VENTURA COUNTY MEDICAL CENTER
SANTA PAULA HOSPITAL
A Division of Ventura County Health Care Agency

Ventura County Health Care System Oversight Committee
Hospital Administrative Policies & Procedures

July 1, 2025

The following administrative policies were reviewed and recommended for approval by appropriate departments and committees.

1. 107.067 Photography, Video and Audio Recording by Patients and Visitors
2. 108.040 Nursing Education Continuing Education Courses
3. 108.058 Nursing Care Plans

Ventura County Health Care System Oversight Committee
Administrative Policies - July 1, 2025
Summary of Changes

#	Title	Review Period	Summary of Changes
1	107.067 Photography, Video and Audio Recording by Patients and Visitors	Trienniel	Trienniel review. Fixed typos.
2	108.040 Nursing Education Continuing Education Courses	Trienniel	Updated CA Code of Regulations link. Fixed typos.
3	108.058 Nursing Care Plans	Trienniel	Revised policy resulting from mock survey findings.

Status **Active** PolicyStat ID **18091980**

Origination	7/20/2022	Owner	Jason Arimura: Associate Hospital Administrator, VCMC & SPH
Last Approved	6/17/2025		
Effective	6/17/2025	Policy Area	Administrative - Operating Policies
Last Revised	6/17/2025		
Next Review	6/16/2028		

107.067 Photography, Video and Audio Recording by Patients and Visitors

POLICY:

Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU) and Ambulatory Care (AC) clinic system has established guidelines for situations where patients, visitors, workforce members, non-employee healthcare professionals, members of the medical staff and other privileged practitioners may or may not be photographed, video or audio recorded or monitored or otherwise imaged in order to maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and any and all other federal regulations and interpretive guidelines promulgated thereunder, and applicable state laws protecting confidential medical information.

This policy does not apply to security cameras on the premises, diagnostic imaging for medical purposes, telemedicine and the documentation of wounds for medical reasons or law enforcement purposes or other photography or audio or video recording approved by the Ventura County Health Care Agency (HCA) to advance the hospital or clinic system's legitimate business purposes, such as video recordings for marketing purposes or telephone recording for quality assurance purposes.

PROCEDURE:

DEFINITIONS

Audio Monitoring:

For the purposes of this policy, “audio monitoring” refers to monitoring an individual’s voice using video

cameras, cellular telephones, tape recorders, wearable technology or other technologies capable of capturing audio or transmitting sound, for monitoring purposes.

Audio Recording:

For the purposes of this policy, “audio recording” refers to the capture and storage of the individual’s voice or sounds using capable technology (*e.g.,* video cameras, cellular telephones, tape recorders, wearable technology).

Photography:

For the purposes of this policy, “photography” refers to recording an individual’s likeness (*e.g.*, image, picture) using photography (*e.g.*, cameras, cellular telephones), video recording (*e.g.*, video cameras, cellular telephones), digital imaging (*e.g.*, digital cameras, web cameras), wearable technology (*e.g.,* Google Glass), or other technologies capable of capturing an image (*e.g.*, Skype, fingerprint or iris scanning technologies). This does not include medical imaging such as Magnetic Resonance Imaging (MRIs), Computerized Tomography (CTs), laparoscopy equipment, etc. or images of specimens.

Video Monitoring:

For the purposes of this policy, “video monitoring” refers to monitoring an individual or transmitting the individual's likeness using technologies capable of transmitting a video (*e.g.,* video cameras, cellular telephones, web cameras, wearable technology) regardless of whether the transmission is recorded.

Video Recording:

For the purposes of this policy, “video recording” refers to the capture and storage of the individual’s likeliness using video technologies (*e.g.,* video cameras, cellular telephones, web cameras, wearable technology).

Photography, Audio Recording, Audio Monitoring, Video Recording and Video Monitoring by Patients, Family Members or Visitors

- Patients, family members or visitors are not permitted to photograph, or audio or video record other patients or staff, physicians and volunteers without each subject's verbal consent.
- Patients, family members or visitors are not permitted to photograph or audio or video record patient procedures, medical equipment or patient records.
- If staff is aware of any inappropriate attempt to photograph or record a patient, staff, a physician or volunteer without consent, staff shall take reasonable steps, including a call to the Security Department, to stop the activity.

Labor/Delivery and Post-Partum:

VCMC/SPH and the AC clinic system understands that the birth of a baby is a special time that many people like to record with pictures and video. The following criteria are established to protect the privacy of all parties involved:

Video recording, photography, audio monitoring and recording *MAY ONLY* be performed by patients and family members in Labory/Delivery and Post-Partum locations, if the following criteria are met:

- Cameras must be battery operated. No electrical cords are allowed as they are a safety hazard.
- Tripods/selfie sticks may not be used.
- Patients, visitors and family members must obtain consent from hospital staff before including hospital staff in any photos/video and also respect the decision of hospital staff if they do not wish to be included in any photography/video or audio recording.
- Support persons/family members shall obtain consent from the patient ***prior to*** any photography/video or audio recording.
- Video recording, photography and audio recording may be done only before and after the birth of the baby.

Video recording, photography, audio monitoring and recording by patients and family members in Labor-Delivery and Post-Partum locations is not allowed under the following circumstances:

- During medical procedures in labor to include, but not be limited to:
    - Placement of an epidural;
    - Cervical exam;
    - Placement of an internal monitor;
- The actual moment of the vaginal or cesarean birth, regardless if the delivery occurs in the delivery room or operating room.
- During medical procedures on the newborn.
- The use of cameras, phones, audio and/or video recording devices shall be discontinued upon the request of the physician, anesthesiologist or nurse participating in the care of the patient.

SIGNAGE

Signage shall be prominently posted in patient areas to support this policy and shall read: ***"Patient and staff permission is required before photos are taken or recordings are made."***

REFERENCES:

- Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information 45 CFR Part 164.
- Hjort, Beth, et al. "Patient Photography, Videotaping, and Other Imaging (Updated) (AHIMA Practice Brief)." Journal of AHIMA 72, no.6 (2001): 64M-Q.
- North Carolina Women's Hospital, Videotaping & Still Photography in Labor and Delivery.

All Revision Dates

6/17/2025, 7/20/2022

Approval Signatures

Step Description	Approver	Date
Hospital Administration	Osahon Ekhaese: Chief Operating Officer, VCMC & SPH	6/17/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/20/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/20/2025
Policy Owner	Jason Arimura: Associate Hospital Administrator, VCMC & SPH	5/20/2025

Status Active PolicyStat ID 18091986

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Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education
Policy Area	Administrative - Nursing

108.040 Nursing Education Continuing Education Courses

POLICY:

The Nursing Education – Inservice Department supports the professional development of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) nurses across the Ventura County Health Care Agency. The Nursing Education – Inservice Department is committed to supporting the educational needs of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) by:

- Providing optimal support for planning and hosting nursing educational events
- Evaluating and updating course content to ensure high quality and evidence-based nursing practice
- Aligning educational offerings with the VCMC/ SPH Strategic Goals, the changing health care environment, and the needs of the community

Through high-quality education, VCMC/ SPH nurses will continue to deliver safe, complex, and evidence-based care to our patients and their families.

PROCEDURE:

I. Continuing Education Courses

A. All Ventura county Medical Center and Santa Paula Hospital educational activities for nurses offering contact hours should be submitted to the Nursing Education department PRIOR to the activity. It is necessary for the Nursing Education – Inservice Department to track all courses and course content as outlined in the California Board of Registered Nurses.

B. Acceptable Course Content is defined as the following by the California Board of Registered Nursing California Code of Regulations Section 1456 and 1457. https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IF62E89E04C8111EC89E5000D3A7C4BC3&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)

1. The content of all courses of continuing education must be relevant to the practice of registered nursing and must be:

a. Related to the scientific knowledge and/or technical skills required for the practice of nursing, or

b. Related to direct and/or indirect patient/client care.

c. Learning experiences are expected to enhance the knowledge of the Registered Nurse at a level above that required for licensure. Courses related to the scientific knowledge for the practice of nursing include basic and advanced courses in the physical, social, and behavioral sciences, as well as advanced nursing in general or specialty areas. Content which includes the application of scientific knowledge to patient care in addition to advanced nursing courses may include courses in related areas, i.e., human sexuality; death, dying, and grief; foreign languages (conversational); therapeutic interpersonal relationship skills; pharmacology; and those related to specialty areas of nursing practice

d. Courses in nursing administration, management, education, research, or other functional areas of nursing relating to indirect patient/client care would be acceptable.

2. Unacceptable Course content includes the following, as defined by the California Board of Registered Nursing.

a. Courses which focus upon self-improvement, changes in attitude, self-therapy, self-awareness, weight loss, and yoga.

b. Economic courses for financial gain, e.g., investments, retirement, preparing resumes, and techniques for job interviews, etc.

c. Courses designed for lay people.

d. Liberal arts courses in music, art, philosophy, and others when unrelated to patient/client care.

e. Orientation programs - orientation meaning a specific series of activities designed to familiarize employees with the policies and procedures of an institution.

f. Courses which focus on personal appearance in nursing.

g. CPR, BLS, basic EKG/dysrhythmia and IV therapy courses that are similar to those used to certify licensed vocational nurses to start IVs.

C. Course Requirements

1. The program or course content must be relevant to both the educational needs of the registered nurse and health needs of the consumer. The content must be current and designed to include recent developments in the subject area being taught.

2. Course offerings must be at least one hour in length.

3. Credit for completing part of a course (continuing education or academic) may NOT be granted. Thus if a person attending the course leaves before the course is over, they are not to be issued a certificate of completion. Continuing Education Provider's who offer multiple day courses can break the course into several segments and provide contact hours for each segment successfully completed.

D. Process for Awarding Contact Hours

1. Complete "Continuing Education Course Provider Request" form. See Attachment A

2. Information on the "Continuing Education Course Provider Request" form includes:

a. Course Title

b. Date(s) and Time(s)

c. Location

d. Overview/ Description

e. Number of Contact Hours/ Number of Continuing Education Units

f. Content:

- Type of Offering (Academic, In-service, Workshop, Other)
- Teaching Methods (Powerpoint, Simulations, lecture, other)
- Attached Required Items
    - Class Flyer
    - Objectives
    - Content Outline
    - Presenter Curriculum Vitae's
    - Class Materials
    - Advertising – see inclusion criteria below
- Evaluation Methods
    - Exam, Observation, and/ or Questionnaire

3. Submit "Continuing Education Course Provider Request" form to Nursing Education -Inservice department 8 weeks prior to Course offering

4. Advertising for Continuing Education Courses must include:

a. The full statement "Provider approved by the California Board of Registered Nursing, Provider Number _____, for _____ contact hours."

b. Provider's policy regarding refunds in cases of non-attendance/ cancellation by the registrant. Refer to Section II- "Refunds and Cancellations."

c. A clear, concise description of the course content and/ or objectives.

d. Provider name stated as officially on file with the BRN. Ventura County Health Care Agency, Continuing education Provider #231.

5. Completed documentation must be submitted to the Nursing Education – Inservice department within 30 days of the course

a. Course Evaluations

b. Sign-In sheets, must include license numbers and related identifiers

c. Record of any certificate(s) issued

6. Request for duplicate copy of Continuing Education Certificate - $10 fee will be charged per certificate. For request: email vcmc.nursinged@ventura.org with Name, course title, and date of course.

II. Refunds and Cancellations for Continuing Education Courses Provided by Nursing Education

A. Refund Process: For cancellations up to the scheduled registration deadline, a full refund will be provided. If cancellation is made after the registration deadline, no refund will be provided. Exceptions apply at the discretion of the Nursing Education department.

B. The Nursing Education – Inservice department reserves the right to cancel courses within 7 days of the start date (e.g. minimal class enrollment, instructor related issues, etc). Notice will be provided with the option to reschedule for a future course date, should one be available, or to receive a full refund of registration fees.

C. All refunds will be processed within 30-60 days.

D. Any student arriving at the course without the required items (e.g. course specific textbooks or pre-course completion certificate) will not be allowed in the course, but is eligible to reschedule to another course for a $20.00 rescheduling fee.

E. Nursing Education – Inservice is not responsible for any outside expenses incurred by the customer when a training course is cancelled.

F. This policy does not include outside contracted courses. These courses may include, but are not limited to, Emergency Nursing Pediatric Course ENPC, trauma Care After Resuscitation TCAR, Trauma Nursing Core Course TNCC, etc)

All Revision Dates

6/13/2025, 7/18/2022

Attachments

Attachment A - Sample/Draft Continuing Education Course Provider Request

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/13/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/13/2025
Policy Owner	Sharon Waechter: Clinical Nurse Manager, Nursing Education	6/13/2025

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Origination	12/1/1989	Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH
Last Approved	6/2/2025		
Effective	6/2/2025	Policy Area	Administrative - Nursing
Last Revised	6/2/2025		
Next Review	6/1/2028		

108.058 Nursing Care Plans

POLICY:

Planning for medical, nursing, and other clinical discipline(s) care, treatment, and service(s) is individualized to meet the patient's unique needs. The first step in the process includes creating an initial plan for care, treatment, and services that is appropriate to the patient's specific assessed needs. To continue to meet the patient's unique needs, the plan is maintained and revised based on the patient's response. The plan may be modified or terminated based on reassessment; the patient's need for further care, treatment, and services; or the patient's achievement of goals. The modification of the plan for care, treatment, and services may result in planning for the patient's transfer to another setting or discharge.

The nursing care plan is an integral part of the plan of care. An individualized care plan will be developed for each patient based on assessment findings. The care plan will be initialized as soon upon admission as possible but no more than 12 hours after admission. The individualized patient care plan will be based upon nursing diagnosis standards and tailored by the Registered Nurse for each individual patient as necessary. The nursing care plan will address the patient's problems both actual and potential with appropriate goals/expected outcomes and nursing interventions to reach the stated goals. The care plan will be updated as often as necessary, but at least every 12 hours, and updated as appropriate to the individual patient's changing condition and/or needs.

PROCEDURE:

A. Patient care is planned to meet the individual needs of the patient and the severity of the patient's disease process, health status, impairment, or disability. The nursing plan of care is documented in the electronic health record (EHR). It may vary based on the patient's goals and the time frames, settings, and services required to meet those goals. For example, a documented nursing plan of care is not required for outpatients or < 24 hour-short stay

observation patients.

B. The patient/family will be provided an opportunity to participate in the development and implementation of the care plan, if possible.

C. The plan may include, but is not limited to, identified physiological and psychosocial problems/ issues, active co-morbidities requiring management during the hospitalization, expected health care outcomes or goals, implementable interventions to reach those outcomes/goals, and time frames governing when interventions occur or to assist in evaluating progress toward those outcomes/goals.

D. The plan of care is not limited to a single tab, screen or document within the patient's medical record, but rather, all components of the patient's medical record combine to form the full plan of care, including but not limited to: medications ordered and administered; physician orders for assessment, care, and treatment; the plan for medical care; progress notes and consults; and assessments and reassessments from all disciplines including rehabilitation, dietary and discharge planning; (if applicable) restraint flow sheets and documentation; intake and output flow sheets; and vital sign flow sheets.

E. Nursing plans of care are most often associated with a patient's active problems that are the reason for or focus of the admission. A patient's chronic problems or comorbidities are often planned for and addressed through physician orders.

F. A collaborative, interdisciplinary approach is used by the patient's care team to:

1. Identify problems.
2. Establish goals and when applicable time frames to meet goals.
3. The time frames associated with the timing of interventions and goal achievement will be defined within the order for care, treatment or service, or goals are assumed to be achieved by the time of the patient's discharge or carried forward as part of the patient's post-discharge plan.
4. Coordinate care with an approach that involves the necessary mix of clinical disciplines
5. Evaluate the effectiveness of the interventions and goals achieved. Ongoing reevaluations measure the patient's progress toward those goals and the care plan is adjusted accordingly.

G. The care plan and education plan is established in concert with and in support of the medical plan of care.

H. Information obtained from the Admission Assessment, the History and Physical, and the nursing assessment is used to initiate the inpatient care plan and implement interventions.

I. Review care plan, document interventions and goals once per shift.

All Revision Dates

6/2/2025, 6/2/2025, 8/24/2022, 10/1/2016, 12/1/2013, 10/1/2011, 11/1/2009, 6/1/2008, 8/1/2007, 12/1/2004, 10/1/2001, 12/1/1998, 1/1/1996, 9/1/1993, 2/1/1992, 12/1/1989

Approval Signatures

Step Description	Approver	Date
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/2/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/2/2025
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/2/2025

VENTURA COUNTY MEDICAL CENTER

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Medical Executive Committee Document Approvals

June 2025

a. Policies & Procedures / Forms / Orders

The following were reviewed and recommended for approval by the appropriate Departments, Committees, and the Medical Executive Committee

#	Title	Summary	Frequency	Page
1.	100.025 Medications: Ordering, Administration and Documentation	Updated held medication instructions	Triennial	2-9
2.	100.201 Sepsis Management Policy	Revised to address pediatric sepsis	Triennial	10-16
3.	102.037 Medical Staff Initial Credentialing/Appointment & Recredentialing/Reappointment Guidelines	Revised to align with health plan delegation agreement requirements.	Triennial	17-21
4.	102.039 Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) Specialists	Revised to align with health plan delegation agreement requirements.	Triennial	22-23
5.	108.015 Nursing Department Accountability to Administration and Medical Staff	No changes	Triennial	24-25
6.	108.018 Unlicensed Nursing Assistive Personnel (UAP)	No changes	Triennial	26-28
7.	108.050 Patient Safety Attendant Care	Revised to include date attendants must complete Crisis Prevention Institute (CPI) training or comparable by.	Triennial	29-32
8.	ER.42 Standardized Nursing Procedures in the Emergency Department	Update to meet the regulatory requirements for standardized nursing procedures.	Annual	33-45
9.	MCH.14 Hypoglycemia in the Newborn	Updated hypoglycemia algorithm attachment	Triennial	46-48
10.	MCH.26 Child Abuse and Neglect, Temporary and Protective Custody	Revised to include contract placement language for discharge purposes when child in protective custody.	Triennial	49-51
11.	N.68 Small Baby Protocol for the NICU	Complete policy re-write	Biennial	52-77
12.	N.79 Gastric decompression in the NICU	New policy	Triennial	78-81
13.	OB.74 Post-Partum Rubella Immunization	No changes	Triennial	82-83
14.	PH.102 Pyxis Anesthesia System	Revised to incorporate language from policy S.38	Triennial	84-87
15.	S.33 Intraoperative Standards of Care	No changes	Triennial	88-90
16.	S.91 Anesthesia Protocol for Bariatric Surgery	Removed requirement of additional anesthesia clinician for intraoperative patient management	Triennial	91-92

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*2/1/1991*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*5/16/2025*
Next Review:	*3 years after approval*
Owner:	*Sara Pendleton: Medication Safety Officer*
Policy Area:	*Administrative - Patient Care*
References:	

100.025 Medications: Ordering, Administration and Documentation

Policy:

Ventura County Medical Center (VCMC), Santa Paula Hospital (SPH), Inpatient Psychiatric Unit (IPU), Crisis Stabilization Unit (CSU) and ambulatory care Infusion Center (INF) maintain processes for the safe and timely prescribing, administration, and documentation of medications to patients.

Definitions:

Licensed Practitioner (LP): physicians or mid-level practitioners contracted with the Health Care Agency to provide patient care.

Health Care Professional (HCP): licensed individuals such as registered nurses and respiratory therapists who are authorized to administer medications.

Procedure:

I. Medication Order Prescribing

A. All medications administered at VCMC, SPH, IPU, CSU, and INF shall be ordered by a licensed practitioner (LP) and noted by a health care professional (HCP) as approved in the Medical Staff bylaws.

B. A current Medical Staff Roster shall be maintained by the Medical Staff Office. A listing of all Medical Staff members recognized as having the privilege to prescribe medications within the facility shall be available to the Department of Pharmacy Services.

C. The Medical Staff Office shall maintain a log documenting Medical Staff and their Drug Enforcement Administration (DEA) numbers.

D. Medication orders to non-providers can be found on policy 100.220 Electronic Order Management.

E. Pharmacy approved prescriptive authority can be found on policy 100.216 Electronic Pharmacy Prescriptive Order Entry Authority.

F. Abbreviations used in medication orders can be found policy 107.005 Medical Abbreviations.

II. Medication Order

A. Medication orders shall be entered into the electronic health record (EHR) and shall include the

following:

1. Medication name
2. Dosage
    i. Dosage should be expressed in the metric system except in instances where dosage must be expressed otherwise (e.g. units).
    ii. For pediatric patients, dosage should be based on weight or body surface area (e.g. milligrams/kilogram [mg/kg] or milligram/meter squared [mg/m^2]).
    iii. Dose ranges are not acceptable (e.g. hydrocodone/acetaminophen 1-2 tablets every [q] 4 hours As Needed for [PRN] pain).
3. Frequency of administration
    i. Interval ranges are not acceptable (e.g. hydrocodone/acetaminophen 1 tablet q 4-6 hours PRN pain)
4. Route of administration
5. Indication for use for the following:
    i. All PRN medications
        a. Indication ranges are acceptable if the order does not create therapeutic duplication(e.g. hydrocodone/acetaminophen 1 tablet every 6 hours PRN mild-moderate pain).
        b. Topical medication orders shall describe the specific location of application.
        c. Acetaminophen and ibuprofen orders must be clarified to describe the specific indication for use (e.g. fever versus [vs] headache or pain). If fever is selected, the actual temperature must also be included.
    ii. Antimicrobial orders
    iii. Anticoagulant orders
6. The date and time of the order
7. The identity of the ordering LP

B. Titratable Intravenous (IV) medication orders shall also include the following
1. Concentration in units/milliliter (mL) such as mg/mL
2. Initial rate of infusion
3. Loading and/or bolus doses, if applicable
4. Titration parameters
    i. Incremental dose
    ii. Titration rate with increase and/or decrease instructions for nurse administration.
    iii. Maximum dose or specified time
    iv. Titration goal, end point, or desired patient response
5. Notify provider parameters

C. All medications orders shall follow Automatic Stop-Orders (see PH.61 Automatic Stop Orders).

III. Medication Order Review and Verification

A. All medication orders are routed to Pharmacy and reviewed by a licensed Pharmacist.

1. See policy PH.55 Medication Order Management
2. See policy PH.19 After Hours Pharmacy Services at Santa Paula Hospital

B. Appropriate HCPs shall review medication orders prior to administration.

IV. 0.0.0.1. Medication Distribution

A. Medications shall be available in the automatic dispensing cabinet (ADC); however, in the event the medication is not supplied in the ADC, Pharmacy shall send the medication to the nursing unit

1. Medications not readily available in the ADC should be placed in the patient's cassette.
2. Any discrepancies noted in the medications or labels should be brought to the attention of a Pharmacist.
3. At no time shall a medication be "borrowed" from one patient for the use of another.

B. When a patient is transferred from unit to unit, the patient's IV solutions, IV antibiotics and medications not stocked in the ADC such as insulin are to be delivered to the new unit by the nurse responsible for the patient.

C. Missing medications shall be requested through the EHR by the appropriate HCP.

a. Intravenous continuous infusions for Intensive Care Unit (ICU), Definitive Observation Unit (DOU) and Pediatric Intensive Care Unit (PICU) patients shall be electronically requested by through the electronic health record (EHR) by the appropriate HCP no later than three hours prior to the time the medication is expected to run out or time of drip change.

D. Medications for Emergency Department (ED) Hold patients

1. HCPs caring for ED Hold patients may request scheduled medications to be dispensed from the pharmacy by submitting a request through the EHR. Any scheduled medication that is not administered immediately shall be stored in a secure location.
2. Controlled substances, immediate (STAT), NOW, and PRN medication should be obtained from the ADCs in the ED.

E. When a patient is discharged, expires, or leaves the hospital Against Medical Advice (AMA), the medications remaining in the cassette are returned to Pharmacy. The label on the outside of the patient cassette is removed and placed with the medications. The medications should be returned to Pharmacy immediately or placed in the Pharmacy "out" box.

F. Pharmacy policies related to medication distribution

1. See policy PH.46 Medication Storage and Security
2. See policy PH.52 Medication Handling
3. See policy PH.55 Medication Order Management
4. See policy PH.88 Controlled Substances
5. See policy PH.92 Automated Dispensing Cabinet Usage and Documentation
6. See policy PH.96 Medication Override from Automated Dispensing Cabinets

V. Medication Administration and Documentation

A. Medication Administration Privileges

1. See policy PH.72 Staff Authorized to Administer Medications
2. Medications are administered only on the order of a member of the Medical Staff, a practitioner who has been granted temporary privileges by the Chief Executive Officer or designee, a pharmacist or nurse who is practicing under the auspices of an approved protocol, or a physician's assistant who is practicing within the context of his/her Medical Staff-supervising physician.

B. Standard Administration Times

1. Scheduled medications shall be given up to one (1) hour before or one (1) hour after the scheduled time.
    i. Initial emergency department (ED) orders placed prior to nursing assignment are to be given within one hour of a nurse being assigned to the patient. Antibiotics, anticoagulants, and insulin are considered time critical and need to be administered within 30 minutes after nurse is assigned to patient.
2. Time critical medications are identified as medications that require administration within 30 minutes before or after the scheduled dosing time. These medications include:
    i. Antibiotics
    ii. Anticoagulants
    iii. Insulin
3. Medications should be given during standard administration times (see Attachment A).
4. Pharmacists may adjust the frequency to comply with standard administration times taking care to ensure the first dose is initiated as originally ordered (see Attachment B - Standard Administration Dosing Matrix).
5. Around the clock (ATC) medications should be limited to intravenous antibiotics & intravenous diuretics and will automatically default to every # hours from the time of the order with initiation or first dose priority per the LIP's order.
6. HCPs can adjust the first administration time. HCPs shall notify pharmacy via electronic change request, if subsequent doses requires adjusting.
7. Administration times may change based on patient care needs.

C. Non-standard Administration Times

1. For medications available from the ADC, all STAT orders shall be given within 15 minutes of order, NOW or ASAP orders shall be given within 20 minutes of order, and PRN shall be given within 30 minutes of order or patient request.
2. For medications NOT available from the ADC, the order shall be verified by pharmacy and processed as follows:
    i. STAT order shall be processed and delivered to nursing units within 30 minutes.
    ii. NOW and ASAP orders within 60 minutes
    iii. Regularly scheduled medications and PRNs within two (2) hours.

D. Seven Rights of Safe Medication Administration

1. The Seven Rights shall be followed: right DRUG, right Patient, right DOSE, right TIME, right ROUTE, right INDICATION, and with the right DOCUMENTATION.
2. Medications are prepared one patient at a time.
3. The HCP shall verify that the medication dispensed is what was ordered by checking the medication label with the provider's order on the medication administration record (MAR). All aspects of the order (patient, medication, name, route, dose, frequency) must be correct.
4. When administering an unfamiliar medication, a known resource shall be used as a reference to determine the correct dose, correct administration technique, indications, contraindications, compatibility, signs/symptoms to monitor, and necessary post administration monitoring requirements
5. The patient's identity shall be verified verbally by the HCP asking the patient to state their name and date of birth and then comparing and scanning that with their identification (ID) band and the MAR each time a medication is administered or blood is taken or given.
6. Non-verbal patient and neonatal and pediatric patient identities shall be verified by the HCP checking the ID band or medication record for name, date of birth, ID band number and/or medical record number. Such identifying information shall also be checked with the MAR.
7. The HCP administering medications takes the medication to the patient's bedside or just outside the room, prepares and verifies the medications to be administered.
8. The HCP shall verify the MAR summary including allergies, scan the patient's ID band, and the medication bar code before immediately administering the medication.
    i. Upon confirmation that the dose was administered, the HCP shall complete the MAR documentation.
    ii. Record patient response to medications in the medical record including PRNs and all new medications.
    iii. If a pain medication is administered, the patient's response must be assessed and documented as per policy 100.076 Pain Assessment, Management and Documentation.
    iv. The HCP shall immediately contact pharmacy if a medication is found to be incorrect, beyond its expiration or beyond use date. If a medication will not scan, the HCP is responsible for completing a Medication Not Scanned Envelope to communicate with the pharmacy team to check the bar coding.
    v. Unless emergent, a HCP should not administer a medication that will not scan until the medication has been verified by a Pharmacist.
    vi. Bar Code Medication Administration (BCMA) is an evidence-based mechanism to maximize medication safety. Though logistical challenges may exist, the HCP administering the medication is responsible for attempting to scan with ALL medications.
    vii. BCMA compliance will be reported periodically by department leadership. HCP staff with scan rates below the departmental goal will be re-mediated.
9. The HCP should adequately assess a patient for adverse reactions following medication administration.
10. Crushed and/or partial dose medications

i. Medications requiring crushing or splitting are scanned prior to opening at the bedside and then manipulated using a patient specific pill crusher/splitter for immediate administration.

E. IV Medication Administration and Documentation

1. See Attachment C - Adult IV Administration Guidelines
2. See Attachment D - Pediatric/PICU IV Push Drug References
3. Intravenous infusions shall be administered using an infusion pump with the medication guardrail parameters in place.
4. The basic infusion setting may only be used in the event the medication to be administered is not contained in the infusion pump library.
5. When an infusion is held or stopped, the nurse must document a zero (0) rate in the IV drip section of the MAR.
6. Documentation at shift change between the hours of 0600-0659 and 1800-1859 is the responsibility of both the ongoing nurse and incoming nurse.
   i. Incoming nurse shall verify rates and document volumes of infusions from 0600-0659 and 1800-1859 at 0705 and 1905, respectively.
   ii. Outgoing nurse shall document infusion rate changes and any titrations.

F. IV Medication Titration (see policy CC.23 IV Medication Titration in Critical Care Areas)

G. Standardized Drug Concentrations for IV Infusions

i. The Pharmacy Department shall maintain guidelines for the administration and compounding of IV infusions.

H. Neonatal Intensive Care Unit (NICU) oral medications shall be administered by syringe through a nipple, gavage tube or buccal cavity as tolerated

i. Follow bitter tasting medication with 5 mL of breast milk or formula.

ii. Flush gavage tube with 2-3 mL of sterile water post medication.

I. Medications ordered to be given on a sliding scale such as insulin, are documented in the same manner as other medications, except that the dose given (e.g. units, mg) shall also be documented.

J. Waste documentation is not required for non-controlled substances. See policy 106.35 for more information on how to properly dispose of pharmaceutical waste.

VI. Holding Medications

a. If a medication is temporarily held because the patient is to have nothing by mouth (NPO) for a test or was unavailable at the scheduled administration time, the dose may be given later. HCPs can reschedule one (1) dose but then must consult pharmacy if further adjustments are needed.

~~If a medication cannot be given, the HCP shall notify the LP. The HCP shall document on the MAR that the dose was held, the reason the dose was not given and that the LP was notified. If the LIP decides to discontinue the medication, then an order to discontinue the medication shall be entered into the EHR.~~

b. If a medication ~~has a hold parameter and is held twice~~cannot be given, the HCP shall notify the LP.

c. See Attachment E - Automatic Hold Parameters

~~See Attachment F - Held medication workflow~~

VII. Documentation of medication errors

a. If a medication is given in error, the medication, name, dose, route, and time must be documented.

b. To this the following steps are followed

   i. If the error involved a medication listed on the MAR, document the time that the dose was given. Notify the patient's LIP to determine if the next scheduled dose should be held.

   ii. For errors involving medications, routes or dosages not listed on the MAR, do not write "Medication error" or "error." Follow VCMC/SPH procedure for notification of LIP and completion of notification and medication error forms.

VIII. Keep vein open (KVO) Nursing Protocol

i. Nurses may order 0.9% sodium chloride KVO orders or flushes per protocol in order to document volumes used during intermittent infusions or flushes

   1. Nurse to enter order into EHR using "KVO adult" or "KVO pediatrics."
   2. Nurse to sign order using "Protocol/Standardize Procedure – co-sign" as the communication type.

ii. Approved KVO rates or flushes

   1. Adults: 0.9% sodium chloride IV at 10 mL/hour (hr)
   2. Pediatrics: 0.9% sodium chloride IV at 3 mL/hr
   3. Neonates: requires an order from the provider

IX. High risk medications

a. Special consideration will be taken for high risk medications and certain high risk medications require an independent double check by two HCPs. See policy PH.70 High Alert Medications for complete list and considerations.

b. All weight-based neonatal and pediatric drug dosages and drug calculations should be double checked by another HCP prior to administration.

c. Radiopaque IV push medications for neonatal or pediatric patients shall be given by a LP.

d. Patient controlled analgesia (PCA) settings and amount administered are to be checked every 4 hours by the nurse and documented in the patient's EHR in the Interactive View (See policy 100.235 Patient-Controlled Analgesia).

All revision dates:	5/16/2025, 5/15/2024, 3/14/2023, 1/12/2022, 8/10/2021, 10/14/2020, 3/4/2020, 5/15/2019, 3/21/2019, 11/26/2018, 10/3/2017, 10/1/2016, 11/1/2015, 2/1/2015, 8/1/2013, 8/1/2012, 2/1/2012, 7/1/2011, 5/1/2006, 5/1/2005, 12/1/2004, 7/1/2004

Attachments

- Attachment A - Standard Administration Times
- Attachment B - Standard Administration Times Dosing Matrix
- Attachment C - Intravenous Administration Guidelines for Adults

- Attachment D - Pediatric/PICU IV Push Drug Reference
- Attachment E - Automatic Hold Parameters
- Attachment F - Held Medication Workflow

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	5/19/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/16/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/16/2025
Policy Owner	Sara Pendleton: Medication Safety Officer	5/16/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Danielle Gabele: Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Patient Care*
References:	

100.201 Sepsis Management Policy

POLICY:

Sepsis is the leading cause of death in non-cardiac intensive care units in the United States. Mortality rates are higher that those of trauma, stroke and myocardial infarction. Studies have demonstrated that early recognition and treatment significantly decreases mortality rates.

To improve care and reduce sepsis mortality for patients at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) a multidisciplinary Sepsis Committee was restarted in 2022. The following policy has been revised to reflect updated requirements for the Centers for Medicare and Medicaid Services and The Joint Commission. In addition, the policy refers to non-obstetric adult patients, 18 years and older. Please note that if any potential sepsis criteria symptoms are presented in obstetric patients, refer to OB.76 Maternal Sepsis Policy.

PROCEDURE:

ADULT SEPSIS DEFINITIONS

The following definitions and guidelines reflect the CMS SEP-1 Core Measure requirements. Care for each patient should be individualized to optimize care.

A. **Systemic Inflammatory Response Syndrome (SIRS):**

A severe systemic response to a condition (as trauma, an infection, or a burn) that provokes an acute inflammatory reaction indicated by the presence of 2 or more of a group of symptoms including:

- Temperature greater than 100.9 F or less than 96.8 F
- Heart rate greater than 90 bpm
- Respiration rate greater than 20 BPM
- White blood cell count greater than 12,000 or less than 4,000 or greater than 10% immature neutrophils

B. **Sepsis:** Presence of infection with 2 or more SIRS- see abnormal vital signs from above.

C. **Severe Sepsis:** Qualifies when sepsis criteria and at least one sign of organ dysfunction or hypoperfusion are present.

Signs of organ dysfunction may include the following:

• Lactate level greater than 2 mmol/L
• Platelets less than 100,000/dL
• PTT more than 60 seconds
• INR more than 1.5 seconds
• Bilirubin greater than 2 mg/dL
• Creatinine greater than 2 mg/dL **OR** a urine output less than 0.5 ml/kg/hr for 2 hours

Signs of hypoperfusion may include 2 readings of the following:

• Systolic blood pressure (SBP) less than 90 mm/Hg;
• Mean arterial pressure (MAP) less than 65 mm/Hg, **OR** a SBP decrease of more than 40 mm Hg from baseline.

D. **Septic Shock:** When severe sepsis criteria is met with lactate ≥ 4 mmol/L **&/or** persistent hypotension (SBP < 90 mm Hg, MAP < 65, SBP decrease more than 40 mm Hg from baseline) is identified within one hour of completion of an intravenous fluid (IVF) bolus of 30 ml/kg fluid by 2 blood pressure readings.

ADULT SEPSIS CARE

A. **Sepsis Screening:** patients who meet 2 or more SIRS criteria with or without hypotension, shall undergo sepsis screening to assess if suspected/confirmed infection is present. For patients that screen positive for sepsis, a lactate order will be automatically generated by Cerner; unless one is already present.

B. **Code Sepsis:** When a patient screens positive for sepsis with a lactate ≥ 4.0 mmol/L **&/or** hypotension, a Code Sepsis will be paged. The Emergency Department (ED) code sepsis will be a silent page, while the Inpatient Department code sepsis will be an overhead page.
   - The following individuals are notified when a Code Sepsis is activated/paged:
     - ICU Resident at VCMC; ~~ICU~~Medicine or ED Attending at SPH
     - ED Nurse and Physician; *when in ED*
     - Rapid Response Nurse, if available
     - Nursing Supervisor
     - Respiratory Therapy
     - Radiology
     - Lab
     - Quality Department Liaison

C. **SEP-1 Bundle Elements:** CMS guidelines require implementation of the following time sensitive interventions once severe sepsis/ septic shock identification.
   - Within the first 3 hours of severe sepsis/septic shock identification:
     - Initial Lactate
     - Blood Cultures (10 minutes apart and from two separate locations)
     - Antibiotics (intravenous or intraosseos)
     - If hypotensive **&/or** Lactate ≥ 4 then 30ml/kg IV crystalloid fluids bolus (normal saline or lactated ringers) to be administered. The rate must be greater than 125 ml/hr. Multiple mini bolus are acceptable. If less than 30ml/kg ordered, license practitioner to document reason why.

- Within 6 hours of severe sepsis/septic shock identification:
  - Repeat lactate level if initial lactate result >2 (Cerner automatically orders to repeat in 4 hours)
  - If patient receives crystalloid fluids:
    - Assess and document BP x 2 within the hour after the targeted fluids finished.
    - License practitioner to assess and document a repeat volume status and tissue perfusion assessment post fluid bolus administration.

D. **Quality Improvement:** The Quality Assessment & Performance Improvement (QAPI) department shall assist with data collection/ abstraction and report SEP-1 bundle compliance to the Sepsis Committee. The Committee will review cases, bundle compliance, identify gaps and initiate performance improvements projects to improve patient care and outcomes.

Emergency Department Personnel Duties for Adult Sepsis:

Non-obstetric patients 18 years and older

A. ED Triage or Primary Nurse:

1. **Emergency Department Adult Patients** who meet 2 or more SIRS criteria with or without hypotension, shall undergo sepsis screening to assess if suspected/confirmed infection is present. For patients that screen positive for sepsis, a lactate order will be automatically generated by Cerner; unless one is already present. **If down time nurse to use Sepsis Clock and Assessment paper form. See Appendix A: Sepsis Assessment Tool and Clock Documentation Form*
2. If sepsis screen is positive, EDN Power Plan (2+ Systemic Inflammatory Response Syndrome) is available for ED RN to initiate when more orders are needed to meet the needs of the patient. *See ER.42 Standardized Nursing Procedures in the Emergency Department policy.*
3. ED Nurse to follow SEP-1 Bundle Elements as outlined above in *Sepsis Care C. SEP-1 Bundle Elements*.
4. If the phlebotomist is unable to draw lactate in a timely manner, the nurse shall draw lactate.

B. ER Phlebotomist (Nurse at SPH):

1. Draw lactate sample and provide to the Respiratory Therapist for testing.
2. If lactate > 2, lactate is to be redrawn within 4 hours. If unable to draw the patient in a timely manner, the nurse will be requested to draw lactate.

C. Respiratory Therapist:

1. Test the lactate sample(s) report result(s) to the primary nurse, regardless of result.
2. Lactate ≥ 4 (critical lab) to be reported to the primary nurse and/or charge nurse.

D. License Practitioner: In addition to other clinically indicated diagnostic testing and treatment, the following sepsis bundle components are to be ordered if there are no contraindications:

1. Intravenous access.
2. Two sets of blood cultures and prior to antibiotics being initiated.
3. Broad spectrum antibiotics to be administered within 3 hours of the severe sepsis time.
4. Patients with SBP < 90 mm Hg, lactate ≥ 4 or SBP decreases ≥ 40 mm Hg from baseline, to have a fluid bolus administered of 30 ml/kg IV crystalloid fluids (normal saline or lactated ringers). Multiple

mini bolus are acceptable. If IV antibiotic(s) is administered that are mixed with crystalloid fluids and the rate is > 125 ml/hr, fluids may apply to the target fluid amount.

   a. If the crystalloid fluid volume ordered is less than the volume required, a license practitioner must document why the target ordered volume is less than 30 ml/kg.

5. Initiate vasopressors in patients with persistent hypotension post 30ml/kg IV NS/LR fluid bolus.
6. If the patient meets criteria for septic shock, then a license practitioner to assess and document a repeat volume status and tissue perfusion assessment post fluid bolus administration, and within 6 hours from septic shock identification. A repeat volume status and tissue perfusion assessment may consist of any one of the following three:
   a. License practitioner documentation attesting to performing or completing a physical examination, perfusion (re-perfusion) assessment, sepsis (severe sepsis or septic shock) focused exam.
   b. License practitioner documentation indicating that at least 5 of the following were assessed: Vitals (HR, B/P, temp and RR), cardiopulmonary assessment, capillary refill, skin color exam, peripheral pulses, urine output, &/or SaO2 or SpO2.
   c. One of the following to be completed: ScvO2 or SvO2, CVP, Bedside CV Ultrasound, Passive Leg Raise or Fluid Challenge.

Pediatric Sepsis:

A. Sepsis Screening: Pediatric patients in the emergency department will be automatically screened via the electronic medical record any time their vital signs are entered. If vital signs are entered that include tachycardia or hypotension, as indicated by the preset age range criteria (see attached – these vital sign parameters are the ones used by the Children's Hospital of Philadelphia [CHOP] in their pediatric sepsis screening protocol), the EMR will alert the nurse or tech that the patient screened positive for possible pediatric sepsis. If the EMR alert populates when a tech is entering vital signs they will notify the assigned nurse or the charge nurse if no nurse is assigned, so that a nurse can complete the sepsis screen

   1. The nurse will be prompted to complete the ED pediatric sepsis screen. This screen consists of the following four questions. Positive qualifiers listed.
      a. Current or history of fever (> 100.4 °F), hypothermia (< 96.8 °F) or signs & symptoms of infection? Yes
      b. Capillary refill (check finger or toe tip) - < 1 seconds, or > 3 seconds
      c. High risk conditions:
         - < 56 days old
         - Asplenia or sickle cell disease
         - Bone marrow or solid organ transplant
         - Central line
         - Malignancy
         - Significant CNS/functional tech dependence
         - Other immunodeficiency/immunocompromise

d. Level of consciousness

- Agitated
- Drowsy
- Listless
- Crying, inconsolable
- Eyes do not open to stimuli
- Non-responsive to stimuli
- Lethargic

2. If one or more of the qualifiers for any of the four questions are selected, the nurse will receive a positive sepsis screen alert.

B. Positive Sepsis Screen – The positive sepsis screen alert requests that the nurse do a bedside sepsis huddle. The bedside sepsis huddle will include a nurse and an attending physician huddling at the patient's bedside to assess the patient. This should be done immediately after the positive sepsis screen alert triggers. Ideally, if the department conditions permit, these patients should be put in a bed for the huddle.

1. The attending physician will determine if this patient is not sepsis, is a sepsis watcher (possible sepsis) or sepsis. The nurse will compete the Pediatric Sepsis Huddle form.
2. Patients who are deemed to be sepsis watcher will receive every 30 minutes vital signs and a repeat huddle at 60 minutes. It will be up to the physician's clinical judgement to determine further evaluation and treatment plan for the patient.
3. For patients who are deemed to have sepsis, appropriate evaluation and treatment should be initiated by the attending physician.

Vital signs Parameters (based on CHOP protocol):

Age	HR
0-89 days	>180
90-359 days (3-11 months)	>170
360 days - 1439 days (12mo – 47 months)	>150
1440 days – 4318 days (48 - 143 months)	>130
>4320 (>144 months)	>120

Age	SBP
0 - 2months	< 50
3 - 11 months	<70
12 - 47 months	<75
48 months – 11 years	<80
>12 years	<85

Inpatient Unit Personnel Duties:

Non-obstetric patients 18 years and older

A. Inpatient Nurse:

1. Patients who meet 2 or more SIRS criteria with or without hypotension, shall undergo sepsis screening to assess if suspected/confirmed infection is present. For patients that screen positive for sepsis, lactate order will be automatically generated by Cerner; unless one is already present. **If down time nurse to use Sepsis Clock and Assessment paper form. See Appendix A: Sepsis Assessment Tool and Clock Documentation Form*
2. Nurse to follow SEP-1 Bundle Elements as outlined above in *Sepsis Care C. SEP-1 Bundle Elements*.
3. Nurse to facilitate lactate draw as soon as possible when the patient meets positive sepsis criteria.

B. Phlebotomist (nurse at SPH night shift):

1. Draw lactate sample and provide to the Respiratory Therapist for testing.
   If lactate > 2, lactate is to be redrawn within 4 hours.
2. If unable to draw the patient in a timely manner, escalate to the charge nurse.

C. Respiratory Therapist:

1. Test the lactate sample(s) and report the result(s) to the primary nurse.
2. Lactate ≥ 4 (critical lab) to be reported to the primary nurse and/or Charge Nurse.

D. License Practitioner: In addition to other clinically indicated diagnostic testing and treatment, the following sepsis bundle components are to be ordered if there are no contraindications:

1. Intravenous access.
2. Two sets of blood cultures and prior to antibiotics being initiated.
3. Broad spectrum antibiotics to be administered within 3 hours of the severe sepsis time.
4. Patients with SBP < 90 mm Hg, lactate ≥ 4 or SBP decreases ≥ 40 mm Hg from baseline, to have a fluid bolus administered of 30 ml/kg IV crystalloid fluids (normal saline or lactated ringers). Multiple mini bolus are acceptable. If IV antibiotic(s) is administered that are mixed with crystalloid fluids and the rate is > 125 ml/hr, fluids may apply to the target fluid amount.
   a. If the crystalloid fluid volume ordered is less than the volume required, a license practitioner must document why the target ordered volume is less than 30 ml/kg.
5. Initiate vasopressors in patients with persistent hypotension post 30ml/kg IV NS/LR fluid bolus.
6. If the patient meets criteria for septic shock, then a license practitioner to assess and document a repeat volume status and tissue perfusion assessment post fluid bolus administration, and within 6 hours from septic shock identification. A repeat volume status and tissue perfusion assessment may consist of any one of the following three:
   a. License practitioner documentation attesting to performing or completing a physical examination, perfusion (re-perfusion) assessment, sepsis (severe sepsis or septic shock) focused exam.
   b. License practitioner documentation indicating that at least 5 of the following were assessed: Vitals (HR, B/P, temp and RR), cardiopulmonary assessment, capillary refill, skin color exam, peripheral pulses, urine output, &/or SaO2 or SpO2.

c. One of the following to be completed: ScvO2 or SvO2, CVP, Bedside CV Ultrasound, Passive Leg Raise or Fluid Challenge.

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Attachments

- Appendix A - Sepsis Assessment Tool and Clock Documentation Form.pdf
- Appendix B - Sepsis Cheat Sheet
- Appendix C - Administration of IV Antimicrobials
- Appendix D - Sepsis Core Measure Requirement.pdf
- Appendix E - Sepsis Clock Guidelines.pdf

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: ED & Medicine	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	3/7/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/8/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/8/2025
Policy Owner	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/8/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*N/A*
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Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.037 Medical Staff Initial Credentialing/ Appointment & Recredentialing/Reappointment Guidelines

Purpose:

To establish a mechanism for obtaining, verifying and assessing relevant information to validate qualifications including but not limited to individual character, clinical competence, training, experience and judgment of practitioners eligible for membership and/or privileges within the Ventura County Health Care System.

Policy Statement:

It is the policy of the Ventura County Health Care System to ensure practitioners eligible for medical staff membership and/or clinical privileges (credentialing) meet the minimum requirements outlined in the Bylaws, Rules & Regulations, Department Rules & Regulations, and established privileging criteria prior to approval by the governing board. All applications will be processed and reviewed in a non-discriminatory manner as outlined in policy 102.034 Non-Discriminatory Credentialing & Recredentialing Process.

Procedure:

Initial Credentialing/Appointment and Recredentialing/Reappointment

Upon receipt of a complete electronic application, including all supporting documentation, the Medical Staff Administration credentialing team will review the application, including the attestation responses and will begin the verification process. The applicant will be notified in writing of any missing information, clarifications or discrepancies, and the applicant will have 14 days to provide a written response or correction.

Processing and Verification:

The following items will be primary source verified (PSV) or verified via the approved designated equivalent sources (refer to Attachment A for a list of links). Verifications must be completed within 120 days of the board approval date, expiring verifications will be reverified. Exceptions to the 120-day requirement include the application, attestation and verifications of education and training, which must be completed within 180 days of the board approval date.

A. **Practitioner Identification (initial application):** Face to face or via video meeting and a valid driver's license/government issued identification. A valid driver's license or state issued identification is required for health plan enrollments.

B. **Criminal Background Check (initial application):** Verifications will be completed via PreCheck.

C. **Education and Training (initial and any additional training completed since last appointment or if required for requests for additional privilege):** Education and training will be verified directly with the program, American Medical Association (AMA) Profiles, American Osteopathic Association (AOA) Profile, National Student Clearinghouse, and Educational Commission for Foreign Medical Graduates (ECFMG) as appropriate.

D. **Medical/Professional License (initial/reappointment/license renewal/requests for additional privileges):** All current and previously held state licenses will be verified through the state licensing agencies and reviewed for disciplinary actions.

E. **Drug Enforcement Administration (DEA) Registration and out of state Controlled Dangerous Substance Certifications (CDS) (initial/reappointment/renewal of registration):** Verified via the DEA, issuing state CDS, or applicable state Department of Public Safety.

F. **Board Certification(initial/reappointment/renewal):** Verified through the issuing board, American Board of Medical Specialties (ABMS) CertiFACTS report, or AOA Profile, Nurse Practitioners (NP) are verified directly through the issuing board, and Physician Assistants (PA) via the National Commission on Certification of Physician Assistants.

G. **Peer/Professional References (initial credentialing/appointment, recredentialing/reappointment, request for additional privileges):** A minimum of 3 peer references will be obtained at initial credentialing/appointment, and a minimum of 2 peer references will be obtained at recredentialing/ reappointment.

H. **Affiliations, practice/work/employment history, including military history (initial credentialing/ appointment, recredentialing/reappointment):** The credentialing team will query the reported hospital, clinic, employer or other health care entity directly. If the entity uses NAMSS PASS, this will be accepted as PSV. At the initial appointment the credentialing team will query affiliations from completion of professional training to current. At reappointment the credentialing team will query current affiliations and any new affiliations since the last appointment. Applicants applying for tele-medicine privileges with excessive affiliations a sampling approved by the Credentials Committee will be verified.

I. **National Practitioner Database (NPDB) (initial credentialing/appointment, recredentialing/ reappointment, request for additional privileges):** All practitioners will be enrolled in the NPDB Continuous Query for ongoing monitoring and notifications. Practitioners are automatically re-enrolled annually. The reports will be reviewed at initial credentialing/appointment, recredentialing/reappointment, requests for additional privileges, and at any time a notification is received from the NPDB of activity related to the enrolled practitioner.

J. **History of Malpractice Claims (initial credentialing/appointment, recredentialing/reappointment):** The credentialing team will query the malpractice carrier(s) directly for the practitioner's claims history report. In the absence of a response, the NPDB report may be used to document the claims history. A minimum of 10 years will be reviewed.

K. **Department of Health & Human Services, Office of Inspector General (OIG) (initial credentialing/ appointment, recredentialing/reappointment/monthly):** Verified by querying the OIG website.

L. **Medi-Cal Provider Suspended and Ineligible List (initial credentialing/appointment, recredentialing/reappointment/monthly):** Verified directly through the most current published list of suspended and ineligible providers posted on the Medi-Cal website.

M. **Medicare Opt-Out Reports (initial credentialing/appointment, recredentialing/reappointment/ monthly):** Verified by querying the CMS Opt-Out website.

N. **U.S. General Service Administration Exclusion List (initial credentialing/appointment, recredentialing/reappointment/monthly):** Verified by querying the Sam.gov exclusions website.

O. **Social Security Administrations' Death Master File (initial credentialing/appointment, recredentialing/reappointment/monthly):** Verified by querying the National Technical Information Service (NTIS).

P. **Medi-Cal Enrollment Validation (initial credentialing/appointment, recredentialing/reappointment):** Verified by querying the Department of Health Care Services (DHCS) ordering, referring and prescribing (ORP) enrollment validation look up and the enrollment Medi-Cal Fee-for-service (FFS) providers list, refer to policy 102.035 Medi-Cal Enrollment Validation.

Q. **Time gaps (initial credentialing/appointment, recredentialing/reappointment if identified):** Any time periods or gaps in training or professional work history that have occurred since graduation from medical/ professional school greater than 3 months must be reported and explained in full on the application and must be sufficient to ascertain that the gap did not occur as a result of adverse and/or reportable situations, occurrences, or activities. For current gaps in professional work history greater than 1 year refer to policy 102.022 Return to Practice Plan.

Additional Credentialing Information:

A. **Resume/curriculum vitae (CV):** The CV will be reviewed during the application review process and compared to the electronic application for accuracy in work history, gaps, or discrepancies. Review of the CV is not intended to be used as a substitute for PSV of work history.

B. **Quality Data (recredentialing/reappointment):** The practitioner's ongoing professional practice evaluation (OPPE) data is reviewed and factored into the recredentialing/reappointment decisions. Quality data that does not meet the established thresholds for OPPE will trigger a focused professional practice evaluation (FPPE), which may include peer review.

C. **Patient Complaints/Grievances (recredentialing/reappointment/ongoing):** Complaints/grievances from patients and staff are included in the practitioner's ongoing professional practice data and reviewed every 6 months, and factored into the recredentialing/reappointment decisions. Complaints/grievances related to quality of care may be referred for peer review. For patient complaints regarding practitioner office sites please refer to AC.27 Patient Complaints at Clinic Facilities.

D. **Continuing Medical Education (CME)/Continuing Education (CE) (initial credentialing/appointment, recredentialing/reappointment):** The credentialing team will review documentation of the required continuing education, including any privilege specific requirements.

E. **Health Status Requirements:** According to hospital policy EHS.02 Pre-employment and Ongoing Staff Health Requirements.

F. **Additional Privileging or Practice Requirements (initial/reappointment/renewal of registration, license or certification):** Examples include but not limited to x-ray/fluouroscopy certification, Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Advanced Trauma Life Support (ATLS), privilege/program specific training certificates or clinical activity reports. If the additional requirements has a mechanism for PSV, the source will be queried.

Requests for application status/updates:

Applicants may request in writing the status of their application. The credentialing team will provide a written response within 7 business days and the response will include a list of outstanding queries or missing information necessary to complete the credentialing process.

Application Review and Recommendation Process:

Initial:

Physicians: Credentials Committee, Department Committee, Medical Executive Committee, and Governing Board.

Allied Health Professionals (AHP): Interdisciplinary Practices Committee, Department Committee, Medical Executive Committee, and Governing Board.

Renewal:

Physicians/AHPs: Department Committee, Medical Executive Committee, and Governing Board.

Notification of Credentialing Decision:

Applicants will be notified in writing of appointment/reappointment decisions within 30 days of approval.

Adverse Recommendations:

Applicants to the Medical Staff shall be, if applicable, entitled to the procedural rights outlined in the Medical Staff Bylaws Article 14. Allied Health Professionals refer to policy 102.033 Allied Health Professionals.

Requirements:

A practitioner who does not meet the general and/or basic qualifications outlined in the Medical Staff Bylaws, or privileging requirements is ineligible to apply and the application shall not be accepted. There is no obligation to release an application to a practitioner who does not meet the requirements. If it is identified after the application has been accepted or during the credentialing process that the applicant failed to meet these requirements, the practitioner will have the opportunity to submit additional information or documentation to support their qualifications within 14 days of the notification. If the applicant still does not meet the criteria, the credentialing process will be discontinued, considered withdrawn, and reported to the Credentials Committee or Interdisciplinary Practices Committee (APPs).

Definitions/Clarifications:

Credentials Committee: A multidisciplinary peer review committee responsible for the review and recommendations of physician initial credentialing/appointment applications. Accountable to the Medical Executive Committee and Governing Board.

Interdisciplinary Practices Committee (IPC): A California required (Cal. Code Regs. Tit. 22, § 70706 and 70706.1) multidisciplinary peer review credentials committee responsible for review and recommendations of advanced practice providers (APP) initial credentialing/appointment applications. Accountable to the Medical Executive Committee and Governing Board.

Medical Executive Committee (MEC): A multidisciplinary peer review committee responsible for all medical staff activities, including the approval of credential files. The MEC serves as the credentials committee for recredentialing/reappointment files. Accountable to the Governing Board.

Complete application: All required electronic application fields are completed and all required supporting documents have been submitted.

Completed application: All credentialing queries have been received, and no further information has been requested by the Credentials Committee or any other approval body.

In writing/written response: may include email correspondence.

Attachments and Additional Document References:

A. Health Plan Audit Ongoing Monitoring Websites 2024

B. 102.029 Ongoing Monitoring and Interventions

C. 102.031 Confidentiality of Medical Staff/Allied Health Professional Staff Records

D. 102.027 Medical Staff Credentialing Information Integrity (CII) and Database User Access

E. Medical Staff Bylaws

F. Medical Staff Rules & Regulations

All revision dates:

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Office	Minako Watabe: Chief Medical Officer, VCMC & SPH	pending
Policy Owner	Tracy Chapman: Director, HCA Medical Staff Administration	6/3/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Tracy Chapman: Director, HCA Medical Staff Administration*
Policy Area:	*Administration - Medical Staff*
References:	

102.039 Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) Specialists

PURPOSE:

To establish a process to identify qualified members of the Medical Staff who meet the definition of an HIV/AIDS specialist according to California Health & Safety Code §1374.16 and comply with the National Committee for Quality Assurance (NCQA) standards for the Health System's delegated credentialing agreements.

POLICY:

On an annual basis, Medical Staff Administration will identify newly qualified physician and reconfirm existing HIV/AIDS specialists by querying the Credential Verification Directory at American Academy of HIV Medicine (AAHIVM) aahivm.org or by emailing credentialing@aahivm.org. Qualifying staff will be required to complete an annual attestation and a list of specialists will be distributed to the clinics.

PROCEDURE(S):

Physicians must hold a current license to practice medicine in the State of California and meet at least one of the following criteria:

A. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine;

B. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine;

C. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:

   1. In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and

   2. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral

therapy per year; or

D. Meets the following qualifications:

1. In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

REFERENCE(S):

National Committee for Quality Assurance (NCQA) - Delegated Credentialing Requirements

California Code, Health and Safety Code - HSC § 1374.16

All revision dates:

Attachments

- Attachment A Annual HIV AIDS Letter and Attestation
- Attachment B HIV AIDS Annual Notification Memo

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Medical Staff Office	Stephanie Denson: Manager, Medical Staff Office	pending
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VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
Policy Area:	*Administrative - Nursing*
References:	

108.015 Nursing Department Accountability to Administration and Medical Staff

POLICY:

The Department of Nursing is responsible and accountable to the Medical Staff and Administration through its Clinical Nurse Manager and ultimately, the Chief Nursing Officer (CNO). Specific accountabilities and responsibilities are delineated below.

PROCEDURE:

1. To Administration
    a. To provide nursing care consistent with defined standards of nursing care and nursing practice and document such care in the medical record according to departmental policies and procedures;
    b. To protect the financial resources of the hospital through sound management practices, to practice cost-effective use of human and material resources, and to protect patients and property (risk management);
    c. Through the CNO, to actively participate in hospital planning and service projection activities;
    d. To make recommendations related to the number of staff, competencies of staff, and type of material resources needed to provide quality nursing care;
    e. To comply with all applicable regulatory standards relative to the provision of nursing care;
    f. To provide communication regarding nursing care issues and management through formal and informal channels on a regular and as needed basis.
2. To the Medical Staff:
    a. To provide nursing care consistent with the defined standards of nursing care and nursing practice;
    b. To collaboratively participate as an integral member of the patient care team;
    c. To notify the attending independent practitioner and other relevant Medical Staff members of significant changes in a patient's condition, concerns expressed by the patient or family related to the patient's medical care, and/or instances in which prescribed treatment can not be rendered;
    d. To clarify any unclear orders or orders that may not represent community practice as known to the nurse (such as medication dosages, medication contraindications, and/or therapy contraindications);
    e. To inform the independent practitioner of the effects of the prescribed therapy and to record such

therapy and effects in the medical record according to departmental policies and procedures.

All revision dates: 11/1/2013, 7/1/2010, 5/1/2006

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	6/2/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/2/2025
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VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Sherri Block: Associate Chief Nursing Executive, VCMC & SPH*
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References:	

108.018 Unlicensed Nursing Assistive Personnel (UAP)

POLICY:

To define the role of Unlicensed Assistive Personnel (UAP) in safe nursing care at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH).

PROCEDURE:

UAP's are individuals who are trained to function in an assistive role to the licensed nurse in the provision of patient care activities as delegated by and under the supervision of the licensed nurse. These health care workers may be trained and/or certified, but are not licensed (i.e. nurse assistance, certified nurse assistants).

In accordance with the California Board of Registered Nursing the following aspects of the Nursing process shall be performed only by Registered Nurses:

1. Performance of admitting assessments
2. Validation of the assessment data
3. Formulation of the nursing diagnosis for the individual patient
4. Identification of goals derived from nursing diagnosis
5. Determination of the nursing plan of care
6. Evaluation of the effectiveness of the nursing care provided

The Registered Nurse (RN), to provide "effective supervision", must take into account the following issues including but not limited to:

1. Patient safety
2. Competency of the unlicensed caregiver to perform the task
3. Number and acuity of patients
4. Number and complexity of tasks
5. Number of staff which the RN is clinically supervising

Tasks, which require a substantial amount of scientific knowledge and technical skill, may not be assigned to unlicensed personnel. These tasks may include but are not limited to:

1. Preprocedure assessment
2. Post procedure evaluation
3. Handling of invasive lines or intravenous therapy
4. Venipuncture
5. Administration of medications
6. Assessment of patient condition including triage
7. Patient education including post-discharge care
8. Parenteral or tube feedings
9. Invasive procedures including insertion of nasogastric (NG) tubes, catheters, or tracheal suctioning
10. Laboratory tests

If the patient is not medically fragile, the RN may assign to UAP's activities of daily living including but not limited to:

1. Bathing
2. Feeding
3. Ambulating
4. Vital Signs
5. Weight
6. Assistance with elimination
7. Helping to maintain a safe environment

In addition to the above listed "traditional" duties of UAP's, tasks which are judged by the direct care RN to not require the professional judgment of an RN may be assigned such as: simple, clean dressing changes (assessment of site by RN and where no wound debridement or packing is involved). Nontraditional, competency based, duties may be assigned to UAP if the following conditions are met:

1. The UAP has documented competency on file to perform these duties
2. The tasks are not one of the above listed technical skills
3. The duties are considered routine care for this patient
4. The duties pose little potential hazard for the patient
5. The duties may be performed with predictable outcome
6. The duty does not inherently involve ongoing assessments, interpretation, or decision-making which could not be logically separated from the procedure itself.

Unlicensed Assistive Personnel (UAP) may not reassign assigned tasks. If an assignment needs to be changed, the primary RN will be notified and reassignments made. The direct care RN must ultimately decide the appropriateness of the assignment of tasks. The assignments will be based on the UAP's education, training, competency and experience.

All revision dates: 8/9/2022, 8/1/2009, 6/1/2006, 12/1/2004, 4/1/2000

Attachments

No Attachments

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/2/2025
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VENTURA COUNTY
HEALTH CARE AGENCY

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References:	

108.050 Patient Safety Attendant Care

PURPOSE:

To define Patient Safety Attendant Care and the guidelines for the use of Patient Safety Attendants within Ventura County Medical Center and Santa Paula Hospital (VCMC/SPH).

POLICY:

1. An individual assigned to the role of a Patient Safety Attendant is a member of the healthcare team of Ventura County Medical Center/Santa Paula Hospital who will remain with a patient throughout a designated period of time for the purpose of maintaining patient's safety (prevention of falls, disruption of patient care, suicidal/homicidal/5150/5585, delirium, confusion, etc.).

2. A Patient Safety Attendant assures patient safety for individuals deemed to be either suicidal or on 5150 status. This requires 1:1 Observation in which an assigned staff member stays within close proximity of the patient and provides direct observation at all times (must maintain line of sight).

3. A Patient Safety Attendant provides and maintains a safe environment (for pulling tubes, airway devices, etc.) for identified patients who have not been classified as either suicidal, homicidal or on 5150/5585 status. A Patient Safety Attendant can observe 1-2 patients in close proximity for these purposes.

4. Patient's families will be encouraged to partner with VCMC/SPH Hospital staff in order to provide a safe environment for the patient. As families provide a stabilizing emotional support for the patient, they will be asked to participate by staying with the patient to prevent pulling tubes, climbing out of bed, etc. Primary RN or Charge Nurse approval required to allow family or other visitor to replace Patient Safety Attendant. The patient's visitor will be instructed to notify the nurse to resume Patient Safety Attendant care when they are leaving the room. Family and visitors will not be permitted to provide sitter care for suicidal/homicidal or 5150/5585 patients.

PROCEDURE(S):

A. Assessment of Safety Attendant Usage

1. The nurse will assess the patient’s physical condition, behaviors, and emotional status to determine if constant observation of the patient is required to ensure the patient’s safety.
2. The nurse assesses for the following:
    a. The patient is on suicide precautions, which requires a sitter 1:1.

b. Patient is on a legal hold.

c. The patient is confused, disoriented or cognitively impaired and at high risk to injure themselves (either by falling, wandering, etc.).

d. A confused, disoriented or cognitively impaired patient pulling at medically necessary tubes/ lines and hand mittens have been unsuccessful.

e. Patient has been placed in restraints due to patient exhibiting a danger to self or others.

3. If the patient meets the above criteria c., d., and e., the nurse will first consider the following alternate options to safety attendant usage. The use of a safety attendant for those criteria should only be considered if no other feasible alternative provides a solution, to include the following interventions with documented ineffectiveness in the medical record.

   a. Can the patient's family members provide supervision of the patient? The nurse will approach the family to determine feasibility.

   b. Can the patient be moved closer to the nursing station to provide more frequent observation by nursing staff?

   c. Have the medications, electrolytes, and blood gases been reviewed as a reversible cause of confusion/delirium?

   d. Where appropriate, can the patient be placed in a room with another patient who has a sitter?

   e. Can current shift assignment be adjusted to utilize scheduled staff to provide adequate supervision?

4. If the patient meets safety attendant criteria and all alternatives have been unsuccessful and documented, the justification for the need is documented on the 'Patient Safety Attendant Care Justification for the Non-Suicidal Patient' form (Attachment C). The patient's bedside nurse completes the form and submits to the Charge Nurse. If criterion is met, the Charge Nurse will speak to the Nursing Supervisor to arrange a Patient Safety Attendant. All completed forms are submitted to the Unit Nursing Clinical Director. Initiation of patient safety attendant will require review and approval each shift or with a change in condition.

B. General Expectations for all Safety Attendants

1. The Charge Nurse will assign a Patient Safety Attendant to provide observation of the patient. A Patient Safety Attendant may be assigned to monitor two patients in the same room or in adjoining rooms for non-suicidal and non-homicidal patients only. The Patient Safety Attendant will position him/herself to maintain an unobstructed view of both patients. If one patient requires individual attention, the Patient Safety Attendant will notify the Primary RN or Charge Nurse to provide temporary monitoring for the other patient.

2. Once Patient Safety Attendant care is initiated, patient will not be left unattended until the nurse notifies the Patient Safety Attendant that the assignment is discontinued. If a patient is in a private room, the safety attendant needs to be in the room with the patient.

3. The Patient Safety Attendant will immediately inform the nurse if there is a sudden change in the patient's condition/behavior.

4. Care provided by a Patient Safety Attendant will be delegated and overseen by the assigned bedside nurse. The nurse will retain the responsibility of the nursing process and administration of medications. A Patient Safety Attendant will provide physical care, within their scope of practice and training, for the patient for whom they are assigned including the documentation of vital signs and

intake and output. Patients who are suicidal/homicidal require every 15 minute documentation on the patient observation log (see Attachment B).

5. The Patient Safety Attendant as directed by the nurse will complete all aspects of Activities of Daily Living (ADL's) for the patient provided they have demonstrated competency. This includes, but is not limited to, the following: bathing, feeding, toileting, and range of motion (ROM). Exception: Security Personnel may provide observation only, not the ADLs/physical care. Patient Safety Attendants (unless Registered Nurses) may not perform assessments.
6. The Patient Safety Attendant will accompany the patient for any clinical tests or procedures off the unit unless patient is already accompanied by the bedside nurse. The staff member accompanying the patient will remain within line of sight of the patient unless otherwise directed by the person performing the test or procedure.
7. The Patient Safety Attendant will remain within direct sight of the patient while patient is using the bathroom or shower. The Patient Safety Attendant will attempt to maintain the patient's dignity and privacy by having same gender assistant assume temporary responsibility of the patient as needed.
8. While on duty, the Patient Safety Attendant will not leave the patient's room without the bedside nurses' approval and/or relief. If a break is needed, a hand-off to the temporary staff member will occur prior to reporting off the unit.
9. The Patient Safety Attendant will refer the patient to the nurse or physician to answer any questions regarding the plan of care.

9. **Patient Safety Attendant/Suicidal/Homicidal or Patient on a 5150/5585**

a. If a Patient Safety Attendant is required for a suicidal or patient on a 5150/5585, the Charge Nurse will assign a staff member to provide 1:1 observation of the patient.

b. If a patient is a danger to self or others, creating a safe environment is essential. The patient will not be permitted to use sharps or other items that could be used to harm self or others. For assistance in creating a safe environment see policy 100.268 Suicidal Environmental Risk Assessment. In addition, the safety attendant should not have any objects on his/her person that could be used to cause harm.

d. Verify dietary order specifies no sharp objects and/or finger foods only. No utensils will be given to patient.

e. The Patient Safety Attendant will immediately inform the nurse:

1. If the patient expresses an intention to hurt self/others.
2. If there is a sudden change in the patient's condition/behavior.
3. The Patient Safety Attendant may not leave the patient for any reason until coverage is obtained and present.

e. The Patient Safety Attendant may not be discontinued without Licensed Practitioner order.

11. **Documentation**

a. All patient care will be documented in the Electronic Health Record.

b. Patient Safety Attendant will complete the Patient Observation Log (Attachment B).

c. Patient Safety Attendant will complete the C.A.S.E. Safety Check form (Attachment A).

12. Competency

a. All Patient Safety Attendants must complete training prior to assuming the role. Training includes a didactic course and results in a competency Assessment.

b. All Patient Safety Attendants used for violent or aggressive behavior must have Crisis Prevention Institute (CPI) training or comparable (e.g., AVADE) by June 1, 2026.

c. All Patient Safety Attendants must participate in an annual refresher course to ensure maintenance of competency.

All revision dates: 6/2/2025, 10/9/2024, 12/20/2023, 7/12/2023, 4/28/2023, 4/13/2023, 4/11/2023, 4/11/2023

Attachments

- C.A.S.E. Safety Checklist.pdf
- Patient Observation Record.PDF
- Patient Safety Attendant Care Justification for the Non-Suicidal Patient.docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	6/3/2025
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VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Julia Feig: Clinical Nurse Manager, Emergency Services*
Policy Area:	*Emergency Services*
References:	

ER.42 Standardized Nursing Procedures in the Emergency Department

POLICY:

To provide a registered nurse (RN) standardized procedures for the initiation of patient care upon patient arrival to the emergency department.

It is the policy of Ventura County Medical Center and Santa Paula Hospital that all standardized procedures are developed collaboratively and approved by the Interprofessional Practice Committee (IPC), whose membership consists of Physicians, Registered Nurses (RN), Pharmacists, Advanced Practice Nurses and Administrators. Standardized procedures are reviewed every three years.

To outline and define responsibility in performing interventions requiring a physician order in accordance with the California Board of Registered Nursing and the Nursing Practice Act, all approved standardized procedures will be kept in Policy Stat. The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures or changes in treatment regimen after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics.

Function to Be Performed:

~~Individuals that present to the Emergency Department (ED) at Ventura County Medical Center/Santa Paula Hospital (VCMC/SPH)~~A triage competent RN will ~~be assessed by a triage-competent Registered Nurse (RN) to~~ determine the patient's presenting complaint and acuity. Once this assessment is complete~~,~~ the triage nurse may initiate care according to the following standardized procedures or assign the responsibility to the patient's primary care RN.

~~The standardized procedures outlined in this policy are established via the established governance process to initiate and expedite care in the ED. Only ED nurses who have demonstrated competency in the role and have received specialized training for this protocol may activate these procedures. This procedure was written collaboratively with nursing and ED physician leadership and is approved via the Interprofessional Practice Committee and approved by medical staff.~~

Applicable Departments:

Emergency Departments at Ventura County Medical Center and Santa Paula Hospital (SPH)- SPH at request

of physician to initiate only

Roles and Responsibilities

Order entry for these procedures will be completed by the triage RN or primary care RN. All orders will be reviewed and implemented by an RN, their designee, or the applicable specialty department.

The standardized procedures outlined in this policy are established to initiate and expedite care in the ED. All standardized procedures are to be documented in the Electronic Health Record (EHR). When additional concerns arise or conditions develop not listed in these procedures, the RN will consult with the patient's licensed practitioner (LP). The RN will initiate all interventions in the appropriate ~~protocol and will add orders as needed based on the conditions outlined in the~~ protocol. The LP will be notified and assume responsibility for reviewing test results and contacting the patient in the event that a patient leaves the hospital prior to completion of test results.

Competency for the procedures listed will be assessed annually and stored in the ED RN personnel files. The procedures herein will be reviewed annually with an interprofessional team including medical staff. When initiating one of the protocols, the ED RN will order under standardized procedure order type, which requires a co-signature by attending physician.

A. Scope of supervision required
    1. The RN is responsible and accountable to the emergency department clinical director
    2. Provider consultation is to be obtained under the following circumstances
        a. Emergency conditions requiring prompt medical intervention
        b. Upon the request of the patient, RN or physician
        c. Anytime any deviation from this protocol is necessary
    3. Limitations on Settings - these standardized procedures to be implemented only in the emergency department at Ventura County Medical Center or Santa Paula Hospital. SPH will not routinely implement these protocols but can do so at the initiation of the LP in the ED.
B. Requirements for the RN
    1. Active California RN license
    2. BLS, ACLS, and PALS
C. Evaluation of the RN competence
    1. Initial upon hire to department: the Nurse director/delegate will assess the RN's ability to initiate the standardized nursing procedures.
    2. Annually: the Nurse director/delegate will evaluate the RN's ability initiate the standardized nursing procedures.

PROCEDURE:

~~I. **STANDARDIZED TREATMENT AND DIAGNOSTIC PROCEDURES**~~
~~The standardized procedure order sheet will include the following:~~

~~A. **Isolated Extremity Injury**~~

~~1. Immobilize joints above and below injury~~

2. ~~Apply ice~~
3. ~~Elevate injured extremity~~
4. ~~Remove rings on injured extremity~~
5. ~~Consult LP for imaging orders~~
6. ~~NPO~~
7. ~~Saline Lock~~

B. ~~**2+ Systemic Inflammatory Response Syndrome (SIRS)**~~

- ~~Temperature less than 96.8ºF or greater than 100.9ºF~~
- ~~HR greater than 90~~
- ~~RR greater than 20~~
- ~~WBC less than 4,000 or greater than 12,000 or~~
- ~~Bands greater than 10% with suspected or confirmed infection (Adult)~~

1. ~~Adults: Initiate EDN SIRS (2+ Systemic Inflammatory Response Syndrome) Power Plan.~~
2. ~~Acetaminophen 650 mg form: Tab, oral, Once. Now.~~
   ~~To be given if patient has a fever greater than or equal to 101ºF, has not received acetaminophen in the last 4 hours, does not have liver disease~~
3. ~~Lab ER panel~~
4. ~~Venous Blood Gas with lactate~~
5. ~~Venous Blood Gas plus electrolytes plus lactate (If patient is Short of breath)~~
6. ~~Point of care UA Urinalysis with reflex micro/culture~~
7. ~~Blood culture x 2 (draw and hold; collect from 2 different sites)~~
8. ~~O2 via nasal cannula to keep O2 sat greater than 94%~~
9. ~~Saline Lock~~
10. ~~Consult LP for imaging orders~~
11. ~~Discuss presence of existing urinary catheter with provider for further instructions.~~

C. ~~**Fever greater than 101ºF Adults**~~

1. ~~Acetaminophen 650 mg form: Tab, oral, once. Now.~~
   ~~To be given if patient has a fever greater than or equal to 101ºF, has not received acetaminophen in the last 4 hours, does not have liver disease~~

D. ~~**Fever greater than 101ºF Pediatrics (patients older than 6 months)**~~

1. ~~Acetaminophen 15mg/kg PO x 1 (Maximum dose: 650 mg) To be given if patient does not have documented history of kidney or liver disease and has not received acetaminophen in the last 4 hours.~~
2. ~~Ibuprofen 10mg/kg PO x 1 to be given if acetaminophen contraindicated (see above) AND patient~~
   i. ~~has not received ibuprofen or other NSAIDS in the last 6 hours~~
   ii. ~~is not pregnant~~

iii. is not on hemodialysis or with known kidney disease

iv. does not have bleeding disorder or cancer

E. **Fever (≥100.4) and Cancer (Adult):**

1. Saline Lock
2. Access Central Line if present, and obtain 1st blood culture and label as central line
3. Draw second blood culture from peripheral vein and label as peripheral
4. Lab ER Panel
5. C-Reactive Protein (CRP)
6. Extra tube for blood bank
7. Notify LIP for HR greater than 140, less than 50 or O2 sat less than 90%
8. Point of care UA Urinalysis with reflex micro/culture
9. O2 via nasal cannula to keep O2 sat greater than 94%
10. Chest x-ray 1 view

F. **Diabetic Ketoacidosis (DKA) Suspected**

1. NPO
2. Venous blood gas plus electrolytes plus lactate
3. Glucose point of care stat
4. Lab ER panel
5. Hemoglobin A1C
6. Point of care UA Urinalysis with reflex micro/culture
7. Saline lock

G. **Fever (≥100.4) and Cancer (Pediatric)**

a. Room patient immediately

b. Obtain IV access

c. Notify LP

H. **Eye Injury**

1. Proparacaine and Fluorescein to provide to LP
2. Visual acuity
3. Consult LP for pain medications

I. **Altered Mental Status (Adult)**

1. Saline Lock
2. Cardiac monitor
3. Lab ER panel
4. Glucose point of care
5. TSH

6. ~~Alcohol level~~
7. ~~Urine drug screen~~
8. ~~Point of care UA Urinalysis with reflex micro/culture~~
9. ~~EKG (NOTE: perform if HR greater than 100 or less than 60)~~
10. ~~Consult LP for imaging orders~~
11. ~~Venous blood gas plus electrolytes plus lactate~~
12. ~~Consult LP if Lithium Level should be drawn~~

J. ~~**Abdominal Pain or Flank Pain**~~

1. ~~Point of care UA Urinalysis with reflex micro/culture~~
2. ~~Saline Lock~~
3. ~~NPO~~
4. ~~Lab ER Panel~~
5. ~~C Reactive Protein (CRP)~~
6. ~~Consult LP for antiemetic medication~~

K. ~~**Dysuria**~~

1. ~~Point of care UA Urinalysis with reflex micro/culture~~

L. ~~**Pregnancy Less Than 20 Weeks with Vaginal Bleeding and/or Abdominal Pain**~~

1. ~~If greater than 20 weeks pregnant, transfer directly to Labor and Delivery Department at VCMC. At SPH, notify LP.~~
2. ~~Saline lock (NOTE: insert if HR>100 or SBP<100)~~
3. ~~Lab ER panel (NOTE: if HR>100 or SBP<100)~~
4. ~~Type and Rh and antibody screen~~
5. ~~Serum HCG~~
6. ~~Point of care UA Urinalysis with reflex micro/culture~~

M. ~~**Chest Pain**~~

1. ~~EKG and give to physician within 10 minutes~~
2. ~~Asprin 81 mg tablet, 4 tablets PO x 1 chewed~~
3. ~~Cardiac monitoring~~
4. ~~Oxygen saturation monitoring~~
5. ~~Oxygen at two (2) liters via nasal cannula if less than 95% O2 sat~~
6. ~~Saline Lock~~
7. ~~Troponin every 2 hours x 2~~
8. ~~Lab ER panel~~
9. ~~PT, PTT (for patient on anticoagulant medication)~~
10. ~~Consult LP for imaging orders~~

11. NPO

N. **Shortness of Breath/Cough (Adults only)**

1. Airborne and droplet isolation until discontinued by LP
2. If wheezing or history of asthma confer with LP for nebulized treatment
3. EKG if history or suspect cardiac disease
4. Oxygen at two (2) liters via nasal cannula if less than 92% 02 sat
5. Oxygen saturation monitoring
6. NPO
7. Consult LP for imaging orders
8. Saline Lock
9. Lab ER panel
10. Venous Blood Gas plus electrolytes plus lactate
11. Blood culture x 2 (NOTE: If febrile)

O. **Shortness of Breath/Cough (Ages 2-17)**

a. Contact respiratory therapy
b. Initiate pediatric asthma score (PAS).
c. Consult LP

P. **Syncope**

1. EKG
2. Cardiac Monitor
3. Saline Lock
4. Lab ER Panel
5. Point of care blood glucose

Q. **Diabetic Wound**

1. Lab ER Panel (includes glucose)
2. C-reactive Protein
3. Erythrocyte Sedimentation Rate (ESR)
4. Venous blood gas plus electrolytes plus lactate
5. Blood Cultures x2
6. Consult LP for imaging orders

R. **Psychiatric Patients**

1. Point of care UA Urinalysis with reflex micro/culture if elderly (65 and above)
2. Mental health panel (NOTE: perform if needs clearance for mental health evaluation)
3. Drug levels if on medication (NOTE: perform for valproic acid, depakote, lithium)
4. COVID mini respiratory panel (NOTE: perform if needs clearance for mental health evaluation/

placement)

5. Aspirin and Acetaminophen levels (NOTE: perform if patient presents with suicidal ideation)
6. Nicotine patch when applicable
7. Consult physician for appropriate diet order

S. **Suspected Stimulant Intoxication**
If patients HR is >120:

1. Saline Lock
2. Consult LP regarding need for IV fluids
3. Lab ER Panel
4. Creatinine Phosphate Kinase
5. Cardiac Monitor
6. EKG

T. **GI Bleed**

1. Lab ER Panel
2. Saline Lock
3. PT, PTT
4. Extra tube for blood bank
5. Cardiac Monitoring
6. NPO

STANDARDIZED TREATMENT AND DIAGNOSTIC PROCEDURES
The standardized procedure order sheet will include the following:

A. **Isolated Extremity Injury**

1. Immobilize joints above and below injury
2. Apply ice
3. Remove rings on injured extremity
4. X-ray orders as follows with Indication: pain, and Portable Required: no.
    a. Right first toe 3 view
    b. Left first toe 3 view
    c. Right second toe 3 view
    d. Left second toe 3 view
    e. Right third toe 3 view
    f. Left third toe 3 view
    g. Right fourth toe 3 view
    h. Left fourth toe 3 view
    i. Right fifth toe 3 view

j. Left fifth toe 3 view
k. Right ankle 3 view
l. Left ankle 3 view
m. Right foot 3 view
n. Left foot 3 view
o. Right tib fib 2 view
p. Left tib fib 2 view
q. Right femur 2 view
r. Left femur 2 view
s. Right thumb 3 view
t. Left thumb 3 view
u. Right index finger 3 view
v. Left index finger 3 view
w. Right middle finger 3 view
x. Left middle finger 3 view
y. Right ring finger 3 view
z. Left ring finger 3 view
aa. Right pinky finger 3 view
ab. Left pinky finger 3 view
ac. Right hand 3 view
ad. Left hand 3 view
ae. Right wrist 3 view
af. Left wrist 3 view
ag. Right forearm 2 view
ah. Left forearm 2 view
ai. Right elbow 3 view
aj. Left elbow 3 view
ak. Right humerus 2 view
al. Left humerus 2 view
am. Right shoulder 3 view
an. Left shoulder 3 view

B. **2+ Systemic Inflammatory Response Syndrome (SIRS) Adults**: Temperature less than 96.8ºF or greater than 100.9ºF, heart rate > 90, respiratory rate > 20 with patient symptoms suggesting a new infection or confirmed infection is present

1. Acetaminophen 650 mg form: Tab, oral, Once. Now. To be given if patient has a fever greater than or equal to 101ºF, has not received acetaminophen in the last 4 hours, does not have liver disease

2. Lab ER panel
3. Venous Blood Gas plus electrolytes plus lactate
4. Point of care UA Urinalysis with reflex micro/culture
5. Blood culture x 2 (draw and hold; collect from 2 different sites)
6. O2 via nasal cannula to keep O2 sat greater than 94%
7. Saline Lock
8. Rad x-ray chest single view

C. **Fever greater than 101ºF Adults**

1. Acetaminophen 650 mg form: Tab, oral, once. Now.
   To be given if patient has a fever greater than or equal to 101ºF, has not received acetaminophen in the last 4 hours, does not have liver disease

D. **Fever greater than 101ºF Pediatrics (patients older than 6 months)**

1. Acetaminophen 15mg/kg PO x 1 (Maximum dose: 650 mg) To be given if patient does not have documented history of liver disease and has not received acetaminophen in the last 4 hours.
2. Ibuprofen 10mg/kg PO x 1 to be given if acetaminophen contraindicated (see above) AND patient
   a. has not received ibuprofen or other NSAIDS in the last 6 hours
   b. is not pregnant
   c. is not on hemodialysis or with known kidney disease
   d. does not have bleeding disorder, cancer or active chemotherapy

E. **Fever (≥100.4) and Cancer (Adult)**:

1. Saline Lock
2. Access Central Line if present, and obtain 1st blood culture and label as central line
3. Draw second blood culture from peripheral vein and label as peripheral
4. Lab ER Panel
5. C-Reactive Protein (CRP)
6. Extra tube for blood bank
7. Notify LP for HR greater than 140, less than 50 or O2 sat less than 90%
8. Point of care UA Urinalysis with reflex micro/culture
9. O2 via nasal cannula to keep O2 sat greater than 94%
10. Chest x ray 1 view

F. **Blood Sugar at or > 300**

1. NPO
2. Venous blood gas plus electrolytes plus lactate
3. Glucose point of care stat
4. Lab ER panel (adults) or Lab Ped ER Panel if < 18 years of age
5. Hemoglobin A1C

6. Point of care UA Urinalysis with reflex micro/culture
7. Saline lock

G. **Fever (≥100.4) and Cancer (Pediatric)**

1. Room patient immediately
2. Access Central Line if present, and obtain 1st blood culture and label as central line. If no central line, obtain IV access.
3. Notify LP

H. **Eye Injury**

1. Fluorescein sodium and benoxinate hydrochloride 0.25/0.4%, 2 drops to affected eye X 1
2. Visual acuity

I. **Altered Mental Status (Adult)**

1. Saline Lock
2. Cardiac monitor
3. Lab ER panel
4. Glucose point of care
5. TSH
6. Alcohol level
7. Urine drug screen
8. Point of care UA Urinalysis with reflex micro/culture
9. EKG (NOTE: perform if HR greater than 100 or less than 60)
10. Venous blood gas plus electrolytes plus lactate
11. Lithium Level should be drawn if patient takes Lithium

J. **Abdominal Pain or Flank Pain**

1. Point of care UA Urinalysis with reflex micro/culture
2. Saline Lock
3. NPO
4. Lab ER Panel
5. C Reactive Protein (CRP)
6. Zofran 4mg ODT for complaint of nausea and/or vomiting x 1

K. **Dysuria**

1. Point of care UA Urinalysis with reflex micro/culture

L. **Pregnancy Less Than 20 Weeks with Vaginal Bleeding and/or Abdominal Pain**

1. If greater than 20 weeks pregnant, transfer directly to Labor and Delivery Department at VCMC. At SPH, notify LP.
2. Saline lock (NOTE: insert if HR>100 or SBP<100)
3. Lab ER panel (NOTE: if HR>100 or SBP<100)

4. Type and Rh and antibody screen
5. Serum HCG
6. Point of care UA Urinalysis with reflex micro/culture

M. **Chest Pain (Adults)**

1. EKG and give to physician within 10 minutes
2. Cardiac monitoring
3. Oxygen saturation monitoring
4. Oxygen at two (2) liters via nasal cannula if less than 95% O2 sat
5. Saline Lock
6. Troponin every 2 hours x 2
7. Lab ER panel
8. PT, PTT (for patient on anticoagulant medication)
9. Rad x-ray chest single view
10. NPO

N. **Shortness of Breath/Cough (Adults only)**

1. Ask patient to wear a simple mask if cough present
2. EKG if history or suspect cardiac disease
3. Oxygen at two (2) liters via nasal cannula if less than 92% 02 sat
4. Oxygen saturation monitoring
5. NPO
6. Rad x-ray chest single view
7. Saline Lock
8. Lab ER panel
9. Venous Blood Gas plus electrolytes plus lactate
10. Blood culture x 2 (NOTE: If febrile)

O. **Shortness of Breath/Cough (Ages 2-17)**

1. Order pediatric asthma score

P. **Syncope**

1. EKG
2. Cardiac Monitor
3. Saline Lock
4. Lab ER Panel
5. Point of care blood glucose

Q. **Diabetic Wound**

1. Lab ER Panel (includes glucose)

2. C-reactive Protein
3. Erythrocyte Sedimentation Rate (ESR)
4. Venous blood gas plus electrolytes plus lactate
5. Blood Cultures x2

R. **Psychiatric Patients**

1. Point of care UA Urinalysis with reflex micro/culture if elderly (65 and above)
2. Mental health panel (NOTE: perform if needs clearance for mental health evaluation)
3. Drug levels if on medication (NOTE: perform for valproic acid, depakote, lithium)
4. COVID antigen test
5. Aspirin and Acetaminophen levels (NOTE: perform if patient presents with suicidal ideation)
6. Consult physician for appropriate diet order

S. **Suspected Stimulant Intoxication**
If patients HR is >120:

1. Saline Lock
2. Lab ER Panel
3. Creatinine Phosphate Kinase
4. Cardiac Monitor
5. EKG

T. **GI Bleed**

1. Lab ER Panel
2. Saline Lock
3. PT, PTT
4. Extra tube for blood bank
5. Cardiac Monitoring
6. NPO

U. **High Acuity Undifferentiated Adult Patient**

1. For patients > 18 years old who present with one or more of the following:
    a. HR <50 or >100 beats per minute
    b. SBP <90 or >180 mmHg
    c. RR <10 or >20 breaths per minute
    d. Pain level > 6
2. Lab ER Panel
3. Saline Lock

Documentation:

A. The RN will document the following in the electronic health record (EHR)

1. All orders in the power plan
2. All patient results not automatically populated

All revision dates:	4/9/2025, 2/24/2025, 6/14/2023, 1/13/2021, 7/23/2019, 3/21/2019, 12/1/2013

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Emergency Department & IPC	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/22/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/9/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/9/2025
Emergency Services	Julia Feig: Clinical Nurse Manager, Emergency Services	4/9/2025

VENTURA COUNTY HEALTH CARE AGENCY

Origination:	*7/1/1999*
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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*Maternal Child Health*
References:	

MCH.14 Hypoglycemia in the Newborn

POLICY:

In most newborns, low blood sugar concentrations are not reflective of any particular problem, but rather representative of the transition to the extra-uterine metabolic state. The precise definition of hypoglycemia for every newborn in regard to gestational age, birth weight, metabolic needs, and illness or their wellness remains quite controversial. For the healthy term infant born after an uneventful pregnancy and delivery, recommendations are to monitor glucose levels only if risk factors are present.

This policy describes nursing actions necessary to ensure newborns are accurately identified, provides guidelines for the management of the newborn who is at risk for, or exhibits signs and symptoms of, hypoglycemia. Newborns which meet criteria and/or present with signs and symptoms as described shall be screened and treated for hypoglycemia. Newborns not meeting criteria for screening and not presenting with signs or symptoms of hypoglycemia shall be managed using standard procedure for preventing hypoglycemia. Skin-to-skin contact between mother and infant as soon as possible following birth will help maintain normal infant body temperature and reduce infant energy expenditure and can help maintain normal infant blood glucose levels. It will also stimulate infant suckling and maternal milk supply.

PROCEDURE:

A. Blood Glucose (BG) screening in the Perinatal units shall be performed on newborns who are at risk for, or exhibit signs of hypoglycemia.

1. The newborns BG will be checked via heel stick after warming the heel for at least three (3) minutes.
2. The physician or registered nurse (RN) will be responsible for identifying newborns that need to have glucose screening, feedings and dextrose gel following the algorithm: ***Hypoglycemia Algorithm* (Attachment A).**
3. Immediate skin-to-skin and breast feeding should be initiated within the first hour of life prior to the first BG check whenever possible.
4. If BG is less than 20, give glucose gel, contact Neonatal Intensive Care Unit (NICU) charge nurse or Neonaologist for consultation. Consider admission to NICU.
5. Up to 6 doses of dextrose gel may be given within 48 hours of birth as per the ***Hypoglycemia Algorithm. (Attachment A)***

B. The following factors will indicate a blood glucose check if not symptomatic within **1** hour of birth and screening for **12** hours following birth are:

1. **Risk Category**:
    a. An Apgar score of 6 or less at 5 minutes
    b. Infants of diabetic mothers (IDM)
    c. Large for gestational age (LGA) or ≥ 4000gm see chart

C.The following factors will indicate a blood glucose check if not symptomatic within **1** hour of birth and screening for up to **24** hours following birth are:

2. Risk Category:
    a. Small for gestational age (SGA) or BW ≤2500 grams
    b. Late preterm 35 0/7-36 6/7 weeks gestation
    c. Congenital Syndrome or midline abnormalities

D. The following requires immediate BG check upon demonstration of symptoms and notify physician, consider notifying the NICU Charge Nurse or Neonatologist for consultation.

a. Jittery, tremors, seizures

b. Lethargy, poor feeding

c. Apnea, respiratory distress

d. Hypotonic, floppy, irritable

e. Exaggerated Moro

f. High pitched, feeble cry

GUIDELINES:

Appropriate hand hygiene and glove use prior to patient contact shall be followed. Apply heel warmer for three minutes. Cleanse with alcohol. Use a lancet to pierce the heel using the lateral and medial posterior surface of the infant's heel. Wipe the initial blood drop and then collect sample (discard lancet appropriately).

A. **Glucose Screening** - Follow ***Hypoglycemia Algorithm*** **(Attachement A)**
    1. An asymptomatic newborn with risk factors may be transferred to couplet care after two consecutive BG results greater than 40 ml/dl. Continual BG checks every 2-3 hours prior to feeding for 24 hours. Treat according to Hypoglycemia Alogrithm, with no more than six (6) gel administrations in 24 hours.
    2. A newborn with signs and symptoms of hypoglycemia without risk factors may be transferred to couplet care after two consecutive BG results greater than 45 ml/dl. BG checks will continue every 2-3 hours prior to feeding until 3 consecutive BG results have reached 45 ml/dl. No further BG POCT are required, unless newborn again becomes symptomatic.

B. **Administration Guidelines**-Refer to Weight-Based Neonatal Dosing Guidelines **(Attachment A)**
    1. Squeeze Glucose gel into medication cup. Draw-up desired amount of gel based on weight of newborn.
    2. Dry the inside of the buccal mucosa with a gauze (2x2)
    3. Squeeze half of the dose onto gloved finger and massage into the buccal mucosa.

4. Repeat same steps on the opposite side of newborn with remaining half dose of glucose gel. DOCUMENTATION

    - All BG results shall be documented in the electronic health record (EHR)
    - Document dextrose gel in the Medication Administration Record
    - Document interventions performed

References:

- Bennett, C., Fagan, E., Chaharbakhshi, E., Zamfirova, I., Fricker, J. Implementing a Protocol for using gel to Treat Neonatal Hypoglycemia. Nursing for Women's Health February-March 2016.
- Harris D., Weston P., Battin M., Harding J.E. Dextrose Gel for Treating Neonatal Hypoglycemia: A Randomized Placebo-Controlled Trial (Sugar Babies Study). Lancet, 2013 published online 25 September
- AAP (2013). Management of Hypoglycemia in the neonate. http://www2.aap.org/sections/perinatal/pediatricians.html
- Rozance and Haye (2016). "New approaches to management of neonatal hypoglycemia." Rozance and Hay. Maternal Health, Neonatology and Perinatology (2016) 2:3

All revision dates: 8/14/2024, 12/8/2020, 2/18/2020, 4/1/2016, 2/1/2014, 7/1/2012, 5/1/2011, 3/1/2010, 9/1/2009, 11/1/2004, 11/1/2001, 3/1/2001

Attachments

VCMC-SPH_OB_Hypoglycemia_Algorithm_Flyer_03-2025.pdf

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	5/1/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/2/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/2/2025
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	4/2/2025

VENTURA COUNTY HEALTH CARE AGENCY

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Owner:	*Kristina Swaim: Clinical Nurse Manager, OB*
Policy Area:	*Maternal Child Health*
References:	

MCH.26 Child Abuse and Neglect, Temporary and Protective Custody

POLICY:

All hospital staff are mandated to report suspected child abuse and/or neglect. At any time during a child's hospitalization, hospital staff who become suspicious of potential child abuse or neglect of that patient may initiate this process. Instances where a diagnosis has an unclear etiology and there is a reasonable suspicion of abuse will be reported. To ensure the safety of the child pending the court intervention investigation by the Ventura County Children and Family Services (CFS).

PROCEDURE:

A. Any multidisciplinary team member may contact the Social Services Department to inform them of his/her concern. And may request a social service consultation.

B. The Social Services Department will conduct a psychosocial assessment of the patient and his/her family. After family members are interviewed and it is determined that a Child Abuse/Neglect Report (8572 report form) needs to be filed, the hospital social worker or mandated reporter will report to Children Family Services (CFS). The report should be made to the Children Family Services (CFS) hotline at 654-3200. If report is submitted by an RN or physician, Social Services Department shall be informed.

C. CFS will then conduct further investigation and determine if a protective custody order is required to be placed on behalf of the child.

D. The hospital social worker will inform the patient's multi-disciplinary team members of any Child Abuse/ Neglect Report that is filed, and if the child(ren) will be placed in protective custody.

E. It is the CFS social worker's responsibility to inform the child's parents or guardians if a Child Abuse/ Neglect Report has been filed, and when pertinent, if the child is under protective custody.

F. The charge nurse on the unit will ensure that any patient in protective custody will be assigned to a room with as much visibility as possible.

G. If supervised visitation is required the CFS team will provide staff to oversee the visitation as needed.

DOCUMENTATION

A. Electronic Health Record

1. The hospital social worker, primary nurse or nursing supervisor will document in the multi-disciplinary

progress notes the date and time that protective custody was established, and the name and phone number of the CFS Social Worker.

2. A note is written in the multi-disciplinary progress note section by the hospital employee obtaining the protective custody (hospital social worker, primary nurse, physician or nursing supervisor) as to the date and time and by whom (name and phone number of CFS Social Worker) the protective custody was obtained.
3. List names of visitors allowed at bedside. The list shall be completed by the registered nurse (RN) in conjunction with the hospital social worker and CFS social worker. A copy of photo identification (ID) placed in chart of CFS approved guardian, if available.
4. A copy of the Order for Protective Custody Warrant provided by the CFS Social Worker will be kept by the health care team.

KEY POINTS

A. Protective Custody indicates that the child may only be discharged to a court authorized person or agency. Protective custody can only be placed by a Children and Family Services (CFS) Social Worker and may be requested by the physician, hospital social worker, or any member of the multidisciplinary team.

B. If an unauthorized person attempts to leave the hospital with the child, hospital security and/or police may be requested to assist. Refer to Code Pink/Code Purple procedures.

C. Temporary custody is effective until the court order for protective custody warrant is provided. (excluding non-judicial days), during which time the CFS worker is mandated to investigate the family situation. Throughout the temporary custody time period, the parents of the child have full visitation privileges and retain all legal parental rights to authorize or refuse treatment. Visitation may be altered on a patient by patient basis and may be restricted at the discretion of physician/nursing staff.

D. Children in protective custody may be placed in a room with as much visibility as possible from the nurses' station. The health care team should be aware and alerted the patient is in temporary custody. Visitors will check in and out at the nursing station as outlined in the visitation policy.

E. If at any time hospital staff feel a child is at risk for abduction, the Ventura Police Department must be immediately notified. The Nursing Supervisor must also be notified, and the Administrator on Duty (AOD) will be alerted if necessary.

F. If the child remains in protective custody, and will be discharged to a court appointed guardian. CFS will provide to the hospital team a Contract Placement Agreement. This agreement must include the name of the guardian who the child may be discharged home to, and will be responsible for medical decisions while the child is in their custody.

G. If protective custody warrant is no longer deemed necessary, or is terminated, the CFS worker, acting as an agent of the court, will notify the hospital. And the child may be released following the standard hospital discharge process.

H. When a patient is transferred from another hospital or facility with a Child Abuse/Neglect Report (8572) the Medical Social Services Department and nursing supervisor will be made aware.

Refer to VCMC Administrative policy 107.050, *Recognition and Evaluation of Abuse.*

REFERENCES:

California Penal Code 11166
County of Ventura Child Protective Services

All revision dates: 4/18/2025, 4/9/2024, 3/9/2021, 8/1/2015, 1/1/2007, 10/1/2004, 2/1/1996

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Staff Committees: Family Medicine, OB, Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/19/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/18/2025
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	4/18/2025

VENTURA COUNTY
HEALTH CARE AGENCY

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Owner:	*Pearl Dahm: Clinical Nurse Specialist*
Policy Area:	*NICU*
References:	

N.68 Small Baby Protocol for the NICU

~~**PURPOSE:To deliver evidence based guidelines of care with emphasis on minimizing complications and improving outcomes in the extremely-low-birth-weight (ELBW) infants. Evidence based studies suggests that specialized care of this population using early management guidelines improves outcome starting in the delivery room.**~~

~~**POLICY: The Golden Hour concept applies to the care of infants 22-27 completed weeks' gestation or weighing less than 1000 grams. The complications in these ELBW infants include hypothermia, chronic lung disease, hypoglycemia, intraventricular hemorrhage, sepsis, and retinopathy of prematurity. The Golden Hour concept uses evidence based interventions to decrease the risk of complications in the VLBW infant in the following areas: Delayed cord clamping; Thermoregulation; Respiratory support; Cardiovascular support, specifically**~~

~~maintaining perfusion; optimal early nutrition; specifically preventing hypoglycemia; Decreasing the risk of infection; Retinopathy of prematurity and Integration of the family in the care of the infant.~~

~~DEFINITION(S): To deliver standardized care via evidence based guidelines to the ELBW in the NICU. The implementation and interventions for the ELBW infant have demonstrated the following benefits; Reduced early fluid administration; significant reduction in IVH; Decreased length of stay; Improved first week survival; Bailey MDI higher in small baby guideline group; and MDI/PDI <70 significantly lower in the small baby guideline group.~~

~~Process: Delayed cord clamping and cord milking. Cord milking in cases of immediate need for resuscitation and the exact process should be established of length of cord to be milked and number of times. The current technique of autologous blood transfusion (delayed cord clamping) is waiting at least 30-60 seconds before clamping the umbilical cord while holding the infant at the same level as the placentae provided that infant is stable at delivery.~~

~~Standardized Antenatal Care~~

~~A. Neonatal Consult (for greater than or equal to 22 weeks with threatened delivery)~~

~~1. Decision to or not to resuscitate on chart and communicated to Perinatal Team~~

~~2. Communication between Neonatologist, OB provider, and Perinatologist~~

~~B. Antenatal Steroids (ANS): Give ANS at 23 weeks and greater unless full support is not planned and consider giving ANS at 22 weeks if full support is planned~~

~~1. ANS given greater than 48 hours prior to delivery (ideal)~~

~~2. ANS given less than 24 hours prior to delivery~~

~~3. Unable to give any prior to delivery~~

~~C. Magnesium sulfate administered for Neurology protection~~

~~D. Mode of Delivery (decision made by the delivering provider)~~

~~1. Cesarean~~

~~2. Spontaneous Vaginal delivery~~

~~PROCEDURE(S): Standardized Delivery and Admission Care~~

~~A. Normothermia is defined as a body temperature between 36.5 degree C and 37.5 degree C or 97.7 degree F and 99.5 degree F.~~

~~(a) Methods that are available may include: Increasing delivery room temperature to 26 degree C to 28 degree C or 78.8 degree F to 82.4 degree F.~~

~~(b) Use of a pre-warmed radiant warmer, Omni-bed, or incubator~~

~~(c) Thermal mattress~~

~~(d) Polyethylene wrap~~

~~(e) Infant hat~~

~~(f) Providing heated humidified gases during stabilization to improve temperatures~~

~~(1) Pre-warm all linens, IVF, and anything that will come in contact with infant~~

~~(2) After delivery, without drying the infant, attach the temperature probe, cover with polyethylene occlusive wrap and turn radiant warmer to servo control.~~

~~(3) Goal is to obtain Head circumference prior to placing CPAP hat. If unable to assess in the delivery room, measure Head circumference with first set of cares. Prepare ventilator/CPAP at bedside including pre-warming the ventilator with humidity.~~

~~(4) Transport the infant to the NICU in pre-warmed Giraffe isolette/shuttle with the polyethylene wrap, porta warmer mattress, Snuggly and hat with humidity set 80%.~~

~~(5) Prepare an admission giraffe to include pre-warming, humidity, warming all linens, snuggly and any other items that will come into contact with the infant. Place the infant immediately in a Snuggly. The goal should be to place a hat on the infant and place the infant in the polyurethane occlusive wrap in the Snuggly while in the delivery room.~~

~~(6) Coordinate assessment with all health care providers (RN, RT, MD) and perform essential interventions(umbilical lines, glucose check and weight)~~

~~(7) No more than 2 people providing hands-on care at any one time. If infant intubated cares must be coordinated with both RN and RT at bedside for first week of life~~

~~(8) Keep head midline; flat for first 72 hours and baby contained in a developmentally supported position (hand hugs/flexed).~~

~~(9) Once lines are placed, the infant should remain in the polyethylene occlusive wrap bag with the hood of the isolette down until a neutral thermal environment is obtained, i.e. humidity set at 80% and stable temperature obtained. The warming bag may then be removed and the infant contained within the Snuggly and diaper.~~

~~B. Skin care Standardized: The skin is a protective organ and its function is to provide a barrier. Any break in integrity creates an opportunity for infection.~~

~~1) Humidification is set to 80% for first week of life (See policy N.71 for ELBW humidification protocol for weaning)~~

~~2) Universal precautions (gloves) should always be used.~~

~~3) Remove betadine or any other skin preparation with saline~~

~~wipe or normal saline~~

~~4) Avoid use of adhesives~~

~~5) Use micro-preemie leads~~

~~6) Avoid peripheral IVs and heel sticks~~

~~7) No routine bathing in the first week of life~~

~~8) Gently clean skin surfaces using warm water; avoid rubbing. If areas of skin breakdown are evident; use sterile water.~~

~~9) Use Mepitel One on areas of skin breakdown and change daily or as needed~~

~~10) Change pulse oximeter probe position with cares using Mepitel underneath.~~

~~11) Universal gloving must be done by all caregivers.~~

~~C. Standardized Respiratory Support:~~

~~The main goals of respiratory support at delivery are to achieve functional residual capacity (FRC) and appropriate tidal volumes (4-6 ml/kg) and decrease work of breathing while avoiding apnea, invasive ventilation, and damage to lung parenchyma.~~

~~1) Surfactant facilitates the establishment and maintenance of FRC.~~

~~A) For infants needing CPAP, the intubation, surfactant, and extubation (INSURE) approach should be completed within the golden hour for infants in whom CPAP failure risk is thought to be high.~~

~~B) Infants needing intubation and assisted ventilation in the delivery room should be given surfactant once diagnosed with~~

~~respiratory distress syndrome.~~

~~2) Ensure the availability of blended oxygen for use in the delivery room and for transport to the NICU. If using tanks, ensure they are full and engaged for transport.~~

~~3) Set the T-piece resuscitator to blender and adjust oxygen delivery appropriately. Ensure that the pulse oximeter is present and the probe is ready to be placed on the infant.~~

~~4) Ensure that intubation equipment is immediately available and prepared as necessary.~~

~~5) After delivery occurs, apply the pulse oximeter probe, intubate as indicated, and ventilate with a T-piece resuscitator. To help prevent oxidative stress, use the minimum amount of oxygen needed to maintain pulse oximetry according to the latest recommendations of the American Academy of Pediatrics Neonatal Resuscitation Program.~~

~~6) Prepare for and assist with surfactant administration.~~

~~7) Use pulse oximeter and blood gases to adjust ventilator settings and oxygen delivery to avoid acidosis or alkalosis~~

~~8) Check monitor including alarms set for SpO2; if requiring oxygen, minimize hyperoxia during resuscitation; use minimum amount of FIO2 resuscitation based on target saturations (per Neonatal Resuscitation Program (NRP) guidelines)~~

~~9) Follow delivery room oximeter protocol per NRP guidelines~~

~~10) No routine airway suctioning~~

~~11) Target Goal Saturations~~

~~a. if infant is < 34 weeks: Goal 90-94%, Alarm Limits 88-96%~~

~~b. If infant is Greater than or = to 34 week: Goal 94-98%, alarm 92-98%~~

~~12) Standardized goals of Respiratory Care~~

~~a. Prevent and minimize risk of pneumothorax and pulmonary interstitial emphysema (PIE)~~

~~b Ventilation via High Frequency oscillator for all 22-25 week infants. Conventional ventilation may be considered for infants 26 weeks or greater depending on needs~~

~~c. Monitoring ABG every 2-3 hours and 30 minutes post ventilator change for the first 72 hours and/or per medical provider orders~~

~~d. Keep PCo2 45-55 first 72 hours of life~~

~~e. Keep pCO2 45-60 in the next 96 hours of life~~

~~f. Give Curosurf 2.5 ml/kg if intubated via ETT within 30 minutes of birth~~

~~g. Avoid Hypocapnia~~

~~h. No routine suctioning.~~

~~**D. Cardiovascular support: Hypotension is poorly defined in the ELBW infant. Furthermore, evidence exist that infants who are treated for what is perceived to be low blood pressure are more likely to have worse short- and long-term outcomes. The following may help support cardiovascular function:**~~

~~**1) Delayed cord clamping or cord milking.**~~

~~**2) Timely intravenous access with initiation of maintenance fluids.**~~

~~**3) Assess the infant for signs of poor perfusion, a better indicator of need for treatment than blood pressure. Signs may include delayed capillary refill, weak pulses, poor muscle tone, and pallor or mottling. Support perfusion with fluid resuscitation or vasopressors as ordered.**~~

~~**4) No four-extremity blood pressures if arterial line is in place.**~~

~~**E. Nutritional Regimen:**~~

~~**1) Hypoglycemia prevention: Because of the interruption of glucose supply, delayed gluconeogenesis, and concurrent stressors, ELBW infants are at particularly high risk for Hypoglycemia. Fluid balance in the first hours to days**~~

~~of birth is critical to the preterm neonate's outcome.~~

~~2) Neonate should be weighed on admission.~~

~~3) Measure glucose upon admission to NICU; then 30 and 60 minutes after delivery.~~

~~4) Placement of umbilical catheters~~

~~A) Umbilical arterial catheter indicated for continuous blood pressure and frequent laboratory or blood gas monitoring. Withdraw UAC blood sampling from infant over a minimum of 40 seconds, and return blood to infant over a minimum of 40 seconds. Use UAC for all lab draws.~~

~~B) Umbilical venous catheter indicated for administration of parenteral fluids and medications~~

~~5) Initiate a dextrose infusion, ideally total parenteral nutrition, to maintain a glucose goal of 50-110 mg/dl. Early protein is well-tolerated by ELBW neonates and is associated with protein accretion and improved growth. Protein intake of 3.5-4 g/kg/day in ELBW is optimal for growth.~~

~~6) Sterile line changes per NICU protocol~~

~~7) All cares will be performed through the portholes and the Giraffe sides will be kept up at all times except for procedures such as line placement and intubation.~~

~~8) Scrub the hub with smart sites alcohol wipes for 15-second scrub and 30 second air-dry per NICU protocol~~

~~9) Expressed breast milk (EBM) or donor breast milk (DBM):~~

~~1) Strict use of expressed breast milk and/or donor breast milk feeds~~

~~2) Counseling of mothers for providing EBM from before delivery at the time of admission to the hospital and also immediately after the birth stating the benefits of breast milk for their babies.~~

~~3) Provide oral care with "touch care times" preferably with colostrum or breast milk~~

~~4) Begin feedings in 24-36 hours with EBM/DBM only if infant is stable~~

~~a) Trophic feeds =10-20 ml/kg/day~~

~~b) Advance feeds by 10-20 ml/kg/day~~

~~c) Infuse feeds on a pump once feedings reach 5 ml in volume~~

~~5) Calculation of full enteral feeds in 24 hours- The birth weight must be used until infant regains the birth weight to calculate feedings. When the current weight has increased in the 24 hour period of time; the feeding is then recalculated and increased on the current weight based on the total feeding goal ordered by the medical provider. The Total feeding goal is multiplied by the current weight and is then divided by 8 feeds for 24 hours. The feedings must be increased by whole numbers based on current weight. Do not round up or down with feeds unless feed amount is equal to or greater than 0.5; then round the feeding up to the next whole number. The feeding is not decreased if infant has lost weight in 24 hours.~~

~~5) Fortification~~

~~a) Begin Prolacta 24 calories once infant is tolerating feeds, based on individual needs~~

~~b) Begin Prolacta 26 calories once infant receiving greater than~~

~~50% of full feeds; based on individual needs~~

~~6) Start Vit D and/or Multivitamins when tolerating full enteral feeds.~~

~~F. Intraventricular hemorrhage prevention: (Refer to policy N.70 VLBW IVH Prevention Protocol)~~

~~1) Maintain thermoregulation in a neutral thermal environment.~~

~~2) Provide developmental support and nonpharmacologic measures to decrease pain and agitation. Monitor pain scores as per NICU standard of care and administer sedation or analgesia as needed.~~

~~3) Keep head midline for the first 72 hours of life;(you must reposition infant with cares); and baby contained in a developmentally supported position (hand hugs/flexed).~~

~~4) Keep HOB flat for first 72 hours~~

~~5) Gentle Handling to avoid trauma to skin and maintain level body position.~~

~~6) Avoid hypotension or hypertension. If hypotension occurs; infuse fluids slowly at least over 30 minutes when possible and attempt to avoid large fluid boluses. (rapid administration may increase the risk of intraventricular hemorrhage.~~

~~G. Infectious Disease Management:~~

~~1) Discontinue antibiotic use as soon as possible to decrease risk of altered gut flora and NEC~~

~~2) Universal precautions (gloves) should always be used and by all caregivers.~~

~~3) Hand Hygiene- before and after direct infant contact~~

~~4) All providers who touch the infant need to be bare from the elbows down.~~

~~H. Hematologic Management~~

~~1) Keep Hct greater than 30%~~

~~2) Keep Hct 35-40% in first week of life in infant on:~~

~~a. Greater than 30% FIO2~~

~~b. Pressors or hydrocortisone for BP support~~

~~3) NPO during Packed Red Blood Cell transfusions~~

~~4) Begin Ferinsol at 2 weeks of life. (Variable practices about iron supplementation after blood transfusion).~~

~~I. Retinopathy of Prematurity- Goals to prevent severe ROP by:~~

~~1) Reducing the effects of oxygen exposure~~

~~2) Provide timely ROP evaluation~~

~~3) Provide safety and comfort during ROP examinations and treatment~~

~~4) Provide early and appropriate education and support to family members~~

~~5) Outcomes can be improved by managing oxygen exposure, reducing inflammation, and early screening with treatment. The following are screening recommendations by the American Academy of Pediatrics:~~

~~a) Screen all infants with Birth Weight < or = 1500 grams or < or = 30 weeks~~

~~b) Screen selected infants 1500-2000 grams Birth weight or > 30 weeks if they have had an acute course of care, or as deemed by the Neonatologist~~

~~6) Timing of initial screening: (see N.40 policy)~~

~~Birth Gestational Age Post-menstrual Age (weeks) Chronologic Age (Weeks)~~

~~23 weeks 31 weeks 8 weeks~~

~~24 weeks 31 weeks 7 weeks~~

~~25 weeks 31 weeks 6 weeks~~

~~26 weeks 31 weeks 5 weeks~~

~~27 weeks 31 weeks 4 weeks~~

~~28 weeks 32 weeks 4 weeks~~

~~c) Prevent hyperoxia and hypoxia fluctuations - preventing wide swings in saturations~~

~~d) Follow a protocol provides a consistent practice by all staff~~

~~1) Changes in oxygen should be made gradually and the infant should be weaned back to baseline~~

~~2) Wean FIO2 by 2-5% at a time~~

~~3) Target Saturations and limits DO NOT change until the infant is off oxygen~~

~~4) When responding to a prolonged desaturation:~~

~~a) Non-intubated infant use tactile stimulation~~

~~b) Intubated infants give 2-5 manual breaths- not oxygen breaths then observe a minimum of 15 seconds to see if the intervention facilitates infant's recovery.~~

~~c) Last response should be to increase the infant's FIO2: if a need to increase the FIO2 follow these guidelines:~~

~~1) Increase the FIO2 by 2-5% of the infant's baseline FIO2~~

~~2) Followed by an observation time of 15 seconds to see if there is a positive patient response~~

~~3) If an increase in FIO2 was done; either there is weaning the FIO2 back to baseline or informing the bedside nurse of the change~~

~~J. Family Support and Developmental care:~~

~~1) Communication with family is an essential aspect of Golden Hour care.~~

~~2) Family members should be updated with infant status and plan of care.~~

~~3) Family presence should be allowed as much as possible, with support and education regarding interaction with their infant.~~

~~4) Educate family on touch times and quiet low stimulation environment.~~

~~5) Include family in cares and rounds.~~

~~6) Introduce family to members of the team and discuss their individual roles~~

~~7) Update white boards each shift with the most current infant information~~

~~8) Coordinate care times, lab draws, procedures, tests, and assessments around touch times and infant's awake state~~

~~9) Make sure area is quiet and lights are dim~~

~~10) Use eye covers when lights are on~~

~~11) Cover all sides of the isolette with an isolette cover~~

~~12) Minimizing opening and closing of incubator doors~~

~~13) Alarms responded to as soon as possible~~

~~14) Promote sleep through Minimal handling, prone positioning after 7 days of life, "nesting" (keeping the neonate in a Snuggly supported from all sides) and clustering of care.~~

~~15) Vital signs should be obtained from monitor every hour in addition to assess with hands every 6 hours~~

~~A. Visual assessment of infant every 3 hours and as needed per NICU protocol~~

~~B. Visual assessment of IV lines/site every hour~~

~~16) Promoting parent involvement and interaction. facilitating skin to skin holding, containment, soft voicing and infant massage as directed by the infant's behavioral cues.~~

~~17) Ensure adequate pain assessment and management. Use of departmental approved sucrose or breast milk presentation on pacifier to help with pain management and self calming of painful procedures.~~

~~18) Decrease stress through facilitation of coping skills (flexion, containment, hand to face or mouth grasping, leg/foot bracing). Take time to calm and organize following stress and pain; never leave an infant in distress~~

~~19) Educating parents on reading their baby's cues and how to respond appropriately.~~

~~20) Provide and support positive oral experiences, non nutritive sucking; non nutritive breast feeding when appropriate.~~

~~21) Encourage and facilitate positive oral feeding experiences at the breast and bottle~~

~~H. Pain Management- infant's comfort should be a priority and is best treated with pharmacological and non-pharmacological methods. Care should also be used to avoid over-medicating. Sedatives and narcotics cause significant change in cerebral~~

~~oxygenation and homodynamics. Preventing, limiting or avoiding noxious stimuli manages pain effectively.~~

~~1) Non- Pharmacological interventions: If all possible; try non-pharmacological pain relief measures such as containment and sucrose(when applicable) before administering pain medications.~~

~~a. Non -nutritive sucking~~

~~b. Skin to skin with Kangaroo care and maternal touch~~

~~c. Swaddling~~

~~d. Facilitated tucking~~

~~e. 24% sucrose-avoid prolonged administration in infants <31 weeks as studies have described a possible risk of impaired neurologic development~~

~~f. Decreasing lights and noise levels~~

~~g. Containment positions~~

~~2) Pain Scale (dose not involve touching infants)~~

~~a. Assess at least every 3 hours or with cares and prn using the NPASS pain scale. NPASS incorporates gestational age as already calculated in Cerner.~~

~~b. If receiving frequent bolus pain medication obtain pain scores every 1-2 hours and prn~~

~~c. Continuous Assessment and evaluation of the medication being given for pain and for what reason~~

~~d. Continuous monitor the infant for pain during a painful procedure; if possible limit the amount of painful procedures.~~

~~I. Documentation:~~

~~1) Document all care and assessment in the infant's EMR.~~

~~2) Document delivery room interventions on the delivery record EMR.~~

PURPOSE:

To deliver evidence based guidelines of care with emphasis on minimizing complications and improving outcomes in the extremely-low-birth-weight (ELBW) infants. Evidence based studies suggests that specialized care of this population using early management guidelines improves outcome starting in the delivery room.

POLICY:

The Golden Hour concept applies to the care of infants 22-30 completed weeks' gestation or weighing less than 1500 grams.. The complications in these ELBW (extremely low birth weight) and Very Low Birth infants (VLBW) include hypothermia, chronic lung disease, hypoglycemia, intraventricular hemorrhage, sepsis, and retinopathy of prematurity. The Golden Hour concept uses evidence based interventions to decrease the risk of complications in the extremely low birth weight (ELBW) and Very Low Birth infants in the following areas: Delayed cord clamping; thermoregulation; respiratory support; cardiovascular support, specifically maintaining perfusion; optimal early nutrition; specifically preventing hypoglycemia; decreasing the risk of infection; retinopathy of prematurity (ROP) and integration of the family in the care of the infant.

DEFINITION(S):

To deliver standardized care via evidence based guidelines to the ELBW and VLBW infants in the NICU. The implementation and interventions for the ELBW and VLBW infants have demonstrated the following benefits; Reduced early fluid administration; significant reduction in IVH; Decreased length of stay; Improved first week survival; Bailey MDI higher in small baby guideline group; and MDI/PDI <70 significantly lower in the small baby guideline group.

PROCESS:

Delayed cord clamping. The current technique of autologous blood transfusion (delayed cord clamping) is waiting at least 30-60 seconds before clamping the umbilical cord while holding the infant at the same level as the placentae provided that infant is stable at delivery. The safest practice for preterm infants appears to be delayed cord clamping for vigorous infants, or immediate cord clamping for those that require immediate resuscitation.

PROCEDURE(S):

Standardized Delivery and Admission Care

A. Normothermia is defined as a body temperature between 36.5 degree C and 37.5 degree C or 97.7 degree F and 99.5 degree F.

   a. Methods that are available may include: Increasing delivery room temperature to 26 degree C to 28

degree C or 78.8 degree F to 82.4 degree F.

b. Use of a pre-warmed radiant warmer, Omni-bed, or incubator

c. Thermal mattress

d. Polyethylene wrap

e. Infant hat

f. Providing heated humidified gases during stabilization to improve temperatures

1. Pre-warm all linens, IVF, and anything that will come in contact with infant
2. After delivery, without drying the infant, attach the temperature probe, cover with polyethylene occlusive wrap and turn radiant warmer to servo control.
3. Goal is to obtain Head circumference prior to placing CPAP hat. If unable to assess in the delivery room, measure Head circumference with first set of cares. Prepare ventilator/CPAP at bedside including pre-warming the ventilator with humidity.
4. Transport the infant to the NICU in pre-warmed Giraffe isolette/shuttle with the polyethylene wrap, porta warmer mattress, Snuggly and hat with humidity set 80%.
5. Prepare an admission giraffe to include pre-warming, humidity, warming all linens, snuggly and any other items that will come into contact with the infant. Place the infant immediately in a developmental positioner such as Snuggly. The goal should be to place a hat on the infant and place the infant in the polyethylene occlusive wrap in the Snuggly or developmental positioner while in the delivery room.
6. Coordinate assessment with all health care providers (RN, RT, MD) and perform essential interventions(umbilical lines, glucose check and weight)
7. No more than 2 people providing hands-on care at any one time. If infant intubated cares must be coordinated with both RN and RT at bedside for first week of life
8. Keep head midline; flat for first 72 hours and baby contained in a developmentally supported position (hand hugs/flexed).
9. Once lines are placed, the infant should remain in the polyethylene occlusive wrap bag with the hood of the isolette down until a neutral thermal environment is obtained, i.e. humidity set at 80% and stable temperature obtained. The warming bag may then be removed and the infant contained within the Snuggly and diaper.

B. Skin care Standardized:

The skin is a protective organ and its function is to provide a barrier. Any break in integrity creates an opportunity for infection.

1. Humidification is set to 80% for first week of life (See policy N.71 for ELBW humidification protocol for weaning and attachment)
2. All cares will be performed through the portholes and the Giraffe sides will be kept up at all times.
3. Universal precautions (gloves) should always be used.
4. Remove betadine or any other skin preparation with saline-wipe or normal saline
5. Avoid use of adhesives
6. Use micro-preemie leads

7. Avoid peripheral IVs and heel sticks
8. No routine bathing in the first week of life
9. Gently clean skin surfaces using warm water; avoid rubbing. If areas of skin breakdown are evident; use sterile water.
10. Use Mepitel One on areas of skin breakdown and change daily or as needed
11. Change pulse oximeter probe position with cares using Mepitel underneath.
12. Universal gloving must be done by all caregivers.

C. Standardized Respiratory Support:

The main goals of respiratory support at delivery are to achieve functional residual capacity (FRC) and appropriate tidal volumes (4-6 ml/kg) and decrease work of breathing while avoiding apnea, invasive ventilation, and damage to lung parenchyma.

1. Surfactant facilitates the establishment and maintenance of FRC.
    a. For infants needing CPAP, the intubation, surfactant, and extubation (INSURE) approach should be completed within the golden hour for infants in whom CPAP failure risk is thought to be high.
    b. Infants needing intubation and assisted ventilation in the delivery room should be given surfactant once diagnosed with respiratory distress syndrome.
2. Ensure the availability of blended oxygen for use in the delivery room and for transport to the NICU. If using tanks, ensure they are full and engaged for transport.
3. Set the T-piece resuscitator to blender and adjust oxygen delivery appropriately. Ensure that the pulse oximeter is present and the probe is ready to be placed on the infant.
4. Ensure that intubation equipment is immediately available and prepared as necessary.
5. After delivery occurs, apply the pulse oximeter probe, intubate as indicated, and ventilate with a T-piece resuscitator. To help prevent oxidative stress, use the minimum amount of oxygen needed to maintain pulse oximetry according to the latest recommendations of the American Academy of Pediatrics Neonatal Resuscitation Program.
6. Prepare for and assist with surfactant administration.
7. Use pulse oximeter and blood gases to adjust ventilator settings and oxygen delivery to avoid acidosis or alkalosis
8. Check monitor including alarms set for SpO2; if requiring oxygen, minimize hyperoxia during resuscitation; use minimum amount of FIO2 resuscitation based on target saturations (per Neonatal Resuscitation Program (NRP) guidelines)
9. Follow delivery room oximeter protocol per NRP guidelines.
10. All infants <30 weeks Gestational age should be transported in a shuttle using a transport ventilator. Avoid hand-bagging during transport.
11. Routine suctioning of the ETT should be avoided during the first 72 hours of life. If suctioning is required use in-line catheter to avoid disconnecting the infant from the ventilator.
12. Target Goal Saturations
    a. if infant is < 34 weeks: Goal 90-94%, Alarm Limits 88-96%

b. If infant is ≥ to 34 week: Goal 94-98%, alarm 92-98%

13. Standardized goals of Respiratory Care

a. Prevent and minimize risk of pneumothorax and pulmonary interstitial emphysema (PIE)

b. Ventilation via High Frequency oscillator for all 22-25 week infants. Conventional ventilation may be considered for infants 26 weeks or greater depending on needs

c. Monitoring-ABG every 2-3 hours and 30 minutes post ventilator change for the first 72 hours and/or per medical provider orders

d. Keep PCO2 45-55 first 72 hours of life

e. Keep pCO2 45-60 in the next 96 hours of life

f. Give Surfactant(Curosurf) if intubated via ETT within 30 minutes of birth

g. Avoid Hypocapnia

h. No routine suctioning.

i. All cares should be performed by 2 people (RT/RN, RN/RN), regardless of whether or not the infant is intubated.

j. Caffeine is recommended to be administered prophylactically to all infants <30 weeks GA(gestational age). Caffeine is neuroprotective and decreases the risk of BPD(Bronchopulmonary Dysplasia) with early administration.

D. Cardiovascular support:

Hypotension is poorly defined in the ELBW infant. Furthermore, evidence exist that infants who are treated for what is perceived to be low blood pressure are more likely to have worse short- and long-term outcomes. The following may help support cardiovascular function:

1. Delayed cord clamping.

2. Timely intravenous access with initiation of maintenance fluids.

3. Assess the infant for signs of poor perfusion, a better indicator of need for treatment than blood pressure. Signs may include delayed capillary refill, weak pulses, poor muscle tone, and pallor or mottling. Support perfusion with fluid resuscitation or vasopressors as ordered.

4. No four-extremity blood pressures if arterial line is in place.

E. Nutritional Regimen:

1. Hypoglycemia prevention: Because of the interruption of glucose supply, delayed gluconeogenesis, and concurrent stressors, ELBW infants are at particularly high risk for Hypoglycemia. Fluid balance in the first hours to days of birth is critical to the preterm neonate's outcome.

2. Neonate should be weighed on admission.

3. Measure glucose upon admission to NICU; then 30 and 60 minutes after delivery.

4. Placement of umbilical catheters

a. Umbilical arterial catheter indicated for continuous blood pressure and frequent laboratory or blood gas monitoring. Withdraw UAC blood sampling from infant over a minimum of 40 seconds, and return blood to infant over a minimum of 40 seconds. Use UAC for all lab draws.

b. Umbilical venous catheter indicated for administration of parenteral fluids and medications. A

Percutaneous inserted central line (PICC) may be needed.

5. Initiate a dextrose infusion, ideally total parenteral nutrition, to maintain a glucose goal of 50-110 mg/dl. Early protein is well-tolerated by ELBW neonates and is associated with protein accretion and improved growth. Protein intake of 3.5-4 g/kg/day in ELBW is optimal for growth.
6. Sterile line changes per NICU protocol
7. All cares will be performed through the portholes and the Giraffe sides will be kept up at all times except for procedures such as line placement and intubation.
8. Scrub the hub with smart sites alcohol wipes for 15-second scrub and 30 second air-dry per NICU protocol
9. Expressed breast milk (EBM) or donor breast milk (DBM):
    a. Strict use of expressed breast milk (EBM) and/or donor breast milk (DBM) feeds
    b. Counseling of mothers for providing EBM from before delivery at the time of admission to the hospital and also immediately after the birth stating the benefits of breast milk for their babies.
    c. Provide oral care with "touch care times" preferably with colostrum or breast milk
    d. Begin feedings per feeding protocol in 24-36 hours with EBM/DBM(expressed breast milk/ Donor Breast milk) only if infant is stable. (See Individualized Enteral Advancement Tables (iEATS) attachment for guidelines to feeding protocol)
        i. Infuse feeds on a pump once feedings reach 5 ml in volume
    e. Fortification per feeding protocol guidelines (See Individualized Enteral Advancement Tables (iEATS) attachment) i.e. for Neonates < or equal1000 grams birth weight(13 day advancement)
    f. Prolacta human milk fortification is a product that provides additional protein, vitamins and minerals to breast-milk for premature infants. Prolacta's fortifiers are made from human breast milk donated by Mothers.
        i. Begin Prolacta +6 once infant is tolerating feeds at 40 ml/kg/day, based on individual needs
        ii. May need to add Prolacta cream with Prolacta +6 starting at 80 ml/kg/day for increased calories based on infant's weight gain requirements.
        iii. Begin Prolacta +8 once infant is receiving 120 ml/kg/day
    g. Start transitioning at 34 weeks corrected gestational age to Breast milk with Human milk fortifier from Prolacta fortification over a period of four days.
    h. Start Vit D and/or Multivitamins when tolerating full enteral feeds.
    i. Calculation of full enteral feeds in 24 hours if infant is tolerating full enteral feeds- The birth weight must be used until infant regains the birth weight to calculate feedings. When the current weight has increased in the 24 hour period of time; the feeding is then recalculated and increased on the current weight based on the total feeding goal ordered by the medical provider. The Total feeding goal is multiplied by the current weight and is then divided by 8 feeds for 24 hours. The feedings must be increased by whole numbers based on current weight. Do not round up or down with feeds unless feed amount is equal to or greater than 0.5; then round the feeding up to the next whole number. The feeding is not decreased if infant has lost weight in 24 hours.

F. Intraventricular hemorrhage prevention: (Refer to policy N.70 ELBW IVH Prevention Protocol)

1. Maintain thermoregulation in a neutral thermal environment.
2. Visual assessment of the infant must be performed hourly.
3. Provide developmental support and nonpharmacologic measures to decrease pain and agitation. Monitor pain scores as per NICU standard of care and administer sedation or analgesia as needed.
4. Keep head midline for the first 72 hours of life;(you must reposition infant with cares); and baby contained in a developmentally supported position (hand hugs/flexed).
5. Keep HOB flat for first 72 hours
6. Gentle Handling to avoid trauma to skin and maintain level body position.
7. Avoid hypotension or hypertension. If hypotension occurs; infuse fluids slowly at least over 30 minutes when possible and attempt to avoid large fluid boluses. (rapid administration may increase the risk of intraventricular hemorrhage.

G. Infectious Disease Management:

1. Discontinue antibiotic use as soon as possible to decrease risk of altered gut flora and NEC(Necrotizing Enterocolitis)
2. Universal precautions (gloves) should always be used and by all caregivers.
3. Hand Hygiene- before and after direct infant contact
4. All providers who touch the infant need to be bare from the elbows down.

H. Hematologic Management:

1. Keep Hct greater than 30%
2. Keep Hct 35-40% in first week of life in infant on:
    a. Greater than 30% FIO2
    b. Pressors or hydrocortisone for BP support
3. NPO during Packed Red Blood Cell transfusions
4. Begin Ferinsol at 2 weeks of life. (Variable practices about iron supplementation after blood transfusion).
5. Epogen may be initiated with Hematocrit of <30% based on infant's corrected gestational age, medical course and stability.

I. Retinopathy of Prematurity (ROP)- Goals to prevent severe ROP by:

1. Reducing the effects of oxygen exposure
2. Provide timely ROP evaluation
3. Provide safety and comfort during ROP examinations and treatment
4. Provide early and appropriate education and support to family members
5. Outcomes can be improved by managing oxygen exposure, reducing inflammation, and early screening with treatment. The following are screening recommendations by the American Academy of Pediatrics (AAP):
    a. Screen all infants with Birth Weight < or = 1500 grams or < or = 30 weeks

b. Screen selected infants 1500-2000 grams Birth weight or > 30 weeks if they have had an acute course of care, or as deemed by the Neonatologist

6. Timing of initial screening: (see N.40 policy)
    a. Prevent hyperoxia and hypoxia fluctuations - preventing wide swings in saturations
    b. Follow a protocol provides a consistent practice by all staff
        i. Changes in oxygen should be made gradually and the infant should be weaned back to baseline
        ii. Wean oxygen (FIO2) by 2-5% at a time
        iii. Target Saturations and limits DO NOT change until the infant is off oxygen
        iv. When responding to a prolonged desaturation:
            a. Non-intubated infant-use tactile stimulation
            b. Intubated infants-give 2-5 manual breaths- not oxygen breaths then observe a minimum of 15 seconds to see if the intervention facilitates infant's recovery.
            c. Last response should be to increase the infant's FIO2: if a need to increase the FIO2 follow these guidelines:
                i. Increase the FIO2 by 2-5% of the infant's baseline FIO2
                ii. Followed by an observation time of 15 seconds to see if there is a positive patient response
                iii. If an increase in FIO2 was done; either there is weaning the FIO2 back to baseline or informing the bedside nurse of the change

J. Family Support and Developmental care:
    1. Communication with family is an essential aspect of Golden Hour care.
    2. Family members should be updated with infant status and plan of care.
    3. Family presence should be allowed as much as possible, with support and education regarding interaction with their infant.
    4. Educate family on touch times and quiet low stimulation environment.
    5. Include family in cares and rounds.
    6. Introduce family to members of the team and discuss their individual roles
    7. Update white boards each shift with the most current infant information
    8. Coordinate care times, lab draws, procedures, tests, and assessments around touch times and infant's awake state
    9. Make sure area is quiet and lights are dim
    10. Use eye covers when lights are on. Care should be taken to not expose infant's eyes to direct light. Indirect light may be used in room for visibility with incubator cover in place. Adverse light exposure is a source of stress and may alter physiologic processes and Central Nervous system organization. Continuous light may alter circadian rhythms leading to abnormal cortisol production and altered sleep-wake periods.
    11. Cover all sides of the isolette with an isolette cover

12. Minimizing opening and closing of incubator doors. Loud sounds can cause changes in heart rate, oxygen saturation, blood pressure and respiratory rate. Excessive auditory stimulation may cause cochlear damage.
13. Alarms responded to as soon as possible
14. Promote sleep through Minimal handling, prone positioning after 7 days of life, "nesting" (keeping the neonate in a Snuggly supported from all sides) and clustering of care.
15. Vital signs should be obtained from monitor every hour with visual assessment of infant; in addition to assess with hands every 6 hours
    a. Visual assessment of infant every one hour and as needed per NICU protocol
    b. Visual assessment of IV lines/site every hour
16. Promoting parent involvement and interaction. Facilitating skin to skin holding, containment, soft voicing and infant massage as directed by the infant's behavioral cues.
17. Ensure adequate pain assessment and management. Use of departmental approved sucrose or breast milk presentation on pacifier to help with pain management and self calming of painful procedures.
18. Decrease stress through facilitation of coping skills (flexion, containment, hand to face or mouth grasping, leg/foot bracing). Take time to calm and organize following stress and pain; never leave an infant in distress
19. Educating parents on reading their baby's cues and how to respond appropriately.
20. Provide and support positive oral experiences, non nutritive sucking; non nutritive breast feeding when appropriate.
21. Encourage and facilitate positive oral feeding experiences at the breast and bottle

K. Pain Management:

Infant's comfort should be a priority and is best treated with pharmacological and non-pharmacological methods. Care should also be used to avoid over-medicating. Sedatives and narcotics cause significant change in cerebral oxygenation and hemodynamics. Preventing, limiting or avoiding noxious stimuli manages pain effectively.

1. Non- Pharmacological interventions: If all possible; try non-pharmacological pain relief measures such as containment and sucrose(when applicable) before administering pain medications.
    a. Non -nutritive sucking
    b. Skin to skin with Kangaroo care and maternal touch
    c. Swaddling
    d. Facilitated tucking
    e. 24% sucrose-avoid prolonged administration in infants <31 weeks as studies have described a possible risk of impaired neurologic development
    f. Decreasing lights and noise levels
    g. Containment positions
2. Pain Scale (dose not involve touching infants)

a. Assess at least every 3 hours or with cares and prn using the NPASS pain scale. NPASS incorporates gestational age as already calculated in Cerner.

b. If receiving frequent bolus pain medication obtain pain scores; 30 minutes post assessment then every 1-2 hours and prn

c. Continuous Assessment and evaluation of the medication being given for pain and for what reason

d. Continuous monitor the infant for pain during a painful procedure; if possible limit the amount of painful procedures.

DOCUMENTATION:

1. Document all care and assessment in the infant's EMR.
2. Document delivery room interventions on the delivery record EMR.

REFERENCE(S):

~~Bissinger, R. L., Annibel, D. J.; Fanning, B.A. (2019) Golden Hours Care of the Very Low Birth Weight Neonate.by National Certification Corporation. 2nd Ed~~

~~Sundquist Beauman, S. and Bowles, S. (2019) Policies, Procedures, and Competencies for Neonatal Nursing Care. 6th edition. National Association of Neonatal Nurses~~

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- Steinhorn, R.H. (May 2021) Umbilical cord milking should be avoided in preterm infants. Journal of Pediatrics, volume 232, Pg 1-3.
- Sundquist Beauman, S. and Bowles, S. (2019) Policies, Procedures, and Competencies for Neonatal Nursing Care. 6th edition. National Association of Neonatal Nurses
- Textbook of Neonatal Resuscitation (2021) 8th edition American Academy of Pediatrics and American Heart Association

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Attachments

Humidification protocol
iEAT 1001g- 1500g 9 day protocol
iEAT less than 1000g 13 day protocol

Approval Signatures

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Pediatrics Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	2/11/2025

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	2/11/2025
NICU	Jennifer Ferrick: Director, Peds/PICU & NICU	2/11/2025
NICU	Robert Posen: NICU Medical Director	2/3/2025
NICU	Pearl Dahm: Clinical Nurse Specialist	1/31/2025

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References:	

N.79 Gastric decompression in the NICU

PURPOSE:

To guide nurses when providing gastric decompression, thus minimizing vomiting and aspiration

POLICY:

A. Gastric decompression may be accomplished by the use of an 8-French or larger single-lumen gastric tube or a double-lumen tube available in a 6-, 8-, or 10-french size. Advantages of a double-lumen tube include the capacity for greater drainage and less risk of obstruction by the stomach wall.

B. Gastric tube insertion and maintenance may be used to treat various gastrointestinal and multisystem disorders with gastrointestinal involvement.

1. Abdominal wall defects (e.g., omphalocele, gastroschisis).
2. Obstruction (e.g., esophageal atresia, tracheo-esophageal fistula, hypertrophic pyloric stenosis, malroatation, meconium ileus or plug, Hirschsprung disease, necrotizing enterocolitis, imperforate anus).
3. Congenital diaphragmatic hernia
4. Prune-belly syndrome (Eagle-Barrett syndrome)

C. Gastric tube insertion and maintenance

1. The largest drainage tube that can comfortably be inserted should be used. This provides for proper drainage and decompression of the stomach and decreases restriction of the diaphragm.
   a. 6-French tube for infants weighing less than 800 grams
   b. 8-French tube for infants weighing less than 1,500 grams
   c. 10-French tube for infants weighing 1,500 grams or more
2. A double-lumen gastric tube should be drained with continuous suction at 40-60 mm Hg. If a single-lumen gastric tube is used, intermittent suction at 30-40 mm Hg is appropriate. Either may be used for gravity drainage.
3. Flushing the tube with air, saline, or water after checking its position ensures patency. The second lumen of a dual-lumen tube is not to be flushed with anything but air because water or saline will prevent adequate intake of air to relieve pressure.
4. Decreasing the risk of emesis and the potential for aspiration is integral to preventing further

complications.

5. Measuring the drainage accurately is necessary to maintain fluid balance.

EQUIPMENT:

A. Measuring Tape

B. Drainage or Specimen trap

C. Appropriate-sized gastric tube

D. Sterile water or water based lubricant

E. Syringe

DEFINITIONS:

Presenting findings of common gastrointestinal conditions include the following:

A. Abdominal distention (ileus, intestinal obstruction, enlarged organ)

B. Bowel movement irregularities (necrotizingenterocolitis, intestinal obstruction, imperforate anus).

C. Bowel exposure (abdominal wall defect)

D. Bilious vomiting (intestinal obstruction)

E. Coughing, choking, drooling (tracheoesophageal atresia or fistula)

F. Cyanosis with feeding (Tracheoesophageal atresia or fistula).

PROCEDURE:

1. With the infant's head turned to the side, measure from the tip of the nose to the earlobe and then from the earlobe to midway between the xiphoid process and the umbilicus then note the centimeter marking for placement. In the absence of pre-placed markings on the tube, mark this length on the catheter to be inserted (tape may be used).
2. Moisten the end of the catheter with sterile water or a water-based lubricant.
3. Slowly and gently pass the catheter through the nare or mouth to the premeasured length. If resistance is met, consult the medical provider. Monitor the infant for bradycardia during insertion. If bradycardia occurs, stop insertion and remove tube to allow for recovery.
4. Tape the catheter securely and comfortably.
5. Connect the specimen trap to suction as ordered. Measure and record drainage collected in the specimen trap every shift as ordered. Record the color and character of the aspirate.
6. Notify the medical provider of any change in drainage color or quantity.
7. X-rays are not routinely ordered but may be needed to check position in infants for whom proper positioning is in doubt.
8. After proper positioning is confirmed, note the centimeter mark at the nare or mouth and record it in the medical record or via a nurse-to-nurse communication tool.
   Note: Measure the tubing only, not the hub or adapter. This mark should be checked every shift to assess for tube migration.

9. Tubes should be changed every 72 hours or according to manufacturer's recommendations.
   Note tubing changes on a sticker on the tube and in the medical record per Cerner and via nurse-to-nurse communication tool.
10. If secretions are very thick or drainage has stopped, the tube may be irrigated to prevent or correct plugging. It may be irrigated with 1 ml/kg (no less than 1 ml with a 5-ml maximum of normal saline periodically, followed by a 1-ml/kg air bolus. If the tube cannot be irrigated, discontinue using it and insert a new gastric tube. If the tube is placed to gravity drainage, irrigate with air only.
11. When calculating intake and output, subtract the amount of normal saline used as irrigant from the total output.
12. Do not block both nares unless the infant's airway is maintained because infants are obligatory nose breathers.

DOCUMENTATION:

A. Initial documentation should include:
   1. The size of the gastric tube and the date and time inserted.
   2. Infant's tolerance of insertion.

B. Ongoing documentation
   1. Amount of drainage
   2. Any replacement fluids given and the special interval.

REFERENCES:

Gomella, T. L., Fabien, G. E., Fayez Bany-Mohammed. (2020) Gomella's Neonatology Management, Procedures, On-Call Problems, Diseases, and Drugs. 8th Edition McGraw-Hill Education

Sundquist Beaman, S. and Bowles, S. (2019) Policies, Procedures, and Competencies. 6th edition (2019) National Association of Neonatal Nurses (NANN)

Verklan, M. T., Walden, M, Forest, S. (2023) Core Curriculum for Neonatal Intensive Care Nursing. 6th ed. Elsevier, Inc. AWHONN(Association of Women's Health, Obstetric and Neonatal Nurses) with endorsements of American Association of Critical-Care Nurses and National Association of Neonatal Nurses

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	4/7/2025

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Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	4/7/2025
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NICU	Robert Posen: NICU Medical Director	3/21/2025
NICU	Pearl Dahm: Clinical Nurse Specialist	3/11/2025

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References:	

OB.74 Post-Partum Rubella Immunization

POLICY:

Prevents congenital measles-mumps-rubella (MMR) in susceptible post-partum women (rubella titer ≤ 1:8) who are not pregnant at the time of injection. Promotes immunity to rubella by inducing production of antibodies.

EQUIPMENT

A. Physician order in electronic health record (EHR)

B. MMR consent and most current vaccine information sheet (VIS)

C. Vial of live attenuated measles-mumps-rubella virus vaccine and supplied diluents

D. Syringe and safety needle

PROCEDURE:

A. As always, refer to drug reference prior to administering unfamiliar medications.

B. Check physician order and ensure Informed Consent is documented by physician in EHR.

C. Verify rubella immunity.

D. Have patient sign bottom portion of MMR consent form.

E. Ensure post-partum patient understands the need for an effective of method of birth control and the importance of avoiding pregnancy for at least three (3) months after MMR vaccination.

F. Reconstitute vaccine using supplied diluent and shake well. Use within 8 hours of reconstitution. Dosage is 0.5 mL.

G. Inject subcutaneously in the outer aspect of upper arm. (Do **NOT** administer IV.)

H. MMR vaccination is contraindicated with a history of allergy neomycin, or if woman is pregnant, active or has untreated tuberculosis. Refer to drug reference for full list of contraindications.

DOCUMENTATION:

A. Electronic Health Record (EHR): date, time of injection, site, lot number of vaccine, expiration date.

B. Patient education: provision of information sheet and birth control/avoidance of pregnancy education

provided.	
All revision dates:	2/9/2022, 10/1/2016, 12/1/2013, 11/1/2012, 11/1/2009, 2/1/2008, 8/1/2007, 12/1/2004, 10/1/2001, 12/1/1998, 10/1/1995, 4/1/1995, 4/1/1992, 4/1/1991, 4/1/1990, 4/1/1989, 4/1/1988, 4/1/1987, 4/1/1986

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Medical Executive Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Medical Staff Committees: Family Medicine & OB	Stephanie Denson: Manager, Medical Staff Office	5/22/2025
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	4/4/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	3/11/2025
Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	3/11/2025
Policy Owner	Kristina Swaim: Clinical Nurse Manager, OB	3/11/2025

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References:	

PH.102 Pyxis Anesthesia System

POLICY:

The Pyxis Anesthesia System provides Ventura County Medical Center & Santa Paula Hospital with secure and identifiable access of medications to anesthesiologists and other staff in the Operating Room. The Pyxis Anesthesia System shall be maintained by the Pharmacy Department.

PROCEDURE:

Authorized Privileges for Access

A. ID/Password

1. Users shall include anesthesiologists, Operating Room (OR) nurses, OR technicians, Obstetrics (OB) nurse, pharmacists, and pharmacy technicians.
2. Security levels vary between users and may include access to only supplies and non-narcotics, or may include narcotics if within the individual's scope of practice.
3. Access to the Pyxis Anesthesia System (P-AS) shall be provided according to PH.92 Automated Dispensing Cabinet Usage and Documentation.

B. BioID scanning technology should be used in place of password whenever possible.

C. Users shall change their password as required.

D. Users shall exit the P-AS when leaving the OR suite. Anyone discovering a P-AS that has not been logged off shall document the incident into the notification system and notify management.

E. Access Privileges

1. Anesthesiologist, OR nurses, and pharmacy staff shall be able to access P-AS for removing, returning and refilling medications.
2. OB nurses shall be able to access P-AS for witness of controlled substance waste.
3. OR technicians shall be able to access P-AS for restocking supplies.
4. No other Pyxis users shall have access to P-AS.

F. Inactivate Users

1. Director of Surgical Services, Human Resources or the Medical Staff office shall notify the Information Technology (IT) department of any employment or contract terminations.

2. The IT department shall remove the terminated users from the Active Directory. Removal from Active Directory will remove user from Pyxis system.

G. Education/Training

1. All staff responsible for administering or handling medications shall receive training prior to use of the P-AS.
2. Training consists of the following:
    a. Self-guided tutorial completion.
    b. Review the P-AS system with a pharmacist, anesthesiologist or other certified trainer.
3. An annual review of the policies and procedures associated with P-AS shall be required with Director of Pharmacy Services or their designee.

H. Pyxis Anesthesia System Medications

1. Medications stored in P-AS are limited to those approved by the Department of Surgery under the Anesthesia Section Chairman, Director of Pharmacy Services, and the Pharmacy & Therapeutics Committee.

I. Medication Access

1. The P-AS shall contain medications used frequently in the OR and shall charge for these medications as they are removed from the station.
2. Controlled substances are contained in mini-drawers and dispensed one at a time.
3. Non-controlled substances are contained in drawers that unlock and remain unlocked while the anesthesiologist is using the P-AS.
4. Emergency drugs are available outside the P-AS.
5. Non-medication supplies shall be maintained in the P-AS by OR technicians.

J. Identification of Patient on the P-AS and Medication Removal

1. Whenever possible, a patient should be identified in the system and medication removal utilizing the patient's name, financial identification number (FIN), or medical record number (MRN).
2. If a patient does not appear on the P-AS census screen, the patient can be added using the Add Temporary Patient function.
3. In case of emergency where no account number is available, the patient's date of birth (DOB) or trauma number can be used as the account number.
4. Removing medications for multiple patient use is **not permitted**.

K. Returned Medications

1. Medications in the original, unopened package and charged but not administered to a patient may be returned using the Return Medication function and placed in the External Return Bin.
2. Return Medication function will allow all unused medications to be credited back to the patient.
3. Return Bin activity is a function and duty of the Pharmacy.
4. Refrigerated items returned in the Return Bin shall be destroyed by Pharmacy.

L. Waste Medications

1. All controlled substances removed from P-AS whether opened, partially used, or compromised in

terms of tamper resistance, shall be wasted and documented in the P-AS and physically disposed in the Controlled Substance RX (CSRX) waste bin with another licensed individual as a witness.

2. Witness may be a registered nurse (RN), anesthesiologist, or a pharmacist.
3. Pharmacy staff shall routinely monitor the content of controlled substance returns with the use of return and waste report.

M. Transfer of Medications From One Patient to Another

1. Medications removed from one patient shall not be transferred and used on another patient.
2. Medication shall be returned using the return medication function. If the medication has been removed and prepared in a syringe, it shall be wasted.

N. Controlled Substance Documentation

1. It is the anesthesiologist's responsibility to accurately document the medication administered on the electronic health record (EHR) and to document any waste or return in the P-AS software within one hour of case closure.
2. A pharmacist shall complete and document physical inventory of all schedule II controlled substance medications quarterly in all P-AS units.
3. Pharmacy department will conduct routine surveillance of controlled substance use and documentation. If discrepancies in removal of medication from P-AS or documentation on the EHR is found, pharmacy will notify the individual anesthesiologist within 7 days of case completion. The anesthesiologist must respond to the inquiry within 2 business days of the initial notification.

O. System Management and Maintenance

1. P-AS Inventory
   a. The Pharmacy Department shall be responsible for maintaining inventory including, loading, restocking, emptying the return bin, unloading and removing outdates.
   b. The P-AS shall be refilled **at least once daily**.
   c. Outdates shall be tracked by P-AS, and shall be routinely checked.
   d. Outdates shall be removed from the P-AS and returned back to the Pharmacy Department.
2. Clinical personnel, including anesthesiologists and nurses, shall be responsible for administering medications per hospital policy (100.025 Medications: Ordering, Administration, and Documentation), properly identifying/selecting patients, removing, wasting and returning medications appropriately.
3. Pharmacy shall be called when the P-AS cannot be recovered by the clinical staff in the OR.

P. Downtime Procedures/Disaster Plan

1. All P-AS are connected to emergency power and have a battery that will keep the system functional for up to 15 minutes between power switches.
2. In the event of emergency power failure, the Pharmacy shall be contacted to bring keys to open any P-AS drawers that are unopened.
3. Medications removed from P-AS during a downtime is logged on a paper anesthesia record.
4. Pharmacy shall have custody of the PA-S keys at all times and the keys shall be stored in a secure place for manual access of the P-AS.
5. Power to the P-AS is never turned off unless instructed to do so by the Pharmacy Department or

Pyxis Support.

Q. Paper Replacement

1. Pharmacy technicians shall check paper daily during the routine refilling of the P-AS and change paper when empty.

R. Reports

1. Reports used to ensure the P-AS is utilized according to policy.
    a. Daily Refill report for controlled substances.
    b. Charge and Credit Report.
    c. Return and Waste Report.
    d. Controlled Substance Discrepancy Report.

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Attachments

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Surgery Committee	Stephanie Denson: Manager, Medical Staff Office	pending
Pharmacy & Therapeutics Committee	Sul Jung: Associate Director of Pharmacy Services	5/1/2025
Pharmacy Services	Sul Jung: Associate Director of Pharmacy Services	5/1/2025

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References:	

S.33 Intraoperative Standards of Care

POLICY:

To state the intraoperative standards of care at Ventura County Medical Center/Santa Paula Hospital.

PROCEDURE:

A. The patient demonstrates knowledge of the physiologic and psychologic response to surgery by:
   1. Remaining oriented to person, place and time.
   2. Confirming, in writing or verbally, consent for the operative procedure.
   3. Expressing feelings about the surgical procedure.

B. The patient will remain free of wound infection as evidenced by:
   1. Oral temperature below 100 degrees.
   2. Approximation of wound edges.
   3. Vital signs within normal limits.

C. The patient's skin integrity is maintained as evidenced by:
   1. No alteration in the patient's skin condition during the intraoperative period, i.e., no bruises, areas of skin breakdown, reddened areas, discolored skin, draining wounds, open skin lesions, excoriation or itching.

D. The patient is free from injury related to positioning as evidenced by:
   1. The patient will maintain an effective breathing pattern throughout the surgical intervention. There will be no mechanical restrictions to ventilation.
   2. The patient will not experience significant alterations in cardiac output. There will be no episodes of significant hypotension or hypertension.
   3. The patient will be positioned in a manner that facilitates gas exchange.
   4. The patient will not experience any neuromuscular damage.
   5. The patient will not experience alterations in tissue perfusion. There will be no reddened, discolored, ulcerated, edematous, or excoriated skin areas.

E. The patient is free from injury related to retained foreign objects as evidenced by:
   1. The patient will not have any retained sponges following wound closure unless such sponge

placement was deliberate and recorded.

2. The patient will not have any retained sharps following wound closure.
3. The patient will not have any retained instruments or instrument parts unless such placement was deliberate and recorded in the electronic health record (EHR).
4. The patient will be free of any other retained foreign object unless such placement is deliberate and recorded in the EHR.

F. The patient is free from injury related to chemical hazards.

1. The patient's skin at the operative site will be prepared so that:
   a. Dirt and transient microbes are removed.
   b. The rebound growth of microbes during the surgical procedure will be inhibited.
2. The patient will experience minimal or no tissue reaction resulting from skin preparation.
3. The patient will be free of allergic or other untoward reactions from the use of dyes, medications, or other chemical agents.

G. The patient is free from injury related to physical hazards as evidenced by:

1. Having supplies and equipment made available and in working order by nursing staff.
2. Experiencing no untoward delays or scheduling conflicts.
3. Having patient care needs coordinated with appropriate departments.
4. Monitoring the patient's vital signs.

H. The patient is free from injury related to electrical hazards as evidenced by:

1. Absence of skin lesions.
2. Maintained skin integrity; under dispersive pad, EKG electrodes, temperature probe entry sites, and positional pressure points.
3. Absence of neuromuscular damage.
4. Absence of central nervous system complication.
5. No signs or symptoms of shock.
6. Patient jewelry removed pre-op, with pre-existing metal implants noted in the EHR.

I. The patient's fluid electrolyte balance is maintained as evidenced by:

1. The patient's level of consciousness will be consistent with perioperative levels.
2. Fluid and electrolyte values will be consistent with preoperative status if applicable.
3. Vital signs will be consistent with preoperative measurement.

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Nursing Administration	Sherri Block: Associate Chief Nursing Executive, VCMC & SPH	5/16/2025
Nursing Administration	Danielle Gabele: Chief Nursing Executive, VCMC & SPH	5/16/2025
Surgical Services	Gwendolyn Vontoure: Director Perioperative Services	5/16/2025

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S.91 Anesthesia Protocol for Bariatric Surgery

PURPOSE

To describe the anesthesia protocol for bariatric patients. This is in addition to, and should not replace the difficult airway protocol.

I. Pre-anesthesia evaluation

A. A pre-anesthesia evaluation by an anesthesia clinician is performed at least 1 day before and, when possible, within 1 month of scheduled metabolic and bariatric surgery.

B. Minimum labs: hematocrit, glucose, creatinine, and blood urea nitrogen within 6 months of metabolic and bariatric surgery.

C. Extended pre-operative testing as indicated by co-morbidities, according to the American Society of Anesthesiologist (ASA) practice advisory on pre-anesthesia evaluation.

II. Intra-operative patient management

A. Standard use of the 30° reverse Trendelenburg (head up) position during pre-oxygenation induction, and emergence from anesthesia

B. Induction techniques to facilitate expeditious tracheal intubation, which may include a "rapid sequence induction."

C. Immediate availability of difficult airway management devices (i.e., air-Q laryngeal mask airway), as well as ~~an additional anesthesia clinician,~~ the circulating operating room nurse, and the surgeon during induction and emergence

D. Prior extubation, the patient should be fully awake and complete reversal of neuromuscular blockade should be established in addition to achieving standard extubation criteria.

III. Maintenance of Anesthesia

A. Tailoring of the anesthetic to promote early return of the patient's protective airway reflexes and maintenance of oxygenation.

B. Maintaining euvolemia, monitoring body temperature, and maintaining normothermia.

C. The use of alternate sites for non-invasive blood pressure assessment if needed, and invasive hemodynamic monitoring as medically indicated.

D. For medications with limited pharmacodynamic and kinetic data, begin dosing closer to the patient's estimated lean body mass (~120% of ideal body weight) and adjust as needed.

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Oversight Committee

Compliance Policies and Procedures

July 1, 2025

Compliance Policy & Procedure Updates

The following are submitted for Oversight Committee approval.

1. 109.002 Identifying and De-Identifying Protected Health Information
2. 109.003 Designation of Privacy Officer
3. 109.004 Disclosure by Whistleblowers and Workforce Member Crime Victims
4. 109.012 Processing Requests for an Accounting of Disclosures of Protected Health Information
5. 109.013 Requests to Amend Protected Health Information
6. 109.014 Request Restrictions on Use and Disclosure of Protected Health Information
7. 109.016 Requirement to Develop Policies and Procedures and Other Documentation
8. 109.019 Use and Disclosure of Protected Health Information for Health Oversight Activities
9. 109.020 Use and Disclosure of Protected Health Information for Cadaveric Organ, Eye or Tissue Donation Purposes
10. 109.021 Use and Disclosure of Protected Health Information for Provider Facility Patient Directories
11. 109.022 Use and Disclosure of Protected Health Information for Fundraising
12. 109.023 Use and Disclosure of Protected Health Information for Marketing or Sale of Protected Health Information
13. 109.027 Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations
14. 109.030 Use and Disclosure of Protected Health Information Required by Law
15. 109.039 Incidental Uses and Disclosure of Protected Health Information
16. 109.040 Limited Data Set
17. 109.050 Processing Requests to Receive Confidential Communications of Protected Health Information by Alternative Methods
18. 109.051 Patient Refund Policy
19. 109.052 Screening of Ineligible Persons
20. 109.053 Overpayments
21. 109.054 Compliance Helpline Reporting
22. 109.055 Non-monetary Compensation and Incidental Benefits
23. 109.058 HCA Compliance Audit & Monitoring Policy
24. 109.059 Federal and State False Claims Act Policy
25. 109.060 Patient Inducements
26. 109.062 Non-Compliance Report Internal Investigation Policy
27. 109.063 No Information Blocking Policy
28. 109.064 Compliance Committee Charter
29. HCA-01 Health Care Agency Code of Conduct
30. HCA-02 VC HCA Compliance Program

VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

Oversight Committee
Compliance Policies and Procedures

Summary of Changes

July 1, 2025

Below is a summary of policy updates reviewed by Compliance Committee and recommended for approval by Oversight Committee.

#	Title	Summary	Frequency	Page
1.	109.002 Identifying and De-Identifying Protected Health Information	Reviewed with minor edits.	Annual	4
2.	109.003 Designation of Privacy Officer	Reviewed and removed activities that are no longer applicable.	Annual	9
3.	109.004 Disclosure by Whistleblowers and Workforce Member Crime Victims	Reviewed with minor edits.	Annual	13
4.	109.012 Processing Requests for an Accounting of Disclosures of Protected Health Information	Reviewed with no changes.	Annual	16
5.	109.013 Requests to Amend Protected Health Information	Reviewed with minor edits.	Annual	21
6.	109.014 Request Restrictions on Use and Disclosure of Protected Health Information	Reviewed with minor edits.	Annual	25
7.	109.016 Requirement to Develop Policies and Procedures and Other Documentation	Addition of staff training documentation and security risk assessment documentation. Otherwise, the policy was reviewed with minor formatting changes.	Annual	28
8.	109.019 Use and Disclosure of Protected Health Information for Health Oversight Activities	Reviewed with no changes.	Annual	32
9.	109.020 Use and Disclosure of Protected Health Information for Cadaveric Organ, Eye or Tissue Donation Purposes	Reviewed with terminology changes "individual" to "donating decedent"	Annual	35
10.	109.021 Use and Disclosure of Protected Health Information for Provider Facility Patient Directories	Reviewed with no changes.	Annual	37
11.	109.022 Use of Protected Health Information for Fundraising	Reviewed with no changes.	Annual	42
12.	109.023 Use and Disclosure of Protected Health Information for Marketing or Sale of Protected Health Information	Reviewed with no changes.	Annual	45
13.	109.027 Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations	Reviewed with no changes.	Annual	47
14.	109.030 Use and Disclosure of Protected Health Information Required by Law	Reviewed with formatting changes.	Annual	51

15.	109.039 Incidental Uses and Disclosures of Protected Health Information	Reviewed with minor edits.	Annual	58
16.	109.040 Limited Data Set	Reviewed and minor edits.	Annual	61
17.	109.050 Processing Requests to Receive Confidential Communications of Protected Health Information by Alternative Methods	Reviewed with no changes.	Annual	66
18.	109.051 Patient Refund Policy	Reviewed with minor edits.	Annual	68
19.	109.052 Screening of Ineligible Persons	Reviewed with minor edits.	Annual	70
20.	109.053 Overpayments	Review with minor formatting changes.	Annual	74
21.	109.054 Compliance Helpline Reporting	Reviewed with minor edits.	Annual	77
22.	109.055 Non-monetary Compensation and Incidental Benefits	Reviewed with updates to 2025 non-monetary compensation amounts. All other changes were minor formatting changes.	Annual	80
23.	109.058 HCA Compliance Audit & Monitoring Policy	Revised the "Annual Audit Plan" to the "Compliance Work Plan" to align terminology. Other minor edits were made for consistency.	Annual	84
24.	109.059 Federal and State False Claims Act Policy	Reviewed with no changes.	Annual	87
25.	109.060 Patient Inducements	Reviewed with minor edits.	Annual	91
26.	109.062 Non-Compliance Report Internal Investigation Policy	Minor formatting and editing changes to align with other like policies.	Annual	94
27.	109.063 No Information Blocking Policy	Reviewed with minor edits.	Annual	99
28.	109.064 Compliance Committee Charter	Reviewed with minor edits.	Annual	107
29.	HCA-01 Health Care Agency Code of Conduct	Title change to align with PolicyStat numbering requirement. Reviewed with no other changes.	Annual	110
30.	HCA-02 VC HCA Compliance Program	Title change to include PolicyStat numbering convention. Minor terminology changes to align with other policies. Remainder of the content reviewed as annually required.	Annual	116

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Policy Area	Administrative - Compliance

109.002 Identifying and De-Identifying Protected Health Information

POLICY:

Under HIPAA, health care organizations are permitted to use or disclose protected health information for the purpose of creating de-identified information. De-identified information is information in which all elements that could be used to identify a patient have been removed. The purpose of this policy is to provide a mechanism to properly de-identify protected health information, as well as to secure any methods of re-identification.

PROCEDURE:

It is the policy of the Ventura County Health Care Agency (HCA) not to disclose protected health information without an authorization from the individual who is a subject of the protected health information (when such an authorization is required), unless the protected health information has been de-identified. HCA may create de-identified information for the following purposes: Quality Assurance, Utilization Management, and Patient Safety Activities.

- **Role of Compliance and Privacy Officer**. The HCA Office of Compliance and Privacy (OCP) at 5851 Thille Street, Ventura, CA 93003, (805) 677-5241, will decide as to whether protected health information should be de-identified and the employee or business associate who is requesting the de-identification. The reason for de-identification will be documented and maintained by OCP.

1. **Limitation of Disclosure**. De-identified information will not be disclosed if the HCA staff creating or disclosing the information, or any other employees of HCA and affiliates, have

actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

2. **Creation of De-Identified Information**. The following individual identifying elements will be removed or otherwise concealed from protected health information in order to create de-identified information:
    a. Names
    b. All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to current Census data:
        i. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people
        ii. The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to "000"
    c. All elements of dates (except year) of dates directly related to an individual, including birth date, admission date, discharge date, date of death, as well as all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
    d. Telephone numbers
    e. Fax numbers
    f. Electronic mail addresses
    g. Social Security numbers
    h. Medical record numbers
    i. Health plan beneficiary numbers
    j. Account numbers
    k. Certificate/license numbers
    l. Vehicle identifiers and serial numbers, including license plate numbers
    m. Device identifiers and serial numbers
    n. Web Universal Resource Locators (URLs)
    o. Biometric identifiers, including finger and voice prints
    p. Full face photographic images and any comparable images
    q. Any other unique identifying number, characteristic or code
    r. Internet Protocol (IP) address numbers

If any of the listed identifiers are not removed, then the information will not be disclosed unless the HCA Compliance/Privacy Officer determines that the risk is very small that the information could be used alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information, and the

HCA Compliance/Privacy Officer documents the methods and results of the analysis that justify such determination.

3. **Using a Business Associate**. HCA may contract with a Business Associate under a Business Associate Agreement to perform the aforementioned de-identification.
4. **Re-Identification**. HCA may assign a code or other means of record identification to allow information de-identified pursuant to this policy to be linked or later re-identified by HCA and affiliates, so long as:
    a. The code or other means of record identification is not derived from or related to information about the individual and is not otherwise capable of being translated so as to identify the individual (e.g., the code may not be a derivative of the individual's Social Security number); and
    b. HCA does not use or disclose the code or other means of record identification for any other purpose, and does not disclose the mechanism for re-identification.

Applicable Laws and Regulations:

- 45 CFR § 164.514(a)
- 45 CFR § 164.514(b)
- 45 CFR § 164.514(c)

All Revision Dates

6/3/2025, 5/1/2013, 6/1/2006, 12/1/2004

Approval Signatures

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VENTURA COUNTY HEALTH CARE AGENCY

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109.003 Designation of Privacy Official and Contact Person

POLICY:

Under HIPAA, health care organizations must designate a privacy official, who shall be responsible for the development and implementation of the organization's policies and procedures related to protected health information, and a contact person or office, which shall be responsible for receiving complaints and provide further information about matters covered by the notice of privacy practices (see Administrative policy 109.005, *Distributing the Notice of Privacy Practices.* The purpose of this policy is to provide for such designations.

Policy:

The organization shall designate a privacy official who is responsible for the development and implementation of the policies and procedures related to protected health information, and a contact person who is responsible for receiving complaints and provide further information about matters covered by the notice of privacy practices.

Procedure:

1. The HCA Director shall designate a privacy official who shall be responsible for the development and implementation of the organization's policies and procedures related to protected health information. The privacy official shall perform the duties and assume the obligations set forth in the job description attached as Exhibit "A" to this policy and procedure.
2. The HCA Director shall also designate a contact person or office, which shall be responsible for receiving complaints and providing further information about matters covered by the notice of privacy practices upon request.

3. The designation of the privacy official and contact person or office shall be documented in the meeting minutes of the Ventura County Medical Center (VCMC) Oversight Committee. The designation of the privacy official and contact person or office shall be communicated to all members of the workforce in documentation that shall be maintained in the organization's privacy policies and procedures manual.
4. Documentation of the designation of the privacy official and contact person or office shall be retained for a period of no less than six years.

Privacy Officer Job Description

Position Title: Privacy Officer

Immediate Supervisor: HCA Director

General Purpose:

The privacy officer oversees all ongoing activities related to the development, implementation, maintenance of, and adherence to the organization's policies and procedures covering the privacy of, and access to, patient health information in compliance with federal and state laws and the healthcare organization's information privacy practices.

Responsibilities:

1. Provides development guidance and assists in the identification, implementation, and maintenance of organization information privacy policies and procedures in coordination with organization management and administration, and legal counsel.
2. Performs initial and periodic information privacy risk assessments and conducts related ongoing compliance monitoring activities in coordination with the entity's other compliance and operational assessment functions.
3. Works with legal counsel and management, key departments, and committees to ensure the organization has and maintains appropriate privacy and confidentiality consent, authorization forms, and information notices and materials reflecting current organization and legal practices and requirements.
4. Oversees, directs, delivers, or ensures delivery of initial and privacy training and orientation to all employees, volunteers, medical and professional staff, contractors, alliances, business associates, and other appropriate third parties.
5. Participates in the development, implementation, and ongoing compliance monitoring of all trading partner and business associate agreements, to ensure all privacy concerns, requirements, and responsibilities are addressed.
6. Establishes with management and operations a mechanism to track access to protected health information, within the purview of the organization and as required by law and to allow qualified individuals to review or receive a report on such activity.
7. Works cooperatively with the Health Information Management Director and other applicable organization units in overseeing patient rights to inspect, amend, and restrict access to protected health information when appropriate.
8. Establishes and administers a process for receiving, documenting, tracking, investigating, and

taking action on all complaints concerning the organization's privacy policies and procedures in coordination and collaboration with other similar functions and, when necessary, legal counsel.

9. Ensures compliance with privacy practices and consistent application of sanctions for failure to comply with privacy policies for all individuals in the organization's workforce, extended workforce, and for all business associates, in cooperation with Human Resources, the information security officer, administration, and legal counsel as applicable.
10. Initiates, facilitates and promotes activities to foster information privacy awareness within the organization and related entities.
11. Serves as the information privacy liaison for users of clinical and administrative systems.
12. Works with all organization personnel involved with any aspect of release of protected health information, to ensure full coordination and cooperation under the organization's policies and procedures and legal requirements
13. Maintains current knowledge of applicable federal and state privacy laws and accreditation standards, and monitors advancements in information privacy technologies to ensure organizational adaptation and compliance.
14. Serves as information privacy consultant to the organization for all departments and appropriate entities.
15. Cooperates with the Office of Civil Rights, other legal entities, and organization officers in any compliance reviews or investigations.
16. Works with organization administration, legal counsel, and other related parties to represent the organization's information privacy interests with external parties (state or local government bodies) who undertake to adopt or amend privacy legislation, regulation, or standard.

Qualifications:

1. Knowledge and experience in information privacy laws, access, release of information, and release control technologies.
2. Knowledge of and the ability to apply the principles of HIM, project management, and change management.
3. Demonstrated organization, facilitation, communication, and presentation skills.

Applicable Laws and Regulations:

45 CFR §164.530(a)

All Revision Dates

6/5/2025, 6/1/2006

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Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.004 Disclosure by Whistleblowers and Workforce Member Crime Victims

PURPOSE

Under the Health Insurance Portability and Accountability Act (HIPAA), protected health information may be disclosed absent the individual's written authorization (i) when the disclosure is made by an employee or business associate concerning unlawful or improper practices of the Ventura County Health Care Agency's (HCA) hospitals, clinics and affiliated clinics, and (ii) when the disclosure is by an employee who is a crime victim and concerns the suspected perpetrator of the crime. The purpose of this policy is to ensure that such disclosures are in compliance with the requirements of applicable State and Federal laws and regulations.

POLICY

HCA shall permit an employee or business associate to disclose protected health information to specified parties when the disclosure concerns unlawful or improper practices of HCA. HCA shall permit disclosure of protected health information by an employee who is a crime victim when the disclosure concerns the suspected perpetrator. Such disclosures shall be in accordance with the requirements of HIPAA set forth in this Policy and Procedure.

PROCEDURE

1. You or a business associate may disclose protected health information if you or the business associate believes in good faith that HCA has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by HCA potentially endanger one or more patients, workers, or the public, and the disclosure is

made to:

a. A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of HCA.

b. An appropriate health care accreditation organization; or

c. An attorney for the purpose of determining your or the business associates legal options with respect to whistle blowing.

2. If you are the victim of a crime (regardless of whether it occurs on the grounds of HCA), you may disclose protected health information to a law enforcement official if:

   a. The protected health information disclosed is about the suspected perpetrator of the crime; and

   b. The protected health information disclosed in limited to:

      i. Name and address;

      ii. Date and place of birth;

      iii. Social Security number;

      iv. ABO blood type and rh factor;

      v. Type of injury;

      vi. Date and time of treatment;

      vii. Date and time of death, if applicable, and

      viii. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

REFERENCES

45 C.F.R. §§164.5020), 164.512(f)(2)

SEE ALSO ADMINISTRATIVE POLICY 100.020.

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109.012 Processing Requests for an Accounting of Disclosures of Protected Health Information

POLICY

Under HIPAA, individuals have a right to receive an accounting of various instances when protected health information about them is disclosed by a covered entity, except for purposes of treatment, payment or health care operations, and subject to certain time-limited exceptions for disclosures to law enforcement and oversight agencies. The purpose of this policy is to provide a mechanism for responding to requests for an accounting of disclosures.

The Ventura County Health Care Agency (HCA) will allow individuals to receive an accounting of disclosures where protected health information about them was used or disclosed, with certain exceptions, as set forth in this policy.

PROCEDURE

1. **Disclosure Tracking Log**. All disclosures of protected health information must be tracked. Disclosures are not limited to written information, but any manner that divulges information, including verbal or electronic data release. The HCA Health Information Management Department will utilize a Disclosure Tracking Log for documenting and maintaining an accounting of when patients' protected health information has been disclosed for purposes other than those excluded below.
2. **Disclosure Requirement**. An individual has a right to receive an accounting of disclosures of protected health information to include unauthorized access "breach" by the HCA during a time period specified up to six (6) years prior to the date of the request for an accounting **except** for disclosures made:

- To carry out treatment, payment or operations as permitted under law;
- Prior to the effective date of the privacy rule (April 14, 2003);
- To the individuals of protected health information about them;
- Pursuant to an individual's authorization;
- That are part of a limited data set;
- That are merely incidental to another permissible use or disclosure;
- For the facility's directory;
- To persons involved in the individual's care or other notification purposes;
- For national security or intelligence purposes;
- To correctional institutions or law enforcement custodial situations; and
- Releases during the suspension time period requested by a health oversight agency or law enforcement official that has provided VCMC with a written statement that such an accounting to the individual would be reasonably likely to impede the agency's activities and specifying the time for which a suspension is required.

3. **Business Associates**. The accounting will be in writing and will include disclosures made to or by business associates of VCMC.
4. **Certain Disclosures for Research Purposes**. A special rule applies when VCMC has made disclosures for research purposes of protected health information relating to 50 or more individuals. If an individual requests an accounting and protected health information about that individual may have been included in such a research disclosure, the accounting may include the following elements:
    - The name of the research protocol of activity;
    - A description (in plain language) of the research protocol or activity including: (i) the purpose of the research; and (ii) the criteria for selecting records to be disclosed for the research;
    - A brief description of the type of protected health information that was disclosed;
    - The date or period of time during which such disclosures occurred, or may have occurred, including the date of the last such disclosure during the accounting period;
    - The name, address, and telephone number of the entity that sponsored the research;
    - The name, address, and telephone number of the researcher; and
    - A statement that protected health information about the individual may or may not have been disclosed for the research protocol or activity.

    If HCA provides the modified content described above (in lieu of the standard content for an accounting), and if it is reasonably likely that the individual's protected health information was disclosed for research, the entity must (if requested to do so by the individual) assist the individual in contacting the entity that sponsored the research and the researcher.
5. **Disclosure Requests**. A patient may make the request for an accounting in writing on the form "Request for an Accounting of Disclosures" or orally. If the request is made orally, VCMC or

SPH should document such on the form "Request for an Accounting of Disclosures." HCA must retain this request and a copy of the written accounting that was provided to the individual, as well as the name of the party responsible for the completion of the accounting. A patient may authorize in writing that the accounting of disclosures be released to another individual or entity.

- Any answer to a request for a disclosure of patient records which is not permissible under the regulations in this part must be made in a way that will not affirmatively reveal that an identified individual has been, or is being, diagnosed or treated for a substance use disorder. An inquiring party may be provided a copy of the regulations in this part and advised that the restrict the disclosure of substance use disorder patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient.
- List of disclosures. Upon request, patients who have consented to disclose their patient identifying information must be provided a list of entities to which their information has been disclosed.
    - Patient requests must be made in writing and are limited to disclosures in the past 6 years.
    - The entity named on the consent form that discloses information must respond within 30 days and provide, for each disclosure, the name(s) of the entity(-ies) to which the disclosure was made, the date of the disclosure, and a brief description of the patient identifying information disclosed.

6. **Disclosure Content Requirements**. Each accounting of a disclosure will include the following:
    - The date of disclosure;
    - The name of the entity or person who received the protected health information and, if known, the address of such entity or person;
    - A brief description of the protected health information disclosed;
    - A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure; or in lieu of such statement.
        - a copy of the individual's written authorization to use or disclose the protected health information, or
        - a copy of a written request for a disclosure required by the Secretary of the U.S. Department of Health & Human Services to investigate or determine the covered entity's compliance with applicable laws and regulations.

    If, during the time period of the accounting, multiple disclosures have been made to the same entity or person for a single purpose, the accounting may provide the information as set forth above for the first disclosure, and then summarize the frequency, periodicity, or number of disclosures made during the accounting period and the date of the last such disclosure during the accounting period.
7. **Time Frame for Responding to Requests**. HCA will act on the individual's request for an accounting not later than 60 days after receipt of the request, it will provide the individual with a written statement of the reasons for the delay and the date by which the covered entity will

provide the accounting.

8. **Extension of Time to Respond**. In the event that HCA extends the time to provide the accounting, within 60 days after receipt of the request, it will provide the individual with a written statement of the reasons for the delay and the date by which the covered entity will provide the accounting. HCA will not extend the time to provide the accounting more than once.
9. **Fees and Charges**. The first accounting to an individual in any 12 month period will be without charge. After the first accounting in any 12 month period, individuals may be charged for reasonable retrieval, report preparation and mailing costs incurred in responding to accounting requests. Any fee imposed by HCA for each subsequent request for an accounting by the same individual within the 12 month period will be cost-based.
10. **Advance Notice of Fees and Charges**. Upon imposing a fee HCA will inform the individual in advance of the fee and provide the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.
11. **Documentation Requirements**. HCA will document and retain the following for a period of at least 6 years, or from the date of its creation or the date when it last was in effect, whichever is later:
    - The information required to be included in an accounting;
    - The written accounting that is provided to the individual;
    - The title of the persons or officer responsible for receiving and processing requests for an accounting by individual.
12. **Responsible Party**. The HIM Manager, who can be reached at 300 Hillmont Avenue, Ventura, CA 93003, 1-805-652-6008, is responsible for responding to a request from an individual for an accounting of disclosures when their protected health information has been disclosed for purposes other than those excluded above.

Applicable Laws and Regulations

- 45 CFR §164.528
- 45 CFR §164.530(j)

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109.013 Requests to Amend Protected Health Information

PURPOSE

Ventura County Health Care Agency (HCA) complies with the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, individuals have a right to request an amendment or correction to their protected health information. The purpose of this policy is to provide a mechanism for responding to such requests in accordance with applicable State and Federal laws and regulations.

POLICY

HCA provides a way for individuals to request an amendment to their protected health information or a record in a designated record set for as long as the information is maintained in the designated record set.

HCA may deny an individual's request for amendment if it determines that the requested protected health information or record:

- was not created by HCA
- is not part of the designated record set;
- would not be available for inspection under the requirements for individual rights to access protected health information; or
- is not accurate and complete.

PROCEDURE

Requesting an Amendment

1. HCA Medical Record Department is responsible for receiving, processing, and responding to requests for amendments to protected health information.
2. All individual requests for amendments to protected or other health information must be in writing, and directed to HCA Health Information Management, 300 Hillmont Avenue, Ventura, CA 93003, (805) 652-6008.
3. The written request must clearly identify the information to be amended as well as the reason(s) for the amendment.
4. The request will be referred to a designated health care professional who was responsible for the patient's care for review.
5. The Health Information Management (HIM) Manager or designee will inform the individual no later than 60 days after receipt, of the decision to accept or deny.
6. On occasions where the HIM Manager or designee needs more than 60 days to make a decision, the time period for the action will be extended by no more than 30 days provided that:
    a. The HIM Manager or designee provides the individual with a written statement of the reasons for the delay and the date by which HIM will complete the action on the request; and
    b. HIM may extend the time period for action no more than once.

Accepting Requests for Amendment

1. If the requested amendment is accepted, the HCA HIM Manager or designee will arrange for:
    a. *Making the amendment.* The health care professional or appropriate personnel will make the necessary amendment to the protected health information or record that is the subject of the request.
2. Upon accepting and completing a requested amendment, the HIM Manager or designee will perform the following tasks:
    a. *Inform the individual.* Timely inform the individual, confirm the individual's identification, and obtain individuals consent to have VCMC/SPH notify the relevant persons with which the amendment needs to be shared.
    b. *Inform others.* Reasonable efforts will be made to inform any relevant person(s) of the amendment and provide them with the amendment within a reasonable time.
        i. If the relevant person is a business associate, that is known to have the affected protected health information and that may have relied, or could foreseeably rely on such information to their detriment, the same reasonable efforts will be made to inform the business associate of the amendment and provide them with the amendment.

Denying Requests for Amendment

1. Upon denying a request to amend, in whole or in part, HIM Manager or designee will provide the individual with a written denial in accordance with in the time frames outlined above.
    a. *Denial.* The denial will include the following:
        i. The basis for the denial;
        ii. The individual's right to submit a written statement disagreeing with the denial which may be limited to 250 words;
        iii. A description of how the individual may file such a statement;
        iv. A description of how the individual may file a complaint to VCMC or SPH pursuant to its complaint procedures including the name, or title, and telephone number of the contact person or office designated to receive such complaints;
        v. A description of how the individual may file a complaint with the Department of Health and Human Services;
        vi. The following statement will be included:
        vii. IF THE INDIVIDUAL DOES SUBMIT A STATEMENT OF DISAGREEMENT, THEN INDIVIDUAL MAY REQUEST VCMC or SPH TO PROVIDE THE INDIVIDUAL'S REQUEST FOR AMENDMENT AND THE DENIAL WITH ANY FUTURE DISCLOSURES OF THE PROTECTED HEALTH INFORMATION THAT IS SUBJECT OF THE AMENDMENT.

    b. *Statement of disagreement.* If the individual provides a statement of disagreement, HCA [may] prepare a written rebuttal to the individual's statement of disagreement.
    c. *Rebuttal statement.* The HIM Manager or designee will provide the individual with a copy of the above rebuttal.
    d. *Recordkeeping*. The HIM Manager or designee will append or otherwise link the following to the designated record set or protected health information that is the subject of the disputed amendment:
        i. The individual's request for an amendment;
        ii. The denial of the request;
        iii. The individual's statement of disagreement, if any; and
        iv. HCA rebuttal, if any.
    e. *Future disclosures.* Any subsequent disclosures of the protected health information to which an individual's written disagreement relates will include the following:
        i. The material appended as described above; or
        ii. An accurate summary of any such information.
    f. *Transmission*. Subsequent disclosures may be transmitted separately from a standard transaction if the standard transaction does not allow the information to be transmitted.

g. *Implementation specifications*. If the individual has not submitted a written statement of disagreement, HCA HIM will include the individual's request for amendment and HCA denial, or an accurate summary of such information, with any subsequent disclosure of the protected health information only upon request.

REFERENCES

45 C.F.R. §§ 164.526

California Health & Safe Code §123111

All Revision Dates

6/12/2025, 6/23/2024, 4/1/2013, 6/1/2006, 12/1/2004

Approval Signatures

Step Description	Approver	Date
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Policy Area	Administrative - Compliance

109.014 Request Restrictions on Use and Disclosure of Protected Health Information

PURPOSE

Under the Health Insurance Portability and Accountability Act (HIPAA), individuals may request restrictions on the use and disclosure of their protected health information (PHI). The purpose of this policy is to provide a mechanism to respond to such requests in accordance with the applicable requirements of HIPAA.

POLICY

Ventura County Health Care Agency (HCA) allows individuals to request to restrict the use and disclosure of protected health information. HCA directs individual's to complete the Request for Special Restriction on Use or Disclosure of Protected Health Information form, attached as Exhibit "A."

HCA is not required to agree to the request except to the extent that an individual requests that HCA restrict disclosure to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid out of pocket in full.

PROCEDURE

1. **Making the Request.** Once HCA receives the completed Request for Special Restriction on Use or Disclosure of Protected Health Information form, HCA will notify individual of the determination concerning individual's request by sending individual a Response to Request for

Special Restriction on Use or Disclosure of Protected Health Information form, attached as Exhibit "B."

a. Upon agreeing to such a restriction, HCA will not violate such restriction except as otherwise specified in this Policy and Procedure.

b. The completed Response to Request for Special Restriction on Use or Disclosure of Protected Health Information and any Termination of Restriction are to be maintained in the individual's medical record.

2. **Emergency Medical Treatment:** Notwithstanding a completed Request for Special Restriction on Use or Disclosure of Protected Health Information by an individual, if the individual is in need of emergency treatment and the restricted protected health information is needed to provide the emergency treatment, HCA can use the individual's protected health information, or can disclose such information to a health care provider, as necessary to provide such emergency treatment to the individual. Any information obtained to help provide emergency treatment cannot be used or disclosed beyond the provision of emergency treatment.

3. **Exceptions Related to Legally Required Disclosures:** Furthermore, notwithstanding a completed Request for Special Restriction on Use or Disclosure of Protected Health Information by an individual HCA may use or disclose the individual's protected health information for any of the following:

a. Inclusion in VCMC/SPH's Hospital directory.

b. Certain public health activities.

c. Reporting abuse, neglect, domestic violence, or other crimes.

d. HCA oversight activities or law enforcement investigations.

e. Judicial or administrative proceedings.

f. Identifying decedents to coroner and medical examiners or determining a cause of death.

g. Organ procurement.

h. Certain research activities.

i. Workers' compensation programs.

j. Uses or disclosures otherwise required by law.

4. **Exceptions Related to Payment Purposes:** Except with respect to restrictions on disclosures to a health plan or insurer if the disclosure is for the purpose of carrying out payment or health care operations and the individual, or someone on the individual's behalf, has paid for the item or service in full, out of pocket, HCA may terminate its agreement to a restriction on the use or disclosure of an individual's protected health information in accordance with a completed Termination of Restriction, attached as Exhibit "C", if:

a. the individual agrees or requests the termination in writing;

b. the individual orally agrees to the termination and the oral agreement is documented; or

c. Covered Entity informs the individual that it is terminating its restriction agreement. If such a restriction agreement is terminated, any protected health information about

the individual created or received before the date of the Termination of Restriction will be maintained as confidential and private. Protected health information about the individual created or received after the date of the Termination of Restriction would not be held as confidential and private.

5. **Record Retention.** HCA will retain copies of each completed Response to Request for Special Restriction on Use or Disclosure of Protected Health Information and Termination of Restriction for six (6) years from the date it was created or the date it was last in effect, whichever is later.

REFERENCES

45 C.F.R. §164.522(a)

All Revision Dates

6/12/2025, 6/23/2024, 9/1/2013, 6/1/2006

Attachments

- A: Request for Special Restrictions on Use or Disclosure of Protected Health Information
- B: Response to Request for Restrictions on Use or Disclosure of Protected Health Information
- C: Termination of Special Restrictions Requests

Approval Signatures

Step Description	Approver	Date
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Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.016 Requirement to Develop Policies and Procedures and Other Documentation

POLICY:

The Ventura County Health Care Agency (HCA) is committed to ensuring the privacy and security of protected health information. Under HIPAA, a health care organization is required to develop and maintain all required policies, procedures and other documentation related to the use and disclosure of protected health information in written or electronic form, and promptly amend such documentation when required by changes in the organization's practices or changes in applicable law. The purpose of this policy is to give guidance and ensure compliance with the requirement to maintain documentation of policies, procedures, and other administrative documents.

HCA develops, implements and maintains all required policies, procedures and other documentation related to the use and disclosure of protected health information in written or electronic form, and shall promptly amend such documentation when required by changes in the organization's practices or changes in applicable law. Policies and procedures will be reasonably designed to take into account the size and type of activities undertaken by HCA with respect to protected health information. Policies and procedures, communications, and other administrative documents shall be retained for a period of at least six years from the date of creation or the date when last in effect, whichever is later.

PROCEDURE:

1. **Effect of Change on Privacy Notice**: If a change in the law materially affects the content of the notice of privacy practices, then the organization shall promptly amend notice of privacy practices.

2. **Documentation:** The following documentation will be maintained by the HCA Administration in the form of the Privacy- Administrative Policy Manual, HCA Health Information Management in the form of the medical record, and the HCA Privacy Officer, in an organized manner that allows necessary availability, while also ensuring the privacy and security of the information:
    - Policies and procedures;
    - Authorizations forms for the use or disclosure of protected health information;
    - Requests to Amend protected health information;
    - Requests for an Accounting of disclosures of protected health information;
    - Requests to Inspect and Copy protected health information
    - Requests to Restrict use or disclosure of protected health information;
    - Requests to Object to certain uses and disclosures
    - Requests for Restrictions on the method of confidential communications;
    - Agreements with Business Associates for the use or disclosure of protected health information;
    - Notice of Privacy Practices and any changes made thereto;
    - Patient complaints regarding the use or disclosure of protected health information (recorded and maintained by Privacy Office in the Privacy Log);
    - Staff training documentation;
    - Security risk assessment documentation.

    A. The following documentation will also be available on the HCA Intranet:
        1. HIPAA/Privacy Policies and Procedures
        2. All HIPAA/Privacy related forms
        3. Notice of Privacy Practices

    B. Individuals who wish to revise any HIPAA/Privacy form or Policy must obtain approval of the Compliance/Privacy Officer and must update the HCA Intranet.

3. **Retention**: All documentation related to the use and disclosure of protected health information shall be retained for a period of six years from the date of its creation or the date when it last was in effect, whichever is later.

Applicable Laws and Regulations:

45 CFR 164.508, 164.512(i), 164.520(e), 164.522, 164.524(e), 164.526(f), 164.528(d), 164.530(i), 164.530(j)

All Revision Dates

6/2/2025, 6/1/2013, 6/1/2006

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Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.019 Use and Disclosure of Protected Health Information for Health Oversight

PURPOSE

Under the Health Insurance Portability and Accountability Act (HIPAA), Ventura County Health Care Agency (HCA) may, for certain health oversight activities, use or disclose protected health information without the individual's written authorization or opportunity to agree or object to the use or disclosure. The purpose of this Policy and Procedure is to ensure that such uses and disclosures are in accordance with HIPAA and applicable State laws.

POLICY

HCA shall use or disclose protected health information for health oversight activities without the individual's written authorization or opportunity to agree or object to the use or disclosure only as permitted under HIPAA and applicable state laws.

PROCEDURE

HCA may use or disclose protected health information without the written authorization of the individual or the opportunity for the individual to agree or object to the use or disclosure for the health oversight activities outlined below:

1. **Permitted disclosures to health oversight agencies**. HCA may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary

for appropriate oversight of:

a. The health care system by regulatory agencies;

b. Government benefit programs for which health information is relevant to beneficiary eligibility;

c. Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

d. Entities subject to civil rights laws for which health information is necessary for determining compliance.

2. **Response to requests from health oversight agencies; authorization and documentation**. Staff shall consult with the appropriate supervisory/management staff upon receipt of a request from an entity that purports to be a health oversight agency in order to determine its authenticity and ensure that the circumstances of the disclosure are in accordance with those set forth in this policy. Staff shall document all relevant facts of any disclosures of this nature in the patient's medical record, including a description of the information disclosed, the date of the disclosure, and the individual and entity to whom/which the disclosure was made.

3. **Exceptions**. For the purpose of the disclosures permitted by item 1 above, a health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

a. The receipt of health care;

b. A claim for public benefits related to health; or

c. Qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

4. **Joint activities or investigations**. Notwithstanding item 3 above, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of this policy.

REFERENCES

45 CFR §164.512(d); California Civil Code §56.10(c)(5), (14).

All Revision Dates

6/3/2025, 6/23/2024, 6/1/2013, 6/1/2006

Approval Signatures

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Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.020 Use and Disclosure of PHI for Cadaveric Organ, Eye or Tissue Donation Purposes

PURPOSE

Under the Health Insurance Portability and Accountability Act (HIPAA), the Ventura Health Care Agency (HCA) for cadaver organ, eye or tissue donation purposes, may use or disclose protected health information without the donating decedent's written authorization or opportunity to agree or object to the use or disclosure. The purpose of this policy is to ensure that such disclosures are made in accordance with the requirements of HIPAA and applicable state laws.

POLICY

HCA shall use or disclose protected health information for cadaver organ, eye or tissue donation purposes without the donating decedent's written authorization or opportunity to agree or object to the disclosure only as permitted under HIPAA and applicable state laws.

PROCEDURE

1. **Responding to requests from organ procurement organizations for a decedent's protected health information**. HCA may disclose protected health information, without the written authorization of or opportunity for the donating decedent to agree or object, to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue, for the purpose of facilitating the donation and transplantation.
2. **Use of a decedent's protected health information by HCA for organ donation purposes**. VCMC/ SPH may use protected health information without the written authorization of the

donating decedent or the opportunity for the donating decedent to agree or object, for the purpose of facilitating organ, eye or tissue donation and transplantation.

3. **Documentation of disclosures for organ donation purposes.** Staff shall document all relevant facts of any disclosure of a decedent's protected health information in the donation recipient's medical record, including a description of the information disclosed, the date of the disclosure, and the individual and entity to whom/which the disclosure was made.

REFERENCES

45 CFR §164.512(h); California Civil Code §56.10(c)(13).

SEE ALSO ADMINISTRATIVE POLICIES: 100.028, 100.031, 100.048, 100.050

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6/3/2025, 6/23/2024, 6/1/2013, 6/1/2006

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Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.021 Use and Disclosure of Protected Health Information for Provider Facility Patient Directories

PURPOSE

Ventura County Health Care Agency (HCA) is committed to ensuring the privacy and security of protected health information. Under the Health Insurance Portability and Accountability Act (HIPAA), protected health information may be disclosed in connection with a facility directory absent the individual's written authorization under specified circumstances. The purpose of this policy is to ensure that protected health information compiled in the form of a facility patient directory will be maintained and disclosed only as permitted under applicable State and Federal laws and regulations.

POLICY

HCA will use and disclose protected health information for the purpose of maintaining its facility directory. Facility patient directory information will be maintained and disclosed only as permitted under applicable State and Federal laws and regulations as set forth in this Policy and Procedure.

DEFINITIONS

- ***Protected Health Information (PHI)*** is defined as individually identifiable health information relating to the, including demographic data, that relates to past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for health care provided to an individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
- ***Individually Identifiable Health Information*** includes many common identifies e.g., name,

address, birth date, Social Security Number.

PROCEDURE

1. **Notice of Use and Disclosure of PHI for Facility Directory Purposes.** Upon admission to the provider facility, Admitting staff shall provide the individual with a written notice describing (a) that their protected health information may be included in a facility directory; (b) the persons to whom their protected health information may be disclosed from the facility directory; and (c) the individual's right to prohibit or restrict those disclosures ("the Notice"). (See Attachment "A.")
2. **Opportunity to Permit or Prohibit.** Upon delivery of the Notice, Admitting staff will inform the individual of the substance of the Notice and ask the individual whether he or she has elected to prohibit or restrict the disclosures.
    a. If the individual replies in the affirmative, Admitting staff will record the requested prohibitions/restrictions in the individual's admission record and provide a copy of the notation to the facility information operator.
    b. If the individual replies in the negative, Admitting staff will indicate on the admission record that the individual did not request any prohibitions or restrictions on the use or disclosure of facility directory information.
3. **Emergent Situations**. If the admission is on an emergency basis or the individual is incapacitated, and the Admitting staff is thereby unable to discuss the content of the Notice with the individual, Admitting staff will record this fact on the admission record.
    a. Admitting staff will then review any prior admission records of this individual to determine whether or not the individual previously expressed a preference to (i) prohibit or restrict the disclosure of directory information, or to (ii) agree to such disclosures as permitted by law.
        i. Previously expressed preferences of the individual shall be observed in the manner described in item 2 above.
        ii. In the absence of previously expressed preferences, the facility may use and disclose directory information regarding the individual only if the facility administrator has determined that, in the exercise of professional judgment, disclosure is in the best interests of the individual. A copy of the admission record shall be provided to the facility administrator in such cases.
        iii. In the absence of previously expressed preferences, and in the absence of a determination by the facility administrator that the information should be released, Admitting staff will place a copy of the notation in the directory information disclosure pending file for future follow-up, and provide a copy of the notation to the facility information operator.
    b. Utilizing the directory information disclosure pending file, Admitting staff will follow up with the appropriate nursing staff on a daily basis to determine whether the individual is capable of discussing the contents of the Notice. If the individual is determined to be capable of discussing the contents of the Notice, the admitting staff shall follow the procedure set forth in items 1 and 2 above.

4. **PHI Used in the Facility Directory.** HCA will use the following types of protected health information to maintain a directory of patients in the facility directory:
    a. the patient's name;
    b. the patient's location in the facility;
    c. the patient's condition described in general terms; and
    d. the patient's religious affiliation.
5. **PHI Disclosed in the Facility Directory.** HCA will only disclose protected health information maintained pursuant to a facility directory to members of clergy or to other persons who ask for the individual by name.
6. **Information Operator Restrictions.** Upon the Information operator's receipt of a request by an individual for the information described above, the Information operator will check his or her file for restrictions or prohibitions on release of information regarding the individual requested. If no restrictions exist, the Information operator may release the information set forth in item 1 above. If restrictions exist, the information will be released only as permitted by the individual.
    a. Information regarding individual's name, location in the facility, condition and religious affiliation shall be provided to the Information operator in accordance with existing policy and procedures.

REFERENCES

45 C.F.R. §164.510(a)

All Revision Dates

6/3/2025, 6/23/2024, 6/1/2013, 6/1/2006

Attachments

A: Regarding Use And Disclosure of Protected Health Information in Provider Facility Patient Directories

Approval Signatures

Step Description	Approver	Date
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Status **Pending** PolicyStat ID **18031986**

VENTURA COUNTY HEALTH CARE AGENCY

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Policy Area	Administrative - Compliance

109.022 Use of Protected Health Information for Fundraising

PURPOSE

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care organization may use, or disclose to a business associate or to an institutionally related foundation, specified protected health information for the purpose of raising funds for its own benefit. The purpose of this policy is to ensure that protected health information is used or disclosed for fundraising purposes only in accordance with the requirements of HIPAA.

POLICY

Ventura County Health Care Agency (HCA) may use, or disclose to a business associate or an institutionally related foundation, specified protected health information for the purpose of raising funds for its own benefit as set forth in this Policy and Procedure.

DEFINITIONS

Business Associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity.

Covered entities are defined in the HIPAA rules as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards.

Protected Health Information (PHI) is defined as individually identifiable health information relating to

the, including demographic data, that relates to past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for health care provided to an individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.

PROCEDURE

1. The following protected health information may be used, or disclosed to a business associate or affiliated foundation, for the purpose of raising funds for HCA's benefit without obtaining an authorization from the patient:
    a. Patient demographic information, including name, address, other contact information, age, gender, and date of birth
    b. Dates of health care provided to the patient
    c. Department of service information
    d. Treating physician
    e. Outcome information
    f. Health insurance status
2. The Notice of Privacy Practices will explain that HCA may use certain protected health information to contact patients in the future to raise money for HCA's organization.
3. HCA will not release any other protected health information for fundraising purposes.
4. HCA must include opt-out notice in any fundraising materials sent to a patient. The method of election may not cause the patient to incur undue burden or more than a nominal cost.
5. HCA will make reasonable efforts to ensure that those patients who indicate that they do not want to receive fundraising materials will be removed from the fundraising mailing list. (if applicable). The patient's rights regarding treatment and payment will not be conditioned on their choice with respect to the receipt of fundraising materials.

REFERENCES

45 C.F.R. §164.514(f)

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Policy Area	Administrative - Compliance

109.023 Use and Disclosure of Protected Health Information for Marketing or Sale

PURPOSE

Under the Health Information Portability Accountability Act of 1996, (HIPAA), the sale of protected health information or the use or disclosure of protected health information for marketing purposes is subject to the individual's written authorization, with some limited exceptions. The purpose of this policy is to ensure that protected health information will not be sold without the individual's authorization and will be used or disclosed for marketing purposes only as permitted under applicable State and Federal laws and regulations.

POLICY

It is Ventura County Health Care Agency (HCA) policy that HCA and/or its workforce may not sell, or use or disclose for marketing purposes (other than as described below), an individual's protected health information without that individual's authorization. If HCA is receiving financial remuneration for the sale for the use or disclosure of protected health information for marketing purposes, the authorization must state that such remuneration is involved.

PROCEDURE

1. **Use and Disclosure of PHI for Marketing Purposes:** HCA must obtain an individual's authorization before using or disclosing a patient's protected health information for marketing purposes.
    a. **Marketing includes.** Marketing under HIPAA is any communication about a product

or service that encourages the recipient of the communication to purchase or use the product or service. Such communications included in the definition of marketing require prior patient authorization.

b. **Marketing does not include.** Marketing under HIPAA does not include communications for the individual's treatment regarding possible alternative treatments, therapies, or other health care providers or settings of care unless financial remuneration is involved. Because such communications are excluded from the definition of marketing, an authorization is not required.

c. **Authorization required.** If the use or disclosure of confidential information for marketing purposes results in financial remuneration to HCA, the authorization must so state.

d. **Authorization not required.** An authorization is not necessary if use or disclosure of protected health information is made to provide refill reminders or otherwise communicate about a patient's current prescription medicines and no financial remuneration (other than the recovery of reasonable costs) is received by HCA in exchange for making the communication. An authorization is also not required if the marketing involves a face-to- face communication between HCA and the patient or if the marketing is limited to a promotional gift of nominal value provided by HCA.

2. **Use and Disclosure for Sale of PHI Purposes:** HCA may not sell an individual's protected health information without first obtaining the individual's authorization. The authorization must state that HCA is obtaining financial remuneration.

REFERENCES

45 CFR 164.501; 45 CFR 164.508

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Policy Area	Administrative - Compliance

109.023 Use and Disclosure of Protected Health Information for Marketing or Sale

PURPOSE

Under the Health Information Portability Accountability Act of 1996, (HIPAA), the sale of protected health information or the use or disclosure of protected health information for marketing purposes is subject to the individual's written authorization, with some limited exceptions. The purpose of this policy is to ensure that protected health information will not be sold without the individual's authorization and will be used or disclosed for marketing purposes only as permitted under applicable State and Federal laws and regulations.

POLICY

It is Ventura County Health Care Agency (HCA) policy that HCA and/or its workforce may not sell, or use or disclose for marketing purposes (other than as described below), an individual's protected health information without that individual's authorization. If HCA is receiving financial remuneration for the sale for the use or disclosure of protected health information for marketing purposes, the authorization must state that such remuneration is involved.

PROCEDURE

1. **Use and Disclosure of PHI for Marketing Purposes:** HCA must obtain an individual's authorization before using or disclosing a patient's protected health information for marketing purposes.
    a. **Marketing includes.** Marketing under HIPAA is any communication about a product

or service that encourages the recipient of the communication to purchase or use the product or service. Such communications included in the definition of marketing require prior patient authorization.

b. **Marketing does not include.** Marketing under HIPAA does not include communications for the individual's treatment regarding possible alternative treatments, therapies, or other health care providers or settings of care unless financial remuneration is involved. Because such communications are excluded from the definition of marketing, an authorization is not required.

c. **Authorization required.** If the use or disclosure of confidential information for marketing purposes results in financial remuneration to HCA, the authorization must so state.

d. **Authorization not required.** An authorization is not necessary if use or disclosure of protected health information is made to provide refill reminders or otherwise communicate about a patient's current prescription medicines and no financial remuneration (other than the recovery of reasonable costs) is received by HCA in exchange for making the communication. An authorization is also not required if the marketing involves a face-to- face communication between HCA and the patient or if the marketing is limited to a promotional gift of nominal value provided by HCA.

2. **Use and Disclosure for Sale of PHI Purposes:** HCA may not sell an individual's protected health information without first obtaining the individual's authorization. The authorization must state that HCA is obtaining financial remuneration.

REFERENCES

45 CFR 164.501; 45 CFR 164.508

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6/3/2025, 8/7/2024, 6/1/2013, 6/1/2006

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109.027 Use and Disclosure of Protected Health Information - Treatment, Payment or Healthcare Operations

PURPOSE

Under the Health Insurance Portability and Accountability Act (HIPAA), subject to certain conditions, an individual's protected health information may be used or disclosed for purposes of treatment, payment or health care operations, absent the individual's authorization or an opportunity to object to the use or disclosure. The purpose of this policy is to ensure that protected health information is disclosed for purposes of treatment, payment or health care operations only in accordance with applicable law.

POLICY

Ventura County Health Care Agency (HCA) permits protected health information to be used or disclosed for purposes of treatment, payment or health care operations, absent the individual's authorization or an opportunity to object to the use or disclosure, in accordance with applicable law.

DEFINITIONS

- ***Protected Health Information (PHI)*** is defined as individually identifiable health information relating to the, including demographic data, that relates to past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for health care provided to an individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
- ***Individually identifiable health information*** includes many common identifies e.g., name, address, birth date, Social Security Number.

- ***Treatment, Payment and Operations (TPO)*** includes all of the following:
    - ***Treatment*** is defined as the provision, coordination, or management of health care and related services, consultation between providers relating to an individual, or referral of an individual to another provider for health care.
    - ***Payment*** is defined as activities undertaken to obtain or provide reimbursement for health care, including determinations of eligibility or coverage, billing, collection activities, medical necessity determinations and utilization review.
    - ***Operations*** includes functions such as quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, conducting or arranging for medical review, legal services and auditing functions, business planning and development, and general business and administrative activities.
- ***Covered Entity*** as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards.
- ***Health Care Providers*** include all "providers of services" and "providers of medical or health services" as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

PROCEDURE

A. General Rule: Permitted Use and Disclosure for Treatment, Payment and Health Care Operations

HCA permits the use and disclose protected health information for purposes of treatment, payment or health care operations absent authorization or an opportunity to object to the use or disclosure by the individual **except** under the following conditions:

1. **Special Rules for Psychotherapy Notes**. HCA must obtain an authorization for any use or disclosure of psychotherapy notes for treatment, payment, or health care operations, with the following exceptions:
    i. Use by the originator of the psychotherapy notes for treatment;
    ii. Use or disclosure by HCA for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or
    iii. Use or disclosure by HCA to defend itself in a legal action or other proceeding brought by the individual.
2. **Special Rules for Marketing.** HCA must obtain an authorization for any use or disclosure of protected health information for marketing, except if the communication is in the form of:
    i. A face-to-face communication made by HCA to an individual; or
    ii. A promotional gift of nominal value provided by HCA
    iii. If the marketing involves direct or indirect remuneration to HCA from a third party,

the authorization must state that such remuneration is involved.

B. Permitted Use and Disclosure by HCA for its Own Purposes

Staff are permitted to use and disclose protected health information for purposes of treatment, payment or health care operations of HCA absent authorization or an opportunity to object to the use or disclosure by the individual.

C. Permitted Use and Disclosure by Health Care Providers and Other Covered Entities

Upon request of a health care provider or another covered entity an individual's protected health information for treatment, payment, or healthcare operation activities, staff may disclose the requested information to the provider absent authorization or an opportunity to object to the use or disclosure by the individual when the following are found;

1. **Relationship Requirements**
    a. The requesting entity and HCA have a relationship with the individual who is the subject of the protected health information being requested;
    b. The protected health information pertains to such relationship; and
    c. The Disclosure is:
        i. For purposes of conducting quality assessment and improvement activities, or reviewing the competence or qualifications of health care professionals or related activities, or
        ii. For the purpose of health care fraud and abuse detection or compliance.
2. **Request Requirements.**
    a. All such requests must be in writing, and shall be delivered to the appropriate Health Information Management (HIM) Manager for review upon receipt of the written request.
    b. If the HIM Manager determines that the request should be approved, the Manager will forward the request and written approval to HIM for processing.
    c. If the HIM Manager determines that the request should be denied, the Manager will inform the requesting health care provider by telephone and document the contact. The HIM Manager will file the written request and the documentation of the denial in the patient's record.
    d. Upon receipt of an approved request from the Manager, staff will file the written request and Manager's written approval in the patient's record. Staff will copy and deliver the information to the requesting provider or other covered entity. Staff will document and file in the patient's record a description of the information released, date of the release, and name/address of the person/entity to whom/which the information was delivered.

REFERENCES

45 C.F.R. §§ 164.501, 164.502(a)(1)(H), 164.506, 164.508(a)(2), (3)
California Civil Code §56.10(c)(1), (2)

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109.030 Use and Disclosure of Protected Health Information Required by Law

PURPOSE

Health care organizations may disclose protected health information absent the individual's authorization when required by law. The purpose of this policy is to provide a mechanism for such disclosures in accordance with the requirements of applicable State and Federal laws and regulations.

POLICY

Ventura County Health Care Agency (HCA) will comply with HIPAA, when the disclosure of protected health information is required by law. Protected health information will be disclosed absent the individual's authorization or consent when such disclosure is required by law and is limited to the relevant requirements of such law.

PROCEDURE

General

1. All requests from governmental authorities (which includes law enforcement agencies) for protected health information absent the individual's written authorization or consent must immediately be directed to legal counsel and/or management. The procedure set forth below will be followed only at the direction of legal counsel and/or management.
2. Upon request of a governmental authority, staff may disclose protected health information to the governmental authority absent a written authorization or consent, when such disclosure is

required by law, only under the circumstances described below, and *only at the direction of legal counsel and/or management*.

Guidelines for Legal Counsel/Management

Abuse, Neglect or Domestic Violence

1. Staff may disclose protected health information about an individual who is reasonably believed to be a victim of abuse, neglect or domestic violence to a governmental authority (including a social services or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence), upon request of the governmental authority, or as a mandated reporter, under the following circumstances:
    a. The disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law (*legal counsel and/or management must review the applicable law cited and the information requested, if applicable, to determine whether this requirement is met)]*
    b. The individual agrees to the disclosure *(this agreement may be oral, but must be documented in the patient's record)]* or
    c. The extent the disclosure is expressly authorized by statute or regulation (as opposed to being *required),* and
        i. Management, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims, or
        ii. If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.
2. When disclosures are made as set forth above, staff must promptly inform the individual (this notification may be oral, but must be documented in the patient's record) that such a report has been made or will be made, *except if*.
    a. Management, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm, or
    b. Believes the personal representative is responsible for the abuse, neglect or other injury and that informing such person would not be in the best interests of the individual as determined by management, in the exercise of professional judgment.
3. Reports of **child abuse or neglect** to a public health authority or other appropriate governmental authority authorized by law to receive reports of child abuse or neglect are not subject to the requirements set forth above.
4. In all cases above, the circumstances of each such disclosure must be documented in the patient's medical record, including but not limited to documentation of the individual's oral

consent to the disclosure (when applicable), the oral disclosure to the individual by staff that a disclosure was made (when applicable), and the determination made by legal counsel and/or management as to the conformity of the disclosure with applicable laws and regulations.

Judicial and Administrative Proceedings

1. Staff may disclose protected health information required in the course of any judicial or administrative proceeding: (Exception for Instructions on Records of Psychiatric, Alcohol & Drug Abuse Patients, See #2 below).
    a. In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order *(the order must be reviewed by legal counsel and/or management to determine the extent of the disclosure authorized*); or
    b. In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:
        i. There is satisfactory assurance, as described in item c. below, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or
        ii. The covered entity receives satisfactory assurance, as described in item d. below, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of item e. below.
    c. For the purposes of item b.(i) above, "satisfactory assurances" means a written statement and accompanying documentation demonstrating that:
        i. The party requesting such information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address);
        ii. The notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal; **and**
        iii. The time for the individual to raise objections to the court or administrative tribunal has elapsed, and:
            1. no objections were filed; or
            2. All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.
    d. For the purposes of paragraph b.(ii), "satisfactory assurances" a written statement and accompanying documentation demonstrating that:
        i. The parties to the dispute giving rise to the request for information have

agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

ii. The party seeking the protected health information has requested a qualified protective order from such court or administrative tribunal.

e. A *qualified protective order* means an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

i. Prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and

ii. Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding.

f. **Special circumstances where "assurances" are not required -** Staff may disclose protected health information in response to lawful process described in item b. without receiving satisfactory assurance under items b.(i) or (ii), if staff makes reasonable efforts to provide notice (such notification may be oral, but must be documented in the patient's record) to the individual sufficient to meet the requirements of item c. or to seek a qualified protective order sufficient to meet the requirements of item d.

2. PSYCHIATRIC, ALCOHOL/DRUG ABUSE RECORDS, Must have:

a. Authorization to Use and Disclose PHI signed by the patient, or

b. The subpoena is accompanied by a court order signed by a judge instructing VCHCA to release records,

c. The judge reviews records in camera and orders release; If these steps are not completed, the records will not be released.

Law Enforcement Purposes

1. **Pursuant to process and as otherwise required by law**. Staff may disclose protected health information:

a. As required by law, including laws that require the reporting of certain types of wounds or other physical injuries (except for laws that pertain to (i) permitted disclosures to governmental authorities authorized to receive reports of child abuse or neglect, and (ii) permitted disclosures to a governmental authority about an individual reasonably believed to be a victim of abuse, neglect or domestic violence); or

b. In compliance with and as limited by the relevant requirements of:

i. A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;

ii. A grand jury subpoena; or

iii. An administrative request, including an administrative subpoena or

summons, a civil or an authorized investigative demand , or similar process authorized under law, provided that:

1. The information sought is relevant and material to a legitimate law enforcement inquiry;
2. The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
3. De-identified information could not reasonably be used.

2. **Limited information for identification and location purposes.** Except for disclosures required by law as permitted by item 1 above, staff may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that:
    a. The covered entity may disclose only the following information:
        i. Name and address;
        ii. Date and place of birth;
        iii. Social security number;
        iv. ABO blood type and RH factor;
        v. Type of injury;
        vi. Date and time of treatment;
        vii. Date and time of death, if applicable; and
        viii. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

    b. Except as permitted by a. above, staff may not disclose for the purposes of identification or location any protected health information related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

3. **Victims of a crime.** Except for disclosures required by law as permitted by item 1 above, staff may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime, other than disclosures that are subject to requirements for disclosures related to health activities and regarding victims of abuse, neglect or domestic violence, if:
    a. The individual agrees to the disclosure *(such agreement may be oral, and must be documented in the medical record*); or
    b. Staff is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that:
        i. The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;

ii. The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and

iii. The disclosure is in the best interests of the individual as determined by management, in the exercise of professional judgment.

4. **Decedents.** Staff may disclose protected health information about an individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the individual if management has a suspicion that such death may have resulted from criminal conduct.

5. **Crime on premises.** Staff may disclose to a law enforcement official protected health information that management believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity.

6. **Reporting crime in emergencies.**

    a. A health care provider providing emergency health care in response to a medical emergency, other than such emergency on the premises of the health care provider, may disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

        i. The commission and nature of a crime;

        ii. The location of such crime or of the victim(s) of such crime; and

        iii. The identity, description, and location of the perpetrator of such crime.

    b. If a covered health care provider believes that the medical emergency described in item a. above is the result of abuse, neglect, or domestic violence of the individual in need of emergency health care, item 6a. does not apply and any disclosure to a law enforcement official for law enforcement purposes is requirements concerning disclosures about victims of abuse, neglect or domestic violence.

7. **Identification of the Governmental/Law Enforcement Representative**

    a. The identity of the governmental or law enforcement representative requesting the disclosure of the protected health information must be verified prior to disclosing protected health information. See Policy and Procedure on Verification of the Identity and Authority of Persons Requested Protected Health Information.

Applicable Laws and Regulations

45 CFR §§160.502(b)(2)(v), 160.512, 160.514(d)(3)(iii)(A), 160.514(h)(1), 164.501
California Civil Code §56.10
California Evidence Code §1158
California Penal Code §§11160, 11161, 11161.8, 11165.7, 11165.9
California Welfare & Institutions Code §§5328, 15630, 15631

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109.039 Incidental Uses and Disclosures of Protected Health Information

POLICY:

Under HIPAA, an individual's protected health information may be used or disclosed incident to a use or disclosure otherwise permitted under HIPAA, absent the individual's authorization or an opportunity to object to the use or disclosure, subject to certain conditions. The purpose of this policy is to ensure that such incidental uses and disclosures are made in accordance with the requirements of HIPAA.

PROCEDURE:

Protected health information may be used or disclosed incident to a use or disclosure otherwise permitted under HIPAA, absent the individual's authorization or an opportunity to object to the use or disclosure, subject to the conditions set forth in this Policy and Procedure.

1. **Definition**. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure.
2. **Uses and Disclosures Incident to Permitted Uses and Disclosures**. Ventura County Health Care Agency (HCA) may use or disclose an individual's protected health information incident to a use or disclosure otherwise permitted under HIPAA so long as HCA has complied with the following requirements:
    a. HCA has implemented the "minimum necessary" standard, as applicable. (See policy 109.008, *Minimum Necessary Use and Disclosure of Protected Health Information*.)
    b. HCA has taken reasonable safeguards to limit incidental uses or disclosures. (See

Policy and Procedure on Requirement to Safeguard Protected Health Information.)

3. **Incidental Disclosures are Not Required to be Included in an Accounting**. HCA is not required to include incidental disclosures in the accounting of disclosures of protected health information that HIPAA requires HCA to provide to an individual upon request.

Applicable Laws and Regulations:

- 45 CFR §164.502(a)(1)(iii)
- 45 CFR §164.528(a)(1)(iii)
- 45 CFR §164.530(c)(2)(ii)
- California Civil Code § 56.10(c)(14)

See Administrative policy 109.012

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109.040 Use of Limited Data Sets in Identifiable Patient Information

POLICY:

Under HIPAA, a health care organization is permitted to use or disclose a limited data set, which is protected health information that excludes certain patient identifiers, so long as the health care organization enters into a data use agreement with the limited data recipient and the limited data set is used only for the purposes of research, public health, or health care operations. The purpose of this policy is to provide a mechanism to properly create a limited data set, as well as provide the requirements that must be included in the data use agreement.

PROCEDURE:

It is the policy of Ventura County Health Care Agency (HCA) not to disclose a limited data set without an authorization from the individual who is a subject of the protected health information (when such an authorization is required), unless HCA enters into a data use agreement with the limited data recipient and the limited data set is used only for the purposes of research, public health, or health care operations.

- **Role of Compliance and Privacy Officer**. The Compliance and Privacy Officer will make decisions as to whether a limited data set should be created from protected health information, and the employee or business associate who is requested to create the limited data set. If so, the reason for creation of the limited data set will be documented and maintained.

1. **Creation of Limited Data Set**. The following individually identifying elements of the individual,

or of the individual's relatives, employers, or household members, will be removed or otherwise concealed from protected health information in order to create a limited data set:

- Names;
- Postal address information, other than town or city, State, and zip code;
- Telephone numbers;
- Fax numbers;
- Electronic mail addresses;
- Social security numbers;
- Medical record numbers;
- Health plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Internet Protocol (IP) address numbers;
- Biometric identifiers, including finger and voice prints; and
- Full face photographic images and any comparable images.

2. **Using a Business Associate**. HCA may contract with a Business Associate under a Business Associate Agreement to perform the aforementioned creation of a limited data set.
3. **Limitation on Use or Disclosure**. HCA may use or disclose a limited data set, so long as HCA enters into a data use agreement, which includes the requirements listed below, with the limited data recipient and the limited data set is used only for the purposes of research, public health, or health care operations.
4. **Data Use Agreement Content Requirements**. The data use agreement between HCA and the limited data recipient must meet the following requirements:
    - Establish the permitted uses and disclosures of such information by the limited data set recipient, which cannot extend beyond research, public health, and health care operations. The data use agreement may not authorize the limited data set recipient to use or further disclose the information in a manner that would violate the requirements of this Policy and Procedure, if done by HCA;
    - Establish who is permitted to use or receive the limited data set; and
    - Provide that the limited data set recipient will:
        - Not use or further disclose the information other than as permitted by the data use agreement or as otherwise required by law;
        - Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the data use agreement;
        - Report to HCA any use or disclosure of the information not provided for by

its data use agreement of which it becomes aware;

- Ensure that any agents, including a subcontractor, to whom it provides the limited data set agrees to the same restrictions and conditions that apply to the limited data set recipient with respect to such information; and
- Not identify the information or contact the individuals.

5. **Oversight Responsibilities**. If HCA knows of a pattern of activity or practice of the limited data recipient that amounts to a material violation of the data use agreement, HCA must attempt to cure the violation, and if such attempt is unsuccessful, terminate the agreement, if feasible, and, if not, discontinue disclosure of protected health information to the limited data recipient and report the violation to the Secretary of U.S. Department of Health and Human Services.

Applicable Laws and Regulations:

- 45 CFR §164.514(e)

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109.050 Requests to Receive Confidential Communications of Protected Health Information by Alternative Methods

PURPOSE

Under the Health Insurance Portability and Accountability Act (HIPAA), health care organizations shall permit individuals to receive communications of protected health information from the organization by alternative means or at alternative locations. The purpose of this policy is to provide a mechanism for responding to requests for restrictions on the method by which protected health information is communicated.

POLICY

The Ventura County Health Care Agency (HCA) will take necessary steps to accommodate reasonable requests by individuals to receive confidential communications of protected health information in the manner requested.

PROCEDURE

HCA shall require individuals to make a request for alternative means of confidential communication in writing.

1. HCA will not require an explanation from the individual as to the basis for the request as a condition of providing communications on a confidential basis.
2. When appropriate, HCA may condition the provision of a reasonable accommodation on information as to how payment, if any, will be handled, and specification of an alternative address or other method of contact.

3. An alternative means or location will be designated on a case by case basis that is satisfactory to HCA and the individual before communication of protected health information is made.
4. Alternative means of communication will be updated by the Health Information Management (HIM) Manager or designee who can approve various types of communication.
5. The HIM Manager or designee will access the individual's protected health information using proper access and authorization procedures.
6. The requested protected health information will be delivered to the individual in a secure and confidential manner, such that the information cannot be accessed by employees or other persons who do not have appropriate access clearance to that information.
7. The HCA HIM Manager or designee will document the request and delivery of the protected health information.
8. In the event that the identity and legal authority of an individual or entity requesting protected health information cannot be verified, personnel will refrain from disclosing the requested information and timely report the case to the HCA Office of Compliance & Privacy at 1-805-677-5241.

REFERENCES

45 C.F.R. § 164.522(b)

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VENTURA COUNTY HEALTH CARE AGENCY

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109.051 Patient Refund Policy

POLICY

It is the policy of Ventura County Medical Center (VCMC)/Santa Paula Hospital (SPH) to ensure that patient account credit balances/overpayments are properly refunded to patients, guarantors or third-party payors.

PROCEDURE

- Patient accounts with overpayments must be refunded promptly to the appropriate patient(s), guarantor(s) or third-party payor(s).
- Accounts with overpayments should not remain unprocessed for more than 60 days following the date of the overpayment.
- For Medicare, Medicaid or CHAMPUS/Tricare, where credit balance reports must be filed with the payor and account adjustments or take-backs must be processed by the payor to resolve the overpayment, the specific payor rules and timeframes for processing must be followed.
- Patient accounts with credit balances are to be researched for errors such as overpayments by an insurance and/or another responsible party, duplicate payment/contractual entries, misapplied charges/credits, and incorrect patient account adjustments, etc. Once researched, all bona fide overpayments must be promptly refunded to the appropriate patient, guarantor or third party payor.
- VCMC/SPH will collect statistical information regarding credit balances and overpayments. This information will be used to develop trendlines for monitoring purposes to identify unusual patterns when they occur.
- The Patient Accounts Manager shall routinely report the status of credit balances and

overpayments to the CFO and the Compliance Committee for review. Any unusual patterns or occurrences will be investigated in accordance with Compliance policy.

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109.052 Screening of Ineligible Persons

PURPOSE

Ventura County Health Care Agency (HCA) prohibits the employment of individuals who are excluded from participation in federally funded healthcare programs or who are otherwise ineligible persons. To ensure that such ineligible persons are not hired or employed HCA screens prospective and current employees, contractors, agents, medical staff members, students and volunteers to ensure they are not barred from participation.

SCOPE

This policy applies to HCA its affiliates and all satellite locations.

POLICY

HCA prohibits employment or contracting with Ineligible Persons. HCA shall ensure that Screened Persons are checked against the Exclusion Lists prior to engaging their services as part of the hiring, credentialing, or contracting process. All Screened Persons shall be re-screened against the Office of Inspector General (OIG) LEIE downloadable database, System for Award Management (SAM) Excluded Parties List Systems (EPLS), and any applicable state health care exclusion list monthly. In addition, all credentialed practitioners will be enrolled in the National Practitioner Data Bank (NPDB) for continuous query and ongoing monitoring. NPDB eliminates the need to query, since it provides notification within 24 hours of any report for the enrolled practitioners.

HCA requires disclosure by all Screened Persons as to whether they are an Ineligible Person. All Screened Persons shall disclose if he/she/they are an Ineligible Person at the time of the initial hiring,

credentialing, or contracting process, or at any point in the future that they are an Ineligible Person.

If HCA has actual notice that an employed or contracted Screened Person has become an Ineligible Person, HCA will remove such Ineligible Person from responsibility for, or involvement in, the business operations related to any Federally funded health care program or provision of items or services.

If HCA has actual notice that a Screened person who is a member of its credentialed medical staff has become an Ineligible Person, HCA shall refer that physician or other practitioner for review pursuant to the Medical Staff Bylaws. HCA will ensure that it does not submit claims for any services provided, ordered, or referred by such Ineligible Person.

DEFINITIONS

A. "**Screened Person**" means prospective and current employees, contractors, agents, practicing medical staff (credentialed, consulting or referring), allied health professionals, students, or volunteers.

B. "**Ineligible Person**" means an individual or entity (a) currently excluded, suspended, debarred, or otherwise ineligible to participate in federally funded health care programs or in federal procurement or non-procurement programs or (b) an individual or entity that has been convicted of a criminal offense that falls within the 42 USC § 1320a-7(a) but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

C. "**Federally Funded Healthcare Programs**" means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, and is funded directly, in whole or in part, by the U.S. Government or a State health care program including Medicare, Medicaid/ MediCal, managed Medicare/Medicaid/MediCal, TriCare/VA/ CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Railroad Retirement Benefits, Black Lung Program and Services Provided to Federal Prisoners.

D. "**Exclusion Lists**" means Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) Excluded Parties List System (EPLS), any applicable state healthcare exclusion list, and, as applicable, the National Practitioner Databank (NPDB).

PROCEDURE

A. HCA shall ensure that all Screened Persons are screened against the Exclusion Lists prior to engaging their services as part of the hiring, credentialing, or contracting process, and monthly thereafter. Documentation of initial screening results, indicating that the Screened Person is not identified as an Ineligible Person, must be maintained in each employee's personnel file, medical staff credentialing file, or in the contract file.

B. Credentialed physicians and allied health practitioners will be screened monthly against the Exclusion Lists by Ventura County Medical Center's Medical Staff Services.

C. Facilities shall develop a process for point of service screening against the Exclusion Lists to ensure that prescriptions, orders, or referrals are not accepted from Ineligible Persons that are

not credentialed or employed.

D. All Screened Persons are required to disclose immediately to his, her, their supervisor, Compliance Officer, HCA Director, or other designated individual in the relevant agreement/ contract, any debarment, exclusion, suspension, or other event that makes that person or entity an Ineligible Person. Failure to do so may result in disciplinary action up to and including suspension or termination, termination of the contract, or other actions as authorized by HCA policies or Medical Staff Bylaws.

E. If HCA has actual notice that a Screened Person has become an Ineligible Person, HCA shall remove such Screened Person from responsibility for, or involvement in, the provision of services or other operations related to any federally funded healthcare programs and remove such Screened Person from any position for which the Screened Person's compensation or the items or services furnished, ordered, or prescribed by the Screened Person are paid in whole or part, directly or indirectly, by federally funded healthcare Programs until such time as the Screened Person is reinstated into participation.

F. If HCA has actual notice that a Screened Person is charged with a criminal offense that falls within 42 U.S.C. § 1320a-7(a) or 42 U.S. §§ 1320a- 7(b)(1)-(3) (see references below), or is proposed for exclusion during employment or contract term, HCA shall take all appropriate actions to ensure that the responsibilities of the Screened Person have not affected the quality of care rendered to any beneficiary, patient, or resident, or the accuracy of any claims. This may include suspension, termination, contract termination, or other actions as authorized by HCA policies or Ventura County Medical Center Medical Staff Bylaws.

G. If the Screened Person refutes the findings contained in the screening results, further investigation will be initiated. The Screened Person may provide documentation indicating he/ she/they are not excluded or reinstatement has been granted. The Screened Person may also submit an affidavit he/she/they are not the Ineligible Person appearing on the Exclusion Lists. Ventura County Human Resources Department, Ventura County Medical Center's Medical Staff Office, or other responsible department shall forward the documentation to HCA's Compliance Officer and HCA's designated Ventura County Counsel. After additional investigation, a decision will be made and a response provided to the Screened Person.

H. The Compliance Department must be notified immediately that a Screened Person has been determined to be an Ineligible Person either by the individual's supervisor or screening department (e.g., Human Resources or Medical Staff Office, Supply Chain). The Compliance Officer or designee will develop a corrective action plan, including any refunding obligations. The Compliance Officer, after consultation with HCA's designated Ventura County Legal Counsel, shall be responsible for making appropriate notifications to the OIG relating to Ineligible Persons.

I. All employees whose responsibilities are affected by this Policy are expected to be familiar with its duties. Failure to comply with this Policy will subject parties to appropriate disciplinary measures.

J. Documentation of the initial and monthly screenings shall be maintained by Ventura County Medical Center's Medical Staff Services, Ventura County's Human Resources Department and HCA's Compliance Department. All documents related to screening processes under this policy shall be maintained in the designated files for a minimum of six (6) years after the expiration or termination of employment, contract, or privileges.

REFERENCES

42 U.S.C. § 1320a-7(a)

42 U.S.C. §§ 1320a-7(b)(1) - (3)

OIG Special Advisory Bulletin on The Effect of Exclusion from Participation in Federal Health Care Programs, 64 FR 52791 (September 30, 1999),

Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs (May 8, 2013)

OIG Exclusion Program website, http://oig.hhs.gov/fraud/exclusions.html

GSA Excluded Parties List System website, https://sam.gov/content/exclusions

See also Policy 102.029 Ongoing Monitoring and Interventions

All Revision Dates

6/3/2025, 8/7/2024, 8/30/2022

Approval Signatures

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Policy Area	Administrative - Compliance

109.053 Overpayments

Purpose

To establish requirements to report and return identified Overpayment's received by Ventura County Health Care Agency (HCA) from Federal and State Healthcare Programs.

Scope

This policy applies to HCA, its affiliates and all satellite locations.

Definitions

A. ***"Federal and State Healthcare Programs"*** means any plan or program that provides health care benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States government or any state healthcare program.

B. ***"Identification or Identified"*** means an amount determined through the exercise of Reasonable Diligence received and quantified.

C. ***"Overpayment"*** means any funds that HCA receives or retains under any Federal or State Health Care Program to which HCA, after applicable reconciliation, is not entitled to receive. Overpayments may stem from various causes including non-covered services, lack of medical necessity, cost reporting errors, duplicate payments, or Medicare payments when another payer has primary responsibility for payment. Overpayments can also arise from clerical or administrative errors identified by HCA. Regardless of source, all Overpayments are reportable, and a refund is required by the later of: (i) the date which is 60 days after the date on which the Overpayment was Identified; or (ii) the date any corresponding cost report is due, if applicable.

D. ***"Lookback Period"*** means the period in which any Overpayment must be reported and returned after its receipt.

E. ***"Reasonable Diligence"*** means timely, good faith investigation of credible information leading to a potential Overpayment. This period is generally no longer than six months except in extraordinary circumstances.

F. ***"Reportable Event"*** means anything that involves: a substantial Overpayment; a matter that a reasonable person would consider a potential violation of criminal, civil, or administrative laws applicable to any Federal Health Care Program for which penalties or exclusion may be authorized; the employment of or contracting with an ineligible person; or the filing of a bankruptcy petition. A Reportable Event may be the result of an isolated event or a series of occurrences.

Policy

HCA will identify Overpayments from Federal and State Healthcare Programs. When detected, all required billing and coding corrections will be made to assure the return of Identified Overpayments. HCA will report and return any Overpayment received during a Lookback Period by the later of: (i) the date which is sixty (60) days after the date on which the Overpayment was Identified; or (ii) the date any corresponding cost report is due, if applicable.

Procedure

A. Routine Overpayments such as duplicate payments, payments more than allowable amounts, payments when another payor is primary, and others that are returned or adjusted pursuant to written payor procedures will be handled in accordance with such guidance.

B. Routine processing errors will be corrected either by the individual who detects the error or the person who made the error. If processing errors result in Overpayments, they will be reported to Director of Revenue Cycle for additional follow-up.

C. Overpayments other than routine processing errors should be reported to HCA's Director of Revenue Cycle and HCA's Compliance Officer who will coordinate the review and repayment of the Overpayment including a determination of the validity and accuracy of the underlying information used to determine the Overpayment. Responses will include a corrective action plan and reporting to appropriate Federal or State Healthcare Programs or to the Health and Human Services Office of Inspector General (OIG), as applicable.

D. When refunding Overpayments to Federal or State Healthcare Programs, the report will identify how the problem was discovered, corrective actions taken, the methodology used to identify claims and whether extrapolation was used in the determination of the Overpayment.

E. Investigations indicating that Overpayments have occurred over a substantial period may require review of a population of claims through sampling. Sampling and extrapolation must be reasonable, credible, and explainable. Records of extrapolated repayments must be retained to substantiate that a repayment has been made for a population of claims and not directly for individual claims.

F. Reducing an Overpayment amount by subtracting out one or more underpayment amounts is not permitted on voluntary refunds except where statistical sampling and estimation have

been used.

G. All identified Overpayments should be refunded to the appropriate payer; however, HCA's Compliance Officer will notify the OIG in writing of any overpayment more than $50,000 after making the determination that the Overpayment meets the definition of a Reportable Event.

References

42 C.F.R. §§ 401.301-401.305;

109.051 Patient Refund Policy

All Revision Dates

6/12/2025, 6/23/2024, 8/30/2022

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Policy Area	Administrative - Compliance

109.054 Compliance Helpline Reporting

PURPOSE

Ventura County Health Care Agency (HCA) takes all reports of non-compliance seriously and seeks to establish reporting methods where employees, patients and members of the community can confidentially report potential compliance matters. The various reporting methods established by HCA Compliance Office are outlined in this policy.

SCOPE

This policy applies to HCA, its subsidiaries and all satellite locations.

POLICY

HCA requires that all employees, volunteers, contractors, and Compliance Committee members report a Potential Compliance Matter (PCM) upon discovery. Individuals may report a PCM directly to HCA Compliance Officer, or through the chain of command. Notifications from a Federal or State Healthcare Program or other regulatory agency shall be reported directly to HCA Compliance Officer.

No retribution or retaliation for good faith reporting of a PCM will be tolerated. Any employee who engages in retaliatory behavior will be subject to disciplinary action.

DEFINITIONS

A. **"Federal or State Healthcare Program"** means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, that are funded directly, in whole or in part, by

the United States Government including, but not limited to: Medicare, Medicaid/MediCal, managed Medicare/Medicaid/MediCal, TriCare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, and Pre-Existing Condition Insurance Plans (PCIP).

B. **"Potential Compliance Matter" (PCM)** means a potential violation of HCA's Code of Conduct, policies, procedures, Compliance Program requirements or laws and regulations relating to Federal and State Healthcare Programs.

PROCEDURE

A. Except for notices of regulatory investigations, PCMs may be reported to an immediate supervisor, HCA Compliance Department, or the HCA Compliance Helpline. HCA's Compliance Helpline is an anonymous reporting mechanism available 24 hours a day, 7 days a week. Reporting mechanisms can be contacted as follows:

   1. Electronic mail or telephone reports to HCA Office of Compliance and Privacy, at HCA.Compliance@ventura.org or 805.677.5241.
   2. A Supervisor
   3. Confidential web intake portal at **vchca.ethicspoint.com** or through the Compliance Helpline at **833-823-6631.** When using HCA Compliance Helpline anonymously, the caller will be given a reference number to enable follow up, as necessary.

B. A supervisor receiving a PCM report is responsible for immediately escalating the report to HCA's Compliance Officer.

C. A notice of investigation by a regulatory agency will be expeditiously reported to HCA's Compliance Officer and Ventura County Legal Counsel designee.

D. The HCA Compliance Officer, or designee, is responsible for ensuring an incident report is opened in the disclosure module within two business days. All PCMs will be recorded, regardless of the potential to be a violation of criminal, civil or administrative law related to Federal or State Healthcare Programs.

E. Records will include a summary of each PCM including whether it was reported anonymously. Non-anonymous reports will identify the reporter. All PCM records will contain a status of the review as well as the individual and associated department primarily responsible for review of the matter.

F. All matters will be fully investigated, documented, and resolved, including reporting to outside agencies and/or plan sponsors, prior to closing. Other disciplinary actions, including personnel actions, will be recorded as applicable.

G. All reports of suspected violations will be treated confidentially to the extent possible without jeopardizing the investigative process.

H. VCHCA will establish mechanisms to periodically inform its workforce of its Compliance Helpline Reporting Program.

Formerly titled: 109.054 Disclosure Program

All Revision Dates

6/3/2025, 6/23/2024, 8/30/2022

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Policy Area	Administrative - Compliance

109.055 HCA Non-Monetary Compensation and Medical Staff Incidental Benefits

PURPOSE

The Physician Self-referral Law commonly known as "Stark" prohibits a physician from making referrals for designated health services (DHS) payable by Medicare or Medicaid to an entity with which he or she (or an Immediate Family Member) has a financial relationship (ownership, investment, or compensation), unless an exception applies. The purpose of this Policy is to establish guidelines to comply with the exceptions promulgated under Stark Law and Regulations when providing Non-Monetary Compensation or Incidental Benefits to Physicians or their Immediate Family Members.

SCOPE

This policy applies to Ventura County Health Care Agency (HCA), its affiliates and all satellite locations.

DEFINITIONS

A. ***"Immediate Family Member"*** means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

B. ***"Incidental Benefits"*** means compensation in the form of items or services (excluding cash or cash equivalents) from HCA to a Physician when the item or service is used on HCA campuses or sites, provided that:

   a. The Incidental Benefit is **offered** to all members of the medical staff practicing in the

same specialty without regard to the volume or value of referrals or business generated between the parties.

b. Except for the identification of medical staff members on HCA website or in advertising, the compensation is provided only during periods when the medical staff members are making rounds or engaged in other on-campus activities that benefit HCA or its patients.

c. Examples include lab coats, Internet access to facilitates patient care, pagers,free parking and cafeteria meals on HCA campus during times when the Physician is in the hospital.

d. Incidental Benefits are not counted against the annual Non-Monetary Compensation limits unless they exceed the threshold established for each occurrence of a benefit. As of 2025, the limit is less than $45 per occurrence.

C. ***"Non-monetary Compensation"*** is items and benefits provided without charge or for less than fair market value to a physician outside of a specific contractual relationship and unsolicited by the Physician or persons under his or her control (i.e., office staff). Non-monetary Compensation may include items such as non-working hour meals, gift baskets, event giveaways, flowers, appreciation events, parties, golf outings, concerts, or sporting events (excluding cash and cash equivalents). Non-monetary Compensation is limited to an aggregate annual amount $519 per Physician as of 2025.

D. ***"Physician"*** means a Doctor of Medicine or Osteopathy, a Doctor of Dental Surgery or Dental Medicine, a Doctor of Podiatric Medicine, a Doctor of Optometry, or a Chiropractor.

E. ***"Responsible Person"*** means any individual or department of HCA that provides or directs the provision of items or services that qualify as Non-Monetary Compensation or Incidental Benefits.

POLICY

HCA monitors non-cash items and services provided to referring Physicians to ensure compliance with Stark Law and Regulations. Non-monetary Compensation and Incidental Benefits shall not, in any manner, be related to the volume or value of referrals or business generated between the parties and cannot be solicited by the referring Physician. This Policy and related procedures provide guidelines for documenting, tracking, and recording Non-Monetary Compensation and Incidental Benefits.

Physicians employed by HCA are exempt from this Policy and may receive items or services under the terms and conditions of their employment.

PROCEDURE

The Non-monetary Compensation and Incidental Benefit limits may be adjusted annually for inflation effective January 1st of each calendar year. Annually, HCA Compliance Officer will consult the Centers for Medicare and Medicaid (CMS) website for the current annual limitations and communicate them to Responsible Persons.

NON-MONETARY COMPENSATION

A. All Responsible Persons providing Non-Monetary Compensation to Physicians must provide detailed information to the Compliance Officer prior to the provision of such items or services to ensure the applicable annual limits are not exceeded.

B. If the applicable limit will be exceeded by the anticipated cost of an item or service, HCA Compliance Officer shall notify the Responsible Person immediately to prevent the provision of such items or services to the Physician.

C. HCA may host one local, annual event for the entire medical staff without the cost subject to the Non-Monetary Compensation annual limit for those in attendance. Giveaways or gifts at such an event will count toward the annual Non-monetary Compensation limit.

D. Continuing Medical Education (CME) provided on-campus which otherwise meets the conditions set forth above in the definition of Incidental Benefits may be offered to Physicians and recorded as an Incidental Benefits unless its value exceeds the annual limits. All other CME or discount related to CME must be counted as Non-Monetary Compensation and toward the annual limit unless provided under a written agreement that satisfies another exception under the Stark Law and Regulations.

E. A single item that exceeds the Non-Monetary Compensation annual limit may not be allocated to several Physicians to fall below the threshold. For example, a gift valued at $750 may not be given to a three-person group practice and allocated to the Physicians at $250 each. The total value of the gift must be allocated to each Physician.

F. The fair market value of items or services provided to Physicians pursuant to this Policy is the full fair market value of the item or service, not HCA cost of providing such item or service.

G. The fair market value of all items or services shall be reported to HCA Office of Compliance and Privacy along with copies of all receipts or other documentation of expenses using the Non-Monetary Compensation and Incidental Benefit Form attached hereto as Appendix A. Compliance shall maintain a complete calendar year log of all reports received by Physician.

H. Within sixty (60) days of the end of the calendar year, HCA Compliance Officer will review all Non-Monetary Compensation and Incidental Benefits provided to Physicians in the preceding calendar year and report on such to HCA Compliance and Oversight Committees.

Excessive Amounts

A. Non-monetary Compensation may be provided from multiple sources, therefore Responsible Persons should contact HCA Office of Compliance and Privacy to determine the availability of additional Non-monetary Compensation to avoid exceeding the annual limits. In the event an exact amount is unavailable, an estimate may be provided until the amount is determined.

B. In the event HCA has inadvertently provided Non-Monetary Compensation to a Physician in excess of the annual limit, such compensation may be deemed to be within the limit if:

    a. the value of the Non-Monetary Compensation is no more than (50%) greater than the annual limit; and,

    b. the Physician returns the excess Non-Monetary Compensation (or an amount equal to its value) by the earlier of the end of the calendar year in which the excess Non-

Monetary Compensation was received; or, within 180 consecutive calendar days following the date that the excess Non-Monetary Compensation was received.

REFERENCES

Stark Law, § 42 U.S.C 1395nn
Non-Monetary Compensation Exception, 42 C.F.R. § 411.357(k)
Medical Staff Incidental Benefits Exception, 42 C.F.R § 411.357(m)

APPENDIX A

HCA Reporting Form for Non-Monetary Compensation For the year

Physician	Item/Service	Cost/Fair Market	Responsible Person
Total		**$**	

This form must be completed and sent to the Compliance Office within 5 business days of providing Non-monetary Compensation to a Physician.

All Revision Dates

6/2/2025, 8/7/2024

Approval Signatures

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Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.058 HCA Compliance Audit & Monitoring Policy

PURPOSE

To ensure organizational compliance Ventura County Health Care Agency (HCA) Office of Compliance and Privacy regularly performs auditing and monitoring activity. The purpose of this policy is to outline the process for performing compliance audit and monitoring activity.

SCOPE

This policy applies to HCA its affiliates and all satellite locations.

POLICY

HCA will take reasonable steps to confirm compliance with applicable laws, regulations, policies and procedures. HCA Compliance Officer will recommend audits and monitoring of identified risk areas related to compliance with laws and regulations, as well as organizational policies, procedures, and HCA Code of Conduct.

Results of audit and monitoring activities will be reported to HCA Compliance and Oversight Committees no less than quarterly. In the event any audit or review reveals potential violations of Federal and State Healthcare law or regulation, HCA Compliance Officer will recommend appropriate action in accordance with its policies. In addition to risk-based Internal Audits, HCA Oversight Committee may periodically request work to assess the effectiveness the HCA Compliance Program by auditors or consultants external to HCA.

DEFINITIONS

A. **"Audit Documentation"** means a record of the planning, performance, and reporting of compliance audits. This documentation should substantiates findings in the audit report.

B. **"Compliance Work Plan"** is an annual list of compliance coding audits and non-coding compliance initiatives that Compliance plans to review during the year based on a compliance Risk Assessment.

C. **"Compliance Monitoring"** means routine ongoing activity intended to provide assurance that a compliance process or internal control is effective and that risks are identified timely.

D. **"External Audits"** means those audits initiated by an external party, including government payers, payer representatives, or other regulatory entities.

E. **"Identification" or "Identified"** means Overpayments that have or will be through the exercise of reasonable diligence, determined quantified.

F. **"Internal Audits"** means those sponsored by HCA and used to determine compliance with legal and regulatory guidelines and/or compliance with an internal policy or operating objective.

G. **"Overpayment"** means any funds that HCA receives or retains under any Federal or State Healthcare Program to which HCA, after applicable reconciliation, is not entitled.

H. **"Research Audits"** means a focused examination of trial-related activities and documents to determine whether the evaluated trial-related activities were conducted, recorded, analyzed, and accurately reported according to the protocol, good clinical practice and the applicable regulatory requirements.

I. **"Risk Assessment"** means an analysis and prioritization of risk areas unique to HCA and based on their probability and impact.

PROCEDURES

A. HCA Compliance Officer is responsible for overseeing that auditing and monitoring is properly executed, documented, and reported. When applicable, audit activities are conducted in a manner that maintains any appropriate legal privilege, including the attorney-client, work product, quality management and self-evaluative privileges. If the Internal Audit is conducted pursuant to attorney client privilege, it will be delivered to Ventura County's Legal counsel for further distribution.

B. HCA performs a compliance Risk Assessment of areas identified through operations, external sources, regulators, and disclosures. HCA Compliance Department will also solicit input from HCA administrative leaders for other perceived high-risk areas.

C. Potential risks will be ranked according to probability of occurrence and impact. The Compliance Work Plan (CWP) will place the greatest emphasis on addressing high risk areas. The CWP will specify the areas of operations which will be audited or reviewed during the year and the persons or entities responsible for conducting the audit or monitoring, if known.

D. HCA CWP will be presented to the Compliance and Oversight Committees for acceptance. Any revisions to the CWP will be presented at the next regularly scheduled meeting of HCA Compliance and Oversight Committees.

E. Changes to the CWP will be made based upon the immediacy of the issue and expected scope, resource availability, and timing of the next regularly scheduled audit. Audits with regulatory risk will have the highest priority.

F. Preliminary communication will be initiated with key stakeholders prior to audit activities to explain the audit's purpose. The communication will specify the audit scope and anticipated timing.

G. Internal Audits or monitoring may be conducted internally or by persons or entities external to HCA that have knowledge of healthcare compliance requirements within a specific area. Internal Audits conducted by persons or entities external to HCA will include both reports and workpapers to support such work, including sampling methodology.

H. Audit results may require further action. These actions can include further investigation of the matter, advising management on enforcement or discipline, developing additional corrective action plans and reporting to applicable government agencies on any Overpayments. The nature of the follow-up will be dictated by the seriousness and complexity of the deficiencies noted.

I. HCA Compliance Officer will assist in the implementation of corrective actions to the extent it does not compromise the Compliance Officer's independence.

J. Research audits will be performed upon request.

K. HCA compliance Internal Audits and formal monitoring will be filed in HCA Office of Compliance and Privacy in conformance with HCA Records Retention policy.

All Revision Dates

6/2/2025, 6/23/2024

Approval Signatures

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Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

109.059 Federal and State False Claims Act Policy

PURPOSE

Ventura County Health Care Agency (HCA) requires that employees, staff, volunteers, contractors and agents report any conduct that may violate the Federal or State False Claims Act's. No retaliation is permitted against any aforementioned person for reporting such conduct. The Federal Deficit Reduction Act (FCA) of 2005 requires organizations to establish policies and procedures detailing their compliance with the Federal and State False Claims Act and associated “whistleblower” protections.

SCOPE

This policy applies to employees, staff, volunteers, contractors and agents of HCA, its affiliates and all satellite locations.

POLICY

HCA is committed to carrying out its mission lawfully and ethically. As a healthcare entity that receives $5 million or more in Medicaid reimbursement, HCA is obligated by the 2005 Deficit Reduction Act to provide its employees, staff, volunteers, contractors and agents with detailed information on both the federal and state False Claims Act statutes. In addition to whistleblower protections under such laws and the organization's policies and procedures regarding detecting and preventing fraud and abuse within the organization.

Any employee, staff, volunteer, contractor or agent who becomes aware of the potential submission of a false claim has an affirmative duty to report it through the proper channels. These channels include reporting concerns to a manager, director, and the Office of Compliance and Privacy via the anonymous

online at **vchca.ethicspoint.com** or through the Compliance Helpline at **1-833-823-6631.** All employees, staff, volunteers, contractors and agents who report in good faith are protected from any form of retaliation. All such reports will be fully investigated, and appropriate corrective action will be taken as warranted.

DEFINITIONS

A. "**Knowing**" and "**knowingly**" means that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and require no proof of specific intent to defraud.

B. "**Claim**" A claim is any request or demand of money from the government, made directly or made through an intermediary, including a contractor, grantee, or other recipient of federal funds.

1. Examples of improper claims include:
    a. Billing codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided
    b. Billing medically unnecessary services
    c. Billing services not provided
    d. Billing services performed by an improperly supervised or unqualified employee
    e. Billing services performed by an employee excluded from participation in the Federal health care programs
    f. Billing services of such low quality they are virtually worthless
    g. Billing separately for services already included in a global fee, like billing an evaluation and management service the day after surgery

Federal False Claims Act

The Federal False Claims Act (FCA) is in the United States Code in chapter 31, sections 3729-3733. The FCA is a statute that imposes civil liability of between $5,500 and $11,000 per claim, plus three times the amount of damages which the government sustains because of the act, to any person or entity who:

- Knowingly submits a false claim to the Federal Government for payment.
- Knowingly makes or uses a false record or statement to obtain payment or approval of a claim by the Federal Government.
- Uses a false statement to decrease an obligation to the government.

Whistleblower Protections under the Federal False Claims Act

Under the “qui tam” (whistleblower) provisions of the FCA, private citizens with knowledge of potential violations (known as relators) may file suit on behalf of the Federal Government. If the Federal Government proceeds with the action, it shall have primary responsibility for prosecuting the action and

the person reporting the violation shall have the right to continue as a party to the action. In these cases, the relator would be entitled to receive a share of the proceeds of the action or settlement ranging from 15 to 25 percent.

If the government elects not to intercede with the action, the relator shall have the right to proceed with the case on their own. In these cases, the relator may be entitled to 25 to 30 percent of the proceeds if the case is successful.

State False Claims Act

In addition to the Federal statute, the State of California has a False Claims Act (FCA), California Code, Government Code, sections 12650-12655. Under the State's FCA, a "claim" includes any request or demand for money, property or services made to any employee, officer, or agent of the state. Under the State's FCA, "'knowing" means:

- Having actual knowledge of the information.
- Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsity of the information.

As with the Federal statute, proof of specific intent to defraud is not required. The California FCA imposes liability of up to $10,000 for each false claim as well as liability for three times the amount of damages that the State sustains for each of the following:

- Knowingly presenting or causing to be presented to an employee or officer of the State a false claim for payment or approval.
- Knowingly making, using, or causing to be made a false record or statement to get a false claim paid or approved by the State.
- Conspiring to defraud the State by getting a false claim allowed or paid by the State.
- Knowingly makes uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State.
- Failing to disclose the inadvertent submission of a false claim once discovered.

Whistleblower Protections under the State False Claims Act

NOTE: This section does not apply to false claims involving an amount of less than $500 in value. Under the California FCA Statute, a person may bring a civil action for a violation of this statute for the person and the State of California or political subdivision. The person bringing the action is referred to as a qui tam plaintiff.

If the State or political subdivision proceeds with an action brought by the qui tam plaintiff, the plaintiff shall receive between 15 and 33 percent of the proceeds of the action or settlement. If the State or political subdivision does not proceed with an action, the qui tam plaintiff shall receive between 25-50 percent of the proceeds of the action or settlement.

The California FCA also states that no employer shall make, adopt, or enforce any rule, regulation, or policy preventing an employee from disclosing information to a government or law enforcement agency or from acting in furtherance of a false claims action. In addition, the statute provides that no employer shall discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against an employee because of lawful acts done by the employee in disclosing information to a government or law enforcement agency. The penalties to the employer for violating these are similar to the Federal statute.

REFERENCES

Federal Deficit Reduction Act, § 6032

Federal False Claims Act, 31 U.S.C. §§ 3729-3733

Federal Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812

California False Claims Act, CAL. GOV'T CODE §§ 12650-12656

CAL. Some other California State Laws with provisions pertaining to false claims or statements include:

WELF. & INST. CODE § 14104, which makes it unlawful to present a claim for payment with intent to defraud.

CAL. PENAL CODE § 550(a), which makes it unlawful to make of submit a false or fraudulent claim or to make false statements or documents in support of a claim for a health care benefit.

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109.060 Patient Inducements

POLICY

Ventura County Health Care Agency (HCA) shall not offer or provide to any prospective or existing patient or their families any free or reduced costs goods and services as an inducement to receive services at any HCA facility, except as permitted by law.

Guidelines

Under the Anti-Kickback Statute, a person or entity is prohibited from offering or transferring anything of value to an individual in order to influence the individual to receive goods or services that are reimbursable under a federal health care program (including Medicare, Medi-Cal, CHAMPUS/TRICARE) from any particular practitioner or supplier. Anyone who offers or gives an unlawful inducement is subject to civil money penalties.

Items and services of nominal value are permitted to be given to Medicare and Medi-Cal patients if not provided with such frequency that the aggregate value is more than nominal.

Incentives given to individuals to promote the delivery of *preventive care,* as determined by regulations, is permitted. *Preventive care* means annual physicals and care associated with, and integral to, preventing the need for treatment or diagnosis of a specific illness, symptom, complaint or injury where such care is provided or directly supervised by HCA. *Preventive care* includes, but is not limited to, prenatal and postnatal care, flu shots and immunizations for childhood diseases, AIDS and HIV testing, mammograms, pap smears and prostate cancer screenings, eye examinations, treatment for alcohol and drug addiction, and treatment designed to prevent domestic violence.

PROCEDURE

A. **Free or Discounted Goods and Services to Beneficiaries.** Any offer of free or reduced price services made to a Medicare or Medi-Cal beneficiary as an inducement to obtain services at a HCA facility, including any marketing program making such offer, must be reviewed for compliance with law and approved by legal counsel and the Compliance Office prior to implementation. Any waiver of coinsurance or deductibles or reduction in patient care charges must be made in conformance with internal policies.

B. **Permissible Incentives.** The Compliance Office and legal counsel are to be be consulted if there are questions about the permissibility of incentives. Examples of permissible incentives include:

- Transportation to and from preventive care services (as defined);
- Car seats, baby formula and child safety devices provided for participating in prenatal or parenting classes;
- T-shirts, exercise videos and water bottles provided for participating in a postcardiac care fitness program;
- Items of nominal value, so long as not given with such frequency that the aggregate value to the individual is not nominal.
- Items of nominal value include:
  - Refreshments
  - Medical literature
  - Complimentary local transportation services
  - Free health fairs

C. **Prohibited Incentives**. Incentives in cash or cash equivalent shall not be provided. Items or services related to promotion of general health and fitness (excluding an annual physical) are prohibited. Examples of prohibited incentives include:

- Cash or cash equivalents
- Health club memberships
- Nonprescription vitamins
- Nutritional supplements
- Beauty aids

D. **Approvals Required.** Any waiver of coinsurance or reduction in patient care charges must be approved by the Patient Accounts Manager in conformance with this Policy and Procedure.

REFERENCES

42 U.S.C. §132 0a-7a(a)(5)

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109.062 Non-Compliance Report Internal Investigation Policy

PURPOSE

Ventura County Health Care Agency (HCA) is responsible to protect against the incidence of fraud, waste, and abuse, under the False Claims Act, Anti-kickback Statute, and Physician Self-Referral, also known as Stark Law and to investigate such allegations. The purpose of this policy is to outline the steps that may be taken to investigate internally report allegations pertaining to fraud, waste, and abuse.

POLICY

HCA takes all reports of non-compliance seriously and seeks to address any non-compliance as early as possible and prevent the recurrence of future situations. HCA will appropriately investigate all claims of non-compliance regardless of reporting channel and will take appropriate steps to investigate and address potential violations.

DEFINITIONS

A. **"Allegation"** A claim or assertion that someone has done something illegal or wrong, typically without proof.

B. **"Anti-Kickback Statute (AKS)"** is a statute that makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce, or in return for, the referral of an individual to a person for the furnishing of, or arranging for the furnishing of, any item or service reimbursable under a Federal health care program.

C. **"False Claims Act"** It is illegal to submit claims for payment to Medicare or Medicaid that you

know or should know are false or fraudulent.

D. **"Fraud, Waste, & Abuse"** as defined by the Centers for Medicare and Medicaid (CMS)
    1. Fraud requires intent to obtain payment and the knowledge the actions are wrong.
    2. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.

E. **"Stark Law"** Physician Self-Referral law commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

F. **Examples of non-compliance**
    - Inappropriate coding/charge code selection, charging, billing or claims submission
    - Overpayments
    - Medical necessity issues
    - Cost reporting issues
    - False or fraudulent documentation issues
    - Failure to follow policies and procedures
    - Failure to follow Code of Conduct
    - Drug diversion
    - Physician relationship issues such as potential violations of Stark law or Anti-kickback statute
    - Potential violations of Anti-Kickback statute related to vendors (e.g., inappropriate gifts)
    - Provider or supplier excluded from Federal or State Health Care Programs
    - Inappropriate Conflict of Interest
    - Retaliation or Intimidation

PROCEDURE

Once a report of non-compliance is received the following procedure is initiated.

A. ***Compliance Offer Responsibility*:** It is the policy of HCA that the Compliance Officer shall be responsible for investigating, or directing the investigation of, conduct at HCA which may violate applicable state and federal laws, the Code of Conduct, or HCA Policies and Procedures, regardless of reporting mechanism.

B. ***Confidentiality*:** While HCA cannot guarantee confidentiality in every circumstance, it will make every effort to protect the identity of any employee making a report in good faith. Investigations will be conducted to the extent possible, without compromising a thorough investigation of the facts, in a manner which (a) maintains the anonymity of the person reporting non-compliance; (b) protects the rights of those against whom allegations of

noncompliance have been made; and (c) ensures the integrity of the investigation.

C. ***No Retaliation:*** All investigations will be conducted in a fair and impartial manner. HCA does not tolerate retaliation against individuals for reporting issues of potential policy and/or legal violations in good faith.

D. ***Evidence Preservation:*** Reporting employees and witnesses who have information or become aware of ongoing investigations must retain potentially relevant records and provide them upon request. Any person who knowingly destroys potentially relevant records or information will be subject to disciplinary action.

E. ***Coordination:*** The Compliance Officer may conduct the investigation or may designate one or more individuals to be responsible for the investigation of any matter. The Compliance Officer will generally delegate responsibility for investigating non-compliance to departmental managers and supervisors ("Internal Investigators"), except to the extent that a conflict of interest exists. Internal Investigators shall conduct the investigation pursuant to the direction of the Compliance Officer and this Policy and Procedure.

F. ***Outside Investigators:*** The Compliance Officer shall determine, in consultation with legal counsel, whether the investigation should be conducted by counsel under attorney-client privilege and/or by an outside auditing firm.

G. ***Research:*** Internal Investigators, with the assistance of legal counsel and the Compliance Officer, as necessary, will review relevant laws, policies, publications, intermediary communication, or other appropriate "expert" sources to identify the expected standards.

H. ***Review of Billing Records:*** If the initial investigation concludes that improper billing is occurring, or that practices are occurring which are contrary to applicable law, the Compliance Officer should direct the Chief Financial Officer to stop billing related to the problem until such time as the Compliance Officer determines that the offending practices are corrected. The Compliance Officer should cause representative bills or claims submitted to the Medicare/ Medicaid programs to be identified and reviewed to determine the nature, scope, frequency, and duration of the problem, and the potential financial magnitude.

I. ***Investigation.*** An investigator should be a neutral party and have no interest in the outcome of a case. An investigator should determine, by witness interviews and review of other relevant information, who was involved in the alleged incident(s), including potential witnesses, what the alleged incident(s) was and the policies that are potentially implicated, when the alleged incident(s) occurred, why the person reporting the incident(s) believes it is a violation, and what the person complaining would like to see happen. If the investigator finds that a policy violation occurred, the investigator will make recommendations as to any appropriate remedy, such as disciplinary action, including but not limited to termination of employment. The request of any person making a complaint will be considered but will not determine the outcome of any case.

J. ***Interviews and Cooperation:*** Internal Investigators should interview appropriate personnel as necessary to determine the facts and circumstances of reported non-compliance. Employees are expected to fully cooperate with any questions or requests from investigators. Failure to cooperate or provide false or misleading information in a HCA investigation may result in disciplinary action. HCA does not consent to recording any investigatory interviews.

K. ***Union Rights:*** Complaints of non-compliance for which a grievance has been filed pursuant to provisions of a collective bargaining agreement shall be investigated in accordance with the

applicable collective bargaining agreement with the County of Ventura, if any. Interviews of employees and disciplinary actions taken in connection with or because of an investigation shall be conducted in accordance with the rights and procedures set forth in such agreements.

L. ***Investigation Report:*** The Compliance Officer shall prepare, or direct Internal Investigators to prepare, a summary report of the investigation that (1) defines the nature of the issue, (2) summarizes the investigation process, (3) identifies any person who the Compliance Officer believes to have either acted deliberately or with reckless disregard or intentional indifference toward applicable laws, rules and policies, (4) estimates the nature and extent of the resulting overpayment by the government, if any, and (5) describes the corrective action plan.

M. ***Corrective Action Plan:*** Based upon the factual findings of Outside or Internal Investigators, the Compliance Officer, in consultation with legal counsel, will determine: (a) if the alleged conduct deviates from applicable laws, regulations or policies; (b) whether the deviation is a "material deficiency" as defined in the Integrity Agreement; (c) whether an overpayment exists or whether an audit should be conducted to determine the existence of an overpayment; and (d) an appropriate corrective action plan. The Compliance Officer shall oversee and ensure that appropriate corrective action is taken by appropriate departments, including, without limitation, repayment of overpayments, disciplinary action, staff training, development or modification of policies and procedures, follow-up monitoring and auditing to [GM1] ensure the conduct has been corrected.

N. ***Closing an Investigation for Lack of Evidence:*** If the investigation results in conclusions or findings that the complained of conduct is permitted under applicable laws and policies, or that the complained of conduct did not occur as alleged, the investigation will be closed.

O. ***Mandated Reporting:*** The Compliance Officer shall make or direct the making of such reports of the investigation as may be required by law or under internal policies.

REFERENCES

31 U.S.C. § § 3729-3733

42 U.S.C. § 1395nn

42 U.S.C. § 1320a-7b

45 C.F.R. §§ 160.102, 160.103

Policy - 109.054 Compliance Helpline Reporting

Policy - 109.045 Privacy Incident Internal Investigation Policy

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109.063 No Information Blocking Policy

PURPOSE

The purpose of this policy is to support the commitment of the Ventura County Health Care Agency (HCA) to facilitating the timely Access, Exchange and Use of Electronic Health Information (EHI) in compliance with applicable law. HCA will implement this policy in a consistent and non-discriminatory manner.

DEFINITIONS

Access means the ability or means necessary to make electronic health information available for Exchange or Use, or both.

Actor means a health care provider, a health IT developer of certified health IT or a health information network/health information exchange.

Designated Record Set (DRS) means medical records, billing records, or any other group of records maintained by or for a covered health care provider to make decisions about individuals.

Electronic Health Information (EHI) means electronic protected health information contained in a designated record set. It does not include psychotherapy notes or information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding.

Electronic Protected Health Information (ePHI) means individually identifiable health information (as defined by HIPAA) that is transmitted by electronic media or maintained in electronic media.

Exchange means the ability for electronic health information to be transmitted between and among different technologies, systems, platforms, or networks; and is inclusive of all forms of transmission

such as bidirectional and network-based transmission.

HIPAA collectively refers to the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), and their implementing regulations.

Information Blocking a practice that prevents or materially discourages the access, exchange, or use of electronic health information (EHI) when an actor knows, or should know, that these practices are likely to interfere with access, exchange, or use of EHI.

- If conducted by a health care provider, there must also be knowledge that such practice is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of EHI.

Use means the ability for electronic health information, once accessed or exchanged, to be understood and acted upon. "Acted upon" includes the ability to read and write and is also bidirectional.

POLICY

HCA and its workforce members will comply with HCA health information policies and procedures and all applicable law in connection with the access, exchange or use of EHI, including this No Information Blocking Policy and the Information Blocking Rule.

What is the Information Blocking Rule? The information blocking rule prohibits actors - including HCA and its workforce members from engaging in practices (such as acts and omissions) that are likely to interfere with the access, exchange or use of EHI, unless the practice is required by law or covered by a regulatory exception. ***(The information blocking rule does <u>not</u> require HCA to disclose EHI if doing so would violate other applicable law, such as HIPAA or other state or federal privacy laws applicable to HCA.)***

The information blocking rule is intent based therefore actors must have the required knowledge and intent to interfere with access, exchange, or use of EHI for a violation to occur however, facts and circumstances unique to each action will be considered when determining whether a violation has occurred. Workforce members will follow this policy and all relevant procedures when engaging in practices that involve the access, exchange or use of EHI over which HCA has control.

If a practice falls within an exception, it will not violate the information blocking rule. **<u>All of the regulatory conditions must be met in order for an exception to apply.</u>**

EXCEPTIONS

HCA will comply with the CURES Act provided exceptions in developing and performing internal practices with respect to accessing, exchanging, or using EHI and meet the conditions of one or more exceptions to ensure the practice is not considered information blocking. In general, HCA practices will be:

- **Reasonable and necessary:** Reasonable and necessary practices include providing appropriate protections to prevent harm to patients and others and promote the privacy and security of EHI.

- **Address significant risk**: Practices intended to address a "significant risk" and that actors would otherwise avoid engaging in out of concern that such activities could be interpreted as info blocking.
- **Subject to strict conditions**. Practices are subject to strict conditions to ensure they are limited to those that are reasonable and necessary.
- **Documentation.** When an exception is used, the specific facts and circumstances associated with the decision to use an exception will be documented.

A. Not fulfilling requests to access, exchange, or use EHI.

1. Preventing Harm Exception

HCA seeks to protect its patients; therefore, if a request to access, exchange, or use EHI presents an unreasonable risk of harm to a patient or other persons, HCA may interfere with or not fulfill the request in order to prevent or substantially reduce a risk of harm to a person.

As long as the conditions of the Preventing Harm Exception are met then the HCA practice may include the below.

- Declining to share data that is corrupt, inaccurate, or erroneous.
- Declining to share data arising from misidentifying a patient or mismatching a patient's EHI.
- Refraining from a disclosure that would endanger the life or physical safety of a patient or another person. The licensed provider who made the determination must have done so in the context of a current or prior clinician-patient relationship.

Conditions being: there is a reasonable belief that the practice will substantially reduce a risk of harm, the practice is no broader than necessary, the practice is related to the type of risk, type of harm, and implementation basis, and satisfies the condition concerning a patients right to request review of an individualized determination of risk of harm is satisfied.

2. Privacy Exception

HCA will follow its HIPAA policies and related procedures with respect to granting, delaying or denying an individual's (or personal representative's) request to access the individual's EHI, including those circumstances where the HIPAA right to access denial is not viewable or it is not appropriate to treat a person as an individual's personal representative.

HCA will follow its HIPAA use and disclosure policies and related procedures with respect to granting, delaying or denying a third-party's request for access, exchange or use of EHI, including when a legal precondition must be met.

Under the privacy exception, HCA practices will meet the criteria of at least one of the following sub-exceptions.

a. ***Precondition not satisfied***. Legal preconditions will be satisfied before HCA provides access, exchange or use of EHI. Examples of legal preconditions include, but are not limited to authorization, consent, verification of identity and authority.

b. ***Denial of an individual's request for their EHI.*** HCA may deny an individual's request for access

to his or her EHI if fulfilling the request would violate HIPAA policies or the HIPAA privacy rule.

c. ***Respecting an individual's request not to share information.*** HCA may choose not to provide access, exchange or use of an individual's EHI if doing so fulfills the wishes of the individual and would not violate HIPAA policies or the HIPAA privacy rule.

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3. Security Exception

HCA will follow its HIPAA security policies, procedures and security risk analyses and risk management plans with respect to granting, delaying, denying or otherwise interfering with the provision of access, exchange or use of EHI.

In the event HCA's HIPAA security policies and procedures do not sufficiently address a known security risk, HCA will determine on a case-by-case basis and document its security practice based on particularized facts and circumstances surrounding the security risk, including.

- How HCA's practice related to safeguarding the confidentiality, integrity, and availability of EHI;
- Why the security practice was necessary to mitigate the security risk to EHI; and
- That there were no reasonable and appropriate alternatives that would address the security risk and be less likely to interfere with the access, exchange or use of EHI.

HCA will not engage in security practices that have the practical effect of disadvantaging competitors or steering referrals.

4. Infeasibility Exception

If HCA faces legitimate practical challenges that limit its ability to comply with a request for access, exchange or use of EHI, it will regard the request as infeasible so long as certain conditions are met. It may be infeasible for HCA to fulfill a request for access, exchange or use of EHI under one the following circumstances:

- uncontrollable event
- inability to segment data
- third party is seeking modification.
- circumstances exist that prevent the fulfillment of the request.
- the manner exception is exhausted, meaning after offering alternatives the request still cannot be fulfilled.

If HCA makes an infeasibility determination due to any of the circumstances listed above, it will notify the requester of the infeasibility determination in writing — including the reason(s) for the infeasibility determination — **within 10 business days** of the EHI request.

5. Health IT Performance Exception

HCA regularly and routinely maintains its health information technology systems to improve performance. These practices may require systems to be taken offline or become temporarily unavailable. In doing so HCA will comply with the regulatory conditions of the health IT performance exception. At least one of four conditions will be met.

- Maintenance and improvement of health IT (e.g., an EHR upgrade).
- Existing service level agreements
- Practices that prevent harm and comply with Preventing Harm Exceptions.
- Security-related practices that comply with Security Exception.

B. Procedures for fulfilling requests to access, exchange, or use EHI

1. Content and Manner Exception

HCA strives to fulfill requests for Access, Exchange or Use of EHI in the manner requested and in compliance with applicable law. However, HCA may fulfill the request in an alternative manner if the conditions of the Content and Manner Exception are met.

- **Alternative Manner Circumstances.** HCA may responds to an EHI request in an alternative manner if one of the following limited circumstances apply:
    - HCA is technically unable to fulfill the request; or
    - HCA is unable to reach agreeable terms with the requestor.

If HCA is technically unable to fulfill the request in the manner requested or cannot reach agreeable terms with the requestor, HCA will fulfill the request in an alternative manner and without unnecessary delay, unless it is infeasible to do so (see the Infeasibility Exception). The requestor will be notified within **10 business days** of the request if fulfilling the EHI request in the manner requested or in an alternative manner.

If responding in an alternative manner is feasible, HCA will technically fulfill the request using the technical standards listed below in the following order of priority, only proceeding to the next technical standard if technically unable to fulfill the request using the higher priority standard:

- Using technology certified to standard(s) adopted by ONC under the Health IT Certification Program (e.g., via application programming interface (API), direct protocol);
- Using content and transport standards specified by requestor and published by the federal government or a standards development organization accredited by the American National Standards Institute (ANSI); or
- Using an alternative machine-readable format agreed upon with the requestor (e.g., Portable Document Format (PDF), comma-separated value (CSV) files.

HCA may also require the requestor to first agree to licensing terms for the interoperability elements and/or fees in accordance with the Licensing Exception and Fees Exception. If applicable, HCA will begin negotiating any licensing terms within **10 business days** of the request and ***offer a negotiated license within* 30 business days** of the request.

2. Fees Exception

Any fees that HCA charges for the access, exchange or use of EHI including those that result in a reasonable profit margin will be established in compliance with regulatory conditions of the Fees

Exception. The practice of charging fees will meet the basis for fees condition, such as that they are based on the following.

- objective and verifiable criteria uniformly applied;
- are reasonably related to costs of providing access, exchange or use of EHI, and;
- are not based on a practice that facilitates competition.

HCA will not charge any fees that are prohibited by HIPAA or based in any part on the electronic access of an individual's EHI by the individual, their personal representative, or another person or entity designated by the individual. For example, HCA will not charge fees for electronic access if an individual directs it to disclose the individual's EHI to a biomedical research program, a personal health application or a personal health record of the individual's choosing. This exception does not permit or support the sale of EHI.

3. Licensing Exception

HCA may protect the value of its innovations and charge reasonable royalties in order to earn returns on investments it made to develop, maintain and update innovations. HCA's licensing practices will meet the conditions of the Licensing Exception with respect to.

- Negotiating a license condition;
- Begining license negotiations with a requestor within **10 business days** of the request; and
- Negotiating in good faith a license within **30 business days** of the request.

The license will meet all of the following requirements (*as applicable*):

- **Scope of License.** Will provide all rights necessary to enable the access, exchange or use of EHI to achieve the intended access, exchange or use of EHI via the interoperability elements.
- **Royalty. I**f a royalty is charged, the royalty will be reasonable, non-discriminatory and based solely on the independent value of HCA's technology to the licensee's products. A royalty will not be based on any strategic value stemming from HCA's control over essential means of accessing, exchanging, or using EHI. HCA will not charge a royalty for intellectual property if it recovered any development costs that led to the creation of the intellectual property.
- **Non-Discriminatory.** The licensing terms will be based on objective and verifiable criteria that are uniformly applied for all similarly situated classes of persons and requests..
- **Collateral Terms.** HCA will not require the requestor to do any of the following:
    - Execute a non-compete in any product, service, or market;
    - Deal exclusively with the HCA in any product, service, or market;
    - Obtain additional licenses, products, or services that are not related to or can be unbundled from the requested interoperability elements;
    - License, grant, assign, or transfer to the HCA any intellectual property of the licensee; or
    - Pay a fee of any kind unless the Fees Exception is met.

INFORMATION BLOCKING REPORTING

1. Information Blocking Reporting and No Retaliation

Workforce members that reasonably believe HCA or one of its workforce members (including any affiliate, agent or vendor) is violating this No Information Blocking Policy or the information blocking rule must promptly notify HCA Office of Compliance and Privacy or anonymously through the Helpline.

HCA will not retaliate against any workforce member for reporting a suspected or actual violation of this No Information Blocking Policy or the information blocking rule.

2. Investigations

HCA Office of Compliance and Privacy will respond to all allegations of information blocking and, where appropriate, investigate such allegations within a reasonable period of time.

3. Sanctions

HCA may discipline workforce members who violate this No Information Blocking Policy or the information blocking rule in accordance with its sanctions policies and procedures.

REFERENCES

Related Policies

109.054 Compliance Helpline Reporting

Non-Compliance Report Internal Investigation Policy

109.045 Privacy Incident Internal Investigation Policy

109.006 Employee Sanctions for Privacy and Security Violations

109.048 Patient Rights to Access, Inspect and Copy Protected Health Information (Patient Access to Medical Records)

VCHCA's HIPAA Use and Disclosure Policies and related procedures – working to edit this policy/policies

Legal References

42 U.S.C. § 300jj-52

45 C.F.R. Part 171

ONC Cures Act Final Rule (85 Fed. Reg. 25462)

United States Core Data for Interoperability, Version 1 (Feb. 2020)

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109.064 Compliance Committee Charter

PURPOSE

Ventura County Health Care Agency (HCA) has established a Compliance Committee (Committee) to assist in the implementing of HCA's Corporate Compliance Program. The Committee's purpose is to serve as an informational and advisory resource to extend the compliance function throughout the organization.

SCOPE

This policy applies to HCA and its affiliates and all satellite locations

POLICY

An effective compliance program continually allows for the prevention and/or detection of violations involving laws, regulations, policies, procedures, and guidelines. HCA's Compliance Committee shall promote a culture of compliance, ensure the provision of quality patient care and ensure reimbursement for health-related services consistent with applicable standards and regulations. The Compliance Committee shall support the Compliance Officer in fulfilling his/her responsibilities.

STRUCTURE

The Compliance Officer serves as the Committee Chair. The Committee's scope encompasses both operational and administrative functions within HCA's various business units. Membership is comprised of senior executives and includes representatives from key business and administrative areas. Members of the Compliance Committee are appointed by HCA's Director under specifications detailed by the HCA

Compliance Program. The Compliance Officer or Committee members may request that other staff, contractors, legal, or financial advisors participate, as necessary, in meetings or other activities to fulfill the Committee's responsibilities.

FUNCTIONS

The Committee's purpose, accomplished through the fulfillment of duties and responsibilities of each member at the operational level, is an integral part of HCA's commitment to the Compliance Program. Its key functions are as follows:

A. The Committee assists with the analysis of Ventura County's risk areas and oversight of its internal and external audits as well as investigations.

B. The Committee participates in the formulation of policies and procedures designed to address specific risk areas.

C. The Committee assists in detecting and evaluating potential regulatory violations.

D. The Committee supports implementation of corrective actions to prevent unlawful or unethical behavior and to correct such behavior as soon as reasonably possible after discovery.

E. The Committee helps identify workable solutions for compliance issues.

F. The Committee contributes to the promotion of compliance throughout the organization.

G. The Committee monitors compliance training and education, including fraud, waste and abuse topics and members are accountable for those areas under their span of control.

RESPONSIBILITIES

A. Committee members will recognize the necessity for confidentiality of sensitive discussion topics. The Compliance Officer will notate such items on the agenda.

B. Committee members must attend regularly scheduled quarterly meetings as well as ad hoc meetings called by the Compliance Officer. Failure to consistently attend Committee meetings will result in removal from the Committee.

C. Committee members should submit to the Compliance Officer concerns, questions, or discussion topics in advance of meetings for inclusion on the agenda.

D. Committee members should review the agenda and supporting documents in advance of the meetings and be prepared to discuss issues especially those related to their areas of responsibility or expertise.

RECORDS

Agendas, meeting minutes, and meeting attendance rosters, shall be maintained by the Compliance Officer in accordance with recordkeeping and retention policies for compliance program documents.

MEMBERSHIP

Senior level managers representing the financial, clinical, legal, internal audit, human resources, and administrative dimensions of HCA will be appointed by the HCA Director to provide leadership through

the Committee.

All Revision Dates

6/3/2025, 6/23/2024

Approval Signatures

Step Description	Approver	Date
Oversight Committee	Melissa Guevarra: Acting Compliance Officer	Pending
Compliance & Privacy Office	Melissa Guevarra: Acting Compliance Officer	6/3/2025

Status **Pending** PolicyStat ID **18032016**

VENTURA COUNTY HEALTH CARE AGENCY

Origination	6/23/2024
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Effective	Upon Approval
Last Revised	6/6/2025
Next Review	1 year after approval
Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

HCA.01 CODE OF CONDUCT

MISSION

Provide comprehensive, cost effective, compassionate health care for our diverse community, especially those facing barriers, through an exceptional workforce, education, and forward thinking leadership.

VISION

Setting the standard in health care excellence. Healthy people in healthy communities throughout Ventura County

CODE OF CONDUCT

SERVICE EXPERIENCE

Ventura County Health Care Agency's (HCA) employees and agents shall strive to deliver quality, patient-centered health care services.

- Patients have the right to choose their health care. Patients will be involved in decisions regarding their care to the greatest practical extent possible.
- No person shall be denied care by HCA solely based on race, gender, religion, creed, color, economic status, or source and amount of payment. Further, employees are to be impartial and are not to discriminate in providing service based on race, color, national origin, religion, ancestry, medical condition, gender, sexual orientation, age, marital status, or disability.
- HCA employees and its agents will seek to understand and respect a patient's objectives for

care and shall treat patients in a manner respecting their background, culture, religion, and heritage.

- HCA employees and agents shall treat all patients with dignity, respect, and courteousness.
- Patients have the right to information for informed health care decisions including therapeutic alternatives and risks associated with their care. Patients also have a right to receive information about HCA's policies, procedures, and charges.
- Quality patient care will only be delivered by qualified, competent staff.
- HCA will maintain an accurate medical record for each patient that is promptly completed, accessible, and retained.

BUSINESS PRACTICES

HCA employees and agents shall comply with all applicable laws and regulations.

- HCA, by and through its employees and agents, shall comply with all applicable laws, regulations, standards, and other requirements including those of Federal and State health care programs.
- Employees or agents who perform billing and/or coding of claims must take reasonable precautions to ensure that their work is accurate, timely, and in compliance with federal and state laws and regulations and policies.
- HCA will bill only for services rendered and which are fully documented in the patient's medical records. If the services are coded, then only billing codes that accurately describe the services provided will be used.
- No claims for payment or reimbursement of any kind that are false, fraudulent, inaccurate, or fictitious will be submitted. No falsification of medical conditions, services, time, or other records that are the basis of claims submission will be tolerated.
- HCA shall act promptly to investigate and correct the problem when errors in claims that have been submitted are discovered.
- All reports or other information required to be provided to any federal, state or local government agency shall be accurate, complete, and timely filed, including the reporting of overpayment's related to the Medicare and Medi-Cal Programs.
- HCA shall maintain a complete and thorough medical and billing record and ensure they are retained according to regulatory requirements and organizational policy.
- HCA will seek positive relationships with government programs and third-party payers including ongoing communication about patient progress and billing.
- No employee or agent is authorized to enter any joint venture, partnership or other risk sharing arrangement with any entity that is a potential or actual referral source unless the arrangement has been reviewed and approved by County Counsel and the Board of Supervisors.

BUSINESS RELATIONSHIPS

HCA employees and agents shall engage in ethical business relationships including maintaining confidentiality.

- Employees and agents must perform their duties in a way that promotes the publics trust in HCA.
- The Federal government prohibits payment for services provided by an individual or entity that the government has excluded from participating in a Federally funded health care program. HCA will not knowingly employ, conduct business with or contract with excluded providers.
- HCA employees and agents shall comply with all laws governing the confidentiality of medical information.
- Employees or agents shall not use or reveal any confidential information obtained as an employee or agent of HCA concerning HCA or its patients.
- HCA, in accordance with Title 22, Section 70707 of the California Code of Regulations, believes that the patient has the right to full consideration of privacy concerning their health care.
- No employee or agent should subordinate his or her professional standards, or objectivity to any individual. If significant differences of opinion in professional judgment occur, then they should be referred to management for resolution.
- Employees and agents should be honest and forthright in any representations made to patients, vendors, payers, other employees or agents, and the community.
- Each employee or agent has an obligation to the citizens, to the people's elected representatives, to fellow employees, and to the County's administration, to accomplish its goals, to expose corruption wherever discovered, to refrain from disclosure of any confidential information, to preserve and safeguard the County's assets, and to uphold these principles, ever conscious that public office is a public trust.

CONFLICTS OF INTEREST

Employees and agents must avoid situations in which their interests' conflict with the duty to act in HCA's best interest.

- Employees and agents should report any potential conflicts of interest concerning themselves or their family members to HCA in accordance with the Conflict-of-Interest Code.
- Employees and agents should avoid any activity that conflicts with the interests of HCA or its patients. Even the appearance of an impropriety should be avoided. If an employee or agent suspects that a conflict may exist or be created, then he or she should consult with management.
- Employees and agents should not have other jobs that interfere with their ability to perform their duties at HCA.
- Employees and agents should not become involved, directly, or indirectly, in outside commercial activities that could improperly influence their actions or otherwise conflict with the Conflict-of-Interest Code without first disclosing that relationship to management.
- Conducting business with any firm in which there is a family relationship may constitute a conflict of interest. Advance disclosure and approval may be required as set forth in Ventura's Conflict of Interest Code for the Health Care Agency (Conflict of Interest Code).
- Employees and agents should not accept or provide benefits that could be seen as creating conflict between their personal interests and legitimate business interests. This includes accepting expensive meals, gifts, refreshments, transportation, or entertainment in connection

with the job.

- No employee shall accept any fee, compensation, payment of expense, or any other item of monetary value in which acceptance may result in, or create the appearance of resulting in, the use of public office for private gain; preferential treatment of any person, impeding governmental efficiency or economy; any loss of complete independence or impartiality; the making of a County decision outside official channels; or any adverse effect on the confidence of the public in the integrity of County government.
- Gifts and benefits to clinicians or referral sources are not appropriate.

PROTECTION AND USE OF INFORMATION, PROPERTY AND ASSETS

HCA employees and agents shall protect County's property and respect the property rights of others.

- HCA will not pursue any business opportunity that requires engaging in unethical or illegal activity.
- Employees and agents must obtain authorization prior to committing or spending HCA's funds.
- Employees and agents are personally responsible and accountable for the proper expenditure of HCA funds and for the proper use of its property.
- Employees and agents may not use either HCA or patient resources for personal or improper purposes or permit others to do so.
- HCA equipment is intended to be used only for HCA or County business.
- Use of electronic assets is for business. Employees and agents may only use computer systems and networks, in a manner consistent with HCA's policies and shall take reasonable steps to protect systems and software from unauthorized access or intrusion. Misuse will result in disciplinary action in accordance with HCA policy.
- Surplus, obsolete, or junked property shall be disposed of in accordance with HCA's and County's procedures. Unauthorized disposal is a misuse of assets.
- Employees and agents have a duty to be productive during work time.
- Any improper financial gain through misconduct involving misuse of either HCA's or a patient's property is prohibited, including the theft of property or of money.
- HCA's confidential and proprietary information is valuable and should be protected from unauthorized use or exploitation. Employees and agents are also expected to respect the intellectual property rights of others with whom HCA does business.
- Employees and agents are expected to report any observed misuse of property to their supervisor or through the Compliance Helpline established for reporting concerns, including anonymously.
- Reasonable meal expenditures or entertainment must comply with the County Reimbursement Policy.

HUMAN RESOURCES

HCA employees and agents shall respect each other as human beings and health care professionals.

- Applicants and employees shall be afforded equal employment and advancement opportunities, pursuant to policies.
- Employees and agents are expected to conform to the standards of their respective professions and exercise sound judgment in the performance of their duties. Any differences of opinion in professional judgment should be referred to appropriate management levels for resolution in accordance with standard grievance procedures.
- All employees and agents shall show proper respect and consideration for each other, regardless of position. Discriminatory treatment, harassment, abuse, or intimidation will not be tolerated. Unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature are serious violations of the standards of conduct and will not be condoned or permitted.
- Employees will be provided with reasonable accommodation, as outlined by the provisions of the Americans with Disabilities Act of 1990 (ADA) and/ or California Fair Employment and Housing Act (FEHA). As an employer, we are responsible for providing reasonable accommodations to the known physical or mental impairments of a qualified individual with a disability, unless to do so would impose an undue hardship on the operation of County business.
- HCA will contribute to an employee's or agent's competence by making available continuing job-related education and training (within the limits of its resources).
- HCA will not permit any action of retaliation or reprisal against an employee who reports a violation of law, policy, or procedure.

HEALTH AND SAFETY

Our highest priority is the health and safety of our patients and ourselves. We shall strive to do our jobs so that no harm is caused to our patients, the public, or ourselves.

- Employees and agents are expected to comply with all work and safety rules.
- HCA shall only employ or work with persons with proper credentials, experience, and expertise.
- HCA is a drug and alcohol-free workplace.
- Smoking is not permitted near any entrance to any HCA buildings or vehicles.
- Drugs, including controlled substances and other pharmaceuticals shall be safely stored, secured, dispensed, and inventoried in conformance with all applicable laws and regulations. Shortages and missing items shall be reported promptly to supervisors.
- Medical and/or County waste or other hazardous materials shall be disposed of properly and lawfully.

REPORTING CONCERNS

Employees and agents shall promptly report all suspected violations of the Code of Conduct, Compliance Guidelines, operational policies, laws, or regulations to their manager or supervisor, through the confidential Compliance Helpline or to the Compliance Officer. You are protected from retaliation if you make a good-faith report.

- One option is to speak with your supervisor or another manager. If you are not comfortable speaking with him/her, or you believe the matter has not been adequately resolved, you should contact the Compliance Officer.
- If you want to anonymously report a concern online at **vchca.ethicspoint.com** or confidentially report at **833-823-6631**. This number is available 24 hours a day, seven days a week. Reports will be forwarded to the Compliance Department for investigation and resolution. You may remain anonymous if you choose, however if you identify yourself, it may assist in the investigation of the matter.
- Retaliation against any employee who, in good faith, reports potential or suspected violations is unlawful and will not be tolerated.

ATTESTATION OF COMPLIANCE

I agree to comply with the Code of Conduct. I represent that I am in complete compliance with the requirements of the Code of Conduct as it applies to my job responsibilities.

I also represent and warrant that I have not been excluded from, or sanctioned by, any Federal health care benefits program, including but not limited to Medicare, Medi- Cal, CHAMPUS or the federal retired railway workers benefit program.

Signature _____ **Date** _____

References

Conflict of Interest - Code found at www.ventura.org/county-executive-office/clerk-of-the-board

Conflict of Interest - Code Health Care Agency found at vcportal.ventura.org/CEO/COB

All Revision Dates

6/6/2025, 6/23/2024

Approval Signatures

Step Description	Approver	Date
Oversight Committee	Melissa Guevarra: Acting Compliance Officer	Pending
Compliance & Privacy Office	Melissa Guevarra: Acting Compliance Officer	6/6/2025

Status Pending PolicyStat ID 18275972

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Next Review	1 year after approval
Owner	Melissa Guevarra: Acting Compliance Officer
Policy Area	Administrative - Compliance

HCA.02 Compliance Program

HEALTH CARE AGENCY COMPLIANCE PROGRAM

Purpose and Overview

Ventura County, its Oversight Committee, and its Health Care Agency (HCA) are committed to quality and efficient patient care; high standards of ethical, professional, and business conduct; and full compliance with all applicable federal and state laws in the delivery or payment of health care. The purpose of this Compliance Program and its component policies and procedures is to establish a structure to facilitate and maintain this commitment through the prevention, detection and resolution of conduct that does not conform to HCA's standards and policies, applicable law, and health care program or payor requirements.

The Compliance Program applies to all personnel, including but not limited to its Oversight Committee, administration, physicians and other practitioners, employees, volunteers, and other entities providing services on behalf of HCA.

The Compliance Program includes the following elements:

1. Written standards, policies and procedures which promote HCA's commitment to compliance with applicable laws and regulations.
2. The designation of a Compliance Officer and Compliance Committee charged with the responsibility of implementing and monitoring the Compliance Program.

3. Regular, effective education and training programs for all affected personnel as appropriate to their functions.
4. A process to receive complaints concerning possible Compliance Program violations, procedures to protect the anonymity of complainants to the extent possible, and policies that protect complainants from retaliation.
5. A process to respond to allegations of improper activities and the enforcement of appropriate disciplinary action against personnel who have violated policies, laws, regulations, or health care program requirements.
6. Periodic audits or other methods to monitor compliance and assist in the reduction of problems in any identified areas.
7. A process for investigating and resolving any identified problems.

As demonstrated by the signatures below, the Compliance Program is enacted at the direction and with the support of the Oversight Committee.

APPROVED BY:

Chairman, Oversight Committee
Date

HCA Director
Date

Compliance Officer
Date

Introduction

Ventura County Health Care Agency (HCA), its affiliates and all satellite locations are committed to conducting business in accordance with its Mission, Vision, and Values. In compliance with its established Code of Conduct and other policies, HCA requires the exercise of high ethical standards in its business and clinical decision making. In addition, as a non-profit tax-exempt county entity, HCA is fully committed to serving and promoting the health of its community.

As a healthcare provider accepting Federal and State health care program funds, HCA is required to establish a compliance program to prevent, detect and correct any instances of fraud, waste, and abuse. Ventura County's Board of Supervisors, therefore, has directed that HCA undertake an integrity program to demonstrate its commitment to high standards of conduct, honesty, and reliability. This integrity program is referred to as the HCA Compliance Program (Program). The Program is largely based on Health and Human Services Office of Inspector General's compliance guidance, United States Sentencing Guidelines, applicable California laws, and continuing guidance received from regulatory agencies.

The Program undertakes a significant and coordinated effort to create system-wide awareness of the importance of preventing, detecting, and correcting fraud, waste, or abuse at HCA. As such, the Program develops appropriate processes, policies, and procedures to help ensure operations are in conformance with Federal and State laws and regulations. In addition, the Program, through regular education and training, promotes an understanding of and adherence to these regulations.

The Program's intent is to create a comprehensive framework to prevent, detect and correct violations of the law by its employees, medical staff, clinical affiliates, volunteers, and other individuals who are representatives or agents of HCA. The Program is intended to support both individual and service specific compliance efforts and applies to all personnel and functions related to the acceptance of Federal and State health care funding. Detailed training, manuals or other materials covering compliance in specific areas will be separately developed and will fit within this framework.

Accountability

Accountability begins with the County Board of Supervisors (Board). The Board has designated an Oversight Committee that is responsible for the review and oversight of matters related to compliance with Federal health care program requirements. The Oversight Committee (Committee) includes independent members as well as HCA executives that serve as staff to the Committee. The Committee is responsible for review and oversight of HCA Compliance Program including the performance of its Compliance Officer and Compliance Committee.

While the workforce has a duty to ensure that the integrity and accountability of HCA is preserved, higher expectations are placed on leaders. The Ventura County Board of Supervisors maintains the ultimate responsibility and accountability for HCA's Compliance Program. Administration, both at the Health Care Agency level and at the County level, are charged with supporting the Board of Supervisors in carrying out its oversight for HCA's Compliance Program. The Administrations will ensure that financial and other operational transactions are open for review and fully transparent. They, along with the Compliance Office, will ensure that best practices are put into place and monitored for compliance to ensure that they continually confront the issues of privacy, fraud, waste, and abuse.

I. Structure - Compliance Officer and Compliance Committee

Compliance Officer

HCA has a Compliance Officer who serves as the leader for day-to-day activities of this Compliance Program. The Compliance Officer occupies a high-level position within HCA and has the authority to carry out the compliance responsibilities described in this Compliance Program.

The Compliance Officer is responsible for fully implementing the Compliance Program to maintain HCA's conformance to the Code of Conduct and all Federal and State health care requirements. Any noncompliance job responsibilities of the Compliance Officer are limited and will not interfere with the ability to perform the duties required under the Compliance Program.

The Compliance Officer will provide periodic reports to the Compliance and Oversight Committees about the functioning of the Compliance Program.

Responsibilities of the Compliance Officer

The Compliance Officer's responsibilities include the following:

- Overseeing and monitoring the implementation and maintenance of the Compliance Program.
- Reporting to the Oversight Committee (no less than annually) on the progress of implementation and operation of the Compliance Program and assisting the Oversight Committee in establishing methods to reduce the HCA's risk of fraud, abuse, and waste.
- Periodically revising the Compliance Program considering changes in the needs of HCA's operations and changes in applicable statutes, regulations, and government policies.
- Reviewing at least annually the implementation and execution of the elements of this Compliance Program. The review includes an assessment of each of the basic elements individually and the overall success of the program. This will include review of the Compliance Department against its established goals and objectives as well as industry standards.
- Developing, coordinating, and participating in educational and training programs that focus on elements of the Compliance Program with the goal of ensuring that personnel are knowledgeable about, and act in accordance with the Compliance Program and all pertinent federal and state requirements.
- Ensuring that independent contractors and agents are aware of the requirements of the HCA Compliance Program.
- Ensuring that HCA does not contract with any individual who has been convicted of a criminal offense related to health care within the previous five years, or who is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in Medicare, Medicaid (Medi-Cal), or any other Federal or State health care program.
- Coordinating internal compliance review and monitoring activities.
- Investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.
- Maintaining a good working relationship with other key operational areas, such as human resources, revenue cycle and clinical departments.
- Designating those individuals that are needed to carry out specific assignments, such as investigating or evaluating a proposed enhancement to the Compliance Program.

The Compliance Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, and arrangements with third parties, including independent contractors, suppliers, agents, and physicians.

The Compliance Officer reports to Ventura County's Chief Executive. The Compliance Officer has direct access to the Oversight Committee, Executive Officer, and other senior management, and to legal counsel, when necessary.

Compliance Committee

HCA has established a Compliance Committee to advise the Compliance Officer and assist in monitoring this Compliance Program. The Compliance Committee provides the perspectives of individuals with diverse knowledge and responsibilities within the HCA. The Compliance Committee consists of representatives including those from the areas designated below and other members, including representatives of senior management, chosen by the Health Care Agency Director in consultation with the Compliance Officer.

The Compliance Officer serves as the chairperson of the Compliance Committee. The Compliance Committee will meet at least quarterly. The Compliance Officer will also consult with members of the Compliance Committee on an interim basis, as necessary. The Compliance Committee serves in an advisory role and its functions include the following:

- Assessing existing and proposed compliance policies for modification or incorporation into the Compliance Program.
- Working with the Compliance Officer to develop further standards of conduct and policies to promote compliance.
- Recommending and monitoring, in conjunction with the Compliance Officer, the development of internal systems and controls to carry out the standards and policies of this Compliance Program.
- Reviewing and proposing strategies to promote compliance and detection of potential violations.
- Assisting the Compliance Officer in the development and ongoing monitoring of systems to solicit, evaluate and respond to complaints and problems related to compliance.
- Assisting the Compliance Officer in coordinating compliance training, education and other compliance related activities in the departments and business units in which the members of the Compliance Committee work.
- Consulting with vendors on a periodic basis to promote adherence to this Compliance Program as it applies to those vendors and to promote their development of formal Compliance Programs.

II. Structure - Written Standards

All of HCA's business affairs must be conducted in accordance with Federal, State, and local laws, professional standards, and with honesty, fairness, and integrity. It is expected that the workforce will perform their duties in good faith, in a manner that he/she reasonably believes to be in the best interest of HCA and its patients, and with the same care that a reasonably prudent person in the same position would use. To further these overall goals, policies and standards have been adopted by HCA. These standards include, but are not limited to, the HCA's Code of Conduct, Ventura County's Employee Handbook, Ventura County Medical Center's Medical Staff Rules, and Regulations as well as other compliance policies and procedures.

These standards are not intended to cover every situation that may be encountered, and individuals

should comply with all applicable laws and regulations regardless of whether they are specifically addressed. Questions about the existence, interpretation or application of any law, regulation, policy, or standard should be directed to an employee's chain of command or directly to the Compliance Officer. Policies, procedures, and standards are reviewed, revised, and updated as needed, but no less than annually to reflect changes in the regulatory environment. Any revisions communicated in a timely manner through administrative notification.

III. Structure - Education and Training

HCA acknowledges that this Compliance Program will be effective only if it is communicated on a routine basis and in a manner that clearly details its requirements. As a result, HCA requires all personnel to attend training programs. Training programs include, as appropriate, training in Federal and State statutes, regulations, guidelines, and HCA's Code of Conduct.

Training programs include sessions that highlight this Program, summaries of fraud and abuse laws, claims development and submission processes, and related business practices upon which regulatory standards are imposed. This training will be developed and conducted by qualified personnel and formal training, undertaken as part of the Compliance Program, is documented. Documentation includes the identification of the personnel participating in the training, the subject matter of the training, the length of the training, the time and date of the training, the training materials used, and any other relevant information. New employees are trained upon hire.

The Compliance Officer evaluates the content of the training program at least annually to ensure that the subject content is appropriate and sufficient to cover the range of issues confronting HCA. The training program is modified as necessary to keep up to date with any changes in federal and state health care program requirements, and to address results of the HCA's audits and investigations; trends in compliance matter reports; and guidance from applicable Federal and State agencies. The appropriateness of the training format is evaluated by reviewing the length of the training sessions; whether training is delivered via live instructors or via computer-based training programs; the frequency of training sessions; and the need for general and specific training sessions. Post-training tests, as appropriate, are used to ensure attendees understand and retain the subject matter.

Targeted training and education is provided to individuals whose work may affect the accuracy of claims submitted to payers. This targeted training includes not only the billing and coding workforce, but also physicians and providers whose documentation of services are used as a basis for payment from Federal and State health care programs. This may include training on ordering of services, medical necessity, coding, documentation, Diagnostic Related Groups (DRGs) and such other information as might be reasonable and useful to enable HCA to comply with applicable laws and claim regulations.

Adherence with the provisions of this Compliance Program, including training requirements, is a factor in the annual evaluation of each employee. Where feasible, outside contractors will be afforded the opportunity to participate in, or be encouraged to develop their own, compliance training and educational programs, to complement the HCA's standards of conduct and compliance policies.

The Compliance Officer will ensure that records of compliance training, including attendance logs and

copies of materials distributed at training sessions, are maintained according to HCA's retention policy. Attendance and participation in compliance training programs is a condition of continued employment. Failure to comply with training requirements will result in disciplinary action, including possible termination.

The members of the HCA's Oversight Committee will be provided with periodic training, not less than annually, on governance responsibilities and specifically with respect to their responsibility to review and provide oversight of the compliance program. The training shall address the unique responsibilities of health care including the risks, oversight areas, and strategic approaches to conducting oversight of health care entities. This training may be conducted by an outside compliance expert and will include a discussion of the OIG's guidance on the Oversight Committee's member responsibilities.

IV. Structure - Auditing and Monitoring

HCA complies with all relevant Federal and State rules and regulations to self-assess and to self-identify any matters that, in HCA's reasonable assessment could potentially violate Federal and State criminal, civil or administrative laws and/or indicate internal billing patterns or operational issues that might affect HCA's right to Medicare or Medi-Cal reimbursement.

The Compliance Officer develops and implements a compliance work plan. The work plan specifies the number, service areas and functions to be audited. The plan will be reviewed and updated no less than annually to confirm that it addresses the proper areas of concern. Areas of emphasis from regulators, findings from previous years' audits, areas previously identified as part of the annual risk assessment, and high-volume or new services are considered in the development of the work plan. These periodic audits are used to confirm compliance and address, at a minimum, regulations governing kickback arrangements, physician self-referrals, claims development and submission and reimbursement. HCA will report and refund any overpayments to Medicare and Medi-Cal within the statutory required mandates determined through the audit process.

HCA, under the direction of the Compliance Office, conducts periodic tests of claims submitted to Medicare, Medi-Cal and other federal health care plans, and reviews the claims development and submission process. These procedures may include reviewing the work of coders, billers; admitting and registration representatives, patient care providers, ancillary departments such as laboratory and diagnostic imaging, and other risk areas identified by the OIG or Medicare Administrative Contractors. Audits also cover HCA's relationship with third party contractors, including physicians, NP's, and PA's that are on the staff of HCA or who provide services for HCA patients and whose services are billed by HCA.

HCA will devote such resources as are reasonably necessary to ensure that audits are adequately funded and performed by persons with appropriate knowledge and experience. These audits are performed by internal or external auditors who have the appropriate qualifications and expertise in federal and state health care health care program requirements. All personnel are expected to cooperate fully with auditors during this process. If any employee has concerns regarding the scope or manner of an audit, the employee should discuss this with his or her immediate supervisor. The

Compliance Office may request that the Director or Manager of each affected area prepare and submit testing and monitoring plans for his or her service area.

Auditors shall have access to all necessary documents including those related to claim development and submission, patient records, e-mail, and the contents of computers. Auditors and reviewers will, always, be held to the strictest standards of confidentiality.

V. Structure - Lines of Communication

HCA recognizes that clear and open lines of communication between the Compliance Officer and the workforce are important to the success of this Compliance Program. HCA maintains an open-door policy for Compliance Program related matters. The workforce is encouraged to seek clarification from the Compliance Officer in the event of questions about a statute, regulation, or policy discussed in this Compliance Program.

HCA has established a telephone helpline to report concerns or possible wrongdoing regarding compliance issues referred to as the Compliance Line. The Compliance Line and the Compliance Officer's phone contacts are posted in conspicuous locations throughout the HCA's facilities.

Calls to the Compliance Helpline are answered by a third-party. All calls are treated confidentially and are not traced. The caller need not provide his or her name. HCA's Compliance Officer or designee investigates all contacts and initiates follow-up actions as appropriate.

Personnel may also submit compliance-related questions or complaints in writing. Letters may be sent anonymously. All such letters should be sent to the Compliance Officer at the following address:

5851 Thille Drive, Suite 102

Ventura, California 93003

Communications via the Compliance Line and other contacts directed to the Compliance Officer are treated as confidential however, it is possible that the identity of a person making a report may become known, or that governmental authorities or a court may compel disclosure of the name of the reporting person.

Matters reported through the Compliance Helpline, or in writing, that suggest violations of compliance policies, statutes, or regulations are documented and investigated promptly. A disclosure log is maintained by the Compliance Officer of calls or communications, including the details of the investigation and subsequent results. A summary of this information is included in reports by the Compliance Officer to the Compliance Committee, Oversight Committee and Executive Director.

It is the HCA's policy to prohibit retaliatory action against any person for making a report, anonymous or otherwise, regarding a potential compliance. However, the HCA workforce cannot use complaints to the Compliance Officer to insulate themselves from the consequences of their own wrongdoing or misconduct. False or deceptive reports may be grounds for termination. It will be considered a mitigating factor if a person makes a forthright disclosure of an error or violation of this Compliance Program, or the governing statutes and regulations.

VI. Structure - Detecting Offenses and Corrective Actions

Violations of HCA's Compliance Program, failure to comply with applicable Federal or State laws, and other types of misconduct can threaten the HCA's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger its business, reputation and can lead to serious sanctions against HCA.

Upon reports of a potential compliance matter involving non-compliance, prompt steps will be taken to investigate the conduct under the direction of the Compliance Officer. The investigation will focus on determining whether a material violation of applicable law or the requirements of the Compliance Program has occurred. Depending upon the nature of the alleged violations, the Compliance Officer's internal investigation might include interviews with relevant persons and review of documents. Legal counsel, auditors or health care experts may be engaged to assist in an investigation where the Compliance Officer deems such assistance is appropriate.

Complete records of all investigations will be maintained which detail the alleged violation, a description of the investigative process. copies of interview notes and key documents, witness log, results of the investigation (e.g., any disciplinary action taken), and corrective actions. If, during the investigation, the Compliance Officer believes its integrity may be at stake because of the employees under investigation, those employees will be removed from their current work activity until the investigation is completed. Where necessary, the Compliance Officer will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

If such a violation has occurred, prompt steps will be taken to correct the problem, with consideration of the root cause of the problem. As appropriate, such steps may include corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or return of any overpayments.

VII. Structure - Enforcement and Discipline

It is the policy of HCA to discipline appropriately and equitably those who fail to comply with the Code of Conduct, or the policies set forth in, or adopted pursuant to, the Compliance Program or any Federal or State statutes or regulations.

HCA may impose sanctions on any member of the workforce who intentionally or unintentionally violates established policies or procedures. Confirmed acts of non-compliance may result in corrective action including the removal of privileges, discharge from employment and, if appropriate, referral for civil and/or criminal prosecution.

Disciplinary action may also be prompted by failure to perform any duty required by the Compliance Program, failure to supervise or manage personnel in a manner to detect non-compliance, and failure to report violations of the Compliance Program. Any instance involving disciplinary action shall be thoroughly documented by the employee's supervisor, Human Resources, and the Compliance Officer.

All Revision Dates

6/2/2025, 8/7/2024

Approval Signatures

Step Description	Approver	Date
Oversight Committee	Melissa Guevarra: Acting Compliance Officer	Pending
Compliance & Privacy Office	Melissa Guevarra: Acting Compliance Officer	6/2/2025