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

AGENDA
May 27, 2025

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

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

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

2. Quality Division Update – Quality Report

    a. Quality

    b. Risk Management and Patient Safety

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

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2027 Estimated date of disclosure May 28, 2025

E. Designation of Sierra Local Health Care District Negotiator Ron Wheaton for Real Property Negotiations Cal. Gov. Code § 54956.8. Property: APN: 215-330-060 and 205-330-060-064, Strathmore, CA 93267. Estimated date of disclosure May 1, 2026

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2027

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

C. Discussion Regarding Trade Secrets Pertaining to Services
Recommended Action: Information Only; No Action Taken

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only; No Action Taken

E. Designation of Sierra Local Health Care District Negotiator for Real Property Negotiations
Action Recommended: Approve/Disapprove Appointment of Ron Wheaton as Negotiator for sale of real property APN: 215-330-060 and 205-330-060-064 in Strathmore, CA 93267

F. Discussion Regarding Trade Secrets Pertaining to Service 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 distributed to the Board at this time, but will not be read by the Board secretary during the public comment period.

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

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

VIII. Approval of Minutes

A. April 22, 2025 Minutes of the Regular Meeting of the Board of Directors

Recommended Action: Approve/Disapprove April 22, 2025 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. Moss Adams Audit Report

Recommended Action: Information Only/No Action Taken

B. April Financials 2025 Financials

Recommended Action: Approve/Disapprove Report as Given

C. Sale of Strathmore Public Utility District (SPUD) Residential Water Shares to Freddie Espinoza

Recommended Action: Approve/Disapprove sale of SPUD Utility Shares to Freddie Espinoza.

D. Appointment of Emergency Services Ad Hoc Committee
Recommended Action: Appoint two (2) board directors to the Emergency Services Ad Hoc Committee.

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

Regular Board of Directors Meeting – June 24, 2025 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

Sierra View Local Health Care District
Board of Directors Regular Meeting
465 West Putnam Avenue, Porterville, CA
Board Room

Senior Leadership Team	5/27/2025
Board of Director's Approval	
Liberty Lomeli, Chairman	5/27/2025

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
May 27, 2025
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 ↓
• Chart Locator	1	
• Diet Manual and Therapeutic Diet Menus	2-3	
• Exam and Treatment Rooms Cleaning	4-5	
• Germicides	6-7	
• Licensure, Registration, Certification	8-9	
• On-Call, Call Back	10-11	
• Patient Observations	12-13	
• Weapons In-House	14-15	
Reports:		
• SCORE Survey Summary Report - Mar 2025	16-18	

SUBJECT: **CHART LOCATOR**	SECTION: **Page 1 of 1**

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

POLICY:

- The Health Information Management Department (HIM) is responsible for tracking the location of patient medical records on assignment from HIM.

- The medical record locator, accessible through the organization's information system, identifies the medical record's current location, its previous location, and its next location. The system also indicates to whom the medical record was assigned, who made the assignment, and the time and date of the assignment.

PROCEDURE:

1. HIM Staff are responsible for logging in returned and verifying location of "out of department" medical records at the end of the day.

2. When assigning multiple medical records to a department, the multiple medical record assignment function should be used.

3. Every two (2) weeks, the medical record locator report should be printed, and any medical record checked out for over 15 days should be located and removed from the list if it is back in the permanent file.

REFERENCE:

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

SUBJECT: **DIET MANUAL & THERAPEUTIC DIET MENUS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish a standard for therapeutic diets and non-therapeutic diets.

POLICY:

A therapeutic diet manual is used for standardization of the diet orders, defining diets, and planning diets. The therapeutic diet manual shall be approved by the dietitian and the medical staff. The publication or revision date of the approved therapeutic diet manual must not exceed five (5) years. The therapeutic diet manual is available to all medical, nursing and food service personnel.

AFFECTED AREAS/PERSONNEL: *FOOD AND NUTRITION SERVICE, PATIENT CARE AREAS*

DEFINITIONS:

Therapeutic diet: A diet ordered as part of the patient's treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

PROCEDURE:

1. The Clinical Nutrition Manager (CNM) will review the therapeutic diet manual annually.

2. The therapeutic diet manual will be updated a minimum of every five (5) years.

3. The CNM, Pharmacy & Therapeutics Committee, Medical Executive Committee (MEC) and the CEO/Board of Directors will approve the manual.

4. A diet manual is available for viewing on Sierra View Medical Center (SVMC) Employee Portal. The SVMC Interpretation of Diet Services serves as a reference for medical and nursing personnel when ordering hospital-specific diets.

5. A hard copy of the therapeutic diet manual is available in the Food & Nutrition Service diet office and in the dietitian office. This serves as a guide for food service staff for special diet food preparation.

6. Nutritional adequacy is based the on weekly averages of each nutrient. Menus are designed to meet nutritional requirements specified in accordance with the Dietary Reference Intake (DRI) from the Food and Nutrition Board, Institute of Medicine, and National Academies of Science's guidelines. Nutritional adequacy is referenced to a male of 51-70 years of age, unless otherwise specified.

7. Any modified diet not outlined in the diet manual will be transcribed by the dietitian(s), using reputable nutrition references.

8. Due to limitations within the nutrient database, not all micronutrient values are available. Every effort shall be made for adequate provision of these micronutrients.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03, EP 22

- Centers for Medicare & Medicaid Services. Title 42 Regulations:
  - A-0629 §482.28(b) (1)
  - A-0631§482.28(b) (3)

SUBJECT: **EXAM AND TREATMENT ROOMS CLEANING**	SECTION: **Page 1 of 2**

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

POLICY:

Follow the standard process used, which covers the daily cleaning instructions for treatment and examination rooms.

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

PROCEDURE:

Materials and Equipment

Use the Standard Cart Setup.

Procedure

1. Prepare the germicidal solution as directed.

2. Perform the 7 step cleaning process:

    - Step 1 – Pull trash and linen.
    - Step 2 – Complete the High Dust process.
    - Step 3 – Damp wipe all contact surfaces.
    - Step 4 – Thoroughly clean the restroom.
    - Step 5 – Dust mop properly.
    - Step 6 – Damp mop all appropriate areas.
    - Step 7 – Inspect the work according to the Shine standards.

3. Wipe down the exam table.

4. Be sure to move the exam table and clean the floor.

5. Make sure sink is thoroughly cleaned and supplies are replenished.

6. Check walls and floors for blood and body fluids.

Inspection Standards

- Ceilings, ledges, countertops, furniture, and cabinets are clean and free of dust.
- Waste receptacles are clean and relined.
- Wash basins are clean and free of mineral build-up.
- Floors are free of dust, spills, blood and body fluids.

- Exam tables are clean and free of dust, blood and body fluids.

REFERENCES:

- The Joint Commission (2025). Hospital accreditation standards. EC.02.06.01 EP20 Joint Commission Resources. Oak Brook, IL.

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

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

POLICY:

Follow the standard process used for the mixing and use of germicides.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS

PROCEDURE:

Mixing Germicides

Mix germicidal cleaning solutions prior to beginning any of the cleaning procedures in this manual. Use the chemical mixing station so the chemicals are always diluted correctly and safely. The procedure listed below (Steps 1-6) is for those times when mixing solutions by hand is required.

1. Wear disposable non-latex rubber gloves and safety glasses whenever handling germicidal concentrate to avoid burns to the skin and eyes.

2. Always read the manufacturer's instructions and mix solutions accordingly. Give special attention to dilution ratios; they are extremely important.

3. Obtain either a five-quart pail or a mop bucket in which you will mix the germicide and water.

4. First add clean cold water to the pail or bucket, then add the appropriate amount of concentrate.

5. Use a mop or cleaning cloth to gently stir the solution.

6. You may remove the safety glasses after putting away the concentrate. You must always wear non-latex rubber gloves when using the germicidal solution.

Using Germicides

1. Use the germicidal solution for all damp wiping, disinfecting, wet mopping, and general cleaning, unless otherwise instructed.

2. Use a container (e.g., pail or bucket) for the germicidal solution. Immerse multiple disposable or reusable cleaning cloths into the solution, wring out, and wipe surfaces as instructed in the procedure. These disposable cloths can be turned and folded to produce a clean side. Be sure to use all sides unless visibly soiled.

3. Allow surface to air dry. Surfaces may be dried using a dry clean cloth or paper towel if there is a risk of skin contact to damp surface or if the surface is a highly reflective surface, such as glass, where streaking might be visible.

REFERENCES:

- The Joint Commission (2025). Hospital accreditation standards. EC.02.06.01 EP20 Joint Commission Resources. Oak Brook, IL.

- Association for the Healthcare Environment (2012). Practice Guidance for Healthcare Environmental Cleaning (2nd Edition) 2012.

SUBJECT: **LICENSURE, REGISTRATION, CERTIFICATION**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define the requirements and procedures of Sierra View Medical Center (SVMC)'s license, registration, and certification verification process.

POLICY:

SVMC, through Human Resources (HR), will ensure staff is licensed to perform services through primary source verification of their licenses, registration and certification as a minimum qualification for the position. For mandatory training that results in a provider card, such as BLS, ACLS, etc., please see the Mandatory Education Policy and Mandatory Provider Card Policy.

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

PROCEDURE:

At the time of employment, current licensure, registration and/or certification are verified with the appropriate issuing primary source. A photocopy of the license, registration, and/or certification and the original verification documentation will be placed in the employee's personnel file.

Thereafter, it is the employee's responsibility to maintain current licensure, registration, and/or certification and provide their Department Director with a copy prior to the expiration date. Human Resources notifies the employee 60 days prior to their expiration date.

After beginning employment, it is the supervisor's responsibility to ensure that proper licensure or certification is obtained, as in the case of those who have temporary permits. It is also the Supervisor's responsibility to ensure the employee has been released from all duties by midnight upon expiration of licensure/certification if not renewed on time.

Prior to expiration, licenses, registrations and/or certifications and their dates will be verified from the primary source of issue. Verification documentation will be placed in the employee's personnel file.

A photocopy of the license, registration, certification, or primary source will be maintained in each staff member's education/competency file and when required, publicly displayed.

Staff with lapsed licenses, registrations, and/or certifications will be placed on unpaid leave until such time their renewal is received by Human Resources for a maximum of up to two weeks. The unpaid leave will be documented on SVMC's Notice of Corrective Action form as a Written Warning and placed in the employee's personnel file. Vac-Hol pay will not be available during the unpaid leave.

Failure to obtain a current and valid license, registration and/or certification within the two (2) week unpaid leave period will result in termination of employment with the Medical Center. An exception will be made if there are extenuating circumstances that are beyond the employee's control and can be verified with the issuing agencies.

Continued monitoring of this policy is the responsibility of Department Directors and Human Resources.

An electronic report of lapsing mandatory documents is available in UKG (under self-service reports) for leaders to run monthly in advance of the expiration dates.

REFERENCES:

- Department of Health Care Services. (n.d.). California Code of Regulations (CCR), Title 22. Retrieved from https://www.dhcs.ca.gov/services/adp/Pages/CA_Code_Regulations.shtml.aspx.

- Comprehensive Accreditation Manual for Hospitals (CAMH). (2019). Retrieved from https://www.jointcommission.org/rss/?bf=/&k=526&b=39&t=4&n=Comprehensive Accreditation Manual for Hospitals (CAMH)-HR.01.01/EP-2.

- OMH CLAS Standards – Standard 6 (n.d). Retrieved from https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf.

CROSS REFERENCES:

- MANDATORY PROVIDER CARDS
- MANDATORY EDUCATION

SUBJECT: **ON-CALL/CALL BACK**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide definitions for "On-Call" and "Call Back" status and provide the compensation calculation of each for payroll purposes.

POLICY:

In order for the Hospital to provide 24 hour/7 day/week coverage in specified areas, employees who are designated to be "on-call" will be compensated as stated below.

DEFINITIONS**:**

***On-Call*:** An employee is considered to be on uncontrolled "On-Call" when placed on a pre-determined schedule and assigned by their Department Director/designee to be available for return to work. On-Call employees must be available and expected to return to work within 30 minutes of notification. However, while an employee is On-Call, s/he is free to use the time for his/her own benefit. The employee will be notified in advance by the Department Director to respond to the needs of the department.

***Call Back*:** Call Back hours will apply when an employee who is on-call is called to return to the work site during their on-call shift. When they arrive on-site and clock-in and are ready to perform their duties, then the hours worked are considered call-back hours.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL NON-EXEMPT EMPLOYEES*

PROCEDURE:

1. Compensation will be calculated on the employee's actual base hourly rate of pay. The On-Call pay is included in calculating the regular rate of pay for purposes of determining overtime rates; however, hours paid for being scheduled On-Call, but for which no work is performed, is not included in calculating the regular rate of pay for purposes of overtime. Pay for hours worked for Call Back will be used in calculating premium overtime rates.

2. An employee who is placed On-Call will be paid a percentage of her/his base hourly rate of pay for all time spent On-Call. When they receive a call to report to work, On-Call status and pay will stop when the employee clocks in at the work site, and at that time, they will be paid at the rate of 1 ½ times their base rate of pay for the first four (4) hours of "Call Back" and double-time (two times their base rate of pay) for any "Call Back" hours worked thereafter, up to and until the beginning of the next business day unless Fair Labor Standards Act (FLSA) overtime rates apply. In addition, they will be paid for a minimum of one (1) hour each time they are called in.

3. On-Call status begins upon the completion of the regularly scheduled working hours.* If placed on call during your regular shift and your called back in, the callback rule will apply.,

4. While On-Call, for all issues resolved remotely, the employee will be paid a minimum of 0.25 hours. When an employee who is on-call is asked to return to work employee's will receive a one (1) hour minimum at the call-back rate once they are on-site and clocked in. Staff who are cancelled to return to work while they are either still at home or in-route to the hospital will not be entitled to the minimum of one (1) hour call-back pay. Employees will continue to be paid at the on-call rate in these circumstances.

5. All other specific department procedures must be followed in accordance with each departments On-Call policy
6. On-Call time must be documented for appropriate compensation.

7. Time On-Call and the time returned to work must be documented on the employee's timecard.

REFERENCES:

- Fair Labor Standards Act of 1938 (Revised May 2011). Retrieved from https://www.dol.gov/whd/regs/statutes/fairlaborstandact.pdf.

CROSS REFERENCES:

- OVERTIME

SUBJECT: **PATIENT OBSERVATIONS**	SECTION: ***Security Management*** **Page 1 of 2**

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

PURPOSE:

To provide guidelines for the implementation of patient observations by assigned patient sitters.

POLICY:

Patient observations are implemented by security personnel or assigned patient sitters, when requested by Nursing Services. Patient observations are implemented when a patient is awaiting mental health evaluation, intoxicated, requires additional observation for safety, or has become a disruption to the nursing care environment. The observation is intended to maintain a safe and secure environment from and for patients who may be a danger to themselves, others, gravely disabled or a disruption to the care environment.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS

PROCEDURE:

- Assigned sitters will position themselves inside the patient's room and maintain a direct, unobstructed view of the patient at all times on a suicidal observation, at the request of a physician, to prevent the patient from causing harm to themselves, others or disruptive behavior to the nursing environment.

- Assigned sitters will maintain continuous observation of the patient while on suicide precautions. This includes bathing and toileting. In the event that the assigned sitter is the opposite sex of the patient, a same sex employee will be engaged to observe bathing and toileting.

- Assigned sitters will not use cell phones or other personal electronic devices while posted on a suicidal observation.

- The security officer will post directly outside of the room if the patient is being observed due to aggressive behavior and not on a suicidal observation.

- Assigned sitters will only leave the room to take breaks when relieved by another staff member.

- Patients awaiting mental health evaluations who express wanting to leave prior to being evaluated and cleared by CRISIS, shall result in the assigned RN being immediately notified.

- Unless the patient is an immediate threat to self or others or is incapable of understanding the risks and benefits associated with leaving, patients shall not be physically restrained from leaving.

- In the event that a patient does leave, initiate Code Green policy.

- Assigned sitters shall uphold the organization's Standards of Performance at all times while on duty and shall make every attempt to maintain the patient's privacy and dignity during observation situations.

- The least restrictive force necessary must be used when performing patient observations. If a patient who has been placed on a security observation becomes violent, staff will immediately initiate a "Code Gray" in order to restore the safety and security of the care environment.

- All sitters (security and otherwise) will be trained in ligature risks and patient observation, via e-learning module.

- All security officers will be trained in a Nonviolent Crisis Intervention (CPI) training program and will also pass e-learning modules on Ligature Risks and Patient Observations.

REFERENCES:

- The Joint Commission (2025). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL. NPSG 15.01.01.

CROSS REFERENCES:

- CODE GRAY-VISITOR OR PATIENT OUT OF CONTROL
- 1799 HOLDS IN THE EMERGENCY DEPARTMENT
- CODE GREEN- MISSING PATIENT OR RESIDENT
- SUICIDAL PATIENT ASSESSMENT & MANAGEMENT

SUBJECT: **WEAPONS IN-HOUSE**	SECTION: ***Security Management*** **Page 1 of 2**

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

PURPOSE:

To prevent weapons from entering the facility. Weapon is defined as any firearm, knife or device that could cause bodily harm or injury.

POLICY:

- Weapons are never permitted on Hospital property. Sworn Law Enforcement officers are exempt from this policy (on and off duty).
- Patients and visitors are instructed to leave weapons at home or lock them in their vehicle prior to accessing the facility.
- If a patient comes to the hospital for admission with a weapon, the weapon will be sent home with a family member if possible.
- Patients being admitted through the Emergency Department, or arriving at the Hospital without a family member, will have their weapon confiscated and stored in the Hospital Security Department until the Porterville Police Department (P.P.D.) can respond and take possession of the weapon.
- Visitors not complying with this regulation will be denied access to the Hospital. Local law enforcement will be called if the visitor becomes disruptive.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS

PROCEDURE:

1. If a patient or visitor volunteers that he/she is in possession of a weapon, call the Security Department to check and secure the weapon.
2. If a weapon is found on a patient in the Emergency Department, the weapon shall be confiscated and the Security Department called.
3. If a patient or visitor is found to have a weapon, but is unwilling to surrender it, the Security Department shall be called.
4. Staff should not attempt to confront the patient/visitor.
5. Porterville Police will be notified immediately. Once P.P.D. is on site, they will take control of the weapon situation.

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

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. EC.02.02.01 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Security Management Plan
- Drug/Alcohol in the Workplace
- Visitor Guidelines
- Access to the ED And Main Hospital After Visiting Hours

SCORE Survey Summary Report

Sierra View Medical Center - Mar 2025

46 Work Settings - 669 Respondents - Response Rate 72%

The Value of an Integrated Survey

The SCOR survey measures important dimensions of organizational culture. The core instrument integrates safety and teamwork culture, local leadership, learning systems, resilience/burnout and work-life balance. The full SCORE survey integrates employee engagement as well.

The insights are critical for organizational improvement and the ability to drive habitual excellence.

Specific actions can be taken to leverage organizational strengths and address areas of fundamental opportunity.

Why is Culture Important?

It reflects the behaviors and beliefs within the organization.

There are behaviors that create value individually, for the patient and the organization.

There are behaviors that create unacceptable risk.

These attitudes and behaviors are reflected in how people interact with each other both internally and externally with patients and their families.

Culture is the social glue.

Percent Positive Respondents by SCORE Domain*

669 respondents in 46 work settings at Sierra View Medical Center

	Facility Percent Positive		Facility Benchmark Percentile†
CULTURE			
Improvement Readiness	**63%**	3% ↑	**49th**
Local Leadership	**57%**	0%	**33rd**
Burnout Climate‡	**42%**	0%	**63rd**
Personal Burnout‡	**58%**	1% ↑	**58th**
Emotional Thriving	**59%**	4% ↓	**52nd**
Emotional Recovery	**63%**	3% ↓	**35th**
Teamwork	**37%**	2% ↑	**48th**
Safety Climate	**46%**	3% ↑	**37th**
Work / Life Balance	**77%**	2% ↑	**89th**
ENGAGEMENT			
Growth Opportunities	**56%**		**52nd**
Job Certainty	**68%**		**41st**
Intentions to Leave	**87%**		**56th**
Decision Making	**47%**		**55th**
Advancement	**15%**		**35th**
Workload Strain	**78%**		**85th**
Workforce Safety	**67%**	1% ↑	**19th**

* Percent who responded positively to most questions in the domain. Domain scores may feel lower as they're not simple averages.

† Benchmark percentiles are based on a US benchmark of facilities dated: 2025 Q1.

‡ Scores reflect percent who state they and others are NOT experiencing burnout.

Notable Insights by Percentile and Key SCORE Items

669 respondents in 46 work settings at Sierra View Medical Center

Cultural Strengths

%ile	
95th	In the past work week skipped a meal.
89th	In the past work week worked through a day/shift without any breaks.
89th	In the past work week arrived home late from work.

Cultural Opportunities

%ile	
8th	I can adapt to events in my life that I can not influence.
10th	My mood reliably recovers after frustrations and setbacks.
24th	I receive appropriate feedback about my performance.

Engagement Strengths

%ile	
67th	With respect to my intentions to leave this organization, I often think about leaving this job.
60th	With respect to my intentions to leave this organization, I have plans to leave this job within the next year.
56th	With respect to advancement in this organization, I am satisfied with my total benefits package.

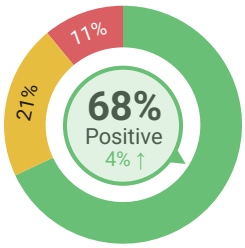
Engagement Opportunities

%ile	
11th	With respect to advancement in this organization, I can live comfortably on my pay.
12th	With respect to advancement in this organization, this organization pays good salaries.
17th	With respect to advancement in this organization, I have opportunities to advance through training courses.

Key Drivers of Culture & Engagement (Green is good)

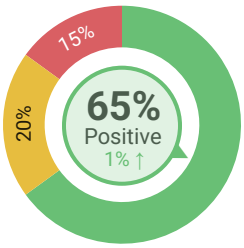
IMPROVEMENT READINESS

The learning environment effectively fixes defects.



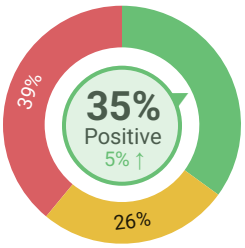
LOCAL LEADERSHIP

Regularly makes time to provide positive feedback to me.



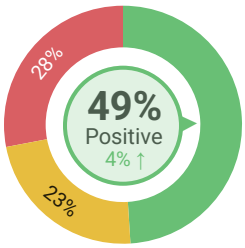
BURNOUT CLIMATE

People in this work setting are burned out from their work.



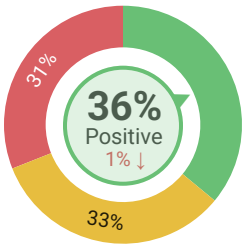
TEAMWORK

Dealing with difficult colleagues is consistently a part of my job.



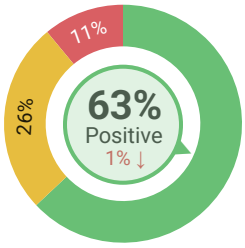
TEAMWORK

Communication breakdowns are common in this work setting.



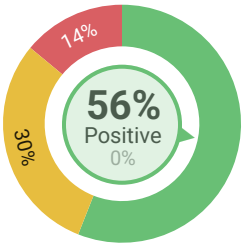
SAFETY CLIMATE

The culture makes it easy to learn from the errors of others.



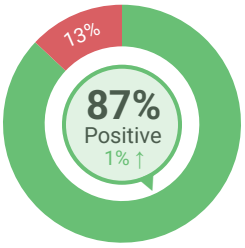
SAFETY CLIMATE

I would feel safe being treated here as a patient.



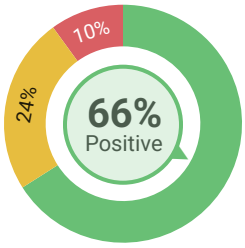
WORK / LIFE BALANCE

Worked through a day/shift without any breaks.



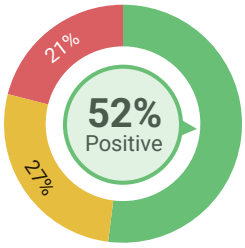
GROWTH OPPORTUNITIES

I have the feeling that I can achieve something.



INTENTIONS TO LEAVE

I often think about leaving this job.



MEDICAL EXECUTIVE COMMITTEE	05/07/2025
BOARD OF DIRECTORS APPROVAL	
	05/27/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
May 27, 2025 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**
• Alaris System Cleaning and Disinfecting	1-3	
• Condition Code 44 (CC44) and Condition Code W2	4-9	
• Disinfection of Ultrasound Transducers and High Level Disinfection Utilizing Trophon Disinfection System	10-13	
• Ebola Virus Disease	14-23	
• Guidelines for the Prevention and Control of Infectious Disease Transmission Related to Hospital Construction	24-27	
• Patient Safety Plan	28-34	
• Pediatric Medication Administration Guidelines	35-38	

SUBJECT: **ALARIS SYSTEM CLEANING AND DISINFECTING**	SECTION: ***Infection Prevention (IP)*** **Page 1 of 3**

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

PURPOSE:

To establish infection prevention guidelines for the cleaning, decontamination and disinfection of BD Alaris System devices, including components such as IV pumps, syringe pumps, modules such as the inter-unit interface connectors (IUI), and PCAs.
IMPORTANT: *Always follow the manufacturer's instructions for use (MIFU) of the specific Alaris System user's manual.*

POLICY:

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

AFFECTED PERSONNEL/AREAS: *HOUSEWIDE*

ACCOUNTABILITY:

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

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

3. Nursing is responsible for removing IV bags and tubing. Nursing, in conjunction with Environmental Services, are responsible to ensure all patient equipment is cleaned, after patient use, and after any contact with blood or any other body fluids.

4. Environmental service staff is responsible for placing Alaris pump in Dirty Utility Room after patient is discharged. IV pole is to be cleaned by EVS and left in the room after it has been cleaned and disinfected.

5. Central Processing Department (CPD) is responsible for picking up the pumps from the different departments, transporting them to CPD, cleaning and disinfecting the pumps and all parts of the device (i.e. IUI modules). CPD will bag the pumps and transport back to the units.

STANDARDS of CLEANLINESS:

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

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

1. Turn instrument off and unplug
2. Instruments and other equipment must be maintained in an upright position.
3. Inspect equipment parts for damage (including cracked or broken door, case, handle, latch, or Inter-Unit Interface Connector (IUI)). Report damage to biomed
4. No part is to be saturated or submerged with cleaning fluid or disinfectant.
5. After donning gloves, clean all exposed surfaces with manufacturer and hospital approved disinfectant EXCEPT the inter-unit interface (IUI) connectors. A dedicated soft brush may be used for hard to reach and narrow areas or to remove hardened organic deposits. DO NOT use any hard, abrasive or pointed objects to clean any part of the instrument.
6. After cleaning, disinfect with approved disinfecting wipe, follow MIFUs for length of contact time. After contact time, remove residue remains with a soft damp cloth.
7. Remove any adhesive residue using 70% isopropyl alcohol.
8. All parts of the pumps are to be cleaned and disinfected, including the power cord.
9. The appearance of any rust must be reported to a supervisor.
10. After devices have been cleaned and bagged, pumps and modules will be replenished and stored in each department.

Inter-unit interface connectors (IUIs) on pumps must be sent to Central Processing for cleaning. Process is as follows:

1. Apply 70 % isopropyl alcohol directly to the dedicated IUI cleaning brush. To prevent cross contamination, do not dip the brush into the IPA.

2. Clean both IUIs with dedicated IUI cleaning brush. DO NOT use any spray cleaners anywhere near the IUI connectors.
3. Central Processing will perform the cleaning of the IUIs connectors as per MIFUs.
4. The Biomed technician will check pumps on an annual basis unless the device requires repair.

*IUI connectors are to be cleaned with 70% isopropyl alcohol. Allow instrument and IUI connectors to dry completely before next use.

REFERENCE:

- Best Practices for Cleaning Alaris System Devices - BD. Quick-guides for all Alaris devices Accessed 20 March 2025, published 2020. https://www.bd.com/content/dam/bd-assets/na/medication-management-solutions/documents/tip-sheet/MMS_IF_1910004811-20-MMS-Best_Practices-Cleaning-Alaris-System-Devices.pdf
- Best Practices for Cleaning Alaris System Devices - BD. Quick-guides for all Alaris devices Accessed 20 March 2025. https://www.bd.com/content/dam/bd-assets/na/medication-management-solutions/documents/clinical-education/mms_if_alaris-system-devices-training-checklist-for-best-practices-cleaning_ts_en.pdf
- California Code of Regulations, 22 CCR § 70015, 22 CCR § 70025, 22 CCR § 70739 and 22 CCR § 70827, Social Security, current through Register 2025, Notice Reg. No. 2, 10, January 2025. (https://casetext.com/regulation/california-code-of-regulations/title-22-social-security/division-5-licensing-and-certification-of-health-facilities-home-health-agencies-clinics-and-referral-agencies/chapter-1-general-acute-care-hospitals/article-7-administration
- Infection Control Basics. Accessed 20 March 2025https://www.cdc.gov/infection-control/about/index.html?CDC_AAref_Val=https://www.cdc.gov/infectioncontrol/guidelines/disinfection/rational-approach.html

SUBJECT:	SECTION:
CONDITION CODE 44 (CC44) AND CONDITION CODE W2	***[Enter manual section here]*** **Page 1 of 6**

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

PURPOSE:

To provide clinical staff and other personnel guidance when changing a Medicare patient status from Inpatient to Outpatient and to ensure Hospital is following Centers for Medicare and Medicaid Services (CMS) regulations as they pertain to use of Condition Code 44 (CC44) or Condition Codee W2 and the outpatient bill.

DEFINITIONS:

Condition code 44: Inpatient admission changed to an outpatient status. It is for the use of outpatient claims only when a provider orders inpatient services but, upon internal utilization review performed and before the patient is discharged and the claim is initially submitted, it is determined the services did not inpatient criteria and could have been provided on an outpatient basis.

Condition Code W2 (Bill Medicare Part B): Inpatient admission billed to Part B. It is for the use of inpatient claims only when a provider orders inpatient services but, upon internal utilization review performed after discharge, it is determined the services did not meet inpatient criteria and could have been provided on an outpatient basis.

Inpatient: A patient is considered an inpatient if formally admitted as an inpatient with the expectation he or she presents with a clinical picture indicative of medical necessity and require hospital care spanning at least two midnights to occupy a bed; it may later develop the patient is discharged or transferred to another hospital and not actually use a hospital bed overnight. Inpatients may also meet one of the exceptions to the two-midnight rule expectation allowed by CMS.

MCG: A product housed in the utilization management documentation system. MCG is utilized to provide objective feedback to providers on Patient Status and Level of Care appropriate for hospital patients. MCG is not a government product and serves only as guidelines to prompt feedback and discussion. The provider order determines Patient Status and Level of Care.

Level of Care: Level of inpatient or outpatient services a patient receives. Level of care may include observation, general – acute, intermediate, intensive care, Level 2 Nursery.

Observation services: A hospital service used to determine if a patient requires inpatient admission or discharge to a lower level of service or home. It is characterized as an extension of information gathering and decision-making process which may include ongoing short-term treatment, assessment, and reassessment. Observation services are for hospital stays in which patient's condition does not meet severity and treatment and does not meet the intensity that would qualify as inpatient criteria following Medicare criteria.

Outpatient: A patient who has not been formally admitted and is registered as an Outpatient. The duration of services and time of day are not determined of outpatient status. Observation services are considered an Outpatient level of care.

Patient status: Inpatient or Outpatient

Physician Advisor: Active member of the medical staff and identified by the UM Committee to act as a liaison between SVMC administration, medical and clinical staff to ensure compliance with regulatory issues, advise physicians on medical necessity, and help the leadership team reach overall organizational goals related to the efficient utilization of health care services. The physician advisor will be a member of the UM Committee and chair meetings.

Provider: Physician who is legally accountable for establishing the patient's diagnosis and has been granted admitting privileges by Hospital medical staff. Emergency Department physicians do not have admitting privileges.

Two (2) – Midnight Rule: Hospital stays in which the provider expects the Medicare Beneficiary to require acute hospital care spanning at least two (2) midnights and admits the Medicare Beneficiary based upon that expectation and medical necessity (CMS- Effective 10/1/2013).

Utilization Management (UM) Committee: A committee of the Medical Staff comprised of two or more physicians and other practitioners charged with the evaluation of medical necessity, extended stay reviews, and to promote the most efficient use of available healthcare resources furnished by members of the medical staff to patients entitle to benefits under the Medicare and Medicaid programs (CMS 42 CFR 482.30 Conditions of Participation: Utilization Review).

Utilization Management (UM) Physician: Active member of the medical staff and delegated the responsibility for internal utilization management and application of medical necessity review authority the UM Committee, i.e., application Code 44 process.

POLICY:

Condition code 44 is applied to a Medicare claim indicating a patient was admitted as inpatient status but, on subsequent review using Milliman (MCG) criteria and physician review, it is determined the admission does not meet inpatient criteria and the patient would have been registered as an outpatient or outpatient with observation services under ordinary circumstances (Medicare Claims Processing Manual, Chapter 1, Section 50.3).

In such cases, hospitals may change a Medicare patient's status from inpatient to outpatient provided all the following conditions are met:

1) The change in patient status from inpatient to outpatient or outpatient with observation services is made prior to discharge or release from the hospital; and

2) A physician member of the Utilization Management (UM) committee concurs; and

3) The ordering provider concurs with the UM committee's decision; and

4) The provider's concurrence with the UM committee's decision is documented in the patient's

medical record; and

5) A letter of explanation is provided to the patient or their representative (no later than 2 days after the decision has been made), the provider caring for the patient and SVMC Compliance Officer.

6) The claim has not been submitted.

AFFECTED PERSONNEL/AREAS: *UTILIZATION REVIEW*

PROCEDURE:

The UM committee determines whether inpatient admission does not meet the inpatient admission criteria.

1) Pursuant to UM Committee delegation, UM personnel will screen inpatient admissions using MCG for satisfaction of admission criteria.

2) UM staff will discuss with the ordering provider patients who do not meet admission criteria to determine if additional information is available to support the need for inpatient admission.

3) If no additional information or documentation is provided to support the inpatient admission, the case will be referred to a physician member of the UM Committee.

4) If the UM physician agrees the patient does not meet inpatient admission criteria, UM staff and/or the Physician Advisor will contact the provider in order to discuss the patient and, if possible, obtain the provider's concurrence the patient's status should be changed to outpatient observation or outpatient.

5) If the provider concurs with the UM physician, the inpatient status order will be updated to outpatient with observation services or outpatient stat us by the provi8der or UM personnel on behalf of the provider per policy. Example order: Place in Outpatient with Observation status, in order comments state "Reviewed by Dr. Schultz, UM Committee"

6) When an inpatient admission is changed to outpatient status notes indicating clinical rationale and the participants in making the decision to change the status will be documented by UM personnel in the patient's medical record. Example: "Dr. Smith states her partner chose the wrong status last night and wants status changed to outpatient with observation services. Reviewed by Dr. Shultz, UM Committee who agrees outpatient with observation services is correct. Telephone order placed; patient notification provided."

7) If the provider does not concur with the UM physician, another physician member of the UM committee will review the chart. If the UM physician agrees with the provider, the patient shall remain inpatient. If the UM physician agrees with the first UM physician, the second physician will attempt to contact the attending to discuss the case and attempt to obtain concurrence. If the concurrence cannot be obtained, the patient will remain inpatient status, and the case will be referred to as self-denial and rebilling as outlined.

8) Neither UM physician may have an affiliation with the case under review.

9) If the UM Committee deems the admission or continued stay is not medically necessary, written notice must be given to the patient prior to discharge and no later than two (2) days after the determination to the hospital and to the provider responsible for the patient's care.

10) Patient Financial Services (PFS) will be notified of the patients' status change by UM.

If all criteria for changing status from inpatient to outpatient are met, PFS will:

1) Bill entire episode as though the inpatient admission never occurred

2) Type of bill 13x

3) Condition Code 44

4) Include charges for services furnished by physician order

Observation Services: Only services provided by provider order may be billed on the outpatient claim. Therefore, providers may not begin counting observation hours until such time as an order for observation is given. For Example: Patient A was admitted at noon on Sunday. On Monday afternoon it was determined the patient did not meet inpatient criteria, the provider concurred, and the status was changed to outpatient with observation services. The outpatient status is considered to begin at noon on Sunday. However, observation hours may not be billed until the provider has written an order for outpatients with observation services. If the order is written at 2 p.m. on Monday, the hospital will begin the observation hours at that time. No observation hours can be charged between noon on Sunday and 2 p.m. on Monday. The outpatient may be placed on the claim with revenue code 0762 but without an applicable HCPCS code. The units of service should equal the total hours minus the carve-out hours for services which are billed and included active monitoring.

If an outpatient with observation services is ordered and the patient is going home, zero hours will be billed.

Condition Code W2 (Bill Medicare Inpatient B)

If the determination is the patient should not have been admitted is made after the patient has been discharged or other criteria for use of condition Code 44 is not met, Medicare may still make payment under inpatient Part B benefits.

The UM physician will review the case to determine if inpatient admission was not medically necessary. If the opinion of the attending physician has not yet been obtained, the attendance must be contacted and given an opportunity to provide input. If the attending agrees or does not respond, the case may be self-denied and rebilled. The change of billing status and written notification must be given no later than 2 days after the determination to the hospital, patient, and the provider responsible for the patient's care.

If all criteria for self-denial and rebilling are met, FS will:

- Bill the stay as 110 type bills
- Apply Occurrence span code M1 to indicate all days of the inpatient admission
- After these 110 claim processes, the stay will be billed as follows:
    - 131 type of bill for all services prior to the inpatient admission order
    - 121 types of bills for all services after the inpatient order
    - Apply condition code W2 to both claims

If an inpatient admission is denied by an auditor for lack of medical necessity for inpatient admission (as opposed to lack of medical necessity for services themselves), and no appeal is planned, the inpatient admission may be rebilled as follows:

- 131 types of bills for all services prior to the inpatient admission order
- 121 types of bills for all services after the inpatient order
- Apply condition code W2 to both claims

REFERENCE:

1. Federal Register, Vol. 69, No. 219, Monday, November 15, 2004, Rules, and Regulations

2. CMS-1601-FC, Hospital Outpatient Prospective Payment – Final Rule with Comment, Centers for Medicare and Medicaid Services, December 10, 2013.

3. Federal Register, Vol. 78, No. 160, Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Hospital Prospective Payment System and Fiscal Year 2014 Rate; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; **Payment Policies Related to Patient Status**, Monday, August 19, 2013.

4. Centers for Medicare and Medicaid Services, Special Open Door Forum, Final Rule CMS 1599-F: Discussion of Hospital Inpatient Admission Order and Certification; 2 Midnight Benchmark for Inpatient Hospital Admissions, Tuesday, November 12, 2013.

5. CMS-1599-F; CMS-1559-CN2, and CMS-1599-IF, August 19, 2013.

6. Hospital Inpatient Admission Order and Certification, CMS Certification and Order Document, September 05, 2013.

7. 42 CFR 482.23 (c) (2) (I), Code of Federal Register, Monday, August 19, 2013.

8. Hospital Inpatient Admission Order and Certification, 42 CFR Part 424 subpart B and 42 CFR 412.3, Code of Federal Register, Monday, August 19, 2013.

9. 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admission on or after October 1, 2013, CMS Frequently Asked Questions, November 04, 2013.

10. Reviewing Hospital Claims for Patient Status: Admission on or After October 1, 2013, CMS Document, and November 01, 2013.

11. Selecting Hospital Claims for Patient Status Reviews: Admissions on or After October 1, 2013, CMS Document, November 4, 2013.

12. CMS Internet-Only Manual (IOM) 100-4; Chapter 4, Section 209, December 30, 2013.

13. MLN Matters SE1037 Guidance on Hospital Inpatient Admission Decisions, Centers for Medicare and Medicaid Services, July 31, 2013.

14. Condition Code 44: MLN Matters Number: SE0622, Related CR Release Date: September 10, 2004, Updated October 1, 2012.

15. CMS – 10611, Medicare Outpatient Observation Notification, Paperwork Reductions Act (PRA) of 1995, Hospital Inpatient Prospective Payment System (IPPS), August 2, 2016.

SUBJECT:	SECTION:
DISINFECTION OF ULTRASOUND TRANSDUCERS AND HIGH LEVEL DISINFECTION UTILIZING TROPHON DISINFECTION SYSTEM	**ULTRASOUND** **Page 1 of 4**

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

PURPOSE:

To provide standardized methods and direction to all staff for method for cleaning and disinfection of ultrasound transducers as well as high-level disinfection for endocavitary probes/transducers and transducers that come in direct contact with blood, bodily fluids, or non-intact skin.

POLICY:

A. All transducers must be disinfected following each use.

1. Transducers utilized on the skin surface and do not come into contact with blood, bodily fluids or non-intact skin must be disinfected following the steps listed in the section of this policy titled "Low Level Disinfection."

2. Endocavitary transducers or any transducer that comes into contact with bodily fluids, blood, or non-intact skin must undergo high level disinfection. The process for high level disinfection utilizing the trophon2 disinfection unit are listed below in the section titled "High Level Disinfection."

AFFECTED PERSONNEL/AREAS: *ULTRASONOGRAPHERS, ER, ICU, MOB: OB/GYN, MULTISPECIALTY CLINICS*

LOW LEVEL DISINFECTION:

Low level disinfection is to be performed on all non-endocavitary transducers following use that do not come into direct contact with blood, bodily fluids or non-intact skin.

Low level disinfection process:

1. Remove excess gel from probe utilizing a dry low lint single use wipe. Clean probe with a manufacturer approved cleaner wipe allowing for specified dry time as stated per wipe manufacturer. Dry thoroughly with a clean single low lint wipe.

HIGH LEVEL DISINFECTION

EQUIPMENT:

- Trophon2 Disinfection Unit (s).
- Ultrasound transducer/endocavitary transducers.
- Manufacturer approved wipe. (PDI Super Sani-Cloth)
- Low lint dry wipe (Nanosonics Trophon Companion Drying wipes.).

SUBJECT:	SECTION:
DISINFECTION OF ULTRASOUND TRANSDUCERS AND HIGH LEVEL DISINFECTION UTILIZING TROPHON DISINFECTION SYSTEM	**ULTRASOUND** **Page 2 of 4**

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PROCEDURE:

A. Keep the trophon2 on at all times.

B. **Wear gloves at all times**.

C. Trophon2 goes into **sleep mode** after an extended period of time, which can be adjusted or turned off (refer to MIFU). Press the restart button to exit sleep mode. It takes approximately 7 minutes for the device to warm up.

D. Purge Cycle: when to run a cycle
1. Prior to transporting the trophon2 device, if it has previously been in use.
2. When an onscreen message states that your trophon2 device requires purging. This will occur upon disinfectant expiry at 30 days after insertion. Follow the onscreen instructions to purge (refer to MIFU for additional instructions if needed).
   NOTE: Purging can be deferred until convenient on the day of expiry.
3. Purging typically takes less than 20 minutes.
4. Load a new trophon Sonex-HL cartridge

E. Loading Sonex-HL Cartridges:
1. The screen on the trophon2 will automatically prompt you to scan (if AcuTrace is enabled) and insert a new disinfectant cartridge, when required. Follow the onscreen instructions and refer to the trophon Sonex-HL MIFU. The Sonex-HL cartridge expires 30 days from the date after it is loaded into device, regardless of the expiry date shown on the disinfectant label. The unit display will prompt the user to purge at the 30 day expiration date.

F. Disinfecting Transducer: HLD process

1. Remove excess gel from probe utilizing a dry low lint single use wipe. Clean probe with a manufacturer approved cleaner wipe allowing for specified dry time as stated per wipe manufacturer. Dry thoroughly with a clean single low lint wipe.
2. Open chamber door. On the inner part of the chamber door, place a **new** chemical indicator in designated area.
3. Insert probe into the device by gently pulling the probe cable against the cable clamp. Then carefully pull the cable upwards until the probe is suspended in the correct location and the probe cable is held by the cable seal.
4. Transducer cord should be secured in the cord clamps. Do not pull the probe down when loaded in the cable clamp.
5. Close chamber door. The chamber door utilizes a two stage closure mechanism. Carefully close the chamber door to the first click and do not force it shut.

6. Start the cycle by either scanning the operator card on the AcuTrace reader or pressing the start button on the screen (if AcuTrace or Log Operator Card is disabled). The HLD cycle will take 7 minutes to complete, the cycle progress in indicated on the screen.

Removing the Probe (always wearing gloves)

7. Open chamber door and follow the onscreen instructions.
8. Using two hands, gently remove probe from unit and lightly wipe dry thoroughly with a single use low lint wipe. Visually inspect the probe and remove any present disinfectant residue.
9. If the display shows a failed disinfecting process, repeat disinfection process with a new chemical indicator. If the disinfecting process fails again, contact the equipment manufacturer for corrective action. Unit cannot be utilized until issue has been resolved.
10. Transducers that have undergone the trophon2 disinfection process must be placed in a clean sheath. Date of disinfection must be documented on probe sheath cover. Documentation of high level disinfection is provided by label printed from trophon2 unit at completion of disinfection process

G. Log Book:

1. Write the patient's medical record number (MRN) in the appropriate box on current log sheet.
2. Place the result label on log sheet just below the MRN.
3. Document the chemical indicator result, operator's initials and the probe that was disinfected) on the result label.
4. **All** information on the top of each log sheet must be completed when opening a new bottle of disinfecting fluid or a new box of chemical indicators.

H. Transportation of Endocavitary transducers and transducers exposed to blood, bodily fluids or non-intact skin post use:

1. All Endocavitary transducers and transducers exposed to blood, bodily fluids, or non-intact skin must be cleaned by intermediate level disinfection in the room before transporting transducer to complete high level disinfection in the trophon2 unit.

I. Regular Cleaning:

1. Wipe the chamber with a damp cloth when cool.
2. Close the chamber door.
3. To clean the outside of the device, wipe with a soft damp cloth. Do NOT submerge the device, or pour liquids over the device.
4. To disinfect the outside of the device, wipe all accessible surfaces with an Isopropanol or Quaternary Ammonium (Quat) wipe (refer to MIFU for approved hospital disinfectant wipe).

5. Take care not to have liquid come in contact with power socket.

J. Service: Once the service interval of 12 months or 5000 cycles is displayed on the screen, contact a customer service representative to arrange service for the device.

REFERENCES:

- American Journal of Infection Control 2018. Ultrasound probe use and reprocessing: Results from a national survey among U.S. infection preventionists. Pp. 914-919. Accessed 31 March 2025. https://www.ajicjournal.org/article/S0196-6553(18)30255-4/pdf.
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SUBJECT: **EBOLA VIRUS DISEASE**	SECTION: ***Infection Prevention*** **Page 1 of 10**

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

PURPOSE:

The purpose and intent of this document is to provide for the use of Sierra View Medical Center (SVMC) administration and planning personnel to identify and communicate key elements of this policy and procedure for screening, identification and initial management of a suspected Ebola patient. This policy is to be considered guidance and is intended to be used as a tool for hospital administration and planning personnel to assist in the effective preparation for, implementation and execution of facility Ebola response plans.

***As information related to recognizing, diagnosing, treating, and prevention of Ebola is updated at the federal, state and local levels, this response plan will be modified accordingly.**

DEFINITIONS:

The Ebola virus, previously known as Ebola hemorrhagic fever, is a rare and sometimes deadly disease. It is caused by infection with a virus of the family *Filoviridae* (https://www.cdc.gov/viral-hemorrhagic-fevers/about/?CDC_AAref_Val=https://www.cdc.gov/vhf/virus-families/filoviridae.html), genus *Ebolavirus*.

Many of the signs and symptoms of Ebola are non-specific and similar to those of many common infectious diseases, as well as other infectious diseases with high mortality rates.
Symptoms may include:

- Temperature >101.5°F
- Myalgia
- Severe Headache
- Muscle Pain
- Vomiting
- Diarrhea
- Abdominal Pain
- Bleeding

POLICY:

A. The hospital monitors infectious diseases that are occurring locally, nationally, or worldwide that could potentially affect our local community. SVMC has developed an Ebola Preparedness Program that includes, but is not limited to, education and training in the following areas:

- Infectious Disease Screening Process
  - Inpatient and Outpatient
- Personal Protective Equipment (PPE)
  - Donning (placing on) and Doffing (removing)
- Equipment (PPE Cart)
- Education of Disease Process
- Patient Movement
- Environmental Safety

B. SVMC will utilize CDC's guidelines for screening and preparedness to handle an Ebola patient: https://www.cdc.gov/ebola/hcp/clinical-guidance/index.html

C. The list of Ebola-affected countries is subject to change. For up-to-date information regarding the Ebola virus disease (EVD), refer to the CDC Ebola Virus Disease webpage at https://www.cdc.gov/mmwr/volumes/65/su/su6503a9.htm#F4_down

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT, INTENSIVE CARE UNIT, NURSING, RESPIRATORY THERAPY, ENVIRONMENTAL SERVICES, INFECTION CONTROL / PREVENTION, FACILITIES, EMERGENCY MANAGEMENT, LABORATORY, RADIOLOGY, PHYSICIANS, SURGICAL SERVICES, CENTRAL PROCESSING SERVICES, LABOR & DELIVERY, AND SURGERY CLINIC.*

PROCEDURE:

INFECTIOUS DISEASE SCREENING

1. An "Infectious Disease Screening" tool will be utilized for all **Newly Admitted** patients and also for all **Outpatients** who have traveled to West Africa in in the last 3 weeks or have come into contact with anyone who has traveled outside the U.S in the last 3 weeks. (See **ADDENDUM A**)

PERSONAL PROTECTIVE EQUIPMENT (PPE)—Donning & Doffing

1. Ebola is spread through direct contact with blood or body fluids of a person who is sick with Ebola or with objects that have been contaminated with infectious blood or body fluids. PPE that fully covers skin and clothing and prevents any exposure of the eyes, nose, and mouth is recommended by CDC. The recommended PPE equipment and steps of applying (donning) and removing (doffing) are found in: (See **ADDENDUM B**)

EQUIPMENT: EBOLA PATIENT CARE CART (Stocked by Materials Management)

1. There will be 1 Ebola PPE Cart stocked with items needed to care for this type of patient. Materials Management will stock and have access to this cart. The cart will be stored in the RME storage room, in the Emergency Department and maintained by Materials Management. (See **ADDENDUM C**)

EDUCATION

1. Competency Verification of Personal Protective Equipment (PPE)

   - All PPE Super Users will complete hands-on training for proper donning and doffing of PPE according to Center for Disease Control (CDC) recommendations. (Training to be done as needed)
   - A return demonstration is required for proper sequence of application and removal of PPE.
   - Advanced PPE (PAPR) will be provided to direct care providers in high-risk areas (ED, ICU).

2. Identify, prompt isolation of patients and starting infection control measures to minimize the spread of infectious diseases to other patients or healthcare providers

3. There will be PPE training based on CDC's recommendations to healthcare workers involved in the care of hospitalized patients with known or suspected Ebola

PATIENT MOVEMENT AFTER PRESENTING TO THE EMERGENCY DEPARTMENT:

1. Ebola screening tool is used initially with the patient that presents to the Emergency Room and outpatient care departments. If patient presents with elevated temperature and one or more additional symptoms along with answering "Yes" to ANY of the questions under the section "Questions to Ask Patient or Family" patient must be isolated and masked immediately:
    - Outpatient departments:
        1. Clinical Licensed staff: Immediately notify the provider in the department, Clinical Manager and Clinical Supervisor and the Infection Prevention Department (IP)
        2. Patient must be kept in private room with door closed
        3. Implement Enhanced Droplet and Contact Precautions
        4. Call EMS and notify of Suspected Ebola Virus patient and location. Copy all records pertaining to work up of patient (vital signs, history provided, symptoms, etc.) for the EMS to take in transport
    - Emergency Department:
        1. The triage nurse, after applying proper PPE, will take patient via wheelchair outside of the ER and wheel patient to the 'Decontamination" room in the ER.
        2. The patient will be held there until one of the designated rooms in ER is set up and available. There are 3 designated rooms that would be set up for the Ebola patient with the use of a pre-fabricated "Containment Kit". All of the items to set up this kit are all included with the kit.
        3. The process would be for designated Engineering Supervisor to call COAST IAQ & Life Safety Services and request the need for the "Containment" to be set up.
        4. The Ebola patient would remain in the isolated ER Decontamination room until the "Containment" is set up and prepared for the patient. (See **ADDENDUM D** for floor plan of patient flow)

ENVIRONMENTAL CLEANING

1. SVMC will follow CDC's recommendations/guidelines for environmental cleaning of a room, equipment, or other surfaces that have been exposed to an Ebola patient.
   h
2. Environmental services staff that perform cleaning after an Ebola patient will only be staff that has been trained with donning/doffing personal protective equipment (PPE) specific for Ebola patients.

3. SVMC follows CDC's recommendation to use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces. EPA-registered hospital disinfectants with label claims against non-enveloped viruses are broadly antiviral and capable of inactivating both enveloped and non-enveloped viruses.
   Including but not limited to:
    - Micro-Kill Bleach Germicidal Bleach wipes
    - Ecolab QC #40
    - Ecolab QC #42
    - Virasept Ready to Use

4. SVMC will handle and dispose of contaminated or suspected to be contaminated materials (e.g., any single-use PPE, cleaning cloths, wipes, single-use microfiber cloths, linens, food service) and linens, privacy curtains, and other textiles in the patient room per CDC recommendations

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About Viral Hemorrhagic Fevers (VHFs). (2024, April 15). Accessed 24 February 2025 from Centers for Disease Control and Infection: https://www.cdc.gov/viral-hemorrhagic-fevers/about/

Clinical Guidance for Ebola Disease. (30 January 2025). Accessed 24 February 2025 from Centers for Disease Control and Prevention: https://www.cdc.gov/ebola/hcp/clinical-guidance/index.html

Donning and Doffing PPE During Management of Patients with Selected VHF in U.S. Hospitals (2024, May 2). Accessed 24 February 2025 *from Centers for Disease Control and Prevention*: https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/index.html#cdc_listing_intro-donning-and-doffing-ppe-during-management-of-patients-with-selected-vhf-in-u-s-hospitals

Ebola Disease Basics. (2024, April 23). Accessed 24 February 2025, from Centers for Disease Control and Prevention: https://www.cdc.gov/ebola/about/index.html

Ebola Outbreak Caused by Sudan virus in Uganda. Accessed 24 February 2025 from Centers for Disease Control and Prevention: https://www.cdc.gov/han/2025/han00521.html#:~:text=On%20January%2029%2C%202025%2C%20the,outbreak%20in%20Uganda%20since%202000.

How Ebola Disease Spreads. (2024, April 25). Accessed 24 February 2025 from Centers for Disease Control and Prevention: https://www.cdc.gov/ebola/causes/

PPE: Confirmed Patients and Clinically Unstable Patients Suspected to have VHF. (2024, May 9). Accessed 24 February 2025 from Centers for Disease Control and Infection: https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/ppe-clinically-unstable.html

ADDENDUM A

Travel Infection History ✔

▾ Travel

Hx Recent Travel	○ Yes ○ No Comment:
Travel Start Date	
Travel End Date	
Travel Locations	For example: *Africa, Uganda, South America, Carribean, Capa Verde, Central America, Mexico, Puerto Rico, El Salvador, Barbados, US Virgin Islands, Samoa, China, Iran, Italy, Japan, Korea
Exposure to anyone with the following diseases?	☐ Ebola ☐ Covid ☐ Zika ☐ Monkeypox ☐ None ☐ Other

▾ Covid Screening

Covid Signs/Symptoms	○ Yes ○ No Comment:
Symptoms Upon Arrival to Unit	Lower resp illness (cough, diff breathing) or chills, repeated shaking with chills, muscle pain, HA, sore throat, new loss of taste or smell, persistent pain or pressure in chest, new confusion or inability to arouse, bluish lips or face? ☐ Temp > 100.4 ☐ Chills ☐ Headache ☐ Bluish Lips or Face ☐ Cough ☐ Repeated Shaking with Chills ☐ Sore Throat ☐ New Confusion or Unable to Arouse ☐ Difficulty Breathing ☐ Muscle Pain ☐ New Loss of Taste or Smell ☐ Persistent Chest Pain or Pressure
Have you had a fever with severe acute lower resp illness (e.g., PNA, ARDS) requiring a previous hospitalization and without an identified source of exposure (e.g.influenza)?	○ Yes ○ No Comment:

▾ Isolation Implementation

Patient Isolated?	○ Yes ○ No
Charge Nurse Notified	○ Yes ○ No Comment: *Enter name of charge nurse notified in comment field

ADDENDUM B

EQUIPMENT: Personal Protective Equipment (PPE)

- Impermeable garment:
  - Single-use (disposable) impermeable fluid-resistant gown extending to at least mid-calf
  - Single-use (disposable) impermeable fluid-resistant coveralls
- Authorized Undergarment (hospital scrubs)
- Authorized Shoes (closed toe and back, without holes or perforations, made of material that will not be compromised by use of disinfectants)
- Respiratory Protection:
  - N95 Mask
  - PAPR (full face shield, helmet or headpiece) covered with a single-use hood that extends the shoulders and fully covers the neck
- 2 pairs of Single-use (disposable) examination gloves with extended cuffs
- Face Shield/Goggles
- Single-use (disposable) boot covers that extend to at least mid-calf
- Single-use (disposable) apron
- EPA-registered disinfectant wipes

PROCEDURE: Donning (placing on) and Doffing (removing) PPE

Donning: (follow these steps in numerical order)

1. Partner (Observer) and Donner engage.
2. Overall donner assessment (Psychological, Emotional, Physical (i.e. diabetic, open/broken areas on the skin), General fitness.
3. Remove all personal clothing and items (i.e. cell phone…).
4. Place hospital scrubs on.
5. Inspect PPE.
6. Put on Boot covers: This step can be omitted if wearing a coverall with integrated socks.

7. 1st pair of gloves.
8. Put on Gown or Coverall.
9. Put on Respirator: N95 mask or PAPR and put on surgical hood that covers hair, ears, neck, and extends to the Shoulder.
10. Goggles/Face shield (if no PAPRs are available).

ADDENDUM B (CONT.)

11. Put on Apron (if available).
12. 2nd pair of gloves: Ensure the cuffs are pulled over the sleeves of the gown or coverall.
13. Inspect 1st gloves, N95 mask/PAPR, or goggles/face shield.
14. Buddy and donner – Verify and confirm proper donning.

Doffing: (follow these steps in numerical order)

1. Observer and doffer engage. (Observer in PPE)
2. Assess gown/coverall and gloves (integrity, amount, and location of contaminant).
3. Disinfect Outer Gloves with EPA-registered disinfectant wipe and allow to dry.
4. Remove apron (if used).
5. Inspect the PPE ensemble for visible contamination or cuts/tears. Clean and disinfect affected areas with EPA-registered disinfectant wipe.
6. Disinfect and remove Outer Gloves.
7. Inspect and disinfect Inner Glove.
8. Inspect PAPR/N-95/goggles/face shield.
9. Remove PAPR/N-95/goggles/face shield.
   - Place all reusable PAPR components in an area or container designated for the collection of PAPR components for disinfection.
10. Disinfect inner gloves with either an *EPA-registered disinfectant wipe.

11. Remove gown/coverall.

    a. Depending on gown design and location of fasteners, the healthcare worker can either untie fasteners, have the doffing assistant or Observer unfasten the gown, or gently break fasteners. Avoid contact of scrubs or disposable garments with outer surface of gown during removal. Pull gown away from body, rolling inside out and touching only the inside of the gown.

ADDENDUM B (CONT.)

    b. To remove coverall, tilt head back and reach zipper or fasteners. Use a mirror to avoid contaminating skin or inner garments. Unzip or unfasten coverall completely before rolling down and turning inside out. Avoid contact of scrubs with outer surface of coverall during removal, touching only the inside of the coverall.

12. Disinfect Inner Glove.

13. Remove Boot Cover.

14. Disinfect Washable Shoes: Use an *EPA-registered disinfectant wipe to wipe down every external surface of the washable shoes.

15. Disinfect and remove inner gloves.

16. Perform Hand Hygiene.

17. Inspect both the observer and healthcare worker for contamination of surgical scrubs. If contamination is identified, the garments should be carefully removed and the wearer should shower immediately. The trained observer should immediately inform the Infection Preventionist or occupational safety and health coordinator or their designee for appropriate occupational health follow-up.

18. Healthcare worker can leave PPE removal area wearing dedicated washable footwear and surgical scrubs proceeding directly to showering area where these are removed.

ADDENDUM C—Ebola PPE Cart

Drawer #1
Gowns

Drawer #2
Face Shields

DRAWER #3
Surgeon Caps

DRAWER #4
Extended Cuff Gloves

DRAWER #5
Gloves

DRAWER #6
Gowns (Bunny suits)

DRAWER #7
Boot Covers

SUBJECT: **EBOLA VIRUS DISEASE**	SECTION: *Infection Prevention* **Page 10 of 10**

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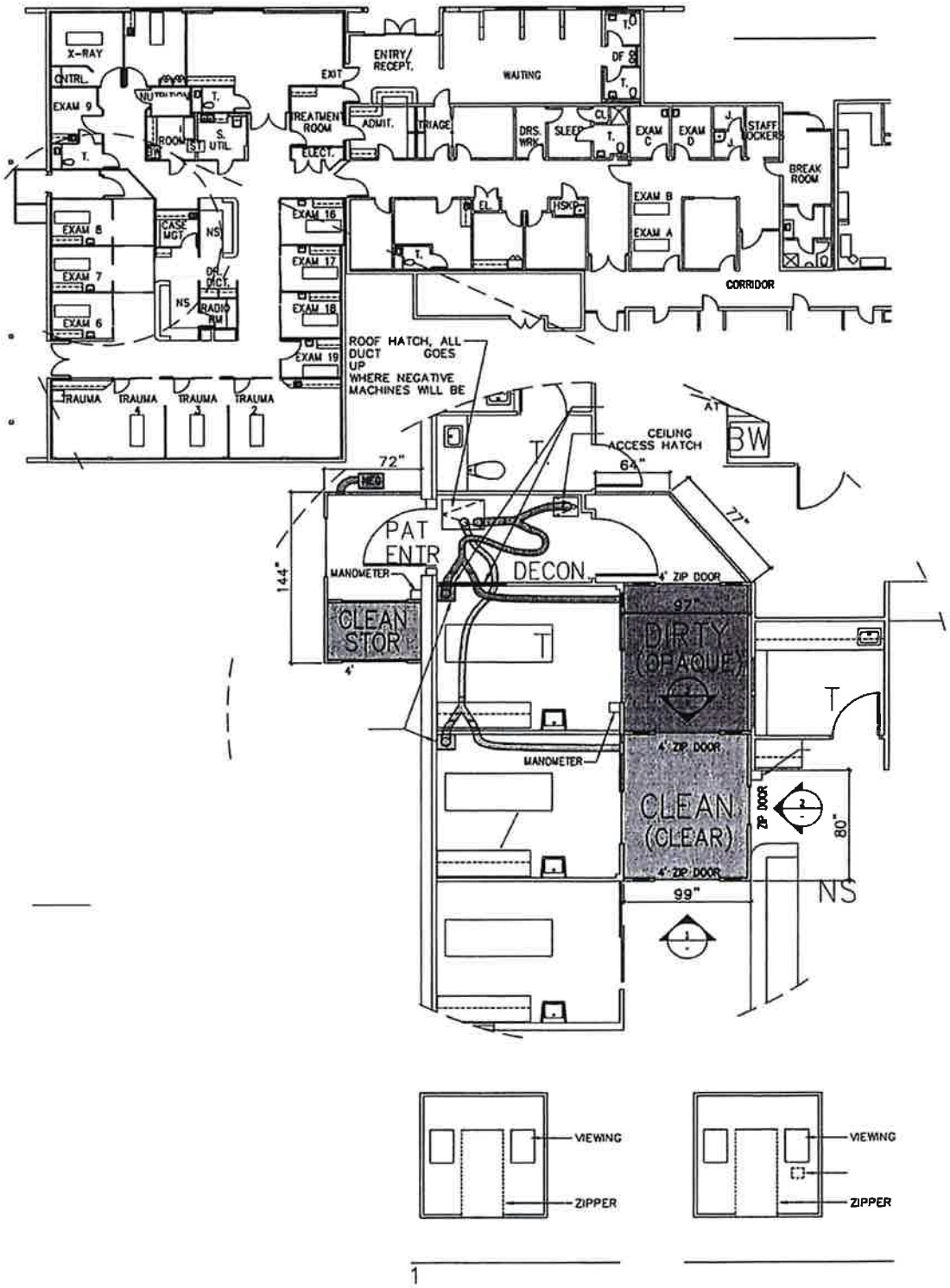
ADDENDUM D



1

SUBJECT: **GUIDELINES FOR THE PREVENTION AND CONTROL OF INFECTIOUS DISEASE TRANMISSION RELATED TO HOSPITAL CONSTRUCTION**	SECTION: **Page 1 of 4**

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

POLICY

PURPOSE:

To prevent transmission of infectious disease during construction or renovation either through exposed air-handling systems (e.g. *Aspergillus*) or water systems (e.g. *Legionella*).

BACKGROUND:

Since its formalization in 1996, the Infection Control Risk Assessment (ICRA) has been used to protect patients, staff, and others during construction and renovation projects within an existing facility. ICRA provided the evidence-based framework for a multidisciplinary team to evaluate and address potential infection risks created by construction in healthcare facilities

More recently, ICRA has been incorporated into the designing phase of health care facilities. As with any other relevant tool or guideline, ICRA has been evolving over the past few decades to keep up with key concepts of Infection Prevention and modern construction practices of health care facilities. In 2020, The American Society for Health Care Engineering (ASHE) assembled a group of health care organizations (such as APIC, AHA and others) and construction experts to clearly spell out what should be included in the next iteration of ICRA to update the guidelines. The result of these efforts, which entitles ICRA 2.0, was published in the 2001 edition of the Guidelines, a product of the Facilities Guideline Institute (FGI). The ASHE ICRA 2.0 version focuses on the actual construction phase of projects. Among the key points made in ICRA 2.0 is that infection preventionists should be included with other stakeholders long before construction or renovation begins. Although the steps (briefly outlined below) remain the same, greater detail is provided to include non-invasive work and inspections (Class I), standing practice procedures (Class II), etc., to take the guesswork and interpretation out of the equation.

Below is a brief outline of the ICRA 2.0 steps:

Action	ICRA 2.0 Tables
1. Define the activity	**Table 1** Identification of Activity Type
2. Identify patient risk	**Table 2** Patient Risk Group
3. Define the class of precautions	**Table 3** Class of Precautions
4. Assess the surrounding areas	**Table 4** Surrounding Area Assessment
5. Establish the mitigation plan	**Table 5** Minimum Required Infection Control Precautions by Class (I – V) – Before and During Work Activity
6. Prepare for completion of work activity	**Table 6** Minimum Required Infection Control Precautions – Upon Completion of Work Activity

SUBJECT: **GUIDELINES FOR THE PREVENTION AND CONTROL OF INFECTIOUS DISEASE TRANMISSION RELATED TO HOSPITAL CONSTRUCTION**	SECTION: **Page 2 of 4**

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PROCEDURE:

General Information

1. The Infection Prevention (IP) Manager and the Infection Prevention Council shall be informed of all construction and/or renovation projects prior to their initiation
2. An ICRA 2.0 will be conducted by a multidisciplinary team that includes the IP Manager and other identified stakeholders before any construction and/or renovation project begins
3. The IP Manager shall be involved in all aspects of construction and/or renovation projects from the planning stage to the final completion and preparation for use on an ongoing basis
4. The IP Manager will provide project updates to the Infection Prevention Council as needed
5. The IP Manager and the Infection Prevention Council shall provide evidence-based advice using the ASHE ICRA 2.0 Guidelines (See Appendix A)
6. Contracted construction companies and their on-site employees or representatives will comply with all safety and control measures as agreed upon by the contract

Conducting the ICRA 2.0

1. **Step 1 – Determine Activity Type:** using Table 1 of ICRA 2.0, identify the construction or renovation activity type. Indicate the type of activity (Type A through Type D) in the space provided in the upper left side of the document. The broad definition of activity types are:
    a. **Type A** – Inspection and non-invasive activities (see Table 1 for examples)
    b. **Type B** – Small-scale, short duration activates that create minimal dust and debris
    c. **Type C** – Large-scale, longer duration activities that create a moderate amount of dust and debris
    d. **Type D** – Major demolition and construction activates
2. **Step 2 – Identify the Patient Risk Group(s)**: Table 2 provides a breakout of 4 different patient risk groups. If more than one risk group will be affected, select the higher of the identified groups and record that on the space on the upper left side of the document. The risk groups include:
    a. **Low Risk**: Non-patient care areas
    b. **Medium Risk**: Patient care support areas
    c. **High Risk**: Patient care areas
    d. **Highest Risk**: Procedural, invasive, sterile support and highly compromised patient care areas
3. **Step 3 – Determine the Class of Precautions to Implement:** Table 3 is a matrix that includes Patient Risk Group versus Construction Project Type is provided to allow the selection of the

appropriate precautions for the construction/renovation project. Once Class Precautions have been identified (I, II, III, IV, or V), record the Class of Precautions in the space provided.

4. **Step 4 – Assessment of the Surrounding Areas**: Use Table 4 to conduct an assessment of the areas surrounding the construction or renovation project. What is the type of impact that will occur during the proposed activity? If more than one risk group will be affected, always select the higher risk group using Table 2. Table 4 includes information for the assessment of:
    a. The surrounding area(s)
    b. Noise and vibration mitigation strategies
    c. Ventilation and pressurization mitigation strategies, and
    d. Impact to other systems
5. **Step 5 – Selection of Precautions by Identified Class**: Table 5, *Minimum Required Infection Control Precautions by Class – Before and During Work Activity*, outlines the types of mitigation activities required by class. Use the outcome from the previous assessments using Tables 1 through 4, to identify the class of precautions to use for the proposed project. The categories run from Class I through Class V. Notice that the higher the class, the more precautions are described.
6. **Step 6 – Determine the Minimum Required Infection Control Precautions required during the Completion of Work Activity**: Table 6 has two major categories of mitigation activities. The first group includes Classes I, II and III, and provides information for cleaning and HVAC systems. The second broad group includes Classes III (Type C activities, only), IV and V. The second broad group includes mitigation information on cleaning of the work area, removal of critical barriers, negative air pressure requirements and HVAC system operations.
7. **Step 7 – Complete the ICRA 2.0 Infection Control Risk Assessment and Permit, Submit to the IP Department for Approval and ICRA Permit Number**. ICRA 2.0 Permit is a 2-page document that requires a better-defined description of the project and required mitigation activities to safely carry out the proposed project. The items that are required to complete the permit include
    a. **Project Information**. Note that if the scope of work changes, or additional toxic or biological substances are identified, *work must be stopped* and additional guidance and approval are required before proceeding.
    b. **Type of Activity** – includes space for explanation
    c. **Patient Risk Area** – includes space for description of key patient risks
    d. **Class of Precautions** – The assessment outcome is recorded here
    e. **Surrounding Area** – The pertinent information is summarized here
    f. **Detailed ICRA Control Plan** – Controls, specifications, materials and verification of method(s) and frequencies are recorded here

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- Flannery J. ASHE Published Revised Infection Control Risk Assessment Guide. 2021. Health Facilities Management Magazine. Accessed on 30 January 2025. https://www.hfmmagazine.com/articles/4334-ashe-publishes-revisedinfection-control-risk-assessment-guide
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- Title 22 California Code of Regulations, Section 70739 (n.d.) Accessed on 25 January 2025 from: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-08-Attachment-02.pdf

CROSS REFERENCES:

Appendix A - ICRA 2.0 Assessment Form

SUBJECT: **PATIENT SAFETY PLAN**	SECTION: *Leadership (LD)* **Page 1 of 7**

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

PURPOSE:

To establish an organizational-wide patient safety plan that promotes a culture of quality and patient safety.

POLICY:

To provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety throughout the organization. This will be accomplished through the establishment of a Patient Safety Committee whose responsibilities will be to:

- Support effective responses to Patient Safety Events;
- Integrate patient safety as a priority into new processes and the redesign of existing processes, functions, and services;
- Minimize individual blame or retribution for involvement in a patient safety event and reporting;
- Champion organization-wide education related to safety, risk reduction, and reporting of potential unsafe events or adverse outcomes;
- Promote an ongoing proactive approach to reducing risk.

AFFECTED AREAS/PERSONNEL:

ALL EMPLOYEES, MEDICAL STAFF, CONTRACTORS, STUDENTS, VOLUNTEERS.

DEFINITION:

Patient Safety Event: An adverse sentinel or potential adverse sentinel event, as described in HSC § 1279.1(b), that is determined to be preventable, e.g. to include misconnection of intravenous, enteral and epidural lines as well as preventable healthcare-associated infections (HAIs) as defined by the National Healthcare Safety Network or the Healthcare Associated Infection Advisory Committee. Refer to House-wide Policy & Procedures: *Patient Safety Event, and Serious Clinical Adverse Event.*

CORE PRINCIPLES AND RESPONSIBILITIES:

A. Performance Improvement and Patient Safety Committee (PIPS)

1. The Board of Directors has the ultimate authority and responsibility to require and support a patient safety program. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California Evidence Code, Section §1157.

2. The Performance Improvement/Patient Safety (PIPS) Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from other committees, departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization.

3. The PIPS Committee shall recognize and reinforce that members of the medical staff are responsible for making medical treatment decisions for their patients.

Membership:

The Patient Safety Committee will report to the PIPS Committee quarterly. The Patient Safety Committee consists of the following members and others as the committee may call on, to accomplish specific goals and objectives within the authorized scope of activities outlined herein:

- Vice President of Quality and Regulatory Affairs (Executive Sponsor)
- Patient Safety Nurse
- Wound Care Nurse
- Director of Pharmacy
- Maternal Child Healthcare representative

- Medical Surgical Nursing Unit representative
- Critical Care Services representative

- Surgical Services representative

- Emergency Department representative
- Imaging representative
- Laboratory representative

Responsibilities:

The Patient Safety Committee will meet at least quarterly, shall maintain a record of its proceedings and activities, and shall report findings, conclusions, recommendations and follow-up to Performance Improvement/Patient Safety Committee, Medical Executive Committee and the Board of Directors.

The Committee will do all of the following:

Receive and review reports of patient safety events to include, but not limited to:

a. All serious clinical adverse events (Patient Safety Events). (Refer to House-wide policy: *Serious Clinical Adverse Event).*

b. Hospital acquired infections (HAI) that are determined to be preventable. (Refer to House-wide policy, Infection Prevention Plan).

Monitor implementation of corrective actions for patient safety events.

Make recommendations to eliminate future patient safety events. The Patient Safety Committee has adopted the failure mode and effects analysis model for proactive process redesign.

Review and revise the Patient Safety Plan at least annually and more often if necessary to evaluate and update the patient safety plan and to incorporate advancements in patient safety practices.

B. Reporting System for Patient Safety Events

The facility has established a reporting system for patient safety events that allows anyone involved, including, but not limited to, healthcare practitioners, employees, patients and visitors, to make a report of a patient safety event to the hospital. Refer to House-wide policy, *Serious Clinical Adverse Event.*

C. Analysis of Adverse Events

The facility has defined and established a policy that outlines the actions to be taken in response to an adverse event. (Refer to House-wide policies *Patient Safety Event and Serious Clinical Adverse Event).*

D. Culture of Safety

Sierra View Medical Center has adopted a just culture model that supports and encourages occurrence reporting, whereby enabling the hospital to carry out its responsibility for providing quality care in a safe environment.

E. Education and Training

Staff and healthcare practitioners receive education and training on hire and during initial and annual orientation on issues regarding job-related aspects of patient safety, including Just Culture and Systems Theory. Records of such education are maintained.

F. Disclosure

Patients, and when appropriate, their families, are to be informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. (Refer to House-wide policy and procedures, *Serious Clinical Adverse Event).*

G. National Patient Safety Goals

Implement the Joint Commission recommended goals through education and monitoring activities to ensure compliance with the standards.

H. Leadership (LD 03.01.01)

Consider information from patient, family, staff and other individuals related to their opinions, needs and perceptions of risks to patients and suggestions for improving patient safety.

SCOPE OF ACTIVITIES

Performance/Quality Improvement

1. Establish measurable objectives for improving patient safety and quality. Measurable objectives shall be based on the elements of patient safety and error reduction, which are described in this plan.

2. Review and disseminate available information about the Joint Commission Sentinel Event Alerts. Review current process and analyze recommendations listed in the Sentinel Event Alert. Implement appropriate action to improve processes related to patient safety.

3. Assure that prioritization is given to those events and processes most closely associated with patient safety when developing the organizational measurement program and in selecting specific improvement activities.

4. Assure that when organizational processes are designed or redesigned, information from other organizations related to potential risk to patient safety, including occurrence of sentinel events, is reviewed and risk reduction strategies are incorporated.

5. Perform a Healthcare Failure Mode Effect Analysis (HFMEA) as required and selected based on information published by the Joint Commission related to patient safety and medical errors and/or through identification of a high-risk problem prone process.

Patient Safety

1. Perform an annual risk assessment and prioritize goals in collaboration with hospital leaders to reduce the risk of patient safety events. (Refer to House wide Policy & Procedure, *Risk Management Plan*).

2. Develop an organization-wide approach to the reporting and evaluation of unusual occurrences.

3. Review all occurrence reports, and when appropriate, develop a thorough and credible root cause analysis, appropriate plan of correction and follow up plan. (Refer to House Wide Policy & Procedure, *Serious Clinical Adverse Event*). All sentinel events will be reported to, evaluated and monitored for completion by the Patient Safety Committee and will be reported to the Performance Improvement/Patient Safety Committee.

4. Develop procedures for immediate response to unusual occurrences, including care of the affected patient, care of involved clinicians, containment of risk to others and preservation of factual information for subsequent analysis.

5. Develop systems for internal and external reporting of information relating to unusual occurrences.

   Aggregate and trend all risk management information/data to identify patterns in processes or outcomes, which may lead to untoward patient events. Evaluate patient grievances and complaint trends and patterns.

Human Resources

1. Assure patient safety information is presented to all new employees as part of the New Hire Orientation Program.

2. Define a mechanism for the support of staff that are involved in medical errors and sentinel events. Provide individuals emotional and psychological support through Care for the Caregiver Program and/or Employee Assistance Program (EAP). Members of the Medical Staff can be referred to the Care for the Caregiver program and/or Medical Staff Office for assistance.

Education

1. Ensure all staff members participate in ongoing in-services, education, and training to increase his or her knowledge of job-related aspects of patient safety. Patient safety information is included in staff annual orientation and training.

2. Assure that ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. Oversee the development of programs to educate the patient and families about their role in helping to facilitate the safe delivery of health care.

Infection Prevention

1. Perform an annual risk assessment and prioritize goals in collaboration with hospital leaders to reduce the risk of transmission of infections and prevent Hospital Acquired Infections (HAI). (Refer to House wide Policy & Procedure, *Infection Prevention Plan*)

2. Conduct infection prevention activities and surveillance to monitor HAI as outlined in the Infection Prevention Plan.

3. Assist with methods to reduce surgical site infections as designed in the Surgical Care Improvement Project.

4. Monitor infections related to indwelling lines, to include but not be limited to, intravenous, enteral, and epidural lines and indwelling catheters.

Pharmacy

1. Ensure safe and optimal use of medications to improve patient's clinical outcomes.

2. Assist with procurement, distribution, storage, dispensing and safe use of pharmaceuticals for patients.

3. Assure that process and product-purchasing decisions support the safe use of intravenous lines to include safeguards such as unique connection ports that prohibit the use of any intravenous, epidural, or enteral feeding line to be used for anything other than its intended purpose except in emergent situations.

4. Facilitate improvement initiatives through the Medication Safety Committee that reduce medication-related patient safety events.

Environment of Care (Safety Officer)

1. Assure that measurements related to patient safety and error reduction are incorporated in the seven (7) plans of the Environment of Care.

2. Aggregate, assess and report organizational data related to patient safety events, intervention and follow-up.

National Patient Safety Goals for Hospitals:

Sierra View Medical Center will follow and educate yearly on patient safety goals, released by the Joint Commission.

National Quality Forum's Four Safe Practices:

Develop structures, programs, policies, and practice that support the National Quality Forum's (NQF) four safe practices involved in creating and sustaining a patient safety culture which includes:

1. Improve the accuracy of patient identification

2. Improve the effectiveness of communication among caregivers,

3. Improve the safety of using medications,

4. Reduce the harm associated with clinical alarm systems.

Compliance with this goal will be guided by the principles as outlined within the Consensus Report: NQF Safe Practices for Better Healthcare – 2010 Update, and monitored by the Patient Safety Committee with results reported to and measured annually by the Leapfrog Group via the Leapfrog Group's Hospital Safety Score.

REFERENCES:

- California Evidence Code 1157, § Title 22 (2017).
- The Joint Commission (2025). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Health and Safety Code § 1279.1(b), 1279.6 and 1279.7.
- Meyer, G., Denham, C. R., Battles, J., Carayon, P., Cohen, M. R., Daley, J., McAuliffe, M. (2010). Safe Practices for Better Healthcare-2010 Update. National Quality Forum Safe Practices, 1-406.

CROSS REFERENCES:

- SERIOUS CLINICAL ADVERSE EVENT
- ANNUAL INFECTION PREVENTION PLAN
- JUST CULTURE
- PATIENT SAFETY EVENT
- RISK MANAGEMENT PLAN

SUBJECT: **PEDIATRIC MEDICATION ADMINISTRATION GUIDELINES**	SECTION: **Page 1 of 4**

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

PURPOSE:

The policy defines the guidelines for medication management in the Pediatric Department. The guidelines also address how to safely and accurately administer medication to a child, taking into account their weight, surface area, and the ability of the child to absorb, metabolize, and excrete the medication.

POLICY:

Medications shall be administered based on a physician order and the necessity of care the patient requires.

1. Those involved in the medication management process shall determine the following, but not limited to:

    a. Age

    b. Sex

    c. Current medications

    d. Diagnosis and co-morbidities

    e. Relevant laboratory data

    f. Allergies and past sensitivities

    g. Weight and Height as appropriate

    h. Pregnancy and lactation status as appropriate

    i. Any other information required for safe medication management

2. To avoid medication errors, always follow these five steps in preparing and administering medication to a pediatric patient.

    a. RIGHT CHILD. Always check the identification band of the child before administering the medication. Never assume that the child in the bed is the child assigned to that bed. If the identification band is missing, the nurse must identify the child by asking a parent, guardian or the child, and then replace the band immediately.

    b. RIGHT DRUG. Check the label on the medication. If the label is not clear or confusing, do not give the medication. Call the pharmacist and have the drug relabeled. Check the drug's expiration date; do not administer outdated drugs. Check the consistency and color of the drug and be aware of the signs of deterioration.

c. RIGHT DOSE. If in doubt about how much medication is an appropriate dose, check a reference before administering it. Always clarify poorly written orders. Check drug references before mixing any medications to determine the compatibility of the drugs.

d. RIGHT ROUTE. Some drugs are never given by certain routes because the route would hinder the action of the drug.

e. RIGHT TIME. Always make a note of when the medication is to be given.

f. RIGHT EDUCATION. Education must be given to the patient (if age appropriate) and family on the following: the name of the medication being administered, common usages, contraindications, side-effects, toxic effects, and the side effects the child's parents or caregiver should be aware of.

g. RIGHT DOCUMENTATION. Always double check all documentation and save in the EMAR this should include verification process.

3. Pediatric patient weights shall be documented on admission in kilograms (kg).

4. The nurse's manner of approach should indicate that she firmly expects the child to take the medication. This manner convinces the child of the necessity of the procedure. Establishing a positive relationship with the child will allow him to express feelings, concerns, and fantasies regarding medication.

5. Never give a child a choice of whether or not to receive the medicine.

6. Explanation about the medication should appeal to the child's level of understanding (i.e., color, comparison to something familiar).

7. Never lie. Do not tell a child that a shot will not hurt.

8. It is often necessary to mix distasteful medications or crushed pills with a small amount of applesauce or juice.

9. Never threaten a child with an injection if he refuses an oral medication.

10. Medication should not be mixed with large quantities of food or with any food that is taken regularly (e.g., milk).

11. Medication should not be given at mealtime unless specifically prescribed.

12. The nurse must know the following about each medication that he/she is administering: common usages and dosages, contraindications, side-effects, and toxic effects and explain the side effects to the child's parents or caregiver.

13. Assure the child that it is all right to be afraid and that it is okay to cry.

14. Do not talk in front of the child as if the child were not there. Include the child in the conversation when talking to parents.

15. Obtain parental cooperation. Parents may be able to calm a frightened child, persuade the child to take the medication and achieve cooperation for care.

16. As a safe practice, medications shall not be left at the patient's bedside.
17. Medications require a second licensed person to verify the correct dose. The second licensed person will check the dosage calculation, as applicable, and the dose that is prepared properly. Both licensed persons, one of which is an RN, will contest in the EMAR that the calculation and dose given was correct and verified. The following doses require two (2) licensed verifications and signatures:

    a. Pediatric/neonatal medications that are High-Alert, IV and IM doses excluding Vitamin K and immunizations; multidose vials, topicals.

AFFECTED PERSONNEL/AREAS: *RNs*

PROCEDURE:

1. Allergies will always be checked before the administration of medications.

2. Identifying the patient:
   Always check a child's identification bracelet using BMV (bedside medication verification) process before administering a medication.

3. Buretrols will be used on all pediatric patients under the age of 13 years old when an IV is running.

4. **Nursing will refer to the book "Pediatric Nursing Procedures" written by Bowden and Greenberg for specific administration processes such as oral, rectal, subcutaneous, intramuscular, etc.**

DOCUMENTATION:

1. The nurse/pharmacists that verifies the dosage prior to the administration of the drug shall document in the EMR (electronic medical record) his/her electronic signature in the patient's EMAR (electronic medication administration record).

2. The Administering RN will document in the EMAR the time, route and dosage of the medication.

3. If giving the child immunizations, the lot number and expiration date of the vaccine, along with the most recently updated VIS (Vaccine Information Sheet) will be documented.

REFERENCES:

Hockenberry, M. J., Gibbs, K. D., & Duffy, E. A. (2025). *Wong's essentials of pediatric nursing*. Elsevier Health Sciences.

Alrabadi, N., Shawagfeh, S., Haddad, R., Mukattash, T., Abuhammad, S., Al-Rabadi, D., Farha, R. A., AlRabadi, S., & Al-Faouri, I. (2021). Medication errors: a focus on nursing practice. *Journal of Pharmaceutical Health Services Research*, *12*(1), 78–86. https://doi.org/10.1093/jphsr/rmaa025

CROSS REFERENCES:

MEDICATION ADMINISTRATION

MINUTES

Sierra View Local Health Care District
Board of Directors Regular Meeting
465 West Putnam Avenue, Porterville, CA
Board Room

MEETING MINUTES

BOARD OF DIRECTORS REGULAR MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **April 22, 2025 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
- Bindusagar Reddy, Vice Chair
- Areli Martinez, Secretary
- Hans Kashyap, Director
- Gaurang Pandya, Director (Arrived At 5:19 P.M.)

Others Present: Donna Hefner, President/Chief Executive Officer, Craig McDonald, Chief Financial Officer, Ron Wheaton, VP of Professional Service, Tracy Canales, VP of Human Resources and Marketing, Terry Villareal, Executive Assistant and Clerk to the Board, Alisia Sanchez, Senior Marketing and Communications Design Specialist, Gary Wilbur, Administrative Director of General Services, Cindy Gomez, Compliance Privacy Officer, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff, Chief of Staff and Sylvia Martinez

I. Approval of Agenda:

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

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Absent
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 Section 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report

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

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

2. Quality Division Update – Quality Report

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

Director Pandya arrived to the Board Room at 5:19 p.m., during item D.

Closed Session Items C, E, F and G 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 5:43 p.m., reconvening in Open Session at 5:44 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.
Information Only; No Action Taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

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

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Abstain
REDDY	Yes
LOMELI	Yes

2. Quality Division Report

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

KASHYAP	Yes
MARTINEZ	Yes

PANDYA	Abstain
REDDY	Yes
LOMELI	Yes

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only; No Action Taken

IV. Public Comments

Sylvia Martinez, Porterville, CA – Has been a volunteer at Sierra View Medical Center for the past seven years, shared her appreciation for the wonderful staff throughout the organization. She commended the employees throughout the many departments for their kindness. Sylvia emphasized that Sierra View is filled with amazing people and that her experience as a volunteer has been deeply rewarding.

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). One policy was pulled for further discussion regarding Parking. Gary Wilbur, Administrative Director of General Services gave an update on enforcement, permitting and new signage. Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director PANDYA, and carried to approve the Consent Agenda. The vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director MARTINEZ and seconded by Director KASHYAP to approve the February 25, 2025 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Abstain
REDDY	Abstain
LOMELI	Yes

B. Following review and discussion, it was moved by Vice Chair REDDY and seconded by Director MARTINEZ to approve the March 25, 2025 Minutes of the

Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

KASHYAP	Abstain
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

C. Following review and discussion, it was moved by Director MARTINEZ and seconded by Vice Chair REDDY to approve the April 10, 2025 Minutes of the Special Board Meeting as presented. The motion carried and the vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Abstain
REDDY	Yes
LOMELI	Abstain

VII. Business Items

A. March 2025 Financials

Craig McDonald, CFO presented the Financials for March 2025.

Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director MARTINEZ and carried to approve the March 2025 Financials as presented. The vote of the Board is as follows:

KASHYAP	Yes
MARTINEZ	Yes
PANDYA	Yes
REDDY	Yes
LOMELI	Yes

B. Capital Report – Quarter Ending March 31, 2025

Craig McDonald, CFO presented the Capital Report for Quarter Ending March 31, 2025.

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

KASHYAP Yes
MARTINEZ Yes
PANDYA Yes
REDDY Yes
LOMELI Yes

C. Investment Report– Quarter Ending March 31, 2025

Craig McDonald, CFO presented the Investment Report for Quarter Ending March 31, 2025.

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

KASHYAP Yes
MARTINEZ Yes
PANDYA Yes
REDDY Yes
LOMELI Yes

The board took a brief three minute break.

D. Formation and Appointment of Operational Efficiency Ad Hoc Advisory Committee

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ, to appoint Vice Chair Reddy and Director Kashyap to a committee tasked with taking a closer look at operational efficiency in the oversight of operations.

KASHYAP Yes
MARTINEZ Yes
PANDYA Yes
REDDY Yes
LOMELI Yes

VIII. CEO Report

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

IX. Announcements:

A. Regular Board of Directors Meeting – May 27, 2025 at 5:00 p.m.

X. Closed Session: Chairman LOMELI adjourned Open Session at 7:11 p.m., reconvening in Closed Session at 7:25 p.m.

C. Pursuant to Gov. Code Section 54954.5(c) and 54956.9(d): Conference with Legal Counsel Regarding Existing Litigation: SVLHCD vs. Dr. Snyder; Tulare County Superior Court Case # VCU308242

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2027

F. Pursuant to Gov. Code Section 54957(b)(1): Public Employee Annual Performance Evaluation of Hospital CEO. Estimated date of disclosure April 23, 2025

President/CEO left the boardroom at 8:20pm so Board could discuss evaluation.

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

XI. Open Session: Chairman LOMELI adjourned Closed Session at 9:06 p.m., reconvening in Open Session at 9:06 p.m.

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

C. Conference with legal counsel regarding Existing Litigation:
SVLHCD vs. Dr. Snyder; Tulare County Superior Court Case # VCU308242
Recommended Action: Information Only; No Action Taken

E. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Action Recommended: Information Only; No Action Taken

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

F. Discussion Regarding Annual Evaluation of Public Employee: Hospital CEO

1. All 16 pages of the CEO's self-evaluation were considered;
2. The Board used pages 15 and 16 of the CEO's evaluation to create a Board Assessment of the CEO Performance following the CEO's own scale. On average, the CEO's performance fully meets expectations using this scale.
3. The Board wished to add the following four goals for the CEO, in addition to those in the self-assessment:

a. Significantly increase accountability in operations from subordinate management;
b. Develop and adopt methods for the earlier detection of mistakes by subordinates, and earlier plans of correction;
c. Develop and adopt methods for the earlier detection of poor policies that negatively impact culture, and earlier plans of correction;
d. Increase in decisiveness and assertiveness from the CEO in the pursuit of accountability and correction of actions by subordinates.

Vice Chair REDDY made a motion to approve the completion of the annual evaluation of the Hospital CEO, seconded by Director KASHYAP and carried to approve the completion of the evaluation. The vote of the Board is as follows:

PANDYA	Abstain
REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
KASHYAP	Yes

Following the vote, Chair LOMELI executed approval of the automatic annual 2% salary increase afforded to the CEO by her employment contract. .

XII. Adjournment

The meeting was adjourned at 9:10 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

FINANCIALS

Sierra View Local Health Care District
Board of Directors Regular Meeting
465 West Putnam Avenue, Porterville, CA
Board Room

FINANCIAL PACKAGE
April 2025

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
April 2025

Statistic	Apr-25 Actual	Apr-25 Budget	Apr-25 Over/ (Under)	Apr-25 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 24 YTD	Increase/ (Decrease) Apr-24	% Change
Utilization											
SNF Patient Days											
Total	-	56	(56)	-100.0%	127	563	(436)	-77.4%	450	(323)	-71.8%
Medi-Cal	-	56	(56)	-100.0%	127	560	(433)	-77.3%	450	(323)	-71.8%
Sub-Acute Patient Days											
Total	998	970	28	2.9%	9,828	9,697	131	1.4%	9,685	143	1.5%
Medi-Cal	493	896	(403)	-45.0%	4,899	8,410	(3,511)	-41.7%	8,405	(3,506)	-41.7%
Acute Patient Days	1,577	1,648	(71)	-4.3%	16,540	16,476	64	0.4%	16,646	(106)	-0.6%
Acute Discharges	440	427	13	3.1%	4,396	4,268	128	3.0%	4,309	87	2.0%
Medicare	191	175	16	9.1%	1,793	1,668	125	7.5%	1,683	110	6.5%
Medi-Cal	190	194	(4)	-1.9%	2,043	2,084	(41)	-2.0%	2,104	(61)	-2.9%
Contract	57	53	4	7.3%	533	485	48	9.8%	491	42	8.6%
Other	2	5	(3)	-59.3%	27	30	(3)	-11.2%	31	(4)	-12.9%
Average Length of Stay	3.58	3.86	(0.28)	-7.1%	3.76	3.86	(0.10)	-2.5%	3.86	(0.10)	-2.6%
Newborn Patient Days											
Medi-Cal	147	161	(14)	-8.8%	1,516	1,602	(86)	-5.4%	1,654	(138)	-8.3%
Other	24	31	(7)	-22.9%	333	320	13	4.2%	293	40	13.7%
Total	171	192	(21)	-11.1%	1,849	1,922	(73)	-3.8%	1,947	(98)	-5.0%
Total Deliveries	84	99	(15)	-15.2%	961	990	(29)	-2.9%	998	(37)	-3.7%
Medi-Cal %	84.52%	83.43%	1.09%	1.3%	82.43%	83.43%	-1.00%	-1.2%	84.51%	-2.07%	-2.5%
Case Mix Index											
Medicare	1.5545	1.6368	(0.0823)	-5.0%	1.6077	1.6368	(0.0291)	-1.8%	1.6184	(0.0107)	-0.7%
Medi-Cal	1.2353	1.1975	0.0378	3.2%	1.1966	1.1975	(0.0009)	-0.1%	1.2130	(0.0164)	-1.4%
Overall	1.3592	1.3724	(0.0132)	-1.0%	1.3686	1.3724	(0.0038)	-0.3%	1.3784	(0.0098)	-0.7%
Ancillary Services											
Inpatient											
Surgery Minutes	6,645	8,224	(1,579)	-19.2%	74,330	82,239	(7,909)	-9.6%	83,160	(8,830)	-10.6%
Surgery Cases	71	94	(23)	-24.3%	874	938	(64)	-6.8%	932	(58)	-6.2%
Imaging Procedures	1,552	1,404	148	10.5%	15,157	14,043	1,115	7.9%	14,169	988	7.0%
Outpatient											
Surgery Minutes	14,729	12,775	1,954	15.3%	137,328	127,751	9,577	7.5%	125,448	11,880	9.5%
Surgery Cases	194	204	(10)	-4.8%	1,869	2,038	(169)	-8.3%	2,024	(155)	-7.7%
Endoscopy Procedures	201	192	10	5.0%	1,823	1,915	(92)	-4.8%	1,816	7	0.4%
Imaging Procedures	4,315	3,886	429	11.0%	41,181	38,858	2,324	6.0%	39,844	1,337	3.4%
MRI Procedures	279	302	(23)	-7.5%	2,995	3,017	(22)	-0.7%	3,052	(57)	-1.9%
CT Procedures	1,237	1,237	0	0.0%	12,284	12,369	(85)	-0.7%	12,409	(125)	-1.0%
Ultrasound Procedures	1,419	1,244	175	14.1%	13,174	12,437	737	5.9%	12,757	417	3.3%
Lab Tests	34,544	32,140	2,404	7.5%	320,485	321,402	(917)	-0.3%	319,436	1,049	0.3%
Dialysis	4	6	(2)	-36.8%	36	63	(27)	-43.2%	38	(2)	-5.3%

Sierra View Medical Center
Financial Statistics Summary Report
April 2025

	Apr-25				YTD					Increase/	
Statistic	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Actual**	**Budget**	**Over/ (Under)**	**% Var.**	**Fiscal 24 YTD**	**(Decrease) Apr-24**	**% Change**
Cancer Treatment Center											
Chemo Treatments	2,020	1,924	96	5.0%	19,367	19,238	130	0.7%	16,987	2,380	14.0%
Radiation Treatments	2,172	1,836	336	18.3%	18,638	18,358	281	1.5%	18,648	(10)	-0.1%
Cardiac Cath Lab											
Cath Lab IP Procedures	8	11	(3)	-28.9%	123	113	11	9.3%	128	(5)	-3.9%
Cath Lab OP Procedures	44	30	14	47.1%	341	299	42	14.0%	291	50	17.2%
Total Cardiac Cath Lab	52	41	11	26.3%	464	412	52	12.7%	419	45	10.7%
Outpatient Visits											
Emergency	3,429	3,415	14	0.4%	34,537	34,146	391	1.1%	34,282	255	0.7%
Total Outpatient	15,357	13,994	1,363	9.7%	141,538	139,943	1,596	1.1%	135,964	5,574	4.1%
Staffing											
Paid FTE's	872.80	855.00	17.80	2.1%	875.12	855.00	20.12	2.4%	861.21	13.91	1.6%
Productive FTE's	752.39	734.21	18.18	2.5%	749.06	734.21	14.85	2.0%	737.47	11.59	1.6%
Paid FTE's/AOB	4.98	4.82	0.15	3.2%	5.15	4.89	0.26	5.4%	5.02	0.13	2.6%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,526	10,552	974	9.2%	11,278	10,552	725	6.9%	10,657	621	5.8%
Cost/Adj.Patient Day	2,777	2,580	196	7.6%	2,809	2,617	192	7.3%	2,680	129	4.8%
Revenue/Adj. Discharge	54,134	53,065	1,069	2.0%	54,927	53,065	1,861	3.5%	53,325	1,602	3.0%
Cost/Adj. Discharge	13,042	12,976	66	0.5%	13,680	13,158	522	4.0%	13,410	270	2.0%
Adj. Discharge	1,120	1,057	63	6.0%	10,604	10,574	29	0.3%	10,419	185	1.8%
Net Op. Gain/(Loss) %	2.36%	-2.78%	5.14%	-184.8%	-1.87%	-2.78%	0.91%	-32.7%	-5.71%	3.83%	-67.2%
Net Op. Gain/(Loss) $	352,824	(371,205)	724,029	-195.0%	(2,664,778)	(5,639,765)	2,974,987	-52.8%	(7,541,300)	4,876,522	-64.7%
Gross Days in Accts Rec.	84.38	95.03	(10.65)	-11.2%	84.38	95.03	(10.65)	-11.2%	93.39	(9.01)	-9.7%
Net Days in Accts. Rec.	36.76	57.75	(20.99)	-36.3%	36.76	57.75	(20.99)	-36.3%	49.81	(13.05)	-26.2%

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

	APR 2025	MAR 2025
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 18,883,526	$ 11,949,566
SHORT-TERM INVESTMENTS	11,644,100	314,737
ASSETS LIMITED AS TO USE	4,523,596	4,035,431
PATIENT ACCOUNTS RECEIVABLE	162,177,723	161,930,035
LESS UNCOLLECTIBLES	(14,484,466)	(13,651,827)
CONTRACTUAL ALLOWANCES	(130,559,992)	(129,409,393)
OTHER RECEIVABLES	24,633,372	29,516,065
INVENTORIES	4,530,035	4,489,599
PREPAID EXPENSES AND DEPOSITS	3,169,166	3,322,053
LEASE RECEIVABLE - CURRENT	279,983	303,872
TOTAL CURRENT ASSETS	84,797,044	72,800,139
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	32,101,372	32,005,619
LONG-TERM INVESTMENTS	126,411,718	137,035,318
PROPERTY, PLANT AND EQUIPMENT, NET	72,321,686	72,592,483
INTANGIBLE RIGHT OF USE ASSETS	303,231	315,261
SBITA RIGHT OF USE ASSETS	3,797,533	3,946,961
LEASE RECEIVABLE - LT	776,561	841,271
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,300,736	1,321,716
TOTAL ASSETS	$ 322,059,880	$ 321,108,767

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

	APR 2025	MAR 2025
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 462,350	$ 346,763
CURRENT MATURITIES OF BONDS PAYABLE	4,235,000	4,235,000
CURRENT MATURITIES OF LONG TERM DEBT	1,109,546	1,382,212
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	4,775,636	4,110,667
ACCRUED PAYROLL AND RELATED COSTS	6,891,940	6,917,816
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	5,100,701	5,609,731
LEASE LIABILITY - CURRENT	133,460	135,181
SBITA LIABILITY - CURRENT	1,700,285	1,702,294
TOTAL CURRENT LIABILITIES	24,408,918	24,439,663
SELF-INSURANCE RESERVES	2,098,506	2,116,478
BONDS PAYABLE, LESS CURR REQT	33,275,000	33,275,000
BOND PREMIUM LIABILITY - LT	2,182,491	2,234,448
LEASE LIABILITY - LT	193,289	203,582
SBITA LIABILITY - LT	2,390,600	2,506,168
DEFERRED INFLOW - LEASES	995,021	1,078,139
TOTAL LIABILITIES	65,543,824	65,853,477
UNRESTRICTED FUND	248,385,511	248,385,511
PROFIT OR (LOSS)	8,130,546	6,869,779
TOTAL LIABILITIES AND FUND BALANCE	$ 322,059,880	$ 321,108,767

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

APR 2025 ACTUAL	APR 2025 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,249,020	5,253,784	4,764	0%	INPATIENT - NURSING	53,580,293	52,537,840	(1,042,453)	2%
18,678,367	17,396,289	(1,282,078)	7%	INPATIENT - ANCILLARY	188,728,213	173,962,896	(14,765,317)	9%
23,927,387	22,650,073	(1,277,314)	6%	TOTAL INPATIENT REVENUE	242,308,506	226,500,736	(15,807,770)	7%
36,726,892	33,463,071	(3,263,821)	10%	OUTPATIENT - ANCILLARY	340,114,626	334,630,716	(5,483,910)	2%
60,654,279	56,113,144	(4,541,135)	8%	TOTAL PATIENT REVENUE	582,423,131	561,131,452	(21,291,679)	4%
				DEDUCTIONS FROM REVENUE				
(18,501,619)	(18,243,309)	258,310	1%	MEDICARE	(175,698,213)	(182,433,090)	(6,734,877)	(4)%
(18,347,770)	(18,032,202)	315,568	2%	MEDI-CAL	(177,629,690)	(180,322,020)	(2,692,330)	(2)%
(7,483,881)	(6,660,852)	823,029	12%	OTHER/CHARITY	(75,934,228)	(66,608,520)	9,325,708	14%
(102,058)	(9,556)	92,502	968%	DISCOUNTS & ALLOWANCES	(14,047,593)	(95,560)	13,952,033	14,600%
(1,775,235)	(499,610)	1,275,625	255%	BAD DEBTS	(2,511,631)	(4,996,100)	(2,484,469)	(50)%
(46,210,563)	(43,445,529)	2,765,034	6%	TOTAL DEDUCTIONS	(445,821,355)	(434,455,290)	11,366,065	3%
14,443,716	12,667,615	(1,776,101)	14%	NET SERVICE REVENUE	136,601,776	126,676,162	(9,925,614)	8%
521,842	682,481	160,640	(24)%	OTHER OPERATING REVENUE	5,792,160	6,824,816	1,032,656	(15)%
14,965,558	13,350,096	(1,615,462)	12%	TOTAL OPERATING REVENUE	142,393,936	133,500,978	(8,892,958)	7%
				***** OPERATING EXPENSE *****				
5,471,939	5,483,206	(11,267)	0%	SALARIES	56,421,210	55,226,763	1,194,447	2%
553,705	666,303	(112,598)	(17)%	S&W PTO	6,196,021	6,725,756	(529,736)	(8)%
1,450,916	1,467,231	(16,315)	(1)%	EMPLOYEE BENEFITS	14,114,362	14,626,924	(512,562)	(4)%
2,049,512	1,399,943	649,569	46%	PROFESSIONAL FEES	18,491,990	14,119,243	4,372,747	31%
911,898	816,379	95,519	12%	PURCHASED SERVICES	8,540,393	8,340,877	199,516	2%
2,231,636	2,030,732	200,904	10%	SUPPLIES & EXPENSES	21,298,891	20,300,735	998,156	5%
293,900	268,896	25,004	9%	MAINTENANCE & REPAIRS	2,633,349	2,731,037	(97,688)	(4)%
232,552	277,064	(44,512)	(16)%	UTILITIES	2,658,270	2,770,640	(112,370)	(4)%
49,197	19,603	29,594	151%	RENT/LEASE	414,504	196,040	218,464	111%
93,297	121,228	(27,931)	(23)%	INSURANCE	1,209,477	1,212,280	(2,803)	0%
850,317	852,720	(2,403)	0%	DEPRECIATION/AMORTIZATION	9,284,736	9,676,638	(391,902)	(4)%
423,865	317,996	105,869	33%	OTHER EXPENSE	3,584,231	3,213,810	370,421	12%
0	0	0	0%	IMPAIRED COSTS	211,281	0	211,281	
14,612,734	13,721,301	891,433	7%	TOTAL OPERATING EXPENSE	145,058,713	139,140,743	5,917,970	4%
352,824	(371,205)	(724,029)	(195)%	NET GAIN/(LOSS) FROM OPERATIONS	(2,664,777)	(5,639,765)	(2,974,988)	(53)%
138,253	138,253	0	0%	DISTRICT TAXES	1,382,530	1,382,530	0	0%
327,804	343,454	15,650	(5)%	INVESTMENTS INCOME	3,774,133	3,434,544	(339,589)	10%
28,138	54,011	25,873	(48)%	OTHER NON OPERATING INCOME	2,727,919	540,105	(2,187,814)	405%
(84,016)	(80,574)	3,442	4%	INTEREST EXPENSE	(796,654)	(805,733)	(9,080)	(1)%
(67,961)	(36,954)	31,007	84%	NON-OPERATING EXPENSE	(402,605)	(369,531)	33,074	9%
342,218	418,190	75,972	(18)%	TOTAL NON-OPERATING INCOME	6,685,323	4,181,915	(2,503,408)	60%
695,042	46,985	(648,057)	1,379%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	4,020,546	(1,457,850)	(5,478,396)	(376)%
565,725	100,000	(465,725)	466%	NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	4,110,000	1,000,000	(3,110,000)	311%
1,260,767	146,985	(1,113,782)	758%	NET GAIN/(LOSS)	8,130,546	(457,850)	(8,588,396)	(1,876)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
04/30/25

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	352,824	(2,664,777)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	850,317	9,284,736
Provision for bad debts	832,639	(9,061,809)
Change in assets and liabilities:		
Patient accounts receivable, net	902,911	15,743,538
Other receivables	4,882,693	(6,383,189)
Inventories	(40,436)	(239,383)
Prepaid expenses and deposits	152,887	(847,762)
Advance refunding of bonds payable, net	20,980	209,796
Accounts payable and accrued expenses	664,969	(1,547,957)
Deferred inflows - leases	(83,118)	(228,895)
Accrued payroll and related costs	(25,876)	(1,667,879)
Estimated third-party payor settlements	(509,030)	1,443,756
Self-insurance reserves	(17,972)	(90,494)
Total adjustments	7,630,964	6,614,458
Net cash provided by (used in) operating activities	7,983,788	3,949,681
Cash flows from noncapital financing activities:		
District tax revenues	138,253	1,382,530
Noncapital grants and contributions, net of other expenses	(58,985)	(105,198)
Net cash provided by (used in) noncapital financing activities	79,268	1,277,332
Cash flows from capital and related financing activities:		
Purchase of capital assets	(567,490)	(4,641,088)
Proceeds from sale of assets	-	3,255,420
Proceeds from lease receivable, net	88,599	236,347
Principal payments on debt borrowings	-	(4,055,000)
Interest payments	(1,224)	(1,493,180)
Net change in notes payable and lease liability	(252,829)	(1,065,475)
Net changes in assets limited as to use	(583,918)	(190,825)
Net cash provided by (used in) capital and related financing activities	(1,316,862)	(7,953,801)
Cash flows from investing activities:		
Net (purchase) or sale of investments	11,189,325	6,433,643
Investment income	327,804	3,774,133
Net cash provided by (used in) investing activities	11,517,129	10,207,776
Net increase (decrease) in cash and cash equivalents:	18,263,323	7,480,988
Cash and cash equivalents at beginning of month/year	12,264,303	23,046,638
Cash and cash equivalents at end of month	30,527,626	30,527,626

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
April 2025

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
May-24	11,564,879	10,488,610	22,053,489
Jun-24	10,598,225	7,664,994	18,263,219
Jul-24	13,499,837	278,849	13,778,686
Aug-24	10,684,807	298,095	10,982,902
Sep-24	12,800,001	1,611,606	14,411,607
Oct-24	14,933,404	1,420,062	16,353,466
Nov-24	11,872,571	1,402,779	13,275,350
Dec-24	13,002,191	6,026,303	19,028,494
Jan-25	12,353,155	4,293,154	16,646,309
Feb-25	9,516,870	8,335,277	17,852,147
Mar-25	13,111,820	451,259	13,563,079
Apr-25	**13,460,422**	**8,143,789**	**21,604,211**

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

April 2025 Summary of Other Activity:

44,219	Beta Healthcare Group Dividend 1st Installment
574,112	M-Cal IP DSH 02/25 - 03/25
3,227,618	Health Net QIP IGT CY23
2,432,784	Health Net DHDP CY23
28,662	Cal Viva DHDP FY23
670,455	M-Cal OP AB915 FY24
590,970	Property Taxes
380,142	M-Care interim payments
194,827	Miscellaneous
8,143,789	04/25 Total Other Activity