SIERRA VIEW
MEDICAL CENTER

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

AGENDA
June 28, 2022

OPEN SESSION (4:30 PM – 4:35 PM)

The Board of Directors will call the meeting to order at 4:30 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 4:35 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:00 P.M. or via Zoom: https://svmc.zoom.us/j/85249774335

Call to Order/Roll Call

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

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 (Time Limit – 5 minutes)

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): (Time Limit – 5 minutes)

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54956.9, Exposure to Litigation to subdivision (d)(2): Conference with Legal Counsel. BETA Claim No. 21-001701 (Time Limit – 5 minutes)

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (2 Items). Estimated Date of Disclosure – November 2024 (Time Limit – 15 min)

E. Pursuant to Gov. Code Section 54956.9, Exposure to Potential Litigation (d)(2): Conference with Legal Counsel; Government Code Sections 54957(b)(1) and 54957(b)(2); Pursuant to Evidence Code Sections 1156 and 1157, 1157.7; Health and Safety Code Section 32106(b) and Health and Safety Code Section 32155. Hearing on the Reconsideration of the July 27, 2021 Public Censure of Director Pandya (Time Limit – 1 hour)

Public Comment

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. 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.

Public Comments as to Reconsideration of July 27, 2021 Public Censure

Reconsideration of the July 27, 2021 Public Censure will be held in closed session to protect confidential information requiring protection by Government Code, sections 54957(b)(4), 54957(b)(1), and 54956.9(d)(2), Health & Safety

Code, section 32155, and Evidence Code Sections 1156, 1157, and 1157.7. The public will be allowed to enter closed session only to give public comment in favor or opposition of the charge. Any person addressing the Board during this time period will be limited to a maximum of three minutes. Public will be allowed to enter the room to provide the comment and must exit the room promptly after comment is completed.

F. Pursuant to Gov. Code Section 54956.9, Exposure to Potential Litigation (d)(2): Conference with Legal Counsel; Government Code Sections 54957(b)(1) and 54957(b)(2); Pursuant to Evidence Code Sections 1156 and 1157, 1157.7; Health and Safety Code Section 32106(b) and Health and Safety Code Section 32155; Pandya v. Sierra View Local Health Care District, Tulare County Superior Court Case # 291990 (1 Item)(Time Limit – 20 min)

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

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

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

2. Quality Division Update –Quality Report
   Recommended Action: Approve/Disapprove

C. Conference with Legal Counsel regarding BETA Claim No. 21-001701
Recommended Action: Approve/Reject BETA Claim No. 21-001701

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

E. Conference with Legal Counsel
Recommended Action: Action taken at Board's discretion

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

G. Conference with Legal Counsel about recent work product
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. 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.

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, then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board.

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
June 28, 2022

VIII. Approval of Minutes

A. May 24, 2022 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove May 24, 2022 Minutes of the Regular Meeting of the Board of Directors

B. June 13, 2022 Minutes of the Special Meeting of the Board of Directors
Recommended Action: Approve/Disapprove June 13, 2022 Minutes of the Special Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. **Infection Prevention Report**
Recommended Action: Information only; no action taken

B. **May 2022 Financials**
Recommended Action: Approve/Disapprove

C. **Investment Report**
Recommended Action: Approve/Disapprove

D. **SVLHCD Fiscal Year 2023 Operating Budget**
Recommended Action: Approve/Disapprove

E. **SVLHCD Fiscal Year 2023 Capital Budget**
Recommended Action: Approve/Disapprove

F. **Public Records Requests**
Recommended Action: Information only; no action taken

- *6/2/2022 Gaurang Pandya*
- *6/6/2022 Kelvin J. Souza on behalf of Family HealthCare Network*

XI. Announcements:

A. Regular Board of Directors Meeting – July 26, 2022 at 4:30pm

XII. Adjournment

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
June 28, 2022

SPECIAL NOTICE

Pursuant to Executive Order N-25-20 signed by Governor Newsom on March 12, 2020, and in an effort to protect public health and slow the rate of transmission of COVID-19, Sierra View Local Health Care District is allowing for electronic public participation at Regular Board Meetings. Public comments may be submitted to wwatts@sierra-view.com and will be read aloud during Public Comments as applicable, for Board consideration. Members of the public are encouraged to submit comments prior to 4:00 p.m. the day of the meeting to participate in said meeting.

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 Fuentes, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 5:00 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

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

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MEDICAL EXECUTIVE COMMITTEE	06/01/2022
BOARD OF DIRECTORS APPROVAL	
	06/28/2022
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
June 28, 2022 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**
• Admission Guidelines for the Ambulatory Surgery Department	1-2	↓
• Alaris System Cleaning and Disinfecting	3-6	
• Apgar Score	7-9	
• Management of Employee Illnesses and Exposures/Duty Restrictions	10-15	
• Nursing Care of Ventilator Patients on the Medical-Surgical Unit	16-19	
• Pyxis Access	20-22	
• Scabies	23-25	
• Suctioning – Naso-Orpharyngeal	26-28	
• Targeted Temperature Management (TTM) – Therapeutic Hypothermia	29-33	

SUBJECT:	SECTION:
ADMISSION GUIDELINES FOR THE AMBULATORY SURGERY DEPARTMENT	**Page 1 of 2**

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

PURPOSE:

To provide guidelines for appropriate patient admissions to the Ambulatory Surgery Department.

POLICY:

1. Anesthesia Patient Classification Criteria will be used to identify appropriate patients for the Ambulatory Surgery Setting. (See Anesthesia Patient Classification Policy.)

2. Class I and Class II will be done without restriction. Class III cases can be performed with appropriate consultation between the physician/surgeon and the anesthesiologist. Class IV and Class V will not be done in the Ambulatory Surgery Department.

   Definitions:

   a. Class I-A normally healthy patient for an elective procedure. A Class I patient has no organic, physiological, biochemical or psychiatric disturbance. The pathologic process for which the operation is to be performed is localized and not conductive to systemic disturbance.

   b. Class II- A patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiological processes. Examples would be the presence of mild diabetes which is treated by pill or diet, mild essential hypertension, moderate obesity and chronic bronchitis.

   c. Class III- A patient with severe systemic disease that limits activity but is not incapacitating. The Class III patient is one who has a rather severe systemic disturbance or pathology from whatever cause. Examples might be diabetes requiring insulin management, moderate to severe degrees of pulmonary insufficiency, severe hypertension that is difficult to manage, angina or recently healed myocardial infarction.

3. Children will be three years of age and above. Anesthesia will review charts of patients under 5 years of age prior to date of surgery.

4. Preoperative workup requirements will be given by the surgeon/anesthesiologist.

5. The anesthesiologist reserves the right to postpone any elective case that is medically unfit for surgery, including non NPO status.

6. Local Anesthesia with or without General Anesthesia Standby, IV Regional, and General Anesthesia may be used in the provision of care at the Ambulatory Surgery Department.

7. Procedural Sedation may be administered by the Registered Nurse, under the direction and orders of the Surgeon. Guidelines have been established by the Medical Director. A second RN will perform circulating duties.

8. Surgical procedures scheduled should be those that are typically completed in less than 120 minutes and require less than 4 hours recovery time at the discretion of Anesthesia.

9. Patients who receive procedural sedation or any type of ~~a general~~ anesthesia should identify a responsible adult to care for them in the first 24 hours after discharge.

10. Patients with infections or communicable diseases requiring extensive isolation precautions, morbid obesity~~y~~, ~~history~~and history of difficult intubations or latex allergies will be eligible for admission to the Ambulatory Surgery Department at the discretion of Anesthesia.

~~10.~~11. Patients with a BMI greater than 50 must have their procedure completed at the hospital in the main operating room with an anesthesia provider.

AFFECTED AREAS/PERSONNEL:

AMBULATORY SURGERY DEPARTMENT PERSONNEL AND MEDICAL STAFF

CROSS REFERENCES:

- ANESTHESIA PATIENT CLASSIFICATION
- SCOPE AND COMPLEXITY OF SERVICES AT THE AMBULATORY SURGERY DEPARTMENT

~~California Code of Regulations (2019). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.~~

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SIERRA VIEW MEDICAL CENTER

House Wide Policy & Procedure Manual

SUBJECT:	SECTION:
ALARIS SYSTEM CLEANING AND DISINFECTING	***Infection Prevention (IP)*** **Page 1 of 4**

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

PURPOSE:

To establish infection prevention guidelines for the cleaning, decontamination and disinfection of ~~specific~~ BD Alaris System ~~equipment~~devices, including components such as IV pumps, syringe pumps, Modules such as the inter-unit interface connectors (IUI), PCAs, IV poles, ~~and~~ feeding pumps, etc.

IMPORTANT: *Always follow the manufacturer's instructions for use (MIFU) of the specific Alaris System user's manual.*

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POLICY:

Sierra View Medical Center (SVMC) is dedicated to minimizing the risk of healthcare--acquired infection by following established~~ing guidelines~~ MIFUs for ~~the~~ cleaning and disinfecting~~ion of~~ equipment. This policy provides guidelines for the recognition of clean and soiled equipment and for storage after use or cleaning. The following procedures define and establish generalized standards for assuring non-critical ~~(defined by Centers for Disease Control and Prevention (CDC) as items that come into contact with intact skin but not mucous membranes),~~ shared patient care equipment is clean before use and that all used equipment is appropriately cleaned before reuse. (The Centers for Disease Control and Prevention (CDC) utilizes Spaulding Classification System which defines non-critical items as those that come into contact with intact skin but not mucous membranes).

AFFECTED PERSONNEL/AREAS: *HOUSEWIDE*

ACCOUNTABILITY:

1. Final accountability for all aspects of cleanliness rests ~~with Clinical~~with Clinical Leadership.

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2. The Director of Environmental Services and departmental Managers/Directors are responsible for ensuring that environmental service is performed in accordance with ~~manufacturer's~~ MIFU guidelines and hospital disinfectants considered safe for use on Alaris System devices.

3. Nursing, in conjunction with Environmental Services, ~~is~~ are responsible to ensure all patient equipment is cleaned between patients, after patient use, and after any contact with blood or ~~other~~any other body fluids.

4. Environmental staff is responsible for ~~the~~ cleaning ~~of~~ the pumps and all parts of the device, after each ~~patient~~ use and between patients after nursing has removed all ~~remaining~~ IV bags and tubing from the IV pump and pole.

STANDARDS of CLEANLINESS:

~~1.~~ At ~~a~~ minimum, the standard of cleanliness is that all parts of pumps, modules, PCAs, syringe pumps and feeding pumps, (including underneath the device housing and the pump cord) should be visibly clean with no blood ~~and~~ or body substances, dirt, debris, dust, adhesive tape, stains or spillages.

PROCEDURE: These are general instructions, always follow the MIFUs of the specific Alaris System user's manual.

1. Turn instrument off and unplug

~~1.~~2. Instruments and other equipment must be maintained in an upright position.

2.3. Inspect equipment parts for damage (~~,~~including c~~C~~racked or broken door, case, handle, latch, or Inter-Unit Interface Connector (IUI)~~)~~. Report damage to biomed

3.4. ~~Instruments and other equipment must be maintained in an upright position.~~ No part is to be saturated or ~~submersed~~submerged with cleaning fluid or ~~/~~disinfectan~~ting fluid~~.

~~4.~~5. ~~Wearing~~ After doning gloves, clean all exposed surfaces with manufacturer and hospital approved disinfectant. A dedicated s~~S~~oft brush may be used for hard to reach and narrow areas or to remove hardened organic deposits.

~~5.~~6. After cleaning, disinfect with approved sani-cloth, follow ~~manufacturer's direction~~MIFUs for length of contact time. After contact time, ~~if~~ remove residue remains~~. remove~~ with a soft damp cloth ~~dampened with water~~.

~~6.~~7. Remove any adhesive residue using 70% isopropyl alcohol.

~~7.~~8. All parts of the pumps are to be cleaned and disinfected, including the power cord, the entire pole, base, and wheels.

~~8.~~9. The appearance of any r~~R~~ust must be reported to a supervisor.

~~9.~~10. When cleaning is complete, tags indicating cleanliness will be placed on machine stating date of cleaning and initialed by the~~initials of~~ person who cleaned and inspected the device~~pump~~.

~~10.~~11. Pumps and at least one module will be cleaned and left in patient room.

~~11.~~12. After devices have been clean~~ed~~~~ing~~ and tagged, extra pumps and modules will be ~~cleaned and~~ stored in each unit.

Inter-unit interface connectors (IUIs) on pumps must be cleaned between all patients, as needed, following manufacturer's guidelines (i.e. evidence of rust, corrosion, or blue/green deposits).

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Process is as follows:

1) Nursing ~~would~~ will remove all bags and tubings from the pump.

2) Nursing ~~would~~ will separate module(s) from the Brain (the main IV pump) and check for any corrosion or blue/green deposits on IUI connectors. If this is found, then nursing ~~would~~ will send the devices to Central Processing for cleaning* of the IUI connectors as ~~per manufacturer's guidelines~~per MIFUs.

3) If ~~looks~~ the device is free of any corrosion or ~~blue/green~~ deposits, ~~then~~ set the module aside until EVS completes the cleaning process. EVS will clean ~~all of the outside~~the external components of the device including the pump, ~~/~~modules, ~~/~~pole, and the cord with ~~purple topped wipes~~the appropriate approved disinfectant wipes.

4) Once EVS completes the cleaning process, ~~they will~~the device will be tagged indicating ~~'tag'~~ that the device ~~pump~~ is clean

5) ~~Biomed~~ The Biomed technician ~~would~~ will check pumps on an ~~'~~annual basis~~'~~ unless ~~needed~~ the device requires ~~for~~ repair

~~*Inter-unit interface~~IUI connectors ~~(IUI)~~ are ~~to be~~ cleaned with 70% isopropyl alcohol. Use a dedicated soft-bristle brush if needed. Allow instrument and IUI connectors to dry completely before next use.

REFERENCE:

- Rational Approach | Disinfection & Sterilization Gudelines (retrieved 5/17/2022. last reviewed 2016. published 2008. https://www.cdc.gov/infectioncontrol/guidelines/disinfection/rational-approach.html)
- ~~Alaris (2016). Alaris System Cleaning & Disinfecting~~Best Practices for Cleaning Alaris System Devices - BD. Quick-guides for all Alaris devices (retrieved 5/17/2022. published 2014. https://www.bd.com/documents/international/guides/quick-guides/infusion/IF_Best-practices-for-cleaning-Alaris-System-devices_QG_EN.pdf

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- Best Practices for Cleaning Alaris System Devices - BD. Quick-guides for all Alaris devices (retrieved 5/17/2022, published 2017. https://www.bd.com/documents/guides/tip-sheets/IF_Alaris-System-Cleaning-Products-Guidelines_TS_EN.pdf)
- Best Practices for Cleaning Alaris System Devices - BD. Quick-guides for all Alaris devices (retrieved 5/17/2022, published 2020. https://www.bd.com/content/dam/bdcom-assets/en/en-us/documents/training/MMS_IF_Alaris-System-Devices-Training-Checklist-for-Best-Practices-Cleaning_TS_EN.pdf)
-
- California Code of Regulations, 22 CCR § 70015, 22 CCR § 70025, 22 CCR § 70739 and 22 CCR § 70827. Social Security, current through Register 2022, Notice Reg. No. 17, April 29, 2022. (https://casetext.com/regulation/california-code-of-regulations/title-22-social-security/division-5-licensing-and-certification-of-health-facilities-home-health-agencies-clinics-and-referral-agencies/chapter-1-general-acute-care-hospitals/article-7-administration)
- ~~California Code of Regulations, Title 22, Social Security, Section 70015, 70025, 70739, 70827.~~

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CROSS REFERENCE:

- Environmental Facility Cleanliness

SUBJECT: **APGAR SCORE**	SECTION: **Page 1 of 3**

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

PURPOSE:

To set nursing guidelines and parameters for Apgar scoring.
To provide an accepted method of reporting the status of the newborn immediately after birth and the response to resuscitation.

POLICY

Apgar scores will be performed on newborns to:

- Provide a systematic and consistent method for assessing the newborn's adjustment to ~~extrauterine~~extra uterine life.
- Provide a method of predicting which infants will require more intensive observation in the nursery.
- Apgar scores will be obtained at 1 minute, 5 minutes after birth. If after birth the 5 minute Apgar score is less than 7, additional scores should be assigned every 5 minutes for up to 20 minutes.
- Apgar scores during resuscitation should be collaborated between the physician, respiratory therapist and the registered nurse who participated in the resuscitation of the newborn.

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AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT, RESPIRATORY CARE DEPARTMENT, REGISTERED NURSES (RN)s, RESPIRATORY THERAPISTS (RT)s*

Sign	Score 0	Score 1	Score 2
Heart Rate	Absent	Less than 100	Greater than 100
Respiratory Effort	Absent	Slow, Irregular Weak Cry	Good Crying
Muscle Tone	Limp	Some flexion of extremities	Active motion, well flexed
Reflex Irritability	No response	Grimace	Vigorous cry
Color	Blue or pale	Body pink, hands and feet blue	Completely pink

PROCEDURE:

1. A score of 0 to 2 is assigned to each item. The total of the five individual assessments is the Apgar score.
2. A total score of 0 to 3 represents severe distress.
3. A total score of 4 to 6 signifies ~~moderate~~moderately abnormal. ~~difficulty.~~
4. A total score of 7 to 10 indicates reassuring ~~adjusting well to extrauterine life~~

5. Evaluations are conducted, minimally, at one and five minutes after delivery of the entire body. If after birth the 5 minute Apgar score is less than 7, additional scores should be assigned every 5 minutes for up to 20 minutes. If Apgar score is 5 or less at 5 minutes, umbilical arterial blood gas samples from a clamped section of the umbilical cord should be obtained.

6. The individual components are evaluated as follows:

   a. ***Heart Rate:*** The heart rate is just as sensitive an indication of hypoxia after birth as it is in utero. A rate below 100 beats per minute is associated with severe asphyxia (lack of oxygen or high carbon dioxide). Initially the heart rate should be counted for at least 6 seconds and multiplied x 10 following the Neonatal Resuscitation guidelines. If the heart rate is below 10 in 6 seconds (100), resuscitation can be started immediately. A score of 2 is assigned if the heart rate exceeds 100, a score of 1 is given if it is below 100 and if no heart beat is detected, the score is 0. If it is less than 100 beats per minute, an urgent need for resuscitation exists.

   b. ***Respiratory Effort:*** Regular respirations and a vigorous cry merit a score of 2. If respirations are irregular, shallow or gasping, a score of 1 is appropriate, where 0 indicates the complete absence of any respiratory effort (apnea).

   c. ***Muscle Tone:*** Muscle tone refers to the degree of flexion and the resistance offered to straighten the extremities. The normal infant's elbows are flexed and his/her thighs and knees are drawn up toward the abdomen (flexed hips). In addition, some degree of resistance is encountered when one attempts to extend the extremities. The normal muscle tone is assigned a score of 2. At the other extreme, an asphyxiated infant is limp and there is no resistance to straightening of the extremities nor is there any semblance of flexion at rest. This state of muscle tone score is 0. Muscle tone that is intermediate, between normal and limp asphyxiated states, is given a score of 1.

   d. ***Reflex Irritability:*** Reflex irritability is determined ~~judged~~ by the infant's response to flicking the sole of the foot or nasal suctioning by catheter or bulb. If the infant cries, a score of 2 is given. If the infant only grimaces or cries feebly, a score of 1 is given. If there is no response, the score is 0.

   e. ***Color Evaluation***: Color evaluation is directed to the presence or absence of pallor and cyanosis. Only a few infants are completely pink, they are assigned a score of 2. Most babies are given a score of 1 because normally their hands and feet are blue, whereas the rest of the body is pink (acrocyanosis). Pallor and cyanosis over the entire is scored 0.

DOCUMENTATION:

Apgar scores are documented in the electronic medical record (EMR) under interventions; OB delivery summary and in the Newborns EMR under interventions; Apgar scoring assessment.

REFERENCE:

- American Academy of Pediatrics & American College of Obstetrics and Gynecologist. (2017). Guidelines for perinatal care (8th Ed.). Elk Grove Village, IL: Authors.
- The Joint Commission (2018). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Kennedy, B. B., & Baird, S. M. (2017). Intrapartum management modules: A perinatal education program (5th ed.). Philadelphia: Wolters Kluwer

SUBJECT:	SECTION:
MANAGEMENT OF EMPLOYEE ILLNESSES AND EXPOSURES/DUTY RESTRICTIONS	**Page 1 of 6**

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

PURPOSE:

To provide guidance for management of infectious illnesses among health care personnel (HCP) in order to ensure a safe environment for personnel, patients, volunteers and visitors.

POLICY:

Sierra View Medical Center (SVMC) shall implement measures to prevent further transmission of infectious illnesses by HCP, which sometimes warrants exclusion of personnel from work or patient contact. Employee Health Services (EHS), Infection Prevention or a designee, such as the ~~(~~ House Supervisor,~~)~~ have authority to temporarily exclude personnel from duty if it is determined that there is risk of transmission to other personnel and/or patients.

AFFECTED AREAS/PERSONNEL: *ALL HCPs, VOLUNTEERS*

PROCEDURE:

1. HCP will report to EHS in person or by phone, independently or as directed by a department manager or supervisor for evaluation of any actual or suspected illness or infection. ~~independently or as directed by a department manager or supervisor~~. When EHS and Infection Prevention are closed, the HCP will report to the House Supervisor.
2. Determine if illness or infection is included in the Disease/Problem list. (See attachment entitled: *Guideline For Infection Control*~~: Table 3~~)
3. Use ~~exclusion~~ criteria as identified in attachment to determine duty restriction or exclusion.
4. If excluded from duty, HCP may choose to either visit the Emergency Department voluntarily, or their primary care provider to obtain clearance to return to work.
5. Refer HCP to Human Resources for guidance on obtaining primary provider clearance to return to work, as well as obtaining information regarding wages, benefits or job status during restriction.

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REFERENCES:

- ~~American Journal of Infection Control (AJIC) (2013). *Summary of suggested work restrictions for health-care personnel exposed to or infected with infectious disease of importance in healthcare settings.* Retrieved on May 09, 2019 from nebula.wsimg.com/3ee2f79b5eba6189105921 6e904469a3?Access...~~
- ~~California Code of Regulations, Title 22, Section 70723~~
- ~~The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.~~
- Bader, M. S., Brooks, A., Kelly, D. V., & Srigley, J. A. (2017). Postexposure management of infectious diseases. *Cleveland Clinic journal of medicine, 84*(1), 65–80. DOI: https://doi.org/10.3949/ccjm.84a.15049
- Bolyard, E.A., Tablan, O.C., Williams, W.W., Pearson, M.L., Shapiro, C.N, Deitchman, S.D., The Hospital Infection Control Practices Advisory Committee (1998). Guideline for infection control in health care personnel, 1998. *AJIC, 26(3), 289-354.* DOI: https://doi.org/10.1016/S0196-6553(98)80015-1
- California Code of Regulations, Title 22. Social Security Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies Chapter 1. General Acute Care Hospitals. AFL-20-08-Attachment-02. Title 22, Section 70723. https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-08-Attachment-02.pdf

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~~TABLE 3:~~ **GUIDELINE FOR INFECTION CONTROL (AMERICAN JOURNAL OF INFECTION CONTROL)**
~~SUMMARY~~ THIS TABLE SUMMARIZES ~~OF~~ SUGGESTED WORK RESTRICTIONS FOR HEALTHCARE PERSONNEL EXPOSED TO OR INFECTED WITH INFECTIOUS DISEASES OF IMPORTANCE IN HEALTHCARE SETTINGS, IN THE ABSENCE OF STATE AND LOCAL REGULATIONS (TAKEN FROM TABLE 3. FROM BOLYARD, *ET AL*... MODIFIED BY THE AMERICAN JOURNAL OF INFECTION CONTROL (AJIC) FROM ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS)

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Disease/Problem	Work Restrictions	Duration
Conjunctivitis	Restrict from patient contact and contact with the patient's environment	Until discharge ceases
Cytomegalovirus infections	No restriction	
Diarrheal diseases		
Acute stage (diarrhea with other symptoms)	Restrict from patient contact, contact with the patient's environment, or food handling	Until symptoms resolve
Convalescent stage, *Salmonella* species	Restrict from care of high-risk patients	Until symptoms resolve; consult with local and state health authorities regarding need for negative stool cultures
Diphtheria	Exclude from duty	Until antimicrobial therapy completed and two cultures obtained ≥ 24 hours apart are negative
Enteroviral infections	Restrict from care of infants, neonates, and immuno-compromised patients and their environments	Until symptoms resolve
Hepatitis A	Restrict from patient contact, contact with patient's environment, and food handling	Until 7 days after onset of jaundice
Hepatitis B		
Personnel with acute or chronic Hepatitis B surface antigemia who do not perform exposure-prone procedures	No restriction; refer to state regulations; standard precautions should always be observed	
Personnel with acute or chronic Hepatitis B e antigenemia who perform exposure-prone procedures	Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into	Until Hepatitis B e antigen is negative

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Disease/Problem	Work Restrictions	Duration
	account specific procedure as well as skill and technique of worker; refer to state regulations	
Hepatitis C	No recommendation	
Herpes simplex		
Genital	No restriction	
Hands (herpetic whitlow)	Restrict from patient contact and contact with the patient's environment	Until lesions heal
Orofacial	Evaluate for need to restrict from care of high-risk patients	
Human immuno-deficiency virus	Do not perform exposure-prone invasive procedures until counsel from an expert panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of the worker. Standard Precautions should always be observed; refer to state regulations.	
Measles		
Active	Exclude from duty	Until 7 days after the rash appears
Postexposure (susceptible personnel)	Exclude from duty	From 5th day after first exposure through 21st day after last exposure and/or 4 days after rash appears
Meningococal infections	Exclude from duty	Until 24 hours after start of effective therapy
Mumps		
Active	Exclude from duty	Until 9 days after onset of parotitis
Postexposure (susceptible personnel)	Exclude from duty	From 12th day after first exposure through 26th day after last exposure or until 9 days after onset of parotitis
Pediculosis	Restrict from patient contact	Until treated and observed to be free of adult and immature lice
Pertussis		
Active	Exclude from duty	From beginning of catarrhal stage through 3rd week after onset of paroxysms or until 5 days after start of effective antimicrobial therapy
Postexposure (asymptomatic personnel)	No restriction, prophylaxis recommended	

Disease/Problem	Work Restrictions	Duration
Postexposure (symptomatic personnel)	Exclude from duty	Until 5 days after start of effective antimicrobial therapy
Rubella		
Active	Exclude from duty	Until 5 days after rash appears
Postexposure (susceptible personnel)	Exclude from duty	From 7th day after first exposure through 21st day after last exposure
Scabies	Restrict from patient contact	Until cleared by medical evaluation
Staphylococcus aureus infection		
Active, draining skin lesions	Restrict from contact with patients and patient's environment or food handling	Until lesions have resolved
Carrier state	No restriction, unless personnel are epidemiologically linked to transmission of the organism	
Streptococcal infection, group A	Restrict from patient care, contact with patient's environment, or food handling	Until 24 hours after adequate treatment started
Tuberculosis		
Active disease	Exclude from duty	Until proved noninfectious
PPD converter	No restriction	
Varicella		
Active	Exclude from duty	Until all lesions dry and crusted
Postexposure (susceptible personnel)	Exclude from duty	From 10th day after first exposure through 21st day (28th day if VZIG given) after last exposure
Zoster		
Localized, in healthy person	Cover lesions; restrict from care of high-risk patients	Until all lesions dry and crust
Generalized or localized in immunosuppressed person	Restrict from patient contact	Until all lesions dry and crust
Postexposure (Susceptible personnel)	Restrict from patient contact	From 8th day after first exposure through 21st day (28th day if VZIG given) after last exposure or, if Varicella occurs, until all lesions dry and crust

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Disease/Problem	Work Restrictions	Duration
Viral respiratory infections, acute febrile	Consider excluding from the care of high-risk patients or contact with their environment during community outbreak of RSV and influenza	Until acute symptoms resolve

SUBJECT: **NURSING CARE OF VENTILATOR PATIENTS ON THE MEDICAL-SURGICAL UNIT**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 4**

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

PURPOSE:

To assure safe, comprehensive quality care to patients requiring continuous ventilator assistance outside of the critical care setting.

POLICY:

Patients who are ventilator dependent will be cared for in a safe and competent manner outside the critical care setting.

Patient Eligibility:

- Does not meet criteria for weaning parameters
- Full DNR (No Code)
- Does not require cardiac monitoring (i.e. Telemetry)

AFFECTED AREAS / AUTHORIZED PERSONNEL: *MED-SURG UNIT; TELEMETRY*

EQUIPMENT REQUIRED:

- Ambu bag with adult mask at bedside at all times
- **2** Spare Trach sets with ties (Trached patients only) at bedside at all times (same size and size smaller) – RT accountable to ensure availability
- Continuous Pulse Oximeter

PROCEDURE:

1. Upon the attending physician's order, a patient who is dependent on ventilator assistance but does not require critical care services may be placed on the medical unit.
2. Licensed nurses rendering care to these patients will be able to demonstrate competence in:
   a. Mechanical ventilator operations
   b. Basic lung auscultation; and
   c. Closed continuous tracheal suction systems.
   d. Be familiar with and competent in all other policies and procedures associated with the care of this particular patient.

3. Nursing personnel will be aware of ventilator parameters as ordered by the physician.

4. Nursing will notify Respiratory Therapy (RT) personnel should ventilator alarms continue to alarm. Nursing will remove the patient from the ventilator and apply bag-valve ventilation if:

   a. Ventilator continues to show low pressure alarm;

   b. Ventilator is in-operative or indicates gas pressure alarm; or

   c. If there is a deterioration of the patient's condition and/or status.

5. Patient assessments will be done minimally once every 12 hours and documented in the 24-hour record.

6. In accordance with established Respiratory Therapy Department policies and procedures:

   a. R.T. personnel will regulate ventilator settings – NO EXCEPTIONS!

   b. All patients on ventilators will be monitored by R.T. at least every 4 hours per their departmental policies.

   c. Maintenance of ventilator equipment and supplies is the responsibility of the RT department.

NURSING INTERVENTIONS

1. Maintain endotracheal tube and/or trach tube are maintained securely.

2. Suction and clean airway apparatus as indicated to maintain patency. Suction patient every 2 hours and PRN. Only suction for a 15-second period at any one time.

3. Prior to suctioning the patient, the nurse must:

   a. Instruct the patient on procedure to be performed.

   b. Comply with established suctioning policies and procedures regarding special instructions

   c. Keep water emptied from tubing and trap. (Never turn patient without emptying first.)

   d. Evaluate ventilatory pattern for rate, quality, signs of respiratory distress, or inappropriate inspiratory to expiratory ratio (should be at least 1:1).
   NOTE: patient chest movement needs to be equal for both sides of the chest. Be aware if patient has any spontaneous respirations.

e. Monitor patient for signs of fighting the ventilator, which indicates that the patient's respiratory cycle is inconsistent with the mechanical cycle; may be due to pain, hypoxia, secretions, fear or anxiety.

SOLUTION: clear airways as indicated or give sedatives as ordered.

f. Ensure that the alarms are always turned on. NO EXCEPTIONS!

g. Carefully check all connections of the ventilator tubings to assure that they are tightly secured.

h. Notify the R.T. department if alarms continue to be set off. If RT is unable to respond immediately or if any concerns arise as to the effectiveness or operations of the ventilator, remove the patient from the ventilator and manually ventilate the patient with an ambu resuscitation bag.

i. Assure at all times that the ventilator is plugged into a red outlet (due to the emergency generator system). NO EXCEPTIONS!

j. Position patient so that all lobes of the lungs are adequately ventilated and perfused.

k. Reposition patient every 2 hours; rotate positioning from right to left lateral positions to a semi-fowler's position.

l. Monitor breath sounds for presence and quality. Assess patient's lung fields for rales, rhonchi, wheezing, etc. every 4 hours being alert to any changes in the lung field.

m. Assure patient that he/she is not alone. Let the patient know that people are near and if they need assistance, nurses will respond rapidly.

- Provide call bell for immediate access.
- Assure patient that adequate ventilation is being provided.
- Provide means for patient to write messages as appropriate.

PATIENT EDUCATION

- Explain all procedures to the patient and why.
- Answer their questions.
- Involve family when applicable.

DOCUMENTATION

1. In the nursing notes:
   a. Problems identified.
   b. Interventions given.
   c. Evaluation of treatment(s).
   d. Document respiratory assessment and characteristics of sputum.
2. On Patient Care Profile
   a. Document type of ventilator with settings and frequency of suctioning.

REFERENCES:

Nettina SM. Respiratory Function and Therapy: Mechanical Ventilation. In: *Lippincott Manual of Nursing Practice*. Philadelphia etc.: Wolters Kluwer; 2019:181-184.

CROSS REFERENCE:

- TRACHEOSTOMY CARE

SUBJECT:	SECTION:
PYXIS ACCESS	***Medication Management (MM)***

PURPOSE:

To describe the management of Pyxis access privileges, to define what personnel will have access to Pyxis, and the termination process.

POLICY:

1. Access privileges to Pyxis shall be managed to ensure adequate security for medications, including controlled substance, to provide for proper and appropriate documentation of medication use.

2. A Pyxis user is defined as anyone with access to Pyxis. User templates will be created based on job titles; each user will be assigned user templates with specific access rights based upon their job duties.

3. Access privileges will be terminated immediately whenever the employee no longer works for the hospital.

4. Staff to complete a Pyxis Tutorial prior to Pyxis access being granted.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, RESPIRATORY THERAPY, ANESTHESIA, EDUCATION*

PROCEDURES:

Access Definition

1. User access may be requested for the following hospital staff:
    a. Pharmacist
    b. Pharmacy Technician
    c. RN Clinical Director/ Manager
    d. Charge Nurse
    e. Staff Nurse
    f. Nursing Instructor
    g. Respiratory Therapist
    h. Anesthesiologist
    i. CRNA (Certified registered nurse anesthetist)

j. Medical Assistants in Urology Clinic

k. Medical Assistants in Rural Health Clinic

l. Medical Assistants at Academic Health Center

m. Medical Assistants at Surgery Clinic

n. IR Technician

o. Medical Imaging Technologist

p. Ultrasonographers

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2. The pharmacy department shall designate an individual as the system manager. The system manager or designee will be responsible for creating and maintaining user template. The template will be reviewed and approved by the pharmacist in charge prior to activation.

Request Access

1. Regular

   a. Access to Pyxis will be requested by the department director and/or manager on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the FormStack database for an existing employee.

   b. Access Right will be assigned by Pharmacy System Manager based on employee's position.

   c. Anesthesiologist, Midwife, and CRNA

      - Access to Pyxis will be requested by Medical Staff on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the Formstack database for an existing employee.

2. Travelers

   a. Access by travelers will have access for only the length of their contract. Their access will automatically terminate on the date their contract expires.

   b. Upon hire, human resources will initiate the Access Request form with the Traveler's name, user name, and date the contract will begin and expire.

c. Once the Access Request has been approved by Department Director, and sent to pharmacy via IT, access will be assigned by Pharmacy System Manager.

d. If a traveler's contract is extended beyond the original time specified, an Access Update form will be initiated by Human Resources at the time the contract is renewed. The form, which including the new contract dates (beginning and expiration dates), will be sent on for approval in the usual manner.

3. Temporary

a. A charge nurse may set up temporary users. These temporary users are given access to the particular Display Terminal (DT) for a limited timeframe (14 hours) with specified rights.

b. Temporary users include any nurse that has floated to a department where access has not been assigned.

c. Float Nurses and Registry Nurses will be given access for 14 hours to cover assign shift in the department only.

d. Traveling Nurse may be given Temporary Access for up to 14 hours if access for length of contract has not yet been approved.

Termination of Access

1. For routine voluntary termination, once the department director or manager receives the notice, a Termination Notice form located in the Approval Database in the Formstack database will be filled out by department director or manager and sent to Human Resources. Human Resources will forward this information to Pharmacy System Manager. Pharmacy System Manager will disable the user's login privileges at the end of the last scheduled day of work.

2. For immediate termination without advance notice, human resources will contact pharmacy immediately. Pharmacy System Manager or designee will disable the user's access privilege right away. The department director or manager will still need to fill out the Termination Notice form. If immediate access removal is needed after pharmacy operating hours, the house supervisor will contact the on-call pharmacist who will remove Pyxis access for that user.

REFERENCE:

- Hospital Accreditation Standards. (2021). Oak Brook, IL: Joint Commission Resources, Inc.

SUBJECT: **SCABIES**	SECTION: **Page 1 of 3**

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

PURPOSE:

To determine if an employee has had an ~~valid~~ exposure to or has ~~acquired~~ become infested with scabies. To provide guidelines for the appropriate treatment for ~~valid~~ an exposure that results in a /confirmed infestation of scabies.

POLICY:

Employees will receive appropriate evaluation and treatment for suspected and/or confirmed scabies infestation.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

GENERAL INFORMATION:

Scabies is a disease of the skin caused by the mite *Sarcoptes ~~scabies~~scabiei*. Transmission occurs primarily through prolonged skin-to-skin contact with an infested person. Transmission through c~~C~~asual ~~contact~~ or brief contact ~~through~~ with objects such as bedding or clothing has been reported to be infrequent~~ly~~. However, healthcare workers will require treatment if they have an ~~valid~~ exposure ~~and/or~~that is followed by ~~show~~ signs of infestation.

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The initial lesion is a burrow ½ to 2 cm in length. A burrow is a minute, slightly raised tunnel in the epidermis ~~and~~ that may end in a vesicle. Skin lesions often include small papules, pustules and/or excoriation.

The most common symptoms after infestation are intense itching and rash. The itching is often worse at night. Lesions commonly occur on the hands, webs of fingers, wrists, ~~and~~ the extensor surfaces of elbows and knees, the outer surfaces of feet, armpits, buttocks and waist.

INCUBATION PERIOD:

~~The~~ Symptoms begin to show about 3-6 weeks after the initial ~~incubation~~ infestation period ~~for primary infestation is 3-6 weeks~~. If previously infested, symptoms may begin to show up as soon as 1-4 days after re-exposure due to sensitization.

PERIOD OF ~~COMMUNICABILITY~~TRANSMISSIBILITY:

Even without symptoms, scabies is considered to be transmissible until mites and eggs are destroyed by treatment. ~~Until mites and eggs are destroyed by treatment, it is still considered to be communicable.~~ One A single treatment is usually effective in eradicating the mite infestation. However, a~~A~~ second treatment one week later may be indicated for some individuals.

PROCEDURE:

1. Infection Prevention should be notified w~~W~~hen a patient is diagnosed with scabies either by a physician ~~diagnosis~~ or by confirmation via a skin scraping~~. Infection Prevention should be notified~~. Departments that have had contact with the patient will be ~~identified~~ notified of the event by Infection Control. The Director (or the Director's /d~~D~~esignee) will identify individual employees that must be notified of the exposure and give instructions for follow up.

2. Employees who have had prolonged skin-to-skin contact with the patient or who develop symptoms of scabies will report to Employee Health Services (EHS) for assessment~~.~~ -and sent for physician evaluation.

3. The EHS Nurse will review and document history and allergies.

4. EHS Nurse will assess skin appearance, location of rash and type of exposure. If an employee develops a rash with a differential diagnosis of scabies, the employee will be sent for physician evaluation and treatment if ~~needed~~necessary.

5. Employees with a positive diagnosis of scabies are not to work for a minimum of 24 hours ~~from~~ after the ~~time of~~ completed treatment.

   a. ~~Employee's~~ Instructions to the employee should include the following:

      - Wash all clothing, towels, bedding and other linen using the hot cycles of ~~both~~ the washer and the dryer. Clean upholstered furniture.
      - All household members and intimate contacts should be treated by their personal physician.
      - Pruritus may persist for as long as 2 weeks after treatment.
      - Notify EHS for continued symptoms.

REFERENCES:

- ~~Centers for Disease Control and Prevention (2017).~~ Parasites/Scabies. The Centers for Disease Control and Prevention. (Last reviewed on Nov. 2, 2010. Retrieved on ~~July~~ May ~~26~~12, 2022~~19~~, from https://www.cdc.gov/parasites/scabies/index.html)
- The Scabies Fact Sheet. Printable Resources. The Centers for Disease Control. (Last review May 24, 2021. Retrieved on May 12, 2022. from www.cdc.gov/parasites/scabies/fact_sheet.html)

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- Parasites/Scabies-Frequently asked questions (FAQs). Centers for Disease Control and Prevention (Last reviewed on Sept. 2, 20202018). ~~Parasites/Scabies-Frequently asked questions (FAQs).~~ Retrieved on ~~July~~ May 12, 2022 ~~26, 2019~~ from www.cdc.gov/parasites/scabies/gen_info/faqs.html)

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SUBJECT: **SUCTIONING –NASO-ORPHARYNGEAL**	SECTION: **Page 1 of 3**

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

PURPOSE:

To set guidelines in the use of suction catheter used to maintain clear nasal and oral passage and removal of any secretions.

POLICY:

To keep airways patent and free of secretions by gently suctioning nasopharynx with a suction catheter.

EQUIPMENT:

1. Gloves
2. Suction catheter/suction catheter kit
3. Sterile normal saline, preservative free
4. Stethoscope
5. Suction equipment and tubing
6. Oxygen, if indicated
7. Catheter Size Guidelines:

Age	Catheter Size
Neonate to 18 months	5-8 french
18 months to 7 years	8-10 french
7 years to 10 years	10-14 french
11 years and up	12-16 french

- Catheter should be one half the diameter of the child's airway
- Suction machine shall be set at lowest possible pressure level of clear secretions

PROCEDURE:

1. Indications for Suctioning:
   a. May hear gurgling of mucous or emesis in infant's mouth or throat.
   b. May see mucous or emesis in nose, mouth or throat.
   c. Infant may be struggling for air:
      - Head thrown back

- Eyes open and staring
- Stiff body motions

d. May be cyanotic.

2. Wash hands.

3. Explain procedure to parent/guardian, and child if applicable.

4. Place the infant's head lower than its chest and hyperextend the neck slightly.

5. To suction the pharynx:

   a. Measure from the child's nose to ear lobe (approximately distance)

6. Put on gloves.

7. Lubricate suction catheter with normal saline.

8. For patients using oxygen, give oxygen before and during suctioning.

9. Infants with thick secretions: instill 1-2 saline drops into infant's nares.

10. Insert suction catheter into the child's nose or mouth.

11. DO NOT apply suction when inserting the catheter.

    Note: Applying suction while inserting the catheter may cause a vagal response in the infant, leading to bradycardia and/or hypoxia and/or trauma to the infant's airway mucosa.

12. Listen to the patient's heart for possible bradycardia.

13. Apply suction and gently rotate catheter between your thumb and forefinger while slowly removing the catheter.

14. DO NOT suction for longer than five (5) seconds.

15. Rinse catheter between passes with saline.

16. Discard gloves and suction catheter in hazardous waste.

17. Flush suction tubing with sterile normal saline until clear.

18. Use suction trap when obtaining secretions for culture.

DOCUMENTATION:

- Patient's tolerance to the procedure
- Patient's respirations, breath sounds, color, respiratory effort before and after suctioning
- Secretions: amount, color, consistency and odor

REFERENCES:

- ~~Bowden, V~~Bowden, V. and Greenberg, C. (201~~6~~2). Lippincott, Pediatric Nursing Procedures forth Ed. ~~3~~3rd P.506-510 Philadelphia, PA. Lippincott Williams & Wilkins
- ~~Edition, Philadelphia, PA. Lippincott Williams & Wilkins~~

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SUBJECT:	SECTION:
TARGETED TEMPERATURE MANAGEMENT (TTM)- THERAPEUTIC HYPOTHERMIA	**1 of 5**

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

PURPOSE:

- To provide a clear outline for patients receiving Targeted Temperature Management (TTM) post cardiac arrest.
- To develop a clinical guideline outlining specific steps in inducing, maintaining, and rewarming patients for optimal neurological recovery.
- To reduce mortality and improve neurological outcomes for patients who achieve Return of Spontaneous Circulation (ROSC) after sudden cardiac arrest.

DEFINITIONS:

- Targeted Temperature Management (TTM) refers to the strict control of a patient's core temperature following cardiac arrest. TTM is also referred to as "Therapeutic Hypothermia".

POLICY:

1. To prevent reperfusion injury, TTM should be started as soon as possible following cardiac arrest
2. Temperature should be strictly kept between 33°C and 36°C during the maintenance phase
3. All patients undergoing TTM will be intubated

INCLUSION CRITERIA:

- Post cardiac arrest patients with Return of Spontaneous Circulation (ROSC)
- GCS of <8 and unresponsive and intubated

EXCLUSION CRITERIA:

- Awake and responsive to verbal commands
- GCS > 9
- Active GI bleed, DIC, or Intracerebral hemorrhage
- Uncontrolled cardiac arrhythmias
- Hemodynamic instability
- Major traumatic injury

AFFECTED PERSONNEL/AREAS: *Intensive Care Unit, Emergency Department, and Cardiac Cath Lab.*

EQUIPMENT:

- Hypothermia Unit and blankets
- Esophageal Probe
- Cardiac Monitor

PROCEDURE:

- Obtain a physician's order
- Documentation will take place under the "Therapeutic Hypothermia" intervention
- Obtain baseline labs and EKG (CBC, CMP, ABG, PT/INR, PTT, Troponin, Magnesium, Lactate)
- Complete a set of PAN cultures as ordered by physician (Sputum, Urine, Blood, Nares, MRSA)

INDUCTION PHASE:

1. Provide education to patient/family
2. Administer analgesia/sedatives as ordered
3. Insert esophageal temperature probe
4. Keep head of bed (HOB) at 30 degrees if patient tolerates
5. Set temperature on the hypothermia unit for automatic control
6. Observe patient for complications (goal is to reach 33°C to 36°C within four hours)
7. Monitoring of temperature and vital signs will occur every 15 minutes until reaching maintenance phase

MAINTENANCE PHASE:

1. Temperature should maintain between 33°C and 36°C for 24 hours.
2. Monitor temperature at minimum of every hour to maintain strict body temperature

REWARMING PHASE:

1. Rewarming should occur slowly, and not exceed 0.25°C per hour.
2. Monitoring of temperature and vital signs will occur every 15 minutes until normothermic
3. Hypothermia unit should be set to auto control at 37°C
4. Once patient reaches 36.5°C, the automatic warming should be discontinued
5. Pt should remain normothermic for 48 hours after reaching goal temperature (37°C)
6. Avoid hyperthermia

RISKS:

- Cardiovascular abnormalities (bradycardia, ventricular tachycardia, ventricular fibrillation, other dysrhythmias)
- Hyperglycemia
- Electrolyte imbalances (monitor magnesium and potassium)
- Bleeding
- Hypotension
- Impaired skin integrity
- Gastrointestinal abnormalities (ileus, aspiration)

REFERENCES:

Omairi, A. M. (2021, January 1). *Targeted Hypothermia Temperature Management*. StatPearls. June 16, 2021. https://www.ncbi.nlm.nih.gov/books/NBK556124/.

Taccone, F. S., Picetti, E., & Vincent, J.-L. (2020). High Quality Targeted Temperature Management (TTM) After Cardiac Arrest. *Critical Care*, *24*(1). https://doi.org/10.1186/s13054-019-2721-1

~~PURPOSE:~~

- ~~To provide a clear outline for patients receiving Targeted Temperature Management (TTM) post cardiac arrest.~~
- ~~To develop a clinical guideline outlining specific steps in inducing, maintaining, and rewarming patients for optimal neurological recovery.~~
- ~~To reduce mortality and improve neurological outcomes for patients who achieve ROSC after sudden cardiac arrest.~~

~~DEFINITIONS:~~

- ~~Targeted Temperature Management (TTM) refers to the strict control of a patient's core temperature following cardiac arrest. TTM is also referred to as "Therapeutic Hypothermia".~~

~~POLICY:~~

1. ~~To prevent reperfusion injury, TTM should be started as soon as possible following cardiac arrest~~
2. ~~Temperature should be strictly kept between 33°C and 36°C during the maintenance phase~~
3. ~~All patients undergoing TTM will be intubated~~

~~INCLUSION CRITERIA:~~

- ~~Post cardiac arrest patients with return of spontaneous circulation (ROSC)~~

~~EXCLUSION CRITERIA:~~

- ~~GCS > 9~~

~~AFFECTED PERSONNEL/AREAS:~~ ~~*Intensive Care Unit, Emergency Department, and Cardiac Cath Lab.*~~

~~EQUIPMENT:~~

- ~~Hypothermia Unit and blankets~~

- ~~Esophageal Probe~~
- ~~Cardiac Monitor~~

~~PROCEDURE:~~

- ~~Documentation will take place under the "Therapeutic Hypothermia" intervention~~

~~INDUCTION PHASE:~~

1. ~~Provide education to patient/family~~
2. ~~Administer analgesia/sedatives as ordered~~
3. ~~Insert esophageal temperature probe~~
4. ~~Set temperature on the hypothermia unit for automatic control~~
5. ~~Observe patient for complications (goal is to reach 33°C to 36°C within four hours)~~
6. ~~Monitoring of temperature will occur every 15 minutes until reaching maintenance phase~~

~~MAINTENANCE PHASE:~~

1. ~~Temperature should maintain between 33°C and 36°C for 24 hours.~~
2. ~~Monitor temperature at minimum of every hour to maintain strict body temperature~~

~~REWARMING PHASE:~~

1. ~~Rewarming should occur slowly, and not exceed 0.25°C per hour.~~
2. ~~Monitoring of temperature will occur every 15 minutes until normothermic~~
3. ~~Hypothermia unit should be set to auto control at 37°C~~
4. ~~Once patient reaches 36.5°C, the automatic warming should be discontinued~~
5. ~~Pt should remain normothermic for 48 hours after reaching goal temperature (37°C)~~
6. ~~Avoid hyperthermia~~

~~Risks:~~

- ~~abnormal heart rhythms~~
- ~~bradycardia~~
- ~~hyperglycemia~~
- ~~electrolyte imbalances~~
- ~~bleeding~~

~~REFERENCES:~~

~~Omairi, A. M. (2021, January 1). *Targeted Hypothermia Temperature Management*. StatPearls. June 16, 2021. https://www.ncbi.nlm.nih.gov/books/NBK556124/.~~

~~Taccone, F. S., Picetti, E., & Vincent, J. L. (2020). High Quality Targeted Temperature Management (TTM) After Cardiac Arrest. *Critical Care*, *24*(1). https://doi.org/10.1186/s13054-019-2721-1~~

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Senior Leadership Team	6/28/2022
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	6/28/2022 Date

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
June 28, 2022
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. Authorization for Uses and Disclosures of Protected Health Information	1-5	
2. Color Coding	6-7	
3. Commercial Insurance Billing	8-9	
4. Contingent Workforce	10-14	
5. Debt Collection and Referral; Patient Notification	15-20	
6. Facsimile Machine, Utilization of	21-22	
7. Job Posting	23-24	
8. Leadership Structured and Responsibilities – SC	25-26	
9. Limited Data Set and Data Use Agreements	27-29	
10. Management of Employees Illnesses and Exposures/Duty Restrictions	30-35	
11. Outside Employment	36-37	
12. Per Diem Protocol (Non-Exempt Employees)	38-41	
13. Policy and Procedure System	42-44	
14. Records Management	45-50	
15. Retrieval of Information/Disease and Operation Indices	51	
16. Self-Pay Discount	52-53	
17. Service Excellence Teams	54-55	
18. Signature, Initials or Computer Key Identification	56	
19. Staffing	57-58	
Forms:		
1. PHQ-2 Patient Health Questionnaire	59-60	

SUBJECT: **AUTHORIZATION FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**	SECTION: **Page 1 of 5**

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

PURPOSE:

To establish the requirements of Sierra View Medical Center (SVMC) to utilize patient authorizations to use or disclose protected health information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPPA), Standards of Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and all Federal regulations and interpretive guidelines.

POLICY:

- A patient's HIPAA compliant authorization is not required for a facility's own payment, treatment and limited healthcare operations activities.
- Per §164.508, an authorization for uses and disclosures of PHI must be obtained for:
  - Uses and disclosures of PHI to non-health care providers for treatment
  - Uses and disclosures of PHI to non-covered entities or health care providers for payment purposes
  - Disclosures of PHI beyond the first two paragraphs of health care operations definition
  - Disclosures of PHI limited to the first two paragraphs of the health care operations definition to non-covered entities
- Uses and disclosures for marketing except for:
  - Face-to-face communication made by the facility to an individual; or
  - A promotional gift of a nominal value provided by the covered entity;
- Uses and disclosures created for research that includes treatment for the individual unless an Institutional Review Board has waived the authorization requirement; and
- Psychotherapy notes except:
  - To carry out the following treatment, payment or health care operations:
    - Use by the originator of the notes for treatment;
    - Use or disclosure in training programs in which trainees, students, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or

- Use or disclosure by a facility to defend itself in a legal action or other proceeding brought on by an individual.

- Use and disclosure with respect to oversight of the originator of the notes.

- The provision of treatment or payment to an individual may not be conditioned on signing an authorization except for:

  - Research-related treatment;

  - Health care that is solely for the purpose of creating information for disclosure to a third party (e.g., employment drug testing).

- An individual may revoke an authorization in writing except to the extent that the facility has taken action in reliance thereon; or if an authorization was obtained as a condition of obtaining insurance coverage.

PROCEDURE:

1. A compliant authorization for all uses and disclosures outlined in the policy statement must be received before using or disclosing PHI.

2. A valid authorization must contain at least the following elements and statements (see Attachment for a sample form):

   a. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.

   b. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;

   c. The name or other specific identification of the person(s), or class of persons, to whom the facility may make the requested use or disclosure;

   d. A description of each purpose of the requested use or disclosure. "At the request of the individual" is sufficient when the individual initiates the authorization;

   e. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. "End of research study", "none", or similar language is sufficient to the authorization is for use or disclosure of PHI for research;

   f. A statement of the individual's right to revoke the authorization in writing and the exceptions to the right to revoke and a description of how the individual may revoke the

authorization or a reference to the facility's Notice of Privacy Practices for further instructions;

g. A statement that the provisions of treatment and payment may not be conditioned on obtaining this authorization unless otherwise allowed (e.g., research related treatment);

h. A statement that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule;

i. A statement that the individual may inspect or copy the PHI to be used or disclosed in response to the authorization;

j. If the use or disclosure of the requested information will result in any direct or indirect remuneration to the facility from a third party, a statement that such remuneration will result;

k. If a facility seeks an authorization from an individual for their own use and disclosure of PHI, the facility must provide the individual with a copy of the signed authorization; and

l. The signature of the individual and date. If the authorization is signed by a personal representative (as defined by state law) of the individual, a description of such representative's authority to act for the individual.

3. The authorization must be written in plain language.

4. Every signed authorization must be retained for a minimum of six (6) years.

5. An authorization for use or disclosure of PHI may not be combined with any other document to create a compound authorization, except as follows:

a. An authorization for the use or disclosure of PHI created for a research study may be combined with any other type of written permission for the research study (e.g., consent to participate in the research study); or

b. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes.

6. To use or disclose PHI for research purposes without an authorization, the facility must obtain documentation of a waiver of authorization from an Institutional Review Board or Privacy Board.

7. A previously unexecuted authorization is not valid if the document has any of the following defects:

a. The expiration date has passed or the expiration event is known by the facility to have occurred;

b. The authorization has not been filled out completely with respect to a required element;

c. The authorization is known by the facility to have been revoked; or

d. Any material information in the authorization is known by the facility to be false.

Thus, no PHI may be disclosed

8. The covered entity may not charge the patient a retrieval fee, but may charge for the actual cost to reproduce a copy of requested information. Other requestors (e.g., attorney, insurance company, subpoenas) may be charged a retrieval fee and the costs to copy the information. See attachment A for California State allowed fees.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.JC.IM.02.01.01, IM.02.01.03
- Health Insurance Portability and Accountability Act (HIPPA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164

CROSS REFERENCES:

- PATIENT PRIVACY PROGRAM REQUIREMENTS
- PATIENTS' RIGHT TO ACCESS
- NOTICE OF PRIVACY PRACTICES
- MARKETING UNDER THE HIPAA PRIVACY STANDARDS/HITECH

Attachment A – California Fee Schedule

REQUESTOR TYPE	REGULATED SEARCH/RETRIEVAL FEE	PER PAGE FEE	LEGAL REFERENCE
State Disability	$14.05 to 21.60 (+ tax)	Per the grid	State sets fees
Workers' Comp/Attorney	$4.00 per quarter hour or $16.00 per hour	$.10 (actual postage)	California Evidence Code § 1158
Subpoena	$4.00 per quarter hour or $16.00 per hour	$.10 (actual postage)	California Evidence Code § 1563
Patient	Reasonable clerical costs in locating and making records available	$.25 (actual postage)	California Health & Safety Code § 123110
Microfilm – Patient	Reasonable clerical costs	$.50	California Health & Safety Code § 123110
Microfilm – Attorney	$4.00 per quarter hour or $16.00 per hour	$.20 (actual postage)	California Evidence Code § 1158

SUBJECT: **COLOR-CODING**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure all medical records are properly color-coded prior to filing.

POLICY:

All charts shall be color-coded to assure organization and appropriately filed medical records.

AFFECTED AREAS/PERSONNEL: *ALL HIM PERSONNEL*

PROCEDURE:

1. All paper medical records are identified by specific color bands. Each color indicates a specific number to assure continuity.

2. The colors described on the attached page are printed and/or adhered to the jacket or folder. Each color represents the particular digit shown as follows:

   a. 0 – Red

   b. 1 – Gray

   c. 2 – Blue

   d. 3 – Orange

   e. 4 – Purple

   f. 5 – Black

   g. 6 – Yellow

   h. 7 – Brown

   i. 8 – Pink

   j. 9 - Green

3. To locate a file, determine the last two (2) digits of the file number.

4. Match these numbers with the corresponding colors on the chart.

5. Locate the color combination on the shelves in the file area. The last number and color of the file number will be on the bottom and the next number - reading left to right - will be directly above.

EXAMPLE:

1. Chart #005198 would use the following colored numbers

   a. Black (5) would be the top number, identifying the 1000 digit.

   b. Green (9) would be the second number, identifying the tens place.

   c. Pink (8) would be the bottom number, identifying the ones place.

REFERENCE:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
COMMERCIAL INSURANCE BILLING	**PATIENT FINANCIAL SERVICES**
	Page 1 of 2

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

PURPOSE:

To ensure accurate billing and cash posting on all commercial insurance payers.

POLICY:

A. Patient Accounting staff will bill on a UB-04 or CMS 1500 form with all appropriate information to the insurance company based on payer requirements for each individual insurance carrier.

AFFECTED PERSONNEL/AREAS: *PATIENT ACCOUNTING PERSONNEL*

EQUIPMENT:

- Experian Health System (Claim Source) Meditech (Expanse)

PROCEDURE:

A. The Patient Account Specialist will ensure that the following information is available for billing to the commercial insurance carrier.

1. Patient's full name
2. Patient's address, date of birth, gender, marital status
3. Full name of policyholder
4. Membership number/policy number
5. Group number and group name
6. Employer's name and address
7. All applicable coding elements
8. Appropriate charges
9. Physician Information
10. Billing Address
11. Authorization (if applicable)
12. Tax ID number
13. National Provider Identifier (NPI)
14. Codes
15. Bill Type
16. Medical Records (if applicable)

The Health Information System will screen the account to ensure all the claim elements are present before creating a claim for the billing vendor. If a claim element is missing or invalid, the system will error with a claim check edit, providing details. These details will be provided to the appropriate department to correct. Once the edit is resolved a claim will be processed from the Health Information System to the hospital's billing vendor software program.

Once claim is received from the Health Information System to billing vendor system, claim edits will be applied, per payer regulations and claims will then be transmitted to the appropriate payer either electronically or in paper format, depending on payer specific requirements.

Any edit related to codes, such as, CPT/HCPCS, diagnostic or procedure, may not be corrected by the Patient Account Specialist staff. The appropriate department must review these edits, such as Health Information Management (HIM), Charge Master, Clinical Charge department etc. and all changes must be made and directed by them to the Patient AccountSpecialist.

In compliance with the No Surprise Act (NSA) and the Provider Relief Fund (PRF), Sierra View Medical Center (SVMC) will not pursue any amount greater than the in-network rate for anyout-of-network patients who presents for emergency services or any collection outside of the cost sharing amount (co-pay, deductible, coinsurance) applied by the insurance unless it is a scheduled service and the patient has signed the applicable notice and consent and patient is fully aware they are receiving services at an out-of-network facility.

REFERENCE:

Consolidated Appropriations Act, 2021 (CAA)

SUBJECT: CONTINGENT WORKFORCE	SECTION: *Human Resources* Page 1 of 5

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

PURPOSE:

To ensure safe patient care and provide departments with guidelines when using a contingent workforce.

DEFINITIONS:

Processed by Education Department:

- **Students**- Individuals who are placed within the hospital to complete educational requirements.
- **Minor Students-** Individuals under the age of 18 who are placed within the hospital to complete educational requirements.
- **Interns-** A student or recent graduate receiving practical training in a working environment after completion of their program.
- **Physicians** - Physicians (Independent Practitioners) who observe only

Processed by Human Resources Department:

- **Volunteers**- Individuals who volunteer to perform non-employee tasks as assigned (18 years of age or older).
- **Clergy-** Individuals who volunteer to assist hospital Chaplain with spiritual care and/or take call.
- **Spiritual Care Volunteer-** Individual who volunteers to assist hospital Chaplain with spiritual care.
- **Registry/Travelers-** Individuals who perform hospital position responsibilities on a per diem/pre-determined basis and are sourced through our staffing vendor management company.
- **Temporary Employee** - Individuals who are hired for a pre-determined amount of time to fill a position on a temporary payroll through the Sierra View Medical Center (SVMC) payroll system.
- **Contracted Staff**- Individuals who replace an existing hospital position or department that is outsourced.

- **Independent Contractor-**Individual must meet the legal requirements of being an Independent Contractor. Please refer to the Employment Development Department (EDD) Benefit Determination Guide for further review of the Independent Contractor classification. Independent Contractor provides goods or services to the hospital under terms specified in a contract.

- **Interim Staff-** Individuals who perform a hospital position for a pre-determined amount of time and have a contract through an agency outside of our contracted staffing vendor management company.

- **Consultants**- Individual who gives professional advice or services to the hospital for a fee.

- **Sierra View Medical Center Governing Board Members and Foundation Board Members**

Processed by Materials Management Department:

- **Vendors**- Individuals who represent companies that provide goods and /or services not performed by hospital personnel.

- **Auditors**- Individuals who work for a contracted business to provide audits of SVMC records and/or services.

- **Business-to-Business contracts**- Businesses contracted with SVMC who will provide operational business services that are not provided by SVMC staff.

- **Construction/Maintenance**- Individuals who perform construction or maintenance work for the hospital and are not regular hospital employees.

POLICY:

For the contingent workforce processed through the Human Resources Department, department Directors/Managers, in collaboration with their respective Vice President, may elect to use a contingent workforce after all staffing options have been exhausted. If it is determined that a contingent workforce is necessary, the department is responsible for obtaining authorization through the appropriate administrative representative.

Contingent workforce staff is required to wear an identification badge displaying their clinical relationship to their patients.

Performance and competency of clinical and non-clinical staff shall be measured initially and thereafter annually by the contracting department. The contracting agency will provide two (2)

professional references for their employee. The department that manages the contracted service will be responsible for managing competency, performance, and references.

Department Directors/Managers are held accountable for ensuring employees/agents of contracted entities are responsible for meeting the spirit and application of this policy.

Department Directors/Managers are responsible for the verification, approval, and submission of payment requests to Accounts Payable.

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES

PROCEDURE:

Following the initial employment decision, contracted staff/independent contractors, temporary staff, registry, travelers, consultants and interims will be processed through Human Resources. Licensure, registration, or certification will be verified at the time of employment. Contingent workforce agencies are responsible for maintaining licensure, certification and insurance liability requirements. Lapsed licensure, certification, or insurance will void the contract/agreement. Verification that the contingent workforce staff are not on the Department of Health and Human Services Office of Inspector General's (HHS OIG) "List of Excluded Individuals/Entities" or General Services Administration's (GSA) "Excluded Parties List System" (EPLS) will be completed prior to employment and annually thereafter.

The original copy of the service agreement/contract will be forwarded to the Contract Administrator for inclusion in a master file of service agreements and contracts.
The Contract Administrator is responsible for notifying Human Resources of contracted employee service arrangements.

Employers of the contingent workforce and/or independent contractors must comply with established health protocols. Please refer to the Non-Employee Matrix found on the Intranet, HR page, Manager Resources, to evaluate all compliance guidelines for a contingent workforce.

Compliance guidelines include:

- Evidence of a purified protein derivative (PPD) (two-step tuberculosis (TB)) skin test within the previous 12 months
- Hepatitis B vaccination, immunity, or declination of the vaccine must be presented.

12

- Proof of flu shot or declination. If the contract employee declines the flu shot, they are to follow SVMC policy.

- Employers of the contingent workforce, independent contractors, and interim staff must also provide clear background screenings, drug tests (for safety-sensitive positions), and signed attestation of SVMC's applicable policies and acknowledgements.

Where appropriate to clinical positions, evidence of CPR training within the last 12 months is required. CPR training must be through American Heart Association.

Orientation:

Contingent workforce staff will participate in the initial electronic orientation, department orientation, and annual orientation. Department Directors/Managers are responsible for ensuring that the contingent workforce or agency staff receives a department orientation and document their participation on the "Initial House Wide Orientation Checklist." New hire and annual hospital orientation attendance will be tracked and monitored in SVMC's e-learning and personnel database.

Contingent workforce staff shall be advised that they are expected to adhere to department and hospital policies.

Where appropriate, the contracting department will provide current position descriptions for contracted positions or a scope of responsibility must be in the contract or on a separate document. A signed copy will be maintained in the individual's file.

The Contracting Department will evaluate the contingent workforce staff's competency initially, and thereafter, annually. Current competency documents are to be provided and maintained by the Department. Physicians may be used to evaluate competency, where appropriate, in the absence of qualified hospital staff. Employers of the contingent workforce may be substituted for this purpose.

Employers of the contingent workforce staff are required to provide proof of annual review, competency evaluation, licensure/certification, and health requirements.

The Contracting Department is responsible for providing initial department orientation to the contingent workforce staff.

Human Resources will maintain current files for the contingent workforce staff. The maintenance of these files shall comply with protocols contained within the scope of policy "Personnel Files." Personnel files shall comply with OSHA, The Joint Commission, IRS guidelines, and professional and credentialing organizations.

Contingent workforce staff personnel and medical files are the business property of the Hospital and shall be kept as historical records for the duration of employment plus thirty years.

Responsibility:

Department Directors/Managers must provide advance notice to Human Resources and set an appointment for the contingent workforce to obtain a badge. Badges will not be issued until compliance for the contingent workforce is verified by Human Resources. Employee Health will issue clearance for the contingent workforce after reviewing their health documents. Contingent workforce may not start working until they are cleared by the respective department of oversight, i.e. Education, Human Resources or Materials Management.

Department Directors/Managers will obtain badges, keys and other property of the Hospital upon termination of the agreement. Department Directors/Managers will submit a termination notice through HR Requests for contract employees, independent contractors, temporary employees, travelers, registry, and interim staff.

REFERENCES:

- The Joint Commission (2018). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- State of California Employment Development Department (2016). Benefit Determination Guide Index. Retrieved January 14, 2019, from https://www.edd.ca.gov/UIBDG/.

CROSS REFERENCES:

- Job Descriptions
- Licensure, Registration, Certification
- Contract Management
- SVMC Intranet: Human Resources: Manager Resources

SUBJECT: **DEBT COLLECTION AND REFERRAL; PATIENT NOTIFICATION**	SECTION: **Page 1 of 6**

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

PURPOSE:

Sierra View Medical Center (SVMC) is committed to meeting the health care needs of all patients in the community and to ensure that consistent collection attempts are made prior to assignment to bad debt based on all state and federal guidelines.

DEFINITIONS:

Bad Debt: Unrecoverable debt as a result of a third-party payer or patient which has not paid in full, and is unlikely to be paid for various reasons.

Reasonable Payment Plan: Defined as monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses. **Charity Packet:** Defined as a completed charity application, hardship letter, recent tax return or recent check stubs (one month) and proof of living expenses.

Essential Living Expenses: Defined as expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses (including insurance, gas and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.

High Medical Costs: a person whose family income does not exceed 400 percent of the federal poverty level For these purposes, "high medical costs" means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

Collection Agency: A "Collection Agency" is any entity engaged by a Hospital to pursue or collect payment from Patients.

POLICY:

Sierra View Medical Center will take all steps necessary to ensure a patient is able to resolve their outstanding balance for any services received at the facility by offering both opportunity and assistance for help with the resolution of a patient account prior to sending to collections.

SVMC uses two collection agencies based on an alpha split. Assignment of accounts to the collection agencies is made with the approval of the Administrative Director of Revenue Cycle or Manager of Patient Accounting. Patient Accounting does not authorize any agency to use threatening tactics when trying to resolve patient accounts. Our goal is to assist the patient with a mutually beneficial arrangement for both the organization and the patient prior to assigning any account for collection.

Collection agencies will abide by all state and federal laws relating to the collection of accounts and will agree to abide by any policies adopted by SVMC and adhere to the hospital's standards and scope of practices. SVMC does not permit liens on residences nor, can there be wage garnishments without a court order for the collection of accounts assigned to any agency.

AFFECTED AREAS: *PATIENT FINANCIAL SERVICES, /CREDIT & COLLECTIONS PERSONNEL/CONTRACTED COLLECTION AGENCIES*

PROCEDURE:

Before an account is assigned to an outside agency for collection efforts, SVMC Patient Accounting staff will investigate to see if the following circumstances are met:

1. Accounts must be greater than 180 days old from date of service unless account returned by the United States Postal Service (USPS) as non-deliverable, then accounts may be sent to bad debt sooner than 180 days. If it is discovered there is a wrong address it will be noted in either the hospital Health Information System (HIS) system or the outsource vendor system. If the USPS provides SVMC with a forwarding address, SVMC will update the address on file to the one provided by the USPS.

2. Before assigning a bill to collections a hospital shall send a patient a notice with all of the following information:
    - i. (1) The date or dates of service of the bill that is being assigned to collections or sold.
    - ii. (2) The name of the entity the bill is being assigned or sold to.
    - iii. (3) A statement informing the patient how to obtain an itemized hospital bill from the hospital.
    - iv. (4) The name and plan type of the health coverage for the patient on record with the hospital at the time of services or a statement that the hospital does not have that information.
    - v. (5) An application for the hospital's charity care and financial assistance.

vi. (6) The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

vii. (g) If a patient is attempting to qualify for eligibility under the hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency, debt buyer, or other assignee, unless that entity has agreed to comply with this article.

3. A hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency or debt buyer, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment before 180 days after initial billing.

4.

5. Patient has not contacted or attempted to cooperate with the hospital relating to alternative options available to them such as:

   a. Eligibility with a third party insurance, auto insurance, work comp, California Health Benefit Exchange or government sponsored programs

   b. Eligibility for discount program by completing the charity packet

   c. Eligibility for financial assistance or charity care

6. Patient has not made a good faith effort to settle the outstanding bill by:

   a. Negotiating a reasonable payment plan.

   b. Request or comply with a payment arrangement. This will include a Good Faith Estimate and the financial clearance agreement approved by the guarantor and SVMC administrator, including a payment arrangement after receiving a partial charity discount.

   d. Or when a payment agreement cannot be reached regarding a payment plan, the monthly payments will not exceed 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" are defined as expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses (including insurance, gas and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.

   c.

7. Patient is not in an appeal or dispute status for the above items.

8. Patient has not applied or have a pending application for another health coverage program.

9. Information has been provided to patients on:

   a. SVMC Charity Care and Financial Assistance Policy

   b. California Health Benefit Exchange (Covered California) and other state-or county-funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services for which they might be eligible. Information regarding the availability of programs is noted on the patient statements that are sent monthly to patient. In addition, Sierra View Medical Center has applications available for patients in the event they request one.

10. Guarantor is not a minor or is not subject to any statutory regulations which allow minors access to their own medical information

11. Patient has failed to comply with their insurance request such as: coordination of benefit questionnaire, accident questionnaire etc.

12. All attempts to collect from all payer sources have been exhausted.

13. Patient provides a copy of their insurance information within the timely filing requirements outlined in the SVMC contracted payer guidelines.

14. Patients with no health insurance coverage or patients with "high medical costs", to include patients with third party coverage who are at the 400% or lower Federal Poverty guidelines who have qualified for a discount on services rendered at the facility based on either income or hardship.

15. Statements are retuned by the Post Office as undeliverable.

If patient qualifies for a discount, Patient Accounting staff will note the discounted balance in the system prior to assignment to collections. The Financial Counselors have primary responsibility for posting the charity adjustment on each individual account utilizing either of the following adjustment codes:

1. ACHAAFTINI

2. ACHAAFTINO

3. ACHARITY I

4. ACHARITY O

Department staff will educate all patients on alternative methods of payment available to them prior to being sent to bad debt by:

1. Providing charity application, contact information for the Financial Counseling department or Patient Accounting department for assistance with our charity and financial assistance programs.

2. Program information is posted at all registration locations, on the SVMC website, SVMC patient portal, all external clinics, cashiers window, Patient Accounting department, on the patient statement and now include "observation units".

3. Providing information on the hospital collection letters that discuss options available to patient.

If the patient or patient family representative fails to provide insurance coverage for the particular date of service in question, but later brings a copy of the insurance information which is then deemed to have been in effect for the patient on the date of service in question, the patient may still be subject to the collection process in the following circumstances:

1. If patient fails to provide the necessary insurance information at time of service or in a timely manner, which is defined by individual contracted payer guidelines and State sponsored program such as Medicare and Medi-cal. SVMC will take all steps available to help patients with resolution of account issues by submitting a claim on behalf of the patient.

2. If patient requests billing to be done to third party payer, i.e. Auto Insurance, and it is later determined that coverage does not exist, patient must have provided health insurance benefit information prior to the timely filing limit.

It is ultimately the patient's responsibility to ensure their account is paid by their insurance company.

REFERENCE:

- HSC 127425; SB1276: AB1020, AB532, No Surprise Act Title XXVII of the Public Health Service Act (PHS Act), as amended by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021

20

SUBJECT: **FACSIMILE MACHINE, UTILIZATION OF**	SECTION:

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

PURPOSE:

To ensure proper utilization of the facsimile machine.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to utilize facsimile (fax) machines to enhance patient care, and to support our physician community, while maintaining the confidentiality of all patient information.

AFFECTED AREAS/PERSONNEL: *ALL PERSONNEL*

PROCEDURE:

Due to the Federal and State Regulations regarding patient privacy, extreme care should be taken when faxing protected health information (PHI) to any outside agency. The California Department of Public Health (CDPH) has interpreted California Health and Safety Code § 1280.15 to mean that misdirected faxes fall into negligent disclosures, therefore the facility must report all such incidences. These disclosures open the facility to penalties and the individual who negligently faxed to a wrong number can face penalties from the California Office of Health Information Integrity (CalOHII).

All staff must follow the steps outlined below when faxing documents inside or outside the facility:

1. Patient-related information may be faxed only if confidentiality may be maintained, and if the patient, or the patient's representative, has consented to the release of information.

2. Recommended all requests for faxed records be accompanied by a fax from the requesting organization/office that includes a return fax number within the body of the request or preprinted on the header with the company name.

3. If the requesting party provides a fax number via verbal communication the sender shall write the number down, and then read back the number to the requesting party to verify that the number is correct. This read back will be completed twice to ensure that the receiving party is actively listening to the sender to ensure that the number is correct. The sender shall make a tick mark by the number each time the number is read back to the requestor to signify that the number has been confirmed as correct.

4. Any fax being originating from SVMC shall include a fax cover sheet, with Confidentiality Disclaimer. This includes faxes being sent within the facility with one exception. Staff members are not required to use a cover sheet if they are faxing to the Pharmacy Department or the MRI unit, and they are using the pre-programmed listed on the fax machine. These are the ONLY instances where a fax cover sheet does not have to be used.

5. The sender must request that the receiving party notify the sender upon receipt of the fax.

6. The sender shall program the receiving fax number into the fax machine. It is recommended that the sender check the number at least twice prior to faxing the documents to ensure that the number has been entered correctly.

7. The sender shall await the fax transmission log to ensure that fax was transmitted correctly, and that it was transmitted to the number as verified in step 2 of these procedures.

8. If an error is detected after the fax is transmitted the sending party shall try to determine where the fax was sent. If the sender can determine who the incorrect receiving party is, the sender shall contact that party and ask that they send all documentation back to the SVMC Additionally, the Privacy Officer is to be notified immediately of the PHI breach. All documentation related to the matter is to be kept and turned over to the Privacy Officer.

All staff members should be aware of the following requirements for faxing of documents:

- Fax transmission of physician's orders is allowed only if the information constitutes an order that could be transmitted verbally.

- Documents that are highly confidential and shall NOT be sent via the fax include, but are not limited to, Peer Review Committee communications, AIDS or HIV results, drug or alcohol abuse, venereal disease and mental health information.

Copies of documents sent via the fax machine may be deemed to have the same force and effect as an original document.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- California Health and Safety Code § 1280.15

22

SUBJECT: **JOB POSTING**	SECTION:

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

PURPOSE:

To provide a consistent and equal employment opportunities process for employees applying for advancement and career opportunities within Sierra View Medical Center (SVMC).

POLICY:

SVMC supports the retention strategy of growing employees and allowing them to gain career growth opportunities while being employed. The job posting system provides employees with a process to apply for advancement and career opportunities which also supports the practice of promotions from within and ensures employees of equal opportunity practices.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

Current qualified employees will be considered for posted positions before external candidates are actively recruited.

Department Directors are responsible for assessing staffing levels following each vacancy and determining if the job description should be modified based on business and departmental needs. If the position should be posted a request for a job posting is initiated with an approved electronic Position Control Request.

Generally, all job openings are posted internally except where departmental staffing realignment and consolidation may otherwise intervene.

Job postings can be viewed online at jobs.sierra-view.com.

Open positions are posted for a minimum of five days. Current employees should apply for posted positions on-line using the "Current Employees" link found on SVMC's website.

To be eligible to transfer:

a. The employee should have been employed in his or her position for at least 6 months.

b. Employees who have been issued corrective actions at the documented written warning level within six months of the date of an interview are required to share the content and expectations with the hiring manager prior to receiving a job offer. This information may be a deciding factor in the hiring decision. Failure to disclose any corrective action prior to accepting an offer of transfer may also result in additional discipline, up to and including denial of the transfer and/or the termination of employment.

c. Employees with a final written warning are not eligible to apply for a transfer within six months of the date of issue of the final written warning.

d. Prior to interview, the hiring Director/Manger is encouraged to review the candidate's employee file and to have informal discussion with the candidates current Director/Manager regarding the candidate's performance, skills, and abilities relevant to the position for which they are applying.

Human Resources will receive and forward application information for eligible employees to the hiring Unit/Department Director for their consideration and action. As a courtesy, the employee's *current* Director will be informed that the employee has submitted a transfer request for consideration. The employee is given first opportunity to disclose their interest in the position. Otherwise, Human Resources will notify them during the recruitment process.

Locum, travelers, agency and temporary staff may apply and be hired to help fill the vacancy during the open posting period.

REFERENCES:

- The Joint Commission (2018). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- STAFF RECRUITMENT, EMPLOYMENT, AND RETENTION
- PERFORMANCE ACCOUNTABILITY AND COMMITMENT

SUBJECT:	SECTION:
LEADERSHIP STRUCTURE AND RESPONSIBILITIES - SC	***Surgery Clinic***

PURPOSE:

The Surgery Clinic shall have a leadership structure to ensure overall safety, quality of care, treatment and assessment of services provided.

POLICY:

A. The Surgery Clinic operates under the same organizational documents as Sierra View Medical Center. The Surgery Clinic is a department of Sierra View Medical Center's as such, through the respective Vice President and Chief Executive Officer act as the chain of command for the Surgery Clinic. The day to day operations are under the direction of the Sierra View Surgery Clinic's Supervising Practitioner and Clinic Manager.

AFFECTED PERSONNEL/AREAS: *ALL SURGERY CLINIC PERSONNEL AND MEDICAL STAFF*

PROCEDURE:

A. Ownership and Control

Sierra View Medical Center has ownership and control of the Surgery Clinic as well as final responsibility for:

1. Administrative decisions,
2. Final approval for contract with outside parties,
3. Final approval for personnel actions,
4. Final responsibility for personnel policies, and
5. Final approval for medical staff appointment in the Surgery Clinics.

B. Clinical Services

1. Professional staff of the Surgery Clinic facilities have clinical privileges and are credentialed through Sierra View Medical Center.

2. The Sierra View Medical Center maintains the same monitoring and oversight of the Surgery Clinics as it does for any other department service line.

3. The Supervising Practitioner maintains a reporting relationship with the Sierra View Medical Center Medical Staff for reporting clinical quality.

4. Performance Improvement Metrics will be reported through Sierra View Medical Center's Performance Improvement/Patient Safety Meeting to ensure coordination and integration of services between the Surgery Clinics and Sierra View Medical Center.

5. Medical Staff Committees at Sierra View Medical Center are responsible for medical activities in the Surgery Clinics including quality assurance, utilization review, and the coordination and integration of services between the Surgery Clinics and Sierra View Medical Center.

25

REFERENCES:

- California Code of Regulations (2022). Title 22. Outpatient Service Staff § 70529. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- State of California, Title 42, Requirements for All Provider Based Entities § 413.65 (2022). Retrieved from https://www.law.cornell.edu/cfr/text/42/413.65.

CROSS REFERENCES:

- DEFINITION OF NURSING SERVICES

SUBJECT:	SECTION:
LIMITED DATA SET AND DATA USE AGREEMENTS	**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 and Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act") and any and all other Federal regulations and interpretative guidelines promulgated under the HITECH and/or HIPAA. To establish guidelines for the proper definition and use of a limited data set and provide guidance regarding the requirements for a data use agreement, as required by the HIPAA Privacy Standards.

POLICY:

A Limited Data Set (LDS) may be used or disclosed without patient authorization if the organization enters into a Data Use Agreement (DUA), see attached example, with the LDS recipient; however, such use or disclosure of a LDS may only be for the purpose of research, public health or health care operations. A facility may use protected health information (PHI) to create a LDS, or disclose PHI to a Business Associate for such purposes, whether or not the LDS is to be used by the organization.

PROCEDURE:

1. An LDS may be used or disclosed only if the facility obtains satisfactory assurance, in the form of a DUA, that the LDS recipient will only use or disclose the PHI for the limited purposes of research, public health or health care operations.

2. A DUA between the facility and the LDS recipient must:

   a. Establish that the permitted uses and disclosures of the LDS are limited to the purposes of research, public health or health care operations;

   b. Establish who is permitted to use or receive the LDS; and

   c. Provide that the LDS recipient will:

      - Not use or further disclose the information other than as permitted by the agreement or as otherwise required by law;
      - Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the agreement;
      - Report to the Sierra View Medical Center (SVMC) privacy officer any use or disclosure of the information not provided for by the agreement of which it becomes aware;
      - Ensure that any agents, including a subcontractor, to whom it provides the LDS agrees to the same restrictions and conditions that apply to the recipient with respect to such information;

- Ensure the LDS is not further de-identified, and
- Not identify the information or contact the individuals.

3. The following identifiers must be excluded from the PHI to create an LDS:

   a. Names;

   b. Street address (town/city, state and zip code can be included);

   c. Telephone numbers;

   d. Fax numbers;

   e. Electronic mail addresses;

   f. Social security numbers;

   g. Medical record numbers;

   h. Health plan beneficiary numbers;

   i. Account numbers;

   j. Certified/license numbers;

   k. Vehicle identifiers and serial numbers, including license plate numbers;

   l. Device identifiers and serial numbers;

   m. Web universal resource locators (URLs);

   n. Internet protocol (IP) address numbers;

   o. Biometric identifiers, including finger and voice points; and

   p. Full face photographic images and any comparable images.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Health Information Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFT Part 164, Section: 164.51(e)

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

CROSS REFERENCES:

- PATIENT PRIVACY PROGRAM REQUIREMENTS

SUBJECT: **MANAGEMENT OF EMPLOYEE ILLNESSES AND EXPOSURES/DUTY RESTRICTIONS**	SECTION: **Page 1 of 6**

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

PURPOSE:

To provide guidance for management of infectious illnesses among health care personnel (HCP) in order to ensure a safe environment for personnel, patients, volunteers and visitors.

POLICY:

Sierra View Medical Center (SVMC) shall implement measures to prevent further transmission of infectious illnesses by HCP, which sometimes warrants exclusion of personnel from work or patient contact. Employee Health Services (EHS), Infection Prevention or a designee, such as the House Supervisor, have authority to temporarily exclude personnel from duty if it is determined that there is risk of transmission to other personnel and/or patients.

AFFECTED AREAS/PERSONNEL: *ALL HCPs, VOLUNTEERS*

PROCEDURE:

1. HCP will report to EHS in person or by phone, independently or as directed by a department manager or supervisor for evaluation of any actual or suspected illness or infection. When EHS and Infection Prevention are closed, the HCP will report to the House Supervisor.

2. Determine if illness or infection is included in the Disease/Problem list. (See attachment entitled: *Guideline For Infection Control*)

3. Use criteria as identified in attachment to determine duty restriction or exclusion

4. If excluded from duty, HCP may choose to either visit the Emergency Department voluntarily, or their primary care provider to obtain clearance to return to work.

5. Refer HCP to Human Resources for guidance on obtaining primary provider clearance to return to work, as well as obtaining information regarding wages, benefits or job status during restriction.

REFERENCES:

- Bader, M. S., Brooks, A., Kelly, D. V., & Srigley, J. A. (2017). Postexposure management of infectious diseases. *Cleveland Clinic journal of medicine*, *84*(1), 65–80. DOI: https://doi.org/10.3949/ccjm.84a.15049

- Bolyard, E.A., Tablan, O.C., Williams, W.W., Pearson, M.L., Shapiro, C.N, Deitchman, S.D., The Hospital Infection Control Practices Advisory Committee (1998). Guideline for infection control in health care personnel, 1998. *AJIC, 26(3), 289-354.* DOI: https://doi.org/10.1016/S0196-6553(98)80015-1

- California Code of Regulations, Title 22. Social Security Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies Chapter 1. General

Acute Care Hospitals. AFL-20-08-Attachment-02. Title 22, Section 70723. https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-08-Attachment-02.pdf

GUIDELINE FOR INFECTION CONTROL (AMERICAN JOURNAL OF INFECTION CONTROL)
THIS TABLE SUMMARIZES SUGGESTED WORK RESTRICTIONS FOR HEALTHCARE PERSONNEL EXPOSED TO OR INFECTED WITH INFECTIOUS DISEASES OF IMPORTANCE IN HEALTHCARE SETTINGS, IN THE ABSENCE OF STATE AND LOCAL REGULATIONS (TAKEN FROM TABLE 3, FROM BOLYARD, *ET AL.*, MODIFIED BY THE AMERICAN JOURNAL OF INFECTION CONTROL (AJIC) FROM ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS)

Disease/Problem	Work Restrictions	Duration
Conjunctivitis	Restrict from patient contact and contact with the patient's environment	Until discharge ceases
Cytomegalovirus infections	No restriction	
Diarrheal diseases		
Acute stage (diarrhea with other symptoms)	Restrict from patient contact, contact with the patient's environment, or food handling	Until symptoms resolve
Convalescent stage, *Salmonella* species	Restrict from care of high-risk patients	Until symptoms resolve; consult with local and state health authorities regarding need for negative stool cultures
Diphtheria	Exclude from duty	Until antimicrobial therapy completed and two cultures obtained $\geq$ 24 hours apart are negative
Enteroviral infections	Restrict from care of infants, neonates, and immuno-compromised patients and their environments	Until symptoms resolve
Hepatitis A	Restrict from patient contact, contact with patient's environment, and food handling	Until 7 days after onset of jaundice
Hepatitis B		
Personnel with acute or chronic Hepatitis B surface antigemia who do not perform exposure-prone procedures	No restriction; refer to state regulations; standard precautions should always be observed	
Personnel with acute or chronic Hepatitis B e antigenemia who perform exposure-prone procedures	Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into	Until Hepatitis B e antigen is negative

Disease/Problem	Work Restrictions	Duration
	account specific procedure as well as skill and technique of worker; refer to state regulations	
Hepatitis C	No recommendation	
Herpes simplex		
Genital	No restriction	
Hands (herpetic whitlow)	Restrict from patient contact and contact with the patient's environment	Until lesions heal
Orofacial	Evaluate for need to restrict from care of high-risk patients	
Human immuno-deficiency virus	Do not perform exposure-prone invasive procedures until counsel from an expert panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of the worker. Standard Precautions should always be observed; refer to state regulations.	
Measles		
Active	Exclude from duty	Until 7 days after the rash appears
Postexposure (susceptible personnel)	Exclude from duty	From 5th day after first exposure through 21st day after last exposure and/or 4 days after rash appears
Meningococal infections	Exclude from duty	Until 24 hours after start of effective therapy
Mumps		
Active	Exclude from duty	Until 9 days after onset of parotitis
Postexposure (susceptible personnel)	Exclude from duty	From 12th day after first exposure through 26th day after last exposure or until 9 days after onset of parotitis
Pediculosis	Restrict from patient contact	Until treated and observed to be free of adult and immature lice
Pertussis		
Active	Exclude from duty	From beginning of catarrhal stage through 3rd week after onset of paroxysms or until 5 days after start of effective antimicrobial therapy
Postexposure (asymptomatic personnel)	No restriction, prophylaxis recommended	

Disease/Problem	Work Restrictions	Duration
Postexposure (symptomatic personnel)	Exclude from duty	Until 5 days after start of effective antimicrobial therapy
Rubella		
Active	Exclude from duty	Until 5 days after rash appears
Postexposure (susceptible personnel)	Exclude from duty	From 7th day after first exposure through 21st day after last exposure
Scabies	Restrict from patient contact	Until cleared by medical evaluation
Staphylococcus aureus infection		
Active, draining skin lesions	Restrict from contact with patients and patient's environment or food handling	Until lesions have resolved
Carrier state	No restriction, unless personnel are epidemiologically linked to transmission of the organism	
Streptococcal infection, group A	Restrict from patient care, contact with patient's environment, or food handling	Until 24 hours after adequate treatment started
Tuberculosis		
Active disease	Exclude from duty	Until proved noninfectious
PPD converter	No restriction	
Varicella		
Active	Exclude from duty	Until all lesions dry and crusted
Postexposure (susceptible personnel)	Exclude from duty	From 10th day after first exposure through 21st day (28th day if VZIG given) after last exposure
Zoster		
Localized, in healthy person	Cover lesions; restrict from care of high-risk patients	Until all lesions dry and crust
Generalized or localized in immunosuppressed person	Restrict from patient contact	Until all lesions dry and crust
Postexposure (Susceptible personnel)	Restrict from patient contact	From 8th day after first exposure through 21st day (28th day if VZIG given) after last exposure or, if Varicella occurs, until all lesions dry and crust

Disease/Problem	Work Restrictions	Duration
Viral respiratory infections, acute febrile	Consider excluding from the care of high-risk patients or contact with their environment during community outbreak of RSV and influenza	Until acute symptoms resolve

SUBJECT: **OUTSIDE EMPLOYMENT**	SECTION: **Page 1 of 2**

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

POLICY:

Sierra View Medical Center (SVMC) recognizes that some employees may need or want to hold additional jobs outside their employment with SVMC. In accordance with California Government Code section 1126, Employees of SVMC are permitted to engage in outside work or hold other jobs, subject to certain restrictions based on reasonable business concerns.

AFFECTED PERSONNEL/AREAS: *ALL EXEMPT EMPLOYEES*

PROCEDURE:

SVMC applies this policy consistently and non-discriminatorily to all employees, and in compliance with all applicable employment and labor laws and regulations. Outside employment requires prior written approval from the employee's respective Vice President (VP). The following rules for outside employment apply to all exempt employees notifying their VPs of their intent to engage in outside employment:

A. Work-related activities and conduct away from SVMC must not compete with, conflict with or compromise the Hospital's interest or adversely affect job performance and the ability to fulfill all responsibilities to SVMC. Employees are prohibited from performing any services for customers of SVMC that are normally performed by SVMC. This prohibition also extends to the unauthorized use of any company tools or equipment and the unauthorized use or application of any company confidential information. In addition, employees may not solicit or conduct any outside business during work time for SVMC.

B. SVMC employees must carefully consider the demands that additional work activity will create before accepting outside employment. Outside employment will not be considered an excuse for poor job performance, absenteeism, tardiness, leaving early, refusal to travel, or refusal to work overtime or different hours. If outside work activity causes or contributes to job-related problems at SVMC, the employee will be asked to discontinue the outside employment, and the employee may be subject to the normal disciplinary procedures.

(1) In evaluating the effect that outside work may have on an employee's job performance and other job related responsibilities, the HR Department, and the respective VP will consider whether the proposed employment:

(a) May reduce the employee's efficiency in working for the Hospital.
(b) Involves working for an organization that does a significant amount of business with the Hospital, such as major contractors, suppliers/vendors and customers.
(c) May adversely affect the Hospital's image.

(2) Employees who have accepted outside employment may not use company vacation/holiday pay to perform work on the outside job.

(3) Fraudulent use of company vacation/holiday pay or continued unsatisfactory job performance due to competing priorities related to other employment outside of SVMC will be addressed through the progressive disciplinary process and may result in disciplinary action, up to and including separation of employment.

CROSS REFERENCES:

- AT WILL EMPLOYMENT
- CONFLICT OF INTEREST
- PERFORMANCE ACCOUNTABILITY AND COMMITMENT

SUBJECT:	SECTION:
PER DIEM PROTOCOL (NON-EXEMPT EMPLOYEES)	***Human Resources***

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

PURPOSE:

To establish the requirements, protocol and work expectations for non-exempt per diem employees working at Sierra View Medical Center (SVMC).

POLICY:

Per Diem Staff:

All non-exempt, per diem employees must provide a minimum of four (4) full shifts in a four (4) week schedule that they would be available to work. Once the Department leadership receives the per diem employee's availability, they will then assess the staffing needs and scheduled the per diem employees for full shift(s) based on their availability in conjunction with the needs of the department. The per diem employee's scheduled shifts could be less than their actual availability provided as it will be based on the needs of the department/hospital.

1. It is the responsibility of all per diem employees to provide their schedule of available shifts to their Department Director/Manager or their designee based on the above minimum requirements.

2. At the discretion of the Department Director/Manager, per diem employees may be scheduled on the dayshift(s) they are needed most by the department for a full complement of staff.

3. Per diem staff who work in departments who are regularly scheduled for on-call shifts may be required to take rotation of the on-call schedule based on the business need.

Clinical Per Diem Staff:

1. Two (2) of the four (4) full shifts scheduled should be one (1) complete weekend or its equivalent as defined below.

2. A complete weekend consists of the following:

   - Saturday **and** Sunday—**OR--** all two (2) Saturdays—**OR--** all two (2) Sundays for the day and/or evening shifts;

   - Friday **and** Saturday—**OR--** Saturday **and** Sunday—**OR**—all two (2) Fridays, Saturdays, or Sundays for the night shift.

   An employee may work two (2) Saturdays **OR** one (1) Saturday and one (1) Sunday during the four (4)-week schedule, as long as the equivalent of a complete weekend has been scheduled. *(Exception: Surgery and PACU Departments)*

3. All per diem nursing employees are required to work a minimum of one (1) Sierra View Medical Center holiday each calendar year. SVMC recognizes the following holidays:

New Year's Day	Labor Day
President's Day	Veteran's Day
Memorial Day	Thanksgiving Day
Independence Day	Christmas Day

4. For the purposes of scheduling, the holiday is considered to be:

   - 0645 AM – 1515 PM; 0645 AM – 1915 PM; and 1445 PM – 2315 PM for the day of the holiday;

   1845 PM – 715 AM; and 2245 PM – 0715 AM for the eve of the holiday.

Seasonal Per Diem Staff

SVMC will designate and recruit for seasonal per diem staff when the business need in a specific department/service line has critical staffing shortages. The seasonal per diem program will be approved by the senior leadership team. Once approved, the seasonal per diem program will include the following guidelines:

- **Seasonal per diem staffing will be scheduled for a designated period of time utilizing either an 8 week (24 full shifts) or 13 week (104 full shifts)assignment.**
- **The number of per diem positions available within each assignment will be determined by the respective VP in coordination with the VP of HR.**
- **A flat rate of pay for seasonal per diem will be assigned by senior leadership team based on the competitive market, availability of the position, and critical staffing levels impacting operations.**
- **Overtime will be paid after completion of forty (40) hours worked in one week.**
- **Seasonal per diem staff will work three full 12 – hour shifts per week or five full 8-hour shifts per week, and will be scheduled according to the need by the department leadership.**
- **If the seasonal per diem staff member calls off for a shift, the number of called off shifts will be added to the end of their assignment. This will apply to both protected and unprotected absences.**
- **Absences will be managed under SVMC's Attendance and Punctuality Policy.**
- **Seasonal per diem staff can work extra shifts beyond the minimum of the three shifts if available**
- **SVMC, as needed, will call off a seasonal per diem without any penalty as follows:**
  - **1 time for an 8 week assignment**
  - **2 times for a thirteen week assignment**

Once the seasonal per diem program is designated and approved, Human Resources will work with key stakeholders to expedite the onboarding and clearance required while still ensuring compliance and proper clearance for each new hire.

Any per diem employee currently employed at SVMC is eligible to apply for a seasonal per diem assignment as long as they meet the eligibility and pre-screening criteria which will be discussed as part of the recruitment process.

Full-time employees who are employed during the seasonal PD period will not be eligible for participation for the next twelve month period. At the end of each seasonalperiod , a needs assessment will be conducted to determine FT eligibility.

At the end of the seasonal per diem assignment, the PD employee will either be placed on inactive status or remain active in the seasonal PD role as approved by senior leadership team for another eight week or thirteen week assignment. Seasonal PD staff who are placed on inactive status, leave SVMC and return for an additional assignment within the year, are not required to go through onboarding and orientation.

AFFECTED AREAS/PERSONNEL: *ALL PER DIEM\ STAFF*

PROCEDURE:

1. All per diem employees will be scheduled based upon department need after all full-time and part-time employees have completed their schedules.

2. Once the schedule is posted, per diem employees are expected to work their scheduled full shifts(s). If assigned to a ***nursing*** unit, trading is allowed according to General Nursing Personnel Policies. All others must receive approval in advance from their Department Director/Manager.

3. Per Diem employees who have been placed on the schedule but are called-off by the hospital for their scheduled shifts will be considered to have met their minimum requirements.

4. Per Diem employees who fail to work their schedule and have no protected leave will be subject to SVMC's Attendance and Punctuality Policy and will be considered to not have met their minimum requirements.

5. Per diem staff who fail to work or provide SVMC with any scheduled shifts over an eight week consecutive period will be provided a letter from the Human Resources Department requesting them to provide availability to their department leadership. If the per diem employee does not contact SVMC within the time designated on the letter, and continue to not offer availability of shifts for SVMC, they will be separated from employment based on lack of availability to provide hours to SVMC.

6. All per diem staff will receive a copy of the "Per Diem Protocol" policy, and an "Acknowledgment of Receipt" form will be signed by the employee. The original will be placed in the employee's Personnel File, and a copy will be given to the employee.

SUBJECT:	SECTION:
POLICY AND PROCEDURE SYSTEM	***Leadership (LD)***
	Page 1 of 3

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

PURPOSE:

To define the Document Management System – PowerDMS used at Sierra View Medical Center (SVMC) and the various applications and documents that will be maintained in the electronic document system.

PowerDMS provides a streamlined collaboration and audit process through their digital document platform. The system has the ability to store, organize, distribute and track facility documents. PowerDMS integrates policies, training and accreditation content to archive and ensure Federal and State compliance.

POLICY:

A. PowerDMS will allow the digital storage of the following:

1. Policy Management
2. Forms Management
3. License Management
4. TJC Assessments/Mock Assessments
5. TJC Standards Manual – Hospital and Laboratory
6. Mobile access for iPhone and Android
7. Standard Operating Procedures (SOP's)
8. Manufacturer's Instructions For Use (MIFU) Logs

B. In order to establish organization-wide consistency, ensure compliance with the requirements for licensing and accreditation, and allow affected personnel to work effectively and efficiently, all levels of affected personnel will have access to policies and procedures. To accomplish these goals, the following guidelines are established:

1. All organizational policies and procedures shall be stored in PowerDMS (Document Management System). All affected personnel will have access to read all policies and procedures in the system.

2. All policies shall follow a standard format and editorial style as outlined in each policy template.

3. Policy Owners (i.e., Department Directors, Managers and Senior Management), are responsible for creating new policies, revising policies when needed, reviewing policies as required and identifying the need to archive obsolete policies.

4. Leadership is responsible for communicating the existence of new policies or policy revisions to employees affected by the changes, and for ensuring employees read new policies and revisions as required.

5. Policies may not be reproduced or distributed to parties outside of Sierra View Medical Center without authorization from the CEO.

6. All policies will remain in effect until archived or until superseded by a policy revision of a later date.

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL PERSONNEL, STUDENTS, RESIDENTS, AND MEDICAL STAFF*

PROCEDURE:

A. Create a New Policy & Archive a Policy

1. Policy Owners are required to generate a Message within PowerDMS to the System Administrator requesting a New Policy or to Archive a Policy. The following elements are to be provided to the System Administrator.

   a. New Policy:
      i. Policy Name
      ii. Policy Owner
      iii. Review Cycle
      iv. Workflow Reviewers
      v. Department Name

      Upon receipt of this Message, System Administrator will create the new policy, attach the Policy Word Template, and set up the Review Cycle and Workflow Template. Communication will be sent to the Policy Owner informing them that setup is complete and to proceed with policy development. When the workflow steps are complete, final step - Board Approval, the policy will be published through the automated process.

   b. Archive Policy:
      i. Policy Name
      ii. Policy Owner
      iii. Document Folder Name
      iv. Detailed explanation for reason to Archive policy

      Upon receipt of this Message, System Administrator will generate an Archive Workflow and request approval by Policy & Procedure Committee. Upon approval by Committee Members, System Administrator will Archive the policy. Although an archived policy will no longer be in the library of published policies, it will be stored in the system and can easily be accessed if needed.

B. Policy Review & Approve Process

1. All policies stored in PowerDMS are automatically flagged for Review & Approval based on the policy's review requirements (i.e., annually, every two years, etc.). Each policy has a set review period, but it is the responsibility of the policy owner to ensure this information is correct and that policies are reviewed when required.

2. All policies require a generation of New Draft from the published version. Policy Owner will assign the Workflow template and proceed with the Review & Approval process. Upon completion of the Final Step, the New Policy will be published and the previous version will be archived.

References:
PowerDMS Lesson 2 Training Document

SUBJECT: **RECORDS MANAGEMENT**	SECTION: **Page 1 of 6**

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

SCOPE:

All affiliated facilities including, but not limited to, hospitals, ambulatory surgery centers, cancer treatment centers, and all facility Departments, for which Sierra View Medical Center (SVMC) is responsible for business records.

PURPOSE:

To establish the policy and procedures for the creation, use, maintenance, retention, preservation, and disposal of Sierra View Medical Center (SVMC) records.

POLICY:

1. It is SVMC's policy to apply effective and cost efficient management techniques to maintain complete, accurate, and high quality records. Records are retained in accordance with all applicable laws and regulations and District policies.

2. Records that have satisfied their required period of retention will be destroyed in an appropriate manner.

3. Records will be managed responsibly, and retention schedules and destruction procedures and methods will be developed applicable to facilities records.

4. All employees and agents are responsible for ensuring that all records are created, used, maintained, preserved, and destroyed in accordance with this Records Management policy.

5. Vital and official records will be retained and protected to ensure the facility's continued operations in the event of a natural or man-made disaster.

6. Records containing confidential and proprietary information will be securely maintained, controlled and protected to prevent unauthorized access.

7. For Medical Records, please review the Medical Records Destruction and Retention Policy.

8. All records generated and received by the facility are the property of SVMC. No employee, by virtue of his or her position, has any personal or property right to such records even though he or she may have developed or compiled them.

9. Unauthorized destruction, removal or use of such records is prohibited.

10. No one may falsify or inappropriately alter information in any record or document.

11. The CEO, Directors and/or Managers shall designate an individual for each department to be responsible for implementing and maintaining the facilities records management programs accordance with this policy (See Records Coordinator Section).

12. The Director of Health Information Management (HIM) will review and approve all changes and revision to the record retention schedules in accordance with the California state and federal guidelines related to Medical Records only.

13. The Director of Compliance will review and approval all changes and revisions to the record retention schedules in accordance with California state and federal guidelines related to business records.

14. Information pertaining to unauthorized destruction, removal or use of facility records or regarding falsifying or inappropriately altering information in a record or document should be reported to management, either directly or through the Compliance hot-line.

SECTION I: GENERAL

Definition of Records

The originator/sender of the e-mail message (or the recipient of a message if the sender is outside the facility) is the person responsible for retaining the message. E-mail messages may be retained in electronic form in the mailbox, or be printed and filed along with other documents related to the same topic or project. Users may delete e-mail messages that they are not required by this policy to retain (such as non-record messages and transitory messages) and messages that are being retained in printed form. Other records maintained on electronic media (except e-mail) may not be destroyed until further notice.

The business records of SVMC include, but are not limited to, letterhead correspondence, legal opinions, real estate documents, directives and policies, official meeting minutes, personnel records, benefit programs purchasing requisitions and invoices, accounts payable and receivable documents, tax documents, reimbursement documents, completed and signed forms, contracts, insurance documents, general ledgers, audit reports, and financial reports.

Medical or patient records include clinical data as well as patient demographic, clinical research and financial data.

Records can only be discarded when the specified retention period has expired and the destruction date will be noted on the record log.

Definition of Non-Records

Non-records material includes duplicate copies of correspondence, duplicate copies of records used for short-term reference purposes, blank forms, stocks of publications, magazines, publications from professional organizations, newspapers, public telephone directories, and transitory messages used primarily for the informal communication of information. Transitory messages do not set policy, establish guidelines or procedures certify a transaction, or become a receipt. Transitory messages may include, but are not limited to, e-mail messages with short-lived or not administrative value, voice mail, self-sticking notes and telephone messages.

Non-records are maintained for as long as administratively needed, and the retention schedules do not apply. Non-records may be discarded when the business use is terminated.

Discretion should be used in determining whether to generate or retain transitory messages in the nature of notes of unofficial meetings, telephone conversations, or other personal notes. If generated, such records should be routinely discarded when they are no longer useful. Preliminary working papers and superseded drafts, particularly after subsequent versions are finalized, should be discarded. E-mail that contains no substantive data, such as invitations to lunch and responses to such, should be routinely discarded.

Definition of E-Mail Communications

E-mail communications, messages and documents transmitted by e-mail are similar to paper documents. They may be considered business records, and are subject to this policy. To determine whether an e-mail message must be retained and for how long, think of it like a paper memo or document. If you would retain a memo due to its content, then you are required to retain an e-mail message of the same content for the same length of time.

The originator/sender of the e-mail message (or the recipient of a message if the sender is outside the facility) is the person responsible for retaining the message. E-mail messages may be retained in electronic form in the mailbox, or be printed and filed along with other documents related to the same topic or project. Users may delete e-mail messages that they are not required by this policy to retain (such as non-record messages and transitory messages) and messages that are being retained in printed form. Other records maintained on electronic media (except e-mail) may not be destroyed until further notice.

Records Coordinators

The CEO, Department Directors/Managers shall designate an individual, using the attached appointment form (Attachment A), to serve as the Records Coordinator for their department. Send a copy of the form to the Director of HIM and Director of Compliance. If the designated person departs, or when a new Records Coordinator assumes these duties, execute a new form will be submitted.. Coordinators will be responsible for implementing and maintaining records management programs within their department.

Development of Records Retention Schedules

1. All records will be maintained and retained in accordance with Federal and State laws and regulations. Minimum retention schedules are available in the intranet.

2. Proposed changes, additions, or revisions to the record retention schedules will be reviewed by the Director of HIM. The HIM Director, in consultation with the Compliance Department will research the legal, fiscal, administrative, and historical value of the records to determine the appropriate length of time the records will be maintained and provide an identifying code. The approved changes will be distributed to the designated Records Coordinators

Active/Inactive Records

Records are to be reviewed periodically to determine if they are active or inactive. Records that are no longer required as active will be reviewed and assessed for storage in the designated on-site and/or off-site storage facility. Duplicate, multiple and non-record materials are not to be sent to the designated on-site and/or off-site storage facility, but should be destroyed. Whenever possible, the official record is the one that will be retained according to the established retention.

SECTION II: RECORDS STORAGE

Records will be stored in accordance with the attached procedures (Attachment B).

SECTION III: RECORDS MANAGEMENT FORMS

Facility Records Coordinators will develop approved control forms relating to facility business and medical records to accomplish the following:

1. Transferring records to storage;

2. Identifying, controlling, and maintaining records in storage;

3. Retrieving and/or returning records from/to storage;

4. Monitoring the record management process.

SECTION IV: RECORDS DESTRUCTION

A. Records that have satisfied their legal, fiscal, administrative, and archival requirements may be destroyed in accordance with the Records Retention Schedules.

B. Records that cannot be destroyed include records of matters in litigation or records with a permanent retention. In the event a lawsuit or government investigation, the applicable records that are not permanent cannot be destroyed until the lawsuit or investigation has been finalized. Once the litigation/investigation has been finalized, the records may be destroyed in accordance with the Records Retention Schedules.

Facility records must be destroyed in a manner that ensures the confidentiality of the records and renders the information no longer recognizable as facility records. The approved methods to destroy facility records include, but are not limited to, recycling, shredding, burning, pulping, pulverizing, and magnetizing. Facility records cannot be placed in trash receptacles unless the records are rendered no longer recognizable as facility records.

SECTION V: TRAINING

Records Coordinators will receive on-going training in the implementation of the Records Management Program. Training also will be provided on an individual basis for new individuals identified as the Records Coordinator and any individual or department that needs assistance.

SECTION VI: DIVESTITURE OR CLOSURE OF FACILITY

A. Divestiture of a Facility

In the event a facility or a line of business is sold, the Risk Management Department must ensure that sales documents will protect the facilities right to access facility business and medical records and will stipulate the non-destruction of facility records as appropriate. Additionally, before divestiture, all facility electronic records must be backed up and transferred to the Healthcare Information Systems. Also, unless the sales documents specify otherwise, software documents must be transferred to Healthcare Information Systems. Patient medical records should remain with the facility to ensure continuity of patient care. Consistent with the overall retention policy, no records shall be disposed of until the period of retention has expired for such records.

B. Closure of a Facility

All electronic records must be backed up. Patient medical records must be transferred in accordance with state requirements. Consistent with the overall retention policy, no records will be disposed of until the period of retention has expired for such records.

SECTION VII: RESPONSIBILITIES

A. Compliance Department

1. The Compliance Department is to serve as liaison with Facility Records Coordinators for business records (Non-medical records) to provide counsel regarding vital records designations and legal and statutory requirements for records retention and other pending legal matters; and

SECTION VIII: EXCEPTIONS REPORTING MECHANISM

In the event that an employee believes another employee, a contractor or other individual is impermissibly destroying records or otherwise violating this policy, he/she should contact his/her supervisor or another member of management at the facility. If the employee is uncomfortable seeking resolution at the local level, he/she may contact the Compliance hot-line at 791-4777.

REFERENCES:

- The Joint Commission (2021). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCE:

- MEDICAL RECORD RETENTION AND DESTRUCTION: DISPOSAL OF PROTECTED HEALTH INFORMATION

- CHA Records Retention Guideline Manual 2018

SUBJECT: **RETRIEVAL OF INFORMATION/DISEASE AND OPERATION INDICES**	SECTION: **Page 1 of 1**

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

POLICY:

Sierra View Medical Center's (SVMC) ability to retrieve pertinent information shall be assured by the use of an acceptable coding system for disease and operation classifications, and by the use of an indexing system to facilitate the acquisition of medical statistical information.

PROCEDURE:

- The Health Information Management Department (HIM) Coders are responsible for applying ICD-CM AND ICD-PCS (Current version), all applicable HCPCS and CPT Procedureal codes to all diagnosis and procedures performed on patients throughout the organization.
- Codes are entered into the patient abstract menu of the current hospital computer system.
- These indices are printed as needed by the HIM Director, or his/her designee. These indices may be printed monthly, or upon request at any time.
- This information is available for performance improvement activities, marketing and planning for the hospital and for physician reference.
- The State PRO (CMS) does a monthly review of randomly selected Medicare medical records and checks the Diagnostic Related Group (DRG) assignment and verifies codes used by the coding staff of the Health Information Management (HIM) Department.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **SELF-PAY DISCOUNT**	SECTION: ***PATIENT FINANCIAL SERVICES*** **Page 1 of 2**

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

PURPOSE:

Sierra View Medical Center's (SVMC) policy is to provide our uninsured patients with a self-pay discount and/or a prompt payment discount when services are paid in full within an agreed upon timeframe.

DEFINITIONS:

1. Self-pay patient: A patient who is uninsured and does not qualify for financial assistance, and does not have any governmental or third party funding sources. For purposes of the Self-pay policy, a patient who has health insurance or health benefit coverage will be considered to be uninsured for a service provided that is not covered by the health insurance or health coverage policy or if benefits are exhausted.
2. Self-pay account: An account owed by a patient who meets the definition of self-pay patient.
3. Financial Assistance and Charity Care Policy: Sierra View Medical Center's policy to provide financial assistance to patients with incomes at or below 400% of the poverty level or have catastrophic balances as defined in the Financial Assistance and Charity Care policy.

POLICY:

Sierra View Medical Center (SVMC) is committed to service the health care needs of its patients. We have established a "Self-Pay Discount Policy" to provide financial relief to those patients who meet the following requirements:

1. Patient does not qualify for financial assistance under the Financial Assistance and Charity Care Policy or other funding sources.
2. Patient requests a discount on non-covered services by their health insurance or health benefit coverage.
3. Patient chooses not to utilize their health insurance plan for payment.
4. Patient complies with the terms of this policy.
5. Service is not deemed a cosmetic procedure.

Sierra View Medical Center is committed to providing emergency and medically necessary healthcare services to patients regardless of their insurance status or ability to pay. This Self-pay discount policy is intended to be in compliance with applicable federal and state laws. Patients qualifying for assistance under this policy will receive a discount for care received at SVMC.

AFFECTED PERSONNEL/AREAS: *PATIENT FINANCIAL SERVICES, CREDIT AND COLLECTIONS*

EQUIPMENT:

- Meditech (Expanse): All self-pay discounts will be reflected on the patient account.

PROCEDURE:

The Self-Pay Discount Policy applies to inpatient services, outpatient services, and Emergency services. Sierra View Medical Center offers a thirty percent (30%) discount off total billed charges on a self-pay account when the patient agrees to pay the balance owed within 12 months based on an agreed payment plan. The plan will be interest free. A prompt pay discount of an additional 20% off total billed charges, if payment in full is made within 30 days after receiving service.

Patients are responsible for communicating with Sierra View Medical Center anytime an agreed upon payment plan cannot be fulfilled. Lack of communication from the patient may result in termination of the payment agreement and the account may be assigned to a collection agency.

1. Self-Pay Discount Policy does not apply to:

    a. Any amount applied to cost sharing: insurance co-payment, coinsurance, deductible other patient responsibility unless they meet qualifications outlined in the Charity Care and Financial Assistance policy.
    b. Accounts that became self-pay due to insurance denial as a result of patient orinsured negligence.
    c. Accounts assigned to a collection agency unless after review and approval of the Patient Accounting Manager or Administrative Director of Revenue Cycle a discount is deemed appropriate

The self-pay patient has the choice of paying the balance owed within 30 days to receive fifty percent (50%) discount (prompt pay discount) or forego the prompt pay discount and make a payment plan for up to 12 months with a 30% discount. Special circumstances may allow for a longer payment plan. A payment plan shall have equal monthly payments, unless otherwise agreed.

1. If the self-pay patient fails to honor the payment plan, the account may be assigned to a collection agency.

If it is determined that the account qualifies under the financial assistance program after payment is made for the episode of care, the adjustment will be added back to the balance and written off under the appropriate adjustment code specific to SVMC charity write off. If it is determined that they self-pay patient has overpaid, SVMC will refund the self-pay patient within 30 days from the charity write off.

REFERENCES: N/A

CROSS REFERENCES:

- Financial Assistance Policy- Full Charity Care and Discount Partial

SUBJECT: **SERVICE EXCELLENCE TEAMS**	SECTION: *Housewide Policy* **Page 1 of 2**

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

PURPOSE:

To identify the purpose and criteria for employee participation on SVMC's hospital service excellence teams. Service Excellent Teams (SET) include the Awards and Recognition Committee, The Culture Team, The EPPEC Team and The Wellness Committee.

POLICY:

Service Excellence Teams are designed to enhance the overall morale and offer staff a fun, engaging and healthy workplace. Each SET will focus on events, activities, and initiatives which support SVMC's mission, vision and values. Each SET will have a VP-level executive sponsor.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

To be eligible to participate on a SVMC SET staff members must meet the following criteria:

- Newly hired staff must complete at least six months of employment.
- Staff must be able to demonstrate success in their position and be viewed as a role-model of SVMC's values to be considered to participate on a service team. If a staff member is placed on a written-level notice of corrective action, the Director/Manager will ask their staff member to step down from their respective SET team and the Director/Manager will notify the SET executive sponsor. The staff member, if no further notice of corrective actions are issued can be re-considered for a SET after six (6) months from the NOCA.
-
- Staff can self-select to join a team if they meet the above criteria with leadership approval and/or be recommended to join a team from their leadership team member.
-
- Existing staff serving on a service team who transfer into a new position Can remain on the SET with the approval of their new department leadership.
- Service on a team is not established for any certain period of time. As long as the staff member remains in good standing and continues to want to serve, they are afforded this opportunity.
- Staff may only serve on one (1) service team at a time.

At any point during the employee's tenure on a team, if any of the above listed criteria have not been met, the employee's membership will be withdrawn from the service team. This will be done discreetly and confidentially, with the assistance of the staff member's SET executive sponsor.

Time spent by employees performing tasks for their respective teams will be considered to be "hours worked" and employees will be paid at their base rate of pay. Service on a SET is not intended to result in receiving overtime pay. To avoid working greater than 40 hours in a work week, employees may be permitted to flex their scheduled hours, with prior authorization from the employee's respective department Director/Manager, based on the needs of the department.

REFERENCES:

- PERSONAL CONDUCT
- PERFORMANCE ACCOUNTABILITY AND COMMITMENT
- ATTENDANCE AND PUNCTUALITY

SUBJECT: **SIGNATURE, INITIALS OR COMPUTER KEY IDENTIFICATION**	SECTION: **Page 1 of 1**

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

POLICY:

- Initials and computer key signatures must be identifiable by the initiating department. Per Medicare payment policy the use of rubber stamps is **NOT** permitted.

PROCEDURE:

- There will be no use of a signature stamp by any individual. Discovery of this practice will immediately result in the loss of this privilege.
- Initials may be used in the medical record only if they are identified in that record with the appropriate individual's signature.
- The departments using computer generated reports with computer key identification shall have proper documentation within the department for identifying the computer signature.
- Digital signatures are used to provide non-repudiation of content or authorship.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL

CMS "Medicare Program Integrity Manual" (Publication [Pub.] 100-08), Chapter 3, Section 3.3.2.4 at http://www.cms.gov/ Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03. pdf on the CMS website.

SUBJECT: **STAFFING**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure the Health Information Management Department (HIM) shall be provided with adequate direction, staffing and facilities to perform all required functions.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that the HIM Department shall be provided with adequate direction, staffing and facilities to perform all required functions.

AFFECTED AREAS/PERSONNEL: *ALL HIM PERSONNEL*

PROCEDURE:

1. A Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT), who is a qualified medical record individual, is responsible to the Chief Financial Officer and is employed by the hospital on a full-time basis. The RHIA must demonstrate successful completion of examination requirements of the American Health Information Management Association. This documentation must be kept within the personnel file.

2. The RHIA/RHIT is capable of providing highly developed organization, management and departmental skills, as measured by an annual evaluation.

3. If employment of a Registered Health Information Administrator or Registered Health Information Technician (RHIT) is impossible, the hospital must secure the consultative assistance of a qualified RHIA or RHIT to assist in the management and organization of the Health Information Management Department. The consultant must also evaluate staff and the quality of the services provided.

4. A consultant may not be used as a supplement to or substitute for the performance of routine duties by HIM staff.

5. If the services of a consultant are required, they must visit not less than quarterly and must submit written reports of the findings and recommended actions to the Chief Executive Officer.

6. When the hospital is using an RHIA or RHIT as a consultant, individuals who are given the responsibility of supervising Health Information Management Department staff, but are not registered, must demonstrate their current competence as measured by an annual evaluation. In addition to competence, the individuals must also demonstrate:

    a. A working knowledge of all medical record activities to include computerization

    b. Orientation, on-the-job training and in-service education of Health Information Management Department staff

c. The role of the HIM in medical staff or departmental committee functions (Information Management Committee, Utilization Management Committee, Department Manager Meetings and any other committees in which they are requested to attend or make report)

7. It is also recommended that these staff enroll in at least the American Health Information Management Association correspondence program to prepare them for eligibility for registered status.

REFERENCE:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

58

SIERRA VIEW MEDICAL CENTER

Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____0_____+_____+_____+_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

PHQ-2

024863 REV 5/22

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

5

SIERRA VIEW MEDICAL CENTER **Patient Health Questionnaire-2 (PHQ-2)**

Durante las *últimas 2 semanas*, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3

For office coding: _____0_____+_____+_____+_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

PHQ-2

024863 REV 5/22

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PATIENT'S LABEL

60

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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 **May 24, 2022 at 4:30 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California and 585 N. Belmont Street, Porterville, California.

I. Call to Order: Chairman REDDY called the meeting to order at 4:36 p.m.

Directors Present: **BEHL, LOMELI, REDDY, PANDYA and SORRELLS**
Others Present: Barlow-Merritt, Devon, Manager of Bridge Care Services Blazar, Dan, Patient Experience Officer Camacho, Lorena, Director of Enterprise Risk Management Canales, Tracy, VP of Human Resources, Marketing and Public Relations Cartwright, Susan, Director of Medical Staff Dickson, Doug, Chief Financial Officer Eckhoff, Richard, Community Member Fernandez, Josue, Director of Operations Fuentes, Melissa, VP Quality and Regulatory Affairs Gomez, Cindy, Director of Compliance Hefner, Donna, President/Chief Executive Officer Hudson-Covolo, Jeffery, VP, Chief Nurse Executive, GME/DIO Hurtado-Ziola, Nancy, Infection Prevention Manager Kellog, Valerie, MA Rural Health Clinic – Terra Bella Martinez, Diego, Practice Management Executive Director Nweze, Margaret, NP Rural Health Clinic – Terra Bella Parsons, Malynda, Public Relations Specialist Pryor-DeShazo, Kimberley, Director of Marketing and Public Relations Reed-Krase, Alex, Legal Counsel Roberts, Silvia, Manager of Care Integration for Social Services and Case Management Sandhu, Harpreet, MD, Chief of Staff Torres, Valerie, MA Rural Health Clinic – Terra Bella Velazquez, Cristina, MA Rural Health Clinic – Terra Bella Verduzco-Silva, Alida, Marketing and Community Relations Manager 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

II. Approval of Agendas: Chairman REDDY asked for approval of the agenda with a motion to move the Consent Agenda to follow Public Comment after the Open Session. It was moved by Director BEHL, seconded by Vice Chairman LOMELI, and carried to approve the agenda as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

III. Approval of Minutes:

Following review and discussion, it was moved by Director SORRELLS and seconded by Vice Chairman LOMELI to approve the April 26, 2022 Minutes of the Regular Meeting of

the Board of Directors The motioned carried and the vote of the Board, taken by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

Following review and discussion, it was moved by Vice Chairman LOMELI and seconded by Director BEHL to approve the May 12, 2022 Minutes of the Special Meeting of the Board of Directors. The motion carried and the vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Abstain
BEHL	Yes
PANDYA	Yes

IV. Closed Session: Board adjourned Open Session and went into Closed Session at 4:40 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update – Patient Safety Report for Quarter 3

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – December 2022

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

V. Open Session: Chairman REDDY adjourned Closed Session at 5:10 p.m., reconvening in Open Session at 5:10 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, Harpreet Sandhu, M.D. 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 SORRELLS, seconded by Vice Chairman LOMELI, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

2. Quality Division Update – Patient Safety Quarter 3 Report. Following review and discussion, it was moved by Director SORRELLS, seconded by Vice Chairman LOMELI, and carried to approve the Quality Division Update – Patient Safety Quarter 3 Report as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

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

VI. Public Comments

Dr. Reddy made a request for Public Comment. None were made.

VII. 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 SORRELLS, seconded by Vice Chairman LOMELI, and carried to approve the Consent Agenda as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

VIII. Hospital CEO Report

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

IX. Business Action Items

A. Patient Experience Report

Dan Blazar, Patient Experience Officer presented to the Board of Directors.

Following review and discussion, it was moved by Director SORRELLS, seconded by Vice Chair LOMELI and carried to approve the Patient Experience Report as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

B. April 2022 Financials

Doug Dickson, CFO presented the Financials for April 2022. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $12,938,580. Supplemental Funds were $1,759,860. Total Operating Expenses were $13,803,984. $865,404 loss from operations.

Following review and discussion, it was moved by Director SORRELS, seconded by Vice Chairman LOMELI and carried to approve the April 2022 Financials as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

C. SVLHCD Fiscal Year 2023 Investment Policy

Following review and discussion, it was moved by Director SORRELLS, seconded by Vice Chairman LOMELI and carried to approve the SVLHCD Fiscal Year 2023 Investment Policy as presented. The vote of the Board by roll call is as follows:

REDDY	Yes

LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

D. Café Price Increase

Zaelin Stringham, Director of Food and Nutrition presented to the Board of Directors.

Following review and discussion, it was moved by Director SORRELLS, seconded by Chairman REDDY and carried to approve Café Price Increase as presented, which was a 15% increase in the pricing and to standardize the employee discount of 15% at both the coffee corner and cafeteria. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

E. Final Map Scenario D

Information only; no action taken. Public comment was received on this agenda item by Richard Eckoff.

F. Medical Staff Bylaws

Following review and discussion, it was moved by Director SORRELLS, seconded by Chairman REDDY and carried to approve Medical Staff Bylaws as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

X. Closed Session: Board adjourned Open Session at 6:20 p.m. and went into Closed Session at 6:20 p.m. to discuss the following items:

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

E. Pursuant to Gov. Code Section 54956.9(d)(2), Exposure to Litigation to subdivision(d)(2): Conference with Legal Counsel. BETA Claim No. 22-000785

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

G. Pursuant to Gov. Code Section 54957(b): Discussion Pertaining to Personnel: Public Employee Performance Evaluation

XII. Open Session: Board adjourned Closed Session and went into Open Session at 8:05 p.m. to discuss the following items:

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

D. Discussion Regarding Trade Secret

Information only; no action taken

E. Conference with Legal Counsel

Following review and discussion, it was moved by Director SORRELLS, seconded by Vice Chairman LOMELI and carried to deny BETA Claim No. 22-000785 as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

F. Conference with Legal Counsel

Information only; no action taken

G. Public Employee Performance Evaluation

Pursuant to Gov. Code Section 54957(b); The Board reported, though counsel, of the Actions taken as a result of discussion(s) in Closed Session:

Due Director Pandya's legal claim against the Hospital arising out of the Board's handling of a personnel issue related to Donna Hefner, Director Pandya was recused from this item.

Discussion occurred after his recusal, after which time Director SORRELLS moved, seconded by Vice Chairman Lomeli, and carried that a conflict of interest and unacceptable potential for bias currently exists between Dr. Pandya and Hospital CEO Donna Hefner, and therefore Dr. Pandya shall not participate in the performance evaluations of the Hospital CEO Donna Hefner until the Board determines that there no longer exists a conflict of interest and/or unacceptable potential for bias. The vote of the Board in closed session was as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Recused

After further discussion and review of President/CEO Donna Hefner's performance evaluation Director SORRELLS moved, seconded by Vice Chairman Lomeli, and carried to find that hospital President/CEO Donna Hefner met and exceeded her annual performance benchmarks. The vote of the Board was as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Recused

The Board reports that there were no discussions of CEO compensation in Closed Session. Further, there are no agreements that have been proposed by the the Board or the CEO to adjust or change the existing contract for employment and compensation between the Board and the CEO.

XIII. Announcements:

A. Regular Board of Directors Meeting – June 28, 2022

Adjournment: There being no further business, the meeting was adjourned at 8:10 p.m.
There being no further business, the meeting was adjourned at 5:47 p.m.
It was moved by Director SORRELLS seconded by Vice Chairman LOMELI, and carried to adjourn. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

Respectfully submitted,

Kent Sorrells, PhD
Secretary
SVLHCD Board of Directors
KS: ww

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

The special meeting of the Board of Directors of Sierra View Local Health Care District was held **June 13 2022 at 4:30 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California and 585 N. Belmont, Porterville, California

Directors Present: **BEHL, LOMELI, REDDY, SORRELLS and PANDYA**

Others Present: Canales, Tracy, VP Human Resources & Marketing, Dickson, Doug, Chief Financial Officer, Fuentes, Melissa, VP Quality and Regulatory Affairs, Hefner, Donna, President/CEO, Hudson, Jeffery, Chief Nurse Executive/VP Patient Care, Reed-Krase, Alex, Legal Counsel, Verduzco-Silva, Alida, Marketing and Community Relations Manager, Watts, Whitney, Executive Assistant and Clerk to Board of Directors

I. Call to Order: Chairman REDDY called the meeting to order at 4:06 p.m.

II. Approval of Agendas: Chairman REDDY asked for approval of the agenda. It was moved by Vice Chairman SORRELLS seconded by Director BEHL, and carried to approve the agenda as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Absent
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

III. Closed Session: Board adjourned Open Session and went into Closed Session at 4:38 p.m. to discuss the following items:

A. Pursuant to Gov. Code Section 54962;Health and Safety Code Section 32106(b): Discussion Regarding Trade Secret, Pertaining to Service (2 Items) Estimated Date of Disclosure – December 2022

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

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

IV. Open Session: Chairman REDDY adjourned Closed Session at 5:44 p.m., reconvening in Open Session at 5:47 p.m.

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

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

B. Conference with Legal Counsel about recent work product. Information only; no action taken.

V. Public Comments

Chairman Reddy made a request for Public Comment. None were made.

XIII. Announcements:

A. Regular Board of Directors Meeting – June 28, 2022

XIV. Adjournment:

There being no further business, the meeting was adjourned at 5:47 p.m.
It was moved by Director SORRELLS seconded by Vice Chairman LOMELI, and carried to adjourn. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Yes
BEHL	Yes
PANDYA	Yes

Respectfully submitted,

Kent Sorrells, PhD
Secretary
SVLHCD Board of Directors
KS: ww

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FINANCIAL PACKAGE
May 2022

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
May 2022

Statistic	May-22 Actual	May-22 Budget	May-22 Over/ (Under)	May-22 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 21 YTD	Increase/ (Decrease) 05/2021	% Change
Utilization											
SNF Patient Days											
Total	82	61	21	34.4%	845	654	191	29.2%	1,018	(173)	-17.0%
Medi-Cal	62	61	1	1.6%	752	624	128	20.5%	975	(223)	-22.9%
Sub-Acute Patient Days											
Total	918	901	17	1.9%	9,957	10,513	(556)	-5.3%	9,917	40	0.4%
Medi-Cal	609	673	(64)	-9.5%	6,595	8,282	(1,687)	-20.4%	7,941	(1,346)	-17.0%
Acute Patient Days	1,847	1,863	(16)	-0.9%	23,895	20,753	3,142	15.1%	20,042	3,853	19.2%
Acute Discharges	474	472	2	0.4%	5,223	5,288	(65)	-1.2%	4,847	376	7.8%
Medicare	179	186	(7)	-3.8%	1,988	1,950	38	1.9%	1,782	206	11.6%
Medi-Cal	232	215	17	8.0%	2,520	2,550	(30)	-1.2%	2,339	181	7.7%
Contract	55	69	(14)	-20.4%	676	742	(66)	-8.9%	687	(11)	-1.6%
Other	8	2	6	276.3%	39	46	(7)	-14.6%	39	-	0.0%
Average Length of Stay	3.90	3.95	(0.05)	-1.3%	4.57	3.92	0.65	16.6%	4.13	0.44	10.6%
Newborn Patient Days											
Medi-Cal	185	205	(20)	-9.8%	1,878	2,255	(377)	-16.7%	1,951	(73)	-3.7%
Other	24	40	(16)	-39.5%	432	438	(6)	-1.5%	471	(39)	-8.3%
Total	209	245	(36)	-14.6%	2,310	2,694	(384)	-14.2%	2,422	(112)	-4.6%
Total Deliveries	107	127	(20)	-15.7%	1,207	1,397	(190)	-13.6%	1,309	(102)	-7.8%
Medi-Cal %	86.79%	82.98%	3.82%	4.6%	82.33%	82.98%	-0.65%	-0.8%	80.21%	2.11%	2.6%
Case Mix Index											
Medicare	1.6128	1.6699	(0.0571)	-3.4%	1.6888	1.6699	0.0189	1.1%	1.6814	0.0074	0.4%
Medi-Cal	1.2164	1.2297	(0.0133)	-1.1%	1.2411	1.2297	0.0114	0.9%	1.2495	(0.0084)	-0.7%
Overall	1.3726	1.4118	(0.0392)	-2.8%	1.4488	1.4118	0.0370	2.6%	1.4245	0.0243	1.7%
Ancillary Services											
Inpatient											
Surgery Minutes	9,652	9,221	431	4.7%	97,030	103,050	(6,020)	-5.8%	96,180	850	0.9%
Surgery Cases	103	122	(19)	-15.6%	1,097	1,279	(182)	-14.2%	1,095	2	0.2%
Imaging Procedures	1,534	1,260	274	21.7%	16,784	14,028	2,756	19.6%	13,123	3,661	27.9%
Outpatient											
Surgery Minutes	9,151	13,027	(3,876)	-29.8%	116,195	143,297	(27,102)	-18.9%	141,432	(25,237)	-17.8%
Surgery Cases	141	270	(129)	-47.8%	1,760	2,710	(950)	-35.1%	2,050	(290)	-14.1%
Endoscopy Procedures	169	222	(53)	-23.9%	1,856	2,442	(586)	-24.0%	1,266	590	46.6%
Imaging Procedures	3,965	3,147	818	26.0%	40,730	34,617	6,113	17.7%	35,182	5,548	15.8%
MRI Procedures	242	293	(51)	-17.4%	3,095	3,233	(138)	-4.3%	2,964	131	4.4%
CT Procedures	1,181	812	369	45.4%	11,444	8,938	2,506	28.0%	9,539	1,905	20.0%
Ultrasound Procedures	1,087	954	133	13.9%	10,464	10,044	420	4.2%	7,976	2,488	31.2%
Lab Tests	33,969	36,517	(2,548)	-7.0%	414,066	401,687	12,379	3.1%	400,817	13,249	3.3%
Dialysis	1	10	(9)	-90.0%	47	110	(63)	-57.3%	80	(33)	-41.3%

Sierra View Medical Center
Financial Statistics Summary Report
May 2022

	May-22				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 21 YTD	(Decrease) 05/2021	% Change
Cancer Treatment Center											
Chemo Treatments	1,901	1,685	216	12.8%	19,832	18,532	1,300	7.0%	17,190	2,642	15.4%
Radiation Treatments	2,005	1,958	47	2.4%	18,242	21,542	(3,300)	-15.3%	18,255	(13)	-0.1%
Cardiac Cath Lab											
Cath Lab IP Procedures	13	6	7	116.7%	110	72	38	52.8%	93	17	18.3%
Cath Lab OP Procedures	25	35	(10)	-28.6%	267	385	(118)	-30.6%	358	(91)	-25.4%
Total Cardiac Cath Lab	38	41	(3)	-7.3%	377	457	(80)	-17.5%	451	(74)	-16.4%
Outpatient Visits											
Emergency	3,549	2,885	664	23.0%	33,934	31,789	2,145	6.7%	27,679	6,255	22.6%
Total Outpatient	12,998	12,353	645	5.2%	136,531	135,349	1,182	0.9%	127,695	8,836	6.9%
Staffing											
Paid FTE's	910.38	918.19	(7.81)	-0.9%	912.61	918.19	(5.58)	-0.6%	880.75	31.86	3.6%
Productive FTE's	783.95	790.79	(6.84)	-0.9%	774.69	790.79	(16.10)	-2.0%	755.16	19.53	2.6%
Paid FTE's/AOB	5.54	5.66	(0.12)	-2.1%	5.19	5.46	(0.27)	-5.0%	5.44	(0.25)	-4.7%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	10,930	10,842	88	0.8%	10,305	10,644	(340)	-3.2%	10,511	(206)	-2.0%
Cost/Adj.Patient Day	2,800	2,506	293	11.7%	2,615	2,449	166	6.8%	2,519	96	3.8%
					-						
					-						
Revenue/Adj. Discharge	57,143	53,491	3,652	6.8%	59,170	52,685	6,485	12.3%	54,578	4,592	8.4%
Cost/Adj. Discharge	14,638	12,367	2,271	18.4%	15,017	12,120	2,896	23.9%	13,082	1,934	14.8%
Adj. Discharge	974	1,019	(45)	-4.4%	10,264	11,383	(1,119)	-9.8%	10,442	(178)	-1.7%
Net Op. Gain/(Loss) %	0.63%	-5.04%	5.67%	-112.6%	-6.42%	-5.04%	-1.38%	27.4%	-6.99%	0.56%	-8.1%
Net Op. Gain/(Loss) $	90,878	(604,586)	695,464	-115.0%	(9,302,385)	(5,811,357)	(3,491,028)	60.1%	(8,919,311)	(383,074)	4.3%
Gross Days In Accts Rec.	87.51	87.97	(0.46)	-0.5%	87.51	87.97	(0.46)	-0.5%	89.65	(2.15)	-2.4%
Net Days in Accts. Rec.	67.08	59.02	8.06	13.7%	67.08	59.02	8.06	13.7%	74.31	(7.23)	-9.7%

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

	MAY 2022	APR 2022
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 18,962,412	$ 21,814,623
SHORT-TERM INVESTMENTS	10,243,236	9,937,909
ASSETS LIMITED AS TO USE	1,807,823	1,809,638
PATIENT ACCOUNTS RECEIVABLE	158,704,678	159,446,941
LESS UNCOLLECTIBLES	(22,715,514)	(21,709,030)
CONTRACTUAL ALLOWANCES	(108,493,702)	(109,641,653)
OTHER RECEIVABLES	8,918,197	5,920,054
INVENTORIES	3,942,436	3,902,850
PREPAID EXPENSES AND DEPOSITS	2,178,808	2,354,184
TOTAL CURRENT ASSETS	73,548,374	73,835,516
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	33,519,707	33,046,991
LONG-TERM INVESTMENTS	135,983,287	135,784,635
PROPERTY, PLANT AND EQUIPMENT, NET	90,974,738	91,622,448
INTANGIBLE RIGHT OF USE ASSETS	509,735	529,394
OTHER ASSETS:		
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	2,035,023	2,056,002
TOTAL ASSETS	$ 336,820,863	$ 337,124,986

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

	MAY 2022	APR 2022
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 793,729	$ 634,983
CURRENT MATURITIES OF BONDS PAYABLE	3,715,000	3,715,000
CURRENT MATURITIES OF LONG TERM DEBT	1,164,509	1,164,509
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	6,539,506	6,334,938
ACCRUED PAYROLL AND RELATED COSTS	8,707,872	8,340,988
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	4,001,047	3,853,074
LEASE LIABILITY - CURRENT	250,968	262,276
TOTAL CURRENT LIABILITIES	25,172,630	24,305,768
SELF-INSURANCE RESERVES	955,605	1,048,759
CAPITAL LEASE LIAB LT	3,047,835	3,129,592
BONDS PAYABLE, LESS CURR REQT	45,445,000	45,445,000
BOND PREMIUM LIABILITY - LT	4,254,751	4,325,729
LEASE LIABILITY - LT	258,767	267,118
OTHER NON CURRENT LIABILITIES	375,854	563,781
TOTAL LIABILITIES	79,510,442	79,085,745
UNRESTRICTED FUND	263,162,280	263,162,280
PROFIT OR (LOSS)	(5,851,859)	(5,123,040)
TOTAL LIABILITIES AND FUND BALANCE	$ 336,820,863	$ 337,124,986

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

MAY 2022 ACTUAL	MAY 2022 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,091,406	5,203,430	112,024	(2)%	INPATIENT - NURSING	62,304,656	56,709,512	(5,595,144)	10%
20,337,413	20,044,319	(293,094)	2%	INPATIENT - ANCILLARY	237,404,320	221,887,285	(15,517,035)	7%
25,428,819	25,247,749	(181,070)	1%	TOTAL INPATIENT REVENUE	299,708,976	278,596,797	(21,112,179)	8%
30,215,430	29,253,967	(961,463)	3%	OUTPATIENT - ANCILLARY	307,628,626	321,127,283	13,498,658	(4)%
55,644,249	54,501,716	(1,142,533)	2%	TOTAL PATIENT REVENUE	607,337,601	599,724,080	(7,613,521)	1%
				DEDUCTIONS FROM REVENUE				
(16,558,928)	(19,133,224)	(2,574,296)	(14)%	MEDICARE	(195,937,160)	(210,465,464)	(14,528,304)	(7)%
(17,832,523)	(14,943,830)	2,888,693	19%	MEDI-CAL	(190,839,015)	(164,382,130)	26,456,885	16%
(7,050,482)	(8,318,072)	(1,267,590)	(15)%	OTHER/CHARITY	(76,193,273)	(91,498,792)	(15,305,519)	(17)%
(32,625)	(26,506)	6,119	23%	DISCOUNTS & ALLOWANCES	(118,769)	(291,566)	(172,797)	(59)%
(1,314,502)	(592,179)	722,323	122%	BAD DEBTS	(5,462,647)	(6,513,969)	(1,051,322)	(16)%
(42,789,060)	(43,013,811)	(224,751)	(1)%	TOTAL DEDUCTIONS	(468,550,865)	(473,151,921)	(4,601,056)	(1)%
12,855,189	11,487,905	(1,367,284)	12%	NET SERVICE REVENUE	138,786,737	126,572,159	(12,214,578)	10%
1,489,208	507,894	(981,314)	193%	OTHER OPERATING REVENUE	6,049,345	5,586,832	(462,513)	8%
14,344,396	11,995,799	(2,348,597)	20%	TOTAL OPERATING REVENUE	144,836,082	132,158,991	(12,677,091)	10%
				***** OPERATING EXPENSE *****				
4,909,590	5,076,904	(167,314)	(3)%	SALARIES	52,160,459	54,911,710	(2,751,251)	(5)%
552,028	616,624	(64,596)	(11)%	S&W PTO	7,088,731	6,650,076	438,655	7%
1,344,752	1,351,696	(6,944)	(1)%	EMPLOYEE BENEFITS	14,331,400	14,724,106	(392,706)	(3)%
2,687,078	1,227,063	1,460,015	119%	PROFESSIONAL FEES	29,703,983	13,495,385	16,208,598	120%
921,867	698,731	223,136	32%	PURCHASED SERVICES	8,477,483	7,741,933	735,550	10%
2,087,377	1,950,042	137,335	7%	SUPPLIES & EXPENSES	22,404,242	21,499,582	904,660	4%
214,923	193,683	21,240	11%	MAINTENANCE & REPAIRS	2,360,837	2,189,362	171,475	8%
200,333	163,719	36,614	22%	UTILITIES	2,270,691	1,800,909	469,782	26%
56,161	62,770	(6,610)	(11)%	RENT/LEASE	864,575	690,472	174,103	25%
104,816	97,200	7,616	8%	INSURANCE	1,041,088	1,069,200	(28,113)	(3)%
842,511	852,592	(10,081)	(1)%	DEPRECIATION/AMORTIZATION	9,437,371	9,748,229	(310,858)	(3)%
332,083	309,361	22,722	7%	OTHER EXPENSE	3,997,608	3,449,384	548,224	16%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,253,518	12,600,385	1,653,133	13%	TOTAL OPERATING EXPENSE	154,138,467	137,970,348	16,168,119	12%
90,878	(604,586)	(695,464)	(115)%	NET GAIN/(LOSS) FROM OPERATIONS	(9,302,385)	(5,811,357)	3,491,028	60%
120,639	110,972	(9,667)	9%	DISTRICT TAXES	1,230,359	1,220,695	(9,664)	1%
184,674	137,501	(47,173)	34%	INVESTMENTS INCOME	1,755,991	1,512,502	(243,489)	16%
(1,336,167)	171,269	1,507,436	(880)%	OTHER NON OPERATING INCOME	11,011,833	1,883,958	(9,127,875)	485%
(91,974)	(92,349)	(375)	0%	INTEREST EXPENSE	(1,016,888)	(1,015,837)	1,051	0%
(24,077)	(56,869)	(32,792)	(58)%	NON-OPERATING EXPENSE	(593,604)	(625,555)	(31,951)	(5)%
(1,146,905)	270,524	1,417,429	(524)%	TOTAL NON-OPERATING INCOME	12,387,691	2,975,763	(9,411,928)	316%
(1,056,027)	(334,062)	721,965	216%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	3,085,306	(2,835,594)	(5,920,900)	(209)%
327,207	0	(327,207)		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	(8,937,165)	0	8,937,165	
(728,819)	(334,062)	394,757	118%	NET GAIN/(LOSS)	(5,851,859)	(2,835,594)	3,016,265	106%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
05/31/22

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	90,878	(9,302,385)
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation and amortization	842,511	9,437,371
Provision for bad debts	1,006,484	(4,373,025)
Changes in assets and liabilities:		
Patient accounts receivable	(405,687)	1,449,116
Other receivables	(2,998,143)	(2,200,602)
Inventories	(39,586)	(242,665)
Prepaid expenses and deposits	175,376	(502,956)
Advance refunding of bonds payable	20,979	230,775
Accounts payable and accrued expenses	204,568	(1,587,553)
Accrued payroll and related liabilities	366,884	1,374,371
Estimated third-party payor settlements	147,973	(868,776)
Self-insured program reserves	(93,154)	(527,248)
Total adjustments	(771,795)	2,188,808
Net cash provided by (used in) operating activities	(680,917)	(7,113,577)
Cash flows from noncapital financing activities:		
District tax revenues	120,639	1,230,359
Noncapital grants and contributions, net of other expenses	(1,360,243)	10,417,636
Net cash provided by (used in) noncapital financing activities	(1,239,604)	11,647,995
Cash flows from capital and related financing activities:		
Purchase of capital assets, net of disposals	(194,801)	(4,683,617)
Intangible right of use assets	19,659	(509,735)
Principal payments on debt borrowings	-	(3,770,000)
Interest payments	(4,206)	(2,039,724)
Net change in notes payable and lease liability	(289,343)	(572,933)
Net changes in assets limited as to use	(470,901)	5,396,110
Net cash provided by (used in) capital and related financing activities	(939,592)	(6,179,899)
Cash flows from investing activities:		
Net (purchase) or sale of investments	128,555	3,437,009
Interest and dividends received from investments	184,674	1,755,991
Net cash provided by (used in) investing activities	313,229	5,193,000
Net increase (decrease) in cash and cash equivalents:	(2,546,884)	3,547,519
Cash and cash equivalents at beginning of month/year	31,752,532	25,658,129
Cash and cash equivalents at end of month	29,205,648	29,205,648

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
May 2022

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Jun-21	11,341,330	6,918,000	18,259,330
Jul-21	8,753,563	5,989,305	14,742,868
Aug-21	11,472,363	601,204	12,073,567
Sep-21	12,759,611	1,650,547	14,410,158
Oct-21	10,376,691	1,244,630	11,621,321
Nov-21	10,974,393	1,575,199	12,549,592
Dec-21	13,662,211	6,342,016	20,004,227
Jan-22	9,101,598	3,002,395	12,103,993
Feb-22	9,223,160	1,873,199	11,096,359
Mar-22	11,160,102	6,179,876	17,339,978
Apr-22	10,302,842	5,121,377	15,424,219
May-22	**10,717,469**	**760,349**	**11,477,818**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - cash receipts for Cafe and Coffee Corner sales, rebates, refunds, and receipts from miscellaneous funding sources

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

- Medi-Cal OP Supplemental and DSH funds received
- Medi-Cal and Medi-Care Tentative Cost Settlements received for prior year
- Grants, IGT, & HQAF

May 2022 Summary of Other Activity:

509,612	Property Taxes
250,737	Miscellaneous
760,349	05/22 Total Other Activity

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SIERRA VIEW
MEDICAL CENTER

PUBLIC RECORDS REQUEST SUMMARY

REQUEST June 2, 2022

Request via Email from Gaurang Pandya

I hereby request copies of the following board public records.

1. Written notes, Audio and video copy of records of board meeting dated July 27 2021. Include records of public and closed sessions of the meeting include records of closed sessions deliberations on Donna Hefner's complaint.

2. Copy of complaint by Donna Hefner regarding July 20 2021 meeting.

3. Written notes audio and video copy of all records of pre board meeting dated July 20 2021. Include all notes kept by Whitney watts.

RESPONSE June 14, 2022

All items requested were responded to via email

SIERRA VIEW
MEDICAL CENTER

PUBLIC RECORDS REQUEST SUMMARY

REQUEST June 6, 2022

Request via Email from Kelvin Sousa, Internal General Counsel and Compliance Officer – Family HealthCare Network

I'm putting in a public records request for the official "minutes" documents associated with the last two Sierra View Local Health Care District board of directors meetings on 05/12/22 and 05/24/22.

RESPONSE June 6, 2022

All items requested were responded to via email