



**SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS**

AGENDA

THURSDAY, APRIL 2, 2026

CLOSED SESSION 4:15 P.M.

REGULAR SESSION 5:00 P.M.

Held in Person at Council Chambers

177 First Street West, Sonoma

To participate via Zoom videoconferencing, use the link below:
<https://sonomavalleyhospital-org.zoom.us/j/91962325850?from=addon>

Meeting ID: 919 6232 5850

One tap mobile +16692192599,,91962325850#

In compliance with the Americans with Disabilities Act, the District will provide reasonable accommodations to persons with disabilities. If you require special accommodations to participate in a District meeting, please contact Whitney Reese at wreese@sonomavalleyhospital.org or 707-935-5035, at least 48 hours prior to the meeting, when possible.

MISSION STATEMENT

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

4:15 p.m. CLOSED SESSION:

Calif. Government Code §37606 and 37624.3: TRADE SECRET; Discussion will concern proposed new service and/or program

5:00 p.m REGULAR SESSION: CALL TO ORDER

Wendy Lee Myatt

Inform

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

Wendy Lee Myatt

Inform

4. CONSENT CALENDAR

- a. BOD Minutes – 03.05.26
- b. Finance Committee Minutes – 02.24.26
- c. Quality Committee Minutes – 01.28.26
- d. Quality Committee Minutes – 02.25.26
- e. Policies & Procedures
- f. Medical Staff Credentialing

Wendy Lee Myatt

Action

Pages
a.3 - 4
b. 5 - 6
c. 7 - 8
d. 9 - 10
e. 11 - 28

5. TODAY & TOGETHER

Christina Gonzalez

Inform

Pages
29 - 43

6. 2025 ANNUAL QUALITY REPORT

Louise Wyatt, RN JD

Inform

Pages
44 - 66

7. MEDICAL STAFF BYLAWS

*Patrick I. Okolo III, MD
MPH*

Action

Pages
67 - 108

8. CEO REPORT

- Board retreat update (Strategic Plan Refresh)

Kelley Kaiser

Inform

Pages
109 - 113

9. CMO REPORT

*Patrick I. Okolo III, MD
MPH*

Inform

Pages
114 - 115

10. FINANCIALS FOR MONTH END FEBRUARY 2026	<i>Ben Armfield</i>	Inform	Pages 116 - 124
11. COMMITTEE UPDATES	<i>Board of Directors</i>	Inform	
12. BOARD COMMENTS	<i>Wendy Lee Myatt</i>	Inform	
13. ADJOURN	<i>Wendy Lee Myatt</i>		

Note: To view this meeting live, you may visit www.youtube.com/@SonomaTV



**SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS' REGULAR & SPECIAL MEETINGS**

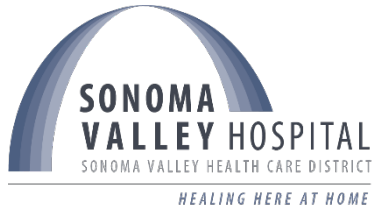
MINUTES

THURSDAY, MARCH 5, 2026

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

SONOMA VALLEY HOSPITAL BOARD MEMBERS		
1. Wendy Lee Myatt, Chair, Present 2. Denise M. Kalos, 1st Vice Chair, Present 3. Daniel Kittleson, DDS, 2nd Vice Chair, Present 4. Dennis B. Bloch, Secretary, Present 5. Ed Case, Treasurer, Present		
MISSION STATEMENT		
<i>The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.</i>		
1. CALL TO ORDER	<i>Wendy Lee Myatt</i>	
Meeting called to order at 5:01 p.m.		
2. PUBLIC COMMENT	<i>Public</i>	none
3. BOARD CHAIR COMMENTS	<i>Wendy Lee Myatt</i>	none
4. CONSENT CALENDAR	<i>Wendy Lee Myatt</i>	Action
a. BOD Minutes – 02.05.26 b. Finance Committee Minutes – 01.27.26 c. Policies & Procedures d. Medical Staff Credentialing	MOTION: motion to approve by Kalos, 2 nd by Bloch. Motion passed. Ayes: 5, Nays: 0	
5. UCSF AFFILIATION AGREEMENT	<i>Kelley Kaiser</i>	Action
Kaiser presented the Amended and Restated Affiliation Agreement between SVHCD and UCSF Health, marking the culmination of an eight-month collaborative revision process. The updated agreement, which succeeds the original 2018 collaboration document and combines its amendments, includes a significant new section on “Professional, Clinical, and Strategic Services” intended to increase community access to UCSF’s clinical expertise and quality of care. Key substantive changes include the restructuring of the Affiliation Oversight Committee to ensure strict Brown Act compliance, a shift to monthly pass-through compensation for executive management with salary increases capped at SVH’s average, and a revised renewal clause that requires action to extend beyond a sixth year. Leadership emphasized that the agreement secures high-level executive talent while formalizing a more robust, results-oriented framework for shared clinical initiatives.		
MOTION: motion to approve by Case to approve, 2 nd by Kittleson. Motion passed. Ayes: 5, Nays: 0		
6. AUDIT ENGAGEMENT (FY26 Financial Statement Assurance Services)	<i>Ben Armfield</i>	Action
Armfield presented a request for Baker Tilly to perform the district’s Fiscal Year 2026 audit, marking the final year of the current three-year agreement. Fees align with the original proposal.		
MOTION: motion to approve by Kittleson to approve, 2 nd by Kalos. Motion passed. Ayes: 5, Nays: 0		
7. CEO REPORT	<i>Kelley Kaiser</i>	Inform
Kaiser provided an update on preparations for the upcoming board retreat on 3/19/26, which will focus on the strategic plan pillars. Notable operational highlights included the successful installation and use of the Stryker system. Jessica Winkler will be retiring after our upcoming survey completion and recruitment for a replacement Chief Nursing Officer has begun. High praise was given to her tenure. SVH received a quality award from Partnership Health Plans for achieving 100% compliance on quality goals. Regarding the CMS star rating, Kelley clarified that the hospital expects an upgrade in April and emphasized that the facility maintains a four-star rating for patient experience, noting that current ratings are often impacted by data reporting lags and small-hospital metrics.		

8. CMO REPORT	<i>Patrick I. Okolo III, MD MPH</i>	Inform
<p>Dr. Okolo reported on the hospital’s positive trajectory, noting that while some retrospective CMS ratings reflect historical data, current performance in patient safety and readmission rates is strong. A key highlight is the SVH’s patient experience (HCAHPS) scores, which rank in the top 10% of similar facilities. Clinical volumes for procedures and infusions show steady growth. The Board discussed the complexity of national scoring systems and emphasized the need to proactively communicate these high standards of care and modern technology to the community.</p>		
9. FINANCIALS FOR MONTH END JANUARY 2026	<i>Ben Armfield</i>	Inform
<p>Armfield reported that January was a softer month with an operating loss, driven by a temporary dip in surgical volumes due to the holiday schedule and surgeon time off. Despite this disruption, year-to-date surgical volumes remain 10% above budget, with strong performance continuing in the ER, inpatient, and MRI departments. Liquidity is significantly improving. The hospital received a \$12 million IGT fund distribution that will reflect in February's cash flow, raising current cash on hand to 13.4 days (projected to reach 28.5 days by fiscal year-end) and allowing for the paydown of payables. Additionally, leadership is initiating the annual budget process, evaluating short- and long-term capital needs including seismic infrastructure, proposing a new financing subcommittee to leverage improved banking ratios, and beginning negotiations for next year's IGT funding.</p>		
10. COMMITTEE UPDATES	<i>Board of Directors</i>	None
11. BOARD COMMENTS	<i>Board of Directors</i>	None
12. ADJOURN	<i>Wendy Lee Myatt</i>	
<p>Regular session adjourned at 5:56 p.m.</p>		



SVHCD FINANCE & AUDIT COMMITTEE MEETING

MINUTES

TUESDAY, FEBRUARY 24, 2026

In Person at Sonoma Valley Hospital

347 Andrieux Street

and Via Zoom Teleconference

Present	Not Present/Excused	Staff/Public
Ed Case, in person Dennis Bloch, via zoom Paul Chakmak, in person Andrew Exner, via zoom Robert Crane, in person Graham Smith, via zoom Catherine Donahue, via zoom	Alexis Alexandridis, MD MBA FACS	Ben Armfield, SVH CFO, in person Kelley Kaiser, SVH CEO, in person Kimberly Drummond, SVH Chief of Support Services, in person Whitney Reese, SVH Board Clerk, in person Lois Fruzynski, SVH Accounting Manager, in person Leslie Petersen, SVH Foundation ED, in person Nathan Davis, via zoom Wendy Lee Myatt, via zoom

MISSION & VISION STATEMENT

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

AGENDA ITEM	PRESENTER	ACTIONS
1. CALL TO ORDER/ANNOUNCEMENTS	<i>Ed Case</i>	Zoom difficulties delayed start. Meeting called to order at 5:06pm
2. PUBLIC COMMENT SECTION	None	
3. CONSENT CALENDAR	<i>Ed Case</i>	Action
Finance Committee Minutes 1.27.26	MOTION: Motion to approve by Chakmak, 2 nd by Crane. All in favor.	
4. DISTRICT HOSPITAL LEADERSHIP FORUM PRESENTATION	<i>Nathan Davis, SVP DHLF</i>	Inform
<p>Davis provided an update on financial advocacy and supplemental funding for California's 33 district hospitals. He highlighted that because Medi-Cal base rates remain stagnant, DHLF's work in securing supplemental payment programs has become vital; these programs generated nearly \$660 million in net benefits for district hospitals in 2025 and are projected to exceed \$1 billion in 2026. While SVH participates in nearly all available programs, Davis noted the administrative complexity and cash-flow challenges of the IGT process required to draw down these federal matching funds.</p> <p>The committee also discussed the long-term outlook regarding HR 1 and the 2030 seismic mandate. While some immediate federal cuts were delayed, Davis warned that upcoming shifts in federal matching rates (FMAP) and stricter Medi-Cal eligibility rules will likely begin reducing supplemental payments by 2027–2028. The unfunded 2030 seismic requirements remain a major concern, with many hospitals currently unable to afford compliance. Despite these looming industry-wide challenges, SVH is currently at a financial "high water mark" in terms of supplemental revenue, which provides a temporary buffer before the anticipated revenue declines.</p>		
5. AUDIT FIRM ENGAGEMENT LETTER FY26 AUDIT	<i>Ben Armfield</i>	Action

Armfield presented an engagement letter to formalize Baker Tilly, formerly Moss Adams, to perform the district's financial statement audit for fiscal year 2026. This is Baker Tilly's third year. They initially gave a proposal for three years and the fees that are in this memo aligned to their initial proposal.

MOTION: Motion to approve by Crane, 2nd by Chakmak. All in favor.

6. CAPITAL PLAN REVIEW	<i>Ben Armfield</i>	Inform
<p>Armfield presented an updated Capital Needs Plan, it as a fluid "working document" rather than an immediate funding request. Improved financial standing through IGT funding now allows the hospital to address a backlog of deferred maintenance and equipment needs totaling approximately \$15 million over the next five years. The plan categorizes items into three "buckets": projects currently in motion, five-year priorities (including critical IT infrastructure and servers), and long-range infrastructure. Discussion highlighted a shift toward a proactive financing strategy (including a potential subcommittee to explore bond renewals) and noted the recent activation of the Cogen project, which is expected to reduce energy costs. The list will be refined with department heads to present a finalized version alongside the FY27 budget.</p>		
7. DETAILED A/R REVIEW	<i>Ben Armfield</i>	Inform
<p>Armfield presented the Accounts Receivable Analysis, which remains in a strong position, with over 90% of total receivables aged under 90 days despite a year-over-year increase in gross revenue and claim volume. Key performance metrics, including a 7.5 to 8-day "discharged, not yet billed" (DNYB) rate and an 8.5% denial rate, continue to be classified as "outstanding" per Epic benchmarks, supported by a strategic five-day bill hold policy that ensures high claim accuracy. While gross A/R rose by \$1.6 million compared to the prior year, the average "days in net AR" improved by 2–3 days, reflecting increased collection velocity and a stable aging profile. During the committee discussion, it was confirmed that the hospital utilizes the native Epic billing system for all revenue cycle management, which effectively handles a payer mix where Medicare represents approximately 50% of receivables and remains the most efficient payer for processing clean claims.</p>		
8. FINANCIAL REPORTS FOR MONTH END JANUARY 2026	<i>Ben Armfield</i>	Inform
<p>While January saw a temporary dip in surgical volume due to holiday scheduling and physician absences, the hospital remains in a strong financial position after a remarkable six-month streak of exceeding budget. Growth in other key areas like the ER, MRI services, and inpatient census, remained robust and consistent. The hospital's liquidity is improving significantly thanks to IGT payments, allowing the team to successfully reduce outstanding payables. Surgical volumes are already rebounding strongly in February and additional revenue streams are secured through the end of the year.</p>		
9. ADJOURN	<i>Ed Case</i>	Inform
<p>Meeting adjourned at 6:15pm</p>		



**SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE**

Wednesday, January 28, 2026, 5:00 PM

MINUTES

Members Present	Excused/Not Present	Public/Staff
Daniel Kittleson, DDS Susan Kornblatt Idell Carol Snyder Wendy Lee Myatt, via zoom	Michael Mainardi, MD Howard Eisenstark, MD Carl Speizer, MD Kathy Beebe, RN PhD Alex Rainow, MD, SVH Vice COS	Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO, in person Whitney Reese, SVH Board Clerk, via zoom Monique Jervan, SVH Executive Assistant, in person Chris Kutza, PharmD, SVH Director of Pharmacy, via zoom Patrick Okolo III, MD MPH, SVH CMO, in person Louise Wyatt, RN JD, SVH Director of Quality, Risk Management & Patient Safety, Infection Prevention and Case Management, in person Leslie Petersen, SVH Foundation ED, in person Dawn Castelli, SVH Community Outreach & Marketing Mngr, via zoom

AGENDA ITEM	PRESENTER	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	<i>Daniel Kittleson, DDS</i>	Called to order at 5:06pm
No quorum present so this will be an informational meeting only. Action items will be skipped.		
2. PUBLIC COMMENT SECTION	<i>Daniel Kittleson, DDS</i>	No public comments
3. CONSENT CALENDAR	<i>Daniel Kittleson, DDS</i>	ACTION
Minutes 12.03.25	<i>Minutes to proceed to Board for approval without QC's official approval.</i>	
4. PHARMACY QA/PI	<i>Chris Kutza, PharmD</i>	INFORM

Kutza highlighted downward trends in high-risk medication and administration errors, alongside stable performance in antimicrobial stewardship, controlled substance monitoring, and Pyxis utilization. Key updates included smart pump drug library adjustments, the annual Medication Error Reduction Plan (MERP) featuring a new Meds2Beds discharge program, Epic barcode scanning for IV prep, and tracking a new CMS metric for safe opioid prescriptions at discharge. Kutza answered Committee questions and clarified that the after-hours remote pharmacy service is utilized every day because the on-site pharmacy closes at 8:00 PM. He also explained that USP 797, which drove recent IV room policy changes, is a specific chapter from the United States Pharmacopeia that details the strict standards for sterile compounding in hospitals.

5. PATIENT CARE SERVICES DASHBOARD Q4 2025	<i>Jessica Winkler, DNP, RN, NEA-BC, CCRN</i>	INFORM
<p>Winkler presented the year-end PCS dashboard, highlighting a significant achievement in the ER where barcode scanning rates reached 90–92%, surpassing the adjusted 85% target. While high-risk patient observation and inpatient mobility metrics fell short of targets due to documentation frequency and logistical challenges, the team saw a marked improvement in on-time surgery starts, which was attributed to a collaborative cultural shift among staff and anesthesia. Winkler also noted that medication safety and organ referral rates remain strong, and nursing turnover is stable. IT has successfully automated chart audits, providing new data that shows a median admission-to-inpatient transfer time of 56 minutes; the team will now focus on increasing the percentage of transfers completed within 60 minutes to the 80% goal.</p>		
6. QUALITY INDICATOR PERFORMANCE & PLAN	<i>Louise Wyatt, RN JD</i>	INFORM
<p>SVH was recognized as a 2024-25 Top Performer in Partnership’s Hospital Quality Improvement Program (HQIP) for achieving a score of 90% or higher. SVH was one of two that received a 100% score. Performance data showed strong results in stroke care and sepsis management, with SEP-1 Early Management Bundle compliance reaching 100% in multiple months. To enhance governance, the 2026 Quality Plan shifts away from rate-based metrics in favor of raw numeric counts for safety events like falls and pressure ulcers, which provides more accurate data for low-volume facilities. While acknowledging a "PR issue" regarding Leapfrog safety grades, leadership is prioritizing CMS Star ratings and real-world clinical outcomes over Leapfrog’s methodology, which they believe often requires "gaming the game" rather than improving patient care. Moving forward, the hospital will focus on new CMS-aligned indicators, including Social Determinants of Health (SDOH) screenings, barcode medication scanning, and timely critical lab value reporting.</p>		
7. POLICIES & PROCEDURES	<i>Louise Wyatt, RN JD</i>	INFORM
<p>Wyatt presented and the committee reviewed.</p>		
8. ADJOURN	<i>Daniel Kittleson, DDS</i>	Adjourned at 6:16 p.m.
CLOSED SESSION: Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	<i>Alex Rainow, MD</i>	ACTION
<p><i>Credentialing will proceed to Board for approval without QC’s official approval this month.</i></p>		



**SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE**

Wednesday, February 25, 2026, 5:00 PM

MINUTES

Members Present	Excused/Not Present	Public/Staff
Daniel Kittleson, DDS Susan Kornblatt Idell Michael Mainardi, MD Howard Eisenstark, MD Carol Snyder Carl Speizer, MD Kathy Beebe, RN PhD Alex Rainow, MD, SVH Vice COS, via zoom	Wendy Lee Myatt, via zoom	Kelley Kaiser, SVH CEO Kelli Cornell, RN, SVH Director of Perioperative Services Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO Whitney Reese, SVH Board Clerk Louise Wyatt, RN JD, SVH Director of Quality, Risk Management & Patient Safety, Infection Prevention and Case Management Lynn McKissock, SVH Chief HR

AGENDA ITEM	PRESENTER	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	<i>Daniel Kittleson, DDS</i>	Called to order at 5:00pm
2. PUBLIC COMMENT SECTION	<i>Daniel Kittleson, DDS</i>	No public comments
3. CONSENT CALENDAR	<i>Daniel Kittleson, DDS</i>	ACTION
None – there wasn’t a quorum present at the last schedule meeting, so official minutes were not presented. Discussion concluded that minutes should be approved even when the meeting is not “official.” January and February’s meeting minutes will be presented in March.		
4. PERIOPERATIVE SERVICES QA/PI	<i>Kelli Cornell, RN</i>	INFORM
Cornell reported on steady departmental growth, highlighting a 20% year-over-year increase in outpatient infusions and the successful integration of new robotic and surgical equipment. She shared strong 2025 quality metrics, notably a 45% reduction in immediate-use sterilization cycles and an impressive increase in first-case on-time starts from 40% to 94%. Looking ahead to 2026, the department will focus on monitoring sterilization error rates, surgical site infections, and patient satisfaction, while anticipating increased gastroenterology volumes when Dr. Okolo begins operating in April. During discussion, Cornell clarified post-op pain management interventions and confirmed the hospital currently has ample operating room capacity to accommodate future growth.		
5. QUALITY INDICATOR PERFORMANCE & PLAN	<i>Louise Wyatt, RN JD</i>	INFORM
Wyatt provided an update on the mock survey (survey window is March 9–May 9), noting that preparation is 75% complete with ongoing policy reviews, patient tracers, and staff readiness drills. January 2026 data showed 15 risk events with no significant trends, alongside strong performance in quality metrics, including a risk-adjusted mortality rate of 0.42 and 100% compliance with sepsis bundles. The committee		

discussed the implementation of new metrics for age-friendly mobility and social determinants of health (SDOH) screening, as well as a refined reporting format for falls and stroke measures to better align with national benchmarks and hospital volume.		
7. POLICIES & PROCEDURES	<i>Louise Wyatt, RN JD</i>	INFORM
Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, presented new policy: <i>Prevention of CAUTI, Urinary Catheter Insertion, Maintenance & Removal</i> The committee reviewed and minor revisions were agreed upon to clarify clinical language.		
8. ADJOURN	<i>Daniel Kittleson, DDS</i>	Adjourned at 6:12 p.m.
CLOSED SESSION: Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	<i>Alex Rainow, MD</i>	ACTION
<i>Motion to approve by Eisenstark, 2nd by Snyder. Seven in favor, Mainardi opposed.</i>		

Document Tasks By Committee

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

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: 81

Committee: 09 BOD-Board of Directors

Committee Members: **Newman, Cindi (cnewman), Reese, Whitney (wreese), Wyatt, Louise (lwyatt)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
Administration of Anesthesia <i>Anesthesia Dept Policies</i>	Pending Approval	3/27/2026	0
Summary Of Changes: Corrected anesthetist to anesthesiologists under purpose section. Reviewed, no other changes.			
Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)			
Lead Authors: Cornell, Kelli (kcornell)			
Approvers: Okolo, Patrick (pokolo) -> 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)			
Administration of Medications <i>Medication Management Policies (MM)</i>	Pending Approval	3/27/2026	0
Summary Of Changes: Updated reference website and date accessed			
Moderators: Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)			
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)			
Advanced Directives <i>Patient Rights Policies (PR)</i>	Pending Approval	3/27/2026	0
Summary Of Changes: Reviewed, no changes			
Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)			
Lead Authors: Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)			
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)			
Aerosol Transmissible Disease Exposure Control <i>Infection Prevention & Control Policies (IC)</i>	Pending Approval	3/27/2026	0
Summary Of Changes: Added scope			

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

**Updated references: to current code of regulations title 8 section 5199 ATD:
website <https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/ATD-Guidance.pdf>
Updated header to reflect current date
Deleted PI/P&T committee approval and added Infection Control Committee instead
Reviewed and approved by ID Medical Director**

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
Lead Authors: Wilder, Ashley (awilder)
Approvers: 14-Infection Control Committee -> 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)

Aminoglycoside Protocol	Pending Approval	3/27/2026	0
<i>Medication Management Policies (MM)</i>			

Summary Of Changes: **Clarified language for timing of the aminoglycoside level: "timed from the start of the infusion of the initial dose."
Corrected some formatting issues.**

Moderators: Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
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)

Annual Performance Evaluations	Pending Approval	3/17/2026	10
<i>Human Resources Policies (HR)</i>			

Summary Of Changes: **Updated all references from "hospital" to "SVH" throughout.
Updated Policy language, adding evaluations must strictly be based on measurable performance standards and free from discrimination, prohibiting the use of the evaluation process as a means of retaliation against employees who engage in protected activities.
Updated definition of Annual (measured by employee's Job Effective Date)
Updated References.**

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
Lead Authors: McKissock, Lynn (lmckissock)
Approvers: 01 P&P Committee -> 09 BOD-Board of Directors - (Committee)

Assessment and Reassessment (CM)	Pending Approval	3/27/2026	0
<i>Discharge Planning (DP)</i>			

Summary Of Changes: **Updated to include scope and language for clarity**

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
Lead Authors: Moreno, Mario (mmoreno)
Approvers: Wyatt, Louise (lwyatt) -> 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)

Authorized Access to Medication Storage Areas	Pending Approval	3/27/2026	0
<i>Medication Management Policies (MM)</i>			

Summary Of Changes: **Removed yellow text highlight from section: "Radiology, Ultrasound, and Interventional Radiology Technologists (Includes retrieval of contrast and other non-controlled medications for the purpose of administration by practitioners licensed to do so)"**

No other changes

Moderators: Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
Lead Authors: Kutza, Chris (ckutza)
Approvers: 01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

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

Automatic Stop Orders	Pending Approval	3/27/2026	0
<i>Medication Management Policies (MM)</i>			
Summary Of Changes:	Updated date accessed for website reference.		
Moderators:	Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)		
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)		
Bio-Ethical Issues	Pending Approval	3/27/2026	0
<i>Patient Rights Policies (PR)</i>			
Summary Of Changes:	Dr. Okolo revised policy to include an update on its purpose, added definitions, removed reference to Bioethics committee since we do not have the bandwidth and updated the process to a structured Clinical Ethics Review, with the CMO acting as the Ethics Review Lead. Procedure outlined based on the new review process and reference updated to include CMS.		
Moderators:	Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)		
Lead Authors:	Okolo, Patrick (pokolo)		
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)		
Bipap ST-D Ventilatory Support System	Pending Approval	3/27/2026	0
<i>Respiratory Therapy Dept</i>			
Summary Of Changes:	Reviewed. Minor changes - replaced BI-PAP with NIV (non-invasive ventilation) as that also covers CPAP. Added section on patient use of own home CPAP. updated reference and reviewers list..		
Moderators:	Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)		
Lead Authors:	Winkler, Jessica (jwinkler), 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)		
Blood and Body Fluid Spills	Pending Approval	3/27/2026	0
<i>Infection Prevention & Control Policies (IC)</i>			
Summary Of Changes:	cn: Deleted PI/P&T committee approval and added Infection Control Committee instead. deleted section A3. Under the section labeled Procedure: deleted the bulk supplies location and edited for smaller spills w/Joseph's guidance. Added on Procedure 1a. prior to cleaning the spill...."proper instructions for steps for different clean up situations. Altered #4, 5, 6, 7 added language about safety with placing non-sharp debris into red-biohazard bags deleting "red lined bags" 9. added "To follow the directions on the disinfectant labels" 10.added "Secure red-biohazard bags while properly doffing used gloves." 12. Deleted "Clean up mop as needed" Updated all references and ordinances with current practice.		
Moderators:	Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)		
Lead Authors:	Wilder, Ashley (awilder)		
Approvers:	14-Infection Control Committee -> 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)		
California Mandatory Reporting for Infection Control.	Pending Approval	3/27/2026	0
<i>Infection Prevention & Control Policies (IC)</i>			
Summary Of Changes:	Updated purpose, added scope and updated procedure to include devices. Reviewed and approved by ID Medical Director.		

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Wilder, Ashley (awilder)**
 Approvers: **14-Infection Control Committee -> 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)**

Case Management Intervention <i>Discharge Planning (DP)</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **Added a scope and updated to reflect current practices.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Moreno, Mario (mmoreno)**
 Approvers: **Wyatt, Louise (lwyatt) -> 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)**

Change from Natural Gas to Propane <i>Engineering Dept</i>	Pending Approval	3/3/2026	24
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Summary Of Changes: **Reviewed and no changes needed.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Tarca, Joseph (jtarca)**
 Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Code of Conduct <i>Governance and Leadership Policies</i>	Pending Approval	3/19/2026	8
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Summary Of Changes: **Updated statement of purpose to be more concise and legally compliant.
 Removed definition of behaviors and incorporated into more concise statements of policy.
 Replaced use of "organization" and "hospital" with "SVH"
 Updated references to the correct, current policy titles.
 Other reorganization for a better informational flow.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **McKissock, Lynn (lmckissock)**
 Approvers: **01 P&P Committee -> 05 MS-Medical Executive - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Communicable Disease Reporting to Public Health <i>Infection Prevention & Control Policies (IC)</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **added scope, reporting procedure, staff training. Updated references and owner/approval of policy. Reviewed and approved by ID Medical Director.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Wilder, Ashley (awilder)**
 Approvers: **14-Infection Control Committee -> 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)**

Compounding Policies, Annual Review <i>Medication Management Policies (MM)\Compounding Policies</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **Updated verbiage regarding staff attestation of changes to include electronic attestation as allowable.
 Removed line stating that attestation statements need to be attached to the policy**

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

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

Condition Code 44 Inpatient to Observation Status <i>Case Management/UM Dept</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **added Scope**
updated owner of policy
added Manager of Patient Access to Reviewer
Updated Policy to reflect actual practice in EMR. No longer are notifications made to departments. The Order by the physician now drives the notification and automatically updates the Patient Class from Inpatient to Observation (or outpatient) status

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Moreno, Mario (mmoreno)**
 Approvers: **Wyatt, Louise (lwyatt) -> 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)**

Discharge Planning for the Homeless Patient <i>Discharge Planning (DP)</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **Updated language to more accurately reflect the definition of "homelessness" as described in CA state code.**
updated policy to more accurately reflect the process and procedures of notifying CM/SW and how to document appropriate interventions.
updated policy on how to notify CM/SW, through EMR ordering and SW cell phone.
updated policy on where to locate forms in the intranet portal.

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Moreno, Mario (mmoreno)**
 Approvers: **Wyatt, Louise (lwyatt) -> 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)**

Dispensing of Medication <i>Medication Management Policies (MM)</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **Added section as follows:**

- The pharmacy will use discharge and transfer notices to ensure that patient medications stored in patient drawers are transferred to the new hospital location, returned to the patient, or returned to pharmacy in a timely manner.**

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

Documentation in the Intensive Care Unit <i>ICU Dept</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **reviewed, no changes**
 Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)**

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

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)**

Equipment Cleaning Policy <i>Infection Prevention & Control Policies (IC)</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **Changes for update and proper formatting include, The purpose statement, scope, I added a section for definitions: each department needs to understand their responsibilities for cleanliness and the disinfection process.
Change to Policy statement: Explaining which department holds what role and responsibility.
Changes to approved cleaning agents and approved disinfectants.
Created a area for general cleaning steps and special procedure cleaning steps.
Finally changes and updates to reflect all current references and regulations.
Reviewed and approved by IC Medical Director 1.6.26**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**

Lead Authors: **Wilder, Ashley (awilder)**

Approvers: **14-Infection Control Committee -> 01 P&P Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Expedited Review of Continued Hospital Stay <i>Case Management/UM Dept</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **Added Scope to policy
updated owner of policy
updated reviewers**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**

Lead Authors: **Moreno, Mario (mmoreno)**

Approvers: **Wyatt, Louise (lwyatt) -> 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)**

Expired Media and Medications <i>Ancillary Services Dept Policies\Sonoma Valley Specialty Clinics 1206(b)</i>	Pending Approval	3/3/2026	24
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Summary Of Changes: **This is not a new policy, it is being added to the portal for the first time. Added Revisions/Clarity from Director of Pharmacy Chris Kutza including clarification of abbreviation, process change, removal of cartridges, updated expiration dates, new references added..**

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

Lead Authors: **Kuwahara, Dawn (dkuwahara), Rodney, Jennifer (jrodney)**

Approvers: **Alexandridis, Alexis (aalexandridis) -> Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 1206(b) Clinic Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Failure of Sewer services <i>Engineering Dept</i>	Pending Approval	3/19/2026	8
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Summary Of Changes: **Reviewed with no changes**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**

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

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

Falls-Management <i>Targeted Quality & Safety Initiatives Policies (QS)</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **Spelled out acronyms; clarified frequency of fall risk assessments; added INTERDISCIPLINARY prevention strategies, clarified the steps to take post-fall; added "Special Considerations: section on Older Adults and Behavioral Health. Updated**

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

References

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)
 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)

Formulary Management <i>Medication Management Policies (MM)</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: Updated reference internet link and date accessed
 Moderators: Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 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)

Good Catch Program <i>Governance and Leadership Policies</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: Reviewed. Updated Risk Manager to Director of Quality, Patient Safety and Risk Management.
 Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Wyatt, Louise (lwyatt)
 Approvers: Okolo, Patrick (pokolo) -> 01 P&P Committee - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)

HIPAA Privacy Risk Assessment and Reporting <i>HIPAA policies</i>	Pending Approval	3/17/2026	10
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Summary Of Changes: Primary change: term from "employee" to workforce to include contractors, medical staff, etc.
 Other minor grammatical changes
 Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Cracraft, Kevin (kcracraft), Pryszmant, Rosemary (rpryszmant)
 Approvers: Lum, Bryan (blum) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)

HIPAA Security – Security Incident Procedures Policy <i>HIPAA policies</i>	Pending Approval	3/19/2026	8
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Summary Of Changes: 2/19/26: Completed light editing. Replace HIPAA Security Officer with HIPAA Compliance Officer.

 Replaced the old 8610-164 with contents from the HIPAA Manual Template provided by BBKLaw legal counsel as part of the Office of Civil Rights Audit response.
 Former name: HIPAA Security Incident and Breach Response & Reporting
 Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Cracraft, Kevin (kcracraft), Pryszmant, Rosemary (rpryszmant)
 Approvers: Lum, Bryan (blum) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)

Hospital Evacuation During Disaster <i>Emergency Preparedness Policies (EP)</i>	Pending Approval	3/3/2026	24
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Summary Of Changes: Reviewed. Updated references to SNF - we will work with them but they also have their own protocols. Updated some

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

departmental locations as they have changed (such as pt finance is NOT on HWY 12 any longer, etc..) Minor grammatical changes. Added language to refer readers to other policies as appropriate

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Winkler, Jessica (jwinkler), Ehret, Marylou (mehret)
 Approvers: 01 P&P Committee -> 09 BOD-Board of Directors - (Committee)

Hot Lab Requirements	Pending Approval	3/27/2026	0
<i>Diagnostic Services Dept Policies</i>			

Summary Of Changes: **No changes**

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Ashford, Troy (tashford)
 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)

Infection Prevention and Control Training for Healthcare Workers	Pending Approval	3/27/2026	0
<i>Infection Prevention & Control Policies (IC)</i>			

Summary Of Changes: **Updated Purpose to include CDC/CAL/OSHA guidance and recommendations for Infection Control and Prevention training for Healthcare workers, Including Covid-19 guidance, Updated references to website:**
<https://www.jointcommission.org/resources/patient-safety-topics/infection-prevention-and-control/>
 California Code of Regulations, Cal/OSHA Title 8, Section 5193 Bloodborne
<https://www.osha.gov/coronavirus/control-prevention/healthcare-workers>
 Guidelines on website updated as recent as Sept. 2023.
 Header updated 12/25
 Policy reviewed and approved by ID Medical Director

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Wilder, Ashley (awilder)
 Approvers: 14-Infection Control Committee -> 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)

Infection Prevention Program	Pending Approval	3/27/2026	0
<i>Infection Prevention & Control Policies (IC)</i>			

Summary Of Changes: **Grammatical and punctuation changes to for clearer understanding, added to Authors/Reviewers: Added; Infectious Disease Physician. Reviewed and approved by ID physician Dr. Andrew Desruisseau.**

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Wilder, Ashley (awilder)
 Approvers: 14-Infection Control Committee -> 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)

Intensity of Service Severity of Illness Screening Process	Pending Approval	3/27/2026	0
<i>Case Management/UM Dept</i>			

Summary Of Changes: **Added Scope to Policy**
updated owner of policy
updated language

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Moreno, Mario (mmoreno)**
 Approvers: **Wyatt, Louise (lwyatt) -> 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)**

Investigational Drug Use	Pending Approval	3/27/2026	0
<i>Medication Management Policies (MM)</i>			

Summary Of Changes: **Updated date accessed for reference website.**
 Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 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)**

Job Descriptions	Pending Approval	3/17/2026	10
<i>Human Resources Policies (HR)</i>			

Summary Of Changes: **Updated Policy language for better clarity and accuracy, reference to legal requirements. Updated reference to "managers" to "Leaders" throughout. Revised language pertaining to Leaders responsibility in developing/maintaining job descriptions for clarity. Updated references.**
 Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **McKissock, Lynn (lmckissock)**
 Approvers: **01 P&P Committee -> 09 BOD-Board of Directors - (Committee)**

Lipid Rescue for Local Anesthetic Toxicity	Pending Approval	3/27/2026	0
<i>Medication Management Policies (MM)</i>			

Summary Of Changes: **Reviewed, no changes**
 Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 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)**

Malignant Hyperthermia	Pending Approval	3/27/2026	0
<i>Medication Management Policies (MM)</i>			

Summary Of Changes: **Pharmacy changes:
 Updated website for North American Malignant Hyperthermia Registry
 Updated MHAUS phone number
 Updated reference websites with date accessed
 Minor formatting corrections
 Expert review performed by Dr. Andrew Solomon (anesthesia) and Kelli Cornell (Surgical Services)**
 Moderators: **Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 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)**

Management of Medical Emergencies in Off-site Locations	Pending Approval	3/3/2026	24
<i>Patient Care Policy</i>			

Summary Of Changes: **reviewed. No changes other than spelling out acronyms. Updated author/approver from CAO to CNO, added ED leadership to approvals (MD and RN) (was reviewed by MD Cusick and RN Ehret)**

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)**
 Approvers: **01 P&P Committee -> 09 BOD-Board of Directors - (Committee)**

Management of Patients in Corridor Locations Pending Approval 3/27/2026 0
Emergency Services Policies (ED)

Summary Of Changes: **Added purpose statement, reiterated this is a process of last resort always; added ED leaders - RN and MD - as reviewers.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Winkler, Jessica (jwinkler), Ehret, Marylou (mehret)**
 Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Mechanical Ventilator Pending Approval 3/27/2026 0
Respiratory Therapy Dept

Summary Of Changes: **reviewed, Added section on "Indications for Mechanical Ventilation" Reorganized sections for reader flow. Updated some procedure steps to reflect new updated equipment requirements. Added documentation requirements; Updated reference and approvers (to include medical director of RT services)**

Reviewed and Approved MD Solomon, and RT

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Winkler, Jessica (jwinkler), 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)**

Medical Equipment Management Plan Pending Approval 3/19/2026 8
Care of the Physical Environment (CE)

Summary Of Changes: **Reviewed and took out Renovo and put in clinical engineering.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Tarca, Joseph (jtarca)**
 Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Menu Analysis Pending Approval 3/27/2026 0
Food & Nutrition Services Dept Policies

Summary Of Changes: **Policy reviewed by Director of Nutritional Services and Registered Dietician. No changes needed.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Finn, Bridget (bfinn)**
 Approvers: **Drummond, Kimberly (kdrummond) -> 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)**

MRI With Contrast - Containing Gadolinium Pending Approval 3/27/2026 0
Diagnostic Services Dept Policies

Summary Of Changes: **No changes**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Kutza, Chris (ckutza), Ashford, Troy (tashford)**
 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)**

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

<p>Multi-Dose and Single-Dose Vials</p> <p><i>Medication Management Policies (MM)</i></p> <p>Summary Of Changes: Updated reference website and date accessed Updated USP 797 Chapter version in references</p> <p>Moderators: Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)</p> <p>Lead Authors: Kutza, Chris (ckutza)</p> <p>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)</p>	Pending Approval	3/27/2026	0
<p>Multidisciplinary Teams Participation</p> <p><i>Case Management/UM Dept</i></p> <p>Summary Of Changes: added Scope of Policy</p> <p>Updated Owner of policy</p> <p>Updated reviewers of policy</p> <p>Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)</p> <p>Lead Authors: Moreno, Mario (mmoreno)</p> <p>Approvers: 01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)</p>	Pending Approval	3/27/2026	0
<p>Nourishment Between Meal Snacks</p> <p><i>Food & Nutrition Services Dept Policies</i></p> <p>Summary Of Changes: No changes needed</p> <p>Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)</p> <p>Lead Authors: Finn, Bridget (bfinn)</p> <p>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)</p>	Pending Approval	3/27/2026	0
<p>Nuclear Medicine Equipment Calibrations</p> <p><i>Diagnostic Services Dept Policies</i></p> <p>Summary Of Changes: No changes OTHER THAN DATE 2/26</p> <p>Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)</p> <p>Lead Authors: Ashford, Troy (tashford)</p> <p>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)</p>	Pending Approval	3/27/2026	0
<p>Nuclear Medicine Procedures</p> <p><i>Diagnostic Services Dept Policies</i></p> <p>Summary Of Changes: Radiopharmaceutical Inventory Review and Reconciliation</p> <p>All radiopharmaceuticals received, used, disposed, or returned are documented and tracked in accordance with hospital policy and regulatory requirements. Inventory records are reviewed on a monthly basis by designated personnel to ensure accuracy and completeness.</p> <p>Any discrepancies between inventory on hand and documented records of receipt, use, disposal, or return are immediately investigated and resolved. Significant discrepancies are reported to the Radiation Safety Officer (RSO) and addressed in accordance with established radiation safety procedures.</p>	Pending Approval	3/27/2026	0

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

Documentation of inventory review and reconciliation is maintained and available for audit.

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Ashford, Troy (tashford)**
 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)**

Nutritional Products	Pending Approval	3/27/2026	0
<i>Food (Nutrition) Services Policies (NU)</i>			

Summary Of Changes: **No changes needed**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Finn, Bridget (bfinn)**
 Approvers: **Drummond, Kimberly (kdrummond) -> 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)**

Observation Status	Pending Approval	3/27/2026	0
<i>Case Management/UM Dept</i>			

Summary Of Changes: **added Scope**

updated Owner of Policy

Added policy changes to reflect current practice in EMR currently.

Added language to reflect such changes.

Policy updated to reflect current practice and proper description of status in EMR.

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Moreno, Mario (mmoreno)**
 Approvers: **Wyatt, Louise (lwyatt) -> 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)**

Ordering and Prescribing	Pending Approval	3/27/2026	0
<i>Medication Management Policies (MM)</i>			

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

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

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)**

Outpatient Infusion Service	Pending Approval	3/27/2026	0
<i>Medication Management Policies (MM)</i>			

Summary Of Changes: **Defined abbreviation for Sonoma Valley Hospital as SVH.
 Added "as applicable" to line describing orders for management of acute infusion reaction.
 Minor formatting corrections.
 Added "home" to describe patient medication list.
 Deleted "using the EHR download" phrase from section on medication list
 Updated attachments to be currently used versions
 Rearranged bullet points to be in a more logical order
 Changed update to H&P to be every 12 months to coincide with requirement for a new order
 Removed workflow from body of policy and made it a separate attachment.**

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

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

Oxygen Protocol <i>Respiratory Therapy Dept</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **Spelled out acronyms; grammatical corrections; moved sections around for better reader flow; removed a duplicated section; removed references to paper documents and changed to Electronic Health Record (as in EPIC). Added reference with link to Clinical Practice Guidelines**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)**
 Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Patient Owned Electrical Equipment <i>Care of the Physical Environment (CE)</i>	Pending Approval	3/19/2026	8
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Summary Of Changes: **reviewed, no changes**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Tarca, Joseph (jtarca)**
 Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Patient Pregnancy Inquiry <i>Diagnostic Services Dept Policies</i>	Pending Approval	3/27/2026	0
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Summary Of Changes: **Added Policy Scope - This policy applies to all Medical Imaging Department personnel involved in X-ray and nuclear medicine procedures and to all female patients from the onset of menstruation through age 55 who may be exposed to ionizing radiation. It includes inpatient, outpatient, and emergency imaging services performed within the facility.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Ashford, Troy (tashford)**
 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 Refunds Overpayments <i>Governance and Leadership Policies</i>	Pending Approval	3/17/2026	10
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Summary Of Changes: **A number of "procedure" changes were made to accurately reflect current process.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Drummond, Kimberly (kdrummond), Armfield, Ben (barmfield), Wyatt, Louise (lwyatt)**
 Approvers: **Armfield, Ben (barmfield) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Patient Safety Evaluation System (PSES) <i>Quality Assessment & Performance Imp. Policies (QA)</i>	Pending Approval	3/17/2026	10
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Summary Of Changes: **Updated Department to Patient Safety, changed CHPSO to Press Ganey PSO and updated approvals.**

Moderators: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Lead Authors: **Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)**
 Approvers: **Okolo, Patrick (pokolo) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

Committee	Status	Effective Date	Count
Patient Status Determination <i>Utilization Review Policies (UR)</i>	Pending Approval	3/27/2026	0
Summary Of Changes: added Scope to Policy- outlines who is responsible for following this policy in practice. updated Observation, Outpatient, Outpatient Surgery, Extended Recovery definitions of status based on Epic EMR orders and CMS guidelines for these terms. updated Owner of Policy to Manager of Case Management from CMO Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt) Lead Authors: Moreno, Mario (mmoreno) Approvers: Wyatt, Louise (lwyatt) -> 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)			
Patient Transportation <i>Case Management/UM Dept</i>	Pending Approval	3/27/2026	0
Summary Of Changes: added Scope updated owner of policy updated Policy to reflect Nursing Supervisor role. updated language to more accurately reflect practice. Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt) Lead Authors: Moreno, Mario (mmoreno) Approvers: Wyatt, Louise (lwyatt) -> 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)			
Pest Management Program <i>Care of the Physical Environment (CE)</i>	Pending Approval	3/19/2026	8
Summary Of Changes: Reviewed with no changes Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt) Lead Authors: Tarca, Joseph (jtarca) Approvers: Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)			
Pharmaceutical Waste Management <i>Medication Management Policies (MM)</i>	Pending Approval	3/27/2026	0
Summary Of Changes: Updated reference web links and date accessed Removed embedded attachment and added as a separate document on policy portal Moderators: Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt) 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)			
Post-Mortem Procedures PC8610-160 <i>Patient Care Policy</i>	Pending Approval	3/27/2026	0
Summary Of Changes: Added language to support consideration of cultural aspect of death and dying, and the need to provide culturally sensitive care to the family and the deceased. Clarified Nursing is to complete SVH "Record of Death" form and who is to notify whom when a patient passes. Added special considerations - that staff may need support, that Social Work (when available) may need to be contacted to provide family support, etc.			

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)
 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)

Prevention of Surgical Site Infections	Pending Approval	3/27/2026	0
<i>Infection Prevention & Control Policies (IC)</i>			

Summary Of Changes: No changes made.

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Wilder, Ashley (awilder)
 Approvers: 14-Infection Control Committee -> 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)

Pulmonary Function Testing	Pending Approval	3/27/2026	0
<i>Respiratory Therapy Dept</i>			

Summary Of Changes: There will be no changes made to this policy.

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Ashford, Troy (tashford)
 Approvers: Kuwahara, Dawn (dkuwahara) -> 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)

Pyxis Medstation, Management and Use	Pending Approval	3/27/2026	0
<i>Medication Management Policies (MM)</i>			

Summary Of Changes: Updated the number of ED department Pyxis stations to be one (1)

Moderators: Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 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)

Required Certifications	Pending Approval	3/17/2026	10
<i>Human Resources Policies (HR)</i>			

Summary Of Changes: Changed "hospital" to "SVH" throughout.
 Updated how employees report education hours to receive pay for time in class of required certification.
 Updated/added References.

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: McKissock, Lynn (lmckissock)
 Approvers: 01 P&P Committee -> 09 BOD-Board of Directors - (Committee)

RETIRE Maggot (Larvae) Debridement Therapy	Pending Approval	3/27/2026	0
<i>Wound Care Dept</i>			

Summary Of Changes: Retire, no longer offer service.

Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)
 Lead Authors: Winkler, Jessica (jwinkler)
 Approvers: 01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

<p>Scope of Service-Respiratory Therapy <i>Respiratory Therapy Dept</i></p>	Pending Approval	3/27/2026	0
<p>Summary Of Changes: Reviewed. No changes other than updated reference.</p> <p>Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)</p> <p>Lead Authors: Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)</p> <p>Approvers: 01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)</p>			
<p>Scope of Services-Diagnostic Services <i>Diagnostic Services Dept Policies</i></p>	Pending Approval	3/27/2026	0
<p>Summary Of Changes: No Changes</p> <p>Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)</p> <p>Lead Authors: Ashford, Troy (tashford)</p> <p>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)</p>			
<p>Self Administration of Medications <i>Medication Management Policies (MM)</i></p>	Pending Approval	3/27/2026	0
<p>Summary Of Changes: Reviewed, no changes</p> <p>Moderators: Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)</p> <p>Lead Authors: Kutza, Chris (ckutza)</p> <p>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)</p>			
<p>Skilled Level of Care Criteria <i>Case Management/UM Dept</i></p>	Pending Approval	3/27/2026	0
<p>Summary Of Changes: Scope added to policy</p> <p>owner of policy updated.</p> <p>Reviewers updated</p> <p>language updated</p> <p>Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)</p> <p>Lead Authors: Moreno, Mario (mmoreno)</p> <p>Approvers: Wyatt, Louise (lwyatt) -> 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)</p>			
<p>Social Work Referrals <i>Discharge Planning (DP)</i></p>	Pending Approval	3/27/2026	0
<p>Summary Of Changes: added Scope. updated language to reflect proper usage. updated social services availability.</p> <p>Moderators: Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)</p> <p>Lead Authors: Moreno, Mario (mmoreno)</p> <p>Approvers: Wyatt, Louise (lwyatt) -> 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)</p>			
<p>Storage of Medications <i>Medication Management Policies (MM)</i></p>	Pending Approval	3/27/2026	0

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

Summary Of Changes:	Reviewed, no changes			
Moderators:	Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)			
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)			
Use of Medication Not Procured by the Facility	Pending Approval	3/27/2026	0	
<i>Medication Management Policies (MM)</i>				
Summary Of Changes:	Reviewed, no changes			
Moderators:	Kutza, Chris (ckutza), Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)			
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)			
Utilization Review Plan	Pending Approval	3/27/2026	0	
<i>Utilization Review Policies (UR)</i>				
Summary Of Changes:	Reviewed and revised: Removed redundant or outdated practices. Revised to reflect UM/UR practices based on hospital organizational flow, current committees and regulatory/accreditation rules and guidelines			
	mm.cn			
Moderators:	Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)			
Lead Authors:	Moreno, Mario (mmoreno)			
Approvers:	Wyatt, Louise (lwyatt) -> Okolo, Patrick (pokolo) -> 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)			
Vapotherm High Flow System	Pending Approval	3/27/2026	0	
<i>Respiratory Therapy Dept</i>				
Summary Of Changes:	Reviewed - no changes			
Moderators:	Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)			
Lead Authors:	Winkler, Jessica (jwinkler), 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)			
Vendor Phone List	Pending Approval	3/19/2026	8	
<i>Engineering Dept</i>				
Summary Of Changes:	Reviewed with no changes			
Moderators:	Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)			
Lead Authors:	Tarca, Joseph (jtarca)			
Approvers:	Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 09 BOD-Board of Directors - (Committee)			
Visitor Policy in the Intensive Care Unit	Pending Approval	3/27/2026	0	
<i>ICU Dept</i>				
Summary Of Changes:	Reviewed, no changes. Updated reference			
Moderators:	Newman, Cindi (cnewman), Wyatt, Louise (lwyatt)			
Lead Authors:	Winkler, Jessica (jwinkler), Taylor, Jane (jtaylor)			

Document Tasks by Committee

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)

Run date: 03/27/2026 2:01 PM

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

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)**

Today & Together



A nonprofit, 501(c)3, Adult Day Program for individuals with dementia and others who need some assistance.

Our Promise



Enriching the lives of adults with a dementia diagnosis or support needs, and those who care for them.

The Need

There are approximately **1,500 people** in the greater Sonoma Valley who have **some form of dementia**.

The main diagnoses of dementia are Alzheimers, Frontotemporal, Lewy body, Parkinsons, and Vascular. A recent classification is late dementia, which is associated with late onset and may accompany other diagnoses of dementia.

Depression often accompanies early to mid stage dementia.

Approximately **33%** of those **over 85 years** of age exhibit **some form of dementia**.

Common Symptoms of Dementia



Symptoms of dementia range widely based on the progression of the disease and the diagnosis.

Some **commonly associated symptoms include** memory loss and physical impairments that contribute to the **inability to perform activities of daily living**, including bathing, dressing and grooming, eating, toileting and incontinence, and mobility.

Wandering may occur, which can lead to becoming lost and not understanding when harmful situations are being created, such as leaving a stovetop on.

In more extreme cases, **combative behavior** may occur, often brought on by the need to redirect the person's behavior.

Today & Together

Primary Caregivers

Primary caregivers for individuals with dementia experience a **higher degree of stress** than those caring for individuals with diseases such as cancer or heart disease.

This statement excludes the emotional impact experienced by caregivers of any disease.

Dementia caregiver stress is higher because individuals with dementia experience **memory loss and behaviors that may cause harm** to themselves or others.

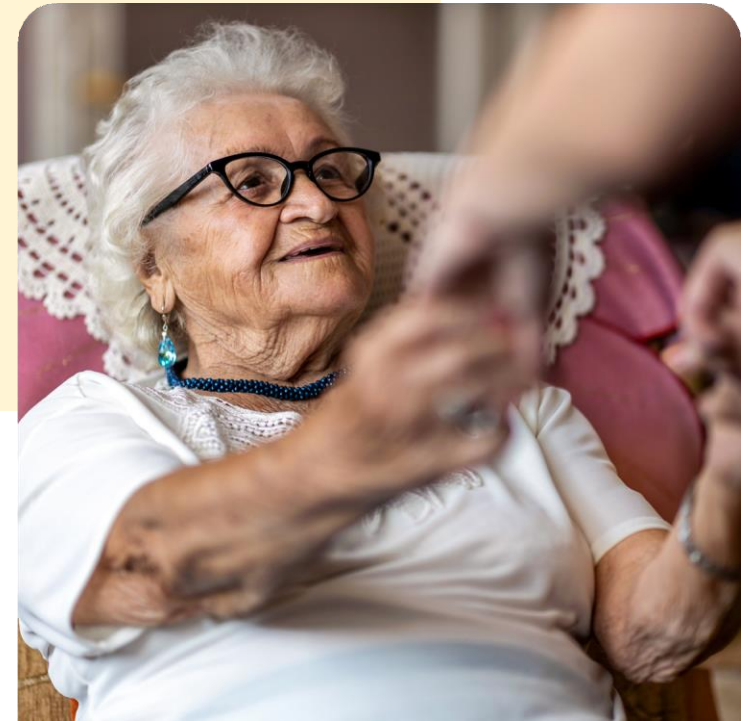
It is a 24 hours per day, 7 days per week responsibility.

Primary caregivers without sufficient support and respite often **suffer from the negative effects of constant stress.**



Options for Caregivers

- **Continue as the primary caregiver without support**, to the detriment of their health and resulting in a less than ideal situation for their loved one.
- **Paid home care** is another option. Personal care aides in Sonoma Valley from agencies typically cost over \$50 per hour and often require a three hour daily minimum.
- Another option is **placement in a memory care facility**, with costs approaching and often exceeding \$10,000 per month for higher quality facilities.
- **Adult day programs** offer a humane and cost effective alternative that enables caregivers to have respite from the demands of constant caregiving.



Today & Together

Solving the Need

Today and Together is an independent 501(c)(3) nonprofit located on the Hanna Center campus that offers adult day program services to individuals experiencing dementia or those needing additional assistance.

The program is open **Monday through Friday from 8:00 am to 6:00 pm**, except for major holidays.

We are licensed by the State of California Department of Social Services for 75 participants per day; however, the intent is to **average 50 participants per day** to ensure a high degree of personalized and intimate service.



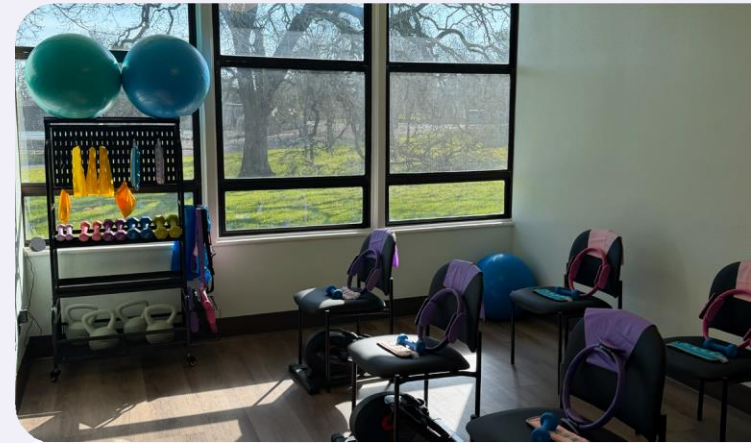
Today & Together | The Space & Experience

Today & Together operates from a **5,600-square-foot, freestanding building** with a **secure garden**, thoughtfully renovated specifically for our program.

The space includes **nine distinct activity rooms**, designed to support both **small, intimate groups of 6–8 participants** and larger shared gatherings.

These spaces include:

- welcoming dining room
- large multipurpose room
- dedicated rooms for art, music, sensory engagement, movement, reading, and therapy
- areas for volunteers and staff





Today & Together

Staff & Volunteer Structure

Most activities take place in small groups and are led by trained staff or volunteers, emphasizing **connection, engagement, and dignity.**



Programming Philosophy

Programming is intentionally designed to meet participants where they are. Throughout the day, multiple activities are offered concurrently, allowing individuals to engage based on their interests, abilities, and energy level.

Enrollment

Daily participation is **\$150 per day**, with a minimum enrollment of two days per week. **Scholarships are available** to ensure access, with fees adjusted as low as **\$25 per day for those with financial need.**



Today & Together

Sample Schedule

Monday

9:00 AM
Daily Chronicle

9:30 AM
Coffee & Conversation

10:30 AM
Chair Yoga

11:00 AM
Simile & Synonyms

1:30 PM
Music Appreciation

2:00 PM
Purim Traditions: Hamantaschen & Songs

3:00 PM
Watercolor Scenes

4:00 PM
Community Map Building

5:00 PM
Andrea Bocelli: Live

Mar
2

Today & Together | Leadership & Care Team

Program Leadership

Today & Together is led by a highly experienced team with deep expertise in dementia care and senior services. Our leadership brings decades of hands-on experience and a shared commitment to dignity, connection, and excellence in daily care.

Leadership & Care Team



Christina Gonzalez, Executive Director

Over 20 years of experience serving older adults, with a specialized focus on dementia care and program leadership.



Nathan Howland, Program Director

More than 10 years of experience supporting older adults living with dementia, with a focus on meaningful engagement and high-quality programming.



Mya O'Neal, Director of Engagement

5 years of experience in senior housing and memory care, leading participant engagement, programming, and community connection.



Victoria, Lead Personal Care Attendant

Over 20 years of experience assisting older adults with dementia. Bilingual and deeply committed to compassionate, person-centered care.



Today & Together | Volunteer Support

Volunteers are key to the program's success in several ways.

General purpose volunteers work with staff and participants throughout their shift to enrich and personalize interaction with participants. General purpose volunteers are requested to commit to one four-hour shift weekly.

Specialized volunteers will lead specific classes such as art, music, and current events, in addition to entertainment. Those leading classes are requested to commit to a four-hour shift bi-weekly, and those leading entertainment may volunteer as available.

Volunteers participate only in activities and tasks with which they feel comfortable. Personal care responsibilities, including toileting and behavioral redirection, are always handled by trained, paid staff.

Today & Together | Program Foundation

Let's Make the Most of Each Day, *Together*

The program design was developed by professionals and staff with over **100 years of combined experience** in the field of aging and memory care.



The **Advisory Committee** is comprised of community leaders.

Funding has been provided by the **Center for Age Related Dementia Services (CARDS)**, a 501(c)(3) nonprofit. Ongoing funding will continue through participant fees and CARDS. No governmental funds have been used, nor are any planned to be used.

Thank You!

Per the program budget, the program must enroll **25 market-rate participants per day** before enrolling participants receiving scholarships.

Over time, enrollment is expected to reach **50% full-pay participants and 50% scholarship participants.**

For more information, visit **todayandtogether.org**.



**Today &
Together**



2025 Sonoma Valley Hospital Annual Quality Report

Louise Wyatt, RN JD
Director of Quality, Risk, Patient Safety,
Infection Prevention, Case Management and Regulatory

2025 QAPI Program Overview and Governance

Governance and Oversight

The QAPI Program is overseen by the Board of Directors with operational accountability delegated to key committees and senior leaders.

Focus Areas and Outcomes


The quality program targets high-risk, systems and processes emphasizing outcome measurement, regulatory readiness, and sustained improvements.

Multidisciplinary Engagement

Nursing, medical staff, pharmacy, infection prevention, and quality leaders collaborate actively in performance review and improvement planning.

Safety and Transparency

The program fosters safety culture through event reporting, risk identification, and focus reviews.



Annual Patient Safety and Risk Management Report and Analysis

Patient Safety Organization (PSO) Update

CHPSO (California Hospital Patient Safety Organization) was disbanded as of December 19, 2025.

CHPSO purpose was to eliminate preventable patient harm by analyzing, disseminating, and archiving patient safety data.

SVH joined **Press Ganey** December 2, 2025 who will now manage our protected patient safety information.

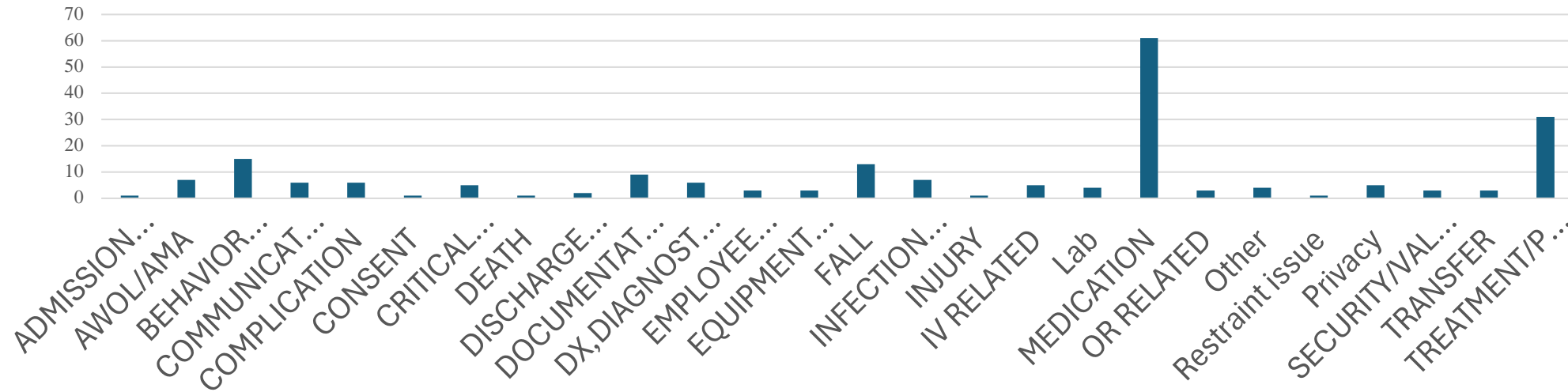
SVH Requirements include:

- Participation in monthly Safety Event Classification (SEC) Advisory Panel meetings and monthly cause analysis webinars.
- Participation in Safe Tables and High Reliability Learning webinars.
- Manage web application and users



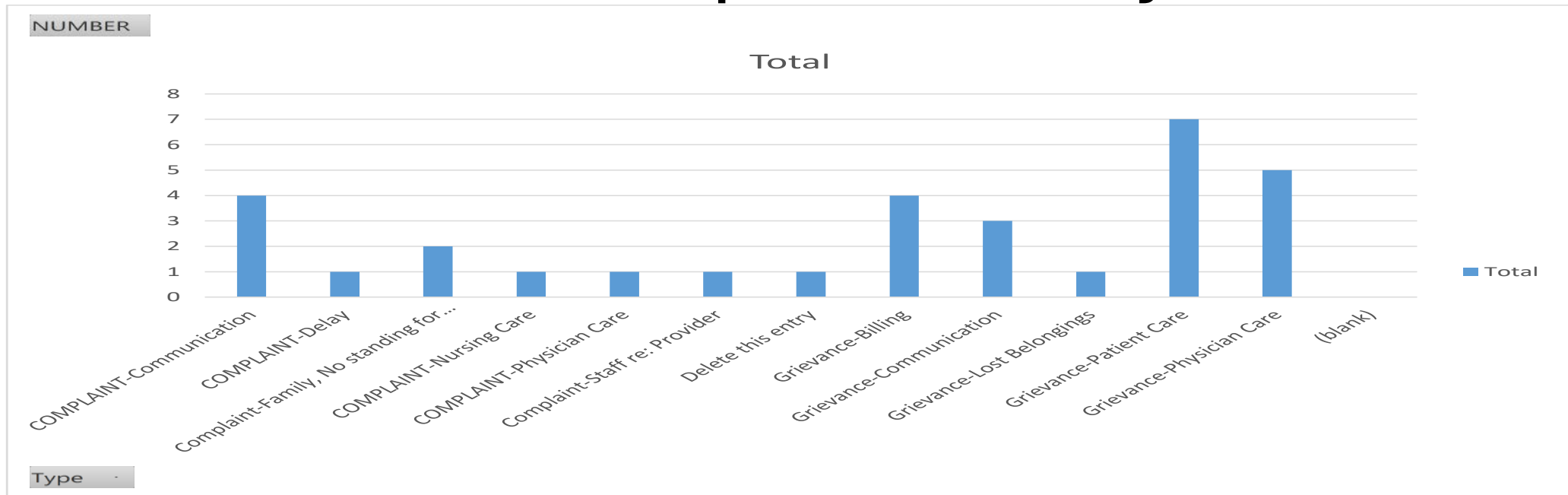
2025 Risk Management Report

Events



- 1. Medication-related events accounted for the largest volume of safety reports**, significantly higher than all other categories. This underscores the importance of existing medication-safety initiatives, including barcode scanning, pharmacy partnerships, and reconciliation workflows.
- 2. Treatment/Procedure-related events were the second-highest category**, suggesting workflow variation, documentation gaps, or delays that warrant deeper process mapping and targeted PDSA cycles.
- 3. Behavior-related and Fall events represented notable mid-frequency categories**, indicating staffing, patient monitoring, and behavior-response workflow opportunities—particularly for high-risk or complex-care patients.
- 4. Moderate clusters in Discharge, Infection-related, and IV-related events** point to opportunities in transitions of care, infection-prevention practices, and IV reliability, aligning with ongoing committee work and collaborative initiatives.
- 5. Most other event categories occurred infrequently**, showing no systemic red flags; however, continued surveillance is essential to detect early signals of risk and sustain a culture of safety and reporting.

2025 Complaints Analysis



1. **Physician Care–related grievances were the highest category**, representing the greatest share of formal grievances. This indicates a need for continued communication training, expectation-setting, and partnering with Medical Staff leadership to reinforce service standards.
2. **Communication complaints (both complaint-level and grievance-level) were the next most common trend**, highlighting opportunities in bedside communication, discharge instructions, handoffs, and expectation alignment.
3. **Patient Care–related grievances also reflected a mid-range frequency**, suggesting opportunities for improved responsiveness, care coordination, and clarity of care plans—consistent with themes commonly seen in small community hospitals.
4. **Billing and Lost Belongings grievances showed a moderate pattern**, indicating cross-department process variability. These categories often signal workflow inconsistencies, handoff gaps, or unclear policies.
5. **Low-frequency categories (Nursing Care, Delay, Provider-related, Staff-related) did not demonstrate systemic issues but will continue to be monitored to ensure they do not develop into emerging trends.**



2025 Quality Performance Measures



2023-24 Partnership's Hospital Quality Improvement Program Award



Sonoma Valley Hospital achieve a perfect 100% score out of 8 hospital.

Measures included:

- Readmissions
- Advance Care Planning
- Clinical Quality
- Patient Safety
- Operations and Efficiency

2025 Quality Improvement Initiatives

Updated the Medical Staff Peer Review Process to strengthen consistency, objectivity, and data-driven evaluation.

Implemented a Quality Scorecard to clearly identify trends, performance gaps, and opportunities for improvement.

Standardized organizational indicators and dashboards for Medical Staff Committees and the SVH Quality Board of Directors.

Implemented environmental departmental rounds in preparation of survey readiness.

Developed and implemented PDSA cycles focused on reducing readmissions for CHF and COPD patients.

Reinstated the Charity Medication Program to support medication access and adherence at discharge.

Established a Meds-to-Beds partnership with Adobe Pharmacy to improve medication management and reduce readmissions.

Implemented the Sepsis Committee and distributed sepsis “badge buddies” to clinical staff to improve early recognition and treatment.

Conducted quarterly collaboration meetings with community Skilled Nursing Facilities to strengthen care transitions and reduce readmissions.

Created and implemented a standardized reporting matrix to ensure consistent departmental reporting of quality indicators to the PI Committee.

Director of Quality & Risk attended national quality and risk-management conferences (HQIP Symposium, CHIQ, Beta Healthcare), bringing back best practices now being adopted.

Completed an annual department budget review identifying staffing/resource needs, resulting in an expansion of the Infection Preventionist position from 0.5 to 0.70 FTE approval of a part-time Quality Coordinator role.

Key Performance Highlights and Patient Safety Outcomes

Strong Clinical Outcomes

2025 showed excellent results in mortality, patient safety, stroke care, and sepsis management with benchmarks exceeded.

Infection Control Highlights

CLABSI and MRSA infections were eliminated, while other infections met national benchmarks indicating opportunities for improvement.

Utilization and Coordination

Effective care coordination led to better utilization metrics such as length of stay and reduced readmissions in 2025.

Improvement Opportunities

Documentation and timely policy review compliance require focus in 2026 to strengthen regulatory readiness and care quality.

Infection Prevention and HAI Performance

Effective Infection Surveillance

The QAPI program showed strong infection surveillance, reporting low infection rates compared to national benchmarks.

Infection Prevention Committee

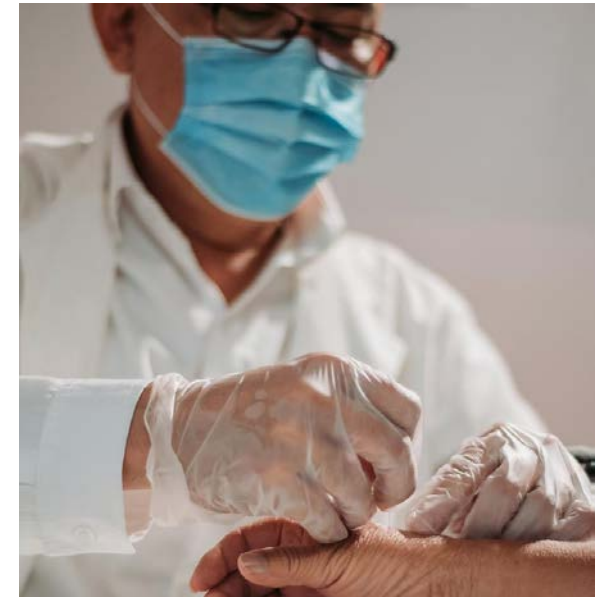
Quality established a multidisciplinary Infection Prevention committee in collaboration with Antimicrobial Stewardship Committee to review infection data and align practices with evidence-based guidelines.

Hand Hygiene Compliance

Hand hygiene compliance reached 93%, reinforcing essential infection control behaviors among staff.

Infection Outcomes

The hospital maintained zero cases of CLABSI and MRSA, demonstrating effective prevention. SVH reported one occurrence for C. difficile, CAUTI, and surgical site infection for 2025.



Sepsis Bundle Compliance and Outcomes

Sepsis Committee Governance

A formal Sepsis Committee was established to oversee case review, education, and performance monitoring.

High Compliance Rates

Sepsis care bundles showed strong compliance with SEP-1 at 84.6% and both three-hour and six-hour bundles at 98.2%, surpassing targets.

Effective Patient Outcomes

Low sepsis mortality and readmission rates reflect effective early recognition and timely intervention in care.

Ongoing Improvement Focus

Efforts on documentation accuracy, implementation of a sepsis checklist for both ED and inpatient units and provider education aim to improve full bundle compliance.



Laboratory and Blood Safety Indicators



Blood Culture Contamination Rates

Blood culture contamination remained below 3%, with laboratory rates as low as 0.7%, showing strong specimen collection and oversight.

Transfusion Effectiveness

Transfusion effectiveness was 94%, slightly below the 100% target, highlighting the need for improved documentation and adherence. *Recommendation – Update target to meet AABB transfusion guidelines of $\geq 90\%$. Also, reviewing PP for appropriateness of a blood transfusion based on clinical criteria.*

Transfusion Reaction Rate

Transfusion reaction rate was low at 0.40%, emphasizing importance of ongoing monitoring and rapid response protocols. *Recommendation – Update target to meet CDC NHSN hemovigilance and Oxford Academic national data to guidelines of $\leq 0.4\%$*

Laboratory Quality and Safety

Overall lab performance supports clinical decisions; focus on documentation and contamination monitoring will enhance patient safety.

Stroke Core Measure Performance



Exceptional Door-to-CT Time

Median door-to-CT time was 3 minutes, well below the 25-minute target, enabling rapid diagnosis.

Immediate Provider Evaluation

Patients received immediate evaluation upon arrival, ensuring timely clinical assessment and treatment.

Timely TNK Decision and Administration

Door-to-TNK decision and administration times of 29- and 48-minutes highlight rapid stroke treatment.

Sustained Stroke Care Excellence

Continued staff training and stroke protocol maintenance are essential for sustaining high performance.

Readmissions, Length of Stay, and Utilization Management

Length of Stay Performance

Risk-adjusted length of stay ratios were below targets, reflecting efficient and shorter hospital stays.

Readmission Rates

All-cause 30-day readmissions were significantly below target, indicating strong inpatient management and discharge planning.

Clinical Collaboration Impact

Strong interdisciplinary teamwork and patient education contributed to improved outcomes and reduced readmissions.

Targeted Improvement Efforts

PDSA focused on patient education, discharge planning, medication access, and follow-up to reduce CHF and COPD readmissions.

Care Transition Collaboration

Quarterly meetings with community skilled nursing facilities to enhance patient transitions, identifying improvement opportunities using case studies to support reduced readmission risk, better care continuity and quality of care.

Emergency Department and Outpatient Performance

Efficient Emergency Department Flow

Left Without Being Seen rate of 0.30% indicates timely patient evaluation and effective throughput in the ED.

Timely ED Arrival-to-Departure

Median ED arrival-to-departure time of 117.5 minutes reflects efficient care in a critical access environment.

Stroke Imaging Performance

88% of stroke imaging completed within 45 minutes, exceeding the 80% target for timely care.

Colonoscopy Follow-up Success

Colonoscopy follow-up for average-risk patients achieved 100%, surpassing the 88% benchmark, showing effective coordination



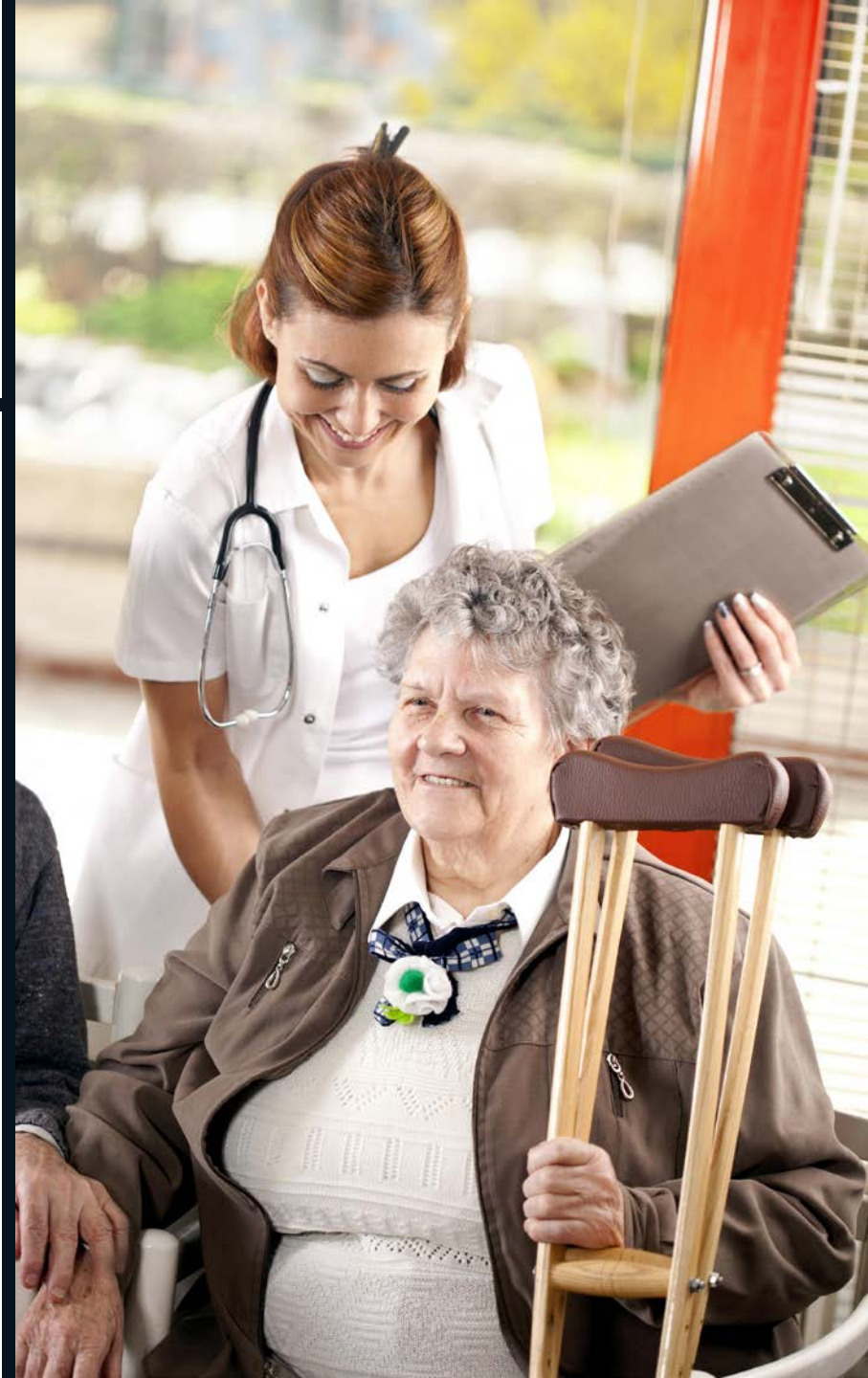
Strategic Performance Improvement Initiatives

Enhanced Care Coordination

Mandated CMS TEAMS Program implemented to improve communication and coordination with healthcare providers for better patient outcomes.

Age-Friendly Health System Progress

Overall, 4 M's are averaging 60%, with mobility at 100%. AFHS domain adherence will be reported on CMS Hospital Care Compare. Consistent application of the 4Ms framework with strong focus on improving identifying what matters most and medication management for this vulnerable population.



Health Equity Improvement Initiatives

HCAI Health Equity Report

California AB1204 an initial examination and report of our top healthcare disparities as identified by a prescribed data algorithm.

Established Health Equity Incubator

A small multidisciplinary workgroup led by our DEI Culture team leaders who completed facility self-assessments to establish a foundation to continue the work on continuous review and improvements.

Health Literacy Improvement Launch

The purpose of this initiative is to ensure patients and their companions can easily find, understand, and use health information and services to make informed decisions about their care



Patient Satisfaction

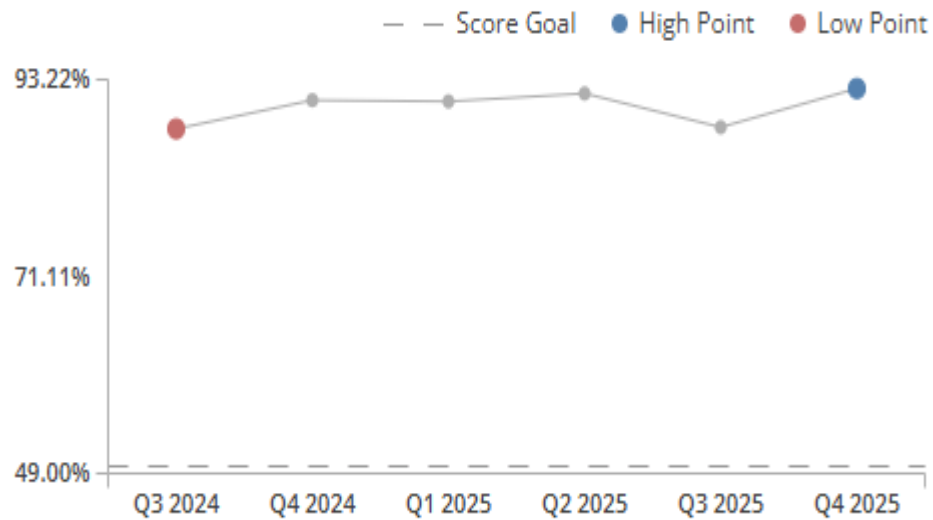
Press Gainey

Q Reviews

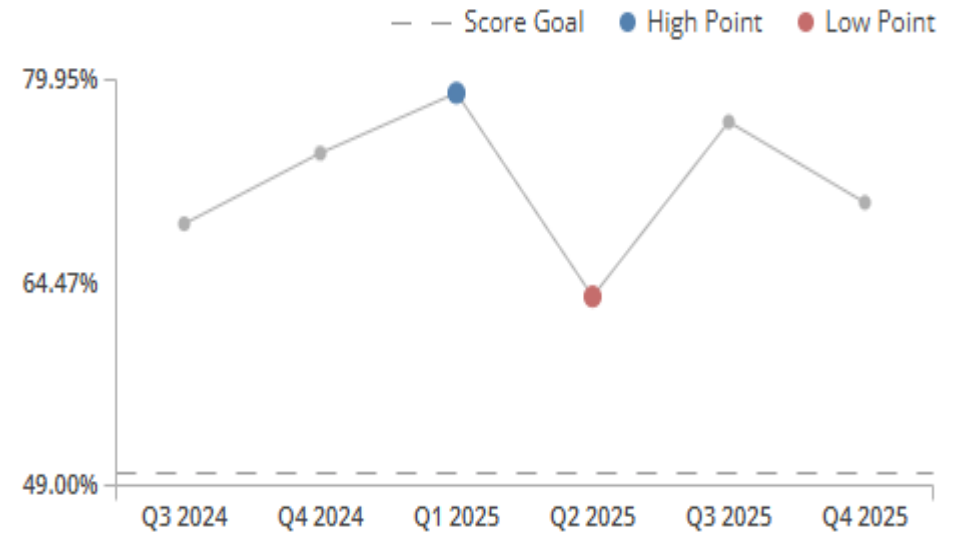


Press Ganey 2025

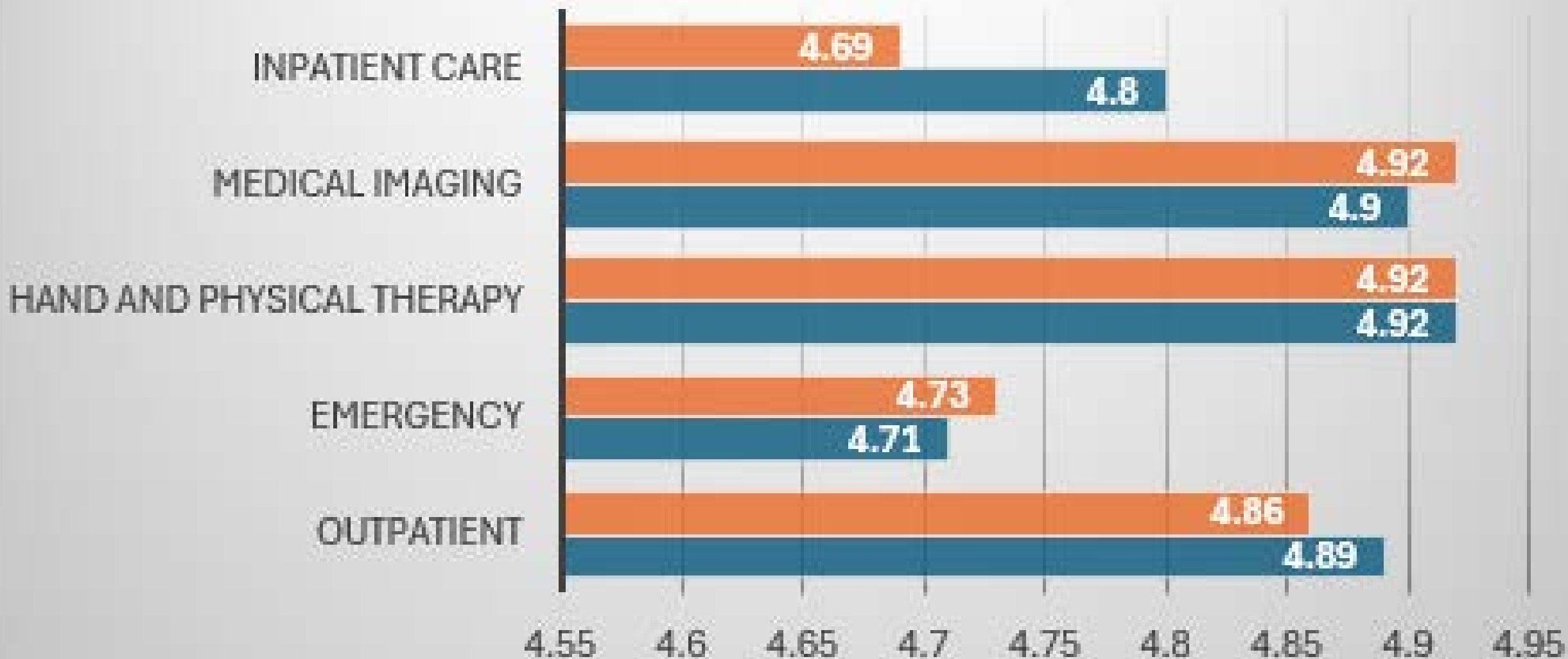
Ambulatory 90.6%



Inpatient 72.4%



Q Reviews





What' Ahead for 2026 Priorities

1. **Enhancing Social Drivers of Health and Health-Related Social Needs (SDOH HRSN) screening**
2. **Improving documentation in high-risk workflows**
3. **Sustaining infection prevention**
4. **Maintain reduced ALOS and readmissions**
5. **Policy and procedures current and ready for migration to new system**
6. **Adhere to documentation compliance for high-risk patients**
7. **Implement culture of safety program**
8. **Onboard new Infection Preventionist and Quality Coordinator.**
9. **Maintain survey readiness**
10. **Continue Health Equity initiatives**
11. **Maintain Quality of care with improved data analysis and collaboration with both hospital and medical staff**

Questions?

SONOMA VALLEY HOSPITAL

MEDICAL STAFF RULES & REGULATIONS

Revised in Accordance With:

CMS Conditions of Participation (42 CFR Part 482)

CIHQ Accreditation Standards

California Health & Safety Code

Effective Date: February 24, 2026

Approved By: Medical Executive Committee & District Board of Directors

SCOPE OF THESE RULES AND REGULATIONS

These Medical Staff Rules and Regulations govern the practice of all practitioners exercising clinical privileges at Sonoma Valley Hospital ("Hospital"). Practitioners should be aware of the following defined boundaries of institutional scope, which are reflected throughout this document:

⚠ OUT OF SCOPE NOTICE: Obstetric Services: Sonoma Valley Hospital does not provide obstetric care or labor and delivery services. Pregnant patients presenting with obstetric emergencies shall be stabilized and transferred to an appropriate facility in compliance with EMTALA. Consultation on obstetric matters, delivery of care to the obstetric patient as an inpatient or outpatient, and related surgical services (except as incidentally required in a life-threatening emergency prior to transfer) are outside the scope of Hospital services and these Rules.

⚠ OUT OF SCOPE NOTICE: Skilled Nursing Facility (SNF): Although a Skilled Nursing Facility operates on the Sonoma Valley Hospital campus, that facility is separately licensed, separately accredited, and independently governed. The SVH SNF is not subject to these Medical Staff Rules and Regulations. Practitioners who provide care at the SNF are governed by the SNF's own governing documents, policies, and applicable Title 22 and CMS SNF Conditions of Participation (42 CFR Part 483). Nothing in these Rules creates obligations or privileges with respect to SNF practice.

All other provisions of these Rules apply to Medical Staff members, practitioners holding temporary privileges, and, where applicable, Allied Health Professional staff holding clinical privileges at the Hospital's licensed acute care facility.

PREAMBLE

These Medical Staff Rules and Regulations ("Rules") are adopted pursuant to and in accordance with the Medical Staff Bylaws of Sonoma Valley Hospital and applicable federal and state law, including the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (42 CFR Part 482), CIHQ accreditation standards, the California Health & Safety Code, and related regulations.

Compliance with these Rules is required of all practitioners exercising clinical privileges at Sonoma Valley Hospital, including Medical Staff members, practitioners holding temporary privileges, and, where applicable, Allied Health Professional (AHP) staff members exercising clinical privileges or practicing pursuant to an approved job description or standardized procedure.

These Rules are intended to complement and be read in conjunction with the Medical Staff Bylaws. In the event of any conflict between these Rules and the Bylaws, the Bylaws shall govern. Where CMS Conditions of Participation or applicable law impose more stringent requirements than these Rules, those external requirements shall govern.

RULE 1 – PATIENT ADMISSIONS

Reference: 42 CFR §482.13 (Patient Rights); 42 CFR §482.41 (Physical Environment); EMTALA (42 CFR §489.24)

1.1 Scope of Admissions

The Hospital accepts patients for diagnostic, therapeutic, and procedural care consistent with its licensed bed capacity and available clinical capabilities. The following categories of patients shall not be admitted and shall instead be stabilized and transferred in accordance with EMTALA:

- Patients with serious burns requiring specialized burn center care;
- Patients with intracranial hemorrhage (ICH) or subarachnoid hemorrhage (SAH) requiring neurosurgical or neurocritical care capabilities beyond those available at this facility;
- Patients with ST-elevation myocardial infarction (STEMI) requiring emergent percutaneous coronary intervention (PCI) when cardiac catheterization capability is not available at this facility;
- Patients with major trauma requiring the capabilities of a designated trauma center, including polytrauma, penetrating trauma, or injuries with hemodynamic instability beyond the scope of this facility's resources;
- Patients whose primary presenting need is psychiatric or substance abuse treatment, unless the Hospital has licensed capacity and staffing to safely provide such care;
- Patients with virulent infectious diseases for which appropriate isolation cannot be reliably maintained in accordance with applicable infection control standards;
- Obstetric patients requiring labor, delivery, or inpatient antepartum or postpartum care. Sonoma Valley Hospital does not provide obstetric services. Pregnant patients presenting to the Emergency Department shall receive an appropriate medical screening examination and, if an emergency medical condition is identified, stabilizing treatment prior to transfer to a facility capable of providing obstetric care. No elective or scheduled obstetric admissions shall occur.

NOTE: Practitioners with obstetric or gynecologic privileges at other institutions may hold clinical privileges at this Hospital only for gynecologic (non-obstetric) services within the Hospital's defined scope. Obstetric privileges are not available and shall not be granted.

Patients whose medical condition exceeds the Hospital's capability to provide safe care shall be transferred to an appropriate higher-level facility in accordance with EMTALA and the Hospital's Transfer Policy.

1.2 Admission Authority and Procedure

1.2.1 A patient may be admitted only by a Medical Staff member who holds admitting privileges, or by a practitioner granted temporary privileges in accordance with the Medical Staff Bylaws.

1.2.2 When a patient is admitted by a dentist or podiatrist, a physician Medical Staff member must assume overall responsibility for the patient's medical care. That physician shall perform or supervise the history and physical examination, excluding those portions specific to dentistry or podiatry.

NOTE: Direct inpatient admission by a dentist is expected to be uncommon and limited to circumstances involving dental or oral-maxillofacial conditions requiring hospital-level care (e.g., deep space neck

infection, osteonecrosis, or serious post-procedural complications). Where the clinical presentation involves conditions within the scope of General Surgery, the Department of Surgery may serve as the primary admitting service. The Medical Executive Committee may issue supplemental guidance on dental and podiatric admission protocols as warranted.

1.2.3 To promote patient safety and accurate identification, each patient shall be assigned two independent patient identifiers at the time of admission: (a) the patient's full legal name; and (b) the patient's date of birth. These identifiers shall be used consistently throughout the patient's stay for all care, treatment, and service activities, in accordance with CIHQ patient safety standards.

1.3 Attending Physician Responsibilities

1.3.1 The attending physician is responsible for the overall direction and coordination of each patient's care, including:

- Completing and documenting a comprehensive medical history and physical examination (H&P) within twenty-four (24) hours of admission, and prior to any surgical or invasive procedure;
- Coordinating all consultations and specialist services;
- Ensuring timely and accurate completion of all medical record entries;
- Communicating the patient's status, care plan, and changes in condition to the patient, family (with patient consent), and the referring physician;
- Providing or arranging for continuous coverage of the patient's care.

1.3.2 When responsibility for a patient's care is transferred to another Medical Staff member, a written order documenting the transfer, the name of the receiving physician, and the date and time of transfer must be entered in the medical record.

1.3.3 If the admitting physician is not assuming the role of attending physician, this must be clearly documented in the admitting order. Another Medical Staff member must be identified as the attending physician prior to or at the time of admission.

1.3.4 Admission laboratory and imaging studies shall be ordered based on the individual patient's clinical needs, age, anticipated procedure, and relevant clinical factors. Routine admission testing without clinical indication is not required or encouraged.

1.3.5 All admitted patients shall be seen by the attending physician or a designated covering physician at least once per day. A dated and timed progress note shall be entered in the medical record for each encounter.

1.4 Provisional Diagnosis

Except in an emergency, no patient shall be admitted without a provisional diagnosis or a clinically valid reason for admission documented in the medical record. In emergencies, this documentation shall be recorded as soon as clinically practicable, and no later than twenty-four (24) hours following admission.

1.5 Standards of Care for All Treating Physicians

1.5.1 All physicians and practitioners providing patient care at the Hospital shall comply with CDC hand hygiene guidelines and the Hospital's Infection Control Manual.

1.5.2 Verbal and telephone orders, and telephonic reporting of critical test results, must be verified through a complete "read-back" process by the receiving clinician, who shall document the complete order or result and confirm it with the ordering provider.

1.6 Precautions for Psychiatric and Infectious Conditions

1.6.1 At the time of admission, the attending physician shall notify nursing and admitting staff whenever there is a clinical concern that a patient may pose a risk of harm to self or others, or has a known or suspected infectious or contagious disease. Recommended precautions shall be documented in the medical record.

1.6.2 All patients with known or suspected infectious disease shall be admitted and managed in accordance with the Hospital Infection Control Manual and applicable public health regulations.

1.6.3 When appropriate protective precautions cannot be maintained in the general acute care setting, the patient shall be transferred to a facility capable of providing appropriate isolation and management.

1.6.4 The attending physician shall seek psychiatric consultation for any patient exhibiting signs of incapacitating psychiatric illness.

1.7 Emergency Admissions

1.7.1 For patients admitted emergently, the attending physician shall be contacted promptly. Patients admitted through the Emergency Department (ED) shall be evaluated by their attending physician immediately prior to admission, or as soon as clinically practicable thereafter, and in no event later than twelve (12) hours following admission.

1.7.2 Emergency admissions must be supported by clinical documentation in the H&P that clearly justifies the emergent nature of the admission.

1.7.3 Patients presenting to the ED without an established attending physician shall be assigned a physician in accordance with the Department Call Policy or referred to the Hospitalist Service.

1.7.4 Physicians on limited suspension for medical record delinquencies who must admit a patient emergently shall comply with the Medical Staff Policy on Medical Record Delinquency and Suspension.

1.7.5 Obstetric Emergencies: In the event a pregnant patient presents to the Emergency Department in obstetric distress, the ED physician shall provide an appropriate medical screening examination and any stabilizing treatment required under EMTALA. The patient shall be transferred to the nearest facility offering obstetric services as expeditiously as clinically possible. No practitioner shall be required to hold obstetric privileges, and no obstetric call panel shall be established.

1.8 Intensive Care Unit (ICU) Admissions

1.8.1 Questions regarding ICU admission or discharge shall be resolved by the attending physician in consultation with the ~~ICU Medical Director and, when necessary, the~~ Chief of Staff or Chief Medical Officer.

1.8.2 All patients admitted to the ICU shall be seen and evaluated by the attending physician immediately or within four (4) hours of admission.

1.8.3 Disputes regarding appropriateness of ICU admission shall be resolved by the ~~ICU Medical Director~~Chief of Staff or Chief Medical Officer in conjunction with the nursing unit manager or supervisor.

1.9 Skilled Nursing Facility – Separate Governance

△ OUT OF SCOPE NOTICE: The Skilled Nursing Facility (SNF) located on the Sonoma Valley Hospital campus is a separately licensed facility operating under its own governing documents, policies, and applicable Title 22 and CMS SNF Conditions of Participation (42 CFR Part 483). Admissions to, discharges from, and clinical governance of the SNF are not subject to these Medical Staff Rules and Regulations. Practitioners who wish to provide care at the SNF must separately comply with the SNF's credentialing and privileging requirements. Questions regarding SNF governance should be directed to the SNF Administrator.

1.10 Admission Prioritization During Capacity Constraints

When the Chief Executive Officer, after consultation with the Chief of Staff, determines that bed capacity is insufficient, admissions shall be prioritized as follows:

First Priority – Emergency Admissions: Patients with life-threatening conditions requiring admission and treatment within four (4) hours.

Second Priority – Urgent Admissions: Patients with serious conditions who may suffer substantial harm without admission within twenty-four (24) hours.

Third Priority – Pre-Scheduled Surgical Admissions: Patients with previously scheduled procedures.

Fourth Priority – Elective Admissions: Patients admitted on a non-urgent, elective basis.

Transfer priorities: (1) ED to an appropriate inpatient bed; (2) ICU to step-down or general care; (3) Temporary placement to an appropriate care setting. All transfers shall follow the Hospital Transfer Policy.

RULE 2 – INFORMED CONSENT

Reference: 42 CFR §482.13(b); California Health & Safety Code §§72523–72528; CAHHS Consent Manual

2.1 Patient Rights and Participation in Care Decisions

Patients have the right to participate in decisions regarding their medical care, including the right to accept or refuse proposed treatments. Practitioners must provide patients or their surrogate decision-makers with sufficient information to enable meaningful, informed decision-making. Complex diagnostic and therapeutic procedures may be performed only after informed consent has been obtained and documented. Complex procedures include all operations and invasive procedures, blood transfusions, and other procedures designated as complex in the CAHHS Consent Manual. Routine blood draws and intravenous access for venous cannulation are not classified as complex procedures.

2.2 Definition of Informed Consent

Informed consent is a process—not merely a signature—through which the patient or surrogate receives sufficient information to reach a voluntary, meaningful decision. The process must include discussion of:

- The nature and purpose of the recommended treatment or procedure;
- Expected benefits and anticipated outcomes;
- Material risks, potential complications, and side effects;
- Reasonable alternatives, including their risks and benefits;
- Risks of declining or deferring the recommended treatment;
- Any physician financial or economic interests that may influence the treatment recommendation (see also Rule 2.10, Conflict of Interest Disclosures).

2.3 Who May Give Consent

Consent must be obtained from a patient with decision-making capacity. When a patient lacks capacity, consent must be obtained from an authorized surrogate in the priority order established by California law. The CAHHS Consent Manual provides specific guidance on consent authority.

2.4 Responsibility for Obtaining Informed Consent

The attending physician is primarily responsible for providing necessary information and documenting the consent process. A consulting or proceduralist physician is independently responsible for consent for specialized services they will perform. Nursing personnel may not obtain informed consent but may verify that consent has been documented and request the patient sign the general hospital consent form.

2.5 Verification of Informed Consent

Prior to any operation or complex procedure, hospital personnel shall verify that informed consent has been obtained, confirm this with the patient, and request the patient or surrogate sign the General Authorization for and Consent to Surgery or Special Therapeutic or Diagnostic Procedures form.

2.6 Emergency Exception to Consent

Consent is implied when a patient requires immediate treatment to prevent death, severe impairment, or to alleviate severe pain, and there is insufficient time to obtain informed consent. This exception applies only to the treatment immediately required. Informed consent must be obtained for all subsequent non-emergency treatment as soon as circumstances permit.

2.7 Special Consents Required by Law

Special consent forms and procedures required by California law include: blood transfusions; HIV testing; elective sterilization; hysterectomy; investigational drugs or devices; human research participation; reuse of hemodialysis equipment; breast and prostate cancer treatment; psychotropic medication administration; and involuntary psychiatric commitment. The attending physician is responsible for ensuring all special consent requirements are completed. The CAHHS Consent Manual provides applicable requirements.

NOTE: California law governing special consent for HIV testing has been significantly revised. Effective January 1, 2023, AB 1194 and prior amendments to California Health & Safety Code §120990 eliminated the requirement for a separate written consent form for HIV testing, permitting general consent to medical care to suffice in most clinical settings. Practitioners should consult the current CAHHS Consent Manual and applicable California law before applying any legacy HIV-specific consent process, as separate consent requirements may no longer apply in the acute care inpatient context. The Hospital Compliance Officer and CAHHS Consent Manual shall be treated as authoritative on this point.

2.7.1 Telehealth Consent: Prior to delivering health care via telehealth, the provider shall inform the patient about the telehealth modality and obtain verbal or written consent, which shall be documented in the medical record, in accordance with California Business and Professions Code §3517 and applicable CMS requirements.

2.8 Physician Documentation of Consent

The physician obtaining informed consent shall document the consent discussion in the patient's medical record. When the emergency exception applies, the physician shall document the nature of the emergency, why consent could not be obtained, and the likely consequences of delay.

2.9 Telephone Consent

When telephone consent is necessary, the physician shall provide the surrogate with all required information orally, with a hospital witness included in the call. The physician shall document the time, nature, and scope of consent. Written confirmation from the surrogate shall be requested and retained in the medical record.

2.10 Conflict of Interest Disclosures

★ **POLICY:** This section establishes a mandatory annual conflict-of-interest disclosure obligation for all Medical Staff members, consistent with CMS Conditions of Participation, CIHQ standards, and California law.

2.10.1 Purpose. Sonoma Valley Hospital is committed to ensuring that clinical decision-making is guided solely by the best interests of patients. Financial, economic, or personal relationships that could—or could reasonably appear to—influence a practitioner's clinical recommendations or resource utilization must be disclosed, managed, and where necessary, recused. This policy is also intended to support compliance with applicable federal and state fraud and abuse laws, including the federal Physician Self-Referral Law (Stark Law, 42 U.S.C. §1395nn) and the Anti-Kickback Statute (42 U.S.C. §1320a-7b(b)).

2.10.2 Annual Disclosure Requirement. All Medical Staff members and AHPs with clinical privileges shall complete and submit a Conflict of Interest Disclosure Form to the Medical Staff Office on an annual basis, no later than the date specified in the annual Medical Staff calendar. Completion of the annual disclosure is a condition of continued Medical Staff membership and privilege exercise. Failure to submit the annual disclosure by the specified deadline shall constitute grounds for administrative suspension of clinical privileges until the disclosure is received.

2.10.3 Scope of Required Disclosures. The annual disclosure shall include, without limitation:

- Any financial interest (ownership, investment, or compensation arrangement) in a healthcare entity, vendor, supplier, device or pharmaceutical manufacturer, or laboratory to which the practitioner refers patients or from which the practitioner receives remuneration;
- Any ownership or investment interest in a competing healthcare facility or ambulatory surgery center;
- Any consulting, speaking, or advisory arrangement with a pharmaceutical, device, or healthcare technology company that compensates the practitioner monetarily or in-kind;
- Any research funding, grants, or sponsored trials in which the practitioner is a named investigator or co-investigator;
- Any immediate family member relationship (spouse, domestic partner, or dependent child) with a person or entity in any of the foregoing categories;
- Any other relationship or circumstance that a reasonable person would consider likely to influence clinical recommendations or practice patterns.

2.10.4 Interim Disclosure Obligation. In addition to the annual disclosure, a practitioner who acquires a new financial interest or relationship meeting the disclosure threshold at any time during the year shall disclose it to the Medical Staff Office within thirty (30) days of the interest arising.

2.10.5 Disclosure at Point of Care. When recommending a specific treatment, procedure, device, medication, or referral in which the practitioner holds a disclosed financial interest, the practitioner shall inform the patient of that interest as part of the informed consent discussion. This disclosure shall be documented in the patient's medical record.

2.10.6 Review and Management. The Medical Executive Committee, or a subcommittee designated by it, shall review all disclosed conflicts of interest at least annually and shall determine whether:

- No further action is required;
- The conflict may be managed through disclosure alone;
- The practitioner must recuse from specified decisions, referrals, or committee votes involving the conflicting interest;
- The interest presents a conflict incompatible with continued unrestricted practice at the Hospital, requiring corrective action under the Medical Staff Bylaws.

2.10.7 Confidentiality. Conflict of interest disclosures shall be maintained as confidential peer review records to the extent permitted by California Evidence Code §1157 and applicable law. Disclosures shall be accessible only to the Medical Executive Committee, Chief of Staff, Chief Medical Officer, and the District Board as necessary for governance purposes.

2.10.8 Non-Retaliation. No practitioner shall be subject to adverse action solely for making a good-faith conflict of interest disclosure. Adverse action may be taken for failure to disclose a required conflict or for acting in a manner that places personal financial interest above patient welfare.

RULE 3 – REFUSAL OF TREATMENT

Reference: 42 CFR §482.13(b)(2); California Health & Safety Code §§7185–7195

Patients and authorized surrogate decision-makers have the right to refuse any treatment, including life-sustaining treatment. When a patient or surrogate refuses recommended treatment:

1. The attending physician shall be notified immediately and shall meet with the patient or surrogate to explain the clinical rationale and potential consequences of refusal. This discussion shall be documented in the medical record.
2. The patient or surrogate shall be presented with the Hospital's Refusal of Treatment form. If the patient or surrogate declines to sign, the notation "refuses to sign" shall be recorded with the signature of the nursing staff member present.
3. An Incident Report shall be completed and forwarded to the Hospital Risk Manager if treatment is ultimately refused.
4. When a minor's parent or guardian refuses necessary treatment, the attending physician shall consult with the Hospital's Risk Manager and legal counsel regarding whether court authorization is warranted.

RULE 4 – CONSULTATIONS

Reference: 42 CFR §482.22(c)(5); CIHQ Standards

4.1 General Principles

Appropriate and timely use of consultation is a fundamental component of high-quality medical practice. The attending physician retains overall responsibility for the patient's care. Any Medical Staff member with applicable clinical privileges may be called upon for consultation within their credentialed area of expertise. Consultation services must generally be provided within the Hospital unless specific capabilities are not available, in which case outside services must meet applicable accreditation standards.

4.2 Requesting Consultations

Consultation requests shall be made by direct communication from the attending physician to the consulting physician. Nursing or support staff shall not serve as intermediaries. The attending physician must document the request in the medical record.

4.3 Indications for Consultation

Consultation is strongly encouraged when:

- The diagnosis remains uncertain after standard evaluation;
- There is uncertainty regarding the therapeutic approach;
- The complexity of the case warrants specialty expertise;
- The patient exhibits significant psychiatric symptoms;
- The patient or surrogate requests consultation.

⚠ OUT OF SCOPE NOTICE: Obstetric Consultation: This Hospital does not maintain obstetric services and does not have an obstetric call panel. Requests for obstetric consultation for inpatients shall be addressed by arranging transfer to an appropriate facility. Practitioners shall not consult or provide obstetric care within the Hospital.

4.4 Required Consultations

- When the Department Chairperson, Chief Medical Officer, or Chief of Staff determines that a patient requires consultation, following discussion with the attending physician.
- When nursing staff safety or quality concerns are referred to the Department Chairperson or Chief Medical Officer.
- When the Medical Executive Committee requires consultations for a specific practitioner's cases.
- For all perioperative patients with an ASA Physical Status of 3 or higher, the surgeon must consider contacting a Hospitalist or Internist with admitting privileges.
- For all surgical patients admitted to the ICU, the surgeon must contact a Hospitalist or Internist with ICU admitting privileges.
- For all total joint replacement patients, the surgeon ~~must contact~~ should strongly consider contacting a Hospitalist or Internist with admitting privileges. Compliance with this recommendation shall be subject to periodic review by the Performance Improvement Committee.

4.5 Performance and Documentation of Consultations

A complete consultation requires: examination of the patient; review of the medical record; communication with the attending physician; and a written report in the medical record. Reports must include: history and record review; pertinent physical examination findings; diagnostic impression; and specific recommendations. A statement of "I concur" is not sufficient. Pre-operative consultations must be completed and documented before surgery, except in emergencies.

NOTE — Telehealth and Remote Consultations: These standards apply equally to consultations rendered via telehealth, telephone, or video. A consultant who reviews only the chart and gathers information solely from the attending physician, without conducting a direct clinical assessment of the patient (whether in-person or via real-time telehealth interaction with the patient), has not completed a consultation meeting the requirements of this Rule. Remote consultants must document a patient-directed clinical assessment. This applies to all specialist consultation services with telehealth arrangements, including but not limited to neurology and psychiatry. The CMO shall review consultation standards with contracted telehealth services and ensure alignment with this Rule.

RULE 5 – PHYSICIAN COVERAGE

Reference: 42 CFR §482.22(c)(7); CIHQ Standards

Each physician is responsible for providing or arranging continuous, uninterrupted care and coverage for all patients for whom the physician is the attending physician. Coverage must be provided by a physician with appropriate clinical privileges who is informed of the patient's condition and available to assume attending responsibilities.

If neither the attending physician nor their designee is available, the Department Chairperson, Chief of Staff, or Chief Medical Officer shall be notified and shall assume or delegate responsibility for the patient's care.

When a physician's patient presents to the Emergency Department, the physician or a designee shall be available for consultation and to admit the patient if clinically indicated. Referring such patients to the ED call panel without advance agreement of that physician is not acceptable.

Physicians on call shall respond to pages and on-site requests within thirty (30) minutes. Failure to arrange appropriate coverage or to respond promptly shall be grounds for corrective action.

RULE 6 – EMERGENCY DEPARTMENT CALL PANEL

Reference: 42 CFR §489.24 (EMTALA); 42 CFR §482.55 (Emergency Services); CIHQ Standards

6.1 Purpose and Structure

The ED Call Panel ensures that unassigned Emergency Department patients receive appropriate specialty consultation, inpatient admission, or outpatient follow-up. Hospital Administration, in collaboration with the Medical Staff and the ED Medical Director, is responsible for maintaining an adequate written ED call schedule covering all specialties within the Hospital's defined scope of services.

⚠ OUT OF SCOPE NOTICE: Obstetrics is not a Hospital service. No obstetric on-call obligation exists. Pregnant patients with obstetric emergencies shall be managed per EMTALA stabilization and transfer requirements.

Practitioners newly appointed to the Active Medical Staff may be assigned to the ED Call Panel upon recommendation of the Department Chairperson and with approval of the Medical Executive Committee, subject to the applicable FPPE requirements during their initial appointment period.

6.2 Call Panel Obligations

6.2.1 A panelist unable to provide scheduled call coverage must notify the Medical Staff Office at least twenty-four (24) hours in advance and arrange for coverage by an appropriately credentialed substitute.

6.2.2 All ED on-call physicians shall comply with all EMTALA requirements, including the obligation to provide a medical screening examination and stabilizing treatment to any patient presenting with an emergency medical condition, regardless of ability to pay.

RULE 7 – MEDICAL STAFF CATEGORIES

Reference: 42 CFR §482.22

The Medical Staff shall consist of the following five categories, with qualifications, rights, and obligations for each category set forth in the Medical Staff Bylaws, Article 3:

- Active Medical Staff – Physicians, surgeons, dentists, podiatrists, and other licensed independent practitioners who regularly admit or attend patients at the Hospital. Active Staff members bear primary responsibility for Medical Staff governance, committee participation, and on-call obligations.
- Courtesy Medical Staff – Licensed independent practitioners who admit or attend patients at the Hospital on an infrequent basis and do not require regular staff privileges. Courtesy Staff members may participate in committee work but do not hold voting rights except as provided in the Bylaws.
- Consulting Medical Staff – Licensed independent practitioners who are appointed to provide consultation services within their specialty when requested but who do not independently admit patients. Consulting Staff members do not hold voting rights and are not required to fulfill on-call obligations except as otherwise agreed.
- Advanced Practice Practitioner (APP) Staff – Licensed advanced practice clinicians, including but not limited to Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Registered Nurse Anesthetists (CRNAs), and Registered Nurse First Assistants (RNFAs), who are granted clinical privileges through the Medical Staff credentialing process. APP Staff members practice within the scope of their clinical privileges and applicable California and federal law, and are not voting members of the Medical Staff except as otherwise provided in the Bylaws.
- Emeritus Medical Staff (Optional) – A non-clinical honorary category available to physicians and other licensed practitioners who have retired from active clinical practice after distinguished service to the Medical Staff or the Hospital community. Emeritus Staff members do not hold clinical privileges, do not vote, and are not subject to dues or mandatory participation requirements. Appointment to Emeritus status is by recommendation of the Medical Executive Committee and approval of the District Board.

Each practitioner seeking or maintaining Medical Staff membership or clinical privileges must continuously satisfy the qualifications applicable to their category. The rights, obligations, and participation requirements for each category are set forth in the Medical Staff Bylaws, Article 3. Clinical privileges shall be granted only within the Hospital's defined scope of services. Obstetric privileges shall not be granted at this institution. APP Staff members who hold clinical privileges at this Hospital are governed by Rule 10 and the applicable provisions of these Rules.

RULE 8 – APPOINTMENT, REAPPOINTMENT, AND ONGOING PROFESSIONAL PRACTICE EVALUATION

Reference: 42 CFR §482.22(a) (Medical Staff Appointment); 42 CFR §482.22(c)(6) (Ongoing Professional Practice Evaluation); CIHQ Standards MS.07, MS.08

8.1 Overview

The process for appointment and reappointment is governed by Bylaws Article 4. Clinical privileges shall be reviewed and granted only for services within the Hospital's defined scope. Privileges for obstetric services are not available and shall not be granted. The Hospital maintains a continuous, data-driven professional practice evaluation program consisting of two complementary components: Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE), as described in Sections 8.10 and 8.11 below.

8.2 Application for Appointment

8.2.1 A completed application and non-refundable fee must be submitted to the Medical Staff Office. The application shall request comprehensive information including education, training, and specialty credentials; hospital affiliations; professional references; current health status attestation; professional liability history; and history of licensure challenges, disciplinary actions, or privilege relinquishment.

8.2.2 By submitting an application, the applicant authorizes release of relevant information from all prior institutions and releases those institutions and the Hospital from liability for acting on such information in good faith.

8.3 Physical and Mental Health Capabilities

The application shall include an attestation of physical and mental health and ability to safely exercise requested privileges. The Medical Executive Committee may require a medical examination or interview when there is concern that a condition may affect patient care. Disclosures of disability are treated as confidential peer review information. The Hospital will endeavor to provide reasonable accommodations to qualified practitioners with disabilities, consistent with applicable law and quality of care standards.

8.4 Effect of Application

By submitting an application, the applicant agrees to: appear for interviews; authorize credential verification; consent to inspection of relevant records; report changes in application information; release from liability all persons acting in good faith; authorize disclosure of performance information to regulatory bodies; comply with all Medical Staff and Hospital bylaws, rules, and policies; comply with CMS Core Measures and CIHQ quality standards; and fulfill the annual conflict-of-interest disclosure obligation under Rule 2.10.

8.5 Credential Verification

The Medical Staff Office or designated CVO shall verify all information through primary source verification, including: current unrestricted California license; DEA certificate; specialty board certification; National Practitioner Data Bank query; malpractice insurance; complete training and practice history; peer references; background check (initial applicants); and Federation of State Medical Boards records.

8.6 Incomplete Applications

Applications unresolvable within sixty (60) days may be suspended. Applicants will be notified and given thirty (30) days to respond. Failure to respond or provide required information within forty-five (45) days results in the application being deemed voluntarily withdrawn.

8.7 Action on the Application

8.7.1 Department Action: The Department Chairperson reviews the application and transmits a recommendation to the Medical Executive Committee.

8.7.2 Medical Executive Committee Action: The MEC reviews departmental recommendations and all available information and formulates a recommendation for the District Board. Adverse recommendations shall be communicated by special notice, with procedural rights as provided in Bylaws Article 13.

8.7.3 District Board Action: The District Board adopts, modifies, or rejects favorable MEC recommendations. Final adverse actions occur only after the applicant has exhausted or waived hearing and appeal rights under Bylaws Article 13.

8.7.4 Notice of Final Decision: Appointment decisions specify: staff category; department/section assignment; clinical privileges granted; and any conditions. Adverse decisions are communicated by special notice.

8.8 Duration of Appointment

Initial appointments shall be to the Active Medical Staff for a period not exceeding twelve (12) months, during which the practitioner shall be subject to Focused Professional Practice Evaluation (FPPE) as set forth in Section 8.10. Reappointments shall be for a maximum of twenty-four (24) months, staggered throughout the year.

8.9 Reappointment Process

8.9.1 Reappointment applications shall be provided at least one hundred twenty (120) days prior to appointment expiration and must be returned at least ninety (90) days prior. Failure to return a completed application by the expiration date results in automatic resignation from the Medical Staff.

8.9.2 Reappointment applications shall update all information from initial appointment, including licensure, certification, insurance, privilege change requests, and disclosure of professional liability claims or disciplinary actions since the last review.

8.9.3 Reappointment evaluation shall incorporate OPPE data accumulated during the appointment period (see Section 8.11) and shall include review of: clinical performance and quality data; continuing medical education; clinical activity; peer references; health status; Medical Staff obligation compliance; and all six competency domains: Patient Care, Medical/Clinical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice. Compliance with the annual conflict-of-interest disclosure requirement under Rule 2.10 shall also be confirmed as part of reappointment.

8.9.4 Reappointment recommendations shall be processed through the same Department, MEC, and District Board review sequence as initial appointments. There are no extensions of appointments; reappointment must occur at least every twenty-four (24) months.

8.10 Focused Professional Practice Evaluation (FPPE)

★ **CMS / CIHQ REQUIREMENT:** FPPE is required under 42 CFR §482.22(c)(6) and CIHQ Standard MS.08 for all new privileges and whenever a concern arises about a practitioner's practice. FPPE is a time-limited, structured monitoring process with a defined end point.

8.10.1 Applicability. FPPE shall be conducted in the following circumstances:

- Upon initial grant of clinical privileges to any new Medical Staff member or AHP (provisional period FPPE);
- Upon grant of new or expanded clinical privileges to an existing Medical Staff member, for those specific new or expanded privileges;
- When a concern is identified about a practitioner's professional practice through OPPE, quality review, peer review, patient complaint, occurrence report, or other mechanism that warrants a more intensive, structured review than routine OPPE.

8.10.2 Structure and Duration. FPPE shall be defined in a written plan that specifies:

- The specific privileges or practice patterns subject to focused review;
- The method and intensity of monitoring (e.g., prospective chart review, direct observation, case-by-case proctoring, retrospective review);
- The criteria by which performance will be evaluated;
- The duration of the focused evaluation period and the minimum number of cases or encounters to be reviewed;
- The individual(s) responsible for conducting the evaluation;
- The process for communicating findings to the practitioner and to the Medical Executive Committee.

8.10.3 Proctoring. When FPPE involves direct observation or proctoring, the proctor shall be a Medical Staff member in good standing with comparable clinical privileges. The proctor shall not be the practitioner's partner, associate, or someone with a financial relationship that could compromise objectivity. Proctor reports shall be submitted to the Department Chairperson and retained as peer review records.

8.10.4 Conclusion of FPPE. At the conclusion of the FPPE period, the Department Chairperson or designee shall review all evaluation data and make one of the following determinations:

- The practitioner has demonstrated competence and FPPE is complete; privileges are confirmed without further restriction;
- The FPPE period shall be extended for a specified additional period to gather additional data;
- Privileges shall be modified, suspended, or recommended for revocation, with notice and procedural rights under Bylaws Article 13.

8.10.5 Documentation. All FPPE plans, proctor reports, case reviews, and conclusions shall be documented and maintained as confidential peer review records.

8.11 Ongoing Professional Practice Evaluation (OPPE)

★ **CMS / CIHQ REQUIREMENT:** OPPE is required under 42 CFR §482.22(c)(6) and CIHQ Standard MS.07 for all practitioners with clinical privileges. OPPE is a continuous, periodic review process that informs reappointment and privilege decisions.

8.11.1 Purpose. The purpose of OPPE is to collect and analyze ongoing performance data for each practitioner holding clinical privileges, in order to identify practice trends, recognize excellence, detect concerns at an early stage, and inform privilege and reappointment decisions with objective, current data.

8.11.2 OPPE Data Elements. OPPE shall incorporate data from multiple sources appropriate to the practitioner's specialty and privilege set, including but not limited to:

- Operative and procedural volume and outcomes data;
- Mortality and morbidity rates (observed vs. expected where applicable);
- Compliance with evidence-based clinical guidelines and Hospital core measures;
- Blood utilization review findings;
- Medication ordering patterns and pharmacy-identified anomalies;
- Medical record completion timeliness and quality;
- Patient satisfaction data attributable to the practitioner;
- Results of peer review case findings;
- Infection control compliance metrics;
- Sentinel event involvement;
- Patient safety event reports and near-miss data;
- Ongoing ED call panel compliance and coverage performance;
- Professionalism and collegial conduct (complaints, disruptive behavior reports);
- Compliance with annual conflict-of-interest disclosure and other administrative obligations.

8.11.3 Review Frequency. OPPE data shall be compiled, reviewed, and summarized for each practitioner at least every six (6) months by the Department Chairperson or the Peer Review Committee. A summary OPPE report shall be provided to each practitioner at least annually and shall be incorporated into the reappointment package.

8.11.4 Practitioner Communication. Each practitioner shall be provided access to their own OPPE data summary on a periodic basis. The Department Chairperson or designee shall meet with a practitioner whose OPPE data reveals a pattern or trend of concern, prior to any formal action, to discuss findings and allow the practitioner to provide context.

8.11.5 Threshold for Action. When OPPE data reveals a pattern, trend, or individual event that raises a concern about patient safety or the quality of care, the Department Chairperson shall report the concern to the Medical Executive Committee, which shall determine whether:

- No further action is warranted;
- Focused education, coaching, or informal performance improvement is appropriate;
- Initiation of FPPE is warranted;
- Summary suspension or other immediate action is required to protect patients.

8.11.6 Documentation. All OPPE reports, summary data, practitioner communications, and resulting actions shall be maintained as confidential peer review records protected under California Evidence Code §1157 and applicable law.

RULE 9 – MEDICAL STAFF COMMITTEES

Reference: 42 CFR §482.22(c); CIHQ Standards

The Medical Staff hereby establishes the following standing committees. Composition, duties, and meeting requirements are set forth in the corresponding appendix below.

9.A Medicine Department Committee

Composition: Minimum of three Active Medical Staff members from the Medicine Department.

Duties: Assists the Department Chairperson in carrying out departmental responsibilities including recommending privilege criteria, reviewing applicants, conducting peer review, and fulfilling performance improvement functions including medical assessment, medication use, blood usage, procedural review, clinical pattern monitoring, patient/family education, care coordination, and medical records. The Department Committee also supports the OPPE process for Medicine practitioners by contributing specialty-specific data and review.

Meetings: Quarterly, at minimum.

9.B Surgery Department Committee

Composition and Duties: Mirrors the Medicine Department Committee, applicable to surgical services. Oversees surgical case appropriateness, tissue review, and operative procedure utilization. Supports the OPPE process for surgical practitioners. Obstetric surgical procedures are outside the scope of this Committee.

Meetings: Quarterly, at minimum.

9.C Anesthesia Department Committee

Composition and Duties: Mirrors the Department Committee structure, applicable to anesthesia services. Reviews pre-anesthetic assessments, anesthesia-related adverse events, medication practices, and related performance improvement activities. Supports the OPPE process for anesthesia practitioners.

Meetings: Quarterly, at minimum.

NOTE: Pending formal constitution of a standalone Anesthesia Department Committee, the Medical Executive Committee may, in its discretion, consolidate the functions of this Committee within the Surgery Department Committee, with designated anesthesia representation, until such time as a separately constituted Anesthesia Committee is operationally viable. Any such consolidation shall be documented by MEC resolution.

9.D Performance Improvement Committee (PIC)

Composition: Vice-Chief of Staff (Chair), Department Chairs or designees, Chief Medical Officer (ex-officio), Infection Control Coordinator, Utilization Review representative, Laboratory Director, Pharmacy

Director, Quality Assurance Director, Radiology Representative, Nursing Representative, Home Health Manager, Medical Records Manager, and Risk Manager.

Duties: The PIC provides organizational leadership for measuring, assessing, and improving the quality of care and patient safety. Core responsibilities include:

- Developing, reviewing annually, and revising a quality improvement plan aligned with CMS Conditions of Participation and CIHQ standards;
- Overseeing review of surgical and invasive procedures, mortality, medication use, blood product utilization, and clinical appropriateness;
- Coordinating department and committee quality review, utilization review, and medical record completeness activities;
- Submitting monthly quality reports to the Medical Executive Committee;
- Overseeing a patient safety program including quarterly review of safety events and monitoring of corrective actions;
- Developing and reviewing infection control surveillance programs and prevention policies;
- Overseeing pharmacy and therapeutics functions including formulary management, investigational drug oversight, and medication error review;
- Providing at least annual evaluation of the overall quality improvement program;
- Utilizing sentinel event and patient safety data in performance assessment activities;
- Supporting the OPPE program by providing aggregate and practitioner-specific quality and safety data to Department Chairs and the Peer Review Committee.

Subcommittees: Bioethics, Bylaws, Infection Control, Institutional Review, Interdisciplinary Practice, Utilization Review, and Patient Safety.

Meetings: Quarterly, at minimum.

9.E Bioethics Committee

Composition: At least three practitioners (including a psychiatrist when possible), one registered nurse, one chaplain or clergy representative, one medical social worker or comparable professional, one hospital administrator, one community member at large, and one ethicist (when available).

Duties: Supports ethical decision-making by providing consultation resources, educating the hospital community on bioethical issues, facilitating communication in ethical dilemmas, and conducting retrospective case reviews to inform policy and education. The Bioethics Committee does not serve as a decision-making authority in individual cases.

Meetings: Annually, or more often as needed.

NOTE: The Bioethics Committee infrastructure is under active development. Pending formal constitution of a Hospital-based Bioethics Committee with the composition described above, the Medical Executive Committee may, in its discretion, designate an external ethics consultation resource (such as the UCSF ethics consultation service or a comparable affiliated program) to fulfill the consultation and case review functions of this Committee on an interim basis. Any such interim arrangement shall be documented by MEC resolution and shall not extend beyond the next formal review cycle of these Rules. The CMO shall report on Bioethics Committee development status at each quarterly MEC meeting until the Committee is formally constituted.

9.F Bylaws Committee

Composition: At least five Active Medical Staff members; Chief Medical Officer serves as ex-officio member.

Duties: Conducts annual review of the Medical Staff Bylaws, Rules, and forms; evaluates proposals for revision; submits recommendations to the Medical Executive Committee; and ensures governing documents accurately reflect Medical Staff structure, credentialing processes, quality improvement mechanisms, OPPE/FPPE requirements, conflict-of-interest obligations, and hearing procedures.

Meetings: As called by the Committee Chair or Chief of Staff.

NOTE: The Bylaws Committee is in the process of being formally constituted. Until five qualifying Active Medical Staff members have been appointed and the Committee has been convened by MEC resolution, the annual review functions of this Committee shall be discharged directly by the Medical Executive Committee, with the CMO serving as the coordinating officer for rules and bylaws review. Formation of the Bylaws Committee shall be a standing agenda item for the MEC until completion.

9.G Institutional Review Board (IRB)

Composition: At least five members with diverse backgrounds, including at least one member with scientific expertise and one whose primary concerns are nonscientific. At least one community member not affiliated with the Hospital. No IRB may consist entirely of members of one gender or profession.

Duties: Exercises oversight of all human subjects research at or sponsored by the Hospital, in accordance with HHS regulations (45 CFR Part 46) and FDA regulations (21 CFR Parts 50 and 56), including initial and continuing protocol review, informed consent oversight, and reporting to federal agencies and Hospital officials.

Meetings: Annually, or more often as the research workload requires.

9.H Peer Review Committee

Composition: Medicine and Surgery Department Chairs and Vice-Chairs, Chief Medical Officer, and additional Medical Staff members as invited. The Committee elects its own Chair and Vice-Chair.

Duties: The Peer Review Committee provides an ongoing, structured mechanism to assess the quality of patient care and practitioner performance. Specific responsibilities include:

- Reviewing inpatient and outpatient clinical care for compliance with safe, correct, and appropriate standards of practice;
- Administering and overseeing the OPPE program: compiling practitioner-specific performance data at least every six (6) months; reviewing data for trends or concerns; communicating OPPE summaries to practitioners and Department Chairs; and submitting OPPE findings to the Medical Executive Committee as part of the reappointment process;
- Coordinating FPPE initiation and monitoring when triggered by new privilege grants or identified practice concerns, in collaboration with Department Chairs;

- Tracking and trending department-level and practitioner-specific quality metrics, recognizing best practices, and identifying opportunities for improvement;
- Providing practitioner education through the review of processes and outcomes;
- Identifying systems and processes requiring improvement to enhance physician practice and patient outcomes;
- Generating valid, objective quality data for use in credentialing and reappointment decisions.

Meetings: Monthly, or more often as necessary.

NOTE: The composition described above shall be reviewed by the Medical Executive Committee for alignment with the Hospital's current Peer Review Policy. Where the Peer Review Policy specifies a different or supplemental composition — including any broader representation adopted by the MEC subsequent to the drafting of these Rules — the Peer Review Policy shall govern as to composition, and this section shall be updated at the next review cycle to reflect the reconciled structure.

9.I Interdisciplinary Practice Committee (IPC)

Composition: Equal number of Medical Staff and nursing staff members, plus a nursing administration representative. AHP representatives serve as consultants and participate in proceedings relevant to their specialty.

Duties: Oversees: (1) development, review, and approval of standardized procedures for nurses and AHPs; (2) credentialing of AHPs, including reviewing applications, recommending privilege criteria, and overseeing peer review and OPPE data for AHPs; and (3) AHP staff education.

Meetings: Quarterly, at minimum.

9.J Well-Being Committee

Composition: At least three Active Medical Staff members; a majority including the Chair shall be physicians; one member should be a psychiatrist when possible. Members serve staggered three-year terms and, when feasible given Medical Staff size and resources, should not concurrently serve on peer review or Performance Improvement Committees.

Duties: Develops and maintains processes to educate Medical Staff about health and impairment recognition; provides confidential resources for practitioners with physical, psychiatric, or emotional impairments; facilitates referrals for evaluation and treatment; monitors affected practitioners for patient safety; and refers to the Chief of Staff when a practitioner's health status poses a risk to patients.

Meetings: Annually, at minimum; reports quarterly to the Medical Executive Committee.

RULE 10 – ALLIED HEALTH PROFESSIONALS (AHPs)

Reference: 42 CFR §482.12(c); 42 CFR §482.22; California Business and Professions Code

10.1 Overview

Allied Health Professionals (AHPs) may be granted clinical privileges to practice at Sonoma Valley Hospital through a credentialing process overseen by the Interdisciplinary Practice Committee. AHPs shall not practice until clinical privileges have been granted and a department assignment has been made. Clinical privileges for AHPs shall not extend beyond the Hospital's defined scope of services. AHPs are subject to both OPPE and, when applicable, FPPE as described in Rule 8.

⚠ OUT OF SCOPE NOTICE: AHP privileges for obstetric services (e.g., certified nurse-midwife privileges for labor and delivery, obstetric anesthesia exclusively for labor) shall not be granted, as obstetric inpatient services are outside the Hospital's scope. Nurse practitioners, CRNAs, and other AHPs may be privileged for their applicable non-obstetric scope of practice.

This Rule applies to all AHPs practicing independently or as employees or contractors of a Medical Staff member, and to hospital-employed physician assistants and advanced practice nurses (CRNAs, RNFAs, NPs).

10.2 Categories of AHPs Eligible for Privileges

The following AHP categories are currently eligible to apply for clinical privileges within the Hospital's defined scope of services:

- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Registered Nurse First Assistants (RNFAs)
- Certified Registered Nurse Anesthetists (CRNAs)

The District Board, upon recommendation of the Medical Executive Committee, may authorize additional AHP categories.

10.3 Application and Credentialing Process

AHP applications are submitted and processed in a manner parallel to Medical Staff appointment applications under Rule 8, with the IPC serving the role of the Department Committee. The IPC evaluates the applicant, confirms appropriate monitoring mechanisms are in place, and forwards recommendations to the applicable clinical department and then to the Medical Executive Committee and District Board.

10.4 Credentialing Criteria

All AHP applicants must meet the following basic requirements:

- Current, unrestricted licensure or certification as required by California law;
- Documented education, training, experience, and demonstrated clinical ability sufficient to provide care of the expected quality;
- Professional liability insurance: at least \$1,000,000 per occurrence and \$3,000,000 aggregate;
- Minimum of two professional references from licensed physicians or credentialed professionals familiar with the applicant's clinical work;
- Active clinical practice of at least twenty (20) hours per week for eighteen (18) of the prior twenty-four (24) months; and, for those in independent practice, at least one year of post-training clinical experience;
- Demonstrated adherence to professional ethics and ability to work cooperatively within the hospital setting.

Specific requirements by AHP category: Nurse Practitioners – Appendix 10A; Physician Assistants – Appendix 10B; Registered Nurse First Assistants – Appendix 10C; Certified Registered Nurse Anesthetists – Appendix 10D.

10.5 Supervising Practitioner Responsibilities

Supervising practitioners employing or contracting with AHPs acknowledge: (a) the AHP is the supervising practitioner's employee or agent, not the Hospital's; (b) the supervising practitioner bears sole responsibility for compensation and legal compliance; and (c) the supervising practitioner agrees to indemnify the Hospital against any expense or liability arising from the AHP's practice at the Hospital.

10.6 Provisional Status and Duration of Privileges

All AHPs shall initially be appointed to provisional status for at least twelve (12) months, during which FPPE shall apply. AHP privileges shall be granted for no more than twenty-four (24) months. Reappointment shall be processed every two years and shall incorporate OPPE data.

10.7 Observation and Evaluation

Each clinical department shall maintain observation and evaluation programs appropriate to each AHP category, including concurrent or retrospective chart review or direct observation, consistent with FPPE and OPPE requirements. AHPs performing surgery or anesthesia shall be observed in the operating room per applicable proctorship guidelines. Evaluators shall be qualified Medical Staff members or, where appropriate, credentialed AHPs who are not the AHP's supervising practitioner.

10.8 AHP Practice Standards

AHPs shall: exercise independent judgment within credentialed privileges and applicable standardized procedures; participate in patient management as authorized; write orders consistent with privileges and applicable policies; maintain patient records as determined by the relevant department; ensure appropriate countersignature of chart entries (excluding routine progress notes) within fourteen (14) days; and comply with all Medical Staff and Hospital bylaws, rules, and policies, including the annual conflict-of-interest disclosure requirement under Rule 2.10. AHPs are not members of the Medical Staff and are not entitled to vote on Medical Staff or department matters.

10.9 Standardized Procedures

Standardized procedures authorizing RNs to perform functions beyond the basic RN scope of practice must be developed collaboratively, reviewed by the relevant department, and approved by the IPC, Medical Executive Committee, and District Board. Each standardized procedure shall specify: authorized functions and circumstances; required training or experience; methods for evaluating competence; supervision requirements; patient recordkeeping requirements; and a schedule for periodic review. Standardized procedures shall not authorize obstetric care services.

Appendix 10A – Nurse Practitioners

NPs shall hold a current California RN license and current NP certification from the California Board of Registered Nursing. NPs may perform functions within the customary scope of nursing practice and may furnish or order drugs or devices (including Schedule III-V controlled substances) in accordance with California Business and Professions Code §2836.1, applicable standardized procedures, and supervising physician requirements. NP privileges at this Hospital are limited to non-obstetric services within the Hospital's defined scope.

Appendix 10B – Physician Assistants

PAs shall hold a current California PA license from the Medical Board of California. Orthopedic PAs shall hold current NBCOPA certification. PAs practice under the direction of a supervising physician who is a current Medical Staff member in good standing. No supervising physician may maintain supervisory relationships with more than two PAs simultaneously (except emergency physicians on duty, who may not oversee more than two simultaneously). PAs may perform services within their supervising physician's non-obstetric practice scope. Supervisory documentation must include countersignature within twenty-four (24) hours (or eight (8) hours for emergencies requiring transfer) and review of at least ten percent (10%) of protocol-governed cases.

Appendix 10C – Registered Nurse First Assistants

RNFAs shall hold current California RN licensure and RNFA certification from the National Certification Board: Perioperative Nursing (or be a graduate of an accredited RNFA program in the process of obtaining certification). RNFAs may perform preoperative, intraoperative, and postoperative services under direct physician supervision. RNFAs shall not concurrently serve as scrub nurse or circulating nurse, and shall not assist in obstetric surgical procedures.

Appendix 10D – Certified Registered Nurse Anesthetists

CRNAs are licensed independent practitioners who collaborate with the operating surgeon to deliver safe anesthesia care for procedures within the Hospital's defined scope. CRNAs shall maintain: current California RN license and advanced practice NA certificate; current CRNA recertification by the NBCRNA; current NRP, ACLS, and BLS certifications; and a Bachelor of Science in Nursing or equivalent degree. CRNAs must have graduated from a COA-accredited nurse anesthesia program and document anesthesia case experience for the prior twelve (12) months. Obstetric anesthesia (including labor epidurals) is outside the scope of services at this Hospital.

CRNAs may perform: pre-anesthesia evaluation and preparation; administration of general, conduction, MAC, and regional anesthesia for non-obstetric procedures; perioperative monitoring and airway management; and post-anesthesia care including PACU discharge and postoperative pain management. All CRNAs shall undergo proctoring (FPPE) upon initial appointment. Reappointment by the District Board is required every two years and shall incorporate OPPE data.

RULE 11 – MEDICAL RECORDS

Reference: 42 CFR §482.24 (Medical Record Services); CIHQ Standards; California Health & Safety Code §32400 et seq.; HIPAA (45 CFR Parts 160, 162, 164)

11.1 Purpose and Scope

The medical record documents patient care, supports continuity of care, enables quality management and utilization review, fulfills legal and regulatory requirements, and supports billing and reimbursement. Medical records must be maintained for all patients receiving care at Sonoma Valley Hospital, including inpatients, outpatients, emergency patients, and patients receiving special procedures. All medical records are property of the Hospital.

11.2 Standards for Documentation

All entries in the medical record must be: legible (illegible entries shall be treated as absent documentation); accurate and complete; dated and timed at the time of entry; authenticated by the author; and made as contemporaneously as practicable following a clinical event.

11.3 Timely Completion Requirements

11.3.1 All medical record entries must be authenticated within fourteen (14) days following patient discharge. Records incomplete for any required element or authentication at fourteen (14) days are classified as delinquent.

11.3.2 The Health Information Management Department shall notify physicians of incomplete records and issue notices per the Medical Staff Delinquency and Suspension Policy.

11.3.3 Records incomplete beyond fourteen (14) days will trigger suspension of admitting privileges and/or monetary fines pursuant to the Delinquency and Suspension Policy.

11.3.4 When a physician accumulates more than thirty (30) days of suspension in any consecutive twelve (12) month period, the Director of Health Information Services shall notify the Chief Executive Officer and Medical Executive Committee for further action.

11.3.5 Medical records shall not be permanently filed until completed by the responsible physician, unless ordered by the Information and Healthcare Resources Committee Chairperson in specified circumstances.

11.4 Electronic Signature and Electronic Medical Records

The Medical Staff permits electronic signature in accordance with the approved Health Information Management Policy. EMR components for which appropriate training and technical support are provided must be utilized by all Medical Staff members.

11.5 Prohibited Abbreviations

No symbols or abbreviations may be used on the face sheet. The following abbreviations are specifically prohibited:

Do Not Use	Use Instead
U (unit)	Write "unit"
IU (International Unit)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Write "daily"
Q.O.D., QOD, q.o.d, qod	Write "every other day"
Trailing zero (X.0 mg)	Write X mg
Lack of leading zero (.X mg)	Write 0.X mg
MS, MSO4	Write "morphine sulfate"
MgSO4	Write "magnesium sulfate"

11.6 Medical Record Corrections

Corrections shall be made by drawing a single line through the incorrect entry (leaving the original legible), noting the reason for the correction, the date, and the author's signature. No entry shall be erased, obliterated, or removed.

11.7 Required Content – Inpatient Medical Records

Each inpatient medical record shall include at minimum:

- Identification data (face sheet);
- Admitting note with chief complaint, presenting symptoms, pertinent findings, provisional diagnosis, and plan;
- History and Physical Examination completed within twenty-four (24) hours of admission and prior to any surgery or invasive procedure. An H&P completed within thirty (30) days prior to elective surgery, validated by a Medical Staff member, may be used with a required admission interval note;
- Consultation reports ("cleared for surgery" notes are not acceptable);
- Physician orders, dated, timed, and signed;
- Progress notes, at least daily and more frequently as warranted;
- Pre-anesthetic assessment including ASA classification, airway assessment, anesthetic plan, and consent – to be completed within seventy-two (72) hours prior to the procedure;
- Operative reports: a postoperative note immediately after surgery, and a complete dictated operative report within seventy-two (72) hours of surgery. Failure to complete the operative report within seventy-two (72) hours will result in immediate suspension of clinical privileges;

- Post-anesthesia evaluation: to be completed and documented within seventy-two (72) hours following surgery or a procedure requiring anesthesia services;
- Nursing and ancillary documentation;
- Consent forms and informed consent documentation;
- Written discharge instructions provided to patient/family;
- Discharge summary dictated within fourteen (14) days of discharge. A clinical resume note may substitute for admissions under forty-eight (48) hours for minor ailments.

11.8 Access and Removal of Medical Records

All medical records are property of the Hospital and shall not be removed from Hospital premises except as required by court order, subpoena, or statute. Access and disclosure shall comply with HIPAA, applicable California law, and Hospital privacy policies. Former Medical Staff members retain access to records of their patients from periods when they provided care at the Hospital.

RULE 12 – SURGERY AND INVASIVE PROCEDURES

Reference: 42 CFR §482.51 (Surgical Services); 42 CFR §482.52 (Anesthesia Services); CIHQ Standards

△ OUT OF SCOPE NOTICE: Obstetric surgical procedures, including Cesarean section and obstetric-specific interventions, are outside the scope of services at this Hospital and shall not be performed. Gynecologic surgical procedures (non-obstetric) are within scope and subject to all provisions of this Rule.

12.1 All surgical and invasive procedures require the patient's informed consent, except in emergencies defined as conditions in which delay would endanger the patient's life or health. Consent shall be obtained and documented in accordance with Rule 2.

12.2 All tissue and specimens removed during operative procedures become property of the Hospital and shall be retained in the laboratory for a sufficient period for the pathologist to prepare a permanent pathological record.

12.3 A history and physical examination must be present in the medical record prior to commencing any procedure requiring anesthesia, including moderate sedation. If a dictated H&P is not yet available, a handwritten H&P must be recorded in the progress notes. Operating room staff must verify the H&P is in the record before the patient enters the operating suite.

12.4 A pre-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia within seventy-two (72) hours prior to surgery or any procedure requiring anesthesia services.

12.5 Minimum preoperative laboratory and imaging requirements shall be determined by the operating physician and anesthesiologist based on the patient's clinical status and the procedure to be performed.

12.6 Surgeons must be present in the operating room and prepared to begin at the scheduled time. Operating room time shall not be held beyond fifteen (15) minutes.

12.7 All medication containers on and off the sterile field must be labeled with: drug name, strength, amount, expiration date (when not used within 24 hours), and expiration time (when expiration is within

24 hours).

12.8 Immediately prior to commencing any procedure, the operative team shall conduct a mandatory pre-procedure “time out” to verify: patient identity (two identifiers); the planned procedure and its inclusion in the consent; the operative site; and required special equipment or studies. This process must be documented.

12.9 Immediately prior to administering moderate or deep sedation or anesthesia, the patient shall be re-evaluated to confirm continued appropriateness and identify any changes in clinical status.

12.10 All prior medication orders are automatically canceled when a patient undergoes an operative procedure. New orders must be written following surgery.

12.11 A post-anesthesia evaluation shall be completed and documented by a qualified anesthesia provider within seventy-two (72) hours after surgery or a procedure requiring anesthesia services. When a post-anesthetic evaluation is not feasible due to early discharge, the discharging physician shall assume and document this responsibility.

12.12 Patients may be discharged from the recovery area to an inpatient bed following evaluation by a licensed independent practitioner or using pre-established discharge criteria. Hospital discharge from a surgical area requires evaluation by a licensed independent practitioner or a registered nurse using an approved standardized procedure.

12.13 A complete dictated operative report shall be prepared within seventy-two (72) hours of each surgical procedure and shall contain at minimum: pre- and post-operative diagnosis; surgeon and assistant surgeon; technical procedure performed; surgical findings; complications; estimated blood loss; condition of the patient postoperatively; anesthetic type; and name of anesthesia provider. Failure to complete the operative report within seventy-two (72) hours will result in immediate suspension of privileges.

12.14 Procedures that may require an assistant surgeon include major orthognathic, head and neck, general intra-abdominal, vascular and thoracic, major gynecologic abdominal and vaginal procedures, specified laparoscopic procedures, major joint revisions, major spine procedures, and all intra-abdominal urological procedures (with specified exceptions). The determination of whether an assistant is clinically required rests with the operating surgeon. The medical necessity for the use of an assistant surgeon must be clinically justified and clearly documented in the operative report in accordance with applicable payer and Medicare requirements.

RULE 13 – PATIENT DEATHS

Reference: 42 CFR §482.13(g); California Government Code §27491; California Health & Safety Code §102850

13.1 Pronouncement of Death

When a patient arrives at the Hospital deceased or dies during hospitalization, a physician shall pronounce death within a reasonable time and document an authenticated entry in the medical record. Nursing staff may pronounce death pursuant to an approved standardized procedure.

13.2 Autopsies

Medical Staff members are encouraged to recommend autopsies in all cases of unusual death or those of medical, legal, or educational significance, including cases meeting College of American Pathologists criteria:

- Deaths in which autopsy may explain unknown or unanticipated medical complications;
- Deaths in which the cause is clinically uncertain;
- Pediatric and neonatal deaths occurring within the Hospital (note: obstetric/perinatal deaths at delivery do not occur at this facility as obstetric services are not provided);
- Deaths from known or suspected illness with hereditary or transplantation significance;
- Deaths from environmental or occupational hazards, or high-risk / contagious infections;
- Sudden, unexpected, or unexplained deaths within the facility;
- Deaths occurring during or following medical, surgical, or therapeutic procedures;
- Deaths waived by forensic medical jurisdiction.

Autopsies require written consent in accordance with California law. Provisional anatomic diagnoses shall be entered in the medical record within seventy-two (72) hours of autopsy completion; final reports within sixty (60) days.

13.3 Coroner Notification

Physicians shall notify the Medical Examiner-Coroner immediately upon awareness of a patient death meeting any criteria under California Government Code §27491 and Health & Safety Code §102850, including: unknown or doubtful cause; violent, sudden, or unusual death; death within 24 hours of admission; death without medical attendance; suspected homicide or criminal action; accidental death, poisoning, or injury; death while in custody; suspected SIDS; or death from contagious disease constituting a public hazard. The Coroner's report shall be placed in the patient's permanent medical record.

13.4 Notification of Next of Kin

The attending physician, or a designated representative, is responsible for promptly notifying the patient's next of kin in all cases of in-hospital death.

13.5 Organ and Tissue Donation

Patient remains shall be managed in accordance with the patient's expressed wishes, advance directive, or next-of-kin instructions per the CAHHS Consent Manual priority order. Consent for organ or tissue donation shall comply with applicable state and federal law. The attending physician shall follow Hospital protocols for identifying potential donors and OPO notification as required.

13.6 Death Certificates

The attending physician or the physician last attending the patient is responsible for completing and signing the death certificate within the time required by law.

RULE 14 – PATIENT DISCHARGE

Reference: 42 CFR §482.13(e); CIHQ Standards

14.1 General Discharge Requirements

Patients shall be discharged only upon written order of the attending physician or a qualified designee. Prior to discharge, the attending physician shall ensure the medical record is complete with a final diagnosis and appropriate entries. Written discharge instructions shall be provided to the patient and, as appropriate, family members or caregivers, covering: activity and restrictions; post-discharge medications; diet; and follow-up instructions. A copy shall be retained in the medical record.

Minors shall be discharged only to their parents, legal guardians, or persons designated in writing by the parent or legal guardian, unless the minor is legally authorized to consent to and assume responsibility for their own care. The CAHHS Health Facility Minor Release Report must be completed whenever a minor is discharged to any person other than a parent, blood relative, or legal guardian.

The attending physician should notify Nursing Services of anticipated discharges as early as possible and shall engage the Discharge Planning Coordinator when complex post-acute care needs are identified.

14.2 Leaving Against Medical Advice (AMA)

When a patient indicates a desire to leave without a discharge order, nursing staff shall attempt to arrange a meeting between the patient and the attending physician. The attending physician shall, when possible, counsel the patient on clinical risks. A patient who insists on leaving shall be asked to sign the “Leaving Against Medical Advice” form; refusal to sign shall be documented in the medical record. An Incident Report shall be submitted to the Hospital Risk Manager.

14.3 Refusal to Leave

When a patient refuses to leave after a discharge order has been issued, Hospital Administration shall be contacted to assist in resolving the situation in a manner that protects the rights and safety of the patient and others.

RULE 15 – WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT

Reference: 42 CFR §482.13(b)(2); California Health & Safety Code §§7185–7195; California Probate Code §4600 et seq.

Decisions to withhold or withdraw life-sustaining treatment, including CPR, shall be made by patients with decision-making capacity, or by authorized surrogate decision-makers, in consultation with the attending physician. These decisions must reflect the patient's values, goals of care, and clinical circumstances.

Do-Not-Resuscitate (DNR) / No-CPR Orders: A No-CPR order is appropriate when CPR would not reasonably be expected to restore function or result in survival with an acceptable quality of life, consistent with the patient's or surrogate's informed preferences. CPR will be initiated upon cardiac or respiratory arrest unless a written No-CPR order is present. All No-CPR orders must be written and signed on the physician order sheet. Partial No-CPR orders must specify precisely which resuscitative modalities shall and shall not be used. All No-CPR orders shall be reviewed whenever there is a significant change in the patient's clinical condition. The Bioethics Committee is available as a resource when ethical conflicts arise.

POLST and Advance Health Care Directives: Physician Orders for Life-Sustaining Treatment (POLST) forms are legally recognized physician orders in California and shall be honored in accordance with their terms when presented by or on behalf of a patient. A valid POLST form may substitute for a No-CPR order where its terms are consistent with the orders recorded in the EMR. Upon admission, nursing staff shall inquire about and document the existence of any POLST form or Advance Health Care Directive (AHCD). Existing POLST orders shall be transcribed into the EMR by the admitting or attending physician as soon as practicable. In cases of conflict between a POLST form and an in-hospital physician order, the most recently executed document consistent with the patient's known current wishes shall govern, and the attending physician shall be notified immediately. Practitioners are encouraged to engage patients and surrogates in goals-of-care conversations upon admission and to complete or update POLST documentation where clinically appropriate. The CMO shall ensure that a standardized POLST and advance directive review process is integrated into hospital admission workflows.

RULE 16 – MEDICATION, TREATMENT, AND DIAGNOSTIC ORDERS

Reference: 42 CFR §482.25 (Pharmaceutical Services); 42 CFR §482.23(c); CIHQ Standards

16.1 General Order Requirements

All medication, treatment, and diagnostic testing orders must be written in the patient’s medical record and signed, dated, and timed by a licensed practitioner authorized to prescribe within their scope of practice and clinical privileges. Orders must include: drug name; dosage; route (if other than oral); frequency; date, time, and prescriber signature. PRN orders must specify the indication. All medications administered shall be from the Hospital formulary or otherwise authorized by the appropriate Medical Staff Committee.

16.2 Medication Review and Automatic Stop Orders

Attending physicians shall regularly review all active medication orders. Automatic stop policies are:

Drug Category	Automatic Stop Period
Antibiotics	7 days
Narcotics / Opioid analgesics	7 days
All other medications	32 days

The pharmacist shall notify the ordering physician approximately two days prior to the automatic stop. Automatic stops do not apply when the prescriber specifies a defined number of doses or precise duration. Automatic stop orders may be renewed upon documented clinical reassessment and re-order by the authorized prescriber prior to expiration. All medication orders are automatically cancelled when a patient undergoes surgery or experiences a change in level of care.

Clinical Exception — Extended Antibiotic and Medication Courses: The seven-day automatic stop period for antibiotics represents a default safety mechanism and is not intended to override clinical judgment in cases requiring prolonged antimicrobial therapy. Conditions that may require extended courses of intravenous or oral antibiotics beyond seven days — including but not limited to endocarditis, osteomyelitis, septic arthritis, deep space infections, and certain opportunistic infections — shall be managed in accordance with current evidence-based guidelines and Infectious Disease consultation where appropriate. In such cases, the prescribing physician shall document the clinical indication for extended therapy at the time of renewal. The Pharmacy Director and the Performance Improvement Committee shall review antibiotic utilization patterns at least annually to assess whether the default stop periods remain clinically appropriate and to recommend adjustments to the Medical Executive Committee as needed.

16.3 Drug Procurement and Storage

All medications shall be procured through the Hospital pharmacy. Medications brought by patients shall be stored securely and may be administered only if identified by the pharmacist and specifically ordered by the attending physician. Generic drug substitution is permitted unless ordered otherwise.

16.4 Verbal and Telephone Orders

Verbal and telephone orders are acceptable in emergencies or when the prescriber is physically unable to write the order. Such orders may be received only by licensed healthcare professionals within their scope of practice. All verbal/telephone orders must be verified by a complete “read-back” and countersigned by the ordering physician within forty-eight (48) hours (twenty-four (24) hours for restraint orders).

16.5 Standing Orders

Standing orders must be authorized by a licensed prescriber, signed and dated promptly upon use, placed in the patient’s medical record, and must specify applicable circumstances, medical conditions, and specific orders. Standing orders must be initially approved and reviewed annually by the appropriate Medical Staff Committee.

16.6 Order Legibility

All physician orders must be written legibly, clearly, and completely. Illegible, unclear, or incomplete orders shall not be carried out until clarified or rewritten.

RULE 17 – MEDICAL STAFF DUES AND APPLICATION FEES

Annual Medical Staff dues shall be determined by the Medical Executive Committee on an annual basis. Allied Health Professionals, as non-members of the Medical Staff, are not subject to dues.

Each applicant for Medical Staff membership shall pay a non-refundable application fee at the time of submission. AHP applicants shall pay a non-refundable application fee, which may be waived at the discretion of the Medical Executive Committee.

RULE 18 – EMERGENCY MANAGEMENT AND DISASTER PREPAREDNESS

Reference: 42 CFR §482.15 (Emergency Preparedness); CIHQ Standards; California Health & Safety Code §1277.3

The Emergency Management Committee is responsible for developing, maintaining, and regularly updating comprehensive emergency operations plans for both internal and external disasters, consistent with the Hospital's Emergency Operations Plan (EOP) and CMS Emergency Preparedness Conditions of Participation.

In the event of a declared disaster or preparedness drill, all Medical Staff members shall report to assigned stations and perform only assigned duties. The Chief of Staff and Chief Executive Officer shall coordinate all professional and administrative activities. In the event of patient evacuation, the Chief of Staff shall authorize movement of patients. In the absence of the Chief of Staff and CEO, the Vice Chief of Staff and CEO designee assume authority in their respective roles.

All Medical Staff members expressly agree that, in a declared Hospital emergency, direction of professional care of their patients may be assumed by the Chief of Staff (or designee) as required for patient safety. This obligation is a condition of Medical Staff membership.

The Emergency Operations Plan shall address communications, resource management, staff roles and responsibilities, utilities management, patient safety activities, and security, and shall be reviewed and tested at least annually.

RULE 19 – ADOPTION AND AMENDMENT

These Medical Staff General Rules and Regulations are adopted by the Medical Executive Committee pursuant to the authority granted in the Medical Staff Bylaws. Amendments shall be initiated by the Medical Executive Committee and shall become effective upon approval by the District Board of Directors.

These Rules shall be reviewed at least annually, and revised as necessary, to reflect changes in Medical Staff practice, applicable law (including CMS Conditions of Participation), CIHQ accreditation standards, and Hospital policy. The Bylaws Committee shall coordinate this review and submit recommended revisions to the Medical Executive Committee.

The Medical Executive Committee may adopt interim policies and procedures between formal review cycles to address emerging regulatory requirements or operational needs, provided such interim measures are ratified at the next regularly scheduled Medical Executive Committee meeting and presented to the District Board for approval.

END OF MEDICAL STAFF RULES AND REGULATIONS

Sonoma Valley Hospital | Effective February 24, 2026 | Revised per CMS CoP & CIHQ Standards



To: SVHCD Board of Directors
From: Kelley Kaiser, Chief Executive Officer
Date: April 2, 2026
Subject: CEO Update – March 2026

UCSF Affiliation agreement

The SVHCD/UCSF Affiliation agreement has been fully executed. The Joint Operating Committee (JOC) will identify, evaluate and implement the initiatives that directly fulfill SVHCD’s mission to improve access and the quality of care in the Sonoma Valley Community. We will continue to update the Board on our progress.

Board retreat update

The areas of Focus included:

- Affiliation Agreement update – As stated above, the document has been fully executed
- EPIC Interoperability Brainstorming - The details and feedback from this session will be shared with the JOC, as that group is tasked with following up on options and next steps
- Strategic Plan updates – Reviewed accomplishments over the last year
- Strategic Plan refresh – going forward the four pillars are: **Quality and Access, Community Engagement, Connected Culture, and Sustainability.**

Stryker outage update

We activated Incident Command on the evening of March 11th to assess the situation following Stryker’s announcement of a global network disruption affecting their Microsoft environment due to a cyberattack. Stryker reported no evidence of ransomware or malware and stated the issue was contained. They also confirmed that critical surgical and endoscopy systems—such as Surgical Visualization Platforms, Connected OR Hub, Studio3, DataMediatOR, and related products—were **not impacted**. As a precaution, our OR nursing team and IS department validated all Stryker equipment, and everything was functioning normally.

Assembly Bill 2311 (AB 2311)

The hospital is supporting AB 2311, which would authorize healthcare districts to directly employ physicians. This legislation could materially strengthen the hospital’s ability to recruit and retain providers in a highly competitive market, especially given the hospital’s payer mix and community needs.



Overall Operating Performance

February delivered a meaningful rebound from January’s softness, with results essentially in line with budget. The hospital recorded an operating loss of \$(210,000) (approximately 1%) — only \$(2,000) unfavorable to budget — and achieved positive Operating EBDA of \$148,000 for the month.

Despite February's shorter calendar and fewer revenue-generating days, performance held steady and demonstrated that January's dip was a temporary disruption rather than a negative trend.

On a normalized per-day basis, core service lines showed broad improvement, including surgical services, the Emergency Department, outpatient physical therapy, and MRI.

Inpatient activity remained strong with an Average Daily Census of 11, continuing a pattern of elevated utilization.

The ED saw 943 visits in February. While total volume dipped slightly due to the shorter month, daily volumes remained steady at 34 visits per day.

Outpatient activity remained stable and on budget:

- Imaging: Slight month-over-month decline driven by calendar days; MRI remained strong at 11+ daily visits.
- Physical Therapy: Continues to reflect robust and consistent demand.

Surgical volumes rebounded meaningfully from January:

- 136 cases, up from 120
This reflects normalization following January's temporary slowdown.

The FY27 budget process is underway, with early work focused on volume assumptions and operational drivers. In addition, a hospital-wide capital needs assessment has launched to establish a prioritized, multi-year capital planning framework. This will directly inform the FY27 budget and long-range facility strategy, including seismic compliance and modernization planning.



Quality as an Operating System:

The hospital continues embedding quality as a core organizing principle, with progress including:

- A more structured cadence of review
- Stronger engagement across clinical and operational leadership
- Increased alignment around interpretation of trends versus point-in-time data

March quality review continued to strengthen trend-based performance assessment and focused follow-up on specific indicators.

2026 Quality Governance Realignment:

Efforts are underway to clarify meeting structures, reporting pathways, and accountability across teams to support long-term consistency and oversight.

CIHQ survey readiness:

The staff continues to evaluate where we are and ensure readiness for the survey window (3/9-5/9) Policies continue to be the main area of focus.



Community Engagement

Strategic Marketing to the community:

- Telling our story
 - Targeted use of Sonoma Index Tribune print ads for Healing Here at Home, elevating our brand, opening service line (GI) and events such as Active Aging and Golden Harvest.
 - “My Hospital” campaign in partnership with the Foundation; print ads monthly in the Sonoma Index Tribune, Sonoma Sun, Kenwood Press.
 - Use of social media to push engagement, in all of the above.
 - Our SVH listserv (emails) push out information (i.e. new weekly imaging hours) and distributes the monthly “Hospital Happenings” to just under 7,000 addresses.
This month the communication focused on:
 - Dr. Okolo’s new practice and Colorectal Cancer Awareness Month
 - Service spotlight around:
 - 3T MRI, Mammography, CT scans, Ultrasound, DEXA (Bone Density) and the addition of weekend imaging hours.
 - A spotlight on Laurie Veal, the SVH lab manager and the expertise she brings to the community.
 - Recognition of SVH as a Top performer in the Partnership Health Plan of California’s Hospital Quality Improvement Program (HQIP) in addition to sharing updates (i.e. Employee Service Awards).
 - Sonoma Valley Hospital Foundation “My Hospital” story – Whitney Evans, sharing his journey with his wife and her dementia and the profound impact that Becky Spear made on them during their journey.
 - Our social media strategy was recently revamped for more engagement, telling the stories the community wants to hear, photos showcasing our staff, getting valuable information out around our quality of care and the services we offer.
- Driving volumes
 - FY25 to FY26: focused on driving MRI volumes there was nearly 30% year over year gain, increasing our ROI; FY25 and first half of FY26 had heavy advertising on 3T
 - Targeting (Mar-May 2026) greater Napa Valley with digital advertising re: Queen getting 3T MRI in late Spring/early Summer, ensuring we focus on keeping our capture rate.
 - Opening of GI last week of April: Sonoma Index Tribune print (4/10) and email listserv (4/1) announcing opening; 4/2 begin scheduling patients
 - FY27 advertising budget targeted to drive volumes in OR, PT, ED, GI
- Community Outreach and Engagement
 - Monthly expert on KSVY.

- Our newsletters, BOD letters and press releases have an average open rate of 8.5-9.8 vs the community average of 7 (per Emma the listserv app we use) In addition we use dedicated emails through the Press Democrat News Group with an average open rate of 55% compared to the industry standard of 30%.
- UCSF reached out this month to understand what we were doing in terms of marketing our 3T MRI as they had seen the positive impact we made and were looking to learn best practices from us.

Productive meetings were held with both the Sonoma Valley Community Health Center and the Hanna Center both focusing on Mental Health and Primary Care Access.

SVH participated in the Sonoma County Behavioral Health Collaborative meeting. This meeting happens quarterly and includes providers from across the County.

I participated in “Soup’s on! at Vintage House, a community service that SVH sponsors on a bi-monthly basis. I also met with the new Executive Director, Danielle Azalinno, from the Boys and Girls clubs of Sonoma Valley.



Cascading communication

Planning is underway for the first All staff meeting to be scheduled for May, the focus will be on the updated strategic plan and the strategies and goals that impact the entire organization. We will also talk through Leadership Rounding and the goals around this task

Leadership rounding

The outline for Leadership rounding has been developed, and the plan will be implemented once we have completed our CIHQ survey.

Employee Engagement survey

This survey is scheduled to go out to all employees within the next few weeks.

SVH Performance Score Card

1. Quality and Safety

Objective	Target	JAN 26	FEB 26	Supporting detail		
Infection Prevention						
Central Line Blood Stream Infection CLABSI volume	<1	0	0			Less than Target is Goal
Catheter Associated Urinary Tract Infection- CAUTI volume	<1	0	0			Less than Target is Goal
CDIFF Infection volume	<1	1	1			Less than Target is Goal
Surgical Site Infections volume	<1	0	0			Cholecystectomy Laminectomy - Less than Target is Goal
Acute Care Falls						
Patient Fall per 1000 pt days	<3.75	0	3			Less than Target is Goal
Patient fall with injury per 1000 pt days	<3.75	0	1			Less than Target is Goal

Core Measures						
Sepsis Early Management Bundle % compliant	>81%	100.00	100.00			Above Target is Goal
Severe Sepsis 3 hour Bundle % compliant	>94%	N/A	100.00			Above Target is Goal
Severe Sepsis 6 hr Bundle % compliant	100%	N/A	100.00			
Core OP 23- Head CT within 45 mins % compliant	70%	N/A	100.00			Above Target is Goal

Mortality						
Acute Care Mortality Rate O/E rate	<95	0.42	0.83			Lower is better

ED						
Core OP 18b Median Time ED arrival to ED Departure mins	<132	87.00	102.00			Lower is better
Core Op 22 ED Left without being seen LWBS	<2%	0.20	0.10			Lower is better

PSI 90						
PSI 90 Composite Acute Care Admissions	0.00	0.00	0.00			Lower is better

Preventable Harm						
Preventable Harm Events Rate % of risk events graded Minor-Major	0.00	0.11	0.00			Complications under review Lower is better
Readmissions to Acute Care within 30 days %	<16.6	9.90	3.50			Lower is better



2. Employees

Objective	Target	Q3.25 Jul-Sep	Q4.25 Oct-Dec	1Q.26 Jan-Mar	Supporting Detail	
Short-term Turnover	<3%	13.1	6.7			Employed less a year is defined as Short-Term Turnover - method of calculation changed as of 1/1/25
Turnover	<10%	5.0	2.1			Total Turnover Rate (Annual Basis)
Workplace Injuries	<20 Per Year	6 (QTR 3)	5 (QTR 4)			

3. Patient Experience

Outpatient Ambulatory Services (OASCAHPS)						
Objective	Target	DEC 25	JAN 26	Supporting Detail		
Recommend Facility	>90%	85.7	85.7			Top Box Scores. % of patients choosing "Always" - Above Target is Goal
Communication	>90%	92.5	87.9			
Discharge Instructions	>95%	97.00	91.87			

HCAHPS (Hospital Inpatient)						
Objective	Target	DEC 25	JAN 26	Supporting Detail		
Recommend the hospital	>90%	74.9	66.7			Top Box Scores. % of patients choosing "Always" - Above Target is Goal
Communication with Nurse	>90%	78.8	87.9			
Communication with Doctor	>90%	79.4	90.7			
Cleanliness of Hospital	>90%	74.7	68.2			
Communication about medicines	>90%	63.5	63.9			
Discharge Information	>90%	87.9	95.0			

4. Volume

Objective	Target	JAN 26	FEB 26	Supporting Detail		
Patient Visits						
Emergency Visits	>920	1,022	943			Higher than Target is Goal
Surgical Volume Outpatient	>135	115	108			Higher than Target is Goal
Surgical Volume Inpatient	>10	5	8			Higher than Target is Goal
Inpatient Discharges	>70	90	85			Higher than Target is Goal

5. Financial

Objective	FY26 Target	JAN 26	FEB 26	Supporting Detail		
Operating EBDA in % (Month) *	varies	-2.6%	2.1%			February Operating EBDA Target 4.8%
Operating EBDA in % (YTD) *	>5.0%	6.1%	5.2%			
Days Cash on Hand @ FYE	>30	28.5	28.4			
Net Operating Revenue (\$M) (annualized)	>\$76.7	\$81.1	\$81.3			Includes Parcel Tax & IGT Revenues



To: SVHCD Board of Directors
From: Patrick Okolo III, MD, Chief Medical Officer
Date: April 2, 2026
Subject: CMO Update – April 2026

Quality Trajectory Update

Quality as the Hospital's Operating System

Over the past several months, we have been intentionally repositioning quality as a core organizing framework for how the hospital operates.

This has included:

- Establishing a more structured and regular cadence of quality review
- Increasing engagement from both clinical and operational leadership
- Beginning to align quality discussions more directly with day-to-day operations
 - This work is still evolving, but the direction is clear: **quality is becoming central to how we think, communicate, and make decisions.**

Snapshot vs. Trajectory

A consistent theme in our recent discussions has been the distinction between a single point-in-time view (“snapshot”) and overall direction of travel (“trajectory”).

Where We Were:

- Quality review processes were less consistent and less integrated
- Limited ability to assess performance trends over time

Where We Are:

- A more defined cadence of review and discussion
- Increased emphasis on trend lines rather than isolated data points
- Greater alignment in how quality is being interpreted across leadership groups

Where We're Going:

- Continued focus on stability and consistency in performance
- Clearer visibility into trends and variation over time
- More disciplined use of data to support decision-making and prioritization

This framing remains important as we interpret current performance and communicate progress.

External Validation: Partnership HQIP Recognition

We recently received recognition through the Partnership HQIP program.

- This reflects measured performance in selected quality domains
- It provides an external reference point as we continue to improve

We view this as encouraging validation of direction, while remaining focused on sustained, consistent performance.

March Quality Scorecard & Oversight

During March, we continued to build consistency in how quality performance is reviewed:

- Ongoing review of key quality indicators
- Continued emphasis on trend interpretation rather than isolated results
- Identification of areas requiring focused follow-up

This process is becoming more structured, with a continued focus on clarity, consistency, and accountability.

2026 Quality Governance Realignment

We have begun to clarify and strengthen our quality governance structure:

- More clearly defined meeting structure and reporting pathways
- Improved alignment between medical staff leadership and administration
- Continued focus on accountability and communication across teams

This work is ongoing and is intended to support more consistent oversight and follow-through over time.

Operational Momentum: Surgical & Infusion Growth

February 2026:

- Stable procedural activity in the operating room
- Ongoing infusion services supporting patient care

March 2026 (Projected):

- Continued procedural volume with attention to operational flow and coordination
- Ongoing infusion activity, with monitoring of demand and capacity

Our focus remains on consistency, coordination, and reliability of operations.

Forward Focus: Next 90 Days

Over the next 90 days, our priorities are to:

- Continue strengthening quality review processes and consistency of oversight
- Improve operational reliability in procedural areas
- Enhance alignment across clinical and administrative leadership
- Maintain focus on trend-based performance assessment and follow-through

Closing Thought

We remain focused on ensuring that our trajectory is clear, steady, and aligned—with the understanding that consistent direction, over time, is what ultimately drives performance.



To: SVHCD Board of Directors
 From: Ben Armfield, Chief Financial Officer
 Date: April 2, 2026
 Subject: Financial Report for February 2026

OVERALL PERFORMANCE SUMMARY | MONTH OF FEBRUARY 2026

- **Operating Performance** – February represented a meaningful rebound from the softer performance experienced in January. The hospital posted an operating loss of **\$(210,000)**, or approximately (1%), essentially in line with budget (unfavorable by just \$(2,000)). Notably, the hospital generated positive Operating EBDA of **\$148,000** for the month.

February’s improvement in performance relative to January is significant. Despite the shorter month, which inherently reduces the number of revenue-generating days and can create modest headwinds to volume, performance remained stable and in line with expectations. This reinforces that January’s softness was a temporary disruption rather than an emerging trend.

	Current Month				Year-To- Date				PY Actual	Var	%
	Actual	Budget	Var	%	Actual	Budget	Var	%			
Operating Margin	\$ (210.3)	\$ (207.7)	\$ (2.6)	-1%	\$ (1,067.6)	\$ (3,013.4)	\$1,945.8	65%	\$ (3,042.9)	\$1,975.3	65%
Operating EBDA	\$ 148.2	\$ 205.7	\$ (57.4)	-28%	\$ 2,692.5	\$ 1,043.3	\$1,649.2	158%	\$ 1,167.2	\$1,525.4	131%
Net Income (Loss)	\$ 86.9	\$ (51.8)	\$ 138.7	268%	\$ 962.7	\$ (1,766.4)	\$2,729.2	155%	\$ (1,546.0)	\$2,508.7	162%

- **Operating Revenues - \$7.0 Million**, which exceeded budget by **9%** or **\$604,000**. This favorable variance continues to be driven by IGT program revenue.

Net Patient Revenue (excluding IGT proceeds) was **\$4.2 million**, approximately **3% below budget**. While modestly under budget, this represents a meaningful improvement from January.

Total volumes for the month were impacted by the reduced number of revenue-generating days, which creates some distortion in month-over-month comparisons. On a normalized, per-day basis, performance improved across all core revenue-generating service lines, including surgical volumes, emergency department visits, outpatient physical therapy, and MRI.

- **Operating Expenses - \$7.2 Million**, which exceeded budget by **9%** or **(\$607,000)**.

The primary driver of this variance relates to the increased net benefit from the Rate Range IGT program. As previously discussed with the Committee, the hospital originally budgeted a \$10 million net benefit but ultimately realized \$12 million. This incremental benefit results in a corresponding increase in IGT program expense (matching fee pay-in), driving a significant portion of the variance above budget.

Excluding IGT program expense, operating expenses were approximately 5% above budget for the month.

Importantly, total operating expenses declined from January levels, as expected, reflecting both the shorter month and the absence of certain one-time expenses incurred in January. Benefit expense also decreased in February following the front-loaded costs recognized in the prior month.

February also included approximately \$40,000 of interest expense associated with the previously outstanding line of credit. With the line now fully repaid, this expense is not expected to recur through the remainder of the fiscal year.

- **Year-To-Date Performance** - Underlying operating performance remains favorable when excluding IGT activity. **Net patient revenue** is approximately **\$3.1 million**, or **9%, above budget**, while **operating expenses (excluding IGT)** are approximately **\$1.9 million**, or **4%, above budget**, reflecting continued positive operating momentum and strengthening core operating performance.
- **Cash** – Cash levels improved significantly during February, driven by the full receipt of Rate Range IGT funds. These inflows resulted in a substantial increase in liquidity, with cash rising to \$6.65 million at month-end and Days Cash on Hand increasing to 42.6 days, up from 13.4 days in January.

With this improved liquidity position, the hospital was able to:

- Fully repay the outstanding line of credit, which had been utilized to support prior IGT matching fee obligations
- Reduce outstanding accounts payable balances, reflected in a significant decline in A/P days from 64.9 to 43.0 days, and begin normalizing vendor payment timing

In addition, patient cash collections remained consistent with recent trends at approximately \$4.6 million for the month.

During February, the hospital also made an additional IGT matching fee payment of approximately \$350,000 related to the District Hospital Directed Payment Program. As previously discussed, this program is expected to generate approximately \$850,000 in gross proceeds, representing a net benefit of approximately \$500,000, with funds anticipated in May.

DRIVERS IN MONTHLY PERFORMANCE

- **Inpatient Activity** - Inpatient volumes remained strong, with Average Daily Census of approximately 11.0, continuing the trend of sustained elevated utilization.
- **Emergency Department** - Emergency Department volumes totaled 943 visits during the month. While total visits declined slightly from January, this is largely attributable to February being a shorter month. On an average daily basis, volumes remained strong at approximately 34 visits per day, marking the third consecutive month of sustained elevated demand.
- **Outpatient Activity** - Outpatient activity remained stable overall, with total visits in line with both budget.
 - **Imaging** – Volumes were modestly lower in total, primarily within MRI, though February’s shorter calendar impacts month-over-month comparisons. On a normalized basis, MRI volumes continue to perform well, averaging over 11 visits per day, exceeding current year targets. Opportunities remain to further optimize and grow this service line.
 - **Physical Therapy** – Volumes remain strong and continue to reflect sustained demand. Similar to imaging, management is focused on continued growth and optimization within this area.
- **Surgical Volumes** - Surgical volumes rebounded in February, driven primarily by improved activity in GI and general surgery.

A total of 136 surgeries were performed during the month, representing a significant increase from 120 cases in January, though still approximately 5% below budget.

This improvement reflects a return toward more normalized surgical activity following January's temporary slowdown.

OTHER FINANCE UPDATES

AC-1 Repair Project

We are pleased to report that the repair of the failing AC-1 condenser was successfully completed over the weekend of March 13th. This was a complex project requiring crane support, temporary closure of portions of the hospital entrance, and a coordinated shutdown of operating room services beginning Thursday afternoon through the weekend. Despite these constraints, the Emergency Department remained fully operational throughout the duration of the project, and surgical services resumed the following week without disruption.

Importantly, the project was completed on schedule and is expected to remain within the approved project budget of \$250,000. The timing proved critical, as the hospital experienced unseasonably high temperatures in the days immediately following completion. The successful execution of this repair helped avoid potential operational disruptions and ensured continuity of patient care.

We would like to recognize the Facilities team for their outstanding coordination and execution in managing this project safely and efficiently.

FY27 Budget Process

Management has formally initiated the FY27 budget development process. Early efforts are focused on establishing baseline volume assumptions, identifying key financial and operational drivers, and aligning departmental expectations with the hospital's broader strategic priorities.

As part of this process, we are placing a strong emphasis on building a budget that continues to advance the hospital toward long-term financial sustainability, while also balancing near-term operational realities.

We will continue to keep the Finance Committee apprised of progress over the coming months, with initial framing and directional assumptions to be shared at upcoming meetings.

IGT Update

Management continues to actively engage with both Kaiser and Partnership Health Plan regarding Rate Range IGT allocations for the CY25 program (FY27). While discussions remain ongoing, early indications suggest continued stability in the program, though final funding levels have not yet been confirmed.

Given the material impact IGT funding has on the hospital's financial position, this remains a key area of focus. We expect to have greater clarity on projected funding levels in the coming months and will provide updates to the Committee as additional information becomes available.

Capital Needs Assessment

Management has launched a comprehensive capital needs assessment across all departments of the hospital. This effort is intended to develop a more structured and prioritized view of both short-term equipment needs and longer-term infrastructure requirements.

The goal is to establish a disciplined, multi-year capital planning framework that aligns with the hospital's strategic priorities and financial capacity. This work will help inform both the FY27 budget process and broader

long-range planning efforts, including future discussions related to seismic compliance and facility modernization.

Assembly Bill 2311 (AB 2311)

The hospital is supporting Assembly Bill 2311 (Schiavo), which would provide healthcare districts with the ability to directly employ physicians.

If enacted, this legislation would represent a meaningful shift for district hospitals, including Sonoma Valley Hospital, by expanding our ability to recruit and retain providers in a highly competitive environment. This is particularly important given the challenges district hospitals face in contracting for physician services while managing high levels of Medi-Cal and uncompensated care.

Management will continue to monitor the progress of this legislation closely and assess its potential implications for our provider alignment strategy.

FINANCE REPORT ATTACHMENTS:

- Attachment A Income Statement
- Attachment B Balance Sheet
- Attachment C Cash Flow Forecast
- Attachment D Key Performance Indicators | Volumes & Statistics
- Attachment E Key Performance Indicators | Overall Performance

Sonoma Valley Health Care District
Income Statement (in 1000s)
For the Period Ended February 28, 2026

ATTACHMENT A

	Month				Year-To-Date						
	CYM Actual	CYM Budget	Var	%	YTD Actual	YTD Budget	Var	%	PYTD Actual	Var	%
Revenues											
1 Net Patient Revenue	\$ 4,218.5	\$ 4,331.2	(112.7)	-3%	\$ 36,181.2	\$ 33,115.5	3,065.7	9%	\$ 33,452.6	2,728.6	8%
2 IGT Program Revenue	2,375.9	1,653.7	722.3	44%	14,689.0	13,229.5	1,459.5	11%	7,699.6	6,989.4	91%
3 Parcel Tax Revenue	316.7	316.7	(0.0)	0%	2,533.3	2,533.3	(0.0)	0%	2,533.3	(0.0)	0%
4 Other Operating Revenue	94.6	99.9	(5.3)	-5%	793.8	799.1	(5.3)	-1%	790.6	3.2	0%
5 Total Revenue	\$ 7,005.7	\$ 6,401.5	604.3	9%	\$ 54,197.2	\$ 49,677.4	4,519.9	9.1%	\$ 44,476.1	9,721.1	22%
Operating Expenses											
6 Labor / Total People Cost	\$ 3,244.1	\$ 3,052.0	192.1	6%	\$ 25,810.6	\$ 24,321.7	1,488.9	6%	\$ 23,059.5	2,751.2	12%
7 Professional Fees	963.0	817.0	146.0	18%	5,849.6	5,602.8	246.8	4%	5,395.1	454.5	8%
8 Supplies	692.9	691.2	1.7	0%	5,778.2	5,535.9	242.3	4%	4,997.7	780.5	16%
9 Purchased Services	526.6	534.0	(7.4)	-1%	3,774.2	3,532.2	242.0	7%	3,162.0	612.2	19%
10 Depreciation	358.5	413.3	(54.8)	-13%	3,760.1	4,056.7	(296.6)	-7%	4,210.1	(450.0)	-11%
11 Interest	70.0	36.6	33.4	91%	439.8	424.2	15.5	4%	297.9	141.8	48%
12 Other	300.7	300.3	0.3	0%	3,144.1	3,100.1	44.0	1%	3,016.7	127.4	4%
13 IGT Program Expense	1,060.2	764.6	295.6	39%	6,708.2	6,117.0	591.1	10%	3,380.0	3,328.2	98%
14 Operating Expenses	\$ 7,216.0	\$ 6,609.2	606.8	9.2%	\$ 55,264.9	\$ 52,690.8	2,574.1	4.9%	\$ 47,519.1	7,745.8	16%
15 Operating Margin	\$ (210.3)	\$ (207.7)	\$ (2.6)	-1%	\$ (1,067.6)	\$ (3,013.4)	\$ 1,945.8	65%	\$ (3,042.9)	\$ 1,975.3	65%
Non Operating Income											
16 GO Bond Activity, Net	235.2	128.6	106.5	83%	1,712.3	1,029.0	683.3	66%	1,291.4	420.9	33%
17 Misc Revenue/(Expenses)	62.0	27.2	34.8	128%	318.1	217.9	100.1	46%	205.5	112.5	55%
18 Total Non-Op Income	\$ 297.2	\$ 155.9	141.3	91%	\$ 2,030.4	\$ 1,247.0	783.4	63%	\$ 1,497.0	533.4	36%
19 Net Income (Loss)	\$ 86.9	\$ (51.8)	138.7	268%	\$ 962.7	\$ (1,766.4)	2,729.2	155%	\$ (1,546.0)	2,508.7	162%
20 Restricted Foundation Contr.	-	125.0	(125.0)	-100%	1,953.2	1,000.0	953.2	95%	2,038.0	(84.8)	-4%
21 Change in Net Position	\$ 86.9	\$ 73.2	13.7	19%	\$ 2,916.0	\$ (766.4)	3,682.4	480%	\$ 492.0	2,424.0	493%
22 Operating EBDA	\$ 148.2	\$ 205.7	(57.4)	-28%	\$ 2,692.5	\$ 1,043.3	1,649.2	158%	\$ 1,167.2	1,525.4	131%

Sonoma Valley Health Care District

ATTACHMENT B

Balance Sheet
As of February 28, 2026
 Expressed in 1,000s

	<u>Current Month</u>	<u>Prior Month</u>	<u>FYE 2025 Prior Year</u>
Assets			
Current Assets:			
1 Cash	\$ 6,653.4	\$ 1,861.4	\$ 4,386.3
2 Net Patient Receivables	8,255.6	7,990.2	7,585.8
3 Allow Uncollect Accts	(1,240.3)	(1,496.5)	(1,256.1)
4 Net Accounts Receivable	\$ 7,015.3	\$ 6,493.7	\$ 6,329.7
5 IGT Program Receivable	891.8	21,047.4	-
6 Parcel Tax Receivable	1,744.6	1,744.6	-
7 GO Bond Tax Receivable	1,626.6	1,626.5	-
8 Other Receivables	836.9	900.0	1,423.3
9 Inventory	978.2	992.5	841.0
10 Prepaid Expenses	1,205.1	1,328.6	788.1
11 Total Current Assets	\$ 20,951.8	\$ 35,994.7	\$ 13,768.5
12 Property, Plant & Equip, Net	\$ 59,955.9	\$ 60,217.9	60,342.6
13 Trustee Funds - GO Bonds	5,017.2	5,004.8	5,986.7
14 Other Assets - Deferred IGT Expense	4,645.1	5,421.1	-
15 Total Assets	\$ 90,569.9	\$ 106,638.4	\$ 80,097.8
Liabilities & Fund Balances			
Current Liabilities:			
16 Accounts Payable	4,642.1	\$ 7,006.0	\$ 7,282.7
17 Accrued Compensation	4,560.1	4,525.4	4,059.9
18 IGT Program Payable	242.0	590.9	-
19 Interest Payable - GO Bonds	201.0	169.5	154.4
20 Accrued Expenses	853.0	808.6	166.1
21 Deferred IGT Revenue	9,553.5	11,929.4	-
22 Deferred Parcel Tax Revenue	1,266.7	1,583.4	-
23 Deferred GO Bond Tax Revenue	1,097.4	1,371.7	-
25 Line of Credit - Summit Bank	-	10,500.0	-
26 Other Liabilities	-	(0.0)	-
27 Total Current Liabilities	\$ 23,155.8	\$ 39,224.9	\$ 12,403.1
28 Long Term Debt, net current portion	\$ 23,568.4	\$ 23,654.7	\$ 27,239.3
29 Total Fund Balance	\$ 43,845.8	\$ 43,758.9	\$ 40,455.4
30 Total Liabilities & Fund Balances	\$ 90,569.9	\$ 106,638.4	\$ 80,097.8

<u>Cash Indicators</u>	<u>Current Month</u>	<u>Prior Month</u>	<u>Prior Year FYE</u>
Days Cash	42.6	13.4	29.2
A/R Days	45.5	42.2	45.8
A/P Days	43.0	64.9	67.2

Sonoma Valley Health Care District
 Projected Cash Forecast (In 1000s)
 FY 2026

ATTACHMENT C

	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	Forecast	Forecast	Forecast	Forecast	TOTAL
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
Hospital Operating Sources													
1 Patient Payments Collected	\$ 4,683.2	\$ 4,292.8	\$ 4,956.9	\$ 4,513.5	\$ 4,208.0	\$ 4,353.9	\$ 4,970.2	\$ 4,666.0	\$ 4,600.0	\$ 4,600.0	\$ 4,600.0	\$ 4,600.0	\$ 55,044.5
2 Other Revenue - Operating & Non-Op	182.5	104.0	101.6	94.6	101.0	129.0	91.8	114.8	105.0	105.0	105.0	105.0	1,339.2
3 IGT Program Revenue	-	-	-	523.7	31.5	-	2,639.8	20,155.6	0.9	-	850.0	161.5	24,363.0
4 Parcel Tax Revenue	110.9	-	-	-	-	2,055.4	-	-	-	1,608.7	-	-	3,775.0
5 Unrestricted Contributions	4.0	-	-	-	-	-	-	-	-	-	-	-	4.0
6 Sub-Total Hospital Sources	\$ 4,980.6	\$ 4,396.8	\$ 5,058.5	\$ 4,608.1	\$ 4,309.0	\$ 7,112.5	\$ 7,701.8	\$ 24,936.4	\$ 4,705.9	\$ 6,313.7	\$ 5,555.0	\$ 4,866.5	\$ 84,544.7
Hospital Uses of Cash													
7 Operating Expenses / AP Payments	\$ 5,649.7	\$ 4,948.5	\$ 4,975.3	\$ 6,009.0	\$ 4,877.2	\$ 5,616.9	\$ 6,661.0	\$ 8,499.2	\$ 5,750.0	\$ 5,500.0	\$ 5,900.0	\$ 5,200.0	\$ 69,586.8
8 Term Loan Paydowns - Summit / CHFFA	73.6	73.6	73.6	73.6	73.6	73.6	131.0	73.6	73.6	73.6	73.6	73.6	940.3
9 IGT Financing Interest	-	-	-	-	106.0	77.1	74.2	43.3	-	-	-	-	300.6
10 IGT Matching Fee Payments	-	228.5	-	-	10,426.1	-	-	348.9	-	409.9	87.7	-	11,501.1
11 Capital Expenditures - SVH Funded	145.6	-	11.3	84.5	59.3	60.0	539.8	723.8	344.5	344.5	244.5	244.5	2,802.4
12 Capital Expenditures - Foundation Funded	876.5	468.8	133.8	205.4	94.3	69.6	-	-	-	-	-	-	1,848.4
13 Total Hospital Uses	\$ 6,745.4	\$ 5,719.5	\$ 5,194.0	\$ 6,372.4	\$ 15,636.6	\$ 5,897.2	\$ 7,406.0	\$ 9,688.8	\$ 6,168.1	\$ 6,328.0	\$ 6,305.8	\$ 5,518.1	\$ 86,979.8
Net Hospital Sources/Uses of Cash	\$ (1,764.7)	\$ (1,322.7)	\$ (135.5)	\$ (1,764.3)	\$ (11,327.6)	\$ 1,215.3	\$ 295.8	\$ 15,247.6	\$ (1,462.2)	\$ (14.3)	\$ (750.8)	\$ (651.6)	\$ (2,435.0)
Non-Hospital Sources													
14 Restricted Donations (rec'd from Foundation)	806.7	538.6	214.6	124.5	94.3	-	-	44.4	-	-	-	-	1,823.2
15 Line of Credit - Draw	-	-	-	-	10,500.0	-	-	-	-	-	-	-	10,500.0
17 Sub-Total Non-Hospital Sources	\$ 806.7	\$ 538.6	\$ 214.6	\$ 124.5	\$ 10,594.3	\$ -	\$ -	\$ 44.4	\$ -	\$ -	\$ -	\$ -	\$ 12,323.2
Non-Hospital Uses of Cash													
18 Line of Credit - Payoff	-	-	-	-	-	-	-	10,500.0	-	-	-	-	10,500.0
20 Sub-Total Non-Hospital Uses of Cash	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 10,500.0	\$ -	\$ -	\$ -	\$ -	\$ 10,500.0
21 Net Non-Hospital Sources/Uses of Cash	\$ 806.7	\$ 538.6	\$ 214.6	\$ 124.5	\$ 10,594.3	\$ -	\$ -	\$ (10,455.6)	\$ -	\$ -	\$ -	\$ -	\$ 1,823.2
22 Net Sources/Uses	\$ (958.0)	\$ (784.1)	\$ 79.1	\$ (1,639.8)	\$ (733.3)	\$ 1,215.3	\$ 295.8	\$ 4,792.0	\$ (1,462.2)	\$ (14.3)	\$ (750.8)	\$ (651.6)	\$ (611.8)
23 Total Cash at beginning of period	\$ 4,386.3	\$ 3,428.3	\$ 2,644.2	\$ 2,723.3	\$ 1,083.5	\$ 350.3	\$ 1,565.6	\$ 1,861.4	\$ 6,653.4	\$ 5,191.2	\$ 5,176.9	\$ 4,426.1	
24 Total Cash at End of Period	\$ 3,428.3	\$ 2,644.2	\$ 2,723.3	\$ 1,083.5	\$ 350.3	\$ 1,565.6	\$ 1,861.4	\$ 6,653.4	\$ 5,191.2	\$ 5,176.9	\$ 4,426.1	\$ 3,774.5	
25 Days of Cash on Hand at End of Month	22.0	17.0	17.5	7.2	4.3	10.0	11.9	42.6	33.3	33.2	28.4	24.2	

Sonoma Valley Health Care District
Key Performance Indicators | Volumes & Statistics
 For the Period Ended February 28, 2026

	Current Month				Year-To-Date							
	Actual	Budget	Var	%	YTD	YTD	Var	%	PYTD			
					Actual	Budget			Actual	Var	%	
Inpatient Volume												
Acute Patient Days	308	250	58	23%	2,369	2,053	316	15%	1,995	374	19%	
Acute Discharges	81	68	13	19%	648	560	89	16%	534	114	21%	
Average Length of Stay	3.8	3.7	0.1	3%	3.7	3.7	(0.0)	0%	3.7	(0.1)	-2%	
Average Daily Census	11.0	8.9	2.1	23%	11.2	9.7	1.5	15%	9.4	2	19%	

	Actual	Budget	Var	%	YTD	YTD	Var	%	PYTD		
					Actual	Budget			Actual	Var	%
Surgical Volume											
IP Surgeries	15	9	6	60%	97	77	20	27%	71	26	37%
OP Surgeries	121	134	(13)	-10%	1,121	1,043	78	7%	1,036	85	8%
Total Surgeries	136	144	(8)	-5%	1,218	1,120	98	9%	1,107	111	10%

	Actual	Budget	Var	%	YTD	YTD	Var	%	PYTD		
					Actual	Budget			Actual	Var	%
Other Outpatient Activity											
Total Outpatient Visits	5,794	5,769	25	0%	47,669	45,603	2,066	5%	45,290	2,379	5%
Emergency Room Visits	943	925	18	2%	7,963	7,147	816	11%	7,333	630	9%

	Actual			Budget			Actual			Budget		
	Actual	Budget	%	Actual	Budget	%	Actual	Budget	%	Actual	Budget	%
Medicare	40.8%	37.7%	3.1%	39.0%	37.9%	1.1%	39.0%	37.9%	1.1%	39.0%	37.9%	1.1%
Medicare Mgd Care	19.6%	18.2%	1.4%	18.2%	18.3%	-0.1%	18.2%	18.3%	-0.1%	18.2%	18.3%	-0.1%
Medi-Cal	15.4%	16.2%	-0.8%	17.7%	16.2%	1.5%	17.7%	16.2%	1.5%	17.7%	16.2%	1.5%
Commercial	20.6%	23.9%	-3.3%	21.4%	23.8%	-2.4%	21.4%	23.8%	-2.4%	21.4%	23.8%	-2.4%
Other	3.5%	3.9%	-0.4%	3.7%	3.8%	-0.1%	3.7%	3.8%	-0.1%	3.7%	3.8%	-0.1%
Total	100.0%	100.0%		100.0%	100.0%		100.0%	100.0%		100.0%	100.0%	

Payor Mix calculated based on gross revenues

Trended Outpatient Visits by Area

Department	Most Recent Six Months						Last 6 Months	YoY Monthly Averages			
	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26		FY26	FY25	Chg	% Chg
Lab	1,481	1,535	1,217	1,355	1,420	1,350		1,401	1,348	53	4%
Medical Imaging	999	1,056	940	1,081	1,041	1,009		1,028	982	46	5%
Physical Therapy	1,502	1,600	1,270	1,337	1,439	1,482		1,427	1,424	3	0%
CT Scanner	482	545	465	508	454	514		492	449	42	9%
Occ. Health	285	313	282	310	279	285		276	267	9	3%
Mammography	250	295	254	301	238	239		255	245	10	4%
Occ. Therapy	195	236	248	285	256	231		243	203	40	20%
Ultrasound	247	281	289	295	244	256		270	218	52	24%
MRI	251	251	202	245	235	206		225	181	44	24%
ECHO	114	131	88	132	100	95		112	129	(17)	-13%
Speech Therapy	53	57	58	57	50	114		64	68	(5)	-7%
Other	19	17	18	33	28	13		25	23	1	6%
TOTAL	6,203	6,601	5,331	5,938	5,784	5,794		5,963	5,789	174	3%
Emergency Room	975	952	932	1,047	1,022	943		1,000	868	132	15%
ER Visits / Day	32.5	30.7	31.1	33.8	33.0	33.7		32.6	28.9	3.7	13%

Sonoma Valley Health Care District
Overall Performance | Key Performance Indicators
 For the Period Ended February 28, 2026

ATTACHMENT E

	Current Month				Year-To- Date				PY Actual	Var	%
	Actual	Budget	Var	%	Actual	Budget	Var	%			
Operating Margin	\$ (210.3)	\$ (207.7)	\$ (2.6)	-1%	\$ (1,067.6)	\$ (3,013.4)	\$ 1,945.8	65%	\$ (3,042.9)	\$ 1,975.3	65%
Operating EBDA	\$ 148.2	\$ 205.7	\$ (57.4)	-28%	\$ 2,692.5	\$ 1,043.3	\$ 1,649.2	158%	\$ 1,167.2	\$ 1,525.4	131%
Net Income (Loss)	\$ 86.9	\$ (51.8)	\$ 138.7	268%	\$ 962.7	\$ (1,766.4)	\$ 2,729.2	155%	\$ (1,546.0)	\$ 2,508.7	162%

Operating Revenue Summary (All Numbers in 1000s)

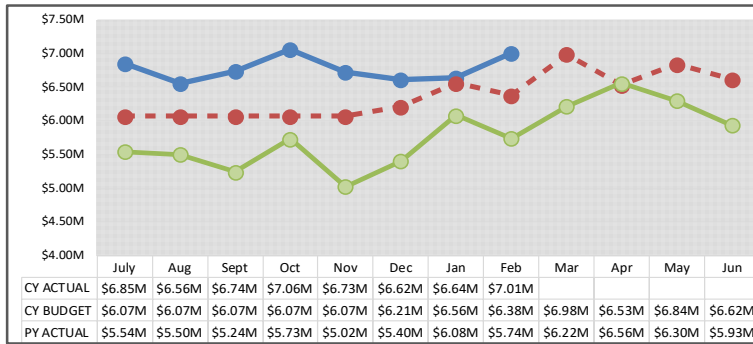
Net Patient Revenue	\$ 4,218	\$ 4,331	\$ (113)	-3%	\$ 36,181	\$ 33,115	\$ 3,066	9%	\$ 33,453	\$ 2,729	8%
NPR as a % of Gross	13.4%	14.4%	-7.1%		13.7%	14.1%	-2.6%		14.2%	-3.3%	
Operating Revenue	\$ 7,006	\$ 6,401	\$ 604	9%	\$ 54,197	\$ 49,677	\$ 4,520	9%	\$ 44,476.1	\$ 9,721	22%

Operating Expense Summary (All Numbers in 1000s)

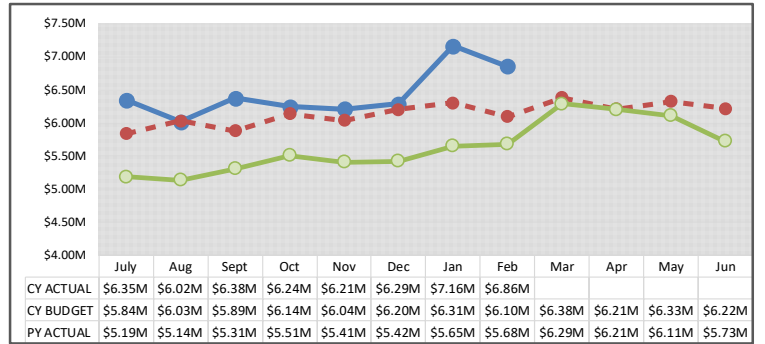
Operating Expenses	\$ 7,216	\$ 6,609	\$ 607	9%	\$ 55,265	\$ 52,691	\$ 2,574	5%	\$ 47,519	\$ 7,746	16%
Op Exp. Excl. Depr.	\$ 6,857	\$ 6,196	\$ 662	11%	\$ 51,505	\$ 48,634	\$ 2,871	6%	\$ 43,309	\$ 8,196	19%
Worked FTEs	234.36	232.11	2.25	1%	232.12	227.72	\$ 4.40	2%	218.09	14.03	6%

Trended Operating Revenue & Operating Expense Graphs

Trended Operating Revenues
 CY Actual vs CY Budget vs PY Actual



Trended Operating Expenses (excl Depreciation)
 CY Actual vs CY Budget vs PY Actual



— CY ACTUAL - - - CY BUDGET — PY ACTUAL

Cash Indicators

	Current Month	Prior Month	Var	% Var
Days Cash	42.6	13.4	29.2	218%
A/R Days	45.5	42.2	3.4	8%
A/P Days	43.0	64.9	(21.9)	-34%