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
December 19, 2023

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

3. Compliance Report – Quarter 4 and Quarter 1

C. Pursuant to Gov. Code Section 54956.9, Exposure to Litigation to subdivision (d)(2): Conference with Legal Counsel. BETA Claim No. 23-001994

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

E. 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: Approve/Disapprove Report as Given

3. Compliance Report – Quarter 4 and Quarter 1
   Recommended Action: Approve/Disapprove Report as Given

C. Conference with Legal Counsel Re: BETA Claim No. 23-001994
   Recommended Action: Approve/Deny BETA Claim No. 23-001994

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

E. 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.

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VIII. Approval of Minutes

A. **November 28, 2023 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove November 28, 2023 Minutes of the Regular Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. **Annual Graduate Medical Education Report**
Recommended Action: Approve/Disapprove Report as Given

B. **Reaffirm Institutional Statement of Commitment to Graduate Medical Education**
Recommended Action: Reaffirm Commitment

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

D. **November 2023 Financials**
Recommended Action: Approve/Disapprove Report as Given

E. **Capital Budget – Quarter 1**
Recommended Action: Approve/Disapprove Report as Given

F. **Board Organization and Election of Officers**
Recommended Action: Approve/Disapprove Report as Given

XI. Announcements:

A. Regular Board of Directors Meeting – January 23, 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.

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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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MEDICAL EXECUTIVE COMMITTEE	12/06/2023
BOARD OF DIRECTORS APPROVAL	
	12/19/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
December 19, 2023 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**
• 340B Drug Pricing Program Compliance	1-10	↓
• Abbreviations in the Medical Record	11-38	
• Administration of Measles, Mumps, and Rubella Vaccine	39-41	
• Blood & Blood Components, Administration of	42-49	
• Certified Nursing Assistant Certification Verification	50-51	
• Change in Resident Condition	52-54	
• Change of Shift Report	55-56	
• Charting	57-58	
• CIWA-Ar: Assessment and Treatment of Acute Alcohol Withdrawal	59-72	
• Clinical Decision Unit Admission Criteria	73-75	
• Counts of Instruments, Sponges and Sharps	76-82	
• DP/SNF Resident/Family Council Policy and Procedure	83-84	
• Discharge Medical Summary	85-86	
• Duties and Responsibilities of Chair of Anesthesiology	87-88	
• Examination of Survey Results	89	
• Exposure Control Safe Engineered Sharps	90-92	
• Fall Prevention (Adult and Geriatric)	93-97	
• Fall Prevention (Adult and Pediatric)	98-104	
• Feeding, Transitional-Enteral to Oral Intake	105-106	
• Financial Counseling in DP/SNF	107	
• Free Choice	108	
• Guidelines for Immunocompromised (Neutropenic) Patients	109-111	
• Hand Care of, Contracture	112-113	
• Health Care Worker Exposure to Meningococcal Disease	114-116	
• Immediate Bedding	117-118	
• Infection Control Chairperson	119	
• Infection Control in Imaging Services	120-122	
• Interdisciplinary Assessment and Reassessment DPSNF	123-132	
• Linen Handling	133-134	
• Mandated Abuse Reporting – DP/SNF	135-142	
• Medical Record Guidelines for Physicians	143-147	
• Medical Records Filed as Incomplete	148	
• Medication Administration	149-157	
• Medication Administration – DP/SNF	158-177	
• Medication Ordering	178-196	
• Nasal Care for Nasogastric Tube Fed Residents	197-198	

• Non-Discrimination on the DP/SNF	199-201	
• Notification and Exercise of Rights and Responsibilities	202-203	
• Nursing Care of Ventilator Residents on the DPSNF Unit	204-206	
• Nursing Documentation of Enteral Feeding	207-210	
• Nutritional Screening and Assessment/Reassessment	211-214	
• Oral Care for the Resident with Special Needs	215-216	
• Oxygen Protocol for Resident Transport	217-218	
• Pacemaker – Permanent Care of	219	
• Pharmaceutical Waste	220-226	
• Physical Examinations Positioning and Draping	227-228	
• Physician's Orders for Life-Sustaining Treatment (POLST)	229-231	
• Point of Use: Instrument Cleaning and Transport	232-234	
• Pressure Ulcer Prevention Plan DPSNF	235-245	
• Procedure for Mouth Care of the Tube Fed Resident	246-248	
• Provision of 24 Hour Nursing Accessibility Guidelines	249-252	
• Range of Motion	253-260	
• Rapid Response Team Adult & Pediatric	261-265	
• Resident Rights – Medical Decisions	266	
• Restorative Program	267	
• Restraint Use – Non-Violent, Non Self-Destructive (NVNSD) and Emergency-Violent Self Destructive (VSD)	268-272	
• Routine Patient Care in the Post-Anesthesia Care Unit (PACU)	273-275	
• Scheduling Surgical Procedures	276-280	
• Scope of Occupational Therapy	281-282	
• Scope of Practice – Licensed Vocational Nurse	283	
• Screening of Long-Term Care Residents for Tuberculosis (TB)	284-285	
• Seasonal Influenza Plan	286-289	
• Skin Care Tips for Nursing Assistants	290-291	
• Skin Preparation for Surgical Patients	292-296	
• Splint Application and Use	297-298	
• Standards of Care: Interdisciplinary Team Assessment	299-307	
• Surgical Services On-Call System	308-310	
• Therapeutic Drug Substitution Protocol	311-321	
• Treatments Related to Medication - CNA	322	
• Verbal & Telephone Orders – Persons Permitted to Accept, Readback and Authentication of	323-326	
• Waived & Point of Care Testing: Binaxnow Influenza A & B with Digival	327-333	
• Waived & Point of Care Testing: COVID-19 AG	334-338	
• Water Pass	339	
• Weight Variance – DP/SNF	340-342	
• Witholding or Withdrawing Life-Sustaining Treatment DP/SNF	343-348	

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Senior Leadership Team	12/19/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	12/19/2023

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
December 19, 2023
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. Contingency Plan for Water Damaged Medical Records	1	
2. Drug and Alcohol in the Workplace	2-11	
3. Equal Employment Opportunity	12-13	
4. Food Service Emergency Plan	14-25	
5. Food Supplies and Storage	26-30	
6. Identification and Process for Receiving Regulatory Inspection	31-32	
7. HIM Coding Compliance Plan	33-37	
8. Leave of Absence – California Mandated	38-42	
9. Photo Identification Badges	43-44	
10. Pre-Employment, Annual/Periodic and Fitness for Duty Evaluations	45-51	
11. Reimbursement of Overpayments	52-55	
12. Safety Management Plan	56-66	
13. Verification of External Requests	67-69	
Forms:		
1. CTC Chemotherapy Infusion Consent	70-72	

SUBJECT: **CONTINGENCY PLAN FOR WATER DAMAGED MEDICAL RECORDS**	SECTION: **Page 1 of 1**

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

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to provide a contingency plan in the event that records are damaged due to water damage. Any type of damage is destructive. Water damage from flood or fire can be most devastating.

PROCEDURE

1. The following procedures should be implemented as soon as the water is removed and the amount of damage is assessed.

    a. Determine what documents should be rescued using the retention requirements.

    b. Prioritize which records should be removed first in order to keep the hospital functioning.

    c. Records are to be removed within 48 hours of damage to prevent mold, mildew and bacteria growth.

    d. Depending on the degree of damage, the records can be restored by:

        - Air drying the records by placing absorbent material between each document and then using fans for increased air circulation.
        - Freezing the records and keeping them in cold storage. This process stops the deterioration of handwritten data on paper records.
        - Freeze-drying is the quickest and most expensive method. It is only for optimal preservation of original records that are totally irreplaceable.
        - Remember that time is a critical factor. Move as quickly as possible to recover damaged information.

REFERENCE:

- California Code of Regulations, Title 22, § 70751

SUBJECT: **DRUGS AND ALCOHOL IN THE WORKPLACE**	SECTION: **Page 1 of 10**

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

PURPOSE:

To define the manner in which the District will provide a drug and alcohol free workplace.

POLICY:

Sierra View Medical Center (SVMC) believes in promoting and enforcing the maintenance of a workplace free of drugs and alcohol. The Hospital has adopted a ZERO TOLERANCE for the employee's use of drugs and/or alcohol affecting their work or work environment.

As part of the drug awareness program, employees must recognize that a drug-free environment is essential. The quality of our work and our customer safety depends, in part, on maintaining a drug-free environment.

A violation of this policy will result in disciplinary action, up to and including termination of employment, or in not being hired.

INDIVIDUALS COVERED:

This policy applies to external applicants for SVMC special needs jobs and to all SVMC employees, volunteers, and contingent workforce. A copy of this policy will be given to all employees. Notices of this Policy are available on the SVMC intranet and copies are available in the Human Resources Department.

CONFIDENTIALITY:

Any information about an employee's use of prescription or non-prescription medication, the results of any pre-employment or reasonable suspicion drug and/or alcohol testing, and/or an employee's past or present participation in rehabilitation or treatment for substance abuse shall be considered confidential personnel information. The information received in enforcing this policy shall be disclosed only as necessary for: (1) disciplinary actions and appeals; (2) interactive process meetings and reasonable accommodation efforts; or (3) resolving legal issues. Any reports or test results generated pursuant to this policy shall be stored in a confidential file, accessible only by those authorized to receive the information and separate and distinct from the employee's personnel file.

DEFINITIONS:

Chain of Custody: For purposes of this policy, "Chain of Custody" refers to procedures to account for the integrity of each specimen by tracking its handling and storage from point of specimen collection to final disposition of the specimen at the certified laboratory.

Collection Location: For the purposes of this policy, "Collection Location" shall mean a designated clinic/facility where applicants or employees may present themselves for the

purpose of providing a specimen to be analyzed. SVMC will select a Collection Location and require that the Collection Location comply with all methods of collection and Chain of Custody and provide documentation of compliance to SVMC.

Medical Review Officer: For purposes of this policy, "Medical Review Officer" or (MRO) shall mean a licensed physician with knowledge of drug abuse disorders as well as appropriate training to interpret and evaluate an employee's positive test results together with an employee's medical history and any other biomedical information. MRO reviews all positive test results and interviews individuals who tested positive to verify the laboratory report before the employer is notified. SVMC shall select a MRO who is a licensed physician.

On-the-Job: For purposes of this policy, an employee is considered "on the job" or "on Hospital premises" whenever the employee is:

- On Hospital property, including parking lots, break rooms, lounges, cafeterias, locker areas, etc., at any time;
- On Hospital time, even if off Hospital premises (including paid lunch, conferences and rest periods);
- On the property and/or at the facilities of customers, clients and/or vendors of the Hospital;
- Operating SVMC equipment, including, but not limited to, all property and equipment, machinery and vehicles owned, leased, rented, or used by SVMC.
- Attending a conference for which the Hospital reimburses expenses;
- At a job site.

Possession: For purposes of this policy, "possession" includes substances being physically held by a person and/or stored or deposited in areas the employee controls (e.g. purses, lunch boxes, personal automobiles, lockers and limited-access work areas).

Testing Positive: For purposes of this policy, "testing positive" means an alcohol blood test resulting in a value of 0.02 or above or urine or blood test results showing the presence of an illicit drug substance and/or the metabolites of an illicit drug.

Reasonable Suspicion: For purposes of this policy, "reasonable suspicion" will be based on specific and timely observations concerning the appearance, behavior, speech, and body odors of the employee, etc. including behavior or symptoms which may indicate

chronic and/or withdrawal effects of the use of controlled substances. This includes information from customers, members of the public, and co-workers. In addition, a job-related accident or near-accident involving human error may trigger a reasonable suspicion test request.

Safety Sensitive: Those positions where employees engage in activities that have the potential to endanger the health and safety of the employee, the public or the Hospital's patients, or those applicants seeking jobs which can directly influence children.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES, VOLUNTEERS & CONTINGENT WORKFORCE*

PROCEDURE:

RESPONSIBILITY

All employees are encouraged to come forward with any information regarding any concerns about compliance with this policy. It is the responsibility of all managers, supervisors and employees to ensure that this policy is enforced. Employees who have reason to believe that another employee is under the influence of drugs and/or alcohol shall immediately notify his or her immediate supervisor or they may be in violation of this policy. Should any Leader have reasonable suspicion to believe an employee may be under the influence of drugs and/or alcohol; the employee shall be removed immediately from the workplace until such time as testing results confirm or refute the presence of drugs and/or alcohol.

PROHIBITIONS

1. *ALCOHOL*

The Hospital strictly prohibits the use, consumption, possession, or being under the influence of alcohol, or having blood/alcohol content (BAC) level of .02 or above while on the job and/or on Hospital premises. EXCEPTION: On occasion, the Hospital may permit alcohol to be served at off-duty and off-site functions to which employees are invited. However, the Hospital strictly prohibits the use of alcohol which results in impairment or intoxication at any time while on Hospital premises and/or while attending Hospital functions.

2. *ILLICIT DRUGS*

The Hospital strictly prohibits the illicit use, sale, solicit, attempted sale, conveyance, distribution, manufacture, cultivation, dispensation, purchase, attempted purchase, and possession of illegal drugs, intoxicants, or controlled substances, at any time and in any amount or in any manner. Illicit drugs include all drugs, the possession of which are illegal under federal law, and include prescription drugs for which the individual does not have a valid prescription. Because the use of marijuana is illegal under federal law, and in accordance with California's Health & Safety Code, the Hospital is neither obligated to nor will it accommodate or permit an employee's medical

marijuana or recreational marijuana use or possession while on the job. Effective 1.1.2024 existing California Law makes it unlawful for an employer to discriminate against a person in hiring, terminating, or any term or condition of employment, or otherwise penalize a person because of the person's use of cannabis off the job and away from the workplace.

3. *PRESCRIPTION AND OVER-THE-COUNTER DRUGS*

The Hospital strictly prohibits the use, possession, or being under the influence of a prescription drug obtained or used without a prescription by a licensed physician at any time and in any amount while on the job or on Hospital premises. Additionally, using or being under the influence of legally obtained prescription or over-the-counter drugs is prohibited where such use may affect the employee's ability to safely and/or efficiently perform his/her job. It is each employee's responsibility to check with their medical care provider and review product packaging to determine whether any prescription or over-the-counter drugs may adversely affect his/her ability to safely and/or efficiently perform assigned duties.

Before commencing work, an employee is required to advise Employee Health Services that he/she is taking prescription or over-the counter drugs that will or may impact the employee's ability to safely and/or efficiently perform assigned duties. The employee should not reveal the name or type of medication he/she is taking nor should the employee reveal why he/she is taking the medication. The ONLY information sought by the Hospital is whether the medication has side effects that preclude the employee from safely and efficiently performing their assigned duties.

Employee Health Services, along with Human Resources and the employee's supervisor, shall determine the employee's ability to perform safely and/or efficiently under the circumstances and whether he or she may work, full duty or light duty, based on the written opinion of the employee's medical provider that the use of the action may impair the employee's ability to perform specific duties. The employee will be assigned to other duties if, in the sole discretion of management, such duties are appropriate and available. The Leader may, upon a determination that the employee is unable to safely or efficiently perform his or her normal duties, or that a modified work assignment is not available, direct the employee not to work and to return home on a paid sick leave, if available, or otherwise on unpaid leave. Notices or communications required by this Section shall be confidential and disclosed only to the Leader and the other employees specifically authorized to receive information pursuant to this Policy.

4. *TESTING*

Refusing to submit to illicit drug and/or alcohol testing pursuant to this policy is strictly prohibited and will be considered a failed test.

5. *ADULTERATING AND/OR TAMPERING WITH SAMPLE*

Adulterating and/or tampering with the collection forms, the testing process and/or with the testing sample, or engaging in behavior which causes suspicions of adulteration or tampering with the sample or the collection or testing process is strictly prohibited and will result in the test results being treated as a failed test.

6. *CONVICTION OF DRUG AND ALCOHOL CRIMINAL VIOLATIONS*

Being convicted of a criminal drug violation occurring in the workplace **is prohibited**.

In order to ensure safe patient care, safety and security, all employees have an ongoing duty to self-report to SVMC at the employee's earliest opportunity any misdemeanor or felony arrests or convictions that occur after the employee begins working for SVMC. Any misdemeanor or felony arrests or convictions must be reported to the Vice President of Human Resources. This would include conviction of DUI. Failure to properly report conviction or arrests of misdemeanor or felony may result in separation of employment up to and including separation.

7. *COMPLIANCE WITH MANDATED PROGRAMS*

Failing to comply with any program mandated by state, federal or local law **is prohibited**.

The Nurse Practice Act makes it clear the responsibility is on the licensee to report any conviction of a felony or misdemeanor to the Board of Nursing within 30-days. This includes DUI conviction and arrests.

Any staff member who is considered a licensee through an agency as a requirement to perform their roles, is responsible to follow the self-reporting guidelines for reporting convictions or arrests of any misdemeanor or felony, including DUI within the agencies established timeline.

DRUG TESTING – NEW HIRES

The Hospital requires all prospective new hires in safety sensitive positions to successfully pass a mandatory drug test. Such pre-employment testing will take place after a conditional offer of employment, but before the applicant begins work.

External job applicants who test positive, attempt to or engage in behavior which causes suspicions of adulterating or tampering with the sample of the collection or testing process, or who fail to cooperate in the testing process will result in the revocation of their conditional offer of employment and they will no longer be considered for employment by the Hospital.

DRUG AND ALCOHOL TESTING – CURRENT EMPLOYEES

The Hospital may require drug and alcohol testing of current employees under the following circumstances:

1. When a reasonable suspicion exists, based upon specific and documented facts and observations, that an employee may be under the influence of any controlled substance, drug or alcohol while on the job, or is otherwise in violation of this policy;

2. When a reasonable suspicion exists to believe, based upon specific and documented facts and observations, that the employee either possesses, uses, sells, transfers, manufactures, purchases or illegally transports alcohol, drugs and/or drug-related paraphernalia or attempts to do so. or when such items are found in an area controlled or used by the employee, such as an employee's desk;

3. When required by state, federal or local law or regulation(including, but not limited to (a) persons driving commercial motor vehicles with a gross vehicle weight rating of 26,001 pounds or more or carrying hazardous materials [DOT testing]; or (b) for other reasons required by law);

4. When transferring from a non-safety sensitive position into a safety sensitive position (drug testing only), such drug testing will take place after the offer of transfer to the safety sensitive position but prior to the start of the new position.

5. Follow up testing for employees who have returned to work following a positive test and testing is required as part of their participation in a drug and/or alcohol rehabilitation program;

6. Following a work-related accident, incident, or mishap that resulted in death, or injury requiring medical treatment away from the immediate scene of the accident, or property damage, where drug and /or alcohol use by the employee cannot be ruled out as a contributing factor.

TESTING PROCEDURE

In conducting an illicit drug or alcohol test, precautions shall be taken to ensure that unadulterated specimens are obtained and correctly identified while simultaneously protecting the privacy of the individual to the extent reasonably practicable.

1. No sample will be collected, and no test will be conducted without the written consent of the individual being tested. However, failure to consent will be considered a refusal to test and viewed as an insubordination and will subject the individual to disqualification from employment or disciplinary action, up to and including discharge. The Hospital will pay the cost of all drug and/or alcohol tests required by the policy.

2. The employee will also be asked to sign an authorization for the release of the test results to the Hospital.

3. Any employee who is asked to submit to a reasonable suspicion illicit drug or alcohol test will be placed on unpaid suspension pending further investigation.

4. The testing will involve collecting urine and/or blood samples, which will be subjected to

An initial screening test. If that test result is positive, the positive result will be confirmed using a different testing methodology.

5. One or more persons in Employee Health Services will be designated to receive test results and will notify Human Resources and other authorized Hospital officials on a need-to-know basis.

6. Employee will present to the collection location at the scheduled date and time. Should a drug or alcohol screen need to be performed after operational hours from Employee Health Services (Monday through Friday, 7:00 a.m. to 3:30 p.m.), the House Supervisor shall be contacted, who in turn will notify the Administrator On-Call and the Director of Quality and Patient Safety or designee for further instructions. Collection location personnel will further explain the mechanics of the collection process.

7. A valid form of photo identification will be requested and photocopied prior to the test.

8. Procedures for urine collection will allow for individual privacy unless there is a reason to believe the individual may alter or substitute the specimen to be provided. Samples will be tested for temperature and subject to other validation procedures as appropriate.

9. The employee must sign the provided "Chain of Custody" forms by attesting that there was no tampering with the specimen prior to its being sealed in the package. The "Chain of Custody" procedures will be continued by the vendor laboratory and shall conform to the Mandatory Guidelines for Federal Workplace Drug Testing Programs, as promulgated by the Department of Health and Human Services, as amended from time to time.

10. Tests will seek only information about the presence of drugs and/or alcohol in an individual's system and will not test for any medical condition. Because the use of marijuana is illegal under federal law, and in accordance with California's Health & Safety Code, the Hospital is neither obligated to and will not accommodate or permit an employee's medical marijuana or recreational marijuana use while on the job. A positive drug test for psychoactive marijuana use will subject the employee to disciplinary action, up to and including termination of employment as provided in this policy.

11. All test results will be directed to the designated contact person in Employee Health Services, who will then notify the designated contact person in Human Resources.

12. Any positive drug or alcohol test will prompt an investigation by the Medical Review Officer (MRO) for confirmation of the positive test. The employee will be notified by the MRO and will be given an opportunity to provide the MRO with any reason he or she may have that would explain the positive test. The MRO's investigation may include the need to gather information from the employee regarding prescription and over the counter medications that may have affected the drug test. If the employee provides an explanation acceptable to the MRO that the positive drug or alcohol test result is due to factors other than the presence of drugs and/or alcohol in the test specimen, the positive test results will be disregarded and reported to the

Hospital as negative. Otherwise, the MRO will report the positive result to the designated contact in Employee Health Services, or other authorized Hospital officials as appropriate. If the MRO determines that a positive drug test is the result of a validly prescribed medication or over the counter medication, the Hospital reserves the right to proceed accordingly under the "Prescription and Over-the-Counter Drugs" section of this policy. Test results will only be disclosed to the extent expressly authorized by this policy and the employee authorization form.

13. Employees may request and receive a copy of their test results from Employee Health Services.

14. Should an employee be observed attempting to substitute or adulterate the sample or an unusual occurrence arise during the collection procedure that creates concern about the accuracy of the specimen, the Director of Quality and Patient Safety and Vice President of Human Resources will be notified.

VOLUNTARY ADMISSION OF A DRUG AND/OR ALCOHOL PROBLEM

1. The Hospital encourages employees with drug and/or alcohol abuse problems to seek needed counseling and treatment.

2. The Hospital encourages employees to contact a supervisor, Human Resources, or Employee Health Services to receive information about the Employee Assistance Program (EAP). An employee requesting this assistance may, at the supervisor's discretion, be transferred, given work restrictions, or placed on leave while receiving treatment and until the employee is drug and/or alcohol free. Any voluntary communications with a supervisor, Human Resources, or Employee Health Services that are initiated by the employee, and not as a result of a violation or suspected violation of this policy, will be treated as confidentially as possible. However, requesting assistance for substance abuse does not relieve the employee of his/her responsibility to meet performance, safety and attendance expectations and to comply with all Hospital policies. Nor will an employee's voluntary disclosure of a substance or alcohol abuse problem terminate any investigation, criminal or administrative, initiated prior to the disclosure.

3. Employees must use available Paid Sick Leave (PSL) or Vacation/Holiday (VAC/HOL) with applicable leaves of absence. If none of the above is available to them and time off from work is necessary for rehabilitation services related to a drug and/or alcohol problem, it will be unpaid. The employee will pay rehabilitation expenses unless coverage is provided under a health insurance policy.

COMPLIANCE WITH THE DRUG-FREE WORKPLACE ACT

1. Employees must, as a condition of employment, report any drug-related conviction under a criminal drug statue for violations occurring on or off Hospital premises. A report of a conviction must be made to the VP of Human Resources within five days of the known conviction.

2. Within 30 days of the date the Hospital learns of an employee's conviction, it may discipline such employee up to and including termination.

3. Each employee, as a condition of employment, shall sign a Notification Statement confirming that the employee will abide by this policy.

4. The Hospital's drug-free awareness program will inform employees of:

   a. The dangers of drug and alcohol abuse on health and in the workplace;

   b. Hospital policy of maintaining a drug-free workplace as set forth herein and which all employees will acknowledge;

   c. The extent of available drug counseling rehabilitation and other employee assistance measures *(see section titled Voluntary Admission of a Drug and/or Alcohol Problem above);* and

   d. The penalties that may be imposed for drug abuse violations *(see Prohibitions discussion above.)*

INVOLVEMENT OF LAW ENFORCEMENT AGENCIES

When the Hospital has reason to believe that federal, state or local law is being violated, the Hospital may refer such activities to law enforcement agencies.

REFERENCES:

- Home. (n.d.). Retrieved February 03, 2021, from https://www.jointcommission.org/.
- Elaws - drug-free Workplace Advisor. (n.d.). Retrieved February 03, 2021, from https://webapps.dol.gov/elaws/drugfree.htm.
- The controlled Substances Act. (n.d.). Retrieved February 03, 2021, from https://www.dea.gov/controlled-substances-act.
- 42 U.S.C. §§ 12101 et SEQ. | Americans with Disabilities ... (n.d.). Retrieved February 3, 2021, from https://americandisabilityrights.org/ada/42-usc-12101-americans-with-disabilities-act.
- The Americans with Disabilities Act Amendments act of 2008. (n.d.). Retrieved February 03, 2021, from https://www.eeoc.gov/statutes/americans-disabilities-act-amendments-act-2008.
- *Nursing, C. (n.d.). Nursing practice act. Retrieved February 03, 2021, from http://www.rn.ca.gov/practice/npa.shtml.*

- *Senate Bill 700- Cannabis use*

- *Assembly Bill 2188- Discrimination in employment: Use of cannabis*

CROSS REFERENCES:

- **SOP – Behavioral Physical Observation For Leaders**
- **SOP – Reasonable Suspicions Guidelines For Leaders**

SUBJECT:	SECTION:
EQUAL EMPLOYMENT OPPORTUNITY	*Human Resources*
	Page 1 of 2

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

PURPOSE:

To ensure compliance with all applicable laws providing equal employment opportunities to all qualified individuals and protection from unlawful discrimination.

POLICY:

Sierra View Medical Center (SVMC) is an equal opportunity employer and makes employment decisions on the basis of merit, qualifications, potential and competency. SVMC policy prohibits unlawful discrimination based on race, color, creed, gender (including gender identity and gender expression), religion (all aspects of religious beliefs, observance or practice, including religious dress or grooming practices) marital status, registered domestic partner status, age, national origin or ancestry, physical or mental disability, medical condition (including cancer or a record or history of cancer, and genetic characteristics), sex (including pregnancy, childbirth, breastfeeding or related medical condition), genetic information, sexual orientation, veteran status or any other consideration made unlawful by federal, state, or local laws. It also prohibits unlawful discrimination based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics. Discrimination can also include failing to reasonably accommodate religious practices or qualified individuals with a disability where the accommodation does not pose an undue hardship. All such discrimination is unlawful.

SVMC is committed to complying with all applicable laws providing equal employment opportunities. This commitment applies to all persons involved in the operations of SVMC and prohibits unlawful discrimination by any employee of SVMC.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES/INTERNS/VOLUNTEERS/JOB APPLICANTS*

PROCEDURE:

To comply with applicable laws ensuring equal employment opportunities to qualified individuals with a disability, SVMC will make reasonable accommodations for the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant, an employee, unpaid intern or student volunteer unless this would result in an undue hardship. . For additional detail, please refer to the policy titled "Reasonable Accommodations."

Religious accommodation requests should be done through the Human Resources Department in conjunction with your department leader.

Any reports or complaints concerning a violation of this policy will be promptly investigated. If SVMC determines that unlawful discrimination has occurred, prompt and effective remedial action will be taken. Appropriate action will also be taken to deter any future discrimination. Whatever action is taken will be made known to the victim of any discrimination, and SVMC will take appropriate action to remedy any losses suffered due to discrimination.

SVMC will not retaliate against any applicant, employee, or unpaid intern or volunteer for filing a good faith complaint, participating in an investigation and/or testifying or assisting in any proceeding involving allegations of discrimination, and SVMC will not tolerate retaliation by a member of management or fellow staff members, interns or volunteers.

Applicants, interns, volunteers or employees shall report all incidents of alleged discrimination to the Human Resources Department.

The Human Resources Department is responsible for ensuring that these requirements are being followed in the hiring and placement of employees and in all other formal actions or events regarding personnel administration.

REFERENCES:

- Title VII of the Civil Rights Act of 1964
- The Age Discrimination in Employment Act of 1967
- The Americans with Disabilities Act of 1990
- The ADA Amendments Act of 2008
- The Immigration and Nationality Act
- AB 1443- Fair Employment and Housing Act Anti-Discrimination and Anti-Harassment Provisions
- 6.30.2023 Supreme Court Fortifies Standard for Religious Accommodations

CROSS REFERENCES:

- REASONABLE ACCOMODATIONS
- ANTI-DISCRIMINATION, HARASSMENT & NON-RETALIATION

SUBJECT: **FOOD SERVICE EMERGENCY PLAN**	SECTION: ***Emergency Management Plan*** **1 of 12**

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

PURPOSE:

Sierra View Medical Center (SVMC) will have the means to provide nutritional assistance to staff and patients for ninety six (96) hours in the event of a disaster or emergency situation.

DEFINITIONS:

Emergency: An 'unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in sudden, significantly changed or increased demand for the organization's services.'

POLICY:

The facility maintains at least a seven days staple and two days perishable foods in inventory. In addition the facility maintains four days (96 hour) emergency meals, potable water and disposable supplies in the facility's secured, temperature-controlled warehouse.

A Nutrition Service disaster and emergency plan is prominently posted in the food service department and reviewed by all department employees at least annually. This plan will be referred to when the facility experiences a loss of water supply, electricity, natural gas, or experiences an emergency/disaster. It is possible that any one or all of these services may be interrupted.

The Food & Nutrition Service Director or Dietitian or Food Service staff member in charge will consult with the House Supervisor or Administrator to determine the nature of the emergency and the anticipated duration.

If needed, all or part of this emergency meal plan will be implemented to ensure provision of nutritious meals to patients despite the limitations of the disaster. The ***Meals for All*** Emergency Solution menu may be used during an emergency/disaster at the discretion of the Food & Nutrition Service Department, House Supervisor or Administration. In the event the emergency/disaster is anticipated to last beyond one meal, the Registered Dietitian will be notified.

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

EQUIPMENT:

Food preparation tool box

PROCEDURE:

At least once a year, the Food & Nutrition Department conducts an in-service session on disaster plans and emergency procedures in regards to the nutritional assistance that will be provided to patients. The *Quick Guide to Emergency Feeding* guidelines will be posted in food service and the house supervisor office. A copy of the disaster and emergency procedures will be stored with the *Meals for All* emergency food and supplies ready reference. (*See attachment I - Quick Guide to Emergency Feeding Guidelines)*

HEATING SOURCE FOR WATER:

If no heating source is available, *Meals for All* may be reconstituted using unheated potable water. All food items are fully cooked and safe to serve at room temperature.

Do not attempt to cook or boil water over an open flame whenever gas leaks are possible.

FOOD TEMPERATURES / FOOD SAFETY:

For best palatability, hot foods are best served at 135°F or more, cold foods are best served at 41° or colder.

However, all foods on this menu may be safely served at room temperature between 41° - 135° if opened, prepared and served within two hours.

HANDWASHING FOR FOOD PREPARERS:

Proper hand washing when water is scarce requires the use of two basins, one with an approved sanitizing agent, and one with clear rinsing water. Approved hand sanitizer may also be utilized.

FOOD PREPARATION:

Follow instructions on the *Meals for All* containers for proper preparation. *See attachment II*

EMERGENCY FOOD ITEMS STORAGE:

The *Meals for All* emergency meals and other emergency supplies will be secured in the facility storage warehouse and easily accessible during an emergency or disaster situation. All food items are dated by the manufacturer and have a ten year shelf life. During the final year of the expected shelf-life, SVMC will determine if the facility will donate the *Meals for All* to a charitable organization or utilize for a facility disaster exercise.

EQUIPMENT FOR FOOD PREPARATION:

The equipment needed for food preparation is secured and stored in the facility storage warehouse. The equipment is in its own marked container and located next to the *Meals for All* pallets. The equipment toolbox includes but not limited to:

- 4 gray scoops (4oz), 4 green scoops (3oz), 4 spoodles (4oz), 2 serving spoons, 2 slotted serving spoons, 4 ladles (3oz), 2 rubber spatulas, 4 tongs, 2 sets measuring spoons, 2 measuring cups, 4 mixing bowls, 2 containers (12 quart), disposable aluminum pans, 2 spot lights, 6 headlamps; 3 lanterns, 10 flashlights, 72 (D) batteries, disposable gloves, 2 can openers, 4 thermometers, 2 boxes storage bags, 2 boxes hairnets, 2 box cutters & extra blades, black markers, 2 scissors, 2 lighters,

masking tape 72 (D) batteries, 2 boxes storage bags, 2 cases disinfectant wipes, 2 boxes alcohol wipes, 4 bottles hand sanitizer, black markers, 2 scissors, 2 lighters, masking tape , garbage bags.

INVENTORY AND VERIFICATION:

The *Meals for All* Emergency Menu Inventory and Supply list will be maintained in the Food & Nutrition Service Director's Office, and a copy will be placed in the Emergency Operations Procedures manual. The inventory and supply list will be inspected on a semi-annual basis to determine all items are present in the quantities specified. The Emergency Supply Inventory Verification form (attached) will be utilized for documenting the inventory, which will include;

- Date of inventory check.
- Results of the inventory.
- Corrective action if needed.
- Signature of person performing the supply inventory.

The Emergency Supply Inventory Verification form will be kept in the Director of Food & Nutrition office and available upon request. (*See attachment IV: Inventory Verification form.*)

DECENTRALIZED FOOD PREPARATION:

The Food & Nutrition Service Director or designee in charge may designate some or all of the emergency food preparation to be conducted at a decentralized location or on each nursing unit or at a remote locations from the facility. The *Meals for All* are packaged to be easily transportable in the event of an evacuation and can be set up in any decentralized location.

MEAL SERVING HOURS:

The meal serving hours for the *Meals for All* will be modified or staggered depending on the emergent situation and will be determined by the Incident Commander, Food & Nutrition Service Director, or designee. The necessary amount of batch cooking to prepare in order to serve in large quantities to the patients and staff members will be taken into consideration. The meals may be served tableside to facilitate having a limited staff to efficiently prepare and serve during an emergency situation. If emergency circumstances warrant, the meals may be served directly from the cooking container directly to the patient / staff.

USE OF EMERGENCY MENUS:

Depending on the time of day and expected duration of the emergency, the Food & Nutrition Service Director or designee may implement the *Meals for All* emergency menus and may be used for a single meal or for several days. (*See attachment III - 4 Day Emergency Menu.)*

MENUS AND THERAPEUTIC DIETS:

The *Meals for All* menus have been planned to provide basic nutrients and meet the needs of most therapeutic healthcare diets. The *Meals for All* menu and products have been specially prepared to allow their use for most healthcare therapeutic diets. The therapeutic menu is appropriate for *Regular, Mechanical Soft, Cardiac, Sodium Restricted, Diabetic and Renal diets.* Specific Therapeutic Diet modifications are as follows:

- Consistent Carbohydrate, Diabetic Gestational Diabetes and Low/No concentrated Sweets Diets may be served all menu items except the pudding. Offer sugar substitute and diet jelly, if available.
- Low Cholesterol/ Low Fat Diets may be served on all menu items.
- No Added Salt/Low Salt Diets may be served on all menu items, but the salt packets are omitted.
- 2 Gram Sodium Diets may be served on all menu items, but the salt packets are omitted.
- Calorie Controlled diets, 1500 Calorie or less, and Consistent Carbohydrate or Diabetic Diets may be served on all menu items except portions of milk, cracker-biscuits and snacks are reduced and the puddings are omitted. Offer sugar substitute and diet jelly if available.
- Renal and Hepatic Diets may be served on all menu items except the milk, pudding and salt packets are omitted. Limit beverages if fluid restriction is prescribed.
- Resident's allergies will be accommodated by knowledgeable staff by offering suitable foods from the *Meals for All* Emergency menu. Diets may be deficient in one or more nutrients.
- Powdered milk is included in the *Meals for All* to meet nutritional needs.

Clear Liquid Diets shall receive broth, gelatin, and clear soda stocked on the nursing units. Nutritional supplements may be ordered to increase calories and nutrient values.

BEVERAGES / CONDIMENTS:

Beverages will be provided as requested or available during an emergency situation. Patients needing thickened liquids will be served beverages thickened to the appropriate level. Substitute dehydrated milk mixed with water for fluid milk if needed. Condiments such as salt, pepper and sugar are made available when possible and not contraindicated by the prescribed diet order. Consistent Carbohydrate or Diabetics shall receive sugar substitute. Sodium-Restricted, Hepatic and Renal diets will not receive salt packets.

WATER STORAGE GUIDELINES:

The facility will maintain designated emergency water in SVMC's secured, temperature controlled warehouse. The water will be stored in a cool, dry area, away from heat sources, and staff will be instructed not to utilize it for any other purpose except an emergency situation. One gallon of water per person per day for proper hydration will be stored. This allows two quarts for drinking water and two quarts for food preparation. However, *Meals for All* dehydrated emergency foods require approximately one quart of water per person per day for reconstitution. *Refer to Water Requirements Appendix in 4-*

Day Meal Plan Guide for water requirements table for exact amounts of water per can. Storing one gallon of water per person per day is adequate to meet emergency water needs.

Although the bottled water packaging may indicate an expiration date, the United States Food and Drug Administration (FDA), which regulates bottled water as a packaged food, has determined that there is no limit to the shelf life of bottled water.

MEAL / WATER ALLOCATION

DAY 1		DAY 2		DAY 3		DAY 4	
Patients	165	Patients	165	Patients	165	Patients	165
Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400
EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85
Water (gallons)	650	Water gallons)	650	Water gallons)	650	Water (gallons)	650

A MINIMUM OF 1 GALLON PER PERSON PER DAY ON SITE.

A MINIMUM OF 2600 GALLONS STORED ON SITE.

Meals for All

Day 1	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 2	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 3	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)
Day 4	26 cases (each case feeds 25 with 3 meals, milk and snack)	1950 (650 x 3 meals)

Emergency Tool Box

Disposables / Dry Supplies

ATTACHMENTS:

- *Attachment I: Quick Guide to Emergency Feeding*
- *Attachment II: Meal Preparation*
- *Attachment III: Four Day Emergency Meal Menu*
- *Attachment IV: Inventory Verification Form*

REFERENCES:

- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission. (2023). TJC Hospital Accreditation Participation Requirements (APR) Manual.
- Nutricopia, *Meals for All* Emergency Solutions (2022). Retrieved from https://www.nutricopiaonline.com.
- International Bottled Water Association (2021). Retrieved from https://www.bottledwater.org/education/bottled-water-storage.

ATTACHMENT I

QUICK GUIDE TO EMERGENCY FEEDING

1. Notify Food & Nutrition Service Director or Clinical Nutritional Manager using the emergency call back list or appoint an alternate to be in charge.

2. Determine nature of emergency or interruption:

   - ELECTRICITY - Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NATURAL GAS - Use alternate heating source if safe. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - WATER SUPPLY - Affects ware washing and cooking, so conserve water and liquids. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NO POWER OR WATER - Use alternate heating source if safe. Affects ware washing and cooking, so conserve water and liquids. Substitute *Meals for All* as needed.

3. SELECT MENU PLAN TO FOLLOW:

   - Usual menu with needed adaptations (uses perishable supplies first)
   - Meals for All emergency solution.

4. DIET MODIFICATIONS: Refer to usual menu, if using.

   - Follow "Emergency Menu Serving Instructions" when using *Meals for All.*
   - Be aware of those with food allergies.
   - Modify texture for chewing/swallow needs (e.g. mince or mash foods, serve thickened liquids.)

5. LOCATE NEEDED ITEMS:

   - Emergency procedures and menus are posted in Nutrition/Food/Dietary Department, Emergency food storage area, and House Supervisor's office.
   - Emergency food supplies are located at the SVMC warehouse.
   - Emergency disposable supplies are located at the SVMC warehouse.
   - Preparation supplies are located in emergency toolbox at the SVMC warehouse.
   - Water supply is located at the SVMC warehouse.

ATTACHMENT II

MEAL PREPARATION

Refer to the label on each product for specific instructions.

General Instructions for Hot Foods:

1. Open can and discard oxygen absorber* packet.
2. Boil water amount as directed, OR mix with room temperature water if there is no heating source.
3. Stir dry contents of can or cans into boiling water.
4. Cover and remove from heat.
5. Allow to stand for 15 minutes for boiling water, 1 hour if room temperature water utilized.
6. Stir and serve 1 1/3 cup (2 x No. 6 Scoop) or as directed

Instructions for Ready to Eat Items (Fruit, Vegetables, Crackers):

1. Remove oxygen absorber* packet.
2. Ready to eat from packaging.
3. If desired, rehydrate as above using cold water for fruit.

Instructions for Pudding Preparation:

1. Open can and discard oxygen absorber* packet.
2. Stir dry contents of one can into cold water, amount as directed.
3. Whisk thoroughly to mix. Allow to stand for 15 minutes.
4. Stir and serve #8 scoop for ½ cup or as directed.

Non-Fat Milk, to prepare:

1. Add water as directed on label, allow to stand 15 minutes, stir and serve 8 ounces or as directed.

Notes:

- Food Safety Note: Food should be consumed within 2 hours of preparation unless maintained at 135° or higher or below 41° for cold foods.
- No heating methods: Allow 1 hour to rehydrate when using cold or room temperature water.
- Product shelf life is ten years when properly stored in a cool, dry environment.

*Contains a non-toxic oxygen

ATTACHMENT III

MEALS FOR ALL EMERGENCY MENU FOUR DAY				
DAY ONE	**DAY TWO**	**DAY THREE**	**DAY FOUR**	**VEGETARIAN**
BREAKFAST				
Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
MID-MEAL				
Beef & Mushrooms with Noodles	Turkey & Potatoes with Cranberry	Southwestern Chicken & Rice	Chicken Curry with Rice	Spaghetti with Mushrooms
Green Peas	Corn Niblets	Green Beans	Garden Mixed Vegetables	Green Peas
Apples Diced	Peaches Diced	Applesauce	Peaches Diced	Applesauce
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
DINNER				
Chicken Curry with Rice	Spaghetti with Mushrooms	Beef Stew with Potatoes	Macaroni & Cheese	Macaroni & Cheese
Carrots	Garden Mixed Vegetables	Broccoli	Green Peas	Green Beans
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Chocolate Pudding	Banana Pudding	Vanilla Pudding	Banana Pudding	Vanilla Pudding
Beverage	Beverage	Beverage	Beverage	Beverage
SNACK				
Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers

ATTACHMENT IV

25 Person Serving Unit

Inventory List (Four Day Emergency Menu)

Case Number	Day	Meal	4-Day Emergency Menu items	Servings Per Can	Number of Cases in Inventory
1-A	1	Breakfast	Apple Cereal, Fortified	25	
	1	Breakfast	Cracker-Biscuits	25	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Beef & Mushrooms with Noodles	12.5	
	1	Mid-meal	Green Peas	25	
	1	Mid-meal	Apples, Diced	25	26
1-B	1	Mid-meal	Cracker-Biscuits	25	
	1	Evening	Curry Chicken and Rice	12.5	
	1	Evening	Curry Chicken and Rice	12.5	
	1	Evening	Carrots	25	
	1	Evening	Cracker-Biscuits	25	
	1	Evening	Chocolate Pudding	25	26
2-A	2	Breakfast	Apple Cereal, Fortified	25	
	2	Breakfast	Cracker-Biscuits	25	
	2	Mid-meal	Turkey and Vegetables	12.5	
	2	Mid-meal	Turkey and Vegetables	12.5	
	2	Mid-meal	Corn	25	26

	2	Mid-meal	Peaches, Diced	25	
2-B	2	Mid-meal	Cracker-Biscuits	25	
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Spaghetti & Mushrooms	12.5	
	2	Evening	Garden Mixed Vegetables	25	
	2	Evening	Cracker-Biscuits	25	
	2	Evening	Banana Pudding	25	26
3-A	3	Breakfast	Apple Cereal, Fortified	25	
	3	Breakfast	Cracker-Biscuits	25	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Green Beans	25	
	3	Mid-meal	Applesauce	25	26
3-B	3	Mid-meal	Cracker-Biscuits	25	
	3	Evening	Beef Stew	12.5	
	3	Evening	Beef Stew	12.5	
	3	Evening	Broccoli	25	
	3	Evening	Cracker-Biscuits	25	
	3	Evening	Vanilla Pudding	25	26
4-A	4	Breakfast	Apple Cereal, Fortified	25	
	4	Breakfast	Cracker-Biscuits	25	
	4	Mid-meal	Curry Chicken and Rice	12.5	26

	4	Mid-meal	Curry Chicken and Rice	12.5	
	4	Mid-meal	Garden Mixed Vegetables	25	
	4	Mid-meal	Peaches, Diced	25	
4-B	4	Mid-meal	Cracker-Biscuits	25	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Green Peas	25	
	4	Evening	Cracker-Biscuits	25	
	4	Evening	Banana Pudding	25	26
Milk	1	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 1A/1B
	2	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 2A/2B
	3	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 3A/3B
	4	B'fast & Mid-Meal	Non Fat Dry Milk	50	incl 4A/4B
Snack	1	Snack	Peanut Butter	25	
	1	Snack	Cracker-Biscuits	25	incl 1A/1B
	2	Snack	Peanut Butter	25	
	2	Snack	Cracker-Biscuits	25	incl 2A/2B
	3	Snack	Peanut Butter	25	
	3	Snack	Cracker-Biscuits	25	incl 3A/3B
Snack	4	Snack	Peanut Butter	25	
	4	Snack	Cracker-Biscuits	25	incl 4A/4B
				EXPIRATION DATE:	March 2024

SUBJECT: **FOOD SUPPLIES AND STORAGE**	SECTION: **Page 1 of 5**

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

PURPOSE:

Food and supplies will be stored within regulatory guidelines to maintain optimal nutritional composition and prevent all sources of contamination.

POLICY:

The Food and Nutrition Service (FNS) Department shall ensure that all foods, non-foods and supplies shall be stored in a manner to prevent physical, chemical and bacterial contamination. All food shall be of good quality and procured from sources approved or considered satisfactory by federal, state, and local regulatory agencies.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. At least one week's supply of staple foods and at least two (2) days' supply of perishable foods shall be maintained on the premises.

2. Emergency food for 96 hours shall be stored separate *(Please refer to FOOD SERVICE EMERGENCY PLAN Link).*

3. The storage areas are well ventilated and clean.

4. Food storage refrigerators, walk-ins, and freezers are provided with reliable thermometers. Temperatures are inspected/recorded daily to ensure proper temperature control. Temperature records are retained for reference for one (1) year.

5. Perishables are stored at 41°F or below after delivery.

6. Frozen foods are stored at 0°F or below after delivery.

7. Dry or staple items are stored a minimum of 12 inches above the floor and 18 inches from the ceiling.

8. Food overages held in storage areas are clearly identified, dated, and appropriately covered. Food items will be labeled with the expiration date and will not be re-used more than once.

9. Chemical materials used for cleaning purposes and pesticides are clearly labeled and stored separately, away from food and supplies.

10. All cans that are dented, bulging or leaking shall be considered a possible health risk and will be placed in a designated area for return or discarded.

11. The store room stock is rotated using the FIFO (first in first out) method.

12. Milk is served in individual containers. All liquid beverages are served capped.

13. Foods refrigerated or in other storage areas shall be stored appropriately, clearly labeled if not easily identifiable, and dated.

14. Hermetically sealed foods or beverages shall have been processed in compliance with applicable federal, state and local codes. No home canned foods will be used.

15. The storeroom is an integral part of the kitchen design and opens directly to the food preparation area. It is in close proximity to the delivery area. It has sufficient light and ventilation, and is of solid construction to discourage rodents and insects. The storeroom is maintained at a temperature between 50-70°F.

16. Only Food & Nutrition Service (FNS) employees are authorized to enter the storeroom. Any person(s) needing to access or survey the storeroom will be escorted by an authorized hospital employee.

17. The storeroom shelves are cleaned and checked weekly. The floor is swept and mopped daily.

18. The outside storage area is organized and cleaned monthly. All paper products used for eating purposes shall be well-wrapped and stored in boxes. Any uncovered containers shall be discarded to avoid possible contamination.

19. All refrigerators in the FNS department are constructed to maintain a temperature at or below 41°F. Freezers will be at 0°F or colder. The temperatures are recorded for all freezers and refrigerators daily.

20. Each refrigeration unit will house an internal thermometer. The inside thermometer is the primary method of recording temperatures and will be used when documenting temperatures. The outside temperature gauges are not utilized to verify temperatures.

21. Shelving will be constructed to allow for adequate air circulation.

22. All refrigerators and freezers are cleaned weekly.

23. All raw food is stored below cooked foods.

24. All foods in process will be covered, labeled when not clearly identifiable, and dated with expiration date.

25. All foods are dated when received to ensure proper rotation.

26. All frozen foods removed from original packaging will be clearly identified with date received. *Example: An eighty (80) pound case of ground beef may contain eight (8) 10 pound tubes. If six (6) tubes were pulled for production, the remaining two (2) may be removed from the original*

box and placed on the freezer shelf if they are each labeled (ground beef) and with the date received.

27. All meat and egg products are thawed in the refrigerator. In an emergency, frozen meat may be thawed under continuous running potable water.

28. Open cans are not stored in the refrigerator.

29. Items that have been thawed are not refrozen.

30. Foods predated with an expiration date such as milk, sour cream, etc. will be dated the day the container was opened. The pre-dated product will be disposed on the manufacturer expiration date on the container.

31. Prepared items such as mayonnaise, pickles, dressings, etc. will be dated with a 30 day expiration date.

32. Canned or perishable items such as peaches, olives, luncheon meat, etc. will be dated with a three (3) day expiration date after opened.

33. Food will be discarded when it exceeds the established standards based on the date listed on the label, or as stated on the preprinted expiration date on the food item.

Non-definitive Food Dating Labels such as "Best By" and "Enjoy by":

Food labels other than "Use by" may be used on food products received, printed by the manufacturer.

- Per FDA, "Consumers should examine foods for signs of spoilage that are past their "Best if used by" date. If the products have changed noticeably in color, consistency or texture, consumers may want to avoid eating them."- https://www.fda.gov/media/101389/download
- Per USDA, "A "Best if Used By/Before" date indicates when a product will be of best flavor or quality. It is not a purchase or safety date."-: https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating

At SVMC, freshness labels will be treated as an expiration date for dry stock items. However for perishable items, such as produce, foods may be used past the "best by" date, if they are inspected for freshness and no signs of spoilage are present, per USDA and FDA guidelines.
No items may be used past an expiration, or "use by" date.

FOOD STORAGE

FROZEN FOOD

Meats
- Uncooked beef, lamb, veal, chicken ..... 6 - 12 months
- Ground meats, sausage, turkey, pork ..... 1 – 3 months
- Cooked ..... 1 month
- Meat casserole ..... 2 – 6 months

Baked goods
- Baked ..... 3 – 6 months
- Unbaked rolls ..... 2 months
- Unbaked cookies ..... 6 months

Ice Cream Products ..... 6 months

Vegetables ..... 8 – 12 months
- Potatoes ..... 2 – 6 months

Fruit juices ..... 8 months

REFRIGERATOR FOODS

Eggs
- Whole raw in shell ..... 30 days
- Cooked whole ..... expiration date

Milk ..... not after date on carton

Cheese ..... 45 – 60 days
- Hard ..... not after date on carton
- Cottage ..... not after date on carton

Juice (thawed) ..... 2 weeks

Canned fruits ..... 3 days

Margarine and butter ..... 30 days

Desserts
- Gelatin (Jell-O) ..... 3 days
- Pudding and custards ..... 3 days

Produce ..... 1 – 2 weeks

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- FDA, Food Facts - How to Cut Food Waste and Maintain Food Safety, Retrieved on 01.16.2023 https://www.fda.gov/media/101389/download
- USDA, Food Product Dating, , Retrieved on 01.16.2023 https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating

CROSS REFERENCES:

- FOOD SERVICE EMERGENCY PLAN Link

SUBJECT:	SECTION:
IDENTIFICATION AND PROCESS FOR RECEIVING REGULATORY INSPECTORS	***Management of Information (IM)***

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

PURPOSE:

To define protocol for the identification and process for receiving regulatory inspectors including, but not limited to, the California Department of Public Health (CDPH), The Joint Commission (TJC), the Occupational Safety and Health Administration (OSHA), or other regulatory agencies, and to identify the process for receiving them.

POLICY:

Visitors are required to check in at the Information Desk or Security in the front lobby of the facility. If the visitors are regulatory<inspectors, the following procedure will be implemented.

PROCEDURE:

1. **Check identification.** Do not hesitate to question strangers to the facility.

   a. A simple "May I help you?" will often deter those who may be here under false pretenses.

   b. Individuals who enter the facility claiming to be a surveyor are to identify themselves with two forms of ID, if possible, including a picture identification card and official agency documentation.

2. **Make a call**. Notify Administration and the Patient Experience Officer or VP of Quality and Regulatory Affairs (or designee) as soon as you have been approached by a surveyor or individual stating they are a surveyor. After normal business hours, please notify the House Supervisor.

3. **Send to Administration to sign in**.

4. **Administration verification**. Administration will verify identification of the visitor entering the facility. If the visitor is unable to produce an official agency ID document, call the agency he or she supposedly represents to verify his or her identity.

5. Once the surveyors' identification has been confirmed, they will be assisted and escorted throughout the Organization at all times.

6. The Patient Experience Officer or VP of Quality and Regulatory Affairs (or designee) will be notified immediately when surveyors have arrived to the facility.

7. The Patient Experience Officer or VP of Quality and Regulatory Affairs(or designee) will be notified when surveyors present to Sierra View Medical Center (SVMC) from the California Department of Public Health (CDPH) for the purpose of investigating complaints. Patient Experience Officer or VP of Quality and Regulatory Affairs will facilitate the review process and assest the surveyors in obtaining requested documents. Patient Experience Officer or VP of

Quality and Regulatory Affairs(or designee) will notify the Information Technology (IT) department if there is a surveyor requesting access to the electronic medical record.

AFFECTED AREAS/PERSONNEL: *ORGANIZATION/ALL PERSONNEL*

SUBJECT: HIM CODING COMPLIANCE PLAN	SECTION:

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

SCOPE:

This policy applies to all Sierra View Medical Center (SVMC) personnel responsible for performing, supervising or monitoring of inpatient and outpatient coding services. This policy applies to diagnosis and procedure code assignment by Health Information Management (HIM) Coders for all inpatient and outpatient services.

PURPOSE:

The purpose of this policy is to affirm SVMC's commitment to ethical, complete, accurate and consistent HIM coding and documentation improvement.

POLICY:

This policy outlines the requirements for validating coding accuracy (e.g., ICD-10-CM, CPT, modifiers) and various types of inpatient reimbursement methodologies (e.g., MSDRG, APRDRG, etc.) for hospital inpatient and outpatient services.

DEFINITIONS:

A. **"AHIMA"** means the American Health Information Management Association. AHIMA is the national organization for HIM professionals. AHIMA is one of four parties that are responsible for establishing national ICD-10-CM coding guidelines.

B. **"HIM coding"** means short-term, DPSNF, or other affiliated departments based on coding and abstracting services on behalf of SVMC for the purpose of claim submission. SVMC HIM coding function includes assignment of any ICD-10-CM diagnosis (including present on admission (POA) indicator) or procedure code, assignment of any CPT procedure code to represent the "technical component" between 10020 and 69990 (excluding 36415), designated HCPCS Level II codes, designated HCPCS modifiers, and designated CPT Category III Codes.

C. **"HIM Coder" or "Coder"** means a SVMC, telework employee, contractor, subcontractor, agent or other person who performs SVMC HIM coding. It also includes those employees or contractors involved indirectly, such as in a supervising or monitoring role, with the HIM coding.

D. **"Clinical Documentation Improvement" or "CDI"** means the entity-based process of reviewing patient records at the point of care and, as needed, working with treating physicians to assure that the clinical documentation in the medical record most accurately reflects the patient's clinical condition and treatment provided.

E. **"Clinical Documentation Improvement Specialist" or "CDIS"** means a SVMC, telework employee, contractor, subcontractor, agent or other person who performs clinical documentation improvement duties. It also includes those employees or contractors involved indirectly, such as in a supervising, assisting or monitoring role, with clinical documentation improvement.

F. **"Office Guidelines"** means applicable portions of the following publications:

1. International Classification of Diseases, 10th revision, Clinical Modification, including addenda, conventions and instructions, (ICD-10-CM)
2. Current Procedural Terminology, including addenda, conventions and instructions, (CPT)
3. ICD-10-CM Office Guidelines for Coding and Reporting
4. Coding Clinic for ICD-10-CM
5. Coding Clinic for HCPCS
6. Online CMS manual system.

Each of the above publications is a CMS-approved reference for hospital inpatient and outpatient coding and reporting. CPT Assistant, while not an official CMS reference, provides additional nationally recognized guidance regarding CPT codes and shall be included as an "official guideline" by HIM Coders in areas not addressed by CMS-approved references.

G. **"Outpatient Procedure"** as used in this policy means any account with a HIM assigned CPT procedure code to represent the "technical component" between 10020 and 69990 (excluding 36415, collection of venous blood by venipuncture), designated HCPCS Level II codes, designated HCPCS Modifiers, and designated CPT Category III codes. Note: Accounts in this group are not limited to those procedures performed in the operating room.

POLICY:

A. HIM coding is to be complete, consistent, accurate and compliant. SVMC must strive to code every patient's claim correctly and take reasonable and necessary efforts to achieve this outcome.

B. Any individual involved in HIM coding and CDI must adhere to the AHIMA Standards of Ethical Coding, Official Coding Guidelines as well as applicable SVMC policies, and Coding Compliance procedures, processes and guidelines.

C. Each patient's account is to be released, or re-released, for billing only when all of the following are met:

1. All ICD-10-CM diagnoses and outpatient procedures CPT/HCPCS codes (including select modifiers) that are submitted for billing purposes under a SVMC provider number must be assigned by a HIM coder.
2. All ICD-10-CM diagnoses and outpatient procedure (CPT/HCPCS) codes reported on the patient's claim are supported by legible, complete, clear, and consistent provider documentation.

3. A sufficient clinical documentation set exists in the patient record from which to assign a complete set of codes.

4. Diagnosis and procedure codes are assigned and sequenced appropriately according to Office Coding Guidelines.

5. Other claim elements, including the discharge disposition code, admission status (inpatient or outpatient) and admit/discharge dates as recorded in the patient accounting system, correlate with documentation in the patient's medical record.

Accounts with identified discrepancies in one or more of the above areas must not be released for billing until the discrepancy is resolved and the account can be billed with an accurate and complete code set.

D. When a discrepancy is detected with the HIM coding on a previously submitted claim, SVMC must undertake reasonable efforts to correct the deficiency and prevent the defect from reoccurring on future claims. Overpayments must be corrected and resubmitted to the payer.

Each HIM coding staff shall have and maintain coding accuracy rates of 95% or as measured by periodic coding compliance audits. Coding staff who do not achieve the accuracy rate are subject to appropriate corrective action.

E. General Coding Compliance Policies

1. SVMC adopts the AHIMA Standards of Ethical Coding as the foundation of its Coding Compliance Program. All employees directly or indirectly involved in coding, clinical documentation and/or revenue cycle processes are required to abide by the AHIMA Standards of Ethical Coding. In addition, all CDI initiatives are to be guided by the AHIMA Ethical Standards of Clinical Documentation Improvement Specialists and the ACDIS Code of Ethics.

2. Physician Queries and Clinical Documentation Improvement Program. Refer to the *REVIEW AND QUERY PROCESS FOR CLINICAL DOCUMENTATION IMPROVEMENT (CDI) PROGRAM Policy and Procedure*.

3. HIM Coder Education and Training

   a. HIM Coders (and other pertinent staff as indicated) are required to complete training activities as assigned.

   b. HIM coders are required to complete the required CEU's to maintain their coding certification. SVMC may provide some educational resources such as audio conferences, which include CEUs. Coders are responsible for the maintenance of their credentials as required by their position.

4. Coding audits for coding accuracy will be conducted periodically. At the conclusion of the audit, investigation as to the causes of any coding discrepancies, remediation of potential claims made in error, education regarding trends identified, if any, and appropriate disciplinary action are to occur under the direction of the HIM Director.

5. The HIM Lead in collaboration with the HIM Manager must ensure all new HIM coders (including newly hired and new contract coders) are provided orientation and training. Additionally, pre-bill coding reviews must be conducted until acceptable coding quality can be demonstrated.

6. SVMC permits final coding of inpatient accounts without a discharge summary. When the patient's payer reimburses based on DRG methodology (including APR-DRG), an account originally coded without the discharge summary (where one is required by hospital/medical staff policy) must be returned to the coder to determine whether the summary supports a change to the final ICD-10-CM code set.

7. Contract Coding Arrangements

    a. Approval by the SVMC Chief Financial Officer (CFO) is required before engaging a new consultant/vendor in coding.

    b. HIM is ultimately responsible for the accuracy of work produced by a contract coder. It is recommended that the contract have provisions to reduce payment or terminate the contract if any contract coder's individual coding error rate is less than 5%.

8. External Coding Consultants and External Clinical Documentation Consultants

    a. Engaging an external consultant/vendor to review patient accounts with the goal of assessing the quality/completeness of coding and/or clinical documentation, requires written approval of the Chief Financial Officer (CFO).

PROCEDURE:

A. Responsible Person

1. The hospital HIM Director is responsible for assuring that all individuals adhere to the requirements of this policy and that all applicable procedures and processes are implemented and followed.

2. Auditing and monitoring

    a. All audits will adhere to this policy as part of its coding compliance audits.

3. Enforcement

   a. All employees whose responsibility is affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination.

REFERENCES:

- AHIMA. Standards of Ethical Coding, 2016. Retrieved from https://bok.ahima.org/CodingStandards

- AHIMA. Code of Ethics, 1957, 1977, 1988, 1998, 2004, 2011, and 2019. Retrieved from http://www.ahima.org/downloads/AHIMACodeofEthicsPrinciplesFINALApprovedApril292019.pdf.

SUBJECT: **LEAVE OF ABSENCE - CALIFORNIA MANDATED**	SECTION: **Page 1 of 5**

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

PURPOSE:

To define the requirements and procedures for Sierra View Medical Center (SVMC)'s California's mandated leaves process.

POLICY:

Sierra View Medical Center will provide its employees with time off for situations as stated below.

AFFECTED PERSONNEL/AREAS: *ALL ELIGIBLE EMPLOYEES*

PROCEDURE:

ELIGIBILITY:

All regular employees employed by Sierra View Medical Center may be eligible.

REQUESTING A MANDATED LEAVE:

It is the employee's responsibility to obtain prior authorization with his or her Director/Manager regarding scheduling of any Mandated Leave. The employee shall give reasonable advance written notice of the intention to take time off, unless the advance notice is not feasible. Directors/Managers must notify Human Resources of any employees that are absent more than three days, without prior approval, as they may qualify for other protected leave of absences (See LEAVE OF ABSENCE - FMLA/CFRA, and LEAVE OF ABSENCE - PERSONAL Policies).

If Vacation/Holiday time is available, you must use Vacation/Holiday time to complete your full schedule.

California Mandated leaves include:

- **Victim of Crime Leave:** This unpaid leave provides time off of work to an employee who is a victim of a crime. This does not create a right for an employee to take unpaid leave that exceeds the unpaid leave time allowed under, or is in addition to the unpaid leave time permitted by the federal Family and Medical Leave Act of 1993 (29 U.S.C. Sec. 2601 et seq).

  A victim of a crime includes any of the following:

  1. A victim of stalking, domestic violence, or sexual assault.
  2. A victim of a crime that caused physical injury or that caused mental injury of a threat of physical injury.
  3. A person who's immediate family member is deceased as a direct result of a crime.
  4. Any person against whom any crime has been committed for the purposes of attending a judicial proceeding.

A victim may take unpaid time off of work for the following reasons:

1. To appear in court to comply with a subpoena or other court order as a witness in any judicial proceedings.

2. To obtain or attempt to obtain any relief. Relief includes, but is not limited to, a temporary restraining order, restraining order, or other injunctive relief, to help ensure the health, safety, or welfare of the victim or their child, such as:

   - To seek medical attention for injuries caused by crime or abuse.
   - To obtain services from a domestic violence shelter, program, rape crisis center, or victim services organization or agency as a result of the crime or abuse.
   - To obtain psychological counseling or mental health services related to an experience of crime or abuse.
   - To participate in safety planning and take other actions to increase safety from future crime or abuse, including temporary or permanent relocation.

An employee must provide a certification when an unscheduled absence occurs within a reasonable amount of time. Certification shall be sufficient in the form of any of the following:

(1) A police report indicating that the employee was a victim.

(2) A court order protecting or separating the employee from the perpetrator of the crime or abuse, or other evidence from the court or prosecuting attorney that the employee appeared in court.

(3) Documentation from a licensed medical professional, domestic violence advocate or advocate for victims of sexual assault, licensed health care provider, or counselor that the employee was undergoing treatment or receiving services for physical or mental injuries or abuse resulting in victimization from the crime or abuse.

(4) Any other form of documentation that reasonably verifies that the crime or abuse occurred, including but not limited to, a written statement signed by the employee, or an individual acting on the employee's behalf, certifying that the absence is for a purpose authorized under "Victim of a Crime Leave."

If an accommodation is needed for a victim of domestic violence, sexual assault, or stalking, we will engage in a timely, good faith, and interactive process to determine effective reasonable accommodations as long as the accommodation being requested does not create a hardship on the operations of the District.

- **School Activities Leave: Sporting, social, academic, or other activities for which students' attendance or participation is sponsored, organized, or funded in whole or in part by a**

school or school district. This will also include time off to find childcare, enroll, or re-enroll child(ren) in school and participate in activities of a licensed childcare provider. This unpaid leave provides time off for eligible employees with up to 40 hours of leave per year. However, no more than 8 hours per month can be taken to participate in school activities with their children. This monthly limitation does not apply, however, if the reason for the leave is due to an emergency. The eligible employee must also give reasonable prior notice. Eligible employees include: Parents, guardians, grandparents, stepparents, foster parents, and persons in Loco Parentis. If both parents work for SVMC, only one (1) must be provided this leave at a time. Leaders may require proof of event/activity in the form of documentation by the school or licensed care provider.

School Appearance Leave: This unpaid leave provides employees with time off in order to appear at school on a child's behalf with regard to school suspension. An employee who is the parent or guardian of a pupil taking time off to appear in the school of a pupil pursuant to a request made under Section 48900.0 of the Education Code must give reasonable notice to employer (if able) that he or she is requested to appear at the school. The following are covered instances:

- **Behavioral or Discipline issues**
- **Provider has requested child to be picked up, or has an attendance policy, excluding planned holidays, that prohibits the child from attending or requires the child to be picked up from the school or child care provider.**
- **Closure or unexpected availability of the school or childcare provider (excluding planned holidays)**
- **A natural disaster (flood, fire, earthquake)**

- **Volunteer Firefighter, Reserve Peace Officer, and Emergency Rescue Personnel Leave.** This unpaid leave permits qualified employee to take unpaid leave to perform emergency duty as a volunteer firefighter, emergency rescue personnel, emergency rescue training or reserve peace officer.

- **Civil Air Patrol Employment Protection:** This unpaid leave permits employees who have been employed 90 or more days to take a leave of absence to respond to an emergency operational mission of the California Wing of the Civil Air Patrol. An eligible employee may take up to 10 days per year. Leave is limited to three days on any one occasion, but can be extended if authorized by the government entity that called for the mission and if SVMC agrees. An employee who takes Civil Air Patrol leave will be reinstated to the same position they had prior to commencing leave with equivalent seniority status, benefits, pay and other terms and conditions, unless the employer can prove the failure to do so was unrelated to the leave. The employee is guaranteed to return to the same position.

- Organ & Bone Marrow Donor Leave: Organ donors must be provided a paid leave of absence of up to 30 business days in any one-year period. The one year period is measured from the date the employee's leave begins and shall consist of 12 consecutive months. A leave of absence, not

exceeding five (5) business days in a one-year period, to an employee who is a bone marrow donor. An employer shall grant an additional unpaid leave of absence, not exceeding 30 business days in a one-year period.

Employees must provide written verification to the employer that the employee IS an organ or bone marrow donor and that there is a medical necessity for the donation of the organ or bone marrow. An employer may require, as a condition of an employee's initial receipt of bone marrow or organ donation leave, that an employee take up to five days of earned but unused sick leave or vacation/holiday that is available to the employee for bone marrow donation and up to two weeks of earned but unused sick leave or vacation/holiday, or paid time off for organ donation. Bone marrow and organ donation leave shall not be taken concurrently with any leave taken pursuant to the federal Family and Medical Leave Act of 1993. Leave may be taken in one or more periods, but in no event shall exceed the amount of leave prescribed above.

Reproductive Loss Leave: Eligible employees may take leave for up to five days when they suffer a reproductive loss event, which is the day, or the final day for a multiple day event, of one of the following:

Failed adoption, failed surrogacy, Miscarriage, Stillbirth, Unsuccessful assisted reproduction

The five days of leave don't need to be consecutive. Plus, if an employee experiences more than one reproductive loss event within a 12-month period, an employee can receive another five days of leave. There is a cap on reproductive loss leave of 20 days within a 12-month period.

Leave must be taken within three months of the reproductive loss event; however, if prior to or immediately following a reproductive loss event, an employee is on or chooses to go on leave under another leave entitlement (e.g., PDL, CFRA, etc) then the employee may complete their reproductive loss leave within three months of the end of the other leave.

Leave is unpaid, but employees can use existing sick leave, or Vacation/Holiday leave that has been accrued and available to them.

Employees do not need to provide documentation to certify reproductive loss leave.

CROSS REFERENCES:

- LEAVE OF ABSENCE - PERSONAL
- LEAVE OF ABSENCE - FMLA/CFRA
- VACATION/HOLIDAY LEAVE

REFERENCES:

- California Labor Code. Employment Regulation and Supervision. (2010). https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=LAB&division=2.&title=&part=5.&chapter=&article=.

- California Assembly Bill No. 2992. Chapter 224. (2020). https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201920200AB2992&showamends=false.

- California Labor Code. Employment Regulation and Supervision. Article 1: General Occupations. 230.4.(2015).https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=230.4

- California Labor Code. Employment Regulation and Supervision. Article 1: General Occupations (230.8). (2016). http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=230.8.

- California Labor Code. Employment Regulations and Supervision. Part 5.5 Organ and Bone Marrow Donation (1508-1513)
- Senate Bill No. 848 – Employment: Leave for reproductive loss.

SUBJECT: **PHOTO IDENTIFICATION BADGES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define the process and establish guidelines for the issuance and display of Photo Identification Badges.

POLICY:

All "Affected Personnel" are required to wear a Sierra View Medical Center ("SVMC") issued employee Photo Identification Badge on Hospital premises. The badge identifies personnel by photo, first name only (for security purposes) in 18 font and position.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES, PHYSICIANS, CLERGY, VOLUNTEERS, STUDENTS AND OTHER PERSONS TO BE DESIGNATED.*

PROCEDURE:

Photo identification badges are issued to Employees, Physicians, Clergy, Volunteers, designated Contingent Workforce and Students. (Note: For vendors, contractors and employees of contractors, name badges will be issued through the Materials Management department.) Badges remain the property of the District at all times.

Photo Identification Badges are obtained from the Human Resources Department and issued to new employees, returning staff and staff who incur name and/or title changes.

- Badges are to be worn above the waist and are to be visible to visitors, patients and other employees.
- Badges may be used for the payroll purpose of electronically recording hours worked for all positions.
- Badges must be worn to receive employee discounts for meals purchased in the Cafe'.
- Badges may be utilized to purchase meals in the Café. or merchandise from pre-authorized vendor fairs.(Please refer to Cashless System policy.)
- Staff members should immediately report any lost or non-working Identification Badge to Human Resources, so a replacement can be issued to ensure compliance with this policy.
- Badges will not be active during leaves of absence.
- Employees may not wear badges if they are not working. Employees not working are to check in at the front desk and adhere to the Visitor Guidelines policy.

Positive identification, such as a state issued identification card, may be required for issuance of the Photo Identification Badge.

All titles on Identification Badges must be pre-approved by the VP of HR.. Titles will be limited to an approved position identifier. Characters have limited spaces; therefore, if a position identifier does not allow for the full title to be included, approved abbreviations may be used.

Upon termination of employment, employees are required to return the Photo Identification Badge to the Human Resources Department. If the employee chooses to give his/her badge to their Department Director/Manager, they will immediately forward the Badge to the Human Resources Department.

REFERENCES:

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

CROSS REFERENCES:

- Cashless System
- Visitor Guidelines

SUBJECT: **PRE-EMPLOYMENT, ANNUAL/PERIODIC AND FITNESS FOR DUTY EVALUATIONS**	SECTION: **Page 1 of 7**

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

PURPOSE:

To define the pre-placement,annual and periodic requirements for protecting the health and safety of employees and patients.

POLICY:

Pre-placement, annual/periodic and fitness for duty health screenings are performed on current and prospective employees to ensure they are free of communicable disease and to determine their physical and mental ability to perform within a job classification without endangering their own health and safety, the health and safety of patients, or their fellow employees.

AFFECTED AREAS/PERSONNEL: *ALL SIERRA VIEW MEDICAL CENTER (SVMC) EMPLOYEES*

PRE-PLACEMENT REQUIREMENTS

A. An offer of employment is contingent upon successful completion of the pre-placement process.

1. Clearance is based on findings related to screening test results, the history and physical findings, and the applicant's ability to perform within the essential requirements of the job description and essential physical demands of the position.

B. All prospective employees must complete a history, physical, and required screening tests prior to the date of hire.

C. The history, physical and screening includes, but is not limited to, the following:

Performed by a designated Medical Practitioner

1. Completion of a health history.

2. Examination based on significant findings in the health history and vital signs.

3. Visual acuity and color vision testing.

Performed at SVMC's Employee Health Department

1. Tuberculosis screening.

2. Evaluation of immunization status for vaccine preventable diseases related to the potential for occupational exposure.

3. Drug screening for safety sensitive positions.

4. Mask Fit Test

5. Examinations and/or tests identified to be necessary for the determination of the ability of the applicant to perform the essential duties of the position offered.

   a. Additional records such as disability ratings and permanent restrictions may be required prior to determination of the prospective employee's ability to perform in a specific position.

D. Accommodation of prospective employees unable to perform within the requirements of the job description will be evaluated in compliance within Americans with Disabilities Act (ADA) regulations.

1. The Human Resources Representative and Department Director will be included in the determination of accommodations or the inability of the facility to accommodate a prospective employee.

E. Failure to provide information regarding prior or current injuries and/or illness, whether work related or not, may be sufficient grounds for withholding clearance for employment or immediate release from employment.

ANNUAL AND PERIODIC EVALUATION/SCREENINGS– RETURN TO WORK-FITNESS FOR DUTY-JOB TRANSFER

A. Annual and/or periodic evaluations and screenings are provided in the following conditions, but not limited to:

1. Required by Regulation from local, state and federal recommendations or mandates For those job categories or departments that require screening as outlined in the regulatory requirements and SVMC's policies, procedures and practices.

2. Fitness for Duty: At the request of Human Resources/Employee Health Services (EHS) who have a valid concern that an employee is working in an unsafe manner that could cause harm to self or others, has a physical or mental impairment, or following a significant change in health due to a serious health condition.

3. Request for Accommodation: At the request of an employee who seeks a job restriction or job accommodation.

4. Job Transfer: When a job transfer is made to a position that is significantly different in scope and skills, the employee must be cleared through Employee Health prior to placement.

   a. Assessment is made to determine the ability of the employee to perform the

essential functions of the job, job accommodations, need for education, and communicable disease surveillance.

5. New baseline screening for infectious diseases may be added to annual evaluations to meet infection prevention criteria.

6. Screenings for infectious diseases may be required periodically due to emergency disasters and pandemics.

B. Evaluations for the above conditions may include:

1. **Personal health review.**

a. A review of illnesses during the past year, especially absences due to illness, to verify, to the extent reasonably possible, that an individual is able to continue performing assigned duties and continues to be free of infectious disease.

2. **Screening Test** as indicated by response to the health review, as required by regulations or job duties. May include:

a. Breath, blood and/or urine drug screen.

b. Blood alcohol level

c. Tuberculin screening.

d. Other diagnostic/screening tests.

e. Respirator fit testing.

f. Other medical surveillance

C. Human Resources and Employee Health Services (EHS) will evaluate with the employee, any noted restrictions and the ability of SVMC to accommodate them. If it is determined that the employee is unable to perform assigned duties, or no reasonable accommodation can be made, the Department Director will be advised.

TUBERCULOSIS SCREENING - INITIAL-PERIODIC-ANNUAL

A. TB Surveillance is performed during the pre-placement exam and at least annually **(in the month of May)** to screen all SVMC Employees for Latent Tuberculosis Infection (LTBI). All employees must complete required skin testing or screening questionnaire for positive convertors each May.

1. Tuberculin Skin Test (TST) done at another facility will be accepted if done within the current month of May.

2. On those occasions where the employee chooses to have TST read by a trained individual other than EHS, it is the responsibility of the employee to provide EHS with documentation.

3. After May 31, non-compliant employees will be placed on administrative leave.

B. Tuberculin Skin Testing/TST (Mantoux technique), questionnaire and/or chest x-ray (if there is a history of a positive skin test), are current methods for screening for tuberculosis.

1. A TST Mantoux will be placed for annual testing and post exposure for employees that have had negative TST in the past.

2. Pregnancy is NOT cause for deferring TSTs.

C. For employees with a history of a positive TST, the TB questionnaire will be reviewed by the employee health nurse and employees with questionable signs and symptoms for tuberculosis will be sent for a chest x-ray.

D. At time of hire, if it has been more than 12 months since a TST was placed, or documentation of TST within the last 12 months cannot be provided, the prospective employee will have another TST (2-Step TST) placed at least one week but no longer than 3 weeks after the first negative test. If the employee fails to have completed this by the end of the third week, they will be removed from the schedule.

E. Employees who convert from negative to positive results from TST or have an initial positive test will be evaluated and treated according to guidelines from the California Department of Public Health.

1. If a skin test is positive, a chest x-ray will be performed to determine evidence of active TB. Current positive reactors are required to have a chest x-ray when symptoms are present during their annual questionnaire screening.

a. Prospective employees in the new hire process will be directed to follow-up with their health care provider or county of residence for possible treatment of latent TB. New hires with a previous positive will complete a baseline questionnaire and X-ray within two weeks of start date. SVMC will accept a prior X-ray as long as it is less than three (3) months old from hire date.

b. If the potential employee has symptoms of active TB or a chest X-ray suggestive of active TB, they will not be cleared to work and will be sent directly to their healthcare provider or the County Health Department.

- Documentation of findings and any necessary treatment for active disease will be completed before the prospective employee will be considered for placement, and they will be referred to their primary care physician.

VACCINE PREVENTABLE DISEASES – IMMUNIZATIONS

A. All employees are tested for and offered immunizations to vaccinate against preventable diseases without cost, if determined to be susceptible to these diseases.

Employees will be required to sign consent for each vaccine administered or sign the declination if they are determined to be susceptible but decline immunization.

If an employee declines a vaccine for a disease they have been determined to be susceptible to, they may later request to be vaccinated.

B. Education regarding the benefits of vaccination and the potential health consequences of disease or illness for themselves, their family members, and patients is provided. The current Vaccine Information Statement (VIS) on the vaccine is provided and the employee is given an opportunity to ask any questions related to the vaccine.

C. Failure to complete mandatory testing, immunizations, or declination documentation within 90 days of hire will result in removal from the schedule or suspension until completed.

D. Immunization is provided for employees as follows:

1. **Tdap** (Tetanus, Diphtheria and Acellular Pertussis)

   a. One (1) time if no prior Tdap.

2. **MMR** (Rubella, Rubeola and Mumps)

   a. Two (2) doses of MMR given at least 28 days apart if Rubeola titer is not sufficient.

   b. One (1) dose of MMR if Rubella titer or mumps is not sufficient.

3. **Varicella** (Chickenpox)

   a. Two (2) doses given at least 4 weeks apart, if titer is not sufficient.

4. **Hepatitis B** Vaccine is available to all employees.

   a. Three (3) doses of vaccine administered over a six-month period.

b. A hepatitis B antibody screen will be done one (1) month after the third dose.

c. Those not responding to the vaccine will be given the option of a booster or repeating the series.

d. Employees may decline the vaccine and may receive the vaccine at any time following declination.

5. **Influenza Vaccine**

a. Annually, every employee must either be vaccinated, provide documentation of vaccination, or sign a written declination.

b. Employees who decline will be required to wear a surgical mask while within three (3) feet of patients, visitors, or other Healthcare Professionals (HCP) for the duration of the flu season as designated by Infection Prevention, but no sooner than March 31st.

6. Other vaccines or medications available will be administered during outbreaks or as advised by the Infection Prevention Committee/Advisor.

DRUG SCREENING

A. All drug and alcohol tests, pre-placement and reasonable suspicion are administered according to National Institute on Drug Abuse standards.

1. Federal standards are recognized when determining results of a drug or alcohol test.

2. Positive results are reviewed by the contracted Medical Review Officer (MRO).

3. If the MRO confirms a positive result, Employee Health Services will notify Human Resources:

a. The applicant is not eligible for hire and Human Resources will communicate withdrawal of the job offer.

b. The employee for reasonable suspicion testing is positive and Human Resources will take the appropriate action.
(For more information please refer to the policy on "Drug and Alcohol in the Workplace")

COMPLIANCE

SVMC employees, at time of hire, agree to participate, as directed, in emergencies and community disasters during scheduled and unscheduled hours. As a designated disaster service worker, SVMC employees are required to assist in times of need pursuant to the California Emergency Services Act. (Gov.t Code 3100, 3102.) Given the level of risk to infectious diseases during pandemics, SVMC employees are expected to comply with local, state, and federal regulatory recommendations and mandates as outlined by the regulatory agency. Failure to do so can constitute a safety risk which will be evaluated by Risk Management and Human Resources.

Employees who fail to comply with the required health evaluations, screenings, and fitness for duty evaluations as outlined in this policy on a routine basis, and in periodic times of health disasters, present a safety risk to themselves or others. Employees failing to comply may be subject to disciplinary action up to and including separation.

REFERENCES:

- California Code of Regulations, Title 22, §70723., 2017.
- California Emergency Services Act, (Gov.t Code §3100. 3102).
- Centers for Disease Control and Prevention (CDC) (2016): Tuberculosis. Retrieved on 02/02/18 from https://www.cdc.gov/tb/topic/testing.
- Centers for Disease Control and Prevention (CDC) (2019) : Guideline for infection Control in Health Care Personnel.
- Evans, G. (2012). A house divided: A muddled mandate on health care worker flu shots goes to HHS. Hospital Infection Control and Prevention: 39: 3.
- The Joint Commission, (2021). 2021 hospital accreditation standards. Oak Brook, Illinois.
- California Department of Public Health

CROSS REFERENCES:

- DRUGS AND ALCOHOL IN THE WORKPLACE Link
- EQUAL EMPLOYMENT OPPORTUNITY Link
- REASONABLE ACCOMODATIONS Link

SUBJECT: **REIMBURSEMENT OF OVERPAYMENTS**	SECTION:

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

PURPOSE:

To ensure accuracy of refunds to all payer sources by adhering to the approved refund approval limits and to define the appropriate steps that the Patient Accounting staff should take when initiating a refund request.

POLICY:

It is the policy of the Patient Financial Services Department to be consistent and accurate during the refund request process.

AFFECTED AREAS/PERSONNEL: *PATIENT FINANCIAL SERVICES*

PROCEDURE:

When there is a credit balance on a patient account, it must be determined if the credit belongs to the patient, to a third-party payer, such as Medicare, Medi-cal or a Third Party Insurance payer or to the District (such as a misapplied contractual adjustment or other posting error). If the credit belongs to the District, the misapplied contractual adjustment or posting error should be corrected. Refunds can be identified in several different ways, such as, by staff who are working insurance and self-pay accounts, or by a vendor working on behalf of the insurance companies, or directly from the insurance company in the form of a letter or call. Once a refund has been identified as belonging to someone other than the District, the following steps must be taken:

If refund is due to a Third Party (including Medi-cal Managed Care):

1. Complete the refund request form.

2. Attach supporting documentation including the explanation of benefits related to the credit, pertinent screen prints, or any documentation to support the refund.

3. Ensure there is a credit on the account matching the refund amount being requested, note the account, and then submit refund request via Hospital Information System (HIS), and email all documents to General Accounting via their invoice email address.

4. Approvals are based on the value of the refund:

    - If the refund amount is less than $500.00 only the manager's approval is needed
    - If the refund amount is between $500.00 - $7500.00 the manger and administrative director's approval are required
    - If the refund amount is greater than $7500.00 the manger, director and the Chief Financial Officer (CFO) approval are required.

5. Once the request has been approved the HIS will forward the request to General Accounting, once they interface the refund will post on the HIS and the check will print on the next check run;clearing the credit.

6. The General Accounting Specialist will mail out the check with the Explanation of Benefit (EOB) attached.

Payer Refunds:

Any credit balance due to a payer that cannot be located must be reported to the State of California after the following process has been initiated:

1. Refund will be generated to the payer.

2. If check returned as undeliverable, Patient Accounting staff will research to determine if payer is still active.

3. If payer is still active, obtain proper billing address and submit refund accordingly.

4. If payer is no longer active, forward documentation and refund documents to General Accounting to report claim to the State of California.

Any credit balance due to a payer that returns refund to SVMC stating any of the following (this list is not all-inclusive):

1. Unable to identify patient.

2. Unable to validate refund is appropriate.

3. Unwilling to accept refund due to age of credit balance.

SVMC will adjust the credit and return the check to General Accounting.

Special Instructions:

Medicare Part A and B credit balance:

1. CMS requires a Credit Balance Report (CMS-838) be submitted within 30 days after the end of each quarter for all providers participating in the Medicare program.
2. A credit balance exists when a facility receives an overpayment for a Medicare service, for example:
   a. A facility is paid twice for the same service either by Medicare or by Medicare and another insurer
   b. A facility is paid for services planned but not performed or for non-covered services

c. A facility is overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts
d. A facility bills and is paid for outpatient services included in a beneficiary's inpatient claim

3. Credit balances are resolved in the DDE/FISS system

Medi-cal Credit Balance:

1. Send an appeal form notifying Medi-cal of the over payment and allow Medi-cal to recoup payment.

2. If Medi-cal is notified of the overpayment and does not recoup payment, it should be reported as a credit on the yearly Medi-cal credit audit conducted by the State of California.

Self-Pay refunds will follow the same process outlined above with a few exceptions. For self-pay refunds the hospital will adhere to HSC 127440,section 685.010-685.110, which states the following:

- "Hospital shall reimburse the patient or patients any amount actually paid in excess of the amount due under this article, including interests. Interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). The hospital shall give the patient a credit for the amount due for at least 60 days from the date the amount is due."

- SECTION 685.010-685.110 (a) Simple interest accrues at the rate of 10 percent per annum on the principal amount outstanding. (b) The Legislature reserves the right to change the rate of interest provided in subdivision (a) at any time to a rate of less than 10 percent per annum, regardless of the date of entry of the judgment or the date any obligation upon which the judgment is based was incurred. A change in the rate of interest may be made applicable only to the interest that accrues after the operative date of the statute that changes the rate. In an attempt to reduce self-pay credits, prior to posting any payment, cashiers will audit the account balance(s) and determine the proper refund process to be followed:

  - If the payment is equal to or less than the balance, cashiers will post the payment.

  - If there is no outstanding balance on any account for the guarantor, cashiers will return the check/money order accompanied by a letter to our customer explaining why we will not be posting their payment.

  - If the check/money order is larger than the outstanding balance, cashiers will post the payment and initiate a refund request for the difference.

SUBJECT: **REIMBURSEMENT OF OVERPAYMENTS**	SECTION: **Page 4 of 4**

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

The Patient Accounting Manager or Administrative Director of Revenue Cycle is responsible for reviewing the Code of Civil Procedure annually to ensure the hospital remains compliant with any and all changes.

Refunds will first be applied to any outstanding accounts before being refunded to the patient or guarantor (if patient is a minor). The refund must be returned to the person who paid the balance. If the guarantor requests the credit back and there are accounts with balances due, refer to management for approval.

APPROVAL LIMITS:

Manager: All refunds less than five hundred dollars ($500.00)

Administrative Director of Business Services: All refunds less than seven thousand dollars five hundred dollars ($7500.00)

All refunds greater than seven thousand five hundred dollars ($7500.00) will require an additional signature from the CFO or the Chief Executive Officer (CEO).

REFERENCES:

- HSC 127440. Hospital Fair Pricing Policies (Effective January 1, 2008). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=127440.
- Code of Civil Procedure, Section 685.010 (1982). Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=CCP&division=1.&title=9.&part=2.&chapter=5.&article=.
- Centers for Medicare and Medicaid Services (2020). Pub 100-06 Medicare Financial Management. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019018.

SUBJECT:	SECTION:
SAFETY MANAGEMENT PLAN	***Safety Management***

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

I. EXECUTIVE SUMMARY

Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Environment of Care Safety (EC) Program is designed to identify and manage the risks of the environments of care operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals coming to the organization's facilities. The management plan and the environmental management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Wound Healing Center, Urology Clinic, Clinical Lab, Community Health Center, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Management Plan for Environmental Safety and associated polices extends to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. The identification of specific risks faced by patients, employees, and others is essential for designing safe work areas and work practices.

B. The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work environments and safe work practices to minimize the potential for adverse impact on them, patients, and other individuals coming into the environment.

C. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase staff knowledge.

III. OBJECTIVES

A. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Sierra View Medical Center.

B. Perform additional risk assessments when changes involving these issues occur.

C. Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.

D. Make changes in the procedures and controls to address identified root causes of incidents.

E. Conduct environmental rounds in all areas of the hospital and affiliated medical practices. Staff making rounds will evaluate the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.

F. Present quarterly reports of EC management activities to the Safety Committee. The reports from each EC area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified EC issues. The Safety Officer coordinates the documentation and presentation of this information.

G. Assure that all departments have current organization wide and department specific procedures and controls designed to manage identified risks.

H. Review the risks and related procedures and controls at least once every three years to assure that the EC programs are current.

I. Assign qualified individuals to manage the EC programs and to respond to immediate threats to life and health.

J. Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the environmental safety program.

K. Design and present environmental safety education and training to all new and current employees, volunteers, members of the medical staff and others as appropriate.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Safety Officer, VP Quality/Regulatory Affairs , and Manager of Infection Control work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk-related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program. They also collaborate with the Performance Improvement/Patient Safety Committee to integrate environment of care safety concerns into the Patient Safety program.

B. The Environmental Safety Leadership Team coordinates the development of reports to the Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.

C. The Safety Committee monitors and evaluates the processes used to manage the environment of care. Members of the Safety Committee are appointed by the Committee Chair. The Safety Committee meets a minimum of four (4) times per year. During each meeting, one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes, and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.

The Committee assigns individual's or group's responsibility for developing solutions to identified issues. Finally, the Committee maintains a tracking log to assure identified issues are acted on and that analysis of activities after implementation of changes demonstrates that the changes are effective.

Membership of the Committee includes representation from Nursing Administration, Facilities Management, Risk Management, Quality and Patient Safety, Human Resources, Senior Administration, Education, Medical Staff, Physician representation, Infection Control, and others as deemed appropriate.

D. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the environmental safety program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer. The Board of Directors collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the environmental safety program.

E. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Environmental Safety Program. The Chief Executive Officer collaborates with the ESLT and other appropriate staff to address environmental safety

issues and concerns. The Chief Executive Officer also collaborates with the Safety Officer to develop a budget and operational objectives for the Environment of Care Safety Program.

F. The Emergency Management Program contains provisions for management staff on duty to take immediate, appropriate action in the event of a situation that poses an immediate threat to life, health, or property.

G. The Human Resources Department, with the assistance from the Education Department and other leadership staff, are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.

H. Department Directors are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work-related activities in a manner consistent with their training. Department Directors also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.

I. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM

EC.01.01.01 EP1 – Appointment of Environmental Safety Leadership

The Chief Executive Officer appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The Environmental Safety Leadership Team (ESLT) includes the Safety Officer, Administrative Director of Quality and Care and the Manager of Infection Control.

The ESLT coordinates the development and implementation of the environmental safety program and assures it is integrated with patient safety, infection control, risk management, and other programs as appropriate.

The ESLT maintains a current knowledge of environmental safety laws, regulations, and standards of safety, and assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of Sierra View Medical Center.

The Emergency Management program includes specific response plans for Sierra View Medical Center that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate event incident commander is appointed at the time any emergency response is implemented.

The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations pose an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

The Chief Executive Officer has appointed the Safety Officer, the Nursing House Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

EC.01.01.01 EP4 – Environmental Safety Management Plan

The Environmental Safety Management Program is described in this management plan. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the facilities of Sierra View Medical Center.

EC.02.01.01 EP1 – The hospital identifies safety risks associated with the environment of care

The ESLT of Sierra View Medical Center performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The risk assessments use information from sources such as environmental rounds, the results of root cause analysis (RCA), incident reports, and external reports such as The Joint Commission Sentinel Event Alerts and FDA product recall notices.

The ESLT coordinates the risk assessment process with the Facilities Manager and Department Directors and others as appropriate.

EC.02.01.01 EP3 – The hospital takes action to minimize or eliminate identified safety risks in the physical environment

The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of

equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.

EC.02.01.01 EP14 & EP16 – The hospital manages safety risks in the MRI environment

The Radiation Safety Officer (RSO) follows the MRI Safety Policy to ensure the safety of all patients, visitors, and staff who enter the MRI Suite. Staff is trained to eliminate or reduce identified risks. MRI staff are familiar with proper screening procedures for all patients and staff (*i.e. ferrous objects, metallic implants and devices)* and trained to recognize when patients display signs of claustrophobia, anxiety, or emotional distress.

LD.04.01.07 EP1 – Development and Management of Policies and Procedures

The Safety Officer follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department heads with the development of department or job-specific environmental safety procedures and controls.

The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar with organizational, departmental, and appropriate job-related procedures and controls. Department Directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to her/his work processes.

The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years.

The Safety Officer coordinates the reviews of policies and procedures with department heads and other appropriate staff.

EC.02.01.01 EP5 – The hospital maintains all grounds and equipment

The Facilities Manager is responsible for managing the appearance and safety of the hospital grounds. In addition, the Facilities Manager is responsible for assuring that the equipment used to maintain the grounds is in proper operating condition and that grounds staff is trained to operate and maintain the equipment.

The grounds include but are not limited to lawns, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage and fences. External equipment includes but is not limited to mobile docking facilities, the oxygen storage facility, electrical service entrances and transformers,

sewage and storm lift stations and equipment yards. Sierra View Medical Center does not provide any patient care, treatment, or services outside of hospital buildings. There are no patient activity areas outside of hospital buildings that require supervision by hospital staff.

The Facilities Manager is responsible for scheduling the work required to maintain the appearance and safety of hospital grounds. The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions. The Security Supervisor and Engineering staff reports all deficiencies to the Facilities Manager for appropriate action.

EC.02.01.01 EP11 – The hospital responds to product notices and recalls

The Manager of the Environment of Care and the Director of Materials Management coordinates a product safety recall system. The system is designed to quickly assess safety recall notices; to respond to those that affect Sierra View Medical Center; and to assure all active safety recalls are completed in a timely manner.

A quarterly report of safety recall notices that required action to eliminate defective equipment or supplies from Sierra View Medical Center is presented to the Environmental Safety Committee by the Manager of the Environment of Care and the Director of Materials Management.

EC.02.01.03 EP1 – The hospital prohibits smoking

Sierra View Medical Center has developed a Tobacco Free Environment policy. The policy prohibits the usage of any tobacco product (i.e.: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes) in any hospital building or grounds by all, including staff, visitors and patients.

Sierra View Medical Center has identified alternatives to tobacco products that are offered to all. Sierra View Medical Center has developed tobacco replacement product resources to assist staff and patients with smoking cessation as desired.

The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.

EC.02.01.03 EP6 – The hospital takes action to maintain compliance with its smoking policy

The procedures for managing the use of smoking materials are followed and enforced by all leadership and staff.

EC.04.01.01 EP1 - EP11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Board of Directors and Senior Leadership as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies, including identification of opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and the Facilities Manager, who represents each of the seven management of the environment of care functions, use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare quarterly reports to the leadership of Sierra View Medical Center. The quarterly reports summarize key issues reported to the Committees, with their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure Hospital leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months, the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the

operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement.

Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.

The annual evaluation is distributed to the Chief Executive Officer, Board of Directors, Senior Leadership, the Performance Improvement/Patient Safety Committee and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement.

Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 Improving the Environment

When the Senior Leadership or the Administrative Director of Quality and Care concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital administration, performance improvement, and patient safety leadership.

GOAL:

- Work to lower the number of Patient Slips and Falls resulting in Class III injuries (Moderate Injuries) per 1000 inpatient days to the 50th percentile in the Osborne Engineering Benchmarking Database. The current rate is the 93rd percentile.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate.

The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with participation from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment.

The Human Resources Department, with participation from the Education Department, maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Administrative Director of Quality and Care, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job-related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each EC program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *BOARD OF DIRECTORS, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, CONTRACTED SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC. 01.01.01 EP4 Joint Commission Resources. Oak Brook, IL.
- The Joint Commission (2023). Laboratory & Point-of-Care standards. EC.04.01.01, EP1 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- WORKPLACE VIOLENCE PREVENTION PLAN

Ldo

SUBJECT: **VERIFICATION OF EXTERNAL REQUESTORS**	SECTION: **Page 1 of 3**

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

Purpose

To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164 and all Federal regulations and interpretive guidelines promulgated there under. To establish guidelines to reasonably ensure the requestor's true identity in instances when the facility receives requests from persons or entities outside the organization for disclosure of a patient's protected health information (PHI).

Policy

Every member of the facility workforce must verify the identity of any person or entity when the person or entity is unknown to the workforce member and is requesting protected health information (PHI) either in person, verbally or via written request.

The **exceptions** to the verification requirement are:

- Disclosures from the facility;
- Disclosures for disaster relief purposes; and
- Disclosures for the involvement in the individual's care and notification purposes.

Procedure

The facility's workforce members must verify the identity of any person or entity, through one of the mechanism listed below, when the person or entity is unknown to the workforce member.

A. Individual or Patient/Patient Representative Requestors.
Approved methods of identity verification are any ***one*** of the following three options:

1. Valid State/Federal Issued Photo ID (*i.e.*, passport, government ID, driver's license); or

2. Requestor is able to provide a **minimum of three** information items from the following list of acceptable identifiers (The information may be provided verbally or in writing as applicable); or
    - Patient Social Security Number, or at least the last 4 digits (required) **and**
    - Patient Date of Birth (required) **and**
    - Any **one** of the following:
        - Account Number
        - Street Address
        - Insurance Carrier Name
        - Insurance Policy Number
        - Medical Record Number
        - Birth Certificate
        - Insurance Card

3. The positive match of signature to a signature on file (*e.g.*, request received from patient via fax or mail and the signature is compared to patient signature on conditions of admission).

   Unacceptable forms of identification for purposes of this policy:
   - Employment Identification Card (ID)
   - Student ID
   - Membership ID Cards
   - Generic Billing Statements (utility bills)
   - Supplemental Security Income (SSI) Card
   - Credit Cards (photo or non-photo)

B. Third-Party Requestors.
To verify that a requestor is truly a representative of the third party and that the request is on behalf of said party, the following elements should be taken into consideration when reviewing the request:

- **Letterhead:** Request is on official printed letterhead and PHI is mailed or faxed to the address or number printed on the letterhead.
- **Fax Coversheet with company logo:** Requested information is mailed or faxed to address or number contained in the coversheet.
- **Fax transmission/header**: May be referenced as additional source of verification.
- **Photo ID:** with official credentials when a third party request is made in person (*e.g.*, Law Enforcement and Public Officials).

  When in doubt, follow-up via telephone calling the entities main phone number.

C. Verification of Public Officials or Someone Acting on the Official's Behalf.

Public officials or someone acting on the official's behalf should have one or more of the following:

- Presentation of agency identification badge.
- Other official credentials.
- Other proof of government status (*e.g.*, photo ID issued by a government agency).
- A request written on appropriate government letterhead.
- A written statement on appropriate government letterhead that the person making the request is acting under the government's authority (*e.g.*, a nonprofit company hired by a county health department to compile statistics on West Nile Virus).

REFERENCE:

- Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164

- American Recovery and Reinvestment Act of 2009, Title XIII, Subtitle D

I have received a copy of Chemotherapy/Therapeutic Procedure Risks and have had the opportunity to talk with my physician / provider about the benefits, potential outcomes, and likelihood of achieving the goals of the planned therapy; risks and possible complications; alternatives to the treatment, including the risks and benefits associated with no treatment; and, possible problems that may occur during my recuperation. I have been thoroughly informed, and had all of my questions answered.

I understand that my diagnosis is:_____

_____

I consent to the following chemotherapy/therapeutic procedures treatment under the supervision of_____

Chemotherapy Regimen: _____

Duration of Treatment and/or Number of Cycles:_____

_____

If you have any issues or questions, please ask your physician/provider before you sign this form.

_____ _____ _____
Patient or Authorized Representative Date Time

_____
Relationship to Patient

_____ _____ _____
Witness Date Time

IMPORTANT INFORMATION FOR WOMEN OF CHILDBEARING AGE:
To the best of my knowledge, I confirm that I am not currently pregnant; I understand that pregnancy MUST be avoided throughout the entire course of my chemotherapy; I agree to take precautions to avoid becoming pregnant during the course of my treatment. _____
Initials

I am currently pregnant and my provider had discussed the benefits and risks of moving forward with treatment verses choosing not to receive treatment. By initialing here _____ I indicate I have had the opportunity to asks questions and am choosing to proceed with treatment.

_____ _____ _____
Signature of Patient Date Time

This sheet explains some important general information about chemotherapy/therapeutic procedures which you should read before giving your consent to have any treatment. Your medical oncologist/hematologist will give you more detailed information regarding your specific treatments.

MEDICAL TERMINOLOGY: Your physician/practitioner can and will explain your proposed treatment using terms which you can understand. Sometimes s/he may use medical terms that are not common words. If you have any questions about what any words may have meant or anything else about the treatment you should ask your physician/provider to explain them until you fully understand the planned treatment.

RISKS OF CHEMOTHERAPY/THERAPUETIC PROCEDURES: The administration of chemotherapy can carry certain risks, including failure to obtain the desired result, discomfort, injury, the need for additional therapy, bleeding, infection and in rare instances, death. You should discuss these risks, possible complications, and any alternatives to the procedure with your medical oncologist/hematologist.

Possible side effects of these drugs include one of the following or a combination of the following:

- ❖ Allergic-like reaction
- ❖ Menstrual irregularities
- ❖ Anemia causing weakness
- ❖ Mouth sores
- ❖ Brief periods of forgetfulness
- ❖ Nausea and vomiting
- ❖ Constipation
- ❖ Numbness of tingling of fingers and/or toes
- ❖ Diarrhea
- ❖ Liver damage
- ❖ Dizziness
- ❖ Life-threatening complications
- ❖ Hair loss
- ❖ Skin and nail darkening
- ❖ Heart damage
- ❖ Skin irritation due to leakage
- ❖ Kidney damage
- ❖ Skin/sunlight sensitivity
- ❖ Loss of appetite
- ❖ Skin rash
- ❖ Low platelet count increasing the risk of bleeding
- ❖ Sterility
- ❖ Low white count increasing the risk of infection
- ❖ Visual changes
- ❖ Lung damage
- ❖ Weight gain or loss
- ❖ Menopausal symptoms
- ❖ Other: _____

UNANTICIPATED CONDITIONS: During the course of your treatment certain conditions may be encountered other than those anticipated before the treatment was started. Your provider may be required to reduce the dose of some or all of the drugs, delay the administration of some or all of the drugs, add or delete drugs from the planned regimen because of these unanticipated findings.

BLOOD TRANSFUSIONS: Some chemotherapy drugs may interfere with the production of red blood cells. This decrease production of red blood cells may make it necessary to administer red blood cells or clotting factors. Your medical oncologist will use his/her best judgment to make this decision. All blood products used are obtained from volunteer donors and are thoroughly tested. Nevertheless, serious reactions, although rare, do occur. These may include fever, allergic reactions, infections (including HIV and Hepatitis), fluid overload, and reduced clotting ability.

NO GUARANTEES: The practice of medicine is not an exact science and results cannot always be anticipated. No guarantees can be made to you concerning the course, duration or results of your chemotherapy/therapeutic procedures by provider or anyone else at SVMC.

The hospital promotes the continuing education and advancement of the healthcare field by providing training opportunities for students of health professions. The students are supervised by hospital and non-hospital staff. You have the right to decide whether to agree to a student observing or participating during this procedures. **Please initial if you DECLINE student observation and/or participation as above.** _____

PHYSICIAN CERTIFICATION: I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

- The nature of the operation or procedure, including other care, treatment or medications, or interventions;
- Potential benefits, risks or side effects of the operation or procedure, including potential problems
- that might occur during recuperation;
- The likelihood of achieving treatment goals;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives,
- including the possible results of not receiving care, treatment or services; and
- When indicated, any limitations on the confidentiality of information learned about the patient.

I certify that the patient was encouraged to ask questions and that all questions were answered.

_____ _____ _____

Signature of Provider Date Time

INTERPRETER'S STATEMENT: I have accurately and completely read the foregoing document to (patient or patient's legal representative)_____ in the patient's or legal representative's primary language_____(identify language). He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

_____ _____ _____

Signature of Interpreter Date Time

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

The regular meeting of the Board of Directors of Sierra View Local Health Care District was held **November 28, 2023 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:06 p.m.

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

Others Present: Canales, Tracy, VP of Human Resources, Dickson, Doug, Chief Financial Officer, Gomez, Cindy, Director of Compliance, Hefner, Donna, President/Chief Executive Officer, Hudson, Jeffery, VPPCS/CNO/DIO, Mitchell, Melissa, VP Quality and Regulatory Affairs, Nanamura, Mark, Mutual Advisors LLC, Nanamura, Patrick, Mutual Advisors LLC, Parsons, Malynda, Public Relations, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, Chief of Staff, Torrez, Larriann, Director of Porterville Adult School, Wallace, Marcella, Director of Communications, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment, Wilbur, Gary, Admin Director of General Services

I. Approval of Agenda:

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

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:07 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

Vice Chairman LOMELI in at 5:12 p.m.

2. Quality Division Update

E. 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

Closed Session Items C, D, F were deferred to the conclusion of Open Session as there was not time for discussion prior to Open Session.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:36 p.m., reconvening in Open Session at 5:37 p.m.

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

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

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

REDDY	Yes
LOMELI	Abstain
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

E. Conference with Legal Counsel

Information only; no action taken.

IV. Public Comments

None.

V. Consent Agenda

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. CEO Report

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

VIII. Business Items

A. Porterville Adult School
Larriann Torrez, Ed.D. provided an overview of CTE Healthcare Programs which are currently provided and will be provided in the near future.

Information only; no action taken.

B. October 2023 Financials

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

Total Operating Revenue was $12,789,162. Supplemental Funds were $1,743,401. Total Operating Expenses were $13,451,446. Loss from operations of $662,284.

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Investment Report

Mark Nanamura of Mutual Advisors, LLC provided an Investment Update to the Board. Approximately 14% of the total portfolio will turn over during the next 12 months. Investment yield is expected to be approximately 1.75% over the next 12 months. A full copy of the Investment Update is attached to the file copy of these minutes.

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

D. Retirement Planning Advisory Committee Report

The Retirement Planning Advisory Committee Report was presented by Doug Dickson, CFO.

2023 Summary: No fund changes were recommended or made. Service performance metrics were met with satisfactory scores. Reviewed results of 2022 Education Plan. Ensure fees for plan participants are within peer fee range.

Reviewed Multnomah Group's (MG) Share Class Comparison Report identifying lower cost share classes. Reviewed Empower Advisory Service Managed Account Program. Reviewed 2023 Regulatory Update, focusing on SECURE 2.0 provisions for 2023 and 2024. From 9/30/22 through 9/30/23: Total combined plan assets increased from $99.1 million to $104.2 million. Total combined contributions of $8.1 million and distributions of $11.9 million

IX. Closed Session: Board adjourned Open Session at 6:37 p.m. and went into Closed Session at 6:47 p.m. to discuss the following items:

C. Pursuant to Gov. Code Section 54956.9(b)(3)(F): Conference with Legal Counsel, significant exposure to litigation; & Gov. Code Section 54962; Health and Safety Code Section 32106(b); Cal. Civ. Code § 3426.1(d): Discussion Regarding Trade Secrets (1 Item) Estimated Date of Disclosure – March 2025

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

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

X. Open Session: Board adjourned Closed Session at 7:31 p.m. and went into Open Session at 7:31 p.m. to discuss the following items:

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

D. Discussion Regarding Trade Secret and Strategic Planning. Information only; no action taken.

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

XII. Announcements:

A. Regular Board of Directors Meeting – December 19, 2023 at 5:00 p.m.

The meeting was adjourned 7:32 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: ww

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INSTITUTIONAL STATEMENT OF COMMITMENT TO GRADUATE MEDICAL EDUCATION

Introduction

Sierra View Medical Center is dedicated to advancing medical knowledge and clinical practice through scholarly research, physician education, and high-quality care. The District nurtures the development of residents and fellows for the benefit of society. Sierra View Medical Center is committed to the recruitment of superior quality residents, fellows and faculty and to providing an outstanding graduate medical education program. The District's educational programs are designed to enhance communication skills, stimulate self-learning and critical inquiry and to exemplify those human values necessary to prepare physicians for excellence in the independent practice of medicine and the professional commitments of a career in medicine. Recognizing its responsibility to meet the educational needs of the residents and fellows, and the diverse needs of the patient community, the District is committed to programs of clinical excellence in a variety of patient care disciplines.

Mission

Our mission is to train physicians with diverse experiences and talents to become positive agents of change that will provide compassionate, high quality, patient-centered, evidence-based care to improve the health of the culturally and socioeconomically diverse patient population in the Central Valley and beyond.

Vision

In training the next generation of physician leaders, Sierra View's GME team will be a driving force for progress in healthcare delivery to our Central Valley community

Commitment

In accordance with its mission, Sierra View Medical Center, as the Sponsoring Institution for Sierra View Medical Center's residency program, is dedicated to pursuing the highest quality of patient care and graduate medical education.

Sierra View Medical Center is committed to serve the community as a vital resource of expertise and knowledge. The District further serves the public through the training of physicians whose backgrounds reflect California's ethnic and cultural diversity and whose professional careers address California's health care needs.

Sierra View Medical Center is committed to creating a learning environment where residents advance and develop the skills needed to provide outstanding health care. Trainees are provided with a safe and professional learning environment which fosters their personal growth and education.

Sierra View Medical Center ensures each trainee will receive a stipend commensurate with the established scale for each postgraduate year of training. Insurance benefits including comprehensive health, dental, vision, mental care, life and long term disability are provided for all trainees and their eligible dependents.

Sierra View Medical Center is committed to providing all necessary financial support for the administrative, educational, financial, human, and clinical resources needed for producing training programs of the highest quality including:

- Funding a central administrative Office of Graduate Medical Education to support all graduate medical education programs, the Graduate Medical Education Committee, faculty, and residents;
- Offering high quality educational resources including teaching space, technology, equipment, information systems, library, and curricula common to all GME programs;
- Ensuring all trainees have the opportunity to learn and provide supervised safe patient care;
- Providing a safe training environment and state-of-the- art facilities for all GME programs.
- Ensuring all trainees are treated fairly and have ample opportunity to communicate any concerns without fear of intimidation or retaliation;
- Providing professional, informational and support services that are adequate to meet the educational goals of each program;
- Creating an environment which encourages education and scholarly activity;
- Coordinating the fair implementation of personnel policies and procedures for all trainees;
- Providing adequate on-call rooms, food services, security and other services beneficial to the well-being of all trainees;
- Allowing adequate protected time and sufficient financial support for Program Directors, Faculty, and the Designated Institutional Official to effectively carryout the educational and administrative responsibilities to graduate medical education.

Sierra View Medical Center, through the Graduate Medical Education Committee and the Office of Graduate Medical Education, is responsible for establishing policies, due process, the oversight of resident/fellow working hours and working conditions, compliance with the internal review process, implementation of and compliance with the ACGME Competencies and requirements, and the distribution of training positions and funding allocations.

_____ _____

Bindusagar Reddy, MD
Chairman, Sierra View Local Healthcare District
Board of Directors

Date

_____ _____

Donna Hefner
Chief Executive Officer

Date

_____ _____

Lori Winston, MD
Designated Institutional Official

Date

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FINANCIAL PACKAGE
November 2023

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
November 2023

Statistic	Nov-23 Actual	Nov-23 Budget	Nov-23 Over/ (Under)	Nov-23 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 23 YTD	Increase/ (Decrease) 11/2022	% Change
Utilization											
SNF Patient Days											
Total	37	108	(71)	-65.7%	360	540	(180)	-33.3%	588	(228)	-38.8%
Medi-Cal	37	81	(44)	-54.3%	360	363	(3)	-0.7%	397	(37)	-9.3%
Sub-Acute Patient Days											
Total	997	871	126	14.5%	4,769	4,355	414	9.5%	4,288	481	11.2%
Medi-Cal	877	592	285	48.2%	3,958	3,033	925	30.5%	2,986	972	32.6%
									0.0%		
Acute Patient Days	1,598	1,848	(250)	-13.5%	8,328	9,241	(913)	-9.9%	8,798	(470)	-5.3%
Acute Discharges	393	480	(87)	-18.1%	2,155	2,400	(245)	-10.2%	2,328	(173)	-7.4%
Medicare	151	195	(44)	-22.7%	820	907	(87)	-9.6%	880	(60)	-6.8%
Medi-Cal	198	235	(37)	-15.6%	1,064	1,170	(106)	-9.0%	1,138	(74)	-6.5%
Contract	41	51	(10)	-19.6%	251	307	(56)	-18.3%	298	(47)	-15.8%
Other	3	2	1	50.0%	20	12	8	62.0%	12	8	66.7%
Average Length of Stay	4.07	3.85	0.22	5.6%	3.86	3.85	0.01	0.4%	3.78	0.09	2.3%
Newborn Patient Days											
Medi-Cal	179	172	7	4.1%	922	850	72	8.5%	907	15	1.7%
Other	16	33	(17)	-51.5%	159	175	(16)	-9.2%	181	(22)	-12.2%
Total	195	205	(10)	-4.9%	1,081	1,025	56	5.5%	1,088	(7)	-0.6%
Total Deliveries	93	116	(23)	-19.8%	531	580	(49)	-8.4%	609	(78)	-12.8%
Medi-Cal %	89.36%	82.81%	6.55%	7.9%	84.18%	82.81%	1.37%	1.7%	82.28%	1.90%	2.3%
Case Mix Index											
Medicare	1.5847	1.6395	(0.0548)	-3.3%	1.5598	1.6395	(0.0797)	-4.9%	1.5446	0.0152	1.0%
Medi-Cal	1.2595	1.1881	0.2190	18.4%	1.1791	1.1881	(0.0090)	-0.8%	1.1676	0.0115	1.0%
Overall	1.4071	1.3732	(0.1137)	-8.3%	1.3393	1.3732	(0.0339)	-2.5%	1.3135	0.0258	2.0%
Ancillary Services											
Inpatient											
Surgery Minutes	8,340	9,041	(701)	-7.8%	42,005	45,205	(3,200)	-7.1%	44,087	(2,082)	-4.7%
Surgery Cases	95	104	(9)	-8.7%	475	520	(45)	-8.7%	533	(58)	-10.9%
Imaging Procedures	1,328	1,479	(151)	-10.2%	6,840	7,396	(556)	-7.5%	7,251	(411)	-5.7%
Outpatient											
Surgery Minutes	11,839	12,448	(609)	-4.9%	65,121	62,240	2,881	4.6%	59,943	5,178	8.6%
Surgery Cases	187	190	(3)	-1.6%	1,004	950	54	5.7%	920	84	9.1%
Endoscopy Procedures	140	142	(2)	-1.4%	969	710	259	36.5%	862	107	12.4%
Imaging Procedures	3,778	3,715	63	1.7%	19,073	18,576	497	2.7%	19,369	(296)	-1.5%
MRI Procedures	255	295	(40)	-13.6%	1,490	1,475	15	1.0%	1,534	(44)	-2.9%
CT Procedures	1,213	1,178	35	3.0%	6,384	5,890	494	8.4%	5,954	430	7.2%
Ultrasound Procedures	1,127	1,102	25	2.3%	6,227	5,510	717	13.0%	4,920	1,307	26.6%
Lab Tests	30,192	33,247	(3,055)	-9.2%	158,801	166,235	(7,434)	-4.5%	171,884	(13,083)	-7.6%
Dialysis	9	3	6	200.0%	17	15	2	13.3%	8	9	112.5%

Sierra View Medical Center
Financial Statistics Summary Report
November 2023

Statistic	Nov-23 Actual	Nov-23 Budget	Nov-23 Over/ (Under)	Nov-23 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 23 YTD	Increase/ (Decrease) 11/2022	% Change
Cancer Treatment Center											
Chemo Treatments	1,691	1,713	(22)	-1.3%	7,671	8,565	(894)	-10.4%	8,820	(1,149)	-13.0%
Radiation Treatments	1,403	1,653	(250)	-15.1%	9,136	8,265	871	10.5%	8,007	1,129	14.1%
Cardiac Cath Lab											
Cath Lab IP Procedures	10	10	-	0.0%	60	50	10	20.0%	47	13	27.7%
Cath Lab OP Procedures	33	28	5	17.9%	166	140	26	18.6%	151	15	9.9%
Total Cardiac Cath Lab	43	38	5	13.2%	226	190	36	18.9%	198	28	14.1%
Outpatient Visits											
Emergency	3,442	3,411	31	0.9%	17,136	17,055	81	0.5%	17,529	(393)	-2.2%
Total Outpatient	12,517	12,811	(294)	-2.3%	66,408	64,055	2,353	3.7%	65,515	893	1.4%
Staffing											
Paid FTE's	853.74	841.56	12.18	1.4%	852.53	841.56	10.97	1.3%	904.95	(52.42)	-5.8%
Productive FTE's	716.35	735.98	(19.63)	-2.7%	734.09	735.98	(1.89)	-0.3%	768.89	(34.80)	-4.5%
Paid FTE's/AOB	4.91	4.90	0.01	0.3%	4.98	5.00	(0.02)	-0.4%	5.39	(0.41)	-7.6%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	10,294	11,032	(738)	-6.7%	10,476	11,032	(556)	-5.0%	10,797	(321)	-3.0%
Cost/Adj.Patient Day	2,559	2,592	(33)	-1.3%	2,589	2,635	(46)	-1.7%	2,719	(131)	-4.8%
Revenue/Adj. Discharge	55,050	53,107	1,943	3.7%	52,421	53,107	(686)	-1.3%	51,326	1,095	2.1%
Cost/Adj. Discharge	13,684	12,479	1,206	9.7%	12,953	12,683	271	2.1%	12,926	27	0.2%
Adj. Discharge	975	1,070	(95)	-8.9%	5,238	5,351	(113)	-2.1%	5,408	(170)	-3.1%
Net Op. Gain/(Loss) %	-2.48%	-1.14%	-1.34%	117.4%	-5.61%	-1.14%	-4.47%	391.5%	-15.82%	10.21%	-64.5%
Net Op. Gain/(Loss) $	(323,126)	(150,740)	(172,386)	114.4%	(3,604,006)	(1,901,416)	(1,702,590)	89.5%	(9,550,076)	5,946,070	-62.3%
Gross Days in Accts Rec.	94.68	88.87	5.81	6.5%	94.68	88.87	5.81	6.5%	86.95	7.72	8.9%
Net Days in Accts. Rec.	58.98	72.82	(13.83)	-19.0%	58.98	72.82	(13.83)	-19.0%	73.74	(14.76)	-20.0%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	NOV 2023	OCT 2023
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 8,293,671	$ 4,901,605
SHORT-TERM INVESTMENTS	2,166,575	1,137,904
ASSETS LIMITED AS TO USE	63,845	64,153
PATIENT ACCOUNTS RECEIVABLE	169,552,171	171,723,030
LESS UNCOLLECTIBLES	(28,182,461)	(28,451,866)
CONTRACTUAL ALLOWANCES	(117,407,949)	(118,426,621)
OTHER RECEIVABLES	21,203,414	23,639,025
INVENTORIES	4,048,601	4,046,428
PREPAID EXPENSES AND DEPOSITS	3,160,195	3,366,181
LEASE RECEIVABLE - CURRENT	299,577	341,565
TOTAL CURRENT ASSETS	63,197,640	62,341,403
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	33,039,765	32,460,475
LONG-TERM INVESTMENTS	129,505,782	129,407,553
PROPERTY, PLANT AND EQUIPMENT, NET	81,979,501	82,639,470
INTANGIBLE RIGHT OF USE ASSETS	509,017	522,888
SBITA RIGHT OF USE ASSETS	3,182,016	3,280,191
LEASE RECEIVABLE - LT	1,169,561	1,296,459
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,657,390	1,678,369
TOTAL ASSETS	$ 314,490,673	$ 313,876,806

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	NOV 2023	OCT 2023
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 653,083	$ 522,467
CURRENT MATURITIES OF BONDS PAYABLE	4,055,000	4,055,000
CURRENT MATURITIES OF LONG TERM DEBT	1,201,171	1,201,171
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	3,492,962	3,428,265
ACCRUED PAYROLL AND RELATED COSTS	6,887,628	6,902,083
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,767,849	3,856,707
LEASE LIABILITY - CURRENT	135,900	137,822
SBITA LIABILITY - CURRENT	1,272,203	1,272,203
TOTAL CURRENT LIABILITIES	21,465,796	21,375,718
SELF-INSURANCE RESERVES	1,488,729	1,518,737
CAPITAL LEASE LIAB LT	1,525,312	1,608,590
BONDS PAYABLE, LESS CURR REQT	37,510,000	37,510,000
BOND PREMIUM LIABILITY - LT	3,112,051	3,170,621
LEASE LIABILITY - LT	389,461	400,544
SBITA LIABILITY - LT	2,109,608	2,207,644
OTHER NON CURRENT LIABILITIES	187,927	187,927
DEFERRED INFLOW - LEASES	1,408,052	1,572,263
TOTAL LIABILITIES	69,196,935	69,552,042
UNRESTRICTED FUND	245,134,891	245,134,891
PROFIT OR (LOSS)	158,847	(810,127)
TOTAL LIABILITIES AND FUND BALANCE	$ 314,490,673	$ 313,876,806

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

NOV 2023 ACTUAL	NOV 2023 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,414,492	5,730,675	316,183	(6)%	INPATIENT - NURSING	26,909,868	28,653,375	1,743,507	(6)%
16,261,395	19,760,695	3,499,300	(18)%	INPATIENT - ANCILLARY	86,254,578	98,804,464	12,549,886	(13)%
21,675,887	25,491,370	3,815,483	(15)%	TOTAL INPATIENT REVENUE	113,164,446	127,457,839	14,293,393	(11)%
31,999,850	31,357,707	(642,143)	2%	OUTPATIENT - ANCILLARY	161,428,483	156,714,843	(4,713,640)	3%
53,675,737	56,849,077	3,173,340	(6)%	TOTAL PATIENT REVENUE	274,592,929	284,172,682	9,579,753	(3)%
				DEDUCTIONS FROM REVENUE				
(16,118,087)	(17,105,659)	(987,572)	(6)%	MEDICARE	(85,829,291)	(85,528,295)	300,996	0%
(17,595,345)	(20,103,940)	(2,508,595)	(13)%	MEDI-CAL	(87,522,216)	(100,519,700)	(12,997,485)	(13)%
(6,985,718)	(6,634,411)	351,307	5%	OTHER/CHARITY	(35,891,570)	(33,172,055)	2,719,515	8%
46,357	(13,158)	(59,515)	(452)%	DISCOUNTS & ALLOWANCES	(161,284)	(65,790)	95,494	145%
(512,016)	(439,236)	72,780	17%	BAD DEBTS	(3,506,583)	(2,196,180)	1,310,403	60%
(41,164,809)	(44,296,404)	(3,131,595)	(7)%	TOTAL DEDUCTIONS	(212,910,944)	(221,482,020)	(8,571,076)	(4)%
12,510,928	12,552,673	41,745	0%	NET SERVICE REVENUE	61,681,986	62,690,662	1,008,677	(2)%
508,492	654,369	145,877	(22)%	OTHER OPERATING REVENUE	2,566,456	3,271,845	705,389	(22)%
13,019,420	13,207,042	187,622	(1)%	TOTAL OPERATING REVENUE	64,248,442	65,962,507	1,714,065	(3)%
				***** OPERATING EXPENSE *****				
5,451,868	5,232,582	219,286	4%	SALARIES	27,815,830	26,442,723	1,373,107	5%
569,455	558,012	11,443	2%	S&W PTO	3,183,138	2,823,698	359,440	13%
1,345,599	1,520,251	(174,652)	(12)%	EMPLOYEE BENEFITS	6,783,927	7,712,545	(928,618)	(12)%
1,391,310	1,394,070	(2,760)	0%	PROFESSIONAL FEES	6,382,261	6,969,462	(587,201)	(8)%
825,866	747,892	77,974	10%	PURCHASED SERVICES	4,331,093	4,250,790	80,303	2%
1,961,232	1,971,581	(10,350)	(1)%	SUPPLIES & EXPENSES	9,896,011	9,892,409	3,602	0%
224,136	237,711	(13,575)	(6)%	MAINTENANCE & REPAIRS	1,132,973	1,248,081	(115,109)	(9)%
204,664	263,897	(59,233)	(22)%	UTILITIES	1,397,761	1,319,485	78,276	6%
32,903	11,257	21,646	192%	RENT/LEASE	140,228	79,453	60,775	77%
120,816	118,267	2,549	2%	INSURANCE	631,863	591,335	40,528	7%
964,082	1,400,802	(436,720)	(31)%	DEPRECIATION/AMORTIZATION	4,872,730	4,931,282	(58,552)	(1)%
250,616	(98,540)	349,156	(354)%	OTHER EXPENSE	1,284,633	1,602,660	(318,027)	(20)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
13,342,546	13,357,782	(15,236)	0%	TOTAL OPERATING EXPENSE	67,852,448	67,863,923	(11,475)	0%
(323,126)	(150,740)	172,386	114%	NET GAIN/(LOSS) FROM OPERATIONS	(3,604,006)	(1,901,416)	1,702,590	90%
116,558	116,558	0	0%	DISTRICT TAXES	582,790	582,790	0	0%
335,302	277,386	(57,916)	21%	INVESTMENTS INCOME	1,537,383	1,386,930	(150,453)	11%
54,498	43,282	(11,216)	26%	OTHER NON OPERATING INCOME	269,341	216,410	(52,931)	25%
(89,554)	(139,747)	(50,193)	(36)%	INTEREST EXPENSE	(456,469)	(447,823)	8,646	2%
(32,739)	(36,775)	(4,036)	(11)%	NON-OPERATING EXPENSE	(228,271)	(183,875)	44,396	24%
384,065	260,704	(123,361)	47%	TOTAL NON-OPERATING INCOME	1,704,774	1,554,432	(150,342)	10%
60,938	109,964	49,026	(45)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(1,899,232)	(346,984)	1,552,248	447%
908,035	0	(908,035)		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	2,058,079	0	(2,058,079)	
968,973	109,964	(859,009)	781%	NET GAIN/(LOSS)	158,847	(346,984)	(505,831)	(146)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
11/30/23

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(323,126)	(3,604,006)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	964,082	4,872,730
Provision for bad debts	(269,405)	440,659
Change in assets and liabilities:		
Patient accounts receivable, net	1,152,182	1,585,312
Other receivables	2,435,611	(5,526,740)
Inventories	(2,173)	(30,642)
Prepaid expenses and deposits	205,986	(777,216)
Advance refunding of bonds payable, net	20,979	104,898
Accounts payable and accrued expenses	64,698	(2,277,967)
Deferred inflows - leases	(164,211)	(283,931)
Accrued payroll and related costs	(14,455)	(469,333)
Estimated third-party payor settlements	(88,858)	612,579
Self-insurance reserves	(30,008)	(177,227)
Total adjustments	4,274,428	(1,926,878)
Net cash provided by (used in) operating activities	3,951,302	(5,530,884)
Cash flows from noncapital financing activities:		
District tax revenues	116,558	582,790
Noncapital grants and contributions, net of other expenses	6,936	(40,719)
Net cash provided by (used in) noncapital financing activities	123,494	542,071
Cash flows from capital and related financing activities:		
Purchase of capital assets	(290,242)	(1,644,278)
Proceeds from lease receivable, net	168,886	281,018
Principal payments on debt borrowings	-	(3,880,000)
Interest payments	(2,685)	(884,397)
Net change in notes payable and lease liability	(96,144)	(472,449)
Net changes in assets limited as to use	(578,982)	1,841,716
Net cash provided by (used in) capital and related financing activities	(799,167)	(4,758,390)
Cash flows from investing activities:		
Net (purchase) or sale of investments	809,806	4,311,583
Investment income	335,302	1,537,383
Net cash provided by (used in) investing activities	1,145,108	5,848,966
Net increase (decrease) in cash and cash equivalents:	4,420,737	(3,898,237)
Cash and cash equivalents at beginning of month/year	6,039,509	14,358,483
Cash and cash equivalents at end of month	10,460,246	10,460,246

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
November 2023

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Dec-22	9,551,250	2,895,404	12,446,654
Jan-23	11,383,815	396,451	11,780,266
Feb-23	10,444,477	1,486,294	11,930,771
Mar-23	11,036,309	4,353,856	15,390,165
Apr-23	9,611,508	8,659,999	18,271,507
May-23	13,011,917	3,474,340	16,486,257
Jun-23	10,589,289	5,045,026	15,634,315
Jul-23	9,542,222	1,209,276	10,751,498
Aug-23	11,411,456	2,278,509	13,689,964
Sep-23	11,153,141	297,374	11,450,515
Oct-23	10,806,912	1,614,798	12,421,710
Nov-23	**11,048,937**	**5,395,178**	**16,444,115**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - Receipts for Café, rebates, refunds, and miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues

- Medi-Cal OP Supplemental and DSH funds
- Medi-Cal and Medi-Care Tentative Cost Settlements
- Grants, IGT, HQAF, & QIP
- Medicare interim payments

October 2023 Summary of Other Activity:

4,055,194	M-Cal HQAF7 IGT CY22 Anthem Blue Cross
1,013,799	M-Cal HQAF7 IGT CY22 Health Net
22,971	M-Cal IP DSH 06/23 Phase 2
303,213	Miscellaneous
5,395,178	11/23 Total Other Activity