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

AGENDA
March 24, 2026

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

1. **General Update;**
2. **Report on Peer Review/Credentials**

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

C. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation: **Conference with Legal Counsel**; (1 Item).

D. Pursuant to Gov. Code Section 54957(b): Discussion Regarding **Confidential Personnel Matter** – One (1) Items. Estimated Date of Disclosure January 1, 2029, for materials that are not part of an individual's private personnel file.

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): **Discussion Regarding Trade Secrets Pertaining to Facilities, Services and Strategic Planning**. Estimated date of disclosure December 1, 2026.

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): **Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning**. Estimated date of disclosure December 1, 2026.

G. Pursuant To Gov. Code Section 54956.9(D)(2), **Conference With Legal Counsel** About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Items).

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

A. Chief of Staff Report:

1. **General Report**
   Recommended Action: Information only; no action taken

2. **Report on Peer Review/Credentials**
   Recommended Action: Approve/Disapprove Report on Peer Review and Credentials as Given

B. **Quality Division Update**
Recommended Action: Approve/Disapprove Quality Division Report as Given

C. **Conference with Legal Counsel**
Recommended Action: Information Only; No Action Taken

D. **Discussion Regarding Confidential Personnel Matter**
Recommended Action: Information Only; No Action Taken

E. **Discussion Regarding Trade Secrets Pertaining to Facilities, Services and Strategic Planning**
Recommended Action: Information Only; No Action Taken

F. **Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning**
Recommended Action: Information Only; No Action Taken

G. **Conference with Legal Counsel**
Recommended Action: Information Only; No Action Taken

VI. Public Comments

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

VII. Consent Agenda
Recommended Action: Approve/Disapprove Consent Agenda as presented

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

VIII. Approval of Minutes

A. February 24, 2026, Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove February 24, 2026, Minutes of the Annual Meeting of the Board of Directors

IX. Business Items

A. February 2026 Financials
Recommended Action: Approve/Disapprove February Report as Presented

B. 2024 Environment of Care Annual Evaluation
Recommended Action: Approve/Disapprove Report as Presented

C. Graduate Medical Education (GME) Match
Recommended Action: Information Only

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

- Regular Board of Directors Meeting – April 28, 2026, at 5:00 p.m.

XIII. Adjournment

PUBLIC NOTICE

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

PUBLIC NOTICE ABOUT COPIES

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

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

HOSPITAL POLICIES AND REPORTS FOR REVIEW
APPROVED BY SENIOR LEADERSHIP TEAM

Senior Leadership Team	3/24/2026
Board of Director's Approval	
Liberty Lomeli, Chairman	3/24/2026

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
March 24, 2026
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 ↓
• Administration of Influenza Vaccine to Non-Patients (Employees & Community Members)	1-4	
• Debt Collection and Referral Patient Notification	5-16	
• Employment Status	17-19	
• Financial Assistance Policy	20-41	
• Leadership Responsibilities, Accountabilities and Standards of Conduct	42-44	
• Physician Medical Record Documentation and Dictation	45-50	
• Reasonable Accommodations	51-58	
• Reimbursement for Relocation Expenses	59-61	
• Retention Guideline Manual	62-141	
• Staff Recruitment Employment and Retention	142-145	
• Transitional Return to Work	146-151	

SUBJECT:	SECTION:
ADMINISTRATION OF INFLUENZA VACCINE TO NON-PATIENTS (EMPLOYEES & COMMUNITY MEMBERS)	**Page 1 of 4**

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

POLICY:

A. Function(s): Administration of influenza vaccine to individuals who meet criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices; as reviewed by Pharmacy.

B. Circumstances:

1. Setting: Any individual meeting criteria (as stated above).

2. Condition/Contraindications: Any individual in need of influenza vaccine, meeting criteria (as stated above). See procedure for contraindications.

3. Other: None

PROCEDURE:

A. Definition: Eligible nurses will utilize the following parameters to identify individuals in need of influenza vaccine and subsequently vaccinate these persons.

B. Data Base:

1. Subjective: N/A

2. Objective:

a. All individuals 6 months of age or older

b. ~~Vaccinate all~~All individuals who are in need of and want vaccination

c. Not excluding individuals having any of the following conditions:

- Chronic disorder of the pulmonary or cardiovascular system, including asthma
- Chronic metabolic disease (e.g. diabetes), renal dysfunction, hemoglobinopathies, or immunosuppression (e.g. caused by medications, HIV) that has required regular medical follow up or hospitalization during the preceding year
- Any condition that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration (i.e.

congestive dysfunction, spinal cord injury, seizure disorder or other neuromuscular disorders)

- Will be pregnant during the influenza season

d. Residence in a nursing home or other chronic-care facility that houses persons of any age who have chronic medical conditions

e. In an occupation or living situation that puts one in proximity to persons at high risk, including:

- A healthcare worker, caregiver, or household member in contact with person(s) at high risk of developing complications from influenza

f. Immunocompromised (i.e. HIV)

3. Screen for contraindications and precautions to influenza vaccine:

a. Serious reaction (i.e. anaphylaxis) ~~after ingesting eggs or~~ after receiving a previous dose of influenza vaccine component.

b. Already immunized this flu season

c. Fever (38 C/100.4 F or above)

d. History of Guillain-Barre Syndrome

C. Plan: Vaccinate all individuals who are in need/want vaccination, and meet criteria.

1. Treatment:

a. Screen all individuals for contraindications and precautions to influenza vaccine.

b. Provide a copy of the most current federal Vaccine Information Statement (VIS). You must document in the medical record or office log, the publication date of the VIS and the date it was given. Provide non-English speakers with a copy of the VIS in their native language, if available; these can be found at www.immunize.org/vis.

c. For ages 6 months to 8 years,~~,~~ please see manufacturer's recommendations on dosage and administration for pediatrics.

d. For ages 9 and older, administer the manufacturer's recommended dose of quadrivalent inactivated influenza vaccine (using a 22-25g, 1-1 ½" needle) in the deltoid muscle by intramuscular (IM) route.
e. For ages 65 and older—administer the manufacturer's recommended dose of the "high dose" influenza vaccine, as recommended by the CDC.
f. Monitor for serious side effects (i.e. anaphylaxis).

2. Consultation Required: None

3. Follow-up: Annual vaccinations of influenza vaccine are needed to ensure adequate protection from influenza.

D. Documentation:

1. Record the name of the individual receiving the vaccination, date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. (For employees, if vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g. medical contraindication, refusal). These individuals must then sign a "Declination of Influenza Vaccine," and it is recorded.

2. Personal Immunization Record Card: Record the date of vaccination and the name/location of the administering clinic, as well as any necessary follow-up.

STAFF AUTHORIZED TO PERFORM THE TESTING: (LVN, RN)

REQUIREMENTS FOR ADMINISTRATION:

A. Education: Licensed Personnel (e.g. LVN, RN)

B. Training: As required by initial and annual internal competencies

C. Initial Evaluation: Review of CDC immunization criteria, SVMC Standardized Procedures for immunizations

D. Continuing Evaluation: Annually

DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE:

A. **Method:** Approval of Infection Control Committee, Infection Control Medical Director and Infection Control Manager.

REFERENCES:

- Centers for Disease Control and Prevention (CDC) (2017). Seasonal Influenza Vaccine Dosage and Administration. Retrieved from www.cdc.gov/flu/about/~~aq~~a/vaxadmin.htm Page last reviewed; November 16, 2020
- Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices— United States, 2020–21 Influenza Season. (2020, August 21). Retrieved from Centers of Disease Control and Prevention: https://www.cdc.gov/mmwr/volumes/69/rr/rr6908a1.htm?s_cid=rr6908a1_w . Page last reviewed: ~~August 20, 2020~~March 8, 2023.
- Seasonal Influenza Vaccination Resources for Health Professionals. (2020, January 3). Retrieved from CDC: Centers for Disease Control and Prevention: https://www.cdc.gov/flu/professionals/vaccination/index.htm . Page last reviewed: September ~~16~~7, 202~~1~~3.

PURPOSE:

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Sierra View Medical Center (SVMC) is committed to meeting the health care needs of all patients in the community ~~and to~~~~To ensure that consistent collection attempts are made prior to assignment to bad debt based on all state and federal guidelines~~through ensuring the outstanding balance owned by patients for medical care delivered by SVMC are collected in a timely and consistent manner. The purpose of this policy is to provide a clear guidelines for conducting billing, collections, and recovery functions to comply with the Revenue Code Section 501® and applicable collection laws and regulations, including California Health and Safety Code section 127400 et seq. This included collection actions on delinquent patient accounts and actions SVMC may take to obtain payment including but not limited to any permissible collection actions.

DEFINITIONS:

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~~**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. not exceeding 10% of a family's monthly income, excluding essential living expenses if a payment plan cannot be agreed upon by both parties.~~

~~**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:~~

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~~(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.~~

1. Collection Agency is an entity engaged by Sierra View Medical Center to pursue or collect payment from patients.

2. Insured Patient refers to an individual whose hospital bill is fully or partially eligible for payment by a third-party payer.

3. Patient refers to the individual who receives services and/or is financially responsible for the care at Sierra View Medical Center.

4. Guarantor refers to the individual who legally promises to cover the financial obligation of the patient.

5. Extraordinary Collection Actions (ECA) are any collection activities, as defined by the IRS. Actions taken by Sierra View Medical Center against any individual related to obtaining payment for care only after reasonable efforts have been made to determine whether the individual is eligible for financial assistance. ECA include

   a. Any action to obtain payment from a patient requires a legal or judicial process, including without limitation the filing of a lawsuit.

   b. Wage garnishment.

   c. Selling patient's debt to another party, including without limitation to a collection agency.

   d. Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of on or more bills for previously provided care covered under SVMC financial assistance.

6. Financial Assistance refers to Charity Care and Discounted Care as defined in Financial Assistance policy.

7. Good Faith Estimate refers to SVMC providing all self-pay and uninsured patients with a good faith estimate before services are provided. This can also be provided upon customers' request.

8. Goodbye Letter a required notice before assigning a patient debt to collection or selling to debt buyer, which must include

   a. Date or dates of service of the bill.

   b. Name of the entity the bill is being assigned or sold to.

   c. Hoe to obtain an itemized hospital bill from the hospital.

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d. Name/plan type of the patient's health coverage or a statement that the hospital does no have that information.

e. Application for the hospital's charity care and financial assistance.

f. Date or dates for the notice sent to patient about applying for financial assistance and/or the financial assistance application sent to patient (including the date for decision on application).

g. Tagline sheet with statement accessibility in 15 languages.

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~~(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.~~

~~Patient medical costs greater than $10,000.00.~~

POLICY:

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Sierra View Medical Center ~~(SVMC)~~ will make diligent efforts to inform guarantors of their financial responsibilities and available financial assistance options through billing statements and phone calls. During this billing and collection process, staff will provide quality customer service and timely follow-up, and all outstanding accounts will be handled in accordance with all applicable laws and regulations. ~~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.~~

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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 ~~being sent~~ 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: ~~*ALL PATIENT ACCOUNTING*~~*PATIENT FINANCIAL SERVICES, /CREDIT & COLLECTIONS PERSONNEL/CONTRACTED COLLECTION AGENCIES*

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PROCEDURE:

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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:

~~Accounts must be greater than 150 180 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 150 180 days. If it is discovered there is a wrong address it will be noted in either the hospital HIS 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.~~

~~1.~~

~~Health Information System (HIS) or outside vendor system indicates that the patient was sent at least three statements with notification that patient will be sent to collections if no contact or arrangements are made. Before assigning a bill to collections a hospital shall send a patient a notice with all of the following information:~~

- ~~(1) The date or dates of service of the bill that is being assigned to collections or sold.~~
- ~~(2) The name of the entity the bill is being assigned or sold to.~~
- ~~(3) A statement informing the patient how to obtain an itemized hospital bill from the hospital.~~
- ~~(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.~~
- ~~(5) An application for the hospital's charity care and financial assistance.~~
- ~~(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.~~
- ~~(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.~~

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~~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.~~

~~2.~~

BILLING PRACTICES

Obtaining Coverage Information

SVMC makes reasonable efforts to obtain information from patients about whether private, third-party or public health insurance or sponsorship may fully or partially cover the services rendered by SVMC to the patient. It is patient's/guarantor's responsibility to know their insurance benefit and coverage and to provide the current and accurate insurance information to SVMC at the time of services or shortly after: well within the timely filing guidelines. Except for emergency care, all required referral(s) or authorizations must be secured prior to receiving services. If patient/guarantor has any questions regarding their financial responsibility or coverage services at SVMC, they can contact their insurance company in advance for service as appropriate.

Third-Party Insurance Billing

SVMC Shall diligently pursue all amounts due from third-party payers, including but not limited to contracted payers, non-contracted payers, indemnity payers, liability, auto insurances, government programs payers that may be financially responsible for a patient's care. This is all based on the information provided by patient's or their representatives.

SMVC will make reasonable efforts to assist patient in obtaining payment for third-party payers by verifying coverage to ensure coverage was active at the time care was provided when possible. If the patient receives third-party reimbursement for care provided by SVMC, patient is responsible for paying SVMC the entire amount they received. If patient receives a legal settlement, judgment, or award under a liable third-party action that includes payment for health care services or medical care related to injury, the patient/guarantor must reimburse SVMC for their related healthcare services rendered up to the amount reasonably awarded for that purpose.

If a claim is denied (or not processed) by the payer due to an error by SVMC, SVMC will not bill the patient for any amount more than what the patient would have owned had the payer paid the claim. If a claim is denied or is not processed by a payer due to factors outside of SVMC control, SVMC will follow up as appropriate to facilitate resolution of the claim. If resolution does not occur after reasonable follow-up efforts, SVMC may bill the patient/guarantor or take other actions in line with industry standards.

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SVMC will bill the patient according to the insurance explanation of benefits (EOB) and as directed by the third-party payer. Balance billing QMB and Medi-Cal patients for covered services is prohibited. Upon receiving proof of Qualified Medicare Beneficiary (QMB) or Medi-Cal eligibility (including but not limited to a copy of the Medi-Cal card, Social Security number, date of birth) SVMC must bill Medicare or Medi-Cal and not the patient during periods of active QMB or Medi-Cal eligibility.

Medi-Cal Insurance Billing

When SVMC receives active Medi-Cal coverage on the State Medi-Cal Eligibility System, SVMC will bill Medi-Cal. If the eligibility system indicates active coverage with other health coverage and sufficient information is not available to bill that other insurance, SVMC will contact the patient/guarantor to get the necessary information. If the patient indicates they do not have other insurance coverage or cannot access necessary information, SVMC will refer the patient/guarantor to their local Medi-Cal office or legal services for further assistance. The patient is responsible for communicating with SVMC once eligibility or other insurance information issue is resolved. SVMC will not refer accounts with active Medi-Cal coverage to collections. This section shall not prevent SVMC from billing a Medi-Cal patient/guarantor patient for non-covered services such as elective services or collecting the Medi-Cal Share of Cost after screening for eligibility for Financial Assistance.

Insured Patient Billing

If patient is insured and patient responsibility was not paid at the time of services, SVMC will bill patient the responsibility according to the insurance explanation of benefits (EOB) and as directed by the third-party payer.

No Surprise Billing

If patient is uninsured or does not have health insurance coverage, SVMC is responsible for providing a written notice to the patient/guarantor that they may be eligible for public or private insurance, and an application for Medi-Cal. In addition, SVMC will provide the patient with a Good Faith Estimate ("GFE") for health care items and services before those items or services are provided. When services are scheduled out at least 4 business days in advance, the financial counselors will provide the uninsured patient with a GFE and the copy of the GFE will be available at the time of service. If a patient receives a bill that is $400 more than the GFE received from that facility, they may dispute the bill.

Extended Payment Plan (EPP)

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SVMC and its collection agencies shall offer uninsured and insured patients the option to enter into an agreement to pay their patient responsibility and any other amount due over time. SVMC and its collection agencies will negotiate with the guarantor and may take into consideration the patient's household income, essential living expenses, the availability of a health saving account and help from patient's family member(s). All EPP shall be interest-free, if SVMC and the patient cannot agree on the EPP the hospital shall create a reasonable payment plan which is defined as a monthly payment that does not exceed 10% of the patient's household income for a month, excluding deductions for essential living expenses.

An EPP may be declared as inoperative after the patient fails to make all consecutive payments during a 90-day period. Before declaring the EPP inoperative, SVMC or its collection agency will make a reasonable attempt to contact the patient by the last known telephone number and provide notice in writing with the last known address to notify the patient that the EPP may become inoperative and provide an opportunity to renegotiate. After an EPP is declared inoperative and over 180 days have passed since the initial billing of the patient SVMC or its collection agencies may commence Extraordinary Collection Actions.

FINANCIAL ASSISTANCE

Sierra View Medical Center notifies individuals that financial assistance is available to eligible individuals by posting notices in a visible manner in locations where there is a high volume of inpatient or outpatient admitting or registration such as emergency department, admitting office, billing office and other hospital outpatient service settings to comply with federal and state regulations. Financial assistance information is on all patient statements with our financial counseling office telephone numbers. Financial assistance can be considered at any time during the billing and collection process.

COLLECTION PRACTICES

In compliance with relevant state and federal laws, SVMC and its collection agencies may engage in collection activities including Extraordinary Collection Actions to collect outstanding patient balances. The contracted collection agencies shall adhere to the terms of SVMC financial assistance policy, credit and collection policy, the health and Safety Code section 127400 et seq. 26 U.S.C. section 501 (r) and "reasonable payment plan." Needs review - reasonable payment plan. SVMC and its collection agencies shall not pursue collection from a patient who is attempting to qualify for financial

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assistance and is attempting in good faith to settle an outstanding billing, SVMC shall not furnish information about any medical debt to any consumer credit reporting agency.

General collection activities by Sierra View Medical Center and the contracted Collection Agencies may include phone calls, statements and other reasonable efforts in conformance with all federal and state laws governing debit collection practices. The efforts include assistance with applications for possible private and government program coverage. All patients/guarantors will have the opportunity to contact SVMC regarding financial assistance, payment plan options and other applicable programs that may be available with respect to their accounts. Financial assistance is available free of charge. Individuals with questions regarding financial assistance may contact the financial counseling office by phone, email or in person.

After general collection activities have not produced regular payments of a reasonable amount and the patient/guarantor has not completed a financial assistance application, or complied with documentation requests or is otherwise non-responsive to the application process, SVMC or any collection agency acting on its behalf shall make reasonable efforts to presumptively determine whether a patient is eligible for Financial Assistance based on prior eligibility for financial assistance or the use of third party data.

If SVMC is aware the patient has a pending appeal for coverage of the claim(s) and has made a reasonable effort to communicate with SVMC about the progress of the appeal, SVMC will wait until a determination of the appeal is made to place the patient's unpaid bill with a collection agency. SVMC will not initiate or continue ECAs for a patient who is attempting to qualify for financial assistance and is attempting in good faith to settle an outstanding bill with SVMC. Accounts may be advanced for collection under the following circumstances:

a. All third-party payers have been billed, payment from a third-party payer is no longer pending; unless guarantor has not complied with payers request outside of SVMC control. SVMC is unaware of any pending insurance payment appeals and the remining debt is patient's financial obligation.
b. At least 180 days have passed since SVMC sent the initial bill to the guarantor.
c. Goodbye or final billing statement indicating the commencement of collection activities may occur if no action to resolve the accounts is attempted by guarantor, the letter is accompanied with a financial assistance application and the name of the collection agency who the account will be referred with a deadline of when to contact SVMC or collection agency to avoid ECA.

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~~3. 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~~

~~Eligibility for financial assistance or charity care~~

~~c.~~

~~4. Patient has not made a good faith effort to settle the outstanding bill by:~~

~~Negotiating a reasonable payment plan.~~

~~a. 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.~~

~~Or when an 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.~~

~~b. 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.~~

~~5. Patient is not in an appeal or dispute status for the above items.~~

~~6. Patient has not applied or have a pending application for another health coverage program.~~

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~~7. Information has been provided to patients on:~~

~~a. SVMC has a Charity Care/Discount Policy 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.~~

~~8. Guarantor is not a minor or is not subject to any statutory regulations which allow minors access to their own medical information~~

~~9. Payment was not denied by insurance company because:pPatient has failed to comply with their insurance request such as: coordination of benefit questionnaire, accident questionnaire etc.~~

~~a. Prior authorization was not received (unless we were not aware an authorization was necessary) or;~~

~~b. In the event we were notified that an authorization was not required prior to services rendered~~

~~10. All attempts to collect from all payer sources have been exhausted.~~

~~11. Patient provides a copy of their insurance information within the timely filing requirements outlined in the SVMC contracted payer guidelines.~~

~~12. Patients with no health insurance coverage or patients with "high medical costs", to include patients with third party coverage who are at the 350400% or lower Federal Poverty guidelines who have qualified for a discount on services rendered at the facility based on either income or hardship.~~

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

~~13. administrator.~~

~~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~~

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Commented [LR1]: I believe we need to remove #9 correct? Since we have secure the authorization prior to services to bill the patient.

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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, as well as being available 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 Ppatient 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 Ppatient 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.

Initiating ECAs

In the situation where an account has been assigned to collection and the collection agencies has information showing the guarantor has an income greater than 400% of the federal poverty level and would not qualify for discounted care and has failed or refused to pay for the medical services, collection agencies may request approval from SVMC to pursue legal action.

Collection agencies must submit an individual written request to the facility for approval before taking any legal action. The request must include the details of the encounter.

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SVMC Patient Financial Services Manager and/or Director of Revenue Cycle will authorize each individual legal action in writing after verifying that SVMC and/or collection agencies working on their behalf have made sufficient reasonable efforts to determine whether the individual is eligible for financial assistance. A copy of the signed authorization for legal action will be maintained in the patient account file.

REFERENCE:

- ~~HSC 127425; SB1276: AB1020, AB532,~~ No Surprise Act
- 26 Code of Federal Regulations 1.501(r)
- • California Health and Safety Code section 124700-127446
- • SVMC Financial Assistance Policy
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SUBJECT: **EMPLOYMENT STATUS**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define the status of employees for the purpose of pay, job classification, benefit eligibility and compliance with Federal and California wage statutes.

POLICY:

Employees are hired into a specific status and are advised of that status at the time a job offer is communicated and during the recruitment and onboarding process. Employees will be placed within one of the categories defined in this policy.

Definitions:

FULL-TIME

1. Positions designated as either eight (8) or ten (10)-hour shifts are regularly scheduled to work 80 hours or more within a two-week (14-day) pay period.

2. Positions designated as 12-hour shifts are regularly scheduled to work six (6) 12-hour shifts or 72 hours or more in a two-week (14-day) pay period.

~~Full-time employees are eligible for employer-sponsored benefits. Eligibility is affected by employee election and position changes initiated by the hospital.~~ Full-time employees are eligible for employer-sponsored benefits. Eligibility may be affected by employee elections, leave status, and position changes initiated by the hospital, in accordance with applicable benefit plan provisions.

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PART-TIME

Part time positions are designated as eight (8), ten (10) or twelve (12)-hour shifts and are regularly scheduled to work a minimum of twenty (20) hours per week, but not more than twenty-nine (29) hours per week.

Part-time employees receive an additional 10% differential added to their base hourly rate of pay "in lieu" of benefit participation. Part-time employees may purchase healthcare insurance and other elective benefit plans and pay 100% of the healthcare and elected benefit premiums.

Part time employees may enroll in Voluntary Deferred Compensation Tax Deferred Savings Plan.

~~PER DIEM~~

~~All per-diem employees must be available to work a minimum of 4 shifts in a 4 week schedule.~~

~~Per-diem employees are scheduled as needed but may be regularly scheduled up to 29 hours per week. Per-diem employees have no guarantee of hours.~~

~~Per-diem employees are not eligible for any benefits unless they qualify for medical benefits under the Affordable Care Act after the measurement period.~~

~~Per-diem employees are paid a fixed rate, regardless of experience, as determined by the pay grade of their position.~~

PER-DIEM & SEASONAL PER-DIEM

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Per-Diem employees must be available to work a minimum of four (4) shifts in a four-week schedule. They are scheduled as needed and may be regularly scheduled for up to 29 hours per week; however, there is no guarantee of hours.

Seasonal Per-Diem (SPD) employees are hired for a defined assignment of up to thirteen (13) weeks. SPDs may work a maximum of three (3) 13-week assignments per calendar year. Any arrangements outside of this, must have Senior leadership approval.

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Per-Diem & Seasonal Per-Diem employees are paid a fixed rate, regardless of experience, based on the pay grade of their position.

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Per-Diem & Seasonal Per-Diem employees are not eligible for any benefits unless they qualify for medical benefits under the Affordable Care act after the measurement period.

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TEMPORARY

Temporary employees are hired for a specific period of time generally not to exceed six (6) months. Temporary employees may be scheduled for full-time hours during their employment. While temporary employees are generally hired for a specified duration, employees will not experience a change in status simply because they remain in the District's service for a longer period.

Temporary employees are not eligible for benefits. The District reserves the right to extend the duration of the temporary employee's services beyond the originally contemplated time without affecting the employee's benefit status. Temporary employees may qualify for medical benefits under the Affordable Care Act.

AFFECTED PERSONNEL/AREAS: *ALL SVMC EMPLOYEES*

PROCEDURE:

CHANGE OF STATUS

1. An employee's status is changed by initiating an electronic Employee Change Notice form.

2. Department ~~Director~~Leaders shall meet with the employee to discuss changes affecting the employee and their status.

3. Change of status shall not become effective until an approved Employee Change Notice is received by Human Resources.

The change of the employee's status will become effective at the beginning of the pay period after all approvals are received. ~~Generally, changes of status occurring in the middle of pay periods are avoided.~~

4.

5. Changes involving retroactive payments require prior approval from the respective Vice President.

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REFERENCES:

- Equal Employment Opportunity Commission. Usa,gov. (n.d.). Retrieved from https://www.usa.gov/federal-agencies/equal-employment.
- Affordable Care Act. U.S. Department of Labor. (n.d.). Retrieved from https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for.
- DFEH. Department of Fair Employment and Housing. (n.d.). Retrieved from https://www.dfeh.ca.gov.

SUBJECT:	SECTION:
FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL~~FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL~~ CARE	Page 1 of 22

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

EFFECTIVE DATE:

The effective date of this policy on Financial Assistance Program for Sierra View Medical Center (Charity Care) is January 1, 2025

~~**PURPOSE:**~~

~~Sierra View Medical Center (SVMC) is a non-profit organization, which provides hospital services to the community of Porterville and the greater area of Southeastern Tulare County. Sierra View Medical Center is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or underinsured. As part of fulfilling this commitment, SVMC provides medically necessary services, without cost or at a reduced cost, to patients who qualify, in accordance with the requirements of this Financial Assistance Policy.~~

PURPOSE:

Sierra View Medical Center (SVMC) is a non-profit organization, which provides hospital services to all persons within Porterville and the greater area of Southeastern Tulare County. Sierra View Medical Center is committed in meeting the health care needs of all persons in the community. SVMC is committed to providing access to Financial Assistance programs on medically necessary services when patients are uninsured, underinsured, or may need help paying their hospital bill. These programs include government sponsored coverage programs, charity care, and discounted care. The purpose of this policy is to establish eligibility guidelines and within for the Financial Assistance Program (FAP) available at Sierra View Medical Center and to outline the process for detraining eligibility.

~~This Financial Assistance Policy is intended to comply with California Health & Safety Code § 127400 et seq. (AB 774), Hospital Fair Pricing Policies, effective January 1, 2007, updated January 1, 2011, and January 1, 2015 (SB 1276), AB 72 (Balance billing) and United States Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") guidance regarding financial assistance to uninsured and underinsured patients. Additionally, this policy provides guidelines for identifying and handling patients who may qualify for financial assistance. This policy also establishes the financial screening criteria to determine which patients qualify for charity care. The financial screening criteria in this policy are based primarily on the Federal Poverty Level ("FPL") guidelines updated periodically by HHS in the Federal Register.~~

AFFECTED AREAS/PERSONNEL: *FINANCIAL COUNSELORS, PATIENT ACCESS & PATIENT FINANCIAL SERVICES*

~~**DEFINITIONS:**~~

~~1. Charity Care: Full Charity~~

SUBJECT:	SECTION:
FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL~~FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL~~ CARE	Page 2 of 22

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~~1.~~

~~1. Partial Charity Care Payment: Not eligible for Full Charity. A partial charitable deduction for all eligible amounts owed to Sierra View Medical Center.~~

~~2. High Medical Cost: Annual out-of-pocket expenses that exceed 10% percent of patient's family gross income and essential living expenses, 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. This shall not include out of pocket expenses for insurance premiums.~~

~~1.~~

~~1. Reasonable Payment Plan: A default plan required by SB 1276 for patients qualifying for partial charity when a negotiated plan cannot be reached. SB 1276 defines the plan as monthly payments that are not more than 10% of a patient's family income for a month, excluding deductions for essential living expenses.~~

DEFINITIONS:

1. **Charity Care** defined as health care services provided at no charge to patients who do not have or cannot obtain adequate financial resources or other means to pay for the care, who qualify free care under the eligibility guidelines specified in this policy.

2. **Discounted Care** defined as health care services provided with a partial discount or reduced charge to patients who do not have adequate financial resources or other means to pay for care; who qualify for a discounted payment under the eligibility guidelines specified in this policy.

3. **Essential Living Expenses** for the purpose of this policy, expenses for all of the following; as applicable to the applicant. Mortgage/rent payment and maintenance, food, house supplies, utilities, telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses (including auto instalment payments, auto insurance, gas and repairs), laundry and other extraordinary expenses.

4. **Family** defined as follows:

A. For persons 18 year of age and older, the patient's family includes the patient's spouse, domestic partner, dependents children under 21 years of age, whether living at home or not, and dependent children of any age, if the child(ren) is disabled.

B. For patients under 18 years of age, or patients who are 18-20 years of age and are a dependent child, the family includes the patient's parent, caretaker relatives, other children under 21 years of age of the parent or caretaker relative, dependent children of the patient's parents or caretaker relatives if those children are disabled.

5. Financially Qualified Patients are eligible for assistance under this policy in the following category:

A. Self-Pay Patient are patients who do not have third party insurance, Medi-Cal, Medicare, or other payment source who do not have a compensable injury for purposes of worker's compensation, automobile insurance, or other insurance as determined by Sierra View Medical Center.

B. Under-insured Patient are patients with high medical cost who have insurance or health coverage but have a remaining patient responsibility balance that they are unable to pay. Patient responsibility balance include deductibles, coinsurance, that constitute high medical costs.

C. Exhausted Benefits where patients with insurance whose benefit limit under insurance have been exhausted prior to admission or whose insurance has denied stays, denied days of care, or refused payment for medically necessary services.

D. Patients who are eligible for Medi-Cal, Medicare, California Children's Services and any other applicable state or local low-income programs who do not receive coverage or payment for all services or for the entire stay.

6. High Medical Cost are defined as annual out-of-pocket medical costs incurred at Sierra View Medical Center that are not reimbursed by insurance or a health coverage program, such as

A. Medicare copays

B. Medi-Cal cost sharing

C. The high medical costs incurred by the patient that exceed 10 percent of the Patient's Family Income in the prior 12 months, or annual out-of-pocket medical expenses incurred in the prior twelve (12) months that exceed 10% of the Patient's Family income.

7. Federal Poverty Level is define as the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under its statutory authority.

~~POLICY:~~

~~Sierra View Medical Center strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. The Financial Assistance Policy will apply to all patients who receive~~

~~services at SVMC. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.~~

~~In accordance with Sierra View Medical Center's mission and values, all patients will receive medically necessary healthcare in compliance with federal law, regardless of the patient's ability to pay for services. The hospital will also provide qualified patients with financial assistance to help cover the costs of services and reduce patients' personal financial responsibilities.~~

POLICY:

In accordance with Sierra View Medical Center's mission and values, we strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. Charity care will not be abridged on the basis of age, sex, race, creed, disability, national origin, sexual orientation, gender identity, or financial status. The Financial Assistance Policy will apply to all patients who receive medically necessary services at SVMC. SVMC recognize that the need for financial assistance is a sensitive and deeply personal issue for recipients. SVMC values' guide staff training and the selection of personnel who implements this policy are committed in maintaining confidentiality of information and individual dignity for all who seek charity care.

Financial assistance is based on income and family size as defined by Federal Poverty Income Guidelines. SVMC provides all patients a written notice about the availability of our charity care and discount care policy, including information about eligibility and contact information to the financial counseling department. This notice also includes how to find our shoppable services and the contact information to the Consumer Alliance; an organization that helps patients understand the billing and payment process, as well as provides information regarding Covered California and Medi-Cal presumptive eligibility. Any member of the medical staff, any employee, the patient, patient family, community advocate or any other responsible party may request financial assistance from SVMC.

Financial Assistance Program is comprised of Charity Care (free care) and Discounted Care. Charity care is available for medically necessary care; charity is not generally available for non-medically necessary, specialized, high-cost services (i.e. experimental, elective etc.). Exceptions maybe made with certain cases with administrations approval. SVMC will actively assist patients in pursuing alternative source of payment from third parties. Those individual of families who qualify for alternative programs and services within the community but refuse to take advantage of them, will not be covered by this policy. SVMC will make reasonable efforts presumptively determine financial assistance eligibility based on prior eligibility charity care or the use of third party to identify charity care.

~~Full Charity Care Defined~~

SUBJECT:	SECTION:
FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL~~FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL~~ CARE	Page 5 of 22

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

~~Full Charity Care is defined as a full charitable deduction (100% discount) for all eligible amounts owed to Sierra View Medical Center. The applicants must have a qualifying income of 200% or less of the Federal Poverty Level. Any necessary[1] inpatient or outpatient hospital service provided to a patient who is either unable to pay for care and who has established qualification in accordance with requirements contained in the SVMC Financial Assistance Policy and by requesting assistance in a timely manner, defined as request being made for financial assistance one year from date of service or date of denial or payment from insurance company.~~

Charity Care

A full write-off of all balances due from a patient, whether the patient is insured, underinsured or self-pay, shall be granted to those financially qualified patients whose family income is up to 200% of the most recent Federal Poverty Guidelines.

SVMC presumes qualified for charity care any patient who can provide proof that they are eligible for or in a public benefits program such as CalWORKS, CalFresh, SSI/SSP, Medicare Savings Program, WIC, or general assistance/general relief.

~~***Partial Charity Care Defined***~~

~~Partial Charity Care is defined as a partial charitable deduction for all eligible amounts owed to Sierra View Medical Center. The applicants must have 1) qualifying income between 201% to 350% (or not to exceed 350%) of the Federal Poverty Level, 2) applicant with a high medical cost to include any necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured.~~

~~Depending upon individual patient eligibility, financial assistance may be granted for full charity care or discount partial charity care. SVMC may exclude patients who would be eligible to apply but who do not apply or otherwise comply with the hospital's reasonable process for qualifying for Full Charity Care and Discount Partial Charity Care. SVMC definition of reasonable process for qualifying for Full Charity Care and Discount Partial Charity Care is to complete the charity application and submit all financial documents and supporting documentation within one year from the date of service or one year from the insurance payment or denial.~~

Discounted Care

Discounted Care will be granted to financially qualified patients earning between 201% and 400% of the Federal Poverty Level based on the most recent Federal Poverty

~~[1] Necessary services are defined as any hospital inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience.~~

Guidelines. For these patients, expected payment for services will be limited to the amount SVMC would have received from Medicare.

In determining what if any payment is due from a patient with insurance, the expected payment amount will be compared to the amount paid by their third-party insurance. If the amount paid by the third-party insurance is greater than the expected payment, no payment will be sought from the patient. If the expected payment is greater than the payment received from the third-party insurance, and the patient has a remaining patient responsibility amount, the difference in payment will be sought from the patient subject to a determination of eligibility for financial assistance.

~~***Full and Discount Partial Eligibility: General Process and Responsibilities***~~

~~The SVMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, SVMC will use a financial assistance application. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application. Uninsured and underinsured patients will also be offered information, application, assistance and referral to the California Health Benefit Exchange as well as government sponsored programs (Medi-Cal and the Healthy Families program) for which they may be eligible. Patients with a qualifying income of 350% or less of the current poverty level who experience high medical costs, including patients with a third-party insurance coverage may also be eligible for financial assistance. In addition, SVMC will provide contact information to a local consumer assistance center, Central California Legal Services, located within Tulare County, and for patients residing outside Tulare County, we will provide the Health Consumer Alliance contact information. Patients presenting with these types of situations will be required to follow the same application process and approval will be reviewed on a case-by-case basis. A patient's application, or pending application, for another health coverage program does not preclude the patient from being eligible for charity care or discount payment program. Any patient who requests financial assistance will be asked to complete a financial assistance application. The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.~~

~~Eligibility is defined for any patient whose family[2] income is 350% or less of the current federal poverty level. Request for Financial Assistance Program can't be for services related to an injury compensable for the purpose of workers' compensation, automobile insurance or other insurance as determined and~~

~~[2] A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.~~

~~documented by the hospital and/or unable to pay for their care, based upon determination of financial need in accordance with this policy.~~

~~Patients' income and other financial criteria are the basis for determining the amount of the hospital-sponsored financial assistance patients receive. While both uninsured and insured patients are eligible for financial assistance from Sierra View Medical Center, patients will also be offered information, application, assistance and referral to the California Health Benefit Exchange as well as government sponsored programs (Medi-Cal and the Healthy Families program) for which they may be eligible. Patients will be given the opportunity to explore these resources before receiving charity care.~~

~~Patients at Sierra View Medical Center who are unable to pay their balances and are in need of financial assistance will be screened without bias toward their gender, ethnicity and religion or employment status. Patients will be objectively assessed by a qualified hospital staff member through the review and assessment of pertinent patients' information. For the purposes of this objective screening process, patients will be required to submit relevant documentation such as the following:~~

- ~~All W-2 earnings or previous tax returns or previous 2 months pay stubs and withholding statements~~
- ~~Pension or Social Security income statements~~
- ~~All statements of financial obligation~~
- ~~Government-sponsored program denial or approval letter with effective date~~
- ~~Hardship letter, if applicable~~

~~Financial assistance will be provided to eligible uninsured and insured patients in the form of discounts of patients' personal financial responsibilities. The following framework, based upon the federal poverty guidelines that consider patients' income and number of dependents, will be utilized to objectively and consistently determine the percentage discount that eligible patients receive:~~

How to Apply

All patients will be notified of the Financial Assistance Policy and how to access the Financial Assistance Application. Patients may request financial assistance application in person by visiting SVMC at 465 W. Putnam Ave in Porterville California 93257, over the phone by calling Financial Counselors at (559) 788-6002 or (559) 788-6143, email by sending written request to financialcounseling@sierra-view.com, or download the application from Sierra View website at https://www.sierra-view.com/patients-visitors/billing. Documentation required to determine eligibility is included on the application.

The application will be available in English and Spanish, and any other language deemed necessary available in Registration or Patient Accounting area. For patient who speak a language other the English or Spanish, or who need other accessibility accommodations, SVMC will provide appropriate language accommodations free of charge.

SVMC determines eligibility for financially qualified patients in accordance with this policy and applicable state and federal laws. A patient, or patient's legal representative, who requests financial assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. SVMC may consider the failure to provide this information in making its determination. The information provided for the application will only be used in reaching a determination of Financial Assistance and will not be used for collection activities.

Financial assistant application only applies to charges or services provided by SVMC. Emergency and other non- employed physicians providing emergency services in SVMC are required to provide discounts to financially qualified patients whose family incomes are at or below 400 percent of the Federal Poverty Guidelines. At the patient's request, SVMC will advise patients to apply for charity care to the physician's billing company upon the patient's receipt of a bill for services from that billing company. This statement shall not be construed to impose any additional responsibilities upon SVMC.

A patient's status or claims with respect to worker's compensation, automobile insurance, or other insurance, including potential payments from pending litigation or third-party liens related to the incident of care, may be taken into consideration when evaluating the patient's eligibility for charity care or discount payments.

Governmental Assistance

The SVMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for charity care or discount care assistance. SVMC makes all reasonable effort to determine whether medical care maybe fully or partially paid for under other private or public health insurance. Consideration include coverage offered through private health insurance, Medi-Cal, Medicare, California Children's Services, the California Health Benefit Exchange (Covered California) or other county-funded programs. SVMC will provider application of program when patient is identifies as potentially eligible for Medi-Cal or any other coverage.

An application is provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care. A patient's application, or pending application, for another health coverage program does not preclude the patient from being eligible for charity care or discount care. Any patient who requests financial assistance will be asked to complete a financial assistance application.

~~Financial Assistance Guidelines~~

~~Percent of Federal Poverty Guidelines~~	~~Charity Care Discount Percentage~~
~~200% or below~~	~~100%~~
~~Percent of Federal Poverty Guidelines~~	~~Partial Charity Care Discount Percentage~~
~~201 – 250%~~	~~75%~~
~~251 – 300%~~	~~50%~~
~~301 – 350%~~	~~25%~~
~~351% or above~~	~~0%~~

Commented [LR1]: Do we want to increase this by 50%

250% or below

251%-300% = 75%
301%-350% = 50%
351%-400% = 25%
401% or above = 0%

~~For example, an individual with two other family members and an annual income of $18,000 is at less than 200% of the federal poverty guidelines and would receive a 100% discount on their bill.~~

Commented [LR2]: If updated scale by 50%, this will ready 250%

~~For example, an individual with two other family members and an annual income of $43,000 is between 251 – 300% of the federal poverty guidelines and would receive a 50% discount on their bill.~~

~~All financial assistance provided to patients, whether covering all or part of their balances, will be documented by SVMC in order to ensure objectivity in the charity care dispersed, and to provide records able to meet all internal and external requirements for providing assistance to patients in need.~~

~~In order to communicate its charity care policy to all patients, SVMC billing statements will include the phone number(s) of SVMC Financial Counselors that patients may call for financial assistance information. Contact information such as phone numbers will also be posted in all hospital registration areas.~~

~~Patients or their family representative may complete an application for the Financial Assistance Program. The application and required supplemental documents are submitted to the Financial Counselors.~~

Eligibility Guidelines

SVMC used the following to determine financially qualified recipients and the amount of charity extended 1) Patient Income, 2) Patient Family Size and 3) The Federal Poverty Guidelines as established by Health and Human Services are use to determine the annual income guide lines and limits. This will require the patient, guarantor or representative to submit:

1. A true, accurate, and complete confidential Financial Assistance application.
2. Acceptable income verification, such as recent payroll stubs, tax returns, or other items or verifications. If the patient is unemployed or does not receive payroll stubs; a written statement of need must be provided, by the patient or the

patient's representative, attesting to their income and employment status as part of their application.

3. Other sources of payment for services rendered; to aid in determining charity care in relation to the amount due after applying all other resourced of payment.

~~SVMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.~~

~~A financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:~~

~~Patient Financial Services Manager: Accounts less than $10,000~~
~~Administrative Director of Revenue Cycle: Accounts less than $25,000~~
~~Chief Financial Officer: Accounts greater than $25,000~~

~~Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include:~~

- ~~No insurance or a valid denial under any government coverage program or other third party insurer;~~
- ~~Limited insurance benefits paid by third party payer~~
- ~~Family income based upon tax returns or recent pay stubs (2 month)~~
- ~~Family size, per tax returns~~
- ~~Monetary assets as provided for under law~~
- ~~Hardship letter, if applicable~~

~~Financial Assistance Program qualification may be granted for full charity care (100% free services) or discount partial charity care (charity care of less than 100%), depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.~~

~~When Financial Assistance is granted, the patient and dependents will remain eligible for 6 months from the month of service. Accounts within the 6 month span can automatically be applied to charity, but on the 7th month and forward, the guarantor/patient will need to complete another Financial Assistance~~

~~application. Patient obligations for Medi-Cal/Medicaid share of cost payments will not be waived under any circumstance.~~

~~Patients at or below 350% of the Federal Poverty Guidelines who do not qualify for 100% discount will not pay more than Medicare would typically pay for a similar episode of service. This shall apply to all necessary hospital inpatient, outpatient and emergency services provided by SVMC.~~

Charity Eligibility Period

Charity care may be determined at any time SVMC is in receipt of the financial assistance application with all necessary documentation and information. While it is preferred that patient be screened for charity care prior to third-party collections, they be screened at any time. Once Financial Assistance is granted, services in the six-month period following the approval will also remain eligible for charity care or discount charity. However, if over the course of six-months period the patient's family income or insurance status changes to such an extent that the patient may be ineligible for free or discount care, the patient has an obligation to report those changes to SVMC. Once ineligible a new charity care application is required. A new charity care application is necessary after the six-month eligibility period has expired. There is no limit on the number of times a person may request financial assistance.

Charity Care Determination Time Requirements

Every effort is made to determine a patient's eligibility for charity care as soon as possible. While it is desirable to determine the amount of charity care for which the patient is eligible as close to the time of service as possible, there is no limit on the time when an application or the eligibility determination is made. A determination will be postponed while insurance or other sources of payment are still pending. The timeframe to make a decision on an application will be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made. The patient shall make a reasonable effort to communicate with SVMC about the progress of any pending appeals. For purposes of this section, "pending appeal" includes any of the following:

1. A grievance or appeal against a health plan
2. An independent medical review
3. A fair hearing for a review of Medi-Cal eligibility or claims
4. An appeal regarding Medicare coverage consistent with federal law and regulations

The timeframe to make a decision on an application may also be extended if a patient is attempting to qualify for coverage under any third-party insurance, Medi-Cal, or

Medicare, or if the patient has a pending claim with respect to workers' compensation, automobile insurance, or other insurance, including potential payments from pending litigation or third-party liens related to the incident of care.

~~***Financial Assistance Exclusions/Disqualification***~~

~~The following are circumstances in which Financial Assistance is not available under this policy:~~

~~a) Uninsured Patient seeks Complex/Specialized Services: Generally, Uninsured Patients who seek Complex/Specialized services (e.g. experimental or investigational procedures), and seek to receive Financial Assistance for such services, must receive administrative approval from the individual responsible for finance at the Hospital (or designee) prior to the provision of such services in order to be eligible for Financial Assistance. Hospital shall develop a process for patients to seek prior administrative approval for services that require such approval. Elective services that are normally exclusions from coverage under health plan coverage agreements (e.g., cosmetic procedures) are not eligible for Financial Assistance.~~

~~b) Patient declines covered services: An Insured Patient who elects to seek services that are not covered under the patient's benefit agreement (such as an HMO patient who seeks out-of-network services.)~~

~~c) Insured Patient does not cooperate with third-party payer: An Insured Patient who is insured by a third-party payer that refuses to pay for services because the patient failed to provide information to the third-party payer necessary to determine the third-party payer's liability is not eligible for Financial Assistance.~~

~~d) Payer pays patient directly: If a patient receives payment for services directly from an indemnity, Medicare Supplement, or other payer, the patient is not eligible for Financial Assistance for the services.~~

~~e) Information falsification: Hospitals may refuse to award Financial Assistance to patients who falsify information regarding Family Income, household size or other information in their eligibility application.~~

~~f) Third party recoveries: If the patient receives a financial settlement or judgment from a third-party tortfeasor that caused the patient's injury, the patient must use the settlement or judgment amount to satisfy any patient account balances, and is not eligible for Financial Assistance.~~

~~***Payment Plans***~~

~~When a determination of discount partial charity has been made by the hospital, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled reasonable payment plan.~~

~~The hospital and patient will work together to negotiate the terms of a payment plan. In the event the hospital and the patient cannot agree on a payment plan, SVMC will abide by the payment plan formula, defined in AB1276. SVMC will take into consideration the patient's family income and essential living expenses when determining a payment plan. The patient is responsible for providing SVMC copies of~~

~~their essential living expenses. If an agreement cannot be reached with the patient, SVMC must institute a reasonable payment plan, with monthly payments not to exceed 10% of a patient's family income for a month after deductions of 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. If the reasonable payment formula results in a payment of less than $10 a month, the subsequent extended payment plan shall be $10 per month.~~

~~Patients who wish to renegotiate the terms of a defaulted extended payment plan are able to enter into another extended payment plan with payments in the amount of either the reasonable payment formula or $10 per month and if the patient fails to make all consecutive payments due during a 90 day period, that extended payment plan is considered inoperative.~~

~~No interest will be charged to the patient for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.~~

Discount Care Payment Plans

In the event a Financially Qualified Patient still has a remaining balance after payment has been received from third-party payers and an application for financial assistance has been processed, expected payment for services will be limited to the amount SVMC would have received from Medicare.

The hospital and the patient shall negotiate the terms of the payment plan and take into consideration the patient's household Income, essential living expenses, and the availability of a health savings account of the patient or the patient's family. If the hospital and the patient cannot agree on the payment plan, the hospital shall create a payment plan where monthly payments will not be more than 10 percent of a patient's household income for a month, excluding deductions for essential living expenses.

If a patient defaults in making regular payments, Sierra View Medical Center makes reasonable efforts to contact the patient by phone and in email/writing, giving notice that the extended payment plan may become invalid. An attempt at renegotiating the payment plan will be done at the request of the patient or their guarantor. SVMC initiates collection efforts only after reasonable efforts to contact the patient have failed and after 90 days of non-payment. SVMC does not report adverse information to a credit-reporting bureau.

Who Grants Charity Care

Sierra View Medical Center personnel according to the following levels of authority approve financial assistance:

Financial Counselor: Accounts less than $5,000
Patient Financial Services Manager: Accounts less than $10,000
Director of Revenue Cycle: Accounts less than $25,000
Chief Financial Officer: Accounts greater than $25,000

Once a determination is made, a notification letter will be sent to each applicant advising him or her of the decision. SVMC keeps financial assistance records for ten years and are ready available.

~~***Special Circumstances***~~

~~In extenuating circumstances, SVMC may at its discretion approve financial assistance outside of the scope of this policy.~~

~~Uncollectible/presumptive charity is approved due to but not limited to the following: social diagnosis, homelessness, bankruptcy, deceased with no estate, and when collection agency assignment would not result in resolution of the account. The accounts eligible for charity due to homelessness are identified by the current ICD-10 per CMS guidelines. No application will be required for these circumstances.~~

~~Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program.~~

Special Circumstances

SVMC may grant charity care in special circumstance to those who would not otherwise qualify for assistance under this policy. SVMC will document the reason charity care was extended and why the patient did not meet. Presumptive charity is approved due to but not limited to the following:

1. Social Diagnosis (i.e. homeless, etc.)
2. Bankruptcy
3. Deceased with no known an estate
4. When collection agency assignment would not result in resolution of the account
5. Collection agency determines the account(s) as uncollectible in accordance with SVMC financial assistance policy

~~***Other Eligible Circumstances***~~

~~SVMC deems those patients that are eligible for government sponsored low-income assistance program (e.g., Medi-Cal/Medicaid, California Children's Services and any other applicable state or local low-income program) to be indigent. Therefore, such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g., CHDP, and CCS) where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance Program coverage. Under the hospital's Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g., restricted coverage) are to be classified as Charity Care. All Service Authorization Request (SAR) denied due to attending physician is not CCS-paneled under the California Children Services (CCS) program will qualify for charity care.~~

~~The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:~~

~~1. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.~~

~~Any patient whose income exceeds 350% of the Federal Poverty Guidelines and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients, who have high incomes, do not qualify for routine full charity care or discount partial charity care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $75,000 may be considered for eligibility as a catastrophic medical event.~~

~~The California law, AB72, which took effect in July 2017, protects consumers who use an in-network hospital or other facility from surprise billing when cared for by a doctor who has not contracted with their insurer. If that happens, consumers are responsible only for the copayment or other cost sharing that they would have owed if they had been seen by an in-network doctor. SVMC utilizes the services of contracted physicians. These physicians are not employed by the district but provide services to the SVMC patient population. In keeping with AB 72, AB 1503 and SB1276, any physician group that bills for services to our patient population will make available charity care and discounted payments to limit expected payment from eligible patients that are uninsured or have high medical costs who are at or below 350% of the federal poverty level. These contracted physicians will make available a policy upon request and extend this policy and all provisions found within to our mutual patient population.~~

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~~SVMC will make every reasonable, cost-effective effort to communicate payment options and programs with each patient who receives services at the hospital. In the event that a patient or guarantor does not respond or communicate with SVMC to resolve an open account, SVMC may forward the account to its collection agency.~~

Other Eligible Circumstances

SVMC deems those patients that are eligible for government sponsored low-income assistance program (e.g., Medi-Cal/Medicaid, California Children's Services and any other applicable state or local low income program) to be indigent. Therefore, such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g., CHDP, and CCS) where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance Program coverage. Under the hospital's Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income
programs, and other denials (e.g., restricted coverage) are to be classified as Charity Care. All Service Authorization Request (SAR) denied due to attending physician is not CCS paneled under the California Children Services (CCS) program will qualify for charity care.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

1. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

On rare occasions, a patient's individual circumstances may be such that while they do not meet the regular charity care criteria in this policy, they do not have the ability to pay their SVMC bill. In these situations, with the approval of management, part or all of their cost of care may be written off as charity care.

~~***Collection Guidelines***~~

SUBJECT:	SECTION:
FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL~~FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL~~ CARE	Page 17 of 22

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

~~SVMC will make reasonable attempts to obtain insurance information. If no insurance was provided at the time of service, patient will receive statements, which includes language telling the patient that he or she may be eligible for coverage offered through the California Health Benefit Exchange and other state or county funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services.~~

~~Calls to obtain insurance information or set up a payment plan with patients may be made. If a patient indicates they are unable to pay, the patient will be referred to a Financial Counselor to assist them with applying for health coverage, to include the California Health Benefit Exchange and other state or county funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services along with the SVMC Financial Assistance program.~~

~~SVMC will assign any financial obligation to a debt collection agency after 150 days from the date of discharge/service where the patient has failed to comply with an established payment plan or non-payment on an account where the patient guarantor is not in process with an eligibility application for a government sponsored insurance program.~~

~~Patients with pending appeal for coverage of services will not be forwarded to a third party billing agency or collection agency until a final determination of that appeal is made. If the appeal is unfavorable and the patient is responsible for the outstanding obligation, the patient will be afforded the opportunity to qualify for charity care or discount payment arrangements as prescribed above. Patient guarantors must keep SVMC Financial Counselors updated on the coverage appeal.~~

~~Certain account categories returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care, provided that the patient cooperates with the Charity Care/Financial Assistance Guidelines outlined in this policy. The following types of claims categories will be reviewed for possible charity:~~

~~1) Self-Pay accounts with no current employment~~

~~2) Any account where the guarantor expressed the inability to pay the accounts~~

~~All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.~~

~~Collection Agencies will return all accounts that meet the following guidelines; 1) Deemed patient is unable to pay, 2) Patient provides 3rd party coverage, 3) Patient requests Financial Assistance, 4) Not able to reach a reasonable payment plan.~~

~~Collection agencies have the responsibility to be familiar with SVMC's policy for Financial Assistance and Charity Care and as such will be responsible for ensuring patients who meet guidelines are returned to SVMC.~~

~~***Dispute Resolution***~~

~~In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with the hospital within thirty days of notification of denial. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.~~

~~Any or all appeals will be reviewed by the hospital's Administrative Director of Revenue Cycle. The director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the director shall provide the patient with a written explanation of findings and determination within thirty days of appeal notification.~~

~~In the event that the patient believes a dispute remains after consideration of the appeal by the Administrative Director of Revenue Cycle, the patient may request in writing, a review by the Chief Financial Officer. The Chief Financial Officer shall review the patient's written appeal and documentation, as well as the findings of the Administrative Director of Revenue Cycle. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient within thirty days of appeal notification. All determinations by the Chief Financial Officer shall be final. There are no further appeals.~~

Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with the hospital within thirty days of notification of denial. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all-additional relevant documentation to support the patient's claim should be attached to the written appeal.

The review process shall consist of this level of management:

1. First Level: Patient Financial Services Manager
2. Second Level: Director of Revenue Cycle

~~***Public Notice***~~

~~SVMC shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas or other common outpatient areas of the hospital. Notices shall also be posted at any location where a patient may~~

~~pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.~~

~~These notices shall be posted in English and Spanish and any other primary languages that are representative of 5% or greater of patients in the hospital's service area.~~

~~A copy of this Financial Assistance Policy will be made available to the public on a reasonable basis.~~

Public Notice/Posting

SVMC shall post notices informing the public of the Charity Care and Financial Assistance Program. Such notices shall be posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas, observation units, where patient may pay their bill or other common outpatient areas of the hospital.

Notice posted include English and Spanish (LEP) plain language statement indicating SVMC has a financial assistance policy, for low-income uninsured or underinsured patient who may not be able to pay their bill. The policy provides charity care or discount care write-off or payment plan in a manner consistent with all the applicable federal and state laws and regulations. How to contact Financial Counseling department for more information about the financial assistance policy and how to request or find the financial assistance application. Where to find financial assistance information on SVMC website. The internet address for the Health Consumer Alliance (https://healthconsumer.org/), an organization that helps patients understand the billing and payment process, as well as provides information regarding Covered California and Medi-Cal presumptive eligibility. For patient who speak a language other the English or Spanish, or who need other accessibility accommodations, SVMC will provide appropriate language accommodations free of charge by contacting Financial Counseling department.

SVMC provides this same written notice upon admission or discharge to every patient. If the patient leaves the facility without receiving the written notice, SVMC will email or mail the notice within 72 hours of providing services.

~~***Confidentiality:***~~

~~It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.~~

~~*Good Faith Requirements*~~

~~SVMC arranges for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.~~

~~Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, SVMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order to qualify for the Sierra View Medical Center financial assistance.~~

Collection Guidelines

SVMC will make reasonable attempts to obtain insurance information. SVMC statements includes language telling the patient that he or she may be eligible for coverage offered through the California Health Benefit Exchange and other state or county-funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services, and the phone number to the Financial Counseling Department. Calls to obtain insurance information or set up a payment plan with patients may be made.

If a patient indicates they are unable to pay, the patient will be referred to a Financial Counselor to assist them with applying for health coverage, to include the California Health Benefit Exchange and other state-or-county-funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services along with the SVMC Financial Assistance program. Accounts with not be sent to collections agency if the patient is in the process of applying for financial assistance. If the patient does not comply with requests for information or refuses to provide SVMC with information, the account can be sent for collections no sooner than 180 days after initial billing. Prior to sending the account to collections, a notice (goodbye letter) along with a charity application, name of the collection agency whom the account will be referred to, along with information on how to receive help will also be included in the final notice to the patient.

External Collection Agencies

Collection agencies are responsible for complying with all state and federal laws pertaining to fair collection of debit, SVMC financial assistance policy and SVMC collection policy.

An account placed with an outside collection agency can be considered for charity care at any time in accordance with SVMC financial assistance policy. When, during the collection process, a patient asserts they cannot afford to pay the debt, has failed to make previously agreed upon extended payments, or is otherwise identified by the collection agency as meeting SVMC charity care eligibility criteria, the collection agency will refer the account to SVMC to screen for charity care eligibility. All accounts returned from a collection agency, the financial counselor department will undertake reasonable efforts to gather eligibility information from the patient. If, after such reasonable efforts, the patient fails or refuses to provide required information, the account will be referred back to the collection agency.

If the patient complies and granted charity, SVMC will evaluate the patient's financial status over the previous eight months to determine eligibility for financial assistance. SVMC will refund financial qualified patients for the amount actually paid over $5.00, if any, in excess of the amount due for debt related to care received from SVMC. Interest will apply for refunds beyond 30 days. An evaluation of any payments made during the previous eight months, when the patient would have been financially eligible for charity, will be conducted identify any possible overpayment in excess of the amount due prior. If the patient is eligible for discounted care, any outstanding balance the patient owes will be reduced according to the discounted care. Any payments the patient made while eligible for discounted care will be applied to any amount due from the patient; any amount the patient paid in excess of the discounted care amount due in that month shall be reimbursed. Payments made for debt related to care received from SVMC at a time when the patient was not eligible for Financial Assistance shall not be reimbursed.

REFERENCES:

- Code of Federal Regulations Title 26 section 1-501
- California Health and Safety Codes Section 127420, 124345, 124345, 127400, 127405, 127410, 127420, 127425, 127426 & 127452
- Assembly Bill 774. ~~Health Facilities, Reporting (2019). Retrieved from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB774~~.
- Assembly Bill ~~72~~ 297~~(2019). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB72~~.
- Assembly Bill ~~1503~~ 1020~~(2019). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1503~~
- Assembly Bill 297

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- Senate Bill 1061~~.~~
- ~~Senate Bill 1276 (2020). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB1276.~~
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SUBJECT:	SECTION:
DEPARTMENTAL DIRECTORS, RESPONSIBILITIES OF~~DEPARTMENTAL LEADERSDIRECTORS, RESPONSIBILITIES OF~~	*Leadership (LD)* **Page 1 of 3**

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

PURPOSE:

To delineate the responsibilities common to all Departmental ~~Directors~~ Leaders of Sierra View Medical Center (SVMC).

POLICY:

Department ~~Directors~~Leaders may delegate work to qualified staff, but are responsible, for the care, treatment and services provided in their department. Additional responsibilities include but are not limited to:

- Integrating the service into the organization's primary functions;
- Creating a culture that enables the Hospital to fulfill its mission and meets the strategic goals;
- Coordinating and integrating interdepartmental and intradepartmental services;
- Developing and implementing policies and procedures that guide and support the provision of services;
- Recommending a sufficient number of qualified and competent staff to provide care, treatment and services;
- Determining the qualifications and competence of department personnel who provide patient care services and who are not licensed independent practitioners;
- Holding all staff accountable for their responsibilities;
- Continuously assessing and improving the performance of care, treatment and services provided;
- Maintaining quality control and performance improvement activities/programs, as appropriate;
- Orienting and providing in-service training and continuing education of all persons in the department;
- Recommending space and other resources needed by the department;
- Participating in the selection of sources for needed services not provided by the department or the organization.
- Providing for the arrangement and allocation of space to facilitate efficient, effective delivery of care, treatment and services.

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Leadership Accountability & Standards of Conduct

Department Leaders are held to a higher standard of accountability due to their role in influencing culture, performance, and staff engagement. Leaders are expected to:

- **Model expected behaviors at all times**, including professionalism, integrity, respect, and compliance with all organizational policies, regulatory requirements, and SVMC values.
- **Maintain visibility and accessibility** through routine rounding, staff check-ins, and timely response to staff needs and operational barriers.

Performance Expectations & Leadership Behaviors

Department Leaders are expected to uphold measurable leadership practices that support staff performance and department success, including:

- **Timely completion of required leadership responsibilities**, including performance reviews, coaching conversations, corrective actions, audits, staff education, and mandatory reporting.
- **Proactive communication** with staff regarding expectations, workflow changes, safety concerns, staffing updates, and department priorities.
- **Consistent follow-through** on commitments, action plans, and issues raised by staff or leadership.
- **Professional conflict resolution**, addressing concerns directly, respectfully, and promptly to prevent escalation or disruption to teamwork.
- **Collaboration and accountability across departments**, demonstrating cooperation and shared ownership of hospital-wide outcomes.

Corrective Action & Leader Accountability

To ensure leaders maintain credibility and set the standard for staff, Department Leaders will:

- **Hold themselves accountable to the same standards they enforce**, including adherence to policies related to attendance, conduct, documentation, safety, and performance.
- **Accept coaching and feedback** from senior leadership, peers, and staff, and demonstrate improvement when opportunities are identified.

- **Escalate issues appropriately and promptly**, including patient safety concerns, compliance risks, harassment/discrimination concerns, or repeated performance issues.

Culture & Staff Development Expectations

Department Leaders are responsible for creating a department culture that reflects SVMC standards by:

- **Recognizing staff performance and reinforcing positive behaviors**
- **Developing staff through coaching, mentorship, and succession planning**
- **Supporting retention efforts** by addressing workload barriers, role clarity, fairness, and morale concerns
- **Maintaining a culture of continuous improvement**, including participation in performance improvement initiatives and leader-driven rounding

Failure to meet leadership accountability standards may result in corrective action, up to and including removal from the leadership role and termination of employment, as determined by SVMC based on the circumstances, including the severity of the issue, impact to operations or patient care, and/or a pattern of behavior.

-

AFFECTED AREAS/PERSONNEL: *ALL DEPARTMENT LEADERS~~DIRECTORS~~*

REFERENCES:

- The Joint Commission (2025~~19~~). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT	Physician Medical Record Documentation & Dictation Requirements.	SECTION: ***Record of Care, Treatment & Services (RC)***

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

PURPOSE:

To ensure that all members of the Medical Staff complete required medical record documentation in a timely, accurate, and compliant manner in accordance with Joint Commission, CMS Conditions of Participation (CoPs), and California Title 22 regulations. Timely physician documentation is essential to patient care, regulatory readiness, coding, billing, continuity of care, and medico-legal integrity.

SCOPE:

This policy applies to all licensed independent practitioners (LIPs), including physicians, advanced practice providers, and contracted/telemedicine providers who generate or authenticate documentation in the patient's legal medical record at Sierra View Medical Center.

POLICY:

❖ **History & Physical (H&P)**

- Regulatory Basis: TJC RC.02.01.03, CMS §482.24(c)(4), Title 22 §70751

➢ **Acute Inpatient Admissions**

- H&P must be completed within 24 hours of admission.
- May be completed up to 30 days prior if:
  - Reviews the H&P within 24 hours of admission, and
  - Documents an update/internal note that includes:
    - ♦ Confirmation of the H&P was reviewed.
    - ♦ Any changes in condition
    - ♦ Any new findings affecting care.

➢ **Surgical/Procedural Cases**

Applies to inpatient and outpatient procedures, including anesthesia cases.

- Timing Requirements
  - H&P must be completed no more than 30 days prior to the procedure.
  - A current H&P must be available in the chart prior to the procedure.
  - If the H&P is older than 30 days, a new H&P is required.
- Update Requirement Prior to the Procedure

  Regardless of when the H&P was completed (same day or up to 30 days prior), an

  Update/Interval Note is required immediately prior to the procedure.
  - The Update note must include:
    - ♦ Confirm the H&P has been reviewed.
    - ♦ Review of Systems

- ♦ Document whether there are no changes or identify any changes in the patient's condition.
- ♦ Be completed by a privileged provider (physician, PA, NP)
- ♦ Be documented before the patient enters the operating room/procedural suite.

➢ **A full H&P is required for:**

- Inpatient Admissions
- Procedures requiring general anesthesia
- Procedures requiring deep or moderate sedation
- High-risk procedures
- Significant change in patient condition

➢ **When a New H&P is Required**

- The patient's condition has changed significantly requiring a new full H&P
- No prior H&P exists.
- The existing H&P is >30 days old.
- The update note identifies significant changes requiring a new full H&P

➢ **Emergency Procedures**

- In true emergencies, an H&P may be deferred until the procedure, but must be documented as soon as possible following stabilization, consistent with CMS and TJC requirements.

❖ **Short Form History and Physical**

When a comprehensive History and Physical Examination is not clinically indicated, a Short Form H&P may be used for outpatient and clinic-based services, provided the nature of the service does not require a full H&P under CMS, Joint Commission, or California Title 22 regulations.

The Short Form H&P must be:

- Appropriate to the patient's condition and procedure
- Completed prior to the service
- Dated, timed, and authenticated by the privileged provider

A Short Form H&P **may not be used** in lieu of a full H&P for inpatient admissions, procedures requiring general or deep sedation, or when the patient's condition warrants comprehensive evaluation.

- At a minimum, the Short Form H&P must include:
  - Chief complaint/reason for visit
  - Focused history relevant to the procedure
  - Relevant past medical/surgical history
  - Medication and allergy review
  - Focused physical exam related to the procedure
  - Assessment and plan

- Statement of medical necessity
- Date, time, and authentication provider signature.

❖ **Operative/Procedural Report**

- Immediate Operative Note (Handwritten or Electronic)

  Must be entered immediately following surgery before the patient leaves the PACU or procedure suite and must include:

  - Pre-op diagnosis
  - Post-op diagnosis
  - Procedure performed
  - Primary surgeon and assistants
  - Estimated blood loss.
  - Findings
  - Complications
  - Specimens removed
  - Condition of patient
- Final Operative Report

  Must be dictated or completed within 24 hours of the surgery or invasive procedure.

❖ **Verbal/Telephone Orders**

- Must be authenticated/signed within 48 hours.

  (CMS §482.24(c)(1), Title 22 §71539)

❖ **Progress Notes**

Regulatory Basis: Title 22 §70749; CMS §482.24(c)(1)

- Physicians must document progress notes daily for inpatients.
- Notes must reflect:

  - Assessment and plan
  - Clinical status
  - Response to treatment
  - Medical Decision-making
- For high-acuity or frequent assessment areas (ICU, L&D), frequency must meet clinical need.

❖ **Consultations**

- Consult notes must be completed within 24 hours of consultation request unless needed state (then must be documented same shift).

❖ **Discharge Summary**

Regulatory Basis: Title 22 §70753; CMS §482.24(c)(4); TJC RC Standards

- Timeline
  - Must be dictated or entered the EMR within 48 hours of discharge.
  - Required Elements:
    - Admission reason
    - Significant findings
    - Procedures
    - Treatment provided
    - Patient condition at discharge
    - Discharge medications
    - Follow-up instructions
    - Pending test results (with follow-up plan)
    - Final Diagnosis
- Short Stay Option
  - For hospital stays <48 hours with minor diagnoses, dictated discharge summary may be replaced by:
    - Final progress note
    - Must include the same required elements.

❖ **Death Summary**

Requirement depends on circumstances:

- Death within 24 hours of admission: Documented by the physician within 24 hours.
- All other deaths: Discharge summary completed within 48 hours.

❖ **Emergency Department Documentation**

Regulatory Basis: CMS §482.24(c)(1), Title 22 §71539

- ED provider note completed before patient discharge or transfer.
- If patient admitted →ED note must be completed within the same shift

❖ **Outpatient Visit Documentation**

Regulatory Basis: CMS §482.24 (timely), TJC RC.02.01.01

- Office Visit/Progress note must be completed within 24-48 hours
- Authentication/Signature must be authenticated within 48 hours
- Procedure notes must be completed immediately post-procedure

❖ **Authentication of Documentation**

SUBJECT	Physician Medical Record Documentation & Dictation Requirements.	SECTION: ***Record of Care, Treatment & Services (RC)***

Regulatory Basis: CMS §482.24(c)(1), Title 22 §71539

- All entries must be dated, timed, and signed (electronic authentication permitted)
- Providers must authenticate all dictations, completions, or verbal orders within 48 hours.
- Use of stamps, signature delegation, or proxy authentication is not permitted.

❖ **Delinquent Medical Records**

➢ Definition

A medical record becomes "delinquent" when required documentation remains incomplete after 30 days from the discharge or service date.

➢ Delinquency Consequences

In alignment with Medical Staff Bylaws:

- Provider placed on Suspension of Admitting/Clinical Privileges once delinquency limits are exceeded.
- Continued noncompliance may result in:
  - Removal from call schedule
  - Administrative suspension
  - Reporting to Medical Executive Committee
  - Correction action per bylaws

❖ **Responsibilities**

➢ Physician/LIPs

- Complete documentation within required timeliness.
- Respond to HIM Deficiencies promptly.
- Authenticate all dictated/transcribed records within 48 hours.

➢ Health Information Management (HIM)

- Monitor delinquent records daily.
- Notify physicians of outstanding deficiencies.

➢ Medical Staff/Chief of Staff

- Enforce suspension policies by Medical Staff Bylaws

➢ Department Director/Medical Directors

- Support monitoring
- Facilitate corrective actions.
- Educate providers on documentation compliance.

AFFECTED PERSONNEL/AREAS: *Medical Staff, All Clinics, Patient Care Areas and Health Information Management.*

REFERENCES:

- **Centers for Medicare & Medicaid Services. (2025).** *State Operations Manual: Appendix A – Survey protocol, regulations, and interpretive guidelines for hospitals (42 CFR Part 482).* U.S. Department of Health and Human Services. https://www.cms.gov

- **Joint Commission. (2025).** *Comprehensive Accreditation Manual for Hospitals: The record of care, treatment, and services (RC) standards.* The Joint Commission. https://www.jointcommission.org

- **California Department of Public Health. (2025).** *California Code of Regulations, Title 22, Division 5: Licensing and certification of health facilities, home health agencies, clinics, and referral agencies.* California Health and Human Services Agency. https://www.cdph.ca.gov
  - §70749 – Progress Notes
  - §70751 – History and Physical Examination
  - §70753 – Discharge Summary
  - §71539 – Authentication of Medical Record Entries

- **Centers for Medicare & Medicaid Services. (2025).** *Conditions of Participation for Hospitals (42 CFR §482.24 – Medical Record Services).* U.S. Department of Health and Human Services. https://www.ecfr.gov

- **Centers for Medicare & Medicaid Services. (2025).** *Conditions of Participation for Surgical Services (42 CFR §482.51).* U.S. Department of Health and Human Services. https://www.ecfr.gov

- **State of California. (2025).** *Business and Professions Code & Health and Safety Code (as related to medical record documentation and provider responsibilities).* California Legislature. https://leginfo.legislature.ca.gov

SUBJECT: **REASONABLE ACCOMODATIONS**	SECTION: **Page 1 of 8**

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

PURPOSE:

The California Fair Employment and Housing Act ("FEHA"), the Americans with Disabilities Act of 1990 ("ADA"), the ADA Amendments Act of 2008 ("ADAAA"), and the Rehabilitation Act of 1973 ("Section 504"), prevent disability discrimination and work to enable individuals with disabilities to participate fully in all aspects of society. One fundamental principle of these regulations is that an employer must engage in the interactive process with individuals with disabilities to determine if a reasonable accommodation exists that would allow such individuals to work without causing an undue hardship to the employer. The Pregnant Workers Fairness Act (PWFA) prevents discrimination with regard to reasonable accommodations related to pregnancy. The fundamental principle of PWFA is that employer must engage in the interactive process with individuals who have known limitations related to pregnancy, childbirth, or related medical conditions, unless the accommodation will cause an undue hardship to the employer.

POLICY:

Sierra View Medical Center ("SVMC") will engage in the interactive process with employees and prospective employees with qualifying disabilities or qualified under PWFA in the administration of all personnel policies, procedures, and benefits procedures.

DEFINITIONS:

Person with a Disability: A person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.

Essential Functions: The basic job duties that an employee must perform, with or without reasonable accommodation and are designated as such in the job description.

Reasonable Accommodation: In general, reasonable accommodation is any change or adjustment to a job or work environment that permits a qualified applicant or employee with a disability to participate in the job application process, to perform the essential functions of a job, or to enjoy benefits and privileges of employment equal to those enjoyed by employees without disabilities without causing an undue hardship on SVMC. Under PWFA, qualified applicants or employees are considered qualified even if they cannot perform all the essential functions of their job, if their inability to perform the essential functions is temporary and could be resolved in the "near future"(approximately 40 weeks), and the accommodation does not create an undue hardship to the employer.

The following are examples of "reasonable accommodations":

1) Modifications or adjustments to a job application process that enable a qualified applicant with a disability or qualified under PWFA to be considered for the position such qualified applicant desires; or

2) Modifications or adjustments to the work environment, or to the manner or circumstances under which the position held or desired is customarily performed, that enable a qualified individual with a disability or qualified under PWFA to perform the essential functions of that position; or

3) Modifications or adjustments that allow SVMC employees with a disability or qualified under PWFA to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities; or

4) Modifications or adjustments to the work schedule, including but not limited to, a medical accommodation leave of absence.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES AND APPLICANTS*

PROCEDURE:

1. APPLICANTS FOR EMPLOYMENT:

Applicants for employment who have a qualifying disability or are qualified under PWFA may request reasonable accommodation at any time during the application process. Requests for accommodation may be made verbally or in writing to the Human Resources Department. Requests will be addressed in a timely fashion. Applicants who make verbal requests will be asked to confirm their request in writing, but the arrangements for accommodation will not depend on receipt of the written request.

Once a request for reasonable accommodation is made, SVMC will engage in the interactive process with the applicant to determine if a reasonable accommodation exists without creating an undue hardship to SVMC.

2. EMPLOYEES:

A. Request for Reasonable Accommodation:

An employee with a ~~whose~~ qualifying disability or are qualified under PWFA that require a ~~es~~ reasonable accommodation in order to perform his/her essential job functions may request a reasonable accommodation at any time. Requests may initially be made verbally to the immediate supervisor; however, the employee will be asked to present the

request in writing to the Human Resources Department in order to allow SVMC to engage in the interactive process to determine if a reasonable accommodation exists without causing undue hardship to SVMC.

B. Process for Addressing Requests for Accommodation:

- Human Resources will engage in a discussion with the employee to identify an appropriate reasonable accommodation.
- The District will attempt to provide the accommodation in the form requested by the employee and will consider the employee's preference but reserves the right to provide an alternative, so long as it reasonably accommodates the employee's qualifying disability.

C. Documentation of Disability and Need for Accommodation:

- Unless both the disability and the need for accommodation are obvious or employee is qualified under PWFA, the employee will be asked to provide written reasonable medical verification that a qualifying disability exists. For PWFA accommodations, medical verification will ONLY be requested if reasonable to do so and accommodation request is not included in the PWFA identified predictable assessments. The employee DOES NOT need to directly identify the underlying medical cause of the disability. Documentation should be from an appropriately certified or licensed health care or rehabilitation professional and must verify the existence of a qualifying disability and explain any physical, mental, or medical restrictions the employee may have and state the employee's need for reasonable accommodation. The District will provide the employee with the ADA and FEHA-Essential Function Job Analysis, Health Care Provider Evaluation and a copy of the employee's job description.
- Documentation provided by an employee should include the following:
  - A statement verifying the existence of a qualifying disability.
  - A statement describing how the disability impacts the performance of essential functions and what reasonable accommodations would permit the employee to perform the essential functions of the job.
  - A description of the expected progression or stability of the disability over time.
  - The relevant credentials of the diagnosing professional(s), such as medical specialties or professional licensure.

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- Any written documentation provided by an employee requesting accommodation should be submitted to Human Resources, where it will be maintained in a confidential file separate from the employee's official personnel file.

- Occasionally, the documentation provided by the employee may not be sufficient to make a determination of the appropriate reasonable accommodation. In such a circumstance, SVMC may require, at SVMC's expense, the employee to go to a health care professional of the District's choice in order to adequately document the need for accommodation and identify appropriate accommodations. Any medical examination required under these circumstances will be limited to determining the existence of a disability and the functional limitations that require reasonable accommodation.

D. Medical Accommodation Leave of Absence

SVMC will engage in the interactive process to determine whether the employee's medical condition qualifies as a disability under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act ("FEHA") or they are qualified under PWFA and whether a medical leave of absence may be available as a reasonable accommodation where an employee is either ineligible for or has exhausted FMLA/CFRA leave and/or any other protected leave.

All medical accommodation leaves of absence under this policy will be evaluated by Human Resources. During the interactive accommodation process, such evaluation shall give consideration to staffing requirements, operational needs, and undue hardship on the operations of the Department and organizationally in accordance with applicable law.

Procedure:

Should it be determined that an employee is eligible for a medical accommodation leave of absence under this policy, he or she should abide by the following procedure:

1. It is the employee's responsibility to obtain authorization for the start of leave, and upon return from a medical accommodation leave of absence. The employee is also responsible for requesting any extensions that are considered necessary through Human Resources. Department Directors must notify Human Resources of any employees that are absent for more than three (3) days, without prior approval, as they may qualify for a medical accommodation leave of absence.

2. If the medical accommodation leave of absence is foreseeable, (i.e., the employee is aware of the need for a leave more than thirty (30) days before its commencement), the employee must give the Hospital at least thirty (30) days

prior notice. If the leave is unforeseeable, notice must be given as soon as is possible and practicable. Employees requesting leave must notify Human Resources immediately. Failure to provide such notice may be grounds for delay or denial of leave. The employee is required to comply with the Hospital's normal attendance call-in and notification procedures as set forth in the Hospital's Attendance Policy until a leave of absence has been requested.

3. For medical accommodation leave that lasts longer than thirty (30) days, the Hospital reserves the right to ~~may~~ require employees to provide re-certifications from their health care provider at reasonable ~~regular~~ intervals.

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4. A fitness-for-duty/physician's certification will be required before the employee may return to work. For that purpose, the Hospital will provide the employee with a job description indicating the essential job functions of the employee's position for consideration by the treating physician.

Benefits:

1. Once an employee is granted a medical accommodation leave of absence, health, dental, vision, and voluntary benefits stop the first of the month following the month in which their medical accommodation leave began.

2. Insurance Benefits: Health, dental, and vision insurance while on medical accommodation leave of absence under this policy is not hospital-subsidized, and the employee may continue coverage at full cost through COBRA. The employee will be notified of COBRA coverage eligibility by either Human Resources and/or SVMC Benefits Center. Once an employee returns from medical accommodation leave, if they wish to reinstate benefits, they will be required to re-enroll and complete a 30 day waiting period. Benefits will continue the first of the month following the 30 days of return date.

3. Vacation/Holiday hours do not accumulate during a medical accommodation leave of absence. (See Vacation/Holiday policy.)

4. Paid Sick Leave (PSL) and Vacation/Holiday hours will be paid biweekly until exhausted~~,~~ for all employees who are eligible for Vacation/Holiday, PSL~~-~~, ~~time~~ and~~-~~ approved for medical accommodation leave of absence, unless they are receiving ~~utilizing~~ State Disability. However, PSL and Vacation/Holiday hours must be used during the State Disability Insurance (SDI) waiting period if available. In addition, eligible employees may use accrued PSL and Vacation/Holiday hours ~~time~~ to supplement State Disability payments during a medical accommodation leave of absence.

Length of Medical Accommodation Leave of Absence:

1. ~~The duration of a Medical Accommodation Leave of Absence is determined on a case-by-case basis, and based on whether it is required by state and federal disability laws as a reasonable accommodation for an employee's own medical condition.~~ The duration of a Medical Accommodation Leave of Absence will be determined on a case-by-case basis. Such leave may be provided when it is determined to be a reasonable accommodation under applicable state and federal disability laws for an employee's own medical condition.

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Reinstatement:

1. No guarantees are made as to reinstatement to the same or an equivalent position and pay rate upon return from a medical accommodation leave of absence for recovery and treatment unless required by law.

2. SVMC will attempt to reassign an employee returning from a leave of absence to their regular position, if available. If their regular position is not available, or they are unable to perform the essential functions of their regular position, SVMC will attempt to reassign the employee to another open position, provided they possess the requisite skills and competencies and are capable of performing in the position with or without a reasonable accommodation. Human Resources shall advise the Director/Manager when an employee is not returned to an existing position within their former Department. If salary adjustments are necessary, decisions are determined by Human Resources.

3. An employee who gives notice of intent not to return to work following a Medical Accommodation Leave of Absence will be considered to have voluntarily resigned. Such notice may be a qualifying event entitling the employee to continuation of health care coverage under COBRA, if COBRA was purchased during initial eligibility.

4. If at the end of the medical accommodation leave, an employee is unable to return to either his/her regular job or an unfilled position which they are qualified for and capable of performing, the employee shall be separated from employment.

E. An applicant or an employee with a disability, as defined by law, who is dissatisfied with the response to his/her request for reasonable accommodation and wishes to take formal action may file a grievance.

COMPLAINT GRIEVANCE RESOLUTION PROCESS

It is the policy of Sierra View Medical Center not to discriminate on the basis of disability or pregnancy related limitations. Sierra View Medical Center has adopted an internal grievance procedure providing

for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no otherwise qualified handicapped individual…shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance…" The law and regulations may be examined in the office of the Vice President of Human Resources, who has been designated to coordinate the efforts of Sierra View Medical Center to comply with Section 504.

Any person who believes he or she has been subjected to discrimination on the basis of disability or pregnancy may file a grievance under this procedure. It is against the law for Sierra View Medical Center to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

PROCEDURE:

- Grievances must be submitted to the Section 504 Coordinator within ten (10) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of Sierra View Medical Center relating to such grievances.
- The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
- The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the Sierra View Medical Center Chief Executive Officer ("CEO") within 15 days of receiving the Section 504 Coordinator's decision.
- The CEO shall issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

Sierra View Medical Center will make appropriate arrangements to ensure that ~~disabled~~ individuals with a qualifying disability~~persons~~ or individuals qualified under PWFA are provided other accommodations, if needed, to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a

barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

REFERENCES:

- Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101 et. Seq (1990). https://www.law.cornell.edu/uscode/text/42/12101.
- ADA Amendments Act of 2008 ("ADAAA"). https://www.eeoc.gov/statutes/ada-amendments-act-2008.
- Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794; 49 C.F.R. § 84 et. Seq. https://www.law.cornell.edu/uscode/text/29/794
- California Fair Employment and Housing Act ("FEHA"). Cal. Gov't Code §12900 et. Seq. (1980). https://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=GOV&division=3.&title=2.&part=2.8.&chapter=&article=.
- EEOC Enforcement Guidance on Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act (October 17, 2002). https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada.
- EEOC Pregnancy Discrimination and Pregnancy-Related Disability Discrimination https://www.eeoc.gov/pregnancy-discrimination

CROSS REFERENCES:

- Equal Employment Opportunity Policy
- Workers' Compensation
- Leave of Absence - FMLA/CFRA
- Vacation/Holiday policy
- Sick Leave Policy

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SUBJECT: **REIMBURSEMENT FOR RELOCATION EXPENSES**	SECTION: ***Human Resources*** **Page 1 of 3**

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

PURPOSE:

This policy is intended to help attract and hire candidates for critical or hard to fill positions by offering assistance with relocation expenses.

POLICY:

At the discretion of the Senior Leadership Team, Sierra View Medical Center (SVMC) may reimburse candidates for approved relocation expenses incurred for moving to the area based on the acceptance of a job offer with SVMC. Where such reimbursement is offered, a separate Relocation Reimbursement Repayment Agreement will need to be voluntarily executed by the new employee. An employee's voluntary execution of the Relocation Reimbursement Repayment Agreement is separate from their employment with SVMC and is not required as a condition of employment.

AFFECTED PERSONNEL/AREAS: *INCUMBENTS OF POSITIONS DESIGNATED BY SENIOR LEADERSHIP TEAM*

PROCEDURE:

1. **Eligibility to Receive Reimbursement for Relocation:**

   In order for relocation expenses to qualify as a reimbursable expense, the following conditions must be met:

   a. The employee's relocation is close to the start of their employment at SVMC. Generally, SVMC will consider moving expenses within one year of their ~~start~~ Start ~~date~~Date.

   b. The distance from the employee's previous residence to SVMC must be at least 50 miles more than the distance from the employee's previous residence to employee's previous main place of work. If the employee is a first-time employee or was previously working part-time or unemployed, the distance to SVMC must be 50 miles from employee's previous residence.

   c. In accordance with California Business and Professions Code section 166608(b)(2)(D), and as provided for in the executed Relocation Reimbursement Repayment Agreement, ~~If~~ if the employee either voluntarily terminates their employment or is terminated for "misconduct" as that term is defined under California Unemployment Insurance Code section 1256 less than one year from date of hire, ~~whether voluntary or involuntary,~~ they will be responsible for paying back to SVMC the relocation expenses paid to them based on a pro-rated amount of hours worked from ~~date of hire~~their Start Date to last day of employment.

2. **Employee Responsibility to Receive Reimbursement of Relocation Expenses:**

Relocation expenses must be documented with receipts and provided to SVMC's payroll department within 30 days following the completion day of the physical move. Employees will receive reimbursement within ~~(15)~~ fifteen (15) days following submission and approval of an expense reimbursement form with attached receipts unless an employee voluntarily elects in their Relocation Reimbursement Repayment Agreement to defer receipt of any eligible relocation expenses until after they have fully completed the one year period from their Start Date. In the event that the employee defers receipt of such eligible relocation expenses, the employee will receive reimbursement within fifteen (15) days of completion of the one year period from their Start Date.

Reimbursement will be withheld in part, or whole, when funds are misused or if circumstances fail to result in the successful relocation of the employee and his/her family. Receipts submitted for reimbursement will be reviewed by Payroll staff for appropriateness of qualifying reimbursements as outlined in this policy. The reimbursement payment will be processed by the Payroll Department.

3. **Human Resources Responsibility:**

The Human Resources Department will initiate the original offer letter to include any approved reimbursement for relocation pursuant to this policy and will provide the employee with the separate Relocation Reimbursement Repayment Agreement that the employee can voluntarily agree to execute. No assurance may be made that all relocation expenses will be reimbursable. The Human Resources Department will submit a copy of the offer letter to the Payroll Department.

No agreement, verbal or written, may be made with prospective employees outside of this policy.

4. **Eligible Reimbursable Relocation Expenses**

The following items are eligible for reimbursement for purposes of this policy:

- Moving of employee's household goods and personal effects.
- Traveling (including lodging but not meals) to your new home.
- Travel by Car: If you use your car to take yourself, members of your household, or your personal effects to your new home, you can figure your expenses by deducting either:

    a.) Your actual expenses, such as the amount you pay for gas for your car if you keep an accurate record of each expense, or

b.) The standard mileage rate as determined by the Internal Revenue Service (IRS) at the time of the move.

For tax years 2018 through 2025, reimbursements for certain moving expenses are no longer excluded from the gross income of non-military taxpayers. The standard mileage rate as set by the IRS will be used to calculate the reimbursement.

5. **Non-Eligible Reimbursable Relocation Expenses**

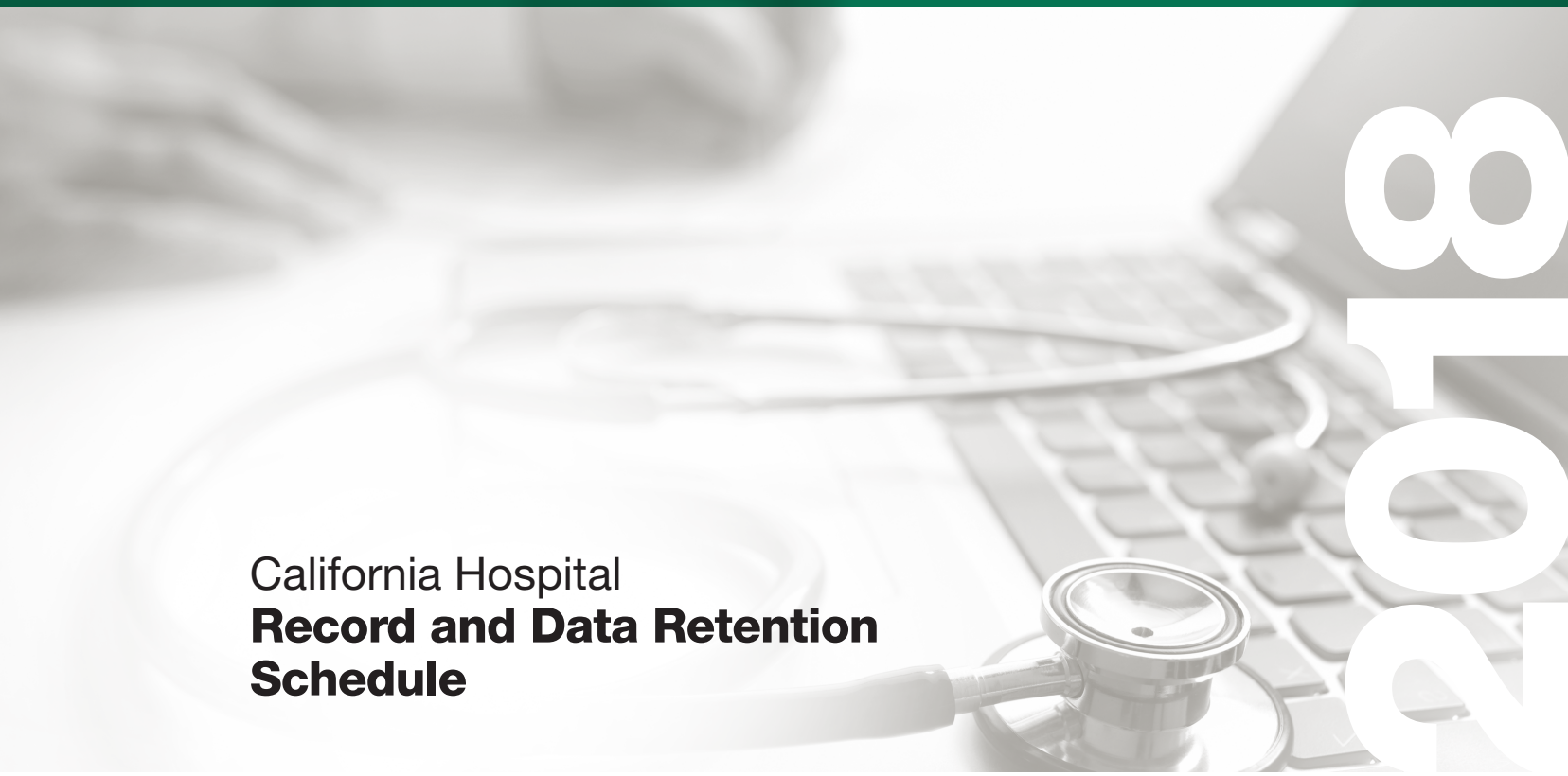
The following items will not be a reimbursed expense for purposes of this policy. (Note: This is intended to be a list of reference and not all-inclusive. SVMC reserves the right to determine eligibility of reimbursable expenses which may not be represented below):

- Any part of the purchase price of employee's new home
- Car tags
- Driver's license
- Expenses related to the buying or selling of a home
- Expenses related to signing or breaking a lease
- Expenses related to home improvements for selling or purchasing of a home
- Loss of the sale of current home
- Losses from disposing of membership in clubs
- Meal expenses
- Mortgage penalties
- Real estate taxes
- Refitting of carpets and draperies
- Security deposits (including any given up due to the move)
- Required licensure and certifications

REFERENCES:

- California Business and Professions Code section 16608.
- Publication 521 (2018), Moving Expenses. (n.d.). Retrieved February 19, 2019, from https://www.irs.gov/publications/p521.

Record Retention



2018

California Hospital
Record and Data Retention Schedule

A guidebook on which records should be kept and for how long

CALIFORNIA HOSPITAL ASSOCIATION

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October 2018
9th Edition

CALIFORNIA HOSPITAL ASSOCIATION

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Table of Contents

Preface

Health care providers create volumes of records dealing with a variety of matters. Some concern the corporate, business and administrative aspects of their operations. Others document unique areas, such as medical staff activities at hospitals. Still others trace the course of care given to patients. Providers naturally consider retaining any record that is of more than passing interest. However, as records accumulate, they occupy valuable space that often could be put to better use. Storing records off-site or in electronic form may alleviate the problem. However, these alternatives are likely to be expensive and do not address the basic question of which records should be kept and for how long.

If health care providers are to deal intelligently with the problem, they must base their decisions upon a firm knowledge of legal requirements and policy considerations. This guide discusses those requirements and considerations, and recommends specific periods for the retention of various classes of records.

The guide contains two sections. The first is a discussion of retention considerations as they pertain to various kinds of records. The second section is a Recommended Retention Schedule. It contains tables listing typical records, legal citations applicable to each health care provider type, and recommended retention periods. This schedule does not list every possible record that may be produced or retained by a health care provider but rather provides recommendations and cites legal requirements for the most common documents. For records not specifically addressed in this guide, CHA recommends considering retention periods for records listed that are of a similar nature or purpose and consulting your legal counsel.

The guide is not designed to serve as a substitute for legal counsel. If there are differences of opinion, or where the law is unclear, a provider should consult legal counsel and then make retention decisions based on the law and its own philosophy, mission and purpose.

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Record Retention Considerations

I. INTRODUCTION

Health care providers create volumes of records dealing with a variety of matters. The question naturally arises, which records should be kept and for how long?

This section of the *Record and Data Retention Schedule* discusses why hospitals and other health care providers should have a record retention policy, the pertinent factors that should be considered when determining how long to keep various documents, and considerations regarding record disposal and/or destruction. The second section of the *Record and Data Retention Schedule* (starting on page 21) is a Recommended Retention Schedule. It contains tables listing typical records, provider types, any applicable legal citations, and recommended retention periods.

The information in this manual applies identically to all records, regardless of media (paper, electronic, microfiche, microfilm, video/audio recording, magnetic tape, CD-ROM, USB sticks, etc.).

This guide is intended to be used as a reference document. The information is accurate at the time of publication; however, the guide does not cover every law, rule or regulation concerning record retention — it focuses on the ones most relevant to hospitals. Due to the dynamic nature of the law, information of this kind is subject to change at any time. **Records should never be destroyed without first verifying that retention requirements have not changed and litigation is not pending.**

All of the laws cited in this manual can be found on the Internet. *(See "Where to Find the Laws Referenced in the Manual," page 75, for instructions on finding the exact language of the laws.)*

II. THE IMPORTANCE OF HAVING A RECORDS MANAGEMENT POLICY

Hospitals and other health care providers are advised to establish and implement written policies and procedures regarding the retention and disposal/destruction of records. Doing so will help the provider achieve compliance with state licensure laws, federal health care program (Medicare, Medi-Cal) requirements, contractual obligations, accreditation organization requirements, and other statutes and regulations. Without a written policy, a provider may retain records longer than necessary, which is costly and inefficient, or dispose of records too soon, resulting in the inability to access important documents when needed. Disposing of records too soon may also lead to fines or penalties. On the other hand, keeping documents too long incurs storage fees. In addition, if a record retention policy limits how long information is kept, the hospital will have less information to search and review if served with a subpoena or other document request. This can save the hospital time and money, both employee time looking through documents and attorney time spent reviewing them.

The policies and procedures should be followed consistently to dispute any allegation that the provider withheld, hid, altered or destroyed evidence relevant to a legal proceeding ("spoliation of evidence"). Spoliation of evidence is a crime in California and at the federal level [Penal Code Section 135; 18 U.S.C. Section 1519]. In addition, if a judge believes that a party to a lawsuit has destroyed evidence, the judge may conclude that the evidence would have been unfavorable to the spoliator.

An employee should be designated to be responsible for implementing and updating the policies and procedures, as well as training and monitoring employees to ensure consistent compliance throughout the organization. It may be helpful to establish a records management committee to review and approve additions and updates to the policies and procedures, and to assist in implementation, training and monitoring/auditing.

A record retention and disposal policy should contain at least the following elements:

1. A statement about the purpose of the policy;
2. Whether the policy covers the entire organization or only certain departments;
3. A statement that the destruction of relevant records will be suspended upon receipt of legal process or other notice of pending or reasonably foreseeable investigations or litigation, whether government or private;
4. A list of employees and/or departments responsible for maintaining and updating the policy;
5. A list of employees and/or departments responsible for moving documents to long-term storage and/or destroying documents in accordance with the policy; and
6. A retention period for each type of record.

III. PRIMARY CONSIDERATIONS IN DEVELOPING A RECORD RETENTION SCHEDULE

A record retention schedule that meets the needs of a health care provider should result from an evaluation of several important primary considerations. Providers should pay particular attention to the following:

1. Legal requirements and considerations;
2. Frequency of use of a record;
3. Space constraints; and
4. Historical or research uses for the records.

These considerations are described more fully below.

A. Legal Requirements and Considerations

Specific Statutes and Regulations

The health care industry is highly regulated. The number of state and federal government agencies that regulate hospitals and other health care providers is astonishing.[1] Each of these agencies has the authority to audit hospitals, inspect their records, issue regulations that hospitals must follow, and sanction hospitals for noncompliance.

Many state and federal government agencies have issued regulations that specify how long hospitals and other health care providers must keep certain documents. The Recommended Retention Schedule found in the second section of this manual lists these requirements. Providers are required to comply with these retention periods. However, in many cases, compliance with these minimum retention requirements is inadequate to protect the health care provider in all situations. Additional considerations in determining an optimal record retention period are discussed below.

Hospitals should check with county and local agencies regarding any record retention requirements they may have, such as local water quality protection agencies or county health departments. The CHA Recommended Retention Schedule does not include local government retention requirements.

Medi-Cal Requirements

A state law that took effect on Jan. 1, 2018, requires hospitals and other providers of health care services rendered under Medi-Cal or any other Department of Health Care Services program to keep records for at least 10 years, including:

1. Billings.
2. Treatment authorization requests.
3. Copies of remittance advices that accompany reimbursement to providers for services/supplies provided to beneficiaries.
4. Individual ledger accounts reflecting credit and debit balances for each beneficiary.
5. Copies of original purchase invoices for medication, appliances, and assistive devices.
6. Written requests for laboratory testing and all reports of test results.
7. Book records of receipts and disbursements by the provider.
8. All medical records (including each service rendered, date of service, and identification of the person rendering services), service reports, and orders prescribing treatment plans.
9. Records of medications, drugs, assistive devices, or appliances prescribed, ordered for, or furnished to beneficiaries.

1 For example, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Drug Enforcement Administration, Equal Employment Opportunity Commission, Food and Drug Administration, Internal Revenue Service, Office for Civil Rights, Occupational Safety and Health Administration, U.S. Department of Labor, California Department of Public Health, California Board of Pharmacy, California Department of Health Care Services, Cal/OSHA, Fair Employment and Housing Commission, Franchise Tax Board, etc.

10. For providers of psychiatric and psychological services, patient logs, appointment books or similar documents showing the date and time allotted for appointments of each patient or group of patients, and the time actually spent with the patients.
11. Employment records including shifts, schedules and payroll records of employees.
12. Records of receipts and disbursements of personal funds of beneficiaries held in trust by the provider, if any.

These records must be kept starting from the date the record was created and running for 10 years from the latest of:

1. The final date of the contract period between the plan and the provider,
2. The date of completion of any audit, or
3. The date the service was rendered.

Because most hospitals and other health care providers serve Medi-Cal beneficiaries, and the contract period or audit process may add several years to the 10-year time frame, CHA's Record Retention Schedule shows a 15-year recommended retention period for the records listed above. This recommendation is reflected in the fourth column of the Recommended Retention Schedule. Providers using the Schedule that do not serve Medi-Cal patients may wish to consider a shorter retention period. *(See also "Contracts with Medicare Advantage or Medicare Part D Plans," page 6, and "Accountable Care Organizations," page 7.)*

This law applies to any individual, partnership, group, association, corporation, institution or other entity that provides goods, services, supplies or merchandise, directly or indirectly, including all ordering, referring and prescribing, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program [Welfare and Institutions Code Section 14043.1(o)]. A health facility or other provider that does not treat Medi-Cal patients or provide any other services regulated by the Department of Health Care Services is not required to comply with this law.

[Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]

Statutes of Limitations

Sometimes hospitals and other health care providers will want to be able to produce records to defend themselves in a lawsuit. It is helpful to understand the time period during which various types of lawsuits may be brought in order to develop an effective retention policy. The time period during which a lawsuit may be brought is called the "statute of limitations." After the statute of limitations has run, it is too late for a plaintiff to bring a lawsuit, and related records will thus not be needed to defend any such suit.

This section of the manual describes several statutes of limitations commonly applicable in the California health care industry. However, it is not possible to list every potentially applicable statute of limitations. Legal counsel should be consulted if a question arises regarding the statute of limitations in a particular situation.

Medical Malpractice Action

In California, a medical malpractice lawsuit (also known as a professional negligence action) must be brought within three years after the date of injury, or one year after the patient discovers, or through the use of reasonable diligence should have discovered, the injury,

whichever occurs first. Minors have three years to bring a lawsuit, but a minor under the age of six years has three years or until the eighth birthday, whichever is later. The applicable time period is indefinite in cases of fraud, intentional concealment, or the presence of a foreign body that has no therapeutic or diagnostic purpose. [Code of Civil Procedure Section 340.5]

It is important to note that California courts have interpreted the medical malpractice statute of limitations fairly leniently in favor of the patient, and allowed actions to be brought many years after the medical care at issue was provided.

Personal Injury Action

In California, a personal injury lawsuit must be brought within two years [Code of Civil Procedure Section 335.1]. This type of lawsuit includes slip-and-fall injuries on hospital premises, car accidents by employees in hospital-owned vehicles, etc.

Breach of Contract Action

In California, a lawsuit for breach of contract must be brought within four years if the contract is evidenced by writing [Code of Civil Procedure Section 337]. This does not mean that the contract must be a formal, written contract signed by both parties. It means that there must be some written evidence (a letter, e-mail, purchase order, etc.) regarding the contract. If the contract is not evidenced by writing, the statute of limitations is two years [Code of Civil Procedure Section 339].

Federal Fraud and Abuse Actions

The federal government must bring an action against a health care provider for civil monetary penalties within six years from the date on which the claim at issue was presented, the request for payment was made, or the incident occurred [42 C.F.R. Section 1003.1570]. The statute of limitations for False Claims Act suits is also six years after the violation was committed (or within three years after the date when material facts were known or should have been known by the government, but in no case later than 10 years after the violation was committed) [31 U.S.C. Sections 3729 and 3731].

However, health care providers should be aware that there are many different fraud statutes under which the federal government may bring a lawsuit, and each has its own limitations period — for example, criminal fraud, mail fraud, wire fraud, racketeering, etc. *(see, for example, 18 U.S.C. Sections 1031 and 3282)*. There are circumstances under which the government may bring a lawsuit after more than six years have elapsed. Legal counsel should be consulted if questions arise with respect to fraud and abuse statutes of limitations.

Internal Revenue Service Actions

The IRS must generally bring an action within three years from the date of filing of tax returns. However, if a false or fraudulent return is filed, if a willful attempt to evade tax takes place, or no return is filed, the IRS may bring an action at any time. [26 U.S.C. Section 6501]

Accreditation Requirements

Hospitals and other health care providers should review all relevant accreditation requirements to determine whether they contain any record retention obligations. If they do, the providers' policies and procedures should be reviewed and revised as necessary to maintain compliance.

The Joint Commission (TJC) generally requires that hospitals determine appropriate records retention periods based on applicable laws, as well as anticipated uses for patient care, legal, research, operational and educational purposes. TJC notes that documents such as crash cart daily checks, temperature monitoring logs, and meeting minutes and agendas are examples of documents that are not considered part of a patient's medical record, but are required to document compliance with TJC standards. TJC requires organizations to keep all records needed to document compliance with standards dating back to the last full survey. Because surveys may be no more than 39 months apart, hospitals accredited by TJC should keep these records for at least 39 months.

Contracts and Grants

Health care providers should carefully review their contracts and grants to determine whether they contain any record retention obligations. If they do, the providers' policies and procedures should be reviewed and revised as necessary to maintain compliance with the contractual obligation.

Three common record retention contractual provisions in the health care industry are described below.

Medicare Access Clause

A hospital may be both a Medicare-participating provider and a subcontractor under the Medicare program at the same time, if the hospital accepts Medicare patients and also provides services under a contract with another Medicare-participating provider.

The records a participating hospital must retain are included in the Recommended Retention Schedule *(see, for example, "Medicare cost report records," page 29)*.

A hospital that is a subcontractor, or a hospital that enters into agreements with subcontractors, must include an "access" clause in its contracts that allows federal government agencies to access the subcontractor's books and records. Specifically, contracts for services between a Medicare institutional provider and a subcontractor must contain an access clause if the value of the services is $10,000 or more over a 12-month period. This includes contracts for both goods and services in which the service component is worth $10,000 or more.

The clause must permit the Comptroller General of the United States, the U.S. Department of Health and Human Services, and their duly authorized representatives to access to the subcontractor's contract, books, documents, and records until four years after the services are furnished under the contract or subcontract.

If a contract subject to these requirements does not contain the clause, CMS will not reimburse the provider for the cost of the services furnished under the contract and will recoup any payments previously made for services under the contract.

[42 C.F.R. Section 420.302]

Contracts with Medicare Advantage or Medicare Part D Plans

Federal regulations governing the Medicare Advantage (MA) program and Medicare Part D (Medicare prescription drug benefit) require the plans to include a provision in their contracts with first tier, downstream and related entities to maintain records for a minimum of 10 years from the final date of the contract period or completion of audit, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2)]. This includes books, contracts, computer or

other electronic systems, medical records, patient care documentation, and other records that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract [42 C.F.R. Sections 422.504(e)(2)–(4) and 423.505(e)(2)–(4)]. Under certain circumstances, CMS may notify the contractor that it must keep its records longer. *(See also* Medicare Managed Care Manual*, Pub. 100-16, Chapter 11, Section 100.5.)*

Hospitals and other health care providers that have contracted with MA or Medicare Part D plans should ensure that relevant records are maintained in accordance with contractual obligations.

Accountable Care Organizations

Accountable Care Organizations (ACOs) must agree to retain their records for 10 years after the agreement with the Centers for Medicare & Medicaid Services ends, or 10 years after any audit, evaluation, or inspection is concluded, whichever is later. In addition, the ACOs must require their ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to do the same. Required records include books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements related to ACO activities) sufficient to enable the audit, evaluation, investigation, and inspection of the ACO's compliance with program requirements, quality of services performed, right to any shared savings payment, or obligation to repay losses, ability to bear the risk of potential losses, and ability to repay any losses to CMS.

The Centers for Medicare & Medicaid Services (CMS) may notify an ACO that it must keep its records longer. In addition, if there has been a termination, dispute, or allegation of fraud or similar fault against the ACO, its ACO participants, its ACO providers/suppliers, or other individuals or entities performing functions or services related to ACO activities, the ACO must retain records for an additional six years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault. [42 C.F.R. Section 425.314]

U.S. Department of Health and Human Services Grants

Recipients of grants from the U.S. Department of Health and Human Services must retain financial, statistical and nonexpendable property records, and any other records pertinent to the grants, for three years from the submission of the final expenditure report, or until resolution of all litigation and federal audit findings. Records for real property and equipment acquired with federal funds must be retained for at least three years after final disposition. [45 C.F.R. Section 75.361] Subrecipients and contractors are also subject to this record retention requirement. Recipients, subrecipients, and contractors may wish to retain many of these records longer in accordance with the Recommended Retention Schedule.

B. Frequency of Use

When establishing retention periods, providers should consider how often records will be needed. Records that are used more frequently should be retained in a more quickly accessible form for longer periods of time. As the frequency of use declines, providers may transfer more important records to an image storage media or to outside storage, or consider whether the records should be destroyed.

C. Space Constraints

The Schedule acknowledges that most providers have limited storage space, both physical and electronic. The amount of space available will influence whether a record should be purged after the minimum required retention period or whether it should be retained longer.

D. Historical or Research Use of Records

These guidelines generally do not address the retention of records for historical or research purposes. However, these considerations may be important to providers. Therefore, providers should consider whether to keep records for historical documentation and/or research activities. The costs of storage, plus the cost of employee and attorney time to review records if a subpoena is received, should be considered.

IV. MEDICAL RECORDS

A. Retention Period Options

Some California health care providers choose to keep their medical records permanently. However, this is not legally required.

Requirements for Providers That Treat Medi-Cal Patients

Until 2018, hospitals and other health facilities were required by CDPH licensing laws to retain medical records of adults for 7 years after discharge or the last patient encounter, and until the age of 19 but no less than 7 years after discharge or the last patient encounter for minors.

However, a state law that took effect on Jan. 1, 2018, requires hospitals and other providers of health care services rendered under Medi-Cal or any other Department of Health Care Services program to keep all medical records of covered patients for at least 10 years starting from the date the record was created until the latest of:

1. The final date of the contract period between the plan and the provider,
2. The date of completion of any audit, or
3. The date the service was rendered.

Because most hospitals and other health care providers serve Medi-Cal beneficiaries, and the contract period or audit process may add several years to the 10-year time frame, CHA's Record Retention Schedule shows a 15-year recommended retention period for medical records. This recommendation is reflected in the fourth column of the Recommended Retention Schedule. Providers using the Schedule that do not serve Medi-Cal patients may wish to consider a shorter retention period. *(See also "Contracts with Medicare Advantage or Medicare Part D Plans," page 6, and "Accountable Care Organizations," page 7.)*

[Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]

This law applies to any individual, partnership, group, association, corporation, institution or other entity that provides goods, services, supplies or merchandise, directly or indirectly, including all ordering, referring and prescribing, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program [Welfare and Institutions Code Section 14043.1(o)].

Additionally, skilled nursing facilities that participate in Medicare or Medi-Cal must keep records of minors until they reach the age of 21 [42 C.F.R. Section 483.70(i)].

The medical records of patients not covered by Medi-Cal or other Department of Health Care Services programs do not need to be kept for this longer period of time *(see below)*.

Requirements for Providers That Do Not Treat Medi-Cal Patients

State licensing laws govern how long providers must keep medical records for patients not covered by Medi-Cal or other Department of Health Care Services programs.

Health facilities, home health agencies, primary care clinics and psychology clinics [Title 22, California Code of Regulations, Sections 70751(c) (general acute care hospitals), 71551(c) (acute psychiatric hospitals), 72543(a) (skilled nursing facilities), 73543(a) (intermediate care facilities), 74731(d) (home health agencies), 75055(a)(primary care clinics), 73543(a) (psychology clinics), 77143(c) (psychiatric health facilities) and 79351(c) (chemical dependency recovery hospitals)] must keep medical records as follows:

1. **Adults:** 7 years after discharge or the last patient encounter,
2. **Minors:** Until the age of 19 but no less than 7 years after discharge or the last patient encounter. However, skilled nursing facilities that participate in Medicare or Medi-Cal must keep records of minors until they reach the age of 21 [42 C.F.R. Section 483.70(i)].

California law is inconsistent with respect to record retention requirements for individual practitioners. There is no required retention period for medical records maintained by a physician in a private office setting. However, the California legislature has passed legislation requiring other types of individual practitioners to retain medical records for the same length of time as health facilities [Business and Professions Code Sections 2570.185 (occupational therapists), 2620.7 (physical therapists), 2919 (licensed psychologists), 3007 (optometrists) and 3641 (naturopathic doctors)]. Individual practitioners not specified above are advised to retain medical records for at least seven years after the last patient encounter, and until the patient has reached the age of 19 (but no less than seven years after the last encounter) for minors.

There are medical record retention requirements in the Medicare Conditions of Participation and the *Interpretive Guidelines* for various types of facilities and clinics. These retention requirements are shorter than the California requirements, so they are not listed in detail in this manual.

Alternative Retention Period

An alternative option calls for a universal 25-year record retention policy. A 25-year retention policy has several advantages:

It relieves the provider of the need to differentiate between the medical records of adult patients and those of minor patients, and for Medi-Cal patients and other patients, as it satisfies applicable legal requirements for all classes.

It reduces even further the possibility that a lawsuit will be filed after the medical records are destroyed.

It ensures the longer retention of medical records containing information regarding medical treatment or medications received during pregnancy.

Each provider must weigh the appropriate factors and determine whether the simplicity and convenience of a 25-year period outweigh the advantages of a shorter period.

B. Test Results, Tracings and Recordings

Providers regularly accumulate the results of diagnostic tests performed upon patients, including radiological studies, laboratory analyses, and tracings and recordings of various kinds. Most will be the subject of an interpretation or report.

California regulations require most types of health facilities to place reports of test results in medical records [Title 22, California Code of Regulations, Sections 70749(a)(8) and (9) (general acute care hospitals), 71549(a)(10) and (11) (acute psychiatric hospitals), 72547(a)(7) and (8) (skilled nursing facilities), 73547(a)(8) and (9) (intermediate care facilities) and 77141(a)(19), (20) and (21) (psychiatric health facilities)]. Accordingly, reports of all diagnostic test results and clinical laboratory test results must be kept as long as the medical record.

X-Ray Films, CT Scans and MRI Results

Under the regulations governing the licensure of general acute care hospitals and acute psychiatric hospitals, "X-ray films or reproduction thereof" must be preserved for at least seven years after discharge, or one year after a minor reaches the age of 18 (but not less than seven years) [Title 22, California Code of Regulations, Sections 70751(c) (general acute care hospitals) and 71551(c) (acute psychiatric hospitals)]. Similarly, skilled nursing facilities, intermediate care facilities and primary care clinics are required to keep all "exposed X-ray film" for seven years [Title 22, California Code of Regulations, Sections 72543(a) (skilled nursing facilities), 73543(a) (intermediate care facilities) and 75055(a) (primary care clinics)]. Most imaging no longer uses "film," but these regulations are still on the books. Although the law is not clear, all imaging records, including CT, PET and MRI, probably should be saved for the prescribed period. Whether radiological studies are kept for a longer period will depend on the same considerations discussed in III. "Primary Considerations in Developing a Record Retention Schedule," page 2.

Clinical Laboratory Test Results

There are specific federal and state laws covering retention of laboratory test results by clinical laboratories [Title 42, Code of Federal Regulations, Section 493.1105; Business and Professions Code Section 1265(j)]. These regulations apply to freestanding laboratories and laboratories situated in hospitals. The laws require laboratories to retain certain information for minimum periods of time, ranging from two to 10 years. These time periods are described in the Schedule.

When a hospital patient is tested at a hospital laboratory, test results will be placed in the patient's hospital medical record where it will be subject to the longer medical record retention periods. A hospital laboratory, therefore, can dispose of information concerning inpatients and outpatients as soon as the minimum legal periods pass.

The situation is different, however, with information concerning individuals who are tested at freestanding laboratories or are referred to a hospital laboratory just to be tested or when just the specimen goes to the hospital laboratory. These patients have no separate medical record on the premises. Therefore, the laboratory should consider keeping its records for a period longer than the minimum prescribed by the law.

Tracings and Recordings

There are no laws requiring a minimum retention period for tracings or recordings like EKGs, EEGs, EMGs or videotapes of diagnostic tests, surgeries or other procedures. Depending on the test involved, these materials can be quite bulky. Accordingly, it makes sense to have the responsible physician identify the portions that demonstrate significant or unusual results. The provider should keep those portions for as long as it keeps the medical record. The remainder, which most likely would include most of the tracings or recordings, could be disposed of as soon as the patient is discharged or the treatment is complete. If an adverse event takes place, however, the provider may wish to retain the entire tracing or recording.

Fetal Heart Monitor Strips

Hospitals may wish to retain in the medical record just those portions of the fetal heart monitor strips chosen by the physician. Alternatively, hospitals may choose to retain these tracings in their entirety for at least 10 years, or even 25 years. The latter options make it more likely that full monitoring records will be available during the period allowed by the statute of limitations for minors to bring suit.

V. ELECTRONIC RECORDS

Many records created by health care providers formerly stored on paper are now created and stored electronically, and communicated through electronic means both within and beyond the provider's location. Civil Code Section 1633.12 states that if a law requires that a record be retained, the requirement is satisfied by retaining an electronic record, if the electronic record accurately reflects the information set forth when the record was first generated in its final form as an electronic record.

A. Electronic Medical Records Requirements

Providers (including hospitals, clinics and home health agencies) that use electronic systems only must meet the following requirements (these requirements do not apply to medical records if hard copy versions are retained):

1. Any use of electronic record keeping to store medical records must ensure the safety and integrity of those records at least to the extent of hard copy records.
2. The provider must ensure the safety and integrity of all electronic media used to store medical records by employing:
    a. An offsite backup storage system,
    b. An image mechanism that is able to copy signature documents, and
    c. A mechanism to ensure that once a record is input, it is unalterable.
3. Access to electronically stored records must be made available to the Division of Licensing and Certification of CDPH staff promptly, upon request.
4. The provider must develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access to electronically stored medical records, authentication by signature keys and systems maintenance.

Original hard copies of medical records may be destroyed once the record has been electronically stored. The printout of the computerized version is considered the original for

the purposes of providing copies to patients, the Division of Licensing and Certification of CDPH and for introduction into evidence in administrative and court proceedings.

This law does not exempt providers from the requirement of maintaining original copies of medical records that cannot be electronically stored. [Health and Safety Code Section 123149]

(See A. "Change or Deletion of Medical Information: Audit Trails," page 13, regarding the requirement that electronic medical record systems must automatically record and preserve any change or deletion of any electronically stored medical information.)

B. Retention of Electronic Records

Electronic information may be stored in greater quantities, placed in varied configurations and retrieved rapidly when needed. Most importantly for this discussion, there may no longer be as great a need to purge records because of space constraints. Because electronic records require much less space, the temptation is to retain more information for longer periods. However, the question of purging information from an electronic system is identical to that of discarding or destroying hard copy. The same record retention periods apply irrespective of whether a record is electronic, paper, microfiche, microfilm, etc.

Retention policies for electronic records should focus both on transferring information for longer-term storage and on purging information from the system.

VI. DUPLICATE, TRANSITORY AND NONSUBSTANTIVE RECORDS

Health care providers create many duplicate, transitory and nonsubstantive records.

Duplicate records do not need to be retained. Only one version of a record, preferably the original, must be retained. However, providers may prefer to retain electronic versions of records that were originally produced on paper or other hard copy. Records may be transferred from hard copy to electronic format without legal risk, if appropriate backup and other security measures are maintained *(see V. "Electronic Records," page 11)*.

Health care providers also create many transitory and/or nonsubstantive records. These are records that do not establish policy, guidelines, or procedures; do not certify a transaction; do not constitute a receipt; and do not contain final substantive information. Transitory records may include personal notes, meeting notices, cover memos, lunch invitations, preliminary drafts, telephone messages, etc.

Transitory and nonsubstantive records may be discarded when no longer needed, unless there is a legal hold in place *(see VII. "Legal Hold," page 12)*.

VII. LEGAL HOLD

If a hospital or other health care provider has reason to believe that it may be sued or may be the subject of an audit or investigation, legal counsel should be consulted immediately to determine whether to initiate a legal hold. If a legal hold (also called a "litigation hold") is initiated, the usual retention and disposal policies are suspended for records relevant to the potential claim, dispute, lawsuit, audit or investigation. All potentially relevant records (paper and electronic) should be retained in their original form until legal counsel authorizes their destruction or deletion in accordance with the usual record retention schedule.

The occurrence of any of the following should provoke the hospital to consider a legal hold:

1. Service of legal process (subpoena, summons, or the like)
2. Learning of an investigation or audit by a government agency, government contractor, or private entity
3. Receipt of a claim (formal or informal)
4. Receipt of a patient complaint (not including minor complaints)
5. A dispute

All records relevant to the issue should be retained. This includes paper records as well as electronic data and documents (including e-mails). If a medical device, product, equipment, drug, other supply, or patient specimen may be involved, it should be sequestered. Employees and other personnel should be notified to suspend destruction of potentially relevant records, and all steps related to compliance with the legal hold should be documented.

VIII. DELETION, DISPOSAL AND DESTRUCTION OF RECORDS

State and federal privacy laws governing information containing protected health information (e.g., medical records, patient-identifiable billing records, labeled prescription bottles, hospital ID bracelets, etc.) and customer/consumer records impose on providers a duty to ensure that records are properly destroyed and are not improperly disclosed during the destruction process. This portion of the Record and Data Retention Schedule provides a brief, general overview of the laws and recommended procedures surrounding destruction of records. This information applies irrespective of whether the records are in electronic or hard copy form.

A. Change or Deletion of Medical Information: Audit Trails

An electronic health record system or electronic medical record system must automatically record and preserve any change or deletion of any electronically-stored medical information. The record of any change or deletion must include:

1. The identity of the person who accessed and changed the medical information,
2. The date and time the medical information was accessed, and
3. The change that was made to the medical information.

[Civil Code Section 56.101]

For purposes of this requirement, **"electronic medical record"** or **"electronic health record"** means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff [42 U.S.C. Section 17921(5)].

Failure to comply with the above requirements may result in significant financial penalties under the Confidentiality of Medical Information Act (CMIA).

B. Disposal or Destruction of Personal Information

State and federal privacy laws governing individually-identifiable health information and customer/consumer records impose a duty on health care providers to ensure that records

are properly destroyed, and are not improperly disclosed during the destruction process. This portion of the manual discusses the laws and recommended procedures for destruction of records. This information applies to records either in electronic or hard copy form.

Medical Records

The CMIA states that every health care provider, health care service plan, pharmaceutical company, or contractor who creates, maintains, preserves, stores, abandons, destroys or disposes of medical information must do so in a manner that preserves the confidentiality of the information contained therein. [Civil Code Section 56.101]

Failure to comply with the requirements described above may result in penalties under Civil Code Section 56.36, which include civil lawsuits by patients and fines of up to $250,000 per violation. Health care facilities may also be fined up to $250,000 by the California Department of Public Health for a privacy breach [Health and Safety Code Section 1280.15].

The HIPAA regulations do not require any particular method of destruction. However, the Department of Health and Human Services (DHHS) has released guidance stating that if one of the methods of destruction described below is used, and the media containing the PHI is later released to, or accessed by, a third party, it will not be considered a breach under the HITECH regulations. The media on which the PHI is stored or recorded must have been destroyed in one of the following ways:

1. Paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction.
2. Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, “Guidelines for Media Sanitization,” such that the PHI cannot be retrieved.

Providers are not required to follow the guidance. However, if the specified technologies and methodologies are used, no breach notification obligation exists even if a breach occurs. This is referred to as a “safe harbor.”

The Secretary of DHHS must annually update this guidance. The guidance can be found on the DHHS website at https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html. DHHS has also published a document, “Frequently Asked Questions About the Disposal of Protected Health Information,” that may be found at https://www.hhs.gov/hipaa/for-professionals/faq/disposal-of-protected-health-information/index.html.

Federally-Assisted Substance Use Disorder Program Records

Special requirements apply when a federally-assisted substance use disorder program is discontinued or is acquired by another entity [42 C.F.R. Section 2.19]. Legal counsel should be consulted in these circumstances.

Customer Records

The Information Practices Act requires any business that maintains customer records which include personal information to take all reasonable steps to destroy, or arrange for the destruction of, such records by:

1. Shredding;

2. Erasing; or
3. Otherwise modifying the personal information in those records to make it unreadable or undecipherable through any means.

[Civil Code Section 1798.80-1798-84]

This law applies to medical records and other records that could identify a customer, such as records containing a name, Social Security number, contact information, insurance policy number, driver's license number, credit card number, certain passwords and security questions and answers, etc.

Employee Records

The California Constitution has been interpreted to provide employees a right to privacy. It is recommended that records containing employee-identifiable information be treated in the same manner as records containing medical information or customer/consumer information.

Information Derived from Consumer Credit Reports

Regulations adopted under the Fair and Accurate Credit Transactions (FACT) Act of 2003 require businesses that possess consumer information derived from consumer credit reports to properly dispose of the information. A person must take reasonable measures to protect against unauthorized access to or use of the information in connection with the disposal. Compliance with the Information Practices Act (described under "Customer Records," page 14) will likely ensure compliance with the FACT Disposal Rule. However, legal counsel should be consulted if questions arise. [16 C.F.R. part 682]

C. Process

A health care provider may dispose of records itself, or may engage an outside company to dispose of records. Any such company would be acting as the provider's business associate, and a written business associate agreement should be executed. The provider has a duty to ensure the company is competent to perform the task and its proposed method of disposal ensures the confidentiality and security of the records and their ultimate destruction.

A certificate of records destruction should be completed for records destroyed or deleted pursuant to the records management policy. In addition, the disposal of records should be documented in a log. A sample certificate of records destruction that providers may adapt to fit their needs may be found at http://library.ahima.org/doc?oid=105016#.WxceSKrruUk.

IX. CHA'S RECOMMENDED RETENTION SCHEDULE

A. General Retention Period

CHA's Recommended Retention Schedule (starting on page 21) recommends a retention period of six years for general records that might prove valuable for litigation, statistical or business purposes, but are not required to support Medi-Cal or Medicare claims. CHA has chosen this period because the utility of most records declines significantly after six years. The six-year period meets or exceeds the normal statute of limitations for civil actions. However, it would not be sufficient when a claimant alleges fraudulent concealment of a wrongful act, or some other occurrence prolongs the limitation period. CHA's Recommended Retention Schedule recommends a retention period of 15 years for records that support claims for Medi-Cal or Medicare services *(see A. "Legal Requirements and Considerations," page 3)*.

After establishing a general retention period, the Schedule was refined to account for particular demands. For example, it is suggested that providers preserve annual reports and significant statistical compilations longer, as these materials do not demand significant storage space and may be useful for historical, research, or business planning purposes. Additionally, special legal requirements that govern the retention of various records have been taken into account. Also recommended is fairly lengthy retention of credentialing and other medical staff records, as these contain information that is increasingly the subject of litigation. Finally, a two- or three-year retention period is assigned to various other records that are usually of only short-term interest.

NOTE: CHA's Recommended Retention Schedule does not include record retention requirements mandated by the U.S. Securities and Exchange Commission or the Sarbanes-Oxley Act, which applies only to investor-owned organizations that are publicly traded. These organizations should consult legal counsel regarding additional record retention requirements.

B. How to Interpret the Schedule

Column 1: "Record"

This column describes a document, record, or data that a hospital may generate.

Column 2: "Provider Types"

This column describes the types of providers that must comply with the retention requirement described in the row.

Column 3: "Legal Requirements"

This column provides any legal requirements that pertain to the providers listed in column 2 regarding the document described in column 1. The provider is legally required to follow the retention period stated in this column.

Column 4: "Recommended Retention Period"

This column provides CHA's recommendation regarding how long to keep the document described in column 1. Please note that this is only a recommendation, not a legal requirement. A particular provider may wish to keep the document longer than the recommended retention period. On the other hand, a provider may wish to destroy or delete the document sooner than the recommended retention period. Each health care provider should consider the factors described in III. "Primary Considerations in Developing a Record Retention Schedule," page 2, and develop its own retention schedule. It is not mandatory to comply with CHA's recommended retention period.

C. Frequently Asked Questions

Q1: Is every document that a hospital may generate included in the Schedule?

A1: No. It is not possible to list every document that a hospital may generate. The Schedule contains those documents that are commonly used by hospitals and other health care providers, and those documents to which the government has assigned a required record retention period.

Q2: Why is the time period under the fourth column, "Recommended Retention Period," sometimes longer than the legally-required retention period stated in the third column, "Legal Requirements"?

A2: It is common to find that the retention period listed under "Recommended Retention Period" is longer than the legally-required retention period listed in the "Legal Requirements" column. This is because there are other factors to be considered when determining the minimum retention period in addition to the legal requirement that is specific to that document *(see III. "Primary Considerations in Developing a Record Retention Schedule," page 2)*.

Q3: Does the "Legal Requirements" column list all possible laws that apply to the document described in the first column?

A3: No. The "Legal Requirements" column lists only the laws that are specific to the document described in column 1. However, it does not list all of the laws that represent more general retention considerations, such as statutes of limitations. The laws that represent more general retention considerations are discussed under III. "Primary Considerations in Developing a Record Retention Schedule," page 2.

Q4. How long should I keep a document that is not included in the Schedule?

A4. CHA recommends reviewing the Schedule to find a similar document or a document used for a similar purpose, and keeping the document in question for as long as the similar document must be kept.

Record Retention Schedule

Health care providers, particularly hospitals, are among the most heavily regulated entities in the United States. State and federal laws specify who is qualified to deliver safe and effective health care, and under what circumstances that care may be provided. In addition, providers are required to meet standards imposed under corporate, labor, tax, workers' compensation, environmental, and criminal law and many, many others.

In order to show that legally-required standards are being met, facilities must document compliance with the law. Records are required by law to be kept by every department of a California health care provider's facility. Sometimes the government specifies precisely how those records are to be maintained and for how long. Most of the time the government does not.

The Schedule that follows gives recommended retention periods for records that are common to health care providers and have statutorily- or regulatorily-mandated retention periods, or are representative of documents that have no legal retention requirements.

Retention Tip: For a document not listed in the Schedule, CHA recommends using the retention period listed for a similar document or for a document required for a similar purpose.

The Schedule gives recommendations for a wide variety of health care providers. In the "Provider Types" column, the following definitions apply:

1. **"All providers"** includes:
    a. Health facilities, as defined below,
    b. Home health agencies,
    c. Primary care clinics,
    d. Psychology clinics,
    e. Individual practitioners,
    f. Groups of practitioners,
    g. Surgery centers, and
    h. Unlicensed outpatient facilities.

2. **"Health facilities"** means a facility that treats persons who are admitted for a 24-hour stay or longer. The term "health facilities" includes the following types of providers:
    a. General acute care hospitals (GACHs),
    b. Acute psychiatric hospitals (APHs),
    c. Skilled nursing facilities (SNFs),
    d. Intermediate care facilities (ICFs),
    e. Special hospitals,
    f. Congregate living health facilities,
    g. Correctional treatment centers,
    h. Psychiatric health facilities (PHFs), and
    i. Chemical dependency recovery hospitals (CDRHs).

[Health and Safety Code Sections 1250 and 1250.2]

The following acronyms are used in the Schedule:

1. **"C.C.R."** means California Code of Regulations.
2. **"C.F.R."** means Code of Federal Regulations.
3. **"U.S.C."** means United States Code.

Retention Tip: *See "Where to Find the Laws Referenced in the Manual," page 75, for instructions on how to find the exact language of the statutes and regulations on the internet.*

ADMINISTRATIVE RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Accident reports		*See "Incident reports," page 24. If an employee is injured, see "Workers' compensation claims files," page 50.*	
Accountable Care Organization (ACO) utilization, quality and financial records	ACO participants, providers and suppliers	Must keep for at least 10 years from end of contract term or completion of audit, whichever is later [42 C.F.R. Section 425.314]	15 years
Accreditation/licensing surveys and plans of correction (TJC, AOA, DNV, CMS, CDPH, IMQ, CAP, etc.)	All providers		6 years (longer if continuing interest)
Adverse event reports to CDPH	Hospitals		6 years after any appeal is concluded
Aerosol transmissible disease and biosafety plan annual review	All providers	Must keep for at least 3 years [8 C.C.R. Section 5199(j)(3)]. *See regulation for required content of record.*	6 years
Appraisal reports (property, building, equipment, etc.)	All providers		Life of asset plus 10 years
Arbitration resolution documents	SNFs that particfipate in Medicare/Medicaid	When facility and resident resolve a dispute by arbitration, must keep arbitration agreement and arbitrator's decision for at least 5 years [42 C.F.R. Section 493.70(n)].	6 years after discharge of patient, longer if readmission is anticipated.
Birth records to local government	Hospitals, practitioners		Permanent
Cancer/tumor registry	Hospitals, practitioners		Permanent
Census (daily)	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep "patient admission rosters," but do not specify a retention period [22 C.C.R. Sections 70733, 71531, 77127, and 79337].	6 years
Certificate of records destruction	All providers		Permanent
Committee agendas, minutes (not otherwise specified in this retention schedule)	All providers		6 years
Communicable disease reports to state and local health departments	All providers		3 years
Construction project contracts and related documents	All providers		Life of building plus 10 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Contracts, leases, and supporting documentation	All providers	Contracts for services between a Medicare institutional provider and a subcontractor must be kept for the life of the contract, plus 4 years, if the value of the services is $10,000 or more over a 12-month period. This includes contracts for both goods and services in which the service component is worth $10,000 or more [42 C.F.R. Section 420.302(b)]. Contracts required by the HIPAA privacy rule must be kept for 6 years [45 C.F.R. Section 164.530(j)]. Regulations require GACHs, APHs, PHFs and CDRHs to keep contracts that are required by regulation, but no retention period is specified [22 C.C.R. Sections 70733, 71531, 77127, 79337]. Contracts that support claims for services rendered to Medicare or Medi-Cal patients must be kept for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	Life of agreement/lease/equipment, plus 6 years; if the agreement supports Medicare or Medi-Cal claims, then life of agreement/lease/equipment plus 15 years
Corporate records, including the following: Articles of Incorporation or partnership agreement; bylaws and rules and regulations of the governing body; minutes of meetings of the governing body	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep these documents, but do not specify retention periods [22 C.C.R. Sections 70733, 71531, 77127 and 79337].	Permanent
Court orders	All providers		Permanent, unless disposal approved by legal counsel
Death records to local government, death certificates	All providers		Permanent
Deeds or titles to property	All providers		Permanent
Disposal of records log	All providers		Permanent

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Donations, endowments, trusts, bequests, contributions	All providers		6 years. If a condition is attached to the gift, the records should be kept permanently.
EHR Incentive Program data (Medicare or Medicaid)	Hospitals, eligible professionals	Must keep for at least 6 years *(see FAQ No. 7711 under "Audits" on the CMS Promoting Interoperability Programs website at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html.)*	15 years
Grants		*See "Health and Human Services Agency grants," page 23.*	
Grievances and resolution documents	SNFs that participate in Medicare/Medicaid	Must keep for at least 3 years [42 C.F.R. Section 483.10(j)(4)(vii)]	6 years
Health and Human Services Agency grants	Health facilities	Keep financial, statistical and nonexpendable property records, and any other records pertinent to grants, for 3 years from the date of submission of the final expenditure report, or until resolution of all litigation and federal audit findings. Records for real property and equipment acquired with federal funds must be kept for at least 3 years after final disposition. [45 C.F.R. Section 75.361]	6 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
HIPAA privacy-related documents (notice of privacy practices; acknowledgment of receipt of notice of privacy practices; correspondence/ forms related to request for access to and amendment of protected health information (PHI); titles of persons/offices responsible for receiving and processing requests for access and amendment; accountings for disclosures; accountings provided to patients; titles of persons/offices responsible for receiving and processing requests for an accounting, correspondence/forms regarding a special restriction; authorization for use/disclosure of PHI; correspondence/forms related to grievances; business associate agreements; breach investigation and notification reports; etc.)	All providers	Must keep for at least 6 years from the date of creation or the date last in effect, whichever is later [45 C.F.R. Section 164.530(j)].	8 years
Incident reports	All providers	*See also "Unusual occurrence reports to CDPH/public health officer (PHO)," page 28.*	10 years
Inspection and approval by state or local fire control agencies	Medicare particiating hospitals	Regulations require written evidence of regular inspection and approval by fire control agencies to be kept, but no retention period is specified [42 C.F.R. Section 482.41].	6 years
Inspection reports by local, state or federal agents	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep inspection reports, but do not specify retention periods [22 C.C.R. Sections 70733, 71531, 77127 and 79337].	6 years
Inspection reports by local, state or federal agents	ICFs	Must keep the latest report of inspection by state or local health authorities with notations made of the actions taken to comply with any recommendations [22 C.C.R. Section 73515].	6 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Institutional review board (IRB) records	All providers	Must keep until research is completed, plus 3 years [21 C.F.R. Section 56.115]. *See regulation for required content of records. See also 21 C.F.R. Sections 312.62 and 812.140 (2-year retention period for related records).*	Completion of research, plus 10 years
Insurance policies, current and expired, and related claims and correspondence	All providers		Permanent
Intellectual property: copyright, trademark, service mark applications, approvals, and related documents	All providers		Duration of use of mark plus 10 years
Leases		*See "Contracts, leases, and supporting documentation," page 22.*	
Licenses or certificates	All providers		Life of license or certificate, plus 6 years
List of contracted services	Medicare-participating hospitals	Regulations require a list of contracted services to be kept, but do not specify retention periods [42 C.F.R. Section 482.12(e)].	6 years
Master patient index/medical record index number	All providers		Permanent
Meaningful use attestations (Medicare or Medicaid) and supporting data	Hospitals, eligible professionals	Must keep for at least 6 years *(see FAQ No. 7711 under "Audits" on the CMS Promoting Interoperability Programs website at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html)*.	15 years
Medical device reports (MDR) and records of MDR reportable events (MedWatch)	Health facilities, clinics, home health agencies, surgery centers	File relating to an adverse MDR event must be kept at least 2 years from the date of the event [21 C.F.R. Section 803.18(c)].	Life of device, plus 6 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medical device tracking records	Health facilities, clinics, home health agencies, surgery centers	Keep for the period of time the device is in use or in distribution for use. (For example, a record may be discarded if the device is no longer in use, has been explanted, returned to the manufacturer, or the patient has died.) [21 C.F.R. Section 821.60] *See 21 C.F.R. Section 821.30 for a list of information that must be kept in the device tracking record.*	Life of device, plus 6 years
Meeting minutes and agendas needed to document compliance with accreditation requirements	The Joint Commission accreditation organizations	Must keep until next full survey	4 years (unless longer period recommended for specific records elsewhere in this chart)
OSHPD reports (financial, patient discharge data, quality)	Hospitals		20 years
OSHPD reports (seismic)	Hospitals		Permanent
Patient admission roster		*See "Census (daily)," page 21.*	
Patient grievances/complaints — complaint, investigation materials, correspondence	Facilities		6 years after resolution
Patient property: deceased patient's property disposition	Health facilities	Records of disposition of deceased patient's property must be kept for at least 3 years [Probate Code Section 330(d)]. *See chapter 14 of CHA's* Consent Manual *for information about disposition of deceased patient's property.*	5 years after discharge
Patient property: patient cash and valuables receipts, personal property inventory	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	5 years after discharge
Patient property: receipts and disbursements of personal funds of Medi-Cal beneficiaries being held in trust by the provider	Facilities		15 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Permits	All providers		Life of permit, plus 6 years
Policies and procedures	GACHs, APHs, PHFs	Regulations require these facilities to keep policy and procedure manuals, but do not specify retention periods [22 C.C.R. Sections 70733, 71531 and 77127]. Policies and procedures required by the HIPAA privacy and security rules must be kept for at least 6 years [45 C.F.R. Sections 164.316(b) and 164.530(j)].	Life of policy or procedure, plus 6 years. Must be kept longer for transplant services.
Real estate transaction records, deeds, easements, zoning permits, building permits	All providers		Permanent
Reports, memos, correspondence (not otherwise specified in this retention schedule)	All providers		6 years (unless desired longer for trending or business planning purposes)
Safe patient handling-related documents	GACHs	Must keep for at least 1 year [8 C.C.R. Sections 3203(b) and 5120(e)(1)(B)]	6 years (may also wish to document attendance at training in employee's personnel file)
Statistical data/reports regarding admissions, discharges, outpatient visits, services rendered, transfers, etc. (not otherwise specified in this retention schedule)	All providers		6 years (unless desired longer for trending or business planning purposes)
Statistics on admissions and services	All providers		6 years (longer if needed for business planning purposes)
Summary record of decisions not to transfer a patient to another facility for airborne infection isolation for medical reasons	All providers	Must keep for at least 3 years [8 C.C.R. Section 5199(j)(3)]. *See regulation for required content of record.* The information must also be documented in the patient's medical record.	6 years
Survey, certification and complaint investigation reports; plans of correction	SNFs that participate in Medicare/Medicaid	Must keep at least 3 years [42 C.F.R. Section 483.10(g)(11)]	6 years
Survey reports		*See "Accreditation/licensing surveys and plans of correction (TJC, AOA, DNV, CMS, CDPH, IMQ, CAP, etc.)," page 21.*	

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Training records — employees (not otherwise specified in this retention schedule)	All providers	Regulations require GACHs to keep documentation as described in 22 C.C.R. Section 70214(d), but do not specify a retention period.	6 years after date of training (may also wish to document attendance in employee's personnel file)
Treatment authorization requests (TARs)	Hospitals	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Unavailability of airborne infection isolation rooms/areas	All providers	Must keep for at least 3 years [8 C.C.R. Section 5199(j)(3)]. *See regulation for required content of record.*	6 years
Unusual occurrence reports to CDPH/public health officer (PHO)	GACHs, APHs	Must keep for at least 2 years [22 C.C.R. Sections 70733 and 71531]. The report made to CDPH/PHO should include only factual information that CDPH/PHO must have. These reports may be obtained by plaintiffs' attorneys from CDPH/PHO by use of a subpoena. The facility likely will also complete an incident report, root-cause analysis, etc. that may be protected from discovery. *See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Unusual occurrence reports to CDPH/public health officer (PHO)	SNFs, primary care clinics	Must keep for at least 1 year [22 C.C.R. Sections 72541 and 75053]. The report made to CDPH/PHO should include only factual information that CDPH/PHO must have. These reports may be obtained by plaintiffs' attorneys from CDPH/PHO by use of a subpoena. The facility likely will also complete an incident report, root-cause analysis, etc. that may be protected from discovery. *See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years
Unusual occurrence reports to CDPH/public health officer (PHO)	PHFs and CDRHs	Must keep for at least 3 years [22 C.C.R. Sections 77137 and 79339]. The report made to CDPH/PHO should include only factual information that CDPH/PHO must have. These reports may be obtained by plaintiffs' attorneys from CDPH/PHO by use of a subpoena. The facility likely will also complete an incident report, root-cause analysis, etc. that may be protected from discovery. *See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years
Workplace violence prevention records: hazard identification, evaluation and correction	Health facilities, HHAs, hospices	Must keep for at least 1 year [8 C.C.R. Sections 3203(b), 3342 and 5120(e)(1)(B)]	6 years

ADMITTING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Admission and discharge records	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep "patient admission rosters," but do not specify a retention period [22 C.C.R. Sections 70733, 71531, 77127 and 79337].	6 years
Advance Beneficiary Notice	Hospitals	Must keep for at least 5 years from discharge or completion of delivery of care [*Medicare Claims Processing Manual*, Publication 100-04, Chapter 30, Section 50.6.4]. However, the original ABN must be retained in the medical record; thus, California hospitals should retain the ABN in accordance with medical record retention requirements.	File in patient's medical record
Conditions of admission agreements	Health facilities		File in patient's medical record
Emergency department log (must include name; date, time and means of arrival; age; sex; record number; nature of presenting complaint; disposition; time of departure; and names of patients who are dead on arrival)	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	6 years
Emergency department transfer records (medical and other records related to individuals transferred to or from the hospital, including "Transfer Summary" required by Health and Safety Code Section 1317.2(f))	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	Medical records: 15 years — adults 25 years — minors Other records: 6 years
Medicare secondary payer beneficiary questionnaire	All providers	Must keep for 10 years after date of service [*Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.2].	15 years

BUSINESS AND FINANCE RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Accountable Care Organization (ACO) utilization, quality and financial records	ACO participants, providers and suppliers	Must keep for at least 10 years from end of contract term or completion of audit, whichever is later [42 C.F.R. Section 425.314]	15 years
Audit reports	All providers		7 years
Bank deposits	All providers		7 years
Bank statements	All providers		15 years
Bond records (including how bond-financed investments are used and disposed of; investment and expenditure of bond proceeds)	Tax-exempt facilities	Must keep for 3 years after final redemption *(see IRS webpage at https://www.irs.gov/tax-exempt-bonds/tax-exempt-bond-faqs-regarding-record-retention-requirements#6)*.	15 years after final redemption
Budgets	All providers		7 years
Cash receipts	All providers	Medi-Cal regulations require that "book records of receipts and disbursements" be retained for 10 years from the date of service, end of Medi-Cal contract period, or audit completion, whichever is later [Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]. A similar timeframe exists for records needed to support claims to certain Medicare patients. [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2)]. It is unclear what "book records of receipts" means.	15 years
Cashiers' tapes from bookkeeping machines	All providers		2 years
Chargemaster	Hospitals		15 years
Check registers	All providers		15 years
Checks — canceled • Payroll • Taxes, capital, purchases, important contracts • Other	All providers		 15 years Permanent 15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Claims, billings, and charges to patients, fiscal intermediaries, third-party payers, etc.	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Depreciation schedules — equipment	All providers		Life of equipment, plus 15 years
Disbursements — unclaimed/returned	All providers	Unclaimed checks and disbursements escheat to state after 3 years; the state then attempts to notify recipients [Code of Civil Procedure Section 1510 *et seq.*].	7 years
Employee expense reports	All providers		15 years
Employment tax records (federal)	All providers	Must keep for at least 4 years after due date of tax, or date tax is paid, whichever is later [26 C.F.R. Section 31.6001–1 *et seq.*].	15 years
Exempt Organization Annual Information Returns (IRS Form 990, State Form 199)	Tax-exempt organizations		Permanent
Financial statements (year-end)	All providers		Permanent
Income — daily summary	All providers		7 years
Income tax returns	All providers		Permanent
Invoices — accounts receivable/payable	Providers that participate in Medicare Advantage, Medi-Cal, accountable care organizations, or Medicare Part D	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Invoices documenting purchase or lease of clinical laboratory equipment and test kits, reagents, or media	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *(See "Invoices — accounts receivable/payable" above.)*	15 years
Invoices — fixed assets, equipment	All providers		Permanent/life of asset or equipment, plus 15 years
IRS rulings, audit records	All providers		Permanent
Journals — general	All providers		15 years
Ledgers — general	All providers		15 years
Ledgers — individual ledger accounts reflecting credit and debit balances for each Medi-Cal beneficiary	Facilities	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Medi-Cal remittance advices	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Medicare Advantage-related documents	All providers that contract with a Medicare Advantage plan	Must keep for at least 10 years after end of contract term or audit, whichever is later. [42 C.F.R. Section 422.504(i)(2)]. *See "Contracts with Medicare Advantage or Medicare Part D Plans," page 6.*	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medicare cost report records	Hospitals	Must keep for at least 5 years after the cost report is filed with the intermediary. The records that must be retained are: 1. Billing material: copies of claim forms, supporting documents and forms (e.g., charge slips, daily patient census records, and other business and accounting records referring to specific claims). 2. Cost report material: all data necessary to support the accuracy of entries on annual cost reports including original invoices, cancelled checks, copies of material used in preparing annual cost reports, and other similar cost items, schedules and related worksheets, and contracts or records of dealings with outside sources of medical supplies and services or with related organizations. 3. Medical record material: utilization review committee reports, physicians' certification and recertifications, discharge summaries, clinical and other medical records relating to health insurance claims. 4. Provider physician material: provider physician agreements on which Part A and Part B allocations are based. [*Medicare Claims Processing Manual*, Publication 100-04, Chapter 1, Section 110.3] *See also 42 C.F.R. Sections 413.20 and 413.24. (See also "Resident rotation schedules — location, nature of assignment, vacation, leave of absence, sick time, orientation time, classroom time, etc.," page 64.)*	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medicare Part D-related documents (prescription drug benefit)	All providers that contract with a Medicare Part D plan	Must keep for at least 10 years after end of contract term or audit, whichever is later [42 C.F.R. Section 423.505(i)(2)]. *See "Contracts with Medicare Advantage or Medicare Part D Plans," page 6.*	15 years
Medicare secondary payer beneficiary questionnaire		*See "Medicare secondary payer beneficiary questionnaire," page 30.*	
Patient accounting files	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Payment receipt books	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Payroll records		*See "Human Resources Records," page 45.*	
Property tax payment records	All providers		Permanent
Purchase orders	All providers		Life of item, plus 7 years
Request for payment	Medicare provider or supplier of DMEPOS, lab, imaging, or home health services	Must keep at least 7 years [42 C.F.R. Section 424.516(f)]	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Returned goods credits	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Tax bills, statements, payments, receipts	All providers		Permanent
Tax-exempt status application, supporting documentation, determination letters from IRS and FTB	Tax-exempt organizations		Permanent
Tax returns	All providers		Permanent
Unemployment tax records	All providers	Must keep for at least 4 years after due date of tax, or the date tax is paid, whichever is later [26 C.F.R. Section 31.6001-1; 22 C.C.R. Section 1085–2(c)].	7 years
Volunteer funds raised		*See "Donations, endowments, trusts, bequests, contributions," page 30.*	
Wage and tax statements (W-2 forms)	All providers	Must keep for at least 4 years after due date of tax, or the date tax is paid, whichever is later [26 C.F.R. Section 31.6001–1].	7 years
Withholding allowance certificates (W-4 forms)	All providers	Must keep for at least 4 years after due date of tax, or the date tax is paid, whichever is later [26 C.F.R. Section 31.6001–1].	7 years after termination of employment or new certificate completed

DEPARTMENT RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Ambulance replenishing records (other than linens)	Facilities	Must keep for at least 5 years [42 C.F.R. Sections 1001.952(v)]	15 years
Appointment books, patient logs, or similar documents showing date and time allotted for appointment of each Medi-Cal patient or group of patients, and time actually spent with such patients	Psychiatric and psychological service providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Appointment calendars (patients' appointments), sign-in sheets	All providers except providers of psychiatric and psychological services to Medi-Cal patients		6 years
Birth records to local government		*See "Birth records to local government," page 21.*	
Compliance audits/ investigations (internal)	All providers		6 years
Compliance hotline log (annual)	All providers		6 years
Crash cart daily records	The Joint Commission accredited organizations	Must keep until next full survey	4 years
Dialysis — hemodialyzer reuse records (procedure, training, equipment, audit records)	Dialysis clinics	Regulations require these documents to be kept, but do not specify a retention period [22 C.C.R. Section 75198]. *See 22 C.C.R. Sections 75189 and 75198 for details about content of required records.*	Life of dialyzer, plus 6 years
Dialysis — dialyzer reuse records (device history records, including patient name, dates of treatment, dates of disinfectant rinsing, type and model, reuse number, results of performance tests, initials or other ID of reprocessing technician, reason for dialyzer failure and subsequent acceptance)	Dialysis clinics	Must keep for at least 6 months after last reprocessing of dialyzer [22 C.C.R. Section 75198(b)(5)]. *See 22 C.C.R. Sections 75189 and 75198 for details about content of required records.*	Life of dialyzer, plus 6 years

DEPARTMENT RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Emergency department log (must include name; date, time and means of arrival; age; sex; record number; nature of presenting complaint; disposition; time of departure; and names of patients who are dead on arrival)	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	6 years
EMTALA-related records, including records of patients transferred in or out, emergency department log, policies and procedures, etc.	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	6 years
Hardware and software operating instructions, warranties, system requirements, configurations, etc.	All providers		Life of product, plus 2 years
Human tissue intended for transplantation (records regarding donor screening and testing; records regarding supplier, donor and lot identification, receipt, name(s) of recipient(s), storage temperatures, distribution, destruction, disposition of human tissue, expiration dates of all tissues, etc.)	GACHs	Must keep at least 10 years after the date of transplantation (if known), distribution, disposition, or expiration of the tissue, whichever is latest [21 C.F.R. Section 1270.33].	Permanent
Infection control committee, minutes and reports of	GACHs, APHs	Regulations require these facilities to keep their documents, but do not specify retention periods [22 C.C.R. Sections 70733 and 71531].	6 years
Labor room log books	Hospitals	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)].	6 years

DEPARTMENT RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medical transportation records (must include time and date of service for each Medi-Cal beneficiary; odometer readings at each pick-up and delivery location; provider-assigned vehicle ID code; name of operator providing the service, names of beneficiaries transported in total or partial group runs)	Medical transportation providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Meeting minutes and agendas needed to document compliance with accreditation requirements	The Joint Commission accreditation organizations	Must keep until next full survey	4 years (unless longer period recommended for specific records elsewhere in this chart)
Motor vehicle maintenance records	All providers		Life of vehicle, plus 6 years
Policy and procedures manuals		*See "Policies and procedures," page 27.*	
Requisitions (internal)	Health facilities		Discretionary
Surgical privileges list	Hospitals	The surgical service of hospitals that participate in Medicare must keep a roster of practitioners specifying the surgical privileges of each practitioner, but no retention period is specified [42 C.F.R. Section 482.51].	Each physician's surgical privileges should be kept in his or her medical staff file *(see "Medical Staff Records," page 63)*. The lists provided to the surgical service should be retained for at least 6 years.
Surgery • Register of operations • Operating room logs	GACHs	Regulations require hospitals to keep a register of operations, but do not specify retention periods [22 C.C.R. Section 70223(f)].	6 years
Temperature monitoring logs	The Joint Commission accredited organizations	`Must keep until next full survey	4 years

NOTE: Individual departments may wish to keep copies of the original records, which are kept at the administrative offices. The department should keep duplicate records only as long as the records are used on a regular basis.

DIETARY DEPARTMENT RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Bacteriological testing of ice	Health facilities		2 years
Dietetic service personnel (number of)	GACHs, APHs	Regulations require these facilities to keep records listing the number of dietetic service workers and their job titles and hours worked, but do not specify retention periods [22 C.C.R. Sections 70275 and 71245].	2 years
Food costs	Health facilities		6 years
Food purchased	GACHs, APHs, SNFs, ICFs	Must keep records of food purchased for at least 1 year [22 C.C.R. Sections 70273(g)(6), 71243(g)(6), 72341(h) and 73333(g)].	3 years
In-service training records for dietetic services personnel (subject areas covered, date and duration of each session, attendance list)	GACHs, APHs, ICFs	Regulations require these facilities to keep these records, but do not specify retention periods [22 C.C.R. Sections 70273(j), 71243(j) and 73335].	6 years after date of training (may also wish to document attendance in employee's personnel file)
Meal counts	Health facilities		2 years
Menus	GACHs, APHs, SNFs, ICFs	Must keep for at least 30 days [22 C.C.R. Sections 70273(g)(5), 71243(g)(5), 72341(g) and 73333(f)].	3 months
Recipes, including ingredients, portion size, nutritional analysis	Health facilities		2 years after discontinuation

ENGINEERING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Autoclaves and sterilizers: thermometer charts (daily checking of recording and indicating thermometers) and monthly bacteriological tests (including the bacterial organism used) (ICFs only: recording thermometers are not required on portable sterilizers and autoclaves)	GACHs, APHs, SNFs, ICFs	Must keep for at least 1 year [22 C.C.R. Sections 70833, 71637, 72619 and 73677].	Life of equipment, plus 6 years
Building blueprints, plans, specifications, inspections	All providers		Permanent (or until property is sold)
Calibration records (all gauging and measuring equipment must be regularly calibrated as specified by the manufacturer)	GACHs, APHs	Must keep for at least 2 years [22 C.C.R. Sections 70837 and 71641].	Life of equipment, plus 6 years
Emergency generator records — inspection, performance, exercising period and repairs	GACHs, APHs, SNFs, ICFs	Regulations require these facilities to keep these records, but do not specify retention periods [22 C.C.R. Sections 70841(e), 71645(e), 72641(f) and 73639(f)].	Life of generator, plus 6 years
Equipment records (purchase, operating instructions, maintenance, inspection, repairs, calibrations)	All providers		Life of equipment, plus 6 years
HVAC air filter maintenance records (record of inspection, cleaning, replacement, including static pressure drop. Record must include a description of filters originally installed, ASHRAE atmospheric dust spot test efficiency rating, and criteria established by manufacturer or supplier to determine when replacement or cleaning is necessary. If filter maintenance is performed by an outside company, the hospital may retain a certification from the company stating that these requirements have been met.)	GACHs, APHs, SNFs, ICFs	Regulations require these facilities to keep these records, but do not specify retention periods [22 C.C.R. Sections 70839(b), 71643(b), 72639(b) and 73637(b)].	Life of air filter, plus 6 years
Inspection reports of grounds and buildings	All providers		6 years

ENGINEERING RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Maintenance logs and manuals (heating, air conditioning, ventilation)	GACHs, APHs, SNFs, ICFs, PHFs	Regulations require health facilities to keep maintenance logs and a written maintenance manual, but do not specify retention periods [22 C.C.R. Sections 70837(d), 71641(d), 72655(b), 73653(b) and 77155(b)].	Life of equipment, plus 6 years
Records of inspection, testing and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems (include name and affiliation of person performing the test/ inspection/maintenance, date, significant findings, actions)	All providers	Must keep for at least 5 years [8 C.C.R. Section 5199(j)(3)(F)].	Life of equipment, plus 6 years
Work orders	All providers		2 years

HOUSEKEEPING/ENVIRONMENTAL SERVICES RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Checkout, transfer, isolation records	All providers		2 years
Cleaning records (rooms, equipment, work surfaces, etc.)	All providers		2 years
Environmental exposure analysis using exposure or medical records	All providers	Must keep for at least 30 years [8 C.C.R. Section 3204(d)(1)(C)]	30 years
Environmental (workplace) monitoring or measuring regarding toxic substances or harmful physical agents (including personal, area, grab, wipe, or other form of sampling; collection and analytical methodologies, calculations, and other background data; and analyses)	All providers	Must be kept for at least 30 years [8 C.C.R. Section 3204]. However, background data to environmental monitoring or measuring, such as laboratory reports and worksheets, need only be kept for 1 year.	30 years
Inspection reports of grounds and buildings	All providers		6 years
Hazardous waste (that is not medical waste) — reports, test results, waste analyses, manifests	All providers that generate hazardous waste	Must keep for at least 3 years from due date of report or date waste accepted by transporter [22 C.C.R. Section 66262.40].	30 years
Material Safety Data Sheets	All providers	Must keep for as long as a material is used or stored at a workplace [8 C.C.R. Sections 3204(d)(1)(B)(2) and 5194]. Once the material is no longer used or stored, if the MSDS is destroyed, a record of the identity of the substance or agent, where it was used, and when it was used must be kept for at least 30 years. MSDSs must be immediately accessible to employes during each work shift.	30 years
Medical waste treatment and tracking documents	Small quantity generators of medical waste	Must keep for at least 3 years [Health and Safety Code Section 117943]. *See Health and Safety Code Section 118040 for required content of records.*	30 years
Medical waste treatment and tracking documents	Large quantity generators of medical waste	Must keep for at least 2 years [Health and Safety Code Section 117975]. *See Health and Safety Code Section 118040 for required content of records.*	30 years

HOUSEKEEPING/ENVIRONMENTAL SERVICES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Pesticide handling training programs	All providers	Must keep for at least 2 years after training program is discontinued [3 C.C.R. Section 6724(a)]. *See regulation for required content of training.* When antimicrobial agents are used only as sanitizers, disinfectants, or medical sterilants, the employer is exempt from complying with this requirement, and instead must comply with Cal/OSHA requirements [3 C.C.R. Section 6720], which require records to be kept for at least one year [8 C.C.R. Section 3203(b)].	6 years after date of training (may also wish to document attendance in employee's personnel file)
Pesticide Safety Information Series leaflets, MSDSs, pesticide use records, employee exposure records, work practice reviews	All providers	Regulations require these records to be kept, but no retention period is specified [3 C.C.R. Section 6723]. When antimicrobial agents are used only as sanitizers, disinfectants, or medical sterilants, the employer is exempt from complying with this requirement, and instead must comply with Cal/OSHA requirements [3 C.C.R. Section 6720]. *See "Material Safety Data Sheets," page 43, and "Employee health (medical) records — Employees subject to OSHA regulations," page 46.*	30 years

HUMAN RESOURCES RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Aerosol transmissible disease training	All providers	Must keep for at least 3 years after date of training [8 C.C.R. Section 5199)(j)(2)]. *See regulation for required content of record.*	6 years after date of training (may also wish to document attendance in employee's personnel file)
Affirmative action program records	All providers subject to affirmative action requirements	Life of program, plus 1 year [41 C.F.R. Section 60-1.12]	Life of program, plus 6 years
Applications for employment		*See "Employee and applicant records ...," below.*	
Bloodborne pathogen training	All providers	Must keep for at least 3 years [8 C.C.R. Section 5193(h)]	6 years (may also wish to document attendance in employee's personnel file)
Collective bargaining agreements and related documents	All providers	Must keep for at least 3 years [29 C.F.R. Section 516.5].	Life of agreement, plus 10 years
Employee acknowledgment of child abuse and neglect reporting requirement, elder and dependent adult abuse and neglect reporting requirement	All providers		File in employee's personnel file
Employee and applicant records required by the California Fair Employment and Housing Act, Title VII of the Civil Rights Act, the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, and the Age Discrimination in Employment Act — any personnel or employment record made or kept by an employer, including application forms and resumes submitted by applicants; requests for reasonable accommodation; records relating to recruitment, testing, hiring, promotion, demotion, transfer, recall, layoff, termination, rate of pay and other terms of compensation, garnishment, and selection for training or apprenticeship programs	All providers	Health facilities and primary care clinics must keep for at least 3 years after termination of employment [22 C.C.R. Sections 70725, 71525, 72533, 73527, 75052, 77119, 79333 and 87866]. Other providers must keep for at least 2 years from date of making record or personnel action involved, whichever is later [Government Code Section 12946]. *See also 29 C.F.R. Sections 1602.14 (one year retention period required) and 1627.3(b) (3 years).* Longer if a charge of discrimination has been filed [29 C.F.R. Section 1602.14]	Duration of employment, plus 10 years

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Employee benefit plans — pension and insurance plans	All providers	Must keep for 1 year after termination of plan [29 C.F.R. Section 1627.3].	Permanent
Employee exposure records, including audiometric test results	All providers	Must keep for at least 30 years [8 C.C.R. Sections 3204(d)(1)(B) and 5100(d)]	Duration of employment plus 30 years
Employee handbook	All providers		Permanent
Employee health (medical) records — Employees *not subject* to OSHA regulations	Health facilities, clinics, HHAs	Must keep these records for at least 3 years after termination of employment [22 C.C.R. Sections 70723, 71523, 72535, 73525, 74723, 75052, 77121 and 79331].	Duration of employment, plus 30 years
Employee health (medical) records — Employees *subject* to OSHA regulations	All providers	Federal and California OSHA regulations require that medical records be kept for the duration of employment plus 30 years for all employees who are exposed, *or potentially exposed*, to hazardous substances (including chemical substances, biological agents, and bloodborne pathogens) or to a hazardous environment [29 C.F.R. Sections 1910.1020(d)(1)(i), and 1910.1030(h); 8 C.C.R. Sections 3204(c)(5), 3204(d)(1), 5193(h) and 5199(j)(1)]. *See regulations for required content of records.* Hazardous substances include those listed in the latest edition of the Registry of Toxic Effects of the National Institute for Occupational Safety & Health. Hazardous environments include noise, heat, cold, vibration, repetitive motion, ionizing and nonionizing radiation, and hypo- and hyperbaric pressure. *See also "Noise exposure records," page 47.*	Duration of employment, plus 30 years
Employee polygraph records	All providers	Must keep for at least 3 years [29 C.F.R. Section 801.30]. See regulation for required content of report. *See also Labor Code Section 432.2 for retrictions on employee polygraphs.*	Duration of employment, plus 10 years
Employer Information Report EEO-1	Employers subject to Title VII of the Civil Rights Act of 1964 that have 100 or more employees	Must keep the most recent annual report [29 C.F.R. Section 1602.7].	30 years

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Employment Eligibility Verification Form (INS Form I-9)	All providers	Must keep for at least 3 years after date of hire or 1 year after termination of employment, whichever is later [8 C.F.R. Section 274a.2].	Duration of employment, plus 10 years
Equal Pay Act records — records that relate to payment of wages, wage rates, job evaluations, job classifications, job descriptions, merit systems, seniority systems, other matters that explain the basis for payment of any wage differential to employes of the opposite sex in the same establishment	All providers	Must keep for at least 2 years [29 C.F.R. Section 1620.32]. (Copies of seniority systems and merit systems must be kept for at least 1 year after termination of the system under the Age Discrimination in Employment Act [29 C.F.R. Section 1627.3(b)(2)]).	Records about specific employees: File in employees personnel file. Other records: 30 years
Family Medical Leave Act records — dates of leave, hours of leave, employee notices, employer policies and practices, records of disputes, premium payments	Providers subject to FMLA	Must keep for at least 3 years [29 C.F.R. Section 825.500]. *See also Government Code Section 12946 (2-year retention period required, longer if ongoing litigation).*	Records about specific employees: File in employees personnel file. Other records: 30 years
Garnishment records	All providers		7 years
Labor/management reporting records to Office of Labor-Management Standards	All providers	Must keep for at least 5 years after filing [29 U.S.C. Section 436; 29 C.F.R. Section 405.9].	6 years after filing report
Log of temporary health services personnel	SNFs	Must keep for at least 3 years [22 C.C.R. Section 72533].	6 years
Mammography personnel qualification records		*See "Mammography personnel qualifications for physicians, mammographic radiologic technologists, medical physicists," page 52*	
Material Safety Data Sheets	All providers	Must keep while chemical is being used by employees. When safety data sheets are destroyed, must keep a record of the identity (chemical name, if known) of the substance, where it was used, and when it was used for at least 30 years. [8 C.C.R. Section 3204(d)(1)(B)]	6 years after use of chemical discontinued
Noise exposure records	All providers	Noise exposure measurement records must be kept for at least 2 years [8 C.C.R. Section 5100].	30 years
Orientation and competency validation	GACHs	Must retain in employee's file for the duration of employment [22 C.C.R. Section 70214(a)(4)]	Duration of employment plus 6 years

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
OSHA logs, summaries and reports; OSHA forms 300, 300A, 301 Incident Reports, privacy case list	All providers	Must keep for at least 5 years following the end of the calendar year that the records cover [29 C.F.R. Section 1904.33; 8 C.C.R. Section 14300.33].	6 years
Payroll records, including: • Employee deduction authorizations • Hours worked (daily) • Leaves of absence • Overtime, vacation and sick leave accruals and entries • Time cards • Wage rates and wages paid • Wage statements, itemized	All providers	Retention of comprehensive payroll records is required under numerous federal and state laws, including the Fair Labor Standards Act, Equal Pay Act, Age Discrimination in Employment Act, Title VII of the Civil Rights Act, Americans with Disabilities Act, California Fair Employment & Housing Act, California Unemployment Insurance Code, ERISA and Medi-Cal/Medicare requirements. Although most of the acts require retention for a period no longer than 4 years, ERISA requires current availability of all payroll records necessary to determine entitlement to pension benefits. It is therefore recommended that payroll records be permanently retained. *(See also Labor Code Sections 226(a) and 247.5.)* (As ERISA requirements vary according to the type of pension plan, facilities may wish to have their attorneys review their plans to determine whether a shorter retention period may be appropriate and to determine which payroll records should be retained.) *See also Labor Code Section 1174; 29 C.F.R. Sections 516.5 and 516.6; 22 C.C.R. Sections 70725, 71525, 72533, 73527, 75052, 77119 and 79333.*	Employees not entitled to pension: 15 years Employees entitled to pension: life of employee plus 6 years
Pension records	All providers	*See box immediately above.*	Permanent

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Pesticide training program records	All providers	Must keep for at least 2 years [3 C.C.R. Section 6724]. *See regulation for required content of training.* When antimicrobial agents are used only as sanitizers, disinfectants, or medical sterilants, the employer is exempt from complying with this requirement and instead must comply with Cal/OSHA requirements [3 C.C.R. Section 6720], which require records to be kept for at least one year [8 C.C.R. Sections 3203, 5194].	6 years after date of training (may also wish to document attendance in employee's personnel file)
Respirator fit-testing	All providers	Must keep until another fit-testing is performed on the employee [8 C.C.R. Section 5144(m)]. *See regulation for required content of record.*	6 years
Sharps injury log	All providers	Must keep for at least 5 years [8 C.C.R. Section 5193(h)]. *See regulation for required content of log.*	10 years
Sharps injury training	All providers	Must keep for at least 3 years [8 C.C.R. Section 5193(h)]. *See regulation for required content of record.*	6 years (may also wish to document attendance in employee's personnel file)
Unavailablility of vaccine for employees who may be exposed to an aerosol transmissible disease	All providers	Must keep for at least 3 years [8 C.C.R Section 5199(j)(3)]. *See regulation for required content of record.*	6 years
Volunteer personnel records	All providers		6 years after termination of volunteer status
Volunteer sign-in sheets, hours worked, assignments	Facilities		6 years
W-2, W-4 forms		*See "Business and Finance Records," page 31.*	

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Workplace violence prevention records: iolent incident log, reports to Cal/OSHA and injury investigations	Health facilities, HHAs, hospices	Must keep for at least 5 years [8 C.C.R. Section 3342(h)(3)]	6 years
Workplace violence prevention training	Health facilities, HHAs, hospices	Must keep for at least 1 year [8 C.C.R. Section 3342(h)]	6 years after date of training (may also wish to document attendance in employee's personnel file)
Workers' compensation claims files	All providers	Must keep for the latest of: 5 years from date of injury; 1 year from date compensation last provided; until all compensation due or which may be due has been paid; or, if an audit has been conducted within 5 years from the date of injury, until the findings are final [8 C.C.R. Section 10102]. *See 8 C.C.R. Section 10101.1 for required content of file.*	6 years after all compensation paid
Workers' compensation claims log	All providers	Must keep for 5 years from the end of the year to which the log relates [8 C.C.R. Section 10103.2]. *See regulation for required content of log.*	6 years
Workers' compensation self-insureds' claims files	All providers	Claim files must be kept for at least 5 years from date of injury or date on which last compensation benefit paid, whichever is later. Must keep indefinitely if open future medical benefits due. Must be kept in California unless written permission is obtained to retain the records out-of-state. [8 C.C.R. Section 15400.2]	6 years after all compensation paid

IMAGING/RADIOLOGY RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Dose surveys, air sampling, bioassays, measurements to evaluate release of radioactive effluents	Health facilities and imaging centers	Must keep for duration of license [10 C.F.R. Section 20.103; 17 C.C.R. Section 30275]. *See 10 C.F.R. Section 20.2103 for required surveys and measurements.*	Duration of license plus 30 years. Must keep any records showing potential employee exposures for at least 30 years *(see "Environmental (workplace) monitoring or measuring regarding toxic substances or harmful physical agents (including personal, area, grab, wipe, or other form of sampling; collection and analytical methodologies, calculations, and other background data; and analyses)," page 43)*.
Dose to individual member of public	Health facilities and imaging centers	Must keep for the duration of license [10 C.F.R. Section 20.2107; 17 C.C.R. Section 30275].	Duration of license, plus 30 years
Equipment inspection records	Health facilities and imaging centers		Life of equipment, plus 6 years
Fluoroscopy monitoring readings	Imaging facilities	Must keep at least 3 years [17 C.C.R. Section 30307(b)(2)] *(See regulation for required content of logs.)*	6 years
Mammograms and reports	Mammography facilities	Must keep in patient's medical record for not less than 7 years, or not less than 10 years if no subsequent mammograms of the patient are performed at the facility, unless the original mammogram is transferred to the patient's health care provider or to the patient [42 U.S.C. Section 263b(f)(1)(G)(i); 21 C.F.R. Section 900.12(c); 17 C.C.R. Section 30317.50].	File in patient's medical record
Mammography consumer complaints	Mammography facilities	Must keep for at least 3 years [21 C.F.R. Section 900.12(h)]	6 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Mammography personnel qualifications for physicians, mammographic radiologic technologists, medical physicists	Mammography facilities	Must keep for at least 2 years after termination of employment/ medical staff membership [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30315.52, 30315.50 and 30455.1 for required qualifications.* In addition, records of personnel no longer employed must be kept until the next annual inspection has been completed and the FDA has determined that the facility is in compliance with MQSA personnel requirements [21 C.F.R. Section 900.12].	File in employee's personnel file
Mammography quality assurance records — records concerning mammography technique and procedures, quality control (including monitoring data, problems detected, corrective actions, effectiveness of corrective actions), safety and protection	Mammography facilities	Must keep until the next annual inspection has been completed and the FDA has determined that the facility is in compliance with the quality assurance requirements, or, for quality control test records, until the test has been performed two additional times at the required frequency, whichever is longer [21 C.F.R. Section 900.12(d)].	Until next inspection, plus 6 years
Mammography records — calibrations, maintenance, machine modifications (must include date of calibration, maintenance, or modification; name of individual making the record; manufacturer's model number, facility's radiation machine ID number)	Mammography facilities	Must keep for at least 3 years [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	Life of equipment, plus 6 years
Mammography records — processor film strips, phantom images, fixer retention test films, darkroom test films, screen-film contact test films	Mammography facilities	Must keep for at least 1 year [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	6 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Mammography records — QA logs, phantom image score sheets, fixer retention log sheets, repeat analyses, darkroom fog log sheets, screen-film contact log sheets, compression test log sheets, darkroom cleaning logs, intensifying screen cleaning logs, view box cleaning logs, medical physicist survey reports, evaluations and instrument calibration reports, evaluations of new/repaired equipment, medical outcomes audit analyses, consumer complaints, mobile service provider documents	Mammography facilities	Must keep for at least 3 years [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	6 years/Life of equipment, plus 6 years
Mammography records — receipt, transfer, and disposal of radiation machines (must include date of receipt, transfer, or disposal; name and signature of individual making the records; manufacturer's model number; facility's radiation machine ID number)	Mammography facilities	Must keep until facility ceases use and disposes of the machine [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	Life of equipment, plus 6 years
Manifests	Health facilities and imaging centers		30 years
NRC Form 4 — prior occupational dose	Health facilities and imaging centers	Must keep for 3 years [10 C.F.R. Section 20.2104(f); 17 C.C.R. Section 30275].	Duration of employment, plus 30 years
NRC Form 5 — occupational monitoring	Health facilities and imaging centers	Must keep for the duration of license [10 C.F.R. Section 20.2106(f); 17 C.C.R. Section 30275]. Keep also in employee health record. *(See "Employee health (medical) records — Employees subject to OSHA regulations," page 46.)*	Duration of license, plus 30 years
Planned special exposure	Health facilities and imaging centers	Must keep for duration of license [10 C.F.R. Section 20.2105; 17 C.C.R. Section 30275].	Duration of license, plus 30 years
Radiation protection program	Health facilities and imaging centers	Must keep for the duration of license [10 C.F.R. Section 20.2102; 17 C.C.R. Section 30275].	Duration of license, plus 30 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Radiation protection program — audits and reviews of content and implementation	Health facilities and imaging centers	Must keep for at least 3 years [10 C.F.R. Section 20.2102; 17 C.C.R. Section 30275].	30 years
Radiation source records: disposal	Health facilities and imaging centers	Must keep for duration of license [17 C.C.R. Sections 30275 and 30293, 10 C.F.R. Section 20.2108].	Duration of license, plus 30 years
Radiation source records: receipt and transfer	Health facilities and imaging centers	Must keep for 3 years following transfer [17 C.C.R. Section 30293].	30 years following transfer
Radiology reports, printouts, films, scans, and other imaging records	Health facilities and imaging centers	Hospitals that participate in Medicare must keep for at least 5 years [42 C.F.R. Section 482.26].	File in patient's medical record
Radioisotopes — receipt, transfer, use, storage, delivery, disposal and reports of overexposure	Health facilities and imaging centers	Must keep for at least 3 years after transfer or disposal of the material. Disposal records must be kept for duration of license. [10 C.F.R. Section 30.51]	30 years
Reports to CDPH of unplanned contamination events involving licensed radioactive material, failure of equipment designed to prevent releases, event requiring unplanned medical treatment, fire or explosion damaging licensed material, etc.	Health facilities and imaging centers	Must keep for duration of license [17 C.C.R. Section 30293]. *See 17 C.C.R. Section 30295 regarding reporting requirements.*	Duration of license plus 30 years. Must keep any records showing potential employee exposures for at least 30 years *(see "Environmental (workplace) monitoring or measuring regarding toxic substances or harmful physical agents (including personal, area, grab, wipe, or other form of sampling; collection and analytical methodologies, calculations, and other background data; and analyses)," page 43)*.
Requests for tests, procedures	Health facilities and imaging centers	Medicare-participating facilities and imaging centers must keep for at least 7 years [42 C.F.R. Section 424.516(f)]	15 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Surveys and calibrations	Health facilities and imaging centers	Must keep for at least 3 years [10 C.F.R. Section 20.2103; 17 C.C.R. Section 30275]. *See 10 C.F.R. Section 20.2103 for required surveys and calibrations.*	Life of equipment, plus 6 years.
Tests of residual fixer level, darkroom fog, corrective actions	Imaging facilities (other than mammography or dental)	Must keep for at least one year from date of test [17 C.C.R. Section 30308.1]	6 years
X–rays, other imaging data and studies	Health facilities and imaging centers	Must keep for time prescribed for retention of medical records. *See "Medical Records," page 61.*	15 years – adults 25 years – minors

LABORATORY RECORDS AND SPECIMENS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Analytic system records: • Quality control and patient test records, including instrument printouts, if applicable; • Records documenting all analytic systems activities specified in CLIA, 42 C.F.R. Sections 493.1252-493.1289; and • Records of quality control procedures in use, including results on standards and reference materials and action limits when appropriate	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	6 years
Analytic system records — records of test system performance specifications that the laboratory establishes or verifies under 42 C.F.R. Section 493.1253	Freestanding and health facility laboratories	Must keep for the period of time the laboratory uses the test system, but no less than 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	Life of system, plus 6 years

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Blood and blood component records (documentation regarding collection processing, testing, storage, distribution, complaints, adverse reaction and quality control records)	Blood banks, freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep for at least 10 years after processing or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d)] *See 21 C.F.R. Section 606.160(d) for further information about required record contents. See also 42 C.F.R. Sections 482.27 and 493.1105.*	15 years after expiration date, unless indefinite retention required *(see remarks to the left)*
Blood donor histories and pertinent records	Blood banks, freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep for at least 10 years after processing or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d)] *See 21 C.F.R. Section 606.160(d) for further information about required record contents.*	15 years after expiration date, unless indefinite retention required *(see remarks to the left)*
Blood: sample of transfused blood	Health facilities	Must keep for further testing in the event of a transfusion reaction [42 C.F.R. Section 493.1271(d)	2 weeks after last transfusion
Blood transfusion records (including source and disposition)	Freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep for at least 10 years after processing or distribution or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d)] *See also 42 C.F.R. Sections 482.27 and 493.1105.*	15 years after expiration date, unless indefinite retention required *(see remarks to the left)*
Blood transfusion-related records for which there is no expiration date	Freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep indefinitely [21 C.F.R. Section 606.160].	Permanent
Correspondence with clinician about malignant neoplasms	Freestanding and health facilities labs	Must keep at least 5 years [Business and Professions Code 1274(a)]	File in patient's medical record

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Cytology lab — records of the total number of slides examined by each employee during each 24-hour period and the number of hours spent examining slides in the 24-hour period irrespective of the site or laboratory	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Sections 1265(j) and 1271]. *See also 42 C.F.R. Sections 493.1105 and 493.1274(d)(3).*	10 years
Cytology reports	Freestanding and health facility laboratories	Must keep for at least 10 years [Business and Professions Code 1271(g)].	File in patient's medical record.
Cytology slides and cell blocks	Freestanding and health facility laboratories	Must keep for at least 5 years from date of examination [Business and Professions Code 1271(g)]. *See also 42 C.F.R. Sections 493.1105 and 493.1274(f).* (Slides may be loaned to proficiency testing programs in lieu of keeping them for the required time period, provided the laboratory receives written acknowledgment of the receipt of slides by the proficiency testing program and keeps the acknowledgment.)	5 years
Equipment inspection, validation, calibration, repair and replacement records	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. If the records relate to equipment used to process blood or blood components, *see "Blood and blood component records (documentation regarding collection processing, testing, storage, distribution, complaints, adverse reaction and quality control records)," page 56, for applicable retention period.*	Life of equipment, plus 6 years
Histopathology slides	Freestanding and health facility laboratories	Must keep for at least 10 years from date of examination [42 C.F.R. Section 493.1105(a)(7)].	10 years
Human tissue intended for transplantation		*See "Human tissue intended for transplantation," page 61.*	

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Immunohematology records and reports	Freestanding and health facility laboratories	Must keep for at least 10 years after processing or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d); 42 C.F.R. Section 493.1105]	Reports about individual patients: file in patient's medical record. Otherwise, keep 15 years unless indefinite retention required *(see remarks to the left)*
Invoices		*See "Invoices documenting purchase or lease of clinical laboratory equipment and test kits, reagents, or media," page 33.*	
Nuclear medicine reports	GACHs, APHs	Must keep for at least 5 years [42 C.F.R. Section 482.53(d)]	File in patient's medical record
Pathology test reports	Freestanding and health facility laboratories	Must keep for at least 10 years [42 C.F.R. Section 493.1105(a)(6)(ii)].	File in patient's medical record
Pathology specimen blocks	Freestanding and health facility laboratories	Must keep for at least 2 years from date of examination. [42 C.F.R. Section 493.1105]	2 years
Patient specimen testing records (including personnel performing the test and, if applicable, instrument printouts)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Sections 493.1105 and 493.1283.*	6 years
Procedure manuals; method of validation (manuals, card files, or flow charts for each procedure performed, including at least: name of procedure, source or reference for the test method, date procedure last reviewed/modified by the director/supervisor, current specific instructions for test performance, standards and controls required, and instructions for collecting and handling specimens to insure test reliability)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)].	Life of manual/ method, plus 6 years

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Proficiency testing records	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Sections 493.801 and 493.1105*.	6 years
Quality control/assessment documentation (documentation regarding calibration, control procedures, maintenance and function tests, test result comparison activities, workload limit records, alarm system checks, proficiency testing, corrective actions, etc.)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section1265(j)]. However, quality control records for blood and blood components and immunohematology must be kept for at least 10 years after processing or 6 months after expiration date, whichever is later. [21 C.F.R. Section 606.160; 42 C.F.R. Section 493.1105] *See also 42 C.F.R. Part 493.*	6 years
Registers of tests — logbooks (chronological), accession logs	Freestanding and health facility laboratories		6 years
Report of imminent life-threatening result or panic value (including name of person contacted)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)].	File in patient's medical record
Requests for tests/test requisitions (patient ID, name of submitter, dates of receipt and report, type of test performed, test results).	Freestanding and health facility laboratories	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); 42 C.F.R. Section 424.516(f) (7-year retention period); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Specimen records	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)].	6 years

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Test procedures (must include dates of initial use and discontinuance)	Freestanding and health facility laboratories	Must keep for at least 3 years after a procedure has been discontinued [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	6 years after procedure discontinued
Test reports not otherwise specifically mentioned (final, preliminary and corrected)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	File in patient's medical record
Tissue specimens	Freestanding and health facility laboratories	Preserve remnants of tissue for pathology examination until a diagnosis is made on the specimen [42 C.F.R. Section 493.1105].	Until diagnosis is made. May wish to keep longer depending upon type of tissue, how it is preserved, and clinical indications.

NOTE: State and federal laws contain detailed requirements regarding the information to be included in various documents. Laboratories should carefully review Business and Professions Code Section 1265(j) and 42 C.F.R. Section 493.1105 (which requires documentation of compliance with CLIA, 42 C.F.R. Sections 1252-1289) to be sure all required information is captured in the appropriate documents, and retained for the required period of time. Laboratories should also review 21 C.F.R. Section 606.160 if blood or blood components are involved. *(See "Where to Find the Laws Referenced in the Manual," page 75, for instructions on where to find the exact text of each statute and regulation.)*

The College of American Pathologists (CAP) has developed a recommended retention schedule that addresses many records and items not covered in this manual. Hospitals and other providers may wish to consult the CAP schedule.

MEDICAL RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Anatomical gift	Hospital		Permanent
Birth certificates	All providers		Permanent
Birth room record	All providers		Permanent
Cancer/tumor registry files	All providers		Permanent
Death certificates	All providers		Permanent
Electrocardiograms (EKGs)	All providers	Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Electroencephalograms (EEGs)	All providers	Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Electromyograms (EMGs)	All providers	Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Fetal heart monitor strips		Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Human tissue intended for transplantation		*See "Human tissue intended for transplantation (records regarding donor screening and testing; records regarding supplier, donor and lot identification, receipt, name(s) of recipient(s), storage temperatures, distribution, destruction, disposition of human tissue, expiration dates of all tissues, etc.)," page 38.*	
Index to patients' medical records		*See "Master patient index/medical record index number," page 25.*	
Orders and certifications	Medicare provider or supplier of DMEPOS, lab, imagery or home health services	Must keep at least 7 years [42 C.F.R. Section 424.516(f)]	File in patient's medical record

MEDICAL RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Patient medical records, including: • Admission records • Autopsy reports (and consents for autopsy) • Consent forms • Consultation reports • Diagnoses • Discharge summary • Imaging/radiology reports • Labor and delivery records • Laboratory reports • Medication records • Nurses' notes • Patient histories • Patient identification information • Patient's principal spoken language • Physical examination notes • Physical therapy notes • Physicians' orders • Progress notes • Psychiatric records • Reports of all other tests: EKG, EEG, etc. • Surgical records, complete with: – Anesthesia records – Findings – Operative report – Pathology report – Postoperative diagnoses – Preoperative diagnoses • Vital signs sheets	All providers	Various types of health facilities, home health agencies and individual practitioners are required to keep medical records for at least the following periods: • Adults and emancipated minors — 7 years • Unemancipated minors — 1 year after the minor has reached age 18, and in no event less than 7 years [Business and Professions Code Sections 2570.185 (occupational therapists), 2620.7 (physical therapists), 2919 (psychologists), 4980.49 (marriage and family therapists), 4989.51 (educational psychologists), 4993 (clinical social workers), 4999.75 (professional clinical counselors); Health and Safety Code Section 123145; 22 C.C.R. Sections 70751(c), 71551(c), 72543(a), 73543(a), 74731(d), 75055(a), 75343(a), 77143(c) and 79351(c)] Records that support claims for services rendered to Medicare or Medi-Cal patients must be kept for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476] SNFs that participate in Medicare/Medicaid must keep records of minors until they reach the age of 21 [42 C.F.R. Section 483.70(i)]. Prescribers of controlled substances must keep specified records at least 3 years [Health and Safety Code Sections 11190-11191].	15 years — adults 25 years — minors

MEDICAL RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Resident assessments	SNFs that participate in Medicare/Medicaid	Must keep for at least 15 months [42 C.F.R. Section 483.20(d)]	File in patient's medical record
Video records of diagnostic tests (e.g., arthroscopies)	All providers	Keep only those portions that are specifically selected by the physician to accompany the report in the patient's medical record.	File in patient's medical record

NOTE: *See "Human Resources Records," page 45, for information about employee health records.*

MEDICAL STAFF RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Bylaws and rules and regulations of the medical staff	GACHs, APHs, PHFs, CDRHs	Regulations require hospitals to keep these records, but do not specify retention periods [22 C.C.R. Sections 70703, 70733, 71503, 71531, 77127, 79303, and 79337].	Permanent
Bylaws, rules and regulations, and minutes of meetings of the professional and other staff	PHFs, CDRHs	Regulations require PHFs and CDRHs to keep these records, but do not specify retention periods [22 C.C.R. Sections 77127 and 79337].	Permanent
Call schedules	Hospitals	Hospitals that participate in Medicare must keep ED call schedules for at least 5 years [42 C.F.R. Section 489.20(r)].	6 years
Medical staff committee records, including minutes, reports and other records	GACHs, APHs, PHFs, CDRHs	Regulations require hospitals to keep these records, but do not specify retention periods [22 C.C.R. Section 70703, 70733, 71503, 71531, 79303 and 79337].	Permanent
Medical staff files (credentialing files) for allied health providers (non-employees), physicians, residents, interns, fellows, impaired practitioners — including applications (accepted and rejected), credentials, complaints, CME records, etc.	Hospitals		Length of practitioner's career, plus 6 years

MEDICAL STAFF RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Peer review records	Hospitals		Records regarding individual practitioners: length of practitioner's career, plus 6 years. Other records: 6 years
Quality assurance records, incident reports, root-cause analyses, etc.	Facilities	*See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years (unless desired longer for trending purposes)
Resident rotation schedules — location, nature of assignment, vacation, leave of absence, sick time, orientation time, classroom time, etc.	Resident employers	Must keep for at least 5 years after the cost report is filed with the intermediary. *See "Medicare cost report records," page 29.*	15 years
Surgical privileges list		*See "Surgical privileges list," page 39.*	

NUCLEAR MEDICINE RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Calibration records (including the model and serial number of the instrument, date of calibration, results of calibration, and the name of the individual who performed the calibration)	All providers	Must keep for at least 3 years [10 C.F.R. Section 35.2060].	Life of equipment, plus 6 years
Exposure records		*See "Employee health (medical) records — Employees subject to OSHA regulations," page 46.*	
Interpretations, consultations, and procedures reports	GACHs, APHs	Medicare-participating hospitals must keep for at least 5 years [42 C.F.R. Section 482.53].	File in patient's medical record
Receipt and disposition of radiopharmaceuticals	All providers	Regulations require Medicare-participating hospitals to keep these records, but do not specify a retention period [42 C.F.R. Section 482.53].	10 years

NOTE: *See "Imaging/Radiology Records," page 51, for additional information.*

NURSING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Nurse staffing data	SNFs that participate in Medicare/Medicaid	Must keep at least 18 months [42 C.F.R. Section 483.35(g)(4)]	15 years
Orientation and competency validation	GACHs	Must retain in employee's file for the duration of employment [22 C.C.R. Section 70214(a)(4)]	Duration of employment plus 4 years
Staff assignment records (including licensing/certification status of staff, patient census for each shift, staff assignment records, posted nurse staffing data)	SNFs	Must keep for at least 3 years [22 C.C.R. Section 72329.1(h)]. *See also 42 C.F.R. Section 483.35.*	15 years
Staffing patterns, including methodology used	APHs	Must keep for at least 6 months [22 C.C.R. Section 71213(i)].	6 years
Staffing plan for each patient care unit, including patient care requirements, staffing levels for registered nurses, and other licensed and unlicensed personnel. Must also record: 1. Staffing requirements as determined by the patient classification system for each unit, documented on a day-to-day, shift-by-shift basis; 2. The actual staff and staff mix provided, documented on a day-to-day, shift-by-shift basis; 3. The variance between required and actual staffing patterns, documented on a day-to-day, shift-by-shift basis; 4. The actual registered nurse, licensed vocational nurse and licensed psychiatric technician assignments to individual patients by licensure category, documented on a day-to-day, shift-by-shift basis.	GACHs	Must keep records of staffing patterns for the time period between licensing surveys. Must keep records of actual RN, LVN, and LPT assignments for at least 1 year. [22 C.C.R. Section 70217(d)(2)]	6 years

PHARMACY RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Alcohol (tax-free), used for medicinal, mechanical (analysis or test), or scientific purposes for patient treatment (records of receipt, shipments, use, destruction, and claims; include date of transaction, quantity and proof)	Hospitals, blood banks, and sanitariums	Must keep for at least 3 years following date of transaction. Must keep records at permit premises. [27 C.F.R. Section 22.164] *See also 27 C.F.R. Sections 22.161 and 22.162 for required content of records.*	6 years
Automated delivery device policies and procedures	Pharmacies	Must keep for at least 3 years after last use [16 C.C.R. Section 1713].	6 years
Chemicals and products used for compounding (records of acquisition, storage, destruction)	Pharmacies	Must keep for at least 3 years [16 C.C.R. Section 1735.3].	6 years
Compounded drug records	Pharmacies	Must keep for at least 3 years. Records to be kept include the master formula; date; personnel who compounded; pharmacist reviewing final product; quantity of each ingredient; manufacturer, expiration date and lot number of each component; equipment used; pharmacy-assigned reference or lot number; expiration date; and quantity compounded. Some exceptions for products compounded on a one-time basis for administration to an inpatient. [16 C.C.R. Section 1735.3]	6 years

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Controlled substances dispensed, prescriptions	Health facilities, pharmacies	Must keep for at least 2 years records showing the kind and quantity of controlled substances dispensed or administered, the date of dispensing, the names and addresses of persons to whom controlled substances were dispensed or administered, and the names or initials of persons who dispensed or administered the controlled substance [21 C.F.R. Sections 1304.04 and 1304.22]. Prescriptions must be kept for at least 3 years [Business and Professions Code Section 4333; Health and Safety Code Sections 11179 and 11205]. Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)]. *See 21 C.F.R. part 1304 for required content of records.*	6 years
Controlled substances inventories and records (by registered location)	Pharmacies	Must keep for at least 3 years [16 C.C.R. Sections 1707 and 1718; 21 C.F.R. Section 1304.04(a)]. Some records may be kept at a central location if DEA and Board of Pharmacy is properly notified [21 C.F.R. Section 1304.04(a); 16 C.C.R. Section 1707]. Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)]. *See also 21 C.F.R. part 1304.11 for required inventory content and procedure.*	6 years
Controlled substance prescription forms (to whom issued, number issued, etc.)	Health facilities, specified clinics	Must keep at least 3 years [Health and Safety Code Section 11162.1]	6 years after last form used or destroyed

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Controlled substances records	Prescribers	Must keep for at least 3 years [Health and Safety Code Section 11191]. *See Health and Safety Code Section 11190 for specific information that must be documented.* Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)].	6 years
Dialysis drugs and devices for home dialysis patients (prescriptions, invoices showing name of drugs/ devices, quantities, manufacturer, lot number, date, pharmacist)	Pharmacies	Must keep for at least 3 years [16 C.C.R. Sections 1787 and 1790].	6 years
Drugs provided to health care facility or prehospital EMS provider for use by EMS provider	Pharmacy, prehospital EMS provider	Must keep for at least 3 years [Business and Professions Code Section 4119].	6 years
Epinephrine auto-injectors furnished to school districts,county offices of education (records regarding acquisition and disposition)	Pharmacies	Must keep for at least 3 years [Business and Professions Code Section 4119.2].	6 years
Inspection reports by pharmacist of emergency drug supplies in nursing units (must be inspected at least monthly)	GACHs, APHs	Must keep for at least 3 years [22 C.C.R. Sections 70263(f) and 71233(f)].	6 years
Invoices		*See "Business and Finance Records," page 31.*	
Log of destruction of discontinued individual patient's drugs not supplied by the hospital which remain at the hospital after the patient is discharged (must include name of patient, name and strength of drug, prescription number, amount destroyed, date of destruction, signature of witness(es))	GACHs, APHs	Must keep for at least 3 years. Alternatively, the information may be kept in the patient's medical record. [22 C.C.R. Sections 70263 and 71233]	6 years

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medicare Part D-related documents (prescription drug benefit)	All providers that contract with a Medicare Part D plan	Must keep for at least 10 years [42 C.F.R. Section 423.505(i)(2)]. *See "Contracts with Medicare Advantage or Medicare Part D Plans," page 6.*	15 years
Order form DEA 222 (Copy 3 for filled orders; also copies returned as unaccepted or defective)	Pharmacies	Must keep for at least 2 years [21 C.F.R. Section 1305.17]. *See 21 C.F.R. Sections 1305.03, 1305.13 and 1305.15 for required content of records.*	6 years
Patient medication profile (patient name, address, phone, date of birth, gender, allergies, current medications, medical conditions, etc.; prescription and prescriber information)	Pharmacies	Must keep for at least 1 year from the date the last prescription filled [16 C.C.R. Section 1707.1].	15 years — adults 25 years — minors
Prescriptions and prescription records	Pharmacies	Must keep for at least 3 years [Business and Professions Code Section 4333; Health and Safety Code Section 11179; 16 C.C.R. Section 1707 and 1717(f)]. Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)].	6 years
Quality assurance reviews (investigation and analysis of medication errors)	Pharmacies	Must keep for at least 1 year [16 C.C.R. Section 1711].	10 years
Quality assurance review required by Board of Pharmacy	Pharmacies	Must keep for at least one year [16 C.C.R. Section 1711(f)]	6 years
Recall records — records regarding manufacturer's recall of drugs and records evidencing removal of drugs from all nursing units, satellite pharmacies, etc.	Health facilities		6 years
Records of sale, acquisition, receipt and disposition of drugs (including DEA Form 222, theft and loss reports)	Health facilities, pharmacy	Must keep for at least 3 years [Business and Professions Code Sections 4081, 4105, 4190 and 4333]. Must be kept on the licensed premises unless a written waiver is granted by the Board of Pharmacy. *See also 42 C.F.R. Section 482.25; 21 C.F.R. Section 1304.22.*	6 years

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Records regarding prescriptions purposely mislabeled (as part of a research study or by order of prescriber)	Pharmacies	Must keep for at least 3 years [Business and Professions Code Section 4078].	Research: 30 years after completion of research Order of prescriber: 15 years — adults 25 years— minors
Returned drugs — credit memo	Health facilities, pharmacies	A facility's return of a drug to the manufacturer is exempt from legally-prohibited sale/resale if a credit memo is created, sent to the manufacturer, and retained [21 C.F.R. Section 203.23]. The credit memo must be kept for at least 3 years [21 C.F.R. Section 203.60]. *See 21 C.F.R. Section 203.23 for required content of credit memo.*	6 years
Self-assessment required by Board of Pharmacy	Pharmacies	Must keep for at least 3 years [16 C.C.R. Section 1715]	6 years
Sterile compounding records	Pharmacies	Must keep for at least 3 years [16 C.C.R. Section 1751.1]. *See regulation for required content of records.*	6 years
Sterile injectable product records: name, lot number, amount, date, compounding information.	Pharmacies	Must keep for at least 3 years. For sterile products compounded from one or more nonsterile ingredients, must also keep training and competency evaluation of employees in sterile product procedures, refrigerator and freezer temperatures, certification of sterile compounding environment, other facility quality control logs, inspection for expired or recalled products, preparation records (including master work sheet, preparation work sheet, and end-product evaluation results). [16 C.C.R. Section 1751.1]	6 years
Temperature monitoring logs	The Joint Commission accredited organizations	`Must keep until next full survey	4 years

PUBLIC RELATIONS RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Advertisements (print, radio, television, etc.)	All providers		10 years; may wish to retain those of historical interest permanently
Authorization to use/disclose protected health information (media interviews, etc.)	All providers	HIPAA regulations require authorizations to be kept for at least 6 years [45 C.F.R. Section 164.530(j)].	8 years
Consent to photograph	All providers	HIPAA regulations require authorizations to be kept for at least 6 years [45 C.F.R. Section 164.530(j)]. Thus, if the photograph depicts a patient (as opposed to an employee, volunteer, or model) and is used for purposes other than treatment, payment or health care operations, the consent to photograph must comply with HIPAA authorization requirements and must be kept for at least 6 years.	8 years after discontinuing use of photograph
Marketing materials	All providers		10 years; may wish to retain those of historical interest permanently
Newspaper and magazine clippings (historical)	All providers		10 years; may wish to retain those of historical interest permanently
Photographs — institutional	All providers		10 years; may wish to retain those of historical interest permanently
Press releases	All providers		10 years; may wish to retain those of historical interest permanently
Publications (in-house)	All providers		10 years; may wish to retain those of historical interest permanently

PURCHASING AND RECEIVING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Invoices		*See "Business and Finance Records," page 31.*	
Packing slips	All providers		Providers may wish to match packing slips with invoices/ purchase orders and retain together.
Purchase orders		*See "Business and Finance Records," page 31.*	
Purchase requisitions (internal documents)	All providers		2 years
Receiving reports	All providers		2 years
Returned goods credits	All providers	*See "Business and Finance Records," page 31.*	

RESEARCH RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Contracts with study sponsors and principal investigators, including related documentation	All providers		30 years after completion of the research
Human subject research records	All providers	Retained records should include medical records.	30 years after completion of the research
Institutional Review Board (IRB) records (research proposals and scientific evaluations; approved sample consent documents; progress reports submitted by investigators; reports of injuries to subjects; minutes of IRB meetings; records of continuing review activities; correspondence between the IRB and investigators; list of IRB members, including name, degrees, representative capacity, experience; any employment or other relationship with the institution; written procedures for the IRB as required by 21 C.F.R. Section 56.108 (a) and (b); statements of significant new findings provided to subjects, as required by 21 C.F.R. Section 50.25)	IRBs	Must keep for at least 3 years after completion of the research [21 C.F.R. Section 56.115; 45 C.F.R. Section 46.115].	Records regarding particular research projects: 30 years after completion of the research General IRB records: 6 years
Other research reports	All providers		6 years (longer if continuing interest)
Research papers published	All providers		10 years; may wish to retain those of historical interest permanently
Research regarding prescriptions purposely mislabeled (as part of a research study)		*See "Records regarding prescriptions purposely mislabeled (as part of a research study or by order of prescriber)," page 71.*	

Where to Find the Laws Referenced in the Manual

All of the laws discussed in the manual can be found on the Internet.

FEDERAL LAW

A federal statute is written by a United States Senator or Representative. It is voted on by the United States Senate and the House of Representatives, and then signed by the President. A federal statute is referenced like this: 42 U.S.C. Section 1395. "U.S.C." stands for "United States Code." Federal statutes may be found at www.gpo.gov/fdsys or at www.law.cornell.edu.

A federal regulation is written by a federal agency such as the U.S. Department of Health and Human Services or the U.S. Food and Drug Administration. The proposed regulation is published in the Federal Register, along with an explanation (called the "preamble") of the regulation, so that the general public and lobbyists may comment on it. The federal agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. The final regulation is also published in the *Federal Register*. A federal regulation is referenced like this: 42 C.F.R. Section 482.1 or 42 C.F.R. Part 2. "C.F.R." stands for "Code of Federal Regulations." Federal regulations may be found at www.ecfr.gov. The preamble, however, is only published in the Federal Register and not in the Code of Federal Regulations. The Federal Register may be found at www.federalregister.gov.

The Centers for Medicare & Medicaid Services (CMS) publishes its *Interpretive Guidelines* on the internet. The *Interpretive Guidelines* include information for surveyors on how CMS interprets the Conditions of Participation, and instructions for surveyors on how to assess hospitals' compliance with the Conditions of Participation. They may be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (click on Publication 100-07, "State Operations Manual, then "Appendices Table of Contents"). There are several appendices that hospitals will find useful, for example, A (hospitals), AA (psychiatric hospitals), V (EMTALA), and W (critical access hospitals).

A federal law must be obeyed throughout the United States, including in California, unless the federal law expressly states otherwise. As a general rule, if a federal law conflicts with a state law, the federal law prevails, unless the federal law expressly states otherwise.

If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed. For example, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal law states that providers must conform to whichever provision of federal or state law provides patients with greater privacy protection or gives them greater access to their medical information.

STATE LAW

A state statute is written by a California Senator or Assembly Member. It is voted on by the California Senate and Assembly, and then signed by the Governor. A state statute is referenced like this: Civil Code Section 56 or Health and Safety Code Section 819. State statutes may be found at www.leginfo.legislature.ca.gov. Proposed laws (Assembly Bills and Senate Bills) may also be found at this website.

A state regulation is written by a state agency such as the California Department of Public Health or the California Department of Managed Health Care. A short description of the proposed regulation is published in the California Regulatory Notice Register, more commonly called the Z Register, so that the general public and lobbyists may request a copy of the exact text of the proposed regulation and comment on it. The state agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. A notice that the final regulation has been officially adopted is also published in the Z Register. The Z Register may be found at www.oal.ca.gov/notice_register.htm.

A state regulation is referenced like this: Title 22, C.C.R., Section 70707. "C.C.R." stands for "California Code of Regulations." State regulations may be found at https://govt.westlaw.com/calregs/Search/Index.

A state law must be obeyed in California only. As a general rule, if a California law conflicts with a federal law, the federal law prevails, unless the federal law expressly states otherwise. (If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed.)

SUBJECT:	SECTION:
STAFF RECRUITMENT, EMPLOYMENT AND RETENTION	***Human Resources*** **Page 1 of 4**

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

PURPOSE:

To assist in the District's goal of promoting equal opportunities for all applicants by providing a consistent process for staff recruitment and for ensuring an engaging and rewarding employment experience resulting in staff retention.

POLICY:

This policy establishes uniform procedures for the recruitment and retention of staff. Employment of candidates is based on qualifications and experience, regardless of race, color, creed, gender (including gender identity and gender expression), religion (all aspects of religious beliefs, observance or practice, including religious dress or grooming practices) marital status, registered domestic partner status, age, national origin or ancestry, physical or mental disability, medical condition (including cancer or a record or history of cancer, and genetic characteristics), sex (including pregnancy, childbirth, breastfeeding or related medical condition), genetic information, sexual orientation, veteran status or any other consideration made unlawful by federal, state, or local laws. It also prohibits unlawful discrimination based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics. Discrimination can also include failing to reasonably accommodate religious practices or qualified individuals with disabilities where the accommodation does not pose an undue hardship.

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES, VOLUNTEERS, CONTRACTORS AND EMPLOYEES OF CONTRACTORS

PROCEDURE:

Job Requisition Form:

1. Appropriate staffing levels shall be reviewed each time a vacancy occurs.

2. A ~~job requisition form (Position Control Form)~~Position Control Request ~~-~~will be completed by Department Leaders for additions or replacement of staff.

3. ~~Job requisitions~~ Position Control Requests must be approved by Financial Planning and ~~-~~the employing ~~unit's~~ Department's Vice President ~~and the Chief Executive Officer/President~~ for all positions.

4. Approved ~~job requisitions~~ Position Control Requests will be received by the Human Resources Department.

New Position:

1. Department Leaders, in collaboration with Human Resources, will prepare a ~~position~~ Job ~~d~~Description. (See policy: ~~Position~~ Job Description)

   Job title, job code and pay range will be assigned and maintained by Human Resources.

Additions and replacement of staff:

1. Job posting occurs ~~when~~ after Human Resources is notified via Formstack that the ~~job requisition~~ position control request has been approved. ~~by Senior Leadership Team .~~ The approval process follows a workflow that is outlined below:

   1. Financial Planning reviews the submitted position control request form. The Financial Planning Analyst will add a note in the form's comments section about the FTE status (e.g., "Available FTE," "Exact Match, "FTE Add"). Financial Planning will then approve the form to go to the next approver, the respective division Vice President.

   2. The VP will receive the position control request via their Formstack queue. They will review the request and either approve or deny. If approved by the VP, the form goes to the HR Recruiter.

   3. The Recruiter reviews the Formstack queue and posts ***only*** the positions with available FTE to the SVMC job board. Positions requested that are anything other than available FTE such as additional FTE, FTE swap, splitting of FTE, or changes to a job description or title, must be reviewed and approved by Senior Leadership Team to be posted.

~~1.~~2. -All job openings are posted on the Hospital's Intranet and the Internet for a minimum of (5) five calendar days. If a significant number of applications from qualified candidates are received, job openings will then be removed from the Hospital's Intranet and the Internet when conducting interviews. If a candidate is not selected, the position will be reposted, and the process will be repeated until the position is filled. Human Resources is responsible for administering this policy and for ~~positing~~ posting job openings.

   Department Leaders and Human Resources will evaluate and determine cost effective recruitment and confirm that it coincides with the time of posting. The use of employment agencies will be determined by Human Resources.

   A deadline for internal and external applicants will be determined on a case-by-case basis by Department Leaders and Human Resources.

   Human Resources is responsible for receiving and screening applications for minimum requirements. Human Resources will conduct additional screening by phone and determine

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candidate(s) to be interviewed. Interviews will be conducted by the ~~d~~Department Leaders and interview teams. ~~and Interview Teams.~~

Human Resources, in collaboration with Department Leaders, will establish interview dates and times.

Department ~~Leaders shall~~Leaders shall determine selection of the final candidate(s). Interview notes and ~~—~~competency score sheets (balance sheets) shall be provided to Human Resources.

Human Resources shall conduct background checks and advise the Department Leaders when the employee has cleared the pre-employment process. Evidence of background checks shall be retained within the employee's personnel file.

Human Resources ~~and~~ in collaboration with Department Leaders will determine the hire date based on the next available orientation schedule and onboarding availability. ~~Preference will be given to the nearest general orientation date.~~

Salary offers will be communicated by Human Resources to candidate(s) by telephone and/or letter. Prospective employees will be offered salaries consistent with their experience and shall not exceed the midpoint of their salary range without approval from the VP of HR. ~~CEO/President approval.~~

~~Vice Presidents have authority to approve salary offers up to 50% of the incumbent's wage grade.~~

Staff Retention:

SVMC is committed to continuously evaluating the retention drivers for top talent and providing an engaging work experience for staff.

Retention of staff is a strategic effort of Senior Management, hospital leadership and the Human Resources Department. It is the goal of SVMC to establish retention tools and ongoing education and data management related to the level of engagement of the workforce. This will be done through engagement surveys, exit surveys, succession planning, development opportunities, staff rounding and day to day interactions which promote the values and mission of SVMC.

Staff retention will also be aligned with educational opportunities and programs, wage and benefit activities, and leadership and recognition initiatives.

REFERENCES:

- Title 22 California Code of Regulations Division 5. (n.d.). Retrieved from http://www.nursealliancecca.org/files/2012/06/Title-22-Chapter-5.pdf

- Title VII of the Civil Rights Act of 1964. (n.d.). Retrieved from https://www.eeoc.gov/laws/statutes/titlevii.cfm
- Immigration Reform and Control Act of 1986. (n.d.). Retrieved from https://www.alipac.us/f12/immigration-reform-control-act-1986-a-35974
- Americans with Disabilities Act. (n.d.). Retrieved from https://www.ada.gov.
- Age Discrimination Act. (n.d.). Retrieved from https://www.eeoc.gov/laws/statutes/adea.cfm.
- Rehabilitation Act of 1973, § Section 504. (n.d.). Retrieved from https://www.govinfo.gov/content/pkg/USCODE-2010-title29/pdf/USCODE-2010-title29-chap16-subchapV-sec794.pdf.

CROSS REFERENCES:

- JOB DESCRIPTIONS

SUBJECT: ~~TRANSITIONAL RETURN TO WORK~~ LIGHT DUTY	SECTION:

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

POLICY:

It is Sierra View Medical Center's (SVMC) policy to support our employees' health and well-being, particularly when they are recovering from injuries, illnesses, or pregnancy-related conditions. To support our workforce, we offer a Light Duty Program that provides temporary, modified duties or alternate work assignments.

This program is available to employees who have sustained industrial injuries or illnesses, as well as to employees who are pregnant and require accommodations under the Pregnant Workers Fairness Act (PWFA). The policy ensures that employees can remain engaged in the workplace while recovering, whether due to a work-related injury, illness, or pregnancy-related condition, while also facilitating a smooth transition back to full-duty work when medically cleared.

Please note, the Light Duty Program is specifically available for industrial injuries and pregnancy-related accommodations only and does not extend to non-industrial injuries or illnesses.

~~, provide transitional return to work and/or accommodations for pregnancy, mental, and physical impairments.~~

This policy is designed to:

- **Support recovery:** Provide temporary, modified duties or alternate work assignments for employees recovering from industrial injuries or illnesses.
- **Ensure employee safety:** Promote a safe work environment by allowing employees to continue contributing while they recover.
- **Maintain productivity:** Help maintain workplace productivity by assigning employees to roles that accommodate their recovery without requiring full-duty tasks.
- **Offer pregnancy accommodations:** In compliance with the Pregnant Workers Fairness Act (PWFA), offer light duty assignments for employees who are pregnant and require modifications to their work duties for health reasons.
- **Promote a smooth transition:** Assist employees in returning to their regular duties once they are medically cleared and able to resume full work duties.
- **Uphold legal compliance:** Ensure the hospital adheres to applicable laws and regulations, including providing accommodations for pregnancy-related conditions as required by the PWFA

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- ~~Facilitate compliance with Federal and California legislation.~~

- ~~Provide department leaders~~

- ~~with guidance when responding to questions and requests expressed by employees for accommodations related to their job responsibilities at SVMC.~~

- ~~Define modified duty and reasonable accommodations processes.~~

~~Transitional return to work assignments and reasonable accommodations to meet pregnancy, mental and physical needs are determined on a case-by-case basis because workplaces and job responsibilities, as do people with impairments and disabilities, vary. Accommodations may involve changes to workplace policies, procedures or practices.~~

Department leaders may refer to the SVMC policies listed at the end of this document for guidance on how to implement and manage the leaves of absence mentioned in this policy, but not covered in detail here.~~Department leaders may refer to supporting SVMC policies referenced at the end of this policy to determine how SVMC will implement and administer leaves of absences that are mentioned but not covered in detail in this policy.~~

Return to Work Following Work-Related Injury

~~Re-entry into the workforce may take precedent to decisions about reaching a medical endpoint and/or inability to perform the position(s) essential function(s). Transitional return to work assignments may be provided within or outside the employee's home department.~~ Supporting an employee's safe return to work may take precedence over determining whether the employee has reached a medical endpoint or is unable to perform the essential functions of their position. Light duty assignments may be provided either within the employee's home department or in another department based on operational needs and available work. Human Resources (HR) will work with the returning employee and the department ~~leaders to~~leaders to determine where the returning employee can return. During this process, ~~Human Resources~~ HR shall be advised immediately when light duty is not available within the employee's home department. When ~~transitional~~light duty return to work assignments are found outside the employee's home department, 100% of the employee's wage accrual will be charged to the employee's home department for the duration of the temporary assignment. Every effort will be made to place the employee in their home department if accommodation allows.

If re-injury is compromised by premature return to work, the employee and their attending physician may be asked to evaluate the position's essential functions. Essential function(s) or cumulative value used to evaluate job participation can only be decided on a case-by-case basis. The impairment's effect must be assessed in the context of providing ~~transitional~~light duty return to work assignments. ~~and/or reasonable accommodation.~~

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~~Transitional~~Light duty ~~return to~~ work assignments are granted for short periods (30 days) of time to meet the immediate health needs of employees and shall not exceed ~~three~~six (~~3~~6) months in duration per incident/disability. . ~~In addition, temporary assignments are for staff who may be needed in other areas and are unable to perform the essential functions of their current role upon return from Medical Leave of Absence. Both transitional and temporary assignments cannot exceed three (3) months per Incident/Disability.~~

If no assignment is available that meets requested restriction(s)~~/accommodation~~, SVMC will continue to accommodate by providing a Leave of Absence along with continuing to engage the employee in the Interactive Process.

Employee Health Services shall advise HR~~uman Resources~~, who will advise Payroll and the department leader, when an employee returns from a work-related injury.

Prior to return, work restrictions shall be discussed and the employee's participation and acceptance of ~~transitional return to~~light duty work assignments agreed upon. HR~~uman Resources~~ and the department the employee returns to shall prepare written job duties defining an employee's participation. Department leaders are responsible for ensuring work restrictions and ~~transitional return to work~~light duty assignments agreed upon are enforced.

HR~~uman Resources~~ shall advise employees that ~~transitional return to work~~light duty assignments are temporary and will be re-evaluated for their medical necessity periodically.

Participation in temporary ~~modified~~light duty assignments ~~is voluntary and~~ shall be credited to "statutory family/medical leave," if an employee returns to ~~transitional work~~light duty on a reduced work schedule.

~~Reasonable accommodations are considered only when the impairment meets the Americans with Disabilities Act (ADA) definition of "disability," and is protected by the Act. Refer to "Reasonable Accommodation" section within this policy.~~

~~**Return From "Statutory Family/Medical Leaves"**~~

~~In limited instances, employees shall be placed in transitional return to work assignments following non-work related injuries and illnesses returning from either Statutory Family/Medical Leaves.~~

~~Employees shall provide notice of their intention to return to work at least two days prior to return from leaves of absence. A release from their attending physician must be provided upon return. Accompanying restrictions and/or requested accommodation must be in writing and shall be directed to Human Resources.~~

~~Approval or denial for return to work is based on medical necessity of the work restrictions, and current medical information in the context of the employee's ability to perform the essential functions of the position.~~

~~If no assignment is available that meets requested restriction(s)/accommodation, we will continue to accommodate by providing a Leave of Absence along with continuing to engage the employee in the Interactive Process.~~

~~Current medical information and recommendation, which alters or ends temporary modified duty assignments, may be requested by the Hospital.~~

~~Transitional return to work assignments, when granted, involve collaborative discussions between department leaders and Human Resources. Department leaders shall not unilaterally accept work restrictions or initiate modified duty programs without discussion and approval from Human Resources.~~

~~Participation in transitional return to work assignments shall be credited to current FMLA leave of absence benefits or any statutory family/medical leaves if an employee returns to transitional work on a reduced work schedule.~~

~~Department leaders are responsible for ensuring work restrictions and modified duty assignments are followed and not revised without further medical necessity and discussion with Human Resources.~~

~~Transitional return to work assignments are granted for short periods (30 days) of time to meet the immediate health needs of employees and shall not exceed (3) months in duration. In addition, temporary assignments are for staff who may be needed in other areas and are unable to perform the essential functions of their current role upon return from Medical Leave of Absence. Both transitional and temporary assignments cannot exceed three (3) months per incident/disability.~~

~~Employees returning from Statutory Family/Medical Leaves shall retain employment rights provided by Federal and California legislation.~~

Pregnancy-Related Light Duty

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In accordance with the **Pregnant Workers Fairness Act (PWFA)**, pregnancy is treated as a medical condition that may require temporary accommodations to help employees continue working while managing pregnancy-related conditions. Employees requesting temporary modified duty assignments due to pregnancy will be provided the same consideration as employees with other medical conditions under this policy.

Process for Pregnancy-Related Light Duty:

- **Request and Evaluation:** When an employee believes their pregnancy affects their ability to perform the essential functions of their job, they should submit a request for temporary modified duty to HR. HR will collaborate with the department leader to evaluate the employee's ability to perform essential job functions, considering any physician-recommended work restrictions.

- **Physician Recommendations:** Work restrictions provided by the employee's physician will be assessed on a case-by-case basis. HR, in partnership with the department leader, will evaluate the impact of the pregnancy-related condition and work restrictions, aiming to provide reasonable accommodations whenever possible.
- **Job Description and Essential Functions:** If an employee expresses concerns that their job duties may pose a risk to their pregnancy, HR and the department leader will work together to review the position description. They will identify essential functions that may need modification and consult with the employee and their physician to determine which tasks can or cannot be performed, as well as recommend work restrictions for the remainder of the pregnancy.
- **Communication of Decisions:** HR will inform the employee whether their requested work restrictions are accepted, denied, or revised. HR is responsible for communicating the decision to the employee in a timely and clear manner, ensuring that the employee understands their options and any changes to their duties.
- **Case-by-Case Basis:** All accommodations, including work restrictions, will be evaluated individually. HR and the department leader will work closely together to assess the employee's specific needs, review medical advice, and determine if accommodations can be made without causing undue hardship to the organization.

~~**Pregnancy**~~

~~**Modified Duty Requests:**~~

~~Pregnancy is treated like other medical conditions affecting an employee's ability to work and perform the essential function/s of their position.~~

~~When employees request temporary modified duty assignments, department leaders shall evaluate how and if the employee is able to continue to perform the essential functions with physician-recommended work restrictions. Work restrictions or their cumulative value used to evaluate job participation can only be decided on a case-by-case basis. The effect of the impairment must be assessed in the context of providing reasonable accommodation(s) whenever possible.~~

~~Position descriptions are used when employees believe their job endangers their pregnancy. Employees and their physicians are asked to identify essential functions which can or cannot be performed, and recommend work restrictions for the remaining period of pregnancy. Employees shall be advised if the work restriction(s) are accepted, denied or revised.~~

~~**Leaves of Absence – Pregnancy**~~

~~Employees and their physicians determine when a pregnancy-related disability begins. When temporary modified duty assignments fail to sustain active employment, continuation of benefits and employment are protected as follows:~~

~~When on a Statutory Family/Medical Leave or California Pregnancy Leave of Absence.~~

~~A return to work release is necessary in cases involving routine pregnancy.~~

REFERENCES:

- ~~Americans with Disabilities Act (ADA) (1990). https://www.ada.gov/pubs/adastatute08.htm.~~
- **Pregnant Workers Fairness Act (PWFA) — EEOC statute and text**
  https://www.eeoc.gov/statutes/pregnant-workers-fairness-act
- **California Workers' Compensation Law**
  https://www.dir.ca.gov/dwc/workerscompensationlaws.html

- ~~Family Medical Leave Act (FMLA). 29 CFR Part 825 (1993). https://www.ecfr.gov/egi-bin/text-idx?c=ecfr&sid=abbd92edff37c5d32de741ee5eee1e81&rgn=div5&view=text&node=29:3.1.1.3.54&idno=29.~~

- ~~California Family Rights Act (CFRA) (1980).~~
  ~~https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=12945.2.~~

CROSS REFERENCES:

- Reasonable Accommodation/ Section 504 of the Rehabilitation Act
- Leaves- Pregnancy Disability Leave
- Leaves – FMLA/CFRA
- ~~Leaves – Personal~~
- Workers' Compensation

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SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	03/04/2026
BOARD OF DIRECTORS APPROVAL	
	03/24/2026
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
March 24, 2026 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**
• Borrowing/Purchasing or Lending/Selling Medications to Other Hospitals and/or Community Pharmacies	1-3	
• Central Venous Catheters, Care and Maintenance of	4-13	
• Exposure Control Plan – Bloodborne Pathogen Standard	14-40	
• Gastric Aspirate Collection for TB	41-44	
• Intra-Aortic Balloon Pump Therapy	45-47	
• Intravenous Therapy	48-51	
• Medication Allergies and Adverse Reactions	52-57	
• Medication – Errors	58-62	
• Medication Procurement, Storage, Distribution and Control	63-75	
• Medications Restricted to Areas or Personnel	76-83	
• Patient's Own Medications	84-87	
• Pharmacy and Therapeutics Committee	88-89	
• Precedex Drip for Sedation of Patients in the Critical Care Setting	90-95	
• Scope of Services of the Surgical Services Department	96-99	
• Vancomycin Protocol Per Clinical Pharmacist	100-103	
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II. Forms		
• Procedural Sedation Physician Progress Note	110	

SUBJECT:	SECTION:
BORROWING/PURCHASING OR LENDING/SELLING MEDICATIONS TO OTHER HOSPITALS AND/OR COMMUNITY PHARMACIES	**Page 1 of 3**

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

PURPOSE:
To ensure the organization addresses and maintains a system to obtain prescribed medications not currently available or routinely stocked by the pharmacy.

POLICY:

The Pharmacy Department ensures that prescribed medications are available 24 hours per day by providing a process for borrowing medications from other facilities in the community, when waiting for normal supply delivery from the wholesaler would cause a delay in therapy to the patient. Records are maintained to ensure accountability of medications either borrowed, loaned, purchased, or sold, and to track the safe transport of those medications.

AFFECTED AREAS/PERSONNEL: *PHARMACY*

PROCEDURE:

A. "BORROWING/PURCHASING"

For any merchandise borrowed or purchased from another Hospital or Community Pharmacy, the procedure outlined below shall be followed:

1. The "Selling-Borrowing Form" bearing the following shall be prepared:

   a. Name & address, of hospital or pharmacy from which the medication was borrowed/purchased & name of contact person at the lending facility

   b. The name, strength, quantity, NDC#, lot#, and expiration date of medication being borrowed and track and trace information

   c. Date of transaction

   d. Signature of the individual (employee of Sierra View Medical Center or courier) picking up merchandise

   e. If any bill or "paperwork" is received from the pharmacy when the merchandise is picked up, it shall be affixed to the Selling-Borrowing Form.

   f. The hospital copy of the Selling-Borrowing Form is given to the pharmacy buyer.

g. The Pharmacy Buyer will reconcile all Selling-Borrowing Forms at the end of the month. Selling-Borrowing Forms for purchased items will be forwarded to accounts payable for processing. Borrowed items will be ordered and returned to the lending facility if not already completed and noted on the form.

2. The "Selling-Borrowing" form for the specific loaning facility will be completed to include:

   a. Date of the transaction
   b. Item/strength of the item borrowed
   c. Quantity borrowed
   d. Indicated that the item was "Borrowed"
   e. Signature of the person completing the transaction
   f. Date the medication was returned

3. All packages either sent or received will have lot numbers and expiration dates affixed so as to expedite drug recall procedures as they arise.

B. LENDING/SELLING

For any medication loaned or sold to another hospital or pharmacy, the following procedure will be followed:

1. It should be determined that by loaning or selling the medication requested, there is a sufficient quantity of medication left to accommodate the needs of the patients of the hospital.

2. Complete a "Selling-Borrowing Form" to include:

   a. The borrowing facilities' name and address
   b. Contact name at the borrowing facility
   c. Date the transaction is taking place
   d. Item loaned (Include strength, , dose form, NDC#, lot#, and expiration date, track and trace information)
   e. Quantity loaned
   g. Signature of Sierra View Medical Center representative completing the transaction

3. A copy of the original receipt is given to the representative of the borrowing facility. The original will be given to the pharmacy buyer.

4. The Pharmacy Buyer will reconcile all Selling-Borrowing Forms at the end of each month. Debit Memo Forms for sold items will be forwarded to accounts receivable for processing and billing. The pharmacy buyer will contact the borrowing facility for all loaned items not yet returned to determine the borrowing facility's disposition.

C. RECONCILING BORROWED/LOANED MEDICATIONS

The Record of Medication Loaned/Borrowed or Purchased/Sold shall be reviewed at the end of the month by the Pharmacy Buyer for reconciliation of items borrowed/loaned or purchased/sold.

D. UTILIZING THE COURIER SERVICE FOR TRANSPORTATION

Whenever possible, hospital staff should be utilized to pick up medications being borrowed or to deliver medications being returned. However, when hospital staff is not available, the contracted courier service will be utilized. The phone number of the courier service is maintained at the Pharmacy Buyer's desk, as well in the Main Pharmacy. The service uses computerized, archived records of dispatches for delivery, which include the pickup location and time, the delivery location and time, and the driver's name and permit number. The courier service is bonded and drivers are screened by the Department of Transportation and undergo pre-employment criminal background checks.

When using the courier service, verify that the quantity of the medication being sent matches the quantity being received and that the package(s) have not been tampered with **before** signing the voucher and before the driver leaves. If a discrepancy occurs, call the lending institution and verify the quantity being sent. If the amount received is not correct, notify the courier dispatcher immediately and report the discrepancy. Notify the Pharmacist in Charge as soon as possible of the report. Staple the copy of the courier voucher to the Borrowed Medication Receipt.

References:

1. ASHP. Specific Patient Need and Emergency Medical Reason: Drug Supply Chain Security Act (DSCSA) FAQ 4. American Society of Health-System Pharmacists. February 2016. Available at: https://www.ashp.org/-/media/assets/practice-management/docs/sppm-dsc-dscsa-faq-specific-patient-need.pdf
2. U.S. Food and Drug Administration. Title II of the Drug Quality and Security Act (Drug Supply Chain Security Act). December 15, 2014. Available at: https://www.fda.gov/drugs/drug-supply-chain-security-act-dscsa/title-ii-drug-quality-and-security-act

SUBJECT:	SECTION:
CENTRAL VENOUS CATHETERS, CARE AND MAINTENANCE OF	***Nursing Procedures (NR)*** **Page 1 of 10**

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

PURPOSE:

To provide standardized guidelines for continuous and intermittent central venous therapy, to minimize the incidence of catheter-related complications and to provide guidelines for removal of central venous catheters.

POLICY:

1. Insertion of a central venous catheter requires signed informed consent.

2. The patient and, as appropriate, the family, will be educated on infection prevention strategies to help reduce central line-associated blood stream infection (CLABSI).

3. The Central Line Insertion Checklist must be completed on the Electronic Medical Record (EMR).

4. No central line is to be used until the catheter tip placement at the juncture of the right atrium and superior vena cava is verified by chest X-ray. **EXCEPTION**: *In an extreme emergency (i.e. code blue, trauma), a central line may be used without X-ray confirmation. However, free-flowing blood return must be present prior to use.*

5. If the physician places injection ports on the end of the central line upon insertion of a central venous catheter, the registered nurse (RN) will immediately replace ports with V-link (silver) valves.

6. Central venous catheters will be clamped at all times when not in use.

7. Flush unused lumens of the central line with 10 ml normal saline every 8 hours and before and after each use.

8. All central venous catheters will be dressed with a sterile, semi-permeable dressing. This dressing will be changed every 7 days or when damp, loose or soiled.

9. V-link valves will be changed every 7 days with sterile dressing change.

10. Central venous catheter V-link valves will be swabbed with an ***alcohol wipe*** and allowed to dry prior to accessing. Only a syringe is to be used for accessing valves. Do not use any device to pierce the valves (i.e. needle).

11. An infusion pump will be used on all central line infusions except in extreme emergencies.

12. Laboratory specimens may be drawn from central venous catheters unless a physician orders otherwise. *Exception: Blood cultures will be drawn from peripheral sites unless otherwise specified by the physician. If the line is used for TPN, stop TPN infusion, flush with 10 mL of normal saline and wait for 5 minutes; then specimen may be drawn.*

13. If a multilumen catheter is used to administer peripheral nutrition, designate one port for hyperalimentation, preferably the medial port. DO NOT use the designated hyperalimentation port for other purposes (e.g. administration of fluids, blood, or blood products.)

14. All central venous catheters established for the acute management of the patient may be removed by a registered nurse with a physician's orders. If any resistance is felt, the RN is to stop the procedure and notify the physician.

INDICATIONS FOR USE

- Fluids
- Blood Products
- Medications
- Dialysis
- Parenteral Nutrition
- Hemodynamic Monitoring
- Lack of Peripheral access
- Other

TRAINING AND COMPETENCY

NURSING

1. All RNs will be educated on central line management, including prevention of central line-associated bloodstream infections upon hire.

2. RN competency on central line management and infection prevention will be validated initially on hire and annually thereafter.

3. Nurses will be responsible for ensuring that the physician central line continuation orders are placed in the chart on a daily basis.

PHYSICIAN

1. Physicians will perform a daily evaluation of the need to continue a central line and document indications for continued use.

2. All physicians who are involved in central line insertion and management will complete a self-learning module on the prevention of central line-associated bloodstream infections initially.

3. Thereafter, education on the prevention of central line-associated bloodstream infections will be provided to physicians annually during medical staff meetings.

AFFECTED AREAS/PERSONNEL: *ALL NURSING UNITS*

PROCEDURE:

Flushing

1. Equipment
   a. Alcohol wipes
   b. Gloves
   c. Prefilled normal saline 10 mL syringe
2. Procedure
   a. Explain procedure to patient.
   b. Wash hands.
   c. Apply gloves.
   d. Cleanse V-Link valve with alcohol wipe. Allow to dry.
   e. Aspirate to verify patency of line before injecting recommended amount of flush solution. *No medication or solution should be infused unless a free-flowing blood return is obtained.*
   f. Flush each unused lumen with 10 mL normal saline
   g. After flushing the catheter, maintain positive pressure by keeping your thumb on the plunger of the syringe while clamping catheter. Remove syringe. This prevents blood backflow and potential clotting of the line.
   h. If the catheter does not flush freely or you meet resistance, change the patient's body position (i.e. raise arm on side of catheter insertion, etc.). If you are still unable to flush the line, notify the physician.
3. Documentation
   a. Chart time of the central line flush and line patency on the MAR. Prior to flush, aspirate for free-flowing blood return. Flush all unused lumens every 8 hours and before and after each use. If multiple lumens are being flushed, indicate line and amount of flush.

Example: 0600

Patency checked
Prox: 10 mL
Med 10 mL
Distal 10 mL
Sideport 5 mL

Dressing Changes:

1. Equipment
   a. Clear semi-permeable dressing
   b. Bio-patch
   c. Gauze, sterile
   d. Chlora-prep applicator 1
   e. Sterile gloves, non-sterile gloves
   f. Mask
2. Procedure
   a. Explain procedure to patient
   b. Assemble equipment
   c. Wash hands.
   d. Ask patient to turn head away from the insertion site or wear a mask
   e. Don gloves and mask
   f. Remove existing dressing and discard
   g. Assess insertion site
   h. Wash hands
   i. Prepare kit and/or supplies
   j. Put on sterile gloves

k. Clean insertion site with chlora-prep applicator in a side to side motion "scrubbing" for 30 seconds. Allow to air dry for 30 seconds

l. Apply Biopatch at catheter site

m. Apply clear semipermeable dressing. Care should be taken not to kink, pinch, or compress the catheter with the dressing

n. Loop the tubing and secure with tape

o. Label dressing with date, time and initials

p. Instruct patient that skin may turn orange temporarily

q. Discard used supplies in appropriate receptacle

r. Wash hands

3. Documentation

a. Record dressing change on nursing notes noting the date and time of the dressing change and a description of the catheter site and skin condition.

b. Document appearance of the insertion site every shift.

Injection Port Changes:

1. Equipment

a. V-Link (silver) valves

b. Gloves

c. Mask

d. Alcohol prep

e. Prefilled 10 mL normal saline syringes

2. Procedure

a. Explain procedure to patient

b. Assemble equipment

c. Wash hands

d. Don mask

e. Clamp the catheter

f. Ask patient to turn head away from insertion site or wear a mask

g. Remove old V-link valve and discard

h. Connect new V-link valve. Note: Remove air prior to flushing, either by flushing valve with normal saline prior to attaching or by aspirating air after attaching to the catheter

i. Flush each valve with a prefilled 10 mL normal saline syringe

j. Discard used supplies in appropriate receptacle

k. Wash hands

Blood Draws:

1. Equipment

a. Non-sterile gloves

b. Alcohol swabs

c. Prefilled 5 mL normal saline syringe

d. Prefilled 10 mL normal saline syringe

e. 10 mL syringe for blood draw

f. Specimen tubes

2. Procedure

a. Wash hands

b. Explain procedure to patient

c. Apply gloves

d. Cleanse V-link valve with alcohol wipe. Allow to dry.

e. Flush with 5 mL normal saline

f. Withdraw 5 mL blood and discard

g. Withdraw blood for specimens

h. Flush with 10 mL Normal Saline

i. Transfer blood into specimen tubes

j. Label specimen tubes with patient identification

SPECIAL CONSIDERATIONS FOR BLOOD BANK SPECIMENS

All blood specimens drawn from a **central line** for the purpose of blood bank testing will be obtained and labeled by an RN and/or physician in the presence of certified/licensed lab personnel or licensed personnel with each initialing the specimen labels and/or additional forms as required, and both confirming that the BBK# has been transcribed correctly from the patient's wrist band to the specimen label.

Removal:

NOTE: RNs may only remove non-tunneled central venous catheters

1. Equipment

   a. Goggles or face shield optional

   b. Mask

   c. Sterile and non-sterile gloves

   d. Chlora-prep applicator

   e. Suture removal kit

   f. Sterile 4 X 4 gauze pads

   g. 2 inch paper or foam tape

   h. Culture container optional if culturing tip

2. Procedure

   a. Wash hands

   b. Explain procedure to patient

   c. Apply personal protective equipment (non sterile gloves, goggles/face shield)

d. Place patient in supine or low semi-fowlers position

e. Don mask

f. Ask patient to turn head away from insertion site or wear a mask

g. Remove catheter dressing and discard

h. Cleanse site with chloraprep and allow to dry (30 seconds)

i. Apply sterile gloves

j. Cut sutures and remove

k. Instruct patient on Valsalva maneuver to decrease the risk of air embolism during removal. Instruct patient to take a deep breath and hold it, "bear down" for 10 seconds, then exhale. *NOTE: Valsalva maneuver is contraindicated in patients with increased intracranial pressure or if intubated.* If patient is on a ventilator, remove catheter at mid-exhalation.

l. Slowly remove catheter while patient is holding breath, bearing down, or exhaling and apply immediate pressure to exit site with a 4 X 4 gauze dressing, holding until hemostasis occurs. Apply pressure for 10 min then check for bleeding. For femoral lines pressure should be held for 10-15 min. Then check for bleeding.

m. Duration can change based on patient hold longer for large bore catheters like Tri flo, if the patient is Obese, on anticoagulated therapy, or has abnormal coagulopathy *Note: Do not repeatedly lift to assess for bleeding*

n. If bleeding or oozing continues, apply pressure for another 10 minutes. Repeat until bleeding stops. If line is removed from a jugular site, apply gentle pressure.

o. Apply occlusive dressing. Dressing should be left in place for 24 hours.

p. Keep patient in supine position for 30-60 minutes, monitoring every 15 minutes for bleeding.

q. Following removal of a femoral line, the patient must be intermittently monitored for 60 minutes. After 60 minutes, if there is no bleeding or oozing, patient may flex hip and ambulate.

r. Document the following:

- Date and time of catheter removal

- Site assessment
- Culture specimen sent (if appropriate)
- Ease of catheter removal
- Inspection of intact catheter
- Length of time pressure applied to obtain hemostasis
- Application of occlusive dressing
- Patient tolerance of the procedure
- Patient and family education
- Any unexpected outcomes and interventions

SPECIAL CONSIDERATIONS

Caution should be taken when removing lines in patients with coagulation disorders and/or patients on anticoagulation therapy. Prior to removal, coagulation labs and platelets should be checked to ensure normal levels. If labs are not within normal limits, the physician should be notified for further orders.

Escalate Immediately for:

Persistent bleeding despite 20+ min pressure

Rapidly expanding hematoma

Hypotension

Severe groin pain

Suspected retroperitoneal bleed (rare but serious)

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SUBJECT: **EXPOSURE CONTROL PLAN – BLOODBORNE PATHOGEN STANDARD**	SECTION: **Page 1 of 27**

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

PURPOSE:

The Exposure Control Plan shall be made available to Sierra View Medical Center (SVMC) personnel and to the Chief of the Division of Occupational Safety and Health of the California Department of Industrial Relations or National Institute for Occupational Safety and Health (NIOSH) or their respective designee upon request for examination and copying.

POLICY:

1. SVMC has charged the Pharmacy and Therapeutics / Infection Prevention Committee with the overall responsibility for the Blood borne Pathogen Program in compliance with Occupational Safety and Health Administration (OSHA) Instruction 29 CFR 1910.1030. The Pharmacy and Therapeutics / Infection Prevention Council have the full support and authority of the Chief Executive Officer (CEO) to ensure compliance is maintained.

   SVMC complies with OSHA regulations including, but not limited to, the following:

   a. Determining exposure risks of personnel

   b. Providing protection against exposure risks

   c. Implementing a blood borne pathogen program

   d. Providing Hepatitis B vaccinations at no cost to personnel

   e. Providing in-service training by personnel with knowledge of this topic and being available to employees' requests for additional safety protection

   f. Being available to answer all employee questions

   The Pharmacy and Therapeutics / Infection Prevention Committee has overall responsibility for implementing the Plan and will review and maintain the Plan. The Plan will be submitted to the Pharmacy and Therapeutics / Infection Prevention Committee for review, revision as needed and approval on an annual basis. The Plan will also be reviewed/approved at other committees as deemed necessary.

2. The goals of the Exposure Control Plan are:

   a. To inform personnel of the contents of the OSHA standards as it applies to Hepatitis and Human Immunodeficiency Virus (HIV).

   b. To ensure employees receive information concerning infection prevention in the work place. This information includes epidemiology, clinical presentation, modes of transmission and prevention of blood borne disease / infection, specifically Human

Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV), as well as protective measures to prevent exposure, such as the use of personal protective equipment (PPE), clothing and safe work practices including Standard Precautions and vaccination protocol.

c. To ensure employees receive information concerning the hazards that they may be exposed to in the workplace. This information includes a comprehensive hazard communication program that incorporate container labeling and other forms of warnings, material safety data sheets and appropriate protective measures to employees.

3. The Plan shall be incorporated into the hospital's departmental policies and procedures, be reviewed, updated and approved annually, or as deemed necessary by the Infection Prevention Committee. Review and revision will reflect the following:

   a. New or modified tasks and procedures which affect occupational exposure.

   b. Progress in implementation of the use of needleless systems and sharps with engineered sharps injury protection.

   c. New or revised employee positions with occupational exposure.

   d. Review and evaluation of the exposure incidents which occurred since the previous update.

   e. Review and respond to information indicating that the Exposure Control Plan is deficient in any area.

4. Information presenting the scope, content and practical application of the Plan will be given to all persons covered by this Plan. Education will be provided annually and as deemed necessary. Documentation of training will be maintained.

5. Each department shall monitor compliance with the Plan, related practices, evaluate the need for further training, and provide training in consultation with Infection Prevention. Compliance with the Plan shall be incorporated into the individual employee evaluation process.

6. Hepatitis B vaccinations, at no cost to the employee, shall be offered to all employees who may be exposed to more than one infection risk per month (blood/body fluids), within ten (10) working days of assignment to exposure-prone duties. Employees who elect not to be vaccinated *must* sign a written declination form.

7. SVMC shall ensure that all medical evaluations and procedures, including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis, are:

   a. Made available at no cost to the employee

b. Made available to the employee at a reasonable time and place

c. Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional

d. Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place.

8. SVMC shall ensure that all laboratory tests are conducted by an accredited laboratory at no cost to the employee.

GENERAL FACTS ABOUT HEPATITIS

1. Hepatitis Transmission

a. Hepatitis B (HBV)

Hepatitis B can be transmitted through occupational exposure by percutaneous exposure to infected blood or bodily fluids. Healthcare workers are at risk for needle stick injuries or mucosal exposure, such as splash into eyes or mouth.

HBV is most prevalent among intravenous drug users who share needles and through sexual contact among sexually active homosexual males and prostitutes. From these groups, it spreads to the community.

Needlestick and sharps injuries (NSSI) are major occupational hazards that are commonly associated with healthcare workers' practice standards. More than 20 different types of bloodborne pathogens can be transmitted as a result of NSSIs.

HBV symptoms resemble the flu in its early stages. More severe clinical illness has symptoms that often include jaundice, a loss of appetite, nausea, and elevated liver enzyme function tests.

b. Hepatitis C

Hepatitis C (HCV),is transmitted parenterally and is responsible for many cases of sporadic acute hepatitis.

HCV is now by far the most common cause of post-transfusion hepatitis.

HCV symptoms resemble the symptoms associated with HBV.

HCV can, like HBV, develop into a chronic carrier state.

2. Hepatitis Protection

Occupational Health and Safety Administration (OSHA) enforces the Center for Disease Control and Prevention (CDC) recommendations. OSHA presently requires every healthcare worker who is exposed to more than one infection risk per month to be offered a Hepatitis B vaccination, to be trained in pathogen safety, and given all necessary protective PPE. SVMC will require that high-risk employees provide proof of immunization or immunity or signed declination prior to employment.

Hepatitis B vaccine is administered in a three (3) dose series to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, or antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons. The vaccination series will be offered within ten (10) days of hire.

NOTE: An employee who refuses vaccination must sign a declination form maintained in the Employee Health file.

Danger of infection from blood borne pathogens can be prevented or reduced in the healthcare setting by:

a. Using protection against body fluids during at-risk procedures including appropriate personal protective equipment, mechanical safety devices, *etc.*

b. Using disinfectants to reduce pathogens in the environment.

c. Taking thorough patient medical histories.

d. Washing hands between patient treatment contacts.

e. Using puncture-resistant sharps containers for needle disposal.

f. Correcting unsafe environment and work practices as they occur.

3. Human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV / AIDS)

HIV / AIDS is not as contagious in a healthcare setting as HBV, but there is still no vaccine for prevention and no means of cure. It is transmitted through body fluids so healthcare workers are exposed to HIV in their daily routine.

OSHA requires that employees be trained in HIV prevention and be required to protect themselves during at-risk procedures. Training is included in, but not limited to, New Hire Orientation and Annual Orientation.

Symptoms of HIV infection are varied and may include fatigue, fever, weight loss, night sweats, rashes, mouth sores or pneumonia.

Because there is no inoculation against HIV / AIDS, CDC recommends and OSHA enforces the use of STANDARD PRECAUTIONS in *all* healthcare settings where exposure to potentially infectious materials may take place.

4. HIV / AIDS Transmission

HIV / AIDS is usually transmitted through blood and semen. It is most commonly seen in men who have sex with men (MSM) and IV drug users.

HIV / AIDS is transmitted sexually and through blood / body fluid exposure or perinatally from mother to child. HIV / AIDS is *not* transmitted through general contact with a carrier.

STANDARD PRECAUTIONS

A. Standard Precautions applies to ALL blood and body fluids, excluding sweat, regardless of the presence or absence of visible blood.

B. Standard Precautions incorporate infection prevention procedures that protect the patient as well as the employee from disease-causing pathogens.

C. The incorporation of Universal Precautions with Standard Precautions has been referred to as STANDARD PRECAUTIONS throughout this plan, as well as the Infection Control Program Manual.

D. Under STANDARD PRECAUTIONS, the assumption is that blood and body fluids from ALL patients is potentially infected with Human Immunodeficiency Virus (HIV) Hepatitis B virus (HBV), Hepatitis C virus (HCV) and other blood borne pathogens, and must be handled accordingly.

E. STANDARD PRECAUTIONS applies to:

1. ALL blood and body fluids that are visibly contaminated with blood,

2. ALL body fluids in situations where it is difficult or impossible to differentiate between body fluids, including (but not limited to) cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal and pericardial fluid, amniotic fluid, saliva in dental procedures, vaginal secretions and semen.

3. It does not include sweat, unless it is visibly contaminated with blood.

F. Contaminated items are defined as those items that contain liquid or semi-liquid blood or are caked with dried blood or other potentially infectious material (OPIM) that are capable of releasing these materials when handled or compressed.

G. SVMC practices Standard Precautions in its regular daily activities.

DEFINITIONS OF INFECTIOUS CONDITIONS

A. Infections need 4 simultaneous conditions for transmission. If you take any condition away, the danger of infection will be reduced or eliminated. The conditions which must exist simultaneously are:

1. A sufficiently large dose of infectious particles to constitute a dangerous quantity

2. A sufficient virulence, or deadliness, to be dangerous

3. A portal of entry, such as through an open cut or the nasal passages

4. A reduced resistance level of the host. For example: If a medical worker is tired, has the flu or a cold, he/she is more susceptible to infection.

INFECTIOUS DISEASES ARE PREVENTED BY REDUCING OR REMOVING ANY OF THESE CONDITIONS. FOR EXAMPLE:

- The use of gloves and masks will reduce or eliminate portals of entry.
- Regular handwashing and the use of disinfectants will remove or reduce the dose and virulence of the disease.
- The placement of sharps and needles into approved sharps containers and the avoidance of recapping needles will reduce needle stick portals of entry.

PERSONAL PROTECTIVE EQUIPMENT

Where occupational exposure remains after implementation of engineering and work practice control, SVMC shall provide, at no cost to the employee, appropriate personal protective equipment (PPE) such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protections, mouthpieces, resuscitation bags, pocket masks, or other ventilation devices.

PPE will be considered "appropriate" only if it does not permit blood or other potentially infectious materials (OPIM) to pass through to or reach the employee's work clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

SVMC shall ensure that the employee uses appropriate PPE unless the employee temporarily and briefly declined to use PPE when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future. The employer shall encourage employees to report all such instances without fear of reprisal.

SVMC provides PPE in the appropriate sizes for all employees. This PPE can be taken to the location where infectious materials are generated. PPE and protective clothing is provided commensurate with the exposure risks.

Hypoallergenic gloves, gloves liners, powderless gloves, or other similar alternatives shall be available to those employees who are found to be allergic to the gloves normally provided.

SVMC shall make provision for cleaning, laundering, and disposal of PPE at no cost to the employee.

The employer shall repair or replace PPE as needed to maintain its effectiveness at no cost to the employee.

If an employee feels more protection should be provided for certain procedures, he / she should make this request to either his / her immediate supervisor or agency management.

The use of protective clothing is an OSHA requirement and a requirement of SVMC. If the procedure requires it, or the manufacturer recommends its use, protective clothing must be used.

Clinical Laboratory Improvement Amendments (CLIA) laboratory rules may be stricter about laboratory garments. If rules conflict, *follow the law that is stricter.*

Disposal of Personal Protective Equipment

1. If a garment is penetrated by blood or OPIM, the garment shall be removed immediately or as soon as feasible.

2. All PPE shall be removed prior to leaving the work area.

3. When PPE is removed it shall be placed in an appropriate designated area or container for storage, washing, decontamination or disposal.

    a. Reusable PPE which is heavily soiled with body fluids shall be handled as little as possible and must be bagged at the location of use in leak proof bags.

4. When removing protective clothing, avoid contamination of exposed body parts.

Gloves

1. Types

   Three basic glove types are provided by SVMC:

   a. Sterile gloves for procedures involving contact with normally sterile areas of the body and invasive procedures. These gloves cannot be reused.

   b. Examination gloves for patient diagnostic procedures not requiring the use of sterile gloves and for routine infection prevention. These gloves cannot be reused.

   c. Utility gloves of strong latex/vinyl for maintenance and scrubbing work. These are reusable until they puncture, tear, or crack.

2. Glove protocol: Gloves shall be worn when it can be reasonably anticipated that the employee may have contact with blood, OPIM, mucous membranes, and non-intact skin; when performing vascular access procedures; and when handling or touching contaminated items or surfaces.

   a. After donning gloves, examine them for physical defects.

   b. Never wear the same pair of gloves with more than one patient or on more than one occasion.

   c. Discard gloves after each patient.

   d. Disposable (single use) gloves shall not be washed or decontaminated for re-use.

   e. Don gloves so they cover the cuff of your clothing if possible to reduce the area of skin exposure.

   f. If torn or punctured or their ability to function as a barrier is compromised, disposable (single use) gloves shall be replaced as soon as feasible. If contaminated, gloves shall be replaced as soon as practical.

   g. Remove gloves before removing mask and gown if worn.

   h. Wash hands after glove disposal.

Masks, Protective Eyewear / Goggles, and Face Shields

Masks in combination with eye protection devices such as goggles, glasses with solid side shields, or chin-length face shields, shall be worn whenever contamination of the eyes, nose or mouth can be reasonably anticipated from splashes, spray, spatter or droplets of blood or OPIM. They are not required for routine care.

Gowns / Aprons or Other Protective Body Clothing

1. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

   NOTE: Gowns, aprons and/or lab coats are required when splashing, misting or aerosolization of blood or OPIM onto skin or clothing are anticipated.

   Resuscitation Equipment:

   Pocket masks, mouthpieces, resuscitation bags and / or other respiratory equipment are available for use in order to minimize exposure in case of emergency mouth-to-mouth resuscitation.

   NOTE: Surgical masks are *not* considered resuscitation equipment.

HANDWASHING

A. Wash hands regularly on the following occasions:

   1. Upon arriving at work
   2. Before gloving
   3. After gloves are removed
   4. Before and after each patient or during prolonged contact with one patient
   5. Before and after touching wounds
   6. After touching excretions / secretions
   7. Before and after performing invasive procedures
   8. Before handling medications
   9. Before and after eating, drinking or preparing food, smoking, etc.
   10. After hands have touched a potentially contaminated surface

11. Before leaving the work area and upon return

12. Upon completing work shift

13. As soon as patient safety permits, when hands and other skin surfaces become contaminated with blood or body fluids

14. After any contact with one's own personal body fluids, using the toilet, blowing or wiping the nose, or similar incidents when soiled

B. Prior to invasive procedures, use of an antimicrobial soap scrub is recommended by the CDC. The CDC recommends the use of antimicrobial soap prior to invasive procedures, when caring for newborns, between caring for patients in high-risk units, and when caring for severely immunocompromised individuals or patients infected with virulent or epidemiologically important microorganisms.

1. The policy at SVMC requires antimicrobial soap to be available in high risk patient care areas as well as isolation rooms.

C. Alcohol-based Hand Sanitizers/ Wipes

Alcohol-based hand sanitizers or wipes are available to all employees whose job performance may take them into areas where sinks are not readily available or accessible. Alcohol-based hand sanitizers or wipes disinfect the hands between patient contacts when handwashing is not possible; however, hand sanitizers and wipes do *not* replace handwashing. Handwashing must be performed as soon as handwashing facilities become available/accessible.

EXPOSURE INCIDENT OCCURRENCE

An exposure incident occurs when a patient's blood or body fluids may have gained entry into an employee during the performance of their job duties. Should this occur, the employee must follow these procedures:

A. Wash the exposed area with soap and running water.

B. Report the incident to the Supervisor immediately.

C. Complete all necessary forms to document the facts.

D. Fill out an Electronic Incident Report.

E. If possible, locate the source patient for a blood sample for serological testing for HIV, HBV and HCV.

F. Report to Employee Health Services or Emergency Room if after hours. Also, if after hours, notify the House Supervisor.

EXPOSURE INCIDENT FOLLOW-UP

Following a report of an exposure incident, SVMC shall make a confidential medical evaluation immediately available to the exposed employee.

A. The employer shall document the route(s) of exposure and the circumstances under which the exposure incident occurred.

B. The employer shall identify and document the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law.

1. The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV, HCV and HIV infectivity.
If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

2. When the source individual is already known to be infected with HBV, HCV or HIV, testing for the source individual's known HBV, HCV or HIV status need not be repeated.

3. Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

C. SVMC shall provide for collection and testing of the employee's blood for HBV, HCV and HIV serological status.

1. The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

2. If the exposed employee consents to a baseline blood collection but not to HIV testing, the blood sample should be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

3. Additional collection and testing shall be made available as deemed appropriate on a case-by-case basis.

D. SVMC shall provide for post-exposure prophylaxis, when medically indicated.

E. SVMC shall provide for counseling and evaluation of reported illnesses.

F. Information provided to Healthcare Professionals:

1. SVMC shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of this regulation.

2. SVMC shall ensure that the health professional evaluating an employee after an exposure incident shall be provided the following information:

   a. A copy of this regulation

   b. A description of the exposed employee's duties as they relate to the exposure incident

   c. Documentation of the route(s) of exposure and circumstances under which exposure occurred

   d. Results of the source individual's blood testing, if available

   e. All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain

G. Healthcare Professional's Written Opinion

SVMC shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within fifteen (15) days of the completion of the evaluation.

1. The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

2. The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

   a. That the employee has been informed of the results of the evaluation

   b. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment

3. All other findings or diagnoses shall remain confidential and shall not be included in the written report.

H. Medical Recordkeeping

Medical records required by blood borne pathogen standard shall be maintained by employer's occupational health provider.

SHARPS INJURY LOG

SVMC's Employee Health Department shall establish and maintain a Sharps Injury Log, which is a record of each exposure incident involving a sharp. The exposure incident shall be recorded on the log within fourteen (14) days of the date the incident is reported to the employer. The information recorded shall include the following information, if known or reasonably available:

A. Type and brand of sharp involved in the exposure incident.

B. A description of the exposure incident which shall include:

1. Job classification of the exposed employee
2. Work area where the exposure incident occurred
3. The procedure that the exposed employee was performing at the time of the incident
4. How the incident occurred
5. The body part involved in the exposure incident
6. If the sharp had engineered sharp injury protection, whether the protective mechanism was activated, and whether the injury occurred before the protective mechanism was activated, during activation of the mechanism or after activation of the mechanism.
7. If the sharp had no engineered sharps injury protection, the injured employee's opinion as to whether and how such a mechanism could have prevented the injury
8. The employee's opinion about whether any other engineering, administrative or work practice control could have prevented the injury

EXPOSURE RESPONSE, PREVENTION AND CONTROL

The Exposure Control Plan is designed to minimize or eliminate employee exposure to blood borne pathogens for those who are potentially exposed at least once per month. These employees are protected by SVMC with safety measures identified below, according to the Blood borne Pathogen Standard of December 6, 1991, which was amended January 15, 1999.

SVMC

1. Reviews major tasks and procedures performed by personnel and identifies all high risk exposure incidents, and how frequently exposure incidents occur per month.

2. Ensures that all major tasks and procedures done by each employee is reviewed and potential exposure incidents identified.

3. Provides employees who are exposed to blood pathogens at least once per month:

   a. Safety training in blood borne pathogens

   b. the protective clothing required by OSHA against pathogen exposure

   c. written safety information from the contents of the agency health and safety manuals

4. Provides for periodic evaluation of the frequency, types and brand(s) of sharps involved in exposure incidents documented in the Sharps Injury Log.

   NOTE: Frequency of use may be approximated by any reasonable and effective method.

5. Provides for the identification of currently available engineering controls and selecting such controls, where appropriate, for the procedures performed by employees in their respective work areas.

6. Provides for documenting patient safety determinations.

7. Provides for obtaining the active involvement of employees in reviewing and updating the exposure control plan with respect to the procedures performed by employees in their respective work areas.

8. Ensures that a copy of the Exposure Control Plan is accessible to employees.

9. Shall prepare an exposure determination form. This exposure determination form shall contain the following:

   a. A list of all job classifications in which employees have occupational exposure

   b. A list of job classifications in which some employees have occupational exposure

   c. A list of all tasks and procedures or groups of closely related tasks and procedures in which occupational exposure occurs. This exposure determination shall be made without regard to the use of personal protective equipment.

A. Methods of Compliance

1. General – Standard Precautions shall be observed to prevent contact with blood or OPIM. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

2. Engineering and Work Practice Controls – General Requirements:

   a. Engineering and work practice controls shall be used to eliminate or minimize employee exposure

   b. Engineering controls shall be reviewed and maintained or replaced on a regular basis to ensure their effectiveness

   c. Routine work practice controls shall be evaluated and updated on a regular basis to ensure their effectiveness

   d. All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

3. Engineering and Work Practice Controls – Specific Requirements:

   a. Needleless Systems. Needleless systems shall be used for:

      - Withdrawal of body fluids after initial venous or arterial access is established
      - Administration of medications or fluids
      - Any other procedure involving the potential for an exposure incident for which a needleless system is available as an alternative to the use of needle devices

   b. Needle Devices. If needleless systems cannot be used, needles with engineered safety devices to prevent sharps injury shall be used for:

      - Withdrawal of body fluids
      - Accessing a vein or artery
      - Administration of medications or fluids

EXCEPTIONS:

- Market Availability. The engineering control is not required if it is not available in the marketplace.

- Patient Safety. The engineering control is not required if a licensed healthcare professional directly involved in a patient's care determines, in the reasonable exercise of clinical judgment, that use of the engineering control will jeopardize the patient's safety or the success of a medical, dental or nursing procedure involving the patient. The determination shall be documented.

- Safety Performance. The engineering control is not required if the employer can demonstrate by means of objective product evaluation criteria that the engineering control is not more effective in preventing exposure incidents than the alternative used by the employer.

- Availability of Safety Performance Information. The engineering control is not required if the employer can demonstrate that reasonably specific and reliable information is not available on the safety performance of the engineering control for the employer's procedures, and that the employer is actively determining by means of objective product evaluation criteria whether use of the engineering control will reduce the risk of exposure incidents occurring in the employer's workplace.

4. Prohibited Practice

a Shearing or breaking contaminated needles and other contaminated sharps is prohibited.

b Contaminated sharps shall not be bent, recapped, or removed from devices.

EXCEPTION: Contaminated sharps may be bent, recapped or removed from devices if the procedure is performed using a mechanical device or a one-handed technique, and it can be demonstrated by the employer that no alternative is feasible or that such action is required by a specific medical or dental procedure.

c Sharps that are contaminated with blood or OPIM shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

d Disposable sharps shall be used.

e Broken glassware, which may be contaminated, shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

f The contents of sharps containers shall not be accessed unless properly reprocessed or decontaminated.

g Sharps containers shall not be opened, emptied or cleaned manually or in any other manner which would expose employees to the risk of sharps injury.

h Activities such as eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure.

i Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or OPIM are present.

B. Requirements for Handling Contaminated Sharps

All procedures involving the use of sharps in connection with patient care, such as withdrawing body fluids, accessing a vein or artery or administering vaccines, medications or fluids shall be performed using effective patient handling techniques and other methods designed to minimize the risk of a sharps injury.

Immediately place contaminated sharps in puncture resistant, leak proof containers.

At all times during the use of sharps, containers for contaminated sharps shall be:

1. Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found.

2. Maintained upright throughout use, where feasible.

3. Replaced as necessary to prevent overfilling.

C. Sharps Containers for Contaminated Sharps:

1. All sharps containers for contaminated sharps shall be:

a. Rigid

b. Puncture resistant

c. Leak proof on the sides and bottom

d. Portable, if portability is necessary to ensure easy access by the user

e. Labeled appropriately with the universal biohazard symbol

2. If discarded sharps are not to be reused, the sharps container shall also be closeable and sealable so that when sealed, the container is leak resistant and incapable of being reopened without great difficulty.

D. Regulated Waste.

The EPA and the State Health Department administer regulated waste disposal laws in the environment **outside** the agency; OSHA administers laws **within** the agency. SVMC rigidly adheres to both.

1. General

Handling, storage, treatment and disposal of all regulated waste shall be in accordance with Health and Safety Code Chapter 6.1, Sections 117600 through 118360, and other applicable regulations of the United States and the State of California (including political subdivisions). The actual treatment and disposal of the regulated waste generated by SVMC shall be the responsibility of Stericycle, Inc., a contract biohazardous waste contractor.

Regulated waste policies must be understood by *all* personnel handling such waste.

Once regulated waste is disinfected, it is no longer considered "infectious" and may be disposed of as regular solid waste *unless* it contains sharps or dangerous materials.

2. Disposal of Sharps Containers

When any container of contaminated sharps is moved from the area of use for the purpose of disposal, the container shall be:

a. Placed in a secondary container if leakage is possible. The secondary container shall be:

- Closeable
- Constructed to contain all contents and prevent leakage during handling, storage, transport or shipping

- Labeled appropriately with universal biohazard symbol

b. Disposal of other Regulated Waste. Regulated Waste not consisting of sharps shall be disposed of in containers which are:

- Closeable
- Constructed to contain all contents
- Labeled appropriately and color-coded
- Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping

c. If outside contamination of a container or regulated waste occurs, it shall be placed in a secondary container. The secondary container shall be:

- Closeable
- Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping
- Labeled appropriately and color-coded
- Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport or shipping

E. Handling Specimens of Blood or Other Infectious Material

1. Specimens of blood or OPIM shall be placed in a container that prevents leakage during collection, handling, processing, storage, transport, or shipping.

   Care shall be taken to avoid contamination of the outside of the container or the laboratory slip.

2. The container for storage, transport or shipping shall be labeled or color-coded and closed prior to being stored, transported, or shipped.

3. If outside contamination of the primary container occurs, the primary container shall be placed within a second container that prevents leakage during collection, handling, processing, storage, transport, or shipping and is labeled or color-coded.

4. If the specimen could puncture the primary container, the primary container shall be placed within a secondary container that is puncture resistant in addition to the above characteristics.

F. Servicing or Shipping Contaminated Equipment

Equipment that may become contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.

1. A readily observable label shall be attached to the equipment stating which portions remain contaminated.

2. Information concerning any remaining contamination shall be conveyed to all affected personnel, the servicing representative, and / or manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

G. Cleaning and Decontamination of the Worksite / Housekeeping

Cleaning and decontamination of the worksite / housekeeping is addressed in this policy because many safety and health injuries occur as a result of inadequate cleaning, repair and maintenance.

1. General Requirements

a. Employers shall ensure that the worksite is maintained in a clean and sanitary condition.

b. Employers shall determine and implement an appropriate written schedule for cleaning and decontamination of the worksite.

c. The method of cleaning or decontamination used shall be effective and shall be appropriate for the specific setting as well as the type of soil or contamination present and the type of surface or equipment to be treated.

d. All equipment, environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the visit. The cleaning and decontamination of equipment and work surfaces may be required more often than is specified below.

2. Specific Requirements

a. Contaminated Work Surfaces. Contaminated work surfaces shall be cleaned and decontaminated immediately or as soon as feasible when:

- Surfaces become overtly contaminated
- There is a spill of blood or OPIM
- Apply hospital-level tuberculocidal disinfectant or fresh bleach solution (1:10) on blood spills
- If bleach solutions are used, the solution must be refreshed every 2 days. Once diluted, bleach solutions lose disinfecting strength rapidly.
- After procedures are completed
- At the end of the visit, if the surface may have become contaminated since last cleaning

b. Receptacles: All bins, pails, cans, and similar receptacles intended for reuse which have a likelihood for becoming contaminated with blood or OPIM shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

c. Instruments: In most cases, disposable instruments shall be used; however, if reusable medical instruments are used, they shall be cleaned with a disinfectant (hospital level – tuberculocidal) before being processed.

d. Protective Coverings: Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of patient care if they may have become contaminated.

e. Physical Area: All places of employment, passageways, storerooms and service areas must be kept clean and orderly and in a sanitary condition.

f. Physical Patient Care Area: Floor must be kept clean and dry. The cleaning in rooms and / or areas where blood or OPIM may be present must be as frequent as necessary to maintain a decontaminated status, giving due regard to the amount and type of contaminants present.

H. Hygiene

1. SVMC shall provide handwashing facilities that are readily accessible to employees.

2. When provision of handwashing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser (or alcohol-based hand sanitizer) in

conjunction with clean paper towels or antiseptic towelettes. When antiseptic hand cleaners or towelettes are used, hands shall be washed with soap and running water as soon as is feasible.

SVMC shall educate employees to wash their hands immediately or as soon as feasible after removal of gloves or OPIM.

3. SVMC shall educate employees to wash hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious material.

I. Laundry

1. Contaminated laundry shall be handled as little as possible with a minimum of agitation.

2. Whenever contaminated laundry is wet and presents a reasonable likelihood of soaking through or leakage when bundled, gloves should be worn and it should be transported in a manner which prevents soak-through, leakage of fluids to the exterior or contamination of the environment.

3. In keeping with Universal / Standard Precautions, all linen will be handled in the same manner as if potentially infectious.

INDIVIDUALS COVERED BY THE PLAN

The Exposure Control Plan practiced at SVMC applies to the following health care providers:

- Full-time, part-time, contract and temporary employees (nursing personnel, medical staff, and support staff) who have direct contact or whose duties are likely to bring them in contact with blood or body fluids of patients or patient specimens.
- Students and trainees, including those from health professional schools; students from other programs; institutions or universities; and post-graduate trainees with clinical responsibilities.
- Volunteers.
- Research personnel whose duties include processing specimens of human blood or body fluids.

TRAINING DOCUMENTATION

All high risk healthcare workers must receive education about precautionary measures, epidemiology, modes of transmission and prevention of HIV/HBV/HCV, and other associated infectious agents. SVMC provides this education at New Hire Orientation, during Annual Orientation, and when deemed necessary.

Training regarding the location and proper use of personal protective equipment, safe work practices, Standard / Universal Precautions, tagging, housekeeping to prevent contamination and needle stick or body fluid exposure procedures must also be carried out.

Training is a continuous responsibility and will occur formally on-hire and annually thereafter as well as informally during the work day with special instructions in certain situations or special departmental in service gatherings (5-minute huddles, etc.). Documentation of training will be maintained by the Staff Development Department.

All regulatory agencies (OSHA, The Joint Commission, Title 22) require documentation of and maintenance of orientation and annual training records related to Infection Control, Standard / Universal Precautions and OSHA Regulations. OSHA standards are the most specific and include the main elements required by The Joint Commission and Title 22. A plan for recordkeeping that will be maintained by the agency for five (5) years and shall include as a minimum, the following information:

- The dates of the training sessions.
- The contents of a summary of the training sessions.
- The names of the persons conducting the training.
- The names of all persons attending the training sessions.

A mechanism for maintaining records of rotation individuals shall be established by the primary educational facility, i.e., records of nursing students are maintained by their school.

All records are available to the employee, his representative, representatives from OSHA or other accrediting bodies.

IDENTIFICATION OF WORKERS "WHOSE REASONABLY ANTICIPATED DUTIES" MAY RESULT IN EXPOSURE TO BLOODBORNE PATHOGENS

RISK EXPOSURE CATEGORIES

Category 1:	HIGH RISK – Individuals whose duties are likely to bring them in contact with blood or OPIM.
Category 2:	LOW RISK – Individuals whose duties are not likely to bring them in contact with blood or OPIM.
Category 3:	NO RISK – Individuals whose duties do not bring them in contact with blood or OPIM.

All positions within the hospital which have direct patient care contact which may involve exposure to blood or OPIM or involve transportation of infectious waste or laboratory specimens have been designated to be "high risk".

Positions, which have direct patient care contact that is not likely to involve exposure to blood or body fluids such as social services, have been designated as "low risk".

Administrative personnel and clerical support personnel, who have no direct patient care contact, have been designated as "no risk".

Administration – All positions	Category 3
Biomedical – All positions	Category 2
Cardiopulmonary Services – All positions	Category 1
Central Processing – All positions	Category 1
Communications – All positions	Category 3
Data Processing – All positions	Category 3
Dietary – All positions	Category 3
Employee Health Services	
All positions	Category 1
Financial Services	
All positions	Category 3
Housekeeping	
Manager	Category 3
All other positions	Category 1
Human Resources	
All positions	Category 3
Infection Control	Category 1

Laboratory	
Manager	Category 2
All other positions	Category 1
Laundry	
All positions	Category 1
Maintenance/Facilities	
Clerk	Category 3
All other positions	Category 2
Materials Management	
All positions	Category 3
Medical Records	
All positions	Category 3
Medical Staff Services	
Medical Director	Category 2
All other positions	Category 3
Medical Staff	
All positions	Category 1
Nursing Services	
Nursing Service Administration	Category 1
Administrative Manager	Category 1
Clinical Manager	Category 1
Clerks	Category 2
RN	Category 1
LVN	Category 1
CNA	Category 1
All other positions	Category 1

Outpatient Services	
Clerk	Category 2
All other positions	Category 1
Patient Accounting – All positions	Category 3
Pharmacy – All positions	Category 3
Physical Therapy – All positions	Category 2
Quality Management – All positions	Category 3
Radiology (including Nuclear Medicine)	
Manager	Category 2
All other positions	Category 1
Risk Management – All positions	Category 3
Social Services – All positions	Category 2
Staff Development	
Clinical Instructor, R.N.	Category 2
Clerk	Category 3
Utilization Review / Case Management – All positions	Category 3
Volunteer Services	
Those with patient contact or potential exposure to blood or other potentially infectious materials	Category 2
All other positions	Category 3

NOTE: HOUSE-WIDE POLICY:

- An employee with a draining skin lesion shall not work in direct patient care requiring physical contact.
- Non-intact skin or hands or forearms (i.e., a cut, abrasion, dry skin lesions) shall be covered with an appropriate barrier.

- Each specialty department may have additional guidelines based upon the type of activities performed. For detailed guidance, see Departmental Specific Infection Prevention Policies and Procedures.

REFERENCES:

- California Code of Regulations, Title 22 – Social Security, Division 5 – Licensing and Certification of Health Facilities. Chapter 1 General Acute Care Hospitals, Article 7. ***Cal. Code Regs. Tit. 22, § 70739 - Infection Control Program***. Accessed 10 February 2026. https://www.law.cornell.edu/regulations/california/22-CCR-70739

- California Code of Regulations, Title 8, Section 5193 - Industrial Relations, Records on Training and Transfer of Training Records. Subchapter 7 General Industry Safety Orders. *Title 8, CCR § 5193 Handling of Blood.* Accessed 10 February 2026.https://www.dir.ca.gov/title8/5193.html

- Needlestick and Sharps Injuries Among Healthcare Workers at a Tertiary Care Hospital: A Retrospective Single-Center Study. National Library of Medicine. 2023, Nov 6. Accessed June 2025 https://pmc.ncbi.nlm.nih.gov/articles/PMC10637236/

- *Occupational Safety and Health Administration (OSHA). Code of Federal Regulations, 29 CFR 1910.1030 – Bloodborne Pathogens.* Accessed 10 February 2026.*https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030*

- Occupational Safety and Health Administration (OSHA). Federal Registers Hazard Communication Standard Publication. Accessed 10 February 2026. https://www.osha.gov/hazcom

CROSS REFERENCES:

- HANDWASHING
- BLOODBORNE PATHOGEN EXPOSURE PROTOCOL FOR HEALTHCARE WORKERS
- ANNUAL INFECTION PREVENTION PLAN

SUBJECT: **GASTRIC ASPIRATE COLLECTION FOR TB**	SECTION:

PURPOSE:

Outlines nursing responsibility in collection of gastric aspirate for the diagnosis of tuberculosis.

POLICY:

Gastric aspirates are performed only by licensed staff that have successfully completed and demonstrated competency. Specimen is collected from young children suspected of having pulmonary tuberculosis. Gastric aspirate are used for collection of mycobacterial cultures in young children when sputum cannot be spontaneously expectorated nor induced by hypertonic saline. During sleep, the lungs' mucocillary system beats mucus into the throat. The mucus is swallowed and remains in the stomach until it empties. Therefore, the highest yield specimens are obtained first thing in the morning. Three gastric aspirate specimens are obtained for three consecutive mornings and sent to the lab for processing with an appropriate doctors order.

AFFECTED AREAS/ PERSONNEL: *RN AND LVNS*

DEFINITIONS:

- Lavage: The therapeutic washing out of an organ or body part.

PROCEDURE:

EQUIPMENT

1. A large bore, double lumen gastric tube, Lavacuator or regular 8 or 10 gastric tube may be used.
2. Sterile water
3. Wall suction set-up.
4. Two 60ml cath tip syringes
5. Sterile specimen cup
6. Emesis Basin
7. Absorbent towels, wash cloths, and chux
8. Tape, securement device
9. Personal protective devices including a N95 mask.

SUBJECT: **GASTRIC ASPIRATE COLLECTION FOR TB**	SECTION:

PROCESS

All specimen collection are preceded be proper patient identification, order verification label verification, knowledge of specimen requirements for tests ordered and observance of isolation precautions required. Have patient remain still. If it is a young child, immobilize with a sheet or papoose board, if necessary.

1. Gather all equipment.

2. Prepare patient.

   a. Patient shall be NPO after midnight.

   b. The procedure should occur first thing in the morning, when child awakens.

   c. Explain the procedure to the patient and parent/care provider. Explain that the procedure is brief, uncomfortable, but is necessary to obtain clinical results.

3. Perform hand hygiene.

4. Don protective eye wear, clean gloves, gown and N95 mask.

   Key points: Protects the caregiver from contaminates and infectious materials.

5. Remove dental appliances and inspect oral cavity for loose teeth.

6. Place gastric tube per enternal tube policy.

7. Verify with physician if chest x-ray is warranted and if so, obtain.

8. If chest x-ray is not warranted, then verify placement with auscultation of a popping sound over the stomach by stethoscope of an injected air bolus of 2-5 ml.

9. Once gastric tube is in place, aspirate gastric contents. The specimen size should be 5 to 10 mls of gastric contents. If unable to aspirate 5 to 10 mls try to reposition the NG tube and or the patient (side to side) and aspirate again.

10. If unable to obtain 5 to 10 mls of gastric contents, prepare to instill water into the tube.

    - Recheck tube placement.
    - Fill a cath tip syringe with 10ml room temperature sterile water.

      Key point: Using room temperature water will prevent rapid temperature changes and prevent discomfort to the patient.

    - Instill 20 – 30ml of the room temperature solution.

- The solution should then be quickly aspirated. If unable to aspirate the needed quantity of gastric contents, reposition the tube and/or the patient and reaspirate.
- If you are able to obtain the 5 – 10 mls of gastric contents, place contents in sterile specimen container and label appropriately for the lab.
- Immediately transport the specimen to lab to neutralize the specimen.

11. Removal of the gastric tube: Pinch the tube lightly and then gently and quickly, in one continuous motion, pull the tube out of the nare.

Key point: Pinching the tube prevents aspiration.

ONGOING ASSESSMENT TO INCLUDE:

- Airway
- Breathing
- Circulation
- Abdomen for signs of distention, discomfort, or rigidity.
- Amount, characteristics, and color of gastric contents.
- For absence of pain.
- Vital Signs

REPORTABLE CONDITIONS:

Notify the physician with

- Changes in vital signs
- Nausea or vomiting

EDUCATION:

Inform the patient and family that this is an uncomfortable procedure but must be done to help with the diagnosis of the patient's illness.

DOCUMENTATION:

- Time of the lavage
- Tube placement, including size and route.
- Amount of irrigating solution instilled.
- Characteristics of gastric return/amount.
- Patient's tolerance of procedure.
- Amount of specimen sent to the lab.

REFERENCES:

- World Health Organization. (2022). WHO consolidated guidelines on tuberculosis. Module 3: Diagnosis – Rapid diagnostics for tuberculosis detection (2022 update). https://www.who.int/publications/i/item/9789240046764
- World Health Organization. (2023). WHO operational handbook on tuberculosis. Module 3: Diagnosis – Rapid diagnostics for tuberculosis detection (2023 update). https://www.who.int/publications/i/item/9789240077430
- Venturini, E., Montagnani, C., Chiappini, E., & Galli, L. (2024). Does multiple gastric aspirate collection increase sensitivity in microbiological confirmation of childhood pulmonary tuberculosis? European Journal of Pediatrics, 183(2), 601–608. https://doi.org/10.1007/s00431-023-05266-1
- Klinkenberg, E., et al. (2025). Implementation of stool Xpert MTB/RIF testing for childhood tuberculosis diagnosis. Emerging Infectious Diseases, 31(3). https://doi.org/10.3201/eid3103.241580
- Mwanza, J., et al. (2025). Routine implementation of stool Xpert MTB/RIF Ultra testing for diagnosis of tuberculosis in children. The International Journal of Tuberculosis and Lung Disease, 29(1), 45–52. https://doi.org/10.5588/ijtld.24.0398
- Centers for Medicare & Medicaid Services Conditions of Participation, §482.23, Nursing Services.
- California Health & Safety Code, Division 2. Licensing Provisions, Chapter 2. Health Facilities, Article 3. Regulations, Section 127.1(b).

SUBJECT:	SECTION:
INTRA-AORTIC BALLOON PUMP THERAPY	***Patient Care Services***

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

PURPOSE:

To provide safety guidelines for staff caring for patient with a requiring counter pulsation by Intra-Aortic Balloon Pump (IABP).

DEFINITIONS:

Intra-Aortic Balloon Therapy (IABP): A cardiac assist device consisting of an invasively placed balloon catheter (IABP) attached to a bedside pump console that controls balloon inflation and deflation. Inflation/deflation is timed to the cardiac cycle. The therapy is designed to increase coronary perfusion and decrease myocardial oxygen consumption.

Critical Care Registered Nurse define in this policy: A registered nurse competent in intensive care management with specific competency in IABP management. These RN's include the ICU and Cardiovascular Cath Lab.

POLICY:

A. Only IABP patients with catheter placed for augmentation will be consider for admission to ICU patients. Patients with high potential for cardiac surgery need should not be admitted but transferred to a higher level of care.
    a. **Indications but not limited to the following:**
        i. Refractory unstable angina.
        ii. Impending myocardial infarction (MI).
        iii. Acute MI with mechanical impairment as a result of mitral regurgitation, ventricular septal defect, papillary muscle dysfunction
        iv. Intractable ventricular tachycardia as a result of myocardial ischemia.
        v. Refractory ventricular arrhythmias.
        vi. Cardiogenic shock.
        vii. Support for diagnostic percutaneous revascularization and interventional procedures.
        viii. Emergency support following PTCA or high-risk percutaneous coronary interventions.
    b. **Contraindications but not limited to the following:**
        i. Severe Aortic Insufficiency.
        ii. Thoracic and abdominal aortic aneurysms.
        iii. Severe calcific aorta-iliac disease or peripheral vascular disease.
        iv. Prosthetic graft in thoracic aorta.
B. The patient with an IABP will be cared for by a critical nurse as defined by this policy. The patient will be considered high acuity and receive 1:1 nurse to patient ratio as needed by a nurse who has IABP competency.
C. Revalidation of IABP knowledge and skills will be done annually.
D. IABP will be inserted in the cardiac cath-lab and stabilized for transport before transferring to the ICU.
E. Cardiovascular Cath Lab will serve as a resource to the ICU until the catheter is removed. *(Cath Lab leadership will make every attempt to have someone on call after hours to assist if needed)*

AFFECTED PERSONNEL/AREAS: *CARDIAC CATHETERIZATION LABORATORY (CCL) AND INTENSIVE CARE UNIT (ICU)*

EQUIPMENT:

- IABP, helium gas supply.
- ECG and arterial pressure monitoring supplies.
- Single-Pressure transducer system.
- Emergency equipment available for immediate use.

PROCEDURE:

A. Before transfer to ICU: Counter pulsation should began immediately after insertion and verification by X- ray in the procedure room

B. Review manufacture manual for IABP equipment use which is kept attached to the IABP machine.

C. Keep limb straight to not kink tubing, use log roll technique to maintain straight limb

D. Head of bed should be kept 30-45 degrees to avoid aspiration and prevent upward migration of catheter

E. Perform a baseline physical assessment this should include all items that are included in the maintenance monitoring section of this policy:

F. **Maintenance Monitoring**

a. Assessment of circulation, including capillary refill on pedal and left radial pulses. This should be done every 15 minutes for the first hour then hourly. *(The IABP or thrombus can obstruct flow to distal extremities; if the catheter migrates to high, it can obstruct flow to the left subclavian artery.)*

b. Monitor blood pressure and MAP during counter pulsation every hour and every 15 minutes during vasoactive drip titration

c. Presence of dorsalis pedialis posterior tibial pulses (these can be marked with indelible ink to facilitate checks) Distal pulses should be checked every 15-30 minutes for the first 6 hours then hourly with VS to monitor for limb ischemia.

d. Monitor Vital Signs (VS) every 15-30 minutes for the first 6 hours then hourly until catheter is removed.

e. Arterial balloon pressure and cardiac output index every hour (can use NICOM for continuous value recording)

f. Neurological checks every hour

g. Urine output every hour

h. Insertion site and dressing evaluation, every hour for 8 hours then every 4 hours monitoring for oozing and hematoma. *(if abnormal finding contact provider immediately)*

i. Palpate extremity with regular physical assessment to monitor for swelling and tension every 4 hours

j. Auscultate bowel sounds every 4 hours with regular physical assessment to detect evidence ischemia

k. Ankle brachial index (ABI) every 4 hours

l. ECG and IABP waveform every 4 hours and prn, print and place strip in the patient chart

m. Observe skin temperature color, sensation, and movement of extremity *(notify provider if dusky, cool, mottled, painful, numb or tingling)*
n. Strict and accurate intake and output daily
o. Monitor weight daily

G. **Ankle Brachial Index (ABI):**
a. Obtain a brachial systolic pressure
b. Record the highest pressure as the "B" brachial pressure
c. Place the blood pressure cuff on the ankle same side at the IABP catheter
d. Using a Doppler find the posterior tibial artery or dorsalis pedis, inflate cuff and listen for the first sound record this as "A" systolic ankle pressure
e. Then divide the "A" ankle by "B" brachial
Example: ankle systolic pressure= 110
Brachial systolic pressure =140
110 divided by 140= .78= 78% flow

(Normal ABI is 097-100%) nursing should contact physician if ABI is below 60% or if patient has signs of vascular compromise

f. **Interpreting Result:** greater than 1.3 results may not be reliable because of calcified vessels such as someone with diabetes, this will show falsely elevated pressures.
1.01 to 1.3: correlate with history
0.97 to 1 normal
0.8 to 0.96 mild ischemia
0.4 to .079 moderate to severe ischemia
0.39 or less severe ischemia in danger of limb loss

H. **Trouble Shooting:**
a. Suspected Balloon Pump leak:
*Observe for loss of augmentation or lack of normal pressure waveform (gas could be gradually leaking from the balloon)
*Check for blood in the catheter or connecting tubing.
* Notify physician, you may need to stop counter pulsation. Prepare for removal of IABP
b. **Actual Balloon perforation (blood in catheter)**
*place IABP on standby
*Clamp catheter
*Disconnect the catheter from the IABP console
*Notify physician and prepare for removal/replacement
c. ALARMS:
* Refer to Operators Manuel

REFERENCES:

- Johnson, K. L. (2024). AACN Procedure Manual for High Acuity, Progressive, and Critical Care. 8th edition. St. Louis: Elsevier.
- Maquet Getinge Group. (2018, December). Mechanisms of Counterpulsation Clinical Support Manual. Wayne, New Jersey, United States of America: Datascop Corp.
- Nettina, S. M., & Nelson-Tuttle, C. (2024). Lippincott manual of nursing practice (12th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins. ISBN 9781975219673

CROSS REFERENCES:

- Intra-Aortic Balloon Pump (IABP) Management

SUBJECT:	SECTION:
INTRAVENOUS THERAPY	***Medication Management (MM)*** **Page 1 of 4**

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

PURPOSE:

To define standards for the practice of Intravenous (IV) Therapy.

POLICY:

1. RNs and California IV Certified LVNs may perform IV therapy.

2. A physician's order is required to initiate an IV/Saline lock. An RN or LVN may start an IV without a physician's order in an emergency situation in order to administer appropriate IV therapy.

3. Standard Precautions will be observed at all times.

4. Veins in the upper extremities should be used for IV infusion. A physician's order is required to use veins in the lower extremities, except in infants. Lower extremities are not recommended for patients with diabetes or peripheral vascular disease.

5. Scalp veins may be used for infants age 6 months or less. A physician's order is required to use scalp veins.

6. Peripheral IV sites will be monitored once a shift and each time the site is used for medication, fluid infusion and/or routine flushes for adult and geriatric patients. When infusing vesicant solutions/medications, the IV site should be monitored more frequently for signs and symptoms of extravasation.

7. Assess and document the condition of the IV site every one (1) hour for pediatric (13 years of age and younger) and neonatal patients.

8. Peripheral IV sites and dressing will be changed as needed per the nurse's discretion. IV sites will be changed if any signs or symptoms of inflammation, swelling, or infiltration are noted.

9. Primary IV tubing and IVPB tubing will be changed every 72 hours. Tubing will be labeled with date, time and initials when hung. Tubing from primary and IVPB must maintain a closed system. Tubing must be changed upon suspecting contamination or when integrity of product or system has been compromised.

10. IV bags, bottles and TPN solutions will be changed every 24 hours. IV Fat Emulsion (IFE) tubing will be changed after every bottle of IFE. The time that the bag is hung and any rate changes will be documented on the designated documentation forms.

11. Infusion pumps are required on all primary and secondary IVs.

    a. *Buretrol's should be used for all pediatric patient (0-13 years).*

12. No more than two (2) unsuccessful IV insertion attempts will be made prior to seeking assistance from another nurse or physician.

13. Transparent occlusive dressings will be used on all peripheral IV sites.

    EXCEPTION: Flex Care

14. **Keep Vein Open (KVO) Orders** – IV orders to "TKO" (To Keep Open) or "KVO" (Keep Vein Open) are, by definition, orders to maintain a patent IV site, and are non-specific as to IV solution or rate.

15. **Minimum IV Rate/Electrolyte-Containing Solutions** – Orders for standard IV solutions running at a rate slower than one bag per day **will NOT** contain electrolyte or vitamin additives.

    NOTE: *Maintenance dosages of electrolytes and vitamins are NOT considered medications.*

AFFECTED AREAS/PERSONNEL: *ALL RNs AND LVNs*

PROCEDURE:

SCOPE OF PRACTICE:

Registered Nurse (RN)

The RN shall be responsible for the overall initiation, maintenance, assessment, and documentation of all aspects of IV therapy. This includes the supervision and delegation of tasks performed by the LVN.

Licensed Vocational Nurse (LVN)

The LVN scope of practice at Sierra View Medical Center (SVMC) is limited to the following peripheral IV therapy skills:

1. Initiate venipuncture

2. Prepare, initiate, superimpose, regulate and discontinue the following:

   a. IV solutions without additives

   b. IV solutions containing maintenance dosages of electrolytes or vitamins.

3. Perform dressing and tubing changes.

4. Initiate and superimpose peripheral TPN without medication additives.

5. Flush a saline lock with 3-5 ml normal saline.

6. Convert a peripheral IV to a saline lock.

7. Witness, hang, regulate and discontinue blood products.

8. Observation and documentation of IV site.

9. Documentation of therapy performed.

10. Calculation and documentation of IV fluid intake.

The following are NOT included in the LVN Scope of Practice at SVMC:

- Initiate or superimpose an IV solution containing a medication.
- Add medication(s) to an IV solution.
- Administer IV Push (IVP) medications.
- Administer IV Piggyback (IVPB's) medication.
- Perform blood withdrawals from central lines.
- Perform any IV therapy with central lines.

Procedure/Documentation:

Refer to Lippincott Manual of Nursing Practice

KEEP VEIN OPEN (KVO) ORDERS

1. Existing IV solution hanging:

    a. Reduce existing IV to a rate of 20ml/hr for adult patients and at ordered rate for pediatric/neonatal patients.

    b. Run until IV runs out or IV has been hanging for 24 hours, whichever occurs first.

    c. Hang a smaller volume IV bag if available for the same ordered solution.

    d. IV solutions running at KVO must be reflected on the doctors orders with the type of solution and documented on the medication administration record (MAR)

2. IV LOCK ORDERS

    a. Insert saline lock.

b. Irrigate with 0.9% sodium chloride a minimum of every (8) hours and before and after every access.

REFERENCES

- Nettina, S. M., & Nelson-Tuttle, C. (2024). *Lippincott manual of nursing practice* (12th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins. ISBN 9781975219673.

SUBJECT:	SECTION:
MEDICATION ALLERGIES AND ADVERSE REACTIONS	***Medication Management (MM)*** **Page 1 of 6**

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

PURPOSE:

To promote the development of a robust patient medication allergy and adverse reaction record in the electronic medical record (EMR). As well as, to provide guidance to the interdisciplinary team responsible for administering a potential allergen or adverse reactant, and provide preparation to respond to potential anaphylaxis.

DEFINITIONS:

1. **Drug allergy** — A drug allergy is an adverse drug reaction that is caused by an immunologic reaction elicited by a drug. Immunologic drug reactions are divided into four categories according to the Gell and Coombs system.

Gell and Coombs classification of immunologic drug reactions

Type	Description	Mechanism	Clinical features
I Immediate reaction (within one hour)	IgE-mediated, immediate-type hypersensitivity	Antigen exposure causes IgE-mediated activation of mast cells and basophils, with release of vasoactive substances, such as histamine, prostaglandins, and leukotrienes.	Anaphylaxis Angioedema Bronchospasm Urticaria (hives) Hypotension
II	Antibody-dependent cytotoxicity	An antigen or hapten that is intimately associated with a cell binds to antibody, leading to cell or tissue injury.	Hemolytic anemia Thrombocytopenia Neutropenia
III	Immune complex disease	Damage is caused by formation or deposition of antigen-antibody complexes in vessels or tissue. Deposition of immune complexes causes complement activation and/or recruitment of neutrophils by interaction of immune complexes with Fc IgG receptors.	Serum sickness Arthus reaction
IV	Cell-mediated or delayed hypersensitivity	Antigen exposure activates T cells, which then mediate tissue injury. Depending upon the type of T cell activation and the other effector cells recruited, different subtypes can be differentiated (ie, types IVa to IVd).	Contact dermatitis, Some morbilliform reactions Severe exfoliative dermatoses (eg, SJS/TEN) AGEP DRESS/DiHS Interstitial nephritis Drug-induced hepatitis Other presentations

IgE: immunoglobulin E; Fc IgG: Fc portion of immunoglobulin G; SJS/TEN: Stevens-Johnson syndrome/toxic epidermal necrolysis; AGEP: acute-generalized exanthematous pustulosis; DRESS/DiHS: drug rash with eosinophilia and systemic symptoms/drug-induced hypersensitivity syndrome.

Adapted from: Weiss ME, Adkinson NF. Immediate hypersensitivity reactions to penicillin and related antibiotics. Clin Allergy 1988; 18:515.

2. The World Allergy Organization (WAO) has recommended dividing immunologic drug reactions into two types:

   - Immediate reactions, occurring within one hour of the first administered dose.

- Delayed reactions, occurring after one hour, but usually more than six hours and occasionally weeks to months after the start of administration.

POLICY:

A. Developing A Detailed Patient Allergy and Adverse Reaction History in the EMR:

1. In order to promote safe and judicious prescribing throughout the organization all direct patient care staff are encourage to consistently question new patients about their medication allergy and adverse reaction history. Furthermore, all direct patient care staff are encouraged to document all new information, in adequate detail, into the patient's EMR.

    a. The house wide procedure for this practice is outlined in the Patient Care Services Policy ALLERGY DOCUMENTATION/ COMMUNICATION

B. Providing the RN with Guidance When Asked to Administer a Medication That is a Potential Allergen or Adverse Reactant:

1. Multiple members of the interdisciplinary team, including but not limited to physicians, RNs and pharmacists are to discuss the potential benefits and harms of administering a potential allergen.

2. If the medication is determined to possess more benefit than harm, and then therefore will be administered, then the interdisciplinary staff will be prepared to respond to an adverse reaction.

AFFECTED PERSONNEL/AREAS: *ALL DIRECT PATIENT CARE PERSONNEL*

EQUIPMENT:

- Medications such as: (Epinephrine 1mg/mL, Diphenhydramine 50mg/mL, Hydrocortisone 100mg/mL)

PROCEDURE:

A. Developing A Detailed Patient Allergy and Adverse Reaction History in the EMR:

1. Please refer to the Patient Care Services Policy ALLERGY DOCUMENTATION/ COMMUNICATION.

B. In the event that the RN is asked by the prescribing Physician to administer a medication in which the patient has a listed allergy or past adverse reaction:

1. The RN is to first call the Physician and alert them of the information regarding the allergy or adverse reaction in the EMR.

2. If the Physician would like to proceed with administration, a discussion with the Pharmacist regarding nature of the reaction, likelihood of adverse reaction, potential alternatives.

3. If potential allergen is determined to possess more benefit than harm, then medications (Epinephrine 1mg/mL, Diphenhydramine 50mg/mL, Hydrocortisone 100mg/mL) should be on hand and ready for use if needed as determined by the provider, and the prescribing physician should be either present for the next 30 minutes or immediately available by telephone. The patient's Physician will determine further treatment of anaphylaxis.

C. Treatment of Anaphylaxis:

1. Patients with anaphylaxis should be assessed and treated as rapidly as possible, as respiratory or cardiac arrest and death can occur within minutes. Anaphylaxis appears to be most responsive to treatment in its early phases, before shock has developed, based on the observation that delayed epinephrine injection is associated with fatalities.

2. *Epinephrine is life-saving in anaphylaxis. It should be injected as early as possible in the episode in order to prevent progression of symptoms and signs.* There are no absolute contraindications to epinephrine use, and it is the treatment of choice for anaphylaxis of any severity. Epinephrine use is recommended for patients with apparently mild symptoms and signs (e.g., a few hives and mild wheezing), as well as for patients with moderate-to-severe symptoms and signs.

3. The route of epinephrine administration depends upon the presenting symptoms. For patients who are not profoundly hypotensive or in shock or cardiorespiratory arrest, intramuscular (IM) injection into the mid-outer thigh as the initial route of administration is advised, in preference to subcutaneous administration or intravenous (IV) administration.

4. All adverse events when be documented in the organization's QAPI software by either the RN, Pharmacist, or Risk representative.

5. Immediate Management for Adults: (see graphic on page 4)

6. Immediate Management for Infants and Children: (see graphic on page 5)

Anaphylaxis in adults: Rapid overview of emergency management

Diagnosis is made clinically:

The most common signs and symptoms are cutaneous (eg, sudden onset of generalized urticaria, angioedema, flushing, pruritus). However, 10 to 20% of patients have no skin findings.

Danger signs – Rapid progression of symptoms, respiratory distress (eg, stridor, wheezing, dyspnea, increased work of breathing, persistent cough, cyanosis), vomiting, abdominal pain, hypotension, dysrhythmia, chest pain, collapse.

Acute management:

The first and most important treatment in anaphylaxis is epinephrine. There are **NO absolute contraindications to epinephrine** in the setting of anaphylaxis. Epinephrine is given immediately upon recognition of anaphylaxis.

Airway - Early intubation if evidence of impending airway obstruction from angioedema. Delay may lead to complete obstruction. Intubation can be difficult and should be performed by the most experienced clinician available. Cricothyrotomy may be necessary.

Monitoring - Continuous noninvasive hemodynamic monitoring and pulse oximetry monitoring should be performed.

Promptly and simultaneously, give:

IM epinephrine (1 mg/mL preparation) - Give epinephrine 0.3 to 0.5 mg IM in the mid-outer thigh. Can repeat every 5 minutes (or more frequently), as needed. If epinephrine is injected promptly IM, most patients respond to 1, 2, or at most, 3 doses. If symptoms are not responding to epinephrine injections, prepare IV epinephrine for infusion (refer to below).

If hypotensive, place patient in recumbent position, if tolerated, and elevate lower extremities.

Oxygen - Give with nonrebreather mask at 15 liters/minute flow rate or commercial high-flow oxygen masks (providing at least 70% and up to 100% oxygen), as needed.

Crystalloid (eg, Ringer's lactate or normal saline) rapid bolus - Establish two large-bore IV lines. Treat hypotension with rapid infusion of 1 to 2 liters IV. Repeat, as needed. Massive fluid shifts with severe loss of intravascular volume can occur. Monitor urine output.

Albuterol - For bronchospasm resistant to IM epinephrine, give 2.5 to 5 mg in 3 mL saline via nebulizer, or 2 to 3 puffs by metered dose inhaler. Repeat, as needed.

Adjunctive therapies (for residual symptoms after adequate response to epinephrine):

H1 antihistamine* - For residual itching or urticaria, give cetirizine (preferred) 10 mg IV (given over 2 minutes) or diphenhydramine 25 to 50 mg IV (given over 5 minutes).

H2 antihistamine* - For residual itching or urticaria, may give famotidine 20 mg IV (given over 2 minutes).

Glucocorticoid* - For residual bronchospasm and for patients requiring more than 2 doses of IM epinephrine or IV epinephrine, give methylprednisolone 80 to 125 mg IV or prednisone 40 to 60 mg orally.

Treatment of refractory symptoms:

Epinephrine infusion¶ - For patients with inadequate response to IM epinephrine and IV saline, give epinephrine continuous infusion, beginning at **0.1 microgram/kg/minute** by infusion pumpΔ. Titrate the dose continuously according to blood pressure, cardiac rate and function, and oxygenation.

Vasopressors¶ - Some patients may require a second vasopressor (in addition to epinephrine). All vasopressors should be given by infusion pump, with the doses titrated continuously according to blood pressure and cardiac rate/function and oxygenation monitored by pulse oximetry.

Glucagon - Patients on beta blockers may not respond to epinephrine and can be given glucagon 1 to 5 mg IV over 5 minutes, followed by infusion of 5 to 15 micrograms/minute. Rapid administration of glucagon can cause vomiting.

Methylene blue - Single bolus of 1 to 2 mg/kg given over 20 to 60 minutes may improve vasoplegia.

Extracorporeal membrane oxygenation (ECMO) - Early consultation with ECMO team, if available, for patients unresponsive to complete resuscitative efforts.

Instructions on how to prepare and administer epinephrine for IV continuous infusions are available as separate tables in UpToDate.

IM: intramuscular; IV: intravenous.

* These medications should not be used as initial or sole treatment.

¶ All patients receiving an infusion of epinephrine and another vasopressor require continuous noninvasive monitoring of blood pressure, heart rate and function, and oxygen saturation.

Δ For example, the initial infusion rate for a 70 kg patient would be 7 micrograms/minute. This is consistent with the recommended range for non-weight-based dosing for adults, which is 2 to 10 micrograms/minute. Non-weight-based dosing can be used if the patient's weight is not known and cannot be estimated.

Anaphylaxis in infants and children: Rapid overview of emergency management[*]

Diagnosis is made clinically:

The most common signs and symptoms are cutaneous (eg, sudden onset of generalized urticaria, angioedema, flushing, pruritus). However, 10 to 20% of patients have no skin findings.

Danger signs – **Rapid progression of symptoms, evidence of respiratory distress (eg, stridor, wheezing, dyspnea, increased work of breathing, retractions, persistent cough, cyanosis), signs of poor perfusion, abdominal pain, vomiting, dysrhythmia, hypotension, collapse.**

Monitoring – Continuous noninvasive hemodynamic monitoring and pulse oximetry monitoring should be performed.

Acute management:

The first and most important therapy in anaphylaxis is epinephrine. There are **NO absolute contraindications to epinephrine** in the setting of anaphylaxis. Epinephrine is given immediately upon recognition of anaphylaxis.

Airway – Early intubation if evidence of impending airway obstruction from angioedema. Delay may lead to complete obstruction. Intubation can be difficult and should be performed by the most experienced clinician available. Cricothyrotomy may be necessary.

IM epinephrine (1 mg/mL preparation) – Epinephrine 0.01 mg/kg should be injected IM in the mid-outer thigh. For large children (>50 kg), the maximum is 0.5 mg per dose. If there is no response or the response is inadequate, the injection can be repeated in 5 minutes (or more frequently). If epinephrine is injected promptly IM, patients respond to 1, 2, or, at most, 3 injections. If signs of poor perfusion are present or symptoms are not responding to epinephrine injections, prepare IV epinephrine for infusion (refer to below).

If hypotensive, place patient in recumbent position, if tolerated, and elevate lower extremities.

Oxygen – Give using a nonrebreather mask at 15 liters/minute flow rate or commercial high-flow oxygen masks (providing at least 70% and up to 100% oxygen), as needed.

Crystalloid (eg, Ringer's lactate or normal saline) rapid bolus – Establish 2 large-bore IV lines. Treat poor perfusion with rapid infusion of 20 mL/kg. Reevaluate and repeat fluid boluses (20 mL/kg), as needed. Massive fluid shifts with severe loss of intravascular volume can occur. Monitor urine output.

Albuterol – For bronchospasm resistant to IM epinephrine, give albuterol 2.5 mg inhaled via nebulizer. Dilute in saline if using a concentrated albuterol solution (≥0.5%). Repeat, as needed.

Adjunctive therapies (for residual symptoms after adequate response to epinephrine):

H1 antihistamine – For residual itching or urticaria, give cetirizine (preferred; children aged 6 months to 5 years can receive 2.5 mg IV, those 6 to 11 years of age can receive 5 or 10 mg IV, over 2 minutes) or diphenhydramine 1 mg/kg (maximum 50 mg IV, over 5 minutes).

H2 antihistamine – For residual itching or urticaria, may give famotidine 0.25 mg/kg (maximum 20 mg) IV, over at least 2 minutes.

Glucocorticoid – For residual bronchospasm or for patients requiring more than 2 doses of IM or IV epinephrine, give methylprednisolone 1 to 2 mg/kg (maximum 125 mg) IV or prednisolone 1 to 2 mg/kg, maximum 60 mg orally.

Treatment of refractory symptoms:

Epinephrine infusion[¶] – In patients with inadequate response to IM epinephrine and IV saline, give epinephrine continuous infusion at 0.1 to 1 microgram/kg/minute, titrated to effect.

Vasopressors[¶] – Patients may require large amounts of IV crystalloid to maintain blood pressure. Some patients may require a second vasopressor (in addition to epinephrine). All vasopressors should be given by infusion pump, with the doses titrated continuously according to blood pressure and cardiac rate/function monitored continuously and oxygenation monitored by pulse oximetry.

Glucagon – Patients on beta blockers may not respond to epinephrine and can be given glucagon 20 to 30 micrograms/kg (maximum 1 mg) IV over 5 minutes. Rapid administration of glucagon can cause vomiting.

Methylene blue – Single bolus of 1 to 2 mg/kg given over 20 to 60 minutes may improve vasoplegia.

Extracorporeal membrane oxygenation (ECMO) – Early consultation with ECMO team, if available, for patients unresponsive to complete resuscitative efforts.

REFERENCES:

- Campbell MD, Kelso MD. Anaphylaxis: Emergency Treatment. https://www.uptodate.com/contents/anaphylaxis-emergency-treatment?search=allergy%20reaction&topicRef=2079&source=related_link#H23 (Accessed on January 7, 2026).
- Pichler MD. An Approach to the Patient with Drug Allergy. https://www.uptodate.com/contents/an-approach-to-the-patient-with-drug-allergy?search=allergy%20reaction&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H39 (Accessed on January 7, 2026).

CROSS REFERENCES:

- SVMC Patient Care Services policy Allergy Documentation / Communication

SUBJECT: **MEDICATION – ERRORS**	SECTION: **Page 1 of 5**

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

PURPOSE:

To define the process to be followed in handling and reporting medication occurrences.

POLICY:

All medication errors shall be defined, documented and addressed. This includes errors in prescribing, interpreting, ordering, dispensing, delivering, storing, administering and any recordation of drugs. Reporting of medication errors is the responsibility of the individual who discovers the error or anyone who has knowledge of an error.

AFFECTED AREAS/PERSONNEL: *ALL DEPARTMENTS*

MEDICATION ERRORS– DEFINITIONS:

A "medication ERROR" means any preventable or unintended medication occurrence that is related to professional practice, or health care products, procedures, and systems, including, but not limited to:

Prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

TYPES OF MEDICATION ERRORS:

Medication errors are analyzed by the types of breakdowns within the medication system. The categories of errors may not be mutually exclusive because of the multidisciplinary and multifactorial nature of medication errors. Medication errors are categorized along each functional step of the medication cycle: ordering, transcription, preparation and dispensing, and administration.

1. Order Error – Are failures in the prescribing process that lead to harm to the patient and are typically committed by credentialed providers such as physicians, nurse practioners, physicians assistants and others. Types of ordering errors include: inappropriate medication selected by , failure to acknowledge allergy, inappropriate dose, illegible order, duplicate order, order not dated/timed, wrong patient/chart selected, contraindications, verbal order misunderstood, verbal order not written in the chart, wrong frequency, route, therapy duration, alert information bypassed or use of nonstandard nomenclature or abbreviations.

2. Transcription error – (typically non-physician related unless CPOE) Transcription involves both the orders that are manually transcribed onto manual record (e.g., electronic medication administration record (eMAR). Types of transcription errors include: wrong medication, time, dose, frequency, duration, rate patient/chart, verbal order misunderstanding, wrong scheduling of doses in the eMAR.

3. Preparation/Dispensing Error – Types of preparation and dispensing errors include: Inaccurate labeling, wrong quantity, medication, dose, diluent, formulation, expired medication, overlooked

drug/drug interactions, duplicate therapies and allergies. Also, Pyxis refill error, and delay in medication delivery.

4. Administration Error – Types of administration errors include: Wrong patient, dose, time, medication, route, rate, omission, extravasation (may be an ADR), pump problems, and unauthorized dose given.

5. Other - Any system breakdown that is not captured with one of the above predefined breakdown point should be classified as "other" and described.

Medication Error Exceptions:

1. Omission Error:

   An omission error is defined as the failure to administer an ordered dose to a patient before the next scheduled dose. Exclusions would be:

   a. a patient's refusal to take the medication or

   b. a decision not to administer the dose because of recognized contraindications. If an explanation for the omission is apparent (e.g. patient was away from nursing unit for tests or medication was not available), that reason should be documented in the appropriate records.

2. Wrong Time Error

   A wrong time error is defined as a failure to administer medication within 60 minutes from its scheduled administration time excluding doses that deviate due to logistical administration.

PROCEDURE:

1. If Medication Error reached the patient- IMMEDIATE ACTION:

   a. Notify the attending physician. If the attending physician is unavailable, the covering physician must be notified. When the covering physician is notified, the patient's attending physician must be notified as soon as available.

   b. Monitor the patient for adverse outcomes.

   c. Involved staff member is to complete the Risk Management Notification which is electronically submitted to the department directors, risk management and pharmacy.

2. If Medication Error did NOT reach the patient:

a. Involved staff member is to complete the Risk Management Notification located in the hospital reporting database which is electronically submitted to the department directors, risk management and pharmacy.

Categorization:

1. Medication errors are stratified into 4 types of error categories and 9 categories of results (A-I)This is the standard accepted by National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP). The medication error index is listed below:

Error Type	Cat. Code	Category Result
No Error	A	Circumstances or events have the capacity to cause an error.
Error, No Harm	B	Error occurred, but the medication did not reach the patient.
	C	Error occurred that reached the patient, but did not cause patient harm.
	D	Error occurred that resulted in the need for increased patient monitoring, but did not cause harm.
Error, Harm	E	Error occurred that resulted in the need for treatment/intervention and caused temporary patient harm.
	F	Error occurred that resulted in initial prolonged hospitalization and caused temporary patient harm.
	G	Error occurred that resulted in permanent patient harm.
	H	Error occurred that resulted in a near-death (e.g., anaphylaxis, cardiac arrest).
Error, Death	I	Error occurred that resulted in patient death.

2. Medication errors are categorized initially by the staff member involved with the error and then reviewed by the pharmacy for appropriateness.

Medication Error Review for Categories I:

1. An ad hoc review council is formed to conduct a root cause analysis on all medication errors with an NCCMERP category of I. The focus of the peer review council is on identifying the root causes that led to the error.

2. The council consists of at minimum: A representative from Risk Management, Pharmacy, the Director or Manager of the unit and the staff involved in the error as determined by aforementioned members.

3. To recreate the sequential activities that resulted in the error, the staff involved in the error is asked to describe in detail the process they followed.

4. The ad hoc review council takes the findings and using a just culture model; will determine the category of culpability. Essential to maintaining a robust reporting of medication errors is that employees feel safe to report. Therefore, using a just culture model insures that employees are not disciplined for system failures; however, compliance with written policy and procedures is essential. Attention to details is critical to preventing medication errors and non-compliance with policies and procedures is unacceptable.

5. Once the category of culpability is determined, the review council, absent of the Professional Practice member and in consultation with leadership from Human Resources will define what action will or will not be taken.

6. The RCAs along with the findings are forwarded to the Medication Patient Safety Committee for review and incorporation into the P&T quarterly report.

Medication Error Analysis: Concurrent and Retrospective:

1. The Multidisciplinary Medication Safety committee comprised of representatives from administration, pharmacy, nursing will regularly analyze all actual and potential medication errors. Appropriate medical staff members will be consulted based on the event to provide feedback regarding potential remediation.

2. Risk Management Department in collaboration with the Pharmacist in Charge & Director of Pharmacy Services will also prepare a quarterly summary of all medication errors. The summary will include, at minimum errors by type, and severity.

3. A summary, as well as the RCAs and associated recommendations will be presented at the Medication Patient Safety Committee for review of trends and to determine further actions. The data, findings, actions and recommendations are then forwarded to the P&T Committee. Actions and recommendations for improvement will be relayed to the Performance Improvement Department.

4. A concurrent review of the medication process will be conducted at least annually the process of which will be determined by the Medication Safety committee, MERP annual meeting.

Safe Medication Practices:

1. The organization will seek to identify and distribute appropriate external medication error alerts to physicians and clinical staff for the purpose of educating and improving current safe medication practices.

REFERENCES:

- American Society of Health-System Pharmacists. ASHP statement on reporting medical errors. Am J Health-Syst Pharm. 2000;57(16):1531-1532.

- American Society of Health-System Pharmacists. ASHP guidelines on preventing medication errors in hospitals. Am J Health-Syst Pharm. 2018;75(19):1493-1517.
- California Health & Safety Code Sections 1339.63, Chapter 2.05. Minimization of Medication-Related Errors.
- National Coordinating Council for Medication Error Reporting and Prevention. NCC MERP Taxonomy of Medication Errors. Updated July 31, 2001. Accessed November 18, 2025. http://www.nccmerp.org/sites/default/files/taxonomy2001-07-31.pdf
- Tariq, R. Vashisht, R. Sinha, A. Scherbak, Y. Medication Dispensing Errors And Prevention. https://www.ncbi.nlm.nih.gov/books/NBK519065/. Accessed November 18, 2025.

CROSS REFERENCES:

- Pharmaceutical Services Manual *Adverse Drug Reactions*
- House-Wide Policy Manual, *Serious Clinical Adverse Event*

SUBJECT:	SECTION:
MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL	***Medication Management (MM)*** **Page 1 of 13**

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

PURPOSE:

To ensure the safe and appropriate use of drug products and drug-related devices at Sierra View Medical Center.

POLICY:

The Pharmacy Department in collaboration and consultation with other professionals, departments and interdisciplinary committees, with approval by the medical staff, is directly responsible for the control and distribution of all stocks of drugs within the organization.

Under this policy, drugs and drug-related devices include, but are not limited to large and small volume injections, orally, topically or intravenous medications, radiopharmaceuticals, diagnostic agents including radiopaque contrast media, anesthetic gases, respiratory therapy drugs, biotechnologically produced drugs,, drugs brought into the hospital by patients or family, and other chemicals and biological substances administered to patients to evoke or enhance pharmacologic responses.

Control and distribution shall include procurement, recordkeeping, storage and inventory control, compounding, packaging, labeling and disposition.

AFFECTED AREAS/PERSONNEL:

PHARMACY, NURSING, RESPIRATORY THERAPY, DIAGNOSTIC IMAGING, MEDICAL STAFF

PROCEDURE:

I. Procurement

A. The Pharmacist in Charge is responsible for maintaining standards to ensure the quality of all pharmaceuticals used at SVMC. The Pharmacy Department is responsible for the procurement of all pharmaceuticals with the following exceptions:

Large and small volume intravenous solutions without additives.

B. The PIC is responsible for specifications as to the quality, quantity and source of supply of all drugs used in the hospital. Special consideration is given to the current ASHP Guidelines for Drug Distribution and Control, as well as the USP-NF. The Pharmacist in Charge evaluates the acceptability of manufacturers and distributors. Said pharmacist has the authority to reject a particular drug product or supplier if quality is an issue.

C. Procedure:

1. Restocking Pyxis machines will be performed at times scheduled by the Pyxis administrator at the direction of the Pharmacist in Charge. The restock quantities will be based on reports generated by the system to reach pre-set par levels. All individuals that retrieve medications from these systems have a responsibility to ensure accurate dispensation to preserve the integrity of the restocking system. Inaccuracies will be reported to SVMC's error reporting system.

2. Requirements for medications and supplies are determined by a combined list of replacements from pharmacy stock and/or by evaluating minimum and maximum levels on high cost and/or fast moving items on a daily basis. Pharmaceuticals are ordered through the wholesaler's computer interface.

3. When the order is received, the contents of the order are verified against the invoice and/or stickers. All items are stickered and placed into stock. Special handling items i.e., refrigerated.

4. Hazardous drugs will be received and stored in areas designated for HD medications.

5. Controlled substances are checked in and placed in the controlled substances safe in accordance with separate policy (see Controlled Substance Policy).

6. Invoices are matched with purchase orders and original forms and given to the pharmacy buyer for processing. Copies are retained in the pharmacy and originals are coded and forwarded to accounts payable for processing.

7. Items not ordered through the wholesaler, (i.e., IV solutions, blood fraction Products, other specialty items) are matched to the packing receipt and given to the pharmacy buyer for processing.

II. Storage and Control

A. All Pharmaceuticals are stored according to the manufacturer' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. In addition, all pharmaceuticals are stored under proper environmental conditions (i.e., proper temperature, light, humidity, conditions of sanitation and segregation). Storage areas must be secure, fixtures and equipment used to store drugs will be constructed to limit access only to designated and authorized personnel. Proper consideration is given to the safe storage of poisons and flammable compounds. Internal medications are stored separately from external medications. Non-medications and flammables are not to be stored in medication refrigerators.

1. Room Temperature – Room temperature, as it applies to medication storage shall be between 15°C (59°F) and 30°C (86°F). Medication rooms and drug storage area temperatures will be maintained within this range. Plant Maintenance will notify pharmacy if the temperature in the storage area falls below or is above this specified range. Medications will be relocated to another storage area until the problem is corrected. The pharmacist will be consulted to insure proper relocation.

2. Refrigerator Temperature - Refrigerator temperature, as it applies to medication storage shall be between 2.2°C (36°F) and 7.7°C (46°F). Medication refrigerator temperatures will be maintained within this range. If the temperature is not within the specified range, both the Pharmacy and Plant Maintenance will be notified immediately. Medications will be relocated to another storage area until the problem is corrected. The pharmacist will be consulted to insure the proper relocation of medications. Action(s) taken will be documented either directly on the Refrigerator Temperature Log or in the temperature monitoring software system.

3. Freezer Temperature - Freezer temperature, as it applies to medication storage shall be below -1°F to -50° F) for all pharmaceuticals requiring freezer storage except Cervidil which shall be stored separately in a freezer with the temperature range of -4° F to 14° F. Medication freezer temperatures will be maintained within this range. . If the temperature is not within the specified range, both the Pharmacy and Plant Maintenance will be notified immediately. Medications will be relocated to another storage area until the problem is corrected. The pharmacist will be consulted to insure the proper relocation of medications. Action(s) taken will be documented either directly on the Freezer Temperature Log or in the temperature monitoring software system. "Frozen" antibiotics will be maintained at a temperature not to exceed manufacturer recommendations.

   Note: *Freezer compartments of refrigerators are not acceptable for medication storage.*

   Each refrigerator/freezer will have a serviceable thermometer or other temperature-recording device capable of monitoring temperatures within the range required.

   Wireless monitoring system that actively records temperatures every fifteen minutes, twenty-four hours a day, seven days a week will alert engineering to any temperature excursions. Engineering will then in turn contact the pharmacy during normal business hours or the on-call pharmacist if excursions occur after normal business hours.

4. All refrigerators and freezers in the pharmacy are connected to back up emergency power so that in the event of a power failure medication storage temperature will be maintained in an acceptable range.

5. All stored medications & the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.

4. Return to Storage

a. Nursing

i. Medications issued by the pharmacy (not obtained from Pyxis) that are discontinued by the physician or upon discharge will be returned to pharmacy. These medications are to be placed in the designated box labeled "return to pharmacy".

ii. Medications obtained from Pyxis that are unopened and not used can be returned to the "return bin" in Pyxis.

b. Pharmacy

i. Medications returned to pharmacy will be removed from the designated pharmacy return boxes by the pharmacy staff during regularly scheduled rounds.

ii. Unused and unopened medications issued by the pharmacy will be credited to the proper patient's account regardless of the ability to re-issue that medication to another patient.

iii. Medications that are expired or close to expiration will be disposed of according to PHARMACEUTICAL WASTE policy.

iv. Medications removed from Pyxis during monthly floor inspections that are expired or close to expiration will be disposed of according to HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN.

III. Control and Security/Accountability

A. Pharmacy – The pharmacy is locked at all times. Only pharmacists will have keys to the pharmacy. During the hours, which the pharmacy is open; pharmacy technical personnel have limited access to the pharmacy during normal pharmacy hours through a pass coded, lock system, while under the supervision of a pharmacist. Non-Pharmacy personnel must have permission from an on duty pharmacist to enter the pharmacy.

B. Controlled Substances – All controlled substances of schedules C-II through C-V will be under a double lock system. A lockable door (i.e., outside door of a medication room or main pharmacy) qualifies as one lock. Within the main pharmacy, controlled substances of schedules C-II through C-IV will be under a double lock system. Procedures for documentation and recording can be found under ("Pharmacy – Controlled Substances Procedures and/or Nursing – Controlled Substances – Procurement, Administration and Documentation).

C. Medication Rooms – Medication rooms are to remain locked at all times. Only authorized personnel will have access to medication rooms. Authorized personnel will include, but are not limited to Registered Nurses, Licensed Vocational Nurses, and Respiratory Therapists. Other hospital employees who access any medication room must be given authorization and must be observed by nursing or pharmacy staff.

D. Pyxis – Lockable medication cabinets are used to store unit-of-use medications in the patient medication dose system. These medication cabinets will be locked when not attended. Access to medication cabinets will be limited to licensed nursing and pharmacy personnel. The Pyxis cabinets maintain control and storage of medications for various nursing units and keeps specific documentation of all transactions in regards to distribution and dispensing.

E. Large and Small Volume IV Solutions – Certain plain IV solutions are purchased and distributed by the materials management department. These solutions are stored either in the materials management department (considered a limited access area) or in the medication rooms in specific patient care areas. Distribution and control of these solutions are under the guidelines of the pharmacy medication distribution system. These solutions are inspected monthly by pharmacy when completing unit/area inspections.

F. Radiopaque Contrast Media – Radiographic contrast media is purchased by pharmacy, stored and used by the diagnostic imaging department. These medications are controlled with limited access. These medications are inspected monthly by pharmacy when completing unit/area inspections.

G. Radiopharmaceuticals – Radiopharmaceuticals are ordered from a certified/licensed distributor and delivered directly to the "hot lab" in Nuclear Medicine. Policies, procedures and protocols for handling, administration and disposition of radiopharmaceuticals are maintained by the Nuclear Medicine Department of Diagnostic Imaging Services. The Director of Pharmacy or PIC confers with the Chief Nuclear Medicine Technologist annually to review these policies, procedures and protocols.

Drug Samples – Drug samples are not allowed at SVMC under any circumstances.

H. Pharmaceutical Sales Representatives – All representatives MUST sign-in with the pharmacy and are ONLY allowed in the pharmacy unless access to other areas in the hospital is approved.

IV. Inspection and Disposition

A. Inspections – All units and/or areas where medications are used or stored will be inspected by pharmacy staff under the direct supervision of a pharmacist no less frequently than every 30 days. The pharmacy staff during such inspections will ensure that at a minimum:

1. Individual patient medications, except those that have been left at the patient's bedside are returned to pharmacy for appropriate disposition.

2. All drug labels are legible and in compliance with state and federal regulation.
3. Test agents, germicides, disinfectants and other household substances are stored separately from drugs.

4. External use drugs are segregated from drugs for internal use.

5. Drugs are stored at appropriate temperatures.

6. Drugs are accessible only to responsible personnel designated by the hospital.

7. Drugs are not kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.

Findings of unit/area inspections and corrective action(s) required, if any, are discussed with the unit/area supervisor. The unit/area supervisor will acknowledge this by signing the inspection form along with the pharmacist conducting the inspection. A report of findings is provided for the V.P. of Patient Care Services and/or the Chief Nursing Officer. Documentation of inspections is retained for 3 years.

B. Return and Disposal of Medications:

All expired or contaminated medications will be quarantined from Pharmacy stock and sent to a certified pharmaceutical recovery service that is under contract with the facility. The quarantined medications shall be logged into a record (drug return log) that contains at least but not limited to the following information: the date quarantined, name and strength of the medication, its NDC (national drug code) number, quantity, lot number, and the signature of the pharmacy staff that quarantined the medication. The contracted recovery service will conform to FDA and DEA guidelines. The recovery service will meet the following service guidelines:

1. Registered Pharmacist on staff.
2. Be a licensed DEA Registrant.
3. Be DEP/EPA registered large quantity hazardous waste generator.
4. Utilize a licensed hazardous waste transporter.
5. Utilize a licensed hazardous waste processing firm for incineration of disposable products.
6. Maintain general liability insurance.
7. Field Service Technicians are bonded and have Power of Attorney to handle narcotics.
8. Provide documentation or return and/or disposal in accordance with FDA and DEA guidelines.

Copies of the recovery service company's current Controlled Substances Registration Certificate, State Restricted Prescription Drug Distributor License and Department of Environmental Protection DEP/EPA ID Certificate will be maintained in the recovery services binder.

At least quarterly, or more frequently as required the recovery company will be notified to send a Field Service Technician to the Pharmacy to inventory and prepare returned items for shipping.

The recovery service Field Service Technician will segregate controlled substances (C-II through C-V) from non-controlled substances. Schedule II medications will be written up on a DEA Form 222. Schedule III, IV and V medications will be recorded on a Controlled Substances Inventory and Transfer. The original of the DEA Form 222 and the Controlled Substances Inventory and Transfer forms will be retained in the Pharmacy and Copies will be sealed with the separated medications and used as a packing list. Duplicate copies will be sent to the recovery service by the Field Service Technician. All non-controlled substances returned according to the drug return log shall be inventoried, signed, and dated by the recovery service field service technician.

The recovery service Field Service Technician will generate a shipping bill and seal all containers for shipping through a bonded transport service.

Upon receipt of the boxed medications, the recovery service will generate the following documentation:

- Credit Tracking Report – for all items being returned to manufacturers for credit by total Calculated Return Value.
- Manufacturer Return Report – details all items returned by NDC #, description, lot #, expiration date, price and quantity by manufacturer.
- Disposal Report – details all items sent for destruction (incineration) by NDC #, description, lot #, expiration date, price and quantity by manufacturer.
- Disposal Report (Hazardous) – details all hazardous items sent for destruction (incineration) by NDC #, description, lot #, expiration date, price and quantity by manufacturer.
- Controlled Substance Inventory Schedule III – V Destruction Certificate - certifies incineration of schedule III – V medications.
- Copy of the Waste Manifest for Schedule C-II through C-V.
- Schedule Medication Incineration Certificate

The above documentation is maintained in the recovery services binder in the pharmacy and reconciled. Original copy of DEA form 222 is mailed to the DEA.

Waste Management and Accountability (On-site disposal)

Disposal of medication waste within the department shall be controlled and accountability held by the Pharmacist in Charge. Pharmacy Staff shall dispose of waste in a manner that is consistent and complies with state and federal regulations.

C. Wasting of Medications
(1) Controlled substances will be wasted as per SVMC's CONTROLLED SUBSTANCES policy.

(2) Non controlled medications will be wasted as per SVMC's PHARMACEUTICAL WASTE policy.

V. Distribution of Medications

The pharmacy will dispense all drugs in single unit of use (unit dose) packaging whenever practical and placed in automated dispensing machines.

A. Medications are contained in, and administered from, single unit or unit dose packages.

B. Medications are dispensed in ready-to-administer form to the extent possible.

C. For medications not available in an automated dispensing machine, not more than a 72 hours supply of doses is provided to or available at the patient-care area at any time.

D. A patient medication profile is concurrently maintained in the pharmacy for each patient.

VI. Blood Derivatives

Blood derivative products such as albumin, gamma globulin, immune globulin, etc., are procured and dispensed exclusively by the pharmacy department. Rh_o(D) Immune Globulin is procured by the pharmacy department and distributed to the Laboratory Blood Bank. The blood bank tracks the receipt and release to patients by lot number, using the same procedure as tracking human blood.

VII. Guidelines For Product Dating

All medications at SVMC will be stored in accordance with the most recent guidelines as established by the United States Pharmacopeia (USP) and The National Formulary (NF), and recommendations form the Centers for Disease Control and Prevention (CDC). Consideration is given to the American Society of Health System Pharmacist (ASHP) practice standards.

General Guidelines:

All multi-dose ***INJECTABLE*** medication containers will be refrigerated after opening, unless specifically labeled "*Do Not Refrigerate*".

Form Specific Guidelines:

1. Injectable:

   a. Ampules – Discard immediately after use. Always use a filter straw.
   b. Single Dose Vials – Discard immediately after use.
   c. Multi-Dose Vials – Discard when empty, when suspected or visible contamination occurs, or if unopened when the manufacturer's expiration date is reached. If opened, use 28 days as expiration or as recommended by manufacturer's guidelines.
   d. Insulin products- 28 days after opening. Must label with expiration date.

2. IV Solutions – Admixed

   a. Mixed on the unit/patient care area – 4 hours after mixing.
   b. Mixed in the Pharmacy – As indicated on the IV labels by the pharmacist.

3. IV Solutions – Unmixed

    a. IVPB's and LVP's over 100ml– 30 days after removal of the moisture protective wrapping.
    b. IVPB under 100ml- 15 days after removal of the moisture protective wrapping.

4. Irrigation Solutions

    a. Sterile Saline & Water – Discard immediately after use.

5. EENT Solutions- 28 days after opening or manufacturer's expiration date whichever is first.

    a. Nasal solutions/sprays
    b. Ophthalmic
    c. Otic

6. Nitroglycerin

    a. Sublingual – 6 months after opening.

7. Oral Liquids & Solids

    a. Non-repackaged – manufacturer's expiration date.
    b. Re-packaged – the expiration dating period used does not exceed (1) 6 months from the date of repackaging; or (2) the manufacture's expiration date; or (3) 25% of the time between the date of repackaging and the expiration date shown on the bulk article container of the drug being repackaged, whichever is earlier.

8. Topicals- 1 month after opening or manufacturer's expiration date, whichever is first.

    a. Solutions – manufacturer's expiration date if not repackaged or opened.
    b. Ointments, Creams- manufactuer's expiration date if not repackaged or opened.
    c. Single use per patient, discard on discharge.

VIII. Drug Supply Chain Security Act

As of July 12, 2024 the FDA has provided notice for DSCSA Exemptions from certain requirements Under Section 582 of the FD&C Act for Small Business Dispensers. Sierra View Medical Center meets the definition of small business dispenser by meeting the definition of a total of 25 or fewer full-time employees licensed as pharmacists or qualified as pharmacy technicians according to the CA board of pharmacy requirements. Sierra View Medical Center claims the exemptions outlined in the letter here to the granted period as described (November 27, 2026). Sierra View Medical Center will continue our efforts to implement the necessary measures to satisfy all requirements.

Trading Partner Verification

A. SVMC will maintain a complete list of drug suppliers and other trading partners. Any company from which SVMC buys pharmaceutical products or to which pharmaceutical products are sold may be a trading partner and their license must be verified prior to business taking place.
B. Prior to doing business with a new supplier or trading partner, SVMC will check the state and/or federal registration licensure status of each by one of the following methods.
    a. Type in the company name in the federal database and look up the address for the facility with which business will be conducted:
        i. Each facility will have its own license. Make sure an out of state supplier is authorized and licensed to sell pharmaceuticals in California.
    b. Check California Board of Pharmacy for licensure verification
    c. Ask supplier to provide a copy of their state or federal license or registration. The document should reflect authorization to sell products in California
    d. Document the supplier's licensure expiration data and make a note to review prior to its expiration.
C. SVMC will check the licensure or registration of any new supplier or trading partner prior to purchasing with the supplier.

Transaction Data Capture and Maintenance

1. SVMC will utilize software and/or manufacturer portals for receiving, storing, and retrieving the transaction data of prescription drugs as defined by 503(b) (1) for six years after the transaction.
2. Before accepting delivery of an order, SVMC will review the transaction data to confirm that it matches the physical product received. After acceptance, store the data for future reference as required by DSCSA. This will be held and searchable/retrievable on demand for 6 years.
3. Exempt from the definition of "prescription drugs" are the following:
    a. Intravenous drug that, by its formulation is intended for the replenishment of fluids and electrolytes (such as sodium, chloride and potassium) or calories (such as dextrose or amino acids).
    b. Intravenous drug used to maintain equilibrium of water and minerals in the body, such a dialysis solution.
    c. A product intended for irrigation or reconstitution
    d. Medical gases
    e. Contrast agents or "imaging agents"
    f. Medications that may be purchased as OTC (over the counter)
    g. or a drug compounded in compliance with section 503A or 503B

Suspect Product Investigation

I. A suspect product is one that there is reasonable belief the product may be counterfeit, stolen, unintentionally adulterated, obtained fraudulently, or otherwise unfit and would cause potential harm or death.
II. In the course of normal daily responsibilities, SVMC staff will remain alert for visual clues that a product appears different or is suspect. This includes review of any information which may give

SVMC staff a reason to suspect that a supplier may be untrustworthy or fraudulent (e.g state license expired, inconsistent customer service or product delivery, etc.). Supplier behavior or any inquiry by state or federal authorities all may be reason to suspect a product and start an investigation, even if the product does not appear counterfeit.

III. Suspect product will be managed via the following actions.

a) Inform the PIC about the suspect product.
b) Place the item in quarantine & clearly mark the product as such. Place product in a temperature appropriate lockable location away from normal inventory.
c) Conduct an investigation of the suspect product, which should be completed timely as required by DSCSA (within a few days).
d) Inspect the product carefully & review transaction data. Inquire from trading partner for clarification as needed. Additionally the manufacturer should be reached out to for assistance with determining product legitimacy.
e) Notify the supplier, the FDA, and the state Board of Pharmacy if evidence of fraud or tampering. To notify the FDA, use Form 3911, which can be located here: http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm. The form should be emailed to FDA at DrugNotifications@fda.hhs.gov.
f) SVMC will keep a product sample and await further instructions from either the FDA, state board of pharmacy, manufacturer or supplier.
g) Records of documentation of the investigation will be maintained for an additional 6 years.

REFERENCES:

1. "Best Practices for Health-System Pharmacy, Positions and Practice Standards of ASHP", American Society of Health System Pharmacists, 1999 – 2000, ASHP Technical Assistance Bulletin on Hospital Drug Distribution and Control, pp. 74 – 82.

2. FDA's role in Drug Recalls, from https://www.fda.gov/drugs/drug-recalls/fdas-role-drug-recalls, access on March 21st, 2022. -

3. "Guideline for Prevention of Intravascular Device-Related Infections", Public Health Service, U.S., Department of Health and Human Services, Centers for Disease Control and Prevention, Am J Infect Control 1996;24:262-93.

4. The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

5. The United States Pharmacopeia, 24th Rev., and The National Formulary, 19th Ed. (USP24/NF19) Supplement, 1999; 25:2589-90.

6. "Revised USP Standards for Product Dating, Packaging, and Temperature Monitoring", Am J Health-Syst Pharm, Vol 57, Aug 1, 2000:1441-1445.

7. State of California, Title 22, § 70263 – 70269

8. "Waivers and Exemptions Beyond the Stabilization Period" https://www.fda.gov/drugs/drug-supply-chain-security-act-dscsa/waivers-and-exemptions-beyond-stabilization-period. Accessed 9/21/2024.

9. "Self-Assessment Manual for Proper Management of Medical Waste", The Self-Assessment Project Partnership between the Ca. Dept. of Health Services and the California Healthcare Association. March 16, 1999, Second Ed. Revised, pp 13-14.

10. U.S. Food & Drug Administration. "DSCSA Exemptions from Certain Requirements Under Section 582 of the FD&C Act for Small Business Dispensers (revised with clarifying edits to June 12, 2024, letter)" Accessed 9/21/2024. https://www.fda.gov/media/179256/download?attachment

CROSS REFERENCES:

- Pharmacy Manual – "Controlled Substances"

SUBJECT:	SECTION:
MEDICATIONS RESTRICTED TO AREAS OR PERSONNEL	***Pharmaceutical Services*** 8 **Page 1 of 6**

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

PURPOSE:

To provide guidelines for the safe administration of specific medications restricted to approved nursing units and patient care areas.

DEFINITIONS:

1. Approved areas: Areas as indicated in policy where medications may be administered.

2. Non-approved areas: Any unit where identified medications are not approved for administration.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that identified medications by nature of their pharmacology and indications require specific monitoring.

AFFECTED PERSONNEL/AREAS: *ALL NURSING AREAS AND PHARMACY*

PROCEDURE:

A. Administration of medications in approved nursing units

   1. Restricted medications will be administered only in the approved units and with the requirements indicated in Addendum A of this policy and more specifically described in medication-specific policies, which may be referenced.

B. Administration of medications in non-approved nursing units

   2. If the physician orders a medication listed in Addendum A for a patient located in an non-approved unit, and/or the requirements listed in Addendum A or medication specific policy, as referenced, cannot be met, the physician will:

      a) Consider an alternative therapy.

      b) Order the patient transferred to an appropriate unit.

      c) Order the medication to be given using the criteria listed below:

         i. The patient must have bedside monitoring to include continuous cardiac monitoring, pulse oximetry, and monitoring at least every 15 minutes or more frequently as indicated in Addendum A or in referenced medication specific policies. These vital signs will be documented as obtained.

         ii. The medication must be administered under the direct supervision of the ordering physician.

iii. The ordering physician, nurse, or allied health professional administering the medication must have the appropriate credentials and meet the requirements listed in Addendum A or in medication-specific referenced policies.

iv. Pharmacy must be notified by telephone that the criteria listed above have been met before they will send the needed medication(s).

v. Staff involved in the care of the patient must complete appropriate competencies to manage the patient's care. It will be the responsibility of the unit manager to ensure their staff have the appropriate competencies and training before assigning them to a unit/or patient that requires use of these orders.

RASS Goal drips: Must complete Rass competencies

TOF Goal drips: Must have completed TOF competencies

Addendum A

Titratable Continuous Infusions				
Drug Name	Approved Units	Additional Requirements Note: All titratable infusions must have a clinical goal to titrate by such as: Level of Pain, Sedation, Heart Rate, Blood Pressure, Mean Arterial Pressure (MAP), Blood Glucose, Train of Four (TOF) Level, etc.	Intubation Required	Intubation requirement exception for Comfort Care Note: If not required in column D, then defaulted to not required in comfort care. If Y in Column D and not explicitly marked Y in this column then default to N.
Cisatracurium	ED, Cath Lab, ICU, OR, OBOR, PACU	Train of Four (TOF); Cardiac Monitoring; Vital signs (HR, BP, RR) per standard of care of unit.	Y	N
Dexmedetomidine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes. Level of Sedation per protocol	N	
Diltiazem	ICU, ED, OR, OBOR, PACU, Cath Lab	Cardiac monitoring & vital signs (BP & HR) every 15 minutes for 30 minutes at start of infusion then every 4 hours.	N	
Dopamine	ICU, ED, OR, OBOR, PACU, Cath Lab	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Epinephrine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Esmolol	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Fentanyl	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & hemodynamics (BP & HR) continuously. Level of Sedation or Pain per protocol.End tidal CO2 monitoring.	Y	Y- See Fentanyl non-titratable
Heparin	All units	Coagulation monitoring per protocol.	N	
Insulin	ICU, ED, OR, OBOR, PACU, Cath Lab.	BG per protocol	N	
Ketamine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes. Level of Sedation or Pain per protocol	Y	N
Lidocaine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Midazolam	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care of unit. Level of Sedation per protocol.	Y	
Milrinone	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Morphine Drip-Sedation (RASS)	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care of unit. End tidal CO2 monitoring.	Y	See Morphine Drip-Comfort Care

Morphine Drip-Comfort Care	All units	Level of Pain & Sedation per care team & protocol. Vital signs per standard of care of unit, unless specific orders exist otherwise for vital sign monitoring. Ex: Provider orders no vitals signs or vital signs per shift etc.	N	
Nicardipine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes..	N	
Nitroglycerin	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Nitroprusside	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes. Max 3 days, monitor for cyanide toxicity.	N	
Norepinephrine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Phenylephrine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Procainamide	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Propofol	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care of unit. Level of Sedation per protocol.	Y	N
Vecuronium	ICU, ED, OR, OBOR, PACU, Cath Lab.	Train of Four (TOF); Cardiac Monitoring; Vital signs (HR, BP, RR) per standard of care of unit.	Y	N
Patient Controlled Anesthesia (PCA's)				
Hydromorphone	All units	Level of Pain per protocol & vital signs per standard of care for unit or as directed by provider order. End tidal CO2 monitoring.	N	
Morphine	All units	Level of Pain per protocol & vital signs per standard of care for unit or as directed by provider order. End tidal CO2 monitoring.	N	
Non Titratable Continuous Infusions				
Acetylcysteine	ICU, ED, OR, OBOR, PACU, Cath Lab, MS & TELE	Reassess LFT's Every 4 to 6 hours unless otherwise directed by protocol	N	
Alteplase: Dose ≤ 2 mg/hr (Ex. Catheter directed thrombolytic therapy for DVT of lower extremity).	All units	Fibrinogen Q6Hr. Daily CBC.	N	

Alteplase: Dose exceeding 2mg/hr	ICU, ED, OR, OBOR, PACU, Cath Lab.	Stroke Tx: Vital signs and neurologic status should be checked every 15 minutes for two hours, then every 30 minutes for six hours, then every 60 minutes until 24 hours from the start of thrombolysis. All other: Continuous cardiac monitoring & hemodynamics (BP). Daily.CBC	N	
Amiodarone	Cath Lab, ED, ICU, OR & OBOR, PACU, TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
Diltiazem	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation. TELE-May not exceed 10mg/hr.	N	
Dobutamine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP & HR) every 15 minutes.	N	
Dopamine	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	TELE: Only for non-titratable doses for renal perfusion. Max on TELE unit is 3 mcg/kg/minute. Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
Epitifibatide	ICU, OR, OBOR, ED, Cath Lab	CBC & CMP at baseline and at least Q24hr while on therapy. Platelet count recommended 2-4 hours after intiation and at 24 hours or prior to discharge whichever is first. Cardiac monitoring & vital signs per standard of care for unit.	N	
Fentanyl	ICU, ED, OR, OBOR, PACU, Cath Lab, TELE & MS.	For TELE & MS must be a fixed dose utilized for comfort care. Cardiac monitoring & vital signs per standard of care for unit.End tidal CO2 monitoring.	N	Y- Alert provider if respiratory rate <12 breaths/minute or persistent episodes of shallow breathing or apnea, oxygen saturation <90% or RASS score -2 or below. Staff must have completed RASS training.
Factor VII	ICU, ED, OR, OBOR, PACU, Cath Lab.	CBC & CMP at baseline and at least Q24hr while on therapy. Cardiac monitoring & vitals signs per standard of care for unit.	N	
Ketamine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit. Level of Sedation or Pain per protocol.	Y	
Lidocaine	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
Magnesium (40g premix)	OBOR, L&D, OR, PACU, ICU	Not for use for routine electrolyte replacement. Approved for use for Eclampsia/Preeclampsia & neuroprotection for imminent preterm birth.	N	
Naloxone	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs (BP, pulse, respiratory rate, oxygen saturation) Q15M x 2 hrs and then per standard of care for unit. End tidal CO2 monitoring.	N	

Octreotide	All units	BG monitoring per protocol.	N	
Prothrombin Complex Concentrate (Kcentra)	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
Vasopressin	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at least x1 5 mins after initiation.	N	
IV Push				
Adenosine	OR, OBOR, ED, PACU, ICU, Cath Lab.	Cardiac monitoring & hemodynamics (BP) continuously. Provider at bedside. Stress Test/Imaging may be performed in ICU and Cath Lab while pt on cardiac m monitor and provider administered. All units acceptable as determined by physician determination for urgent need but physician must be at bedside. Recommend pads in place and crash cart nearby.		
Alteplase- Bolus	Cath Lab, ED, or ICU			
Alteplase- Parapneumonic effusion	All units	Physician administered		
Alteplase- Catheter Occlusion	All units			
Amiodarone	All units as part of ACLS	IV push should only be used as part of ACLS. Otherwise use of controlled infusion pump required, refer to continuous non-titratable section above.		
Cisatracurium	ICU, ED, OR, OBOR, PACU, Cath Lab.	IV push should only be used as part of Rapid Sequence intubation outside of the approved areas for life saving treatment.		
Diltiazem	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR at x1 at least 5-30 min after administration of bolus.		
Eptifibatide	ICU, OR, OBOR, ED, Cath Lab	See infusion section for additional parameters		
Esmolol	ICU, ED, OR, OBOR, PACU, Cath Lab	Cardiac monitoring & vital signs per standard of care of unit. OK in Tele/MS followed by transfer to appropriate unit for maintenance.		
Etomidate	All units	Administered by Anesthesia staff, physicians credentialed in Rapid Sequence Intubation and Deep Procedural Sedation and RNs who have completed RSI education. Cardiac monitoring & hemodynamics (BP & HR)		

Fentanyl	All units			
Glycopyrrolate	IV: Operating Suites End of Life Secretions (IM/SC/Oral/SL) All units	IV doses administered by Providers only		
Haloperidol	All units	All IV administration (at any dose) requires cardiac monitoring.		
Heparin	All units	Daily CBC		
Hydralazine	All units	BP x1 at least 10 mins after administration of bolus.		
Hydromorphone	All units			
Insulin Regular	All units	Baseline BG & BG Q1HR x2 post administration. Orders for IV bolus shall be restricted to x1 orders in MS & TELE.		
Ketamine	All units a part of RSI. Otherwise: ICU, ED, OR, OBOR, PACU, Cath Lab	Administered by Anesthesia staff, physicians credentialed in Rapid Sequence Intubation and Deep Procedural Sedation and RNs who have completed RSI and Procedural Sedation education. Cardiac monitoring & hemodynamics (BP & HR) continuous during Deep Sedation. May be administered outside of		
Labetalol	All units	Cardiac monitoring & vital signs per standard of care for unit. BP x1 after 5 mins since administration. RN to be ACLS certified		
Lidocaine	All units as part of ACLS	IV push should only be used as part of ACLS. Otherwise use of controlled infusion pump required, refer to continuous non-titratable section above.		
Metoprolol	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR x1 at least 5 minutes after bolus administration. RN to be ACLS certified.		
Midazolam	All units			
Morphine	All units			
Octreotide	All units			
Physostigmine	ICU, ED, OR, OBOR, PACU, Cath Lab	Cardiac monitoring & vital signs per standard of care for unit. If administering for reversal of toxic effects refer to poison control center for additional monitoring recommendations.		
Propofol	ICU, ED, OR, OBOR, PACU, Cath Lab	Administered by Anesthesia staff, physicians credentialed in Rapid Sequence Intubation and Deep Procedural Sedation and RNs who have completed RSI education. Cardiac monitoring & hemodynamics (BP & HR) continuous during Deep Sedation.		
Propanolol	ICU, ED, OR, OBOR, PACU, Cath Lab.	Cardiac monitoring & vital signs per standard of care for unit.		

Rocuronium	All units as part of Rapid Sequence Intubation, transfer to critical care unit for sustained intubation/deep sedation.			
Succinylcholine	All units as part of Rapid Sequence Intubation, transfer to critical care unit for sustained intubation/deep sedation.			
Tenectaplase	ICU, ED, OR, OBOR, Cath Lab. All units for stroke alert	Ischemic Stroke Tx: Measure BP and perform neurological assessments every 15 minutes for the first 2 hours of initiation then every 30 minutes for the next 6 hours, then hourly until 24 hours after initiation of tenecteplase.		
Vecuronium	All units as part of Rapid Sequence Intubation, transfer to critical care unit for sustained intubation/deep sedation.			
Verapamil	ICU, ED, OR, OBOR, PACU, Cath Lab & TELE	Cardiac monitoring & vital signs per standard of care for unit. BP & HR x1 at least 5 minutes after bolus administration.		
General Anesthetic, Inhalation				
Desflurane	Operating Suites	Anesthesia staff only		
Isoflurane	Operating Suites	Anesthesia staff only		
Sevoflurane	Operating Suites	Anesthesia staff only		

SUBJECT: **PATIENT'S OWN MEDICATIONS**	SECTION: **Page 1 of 4**

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

PURPOSE:
To define conditions under which patient's medications may be brought into the facility.

POLICY:
It is policy that pharmacy dispenses all formulary medications from the hospital supply. Non-formulary medications are held until a decision is made as to whether they will be ordered on admission. Under limited and unusual circumstances, the patient may use their own medication (s) under the following circumstances:

1. Pharmacy cannot supply the medication.

2. When the physician has been contacted regarding use of another formulary agent and has stated that this medication is required for treatment of the patient.

3. A pharmacist can positively identify the medication, confirm the medications expiration date, and determine that the medication is in a usable condition. If these conditions cannot be met, these medications will only be used in extraordinary circumstances.

    a) Pharmacy shall ensure the medication container is clearly and properly labeled. The pharmacist will log the medication into the "Patient Own Medication Log Sheet". The pharmacist will take appropriate measures to identify the medication and confirm it matches the ordered medication by use of a pill identifier database. Once confirmation is achieved, the pharmacist may process the order if the requirements have been met. If the medication is unidentifiable, it may not be used.

Patient's own herbal remedies may not be used at Sierra View Medical Center due to the following reasons:

1. Herbal medications are categorized as a food (dietary supplement) under the Dietary Supplement Health and Education Act of 1994 by the Food and Drug Administration and are not held to the standards for the manufacturer of drugs.

2. These dietary supplements are not marked or identified with a stamp or number which does not satisfy the requirements for "positive identification" as stipulated in Title 22 § 70263 (m)(3).

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

Storage
1. If med is able to be sent home (or to transferring facility)
    a) Nursing:

i) If patient in ED or outpatient setting, store all patient's own medications with patient belongings, with family member, or in medication room.
ii) Send medications home (family member), or to transferring facility as quickly as possible
iii) Recommend documentation of medications returned to the patient or family.

2. If unable to send med(s) home (or not sent home before admission).
   a) Nursing
      i) All medication containers should be handled with gloves.
      ii) All medications should be placed inside a plastic bag to eliminate risk of contamination.
      iii) Deliver patient's own medications to pharmacy. If they cannot be delivered, store medication in the medication room and contact pharmacy to pick up.
   b) Pharmacy
      i) If not delivered by nursing, pick up medications from unit and bring to pharmacy. Document receipt in Patient's Own Medications Log and document:
         (1) Patients name, date received, list of medications and quantity. If medication obtained in a pill box or in mixed container, document as much as possible (including imprints and color).
            (a) All controlled medications must have an exact count received.

Dispensing

1. If it is necessary for a patient to use their own med.
   a) Pharmacy
      i) A provider must write a complete order (see medication ordering policy).
      ii) Pharmacist enters order as Patient's Own Medication or Patient Own Controlled as appropriate.
      iii) An identification label (for scanning/administration) is placed on the product containing the information for the drug & the pharmacist will initial this label to show confirmation that the order was checked by pharmacy. Upon dispensing, the pharmacy will label the container stating to return patient's own medications to patient upon discharge.
      iv) All medication containers are placed inside a plastic bag to eliminate the risk of contaminating other medications.
         (1) Non-controlled medications: The identified medication is delivered to the nursing unit and stored in the patient specific medication drawer or in the refrigerator as appropriate.
         (2) Controlled medication: Each dose may be dispensed from the pharmacy at the time medication is due to be administered and signed by receiving nurse. Alternatively, send and delivered to the patient's own controlled pocket in Pyxis.

Discharge.

1. Patient has not yet been discharge.
   a) Nursing must notify pharmacy as soon as they are aware of impending patient discharge.
   b) Pharmacy will document in Patient's Own Medication Log that the medication was returned to nursing unit/family.
   c) Nurse is to return the medications to patient if they received.
2. Patient leaves without medications or patient expires.

a) It is the responsibility of the discharging unit to verify that the patient has all of their belongings prior to discharge. If the patient leaves prior to receiving any of their medication, the pharmacy will store the medication for a minimum of 30 days. During which time the patient or family member will be contacted to pick up. Documentation of attempts shall be recorded in patient's own medication logs. In the event not all medications are returned within 30 days due to patient discharge or expiration, the pharmacy will document the destruction of the products. Documentation shall include the name of the patient, the name and strength of the drug, the prescription number, the amount destroyed the date of destruction and the signatures of the required witnesses. The names of the witnessing pharmacists shall also be recorded.

In the event that a patient has an attached medication delivery device, (e.g., pump , etc.), the nurse will contact the pharmacist to come to the patient's bedside for a visual inspection of the device.

MEDICATION INFUSION DEVICES

1. The pharmacist will contact the pharmacy that provided the pump and determine concentration, original volume, expiration of the drug and any other pertinent information deemed necessary at the time and enter that information into the medical record.

2. The pharmacist will also contact the prescriber to validate dose and delivery rate of the medication being infused as well as any parameters under which the infusion should be slowed or stopped and enter that information into the medication profile.

3. Instructions on how to stop the pump or change the rate will be obtained from the original prescriber or manufacturer and kept at the nursing station.

Sierra View Medical Center shall permit patient use of medical cannabis for terminally ill patient's (prognosis of life of one year or less, if the disease follows it's natural course) and shall do all of the following:

1. Prohibit smoking or vaping as methods to use & include the use of medicinal cannabis within the patient's medical record. This will be done by following the process outlined in Patient's Own Medication policy & in adherence to the Controlled Substances Policy.

2. Patient is required to provide a copy of their medical marijuana card or written documentation that the use of medicinal cannabis is recommended by a physician prior to its use. This must be documented in the medical record. Patient's qualifying status as terminally ill by provider must also be documented into the medical record.

3. Require a patient or a primary caregiver, as defined in Section 11362.7, to be responsible for acquiring, retrieving, administering, and removing medicinal cannabis.

4. Medicinal cannabis is to be stored securely at all times in a locked container & with the patient's primary caregiver. Sierra View Medical Center also prohibits health care professionals and

facility staff, including but not limited to physicians, nurses, and pharmacists from administering medicinal cannabis or retrieving medicinal cannabis from storage.

5. Use is not permitted by a patient receiving emergency services and care, as defined in Section 1317.1, or to the emergency department of a health care facility, as specified in subdivision (a) of Section 1250, while the patient is receiving emergency services and care.

6. Medicinal cannabis will not be supplied by Sierra View Medical center.

7. Medicinal cannabis will be allowed to be brought in by the patient or by someone on the patient's behalf, for the patient's exclusive use. It is the personal property of the patient.

8. Only oral and topical forms of medical cannabis may be brought into Sierra View Medical Center for use under this policy.

9. Upon discharge, all remaining medicinal cannabis shall be removed by the patient or patient's primary caregiver. If a patient cannot remove the medicinal cannabis and does not have a primary caregiver that is available to remove the medicinal cannabis the product shall be disposed of in accordance with health facility policy and procedure for controlled substances.

Sierra View Medical Center will not prohibit patient use of medicinal cannabis due soley to that fact cannabis is a schedule I drug in the federal Uniform Controlled Substances Act, or other federal constraints on the use of medicinal cannabis that were in existence prior to January 1, 2022.
Sierra View Medical center reserves the right to suspend patient use of medicinal cannabis if a federal regulatory agency, the United States Department of Justice, or CMS does one of the following:

Initiates enforcement action against Sierra View Medical center related to the facility's compliance with the state-regulated mandate.

Issues a rule or otherwise provides the facility with notification that prohibits the use of medical marijuana in health care facilities or otherwise prohibits compliance with the state-regulated medical marijuana program.

REFERENCES:

- Pharmacy Law: California Edition.(2026) San Clemente, California: Law Tech Publishing Group.
- SB 311, Hueso. Compassionate Access to Medical Cannabis Act or Ryan's Law. Retrieved on December 31, 2025. https://legiscan.com/CA/text/SB311/id/2434836
- The Joint Commission (2026). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Title 22 (n.d.).Retrieved on December 31, 2025, from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **PHARMACY AND THERAPEUTICS COMMITTEE**	SECTION:

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

POLICY:

The Pharmacy and Therapeutics Committee is a policy recommending body to the medical staff governing body, hospital administration and, ultimately, the Board of Directors on matters related to the therapeutic use of drugs as well as pharmacy processes and procedures. The Committee will consist of at least two physicians, the Director of Pharmacy, the Chief Nurse Executive and the administrator or his or her representative designee. The Committee will meet at least quarterly.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, MEDICAL STAFF*

PROCEDURE:

The Committee is responsible for developing policies and procedures regarding the procurement, distribution, storage, dispensing and safe use of pharmaceuticals within the hospital. The Committee will also participate in quality assurance and performance improvement activities surrounding pharmaceutical care.

1. Any processes surrounding policies, procedures, or activities of pharmaceutical care should involve Pharmacy Services for review and/or development.

2. Upon approval by the subgroups involved, the policy, procedure or reports will be taken to the Pharmacy and Therapeutics Committee for approval and/or discussion.

3. All reports given to the Committee on studies performed, reports, trends or results are strictly confidential. When deemed appropriate by the Pharmacy and Therapeutics Committee, request may be made to the individual medicine departments for their review of data.

4. The Director or Manager of Pharmacy or his representative will participate in the implementation of all decisions made by the Pharmacy and Therapeutics Committee throughout the Hospital.

5. Developing and reviewing the formulary and Medication Error Reduction Plan (MERP) data.

6. Evaluating data on new drugs or preparations suggested by staff.

7. Reviewing performance improvement data from pharmacy department.

8. Review and approve clinical practice guidelines that involve pharmacotherapy. Including review and update order sets on an annual basis or sooner as needed based on current evidence/practice.

9. Policies adopted by the Committee will be approved by the Executive Committee of the Medical Staff, and when appropriate, by Hospital Administration and the Board of Directors.

VOTING PRIVLIGES

1. The voting members shall consist of two physician representatives, the Director/Manager of Pharmacy or designee, Chief Nurse Executive or designee, and the administrator or his or her representative such as, the VP of Quality.

2. A quorum is needed to conduct business and shall consist of the members present and no less than two voting members.

REFERENCES:

- Title 22 Social Security. Division 5. Chapter 1. Article 3. Retrieved on December 31, 2025, from https://govt.westlaw.com/calregs/Document/IB0E3FEDC5B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=StatuteNavigator&contextData=%28sc.Default%29

- Hospital Accreditation Standards. (2025). Oak Brook, IL: Joint Commission Resources, Inc. MM.04.01.01, EP 7

SUBJECT:	SECTION:
PRECEDEX DRIP FOR SEDATION OF PATIENTS IN THE CRITICAL CARE SETTING	**Page 1 of 6**

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

PURPOSE:

To outline the appropriate use of Precedex® (Dexmedetomidine) for the sedation of initially intubated and mechanically ventilated patients during treatment in an intensive care setting and for sedation of non-intubated patients prior to and/or during surgical and other procedures.

POLICY:

A. When using Precedex® (Dexmedetomidine) the following should be considered:

1. Precedex® should be administered by continuous infusion not to exceed 24 hours (24 hour stop time will default in CPOE). Precedex® infusions may exceed 24 hours in mechanically ventilated patients after explicit physician orders.
2. Precedex® should be administered only by persons skilled in the management of patients in the critical care setting.
3. Precedex® patients should be under continuous cardiac monitoring.
4. The most common adverse reactions with Precedex® (incidence >2%) are hypotension, bradycardia and dry mouth.
5. Due to increased incidence of bradycardia and hypotension in the elderly, and the potential for reduced clearance in patients with impaired hepatic or renal function, dose reductions should be considered in these patient types.

AFFECTED PERSONNEL/AREAS: RN/ICU/ED, *PHARMACY*

EQUIPMENT:

- Smart Infusion Pump
- Cardiac Monitor

PROCEDURE:

A. <u>Physician</u>

1. Before ordering ensure patient is adequately hydrated, to minimize cardiovascular side effects, and does not possess the following contraindications.

   a. Patients with refractory hemodynamic instability, including:

      i. SBP <90 mmHg or MAP <60 mmHG despite significant vasopressor support.
      ii. HR <55 BPM not induced by beta blocking agents
      iii. AV block in the absence of a pacemaker

   b. Microvascular free flap procedures, as α2 agonists may cause direct vasoconstriction and reduction in flap blood flow.

c. Severe liver dysfunction (Child-Pugh class-C)

d. Recent acute epilepsy or uncontrolled seizure activity

e. Neurovascular patients including those with recent intervention for a cerebral aneurysm or arteriovenous malformation, particularly patients within 7 days of aneurysmal or traumatic subarachnoid hemorrhage or those considered at high risk of vasospasm.

f. Pregnancy or breast feeding.

g. Precedex® use has been deemed inappropriate for the following:

i. Deep sedation for the control of intracranial hypertension or to facilitate high frequency or controlled ventilation in acute lung injury
ii. Concomitant use of neuromuscular blocking drugs other than for intubation/mechanical ventilation
iii. Acute encephalopathy that is not delirium induced
iv. Convulsive state

2. When utilizing CPOE to order Precedex® (Dexmedetomidine) for patient sedation always specify the target RASS score and initial rate.

3. If desired, place subsequent order for daily Wake-Up protocol ("sedation vacation/sedation holiday")

4. Be ready to assist RN at bedside upon initiation of infusion and as needed for near maximum titrations.

B. Pharmacist

1. Survey patient's medication profile and EMR to rule out any absolute contraindications.

2. Verify order when appropriate. If not appropriate discuss order with physician in an interdisciplinary manner.

3. Assess patients liver function. Dexmedetomidine is metabolized almost completely in the liver to inactive metabolites while less than 5% is excreted unchanged. Therefore, a patient with poor hepatic function (i.e. elevate bilirubin, low albumin, elevate INR (not on Warfarin,) etc…) may require a more conservative dose. **Communicate this fact to the RN when these patients are identified.**

4. Prepare Precedex® (Dexmedetomidine) drip according to master formulary and deliver to if not available in premixed formulation.

a. Forward calculate overnight needs to ensure to supply overnight team with enough medication to infuse until 0700 the next morning.

C. Registered Nurse

1. Upon receiving the prepared drip begin administration utilizing the appropriate smart pump safety guardtails.

   a. Consider the following when initiating a Dexmedetomidine infusion:

      i. Dexmedetomidine produces a dose-dependent sedation with peak effect reached 45-60 minutes after commencement of an infusion.
      ii. Dexmedetomidine has a strong synergistic effect with other sedatives and opioids, with a 50 to 70% reduction in Propofol (Diprivan®), Midazolam (Versed®) and opioid requirements having been observed.
      iii. High dose infusion (> 0.7mcg/kg/hr) can lead to loss of muscle tone with potential for airway obstruction in non-intubated patients.
      iv. An average of 10% fall in systolic blood pressure, heart rate and cardiac output has been observed when a dose of 1 mcg/kg/hr is used
      v. Dexmedetomidine produces a unique sedation that is best described as "cooperative sedation" where patients respond promptly to verbal stimuli or light touch.
      vi. A loading dose is usually unnecessary and not recommended due to the risk of hypotension, especially if patient is dehydrated.
      vii. There is no need to wean off of a Dexmedetomidine solution slowly.
      viii. Dexmedetomidine is NOT a sedative that can be used for immediate control of a very agitated or combative patient. Therefore, rescue sedation with boluses of Midazolam or Propofol will sometimes be necessary.
      ix. If the desired RASS sedation score requires frequent boluses of additional sedatives (i.e. Midazolam or Propofol,) aim to maximize the infusion rate of Dexmedetomidine up to 1.4mcg/kg/hr (may exceed this rate at the physician's discretion) prior to starting infusions of other sedative agents.

   b. Dexmedetomidine initial rate should be **0.2mcg/kg/hr (or the rate the physician specifies in the order) for 45 to 60 min,** then

      i. **Titrate by 0.2mcg/kg/hr** approximately **every 30 minutes. Maximum rate is 1.4mcg/kg/hr (may exceed this rate at the physician's discretion)** (see figure 1 below)
      ii. **Assessment and documentation of RASS score and pain scales** should be performed as part of an ongoing evaluation **at least every 4 hours.**

   c. Transitioning from other IV sedatives and analgesics to Dexmedetomidine (see figure 2 below):

i. The Dexmedetomidine infusion should be started at least 2 hours before stopping other sedative medications.
ii. Consider weaning off of other sedatives and analgesia which should be done by decreasing their rates by 25 to 50% every hour, or as per physician discretion or order.
iii. The Dexmedetomidine infusion can be **titrated by 0.2mcg/kg/hr every 30 minutes** to the targeted RASS and pain score. **Maximum rate is 1.4mcg/kg/hr (may exceed this rate at the physician's discretion.)**

d. Patients with emergence delirium and/or agitation

i. This group of patients often requires the highest level of Dexmedetomidine infusion at a dose often greater than 0.7mcg/kg/hr.
ii. Begin infusion at 0.2mcg/kg/hr (may start at higher rate at the physician's discretion)

REFERENCES:

- Precedex [package insert]. Lake Forest, IL: Hospira, Inc; 2008. 2. Data on file, #3. Hospira, Inc.
- Jacobi J, Fraser GL, Coursin DB, Riker RR, Fontaine D, Wittbrodt ET et al. Clinical practice guidelines for the sustained use of sedatives and analgesics in the critically ill adult. Crit Care Med 2002;30:119-141
- Gerlach AT, Dasta JF. Dexmedetomidine: an updated review. Ann Pharmacother 2007;41:245-52.
- Venn M, Newman J, Grounds M. A phase II study to evaluate the efficacy of dexmedetomidine for sedation in the medical intensive care unit. Intensive Care Med 2003;29:201-7
- Ickeringill M, Shehabi Y, Adamson H, Ruettimann U. Dexmedetomidine infusion without loading dose in surgical patients requiring mechanical ventilation: Haemodynamic effects and efficacy. Anaesth Intensive Care 2004;32:741-5.
- Shehabi Y, Ruettimann U, Adamson H, Innes R, Ickeringill M. Dexmedetomidine infusion for more than 24 hours in critically ill patients: sedative and cardiovascular effects. Intensive Care Med 2004;30:2188-96.
- Kobayashi A, Okuda T, Kotani T, Oda Y. Efficacy of dexmedetomidine for controlling delirium in intensive care unit patients. Masui 2007;56:1155-60.

Figure 1: Critically ill Ventilated Patients

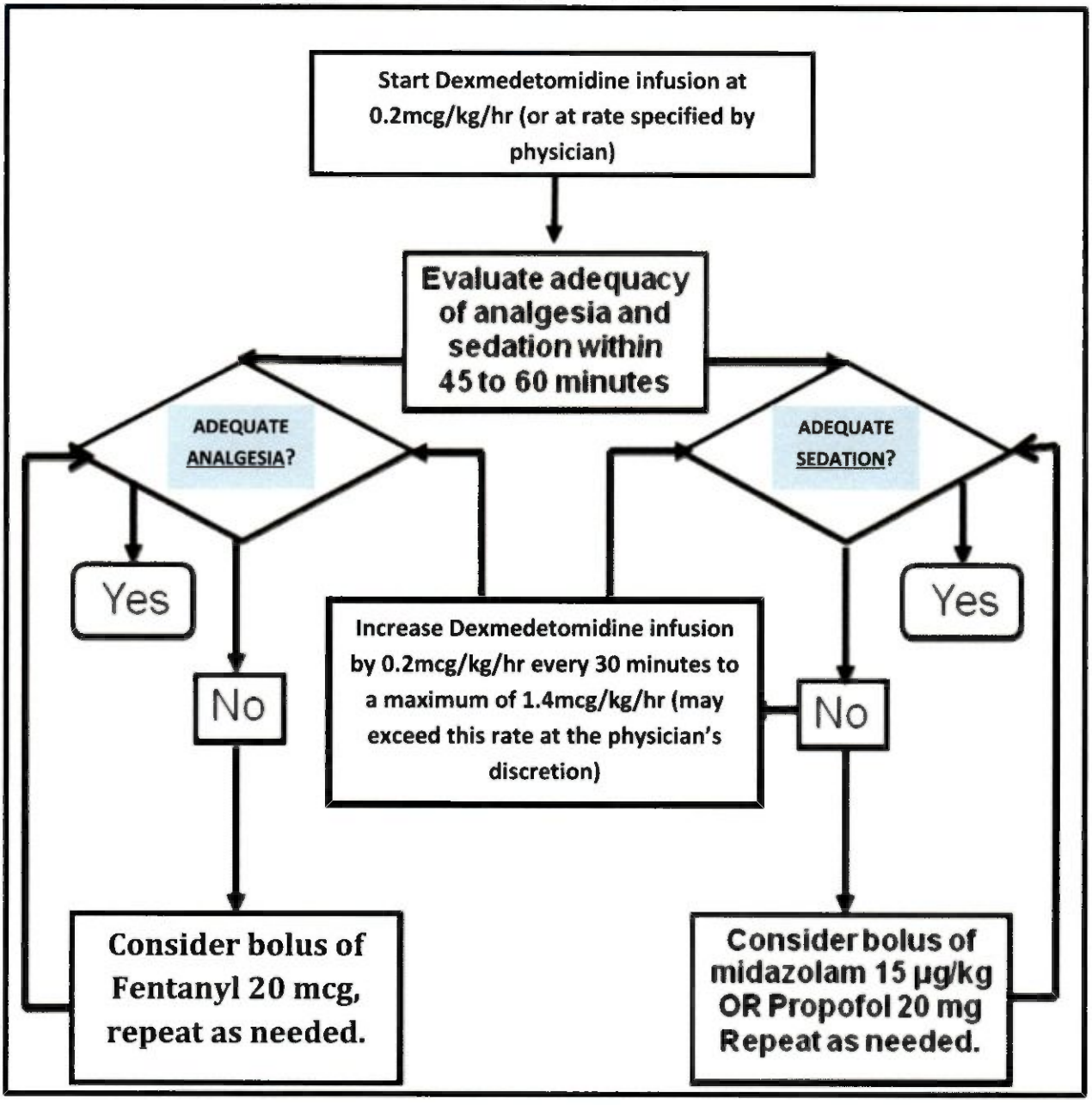
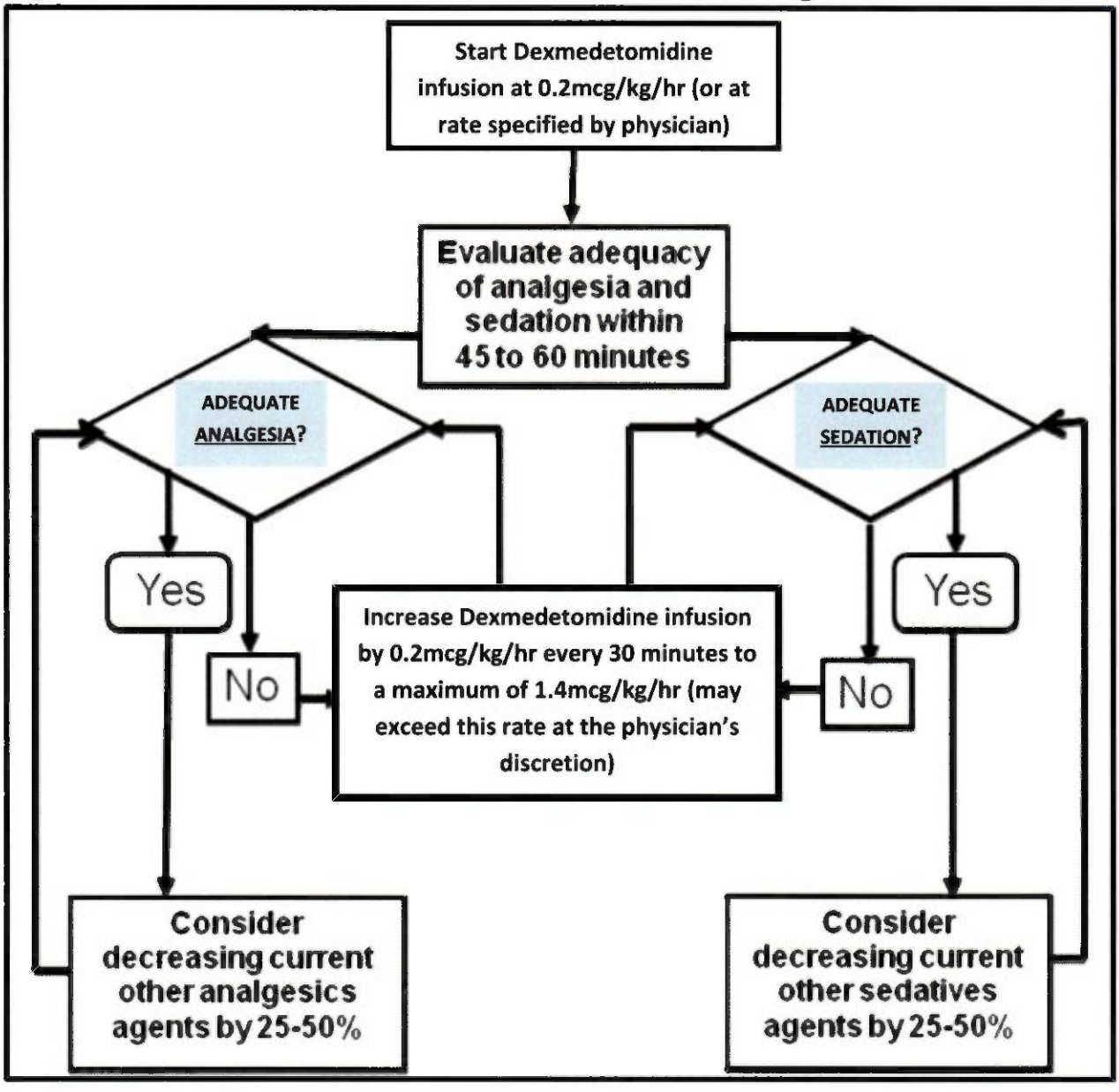


Figure 2: Transition From Other Sedatives and Analgesics



SUBJECT:	SECTION:
SCOPE OF SERVICES OF THE SURGICAL SERVICES DEPARTMENT	**Page 1 of 4**

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

PURPOSE:

To provide a safe and comfortable environment for both patients and personnel in order to provide optimum assistance to the surgeons in meeting the emergency, preventive and restorative health needs of the patients. To perform high quality surgical procedures with the appropriate staff, space, equipment and supplies.

POLICY:

The Surgical Services Staff will provide their patient quality-conscious, competent and cost-effective care.

SCOPE OF SERVICE AND COMPEXITY OF CARE:

1. Type of Patients -
   Surgical Services provides care for patients undergoing inpatient or outpatient surgical and invasive procedures.

2. Age of Patients -
   The patient population served by the Surgical Services Department consists of the pediatric patient (1 year-12 years), adolescent patient (12 years-18 years), adult patient (18 years-65 years) and geriatric patient (65 years and older).

3. Services and Procedures -

   a. Operating Room – The surgery and procedural services provided are Ear, Nose & Throat (ENT), General, Obstetrics-Gynecology (Ob-Gyn), Orthopedics, Podiatry, Urology and Vascular. The list of procedures for each service performed are delineated and approved by the Medical Staff.

   b. Post Anesthesia Care Unit (PACU)/Flex Care – Service provides ambulatory surgery procedures, pre-operative teaching and preparation, post anesthesia/recovery care and procedural care, examples being:

      - Transfusions blood/iron
        Antibiotic infusions
        Intramuscular Injections
        Bladder instillations

   c. Endoscopy – This Gastroenterology service provides diagnostic and therapeutic procedures.

4. Hours of Operation -

The Surgical Services Department provides services for operative and other invasive procedures and immediate postoperative care twenty-four hours a day, seven days a week. The Department has staff available to operate four operating room (OR) suites, two endoscopy suites from 7:30 a.m. to 3:15 p.m. each day. One OR suite is open until 5:00pm. PACU/Flex Care is staffed from 5:30 a.m. to 4:30p.m. An "on-call" staff is available to cover the additional hours from 3:15 p.m. until 6:45 a.m. Weekend and holiday services are covered by the on-call staff or additional staff may be arranged if needed.

5. Staffing Plan -

The Surgical Services Department is under the direction of the Director of Surgical Services. The Operating Room and Flex Care/Post Anesthesia Care Unit have Registered Nurse Clinical Managers to facilitate provision of quality patient care. The Surgical Liaison nurse communicates with the patient/family before the scheduled procedure in order to obtain the nursing assessment, provide information for the patient/family and answer their questions. Upon admission to the pre-op area, the patient is assessed by a Registered Nurse. Intraoperatively and postoperatively, the patient is continually reassessed. Modifications to that plan of care are based on reassessment of the patient. In the immediate postoperative phase, the patient is under the indirect supervision of the anesthesiologist/anesthetist, who maintains responsibility for the needs of the patient until the patient has been appropriately discharged from the PACU. Disposition of the patient from the PACU is based on the complexity of the patient's care needs. This decision is made collaboratively between the anesthesiologist and surgeon, with information related to clinical data provided by the PACU staff.

The Flex Care and PACU registered nurses provide pre and postoperative care. The surgical team for a procedure is composed of a Registered Nurse Circulator, a Surgical Technician or RN scrub nurse and, if needed for the procedure, a Registered Nurse First Assistant (RNFA). Unlicensed Assistive Personnel are Scheduling Secretaries, Unit Clerks and EVS/Orderlies. For procedural sedation procedures, an additional RN must be present to monitor the patient.

Staffing is based on the number of scheduled cases and complexity of the cases. In the event that adequate staffing is unavailable, or if during regular hours of operation an emergency or disaster occurs, cases will be prioritized based on the following criteria:

a. acuity of the patient needs

b. special circumstances, i.e., bowel prep needed for procedure, needle marker inserted pre-procedure, age of patient

c. special equipment needs

d. vendor availability

e. surgeon's schedule

The Director of Anesthesia will be the resource person to assist in a satisfactory resolution to the issue, minimizing the need for case cancellations.
The Disaster manual call-in roster will be used to augment staff in the event of an emergency.

6. Equipment and Supplies

There shall be adequate and appropriate equipment and supplies related to the needs and services offered, including but not limited to:

a. Cardiac monitor with pulse oximeter
b. Electrocardiographic monitor
c. Oxygen and CO_2 respiratory rate alarms
d. D. C. defibrillator
e. Appropriate supplies and drugs for emergency use (crash cart, Pyxis, and pharmacy)
f. Clinical educator will be responsible for training and maintaining records of all staff

7. Qualifications of Staff

a. Registered Nurse with experience in and demonstrated competencies in Surgical Services nursing (Flex Care/PACU, Operating Room) require BLS, ACLS, and PALS (PALS not required for operating room nurses). CNOR (Certified Nurse in the Operating Room) and CPAN (Certified Peri-Anesthesia Nurse) are strongly encouraged.

b. Registered Nurse First Assistant (RNFA) – BLS, ACLS, CNOR, attendance at an AORN approved RNFA program, CRNFA encouraged.

c. Operating Room (Surgical) Technician with experience in and demonstrated competencies in surgical procedures. Newly hired surgical technicians must have graduated from an accredited school of surgical technology. – BLS

d. Unlicensed assistive personnel that demonstrate competencies in providing support for surgical services – BLS

An ongoing program of assurance, education and clinical skill competency evaluation for all staff will be maintained by the Perioperative Clinical Educator and the Hospital Education Department.

REFERENCES:

- Association of Perioperative Registered Nurses (AORN) ~~(2019)~~ (2025). Guidelines for Perioperative Practice. AORN, Inc.
- American Society of Perianesthesia Nurses. Perianesthesia Nursing Standards Practice Recommendations and Interpretive Statements (~~2019-2020~~) (2023-2024).

- ~~California Code of Regulations (2019). Title 22. §70221, 70223, 70225, 70227. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.~~

CROSS-REFERENCE:

- Emergency Operations Plan policy
- Staffing Patterns PACU policy

SUBJECT:	SECTION:
VANCOMYCIN PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

PURPOSE:

To provide a guide for safe and effective dosing of vancomycin.

POLICY:

The pharmacist will monitor vancomycin and assess for appropriate empiric vancomycin dosing; assess and adjust vancomycin doses to maintain trough goals and minimize vancomycin toxicity; assess laboratory trends; and maximize the use of each hospital stay to achieve the therapeutic goals.

AFFECTED PERSONNEL/AREAS: *MEDICAL STAFF, PHARMACY, NURSING*

PROTOCOL AND PROCEDURE:

The guideline that follows is not a substitute for good clinical judgment. Upon request of the physician, the pharmacist will initiate the monitoring process as stated in the policy above.

A. Vancomycin Drug Overview

1. Vancomycin is a glycopeptide antibiotic that exhibits (slow) bactericidal activity on most Gram positive (+) bacteria.

2. Vancomycin exhibits "concentration-independent" or "time-dependent" bactericidal activity. Therefore, increasing antibiotic concentration beyond the therapeutic threshold will not result to faster killing or elimination of bacteria.

3. Vancomycin is approximately 55% protein bound; a half-life of 4 to 6 hours with normal renal function but the half-life can be up to 7.5 days with renal impairment.

B. Indications and Trough Goals (or desired trough goal as requested by physician order)

Indication	**Recommended Trough Concentration (mcg/mL)**
Skin and Soft Tissue Infections	10 – 15
Bacteremia	15 – 20
Endocarditis	15 – 20
Hospital-Acquired Pneumonia (Staph. aureus)	15 – 20
Meningitis	15 – 20
Osteomyelitis	15 – 20

C. Monitoring: Initial Patient Assessment

1. When an order for vancomycin is requested for a patient, the pharmacist will assess the following baseline parameters prior to initiation of vancomycin:

   a. Past medical history and allergy history;

   b. Indication for vancomycin and trough goal;

   c. Renal function (e.g. serum creatinine, calculated CrCl);

   d. Appropriate objective measures (e.g. UA, CBC, culture and sensitivities);

   e. Refer to SVMC Antibiotic Susceptibility Report.

2. Drug-drug interactions will be assessed.

D. Dosing

1. Loading dose
   a. Seriously ill patients with documented/suspected MRSA infection should consider a loading dose of 20 to 35mg/kg (based on actual body weight; maximum of 3g/dose)

2. Intermittent infusion:
   a. 15 to 20 mg/kg/dose (rounded to nearest 250mg) every 8 to 12 hours, adjusted based on therapeutic monitoring to achieve target.

3. Altered kidney function dosing
   a. Estimate the creatinine clearance using the Cockcroft and Gault Formula in patients not receiving dialysis & adjust dosing interval accordingly.

Vancomycin IV Initial Dose Adjustments in Altered Kidney Function

CrCl (mL/minute)	Suggested loading dose (when applicable)[a]	Suggested initial maintenance dose	Suggested dosing interval
>90 to <130	25 to 30 mg/kg	15 to 20 mg/kg	8 to 12 hours
50 to 90	20 to 25 mg/kg	15 to 20 mg/kg	12 hours
15 to <50	20 to 25 mg/kg	10 to 15 mg/kg	24 hours
<15[b]	20 to 25 mg/kg	10 to 15 mg/kg	48 to 72 hours

1. *Dose Adjustment*

   a. The dosing interval and/or dose will be adjusted as needed based on the kinetics of the drug in the individual calculated using the vancomycin levels.

   b. In light of declining or increasing renal function, vancomycin dosing interval and/or dose will be adjusted in order to maintain therapeutic levels.

Note: Vancomycin should be administered intravenously at a rate no faster than 10mg/min. This has been shown to significantly reduce infusion related reactions. Use of clinical dosing calculators will be at the discretion of pharmacist (ex. ClinCalc & GlobalRph)

E. Monitoring: Laboratory trends for Vancomycin

1. When a patient has an active order for vancomycin the pharmacist will monitor for trough goals to reach intended therapeutic target. Monitoring process will be done on a daily basis, and for the duration of therapy and/or the duration of hospital stay.

2. The trough level should be drawn 30 minutes prior to the next scheduled dose of vancomycin when deemed by pharmacist to be at steady-state concentrations. Based on clinical judgment of the pharmacist, random vancomycin levels may be drawn before and after steady-state concentration is reached (e.g. patients with severe renal insufficiency).

3. Drawing >1 trough concentration prior to the fourth dose for short course (<3 days) or lower intensity dosing (target trough concentrations <15 mg/L) is not recommended. For patients with uncomplicated skin and soft tissue infections who are not obese and have normal renal function, serum trough monitoring is generally not needed (IDSA [Liu 2011]).

4. The RN may order troughs, or random vancomycin levels at the request of the pharmacist or physician (a common example of this practice may occur for obtaining accurate post hemodialysis troughs).

5. The following monitoring parameters will be assessed by the clinical pharmacist:

   a. Renal function: BUN, SCr, CrCl.

   b. Laboratory data: Culture and sensitivities, CBC, trough levels, etc.

   c. Physical findings: Vital signs, weight, temperature, etc.

   d. Other pertinent tests or data that the clinical pharmacist deems necessary to maintain and/or achieve therapeutic goals and ensure patient safety.

4. The clinical pharmacist will document all pharmacokinetic monitoring and adjustments on their daily review sheet.

REFERENCES:

- American Journal of Health-System Pharmacy. Therapeutic monitoring of vancomycin for serious methicillin-resistant *Staphylococcus aureus* infections: A revised consensus guideline and review by the American Society of Health-System Pharmacists, the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society, and the Society of Infectious Diseases Pharmacists. https://academic.oup.com/ajhp/article/77/11/835/5810200?login=false Accessed December 30, 2025.

- Bartlett JG, Auwaerter PG, Pham PA. (2015) John Hopkins ABX Guide: Diagnosis and treatment of infectious diseases. The John Hopkins University School of Medicine; pg. 613-615.

- Lexi-Comp, Inc. Vancomycin Monograph. Lexi-Comp OnlineTM. Retrieved December 30, 2025 from www.online.lexi.com.

- Rybak M, Lomaestro B, Rotschafer JC, et al. (2009) Therapeutic monitoring of vancomycin in adult patients: A consensus review of the American Society of Health-System Pharmacist, the Infectious Diseases Society of America, and the Society of Infectious Diseases Pharmacist. Am J Health-Syst Pharm; 66: 82-98.

SUBJECT: **RESUSCITATION OF INFANT**	SECTION: **Page 1 of 6**

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

PURPOSE:

To perform neonatal resuscitation and achieve best patient outcomes, reducing morbidity and mortality. To provide guidelines for effectiveness and completeness of resuscitation team managing infants needing resuscitation.

POLICY:

A. Appropriate staff and equipment for resuscitation will be provided at all deliveries.

B. Infants requiring resuscitation will be resuscitated following American Heart Association/American Academy of Pediatrics Neonatal Resuscitation Program (NRP) protocol.

C. In addition to the Labor & Delivery Registered Nurse (RN), a second nurse with current NRP certification will be available for each delivery with the sole responsibility for resuscitation of the newborn if needed.

D. A pediatrician trained in infant resuscitation and capable of endotracheal intubation will be present (on request) for Cesarean sections and high-risk vaginal deliveries.

E. All Licensed Maternal Child Health (MCH) Department personnel will maintain current NRP certification.

F. Newborn Crash Cart will be available in:

1. Nursery and OB Surgical Suite
2. Central Supply
3. Will be checked daily utilizing "Newborn Crash Cart Integrity Check List"

G. Nurse will check equipment and crash cart, utilizing the Crash Cart Check List daily.

H. Nurse will check the warmer before delivery, assuring the appropriate equipment is ready and set up.

AFFECTED AREAS/ PERSONNEL: *MCH DEPARTMENT/REGISTERED NURSES (RNs)*

EQUIPMENT:

1. Radiant warmer
2. Gloves
3. Defibrillator (kept in supply closet on adult cart with pediatric pads)

4. Pulse oximeter and pulse ox probes.

5. Suction equipment:

   a. Bulb syringe

   b. Suction catheters

   c. Meconium aspirator- **Only to be used for removal of thick secretions if a 5-8 Fr cath is unsuccessful**

   d. DeLee suction

- **NRP no longer recommends intubation for the removal of meconium in a non-vigorous meconium-stained fluid infant.**

6. Bag and mask ventilation equipment or T connector:

   a. Infant resuscitation bag or T connector

   b. Face masks: newborn and low birth weight sizes

   c. Oral airways: newborn and low birth weight sizes

   d. Oxygen with flow meter and tubing

7. Intubation equipment:

   a. Laryngoscope with #1 and #0 blades

   b. Extra batteries and bulbs

   c. Endotracheal tubes: Sizes 2.5, 3.0, 3.5 and 4.0 mm.

   d. Scissors

   e. Tape

8. Stethoscope

9. Warmed linen

PROCEDURE:

1. Follow the guidelines on Neonatal Resuscitation of the American Heart Association and American Academy of Pediatrics.

    a. Place infant under preheated radiant warmer.

    b. Dry thoroughly, if thick meconium not present.

    c. Remove wet linen.

    d. Position with head slightly extended or in "sniffing position".

    e. Suction if necessary.

    f. Provide tactile stimulation by gently rubbing back and flicking the soles of the feet.

    g. Give O2 (as necessary).

    h. Evaluate respirations, heart rate and color; follow NRP guidelines.

2. If not present, notify Pediatrician/Hospitalist immediately.

3. When stable, transfer to the NICU for further observation and treatment if necessary.

4. **NOTE: IF DECISION TO USE DOPAMINE DRIP, PHARMACY WILL PREPARE AND MIX AND SEND TO THE NICU.**

DOCUMENTATION:

1. One Nurse should be dedicated to documentation of resuscitation, medications, and treatments provided for the infant.

2. Fully completed Newborn Resuscitation Record should be kept on the chart, one copy to the Nursery/NICU manager and one to risk management.

3. The RN will complete the immediate delivery summary in the EMR.

EXCHANGE CART PROCEDURE:

1. A licensed Nurse from the department/unit treatment area (where the Code Blue occurred) is "*responsible for delegating and ensuring*" that a fully stocked crash cart from Central Processing

Department (CPD) is obtained as soon as possible after the termination of the Code Blue. **The used cart shall NOT be removed from the area until a new cart is available.**

2. Exchange Procedure when Pharmacy is open:

   a. Central Processing Department is notified that a replacement cart is required. The licensed pharmacy staff will come to the unit and remove the medication tray from the used crash cart before the CPD technician exchanges the cart. If a licensed pharmacy staff is not available to come to the unit right away, the CPD technician will bring a new crash cart to the code area without retrieving the used crash cart. After the medication tray of the used crash cart has been removed by a licensed pharmacy technician, he/she or the unit clerk will contact the CPD technician to come to the unit to retrieve the used crash cart.

   b. Used carts will be returned to the CPD first for processing of non-medication items during normal business hours. When finished, the cart will be brought to Pharmacy.

   c. A pharmacist will load a new medication tray into the crash cart and secure the entire cart with red locks, with proper documentation. The central processing department is called immediately to pick up the stocked and locked cart to return to CPD storage.

3. Exchange procedure when pharmacy is closed:

   a. The night administrative Supervisor will obtain a newly supplied exchange cart from CPD and transport the cart to the patient care area where the code situation has terminated. **The used cart shall not be removed from the area until a new cart is available.**

   b. The night Supervisor will leave the used medication tray in the after hours pharmacy night locker. The rest of the cart will be returned to the dirty side of CPD.

4. Medication Trays and Supplies:

   a. The neonatal crash carts will contain a medication tray that is prepared by Pharmacy, and contains a checklist that includes the name of the medication, strength, dispensing unit, and quantity. All medications contained within the medication tray will be consistent with medications used in NRP (Neonatal Resuscitation Program).

   b. The checklist will identify the "First Medication to Expire" and the "Expiration Date" of that item.

   c. Medications placed in the tray will have at least 2 months dating prior to expiration.

   d. The trays will be verified by a Registered Pharmacist (See "Emergency Medication Crash Cart List" form).

e. Non-pharmaceutical crash cart supplies will be replenished by CPD based upon the items and quantities listed on the Crash Cart Contents List, kept in CPD.

5. **Location of the Neonatal Crash Carts:**

a. NICU (Neonatal Intensive Care Unit)

b. OB Surgical Suite

c. Central Processing Department (2 Carts)-
   - One cart as a replacement cart for MCH unit when used.
   - One cart for MCH overflow on the 3rd floor (3 west) when it is open (Nurse to call CPD when open to obtain cart, nurse to call Supervisor when open on off shifts to obtain cart).

6. Inspection Procedure:

a. Daily Inspection:

- Nurse will make sure that the top of the Crash Cart is clean and organized and ready for use.
- Nurse will make sure that the Crash Cart binder is present with medication dosing.
- Nurse will follow hospital policy regarding crash cart checks and verify that the tamper-evident seals are locked and that the lock number corresponds to the number recorded on the crash cart check list. If the lock is broken, the nurse will follow steps to replace the cart, and the cart will not be used.
- Nurse will sign the crash cart check off sheet daily.

b. Monthly Inspection:

- The Pharmacist will check the contents of the medication trays for dating during the Monthly Unit Area Inspections.
- Trays with contents outdated within 2 months will be removed and replaced with a new tray.

c. Quarterly Inspection:

- The CPD department will follow hospital policy on the crash carts.
- All carts will be restocked according to the Neonatal Crash Cart Contents List, periodically reviewed and updated by the Code Blue Committee and NICU staff.

REFERENCES:

- American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2021). *Guidelines for perinatal care* (8th ed.). American Academy of Pediatrics.
- American Academy of Pediatrics. (2020). *Textbook of neonatal resuscitation* (8th ed.). American Academy of Pediatrics.
- California Code of Regulations (2020). Title 22. § 70547 (b) (11) (22). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- Gardner, S. L., Carter, B. S., Hines, M. E., & Hernandez, J. A. (2021). *Merenstein & Gardner's handbook of neonatal intensive care* (9th ed.). Elsevier.
- The Joint Commission (2020). Hospital accreditation standards. NPSC.02.03.01. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCE:

- Crash Carts – Exchanging, Restocking, Security and Certification

SIERRA VIEW MEDICAL CENTER

PROCEDURAL SEDATION PHYSICIAN PROGRESS NOTE

PRE- PROCEDURE ASSESSMENT

❑ H&P reviewed and patient remains unchanged

❑ H&P reviewed and update needed (see Short Form H&P)

Review of Systems (Recent History)

Neg		Relevant History	Neg		Relevant History
	General:			GU:	
	EENT:			MUSCULOSKELETAL:	
	RESP:			NEURO:	
	CV:			PSYCH:	
	GI:			OTHER:	

AIRWAY ASSESSMENT/MALLAMPATI SCORE (Check appropriate score after assessing patient)

❑ Class 1: Full visibility of tonsils, uvula and soft palate
❑ Class 2: Visibility of hard and soft palate, upper portion of tonsils and uvula
❑ Class 3: Soft and hard palate and base of the uvula are visible
❑ Class 4: Only hard palate visible

ASA (Must be assigned by Physician prior to procedure) Check appropriate score below:

❑ ASA Class I: A normal healthy patient
❑ ASA Class II: A patient with mild systemic disease (mild diabetes, controlled HTN, anemia, chronic bronchitis, and morbid obesity)
❑ ASA Class III: A patient with a severe systemic disease that limit activity (angina, COPD, or MI)
❑ ASA Class IV: A patient with incapacitating disease that is a constant threat to life, (heart failure, renal failure)
❑ ASA Class V: A morbid patient not expected to survive,-ruptured aneurysm, head trauma with increasing intracranial pressure

IMMEDIATE PATIENT RE-EVALUATION PRIOR TO PROCEDURE

❑ ASA > 3 Anesthesia consult completed prior to commencement of procedure
❑ No change in the above assessment just prior to procedure
❑ Change in patient assessment just prior to procedure. Case cancelled.

Physician Signature: _____ Date: _____ Time: _____

POST PROCEDURE IMMEDIATE OPERATIVE NOTE

Procedure Performed: _____

Post Operative Diagnosis: _____

Pre Operative Diagnosis: _____

Assistant: _____

Findings: _____

EBL _____ OR ❑ NA

Specimens Removed _____ OR ❑ NA

Physician Signature: _____ Date: _____ Time: _____

PATIENT'S LABEL

SIERRA VIEW
MEDICAL CENTER

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

MEETING MINUTES

BOARD OF DIRECTORS ANNUAL MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly February 24, 2026 at 5:00 P.M. in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman Lomeli called the meeting to order at 5:00 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Present
- Areli Martinez, Secretary – Present Via Telephone
- Hans Kashyap, Director – Present
- Martha A. Flores, Director - Present

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Melissa Crippen, Vice President of Quality and Regulatory Affairs, Ron Wheaton, Vice President of Professional Services & Physician Recruitment, Brandy Irwin, Chief Nursing Officer, Tracy Canales, Vice President of Human Resources and Marketing, Kim Pryor-DeShazo, Director of Marketing, Jennifer Regalado, Compliance Privacy Manager, Terry Villareal, Clerk to the Board, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

Board Director Request to Participate via Teleconference

Board Director Martinez requested to participate remotely pursuant to Government Code Section 54953.8.3 under the 'just cause" provision due to a qualifying caregiving need. A motion was made to allow Director Martinez to join via telephone, seconded by Vice Chair REDDY. The motion was carried with the following vote:

FLORES	Yes
KASHYAP	Yes
REDDY	Yes
LOMELI	Yes

Legal Counsel participated in the meeting via teleconference until he arrived in the Board Room at 5:20pm.

I. Approval of Agenda:

Chair LOMELI inquired if there was a motion to approve the agenda. Vice Chair REDDY moved to approve the agenda, the motion was seconded by Director FLORES. The motion was carried with the following vote:

FLORES	Yes

KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:04 p.m. to discuss the following items:

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

1. General Update;
2. Report on Peer Review/Credentials

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): Quality Division Update:
1. General Update
2. Compliance Quarterly Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Financial Services and Strategic Planning and Gov. Code Section 54956.9 (E)(1):Conference with Legal Counsel, Anticipated litigation. Estimated date of disclosure December 1, 2026.

Closed Session Items D & E were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session's scheduled start time.

III. Open Session: Chair LOMELI adjourned Closed Session at 5:35 p.m., reconvening in Open Session at 5:35 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:

1. General Report
Recommended Action: Information only; no action taken

2. Report on Peer Review/Credentials
Following review and discussion, Vice Chair REDDY made a motion to approve the Quality of Care/Peer Review/Credentials as presented. The motion was seconded by Director FLORES. The motion was carried with the following vote by the Board:

FLORES Yes
KASHYAP Yes
MARTINEZ Yes

REDDY	Yes
LOMELI	Yes

B. Quality Division Update

1. Quality Division Report
   Following review and discussion, Vice Chair REDDY made a motion to approve the Quality Division Update as presented. The motion was seconded by Director KASHYAP. The motion was carried with the following vote by the Board:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

2. Quarterly Compliance Report
   Following review and discussion, Director FLORES made a motion to approve the Quarterly Compliance Report as presented. The motion was seconded by Vie Chair REDDY. The motion was carried with the following vote by the Board:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

C. Discussion Regarding Trade Secrets Pertaining to Services and Facilities
   Information Only: No Action Taken

IV. Public Comments
None

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

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes

LOMELI Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director FLORES and seconded by Vice Chair REDDY to approve the January 27, 2026 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

FLORES Yes
KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

VII. Business Items

A. January 2026 Financials

Craig McDonald, CFO presented the Financials for January 2026.

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

FLORES Yes
KASHYAP Yes
MARTINEZ Yes
REDDY Yes
LOMELI Yes

B. Board Self Evaluation and Goals
Information Only: No Action Taken

VIII. SVLHCD Board Chair Report

No Report Given

IX. CEO Report

- Best of Central California Voting is now open until March 6th. SVMC has been nominated in the following categories: Best Hospital, Best Place to Work, Best Place to Have a Baby, Best Cancer Treatment Center, Best Physical Therapy, Best Surgery Center, Best Medical Facility (Terra Bella), Best Orthopedic Surgery, Best Women's Clinic, Best Nonprofit Organization (Sierra View Foundation).
- CEO Donna Hefner met with Vince Fong to discuss key healthcare topics.
- SVMC rocked Red to support Women's Heart Health.

- Daisy Award was presented to Kayla, Float Pool RN.
- SVMC team members attended the 2026 BETA HEART Workshop hosted by BETA Healthcare Group.
- We were proud to be well represented at two events in Lindsay: the Lindsay High School Health Science Academy Mentor Breakfast and the Lindsay Unified Career Fair. Both events provided meaningful opportunities to engage with students and introduce them to careers in healthcare.
- Upcoming events include Sierra View Foundation Golf Classic on April 10th, First Friday Coffee Sponsored by SVMC on March 6th and the Physician Appreciation Dinner.

X. Announcements:
Regular Board of Directors Meeting – March 24, 2026, at 5:00 p.m.

XI. Closed Session: Board adjourned Open Session at 6:06 p.m., reconvening in Closed Session at 6:12 p.m. to discuss the following items:

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(c): Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning. Estimated date of disclosure December 1, 2026.

E. Pursuant To Gov. Code Section 54956.9(D)(2), Conference With Legal Counsel About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Items).

XII. Open Session: Chairman REDDY adjourned Closed Session at 6:57 p.m., reconvening in Open Session at 6:58 p.m.

C. Discussion Regarding Trade Secrets Pertaining to Services and Strategic Planning
Information Only; No Action Taken

D. Conference with Legal Counsel
Information Only; No Action Taken

XIII. Adjournment

The meeting was adjourned at 6:58 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SIERRA VIEW
MEDICAL CENTER

Business Items

Sierra View Medical Center

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

January 1, 2024 – December 31, 2024

This annual evaluation of the objectives, scope, performance and effectiveness of Sierra View Medical Center's Environment of Care, Life Safety and Emergency Management programs applies to Sierra View Medical Center and all affiliated properties and all locations where patient care is provided.
Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. The database provides Sierra View Medical Center with comparative data in 89 areas of performance within the Environment of Care. Sierra View Medical Center was within the national target results in 87 of those areas, the Medical Center was rated above the national target results in 5 areas with only 2 areas being rated below national target results.

I. SAFETY MANAGEMENT

A. Objective:

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

B. Scope:

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

C. Performance and Effectiveness:

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

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

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

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

Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. 14 performance monitors were within control limits in 2024 (i.e., within one standard deviation of the database mean). 1 area rated below target results, High OSHA Lost Workday Injury/Illness quarterly rate. The current set of performance monitors will continue to be monitored in 2025.

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. 15 areas of Safety performance are benchmarked. The 15 areas focus on both patient safety and worker safety.

Significant issues addressed during 2024 in the Safety Management Program via the Safety Committee are listed below:

- Commonly cited deficiencies identified during Environmental tours include:
  a. Corridor clutter and high storage.
  b. Stained ceiling tiles.
  c. Expired supplies.

- A revised Safety Management Plan was approved and adopted in 2024. The revised plan addresses the changes within the 2024 EC Standards of The Joint Commission.

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

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

D. <u>Review of 2024 Goal</u>:

- Work to lower the OSHA Lost Workday Injury/Illness quarterly rate to the 50th percentile in the Osborne Engineering Benchmarking database.

E. <u>Goal for 2025</u>:

- Continue working to lower the OSHA Lost Workday Injury/Illness quarterly rate to the 50th percentile in the Osborne Engineering Benchmarking database. *Review and assess with Risk Management and Department Leaders.*

II SECURITY MANAGEMENT

A. Objective:

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

B. Scope:

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

C. Performance and Effectiveness:

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

The Safety Committee using the Osborne Engineering Inc. Environment of Care Benchmarking database tracks performance-monitoring data. Sierra View Medical Center's security staffing level exceeded control limits (i.e., w/i one standard deviation of the database mean). Security staffing for 2024 averaged 3.65 FTE's per 100,000 square feet of buildings including parking which placed the facility at the 78th percentile.

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

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

Significant issues addressed during 2024 in the Security Management Program via the Safety Committee are listed below:

- Review all security incident rates and statistics
- Review results of all Code Gray (Violent Patient/Visitor) and Code Strong (Hospital Lockdown) and Code Green (Missing Patient) incidents
- Revised Security Management Plan adopted to comply with the 2024 Joint Commission Standards

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

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

D. <u>Review of 2024 Goal</u>:

- Work to reduce the number of Incidents of Property Damage & Vandalism/100,000 Total Square Feet to the 50th percentile in the Osborne Engineering Benchmarking Database. The current rate is the 66th percentile. *This Goal was met as the facility made it to the 25th percentile.*

E. <u>Goal for 2025:</u>

- Work to reduce the number of Incidents of Automobile Thefts/100,000 Square Feet of Parking Area to the 50th percentile in the Osborne Engineering Benchmarking Database. The current rate is the 83rd percentile. *Meet with On-Site Security to assess the current situation.*

III HAZARDOUS MATERIALS AND WASTE MANAGEMENT

A. Objective:

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

B. Scope:

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

C. Performance and Effectiveness:

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

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

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

Significant issues addressed during 2024 in the Hazardous Materials and Hazardous Wastes Management Program via the Safety Committee listed below:

- Revised Hazardous Materials and Hazardous Waste Management Plan adopted
- Tulare County EH&S inspected and reviewed hazardous materials business plan (CUPA) and hazardous materials inventory, no violations
- Hazardous materials disposed of in 2024 maintained required manifests.

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

- Performance Monitoring and Benchmarking Data Results
- Training and Education Results
- Safety Committee Activity

D. <u>Review of 2024 Goal</u>:

- Work with staff to reduce the cost of Medical Waste Disposal/Adjusted Patient Day/Quarter. *This goal was met.*

E. <u>Goal for 2025</u>:

- Work with Environmental Services and Stericycle to develop a more accurate Hazardous Waste report that reflects not only cost but also pound of waste for the facility. *Meet with Environmental Services Manager to address goal.*

IV EMERGENCY MANAGEMENT PROGRAM / EMERGENCY OPERATIONS PLAN

A. <u>Objective</u>:

The objective of the Sierra View Medical Center Emergency Management Program is to establish and maintain an effective response to emergencies within the organization or in the community that would suddenly and

significantly affect the need for Sierra View's services, or its ability to provide these services for extended periods, up to ninety-six hours.

B. <u>Scope</u>:

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

C. <u>Performance and Effectiveness</u>:

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

The Central California Healthcare Coalition met in July 2024 to review and revise the Hazard Vulnerability Analysis to identify events that by scoring matrix have a potential to occur. Representatives from Tulare County, Fresno County, Kings County, Sierra View Medical Center, Adventist Tulare Medical Center, Kaweah Health, Porterville Developmental Center, Tulare County Sheriff's Office, Red Cross and local Religious Leaders participated in the process.

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

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

Significant issues addressed during 2024 in the Emergency Management Program via the Safety Committee are listed below:

- Emergency Management implementation requirements

- Hazard Vulnerability Analysis was affirmed with changes

- Participation in disaster planning with the County of Tulare Emergency Preparedness program
- California Health Alert Network (CAHAN) participation

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

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

D. <u>Review of 2024 Goal</u>:

- Begin coordinating with Tulare County Public Health/Emergency Services on performing a community wide drill to meet Joint commission standards. *This goal was met.*

E. <u>Goal for 2025</u>:

- Meet with local schools to plan and perform an evacuation drill on a district campus.

V. LIFE SAFETY MANAGEMENT

A. <u>Objective</u>:

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

B. <u>Scope</u>:

The Life Safety Management Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center,

Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, Cardiac Cath Lab, Sierra View Community Health Center (SVCHC),

Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Life Safety Management Plan is current and appropriate.

C. <u>Performance and Effectiveness</u>:

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

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

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

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

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

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

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

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

Additional noteworthy actions taken during 2024 include the following:

- Environment of Care Committee worked on reducing hallway clutter
- Life Safety Management Plan was revised and adopted
- All life safety systems inspected and tested as required in 2024
- Hot Work Permit Program continues to be utilized and successful.
- Interim Life Safety Measures (ILSM) utilized when appropriate.

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

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

D. <u>Review of 2024 Goal</u>:

- Confirm that all Evacuation Maps throughout the main facility and outpatient buildings are accurate and up to date. *This goal was met.*

E. <u>Goal for 2025:</u>

- Update the facility fire drill form to ensure that all regulatory requirements are being met during Fire Drills. *Meet with Engineering Leadership and Staff to review and update.*

VI. MEDICAL EQUIPMENT MANAGEMENT

A. Objective:

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

B. Scope:

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

C. Performance and Effectiveness:

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

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

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

Performance monitoring data is tracked using the Osborne Engineering, Inc. Environment of Care Benchmarking database. All Medical Equipment

Management performance data results were within control limits (i.e., w/i one standard deviation of the database mean).

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

Additional noteworthy actions taken during 2024 include the following:

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

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

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

D. <u>Review of 2024 Goal</u>:

- Work with Renovo to complete an updated inventory of all medical equipment that could not be located during scheduled preventative maintenance with the goal of tracking down all missing equipment. *This goal was met.*

E. <u>Goal for 2025</u>:

- Work with Renovo to develop a tracking system that can assist the hospital in locating equipment that is transported with a patient who has been sent to another facility. *Meet with Renovo to discuss.*

VII. UTILITIES MANAGEMENT

A. Objective:

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

B. Scope:

The Utility Systems Management Plan and related policies and procedures extend to the Sierra View Medical Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic,

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

C. Performance and Effectiveness:

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

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

Preventative maintenance (P.M.) is provided as detailed in the hospital's Utilities Management Program. At least a 100% Preventive Maintenance (PM) completion rate was maintained. All PM records are located in the facility's Engineering Department.

The Engineering Department continues to work with Infection Control on all construction projects to ensure adequate infection control measures are

in place. An infection control risk assessment program is in place to minimize the risk of facility-acquired illnesses for patients.

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

Performance monitoring data is tracked using the Osborne Engineering, Inc. Environment of Care Benchmarking database. Fifteen of the sixteen Utility Systems performance data results were within control limits (i.e., w/i one standard deviation of the database mean) with the Electricity Purchase Cost Rate exceeding control limits.

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

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

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

D. <u>Review of 2024 Goal</u>:

- Continue working with Engineering to improve the Preventative Maintenance quarterly completion rate to 100% in the Osborne Engineering Benchmarking Database. *This goal has been met.*

F. <u>Goal for 2025</u>:

- Work with Engineering to find opportunities to conserve electricity throughout the facility. This will include changing of light fixtures and

better management of timers for lighting and other equipment. *Meet with Engineering leadership to assess and plan.*

VIII. WATER MANAGEMENT

D. Objective:

The objective of the Water Management Plan is to control and manage Legionella and other Waterborne Pathogens in the facility water systems, and to control epidemic in the facility.

E. Scope:

The Water Management Plan and related policies and procedures extend to the Sierra View Medical Center, Distinct Part Skilled Nursing Facility (DPSNF) and the Cardiac Cath Lab The scope of the Water Management Plan is current and appropriate.

F. Performance and Effectiveness:

The Water Management Plan is comprised of multiple tasks and procedures including, but not limited to, the following:

1. System Identification and Hazard Analysis
2. Management Team and Control Tasks
3. Standard Operating Procedures and Protocols
4. Task Scheduling and Verification
5. Program Monitoring and Action Plans
6. Process Flow Diagrams

Quarterly Legionella testing is provided as detailed in the hospital's Water Management Plan, 26 areas are sampled at that time, those areas include:

1. Cold Water Supply
2. Cold Water Point of Use Taps
3. Hot Water Point of Use Taps
4. Decorative Fountains
5. Cooling Towers
6. Hot Water Storage Tanks

The results from the quarterly test are sent directly to the hospital along with recommendations for corrective actions, remediation and re-test.

The 2024 testing schedule saw 104 samples taken with 0 instances of Legionella from the Serogroup 1 category, and 38 instances of detectable Legionella in the Serogroups 2-14.
The facility followed all recommended remediation and safety protocols that included flushing of fixtures with detectable amounts of legionella for 7 to 10 days for 10 minutes a day, adding point of use filters on fixtures and system wide chlorination. The facility continues to expand its Water Management Plan and Legionella testing program.
The Water Management Plan is reviewed and updated annually to reflect lessons learned from the previous year and implement changes that improve the hospital's environment.

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

- Legionella Testing Results
- Remediation and Safety Protocols
- Safety Committee Activity
- No Instances of Legionella Outbreaks in the facility
- Water Management Plan revised and adopted

SIERRA VIEW MEDICAL CENTER

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Feb-26

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
February 2026

Statistic	Feb-26 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 25 YTD	Increase/ (Decrease) Feb-25	% Change
Utilization											
SNF Patient Days											
Total	-	-	-	0.0%	93	-	93	0.0%	127	(34)	-26.8%
Medi-Cal	-	-	-	0.0%	93	-	93	0.0%	127	(34)	-26.8%
Sub-Acute Patient Days											
Total	980	868	112	12.9%	8,179	8,259	(80)	-1.0%	7,891	288	3.6%
Medi-Cal	476	434	42	9.6%	3,780	4,132	(352)	-8.5%	3,948	(168)	-4.3%
Acute Patient Days	1,404	1,531	(127)	-8.3%	12,882	13,345	(463)	-3.5%	13,238	(356)	-2.7%
Acute Discharges	425	406	19	4.7%	3,643	3,538	105	3.0%	3,538	105	3.0%
Medicare	176	175	1	0.6%	1,361	1,402	(41)	-2.9%	1,402	(41)	-2.9%
Medi-Cal	198	195	3	1.5%	1,764	1,679	85	5.1%	1,679	85	5.1%
Contract	47	34	13	38.2%	487	435	52	12.0%	435	52	12.0%
County	-	-	-	0.0%	-	-	-	0.0%	-	-	0.0%
Capitated	-	-	-	0.0%	-	-	-	0.0%	-	-	0.0%
Self Pay/Other	4	2.00	2	100.0%	31	22	9	40.9%	22	9	40.9%
Other	4	2	2	100.0%	31	22	9	40.9%	22	9	40.9%
Average Length of Stay	3.30	3.77	(0.47)	-12.4%	3.54	3.77	(0.24)	-6.3%	3.74	(0.21)	-5.5%
Newborn Patient Days											
Medi-Cal	163	143	20	14.0%	1,326	1,264	62	4.9%	1,229	97	7.9%
Other	35	28	7	25.0%	338	256	82	31.8%	291	47	16.2%
Total	198	171	27	15.8%	1,664	1,520	144	9.5%	1,520	144	9.5%
Total Deliveries	98	91	7	7.7%	894	788	106	13.5%	793	101	12.7%
Medi-Cal %	80.61%	83.43%	-2.82%	-3.4%	79.40%	83.43%	-4.03%	-4.8%	81.76%	-2.36%	-2.9%
Case Mix Index											
Medicare	1.2997	1.6368	(0.3371)	-20.6%	1.5432	1.6368	(0.0936)	-5.7%	1.6128	(0.0696)	-4.3%
Medi-Cal	1.0933	1.1975	(0.1042)	-8.7%	1.1333	1.1975	(0.0642)	-5.4%	1.1986	(0.0653)	-5.4%
Overall	1.1604	1.3724	(0.2120)	-15.4%	1.2854	1.3724	(0.0870)	-6.3%	1.3667	(0.0813)	-5.9%
Ancillary Services											
Inpatient											
Surgery Minutes	5,544	7,378	(1,834)	-24.9%	57,382	62,175	(4,793)	-7.7%	60,777	(3,395)	-5.6%
Surgery Cases	74	87	(13)	-15.4%	681	726	(45)	-6.1%	727	(46)	-6.3%
Imaging Procedures	1,359	1,369	(10)	-0.7%	12,462	11,842	620	5.2%	12,064	398	3.3%
Outpatient											
Surgery Minutes	14,393	12,835	1,558	12.1%	118,492	111,020	7,472	6.7%	109,190	9,302	8.5%
Surgery Cases	190	178	12	6.8%	1,518	1,538	(20)	-1.3%	1,500	18	1.2%
Endoscopy Procedures	194	170	24	14.4%	1,408	1,467	(59)	-4.0%	1,461	(53)	-3.6%
Imaging Procedures	4,024	3,813	211	5.5%	33,161	32,981	180	0.5%	32,609	552	1.7%
MRI Procedures	310	276	34	12.3%	2,540	2,388	152	6.4%	2,406	134	5.6%
CT Procedures	1,317	1,147	170	14.8%	11,310	9,922	1,388	14.0%	9,792	1,518	15.5%
Ultrasound Procedures	1,431	1,236	195	15.8%	11,815	10,692	1,123	10.5%	10,408	1,407	13.5%
Lab Tests	32,533	29,370	3,163	10.8%	276,035	254,053	21,982	8.7%	251,149	24,886	9.9%
Dialysis	12	3	9	291.5%	53	27	26	99.9%	27	26	96.3%

Sierra View Medical Center
Financial Statistics Summary Report
February 2026

	Feb-26				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 25 YTD	(Decrease) Feb-25	% Change
Cancer Treatment Center											
Chemo Treatments	1,727	1,831	(104)	-5.7%	15,665	15,834	(169)	-1.1%	15,199	466	3.1%
Radiation Treatments	1,491	1,745	(254)	-14.6%	13,327	15,098	(1,771)	-11.7%	14,704	(1,377)	-9.4%
Cardiac Cath Lab											
Cath Lab IP Procedures	14	13	1	10.1%	123	110	13	11.8%	100	23	23.0%
Cath Lab OP Procedures	40	30	10	32.2%	250	262	(12)	-4.5%	263	(13)	-4.9%
Total Cardiac Cath Lab	54	43	11	25.6%	373	372	1	0.3%	363	10	2.8%
Outpatient Visits											
Emergency	3,403	3,288	115	3.5%	28,001	27,623	378	1.4%	27,597	404	1.5%
Total Outpatient	14,375	13,012	1,363	10.5%	116,919	112,555	4,364	3.9%	111,418	5,501	4.9%
Staffing											
Paid FTE's	873.77	900.16	(26.39)	-2.9%	874.55	900.16	(25.61)	-2.8%	872	2.42	0.3%
Productive FTE's	763.80	772.13	(8.33)	-1.1%	754.23	772.13	(17.90)	-2.3%	747	7.62	1.0%
Paid FTE's/AOB	4.85	5.31	(0.46)	-8.8%	4.99	5.22	(0.23)	-4.3%	5	(0.17)	-3.2%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,137	11,412	(275)	-2.4%	11,314	11,153	161	1.4%	11,241	73	0.6%
Cost/Adj.Patient Day	2,866	3,070	(204)	-6.6%	2,863	2,909	(47)	-1.6%	2,805	58	2.1%
Revenue/Adj. Discharge	49,633	55,241	(5,608)	-10.2%	52,648	55,088	(2,440)	-4.4%	54,529	(1,881)	-3.5%
Cost/Adj. Discharge	12,773	14,860	(2,087)	-14.0%	13,321	14,370	(1,049)	-7.3%	13,604	(283)	-2.1%
Adj. Discharge	1,133	980	152	15.5%	9,152	8,490	662	7.8%	8,472	679	8.0%
Net Op. Gain/(Loss) %	4.72%	-3.80%	8.52%	-224.1%	1.86%	-3.80%	5.66%	-148.8%	-2.29%	4.14%	-181.1%
Net Op. Gain/(Loss) $	716,209	(533,477)	1,249,686	-234.3%	2,305,094	(2,342,375)	4,647,469	-198.4%	(2,576,917)	4,882,011	-189.5%
Gross Days in Accts Rec.	104.84	95.03	9.82	10.3%	104.84	95.03	9.82	10.3%	85.87	18.98	22.1%
Net Days in Accts. Rec.	49.00	57.75	(8.75)	-15.1%	49.00	57.75	(8.75)	-15.1%	42.75	6.25	14.6%

Sierra View Local Health Care District
Balance Sheet

	Feb-26	Jan-26
Assets		
Current Assets:		
Cash & Cash Equivalents	5,566,878	7,655,278
Short-Term Investments	3,317,296	1,318,521
Assets Limited As To Use	3,766,320	3,293,988
Patient Accounts Receivable	210,973,526	215,526,614
Less Uncollectables	(14,733,646)	(16,015,977)
Contractual Allowances	(172,647,269)	(176,066,396)
Other Receivables	33,156,622	31,099,891
Inventories	4,423,241	4,527,053
Prepaid Expenses and Deposits	3,802,027	3,078,830
Less Receivable - Current	301,020	301,020
Total Current Assets	**77,926,015**	**74,718,824**
Assets Limited as to use, Less		
Current Requirements	32,760,859	32,690,723
Long-Term Investments	139,937,501	141,101,624
Property, Plant and Equipment, Net	69,843,598	70,254,015
Intangible Right of use Assets	187,920	198,242
SBITA Right of use Assets	2,220,883	2,350,136
Lease Receivable - LT	507,261	532,473
Other Investments	250,000	250,000
Prepaid Loss on Bonds	1,090,940	1,111,920
Total Assets	**324,724,976**	**323,207,955**
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	202,942	101,471
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	257,361	342,973
Account Payable and Accrued Expenses	5,561,363	5,558,796
Accrued Payroll and Related Costs	7,318,854	7,316,910
Estimated Third-Party Payor Settlements	4,382,634	4,365,134
Lease Liability - Current	129,125	129,125
SBITA Liability - Current	1,472,212	1,472,212
Total Current Liabilities	**23,559,490**	**23,521,620**
Self-Insurance Reserves	2,073,153	2,084,541
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	29,040,000	29,040,000
Bonds Premium Liability - LT	1,714,416	1,759,936
Lease Liability - LT	79,546	90,389
SBITA Liability - LT	1,234,175	1,383,795
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	750,054	774,551
Total Liabilities	**58,450,834**	**58,654,832**
Unresticted Fund	258,350,395	258,350,395
Profit or (Loss)	7,923,747	6,202,728
Total Liabilities and Fund Balance	**324,724,976**	**323,207,955**
	-	-

Sierra View Local Health Care District
Income Statement

For Period **Feb-26**

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	4,898,321	5,051,258	(152,937)	(3%)	43,848,239	44,119,198	(270,959)	(1%)
Inpatient - Ancillary	16,195,905	17,376,701	(1,180,796)	(7%)	148,434,647	150,782,231	(2,347,584)	(2%)
Total Inpatient Revenue	**21,094,226**	**22,427,959**	**(1,333,733)**	(6%)	**192,282,886**	**194,901,429**	**(2,618,543)**	(1%)
Outpatient - Ancillary	35,129,266	31,727,835	3,401,431	11%	289,525,143	272,792,848	16,732,295	6%
Total Patient Revenue	**56,223,492**	**54,155,794**	**2,067,698**	4%	**481,808,030**	**467,694,277**	**14,113,753**	3%
Medicare	(17,960,588)	(17,775,353)	(185,235)	1%	(148,139,036)	(153,979,988)	5,840,952	(4%)
Medi-Cal	(19,608,164)	(16,571,361)	(3,036,803)	18%	(162,347,777)	(143,861,168)	(18,486,609)	13%
Other/Charity	(4,814,017)	(6,359,383)	1,545,366	(24%)	(46,157,794)	(54,792,807)	8,635,013	(16%)
Discounts & Allowances	(120,236)	(16,948)	(103,288)	609%	(1,259,480)	(146,366)	(1,113,114)	761%
Bad Debts	721,196	(216,623)	937,819	(433%)	(6,510,658)	(1,870,777)	(4,639,881)	248%
Total Deductions	**(41,781,809)**	**(40,939,668)**	**(842,141)**	2%	**(364,414,746)**	**(354,651,106)**	**(9,763,640)**	3%
Net Service Revenue	**14,441,683**	**13,216,126**	**1,225,557**	9%	**117,393,284**	**113,043,171**	**4,350,113**	4%
Other Operating Revenue	743,528	818,039	(74,511)	(9%)	6,821,583	6,615,887	205,696	3%
Total Operating Revenue	**15,185,211**	**14,034,165**	**1,151,046**	8%	**124,214,867**	**119,659,058**	**4,555,809**	4%
Salaries	5,559,876	5,569,374	9,498	0%	47,870,002	48,211,224	341,222	1%
S&W PTO	622,183	661,428	39,245	6%	5,444,543	5,713,807	269,264	5%
Employee Benefits	1,345,085	1,460,204	115,119	8%	11,984,918	11,681,632	(303,286)	(3%)
Professional Fees	2,048,008	1,868,002	(180,006)	(10%)	14,776,116	15,130,385	354,269	2%
Purchased Services	836,246	904,742	68,496	8%	7,178,332	7,256,876	78,544	1%
Supplies & Expenses	2,193,149	2,124,589	(68,560)	(3%)	19,093,417	18,195,044	(898,373)	(5%)
Maintenance & Repairs	245,136	303,754	58,618	19%	2,272,685	2,430,032	157,347	6%
Utilities	228,510	306,217	77,707	25%	2,379,491	2,449,736	70,245	3%
Rent/Lease	24,344	30,041	5,697	19%	306,060	240,328	(65,732)	(27%)
Insurance	118,061	122,727	4,666	4%	948,346	981,816	33,470	3%
Depreciation/Amortization	876,010	811,079	(64,931)	(8%)	6,536,715	6,488,632	(48,083)	(1%)
Other Expense	372,395	405,485	33,090	8%	3,119,150	3,221,921	102,771	3%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	**14,469,002**	**14,567,642**	**98,640**	1%	**121,909,774**	**122,001,433**	**91,659**	0%
Net Gain/(Loss) From Operations	**716,209**	**(533,477)**	**1,249,686**	**(234%)**	**2,305,094**	**(2,342,375)**	**4,647,469**	**(198%)**
District Taxes	138,477	138,477	-	0%	1,107,816	1,107,816	-	0%
Investment Income	434,680	488,226	(53,546)	(11%)	4,137,868	3,905,808	232,060	6%
Other Non - Operating Income	28,040	40,308	(12,268)	(30%)	232,308	322,464	(90,156)	(28%)
Interest Expense	(69,180)	(70,649)	1,469	2%	(571,772)	(565,192)	(6,580)	(1%)
Non-Operating Expense	(21,127)	(39,853)	18,726	47%	(294,962)	(318,826)	23,864	7%
Total Non-Operating Income	**510,889**	**556,509**	**(45,620)**	(8%)	**4,611,257**	**4,452,070**	**159,187**	4%
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**1,227,098**	**23,032**	**1,204,066**	**5,228%**	**6,916,350**	**2,109,695**	**4,806,655**	**228%**
Net Incr/(Decr) in the Fair Value Invstmt	493,921	162,500	331,421	204%	1,007,396	1,300,000	(292,604)	(23%)
Net Gain/(Loss)	**1,721,019**	**185,532**	**1,535,487**	828%	**7,923,747**	**3,409,695**	**4,514,052**	132%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
February-26

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	716,209	2,305,094
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	876,010	6,536,715
Provision for bad debts	(1,282,330)	512,849
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	1,133,962	(4,709,118)
Other receivables	(2,056,730)	(12,888,167)
Inventories	103,812	69,670
Prepaid expenses and deposits	(723,197)	(1,182,109)
Advance refunding of bonds payable, net	20,980	167,837
Accounts payable and accrued expenses	2,567	63,415
Deferred inflows - leases	(24,497)	(195,976)
Accrued payroll and related costs	1,944	(1,876,581)
Estimated third-party payor settlements	17,500	(26,079)
Self-insurance reserves	(11,388)	(55,936)
Total adjustments	(1,941,368)	(13,583,480)
Net cash provided by (used in) operating activities	(1,225,159)	(11,278,386)
Cash flows from noncapital financing activities:		
District tax revenues	138,477	1,107,816
Noncapital grants and contributions, net of other expenses	(5,966)	(186,559)
Net cash provided by (used in) noncapital financing activities	132,511	921,257
Cash flows from capital and related financing activities:		
Purchase of capital assets	(455,272)	(4,841,651)
Proceeds from sale of assets	-	5,000
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	25,212	199,374
Principal payments on debt borrowings	-	(4,235,000)
Interest payments	(351)	(1,307,611)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(116,821)	(642,439)
Net changes in assets limited as to use	(542,468)	1,250,944
Net cash provided by (used in) capital and related financing activities	(1,089,700)	(9,571,383)
Cash flows from investing activities:		
Net (purchase) or sale of investments	1,658,043	125,623
Investment income	434,680	4,137,868
Net cash provided by (used in) investing activities	2,092,723	4,263,491
Net increase (decrease) in cash and cash equivalents:	(89,625)	(15,665,021)
Cash and cash equivalents at beginning of month/year	8,973,799	24,549,196
Cash and cash equivalents at end of month	8,884,174	8,884,174
	8,884,174	8,884,174
	0.00	(0.00)

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
February 2026

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Mar-25	13,111,820	451,259	13,563,079
Apr-25	13,460,422	8,143,789	21,604,211
May-25	12,344,513	9,292,615	21,637,128
Jun-25	10,549,177	4,753,556	15,302,733
Jul-25	13,219,919	932,239	14,152,158
Aug-25	9,922,993	1,161,531	11,084,524
Sep-25	12,323,268	233,998	12,557,266
Oct-25	12,181,755	7,001,985	19,183,740
Nov-25	10,154,998	601,439	10,756,437
Dec-25	13,361,348	2,861,896	16,223,244
Jan-26	10,470,878	6,040,603	16,511,481
Feb-26	**12,005,852**	**5,418,366**	**17,424,218**

NOTE:

Cash receipts in "Other Activity" include the following:

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

- Non-Operating Revenues - rental income, property tax revenues, sale of assets

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

February 2026 Summary of Other Activity:

4,163,586	Anthem Blue Cross Rate Range IGT YCY24
718,220	M-Cal IP DSH 12/25 - 01/26
253,428	M-Care interim payments
9,699	M-Cal DHDP CY25 Phase 2
47,500	California Medic GME
225,933	Miscellaneous
5,418,366	02/26 Total Other Activity