SoHum Health

Southern Humboldt Community Healthcare District

GOVERNING BOARD MEETING

March 30, 2023
1:30 p.m.

(In person and Via Webex Conferencing)

Sprowel Creek Campus, Rm 106
286 Sprowel Creek Road
Garberville, CA 95542

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CNO BOARD REPORT
for February, 2023

We continue with the visiting nurse program, and the mobile Clinic has been serving the community once a week in a different location.

Infection Prevention:
Vaccines for the bivalent booster and Flu vaccines are being offered in the Clinic on Wednesdays. Here are some current numbers to consider if you are on the fence about getting either of the vaccines.

COVID Bivalent vaccine continues:
Pfizer is available for 12 years and older. The new booster COVID Bivalent vaccine is expected to increase protection for the new circulating omicron variant. COVID Bivalent vaccine: 49 employees have received the Pfizer Bivalent vaccine since it became available. We follow the CDC COVID guidelines for precautions and isolation when testing positive for covid. The SNF residents continue to be free from covid, thanks to the consistent staff following all the infection prevention regulations and protocols. We will continue following CDC COVID guidelines to protect residents, patients, and staff from COVID.

ED/Acute:
The ED continues to serve the community by providing emergency care and outpatient services. We are fully staffed in the ED and Acute, and we have no traveler RNs at this time. We have four traveler LVNs who are helping on the Acute side with the SWING bed program.
The nursing department continues to have monthly nursing and patient safety meetings.
Our goal continues to be that our patients and the community get the highest quality of care, and when they come to our hospital, they can see that the care reflects excellence, compassion, and love.

Laboratory:
The laboratory continues to have morning huddles and twice-weekly lab meetings. The lab team has been busy with the EPIC/OCHIN implementation meetings and paperwork and continuing to prepare for the COLA Survey. The lab team is confident that everything is ready for the COLA team to come and do the survey.

Skilled Nursing Facility:
Mary Spring, RN, continues to be the interim DON and has expressed interest in taking the DON position. Daisy Yanez, RN, continues to assist Mary, and they are working together to keep the SNF a safe place and provide high-quality care to the residents.

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The two SNF beds have been filled with two members of the community. With eight residents who continue to be covid free, the residents continue to get together for lunch daily, go on outings, and do fun activities.

The state was in the week of 01/31/23 and performed an Infection Control survey in the SNF. We are still awaiting the results of the survey.

Clinic:

The Clinic continues to provide excellent service to the community. Jessie Bugbee, FNP, continues to see patients and accept new patients. Laura Mojica, our Pediatric Nurse Practitioner, continues seeing pediatric patients and accepting new patients.

The Visiting Nurse program has been back and running since the beginning of this year. The Mobile Clinic continues to provide services once a week. The following includes the mobile clinic scheduled days:

Mobile Clinic Scheduled days:
2/16/23 Rio Dell -Fire dept. 10-3
2/24/23 Shelter Cove RID parking lot 10-3
3/2 Blocksburg – park on Church Street 10-3
3/9 No clinic. Jessie is out of town
3/23 Petrolia – tentative (working on details)
3/30 Shelter Cove RID parking lot 10-3
4/6 Blocksburg – Church Street 10-3
4/13 TBD
4/20 Rio Dell – Fire department 10-3
4/27 Shelter Cove – RID parking lot 10-3
5/4 Blocksburg – Church Street 10-3
5/11 TBD
5/18 Rio Dell – Fire Department 10-3
5/25 Shelter Cove – RID parking lot 10-3

The Clinic will have a meeting on February 22, 2023, to discuss quality measures for this year. The Clinic continues to look for a Physician for the Clinic and an LCSW for the Behavioral Health program. We wish the best to the LCSW that has separated from the clinic team at the beginning of February 2023.

Leo, the new Substance Use Navigator, continues to help the community and is expanding her services by assisting the community with counselor services and working on the FRC. She continuously helps in the ED, Acute, Swing, and SNF.

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Radiology

Radiology is growing, getting new services, and improving the services being provided to the community. The 3D mammogram and the ultrasound are up and running and available to the community. A new X-ray table was ordered, and it has arrived. The new table will provide a safer and more comfortable patient experience.

Adela Yanez, RN, BSN, CNO

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CNO BOARD REPORT March 2023
Thursday, March 2023

March Updates

The new EPIC implementation is going well, and everything is going as planned. The go-live day still schedules for July 2023. All the different departments are working hard with the EPIC training while working on all their daily responsibilities to continue serving the community.

Infection Prevention/Employee Health

We have had an increase in covid positives this month on the clinical hospital side and have had to perform post-exposure and response testing in the SNF/Acute and ED units. For residents/patients and staff, this involves testing twice weekly anyone who works in the department or meets the definition of confirmed close contact with unit staff or residents. Symptom screening is still required of all employees before arrival to work, and on the SNF/Acute side, a screening log is kept at the nurse station. COVID-bivalent vaccines are offered and provided to all employees are also offered in the Clinic on Wednesdays.

ED/Acute:

The ED continues to serve the community by providing emergency care and outpatient services. We are fully staffed in the ED and even though several staff members were unable to come to work due to the stormy cold weather and we had several COVID positive ED staff members, we could continue providing 24/7 ED services to the community without any delays. There were 219 ED patients seen in February.

The nursing department continues to have monthly nursing and patient safety meetings.

Our goal continues to be that our patients and the community get the highest quality of care, and when they come to our hospital, they can see that the care reflects excellence and compassion.

Laboratory:

The laboratory continues to have morning huddles and twice-weekly lab meetings. The lab team has been busy with the EPIC/OCHIN implementation. The lab will get another staff member to help during the EPIC/OCHIN implementation and the go-live time. Jennifer is a traveler Lab Technician who worked in the lab last year. So, Jennifer will not need additional orientation or training when she starts in May. The lab team is confident that everything is ready for the COLA survey since they are expected to perform it sometime this year.

Skilled Nursing Facility:

Mary Spring, RN, continues to be the interim DON and has expressed interest in taking the DON position. The SNF has no available beds currently, and all the residents continue to be covid free; the residents continue to get together for lunch daily, go on outings, and do fun activities.

The state was in the week of 01/31/23 and performed an Infection Control survey in the SNF, and they found one deficiency regarding policy updates, and a plan of correction was sent, and it was accepted. We must have all the Policies and procedures reviewed and updated by March 30, 2023.

Clinic:

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The Clinic continues to provide excellent service to the community. Jessie Bugbee, FNP, continues to see patients and accept new patients. Laura Mojica, our Pediatric Nurse Practitioner, continues seeing pediatric patients and accepting new patients.
The Visiting Nurse program has been back and running since the beginning of this year. The Mobile Clinic continues to provide services once a week. Please keep in mind the weather conditions and that the schedule could change due to weather conditions.
The following includes the mobile Clinic scheduled days:
Mobile Clinic Scheduled days:
3/23 Petrolia – tentative (working on details)
3/30 Shelter Cove RID parking lot 10-3
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The Clinic has had more staff meetings since the beginning of this year and continues to improve in all areas of patient care and communication with the community and the team.
The Clinic continues to look for a Physician for the Clinic and an LCSW for the Behavioral Health program. We wish the best to the LCSW that has separated from the clinic team at the beginning of February 2023.

Leo, the new Substance Use Navigator, continues to help the community and is expanding her services by assisting the community with counselor services and working on the FRC. She continuously helps in the ED, Acute, Swing, and SNF.

Radiology
Lora, our Radiology manager, reports, "In February, Radiology performed 127 x-ray exams, 64 CTs, 21 ultrasounds, and 26 mammograms. Documents and images have been submitted to the ACR for accreditation on the new machine. We have been very busy with OCHIN/Epic meetings, training, and spreadsheets."

Adela Yanez, RN, BSN, CNO

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Infection Prevention Annual Report
FYE 2022 (July 2021-June 2022)

The District

Southern Humboldt Community Healthcare District (SHCHD) is a California Special Healthcare District located at 733 Cedar Street, Garberville, California, 95542. It is comprised of the Jerold Phelps Community Hospital, the Southern Humboldt Community Clinic, and off-site Sprowel Creek Campus with retail outpatient pharmacy and Family Resource Center that provides numerous support services to the community. The hospital is a Medicare certified Critical Access Hospital consisting of 9 licensed acute/swing beds and an 8-bed "distinct part" Skilled Nursing Facility (SNF). The district has no intensive care unit (ICU), obstetrics unit, or operating room. Direct services include a 24/7 Emergency Department (ED), Laboratory, diagnostic Radiology including CT scan and screening Mammography, Behavioral Health, retail outpatient pharmacy, and a Visiting Nurse Program (currently on hold until able to hire a nurse). Additional services that are being added or expanded: Mobile Health Clinic, Behavioral Health, outpatient Ultrasound and 3D Mammography.

Service Area

Southern Humboldt Community Health Care District (SHCHD) serves populations in southern Humboldt, northern Mendocino, and western Trinity counties. It is a large rural area of approximately 775 square miles and includes the communities of Alderpoint, Blocksburg, Ettersburg, Garberville, Harris, Honeydew, Miranda, Myers Flat, Leggett, Petrolia, Phillipsville, Piercy, Redcrest, Redway, Shelter Cove, Weott, Whitethorn, and Zenia. The area has a predominantly white population of about 10,365 full-time residents that increases during summer months. The hospital provides services to the local community and seasonal tourists.

SHCHD provides the only Emergency Department in this area. Severe winter weather, rugged terrain and rough roads can make travel difficult and delay medical treatment.

SHCHD Statistics

	FYE 2018	FYE 2019	FYE 2020	FYE 2021	FYE 2022
Emergency Visits	3102	3035	2778	2601	3126
Outpatient Visits	4223	3950	4059	11,436	9059
Clinic Visits	5504	5248	5950	5048	5067
SNF patient days	2914	2794	2890	2713	2689
Acute care days	109	133	142	93	102
Swing patient days	1091	1015	1066	1043	604
Observation patient days	58	67	91	100	117

Infection Preventionist Position

At the end of this fiscal year, the district has one full-time individual filling the Infection Preventionist (IP) role. The current IP is not a Certified Infection Control (CIC) Nurse but comes in with one year experience serving as the Infection Preventionist (IP)/Inpatient Certified Wound/Ostomy Nurse and Outpatient Wound Center Manager at a local General Acute Care Hospital with an additional 10 plus years of experience specializing in wound/ostomy care. Prior to the current IP's arrival, the majority of the FYE 2021 consisted of three part-time individuals who together filled the IP role. The lead CIC began orientation of the current IP late August of 2021. The new IP's goal is to become proficient in this role and then sit for the CIC exam. The previous lead CIC continues to serve as a consultant with the district to assist and ensure that the current IP is competent in all the areas important for a good infection prevention program.

Infection Prevention Reporting

The Infection Prevention program performs active surveillance for hospital-associated infections (HAI) using daily review of culture and sensitivity reports and weekly review of new antibiotic orders. All infections identified, whether requiring external reporting or not, are reported internally to the Medical Staff Committee.

NHSN Patient Safety Module

Certain infections and conditions occurring in Acute and Swing Bed patients are reportable to the Centers for Medicare and Medicaid (CMS) and the California Department of Public Health (CDPH) via the National Healthcare Safety Network (NHSN) reporting system. These include:

- Catheter-associated urinary tract infection (CAUTI)
- Central line associated bloodstream infection (CLABSI)
- Clostridium difficile infection (CDI)

Certain Lab results are reportable for both in-patients and out-patients:

- Multi-drug resistant organisms (MDROs), including methicillin resistant staphylococcus aureus (MRSA) bacteremia.
- Vancomycin resistant enterococcus (VRE) identified on lab reports.

NHSN Reporting FYE 2022 (Acute and Swing Bed units only)

2021-2022 =>	FY Q1	FY Q2	FY Q3	FY Q4
CLABSI	0	0	0	0
CAUTI	0	0	0	0
Clostridium difficile infection (CDI)	0	0	2 (not HAI)	0
VRE (lab IDs events only)	0	0	1	0
MRSA (+ Blood Culture only)	0	0	0	0

NHSN Device Days FYE 2018-FYE 2022

	FYE 2018	FYE 2019	FYE 2020	FYE 2021	FYE 2022
Ventilator days/VAPS	N/A	N/A	N/A	N/A	N/A
Surgeries/Surgical site infections	N/A	N/A	N/A	N/A	N/A
Central Line Days (Acute/Swing*)	100	60	0	14	0
Urinary catheter days (Acute/Swing*)	20	108	126	59	61

NHSN Healthcare Personnel Safety module

Healthcare personnel influenza vaccination rates are reported to NHSN every May. See Employee Health Annual Report.

Public Health Reporting

As required by Title 17, section 2500, certain conditions and diseases are reportable to the Humboldt County Public Health Department. A total of 15 California Morbidity Reports (CMR) were submitted in FYE 2022.

Of those 15 reports, a large number were STIs (sexually transmitted infections). Gonorrhea: 5; Chlamydia: 2; Hepatitis C: 1; Hepatitis B: 1; Lyme Disease: 3; Campylobacteriosis: 2; and Coccidioides: 1.

Evaluation: Mandatory reporting was completed as required in FYE 2022.
Plan: Continue surveillance and reporting as required by law.

Internally Reported HAIs in SNF and Swing Bed Unit FYE 2019-2022

Infections that do not currently require external reporting are reported internally to the Medical Staff Committee and include the following:

1. Infections in the Skilled Nursing Facility (SNF)
2. Non-catheter associated urinary tract infection (UTI)
3. Catheter associated urinary tract infections that DO NOT meet NHSN criteria for CAUTI
4. Hospital acquired pneumonia (HAP)
5. Skin and soft tissue infection (SSTI)

For this report, infection and census data were collected from Infection Prevention quarterly reports and Health Information Management (HIM) reports.

Internally Reported	FYE 2019	FYE 2020	FYE 2021	FYE 2022
Catheter associated urinary tract infections (CAUTIs) in SNF	0	0	0	0

Urinary tract infection (UTI)- not catheter associated in SNF and Swing	0	0	0	1
Hospital-Associated pneumonia (HAP) in SNF and Swing	0	0	0	1

Evaluation: The zero incidence of CAUTI (no cases in the last five fiscal years) is largely attributable to very infrequent use of indwelling urinary catheters and prompt removal.

The Antibiotic Stewardship program encourages stricter diagnostic criteria for UTI's which may have resulted in fewer cases being diagnosed and treated. Many of those that were called UTI's in the past are asymptomatic bacteriuria's and do not require antibiotic therapy.

The facility uses the 2012 revised McGeer Criteria for HAP surveillance. Due to inconsistencies in the definition of HAP, there are no reliable, published benchmarks for long term care facilities to compare rates.

Plan: Continue surveillance and internal reporting on significant infections that do not require external reporting.

Multidrug Resistant Organisms (MDROs) and Clostridium difficile infections

Positive Lab reports	FYE 2018	FYE 2019	FYE 2020	FYE 2021	FYE 2022
Methicillin Resistant Staph Aureus (MRSA)	14/no HAI	0	0	?	5/ not HAI
Vancomycin resistant enterococci (VRE)	1- in ED	0	0	0	1
Clostridium difficile infection (CDI)	0	0	0	0	2/not HAI
Carbapenem resistant enterobacteriaceae (CRE)	0	0	0	0	0
MRSA bacteremia	2- Both in ED	0	0	0	0
E. coli ESBL	2/not HAI	0	1/not HAI	0	4/not HAI

Evaluation: For FYE 2022, there has been one case of hospital-associated infection (or known colonization) by VRE, no cases of CRE, no cases of hospital associated MRSA bacteremia, and no cases of hospital associated Clostridium difficile infection (CDI) from this facility during the last five years for which district infection prevention records are available. The two CDI infection noted above for this fiscal year were both present on admit and involved the same patient.

A number of factors contribute to the low incidence of these and other infections in the hospital:

- Low patient acuity
- Short lengths of stay
- Low utilization of invasive devices like indwelling urinary catheters and central lines

- Few invasive procedures
- Judicious use of antibiotics
- Good staffing ratios
- Staff adherence to hand hygiene policy and equipment cleaning policy and environmental cleanliness

Plan: Continue to monitor and report.

Community Associated Infections

Infections present upon admission (POA):

In FYE 2022, there were 38 inpatient admissions. All those admitted, 18 had infections present at the time of inpatient admission. In order of frequency, these infections were:

Sepsis: 7
Cellulitis: 5
Pneumonia: 4
Urinary Tract Infection: 2

Infections diagnosed in the ED

COVID-like disease and/or potential exposure to COVID positive person was the #1 primary diagnosis in the Emergency Department this fiscal year with 78 patients. “Urinary tract infections” (62 patients) “Viral infection, unspecified” (35 patients).

Sepsis (ICD10 A41.9, Sepsis, unspecified organism)

A total of 7 patients were admitted with a diagnosis of Sepsis. All but one was present at time of admission. One SNF resident developed sepsis and was transferred to inpatient.

Community Associated MRSA

There were 12 total Staphylococcus aureus positive cultures in FYE 2022. Four of those were positive for MRSA for a 33% MRSA rate. The remaining eight were sensitive to methicillin (MSSA).

Noted in FYE 2021, there still appears to be a high local MRSA resistance to ciprofloxacin, levofloxacin, erythromycin and FYE 2022 there now appears to be high resistance to oxacillin. However, these numbers are small and are prone to variation from year to year.

MRSA Antibiotic Resistance Profile FYE 2021	**Total # tested**	**Total # resistant**	**% resistant**	**% sensitive**
Gentamicin	4	0	0.0%	100%
Tetracycline	4	0	0.0%	100%
Vancomycin	4	0	0.0%	100%
Clindamycin	4	1	25%	75%
Trimeth/Sulfa	4	0	0%	100%
Ciprofloxacin	4	4	100%	0%
Levofloxacin	4	4	100%	0%
Erythromycin	4	4	100%	0%
Oxacillin	4	4	100%	0%

Evaluation: For the FYE 2022, the district utilized the Antiobiogram from PSJH.
Plan: Continue to monitor and report on local antibiotic resistance trends.

Blood Cultures

Blood culture surveillance reports are a part of quarterly infection prevention reporting. Reports include the clinical signs/symptoms, empiric antibiotic treatment, organism(s) cultured, and sensitivity to ordered antibiotic. Follow-up with providers is done if sensitivity reports indicate resistance to ordered antibiotics.

Organisms isolated and empiric antibiotic treatment:

FYE 2022	Location	Blood Culture Organism(s) Isolated	Treatment
Q1	Acute/SWB transferred in for surgical aftercare	Streptococcus dysagalactiae	IV Ceftriaxone 2 gm
Q1	ED/admitted	Staphylococcus epidermidis	IV Clindamycin, left AMA, RX for Clindamycin to pharmacy
Q1	ED/transferred	Peptoniphilus asaccharolyticus	IM Ceftriaxone 2 gr in ED prior to transfer
Q1	ED/admitted	Streptococcus pneumonia	IV Azithromycin and Ceftriaxone. Left AMA and RX for cefpodoxime sent to pharmacy
Q2	ED/DC'd	Escherichia coli	Abx IV Ceftriaxone, RX for Cefdinir
Q2	ED/admitted	Enterococcus faecalis	Abx IV Vancomycin and Unasyn
Q2	ED/transferred out	Streptococcus pneumoniae	Transferred to higher level of care, results of BC called to other facility to report
Q2	ED/eloped	Globicatella sulfidiaciens	IV Rocephin, RX for Keflex to pharmacy
Q2	ED/admitted	Streptococcus pneumoniae	IV Zosyn and Levaquin
Q3	ED/DC'd	Streptococcus pneumoniae	IV Ceftriaxone. Rx for Azithromycin
Q3	ED/DC'd	Staphylococcus epidermidis	IV Vancomycin and Cefepime as outpatient
Q3	ED/Transferred out	Staphylococcus aureus	IV Cefepime, Gentamicin, and Vancomycin
Q3	ED/Transferred out	Staphylococcus epidermidis	Transferred out for other medical issue.
Q3	ED/DC'd	Staphylococcus hominis	Azithromycin, Rocephin, Cefpodoxime
Q4	ED/DC'd	Micrococcus luteus	Doxycycline for UTI, CXR poss. pneumonia

Blood culture contamination and low volume blood culture numbers for FYE 2022: 5 total for probable contamination and 8 total cultures had low volume.

Evaluation: Blood culture review and follow up to continue.
Plan: Continue surveillance and reporting.

Urine Cultures

Infection Prevention does surveillance on urine culture reports for the ED, SNF, Swing Bed, and Acute units. If the patient is being treated empirically with antibiotics and the sensitivity report shows resistance to that antibiotic, the ordering provider (or current physician, if the patient was seen in ED) is informed. An alternate antibiotic may be ordered.

In FYE 2022, a total of 433 urine culture results were received from Quest. These included cultures ordered by outside providers that use our Lab service.

Results:
No Growth or multiple organisms.
There was two positive VRE urine cultures (both on same patient).
There were four positive E. Coli (ESBL) urine cultures.
Most common urine cultures consisted of E. Coli, Proteus mirabilis, and Enterococcus faecalis.

TB Screening

SNF residents and long-term Swing Bed patients (those who will be admitted for longer than 30 days) are screened for tuberculosis (TB) upon admission and annually. Seven SNF residents were screened with QFGs in FYE 2022. All screenings were negative. On SNF resident has had a positive QFG in the past and completed the TB screening questionnaire, which was negative for TB signs and symptoms. Fifteen Swing Bed patients were screened, and all were negative.

Evaluation: The TB screening program is adequate.

Plan: Continue to screen SNF residents and Swing Bed patients (for those staying > 30 days) as needed and annually.

Antibiotic Stewardship Program (ASP)

The facility's Antibiotic Stewardship Program was started in 2015 and has been tasked with ensuring the judicious and appropriate use of antibiotics. The ASP committee is comprised of the Medical Director, Chief Nursing Officer, Pharmacist, and Infection Preventionist.

Activities in FYE 2022 included:

- Completion of an ASB course for the district infection preventionist.
- Nursing staff assigned antibiotic stewardship education through the Relias program.
- Continuing spreadsheet listing Acute, Swing Bed and SNF resident antibiotic orders, maintained by the Infection Preventionist.
- Continued ED, in-patient, and SNF culture follow-up by the Infection Preventionist with action taken when the sensitivity report indicates resistance to the ordered antibiotic.

Evaluation: Progress has been made in implementing the Antibiotic Stewardship policy, but challenges continue:

- Difficulty obtaining complete antibiotic usage data from the HealthLand system
- Difficulty convening regular meetings of the Antibiotic Stewardship Committee due to time and schedule limitations of committee members. The COVID pandemic continued to take precedence over many district functions making it challenging to meet.

Plan: Continue improving the processes and review current evidence-based protocols for antibiotics for commonly seen infections and update current protocols, as necessary.

Water Program

The Water Program Committee has not been active this last fiscal year. Committee membership is composed of the Chief of Operations, the Engineering Manager, the Chief Nursing officer, and the Infection Preventionist. The Engineering Manager continues to monitor the two areas of risk previously identified: the outdoor fountain and the inpatient shower. Neither area grew Legionella pneumophila (causative agent of Legionnaire's Disease) in the water system. In addition, the Engineering Manager continues to eliminate deadheads in the hospital water system.

Evaluation: Although monitoring has been done, the Water program has not been functioning as needed but engineering and infection prevention do communicate regarding any issues. The committee will begin meeting again in the first quarter of FYE 2023.

Plan: Begin holding active meetings again.

Environmental Rounds

There was a total of three Environmental Rounds performed in FY 2022. Members of the team include Infection Prevention, Nursing, Environmental Services, and Engineering. They use a written tool to inspect and evaluate the physical environment for cleanliness, safety, supply outdates, repairs, and other safety issues. Findings are sent to the appropriate managers with timelines for correction and results are reported to Medical Staff quarterly.

Evaluation: As of the end of this fiscal year, there were still corrections to be made from issues that were found during previous rounds.

Plan: Quarterly rounds will be performed follow up rounds performed to check on status of corrections. Will increase frequency if needed. Reminder emails to be sent to managers and supervisors as appropriate.

Educational Presentations and Staff Training in FYE 2022

- Video titled "Infection Prevention for General Orientation: The Ongoing Challenge" with post-test required for all new staff. Newly hired patient care staff received additional 1-on-1 instruction specific to facility policies which involves return demonstration of hand hygiene and donning and doffing PPE.
- Video titled "Preventing Occupational Exposure to Bloodborne Pathogens" with post-test required for all new staff and annually for all employees in high-risk setting.
- Video titled "Overcoming the Obstacles: Improving Hand Hygiene Compliance" with post-test required for all new staff and annually for all employees.
- UCSF video "Donning and Doffing of PPE" for all new hires and at annual nursing skills day.
- Nursing skills day covered education on hand hygiene, isolation precautions, one needle, one syringe, on time, Safe Patient Handling, and safe use of lifting devices.
- Sterile Processing training: 6 videos with post-tests and competency completed by new sterile processing tech.
- Environmental Services staff training with DVD titled "The Front Line of Infection Control" Hand Hygiene, and Bloodborne Pathogens
- "Cleaning and Disinfecting of Patient Care Equipment' ongoing with nursing and EVS
- Annual IP training is online required online by staff in July 2022.

Evaluation: Infection prevention training topics mandated by law, regulation, and facility-based need were provided to appropriate staff in FYE 2022.

Plan: Continue infection prevention training upon hire, annually, and as needed.

Policy Changes

New policies

Purewick Female External Catheter	01/28/2022

Revised policies

Cleaning and Repair of Patient Equipment	01/27/2022
Linen Handling	01/27/2022
Use of Powered Air Purifying Respirators	08/26/2021

Evaluation: The majority of reviews and revisions of all Infection Prevention policies have been completed are being switched to the updated district template and then will be sent for approval from Medical Staff.

Plan: Review and revise policies annually.

Infection Prevention Performance Improvement Projects

1. Sterile Processing (QAPI)

- The sterile processing program was completely restructured between January and March 2018 with oversight shifting to Infection Prevention. The program was revised, a training program including competencies was devised which meets AAMI standards, logs were created, MSDS's and IFU's for all instruments were gathered, and a step by step process was posted for the tech to follow. A policy and procedure was written encompassing these processes.
- One EMT and the Materials Tech completed training and sterile processing was resumed on March 26, 2018.
- Since that time, a clinic Medical Assistant (MA) completed the AAMI training and completed the didactic portion and took over the responsibilities for the day-to-day processing of the instruments. Infection Prevention has been performing monthly checks of sterile instrument packages for evidence of proper processing and checks logs for completeness and accuracy with a goal of 100%.

	FYE 2019	FYE 2020	FYE 2021	FYE 2021	FYE 2022
Correct packs	323	383	248	248	1191
Number checked	324	394	256	256	1240
RATE:	99.7%	97.2%	96.8%	96.8%	96.0%

- Load recalls: none
- Results of auditing are reported quarterly to Medical Staff and QAPI Committees.
- Corrective action was taken on any issue identified.

Evaluation: During the FYE 2022, at the first of each new month, all sterile packs that remained in the bins in the clinic and the ED were examined and counted which explains the significant increase in numbers for this past fiscal year. The CME/Sterile Processing Tech transferred to the Human Resources (HR) department after accepting a full-time position as the HR assistant. During this time, the tech continued performing the tasks for the sterile processing on a part time basis. There were some minor issues with the sterile processing program (occasionally tip protectors falling off, water marks on package, or expired packs being left in the bins) but due to demands from the

other position, an official resignation letter was submitted in February 2022. Both the hospital and clinic side were unable to find someone willing to accept the additional responsibilities that this part time position involved so the district began to explore switching over to disposable instruments. During this time, the current technician has continued to perform the job responsibilities but has not officially rescinded the resignation.

Plan: Switch over to use of disposable instruments. Charges have been adjusted to incorporate the cost of the disposable instruments into the visit. The district now uses single use disposable instruments for all procedures, there are a few items that had not been able to be replaced to the providers standards (mainly on the clinic side) but single use disposable replacements have been found. There remains some discussion regarding possibility of moving autoclave equipment over to the clinic side where the clinic staff could take over the responsibility of processing the occasional instrument but space is an issue, so the equipment remains on the hospital side.

The district is now using disposable single use instruments for all procedures in clinic and the ED setting.

MRSA Admission Screening (QAPI)

State law (SB 1058) requires MRSA screening (nares swab) within 24 hours of admission for certain patient populations. The District has in the past chosen to screen all new patients and residents with the exception of 24-hour Observation patients. Compliance is reported to Medical Staff and QAPI Committees.

The rate is showing a downward trend.

47 of 57 admissions were screened (82.5%). The last fiscal year rate was 71.8%.

Evaluation: All Inpatient, Swing bed, and SNF patients are screened under this requirement. Observation patients are not included in this requirement and since many patients are admitted to observation first before being transferred to inpatient, there have been some incidents where the MRSA screening test has been missed.

Plan: Recommend that everyone admitted to the ACUTE/SNF unit be tested. Staff will be reminded of the need for the testing and the time frame. Staff will be encouraged to sustain 100% compliance and monitoring with feedback will continue.

Hand Hygiene

In August, 2016, Infection Prevention introduced a program that centers on nurse manager observations of hand hygiene with emphasis on immediate feedback to staff. This strategy makes use of the well-known Hawthorne Effect (behavior changes when observed) to help staff develop a habit of performing hand hygiene before entering a patient room and after exiting.

Each nurse manager and the Infection Preventionist is expected to contribute a minimum of ten (10) hand hygiene observations per month (24 observations per month).

- Observations are documented on a standardized worksheet and to be turned in to the Infection Preventionist at the end of each month.
- Infection Prevention compiles a quarterly summary of observations and reports to the Medical Staff, Safety Committee, and Survey Readiness Committee.

Evaluation: This program has not been followed consistently, there have been manager changes which have negatively affected the number of monthly hand hygiene observation, but the district now has filled those manager positions and hand hygiene observations have increased.

Plan: The program will be reinforced going forward and EVS has now been added to help with observations as their department plays a very important role in helping to prevent the spread of infections. Monthly reminders are again being sent to nurse managers. Also, will request help from nursing staff to assist with observations during slower times.

Evaluation of FYE 2022 Goals

Program Goal #1: Assure appropriate antibiotics and antibiotic regimens are used.

Objective #1: Improve compliance with evidence-based Antibiotic Stewardship recommendations

Objective #2: Have a functioning Antibiotic Stewardship Program

Evaluation: This goal is still ongoing. The COVID-19 pandemic had taken precedence over many of the district's routine activities and that, along with the IP position being filled previously by multiple people, consistency with following the program had been challenging. The Infection Prevention department has continued to work together with pharmacy, clinic and ED providers, and nursing to ensure patients are placed on the appropriate antibiotics per culture results at the appropriate time, for the appropriate reason. In addition, public health guidelines and CDC guidelines continue to be forwarded to providers as they were received. During this FY, the IP has successfully completed the Centers for Disease Control Antibiotic Stewardship Training and Foundations of Infection Prevention presented by California APIC Coordinating Council. These programs have both helped provide needed training to help lead this program. Regular meetings have also begun again.

Program Goal #2: Improve preparedness for outbreak management in the facility and the community.

Objective #1: Meet all standards by CDC, CDPH, HCPHD, for Mitigation of COVID-19.

Evaluation: This goal is a carry-over from the previous year and continued to be carried out throughout the entire fiscal year through maintaining a COVID Mitigation Plan, testing residents and staff for COVID-19, follow-up as appropriate for staff and patients with COVID exposures which involved appropriate isolation/quarantine and testing as needed. There continues regular monitoring of both PPE and hand sanitizer to ensure the district maintains adequate supplies necessary to keep patients and staff safe. There also was a continuation of in-servicing of staff in donning and doffing PPE and N-95 particulate respirators FIT testing or PAPR training if appropriate.

References

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McDonald EG, et al. Hand hygiene hall monitors: leveraging the Hawthorne effect. "Am J Infect Control" 2018: 46:706-7.

Nicolle LE. Urinary tract infection in long-term care facility residents. 'Clin Infect Disease." 2000;31(3):757–61.

Smith PW, Watkins K., Miller H. "Annals of Long-Term Care: Clinical Care and Aging." 2011;19[4]:20-2

SoHum Health
FOUNDATION
A California Nonprofit Public Benefit Corporation

BYLAWS
SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE FOUNDATION

Amended and Effective Date: February 16, 2023

ARTICLE I
NAME AND PURPOSE

The name of this Corporation and the purpose for which this Corporation is formed shall be "The Southern Humboldt Community Healthcare Foundation" aka "SoHum Health Foundation". This Corporation shall be dedicated to exclusively function as a community-based support and outreach organization for the Southern Humboldt Community Healthcare District (SHCHD).

ARTICLE II
MEMBERSHIP

1. Qualifications. The SHCHD (doing business as "Jerold Phelps Community Hospital" and the "Southern Humboldt Community Clinic") a political subdivision of the State of California, shall be the sole corporate member of this Corporation, effective as of October 7, 2015. No membership certificate shall be issued. No membership fees or dues shall be assessed. The SHCHD shall not be liable for the debts, liabilities, or obligations of the Corporation. By reason of the rights or status of the SHCHD herein, there has been no express or implied delegation of any public agency authority from the SHCHD to this Corporation.

2. Transferability of Membership. The SHCHD may resign and/or substitute another member in its stead (with the written consent of the substituted member) as provided by the California Corporations Code.

3. Exercise of Membership Rights. The SHCHD shall exercise its membership rights through its Board of Directors.

4. Support Services Provided by the SHCHD. In consideration of its membership, the SHCHD shall provide such support staffing and services as may be necessary for the Corporation to fulfill its purposes, as such needs are identified by mutual agreement of the Corporation and the SHCHD.

ARTICLE III
BOARD OF DIRECTORS

1. Responsibility. Except as otherwise provided by the Articles of Incorporation or by these Bylaws and the laws of the State of California, the management of the affairs of this Corporation shall be vested in a Board of Directors (the "Board").

2. Number of Members. The Board shall, until changed by amendment to these Bylaws, consist of not fewer than five (5) nor more than twelve (12) directors, which will include the SHCHD Chief Executive Officer or their designee, and the SHCHD Medical Staff Director or their designee.

3. Qualifications. The Chief Executive Officer of the SHCHD their designee, and the Medical Staff Director or their designee members serve by reason of official capacity, and the resignation or removal of any such person from their position shall automatically terminate such person's membership on the Board. No person may hold more than one directorship by reason of official capacity or any other reason. The remaining members of the Board shall consist of individuals, who will provide expertise for the Board, enhance the Board's capabilities in striving to support the SHCHD and who are experienced in organization and community activities.

4. Appointment of Directors. Directors shall be selected for nomination and appointment for their willingness and ability to participate effectively in fulfilling the Board's responsibilities. No director shall profit financially by reason of their membership on the Board. No director shall be employed by the Corporation. Directors may not receive any compensation for their services as such but may receive reasonable compensation incurred in the performance of their duties. Appointees will be approved by two-thirds majority vote of the existing Board at time of appointment.

No more than three (3) members of the Board of Directors may, at any one time, be employees of the SHCHD.

5. Term. Directors (other than the SHCHD CEO or their designee, SHCHD Medical Director or their designee, or the SHCHD board member) shall hold their term of office for three (3) years beginning at the annual meeting of the year of first appointment. Directors may serve an unlimited number of terms, subject to periodic re-appointment by the Board at the end of their term. The terms shall be staggered so that, normally, no more than one-third of Board members will have terms terminate in the same year.

6. Vacancies. A vacancy on the Board of Directors, whether by death, resignation or removal, or if the authorized number of directors is increased, may be filled by a majority vote of the directors then in office, whether or not the number of directors meets the minimum required. Any director may resign effective upon giving written notice to the Chair of the Board, the Secretary or to the Board of Directors of the Corporation unless such notice specifies a later time for the effectiveness of such resignation.

7. Removal. Upon a majority vote of the remaining members of the Board, the Board may declare vacant the office of any director-at-large who has: (a) been declared of unsound mind by a final order of judgment of any court; (b) breached any duty of a director under these Bylaws, the Articles of Incorporation or the California Corporations Code; (c) failed to attend three regular consecutive meetings of the Board; (d) engaged in repeated and continuing conduct disruptive to the operation of the Board; or, (e) is deemed unable or unfit to properly discharge their duties and responsibilities. Board members may also be removed without cause by the SHCHD after a 30-day written notice is provided to the Board.

8. Voting Rights. Each director shall be entitled to one vote on each matter before the Board and there will be no proxy voting.

9. Organization Meetings. The election of officers and the transaction of such other business regarding organization as my arise shall take place at the annual meeting to take place on June 1st of each year, or as soon thereafter as the meeting may be set.

10. Regular Meetings. The Board shall hold regular meetings at such time and place as the Board shall from time-to-time determine; provided, however, that regular meetings shall be held at least quarterly. Notice of the time and place will be sent to each director by email at least four (4) days in advance.

11. Special Meetings. Special meetings of the Board for any purpose or purposes shall be called by the Board Clerk upon the request of the Chair, Vice-Chair, the SHCHD, or any three (3) members of the Board. Notice of the time and place will be sent to each director by email at least forty-eight (48) hours in advance with return receipt requested.

12. Quorum. A majority of the voting members of the Board then serving shall constitute a quorum at any meeting of the Board. The act of the majority of the voting power present at any meeting at which a quorum is present shall be considered the act of the Board.

13. Action Without Meeting. Any action required or permitted to be taken by the Board under the provisions of the California Corporations Code, the Articles of Incorporation, or these Bylaws may be taken without a meeting, if a two-thirds majority of members of the Board shall individually or collectively consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the Board. Such action by written consent shall have the same force and effect as unanimous vote of such directors. Any certificate or other document filed on behalf of the Corporation relating to an action taken by the Board without a meeting shall state that the action was taken by a two-thirds majority written consent of the Board without a meeting and that the Bylaws of this Corporation authorize its directors so to act.

14. Quorum Initially Present. A meeting at which a majority of the members are initially present may continue to transact business notwithstanding the withdrawal of directors if any action is approved by at least a majority of the required quorum for such meeting, or such greater number as required by the California Corporations Code, the Articles of Incorporation, or these Bylaws.

15. Telephonic Meeting. Members of the Board may participate in a meeting through use of a conference telephone or similar communications equipment so long as each director participating in such meeting can simultaneously hear all other directors so participating. Participation in a meeting pursuant to this Section constitutes presence in person at such meeting.

16. Validity of a Defectively Called or Noticed Meeting. The transactions of any meeting of the Board, however called and noticed, shall be as valid as though they had occurred at a meeting duly held after regular call and notice, if a quorum is present and if, either before or after the meeting, each of the directors not present, or who, though present, has prior to the meeting or at its commencement protested the lack of proper notice to him, signs a written waiver of notice or consent to holding such meeting or an approval of the minutes thereof. All such waivers, consent or approvals shall be filed with the corporate records or made a part of the minutes of the meeting. Or such actions taken may be ratified by the majority at the next and properly called meeting.

17. Adjournment. A quorum of the directors may adjourn any director's meeting to meet again at a stated day and hour; provided, however, that in the absence of a quorum a majority of the directors present at any director's meeting, either regular or special, may adjourn from time to time until the time fixed for the next regular meeting of the Board. If the meeting is adjourned for more than twenty-four (24) hours, notice of any adjournment to another time or place shall be given prior to the time of the adjourned meeting to the directors who were not present at the time of adjournment. Otherwise, notice of the time and place of holding of

adjournment meetings need not be given to the absent directors of the time and place be fixed at the meeting adjourned.

18. Quarterly Reports. The Board shall submit quarterly reports to the SHCHD, in a form acceptable to the SHCHD.

19. Annual Capital Development and Operating Budget Report. The Board shall submit an anticipated annual capital development and operating budget report to the SHCHD.

ARTICLE IV
OFFICERS

1. Officers of the Corporation. The officers of the Corporation shall be the Chair of the Board, the Vice Chair of the Board, the Secretary of the Board, and the Treasurer of the Board (which office shall be separate from the SHCHD's Chief Financial Officer). The Vice Chair of the Board or the Secretary of the Board may serve concurrently as the Treasurer of the Board.

The Corporation may also have, at the Board's discretion, such additional Vice Chairs and Assistant Secretaries as the Board deems appropriate.

2. Officers Elected by the Board. The Chair of the Board, the Vice Chair of the Board, the Secretary of the Board, and the Treasurer, shall be elected by the Board at its annual meeting. Each officer elected by the Board shall hold office at the pleasure of the Board and until his or her successor shall be elected and qualified to serve.

3. Term. Officers of the Board may serve an unlimited number of consecutive two-year (2) terms if nominated and approved by the Board.

4. Resignation or Removal. Subject to the terms of any written employment contract, any officer, appointed pursuant to Section 2 may resign at any time or be removed by the vote of the Board.

5. Vacancies in Office. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board for the unexpired term at any meeting of the Board.

6. Chair. The Chair of the Board (Chair) shall preside at all meetings of the Board. Should the signature of a President be required by law, the Chair shall possess the same power as the President to sign all certificates, contracts, or other instruments of the Corporation when so authorized by the Board. The Chair or their designee may be a voting member of each committee. The Chair shall exercise and perform such other powers and duties as may be prescribed by the Board from time-to-time and as delineated in Policy I - Foundation Officers Roles.

7. Vice Chair. In the absence of the Chair or in the event of the Chair's disability, inability, or refusal to act, the Vice Chair of the Board (Vice Chair) shall perform all the duties of the Chair and in so acting shall have all the powers of the Chair. The Vice Chair shall have such other powers and perform such other duties as may be prescribed from time-to-time by the Board or by the Chair and as delineated in Policy I – Foundation Officers Roles.

8. Treasurer. The Treasurer of the Corporation shall keep and maintain or cause to be kept and maintained adequate and correct account of the properties and business

transactions of the Corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses. The books of account shall at all times be open to inspection by any Board member. The Treasurer shall be charged with safeguarding the assets of the Corporation and he or she shall sign financial documents on behalf of the Corporation in accordance with the established policies of the Corporation. The Treasurer shall have such other powers and perform such other duties as may be prescribed by the Board from time-to-time and as delineated in Policy I – Foundation Officer Roles.

9. Secretary. The Secretary shall keep or cause to be kept a book of minutes at the principal office or at such other place as the Board may order of all meetings of the Board with the time and place of holding, whether regular or special, and if special, how authorized, the notice thereof given, the names of those present at the Board meetings, and the proceedings thereof. The Secretary shall give or cause to be given notice of all the meetings of the Board required by these Bylaws or by law to be given, and the Secretary shall have such other powers and perform such other duties as may be prescribed, by the Board from time-to-time and as delineated in Policy I – Foundation Officer Roles.

ARTICLE V
COMMITTEES

1. Committees Generally. Committees shall be standing or special. Standing Committees may establish such sub-committees as are appropriate. Each committee shall exercise such power and carry out such functions as are designated by the Bylaws or as delegated by the Board from time-to-time. Such committee shall be advisory only and subject to the control of the Board. Any person appointed to a standing committee shall be a voting member of such committee.

2. Standing Committees. Standing advisory committees shall consist of the Executive Committee and such other standing advisory committees as the Board may authorize from time-to-time. Each such committee shall stand discharged when a new committee is appointed for the same task.

3. Special Committees. Special committees may be appointed by the Chair for such special tasks as circumstances warrant. A special committee shall limit its activities to the accomplishment of the task for which it is appointed and shall have no power to act except such as is specifically conferred by the action of the Board. Upon completion of the task for which appointed, such special committee shall stand discharged.

4. Committee Appointments. The chair and members of each committee shall, except as herein provided, be appointed by the Chair of the Board, subject to approval by the Board.

5. Quorum: Meeting. A majority of the members of the committee shall constitute a quorum at any meeting of that committee. Each committee shall meet as often as necessary to perform its duties, as such times and places as directed by its chair or by the Board of Directors. Each committee shall keep accurate minutes of its meeting, the chair designating a secretary of the committee for this purpose and shall make periodic reports and recommendations to the Board.

6. Vacancies. Vacancies in any committee shall be filled in the same manner as provided in the case of original appointment.

7. Expenditure. Any unbudgeted expenditure of Corporate funds shall require prior approval of the Board.

8. Executive Committee.

a) The Executive Committee consists of the Chair of the Board, and a minimum of two (2) additional statutory officers of the Corporation (the CEO of SHCHD, Vice Chair, the Secretary, and the Treasurer).

b) The duties and responsibilities of the Executive Committee shall include the following:

(1) To set the agenda for future meetings of the Board of Directors of this Corporation; and
(2) To act, to the extent permitted by the California Corporations Code, for the full Board when action is required between regular meetings.

ARTICLE VI
TRANSACTIONS REQUIRING APPROVAL BY SHCHD

1. Approval Requirement. Notwithstanding anything in these Bylaws to the contrary, neither the Board nor any officer or employee of this Corporation may take any of the following actions without the authority first had and obtained from the SHCHD;

(a) Merger, consolidation, reorganization, or dissolution of this Corporation or any subsidiary or affiliate entity;

(b) Amendment of restatement of the Articles of Incorporation or the Bylaws of the Corporation;

(c) Long-term borrowing including, but not limited to, capitalized lease agreements and installment contracts having a present value by the Board of Directors of the SHCHD;

(d) Purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance by the Corporation of any asset, real or personal, with a fair market value in excess of a dollar amount equal to ten percent (10%) of the consolidated fund balance of this Corporation and all its subsidiaries and affiliates if the transaction was not included in an approved capital budget;

(e) Appointment of an independent auditor and approval of independent counsel, provided that in conflict situations occurring between the SHCHD and this Corporation, the Board shall be entitled to select its own independent counsel without the SHCHD's approval;

(f) The creation or acquisition of any subsidiary or affiliate entity;

(g) Approval of major new programs of this Corporation or any subsidiary or affiliate entity. The SHCHD shall from time-to-time define the term "major" in this context;

(h) Approval of strategic plans; or

(i) Other major activities (as hereinafter defined), "Major Activities" shall be those which the SHCHD Board of Directors has declared major by written notice to this Corporation, delivered personally or deposited by registered or certified mail, return

receipt requested. Such notice shall specifically identify the matter or matters requiring approval of the SHCHD and shall refer to this Bylaw provision granting such approval rights to the SHCHD. Notices received pursuant to this Section shall be recorded in the minutes of the Corporation and shall be filed with the minutes of this Corporation.

2. Requirement of Reasonableness and Consistency. In exercising any approval rights described in Section 1 of this Article VI, the SHCHD shall act in a reasonable and consistent fashion. Approval may be obtained as required by this Article VI from the SHCHD Chief Executive Officer on behalf of the SHCHD.

ARTICLE VII
GENERAL PROVISIONS

1. Offices. This Corporation shall have and continuously maintain a registered office in Humboldt County and may have other offices within the State of California, as the Board may from time-to-time determine.

2. Self-Dealing. In the exercise of voting rights by members of the Board, no individual shall vote on any issue, motion, or resolution which directly or indirectly inures to his or her benefit financially or with respect to which he or she has any other conflict of interest, except that such individual may be counted in order to qualify a quorum and, except as the Board may otherwise direct, may participate in the discussion of such an issue, motion, or resolution if he or she first discloses the nature of his or her interest.

3. Indemnification. This Corporation shall indemnify any director, officer, employee or agent of this Corporation for liability incurred by such person in the exercise of his or her duties with respect to this Corporation to the extent permitted by Section 5238 of the California Corporations Code or any such successor statute. The Foundation's Directors and Officers Liability Insurance is covered under SHCHD's insurance policy.

4. Fiscal Year. The fiscal year of this Corporation shall end on December 31 of each year.

5. Construction and Definitions. Unless the context requires otherwise, the general provisions, rules of construction and definitions in the California Nonprofit Corporation Law shall govern the construction of these Bylaws. Without limiting the generality of the preceding sentence, the masculine gender includes the feminine and neuter, the singular number includes the plural, the plural number includes the singular and the term "person" includes both a legal entity and a natural person.

6. Records. The Corporation shall keep adequate and correct books and records of accounts and shall keep minutes of the proceedings of its General Member as such, its Board of Directors, and committees, if any, of the Board. Such minutes shall be in written form. Such books and records shall be kept either in written form or in any other form capable of being converted into written form.

ARTICLE VIII
AMENDMENTS

These Bylaws may be amended or repealed, or new Bylaws may be adopted, by the vote of the SHCHD.

At the February 16, 2023, Foundation Board meeting Justin Crellin moved to adopt the Amended Bylaws as shown above and Marisa Formosa seconded.
The roll call vote results were as follows:
Ayes: Pat Neighbors, Nick Vogel, Justin Crellin, Matt Rees, Marisa Formosa
Absent: Jennifer Gutierrez, Ross Huber.
Abstentions: Corinne Stromstad
Nays: None
Motion carried to adopt the Amended Bylaws.

These amended Bylaws were adopted by vote of the SHCHD on _____.
(Approved SHCHD Board meeting minutes and Resolution attached)

Foundation Officer signatures:

Pat Neighbors, Chair	Date
Jennifer Gutierrez, Vice Chair	Date
Nick Vogel, Secretary	Date
Justin Crellin, Treasurer	Date