SAN GORGONIO MEMORIAL HOSPITAL

AGENDA

REGULAR MEETING OF THE BOARD OF DIRECTORS
Tuesday, January 7, 2020 – 5:00 PM

Modular C Classroom
600 N. Highland Springs Avenue, Banning, CA 92220

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the Administration Office at (951) 769-2160. **Notification 48 hours prior to the meeting** will enable the Hospital to make reasonable arrangement to ensure accessibility to this meeting. [28 CFR 35.02-35.104 ADA Title II].

TAB

I. Call to Order — S. DiBiasi, Chair

II. Public Comment

A five-minute limitation shall apply to each member of the public who wishes to address the Hospital Board of Directors on any matter under the subject jurisdiction of the Board. A thirty-minute time limit is placed on this section. No member of the public shall be permitted to "share" his/her five minutes with any other member of the public. (Usually, any items received under this heading are referred to staff for future study, research, completion and/or future Board Action.) (PLEASE STATE YOUR NAME AND ADDRESS FOR THE RECORD.)

On behalf of the Hospital Board of Directors, we want you to know that the Board acknowledges the comments or concerns that you direct to this Board. While the Board may wish to occasionally respond immediately to questions or comments if appropriate, they often will instruct the Hospital CEO, or other Hospital Executive personnel, to do further research and report back to the Board prior to responding to any issues raised. If you have specific questions, you will receive a response either at the meeting or shortly thereafter. The Board wants to ensure that it is fully informed before responding, and so if your questions are not addressed during the meeting, this does not indicate a lack of interest on the Board's part; a response will be forthcoming.

OLD BUSINESS

III. ***Proposed Action - Approve Minutes** — S. DiBiasi
- December 3, 2019 regular meeting — A

NEW BUSINESS

IV. Healthcare District Board meeting report - informational — D. Tankersley — verbal

V.	Hospital Board Chair monthly report	S. DiBiasi	B
VI.	CEO Monthly report	S. Barron	verbal
VII.	January, February & March Board/Committee meeting calendars	S. DiBiasi	C
VIII.	Patient Care Services bi-monthly report	P. Brown	handout
IX.	*** All Hospital Board members annual execution of Confidentiality and Nondisclosure Agreement** ▪ **ROLL CALL**	S. DiBiasi	D
X.	*** Proposed Action – Annual approval of Hospital Bylaws** (per bylaws Section 4.05, (i)) ▪ **ROLL CALL**	S. DiBiasi	E
XI.	*** Proposed Action - Approve 2020 Environment of Care Plans** ▪ **ROLL CALL**	D. Mares	F
XII.	Committee Reports:		
	• Ad Hoc Audit Selection Committee	S. DiBiasi	verbal
	• Executive Committee o December 17, 2019 special meeting minutes o Community Health Needs Assessment- final now posted on Hospital's website See link: https://sgmh.org/wp-content/uploads/2019/12/12.9_Draft_San-Gorgonio-2019-CHNA_R11.pdf	S. DiBiasi	G
	• Finance Committee o December 19, 2019 regular meeting minutes *** Proposed Action – Approve November 2019 Financial Statement** (approval recommended by Finance Committee 12/19/19) ▪ **ROLL CALL**	O. Hershey D. Recupero	H
XIII.	*** Proposed Action - Approve Policies and Procedures** ▪ **ROLL CALL**	Staff	I
XIV.	Community Benefit events/Announcements/ and newspaper articles	S. DiBiasi	J
*******	**ITEMS FOR DISCUSSION/APPROVAL IN CLOSED SESSION**	S. DiBiasi	
	➢ Proposed Action - Approve Medical Staff Credentialing *(Health & Safety Code §32155; and Evidence Code §1157)*		

- Receive Quarterly Environment of Care/Life Safety/Utility Management report
  (Health & Safety Code §32155)

- Receive 2019 Annual Environment of Care Evaluations
  (Health & Safety Code §32155)

- Telephone conference with legal counsel regarding potential litigation
  Significant exposure to litigation pursuant to paragraph (2) or (3) of subdivision (d) of Section 54956.9: (one potential case)

XV. **ADJOURN TO CLOSED SESSION**

*** The Board will convene to the Open Session portion of the meeting approximately 2 minutes after the conclusion of Closed Session.**

RECONVENE TO OPEN SESSION

*** **REPORT ON ACTIONS TAKEN DURING CLOSED SESSION** S. DiBiasi

XVI. Future Agenda Items

XVII. **ADJOURN** S. DiBiasi

***Action Required**

In accordance with The Brown Act, *Section 54957.5*, all public records relating to an agenda item on this agenda are available for public inspection at the time the document is distributed to all, or a majority of all, members of the Board. Such records shall be available at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Certification of Posting

I certify that on January 3, 2020, I posted a copy of the foregoing agenda near the regular meeting place of the Board of Directors of San Gorgonio Memorial Hospital, and on the San Gorgonio Memorial Hospital website, said time being at least 72 hours in advance of the regular meeting of the Board of Directors (*Government Code Section 54954.2*).

Executed at Banning, California, on January 3, 2020

Bobbi Duffy, Executive Assistant

TAB A

MINUTES: Not Yet Approved By Board

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

December 3, 2019

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors was held on Tuesday, December 3, 2019 in Modular C meeting room, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Lynn Baldi, Phillip Capobianco III, Steve Cooley, Susan DiBiasi (Chair), Andrew Gardner, Olivia Hershey, Estelle Lewis, Ehren Ngo, Ron Rader, Steve Rutledge, Lanny Swerdlow, Dennis Tankersley

Absent: Georgia Sobiech

Required Staff: Steve Barron (CEO), Pat Brown (CNO), Annah Karam (CHRO), Dave Recupero (CFO), Holly Yonemoto (CBDO), Steven Hildebrand, MD (Chief of Staff), Susan Sommers (Director, Infection Control/Risk Management), Bobbi Duffy (Executive Assistant)

AGENDA ITEM		ACTION / FOLLOW-UP
Call To Order	Chair Susan DiBiasi called the meeting to order at 5:00 pm.	
Public Comment	None.	
EDUCATION		
Prioritize – Community Health Needs Assessment	Holly Yonemoto re-introduced Laura Acosta of HC2 Strategies who reviewed the top 5 categories that came from the Community Health Needs Assessment (CHNA) report. She asked board members to place sticky dots on their top 3 choices for the board to focus on. The Executive Committee will meet mid-December to review and potentially approve the posting of the CHNA report to be posted on the Hospital's website. The approved document will be brought back to the full Board at their January 2020 meeting as informational. It was stressed that this document is a growing/changing document and may change as we move through the three-year cycle as new priorities evolve.	
OLD BUSINESS		
Proposed Action -	Chair DiBiasi asked for any changes or corrections to the	**The minutes of**

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td>Approve Minutes

November 5 , 2019 regular meeting</td><td>minutes of the November 5, 2019 regular meeting as included on the board tablets.

There were none.</td><td>the November 5, 2019 regular meeting will stand correct as presented.</td></tr>
<tr><td colspan="3">NEW BUSINESS</td></tr>
<tr><td>Healthcare District Board report - informational</td><td>Healthcare District Board Chair Dennis Tankersley, reported that a copy of the Healthcare District’s meeting agenda and enclosures were included on the board tablets. He reviewed the actions taken at that meeting.</td><td></td></tr>
<tr><td>Hospital Board Chair report</td><td>Chair DiBiasi noted that her written monthly report was included on the board tablets.</td><td></td></tr>
<tr><td>CEO Monthly report</td><td>Steve Barron reported that we are working on setting up a strategic planning session on a Saturday in February. Staff noted that we are waiting to hear back from one board member.</td><td></td></tr>
<tr><td>Calendars</td><td>Calendars for December, January, and February were included on the board tablets and “take home” copies were at each board member’s seat.</td><td></td></tr>
<tr><td>For review – Hospital Bylaws</td><td>Chair DiBiasi noted that the Hospital Bylaws are slated for their annual approval at the January 2020 meeting. Any suggested changes and/or additions should be directed to staff.

Staff has no recommended changes.</td><td></td></tr>
<tr><td>Proposed Action – Approve Mission/Vision/ Values Statement</td><td>Steve Barron noted that the Mission, Vision and Values Statement is reviewed and re-approved annually by the Hospital Board. It was included in the board packets last month for review.

There were no suggested changes at this time.

BOARD MEMBER ROLL CALL:

<table><tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr><tr><td>Cooley</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr></table></td><td>M.S.C., (Ngo/ Rader), the SGMH Board of Directors approved the Mission/Vision/ Values Statement as presented.</td></tr>
</table>

<table>
<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td>
<table>
<tr><td>Gardner</td><td>Yes</td><td>Hershey</td><td>Yes</td></tr>
<tr><td>Lewis</td><td>Yes</td><td>Ngo</td><td>Yes</td></tr>
<tr><td>Rader</td><td>Yes</td><td>Rutledge</td><td>Yes</td></tr>
<tr><td>Sobiech</td><td>Absent</td><td>Swerdlow</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Yes</td><td colspan="2">Motion carried.</td></tr>
</table>
</td><td></td></tr>
<tr><td>2020 Slate of Officers</td><td>Chair DiBiasi noted that a copy of the 2019 Slate of Officers was included on the Board tablet.

A motion was made and seconded for the current slate to remain the same for 2020:

Chair – Susan DiBiasi
Vice Chair – Ehren Ngo
Secretary – Estelle Lewis
Treasurer – Lynn Baldi

BOARD MEMBER ROLL CALL:

<table>
<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
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<tr><td>Tankersley</td><td>Yes</td><td colspan="2">Motion carried.</td></tr>
</table>
</td><td>M.S.C., (Rutledge/ Baldi), the SGMH Board of Directors approved the 2020 Slate of Officer to remain the same as 2019.</td></tr>
<tr><td colspan="3">COMMITTEE REPORTS:</td></tr>
<tr><td>Finance Committee

Proposed Action – Approve October 2019 Financial Statement</td><td>At the request of Committee Chair Olivia Hershey, Dave Recupero, Chief Financial Officer, briefly reviewed a handout Executive Summary along with the October 2019 Financial report which was included on the board tablet. A copy of the Finance Committee's November 19, 2019 meeting minutes were also included on the board tablet. It was noted that the Finance Committee recommends approval of the October 2019 Financial report as presented.

BOARD MEMBER ROLL CALL:

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<tr><td>Baldi</td><td>Yes</td><td>Capobianco</td><td>Yes</td></tr>
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<tr><td>Gardner</td><td>Yes</td><td>Hershey</td><td>Yes</td></tr>
<tr><td>Lewis</td><td>Yes</td><td>Ngo</td><td>Yes</td></tr>
</table>
</td><td>M.S.C., (Hershey/ Gardner), the SGMH Board of Directors approved the October 2019 Financial report as presented.</td></tr>
</table>

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<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
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<tr><td>Tankersley</td><td>Yes</td><td colspan="2">Motion carried.</td></tr>
</table>
</td><td></td></tr>
<tr><td>Community Planning Committee</td><td>Community Planning Committee Chair Lynn Baldi noted that a copy of the meeting minutes and materials of the November 19, 2019 meeting were included on the board tablets.</td><td></td></tr>
<tr><td>Executive Committee</td><td>Executive Committee Chair Susan DiBiasi noted that a copy of the minutes of the November 19, 2019 were included on the board tablets. She noted that the Committee discussed utilizing Hospital Board members' talents in the various Committees.</td><td></td></tr>
<tr><td>Announce 2020 Committee Assignments</td><td>Chair DiBiasi announced the 2020 Committee Assignments as follows:

Finance Committee:
• Susan DiBiasi
• Andrew Gardner
• Olivia Hershey, Chair
• Ehren Ngo
• Lanny Swerdlow

Human Resources Committee:
• Steve Cooley
• Olivia Hershey
• Estelle Lewis, Chair
• Ron Rader
• Georgia Sobiech

Community Planning Committee:
• Lynn Baldi, Chair
• Susan DiBiasi
• Ron Rader
• Steve Rutledge
• Dennis Tankersley</td><td></td></tr>
</table>

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<tr><th>AGENDA ITEM</th><th></th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td>Proposed Action – Approve Recommendations of the Medical Executive Committee</td><td>Steven Hildebrand, MD, Chief of Staff briefly reviewed the Medical Executive Committee report as included on the Board tablets.

Approval Items:

Policies & Procedures:
• 55 Infection Control Policies & Procedures
• Discharge Planning Evaluation
• Transport of Infant in Hospital
• Pediatric Patients

Medication Error Reduction Plan (MERP)
Utilization Management (UM) Plan – 2020

A wording change was discussed on the Medication Error Reduction Plan (MERP). Pat Brown will make this change prior to this document being finalized.

BOARD MEMBER ROLL CALL:

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<tr><td>Proposed Action – Approve Policies and Procedures</td><td>There were sixty-two (62) policies and procedures included on the board tablets presented for approval by the Board.

Pat Brown noted that all the Infection Control policies are the same as discussed under Medical Executive report/approval.

Susan Sommers noted that the Infection Control policies must be reviewed and approved by the Board on an annual basis.

BOARD MEMBER ROLL CALL:

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</table>

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<tr><td>Tankersley</td><td>Yes</td><td colspan="2">Motion carried.</td></tr>
</table>
</td><td></td></tr>
<tr><td>Community Benefit events/Announcements/and newspaper articles</td><td>A reminder of the Hospital's Annual Tree Lighting ceremony on Wednesday, December 5th at 5:00 pm.

Annah Karam noted that she still has 3 seats available to attend the Press Enterprise's Top Workplace luncheon on Wednesday, December 5th. She added that the Hospital has again placed in the top work places in California and is being recognized by the Press Enterprise.</td><td></td></tr>
<tr><td>Adjourn to Closed Session</td><td>Chair DiBiasi reported the items to be reviewed and discussed and/or acted upon during Closed Session will be:

➢ Proposed Action - Approve Medical Staff Credentialing
➢ Receive Quarterly Infection Control/Risk Management report
➢ There will be no telephone conference call with legal counsel

The meeting adjourned to Closed Session at 6:26 pm.

The public, Dave Recupero, Annah Karam, and Holly Yonemoto left the meeting prior to the closed session.</td><td></td></tr>
<tr><td>Reconvene to Open Session</td><td>The meeting reconvened to Open Session at 6:52 pm.

No public was waiting to return to the meeting

At the request of Chair DiBiasi, Bobbi Duffy, Executive Assistant, reported on the actions taken/information received during the Closed Session as follows:

➢ Approved Medical Staff Credentialing
➢ Received Quarterly Infection Control/Risk Management report</td><td></td></tr>
<tr><td>Future Agenda Items</td><td>None.</td><td></td></tr>
</table>

AGENDA ITEM		ACTION / FOLLOW-UP
Adjourn	The meeting was adjourned at 6:53 pm.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Respectfully submitted by Bobbi Duffy, Executive Assistant

TAB B

SAN GORGONIO
MEMORIAL HOSPITAL

Report from Chair Susan DiBiasi
January 7, 2020

During the month of December:

- Annual Tree Lighting Holiday Event including the Choir from Mountain View Middle School and visit from Mr. and Mrs. Santa delivered by lighted fire trucks.
- Ad Hoc Audit Selection Committee meeting
- Medical Staff Holiday Party
- Executive Committee meeting

TAB C

January 2020

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1 **New Year's Day Administration Closed**	**2**	**3**	**4**
5	**6**	**7** **4:00 pm Healthcare District Board** **5:00 pm Hospital Board**	**8**	**9** * 3:00 pm—Cafeteria General Staff mtg and Associate of the Month	**10**	**11**
12	**13**	**14**	**15**	**16**	**17**	**18**
19	**20**	**21**	**22**	**23**	**24**	**25**
26	**27**	**28** **9:00 am Finance Committee**	**29**	**30**	**31**	

As of December 19, 2019 in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

February 2020

SAN GORGONIO MEMORIAL HOSPITAL

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4 **4:00 pm Healthcare Dist. Board mtg.** **5:00 pm Hospital Board mtg.**	5	6 3:00 pm—Cafeteria General Staff mtg and Associate of the Month	7	8
9	10	11	12	13	14	15
16	17 **President's Day** Administration Closed	18	19 **9:00 am HR Comm. mtg.**	20	21	22 **Hospital Board Strategic Planning Session—Location and time TBD**
23	24	25 **9:00 am Finance Committee mtg.**	26	27	28	29

As of December 19, 2019 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

March 2020

SAN GORGONIO MEMORIAL HOSPITAL

Board of Directors Calendar

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3 **4:00 pm Healthcare District Board mtg.** **5:00 pm Hospital Board mtg.**	4	5 3:00 pm—Cafeteria General Staff mtg and Associate of the Month	6	7
8 	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31 **9:00 am Finance Committee mtg.** **10:00 am Executive Committee mtg.**				

As of December 19, 2019 Items in **bold** = Board/Committee meetings Items with * = Associate functions that Board members are invited to attend

TAB D

CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT

HOSPITAL BOARD

This Confidentiality and Nondisclosure Agreement ("Agreement") is entered into on _____. _____ between San Gorgonio Memorial Hospital, a California nonprofit public benefit corporation ("Hospital") and _____, an individual ("Board/Committee Member"). The Hospital and Board/Committee Member are each a "Party" and sometimes collectively referred to herein as the "Parties".

RECITALS

A. Board/Committee Member has been appointed as a member of Hospital's Board of Directors and its Committees wherein Board/Committee Member will have access to certain business information, including, but not limited to, financial information exchanged in closed door sessions of the Board of Directors ("Confidential Information").

B. Board/Committee Member desires to assure Hospital that the Confidential Information will not be disclosed to other individuals or entities, except as expressly authorized by this Agreement.

NOW, THEREFORE, the Parties hereby agree as follows:

OPERATIVE PROVISIONS

1. Acknowledgment. The Parties acknowledge and understand that the Confidential Information contains sensitive and private information, some of which may constitute trade secrets of Hospital.

2. Restriction on Use. The Parties agree that only individuals authorized by Hospital ("Authorized Persons"), shall have access to the Confidential Information and that Hospital shall cause any such Authorized Persons having access to the Confidential Information to sign an agreement substantially in the form of this Agreement, in which said Authorized Person agrees to be bound by terms and provisions substantially identical to those set forth in this Agreement.

3. Restriction on Disclosure. Each Party further agrees on behalf of itself and any Authorized Persons, that it shall hold, maintain and protect the confidential nature of the Confidential Information and shall not disclose the existence or contents of the Confidential Information to any person or entity, except as expressly authorized by this Agreement.

4. Exceptions to Restriction on Disclosure. Nothing contained in this Agreement shall prevent or be interpreted as preventing either Party or the Authorized Persons from disclosing the Confidential Information under the following circumstances:

(a) Where written consent is provided by the non-disclosing Party; and

(b) Where disclosure of the Confidential Information is required by subpoena or

other process of law; provided the subpoenaed Party or the Authorized Persons, as the case may be, shall promptly notify the non-subpoenaed Party of the receipt of said process so as to allow the non-subpoenaed Party every opportunity to resist the subpoena, service of process or court order.

5. No Rights in Confidential Information. No rights or licenses in the Confidential Information, expressed or implied, are granted to Board/Committee Member as a result of this Agreement.

6. Survival. Board/Committee Member's obligations with respect to the Confidential Information shall survive any expiration, termination or cancellation of this Agreement and continue to bind Committee Member.

7. Governing Law. This Agreement shall be governed by the laws of the State of California.

8. Remedies. Board/Committee Member acknowledges that money damages alone would not be a sufficient remedy for its breach of this Agreement. In addition to all other remedies, Hospital shall be entitled to specific performance and injunctive or equitable relief to remedy a breach. Board/Committee Member agrees to waive any requirement for the securing or posting of a bond in connection with such remedy. Board/Committee Member agrees to be fully responsible for its breach of any provision of this Agreement.

9. Entire Agreement. This Agreement constitutes the entire agreement and understanding of the Parties with respect to the subject matter herein and supersede all prior agreements and understandings, whether oral or written.

10. Severability. Whenever possible, each provision of this Agreement will be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be invalid, illegal or unenforceable in any respect under any applicable law or rule in any jurisdiction, such invalidity, illegality or unenforceability will not affect any other provision or any other jurisdiction but this Agreement will be reformed, construed and enforced in such jurisdiction as if such invalid, illegal or unenforceable provision had never been contained herein.

IN WITNESS WHEREOF, this Agreement has been executed as of the day and year first above written.

BOARD/COMMITTEE MEMBER:

By: _____
(signature)

Name: _____
(printed)

TAB E

AMENDED AND RESTATED BYLAWS

OF

SAN GORGONIO MEMORIAL HOSPITAL

HOSPITAL BOARD

A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION

TABLE OF CONTENTS

AMENDED AND RESTATED BYLAWS

OF

SAN GORGONIO MEMORIAL HOSPITAL

A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION

ARTICLE 1
OFFICES

Section 1.01 Principal Office

The principal office of the Corporation for the transaction of its business shall be located at San Gorgonio Memorial Hospital, which is located at the southeastern corner of Highland Springs Avenue and West Wilson Street in the City of Banning, in the County of Riverside, State of California, or such other place or places within the boundaries of the San Gorgonio Memorial Healthcare District ("District") as the Board of Directors may from time to time designate.

ARTICLE 2
NONPROFIT NATURE

Section 2.01 Goals and Purposes

The Corporation leases the San Gorgonio Memorial Hospital from the San Gorgonio Memorial Healthcare District, a local healthcare district under California Health & Safety Code Section 32000. Under the lease between the District and the Corporation, the Corporation is charged with operating the Hospital for the benefit of the communities served by the District. The goals and purposes of this Corporation are to:

a. operate and maintain the Hospital and provide hospital services for the benefit of the communities served by the San Gorgonio Memorial Healthcare District.

b. maintain a hospital for the care of persons suffering from illnesses or disabilities which require that the patients receive hospital care.

c. carry on any activities related to healthcare services which, in the opinion of the Board of Directors, may be justified by the facilities, personnel, funds or other assets that are or can be made available.

d. participate, so far as circumstances may warrant, in any activity designed and carried on to promote the general health of the community.

e. provide health education to the Hospital's patients and members of the community regarding wellness and prevention.

f. attract and retain a diverse staff of qualified well trained and competent healthcare practitioners and support personnel who will provide care in a competent manner.

Section 2.02 Exempt Purposes

The purposes for which this Corporation is organized are exclusively charitable and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended from time to time (or any successor statute). Notwithstanding any other provisions of these Bylaws, the Corporation shall not, except to an insubstantial degree, engage in or carry on any activities or exercise any power that is not in furtherance with the goals and purposes of this Corporation, or which are not permitted to be carried on (i) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended from time to time (or any successor statute) or Section 23701d of the California Revenue and Taxation Code, as amended from time to time (or any successor statute) or (ii) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1986, as amended from time to time (or any successor statute) or under Section 17201 and related Sections of the California Revenue and Taxation Code, as amended from time to time (or any successor statute).

Section 2.03 Dedication of Assets

The property of this Corporation is irrevocably dedicated to the charitable and educational purposes set forth in these Bylaws, and no part of the net income or assets of this Corporation shall inure to the personal benefit of any Director, Officer, or Member of this Corporation or to the benefit of any other private person. Upon the winding up and dissolution of this Corporation, its assets remaining after payment of, or provision for payment of, all the Corporation's debts and liabilities shall be distributed to the San Gorgonio Memorial Healthcare District, or any successor public agency charged with carrying out the purposes of the District, to continue to promote and accomplish the public purpose of this Corporation as set forth in these Bylaws. If the District, or the successor entity referred to in the preceding sentence, shall no longer exist at such time, then upon the winding up and dissolution of this Corporation, its assets remaining after payment of, or provision for payment of, all the Corporation's debts and liabilities shall be distributed to another non-profit corporation, trust or fund which is organized and operated exclusively for charitable purposes and which has established its tax exempt status within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended from time to time (or any successor statute), and Section 23701(d) of the California Revenue and Taxation Code, as amended from time to time (or any successor statute), such assets to be used exclusively for the purpose of continuing to promote and accomplish the charitable purpose of this Corporation as set forth in the Articles and in the Bylaws of the Corporation.

ARTICLE 3
MEMBERS

Section 3.01 No Members

The Corporation shall have no members, within the meaning of California Corporations Code Section 5056.

ARTICLE 4
DIRECTORS

Section 4.01 Number

This Corporation shall have thirteen (13) regular Directors, who shall be known collectively as the Board of Directors. Members of the Board of Directors shall be elected, as set forth in Article 5, provided that each individual who takes office as a Director of the District shall be an *ex officio* Director of the Corporation, with full voting rights and shall count for purposes of establishing a quorum. All of the Directors, including *ex officio* Directors, shall be subject to the same terms and provisions of these Bylaws and applicable law except as expressly provided to the contrary by these Bylaws. Subject to the discretion of the Board, two members of the Board of Directors may be members of the Medical Staff of San Gorgonio Memorial Hospital.

The Chief of Staff shall be an invited guest at all meetings of the Board of Directors, but shall excuse himself or herself from Board meetings when requested to do so by the Chair, and may not attend closed session meetings of the Board unless his or her experience and expertise is required by the Board and he or she is asked to attend by the Board. As the Chief of Staff is not a Director, the Chief of Staff shall have no voting rights and shall not count for purposes of establishing a quorum. The Chief of Staff shall abide by all policies of the Corporation applicable to Directors with respect to conflicts of interests and maintaining the confidentiality of trade secret, competitively sensitive information and closed session information.

Section 4.02 Use of Terms "Directors" and "Board"

The words "Directors" and "Board", as used in the Articles of Incorporation of this Corporation, or in these Bylaws, in relation to any power or duty requiring collective action, mean "Board of Directors".

Section 4.03 Restriction on Interested Persons and Employees as Directors

Subject to the additional restrictions in Section 4.18 of these Bylaws, no more than forty-nine percent (49%) of the persons serving on the Board may be interested persons. An interested person is (a) any person compensated by the Corporation for services rendered to it within the previous twelve (12) months, such as an independent contractor, or otherwise, excluding any reasonable compensation paid to a Director as Director; and (b) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, or father-in-law of such person. Employees of the Corporation or District may not serve on the Board. However, except as provided to the contrary by Government Code Section 1090, any violation of the provisions of this paragraph shall not affect the validity or enforceability of any transaction entered into by the Corporation.

Section 4.04 Powers

The Directors shall exercise the powers of the Corporation, control its property, and conduct its affairs, except as otherwise provided by law, by the Articles of Incorporation, or by these Bylaws. The Directors shall not be personally liable for the debts, liabilities, or other obligations of the Corporation.

Section 4.05 Duties

The Board of Directors has responsibility to establish policy for the Hospital and its business including, but not limited to, all matters pertaining to quality of care rendered within the Hospital. The Board of Directors shall exercise this authority in conformity with applicable laws, regulations and accreditation requirements. In furtherance of the foregoing, the role of the Directors shall be as follows:

a. establish policy for the operation, maintenance and development of the Hospital and its business including, but not limited to, assuring the quality of care within the Hospital.

b. appoint a competent and experienced Chief Executive Officer who shall be its direct representative in the management of the Hospital.

c. review the performance of the Chief Executive Officer on an annual basis.

d. approve the annual operating budget and capital expenditures.

e. approve the strategic plan on an annual basis.

f. review and approve periodic financial statements and other financial matters of the Corporation.

g. assure that adequate revenues are retained by the Corporation and expended in accordance with its charitable purposes.

h. review and act on financing arrangements recommended by the Chief Executive Officer for the Corporation.

i. review these Bylaws, the Bylaws of the Medical Staff and all committees on an annual basis, and approve needed changes.

j. review and approve written personnel policies and establish a procedure for notifying employees of changes in such personnel policies.

k. review and, where appropriate, approve policies and procedures to promote care, treatment and rehabilitation of patients.

l. review and revise, as appropriate, all department and service policies and procedures when warranted and ensure that the Medical Staff participates, as appropriate.

m. act as the final decision-making authority with respect to all matters pertaining to credentialing and privileges. Upon the recommendation and advice of the Medical Staff, the Board shall appoint members of the Medical Staff and grant such privileges as may, in their judgments, be warranted by the experience and training of the applicant.

Section 4.06 Compensation

The members of the Board of Directors shall be entitled to receive compensation equivalent in amount to that which is payable to the members of the Board of Directors of a California Healthcare District pursuant to the terms of Health & Safety Code Sections 32103. Such amounts shall not be mandatory and Board Members choosing not to accept compensation may do so. Additionally, each Board member shall also be entitled to receive reimbursement for expenses reasonably incurred in conjunction with educational seminars directly related to their function as a hospital board member, subject to such annual budgetary limitations as may be determined from time to time by the Board of Directors.

Section 4.07 Meetings Generally: Organizational Meeting

The meetings of the Board of Directors of the Corporation are subject to the Ralph M. Brown Act, as provided in California Government Code Section 54952(c). The Board of Directors shall hold its meetings in accordance with the agenda, open meeting and other requirements of the Ralph M. Brown Act, Government Code Section 54950 et seq. The Board of Directors shall annually hold organizational meeting where it shall organize by electing from its number the officers provided in Article 6 hereof to hold office until their successors are appointed as herein provided.

Section 4.08 Place

Meetings of the Board of Directors shall be held on the campus of the San Gorgonio Memorial Hospital or at such other place within the boundaries of the District as may be designated from time to time by the Board of Directors.

Section 4.09 Regular Meetings

Regular meetings of the Board of Directors shall be held at such times as may be prescribed from time to time by resolution of the Board of Directors, but not less than ten times annually. Upon adoption of such a resolution, a copy of the resolution shall be delivered to each member of the Board of Directors. Thereafter, no notice of any meeting held pursuant to the schedule described in the resolution shall be required, other than as may be required by law.

Section 4.10 Special Meetings

Special meetings of the Board of Directors shall be held whenever called by the Chair, or not less than four (4) of the Directors.

Section 4.11 Meeting by Telephone

Members of the Board may participate in a meeting through use of conference telephone, electronic video screen communication, or other communications equipment so long as (i) each member participating in the meeting can communicate with all of the other members concurrently, and (ii) each member is provided the means of participating in all matters before the Board, including the capacity to propose, or to interpose an objection, to a specific action to be taken by this Corporation, provided that it complies with California Government Code Section 54953(b).

Section 4.12 Notice and Agenda

At least 72 hours before a regular meeting and at least 24 hours before a special meeting, the Corporation shall post an agenda containing a brief but descriptive general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session in accordance with the Ralph M. Brown Act.

Notice of the time and place of all special meetings of the Board of Directors shall be given to each Director by one of the following methods: (a) by personal delivery of written notice; (b) by first-class mail, postage prepaid; (c) by telephone, including a voice messaging system or technology designed to record and communicate messages, or electronic transmission by the corporation (as defined in California Corporations Code Section 20). All such notices shall be given or sent to the Director's address or telephone number as shown on the records of the Corporation.

Notices sent by first-class mail shall be deposited in the United States mails at least four (4) days before the time set for the meeting. Notices given by personal delivery, telephone, telegraph, facsimile, electronic mail, or other electronic means shall be delivered, telephoned or given to the telegraph company at least forty-eight (48) hours before the time set for the meeting.

The notice shall state the time of the meeting, and the place if the place is other than the principal office of the Corporation. It need not specify the purpose of the meeting.

Notice of the time and place of holding an adjourned meeting need not be given to absent Directors if the time and place are fixed at the meeting adjourned.

Section 4.13 Quorum

A quorum shall consist of a majority of the members of the Board of Directors, unless a greater number is expressly required by statute, by the Articles of Incorporation of this Corporation, or by these Bylaws. Every act or decision done or made by a majority of the Directors present at a meeting duly held at which a quorum is present shall be the act of the Board of Directors, except where any law, regulation, or policy of any governmental agency requires a larger minimum vote in favor of any resolution.

Section 4.14 Conduct of Meetings

The Chair, or in his absence, the Vice Chair or, in the absence of both, a chair chosen by a majority of the Directors present, shall preside at all meetings of the Board of Directors. Meetings shall be governed by such rules of procedure as may be reasonably appropriate under the circumstances, insofar as such rules are not inconsistent or in conflict with these Bylaws, with the Articles of Incorporation of this Corporation, or with law. Each Director present shall have an affirmative duty to vote for or against each matter presented for a vote unless the Director has a conflict of interest that requires the Director to recuse himself. If a Board Member abstains from voting the abstention shall be counted on the side of the matter receiving the highest number of votes. Recusal for these purposes means (i) not voting, and (ii) leaving the meeting after answering any questions posed by the other Directors.

Section 4.15 Meetings Public

All meetings of the Board of Directors shall be open to the public in accordance with the Ralph M. Brown Act, Government Code Section 54950, et seq. and subject to the other terms of said Act. However, certain items, including but not limited to personnel matters, labor negotiations, quality improvement and other protected Medical Staff matters and litigation matters, are not appropriate for public discussion. Accordingly, where an exception to the open meeting requirement exists under the Brown Act, the Health & Safety Code or other applicable law and where the matter is properly agendized the Board of Directors may meet in closed session.

Section 4.16 Adjournment

The Board may adjourn any regular, adjourned, special or adjourned special meeting to a time and place specified in the order of adjournment. A copy of the notice of adjournment shall be conspicuously posted on or near the door of the place where the regular, adjourned regular, special or adjourned special meeting was held within 24 hours after the time of adjournment in accordance with Government Code Section 54955.

Section 4.17 Ethics Training and Sexual Harassment Avoidance Training Requirements

All members of the Board of Directors shall complete a course with a minimum of two hours of training in ethics pursuant to Government Code 54235 (AB 1234), similar to that as is required of the District Board of Directors. Such training will be required of newly appointed Directors within one year of assuming office and shall be renewed each two years thereafter. A certificate of completion showing at least two hours of training must be submitted and placed in each board member's file.

In addition to ethics training, all members of the Board of Directors shall complete a course with a minimum of two hours of training in sexual harassment avoidance pursuant to Government Code 12950.1 (AB 1825 & AB 1661) and 2 CCR 11024. Such training will be required of newly appointed Directors within six months of assuming office and shall be renewed each two years thereafter. A certificate of completion showing at least two hours of training must be submitted and placed in each board member's file.

Section 4.18 Conflicts of Interest and Other Policies

Members of the Board of Directors shall comply with the District's Conflict of Interest Code, as it may be amended or supplemented from time to time, applicable provisions of the Political Reform Act, Government Code Section 81000, et seq., Government Code Section 1090, et seq. and other policies adopted by the Board, including but not limited to its confidentiality policies. As required by the forgoing laws, Board members shall file an FPPC Form 700 with the Corporation within 30 days of taking office, annually, and within 30 days of leaving office.

Section 4.19 Confidentiality: Public Statements

The Board of Directors, and each of its members, shall maintain the confidentiality of any and all information that has been discussed in closed session or that is normally discussed in closed

session. Further, each Director with access to confidential information regarding this Corporation or this Corporation's business is expected to hold such information in confidence and to refrain from either using such information for personal gain or disclosing it unnecessarily outside the scope of the Director's duty with respect to this Corporation. No Board member shall make a public statement on behalf of the Board, or in a manner that appears to be on behalf of the Board, unless a majority of the Board has given prior authorization for the public statement at a duly noticed meeting of the Board of Directors.

Section 4.20 Appropriation of Business Opportunity and Confidential Information

No Director of this Corporation may appropriate or divert to others any opportunity for profit in connection with a transaction in which it is known or could be anticipated that this Corporation is or would be interested. Such opportunities include but are not limited to, acquisition of real or personal property, appointment of suppliers, or design or development of new products, services or areas of business related to this Corporation's present or planned services or service areas.

ARTICLE 5
ELECTION OF DIRECTORS

Section 5.01 Votes Required to Elect Director

Except as provided in Section 4.01 with respect to *ex officio* Directors, a candidate must receive the vote of a majority of the Directors present to be elected as a Director.

Section 5.02 Term of Office of Directors

Directors shall serve a term of four (4) years. Each Director may serve a maximum of two (2) consecutive terms. Former directors will be eligible to serve again after one (1) year of non-service. However, *ex officio* Board members shall serve for a term equal to their term on the District Board, and upon their resignation or removal from the District Board for any reason whatsoever, their terms of office as Directors of this Corporation shall cease and terminate, and their successors on the District Board shall be *ex officio* Directors of this Corporation in their place and stead. Each Director other than *ex-officio* Directors, including a Director elected to fill a vacancy, shall hold office until the expiration of the term for which elected, and until a successor has been appointed. The successor Director shall serve the unexpired term of the predecessor Director. If the unexpired term is two (2) years or less, then the successor Director shall serve a term of four (4) years plus the unexpired term. If the unexpired term is more than two (2) years, then the successor Director shall serve the unexpired term and face re-election to serve a new four (4)-year term.

5.03 Vacancies

a. Events Causing Vacancies. A Board member, including but not limited to an *ex officio* Director as a consequence of being a District Board member, shall be deemed to have vacated his seat on the occurrence of any of the following:

(1) The death or resignation of the Director.

(2) The declaration or resolution of the Board of the vacancy of the office of a Director who has been declared of unsound mind by an order of court or convicted of a felony or has been found by a final order or judgment of any court to have breached a duty under Sections 5230, et seq., of the California Nonprofit Public Benefit Corporation Law.

(3) Except as provided in Section 4.01 with respect to *ex officio* Directors, any Director may be removed, either with or without cause, by majority vote of the Directors then in office, at any regular or special meeting of the Board of Directors.

(4) Except as provided in Section 4.01 with respect to *ex officio* Directors, the absence of a Director from three consecutive meetings of the Board of Directors, and the determination of a majority of the remaining members of the Board of Directors that such absence was not excused.

(5) An increase in the authorized number of Directors.

(6) The failure of the Directors, at any meeting of the Directors at which any Director or Directors are to be elected, to fill a vacancy scheduled to be filled by election at such meeting.

b. Resignations. Any Director may resign, which resignation shall be effective upon giving written notice to the Chair, the Chief Executive Officer, the Secretary, or the Board of Directors, unless the notice specifies a later time for the resignation to be effective. If the resignation of a Director is effective at a future time, the Board of Directors may elect a successor to take office when the resignation becomes effective.

c. Vacancies of Directors. An Ad Hoc nominating committee will be formed for the purpose of recommending candidates to fill vacancies of Directors. This committee will be appointed in adherence with Section 7.06 and will include no less than two (2) *ex officio* Directors from the District Board. The Directors may elect a Director or Directors at any time to fill any vacancy or vacancies in the Board of Directors. Directors elected to fill a vacancy or vacancies in the Board of Directors of *ex officio* Directors by virtue of being a District Board member need to be the Director elected to the District Board to fill the vacancy on the District Board.

d. No Vacancy on Reduction of Number of Directors. No reduction of the authorized number of Directors shall have the effect of removing any Director before that Director's term of office expires unless such an intent is shown in the records of the meeting and a majority of the directors approve the reduction in number of directors.

ARTICLE 6
OFFICERS

Section 6.01 Number and Titles

The Officers of this Corporation shall be a Chair of the Board, a Vice Chair, a Secretary, and a Treasurer. This Corporation may also have, at the Board's discretion, one or more Assistant Secretaries, one or more Assistant Treasurers, and such other officers as may be appointed in accordance with these Bylaws. Any number of offices may be held by the same person, except that neither the Secretary nor the Treasurer may serve concurrently as the Chair of the Board. The Board shall also appoint a Chief Executive Officer and a Chief Financial Officer of the Corporation who shall be salaried employees of the Corporation.

Section 6.02 Other Officers

The Board may appoint and may authorize the Chair of the Board, or other officer, to appoint such additional officers that the Corporation may require. Each Officer so appointed shall have the title, hold office for the period, have the authority, and perform the duties specified in these Bylaws or determined by the Board.

Section 6.03 Qualification, Election, and Term of Office

The Officers of the Corporation, except those appointed under Section 6.02 of these Bylaws, shall be elected by majority vote of the Directors present at the annual organizational meeting of the Board of Directors. No more than two (2) Officers of the Corporation may be Directors of the District serving as ex officio Directors. Each such Officer shall hold office until the next organizational meeting, or until his removal, death, or resignation. The Officers shall hold their respective offices at the pleasure of the Board of Directors and shall be subject to removal by the Board of Directors at any time.

Section 6.04 Removal and Resignation

Any Officer may be removed, either with or without cause, by majority vote of the Directors then in office, at any regular or special meeting of the Board of Directors, and such Officer shall be removed should he cease to be qualified for the office as herein required. Subject to the terms of any written employment agreement between an officer and the Corporation, any Officer may resign at any time by delivering written notice to the Board of Directors or to the Chair or to the Secretary of the Corporation. Acceptance by the Board of Directors of any such resignation shall not be necessary to make it effective.

Section 6.05 Vacancies

Any vacancy caused by the death, resignation, removal, disqualification, or the like, of an Officer shall be filled by majority vote of the Board of Directors for the unexpired portion of the term.

Section 6.06 Duties of Chair

The Chair of the Board shall preside at meetings of the Board and shall exercise and perform such other powers and duties as the Board may assign from time to time.

Section 6.07 Duties of Vice Chair

If the Chair is absent or disabled, the Vice Chair shall perform all duties of the Chair. When so acting, the Vice Chair shall have all powers of and be subject to all restrictions on the Chair. The Vice Chair shall have such other powers and perform such other duties as the Board or these Bylaws may prescribe.

Section 6.08 Duties of Secretary

The Secretary shall keep or cause to be kept, at the Corporation's principal office or such other place as the Board may direct, a book of minutes of all meetings, proceedings, and actions of the Board and Committees of the Board. The Secretary shall keep or cause to be kept, at the principal office in California, a copy of the Articles of Incorporation and Bylaws, as amended to date.

The Secretary shall give, or cause to be given, notice of all meetings of the Board and of Committees of the Board required by these Bylaws or the California Corporations Code. The Secretary shall keep the Corporate Seal in safe custody and shall have such other powers and perform such other duties as the Board or these Bylaws may prescribe.

Section 6.09 Duties of Treasurer

The Treasurer shall keep and maintain, or cause to be kept and maintained, adequate and correct books and accounts of the Corporation's properties and transactions. The Treasurer shall send or cause to be given to the Directors such financial statements and reports as are required to be given by law, by these Bylaws, or by the Board. The books of account shall be open to inspection by any Director at all reasonable times.

The Treasurer shall deposit or cause to be deposited, all money and other valuables in the name and to the credit of the Corporation with such depositories as the Board may designate, shall disburse the Corporation's funds as the Board may order, shall render to the Chair of the Board, to the Chief Executive Officer, and to the Board, when requested, an account of all transactions as Treasurer and of the financial condition of the Corporation, and shall have such other powers and perform such other duties as the Board or these Bylaws may prescribe. If required by the Board, the Treasurer shall give the Corporation a bond in the amount and with the surety or sureties specified by the Board for faithful performance of the duties of the office and for restoration to the Corporation of all of its books, papers, vouchers, money, and other property of every kind in the possession or under the control of the Treasurer on his or her death, resignation, retirement or removal from office.

Section 6.10 Duties of Chief Executive Officer

Subject to such supervisory powers as the Board may give to the Chair of the Board, if any, and subject to the control of the Board, the Chief Executive Officer ("CEO") shall be the General Manager of the Corporation and shall supervise, direct, and control the Corporation's activities, affairs, and officers. The Chief Executive Officer shall have such other powers and duties as the Board or these Bylaws may prescribe. The authority and responsibility of the CEO shall include

a. carrying out all policies established by the Board.

b. development, and submission to the Board for approval, of a strategic plan for the organization and operation of the Hospital.

c. preparation of an annual budget showing the expected receipts and expenditures of the Corporation.

d. selection, employment, control and discharge of employees, and development and maintenance of personnel policies and practices for the Hospital.

e. maintenance of physical properties in a good state of repair and operating condition.

f. supervision of all business affairs to ensure that funds are collected and expended to the best possible advantage.

g. cooperation with the Medical Staff and with all those concerned with the rendering of professional services to the end that high quality care shall be rendered to the patients.

h. presentation to the Board of periodic reports reflecting the services provided by the Hospital and the financial activities of the Corporation and preparation and submission of such special reports as may be required by the Board.

i. attendance at all meetings of the Board and committees thereof.

Section 6.11 Execution of Contracts

The Board may authorize any officer or officers, agent or agents, including but not limited to the Chief Executive Officer, to enter into any contract or execute any instrument in the name of and on behalf of the Corporation. Such authority may be general or confined to specific instances and may be established by the Bylaws, Resolutions or the adoption of specific policies and procedures from time to time; provided, however, that unless so authorized by the Board, no officer, agent, or employee shall have any power or authority to bind the Corporation by a contract or engagement, or to pledge its credit, or to render it liable for any purpose or any amount.

ARTICLE 7
COMMITTEES

Section 7.01 Committees of the Board

The committees of the Board may be standing or special. Standing committees shall be the Finance Committee, the Human Resources Committee, and the Community Planning Committee, and other standing committees may also be authorized by the approval of the Board of Directors (collectively, "standing committees").

For special committees, the Board, by resolution adopted by a majority of the Directors then in office, provided a quorum is present, may create one (1) or more special Committees ("special committees"). Each special committee will have a minimum of three (3) and a maximum of five (5) members who may be Directors and persons who are not Directors who serve at the pleasure of the Board. No more than two (2) members of any special committee may be Directors of the District serving as *ex officio* Directors.

Except as otherwise provided in these Bylaws, all committee member appointments (including the appointment of Committee Chairs) shall be made by the Chair of the Board. The Chair of each Committee must be a member of the Board of Directors. A committee member shall serve his or her designated term unless he or she resigns, is removed or otherwise disqualified to serve, and all committee member terms shall terminate with the reorganization of the Board of Directors at the annual organizational meeting. Committee members shall not be entitled to compensation.

Each committee member shall be entitled to one (1) vote, to be exercised in person. Neither cumulative, substitute, nor proxy voting shall be allowed. A majority of the committee members shall constitute a quorum. All matters submitted to the committee for determination shall be decided by a minimum of a majority of a quorum of committee members.

Except as otherwise provided in these Bylaws, meetings of the committee may be called at any time by the Board Chair or the Chair of the committee. Meetings of all committees shall be open to the public in accordance with the Ralph M. Brown Act, Government Code Section 54950, et seq. and subject to the other terms of said Act as set forth in Section 4.15 of these Bylaws. A summary of all committee meetings including but not limited to all action of such committees shall be reported to the Board of Directors at the next regular or special meeting thereof.

Except as otherwise specifically described herein, the following Sections of these Bylaws pertaining to the Board of Directors shall pertain to members of committees: Section 4.17 Ethics Training and Sexual Harassment Avoidance Training Requirements, Section 4.18 Conflicts of Interest and Other Policies, Section 4.19 Confidentiality: Public Statements, and Section 4.20 Appropriation of Business Opportunity and Confidential Information.

All committees shall be advisory and no committee shall have the power to bind the Board, except when specifically authorized by the Board. The Board may delegate management of certain activities of the Corporation to any such committee as specified in the Board resolution, provided that the activities and affairs of the Corporation shall be managed and all corporate powers shall

be exercised under the ultimate direction of the Board and provided further that no committee, regardless of Board resolution, may:

a. Take any final action on any matter that, under the California Nonprofit Public Benefit Corporation Law, also requires approval of the members or of the Board of Directors or approval of a majority of all members or of the Board of Directors;

b. Fill vacancies on the Board or on any Committee that has the authority of the Board;

c. Fix compensation of the Directors for serving on the Board or on any Committee;

d. Amend or repeal Bylaws or adopt new Bylaws;

e. Amend or repeal any resolution of the Board that by its express terms is not so amendable or repealable;

f. Create any other Committees of the Board or appoint the members of the Committees of the Board;

g. Expend corporate funds to support a nominee for Director after more people have been nominated for Director than can be elected; or

h. Approve any contract or transaction to which the Corporation is a party and in which one (1) or more of its Directors has a material financial interest, except as special approval is provided for in Section 5233(d)(3) of the California Corporations Code.

Section 7.02 Executive Committee

The Executive Committee of the Board of Directors, shall consist of the Board Chair, the Board Vice Chair, the Board Secretary, the Board Treasurer and one (1) Director to be selected via a vote held by the Directors of the District serving as ex officio Directors. Each member of the Executive Committee must be a Director. No more than two (2) members of the Executive Committee may be Directors of the District serving as ex officio Directors.

The Executive Committee shall be delegated all powers and authority of the Board of Directors in the management of the business and affairs of the Corporation, except those powers reserved to the Board of Directors as a whole pursuant to Section 7.01. The Executive Committee shall meet quarterly to conduct its business, at a time and place to be designated by the members, or as otherwise provided by an appropriate resolution. The Executive Committee shall also hold special meetings on the call of the Chair.

Section 7.03 Finance Committee

The Finance Committee shall consist of a minimum of three (3) and a maximum of five (5) members of the Board of Directors, together with the Chief Executive Officer and the Chief Financial Officer. No more than two (2) members of the Finance Committee may be Directors of the District serving as *ex officio* Directors. The Finance Committee shall meet monthly, and shall be responsible for advising the Board for the management of all funds of the Corporation. It shall review and submit to the Board each year a proposed budget showing the expected receipts and income for the ensuing year. It shall make recommendations on all major capital expenditures, and significant hospital rate changes. It shall review and make recommendations to the Board of Directors with respect to all salary and wage adjustments, and for overall budget projections. It shall recommend a written plan for annual operations and for a three-year capital expenditure plan, which shall be updated annually.

Section 7.04 Human Resources Committee

The Human Resources Committee shall consist of a minimum of three (3) and a maximum of five (5) members of the Board of Directors, together with the Chief Executive Officer and the Director of Human Resources. No more than two (2) members of the Human Resources Committee may be Directors of the District serving as *ex officio* Directors. The Human Resources Committee shall meet bi-monthly for the purpose of determining the changing personnel requirements of the Hospital, reviewing and analyzing potential modifications to the Hospital's wage and benefit plans, and generally making recommendations to the full Board of Directors regarding personnel matters within the Hospital.

Section 7.05 Community Planning Committee

The Community Planning Committee shall consist of a minimum of three (3) and a maximum of five (5) members of the Board of Directors in addition to the Chief Executive Officer. No more than two (2) members of the Community Planning Committee may be Directors of the District serving as *ex officio* Directors. Community Planning Committee shall meet quarterly for the purpose of determining proposed long range goals for the Hospital and recommendations for methods whereby such goals may be accomplished. Areas of planning shall include, but shall not be limited to, potential expansion, contraction or modification of services rendered by the Hospital, determining and seeking methods of accomplishing marketing goals for the Hospital, including but not limited to those relating to advertising, community involvement, physician recruitment, patient relations and insurance and other third party payment programs (such as HMOs, PPOs and employer groups). All recommendations shall be presented to the Board of Directors for approval or action.

Section 7.06 Ad Hoc Committees

Ad hoc committees may be appointed by the Chair of the Board, with the concurrence of the majority of the Board and in such numbers and for such special tasks as circumstances warrant. Such special Committees shall limit their activities to the accomplishment of the task for which created and appointed, and shall have no power to act except such as is specifically conferred by

action of the Board. Upon completion of the tasks for which appointed, each such special committee shall stand discharged.

ARTICLE 8
MEDICAL STAFF

Section 8.01 Organization

The Board shall cause to be created a Medical Staff organization, to be known as the Medical Staff of San Gorgonio Memorial Hospital, whose membership shall be comprised of all duly licensed physicians, dentists, psychologists and podiatrists who are privileged to attend patients in the Hospital. Membership in this Medical Staff organization shall be a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. No applicant to the Medical Staff shall be denied Medical Staff membership on the basis of sex, race, creed, color or national origin, or on the basis of any other criterion lacking professional justification.

Section 8.02 Medical Staff Bylaws, Rules and Regulations

a. **Purpose.** The Medical Staff organization shall propose and adopt by vote bylaws, rules and regulations for its internal governance ("Medical Staff Bylaws") which shall be effective when approved by the Board. These Medical Staff Bylaws shall create an effective administrative unit to discharge the functions and responsibilities assigned to the Medical Staff by the Board. The Medical Staff Bylaws, rules and regulations shall state the purposes, functions and policies by which the Medical Staff exercises its responsibilities. The Board of Directors will review and approve the Medical Staff Bylaws annually.

b. **Procedure.** The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. If the Medical Staff fails to exercise this responsibility in good faith and in a reasonable, timely and responsible manner and after written notice from the Board to such effect including a reasonable period of time for response, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws. In such event, staff recommendations and views shall be carefully considered by the Board during its deliberation and in its actions.

Section 8.03 Medical Staff Membership and Clinical Privileges

a. **Responsibilities of the Medical Staff Members.** Each member of the Medical Staff shall have appropriate authority and responsibility for the care of his/her patients, subject to such limitations as are contained in these Bylaws, and in the Medical Staff Bylaws, and subject, further, to limitations attached to his/her appointment. The attending physician shall be responsible for preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include, at a minimum: identification data; chief complaint; past history; family history; history of present illness;

physical examination; special reports such as necessary consultations; clinical laboratory reports and radiology reports and others; provisional diagnosis; appropriate consents; medical and surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge summary and autopsy report when applicable. The CEO shall arrange for all administrative assistance to receive appointment applications to the Medical Staff, and further to provide for necessary administration support to process all materials pertinent to the application of any potential member of the Medical Staff. All applications for and appointments to the Medical Staff shall be in writing and addressed to the Medical Staff Office. The application shall contain full information concerning the applicant's education, licensure, practice, previous hospital experience, and any unfavorable history with regard to licensure and hospital privileges. This information shall be verified by the appropriate body within the Medical Staff. Upon appointment, the applicant will agree in writing to follow the Bylaws, rules and regulations of the Corporation and of the Medical Staff, and all other approved policies of the Medical Staff and the Corporation. All applications shall be reviewed by the Medical Staff prior to being submitted to the Governing Body for approval. When an appointment is not renewed or when privileges have been proposed to be reduced, altered, suspended, or terminated, the staff member shall be afforded the opportunity of a hearing in accordance with the Fair Hearing Plan then in effect. It is the Board of Directors' policy that: (1) only a member of the Medical Staff with admitting privileges shall admit patients to the Hospital; (2) only an appropriately licensed practitioner with clinical privileges shall be directly responsible for a patient's diagnosis and treatment within the area of his privileges; (3) each patient's general medical condition shall be the responsibility of a physician member of the Medical Staff; (4) each patient admitted to the Hospital shall receive a baseline history and physician examination by a physician who is either a member of, or approved by, the Medical Staff; and (5) direct medical care of patients provided by Allied Health Personnel shall be under the appropriate degree of supervision by a licensed practitioner with clinical privileges.

b. **Delegation to the Medical Staff.** The Board shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges and corrective action, and shall require that the Medical Staff adopt and forward to it specific written recommendations with appropriate supporting documentation that will allow the Board to take informed action.

c. **Action by the Board.** Final action on all matters relating to Medical Staff membership status, clinical privileges and corrective action shall be taken by the Board after considering the Medical Staff recommendations, provided that the Board shall act in any event if the Medical Staff fails to adopt and submit any such recommendation within the time period set forth in the Medical Staff Bylaws. Such Board action without a Medical Staff recommendation shall be based on the same kind of documented investigation and evaluation of current

ability, judgment and character as is required for Medical Staff recommendation, and shall be taken only after written notice to the Medical Executive Committee.

d. **Criteria for Board Action.** In acting on matters of Medical Staff membership status, the Board shall consider the Medical Staffs recommendations and the extent of applicant's utilization of this Hospital, the Hospital's and the community's needs, and such additional criteria as are set forth in the Medical Staff Bylaws. No aspect of membership status nor any specific clinical privileges shall be limited or denied to a practitioner on the basis of sex, race, creed, color, or national origin, nor on the basis of any other criterion unrelated to: (i) good patient care at the Hospital, (ii) professional qualifications, (iii) the Hospital's purposes, needs and capabilities, or (iv) community needs.

e. **Terms and Conditions of Medical Staff Membership and Clinical Privileges.** The terms and conditions of membership status in the Medical Staff, and the exercise of clinical privileges, shall be as specified in the Medical Staff Bylaws or as more specifically defined in the notice of individual appointment. At a minimum, however, each member of the Medical Staff shall (1) exhibit the skill necessary to allow him to appropriately carry out his duties and (2) carry such malpractice insurance as may be determined to be appropriate from time to time by the Board of Directors. Additionally, each member of the Medical Staff having active staff privileges shall provide on-call back-up coverage within his field of specialty to the Hospital's Emergency Room, pursuant to such back-up call schedule as may be adopted by his Service of the Medical Staff. If no other back-up call coverage schedule is adopted by a Service, Emergency Room back-up call coverage for such Service shall be scheduled on the basis of alphabetical order by last name within such Service, rotating among all active staff physicians within the Service, each being responsible for 24 hour back-up coverage.

f. **Ethics.** The Principles of Ethics of the appropriate National Association as now in effect or as may be hereinafter amended by that association shall govern the professional conduct of the members of the Medical Staff.

g. **Procedure.** The procedure to be followed by the Medical Staff and the Board in acting on matters of membership status, clinical privileges, and corrective action shall be specified in the Medical Staff Bylaws. However, each member of the Medical Staff shall be required to obtain and maintain, at his or her own expense, malpractice insurance in such amount as may be determined to be appropriate from time to time by the Board of Directors.

h. **Fair Hearing Plan.** The Board shall require that any adverse recommendation made by the Medical Executive Committee or any adverse action taken by the Board of Directors with respect to a practitioner's staff appointment, reappointment, Service affiliation, staff category, admitting prerogative or clinical privileges, shall, except under circumstances for which specific

provision is made in the Medical Staff Bylaws, be accomplished in accordance with the Fair Hearing Plan then in effect. Such plan shall provide for procedures to assure fair treatment and afford an opportunity for presentation of all pertinent information. For the purposes of this Section an "adverse recommendation" of the Medical Executive Committee and "adverse action" of the Board shall be defined in the Fair Hearing Plan. The Fair Hearing Plan shall provide for an appeals procedure whereby any applicant for Medical Staff Membership feels a decision of the Medical Staff has been unjust shall have recourse to a hearing by a joint committee composed of Directors and Medical Staff Members. The appellant in such a case shall have the opportunity to present any and all evidence and testimony bearing upon his qualifications for appointment to the Medical Staff. Following such presentation of evidence, the Committee shall present evidence in support of its findings. Failure of an applicant to request a hearing within the time frames set forth in the Fair Hearing Plan shall constitute a waiver of the applicant's rights to a hearing under the Fair Hearing Plan.

ARTICLE 9
QUALITY OF PROFESSIONAL SERVICES

Section 9.01 Board Responsibility

The Board shall require, after considering the recommendations of the Medical Staff, and the other health care professional staffs providing patient care services, the conduct of specific review and evaluation activities to assess, preserve and improve the overall quality and efficiency of patient care in the Hospital. The Board, through the CEO, shall provide whatever administrative assistance is reasonably necessary to support and facilitate the implementation and the ongoing maintenance and operation of these review and evaluation activities.

Section 9.02 Accountability to Board

The Medical Staff and the other health care professionals providing patient care services shall conduct and be accountable to the Board for conducting activities that contribute to the preservation and improvement of the quality, safety and efficiency of patient care provided in the Hospital. These activities include:

a. Review and evaluation of the quality of patient care (generally on a retrospective basis) through a valid and reliable patient care review procedure.

b. Ongoing monitoring and evaluation of patient care practices through the defined functions of the Medical Staff, the other professional services, and the Hospital administration.

c. Delineation of clinical privileges for members of the Medical Staff commensurate with individual credentials and demonstrated ability and judgment and assignment of patient care responsibilities to other health care professionals consistent with individual qualification and demonstrated ability.

d. Review of utilization of the Hospital's resources to provide appropriate allocation of those resources to patients in need of them.

e. Such other measures as the Board may, after considering the advice of the Medical Staff, the other professional services and the Hospital administration, deem necessary for the preservation and improvement of the quality, safety and efficiency of patient care.

Section 9.03 Documentation

The Board shall require, receive, consider and act upon the findings and recommendations emanating from the activities required by Article 8. All such findings and recommendations shall be in writing, and shall be supported and accompanied by appropriate documentation upon which the Board can take informed action.

ARTICLE 10
BOARD OF DIRECTORS INITIATION OF PEER REVIEW

Section 10.01 Basic Policy

It is the policy of this Hospital that peer review be performed by members of the Medical Staff, inasmuch as only licentiates who possess the same or similar education, training and experience have the requisite expertise to insure an efficient, fair and responsive peer review system. Notwithstanding the foregoing, however, in those instances in which the Medical Staffs failure to investigate or to initiate disciplinary action is contrary to the weight of the evidence, the Board of Directors shall have the authority to direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consultation with the Chief of Staff. No action shall be taken in an unreasonable manner. In the event the Medical Staff fails to take action in response to a direction from the Board of Directors, the Board of Directors shall have the authority to take action against a member of the Medical Staff. Such action shall be taken only after written notice to the Medical Staff and shall fully comply with the procedures and rules applicable to peer review proceedings established by Sections 809.1 through 809.6, inclusive, of the Business and Professions Code of the State of California.

Section 10.02 Suspension of Privileges

When no person authorized by the Medical Staff is available to summarily suspend or restrict clinical privileges, the Board of Directors, or its designee, may immediately suspend the clinical privileges of a member of the Medical Staff if the failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any individual; provided the Board of Directors has, before the suspension, made reasonable attempts to contact the Medical Executive Committee. A suspension by the Board of Directors which has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, shall terminate automatically.

ARTICLE 11
INDEMNIFICATION

Section 11.01 Right of Indemnity

To the fullest extent permitted by law, this Corporation shall indemnify its Directors, Officers, employees, and other persons described in Section 5238(a) of the California Corporations Code, including persons formerly occupying any such position, against all expenses, judgments, fines, settlements and other amounts actually and reasonably incurred by them in connection with any "proceeding", as that term is used in that section, and including an action by or in the right of the Corporation, by reason of the fact that the person is, or was, a person described in that section. "Expenses", as used in these Bylaws, shall have the same meaning as in Section 5238(a) of the California Corporations Code.

Section 11.02 Approval of Indemnity

On written request to the Board by any person seeking indemnification under Section 5238(b) or Section 5238(c) of the California Corporations Code, the Board shall promptly determine under Section 5238(e) of the California Corporations Code whether the applicable standard of conduct set forth in Section 5238(b) or Section 5238(c) has been met and, if so, the Board shall authorize indemnification.

Section 11.03 Advancement of Expenses

To the fullest extent permitted by law, and except as otherwise determined by the Board in a specific instance, expenses incurred by a person seeking indemnification under Sections 11.01, 11.02 or 11.03 of this Article in defending any proceeding covered by those sections shall be advanced by the Corporation before final disposition of the proceeding, on receipt by the Corporation of an undertaking by or on behalf of that person that the advance will be repaid unless it is ultimately determined that the person is entitled to be indemnified by the Corporation for those expenses.

Section 11.04 Insurance

The Corporation shall have the right to purchase and maintain insurance to the full extent permitted by law on behalf of its Officers, Directors, and employees.

Section 11.05 Other Fiduciary Positions

This Article does not apply to any proceeding against any trustee, investment manager or other fiduciary of an employee benefit plan in such person's capacity as such, even though such person may also be covered by the first sentence of Section 1 of this Article 11. This Corporation shall have power to indemnify such trustee, investment manager or other fiduciary to the extent permitted by subsection (f) of Section 5140 of the California Corporations Code.

Section 11.06 Provisions Not Exclusive

The indemnification and advancement of expenses provided by this Article 11 of these Bylaws shall not be deemed exclusive of any rights to which those seeking indemnification or expense advancement may be entitled under any agreement, vote of disinterested Directors, or otherwise, both as to action in his or her official capacity while holding such office, and shall continue as to a person who has ceased to be a Director, officer, or employee and agent, and shall inure to the benefit of the heirs, executors and administrators of such person.

Section 11.07 Contractual Rights of Non-Directors and Non-Officers

Nothing contained in this Article 11 shall affect any right to indemnification to which persons other than Directors of the Corporation, or any of its subsidiaries, may be entitled by contract or otherwise.

ARTICLE 12
CORPORATE RECORDS, REPORTS, AND SEAL

Section 12.01 Minutes of Meetings

The Corporation shall keep at its principal office, or at such other place as the Board of Directors may order, a book of the minutes of all meetings of Directors with the time and place of holding, whether regular or special, and, if special how authorized, the notice given and the names of those Directors and presenting staff present.

Section 12.02 Books of Account

The Corporation shall keep and maintain adequate and correct accounts of its properties and business transactions, including accounts of its assets, liabilities, receipts, disbursements, gains, and losses.

Section 12.03 Annual Report

The Corporation shall cause an annual report or statement to be sent to the Board of Directors not later than 120 days after the close of the fiscal year in accordance with the provisions of Sections 1500 and 1501. Such report shall contain a balance sheet as of the end of the fiscal year, an income statement and a statement of changes in financial position for such fiscal year, all prepared according to generally accepted accounting procedures, and accompanied by any report thereon of an independent accountant, or if there is no such report, a certificate of the Chief Financial Officer or Chief Executive Officer that such statements were prepared without audit from the books and records of the Corporation. The report shall also provide any information required by California Corporations Code Section 6322.

Section 12.04 Maintenance of Records and Inspection by Directors

The Corporation shall keep at its principal executive office the original or a copy of the Articles of Incorporation, Bylaws, and other records of the Corporation. Every Director shall have the absolute right at any reasonable time to inspect all books, records, and documents of every

kind and the physical properties of the Corporation and each subsidiary corporation. This inspection by a Director may be made in person or by an agent or attorney, and the right of inspection includes the right to copy and make extract of documents.

Section 12.05 Corporate Seal

The Board of Directors shall provide a corporate seal consisting of two concentric circles with the words "San Gorgonio Memorial Hospital", and the words and figures, "INCORPORATED May 8, 1990, CALIFORNIA."

ARTICLE 13
HOSPITAL AUXILIARY AND FOUNDATION

The Hospital Auxiliary shall be an integral part of this Corporation, and shall have no separate existence as a corporation or other unincorporated association. The Bylaws of the Hospital Auxiliary shall be approved by the Board of Directors of the Hospital. The Hospital Foundation shall be a separate and independent corporation existing for the benefit of the Hospital.

ARTICLE 14
EFFECTIVE DATE & AMENDMENT

Section 14.01 Effective Date

These Bylaws shall become effective immediately upon their adoption and shall supersede and replace all previous Bylaws of the Corporation. Amendments to these Bylaws shall become effective immediately upon their adoption.

Section 14.02 Amendment

Except as otherwise provided herein or by law, the Board may, after lawful notice to all Directors then in office, adopt, amend or repeal these Bylaws upon the majority vote of the Directors, provided a quorum is present.

CERTIFICATE OF SECRETARY

I certify that I am the duly elected and acting Secretary of SAN GORGONIO MEMORIAL HOSPITAL, and that the above Amended and Restated Bylaws, consisting of 2~~3~~8 pages, are the Bylaws of this Corporation as adopted by the Corporation's Board of Directors on ~~March 5, 2019~~ January 7, 2020, that they supersede all previous versions of the Bylaws for the Corporation.

Executed on ~~March 5, 2019~~ January 7, 2020, at Banning, California.

Estelle Lewis, Secretary

TAB F

2020 Environment of Care Plans

Presented for Approval to Hospital Board of Directors
on January 7, 2020

- 2020 Hazardous Materials and Waste Management Plan
- 2020 Life Safety (Fire Safety) Plan
- 2020 Utilities Management Plan
- 2020 Medical Equipment Management Plan
- 2020 Environmental Safety and Security Management Plan
- 2020 Emergency Management Plan

San Gorgonio Memorial Hospital
Environment of Care
2020 Hazardous Materials and Waste Management Plan

I. PURPOSE

San Gorgonio Memorial Hospital's Hazardous Materials and Waste Management Plan is designed to provide a safe, functional, supportive and effective environment for patients, associates, and others utilizing the facility through the coordination, management, control, safe handling, storage and disposal of hazardous material and waste that is in accordance with Federal, State and Local regulations.

II. GOAL & OBJECTIVE

It is the goal of the Hazardous Materials and Waste Management Plan to:

1. Identify materials and waste that require special handling. The EPA has published listing of known hazardous substances with an identification number assigned to each. Also, the State of California has a "Director's List" of hazardous substances. These lists are incomplete. The basic designations should be used when determining what is and what is not hazardous waste.

2. Implement a process to minimize the risks that are associated with unsafe use of Hazardous Material and improper disposal of Hazardous Waste. Training employees regarding hazardous wastes, including identification of hazardous wastes, the hazardous effect, safe handling procedures, use of personal protective equipment and emergency procedures.

III. SCOPE

The scope of the Hazardous Materials and Waste Management Plan is organization wide in scope, and applies to all care settings, departments and services.

IV. AUTHORITY

The Hazardous Materials and Waste Management Plan is authorized by the Chief Executive Officer (CEO) and the hospital governing board. The EOC/Safety Committee has been charged with the responsibility to develop, implement, and evaluate this plan on at least an annual basis.

V. ELEMENTS OF THE PLAN

- Development and maintenance of a written management plan describing the processes it implements to effectively manage hazardous materials and waste.

- Creation and maintenance of an inventory that identifies hazardous materials and waste used, stored, or generated using criteria consistent with applicable law and regulation.
- Establish and implement processes for selecting, handling, storing, transporting, using, and disposing of hazardous materials and waste from receipt or generation through use and/or final disposal; including managing the following:
  - Hazardous chemicals and waste
  - All hazardous wastes will be approximately labeled with written information that explains what the material is. Its strength (if applicable) and the type of hazards it represented (if not obvious). All hazardous wastes will be packaged, labeled, placarded and marked according to the Department of Transportation Regulations. These regulations are found in the code of Federal Regulations at 49CFR parts 172, 173, 178 and 179. These regulations specify packaging requirements for regulated materials, labeling requirements according to hazard category and all necessary placarding for use when transporting hazardous wastes.
    - Labels must be clear and undamaged.
    - Labels, when required, will be printed on or affixed to the surface of the package near the proper shipping name.
    - When two or more different labels are required, they will be displayed next to each other.
    - When two or more packages containing compatible hazardous wastes are packaged within the same over pack, the outside container will be labeled as required for each class of material contained therein.
    - Certain hazardous wastes can be stored in bags without labels provided a universally accepted coloring system is used. For example, all infectious wastes would be disposed of in red bags.
  - Chemotherapeutic materials and waste
  - Radioactive materials and waste
  - Infectious and regulated medical waste
- Provision of adequate and appropriate space and equipment for safe handling and storage of hazardous materials and waste
- Biohazardous waste is removed from specific pickup area in each department. It is then transported to the locked biohazardous holding area to await pick up from "Waste Hauler.
- Hazardous wastes which cannot be legally disposed of by incineration, chemical neutralization or through the sewage system, will be stored in approved drums and containers in specially designated areas that are accessible only to authorized personnel.

- Hazardous wastes will be stored on site for a maximum of 90 days. In rare cases a 30 days extension is allowed by obtaining a treatment storage and handling permit from the California Department of Health Services.

  Hazardous wastes will be segregated by class and separated by space.

  Lists of incompatible chemicals (i.e., acids and bases) will be readily available for personnel who handle waste chemical storage.

- Minimizes risks associated with selecting, handling, storing, transporting, using and disposing of hazardous gases and vapors, including monitoring levels of hazardous gases and vapors to determine that they are in safe range.

- Flammable will be kept in a flammable liquid storage cabinet.

  Irritants and highly volatile materials will be kept in ventilated storage under slightly negative pressure.

  Ignitable or reactive wastes will be stored at least 15 meters (50 feet) from the property line.

  If a container is holding a hazardous waste that is stored near any incompatible substance, it will be separated by means of a dike, berm, wall or other device.

- Identification and implementation of emergency procedures that include the specific precautions, procedures, and protective equipment used during hazardous materials and waste spills or exposures.

- Any hazardous material spill or exposure will be safely contained and cleaned up in accordance with policies and procedures, with notifications made to the appropriate municipal, state and federal agencies and/or emergency response agencies as required.

  - Maintenance of documentation, including required permits, licenses, manifests, and safety data sheets as required by law and regulation
  - Department of Environmental Health- Annually
  - Medical Waste Management Annually
  - Dot Training – Annually
  - Manifests – Daily
  - Safety Data Sheets are changed when a new product is implemented
  - Proper labeling of hazardous materials and waste
  - Bio Hazardous waste is labeled with the hazardous symbol

VI. EVALUATION

The scope, goals and objectives, and plan elements of the Hazardous Materials and Waste Management Plan will be evaluated annually for effectiveness by the EOC/Safety Committee. The annual evaluation is submitted to the EOC/Safety Committee for review and include the following criteria:

1. The number of potential spills/exposure incidents.
2. The number and type of potential improperly segregated waste disposal.
3. The number and type of potential deficiencies during Riverside County Environmental Health Survey.

VII. EDUCATION & TRAINING

- All associates will receive education in Hazardous material and waste management at new hire orientation by the Safety Officer and thereafter by their Department Director, immediate Supervisor, the Infection Control Practitioner and/or Employee Health Nurse.

- The EOC/Safety Committee in coordination with the Safety Officer will provide annual organization-wide safety education, which will include hazardous material and waste management.

VIII. MONITORING OF PERFORMANCE

- The Hazardous Material and Waste Management Program Performance Standards will be monitored on an on-going basis and be reported quarterly to the EOC/Safety Committee, and will include the following:
  - Associate knowledge of hazardous material and waste management;
  - Monitoring and inspection activities;
  - Emergency and incident reporting;
  - Equipment and hazardous environmental monitoring and/or testing;
  - Emergency response procedures performed satisfactorily in the event of a potential spill to include the following: use of appropriate Personal Protective Equipment (PPE); containment and cleaned-up; and appropriate initiation of notifications in alignment with Federal, State and Local regulatory requirements.

San Gorgonio Memorial Hospital
Environment of Care/Safety Committee
Life Safety (Fire Safety) Plan
2020

I. PURPOSE

San Gorgonio Memorial Hospital's Fire Safety Plan provides a method to effectively maintain a fire-safe environment.

II. OBJECTIVE

The objective of the San Gorgonio Memorial Hospital's Fire Safety Plan is to minimize the potential for harm to patients, visitors and staff through inspection, testing, surveillance, education and response preparedness.

III. SCOPE

The scope of the Fire Safety Plan addresses San Gorgonio Memorial Hospital's Main Hospital, Behavioral Health Center, Cooling Tower/Oxygen Farm, Central Plant.

IV. GOAL

To maintain compliance to all applicable NFPA standards and ensure the fail-safe operation of all fire detection, containment and suppression systems.

V. AUTHORITY

San Gorgonio Memorial Hospital's Chief Executive Officer has final authority and responsibility for the assurance of a comprehensive Fire Safety Plan to the Board of Directors. The Chief Executive Officer delegate the monitoring of the Fire Safety Plan to the Safety Committee and the Safety Officer. The EOC/ Safety Committee is responsible for ensuring that the Fire Safety is compatible with Federal, State and Local requirements.

VI. ELEMENTS OF THE PLAN

Protect patients, visitors, staff and property from fire, smoke and other products of combustion.

- The San Gorgonio Memorial Hospital fire protection program is designed to limit the development and spread of fire through maintenance of a smoke-free facility; emergency response education, training and performance evaluation; facility flammability control; fire safety inspection and monitoring; and maintenance and testing of fire protection and life safety systems.
- Elements of the fire protection program are inspected annually by the State of California.

Inspect, test and maintain fire protection and life safety systems, equipment and components on a regular basis.

- Elements of the facility fire detection and suppression systems are inspected, tested and maintained in accordance to applicable NFPA standards:

  NFPA 72
  Supervisory Signal Devices-tested annually
  Tamper Switches and Water Flow-tested quarterly
  Occupant Alarm Notification-tested quarterly with each day evening, and night shift fire drills
  Off Premises Emergency Response Notification-event driven, tested annually

  NFPA 25
  Riser systems-main drain test, annually
  Fire Department Connections-inspected quarterly
  Kitchen Detection/Suppression Systems-tested semi-annually

  NFPA 10
  Manual Fire Extinguishers are:
  Clearly identified
  Inspected monthly
  Maintained annually

NFPA 90A
All fire and smoke dampers are operated (with fusible links removed where applicable) every six years to verify they fully close.
All automatic smoke detection shutdown devices for air handling equipment are tested at least annually.
NFPA 80 fire doors are tested for proper operation annually and with each quarterly, day, evening, and night shift fire drills where observable.

- Elements of the facility fire detection and suppression systems are inspected and tested annually by the State of California.

Report and investigate fire protection of deficiencies, failures and user Errors.

- Fire protection deficiencies, failures and user errors are reported to and investigated, as appropriate, by the Safety Officer and the Plant Operations Director/Manager for immediate resolution and are reported, as applicable, to the EOC/Safety Committee.

Review proposed acquisitions of bedding, window draperies, and other Curtains, furnishings, decorations, wastebaskets and other items for fire Safety.

- All proposed acquisitions to furnish or decorate the facility are reviewed, as applicable to Life Safety Code, by Materials Management to ensure that compliance to mandated fire retardant ratings.

- Wastebaskets, and other items as appropriate, are made of non-combustible materials and are labeled as required to verify UL or FM approval.

EVALUATION

- The Fire Safety Plan's scope, program objectives and performance standards measures will be evaluated annually for effectiveness by the EOC/Safety Committee. The annual evaluation is submitted to Administration and the Board of Directors.

The criteria used to measure the effectiveness of the Life Safety Plan are:

1. A summary of non-complying factors related to Life Safety Codes, with action plan recommendation.

2. Preventative maintenance completion rates.

3. Fire drill completion rates.

4. General orientation and annual update training compliance rates.

EDUCATION & TRAINING

- Fire prevention training of all San Gorgonio Memorial Hospital staff is provided by the employee's Department Director/Nurse Manager, the Safety Officer/designee.

- The Safety Officer/designee presents fire prevention training at new employee orientation.

- The Safety Officer and the EOC/Safety Committee coordinate annual organization wide fire prevention education.

MONITORING OF PERFORMANCE

- In an effort to improve the Fire Safety Plan, the Goals and Performance Standards Measures, as approved by the EOC/Safety Committee, will be monitored on an ongoing basis and annually by the Safety Officer and the EOC/Safety Committee. Performance measurements address: staff fire prevention knowledge, skills and level of participation in fire drill exercises, and the monitoring and inspection of related fire prevention programs. The results of the fire prevention performance monitoring are reported to Administration and Department Directors/Managers on a quarterly basis, and annually to the Board of Directors.

EMERGENCY PROCEDURES

- Established emergency procedures (RACE) are evaluated through fire drills. Fire Drills to assess staff knowledge of:

  Use, function and transmission of fire alarm systems
  Containment of smoke and fire
  Horizontal transfer to refuge areas

Fire extinguishments (PASS)

Specific fire-response duties

- The San Gorgonio Memorial Hospital life safety orientation and education programs address:

  Specific roles and responsibilities of staff, physicians and other licensed independent practitioners at the fire's point of origin.

  Specific roles and responsibilities of other personnel who must participate in the fire plan, such as volunteers, students and physicians.

  Use and function of fire alarm systems.

  Specific roles and responsibilities in preparing for building evacuation.

  Location and proper use of equipment to evacuate or transport patients to areas of refuge.

  Building compartmentalization features and procedures for containing fire and smoke.

In accordance with Life Safety Code NFPA 101, use of interim life safety measures is utilized to evaluate various deficiencies and hazards prior to the onset of building renovation or construction. Written criteria are established to address each of the interim life safety measures and are approved by the Safety Officer, Director of Plant Operations, and the responsible managing architect.

All renovation and construction areas where interim life safety measures have been activated are monitored daily for hazard surveillance, infection control and contractor compliance to the measures identified for the duration of the activation.

San Gorgonio Memorial Hospital
Environment of Care
Utilities Management Plan
2020

I. PURPOSE

San Gorgonio Memorial Hospital's Utilities Management Plan provides a method to effectively maintain a safe and comfortable environment of care through continuous evaluation, improvement and maintenance of utility systems.

II. OBJECTIVE

The objective of San Gorgonio Memorial Hospital's Utilities Management Plan is to establish and maintain utility systems within the facility that promote a safe, controlled environment; reduce the potential for organization-acquired illness; minimize the risk of utility failures; and ensure operational reliability.

III. SCOPE

The scope of the Utilities Management Plan addresses San Gorgonio Memorial Hospital's Main Hospital, Cooling Tower/Oxygen Farm,
Central Utility Plant and ED/ICU building.

IV. GOAL

To reduce the potential for utility service disruptions or malfunctions; to reduce any resulting risk of injury to patient care and staff; and to prolong equipment life through inspection, testing, preventive maintenance and staff education.

V. AUTHORITY

San Gorgonio Memorial Hospital's Chief Executive Officer has final authority and responsibility for the assurance of a comprehensive Utilities Management Plan to the Board of Directors. The Chief Executive Officer delegates the monitoring of the Utilities Management Plan to the EOC/Safety Committee and the Safety Officer. The EOC/Safety Committee is responsible for ensuring that the Utilities Management Plan is compatible with Federal, State and Local requirements.

VI. ELEMENTS OF THE PLAN

Promote a safe, controlled, comfortable environment of care.

- San Gorgonio Memorial Hospital promotes a safe, controlled, comfortable environment of care through management of preventive maintenance of utility systems that maintain life support; the prevention and control of infection; environmental support; and equipment support.

- Such systems include electrical distribution; emergency power; horizontal transport; heating, ventilating and air conditioning; plumbing; boiler and steam utilization; piped gas and vacuum systems; communication systems; and information systems.

Reduce the potential for hospital-acquired illness.

- Reducing the potential for hospital-acquired illness is accomplished through management of building utilities that address infection control, including: air handling and environmental automation systems, domestic hot/cold water, steam distribution, hot water heating, and chilled water distribution.

Assess and minimize risks of utility failures.

- The risk of utility failure is minimized through the inspection, testing, and maintenance of critical operating components, and through the education of users and maintainers of utility systems.

Ensure the operational reliability of utility systems.

- Operational reliability of utility systems is accomplished through the completion and review of scheduled preventive maintenance; the ongoing assessment and scheduled upgrade of utility system components; and through the review and investigation of problems, failures, unscheduled outages or user errors to determine cause and corrective action necessary to minimize recurrence.

Establish risk criteria for identifying, evaluating, and inventorying of critical Operating components.

- Risk criteria used to prioritize maintenance of critical operating components address: threat to general patient safety; life threat to patient safety; the risk of treatment delays due to equipment failure or lack of capacity; and the potential discomfort to patients, visitors and staff, or danger to life or health as a result of equipment failure, accidental discharge or lack of capacity.

Maintenance strategies for all inventoried critical components.

- Maintenance strategies of inventoried critical components are established utilizing predictive maintenance records, interval-based inspections, metered maintenance and corrective maintenance histories.

Intervals for inspection, testing and maintenance of inventoried critical Components.

- Intervals for inspection, testing and maintenance to minimize clinical or physical risk are established based on manufacturers' recommendations, risk levels identified, and health care system experience.

Inspection, testing and maintenance of critical components of piped gas medical Systems.

- Medical gas system master signal panels and area alarms are inspected and tested annually. Automatic pressure switches, main and area shutoff valves, connectors and outlets are inspected and tested annually.

Medical gas pipe systems are tested when installed, modified or repaired.

- Medical gas systems are initially certified upon installation and are re-certified in the event of modification or repair. The certification and re-certification process shall include cross-connection testing, piping purity testing, and pressure testing.

Maintain accessibility to and clear labeling of medical gas system main supply valve and area shutoff valves.

- Medical gas system main shutoff and area shutoff valves are readily accessible and clearly labeled in the event of scheduled or emergency shut down.

Manage pathogenic agents in cooling towers, domestic hot water, and other Aerosolizing systems.

- The potential for growth of and exposure to pathogenic agents is minimized through the treatment and maintenance of hospital cooling towers, and scheduled cleaning and disinfecting of aerosolizing water systems (sinks, showers and drinking fountains), hydrotherapy tubs, respiratory treatment equipment, and decorative fountains.

Install and maintain appropriate pressure relationships, air exchange rates and filtration efficiencies for ventilation systems that serve areas specially designed to control airborne contaminants.

- Specially designed areas to control airborne contaminants: operating rooms, special procedure rooms, delivery rooms, negative isolation rooms, laboratories and sterile supply rooms are tested annually to ensure air exchange rates and filtration efficiencies, or as required to ensure proper isolation pressure relationships are maintained.

Develop and maintain utility system operating plans.

- Utility system operating plans are maintained to help ensure equipment reliability and to reduce the risk of malfunction or failure.

Map the distribution of utility systems and label controls.

- Blueprints and single-line drawings are maintained to identify how utility systems are distributed, and all controls points are clearly labeled to facilitate partial or complete emergency shutdown.

Investigate utility systems management problems, failures, user errors or reported incidents.

- Reports of utility system failures, problems and/or user errors are reviewed and investigated by the Plant Operations Director/Manager for corrective action, reviewed by the Safety officer, and reported to the EOC/Safety Committee.

EDUCATION & TRAINING

- Plant Operations Supervision is responsible for ensuring the orientation, education and annual evaluation of staff responsible for maintaining utility systems.

- The Safety Officer presents appropriate staff response to utility system failures at new employee orientation; and, department level utility system user training is provided by the employee's Department Director/Nurse Manager, Plant Operations representative.

- The Safety Officer and EOC/Safety Committee coordinate annual organization wide utility systems education.

MONITORING OF PERFORMANCE

In an effort to improve the Utilities Management Program, the Goals and Performance Standards Measures, as approved by the EOC/Safety Committee, will be monitored on an ongoing basis and annually by the Safety Officer.

The EOC/Safety Committee. Performance measurements address: user utility systems knowledge, completion of preventive

Maintenance, monitoring, testing and inspection of identified critical components, and review and investigation of emergency and incident reporting. The results of the utility systems performance monitoring are reported to Administration and Department Directors/Managers on a quarterly basis, and annually to the Board of Directors.

Emergency procedures for utility system disruptions or failures.

- Emergency procedures are maintained that address specific procedures to follow in the event of utility disruption; the identification and procurement, if applicable, of alternative sources; instructions for shutoff of malfunctioning systems and how to obtain repair; and when and how to perform emergency clinical intervention.

EVALUATION

- The Utility Systems Management Plan's scope, program objectives and performance standards measures will be evaluated annually for effectiveness by the EOC/Safety Committee. The annual evaluation is submitted to Administration and the Board of Directors for review.

  The criteria used to measure the effectiveness of the Utility Plan are:

  1. The effectiveness of current preventative maintenance procedures.

  2. Evaluation of incident reporting procedures (quality review reports).

  3. Status of compliance with employee training and orientation.

EMERGENCY POWER SOURCE

San Gorgonio Memorial Hospital provides and tests reliable emergency power systems that have:

An adequately sized, designed and fueled emergency power source

- and support services. Sufficient fuel storage is maintained on campus to provide a minimum of ninety six (96) hours of service.

Provide reliable emergency power and stored energy power systems as

required by occupancy classification.

- San Gorgonio Memorial Hospital maintains emergency power generators and stored energy systems to provide electricity to the following systems when normal power is interrupted:

  Alarm systems
  Exit route and exit signs illumination
  Emergency communication systems

Provide reliable emergency power systems as required by services provided and patients served.

- San Gorgonio Memorial Hospital maintains emergency power generators to provide electricity to the following areas when normal power is interrupted:

  Blood storage units
  Emergency/Urgent care areas
  Medical air compressors
  Medical and surgical vacuum systems
  Operating rooms
  Postoperative recovery rooms
  Patient and special care units
  Obstetrical delivery rooms
  Newborn nurseries
  Air Conditioning Units
  Food Storage Units
  Pharmacy Supply Units

San Gorgonio Memorial Hospital
Environment of Care
Medical Equipment Management Plan
FY 2020

I. PURPOSE

San Gorgonio Memorial Hospitals Medical Equipment Management Plan provides for the safe and reliable operation of medical equipment used in the treatment of patients throughout San Gorgonio Memorial Hospital. The Medical Equipment Management Plan will ensure that the equipment provides accurate, reliable information to the clinicians. It is safe for patients, operators and visitors, and is utilized to its fullest capacity in order to optimize patient care.

II. OBJECTIVE

The objective of San Gorgonio Memorial Hospitals Medical Equipment Management Plan is to ensure the safe, hazard-free operation of equipment through risk-based preventive maintenance and management of equipment problems, recalls, failures and user errors.

III. SCOPE

The scope of the Medical Equipment Management Plan addresses the Main Hospital of San Gorgonio Memorial Hospital and the Behavioral Health Center.

IV. GOAL

To identify life support equipment as part of the hospital equipment inventory, and reduce potential injuries for patients and/ or associates. This is done through equipment risk assessment, completion of preventive maintenance, equipment inventory, responding to product safety alerts, hazards and recalls, and staff education

V. AUTHORITY

San Gorgonio Memorial Hospital Chief Executive Officer has final authority and responsibility for the assurance of a comprehensive Medical Equipment Management Plan to the Board of Directors. The Chief Executive Officer delegates the monitoring of the Medical Equipment Management Plan to the Director of Materials Management, who then reports to the Environment of Care Committee. The EOC/Safety Committee is responsible for ensuring that the Medical Equipment Management Plan is compatible with all Federal, State and Local requirements.

VI. ELEMENTS OF THE PLAN

Equipment selection and acquisition:

- Selection is based on the efficacy, safety, acceptability, serviceability, and standardization of equipment. Equipment replacement include, but not limited to, submitting planned capital equipment requests based on depreciation of equipment, schedules, monitoring approved capital equipment, hazard/product recalls, and reactively replacing based on inability to further maintain.

- A recommendation for new or replacement equipment may be originated by any department.

    - The recommendation is a multi-disciplinary process that may include other pertinent parties as necessary, e.g. Materials Management, medical staff, risk management, and end users. This process may include developing a list of potential vendors, developing and implementing an evaluation tool, defining bid document specifications, attending vendor presentations, conducting technical evaluations, participating in clinical trials, making site visits and final evaluation of bid response documents. Utilizing facility GPO contracted vendors.

- The Materials Management Department shall be made aware of any disposables/ consumables required in conjunction with equipment so that availability and cost are addressed prior to equipment acquisition. The user and the Materials Management Department are responsible for coordinating the arrival of new equipment, installation, and removal of old equipment, along with Bio-Medical Company.

- Establishment of risk criteria to identify, evaluate, and take inventory of equipment to be included in the management program before the equipment is used. The risk criteria address: equipment function, the physical risks associated with use, and equipment incident history. Contracted Bio-Medical Company shall be on site twice per month as per agreement will also be responsible for:

- All equipment included in the Biomedical Department inventory database for San Gorgonio Memorial Hospital shall be included in this program and kept in Materials Management; a web site database with equipment inventory will be made accessible via computer.

- Prior to placing any new, rental, leased, demo, borrowed or loaner medical equipment into service, the Engineering Department performs an electrical

safety/ground check. All new equipment purchased must first be inspected by contracted Bio-Medical Company which will perform safety, operational and functional check and is responsible for the initial incoming inspection, risk assessment, and assignment of inspection interval for preventive/routine maintenance.

- Equipment will be added to equipment inventory listing. A unique number is assigned to each piece of equipment and is recorded in the central database by Bio-Medical Company.

- The Materials Management Department maintains a current and accurate inventory of medical equipment for which they are responsible. This inventory includes a minimum of the reference number, manufacturer, model number, description, serial number, assigned location of the equipment, and Bio-Medical ID code.

- The Materials Management Department shall maintain and make available upon request an inventory list and equipment history.

- Monitor and act on equipment safety alerts, hazard notices and recalls.

- All medical equipment recalls, alerts, and hazard notices are addressed in accordance with all applicable policies, procedures, and governing agencies (e.g. Economic Cycle Research Institute (ECRI, Food and Drug Administration (FDA), and Manufacturer).

- Monitor and report all incidents, in which a medical device is connected to death, serious injury or serious illness of any individual, as required by the Safe Medical Devices Act (SMDA) of 1990. Any medical equipment device related incidents are to be reported immediately and coordinated through Risk Management or Administration when the Risk Management Director is not available.

- All incidents in which a medical device may have caused or contributed to the death, serious injury, or serious illness of a patient are addressed and reported per Safe Medical Devices Act (SMDA) requirements.

- Report and investigate equipment management problems, failures, and user errors.

- Any associate, upon becoming aware of a potential patient incident either involving a medical device or resulting from user error, will act in accordance with the Medical Equipment Management Plan including, but not limited to:

- Immediately notify a supervisor and other pertinent personnel (Risk Management, Safety Officer, etc.) as appropriate.

- Complete a quality review report via Verge Incident Report System.

- Impound equipment and all consumables/disposables pending investigation and release**.**

- All occurrences of incident, abuse, operator error and "could not duplicate" shall be reported to the Safety Officer for review and action as necessary.

- Utilize maintenance strategies appropriate to equipment identified the inventory to ensure safe operation.

- Establish intervals for the inspection, testing and maintenance of equipment to minimize clinical and physical risks based on criteria such as manufacturers' recommendations, risk levels, and current organization experience.

- The Materials Management Department shall complete a risk assessment for each type of device in the Medical Equipment Management Plan. Risk and preventive maintenance frequency shall be established using a weighted scoring system as follows:

  Equipment function (34%)
  Physical Risks (33%)
  Maintenance requirements (33%)

- The Contracted Bio-Medical Company shall perform inspections, testing, and maintenance as determined by the risk assessment or per manufacturer recommendations and Economic Cycle Research Institute (ECRI) procedures. Will be responsible for equipment level of services graphs each month and provided to EOC/Safety Committee meetings on a regular basis. These measures will evaluate performance level of Bio-Medical Company.

- A review annually shall be conducted to determine if any preventive maintenance program needs to be adjusted to any item in the equipment inventory.

  The Medical Equipment Plan consists of the following overlapping programs:
  Risk Management program
  Infection Control Committee
  Employee Orientation
  Education Program
  Performance Improvement Committee
  Emergency Preparedness Plan

Patient Safety Program
Safety Program
Life Safety Plan
Utility Systems Plan

EVALUATION

The Medical Equipment Management Plans scope, program objectives and performance standards measures will be evaluated annually for effectiveness by the EOC/Safety Committee.

The annual evaluation is submitted to Administration and the Board of Directors for review.

The criteria used to measure the effectiveness of the Medical Equipment Plan are:

1. The effectiveness of the preventative maintenance procedures.
2. The completion of the preventative maintenance schedules.
3. Staff response capability and their understanding of training.
4. Status of compliance with employee training and orientation.

EDUCATION & TRAINING: EQUIPMENT MAINTAINERS

- Emergency procedures that address: equipment disruption or failure; when and how to perform emergency clinical interventions when medical equipment fails; the availability of backup equipment; and how to obtain repair services by Bio-Medical Company and/or direct manufacturer.
- Service providers meet minimum educational and/or experience requirements upon employment.
- The Biomedical service is responsible for the technical and engineering support of the majority of medical equipment at San Gorgonio Memorial Hospital. The Engineering Department supports, maintains records on electrical safety performed on all in-coming equipment to include rental, and hospital own equipment. The Engineering department will have a working knowledge of equipment maintenance through service schools, seminars, and on-the-job/cross training.

- The Engineering Department maintains documentation of training/ education provided and received. Training/education content includes, but is not limited to:

  - Participate in the development of area specific Medical Equipment Management related policies and procedures as necessary.

  - Development, provision, and documentation of department/job specific Medical Equipment Management training as required.

  - Maintain appropriate Medical Equipment Management procedural knowledge regarding policies, practices, procedures, and safety emergency plans affecting their area(s) of responsibility and clinical interventions in the event of failure.

  - Processes for requesting backup medical equipment and equipment repair or service as needed.

  - Orientation and annual skills performance checks administered according to clinical user group needs ensuring that a level of competence is maintained.

EDUCATION & TRAINING: EQUIPMENT USERS

- The Materials Management and Engineering Department, in coordination with vendor representatives and clinical staff, as appropriate, ensures that training of users is addressed prior to placing new types of equipment into service.

- The Materials Management and Engineering Department work together to ensure training as requested or in response to suspected operator error.

- Users are assigned the responsibility and accountability for establishing and documenting appropriate internal policies and procedures establishing safe practices for their areas of operation including, but not limited to:

- Capabilities, limitations, and special applications of equipment

- Basic operating and safety procedures for equipment use.

- Processes for reporting medical equipment problems, failures, and operator errors.

- Processes for reporting incidents and adverse patient outcomes.

- The Safety Officer presents safe medical equipment practices at new associate orientation.

- The Safety Officer and the EOC/Safety Committee Chairperson coordinate annual organization wide medical equipment safety education programs, updates.

PRODUCT EVALUATION COMMITTEE

- The Product Evaluation Committee meets as needed when new products are being considered and involving the end users.

MONITORING OF PERFORMANCE

- In an effort to improve the Medical Equipment Management Program, the Goals and Performance Measures, as approved by the Environment of Care Committee, will be monitored on an ongoing basis and annually by the Safety Officer and the EOC/Safety Committee. Performance measurements address: staff knowledge, monitoring and inspection activities, emergency and incident reporting, and preventive maintenance and testing of equipment. The results of medical equipment performance monitoring are reported to Administration and Department Directors/Managers on a quarterly basis, and annually to the Board of Directors.

San Gorgoino Memorial Hospital
Environmental Safety and Security Management Plan
2020

I. PURPOSE:

The Environmental Safety and Security Management Plan has combined two of planning documents, which are designed to provide a safe, secure, functional, supportive, and effective environment for patients, associates, visitors and all others utilizing the facility(s).

II. GOALS & OBJECTIVES:

The 2020 Goals and Objectives for Environmental Safety and Security Plan are based on past performance, data analysis, and information from both internal and external sources. These goals and objectives will have leadership oversight with approval from the hospital governing board and the Environment of Care (EOC)/Safety Committee, and will be reported on a quarterly basis, or sooner if deemed appropriate by the Chief Executive Officer (CEO) or the Chief Nursing Officer (CNO).

- Identification of an individual(s) to manage, coordinate, and mitigate risk reduction activities in the physical environment through data collection and dissemination, which will lead to appropriate actions and results.

- Identification of an individual(s) to intervene whenever an environmental safety or security condition immediately threaten life or health, or damage to the property or the environment.

- To incorporate an effective process of identifying individuals entering and/or leaving the facility(s).

- Development of appropriate policies and procedures for controlling the access to and from departments, which are identified as security sensitive.

- Establishment of appropriate policies and procedures to follow in the event of a security incident, such as: a Code Gray, Code Silver (Active Shooter), Code Pink, Code Yellow, as well as a partial or complete lockdown of a department or the entire facility(s).

- Ensure compliance of non-smoking campus by patients, associates, visitors, and others utilizing the facility(s).

- Present new hire, annual and on-going training in environmental safety and security, to associates, department directors, medical staff and other volunteer and/or contract staff.

- Promote the newly developed Avade Workplace Violence Prevention Program and Policy, including review and reporting of trends and incidents. These reports

will be compiled by the Environmental Safety Officer, who will assemble a threat assessment team as per policy, to ensure appropriate investigation of all incidents, especially those which are the result of an identified environmental safety, security issue or potential workplace violence. Ensure facility is in compliance with the law regarding workplace violence.

- Ensure that an annual, proactive Environmental Safety and Security Risk Assessment is conducted and reported to the hospital governing board, the Executive Team and the EOC/Safety Committee.

- Ensure that identified potential environmental safety and security threats from Environmental Safety and Security Risk Assessment, are incorporated into future plans in order to mitigate the threat, risk and potential impact on the organization and the community, as a whole.

III. SCOPE AND APPLICABILITY:

The Environmental Safety and Security Management Plan is organization-wide in scope and applies to all inpatient and outpatient care settings, departments, and services.

IV. AUTHORITY:

The Environmental Safety and Security Management Plan is authorized by San Gorgonio Memorial Hospital's (SGMH) governing board. The CEO delegates the monitoring of the Environmental Safety and Security Management Plan and Program to the Environmental Safety Officer, who will work in collaboration with the EOC/Safety Committee members.
The EOC/Safety Committee is currently chaired by the Director of Engineering and is intended to be a multidisciplinary committee with representation from the hospital governing board, Administration, Clinical Laboratory, Diagnostic Imagining, Dietary Services, Emergency Preparedness, the Emergency Department, Employee Health, Engineering, Environmental Services, Human Resources, Infection Control/Risk Management, Materials Management, Medical Staff, Nursing Leadership, Performance Improvement, Security and Surgical Services.

V. PROGRAM ELEMENTS:

- Development, implementation and maintenance of the Environmental Safety and Security Plan and the processes that will be used to effectively manage the environmental safety and security of patients, associates, visitors and all others utilizing the facility(s).

- Identification of an individual(s) who will identify, manage, and coordinate environmental safety and security risk reduction activities in the physical

environment, through data collection and dissemination, which will lead to appropriate actions and results.

- Identification of an individual(s) to intervene whenever environmental safety and security conditions immediately threaten life, health, or the property of the organization (equipment and/or buildings).

- Identification of environmental safety and security risks associated with the environment of care.

- Identification of individuals entering the facility(s).

- Control of the access to and from areas that are identified as security sensitive within the facility.

- Ensure that effective policies and procedures are in place to be followed in the event of a security incident, including an infant or pediatric abduction, as well as a workplace violence incident.

- Respond, review, and collection of data regarding injuries to patients, associates, and/or others within the facility which are or could potentially have been caused by an environmental safety and security issue or practice and/or the result of workplace violence.

- Respond, review and collection of data on security incidents involving patients, associates, others within the facility and damage to hospital property or the property of others.

- Establish and maintain environmental safety and security policies and procedures, which will be reviewed for effectiveness as needed, but at least once every three years.

- Report and investigate all other incidents, which result in injury to patients, associates, visitors, and other utilizing the facility(s) including property damage and “never events,” in collaboration with the EOC/Safety Committee members.

- Reports on this plan, goals, objectives and plan elements will be presented quarterly to the hospital governing board, the EOC/Safety Committee, or as deemed appropriate by the Chief Executive Officer (CEO) or Chief Nursing Executive (CNE).

VI. ADDITIONAL PROGRAM ELEMENTS:

The multi-disciplinary EOC/Safety Committee shall report, collect data, analyze, investigate, and take required action on additional program elements. These additional program elements will include, but is not necessarily limited to the following:

- Conducting environmental tours every quarter in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks
- Conducting annual environmental tours in non-patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate risks in the environment.
- Occupational illnesses and staff injuries, including any workplace violence incidents
- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies and failures
- Utility systems management problems, failures or use errors

VII. EDUCATION AND TRAINING:

Environmental Safety and Security training is provided to all associates at new hire, general orientation. Additional education and training is provided by the Environmental Safety Officer, the Security department and/or members of the EOC/Safety Committee, as needed and to include attendance at departmental staff meetings. However, at San Gorgonio Memorial Hospital, environmental safety and security is everyone's responsibility and all associates are encouraged to report or say something immediately, if they see something doesn't appear safe, secure, or looks suspicious.

Additional education on department specific and general environmental safety and security topics, are available to associates on-line with competencies to be completed, in order to ensure understanding.

The Environmental Safety Officer in collaboration with the EOC/Safety Committee will coordinate an annual organization-wide environmental safety and security education program event, by providing two Annual Environmental Safety Fairs.

VIII. OTHER TRAINING:

- Department level training is provided to educate associates to specific job-related hazards and is assessed and monitored by Department Directors or designees.

- EOC/Safety Inspection Rounds, regulatory surveys, emergency code exercises and drills are utilized to ensure associates are following appropriate environmental safety and security practices, evaluate associate understanding of practices, policies and procedures as well as provide “just in time” training to prepare associates and help them become more comfortable in responding to and recovering from an actual incident or emergency code.

- All education and training programs are conducted in accordance with state and federal regulatory requirements in an effort to reduce the risk of workplace injury, exposure, and/or violence.

- As new or revised environmental safety or security regulations are established, they will be presented to associates promptly through appropriate training and/or education programs, as required to ensure understanding.

- Environmental safety and security education is also provided for associates, through articles published in the hospital newsletter and information posted in display cases, outside of the cafeteria and other locations throughout the facility, if required.

IX. PERFORMANCE MEASUREMENT:

In an effort to improve Environmental Safety and Security and assist in meeting annual goals and objectives of this plan, performance measures will be monitored and evaluated on an on-going basis throughout the organization to determine effectiveness.
Performance measures for the coming year include (but are not limited to):

- Monitoring for environmental “never events”
- Assess associates knowledge regarding environmental safety and security policies and procedure by conducting emergency code exercises/drills. Any corrective actions items identified will be addressed in an After Action Report and become part of an Improvement Plan, which assigns associate responsible and a time line for completion to ensure appropriate follow-up.
- Conduct at least one Code Pink (infant/child abduction) exercise annually.
- Ensure appropriate reporting and follow-up on findings from the annual Environmental Safety and Security Threat Assessment.

PROGRAM EVALUATION:

The goals, objectives, scope, and performance measures of the Environmental Safety and Security Management Plan will be evaluated on an annual basis. Revisions and/or changes in laws regulations and standards will be addressed as part of the annual evaluation process and incorporated into the Environmental Safety and Security Management Program and Plan for the coming year.

Annual evaluation of the plan and any revisions to the plan for the coming year will be done with leadership oversight and reported to the hospital governing board and EOC/Safety Committee annually, or sooner if indicated.

REFERENCES

1. CIHQ Standards CE-3, CE-4
2. CMS Conditions of Participation for Acute Care Hospitals – §482.41

SAN GORGONIO MEMORIAL HOSPITAL
Emergency Management Plan
2020

I. PURPOSE:

The purpose of the Emergency Management Plan is to maintain effective systems to manage natural and other emergencies in the organization or the community that disrupt the organization's ability to provide care and treatment, to provide plans to be implemented during an emergency so that patient care can be continued as effectively as possible and to establish actions to be taken to prepare for, mitigate, respond to and recover from the effects of any emergency.

II. GOALS AND OBJECTIVES:

The 2020 Goals and objectives for Emergency Management Plan is based on past performance, data analysis, and information from both internal and external sources. These goals and objectives will have leadership oversight with approval from the hospital governing board and the Environment of Care (EOC)/ Safety Committee, and will be reported on a quarterly basis, or sooner if deemed appropriate by the Chief executive Officer (CEO) or the Chief Nursing Officer (CNO).

III. SCOPE AND APPLICABILITY:

The Emergency Preparedness Plan applies to all organizational departments, associates, and physicians and is applicable throughout all organizational buildings, grounds, and San Gorgonio Memorial Hospital owned; rented or leased buildings.

The plan provides for a systematic all hazard approach to emergency management. Key personnel utilize an all hazard incident command structure to manage internal and external disasters. Facility personnel coordinate internal efforts in conjunction with external emergency response agencies. The facilities emergency management plan is developed and activated within the contexts of the local jurisdiction's Emergency Medical Services community wide disaster plan. The facility's performance of a hazard vulnerability analysis guide the identification of potential and actual risks.

IV. AUTHORITY:

The Emergency Preparedness Program is authorized by San Gorgonio Memorial Hospital's (SGMH) governing board. The Chief Executive Officer delegates the monitoring of the Emergency Preparedness Program, to the Emergency Preparedness coordinator who will work in collaboration with the EOC/Safety Committee members.

The EOC/Safety Committee is currently chaired by the Director of Engineering and is intended to be a multidisciplinary committee with representation from the hospital governing board, Administration, Clinical Laboratory, Diagnostic Imaging, Dietary Services, Emergency Preparedness, the Emergency Department, employee Health, Engineering, Environmental Services, Human Resources, Infection Control/Risk Management, Materials Management, Medical Staff, Nursing Leadership, Performance Improvement, Security and Surgical Services.

V. PROGRAM ELEMENTS:

- Development, implementation and maintenance of the Emergency Management Plan and the process that will be used to effectively manage the environment during a disaster, using an All-Hazard approach.

Emergency Operations Plan
For details on the Emergency Management CIHQ standards that reference the following categories refer to the San Gorgonio Memorial Medical Center Emergency Operations Plan (EOP):

1. EP-1: Establishment of an Emergency Preparedness Program
2. EP-2: Emergency Preparedness Plan and Risk Assessment
3. EP-3: Emergency Preparedness Policies & Procedures
4. EP-4: Emergency Preparedness Communication Plan
5. EP-5: Emergency Preparedness Training Program
6. EP-6: Testing of the Emergency Preparedness Plan
7. EP-7: Emergency and Standby Power Systems
8. EP-8: Healthcare System & Emergency Preparedness
9. EP-10: References for Informational Purposes

Emergency Management Exercises and Community Involvement
For details on the Emergency Management Exercises refer to the San Gorgonio Memorial Medical Center Emergency Operations Plan (EOP):

Orientation, Education and Training
The orientation, education, and training component of the Emergency Preparedness Program is designed to provide all who work in or enter the organization with information which may include:

- Specific information detailing roles and responsibilities;
- Skills needed to recognize specific types of emergencies (i.e. symptoms caused by agents that may be used in chemical or bioterrorist attacks);
- The information and skills needed to perform the required duties of the emergency management plan;

- The organization's contingent method of communication, transportation, evacuation during emergencies; and
- The method of obtaining supplies and equipment during emergencies.

Performance Standards
The performance measurements for the Emergency Management Program for 2020 include:

- Individuals trained/re-trained for WMD (decontamination) participation
- Timely follow-up of incident or exercise requiring follow-up actions, After Action Report (AAR)
- Compliance with National Incident Management System's (NIMS), Standardized Emergency Management System (SEMS) Implementation
- Annual review of the Emergency Management Plan
- Annual Emergency Management risk assessment
- Annual review of the Emergency Operations Plan (EOP)

The information outlined in these performance standards will be reported to the (Environment of Care Committee) quarterly, and to the hospitals governing board. Aggregate information will also be reported on a quarterly basis using at least one year's data and information. Conclusions, actions, and results of follow-up monitoring will be documented in the minutes of the Committee or in action logs designed to monitor performance and results.

Related and Supportive Documentation

- After Action Reports from Drills and Exercises
- Hazard Vulnerability Analysis both facilities and community based
- Policies addressing preparation, mitigation, response and recovery from a disaster or emergency in the ten defined areas of the (EOP) Emergency Operations Plan
- Minutes, exercise critiques, agreements from community integration activities with local, state or federal agencies
- Minutes from Emergency Management Meetings
- Evacuation Plans
- Annual Program Evaluation
- Annual Safety Fair Testing

SAN GORGONIO MEMORIAL HOSPITAL
Emergency Management Plan
2020

TAB G

MINUTES: Not Yet Approved By Committee

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS EXECUTIVE COMMITTEE
December 17, 2019

The regular meeting of the San Gorgonio Memorial Hospital Board of Director's Executive Committee was held on Tuesday, December 17, 2019 in the Administration Boardroom, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Lynn Baldi, Susan DiBiasi (C), Estelle Lewis, Steve Rutledge

Members Absent: Ehren Ngo

Required Staff: Steve Barron (CEO), Bobbi Duffy (Executive Assistant)

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Call To Order	Committee Chair Susan DiBiasi called the meeting to order at 10:07 am.	
Public Comment	Lanny Swerdlow spoke regarding his displeasure and an analysis that he created in response to the Community Health Needs Assessment being presented for approval at this morning's meeting.	
OLD BUSINESS		
Proposed Action - Approve Minutes **November 22, 2019 special meeting**	Chair DiBiasi asked for any changes or corrections to the minutes of the November 22, 2019 special meeting. There were none.	**The minutes of the November 22, 2019 special meeting will stand correct as presented.**
NEW BUSINESS		
Proposed Action – Approve Community Health Needs Assessment to be posted on Hospital's website	Chair DiBiasi asked for any discussion regarding the document included on the on board tablets. Steve Barron stated that he has read dozens of these reports over the years and that it is a requirement for quite a few hospitals. He stated that a number of years ago a lot of hospitals used Loma Linda to create the report. We have also used HASC whose reports include the entire Inland Empire. This time we engaged a	**M.S.C. (Baldi/ Lewis), the SGMH Board of Directors Executive Committee approved the Community Health Needs Assessment as presented to be**

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td>consultant to be able to obtain more local information. He stated there is a lot of good demographic research reported in this report, including the types of patients that we see.

Steve stated that at the Hospital Board's planning retreat in February, the Board will be discussing and putting specific action plans into place. The information in this report will point us in the right directors with regard to the services that our hospital can provide to the public.

Steve noted that the Hospital Board has received several staff education reports regarding the type of charity care, write offs, mental health, etc., that we already provide to our community. We also work very closely with our uninsured patients to get them signed up with MediCal.

Committee members discussed the results of the survey and that it generally touches very large sections of our community and we can use this report to move forward in planning future endeavors.

Chair DiBiasi stated that this reports provides us with what the general focus' in health care are. She noted that a part of our new IT system will allow us to collect more specific information on cross-over issues for our population and how we can address them.

ROLL CALL:

<table>
<tr><td>Baldi</td><td>Yes</td><td>DiBiasi</td><td>Yes</td></tr>
<tr><td>Lewis</td><td>Yes</td><td>Ngo</td><td>Absent</td></tr>
<tr><td>Rutledge</td><td>Yes</td><td colspan="2">Motion carried.</td></tr>
</table>
</td><td>posted on the Hospital's website.</td></tr>
<tr><td>Adjourn</td><td>The meeting was adjourned at 10:48 am.</td><td></td></tr>
</table>

Minutes submitted by Bobbi Duffy, Executive Assistant

TAB H

MINUTES: Not Yet Approved By Committee

REGULAR MEETING OF THE
SAN GORGONIO MEMORIAL HOSPITAL
BOARD OF DIRECTORS

FINANCE COMMITTEE
Tuesday, December 19, 2019

The regular meeting of the San Gorgonio Memorial Hospital Board of Directors Finance Committee was held on Thursday, December 19, 2019 in the Administration Boardroom, 600 N. Highland Springs Avenue, Banning, California.

Members Present: Andrew Gardner, Olivia Hershey (C), Ron Rader

Members Absent: Susan DiBiasi, Dennis Tankersley

Required Staff: Steve Barron (CEO), Dave Recupero (CFO), Pat Brown (CNO), Holly Yonemoto (CBDO), Bobbi Duffy (Executive Assistant)

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Call To Order	Committee Chair Olivia Hershey, called the meeting to order at 9:06 am.	
Public Comment	There was no public present.	
OLD BUSINESS		
Proposed Action - Approve Minutes **November 19, 2019 regular meeting**	Chair Hershey asked for any changes or corrections to the minutes of the November 19, 2019 regular meeting. There were none.	**The minutes of the November 19, 2019 regular meeting will stand correct as presented.**
NEW BUSINESS		
Proposed Action – Recommend Approval to Hospital Board of Directors - Monthly Financial Report – November 2019	Dave Recupero distributed a hard copy of the November 2019 finance report that was included on the tablets. This handout included one additional page – the last page. Dave referred Committee members to the graph at the bottom of page 3 noting that the Adjusted Discharges red line is for the current fiscal year and reflects that the first five (5) months of this year have been higher than the previous three (3) years.	**M.S.C. (Rader/ Gardner), the SGMH Finance Committee voted to recommend approval of the November 2019 Financial report to the Hospital Board**

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>ACTION / FOLLOW-UP</th></tr>
<tr><td></td><td>Dave referred Committee members to page 4 “Statement of Revenue and Expense – Current Month”, line 6 “Total Gross Patient Revenue” noting that Actual was $23,189,739 compared to the budget of $23,370,459, a negative variance of $180,720, or less than 1% variance.

On line 11, “Total Deductions From Revenue”, Dave noted a favorable variance of $160,657.

On line 14, “IGT/DSH Revenues”, Dave that in November we were ahead of budget by $528,843 but that this is a conservative estimate until we actually receive IGT funds.

Dave noted that Total Operating Expenses as shown on line 33, for the month were over budget by $394,204 or 3.41%.

Dave referred Committee members to page 5 “Statement of Revenue and Expense – Year-to-Date”, line 33 “Total Operating Expenses” are over budget by $1,004,536 mostly due to unbudgeted salaries and anesthesia issues. He reviewed these on the last page of the handout.

Dave noted that line 34, “EBIDA” is $1,129,136 variance for the first five (5) months of the fiscal year.

Dave referred Committee members to the bottom of page 8, “Supplemental Cash Flow Summary” noting that we show a negative $1,329,750 for IGTs for this month, but that will even out over the total 12 months.

Dave referred Committee members to page 10, “AR Report”, noting that as shown in the last four (4) columns, “August – November” we have been experiencing “growing” pains as a result of Navigant taking over our revenue cycle. Dave noted that we are not worried about this, that it will improve over time as they work out processes.

ROLL CALL:

<table>
<tr><td>DiBiasi</td><td>Absent</td><td>Gardner</td><td>Yes</td></tr>
<tr><td>Hershey</td><td>Yes</td><td>Rader</td><td>Yes</td></tr>
<tr><td>Tankersley</td><td>Absent</td><td colspan="2">Motion carried.</td></tr>
</table>
</td><td>of Directors.</td></tr>
<tr><td>Future Agenda Items</td><td>None</td><td></td></tr>
</table>

AGENDA ITEM	DISCUSSION	ACTION / FOLLOW-UP
Next Meeting	The next Finance Committee meeting will be held on January 28, 2020.	
Adjournment	The meeting was adjourned at 9:52 am.	

In accordance with The Brown Act, *Section 54957.5*, all reports and handouts discussed during this Open Session meeting are public records and are available for public inspection. These reports and/or handouts are available for review at the Hospital Administration office located at 600 N. Highland Springs Avenue, Banning, CA 92220 during regular business hours, Monday through Friday, 8:00 am - 4:30 pm.

Minutes respectfully submitted by Bobbi Duffy, Executive Assistant

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA

Unaudited Financial Statements

for

FIVE MONTHs ENDING NOV 30, 2019

Certification Statement:

To the best of my knowledge, I certify for the hospital that the attached financial statements, except for the uncertainty of IGT revenue accruals, do not contain any untrue statement of a material fact or omit to state a material fact that would make the financial statements misleading. I further certify that the financial statements present in all material respsects the financial condition and results of operation of the hospital and all related organizations reported herein.

Certified by:

David D. Recupero

CFO

San Gorgonio Memorial Hospital
Financial Report – Executive Summary
For the month of November 2019 (Five months in FY 20)

Profit/Loss (EBIDA) Summary

In the current month, there was a $181K favorable budget variance for Earnings before Interest, Depreciation and Amortization (EBIDA). November EBIDA came in at -$141K, a -1.6% EBIDA margin but was better than the expected lower budget figures. The comparison to same month last year was an improvement by $127K. The resulting Year-to-Date (YTD) EBIDA budget favorable variance is now $1.3M and for the first five months and was $1.8M improved over first five months of last fiscal year. For the year, increase/decrease in unrestricted net assets (net profit) showed a $1.01M loss compared to the budgeted YTD loss of $2.05M and last year's YTD loss of $2.93M.

Analysis

Patient activity and volumes came in very close to budget. The favorable $181K EBIDA variance came mostly from revenues (+$575K over budget) but were partially offset by expenses were (+$394K higher than budget). The improved payor mix (+$10K) and IGT accrued revenue accruals (+$595K) were primary factors on the revenue side when analyzing the monthly variance. For the year net patient revenues remain +$1.0 million better than budget and are now close to $2.0 million better than last Year-to-Date.

Revenues (favorable $575K) . As mentioned above there were no volume related issues affecting the revenue variance instead improved payment rates/payor mix favorably impacted November's revenue picture. One area in particular was better than expected payments coming on the new GI business we are receiving from Dr. Reddy, a Beaver physician, Resulting contractual percentage improved from 83.5% down to 82.7% write-offs The other large revenue variance (+$595K) comes from higher than expected IGT (Intergovernmental Transfer) revenue accruals.

Other patient statistics variances included:
Average Daily Census (ADC) (25.0 actual vs 25.8 budget and 24.3 last year). YTD ADC is very close to budget, actual YTD ADC= 25.6 vs budget 25.8 and last year first 5 months ADC was 24.3. YTD ED visits were 0.51% ahead of budget. Outpatient GI lab procedures reached an all-time monthly high of 226 procedures compared to 77 last November. Areas of declined patient activity include observation bed days (down 15.3%YTD) and outpatient surgeries (down 31.4% YTD). The over-all measurement of patient activity YTD adjusted acute discharges were up 1.32% compared to budget and up 3.96% compared to last year.

In summary, it was supplemental revenues for the improved financial performance in month.
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Expenses (unfavorable $394K) November expenses were higher than budget by 6.5%. The budget variance was mostly due to physician fees (anesthesia) (+$62K) and Purchased Services (mostly legal) (+$151K) higher for the month. Year-to Date overall actual expenses are now 3.4% over budget. The main issue for the November anesthesia is in the process of being resolved with new contracts to be put in place early next calendar year. The potential improvement cost savings after fully implemented is at or in excess of $1.0 million annually.

BALANCE SHEET/CASH FLOW

Cash Balances fell again slightly due to the continued (as expected) low supplemental funding. We sent out $500K for IGT matching and went thru with the expected $900K DSH payout. The Cash Flow report (page 8) now shows only $294K in supplemental cash has been collected so far for the first five months of the fiscal year compared to the year-end projected supplemental total of $17.7 million. Page 8 cash flow line 8 shows November patient collections of $3,375,239 compared to $4,675,028 collected in October. December collection so far have improved significantly and helping us get back on track year-to-date. We also increased the line of Credit balance to $7.5 million as a result of IGT and patient collection slowdown. The LOC balances are expected to increase in the next few months up to the $10.0 million maximum balance allowed. Pacific Premiere has express a desire to assist us if needed in the short term should we need a little more than the $10.0 million. Gross Days in Accounts Receivable was 66.3 in November compared to 62.2 last month, see new page 10 analysis on the AR detail by payor.

The YTD actual and projected cash picture continues to track very close to budgeted estimates.

Concluding Summary

Positive takeaways for the month:

1) Favorable variances for supplemental and IGT revenues
2) Outpatient GI and ED patient activity improvements.
3) Continued adding the favorable YTD EBIDA budget variance, (+$1,129,136)

Negative takeaways for the month:

1) Cash flow challenges as anticipated mostly due timing issues with IGTs
2) Higher than expected physician fees especially related to anesthesia costs.

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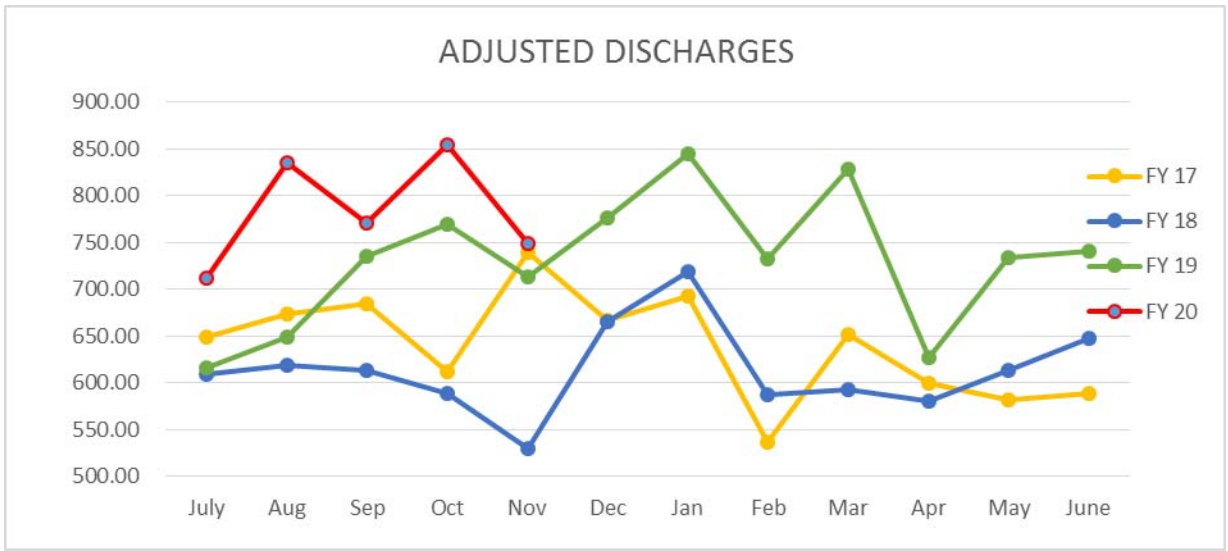
Prepared 11/13/2019
Dave Recupero, CFO



Statement of Revenue and Expense
SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FIVE MONTHs ENDING NOV 30, 2019

		CURRENT MONTH				
	DISTRICT ONLY	COMBINED		Positive		Prior
	Actual 11/30/19	Actual 11/30/19	Budget 11/30/19	(Negative) Variance	Percentage Variance	Year 09/30/18
Gross Patient Revenue						
[1] Inpatient Revenue	$0	$7,150,027	$7,001,541	$148,486	2.12%	$6,813,239
[2] Inpatient Psych/Rehab Revenue	0	0	0	0	0.00%	0
[3] Outpatient Revenue	0	16,039,712	16,368,918	(329,206)	-2.01%	15,675,259
[4] Long Term Care Revenue	0	0	0	0	0.00%	0
[5] Home Health Revenue	0	0	0	0	0.00%	0
[6] Total Gross Patient Revenue	0	23,189,739	23,370,459	(180,720)	-0.77%	22,488,497
Deductions From Revenue						
[7] Discounts and Allowances	0	(18,647,221)	(18,544,472)	(102,749)	-0.55%	(18,440,591)
[8] Bad Debt Expense	0	(585,747)	(783,264)	197,517	25.22%	(387,540)
[9] Prior Year Settlements	0	0	(53,581)	53,581	100.00%	0
[10] Charity Care	0	(33,645)	(45,953)	12,308	26.78%	(11,681)
[11] Total Deductions From Revenue	0	(19,266,613)	(19,427,270)	160,657	0.83%	(18,839,812)
[12]		83.08%	83.13%			83.78%
[13] Net Patient Revenue	0	3,923,126	3,943,189	(20,063)	-0.51%	3,648,686
Non Patient Operating Revenues						
[14] IGT/DSH Revenues	0	1,728,843	1,200,000	528,843	44.07%	1,054,388
[15] Tax Subsidies Measure D	188,750	188,750	179,251	9,499	5.30%	175,000
[16] Tax Subsidies Prop 13	112,500	112,500	107,712	4,788	4.45%	105,000
[17] Tax Subsidies County Supplemental Funds	0	0	0	0	0.00%	0
[18] Other Operating Revenue	11,160	307,554	239,446	68,108	28.44%	227,552
[19] Clinic Net Revenues	11,286	11,286	27,753	(16,467)	-59.33%	18,664
Non- Patient Revenue	323,696	2,348,933	1,754,162	594,771	33.91%	1,580,604
Total Operating Revenue	**323,696**	**6,272,059**	**5,697,351**	**574,708**	**10.09%**	**5,229,290**
Operating Expenses						
[20] Salaries and Wages	0	3,164,641	3,047,422	(117,218)	-3.85%	2,744,990
[21] Fringe Benefits	0	678,275	725,524	47,249	6.51%	759,903
[22] Contract Labor	0	60,457	55,579	(4,878)	-8.78%	96,266
[23] Physicians Fees	0	258,261	195,484	(62,777)	-32.11%	262,317
[24] Purchased Services	37,944	905,780	754,418	(151,362)	-20.06%	425,827
[25] Supply Expense	65	655,136	680,658	25,522	3.75%	629,620
[26] Utilities	0	83,997	71,386	(12,611)	-17.67%	63,291
[27] Repairs and Maintenance	0	86,360	45,038	(41,322)	-91.75%	61,420
[28] Insurance Expense	0	87,282	101,452	14,170	13.97%	39,930
[29] All Other Operating Expenses	5,830	188,653	174,257	(14,396)	-8.26%	194,624
[30] IGT Expense	0	0	0	0	0.00%	0
[31] Leases and Rentals	0	61,661	68,143	6,482	9.51%	119,187
[32] Clinic Expense	162,541	182,880	99,817	(83,063)	-83.22%	100,026
[33] **Total Operating Expenses**	**206,379**	**6,413,383**	**6,019,179**	**(394,204)**	**-6.55%**	**5,497,401**
[34] **EBIDA**	**117,316**	**(141,324)**	**(321,828)**	**180,504**	**-56.09%**	**(268,112)**
Interest Expense and Depreciation						
[35] Depreciation	502,454	502,454	500,000	(2,454)	-0.49%	494,513
[36] Interest Expense and Amortization	389,022	389,022	399,474	10,452	2.62%	397,880
[37] **Total Interest & depreciation**	891,476	891,476	899,474	7,998	0.89%	892,393
Non-Operating Revenue:						
[38] Contributions & Other	0	0	16,667	(16,667)	-100.00%	0
[39] Tax Subsidies for GO Bonds - M-A	598,629	598,629	605,781	(7,152)	-1.18%	585,613
[40] **Total Non Operating Revenue/(Expense)**	**598,629**	**598,629**	**622,448**	**(23,819)**	**-3.83%**	**585,613**
[41] **Total Net Surplus/(Loss)**	**($175,531)**	**($434,171)**	**($598,854)**	**$164,683**	**-27.50%**	**($574,892)**
[42] Extra-ordinary loss on FInancing						
[43] **Increase/(Decrease in Unrestricted Net Assets**	**($175,531)**	**($434,171)**	**($598,854)**	**$164,683**	**-27.50%**	**($574,892)**
[44] **Total Profit Margin**	**-54.23%**	**-6.92%**	**-10.51%**			**-10.99%**
[45] **EBIDA %**	**36.24%**	**-2.25%**	**-5.65%**			**-5.13%**

Statement of Revenue and Expense
SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FIVE MONTHs ENDING NOV 30, 2019

	DISTRICT ONLY Actual 11/30/19	YEAR-TO-DATE Actual 11/30/19	Budget 11/30/19	Positive (Negative) Variance	Percentage Variance	Prior Year 09/30/18
Gross Patient Revenue						
[1] Inpatient Revenue	$0	$36,813,781	$35,767,487	$1,046,294	2.93%	$34,320,885
[2] Inpatient Psych/Rehab Revenue	0	0	0	0	0.00%	0
[3] Outpatient Revenue	0	85,052,070	85,331,866	(279,796)	-0.33%	82,455,742
[4] Long Term Care Revenue	0	0	0	0	0.00%	0
[5] Home Health Revenue	0	0	0	0	0.00%	0
[6] Total Gross Patient Revenue	0	121,865,851	121,099,353	766,498	0.63%	116,776,627
Deductions From Revenue						
[7] Discounts and Allowances	0	(96,833,352)	(96,528,746)	(304,606)	-0.32%	(93,712,898)
[8] Bad Debt Expense	0	(3,659,747)	(4,058,661)	398,914	9.83%	(3,755,587)
[9] Prior Year Settlements	0	0	(277,643)	277,643	100.00%	0
[10] Charity Care	0	(313,319)	(238,113)	(75,206)	-31.58%	(235,103)
[11] Total Deductions From Revenue	0	(100,806,418)	(101,103,163)	296,745	0.29%	(97,703,589)
[12]		82.7%	83.5%	-0.8%		83.7%
[13] Net Patient Revenue	0	21,059,432	19,996,190	1,063,242	5.32%	19,073,039
Non Patient Operating Revenues						
[14] IGT/DSH Revenues	0	7,044,595	6,000,000	1,044,595	17.41%	4,530,342
[15] Tax Subsidies Measure D	930,000	930,000	915,707	14,293	1.56%	875,000
[16] Tax Subsidies Prop 13	555,000	555,000	550,249	4,751	0.86%	525,000
[17] Tax Subsidies County Supplemental Funds	0	0	0	0	0.00%	0
[18] Other Operating Revenue	23,305	1,257,178	1,207,337	49,841	4.13%	1,193,860
[19] Clinic Net Revenues	95,715	95,715	138,765	(43,050)	-31.02%	130,010
Non- Patient Revenue	1,604,020	9,882,488	8,812,058	1,070,430	12.15%	7,254,211
Total Operating Revenue	**1,604,020**	**30,941,920**	**28,808,248**	**2,133,672**	**7.41%**	**26,327,250**
Operating Expenses						
[20] Salaries and Wages	0	15,664,106	15,078,542	(585,564)	-3.88%	14,072,298
[21] Fringe Benefits	0	3,548,712	3,680,593	131,881	3.58%	3,728,146
[22] Contract Labor	0	346,701	277,895	(68,806)	-24.76%	454,294
[23] Physicians Fees	8,800	1,608,771	977,420	(631,351)	-64.59%	1,032,902
[24] Purchased Services	174,943	3,199,486	3,217,150	17,664	0.55%	2,134,594
[25] Supply Expense	314	3,335,515	3,444,724	109,209	3.17%	3,114,631
[26] Utilities	3,000	435,377	356,930	(78,447)	-21.98%	414,096
[27] Repairs and Maintenance	6,475	271,178	225,190	(45,988)	-20.42%	246,408
[28] Insurance Expense	0	445,181	507,260	62,079	12.24%	545,413
[29] All Other Operating Expenses	65,608	771,686	871,285	99,599	11.43%	677,720
[30] IGT Expense	0	(201)	0	201	0.00%	0
[31] Leases and Rentals	0	354,211	340,715	(13,496)	-3.96%	734,921
[32] Clinic Expense	378,579	500,602	499,085	(1,517)	-0.30%	539,289
[33] **Total Operating Expenses**	**637,719**	**30,481,325**	**29,476,790**	**(1,004,536)**	**-3.41%**	**27,694,713**
[34] **EBIDA**	**966,301**	**460,595**	**(668,542)**	**1,129,136**	**-168.90%**	**(1,367,463)**
Interest Expense and Depreciation						
[35] Depreciation	2,504,329	2,504,329	2,500,000	(4,329)	-0.17%	2,545,640
[36] Interest Expense and Amortization	1,954,234	2,003,789	1,997,370	(6,419)	-0.32%	1,997,931
[37] **Total Interest & depreciation**	4,458,564	4,508,118	4,497,370	(10,748)	-0.24%	4,543,571
Non-Operating Revenue:						
[38] Contributions & Other	52,112	52,112	83,335	(31,223)	-37.47%	50,524
[39] Tax Subsidies for GO Bonds - M-A	2,980,129	2,980,129	3,028,905	(48,776)	-1.61%	2,928,063
[40] **Total Non Operating Revenue/(Expen**	**3,032,241**	**3,032,241**	**3,112,240**	**(79,999)**	**-2.57%**	**2,978,587**
[41] **Total Net Surplus/(Loss)**	**($460,021)**	**($1,015,282)**	**($2,053,672)**	**$1,038,389**	**-50.56%**	**($2,932,447)**
[42] Extra-ordinary loss on FInancing						
[43] **Increase/(Decrease in Unrestricted Net A**	**($460,021)**	**($1,015,282)**	**($2,053,672)**	**$1,038,389**	**-50.56%**	**($2,932,447)**
[44] **Total Profit Margin**	**-28.68%**	**-3.28%**	**-7.13%**			**-11.14%**
[45] **EBIDA %**	**60.24%**	**1.49%**	**-2.32%**			**-5.19%**

Balance Sheet - Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FIVE MONTHs ENDING NOV 30, 2019

				ASSETS		
Percent of Net AR to Gross AR>	DISTRICT ONLY	16.90%	16.90%	Curr vs Prior Mo.	17.33%	Curr vs Prior YE
	Current Month 11/30/2019	Current Month 11/30/2019	Prior Month 10/31/2019	Positive/ (Negative) Variance	Prior Year End 06/30/2019	Positive/ (Negative) Variance
Current Assets						
[1] Cash and Cash Equivalents	$1,715,870	$2,930,710	$2,133,945	$796,764	$4,175,227	($1,244,517)
[2] Gross Patient Accounts Receivable	0	53,311,687	50,787,617	2,524,069	49,210,703	4,100,984
[3] Less: Bad Debt and Allowance Reserves	0	(44,299,835)	(42,204,025)	(2,095,810)	(40,680,940)	(3,618,894)
[4] Net Patient Accounts Receivable	0	9,011,852	8,583,592	428,260	8,529,763	482,089
[5] Taxes Receivable	4,583,128	4,583,128	3,634,453	948,675	566,680	4,016,448
[6] Other Receivables	0	956,464	19,200	937,264	436,869	519,595
[7] Inventories	0	1,672,505	1,674,191	(1,685)	1,632,865	39,640
[8] Prepaid Expenses	116,590	512,092	475,439	36,653	1,326,928	(814,836)
[9] Due From Third Party Payers	0	949,604	855,258	94,346	554,344	395,260
[10] Malpractice Receivable	0	0	0	0	0	0
[11] IGT Receivables	0	16,820,653	15,105,015	1,715,638	10,058,792	6,761,861
Total Current Assets	**6,415,588**	**37,437,008**	**32,481,095**	**4,955,913**	**27,281,468**	**10,155,540**
Assets Whose Use is Limited						
[12] Cash	0	0	0	0	0	0
[13] Investments	0	0	0	0	0	0
[14] Bond Reserve/Debt Retirement Fund	5,008,812	5,015,234	5,054,941	(39,707)	8,867,208	(3,851,974)
[15] Trustee Held Funds	0	0	0	0	0	0
[16] Funded Depreciation	0	0	0	0	0	0
[17] Board Designated Funds	0	0	0	0	0	0
[18] Other Limited Use Assets	0	0	0	0	0	0
Total Limited Use Assets	**5,008,812**	**5,015,234**	**5,054,941**	**(39,707)**	**8,867,208**	**(3,851,974)**
Property, Plant, and Equipment						
[19] Land and Land Improvements	4,820,671	4,820,671	4,820,671	0	4,820,671	0
[20] Building and Building Improvements	129,283,884	129,283,884	129,283,884	0	129,283,884	0
[21] Equipment	25,848,777	25,848,777	25,819,215	29,561	25,586,875	261,901
[22] Construction In Progress	8,391,329	8,391,329	8,391,329	0	8,390,249	1,080
[23] Capitalized Interest	0	0	0	0	0	0
[24] Gross Property, Plant, and Equipment	168,344,660	168,344,660	168,315,099	29,561	168,081,679	262,981
[25] Less: Accumulated Depreciation	(73,585,543)	(73,585,543)	(73,083,089)	(502,454)	(71,114,751)	(2,470,792)
[26] **Net Property, Plant, and Equipment**	**94,759,117**	**94,759,117**	**95,232,009**	**(472,893)**	**96,966,928**	**(2,207,811)**
Other Assets						
[27] Unamortized Loan Costs	1,461,293	1,461,293	1,462,953	(1,660)	1,522,444	(61,151)
[28] Assets Held for Future Use	0	0	0	0	0	0
[29] Investments in Subsidiary/Affiliated Org.	11,631,706	0	0	0	0	0
[30] Other	0	0	0	0	0	0
[31] **Total Other Assets**	**13,092,999**	**1,461,293**	**1,462,953**	**(1,660)**	**1,522,444**	**(61,151)**
[32] **TOTAL UNRESTRICTED ASSETS**	**119,276,515**	**138,672,652**	**$134,230,998**	**$4,441,654**	**134,638,048**	**$4,034,604**
Restricted Assets	0	0	0	0	0	0
[33] **TOTAL ASSETS**	**$119,276,515**	**$138,672,652**	**$134,230,998**	**$4,441,654**	**$134,638,048**	**$4,034,604**

Balance Sheet - Liabilities and Net Assets

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FIVE MONTHs ENDING NOV 30, 2019

		District Only Current Month 11/30/2019	Current Month 11/30/2019	LIABILITIES AND FUND BALANCE Prior Month 10/31/2019	Positive/ (Negative) Variance	Prior Year End 06/30/2019	Curr vs Prior YE Positive/ (Negative) Variance
Current Liabilities							
[1]	Accounts Payable	$163,676	$5,923,555	$5,144,017	$779,538	$4,436,438	$1,487,118
[2]	Notes and Loans Payable (Line of Credit)	0	7,500,000	$4,000,000	3,500,000	$0	7,500,000
[3]	Accounts Payable- Construction	0	0	$0	0	$0	0
[4]	Accrued Payroll Taxes	0	3,043,151	$2,811,399	231,752	$3,844,094	(800,943)
[5]	Accrued Benefits	0	88,381	$84,798	3,583	$76,513	11,869
[6]	Accrued Benefits Current Portion	0	0	$0	0	$0	0
[7]	Other Accrued Expenses	0	0	$0	0	$0	0
[8]	Accrued GO Bond Interest Payable	1,616,183	1,616,183	$1,212,137	404,046	$2,049,304	(433,120)
[9]	Malpractice Payable	0	0	$0	0	$0	0
[10]	Due to Third Party Payers (Settlements)	0	0	$0	0	$0	0
[11]	Advances From Third Party Payers	0	0	$0	0	$0	0
[12]	Current Portion of LTD (Bonds/Mortgages)	2,335,000	2,335,000	$2,335,000	0	$0	2,335,000
[13]	Current Portion of LTD (Leases)	0	0	$0	0	$0	0
[14]	Other Current Liabilities	0	13,174	40,515	(27,342)	15,758	(2,585)
	Total Current Liabilities	**4,114,859**	**20,519,445**	**15,627,867**	**4,891,578**	**10,422,106**	**10,097,338**
Long Term Debt							
[15]	Bonds/Mortgages Payable (net of Cur Portic	108,324,091	108,324,091	108,339,844	(15,753)	112,856,547	(4,532,456)
[16]	Leases Payable (net of current portion)	0	0	0	0	0	0
[17]	**Total Long Term Debt (Net of Current)**	**108,324,091**	**108,324,091**	**108,339,844**	**(15,753)**	**112,856,547**	**(4,532,456)**
Other Long Term Liabilities							
[18]	Deferred Revenue	0	0	0	0	0	0
[19]	Accrued Pension Expense (Net of Current)	0	0	0	0	0	0
[20]	Other	0	0	0	0	0	0
[21]	**Total Other Long Term Liabilities**	**0**	**0**	**0**	**0**	**0**	**0**
	TOTAL LIABILITIES	**112,438,950**	**128,843,536**	**123,967,711**	**4,875,825**	**123,278,653**	**5,564,883**
Net Assets:							
[22]	Unrestricted Fund Balance	7,297,586	10,844,398	$10,844,398	0	10,416,645	427,754
[23]	Temporarily Restricted Fund Balance	0	0	0	0	0	0
[24]	Restricted Fund Balance	0	0	0	0	0	0
[25]	Net Revenue/(Expenses)	(460,021)	(1,015,282)	(581,111)	(434,171)	942,750	(1,958,032)
[26]	**TOTAL NET ASSETS**	**6,837,565**	**9,829,116**	**10,263,287**	**(434,171)**	**11,359,394**	**(1,530,279)**
[27]	**TOTAL LIABILITIES AND NET ASSETS**	**$119,276,515**	**$138,672,652**	**$134,230,998**	**$4,441,654**	**$134,638,048**	**$4,034,604**
		$0	$0	$0.00		$0	

BANNING, CALIFORNIA
FIVE MONTHs ENDING NOV 30, 2019

	HEALTHCARE SYSTEM MINI CASH FLOW		CASH FLOW Current Month 11/30/2019		Year-To-Date 11/30/2019
	BEGINNING CASH BALANCES				
[1]	Cash: Beginning Balances- HOSPITAL	10/31>	$651,039	06/30>	1,049,179.00
[2]	Cash: Beginning Balances- DISTRICT	10/31>	2,299,517	06/30>	3,126,083
[3]	Cash: Beginning Balances TOTALS	10/31>	$2,133,945	06/30>	$4,175,262
	Receipts				
[4]	Pt Collections		3,375,239		19,911,030
[5]	Tax Subsidies Measure D		1,950		134,442
[6]	Tax Subsidies Prop 13		0		51,230
[7]	Tax Subsidies County Supplemental Funds		0		0
[8]	IGT & other Supplemental (see detail below)		(1,329,750)		(535,532)
[9]	Draws/(Paydown) of LOC Balances		3,500,000		7,500,000
[10]	Other Misc Receipts/Transfers		244,120		1,278,173
	TOTAL RECEIPTS		**5,791,559**		**28,339,342**
	Disbursements				
[11]	Payroll/ Benefits		3,613,309		19,319,578
[12]	Other Operating Costs		2,454,802		11,153,042
[13]	Capital Spending		20,000		253,420
[14]	Debt serv payments (Hosp onlyw/ LOC interest)		85,034		393,675
[15]	Other (increase) in AP /other bal sheet		(1,178,350)		(1,535,854)
[16]	**TOTAL DISBURSEMENTS**		**4,994,795**		**29,583,860**
[17]	**TOTAL CHANGE in CASH**		**796,764**		**(1,244,517)**
	ENDING CASH BALANCES				
[18]	Ending Balances- HOSPITAL	11/30>	$1,214,840	08/31>	$1,214,840
[19]	Ending Balances- DISTRICT	11/30>	1,715,870	08/31>	1,715,870
[20]	Ending Balances- TOTALS	11/30>	$2,930,710	08/31>	$2,930,710
	ADDITIONAL INFO				
[21]	LOC CURRENT BALANCES		7,500,000		7,500,000
[22]	LOC Interest Expense Incurred		35,034		76,310

	SUPPLEMENTAL CASH FLOW SUMMARY (By Program)	Current Month 11/30/2019	Current Year-To-Date 11/30/2019
	IGT/SUPPLEMENTAL CASH INFLOWS		
[24]	HQAF Managed Care Funds	0	0
[25]	Prime IGT	(525,000)	(525,000)
[26]	Rate Range Managed Care IGTs	0	0
[27]	AB 113	0	0
[28]	HQAF FFS Direct Grants	0	503,027
[29]	IEHP MCE Bed Funds	0	24,396
[30]	MediCal Outpatient SRH Program	25,000	50,977
[31]	Foundation Contributions	0	52,112
[32]	AB 915 newly Eligible	0	0
[33]	Cost Report Settlements	0	35,514
[34]	Medi-CAL DSH	(829,750)	153,191
[35]	**TOTALS (see line 8 above)**	**(1,329,750)**	**294,218**

Patient Statistics

SAN GORGONIO MEMORIAL HOSPITAL
BANNING, CALIFORNIA
FIVE MONTHs ENDING NOV 30, 2019

Line Ref #	Actual 11/30/19	Budget 11/30/19	Prior Year 09/30/18	STATISTICS	Year-To-Date Actual 11/30/19	Year-To-Date Budget 11/30/19	Year-To-Date Prior Year 09/30/18	YTD % VAR Vs Bud	YTD % VAR Vs Prior Yr
				Discharges					
[1]	231	228	216	Acute	1,185	1,143	1,109	3.63%	6.85%
[2]	3.24	3.34	3.30	O/P Adjustment Factor	3.31	3.39	3.40	-2.23%	-2.71%
[3]	749	760	713	Adjusted Acute Discharges	3,923	3,872	3,773	1.32%	3.96%
[4]	34	21	33	Newborn	125	107	131	16.82%	-4.58%
[5]	265	249	249	Total Discharges	1,310	1,250	1,240	4.76%	5.65%
				Patient Days:					
[6]	749	774	728	Acute	3,922	3,951	3,719	-0.73%	5.46%
[7]	68	42	53	Newborn	250	214	240	16.82%	4.17%
[8]	817	816	781	Total Patient Days	4,172	4,165	3,959	0.17%	5.38%
				Average Length of Stay (ALOS)					
[9]	3.24	3.40	3.37	Acute	3.31	3.46	3.35	-4.21%	-1.31%
[10]	2.0	2.0	1.6	Newborn ALOS	2.0	2.0	1.8	0.00%	9.17%
				Average Daily Census (ADC)					
[11]	25.0	25.8	24.3	Acute	25.6	25.8	24.3	-0.73%	5.46%
[12]	2.3	1.4	1.8	Newborn	1.6	1.4	1.6	16.82%	4.17%
				Emergency Dept. Statistics					
[13]	200	202	195	ED Visits - Admitted	1,038	1,017	961	2.10%	8.01%
[14]	1,535	1,496	1,491	ED Visits - Higher Acuity Ops	7,680	7,837	8,066	-2.01%	-4.79%
[15]	1,928	1,744	1,702	ED - Rapid Care Visits Ops	9,319	9,091	8,955	2.51%	4.06%
[16]	**3,663**	**3,442**	**3,388**	**Total ED Visits**	**18,037**	**17,945**	**17,982**	0.51%	0.31%
[17]	5.46%	5.88%	5.76%	% of ER Visits Admitted	5.75%	5.67%	5.34%	1.58%	7.68%
[18]	86.58%	88.91%	90.28%	ER Admissions as a % of Total	87.59%	88.91%	86.65%	-1.48%	1.09%
				Other Key Statistics:					
[19]	4,296	4,161	3,988	Total Outpatients Visits	21,174	21,677	21,411	-2.32%	-1.11%
[20]	149	159	169	Observation Bed Days	686	810	839	-15.31%	-18.24%
[21]	16.6%	17.0%	18.8%	Obs. Bed Days as a % of Total	14.9%	17.0%	18.4%	-12.50%	-19.12%
[22]	422	506	500	Behavioral Health Visits	2,306	2,641	2,814	-12.68%	-18.05%
[23]	38	32	31	IP Surgeries	220	163	158	34.97%	39.24%
[24]	36	62	49	OP Surgeries	223	325	339	-31.38%	-34.22%
[25]	226	200	77	Outpatient Scopes	960	1,042	460	-7.87%	108.70%
				Productivity Statistics:					
[26]	445.71	455.70	428.84	FTE's - Worked	436.67	455.70	422.69	-4.18%	3.31%
[27]	468.95	489.60	457.62	FTE's - Paid	472.69	489.60	460.85	-3.45%	2.57%
[28]	5.50	4.78	5.35	Worked FTE's per AOB	5.15	4.78	5.11	7.66%	0.69%
[29]	5.79	5.13	5.71	Paid FTE's per AOB	5.57	5.13	5.57	8.59%	-0.03%
[30]	1.2185	1.2621	1.2621	Case Mix Index -Medicare	1.2478	1.2621	1.2621	-1.13%	-1.13%
[31]	0.9968	1.0419	1.0419	Case Mix Index - All payers	1.0208	1.0419	1.0419	-2.02%	-2.02%

AR Report

30-Nov-19

A/R & CASH FLOW TRENDS

	GROSS ACCTS RECEIVABLE BY PAYC	FY 20 30-Nov-19 ACTUAL	Prior Year FY 19 JUNE	Monthly Trends FY 20 AUG	FY 20 SEP	FY 20 OCT	FY 20 NOV
1	Blue Shield	197,194	233,330	335,557	398,041	445,469	197,194
2	Blue Cross	2,362,250	1,946,555	2,487,071	2,690,718	2,466,779	2,362,250
3	MediCal	2,620,067	1,701,380	2,208,173	1,723,329	2,004,927	2,620,067
4	IEHP /Other MediCal HMO	10,725,297	6,301,624	8,096,818	7,410,413	10,120,703	10,725,297
5	Champus /Other Govt	3,336,047	2,835,303	2,937,561	2,787,538	3,207,902	3,336,047
6	HMO/PPO/Commercial	7,428,094	7,323,981	6,118,113	6,674,906	7,151,105	7,428,094
7	Medicare	5,404,188	8,498,471	4,769,553	7,323,482	4,639,186	5,404,188
8	Self Pay/Credit Bals	6,353,626	6,670,232	6,613,949	6,608,189	6,566,405	6,353,626
9	Senior HMO	14,295,098	13,054,309	12,364,964	14,023,136	13,521,960	14,295,098
10	Workers Comp	590,275	645,516	514,754	578,248	663,846	590,275
11	TOT GROSS AR	53,312,136	49,210,701	46,446,513	50,217,999	50,788,281	53,312,136

	PATIENT CASH COLLECTIONS	FY 20 Year-To Date	FY 19 Year-To Date	FY 20 AUG	FY 20 SEP	FY 20 OCT	FY 20 NOV
12	Blue Shield	217,420	213,786	50,442	41,148	50,083	41,747
13	Blue Cross	896,699	970,947	148,672	217,692	237,896	158,720
14	Medi-Cal	1,049,038	1,119,942	229,907	366,866	189,620	147,499
15	IEHP /Other MediCal HMO	3,094,565	3,282,930	777,491	604,073	538,887	623,078
16	Champus /Other Govt	555,293	384,203	74,240	99,706	96,420	108,046
17	HMO/PPO/Commercial	3,838,479	3,536,642	675,671	648,403	731,274	627,155
18	Medicare	3,939,214	3,200,184	721,370	60,762	1,354,209	547,789
19	Self Pay/Credit Bals	680,000	614,847	152,638	132,546	134,403	132,685
20	Senior HMO	5,566,810	5,043,172	928,043	903,489	1,331,627	977,299
21	Workers Comp	73,492	75,475	16,364	22,534	10,609	11,220
22	TOT CASH COLLECTIONS	19,693,590	18,442,127	3,774,838	3,097,221	4,675,028	3,375,239
	Percent Change vs. Prior>						
23	% change vs. Prior yr.>		6.8%	100.7%	100.3%	105.8%	116.0%

	GROSS DAYS IN AR BY PAYOR	FY 20 Year-To Date	FY 19 06/30/2019	TARGET 10/31/2016	FY 20 AUG	FY 20 SEP	FY 20 OCT	FY 20 NOV
24	Blue Shield	30.4	30.7	60.4	41.3	45.9	51.9	30.4
25	Blue Cross	62.4	55.6	44.6	66.9	70.4	64.2	62.4
26	MediCal	81.5	57.0	66.3	68.4	51.5	60.4	81.5
27	IEHP /Other MediCal HMO	46.6	27.3	27.5	36.3	33.2	44.1	46.6
28	Champus /Other Govt	167.1	147.6	132.2	120.4	114.5	127.8	167.1
29	HMO/PPO/Commercial	86.2	96.0	86.4	80.5	84.2	82.2	86.2
30	Medicare	47.1	58.0	36.3	38.3	62.9	38.8	47.1
31	Self Pay/Credit Bals	111.8	82.5	80.5	102.5	106.5	111.2	111.8
32	Senior HMO	67.1	64.5	59.5	65.3	69.8	64.2	67.1
33	Workers Comp	93.3	111.6	136.2	100.7	106.1	116.9	93.3
34	TOT GROSS DAYS IN AR	66.31	59.00	53.9	59.20	63.44	62.20	66.31

Finance Committee Handout

HANDOUT
Finance Committee
December 19, 2019

YTD Expense over budget VARIANCES

		Thru Nov	Five Months
Salaries	600,000		
It Related		200,000	
Market pay adj in the OR		400,000	$100K due to volume
Physician Fees	630,000		
Anesthesia		605,000	
all other		25,000	
Supples & OTHER	(226,000)		
TOTAL over BUD	**$1,004,000**		

TAB I

POLICIES AND PROCEDURES FOR BOARD APPROVAL - Hospital Board meeting of January 7, 2020

	Title	Policy Area	Owner	Workflow Approval
1	Biological Debridement: Maggot Therapy: Standardized Procedure	Nursing	Pat Brown, CNO	Bobbi Duffy for Hospital Board of Directors
2	Environment of Care/Safety Committee Live Safety (Fire Safety) Plan 2020	Environment of Care	Joey Hunter, Director	Bobbi Duffy for Hospital Board of Directors
3	Nurse-Driven Indwelling Urinary Catheter Removal Standardized Procedure	Nursing	Pat Brown, CNO	Bobbi Duffy for Hospital Board of Directors
4	Parking Policy	Security	Joey Hunter, Director	Bobbi Duffy for Hospital Board of Directors

Origination:	*12/2017*
Approved:	*N/A*
Last Revised:	*12/2017*
Policy Area:	*Nursing*
References:	*CA Code of Regulations 70706.2*

Biological Debridement: Maggot Therapy: Standardized Procedure

Policy:

San Gorgonio Memorial Hospital in order to provide a high standard of safe, appropriate, and effective care for patients requiring wound debridement utilizing different types of debridement of necrotic/ devitalized tissue on suitable patient.

Patient comfort and safety is optimized by:

- Completion of a patient assessment carried out by a wound care nurse/physician so the most appropriate method of debridement is chosen.
- Offering ordered analgesia prior to debridement / dressing changes as needed.
- Obtaining the patient's consent and providing privacy during procedures.
- Acting within the accordance of universal precautions.

Advantages:

Larvae include:

1. They are usually fast and efficient.
2. Larvae secretions appear to amplify the wound healing effect of the host epidermal growth factor.
3. Effective against a wide range of bacteria including MRSA.

Disadvantages:

1. Contraindicated in people with allergies to adhesives, fly, larvae, chicken, eggs, and soybeans.
2. Psychological distress may be socially unacceptable to the individual patient.
3. Time consuming.
4. A slight pyrexia may occur as a result of bacteria by larvae.
5. Irritation may occur if larvae come in contact with surrounding skin.

Procedure:

The biological or larval therapy involves the deliberate infestation of disinfected fly larvae or maggots into a

necrotic wound. The larvae secrete a proteolytic enzyme which liquefies dead tissue which is then ingested clearing the bacteria and infection.

Larvae are supplied in sterile containers, or sterile nets, which contain approximately 100 larvae with a sterile net cage for retention of larvae.

Documentation of the patient's consent, education, and counseling is essential prior, during, and after to the patient and caregivers.

The larvae will be applied only by wound care certified nurse according to principles of basic aseptic dressing and Infection Control Standards, ensuring larvae are confined to the necrotic tissue or sterile receptacle. A barrier dressing is applied on the intact skin with hydrocolloid to prevent larvae/maggots from migrating and ensure a sufficient border to allow for tapping of the silk net. Cover the cage with a secondary absorbent dressing. This second outer dressing will be checked every four hours through therapy session which usually is 48 hours. This secondary dressing may require changing, if soiled with drainage.

The wound care nurse will be notified immediately for any untoward events.

Removal of larvae will be conducted by the wound care nurse. Disposal of used maggots will be into a secure container with alcohol added. The wound will be washed and appropriately redressed.

References:

Caville, K. (2005). Wound Care Manual 5th Ed. Silver Chain Foundation, Osborne Park.

Advanced Wound Care Network, (2007). Wound Glossary- Terminology for Practitioners, Health Education & Management Innovations:Sidney.

Prete PE. (1997) Growth effects of Phaenicia sericata larval extracts on fibroblasts: mechanism for wound healing by maggot therapy. Life Science; 60:505-10.

Maggot Therapy Certification Course. Sponsored by BioTherapeutics, Education and Research (BTER) Foundation. Monarch Labs.

Krasner, D (2014) Chronic Wound Care: The Essentials, Doughty D.

Wound Management. McNicholas, L (2016). Core Curriculum Wound Ostomy and Continence Nurses Society. Chapter 10

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board	Bobbi Duffy: Executive Assistant	pending
Med Executive Committee	Amelia Frazier: Director Medical Staff Services	12/2019
Interdisciplinary Practice Committee	Amelia Frazier: Director Medical Staff Services	12/2019
Policy and Procedure	Gayle Freude: Nursing Director Med/Surg	11/2019
Nursing	Gayle Freude: Nursing Director Med/Surg	11/2019

Origination:	*03/2013*
Approved:	*N/A*
Last Revised:	*12/2019*
Policy Area:	*Environment of Care*
References:	

Environment of Care/Safety Committee Life Safety (Fire Safety) Plan 2020

~~Purpose:~~

~~San Gorgonio Memorial Hospital's Fire Safety Plan provides a method to effectively maintain a fire-safe environment.~~

~~Objective:~~

~~The objective of the San Gorgonio Memorial Hospital's Fire Safety Plan is to minimize the potential for harm to patients, visitors and staff through inspection, testing, surveillance, education and response preparedness.~~

~~Scope:~~

~~The scope of the Fire Safety Plan addresses San Gorgonio Memorial Hospital's Main building, Behavioral Health Center, Cooling Tower/Oxygen Farm, Central Plant and ED/ICU Building.~~

~~Goal:~~

~~To maintain compliance to all applicable National Fire Protection Association (NFPA) standards and ensure the fail-safe operation of all fire detection, containment and suppression systems.~~

~~Authority:~~

~~San Gorgonio Memorial Hospital's Chief Executive Officer has final authority and responsibility for the assurance of a comprehensive Fire Safety Plan to the Board of Directors. The Chief Executive Officer delegates the monitoring of the Fire Safety Plan to the Safety Committee and the Safety Officer. The EOC/ Safety Committee is responsible for ensuring that the Fire Safety is compatible with Federal, State and Local requirements.~~

~~Elements of the Plan:~~

~~Protect patients, visitors, staff and property from fire, smoke and other products of combustion.~~

Policy:

I. **PURPOSE**

II. San Gorgonio Memorial Hospital's Fire Safety Plan provides a method to effectively maintain a fire-safe environment.

III. **OBJECTIVE**
The objective of the San Gorgonio Memorial Hospital's Fire Safety Plan is to minimize the potential for harm to patients, visitors and staff through inspection, testing, surveillance, education and response preparedness.

IV. **SCOPE**
The scope of the Fire Safety Plan addresses San Gorgonio Memorial Hospital's Main Hospital, Behavioral Health Center, Cooling Tower/Oxygen Farm and Central Plant.

V. **GOAL**
To maintain compliance to all applicable National Fire Protection Association (NFPA) standards and ensure the fail-safe operation of all fire detection, containment and suppression systems.

VI. **AUTHORITY**
San Gorgonio Memorial Hospital's Chief Executive Officer has final authority and responsibility for the assurance of a comprehensive Fire Safety Plan to the Board of Directors. The Chief Executive Officer delegate the monitoring of the Fire Safety Plan to the Safety Committee and the Safety Officer. The EOC/ Safety Committee is responsible for ensuring that the Fire Safety is compatible with Federal, State and Local requirements.

VII. **ELEMENTS OF THE PLAN** Protect patients, visitors, staff and property from fire, smoke and other products of combustion.

- The San Gorgonio Memorial Hospital fire protection program is designed to limit the development and spread of fire through maintenance of a smoke-free facility; emergency response education, training and performance evaluation; facility flammability control; fire safety inspection and monitoring; and maintenance and testing of fire protection and life safety systems.
- Elements of the fire protection program are inspected annually by the ~~hospital vendor of record~~State of California. ~~Every three years survey results are reviewed by either the Center for Improvement in Healthcare Quality (CIHQ) or California Department of Public Health(CDPH).~~

Inspect, test and maintain fire protection and life safety systems, equipment and components on a regular basis.

- Elements of the facility fire detection and suppression systems are inspected, tested and maintained in accordance to applicable NFPA standards:

~~NFPA 72~~
~~Supervisory Signal Devices-tested annually~~
~~Tamper Switches and Water Flow-tested quarterly~~
~~Occupant Alarm Notification-tested quarterly with each day evening, and night shift fire drills~~
~~Off Premises Emergency Response Notification-event driven, tested annually~~

~~NFPA 25~~
~~Riser systems-main drain test, annually~~
~~Fire Department Connections-inspected quarterly~~
~~Kitchen Detection/Suppression Systems-tested semi-annually~~

~~NFPA 10~~

~~Manual Fire Extinguishers are:~~
~~Clearly identified~~
~~Inspected monthly~~
~~Maintained annually~~
~~Fire Safety Plan~~

~~NFPA 90A~~
~~All fire and smoke dampers are operated (with fusible links removed where applicable) every six years to verify they fully close.~~
~~All automatic smoke detection shutdown devices for air handling equipment are tested at least annually.~~
~~All fire/smoke doors are tested for proper operation annually and with each quarterly day, evening, and night shift fire drills where observable.~~

- NFPA 72
  - Supervisory Signal Devices-tested annually
  - Tamper Switches and Water Flow-tested quarterly
  - Occupant Alarm Notification-tested quarterly with each day evening, and night shift fire drills
  - Off Premises Emergency Response Notification-event driven, tested annually
- NFPA 25
  - Riser systems-main drain test, annually
  - Fire Department Connections-inspected quarterly
  - Kitchen Detection/Suppression Systems-tested semi-annually
- NFPA 10
  - Manual Fire Extinguishers are:
  - Clearly identified
  - Inspected monthly
  - Maintained annually
- NFPA 90A
  - All fire and smoke dampers are operated (with fusible links removed where applicable) every six years to verify they fully close.
  - All automatic smoke detection shutdown devices for air handling equipment are tested at least annually.
  - NFPA 80 fire doors are tested for proper operation annually and with each quarterly, day, evening, and night shift fire drills where observable.

- Elements of the facility fire detection and suppression systems are inspected and tested annually by the ~~vendor of record~~State of California.

~~Report and investigate fire protection of deficiencies, failures and user errors.~~
~~Fire protection deficiencies, failures and user errors are reported to and investigated, as appropriate, by the Safety Officer and the Plant Operations Director/Manager for immediate resolution and are reported, as applicable, to the EOC/Safety Committee.~~

~~Review proposed acquisitions of bedding, window draperies, and other curtains, furnishings, decorations, wastebaskets and other items for fire safety.~~
~~All proposed acquisitions to furnish or decorate the facility are reviewed, as applicable to Life Safety Code, by Materials Management to ensure that compliance to mandated fire retardant ratings.~~
~~Wastebaskets, and other items as appropriate, are made of non-combustible materials and are labeled as required to verify UL or FM approval.~~

~~Evaluation:~~

Report and investigate fire protection of deficiencies, failures and user errors.

- Fire protection deficiencies, failures and user errors are reported to and investigated, as appropriate, by the Safety Officer and the Plant Operations Director/Manager for immediate resolution and are reported, as applicable, to the EOC/Safety Committee.

Review proposed acquisitions of bedding, window draperies, and other curtains, furnishings, decorations, wastebaskets and other items for fire safety.

- All proposed acquisitions to furnish or decorate the facility are reviewed, as applicable to Life Safety Code, by Materials Management to ensure that compliance to mandated fire retardant ratings.
- Wastebaskets, and other items as appropriate, are made of non-combustible materials and are labeled as required to verify UL or FM approval.

Evaluation:

- The Fire Safety Plan's scope, program objectives and performance standards measures will be evaluated annually for effectiveness by the EOC/Safety Committee. The annual evaluation is submitted to Administration and the Board of Directors.

~~The criteria used to measure the effectiveness of the Life Safety Plan are:~~

1. ~~A summary of non-complying factors related to Life Safety codes, with action plan recommendation.~~
2. ~~Preventative maintenance completion rates.~~
3. ~~Fire drill completion rates.~~
4. ~~General orientation and annual update training compliance rates.~~

~~Education & Training:~~

The criteria used to measure the effectiveness of the Life Safety Plan are:

1. A summary of non-complying factors related to Life Safety Codes, with action plan recommendation.
2. Preventative maintenance completion rates.
3. Fire drill completion rates.
4. General orientation and annual update training compliance rates.

Education and Training:

- Fire prevention training of all San Gorgonio Memorial Hospital staff is provided by the employee's Department Director/Nurse Manager, the Safety Officer/designee.
- The Safety Officer/designee presents fire prevention training at new employee orientation.
- The Safety Officer and the EOC/Safety Committee coordinate annual organization wide fire prevention education.

~~Monitoring of Performance:~~

Monitoring of Performance:

In an effort to improve the Fire Safety Plan, the Goals and Performance Standards Measures, as approved by the EOC/Safety Committee, will be monitored on an ongoing basis and annually by the Safety Officer and the EOC/Safety Committee. Performance measurements address: staff fire prevention knowledge, skills and level of participation in fire drill exercises, and the monitoring and inspection of related fire prevention programs. The results of the fire prevention performance monitoring are reported to Administration and Department Directors/ Managers on a quarterly basis, and annually to the Board of Directors.

~~Emergency Procedures:~~

Emergency Procedure:

Established emergency procedures **R**escue, **A**larm, **C**onfine, **E**xtinguish (RACE) are evaluated through fire drills. Fire Drills to assess staff knowledge of:

- Use, function and transmission of fire alarm systems
- Containment of smoke and fire
- Horizontal transfer to refuge areas
- Fire extinguishment: **P**ull, **A**im, **S**queeze, **S**weep (PASS)
- Specific fire-response duties

The San Gorgonio Memorial Hospital life safety orientation and education programs address:

~~Established emergency procedures (RACE) are evaluated through fire drills. Fire Drills to assess staff knowledge of:~~
~~Use, function and transmission of fire alarm systems~~
~~Containment of smoke and fire~~
~~Horizontal transfer to refuge areas~~
~~Fire extinguishment (PASS)~~
~~Specific fire-response duties~~
~~The San Gorgonio Memorial Hospital life safety orientation and education programs address:~~

~~Specific roles and responsibilities of staff, physicians and other licensed independent practitioners at the fire's point of origin.~~

~~Specific roles and responsibilities of other personnel who must participate in the fire plan, such as volunteers, students and physicians.~~

~~Use and function of fire alarm systems.~~

~~Specific roles and responsibilities in preparing for building evacuation.~~

~~Location and proper use of equipment to evacuate or transport patients to areas of refuge.~~

~~Building compartmentalization features and procedures for containing fire and smoke.~~

- Specific roles and responsibilities of staff, physicians and other licensed independent practitioners at the fire's point of origin.
- Specific roles and responsibilities of other personnel who must participate in the fire plan, such as volunteers, students and physicians.
- Use and function of fire alarm systems.
- Specific roles and responsibilities in preparing for building evacuation.
- Location and proper use of equipment to evacuate or transport patients to areas of refuge.
- Building compartmentalization features and procedures for containing fire and smoke.

In accordance with Life Safety Code ~~(~~NFPA 101~~)~~, use of interim life safety measures is utilized to evaluate various deficiencies and hazards prior to the onset of building renovation or construction. Written criteria are established to address each of the interim life safety measures and are approved by the Safety Officer, Director of Plant Operations, and the responsible managing architect.

All renovation and construction areas where interim life safety measures have been activated are monitored daily for hazard surveillance, infection control and contractor compliance to the measures identified for the duration of the activation.

Attachments:

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Environment of Care Committee	Dan Mares: Director Engineering	12/2019
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	12/2019
	Dan Mares: Director Engineering	12/2019

Origination: *12/2018*
Approved: *N/A*
Last Revised: *12/2018*
Policy Area: *Nursing*
References: *APIC Text of Infection Control & Epidemiology, Agency for Healthcare Research and Quality, American Nurse Association-Evidence Based RN tool, CDC CAUTI Guidelines, Perry Potter Clinical Nursing Skills @ Techniques, www.ahrq.gov, www.catheterout.org*

Nurse-Driven Indwelling Urinary Catheter Removal Standardized Procedure

Policy:

To give authority to the Registered Nurse (RN) at San Gorgonio Memorial Hospital (SGMH) to perform the removal of an indwelling urinary catheter without the direct supervision or order from a physician by following this Nurse-Driven Indwelling Urinary Catheter Removal Standardized Procedure.

Purpose:

A. To decrease the risk of Catheter Associated Urinary Tract infections (CAUTI) by identifying appropriate indications for continuation, and criteria for timely discontinuation of an Indwelling Urinary Catheter (IUC).

B. To allow the RN to discontinue an IUC, without a physician order, when continuation of an IUC is no longer indicated.

C. To provide a process to outline nursing responsibilities and care of the patient that will assist in bladder management and bladder emptying following the removal of an IUC,

Circumstances:

A. Patient population: All inpatients and outpatient observation patients with IUC.

B. Appropriate indications to continue an IUC:

1. Urinary retention including obstruction and neurogenic bladder: The patient is unable to pass urine because of an enlarged prostate, blood clots, or an edematous scrotum/penis, or is unable to empty the bladder because of neurologic disease/medication effect
2. Perioperative use in selected surgeries
    a. Patients undergoing urologic surgery or other surgeries on contiguous structures of the genitourinary tract
    b. Anticipated prolonged duration of surgery (catheters inserted for this reason should be removed in Post Operative Care Unit (PACU)
    c. Patients anticipated to receive large-volume infusions or diuretics during surgery

d. Need for intraoperative monitoring of urinary output

3. Placed by urology service
4. Required highly accurate output measurements in the critical care units (e.g. hourly measurement)
5. Assist healing of severe perineal and sacral wounds in incontinent patients to avoid further deterioration of wound or skin
6. Required strict or prolonged immobilization for trauma or surgery
7. To improve comfort for end of life care if needed, unless patient/patient representative requests that no IUC be placed

C. Note: A physician order is required to place an indwelling urinary catheter (IUC).

D. Inappropriate indications/contraindications for IUC use:

1. Diarrhea
2. Receiving a diuretic oral or IV and NOT on strict input and output
3. Invasive procedure less than 2 hours in length
4. As a substitute for nursing care for patients with incontinence
5. As a means of obtaining a urine culture or other diagnostic tests when the patient can voluntarily void
6. For postoperative duration without appropriate indications

E. Appropriate indications to discontinue/remove an IUC:

1. If no appropriate indications to continue IUC are present
2. If there is no physician order to "continue IUC and do not discontinue IUC without a physician order"

Setting:

All SGMH inpatients and outpatient observation patients.

Function:

The qualified Registered Nurse (RN) at San Gorgonio Memorial Hospital (SGMH) will be able to perform the removal of an indwelling urinary catheter without the direct supervision or order from a physician by following this Nurse-Driven Indwelling Urinary Catheter Removal Standardized Procedure.

Criteria for RNs Eligible to Perform the Nurse-Driven Indwelling Urinary Catheter Removal

Qualified Registered Nurse (RN)

A. Education: Active California RN license

B. Training: Completion of hospital orientation in an inpatient unit

C. Experience: None required

D. Initial Evaluation/Skill Validation:

1. The RN will participate in the initial orientation upon hire
2. The RN will meet standard in initial competency upon hire

Documentation:

A. RN will assess and document the need for the IUC daily in the nursing focus assessment of the electronic medical record.

B. RN will document the IUC removal date, time, amount and character of the urine.

C. RN will document bladder management and bladder emptying activities performed after IUC removal.

Supervision:

None required.

Protocol:

Removal of IUC:

A. The qualified RN using the Nurse-driven Indwelling Urinary Catheter Removal Algorithm will determine if the criteria for removal of the IUC is met.

B. If the criteria for continuing the IUC is met, the RN should continue daily shift evaluations of the need for the IUC.

C. The RN will check for a physician order to "continue IUC and do not discontinue IUC without a physician order."

D. The RN will assess the patient's elimination needs and if the needs can be managed by an alternative method. Alternatives to IUC should be considered

Post-Removal of IUC:

A. RN will assess for voiding every 2 hours times 8 hours.

B. Assist patient to sit or stand to attempt voiding, if not contraindicated.

C. If patient voids within 6-8 hours and has no symptoms; RN will continue to observe and document intake and output.

D. If patient is unable to void after 6-8 hours and/or voids but complains of bladder fullness or discomfort or voids less than 250 mL over 4-6 hours or is incontinent; RN will assess, bladder scan and document bladder volume by bladder scan. If bladder scan volume is less than 300 mL, observe. If patient voids and symptoms persist, repeat post void bladder scan and contact the physician.

E. If bladder volume by bladder scan is greater than 300 mL (with no discomfort/retention) the RN will continue to monitor every 2 hours for spontaneous voiding, documenting intake and output.

F. If patient is unable to void after 6-8 hours and/or voids but complains of bladder fullness or discomfort or voids less than 250 mL over 4-6 hours; RN will assess, bladder scan and document bladder volume by bladder scan. If bladder scan volume is greater than 300 mL, patient complains of bladder fullness or discomfort, perform intermittent catheterization. Repeat post void bladder scan if symptoms persist and contact physician.

Procedure:

Referencing the guidelines in the Potter Perry Clinical Nursing Skills & Techniques, 9th Edition, the IUC will be removed.

Equipment:

A. Waterproof pad or towel to protect from possible IUC leaking once removed
B. Washcloth
C. Measurement container for urine output
D. A urinal or hat to measure voided urine
E. 10 mL Syringe to deflate IUC balloon or larger syringe if needed
F. Gloves

Patient teaching:

A. Provide information to the patient the reason for the removal of the catheter
B. Provide the patient with information about procedure of removing the IUC and what they might expect. Explain that they should take a few slow, deep breaths when IUC is being removed. Explain that they might feel a slight pulling and possibly a small amount of pressure.
C. Provide the patient with information regarding post IUC removal:
    1. The need to void within 6 - 8 hours
    2. Void using a urinal or the hat placed in the toilet or bed side commode.
    3. The nurse must be called after each voiding regardless of the amount of urine.
    4. The nurse will measure the urine output from the urinal or hat.
    5. The nurse will empty the urine once it is measured and amount recorded.
    6. They should call the nurse to assist them with getting out of bed if appropriate
    7. Advise patient that when they first void they might feel slight discomfort or burning
    8. Let the nurse know if they are unable to void or painful urination.
D. Always allow time for questions, answers and additional teaching

Removal of IUC:

1. Prepare equipment
2. Perform hand hygiene
3. Check patient identification band for correct patient per procedure
4. Provide teaching to patient
5. Pull curtain for privacy
6. Don gloves
7. Empty, measure and document urine from collection bag; noting color and odor if any
8. Remove gloves, perform hand hygiene
9. Elevate bed for nurse comfort
10. Position patient to visualize perineal area or penis; providing as much privacy and comfort as possible
11. Don gloves
12. Place the waterproof pad or towel under the perineal area of the patient

13. Remove the Velcro leg catheter strap if there is one in place
14. Clean the IUC tubing around the meatus, using a washcloth with soap and water, prior to removal of IUC
15. Attach the syringe to the balloon port and deflate the catheter balloon by pulling back and extracting the water filling the balloon. Detach the syringe and squirt a little of the water out of the syringe, then reattach and pull back to remove any additional water and to assure all of the water has been removed from the balloon. Be sure to hold onto the tubing as it may slip out when balloon is deflated
    a. Please note: Be knowledgeable about the amount of fluid in the IUC balloon that you are removing, as some may have larger or smaller sized balloons and may require a larger syringe to deflate the liquid from the balloon
16. Instruct the patient to take slow, deep breaths, the tube should slip our easily but they might feel a slight pulling or slight pressure
17. If patient expresses pain or more that slight discomfort, reattach the syringe to the balloon port and pull back to remove any remaining water in the balloon. If pain continues contact the physician immediately
18. Wrap the tubing and collection bag in the waterproof pad and discard in waste receptacle
19. Provide perineal hygiene if needed
20. Remove gloves
21. Cover and reposition patient for comfort and privacy
22. Provide the patient with information regarding post IUC removal
    a. They need to void within 6 - 8 hours
    b. They will measure their urine output by using the urinal or hat
    c. Call the nurse to assist them with getting out of bed if appropriate and so that the urine can be measured and recorded
    d. Advise patient that when they first void they might feel slight discomfort or burning
    e. Let the nurse know if they are unable to void or painful urination
    f. Allow time for questions and answers
23. Document date and time of removal of IUC, the amount and character of urine.

Annual Review:

This policy/procedure requires annual review and approval by interdisciplinary Practice Committee, Medical Executive Committee and Hospital Board of Directors.

References:

https://www.cdc.gov/infectioncontrol/pdf/guidelines/cauti-guidelines.pd

APIC Text of Infection Control & Epidemiology. 2009. 4th Edition.

Attachments:

Criteria for Appropriate Use of IUC.docx
Nurse-Driven IUC Removal Algorithm.docx

Approval Signatures

Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Medical Executive Committee	Amelia Frazier: Director Medical Staff Services	12/2019
Interdisciplinary Practice Committee	Amelia Frazier: Director Medical Staff Services	12/2019
Infection Control Committee	Susan Sommers: Director of Infection Control and Risk Management	11/2019
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	11/2019
	Gayle Freude: Nursing Director Med/Surg	11/2019

Origination:	*08/1986*
Approved:	*N/A*
Last Revised:	*02/2019*
Policy Area:	*Security*
References:	

Parking Policy

Policy:

San Gorgonio Memorial Hospital (SGMH) controls the use of parking areas for optimum benefit of patients, medical staff, associates, vendors and visitors. All persons entering or remaining on the grounds of SGMH are required to comply with applicable traffic laws of the State of California. The Security Department is responsible for implementing and managing the SGMH parking program.

SGMH provides free parking for associates in designated areas. Associates are not permitted to park in patient/visitor designated areas unless the associate is being seen as a patient or, is visiting or assisting a patient who is using the SGMH services. Authorized associate parking is listed below in this policy. For the purpose of this policy contract staff and students must adhere to the same policy and procedures.

Parking spaces for the disabled are provided throughout SGMH campus as required by law. Any individual, who is authorized by the Department of Motor Vehicles (DMV) to park in handicap designated parking, must properly display a valid placard or have affixed to the vehicle a valid handicap license plate. Associates who require handicap parking may park in designated handicap parking spaces anywhere on the campus as long as a valid handicap license plate or handicap permit is displayed.

The hospital does not accept responsibility for any damages to vehicles or loss of personal property while parked on the campus. SGMH reserves the right to tow any vehicle found on the property that is abandoned or in violation of this policy.

Associates will be issued an SGMH warning citation for the first occasion of parking in an area, which is not designated as associate parking and or not displaying or improperly displaying their SGMH vehicle permit. Any repeat violations will result in corrective action up to and including termination of employment as specified in Human Resources Policy (Policy Stat ID: 4611533 Disciplinary Action Steps).

Directors and Managers are required to orient associates on the SGMH parking requirements.

Procedure:

The following areas, are designated for associate parking. All hospital associates are expected to park in the designated parking areas listed below, when they arrive to work.

Upon hire (orientation) hospital associates will be issued a parking permit for their vehicle. The parking permit must be visibly displayed while the vehicle is parked on the campus.

The speed limit of all parking areas, shall not exceed 5 mph.

AUTHORIZED PARKING FOR ASSOCIATES (Vehicles and Motorcycles)

A. **Lot A** - Reserved for Physicians, Hospital Executives (West of the Women's Center entrance).

B. **Lot B** - Modular C parking lot (East of the Women's Center entrance) in any parking space not designated.

C. **Lot C** - Tree line parking lot (East of Modular C). Associates may park in any open parking space.

D. **Lot D** - Trailer H & I parking lot. Associates may park in any open parking, including the open dirt parking lot.

E. **Lot E** - Emergency Room parking lot. Associates may park in any open parking spaces East of the Yellow line.

F. **Lot F** - Medical Office building. Associates may park in any open parking spaces East of the Yellow line.

Motorcycles are to be parked in regular associate parking. For the purpose of this policy motorcycles are treated as any other motor vehicle.

Bicycles are to be parked and locked in the stands provided. No bicycles are permitted in the building at any time.

Double parking is not allowed at any time while parked on the campus, and will be subject to tow at owner expense at any time.

UNAUTHORIZED PARKING FOR ASSOCIATES:

The following areas, are unauthorized parking areas.

A. Parking in the spots designated for Associate of the Month, Associate of the Year, and OB sponsored associate, unless designated to park in this area.

B. Parking West of the yellow line around the five medical office buildings.

C. Parking along Highland Springs Avenue and Wilson Street West of the Women's Center entrance. This area is designated for patients, visitors, and physicians. There are also 5 designated parking spots for Volunteers along Wilson Street in this section.

D. Parking on sidewalks

E. Parking within 20 feet of a fire hydrant

F. Parking next to Red curbs

G. Parking in any designated disabled parking space without displaying a valid placard or current handicap license plate

H. Parking in a No Parking zone

I. Any area not designated as associate parking

J. Reserved veteran parking spaces

K. Central Utility Plant parking (reserved for facility vehicles and Contractor and Vendors) vehicles only.

L. Any parking areas marked Behavioral Health Center (BHC).

VIOLATIONS DUE TO UNAUTHORIZED PARKING BY ASSOCIATES:

- Associates who park in any areas not authorized or with a vehicle permit not displayed or improperly displayed will be subject to a Parking Violation Notice issued by the Security Department. Upon receipt of

notice, the associate will be expected to move the vehicle immediately or the associates vehicle may be towed at the associates expense.

- Repeat violators will be subject to progressive disciplinary action up to and including termination. Violations will be tracked using a 12 month rolling calendar.
  - 1st (Citation/Offense) - *Verbal Warning*
  - 2nd (Citation/Offense) - *Written Warning*
  - 3rd (Citation/Offense) - *Suspension*
  - 4th (Citation/Offense) - *Separation of Employment*

Attachments:

Vehicle Registration Form

Approval Signatures

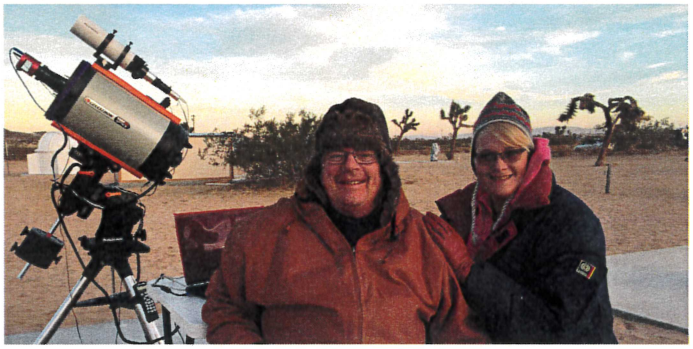
Step Description	Approver	Date
Hospital Board of Directors	Bobbi Duffy: Executive Assistant	pending
Policy & Procedure Committee	Gayle Freude: Nursing Director Med/Surg	12/2019
	Joey Hunter: Director Emergency Preparedness, EOC & Security	12/2019

TAB J

IN THE SPOTLIGHT:

Susan D. Harrington, MS, RD

Executive Director, Communities Lifting Communities
Hospital Association of Southern California



The Andromeda Galaxy image above was created by Susan and Mark Harrington using a Celestron Schmidt-Cassegrain telescope (pictured in accompanying photo).

By Erik Skindrud, HASC Publications Director

Susan Harrington is executive director of Communities Lifting Communities — the HASC initiative aimed at health disparities and upstream factors affecting diabetes, preterm births and other public health challenges.

She recently sat down with the HASC Strategic Communications team to discuss the initiative's goals and work.

CLC sees hospitals working with public health departments and others to improve outcomes for preterm births, diabetes, food insecurity, and other difficult issues. What's it going to take to implement the vision together?

It's going to take strategic partnerships between hospitals and health systems, health plans, public health departments, community-based organizations, community development organizations and community members. These partnerships are place-based and can represent a regional approach to community health improvement at a county level, like the diabetes prevention project in Ventura County, or can focus on a service planning area like Cherished Futures for Black Moms and Babies in South Los Angeles and Antelope Valley in Los Angeles County. Strategic partnerships allow all stakeholders to collectively impact community health through an informed view of community needs, assets and alignment of strategies and opportunities for co-investment and shared ownership.

A degree of mistrust of health care and governmental organizations must be present in underserved communities. How do health workers gain the confidence of underrepresented segments of the population?

Engaging the community when assessing health and social needs, identifying service capacity as well as when programs and plans are developed and implemented are essential to gain trust and ensure that the strategies identified to improve health will address the community's needs. Community members know what social and non-medical needs impact their health, e.g., food insecurity, economic insecurity, transportation, access to health and social services and affordable housing. Community members representing low income, minority and underserved populations often participate in focus groups, complete quality of life surveys as well as serve as members of various partnerships with the goal to improve community health and reduce disparities.

> "My passion to improve the public's health and ensure individuals and communities have access to health care, social services and a healthy and safe community has been my guiding principle."

There's a growing consensus that behavioral health is a priority community health need. How do professionals help patients and clients overcome fear and stigma in this area?

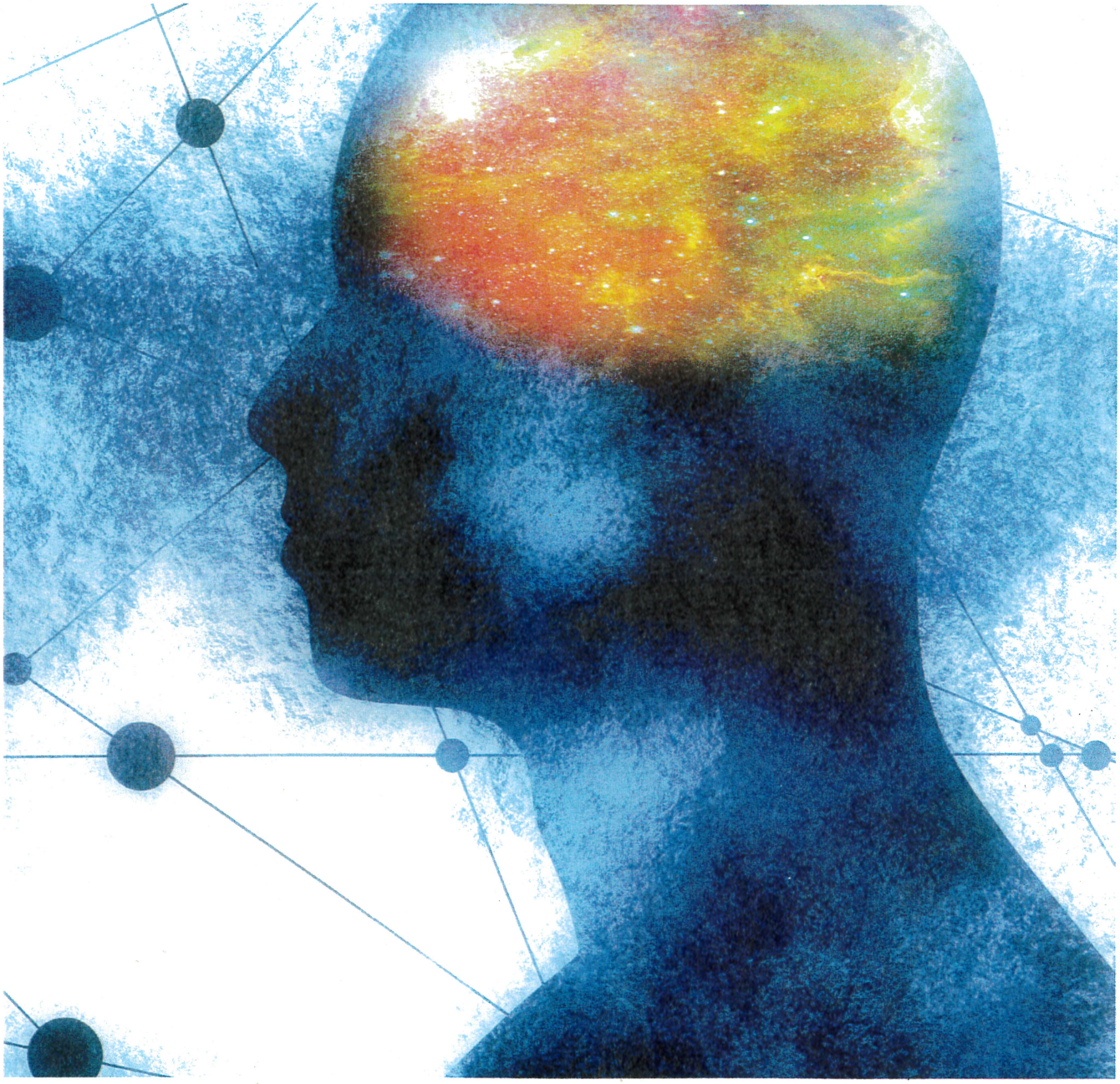
Behavioral health was named a priority area for policy and advocacy work by HASC members in 2018 and again in 2019. HASC is conducting a Behavioral Health Needs Assessment and will be identifying local advocacy activities to engage local managed care and mental health care plans and encourage provider collaboration focused on pre- and post-hospital services ranging from community-based prevention and early intervention to outpatient therapeutic services.

Similarly, in 2019, many Community Health Needs Assessments conducted by non-profit hospitals and public health departments are identifying behavioral health as a priority area. Once the health need is identified, partners are developing strategic implementation plans to increase access to mental health care services in clinical and community settings, reduce stigma and improve knowledge and resilience for individuals and organizations, and build skills for the current and emerging workforce.

You've enjoyed several successful decades in a challenging field. How do you maintain your balance and optimism and keep moving forward?

For over 30 years, my passion to improve the public's health and ensure individuals and communities have access to health care, social services and a healthy and safe community has been my guiding principle. The opportunity to work with Communities Lifting Communities at HASC in partnership with hospitals and health systems, public health departments, health plans and communities was too good to pass up, so I came out of retirement. Work-life balance is key to any successful career and I enjoy spending time with my husband, three children and four grandchildren. I even took up a new hobby — astrophotography — where my husband brings his love of photography and I bring my interest in astronomy together with technology and spending time with friends who also like to gaze at the night sky.

THE WELLBIES



HEALTH AWARDS

WHEN YOU NEED TO CHECK INTO A HOSPITAL, HOW DO YOU KNOW YOU'RE GETTING THE BEST CARE POSSIBLE? FOLLOWING IS A SHORT SAMPLE OF RECENT AWARDS, HONORS AND ACCOLADES EARNED BY AREA HOSPITALS AND OTHER MEDICAL PROVIDERS.

of Surgeons, 2018 • Laboratory Accreditation, Joint Commission, 2018 • Comprehensive Stroke Center Accreditation, Joint Commission and Emergency Medical Services Agency, 2018 • Smart Care California, Achievement Award for Healthy People 2020 target for low-risk, first-birth C-section rate, 2018.

RADY CHILDREN'S HOSPITAL-SAN DIEGO is a 524-bed pediatric care facility providing the largest source of comprehensive pediatric medical services in San Diego, southern Riverside and Imperial counties. *rchsd.org*

In June 2019, *U.S. News & World Report* ranked Rady Children's among the best children's hospitals in the nation in all ten pediatric specialties the magazine surveyed.

REDLANDS COMMUNITY HOSPITAL Conveniently located between Los Angeles and Palm Springs, Redlands Community Hospital is a 229-bed facility with a team of over 300 physicians, 1,800 employees, and 250 volunteers. The hospital has recently undergone major renovations expanding the Emergency Department, adding four new operating rooms including a Hybrid Interventional Suite, and remodeling the hospital's entry plaza with a new and larger gift shop and coffee cart.

Redlands Community Hospital has provided patients and their families with an exemplary level of care and respect for over 100 years. The most recent 2020 Specialty Clinical Quality Awards from Healthgrades include America's 100 Best Hospitals for Orthopedic Surgery Award (2012-2020), America's 100 Best Hospitals for Prostate Surgery Award (2017-2020), and the prestigious Joint Replacement Excellence Award (2020). They received the coveted "A" grade from The Leapfrog Group for patient safety, and the Centers for Medicare & Medicaid Services (CMS) gave the hospital a 4-Star Rating for Hospital-level Quality of Care 2019. They have also been certified by the Joint Commission as an Advanced Primary Stroke Center.

SAN GORGONIO MEMORIAL HOSPITAL in Banning is a health care district community hospital with a high volume emergency department. San Gorgonio Memorial Hospital provides many healthcare services to the community. *sgmh.org*

San Gorgonio Memorial Hospital has been honored with multiple awards and recognitions. The highlights of awards and recognition during the year include *U.S. News & World Report* 2019-20 Best Hospitals honor roll and specialty rankings in which San Gorgonio Memorial Hospital was recognized as one of the high performing hospitals for knee replacement.

San Gorgonio Memorial Hospital also received geriatric accreditation from the American College of Emergency Physicians this year showing the commitment to the community and geriatric patients. The emergency department has also been nationally nationally for exceptional patient satisfaction.

As an employer San Gorgonio Memorial Hospital has once again been awarded the Inland Empire's Top Work Places award for 2019. This is a very special award because it is based solely on employee survey results and given to less than 40 employers. Additionally, receiving recognition for exceptional safety and security in Security Magazine Top 500.

MEDICAL GROUPS

BEAVER MEDICAL GROUP is one of the most comprehensive medical groups in Southern California with more than 200 doctors in 25 specialties along with many on-site services such as laboratory drawing, radiology, optical shops and more. Recipient of America's Physician Group Standards of Excellence Elite Status, 2017, 2018. • Accreditation by the Institute of Medical Quality, 2016-2018. • 4-Star Medicare Award, 2018, State of California Office of the Patient Advocate. • Best Medical Group, Urgent Care, Primary Care Physician, Pediatrician, 2018, *Sun* and *Daily Facts* Readers' Polls. *beavermedicalgroup.com*

SAN GORGONIO MEMORIAL HOSPITAL

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24 HOUR EMERGENCY & RAPID CARE SERVICES

EXPERT TREATMENT FOR PATIENTS OF ALL AGES FROM CHILDREN TO OLDER ADULTS

2019-2020 U.S. NEWS & WORLD REPORT HIGH PERFORMING HOSPITAL

ACCREDITED Center for Improvement CIHQ in Healthcare Quality HOSPITAL

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS ACCREDITED GERIATRIC EMERGENCY DEPARTMENT

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Lakeisha Hawthorne and Joan Kiefhold are behind fruitful changes at San Gorgonio Memorial Hospital.

The Change Makers

FSD **celebrates movers and shakers building community ties.** P. 24

FOODSERVICE OPERATION OF THE MONTH
Tahoe Truckee Unified School District
Truckee, Calif.
P. 36

FSD 12.19 Contents

COMMUNITY TIES

Jean Kielhold, chief registered dietitian for San Gorgonio Memorial Hospital, works with participants in a community cooking class.

PHOTOGRAPH BY GREGG SEGAL

This year's Change Makers are moving beyond brick-and-mortar to take their operations into the future.

To be successful in 2019 and beyond, stagnation is not an option. Foodservice operators across the country are adapting to a shifting sea of new trends, fresh technologies and changing diner preferences. (If only every chef coat came with a crystal ball.) This year's class of Change Makers isn't sitting still. Instead, they're thinking outside the four walls of their business and seeing it as the nexus for something bigger. By bringing their operations out into the community, or vice versa, these forces in foodservice are going beyond brick-and-mortar to boost health, provide convenience, support local startups and rethink school meals. Here's how they're doing it.

HEALTHCARE

The health heroes

A hospital's nutrition team is fostering healthy choices by casting a wider net.

By Benita Gingerella

Lakeisha Hawthorne and Jean Kielhold, top left, of San Gorgonio Memorial Hospital, worked to improve the health of their community by introducing healthier menu items and hosting cooking classes for families.

About three years ago, the nutrition team at San Gorgonio Memorial Hospital in Banning, Calif., set out to improve the health of people beyond its patients.

"Our call was for us to look at how we can make a healthier community," says Chief Clinical Registered Dietitian Jean Kielhold. The hospital offered to participate in a Public Hospital Redesign Incentive and MediCal (PRIME) program, which challenged and incentivized its team to come up with initiatives that would help tackle obesity in Banning, where 23.4% of the population is below the poverty line, according to the U.S. Census Bureau, and amenities such as a local farmers market did not exist.

Since then, the foodservice team has worked to transform the health of those inside the hospital—and outside.

INSTRUCTING THE COMMUNITY

The nutrition team established a two-pronged approach that expanded the number of healthy meals served in the hospital's cafe as well as implemented community initiatives such as a weekly farmers market and cooking classes, both of which are open to the public.

Kielhold started with a class solely focused on obesity due to the PRIME goals, but quickly saw that students required additional instruction: "I found that they needed more than just weight loss—they needed ideas on how to cook and what to cook and how to use a budget."

She did some research and decided to instead teach a government program called Eat Well, Be Active, which included further information on topics such as cholesterol intake and cooking on a budget.

Families with children have their own cooking class, Strong for Life, in which kids work with their guardians to create healthy snacks and meals. "The kids get some hands-on fun with food, and the parents get all kinds of ideas on how they can incorporate five fruits and vegetables a day," Kielhold says.

The classes' success led the nutrition team to expand its instructional outreach. Kielhold now visits the hospital's behavioral health facility, located 40 minutes from its main campus, to host lunch-and-learn events with food tastings around a nutrition topic. She also has begun setting up a monthly instructional booth at the local Women, Infants and Children (WIC) Food Center.

> "I think even after this is over, we want to continue to strive to have a healthier community and do whatever we can do outreach-wise." —Lakeisha Hawthorne

PHOTOGRAPHS BY GREGG SEGAL

MAKING CHANGES INSIDE

Part two of the initiative sought to transform the hospital's cafe into someplace healthier.

"We really wanted to focus on marketing healthier [produce], so we redid all of our art on the walls to be fruits and vegetables," says Director of Food and Nutrition Services Lakeisha Hawthorne. The team also redid the wall and floors, added free water in soda machines and began offering infused water and a larger salad bar. "We made it feel like more of like a welcoming place where people can come and relax," she says.

The menu also got a makeover. To spur better choices, San Gorgonio began selling select wellness meals for just $5, which include an entree such as a salmon burger served with a side of vegetables, a fruit and a choice of yogurt or milk. It also partnered with a local food hub that supplies the hospital and an area school district with ingredients from nearby farmers.

"Our prices are very affordable for staff because they have a discount, but we wanted to make sure that we offer [healthy] meals that not only the staff can afford but that people in the community can come in and afford," Hawthorne says, adding that staff have shared how excited they are about the expanded healthy options.

Diners also have access to a basket of seasonal fruits at the checkout, which are available for 50 cents. In the future, the team hopes to offer a free piece of fruit to every child who visits the cafe.

STAFF ARE CENTRAL

Their progress so far couldn't have been achieved without the support of employees, who were involved from the beginning, Hawthorne says. Each week, she holds a team huddle during which employees are encouraged to share their thoughts about anything on their minds, including giving their co-workers a shoutout—something Hawthorne says has boosted employee morale.

During this time, staff are also encouraged to give feedback on any upcoming health initiatives they plan to roll out. "I'm listening to everybody's opinions because I really think that we couldn't have made all the change and all the transitions that we have without their opinions, without their feedback and without their help," says Hawthorne, adding that PRIME has inspired the team to build upon their community engagement.

"I think even after this is over, we want to continue to strive to have a healthier community and do whatever we can do outreach-wise," she says. "We want to continue to go even beyond what we're doing now."

San Gorgonio's revamped cafe menu focuses on healthy, affordable meals.

PHOTOGRAPH BY GREGG SEGAL

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Good Morning Beaumont Breakfast San Gorgonio Memorial Hospital Update

Steve Barron

On Friday, January 10, 2020, the Beaumont Chamber of Commerce is proud to present speaker Steve Barron, Chief Executive Officer, San Gorgonio Memorial Hospital, at our Good Morning Beaumont Breakfast. Mr. Barron brings more than 28 years of experience leading hospitals prior to his role at San Gorgonio Memorial Hospital. He previously served as Vice President of operations Southern California at San Francisco-based Dignity Health. In that role, he was responsible for developing long range strategic and financial plans for six medical centers in Southern California. Don't miss this informative event.