SONOMA VALLEY HEALTH CARE DISTRICT

BOARD OF DIRECTORS

AGENDA

THURSDAY, MAY 7, 2026

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:
Zoom Link: Meeting 91962325850

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.*			
1. 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 – 04.02.26 b. BOD Minutes – 11.06.25 revised c. Finance Committee Minutes – 03.24.26 d. Quality Committee Minutes – 03.25.26 e. Policies & Procedures f. Medical Staff Credentialing g. Board policies* h. Medical Staff Bylaws* i. SVHCD Bylaws* j. MOU SVHCD-SVHF* k. AOC Charter* *These will drafts are pending approval by the Governance Committee 5/6/26, any revisions and additional correlating documents will be sent to the Board and public following the meeting that evening.	*Wendy Lee Myatt*	Action	Pages 3 - 69
5. CHIEF OF STAFF REPORT	*Amara*	Inform	
6. NOMINATION TO FINANCE COMMITTEE: DAVE PIER	*Ed Case*	Inform	Pages 70 - 71
7. FY27 BUDGET UPDATE	*Ben Armfield*	Inform	
8. CEO REPORT	*Kelley Kaiser*	Inform	Pages 72 - 79

9. CMO REPORT	*Patrick I. Okolo III, MD MPH*	Inform	Pages 80 - 81
10. FINANCIALS FOR MONTH END MARCH 2026	*Ben Armfield*	Inform	Pages 82 - 89
11. COMMITTEE UPDATES	*Board of Directors*	Inform	
12. BOARD COMMENTS	*Wendy Lee Myatt*	Inform	
13. ADJOURN	*Wendy Lee Myatt*		

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, NOVEMBER 6, 2025
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 *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*		
1. CALL TO ORDER	*Wendy Lee Myatt*	
Meeting called to order at 5:00 p.m.		
2. PUBLIC COMMENT	*Public*	none
3. BOARD CHAIR COMMENTS	*Wendy Lee Myatt*	
Lee Myatt welcomed new CEO Kelley Kaiser		
4. CONSENT CALENDAR	*Wendy Lee Myatt*	Action
a. BOD Minutes – 10.06.25 b. Quality Committee Minutes – 08.26.25 c. Finance Committee Minutes – 09.24.25 d. Policies & Procedures e. Medical Staff Credentialing	**MOTION:** motion to approve by Kalos to approve, 2nd by Kittleson. All in favor.	
5. CHIEF OF STAFF REPORT	*D. Paul Amara, MD, FACOG*	Inform
Dr. Amara provided the Chief of Staff report for July through October, confirming that the quality of the medical staff remains exceptionally high despite an industry-wide shift from independent primary care physicians to contracted hospitalist groups. A primary concern is the critical shortage and retention of local primary care physicians, as independent practices struggle to compete with corporate "foundation models" that attract new graduates. This shortage negatively impacts both continuity of care and hospital revenue, as patients increasingly seek primary and specialized services out of town. Operationally, a new Quality Committee has been established to drive efficiency, and the hospital has welcomed several new leaders. Praise was given for Dr. Cusick's excellence as the interim CMO. Moving forward, leadership aims to navigate ongoing economic uncertainties, such as recent health plan bankruptcies, and explore ways to better leverage the UCSF affiliation to improve patient transfers and boost physician recruitment.		
6. SONOMA VALLEY HOSPITAL FOUNDATION UPDATE	*Leslie Petersen*	Inform
Petersen provided an update on the hospital foundation's recent initiatives, highlighting the successful launch of the "My Hospital Campaign," which focuses on sharing positive community stories and has already raised $274,000 in highly versatile unrestricted funds. Recent foundation-supported projects included the newly opened physical therapy clinic, an ultrasound machine, a microscope, and an orthopedic saw. Petersen introduced the end-of-year campaign to raise $1 million for a new Stryker system for the operating room (having already secured $220,000) and emphasized the importance of 100% board participation (of both the Foundation and the Healthcare District) to encourage further community giving.		
7. RESOLUTION No. 388: Designation of Admin Responsibility and Bank Signature Authority	*Wendy Lee Myatt*	Action
MOTION to approve by Kittleson to approve, 2nd by Bloch. All in favor.		
8. FY25 AUDIT REPORT	*Ben Armfield*	Action
Armfield presented FY25 audit report with special thanks to Lois Fruzynski for her leadership through the audit process. Case and Bloch both complimented SVH and Baker Tilly for the results and professional and efficient process.		

MOTION to approve by Case to approve, 2nd by Bloch. All in favor.		
9. LOC RENEWAL	*Ben Armfield*	Action
Armfield presented the renewal and expansion of the SVH's line of credit with Summit Bank, which increases the available limit from $5.5 million to $10.5 million to support operating cash flow. The board noted that while this agreement provides essential liquidity to bridge the gap until IGT payments are received, it includes a 150-day cleanup provision. This renewal meets immediate needs and allows for five future iterations, but the Finance Committee emphasized the importance of exploring alternative long-term financing options that offer greater flexibility as the district's financial requirements grow. **MOTION** to approve by Bloch to approve, 2nd by Case. All in favor.		
10. CMO REPORT	*Patrick I. Okolo III, MD MPH*	Inform
Dr. Okolo reported that hospital patient volumes have successfully recovered post-pandemic, with 2024 figures on track to surpass 2017-2018 levels. While current operations are lean and fiscally efficient, he noted that a lack of staffing remains a key weakness that impedes growth. To address this, Dr. Okolo proposed a strategy to broaden the primary care base as a foundation for expanding specialty services, such as gastroenterology and nephrology. There is a critical need for "technological courage" to achieve seamless digital interoperability with UCSF, moving away from manual referral processes toward a unified platform. Discussion was had regarding a focus on leveraging UCSF partnerships and Sonoma's geographic appeal to recruit new physicians.		
11. CEO REPORT	*Ben Armfield*	Inform
Armfield provided a combined update highlighting significant financial and operational progress, noting a projected $12 million net from the IGT program with payments expected in January. First-quarter financials significantly outperformed expectations, showing an operating EBITDA of approximately $1.5 million and containing the operating loss to just $100,000 against a budgeted $1 million loss. Patient volumes remain robust, with ER visits up 10% year-to-date, October surgical volumes 15% over budget, and a record-setting 250 MRI exams in September bolstered by growing UCSF referrals. Facility updates include the completed ICU refresh, full permit occupancy achieved for the PT space, and ongoing city reviews for the permanent MRI trailer. Armfield confirmed during Q&A that the Rosa robot, primarily utilized by Dr. Walter, is yielding overall cost savings through improved implant contracts, despite not yet meeting specific usage thresholds.		
12. FINANCIALS FOR MONTH END SEPTEMBER 2025	*Ben Armfield*	Inform
See above		
13. COMMITTEE UPDATES • Quality 2025 Work Plan	*Board of Directors*	Action
Quality meeting will be *last* Wednesday instead of previous 4th Wednesday. **MOTION** to approve by Kittleson to approve, 2nd by Bloch. All in favor.		
14. BOARD COMMENTS	*Board of Directors*	none
15. ADJOURN	*Wendy Lee Myatt*	
Regular session adjourned at 5:58 p.m.		

SVHCD FINANCE & AUDIT COMMITTEE MEETING

MINUTES

TUESDAY, MARCH 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, in person Paul Chakmak, in person Andrew Exner, in person Robert Crane, via zoom Alexis Alexandridis, MD MBA FACS, via zoom Catherine Donahue, via zoom	Graham Smith	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 Lynn McKissock, SVH Chief of HR, in person Dawn Castelli, SVH Community Outreach & Marketing Mngr, 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	*Ed Case*	Meeting called to order at 5:00 p.m.
2. PUBLIC COMMENT SECTION	None	
3. CONSENT CALENDAR	*Ed Case*	Action
Finance Committee Minutes 2.24.26	**MOTION:** Motion to approve by Bloch, 2nd by Exner. All in favor.	
4. UCSF/SVH AFFILIATION AGREEMENT UPDATE	*Dennis Bloch*	Inform
Newly signed Affiliation Agreement key updates include streamlined procedures for executive management expenses, Brown Act clarifications, and a shift toward "professional, clinical, and strategic services" focused on intentional collaboration in areas like recruitment and interoperability. Joint physician privileges and direct financial funding from UCSF are unlikely but the partnership will prioritize operational synergy and specific community health initiatives through the Joint Operating Committee (JOC) and Affiliation Oversight Committee (AOC).		
5. SESIMIC UPDATE	*Ben Armfield*	Inform
SVH has submitted its seismic compliance plan and applied for a three-year extension under Assembly Bill 869, which could move the deadline from 2030 to 2033. Leadership remains cautious about the high costs and logistical disruptions of retrofitting versus building new, and they are closely monitoring state-level legislative changes that might provide further relief.		
6. FINANCIAL REPORTS FOR MONTH END FEBRUARY 2026	*Ben Armfield*	Inform

In February, Armfield reported a strong financial rebound from a difficult January, returning to a positive EBDA and finishing nearly on budget despite the shorter month. Operating revenues exceeded the budget by nearly 10% (driven largely by an IGT increase) while the hospital's balance sheet saw a significant improvement with cash reserves rising to nearly $7 million, allowing for a 30% reduction in accounts payable. SVH successfully completed a critical repair of its AC1 unit for under $250k, avoiding an $800k replacement and ensuring the operating rooms remained functional during a recent heatwave. Discussion also focused on the ROSA (Robotic Surgical Assistant), which achieved first-year cost savings but faces increased volume pressure in year two due to a new $85k annual service contract.		
7. ADJOURN	*Ed Case*	Meeting adjourned at 5:25 p.m.
5:26 p.m. CLOSED SESSION: Calif. Government Code §37606 and 37624.3: TRADE SECRET; Discussion will concern proposed new service and/or program		
5:55 p.m. Returned to Open Session: No action taken to report.		

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
Wednesday, March 25, 2026, 5:00 PM
MINUTES

Members Present	Excused/Not Present	Public/Staff
Daniel Kittleson, DDS Wendy Lee Myatt Michael Mainardi, MD Carol Snyder Carl Speizer, MD Alex Rainow, MD, SVH Vice COS, via zoom	Kathy Beebe, RN PhD Howard Eisenstark, MD Susan Kornblatt Idell	Kelley Kaiser, SVH CEO 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 Leslie Petersen, SVH Foundation ED Patrick Okolo III, MD MPH, SVH CMO

AGENDA ITEM	PRESENTER	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Daniel Kittleson, DDS*	Called to order at 5:00pm
2. PUBLIC COMMENT SECTION	*Daniel Kittleson, DDS*	No public comments
3. CONSENT CALENDAR • QC Minutes 01.28.26 • QC Minutes 02.25.26	*Daniel Kittleson, DDS*	ACTION
Motion to approve by Mainardi, 2nd by Snyder. Five in favor, zero opposed.		
4. ANNUAL QUALITY REPORT 2025	*Louise Wyatt, RN JD*	INFORM
Wyatt presented the 2025 Annual Quality Report, highlighting a year of significant operational transitions and sustained clinical excellence for SVH. A primary achievement was the successful migration to Press Ganey for safety event tracking. SVH received a perfect 100% score in the 2023-24 Partnership's Hospital Quality Improvement Program Award. Overall metrics for mortality, stroke care, and infection control remain strong. To address challenges, the hospital launched several high-impact initiatives in 2025, including a charity medication program, a "med-to-bed" service, and a dedicated sepsis committee. Emergency Department efficiency remains high, supported by rapid, evidence-based stroke protocols. Looking toward 2026, the strategic focus will shift toward fostering a "just culture" to increase error reporting, implementing Social Determinants of Health (SDOH) screenings for better discharge planning, and maintaining continuous state survey readiness while navigating new CMS financial programs.		
5. QUALITY INDICATOR PERFORMANCE & PLAN	*Louise Wyatt, RN JD*	INFORM

The team had a highly successful February, highlighted by receiving the Partnership Quality Award for their Medi-Cal services. Most performance metrics are currently "in the green," and the group is making steady progress on updating essential policies and procedures. Everyone is feeling proactive and well-prepared as they focus on staff readiness for their upcoming survey window.		
7. POLICIES & PROCEDURES	*Louise Wyatt, RN JD*	INFORM
The committee reviewed and minor revisions were agreed upon to clarify clinical language.		
8. ADJOURN	*Daniel Kittleson, DDS*	Adjourned at 6:02 p.m.
CLOSED SESSION: Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Alex Rainow, MD*	ACTION
Motion to approve by Mainardi, 2nd by Lee Myatt. Six in favor, zero opposed.		

Document Tasks By Committee

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

Sonoma Valley Hospital

Run by: Reese, Whitney (wreese)
Run date: 05/04/2026 4:43 PM

Report Parameters

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

Grouped by: Committee

Sorted by: Document Title

Report Statistics

Total Documents: 2

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
Preventive Maintenance Program *Care of the Physical Environment (CE)*	**Pending Approval**	4/7/2026	27

Summary Of Changes: **Removed specific lists of equipment types. Removed bio-medical Engineering references as that is outlined in its own policy – Clinical Engineering Equipment Safety/PM Program CE8610-108.**

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)**

Document	Task/Status	Pending Since	Days Pending
RETIRE: HIPAA Security – Evaluation Policy *HIPAA policies*	**Pending Approval**	4/7/2026	27

Summary Of Changes: **Retire. This policy is superficial, redundant, and covered in the policy HIPAA Security Audit Control (IM8480-402)**

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)**

To:	SVHCD Governance Committee
From:	Patrick Okolo III, MD, Chief Medical Officer
Date:	May 6, 2026
Subject:	Medical Staff Bylaw update

Medical Staff Bylaw update April 2026:

This revision is the most comprehensive update to the Medical Staff Rules and Regulations since the document's original adoption in 2017. It brings the Rules into full alignment with CMS Conditions of Participation, CIHQ accreditation standards, and California law — and closes structural gaps the prior version left unaddressed. Four areas of change are summarized below.

Institutional Scope and Regulatory Alignment

Out-of-Scope Notices now formally document that obstetric services are not offered at SVH and that the on-campus SNF operates under separate governance — resolving a longstanding ambiguity. Admissions procedures have been updated with explicit EMTALA cross-references and a restructured attending physician responsibility framework. Consent and refusal-of-treatment provisions have been expanded to reflect current California law, and a new annual conflict-of-interest disclosure requirement has been added for all Medical Staff members, with compliance tied to reappointment.

Physician Coverage and ED Call Obligations (New Rules 5 and 6)

Two new rules codify coverage standards that were previously informal. Rule 5 establishes a 30-minute on-call response requirement, prohibits redirecting established patients to the ED without prior agreement, and creates a clear escalation path to the CMO when coverage gaps arise. Rule 6 governs ED call panel structure, embedding EMTALA compliance obligations and advance-notice requirements directly into the Rules.

Credentialing, Performance Evaluation, and Allied Health (Rules 8 and 10)

Rule 8 replaces the 2017 document's basic credentialing procedures with fully developed FPPE and OPPE frameworks — specifying data elements, review frequency, and threshold-for-action criteria tied to the six ACGME competency domains. This gives the Medical Staff a defensible, data-driven foundation for performance oversight. Rule 10 has been comprehensively rewritten to establish specific credentialing criteria, supervision requirements, and insurance minimums for NPs, PAs, RNFAs, and CRNAs.

Committee Structure, Emergency Management, and Governance (Rules 9, 18, and 19)

Rule 9 formalizes the charters of the Peer Review, Performance Improvement, and a newly established Well-Being Committee — the latter reflecting current accreditation expectations around physician wellness. Rule 18 codifies Medical Staff obligations during declared emergencies, including the Chief of Staff's authority to direct patient care in a disaster. Rule 19 establishes an annual review cycle for the Rules and grants the MEC authority to adopt interim policies between cycles, subject to Board ratification.

These revised Bylaws have been approved by The Medical Executive Committee and are presented to the Board for final adoption.

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

MEDICAL STAFF BYLAWS

2026

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT

MEDICAL STAFF BYLAWS

Table of Contents

- Active, Courtesy, Consulting, APP, and Emeritus Staff

Rule 8: Appointment & Professional Practice Evaluation

- 8.2–8.7 Application, Health Attestation, and Action Process
- 8.8–8.9 Duration and Reappointment Process
- 8.10 Focused Professional Practice Evaluation (FPPE)
- 8.11 Ongoing Professional Practice Evaluation (OPPE)

Rule 9: Medical Staff Committees

- 9.A–C Medicine, Surgery, and Anesthesia Departments
- 9.D Performance Improvement Committee (PIC)
- 9.E Bioethics Committee
- 9.F Bylaws Committee

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:
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 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.
- 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.

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 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 in conjunction with the nursing unit manager or supervisor.
1.9 Skilled Nursing Facility – Separate Governance
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.

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

210.1 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:

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.

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.

An Incident Report shall be completed and forwarded to the Hospital Risk Manager if treatment is ultimately refused.

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.

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 a Hospitalist or Internist with admitting privileges.

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.

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.

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)

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)

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 obligation.

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.

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.

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.

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.

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.

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:

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

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.

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:

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.

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 _____ | Revised per CMS CoP & CIHQ Standards

BYLAWS

of the

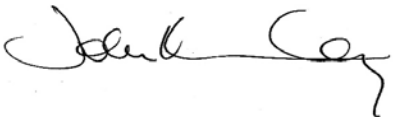
SONOMA VALLEY HEALTH CARE DISTRICT

Sonoma, California

BYLAWS
of the
SONOMA VALLEY HEALTH CARE DISTRICT

~~**Approved by the**~~ **Board of Directors** ~~**April 6**~~xxxx, ~~**2023**~~2026

~~**Judith Bjorndal**~~Wendy Lee Myatt, SVHCD Board **Chair**



~~**John Hennelly**~~Kelley Kaiser, **President and Chief Executive Officer Sonoma Valley Hospital**

Orig. Date:	*10.31.90*		
Revised:	02.27.91	12.06.06	08.04.16
	12.02.92	05.30.07	01.11.18
	01.05.94	07.01.09	06.04.20
	07.30.97	11.05.09	09.02.21
	01.08.03	09.02.10	04.06.23
	02.28.03	10.07.10	05.06.26
	02.25.04	02.03.11	
	06.29.05	12.01.12	
	09.27.06	03.06.14	

TABLE OF CONTENTS

Bylaws of the Sonoma Valley Health Care District

Article I Preamble

These District Bylaws are adopted by the Sonoma Valley Health Care District (the District) Board of Directors (the Board) pursuant to and consistent with Division 23 of the Health and Safety Code of the State of California, known as "The Local Health Care District Law." These District Bylaws are established to further enable the Board to faithfully exercise its powers and fiduciary duties in accordance with applicable law. The Board-approved Policies shall be used to assist further in implementing the responsibilities of the Board.

Section 1. Mission

The Mission of the Sonoma Valley Health Care District is to maintain, improve, and restore the health of everyone in our community.

This mission is pursued subject to available financial and human resources and leadership consistent with the Local District Health Care Law of California. The District sets forth Core Values as a framework to provide operational guidance for achieving its mission.

The Core Values of the Sonoma Valley Health Care District are that those who live in Sonoma Valley will experience outstanding health care because:

a. There will be direct access to appropriate care when needed and overall health will be coordinated in a comprehensive fashion.
b. Care will show respect and honor the dignity of everyone.
c. The available services will (a) match the needs of the community, (b) be fiscally sustainable, and (c) meet or exceed all quality standards.
d. Wise stewardship will be exercised regarding the District's financial resources to ensure stability, agility, and prudent growth.
e. Partnerships with physicians, other healthcare providers, and payers will extend the range of available services and conserve resources.
f. We will feel informed and proud of the quality of health care available in the District.

Section 2. Relationships

The Board recognizes that it is most effective in maintaining, improving, and restoring the health of everyone in our community when it works in collaboration with others. Among our partners are the community, the Hospital, the medical community, other healthcare providers such as the Sonoma Valley Community Health Center and UCSF Health, and the Sonoma Valley Hospital Foundation. Although the responsibilities of the Board are set forth in our public trust as the duties of fiduciary responsibility and care and in state law, it is the intent of the Board to maximize its impact on health by building strong, cooperative relationships.

a. The Community

The Board is publicly elected to represent the collective interests of all people in the District, regardless of whether they may be patients at the Hospital. That trust is exercised by inquiring and listening to the concerns of the entire community regarding health care expectations, community resources that might be available, and matters of good organizational citizenship. It is also the Board's responsibility to ensure that the public is informed about its own health and the operations of the Hospital and other healthcare services. The public is also welcome and encouraged to monitor District operations and policy and participate in the discussion of the public actions of the Board. It is the intent of the Board to honor the full spirit of transparency in its work.

b. The Hospital

The major resource available to the Board for serving the community's health needs is Sonoma Valley Hospital. This is an Acute Care, community hospital providing emergency care, in-patient and ambulatory (inpatient) acute care, post-acute care, therapy, diagnostics, and related services. It serves the community by providing prompt response to acute health needs and coordination of care and by providing resources to the medical community.

c. The Medical Staff

Physicians are a self-governing community of peers who set standards for quality of care and professional conduct. Some of these professionals are Hospital employees; most are not. The community is best served when an appropriate mix of practitioners is free to reach professional excellence, with the Board providing required oversight and necessary resources. The physicians accredited at the Hospital are governed by the Medical Staff Bylaws which are reviewed every three years.

d. Other Healthcare Providers

The District recognizes that maintaining, improving, and restoring the health of everyone in our community involves collaboration with the entire health care community. Individuals who have insurance plans that involve providers outside the Valley who use only the Hospital's emergency or diagnostic and support services are included in our mission. So are those who use the services of other local providers and are referred to Sonoma Valley Hospital for supportive care. Patients of the Hospital can expect that their care will include referral for advanced treatment at Bay Area hospitals that offer specialized services. The District works with local adjunctive services to ensure a supportive community environment.

e. Sonoma Valley Hospital Foundation

Though not a healthcare provider as such, the District recognizes the indispensable role being played by the Sonoma Valley Hospital Foundation as an independent and self-governed entity in funding certain capital requirements and other defined needs of the Hospital as may be determined and coordinated between the two organizations from time to time.

Article II The Board as a Legal Entity

The name of the District shall be the Sonoma Valley Health Care District (the District).

The principal office for transacting business and maintaining records of the Sonoma Valley Health Care District shall be the Sonoma Valley Hospital (the Hospital), located at 347 Andrieux Street, Sonoma, California 95476. The District also maintains a website at ~~http://~~www.sonomavalleyhospital.org.

Section 1. Powers

The Board shall have accountability and authority for those powers set forth in the Local Health Care District Law of California [California Health and Safety Code (H&S) 32,000] that are necessary for fulfilling its mission. These shall include, but are not limited to the following abilities to:

a. Form a medical staff to be known as "The Medical Staff of Sonoma Valley Hospital"; such medical staff shall be self-governing, subject to the District Board's final approval

of members and their privileges, hospital rules for quality of patient health and safety, indemnification of practice, and Medical Staff Bylaws [California Health and Safety Code (H&S) 32128, 32129].

b. Recruit and manage such volunteers from the community, serving without compensation, as may be needed from time to time to support the Hospital and the District.

c. Hire, direct, evaluate, and terminate if necessary, the President and Chief Executive Officer of the Hospital and any other individuals neither working for the Hospital or reporting directly to the Chief Executive Officer but necessary for meeting the Mission of the District [H&S 32121].

d. Enter into contracts for provision of health care and make certain resources are available to medical staff members who are serving the community [H&S 32121, 32129].

e. Establish and maintain standards for quality of care in facilities under the District's direction [H&S 32125].

f. Create entities or enter into contractual relationships with existing entities useful for promoting the District's Mission [H&S 32121, 32131].

g. Acquire, lease, manage, and dispose of real assets for the purpose of meeting its Mission [H&S 32121, 32123, 32126].

h. Authorize the purchase, lease, management, and disposal of capital and other equipment needed to meet its Mission [California Health and Safety Code 32122, 32132].

i. Place before the public for vote parcel tax and bond measures to finance healthcare services and facilities [H&S 32127].

j. Sue and be sued and exercise related actions as a corporate entity [H&S 32121].

k. Manage its financial assets in a responsible fashion, including authorization for borrowing funds and letting of contracts [H&S 32127, 32130, 32132, 32133, 32136, 32138].

l. Create committees, develop policy, and take other actions necessary to enhance the mission of the District [H&S 32121].

m. Receive input from the public and inform the public regarding matters related to the operation of the District.

The Board exercises its responsibilities through setting goals, conducting periodic self-evaluations, assessing the healthcare environment and performance of the hospital, and when appropriate, initiating responsive action. All District powers shall only be exercised pursuant to specific delegation by the Board of Directors.

Section 2. District Bylaws as Basis of Authority

a. Amendment

These District Bylaws shall be reviewed ~~bi-annually~~biennially at the beginning of even numbered years. They may be changed by an affirmative vote of at least three Board members at a regularly scheduled board meeting.

b. Relationship to Other Bylaws

The Bylaws of the Sonoma Valley Health Care District Medical Staff (the Medical Staff) are understood to be a subset of the District Bylaws with respect to their relationship with the District. Any action or procedure that is required, allowed, or prohibited in the Medical Staff Bylaws will also be required, allowed, or prohibited in the District Bylaws. The District Board and the Medical Staff shall consult on any proposed changes in either document that may affect both groups. Changes in the Medical Staff Bylaws shall be approved by the District Board; changes in District Bylaws that may affect the Medical Staff require corresponding revision of the Medical Staff Bylaws. In any case where there is a conflict between the Medical Staff Bylaws and the District Bylaws, the District Bylaws shall be controlling.

Article III Board of Directors

Section 1. Members

a. Selection

The Board shall consist of five members, having permanent residence in the District and elected by the public from registered voters of the District in accordance with California Health and Safety Code Section 32100. Three members shall be elected in years evenly divisible by four and two members shall be elected in alternating even-numbered years. In the event of a Board vacancy, a new Board member shall be appointed to fill the vacated position from applying individuals who meet qualification for election by vote of the remaining Board members in a publicly noticed and open meeting. The appointed Board member shall serve until the next general election returns are certified by the registrar of voters unless the vacancy occurs in the first half of the director's term, but less than 130 days prior to the next general election. In this case the appointed director shall serve the balance of the term. (Section 1780 of the California Government Code)

b. Fiduciary Responsibilities

Board members have fiduciary responsibilities to the District. Those living in the District trust the Board to act on their behalf.

(1) The duty of care requires that Board members act toward the District with the same watchfulness, attention, caution, and prudence that a reasonable person in the circumstances would. The duty of loyalty requires that Board members not place their personal interests above those of the District.
(2) Board members shall comply with the District's Conflict of Interest Code as detailed in the Board Policies.
(3) The only actions of the Board are those agreed by a majority of Board members in publicly noticed meetings that are consistent with state law and regulations. Diversity of informed and well-articulated opinion among Board members is expected while questions are open before the Board.
(4) Board members respect privacy of information by not requesting or seeking to obtain information that is not authorized or necessary for conducting the business of the Board. Board members respect confidentiality by not revealing information to others who are not legally authorized to have it or which may be prejudicial to the good of the District. Board members respect information security by requesting and monitoring policies that protect the privacy of individuals served by or doing business with the District.

c. Personal Qualifications

In their service to the District, Board members are expected to

(1) Actively promote the mission of the District: to maintain, improve, and restore the health of everyone in our community.
(2) Devote sufficient time to their duties to ensure they are fully knowledgeable regarding matters about which the Board deliberates
(3) Provide respectful, positive, independent input into the group decision making process
(4) Seek input from the community and represent the District to the community as ambassadors
(5) Maintain a high level of personal integrity

Section 2. Officers

The officers of the Board and their duties shall consist of the following:

a. Chair

(1) Serve as the Board's primary liaison with the Chief Executive Officer and with the press and the public
(2) Prepare the Board agenda and request necessary support materials for meetings
(3) Conduct meetings of the Board
(4) Sign documents as authorized by the Board
(5) Appoint members to committees subject to approval by a majority of the Board
(6) Coordinate the Board's performance evaluation of the President and Chief Executive Officer
(7) Coordinate the Board's annual self-evaluation and annual retreat process

b. First Vice Chair

(1) Serve in the capacity of the chair when necessary or as delegated
(2) Serve as the permanent Board representative on the Joint Conference Committee of the Medical Executive Committee

c. Second Vice Chair

(1) Serve as chair or member of the Board Quality Committee
(2) Serve in the capacity of the chair when necessary or as delegated

d. Secretary

(1) Direct that minutes, records, and other support material are prepared and made available in a timely fashion
(2) Serve or cause to be served all notices of the board
(3) Sign~~,~~ documents as authorized by the Board
(4) Serve as chair or member of the Board Governance Committee

e. Treasurer

(1) Serve as chair or member of the Board Finance Committee

Section 3. Elections

Officers will be elected at the first regular Board meeting in December of each year for a term of one year. Election is by majority vote of the members of the newly- installed Board in even numbered years and by majority vote of existing members in odd numbered years. Officers may be elected to consecutive terms. In the event that the Board fills a vacant position, it may decide either to confirm the new Board member in the previous Board member's office or conduct a new set of elections.

Section 4. Committees

The Board may create committees in order to facilitate its business and to ensure access to expertise and citizen input. All committees shall be advisory to the Board and have no authority to make decisions or take actions on behalf of the Board unless specifically delegated by the Board. A committee is created or disbanded by majority vote of the Board.

a. Types of Committees

(1) Standing Committees assist the Board by gathering information, evaluating proposals and policies, and making recommendations regarding key and continuous or regularly recurring functions of the District, and are subject to Ralph M. Brown Act provisions. The Board Standing Committees shall be:

i. Finance & Audit Committee
ii. Quality Committee
iii. Governance Committee
iv. Affiliation Oversight Committee

(2) ~~Advisory~~ Temporary advisory Committees ("Ad Hoc") may be established to study and make recommendations to the Board on specific matters. The scope of such committees shall be for a limited purpose and shall ~~not be of continuous or on-going nature~~be dissolved when their assigned work is completed. ~~Upon determination by the Board that the period for advice has passed or upon acceptance of the Advisory Committee's written report by the Board, the Advisory Committee shall be disbanded.~~ A temporary Advisory Committee~~s~~ shall be comprised of two Board members and are not subject to Brown Act provisions.

(3) Members of Standing Committees and Advisory Committees shall be residents of the District or practitioners or business owners having their primary activity within the District.

Formatted: Normal, Line spacing: Multiple 1.15 li

(4) Community members of Advisory Committees may serve up to four years with the option to be reappointed.

b. Types of Meetings

Meetings of the Board and its standing Committees are conducted in accordance with the Ralph M. Brown Act (the Brown Act). A quorum for the Board or for its standing committees shall consist of a majority. Agendas for regular Board and standing committee meetings will be available 72 hours in advance of meetings, and for special meetings 24 hours in advance, giving the date, time and location of meetings. No action will be taken concerning an item not previously noticed on the published agenda. Exceptions exist in the case of an emergency where the majority of the Board determines that an emergency exists (Government Code 54956.5), in which case there is a need to take immediate action. The other exception is if a regular or special meeting is appropriately noticed and the need for urgent action came to the attention of the District subsequent to the agenda being posted. In that case, if two-thirds of the Board members present vote (or there is a unanimous vote if less than two-thirds are present) that there is a need to take immediate action. Public comment will be invited and considered at all open meetings (regular, emergency and special Board meetings and standing committee meetings), and meeting agendas, support materials, and minutes will be available to the public.

(1) Emergency Board meetings can be called on one hour's notice by the Chair or any Board member. News media that has submitted a prior written request for notification of emergency meetings shall be notified in advance of the meeting.

(2) Special Board meetings may be called by any two Board members with 24 hours' notice and are subject to rules applying to regular meetings. News media that has submitted a prior written request for notification of special meetings shall be notified in advance of the meeting.

(3) Closed Board meetings may be held for purposes of considering the appointment, employment, evaluation of performance, discipline, dismissal or to hear complaints or charges concerning a Hospital employee or member of the Medical Staff; in consideration of pending litigation; or in matters of negotiations concerning real property, labor contracts, or discussion of trade secrets. Closed meetings shall be announced, conducted, and reported in accordance with the Brown Act, and the public may not participate. Standing committees may hold closed meetings if their charter or Board delegation includes issues allowing closed meetings.

c. Participation of Directors on Standing Committees

No more than two Board members shall be appointed to serve on any Standing Committee at one time. Other Board members may attend standing Committee Meetings as members of the public at any time. In the event of the absence of a regular Board member on a Standing Committee, the Chair of the Board, or in succession, the Chair of the Standing Committee may designate other Directors to serve in the capacity of absent Board committee members. All appointed members of Board committees, including *ex officio* appointments and recognized alternates shall be voting members and shall count toward establishing a quorum. Board members who attend standing committee meetings as members of the public may not participate in the discussions to avoid a possible violation of the Brown Act.

Section 5. Compensation

Each member of the Board of Directors shall be allowed his/her necessary traveling and incidental expenses incurred in the performance of official business of the District pursuant to the Board's policy.

Section 6. Indemnification

a. Any person made or threatened to be made a party to any action or proceeding, whether civil or criminal, administrative or investigative, by reason of the fact that he/she, his/her estate, or his/her personal representative is or was a Director, officer or employee, of the District, or an individual (including a medical staff appointee or committee appointee) acting as an agent of the District, or serves or served any other corporation or other entity or organization in any capacity at the request of the District while acting as a Director, officer, employee or agent of the District shall be and hereby is indemnified by the District, as provided in Sections 825 et~~.~~ seq. of the California Government Code.

b. Indemnification shall be against all judgments, fines, amounts paid in settlement and reasonable expenses, including attorney's fees actually and necessarily incurred, as a result of any such action or proceeding, or any appeal therein, to the fullest extent permitted and in the manner prescribed by the laws of the State of California, as they may be amended from time to time, or such other law or laws as may be applicable to the extent such other law or laws is not inconsistent with the law of California, including Sections 825 et. seq. of the California ~~government~~ Government Code.

c. Nothing contained herein shall be construed as providing indemnification to any person in any malpractice action or proceeding arising out of or in any way connected with such person's practice of his or her profession

Article IV Delegation of Authority

The Board honors the distinction between governance and management. The Board shall exercise its responsibilities for oversight by operating at the policy level, setting strategic direction and goals, monitoring key outcomes, and taking corrective action where needed.

Section 1. Chief Executive Officer

The District employs or contracts with a President and CEO for the Hospital who acts on behalf of the District within the constraints of the Board Bylaws and Board Policies set by the Board. The Board delegates to the President and CEO the authority to perform the following functions:

a. Manage the District's human, physical, financial, knowledge, and community good will resources in support of the District's Mission to maintain, improve, and restore the health of everyone in our community
b. Manage the activities and resources of the Sonoma Valley Hospital
c. Ensure that the hospital complies with applicable laws, regulations, and standards
d. Provide supporting resources to the Board and its committees as requested
e. Support the operations of the Board by providing reports, general information, staff support, and other resources
f. Annually, create a draft update on the District's rolling Three -Year Strategic Plan and the Budget
g. Promote awareness of the hospital, good will in the community, and philanthropic support
h. Serve as the contact executive in affiliation agreements with other district hospitals, physician foundations, and other healthcare partners
i. Negotiate, sign, monitor, and terminate or renegotiate contracts.
j. Sign checks to meet the District's financial obligations in accordance with Board Policy.
k. Execute and sign borrowing notes as authorized by the Board.
l. Discharge these functions in a positive, legal, and ethical fashion so as to bring respect to the District
m. Carry out directives from the Board

Section 2. Medical Staff

a. Establishment of a Medical Staff

There shall be a Medical Staff for the Hospital established in accordance with the requirements of the Local Healthcare District Law [California Health and Safety Code **HSC § 32000**~~(H&S) 32,000~~], whose membership shall be comprised of all physicians, dentists and podiatrists who are duly licensed and privileged to admit or care for patients in the Hospital. The Medical ~~staff~~ Staff shall be an integral part of the Hospital. The District shall appoint the Medical Staff by approving their credentialing. The Medical Staff shall function in accordance with the Medical Staff Bylaws, Rules and Regulations and Policies that have been approved by the Medical Staff and by the District.

The Medical Staff shall be represented as described in Article IV of these Bylaws and shall be afforded full access to the District through the Board's regular meetings and committees as described herein. The Medical Staff, through its officers, department chiefs, and committees, shall be responsible and accountable to the District for the discharge of those duties and responsibilities set forth in the Medical Staff's Bylaws, Rules and Regulations, and Policies and as delegated by the District from time to time.

b. Bylaws, Rules, and Regulations

The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Bylaws and Rules and Regulations, consistent with these District Bylaws, applicable laws, government regulation, and accreditation standards. The Medical Staff Bylaws, Rules and Regulations and all amendments thereto, shall become effective upon approval by the Medical Staff and the District. Whenever there is a reference in the Medical Staff Bylaws, Rules and Regulations, to the "Board of Directors" or "the District," that term shall refer to and be considered as the Sonoma Valley Health Care District as described in Article I of these Bylaws.

c. District Action on Membership and Clinical Privileges

(1) Medical Staff Responsibilities: The Medical Staff is accountable to the District for the quality of care, treatment and services rendered to patients in the Hospital. The Medical Staff shall be responsible for investigating and evaluating matters relating to Medical Staff membership status, clinical privileges, and corrective action, except as provided in Article 4 of the Medical Staff bylaws. The Medical Staff shall adopt and forward to the District specific written recommendations, with appropriate supporting documentation, that will allow the District to take informed action. When the District does not concur with a Medical Staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and

applicable law before the District renders a final decision. The District shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the District.

(2) Criteria for District Action: The process and criteria for acting on matters affecting Medical Staff membership status and clinical privileges shall be as specified in the Medical Staff Bylaws.

(3) Terms and Conditions of Staff Membership and Clinical Privileges: The terms and conditions of membership status in the Medical Staff, and the scope and exercise of clinical privileges, shall be as specified in the Medical Staff bylaws unless otherwise specified in the notice of individual appointment following a determination in accordance with the Medical Staff Bylaws.

(4) Initiation of Corrective Action and Suspension: Where in the best interests of patient safety, quality of care, or the Hospital staff, the District may take action subject to the standards and procedures in the Medical Staff Bylaws, Rules and Regulations and applicable law.

i. The Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member subject to the standards and procedures in the Medical Staff Bylaws, Rules and Regulations and applicable law.

(5) Fair Hearing and Appellate Procedures: The Medical Staff Bylaws shall establish fair hearing and appellate review mechanisms in connection with Staff recommendations for the denial of Staff appointments, as well as denial of reappointments, or the curtailment suspension or revocation of privileges. The hearing and appellate procedures employed by the District upon referral of such matters shall be consistent with the Local Healthcare District Law [California Health and Safety Code (H&S) 32,150~~,~~ and those specified in the Medical Staff Bylaws, Rules and Regulations.

d. Accountability to the District

The Medical Staff shall conduct and be accountable to the District for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the Hospital.

e. Documentation

The District shall receive and act upon the findings and recommendations emanating from the activities required by Article IV, Section 2(d). All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the District can take appropriate action.

Section ~~6~~3. Contractual, Collaborative and Affiliation Relationships

The District may enter into contractual, collaborative and affiliation relationships with other Districts, provider organizations, or consortia in order to share resources and improve access to care to better serve the needs of those in the Valley.

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE SONOMA VALLEY HEALTH CARE DISTRICT
AND
THE SONOMA VALLEY HOSPITAL FOUNDATION FOR FUND RAISING ACTIVITIES

This Agreement is made and executed in Sonoma, California, on February 10, 2026, by and between the Sonoma Valley Health Care District (hereinafter referred to as "District"), a District duly organized and existing under the Local Health Care District Law of the State of California (California Health and Safety Code, Division 23, Sections 32000-32492), with its principal place of business at Sonoma, California and the Sonoma Valley Hospital Foundation, a hospital foundation organized and operating as a tax-exempt 501(c)(3) corporation with its principal place of business at Sonoma, California (hereinafter referred to as "Foundation"). The District and the Foundation may be referred to herein as "Party" or "Parties." The District and the Foundation desire to enter into this Agreement for fund raising activities with respect to the following:

RECITALS

Whereas, the District and the Foundation agree that significant philanthropic support is needed to continue to provide patient-focused, state-of-the-art health care and health-related programs to residents and visitors in its service area; and

Whereas, the District and the Foundation agree that such support can most effectively be garnered through a hospital foundation operated as a 501(c)(3) corporation, and as such an organization, the Foundation is best suited to provide and develop philanthropic support for the District; and

Whereas, the District and the Foundation agree that in order to provide and develop philanthropic support for the District, the Foundation will develop and implement a fund development program in support of health care for residents and visitors of the District.

Now therefore, in consideration of the promises and the mutual covenants herein contained, and for other good and valuable consideration, it is agreed:

1. Responsibilities and Mutual Expectations

A. Responsibilities of the Foundation

i. The Foundation will develop, implement and refine a rolling three-year philanthropic strategic plan to maximize community support for the health care of the residents and visitors of the District.
ii. The Foundation will continue to work with the Hospital and District leadership to determine annual and longer term goals and mission.
iii. The Foundation agrees to support the capital, program, and other needs of District-owned facilities and District-operated programs.
iv. The Foundation shall ensure there are two (2) ex-officio directors on the Foundation Board. Ex-officio directors shall be selected as follows: one shall be selected by the Board or Directors of the District; one shall be selected by the CEO of the Hospital.
v. The Foundation will accept and process all gifts in accordance with all applicable laws and regulations.
vi. The Foundation shall operate according to fundraising best practices and ethical

standards.

vii. The Foundation shall make its books and records available to the District and its agents for review and inspection upon reasonable written notice and at reasonable times.

viii. The Foundation shall present annually a report of its activities, funding, and otherwise to the Board of Directors of the District.

B. Responsibilities of the District.

i. The District will direct all charitable contributions in support of the District to the Foundation for acceptance and gift processing. If unusual circumstance requires a gift to be accepted directly by the District, the District will do so in accordance with the Foundation's Gift Acceptance Policy. (see attachment)

ii. The District agrees to honor donor instructions by using the restricted funds it receives from the Foundation only for the purposes intended by the donor.

iii. The District shall select one (1) ex-officio director on the Foundation Board, as described in Section 1.A.iv above.

iv. The District agrees to make all books and records pertinent to the Foundation available to the Foundation for review and inspection upon reasonable notice and at reasonable times.

v. The District shall be responsible for funding 50% of the cost for annual independent audits of the Foundation's financial statements.

2. Request for and Transfer of Funds

A. All grant funding requests for the District from the Foundation will be submitted in writing to the Foundation and have the Hospital CEO's written approval. The Foundation agrees to review grant requests submitted by the CEO within sixty (60) calendar days of receipt.

B. If a grant is approved by the Foundation Board, the Foundation will notify the primary project contact, as indicated on the grant application, within seven (7) calendar days of approval.

C. If a grant is denied by the Foundation Board, explanation of the Board's decision will be submitted in writing to the Hospital CEO within seven (7) calendar days, of denial.

D. Grants approved by the Foundation Board will be paid within thirty (30) days of receiving request for payment, which shall be submitted in writing by the Hospital CEO or Accounting Department and shall be accompanied by the corresponding invoice or purchase order..

3. Funding Cost of Foundation Operations

A. Based on a budget approved by the Foundation Board, the Sonoma Valley Hospital will assist in funding an agreed upon portion of operating expenses of the Foundation.

4. Terms and Termination

A. *Term.* The term of this Agreement shall automatically renew at midnight on June 30 of

each calendar year unless either Party exercises their right to terminate the Agreement under Section B below.

B. *Termination.* This Agreement may be terminated by either Party, with or without cause, by giving sixty (60) days written notice as provided in Paragraph 11 of this Agreement.

C. *Dissolution and Distribution* of *Assets.* In the event that this MOU is terminated or the Foundation is dissolved by the Foundation Board, all properties, monies, and assets will be distributed as outlined in section four of the Foundation's Articles of Incorporation.

5. **Negotiation and Mediation Clause**. In the event of a disagreement or dispute between the Parties arising out of or connected with this Agreement, the disputed matter shall be resolved as follows:

A. *Negotiation.*

i. The parties shall attempt in good faith to promptly resolve any dispute arising out of or relating to this Agreement by negotiation between the District and Foundation Board Chairs. Any party may give the other party written notice of any dispute not resolved in the normal course of business. Within 15 days after delivery of the notice, the receiving party shall submit to the other a written response. The notice and response shall include with reasonable particularity (a) a statement of each party's position and a summary of arguments supporting that position, and (b) the name and title of the executive who will represent that party and of any other person who will accompany the executive. Within 30 days after delivery of the notice, the chairs of both parties shall meet at a mutually acceptable time and place.

ii. Unless otherwise agreed in writing by the negotiating parties, the above described negotiation shall end at the close of the first meeting of chairs described above ("First Meeting"). Such closure shall not preclude continuing or later negotiations, if desired.

iii. All offers, promises, conduct and statements, whether oral or written, made in the course of the negotiation by any of the parties, their agents, employees, experts and attorneys are confidential, privileged and inadmissible for any purpose, including impeachment, in arbitration or other proceeding involving the parties, provided that evidence that is otherwise admissible or discoverable shall not be rendered inadmissible or non-discoverable as a result of its use in the negotiation.

iv. At no time prior to the First Meeting shall either side initiate an arbitration or litigation related to the Agreement except to pursue a provisional remedy that is authorized by law or by agreement of the parties. However, this limitation is inapplicable to a party if the other party refuses to comply with the requirements of Paragraph i above.

v. All applicable statutes of limitation and defenses based upon the passage of time shall be tolled while the procedures specified in Paragraphs i and ii above are pending and for 15 calendar days thereafter. The parties will take such action, if any, required to effectuate such tolling.

B. Mediation.

i. If the matter is not resolved by negotiation pursuant to paragraphs i -v above, then the matter will proceed to mediation as set forth below.
ii. Either party may commence mediation by providing the other party a written request for mediation, setting forth the subject of the dispute and the relief request.
iii. The parties agree that any and all disputes, claims or controversies arising out of or relating to this Agreement shall be submitted for mediation.
iv. The parties will cooperate in selecting a mediator and in scheduling the mediation proceedings. The parties agree that they will participate in the mediation in good faith and that they will share equally in its costs.
v. All offers, promises, conduct and statements, whether written or oral, made in the course of the mediation by any of the parties, their agents, employees, experts and attorneys, and by the mediator, are confidential, privileged and inadmissible for any purpose, including impeachment, in any arbitration or other proceeding involving the parties, provided that evidence that is otherwise admissible or discoverable shall not be rendered inadmissible or non-discoverable as a result of its use in the mediation.

6. **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of California.

7. **Forum.** Any mediation to enforce or interpret the provisions or this Agreement or the Parties' rights and liabilities arising out of this Agreement or the performance hereunder shall be maintained only in the County of Sonoma, California, or within one or such County's incorporated cities.

8. **Severability.** If any provision of the Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force and effect without being impaired or invalidated in any way.

9. **Integration.** This Agreement contains the entire agreement among the Parties and supersedes all prior and contemporaneous oral and written agreements, understandings, and representations among the Parties. No amendments to this Agreement shall be binding unless executed in writing by all of the Parties.

10. **Waiver.** No waiver of any of the provisions of this Agreement shall be deemed, or shall constitute a waiver of any other provision, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in writing by the Party making the waiver.

11. **Notices**. Any notice required by this Agreement shall be effective only if sent by certified or registered mail, postage prepaid, as follows:

If to District:
Chair, Board of Directors and President/CEO
Sonoma Valley Hospital, 347 Andrieux St, Sonoma, CA 95476

If to Foundation:
Chair, Board of Directors and Executive Director
Sonoma Valley Hospital Foundation, 347 Andrieux St, Sonoma, CA 95476

For the purpose of determining compliance with any time limit in this Agreement, a notice shall be deemed to have been duly given on the second business day after mailing, if mailed to the Party to whom notice is to be given in the manner provided in this Section. Either Party may, at any time, change its address designated above by giving to the other Party thirty (30) days' written notice of the new address to be used for the purposes of this Section.

12. **Assignability.** Neither this Agreement nor any duties or obligations hereunder shall be assignable by any Party hereto without the prior written consent of the other Parties.

In witness whereof, the Parties have executed this Agreement as of the date first above written.

Sonoma Valley Health Care District

By:_____ Date:_____
Wendy Lee Myatt, Chair, Board of Directors

Sonoma Valley Hospital Foundation

By: _____ Date:_____
Lindsay Bennett, Chair, Board of Directors

SUBJECT: Affiliation Oversite Committee Charter	PAGE 1 of 3
REVISED: 05.06.26	EFFECTIVE: 05.08.26

PURPOSE:

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

The AOC's purpose is to assist the BOD in its oversight of SVHCD's collaboration with UCSF Health (UCSF), including the review of progress made towards the goals of the ~~Collaboration~~ amended and restated Affiliation Agreement (the "Agreement") ~~entered into~~signed by SVHCD and UCSF in ~~December~~ March of ~~2020~~2026. The AOC will coordinate with and review the progress of the Joint Operations Committee (the "JOC") in the process of updating and making recommendations to BOD on all decisions relating to the affiliation between the two organizations.

RESPONSIBILITIES:

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

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

POLICY:

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

Oversight

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

To this end the AOC shall:

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

PROCEDURE:

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

Required Annual Calendar Activities

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

SUBJECT: Affiliation Oversite Committee Charter	PAGE 3 of 3
REVISED: 05.06.26	EFFECTIVE: 05.08.26

Rules

Charter Review:	Will be reviewed/revised, at a minimum, every three years. Changes will be submitted to the BOD of Directors for approval.
Authority to Act:	In compliance with the Charter and as directed by Executive Leadership and the BOD
Meeting Schedule:	At least two meetings per year

~~Voting~~ Members:	The AOC shall be comprised of ~~have at least four voting~~two SVHCD Board members and two UCSF Health liaisons.
	• Two BOD members, one being the BOD Chair
	  ~~o~~ One of whom shall be the AOC chair, the other the vice-chair
	• Two representatives from UCSF
	  o UCSF Health President, Affiliates Network and an additional designee

Quorum Requirement:	~~Half plus o~~One member and at least one liaison present.
Chair:	BOD Chair
Composition:	~~Voting~~ Committee Members, SVHCD liaisons, and the Sonoma Valley Hospital CEO, who will provide all materials for review by the AOC.

Formatted: Font: 11 pt

Formatted: Don't allow hanging punctuation, Font Alignment: Baseline

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

Dave Pier

Sonoma, CA
Phone: 707.320.3017 E-Mail: davepier@gmail.com

LinkedIn: http://www.linkedin.com/in/dave-pier-72913210

Objective

Become a member of SVHCD finance committee

Experience

Larry L. Hillblom Foundation, Executive Director [2024-present]

Manage all aspects of philanthropic foundation that primarily supports medical research in California, with a focus on age degenerative diseases and diabetes.

Sonoma Valley Hospital Foundation, Executive Director [2015-2024]

Led the rebuilding of the organization through Board development and community outreach. Responsible for all aspects of the organization including community relations & fundraising, grant making and oversight, strategic vision and planning, board development, staff development, governance, and fiscal oversight. Positioned SVHF for success through leading, planning, and executing all phases of a $21 million capital campaign for a diagnostic center. Improved ongoing relationships and trust with key stakeholders through relationship building. Led successful branding initiative for the hospital. Established as an integral member of the hospital's executive team.

Boys & Girls Clubs of Sonoma Valley, CEO [2007-2015]

Supervised and led all aspects of a $2.4M organization including 50 staff and 36 volunteer board and committee members. Built excellent community relations, driving a collaborative approach to program impact. Led the organization from precarious standing in 2007 to financial stability during the economic downturn. Improved the programs, infrastructure, and public perception of the Club through effective strategic planning, community relations, and leadership of board & staff, Developed new programs to meet community needs, including *College Bound*. Led and implemented the governance restructure of the board of directors. Grew the organization from <$1M with two sites serving 230 youth daily, to $2.4M with five locations serving 600 daily. Developed a strong and effective leadership team.

Hanna Boys Center [1995-2007]

Supervised all aspects of the residential setting for youth and their well being. Integral contributor to the tactical implementation of increasing the Center's involvement with the surrounding community. Coordinated outdoor educational and volunteer opportunities.

Other Relevant Experience

- Member of Council on Foundations (2025)
- Member of Northern California Grantmakers (2020-present)
- Member of Executive Director Roundtable (2007-2024)
- Member of Rotary Club International (2007-2021). Board member 2008-2012, 2016.
- Volunteer with Sonoma Catalyst Fund (2020-2022)
- Member of Sonoma Valley Health Roundtable (2011-2019)
- Board member of The Presentation School (2015-2019)
- Board member (2011-2013) of the Sonoma Valley Fund, a CFSC affiliate
- Member of the Sonoma Valley Community Advisory Council (2005-2012)
- Proficiency in Microsoft Office Suite.
- Graduating member of the Association of Healthcare Philanthropy Madison Institute (2016), Sonoma Leadership Systems (2011), Advanced Leadership Program through Boys & Girls Clubs of America (2009), and Sonoma Valley Leadership (2005) through the Chamber of Commerce.

Education

M.A., Counseling Psychology from Sonoma State University

B.A., Psychology, minor in Sociology from College of Notre Dame (Notre Dame de Namur University)

Skills & Interests

- A collaborator, consensus builder, and planner who is committed to results. Ability to understand the tactical details, with a focus on strategic objectives, and possess the leadership skills to help others successfully strive toward a common goal.
- Deep appreciation for the impact that philanthropy can have on a community and clear understanding of the need for ongoing investment in critical organizations as well as expanding the horizon for new ideas and solutions to community issues.
- Love for continued education, cycling, hiking, diving, traveling, volunteering, guitar, gardening, reading, and family time.

To:	SVHCD Board of Directors
From:	Kelley Kaiser, Chief Executive Officer
Date:	May 7, 2026
Subject:	CEO Update – April 2026

Overall, the hospital remains operationally stable while continuing to navigate a dynamic healthcare environment. Over the past month, we have seen steady performance in our core operations, meaningful progress on several strategic priorities, and clear opportunities for continued improvement. Our teams remain focused on delivering safe, high-quality care while advancing efficiency, strengthening financial stewardship, and positioning the organization for long-term sustainability.

We continue to evaluate the anticipated impact of HR 1, H.R. 1 represents a multi-year structural shift in Medi-Cal financing and eligibility that will materially affect district hospitals through reduced reimbursement, increased uncompensated care, higher administrative burden, and greater strain on emergency and safety-net services. H.R. 1 introduces **new work requirements, semi-annual eligibility redeterminations, and immigrant coverage restrictions** that are projected to significantly reduce Medi-Cal enrollment. We are working closely with our Community Partners as well as Sonoma County to understand the impact in our area. **Mandatory Medicaid work requirements** for expansion adults begin **January 1, 2027**, Six**-month Medi-Cal eligibility redeterminations** begin, doubling churn risk **Shortened retroactive Medi-Cal coverage**, increasing uncompensated care.

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. We continue to track this, Bill; it was referred to Business and Professionals committee, it was approved on 4/21/26 and passed onto the Committee on Appropriations.

Quality and Access

CIHQ survey:

CIHQ surveyors arrived onsite on April 21st. There were 3 surveyors and they were on site for two and a half days. We received our official report on April 29th. We have no Condition Level deficiencies, only Standard level deficiencies for which we will submit Corrective Action Plans for. I am extremely proud of the team and how well they performed on this survey.

New GI practice:

Dr. Patrick Okolo, our Chief Medical Officer, began his clinical practice on April 28th.

He will transition to a 50/50 split between his Chief Medical Officer responsibilities and clinical practice as a gastroenterologist. This structure is consistent with the original design of the role and allows for continued clinical engagement alongside his leadership responsibilities.

Quality

Sonoma Valley Hospital – CMS Star rating overview

Key implications:

- A hospital can be **"same as national average" on most measures and still land at 2 stars, as you can see below, we are same as the national average in 3 categories yet still considered a 2 Star.**
- You are graded **only on measures you qualify for**
- Missing data does *not* help you—scores are reweighted to what remains

This design disproportionately hurts **small and rural hospitals**.

- Our current Star Rating is a 2, and this will be published in May 2026.
- In some metrics the number of cases/patients is not enough to report. The most likely pressure points are in the Mortality and Readmissions domains. Both are heavily influenced by case mix and volume — when we see patients who are more acutely ill or more socially complex (as is common in a community serving aging, lower-income, and rural residents), outcomes can be harder to benchmark favorably.
- **Low volume statistically penalizes small hospitals,** SVH has Low inpatient volume, very small denominators for mortality, complications, and readmissions. One or two adverse events can swing a rate dramatically. CMS does risk adjustment, but **not in a way that neutralizes small-n volatility.** Many measures show "same as national," but not "better," which is what it takes to climb stars
- In 2025, Sonoma Valley Hospital received the Get With The Guidelines® Stroke Silver Plus Award from the American Heart Association.
- For the second consecutive year, Sonoma Valley Hospital has also been recognized as a Top Performer in Partnership HealthPlan of California's Hospital Quality Improvement Program (HQIP), achieving a score of 90 percent or higher.

We recognize that we need to do better, the Partnership award is real-time, external validation that our current direction is strong, and it gives us a clear narrative.

The CMS snapshot reflects where we were; the award reflects where we are; and our leading indicators show where we're going.

Community Engagement

Hospital Happenings:
This month, we are highlighting the people who make that experience possible. You will meet **Carmen Ramos** from our Patient Access team, often one of the first faces patients see, and hear the story of ER Physician **Dr. Seric Cusick** through our ***My Hospital*** series. You will also get a closer look at the many individuals working together behind the scenes to support each visit.

We are proud to recognize team members who go above and beyond, including **Tracey Airth-Edblom**, whom we are celebrating during National Occupational Therapy Month for her work helping patients return to the activities that matter most.

April is also **Advance Directive and POLST Awareness Month**, and we are sharing insights from Geriatric Nurse Practitioner **Becky Spear** on the importance of planning ahead and making sure your care reflects what matters most to you.

Together, these stories reflect what makes Sonoma Valley Hospital special—care that is not only high quality, but personal and rooted in community.

Congratulations to **Marylou Ehret, SVH Director of Emergency Services,** on being selected as a winner of the North Bay Business Journal's 2026 Influential Women Awards!

Thank you to those who helped craft our nomination by sharing your experiences of working with Marylou: Jessica Winkler, Amy Lawrence, Pauline Headley, Lisa White, and Meghan Hofer.

And a special thank you to the Sonoma Valley Fire District's EMS Crew for giving insights into Marylou's strong partnership skills, continuously elevating care in our community.

We are scheduling a meeting with the Editor of the **Sonoma Index Tribune** to develop a **monthly** column that will provide updates on what is happening at the hospital.

Connected Culture

Daisy Award winner

The DAISY Foundation was established in 1999 by the family of J. Patrick Barnes, who died of complications of the autoimmune disease idiopathic throbocytopenia purpura (ITP) at the age of 33. (DAISY is an acronym for *Diseases Attacking the Immune SYstem*). During Pat's eight-week hospitalization, his family was awestruck by the care and compassion his nurses provided to him and everyone in his family. When they created the foundation in Pat's memory, one of their goals was to recognize extraordinary nurses everywhere who make an enormous difference in the lives of people through the super-human work they do everyday. The DAISY Award is nationally recognized.

At Sonoma Valley Hospital we realize the valuable contribution our individual team members make in helping achieve our mission to *improve and maintain the health of everyone in our community*. The DAISY AWARD is presented each year during Nurses' Week, on Florence Nightingale's birthday in May.

A caregiver may be nominated by anyone who exemplifies any of the following characteristics:

- Excellent Clinical Skills paired with Compassionate Care
- Has made a significant difference in the healthcare experience for you
- Uncompromising commitment to empathetic, ethical, and high-quality patient care
- Dedication to providing extraordinary service with each opportunity
- Demonstrates a Can-Do attitude, and remains positive and supportive in all situations
- Respect for Everyone

The Nursing Leadership Team at SVH nominated Jessica as a Daisy award winner. This was the first Daisy Award for Jessica.

Employee Engagement survey

The Employee Engagement survey was sent out on April 8th, we anticipate the survey closing within a few weeks. Once the data is in, we'll share results across the organization, about what we'll be celebrating and where we'll be focusing our efforts going forward. In the months that follow, teams will review their departmental results together and talk about what's working well and what needs attention. This ongoing work is part of our commitment to making Sonoma Valley Hospital the **best place to work**.

Hospital week/Nurse's week

Hospital week is scheduled for May10th – May 16th we have daily activities planned, Nurses week is scheduled for May 6th through May 12th. We have several activities scheduled to celebrate and recognize our nurses, including the Daisy award winners

Earth Day

In recognition of Earth Day, the Wellness Culture Team planned several events, including the planting of a mandarin tree on campus as a symbolic commitment to environmental stewardship and community well-being. This small but visible action reflects our broader values around sustainability, and long-term investment in the health of the community we serve.

Sustainability

Overall Operating Performance

March 2026 represents one of the strongest financial and operating months in Sonoma Valley Hospital's recent history, driven by broad-based growth across inpatient and outpatient services and strong core operational execution.

The hospital generated an **operating margin of approximately $1.1 million**, far exceeding the **budgeted $112,000**. Importantly, this performance was **not driven by IGT timing**, but by **meaningful underlying**

growth in patient volumes and activity across multiple service lines. As a result, year-to-date operating performance has returned to approximately **break-even**, with a modest positive operating margin of about **$41,000 through the first three quarters of the fiscal year**, marking a significant improvement versus both budget and prior year results.

Key Operational Drivers

- **Emergency Department** volumes reached a record **1,147 visits** (approximately 37 visits per day).
- **Imaging volumes** surged across all modalities, with **MRI exams reaching an all-time high of 287**, driven in part by the successful implementation of **Saturday MRI coverage**.
- **Surgical volumes** continued to recover, with **150 cases performed**, reinforcing that January represented a temporary low point.
- **Inpatient utilization** remained strong with an average daily census of approximately **10.7**.

Overall, March 2026 reflects a meaningful inflection point for Sonoma Valley Hospital, demonstrating strong demand, effective operational execution, improved financial stability, and positive momentum heading into the remainder of the fiscal year.

Service Line Optimization and Operational Streamlining

After careful evaluation, management has determined that continuing to accept Workers' Compensation cases in our Occupational Health clinic is not operationally sustainable under California's regulatory and administrative framework. The decision reflects growing complexity, reimbursement challenges, and administrative burden that divert resources from core occupational health and patient care services.

California has **one of the most highly regulated Workers' Compensation systems in the nation**, overseen primarily by the **Division of Workers' Compensation (DWC)**.

Key challenges include:

- **Extensive documentation and compliance requirements**
- Frequent regulatory updates
- Strict timelines for reporting, utilization review, and medical determinations
- Significant exposure to audits, disputes, and penalties for administrative errors
- Inability to find specialty care providers willing to accept Workers' Compensation insurance

For a hospital-based occupational health clinic, like Sonoma Valley Hospital, maintaining compliance requires **specialized staffing and infrastructure** that goes well beyond standard clinical operations. Staffing continues to be a challenge for us at SVH

The decision allows the hospital to:

- Focus the Occupational Health clinic on **services aligned with community and employer needs**, such as:

    - Pre-employment exams
    - Fitness-for-duty evaluations
    - Immunizations
    - Wellness and prevention programs
- Reduce administrative inefficiency
- Improve access, consistency, and staff satisfaction
- Redirect resources toward core hospital priorities

In support of this effort, we will stop accepting new Workers' Compensation cases effective June 15, with July 17 serving as the final date for follow-up services. The Occupational Health clinic will continue to offer employer services such as new hire physicals and travel medicine. Employers, Workers' Compensation insurance carriers and adjusters, and patients will be notified. This notification will include a list of Occupational Health clinics that offer Workers' Compensation services in the area (it is notable that none of those in the area are part of a smaller hospital as it is not sustainable)

As we wind down Workers' Compensation services in the Occupational Health clinic, affected staff will be notified in advance. We are committed to supporting employees through this transition and will actively communicate available positions within the organization for which they may apply.

SVH Performance Score Card

1. Quality | Access

Objective	Target	FEB 26	MAR 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	N/A				Less than Target is Goal
CDIFF Infection volume	<1	1	0				Less than Target is Goal
Surgical Site Infections volume	<1	0	0				Cholecystectomy Laminectomy - Less than Target is Goal
Acute Care Falls							
Patient fall *with injury* per 1000 pt days	<3.75	3	N/A				Less than Target is Goal
Core Measures							
Sepsis Early Management Bundle % compliant	>81%	100.00	66.70				Above Target is Goal
Mortality							
Acute Care Mortality Rate O/E rate	<1	0.83	0.00				Lower is better
ED							
Core OP 18b Median Time ED arrival to ED Departure mins	<132	102.00	130.00				Lower is better
Core Op 22 ED Left without being seen LWBS	<2%	0.10	0.30				Lower is better
PSI 90							
PSI 90 Composite Acute Care Admissions	0.00	0.77	0.31				Lower is better
Preventable Harm							
Readmissions to Acute Care within 30 days %	<16.6	3.40	9.70				Lower is better

3. Experience

Outpatient Ambulatory Services (OASCAHPS)

Objective	Target	JAN 26	FEB 26				Supporting Detail
Recommend Facility	>90%	85.7	N/A				Top Box Scores. % of patients choosing "Always"- Above Target is Goal

HCAHPS (Hospital Inpatient)

Objective	Target	DEC 25	JAN 26				Supporting Detail
Recommend the hospital	>90%	66.7	N/A				Top Box Scores. % of patients choosing "Always" - Above Target is Goal

2. Connected Culture

Objective	Target	Q3.25 Jul-Sep	Q4.25 Oct-Dec	1Q.26 Jan-Mar			Supporting Detail
Short-term Turnover	<3%	13.1	6.7	N/A			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	N/A			Total Turnover Rate (Annual Basis)
Workplace Injuries	<20 Per Year	6 (QTR 3)	5 (QTR 4)	N/A			

4. Sustainability

Objective	Target	FEB 26	MAR 26				Supporting Detail
Volume							
Emergency Visits	>920	943	1,147				Higher than Target is Goal
Surgical Volume Outpatient	>135	104	151				Higher than Target is Goal
Surgical Volume Inpatient	>10	8	11				Higher than Target is Goal
Inpatient Discharges	>70	85	69				Higher than Target is Goal
MRI Volumes	N/A	206	286				
PT Volumes	N/A	1,482	1,628				
Financial							
Operating EBDA in % (Month) *	varies	2.1%	18.0%				March Operating EBDA Target 7.5%
Operating EBDA in % (YTD) *	>5.2%	5.2%	6.7%				
Days Cash on Hand @ FYE	>30	28.4	28.9				Projected based on current data
Net Operating Revenue ($M) (annualized)	>$76.7	$81.3	$83.2				Includes Parcel Tax & IGT Revenues

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

To:	SVHCD Board of Directors
From:	Patrick Okolo III, MD, Chief Medical Officer
Date:	May 7, 2026
Subject:	CMO Update – March 2026

I. Clinical Quality Performance: Snapshot and Trajectory

SVH continues to demonstrate strong clinical performance across core inpatient measures. Stroke care (STK bundle) and VTE prophylaxis (VTE1/VTE2) remain at or near 100% compliance, reflecting sustained adherence to evidence-based care pathways. Core bundles are stable.

Three areas are under active focused improvement:

- **Global Malnutrition Composite Score (CMS GH)** Standardized screening and nutrition consult triggers are in place and being refined.
- **Opioid Safety (CMS 506)** Month-to-month prescribing variation persists; EMR decision support and standardization are underway.
- **Harm Metrics Integrity —** Rates of hypoglycemia, hyperglycemia, AKI, and pressure injury appear low. Working to improve detection sensitivity and documentation alignment ensures these rates reflect true absence of harm, not underreporting.

Bottom line: This is a story of clinical strength with targeted consistency work — not a story of system failure.

II. New Service Line: Gastroenterology

SVH has successfully launched an outpatient gastroenterology clinic. Implementation was smooth, and community members are actively being served. Select GI procedures that previously required patients to travel to UCSF are now being performed locally — a meaningful expansion of access and a direct benefit to the communities we serve. This service line strengthens SVH's ambulatory footprint and care retention within the district.

III. Quality Department Infrastructure

A Quality Coordinator has been hired to strengthen reporting rigor and reduce single-point-of-failure risk within the Quality department. This addition improves our capacity for data integrity and operational continuity.

The CMO is requesting authorization for additional Quality personnel to address two high-priority gaps:

- Dedicated focus on external regulatory and rating metrics, including CMS Star Ratings and other external benchmarks.
- Enhanced oversight of sepsis bundle compliance, which carries both direct clinical and reputational significance.

These additions are essential to building a Quality infrastructure commensurate with SVH's aspirations and external visibility.

IV. Infection Prevention — 2025 Annual Summary

Ashley Wilder, Infection Preventionist, presented the annual IP report. Key highlights:

Reportable Conditions

Six reportable conditions were reported to the Department of Health in 2025, spanning GI/foodborne illness, a sputum-related finding, and one CRE case. Each was managed per regulatory protocol.

Hospital-Acquired Infections & Hand Hygiene

2025 HAI and hand hygiene compliance data were reviewed. One case involved an Infection Present at Time of Surgery (PATOS), appropriately flagged.

Environment of Care Rounds

IP rounds identified findings requiring remediation, including:

- Corrugated cardboard in clean storage areas
- Supplies stored within three feet of sinks without splash guards
- Expired supplies, dusty vents and equipment, and ceiling tile deficiencies

These findings have been communicated to EVS and Facilities leadership for corrective action.

Laundry Vendor Compliance

EVS Manager and IP conducted an on-site review of Mission Linen Supply. The facility demonstrated near-complete automation with physical separation of clean and dirty linen throughout the process. No infection control concerns were identified.

V. Summary Assessment

SVH's quality infrastructure is performing well at its foundation. Focus areas — malnutrition documentation, opioid stewardship, harm detection, environmental compliance, and sepsis bundle performance — are all active workstreams, not deferred concerns. The new GI service line marks a meaningful expansion of local access and community care. The Board can expect continued progress reporting on these domains at the next quality cycle.

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.

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

To: SVHCD Board of Dir
From: Ben Armfield, Chief Financial Officer
Date: May 7, 2026
Subject: Financial Report for March 2026

OVERALL PERFORMANCE SUMMARY | MONTH OF MARCH 2026

- **Operating Performance** – March represents one of the strongest months the hospital has experienced in recent history, driven by broad-based growth across both inpatient and outpatient services.

  The hospital posted an operating margin of approximately **$1.1 million**, significantly exceeding the budgeted $112,000. In addition, Operating EBDA totaled approximately **$1.47 million**, nearly three times the budgeted level of $526,000.

  While the magnitude of the performance is notable, the more important takeaway is the quality and composition of the month. Unlike prior periods where favorable results were largely driven by IGT timing, March's performance was supported by strong core operating activity across multiple service lines, reflecting both sustained demand and improved operational execution.

  This performance reflects a meaningful step forward in the hospital's financial trajectory and brings year-to-date operating performance back to approximately break-even, with a modest positive operating margin of ~$41,000 through the first three quarters of the fiscal year.

	Current Month				Year-To- Date						
	Actual	Budget	Var	%	Actual	Budget	Var	%	PY Actual	Var	%
Operating Margin	$ 1,108.5	$ 112.4	$ 996.1	887%	$ 40.9	$ (2,801.1)	$ 2,842.0	101%	$ (3,600.1)	$ 3,641.0	101%
Operating EBDA	$ 1,472.1	$ 525.7	$ 946.4	180%	$ 4,164.7	$ 1,669.0	$ 2,495.6	150%	$ 1,124.8	$ 3,039.9	270%
Net Income (Loss)	$ 1,373.3	$ 268.2	$1,105.1	412%	$ 2,336.1	$ (1,398.2)	$ 3,734.3	267%	$ (1,906.1)	$ 4,242.2	223%

- **Operating Revenues** - **$8.2 Million,** significantly outpacing budget by **17%** or approximately **$1.2 million**.

  Importantly, unlike prior months where favorable performance was primarily driven by IGT program activity, March's results were driven by core operating performance. Net patient revenue (excluding IGT) exceeded budget by approximately **14%**, reflecting a significant increase in underlying volume and activity levels across the organization.

  The hospital also achieved an all-time high in gross charges, surpassing $36 million for the first time. This growth was broad-based, with strong performance across emergency services, inpatient care, imaging, physical therapy, and surgical services. On a volume basis:

  - Emergency Department volumes reached an all-time high of **1,147 visits**, or approximately **37 visits per day**.
  - Outpatient activity increased significantly, particularly within imaging and rehab services.
  - Inpatient utilization remained strong, with sustained elevated census levels.

  This level of performance reflects not only strong demand, but also improved operational execution across multiple service lines.

- **Operating Expenses** - **$7.1 Million**, which exceeded budget by approximately **2%,** or **$165,000**.

Expense performance remained well controlled relative to the significant increase in volume. Labor costs were below budget for the month, reflecting improved staffing alignment, while professional fees also trended favorably.

As expected, expenses continued to normalize following elevated levels in January related to one-time items and benefit timing. Interest expense also declined materially to approximately **$25,000** (had been running ~$70,000 monthly since December), following the full repayment of the line of credit in February.

Excluding IGT program expense, total operating expenses were approximately **2% below budget**, reinforcing that underlying cost structure remains well managed despite increased activity levels.

- **Year-To-Date Performance** - Through the first nine months of the fiscal year, performance remains strong and continues to trend positively.
    - Operating revenues are approximately **10% above budget**.
    - Operating expenses are approximately **5% above budget**.

  Operating EBDA totals approximately **$4.2 million** year-to-date, significantly exceeding budget and prior year levels.

  Following March's strong performance, the hospital has returned to a slightly positive operating margin year-to-date, a meaningful improvement compared to both budgeted expectations and prior year performance, which reflected a significant operating loss through the same period.

  Underlying operating performance also remains favorable when excluding IGT activity, with net patient revenue approximately **10% above budget** and operating expenses (excluding IGT) approximately **4% above budget**, reflecting continued positive momentum in core operations.

- **Cash** – Cash at month-end totaled approximately **$5.7 million**, with Days Cash on Hand of **36.5 days**.

  As discussed last month, February reflected a temporary spike in cash driven by the receipt of Rate Range IGT funds, which increased Days Cash from 13.4 to 42.6. March represents a normalization from that elevated level.

  Days Cash remains above prior forecast at 36.5 days (vs. ~33 days projected), and overall liquidity remains stable.

  Overall, liquidity remains stable and meaningfully improved relative to earlier in the fiscal year, and the organization continues to operate from a significantly stronger financial position following the repayment of the line of credit and normalization of vendor obligations.

DRIVERS IN MONTHLY PERFORMANCE

- **Inpatient Activity** - Inpatient volumes remained strong, with Average Daily Census of approximately **10.7**, continuing the trend of sustained elevated utilization
- **Emergency Department** - Emergency Department volumes reached an all-time high, with **1,147 visits** during the month, equating to approximately **37 visits per day**. This represents a significant increase relative to historical averages and reflects continued growth in demand for emergency services.
- **Outpatient Activity** - March represented a strong month for outpatient services, with total visits exceeding budget by approximately **10%**.

- **Imaging** – Imaging volumes increased significantly across all major modalities, including MRI, CT, ultrasound, and mammography, representing one of the strongest months to date.

  A key driver of this performance was the introduction of **Saturday MRI coverage**, where the hospital opened additional capacity on select weekends during the month. This operational change proved highly effective, directly contributing to increased access and utilization.

  As a result, MRI volumes reached **287 exams in March**, establishing a new all-time high and exceeding the prior peak by approximately 15%.

  This is a strong validation that expanded access - particularly through weekend availability - can drive meaningful incremental volume. Based on early results, management is evaluating opportunities to continue and potentially expand this approach.

- **Surgical Volumes** – Surgical volumes continued to recover, with 150 total cases performed. This represents continued improvement from January and February levels. While still approximately 5% below budget, the upward trend reinforces that January represented a temporary low point, with volumes continuing to normalize.

OTHER FINANCE UPDATES

FY27 Budget Process

Management continues to make strong progress on the FY27 budget development process. Department-level meetings are nearing completion, with final assumptions and adjustments to be refined over the coming weeks.

The proposed budget will incorporate key strategic initiatives and targeted investments aligned with the hospital's long-term priorities, with a continued emphasis on growth in core service lines. Management remains on track to present a balanced and actionable budget consistent with organizational expectations at the end of May.

Capital Needs Assessment

Management has initiated a comprehensive review of capital needs across the organization, encompassing both short-term equipment requirements and longer-term infrastructure priorities.

This effort is intended to support the development of a more structured and prioritized multi-year capital plan, which will be incorporated into the FY27 budget and inform broader long-range planning efforts.

Legacy MRI Unit

The hospital is currently working with a prospective vendor regarding the sale of the existing 1.5T MRI unit (located on-site, adjacent to the front entrance of the hospital). The process is progressing, with final inspection and coordination of removal activities anticipated in the coming weeks.

MRI Volumes and UCSF Collaboration

Management has formalized a joint workgroup with UCSF focused on redirecting a portion of their existing MRI backlog to Sonoma Valley Hospital.

While still in early stages, this initiative is expected to support incremental and more consistent volume growth by leveraging SVH capacity and UCSF demand constraints. Further updates will be provided as the program develops.

Foundation Capital Support

We are pleased to report that the Foundation recently approved reimbursement for two critical capital investments: the Stryker operating room equipment and Mindray telemetry monitoring system replacements.

This represents a meaningful benefit to the hospital. These were essential investments that directly support patient care and operational capability, and would have been very difficult to execute without Foundation support. We are extremely grateful for the partnership and financial backing that made these projects possible.

Chief Medical Officer Update

Dr. Patrick Okolo, our Chief Medical Officer, is expected to begin clinical practice in the community by the end of April.

He will transition to a 50/50 split between his Chief Medical Officer responsibilities and clinical practice as a gastroenterologist. This structure is consistent with the original design of the role and allows for continued clinical engagement alongside his leadership responsibilities.

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 March 31, 2026

ATTACHMENT A

		Month				Year-To- Date						
Revenues		**CYM Actual**	**CYM Budget**	**Var**	**%**	**YTD Actual**	**YTD Budget**	**Var**	**%**	**PYTD Actual**	**Var**	**%**
1	Net Patient Revenue	$ 5,621.0	$ 4,939.6	681.4	14%	$ 41,802.1	$ 38,055.0	3,747.1	10%	$ 37,835.8	3,966.3	10%
2	IGT Program Revenue	2,125.9	1,653.7	472.3	29%	16,814.9	14,883.2	1,931.8	13%	9,119.4	7,695.6	84%
3	Parcel Tax Revenue	316.7	316.7	(0.0)	0%	2,850.0	2,850.0	(0.0)	0%	2,850.0	(0.0)	0%
4	Other Operating Revenue	107.8	99.9	7.9	8%	901.6	898.9	2.6	0%	917.5	(16.0)	-2%
5	**Total Revenue**	**$ 8,171.4**	**$ 7,009.8**	**1,161.6**	**17%**	**$ 62,368.6**	**$ 56,687.2**	**5,681.4**	**10.0%**	**$ 50,722.7**	**11,645.9**	**23%**
Operating Expenses		**CYM Actual**	**CYM Budget**	**Var**	**%**	**YTD Actual**	**YTD Budget**	**Var**	**%**	**PYTD Actual**	**Var**	**%**
6	Labor / Total People Cost	$ 3,052.0	$ 3,195.2	(143.2)	-4%	$ 28,862.7	$ 27,516.9	1,345.7	5%	$ 26,362.7	2,500.0	9%
7	Professional Fees	689.3	748.5	(59.2)	-8%	6,538.9	6,251.3	287.6	5%	6,154.1	384.8	6%
8	Supplies	804.9	717.5	87.5	12%	6,583.2	6,253.4	329.8	5%	5,767.4	815.7	14%
9	Purchased Services	679.4	634.0	45.4	7%	4,453.6	4,166.2	287.4	7%	3,646.5	807.1	22%
10	Depreciation	363.6	413.3	(49.7)	-12%	4,123.8	4,470.1	(346.3)	-8%	4,724.9	(601.1)	-13%
11	Interest	25.6	21.6	4.1	19%	465.4	445.8	19.6	4%	330.6	134.8	41%
12	Other	387.7	402.7	(15.0)	-4%	3,531.8	3,502.8	29.0	1%	3,378.0	153.8	5%
13	IGT Program Expense	1,060.2	764.6	295.6	39%	7,768.4	6,881.7	886.7	13%	3,958.6	3,809.8	96%
14	**Operating Expenses**	**$ 7,062.8**	**$ 6,897.4**	**165.4**	**2.4%**	**$ 62,327.7**	**$ 59,488.2**	**2,839.5**	**4.8%**	**$ 54,322.8**	**8,004.9**	**15%**
15	**Operating Margin**	**$ 1,108.5**	**$ 112.4**	**$ 996.1**	**887%**	**$ 40.9**	**$ (2,801.1)**	**$ 2,842.0**	**101%**	**$ (3,600.1)**	**$ 3,641.0**	**101%**
Non Operating Income		**CYM Actual**	**CYM Budget**	**Var**	**%**	**YTD Actual**	**YTD Budget**	**Var**	**%**	**PYTD Actual**	**Var**	**%**
16	GO Bond Activity, Net	235.2	128.6	106.5	83%	1,947.5	1,157.7	789.8	68%	1,454.2	493.2	34%
17	Misc Revenue/(Expenses)	29.7	27.2	2.4	9%	347.7	245.2	102.5	42%	239.7	108.0	45%
18	**Total Non-Op Income**	**$ 264.8**	**$ 155.9**	**108.9**	**70%**	**$ 2,295.2**	**$ 1,402.8**	**892.3**	**64%**	**$ 1,693.9**	**601.2**	**35%**
19	**Net Income (Loss)**	**$ 1,373.3**	**$ 268.2**	**1,105.1**	**412%**	**$ 2,336.1**	**$ (1,398.2)**	**3,734.3**	**267%**	**$ (1,906.1)**	**4,242.2**	**223%**
20	Restricted Foundation Contr.	-	125.0	(125.0)	-100%	1,953.2	1,125.0	828.2	74%	2,105.5	(152.3)	-7%
21	**Change in Net Position**	**$ 1,373.3**	**$ 393.2**	**980.1**	**249%**	**$ 4,289.3**	**$ (273.2)**	**4,562.5**	**1670%**	**$ 199.4**	**4,089.9**	**2051%**
22	**Operating EBDA**	**$ 1,472.1**	**$ 525.7**	**946.4**	**180%**	**$ 4,164.7**	**$ 1,669.0**	**2,495.6**	**150%**	**$ 1,124.8**	**3,039.9**	**270%**

Sonoma Valley Health Care District **ATTACHMENT B**

Balance Sheet
As of March 31, 2026
Expressed in 1,000s

		Current Month	Prior Month	FYE 2025 Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 5,697.8	$ 6,653.4	$ 4,386.3
2	Net Patient Receivables	9,238.6	8,255.6	7,585.8
3	Allow Uncollect Accts	(1,191.5)	(1,240.3)	(1,256.1)
4	Net Accounts Receivable	$ 8,047.2	$ 7,015.3	$ 6,329.7
5	IGT Program Receivable	891.8	891.8	-
6	Parcel Tax Receivable	1,744.6	1,744.6	-
7	GO Bond Tax Receivable	1,626.6	1,626.6	-
8	Other Receivables	1,004.9	836.9	1,423.3
9	Inventory	969.5	978.2	841.0
10	Prepaid Expenses	1,130.8	1,205.1	788.1
11	Total Current Assets	$ 21,113.1	$ 20,951.8	$ 13,768.5
12	Property,Plant & Equip, Net	$ 60,260.6	$ 59,955.9	60,342.6
13	Trustee Funds - GO Bonds	4,838.9	5,017.2	5,986.7
14	Other Assets - Deferred IGT Expense	3,559.9	4,645.1	-
15	**Total Assets**	**$ 89,772.5**	**$ 90,569.9**	**$ 80,097.8**
	Liabilities & Fund Balances			
	Current Liabilities:			
16	Accounts Payable	5,650.7	$ 4,642.1	$ 7,282.7
17	Accrued Compensation	4,941.7	4,560.1	4,059.9
18	IGT Program Payable	242.0	242.0	-
19	Interest Payable - GO Bonds	41.0	201.0	154.4
20	Accrued Expenses	581.1	853.0	166.1
21	Deferred IGT Revenue	7,177.5	9,553.5	-
22	Deferred Parcel Tax Revenue	950.0	1,266.7	-
23	Deferred GO Bond Tax Revenue	823.0	1,097.4	-
25	Line of Credit - Summit Bank	-	-	-
26	Other Liabilities	-	-	-
27	Total Current Liabilities	$ 21,147.1	$ 23,155.8	$ 12,403.1
28	Long Term Debt, net current portion	$ 23,436.4	$ 23,568.4	$ 27,239.3
29	Total Fund Balance	$ 45,189.1	$ 43,845.8	$ 40,455.4
30	**Total Liabilities & Fund Balances**	**$ 89,772.5**	**$ 90,569.9**	**$ 80,097.8**

Cash Indicators	Current Month	Prior Month	Prior Year FYE
Days Cash	36.5	42.6	29.2
A/R Days	52.2	45.5	45.8
A/P Days	52.3	43.0	67.2

Sonoma Valley Health Care District

Projected Cash Forecast (In 1000s)

FY 2026

ATTACHMENT C

		ACTUAL July	*ACTUAL* Aug	*ACTUAL* Sept	*ACTUAL* Oct	*ACTUAL* Nov	*ACTUAL* Dec	*ACTUAL* Jan	*ACTUAL* Feb	*ACTUAL* Mar	*Forecast* Apr	*Forecast* May	*Forecast* Jun	TOTAL
	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	$ 4,598.5	$ 4,300.0	$ 4,600.0	$ 4,600.0	$ 54,743.1
2	Other Revenue - Operating & Non-Op	182.5	104.0	101.6	94.6	101.0	129.0	91.8	114.8	107.2	105.0	105.0	105.0	1,341.4
3	IGT Program Revenue	-	-	-	523.7	31.5	-	2,639.8	20,155.6	-	730.0	-	161.5	24,242.2
4	Parcel Tax Revenue	110.9	-	-	-	-	2,055.4	-	-	-	1,500.0	-	-	3,666.3
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**	**$ 4,705.8**	**$ 6,635.0**	**$ 4,705.0**	**$ 4,866.5**	**$ 84,015.9**
	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	$ 5,587.8	$ 6,000.0	$ 5,900.0	$ 5,200.0	$ 69,924.7
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	-	-	87.7	-	11,091.3
11	Capital Expenditures - SVH Funded	145.6	-	11.3	84.5	59.3	60.0	539.8	723.8	-	50.0	50.0	50.0	1,774.4
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**	**$ 5,661.4**	**$ 6,123.6**	**$ 6,111.3**	**$ 5,323.6**	**$ 85,879.6**
	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**	**$ (955.6)**	**$ 511.4**	**$ (1,406.3)**	**$ (457.1)**	**$ (1,863.7)**
	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**	**$ (955.6)**	**$ 511.4**	**$ (1,406.3)**	**$ (457.1)**	**$ (40.5)**
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	$ 5,697.8	$ 6,209.2	$ 4,802.9	
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**	**$ 5,697.8**	**$ 6,209.2**	**$ 4,802.9**	**$ 4,345.8**	
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**	**36.5**	**39.8**	**30.8**	**27.9**	

Sonoma Valley Health Care District **ATTACHMENT D**

Key Performance Indicators | Volumes & Statistics

For the Period Ended March 31, 2026

	Current Month				Year-To- Date						
	Actual	Budget	Var	%	YTD Actual	YTD Budget	Var	%	PYTD Actual	Var	%
Inpatient Volume											
Acute Patient Days	332	270	62	23%	2,701	2,323	378	16%	2,332	369	16%
Acute Discharges	89	74	16	21%	738	633	105	17%	616	122	20%
Average Length of Stay	3.7	3.7	0.0	1%	3.7	3.7	(0.0)	0%	3.8	(0.1)	-3%
Average Daily Census	10.7	8.7	2.0	23%	9.9	8.5	1.4	16%	8.5	1	16%
Surgical Volume											
IP Surgeries	10	10	(0)	-1%	107	87	20	23%	84	23	27%
OP Surgeries	140	148	(8)	-6%	1,261	1,191	70	6%	1,199	62	5%
Total Surgeries	**150**	**158**	**(8)**	**-5%**	**1,368**	**1,278**	**90**	**7%**	**1,283**	**85**	**7%**
Other Outpatient Activity											
Total Outpatient Visits	6,533	5,929	604	10%	54,202	51,532	2,670	5%	51,184	3,018	6%
Emergency Room Visits	1,147	1,020	127	12%	9,110	8,167	943	12%	8,259	851	10%

Payor Mix	Actual	Budget	%	Actual	Budget	%
Medicare	39.3%	37.7%	1.6%	39.2%	37.9%	1.3%
Medicare Mgd Care	20.1%	18.2%	1.9%	18.3%	18.3%	0.1%
Medi-Cal	14.9%	16.2%	-1.3%	17.4%	16.2%	1.3%
Commercial	22.1%	23.9%	-1.8%	21.3%	23.8%	-2.5%
Other	3.5%	3.9%	-0.4%	3.7%	3.8%	-0.1%
Total	**100.0%**	**100.0%**		**100.0%**	**100.0%**	

Payor Mix calculated based on gross revenues

Trended Outpatient Visits by Area

	Most Recent Six Months							YoY Monthly Averages			
Department	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Last 6 Months**	**FY26**	**FY25**	**Chg**	**% Chg**
Lab	1,535	1,217	1,355	1,420	1,350	1,644		1,428	1,348	80	6%
Medical Imaging	1,056	940	1,081	1,041	1,009	1,059		1,031	982	49	5%
Physical Therapy	1,600	1,270	1,337	1,439	1,482	1,623		1,449	1,424	25	2%
CT Scanner	515	465	508	454	420	534		478	449	28	6%
Occ. Health	313	282	310	279	285	249		273	267	6	2%
Mammography	295	254	301	238	239	299		260	245	15	6%
Occ. Therapy	236	248	285	256	231	251		244	203	41	20%
Ultrasound	306	270	276	227	233	321		281	218	64	29%
MRI	251	202	245	235	206	287		232	181	51	28%
ECHO	131	88	132	100	95	120		113	129	(16)	-12%
Speech Therapy	57	58	57	50	114	126		70	68	2	3%
Other	17	18	33	28	13	20		26	23	2	10%
TOTAL	**6,596**	**5,312**	**5,919**	**5,767**	**5,677**	**6,533**		**6,031**	**5,789**	**242**	**4%**
Emergency Room	952	932	1,047	1,022	943	1,147		1,012	868	144	17%
ER Visits / Day	30.7	31.1	33.8	33.0	33.7	37.0		33.2	28.9	4.3	15%

Sonoma Valley Health Care District **ATTACHMENT E**

Overall Performace | Key Performance Indicators

For the Period Ended March 31, 2026

	Current Month				Year-To- Date						
	Actual	Budget	Var	%	Actual	Budget	Var	%	PY Actual	Var	%
Operating Margin	$ 1,108.5	$ 112.4	$ 996.1	887%	$ 40.9	$ (2,801.1)	$ 2,842.0	101%	$ (3,600.1)	$ 3,641.0	101%
Operating EBDA	$ 1,472.1	$ 525.7	$ 946.4	180%	$ 4,164.7	$ 1,669.0	$ 2,495.6	150%	$ 1,124.8	$ 3,039.9	270%
Net Income (Loss)	$ 1,373.3	$ 268.2	$1,105.1	412%	$ 2,336.1	$ (1,398.2)	$ 3,734.3	267%	$ (1,906.1)	$ 4,242.2	223%

0.07%

Operating Revenue Summary **(All Numbers in 1000s)**

Net Patient Revenue	$ 5,621	$ 4,940	$ 681	14%	$ 41,802	$ 38,055	$ 3,747	10%	$ 37,836	$ 3,966	10%
NPR as a % of Gross	14.7%	14.9%	-1.5%		13.8%	14.2%	-2.5%		14.1%	-1.9%	
Operating Revenue	$ 8,171	$ 7,010	$ 1,162	17%	$ 62,369	$ 56,687	$ 5,681	10%	$ 50,722.7	$ 11,646	23%

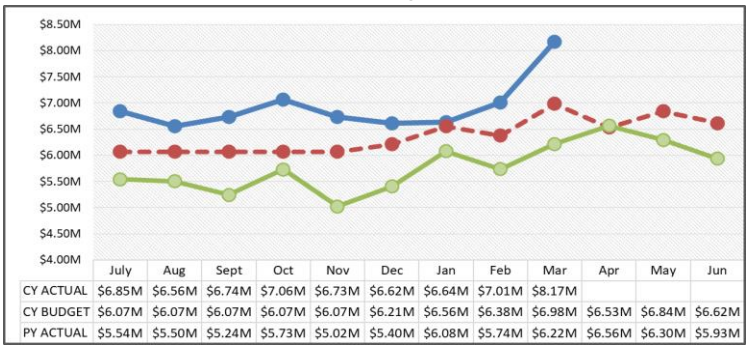
Operating Expense Summary **(All Numbers in 1000s)**

Operating Expenses	$ 7,063	$ 6,897	$ 165	2%	$ 62,328	$ 59,488	$ 2,839	5%	$ 54,323	$ 8,005	15%
Op Exp. Excl. IGT Fees	$ 6,003	$ 6,133	$ (130.2)	-2%	$ 54,559	$ 52,607	$ 1,952.8	4%	$ 50,364	$ 4,195.1	8%
Worked FTEs	239.98	232.11	7.87	3%	232.99	228.21	$ 4.78	2%	218.09	14.91	7%

Trended Operating Revenue & Operating Expense Graphs

Trended Operating Revenues

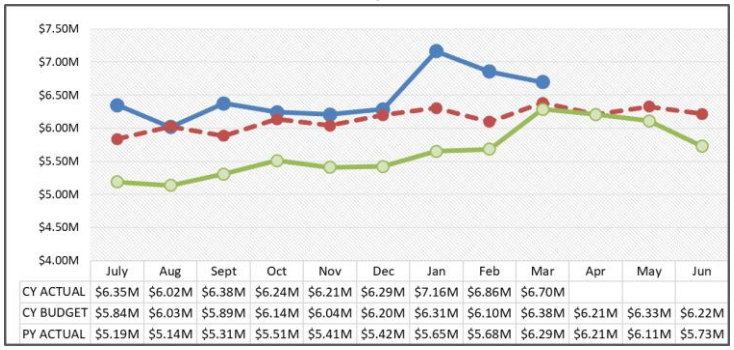
CY Actual vs CY Budget vs PY Actual



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
CY ACTUAL	$6.85M	$6.56M	$6.74M	$7.06M	$6.73M	$6.62M	$6.64M	$7.01M	$8.17M			
CY BUDGET	$6.07M	$6.07M	$6.07M	$6.07M	$6.07M	$6.21M	$6.56M	$6.38M	$6.98M	$6.53M	$6.84M	$6.62M
PY ACTUAL	$5.54M	$5.50M	$5.24M	$5.73M	$5.02M	$5.40M	$6.08M	$5.74M	$6.22M	$6.56M	$6.30M	$5.93M

Trended Operating Expenses (excl Depreciation)

CY Actual vs CY Budget vs PY Actual



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
CY ACTUAL	$6.35M	$6.02M	$6.38M	$6.24M	$6.21M	$6.29M	$7.16M	$6.86M	$6.70M			
CY BUDGET	$5.84M	$6.03M	$5.89M	$6.14M	$6.04M	$6.20M	$6.31M	$6.10M	$6.38M	$6.21M	$6.33M	$6.22M
PY ACTUAL	$5.19M	$5.14M	$5.31M	$5.51M	$5.41M	$5.42M	$5.65M	$5.68M	$6.29M	$6.21M	$6.11M	$5.73M

CY ACTUAL • • • CY BUDGET PY ACTUAL

Cash Indicators

	Current Month	Prior Month	Var	% Var
Days Cash	36.5	42.6	(6.1)	-14%
A/R Days	52.2	45.5	6.7	15%
A/P Days	52.3	43.0	9.3	22%