SONOMA VALLEY HEALTH CARE DISTRICT

BOARD OF DIRECTORS

AGENDA

THURSDAY, SEPTEMBER 5, 2024

REGULAR SESSION 6:00 P.M.

Held in Person at
Council Chambers
177 First Street West, Sonoma
and via Zoom Videoconferencing

To participate via Zoom videoconferencing, use the link below:
https://sonomavalleyhospital-org.zoom.us/j/98359610569

Meeting ID: 983 5961 0569

One tap mobile
+16699009128,,98359610569#
+12133388477,,98359610569#

In compliance with the Americans Disabilities Act, if you require special accommodations to participate in a District meeting, please contact Whitney Reese, Board Clerk at wreese@sonomavalleyhospital.org at least 48 hours prior to the meeting.	**RECOMMENDATION**		
AGENDA ITEM			
MISSION STATEMENT *The mission of SVHCD is to maintain, improve, and restore the health of everyone in our community.*			
1. CALL TO ORDER	*Judith Bjorndal, MD*		
2. PUBLIC COMMENT *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration.*			
3. BOARD CHAIR COMMENTS	*Judith Bjorndal, MD*		
4. CONSENT CALENDAR a. BOD Minutes – 08.01.24 b. Finance Committee Minutes – 07.23.24 c. Quality Committee Minutes – 06.26.24 d. Audit Committee Minutes – 03.19.24 e. Medical Staff Credentialing f. Policies and Procedures	*Judith Bjorndal, MD*	Action	Pages a. 3 - 4 b. 5 - 6 c. 7 - 9 d. 10 f. 11 - 66

5. RESOLUTION 375 - ELECTION FOR OPEN BOARD POSITIONS IN CONSOLIDATION WITH DISTRICT ELECTION 2024	*Judith Bjorndal, MD*	Action	Pages 67 - 69
6. CHIEF OF STAFF REPORT	*Dr. Ako Walther*	Inform	Pages 70 - 82
7. SEISMIC UPDATE: Hospital Council – Northern and Central California	*Meghan Hardin, Regional Vice President* *Bryan Bucklew, President & CEO*	Inform	
8. ANCILLARY SERVICES ANNUAL REPORT	*Dawn Kuwahara, RN BSN*	Inform	Pages 83 - 94
9. ICU PROJECT BID and BUDGET	*Kimberly Drummond*	Action	Pages 95 - 106
10. CEO REPORT	*John Hennelly*	Inform	Pages 107 - 110
11. CMO UPDATE	*Sabrina Kidd, MD*	Inform	Page 111
12. RESOLUTION 376 - SETTING TAX RATE FOR FY24-25 GO BONDS	*Ben Armfield*	Action	Pages 112 - 115
13. BANK RELATIONSHIP UPDATE • New Relationship Update • US Bank LOC Extension	*Ben Armfield*	Action	Pages 116 - 127
14. FINANCIALS FOR MONTH END JULY 2024	*Ben Armfield*	Inform	Pages 128 - 141
15. REACTIVATING THE JOINT CONFERENCE COMMITTEE AND ENGAGEMENT WITH THE MEDICAL EXECUTIVE COMMITTEE	*Bill Boerum*	Action	Pages 142 - 144
16. COMMITTEE UPDATES a. Committee Charters b. Audit Committee update	*a. Susan Kornblatt Idell* *b. Bill Boerum*	a. Action b. Inform	Pages a. 145 - 158
17. BOARD COMMENTS	*Judith Bjorndal, MD*	Inform	
18. ADJOURN	*Judith Bjorndal, MD*	Inform	

Note: To view this meeting, you may visit http://sonomatv.org/ or YouTube.com.

SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS' REGULAR MEETING

MINUTES

THURSDAY, AUGUST 1, 2024

HELD IN PERSON AT 177 FIRST STREET WEST, SONOMA,
AND VIA ZOOM TELECONFERENCE

	RECOMMENDATION	
SONOMA VALLEY HOSPITAL BOARD MEMBERS 1. Judith Bjorndal, MD, Chair, Present 2. Susan Kornblatt Idell, Secretary, Present 3. Denise M. Kalos, Second Vice Chair, excused 4. Bill Boerum, Treasurer, Present 5. Wendy Lee Myatt, First Vice Chair, via zoom		
MISSION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*		
1. CALL TO ORDER	*Bjorndal*	
Meeting called to order at 6:00 p.m.		
2. PUBLIC COMMENT		
None		
3. BOARD CHAIR COMMENTS	*Bjorndal*	
4. CONSENT CALENDAR	*Bjorndal*	Action
a. BOD Minutes – 07.11.24 b. Joint BOD & Finance Committee Minutes – 05.28.24 c. Finance Committee Minutes – 05.28.24 d. Medical Staff Credentialing		**MOTION:** by Boerum to approve, 2nd by Myatt Lee. All in favor.
~~**5. SEISMIC UPDATE**~~		Inform
Rescheduled for next month		
6. CEO ASSESSMENT AND COMPENSATION	*Bjorndal*	Inform
7. UCSF AFFILIATION	*John Hennelly*	Inform
Hennelly provided an update on the affiliation between SVH and UCSF, focusing on physician recruitment and clinical coordination. One challenge that they face is finding suitable space to host UCSF physicians. The affiliation agreement is nearing expiration, giving opportunity for revisions.		
8. CEO REPORT	*John Hennelly*	Inform
Hennelly reiterated the recognitions that SVH continues to get regarding its performance across various categories nationally, including equity, inclusion, and patient satisfaction. The temporary MRI project is completed and awaiting final licensing.		

Investigative work and legislative developments continue regarding seismic compliance, with potential regulatory changes in progress. Business plans are being developed for GI, cardiology, orthopedics, and UCSF clinical services.		
9. BANKING PROPOSALS	*Ben Armfield*	Action
Armfield presented SVH's recommendation to partner with Summit State Bank due to several factors outlined in detail in the report. While Summit's offer has higher initial costs, the benefits outweigh this drawback. The Finance Committee supports this recommendation, contingent on a request for a three-year term. Hennelly confirmed with Board for approval: Armfield is authorized to enter into Summit State Bank's agreement if it is three years or beyond or if US Bank or another bank comes back with a better offer, he is authorized to go into that agreement as outlined.	**MOTION:** by Boerum to approve SVH management to continue moving forward in negotiations with Summit State Bank to request a three-year term, 2nd by Kornblatt Idell. All in favor.	
10. FINANCIALS FOR MONTH END JUNE 2024	*Ben Armfield*	Inform
Armfield presented June's financials. Revenue continues to be behind budget due to reduced volumes from Dr. Brown's departure, however there is still optimism – high volume in ER and fourth month in a row where operating expenses were under budget. Next fiscal year looks promising with Dr. Walter coming on board and IGT funds approved to be doubled (additional $3 million incremental income). Revenue generation was highlighted as priority.		
11. COMMITTEE UPDATES	*Bjorndal*	Inform/Action

• **Finance Committee Quarterly Update**
• **Governance report**
  o **Gift, Ticket, and Honoraria Policy**
  o **Committee Charters**
	Boerum
	Kornblatt Idell
		MOTION: by Kornblatt Idell to approve Gift, Ticket, and Honoraria Policy, second by Boerum. All in favor.

12. BOARD COMMENTS	*Board Members*	Inform
13. ADJOURN	*Bjorndal*	
Adjourned at 7:09 p.m.		

SVHCD
FINANCE COMMITTEE MEETING

MINUTES

TUESDAY, JULY 23, 2024
In Person at Sonoma Valley Hospital
347 Andrieux Street
and Via Zoom Teleconference

Present	Not Present/Excused	Staff/Public
Bill Boerum, in person Wendy Myatt Lee, in person Dennis Bloch, in person Ed Case, in person Catherine Donahue, via zoom Robert Crane, in person Carl Gerlach, in person	Graham Smith Subhash Mishra, MD	Ben Armfield, SVH CFO, in person John Hennelly, SVH CEO, in person Dave Pier, ED of SVH Foundation, via zoom Dan Kittleson, in person Whitney Reese, SVH Board Clerk, in person Dawn Kuwahara, RN BSN, SVH Chief Ancillary Officer, in person

MISSION & VISION STATEMENT
The mission of SVHCD is to maintain, improve, and restore the health of everyone in our community.

AGENDA ITEM	DISCUSSION	ACTIONS
1. CALL TO ORDER/ANNOUNCEMENTS	*Bill Boerum*	
	Committee members excused absent: Subhash Mishra	Meeting called to order 6:00pm
2. PUBLIC COMMENT SECTION	None	
3. CONSENT CALENDAR	*Bill Boerum*	Action
a. BOD & Finance Committee Joint Minutes 05.28.24 b. Finance Committee Minutes 05.28.24	a. Motion to approve by Bloch, 2nd by Crane b. Motion to approve by Bloch, 2nd by Myatt Lee	**MOTION:** Both minutes approved. All in favor
4. BANK PROPOSALS	*Ben Armfield*	Action
	Armfield presented two banking proposals, Summit Bank and Poppy Bank, detailing the pros and cons. The committee discussed challenges faced with several banks, including Wells Fargo and Exchange Bank, that declined involvement due to the hospital's fragile financial situation and the complexities of healthcare as an industry. The discussion also covered the difficulty in securing collateral, with concerns about the enforceability of a lien and the legal counsel's hesitancy to provide a definitive opinion on it. Summit's offer includes a one-year line of credit, with fees significantly influenced by a third-party guarantee program, while Poppy offers a five-	**MOTION:** recommend to the BOD to agree to Summit's terms with a counter offer for a 5 year agreement (will accept 3 year+) by Bloch to approve, 2nd by Case. All in favor

	year line of credit secured by hospital property. The committee expressed concerns about the risks associated with Summit's one-year term and debated the merits of each option, including the potential need for further discussions with U.S. Bank and legal counsel to ensure the best outcome.	
5. FINANCIAL REPORTS FOR MONTH END MAY & JUNE 2024	*Ben Armfield*	Inform
	Armfield presented Financial Reports for month end for May & June. Discussion highlighted concerns about the hospital's negative operating margin and the challenges of sustaining financial stability. Recent successes included receiving additional funds through the IGT (Intergovernmental Transfer) program. Rate Range IGT Resetting was presented.	
6. ADJOURN	*Bill Boerum*	Meeting adjourned at 7:02pm

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
Wednesday, June 26, 2024, 5:00 PM
MINUTES
Via Zoom Teleconference

Members Present – In Person	Excused/Not Present	Public/Staff – Via Zoom
Susan Kornblatt Idell Howard Eisenstark, MD Michael Mainardi, MD Judy Bjorndal, MD, via zoom	Carl Speizer, MD (excused) Kathy Beebe, RN PhD Carol Snyder Denise Kalos Paul Amara, MD, FACOG	Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, CNO Whitney Reese, Board Clerk Sabrina Kidd, MD, FACS, FASCRS, CPE, CMO & Colorectal Surgeon, via zoom Alfred Lugo, CLS, Lab Technical Supervisor Nicolaos Hadjiyianni, Laboratory Manager Dan Kittleson

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Kornblatt Idell called meeting to order at 5:01pm. Bjorndal filled in for Kalos as a voting member to achieve a quorum.	
2. PUBLIC COMMENT SECTION	*Kornblatt Idell*	
	No public comments	
3. CONSENT CALENDAR Minutes 05.22.24	*Kornblatt Idell*	ACTION
		Motion to approve Mainardi,

		2nd by Eisenstark
4. LAB QA/PI	*Alfred Lugo* *Nicolaos Hadjiyianni*	INFORM
	Lugo provided an overview of the laboratory's operations, staffing, and challenges. Key points included the current staffing structure, the lab's wide range of services, and ongoing efforts to upgrade outdated analyzers and improve space utilization. He highlighted challenges like staffing difficulties, particularly in attracting full-time employees, and issues with aging equipment. Lugo also discussed recent accomplishments, such as improved communication with the ER and the lab's consistent performance metrics, including low blood contamination rates and effective manual test entries. The presentation emphasized the lab's need for modernization and efficient space management to enhance productivity.	
6. QUALITY INDICATOR PERFORMANCE & PLAN	*Cooper*	INFORM
	Cooper presented data for May 2024: In May, the hospital reported 0% mortality and no adverse events, with excellent performance in patient safety and medication management. While there were some challenges, including a higher-than-target blood culture contamination rate and delays in TNK administration for stroke patients, overall sepsis metrics and infection control were strong. The Emergency Department faced high patient volumes, impacting wait times, but patient satisfaction remained high, particularly in Physical Therapy. Issues were noted with appointment scheduling and communication, especially in imaging, which require further attention.	*Kylie Cooper presented the Quality department's May 2024 data*
7. POLICIES AND PROCEDURES	*Cooper*	INFORM
	Cooper presented to the committee for approval to the Board of Directors: • NEW: Hazardous Drug Handling-USP 800 • NEW: Health Equity-Screening for Social Drivers of Health (SDOH) • NEW: Hypoglycemia Protocols	*Cooper presented to committee.*

8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Kornblatt Idell*	ACTION
		Motion to recommend to Board of Directors for approval Eisenstark, 2nd by Mainardi
9. ADJOURN	*Kornblatt Idell*	
	Meeting adjourned at 5:48 pm	

SVHCD AUDIT COMMITTEE MEETING

MINUTES

TUESDAY, MARCH 19, 2024 4:00 PM
In Person at Sonoma Valley Hospital
347 Andrieux Street
Administration Conference Room
and Via Zoom Teleconference

Present	Excused	Staff	Public
Bill Boerum Dennis Bloch Art Grandy Wendy Lee Myatt		Ben Armfield, CFO Lois Fruzynski, Accounting Manager Whitney Reese, Board Clerk	

AGENDA ITEM	DISCUSSION	ACTIONS
MISSION & VISION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Boerum*	
	Called to order at 4:00 pm.	
2. PUBLIC COMMENT SECTION	*Boerum*	
	None	
3. CONSENT CALENDAR	*Boerum*	
Minutes 01.09.24		**MOTION:** by Bloch to approve, 2nd by Grandy. All in favor.
4. RECOMMEND FIRM FOR EXTERNAL FINANCIAL AUDIT	*Armfield*	
	Armfield presented bids and recommendation from three firms – Moss Adams LLP, Wipfli LLP, and Armanino LLP. Evaluation for the bids involved analyzing the service contracts, focusing on fees, expertise, and value, particularly in the healthcare sector. Moss Adams was recommended and ultimately selected for their strong industry expertise and local presence.	**MOTION:** Accept Armfield's recommendation by Bloch to approve, 2nd by Grandy. All in favor.
5. ADJOURN	*Boerum*	
	Meeting adjourned at 4:23 pm	

Document Tasks By Committee

Listing of currently pending and/or upcoming document tasks grouped by committee.

Sonoma Valley Hospital

Run by: Reese, Whitney (wreese)
Run date: 08/30/2024 8:15 PM

Report Parameters

Filtered by: Document Set: - All Available Document Sets -
Committee: 09 BOD-Board of Directors
Include Current Tasks: Yes
Include Upcoming Tasks: No

Grouped by: Committee

Sorted by: Document Title

Report Statistics

Total Documents: 44

Committee: **09 BOD-Board of Directors**

Committee Members: **Finn, Stacey (sfinn), Newman, Cindi (cnewman), Reese, Whitney (wreese)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Adverse Tissue Reactions *Surgical Services/OR Dept*	**Pending Approval**	8/28/2024	2

Summary Of Changes: **Changed References**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Cornell, Kelli (kcornell)**
ExpertReviewers: **Medical Director-Surgical Services**
Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Allografts and Tissue; Procurement for Surgical Procedures Requiring Grafting *Surgical Services/OR Dept*	**Pending Approval**	8/28/2024	2

Summary Of Changes: **reviewed no changes, References updated**
Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Cornell, Kelli (kcornell)**
ExpertReviewers: **Medical Director-Surgical Services**
Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Aminoglycoside Protocol *Medication Management Policies (MM)*	**Pending Approval**	8/28/2024	2

Summary Of Changes: **Reviewed, no changes**
Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors: **Kutza, Chris (ckutza)**
Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document	Task/Status	Pending Since	Days Pending
Assessment and Admission of OR Patients *Surgical Services/OR Dept*	**Pending Approval**	8/28/2024	2

Summary Of Changes:	**Reviewed, Updated References**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Cornell, Kelli (kcornell)**
ExpertReviewers:	**Medical Director-Surgical Services**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Attire Surgical in the Operating Room — **Pending Approval** — 8/28/2024 — 2

Surgical Services/OR Dept

Summary Of Changes:	**Reviewed, Added line regarding nail polish, "should be freshly applied and free of chips", it was not previously addressed in policy. Updated references.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Cornell, Kelli (kcornell)**
ExpertReviewers:	**IP-Infection Preventionist, Medical Director-Surgical Services**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Autopsy — **Pending Approval** — 8/28/2024 — 2

Medical Staff Policies (MS)

Summary Of Changes:	**No changes.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kidd, Sabrina (skidd)**
ExpertReviewers:	**Taylor, Jane (jtaylor)**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Cardiac Rhythm Monitoring — **Pending Approval** — 8/28/2024 — 2

Patient Care Policy

Summary Of Changes:	**Removed reference to Spacelabs and exchanged for "electronic monitoring system." Clarified that an ED pt with cardiac complaints will have a 12 lead EKG per orders, but also be placed on continuous cardiac monitor. Added that a patient on continuous cardiac monitoring must be accompanied by an RN if going off unit for diagnostic testing unless MD orders otherwise. Added documentation requirements on the actual rhythm strip (which is scanned into medical record) as well as in the EHR. Added updated reference to EBSCO**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Winkler, Jessica (jwinkler)**
ExpertReviewers:	**Medical Director-Patient Care Services**
Approvers:	**00 Clinical P&P multidisciplinary review, 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Care of Patients Under Legal Restriction — **Pending Approval** — 8/28/2024 — 2

Patient Care Policy

Summary Of Changes:	**Reviewed, acronyms fixed. No content changes**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Taylor, Jane (jtaylor)**
ExpertReviewers:	**00 Clinical P&P multidisciplinary review, Medical Director-Patient Care Services**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Clinical Practice Guidelines	**Pending Approval**	8/28/2024	2
Governance and Leadership Policies			

Summary Of Changes: **Reviewed. No changes**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kidd, Sabrina (skidd)**
ExpertReviewers: **Director, QUALITY (QDIR), Kutza, Chris (ckutza), Winkler, Jessica (jwinkler)**
Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

CMS 1135 Waiver for Disaster Conditions	**Pending Approval**	8/6/2024	24
Emergency Preparedness Policies (EP)			

Summary Of Changes: **reviewed - no changes**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Winkler, Jessica (jwinkler), MANAGER, ED (edmanager)**
ExpertReviewers: **Director, QUALITY (QDIR), Kuwahara, Dawn (dkuwahara), Tarca, Joseph (jtarca)**
Approvers: **Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Contact Plus Enteric Isolation Precautions	**Pending Approval**	8/28/2024	2
Infection Prevention & Control Policies (IC)			

Summary Of Changes: **Amended to reflect changes in ordering specimens due to Epic protocols. Removed Paragon ordering instructions. Removed reference to cohorting patients with same infection. When a patient is receiving antibiotics and he/she has a liquid stool, the RN is authorized to immediately obtain a stool specimen and order C. difficile testing per protocol order. Patients who are taking antibiotics at the time of admission and have loose stool will be placed on precautions and tested. Added to purpose statement, reference to CDC and CIHQ. Added to provide ppe and education to visitors.**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Winkler, Jessica (jwinkler), Montecino, Stephanie (smontecino)**
ExpertReviewers: **Director, QUALITY (QDIR)**
Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

CPOE Order Set Management	**Pending Approval**	8/28/2024	2
Medical Staff Dept			

Summary Of Changes: **Revised to include new workflow since Epic Implementation (2023)**
PROCEDURE
Sonoma Valley Hospital utilizes Epic Community Technologies (CT) as the organization's EHR via a contractual agreement with Providence Health.

- **The Providence Health clinical operations and clinical informatics governance groups are the identified owners of order set clinical content review and approval, wherein physicians, nurses, pharmacists, and/or other clinical staff as needed complete the clinical content review of order sets and establish the frequency of such reviews.**
- **Periodic review should occur based on the governance group's recommendation but should not exceed 2 years in frequency. The review will be documented for tracking and to provide evidence of review per survey guidelines.**
- **Testing prior to launch of new or updated order sets is managed by the Providence Health clinical operations and clinical informatics governance groups.**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Kidd, Sabrina (skidd)**
ExpertReviewers: **Kutza, Chris (ckutza), Winkler, Jessica (jwinkler)**

Approvers:	**00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Dispensing of Medication | **Pending Approval** | 8/28/2024 | 2

Medication Management Policies (MM)

Summary Of Changes:	**Reviewed, no changes**
Moderators:	**Kutza, Chris (ckutza), Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Drugs and Alcohol-Free Workplace | **Pending Approval** | 8/6/2024 | 24

Human Resources Policies (HR)

Summary Of Changes:	**Added minor language here and there to provide clarity. Removed language that was in conflict with California Law, ADA, and/or FEHA**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**McKissock, Lynn (lmckissock)**
Approvers:	**Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Fire Safety Management Plan | **Pending Approval** | 8/6/2024 | 24

Care of the Physical Environment (CE)

Summary Of Changes:	**Reviewed policy. No changes.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Tarca, Joseph (jtarca)**
Approvers:	**Drummond, Kimberly (kdrummond) -> Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Handling of Sharps | **Pending Approval** | 8/6/2024 | 24

Materials Management Dept

Summary Of Changes:	**11/20/2023 - 1) Updated Materials Manager to Materials Management Director in Procedure section 3 & 4. 2) Updated notification to e-notification report in Procedure section 4. 3) Add reference to Policy #GL861-144 4) Added Owner, Author/reviewers.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Dugger, James (jdugger)**
Approvers:	**Drummond, Kimberly (kdrummond) -> Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Infection Control Risk Assessment (ICRA) | **Pending Approval** | 8/28/2024 | 2

Infection Prevention & Control Policies (IC)

Summary Of Changes:	**Changed the word "Prevention" to "Control" for concordance with acronym: (ICRA) --Infection Control Risk Assessment. Updated the current risk assessment year to 2024**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Montecino, Stephanie (smontecino)**
ExpertReviewers:	**Director, QUALITY (QDIR)**
Approvers:	**Kidd, Sabrina (skidd) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Labeling Medications | **Pending Approval** | 8/28/2024 | 2

Medication Management Policies (MM)

Summary Of Changes: **Reviewed, no changes**

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Licensed Pharmacy Employee Theft or Impairment | **Pending Approval** | 8/28/2024 | 2

Medication Management Policies (MM)

Summary Of Changes: **Reviewed, no changes**

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Look Alike Sound Alike | **Pending Approval** | 8/28/2024 | 2

Medication Management Policies (MM)

Summary Of Changes: **Reviewed, no changes**

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Medication Recalls | **Pending Approval** | 8/28/2024 | 2

Medication Management Policies (MM)

Summary Of Changes: **Reviewed, no changes**

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW: Code Orange Hazardous Material Spill Response | **Pending Approval** | 8/6/2024 | 24

Emergency Code Alerts Policies

Summary Of Changes: **NEW Policy:**
Major revision of previous Haz-Mat spill response policy and procedures. Reflects current standards, best practice and current Sonoma Valley Hospital processes.

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Tarca, Joseph (jtarca)**

ExpertReviewers: **12-Safety Committee, Ramirez, Joseph (jramirez)**

Approvers: **Drummond, Kimberly (kdrummond) -> Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW: MRI Emergency Procedures – Quench and Emergency Stop | **Pending Approval** | 8/28/2024 | 2

Radiology Services Policies (RD)

Summary Of Changes: **To Describe the difference between an Emergency Shutdown of the MRI and a Quench.**

To Define reasons for both procedures.
Safety of staff and emergency responder(s).

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Young, Dave (dyoung)**
ExpertReviewers: **12-Safety Committee, Director, QUALITY (QDIR), MANAGER, ED (edmanager), Medical Director-Diagnostic Radiology, Tarca, Joseph (jtarca), Winkler, Jessica (jwinkler)**
Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW: MRI Safety — **Pending Approval** — 8/28/2024 — 2

Diagnostic Services Dept Policies

Summary Of Changes: **Added details for new 3T scanner and updated verbiage reflecting two MRI scanners.**
Added Definitions for MR zones and MR safe categories reflecting the American College of Radiology accepted terminology.
Added sections on-
Implants/Stents
Device Screening
Orthopedic Implants
Heart Valves and Annuloplasty Rings
Unconscious patient screening
Heating and Thermal burn prevention
Patient Communication
Hearing Protection
Infection Control and Waste
Reporting Requirements for adverse events

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Young, Dave (dyoung)**
ExpertReviewers: **IP-Infection Preventionist, Medical Director-Diagnostic Radiology**
Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW: MRI-Quality Control of Equipment — **Pending Approval** — 8/28/2024 — 2

Radiology Services Policies (RD)

Summary Of Changes: **NEW:**

Magnetic resonance imaging (MRI) scanners shall have routine quality control (QC) performed to include daily and/or weekly MRI technologist QC, an annual evaluation by a certified medical physicist, and routine preventative maintenance by a service provider.

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Young, Dave (dyoung)**
ExpertReviewers: **Medical Director-Diagnostic Radiology**
Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Patient Safety Program — **Pending Approval** — 8/28/2024 — 2

Governance and Leadership Policies

Summary Of Changes: **Reviewed no changes**

Moderators: **Newman, Cindi (cnewman)**
Lead Authors: **Director, QUALITY (QDIR)**
ExpertReviewers: **Winkler, Jessica (jwinkler)**
Approvers: **Kidd, Sabrina (skidd) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Patient's Own Medication Procedure	**Pending Approval**	8/28/2024	2
Pharmacy Dept			

Summary Of Changes: **Reviewed no changes**

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Patient's Rights to Access Protective Services	**Pending Approval**	8/28/2024	2
Patient Rights Policies (PR)			

Summary Of Changes: **Reviewed, no changes**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Director, QUALITY (QDIR)**

ExpertReviewers: **Kidd, Sabrina (skidd)**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Personnel Records	**Pending Approval**	8/6/2024	24
Human Resources Policies (HR)			

Summary Of Changes: **The core substance of this policy was not changed, but did make several language edits to provide better descriptions, instructions, and improve clarity.**
Added expectation for current employees to keep HR up-to-date on personal contact information.
Added option for employee to add a written comment or correction of personal information to their file.
Updated references.

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **McKissock, Lynn (lmckissock)**

Approvers: **Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Phone Tree	**Pending Approval**	8/6/2024	24
Materials Management Dept			

Summary Of Changes: **7/16/2024 - No changes. Previous message log mentions OneCall but not everyone in this department wants to sign up for that service. Will keep this in place for department to be notified in event of emergency. All staff in department has phone tree for this department.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Dugger, James (jdugger)**

Approvers: **Drummond, Kimberly (kdrummond) -> Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Piperacillin-Tazobactam Extended Infusion Dosing	**Pending Approval**	8/28/2024	2
Medication Management Policies (MM)			

Summary Of Changes: **Reviewed, no changes**

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Product Failure	**Pending Approval**	8/6/2024	24
Materials Management Dept			

Summary Of Changes: **7/17/2024 - 1) Replaced Notification form with eNotification Report under Policy. 2) Replaced Notification Report and added "found on the intranet" under Procedure. 3) Updated Materials Manager to Director. 4) Added Reference to Organizational Policy GL8610-144.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Dugger, James (jdugger)**

Approvers: **Drummond, Kimberly (kdrummond) -> Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Rapid Sequence Intubation (RSI) Kit	**Pending Approval**	8/28/2024	2
Medication Management Policies (MM)			

Summary Of Changes: **Removed section pertaining to retrieving and returning controlled substances from Pyxis**
Updated attachment contents list to include ketamine and midazolam, removed atropine, fentanyl, and vecuronium.
Updated Up To Date references used and date accessed

Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Reporting of Quality Monitoring and Performance	**Pending Approval**	8/28/2024	2
Quality Assessment & Perfomance Imp. Policies (QA)			

Summary Of Changes: **Reviewed. Grammatical changes. Fixed acronyms**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Director, QUALITY (QDIR)**

ExpertReviewers: **00 Clinical P&P multidisciplinary review, Newman, Cindi (cnewman)**

Approvers: **Kidd, Sabrina (skidd) -> 01 P&P Committee - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

RETIRE: Discharge ED	**Pending Approval**	8/28/2024	2
Emergency Dept			

Summary Of Changes: **Recommend retiring. It was last revised 2013. It is obsolete and references EHR programs we no longer have (Exit Writer, Care Glance, etc..). Also, Ebsco has discharge guidance for specific types of patients - such as pediatrics, or inter-facility transfers.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Winkler, Jessica (jwinkler), MANAGER, ED (edmanager)**

Approvers: **00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

RETIRE: E-notification in the ED 7010-9	**Pending Approval**	8/28/2024	2
Emergency Dept			

Summary Of Changes: **Recommend retiring. Organizationally we strongly encourage staff to enter eNotification reports into Midas and there is an organizational policy to address this. (# GL8610-144)**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Winkler, Jessica (jwinkler), MANAGER, ED (edmanager)**

Approvers: **00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -**

> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)

RETIRE: Infusion Pump Cleaning, Disinfection and Storage | **Pending Approval** | 8/28/2024 | 2

Patient Care Policy

Summary Of Changes: **Recommend retiring this policy. It is outdated. With the new pumps purchased a few years ago, the cleaning process is changed (pumps are not brought to Central Sterile for cleaning). EVS is trained appropriately on the cleaning process of all equipment including IV pumps. We no longer supply SNF or OB with IV pumps. We do not rent pumps.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Tarca, Joseph (jtarca)**

ExpertReviewers: **00 Clinical P&P multidisciplinary review, Medical Director-Patient Care Services**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

RETIRE: Pulmonary Function Screening Brochospasm Evaluation | **Pending Approval** | 8/28/2024 | 2

Respiratory Therapy Dept

Summary Of Changes: **Retire- this is a department protocol/procedure, not a hospital policy.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Taylor, Jane (jtaylor)**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Sara Lite Sit-to-Stand Lift | **Pending Approval** | 8/28/2024 | 2

Patient Care Policy

Summary Of Changes: **Reviewed- left as is**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Gallo, Christopher (cgallo)**

ExpertReviewers: **00 Clinical P&P multidisciplinary review, Medical Director-Patient Care Services**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Senior Management Team | **Pending Approval** | 8/6/2024 | 24

Governance and Leadership Policies

Summary Of Changes: **Reviewed, no changes.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Hennelly, John (jhennelly)**

Approvers: **01 P&P Committee -> 09 BOD-Board of Directors - (Committee)**

Surge Planning-Pharmacy | **Pending Approval** | 8/28/2024 | 2

Emergency Preparedness Policies (EP)

Summary Of Changes: **Reviewed, no changes**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Vandalism, Theft, Unlocking Svcs, Lost & Found	**Pending Approval**	8/6/2024	24
Care of the Physical Environment (CE)			

Summary Of Changes:	**Reviewed. No changes**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Tarca, Joseph (jtarca)**
Approvers:	**Drummond, Kimberly (kdrummond) -> Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Virtual Radiology Services	**Pending Approval**	8/28/2024	2
Diagnostic Services Dept Policies			

Summary Of Changes:	**Updated hours of teleradiology coverage.** **Updated escalation timelines if report isn't available within expected timeframes.** **Updated current process steps for staff.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Young, Dave (dyoung)**
ExpertReviewers:	**Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Withdrawal of Life Sustaining Treatment	**Pending Approval**	8/28/2024	2
Patient Rights Policies (PR)			

Summary Of Changes:	**No changes**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kidd, Sabrina (skidd)**
ExpertReviewers:	**Director, QUALITY (QDIR), Winkler, Jessica (jwinkler)**
Approvers:	**01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

PURPOSE:

The purpose of the Spill Response Policy is to describe procedures for appropriate response to hazardous chemical spills.

POLICY:

The program will ensure that hazardous materials spills are handled appropriately in accordance with all federal, state and local government regulations. It will also ensure that there is minimal risk to our patients, staff, community and the environment.

- The Safety Committee and the Environmental Services Manager are responsible to assign trained staff in coordinating the Hazardous Materials Spill Plan.
- Department managers are responsible for orienting new personnel to the department and, as appropriate, to job and task specific uses of hazardous material or wastes.

Individual personnel are responsible for learning and following job and task specific procedures for safe handling and use of hazardous materials and wastes.

PROCEDURE:

Incidents involving hazardous materials pose unique fire and safety problems. Extreme caution shall be exercised during all suspected or actual incidents involving hazardous material. Since each incident will require very specific actions, standard operating procedures must be general in nature.

General Requirements

When working with hazardous materials, follow the manufacturer's recommendations

1. Review the SDS/MSDS
2. Utilize the products published recommendations or contact the manufacturer's representative.
3. Utilize the prescribed personal protective gear (gloves, goggles, masks, etc.).PPEs
4. Always exercise extreme caution.

If A Small Release Should Occur

1. Notify emergency personnel immediately if medical treatment is required.
2. Notify the Environmental Services Manager/Hazardous Materials Manager and Safety Officer upon suspected hazardous material incident.

3. Confine incident to the smallest possible area.
4. Contain the release per the product SDS/MSDS instructions.
5. Isolate or clean up the spill as per the product MSDS instructions.
6. Prepare the hazardous material for shipment by a D.O.T. certified waste hauler per the product SDS/MSDS instructions.
7. File a Midas report

If A Large Release Should Occur:

1. Call **5555** to report a CODE ORANGE.
2. PBX will initiate CODE ORANGE, internal incident procedure. Announce Code Orange, location twice in succession, pause 5 seconds and repeat the announcement x 1.
3. The Hazmat Response Team will be initiated. Hazmat Response Team members on site will respond to keep the area isolated and collect identification of hazardous material, if possible.
4. Notify emergency personnel immediately if medical treatment is required.
5. Notify the Environmental Services Manager/Hazardous Materials Manager, Pharmacy Manager, Chief Engineer and Safety Officer upon suspected hazardous material incident.
6. SDS/MSDS are located online and in Engineering and Emergency Departments on a 24-hour basis for detailed information on fire, health and clean-up procedures on each hazardous chemical used in the facility.

Exposure:

1. All exposures, regardless of size, should be reported to the Environmental Services Manager, ext. 5144, Pharmacy Manager ext. 5340 and Safety Officer ext. 5355
2. If immediate attention is needed, report directly to the Emergency Department.

APPENDICES:

Appendix A: Hazardous Material Spill Response

REFERENCES:

CIHQ 482.41 CE-7 Management of Hazardous Materials

OWNER:

Director of Environmental Services

AUTHORS/REVIEWERS:

Mark Kobe, Chief Nursing Officer

APPROVALS:
Policy & Procedure Team: 3/19/19
Board Quality Committee: 3/27/19
The Board of Directors: 5/2/19

APPENDIX A

Policy & Procedure for Hazardous Material Spill Response

Department: ACIDS

Substances Covered

❑	Acetic Acid	❑	Perchloric Acid
❑	Hydrochloric Acid	❑	Sulfuric Acid
❑	Nitric Acid	❑	Other

NFPA Rating System Hazards[1]

❑	**Health Hazards** •Corrosive — contact causes burns to skin and eyes. •Severe irritant if inhaled.	❑	**Reactivity** •Nitric, Perchloric and sulfuric acids are water-reactive oxidizers.
❑	**Physical Hazards** •Fire or contact with metal may produce irritating or poisonous gas.	❑	Other

Incidental Spills	**Minor Spills**	**Major Spills**
❑ Amount: _____	❑ Amount: _____	❑ Amount: _____
❑ May be safely cleaned up by trained department staff.	❑ May be safely cleaned up by trained department staff.	❑ Clean up by facility spill response team or outside hazardous materials team.

[1] This list of principle hazards is not intended as a substitute for the specific MSDS information. In the case of a spill or if any questions arise, always refer to the chemical specific MSDS for more complete information.

❑ Personal Protective Equipment (PPE) [that is acid resistant]	❑ Personal Protective Equipment (PPE) [that is acid resistant]	❑ Personal Protective Equipment (PPE) [that is acid resistant]
⇒ Goggles	⇒ Goggles	⇒ Gloves (double set)
⇒ Gloves	⇒ Gloves	⇒ Coveralls with hood (feet optional)
⇒ Apron or Overalls	⇒ Apron or Overalls	⇒ Neoprene work boots
⇒ Foot Covers	⇒ Foot Covers	⇒ Self-Contained Breathing Apparatus (SCBA) with full-face piece.

Control Materials to be contained in Spill Kit

❑ Neutralizer/absorbent	❑ Shovel (plastic, non-metal)
❑ Absorbent Pillows	❑ pH Paper
❑ Absorbent Boom	❑ Hazardous Waste Bags
❑ Mat (to cover drain)	❑ Leak Proof Containers

ACIDS

SPILL CLEANUP

Step	Action
Evacuate	Evacuate everyone from the area surrounding the spill (the entire room, if necessary); except for those responsible with the spill clean up. Secure area.
Personal Protective Equipment (PPE)	If not already worn, put on personal protective equipment.

Confine Spill	Confine spill to initial spill area using appropriate control equipment and material.
Neutralize Spill	Apply NEUTRALIZER to spilled material (start at perimeter and work inwards). Mix spill clean up product with spill kit paddle or shovel until liquid is solidified. Allow solidified material to cool until neutralization is complete. Check pH with pH paper to determine level of neutralization. When neutral, proceed to clean up.
Spill Area Clean Up	❑ **Spill Waste:** Scoop up solidified material, booms, pillows, and any other materials used to clean the spill and put them into a hazardous waste bag. Label the bag with name of hazardous material. Wipe up residual material. Wipe spill area surface 3 times with a detergent solution. Rinse with clean water. ❑ **Reusable Spill Supplies:** Collect supplies and remove gross contamination. Wipe surfaces so they are free of visible contamination. Put into separate bag that contains equipment that will be thoroughly washed with detergent and water.
Disposal Procedure	**Important:** Dispose of spill clean up materials as hazardous waste. Label with appropriate hazardous waste label and DOT diamond label.
Reporting	Follow appropriate internal & external spill notification procedures.

Department: **BASES & CAUSTICS**

Substances Covered

❑	Potassium Hydroxide	❑	Radiology Developer
❑	Sodium Hydroxide	❑	

NFPA Rating System Hazards[2]

❑ **Health Hazards** •Corrosive — contact causes burns to skin and eyes. •Harmful if inhaled.	❑ **Reactivity**
❑ **Physical Hazards** •Fire may produce irritating or poisonous gas.	❑ Other

Incidental Spills	**Minor Spills**	**Major Spills**
❑ Amount: _____	❑ Amount: _____	❑ Amount: _____
❑ May be safely cleaned up by trained department staff.	❑ May be safely cleaned up by trained department staff.	❑ Clean up by facility spill response team or outside hazardous materials team.
❑ Personal Protective Equipment (PPE) [that is resistant to chemicals]	❑ Personal Protective Equipment (PPE) [that is resistant to chemicals]	❑ Personal Protective Equipment (PPE) [that is resistant to chemicals]
⇒ Goggles	⇒ Goggles	⇒ Gloves (4H under glove and butyl or nitride over glove)

[2] This list of principle hazards is not intended as a substitute for the specific MSDS information. In the case of a spill or if any questions arise, always refer to the chemical specific MSDS for more complete information.

⇒ Gloves	⇒ Gloves	⇒ Coveralls with hood (feet optional)
⇒ Apron or Overalls	⇒ Apron or Overalls	⇒ Self-Contained Breathing Apparatus (SCBA) with full-face piece.
⇒ Foot Covers	⇒ Foot Covers	

Control Materials to be Contained in Spill Kit

❑	Base Neutralizer/absorbent	❑	Shovel (plastic, non-metal)
❑	Absorbent Pillows	❑	pH Paper
❑	Absorbent Boom	❑	Hazardous Waste Bags
❑	Mat (to cover drain)	❑	Leak Proof Containers

BASES & CAUSTICS

SPILL CLEANUP

Step	Action
Evacuate	Evacuate everyone from the area surrounding the spill (the entire room, if necessary), except for those responsible with the spill clean up. Secure area.
Personal Protective Equipment (PPE)	If not already worn, put on personal protective equipment.
Confine Spill	Confine spill to initial spill area using appropriate control equipment and material.
Neutralize Spill	Apply NEUTRALIZER to spilled material (start at perimeter and work inwards). Mix spill clean up product with spill kit paddle or shovel until liquid is solidified. Allow solidified material to cool until

	neutralization is complete. Check pH with pH paper to determine level of neutralization. When neutral, proceed to clean up.
Spill Area Clean Up	❑ **Spill Waste:** Scoop up solidified material, booms, pillows, and any other materials used to clean the spill and put them into a hazardous waste bag. Label the bag with name of hazardous material. Wipe up residual material. Wipe spill area surface 3 times with a detergent solution. Rinse with clean water. ❑ **Reusable Spill Supplies:** (e.g., goggles, shovels, etc.) Collect supplies and remove gross contamination. Wipe surfaces so they are free of visible contamination. Put into separate bag that contains equipment that will be thoroughly washed with detergent and water.
Disposal Procedure	**Important:** Dispose of spill clean up materials as hazardous waste. Label with appropriate hazardous waste label and DOT diamond label.
Reporting	Follow appropriate internal & external spill notification procedures.

Department: **FORMALDEHYDE**

NFPA Rating System Hazards[3]

❑ **Health Hazards**: •Harmful if inhaled or absorbed through the skin. •Irritation to skin, eyes and respiratory tract. •Suspect human carcinogen.	❑ **Reactivity:**
❑ **Physical Hazards:** •Keep away from heat, sparks and flame.	❑ Other

Incidental Spills	**Minor Spills**	**Major Spills**
❑ Amount: _____	❑ Amount: _____ quart.	❑ Amount: _____ quart(s).
❑ May be safely cleaned up by trained department staff. *	❑ May be safely cleaned up by trained department staff. *	❑ Clean up by facility spill response team or outside hazardous materials team.
❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]
⇒ Goggles	⇒ Goggles	⇒ Gloves (Silver Shield under glove & butyl or nitrile over glove)

[3] This list of principle hazards is not intended as a substitute for the specific MSDS information. In the case of a spill or if any questions arise, always refer to the chemical specific MSDS for more complete information.

⇒ Gloves	⇒ Gloves	⇒ Coveralls with hood (feet optional)
⇒ Apron or Overalls	⇒ Apron or Overalls	⇒ Neoprene work boots
⇒ Foot Covers	⇒ Foot Covers	⇒ Self-Contained Breathing Apparatus (SCBA) with full face piece.

Control Materials to be Contained in Spill Kit

❑	ALDEHYDE Neutralizer/Absorbent	❑	Mat (to cover drain)
❑	Absorbent Boom	❑	Shovel/Paddle (plastic, non-metal)
❑	Absorbent Pillow	❑	Hazardous Waste Bags
❑	Leak proof container		

FORMALDEHYDE

SPILL CLEANUP

Step	Action
Evacuate & Secure Area	Evacuate everyone from the area surrounding the spill (the entire room, if necessary), except for those responsible with the spill clean up. Secure area. Provide maximum explosion proof ventilation.
Personal Protective Equipment (PPE)	If not already worn, put on personal protective equipment.
Confine Spill	Stop the source, if possible, and attempt to confine spill to initial spill area using appropriate control equipment and material.

Neutralize Spill	Apply ALDEHYDE NEUTRALIZER/ABSORBENT to spilled material (start at perimeter and work inwards). Completely blanket the spilled material. DO NOT MIX. Allow to stand according to manufacturer's directions.
Spill Area Clean Up	❑ **Spill Waste:** Scoop up solidified material, booms, pillows, and any other materials used to clean the spill and put them into a hazardous waste bag. Label the bag with name of hazardous material. Wipe up residual material. Wipe spill area surface 3 times with a detergent solution. Rinse with clean water. Place any additional waste articles in hazardous waste bag. ❑ **Reusable Spill Supplies: (e.g., goggles, shovels, etc.)** Collect supplies and remove gross contamination. Wipe surfaces so they are free of visible contamination. Put into separate bag that contains equipment that will be thoroughly washed with detergent and water.
Disposal Procedure	**Important:** Dispose of spill clean up materials as hazardous waste. Label with appropriate hazardous waste label and DOT diamond label.
Reporting	Follow appropriate internal & external spill notification procedures.

Department: **10% FORMALIN**

NFPA Rating System Hazards[4]

❑ **Health Hazards**: •Harmful if inhaled or absorbed through the skin. •Irritation to skin, eyes and respiratory tract. •Suspect human carcinogen.	❑ **Reactivity:**
❑ **Physical Hazards:**	❑ Other

Incidental Spills	**Minor Spills**	**Major Spills**
❑ Amount: _____	❑ Amount: _____ quart.	❑ Amount: _____ quart(s).
❑ May be safely cleaned up by trained department staff. *	❑ May be safely cleaned up by trained department staff. *	❑ Clean up by facility spill response team or outside hazardous materials team.
❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]
⇒ Goggles	⇒ Goggles	⇒ Gloves (Silver Shield under glove & butyl or nitrile over glove)

[4] This list of principle hazards is not intended as a substitute for the specific MSDS information. In the case of a spill or if any questions arise, always refer to the chemical specific MSDS for more complete information.

⇒ Gloves	⇒ Gloves	⇒ Coveralls with hood (feet optional)
⇒ Apron or Overalls	⇒ Apron or Overalls	⇒ Neoprene work boots
⇒ Foot Covers	⇒ Foot Covers	⇒ Self-Contained Breathing Apparatus (SCBA) with full face piece.

Control Materials to be Contained in Spill Kit

❑	ALDEHYDE Neutralizer/Absorbent	❑	Mat (to cover drain)
❑	Absorbent Boom	❑	Shovel/Paddle (plastic, non-metal)
❑	Absorbent Pillow	❑	Hazardous Waste Bags
❑	Leak proof container		

10% FORMALIN

SPILL CLEANUP

Step	Action
Evacuate & Secure Area	Evacuate everyone from the area surrounding the spill (the entire room, if necessary), except for those responsible with the spill clean up. Secure area. Provide maximum explosion proof ventilation.
Personal Protective Equipment (PPE)	If not already worn, put on personal protective equipment.
Confine Spill	Stop the source, if possible, and attempt to confine spill to initial spill area using appropriate control equipment and material.

Neutralize Spill	Apply ALDEHYDE NEUTRALIZER/ABSORBENT to spilled material (start at perimeter and work inwards). Completely blanket the spilled material. DO NOT MIX. Allow to stand according to manufacturer's directions.
Spill Area Clean Up	❑ **Spill Waste:** Scoop up solidified material, booms, pillows, and any other materials used to clean the spill and put them into a hazardous waste bag. Label the bag with name of hazardous material. Wipe up residual material. Wipe spill area surface 3 times with a detergent solution. Rinse with clean water. Place any additional waste articles in hazardous waste bag. ❑ **Reusable Spill Supplies: (e.g., goggles, shovels, etc.)** Collect supplies and remove gross contamination. Wipe surfaces so they are free of visible contamination. Put into separate bag that contains equipment that will be thoroughly washed with detergent and water.
Disposal Procedure	**Important:** Dispose of spill clean up materials as hazardous waste. Label with appropriate hazardous waste label and DOT diamond label.
Reporting	Follow appropriate internal & external spill notification procedures.

Department: **2% GLUTARALDEHYDE (CIDEX®)**

NFPA Rating System Hazards[5]

❑ **Health Hazards**: •Harmful if inhaled or absorbed through the skin. •Irritation to skin, eyes and respiratory tract.	❑ **Reactivity:**
❑ **Physical Hazards:**	❑ Other

Incidental Spills	**Minor Spills**	**Major Spills**
❑ Amount: _____	❑ Amount: _____ quart	❑ Amount: _____ quart(s).
❑ May be safely cleaned up by trained department staff. *	❑ May be safely cleaned up by trained department staff.	❑ Clean up by facility spill response team or outside hazardous materials team.
❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]
⇒ Goggles	⇒ Goggles	⇒ Gloves (Silver Shield under glove & butyl or nitrile over glove)
⇒ Gloves	⇒ Gloves	⇒ Coveralls with hood (feet optional)

[5] This list of principle hazards is not intended as a substitute for the specific MSDS information. In the case of a spill or if any questions arise, always refer to the chemical specific MSDS for more complete information.

⇒ Apron or Overalls	⇒ Apron or Overalls	⇒ Neoprene work boots
⇒ Foot Covers	⇒ Foot Covers	⇒ Self-Contained Breathing Apparatus (SCBA) with full face piece.

Control Materials to be Contained in Spill Kit

❑	ALDEHYDE Neutralizer/Absorbent	❑	Mat (to cover drain)
❑	Absorbent Boom	❑	Shovel/Paddle (plastic, non-metal)
❑	Absorbent Pillow	❑	Hazardous Waste Bags
❑	Leak proof container		

2% GLUTARALDEHYDE (CIDEX®)

SPILL CLEANUP

Step	Action
Evacuate & Secure Area	Evacuate everyone from the area surrounding the spill (the entire room, if necessary), except for those responsible with the spill clean up. Secure area. Provide maximum explosion proof ventilation.
Personal Protective Equipment (PPE)	If not already worn, put on personal protective equipment.
Confine Spill	Stop the source, if possible, and attempt to confine spill to initial spill area using appropriate control equipment and material.
Neutralize Spill	Apply ALDEHYDE NEUTRALIZER/ABSORBENT to spilled material (start at perimeter and work inwards).

	Completely blanket the spilled material. DO NOT MIX. Allow to stand according to manufacturer's directions.
Spill Area Clean Up	❑ **Spill Waste:** Scoop up solidified material, booms, pillows, and any other materials used to clean the spill and put them into a hazardous waste bag. Label the bag with name of hazardous material. Wipe up residual material. Wipe spill area surface 3 times with a detergent solution. Rinse with clean water. Place any additional waste articles in hazardous waste bag. ❑ **Reusable Spill Supplies: (e.g., goggles, shovels, etc.)** Collect supplies and remove gross contamination. Wipe surfaces so they are free of visible contamination. Put into separate bag that contains equipment that will be thoroughly washed with detergent and water.
Disposal Procedure	**Important:** Dispose of spill clean up materials as hazardous waste. Label with appropriate hazardous waste label and DOT diamond label.
Reporting	Follow appropriate internal & external spill notification procedures.

Department: **NITROUS OXIDE**

NFPA Rating System Hazards[6]

❑ **Health Hazards:** •Asphyxiation — displaces oxygen. •Contact with liquid can produce frostbite. •Anesthetic effects.	❑ **Reactivity**
❑ **Physical Hazards**	❑ **CAUTION: MAY BE OXYGEN DEFICIENT ATMOSPHERE.**

Incidental Spills	Minor Spills	**Major Spills**
❑ Amount	❑ Amount	❑ Broken bottle, spill, or leaking cylinder.
❑ Clean up	❑ Clean up	❑ Clean up by facility spill response team, or outside hazardous materials team.
❑ PPE	❑ PPE	❑ Personal Protective Equipment (PPE)
		⇒ Neoprene boots
		⇒ Gloves (leader to protect from the cold or cryogenic gloves

[6] This list of principle hazards is not intended as a substitute for the specific MSDS information. In the case of a spill or if any questions arise, always refer to the chemical specific MSDS for more complete information.

		⇒ Coveralls with hood and feet
		⇒ Self Contained Breathing Apparatus (SCBA) with full face piece

Control Materials to be Contained in Spill Kit

❑ Hand truck (to transport cylinder outdoors if necessary.	❑ Putty (to stop minor pipe and line leaks)
❑ Soap solution (to check for leaks)	❑

NITROUS OXIDE

SPILL CLEANUP

Step	Action
Evacuate & Secure Area	Evacuate everyone from the area surrounding leak (entire room if necessary), except for those responsible with the lean up. Secure area.
Personal Protective Equipment (PPE)	Put on self-contained breathing apparatus (SCBA) and protective clothing. Wear appropriate gloves to protect hands from extreme cold.
Confine Spill	Turn off source if possible. Turn off cylinder valve or valve to line to stop release. Use soap bubble solution to check for the presence and location of leak. If possible, stop leaks in pipes and lines with putty. If leak is not controllable, consider relocating cylinder outdoors.
De-energize	De-energize FROM BREAKER PANEL OR OTHER SOURCE OUTSIDE ROOM OR AREA IF POSSIBLE

	and remove all sources of ignition for nitrous oxide release.
Supplemental Evacuation	If the gas cylinder will be removed from the building, evacuate and secure the corridor that will be used to transport the cylinder out of the building. Close all doors along corridor. Keep doors closed for 15 minutes after cylinder is transported through corridor.
Cylinder Venting Outdoors	If it is necessary to move the source out of the building, once outdoors, secure cylinder to prevent tipping over. Allow the cylinder to discharge at a moderate rate.
Cylinder Venting Indoors	If the source cannot easily be moved and it will be necessary to vent indoors, exit and secure the work zone. Allow cylinder to discharge at a moderate rate. While the cylinder is discharging, no one except the leak responders should re-enter the work area. Wait 30 minutes before re-entering to allow venting and ventilation to occur.
Reporting	Follow appropriate internal and external spill notification procedures.

Department: **XYLENE**

NFPA Rating System Hazards[7]

❑ **Health Hazards**: •Vapors harmful if inhaled (central nervous system depression). •Harmful via skin absorption.	❑ **Reactivity:**
❑ **Physical Hazards:** •Liquid evaporates to form flammable vapors.	❑ Other

Incidental Spills	**Minor Spills**	**Major Spills**
❑ Amount: _____	❑ Amount: _____ gal	❑ Amount: _____ gal(s)
❑ May be safely cleaned up by trained department staff.	❑ May be safely cleaned up by trained department staff.	❑ Clean up by facility spill response team or outside hazardous materials team.
❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]
⇒ Goggles	⇒ Goggles	⇒ Gloves (Silver Shield under glove & butyl or nitrile over glove)
⇒ Gloves	⇒ Gloves	⇒ Coveralls with hood (feet optional)

[7] This list of principle hazards is not intended as a substitute for the specific MSDS information. In the case of a spill or if any questions arise, always refer to the chemical specific MSDS for more complete information.

⇒ Apron or Overalls	⇒ Apron or Overalls	⇒ Neoprene work boots
⇒ Foot Covers	⇒ Foot Covers	⇒ Self-Contained Breathing Apparatus (SCBA) with full face piece.

Control Materials to be Contained in Spill Kit

❑ SOLVENT HANDLER or other absorbent	❑ Mat (to cover drain)
❑ Absorbent Boom	❑ Shovel/Paddle (plastic, non-metal)
❑ Absorbent Pillow	❑ Hazardous Waste Bags
❑ Leak proof container	

XYLENE

SPILL CLEANUP

Step	Action
De-Energize	De-Energize FROM BREAKER PANEL OR OTHER SOURCE OUTSIDE ROOM OR AREA and remove all sources of ignition.
Evacuate	Evacuate everyone from the area surrounding the spill (the entire room, if necessary), except for those responsible with the spill clean up. Secure area.
Personal Protective Equipment (PPE)	If not already worn, put on personal protective equipment.
Confine Spill	Stop the source, if possible, and attempt to confine spill to initial spill area using appropriate control equipment and material. Dike off all drains.

Neutralize Spill	Apply SOLVENT HANDLER or inert solid absorbent to spilled material (start at perimeter and work inwards). Completely blanket the spilled material. Using a non-sparking shovel or paddle, mix HANDLER as needed to facilitate the absorption process. Continue to add HANDLER until vapor is eliminated.
Spill Area Clean Up	❑ **Spill Waste:** Scoop up solidified material, booms, pillows, and any other materials used to clean the spill and put them into a hazardous waste bag. Label the bag with name of hazardous material. Wipe up residual material. Wipe spill area surface 3 times with a detergent solution. Rinse with clean water. Place any additional waste articles in hazardous waste bag. ❑ **Reusable Spill Supplies: (e.g., goggles, shovels, etc.)** Collect supplies and remove gross contamination. Wipe surfaces so they are free of visible contamination. Put into separate bag that contains equipment that will be thoroughly washed with detergent and water.
Disposal Procedure	**Important:** Dispose of spill clean up materials as hazardous waste. Label with appropriate hazardous waste label and DOT diamond label.
Reporting	Follow appropriate internal & external spill notification procedures.

(ETO) ETHYLENE OXIDE
SPILL CLEANUP

Step	Action
Evacuate & Secure Area	Evacuate everyone from the area surrounding leak (entire room if necessary), except for those responsible with the clean up. Secure area.
Personal Protective Equipment (PPE)	Put on self-contained breathing apparatus (SCBA) and protective clothing. Wear appropriate gloves to protect hands.
Confine Spill	Turn off source if possible. Turn off cylinder valve or valve to line to stop release. Use soap bubble solution to check for the presence and location of leak. If possible, stop leaks in pipes and lines with putty.
Small Spill	Wipe/soak up with paper towel or inert absorbent. Put in disposal container. Remove residue with water.
Large Spill	Evacuate and ventilate area.
De-energize	De-energize FROM BREAKER PANEL OR OTHER SOURCE OUTSIDE ROOM OR AREA IF POSSIBLE and remove all sources of ignition for ethylene oxide release.
Venting Indoors	If the source cannot easily be moved and it will be necessary to vent indoors, exit and secure the work zone. Allow discharge at a moderate rate. While the vapor is discharging, no one except the leak responders should re-enter the work area. Wait 30 minutes before re-entering to allow venting and ventilation to occur.
Reporting	Follow appropriate internal and external spill notification procedures.

Department: **LIQUID NITROGEN**

NFPA Rating System Hazards[8]

❑ **Health Hazards**: **3** •Inhalation: Asphyxiant. Nitrogen is nontoxic, but may cause suffocation by displacing the oxygen in air. •May cause severe frostbite.	❑ **Reactivity: 0**
❑ **Physical Hazards:** •Liquid evaporates to form flammable vapors.	❑ Other

Incidental Spills	**Minor Spills**	**Major Spills**
❑ Amount: _____	❑ Amount: > 2 oz.	❑ Amount: < 2oz.
❑ Remove everyone from the room, close the door and allow for evaporation.	❑ Remove everyone from the room, close the door and contact Safety Officer.	❑ Clean up by facility spill response team or outside hazardous materials team.
❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]	❑ Personal Protective Equipment (PPE) [that is chemical resistant]
⇒ Goggles	⇒ Goggles	⇒ Gloves (Silver Shield under glove & butyl or nitrile over glove)

[8] This list of principle hazards is not intended as a substitute for the specific MSDS information. In the case of a spill or if any questions arise, always refer to the chemical specific MSDS for more complete information.

⇒ Gloves	⇒ Gloves	⇒ Coveralls with hood (feet optional)
⇒ Apron or Overalls	⇒ Apron or Overalls	⇒ Neoprene work boots
⇒ Foot Covers	⇒ Foot Covers	⇒ Self-Contained Breathing Apparatus (SCBA) with full face piece.

LIQUID NITROGEN

SPILL CLEANUP

Step	Action
Evacuate	Evacuate everyone from the area surrounding the spill (the entire room, if necessary), Secure area.
Spill Area Clean Up	❑ Assess whether air in spill area is vented to outside or is re-circulated. Contact Facility Manager and Safety Officer immediately. One entry will allowed until the air has been tested for sufficient oxygen content.
Reporting	Follow appropriate internal & external spill notification procedures.

NEW POLICY
To replace the legacy policy: MRI Safety

WHY:

Substantially changed to include best practices and updates for technology

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Director of Diagnostic Services
Radiology Medical Director
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Surgery Committee:
Medical Executive Committee:
The Board of Directors:

PURPOSE:

This policy is designed to provide a safe environment for patients, visitors and staff working in the MRI magnetic environment. The field near the magnet is strong enough to attract ferromagnetic objects with great force. These objects can become projectiles and cause severe injury, death or damage to the MRI equipment.

POLICY:

All MRI technologists will be trained in magnet safety. MRI personnel are responsible for screening all patients, family members, visitors or other staff members for ferromagnetic materials before entering the MRI scan room. MRI personnel are responsible for checking all equipment that enters the MRI room to make sure it is MRI safe or conditional.

DEFINITIONS:

Zone I: Accessible areas by the general public outside MR environment (public waiting room, hospital grounds, public hallways).
Zone II: Area before Zone III where individuals are accompanied by MR personnel.
Zone III: Restricted area before Zone IV that is controlled by MR personnel (control room).
Zone IV: Area controlled MR technologist. This is a potentially hazardous area with the presence of very strong magnetic fields. (MR Scan Room).
MRI Safe: items, components or material that do not pose any known hazards in MRI environments. Non-conducting, non-metallic and non-magnetic items (silicone, plastic, glass, etc.)
MR Conditional: items, components or material that pose no known hazards in a specified MRI environment with specified conditions of use.
MR Unsafe: items, components or materials that pose a potential or realistic risk or hazard in the MRI environment. These objects are considered to be a contraindication for an MR procedure and/or the individual to enter the MR environment.

PROCEDURE:

**** The MRI magnetic field is on at all times, 24 hours a day, 7 days a week****

1. Access to MR Zones 3 and 4 is for authorized personnel trained in magnetic safety.
2. All patients, family members, visitors and other personnel must be screened for ferromagnetic materials prior to entering the MRI Zones 3 and 4 by trained personnel. This screening will occur at multiple points for patients having MRI exams to ensure safety.

Outpatients:

- At the time of the initial scheduling, the individual requesting the MRI exam is to provide clinical information pertinent to the exam. This information is sought to identify if the patient has a pacemaker, intracranial aneurysm clips, neurostimulators, retained metal in the eye or other implanted metallic objects that may be a contraindication due to the MRI radiofrequency or the presence of a strong magnetic field.
- **Cardiac pacemakers or defibrillators are an absolute contraindication for MRI and are not allowed in the MRI Zone 4.**
- If a patient has worked around metal and has the possibility of retained metal in their eyes, a pre-MRI orbit x-ray is done prior to patient being brought to the MRI trailer and is the responsibility of the MRI technologist scanning the patient to check to make sure this is completed prior to scanning patient.
- On the day the patient arrives for the MRI scan, they are requested to complete a patient screening and history form. The screening questionnaire helps determine if the individual has any of the various implants, materials, or devices that are contraindicated for the MRI procedure. The MRI technologist and / or radiologist review the screening form for completeness and will discuss any concerns with the patient prior to scanning.
- Patients are instructed to arrive in comfortable clothing without metal. However, if needed, the patient is taken to the dressing room and asked to remove street clothes and given a gown. Any person undergoing an MRI exam must remove all metallic attire (antimicrobial, moisture wicking, silver or copper-lined athletic attire or accessories), personal belongings and devices (i.e. watches, jewelry, clothing with snaps, hooks or zippers, etc.).
    - While SVH closely adheres to American College of Radiology guidelines regarding patient attire during their MRI exam, final decisions will be at the radiologist and MRI technologist discretion on a case-by-case basis.
- Prior to entering the MRI Zone 3, the patient is again questioned by the technologist regarding ferromagnetic materials.
- Any visitor or person accompanying a patient (family member, sitter, nurse) shall be screened like a patient and should remove watches, credit cards, keys, jewelry or any other loose objects as they can become projectiles in the magnetic field.
- Radiologists will not prescribe sedation or monitor sedated patients in the MRI trailer. If the patient can care for themselves while sedated (small amounts of valium, etc) and their respiratory functions are not compromised, then the patient may be scanned. If the patient cannot care for themselves, or if their respiratory system is compromised due to sedation, they will not be scanned.

Inpatients and Emergency Department patients:

- All inpatients scheduled for MRI exams should be verbally and visually screened prior to being transported to the MRI trailer. This is done to check for possible

contraindications and to determine if the patient is able to cooperate for the exam. If there are any questions about the ability of the patient to cooperate for the exam, the MRI technologist will consult with the radiologist.

- If an inpatient is unable to supply screening information due to their condition, a family member who knows the patient well should be contacted to answer questions. If no family member is available, the radiologist shall be notified and a screening skull and Chest x-ray shall be performed. Additional x-rays can be ordered if needed to clear the patient for the MRI exam.
- All inpatients shall be screened again when they arrive in the MRI Zone 3. Patients should be checked to be sure that they are not wearing any clothing that contains metal (snaps on patient gowns). ECG patches should be removed as they can heat during exam and replaced with MRI approved patches and leads. Metallic drug delivery patches must be removed with physician approval.
  - A handheld magnet will be used to screen for metal on or around the patients prior to bringing them into Zone 4, the scan room.
- **Oxygen tanks are highly magnetic and should never be brought into Zone 4, the scan room!** There are non-ferrous aluminum oxygen tanks available for MRI purposes located in MRI and the Imaging Department. These aluminum tanks are MR conditional and approved to use for patients requiring oxygen during their exams. These tanks are clearly labeled for MRI use and are in a white O2 tank cart.
  - Oxygen tanks will be tested by a MRI technologist with a handheld magnet prior to entering MR Zone 4.
- No medication pumps, monitoring devices, gurneys, wheelchairs or other patient devices are allowed in the scan room unless approved by the MRI technologist or radiologist. Use MR safe or compatible equipment only.
- Sedated and monitored patients are not permitted in the MRI scan room unless all persons and equipment are noted to be free of ferrous material (nurses, respiratory therapists, ventilators, cardiac monitors, IV pumps). All equipment and personnel prior to proceeding shall be checked for magnetism by the MRI technologist.

CODE BLUE or RAPID RESPONSE:

- Recognize and confirm cardiac and / or respiratory arrest or patient is in distress.
- MRI personnel will initiate Code Blue and Rapid Response procedures by dialing 5555, stating Code Blue or Rapid Response and the appropriate MRI scanner.
- Remove patient from MRI scan room. MRI technologists and assisting staff will initiate CPR outside MRI Zone 4 in a magnetically safe location. When other personnel arrive, begin transporting patient to the Emergency Department. The Code team will assume control of the code during transportation to the Emergency Department.
- Crash carts and other emergency equipment containing ferromagnetic material **must not** be brought into the scanning room Zone 4.

- In accordance with the State of California regulations, a Code Blue drill will be held in the mobile MRI van at least one time each year.

IMPLANTS and DEVICE SCREENING

- Implants and devices are evolving rapidly and must be thoroughly investigated if potential patients or individuals who will enter the magnetic environment indicate their presence.
- If the individual knows or has documentation as to the specific manufacturer and type of device, then the following steps are implemented:
  Look up the item by the manufacturer in the current *Reference Manual for Magnetic Resonance Safety, Implants, and Devices* by Frank G. Shellock, Ph.D. or on the web site: http://www.mrisafety.com
- If the device or object is not listed there or has not been tested at the field that the patient is subjected to, then contact the manufacturer for documentation that the device is MRI safe, and the magnetic field strength(s) and conditions for safety. If this information is not available on the manufacturer's website, the manufacturer must be contacted directly and written documentation regarding the device must be faxed to the department.
- A Radiologist must be consulted about the safety of any device in question. For any device of unknown type or manufacture, the radiologist will make any decision to proceed with MRI based on the information provided by the ordering caregiver. If a potential contraindication is found on screening, and a decision is made to proceed with the MRI exam, resolution of this finding must be documented on the Patient Safety form or in a note and retained in the health record. If the safety of a device is unknown, the manufacturer must be contacted to provide a letter or written safety statement. If a medical device is investigated and it is determined the patient must not be imaged while the device is in place, the contraindication must be documented in the medical record. Likewise, complications resulting from MRI of a device must also be documented.

Coronary Artery Stent Guidelines:

A patient with a with coronary artery stent (including a drug-eluting, non-drug eluting or bare metal version), including situations where there are two or more stents or two or more overlapping stents, may undergo MRI using the following guidelines:

- 3-Tesla or less
- No restriction for the spatial gradient magnetic field
- Whole body averaged specific absorption rate (SAR) of 2-W/kg (i.e., operating in the Normal Operating Mode for the MR system)
- Maximum imaging time, 15 minutes per pulse sequence (multiple pulse sequences per patient are allowed)
    - http://www.mrisafety.com/SafetyInformation_view.php?editid1=352

Passive Orthopedic Implants Guidelines:
A patient with a passive, internal orthopedic implant may undergo MRI using the following guidelines:

- 3-Tesla or less, including horizontal and vertical field MR system
- No restriction for the spatial gradient magnetic field
- For a passive, internal orthopedic implant located *inside* of the area of the transmitted RF energy, use a whole-body averaged specific absorption rate (SAR) of 2-W/kg (i.e., operating the MR system in the Normal Operating Mode)
- For a passive, internal orthopedic implant located entirely *outside* of the area of the transmitted RF energy, there is no restriction for the RF energy.
- Maximum imaging time, 15 minutes per pulse sequence (multiple pulse sequences are allowed)

Exclusions: Orthopedic implants that are excluded from these guidelines include external fixation systems, external cervical fixation systems (e.g., halo vests), traction devices, magnetically-controlled or programmable implants (e.g., PRECISE System, MAGEC System), bone fusion stimulation systems, prosthetic limbs, and prostheses with microprocessors.

- https://www.mrisafety.com/SafetyInformation_view.php?editid1=368

Heart Valves and Annuloplasty Ring Guidelines:

MRI at 3-Tesla and Heart Valve Prostheses and Annuloplasty Rings. Findings obtained at 3-Tesla for various heart valve prostheses and annuloplasty rings that underwent testing indicated that certain implants exhibit relatively minor magnetic field interactions. Similar to heart valve prostheses and annuloplasty rings tested at 1.5-Tesla, because the actual attractive forces exerted on these implants are deemed minimal compared to the force exerted by the beating heart, MR procedures at 3-Tesla are not considered to be hazardous for patients or individuals that have these devices. To date, for the heart valves that have been tested, MRI-related heating has not been shown to reach substantial levels.

- https://www.mrisafety.com/SafetyInformation_view.php?editid1=179

Below is a partial list of items that should not be brought into the MRI Zone 4 scanning room (unless clearly labeled MR safe or MR conditional). Lists are not exhaustive:

- O2 tanks (use only aluminum, non-ferrous tanks with non-ferrous regulators and attachments, clearly labeled for MRI)
- Gurneys (there is one MRI safe table/gurney kept in the Imaging department for use in transporting or transferring the patient.
- Wheelchairs
- IV poles
- IV and pain pumps
- Crash carts

- Monitors
- Stethoscopes
- Mayo stands
- Clipboards
- Pens
- Paper clips
- Scissors
- Hemostats
- Pagers / telephones
- Chairs
- Tables
- Patient charts
- Keys
- Aerosol cans of disinfectant
- Buckets and mops
- Floor buffers
- Hammers, screwdrivers, drills, etc.
- Flashlights
- Fans
- CD or tape players
- Cameras

Below is a list of medical or surgical items that may be contraindicated for MRI Zone 4:

ABSOLUTELY CONTRAINDICATED

- **Pacemaker, cardiac defibrillators and stimulators**
- **3m Cochlear implants**

More than likely contraindicated

- Intra-cranial aneurysm clips
- Retained metal in the eyes
- Eye prosthesis-unless removed
- Neurostimulators
- Biostimulators
- Tissue expanders
- Swan-Ganz catheter
- Implanted Insulin pump

Possibly contraindicated or effect scan quality

- Detached retinal surgery tacks
- Stapedectomy
- Hip prosthesis
- Orthopedic pins, screws, plates
- Intravascular stents or devices
- Vascular access ports
- Heart valves
- Dental devices and materials
- Penile implants
- Ontological implants
- Bullets, pellets and shrapnel
- Abdominal surgical clips
- Hearing aids
- Intraventricular shunt
- Dentures
- Diaphragm / IUD / pessary (a device worn in the vagina to support the uterus, remedy a malposition, or prevent conception)
- Wire mesh

PREVENTION of EXCESSIVE HEATING and THERMAL BURNS during MRI IMAGING

- Prepare the patient for the MR procedure by ensuring that there are no unnecessary metallic objects contacting the patient's skin (e.g., drug delivery patches with metallic components, jewelry, necklaces, bracelets, key chains, antimicrobial, moisture wicking, or metallic lined clothing or accessories, etc.).
- Prepare the patient for the MR procedure by using insulation material (i.e., appropriate padding) to prevent skin-to-skin contact points and the formation of "closed loops" from touching body parts.
- Insulating material (minimum recommended thickness, 1-cm) should be placed between the patient's skin and transmit RF coil that is used for the MR procedure (alternatively, the transmit RF coil itself should be padded).
- Use only electrically conductive devices, equipment, accessories (e.g., ECG leads, electrodes, etc.), and materials that have been thoroughly tested and determined to be safe conditional for MR procedures.
- Carefully follow specific MR safety criteria and recommendations for implants made from electrically conductive materials (e.g., bone fusion stimulators, neurostimulation systems, cardiac pacemakers, cochlear implants, etc.).
- Before using electrical equipment, check the integrity of the insulation and/or housing of all components including surface RF coils, monitoring leads, cables, and wires. Preventive maintenance will be practiced routinely for such equipment.

- Remove all non-essential electrically conductive materials from the MR system (i.e., unused surface RF coils, ECG leads, EEG leads, cables, wires, etc.).
- Keep electrically conductive materials that must remain in the MR system from directly contacting the patient by placing thermal and/or electrical insulation between the conductive material and the patient.
- Keep electrically conductive materials that must remain within the body transmit RF coil or other transmit RF coil of the MR system from forming conductive loops.
- Position electrically conductive materials to prevent “cross points”. A cross point is the point where a cable crosses another cable, where a cable loops across itself, or where a cable touches either the patient or sides of the transmit RF coil more than once. Even the close proximity of conductive materials with each other should be avoided because cables and transmit RF coils can capacitively couple (without any contact or crossover) when placed close together.
- Position electrically conductive materials to exit down the center of the MR system (i.e., not along the side of the MR system or close to the transmit RF body coil or other transmit RF coil).
- Do not position electrically conductive materials across an external metallic prosthesis (e.g., external fixation device, cervical fixation device, etc.) or similar device that is in direct contact with the patient.
- Allow only properly trained individuals to operate devices (e.g., monitoring equipment) in the MR environment.
- Follow all manufacturer instructions for the proper operation and maintenance of physiologic monitoring or other similar electronic equipment intended for use during MR procedures.
- Electrical devices that do not appear to be operating properly during the MR procedure will be removed from the patient immediately.
- Closely monitor the patient during the MR procedure. If the patient reports sensations of heating or other unusual sensation, discontinue the MR procedure immediately and perform a thorough assessment of the situation.
- RF surface coil decoupling failures can cause localized RF power deposition levels to reach excessive levels. The MR system operator will recognize such a failure as a set of concentric semicircles in the tissue on the associated MR image or as an unusual amount of image non-uniformity related to the position of the transmit RF coil.

UNCONSCIOUS or UNRESPONSIVE PATIENT SCREENING

- If no reliable patient metal exposure history can be obtained, frontal radiography of the Skull, Chest and Abdomen to exclude metallic foreign objects is required (if recently obtained radiographs or CT studies of such areas are not available). Consultation with a Radiologist is required in these situations to determine the exact course of action.

PATIENT COMMUNICATION

- All Patients that are undergoing an MRI examination are in constant visual and verbal communication during MRI exams.
- Patients are also provided with the MRI call ball and instructed on how to use it. Once the call ball is squeezed, an alarm will sound in the MRI control room. The MRI scan will be stopped and the MRI Technologist will respond to the alarm and address any concerns.

HEARING PROTECTION

- Patients or others in the scan room during an MRI examination will be urged to use ear plugs and/or headphones that are supplied for use during an MRI study. Use of ear plugs is encouraged since some patients may find the noise level unacceptable, and the noise level may affect hearing.

INFECTION CONTROL and WASTE

- The MRI Department complies with Institution Infection prevention policies.
- MRI maintains a clean environment for patients, personnel and visitors which will prevent and reduce disease transmission.
- All MRI equipment is cleaned with a hospital-approved disinfectant or per manufacturer's recommendations. All employees follow standard precautions when handling contaminated or dirty medical equipment.
- The MRI Department ensures appropriate collection, storage and disposal of all medical waste and recyclables, in accordance with all applicable state regulations and ensures areas are clean and odor-free.
    - Only MRI technologists clean MR Zone 4. If occasional deep cleaning is needed the MRI technologist will supervise and assist any personnel involved in the cleaning.
    - Trash and linen collection or other tasks like supply stocking will only be done by an MRI technologist in Zone 4. Trash and dirty linens will be brought from Zone 4 to Zone 3 for general collection and disposal.

REPORTING REQUIREMENTS

- All adverse events, MR safety incidents, or ‘‘near incidents’’ that occur in the MR site must be documented in the Hospital's Safety Reporting System.
- The incidents must be reported to the Diagnostic Services Director, Imaging Services Medical Director, the MR Safety Officer in a timely manner via e-mail or phone call within 12 hours of occurrence).
- An MRI physicist can be consulted if necessary.

- The person involved and/or most knowledgeable about the event will complete an online incident report in a timely manner, or by end-of-shift.

REFERENCES

Magnetic Resonance-Bioeffects, Safety and patient Management: Second Edition-(Frank G. Shellock) Lippincott-Raven, 2022
Pocket Guide to MR procedures and metallic objects: Update 2001-(Frank G. Shellock), Lippincott Williams & Wilkins, 2001.
www.mrisafety.com
www.Kanal.upmc.edu/mrsafety.html

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Director of Diagnostic Services
Radiology Medical Director
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Surgery Committee:
Medical Executive Committee:
The Board of Directors:

NEW POLICY

WHY:

- Describe the difference between an *Emergency Shutdown* of the MRI and a *Quench*.
- Define reasons for both procedures.
- Safety of staff and emergency responder(s).

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Director of Diagnostic Services
Medical Director of Radiology
Chief Ancillary Officer
Safety Officer/Safety Committee
Director of Quality & Risk Management
Emergency Management Coordinator
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Surgery Committee:
Medical Executive Committee:
The Board of Directors:

PURPOSE:
To provide guidelines for proper action in the event of an emergency shutdown or quench is needed or if it occurs unintentionally.

DEFINITIONS:
Quench - the process whereby there is a sudden loss of temperature in the magnet coils to absolute zero so that they cease to be super conducting and become resistive, thus eliminating the magnetic field. This results in helium escaping from the cryogen bath extremely rapidly. It may happen accidentally or can be manually instigated in the case of an emergency.

Quenching could be either unintentional/spontaneous or intentional/controlled. The most common causes of unintentional quenches are equipment malfunctions, improper filling of the cryogen tank, contaminants inside the cryostat and extreme magnetic or vibrational disturbances (such as those accompanying an earthquake). An intentional quench ("Magnet Stop" or "Quench" button is depressed) should only be performed under certain life-threatening situations, such as magnetic field life threatening event, or an un-contained fire in the scanner room.

Emergency Power Stop – The Emergency Stop button turns off all incoming electrical power to the magnet power distribution unit (PDU) but **the magnetic field is still up/active**. Shutting off power to the PDU may be required for life threatening situations, such as fire or flood. **Pressing the Emergency Stop button does not initiate a quench.**

POLICY:
The "Magnet Stop" or "Quench" button should only be used under the following conditions (Intentional Quench):

1. Forces due to the magnetic field causing the patient or personnel injury.
2. Fire or other unexpected occurrences demanding immediate action and entry into Zone IV (magnet room) by emergency personnel or responders.
3. Any other situation that would require immediate relief from the forces of the magnetic field.

In the event a ferromagnetic object is attracted by the scanner and attached to it without causing any harm **DO NOT** try to pull the object away from the scanner as during this process there is risk for injuring yourself, others in the room, and damaging the scanner itself. Note that objects attracted to the side of the magnet may turn around on themselves during the removal process and end up lodging inside the bore, again potentially hurting someone.

Do not touch a quenched magnet. Under certain conditions an electrical potential of >1,000 volts could exist on the surface of the magnet.

Quenching may cause severe and irreparable damage to the superconducting coils (magnet). A quench results in several days of downtime, and significant financial burden. It should only be activated in true emergencies:

1. It is a life-or-death situation in which a person is pinned to the magnet by a ferromagnetic object and there is possibility of loss of life or limb.
2. There is a fire that cannot be contained using the non-magnetic “conditional” fire extinguisher and requires the assistance of the fire department.

A quench is **NOT** necessary:

1. For an isolated projectile in the magnet, without patient risk; the service engineer should be contacted.
2. In an emergency event such as a Code Blue or fire if the patient can be removed safely.

Spontaneous quench is exceedingly rare. This type of quench is normally caused by a system failure. Normally associated with the shutdown of the cold head or chiller devices.

Each magnet is equipped with Emergency Stop buttons. These are the plain red buttons located in the scan room, control room, and are **not** under plastic. Shutting the power off may be required for situations such as:

1. Fire in the computer room.
2. Fire, sparks, loud noises emanating from the scanner room.
3. Flooding or sprinkler system goes off.
4. Catastrophic equipment failure.

PROCEDURE:

The process of a quench cannot be stopped.

MRI Staff Workflow – Intentional / Controlled Quench

1. Never attempt to test the Quench button.
2. Respond to audible warnings, i.e. O2 sensor.
3. Call 5555 code Triage to the MRI (back or front).
4. Remove the patient from the scanner room quickly and carefully. Remain calm and reassure the patient.
5. Close all doors when leaving the area.
6. The quench button is to be pressed by Level Two MR personnel. After hours, when the MRI unit is closed, a fire captain can initiate the quench after contacting the vendors service hotline and/or Level Two MR personnel to guide subsequent actions.
    a. Please note that upon a quench it can take 1-2 minutes for the magnet field to dissipate.
7. Evacuate patient and personnel to safe location.

8. Collaborate and assist with instructions to responding people, i.e. Facilities, Clinical Engineering, Sonoma Fire Department, Nurse Supervisor, MRSO.
9. Notify department leadership.
10. Call service provider to service the magnet.
11. Complete an online occurrence/incident report (eNotification).

MRI Staff Workflow – Unintentional / Spontaneous Quench

1. Respond to audible warnings, i.e. O2 sensor.
2. Call 5555 code Triage to the MRI (back or front).
3. If there is a patient in the scanner room, remove the patient quickly and carefully. Remain calm and reassure the patient.
4. Close all doors when leaving the area.
5. Evacuate patient and personnel to safe location.
6. Collaborate and assist with instructions to responding people, i.e. Facilities, Clinical Engineering, Sonoma Fire Department, Nurse Supervisor, MRSO.
7. Notify department leadership.
8. Call service provider to service the magnet.
9. Complete an online occurrence/incident report (eNotification).

Cryogen Safety

MR systems with a superconductive magnet must be equipped with a quench pipe that is vented to the outside of the facility. Nitrogen and helium are odorless, non-flammable and non-poisonous. When these gases evaporate, they form a cold mist with helium rising and nitrogen descending to the ground. They can be harmful due to displacement or dilution of oxygen in the air. If helium “clouds” or “fog” are present around or above the MR scanner, there is risk of asphyxiation and frostbite.

All helium may not be dissipated during a quench so no ferrous material, including rescue equipment, should be allowed in the magnet room (Zone 4) until proper clearance is given.

Please note that upon a quench it can take 1-2 minutes for the magnet field to dissipate.

In the event of a system quench, all personnel and patients must be evacuated from the MR scan room as quickly as safely feasible. Site access must also be restricted to all individuals until the arrival of MR equipment service personnel.
The appearance of white “clouds” or “fog” around or above the MR scanner is a possible sign of cryogen gases escaping the MRI system. If this is seen evacuation of the MR room is necessary and investigation and clearance by MR equipment service personnel is necessary.

MRI personnel will monitor the helium level and pressure daily whenever MRI services are performed.

REFERENCES:
American College of Radiology Manual on MRI Safety (draft): 2024
ACR Guidance Document on MR Safe Practices: 2013
Siemens Healthineers. (2016, February 24) Operator Manual – MR System and Coils Syngo MR XA60. Siemens Healthineers. https://www.siemens-healthineers.com/

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Director of Diagnostic Services
Medical Director of Radiology
Chief Ancillary Officer
Safety Officer/Safety Committee
Director of Quality & Risk Management
Emergency Management Coordinator
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Surgery Committee:
Medical Executive Committee:
The Board of Directors:

NEW POLICY

WHY:

To ensure the Magnetic Resonance Imaging (MRI) equipment is operating in a safe manner for both the patient and operator(s) and is producing high quality images.

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Chief Ancillary Officer
Director of Diagnostic Services
Radiology Medical Director
Board Quality Committee

PURPOSE:

To ensure the Magnetic Resonance Imaging (MRI) equipment is operating in a safe manner for both the patient and operator(s) and is producing high quality images.

POLICY:

Magnetic resonance imaging (MRI) scanners shall have routine quality control (QC) performed to include daily and/or weekly MRI technologist QC, an annual evaluation by a certified medical physicist, and routine preventative maintenance by a service provider.

PROCEDURE:

A. QC by the MRI technologist will be performed in accordance with manufacturers guidelines.
B. An annual evaluation by a certified medical physicist will be performed in accordance with the American College of Radiology MRI Quality Control Manual and Center for Improvement in Healthcare Quality (CIHQ) requirements. A report will be prepared to summarize the results of the evaluation and any corrective action needed. The evaluation will include at a minimum the following tests.
    a. Image uniformity for all clinically used volume RF coils
    b. Signal-to-noise for all clinically used RF coils
    c. Slice thickness accuracy
    d. Slice positioning and alignment accuracy
    e. High contrast resolution
    f. Low contrast resolution
    g. Geometric accuracy
    h. Magnetic field homogeneity
    i. Artifact evaluation
C. Regular preventative maintenance will be performed by a trained service provider.
D. Documentation of all QC activities will be maintained.

REFERENCES:

American College of Radiology, 2015 Magnetic Resonance Imaging Quality Control Manual
CIHQ Accreditation Standard & Requirement(s), RD-1,E and RD-4,B

Siemens Healthineers. (2016, February 24) Operator Manual – MR System and Coils Syngo MR XA60. Siemens Healthineers. https://www.siemens-healthineers.com/

OWNER:
Chief Ancillary Officer

AUTHORS/REVIEWERS:
Director of Diagnostic Services
Radiology Medical Director
Board Quality Committee

APPROVALS:
Policy & Procedure Team:
Surgery Committee:
Medical Executive Committee:
The Board of Directors:

RESOLUTION NO. 375

DATED_____

RESOLUTION OF THE BOARD OF DIRECTORS OF THE
Sonoma Valley Health Care DISTRICT, COUNTY OF SONOMA
STATE OF CALIFORNIA, ORDERING AN ELECTION TO
BE HELD AND REQUESTING CONSOLIDATION
WITH THE NOVEMBER 5, 2024,
CONSOLIDATED DISTRICT ELECTION

WHEREAS, an election will be held on NOVEMBER 5, 2024, in the **Sonoma Valley Health Care** DISTRICT for the purpose of electing District Directors to fill positions that will expire in 2028;

BE IT RESOLVED THAT, the District Directors of said district hereby request consolidation with any election that may be held on the same day, in the same territory or in territory that is in part the same.

THE FOREGOING RESOLUTION was introduced by Director **Bjorndal**, who moved its adoption, seconded by Director _____ and then adopted on roll call by the following vote:

Director **Bjorndal** Aye_____ No_____ Abstain_____
Director **Boerum** Aye_____ No_____ Abstain_____
Director **Kornblatt Idell** Aye_____ No_____ Abstain_____
Director **Myatt Lee** Aye_____ No_____ Abstain_____
Director **Kalos** Aye_____ No_____ Abstain_____

AYES_____ NOES _____ ABSTAIN _____ ABSENT _____

WHEREUPON, the Chairperson declared the foregoing resolution adopted and SO ORDERED

_____
District Administrator/Secretary

M E M O R A N D U M

TO: DEVA MARIE PROTO, COUNTY CLERK & REGISTRAR OF VOTERS

FROM: _____DISTRICT

SUBJECT: NOTICE OF OFFICES TO BE FILLED AND STATEMENT OF RESPONSIBILITY FOR STATEMENTS OF QUALIFICATIONS

Notice is hereby given that, pursuant to Elections Code Section 10509 (which requires notification prior to the 125th day before the election, *July 3, 2024), the following are the elected office holders of this district whose terms will expire in 2024, and whose successors will be required to be elected at the upcoming election to be held on NOVEMBER 5, 2024.

DIRECTOR	LENGTH OF NEXT TERM (Commencing 12/06/2024)
1. **Bjorndal**	**4** YEARS
2. **Boerum**	**4** YEARS
3. **Kornblatt Idell**	**4** YEARS
4. _____	_____ YEARS
5. _____	_____ YEARS

(MARK APPROPRIATE OPTIONS BELOW)

The length of the Statements of Qualifications shall not exceed 200 words.

1. The costs incurred in the printing of the optional Statements of Qualifications (English & Spanish, if requested by the candidate) in the Voter Information Pamphlet is the responsibility of the (select one):

[ ] District
[**X**] Candidate

a. If the candidate is responsible for costs of the Statement of Qualifications, the district opts to (select one):

[**X**] Require payment in advance to the District Secretary.
[ ] Bill the candidate after the date of the election.

Note: It is the responsibility of the District to collect the costs of Statements of Qualifications from the candidates whether payment in advance or payment after the fact is required. **If advance payment is required, candidates must present a receipt from the district at the time the Statement of Qualifications is filed with the Registrar of Voters Office. Multi-county districts please be advised that the estimated cost reflects only the Sonoma County portion of the cost.**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND SUBMIT THIS STATEMENT IN COMPLIANCE WITH ELECTIONS CODE SECTIONS 10509 AND 13307.

SEAL SIGNED: _____ DATE: _____

M E M O R A N D U M

TO: DEVA MARIE PROTO, COUNTY CLERK & REGISTRAR OF VOTERS

FROM: **Sonoma Valley Health Care** DISTRICT

SUBJECT: NOTICE OF DISTRICT BOUNDARIES/STATEMENT IN LIEU OF MAP

DATE: _____

Pursuant to Elections Code Section 10522 (which requires notification prior to the 125th day before the election (July 3, 2024) regarding district boundaries in the above named district), we are hereby notifying the Registrar of Voters Office that:

[X] As of this date, there has been no change in the boundaries of this district since the date of the last election. A map of the district is already on file with your office; therefore this notice is in lieu of providing a duplicate map.

[ ] A map of the above district, with all annexations and detachments shown thereon, is attached to this notification and incorporated for reference herein.

[ ] There have been changes in the boundaries of this district since the date of the last election. A verified map of the above district containing all recent annexations and details shown thereon, is already on file with your office.

Submitted by _____
District Administrator/Secretary

SEAL

Chief of Staff Board Report

Ako Walther, MD, MMM

Term of report : January 2024- July 2024

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Subjects

1. **Current Medical Staff**
2. **Medical Staff Quality**
   - I. ED Q-Reviews
   - II. Ambulatory Surgery
   - III. HCAHPS, Inpatient Service Survey
3. **Medical Staff Summary**
   - I. Meetings Update
   - II. concerns and update
   - III. Follow-up on three goals set by Chief of staff

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Current Medical Staff By The Numbers

- Total Medical Staff: **142**
- Active Medical Staff: **34**
- New Medical Staff (since May 2024) : **3**
  - *Christopher Walter, MD Orthopedics*
  - *Maryam Aghighi, MD Pathology*
  - *Kevin Junus, MD Radiology*
- Resignations: **6** --They are all voluntary

2 Hospitalists, 1 Orthopedic PA, 1 Radiology, 1 Anesthesia

1 Ophthalmology

ED Q-Reviews

6 Questions

1. How would you rate the **courtesy** of your doctor?
2. How would you rate the **waiting time** at the ED?
3. How well were your tests, treatments, and medications **explained** to you?
4. **Overall**, how would you rate your **experience** with us?
5. How likely are you to **recommend** us to a friend or loved one?
6. How would you rate **the time** your **doctor spent** with you?

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ED Care Feedback

	Mar 2024	Apr 2024	May 2024	June 2024	July 2024
Overall Score	4.55 96 Responses	4.71 116 Responses	4.61 107 Responses	4.77 130 Responses	4.73 129 Responses
How would you rate the courtesy of your doctor?	Average Score **4.600** ★ ★ ★ ★ ★ Total Responses **90**	Average Score **4.772** ★ ★ ★ ★ ★ Total Responses **114**	Average Score **4.635** ★ ★ ★ ★ ★ Total Responses **104**	Average Score **4.941** ★ ★ ★ ★ ★ Total Responses **118**	Average Score **4.795** ★ ★ ★ ★ ★ Total Responses **117**

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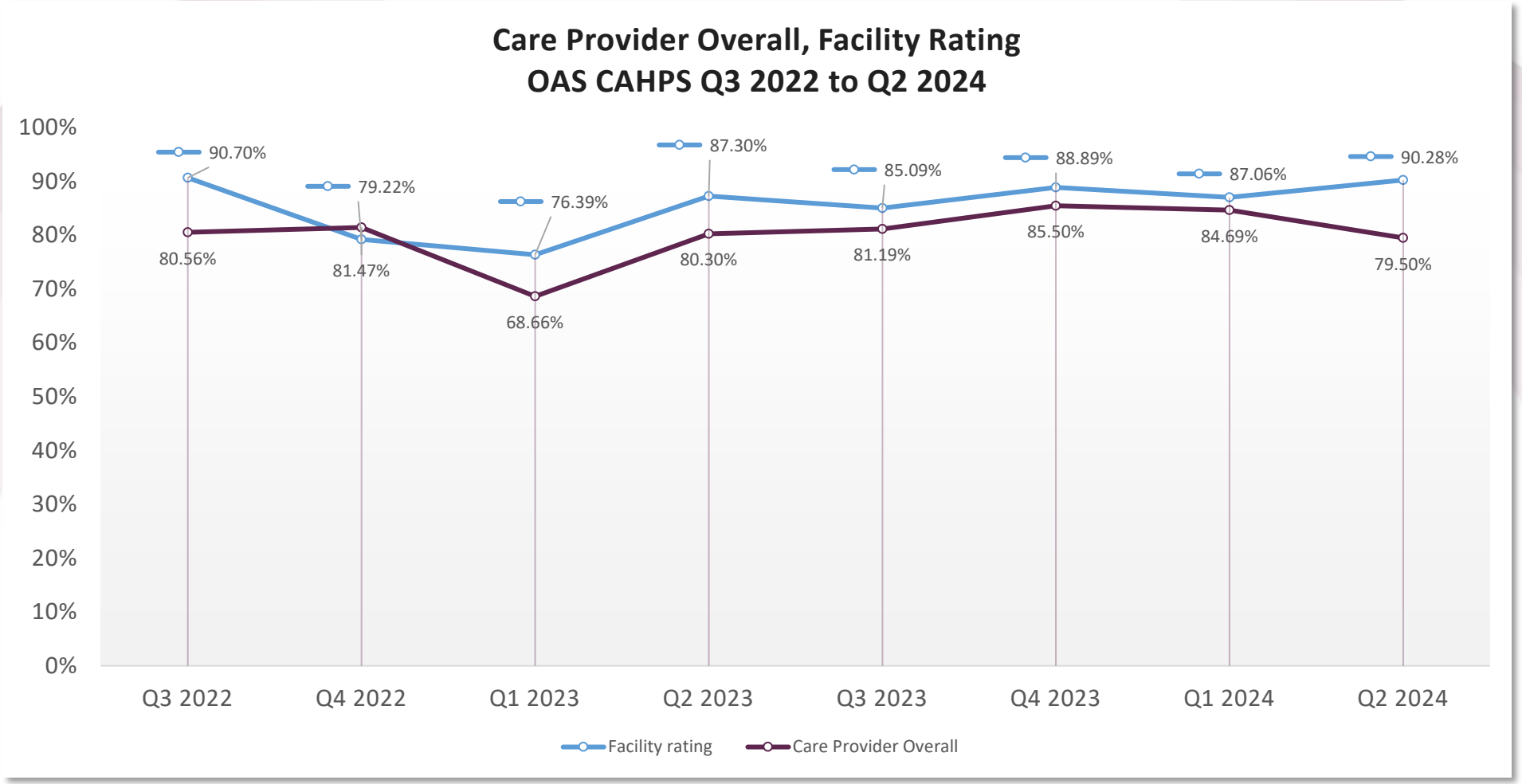
Ambulatory Surgery



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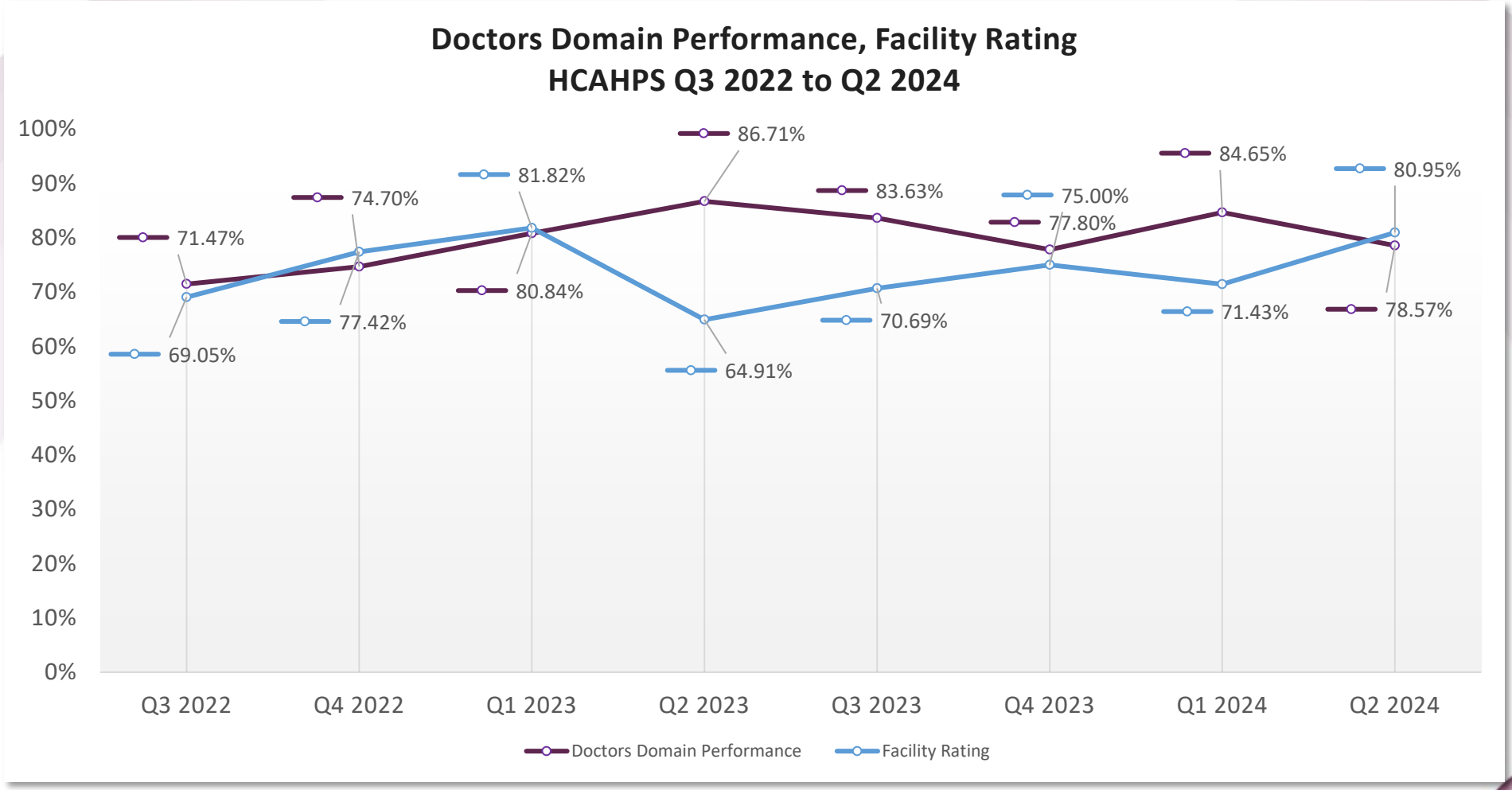
HCAHPS



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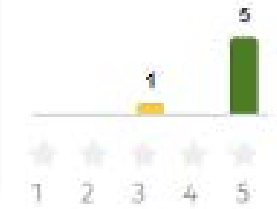
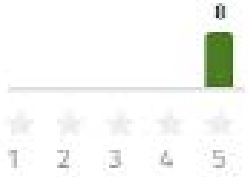
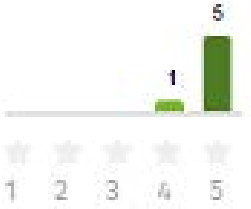
Inpatient Care Feedback

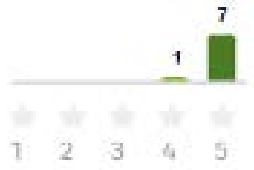
How would you rate the courtesy of your doctor?

March 2024	April 2024	May 2024	June 2024	July 2024
Average Score	Average Score	Average Score	Average Score	Average Score
4.670	**4.800**	**5.000**	**4.830**	**4.880**
★ ★ ★ ★ ★	★ ★ ★ ★ ★	★ ★ ★ ★ ★	★ ★ ★ ★ ★	★ ★ ★ ★ ★
Total Responses	Total Responses	Total Responses	Total Responses	Total Responses
6	**5**	**8**	**6**	**8**









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Medical Staff Meetings Update

Medicine Committee

- **ED**-In conjunction with the new ED RN director, Marylou, ED continued to improve ED RN staffing patient flow models, leading to improved wait times and decreased LWBS.
- **Inpatient** : Maintain target LOS and high patient satisfaction by enhancing collegial care with inpatient staff. Strengthen collaboration with ID and Micro Labs to enhance patient care. There are some challenges due to the absence of a social worker.
- **PHC**-Care has been enhanced with the new ED group, and communication between ED, hospitalists, and PC is more robust, though some challenges remain.
- **Subspeciality**-runs smooth with no specific issues

Medical Staff Meetings Update

Surgery Committee

o Dr Walter is up and running an orthopedic service.

o Staffing remains a challenge due to uneven caseloads.

o The surgery team remains committed to providing excellent care.

o Our anesthesia services consistently remain top-tier.

MEC

Meet regularly to discuss subjects. We held an additional dinner meeting to address challenges and concerns and provide in-depth updates.

Medical Staff Meetings Update

Performance Improvement/Pharmacy & Therapeutics

- Reviewed updated facility Antibiogram and Empiric Antibiotic therapy guidelines
- Reviewed facility high alert list & look alike-sound alike list
- Reviewed antimicrobial stewardship committee meeting minutes
- Reviewed medication safety action items from ISMP (Institute for Safe Medication Practices)
- Added to formulary
    - Lokelma
    - Jardiance
    - Myrbetriq
- Deleted from formulary
    - Olumiant
- Reviewed Pharmacy QAPI results
- Multiple medication management policy updates approved

Medical Staff Concerns and Update

- The departure of Dr. Kidd and Dr. Lee's retirement reduced the number of surgical cases.
- The absence of a CMO
- Challenges continue with EMS transport for higher levels of care, and significant difficulties remain in transferring patients to UCSF.
- Enhancing PCP access to patient data: bridging gaps in EHR systems remains challenging.

Medical Staff Summary

Goals	Actions
Foster trust and unity among medical staff leadership to forge a strong, cohesive team.	We continue holding off-site quarterly meetings with medical staff leaders to build team cohesion and trust, which has proven successful.
Build a strong partnership with the new ER group for exceptional patient care.	Dr. Cusick and I promptly address any issues and concerns. We regularly review patient flow and update and revise patient care protocols.
Strengthen connections with local PCPs for smoother patient care transitions.	I coordinate with all local PCPs to address any issues or concerns, ensuring a smooth transition from PCP to ED, inpatient care, and discharge.

Ancillary Services Annual Report 2023

SVHCD Board of Directors

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
HEALING HERE AT HOME

AGENDA

- Who Are We
- Our Dashboard
  - Quality, Patient, and Staff Satisfaction
- Volumes
- Professional Growth
- Community Service
- Accomplishments
- Challenges
- What’s Next

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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WHO ARE WE

- Diagnostic Services
  - Imaging and Cardiology
- Laboratory
  - Clinical Lab, Pathology, and Blood Bank
- Rehab Services
  - Physical Therapy, Occupational Therapy, Speech Therapy
- Occupational Health
- Wound Care
- Patient Access
- Physician Clinics

Total Staff - 116

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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QUALITY DASHBOARD

Wound Care	2023				
	Q1	Q2	Q3	Q4	Goal
Mean Time to Heal	14	11	12	13	*<31 days*
Percent Outliers	6%	0%	2%	1%	*<22%*
Percent Healed	100%	98%	95%	99%	*>97%*
Rehab Services	**2023**				
	Q1	Q2	Q3	Q4	Goal
Functional Ability/OP	100%	100%	93%	100%	*90%*
Ambulation Distance/IP	60%	59%	66%	79%	*>150 feet*
Occ Health	**2023**				
	Q1	Q2	Q3	Q4	Goal
Chart Audits	100%	100%	100%	100%	*100%*
Employer Complaints	0	0	1	1	*<3*
Patient Complaints	0	0	0	0	*<3*

Diagnostic Services	2023				
	Q1	Q2	Q3	Q4	Goal
Extravasations	1	1	1	3	*0*
Repeat Analysis	3.68 %	3.64%	3.88 %	3.58 %	*<5%*
CTDI Dose	0	0	0	0	*0*
Laboratory	**2023**				
	Q1	Q2	Q3	Q4	Goal
Blood Culture Contamination	2.6%	2.3%	2.0%	1.8%	*≤3%*
Critical Values Timely Report	100%	95.6%	91%	89.5 %	*100%*
Patient Access	**2023**				
	Q1	Q2	Q3	Q4	Goal
RMH- Patient Scheduling	2.7	3	3	2	*≤3*
MSP Completion	100%	99%	100%	100%	*100%*
IMM Signed	90%	90%	100%	94%	*100%*

Staff Turnover Rate	2023
Wound Care	0.0%
Rehab Services	7.6%
Occ Health	24.5%
Family Practice	0.0%

Staff Turnover Rate	2023
Diagnostic Svcs	5.4%
Laboratory	9.8%
Patient Access	62.0%

TOTAL	19.80%

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PATIENT SATISFACTION
Rate My Hospital 2023

Department	Q1	Q2	Q3	Q4
Medical Imaging	4.85	4.86	4.81	4.87
OP Rehab	4.91	4.92	4.94	4.92

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STAFF SATISFACTION

Department	2023	2024
Patient Access	3.24	4.20
Occ Health	2.98	4.55
Laboratory	3.95	4.00
Direct Reports	4.23	4.32
Family Practice	3.49	4.25
Diagnostic Imaging	4.13	4.38
Rehab Services	4.33	4.06

Annual Volumes

Department	FY 2023	FY 2024
OP Rehab	25,639	32,261
Lab	148,212	126,363
X-ray	11,587	12,074
CT	6,788	7,060
Ultrasound	3,041	2,967
Mammography	2,862	3,228
MRI	1,736	1,679
PFT	347	381
Echo	1,192	1,513
EKG	141	248
Occ Health	4,141	3,561
Wound Care	2,839	2,324

PROFESSIONAL GROWTH

- Diagnostic Services
  - MRI Tech - MRI Safety Officer
  - MRI Tech – MRI Certification
  - 2 Xray Techs – CT Certification
  - Ultrasound Tech – Physician Assistant
- Laboratory
  - Lab Assistant – ER RN
  - Lab Assistant - Clinical Lab Scientist (in school)
- Occupational Health
  - Medical Assistant – Ultrasound Tech (in school)
  - Medical Assistant – Accepted to LVN School
- Wound Care
  - Medical Assistant – Respiratory Therapist (in school)
- Patient Access
  - Registration – RN (in school)
  - Registration – Physician Assistant (in school)

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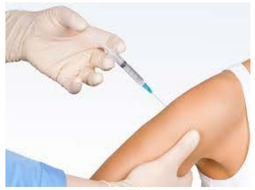
COMMUNITY SERVICE

- Redwood Empire Food Bank
- Flu Clinics – St. Leos Church, Vintage House
- Mammography Spa Day
- Diabetes Initiative
- Emergency Preparedness
- Back To School Health Fair
- Homeless Action Sonoma



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ACCOMPLISHMENTS

- New Leadership Family Practice
- New Technical Supervisor Laboratory
- Surgeon Clinic added to 1206B
- New MRI

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CHALLENGES

- Staffing
- Space
- Aging Equipment

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WHAT'S NEXT

- Completion Phase II ODC
- Relocation Surgeon Clinic
- Expansion Physical Therapy
- New Analyzer Equipment
- More Mid Level Providers
- MRI to Permanent Building

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ICU Nurse Station Replacement

Project

Sonoma Valley Health Care District
Board of Directors Meeting
September 5, 2024

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Overview

ICU Project

- Plan Overview
- Scope Overview
- Budget
- Risks/Contingency Overview
- Schedule
- Bid Overview
- Board Recommendation – Approve budget; Bid Award

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Project Plan Overview

- 2020 - original budget scoped assuming no permit - $327K
- 2021 - SVH Foundation completed fundraising in 2021
- 2023 - Architect confirmed that a portion of the project required permitting. Project and budget were reviewed. Funds available from Foundation $405K
- 2024 – Project construction estimated to be $383K based on Architect schematic design with overall costs projected at $711K. Foundation committed additional funds towards the $711K project estimate.
- Summer 2024 - Public bid with competition for project construction resulted in the lowest bid at $302K, which reduced the overall budget for the project from $711K to $630K.

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Project Scope Overview

ICU Project Scope

- Replace nurse station casework with systems furniture
- Replace Med Prep station in nurse area. Infill window above med prep station for vertical storage.
- Replace Isolation room hand wash and storage area
- Paint and replace flooring in Main ICU area (similar to 2018 Med Surg refurbishment)
- Replace laminate in headwalls in all ICU patient rooms
- ICU Room footwalls – add TVs in 5 patient rooms with new electrical, accent paint, refresh communication board & organize clinical accessories for nurse functionality
- Add emergency power outlets outside patient rooms 1 & 6 to complete emergency power throughout ICU unit
- IT cabling upgrade to nurse station and Pyxis medication dispenser

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PROJECT BUDGET

BUDGET BREAKDOWN	
Design	$122K
Permit & Inspection Service Costs	$39K
Construction Costs	$302K
Furniture Fixtures & Equipment Costs	$51K
Communication & Low Voltage Costs	$10K
Owner Costs/Project Management	$39K
Contingency	$67K
TOTAL PROJECT	**$630K**

POTENTIAL SCOPE ADDS*	
Flooring – patient rooms, physician office, lockers	Cost TBD – Contractor
IT Cabling patient rooms	$20K

$601K funded by the Foundation; $29K funded by SVH Capital

*Scope adds to be reviewed by the Finance Committee/Board of Directors and funded by SVH Capital if approved

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PROJECT RISKS AND CONTINGENCY

Projects Risks

Potential risks include: inspection delays, unforeseen field conditions or material delivery delays that could extend the schedule.

4 week Contractor general conditions from a schedule extension could cost approximately $45K

Occupancy of ICU unit was reviewed with our Architect. The project is structured for continual HCAI occupancy and unit will continue operations at reduced capacity. 3 patient rooms, Nurse station, hand wash station, med prep, pyxis medication dispenser will be active throughout project.

Owner Project Contingency - $67,309

- **Represents: 10.5**% of $630K overall project cost
- **Usage:** Update discovered existing non-compliant field conditions to current building code. Costs for construction, materials, design alterations, HCAI approvals and project management coordination
- **Construction bid -** $302K for bid scope, any scope change results in a change order from the contractor to owner. Contingency to be used to cover change orders

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PROJECT SCHEDULE

SCHEDULE	TARGET COMPLETION
START OF CONSTRUCTION	9/30/24
SYSTEM FURNITURE ARRIVAL AT SITE	OCTOBER 2024
END OF CONSTRUCTION	DECEMBER 2024
HCAI PROJECT SIGN-OFF AND CLOSURE	JANUARY 2025

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BID OVERVIEW

PUBLIC BID – ICU NURSE STATION REPLACEMENT

- 5 – GENERAL CONTRACTORS ATTENDED PRE-BID WALKTHROUGH
- 5 – PARTICIPANTS AT PRE-BID WALKTHROUGH ARE ELIGIBLE TO BID
- 3 – BID PACKAGE RECEIVED AT BID DEADLINE
  - RIDGEVIEW BUILDERS - $302,000.00
  - COLIN CONSTRUCTION - $328,987.00
  - GMH BUILDERS - $448,300.00

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BID AWARD RECOMMENDATION

PUBLIC BID – ICU NURSE STATION REPLACEMENT

- HOSPITAL ADMINISTRATION IS RECOMMENDING THE BID AWARD TO RIDGEVIEW BUILDERS, INC. AS LOWEST RESPONSIVE BIDDER
- BID AMOUNT - $302,000.00
- BID AMOUNT WITHIN ORIGINAL PROJECTED CONSTRUCTION ESTIMATE OF $383,000.00
- NOTE: IT IS FURTHER RECOMMENDED THAT A BID INFORMALITY BE WAIVED IN ACCORDANCE WITH BID MANUAL 00 11 16 NOTICE INVITING BIDS AND SECTION 4.10.8 MINOR DEVIATIONS FROM THE POLICY AND PROCEDURES GOVERNING BIDDING FOR FACILITY PROJECTS

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BID INFORMALITY / MINOR DEVIATION

00 11 16 – NOTICE INVITING BIDS

NOTICE IS HEREBY GIVEN that the Sonoma Valley Healthcare District ("District") invites and will receive sealed Bids up to but not later than **12:00 Noon on August 2nd, 2024** at the Sonoma Valley Hospital Basement Conference Room, located at 347 Andrieux Street, Sonoma, California, for the furnishing to District of all labor, equipment, materials, tools, services, transportation, permits, utilities, and all other items necessary for **ICU Nurse Station Replacement Project** (the "Project"). At said time, Bids will be publicly opened and read aloud. Bids received after said time shall be returned unopened. Bids shall be valid for a period of 90 calendar days after the Bid opening date.

District shall award the contract for the Project to the lowest responsive, responsible Bidder as determined by the District from the Base Bid. District reserves the right to reject any or all bids or to waive any irregularities or informalities in any bids or in the bidding process.

END OF NOTICE INVITING BIDS

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POLICY AND PROCEDURES GOVERNING BIDDING FOR FACILITY PROJECTS # P-2019.08.01

4.10.8 **Minor Deviations.** The Board reserves the right to waive inconsequential deviations from the specifications in the substance or form of formal bids received.

- PRINCIPAL/CONTRACTOR DID NOT SIGN THE BID BOND; HOWEVER, IT WAS SIGNED BY THE SURETY
- THE INFORMALITY OR INCONSEQUENTIAL DEVIATION DOES NOT AFFECT THE ENFORCIBILITY OF THE BOND ACCORDING TO LEGAL COUNSEL

Reference cited by SVH Legal Counsel - "(A) bond is enforceable if signed by the surety, regardless of whether it is signed by the principal/contractor. (Civ. Code, § 2793; *Pacific Mill & Timber Co. v. Massachusetts Bonding & Ins. Co.* (1923) 192 Cal. 278, 282-292; *Hill v. New Amsterdam Cas. Co.* (1930) 105 Cal.App. 156, 158 -159; *C. Ganahl Lumber Co. v. Thompson* (1928) 205 Cal. 354, 358).)"

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NEXT STEPS

- QUESTIONS?
- THE ICU PROJECT BUDGET AND PUBLIC BID WERE REVIEWED AT THE AUGUST 2024 FINANCE COMMITTEE. THE FINANCE COMMITTEE RECOMMENDED TO PROCEED WITH A $630K BUDGET AND AWARD THE CONTRACT TO THE LOWEST RESPONSIVE BIDDER
- BOARD ACTION: HOSPITAL ADMINISTRATION IS REQUESTING THE BOARD OF DIRECTORS TO APPROVE THE ICU PROJECT $630K BUDGET AND AWARD THE BID PER THE AGENDA MOTION TO RIDGEVIEW BUILDERS, INC. – ICU NURSE STATION REPLACEMENT - $302,000.00

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To:	**SVHCD Board of Directors**
From:	**Kimberly Drummond, Chief of Support Services**
Meeting Date:	**September 5, 2024**
Subject:	**ICU Project Bid**

Request to the Board of Directors to consider a motion to award contract to RIDGEVIEW BUILDERS in the amount of $302,000.00 as lowest responsible responsive bidder for the project and to waive any irregularities in connection therewith including by way of illustration and not by limitation minor irregularity in connection therewith of bid bond not being executed by contractor but being executed by the surety pursuant to applicable law providing that bid bond is nonetheless enforceable when executed by surety.

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To: SVHCD Board of Directors
From: John Hennelly
Date: 09.5.24
Subject: CEO Report

Strategic Plan

As related to our new **strategic plan**, our efforts in FY24 will focus on:

- *Campus Realignment*: discussions with UCSF regarding how they might participate, business plan development on SNF, Sub Acute, Memory Care service lines; working to engage a firm to assist with the development of a master facility plan.
- *Community Care*: market sizing for various community opportunities, urgent care, diagnostic center, specialty clinics, PT/OT
- *Sustainability*: business plan development on GI, cardiology, orthopedics, and UCSF clinical services
- *Seismic*: continued research on possible options. The hospital has engaged HED to assist in the assessment.

We are excited that the hospital was again recognized by the Lown Institute for its performance across various facets of outcomes, value and equity. The hospital ranked **2nd in the state** out of 258 and ranked **10th nationally** out of 2758 acute care hospitals.

Sonoma Valley Health Care District - Lown Institute Hospital Index (lownhospitalsindex.org)

Operations

The hospital saw strong volumes in July with the ER exceeding 1000 visits while both inpatient and OR fell below budget. Outpatient services led by physical therapy and imaging exceeded budgets. This led to exceptional financial performance with Operating Margin exceeding budget by 58%, ($458k), EBDA exceeding budget by 111%, $61k, and Net Income ahead of budget by 101% at $3k.

The new 3-tesla MRI is open and seeing patients. The magnet is housed in a temporary building, awaiting construction of its permanent location connected to the hospital next year.

Our Chief Medical Officer recruitment continues. The UCSF recruitment team is screening candidates for interview. Once qualified candidates are identified, an internal search committee comprised of medical staff members and hospital management will work to select our next CMO.

Patient satisfaction continued to be strong. Survey results show high satisfaction with both care and service. A few examples:

Easy, seamless process. Staff are friendly, professional, technically competent, and efficient.

Excellent down to earth employees and easy parking!

Muy bien lugar para operarse son muy eficientes y profesionales (Very good place to have surgery, they are very efficient and professional)

Capital

The Outpatient Diagnostic Center (ODC) project is 75% complete. The temporary location for the new **MRI** is complete. The permanent MRI location is being developed. The demolition phase was awarded to GMH to take place through the summer and into the fall. The project review with HCAI is proceeding.

The **ICU renovation** has been approved by HCAI. A bid package for the construction work has been published, responses received, and a contractor has been selected awaiting approval by the Board. We expect construction to begin in late Fall. The project is scheduled for completion in early 2025.

SVH Performance Score Card

1. Quality and Safety

Objective	Target	JUN.24	JUL.24	Trend	Supporting detail
Infection Prevention					
Central Line Blood Stream Infection CLABSI per 10k pt days	<1	0.00	0.00	⇆	
Catheter Associated Urinary Tract Infection- CAUTI per 10k pt days	<1	0.00	0.00	⇆	
CDIFF Infection per 10k pt days	<0.9	0.00	0.00	⇆	
Patient Fall per 1000 pt days	<3.75	0.00	4.35	↑	1 pt fall no injury
Patient fall with injury per 1000 pt days	<3.75	0.00	0.00	⇆	
Surgical Site Infections per 1000 Acute Care Admissions	0.00	0.00	0.00	⇆	
Core Measures					
Sepsis Early Management Bundle % compliant	>81%	50 (n=2)	66.7 (n=3)	↑	
Severe Sepsis 3 hour Bundle % compliant	>94%	100 (n=5)	66.7 (n=3)	↓	
Severe Sepsis 6 hr Bundle % compliant	100.00	50 (n=2)	100 (n=2)	↑	
Core OP 23- Head CT within 45 mins % compliant	70.00	66.7 (n=3)	N/A		
Mortality					
Acute Care Mortality Rate %	<15.3	3.40	4.60	↓	Lower is better
ED					
Core OP 18b Median Time ED arrival to ED Departure mins	<132	141 (n=30)	117 (n=30)	↑	Lower is better
Core Op 22 ED Left without being seen LWBS	<2%	0.1 (n=1)	0.4 (n=4)	↓	
PSI 90					
PSI 90 Composite Acute Care Admissions	0.00	0.00	60.33	↓	Pressure ulcer
Preventable Harm					
Preventable Harm Events Rate % of risk events graded Minor-Major	0.00	0.10	0.05	↑	
Readmissions to Acute Care within 30 days %	<15.3	7.69 (n=4)	3.57 (n=2)	↑	Lower is better

2. Employees

Objective	Target	JUN.24	JUL.24	Trend	Supporting Detail
Turnover	<3%	0.1	1.2	↓	
Workplace Injuries	<20 Per Year	0 (QTR 2)	0 (QTR 3)	⇆	

3.Patient Experience

Objective	Target	MAY.24	JUN.24	Trend	Supporting Detail
Outpatient Ambulatory Services					
Recommend Facility	>90%	88 (n=25)	71.43 (n=7)	↓	Top Box Scores. % of patients that ranked us 5/5
Communication	>90%	86 (n=25)	100 (n=8)	↑	
Discharge Instructions	>95%	91 (n=25)	97.92 (n=8)	↑	
HCAHPS					
Recommend the hospital	>90%	69 (n=13)	82.35 (n=17)	↑	Top Box Scores. % of patients that ranked us 5/5
Communication with Nurse	>90%	69 (n=13)	84.21 (n=19)	↑	
Communication with Doctor	>90%	69 (n=13)	85.19 (n=19)	↑	
Cleanliness of Hospital	>90%	61 (n=13)	83.33 (n =18)	↑	
Communicaiton about medicines	>90%	59 (n=13)	65 (n=15)	↑	
Discharge Information	>90%	95 (n=13)	93.93 (n=17)	↓	

4. Volume

Objective	Target	JUN.24	JUL.24	Trend	Supporting Detail
Patient Visits					
Emergency Visits	>855	994.0	1006.0	↑	
Surgical Volume Outpatient	>140	128.0	131.0	↑	
Surgical Volume Inpatient	>13	7.0	7.0	⇆	
Inpatient Discharges	>70	58.0	65.0	↑	

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5. Financial

Objective	Target	JUN.24	JUL.24	Trend	Supporting Detail
Operating EBDA in %	>-4.5%	-15.0%	1.2%	↑	
Days Cash on Hand @ FYE	>30	22.7	22.0	⇆	**On track to end year @ 31.0**
Net Operating Revenue ($M) (annualized)	>$62	$ 58.0	$ 61.8	↑	

Scorecard Definitions for Quality Metrics

Central Line Associated Blood Stream Infection (CLABSI)
Blood stream infection found in a patient with a central line in place and has been >48 hours since admission.

Catheter Associated Urinary Tract Infection (CAUTI)
Urinary tract infection found in a patient who has a catheter in place and has been >48hrs since admission.

CDIFF (Clostridium Difficile)
Clostridium Difficile found from a stool sample in a patient that has been admitted >48hrs

Sepsis Early Management
Obtain Blood Cultures BEFORE antibiotics
Administer Antibiotics
Obtain Lactate Level
Lactate Level repeated (if elevated)

Severe Sepsis 3 hour bundle
All above included plus-
Administer 30ml/kg of crystalloid for hypotension or Lactate >4
Focused MD exam

Severe Sepsis 6 hour bundle (septic shock only)
Lactate greater than 4 or
If persistent hypotension with 1 hour of fluid administration add Vasopressor
Shock reassessment by physician

Mortality
Acute care mortality benchmark is derived from CMS 5-star rating benchmark which is 15.3%, our average mortality rate each month is around 2-6%, most of our deaths are expected a

PSI 90
Summarizes patient safety across multiple indicators including-
Pressure Ulcers
Falls with Hip Fracture
Perioperative (while in surgery) complications
Postoperative complications

Preventable Harm
Unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment or hc events that have a significance level of minor-major harm. Derived from the risk events entered into our risk reporting platform. Examples of risk events are- Patient falls, surgical comp AMA, Transfers to other facilities, Documentation issues. Goal is 0, Alarm is 5.0 which is the benchmark set by UCSF and chosen by Dr Kidd.

Readmissions
Percentage of patients that get readmitted to the hospital within 30 days of discharge.

To:	**SVHCD Board of Directors**
From:	**Sabrina Kidd, MD**
Meeting Date:	**September 5, 2024**
Subject:	**CMO Report**

August Highlights Included:

1. Contracts:
    a. Hanna Center: we signed a MOU with the Mental Health Hub at Hanna Center. This will allow their Community Health Workers to aid in outpatient Navigation of mental health services for patients who present to the SVH ED.
    b. Anesthesiology: we renewed our long standing contract for anesthesia services with ACM (Anesthesia Consultants of Marin).
2. Orthopedics: Dr. Walter began in the OR mid-August. The feedback from staff and patients has been very positive.
3. Director of Quality:
    a. Kylie Cooper's last day with SVH was August 23. She will be missed greatly. Recruitment for a new Director of Quality is underway with a couple of promising potential candidates undergoing interviews. For the interim, Jessica Winkler, our CNO and several of the Nursing Directors will be assisting in overseeing the duties of the Quality Department.
4. Medical Staff:
    a. August meetings included: MEC/Peer Review, PI/PT.

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To:	SVHCD Board of Directors
From:	Ben Armfield, Chief Financial Officer
Date:	September 5, 2024
Subject:	Resolution No. 379 - Setting the Tax Rate for the 2024-25 Fiscal Year GO Bonds

Recommendation:
Management recommends to the SVHCD Board of Directors the approval of the General Obligation Bonds tax rate of $18.50 per $100,000 of the assessed value of the secured property in the District.

Background and Reasoning:
This is consistent with prior year resolutions. The total assessed value of the secured property in the District is $13,501,129,238, which is an increase of 5% over the assessed value of secured property from last year. The tax required to assure payment of the principle, interest, and reasonable reserve for the Bonds for Fiscal Year 2024-2025 is $2,568,326. The rate, calculated per the Sonoma County's approved formula is $18.50 per $100,000 of assessed valuation.

Consequences of Negative Action/Alternative Actions:
Without the resolution, the County is directed to apply the most recently provided tax rate.

Financial Impact:
The resolution will instruct the County to collect the General Obligation Bond tax to be paid to the bond holders.

Selection Process and Contract History:
The Hospital has done similar resolutions in the past and the same methodology was applied for setting the tax rate for 2024-25. In addition, the proposed tax rate calculation and resolution has been reviewed by our consultant Gary Hicks, who has been a subject matter expert for SVH in this space for many years.

Finance Committee Approval:
This item was brought forward to the SVHCD Finance Committee on 8/27, and the committee formally approved management's recommendation for the SVHCD Board of Directors to approve.

Attachments:
Resolution No. 379

SONOMA VALLEY HEALTH CARE DISTRICT

RESOLUTION No. 379

RESOLUTION SETTING THE TAX RATE FOR THE 2024-25 FISCAL YEAR FOR THE PAYMENT OF PRINCIPAL AND INTEREST ON THE SONOMA VALLEY HEALTH CARE DISTRICT (SONOMA COUNTY, CALIFORNIA) GENERAL OBLIGATION BONDS, ELECTION OF 2008

WHEREAS, by resolution, adopted by the Board of Directors (the "Board") of the Sonoma Valley Health Care District (the "District") on August 6, 2008, the Board determined and declared that public interest and necessity demanded the need to raise moneys for the expansion, improvement, acquisition, construction, equipping and renovation of health facilities of the District (the "Project"), and the Board called an election to be held within the boundaries of the District in accordance with the California Elections Code;

WHEREAS, a special municipal election was held in the District on November 4, 2008 and thereafter canvassed pursuant to law;

WHEREAS, an election there was submitted to and approved by the requisite two-thirds (2/3) vote of the qualified electors of the District a question as to the issuance and sale of general obligation bonds of the District for the purpose of raising money for the Project in the maximum aggregate principal amount of $35,000,000, payable from the levy of an *ad valorem* tax against all taxable property in the District;

WHEREAS, pursuant to Chapter 4 of Division 23 (commencing with section 32300) of the California Health and Safety Code (the "Act"), the District is empowered to issue general obligation bonds;

WHEREAS, the District sold, on January 27, 2009, an initial series of bonds for the purpose of raising funds needed for the Project and for other authorized costs in the aggregate principal amount of $12,000,000, identified as the "Sonoma Valley Health Care District (Sonoma County, California) General Obligation Bonds, Election of 2008, Series A (2009)" (the "2009 Bonds"); and

WHEREAS, the District sold, on August 1, 2010, an additional series of bonds for the purpose of raising funds needed for the Project and for other authorized costs in the aggregate principal amount of $23,000,000, identified as the "Sonoma Valley Health Care District (Sonoma County, California) General Obligation Bonds, Election of 2008, Series B (2010)" (the "2010 Bonds"); and

WHEREAS, the District sold, on January 28, 2014, a refunding series of bonds for the purpose of refunding the 2009 Bonds in the aggregate principal amount of $12,437,000, identified as the "Sonoma Valley Health Care District (Sonoma County, California) 2014 General Obligation Refunding Bonds" (the "2014 Bonds"); and

WHEREAS, the District sold, on July 28, 2021, a refunding series of bonds for the purpose of refunding the 2010 Bonds in the aggregate principal amount of $15,825,000, identified as the "Sonoma Valley Health Care District (Sonoma County, California) 2021 General Obligation Refunding Bonds" (the "2021 Bonds" and together with the 2014 Bonds, the "Bonds"); and

WHEREAS, Sonoma County (the "County") has requested that the District provide to the County the tax rate required for Fiscal Year 2024-25 to pay principal and interest on the Bonds and to provide a reasonable reserve;

NOW, THEREFORE, THE BOARD OF DIRECTORS OF SONOMA VALLEY HEALTH CARE DISTRICT DOES HEREBY RESOLVE, DETERMINE AND ORDER AS FOLLOWS:

Section 1. Recitals. All of the recitals herein are true and correct. To the extent that the recitals relate to findings and determinations of the Board, the Board declares such findings or determinations to be made thereby.

Section 2. Tax Rate; Remittance.

(a) Based upon the County's estimate of assessed valuation of all secured property in the District ($13,501,129,238) the tax rate required to assure payment of the principal of, interest on and a reasonable reserve for the Bonds for Fiscal Year 2024-25 is $18.50 per $100,000 of assessed valuation. It is the intent of the District to provide to the County, by resolution, the tax rate required to assure payment of the principal of, interest on and a reasonable reserve for the Bonds for Fiscal Year 2024-25 and each Fiscal Year thereafter, so long as the Bonds remain outstanding. However, in the event the District fails to provide a tax rate in any year, the County is directed to apply the most recently provided tax rate in such year.

(b) The District hereby delegates to the County Board of Supervisors the authority to annually levy and collect the annual *ad valorem* property taxes required for the payment of the principal of and interest on the Bonds.

(c) The District hereby requests that such amounts, as collected, be remitted directly to The Bank of New York Mellon Trust Company, N.A., the District's paying agent for the Bonds.

Section 3. Request for Necessary County Actions. The County Board of Supervisors and the County Auditor-Controller-Treasurer-Tax Collector, and other officials of the County, are hereby directed to take whatever action that may be necessary pursuant to law to provide for the levy and collection of a property tax on all taxable property within the District at the tax rate specified in Section 2(a) above.

Section 4. General Authority. The Chair, the Secretary, the Chief Executive Officer and the Chief Financial Officer, and their respective designees, are each hereby authorized, empowered and directed in the name and on behalf of the District to take any and all steps which they or any of them might deem necessary or appropriate in order to give effect to this resolution.

Section 5. Effective Date. This resolution shall take effect immediately on and after its adoption.

* * * * * * * *

PASSED AND ADOPTED this 5th day of September 2024, by the following vote:

AYES:

NAYS:

ABSTAIN:

ABSENT:

Judith Bjorndal
Chair, Board of Directors
Sonoma Valley Health Care District

ATTEST:

Susan Kornblatt Idell
Secretary, Board of Directors
Sonoma Valley Health Care District

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
HEALING HERE AT HOME

To: SVHCD Board of Directors
From: Ben Armfield, Chief Financial Officer
Date: September 5, 2024
Subject: Banking Agreements

Recommendation:

Management recommends to the SVHCD Board of Directors the approval of the following:

1) Approve management to move forward with Summit State Bank's formal proposal and begin the transition process of entering into a new banking relationship.
2) Approve management to move forward with executing an extension with US Bank to extend the hospital's current line of credit for an additional three months.

Background and Reasoning:

During the last board meeting, management received approval to proceed in negotiations regarding Summit State Bank's proposal, with the approval contingent upon the maturity of the loan agreement increasing to a minimum of 3 years. Summit Bank has since provided a formal proposal that extends the maturity of the loan agreement up to seven years, with annual renewals contingent on meeting specified covenants.

Concurrently, management has mutually agreed with US Bank to extend the hospital's existing line of credit for an additional 90 days, moving the maturity date from the end of August to the end of November. This extension provides the necessary time to fully transition this loan over to our new bank.

Finance Committee:

Both the new loan proposal and US Bank Extension were brought forward to the SVHCD Finance Committee on 8/27, and the committee formally approved management's recommendation for the SVHCD Board of Directors to approve management to move forward with both.**

** During the SVHCD Finance Committee meeting on 8/27, the formal extension from US Bank was not yet available. As such, the committee approved the extension based on the understanding that the maturity date would be the only modification to the previous terms. Management has since received the formal extension agreement and confirms that the maturity date is indeed the sole change.

Attachments:

Summit State Bank Expression of Interest Letter

US Bank Line of Credit Extension

August 22, 2024

VIA: EMAIL DELIVERY

Mr. Benjamin Armfield, MBA
Chief Financial Officer
Sonoma Valley Hospital
347 Andrieux Street
Sonoma, CA 95476

RE: $1.9MM Term Loan and $5.5MM Revolving Line Of Credit

Dear Mr. Armfield:

As follow up to our conversation, Summit State Bank (Bank) is pleased to provide Sonoma Valley Healthcare District DBA Sonoma Valley Hospital (Borrower or SVH) this Expression of Interest letter for a new commercial term loan and revolving line of credit. Below is a summary of the proposed terms and conditions for the loan:

Borrower(s): Sonoma Valley Healthcare District DBA Sonoma Valley Hospital.

Guarantor(s): N/A.

Credit Facility #1

Loan Purpose: To refinance a balance of existing Revolving Line Of Credit as a term loan for $1.9MM.

Loan Amount: $1,900,000, subject to a minimum business DSCR of 1.00X based on change in Net Assets before interest, depreciation and other non-cash items.

Interest Rate: The first 5 years of the loan term shall be fixed at an interest rate of 7.75%.

The quoted rate above will be held for 60 days after the expiry of this letter, so long as this Expression of Interest letter is accepted prior to the stated expiry date.

Loan Maturity: 5 years.

Amortization: 5 year-amortization.

Repayment: Monthly Principal and Interest for the loan term. All payments are calculated on a 365/360 basis.

Prepayment: For the first 3 years of the loan, the Prepayment Fee is: 3%,2%,1% of the principal balance prepaid. Notwithstanding, Borrower shall be able to make partial prepayments up to 10% of the original principal balance of the loan each year on a non-cumulative basis without a prepayment

premium. Prepayment penalty may be waived in years 2 and 3 if repaid in full by Borrower and not refinanced by another Lender.

Loan Fee: 1.00% of the loan amount, or $19,000.

The loan fee is payable upon closing of escrow, with any remaining out of pocket costs, and not refundable.

Doc Fees: $2,500.

Collateral: UCC-1 filing.

Business DSCR: Minimum Debt Service Coverage Ratio for Sonoma Valley Hospital of 1.00:1 must be maintained and tested.

Based on change in net assets before interest, depreciation and other non-cash items.

☒ Applicable to only Sonoma Valley Healthcare District DBA Sonoma Valley Hospital.

Nor Cal Guaranty: $1,520,000 (max 80% of combined loan amount not to exceed $5,000,000)

Nor Cal Guaranty Fee: $38,000 (2.5% x $1,520,000)

Nor Cal Doc Fee: $500

Insurance: Borrower is to maintain liability insurance during the term of the loan, at a level acceptable to the Bank.

Credit Facility #2

Loan Purpose: To provide a $5.5MM revolving line of credit to support SVH's business operations aimed at expanding the hospital's capacity to deliver comprehensive care to Medi-Cal beneficiaries.

Loan Amount: $5,500,000

Interest Rate: WSJ Prime plus 1.50%. The floor rate shall be 8.00%.

The quoted rate above will be held for 60 days after the expiry of this letter, so long as this Expression of Interest letter is accepted prior to the stated expiry date.

Loan Maturity: The loan shall be annually renewable (0.25% renewal fee) for a maximum of 7 years.

Amortization: NA-Interest Only.

Repayment: Monthly I/O for the loan term. If in any year the line is not revolved as agreed the outstanding balance on the line shall become due and payable and the line cancelled. All payments are calculated on a 365/360 basis.

Loan Fee: .50% of the loan amount, or $27,500.

The loan fee is payable upon closing of escrow, with any remaining out of pocket costs, and not refundable.

Doc Fees: $2,500.

Collateral: UCC-1 filing.

Nor Cal Guaranty: $3,480,000 (max 80% of the combined loan amount not to exceed $5,000,000)

Nor Cal Guaranty Fee: $80,750 (2.5% x $980,000 = $24,500 + 2.25% x$2,500,000 = $56,250)

Nor Cal Doc Fee: $500

Insurance: Borrower is to maintain liability insurance during the term of the loan, at a level acceptable to the Bank.

Reporting/Covenants: To be determined based on receipt and review of a complete financial package.

- Annual financial statements and tax returns from Borrower including liquidity statements, an updated real estate schedule if appropriate, and any supplemental program documentation SVH participates in.
- Annual audited financial statements.
- Annual Board Approved Budget within 30 days of approval.
- The line shall be used to provide working capital to support and expand SVH's ability to deliver comprehensive care to Medi-Cal beneficiaries.
- The line shall have a 30 day out of debt clause.
- Borrower to maintain full account relationship with Summit State Bank.
- Annual business DSCR to be maintained.

Due Diligence/Conditions:

1. Full business operating account to be moved to Summit State Bank in advance of loan closing _____ Initial
   This step should commence upon acceptance of the Expression of Interest Letter
2. Autopay from operating account _____Initial
3. Satisfactory review of Borrower financial information.
   ~~a. 2021-2023 audited financial statements~~ received

b. ~~Draft 2024 financial statements~~ received
c. YTD financial statement
d. Most recent Annual Board Approved Budget
e. Borrower to complete attached Application form
f. Borrower, if a separate entity, to complete attached Entity form
g. Borrower, if applicable, to provide copies of entity documents (Operating Agreement and Articles of Organization)
h. Current liquidity statements for Borrower

4. Letter from Partnership Health Plan articulating their agreement to, at the very least, reimburse SVH for any funds contributed to the Voluntary Rate Range IGT Program within 75 days.
5. Contact person to set up SSB operating and auto account.
6. Evidence of Insurance coverage and name / contact for insurance agent
7. Borrower agrees to pay all third-party costs associated with this transaction.
8. Other items that the Bank may require.

The proposed credit facility is subject to the performance of such additional due diligence as Bank deems necessary, Bank loan approval, appraisal, and documentation acceptable to Bank, and its participant Bank. This letter is not intended to address all aspects of the facility and the documentation but is designed as an outline for subsequent discussions between us. As such, it cannot be construed as a commitment nor an offer to lend on the part of Bank or any participant bank. It is conceivable that certain information obtained during the processing of this request may cause changes to the proposed facilities.

This expression of interest by Bank may not be transferred, assigned, nor disclosed to any other individual or entity. If you wish that Bank proceed and process your request for the proposed credit facility, please acknowledge the enclosed copy of this letter and return the same to our attention by the expiry date of Monday August 23, 2024, along with the items listed above and a check for $25,000 made payable to Summit State Bank as a deposit and to cover any upfront 3rd party costs. These costs may be greater than or less than what is estimated. If less, the difference will be refunded or applied to the loan fee. If more, Bank will request an additional check for the difference.

We appreciate the opportunity to do business with you. Please call or email me with any questions or comments, I can be reached at 707-888-1497 or jconnors@summitstatebank.com.

Sincerely,

Janet M Connors
SVP/Sr. Relationship Manager

Brandy Seppi
EVP/Chief Lending Officer

If the terms herein are acceptable, please sign and date the enclosed acknowledgement copy and return to Summit State Bank, on or before the expiry date of August 23, 2024.

REVIEWED & ACCEPTED:

Date: _____

Borrower: _____

By: _____ Title:

FIRST AMENDMENT TO AMENDED AND RESTATED LOAN AGREEMENT

dated as of August __, 2024,

by and between

SONOMA VALLEY HEALTHCARE DISTRICT

AND

U.S. BANK NATIONAL ASSOCIATION

This **FIRST AMENDMENT** to **AMENDED AND RESTATED LOAN AGREEMENT**, dated as of August __, 2024 (this "Amendment"), is by and between the SONOMA VALLEY HEALTHCARE DISTRICT, a California health care district (the "Borrower") and U.S. BANK NATIONAL ASSOCIATION, a national banking association (together with its successors and assigns, the "Lender"). Terms used herein with initial capital letters and not otherwise defined shall have the respective meanings attributed thereto in the Agreement (as defined below).

RECITALS

WHEREAS, the Lender and the Borrower previously executed the Amended and Restated Loan Agreement dated June 7, 2024 (the "Prior Agreement"), pursuant to which the Lender agreed to extend certain prior loans and to make certain new loans to the Borrower all as more particularly described in the Prior Agreement (collectively, the "Loans"); and

WHEREAS, the Prior Agreement required that the Borrower repay the Loans on or before the "Facility Termination Date" of August 31, 2024 (the "Prior Termination Date"); and

WHEREAS, the Borrower has requested, and the Lender has agreed, to extend the Prior Termination Date to November 28, 2024 (the "New Facility Termination Date"); and

WHEREAS, the Borrower and the Lender have determined that it is necessary to make certain clarifying amendments to the Prior Agreement; and

NOW, THEREFORE, in consideration of the respective agreements contained herein and in the Agreement, and intending to be legally bound, the Borrower and the Lender hereby agree as follows.

ARTICLE I. INTENTION OF PARTIES, AGREEMENT PROVISIONS.

The Borrower and the Lender have entered into this Amendment pursuant to Section 8.1 of the Prior Agreement to change certain terms set forth in the Prior Agreement. The terms of the Prior Agreement, as amended by this Amendment (as so amended, the "***Agreement***"), shall govern the rights and obligations of the Borrower and the Lender in connection with the transactions contemplated by the Agreement.

ARTICLE II. AMENDMENTS AND AGREEMENT.

The Prior Agreement is hereby amended as follows:

(a) The definition of "Facility Termination Date" in Section 1.1 of the Prior Agreement is hereby amended by deleting "August 31, 2024" therein and replacing it with "November 28, 2024".

(b) Section 1.1 of the Prior Agreement is hereby amended by adding the following defined term in alphabetical order therein:

" 'First Amendment' means that certain First Amendment to the Amended and Restated Loan Agreement, dated as of August __, 2024, between the Borrower and the Lender."

(c) Section 2.1(b) of the Prior Agreement is hereby amended by deleting "August 31, 2024;" therein and replacing it with "November 28, 2024".

(d) Section 8.1 of the Prior Agreement is hereby amended by deleting it in its entirety and replacing it with the following:

" 8.1(a) Notices. Except in the case of notices and other communications expressly permitted to be given by telephone, all notices and other communications provided for herein must be in writing and must be delivered by hand or overnight courier service, mailed by certified or registered mail or sent by facsimile as follows: (a) if to the Borrower, at 347 Andrieux Street, Sonoma, CA 95475, Attention: Benjamin Armfield, Chief Financial Officer, email: barmfield@sonomavalleyhospital.org; and (b) if to the Lender, at 9467 Milliken Ave, Rancho Cucamonga, CA 91730, Attention and email: sagwest.la@usbank.com. Notices sent by hand or overnight courier service, or mailed by certified or registered mail, shall be deemed to have been given when received; notices sent by facsimile shall be deemed to have been given when sent (or, if not sent during normal business hours for the recipient, at the opening of business on the next business day for the recipient), except that notices to the Lender under Article II shall not be effective until actually received. Notwithstanding the foregoing, the Lender or the Borrower may, in its discretion, agree to accept electronic communications pursuant to procedures approved by it or as it otherwise determines. Email communications are deemed received upon the sender's receipt of an acknowledgement from the intended recipient (such as by the "return receipt requested" function, as available, return email or other written acknowledgement), or if not sent during the normal business hours of the recipient, at the opening of business on the next business day for the recipient. Any party hereto may change its address or facsimile number above by notice to the other party hereto as provided in this Section 8.1.

(b) Modifications. Notwithstanding any provision to the contrary herein, no amendment, modification, or waiver of any provision of any Loan Document or consent to any departure therefrom is effective unless in writing and signed by the Lender, and then such amendment, modification, waiver, or consent is effective only in the specific instance and for the purpose for which given."

ARTICLE III. CONDITIONS TO DELIVERY OF THIS AMENDMENT.

The amendments to the Prior Agreement provided for in Article II hereof shall become effective on the date hereof; *provided* that each of the following conditions shall be fulfilled to the satisfaction of the Lender:

(a) Documentation:

(i) Executed counterparts of this Amendment signed by the Borrower and the Lender; and

(ii) All other legal matters pertaining to the execution and delivery of this Amendment shall be satisfactory to the Lender and the execution and delivery hereof by the Lender shall constitute conclusive evidence that all such legal matters have been completed to the satisfaction of the Lender.

(b) Representations and Warranties True.

(i) The representations and warranties of the Borrower contained in Article V of the Prior Agreement and in this Amendment shall be true and correct with the same effect as though made on and as of the date hereof, except to the extent a representation or warranty relates specifically to an earlier date (in which case, such representation and warranty shall be true and correct as of such date).

(ii) In addition to the foregoing representations, the Borrower hereby represents and warrants as follows:

(A) The execution, delivery and performance by the Borrower of this Amendment are within its powers, have been duly authorized by all necessary actions and do not contravene any law or any contractual restriction binding on or affecting the Borrower;

(B) No further authorization, approval or other action by, and no notice to or filing, is required for the due execution, delivery and performance by the Borrower of this Amendment that has not been received as of the date hereof; and

(C) This Amendment constitutes the legal, valid and binding obligation of the Borrower and is enforceable against the Borrower in accordance with its terms.

(c) Performance and Compliance. On or before the date hereof, the Borrower shall have performed and complied with all agreements and conditions in the Agreement and the other Loan Documents which are required to be performed or complied with by the Borrower on or prior to the date hereof.

(d) Absence of Certain Events. (i) There shall not have occurred any material adverse change in the affairs, condition and/or operations, financial or otherwise, of the Borrower since the date of the most recent financial information provided to the Lender pursuant to the Agreement; on or prior to the date hereof, no change shall have occurred in any law, rule or regulation or in any interpretation thereof that, in the opinion of the Lender, would make it illegal for the Lender to execute and deliver this Amendment; and (ii) no event has occurred which constitutes an Event of Default under the Agreement.

(e) Other Approvals. The Lender shall have received such other approvals, opinions, certificates, instruments and documents as it may reasonably request.

ARTICLE IV. MISCELLANEOUS.

(a) The parties hereto acknowledge and confirm that, from and after the date hereof, any reference in the Agreement or in the other Related Documents to the "Agreement" shall mean and refer to the Agreement as amended hereby.

(b) Except as provided herein, the Agreement shall remain in full force and effect and unaffected hereby except, as set forth herein, from and after the date hereof.

(c) This Amendment and the Prior Agreement, as amended hereby, shall be subject to Section 8.17 of the Agreement. In case any one or more of the provisions contained herein should be invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired hereby.

(d) This Amendment may be executed in one or more counterparts, each of which taken together shall constitute one original and all of which shall constitute one and the same instrument.

[SIGNATURES BEGIN ON THE FOLLOWING PAGE.]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed and delivered as of the date hereof.

U.S. BANK NATIONAL ASSOCIATION

By_____
Name:
Title:

SONOMA VALLEY HEALTHCARE DISTRICT, a California health care district

By:_____
Name:
Title:

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
HEALING HERE AT HOME

To: SVHCD Board of Directors
From: Ben Armfield, Chief Financial Officer
Date: September 5, 2024
Subject: Financial Report for July 2024

Overall Summary

July marked the beginning of our new fiscal year, and it was a positive start from operations as July's performance rebounded from a subpar June to deliver a strong month. In fact, this past month marks one of the better financial performances from operations in recent months as July's operating margin far exceeded both budget and the hospital's most recent 6-month trend. The hospital posted a positive Operating EBDA in July, which marks just the third time this has happened during the last 13 months. This is notable given that July does not include any surgical activity from our new orthopod or the 3 Tesla MRI magnet.

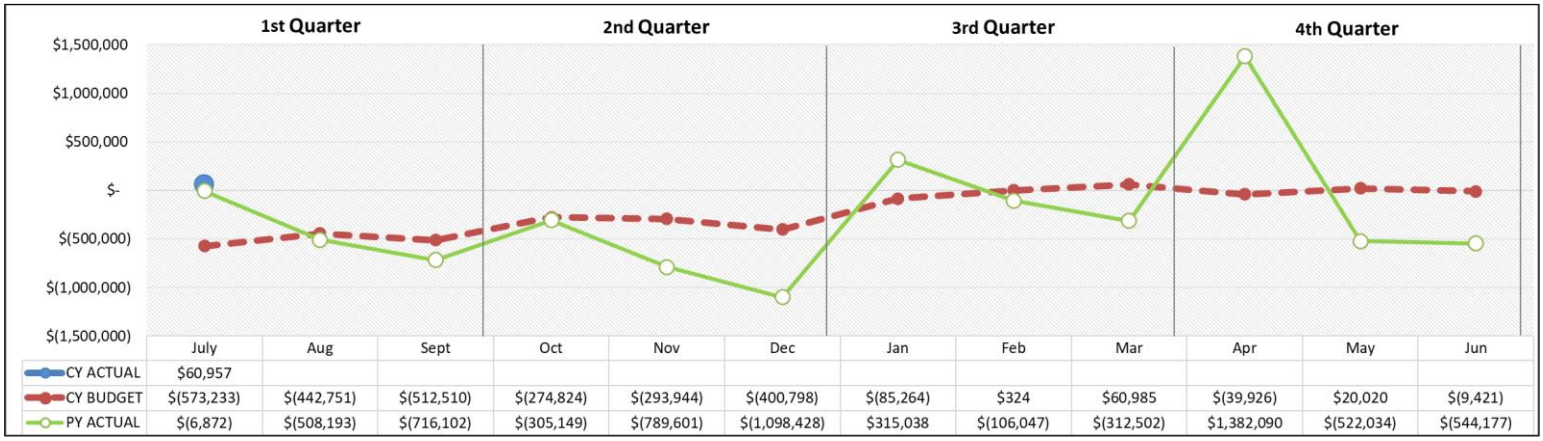
Revenue was the main driver in July's uptick. While surgical volumes remained flat from June, strong emergency room and physical therapy volumes headlined an increase in activity that resulted in gross revenues exceeding budget by over 10%.

The budget targets will be ramping up as we progress through the first quarter of the fiscal year so it will be important to maintain this momentum, but this certainly is a strong start to FY25.

Table 1 | Overall Performance - July 2024

	Current Year Month		Variance		Current Year YTD		Variance		PY YTD	Variance	
	Actual	Budget	$	%	Actual	Budget	$	%	Actual	$	%
Operating Margin	$ (458,136)	$ (1,094,938)	$636,802	58%	$ (458,136)	$ (1,094,938)	$ 636,802	58%	$(247,086)	$ (211,050)	-85%
Operating EBDA	$ 60,957	$ (573,233)	$634,191	111%	$ 60,957	$ (573,233)	$ 634,191	111%	$ (6,872)	$ 67,829	987%
Operating EBDA w Parcel	$ 377,624	$ (260,733)	$638,358	245%	$ 377,624	$ (260,733)	$ 638,358	245%	$ 309,795	$ 67,829	22%
Net Income (Loss)	$ 3,717	$ (594,334)	$598,051	101%	$ 3,717	$ (594,334)	$ 598,051	101%	$ 267,167	$ (263,450)	-99%

Graph 1.1 | SVH Trended Operating EBDA



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
CY ACTUAL	$60,957											
CY BUDGET	$(573,233)	$(442,751)	$(512,510)	$(274,824)	$(293,944)	$(400,798)	$(85,264)	$324	$60,985	$(39,926)	$20,020	$(9,421)
PY ACTUAL	$(6,872)	$(508,193)	$(716,102)	$(305,149)	$(789,601)	$(1,098,428)	$315,038	$(106,047)	$(312,502)	$1,382,090	$(522,034)	$(544,177)

Drivers in Month's Performance:

IGT Accrual

One of the main drivers in July's perfomance relates to a change in how we recognize our Intergovernmental Transfer (IGT) funding. Starting in July and new for FY25, we have modified the accounting method for how we recognize our IGT revenues and expenses. In previous years, we would recognize both the revenue and the expense in the month that the hospital's matching fee was paid, which triggered the IGT funding process. This method created significant month-to-month variances in our financial statements, particularly over the last two fiscal years as the timing of IGT payments fluctuated from their historical timelines. These variances made it very challenging to accurately track our financial performance on a consistent basis.

We have adopted a new approach for this fiscal year. Starting in July we are now accruing our estimated IGT activity—based on what was budgeted for the fiscal year—equally over the 12-month period. This change aims to smooth out the financial impact and provide a more stable and predictable reflection of our performance throughout the year. As IGT funds are paid, we will reconcile these amounts to true-up what has been accrued, ensuring accuracy and alignment with actual payments.

Our income statement will now include $506,356 of monthly net income related to our IGT programs, which consists of $871,547 in revenue and $365,191 in expense. This change should help us avoid the significant variances we experienced in the past and provide better visibility into our financial health.

Surgical Volumes

Surgical volumes in July did trail budget as the 131 surgeries matched the total from the prior month. We did see a big spike in GI volumes, which helped mitigate another decrease in orthopedic surgeries. There were some incremental volumes budgeted in July for our new Orthopod, so that is driving some of the variance as Dr. Walter's injury prevented him from performing any surgeries last month. The good news on this front is that he did start performing cases in August, so orthopedic volumes should start ramping up immediately.

Emergency Room Volumes

Emergency room visits continue to be strong, with volumes running 12% over budget. July marked the second busiest month in the ER over the last couple of years, only falling short of the prior month. Between June and July, we have started to realize close to 30 visits per day. That was the goal when the new group was brought in, and represents a 15% increase over historical volumes with the prior group. There is further capacity to grow and we are working operationally to facilitate. Meanwhile, the increase in volumes is a clear indication of the demand, and our team has done an excellent job managing the higher patient load.

Physical Therapy Volumes

July was a banner month for our physical therapy department, providing care for over 1,400 visits in the month. As far as we can tell, this marks an all-time high for the department. Very encouraging and also speaks to the ability of our team and their continued ability to meet the ever-growing demand for PT services.

Other Volumes

Many of our other outpatient departments found themselves busy in July as well, as our total outpatient visits exceeded budget by 15%. As mentioned above, physical therapy volumes were a significant driver in this, but we also saw notable surges in medical imaging, CT, ultrasound, and wound care. CT volumes in particular, as July now marks six straight months of consistent volume growth.

MRI volumes remained consistent with prior months, but that should start to change now that our 3 Tesla Magnet is live and operational.

Other Updates:

Orthopedics: We are pleased to report that our new orthopedic surgeon, Dr. Chris Walter, performed his first surgical case at SVH last week. All went well and he was very complimentary of the surgical team and facilities. He has scheduled his first major surgeries (hip replacements) for September, and we will start to see our orthopedic surgical volumes increase now that he is up and running. We are currently working with him to see where we can make some strategic investments to help solidify our orthopedic program and also grow our market share here in the Valley.

Temporary MRI Project: We are pleased to report that the 3T MRI magnet has received approval and is now fully operational as of a couple of weeks ago. We have already observed modest increases in volume, which is encouraging. Looking ahead, key training sessions for urologic and breast imaging are scheduled for mid-September, and we anticipate a significant increase in utilization once these trainings are completed. We also continue to work with UCSF to improve referrals from their waiting lists.

Distressed Hospital Loan Program: After finally receiving official sign-offs on all documents and agreements associated with our Distressed Hospital Loan Program funds, we received the actual funding earlier this month. We turned around and applied this to our outstanding line of credit with U.S. Bank, which brings our current balance from $4.9 million to $1.9 million. This will save the hospital an estimated $250K annually in interest expense. Our repayment of the $3 million will start in 18 months.

Audit Update: Auditors from Moss Adams were on-site last week as field work continues on our Fiscal Year 2024 audit.

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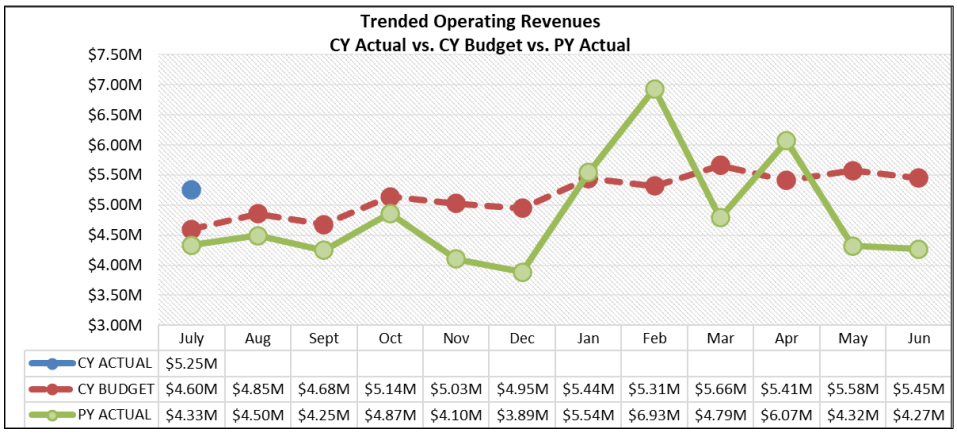
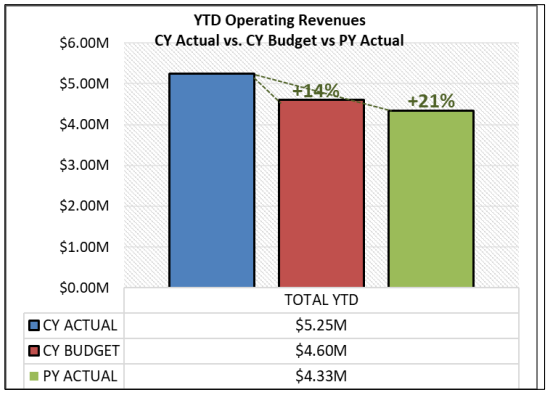
2. NET REVENUE AND VOLUME SUMMARY:

Table 2 | Net Patient Revenue – Actual vs. Budget – July 2024

	Current Year Month		Variance		Current Year YTD		Variance		PY YTD	Variance	
	Actual	Budget	Var	%	Actual	Budget	$	%	Actual	$	%
Gross Revenue	$ 27.98M	$ 25.20M	$ 2.79M	11%	$ 27.98M	$ 25.20M	$ 2.79M	11%	$ 27.70M	$ 0.29M	1%
Net Patient Revenue	$ 5.15M	$ 4.51M	$ 0.64M	14%	$ 5.15M	$ 4.51M	$ 0.64M	14%	$ 4.25M	$ 0.90M	21%
NPR as a % of Gross	15.3%	14.4%	6.0%		15.3%	14.4%	6.0%		15.3%	-0.3%	
Total Operating Revenue	$ 5.25M	$ 4.60M	$ 0.65M	14%	$ 5.25M	$ 4.60M	$ 0.65M	14%	$ 4.33M	$ 0.92M	21%

Graph 2.1 | SVH Trended Operating Revenue





Graph 2.2 | SVH Trended Surgeries (Total) - 13 Month Trend

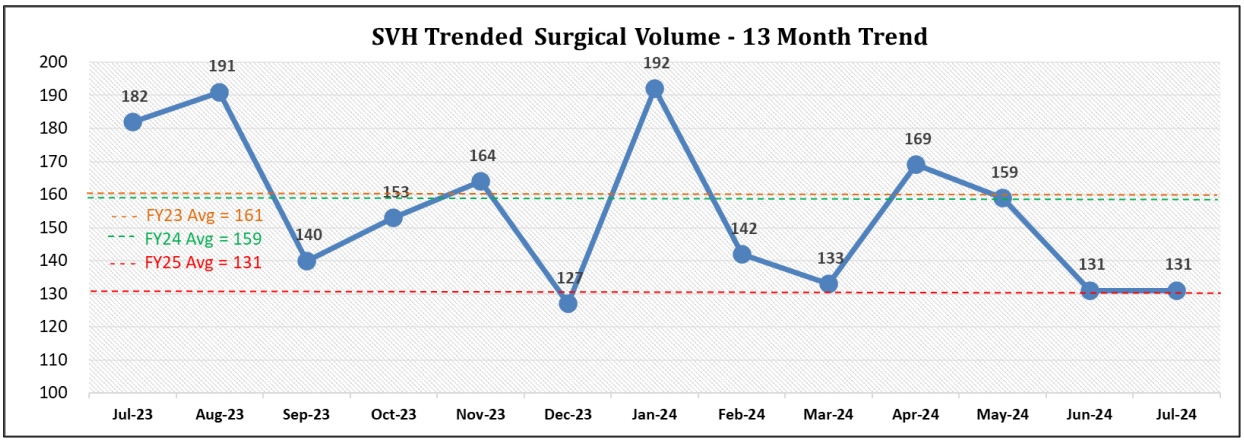


Table 2.3 | Surgical Volumes Top 4 Service Lines – July 2024 vs Prior Month & Six-Month Trend

	Current Mth vs. Previous Mth				6 Month Trend						Current Mth vs. 6 Mth Trend		
Service Line	JuL24	Jun24	Var	% Var	Jan24	Feb24	Mar24	Apr24	May24	Jun24	6 Month Trend	Var	% Var
Orthopedics	26	35	(9)	-26%	67	40	33	46	27	35	41	(15)	-37%
Gastroenterology	77	53	24	45%	67	59	62	73	85	53	67	11	16%
Ophthalmology	14	23	(9)	-39%	22	20	18	18	20	23	20	(6)	-31%
General	5	14	(9)	-64%	18	11	15	17	14	14	15	(10)	-66%
SubTotal	**122**	**125**	**(3)**	**-2%**	**174**	**130**	**128**	**154**	**146**	**125**	**143**	**(21)**	**-15%**
Other	9	6	3	50%	18	12	5	15	13	6	12	(3)	-22%
Grand Total	**131**	**131**	-	**0%**	**192**	**142**	**133**	**169**	**159**	**131**	**154**	**(23)**	**-15%**

Table 2.4 | Patient Volumes – July 2024

	Current Year Month		Variance		Current Year YTD		Variance		PY YTD	Variance	
	Actual	Budget	Var	%	Actual	Budget	Var	%	Actual	Var	%
Acute Patient Days	230	259	(29)	-11%	230	259	(29)	-11%	235	(5)	-2%
Average Daily Census	7.4	8.4	(1.0)	-11%	7.4	8.4	(1.0)	-11%	7.6	(0.2)	-2%
Acute Discharges	65	72	(7)	-10%	65	72	(7)	-10%	58	7	12%
IP Surgeries	7	12	(5)	-40%	7	12	(5)	-40%	14	(7)	-50%
OP Surgeries/Spec Proc	124	135	(11)	-8%	124	135	(11)	-8%	168	(44)	-26%
Total Surgeries / Procedures	**131**	**147**	**(16)**	**-11%**	**131**	**147**	**(16)**	**-11%**	**182**	**(51)**	**-28%**
Total Outpatient Visits	5,293	4,588	705	15%	5,293	4,588	705	15%	4,563	730	16%
Emergency Room Visits	929	830	99	12%	929	830	99	12%	869	60	7%

Table 2.5 | Outpatient Volumes Trended – Last 6 Months

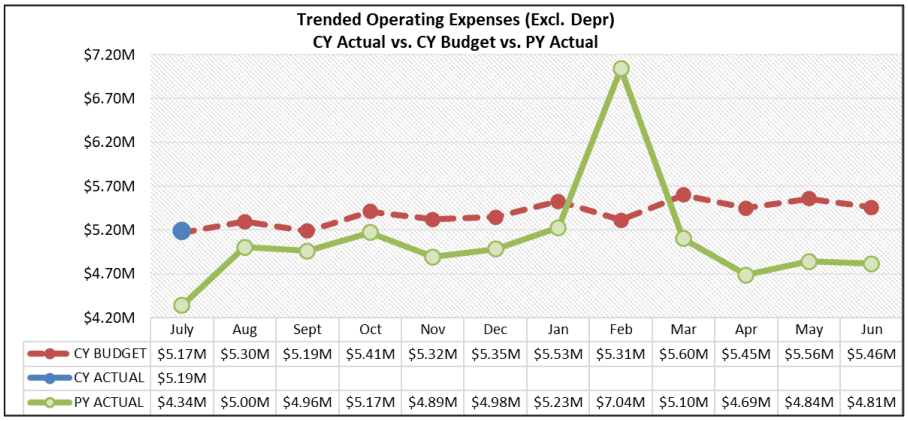
Department	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Last 6 Months
Lab	1,261	1,271	1,407	1,364	1,282	1,363	
Medical Imaging	896	858	857	900	830	923	
Physical Therapy	1,238	1,351	1,365	1,196	1,095	1,415	
CT Scanner	355	368	387	398	409	411	
Occ. Health	230	209	300	315	308	295	
Mammography	233	232	241	217	211	167	
Occupational Therapy	202	317	224	197	190	196	
Ultrasound	242	220	198	222	182	256	
Wound Care	166	175	201	213	152	205	
MRI	167	123	127	135	121	130	
ECHO	135	110	104	132	106	116	
Speech Therapy	49	45	53	43	53	93	
Other	30	14	22	25	14	23	
TOTAL	**5,204**	**5,293**	**5,486**	**5,357**	**4,953**	**5,593**	
Emergency Room	779	875	862	867	994	929	

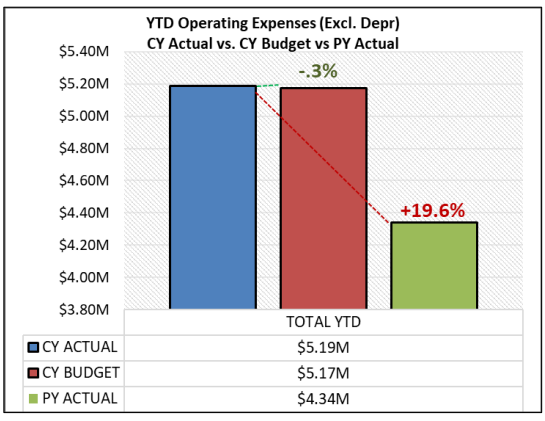
3. OPERATING EXPENSE SUMMARY:

Table 3 | Operating Expenses – Actual vs. Budget – July 2024

	Current Year Month		Variance		Current Year YTD		Variance		PY YTD	Variance	
	Actual	Budget	Var	%	Actual	Budget	$	%	Actual	$	%
Operating Expenses	$ 5.71M	$ 5.69M	$ 0.01M	0%	$ 5.71M	$ 5.69M	$ 0.01M	0%	$ 4.58M	$ 1.13M	25%
Operating Exp. Excl. Depr.	$ 5.19M	$ 5.17M	$ 0.02M	0%	$ 5.19M	$ 5.17M	$ 0.02M	0%	$ 4.34M	$ 0.85M	20%
Worked FTEs	211.3	210.2	1.0	0%	211.3	210.2	1.0	0%	215.4	(4.1)	-2%

Graph 3.1 | SVH Trended Operating Expenses (excluding Depreciation)





4. CASH ACTIVITY SUMMARY:

Table 4 | Cash / Revenue Cycle Indicators - July 2024

	Jul-24	Jun-24	Var	%
Days Cash on Hand	22.0	22.8	(0.8)	-3%
A/R Days	57.6	60.1	(2.5)	-4%
A/P Days	58.9	57.5	1.4	2%

ATTACHMENTS:

- Attachment A is the Payer Mix Analysis
- Attachment B is the Operating Indicators Report
- Attachment C is the Balance Sheet
- Attachment D is the Balance Sheet Variance Analysis
- Attachment E (two pages) is the Statement of Revenue and Expense. The first page breaks out the hospital operations and page two includes all other activity.
- Attachment F is the Trended Income Statement
- Attachment G is the Cash Projection

Sonoma Valley Hospital
Payer Mix for the month of July, 2024

ATTACHMENT A

	MONTH				YEAR TO DATE			
Gross Revenue	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	9,767,557	9,615,144	152,413	0.6%	9,767,557	9,615,144	152,413	0.6%
Medicare Managed Care	5,587,526	4,626,233	961,293	3.8%	5,587,526	4,626,233	961,293	3.8%
Medi-Cal	4,660,158	4,056,718	603,440	2.4%	4,660,158	4,056,718	603,440	2.4%
Self Pay	519,721	294,239	225,482	0.9%	519,721	294,239	225,482	0.9%
Commercial & Other Governn	6,609,090	5,973,914	635,176	2.5%	6,609,090	5,973,914	635,176	2.5%
Worker's Comp.	816,046	658,870	157,176	0.6%	816,046	658,870	157,176	0.6%
Total	**27,960,099**	**25,225,118**	**2,734,981**	**10.8%**	**27,960,099**	**25,225,118**	**2,734,981**	**10.8%**

	MONTH			YEAR TO DATE		
Payor Mix	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
Medicare	34.9%	38.1%	-3.2%	34.9%	38.1%	-3.2%
Medicare Managed Care	20.0%	18.3%	1.6%	20.0%	18.3%	1.6%
Medi-Cal	16.7%	16.1%	0.6%	16.7%	16.1%	0.6%
Self Pay	1.9%	1.2%	0.7%	1.9%	1.2%	0.7%
Commercial & Other Governn	23.6%	23.7%	0.0%	23.6%	23.7%	0.0%
Worker's Comp.	2.9%	2.6%	0.3%	2.9%	2.6%	0.3%
Total	**100.0%**	**100.0%**		**100.0%**	**100.0%**	

SONOMA VALLEY HOSPITAL
OPERATING INDICATORS
For the Period Ended July 31, 2024

ATTACHMENT B

	CURRENT MONTH				YEAR-TO-DATE			YTD
	Actual 07/31/24	Budget 07/31/24	Favorable (Unfavorable) Variance		Actual 07/31/24	Budget 07/31/24	Favorable (Unfavorable) Variance	Prior Year 07/31/23
				Inpatient Utilization				
				Discharges				
1	43	54	(11)	Med/Surg	43	54	(11)	40
2	22	18	4	ICU	22	18	4	18
3	65	72	(7)	Total Discharges	65	72	(7)	58
				Patient Days:				
4	151	173	(22)	Med/Surg	151	173	(22)	155
5	79	86	(7)	ICU	79	86	(7)	80
6	230	259	(29)	Total Patient Days	230	259	(29)	235
7	18	-	18	**Observation days**	18	-	18	17
				Average Length of Stay:				
8	3.51	3.20	0.3	Med/Surg	3.51	3.20	0.31	3.88
9	3.59	4.73	(1.1)	ICU	3.59	4.73	(1.14)	4.44
10	3.54	3.59	(0.1)	Avg. Length of Stay	3.54	3.59	(0.05)	4.05
				Average Daily Census:				
11	4.9	5.6	(0.7)	Med/Surg	4.9	5.6	(0.7)	5.0
12	2.5	2.8	(0.2)	ICU	2.5	2.8	(0.2)	2.6
13	7.4	8.4	(1.0)	Avg. Daily Census	7.4	8.4	(1.0)	7.6
				Other Utilization Statistics				
				Emergency Room Statistics				
14	929	830	99	OP ER Visits	929	830	99	869
				Outpatient Statistics:				
15	5,593	4,588	1,005	Total Outpatients Visits	5,593	4,588	1,005	4,563
16	7	12	(5)	IP Surgeries	7	12	(5)	14
17	124	120	4	OP Surgeries / Special Procedures	124	120	4	168
18	308	309	(1)	Adjusted Discharges	308	309	(1)	305
19	1,090	1,123	(33)	Adjusted Patient Days	1,090	1,123	(33)	1,255
20	35.2	36.2	(1.1)	Adj. Avg. Daily Census	35.2	36.2	(1.1)	40.5
21	1.338	1.400	(0.062)	Case Mix Index -Medicare	1.338	1.400	(0.062)	1.405
22	1.361	1.400	(0.039)	Case Mix Index - All payers	1.361	1.400	(0.039)	1.383
				Labor Statistics				
23	211	210	(1)	FTE's - Worked	211	210	(1.0)	215
24	235	234	(1)	FTE's - Paid	235	234	(0.7)	237
25	48.37	49.66	1.29	Average Hourly Rate	48.37	49.66	1.29	46.44
26	6.68	6.47	(0.22)	FTE / Adj. Pat Day	6.68	6.47	(0.22)	5.86
27	38.1	36.9	(1.2)	Manhours / Adj. Pat Day	38.1	36.9	(1.2)	33.4
28	134.8	133.9	(0.8)	Manhours / Adj. Discharge	134.8	133.9	(0.8)	137.5
29	27.3%	30.2%	2.9%	Benefits % of Salaries	27.3%	30.2%	2.9%	25.4%
				Non-Labor Statistics				
30	9.4%	10.7%	1.4%	Supply Expense % Net Revenue	9.4%	10.7%	1.4%	10.8%
31	1,565	1,565	1	Supply Exp. / Adj. Discharge	1,565	1,565	1	1,512
32	18,665	18,582	(84)	Total Expense / Adj. Discharge	18,665	18,582	(84)	15,189
				Other Indicators				
33	22.0			Days Cash - Operating Funds				
34	57.6	50.0	7.6	Days in Net AR	57.6	50.0	7.6	65.5
35	108%			Collections % of Cash Goal	108%			100.7%
36	58.9	55.0	3.9	Days in Accounts Payable	58.9	55.0	3.9	-
37	18.4%	17.9%	0.5%	% Net revenue to Gross revenue	18.4%	17.9%	0.5%	15.3%
38	35.7%			% Net AR to Gross AR	35.7%			36.4%

ATTACHMENT C

Sonoma Valley Health Care District
Balance Sheet
As of July 31, 2024
UNAUDITED

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	3,428,185	3,748,581	5,383,983
3	Net Patient Receivables	11,758,181	11,860,187	10,258,272
4	Allow Uncollect Accts	(3,948,126)	(3,823,181)	(1,917,101)
5	Net A/R	7,810,055	8,037,006	8,341,171
6	Other Accts/Notes Rec	1,376,217	1,792,370	1,627,361
7	Parcel Tax Receivable	3,800,000	-	3,800,000
8	GO Bond Tax Receivable	2,568,326	-	2,617,464
9	3rd Party Receivables, Net	568,677	64,281	(26,491)
10	Inventory	917,067	913,408	990,158
11	Prepaid Expenses	1,170,136	637,492	1,211,774
12	Total Current Assets	$ 21,638,664	$ 15,193,138	$ 23,945,420
13	Property,Plant & Equip, Net	$ 58,940,675	$ 59,212,559	$ 57,748,859
14	Trustee Funds - GO Bonds	5,957,336	5,957,336	5,774,189
15	Designated Funds - Board Approved	-	-	-
16	**Total Assets**	**$ 86,536,674**	**$ 80,363,033**	**$ 87,468,469**
	Liabilities & Fund Balances			
	Current Liabilities:			
17	Accounts Payable	$ 6,652,215	$ 6,422,565	$ 4,689,310
18	Accrued Compensation	3,768,145	3,648,819	3,586,699
19	Interest Payable - GO Bonds	225,861	189,398	271,795
20	Accrued Expenses	465,935	409,575	1,696,777
21	Advances From 3rd Parties	-	-	-
22	Deferred Parcel Tax Revenue	3,483,333	-	3,483,333
23	Deferred GO Bond Tax Revenue	2,206,896	-	2,399,343
24	Current Maturities-LTD	217,475	217,475	217,475
25	Line of Credit - Union Bank	1,873,734	4,973,734	4,973,734
26	Other Liabilities	92,511	57,511	57,511
27	Total Current Liabilities	$ 18,986,105	$ 15,919,078	$ 21,375,978
28	Long Term Debt, net current portion	$ 28,034,698	$ 24,997,762	$ 29,775,694
29	Fund Balances:			
30	Unrestricted	$ 24,043,708	$ 20,634,705	$ 15,671,286
31	Restricted	15,472,163	18,811,489	20,645,512
32	Total Fund Balances	$ 39,515,870	$ 39,446,193	$ 36,316,798
33	**Total Liabilities & Fund Balances**	**$ 86,536,674**	**$ 80,363,033**	**$ 87,468,469**

Sonoma Valley Health Care District **ATTACHMENT D**
Balance Sheet Variance Analysis
As of July 31, 2024

Assets	Monthly Change	Current Month	Prior Month	Prior Year	Variance Commentary
CURRENT ASSETS					
Cash	(320,396)	3,428,185	3,748,581	5,383,983	Cash receipts of $4.2 million vs. $5.0 million in AP payments. Included in July's AP vendor payments were $500,000 for annual service contracts and insurance premiums that will be expensed/amortized over the course of the fiscal year.
Net A/R	(226,950)	7,810,055	8,037,006	8,341,171	Net A/R decreased with increased focus on reducing hospital's Open A/R.
Other Receivables	6,456,569	8,313,220	1,856,651	8,018,334	Change in July relates to the recording of the current fiscal year income receivables for the bond and parcel taxes.
Inventory	3,659	917,067	913,408	990,158	
Prepaid Expenses	532,644	1,170,136	637,492	1,211,774	Payments made for service contracts and insurance coverages that will be recognized as prepaid assets and expensed/amortized over the course of the fiscal year.
TOTAL CURRENT ASSETS	**6,445,525**	**21,638,664**	**15,193,138**	**23,945,420**	
NON-CURRENT ASSETS					
Net Fixed Assets	(271,885)	58,940,675	59,212,559	57,748,859	
Trustee Funds - GO Bonds	-	5,957,336	5,957,336	5,774,189	
TOTAL ASSETS	**6,173,640**	**86,536,674**	**80,363,033**	**87,468,469**	

Liabilities / Fund Balance	Monthly Change	Current Month	Prior Month	Prior Year	Variance Commentary
CURRENT LIABILITIES					
Accounts Payable	229,649	6,652,215	6,422,565	4,689,310	Small increase from prior month
Accrued Expenses	175,686	4,234,080	4,058,395	5,283,476	
Interest Payable	36,463	225,861	189,398	271,795	Go Bond interest accrual
Deferred Revenues	*5,690,229*	5,690,229	-	5,882,676	Deferred revenue for Parcel Tax and Go Bond proceeds for Fiscal Year 25
Line of Credit	(3,100,000)	1,873,734	4,973,734	4,973,734	Paydown of LOC with long-term debt loan of $3,100,000
Other Liabilities	*35,000*	309,986	274,986	274,986	GASB amortization
TOTAL CURRENT LIABILITIES	**3,067,027**	**18,986,105**	**15,919,078**	**21,375,978**	
NON-CURRENT LIABILITIES					
Long Term Debt	3,036,936	28,034,698	24,997,762	29,775,694	Increase of $3M related to the recognition of the CA Distressed Loan that was received during the month that was used to pay down existing LOC.
TOTAL LIABILITIES	**6,103,964**	**47,020,804**	**40,916,840**	**51,151,671**	
FUND BALANCES					
Fund Balance	69,677	39,515,870	39,446,193	36,316,798	Change in Net Position for July24 $69,676
TOTAL LIABILITIES & FUND BALANCES	**6,173,640**	**86,536,674**	**80,363,033**	**87,468,469**	

Sonoma Valley Health Care District
Statement of Revenue and Expenses
For the Period Ended July 31, 2024

ATTACHMENT E

		Month				Year-To- Date						
		This Year		Variance		This Year		Variance			Variance	
		CYM Actual	CYM Budget	Var	%	YTD Actual	YTD Budget	Var	%	PYTD Actual	Var	%
	Volume Information											
1	Acute Discharges	65	72	(7)	-10%	65	72	(7)	-10%	58	7	12%
2	Patient Days	230	259	(29)	-11%	230	259	(29)	-11%	235	(5)	-2%
3	Observation Days	18	-	18	n/a	18	-	18	n/a	17	1	6%
4	Gross O/P Revenue (000's)	22,085	19,309	2,776	14%	22,085	19,309	2,776	14%	22,412	(327)	-1%
	Financial Results											
	Gross Patient Revenue	**CYM Actual**	**CYM Budget**	**Var**	**%**	**YTD Actual**	**YTD Budget**	**Var**	**%**	**PYTD Actual**	**Var**	**%**
5	Inpatient	5,899,154	5,888,336	10,818	0%	5,899,154	5,888,336	10,818	0%	5,270,930	628,224	12%
6	Outpatient	11,707,197	11,848,912	(141,715)	-1%	11,707,197	11,848,912	(141,715)	-1%	13,362,380	(1,655,183)	-12%
7	Emergency	10,377,802	7,460,227	2,917,575	39%	10,377,802	7,460,227	2,917,575	39%	9,064,276	1,313,526	14%
8	**Total Gross Patient Revenue**	**27,984,153**	**25,197,476**	**2,786,677**	**11%**	**27,984,153**	**25,197,476**	**2,786,677**	**11%**	**27,697,586**	**286,567**	**1%**
	Deductions from Revenue											
9	Contractual Discounts	(23,449,018)	(21,493,386)	(1,955,632)	9%	(23,449,018)	(21,493,386)	(1,955,632)	9%	(23,186,323)	(262,695)	1%
10	Bad Debt	(150,000)	(119,319)	(30,681)	26%	(150,000)	(119,319)	(30,681)	26%	(100,000)	(50,000)	50%
11	Charity Care Provision	(105,349)	51,261	(156,610)	-306%	(105,349)	51,261	(156,610)	-306%	(164,591)	59,242	-36%
12	Supplemental Funding	871,547	871,547	0	0%	871,547	871,547	0	0%		871,547	n/a
13	**Total Deductions from Revenue**	**(22,832,820)**	**(20,689,897)**	**(2,142,923)**	**10%**	**(22,832,820)**	**(20,689,897)**	**(2,142,923)**	10%	**(23,450,914)**	**618,094**	**-3%**
14	**Net Patient Service Revenue**	**5,151,333**	**4,507,578**	**643,755**	**14%**	**5,151,333**	**4,507,578**	**643,755**	**14%**	**4,246,672**	**904,661**	**21%**
15	Other Operating Revenue	97,950	91,993	5,957	6%	97,950	91,993	5,957	6%	85,509	12,441	15%
16	**Total Operating Revenue**	**5,249,283**	**4,599,572**	**649,711**	**14%**	**5,249,283**	**4,599,572**	**649,711**	**14%**	**4,332,181**	**917,102**	**21%**
	Operating Expenses	**CYM Actual**	**CYM Budget**	**Var**	**%**	**YTD Actual**	**YTD Budget**	**Var**	**%**	**PYTD Actual**	**Var**	**%**
17	Salary and Wages and Agency Fees	2,008,288	2,055,848	(47,560)	-2%	2,008,288	2,055,848	(47,560)	-2%	1,945,424	62,864	3%
18	Employee Benefits	844,382	838,151	6,231	1%	844,382	838,151	6,231	1%	735,985	108,398	15%
19	Total People Cost	2,852,670	2,893,999	(41,328)	-1%	2,852,670	2,893,999	(41,328)	-1%	2,681,409	171,262	6%
20	Med and Prof Fees (excld Agency)	735,435	649,924	85,511	13%	735,435	649,924	85,511	13%	557,320	178,115	32%
21	Supplies	481,999	483,742	(1,743)	0%	481,999	483,742	(1,743)	0%	460,649	21,350	5%
22	Purchased Services	380,330	400,732	(20,402)	-5%	380,330	400,732	(20,402)	-5%	305,922	74,408	24%
23	Depreciation	519,093	521,705	(2,612)	-1%	519,093	521,705	(2,612)	-1%	240,214	278,879	116%
24	Utilities	184,101	175,209	8,892	5%	184,101	175,209	8,892	5%	157,932	26,170	17%
25	Insurance	72,750	74,736	(1,986)	-3%	72,750	74,736	(1,986)	-3%	66,583	6,167	9%
26	Interest	12,973	29,445	(16,472)	-56%	12,973	29,445	(16,472)	-56%	42,598	(29,625)	-70%
27	Other	102,876	99,828	3,048	3%	102,876	99,828	3,048	3%	66,641	36,235	54%
28	Supplemental Funding Fees	365,191	365,191	0	0%	365,191	365,191	0	0%	-	365,191	n/a
29	**Operating Expenses**	**5,707,419**	**5,694,510**	**12,909**	**0%**	**5,707,419**	**5,694,510**	**12,909**	**0%**	**4,579,267**	**1,128,152**	**25%**
30	**Operating Margin**	**(458,136)**	**(1,094,938)**	**636,802**	**58%**	**(458,136)**	**(1,094,938)**	**636,802**	**58%**	**(247,086)**	**(211,050)**	**-46%**

Sonoma Valley Health Care District
Statement of Revenue and Expenses
For the Period Ended July 31, 2024

ATTACHMENT E

		Month				Year-To- Date						
		This Year		Variance		This Year		Variance			Variance	
		CYM Actual	CYM Budget	Var	%	YTD Actual	YTD Budget	Var	%	PYTD Actual	Var	%
	Non Operating Rev and Expense											
31	Miscellaneous Revenue/(Expenses)	(12,506)	14,488	(26,994)	-186%	(12,506)	14,488	(26,994)	-186%	27,167	(39,673)	-146%
32	Donations	-	(3,955)	3,955	-100%	-	(3,955)	3,955	-100%	-	-	n/a
33	Parcel Tax Assessment Rev	316,667	312,500	4,167	1%	316,667	312,500	4,167	1%	316,667	-	0%
34	Extraordinary Items	-	-	-	n/a	-	-	-	n/a	-	-	n/a
35	**Total Non-Operating Revenue/(Expense)**	**304,161**	**323,033**	**(18,872)**	**-6%**	**304,161**	**323,033**	**(18,872)**	**-6%**	**343,834**	**(39,673)**	**-12%**
36	**Net Income / (Loss) prior to GO Bond(net)**	**(153,975)**	**(771,905)**	**617,930**	**80%**	**(153,975)**	**(771,905)**	**617,930**	**80%**	**96,748**	**(250,723)**	**259%**
37	GO Bond Activity, Net	157,692	177,571	(19,879)	-11%	157,692	177,571	(19,879)	-11%	170,419	(12,727)	-7%
38	**Net Income / (Loss) with GO Bond(net)**	**3,717**	**(594,334)**	**598,051**	**101%**	**3,717**	**(594,334)**	**598,051**	**101%**	**267,167**	**(263,450)**	**99%**
39	Restricted Foundation Contributions	65,959	157,410	(91,451)	-58%	65,959	157,410	(91,451)	-58%	-	65,959	n/a
40	**Change in Net Position**	**69,676**	**(436,924)**	**506,600**	**116%**	**69,676**	**(436,924)**	**506,600**	**116%**	**267,167**	**(197,491)**	**74%**
	Operating EBDA	**60,957**	**(573,233)**	**634,191**	**-111%**	**60,957**	**(573,233)**	**634,191**	**-111%**	**(6,872)**	**6,872**	**-100%**
	Total EBDA - Excl Rest Contributions	**522,810**	**(72,629)**	**595,439**	**-820%**	**522,810**	**(72,629)**	**595,439**	**-820%**	**507,381**	**(507,381)**	**-100%**
	Total EBDA - Incl Rest Contributions	**588,769**	**84,780**	**503,989**	**594%**	**588,769**	**84,780**	**503,989**	**594%**	**507,381**	**(507,381)**	**-100%**

Sonoma Valley Health Care District **ATTACHMENT F**
Trended Income Statement - Last 6 Months
For the Period Ended July 31, 2024

		Feb FY24	March FY24	April FY24	May FY24	June FY24	July FY25	FY25 YTD Month Avg	FY24 YTD Month Avg
1	Acute Discharges	63	59	70	63	58	65	65	68
2	Patient Days	229	192	230	197	201	230	230	245
3	Observation Days	15	17	19	22	29	18	18	22
4	Gross O/P Revenue (000's)	$ 19,700	$ 21,438	$ 21,913	$ 21,663	$ 21,914	$ 27,960	$ 27,960	$ 21,821
	Financial Results								
	Gross Patient Revenue								
5	Inpatient	$ 5,561,483	$ 4,451,229	$ 6,001,401	$ 4,589,215	$ 5,247,297	$ 5,899,154	$ 5,899,154	$ 5,855,907
6	Outpatient	11,809,432	12,014,729	12,349,015	12,028,739	11,630,429	11,683,143	11,683,143	12,948,617
7	Emergency	7,890,643	9,423,709	9,563,637	9,634,326	10,284,037	10,377,802	10,377,802	8,872,108
8	**Total Gross Patient Revenue**	**$ 25,261,558**	**$ 25,889,667**	**$ 27,914,053**	**$ 26,252,280**	**$ 27,161,763**	**$ 27,960,099**	**$ 27,960,099**	**$ 27,676,632**
	Deductions from Revenue								
9	Contractual Discounts	(21,395,686)	(21,920,503)	(21,690,696)	(22,184,344)	(22,711,319)	(23,449,018)	(23,449,018)	(23,322,102)
10	Bad Debt	(202,507)	(216,128)	(2,013,340)	(72,256)	(151,047)	(150,000)	(150,000)	(274,192)
11	Discounts / Other Deductions	(240,123)	165,606	(102,784)	22,408	(118,043)	(105,349)	(105,349)	(8,882)
12	IGT Revenue	3,420,534	780,000	1,861,463	207,222	-	871,547	871,547	656,761
13	**Total Deductions from Revenue**	**$ (18,417,782)**	**$ (21,191,025)**	**$ (21,945,357)**	**$ (22,026,970)**	**$ (22,980,409)**	**$ (22,832,820)**	**$ (22,832,820)**	**$ (22,948,415)**
14	**Net Patient Service Revenue**	**$ 6,843,776**	**$ 4,698,642**	**$ 5,968,696**	**$ 4,225,310**	**$ 4,181,354**	**$ 5,127,279**	**$ 5,127,279**	**$ 4,728,217**
15	Other Operating Revenue	$ 88,514	$ 92,702	$ 102,300	$ 92,828	$ 89,091	$ 122,004	$ 122,004	$ 92,739
16	**Total Operating Revenue**	**$ 6,932,290**	**$ 4,791,344**	**$ 6,070,996**	**$ 4,318,138**	**$ 4,270,445**	**$ 5,249,283**	**$ 5,249,283**	**$ 4,820,956**
	Operating Expenses								
17	Salary and Wages and Agency Fees	$ 2,025,982	$ 2,056,165	$ 2,054,463	$ 2,080,929	$ 1,996,137	$ 2,008,288	$ 2,008,288	$ 2,026,203
18	Employee Benefits	729,229	925,525	856,322	808,621	842,715	844,382	844,382	785,416
19	Total People Cost	$ 2,755,211	$ 2,981,690	$ 2,910,785	$ 2,889,550	$ 2,838,852	$ 2,852,670	$ 2,852,670	2,811,618
20	Med and Prof Fees (excld Agency)	$ 621,045	$ 639,293	$ 579,135	$ 643,707	$ 652,661	$ 735,435	$ 735,435	$ 598,762
21	Supplies	552,783	473,260	361,713	550,525	608,089	481,999	481,999	626,803
22	Purchased Services	379,540	372,201	403,065	307,662	463,462	380,330	380,330	413,583
23	Depreciation	395,082	427,561	422,819	441,840	500,000	519,093	519,093	441,044
24	Utilities	256,678	119,082	151,806	135,364	227,263	184,101	184,101	162,052
25	Insurance	66,583	66,583	98,995	68,544	34,172	72,750	72,750	68,293
26	Interest	84,472	54,108	20,453	50,300	120,563	12,973	12,973	59,272
27	Other	56,720	104,090	115,482	108,036	88,499	102,876	102,876	100,025
28	Matching Fees (IGT)	2,265,305	293,539	47,472	86,484	-	365,191	365,191	266,458
29	**Operating expenses**	**$ 7,433,419**	**$ 5,531,407**	**$ 5,111,725**	**$ 5,282,012**	**$ 5,533,561**	**$ 5,707,419**	**$ 5,707,419**	**$ 5,547,909**
30	**Operating Margin**	**$ (501,129)**	**$ (740,063)**	**$ 959,271**	**$ (963,874)**	**$ (1,263,116)**	**$ (458,136)**	**$ (458,136)**	**$ (726,953)**
	Non Operating Rev and Expense								
31	Miscellaneous Revenue/(Expenses)	$ 14,540	$ 37,899	$ 40,512	$ 41,366	$ 64,651	$ (12,506)	$ (12,506)	$ 36,743
32	Donations	(3,586)	(1,459)	67	-	-	-	-	(1,005)
33	Parcel Tax Assessment Rev	316,667	316,667	316,667	316,668	316,663	316,667	316,667	316,667
34	Extraordinary Items	-	-	-	-	-	-	-	-
35	**Total Non-Operating Rev/Exp**	**$ 327,621**	**$ 353,107**	**$ 357,246**	**$ 358,034**	**$ 381,314**	**$ 304,161**	**$ 304,161**	**$ 352,405**
36	**Net Income / (Loss) Excl GO Bond**	**$ (173,508)**	**$ (386,956)**	**$ 1,316,517**	**$ (605,840)**	**$ (881,802)**	**$ (153,975)**	**$ (153,975)**	**$ (374,548)**
37	GO Bond Activity, Net	175,187	175,187	175,187	175,187	175,188	157,692	157,692	174,790
38	**Net Income/(Loss) Incl GO Bond**	**$ 1,679**	**$ (211,769)**	**$ 1,491,704**	**$ (430,653)**	**$ (706,614)**	**$ 3,717**	**$ 3,717**	**$ (199,759)**
39	Restricted Foundation Contributions	$ 516,187	$ 2,442,308	$ 1,202,053	$ 153,261	$ 448,716	$ 65,959	$ 65,959	$ 449,199
40	**Change in Net Position**	**$ 517,866**	**$ 2,230,539**	**$ 2,693,757**	**$ (277,392)**	**$ (257,898)**	**$ 69,676**	**$ 69,676**	**$ 249,440**
	Operating EBDA	**$ (106,047)**	**$ (312,502)**	**$ 1,382,090**	**$ (522,034)**	**$ (763,116)**	**$ 60,957**	**$ 60,957**	**$ (285,910)**
	Total EBDA - Excl Rest Contributions	$ 396,761	$ 215,792	$ 1,914,523	$ 11,187	$ (206,614)	$ 522,810	$ 522,810	$ 241,285
	Total EBDA - Incl Rest Contributions	$ 912,948	$ 2,658,100	$ 3,116,576	$ 164,448	$ 242,102	$ 588,769	$ 588,769	$ 690,484

Sonoma Valley Hospital
Cash Forecast
FY 2025

ATTACHMENT G

		Actual July	Forecast Aug	Forecast Sept	Forecast Oct	Forecast Nov	Forecast Dec	Forecast Jan	Forecast Feb	Forecast Mar	Forecast Apr	Forecast May	Forecast Jun	TOTAL
	Hospital Operating Sources													
1	Patient Payments Collected	4,211,654	4,000,000	4,000,000	4,000,000	4,100,000	4,100,000	4,100,000	4,100,000	4,200,000	4,200,000	4,250,000	4,250,000	49,511,654
2	Other Operating Revenue	316,656	150,000	37,000	95,000	200,000	93,000	115,000	150,000	20,000	110,000	100,000	100,000	1,486,656
3	Other Non-Operating Revenue	12,149	5,250	10,861	46,651	19,716	11,380	24,169	9,420	11,309	18,628	3,587	8,000	181,120
4	Unrestricted Contributions													-
	Sub-Total Hospital Sources	**4,540,458**	**4,155,250**	**4,047,861**	**4,141,651**	**4,319,716**	**4,204,380**	**4,239,169**	**4,259,420**	**4,231,309**	**4,328,628**	**4,353,587**	**4,358,000**	**51,179,430**
	Hospital Uses of Cash													
5	Operating Expenses / AP Payments	5,002,977	4,843,000	5,032,000	5,047,000	5,057,000	5,139,000	5,407,200	4,878,000	4,954,000	5,030,000	5,403,000	4,977,000	60,770,177
6	Term Loan Paydown - $1.9M LOC	-	-	-	38,525	38,525	38,525	38,525	38,525	38,525	38,525	38,525	38,525	346,725
7	Capital Expenditures	65,959	25,000	-	25,000	25,000	-	100,000	150,000	100,000	200,000	225,000	50,000	965,959
	SVH Capital	-	25,000		25,000	25,000		100,000	150,000	100,000	200,000	225,000	50,000	900,000
	Foundation Capital	65,959		-										65,959
	Total Hospital Uses	**5,068,936**	**4,868,000**	**5,032,000**	**5,072,000**	**5,082,000**	**5,139,000**	**5,507,200**	**5,028,000**	**5,054,000**	**5,230,000**	**5,628,000**	**5,027,000**	**61,736,136**
	Net Hospital Sources/Uses of Cash	**(528,478)**	**(712,750)**	**(984,139)**	**(930,349)**	**(762,284)**	**(934,620)**	**(1,268,031)**	**(768,580)**	**(822,691)**	**(901,372)**	**(1,274,413)**	**(669,000)**	**(10,556,707)**
	Non-Hospital Sources													
8	Restricted Capital Donations	65,959												65,959
9	Parcel Tax Revenue	142,457				2,059,056					1,500,627			3,702,141
10	Other Payments			300,000										300,000
11	Other:													-
12	IGT - QIP (PY 6/CY23)									750,000				750,000
13	IGT - Rate Range (CY23)							11,105,844						11,105,844
14	IGT - HQAF VIII (CY23)											780,000		780,000
15	IGT - NDPH (SFY23-24)												-	-
16	IGT - NDPH (SFY24-25)												160,600	160,600
17	IGT - DHDP (CY23)									-		838,658		838,658
18	Distressed Hospital Loan Program	3,100,000												3,100,000
19	Line of Credit Draw - New Bank				5,400,000									5,400,000
	Sub-Total Non-Hospital Sources	**3,308,416**	**-**	**300,000**	**5,400,000**	**2,059,056**	**-**	**11,105,844**	**-**	**750,000**	**1,500,627**	**1,618,658**	**160,600**	**26,203,202**
	Non-Hospital Uses of Cash													
20	IGT Matching Fee Payments	-	-	-	-	5,157,563	-	-	486,730	294,000	86,480	-		6,024,773
21	Line of Credit Repayment - Existing LOC	3,100,000												3,100,000
22	Line of Credit Repayment - New LOC							5,400,000						5,400,000
	Sub-Total Non-Hospital Uses of Cash	**3,100,000**	**-**	**-**	**-**	**5,157,563**	**-**	**5,400,000**	**486,730**	**294,000**	**86,480**	**-**	**-**	**14,524,773**
	Net Non-Hospital Sources/Uses of Cash	**208,416**	**-**	**300,000**	**5,400,000**	**(3,098,507)**	**-**	**5,705,844**	**(486,730)**	**456,000**	**1,414,147**	**1,618,658**	**160,600**	**11,678,429**
	Net Sources/Uses	**(320,062)**	**(712,750)**	**(684,139)**	**4,469,651**	**(3,860,791)**	**(934,620)**	**4,437,813**	**(1,255,310)**	**(366,691)**	**512,775**	**344,245**	**(508,400)**	**1,121,722**
	Total Cash at beginning of period	3,748,581	3,428,519	2,715,769	2,031,631	6,501,282	2,640,491	1,705,871	6,143,684	4,888,374	4,521,683	5,034,458	5,378,703	
	Total Cash at End of Period	**3,428,519**	**2,715,769**	**2,031,631**	**6,501,282**	**2,640,491**	**1,705,871**	**6,143,684**	**4,888,374**	**4,521,683**	**5,034,458**	**5,378,703**	**4,870,303**	
	Days of Cash on Hand at End of Month	**22.0**	**17.4**	**13.0**	**41.7**	**16.9**	**10.9**	**39.4**	**31.3**	**29.0**	**32.3**	**34.5**	**31.2**	

To: Board of Directors – Sonoma Valley Health Care District
From: Bill Boerum, Board Member
Subject: Reactivate Joint Conference Committee & Reengage with Medical Executive Committee

September 5, 2024

Background:

When I came on the Board in March 2007, there was the practice of two Board Members attending the monthly Medical Executive Committee meetings. One such Member was a permanent representative of the Board, the Board Chair during his/her term of office. The other representative position was rotational through the Board each having a turn. There was and is today, two parts to the meeting: the general session (basically reports by the department heads and other discussion); the other part was private (basically discussions and matters relating to clinical performance and peer review). Both of the Board representatives were excused from that second session. The general format of the meetings continues to this day, but without Board participation.

At some point in years gone by, a previous CEO concluded that it was not necessary for Board Members to attend the monthly Med Exec meetings, and in recommended to the Board, a vote taken – 4 to 1 as I recall – and the Board ceased to attend the meetings. It would be pejorative to say why the CEO made that recommendation, but essentially it cut off an important channel of direct dialogue, communication and observation (and learnings) by the Board of the workings of the Med Exec Committee and of clinical matters under discussion by the Committee. Part of the rationalization of suspending the participation was that it was burdensome for the Board Members – an argument which was persuasive from the CEO to the Board. I found attending such meetings invaluable in understanding what was going on in the hospital and the challenges in treatment of the patient population. The Board Chair had the opportunity to report on decisions and discussion by the Board from its recent meeting, which I did during my three years as Board Chair. This gave the Med Exec Committee a direct view into current matters before the Board.

Since the suspension of Board Member participation, the only channel of communication between the Board and the Med Exec Committee are reports at the quarterly dinner meetings. Though there are reports by department heads, in effect, these are social events with hardly any questions or issues raised.

I believe it is essential that the Board have routine, direct access to the medical staff rather than only relying on reports by the CEO. This is especially critical with three new Board Members coming on in December. Within the Medical Staff By-Laws (its 105 pages recently approved by Med Exec and the Board as the governing authority) there is provision for a resumption of Board Member participation in the monthly meetings. Additionally, there is provision for the activation of the "Joint Conference Committee." Attached is the relevant one-page section of the By-Laws. This bears reading for its importance for the Board's active oversight of the medical staff as well as its direct understanding of the performance of the medical staff. I have reason to believe that the Chief of Staff of the Medical Executive Committee would be agreeable to participation by the Board in the monthly meetings.

I believe it is essential that a newly composed Board – with three new Members – re-engage directly with the Med Exec Committee as part of its governance oversight as well as revive its legitimate role via the Joint Conference Committee as stipulated in the By-Laws.

Recommendations:

- The current, incumbent Board at this meeting give active discussion to the issues raised, herein;
- The current Board resolve to resume participation in the monthly meetings; and,
- The incumbent Board Chair enter into discussion with the Chief of Staff to plan for implementation of the role of the Joint Conference Committee.

Financial Impact:

There is no financial impact for implementing these governance practices.

Article 8
COMMITTEES

8.1-11 **Accountability**

All committees shall be accountable to the Medical Executive Committee.

8.1 Joint Conference Committee

8.2-1 **Composition**

The Joint Conference Committee shall be composed of six members: the Chief of Staff, the Vice-Chief of Staff, two members of the hospital's District Board, the Chief Medical Officer, and the Chief Executive Officer. All members are voting members. The person serving as the Joint Conference Committee chair shall alternate annually between the Chief of Staff and one of the District Board representatives.

8.2-2 **Duties and Meeting Frequency**

a. This committee shall serve as a focal point for furthering an understanding of the roles, relationships, and responsibilities of the District Board, administration, and the Medical Staff. It may also serve as a forum for discussing any hospital matters regarding the provision of patient care. It shall meet as often as necessary to fulfill its responsibilities. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee.

b. The committee may also serve as the initial forum for exercise of the meet and confer provisions contemplated by Section 14.6 of these bylaws; provided, however, that upon request of at least three committee members, a neutral mediator, acceptable to both contingents, shall be engaged to assist in dispute resolution.

8.2-3 **Accountability**

The Joint Conference Committee is directly accountable to the Medical Executive Committee and to the District Board.

SUBJECT: Affiliation Oversite Committee Charter	PAGE 1 of 3
REVISED: 05.31.24	EFFECTIVE: 06.06.24

PURPOSE:

This charter sets forth the duties and responsibilities and governs the operations of the Affiliation Oversight Committee (the "AOC") of the Board of Directors (the "BOD") of Sonoma Valley Health Care District ("SVHCD"), a local Health Care District organized and existing under the California Law.

The AOC's purpose is to assist the BOD in its oversight of SVHCD's collaboration with UCSF Health (UCSF), including the review of progress made towards the goals of the Collaboration Agreement (the Agreement) entered into by SVHCD and UCSF in December of 2020. The AOC will coordinate with and review the progress of the Joint Operations Committee (the JOC) in the process of updating and making recommendations to BOD on all decisions relating to the affiliation between the two organizations.

RESPONSIBILITIES:

The Committee's primary duties and responsibilities are, as follows:

- Annually, draft and recommend to the BOD for approval, objectives for the affiliation for coming year; a proposed draft of annual goals shall be submitted to the Affiliation Oversight Committee by the Joint Operations Committee;
- Review the progress made by the Joint Operations Committee against the objectives of the Collaboration Agreement and annual objectives; including any significant changes to timelines and/or objectives themselves

POLICY:

The AOC shall submit recommendations for action to the BOD on any draft policies developed by the AOC, the Joint Operations Committee and those developed by the Hospital regarding the Collaboration Agreement and/or the affiliation.

Oversight

The AOC shall review and monitor the ongoing performance of the UCSF and SVHCD affiliation. The AOC shall constitute a committee of BOD. The BOD shall refer all matters brought to it by any party regarding this agreement to the AOC for review, assessment, and recommended BOD action. The AOC makes recommendations and reports to the BOD. The AOC is an advisory committee and has no authority to make decisions or take actions on behalf of SVHCD unless the BOD specifically delegates such authority.

To this end the AOC shall:

- Regularly review the strategic objectives for the Collaboration Agreement, seek approval from the BOD for any changes to these objectives and timelines;
- Provide oversight, monitoring and assessment of the Collaboration Agreement and report to the BOD regularly on that progress;

PROCEDURE:

Annual JOC Work Plan

Each year, the AOC shall review and approve a proposed Work Plan comprised of any required annual activities and additional activities selected by the JOC. The Annual JOC Work Plan shall be reviewed and approved by the BOD in December of each year.

Required Annual Calendar Activities

- Draft recommendations for the affiliation partners for the year
- The JOC Work Plan shall be approved by the AOC and submitted to the BOD for its review and approval no later than each December.
- The AOC shall deliver a report to the BOD on the status of its prior year's Work Plan accomplishments each February.

Rules

Charter Review:	Will be reviewed/revised, at a minimum, every three years. Changes will be submitted to the BOD of Directors for approval.
Authority to Act:	In compliance with the Charter and as directed by Executive Leadership and the BOD
Meeting Schedule:	At least two meetings per year
Voting Members:	The AOC shall have at least four voting members. • Two BOD members, one being the BOD Chair o One of whom shall be the AOC chair, the other the vice-chair • Two representatives from UCSF o UCSF Health President, Affiliates Network and an additional designee
Quorum Requirement:	Half plus one member present.
Chair:	BOD Chair
Composition:	Voting Committee Members and Sonoma Valley Hospital CEO, who will provide all materials for review by the AOC.

Public Participation

All AOC meetings shall be announced and conducted pursuant to the Brown Act. The general public, patients, and their families and friends, Medical and SVH Staff are always welcome to attend and provide input. Other BOD members may attend but only as “observers” as defined in the Brown Act.

SUBJECT: Finance Committee Charter	PAGE 1 of 3
REVISED: 03.26.24	EFFECTIVE: 06.06.24

PURPOSE:

This charter sets forth the duties and responsibilities and governs the operations of the Finance Committee ("FC") of the Board of Directors ("BOD") of Sonoma Valley Health Care District ("SVHCD"), a nonprofit corporation organized and existing under the California Law.

The FC's purpose is to assist the BOD in its oversight of the SVHCD's financial affairs, including SVHCD's financial condition, financial planning, operational, and capital budgeting, debt structure, debt financing and refinancing and other significant financial matters involving the SVHCD. The FC is the body which makes recommendations to the BOD on all financial decisions.

RESPONSIBILITIES:

Review Monthly Financial Operating Performance

- Review the SVHCD's monthly financial operating performance. The FC will review the monthly financial statements, including but not limited to the Statement of Revenues and Expenses, Balance Sheet, Statement of Cash Flows, and Operating Indicator Report, prepared by management. The FC will also review other financial indicators as warranted.
- Review management's plan for improved financial and operational performance including but not limited to new patient care programs, cost management plans, and new financial arrangements. The FC will make recommendations to the BOD when necessary.

Budgets

- Review and recommend to the BOD for approval an annual operating budget for the SVHCD.
- Review management's budget assumptions including volume, growth, inflation, and other budget assumptions.
- Review and recommend to the BOD for approval an annual capital expenditures budget, and unbudgeted capital expenditures for SVHCD. If deemed appropriate by the FC, review and recommend to the BOD for approval projected capital expenditures budgets for one or more succeeding years.

Debt, Financing, and Refinancing

- Evaluate and monitor SVHCD's long and short-term indebtedness, debt structure, collateral or security, therefore, cash flows, and uses and applications of funds.
- Evaluate and recommend to the BOD for approval proposed new debt financing, including lines of credit, financings and refinancing, including (i) interest rate and whether the rate will be fixed or floating rate; (ii) collateral or security, if any; (iii) issuance

costs; (iv) banks, investment banks, and underwriters retained or compensated by SVHCD in connection with any financing or refinancing.
- Review and recommend to the BOD all guarantees or other obligations for the indebtedness of any third party.

Insurance
- Review on an annual basis all insurance coverage, including (i) identity and rating of carriers; (ii) premiums; (iii) retentions; (iv) self-insurance; (v) stop-loss policies; and (vi) all other aspects of insurance coverage for healthcare institutions.

Investment Policies
- Review and recommend to the BOD, SVHCD's cash management and cash investment policies, utilizing the advice of financial consultants as the FC deems necessary or desirable.
- Review and recommend to the BOD, SVHCD's investment policies relating to assets of any employee benefit plans maintained and controlled by SVHCD, utilizing the advice of financial consultants as the FC deems necessary or desirable.

General
- Review and recommend the services of all outside financial advisors, financial consultants, banks, investment banks, and underwriters for SVHCD. Review annually SVHCD's significant commercial and investment bank relationships.
- Review and recommend consideration of any acquisition, merger, combination, or affiliation with another healthcare enterprise.
- Perform any other duties and responsibilities as the BOD may deem necessary, advisable or appropriate for the FC to perform.
- Perform such other duties and responsibilities as the FC deems appropriate to carry out its purpose as provided in this Charter.
- The FC will be invited to attend the presentation by SVHCD's independent auditors.
- The FC shall report to the BOD on the status of its prior fiscal year's work plan accomplishments by after the completion of the Financial Statement Audit.

Rules

Charter Review:	Will be reviewed/revised, at a minimum, every three years. Changes will be submitted to the BOD of Directors for approval.
Authority to Act:	In compliance with the Charter and as directed by Executive Leadership and the BOD
Meeting Schedule:	At least ten meetings per year
Voting Members:	The FC shall have at least seven and no more than nine voting members. • 2 BOD members, one being the Treasurer o One of whom shall be the FC chair, the other the vice-chair • 4-6 SVHCD Citizens • At least one (1) member of the Medical Staff of Sonoma Valley Hospital (SVH)
Quorum Requirement:	Half plus one member present
Chair:	One of the appointed BOD Members
Composition:	Voting FC Members, Presenters, SVH Chief Executive Officer, and SVH Chief Financial Officer

FC Membership
The FC's membership is subject to the Approval of the BOD. The BOD shall recruit members of the FC that are representative of the diverse constituencies of SVHCD.

Public Participation
All FC meetings shall be announced and conducted pursuant to the Brown Act. The general public, patients, and their families and friends, Medical and SVH Staff are always welcome to attend and provide input. Other BOD members may attend but only as "observers" as defined in the Brown Act.

SUBJECT: Governance Committee Charter	PAGE 1 of 2
REVISED: 03.19.24	EFFECTIVE: 06.06.24

PURPOSE:

Consistent with the Mission of the District, the Governance Committee ("GC") assists the Board of Directors ("BOD") to improve its functioning, structure, and infrastructure, while the BOD serves as the steward of the Sonoma Valley Health Care District ("SVHCD").

RESPONSIBILITIES:

The GC shall assist the Board in its responsibility to ensure that the Board functions effectively. To this end the GC shall:

- Formulate policy to convey Board expectations and directives for Board action;
- Make recommendations to the Board among alternative courses of action;
- Ensure, with the Chair of the Board, that an annual Board self-assessment is completed.
- The GC, shall remain a Standing Committee, to review the composition of the Standing Committees annually for vacancies, including an assessment of the desired.

POLICY:
Draft policies and decisions regarding governance performance and submit them to the BOD for deliberation and action, such as policy on gifts and honoraria.

Oversight
The Board shall use the GC to address these duties and shall refer all matters brought to it by any party regarding Board governance to the GC for review, assessment, and recommended Board action, unless that issue is the specific charge of another Board Standing Committee. The GC makes recommendations and reports to the Board. It has no authority to make decisions or take actions on behalf of the District.

PROCEDURE:
Annual GC Calendar

- Scheduled review and assessment of all board policies regarding governance, specifically including the GC and all other Standing Committee Charters, and make recommendations to the Board for action per the schedule.
- The calendar year work plan shall be submitted to the Board no later than November for approval.
- The GC shall report on the results of its prior year's work plan accomplishments by
- December.
- The GC shall establish the next calendar meeting schedule at the last meeting of the year.
- Ensure that the CEO shall develop and provide a 12 month calendar of all scheduled Regular and Special Board Meetings and post on the SVH website at the beginning of the calendar year. It shall be kept updated.

Rules

Charter Review:	Will be reviewed/revised, at a minimum, every three years. Changes will be submitted to the BOD for approval.
Authority to Act:	In compliance with the Charter and as directed by Executive Leadership and the BOD
Meeting Schedule:	At least two meetings per year. Meetings may be held at irregular intervals.
Voting Members:	The GC shall have three voting members. • Two BOD members o One of whom shall be the GC chair, the other the vice-chair • One member of the public.
Quorum Requirement:	Half plus one member present.
Chair:	The BOD Chair shall serve as Chair of the GC, unless the BOD specifically acts to delegate otherwise.
Composition:	Voting Committee Members, Presenters, Sonoma Valley Hospital CEO and/or Administrative Representative. At the request of the GC Chair, the Compliance Officer shall attend GC meetings.

GC Membership

The GC's membership is subject to the Approval of the BOD. The BOD shall recruit members of the GC that are representative of the diverse constituencies of SVHCD.

Public Participation

All GC meetings shall be announced and conducted pursuant to the Brown Act. The general public, patients, and their families and friends, Medical and SVH Staff are always welcome to attend and provide input. Other BOD members may attend but only as "observers" as defined in the Brown Act.

SUBJECT: Quality Committee Charter

DEPARTMENT: ORGANIZATIONAL

EFFECTIVE: 09.03.20

REVISED: 03.27.24

PURPOSE:

The Board Quality Committee is responsible for guiding and assisting the Executive Leaders, Medical Staff, and the Governing Board in fulfilling their responsibility to oversee safety, quality, and effectiveness of care at Sonoma Valley Hospital; and to meet or exceed standards and regulations that govern health care organizations.

RESPONSIBILITIES:

The Committee has three broad sets of responsibilities.

- To oversee that quality assurance and improvement processes are in place and operating in the hospital.
- To enhance quality across and throughout the patient care, technical, and operation areas of Sonoma Valley Hospital. This encompasses all aspects of the interface and experience between patients, families, and the community. This also includes coordination and alignment within the organization.
- To assure continual learning and skills development for risk surveillance, prevention, and continuous improvement.

The committee examines all activities against the Institute of Medicine's Six Aims for Improvement: safe, effective, patient/family-centered, efficient, timely, and equitable. This also aligns with the strategic plan of Sonoma Valley Hospital.

POLICY:

Oversight

As the governing body, the Governing Board is charged by law and by accrediting and regulatory organizations (e.g., Center for Improvement in Healthcare Quality CIHQ) with ensuring the quality of care rendered by Sonoma Valley Hospital through its various divisions and departments. The Committee has the delegated authority to establish accountability in medical staff and management to assure improvement is occurring and targeted outcomes are achieved. To help meet this responsibility, the Board Quality Committee exists to:

- Develop the quality goals and blueprint (priorities and strategies) for Sonoma Valley Hospital, using an inclusive and data driven-process.

- Review and monitor patient safety, risk mitigation, quality assurance, and improvement plans and progress.

- Have the authority to initiate inquiries, studies, and investigations within the purview of duties assigned to the Committee.

- Perform, on behalf of the Governing Board and Medical Staff Leadership, such other activities as are required by the CIHQ, Centers for Medicaid and Medicare Services (CMS), and other external accrediting and regulatory bodies.

- Render reports and recommendations to the Executive Leadership Committee of Sonoma Valley Hospital and SVH Medical Staff on its activities.

- Review all new and updated hospital patient care policies for adherence to quality and safety priorities.

- Review all Medical Staff credentialing.

Quality Integration

- The Committee monitors the quality assurance and improvement activities of Sonoma Valley Hospital's entities to enhance the quality of care provided throughout the hospital or medical center system and encourage a consistent standard of care. Monitored activities include but are not limited to:
    - Quality Performance Indicator Set
        - Mortality
        - Preventable Harm Events
        - Healthcare Acquired Infections
        - Medication Events
        - Never Events
        - Core Measures
        - Readmissions
        - Utilization Review
    - Patient Experience
    - Accreditation & Regulatory Standards
    - Quality Assurance Performance Improvement
    - Culture of Safety
    - Risk Event Reports
    - Policies & Procedures

- The Committee ensures the coordination and alignment of quality initiatives throughout Sonoma Valley Hospital.

- The Committee conducts annual reviews of the following key areas:
    - Improvement goal achievement
    - Clinical outcomes (priorities and improvement)
    - Patient Safety/Event Analysis/Risk Trending
    - Culture of Patient Safety
    - Accreditation and Regulatory Reviews
    - Emergency Operations Plans

- The Committee monitors the progress of quality assurance and improvement processes and serves as champion of issues concerning quality to other committees.

- The Committee identifies barriers to improvement for resolution and systematically addresses and eliminates barriers and excuses.

PROCEDURE:

All Committee meetings will have a Standard Agenda, which will include:

- Quality Performance Indicator Set
- Clinical Priorities (clinical outcomes/process improvement), including:
    - Quality Assurance Performance Improvement
    - Patient harm
    - Patient safety (adverse event reduction, healthcare acquired infection reduction, risk mitigation)
    - Performance to accreditation and regulatory standards and requirements
    - Patient Experience
    - Culture of Safety
    - Policies and Procedures
    - Medical Staff Credentialing

SUBJECT: Quality Committee Charter

DEPARTMENT: ORGANIZATIONAL

EFFECTIVE: 09.03.20

REVISED: 03.27.24

Rules

Charter Review	Will be reviewed/revised, at a minimum, every three years. Changes will be submitted to the Board of Directors for approval.
Authority to Act	In compliance with the Charter and as directed by Executive Leadership and the District Board
Meeting Schedule	At least ten meetings per year
Voting Members:	The Board Quality Committee shall have at least seven and no more than nine voting members. • Two Board members o One of whom shall be the QC chair, the other the vice-chair • Vice Chief of Staff • At least four and no more than six members of the public are selected by the Governing Board.
Quorum Requirement:	Half plus one member present.
Chair	One of the appointed Board Members
Composition	Voting Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO), Director of Quality

REFERENCES:

www.ihi.org/improvement-areas/triple-aim-population-health
www.ihi.org/insights/quintuple-aim-why-expand-beyond-triple-aim

SUBJECT: Audit Committee Charter	PAGE 1 of 2
REVISED: 03.19.24	EFFECTIVE: 06.06.24

PURPOSE:

The purpose of the Audit Committee ("AC") of Sonoma Valley Health Care District ("SVHCD) is to assist the District Board of Directors ("BOD") in its annual audit process. Subject to the ultimate authority of the BOD, the AC shall select, engage and oversee SVHCD's outside auditor and approve and oversee all audit services provided by SVHCD's outside auditor.

RESPONSIBILITIES:

Subject to the ultimate authority of the BOD, the AC shall:

- Recommend the appointment and compensation of the independent auditor and provide oversight of the annual financial audit process. The independent auditor shall report directly to the AC.
- Establish policies and procedures for the review and pre-approval by the AC of all auditing services.
- Review and discuss with the independent auditor: (a) its audit plans and audit procedures, including the scope, fees and timing of the audit; (b) the results of the annual audit examination; and (c) the annual financial statements audited by the independent auditor.
- Review the annual financial audit with management and determine whether to recommend the acceptance of the audit to the BOD.
- Review with the independent auditor its judgment as to the quality, and not just the acceptability, of SVHCD's accounting practices and internal controls, and such other matters as are required to be discussed with the AC under generally accepted auditing standards.
- Review with the independent auditor and management any changes or improvements in financial or accounting practices that are necessary or desirable, and the extent to which any changes or improvements previously approved by the AC have been implemented.
- Review with the independent auditor any audit problems or difficulties and management's response to these issues.
- Oversee the resolution of any disputes between management and the independent auditor if and when such disputes arise.

Rules

Charter Review:	Will be reviewed/revised annually. Changes will be submitted to the BOD for approval.
Authority to Act:	In compliance with the Charter and as directed by Executive Leadership and the BOD
Meeting Schedule:	At least two meetings per year. Meetings may be held at irregular intervals.
Voting Members:	The AC shall have three voting members. • Two BOD members (BOD Chair & BOD Treasurer) o One of whom shall be the AC chair, the other the vice-chair • Two members of the public.
Quorum Requirement:	Half plus one member present.
Chair:	The BOD Chair shall serve as Chair of the AC, unless the BOD specifically acts to delegate otherwise.
Composition:	Voting Committee Members, Presenters, Sonoma Valley Hospital CEO and Sonoma Valley Hospital CFO.

AC Membership
The AC's membership is subject to the Approval of the BOD. The BOD shall recruit members of the AC that are representative of the diverse constituencies of SVHCD.

Public Participation
All AC meetings shall be announced and conducted pursuant to the Brown Act. The general public, patients, and their families and friends, Medical and SVH Staff are always welcome to attend and provide input. Other BOD members may attend but only as "observers" as defined in the Brown Act.