurse, and/or physician initials are acceptable. For Outpatient, phlebotomist and lab clerk initials can be used.)

k. If tests are to be performed on newborns, the medical record number of the mother is also available on the baby's requisition.

l. Additional information, such as clinical diagnosis, ordering physician, medication, date and time blood products are needed for transfusions and the initials of the nursing personnel placing the order, are also required.

m. Incomplete orders will not be accepted by the blood bank for processing. This includes any sample missing a second set of initial's from witness, BBK number of the patient obtained from the wristband and time of collection.

B. Blood Samples:

1. The patient and the blood sample shall be positively identified at the time of collection by comparing the information on the blood bank specimen label with the information on the patient's ID wristband. The technician will verify the patient's name verbally with the patient, family member, or nurse when the patient is unable. In cases such as an ED emergency, a stat admit kit with temporary ID will be used. Blood specimens drawn will be labeled at the bedside with the computer generated or handwritten label containing the following:

a. Patient's first and last name

b. Patient's account number

c. Patient's DOB

d. BBK Number (handwritten by phlebotomist – found on patient's wristband) All specimens drawn for blood bank testing will be obtained and labeled by a certified/licensed lab personnel or licensed personnel in the presence of a second licensed personnel. All personnel involved in obtaining the specimen will each initial the specimen labels and/or additional forms as required, and confirm that the BBK# has been transcribed correctly from the patient's wrist band to the specimen label. The outpatient lab setting may use a lab clerk as the second personnel.

e. Date/time specimen drawn (handwritten by phlebotomist)

f. Initial of phlebotomist (handwritten by phlebotomist)

C. Identifying Information:

1. Before a specimen is used for blood bank test processing, the blood bank CLS shall confirm that all identifying information on the blood bank order is in agreement with that on the blood bank sample tube label.

2. A properly labeled BB specimen is defined as containing the above list of identification points. Any deviation from the above accurate identification will result in specimen rejection and another specimen must be obtained.

AFFECTED AREAS/PERSONNEL: *LABORATORY STAFF, NURSING, PHYSICIANS*

REFERENCES:

- American Association of Blood Banks (AABB) STDS, 33rd Ed, pgs. 38-39, 5.11.1 - 5.11.3, 2022.
- The Joint Commission (2023). Hospital accreditation standards (DC.01.01.01 and DC.01.03.01). Joint Commission Resources. Oak Brook, IL.

SUBJECT: **INJURY AND ILLNESS PREVENTION PROGRAM**	SECTION: *Safety Management* **Page 1 of 6**

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

PURPOSE:

To prevent injuries, illnesses and accidents within the facility. To ensure the safety and health of all personnel and to provide a safe and healthful work environment.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that the personal safety of each employee is of primary importance. Prevention of occupationally-induced injuries and illness of such consequence is that it will be given precedence over operations, whenever necessary. To the greatest degree possible, management will provide all mechanical and physical activities required for personal safety and health, in keeping with the highest standards.

We will maintain a safety and health program conforming to the best practices available. To be successful, such a program must embody proper attitudes toward injury and illness prevention on the part of the supervisors and employees. It also requires cooperation for all safety and health matters; not only between supervisors and employees, but also between each employee and his or her co-workers. Only through such a cooperative effort can a safety program in the best interest of all be established and pursued.

AFFECTED PERSONNEL/AREAS: *GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS*

PROCEDURE:

OBJECTIVES:

1. To identify and assign responsibilities to the person(s) to implement the program.
2. To provide means to identify and evaluate occupational safety and health hazards through periodic scheduled inspections and investigations of occupational injuries and illnesses.
3. To institute methods for timely correction of unsafe conditions detected based on severity of the hazard.
4. To provide safety training to current, new, and reassigned personnel.
5. To provide a system for communicating with employees on safety matters by clearly indicating how compliance with safe work practices will be ensured.
6. To encourage employees to participate in reporting unsafe conditions without fear of reprisal.
7. To coordinate the functions of this program with an Employee Health Program, the Infection Control Program, and Risk Management through the Safety Management Program.

AUTHORITY:

1. The Chief Financial Officer (CFO) and the Board of Directors (BOD) of Sierra View Medical Center are responsible for providing the financial support necessary for specific services, equipment and personnel required to maintain the Injury/Illness Prevention Program.

2. The Sierra View Medical Center Chief Executive Officer (CEO delegates the management and implementation of the program to the Safety Committee.

3. The Safety Officer is responsible for reviewing all applicable general industry safety orders and other safety orders applicable to the operations of this program.

HAZARD SURVEILLANCE/LIFE SAFETY ROUNDS
SUBJECT: ACCIDENT, ILLNESS AND INJURY INVESTIGATIONS

It is the policy of the Injury and Illness Prevention Program to establish a protocol for employees to follow in the event of a work-related injury or illness and to investigate and correct any significant hazards.

PROCEDURES:

1. Any employee who becomes injured or ill on duty must report his or her condition to the department manager or supervisor immediately.

2. The Employee or Supervisor must enter an electronic event report.

3. If the supervisor or employee believes that an evaluation by a physician is required, the Employee must report to Employee Health during the hours of 7:00 a.m. to 3:30 p.m. Monday through Friday. After hours and on weekends or holidays, the employee should report to the Emergency Department if medical treatment is urgent or necessary.

4. The Manager/Director of the employee's department will complete a review and action plan in the electronic event report.

5. When an employee identifies a hazard, they will report it in the electronic event reporting system.

6. Employee Health will compile reports on occupational injury and illness and report significant trends and incidents to the Safety Committee and Management.

7. The Safety Committee, with the assistance and input of Directors and Managers of affected areas will investigate the causes of the incidents, make corrective recommendations and carry out corrective actions based on reports provided by Employee Health.

SUBJECT: ACCIDENT INVESTIGATION

Accident investigations will be conducted by trained individuals. The primary focus will be on understanding why the accident or near miss occurred and what actions can be taken to preclude its recurrence. Furthermore, the investigation will be in writing and identify the cause(s) of the accident or near miss.

The following questions will be answered during the investigation of an occurrence:

1. WHAT HAPPENED? WHAT NORMALLY HAPPENS? WHAT DOES PROCEDURE REQUIRE? (IF APPLICABLE)

   The investigation must obtain all the facts surrounding the occurrence. For example, what caused the situation to occur, who was involved; was/were the employee(s) qualified to perform the function involved in the accident; were they properly trained; were proper operating procedures established for the task involved; were those procedures followed, and if not, why not; does this situation exist in other departments; how can it be corrected?

2. WHY DID IT HAPPEN?

   The Safety Officer or designee must determine which aspects of the operation or process require additional attention. It is important to note that the purpose here is not to establish blame, but to determine what type of constructive action can eliminate the cause(s) of the accident or near miss.

3. HOW WAS THE ORGANIZATION MANAGING THE RISK?

   Actions already taken to reduce or eliminate the exposures being investigated will be noted, along with those remaining to be addressed. Any interim or temporary precautions will also be noted. Additionally, any pending corrective action or reason for delay will be noted.

JUST CULTURE:

Sierra View Medical Center's philosophy for building and supporting the culture of patient safety includes promoting a fair, just and supportive environment for those employees that self-report potential or actual safety risk, hazard events and/or ethical risks.

COACHING:

Coaching discussions are recommended for making constructive suggestions to improve individual competency or skills where some improvement is required to improve performance, and formal discipline may not yet be appropriate. Employee coaching is considered to be educational and is not considered to be disciplinary. However, if the employee's performance does not improve following coaching, disciplinary action may result per SVMC policy.

SUBJECT: EMPLOYEE TRAINING AND DOCUMENTATION

It is the policy of Sierra View Medical Center to define the requirements and responsibilities for safety education and training as means to minimize injuries, illnesses and accidents.

PROCEDURES:

1. Mandatory Education – all Sierra View Medical Center Department Leaders will ensure that their employees will complete the E-learning modules specified below:

   A. Fire Safety (annually)

   B. Safe Lifting Procedures and Use of Mechanical Aids To Decrease Risk of Injury (annually)

   C. Infection Control/Universal Precautions and Blood Borne Pathogen Standard (annually)

   D. Safe Patient Handling

   E. Electrical Safety (annually)

   F. Equipment Safety (annually)

   G. Hazardous Materials and Waste Safety Communication (annually)

   H. Workplace Violence Prevention (annually)

   I. Health and Safety Handbook (annually)

   J. Worker's Compensation (annually)

2. Departmental Specific Training

   A. Department Leaders must orient their employees to any potential occupational hazards related to their departments and conduct a refresher orientation at least annually.

   B. Department Leaders must in-service employees of new hazards introduced by a change in equipment, processes, raw materials, etc.

   C. Department Leaders must provide safe work conditions, practices and personal protective equipment as a means of minimizing departmental specific hazards.

3. Education Records

   Records of all completed education programs are maintained by the employee's department managers and/or the Education Department.

SUBJECT: EMPLOYER-EMPLOYEE SAFETY COMMUNICATION SYSTEM

It is the policy of Sierra View Medical Center to establish a communication network between staff and appropriate administrative contacts regarding any safety concerns.

PROCEDURES:

1. Employee compliance with safe work practices is assessed through his or her annual job performance evaluation.

2. Safety rules and information on occupational hazards are communicated through the following means:

   A. Annual or as needed

   B. Department's specific training

   C. Self-study modules

   D. Other means of communication

3. Employees are encouraged to report safety concerns to their immediate supervisor.

4. Employees are also encouraged to inform the Safety Officer about workplace hazards without fear of reprisal or other discrimination.

5. Employees may use the Electronic Reporting System anonymously to report safety concerns or workplace hazards.

6. The Safety Officer will discuss and evaluate the Employee Safety Reports on a quarterly basis at the Safety Committee meeting.

SUBJECT: GENERAL SAFETY RULES

1. Department Leaders are responsible for maintaining safety standards, developing safety rules, and supervising and training personnel in the department standards.

2. Department Leaders are responsible for notifying the Safety Officer in case of any unsafe condition or hazard.

3. All department employees will report defective equipment, unsafe conditions, acts, or safety hazards to their supervisor. This may be done using the Electronic Reporting System.

4. Employees will keep all electrical cords clear of passageways. Electrical extension cords will not be used without written approval of Engineering.

5. All equipment and supplies must be properly stored. All personal electrical appliances will be safety inspected by Engineering prior to use.

6. Scissors, knives, pins, razor blades and other sharp instruments must be safely stored and used.

7. All electric machines with heat producing elements must be turned off when not in use.

8. Smoking is prohibited on Hospital property.

9. Rubbish or trash will not be permitted to accumulate.

10. Advise Engineering immediately of improper illumination and ventilation.

11. Furniture and equipment must be arranged to allow passage and access to exits at all times.

12. Minor spills (i.e., water) should be cleaned by the employee who discovers the spill. This should be done immediately. Major spills will be cleaned by the Environmental Services (EVS) Department. Spill kits are available for spills involving hazardous waste.

13. Report all faulty equipment to the Engineering Department and apply "defective-Do Not Use" tag.

14. All warning signs will be obeyed.

15. File drawers and cabinet doors should be kept closed when not in use.

16. Suitable clothing will be worn (High heels or jewelry that may catch in machinery will be avoided).

REFERENCES:

- The Joint Commission (2023) Hospital accreditation standards. EC.04.01.05 EP1 Joint Commission Resources. Oak Brook, IL.
- Occupational Safety and Health. (n.d.). Injury and Illness Prevention Program . Retrieved from https://www.dir.ca.gov/dosh/etools/09-031/.
- Giso. (n.d.). Retrieved from https://www.dir.ca.gov/title8/3203.html.

SUBJECT: **MEDICAL GASES**	SECTION: ***Utility Management*** **Page 1 of 4**

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

PURPOSE:

To define the process for providing medical gas supply for patients at Sierra View Medical Center (SVMC).

POLICY:

Sierra View Medical Center maintains medical gases for use in the facility. The hospital Engineering Department is responsible for the storage, ordering, handling, and transport of these gases. Personnel concerned with the use and transport of medical gases shall be trained in the proper handling of cylinders, cylinder trucks and supports, and cylinder-valve protection caps. All cylinder storage areas, outside and inside, shall be protected from extremes of heat and cold and from access by unauthorized individuals.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARDS, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, SIERRA VIEW COMMUNITY HEALTH CENTER (SVCHC) STAFF

PROCEDURE:

Bulk Gases

- The liquid oxygen delivery system is composed of two reservoirs. A main supply and emergency reserve supply.
- The hospital Engineering Department assumes responsibility for the oxygen storage system and for the ordering of liquid oxygen and the exchange of all cylinders.
- Engineering Department checks the bulk oxygen system once each day.
- The bulk oxygen system is inspected annually by a licensed contractor for compliance with National Fire Protection Agency (NFPA) 50. Inspection reports are maintained by Engineering and are submitted to the Safety Committee for review. All identified repairs are tracked and reported to the Safety Committee.

Cylinders

- General Standards
  - Cylinders must be secured at all times so they cannot fall.
  - Valve safety covers shall be left on until pressure regulators are attached.

- Containers must be marked clearly with the name of the contents. Tanks with wired on tags or color code only shall not be accepted.
- The use of oil, grease or lubricants on valves, regulators or fittings is prohibited.
- Do not attempt to repair damaged cylinders or to force frozen cylinder valves.

- Flammable Gases
  - Special care must be used when gases are used in confined spaces.
  - No more than two cylinders shall be manifold together; however, several instruments or outlets are permitted for a single cylinder.
- Pressure Regulators and Needle Valves
  - Needle valves and regulators are designed specifically for different families of gases. Use only the properly designed fittings.
  - Throats and surfaces must be clean and tightly fitting. Do not lubricate.
  - Tighten regulators and valves firmly with the proper sized wrench. Do not use adjustable wrenches or pliers. Do not force tight fits.
  - Open valves slowly. Do not stand directly in front of gauges (the gauge face may blow out). Do not force valves that stick.
  - Check for leaks at connections. Leaks are usually due to damaged faces at connections or improper fittings. Do not attempt to force an improper fit. (It may only damage a previously undamaged connection and compound the problem).
  - Valve handles must be left attached to the cylinders.
  - The maximum rate of flow shall be set by the high-pressure valve on the cylinder. Fine tuning of flow shall be regulated by the needle valve.
  - Shut off cylinder when not in use.
- Leak Testing
  - Cylinders and connections shall be tested by "snoop" or a soap solution. First test the cylinders before regulators are attached and test again after the regulators or gauges are attached.

- Empty Cylinders
  - Must be marked empty.
  - Empty or unused cylinders must be returned promptly.
  - Replace valve safety caps.

Oxygen Use

- Policy:
  - Oxygen and other gases are potentially dangerous. Special safety precautions shall be followed at all times while using or storing oxygen.
- Procedure:
  - Be sure cylinders are secure on rack and never hang anything on cylinder.
  - Crack valves to clear them before bringing tank into patient's room.
  - Read labels, tags and color code before administering any compressed gas.
  - Do not use wool or nylon inside the tent - they may cause sparks.
  - Check oxygen supply regularly.
  - Store oxygen cylinders upright and secured.

Handling, Storage, and Transport of Cylinders

- All personnel must be properly trained to handle cylinders, trucks, support valves, regulators and protection caps.
- Cylinder caps must be in place at all times unless there is a regulator in place.
- Cylinders shall always be stored according to NFPA 56 .
- All compressed gas cylinders must be stored in racks or properly anchored to prevent tipping. All cylinders in use must be attached to a cylinder stand, therapy apparatus or other means of anchoring support. Empty cylinders shall be stored in the same manner as full cylinders.

- Care must be exercised not to drop, drag or roll a cylinder. Cylinders must be transported on approved dollies or hand trucks.
- Free standing cylinders must be chained or supported by a cylinder stand or cart.
- Cylinders may not be placed near radiators, steam pipes or heat ducts.
- Medical and industrial grade gases must be separated to prevent cross contamination. Cylinder storage areas shall be identified with appropriate signage to designate USP or Industrial use.
- Empty cylinders will be transported by Engineering staff and secured in the designated exterior cylinder storage area for replacement by the contracted supplier.

Verification of Ordered Medical Gases

- When cylinders are requested, Engineering will transport appropriate full cylinders to the requested area. A licensed or trained individual will verify gas type and grade prior to connection to equipment or regulator to ensure patient safety.

Education and Training

- All patient care and Engineering staff will be trained in proper storage, transporting, anchoring and for gas grade and type. Records for in-service training will be maintained on file for reference purposes.

REFERENCES:

- National Fire Protection Association (NFPA) 50 and 56 (2001). Retrieved from https://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards/detail?code=50.
- The Joint Commission (2023). EC.02.05.09 Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **MEDICAL RECORDS TO BE SENT WITH PATIENT TRANSFERS**	SECTION:

POLICY:

Sierra View Medical Center (SVMC) shall facilitate communication between all units of the Hospital and the nursing unit (other facility patient care unit, i.e., skilled nursing facility (SNF), Behavioral Health) for the best of the patient. Transfers between the acute hospital and other hospital units shall be carried out efficiently and effectively.

PROCEDURE:

1. When receiving patients from other units, these records will be sent:

   a. Complete Transfer and Referral Record

   b. Copy of most recent CXR

   c. Copy of most recent History and Physical

   d. Copy of Discharge Planning Notes

   e. Current lab results

   f. Medication Administration Record and Medication Reconciliation/Verification Form

   g. Copies of any and all advance directives, including a Living Will, Durable Power of Attorney, signed advance directive form, etc.

   h. The current acute hospital medical records will be sent in the hard binder along with the patient. This medical record will remain on the patient care unit until the next morning.

   i. It is the responsibility of the receiving unit staff to break down the medical record from the binder and return the empty binder to the proper acute (sending) unit once Health Information Management Department staff has picked up the medical record.

      - If the patient arrived on the receiving unit between the hours of 0800 and 1430, the medical record will be picked up by Health Information Management Department staff the next morning at 0800.

      - If the patient arrived between 1430 and midnight, the medical record will be picked up at 1200 the next day.

   j. The Health Information Management Department staff will assemble, code and return the original patient location medical record to the receiving unit ASAP for reference purposes until the patient is discharged.

2. From the DP/SNF, a resident/patient with an assessed need for acute hospitalization will be sent to the Emergency Department for evaluation. The physical chart/medical record will be sent with the resident/patient, including medication and treatment sheets.

   a. After evaluation, if the resident/patient meets the criteria for acute hospitalization, he/she will be transferred to the appropriate acute care unit. The physical chart/medical record will stay with the resident/patient on the acute side until the acute unit staff have obtained all necessary medical records that they will need, after which the chart will be picked up by the DP/SNF's medical record staff.

      - When the resident/patient returns to the DP/SNF unit within a bed-hold timeframe (as applicable), the medical record will be continued as current. If beyond bed-hold, the resident/patient is discharged from DP/SNF and the medical record will be sent to the Health Information Management Department by the DP/SNF Records staff within 24-48 hours.

   b. If the resident's/patient's stay in the Emergency Department is extended, a DP/SNF staff will follow-up with the Emergency Department staff in regards to the latter unit's need for obtaining all necessary medical records from the physical chart. Once all necessary records have been obtained, the chart will be brought back to the DP/SNF. Once the resident/patient evaluation have been completed and acute hospitalization is necessitated, the physical chart can be requested by the acute care unit staff where the resident/patient is transferred to. From there, the handling of the chart will be as per the instructions in #2.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. RC.02.04.01. Joint Commission Resources. Oak Brook, IL.

- California Code of Regulations (2023). Title 22. § 70751,

  Retrieved from https://govt.westlaw.com/calregs/Document/IB47D04195B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1

- Code of Federal Regulations (2020). §482.24,

  Retrieved from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.24

SCOPE

This policy applies to agreements pursuant to which Sierra View Medical Center ("*Sierra View*") enters into any type of financial arrangement relating to the recruitment of a physician or non-physician practitioner to Sierra View's service area.

PURPOSE

The purpose of this policy is to ensure that:

A. Recruitment arrangements are undertaken only when there is an objectively and independently demonstrated community need in Sierra View's service area[1] (1) for the particular medical specialty practiced by the recruited physician or (2) for the primary care services[2] or mental health services to be furnished by the recruited non-physician practitioner ("*NPP*").[3]

B. Recruitment arrangements are undertaken only to help provide reasonable financial assistance (1) to or on behalf of a recruited physician in the start-up phase of his or her medical practice in Sierra View's service area; or (2) to a physician to contribute to the costs of employing a NPP to provide primary care or mental health care services.

C. Recruitment arrangements comply with applicable laws and regulations, including the federal Anti-Kickback Statute and the Stark law.

D. Under no circumstances will any recruitment arrangement involve Sierra View paying remuneration[4] to a physician or any other individual or entity, directly or indirectly, with the intent to induce the physician, or such other individual or entity, to refer patients to, or otherwise generate business for, Sierra View.

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1 "Service area" means the lowest number of contiguous postal zip codes from which Sierra View draws at least seventy-five percent (75%) of its inpatient discharges during the most recent calendar year for which data is available.

2 "Primary care services" means general family practice, general internal medicine, pediatrics, geriatrics and obstetrics and gynecology services.

3 "Non-Physician Practitioner" means a physician assistant, nurse practitioner or clinical nurse specialist, a certified nurse mid-wife, a clinical social worker or clinical psychologist.

4 "Remuneration" means any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind.

POLICY AND PROCEDURE

Sierra View will only enter into recruitment arrangements when the purpose of the arrangement is to fill an objectively and independently determined community need in Sierra View's service area.

The following steps in Section I of this Policy and Procedure must be taken in connection with the development of a recruitment arrangement for a physician, and the following steps in Section II of this Policy and Procedure must be taken in connection with the development of a recruitment arrangement for a recruited NPP.

SECTION I
FOR RECRUITMENT ARRANGEMENTS FOR PHYSICIANS

A. Determine Whether Community Need is Established.

Sierra View must have objective documentation evidencing an identifiable need for the medical specialty of the recruited physician. Sierra View should base its determination upon independent third party physician demand or needs analysis or similar data.

B. Determine Whether the Physician Has Medical Staff Privileges at Sierra View.

A physician is eligible for a recruitment arrangement only if he/she does not already have medical staff privileges at Sierra View.

C. Determine Whether the Physician Has an Established Practice in the Service Area.

A physician is eligible for a recruitment arrangement only if:

1. The physician's existing medical practice is located outside of Sierra View's service area and the physician either (a) relocates his/her medical practice at least twenty-five (25) miles into Sierra View's service area, or (b) relocates his/her medical practice into Sierra View's service area and derives at least seventy-five percent (75%) of his/her revenues from professional services furnished to patients (including hospital inpatients) not seen or treated by the physician at his or her prior medical practice site during the preceding three (3) years.[5]

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[5] The relocating physician (or, in a 3-Party Agreement, the group practice) may elect whether to use a fiscal year or calendar year.

2. The physician currently is in residency training or has been in medical practice for one (1) year or less (regardless of where that new medical practice is located).

3. The physician was a full-time employee of a federal or state prison, the Department of Defense or Veteran Affairs, or the Indian Health Service (regardless of where that employment is located) for at least two (2) years.

D. Terms to be Contained in a Recruitment Arrangement.

Sierra View must confirm that each proposed recruitment arrangement contains all of the following terms, conditions and/or requirements:

1. The arrangement must be evidenced by a written recruitment agreement signed and dated by each party. A recruitment agreement may be entered into directly with the recruited physician (a "*2-Party Agreement*"), or with the recruited physician and the group practice[6] that will employ the recruited physician (a "*3-Party Agreement*").

2. The recruitment agreement may not be conditioned on the recruited physician (or, in a 3-party Agreement, the recruited physician, the group practice or any individual or entity affiliated with the group practice) making referrals (actual or anticipated) to Sierra View or being in a position to make or influence referrals to, or otherwise generating business for, Sierra View.

3. The remuneration provided by Sierra View may not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any actual or anticipated referrals[7] by the recruited physician (or, in a 3-Party Agreement, referrals by the recruited physician, the group practice or any individual or entity affiliated with the group practice), or other business generated for Sierra View.

4. The recruited physician (or, in a 3-Party Agreement, the recruited physician or any other physician affiliated with the group practice) may not be restricted from establishing staff privileges at any other hospital or health care facility, or

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[6] "Group practice" means two (2) or more physicians (including the relocating physician) who practice through a single legal entity, using a common trade name and a common tax identification number. A "group practice" also includes the medical practice that is formed when a physician joins one or more solo practitioners.

[7] Compensation from an entity furnishing designated health services to a physician takes into account the volume or value of referrals only if the formula used to calculate the physician's compensation includes the physician's referrals to the entity as a variable, resulting in an increase or decrease in the physician's compensation that positively correlates with the number or value of the physician's referrals to the entity.

referring patients to or utilizing the services of, or otherwise generating business for any other hospital or health care facility.

5. The standard for establishing the fair market value[8] of an "income guarantee" for a recruited physician must be consistently applied in all recruitment arrangements. For purposes of this policy, an "*income guarantee*" cannot exceed the 50th percentile compensation rate for a recruited physician's medical specialty as set forth in "*Table 1 Physician Compensation*" in the most recent physician compensation survey published by the Medical Group Management Association ("*MGMA*") or its successor table or organization, plus fifteen percent (15%), absent prior written approval from Sierra View's CEO which shall be based on the advice of outside legal counsel with a specialty in health care law that it is reasonable to utilize a different compensation rate under the particular set of circumstances for a specific recruited physician.

6. The time period (the "*guarantee period*") during which Sierra View may offer the recruited physician an income guarantee typically will be for one (1) year and may not exceed two (2) years.

7. In the recruitment agreement, the recruited physician (or, in a 3-Party Agreement, the recruited physician and the group practice) must represent and warrant that he/she (or it) expects that the recruited physician's new medical practice will, in each year of the guarantee period, derive at least seventy-five percent (75%) of its revenues from professional services furnished to patients (including hospital inpatients) residing in Sierra View's service area.

8. The terms of the recruitment agreement may not be renegotiated, renewed, extended or amended after the recruitment agreement has been executed by the parties absent prior written approval from Sierra View's CEO which shall be based on the advice of outside legal counsel with a specialty in health care law that it is legally appropriate to do so.

9. A physician should be recruited to practice in Sierra View's service area on a full-time basis, and no recruitment agreement will be entered into permitting a physician to practice less than eighty percent (80%) of full-time in Sierra View's service area absent prior written approval from Sierra View's CEO which shall be based on the advice of outside legal counsel with a specialty in health care law that it is legally appropriate to do so.

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8 "Fair Market Value" means the value in an arm's-length transaction, consistent with the general market value of the subject transaction.

E. Additional Terms Applicable to a 3-Party Agreement.

The following additional provisions are applicable if the recruited physician is joining a group practice:

1. Sierra View must confirm that the recruited physician is joining the group practice as an employee.

2. The group practice must sign the written recruitment agreement in addition to the physician if the remuneration will be paid indirectly to the physician through payments made to the physician practice and the physician practice does not pass all of the renumeration directly through to the physician.

3. Sierra View must obtain for its files and review a copy of the executed employment agreement between the recruited physician and the group practice and confirm that:

   (a) The entire income guarantee subsidy provided for in the recruitment agreement is passed through to the recruited physician in the employment agreement.

   (b) The total compensation paid to the recruited physician is commercially reasonable,[9] consistent with fair market value, and does not take into account, directly or indirectly, the value or volume of patient referrals (actual or anticipated) to, or other business generated for, Sierra View.

   (c) Any practice limitations imposed on the recruited physician by the group practice are reasonable (*e.g.*, a trade secret provision protecting the group practice's patients or vendor lists likely would be reasonable, but a non-compete that was unenforceable under state law or that did not allow the recruited physician to treat patients residing in a significant part of Sierra View's service area likely would be unreasonable).

4. The group practice must provide a written representation and warranty in the 3-Party Agreement that:

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[9] "Commercially reasonable" means that the particular arrangement furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope and specialty. An arrangement may be commercially reasonable even if it does not result in profit for one or more of the parties.

(a) The compensation of each physician affiliated with the group including, without limitation, shareholders, members, partners, employees and independent contractors (i) will be commercially reasonable and consistent with fair market value, and (ii) will not vary with, or reflect or relate to, directly or indirectly, the volume or value of patient referrals (actual or anticipated) to, or other business generated for, Sierra View.

(b) Records of the actual costs incurred on behalf of the recruited physician and amounts paid to the recruited physician will be maintained for at least six (6) years.

F. Obtain a Secured Promissory Note for the Remuneration.

All remuneration provided pursuant to this policy must be repaid to Sierra View pursuant to the terms and conditions of a secured promissory note with appropriate collateral, unless forgiven by Sierra View as permitted by this policy. Sierra View should file a UCC-1 financing statement with the California Secretary of State.

G. Types of Remuneration Payable Pursuant to the Recruitment Agreement.

Sierra View may provide only the following types of remuneration pursuant to this policy. If the recruited physician will be a solo practitioner, the payments must be made directly to the recruited physician or the recruitment firm, as appropriate. If the recruited physician is joining a group practice, the payments must be made directly to the group practice or the recruitment firm, as appropriate, but not directly to the recruited physician. The remuneration described in Section I, Paragraph G.4 (*i.e.*, medical school loan repayment) should be paid directly to the medical school or lending institution, if possible.

1. An amount no more than the documented, actual relocation expenses, such as moving, storage and temporary lodging, reasonably incurred in connection with the recruited physician's relocation to Sierra View's service area.

2. Payment of a reasonable recruitment (or "headhunter's") fee paid directly to the recruitment firm, when applicable. A headhunter's fee will not be paid to the recruited physician, the group practice or to any other person or entity other than to the recruitment firm retained by Sierra View in connection with the physician recruitment process.

3. An amount no more than the documented, actual malpractice insurance premiums incurred in connection with the purchase of a professional liability insurance

policy for the recruited physician's services provided in Sierra View's service area (or, alternatively, the additional cost for adding the recruited physician as an additional insured on the group practice's professional liability insurance policy). Malpractice insurance premiums are a reasonably necessary operating expense as defined in Section I, Paragraph G.4(c) below.

4. Medical school loan repayment of up to Seventy-Five Thousand Dollars ($75,000), paid in equal monthly, quarterly or annual installments over the term of the recruitment agreement to, if possible, the medical school or lending institution. No medical school loan repayment amount may exceed Seventy-Five Thousand Dollars ($75,000) absent prior written approval from Sierra View's CEO which shall be based on the advice of outside legal counsel with a specialty in health care law that it is legally appropriate to do so.

5. As previously stated in this policy, the "*income guarantee*" amount (which is limited as described in Section I, Paragraph D.5 of this policy) must be consistent with fair market value. In addition, a recruited physician's "*net income*" for purposes of calculating Sierra View's obligation under an income guarantee in a recruitment agreement will be determined as follows:

   (a) The recruited physician's "*net income*" will be defined as the recruited physician's "*collections*" (as defined in Section I, Paragraph G.5(d) below) received in a particular month, less reasonably necessary monthly operating expenses actually incurred by the recruited physician in that particular month.

   (b) A cap must be placed on the maximum amount that a recruited physician may claim for reasonably necessary operating expenses, which maximum amount must be based on written documentation reflecting the anticipated reasonably necessary operating expenses of the recruited physician's medical practice during the guarantee period. Sierra View must retain such documentation in a compliance file created for each recruited physician.

   (c) Reasonably necessary operating expenses include salaries and benefits of support personnel, rent for medical office space, purchasing new equipment (capital equipment shall be reimbursed monthly based upon Sierra View's amortization schedules), purchasing medical and office supplies, utilities and insurance (other than as may be covered above), and other usual and customary business expenses reasonably necessary to operate the recruited physician's medical practice, so long as such other

business expenses have been determined by Sierra View in advance to be reasonable and an expense directly related to the recruited physician's medical practice. The recruited physician's salary is not an operating expense.

(d) The term "*collections*" means all monthly fees and charges resulting and collected from items or services furnished by or under the direction of the recruited physician (including without limitation a reasonable allocation for services provided under capitated payment arrangements), regardless of where or to whom such services are provided and must also include compensation for all personal services arrangements.

(e) If the recruited physician joins an existing medical group, the same definition of "*net income*" will apply, as described in Section I, Paragraph G.5(a) above, except that reimbursable business expenses may reflect only the actual additional *incremental* expenses[10] incurred by the group practice and directly attributable to the recruited physician.

H. Obtain Physician Certification for Amounts Paid

1. If the guarantee period exceeds one year and the recruited physician is a solo practitioner, within thirty (30) days following the conclusion of the first year of the recruitment agreement, the recruited physician must provide Sierra View with a certification that, during the first year of the guarantee period (a) at least seventy-five percent (75%) of the revenues of the recruited physician's new medical practice were, in fact, derived from professional services furnished to patients (including hospital inpatients) not seen or treated by the recruited physician at his or her prior medical practice site during the preceding three (3) years, and (b) at least seventy-five percent (75%) of the revenues of the recruited physician's new medical practice were, in fact, derived from professional services furnished to patients (including hospital inpatients) residing in Sierra View's service area.

2. If the guarantee period exceeds one (1) year and the recruited physician joined a group practice, within thirty (30) days following the conclusion of the first year of

[10] A physician's fringe benefits (excluding salary), malpractice premiums and the cost of hiring a nurse who will work solely for the recruited physician are examples of incremental expenses. Any group practice expenses that existed prior to the recruitment agreement (*i.e.,* medical office space that was already rented or support personnel who were already employed by the group practice) are not incremental and cannot be reimbursed to the group practice.

the guarantee period, the recruited physician and the group practice must each provide Sierra View with a certification that, during the first year of the recruitment agreement (a) at least seventy-five percent (75%) of the revenues of the group practice were, in fact, derived from professional services furnished to patients (including hospital inpatients) not seen or treated by the recruited physician at his or her prior medical practice site during the preceding three (3) years, and (2) at least seventy-five percent (75%) of the revenues of the recruited physician were, in fact, derived from professional services furnished to patients (including hospital inpatients) residing in Sierra View's service area.

3. If the recruited physician and, if applicable, group practice, are unable to provide Sierra View with this certification, Sierra View will terminate the recruitment agreement and require the repayment of the amounts paid in accordance with the terms of the recruitment agreement.

I. Payments Only Pursuant to the Recruitment Arrangement.

1. On a monthly basis, the recruited physician (in a 2-Party Agreement) or the group practice (in a 3-Party Agreement) must furnish Sierra View with a monthly statement of the recruited physician's net income, which monthly statement must include supporting documentation of the recruited physician's collections and reasonably necessary operating expenses actually incurred for that month. If the recruited physician joined a group practice, the supporting documentation must reflect only the actual additional incremental expenses incurred by the group practice and directly attributable to the recruited physician.

2. If the net income for the prior month is less than the income guarantee in any month during the guarantee period, Sierra View must pay to the recruited physician (in a 2-Party Agreement), or the group practice (in a 3-Party Agreement), the shortfall amount. The shortfall amount may not exceed the sum of the income guarantee, plus the reasonably necessary operating expenses actually incurred for that prior month (but not to exceed the expense cap maximum amount in such month or any overall expense cap maximum).

3. If the recruited physician's net income exceeds the income guarantee in any month during the guarantee period, the recruited physician (in a 2-Party Agreement) or the group practice (in a 3-Party Agreement) must reimburse to Sierra View all excess amount, but only until all amounts previously paid by Sierra View to the recruited physician (in a 2-Party Agreement) or to the group practice (in a 3-Party Agreement) have been repaid in full.

J. Perform a Reconciliation.

1. No later than one hundred twenty (120) days following the end of the guarantee period in each recruitment agreement, Sierra View's CFO or his/her designee must perform an audit of the back-up documentation provided by the recruited physician (in a 2-Party Agreement) or the group practice (in a 3-Party Agreement), and reconciliation of the "*total income*"[11] attributable to the recruited physician during the guarantee period to determine whether recruited physician (in a 2-Party Agreement) or the group practice (in a 3-Party Agreement) has a repayment obligation pursuant to the recruitment agreement.

2. If the total income of the recruited physician exceeds the aggregate net payments made by Sierra View during the guarantee period (*i.e.,* the income guarantee payments, plus the operating expense reimbursement, less any excess payments remitted back to Sierra View), then the recruited physician (in a 2-Party Agreement) or the group practice (in a 3-Party Agreement) must repay to Sierra View the excess amount, except that the repayment of such excess amount will not exceed the aggregate amount paid to the recruited physician (in a 2-Party Agreement) or to the group practice (in a 3-Party Agreement) pursuant to the recruitment agreement. Repayment must be made within ninety (90) days following receipt of Sierra View's reconciliation report.

3. If the total income is less than or equal to the aggregate net payments made by Sierra View during the guarantee period (*i.e.*, the income guarantee payments, plus the operating expense reimbursement, less any excess payment remitted back to Sierra View), then the recruited physician (in a 2-Party Agreement) or the group practice (in a 3-Party Agreement) must repay the net shortfall amounts paid by Sierra View under the recruitment agreement by executing a secured promissory note with adequate collateral, subject to forgiveness as described below.

K. Forgive the Promissory Note in Increments.

1. If the recruitment agreement includes a forgiveness provision and the income guarantee period is for one (1) year, the forgiveness period must be for not less than two (2) years.

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[11] "*Total income*" means the sum of the recruited physician's aggregate net income during the recruitment agreement, plus the aggregate net payments made by Sierra View to the recruited physician (in a 2-Party Agreement) or to the group practice (in a 3-Party Agreement) in accordance with the recruitment agreement.

2. If the recruitment agreement includes a forgiveness provision and the income guarantee period is for two (2) years, the forgiveness period must be not less than two (2) years and should be for not less than three (3) years.[12]

3. The forgiveness period should commence at the conclusion of the guarantee period. Any amounts not forgiven under the secured promissory note must be repaid in accordance with the terms of the secured promissory note.

L. Collect Overpayments.

Sierra View's CFO is responsible for ensuring that diligent efforts are made to collect any and all money due from a recruited physician or group practice in accordance with the terms of the recruitment agreement and/or a secured promissory note. Sierra View must maintain all documentation of its efforts to collect any amounts that may be owing to Sierra View pursuant to the recruitment agreement and/or a secured promissory note. Sierra View may not write off any amounts that may be owing from a recruited physician or a group practice to Sierra View pursuant to a recruitment agreement and/or a secured promissory note absent prior written approval from Sierra View's CEO which shall be based on the advice of outside legal counsel with a specialty in health care law that it is legally appropriate to do so.

SECTION II
FOR RECRUITMENT AGREEMENTS FOR NON-PHYSICIAN PRACTITIONERS.

A. Eligibility for Assistance.

An individual physician or a physician standing in the shoes of his or her physician organization (collectively, the "*Physician*") is eligible to receive assistance from Sierra View in relocating a NPP only if all the following criteria are met:

1. Primary Care or Mental Health Services. NPP specializes in primary care services or mental health care services, and at least seventy-five percent (75%) of all the services that NPP will furnish to patients of the Physician will be primary care services or mental health services.

2. NPP Has Not Previously Practiced in Sierra View's Geographic Service Area.[13]

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12 For example, in a recruitment agreement that provides for a two (2) year income guarantee period, Sierra View will forgive one-thirty-sixth (1/36) of the principal and accrued interest under the secured promissory note for each month beyond the guarantee period that the recruited physician continues to meet his or her duties and obligations under the recruitment agreement.

NPP has not, within one (1) year of the commencement of his or her employment or independent contractor arrangement with the Physician either (a) practiced in the geographic area served by Sierra View; or (b) been employed or otherwise engaged to provide patient care services by any physician or physician organization that has a medical practice site located in the geographic area served by Sierra View (regardless of whether the recruited NPP furnished services at the medical practice located in the geographic area served by Sierra View).

3. No NPP Recruitment Assistance Provided by Sierra View to Physician Within Prior Three (3) Years. Sierra View has not provided the Physician with assistance to relocate a NPP within the preceding three (3) years, except to (a) replace a NPP who terminated his or her employment or independent contractor arrangement with the Physician within one (1) year of the commencement of such employment or independent contractor arrangement; and (b) the remuneration to be provided by Sierra View to the Physician does not exceed two (2) consecutive years, as measured from the commencement of the employment or independent contractor arrangement between NPP who is being replaced and the Physician.

4. Requirements for the Employment or Independent Contractor Agreement Between the Physician and NPP.

   (a) NPP must have an employment or independent contractor arrangement directly with the Physician.

   (b) The actual, aggregate compensation paid by the Physician to NPP under the employment or independent contractor arrangement must be consistent with fair market value.

   (c) The Physician's arrangement with NPP must not restrict NPP's ability to provide patient care services in Sierra View's geographic service area.

5. Restrictions on Remuneration Paid by Sierra View to Physician.

   (a) The remuneration from Sierra View must not exceed fifty percent (50%) of the actual, aggregate compensation (including signing bonus and employee benefits, such as relocation costs, health insurance, paid-time off leave and other benefits offered to similarly situated employees) paid by the Physician to NPP during a period not to exceed the first two (2)

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[13] As noted above, "service area" means the lowest number of contiguous postal zip codes from which Sierra View draws at least seventy-five percent (75%) of its inpatient discharges during the most recent calendar year for which data is available.

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consecutive years of the employment or independent contractor arrangement between NPP and the Physician.

(b) The remuneration paid by Sierra View must not be determined in a manner that takes into account (directly or indirectly) the volume or value of any actual or anticipated referrals by:

(i) The Physician or other business generated between the parties; or

(ii) NPP (or any other NPP in the Physician's practice) or other business generated between the parties.

6. No Conditioning of Recruitment Arrangement on Physician Referrals or NPP Referrals. NPP recruitment agreement may not be conditioned on the Physician or NPP making referrals (actual or anticipated) to Sierra View or being in a position to make or influence referrals to, or otherwise generate business for, Sierra View.

7. Recruitment Arrangement does not Violate Anti-Kickback State/Billing or Claims Submission Laws. The recruitment arrangement must not violate the federal Anti-Kickback Statute or any federal or state law or regulation governing billing or claims submission.

C. Terms to be Contained in NPP Recruitment Agreement.

Sierra View must confirm that NPP recruitment agreement satisfies all of the following terms, conditions and/or requirements:

1. The arrangement must be evidenced by a written recruitment agreement signed and dated by the recruited NPP, the Physician and Sierra View.

2. The term of the recruitment agreement must not exceed two (2) years. The term of the recruitment agreement must run contemporaneously within the first two (2) years of the employment or independent contractor agreement between the Physician and NPP.

3. There shall be no oral or implied understandings regarding NPP recruitment arrangement that are not incorporated in the written agreement.

4. The recruitment agreement may not contain language conditioning the arrangement on the Physician or NPP making referrals (actual or anticipated) to

Sierra View, or restricting the Physician or NPP's ability to make referrals to, or generating business for, any other hospital or facility.

5. The terms of the recruitment agreement may not be renegotiated, renewed, extended or amended after the recruitment agreement has been executed by the parties absent prior written approval from Sierra View's CEO (which approval from Sierra View's CEO shall be based on the advice of outside legal counsel with a specialty in health care law that it is legally appropriate to do so).

6. The remuneration to be paid by Sierra View pursuant to the terms of the recruitment agreement will not vary (or will not be adjusted or renegotiated) in any manner based on the volume or value of any actual or anticipated referral or other business generated between or among the parties.

7. The Physician and NPP must provide the following representations, warranties and covenants in the recruitment agreement:

   (a) NPP has not previously practiced in Sierra View's geographic service area, nor has NPP been previously employed or otherwise engaged by any physician or group practice that has a medical practice site in Sierra View's geographic service area.

   (b) At least seventy-five percent (75%) of NPP's services furnished to the Physician's patients will be primary care services or mental health services.

   (c) The actual, aggregate compensation paid by the Physician to NPP, pursuant to an employment agreement or independent contractor agreement between the parties, will be consistent with fair market value.

   (d) The Physician will not impose practice restrictions on NPP that unreasonably restrict NPP's ability to provide patient care services in the geographic area served by Sierra View.

   (e) The Physician will maintain records of the actual amount of remuneration paid by the Physician to NPP for a period of at least six (6) years and make such records available to Sierra View and the U.S. Department of Health and Human Services Secretary upon request.

D. Obtain Physician Documentation for Amounts Paid; Sierra View Payments.

1. On a monthly basis, during to the term of the recruitment agreement, the Physician must provide Sierra View with a monthly statement, or other supporting documentation requested by Sierra View, to substantiate the actual salary, costs and employee benefits paid by the Physician to NPP.

2. Sierra View will provide remuneration to the Physician consistent with the terms of the recruitment agreement only after Sierra View receives all necessary monthly statements and supporting documentation that Sierra View needs to substantiate the actual salary, costs and employee benefits paid by the Physician to NPP.

E. Records Must be Maintained for at Least Six (6) Years.

1. Records of the actual amount of remuneration provided by the Physician to NPP pursuant to the terms of the employment agreement or independent contractor agreement must be maintained for at least six (6) years and made available to Sierra View and the U.S. Department of Health and Human Services Secretary upon request.

2. Records of the actual amount of remuneration provided by Sierra View to the Physician pursuant to the terms of the recruitment agreement must be maintained for at least six (6) years and made available to the U.S. Department of Health and Human Services Secretary upon request.

F. Monitoring; Collecting Overpayments.

1. Sierra View is responsible for monitoring compliance with the terms of NPP recruitment agreement and this policy.

2. If there are any repayments of any overpayments due from the Physician in connection with a NPP recruitment agreement, Sierra View's CFO is responsible for ensuring that diligent efforts are made to collect any and all such money due from such Physician. Sierra View may not write-off any amounts that may be owed from the Physician to Sierra View pursuant to a recruitment agreement absent prior written approval from Sierra View's CEO, which shall be based on the advice of outside legal counsel with a specialty in health care law that it is legally appropriate to do so.

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SUBJECT: **RISK MANAGEMENT PLAN**	SECTION: ***Improving Organizational Performance (PI)*** **Page 1 of 6**

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

PURPOSE:

The Risk Management Plan is designed to support the mission and vision of the organization as it pertains to clinical risk, as well as potential business, operational, and property risks.

GUIDING PRINCIPLES:

The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives and activities. The plan is operationalized through a formal, written risk management and patient safety program.

The organization's Risk Management Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Claims management
- Complaint resolution
- Trend analysis of events, near misses, and claims

GOVERNING BODY LEADERSHIP

The success of the organization's Risk Management Program requires top-level commitment and support. The Governing Board authorizes the formal program and adoption of this Plan as documented in Board meeting minutes.

Risk management will provide quarterly reports. to the governing body summarizing activities, achievements, and ongoing risk management issues that have occurred since the prior report. As necessary, the Board will receive interim reports of new risk exposures that require board intervention and action.

PROGRAM GOALS AND OBJECTIVES

The Risk Management Program goals and objectives are to:

- Minimize adverse effects of errors, events, and system breakdowns when they occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.
- Facilitate compliance with regulatory, legal, and accrediting agency requirements.
- Protect human and intangible resources (e.g., reputation).

SCOPE AND FUNCTIONS OF THE PROGRAM

The organization's Risk Management program interfaces with many operational departments and services throughout the organization. Risk Management's role is to influence, persuade and educate leaders within the organization in order to achieve quality care in a safe environment and protect the organization's resources.

Recognizing that the effectiveness of risk management activities is contingent upon collaboration and integration with facility-wide performance improvement activities, Risk Management will work with the various committees structured to enhance the performance of the facility in the communication and resolution of risk-related issues. Risk management will collaborate with any hospital department as needed to help mitigate risk and/or improve patient safety.

5.1 Functional Interfaces

Risk Management will collaborate with any hospital department as needed to help mitigate risk and/or improve patient safety.

5.2 Risk Management Program Functions

Risk Management functional responsibilities include, but are not limited to:

- Promoting the quality of patient care, in collaboration with quality/performance improvement activities.
- Enhancing patient satisfaction.
- Minimizing the frequency and severity of adverse events.
- The timely reporting of events as it pertains to the following:
  - Centers for Medicare and Medicaid Services (CMS) established reportable requirement for certain restraint and seclusion events.
  - Assists in Food and Drug Administration (FDA), Safe Medical Device Act both mandatory and voluntary reporting elements related to device malfunctions and/or biological malfunctions.
- Assisting in the maintenance of a robust event reporting system that is used to report actual events or events with the potential of causing adverse patient outcomes or other injuries to people, property or other assets of the organization. (Refer to housewide policy & procedure, *Patient Safety Event*).

- Managing of patient and family complaints/grievances as required by CMS. (refer to house-wide policy and procedure, Complaints and Grievances, Handling of)
- Maintaining a robust insurance portfolio to safeguard the organization against financial risk arising from claims made.
- Decreasing the likelihood of lawsuits through effective claims management, and investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.
- Enhancing environmental safety for patients, visitors and staff through participation in various improvement committees.
- Utilizing risk management strategies to identify and minimize the frequency and severity of near misses, incidents and claims.
- Monitoring adverse events and injuries to minimize financial loss to include employment-attributed injury and illnesses (worker's comp).
- Evaluating systems that can contribute to patient care, error or injury.
- Educating stakeholders on emerging and known risk exposures and risk reduction initiatives.
- Serving as a resource for staff concerning actual or potential legal matters related to the provision of care.
- Contributing to the achievement of requirements implemented by accrediting organizations.
- Complying with state-specific scope of practice, applicable laws, regulations and standards.
- Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include:
  - Claims and claim trends
  - Ongoing risk assessment information
  - Patient's and/or family's perceptions of how well the organization meets their needs and expectations
  - Quality performance data

- Research data
- Completing insurance and deeming applications.

1. ADMINISTRATIVE AND COMMITTEE STRUCTURE AND MECHANISMS FOR COORDINATION

The Risk Management Program is administered through the Risk Department's leadership, and reports to the Vice President of Quality & Regulatory Affairs. Department leadership interfaces with administration, staff, medical providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The Leader (or alternate as designated by VP) chairs the activities of the Patient Safety Committee and the Threat Assessment Team. The two committee's activities are an integral part of patient safety, quality improvement, and risk mitigation activities.

Risk Leadership is responsible for overseeing day-to-day monitoring of patient safety and risk management activities to include the investigation of and reporting to the insurance carrier actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to requirements specified in the insurance policy and/or contractsk Risk Leadership serves as the primary contact between the organization and other external parties on matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. Risk Leadership or alternative as designated by VP of Quality and Regulatory Affairs oversees the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback of reported risk management and patient safety information to the organization for action.

2. ANNUAL PROGRAM EVALUATION

Risk Management/Patient Safety, in concert with members of the Performance Improvement and Patient Safety (PIPS) Committee, analyzes data and trends. During the year, events that have shown a trend of reoccurrence, a high likelihood of harm to patients or staff, or that have created delays in care across two or more departments are reviewed by responsible leadership in collaboration with Risk Management and Patient Safety. The events are reviewed via the Crisis Management Team (CMT) and Root Cause Analysis (RCA) process. CMTs and RCAs are reported quarterly to the PIPS Committee. At the end of each year, a risk assessment is conducted based on CMT, RCA, and Incident Reporting System data using a numeric scoring to assign a degree of likelihood, consequence and response to arrive at a collective risk score and a hierarchy of action. Specific risk reduction goals will focus on elements scored in the upper quartile. The reduction of risk-related exposures is a facility-wide initiative and is owned by everyone. The successful attainment of the identified goals will involve stakeholders who have influence and experience with key components of the issue.

7.1 GOALS FOR 2024-2025

1. Continue occurrence reporting training housewide to ensure quality data
2. Continue Just Culture training to support Culture of Safety in organization.

3. Maintain a current and robust insurance portfolio
4. Remain current on grievance and complaints (logs and correspondence)

3. PROTECTION OF RISK MANAGEMENT INFORMATION

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

REFERENCES:

- California Evidence Code §1157 (January 1, 2018). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=EVID&sectionNum=1157.
- Department of Health and Human Services, FDA: 21 CFR Parts 803 and 804 (April 1, 2021). Retrieved from https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?CFRPart=803.
- California Health & Safety Code, §1279.1(b): 1279.2, 1279.3, 1279.4, &100171 (January 1, 2008). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1279.1.&lawCode=HSC
- *The Safe Medical Devices Act of 1990 and the Medical Device Amendments of 1992.* (1993). Washington, D.C.: U.S. Dept. of Health and Human Services, Public Health Services / Food and Drug Administration, Center for Devices and Radiological Health.
- Code of Federal Regulations 482.13(e)-(g) (September 30, 2019). Retrieved from https://www.law.cornell.edu/cfr/text/42/482.13.
-
- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES

- *Patient Safety Event*
- Housewide Policy & Procedure Manual, *Serious Clinical Adverse Event*
- Housewide Policy & Procedure, *Complaints and Grievances, Handling of*

- Housewide Policy & Procedure, *Patient Safety Plan*
- *Environment of Care Policy and Procedure Manual, Medical Device Tracking & FDA Reporting Product Recalls*

Respiratory Syncytial Virus (RSV) Vaccine Consent / Declination

PLEASE SIGN AND RETURN THIS FORM AFTER READING THE VACCINE INFORMATION SHEET PROVIDED

CONSENT: "I _____ , have read or have had explained to me the information in the vaccine information sheet about RSV Vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to my infant."

DECLINATION: "I_____ , have read or have had explained to me the information in the vaccine information sheet about RSV Vaccine. I have had a chance to ask questions that were answered to my satisfaction. I decline to have the RSV Vaccine given to my infant."

Signature of Legal Guardian: _____ Date: _____ Time:_____

Signature of Witness: _____ Date: _____ Time:_____

POR FAVOR FIRME Y DEVUELVE ESTA FORMA DESPUES DE HABER LEIDO EL FOLLETO DE INFORMACION SOBRE VACUNA.

Consentir: "Yo _____ he leído o me han explicado la información en este folleto acerca de la vacuna (RSV) para Virus Sincitial Respiratorio. He tenido la oportunidad de hacer preguntas las cuales fueron contestadas con satisfacción. Entiendo los beneficios y riesgos de la vacuna y autorizo que le administren a mi niño(a) la vacuna indicada de (RSV) para Virus Sincitial Respiratorio."

DECLINACION: Yo_____ he leído o me han explicado la información en este folleto acerca de la vacuna (RSV) para Virus Sincitial Respiratorio. He tenido la oportunidad de hacer preguntas las cuales fueron contestadas con satisfacción. Entiendo los beneficios y riesgos de la vacuna y pido que no administren a mi niño(a) la vacuna indicada de (RSV) para Virus Sincitial Respiratorio."

Firma de Legal Guardián: _____ Fecha: _____ Hora: _____

Firma de Testigo: _____ Fecha: _____ Hora: _____

MEDICAL EXECUTIVE COMMITTEE	01/03/2024
BOARD OF DIRECTORS APPROVAL	
	01/23/2024
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
January 23, 2024 BOARD APPROVAL

The following Policies/Procedures/Protocols/Plans/Forms have been reviewed by the Medical Executive Committee and are being submitted to the Board of Directors for approval:

	Pages	Action
I. Policies:		APPROVE ↓
• Administration of Influenza Vaccine to Inpatients	1-3	
• Administration of Pneumococcal Vaccine to Inpatients	4-9	
• Admission Criteria to the Pediatric Area	10-12	
• Annual Infection Prevention Plan	13-44	
• Blood Bank Refrigerator Maintenance Procedures	45-46	
• Communicable Disease Reporting	47-48	
• Criteria for Service	49-50	
• Discharge Instructions	51	
• Disposal, Accidental Exposure, and Spills of Chemotherapeutic Agents	52-54	
• Disposal of Infectious, Contaminated Wastes	55-57	
• Education of Patient	58-59	
• Emergency Response and Transfer	60-61	
• Evaluation Procedures	62-64	
• Event Related Sterilization Process (Shelf Life)	65-66	
• Extravasation of Antineoplastic Agents	67-75	
• Gender Preference for Exam/Treatment Provider	76	
• Identification of Patient's Requests and Samples (Blood Bank)	77-79	
• Inpatients Receiving Radiation Therapy Services	80-81	
• Intra-Aortic Balloon Pump Therapy	82-85	
• Laser Surgery – Practice and Safety	86-91	
• Legal Medical Record Standards	92-108	
• Loaner Instrument Sterilization Process	109-110	
• Management of Infusion Reactions to Cancer Chemotherapy and Biotherapy Agents	111-114	
• Modalities: Hotpacks	115-117	
• Modified Barium Swallow	118-119	
• Nutritional Health Services	120-121	
• Physical and Speech Therapy Medical Records Storage and Safe Keeping	122	
• Physician Notification Criteria	123-124	
• Processing of Medication Orders and Dispensing of Medications	125-132	
• Radiation Therapy General Requirements	133	
• Scope of Physical Therapy	134-136	
• Scope of Service – Cancer Treatment Center	137-139	
• Standards of Practice	140-142	
• Stomatitis Grading and Care	143-144	

	• Storage of Blood Components in the Event of the Loss of Monitored Refrigeration	145	
II.	**<u>Forms</u>:**		
	• Procedural Sedation Flow Sheet	146-148	

SUBJECT:	SECTION:
ADMINISTRATION OF INFLUENZA VACCINE TO INPATIENTS	***Surveillance, Prevention, Control of Infection (IC)*** 3

INTRODUCTION:

Influenza (the flu) is a contagious viral respiratory illness with different viral strains that circulate perennially around the world. Depending on the strain, the virus may cause mild to severe illness and possibly even death especially in high-risk populations. Therefore, Sierra View Medical Center (SVMC) will offer and administer the influenza vaccine to all inpatients who meet the criteria established by the Centers for Disease Control and Prevention (CDC) and the CDC's Advisory committee on Immunization Practices (ACIP).

POLICY:

SVMC will administer the influenza vaccine to all inpatients who meet the criteria set by the CDC and ACIP and who give consent to receive influenza vaccination.

PROCEDURE:

Influenza Season - Although each year varies, influenza season usually begins in October and may run through March/late spring. During this time inpatients will be evaluated to determine if they are eligible influenza vaccination.

1. Influenza vaccination may be administered by nurses (see below for full description) that have bet the initial and annual internal competencies. Those eligible to administer the vaccine will use the following parameters to identify inpatients in need of influenza vaccination, obtain consent and subsequently vaccinate the inpatient.
2. Eligible inpatients include:
    a. All inpatients ≥ 6 months of age
    b. Inpatients with chronic medical disorders
3. Inpatients will be screened for contraindications and precautions such as:
    a. Serious reaction (e.g. anaphylaxis) after ingesting eggs or after receiving a previous dose of influenza vaccine or an a component of the influenza vaccine
    b. Already immunized for the current flu season
    c. Admitted from a long-term care facility that routinely immunizes residents
    d. Fever (≥38°C/100.4°F)
    e. History of Guillain-Barre Syndrome
    f. Physician orders to withhold influenza vaccine
    g. Patient refused – NOTIFY PHYSICIAN

4. Plan – vaccinate all inpatients who meet criteria for influenza vaccine
    a. Treatment:
        i. Screen all adults for contraindications and precautions to influenza vaccine
        ii. For age 9 and older, administer manufacturer's recommended dose of injectable inactivated quadrivalent influenza vaccine IM (usually a 22-25 g, 1-1 ½ inch needle) in the deltoid muscle. For ages 6 months to 8 years, see manufacturer's recommendations on dosage and administration for pediatric inpatients
        iii. Monitor for serious side effects (i.e. anaphylaxis)
        iv. Consultation required – none
    b. Education:
        i. Provide a copy of the most current federal Vaccine Information Statement (VIS) sheet. You must document in the patient's medical record or office log, the publication of the VIS and the date it was given. Provide non-English speakers with a copy of the VIS in their native language if it is available, which may be found at: www.immunize.org/vis
    c. Follow-up
        i. Reassess patient in 30 minutes or less as needed. Annual vaccinations of influenza vaccine are needed to ensure adequate protection from influenza
5. Documentation
    a. Electronic Medical Record – record the date that the vaccine was administered, the manufacturers and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g. medical contraindication, refusal, etc.)

Staff Authorized To Perform Vaccination:

Included are:

1. Licensed Vocational Nurse (LVN)
2. Registered Nurse (RN)
3. Family Nurse Practitioner (FNP)
4. Physician Assistant (PA)

5. Physician (MD or DO)

Requirements for administration:

1. Education – licensed personnel (see list above)
2. Training as required by initial and annual internal competencies
3. Review of CDC immunization criteria upon initial training
4. Annual review of CDC immunization criteria

Development & Approval of the Standardized Procedure:

1. Method: Infection Prevention Committee, Infection Prevention Manager and the Medical Director of Infection Prevention
2. Review of schedule: yearly

REFERENCES:

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SUBJECT:	SECTION:
ADMINISTRATION OF PNEUMOCOCCAL VACCINE TO INPATIENTS	***Surveillance, Prevention, Control of Infection (IC)***

POLICY

PURPOSE

To provide guidelines for the administration of pneumococcal vaccine to all inpatients who meet the criteria established by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

BACKGROUND

Streptococcus pneumoniae (*S. pneumoniae*) is a gram-positive facultative anaerobe with more than 100 known serotypes. Although most serotypes cause serious disease only a few cause pneumococcal infections such as meningitis, bacteremia and pneumococcal pneumonia. Vaccination opportunities for those with an increased risk of pneumococcal disease are often missed during two critical times – regular office visits and during hospitalization. Screening followed by immunization of at-risk hospital patients (see Table 1) would significantly reduce the complications associated with pneumococcal disease, up to and including death.

A. PREREQUISITES

a. Offer to any inpatient who meets the criteria in Table 1, especially:

   i. Patients age 65 years or older

   ii. Immunocompromised patients including, but not limited to, patients with chronic heart, pulmonary renal, metabolic or liver disease; cancer, anemia, alcoholism, HIV/AIDS, etc. (See Table 1, from Epidemiology and Prevention of Vaccine-Preventable Diseases, CDC)

   iii. Any vaccine recipients with more than 5 years since the last vaccination

   iv. In 2021, ACIP recommended use of PCV20 for all adults aged ≥65 years who have not previously received a pneumococcal vaccine or whose previous vaccination history is unknown

B. PRECAUTIONS

a. The following should be taken into consideration before administering pneumococcal vaccination:

   i. The patient should wait to be vaccinated if moderately or severely ill

   ii. The patient should wait to be vaccinated if the health care provider decides to postpone vaccination

C. CONTRAINDICATIONS AND RISKS

a. The patient should tell the vaccination provider if any of the following conditions exist:
   i. The patient has received two pneumococcal vaccine doses
   ii. The patient received the vaccine less than 5 years ago
   iii. The patient is allergic to the vaccine or any component of the vaccine
   iv. The patient is pregnant – women who are at increased risk of pneumococcal disease and who are candidates for pneumococcal vaccine should be vaccinated before pregnancy, if possible
   v. The patient has had any neurological reaction(s) to the vaccine
   vi. The patient is at risk for having less than 50,000 platelets per microliter of blood
   vii. The patient has a fever greater than 38°C/100.4°F at the time of vaccination
   viii. The patient refused vaccination (notify the physician)
   ix. Physician provides orders that the patient not be given the vaccine
   x. Lesser known risks or reactions include pain, redness or swelling at the injection site, mild fever, headache, feeling tired, etc. (Consult product insert for additional lesser known risks)

D. RESPONSIBILITIES

a. Any of the following health care professionals with current California licenses may administer the vaccine: Licensed Vocational Nurse (LVN), Registered Nurse (RN), Family Nurse Practitioner (FNP), Physician's Assistant (PA), or a physician (MD or DO)

b. Prior to administering vaccines for the first time at SVMC, the health care professional must conduct an initial review of the CDC immunization criteria and the SVMC Standardized Procedures for Immunizations

c. The Nursing Staff will review the SVMC Standardized Procedures for Immunizations annually during the Annual Competency Fair

d. A copy of the most current Vaccine Information Statement (VIS) in the appropriate language must be provided to the vaccine recipient and recorded in the EMR or office log, along with the publication date of the VIS (See References for link to the VIS)

E. PROCEDURE

a. Treatment

i. Assess the inpatient for the need of pneumococcal vaccination.

ii. Screen all adult inpatients for contraindications and precautions associated with the administration of pneumococcal vaccine.

iii. If inpatient gives consent provide a copy of the most current Pneumococcal Vaccine Information Statement (VIS) in the language appropriate for the recipient.

TABLE 1: Recommendations for use of PCV15 or PCV20 in pneumococcal conjugate vaccine – naïve adults aged ≥ 19 years. Advisory Committee on Immunization Practices, United States, 2023

Medical indication group	Specific underlying medical condition	Age group, yrs	
		19–64	≥65
None	None	None	1 dose of PCV20 alone, or 1 dose of PCV15 followed by a dose of PPSV23 ≥1 year later*
Underlying medical conditions or other risk factors	Alcoholism Chronic heart disease† Chronic liver disease Chronic lung disease§ Chronic renal failure¶ Cigarette smoking Cochlear implant Congenital or acquired asplenia¶ Congenital or acquired immunodeficiencies¶,** CSF leak Diabetes mellitus Generalized malignancy¶ HIV infection Hodgkin disease¶ Iatrogenic immunosuppression¶,†† Leukemia¶ Lymphoma¶ Multiple myeloma¶ Nephrotic syndrome¶ Sickle cell disease or other hemoglobinopathies¶ Solid organ transplant¶	1 dose of PCV20 alone or 1 dose of PCV15 followed by a dose of PPSV23 ≥1 year later*	1 dose of PCV20 alone or 1 dose of PCV15 followed by a dose of PPSV23 ≥1 year later*

Abbreviations: CSF = cerebrospinal fluid; PCV15 = 15-valent pneumococcal conjugate vaccine; PCV20 = 20-valent pneumococcal conjugate vaccine; PPSV23 = 23-valent pneumococcal polysaccharide vaccine.
* Adults with immunocompromising conditions, a CSF leak, or a cochlear implant might benefit from shorter intervals (e.g., ≥8 weeks). These vaccine doses do not need to be repeated at age ≥65 years if administered at age <65 years.
† Includes congestive heart failure and cardiomyopathies.
§ Includes chronic obstructive pulmonary disease, emphysema, and asthma.
¶ Indicates immunocompromising conditions
** Includes B- (humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease).
†† Diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy.

From: https://www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm

iv. Administer the manufacturer's recommended dose of the pneumococcal vaccine

b. Education

i. As stated in the treatment section above, provide a copy of the most current VIS. Document in the inpatient's medical record or office log that the VIS was provided, the publication date of the VIS and the date the education was provided (see below for more information on documentation). Provide non-English speakers with a copy of the VIS in their native language if it is available. These may be obtained through the link in the cross-reference below or at the website www.immunize.org/vis

c. Follow-up

i. Reassess the inpatient within 15 to 30 minutes to make sure that there are no immediate adverse side effects such as anaphylaxis, to any component of the vaccine

ii. Be prepared to manage any medical emergency related to the administration of the vaccine.

1. Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). VAERS for reporting only, no medical advice is available. Contact VAERS at **www.vaers.hhs.gov** or call **1-800- 822-7967** (verified on 11-22-23)

2. The following items should be available at the time of vaccination:

a. A written emergency protocol specifically for vaccination reactions

b. Equipment and/or medication described in the written emergency protocol

d. Documentation

i. The following items should be documented in the electronic medical record

1. Date of vaccination
2. The manufacturer and lot number
3. The vaccination site and route
4. The name and title of the person administering the vaccine
5. Note that the VIS was provided (see above in Education)
6. If the vaccine was not administered, record the reason(s) (e.g. medical contraindication, refusal, etc.)

F. DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE

a. The Infection Prevention Committee, the Infection Prevention Manager and the Medical Director of Infection Prevention will participate in the development and approval of the standardized procedure for the administration of pneumococcal vaccine to inpatients

b. The review is to be done on a yearly basis to incorporate any updated or new information on pneumococcal vaccines.

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SUBJECT: **ADMISSION CRITERIA TO THE PEDIATRIC AREA**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 3**

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

PURPOSE:

To establish the criteria for admission to the Medical Surgical designated Pediatric area, or if this area is full, to the Medical/Surgical Unit.

POLICY:

All patients 18 years and younger who present to Sierra View Medical Center (SVMC) and who meet the admitting criteria, are eligible to be admitted to the Medical/Surgical designated Pediatric area. If the Medical/Surgical designated Pediatric area is full, then these patients can be admitted to the Medical/Surgical Unit. It is the policy of Sierra View Medical Center that pediatric patients are defined as 13 years of age and under.

Classification of Pediatric Patients:

- Newborns- birth to 30 days
- Infant- 31 days to 1 year
- Toddler-1-3 years
- Pre-school- 3-5 years
- School Age- 6-11 years
- Adolescent- 12-14
- Teen- 14-18

AFFECTED PERSONNEL/AREAS:

EMERGENCY DEPARTMENT, MEDICAL/SURGICAL UNIT, CLINICAL DECISION UNIT, ADMITTING

PROCEDURE:

1. The above classification of patients will be admitted to the Medical/Surgical designated Pediatric Area. If the designated Pediatric Area is full, then the pediatric patient will be admitted to the Medical Surgical unit.

2. Patients requiring Critical Care Services, such as Diagnostic Cardiopulmonary Monitoring, vasoactive drugs, and nursing care in excess of eight hours/day, will be transferred to an appropriate pediatric facility such as Valley Children's Hospital.

3. Patients with known or suspected acute disease processes (e.g., meningitis), which may require one or more consultants, will be assigned to a room with appropriate isolation precaution or transferred to an appropriate pediatric facility for a higher level of care.

4. The Medical/Surgical Unit provides only non-diagnostic Cardio-Respiratory Monitoring for Cardiac and Respiratory rates.

5. Patients with expressed or reliably reported suicidal ideation or behavior can be admitted to the designated Pediatric area based on their medical needs. *(See "Suicidal Patient Assessment & Management" policy.)*

6. **Most Common Diagnosis for Admission:**

- Stable Medical Surgical Level patients
- Pneumonia, simple
- Respiratory Syncytial Virus (RSV)
- Bronchiolitis
- Croup
- Asthma Parasitic Infection
- Gastroenteritis
- Child Abuse
- Trauma-related Orthopedic Conditions
- Drug and Foreign Substance Ingestions
- Cellulitis
- Hyperbilirubinemia
- Mental Retardation/Developmental Delay (*As 2nd diagnosis only*)
- Surgical conditions such as:
  - Appendectomy
  - Minor surgery (Incision and Drainage of Abscess)
  - Orthopedic surgery

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Diagnosis that would require transfer include but are not limited to:

a. Newly diagnosis cardiac conditions

b. Head Trauma with loss of consciousness

c. Neuro-Surgical diagnosis

d. 2nd and 3rd degree burns

e. Peripheral and cardio vascular surgeries

REFERENCES:

- American Academy of Pediatrics, April 2023, Clinical Practice Guidelines & Policies 23rd edition, Elk Grove Village, IL,

CROSS REFERENCES:

- SUIIDAL PATIENT ASSESSMENT & MANAGEMENT

PURPOSE:

The goal of the Annual Infection Prevention Plan is to establish a comprehensive Infection Prevention (IP) and Control Program. By doing so, SVMC will continue to have a functioning, coordinated process in place to reduce the risks of endemic and epidemic healthcare-associated infections (HAIs) in patients, personnel, volunteers, licensed independent practitioners (LIPs), and the community.

The update of the Annual Infection Prevention Plan is based on current epidemiological principles and methods. This will ensure appropriate standards and measures are set to maintain awareness and working knowledge of guidelines and recommendations that are published by regulatory and accrediting agencies (such as The Joint Commission and others), professional allied health organizations (APIC, SHEA, AORN and others) that provide current, evidence-based infection control services. The Infection Prevention Manager, under the guidance of the Pharmacy, Therapeutics and Infection Prevention Committee (P&T/IPC) and the IP Chairperson, will develop and conduct infection surveillance, prevention and control to promote optimal health of patients, personnel and the community surrounding Sierra View Medical Center (SVMC).

The Infection Prevention and Control Program will incorporate the following items in a continuing series within this policy:

- Surveillance, prevention and control of infections throughout the organization, in both inpatient and outpatient areas (IC.02.01.01).
- Screening and surveillance of diseases with pandemic potential (e.g., Ebola, Zika, COVID-19, Mpox)
- Develop alternative techniques to address real and potential exposures (IC.01.04.01)
- Select and implement the best interventions to minimize adverse processes/outcomes (IC.01.04.01)
- Evaluate and monitor the results and revise techniques as needed (IC.03.01.01)

DEFINITIONS:

National Healthcare Safety Network (NHSN) – Oversees a national database which is the nation's most widely used healthcare-associated infection tracking system

Division of Healthcare Quality Promotion (DHQP) – This organization is a division of the CDC and works to protect patients and healthcare workers through safe healthcare delivery systems in the U.S. Among its other activities, the DHQP oversees NHSN activities.

Centers for Disease Control and Prevention (CDC) – The nation's leading science-based, data-driven, service organization that protects the public's health which in addition to other departments, houses DHQP and NHSN.

OVERVIEW:

Infection Prevention and Control at SVMC is an important consideration for every decision and plan made within the organization. Infection Prevention is an integral responsibility of all personnel beginning with leadership on through to all staff. A successful program requires cooperation between all departments. The Hospital administration has responsibility to oversee and provide resources for the Infection Prevention Program and to ensure that all hospital personnel including medical staff, volunteers, students and contract personnel, etc. are made aware of their responsibilities related to Infection Prevention.

All personnel, in partnership with medical staff, are responsible for the safety and health of all patients, residents, visitors, and hospital staff while at SVMC. The responsibility may be met by working together to promote safe infection prevention practices, observing all rules, regulations and procedural guidelines, and continually striving to improve the quality of patient care. For those reasons, SVMC has established an Infection Prevention Program that requires the participation, support and cooperation of all personnel. (IC.02.01.01)

Each department, in partnership with medical staff, will be responsible and held accountable for its role in SVMC's Infection Prevention Program. Each department will be responsible for reporting any IP concerns to the Manager of Infection Prevention. Each department will be responsible for full and timely cooperation with the Pharmacy & Therapeutics/Infection Prevention and Control Committee (P&T/IPC). Individuals within each department may be given specific assignments or assigned to IP-related committees. When assigned, completion of assignments in a timely and thorough manner is expected. To coordinate infection prevention and control activities, infection prevention management functions are delegated to the Infection Prevention Manager and the P&T/IPC Committee to investigate and follow-up on clinical issues.

The scope of service within this policy includes all departments within the acute care facility and the following outpatient areas: the Distinct Part Skilled Nursing Facility (DP/SNF), Cancer Treatment Center (CTC), Medical Office Building (MOB), Ambulatory Surgery Department (ASD), Wound Care Center, the Urology Center, Outpatient Physical Therapy Center, Urgent Care, Sierra View Community Health Center-Terra Bella, Cardiac Catheterization Laboratory and Surgery Clinic.

Hospital personnel and medical staff are hereby directed to assist the President and Board of Directors wherever possible in the implementation of an effective hospital Infection Prevention Program.

POLICY:

1. IP Policy Foundation
    a. Infection Prevention and Control policies are based on recognized guidelines, applicable laws and regulations. The policies address measures to prevent the transmission of infections among patients, employees, medical staff, volunteers, visitors, and the general public. Policies have been developed that define surveillance, prevention and control measures in all patient care, support and service areas, and identify methods effective in reducing the risk of transmission of microorganisms, while increasing patient safety.
    b. Policies are reviewed and revised by Infection Prevention and contributing departments at least every three years and as needed. New policies and those policies with major revisions are approved by the P&T/IP Committee. Hospital-wide policies include those that are general, which are followed throughout the hospital, and are located on the SVMC intranet in the Policy Library. Department-specific policies may include policies for tasks or IP measures unique to that particular area. Many of the IP approved practices are integrated into department policies that are kept by the Director/Manager of the department, and Infection Prevention is consulted for input and revisions.
2. Oversight of the Infection Prevention and Control Program (IC.01.01.01)
    a. Qualified individuals implement the infection prevention program. A full-time Infection Prevention Manager, an Infection Prevention Registered Nurse, Infection Prevention Analyst, and the P&T/IP Committee (including the ID Specialist) oversee the Infection Prevention program. The Infection Prevention Manager reports to the Vice President of Quality & Regulatory Affairs.
    b. Employee Health, the Education Department and Infection Prevention collaborate to develop policies and provide education to staff. Policies and educational offerings are created collaboratively with the goal to reduce infections.
    c. The P&T/IP Committee assists with the development and approves all Infection Prevention activities and the surveillance program. This approval process considers the following elements:
        i. Criteria used for defining a hospital acquired infection (HAI) and for differentiating them from community-acquired infections. The National Healthcare Safety Network (NHSN) definitions for HAI are utilized.
        ii. Rationale for selecting a specific approach or combination of approaches, and the time frame for using that approach. Targeted surveillance for NHSN and SVMC–specific indicators are used, as described below:

1. Patient population to be studied
2. Data collection methods employed
3. Quality control procedures for ensuring accuracy and completeness of case findings
4. Assignment or responsibility for data evaluation and follow-up
5. Method for reporting and follow-up
6. Reporting of infections to public health as required
7. Documentation of infections of epidemiological significance among healthcare personnel

3. Risk Assessment (Appendix A) (IC.01.03.01)
    a. At least once a year, P&T/IP Committee completes a risk assessment, evaluates, revises as necessary, and approves the type and scope of surveillance activities by reviewing the following items:
        i. Data trend analysis generated by surveillance activities during the past year
        ii. Effectiveness of prevention and control intervention strategies in reducing the HAI risk
        iii. Services instituted, procedures performed, priorities of significant community and world health, and problems identified during the past year
4. Resources for Infection Prevention and Control Program (IC.01.02.01)
    a. SVMC provides resources for the program through MEDITECH Expanse Live computer services, laboratory services, equipment, supplies and personnel.
5. Healthcare-Associated Infection Surveillance Overview
    a. The SVMC Infection Prevention Program is responsible for monitoring HAIs. Since July 2008, the SVMC Infection Prevention Program has been an active participant in the CDC NHSN program using NHSN infection indicators, definitions, and methodologies for data collection and analysis. Data is entered into the Infection Prevention Database regularly and electronically transmitted into an Infection Prevention Database maintained by NHSN.
    b. Since 2003, a targeted surveillance program for an HAI has been utilized at SVMC. With targeted surveillance, infection prevention outcome objectives are determined, priorities are established, and resources are allocated to the major types of infections and the patient populations at highest risk of acquiring an HAI. Numerators and denominators are clearly

established with the focus on procedures that have preventable risk factors that may contribute to the development of an HAI.

c. In addition to the infection types specified in the targeted surveillance plan, non-targeted infections, single occurrences, and/or outbreaks of an HAI related to any unusual or virulent pathogenic organism are evaluated. The Infection Prevention Manager, Vice President of Patient Care Services, and P&T/IP Committee determine interventions.

6. Definitions for Healthcare-Associated Infections (HAI)

   a. Determination of an HAI depends on evaluation of clinical, laboratory and other diagnostic information gathered on the patient. Consistency in determining HAIs within the healthcare setting is necessary to compare infection rates from one evaluation period to the next. When comparing hospital infection rates to a national infection rate, consistent determination of HAIs from all participating hospitals is essential.

   b. The CDC is the recognized authority for HAI surveillance in the United States. Definitions published by the CDC and NHSN system are the standard for use in hospitals. Updated definitions from NHSN are utilized as provided. A hard copy of these definitions is located in the NHSN binder in the Infection Prevention office. There is also access to NHSN electronically.

7. Priorities for Healthcare-Associated Infection (HAI) Surveillance

   a. Surgical Site Infections (SSIs) (NPSG.07.01.01): Prevention of surgical site infections is a high priority. CDC (2021) estimates that surgical site infections are associated with nearly 1 million additional inpatient days annually and an estimated annual cost of $3.3 billion. Methods to reduce surgical site infections are well documented in medical literature by medical associations/organizations (e.g., AORN, APIC, ASA). SSIs are monitored, reported, and analyzed on an ongoing basis.

   b. Ventilator Associated Pneumonia (VAP): Prevention of VAP in the Intensive Care Unit (ICU) is a high priority because of high mortality rates, expense associated with prolonged ICU stays, and many preventable factors contributing to these infections. At SVMC, VAP in ICU is monitored on an ongoing basis. All VAPs will be monitored and reported.

   c. Central Venous Catheter-Associated Blood Stream Infections (CLABBSI) (NPSG.07.01.01): Nationally, bloodstream infections associated with central venous catheters are often preventable and have a high mortality rate. It is a high priority to reduce risk factors leading to these infections. Patients in the ICU who develop a BSI are 2-3 times more likely to die and stay in the hospital an average number of 24 days (https://www.cdc.gov/HAI/bsi/CLABSI-resources.html). Estimates of added costs attributed to Central Line Associated Blood Stream Infections (CLABSI) $40,034,450

annually. At SVMC, CLABSI are monitored house-wide and reported on an ongoing basis to P&T/& IPC and to the involved clinical units.

d. Catheter-Associated Urinary Tract Infections (CAUTI): Urinary tract infections associated with indwelling urinary catheters have relatively small morbidity and financial consequences. UTIs account for more than 9.5% of infections reported by acute care hospitals. It has been estimated that each year, more than 13,000 deaths are associated with UTIs. At SVMC, house-wide monitoring for CAUTIs in all units will be continued and reported upon.

8. Surveillance Documentation of All Infections

   a. Infection Prevention has created databases for documenting targeted and non-targeted HAIs as a method to track and trend occurrences. The surveillance fulfills internal requirements for SVMC, California Department of Public Health Services (CDPH), and the Joint Commission (TJC) standard of IP that requires a review for any HAI sentinel event(s) that cause death.

   b. Excel spreadsheets (supplemented by MEDITECH Expanse) have been created and contain information about the infection surveillance of many types of infections and may be used to guide the response to any outbreak of HAI.

   c. Surveillance includes, but is not limited to, surgical procedures, obstetric procedures, catheterization procedures, and antibiotic resistant bacteria (MDROs).

9. Infection Control Reports

   a. The SVMC infection prevention process is designed to lower risks and decrease rates or numerical trends of epidemiologically significant infections. Infection prevention reports are presented in a manner that facilitates this process. Infection rates are established using recognized statistical methodology. Histograms and process control charts are utilized when feasible to enhance the identification of infection trends and variations.

   b. Results of infection surveillance are reported regularly by Infection Prevention to P&T/IP Committee and documented in the meeting minutes. Minutes are forwarded to the Chief Executive Officer, Vice President of Patient Care Services, Vice President of Quality & Regulatory Affairs, and to the medical staff through various committees. A report of HAI rates is provided regularly by Infection Prevention to the Performance Improvement/Patient Safety (PIPS) Committee, various nursing departments, individual medical staff members, nursing staff, and anyone who may benefit from and provide prevention measures toward decreasing infections. Additional reporting of infection rates, when benchmark rates are exceeded, is managed by Infection Prevention utilizing a team approach of performance improvement processes. If infections require immediate