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

AGENDA
August 25, 2026

OPEN SESSION (5:00 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. **The public meeting will reconvene in person at 5:30 P.M.** In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq. Per California Government Code § 54953, the public may use the following link for remote participation during open session: https://svmc.zoom.us/j/88404540610?pwd=7CtubXbReTUOjRqdyPV9oxxtgAhX0e.1

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

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

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

1. **General Update**
2. **Compliance Report**

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

D. **Conference with Sierra View Local Health Care District Real Property Negotiator regarding purchase of property for sale.** Cal. Gov. Code § 54956.8.
Property: 380 W. Putnam Avenue, Porterville, CA 93257.
SVMC Negotiator: Ron Wheaton
Negotiating Party: George Wilson, represented by Rebecca Brann, Henry Schein Dental Practice Transitions. Estimated date of disclosure October 1, 2026.

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

F. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation; and Pending Litigation: **Conference with Legal Counsel**. Estimated Disclosure: 3 years after completion of the matter.

G. Pursuant to Gov. Code Section 54957(b): **Discussion Regarding Confidential Personnel Matter** – One (1) Item. Estimated Date of Disclosure January 1, 2027, for materials that are not part of an individual's private personnel file.

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

A. Chief of Staff Report:

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

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

B. Quality Division Update

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

2. **Compliance**
   Recommended Action: Approve/Disapprove Compliance Report as Given

C. Discussion Regarding Trade Secrets and Strategic Planning
Recommended Action: Information Only; No Action Taken

D. Discussion Regarding Real Property for Sale Located at 380 W. Putnam Avenue
Recommended Action: Information Only; No Action Taken

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

F. Conference with Legal Counsel Regarding Pending Litigation
Recommended Action: Information Only; No Action Taken

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

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

VI. Public Comments

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

VII. Consent Agenda

Recommended Action: Approve/Disapprove Consent Agenda Policies and Accept Reports therein as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff, Hospital policies and Informational Reports, these items are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff, Hospital policies and Informational Reports 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. July 28, 2026 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove July 28, 2026, Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MONTHLY MEETING AGENDA
August 25, 2026

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

B. Investment Report – Quarter Ending June 30, 2026
Recommended Action: Approve/Disapprove Investment Report as Presented

C. Capital Report – Quarter Ending June 30, 2026
Recommended Action: Approve/Disapprove Capital Report as Presented

D. Conflict of Interest Code
Recommended Action: Approve/Disapprove Adoption of Conflict of Interest Code

E. Resolution 08-25-26/01 Resolution to Purchase Real Property at 380 W. Putnam Avenue, Porterville, CA 93257
Recommended Action: Adopt Resolution 08-25-26/01

X. SVLHCD Board Chair Report

XI. SVMC CEO Report

XII. Announcements:

- Regular Board of Directors Meeting – September 22, 2026, at 5:00 p.m.

XIII. Adjournment

PUBLIC NOTICE

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

PUBLIC NOTICE ABOUT COPIES

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

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

HOSPITAL POLICIES AND REPORTS FOR REVIEW
APPROVED BY SENIOR LEADERSHIP TEAM

Senior Leadership Team	8/25/2026
Board of Director's Approval	
Liberty Lomeli, Chairman	8/25/2026

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
August 25, 2026
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	**Action**
Policies:		Approve ↓
• Contingent Workforce	1-6	
• Organized Health Care Arrangement	7-8	
• Performance Improvement Plan	9-14	

SUBJECT: **CONTINGENT WORKFORCE**	SECTION: ***Human Resources*** **Page 1 of 6**

PURPOSE:

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

DEFINITIONS:

Processed by Education Department:

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

Processed by Human Resources Department:

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

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

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

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

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

Processed by Materials Management Department:

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

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

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

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

POLICY:

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

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

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

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

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

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

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES

PROCEDURE:

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

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

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

Compliance guidelines include:

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

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

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

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

Orientation:

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

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

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

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

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

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

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

~~Human Resources will maintain current files for the contingent workforce staff. The maintenance of these files shall comply with protocols contained within the scope of policy "Personnel Files." Personnel files shall comply with OSHA, The Joint Commission, IRS guidelines, and professional and credentialing organizations.~~ Human Resources will maintain current files for all contingent workforce staff, including a signed attestation from the employing agency in accordance with the organization's Personnel Files policy. This attestation confirms that the employing agency has verified all required documentation and that it meets applicable regulatory and accreditation standards, including those established by OSHA, The Joint Commission, IRS guidelines, and relevant professional and credentialing organizations. The employing agency is responsible for ensuring that all agency staff hold the appropriate licensure and certifications.

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

Responsibility:

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

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

REFERENCES:

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

- State of California Employment Development Department (2016). Benefit Determination Guide Index. Retrieved January 14, 2019, from https://www.edd.ca.gov/UIBDG/.

CROSS REFERENCES:

- Job Descriptions

~~Personnel/Health Files~~

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- Licensure, Registration, Certification
- ~~Initial Orientation~~
- ~~Departmental Orientations~~
- Contract Management
- SVMC Intranet: Human Resources: Manager Resources

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SUBJECT: **ORGANIZED HEALTH CARE ARRANGEMENT**	SECTION: **Page 1 of 2**

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

PURPOSE:

This policy/procedure recognizes the establishment of an Organized Health Care Arrangement (OHCA) between Sierra View Medical Center (SVMC) and Sierra View Medical Staff. The HIPPA Privacy Rule permits multiple Covered Entities who provide care in a clinically integrated care setting, such as the hospital setting, to declare themselves an OHCA. The OHCA's purpose is to protect patient privacy while minimizing disruption to quality patient care.

POLICY:

Under the Health Insurance Portability and Accountability Act (HIPAA), privacy rule, an OHCA is an arrangement or relationship that allows two or more Covered Entities who participate in joint activities to share Protected Health Information (PHI) about their patients in order to manage and benefit their joint operations. OHCA's are arrangements involving clinical or operational integration among legally separate Covered Entities in which it is often necessary to share PHI for the joint management and operation of the OHCA. Participating Covered Entities hold themselves out to the public as a joint arrangement and participate jointly in utilization review, quality assessment, improvement, and payment activities. A common example of an OHCA is an inpatient or outpatient hospital setting where the hospital, medical staff and other health care providers, collectively provide treatment, share PHI and improve hospital quality and operations. These definitions are met between SVMC and the medical staff to permit entering into an OHCA.

OHCA's are an administrative tool and are specific to the HIPAA privacy rule to ease administrative burdens. An OHCA is not to be construed as evidence of a closer association such as an employment relationship or joint venture. Covered Entities participating in the OHCA remain separate Covered Entities for HIPAA privacy purposes, except for the acceptance of a Joint Notice of Privacy Practices developed and distributed to all patients by the hospital.

The greatest benefit of the OHCA is to the patients. HIPAA requires all providers provide a "Joint Notice of Privacy Practices" to each patient upon admission. The OHCA eliminates the burden of multiple notices by each physician treating the patient. One Joint Notice of Privacy Practices would be given to each SVMC patient and the single written acknowledgement of the patient will meet the HIPAA regulations.

The SVMC Joint Notice of Privacy Practices only pertains to the use and disclosure of SVMC patient protected health information related to care and treatment received at SVMC. The physicians in the OHCA must provide their own privacy notice for patients seen in their private offices.

AFFECTED AREAS/PERSONNEL: *ALL MEDICAL STAFF CREDENTIALED WITH SIERRA VIEW MEDICAL CENTER AND ALL EMPLOYEES*

PROCEDURE:

1. It is the policy of SVMC that an OHCA, as defined in 45 CFR 164.501, be established for uses and disclosures of PHI to carry out treatment, payment, or health care operations as specified in 45 CFR 164.506(C)(5).

2. Participants of the OHCA consist of all SVMC employees, all medical staff members and their representatives.

3. The participants have adopted a Joint Notice of Privacy Practices for the sharing of PHI contained in the SVMC designated record set as defined in 45 CFR 164.501.

4. Following recommendations and guidance from the Office of Civil Rights and Department of Health & Human Services, the Sierra View Medical Center Medical Staff Bylaws has declared an OHCA with Sierra View Medical Center to expedite the sharing of data for improvement of patient care and operations. A written designation of an OHCA is not required. However, the OHCA and Joint Notice of Privacy Practices will be reflected in the Medical Staff Bylaws and approved by the SVMC's Medical Staff Executive Committee.

5. As part of the credentialing process the medical staff will sign and acknowledge that they agree to be bound by the OHCA as they agree to be bound by the bylaws.

6. Implementation of a Joint Notice of Privacy Practices streamlines compliance with the Privacy Rule. Under the OHCA, it will not be necessary for a physician or Allied Health Professional to produce a Notice of Privacy Practices to patients on their first encounter in the hospital setting. It will be necessary for physicians to present their own Notice of Privacy Practices to patients on their first encounter in the physician's office setting.

7. Each OHCA participant is a separate entity and is responsible for their own HIPAA privacy compliance efforts. The agreement does not imply that OHCA participants are joined in one another's HIPAA privacy compliance, nor does it mean that any member is responsible for the violations of another participant.

REFERENCES:

- 45 CFR §~~§~~ 164.501, 164.506, 164.520, https://www.law.cornell.edu/cfr/text/45/164.501, https://www.law.cornell.edu/cfr/text/45/164.506, https://www.law.cornell.edu/cfr/text/45/164.520

CROSS REFERENCES:

- Notice of Privacy Practices
- Sierra View Medical Staff Bylaws ~~2017~~2022

SUBJECT:	SECTION:
PERFORMANCE IMPROVEMENT PLAN	***Performance Improvement*** **Page 1 of 6**

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing quality health care services to all of our patients. As an organization, we realize that in order to provide this level of care, we must continually measure and assess systems and outcomes related to those services provided. This plan describes the organizational procedures to be utilized in performance measurement, performance assessment and performance improvement activities. It is the intent of the organization's leaders to develop a performance improvement program that allows all departments and services to collaboratively perform improvement activities utilizing the Plan, Do, Study, Act (PDSA) methodology. This plan describes the communication and coordination for all organizational activities directed toward improving patient care services.

POLICY:

A. Authority and Responsibility

1. The Board of Directors has the ultimate authority and responsibility to require and support a Performance Improvement program at Sierra View Medical Center. The Board of Directors has delegated the responsibility of implementing an organization-wide performance improvement program to Administration, the Medical Staff and the Performance Improvement/Patient Safety (PIPS) Committee.

B. Specific Performance Improvement Components

1. **Hospital Support Service**

   Senior Leadership shall oversee the development and implementation of performance improvement activities for Nursing and other hospital support services, assuring the integration and coordination of service-specific activities into the organization-wide performance improvement program. The substantive results of support service performance improvement activities will be reported to the Performance Improvement/Patient Safety Committee. A summarized report will be presented to the Board of Directors at least quarterly. Relevant information from the support service performance improvement activities will be shared organizationally as needed.

2. **Medical Staff Peer Review Program**

   The Medical Staff has empowered the Medical Executive Committee to develop and oversee the Medical Staff Peer Review Program. The Medical Executive Committee shall assure the integration and coordination of all Medical Staff peer review activities into the organization-wide Performance Improvement Program when indicated.

3. **Medical Staff Committees**

   The Medical Staff Committees review quality data and determine necessary actions to make or sustain improvements. The Medical Staff coordinates their improvement activities with other Medical Staff and administrative committees as necessary to achieve

the desired outcome. Medical staff committee reports are submitted to the Medical Executive Committee by the designated chairperson.

4. **Patient Safety Program**

   The organization has developed an integrated Patient Safety Program to collect data and investigate occurrences related to patient safety and risk reduction. Hospital occurrences which may be related to patient safety or medical errors are reported to Risk/Patient Safety Management. The Risk/Patient Safety Department assures timely integration of this Risk Management information into the Organizational Performance Improvement Program. Information related to sentinel events and error reduction is reviewed by the Performance Improvement/Patient Safety Committee (PIPS). The PIPS Committee has adopted the failure mode, effects, and analysis (FMEA) model for proactive process redesign and BETA HEART for situations indicative of medical harm.~~.~~

5. **Performance Improvement/Patient Safety Committee (PIPS)**

   The Performance Improvement/Patient Safety (PIPS) Committee has been empowered to develop and oversee the organization-wide performance improvement program with focus on the safe delivery of care. This program supports the integration and coordination of medical staff, nursing and support services in order to be successful in their improvement efforts. The PIPS Committee supports and follows the fundamental principles of performance improvement set forth by each department, through their collecting and analyzing data, and taking actions to make improvements and/or to sustain achievements. Emphasis is placed on patient outcomes and meeting regulatory requirements that support safe delivery of care. Departments prepare reports and present findings, actions, and recommendations to the committee.

6. **Process Improvement Teams**

   The organization supports the development of process improvement teams to improve patient care and services. Prioritization of team activities are determined based on organization assessment and evaluation of organizational goals. Process Improvement teams are chartered through PIPS to avoid duplication of activities throughout the organization and to standardize the process. Teams will be further prioritized based on organization need with focus on improved patient outcomes, considering high volume and problem prone, high risk and low volume areas. Team activities will be tracked and reported through the Performance Improvement/Patient Safety Committee. Process improvement teams shall follow the PDSA model. Other Performance Improvement teams may be formed within the organization as needed and shall follow the performance improvement model most appropriate for the process which is being reviewed.

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL STAFF*

PROCEDURE:

A. Reporting and Coordination

1. *Hospital Support Services*: The following hospital support services shall analyze their scope of service and goals and recommend to the appropriate Executive and/or the Performance Improvement /Patient Safety Committee specific quality control and other measures for inclusion in the organization-wide performance improvement program. Hospital support services include:

   a. Care ~~Management~~ Integration
   ~~b. Population Health~~
   ~~c.~~b. Risk/Patient Safety
   ~~d.~~c. Donor Network West
   ~~e.~~d. Food and Nutrition
   ~~f.~~e. Infection Prevention
   ~~g.~~f. Laboratory
   ~~h.~~g. Pharmacy
   ~~i.~~h. Rescue/Resuscitation
   ~~j.~~i. Regulatory
   ~~k.~~j. Radiology
   ~~l.~~k. Physical Therapy
   l. Graduate Medical Education
   ~~m.~~

2. *Hospital Service Departments* – These departments shall analyze their scope of services and goals and recommend to the appropriate Executive and/or the Performance Improvement/Patient Safety Committee specific quality control and other measures for inclusion in the organization-wide performance improvement program. Hospital Service Departments include:

   a. *Critical Care*
   b. *Emergency Services*
   c. *Operative/Invasive Services*
   d. *Renal Services*
   e. *Cancer Treatment Center (CTC)*
   f. *Distinct Part Skilled Nursing Facility (DP/SNF)*
   g. *Wound Care*
   h. *Cardiac Cath Lab*
   i. *Urology Clinic*
   j. *OBGYN – Women's services clinic*
   k. *Pediatrics*
   l. *Maternal Child Health*
   m. *Academic Health Center*
   n. *Sierra View Multi Specialty Center*

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~~n.~~o. *Rural Health Center*

3. *Nursing Care Units/Departments* –Nursing shall analyze their scope of service and goals and recommend to the Performance Improvement/Patient Safety Committee specific quality measures for inclusion in the organization-wide performance improvement program. Nursing participates in the National Database of Nursing Quality Indicators (NDNQI) program for submitting data for: Restraints, Pressure Ulcers, Falls, Patient Days, Nursing Care Hours, and Unplanned Post-Operative Transfers. Data is analyzed and actions taken to achieve desired goals.

4. *Contract Services* –Contracted services shall be monitored and evaluated yearly by the clinical leaders and medical staff. Improvement efforts will be implemented when contracted services do not meet their determined expectations as defined in their contract. This may include increased monitoring of services, training, and re-negotiation of terms. Applying penalties and termination would be considered as a last resort. Results of the yearly evaluation will be reported to the Governing Board. Oversight of Contract Services is shared with the Compliance Office.

5. *Medical Staff Department/Peer Review Committees* –The Medical Staff departments shall analyze their scope of service and goals and recommend to the Medical Executive Committee specific quality monitoring and other measures for inclusion in the organization-wide performance improvement program. Medical staff peer review committees include:

   a. *Emergency Medicine*
   b. *Family Medicine*
   c. *Pediatrics*
   d. *Radiology/Pathology*
   e. *Internal Medicine*
   f. *OB/GYN*
   g. *Surgery*
   h. *Anesthesia*

6. *Medical Staff Committees* – The following Medical Staff committees shall analyze their scope of monitoring and committee goals and recommend to the Medical Executive Committee specific quality measures for inclusion in the organization-wide performance improvement program by way of a designated Chairperson. Medical Staff Committees include:

   a. *Pharmacy and Therapeutics/Nutrition Care Committee/Infection Prevention*
   b. *Bioethics Committee*
   c. *Utilization Review Committee*
   d. *Performance Improvement/Patient Safety Committee*

B. Individual Practitioner Competence Issues

1. Issues related to the competence of individual physicians, other independent practitioners, or allied health practitioners will be referred to the appropriate Medical Staff peer review committee for review and will be reported on to the Medical Executive Committee and Board of Directors as indicated by defined Medical Staff processes. Advanced practice nurses also fall under the auspice of the Chief Nurse Executive. This includes Certified Registered Nurse Anesthetists (CRNAs), nurse practitioners, and nurse midwives who are privileged through the medical staff.

2. Issues related to the performance of practitioners who are hospital employees or work under a hospital job description will be referred to the appropriate service director for evaluation and referred to hospital administration and the Board of Directors as indicated.

3. Written complaints or allegations regarding a provider's sexual misconduct or sexual abuse of a patient will be reported within 15 days to the provider's professional licensing board and to CDPH within 5 days. Provider is defined to include any person with a license to practice in the healing arts.

C. Communication and Coordination of Results

1. The relevant results of Performance Improvement activities are used primarily to study and improve processes that affect patient outcomes and are related to patient safety. When relevant to the performance of an individual, performance improvement information will be utilized in the evaluation of individual capabilities as part of the human resources assessment or Medical Staff credentialing processes. The information will be communicated as may be necessary to achieve this goal.

2. The conclusions, recommendations, actions and results of the actions taken shall be documented and reported through established channels as noted in this plan.

3. Relevant information shall be communicated among departments, services and professional disciplines when opportunities to improve care involve more than one department or service in the organization. The purpose of reporting and communicating is to share information with those in the organization to whom the information is pertinent.

D. Annual Appraisal

1. The Performance Improvement / Patient Safety Committee shall report, on an on-going and periodic basis, an appraisal of the organizational Performance Improvement program. The appraisal should contain information regarding significant opportunities to improve care identified through the performance improvement process and the effectiveness of actions taken. The on-going and periodic appraisal should discuss both the strengths and weaknesses of the existing program, discuss the degree of overall integration and coordination of improvement activities, and contain recommendations for program improvement. The Performance Improvement/Patient Safety Committee shall submit on-going reports to the Medical Executive Committee and Board of Directors.

REFERENCES:

- Centers for Medicaid Services. (2025). The CMS Compliance Crosswalk. § 482.21 Quality Assessment and Performance Improvement Program. Brentwood, TN.
- The Joint Commission. (2026~~5~~). Hospital Comprehensive Accreditation Manual. Standards: (PI 01.01.01, LD 03.07.01, MS05.01.01, PI 02.01.01 Oakbrook Terrace, IL.
- The Joint Commission (2026~~5~~) Laboratory and Point-of-Care Testing Standards Manual. Standards – PI 01.01.01, PI 02.01.01, LD 03.07.01, LD 03.05.01, LD 04.03.09 Oakbrook Terrace, IL.

SIERRA VIEW
MEDICAL CENTER

CONSENT AGENDA

POLICIES APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE	08/05/2026
BOARD OF DIRECTORS APPROVAL	
	08/25/2026
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
August 25, 2026 BOARD APPROVAL

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

	Pages	Action
I. Policies:		**APPROVE**
• Breastfeeding	1-10	
• Central Venous Catheters, Care and Maintenance of	11-20	
• Comprehensive Perinatal Services Program (CPSP)	21-24	
• Fetal Demise – Care of Fetus	25-28	
• Newborn Hearing Screening	29-39	
• Urinary Catheter Discontinuation Protocol	40-42	

SUBJECT: **BREASTFEEDING**	SECTION: **Page 1 of 10**

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

PURPOSE:

The purpose of this policy is to facilitate and encourage successful breastfeeding during hospitalization and after discharge. This policy has been developed to meet the requirements recommended by the World Health Organization (including Baby-Friendly Guidelines), the California Hospital Infant Feeding Act, and The Joint Commission's Perinatal Core Measure to increase the proportion of infants being breastfed. Additionally, the policy supports the Healthy People 2030 objectives to increase the proportion of infants who are breastfed exclusively through 6 months and who continue breastfeeding through 12 months and beyond as mutually desired by the parent and child.

POLICY:

A. Maternal Child Heath (MCH) staff and the Lactation Consultants will educate, inform, and assist patients with breastfeeding techniques and any needs that arise concerning breastfeeding.

B. All Maternal Child Health and maternity care providers will be oriented to the Breastfeeding policy during their initial thirty (30) day hospital orientation. Staff will be expected to read and sign off on the policy.

C. All staff will **protect**, **promote**, and **support** patients wishing to breastfeed their infants.

D. To ensure consistent quality care and patient education, staff education and competency validation shall be maintained consistent with current Baby-Friendly USA requirements, Joint Commission standards, California regulations, and organizational competency requirements. The curriculum for this education will cover the 15 sessions identified by Baby Friendly USA and compliance of education will be documented in the employee education (blue) file and followed by the MCH Leadership. Initial lactation education will be completed within six (6) months of hire or transfer to MCH department. This facility does not accept training prior to hire.

E. The staff provides up-to-date and accurate, evidence-based, written information and resources to all pregnant women (outpatient and inpatient) related to lactation science and breastfeeding best practice. This information includes benefits of breastfeeding and explanation of the practices implemented in the MCH unit that support successful breastfeeding.

F. Sierra View Medical Center (SVMC) adheres to the International Code of Breast Milk Substitutes which states:

1. Employees of manufacturers or distributors of breast milk substitutes, bottles, nipples, and pacifiers have no direct communication with pregnant women and mothers.

2. The facility does not receive free gifts, non-scientific literature, materials, equipment, money, or support for breastfeeding education or events from manufacturers of breast milk substitutes, bottles, nipples, and pacifiers.

3. No pregnant women, mothers, or families are given marketing materials, samples, or gift packs by the facility that consists of breast milk substitutes, bottles, nipples, pacifiers, or other infant feeding equipment or coupons for the above items.

4. Any educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drinks other than breast milk.

5. Education shall be culturally sensitive, trauma-informed, and provided in the patient's preferred language using qualified interpretation services when indicated.

G. Sierra View Medical Center pays fair market value for breast milk substitutes and products covered under the International Code of Marketing of Breast-milk Substitutes.

H. This policy will be reviewed and revised according to the House-Wide Policy & Procedure, "POLICY AND PROCEDURE SYSTEM."

AFFECTED AREAS/PERSONNEL: *All MCH/pediatrics staff, physicians, and hospital staff caring for infants and/or lactating women*

PROCEDURE:

Upon admission

1. Patients are provided evidence-based education regarding infant feeding options, including the benefits of breastfeeding, risks associated with early formula supplementation when not medically indicated, and safe formula feeding practices when formula is chosen.

2. Once educated, patients will choose a feeding preference for their infant. This preference will be documented in both the patient's and infant's medical record.

Upon delivery:

1. Immediate and uninterrupted skin-to-skin contact should begin as soon as medically appropriate after birth and continue until completion of the first feeding or longer as desired by the family.

2. All infants (regardless of infant feeding choice), unless there are medically justifiable reasons for delayed contact (such as neonatal resuscitation, physical signs of distress or abnormality), will be placed skin to skin with mother. This contact will continue until the completion of the first feeding. This practice is referred to as "The Golden Hour." When a delay of initial skin to skin contact has occurred, staff will ensure that the mother and infant receive skin to skin care as soon as medically possible.

3. Skin to skin contact is defined as the infant allowing to be naked or diapered and placed prone on the parent's bare chest with warm blankets placed over the dyad. VAGINAL BIRTHS, skin to skin contact is initiated within the first five (5) minutes after birth. For C-SECTIONS, skin to

skin contact is initiated as soon as the mom is alert and able to respond. Documentation of skin to skin start and stop times are noted in the electronic medical record (EMR).

4. Routine admission procedures such as assessment and vital signs should be completed with the infant skin to skin with the mother. Procedures requiring separation from the mother (e.g. bathing, and newborn medications) can be delayed up to two (2) hours after the initial period of skin to skin contact and initial latch to promote breastfeeding and "The Golden Hour."

5. Visitation should be kept to a minimum during these first two (2) hours to allow for parents - infant bonding (or those present at birth).

6. The room should be kept warm to avoid thermal stress to the infant.

7. Breastfeeding mothers should be offered assistance by MCH staff with initiating breastfeeding in the LDR (labor and delivery room) or in the PP (postpartum) room (for C-section recoveries) within the first half (½) an hour of birth to take advantage of the infant's alert state, unless otherwise ordered by the physician.

8. Assist the mother with proper positioning of the infant at the breast:

   a. Use extra pillows, folded blankets or towels to assist in proper positioning of the infant.

   b. Educate the mother on the Laid back position, Cross-cradle, Cradle, Football, Side-lying, and various alternative positions.

   c. The Registered Nurse (RN) will document a LATCH assessment (see Attachment A) at least once per shift or more often as needed. Breastfeeding assessments will optimally begin within the first two (2) hours during the recovery period after birth, but no longer than six (6) hours after birth.

9. Instruct the mother about proper latch and assess breastfeeding technique.

   a. Help the mother position the baby so his/her nose is level to the mother's nipple. Bring the baby's chin in contact with her breast. Instruct the mother to lightly stroke the infant's bottom lip with her nipple. When the infant opens its mouth wide, the mother should move the baby quickly and gently towards her, ensuring the infant's tongue is down and the chin makes first contact with her breast. Ensure that the baby's lips are flanged outward and his/her nose is slightly away from the breast for easier breathing. Baby should be latching past the nipple deep onto the areola to allow for more efficient milk transfer and comfort.

   b. If the infant's breathing is obstructed, the infant's position should be adjusted without the breast being depressed away from the infant's nose. Breathing is quite adequate through the side channels of the nares.

c. Be sure the mother realizes that the breast fed infant does not suck continuously but will stop and resume sucking at frequent intervals.

d. Remove infant from breast by breaking suction with little finger inserted into the side of the infant's mouth.

e. Instruct mother to burp infant after she/he finishes nursing, teaching techniques for holding infant upright, applying gentle pressure against the abdomen and patting or rubbing the back.

Ongoing care of the breastfeeding couplet:

1. In collaboration with the RN Staff, all mothers are provided with Lactation Consultant Services, bedside consultation, hands-on assistance with positioning, ongoing assessment of effectiveness of breastfeeding, interventions for sore nipples, latch concerns, engorgement, and breastfeeding education.

2. Feeding Frequencies

   a. Healthy term newborns should be encouraged to feed based on feeding cues, generally 8–12 or more times per 24-hour period. Educate the mother about infant-led feeding patterns including feeding cues, feeding frequencies, average duration, and signs of effective latch and suck.

3. Rooming in, or couplet care, is provided to promote bonding and uninterrupted breastfeeding. As appropriate, all routine procedures will be performed at the mother's bedside.

   a. Regardless of maternal feeding choice, Rooming-in is encouraged 24 hours per day unless separation is medically indicated or requested by the parent. Any interruption of rooming in will be documented in the infant's medical record, including reason for separation, time separation began and ended, and location of infant during separation.

   b. When a mother requests that her baby be cared for in the nursery or outside the room, the health care staff should explore the reasons for the request and should encourage and educate the mother about the advantages of rooming in 24 hours a day. This education will be documented. If the mother still requests that the baby be cared for in the nursery, the infant will be taken to the mother for feedings whenever the infant demonstrates feeding cues. Interruption of rooming in will be documented as previously described.

4. Breast and nipple care:

   a. Daily bath or shower, routine hygiene.

   b. Breast pads may be used but should be changed often.

c. Reassure mothers that breastfeeding can continue or quickly resume with the correction of problems such as:

- Painful or bleeding nipples
- Cracked or fissured nipples
- Engorged breasts
- Inverted nipples

5. Infant Separation

a. Parents whose babies are being cared for in the special care nursery can place the baby skin to skin as soon as the baby is considered ready for such contact.

b. Education is provided regarding how to begin pumping and the importance of pumping eight (8) to twelve (12) times in a twenty four (24) hour period to stimulate milk production. If mother and infant are separated, hand expression and/or pumping should begin as soon as possible, ideally within one hour of birth and no later than six hours after delivery.

c. Education regarding hand expression, and breast milk collection and storage is provided. Patient is educated on cleaning the pump and collection parts after each use.

d. Supplies are available for collection of breast milk. Labeled containers will be stored in the NICU breast milk refrigerator. (See Policy: BREAST MILK COLLECTION AND STORAGE).

6. Supplemental Feedings

a. Supplementation decisions shall be individualized based on infant clinical status, maternal preference, and provider assessment.

b. If a mother requests her infant be supplemented with a breast milk substitute, staff will explore and address the mother's concerns. Pasteurized donor human milk should be considered when supplementation is medically indicated and maternal milk is unavailable or insufficient. The mother will be educated on breast milk substitutes, and education will be documented.

c. Medical indications for formula supplementation include, but are not limited to the following:

- Hypoglycemia (less than or equal to 40 mg/dl) that fails to respond to optimal breastfeeding and/or breast milk feeding.

- Weight loss greater than 10% or other evidence of dehydration that is not improved after skilled assessment and proper breastfeeding management

- Hyperbilirubinemia management shall follow current American Academy of Pediatrics clinical practice guidelines.
- Unstable infant admitted to NICU. (Respiratory, GI, prematurity, congenital abnormalities).

d. Prior to supplementing the infant, the staff will discuss with the mother the feeding options available and the rationale for avoiding a bottle and nipple due to the potential negative consequences for breastfeeding. Education will be documented. The mother will be taught to safely administer a feeding with the chosen device. Options for supplementation include: gavage, cup, syringe, or supplemental nursing system (SNS). Feedings should be provided at the breast whenever possible. The reason for supplementation will be documented in the infant's medical record.

e. Parents shall receive education regarding the potential impact of early non-nutritive sucking on breastfeeding establishment. Pacifier use shall be based on informed parental decision-making and clinical indications.

i. Pacifiers may be used for the breastfeeding infant during painful procedures and/or therapeutic medical procedures (e.g. blood draws, prematurity, neonatal abstinence syndrome). Discard the pacifier after procedure. Pacifier should not be with the infant when infant is returned to mother.

ii. If a mother requests a pacifier, education will be provided and documented as to why we don't provide pacifiers. The potential hazards associated with pacifier use may include, but are not limited to:

- Not latching and/or sucking properly at the breast
- Disruptions in milk supply
- Weight loss and/or slow weight gain

7. Contraindications for breastfeeding: Only a Physician or Lactation Consultant may document contraindications to breastfeeding. Documentation must be in the infant's chart.

Contraindications may include, but are not limited to:

a. Infant with classic galactosemia

b. Maternal use of certain chemotherapy agents

c. Maternal radioactive isotope therapy

d. Untreated active tuberulosis

e. Active herpetic breast lesions

f. Maternal substance use disorder with ongoing unsafe substance use

g. HIV infection

h. Contraindicated medications- (Medications and Mothers' Milk, 2025-2026, by Thomas Hale)

8. Education and Support

a. Inpatient and outpatient lactation support and education are provided to patients by the MCH RN staff and/or Lactation Consultants. Prenatal childbirth and separate breastfeeding classes which follow the Baby-Friendly Guidelines and curriculum are offered monthly in English and Spanish.

b. Lactation Consultants provide a prenatal breastfeeding education curriculum and supportive education to the outpatient OB participants. The MCH RN staff and Lactation Consultants collaborate with the community-based Women, Infants and Children (WIC) Program, the Tulare County Breastfeeding Coalition (TCBC) and county resources alongside First 5 Tulare County. These agencies help to promote a consistent, coordinated message about health and the importance of breastfeeding within our county.

c. The MCH department has a breastfeeding help line (infant nutrition phone line) and a breastfeeding support group that is available to the mothers after discharge. Information about these support services are provided at discharge from the postpartum unit.

d. Education shall include safe formula preparation and feeding for families choosing partial or exclusive formula feeding.

e. Discharge instructions will include the following:

i. Assessment regarding long term feeding plans

ii. Education regarding the importance of exclusive breastfeeding for six (6) months, how to maintain lactation, signs of effective breastfeeding and adequate nutrition (including urinary output, stool changes and weight gain), how to hand express and/or use the breast pump, how to handle and store breast milk, and maintain lactation if the mother is separated from the infant or will not be exclusively breastfeeding after discharge

iii. Education is given regarding proper diet, increased fluid intake, and continuation of prenatal vitamins and iron as prescribed by the physician. This will aid in establishing and maintaining an adequate supply of breast milk and also aid in the health of the mother and baby

iv. Education is provided regarding signs and symptoms of infant feeding issues which require follow up with a qualified health care provider. These include but are not limited to: decrease output, weight loss and latch or breast issues.

v. Information regarding current outpatient breastfeeding resources and breastfeeding support utilizing community-based programs, which provide individual and group counseling on breastfeeding and collaborate together to assure breastfeeding success. Outpatient support is offered to any patient requesting a consultation with a lactation consultant after discharge.

vi. Mother's feeding preference and any reason she deviated from her preference will be documented in the infant's medical record.

vii. The mother who chooses to feed her infant a breast milk substitute will be given written and verbal information regarding preparation, storage, handling and feeding of the substitute. This education will be documented in the electronic medical record.

viii. Recommendation for a routine follow-up with the health care provider 2-4 days following discharge is reviewed with all patients, regardless of feeding method.

REFERENCES:

- American Academy of Pediatrics. (2022). Policy statement: Breastfeeding and the use of human milk. *Pediatrics, 150*(1), e2022057988. https://doi.org/10.1542/peds.2022-057988
- Baby-Friendly USA. (2024). *Guidelines and evaluation criteria*. https://www.babyfriendlyusa.org
- Centers for Disease Control and Prevention. (2025). *Breastfeeding*. https://www.cdc.gov/breastfeeding
- Hale, T. W., & Krutsch, K. (2024). *Hale's medications & mothers' milk 2025–2026: A manual of lactational pharmacology* (21st ed.). Springer Publishing Company.
- World Health Organization, & United Nations Children's Fund (UNICEF). (2020, February 11). *Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: The revised Baby-friendly Hospital Initiative: 2018 implementation guidance: Frequently asked questions*. https://www.who.int/publications/i/item/9789240001459

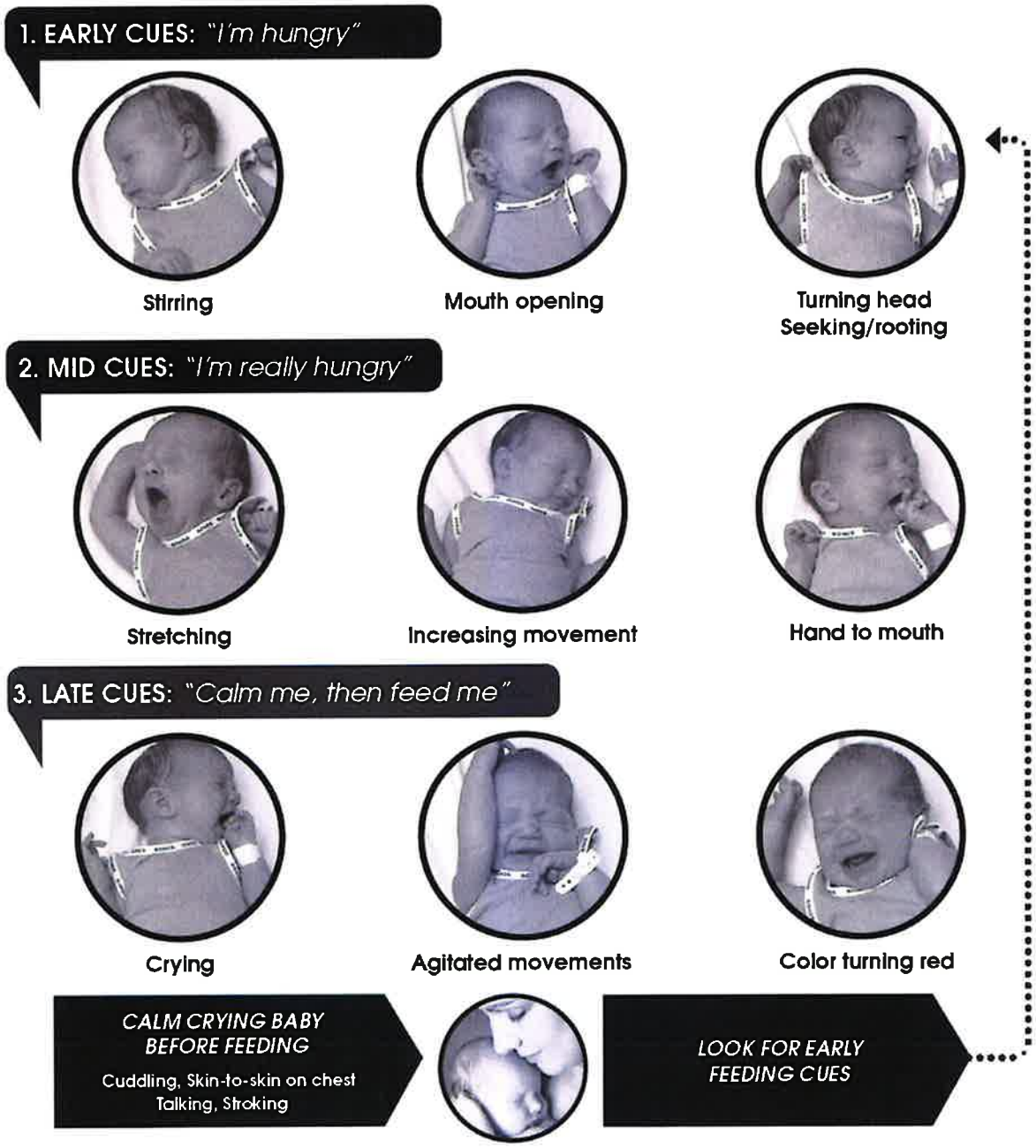
CROSS REFERENCE:

- BREAST MILK COLLECTION AND STORAGE
- POLICY AND PROCEDURE SYSTEM

Attachment A: Latch Score

	0	1	2
L - Latch	* Too sleepy or reluctant * No latch achieved	* Repeated attempts * Hold nipple in mouth * Stimulate to suck	* Grasps breast * Tongue down * Lips flanged * Rhythmic sucking
A – Audible swallowing	None	A few with stimulation	* Spontaneous and intermittent < 24 hours old * Spontaneous and frequent > 24 hours old
T – Type of nipple	Inverted	Flat	Everted (after stimulation)
C – Comfort (breast/nipple)	* Engorged * Cracked, bleeding, large blisters or bruises * Severe discomfort	* Filling * Reddened small blisters or bruises * Mild or moderate discomfort	* Soft * Nontender
H – Hold (positioning)	Full assist (staff holds infant at breast)	* Minimal assist (i.e., place pillows for support, elevate head of bed) * Teach one side; mother does other * Staff holds and then mother takes over	* No assist from staff * Mother able to position and hold baby

Attachment B: Feeding Cues



COUNTY OF LOS ANGELES Public Health

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BreastfeedLA

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SUBJECT: **CENTRAL VENOUS CATHETERS, CARE AND MAINTENANCE OF**	SECTION: ***Nursing Procedures (NR)*** 10 **Page 1 of 11**

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

PURPOSE:

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

DEFINITIONS:
Central Line: An intravascular catheter that terminates at or close to the heart or in one of the great vessels (CDC, 2024).

POLICY:

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

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

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

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

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

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

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

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

9. The needless connector will be changed every 7 days with sterile dressing change.

10. Central venous catheter needless connectors will be swabbed with an ***alcohol wipe for at leasat 15 seconds or an alcohol impregnated cap will be used*** and allowed to dry prior to accessing. Only a syringe is to be used for accessing connectors. Do not use any device to pierce the valves (i.e. needle).

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

12. Laboratory specimens may be drawn from central venous catheters unless a physician orders otherwise. *Exception: Blood cultures will be drawn from peripheral sites unless otherwise specified by the physician. If the line is used for TPN, stop TPN infusion, flush with 10 mL of normal saline and wait for 5 minutes; then specimen may be drawn.*
13. If a multilumen catheter is used to administer peripheral nutrition, designate one port for hyperalimentation, preferably the medial port. DO NOT use the designated hyperalimentation port for other purposes (e.g. administration of fluids, blood, or blood products.)

14. Central venous catheters established for the acute management of the patient may be removed by a registered nurse with a physician's orders. If any resistance is felt, the RN is to stop the procedure and notify the physician. RN should not remove catheters removed for dialysis example (Tri-Flow, Vas Cath) these should be removed by provider.

INDICATIONS FOR USE

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

TRAINING AND COMPETENCY

NURSING

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

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

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

PHYSICIAN

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

2. All physicians who are involved in central line insertion and management will complete a self-learning module on the prevention of central line-associated bloodstream infections initially.
3. Thereafter, education on the prevention of central line-associated bloodstream infections will be provided to physicians annually during medical staff meetings.

AFFECTED AREAS/PERSONNEL: *ALL NURSING UNITS*

PROCEDURE:

Flushing

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

3. Documentation

   a. Chart central line flush and line patency and reason for continued use in the electronic medical record (EMR) every shift.

Dressing Changes:

1. Equipment

   a. Clear semi-permeable dressing

   b. Anti-microbial dressing (Bio-Patch)

   c. Gauze, sterile

   d. Chlora-prep applicator 1

   e. Sterile gloves, non-sterile gloves

   f. Mask

2. Sterile Procedure

   a. Explain procedure to patient

   b. Assemble equipment

   c. Wash hands.

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

   e. Don gloves and mask

   f. Remove existing dressing and discard

   g. Assess insertion site

   h. Wash hands

   i. Prepare kit and/or supplies

   j. Put on sterile gloves

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

l. Apply Anti-microbial dressing (Biopatch) at catheter site

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

n. Loop the tubing and secure with tape

o. Label dressing with date, time and initials

p. Instruct patient that skin may turn orange temporarily

q. Discard used supplies in appropriate receptacle

r. Wash hands

3. Documentation

a. Record dressing change in EMR include a description of the catheter site and skin condition.

b. Document appearance of the insertion site every shift.

Injection Port Changes:

1. Equipment

a. needless connector

b. Gloves

c. Mask

d. Alcohol prep

e. Prefilled 10 mL normal saline syringes

2. Procedure

a. Explain procedure to patient

b. Assemble equipment

c. Wash hands

d. Don mask

e. Clamp the catheter

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

g. Remove old needless connector and discard

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

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

j. Discard used supplies in appropriate receptacle

k. Wash hands

Blood Draws:

1. Equipment

a. Non-sterile gloves

b. Alcohol swabs

c. Prefilled 5 mL normal saline syringe

d. Prefilled 10 mL normal saline syringe

e. 10 mL syringe for blood draw

f. Specimen tubes

2. Procedure

a. Wash hands

b. Explain procedure to patient

c. Apply gloves

d. Cleanse needless connector with alcohol wipe or remove alcohol impregnated cap. Allow to dry.

e. Flush with 5 mL normal saline

f. Withdraw 5 mL blood and discard

g. Withdraw blood for specimens

h. Flush with 10 mL Normal Saline

i. Transfer blood into specimen tubes

j. Label specimen tubes with patient identification

SPECIAL CONSIDERATIONS FOR BLOOD BANK SPECIMENS

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

Removal:

NOTE: RNs may only remove non-tunneled central venous catheters (nurse should not remove catheters used for dialysis, like Vas. Cath, or Tri-Flow)

1. Equipment

   a. Goggles or face shield optional

   b. Mask

   c. Sterile and non-sterile gloves

   d. Chlora-prep applicator

   e. Suture removal kit

   f. Sterile gauze pads

   g. Occlusive dressing

   h. Culture container optional if culturing tip

2. Sterile Procedure

a. Wash hands

b. Explain procedure to patient

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

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

e. Don mask

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

g. Remove catheter dressing and discard

h. Cleanse site with chloraprep and allow to dry (30 seconds)

i. Apply sterile gloves

j. Cut sutures and remove

k. Instruct patient on Valsalva maneuver to decrease the risk of air embolism during removal. Instruct patient to take a deep breath and hold it, "bear down" for 10 seconds, then exhale. *NOTE: Valsalva maneuver is contraindicated in patients with increased intracranial pressure or if intubated.* If patient is on a ventilator, remove catheter at mid-exhalation.

l. Slowly remove the catheter while the patient is holding their breath, performing a Valsalva maneuver, or exhaling. Immediately apply firm, continuous pressure to the exit site using sterile 4 × 4 gauze until hemostasis is achieved. Maintain pressure for a minimum of 10 minutes, then assess for bleeding.
For femoral catheter sites, apply pressure for at least 10–15 minutes before assessing.
If the patient has one or more high-risk factors for bleeding, extend the duration of pressure accordingly. High-risk factors include, but are not limited to:
    - Anticoagulation therapy
    - Coagulopathy or abnormal coagulation laboratory values
    - Obesity
    - Large-bore catheters (e.g., multi-lumen or dialysis catheters)
    - Non-compressible or difficult-to-compress insertion sites

In these cases, pressure may need to be held for 15–20 minutes or longer, depending on clinical judgment and patient response.
Important: Do not repeatedly lift the dressing to check for bleeding, as this may disrupt clot formation. Each additional risk factor may increase the time required to achieve hemostasis.

m.

n. If bleeding or oozing continues, apply pressure for another 10 minutes. Repeat until bleeding stops. If line is removed from a jugular site, apply gentle pressure. *At this point consider absorbable hemostat dressing like surgical dressing*

o. Apply occlusive dressing. Dressing should be left in place for 24 hours.

p. Keep patient in supine position for 30-60 minutes, monitoring every 15 minutes for bleeding.

q. Following removal of a femoral line, the patient must be continuously monitored for 30 minutes, if GCS less than 15 continue intermittently monitoring for additional 30 minues (total 60 minutes). For Patient with GCS of 15 monitor intermittently for 60 minutes. After 60 minutes, if there is no bleeding or oozing, patient may flex hip and ambulate. ***Educate patient to call if they notice bleeding or feel wet ensure call light is within reach***

r. Document the following:

- Date and time of catheter removal
- Site assessment
- Culture specimen sent (if appropriate)
- Ease of catheter removal
- Inspection of intact catheter
- Length of time pressure applied to obtain hemostasis
- Application of occlusive dressing
- Patient tolerance of the procedure
- Patient and family education
- Any unexpected outcomes and interventions

SPECIAL CONSIDERATIONS

Caution should be taken when removing lines in patients with coagulation disorders and/or patients on anticoagulation therapy. Prior to removal, coagulation labs and platelets should be checked to ensure normal levels. If labs are not within normal limits, the physician should be notified for further orders.

Escalate Immediately for:

Persistent bleeding despite 20+ min pressure

Rapidly expanding hematoma

Hypotension

Severe groin pain

Suspected retroperitoneal bleed (rare but serious)

REFERENCES:

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SUBJECT:	SECTION:
SVMC OB/GYN CLINIC - COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)	**Page 1 of 4**

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

PURPOSE:

To establish standardized guidelines for the implementation and delivery of the Comprehensive Perinatal Services Program (CPSP), ensuring high-quality, coordinated, and culturally competent care to pregnant and postpartum patients in accordance with state and regulatory requirements.

POLICY:

A. Provide CPSP services to all eligible pregnant patients on Medi-Cal.

B. Services include nutrition, health education, and psychosocial support integrated into routine prenatal, intrapartum, and postpartum care to improve maternal and neonatal outcomes.

C. All CPSP trained employees will be required to complete training provided by California Department of Public Health (CDPH).

D. Obstetrician/Gynecologist (OB/GYN) providers will provide all medical assessments and refer to Comprehensive Perinatal Health Worker (CPHW) for case coordination.

AFFECTED PERSONNEL/AREAS: *ALL OB/GYN CLINIC PROVIDERS AND STAFF.*

DEFINITIONS:

- **CPSP:** A state-supported program providing enhanced perinatal services.
- **Perinatal Period:** Pregnancy through 12 months postpartum.
- **Initial Assessment:** Comprehensive evaluation performed early in pregnancy.
- **Reassessment:** Follow-up evaluation to update care plans.

PROCEDURE:

A. PATIENT ELIGIBILITY & ENROLLMENT

1. All pregnant patients shall be screened for CPSP eligibility at initial intake.
2. Eligible patients include those with Medi-Cal or qualifying insurance.
3. CPSP services must be offered and documented.
4. Signed consent or declination must be obtained.

B. INITIAL ASSESSMENT (COMPLETED BY 1ST OR 2ND TRIMESTER)

Performed by trained CPSP staff and includes:

1. Psychosocial Assessment - Provider

- Mental health screening (e.g., depression, anxiety)
- Substance use
- Domestic violence screening
- Housing and financial stability
- Support systems

2. Nutritional Assessment – Provider

- Dietary habits
- Weight gain tracking
- BMI evaluation
- Food insecurity

3. Health Education Assessment – Provider

- Understanding of pregnancy
- Barriers to care
- Cultural considerations
- Language needs

C. INDIVIDUALIZED CARE PLAN

1. A care plan shall be developed based on assessment findings
2. Plan must include:
   - Identified risks
   - Interventions
   - Referrals (e.g., Women, Infant, and Children (WIC), behavioral health)
3. Care plans must be reviewed and updated throughout pregnancy.

D. ONGOING SERVICES

- Education on:
  - Prenatal care
  - Labor and delivery
  - Breastfeeding
  - Postpartum care
- Nutritional counseling
- Psychosocial support
- Coordination with specialty services (e.g., high-risk OB)

E. REASSESSMENTS

Conducted during:

- 2nd trimester
- 3rd trimester
- Postpartum visit

Must update:

- Risk status
- Care plan
- Referrals

F. POSTPARTUM SERVICES

1. Conduct postpartum CPSP assessment within 6–8 weeks
2. Address:

- Depression screening (e.g., Edinburgh Postnatal Depression Scale (EPDS))
- Infant bonding
- Feeding (breast/formula)
- Family planning

3. Ensure continuity of care and referrals.

G. DOCUMENTATION

- All CPSP services must be documented in the Electronic Medical Record (EMR)
- Documentation must include:
  - Assessments
  - Care plans
  - Education provided
  - Referrals and follow-ups
- Must meet state and billing requirements

H. STAFF TRAINING & COMPETENCY

- CPSP staff must complete required state training
- Annual competency validation required
- Cultural competency training is mandatory

I. QUALITY ASSURANCE / PERFORMANCE IMPROVEMENT

- Monitor CPSP metrics:
  - Enrollment rates
  - Completed assessments
  - Birth outcomes
  - Patient satisfaction
- Conduct quarterly audits

- Implement corrective actions as needed

IX. APPROVAL SIGNATURES

- Medical Director
- Administrator
- OB/GYN Clinic Manager
- CPHW
- Health Information Management (HIM)
- Advanced Clinical Systems (ACS)
- Patient Access/Communications
- Patient Financial Services

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- California Department of Public Health (CDPH). (2026). *CPSP (Comprehensive Perinatal Services Program)*. Retrieved April 21, 2026, from https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

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SUBJECT: **FETAL DEMISE – CARE OF FETUS**	SECTION: **Page 1 of 4**

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

PURPOSE:

To establish guidelines in the care of a patient experiencing perinatal loss.

POLICY:

1. All patients experiencing perinatal loss will be given emotional support and grief counseling along with appropriate nursing care.

2. Fetal burial/cremation is mandated by law when certain criteria are met.

   a. A mortician must bury or cremate any live birth. A live birth has occurred when any <u>one</u> of the following conditions are met:

      - Heartbeat (distinguished from transient cardiac contractions)
      - Breathing (distinguished from fleeting respiratory efforts or gasps)
      - Cry
      - Movement of voluntary muscles

   b. A stillbirth must be buried/cremated if any two of the following occur:

      - Over twenty weeks gestation
      - With a fetus weighing 350 grams or more (approximately 12.3 ounces)
      - Over 9.8 inches (25 centimeters) in length

3. California Newborn Screening Test Request Form (TRF) will be completed in cases of live births when the newborn expires and in stillbirths

4. Mandatory state forms (including Fetal Death Certificate) and hospital documents regarding disposition will be filled out by Medical Records Personnel.

AFFECTED AREAS/PERSONNEL: *MCH STAFF; RNs, LVNs, UNIT CLERKS, OB TECH*

<u>EQUIPMENT</u>:

- Scale
- Tape measure
- Crib

- Blankets
- Memory box
- Camera

PROCEDURE:

1. Admission:

   a. If probable/pending perinatal loss, the Registered Nurse in charge of the patient should notify the Social Worker.

   b. If possible, the social worker will make initial contact with the patient prior to delivery.

2. If the mother chooses burial, she must sign the "Authority for Release of Remains" form. This form remains on the chart and is signed by the mortuary representative. *Note: The mortuaries are on call for those patients who do not have a preference.

3. Healthcare provider to discuss autopsy with parents. If they wish to have an autopsy done, obtain an order from the healthcare provider.

4. Delivery – care of all infants:

   a. Viewing/visiting immediately after delivery if patient wishes to see the infant.

   b. Suggestions for photography:

      - Lying on pillow, loosely wrapped
      - Anomaly (parents may want or need this later to validate memory of anomaly)
      - Infant held by parents, grandparents or other family members if desired
      - Infant with memento (Christmas ornament, plant, toy, etc.)
      - Infant's features that parents have commented on (hands, feet, etc.)
      - If parents are hesitant, place pictures in a sealed envelope with instructions to open when ready

   c. Allow parents to have time with infant.

   d. Offer to call a minister or hospital chaplain.

   e. Notify Social Services.

f. Call to the California Transport Donor Network within an hour of delivery and document OPA# on the Authorization for Release of Remains form.

g. Offer to have baby blessed or baptized.

h. Give literature to assist family in grieving process.

i. Apply baby band to infant (if appropriate due to age and condition of fetus) and give one to mother.

j. Obtain footprints (if prints are not possible, trace feet and hands on paper) and with parent's permission, a lock of hair.

k. Consider bathing. If appropriate, place cap on head, dress infant in clothes (optional), wrap in blanket (parents may have special outfit they wish infant to be dressed in).

l. Place all mementos in memory box.

m. Assist parents by explaining the options available.

5. If fetal genetic studies are to be done:

   a. To protect for fetal studies, follow instructions as per physician orders.

6. Do not use formalin; place in normal saline or wrap in saline moistened baby blanket and cover with a Chux. Transfer of fetus to Mortuary:

   a. Notify Mortuary of parents' choice once the parents state they are ready to release fetus.

   b. Confirm

7. Transfer of fetuses to Pathology that don't meet criteria for mortuary:

   a. Place fetus and placenta in separate lab specimen containers and cover with formalin.

   b. Fill out Pathology slip:

      - Gestational age and maternal history
      - Note parents' wishes for disposition of fetus:
        - "Funeral Requested" or
        - "Hospital Disposition" or

- "Autopsy Requested" or
- "No Decision Regarding Final Disposition"

DOCUMENTATION:

1. Document birth time and circumstances
2. Appropriate/inappropriate signs of grieving
3. Parents' wishes regarding disposal/funeral services
4. Arrangements made
5. Disposition of fetus/surgical specimen in the mother's chart including name of mortuary.
6. The mortuary will complete the death certificate if not completed by the MD.
7. Social Services/Chaplain referrals
8. Photo or keepsakes (memory box) given to parents
9. Delivery record to be completed on all deliveries
10. Complete incident report in appropriate cases:
    a. Any neonatal death (born alive and then dies)
    b. Coroners cases (stillbirth or neonatal death suspected to be caused by external trauma)
    c. Unusual circumstances

REFERENCES:

- AWHONN Standards and Guidelines for Professional nursing practice in the care of women and newborns (2024) (9th Ed.). Washington, D.C.: AWHONN.
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SUBJECT: **NEWBORN HEARING SCREENING**	SECTION: ***PC, RI*** **Page 1 of 11**

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

PURPOSE:

To establish guidelines for screening all infants born at Sierra View Medical Center (SVMC) for hearing impairments, in compliance with California Health and Safety Code §124119 (Newborn Hearing Screening (NHS) Program).

POLICY:

A. An Auditory Brainstem Response (ABR) testing, or Newborn Hearing Screen (NHS), will be offered to all infants both in postpartum and in the neonatal intensive care unit (NICU).

B. Licensed health care providers will educate parents regarding the importance and specifics of newborn hearing screen.

C. California Health and Safety Code §124119 requires hospitals to offer newborn hearing screening prior to discharge and participate in the California Newborn Hearing Screening Program.

D. Parent/guardian may opt-out, however they must sign a waiver of NHS if these services are refused.

   a. Parent/guardian will receive a copy of the California Newborn Hearing Screening Program (CNHSP) Waiver of Newborn Hearing Screening brochure.

   b. Parent/guardian will receive a copy of the signed waiver form.

   c. A third copy of the signed waiver form will be forwarded to the primary care physician.

   d. An Infant Reporting Form shall be completed for all infants whose parents waive the NHS testing.

   e. Documentation of the refusal must be made part of the patient's permanent record.

   f. Infants whose parent/guardian waived testing while inpatient may be tested as outpatients.

E. Screening services will be available seven days per week to support screening prior to discharge.

F. For well newborns, hearing screening should ideally occur after 12–24 hours of age and prior to discharge whenever possible. Earlier screening may be necessary for early discharge or clinical circumstances.

   a. AAP and CDC guidance recommend screening after 24 hours of age for well newborns, if possible, because testing too early increases false-positive REFER results. Screening

before 24 hours can be done in NICU or if early discharge is necessary, but it should be noted that early screens have a higher chance of false positives

G. Hearing screening will be performed in the mother's room if the environment is quiet. If for some reason, this is not possible due to barriers like presence of visitors, screening will be performed in an alternate designated quiet testing area.

H. A second screening will be done on all infants with a REFER result in either ear. This is communicated through change of shift report, if necessary.

1. The second screening will be done 6 to 12 hours after the first screen or as close to discharge as possible.

2. All infants who do not pass their second inpatient hearing screening will have an outpatient re-screen appointment scheduled within four weeks of discharge.

3. Appointment information shall be documented in the medical record.

I. Infants that are discharged before testing may be tested as outpatients.

J. Initial hearing screening and/or repeat screening will be documented on the newborn flow record when completed.

K. Infant Reporting Form must be completed on all infants that are transferred out.

L. Reporting of all NHS results will be submitted to the Hearing Coordination Center (HCC) as per requirement.

AFFECTED PERSONNEL/AREAS: *MCH STAFF, RNs, LVNs, ORTs, and UNIT CLERKS*

EQUIPMENT:

- Algo 5 Newborn Hearing Screener
- Ear couplers
- Hydrogel electrodes
- Newborn Hearing Screening Reporting Form (Inpatient or Outpatient)

PROCEDURE:

A. HOSPITAL STAFF

1. Director of Newborn Hearing Screening Program (NHSP)

a. Manager of Maternal Child Health will designate a qualified Program Director

b. Responsibilities include:

i. Program management
ii. Training and oversight of individuals performing the screening
iii. Reporting to Hearing Coordination Center (HCC)
iv. Providing staff and parent education
v. Coordinating services
vi. Quality Assurance
vii. Certification and documentation of screeners competency

2. A CCS-paneled Audiologist

a. Responsibilities include:

i. Provision of consultation on selection of screening equipment and verifies that screening equipment is FDA-approved otoacoustic emissions and/or evoked potential testing that detects mild (≥30 dB) hearing loss in infants in the frequency range of 1000-4000 Hz.
ii. Reviews policies and procedures for hearing screening
iii. Reviews maintenance and calibration protocol
iv. Reviews competency criteria and evaluation tool
v. Reviews procedure for staff training
vi. Performs annual program assessment

3. Hearing Screeners

a. Registered Nurses, Licensed Vocational Nurses, nursing assistants, ORTs, and unit clerks may be trained and become responsible to do the hearing screenings.
b. Each screener must meet initial and annual competency criteria.
c. Hand out information packets, as appropriate, to parents.
d. Conducts the hearing screening tests and reports all REFER results to HCC.
e. Licensed staff shall also provide results to parents.
f. Schedules follow-up appointments for outpatient screening.
g. Reports all screens not done (missed, transferred, waived, deceased) to the HCC.

4. Program Coordinator

a. Notifies the HCC, in writing when the Director of the NHSP changes within 7-10 days of the change.
b. Certifies and documents that all screeners pass competency tests with assistance from the Director of the NHSP.
c. Maintains copies of completed competency checklists on all screeners in the employee credential files.
d. Coordinate services between the newborn nursery, billing and outpatient providers.

e. Oversees care coordination and referrals.

5. Staff Training

a. NHSP Director shall provide written information and education regarding the NHSP to all Maternal Child Health Staff at the regular staff meetings. Medical staff shall receive information on the NHSP through the medical staff meeting.
b. Staff education shall occur at new hire and at minimum annually.
c. Core staff trainers shall receive formal instruction from the equipment manufacturer and shall demonstrate competency as evidenced by return demonstration.
d. Core staff trainers shall train screeners to include:
   i. Demonstration of hearing screening
   ii. Return demonstration on at least three infants
   iii. Written competency exam verified annually

B. FACILITY AND EQUIPMENT

1. Natus Algo 5 will be used for NHSP which is FDA-approved for hearing screening and is capable of detecting mild (≥30 dB) hearing loss in infants and newborns in the 1000-4000 Hz frequency range.

2. The Biomedical Department will be responsible for ensuring that instruments are calibrated annually in accordance with the manufacturer's recommendation. The Biomedical Department will maintain a log documenting the dates of calibration, repair or replacement of parts.

3. Should back-up instrument be necessary, the Program Coordinator will make arrangements for rental from Natus within 24 hours.

4. Materials Management will be responsible for maintaining par levels of disposable supplies.

5. Unit Clerks will maintain par levels of program paper supplies (program brochures, waiver forms etc.).

6. The newborn nursery nurse's station/work room will be the designated location for storage of Natus Algo 5 and screening supplies.

7. All disposable components of hearing screening will be discarded and not reused.

8. If an infant is screened in an isolette, the isolette's motor will be turned off during the screen.

C. NEWBORN SCREENING SERVICES

1. All births shall be entered in the Newborn Hearing Screening Log Book.

2. All screening staff will practice standard precautions while performing hearing screening.

3. All screening staff will wash hands prior to and after handling each infant.

4. All screening staff will clean equipment and dispose of screening supplies after each use.

5. Coordination of the test will be the responsibility of the nurse caring for the infant.

D. REPORTING DATA MANAGEMENT

1. The data manager performs the following:

   a. Screening data shall be securely uploaded into the approved DMS for the HCC

   b. Referrals are manually entered into the DMS to include the patient's name, appointment day, time and location of appointment.

   c. On a daily basis sends information to HCC by entering data in to the DMS system.

   d. On a monthly basis, provides the total number of all births.

   e. All passes, refers, misses, waives, NMIs, transfers, expires, and outpatient appointments will be entered in the electronic data management system daily.

E. DISTRIBUTION OF INFORMATION, RESULTS AND REFERRAL

1. Information on the NHSP will be given to parents through the pre-admission process, the Childbirth Education Program and physician offices.

2. Parents will be informed that hearing-screening tests will be conducted on all newborns unless waived.

3. Nursing staff will provide parents with a brochure explaining the NHSP during the hospital admission.

4. Written information on screening results and any scheduled appointments will be given to the parents prior to discharge by licensed nursing staff.

5. PASS results (1 original and 2 copies)

a. The original PASS printed results will be placed on the Newborn Hearing Screening Inpatient form and placed in the infant's chart.
b. Licensed nursing staff will provide the parents with a copy of the PASS results and the PASS brochure.
c. Licensed nursing staff will be responsible to notify the PCP named by parents of PASS results by providing copy of the PASS results.

6. REFER results (1 original and 2 copies)

a. A second screen for both ears will be performed on the infant with initial REFER results.
b. If the infant passes the second screen, follow process above for PASS results.
c. It the infant has a second REFER result, or if the staff is unable to perform a second screen prior to discharge, licensed staff caring for the infant will schedule a re-screening for Outpatient Hearing Screening as soon as possible and ideally before 1 month of age.
d. Parents will be provided with a brochure explaining the REFER result.
e. Parents will be provided with written information concerning the scheduled appointment for outpatient screening.
f. Nursing staff will verify address and phone number of the parents and a second contact.
g. Licensed nursing staff shall notify the PCP of results and scheduled follow-up appointment in writing. A copy of REFER results will be provided to the PCP named by the parents and will include the appointment date, time and location. Outpatient referral results will be faxed to the PCP.
h. Original REFER results and appointment information shall be entered into the newborn's medical record by licensed nursing staff along with documentation of special needs (e.g. "the parents are non-English speaking, deaf, blind, or the infant is in foster care) that must be accommodated.
i. Nursing staff or designee shall also submit an entry in the Data Management System (DMS) notifying the HCC that an infant was a REFER. This is to include all infants that are transferred out to another facility with a higher level of care, including infants with Atresia or Microtia.
j. For babies with known Atresia, parents will be notified in writing to have an appointment and referral to Early Start.
k. Babies with Microtia do not need to be referred to Early Start.
l. Babies with Atresia/Microtia:
   - Refer baby for diagnostic and do not screen the malformed ear.
   - Request for Service form (California Children's Services). This is an initial request for services, but also constitutes a referral to the program.
   - Assist the family in completing the application to determine CCS program eligibility.
   - Fax a copy of the noted malformation, the Request for Service form and the Application for Service to the Hearing Coordination Center and the CCS county office of the family's residence.

- Schedule follow-up appointment for diagnostic evaluation if possible and provide parent with written appointment.
- Make certain the parent/guardian understands the diagnostic testing is covered by CCS despite family income.

F. MISSED CASES

1. The RN Director or designee will verify, by reviewing NHSP logbook weekly, that all newborns entered have hearing screen results or a waiver signed by the parent.

2. If the screening results are not available and parents have not waived, the RN Director will see if the infant is still in the hospital and arrange for screening.

3. If the infant has been discharged, the nursing staff shall schedule an appointment within four weeks of discharge for outpatient screening and contact the parents with appointment information:

   a. Written notification of follow-up appointment will be mailed to the parents.
   b. Written notification of follow-up appointment will be sent via FAX to the PCP.
   c. Nursing staff or designee shall also submit an entry in the Data Management System (DMS) notifying the HCC that an infant was missed (not screened).

4. Licensed nursing staff will document in the infant's medical record that the hearing screen was not done and the arrangements made for outpatient screening

NICU SPECIFIC:

All neonates admitted directly into the NICU will be screened prior to discharge.

Infants admitted to the NICU for greater than five days or with Joint Committee on Infant Hearing (JCIH) risk indicators (e.g., ototoxic medication) shall undergo ABR screening prior to discharge.

If an infant in the NICU will be transferred to another facility, prior hearing screen will be communicated by providing the receiving facility a copy of the nurses documentation of the test and a copy of the medical record that has the results of the screening.

G. QUALITY ASSURANCE

1. On a quarterly basis, the Program Director will compare the total number of live births to the total number of infants screened. 98% of well newborns will be screened. 100% of NICU babies will be screened prior to discharge.

2. For the first 6 months of the program, the REFER rate must be no greater than 10%.

3. After the first 6 months, the Program Director will evaluate the program and each screener so that the REFER rate is between 1% and 5%.

4. If the program or a screener exceeds the 5% REFER rate, the Program Director will initiate the following corrective action:

   a. Assess the equipment.
   b. Identify the screener and provide additional training by the core staff trainers or designee. Screener must perform three (3) return demonstrations before being re-certified.

5. The hospital will participate in semiannual meetings with other Inpatient Hearing Screening Providers in the geographic area, facilitated by the HCC.

H. TESTING

1. Set-up:

   a. Turn power switch on. Internal integrity check occurs. Green READY light will flash.
   b. Plug electrode cable assembly into junction box – match labels.
   c. Firmly push acoustic tubes into junction box – red tube to red port, blue tube to blue port.
   d. Replace battery if required. Charge for 18 hours after 4 to 5 hours of use or when "battery low" message appears.

2. Prepping (Note: Do not use alcohol at any time. Wash hands before handling baby):

   a. Prep the following sites if necessary:

      i. VERTEX = midline high forehead
      ii. NAPE = nape of neck midline
      iii. COMMON = high shoulder

   b. Apply a small amount of prep to 2 x 2. Use circular motion over skin. Remove all excess with a dry 2 x 2.

   c. Clean with damp gauze to remove all prep solution.

3. Application of electrodes:

   a. Place electrodes over prepped area.
   b. Connect electrode clips to 2 electrodes - black to vertex, green to common.
   c. Check electrode impedance by pressing START (must be 12k ohms or less). VC equals impedance between vertex and common electrodes.
   d. Connect remaining clip to electrode – white to nape.

e. Check impedance. Algo will not screen if > 12k, remove electrodes while still on plastic card. NC is impedance between nape and common.

4. Application of ear couplers:

a. Insert acoustic tubes into couplers while still on plastic card. Avoid twisting.
b. Remove ear coupler with red tube from liner. Allow tubes to un-kink to release torque caused by twisting.
c. Position over right ear. Coupler should enclose pinna and not cross tragus. Ear should be in lower corner of coupler.
d. Gently press coupler into place. Coupler should form a seal. Tips of acoustic tube should not touch skin.
e. Repeat above steps with coupler and blue tube. Blue tube goes over left ear.

5. Screening:

a. Swaddle infant and position comfortably.
b. Press START.
c. Monitor ambient noise and myogenic interference lights. If interference is excessive, push STOP until infant is quiet or noise is reduced.
d. Observe LR/sweeps rates.
e. Observe for PASS message.
f. Troubleshoot for REFER message.
g. Remove electrodes and ear couplers, and then turn screener off.
h. Discard disposable products.
i. Wash cables according to hospital protocol.
j. Wash hands.

6. Management of equipment:

a. Turn off when not in use. Unplug battery charger.
b. Clip 3 electrode clips together when not in use. Prevent arcing of static electricity with potential of damage of equipment.
c. Clip electrode clips to junction box when not in use to prevent arcing of static electricity.
d. Battery maintenance:
   i. Charge after 4 to 5 hours use time or when "battery low" message appears.
   ii. Charge battery for at least 18 hours.
   iii. Leave battery connected to charger until needed.

7. Battery trouble-shooting – battery not lasting 4 to 5 hours of use time:

a. Check charger.
b. Charge for longer period.
c. Have Bio-med perform voltage check (13.0).

I. OUTPATIENT TESTING

1. Parent or guardian will be asked to go to admissions and register the infant as an outpatient.

2. Once registered, the infant will be brought to the Hearing Screen Area in the Maternal Child Health Department.

3. Following protocol, the infant will be tested.

4. Using an outpatient form (see attached copy) with appropriate sticker, PASS/REFER results will be placed on Newborn Hearing Screening form.

5. Parent/guardian will be given:
   a. The appropriate brochure(s)
   b. Any follow-up appointment information
   c. Copy of test results

6. Discharge the infant.

7. Send copy of Outpatient form to Pediatrician named by parents.

8. Send original of Outpatient form to Medical Records to be added to the infant chart.

J. DOCUMENTATION:

1. Report to HCC all data via the current DMS requirements.

2. Attach test results printout onto Newborn Hearing Screening form (see attached copy).

3. Enter date, time and signature under printout.

4. Log patient in the NHS log book.

5. Notify MD of test results per policy (fax or mail a copy).

6. Send outpatient form to Medical Records to be added to the infant chart.

7. If the infant refers, follow established protocol for follow-up, including:

   a. Request for Service form (California Children's Services). This is an initial request for services, but also constitutes a referral to the program.
   b. Assist the family in completing the application to determine CCS program eligibility.

c. Fax a copy of the completed Outpatient Screening form, the Request for Service form and the Application for Service to the Hearing Coordination Center.
d. Schedule follow-up appointment for diagnostic evaluation.
e. Make certain the parent/guardian understands the diagnostic testing is covered by CCS despite family income.

REFERENCES:

- American Academy of Pediatrics (AAP) Joint Committee on Infant Hearing. (2019). Year 2019 position statement: Principles and guidelines for early hearing detection and intervention programs. Pediatrics, 145(1), e20191530. https://doi.org/10.1542/peds.2019-1530

- California Health and Safety Code § 124119. (n.d.). Newborn Hearing Screening Program. Retrieved April 6, 2026, from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=124119.&lawCode=HSC

- Centers for Disease Control and Prevention (CDC). (2021). Newborn hearing screening: Early hearing detection and intervention (EHDI) program. https://www.cdc.gov/ncbddd/hearingloss/ehdi.html

- California Department of Health Care Services. (2022). Newborn hearing screening program standards and guidelines. California Department of Public Health. https://www.dhcs.ca.gov/services/nhsp

SUBJECT: **URINARY CATHETER DISCONTINUATION PROTOCOL**	SECTION: **Page 1 of 3**

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

URINARY CATHETER DISCONTINUATION PROTOCOL

PURPOSE:

To reduce the incidence of catheter-associated urinary tract infections (CAUTI).

PRINCIPLES:

Urinary tract infection is the most common hospital-acquired infection; 80 percent of these infections are attributable to an indwelling urethral catheter.

The duration of catheterization is the most important risk factor for development of infection.

DEFINITION:

Catheter-Associated Urinary Tract Infection: A hospital-acquired infection that can develop in patients who have had an indwelling urinary catheter.

PROTOCOL:

Upon admission, patients will be assessed for symptoms of existing urinary tract infection. Further, patients meeting specific criteria will have their urinary catheter removed by the nurse

Surgical patients will have urinary catheter removed on Post-Operative Day 1, with date of surgery as "zero" unless physician documents otherwise. Surgical patients are the exception, and will require a physician order prior to removal of catheter.

Non-surgical patients with indwelling urinary catheters will be assessed each shift and have catheter removed as soon as patient no longer meets any of the following criteria:

CRITERIA FOR PLACING AN INDWELLING URINARY CATHETER:

- Obstruction of the urinary tract distal to the bladder
- Alteration in BP (blood pressure) or volume status requiring accurate volume measure
- Continuous bladder irrigation for urinary tract hemorrhage/TURP (Transurethral Resection of Prostate).
- Pre-op catheter insertion for patient going to OR (operating room) procedure
- Neurogenic bladder dysfunction, acute urinary retention or bladder outlet obstruction
- Incontinence in patients with open sacral or perineal wounds (Key Point: Incontinence alone in general is not an indication)
- Prolonged immobilization (e.g., unstable thoracic or lumbar spine, pelvic fractures, etc.)
- Improve comfort for end-of-life care

DISCONTINUATION OF INDWELLING URINARY CATHETER:

Following removal of urinary catheter:

- Document removal of urinary catheter in EMR
- Monitor patient's ability to urinate post-catheter removal within 6 hours.
    - If patient voids within 6 hours $\geq$ 300 mls, no action is required.
    - If patient voids $\leq$ 300 mls in 6 hours, use bladder scan, and then contact physician for further orders.

STAFF AUTHORIZED TO PERFORM THE STANDARDIZED PROTOCOL: LVN's, RNs

REQUIREMENTS TO PERFORM STANDARDIZED PROCEDURE:

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

B. Training: Meets initial and annual competency for the standardized procedure

C. Experience: All RNs and LVN's that have completed competency for this standardized procedure.

DEVELOPMENT & APPROVAL of the STANDARDIZED PROCEDURE:

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

B. **Review Schedule:** Yearly

REFERENCES:

Hoxworth C, *Urinary Tract Infection*. In: Boston K.M., et al, eds. APIC Text. Published 2014. Revised Jan 2024. Available at: https://text.apic.org/toc/prevention-measures-for-healthcare-associated-infections/urinary-tract-infection#embed-16980 Accessed July 13, 2026.

Gould, Carolyn V.; Umscheid, Craig A.; Agarwal, Rajender K.; Kuntz, Gretchen; Pegues, David A. *Guideline for prevention of catheter-associated urinary tract infections 2009*. Updated June 6, 2019. Corporate Authors(s): Healthcare Infection Control Practices Advisory Committee (U.S.); Centers for Disease Control and Prevention (U.S.). Available at: https://stacks.cdc.gov/view/cdc/49910. Accessed July 13, 2026.

Greene, Linda R. *CAUTI prevention and urinary catheter maintenance*. April 2, 2020. American Nurse. https://www.myamericannurse.com/cauti-prevention-and-urinary-catheter-maintenance/. Accessed July 13, 2026.

SIERRA VIEW
MEDICAL CENTER

MEETING MINUTES

MINUTES FROM PREVIOUS MEETING SUBMITTED FOR APPROVAL

MEETING MINUTES

BOARD OF DIRECTORS MONTHLY MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **July 28, 2026** at 5:00 P.M. in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California.

Members of the public were provided the opportunity to attend and participate remotely through Zoom, a two-way audiovisual platform that allowed participants to hear and visually observe the meeting and provide public comment in real time.

Call to Order: Vice Chair Reddy called the meeting to order at 5:05 p.m.

Board Attendance:

- Liberty Lomeli, Chair - Present
- Bindusagar Reddy, Vice Chair - Present
- Areli Martinez, Secretary – Present
- Hans Kashyap, Director – Present
- Martha A. Flores, Director – Present

Others Present: Donna Hefner, President/Chief Executive Officer, Roger Larsen, Interim Chief Financial Officer, Melissa Crippen, Vice President of Quality and Regulatory Affairs, Brandy Irwin, Chief Nursing Officer, Ron Wheaton, Vice President of Professional Services and Physician Recruitment, Kim Pryor-DeShazo, Director of Marketing and Marketing & Community Services, Terry Villareal, Clerk to the Board, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff and Dr. Arturo Guzman

I. Approval of Agenda:

Chair LOMELI inquired if there was a motion to approve the agenda. Vice Chair REDDY moved to approve the agenda, the motion was seconded by Director FLORES. The motion was carried with the following vote:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:06 p.m. to discuss the following items:

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

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

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

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

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

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

III. Open Session: Chair LOMELI adjourned Closed Session at 5:37 p.m., reconvening in Open Session at 5:37 p.m.

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

A. Chief of Staff Report:

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

2. Report on Peer Review/Credentials
   Following review and discussion, Director FLORES made a motion to approve the Quality of Care/Peer Review/Credentials as presented. The motion was seconded by Vice Chair REDDY. The motion was carried with the following vote by the Board:

FLORES	Yes
KASHYAP	Abstain
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

B. Quality Division Update

1. Following review and discussion, Vice Chair REDDY made a motion to approve the Quality Division Update as presented. The motion was seconded by Director FLORES. The motion was carried with the following vote by the Board:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

IV. Public Comments

Ron Wheaton, Vice President of Professional Services and Physician Recruitment introduced general surgeon, Dr. Arturo Guzman. Dr. Guzman expressed that he is excited to serve the community and to get started taking care of patients.

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).

Director FLORES expressed wanting to change the language of the Consent agenda in future agendas to include informational reports as well. Following review and discussion, it was moved by Director FLORES, seconded by Vice Chair REDDY, and carried to approve the Consent Agenda Policies and Accept Reports therein as presented. The vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

VI. Approval of Minutes:

A. Motion made by Director MARTINEZ and seconded by Director FLORES to approve the June 23, 2026, Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

VII. Business Items

A. June 2026 Financial Report

Roger Larsen, Interim CFO presented the June monthly financial report.

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

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

B. Chandler Asset Management Contract Proposal

Following review and discussion a motion was made by Director FLORES, seconded by Vice Chair REDDY to direct management to sign the proposal submitted by Chandler Asset Management. The motion carried and the vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

C. Resolution07-28-26/01 Rural Health Transformation Grant Submission

Motion made by Director FLORES and seconded by Director MARTINEZ to approve Resolution 07-28-26/01 to authorize the pursuit of funding through the California Rural Health Transformation (CalRHT) Program and authorizing the Chief Executive Officer or designee to prepare, execute, and submit applications and related documents. The motion carried and the vote of the Board is as follows:

FLORES	Yes
KASHYAP	Yes
MARTINEZ	Yes
REDDY	Yes
LOMELI	Yes

VIII. SVLHCD Board Chair Report

Board Chair Lomeli did not have a report but commented on the previous item on seeking funding through CalRHT, he emphasized the importance of addressing mental health issues among veterans. He highlighted that, despite available funding there are still gaps in treatment and insufficient care.

IX. CEO Report

The CEO provided an overview of July performance highlights, organizational accomplishments, community engagement, and upcoming initiatives.

- Wound Healing Center: Recognized by Healogics as a Center of Distinction for exceptional patient satisfaction and healing outcomes.

- Stroke Care Recognition: Earned the American Heart Association Get With The Guidelines®–Stroke Gold Plus, Target: Stroke Honor Roll Elite, and Target: Type 2 Diabetes Honor Roll achievements, recognizing SVMC's commitment to timely, high-quality stroke and diabetes care.

- Graduate Medical Education (GME) Internal Medicine Residency: Celebrated the graduation of Internal Medicine residents on June 26, recognizing completion of their residency training and service to patients throughout Tulare County.

- Employee Recognition: Connie, RN in the Nursery, was recognized for compassionate care of newborns and families. Darwin, Pharmacy Tech Supervisor, was recognized for outstanding leadership, teamwork, and dedication to supporting his staff.

- Upcoming Events: Blood Drive, Aug. 6; Fiesta de Oro Employee Celebration, Aug. 27; Terra Bella Back-to-School Giveaway, Aug. 31; Run for Life, Sept. 5; Scrub Fair, Sept. 8–10; Sierra View Foundation's Midnight in Manhattan fundraiser, Sept. 18; and Unitek Graduation, Sept. 25.

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

XIII. Adjournment

The meeting was adjourned at 6:23 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

SIERRA VIEW
MEDICAL CENTER

Business Items

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
CONFLICT OF INTEREST CODE POLICY

PURPOSE:

The Political Reform Act, Government Code section 81000 et seq., requires state and local government agencies to adopt and promulgate Conflict-of-Interest Codes. The Fair Political Practices Commission (FPPC) has adopted a regulation, Title 2, California Code of Regulations, section 18730, which contains the terms of a standard Conflict-of-Interest Code, which can be incorporated by reference, and which may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act after public notice and hearings. Therefore, the terms of Title 2, California Code of Regulations, section 18730, and any amendments to it duly adopted by the Fair Political Practices Commission, along with the attached appendices in which officials and employees are designated and disclosure categories are set forth, are hereby incorporated by reference and constitute the Conflict-of-Interest Code of Sierra View Local Health Care District (SVLHCD). This policy reflects the law, which is subject to updates and revisions. The information stated in this policy is a summary of applicable law and is intended to be a helpful guide, however may not entirely describe each possible circumstance or scenario that may occur.

POLICY STATEMENT:

In addition to the Conflict of Interest and Disclosure Code approved and adopted by the Board of Directors, attached hereto as Exhibit 1 and made a part of this policy, all board members, senior management, leaders of the organized medical staff and employees of SVLHCD shall seek to promote, enhance and protect the best interests of SVLHCD and to avoid taking any actions which may be adverse to the best interest of SVLHCD or our patients.

AFFECTED AREAS/PERSONNEL: *INDIVIDUALS AS MAY BE DETERMINED BY THE BOARD OR CEO.*

DEFINITIONS:

For the purpose of this policy, the following definitions apply:

The definitions contained in the Political Reform Act of 1974, regulations of the Fair Political Practices Commission (Regulations 18110, et seq.), and any amendments to the Act or regulations, are incorporated by reference into this Conflict of Interest Code.

Disclosing member: The persons holding positions on Appendix A of the Conflict of Interest Code. It has been determined that these individuals make or participate in the making of decisions which may foreseeably have a material impact on economic interests.

Immediate Family member: For purposes of this Policy, an "immediate family member" of a disclosing member shall include spouse, parent, grandparents, grandchildren, daughter, son, step-daughter, step-son, siblings, step-parents, mothers and fathers-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such person.

GUIDELINES:

Under the Act, a disclosing member has a disqualifying conflict of interest in a decision if it is foreseeable that the decision will have a financial impact on his or her personal finances or other financial interests. In such cases, there is a risk of biased decision-making that could sacrifice the public's interest in favor of the disclosing member's private financial interests. To avoid actual bias or the appearance of possible improprieties, the disclosing member is prohibited from participating in the decision.

DISQUALIFYING FINANCIAL INTERESTS:

There are five types of interests that may result in disqualification:

- **Business Entity.** SVLHCD will follow 2 CCR§ 18702.1 to determine if a material conflict exists. Generally, a conflict exists if the disclosing member has (1) an investment of $25,000 or more in a business entity and no ownership or control of the business entity or (2) an investment of $2,000 or more in a business entity in which he or she is a director, officer, partner, trustee, employee, or manager.

- **Real Property.** SVLHCD will follow 2 CCR § 18702.2 to determine if a material conflict exists. Generally, a conflict exists if the disclosing member has an interest in real property of $2,000 or more including leaseholds. (However, month-to-month leases are not considered real property interests.)

- **Income.** SVLHCD will follow 2 CCR § 18702.3 to determine if a material conflict exists. Generally, a conflict exists if the disclosing member has received income or promised income aggregating to $500 or more in the previous 12 months, including the disclosing member's community property interest in the income of his or her spouse or registered domestic partner from any individual or entity.

- **Gifts.** SVLHCD will follow 2 CCR § 18702.4 to determine if a material conflict exists. Generally, a conflict exists if the disclosing member and/or his or her immediate family has/have received gifts aggregating to $500 or more in the previous 12 months from any individual or entity.

- **Personal Finances. SVLHCD will follow 2 CCR §18702.5 to determine if a material conflict exists. Generally, a conflict exists if** the disclosing member's personal finances are positively impacted by a decision, including his or her expenses, income, assets, or liabilities, as well as those of his or her immediate family in an amount of $500 or more in a 12 month period.

DISQUALIFYING FINANCIAL IMPACT OR EFFECT:

If a decision may have a financial impact or effect on any of the foregoing interests, a disclosing member is disqualified from a decision if the following two conditions are met:

- The financial impact or effect is foreseeable, and

- The financial impact or effect is significant enough to be considered material.

Generally, a financial impact or effect is presumed to be both foreseeable and material if the financial interest is "explicitly" or directly involved in the decision. A financial interest is explicitly involved in the decision whenever the interest is a named party in, or the subject of a decision before the District.

If the interest is "not explicitly involved" in the decision, a financial impact or effect is reasonably foreseeable if the effect can be recognized as a realistic possibility and more than hypothetical or theoretical. A financial effect need not be likely to occur to be considered reasonably foreseeable.

However, for interests "not explicitly involved" in the decision, different standards apply to determine whether a foreseeable effect on an interest will be material depending on the nature of the interest. The FPPC has adopted rules for deciding what kinds of financial effects are important enough to trigger a conflict of interest. These rules are called "materiality standards," that is, they are the standards that should be used for judging what kind of financial impacts resulting from decisions are considered material or important.

There are too many materiality standards to adequately review all of them here. To determine the applicable materiality standard, or to obtain more detailed information on conflicts, a disclosing member may consult the FPPC's guide to Recognizing Conflicts of Interest. Alternatively, the disclosing member shall inform the Compliance Officer (CO) or designee that he/she may require assistance from the District's counsel or the FPPC anytime the disclosing member has reason to believe a decision may have a financial impact or effect on his/her personal finances or other financial interests.

PROCEDURE:

A. The Board of Directors of SVLHCD is vested with ultimate authority and responsibility to determine the applicability of this policy to any set of facts that may arise and to determine any steps that should be taken to

correct a situation deemed not in the best interests of SVLHCD including, if deemed appropriate, disciplinary action.

B. The Compliance Officer (CO) or designee of SVLHCD will annually notify the individual holding one of the positions listed in Appendix A of the Conflict Code of the need to complete the Fair Political Practices Commission Form 700, maintained in Administration. The CO or designee will monitor and review all responses from recipients. If the CO or designee finds that the facts set forth in any particular response give rise to a potential conflict of interest contrary to this policy, the CO or designee will forward all information relating to any such potential conflict, together with any recommended course of action, to the CEO and the Board of Directors.

C. Additionally, any individual in the described positions, in accordance with the Political Reform Act of 1974, is required to file a Conflict of Interest Statement within 30 days after assuming the position, annually during the month of March each year, and within 30 days of leaving the position. It will be the responsibility of the Human Resources Department to notify the CO when employees are hired or terminate their employment in these positions.

D. The Conflict of Interest Code of SVLHCD is reviewed biennially and the Local Agency Biennial Notice is filed with the Board of Supervisors, County of Tulare.

REFERENCES:

- The Political Reform Act, Government Code section 81000 et seq (1974). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=81000.

- Regulations of the Fair Political Practices Commission (Regulations 18110, et seq.) (August 2015). http://www.fppc.ca.gov/content/dam/fppc/NS-Documents/LegalDiv/Conflicts%20of%20Interest/Conflicts-Guide-August-2015-Jan-2016-Edits.pdf.

- Title 2, CA Code of Regulations, Sections 18702.1 to 18702.5 (1992). https://govt.westlaw.com/calregs/Document/I217C89F0849E45F4AB521DCF019F4F41?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default).

- Title 2, CA Code of Regulations, section 18730 (1992). http://www.fppc.ca.gov/content/dam/fppc/NS-Documents/LegalDiv/Regulations/Index/Chapter7/Article2/18730.pdf.

Exhibit 1: Conflict of Interest Code and Appendices

CONFLICT-OF-INTEREST CODE
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The Political Reform Act (Government Code §§ 81000 *et seq.*) requires local government agencies to adopt and promulgate a conflict-of-interest code. This code is designed to ensure that board members and employees of this agency do not engage in government decision-making in which the officer or employee may have a personal financial interest. In addition, board members and decision-making employees designated in the agency's code[1] are required to file periodic public statements disclosing their personal economic interests (Form 700).[2]

The Fair Political Practices Commission (Commission") has adopted Regulation 18730,[3] that contains the terms of a model conflict-of-interest code. The Board for Sierra View Local Health Care District ("Sierra View") hereby adopts the terms of Regulation 18730, and any amendments to it duly adopted by the Commission in the future, along with the attached Appendix B in which officials and employees are designated and disclosure categories are set forth, together all of which are incorporated by reference and (constitute the conflict-of-interest code of Sierra View.[4]

Persons serving in designated positions (APPENDIX B) shall file periodic disclosure statements (Form 700) with this agency, as required by law, and pursuant to notice from this agency's filing officer. The disclosure statements shall be retained by the agency for no less than seven years, and shall be made available for public inspection and reproduction upon request.

Adopted by Agency: Meeting Date: _____

Approved by Tulare County Board of Supervisors: Meeting Date: _____

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[1] Government Code section 82019

[2] Government Code section 87302(b)

[3] Copy of Regulation as of date of adoption of this code attached hereto for convenience.

[4] Agency also has a conflict of interest policy that applies to all employees, a copy of hich (as of the date of adoption of this resolution) is attached hereto for convenience.

SIERRA VIEW LOCAL HEALTH CARE
DISTRICT APPENDIX B
LIST OF DESIGNATED POSITIONS

Designated Position	Assigned Disclosure Categories
Board Member	1
Chief Executive Officer / President	1
Chief Financial Officer	1
Vice President of Patient Care Services & Chief Nurse ~~Executive~~ Officer (CNO~~E~~) ~~AND Chief Academic Officer~~	2
Vice President of Professional Services and Physician Recruitment	1
~~Vice President~~Director of Human Resources	2
Vice President of Quality and Regulatory Affairs	2
Contracts Specialist	4
Admin Director of General Services	2
Admin Director of Imaging Services	4
Director of Information and Technology	4
Director of Materials Management	4
Manager of Environmental Services	4
Manager of Facilities	4
~~Manager~~ Director of Pharmacy	4
Director of Food and Nutrition Services	4
Director of Surgical Services	4
Manager of Labor, Delivery and Obstetrics	4
General Counsel	1
Consultant	1*

*Consultants/New Positions are included in the list of designated positions and shall disclose pursuant to the broadest category in the code, subject to the following limitations:

The Chief Executive Officer or his or her designee may determine in writing that a particular consultant or new position, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with disclosure requirements in this section. Such written determination shall include a description, a statement of the consultant's or new position's duties and, based upon that description, a statement of the extent of disclosures requirements. The CEO's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code. (Gov. Code Section 81008.)

SIERRA VIEW LOCAL HEALTH CARE
DISCLOSURE CATEGORIES

Category 1:

A designated person in this category must report all investments, business positions, and sources of income, including gifts, loans and travel payments. Additionally, individuals designated in this category must report all interests in real property located entirely or partly within the District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interests or option to acquire such interest in real property.

Category 2:

A designated person in this category must report all investments, business positions, ownership and sources of income, including gifts, loans and travel payments.

Category 3:

A designated person in this category must report all interests in real property located entirely or partly within this District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold ownership interests or option to acquire such interest in real property.

Category 4:

A designated person in this category must report investments and business positions in business entities and income, including receipt of gifts, loans and travel payments, from sources that are of the type that within the previous two years has

A. Provided services, equipment, leased space, materials, or supplies to Sierra View;

B. Filed a lawsuit and/or claim, or have a suit pending against Sierra View;

BEFORE THE BOARD OF DIRECTORS OF THE

SIERRA VIEW LOCAL HEALTH CARE DISTRICT

Resolution to Purchase Real Property)
At 380 W. Putnam Avenue)
Porterville, CA)

RESOLUTION
NO. 08-25-26/01

WHEREAS, the Board on April 28, 2026 appointed Vice President Ron Wheaton ("Negotiator") to negotiate a contract for Sierra View Local Health Care District ("District") for the purchase of real property located at 380 W. Putnam, Porterville, CA, APN 252-231-004, whose legal description is attached hereto as Exhibit A and incorporated herein by reference, owned by George M. Wilson & Susan M. Wilson ("Subject Property") and;

WHEREAS, the Board on April 28, 2026 declared that the acquisition of the Subject Property is necessary and appropriate for the business of the District, and;

WHEREAS, the Negotiator has negotiated and entered into a Commercial Property Purchase Agreement and Joint Escrow Instructions dated August 19, 2026 prepared by the brokerage firm Henry Schein PPT, Inc., for purchase in the sum of $390,000.00 subject to the terms and conditions of that Commercial Property Purchase Agreement and Joint Escrow Instructions, a copy of which is attached hereto as Exhibit B and incorporated herein by this reference, and;

WHEREAS, the Commercial Property Purchase Agreement requires ratification of the Contract by the Board;

IT IS THEREFORE RESOLVED, that the Board for the District hereby finds, determines and orders as follows:

1. Adopts the foregoing recitals as true and correct;
2. The Board ratifies the Commercial Property Purchase Agreement and Joint Escrow Instructions dated August 19, 2026 attached at Exhibit B pursuant to this Resolution;
3. The CEO for Sierra View, or her designee, is authorized and directed to execute escrow instructions and any/all supplementary agreements necessary to carry out the provisions of this Resolution and the terms of the Purchase Agreement,

including any adjustments to total purchase price, escrow fees and costs deemed necessary by the CEO, or her designee, to finalize the sale:

THE FOREGOING RESOLUTION WAS ADOPTED upon motion of Director _____ and seconded by Director _____, at a _____ meeting of the Board on this _____ day of _____, 2026, by the following vote:

AYES: _____

NAYS: _____

ABSENT: _____

ABSTAIN: _____

_____
(Secretary of said District)

SIERRA VIEW MEDICAL CENTER

FINANCIALS

FINANCIAL REPORTS FROM THE PREVIOUS MONTH

FINANCIAL PACKAGE
Jul-26

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
July 2026

Statistic	Jul-26 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 26 YTD	Increase/ (Decrease) Jul-25	% Change
Utilization											
SNF Patient Days											
Total	31	-	31	0.0%	31	-	31	0.0%	-	31	0.0%
Medi-Cal	31	-	31	0.0%	31	-	31	0.0%	-	31	0.0%
Sub-Acute Patient Days											
Total	1,054	1,057	(3)	-0.3%	1,054	1,057	(3)	-0.3%	1,069	(15)	-1.4%
Medi-Cal	465	491	(26)	-5.2%	465	491	(26)	-5.2%	496	(31)	-6.3%
Acute Patient Days	1,535	1,765	(230)	-13.0%	1,535	1,765	(230)	-13.0%	1,753	(218)	-12.4%
Acute Discharges	409	480	(71)	-14.7%	409	480	(71)	-14.7%	480	(71)	-14.8%
Medicare	175	184	(9)	-4.8%	175	184	(9)	-4.8%	184	(9)	-4.9%
Medi-Cal	186	242	(56)	-23.1%	186	242	(56)	-23.1%	242	(56)	-23.1%
Contract	41	51	(10)	-19.6%	41	51	(10)	-19.6%	51	(10)	-19.6%
Other	7	3	4	133.5%	7	3	4	133.5%	3	4	133.3%
Average Length of Stay	3.75	3.68	0.07	2.0%	3.75	3.68	0.07	2.0%	3.65	0.10	2.8%
Newborn Patient Days											
Medi-Cal	177	188	(11)	-5.8%	177	188	(11)	-5.8%	190	(13)	-6.8%
Other	29	43	(14)	-32.0%	29	43	(14)	-32.0%	42	(13)	-31.0%
Total	206	231	(25)	-10.7%	206	231	(25)	-10.7%	232	(26)	-11.2%
Total Deliveries	95	117	(22)	-19.0%	95	117	(22)	-19.0%	119	(24)	-20.2%
Medi-Cal %	88.42%	79.49%	8.93%	11.2%	88.42%	79.49%	8.93%	11.2%	81.82%	6.60%	8.1%
Case Mix Index											
Medicare	1.4069	1.4491	(0.0422)	-2.9%	1.4069	1.4491	(0.0422)	-2.9%	1.3362	0.0707	5.3%
Medi-Cal	1.1430	1.0840	0.0590	5.4%	1.1430	1.0840	0.0590	5.4%	1.0458	0.0972	9.3%
Overall	1.2422	1.2216	0.0206	1.7%	1.2422	1.2216	0.0206	1.7%	1.1640	0.0782	6.7%
Ancillary Services											
Inpatient											
Surgery Minutes	5,709	7,660	(1,951)	-25.5%	5,709	7,660	(1,951)	-25.5%	7,987	(2,278)	-28.5%
Surgery Cases	76	95	(19)	-20.1%	76	95	(19)	-20.1%	97	(21)	-21.6%
Imaging Procedures	1,370	1,640	(270)	-16.4%	1,370	1,640	(270)	-16.4%	1,738	(368)	-21.2%
Outpatient											
Surgery Minutes	14,636	15,551	(915)	-5.9%	14,636	15,551	(915)	-5.9%	16,020	(1,384)	-8.6%
Surgery Cases	203	201	2	1.0%	203	201	2	1.0%	205	(2)	-1.0%
Endoscopy Procedures	206	196	10	5.0%	206	196	10	5.0%	193	13	6.7%
Imaging Procedures	4,534	4,445	89	2.0%	4,534	4,445	89	2.0%	4,196	338	8.1%
MRI Procedures	332	325	7	2.0%	332	325	7	2.0%	341	(9)	-2.6%
CT Procedures	1,497	1,429	68	4.7%	1,497	1,429	68	4.7%	1,394	103	7.4%
Ultrasound Procedures	1,589	1,479	110	7.4%	1,589	1,479	110	7.4%	1,480	109	7.4%
Lab Tests	36,889	36,439	450	1.2%	36,889	36,439	450	1.2%	35,940	949	2.6%
Dialysis	18	6	12	219.2%	18	6	12	219.2%	7	11	157.1%

Cancer Treatment Center											
Chemo Treatments	2,173	2,103	70	3.4%	2,173	2,103	70	3.4%	2,125	48	2.3%
Radiation Treatments	1,879	1,829	50	2.8%	1,879	1,829	50	2.8%	1,180	699	59.2%
Cardiac Cath Lab											
Cath Lab IP Procedures	10	20	(10)	-49.4%	10	20	(10)	-49.4%	16	(6)	-37.5%
Cath Lab OP Procedures	36	40	(4)	-9.2%	36	40	(4)	-9.2%	33	3	9.1%
Total Cardiac Cath Lab	46	59	(13)	-22.6%	46	59	(13)	-22.6%	49	(3)	-6.1%
Outpatient Visits											
Emergency	3,492	3,706	(214)	-5.8%	3,492	3,706	(214)	-5.8%	3,243	249	7.7%
Total Outpatient	16,003	15,568	435	2.8%	16,003	15,568	435	2.8%	15,109	894	5.9%
Staffing											
Paid FTE's	903.24	902.60	0.64	0.1%	903.24	902.60	0.64	0.1%	909.38	(6.14)	-0.7%
Productive FTE's	768.69	781.84	(13.15)	-1.7%	768.69	781.84	(13.15)	-1.7%	762.92	5.77	0.8%
Paid FTE's/AOB	4.86	4.93	(0.07)	-1.5%	4.86	4.93	(0.07)	-1.5%	4.99	(0.13)	-2.6%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,416	11,192	224	2.0%	11,416	11,192	224	2.0%	10,821	595	5.5%
Cost/Adj.Patient Day	2,809	2,924	(115)	-3.9%	2,809	2,924	(115)	-3.9%	2,615	194	7.4%
Revenue/Adj. Discharge	57,772	53,517	4,255	8.0%	57,772	53,517	4,255	8.0%	51,461	6,311	12.3%
Cost/Adj. Discharge	14,213	13,981	232	1.7%	14,213	13,981	232	1.7%	12,435	1,778	14.3%
Adj. Discharge	1,138	1,186	(48)	-4.0%	1,138	1,186	(48)	-4.0%	1,188	(50)	-4.2%
Net Op. Gain/(Loss) %	2.58%	-1.07%	3.65%	-341.3%	2.58%	-1.07%	3.65%	-341.3%	1.30%	1.28%	97.9%
Net Op. Gain/(Loss) $	428,042	(175,252)	603,294	-344.2%	428,042	(175,252)	603,294	-344.2%	194,980	233,062	119.5%
Gross Days in Accts Rec.	97.39	100.75	(3.36)	-3.3%	97.39	100.75	(3.36)	-3.3%	89.17	8.22	9.2%
Net Days in Accts. Rec.	33.58	43.55	(9.97)	-22.9%	33.58	43.55	(9.97)	-22.9%	37.23	(3.65)	-9.8%

Sierra View Local Health Care District
Balance Sheet

	Jul-26	Jun-26
Assets		
Current Assets:		
Cash & Cash Equivalents	10,539,159	15,210,198
Short-Term Investments	-	351,176
Assets Limited As To Use	1,168,353	5,700,629
Patient Accounts Receivable	195,083,692	194,851,268
Less Uncollectables	(13,974,094)	(13,395,833)
Contractual Allowances	(164,008,600)	(164,760,231)
Other Receivables	32,020,026	29,722,615
Inventories	4,673,990	4,605,905
Prepaid Expenses and Deposits	4,236,070	2,801,744
Less Receivable - Current	301,020	301,020
Total Current Assets	**70,039,617**	**75,388,491**
Assets Limited as to use, Less		
Current Requirements	33,152,142	33,070,246
Long-Term Investments	143,044,519	142,836,282
Property, Plant and Equipment, Net	69,257,659	69,574,651
Intangible Right of use Assets	136,289	146,618
SBITA Right of use Assets	1,949,981	2,087,195
Lease Receivable - LT	379,969	405,614
Other Investments	250,000	250,000
Prepaid Loss on Bonds	986,042	1,007,021
Total Assets	**319,196,217**	**324,766,119**
Liabilities and Funds Balances		
Current Liabilities		
Bond Interest Payable	86,804	608,825
Current Maturities of Bonds Payable	4,235,000	4,235,000
Current Maturities of Long Term Debt	0	0
Account Payable and Accrued Expenses	5,959,920	5,672,917
Accrued Payroll and Related Costs	7,637,771	10,070,787
Estimated Third-Party Payor Settlements	3,762,840	2,517,030
Lease Liability - Current	129,125	129,125
SBITA Liability - Current	1,759,193	1,759,193
Total Current Liabilities	**23,570,652**	**24,992,877**
Self-Insurance Reserves	1,933,422	1,941,663
Capital Lease Liab LT	0	0
Bonds Payable, Less Curr Reqt	24,640,000	29,040,000
Bonds Premium Liability - LT	1,493,511	1,532,336
Lease Liability - LT	24,476	35,605
SBITA Liability - LT	585,121	741,708
Other Non Current Liabilities	-	-
Deferred Inflow - Leases	627,569	652,066
Total Liabilities	**52,874,752**	**58,936,255**
Unresticted Fund	265,829,863	265,829,863
Profit or (Loss)	491,602	-
Total Liabilities and Fund Balance	**319,196,217**	**324,766,119**
	-	-

Sierra View Local Health Care District
Income Statement

For Period **Jul-26**

	ACTUAL	BUDGET	VARIANCE	% VARIANCE	ACTUAL YTD	BUDGET YTD	VARIANCE YTD	% VARIANCE
Operating Revenue								
Inpatient - Nursing	5,371,337	5,856,627	(485,290)	(8%)	5,371,337	5,856,627	(485,290)	(8%)
Inpatient - Ancillary	18,257,480	19,817,435	(1,559,955)	(8%)	18,257,480	19,817,435	(1,559,955)	(8%)
Total Inpatient Revenue	**23,628,817**	**25,674,062**	**(2,045,245)**	(8%)	**23,628,817**	**25,674,062**	**(2,045,245)**	(8%)
Outpatient - Ancillary	42,113,659	37,788,709	4,324,950	11%	42,113,659	37,788,709	4,324,950	11%
Total Patient Revenue	**65,742,476**	**63,462,771**	**2,279,705**	4%	**65,742,476**	**63,462,771**	**2,279,705**	4%
Medicare	(20,928,171)	(22,140,174)	1,212,003	(5%)	(20,928,171)	(22,140,174)	1,212,003	(5%)
Medi-Cal	(20,540,980)	(17,820,748)	(2,720,232)	15%	(20,540,980)	(17,820,748)	(2,720,232)	15%
Other/Charity	(6,711,702)	(7,367,914)	656,212	(9%)	(6,711,702)	(7,367,914)	656,212	(9%)
Discounts & Allowances	(834,642)	(59,138)	(775,504)	1,311%	(834,642)	(59,138)	(775,504)	1,311%
Bad Debts	(1,010,626)	(367,870)	(642,756)	175%	(1,010,626)	(367,870)	(642,756)	175%
Total Deductions	**(50,026,121)**	**(47,755,844)**	**(2,270,277)**	5%	**(50,026,121)**	**(47,755,844)**	**(2,270,277)**	5%
Net Service Revenue	**15,716,356**	**15,706,927**	**9,429**	0%	**15,716,356**	**15,706,927**	**9,429**	0%
Other Operating Revenue	885,129	696,797	188,332	27%	885,129	696,797	188,332	27%
Total Operating Revenue	**16,601,484**	**16,403,724**	**197,760**	1%	**16,601,484**	**16,403,724**	**197,760**	1%
Salaries	6,527,868	6,688,008	160,140	2%	6,527,868	6,688,008	160,140	2%
S&W PTO	697,597	726,445	28,848	4%	697,597	726,445	28,848	4%
Employee Benefits	1,613,604	1,555,958	(57,646)	(4%)	1,613,604	1,555,958	(57,646)	(4%)
Professional Fees	2,102,591	1,951,955	(150,636)	(8%)	2,102,591	1,951,955	(150,636)	(8%)
Purchased Services	826,558	1,007,015	180,457	18%	826,558	1,007,015	180,457	18%
Supplies & Expenses	2,517,627	2,604,818	87,191	3%	2,517,627	2,604,818	87,191	3%
Maintenance & Repairs	311,501	299,082	(12,419)	(4%)	311,501	299,082	(12,419)	(4%)
Utilities	278,678	293,888	15,210	5%	278,678	293,888	15,210	5%
Rent/Lease	36,823	38,646	1,823	5%	36,823	38,646	1,823	5%
Insurance	151,338	124,899	(26,439)	(21%)	151,338	124,899	(26,439)	(21%)
Depreciation/Amortization	794,668	851,186	56,518	7%	794,668	851,186	56,518	7%
Other Expense	314,591	437,076	122,485	28%	314,591	437,076	122,485	28%
Impaired Costs	-	-	-	0%	-	-	-	0%
Total Operating Expense	**16,173,442**	**16,578,976**	**405,534**	2%	**16,173,442**	**16,578,976**	**405,534**	2%
Net Gain/(Loss) From Operations	**428,042**	**(175,252)**	**603,294**	**(344%)**	**428,042**	**(175,252)**	**603,294**	**(344%)**
District Taxes	140,212	140,212	-	0%	140,212	140,212	-	0%
Investment Income	617,391	458,286	159,105	35%	617,391	458,286	159,105	35%
Other Non - Operating Income	28,071	40,585	(12,514)	(31%)	28,071	40,585	(12,514)	(31%)
Interest Expense	(58,770)	(72,113)	13,343	19%	(58,770)	(72,113)	13,343	19%
Non-Operating Expense	(63,976)	(34,963)	(29,013)	(83%)	(63,976)	(34,963)	(29,013)	(83%)
Total Non-Operating Income	**662,928**	**532,007**	**130,921**	25%	**662,928**	**532,007**	**130,921**	25%
			-				-	
Gain/(Loss) Before Net Inc/(Decr) FV Invstmt	**1,090,970**	**356,755**	**734,215**	**206%**	**1,090,970**	**356,755**	**734,215**	**206%**
Net Incr/(Decr) in the Fair Value Invstmt	(599,369)	166,666	(766,035)	(460%)	(599,369)	166,666	(766,035)	(460%)
Net Gain/(Loss)	**491,602**	**523,421**	**(31,819)**	(6%)	**491,602**	**523,421**	**(31,819)**	(6%)

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
July-26

	Current Month	YTD
Cash flows from operating activities:		
Operating Income/(Loss)	428,042	428,042
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation/Amortization	794,668	794,668
Provision for bad debts	578,260	578,260
		-
Change in assets and liabilities:		-
Patient accounts receivable, net	(984,055)	(984,055)
Other receivables	(2,297,412)	(2,297,412)
Inventories	(68,085)	(68,085)
Prepaid expenses and deposits	(1,434,326)	(1,434,326)
Advance refunding of bonds payable, net	20,980	20,980
Accounts payable and accrued expenses	287,003	287,003
Deferred inflows - leases	(24,497)	(24,497)
Accrued payroll and related costs	(2,433,016)	(2,433,016)
Estimated third-party payor settlements	1,245,809	1,245,809
Self-insurance reserves	(8,240)	(8,240)
Total adjustments	(4,322,910)	(4,322,910)
Net cash provided by (used in) operating activities	(3,894,868)	(3,894,868)
Cash flows from noncapital financing activities:		
District tax revenues	140,212	140,212
Noncapital grants and contributions, net of other expenses	(46,696)	(46,696)
Net cash provided by (used in) noncapital financing activities	93,516	93,516
Cash flows from capital and related financing activities:		
Purchase of capital assets	(467,348)	(467,348)
Proceeds from sale of assets	-	-
Proceeds from debt borrowings	-	-
Proceeds from lease receivable, net	25,645	25,645
Principal payments on debt borrowings	(4,400,000)	(4,400,000)
Interest payments	(608,825)	(608,825)
Issuance of bonds payable and bond premium liability	-	-
Net change in notes payable and lease liability	(30,502)	(30,502)
Net changes in assets limited as to use	4,450,379	4,450,379
Net cash provided by (used in) capital and related financing activities	(1,030,651)	(1,030,651)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(807,605)	(807,605)
Investment income	617,391	617,391
Net cash provided by (used in) investing activities	(190,214)	(190,214)
Net increase (decrease) in cash and cash equivalents:	(5,022,216)	(5,022,216)
Cash and cash equivalents at beginning of month/year	15,561,375	15,561,375
Cash and cash equivalents at end of month	10,539,159	10,539,159

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
July 2026

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Aug-25	9,922,993	1,161,531	11,084,524
Sep-25	12,323,268	233,998	12,557,266
Oct-25	12,181,755	7,001,985	19,183,740
Nov-25	10,154,998	601,439	10,756,437
Dec-25	13,361,348	2,861,896	16,223,244
Jan-26	10,470,878	6,040,603	16,511,481
Feb-26	12,005,852	5,418,366	17,424,218
Mar-26	16,266,557	2,876,805	19,143,362
Apr-26	13,143,789	7,283,225	20,427,014
May-26	12,237,289	6,326,173	18,563,462
Jun-26	12,077,436	4,017,650	16,095,086
Jul-26	**12,659,822**	**2,053,834**	**14,713,656**

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

July 2026 Summary of Other Activity:

1,315,672	M-Care Temporary Allowance Cost Report FY23
220,500	M-Care interim payments
46,682	Property Taxes
470,980	Miscellaneous
2,053,834	07/26 Total Other Activity