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

AGENDA
February 25, 2025

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

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

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

2. Compliance Report – Quarter 2

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (2 Items). Estimated date of Disclosure: January 1, 2027

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

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 (2 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
Recommended Action: Information only; no action taken

B. Quality Review

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

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

C. Discussion Regarding Trade Secrets Pertaining to Service(2 Items)
Recommended Action: Information Only; No Action Taken

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

E. Conference with Legal Counsel (2 Items)
Recommended Action: Information Only; No Action Taken

VI. Public Comments

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

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

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

VIII. Approval of Minutes

A. **January 28, 2025 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove January 28, 2025 Minutes of the Regular Meeting of the Board of Directors

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING AGENDA
February 25, 2025

IX. Business Items

A. **January 2025 Financials**
Recommended Action: Approve/Disapprove Report as Given

B. **Board Self Evaluation and Goals**
Recommended Action: Information only; No Action Taken

C. **President/CEO Contract Renewal**
Recommended Action: Approve/Disapprove

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – March 25, 2025 at 5:00 p.m.

B. Form 700 due April 1, 2025. Disclosure forms must be on file with the Board Administrator by that date.

XII. Adjournment

PUBLIC NOTICE

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

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.

Senior Leadership Team	2/25/2025
Board of Director's Approval	
Liberty Lomeli, Chairman	2/25/2025

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
FEBURARY 25, 2025
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	Action
Policies:		Approve ↓
• Overtime	1-3	
• Tobacco Free Environment	4-7	
• Security Program	8-17	
Reports:		
• SVMC Human Resources Report Q4	18-54	
Forms		
• 009427 Emergency Dept Call Back Sheet	55	
• 015682 Financial Agreement – English	56-57	
• 016903 Financial Agreement - Spanish	58-59	

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

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

PURPOSE:

To define the process to provide uniform wage practices for the payment of overtime hours worked.

POLICY:

Payment of overtime complies with the Fair Labor Standards Act. Pay practices contained within this policy apply to non-exempt employees. Exempt employees are paid a salary for the total job performed without regard for the number of hours worked. (See policy: Recording Hours Worked, Exempt Employee Compensation and Exempt Staff Working Extra Shifts.) The Human Resources Department is responsible for determining exempt and non-exempt classifications.

DEFINITIONS:

Workweek:	The "workweek" begins on Sunday at 12:00 A.M. and ends on the following Saturday at 11:59 P.M.
Pay period:	Fourteen (14) consecutive Work Days, beginning Sunday at 12:00 AM and ending two weeks later on Saturday at 11.59 PM.
Work day:	Twenty-four consecutive hours beginning at 12:00 A.M. and ending at 11:59 P.M.
Authorized Overtime:	Overtime specifically authorized by schedule or Department Director.

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

PROCEDURE:

1. Overtime will be paid for all hours worked in excess of 40 hours in a workweek. Overtime is paid at the rate of not less than one and one half (1½) times an employee's regular rate of pay. An employee's calculated regular rate of pay is determined by taking all of his or her compensation in the workweek including base hourly rate, shift differentials, on-call pay, etc. and dividing that total compensation by the total hours actually worked by the employee in that week. Payments excluded from the regular rate of pay include pay for expenses, premium payments for overtime work, bonuses, gifts and payments for periods when no work is performed (e.g., Vacation, holiday) in the workweek.

   This process applies to all non-exempt employees regardless of work schedules.

2. Federal and California wage laws require accurate record keeping of hours worked for non-exempt employees. For greater detail, refer to the policy Recording Hours worked. Employee requests to work during lunch periods must be pre-approved and documented. For greater detail, refer to the policy Meal and Rest Breaks.

3. All overtime must be approved in advance by the Department Director or his/her designee. Employees who disregard this policy will be subject to discipline. Overtime specifically authorized by schedule or Department Director is considered authorized overtime. While unauthorized overtime will be paid, working overtime without the authorization by a supervisor is grounds for disciplinary action; and in the case of repeated violations, working unauthorized overtime may be grounds for termination.

4. Schedule of hours for employees is determined by the Department Director or their designee. Employees will be notified of their work schedule at least four weeks in advance and authorized overtime will be included. Department Directors or their designees reserve the right to authorize additional overtime, including mandatory overtime for employees, based on changes in census, work schedule, sick calls, and/or other unforeseen circumstances or operational conditions warranting the need for such overtime. Department Directors are accountable for meeting fiscal budgets and justifying both authorized and unauthorized overtime variances.

5. Deviation from the above overtime pay practices must be documented and pre-approved by the V.P. of Human Resources and the Vice President of the incumbent's department.

USE OF BENEFIT TIME

Only hours worked are considered for the purpose of calculating overtime pay. Overtime pay is based on the total hours worked and not the number of hours paid. Vacation, Holidays, Sick time, leaves of absence, or other benefit time are not considered as hours worked and are excluded for purposes of calculating total hours for payment of overtime.

SECONDARY JOB CODES

When an employee is assigned, and works in, a secondary job code with a different rate of pay, the regular rate for that week will be calculated based upon the weighted average of such rates. That is, the earnings from all such rates will be added together and this total will be divided by the total number of hours worked at all jobs. The department in which the employee is scheduled for overtime will be responsible for paying the overtime rate to the employee.

REFERENCES:

- United States Department of Labor, Wage and Hour Division (2016)
- California Labor Code and Industrial Welfare Commission (2006) Regulating wages, hours and working conditions, Oder No. 4-2001

CROSS REFERENCES:

- Recording Hours Worked
- Holiday

- Exempt Employees Working Extra Shifts
- Exempt Employee Compensation
- Job Titles

SUBJECT: **TOBACCO FREE ENVIRONMENT**	SECTION: ***Life Safety Management*** **Page 1 of 4**

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

PURPOSE:

It is the policy of Sierra View Medical Center (SVMC) to prohibit the use or the sale of any tobacco-related products on all Sierra View Medical Center campuses.

As a health care provider committed to the health and safety of staff, patients, physicians, visitors and vendors, SVMC is taking a leadership role on the major public health issue of tobacco use. To promote SVMC's commitment to public health and safety and to reduce the health and safety risks to those served and employed at the workplace, all SVMC facilities, campuses, vehicles and other properties will be tobacco free environments as of January 1, 2014. No smoking of cigarettes, cigars, pipes or use of chewing tobacco or e-cigarettes in any form or other tobacco-related products will be permitted on any campus or properties of Sierra View Medical Center.

This policy is applicable to all staff on the SVMC campus whether they are employees of SVMC or other agencies, to medical staff, visitors, students, volunteers, vendors and contracted services. This policy is applicable to all patients and outpatients

A ban on tobacco-related products does not take away an individual's rights as there is no "right to smoke" in California. SVMC does not require staff, patients or visitors to stop using tobacco-related products; however, it is required that people do not smoke or use other tobacco-related products on all SVMC physical sites, campus or during work time.

The purpose of this policy is to describe how the tobacco-free environment requirements will be implemented.

POLICY:

It is the policy of SVMC to provide a safe, healthful and comfortable work environment for all employees, contracted staff, vendors, patients, visitors and physicians by prohibiting tobacco-related products on all facilities owned and/or operated by SVMC.

Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from utilizing any tobacco-related products on or in any SVMC facility, adjacent grounds, including parking lots and SVMC leased or owned vehicles. Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from smoking in their own or other's vehicles when the vehicles are on SVMC property.

DEFINITIONS

Tobacco or Nicotine Delivery Products – Cigarettes, pipes, pipe tobacco, tobacco substitutes (e.g., clove cigarettes), chewing tobacco, cigars, e-cigarettes, vaping devices, and JUUL pods.

Tobacco Paraphernalia – Combustible material is contraband unless authorized.

Nicotine Replacement Products – e.g., gum, patches, lozenges, inhalers.

Workplace – Workplace means facilities or properties including, but not limited to, patient care buildings, clinics, facilities, office buildings, parking lots, SVMC owned vehicles, or property leased or rented out to other entities. This policy applies regardless of whether a SVMC facility or property is owned or whether or not the other tenants follow similar guidelines. Employees and clients at all off-site patient activities shall not use tobacco- related products.

ACCOUNTABILITY

It is the responsibility of all SVMC staff members to enforce the organization's tobacco-free environment policy by encouraging their colleagues, guests, visitors and others to comply with the policy. Directors, Managers and Supervisors are responsible for implementing and enforcing the SVMC Tobacco-Free Environment policy.

The community, staff, clients and visitors will be informed of the policy through a variety of communication methods.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; VISITORS; AND STUDENTS

PROCEDURE:

GENERAL POLICY PROVISIONS

- Signs declaring this campus "tobacco free" shall be posted at the SVMC campus entrances and other conspicuous places.
- SVMC staff and other employees who work on the SVMC campus will be advised of the provisions of this policy during New Hire & Annual Orientation. The Tobacco Free Environment policy will also be placed in the New Employee Orientation Handbook.
- SVMC is committed to providing helpful intervention strategies and treatment resources in addressing this issue and to offering programs and smoking cessation assistance for employees and patients to reduce their dependence.

A. HOSPITAL EMPLOYEES AND CONTRACTED STAFF:

1. Respectful enforcement of this policy is the responsibility of all SVMC employees and all personnel are responsible for the adherence to the Tobacco Free Environment policy.

2. Employees, Medical staff, volunteers, vendors, contractors and students are expected to comply with this policy.

3. Job announcements for all positions on the SVMC campus will display a notice that SVMC has a tobacco free environment.

4. Employees are prohibited from smoking or using other tobacco products during any and all parts of their paid work shift excluding lunches. Employees may not smoke or use tobacco-related products in their private vehicles while the vehicle is on SVMC grounds.

5. Lack of employee and contracted staff cooperation on the Tobacco Free Environment policy or repeated violations shall be reported to Human Resources. Human Resources will contact the individual's department director or the contracted services director who will address the issue.

6. Standard disciplinary procedures will be followed for compliance problems with employees. Violations of this policy will result in progressive disciplinary actions, up to and including termination.

7. New employees and new contracted staff will be informed of SVMC's Tobacco Free Environment policy during the new hire process and the facility orientation.

8. All personnel are responsible for adherence to and enforcement of the Tobacco Free Environment policy.

B. MEDICAL STAFF

1. New medical staff members will be informed of the hospital's Tobacco Free Environment policy and during staff orientation.

2. Physicians or medical staff employees violating SVMC's Tobacco Free Environment policy will be reported to the Medical Staff department for appropriate action under the medical staff bylaws.

C. PATIENTS AND NON-EMPLOYEES PERSONS ON CAMPUS

1. Patients will be provided with education regarding the Tobacco Free Environment policy upon admission.

2. Patients will be provided with education regarding the benefits and resources for smoking cessations.

3. Staff will notify patient's physician to request smoking cessation aids if needed for patient.

4. Staff will educate and counsel patients and non-employee persons on campus if tobacco-related violations are observed, respectfully requesting their compliance; however, the policy will be strictly enforced.

5. Smoking / tobacco violations by patients will be reported to their respective patient care unit.

6. Smoking / tobacco use by visitors will be reminded by hospital staff or security in a respectful and courteous manner.

D. MANAGEMENT STAFF / RESPONSIBILITIES

1. Ensure employee compliance and enlist employee support in accomplishing SVMC's commitment to a tobacco free facility and workplace.

2. Human Resources shall inform prospective applicants that SVMC is a Tobacco Free facility.

3. The Education Department will be responsible for educating staff and contracted staff regarding SVMC's Tobacco Free Environment policy during orientation and reinforcement education during annual update.

4. The Safety Committee will evaluate compliance through periodic monitoring of violations and will make recommendations for strategies to obtain compliance.

REFERENCES:

- The Joint Commission (2025). Hospital accreditation standards. EC.02.01.03 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **SECURITY PROGRAM**	SECTION: ***Security Management*** **Page 1 of 10**

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

POLICY:

HOSPITAL SECURITY HOSPITAL-WIDE

The Environment of Care/Safety and Security Manager, shall be responsible for providing hospital-wide security services to the facility. Security Services are performed through contract with On-Site Security Services. All On-Site Security personnel shall conform and adhere to all Sierra View Medical Center policies at all times. All On-Site Guards shall have appropriate Guard certificates and will be subject to a complete background investigation prior to employment.

TRAINING

All appropriate personnel shall receive security training. Training will meet state and local government requirements. Other hospital employees, such as engineering maintenance personnel, who perform security duties will also receive specialized security and Managing Assaultive Behavior training or equivalent program.

SPECIAL CONSIDERATION

Special consideration of security needs will be addressed for the following areas:

Access Control:

- Security door lockout
- Providing access control as appropriate to sensitive areas: Emergency Department, Pharmacy, Special Care Units.
- Limiting access to the hospital between 2100 and 0530.
- Locking and reopening the entrances and exits to the hospital.
- Limiting access to the hospital through the Emergency Department.
- All hospital areas not in use during evening and night hours, weekend and holidays are to be locked. These areas must be checked at least once during the night shift.
- **Delivery of Radiopharmaceuticals:** A member of the security team will escort the delivery person to and from the Nuclear Medicine Department at all times.

EMPLOYEE RESPONSIBILITY

Sierra View Medical Center employees are the key to a successful Security Management Program and shall be responsible for the following:

- Knowing who should legitimately be in their work areas and request that all staff display their identification badge.
- Securing offices not in use, utilize lockers, lock desks as appropriate.
- Observing and reporting suspicious activities or personnel.
- Providing directions and taking time to escort visitors to their destination.
- Notifying appropriate personnel immediately when observing a person who acts suspiciously.
- Reporting security incidents on the hospital incident reporting form

IDENTIFICATION

Hospital identification badges shall be worn above the waist by all employees at all times while on duty.

Inpatients shall wear permanent identification bands. Outpatients and Emergency Department patients shall wear temporary identification bands.

SECURITY INCIDENT REPORTING

Any employee witnessing or having knowledge of a security incident shall report the occurrence on a hospital incident reporting form. The following are examples of types of incidents that shall be reported:

- Assaultive or threatening behavior.
- Unauthorized entry into hospital, including entry through any door other than Emergency Room after 2100 and before 0530.
- Theft/vandalism.
- Any situation in which staff feels uncomfortable with regard to a potential security risk.
- Any area that should be locked, found open.

The Environmental Safety Committee will track the incidents to assist in determining the effectiveness of the Security Management Program, and to make any changes necessary to provide for the best security possible for all staff, patients, visitors and property.

The completed form shall be routed to the Safety / Security Officer for trending. The Environmental Safety Committee will review trends on a quarterly basis, or more often if deemed necessary.

CIVIL DISTURBANCE

- A civil disorder may escalate a minor disturbance to a major riot, through the actions of one or a group of individuals who are well organized. The first ingredient is a "cause" or reason for upsetting the normal routine or committing aggressive action against the hospital, its personnel or one or more of its patients.

- A hospital is particularly susceptible to incursions by malcontents or individuals with a "cause," because of its lack of security and open admissibility to the public.

- An individual determined to enter the hospital to start trouble will pay no attention to signs restricting entrance, such as "Emergency Ambulance Entrance," "Authorized Personnel Only," "Hospital Personnel Only" and other similarly restrictive notices. In fact, such an individual will probably go to the rear or side entrance where he/she is not likely to be observed and probably won't be challenged if he/she is seen entering the building.

WEAPONS

Definition: Weapon is defined as any firearm, knife or device that could cause bodily harm or injury.

- Weapons are never permitted on Hospital property. Sworn Law Enforcement officers are exempt from this policy (on and off duty).

- Patients and visitors are instructed to register all weapons with the Hospital Security Department.

- If a patient comes to the hospital for admission with a weapon, the weapon will be sent home with a family member if possible.

- Patients being admitted through the Emergency Department, or arriving at the Hospital without a family member, will have their weapon confiscated and stored in the Hospital Security Department until discharge.

- Visitors will be advised of the need to check any weapon with the Security Department prior to entering the Hospital. Visitors not complying with this regulation will be denied access to the Hospital. Local law enforcement will be called if the visitor becomes disruptive.

- If a patient or visitor volunteers that he/she is in possession of a weapon, call the Security Department to check weapon.

- If a weapon is found on a patient in the Emergency Department, the weapon shall be confiscated and the Security Department called.

- If a patient or visitor is found to have a weapon, but is unwilling to surrender it, the Security Department shall be called.

- Do not attempt to confront the patient/visitor.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

GENERAL:

- As soon as it is determined or suspected that a person with no official business or medically-related reason for being in the hospital is, in fact, circulating within the premises, he/she shall be challenged, preferably by an official of the hospital and escorted out of the building as discreetly as possible, on the basis that he/she has no reason for being in any part of the facility except the reception area, and that it is a private institution. If he/she objects, the hospital official shall notify the police department, and the challenged individual shall be allowed to speak to the police department on the telephone. In most cases, the person will not avail himself/herself of the opportunity, but the hospital will have protected itself from any charges of unfair treatment or discrimination.

- When it has been determined that a group of individuals are in the hospital on other than official or medically-related business, all entrances shall be secured and, where possible, the group shall be isolated, by activating the fire doors, and prevented from circulating through the rest of the hospital. The police shall be summoned by the Security Supervisor or designees, who shall brief the police watch commander over the telephone.

RESPONSIBILITIES - POTENTIALLY VIOLENT SITUATION:

Security Department:

- Maintain contact with the police and fire departments.

- Familiarize Security Department and Engineering Department personnel with the procedures used by the police department for handling unrest, civil disorders or riots. Since Security Department personnel are often the first contact with participants in any type of civil disturbance, it is most important that they correctly estimate the situation and avoid aggravation of the existing situation. Security Department personnel will be the first and most reliable sources of information needed by the Police to properly respond to a potentially violent situation. Information regarding the circumstances surrounding the situation of unrest shall help hospital officials in dealing with the group or individual ringleader in the early stages of the controversy.

- In the case of an organized group attempting to reach a patient or a member of the hospital staff with intent to harm, the Security Manager's only recourse is to prevent entry to the area where the target individual is located.

- Be prepared to call the police if a trouble situation appears to be developing. If there is any doubt, it is better to inform them too early rather than too late, as the situation can often be resolved before violence occurs.

Telecommunications:

- Maintain a current list of phone numbers for the police, fire departments and key hospital personnel to be notified in an emergency situation; also the code designation, Code Gray, familiar only to hospital personnel to be announced over the public address system to alert them to a possible or actual civil disturbance.

- Be prepared to report any disturbance in accurate detail. It is essential that the true nature of the disturbance be reported, in order that the appropriate course of action and corrective measures can be applied.

Engineering Department:

- Special precautions shall be taken to protect the liquid oxygen storage area and tank; a supply of auxiliary cylinders shall be maintained in the hospital as back-up to the main storage and supply source and for use in an emergency situation. The generator and boiler room shall also be guarded against actions by intruders.

RESPONSIBILITIES - VIOLENCE IMMINENT OR IN PROGRESS:

Security Department:

- Contacts police and fire departments. (Use business phone numbers, if no violence has occurred.) Use emergency phone numbers, if violence has occurred or is imminent. Carefully report the incident in terms of numbers of participants, reasons for unrest, observed conduct of group leaders and any other information requested by the police. Write down any instructions given by the police and follow their procedures precisely.

- Contact Telecommunications and report nature and extent of incident.

Telecommunications:

- Notify the hospital Chief Executive Officer or his/her designated representative, and give details of the incident or disorder, including steps taken by the Security Department.

- Follow instructions received from Chief Executive Officer.

Hospital Chief Executive Officer or Designated Representative:

- Decide on course of action to be taken, pending arrival of police.

  – Hospital could be closed to all except bona fide emergency cases, i.e., those confirmed by the operator, or by calls from staff physicians or other authentic sources. The Emergency Department entrance could be guarded by Security/Engineering Department personnel until arrival of police.

- Instruct Directors and Managers to call off-duty personnel and inform them of the situation. All except Security/Engineering Department personnel shall be instructed to remain out of the hospital until further notice. Security/Engineering Department personnel shall be directed to report immediately to assist in coping with the situation.

- Depending on estimate of the seriousness of the situation, determine whether to secure vital records by locking them in a vault or in a safe cabinet or turning them over to key employees for transport to a safe place off the hospital premises. Special care shall be taken to safeguard the accounting office and any electronic or computer operations areas.

- Instruct the Administrative Director of General Services to prepare for a fire alert and to have his/her forces standing by to shut off electrical power, natural gas or any source of ignition. It is imperative that the Security/Engineering Department forces of the hospital cooperate fully with the police and fire services of the community responding to the disturbance.

In the final analysis, any local condition of unrest or social upheaval which affects the orderly conduct of the hospital functions shall be handled by the local public protection services with full assistance and cooperation from the hospital and its staff.

REPORTING TO POLICE

Pursuant to California Health and Safety Code section 1257.7, all incidents which may constitute an aggravated assault will be reported to the Police Department. The form will be filled out and faxed to the police department by the Risk Manager. A copy of the faxed reporting form and a hospital incident report will be forwarded to the Safety Committee.

TO: Porterville Police Department

FROM: Sierra View Medical Center

DATE:

Pursuant to California Law Sec 1257.7 of the Health and Safety Code, we are hereby reporting to you that an incident occurred involve an aggravated assault upon an on duty employee on the _____ day of _____20____ at _____ ___M. This being done to comply with the reporting requirements of the law. Should any further action regarding this matter be necessary we will advise you.

HIGH RISK VISITORS

Violence is a major issue facing health care. This hospital shall attempt to protect patients, staff and visitors from aggressive or violent behavior by monitoring and/or limiting visitation in the following categories:

- Patients in police custody: Visitors not recommended. Must have permission of arresting officer.
- Victims of violent crime: Police will be called in for a report. Visitors only by physician or police orders.
- Patients involved in physical altercations. No visitors because staff may not know who the combatants are; it may be one of the visitors.
- Overdose patients: No visitors recommended. Physician order only.
- Gang members: Many visitors (gang members) may be present at the hospital. Police shall be notified. One visitor permitted after clearance by police and with physician order.
- Known criminals: No visitors

- Intoxicated patients: Visitors may also be intoxicated. Recommend no visitors. One visitor with physician order.

- Psychiatric patients: Visitors with physician order.

In addition to following the above guidelines, if any employee has reason to believe that a high risk visitor is present or expected within the facility, that employee will notify the Administrative Supervisor, who will then notify personnel as appropriate. Emergency Department, Registration, and Visitor's Desk will also be notified.

NOTIFY APPROPRIATE PERSONNEL OF ANY VISITOR THAT MAY BE ABUSIVE OR CREATING DISTURBANCE. IF VISITOR REFUSES TO LEAVE, THE POLICY WILL BE CALLED.

High Security Risk Patients

Patients who may pose a security risk to the hospital should be identified and may include patients who:

- Are involved in gang related incidents;

- Are involved in domestic disputes;

- Present under the influence of drugs or alcohol;

- Previously presented a security problem;

- Known history of violent acts;

- Presenting with mental illness

Identification of high security risk patients may be made through police or ambulance report, personal history of patient, or observation by the staff.

Patients who are a security risk shall be identified at the earliest possible time, by the staff caring for the patient and this information clearly transmitted to others who are or will be caring for the patient, and the Nursing Supervisor. High security risk patients shall have their identification bands marked with blue tape. Information regarding the security risk of the patient will be part of the medical record, but will be for hospital use only.

As deemed necessary for the protection of the patient, the identity of the patient may be kept confidential, up to and including the use of an alias for public information purposes.

The Administrative Supervisor will be responsible for notifying appropriate personnel of the admission to the hospital of a high security risk patient.

High risk security patients will be classified as follows:

Level I

- Patient poses a potential risk to hospital staff/visitors through combative or hostile behavior.
- Level I security risk patients being transferred between units will be accompanied by appropriate personnel if exhibiting aggressive or hostile behavior, or if deemed necessary by the nursing staff.
- Level I security risk patients shall be evaluated daily by the nursing staff caring for the patient. Assessment shall be made of any hostile/aggressive behavior. If there is no evidence of this behavior, the patient will be removed from security risk.
- If there is a change in a patient's security status, the staff will notify the Nursing Supervisor.

Level II

- Level II security risk patients being transferred between units will be accompanied by appropriate personnel.
- These patients shall not appear on the hospital census list. (An alias may be used).
- Level II patient will be admitted to the Medical/Surgical unit in a pre-designated room considered safe.
- Visitors will be restricted to those cleared by police, or with physician order. A visitor restricted sign will be posted on the door and all visitors referred to the nurses' station for clearance. This will be enforced by all staff members and the Nursing Supervisor.
- These patients shall remain Level II security risk for the duration of the hospital stay.

EMERGENCY DEPARTMENT SECURITY

Sierra View Medical Center is open for business 24 hours a day. The following measures shall be in effect in order to maintain a secure environment:

Staff:

The Emergency Department shall be staffed in accordance with Title 22.

Access Control:

Access to the treatment areas of the hospital will remain closed and/or secured, limiting access to authorized personnel only.

Admission to the Emergency Department will be by remote electronic lock release.

REFERENCES:

- The Joint Commission (2025). Hospital accreditation standards. EC. 01.01.01 Joint Commission Resources. Oak Brook, IL.

- AB 508 (1993). Retrieved from http://www.leginfo.ca.gov/pub/93-94/bill/asm/ab_0501-0550/ab_508_bill_931008_chaptered.


SIERRA VIEW
MEDICAL CENTER
HR Report 2024 QTR 4

Dashboard

Measurement	QTR 1	QTR 2	QTR 3	QTR 4	YTD	Annualized	Goal	Variance
EE Referral Rate	35%	31%	6%	19%	23%	23%	NA	NA
Geofencing Rate	2%	8%	0%	0%	3%	3%	NA	NA
Timely Eval	74%	83%	76%	65%	75%	75%	90%	-15.2%
Turnover	3.7%	4.1%	6.0%	4.2%	18%	18%	12%	-6.5%
RN Turnover	3.0%	4.0%	3.3%	6.4%	17%	17%	13%	-3.5%
Employee Retiention >5 Years	45%	46%	46%	46%	46%	46%	50%	-4.0%

SVMC RECRUITMENT

Recruitment Update – Q4

50

Full Time Staff Hired

12

Per Diem Staff Hired

25

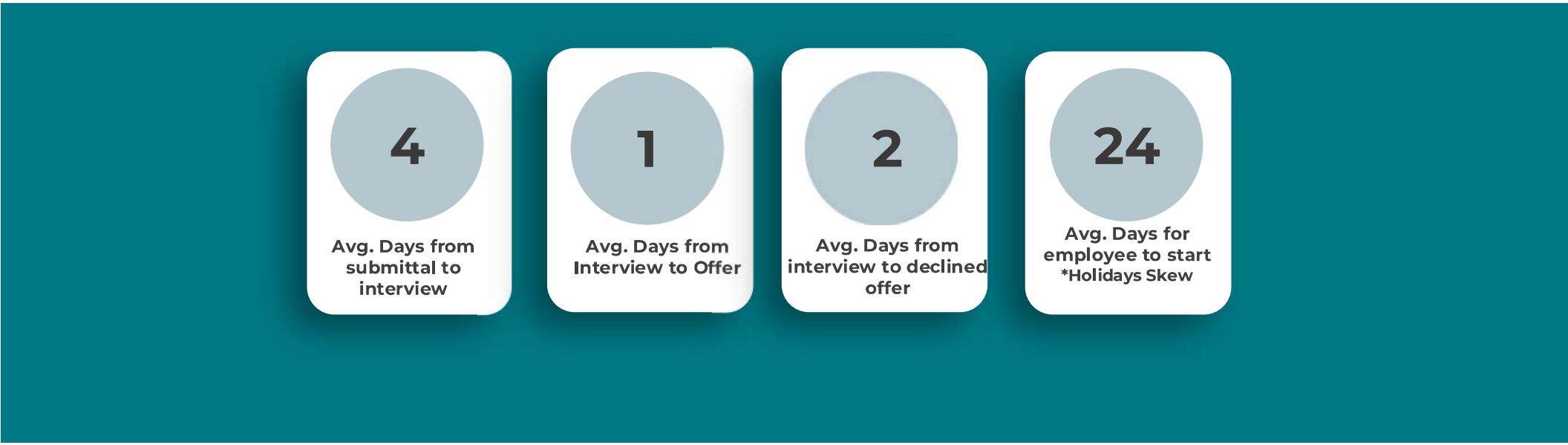
RNs Hired

*Includes 10 internal transfers

92

Total positions filled **including transfers**

Candidate Activity Metrics



Recruitment Metrics

98	92	1196	155	9
Jobs Opened	Total Accepted Offers	Total Applications Screened	Scheduled Interviews	Declined Offers

*Top reason for candidate decline: Hourly Rate/Internal Equity

Quarter 4

Recruitment Events/Projects

- 10/1/24 – PHS Career Event
- 10/2/24 – TCWIB Job Fair
- 10/3/24 – Fresno St. Career Fair
- 10/28/24 – PC Luncheon
- 11/6/24 – SJVC Meet Greet with LVN to RN students
- 11/14/24 – SJVC Meet Greet with RN students
- 11/18/24 – New Grad Interviews
- 12/4/24 – Porterville Adult School, Meet with Surg Tech Students
- 12/6/24 – Visalia Adult School Career Fair

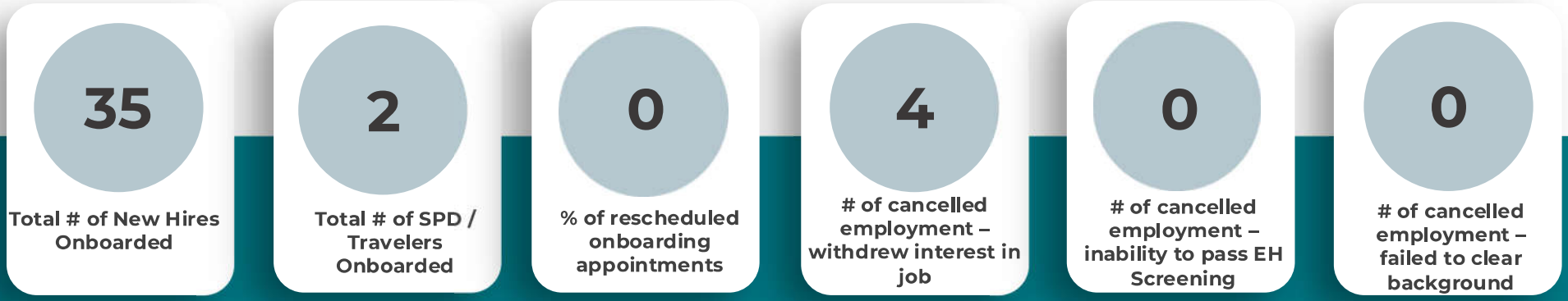
Upcoming Quarter 1 (2025)

Recruitment Events/Projects

- February 2025 – Meet N Greet with Graduating Students, intro to RN New Grad Program
- March 2025 – Luncheon for New Grad RNs
- March/April 2025 – New Grad Interview Day

ONBOARDING UPDATE

Onboarding Stats



EMPLOYEE RELATIONS

Employee Relations Activity

Human Resources

Performance Management Activities

INVESTIGATIONS CONDUCTED

29

PACPs SUPPORTED

1

EXIT INTERVIEWS CONDUCTED

6

GRIEVANCES MANAGED

1

Progressive Disciplinary Action

35
Attendance NOCAs

20
Performance NOCAs

49
Terminations Processed

1
Suspension Letters Pending Investigation

Employee Relations

Unemployment Insurance Activity

22	Submitted UI Claims
3	Appeal Hearings Attended
86%	Traditional Claims Win Ratio
1	Hearings Won
$5,119	Savings
2	Hearings Pending

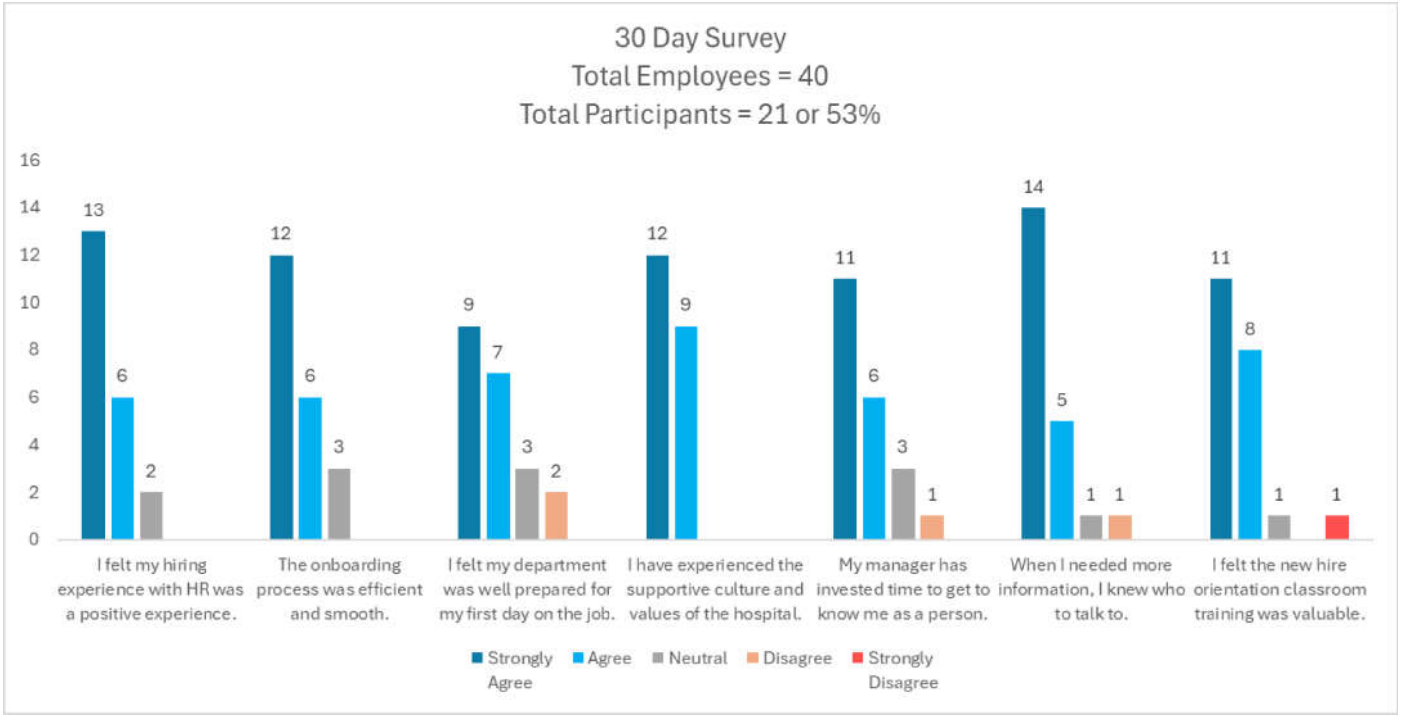
SIERRA VIEW
MEDICAL CENTER

Training & Development

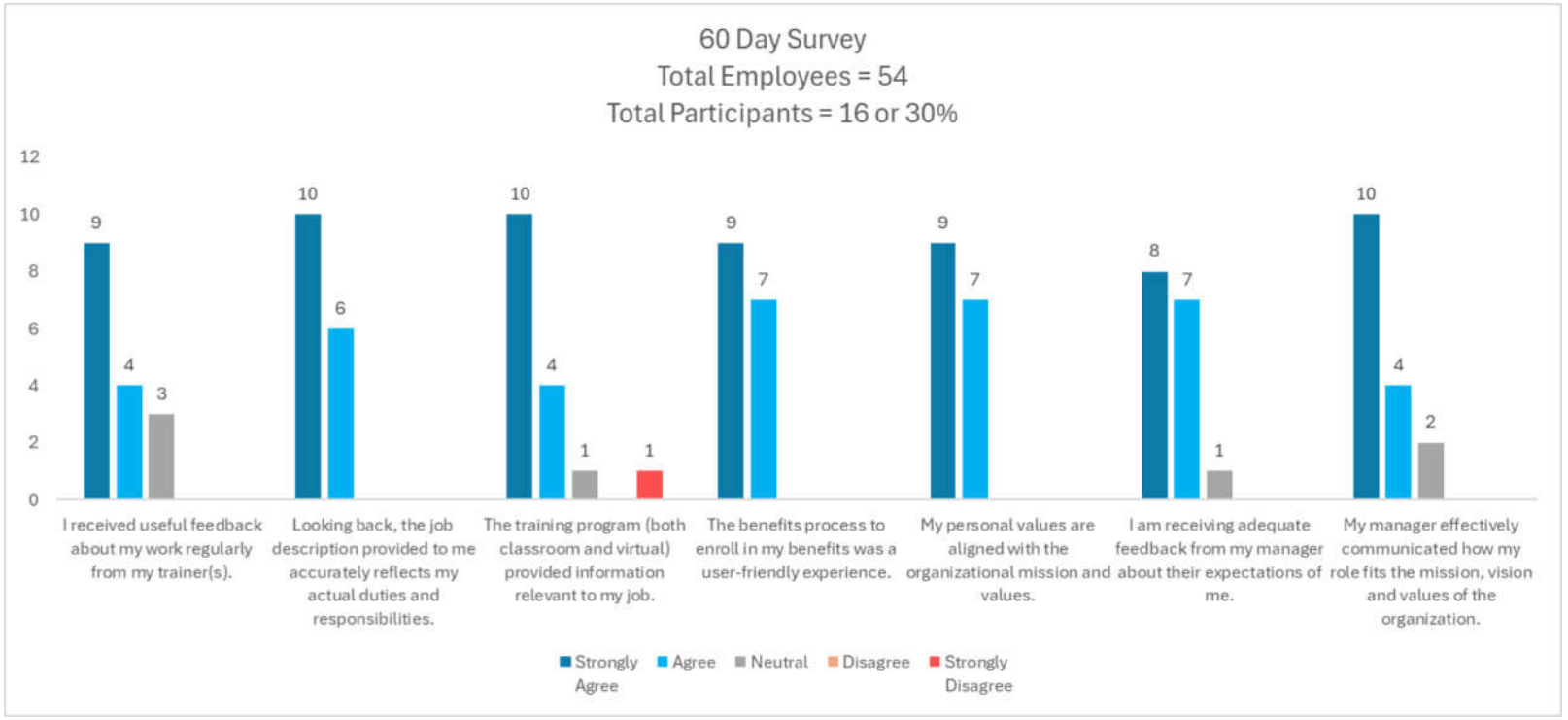
- ✓3 NHO Sessions Facilitated
- ✓34 New Hires Trained
- ✓612 Sexual Harassment Modules Launched

EMPLOYEE ENGAGEMENT

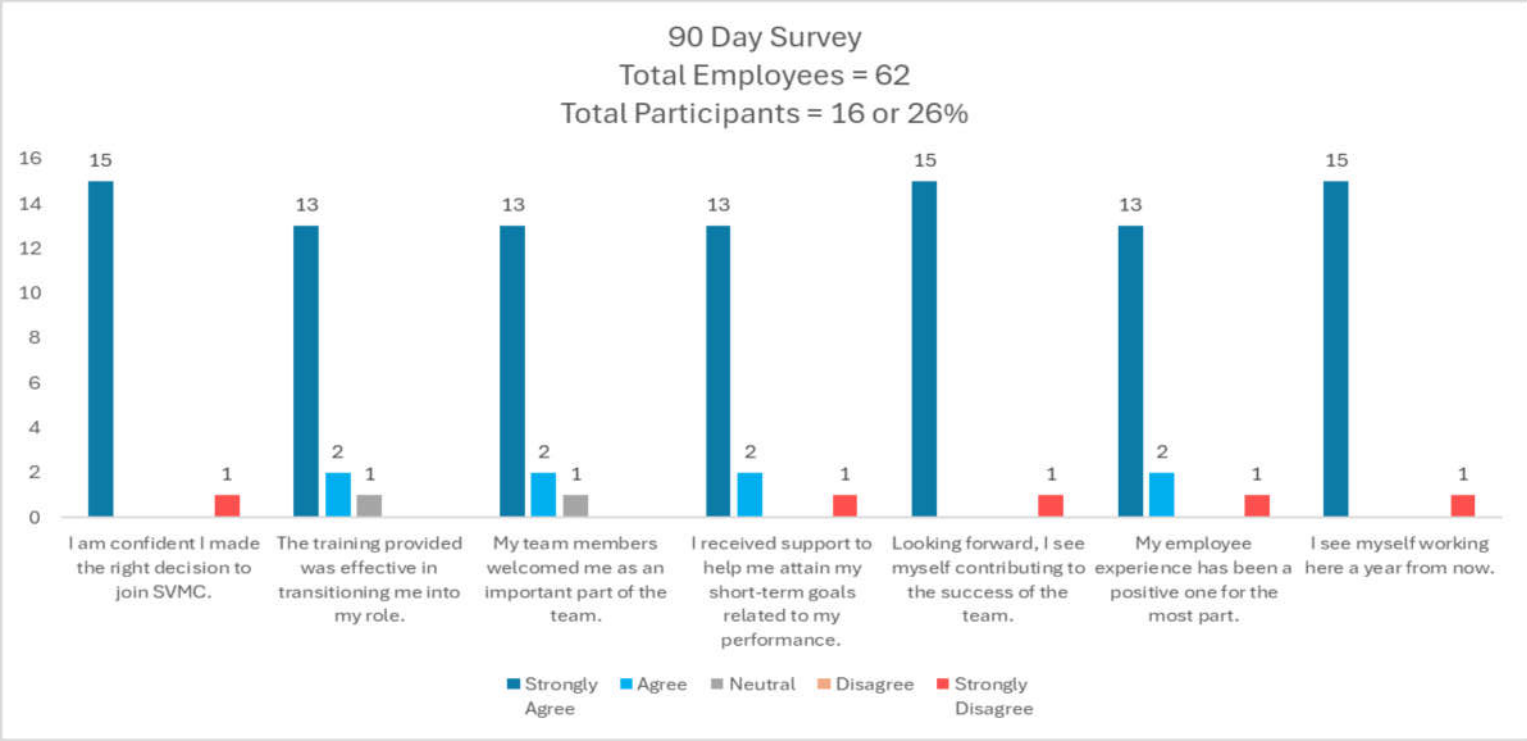
New Hire Survey



New Hire Survey



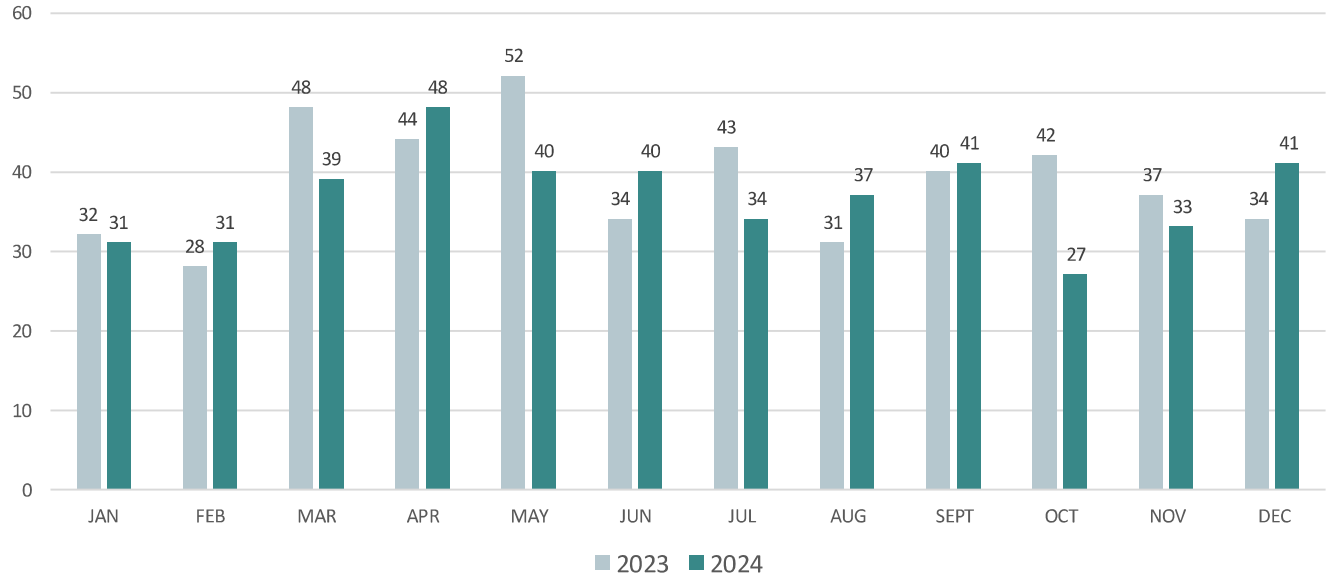
New Hire Survey



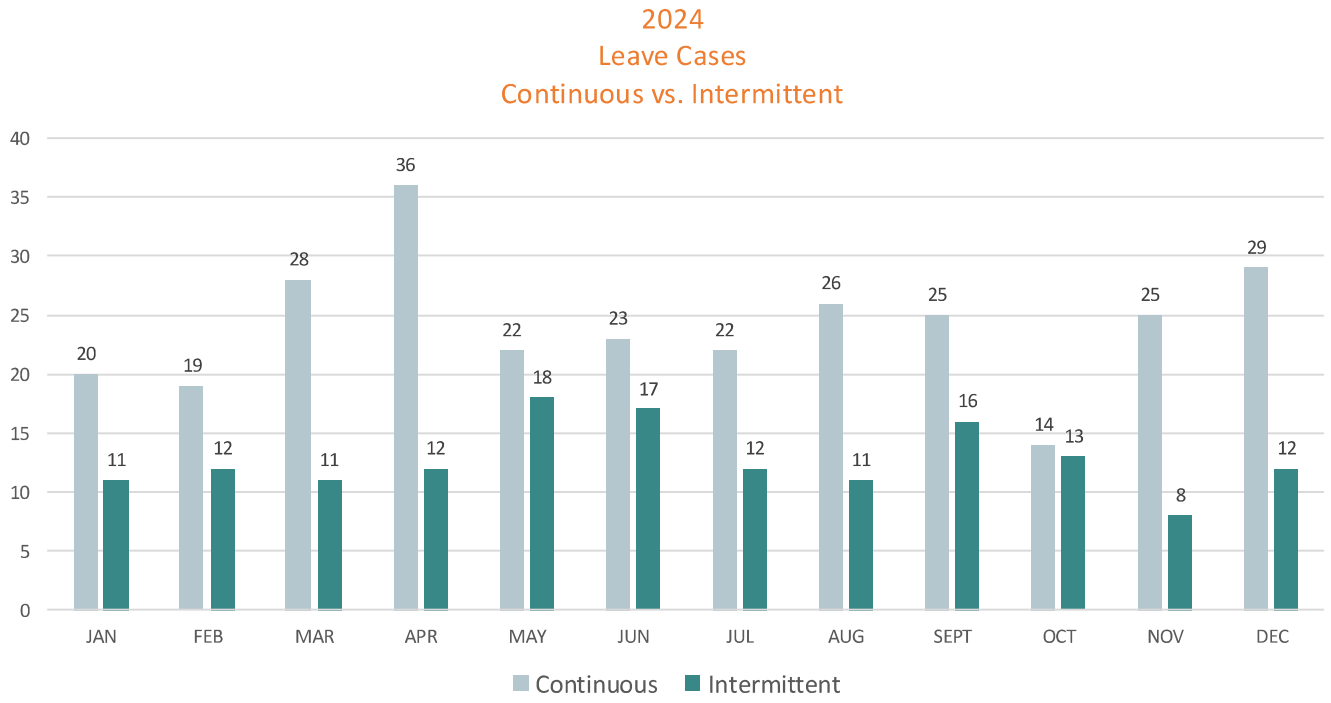
LEAVE OF ABSENCE UPDATE

Leave of Absence Update

Leave Cases
2023 vs. 2024
CY24: Q1 = 101 | Q2 =128 | Q3 = 112 |Q4 = 101



Leave of Absence Update



Leave of Absence & Accommodations

Leave Designation & Totals

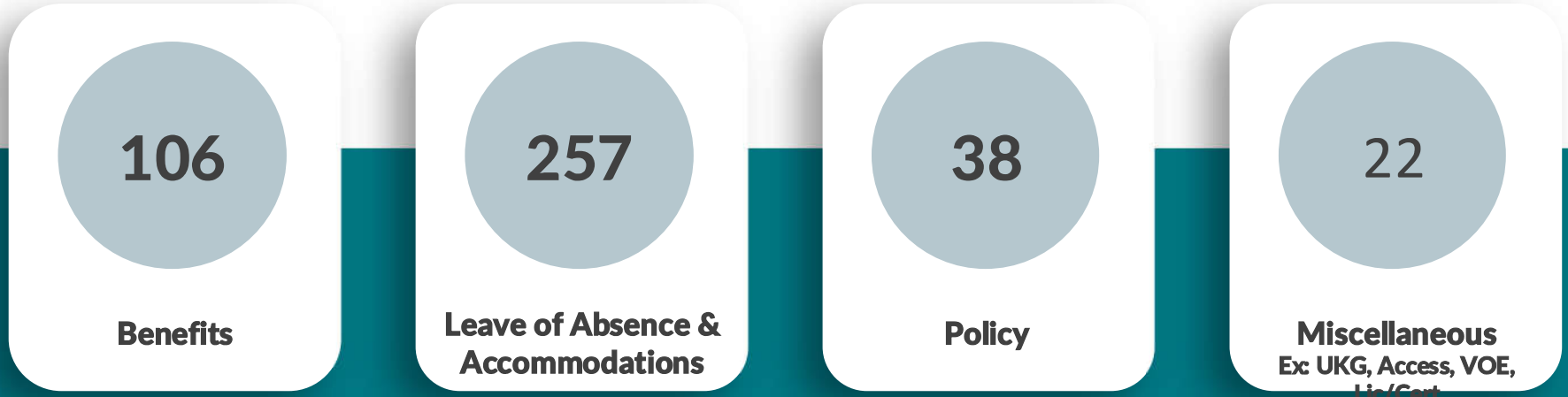
- FMLA- 52
- FMLA Intermittent- 33
- ADA Accommodation- 11
- Personal- 0
- Administrative- 5
  - Expired licensure/certification- 5
  - Expired I-9 documentation- 0
- Workers Compensation- 4
- Extensions- 32
- Return to Work- 56
- Total of ALL Leaves- 101

Accommodations Requests

- Light Duty/Modified Duty- 8

Consultations with Benefits/Leave Coordinator

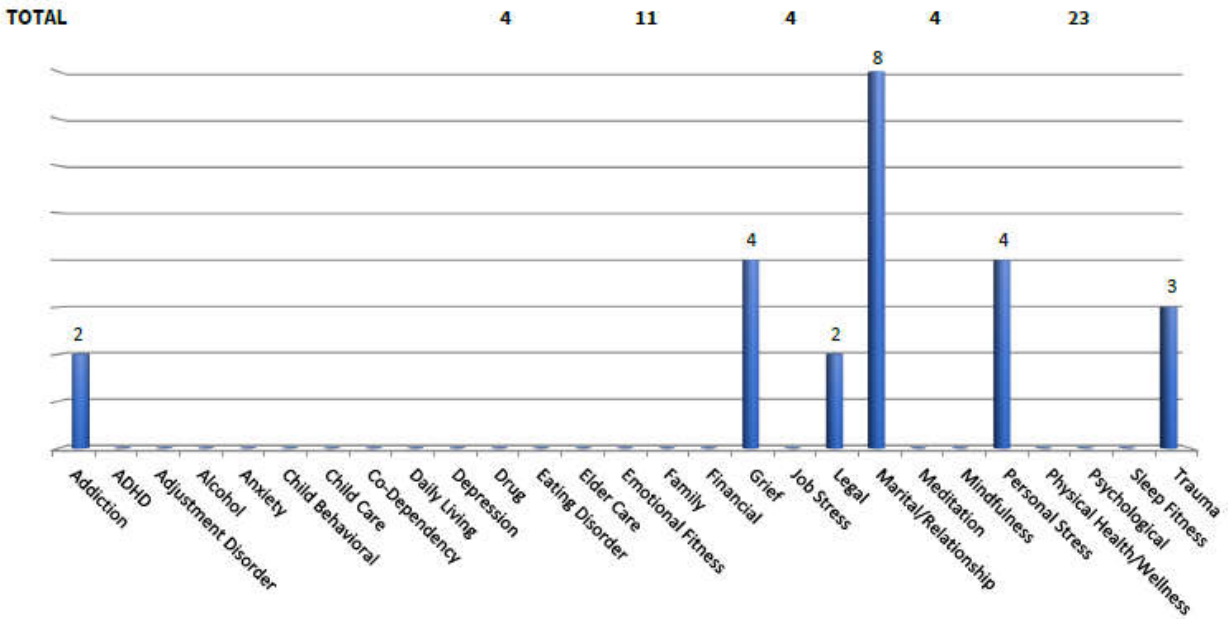
Q4 Total= 423



BENEFITS UPDATES

7/1/2024 thru 9/30/2024
* Always a QTR behind

Simple Therapy- EAP



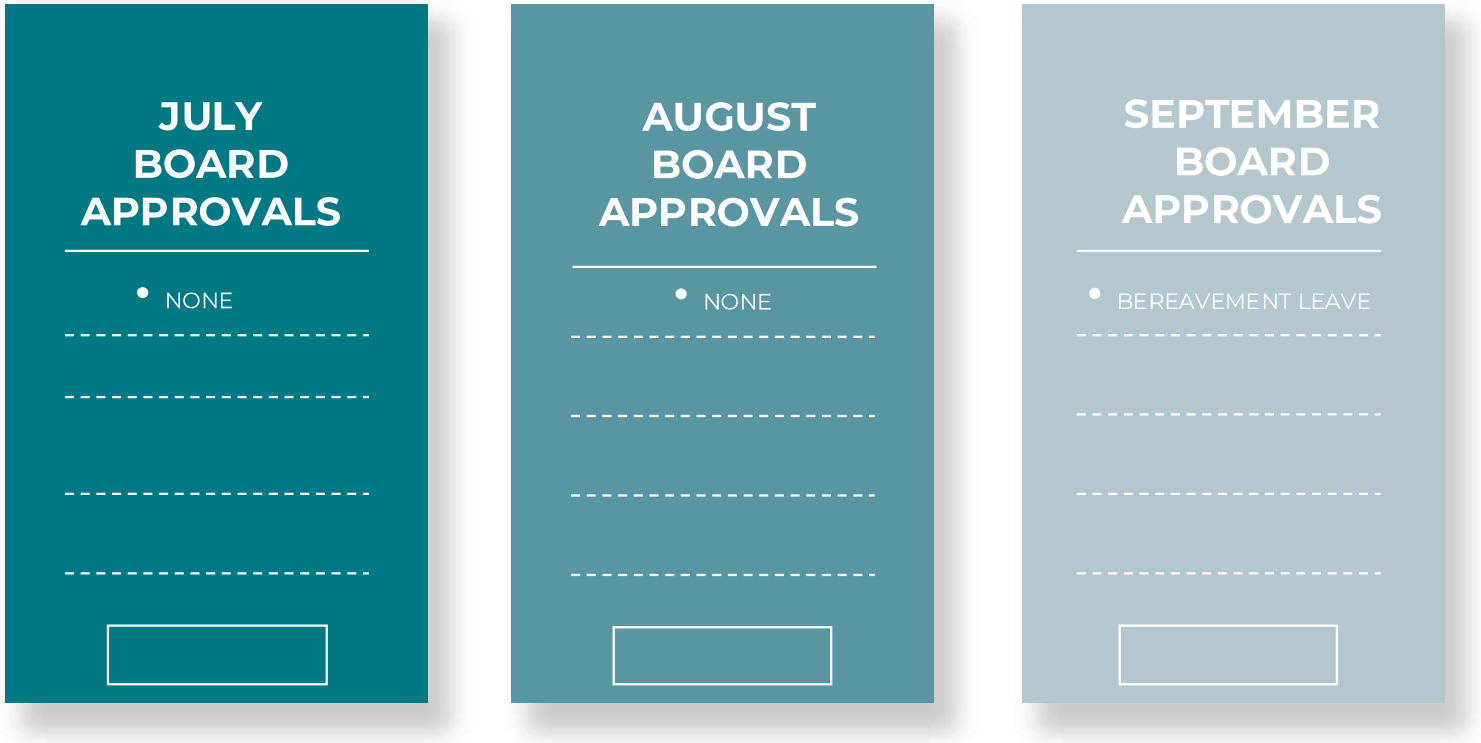
Benefits Conversational Report

* Always a QTR behind

HR POLICY REVIEW

Infographic

HR Policies



REGULATORY COMPLIANCE AUDIT UPDATES

Regulatory Audits/Internal Audits

Below is a glimpse into our department's participation in regulatory surveys along with Internal Audits to ensure data is accurate.

INTERNAL AUDITS CONDUCTED

- Job Pay Grade
- Variance from Pay Grade
- Users Roles

REGULATORY SURVEYS CONDUCTED

- ZERO this quarter

Regulatory Compliance

214
License and Certification Renewals Processed

62
Employment Verifications

236
Evaluations Processed

132
Employee Change Notices

HR PROJECT UPDATES

HRIS Project Update

- **Performance Management**
  - Kickoff Call scheduled for Jan 2025
- **ACA Hours Integration**

  Interface file complete, pending validation

Report Requests – Q4

19

Total Report Requests

7

Total analyses

12

Total staff support reports

HR KEY ACCOMPLISHMENTS

- Implemented internal control for rate entries
- UKG Secondary Job Process
- Completion of Physician Resident Salary Administration
- Created Form stack for LCSW Agreement
- Supported Organization Restructure
- Developed New Exit Interview Process

SIERRA VIEW MEDICAL CENTER

EMERGENCY DEPARTMENT
PATIENT CALL-BACK SHEET

Patient's Name: _____ Date of Service: _____

ED Physician: _____ Medical Record Number: _____

Nurse Completing Form: _____

REASON FOR CALL-BACK: _____ Date Delivered to ED Physician: _____

_____

Necessary Action:

____ Class I variant: no action
____ Class II variant: contact only, no change in treatment plan
____ Class III variant: change in treatment plan, make every attempt to contact patient

Explanation of Call-Back to patient: _____

Direct contact should be made by: Telephone Letter Authorities
(circle all that apply)

_____
MD's Signature/Review Date/Time

Documentation of Call-Back:

Contacted by	Date/Time	Person Contacted	Action	Nurse's Signature
Phone				
Letter				
Authorities				

- *Phone calls must be made directly to patient, parent, or care provider. If direct contact is not made then a letter is to be immediately sent*
- *After one week without response to a letter have the ED physician re-evaluate the case?*

Comments: _____

_____

_____

_____

_____
Nurse's Signature/Date/Time

Re-evaluation Comment:

_____
MD's Signature/Date/Time

HEALTH PLAN CONTRACTS

This hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the financial office. All physicians and surgeons, including the radiologist, pathologist, emergency physicians, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if the hospital or the physicians providing services to me contract with my health plan.

I certifiy that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

ASSIGNMENT OF INSURANCE BENEFITS

I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable to this hospitalization or for these outpatient services. I agree that the insurer or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this hospital to perfect, confirm, or validate this assignment.

Patient Initials:_____

FINANCIAL AGREEMENT

I agree to promptly pay all hospital bills in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. I understand that I may review the hospital's charge description master before (or after) I receive services from the hospital. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. If any account is referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless probibited by law.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Patient Initials:_____

Signature of patient/parent/Legal Representative	*Date/Time*	*Print Name*
If Signed by someone other than the patient, indicate relationship		
Hospital Representative	*Date/Time*	*Print Name*
Hospital Representative	*Date/Time*	*Print Name*

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above.

Signature of Financially Responisble Party *Date/Time* *Print Name*

Address

Phone Number (xxx-xxx-xxxx)

Hospital Representative *Date/Time* *Print Name*

INTERPRETER'S STATEMENT

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

Signature of interpreter, or remote interpreter's number *Date/Time*

Print Name

❑ Declined copy of form:_____
Initials

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

FINANCIAL AGREEMENT

Form # 015682 REV 1/25

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

PATIENT'S LABEL

CONTRATOS DE PLAN DE SEGURO MÉDICO

Este hospital mantiene una lista de planes de seguro médico con los cuales tiene contratos. Una lista de dichos planes está disponible a solicitud en la oficina de finanzas. Todos los médicos y cirujanos, incluyendo el radiólogo, el patólogo, los médicos de urgencias, el anestesiólogo, y otros facturarán por separado por sus servicios. Es mi responsabilidad determinar si el hospital o los médicos que me proporcionan los servicios tienen un contrato con mi plan de seguro médico.

Yo certifico que he leído lo anterior y que he recibido una copia del mismo. Yo soy el paciente, el representante legal del paciente, o de alguna otra manera estoy autorizado por el paciente para firmar lo anterior y aceptar sus términos en su nombre.

CESIÓN DE LOS BENEFICIOS DEL SEGURO

Yo cedo y transfiero irrevocablemente al hospital todos los derechos, beneficios y cualesquiera otros intereses con respecto a cualquier plan de seguro, plan de beneficios de salud, o alguna otra fuente de pago por mi atención. Esta cesión incluye ceder y autorizar el pago directo al hospital de todos mis beneficios del plan de seguro y plan de beneficios de salud pagaderos por esta hospitalización o por estos servicios de paciente ambulatorio. Yo estoy de acuerdo con que el pago de la aseguradora o del plan al hospital de conformidad con esta autorización dará cumplimiento a sus obligaciones en la medida de dicho pago. Yo entiendo que soy responsable financieramente por los cargos no pagados de conformidad con esta cesión, en la medida permitida por la ley estatal y federal. Acepto cooperar con, y tomar todas las medidas solicitadas razonablemente por este hospital para perfeccionar, confirmar o validar esta cesión.

Iniciales del Paciente:_____

CONVENIO FINANCIERO

Yo convengo en pagar puntualmente todas las facturas del hospital de conformidad con los cargos anotados en el documento maestro de descripción de los cargos del hospital y, si procede, las políticas de pago por asistencia caritativa y de descuento del hospital y la ley estatal y federal. Yo entiendo que puedo examinar el documento maestro de descripción de cargos del hospital antes (o después) de recibir los servicios del hospital. Yo entiendo que todos los médicos y cirujanos, incluyendo el radiólogo, el patólogo, el médico de urgencias, el anestesiólogo y otros me facturarán por separado por sus servicios. Si alguna factura es canalizada a un abogado o agencia de cobranzas para su cobro, yo pagaré los honorarios reales del abogado y los gastos de cobranza. Todas las facturas no pagadas acumularán intereses a la tasa legal, a menos que lo prohíba la ley.

La Sección 1785.27 del Código Civil prohíbe al titular de este contrato de deuda médica proporcionar cualquier información relacionada con esta deuda a una agencia de informes crediticios del consumidor. Además de cualquier otra sanción permitida por la ley, si una persona viola a sabiendas esa sección al proporcionar información sobre esta deuda a una agencia de informes crediticios del consumidor, la deuda será nula e inaplicable.

Iniciales del Paciente:_____

Firma del paciente/padre/Representante Legal	Fecha/Hora	Nombre en letra de molde
Si es firmado por alguien que no sea el paciente, indique la relación		
Hospital Representative	Date/Time	Print Name
Hospital Representative	Date/Time	Print Name

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

FINANCIAL AGREEMENT

Form # 016903 REV 1/25

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

PATIENT'S LABEL

CONVENIO DE RESPONSABILIDAD FINANCIERA POR PARTE DE UNA PERSONA QUE NO SEA EL PACIENTE O EL REPRESENTANTE LEGAL DEL PACIENTE

Estoy de acuerdo en aceptar la responsabilidad financiera por los servicios prestados al paciente y en aceptar los términos del Convenio Financiero, la Cesión de los Beneficios del Seguro, y las disposiciones anteriores respecto a la Obligación del Plan de Salud.

Firma de la parte financieramente responsable Fecha/Hora Nombre en letra de molde

Dirección

Número Telefónico (xxx-xxx-xxxx)

Hospital Representative Date/Time Print Name

INTERPRETER'S STATEMENT

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

Signature of interpreter, or remote interpreter's number Date/Time

Print Name

❑ Declined copy of form:_____
Initials

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

FINANCIAL AGREEMENT

Form # 016903 REV 1/25

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

PATIENT'S LABEL

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MEDICAL EXECUTIVE COMMITTEE	02/05/2025
BOARD OF DIRECTORS APPROVAL	
	02/25/2025
LIBERTY LOMELI, PA-C, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
February 25, 2025 BOARD APPROVAL

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

		Pages	Action
I.	**Policies**:		**APPROVE**
	• 340B Drug Pricing Program Compliance	1-34	
	• Continued Stay Review	35-36	
	• Formula Dating and Storage	37	
	• Insurance Reviews	38-39	
	• MRI Safety	40-43	
	• Pediatric Admission Guidelines and Procedures	44-49	
	• Sequential Ultrafiltration (SUF) – Acute Renal Services	50	
	• Thrombolytic Therapy in Acute Ischemic Stroke	51-61	
	• V.A.C. Therapy Negative Pressure Wound	62-71	
	• Weight Variance – DP/SNF	72-74	

SIERRA VIEW
MEDICAL CENTER

340B Policy and Procedure Manual

Revision History:	1.0
Effective Date:	10/18/2024
Last Reviewed:	
Last Revision:	

Table of Contents

Purpose: This manual contains the written policies and procedures that Sierra View Medical Center uses to oversee 340B Program operations, provide oversight of contract pharmacies, and maintain a compliant 340B Program.

Policy 340B.00

- Purpose
- Background
- 340B Policy Statements
- Definitions
- References
- Policy Review, Updates, and Approval

Procedures

- Procedure 340B.01 - Covered Entity Eligibility
- Procedure 340B.02 - 340B Program Enrollment Recertification, and Change Requests
- Procedure 340B.03 - 340B Eligibility (Including Patient and Health Care Professional Definitions)Patient Eligibility/Definition
- Procedure 340B.04 - Prevention of Duplicate Discounts
- Procedure 340B.05 - 340B Program Roles and Responsibilities
- Procedure 340B.06 - 340B Program Education and Competency
- Procedure 340B.07 - Inventory Management
- Procedure 340B.08 - Contract Pharmacy Operations
- Procedure 340B.09 - Referral Process
- Procedure 340B.10 - 340B Noncompliance/ Material Breach
- Procedure 340B.11 - 340B Program Compliance Monitoring/Reporting
- Procedure 340B.12 - Contract Pharmacy Oversight and Monitoring
- Procedure 340B.13 - Prime Vendor Program (PVP) Enrollment and Updates
- Procedure 340B.14 - State of Emergency Management

340B Policy

340B.00 – Policy Statements

Purpose: This document defines policies that Sierra View Medical Center uses to oversee 340B Program operations, provide oversight of contract pharmacies, and maintain a compliant 340B Program.

Background: Section 340B of the Public Health Service Act (1992) requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services. This agreement limits the price that manufacturers may charge certain covered entities for covered outpatient drugs.

The 340B Program is administered by the Federal Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (DHHS). Upon registration on 340B OPAIS (Office of Pharmacy Affairs Information System), the hospital:

- Agrees to abide by specific statutory requirements and prohibitions.
- May access 340B drugs.

340B Policy Statements

- The hospital complies with all requirements and restrictions of Section 340B of the Public Health Service Act including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity. (REFERENCE: Public Law 102-585, Section 602, 340B Guidelines, 340B Policy Releases).
- The hospital uses any savings generated from 340B in accordance with 340B Program intent, "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." It is the intent of the hospital to use 340B savings for charity care.
- The hospital meets the requirements of 42 USC §256b(a)(4)(L) to be eligible for enrollment in, and the purchase of drugs through, the 340B Program.
- Per the Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility, 340B drugs are to be provided only to individuals eligible to receive 340B drugs from covered entities.
- The hospital has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.
    - It is the policy of the hospital to maintain the ability to track and account for all 340B drugs to prevent diversion or duplicate discounts. This oversight includes the acquisition, administration, dispensation, and waste of all 340B medications.
    - The hospital remains responsible for ensuring that its contract pharmacy operations comply with all 340B Program requirements, such that the covered entity remains responsible for the 340B drugs it purchases and dispenses through a contract pharmacy. The hospital ensures oversight of their contract pharmacy arrangements compliance.
    - 42 USC §256b(a)(5)(A)(i) prohibits duplicate discounts; that is, manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. The hospital has mechanisms in place to prevent duplicate discounts.
- The hospital deems certain referral prescriptions eligible for the 340B program. Patients seeing a physician outside of the hospital are eligible to receive medications from the 340B stock, if sufficient

documentation to support 340B eligibility based on HRSA's patient definition is present within the medical records.

- The hospital has processes in place to maintain compliance with all 340B requirements, including during states of emergency.
- The hospital maintains auditable records demonstrating compliance with the 340B Program.
  - Annually, the hospital engages an independent organization to perform external compliance reviews (audits) of its 340B Program, including contract pharmacies.
  - Documents and records associated with the hospital's participation in the 340B Drug Pricing Program are to be kept for three (3) years.
- The hospital acknowledges that if there is a breach of the 340B requirements, it may be liable to the manufacturer of the covered outpatient drug that is the subject of the violation. Depending upon the circumstances, the hospital may be subject to the payment of interest, reimbursement, penalties, and removal from the list of 340B entities. The hospital is responsible for contacting HRSA as soon as reasonably possible if there is any material breach by the covered entity or any instance of noncompliance with any of the 340B Program requirements.

Definitions:

I. Definitions of terms may be found in the Apexus 340B Glossary of Terms.
II. Acronym guide may be found in the Apexus Acronym Guide.

References: Each section includes other references to P&Ps, HRSA website, etc.

Policy Review, Updates, and Approval: These written policies and procedures will be reviewed and approved annually by Sierra View Medical Center 340B Oversight Committee and Board of Directors and updated whenever there is a clarification or change to the 340B Program requirements.

340B Procedure Manual

340B.01 - Covered Entity Eligibility

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: The hospital must meet the requirements of 42 USC §256b(a)(4)(L) to be eligible for enrollment in, and the purchase of drugs through, the 340B Program.

PURPOSE: To ensure the hospital's eligibility to participate in the 340B Program.

DEFINITIONS:

- Covered outpatient drug (COPD) as defined in Section 1927(k) of the Social Security Act:
  - Includes all prescription medications where the manufacturer has a pharmaceutical pricing agreement (PPA) in place including over-the-counter medications that are ordered by prescription
  - Includes biologic products, other than vaccines
  - Includes insulin medications

PROCEDURE:

1. The hospital's basis for 340B eligibility is determined by the following:
   Is owned or operated by a unit of state or local government.
   340B ID: DSH050261
2. The hospital has a disproportionate share adjustment percentage greater than 11.75%.
   - Worksheet E Part A, line 33 of most recently filed Medicare Cost Report
3. The hospital does not obtain covered outpatient drugs through a group purchasing organization (GPO) or other group purchasing arrangement, except in accordance with GPO Policy Release.

   a. Covered entities should maintain auditable records, policies, and procedures related to the definition of covered outpatient drug and the use of a GPO that is consistent with the 340B statute and Social Security Act.
   b. Define covered outpatient drugs based on section 1927(k) of the Social Security Act.

      i. Exceptions to a listed covered outpatient drug (as defined in the Medicaid rebate statute) can be made if the drug is part of a bundled charge or incident to another service. Outpatient purchases may be made on a group purchasing organization (GPO) account for drugs that do not meet the definition of a covered outpatient drug.

         - The drug is "part of" or "incident to" a service
         - The drug is given in the same setting as the service
         - The drug is paid as part of the service

      ii. Any drug that is given to or administered to an ambulatory patient that is billed separately with the intention of getting paid, shall be considered a covered outpatient drug.

iii. Contrast Media, IV solutions, and anesthesia gases are considered "part of" or "incident to" a service and billed without the intention of getting paid above and beyond the service. These drugs and IV solutions shall be considered an exception, and not a covered outpatient drug.

iv. These drugs, along with potassium fluids, tuberculosis skin test solutions, and vaccines shall be flagged in the accumulators for the mixed-use hospital sites, allowing for ambulance and inpatient purchases to be made on the sites' GPO account.

c. The hospital maintains a non-GPO/wholesaler acquisition cost (WAC) account(s).
d. The hospital has tracking systems and safeguards in place to prevent GPO violations.
   - Established 340B/GPO/WAC accounts, split-billing software with Macro Helix

4. The hospital has identified locations where it dispenses or prescribes 340B drugs:
   - Within the four walls of the parent entity.

   and/or

   - Within off-site outpatient locations that are fully integrated into the hospital, reimbursable on the most recently filed Medicare Cost Report, and registered on 340B OPAIS.
5. The hospital ensures that 340B OPAIS is complete, accurate, and correct for all 340B eligible locations (including the parent entity, off-site locations, and contract pharmacies). [Refer to the hospital's Policy and Procedure "340B Program Enrollment, Recertification, and Change Request", 340B Manual, Policy 340B.02].
   - All main/child site addresses, billing and shipping addresses, the authorizing official, and the primary contact information are correct and up to date.
   - The hospital regularly reviews its 340B OPAIS records [Refer to the hospital's Policy and Procedure "340B Program Compliance Monitoring and Reporting", 340B Manual, Policy 340B.11].
   - The hospital informs HRSA immediately of any changes to its Medicaid information by updating the 340B OPAIS Medicaid Exclusion File within 30 days. The data included in the Medicaid Exclusion File is provided by covered entities for drugs billed under Medicaid fee-for-service and does not apply to Medicaid managed care organizations.
   - The hospital carves-in Medicaid reimbursement for eligible contract pharmacies.
6. The hospital annually recertifies 340B registration information on 340B OPAIS. [Refer to the hospital's Policy and Procedure "340B Program Enrollment, Recertification, and Change Request", 340B Manual, Policy 340B.02].
7. The hospital will notify HRSA immediately of any changes to the hospital's Medicare disproportionate share adjustment percentage resulting in a disproportionate share percentage less than 11.75%. [Refer to the hospital's Policy and Procedure "340B Program Enrollment, Recertification, and Change Request", 340B Manual, Policy 340B.02

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340B.02 - Program Enrollment, Recertification, and Change Requests

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: Eligible entities must maintain the accuracy of 340B OPAIS and be actively registered to participate in the 340B Program.

PURPOSE: To ensure that the hospital is registered appropriately on 340B OPAIS and maintains accurate records.

References:

- 340B Drug Pricing Program: Grantee Registration Instructions at HRSA OPA Registration
- Registration dates may vary slightly per weekends, holidays, etc.:
  - January 1–January 15 for an effective start date of April 1
  - April 1–April 15 for an effective start date of July 1
  - July 1–July 15 for an effective start date of October 1
  - October 1–October 15 for an effective start date of January 1
- 340B Contract Pharmacy Guidelines

PROCEDURE:

- **Enrollment**
  - The hospital is eligible to participate in the 340B Program [Refer to the hospital's Policy and Procedure "Covered Entity Eligibility", 340B Manual, Policy 340B.01].
  - The hospital identifies upcoming OPAIS registration dates and deadlines.
  - The hospital identifies the hospital's authorizing official and primary contact.
  - The hospital has available the required documents/contracts.
    - Medicare Cost Report:
    - Worksheet S, S-2, S-3
    - Worksheet E, part A
    - For outpatient facilities:
      - Worksheet C
      - Worksheet A
      - Working trial balance
    - Certification of ownership status
  - The hospital completes registration on 340B OPAIS.

- **Recertification Procedure**
  - The hospital annually recertifies the hospital's information on 340B OPAIS.
  - The hospital's Authorizing Official completes the annual recertification by following the directions in the recertification email sent from HRSA prior to the stated deadline.
  - The hospital annually recertifies the following information on the HRSA's 340B Database:
    - The authorizing official, along with the primary contact, must perform this procedure at least annually. This should also be done whenever there is a change in site location.

- HRSA / OPA will send an advanced email notification with preliminary information about the recertification process to the primary contact and authorizing official listed on the HRSA Database.
- As part of the recertification process, the hospital verifies and attests to the accuracy of all information they have listed on 340B OPAIS. This process includes verifying and correcting where needed:
    - Medicaid billing practice information: If the site bills Medicaid for drugs purchased through the 340B Program, the Medicaid numbers, NPI numbers, and states listed on OPAIS must match the billing numbers used by the site.
    - Contract pharmacy agreements include all registered locations. Contract pharmacies should be listed with, at minimum, one location. If they are listed with one location, they may be used by any of the child sites registered on the database, unless otherwise restricted in the contract agreement.
    - Ancillary information including authorizing official, primary contact, billing, and shipping addresses, etc.
- Failure to recertify would result in termination from the 340B Program. The covered entity would not be able to reapply for participation in the program until the next open enrollment period with a start date of the following quarter.
- The hospital submits specific recertification questions to 340b.recertification@hrsa.gov.

- **Enrollment Procedure: New Outpatient Facilities**
    - The hospital determines that a new outpatient service or facility is eligible to participate in the 340B Program.
    - The criteria used include that the outpatient service is fully integrated into the hospital, appears as a reimbursable service or clinic on the most recently filed Cost Report, has outpatient drug use, and has patients who meet the 340B patient definition.
    - The hospital's authorizing official completes the online registration process in 340B OPAIS during the registration window.
        - The hospital will submit any updated Medicare Cost Report Information, as required by HRSA.

- **Enrollment Procedure: New Contract Pharmacies**
    - The hospital has a signed contract pharmacy services agreement between the entity and contract pharmacy prior to registration on 340B OPAIS.
    - Notice Regarding 340B Drug Pricing Program—Contract Pharmacy Services
    - The hospital's legal counsel has reviewed the contract and verified that all federal, state, and local requirements have been met.
    - The hospital has contract pharmacy oversight and monitoring policy and procedure developed, approved, and implemented. [Refer to the hospital's Policy and Procedure "Contract Pharmacy Oversight Management and Monitoring", 340B Manual, Policy 340B.12]
    - The hospital's authorizing official or designee completes the online registration during one of four registration windows.

- Within 15 days from the date of the online registration, the authorizing official certifies online that the contract pharmacy registration request was completed.
- The hospital begins using the contract pharmacy services arrangement only on or after the effective date shown on 340B OPAIS.

- **Procedure for Changes to the Hospital's Information in 340B OPAIS**
  - The hospital notifies HRSA immediately of any changes to the hospital's Medicare disproportionate share adjustment percentage resulting in a disproportionate share percentage ≤ 11.75%.
    - The hospital will stop the purchase of 340B drugs as soon as the hospital files its cost report with a disproportionate share percentage ≤ 11.75%. [Refer to the hospital's Policy and Procedure "Covered Entity Eligibility", 340B Manual, Policy 340B.01].
  - The hospital's authorizing official will complete the online change request as soon as a change in eligibility is identified.
    - The hospital will expect changes to be reflected within two weeks of submission of the changes/requests.
  - The hospital will notify HRSA immediately of any changes to the hospital's information on 340B OPAIS. [Refer to the hospital's Policy and Procedure "Covered Entity Eligibility", 340B Manual, Policy 340B.01].
  - The hospital's authorizing official will complete the online change request as soon as a change in eligibility is identified.
    - The hospital will expect changes to be reflected within about 2 weeks of submission of the changes/requests.

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340B.03 – 340B Patient and Provider Eligibility

(Including Patient and Health Care Professional Definitions)

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: Per 340B statutory provision "Prohibiting resale of drugs." 42 U.S.C. § 256b(a)(5)(B).the Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility, a covered entity shall not resell or otherwise transfer the drug to a person who is not a patient of the entity." 340B drugs are to be provided only to individuals eligible to receive 340B drugs from covered entities.

PURPOSE: The hospital ensures that 340B drugs are dispensed/administered/prescribed only to eligible patients of the entity.

DEFINITIONS:

Administer: Give medication to an individual, typically in a clinic, based on a health care provider's order.

Dispense: Provide medication, typically in clinic, based on a health care provider's order to be administered to a patient.

Inpatient status: An individual who has received health care services in-person in the hospital facility from a health care professional employed by or contracted with the covered entity and remained in the facility and has been registered into an inpatient status

Outpatient status: All patients seen at the hospital for ambulatory care.

Prescribe: Provide a prescription for a medication to an individual to be filled at an outpatient pharmacy.

ELIGIBILITY:

Patient

- To be considered a patient of the covered entity, i.e. 340B eligible, the patient must have a documented encounter, either face-to face or via telemedicine with a health care professional employed by or contracted with the hospital within the past two years.
  - To be 340B eligible the patient is outpatient when the medication is dispensed/administered.

Health Care Professional

- The hospital determines provider eligibility.
  - A health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity.
    - The hospital defines health care professionals to include physicians, physician assistants, nurse practitioners, pharmacists, dentists, optometrists, chiropractors, registered nurses, and other professionals licensed to provide healthcare.

- The eligible provider list, updated monthly, is uploaded into the EHR (electronic health record), pharmacy operating system, 340B split-billing software, and other software providers or vendors as appropriate.
- It is the policy of the hospital to deem certain referral prescriptions eligible for the 340B program. Patients seeing a physician outside of the hospital are eligible to receive medications from the 340B stock, as long as sufficient documentation to support 340B eligibility based statutory requirement for 340B eligibility of a person is that the person be a patient of a covered entity, as clearly stated in 42 U.S.C is present within the medical records. [Refer to the hospital's Policy and Procedure "Referral Process" 340B Manual, Procedure 340B.09]

Health Care Records

- The hospital maintains records of individual's health care. Patient health records are defined by the hospital to include all electronic health record (EHR) systems, including traditional EHR systems, shared medical records, and cloud-based portals.
  - Primary EHR: Meditech
- The hospital has processes in place to determine patient's Medicaid status [Refer to the hospital's Policy and Procedure "Prevention of Duplicate Discounts" 340B Manual, 340B.04].

POLICY

PROCEDURE RATIONALE:

HRSA 1996 Patient Definition Considerations *Note: Covered entities need to ensure that the following 340B eligibility determination filters are implemented:*

- The hospital validates site eligibility.
  - Refer to the hospital's Policy and Procedure "Covered Entity Eligibility" [340B Manual, Policy 340B.01].
  - The hospital determines patient eligibility. Per HRSA 1996 Patient Definition Guidance (FR Doc. 96–27344 October 24, 1996), an individual is a "patient" of a covered entity only if:
    - The covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual's health care; AND
    - The individual receives health care services, *(in-person or via telehealth, (emphasis added)* from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity; AND

- The individual receives a health care service or range of services from the covered entity which is consistent with the hospital scope grant of services.
- An individual will not be considered a "patient" of the entity for purposes of 340B if the only health care service received by the individual from the covered entity is the dispensing of a drug or drugs for subsequent self-administration or administration in the home setting.
- The EHR keeps record, in real time, of when a patient is considered in outpatient status, admitted into inpatient status, discharged and/or transferred.

- **Genesis Health Care Vs Becerra Summary Judgement Policy Considerations 2023 Update**

Per the Genesis Summary Judgement:

- "The only statutory requirement for 340B eligibility of a person is that the person be a patient of a covered entity, as clearly stated in 42 U.S.C. § 256b(a)(5)(B)."
- "The statute does require an ongoing patient relationship between the individual and the "covered entity."
- "The plain wording of the 340B statute does not require the 'covered entity' to have initiated the healthcare service resulting in the prescription."
- "Nothing in the statute conditions an individual's eligibility as a 340B patient on whether the health care service resulting in the prescription was initiated by the "covered entity."
- HRSA does have the authority to implement its interpretation of the statutory term Patient.
- HRSA's interpretation of the term "patient" must be consistent with the plain language of the statute and the intent of Congress.
    - Example: Patient: "an individual awaiting or under medical care and treatment." https://www.merriam-webster.com/dictionary/patient
    - Genesis Summary Judgement also references the American Medical Association's definition of an established patient to be an individual who has received a health care service from a physician or other qualified health care professional within the last three years. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
- While the 1996 Patient Definition guidance does not dictate time-period or look-back period during which the "patient" must have had a health care encounter with the "covered entity", HRSA expects CEs to define an appropriate time-period based on care delivery standards and other pertinent State or Federal regulations.
- The 1996 Patient Definition guidance does not condition 340B eligibility on whether a particular outpatient prescription originated from the "covered entity" or was otherwise initiated by the "covered entity."

    - The judge ruled that, contrary to HRSA's assertion, in order for an individual to qualify as a 340B patient, the CE is not required to have initiated the healthcare service resulting in the prescription, and statutory patient definition may be created if the individual had an unrelated Sierra View Medical Center encounter.
  - The plain text of the 340B statute does not require the origination of a prescription from the CE in order for an individual to be an eligible 340B patient, nor does the statute place any requirement that the 340B prescription be initiated from a "covered entity" or contract provider for that "covered entity" to be eligible.
    - "The Court agrees that the **statute does require an ongoing patient relationship between the individual and the "covered entity**." Pg 21/31
- To be considered 340B eligible, the patient must have a documented encounter (visit) face-to face with a health care professional employed by or contracted with the hospital within the past two years.
  - Patient is outpatient when the medication is dispensed/administered.
- The hospital determines provider eligibility.
  - A health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity.
    - The hospital defines health care professionals to include physicians, physician assistants, nurse practitioners, pharmacists, dentists, optometrists, chiropractors, registered nurses, and other professionals licensed to provide healthcare.
    - The eligible provider list (updated monthly) is uploaded into the EHR (electronic health record), pharmacy operating system, 340B split-billing software, and other software providers or vendors as appropriate.

It is the policy of the hospital to deem certain referral prescriptions eligible for the 340B program. Patients seeing a physician outside of the hospital are eligible to receive medications from the 340B stock, as long as sufficient documentation to support 340B eligibility based on HRSA's patient definition is present within the medical records. [Refer to the hospital's Policy and Procedure "Referral Process" 340B Manual, Procedure 340B.09]

- The hospital maintains records of individual's health care. Patient health records are defined by the hospital to include all electronic health record (EHR) systems, including traditional EHR systems, shared medical records, and cloud-based portals.
  - Primary EHR: Meditech
- The hospital has processes in place to determine patient's Medicaid status [Refer to the hospital's Policy and Procedure "Prevention of Duplicate Discounts" 340B Manual, 340B.04].

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340B.04 – Prevention of Medicaid Duplicate Discounts

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: 42 USC §256b(a)(5)(A)(i) prohibits duplicate discounts; that is, manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must have mechanisms in place to prevent duplicate discounts.

PURPOSE: To ensure that the hospital is preventing duplicate discounts.

REFERENCES

Guidance for 340B Drug Claim Submissions:

- In order to prevent the "duplicate discount", providers must include the appropriate code on the claim. Physician Administered Drug claims require a "UD" modifier. Pharmacy claims need to have a "08" in the Basis of Cost Determination field. Both the "UD" modifier and the "08" inform DHCS that a 340B purchased drug was used for the claim. Our rebate system removes the claims from the drug manufacturers rebate invoice ensuring that the drug manufacturer is not subject to the "duplicate discount". *Reference:* Medi-Cal Drug Rebate FAQs

PROCEDURE:

- The hospital complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity.
- It is the policy of the hospital to not resell, or otherwise transfer, 340B drugs to ineligible patients by adhering to 340B requirements. The hospital will not dispense 340B medications to any person that does not meet the hospital's patient definition.
- The 340B statute prohibits manufacturers from being subject to providing a discounted 340B price and a Medicaid drug rebate for the same drug, i.e., duplicate discounts. The hospital has mechanisms in place to prevent duplicate discounts for both Medicaid Fee-For-Service (FFs) and Medicaid Managed Care (MCO) claims. The hospital ensures that drugs purchased under the 340B Program are not subject to a rebate claim by the state Medicaid agency. The hospital works closely with State Medicaid agencies to prevent duplicate discounts for Medicaid FFS and MCO claims.
- **Clinic Administered Drugs**
  - **Medicaid Fee For Service (FFS) and Medicaid MCO Carve-In:** The hospital has elected to purchase drugs for its Medicaid patients through 340B (carve-in) and complies with all State and Federal billing requirements to prevent duplicate discounts from occurring.
    - For Medicaid FFS patients and Medicaid Managed Care (MCO) patients, the hospital provides and bills 340B drugs, including the required claims modifiers.
    - The hospital has answered "yes" to the question, "Will the covered entity dispense 340B purchased drugs to Medicaid patients AND subsequently bill Medicaid for those dispensed 340B drugs?" on 340B OPAIS and has listed all applicable Medicaid billing numbers and/or NPI on 340B OPAIS and the MEF.

- Physician Administered Drug claims require a "UD" modifier. Pharmacy claims need to have a "08" in the Basis of Cost Determination field. Both the "UD" modifier and the "08" inform DHCS (California Department of Health Care Services) that a 340B purchased drug was used for the claim.

- **Contract Pharmacies**
  - Contract Pharmacies are required to carve-out for fee for service Medicaid, unless the covered entity, the contract pharmacy and the State Medicaid agency have established an arrangement to prevent duplicate discounts. Any such arrangement shall be reported to OPA by the hospital.
    - The hospital's contract pharmacies will carve-in Medicaid FFS.
    - The state of California processes all retail pharmacy claims through Medi-Cal Rx (Fee-For-Service). 340B Medicaid Profiles by State/Territory (340bpvp.com)

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340B.05 – Program Stakeholders Roles and Responsibilities

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: Covered entities participating in the 340B Program must ensure program integrity and compliance with 340B Program requirements.

PURPOSE: To identify the hospital's key stakeholders and determine their roles and responsibilities in maintaining 340B Program integrity and compliance.

PROCEDURE:

- 340B Oversight Committee: The hospital's key stakeholders comprise the 340B Oversight Committee and their roles and responsibilities involved with the hospital's 340B Program are:
  - Chief Executive Officer (CEO)
    - Assists the hospital with patient matters related 340B access and usage of savings
  - Chief Financial Officer (CFO)
    - Potentially responsible for attesting to the compliance of the program through recertification
  - 340B Program Coordinator – Committee Sponsor
    - Accountable agent for 340B compliance
    - Responsible as the primary contact for the 340B Program
    - Agent of the CEO responsible to administer the 340B Program to fully implement and optimize appropriate savings and ensure that current policy statements and procedures are in place to maintain program compliance
    - Maintain knowledge of the policy changes that affect the 340B Program, including, but not limited to, HRSA rules and Medicaid changes
    - Monitor any changes in clinic eligibility/information
    - Responsible for maintenance and testing of tracking software
  - Director of Pharmacy
    - Responsible for establishing three distribution accounts and maintaining those accounts: non-GPO account, 340B account and GPO account
    - Maintains system databases to reflect changes in the drug formulary or product specifications
    - Manages purchasing, receiving, and inventory control processes
    - Ensures appropriate safeguards and system integrity
    - Ensures compliance with 340B Program requirements for qualified patients, drugs, providers, vendors, payers, and locations
  - Pharmacy Buyer
    - Monitors ordering processes, integrating most current pricing from wholesaler, and analyzes invoices, shipping, and inventory processes
    - Reviews and refines 340B cost savings report, detailing purchasing, and replacement practices as well as dispensing patterns
  - Corporate Compliance Officer
    - Shall be responsible for overseeing compliance with this policy

- VP Professional Services
  - Responsible as the authorizing official in charge for the compliance and administration of the program
  - Responsible for attesting to the compliance of the program through recertification
  - Assists the hospital with 340B provider related matters
- Add IT/data feed employee
  - Responsible for process and access to data for compliant identification of outpatient utilization for eligible patients
- Patient Experience Officer
  - Assists the hospital with patient matters related 340B access and usage of savings

- The hospital's 340B Oversight Committee:
  - Meets quarterly on a regular basis.
  - Reviews 340B rules/regulations/guidelines to ensure consistent policies/procedures/oversight throughout the entity.
  - Identifies activities necessary to conduct comprehensive reviews of 340B compliance.
    - Ensure that the organization meets compliance requirements of program eligibility, patient definition, 340B drug diversion, and duplicate discounts via ongoing multidisciplinary teamwork.
    - Integrate departments such as information technology, legal, pharmacy, compliance, and patient financial services to develop standard processes for contract/data review to ensure program compliance.
  - Oversees the review process of compliance activities, as well as taking corrective actions based on findings.
    - 340B Oversight Committee assesses if the results are indicative of a material breach [Refer to the hospital's Policy and Procedure "340B Non-Compliance/Material Breach" 340B Manual, Policy 340B.10].
  - Reviews and approves work group recommendations (process changes, self-monitoring outcomes and resolutions).

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340B.06 –Program Education and Competency

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: Program integrity and compliance are the responsibility of all 340B key stakeholders. Ongoing education and training are needed to ensure that these 340B key stakeholders have the knowledge to guarantee compliant 340B operations.

PURPOSE: To establish 340B education and competency requirements for the hospital's 340B key stakeholders based on their roles and responsibilities in the 340B Program.

PROCEDURE:

- The hospital determines the knowledge and educational requirements for each 340B Program role (Refer to the hospital's Policy and Procedure "340B Program Stakeholder Roles and Responsibilities" 340B Manual, Policy 340B.05).
- Individuals requiring basic 340B knowledge will watch the Introduction to the 340B Drug Pricing Program upon hire and annually thereafter.
- 340B key stakeholders responsible for day-do-day program operation will complete 340B University OnDemand modules on the PVP website (https://www.340bpvp.com/340b-university) upon hire and annually thereafter.
- 340B key stakeholders responsible for day-to-day program operation may need to complete additional online or in-person training, attend webinars, etc., to stay up to date with 340B program changes.
- The hospital provides educational updates and training, as needed (e.g., 340B policy changes, updates in HRSA guidance).
- The hospital conducts annual verification of 340B Program competency for key stakeholders responsible for day-to-day program operation.
- The hospital conducts annual updates to the hospital employees or contracted employees to remain up to date in 340B program changes.
- Training and education records are maintained per organizational policy and available for review.

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340B.07 - Inventory Management

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: It is the policy of the hospital to maintain the ability to track and account for all 340B drugs to prevent diversion or duplicate discounts. This oversight includes the acquisition, administration, dispensation, and waste of all 340B medications.

PURPOSE: Ensure the proper procurement and inventory management of 340B drugs to maintain the ability to track and account for all 340B drugs to prevent diversion or duplicate discounts. This oversight includes the acquisition, administration, dispensation, and waste of all 340B medications.

BACKGROUND:

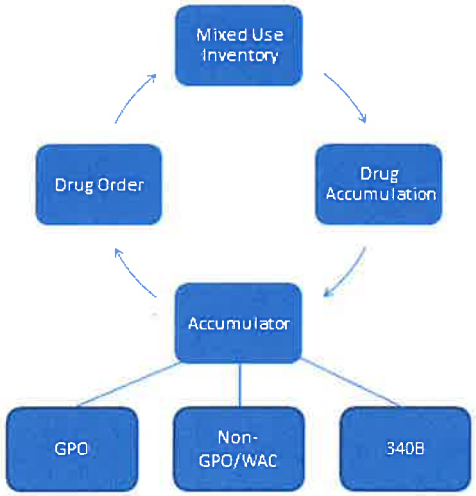
- 340B inventory may be procured and managed in the following settings:
  - Clinic site administration
  - Contract pharmacy
- All 340B stock is tracked on an 11-digit NDC level.
- Inventory methods for each of the above areas within the entity shall be described within the inventory management policy and procedures.
- The hospital may use the following inventory methods:
  - Physical 340B-only inventory
    - In-house pharmacy
  - Physically separated 340B and non-340B inventory
    - Clinic administered drugs
  - Virtual mixed-use replenishment inventory (i.e., neutral)
    - Contract pharmacy
  - Hybrid (physical and virtual) approach, stocking physically identifiable 340B inventory and maintaining a virtual mixed-use replenishment system
- Pharmacists, technicians, and clinicians dispense 340B drugs only to patients meeting all the criteria in the hospital's Policy and Procedure "Patient and Provider Eligibility" [340B Manual, Policy 340B.03].

PROCEDURE:

- Physical inventory (both 340B and non-340B drugs) is maintained at Sierra View Medical Center.
  - The hospital identifies all 340B and non-340B accounts used for purchasing drugs in each practice setting (parent site, off-site locations, in-house retail pharmacies, contract pharmacies).
  - The hospital separates 340B inventory from non-GPO/WAC inventory and/or (GPO, if appropriate). Entity specific process?
  - The hospital performs daily inventory reviews and shelf inspections of periodic automatic replenishment (PAR) levels to determine daily purchase order.
  - The hospital places 340B and non-340B drug orders.
  - The hospital receives shipment.

- The hospital verifies quantity received with quantity ordered.
  - Identifies any inaccuracies.
  - Resolves inaccuracies.
  - Documents resolution of inaccuracies.
- The hospital maintains records of 340B-related transactions for 3-year period of time in a readily retrievable and auditable format located [insert entity specifics here].
  - These reports are reviewed by the hospital quarterly as part of its 340B oversight and compliance program.

Mixed-use inventory replenishment system (340B/non-340B) is maintained at Sierra View



1. Identifies all accounts used for purchasing drugs in each practice setting (parent site, off-site locations, in-house retail pharmacies, contract pharmacies), for 340B, GPO, and non-340B/non-GPO (WAC).
2. Purchases mixed-use inventory (according to eligible accumulations).
3. Administers/dispenses drugs to patients.
4. Split-billing software accumulates drug utilization based on patient status, patient location and provider information. This accumulation occurs at the 11-digit NDC level and a full package size is accumulated before replenishment.

340B	Non-GPO/WAC	GPO
Patients met 340B patient definition and received services on an outpatient basis in a 340B registered/participating hospital clinic	Products that do not have an 11-digit NDC match on the 340B contract but are otherwise eligible for 340B purchase Products that currently are not available (e.g., drug shortages) such that an 11-digit NDC match is not available Non-340B eligible outpatients, e.g.: • Administration or dispensing occurred at a clinic within four walls of parent, but not 340B eligible • Non-patient of the CE seen at an entity owned retail pharmacy open to public • Medicaid carve-out outpatients • Lost charges or wasted product	GPO/Inpatient class of trade: Inpatient status determined by hospital at the date/time of administration GPO/Outpatient class of trade: Offsite/unregistered outpatient clinics

5. Replenishment drug order(s) are placed according to eligible accumulations.

- Split-billing operations manual: Marcro Helix: Helix Helper

Mixed-Use Pharmacy Replenishment Sample Standard Process:

Key points to address appropriate access to wholesaler accounts and split-billing software include:

- The names and types of pharmacy ordering accounts.
- The process the entity uses for determining how accumulations are identified as 340B eligible.
- The eligibility filters process for mapping, maintenance, and updating (location eligibility, health care record, patient status; provider eligibility, Medicaid carve-in/-out status).
- Basis for replenishment order (e.g., patient administration data to the 11-digit NDC); reporting elements (frequency).
- Plan for accurate data capture (e.g., time stamps, conversions from "pharmacy system units" to "split-billing units").
- NDC–CDM crosswalk updates.
- Hospital EHR–split-billing system interface; frequency of patient eligibility and order data updates; manual creation of purchase orders directly from manufacturer/incorporation of purchase data to the purchase history; PAR levels.
- Procedures for accumulation when there are lost charges, procedures for decrementing accumulation for manufacturer and wholesaler returns and unused returns to stock, 340B priced product is not available, or waste.
- Explanation of charge on dispensing vs. charge on administration and NDC match.

1. The hospital identifies all pharmacy purchasing accounts.
2. The hospital identifies which accounts are used for each 340B-eligible location to purchase 340B drugs.
3. The hospital places 340B, GPO, and WAC drug orders, based on orders created from the split-billing system. [Insert entity-specific process here].
    a. 340B drugs are ordered at an 11-digit NDC level.
    b. Appropriate processes are in place to ensure proper ordering, tracking, and adjusting of accumulators for controlled substances
    c. In some cases, direct 340B orders may be purchased after verification with split-billing software.
4. The hospital receives shipment.
5. The hospital verifies quantity received with quantity ordered.
    a. Identifies inaccuracies.
    b. Resolves inaccuracies.
    c. Documents resolution of inaccuracies.
6. The hospital documents manual manipulations to the 340B split-billing accumulator, including reason for manual manipulation. [Insert entity-specific process here].
7. The hospital staff reports significant discrepancies (excessive quantities based on utilization or product shortages) to the hospital management within 3 business days after verification of discrepancy.
8. The hospital maintains records of 340B-related transactions for a period of 3 years in a readily retrievable and auditable format in the accumulation details of split billing software and EHR system.

a. These reports are reviewed by the hospital quarterly as part of its 340B oversight and compliance program.

Wasted 340B medication

- The hospital pharmacy staff documents destroyed or wasted drug not administered to the patient.
- The hospital pharmacy staff communicates wastage to the Hospital PIC.
- The hospital pharmacy staff adjusts 340B accumulator.
- The hospital documents adjustment with reason.
- The hospital replaces medication through appropriate purchasing account.

Contract Pharmacy Processes

- The hospital has a written contract in place for each contract pharmacy location.
- The contract pharmacies of the hospital utilize virtual inventory models and do not hold 340B stock in the pharmacy.
- Processes are in place to ensure that only 340B eligible hospital patients receive 340B medications from the contract pharmacy.
- The contract pharmacies utilize their own retail stock to provide medications to the hospital's patients. Once confirmed that the dispensation is qualified for the hospital's 340B program, the hospital will replenish the pharmacy with 340B stock using a bill-to ship-to arrangement.
- Though the stock used to replenish the contracted pharmacy is 340B, it is replacing retail stock. Therefore, at the time of shipment, it converts to retail medication (i.e., neutral inventory).
- The hospital does not replenish contract pharmacy inventory until the 11-digit NDC accumulation reaches a full package size.
- The hospital, consultants, and third-party administrators all work together to track and confirm the accumulator counts.
- The hospital does not bill Medicaid Fee for Service (FFS) for 340B purchased drugs at contract pharmacies and therefore carves-out Medicaid FFS prescriptions from being qualified as 340B eligible.

340B Procedure Manual

340B.08 – Contract Pharmacy Operations

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: Covered entity remains responsible for ensuring that its contract pharmacy operations comply with all 340B Program requirements, such that the covered entity remains responsible for the 340B drugs it purchases and dispenses through a contract pharmacy.

PURPOSE: To ensure that the hospital remains responsible for all 340B drugs used by its contract pharmacies.

REFERENCE: Federal Register / Vol. 61, No. 165 / Friday, August 23, 1996 / Notices
https://www.gpo.gov/fdsys/pkg/FR-2010-03-05/pdf/2010-4755.pdf

BACKGROUND: The hospital has obtained sufficient information from the contract pharmacy contractor to ensure compliance with applicable policy and legal requirements. As a best practice, the signed contract pharmacy services agreements should address the 12-contract pharmacy essential compliance elements: https://www.gpo.gov/fdsys/pkg/FR-2010-03-05/pdf/2010-4755.pdf.

PROCEDURE:

- The hospital contracts with third party administrators (TPA) to facilitate both the design and implementation of the 340B contract pharmacy program. Contracts are saved electronically in a secure folder. [Sierra View Contract Management Software]
- The hospital has a written contract in place for each contract pharmacy location. Contracts are saved electronically in a secure folder. [Sierra View Contract Management Software]
- Reference the 340B OPAIS for a current list of contract pharmacies associated with the hospital. 340B ID: DSH050261
- The hospital registers each contract pharmacy location on the hospital's 340B OPAIS prior to the use of 340B drugs at that site.
- The hospital uses a replenishment model at an 11-digit NDC level.
- 340B-eligible prescriptions are presented to the contract pharmacy via e-prescribing, hard copy, fax, or phone.
    - The Contract Pharmacy will verify the patient, prescriber, and outpatient clinic eligibility via TPA eligibility file.
    - Updates are made to 340B eligibility data by the hospital and TPA at least monthly.
- Contract Pharmacies dispense prescriptions to 340B eligible patients using Contract Pharmacies' non-340B drugs.
- The hospital implements a bill-to, ship-to arrangement with the contract pharmacies.
    - Contract Pharmacies order 340B drugs based on 340B eligible use as determined by TPA accumulator system from the wholesaler.
        - Orders are triggered by package size used and placed by using online system.
        - Invoices are billed to the hospital.
- Contract pharmacies receive shipment and verify quantity received with quantity ordered.

  - Identifies inaccuracies.
  - Resolves inaccuracies.
  - Documents resolution of inaccuracies.
- Contract Pharmacies will notify TPA if Contract Pharmacy doesn't receive 11-digit NDC replenishment order within 1 week of original order fulfillment request.
- The hospital reimburses Contract Pharmacy at a pre-negotiated rate for such drugs.
- The hospital receives and reviews the invoice for drugs shipped to its contract pharmacies.
- The hospital pays invoice to Wholesaler for all 340B drugs.
- Contract Pharmacies provides a report at least monthly to the hospital via TPA.
- Contract Pharmacies will adjust claims with supporting documentation when variance or discrepancy has occurred.
  - Contract Pharmacy uses approved methods with knowledge and agreement of the hospital regarding reconciliation between inventory and invoices with adjustments as necessary to match changes.
  - Claim adjustments may occur only within 90 days of original billing and with prior notice and approval of entity.
- The hospital and Contract Pharmacies have agreed to a procedure for inventory reconciliation if the relationship is terminated by either party. Refer to specific contract for each Contract Pharmacy.
  - The hospital works with manufacturers to determine most appropriate method for handling.
  - For virtual inventories, the hospital pays unreplenished accumulations to Contract Pharmacy at an agreed upon amount specified in contract.
  - The hospital and Contract Pharmacy maintain auditable records to ensure the process is transparent to manufacturers and wholesalers.
  - The procedure may include transferring inventory to an associated covered entity site/ pharmacy that is still 340B registered, credit/rebill, return, or destruction according to state law.
- The hospital will not use 340B drugs for Medicaid FFS patients at its contract pharmacies (carve-out). Refer to the hospital's policy and procedures "Patient and Provider Eligibility" 340B Manual, Policy 340B.03 and "Prevention of Duplicate Discounts" 340B Manual, Policy 340B.04.

340B Procedure Manual

340B.09 – Referral Process

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: It is the policy of the hospital to deem certain referral prescriptions eligible for the 340B program. Patients seeing a physician outside of the hospital are eligible to receive medications from the 340B stock, if sufficient documentation to support 340B eligibility based on HRSA's patient definition is present within the medical record.

PURPOSE: The hospital has the following system in place to monitor compliance for 340B eligible prescriptions generated from referral arrangements.

PROCEDURE:

To qualify as an eligible 340B referral transaction:

- There must be documentation of the referral from the hospital to the specialist or specialty department in EHR.
    - Referral orders for the hospital's patients are considered valid with no expiration date if the patient remains active. (See Patient Eligibility Definition)
        - If the EHR auto-populates referral orders with an expiration date, this does not impact 340B eligibility.
    - 340B eligibility is dependent on the presence of documentation supporting the referral in the EHR, however, there may be instances where the referral is dated after the written or fill date of the prescription.
        - There may be instances where the dating on the readily retrievable referral falls after the date of the qualified prescription. This may be a result of orders being "discontinued" by the EHR due to aging out or changing EHR platforms (with the original outgoing referral being present in the legacy EHR) requiring new orders to be placed. Additionally, some organizations may require referrals to be placed at updated intervals (e.g., every other year).
    - Referrals can be placed either to an individual provider or practice.
        - Whether referrals are written at the provider or practice level, it is the policy of the hospital to deem prescriptions written by all providers associated with the practice where the patient was referred as 340B eligible, to account for standard coverage by other clinicians.
        - e.g., Patient is referred to Dr. Smith at Community Cardiology. At a subsequent specialist visit, the patient was seen by Jane Doe, FNP-C, who works with Dr. Smith, at Community Cardiology. The resulting prescriptions are deemed 340B eligible if all other elements of the patient definition are met.
    - The presence of consult note/clinical summary within the patient's medical record does not qualify nor disqualify 340B eligibility.
        - The lack of a consult note should not be a barrier for an eligible patient receiving medication.

        - Shared medical records between the eligible provider and referral specialist also serve as consult note/clinical summary.

- Types of elements which add together to support the responsibility for the care provided remains with the covered entity include (but are not limited to):
    - Consult notes or visit summaries from consulting (referral) prescriber are present in the patient's medical record.
        - If there is no consult note in the patient's medical record, the staff will attempt to obtain the consult note/clinical summary. If a note/summary is obtained, it will be added into the patient's medical record.
    - Shared medical records between the eligible provider and referral specialist including clinical documentation, consult notes and clinical summary.
    - The medication or consulting prescriber is mentioned in hospital visit note.
    - Documentation of the specialist prescription is included in the patient's medication list.
    - Associated diagnosis is documented in the patient's problem list.
- In the event a documented referral cannot be readily located within the EHR, the hospital staff will verify that the patient remains active with the covered entity and that the hospital maintains responsibility of care for the patient (i.e., continues to meet HRSA patient definition) then the care team will update the medical record to document the ongoing referral relationship.
    - When the referral is placed, the hospital staff will request updated consult notes from the consulting prescriber and update patients' medication list to include newly prescribed medications, if necessary.
    - For secondary referrals, where the specialist refers the patient to a second specialist, these relationships will also be documented in the medical record under a care coordination referral, so long as the patient continues to meet HRSA patient definition, and the hospital maintains responsibility for care.

340B Eligibility Across the Continuum of Care (Including Post Hospital/Urgent Care Visits)

- Within the patient centered medical home (PCMH) model, the hospital is the primary care provider for the patient, taking responsibility for the continuum of the patient's health care. The hospital maintains continued responsibility of care for patients who are discharged from the hospital or urgent care, with continuing care being provided by the hospital's clinicians.
- Under the PCMH primary care model, provided by the hospital, prescriptions resulting from self-referral to hospitals, emergency department, or Urgent Care centers are deemed by the hospital, in the continuum of care, to be 340B eligible so long as the patient continues to meet HRSA patient definition. Best practice is to update patients' medication list to include newly prescribed medications. If it is a medication for an acute condition, updates to the medication list are recommended but not required (e.g., short term antibiotics).

340B Procedure Manual

340B.10 - Noncompliance/ Material Breach

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: The hospital acknowledges that if there is a breach of the 340B requirements, it may be liable to the manufacturer of the covered outpatient drug that is the subject of the violation. Depending upon the circumstances, the hospital may be subject to the payment of interest, reimbursement, penalties, and removal from the list of 340B entities. The hospital responsible for contacting HRSA as soon as reasonably possible if there is any material breach by the covered entity or any instance of noncompliance with any of the 340B Program requirements.

PURPOSE: To define the hospital's material breach of 340B compliance and self-disclosure process.

DEFINITIONS:

- Materiality: A convention within auditing/accounting pertaining to the importance/significance of an amount, transaction, and/or discrepancy.
- Threshold: The point that must be exceeded, as defined by the covered entity, resulting in a material breach.

REFERENCE:

- 340B PVP Education Tool: Establishing Material Breach Threshold
- 340B PVP Education Tool: Self-Disclosure to HRSA and Manufacturer Template

PROCEDURE:

- The hospital's established threshold of what constitutes a material breach of 340B Program compliance is calculated as a material breach as a discrepancy that results in a negative impact of more than 5% of the total 340B purchases for the calendar year and does not self-correct within six (6) months.
- The hospital ensures that identification of any threshold variations occurs among all its 340B settings, including contract pharmacies.
- The hospital will use a $1,000 minimum nuisance threshold when determining manufacturer repayments.
- The hospital 340B Oversight committee reviews potential violations, performs materiality assessment, and determines if a material breach has occurred. The committee identifies to whom to self-disclose the breach dependent on the materiality determination and corrective action plan resolution.
- Management reserves the right to use professional judgement to review issues that may not meet these criteria but may want to be treated as a material breach and disclosed to HRSA.
- Any material breach discovered is required to be disclosed to HRSA as soon as reasonably possible after confirmation of material breach: 340Bselfdisclosure@hrsa.gov
- The hospital maintains records (including all internal/external communication and corrective action plans) of violations, materiality assessment, and resolution to the manufacturer and/or HRSA.

340B Procedure Manual

340B.11 - Program Compliance Monitoring/Reporting

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: Covered entities are required to maintain auditable records demonstrating compliance with the 340B Program requirements.

PURPOSE: To provide an internal monitoring program to ensure comprehensive compliance with the 340B Program.

PROCEDURE:

- The hospital develops an internal audit plan adapted by management and an independent consultant.
- The hospital reviews 340B OPAIS to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies (if applicable).
- The hospital reviews the Medicaid Exclusion File (MEF) to ensure the accuracy of the information for the parent site, off-site locations, and contract pharmacies (if applicable).
- The hospital ensures compliance with the GPO Prohibition.
- The hospital uses the following self-audit process to ensure 340B compliance:
  - On a monthly basis, SVMC shall select a sample of claims from the following areas:
    - 15 hospital claims
    - 5 Cancer Treatment Center claims
    - 5 Ambulatory Surgery Center
    - 5 Urology Clinic
    - 5 Wound Healing
    - 5 Rural Health Clinic
    - As needed for Medical Office Building

SVMC shall review the hospital claims for the following criteria:

- The patient was an outpatient at the time the drug was administered. Patient status, either inpatient or outpatient, will be determined by the patient's recorded disposition in the electronic medical record

- The drug accumulated on the correct account (i.e., 340B, GPO, WAC). Furthermore, accumulation will be checked on all sample claims in each of the areas monitored monthly. In addition, at least quarterly a split billing software report will be run to survey for accumulation inaccuracies. Any found discrepancy will be immediately reported to the Primary Contact. Reconciliation will be made immediately in the software so that correct accumulations are maintained.

- The patient was an eligible patient, the medical records are owned and maintained by SVMC.

- Once monthly, self-audit report lists are pulled from third party administrators' (TPA) online portals and clinic medication records in the EHR.
  - For pharmacy claims, these reports include payer, patient name, patient's date of birth, prescription number, physician NPI, physician name, bin number, drug name, date of service, date of approval, quantity, and costs. Reports will be run for each contracted pharmacy TPA.
  - For clinic administered claims, these reports include payer, patient name, patient's date of birth, physician NPI, physician name, drug name, administration details. date of service, quantity, and costs.
- Once monthly, the hospital completes internal audits of each Contract Pharmacy TPA record. With each TPA's records, 20 random prescriptions will be audited for the following items:
  - The party prescribed the medication meets the eligible patient definition.
  - The provider issuing the prescription is written by an eligible provider.
  - The location where the prescription is associated with an eligible site.
  - The medication, strength, and quantity agree to the EHR.
  - The prescription is properly documented in the EHR.
  - The prescription demonstrates that the hospital's practice is following the Medicaid billing question on 340B OPAIS.
- Quarterly and during the annual recertification period, compliance reviews are conducted of the OPAIS database for completeness and accuracy. This review includes:
  - Verifying the accuracy of location listing, Medicaid Exclusion File, and Contact information for the Authorizing Official and Primary Contact.
- Annually, the hospital engages an independent organization to perform external compliance reviews (audits) of its 340B Program including contract pharmacies.

- Documentation Records of each review completed are retained.
  - The results of each review will be reported to the hospital 340B Oversight Committee at the next occurring meeting.
    - Assess whether audit results are indicative of a material breach [Refer to the hospital's Policy and Procedure "340B Non-Compliance/Material Breach" 340B Manual, Policy 340B.10]
  - Any changes requiring a 340B OPAIS open enrollment period will then be made in the subsequent period and change requests will be made immediately upon discovery.
  - If errors or omissions are identified, the PC and AO will make the necessary corrections required to remain compliant.
  - As needed, issues identified will be reviewed with the Apexus Prime Vendor Program or HRSA OPA for direction on the appropriate corrective action.
  - Records of any such self-report and corrections will be maintained as auditable records.
- The hospital will maintain records of 340B-related transactions for a period of 3 years in a readily retrievable and auditable format located in a secure electronic format.

340B Compliance Review Summary

The 340B compliance review summarizes all activities necessary to ensure comprehensive review of 340B compliance at the hospital. The AO and PC are responsible and accountable for overseeing this review process, as well as taking corrective actions based on the findings.

		Area of Focus			
Activity	**Frequency (suggested)**	**Entity Eligibility**	**Diversion**	**Duplicate Discount**	**GPO Prohibition**
Review of all HRSA 340B Database information. Staff responsible: Compliance Manager CEO (AO)/340B Program Coordinator (PC)	Quarterly	X			
Review of 340B self-audit reports, including internal contract pharmacy compliance audits. Staff responsible: Director of Pharmacy/340B Program Coordinator (PC)	Monthly		X	X	X
Update of prescriber and patient eligibility files with TPA/contract pharmacy. Staff responsible: Director of Pharmacy (PC)/340B Program Coordinator	Monthly		X		X
Annual 340B Program Compliance Review (Independent External Audit)	Annually	X	X	X	X

340B Procedure Manual

340B.12 - Contract Pharmacy Oversight and Monitoring

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: Covered entities are required to provide oversight of their contract pharmacy arrangements to ensure ongoing compliance. The covered entity has full accountability for compliance with all requirements to ensure eligibility and to prevent diversion and duplicate discounts. Auditable records must be maintained to demonstrate compliance with those requirements

PURPOSE: To ensure that the hospital maintains 340B Program integrity and compliance at its contract pharmacies.

REFERENCE: Federal Register / Vol. 75, No. 43 / Friday, March 5, 2010 / Notices (Notice Regarding 340B Drug Pricing Program—Contract Pharmacy Services)

PROCEDURE:

- The hospital routinely conducts internal reviews of each registered contract pharmacy for compliance with 340B Program requirements. The following elements will be included when conducting self-audits of contract pharmacies to ensure program compliance:
  - Prescription is written from a 340B eligible site of care that provides healthcare services is an integral part of the hospital, and is listed as reimbursable on its most recently filed Medicare Cost Report.
  - Patient eligibility: The episode of care that resulted in the 340B prescription is supported in the patient's medical record.
  - Provider eligibility: The prescribing provider is employed, contracted, or under another arrangement with the entity at the time of writing the prescription so that the entity maintains responsibility for the care.
  - The 11-digit NDC level is documented for accumulation and/or replenishment of a 340B dispensation or administration (if a virtual inventory is used).
  - The hospital can document that no prescriptions were billed to Medicaid unless the contract pharmacy is listed as a carve-in contract pharmacy on 340B OPAIS.
- The hospital conducts annual independent audits of each registered contract pharmacy for compliance with the 340B Program requirements.
  - Independent audits will include reviews of:
    - 340B eligibility.
    - 340B registration.
    - Documented policies and procedures.
    - Inventory, ordering, and record keeping practices for all 340B accounts.
    - Review of the listing in the Medicaid Exclusion File and its reflection in actual practices.
    - Testing of claims sample to determine any instance of diversion or duplicate discounts over a set period of time.
- The hospital has mechanisms in place to demonstrate compliance with all state Medicaid billing requirements to prevent duplicate discounts at all sites, including off-site outpatient facilities.

- The hospital follows all state practices consistent with state guidance and the hospital Medicaid billing numbers/NPI numbers are properly reflected in the Medicaid Exclusion File.
- The hospital's 340B Oversight Committee reviews audit results at the next scheduled meeting.
  - The committee will assess if audit results are indicative of a material breach [Refer to the hospital's Policy and Procedure "340B Noncompliance/Material Breach" 340B Manual, Policy 340B.10].
- The hospital maintains records of 340B-related transactions for a period of 3 years in a readily retrievable and auditable format.

340B Procedure Manual

340B.13 - Prime Vendor Program (PVP) Enrollment and Updates

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: The purpose of the Prime Vendor Program (PVP) is to improve access to affordable medications for covered entities and their patients.

PURPOSE: Support the hospital's participation in the PVP to receive the best 340B product pricing, information, and value-added products.

PROCEDURE:

- **Enrollment in PVP:**
  - The hospital completes online 340B Program registration with HRSA.
  - The hospital completes online PVP registration (PVP Entity Enrollment).
  - PVP staff validates information and sends confirmation email to the hospital.
  - The hospital logs in to www.340bpvp.com, selects username/password.
- **Update PVP Profile:**
  - The hospital accesses PVP Entity Enrollment.
  - The hospital clicks Login in the upper right corner.
  - The hospital inputs PVP log-in credentials.
    - In the upper right corner click "My Profile" to access page. https://members.340bpvp.com/webMemberProfileInstructions.aspx.
  - The hospital clicks "Continue to My Profile" to access page https://members.340bpvp.com/webMemberProfile.aspx.
    - Find a list of your facilities.
      - Click on the 340B ID number hyperlink to view or change profile information for that facility.
  - Update HRSA Information:
    - Complete the 340B Change Form as detailed above.
      - After 340B OPAIS has been updated, the PVP database will be updated during nightly synchronization.
  - The hospital updates the 340B Prime Vendor Program (PVP) Participation Information:
    - Edit The hospital's DEA number, distributor and/or contacts.
    - Click submit.

340B Procedure Manual

340B.14 – State of Emergency Management

SCOPE: Sierra View Medical Center adopts this policy for all personnel, including contracted employees.

POLICY: The hospital has processes in place to maintain compliance with all 340B requirements, including during states of emergency.

PURPOSE: To ensure that the hospital has processes in place in case of a state of emergency

PROCEDURE:

- **Hospital 340B Eligibility**
  - During a state of emergency, if additional space is required for expanding the delivery of patient care at a 340B eligible, expanded care delivery location at physical address of the hospitals' registered location will be considered 340B eligible. Examples may include but are not limited to conversion of non-clinical areas to patient care areas and expansion into parking lots.
- **Patient 340B Eligibility**
  - During a state of emergency, patient care may be relocated as required by applicable patient care standards. Patients will still be considered eligible patients, if care is moved outside standard care areas or telehealth practices are utilized, if the patient is registered to the hospital.
- **Health Care Professional Eligibility**
  - During a state of emergency, where volunteer health professionals are providing health care, documentation should be generated and maintained to make the relationship between the provider and the hospital clear and to confirm the hospital's responsibility for providing patient care. This documentation should recognize the emergency nature of the situation, the name and address of the volunteer, and his/her relationship to the hospital, and should be kept on file by the CE. Additionally, Health Care Providers may work at the CE on a short-term or temporary basis. The Health Care Provider definition will still be in place and all providers including short-term or temporary providers are considered eligible.
- **Health Record**
  - During states of emergency, an abbreviated health record will be deemed adequate for purposes of the 340B Program. The record must identify the patient, record the medical evaluation (including any testing, diagnosis, or clinical impressions) and the treatment provided or prescribed. For purposes of 340B Program eligibility, the record may be a single form or note page. It is the recorded information that creates a record.
    - In the case of a State of Emergency, HRSA has considered that self-reporting of identity, condition, and history to be adequate for purposes of 340B recordkeeping requirements
  - HRSA recognizes that during a State of Emergency, 340B drug shortages may occur. In this state of emergency hospital will continue to ensure it has policies and procedures in place to address the purchase and dispensing of 340B drugs, and it must continue to keep auditable records.

SUBJECT: **CONTINUED STAY REVIEW**	SECTION: **Page 1 of 2**

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

PURPOSE:

To promote effective and efficient use of hospital resources that will assure quality patient care and provide physicians with assistance in identifying alternatives to inpatient care.

POLICY:

Patients will be reviewed during their stay to ensure an appropriate level of care, and appropriate utilization of resources.

AFFECTED AREAS/ PERSONNEL: *UTILIZATION REVIEW*

PROCEDURE:

1. On the assigned review date, the chart is screened using InterQual and/or Milliman Care Guidelines (MCG) continued stay criteria to ensure the patient still requires hospitalization.

2. The ***Utilization Review Nurse*** verifies that there are no delays in treatment and that resource utilization is appropriate. Cases in which unrelated outpatient workups are scheduled after the primary problem has been treated are referred to the Physician Advisor (Chair of the Utilization Review Committee) or outside Physician Reviewer.

3. If the documentation does not reflect the need for continued hospitalization, the attending physician will be contacted for further information.

4. If the patient no longer meets the criteria for continued stay, the Physician Advisor or outside Physician Review will be contacted to review the case.

5. If the patient continues to require acute hospitalization, a new review date (not to exceed three days) is assigned.

6. If the continued stay is medically unnecessary, the Physician Advisor or outside Physician Reviewer will request that Utilization Management (UM) issue a denial in accordance with Peer Review Organization (PRO) guidelines. (See policy Hospital Issued Notice of Non-Coverage Guidelines).

REFERENCES:

- California Code of Regulations (2024). Title 22, Chapter 7, Section 70717. Retrieved from https://www.law.cornell.edu/regulations/california/22-CCR-70717
- The Code of Federal Regulations, Title 42, Chapter IV, Part 456; 2024. Retrieved from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-456
- 42 CFR 482.30; Retrieved from https://www.ecfr.gov/current/title-42/part-482/section-482.30

CROSS REFERENCES:

- Hospital Issued Notice of Non-Coverage Guidelines

SUBJECT: **FORMULA DATING AND STORAGE**	SECTION: **Page 1 of 1**

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

PURPOSE:

To supply ready-to-feed formula to in-house pediatric patients.

POLICY:

All infant formulas, glucose water, sterile water and nipples should be stored in a clean storage area.

PROCEDURE:

1. Formula will be checked monthly for expiration dates and rotated for the most recent expiration date in front by materials management.
2. All formula should be labeled with expiration date visible.
3. All expired formula should be discarded immediately.
4. Expired formula is not to be used for any reason.
5. Never microwave formula
6. Formula should be ordered as needed to maintain adequate stock by the Distribution Department.
7. Ready to feed formula is always to be used unless otherwise ordered by the physician or unavailable.

   Note: if powder is used ensure proper mixing instructions are followed

REFERENCE:

- Centers for Disease Control and Prevention. (2021). HOW TO PREPARE AND STORE POWDERED INFANT FORMULA. https://www.cdc.gov/nutrition/downloads/prepare-store-powered-infant-formula-508.pdf

SUBJECT: **INSURANCE REVIEWS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide guidelines for obtaining authorization for a patient's stay in the hospital following the Insurance Review Process.

POLICY:

The Utilization Management Department will be responsible for conducting Insurance Reviews on all patients admitted to the hospital for inpatient or outpatient services

AFFECTED AREAS/ PERSONNEL: *UTILIZATION MANAGEMENT/REGISTRATION STAFF*

PROCEDURE:

1. Upon admission into Sierra View Medical Center, the patient's financial status will be obtained. The assigned Registration Clerk will then notify the insurance company of the patient's admission.

2. The insurance company will contact the Utilization Review (UR) Department for request of review for medical necessity. The (UR) Staff will input the requested information into the patient's records using the Meditech systems Utilization Review Screen.

3. The staff will state date/time of call, who called, name of insurance reviewer expecting review, phone and fax numbers of the insurance reviewer, reference number, length of stay approved and any other pertinent information obtained from call.

4. They will use the Meditech systems Utilization Review Screen to input all pertinent information; this will include the Patient's admission date, diagnosis, vital signs, surgical procedures if any, abnormal lab and radiology results, MD plans for continued stay, orders and discharge plans.

5. Completed reviews will be phoned or faxed to the insurance reviewer with request for authorization for stay.

6. Any further requests for reviews will be completed and provided until the patient is discharged.

7. If the insurance reviewer feels that the patient has been admitted without medical necessity the denial process will be initiated.

8. All correspondence with the insurance reviewer will be documented in the patient's record using the Meditech systems Utilization Review Screen by all (UR) staff.

9. If there are any questions that arise by billing, they can access the Utilization Review Screen as a read only file and review documentation for clarification.

REFERENCE:

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **MRI SAFETY**	SECTION: **Page 1 of 4**

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

PURPOSE:

To prevent injuries to patients, Sierra View Medical Center (SVMC) personnel, and the public, as well as damage to the MRI machine due to the entry of objects composed of ferrous materials into the MRI scan room.

Definitions:

- **Ferrous Materials**: Materials composed of elements that are attracted to magnetic fields.
- **Non-Ferrous Materials**: Materials composed of elements that are not attracted to magnetic fields.

MRI Access Restrictions/Zones

- Zone 1: All areas accessible to the general public. This area is outside of the MRI environment and is the area through which patients and SVMC personnel access the MRI environment.
    - Zone 1 includes the periphery area of the MRI building up to the entrance of the MRI building.
- Zone II: This area is designated for unscreened SVMC personnel and patients. This area is the interface between the publicly accessible areas (Zone I) and the strictly controlled Zones III and IV.
    - Zone II begins immediately inside the entrance doorway of the MRI building and includes the area between the technologist control area and the door leading to Zone III.
- Zone III: This area is designated for screened employees and patients only. This area is the region in which free access by unscreened non-MRI personnel or ferromagnetic objects or equipment may result in serious injury or death as a result of interactions between individuals or equipment and the magnetic field within the MRI environment. Access to Zone III is strictly controlled and monitored by MRI personnel. Only those individuals that have completed the appropriate screening form are allowed access to Zone III. The door to Zone III shall be locked at all times that personnel are not present and directly monitoring the area.
    - Zone III begins at the doorway access from Zone II and includes the patient changing and exam prep area. Zone III is directly adjacent to Zone IV and ends at the doorway to Zone IV.
- Zone IV: This area is the MRI scan room. Zone IV is designated for screened patients and SVMC personnel. The area is to be monitored at all times by MRI personnel when a patient is within Zone IV.

POLICY:

MRI Safety

All patients, authorized SVMC personnel, and members of the public who enter the scan room must be free of ferrous objects on their person which could be attracted to the magnetic field. All ferrous objects

on the person entering the scan room must be removed before entering the scan room. Lockers are provided for patient and employee use.

Only authorized personnel and patients are allowed access to Zones III and IV.

Note: The magnetic field within the scan room is present at all times. Loss of electricity does not affect the magnetic field strength.

AFFECTED AREAS/ PERSONNEL:

ALL PERSONNEL, PATIENTS, AND MEMBERS OF THE PUBLIC

PROCEDURE:

- **Patient Safety:**

1. All outpatients shall be screened for ferrous materials on or in their person before entering Zones III and IV utilizing the Magnetic Resonance (MR) Procedure Screening Form for Patients, (SVMC Form # 014285).

2. The technologist performing the exam is responsible for reviewing, explaining and obtaining the signature of the patient, guardian or conservator for all outpatients on the Magnetic Resonance (MR) Procedure Screening Form for Patients,(SVMC Form # 014285) and note all contraindications pertaining to ferrous objects or implants in or on the person, as indicated on the screening form.

3. All ER patients and inpatients shall be screened by nursing personnel utilizing the MRI patient questionnaire within the Meditech PCS module prior to transport to MRI.

4. MRI technologists must review all screening forms prior to patient entering Zones III and IV.

5. Patients who have objects on their person or implanted objects that are a contraindication as identified during the screening process will not be allowed in MRI Zones III and IV.

- **Staff/Patient Safety:**

All SVMC employees or visitors that are required admittance to MRI Zones III and IV must be screened for ferrous or contraindicated materials on their person or implanted objects that contraindicate entrance to MRI Zones III and IV utilizing the Employee/Visitor MRI Safety Screening Form (SVMC Form # 023660). If it is determined through the screening process that the employee or visitor has ferrous materials either implanted in or on their person, the employee or visitor will not be allowed to enter MRI Zones III and IV.

- **Noise Safety**

  MRI technologists are to inform patients about the noise generated during scans and offer hearing protection devices to the patient. The use of hearing protection is recommended by the machine manufacturer.

  a. Hearing protection devices available for use are single use disposable ear plugs and headphones connected to the MRI audio system.

  b. In the event that hearing protection is refused by a person accompanying the patient, the person accompanying the patient will be asked to leave the MRI scan room.

  c. If a patient refuses hearing protection, the refusal will be noted in the technologist notes within the PACS system indicating the patient refused hearing protection against medical advice to utilize hearing protection devices readily available.

- **Gurneys/Wheelchairs**

  1. Only those gurneys or chairs designated as MRI safe are allowed to enter Zone IV (scan room). MRI compatible gurneys and wheelchairs shall be clearly labeled. Gurneys or wheelchairs not labeled as MRI compatible may not be taken into the scan room at any time.

- **Oxygen Cylinder**

  1. E-cylinders constructed of aluminum are the only oxygen cylinders approved for use in the MRI suite. These cylinders are easily identified by the following attributes:

     a. Approved cylinders are constructed of aluminum.

     b. The cylinders have an aluminum finish and the top portion of each cylinder is painted green.

     c. All cylinders must be tested for ferrous vs non-ferrous materials and labeled "MRI Compatible." This function is to be performed by the MRI technologist.

- **Waste Receptacles/Dirty Linen Receptacles.**

  1. All waste receptacles (trash cans, sharps containers, etc.) within the MRI suite are to be constructed of plastic.

  2. All dirty linen receptacles located within the scan room are to be constructed of non-ferrous material and must be clearly labeled "MRI compatible."

Patient Monitoring Equipment/Infusion Pumps.

1. All patient monitoring equipment utilized in MRI environment must be approved for use in the MRI environment.
2. All infusion pumps utilized in MRI environment must be approved for use in the MRI environment.
3. MRI department will supply monitoring equipment and infusion pump for use in the MRI environment that has been designed to operate safely in the MRI environment.

REFERENCE:

- ACR Manual on MR Safety, 2024. ACR Committee on MR Safety. Retrieved from https://www.acr.org/-/media/ACR/Files/Radiology-Safety/MR-Safety/Manual-on-MR-Safety.pdf.

SUBJECT: **PEDIATRIC ADMISSION GUIDELINES AND PROCEDURES**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 6**

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

PURPOSE:

- To outline nursing responsibilities in the proper completion of the nursing assessment documentation.
- To accurately and thoroughly document all aspects of the admission process including patient history, patient lifestyle information, physical assessment, parental skills, psychosocial needs, teaching needs, and discharge planning needs.
- To exchange information about the child and the hospital procedures.
- To introduce the patient(s) and the parent(s) in age-appropriate terms to the hospital.

POLICY:

1. It is the policy of the Medical/Surgical Unit to efficiently and safely stabilize all pediatric admissions in a timely manner. The admissions assessment must be completed within the first four (4) hours of admission.

2. Assessment of pediatric patients is the responsibility of the Registered Nurse (RN).

AFFECTED PERSONNEL/AREAS: *RN*s

EQUIPMENT:

- Admission Kit
- Hospital gown or infant clothes
- Diapers and wipes, if necessary
- Pediatric urine collector, if specimen is needed
- Thermometer
- BP Apparatus
- Stethoscope
- Weighing Scale
- Tape measures
- Admission forms

ASSESSMENT:

The following assessment outlines need to be completed on all children upon their admission to the hospital.

1. Chief complaints – includes a brief description of the parents or child's perception of the primary reason for the admission.
    a. Reason for admission.
    b. Duration of symptoms, locations, quality, quantity, course of the illness.
2. Historians – include those people accompanying the child to the hospital, family or guardian's expectations for, and involvement in, the patient's assessment, initial treatment and continuing care.
3. Sources of healthcare – include the prior sources of healthcare and reason of previous hospitalization.
4. Past health history – included a well-organized, concise presentation of health history.
    a. Child's condition at birth
    b. Common childhood illnesses
    c. Surgical procedures
    d. Allergies
    e. Medications taken at home
    f. Immunization status
5. Patient profile – include a well-organized picture of the child's current life situation.
    a. Social history – household members, language spoken at home, primary care givers, day care, school, economic situation, and agencies involved with the family.
    b. Developmental history – general description of the child's personality, fears, habits, language, and communication, motor skills, and cognitive skills.

6. Review of systems – includes a thorough checklist of questions about recent symptoms that are applicable to children.

   a. General appearance – overall state of health, frequent infections, weight gain or loss, fevers, night sweats.

   b. Vital signs

   c. Integumentary – acne, cuts, abrasions, tendency to bruise, dryness, deformities of nails.

   d. Musculoskeletal – weakness, lack of coordination, muscle pains, fractures, sprains, abnormal gaits, stiffness, cramps.

   e. Lymph nodes – enlarged nodes or masses, discharge.

   f. Head – Headache, dizziness, circumference of the head.

      - Head circumference must be measured for infants up to the age of 24 months.
      - Head circumference must be measured for pediatric patients with history of head injury, hydrocephalus, and suspected meningitis, repair of meningomyelocele, microcephaly and neurosurgical patient.

   g. Eyes – visual problems, strabismus, eye infections, edema of lids, excessive or lack of tearing, use of glasses.

   h. Ears – pain, discharge, hearing loss.

   i. Nose – nosebleeds, congestion, obstructions.

   j. Mouth – problems with teeth, bleeding gums, presence of sore or thrush.

   k. Throat – sore throats, choking, hoarseness, enlarged tonsils.

   l. Neck – pain, limited movement, masses.

   m. Breast – enlargement, discharge, masses.

   n. Respiratory – cough, colds, wheezing, shortness of breath, presence of abnormal breath sounds

   o. Cardiovascular – cyanosis, fatigue, murmur, anemia, capillary refill, fontanel.

   p. Gastrointestinal – nausea, vomiting, diarrhea, constipation, blood in stool, bowel pattern.

q. Genitalia – vaginal discharge, pruritus, pain on urination, hematuria, change in size of scrotum.

r. Rectum/anus – bleeding.

s. Nervous system – seizures, tremors, speech problems, fears.

UPON ADMISSION:

1. The admitting nurse will assess and prioritize the patient's needs.

2. The admitting nurse will complete the Initial Assessment.

3. Multidisciplinary Care Plans should be initiated upon admission.

4. The patient's psychosocial and developmental needs will be incorporated into the plan of care and steps will be taken to decrease the anxiety levels of the patient being admitted.

5. Specific teaching and discharge needs should be identified at the time of admission.

PROCEDURE:

1. The charge nurse or the Clinical Supervisor will determine the initial room assignment based on the diagnosis, age and sex of the patient, and room availability.

   a. To facilitate a smooth admission, have room prepared with patient's gown, scale, vital signs equipment and admitting kit.

2. The child can be admitted through Emergency Department, PACU, or through Admitting Department and brought to the Pediatric Designated area or designated overflow area.

3. Greet the child and parent(s) and introduce yourself and bring him/her to the assigned room.

4. Interview the child and parent(s), do a physical assessment and complete admission.

5. Apply the patient's ID band to confirm correct identity by asking the parent or legal guardian to double-check the band for safety purposes. The band can be placed on the child's wrist or ankle.

6. Explain all the procedures, treatments, and plan of care to parents or legal guardians to alleviate anxieties.

7. Orient the parents and/or legal guardian into the room and educate them regarding safety, infection control, unit routine, rooming-in information and visiting restrictions if any.

8. Perform nursing admission history by asking the parent or legal guardian the patient history and general admission questions.

9. Call the attending physician for orders inform him of child's admission.

10. Carry out STAT orders within 30 minutes.

INFANT (2 DAYS – 8 MONTHS)

1. Do as much of the physical exam and assessment as possible with the infant held in the parent's/legal guardian's lap. Assess parent-child bonding (eye contact and physical touch).

2. Let the older infant touch the instruments before examiner uses them to gain the infant's cooperation.

3. Perform the least distressing task first.

    a. Listen to heart rate and respiration. Use stethoscope to accurately count pulse and respiration.

    b. Take height/length and weight.

    c. Take temperature and blood pressure.

    d. For children up to one (1) year old head circumference must be taken and recorded into the growth chart including height and weight.

INFANT (9 – 12 MONTHS)

1. Gather as much information as possible about the infant by just observing – not touching.

2. Keep the parent/legal guardian within the child's range of vision. At this age, anything or anybody not within view is assumed to be gone.

TODDLER (1 – 3 YEARS)

1. Undress the child. Expose only part of the child's body at any one time. At this age, the child does not like to be nude. Observe skin color, bruises and lacerations.

2. Dress the child in hospital gown, shirt or diaper.

3. Return the clothing to the child's parents to be taken home. Allow the toddler to hold familiar objects. Ask the parents to bring the child's favorite toy and blanket because toddlers can deal with symbols.

PRE-SCHOOLERS (3 – 5 YEARS)

1. The nurse can ask children of this age questions and sometimes get a reliable response.

2. The preschooler needs feedback and explanations of what needs to be accomplished. Preschoolers are egocentric and experience a large variety of terrors and fantasies.

SCHOOL AGE

1. The physical exam can progress along an adult pattern from head to toe, after giving a brief explanation of each procedure. Children at this age can accept information but may not yet be able to integrate it into their surroundings.

2. A concern for privacy is important. Provide privacy by closing bedside drapes or the door to the room and provide a hospital gown.

ADOLESCENT

1. Obtain the consents for the procedure before the parents leave. Ask the parent to leave the room during an explanation.

    a. Adolescents want identity and independence. Check accuracy of procedure spelling, date and time. Ascertain the parents understanding of what they are signing.

2. Encourage good health habits at this time. The adolescent is receptive to wellness teaching.

3. Explain the use of equipment: call light, TV, telephone and bed side rails.

4. Communicate with the parents/legal guardian about the reasons for admission and educate them on the disease process.

REFERENCE:

- Bowden, Vicky, & Smith Greenberg, Cindy. (2015). Pediatric Nursing Procedures Forth Edition. Philadelphia, PA, Lippincott Williams & Wilkins.

- How to approach Pediatric Patients - AACN. (2023). AACN. https://www.aacn.org/blog/how-to-approach-pediatric-patients

SUBJECT: **SEQUENTIAL ULTRAFILTRATION (SUF)- ACUTE RENAL SERVICES**	SECTION: **Page 1 of 1**

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

PURPOSE:

Ultrafiltration during dialysis is performed for the purpose of removing water accumulated by ingestion of fluid or by metabolism of food during the interdialytic period in which the dialysate is away from the dialyzer.

POLICY:

Sequential Ultrafiltration

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

PROCEDURE:

- Obtain the nephrologist order for Sequential Ultrafiltration and routine hemodialysis phase. Treatment shall be initiated as soon as possible after initiation of dialysis for optimal results (i.e., before osmotic shifts have time to occur).
- Select Sequential in Dialyis Flow Rate (DFR) options.
- Scissor clamp acid and bicarb lines.
- Maintain the blood pump speed per the nephrologist's orders.
- Document the initiation time.
- Check vital signs every 15-30 minutes.
- To discontinue sequential ultrafiltration, remove clamp from acid and bicarb lines. Discontinue Sequential Ultrafiltration (SEQ) option and selected ordered DFR. Continue hemodialysis treatment as ordered by the physician.

REFERENCES:

Fresenius Medical Care. (n.d) Ultrafiltration. retrieved on January 7, 2025 from https://fmcna.com/content/dam/fmcna/live/support/documents/operator's-manuals---hemodialysis-(hd)/2008k-operator's-manuals/490042_Rev_P.pdf

SUBJECT: **THROMBOLYTIC THERAPY IN ACUTE ISCHEMIC STROKE**	SECTION: **Page 1 of 11**

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

PURPOSE:

The purpose of this policy is to outline patient eligibility for thrombolytic therapy, drug administration, patient monitoring, and documentation for the care of the patient experiencing Acute Ischemic Stroke (AIS). These guidelines focus on early assessment and management of Emergency Department (ED) and inpatients with AIS.

Tenecteplase (TNK) is also a thrombolytic drug. It is endorsed by the American Heart Association as an alternative to Alteplase (TPA). Compared to Alteplase, it has a longer half-life and higher fibrin specificity. TNK has the benefit of a single bolus administration. TNK is recommended at a dose of 0.25 mg/kg (max 25 mg), administered within 4.5 hours of symptom Inclusion / exclusion criteria and contraindications are the same as Alteplase (TPA) for acute ischemic stroke.

Treatment should be initiated within 4.5 hours after the onset of stroke symptoms, and after exclusion of intracranial hemorrhage by a cranial computerized tomography (CT) scan or other diagnostic imaging method sensitive for the presence of hemorrhage.

Treatment Goals:

To act in accordance with the 8 D's of stroke survival:

a. Detection (Early recognition)
b. Dispatch (Early EMS activation)
c. Delivery (Transport & management)
d. Door (ED triage)
e. Data (ED management, activation of stroke alert)
f. Decision (Neurology & therapy selection)
g. Drug (Reperfusion approaches)
h. Disposition (admit or transfer)

For the inpatient: Early recognition, activation of the Rapid Response Team (RRT) & stroke alert, Decision, Drug, and Disposition.

- Management of the acute stroke patient as measured by time targets for stroke care, including consideration and administration of thrombolytic therapy.
- Reduce the complications of stroke through thrombolysis in eligible patients.
- Improve patient outcomes.

DEFINITIONS:

1. **Acute Ischemic Stroke (AIS):** A disruption of blood flow to the brain that can result in permanent damage. This disruption is usually caused by either cerebral thrombosis or cerebral embolism. AIS accounts for about 87% of all strokes.

2. **Alteplase (rt-PA)**: The only FDA approved thrombolytic for AIS treatment.

3. **Last Known Well Time (LKWT):** The time in hours and minutes that the patient was last known to be at their "baseline" self.

4. **NIHSS – National Institute of Health Stroke Scale**: A stroke severity assessment scale.

5. **Stroke Alert:** An overhead page or electronic notification announcing the presence and location of a potential stroke patient. Activated anytime for any patient, via a defined process, that displays stroke signs and/or symptoms.

    a. Patients with new or worsening neurological deficits (if prior NIHSS done, worsening of 3 or more points).
    b. Anyone with a positive BE FAST, or FAST, exam
    c. Any other sign or symptom concerning for stroke

The alert activates members of the stroke team who respond to the alert in a role-specific way.

6. **Tenecteplase** – a thrombolytic agent similar to Alteplase (TPA) with greater fibrin specificity and a longer half – life. Not FDA approved but is recommended in the American Heart / American Stroke Association clinical practice guidelines for specific AIS

7. **Thrombolytic**: An intravenously administered medication that binds to a thrombus in a blood vessel causing fibrinolysis, thereby restoring blood flow to the area distal of the clot. Alteplase and Teneceteplase are are thrombolytics.

POLICY:

A. A "stroke alert" may be called for any ED or Intensive Care Unit (ICU) patient presenting with signs or symptoms of an acute stroke. Inpatients, outside of the ICU, will precede the stroke alert with a Rapid Response Team (RRT) notification. The RRT will evaluate the patient and call the stroke alert.

B. Also see policy "Stroke Alert and Acute Care Stroke Management" for additional treatment details.

C. Prior to initiating thrombolytics for the treatment of AIS, the treating physician will evaluate all patients for inclusion and exclusion criteria. Inclusion and exclusion criteria are consistent with FDA approval guidelines.

    1. Inclusion Criteria

        a. Age 18 years or older – equally recommended for ages ≤80 and > 80
        b. Does not have diabetes and prior stroke

c. Working diagnosis of acute ischemic stroke with a measurable neurologic deficit. Mild, but disabling stroke symptoms (as defined by the patient) – thrombolysis is still recommended.

i. Sudden numbness, weakness, or paralysis of the face, arm, or leg
ii. Difficultly speaking or understanding simple statements
iii. Decreased vision or transient blindness in one eye
iv. An episode of double vision
v. Unexplained dizziness, loss of balance, or sudden falls
vi. Sudden, severe headache with no apparent cause

d. LKWT established to be less than 180 minutes (3 hours) before treatment would begin.

i. In some cases, this window may include those with symptom onset 180 to 270 minutes (3 to 4.5 hours) prior to presentation, with these additional EXCLUSION criteria:

- Age > 80 years
- Oral anticoagulant use regardless of INR
- Baseline NIHSS score > 25
- Imaging evidence of ischemic injury involving more than one third of the middle cerebral artery (MCA) territory
- History of both stroke and diabetes
- Intracranial hemorrhage has been **excluded** as the primary cause of stroke signs and symptoms prior to the initiation of Alteplase treatment.

NOTE: Physician discretion may modify this list

2. Exclusion Criteria / Contraindications: Alteplase therapy in patients with AIS is contraindicated in the following situations because of an increased risk of bleeding, which could result in significant disability or death:

a. Evidence of intracranial hemorrhage on pretreatment evaluation

b. History of intracranial hemorrhage

c. Symptoms or imaging suggest subarachnoid hemorrhage on pretreatment evaluation

d. Active internal bleeding

e. Patient / family refusal

f. Presence of intra-cranial conditions that increase the risk of bleeding, such as intracranial neoplasm, arteriovenous malformation, or aneurysm

g. Recent (within 3 months) intra-cranial, intra-spinal surgery, or serious head trauma

h. History of ischemic stroke in previous 3 months

i. Known aortic arch dissection

j. Infective endocarditis (increased risk of intracranial hemorrhage)

k. CT scan: No frank hypodensity, but early ischemic changes (mild to mod) are OK

l. Blood glucose concentration of < 50 mg/dl or > 400 mg/dl

m. Bleeding diathesis including, but not limited to:

i. Platelet count < 100,000/mm3, INR > 1.7, aPTT > 40 seconds, **or** PT > 15 seconds.

ii. History of warfarin use and an INR > 1.7 or PT > 15 sec

iii. Administration of heparin within 48 hours preceding stroke onset with an elevated aPTT greater than upper limit of normal at presentation

iv. Who have received a treatment dose of low-molecular-weight heparin within the previous 24 hours

v. Who are taking direct thrombin inhibitors or direct Factor Xa inhibitors, unless the laboratory tests are normal or the patient has not received a dose of these agents for > 48 hours.

n. Current, severe, uncontrolled hypertension. Warning exists for systolic blood pressure (SBP) > 185 and diastolic blood pressure (DBP) > 110. Must be controlled and stabilized prior to thrombolysis.

1. Post-thrombolysis, BP is **be maintained less than 180/105**.bold font here

o. Arterial puncture at a non-compressible site in the previous 7 days.

3. Criteria with warnings (consider risk to benefit):

a. Pregnancy (Category C- consult with obstetrician-gynecologist and, possibly, a perinatologist)

b. Major surgery or serious trauma within previous 14 days

c. Recent (within 21 days) gastrointestinal or genitourinary hemorrhage

d. Recent (within 3 months) acute myocardial infarction (AMI) – Treatment with Alteplase is reasonable if the MI was a STEMI involving the right or inferior myocardium

Notes:

- Physician discretion may result in modification of this list based on clinical knowledge.
- In patients without recent use of oral anticoagulants or heparin, treatment with thrombolytics can be initiated before availability of coagulation test results but should be discontinued if INR is > 1.7 or PT is abnormally elevated.
- In patients without a history of thrombocytopenia, treatment with Alteplase can be initiated before availability of platelet count but should be discontinued if platelet count is < 100,000 mm3.

AFFECTED PERSONNEL/AREAS: *ALL INPATIENT NURSING UNITS, EMERGENCY DEPARTMENT, CT, PHARMACY, LABORATORY, MEDICAL STAFF*

EQUIPMENT:

- Stroke Reference Binder or Stroke Box
- Alteplase (rt-PA), from pharmacy or Pyxis
- Intravenous infusion pump with non-vented tubing

PROCEDURE:

A. Pre-Treatment:

Nurse responsibilities

1. Identify patients with symptoms of neurological changes or acute stroke based on clinical presentation, positive (+) BE FAST exam, or early notification from pre-hospital personnel.

2. Establish and document the LKWT in a date and time format.

3. Immediately call an RRT, or stroke alert, based on nursing unit. The RRT will contact the responsible physician.

4. RRT or ED registered nurse (based on location of the stroke alert) will accompany the patient to the CT scanner and to final disposition.

5. If in the ED, immediately notify the ED physician.

Note: For additional roles and responsibilities, see Stroke Alert and Acute Care Stroke Management: Emergency Department & Inpatient Units policy.

B. Treatment – thrombolytic administration:

Physician responsibilities

1. Definitive treatment decisions regarding thrombolytics and medical management of the patient may be made by the treating physician, in collaboration with the neurologist or tele-neurologist. When on-screen and consulting, the TeleNeurologist will determine eligibility for thrombolytic therapy.

2. Validate inclusion / exclusion criteria

3. Document verbal consent obtained from the patient's family

4. Document education provided to the patient and family regarding the risks and benefits of Alteplase.

5. Review the patient's vital signs and recent medical history

   a. Initiate treatment for blood pressure as needed.

   b. If SBP is 180-230 mmHg or DBP is 105-120 mmHg, suggested treatment is:

      i. Labetalol 10 mg IV x 2 doses, followed by
      ii. Nicardipine 5 mg/hour; titrate up to desired effect by 2.5 mg/hour every 5-15 minutes to a maximum of 15 mg/hour

      iii. If BP is not controlled or DBP is > 140 mmHg, consider IV sodium nitroprusside (Nipride)

      iv. Other agents, such as Hydralazine, can be considered

6. Final review of thrombolytic dose to be administered, in collaboration with nursing and pharmacy, as appropriate.

Tenecteplase: dosing is 0.25 mg/kg, MAX of 25 mg., given as an IV push over 5 seconds.

7. Participate in the Thrombolytic time out process and sign the time out form. Presence of TeleNeurologist for time out will be documented.

Nursing Responsibilities:

1. Establish / document accurate patient weight.

2. Perform and document the NIHSS prior to treatment, if not done by TeleNeurologist.

3. Alteplase & Tenecteplase are a high alert medication, requiring a 2nd registered nurse to verify:

   a. Right patient, right medication, right dose, right time, and right route.

   b. Ensure infusion is going into the intended channel by physically tracing the line from the solution, through the pump, and to the insertion site.

   c. The infusion pump is programmed at the proper rate, including correct entry of patient's weight.

4. Prior to administration of the thrombolytic bolus, everyone in the room will participate in a "Thrombolytic Time Out"; an intentional pause to verify:

   a. Right patient

   b. Negative head CT

   c. Home medications have been reviewed with the Alteplase prescriber (physician)

   d. Patient is not taking anticoagulation

   e. Thrombolytic checklist completed

   f. Blood pressure is controlled at or less than 180/105

6. Alternatively, administer a single IV bolus of Tenecteplase (TNK) over 5-10 sec. using a peripheral vein. Follow with a NS flush. Do not administer in a line containing a **dextrose solution as it is incompatible**.

7. Document medication administration.

8. Patient monitoring will be completed in the ED or ICU:

   a. Hypertension management:

9. **Must maintain blood pressure (BP) less than 180 / 105 mmHg to limit the risk of intracranial hemorrhage**

    a. Baseline neuro checks and vital signs will be taken with subsequent neurological (neuro) checks and vital signs every 15 min for 2 hours

    b. Neuro checks and vital signs every 30 minutes from hour 2 to hour 6.

    c. Neuro checks and vital signs every 1 hour for the remaining 16 hours.

Note: Any patient that receives thrombolytics will be monitored at an ICU level of care for the first 24 hours.

Management of suspected intracranial hemorrhage:

1. Suspect the occurrence of intracranial hemorrhage following the start of the thrombolytic infusion if there is any acute neurological deterioration, new headache, acute hypertension, or nausea with vomiting.

2. If hemorrhage is suspected, do the following:

    a. Immediately notify the responsible physician and the charge nurse.

    b. Immediate non-contrast head CT, stroke protocol, or other imaging sensitive for hemorrhage.

    c. If ordered, draw blood for CBC, PT, PTT, Fibrinogen, and Type and Cross.

3. If intracranial hemorrhage is present, as ordered by the physician:

    a. Obtain fibrinogen results

    b. Consider administering cryoprecipitate or platelets as needed

    c. Consult neurologist and neurosurgeon as needed to arrange for treatment plan and possible surgical treatment options

    d. Prepare for stat transfer to higher level of care

    e. Also see the Thrombolytic Induced Intracranial Hemorrhage pathway.

C. Post-Treatment:

Complete and document post- thrombolytic infusion NIHSS score by RN at hour 2, hour 8, and at hour 24.

- Neuro checks and vital signs as listed above.
  - a. Monitor and control blood pressure – less than 180/105
- Continue to monitor for complications:
  - a. Bleeding – major and/or minor:
    - i. Avoid intramuscular injections and trauma to the patient
    - ii. Monitor any arterial and venous puncture sites frequently
    - iii. Gentle teeth brushing
    - iv. Avoid use of a manual razor for 24 hours
  - b. Orolingual angioedema or anaphylaxis
    - i. Has been observed up to several hours after rt-PA infusion, especially in patients receiving concomitant angiotensin-converting enzyme inhibitors.
    - ii. Treatment:
      - i) Maintain airway – intubation may be necessary
      - ii) Discontinue alteplase infusion and hold ACE inhibitors
      - iii) Administer IV methylprednisolone 125 mg, as ordered
      - iv) Administer IV diphenhydramine 50 mg, as ordered
      - v) Administer famotidine 20 mg IV, as ordered
      - vi) If further increase in angioedema, administer epinephrine (0.1%) 0.3 ml subcutaneously or by nebulizer, 0.5 ml, as ordered.
      - vii) Infusion of Fresh Frozen Plasma (FFP) may be considered for ACEI – related, or refractory angioedema
  - c. Cholesterol embolization (rare)
  - d. Other allergic type reactions – rash, urticaria
- Obtain a follow up CT or MRI 24 hours post-treatment, before starting anti-coagulants or antiplatelet agents.

- Perform nursing swallow screen prior to patient receiving any oral medications, liquid, or food (See policy: Stroke Alert and Acute Care Stroke Management: ED & Inpatient Units).

- If in the ED, provide SBAR (Situation, Background, Assessment, Recommendation) nursing report to accepting nurse, specifying details of thrombolytic administration and current status of neuro checks / vital signs. It is imperative that no vital sign or neuro check is missed.

REFERENCES:

- Demaerschalk, B.M., Kleindorfer, D.O., Adeoye, O.M., et al. (2015). Scientific rationale for in the inclusion and exclusion criteria for intravenous Alteplase in acute ischemic stroke: A statement for healthcare professionals from the American Heart Association / American Stroke Association. Stroke, 2016;(47), pages 1 – 61. http://stroke.ahajournals.org.

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CROSS REFERENCES:

- *Stroke Alert & Acute Care Stroke Management: Emergency Department & Inpatient Units* – SVMC Policies and Procedures

- *High-Alert Medications and Look Alike Sound Alike Medications* – SVMC Policies and Procedures

ADMINISTRATION (Intravenous only) – After dose is calculated and medication is verified by 2nd RN, as detailed in attached policy.

1. Calculate the volume that will be unused (excess).

PRECAUTIONS

1. Use only for ACUTE ISCHEMIC STROKE.
2. Always use an infusion pump.
3. Use vented IV tubing.
4. Account for the amount of drug used to prime the IV tubing when withdrawing excess drug from the vial prior to administration.
5. Use caution for lab draws due to bleeding risk. Use IV lock when possible; avoid drawing through IV used for rt-PA administration.

SUBJECT: **V.A.C. THERAPY NEGATIVE PRESSURE WOUND**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 10**

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

PURPOSE:

- To provide guidelines on how to identify patients who would benefit from Vacuum Assisted Closure (V.A.C.) Therapy.
- To provide instruction on how to initiate treatment, conduct continuous monitoring and discontinuation of therapy.

Vacuum Assisted Closure Therapy is utilized to:

- Promote rapid granulation tissue formation by increasing blood supply to the wound.
- Remove excessive interstitial fluid, bacteria and wound exudates.
- Convert an open wound to a closed moist wound healing environment.
- Identify and evaluate risk factors and changes in the patient's condition that would warrant removal of the V.A.C. (e.g. hemorrhage).

Definition:

V.A.C. Therapy is a non-invasive active therapy utilizing a controlled localized sub-atmospheric/negative pressure which is applies directly to the wound. The V.A.C. may be applied to one or more wounds to supply negative pressure therapy. The V.A.C. increases blood supply to the wound thereby promoting granulation tissue formation. It stretches cells, enhances epithelial migration and converts an open wound into a controlled closed moist wound healing environment. The V.A.C. removes excessive interstitial fluid, bacteria and wound exudates into a disposable V.A.C. canister.

POLICY:

The wound V.A.C. Therapy education will include:

- Identification of patients whose wound(s) qualifies for V.A.C.
- Monitoring the effectiveness of the V.A.C. each dressing change
- Discontinuance of the V.A.C. if there is no evidence of wound healing
- All licensed nursing staff (i.e. RN, LVN) will complete an initial V.A.C. competency on hire and on annual competency thereafter which includes application, maintenance and troubleshooting.

AFFECTED PERSONNEL/AREAS: *PHYSICIANS; REGISTERED NURSES (RN)s; LICENSED VOCATIONAL NURSES (LVN)s*

PROCEDURE:

A. The wound will be assessed by the Wound Specialist or physician. An order will be entered, to include the following information:

1. When to initiate V.A.C. therapy
2. Location and number of wounds to receive V.A.C. therapy
3. Negative pressure setting in mmHg (125 mmHg) or desired pressure. If no pressure setting is specified, the default setting of 125 mmHg will be delivered until clarification can be obtained.
4. Type of therapy (basic, automated topical wound solution installation and removal, or incision management therapy).
5. Mode of therapy for Basic wound V.A.C, and incisional management therapy, (Continuous or Intermittent). If no mode of therapy is written, the default setting of Continuous will be delivered until clarification is obtained.
6. Automated topical wound solution installation therapy the physician order will include medication to be installed, the delay time, and continuous therapy time. (Example: Normal saline 22ml to be installed for 20min soak time followed by 2 hours of continuous negative pressure at 125mmHg)
7. Size and type of wound dressings.

B. The order will be called to Central Pressing (CPD) where the V.A.C. will be made available for pick-up. Please inform CPD of the patient's name, room number and date of V.A.C. activation. CPD will obtain a purchase order number from Materials Management and contact KCI at 1-800-275-4524 to initiate billing of the V.A.C.

C. Supplies are currently located in the storage rooms. For ordering additional supplies, contact Materials Management department or the wound nurse specialist.

D. The V.A.C. will be applied by a qualified competent staff member.

E. Nursing will return the V.A.C. pump to the "dirty" side of CPD when V.A.C. therapy is discontinued

NEGATIVE PRESSURE WOUND THERAPY CONSIDERATIONS

Indications:

- Acute surgically dehisced wounds (Orthopedics)
- Traumatic wounds
- Dehisced incisions
- Pre/post-split thickness meshed grafts and flaps
- Stage III and IV pressure ulcers
- Enteric fistulas
- Partial-thickness burns

Contraindications for Basic Wound V.A.C. therapy but may not be limited to:

- Presence of necrotic tissue
- Greater than 30% necrotic tissue (slough) present in the wound
- Untreated osteomyelitis (may initiate V.A.C. therapy 24-hours after initiation of systemic antibiotic therapy)
- Cancer within the wound bed or its margins
- Unexplored non-enteric fistulas
- DO NOT place foam dressing directly over exposed organs, veins or arteries
- Enteric fistulas

Contraindications for Automated topical wound solution installation therapy include but may not be limited to:

- Do not place foam dressing directly in contact with exposed blood vessels, anastomotic sites, organs, or nerves
- Malignancy in wound
- Untreated osteomyelitis
- Non- enteric and unexplored fistulas

Contraindications for Incisional management therapy but may not be limited to:

- Open wounds
- Sensitivity to silver

Documentation:

The following will be documented in the patient's medical record:

- Measurement and documentation of the wound's length, width and depth along with undermining/tunneling must preclude V.A.C. placement and must occur weekly.
- Initiation of V.A.C. including therapy mode, negative pressure setting and type of foam used (examples: Black, Silver or White)
- Dressing changes (example: M-W-F- or Tu-Th-Sat)
- Number of foam pieces used inside the wound
- Drainage amount if applicable
- Patient tolerance (pain), daily
- Appearance of dressing (raisin-like) on days when dressing change is not due
- Discontinuance of V.A.C.

GUIDELINES:

- For Automated topical wound solution installation: the medication rights should be used when initiating therapy and medication should include label for wound irrigation only
- For Automated topical wound solution installation basic and silver foam may not be used
- Specific guidelines for wounds will be determined by the Physician or Wound care nurse specialist
- Incisional Management system should only be used on clean closed incisions

NOTE: V.A.C. dressing should never be used in conjunction with wall or other suction devices.

DRESSING CARE & MANAGEMENT –

Supplies Needed:

- V.A.C. Pump
- V.A.C. Dressing Kit of choice that includes foam dressing, transparent/occlusive drape and TRAC pad.
- Wound Cleanser
- Scissors
- Towels and/or gauze to maintain a dry peri-wound area.
- Skin Prep
- Gloves
- Optional-clippers to clip hair, Y-connector to connect multiple wounds
- Medication ordered if applicable

Dressing Application Using Aseptic Technique:

- Aggressively clean and irrigate wound with wound cleanser.
- Achieve hemostasis
- Clip hair around boarder if needed
- Dry peri-wound area. Skin prep to be applied to secure occlusive drape.
- Cut foam dressing to shape and size of wound if necessary.
- Gently place the foam into the wound. DO NO PACK the wound tightly.
- Multiple pieces of foam dressing may be used when faced with a large or odd shaped wound as long as foam touches foam. This will ensure collapse of the foam when negative pressure is applied.
- When cutting foam, make sure to remove excess foam fragments that may become embedded into granulation tissue.
- Cover the foam and surrounding healthy tissue with the occlusive drape.

- Cut a portion of the occlusive drape where the TRAC pad is to be placed. The cut should measure the size of a nickel or quarter. Take care in positioning tubing near areas of bony prominence.

- Position clamps away from patient to avoid additional source of pressure.

Undermining Wounds:

- DO NOT over pack the dead space created by undermining. Gently fill it. Over packing can cause capillary compression which prohibits adequate wound perfusion.

- Fill the distal portion of the undermined area first, remembering to stop about a centimeter from the wound wall to allow granulation tissue to form.

Tunneling Wounds:

Tunneling can result in abscess formation when the main body of the wound heals and closes the entrance to the tunnel. To avoid this from happening, appropriate foam should be inserted into the tunneled area approximately a centimeter from the distal end of the tunnel (example: white foam for basic V.A.C.) Leave a portion of the foam extending beyond the surface to allow for easy removal. Record the number of individual foam pieces to ensure the total number gets removed during the next dressing change.

Wounds Small in Diameter:

Frame outer wound edge with skin prep and V.A.C. drape. Place foam dressing inside wound and lay a large piece of foam directly on top making sure that foam touches foam. Cover foam with V.A.C. drape and apply TRAC pad after creating a nickel or quarter size opening in drape.

Multiple Wounds:

When treating multiple wounds a "Y" connector can be inserted into the system as long as the surface area of total wounds does not exceed the V.A.C. pump's ability to achieve an adequate negative pressure seal.

Wounds that are in close proximity to one another may be dressed using the "Bridging" technique. The advantage to this technique is that multiple wounds can receive therapy with the use of only one TRAC pad.

- It is critical to protect intact skin between the wound with skin prep and the clear V.A.C. drape to prevent breakdown of healthy tissue from constant negative pressure and moisture applied through the porous dressing.

- Cover each wound with the V.A.C. foam dressing of choice. Attach an additional piece of foam between wound(s), acting as the "Bridge". Remember to place foam on top of the V.A.C. drape and ensure that foam touches foam in order to achieve proper collapse of the foam when negative pressure is initiated.

- Apply the TRAC pad to only one of the foam dressings. When negative pressure is applied, evaluate the entire area to ensure that collapsing of all foam is achieved.

Maintaining an airtight sealed dressing:

To assure optimal outcomes in utilizing the V.A.C., an airtight dressing seal is critical. The following techniques will be helpful in achieving a tight dressing seal:

- Dry the peri-wound area thoroughly. Use skin prep to prepare the area before applying the clear occlusive drape.
- Frame the wound with the skin prep when the skin around the wound is delicate or convoluted.

Reduce the height of the foam dressing by cutting or beveling the edges when treating shallow wounds or wounds near the perineal area.

Fecal Incontinence:

When a tight seal is difficult to achieve on a patient who has fecal incontinence and the wound is in the sacral, coccyx or perineal region, the following techniques may be helpful in achieving a tight dressing seal.

- Utilize a fecal collection bag or a rectal tube with a collection device.
- Frame the wound with skin prep and V.A.C. drape. May frame the wound with Stoma adhesive as well.
- Wound Specialist to consult with the physician about the possibility of a temporary Ostomy until the wound heals or improves.

Dressing Changes

Dressing changes are performed every forty-eight to seventy-two hours by competent and qualified personnel. Deviations from the 48-72 hour dressing are as follows:

- Physicians Order to modify frequency of dressing change
- Infected wounds -- (bacterial count >10 to the 5th power) dressing changes are to be performed every 12 hours. When the bacterial count decreases to <10 to the 5th power, or clinical signs of wound improvement are present, resume dressing changes every 48 hours.
- Status Post graft -- Perform dressing change every 4 – 5 days.

Dressing Removal:

1. Raise tubing above V.A.C. pump to allow the pump to pull exudates remaining in the tubing into the canister.

2. Press the Therapy ON/OFF button to deactivate pump.

3. Clamp both dressing and canister clamps.

4. Gently remove occlusive drape. The drape may be stretched horizontally to release the adhesive which allows for gentle removal when sensitive skin is present.

5. If dressing adheres to the base of the wound:

   a. For basic V.A.C. therapy consider a single layer of Adaptic or White foam between the wound base and foam dressing.

   b. Turn V.A.C. pump off. Inject foam with wound cleanser or normal saline. Allow the foam to become completely saturated. Wait 5 – 15 minute prior to removal of dressing.

6. If pain is present during dressing changes, turn the V.A.C. pump off. Inject the foam with 1-2% Lidocaine. Wait 5-15 minute prior to removal of dressing.

Canister Changes:

The canister is to be changed every five (5) days or prn when full. The canister is self-contained and cannot be emptied.

1. Close both dressing and canister clamps.

2. Disconnect canister tubing at the male/female connector.

3. Push the canister release button on the pump. This releases the canister which can now be removed from the pump.

4. Dispose of the canister in the appropriate receptacle per hospital policy.

CARE AND SAFETY RECOMMENDATIONS:

1. Keep NPWT ON – V.A.C. therapy must be applied to the wound at least twenty-two (22) hours a day. Should therapy be interrupted for more than two consecutive hours, the entire dressing must be changed to avoid bacterial colonization in the foam dressing.

2. Dressing Changes – Always use sterile unopened foam disposables when performing dressing changes. Do not "save" foam after package is opened. It is acceptable to use excessive occlusive drape.

3. Daily Wound Care – Inspect wound frequently. Visually observe the V.A.C. dressing to assure that it has the collapsed appearance of a raisin. Review the pump screen to verify proper negative pressure setting and mode of therapy. Watch for signs/symptoms of infection (fever, redness, increased warmth to wound area and purulent discharge or strong odor).

4. Discomfort – Consider lowering the V.A.C. target pressure. A physician order is required.

5. Wound Appearance – A steady decrease in wound volume should be noted. Initially the wound may appear larger due to the wound edges softening and the reduction of edema. The wound may appear paler as the amount of collagen in the wound increases.

ALARMS:

There are a total of five (5) alarms. Each alarm will be displayed on the LED screen when it is activated and there will be a prompt to troubleshoot the alarm condition.

1. **Leak**: The screen message will display – "Tubing and/or Dressing has Leaks"

   Action: Check that the canister is securely connected to the dressing. If that does not resolve the alarm condition, apply pressure with your fingers around the dressing and clear occlusive drape. When the leak is located and sealed, the dressing will collapse. It may be necessary to cut away the drape and reapply drape to area to achieve an effective seal.

   a. If the alarm condition is not corrected in two minutes, the audible alarm will sound.

   b. If the alarm condition is not corrected, the pump will shut down five minutes after the audible alarm is activated.

2. **Tubing blocked**: The screen will display – "Tubing is Blocked"

   Action: Ensure tubing clamps are open and check that the tubing is no kinked or pinched.

3. **Canister Full**: The screen will display – "Canister full." (The canister has reached the maximum capacity of 500 ml)

   Action: Turn pump off. Clamp and disconnect the canister from the dressing tubing. Remove the canister and dispose of it per hospital policy. Insert a new canister and reconnect it to the dressing tubing. Open the clamps. Activate the pump. Observe the dressing for proper compressing. The dressing should appear "raisin-like".

4. **Therapy is not activated**: The screen will display – "Therapy not Activated"

Action: Turn therapy on.

5. **Low Battery**: The screen will display – "Battery is Low"

   Action: Plug the AC cord into a red electrical outlet. Be sure that the plug to the pump unit is also firmly attached.

6. **Back Up Battery Operation**:

   The backup battery will be automatically activated when the pump is disconnected from the AC source. The plug symbol will disappear from the screen. Once the AC is plugged into the AC source, the unit will begin recharging.

   a. Average battery life is approximately four (4) hours

   b. Average time to recharge the battery is four (4) hours to reach 85% charge capacity and approximately ten (10) hours to achieve full charge.

   c. The battery life is represented by the battery symbol on the display screen. The lines inside the battery symbol represent the battery time remaining. Each line has a value of one hour.

   d. Automatic pump shutdown will occur when the battery has reached a critical level. The pump will remain off even when AC power is restored. The operator must flip the green power button to regain pump function.

7. **Mute Button**: Silences the alarm for two minutes.

REFERENCE:

3M. (n.d.). *Clinical guidelines*. **https://multimedia.3m.com/mws/media/2028885O/3m-v-a-c-therapy-clinical-guidelines-clinicians-reference-source.pdf**

SUBJECT: **WEIGHT VARIANCE - DP/SNF**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish guidelines for treatment of residents with unusual or significant weight variance.

POLICY:

Monitoring and treatment for unusual or significant weight variances will be based on best practice. The weekly disciplinary team will discuss treatment options. Treatment will proceed once a physician's order and consent is secured and on record.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, DP/SNF*

PROCEDURE:

1. Each resident will have their weight and length measured on admission. The facility will establish a schedule to obtain each resident's weight. A new resident will be weighed weekly for four (4) weeks and then monthly, unless ordered otherwise. Weights will be recorded in pounds. Increased frequency of weight monitoring will be determined by the resident need at the discretion of the physician, clinical director, dietitian, or registered nurse.

2. The facility will adhere to the guidelines for obtaining accurate weights to ensure accuracy.

3. Staff members obtaining residents' weight will be in-serviced on procedures for obtaining accurate weights and for reporting unusual or significant weight variances to the licensed nurse.

4. Scales will be re-balanced by staff prior to obtaining each resident's weight.

5. Unusual or significant weight variance includes the following:

    a. Gain or loss of five (5) pounds or more or 5% of weight (whichever is greater) in one month when the resident weighs over 100 pounds.

    b. Gain or loss of three (3) pounds in one month when the resident weighs 100 pounds or less.

    c. Gain or loss of three (3) pounds or more in one week if the resident is on weekly weights.

    d. Consistent weight gain or loss of 7.5% in 3 months or 10% of weight in 6 months.

6. Significant weight losses/gains, (both planned and unplanned) will be reported to the physician and the dietitian.

7. When a weight loss or gain trend has been identified as undesirable, an entry will be included on the resident care plan and reported to the dietitian.

8. Residents requiring a weight loss/gain regimen will be presented at the weekly interdisciplinary meeting. If the team agrees with the recommendation, the Registered Dietitian will secure consent for weight loss/gain from the resident or patient family member. A physician order will be placed in the medical record.

9. All obtained weights will be recorded in the resident's permanent record.

10. All physician notifications will be documented in the nurse's notes.

11. If a patient refuses to be weighed, reattempt in three (3) days. After two refusals, the physician and dietitian will be notified and refusals documented in the medical record.

GUIDELINES FOR OBTAINING ACCURATE WEIGHTS:

1. Locate the scale in a convenient place and avoid moving it if at all possible.

2. Try to weigh residents within time frames as consistent as possible.

3. Try to maintain consistency in staff performing weights. This increases accuracy.

4. Validate weight discrepancies by re-weighing prior to notification of the physician.

5. The contracted bio-med company will calibrate scales routinely (according to policy) and document the calibration.

"Consent for Weight Gain / Loss Regimen" Form Attached

REFERENCES:

- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html.

- Med Pass, Inc. (Updated February 6, 2015), Facility Guide to OBRA Regulations,483.35 (1),483.25 (i).

SIERRA VIEW MEDICAL CENTER
DISTINCT PART SKILLED NURSING FACILITY
CONSENT FOR WEIGHT GAIN/LOSS REGIMEN

INFORMED CONSENT FOR DIET REGIMEN

CIRCLE ONE : **WEIGHT LOSS** **WEIGHT GAIN**

NAME OF RESIDENT_____

ADVANTAGE: To allow the dietitian and physician to adjust calories in the diet as needed to maintain a healthy weight.

SIDE EFFECTS: If a resident chooses not to follow dietary regimen recommended by the dietitian and physician, subsequent clinical manifestations may arise over time (i.e. obesity, cardiovascular disease, skin and respiratory issues).

The above information has been explained to me. I consent and agree with the treatment recommended by the physician and dietitian to change the diet when needed for a healthy nutrition status.

CHECK A BOX : Telephone conversation ☐ In person ☐

_____ _____
(Resident Name or Representative) Date
If signed by other than resident, indicate relationship.

_____ _____
Registered Dietitian Date

_____ _____
Physician Date

_____ _____
Registered Nurse (Witness) Date

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MEETING MINUTES

BOARD OF DIRECTORS REGULAR MEETING
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **January 28, 2025 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman Lomeli called the meeting to order at 5:04 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ**
Appointed During the Meeting: KASHYAP

Others Present: Donna Hefner, President/Chief Executive Officer, Melissa Mitchell, VP of Quality and Regulatory Affairs, Craig McDonald, Chief Financial Officer, Jeffery Hudson, VPPCS/CNO/DIO, Ron Wheaton, VP of Professional Service, Tracy Canales, VP of Human Resources and Marketing, Terry Villareal, Executive Assistant and Clerk to the Board, Kim Pryor DeShazo, Director of Marketing and Community Services, Gary Wilbur, Administrative Director of General Services, Zaelin Stringham, Rosalva Gonzales, Cindy Gomez, Compliance Privacy Officer, Silvia Robert Director of Care Integration, Mark Nanamura, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff, Chris Peterson and Hans Kashyap

I. Approval of Agenda:

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

LOMELI	Yes
REDDY	Yes
MARTINEZ	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:04 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update – Quality Report

C. Pursuant to Gov. Code Section 54954.5(c) and 54956.9(d): Conference with Legal Counsel Regarding Significant Exposure to Litigation

Closed Session Items D and E were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session's scheduled start time.

III. Open Session: Chairman LOMELI adjourned Closed Session at 5:35 p.m., reconvening in Open Session at 5:35 p.m.

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

A. Chief of Staff Report provided by Chief of Staff Sandhu.
Information Only; No Action Taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

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

LOMELI	Yes
REDDY	Yes
MARTINEZ	Yes

2. Quality Division Update – Quality Report

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

LOMELI	Yes
REDDY	Yes
MARTINEZ	Yes

C. Conference with Legal Counsel Regarding Significant Exposure to Litigation
Recommended Action: Information Only; No Action Taken

IV. Public Comments

None

V. Consent Agenda

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

LOMELI	Yes
REDDY	Yes
MARTINEZ	Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Vice Chairman REDDY and seconded by Director MARTINEZ to approve the December 17, 2024 Minutes of the Regular Board Meeting as presented. The motion carried and the vote of the Board is as follows:

LOMELI	Yes
REDDY	Yes
MARTINEZ	Yes

B. Following review and discussion, it was moved by Vice Chairman REDDY and seconded by Director MARTINEZ to approve the January 20, 2025 Minutes of the Special Board Meeting as presented. The motion carried and the vote of the Board is as follows:

LOMELI	Yes
REDDY	Yes
MARTINEZ	Yes

VII. Business Items

A. Sierra View Foundation Check Presentation
Recommended Action: Information Only: No Action Taken

B. Vote to Appoint Director to Fill Vacancy for Zone 3

Two candidates, Chris Peterson and Hans Kashyap, submitted applications and were verified as residents of Zone 3. Both were present in the Board Room and participated in interviews conducted by the Board. Following a review and discussion, Chairman Lomeli opened the floor for voting. The Board unanimously voted to appoint Hans Kashyap to fill the Zone 3 vacancy. The votes in the order they were placed is as follows:

REDDY	Hans Kashyap
MARTINEZ	Hans Kashyap
LOMELI	Hans Kashyap

C. Administer Oath of Office to Appointed Director for Zone 3

The Oath of Office was administered by CEO, Donna Hefner to appointee, Hans Kashyap.

Director Martinez exited the meeting and the Board Room after Hans Kashyap took the Oath of Office and took his seat on the Board.

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Chairman LOMELI and carried to direct hospital administration to immediately notify the Tulare County Elections Official of the appointment. The vote of the Board is as follows:

LOMELI	Yes
REDDY	Yes
KASHYAP	Yes

D. December 2024 Financials

Craig McDonald, CFO presented the Financials for December 2024. A copy of this presentation is attached to the file copy of these minutes.

Following review and discussion, it was moved by Chairman LOMELI, seconded by Vice Chairman REDDY and carried to approve the December 2024 Financials as presented. The vote of the Board is as follows:

LOMELI	Yes
REDDY	Yes
KASHYAP	Yes

E. Investment Report – Quarter Ending December 31, 2024

Craig McDonald, CFO presented the Investment Report for Quarter Ending December 31, 2024. Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director KASHYAP and carried to approve the Investment Report as presented. The vote of the Board is as follows:

LOMELI	Yes
REDDY	Yes
KASHYAP	Yes

F. Capital Report – Quarter Ending December 31, 2024

Craig McDonald, CFO presented the Capital Report for Quarter Ending December 31, 2024. Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Vice Chairman REDDY and carried to approve the Capital Report as presented. The vote of the Board is as follows:

LOMELI Yes
REDDY Yes
KASHYAP Yes

G. Annual Appointments

1. Food and Dietetic Services Director

Ron Wheaton, Vice President of Physician Recruitment and Professional Services presented credentials for Zaelin Stringham, Director of Food and Nutrition.

Following review and discussion, it was moved by Vice Chair REDDY, seconded by Director KASHYAP and carried to approve Zaelin Stringham as the Food and Dietetic Services Director as presented. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
KASHYAP Yes

2. Environmental Safety/Security Officer

Craig McDonald, Vice President and Chief Financial Officer presented credentials for Gary Wilbur, Administrative Director of General Services.

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director KASHYAP and carried to approve Gary Wilbur as the Environmental Safety/Security Officer as presented. The vote of the Board is as follows:

REDDY Yes
LOMELI Yes
KASHYAP Yes

3. Patient Safety Officer

Donna Hefner, President and CEO presented credentials for Melissa Mitchell, Vice President of Quality and Regulatory Affairs.

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director KASHYAP and carried to approve Melissa Mitchell as the Patient Safety Officer as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
KASHYAP	Yes

4. Infection Control Officer

Melissa Creppin, Vice President of Quality and Regulatory Affairs presented credentials for Rosalva Gonzalez, Infection Prevention Manager.

Following review and discussion, it was moved by Vice Chairman REDDY, seconded by Director KASHYAP and carried to approve Rosalva Gonzalez as the Infection Control Officer as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
KASHYAP	Yes

H. Board Self Evaluation and 2025 Goals According to 4.2 Bylaw Requirement
Recommended Action: Information Only; No Action Taken

VIII. CEO Report

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

IX. Announcements:

A. Regular Board of Directors Meeting – February 25, 2025 at 5:00 p.m.

Closed Session: Board adjourned Open Session at 6:30 p.m., reconvening in Closed Session at 6:34 p.m. to discuss the following items.

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

X. Open Session: Chairman REDDY adjourned Closed Session at 6:51 p.m., reconvening in Open Session at 6:52 p.m.

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

E. Conference With Legal Counsel
Information Only; No Action Taken

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

XI. Adjournment

The meeting was adjourned at 6:53 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: trv

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FINANCIAL PACKAGE
January 2025

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

	Pages
Statistics	1-2
Balance Sheet	3-4
Income Statement	5
Statement of Cash Flows	6
Monthly Cash Receipts	7

Sierra View Medical Center
Financial Statistics Summary Report
January 2025

	Jan-25				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	(Decrease) Jan-24	% Change
Utilization											
SNF Patient Days											
Total	-	56	(56)	-100.0%	127	394	(267)	-67.7%	422	(295)	-69.9%
Medi-Cal	-	56	(56)	-100.0%	127	392	(265)	-67.6%	422	(295)	-69.9%
Sub-Acute Patient Days											
Total	955	970	(15)	-1.5%	7,062	6,788	274	4.0%	6,827	235	3.4%
Medi-Cal	455	852	(397)	-46.6%	3,533	5,751	(2,218)	-38.6%	5,793	(2,260)	-39.0%
Acute Patient Days	1,919	1,648	271	16.5%	11,679	11,533	146	1.3%	11,720	(41)	-0.3%
Acute Discharges	499	427	72	16.9%	3,132	2,988	144	4.8%	3,005	127	4.2%
Medicare	201	183	18	10.1%	1,227	1,158	69	5.9%	1,164	63	5.4%
Medi-Cal	228	206	22	10.6%	1,484	1,484	0	0.0%	1,492	(8)	-0.5%
Contract	66	37	29	78.7%	401	324	77	23.7%	327	74	22.6%
Other	4	1	3	300%	20	22	(2)	-7.3%	22	(2)	-9.1%
Average Length of Stay	3.85	3.86	(0.01)	-0.4%	3.73	3.86	(0.13)	-3.4%	3.90	(0.17)	-4.4%
Newborn Patient Days											
Medi-Cal	163	161	2	1.2%	1,081	1,119	(38)	-3.4%	1,235	(154)	-12.5%
Other	43	31	12	38.7%	268	226	42	18.4%	195	73	37.4%
Total	206	192	14	7.3%	1,349	1,345	4	0.3%	1,430	(81)	-5.7%
Total Deliveries	104	99	5	5.1%	701	693	8	1.2%	719	(18)	-2.5%
Medi-Cal %	78.85%	83.43%	-4.59%	-5.5%	80.91%	83.43%	-2.52%	-3.0%	85.10%	-4.19%	-4.9%
Case Mix Index											
Medicare	1.5451	1.6368	(0.0917)	-5.6%	1.6099	1.6368	(0.0269)	-1.6%	1.6129	(0.0030)	-0.2%
Medi-Cal	1.2264	1.1975	0.0289	2.4%	1.2076	1.1975	0.0101	0.8%	1.2002	0.0074	0.6%
Overall	1.3487	1.3724	(0.0237)	-1.7%	1.3656	1.3724	(0.0068)	-0.5%	1.3702	(0.0046)	-0.3%
Ancillary Services											
Inpatient											
Surgery Minutes	7,986	8,224	(238)	-2.9%	53,689	57,567	(3,878)	-6.7%	57,980	(4,291)	-7.4%
Surgery Cases	96	94	2	2.4%	644	656	(12)	-1.9%	656	(12)	-1.8%
Imaging Procedures	1,888	1,404	484	34.4%	10,775	9,830	945	9.6%	9,818	957	9.7%
Outpatient											
Surgery Minutes	13,810	12,775	1,035	8.1%	95,789	89,426	6,363	7.1%	80,949	14,840	18.3%
Surgery Cases	201	204	(3)	-1.3%	1,334	1,426	(92)	-6.5%	1,393	(59)	-4.2%
Endoscopy Procedures	214	192	23	11.7%	1,271	1,341	(70)	-5.2%	1,290	(19)	-1.5%
Imaging Procedures	4,531	3,886	645	16.6%	28,813	27,200	1,613	5.9%	27,338	1,475	5.4%
MRI Procedures	321	302	19	6.4%	2,106	2,112	(6)	-0.3%	2,102	4	0.2%
CT Procedures	1,277	1,237	40	3.2%	8,734	8,658	76	0.9%	8,741	(7)	-0.1%
Ultrasound Procedures	1,360	1,244	116	9.4%	9,191	8,706	485	5.6%	8,591	600	7.0%
Lab Tests	33,949	32,140	1,809	5.6%	218,902	224,981	(6,079)	-2.7%	221,640	(2,738)	-1.2%
Dialysis	4	6	(2)	-36.8%	24	44	(20)	-45.9%	25	(1)	-4.0%

Sierra View Medical Center
Financial Statistics Summary Report
January 2025

	Jan-25				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	(Decrease) Jan-24	% Change
Cancer Treatment Center											
Chemo Treatments	1,630	1,924	(294)	-15.3%	13,301	13,466	(165)	-1.2%	11,105	2,196	19.8%
Radiation Treatments	1,281	1,836	(555)	-30.2%	12,741	12,850	(109)	-0.9%	12,342	399	3.2%
Cardiac Cath Lab											
Cath Lab IP Procedures	21	11	10	86.7%	88	79	9	11.7%	87	1	1.1%
Cath Lab OP Procedures	37	30	7	23.7%	247	209	38	17.9%	210	37	17.6%
Total Cardiac Cath Lab	58	41	17	40.9%	335	288	47	16.3%	297	38	12.8%
Outpatient Visits											
Emergency	3,688	3,415	273	8.0%	24,312	23,902	410	1.7%	24,329	(17)	-0.1%
Total Outpatient	14,795	13,994	801	5.7%	97,690	97,960	(270)	-0.3%	92,915	4,775	5.1%
Staffing											
Paid FTE's	856.31	855.00	1.31	0.2%	870.07	855.00	15.07	1.8%	854.06	16.01	1.9%
Productive FTE's	752.79	734.21	18.58	2.5%	744.65	734.21	10.44	1.4%	732.83	11.82	1.6%
Paid FTE's/AOB	4.99	4.98	0.01	0.2%	5.15	4.94	0.21	4.3%	5.06	0.09	1.9%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,833	10,552	1,281	12.1%	11,273	10,552	721	6.8%	10,641	632	5.9%
Cost/Adj.Patient Day	2,829	2,619	210	8.0%	2,781	2,633	148	5.6%	2,660	120	4.5%
Revenue/Adj. Discharge	56,602	53,065	3,537	6.7%	54,693	53,065	1,628	3.1%	53,886	807	1.5%
Cost/Adj. Discharge	13,532	13,172	359	2.7%	13,491	13,238	252	1.9%	13,471	20	0.1%
Adj. Discharge	1,111	1,057	54	5.1%	7,486	7,402	84	1.1%	7,172	314	4.4%
Net Op. Gain/(Loss) %	4.53%	-4.33%	8.87%	-204.6%	-2.40%	-4.33%	1.94%	-44.7%	-6.04%	3.64%	-60.3%
Net Op. Gain/(Loss) $	714,139	(578,510)	1,292,649	-223.4%	(2,364,072)	(4,540,872)	2,176,800	-47.9%	(5,500,600)	3,136,528	-57.0%
Gross Days in Accts Rec.	84.29	95.03	(10.74)	-11.3%	84.29	95.03	(10.74)	-11.3%	96.89	(12.59)	-13.0%
Net Days in Accts. Rec.	40.78	57.75	(16.97)	-29.4%	40.78	57.75	(16.97)	-29.4%	58.90	(18.12)	-30.8%

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

	JAN 2025	DEC 2024
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 16,818,418	$ 13,026,237
SHORT-TERM INVESTMENTS	1,333,176	0
ASSETS LIMITED AS TO USE	3,085,080	3,292,615
PATIENT ACCOUNTS RECEIVABLE	162,310,970	162,112,303
LESS UNCOLLECTIBLES	(16,263,133)	(15,489,450)
CONTRACTUAL ALLOWANCES	(127,666,011)	(128,241,181)
OTHER RECEIVABLES	25,233,274	27,955,672
INVENTORIES	4,446,092	4,441,080
PREPAID EXPENSES AND DEPOSITS	3,206,660	3,164,140
LEASE RECEIVABLE - CURRENT	303,872	339,208
TOTAL CURRENT ASSETS	72,808,398	70,600,624
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	31,837,518	31,745,341
LONG-TERM INVESTMENTS	134,652,017	135,485,326
PROPERTY, PLANT AND EQUIPMENT, NET	73,150,516	72,973,020
INTANGIBLE RIGHT OF USE ASSETS	339,308	351,323
SBITA RIGHT OF USE ASSETS	2,193,204	2,209,745
LEASE RECEIVABLE - LT	893,716	970,383
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,363,675	1,384,655
TOTAL ASSETS	$ 317,488,351	$ 315,970,416

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

	JAN 2025	DEC 2024
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 115,588	$ 693,525
CURRENT MATURITIES OF BONDS PAYABLE	4,235,000	4,235,000
CURRENT MATURITIES OF LONG TERM DEBT	1,551,431	1,635,911
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	5,832,376	4,817,040
ACCRUED PAYROLL AND RELATED COSTS	6,678,290	6,597,959
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,321,777	3,434,136
LEASE LIABILITY - CURRENT	138,613	140,323
SBITA LIABILITY - CURRENT	1,113,638	1,085,400
TOTAL CURRENT LIABILITIES	22,986,712	22,639,294
SELF-INSURANCE RESERVES	2,126,435	2,165,227
BONDS PAYABLE, LESS CURR REQT	33,275,000	33,275,000
BOND PREMIUM LIABILITY - LT	2,338,362	2,390,319
LEASE LIABILITY - LT	224,008	234,141
SBITA LIABILITY - LT	1,244,293	1,306,610
DEFERRED INFLOW - LEASES	1,131,175	1,237,162
TOTAL LIABILITIES	63,325,984	63,247,753
UNRESTRICTED FUND	248,385,511	248,385,511
PROFIT OR (LOSS)	5,776,857	4,337,152
TOTAL LIABILITIES AND FUND BALANCE	$ 317,488,351	$ 315,970,416

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

JAN 2025 ACTUAL	JAN 2025 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,925,796	5,253,784	(672,012)	13%	INPATIENT - NURSING	38,066,984	36,776,488	(1,290,496)	4%
22,432,044	17,396,289	(5,035,755)	29%	INPATIENT - ANCILLARY	133,751,719	121,774,029	(11,977,690)	10%
28,357,840	22,650,073	(5,707,767)	25%	TOTAL INPATIENT REVENUE	171,818,703	158,550,517	(13,268,186)	8%
34,529,251	33,463,071	(1,066,180)	3%	OUTPATIENT - ANCILLARY	237,615,230	234,241,501	(3,373,729)	1%
62,887,090	56,113,144	(6,773,946)	12%	TOTAL PATIENT REVENUE	409,433,934	392,792,018	(16,641,916)	4%
				DEDUCTIONS FROM REVENUE				
(18,491,495)	(18,243,309)	248,186	1%	MEDICARE	(122,481,437)	(127,703,163)	(5,221,726)	(4)%
(20,988,107)	(18,032,202)	2,955,905	16%	MEDI-CAL	(126,697,184)	(126,225,414)	471,770	0%
(6,128,942)	(6,660,852)	(531,910)	(8)%	OTHER/CHARITY	(49,738,262)	(46,625,964)	3,112,298	7%
(67,772)	(9,556)	58,216	609%	DISCOUNTS & ALLOWANCES	(13,576,997)	(66,892)	13,510,105	20,197%
(2,041,546)	(499,610)	1,541,936	309%	BAD DEBTS	(2,290,556)	(3,497,270)	(1,206,714)	(35)%
(47,717,862)	(43,445,529)	4,272,333	10%	TOTAL DEDUCTIONS	(314,784,437)	(304,118,703)	10,665,734	4%
15,169,229	12,667,615	(2,501,614)	20%	NET SERVICE REVENUE	94,649,497	88,673,315	(5,976,182)	7%
578,827	682,481	103,654	(15)%	OTHER OPERATING REVENUE	3,978,058	4,777,373	799,315	(17)%
15,748,056	13,350,096	(2,397,960)	18%	TOTAL OPERATING REVENUE	98,627,555	93,450,688	(5,176,867)	6%
				***** OPERATING EXPENSE *****				
5,841,292	5,547,032	294,260	5%	SALARIES	39,732,101	38,838,544	893,557	2%
717,337	675,338	41,999	6%	S&W PTO	4,436,216	4,735,094	(298,878)	(6)%
1,440,237	1,472,994	(32,758)	(2)%	EMPLOYEE BENEFITS	10,325,448	10,230,041	95,407	1%
2,145,430	1,400,468	744,962	53%	PROFESSIONAL FEES	11,958,322	9,919,937	2,038,385	21%
906,080	816,773	89,307	11%	PURCHASED SERVICES	5,917,486	5,820,638	96,848	2%
1,919,601	2,028,097	(108,496)	(5)%	SUPPLIES & EXPENSES	14,437,738	14,215,297	222,441	2%
162,531	283,512	(120,981)	(43)%	MAINTENANCE & REPAIRS	1,770,626	1,930,556	(159,930)	(8)%
299,536	277,064	22,472	8%	UTILITIES	1,987,134	1,939,448	47,686	3%
38,305	19,605	18,700	95%	RENT/LEASE	242,339	137,231	105,108	77%
124,209	121,228	2,981	3%	INSURANCE	848,875	848,596	279	0%
908,422	978,565	(70,143)	(7)%	DEPRECIATION/AMORTIZATION	6,663,215	7,114,044	(450,829)	(6)%
495,789	307,930	187,859	61%	OTHER EXPENSE	2,460,847	2,262,134	198,713	9%
35,149	0	35,149		IMPAIRED COSTS	211,281	0	211,281	
15,033,917	13,928,606	1,105,311	8%	TOTAL OPERATING EXPENSE	100,991,627	97,991,560	3,000,067	3%
714,139	(578,510)	(1,292,649)	(223)%	NET GAIN/(LOSS) FROM OPERATIONS	(2,364,072)	(4,540,872)	(2,176,800)	(48)%
138,253	138,253	0	0%	DISTRICT TAXES	967,771	967,771	0	0%
383,430	343,455	(39,975)	12%	INVESTMENTS INCOME	2,705,287	2,404,181	(301,106)	13%
49,220	54,010	4,790	(9)%	OTHER NON OPERATING INCOME	2,638,805	378,073	(2,260,732)	598%
(76,278)	(80,573)	(4,295)	(5)%	INTEREST EXPENSE	(537,538)	(564,013)	(26,475)	(5)%
(67,811)	(36,952)	30,859	84%	NON-OPERATING EXPENSE	(292,571)	(258,671)	33,900	13%
426,814	418,193	(8,621)	2%	TOTAL NON-OPERATING INCOME	5,481,754	2,927,341	(2,554,413)	87%
1,140,953	(160,317)	(1,301,270)	(812)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	3,117,682	(1,613,531)	(4,731,213)	(293)%
298,752	100,000	(198,752)	199%	NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	2,659,175	700,000	(1,959,175)	280%
1,439,705	(60,317)	(1,500,022)	(2,487)%	NET GAIN/(LOSS)	5,776,857	(913,531)	(6,690,388)	(732)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
01/31/25

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	714,139	(2,364,072)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	908,422	6,663,215
Provision for bad debts	773,683	(7,283,142)
Change in assets and liabilities:		
Patient accounts receivable, net	(773,837)	12,716,311
Other receivables	2,722,398	(6,983,091)
Inventories	(5,012)	(155,440)
Prepaid expenses and deposits	(42,520)	(885,256)
Advance refunding of bonds payable, net	20,980	146,857
Accounts payable and accrued expenses	1,015,333	(491,218)
Deferred inflows - leases	(105,987)	(92,741)
Accrued payroll and related costs	80,331	(1,881,529)
Estimated third-party payor settlements	(112,359)	(335,168)
Self-insurance reserves	(38,792)	(62,565)
Total adjustments	4,442,640	1,356,233
Net cash provided by (used in) operating activities	5,156,779	(1,007,839)
Cash flows from noncapital financing activities:		
District tax revenues	138,253	967,771
Noncapital grants and contributions, net of other expenses	(29,755)	(19,986)
Net cash provided by (used in) noncapital financing activities	108,498	947,785
Cash flows from capital and related financing activities:		
Purchase of capital assets	(1,073,903)	(2,884,474)
Proceeds from sale of assets	-	3,255,420
Proceeds from lease receivable, net	112,003	95,303
Principal payments on debt borrowings	-	(4,055,000)
Interest payments	(695,008)	(1,489,247)
Net change in notes payable and lease liability	(113,861)	(716,343)
Net changes in assets limited as to use	115,358	1,511,545
Net cash provided by (used in) capital and related financing activities	(1,655,411)	(4,282,796)
Cash flows from investing activities:		
Net (purchase) or sale of investments	1,132,061	(3,257,481)
Investment income	383,430	2,705,287
Net cash provided by (used in) investing activities	1,515,491	(552,194)
Net increase (decrease) in cash and cash equivalents:	5,125,357	(4,895,044)
Cash and cash equivalents at beginning of month/year	13,026,237	23,046,638
Cash and cash equivalents at end of month	18,151,594	18,151,594

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
January 2025

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Feb-24	10,531,309	1,474,392	12,005,701
Mar-24	11,275,398	3,178,205	14,453,603
Apr-24	13,314,378	6,920,700	20,235,078
May-24	11,564,879	10,488,610	22,053,489
Jun-24	10,598,225	7,664,994	18,263,219
Jul-24	13,499,837	278,849	13,778,686
Aug-24	10,684,807	298,095	10,982,902
Sep-24	12,800,001	1,611,606	14,411,607
Oct-24	14,933,404	1,420,062	16,353,466
Nov-24	11,872,571	1,402,779	13,275,350
Dec-24	13,002,191	6,026,303	19,028,494
Jan-25	**12,353,155**	**4,293,154**	**16,646,309**

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

January 2025 Summary of Other Activity:

907,726	M-Cal HQAF8 Direct Grant CY24
2,918,057	Health Net QIP IGT CY23
82,487	Health Net DHDP CY23 DPSNF
384,884	Miscellaneous
4,293,154	01/25 Total Other Activity

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EMPLOYMENT AGREEMENT

This EMPLOYMENT AGREEMENT effective March 1, 2025 is by and between SIERRA VIEW LOCAL HEALTH CARE DISTRICT, a political subdivision of the State of California (hereinafter "District") and Donna Hefner (hereinafter "Employee"):

R E C I T A L S

A. District is the operator of an acute care hospital in Porterville, California and related facilities and projects (hereinafter "Hospital"); and

B. Employee is being hired under this contract to be employed as and to hold the position of Administrator/President/CEO of the Hospital and District. Employee has been President/CEO since May 5, 2013, was formerly Interim CEO since January 15, 2013, was prior to that Executive Director of Risk Management, has been part of the Hospital's Senior Management Team since July 31, 2007 and has been employed by the District since July 23, 1990.

THEREFORE, IT IS AGREED as follows:

1. **Engagement**: District hereby employs Employee and Employee accepts employment by District as Administrator/President/CEO of the District and Hospital under this Agreement as of its effective date recited above, for the compensation as hereinafter specified, and upon all of the further terms and conditions of this Agreement. For any matters not covered by this Agreement, the parties shall act in accordance with their past practices or with general District employment policy if there are no such past practices.

2. **Duties of Employee**: During the term of this Agreement, Employee shall act as Administrator/President/CEO for the District. In this connection, she shall have all of the duties and responsibilities generally set forth in the job description,

Exhibit A hereto, as outlined in the Bylaws of the District, as imposed by statute or regulation existing now or in the future, and as imposed by policies and directives of the District's Board of Directors commensurate with her position, as such documents, statutes and regulations may be amended from time to time. Employee shall also perform such duties and have such responsibilities as the Board of Directors of the District may from time to time require of her commensurate with her position and expected tenure as CEO. In the performance of her duties, Employee shall report to the Board of Directors.

3. Devotion of Entire Time: Employee shall devote her entire time, energy and ability to the performance of the duties under this Agreement, which shall average at least forty (40) hours/week. Without District's prior written consent, Employee shall not engage directly or indirectly in any activity competitive with or adverse to the business or welfare of the Hospital or the District, whether alone or as a partner, officer, director, consultant, employee or agent thereof, and whether for compensation or not. Employee shall not undertake actions that create the appearance of impropriety.

4. Term: The term of Employee's employment under this Agreement shall commence on the effective date of this Agreement and shall continue for four (4) years. At the end of each year of this Agreement, the Board shall do a performance review and salary review of the Employee's performance at or by the regular April Board meeting. At any time after two (2) years of this Agreement have been completed, the parties may negotiate a replacement of this Agreement.

If at the end of the term of this Agreement no extension or replacement agreement has been agreed on, provided Employee continues to be employed with

District after the end of the term stated above, unless the parties have entered into a written extension, replacement or modification of this Agreement to provide for continued employment and/or for an extension of its term, this Agreement shall automatically be renewed and extended for a successive term or terms of one year each. A written notice by either party to the other at least thirty (30) days prior to the end of the initial term or any successive term shall prevent such automatic renewal. Either party may terminate this Agreement at any time without cause as provided in Paragraph No. 9 below or for cause as provided in Paragraph 10 below, or upon death or disability as provided in Paragraph 11 below, without regard to this second paragraph of paragraph 4 or its automatic renewal provision.

5. Compensation: Under this Agreement, Employee shall initially receive as compensation a base salary of $ $442,332.80 annually. This salary may be adjusted from time to time by agreement of the parties. In spite of this being a four-year contract, compensation shall be reviewed by the parties at least annually. Notwithstanding the preceding sentence, and in the absence of any other agreement that parties may make as to the amount of salary, the base salary shall be automatically increased annually by three percent (3%) over the prior year's base salary as of May First of each year. Upon annual review and evaluation of the Employee's performance and comparable salaries in the industry, which the parties foresee occurring in April of each year the Board of Directors of the District may increase the salary at any time more than the automatic 3%.

6. Expenses: District shall also reimburse Employee for out-of-pocket expenses reasonably incurred by her in connection with the performance of the duties hereunder, including entertainment and commercial travel; provided that it is in the

normal course of her duties, specifically allowed by the Board, or implied by the Board's policy/instruction; and provided, however, that such reimbursement shall only be made upon the submission by Employee to the accounting department of the District an expense statement showing the time, place, business reason, names and other information concerning persons entertained, together with vouchers showing the amount of each item of expenditure for which reimbursement is claimed. Expense statements must be approved for payment by the District's CFO prior to payment.

In addition to the foregoing, Employee shall receive from the District a monthly automobile allowance of $500.00 on account of Employee's use of her personal vehicle while in the course and scope of her employment. This benefit shall not be adjusted for actual mileage or cost of vehicle operation.

7. Benefits: Employee shall be eligible for participation in all the following benefits:

a. Health, Vision and Dental Insurance Plan: Employee shall receive for herself and her entire immediate family (spouse and natural/adopted children provided that such children would qualify for benefits if the Employee were a general employee of the District and not subject to this special agreement) health, vision and dental insurance plans with the entire premium for both the Employee and such immediate family paid in full by the District. This benefit shall continue during employment and for such period after employment as are specifically provided in this Agreement and no longer:

b. Disability Coverage. District shall obtain and pay for a disability policy or policies covering Employee on the Employee's behalf which policy(ies) may change from time to time based upon and pricing. However, the policy or policies shall

provide at least the following coverage to Employee: i) Sixty-percent (60%) of the Employee's base earnings to a maximum benefit of $3,230.00 per week for the first twenty-four (24) weeks of disability after the initial fourteen (14) day period, and then sixty-percent (60%) of the Employee's base earnings to a maximum of $14,000.00 per month thereafter until termination of benefits; and in both cases minus other income paid to Employee on account of disability or minus other benefit reductions as defined in any such policy until termination of benefits; ii) Benefits shall begin no later than fourteen (14) days after the start of the disability and continue until the end of the disability, or until age sixty-five (65) or after age 65 as the policy(ies) may provide, or until Employee is deceased, whichever comes first. For the initial fourteen (14) days of any disability, Employee first shall utilize all of her accrued paid time off, and, if all available paid time off is exhausted, the District shall thereafter pay to the Employee her base salary for the balance of the initial fourteen (14) day period less income received from other sources on account of the disability. For the purposes of this sub-paragraph, Long Term and Short-Term disability shall be defined as set forth by the insurance carrier in such policy or policies. If the District obtains a policy affording greater coverage than as stated in this sub-paragraph, Employee shall be entitled to the benefits of such greater coverage, and the District's obligation under this paragraph shall be reduced to the extent such benefits are made available by such insurance coverage. If the District obtains a policy affording less coverage than stated in this sub-paragraph or if there is no policy in effect, then in such case, the District shall provide sufficient benefits directly to the Employee to achieve the benefits recited herein. However, the intent of the parties is to utilize all available insurance benefits first, and the District's obligation is secondary to any existing applicable policy. If there is recovery

of damages by the Employee from a third party for having caused or contributed to the disability, the Employee shall reimburse the District for its actual out of pocket expenses under this sub-paragraph, and reimburse the policy provider but only to the extent required and set forth in the policy.

c. Paid Time Off: Effective as of July 24, 2016, as an exempt employee, Employee shall accrue annually 0.15762 hours of vacation/holiday time for each working hour based on a 40-hour work week, regardless of Employees' actual hours worked, in accordance with the District's vacation/holiday policy. Employee shall receive three days of sick leave annually on her work anniversary date which is on July 23rd based on Employee's initial hire date with the District. The sick leave is front loaded each year on the work anniversary and does not carry over in accordance with the Sick Leave policy of the District.

d. Retirement: Employee shall be eligible and entitled to Hospital retirement plans the same as all other District employees. On each June 30 of each year that the Employee remains in the employ of the District, the Employer will contribute on behalf of the Employee to the 401(a) Management Plan the lesser of the following: the maximum match amount allowable to not exceed the IRS Section 415 limits as set annually by the IRS for each year OR a contribution matching the Employee's contribution, capped at 10% of the Employee's salary.

e. Retention Bonus: On each June 30th of each year that Employee remains in the employ of District, Employee shall receive a retention bonus of $20,000.00 payable in the pay period that includes June 30th. This retention bonus shall not be pro-rated regardless of the reason for termination, and Employee must be an employee of the District on June 30th to receive this retention bonus.

f. Merit/Incentive Program: The amount of merit pay and the timing of its payment shall be at the sole discretion of the Board regardless of any merit or incentive programs for other employees, including senior management. Any such merit pay approved by the Board shall be paid to Employee as an annual bonus or, at the discretion of the Board, may be added to base salary.

g. Other Benefits: Employee shall be entitled to any other benefits offered generally to all of the Hospital's full-time employees, unless the Board specifically denies any to her.

8. Evaluation/Training: The Board of Directors may from time to time evaluate Employee's performance and her compliance with the conditions of her employment. There shall be a review on the one-year anniversary as provided in Paragraph 4 above. Upon request of the Board or on the initiative of Employee, the Employee shall report about her performance and compliance to the Board.

In order to advance Employee's skills as Administrator/President/CEO of the District and Hospital, the parties understand that Employee should participate in applicable training programs and seminars. The Board understands that this will cause Employee to be absent, and the District will incur expenses in connection with the participation in such programs. Employee understands that while at such training or seminars, she still has all of the obligations of her position and that she may be required to dedicate additional time to her job due to such absences for training.

9. Voluntary Termination Without Cause: Either the District or the Employee may terminate this Agreement without cause at any time, subject to the following conditions:

a. Termination under this paragraph by the District must be upon an affirmative majority vote of the Board of Directors effective as of the date set by the District. Upon majority vote, the Board may suspend the Employee pending a final determination by the Board, which final determination shall occur as promptly thereafter as practical.

b. In the event of termination by the District under Paragraph 9(a), Employee shall be entitled to receive severance pay and other benefits as follows:

(1) An amount as severance pay equal to the lesser of eighteen (18) months of the Employee's base salary (paid either as a lump sum or over eighteen (18) months, at the election of the Employee) or the number of months remaining on this contract (paid either as a lump sum or over the number of months remaining on the contract). This payment shall be as a lump sum, unless the Employee requests in writing to the District within seven (7) days of termination that the payout be over time. The payout over time shall be paid on the same payroll cycle as District employees. The automatic renewal provided in the second paragraph of Paragraph 4 above shall not be considered in determining the months remaining on the Agreement.

(2) Health, vision and dental insurance for Employee and for the entire previously-covered family of the Employee, as provided in Paragraph No. 7(a) above, for eighteen (18) months from the effective date of the termination, or until other full time, equivalent employment is obtained which employment provides for substantially equal coverage for the same persons, or balance of the contract term, whichever time period is the shortest.

(3) And in addition, to defer Employee's anticipated expenses arising out of such early termination, the District agrees to provide to Employee the following reimbursements:

i. Out-placement services not to exceed ten percent (10%) of the Employee's base salary, which shall be with a bona-fide service, and paid only upon invoicing to the District for review and assurance that the funds are being spent on out-placement.

ii. Since Employee may have to relocate to obtain other comparable employment, which may result in real estate commissions, escrow charges and loan charges arising out of early pay-off, and moving expenses, the District shall reimburse Employee upon such termination without cause, upon submittal of valid receipts, invoices or other proof up to the sum of $50,000.00, and not more, solely to defer the expenses of sale (as outlined above) of Employee's primary residence to relocate to a new area beyond range of commute or to downsize and the expenses for moving Employee's personal property.

iii. Benefits under the sub-Paragraph 9(b)(3) shall be available for expenses incurred within one (1) year of termination of employment, and all claims for reimbursement must be received by the District within eighteen (18) months of termination of employment.

c. As of the effective date of any such termination, all employment described herein shall cease, and except as specifically provided as severance pay and other benefits above in Paragraph 9(b), Employee shall be entitled to no other continued compensation or benefits, and all such other benefits shall stop as of the effective date of termination.

d. In the event of termination by Employee, all salary and benefits payable under this Agreement shall terminate on the effective date of the termination. There shall be no severance pay or continued benefits of any kind. Employee shall give thirty (30) days notice of such termination.

e. Termination under this Paragraph 9 does not preclude termination upon expiration of this Agreement or as provided in Paragraphs 10 and 11.

10. Termination for Cause: The District shall have the right to terminate Employee's employment under this Agreement at any time for "cause", in which case all compensation, benefits and severance pay provided hereunder for Employee shall immediately cease, and the benefits listed in paragraph 9b shall not be payable. Such termination must be on the affirmative majority vote of the Board. The termination shall be effective as of the date set by the District. Upon majority vote, the Board may suspend the Employee pending a final determination by the Board, which final determination shall occur as promptly thereafter as practical. In the event of a dispute as to whether there is cause for termination; Employee shall be treated as terminated for cause until such decision by the Board is reversed. The Board may concurrently terminate not-for-cause under Paragraph 9, to confirm the termination, should the for-cause termination be reversed, but payment of amounts due shall be deferred until any such reversal occurs and is final.

As used herein, the term "cause" shall mean and include all of the following acts of the Employee:

a. Breach of any of the terms or conditions of this Agreement or of any District By-Law, written rule or written procedure;

b. Failure to follow a specific directive or policy set by the Board either intentionally, or due to gross negligence, or due to repeated acts of negligence;

c. Intentional or gross negligent failure to report to or disclose to the Board significant events, actions or omissions concerning the Hospital or District, not known to the Board, even if such disclosure is not otherwise specifically required;

d. Willful failure to comply with any applicable law or regulation or with any ruling of any governmental agency or court of competent jurisdiction;

e. Conviction or confession of any theft, embezzlement, fraud or any other felony or misdemeanor involving moral turpitude.

f. Insolvency, filing of a petition for bankruptcy, being adjudicated a bankrupt or the making of a general assignment for the benefit of creditors, it being understood and agreed that the exhibition by Employee of financial responsibility is necessary so as not to prejudice the District's financial credibility and its ability to raise funds and receive gifts or contributions from members of the community at large are material elements and conditions to Employee's employment hereunder, or

g. Frequent and proven use of alcohol or drugs certified by a mutually agreed upon physician.

h. Any act of intentional conflict of interest resulting in a benefit to the Employee, whether or not the District has a loss; a conflict of interest of any kind on the part of the Employee resulting in a significant loss to the District.

11. Termination Upon Death or Disability:

a. This Agreement and all compensation and benefits payable hereunder shall terminate upon the death of the Employee, except for benefits fully earned and accrued but unpaid or benefits specifically payable upon death and except

for health, vision and dental insurance for the surviving family which shall continue for one year.

b. Upon the disability of Employee, the District may terminate this Agreement, but only after the District determines, after engaging in a good faith interactive process, that either it cannot reasonably accommodate her disability based on an inability to undertake the essential functions of the job or where such accommodation creates an undue hardship on the District. All future compensation under this Agreement shall thereupon terminate, other than benefits to which the Employee may be entitled under paragraph 7b above.

c. Except as provided in this Paragraph 11, upon death or disability, payments or benefits to the Employee or to others and all other payments and benefits shall cease as of the effective date of the termination under this Paragraph 11.

12. Trade Secrets/Confidential Information/Non-Solicitation: It is understood and agreed that as a result of her employment by the District, Employee has and will continue to have access to trade secrets and confidential information concerning the business of the District and the Hospital, its employees, medical staff, marketing efforts, long range strategic plans, methods of doing business, accounting information, financial information, donor lists and other matters. Employee agrees that all such information is propriety in nature and the property of the District. Employee shall not misuse, misappropriate or disclose any of said information, directly or indirectly, or use it in any way except as required in the course of her employment hereunder. Employee shall not make use of any such information outside of her employment duties with the District except with the prior written consent of the District. The restrictions of this paragraph are not limited in time, as long as the information

remains a trade secret or confidential, and the restrictions shall remain in full force and survive termination of this Agreement and termination of employment.

During the term of this Agreement or for a period of one (1) year after termination of this Agreement or after termination of Employee's employment with the District, whichever is later, Employee shall not directly or indirectly solicit or attempt to solicit any of District's employees or medical staff for employment or affiliation elsewhere.

Employee agrees that all memoranda, notes, records, paper, and other documents and all copies thereof relating to Hospital and/or District operations or business, some of which may be prepared by the Employee herself, and all objects associated therewith, such as models and samples, in any way obtained by Employee, shall be the District's proprietary property. Employee shall not, except for Hospital use, copy or duplicate any of the aforementioned documents or objects, nor remove them from District facilities, nor use any information concerning them, except for the District's benefit, either during employment or thereafter. Employee agrees that she will turn over all of the aforementioned documents and objects that may be in her possession to the District upon termination of her employment, or at any time upon the request of the Chairperson of the Board of Directors, or any other designate of the Board.

A breach of this Paragraph 12, leading to damages or injunctive relief, while Employee is employed by The District, shall be based solely on intentional or grossly negligent acts or omissions. Mere negligent or unintended acts or omissions shall be subsumed as a part of Employee's job performance only. Employee shall not be responsible for acts of others or subordinates unless Employee instructed such persons or subordinates to do the action or omission that is a component of the breach. After termination of employment, Employer shall be responsible for all actions or omissions

resulting in a breach that occurs after termination, regardless of characterization. The parties agree that establishing damages for a breach of this Paragraph 12 would be impractical or difficult to prove. Therefore, the parties agree that injunctive relief is appropriate. Further, the parties agree as to liquidated damage for each disclosure of trade secrets or confidential information that liquidated damages of $10,000.00 per disclosure is a reasonable estimate of the damages that the District would suffer. The parties also agree that liquidated damages for wrongful solicitation of an employee shall be 25% of that employee's annual base salary, which is a reasonable estimate of the damages, based on a recruiter's possible charges.

This entire Paragraph 12 shall survive both the termination of this Agreement, however terminated, and the termination of Employee's employment with the District.

13. Protected Health Information. Employee has executed the District's current HIPAA Employee Confidentiality Agreement and agrees to execute any future HIPAA Employee Confidentiality Agreement the District deems necessary to safeguard protected health information of patients as required by federal law and regulations. Employee understands that such an agreement is material and necessary for her employment.

14. Return of Property: Employee agrees to return and shall return to District upon Employee's termination for any reason 1) all keys to any of District's facilities, cabinets or other property, 2) all equipment and tangible personal property belonging to District, and 3) all items described in Paragraph 12 above in Employee's possession and held by Employee outside of the District's facilities. Any such items located other than at the District's facilities shall be returned to the District within two (2) days of termination.

15. **Notices**: All notices or communications required or permitted under this Agreement shall be given in writing and either delivered personally to the other party or sent by United States registered or certified mail, postage prepaid and return receipt requested, and addressed to the other party at the following addresses or such other addresses as may hereafter be designated by a party by written notice thereof to the other party:

To District: **Chairman, Board of Directors**
SIERRA VIEW LOCAL HEALTH CARE DISTRICT
465 West Putnam Avenue
Porterville, CA 93257
- and -
To the home address of the Chairman

To Employee: **Donna Hefner**
31728 Roadrunner
Springville, California 93265

16. **Governing Law**: The validity, interpretation, enforceability and performance of this Agreement shall be governed by and construed and enforced in accordance with the law of the State of California.

17. **Entire Agreement**: The parties intend that the terms of this Agreement shall be the final expression of their agreement with respect to the subject matter hereof and may not be contradicted by evidence of any prior or contemporaneous agreement, communication or understanding.

18. **Amendments and Waivers**: This Agreement may be amended only by a writing signed by both the District and the Employee. It is contemplated that this is long-term employment and that this Agreement may be amended from time to time and as so amended will continue to apply.

19. **Severability**: If any provision of this Agreement or the application thereof to any person, place or circumstances shall be held by a Court of competent jurisdiction to be invalid, unenforceable or void, the remainder of this Agreement and such provisions as applied to other persons, places and circumstances shall remain in full force and effect.

20. **Successors and Assigns**: This Agreement and the provisions hereby shall be binding upon and shall inure to the benefit of each of the parties hereto and the successors and assigns of the District and the personal representative, heirs and successors of Employee. Nothing herein contained, however, shall be construed as permitting a transfer or assignment by Employee or of any right or interest hereunder, and any such attempted assignment shall be void and of no force or effect.

21. Waiver: In the event a party hereto waives one or more breaches of any covenant or condition herein, that party shall not thereafter be precluded from later preventing any further breaches of that covenant or condition or from requiring the strict performance of them.

22. Titles: Titles of the paragraphs are for convenience only and do not control or limit the content thereof.

IN WITNESS WHEREOF, the parties have executed this Agreement on the day and year first above written, which shall be its effective date.

SIERRA VIEW LOCAL HEALTH CARE DISTRICT

Employer:

By:_____ Date:
Chairman of the Board of Directors

Employee:

By:_____ Date:
Donna Hefner