SoHum Health

Southern Humboldt Community Healthcare District

MEETING NOTICE
Governing Board

A regular meeting of the Board of Directors of the Southern Humboldt Community Healthcare District will be held on January 30, 2025, at 1:30 p.m., by teleconference and in-person. Members of the public may participate virtually via Webex or telephone, or appear in person at the Sprowel Creek Campus at 286 Sprowel Creek Road, Garberville, California 95542.

Call-In Information:

https://shchd.webex.com/shchd/j.php?MTID=mf67b3a22d08784a22d0856ab9904f208
Join by phone +1-415-655-0001 US Toll

Webex Link:

Written comments may also be sent to boardcomments@shchd.org. Comments received no later than two hours prior to the start of the meeting will be provided to the Board or may be read aloud or summarized during the meeting. Members of the public may also comment in real time during the meeting by attending in person or via Webex or phone.

Agenda

Page **Item**

A. Call to Order

B. Approval of the Teleconferencing of a Board Member

C. Approval of the Agendas

D. Public Comment on Non-Agendized Items
See below for Public Comment Guidelines

E. Board Member Comments
Board members are invited to address issues not on the agenda and to submit items within the subject jurisdiction of the Board for future consideration. Please limit individual comments to three minutes.

F. Announcements
1. Board Resignation

G. Approval of Consent Agenda –

6 - 13
1. Approval of Previous Minutes
   a. Governing Board Meeting Minutes, January 6, 2025
2. SHCHD New and Updated Policies

14 - 17
Outreach
   a. Use of Personal Social Media Accounts
   b. Managing Social Media Presence

18 - 27
SLS
   c. Separation of Psychotherapy Notes for Mental Health Record
   d. Risk Management
   e. Requirements for the Telepsychiatry Process

28 - 29
ER
   f. Routine Syphilis, HIV & HCV Testing, Treatment, and Linkage to Care Program (EDSP)

30 - 32
Medstaff
   g. Medical Staff Credentialing and Privileging

33
Mammography
   h. Corrective Action

34 - 39
Lab
   i. Lab Complaints
   j. Quality
   k. Reporting
   l. Licensure
   m. Provision

3. Quarterly Reports - (Feb, May, Aug, Nov) - None
   a. Quality and Risk Management – Kristen Rees, Chief Quality and Compliance Officer and Risk Manager
   b. Human Resources – Season Bradley Koskinen, HR Manager
   c. Foundation – Chelsea Brown, Outreach Manager
   d. Operations – Kent Scown, Chief Operations Officer

H. Last Action Items for Discussion –
1. Election of Officers
2. Governing Board Committees
   a. Facilities
   b. Outreach
   c. Bylaws

d. Compensation and Retention
e. Finance

I. Correspondence, Suggestions, or Written Comments to the Board

J. Administrator's Report – Matt Rees, CEO

1. Department Updates
   a. Milestones
   b. December Employee Anniversaries – Cherie Hurt, Controller 1 year and Lula Williams, Security 10 years
40 - 44
   c. Approval of the July - December Income Sheet and the December 2024 Balance Sheet – Paul Eves
45 - 85
   d. Nursing and Quality and Risk Management Annual Report – Kristen Rees, CQO and Adela Yanez, CNO
   e. Family Resource Center – Amy Terrones – Mar and Oct

K. Old Business - None

L. New Business

1. Meeting Schedule
2. Elect Officers
3. Updated Brown Act Teleconferencing Matrix - Darrin

M. Parking Lot

1. Sprowel Creek Campus parking

N. Meeting Evaluation

O. New Action Items

P. Next Meetings

1. Medical Staff Policy Development Committee – Tuesday, February 11, 2025, 10:00 a.m
2. QAPI Meeting – Wednesday, February 12, 2025, at 10:00 a.m.
3. Medical Staff Committee – Thursday, February 13, 2025, at 12:30 p.m
4. Finance Committee – TBD, 2025
5. Governing Board Meeting – TBD, 2025

Q. Adjourn to Closed Session

1. Closed Session
2. Reports of Quality Assurance Committees **[H&S Code § 32155]**
3. Compliance and Risk - Kristen Rees, CQO
4. Quarterly Reports - Adela Yanez, CNO -None
   a. Patient Safety – Mar., June, Sept., Dec.
   b. Medication Error – Feb., May, Aug., Dec.
   c. Approval of Medical Staff Appointments/Reappointments [**H&S Code § 32155**]
      i. Daniel Lucas, MD, Reappointment to Associate for Diagnostic Radiology privileges, 2/01/2025 to 1/31/2027
      ii. Jose Ospina, MD, Reappointment to Associate for Diagnostic Radiology privileges, 2/01/2025 to 1/31/2027
      iii. Scott Bymiller, MD, Appointment to Associate for Telepsychology privileges, 2/01/2025 to 1/31/2028
      iv. Gurkiran Gill, MD, Appointment to Associate for Telepsychology privileges, 2/01/2025 to 1/31/2028
      v. Amy Fraizer, MD, Appointment to Associate for Telepsychology privileges, 2/01/2025 to 1/31/2028
      vi. Heather Grant, NP, Time Limited Appointment as Active for Clinic/Ambulatory privileges, 1/30/2025 to 3/31/2028
      vii. Steven Kushel, MD, Time Limited Appointment as Active for emergency and inpatient privileges, 1/30/2025 to 3/31/2028
5. Personnel Matter –Evaluation § 54957
   a. CQCO Kristen Rees

R. Adjourn Closed Session; Report on Any Action Taken, If Needed

S. Resume Open Session

T. Adjourn

Abbreviations

ACHD	Association of California Healthcare Districts	*ACLS*	Advanced Cardiac Life Support Certification
AR	Accounts Receivable	*BLS*	Basic Life Support Certification
CAIR	California Immunization Registry	*CEO*	Chief Executive Officer
CFO	Chief Financial Officer	*CMS*	Centers for Medicare and Medicaid Services
CNO	Chief Nursing Officer	*COO*	Chief Operating Officer
CPHQ	Certified Professional in Healthcare Quality	*CQO*	Chief Quality and Compliance Officer
EMR	Electronic medical record	*ER*	Emergency Room
FTE	Full Time Equivalent/Full Time Employee	*HIM*	Health Information Management
HRG	Healthcare Resource Group	*HVAC*	Heating, Ventilation and Air Conditioning system
IGT	Intergovernmental transfer	*IT*	Information Technology
JPCH	Jerold Phelps Community Hospital	*LCSW*	Licensed Clinical Social Worker
LVN	Licensed Vocational Nurse	*MPH*	Master of Public Health
OBS	Observation	*PALS*	Pediatric Advanced Life Support Certification
PFS	Patient Financial Services	*QAPI*	Quality Assurance Performance Improvement

QIP	Quality Improvement Project/Program	*RN*	Registered Nurse
SHCC	Southern Humboldt Community Clinic	*SHCHD*	Southern Humboldt Community Healthcare District
SNF	Skilled Nursing Facility	*SWG*	Swing beds
DO	Doctor of Osteopathic Medicine		

PUBLIC COMMENT ON MATTERS NOT ON THE MEETING AGENDA: Members of the public are welcome to address the Board on items not listed on the agenda and within the jurisdiction of the Board of Directors. The Board is prohibited by law from taking action on matters not on the agenda, but may ask questions to clarify the speaker's comment and/or briefly answer questions. The Board limits testimony on matters not on the agenda to three minutes per person and not more than ten minutes for a particular subject, at the discretion of the Chair of the Board.

PUBLIC COMMENT ON MATTERS THAT ARE ON THE AGENDA: Individuals wishing to address the Board regarding items on the agenda may do so after the Board has completed their initial discussion of the item and before the matter is voted on, so that the Board may have the benefit of these comments before making their decision. Please remember that it is the Board's responsibility to discuss matters thoroughly amongst themselves and that, because of Brown Act constraints, the Board meeting is their only opportunity to do so. Comments are limited to three minutes per person per agenda item, at the discretion of the Chair of the Board.

OTHER OPPORTUNITIES FOR PUBLIC COMMENT: Members of the public are encouraged to submit written comments to the Board at any time by writing to SHCHD Board of Directors, 733 Cedar Street, Garberville, CA 95542. Writers who identify themselves may, at their discretion, ask that their comments be shared publicly. All other comments shall be kept confidential to the Board and appropriate staff.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, if you require special accommodations to participate in a District meeting, please contact the District Clerk at 707-923-3921, ext. 1276 at least 48 hours prior to the meeting."

**Times are estimated*

COPIES OF OPEN SESSION AGENDA ITEMS: Members of the public are welcome to see and obtain copies of the open session regular meeting documents by contacting SHCHD Administration at (707) 923-3921 ext. 1276 or stopping by 291 Sprowel Creek Rd, Garberville, CA 95542 during regular business hours. Copies may also be obtained on the District's website, sohumhealth.org.

Posted Monday, January 27, 2025

Governing Board

Date: January 6, 2025
Time: 1:30 p.m.
Location: Sprowel Creek Campus and Via Webex Conferencing
Facilitator: Board President, Corinne Stromstad

Minutes

The following people attended at Sprowel Creek Campus and via Webex

Governing Board: Corinne Stromstad, Barbara Truitt, and Jay Sooter, all in-person.

Not Present: Galen Latsko and Kevin Church

Also in person: CEO Matt Rees, CNO Adela Yanez, PFS Manager Marie Brown, HIM Manager Remy Quinn, CFO Paul Eves, Administrative Assistant Darrin Guerra, and CQO Kristen Rees

Also via Webex: COO Kent Scown, Chief of Staff Joseph Rogers, Quality Specialist Adam Dias, Lab Manager Adam Summers and Vice Chief of Staff Dr. Carl Hsu.

A. Call to Order – Board president Corinne Stromstad called the meeting to order.

B. Approval of the Teleconferencing of a Board Member – None

C. Approval of the Agenda

Motion:	Barbara Truitt motioned to approve the agenda.
Second:	Jay Sooter
Ayes:	Corinne Stromstad, Jay Sooter, and Barbara Truitt
Noes:	None
Not Present:	Galen Latsko and Kevin Church
Motion Carried	

D. Public Comment on Non-Agendized Items - None

E. Board Member Comments – None

F. Announcements

1. Matt announced that Dr. Rogers has accepted the position of Chief of Staff, and that Dr. Hsu will be the new Vice Chief of Staff.

G. Consent Agenda
    1. Approval of Previous Minutes
        a. Governing Board Meeting Minutes, November 21, 2024
    2. SHCHD New and Updated Policies
        Fortuna Optometry
        a. Storage and Administration of Medication
        b. Scope of Service
        SLS
        c. Contraband
        d. Access to Services
        e. Conduct to Minimize Violence
        f. Confidentiality of Information-General Issues
        g. Duty to Protect
        h. Follow-up
        i. Food Service
        j. In-service
        k. Master Treatment Planning and Patient Care
        l. Multiple Relationships
        m. Organizational Structure
        n. Patient Orientation
        o. Patient Satisfaction Survey
        p. Program Overview
        q. Program Violations-Patient use of Drugs or Alcohol
        r. Referral Process and Screening
        s. Scope of Practice
        t. Telehealth Emergencies
        Revised Security and Transportation Policies
        u. Patient Transport and Vehicle Safety
        v. Vehicle Maintenance
    3. Quarterly Reports - (Feb, May, Aug, Nov) - None
        a. Quality and Risk Management – Kristen Rees, Chief Quality and Compliance Officer and Risk Manager
        b. Human Resources – Season Bradley Koskinen, HR Manager
        c. Foundation – Chelsea Brown, Outreach Manager
        d. Operations – Kent Scown, Chief Operations Officer

Motion:	Barbara Truitt motioned to approve the consent agenda.
Second:	Jay Sooter
Ayes:	Corinne Stromstad, Jay Sooter, and Barbara Truitt
Noes:	None
Not Present:	Galen Latsko and Kevin Church
Motion Carried	

H. Last Action Items for Discussion – None

I. Correspondence Suggestions or Written Comments to the Board – None

J. Administrator's Report – Matt Rees, CEO

Matt Rees presented the administrative report and updated the Board on some of our current projects such as the completion of two Quality Measures, the two new providers joining the clinic at the end of January, and the grand opening of the Optometry service in Garberville.

1. Department Updates
   a. Milestones
   b. Employee Anniversaries - None
   c. Approval of September and October 2024 Income Sheets and Balance Statements – CFO Paul Eves
      i. Paul presented the September and October financials and answered corresponding questions.
   d. Nursing – Adela Yanez, CNO
      i. Adela Yanez presented her Board report.
   e. Quality and Risk Management – Kristen Rees, CQO
      i. Kristen presented her staff report and shared that through the QIP Quality Measures, we may be eligible for an additional $750k in funding.
   f. Family Resource Center – Amy Terrones – (Mar and Oct)

Motion:	Barbara Truitt motioned to approve the September and October Financials.
Second:	Jay Sooter
Ayes:	Corinne Stromstad, Jay Sooter, and Barbara Truitt
Noes:	None
Not Present:	Galen Latsko and Kevin Church
Motion Carried	

K. Old Business
   1. Proposal and Approval of the medical Staff Attorney Budget
      a. Matt Rees proposed to set the monthly Medical Staff attorney budget to $1,000 a month

Motion:	Barbara Truitt motioned to approve setting the monthly Medical Staff Budget to $1,000 a month.
Second:	Jay Sooter
Ayes:	Corinne Stromstad, Jay Sooter, and Barbara Truitt
Noes:	None
Not Present:	Galen Latsko and Kevin Church
Motion Carried	

2. Approval of the Updated Strategic Plan

Motion:	Barbara Truitt motioned to approve the updated Strategic Plan.
Second:	Jay Sooter
Ayes:	Corinne Stromstad, Jay Sooter, and Barbara Truitt
Noes:	None
Not Present:	Galen Latsko and Kevin Church
Motion Carried	

L. New Business
1. Oath of Office [**Government Code Section 1360-1363, Inclusive, 3105 Section 3, Article XX, State Constitution**]
   a. Corinne Stromstad
   b. Barbara Truitt

Barbara Truitt and Corinne Stromstad accepted their Oaths of Office for the next 4 years, ending on the first Friday of December 2028

2. Surplus Vehicle Disposition - Kent
   a. Authorization to Sell the 2018 Nissan Rouge
   b. Authorization to Sell and Replace the 2018 GMC Canyon

Motion:	Barbara Truitt motioned to approve the Surplus Vehicle Disposition as presented.
Second:	Jay Sooter
Ayes:	Corinne Stromstad, Jay Sooter, and Barbara Truitt
Noes:	None
Not Present:	Galen Latsko and Kevin Church
Motion Carried	

3. Ad Hoc Committee Discussion and Implementation.

Jay Sooter agreed to join the Annual Outreach Committee. The other Committees will be decided on at a future meeting.

M. Parking Lot - None

N. Meeting Evaluation – Happy New Year!

O. New Action Items
   1. New Brown Act Teleconferencing Matrix
   2. Board Committees
   3. Election of Officers

P. Next Meetings
   1. QAPI Meeting – Wednesday, January 8, 2025, at 10:00 a.m.
   2. Medical Staff Committee – Thursday, January 9, 2025, at 12:30 p.m
   3. Medical Staff Policy Development Committee – Tuesday, January 14, 2025, 10:00 a.m.
   4. Finance Committee – January 24, 2025, 10:00 a.m.
   5. Governing Board Meeting – January 30, 2025, 1:30 p.m.

Q. Corinne Stromstad Adjourn to Closed Session
   1. Closed Session Opened
   2. Reports of Quality Assurance Committees **[H&S Code § 32155]**
   3. Compliance and Risk - Kristen Rees, CQO
   4. Quarterly Reports - Adela Yanez, CNO
      a. Clinic – Jan., Apr., July, Oct.
      b. Patient Safety – Mar., June, Sept., Dec.
      c. Medication Error – Feb., May, Aug., Nov
   5. Approval of Medical Staff Appointments/Reappointments [**H&S Code § 32155**] - None
   6. Personnel matter –Evaluation § 54957 - None
      a. CEO Matt Rees

R. Corinne Stromstad Adjourned Closed Session

S. Corinne Stromstad Resumed Open Session

T. Corinne Stromstad Adjourned Open Session

Submitted by Darrin Guerra

Abbreviations

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JPCH	Jerold Phelps Community Hospital	*LCSW*	Licensed Clinical Social Worker
LVN	Licensed Vocational Nurse	*MPH*	Master of Public Health
OBS	Observation	*PALS*	Pediatric Advanced Life Support Certification
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SNF	Skilled Nursing Facility	*SWG*	Swing beds
DO	Doctor of Osteopathic Medicine		

GOVERNING BOARD MEMBER – SPECIAL DISTRICT

CERTIFICATE OF APPOINTMENT IN LIEU OF ELECTION

Elections Code, Section 10515

I, JUAN PABLO CERVANTES, Humboldt County Registrar of Voters, do hereby certify that **BARBARA TRUITT** was nominated for the position of Director of the **SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT** and that the number of candidates was equal to or did not exceed the number of offices to be filled at the Presidential General Election held on November 5, 2024. Therefore pursuant to Section 10515 of the California Elections Code the appointment was made by the Humboldt County Board of Supervisors. The term of this office is 4 years ending on the first Friday of December, 2028.

Dated: November 29, 2020
Juan Pablo Cervantes
County Registrar of Voters

By _____
Deputy Clerk

OATH OF OFFICE

Govt Code Section 1360-1363, inclusive,
3105 Section 3, Article XX, State Constitution

I, **BARBARA TRUITT**, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

Barbara Truitt 1/6/25
Signature Date

Residential Address:

948 A Riverview Ln
Garberville CA 95542

_____
Signature of person administering oath

Return signed original form to the Humboldt County Office of Elections:

2426 6th Street, Eureka, CA 95501

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ELECTIONS

GOVERNING BOARD MEMBER – SPECIAL DISTRICT

CERTIFICATE OF APPOINTMENT IN LIEU OF ELECTION

Elections Code, Section 10515

I, JUAN PABLO CERVANTES, Humboldt County Registrar of Voters, do hereby certify that **CORINNE STROMSTAD** was nominated for the position of Director of the **SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT** and that the number of candidates was equal to or did not exceed the number of offices to be filled at the Presidential General Election held on November 5, 2024. Therefore pursuant to Section 10515 of the California Elections Code the appointment was made by the Humboldt County Board of Supervisors. The term of this office is 4 years ending on the first Friday of December, 2028.

Dated: November 29, 2020
Juan Pablo Cervantes
County Registrar of Voters

By _____
Deputy Clerk

OATH OF OFFICE

Govt Code Section 1360-1363, inclusive,
3105 Section 3, Article XX, State Constitution

I, **CORINNE STROMSTAD**, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

Corinne Stromstad 1-6-25
Signature Date

Residential Address:

300 Isabella Lane
Garberville, Ca. 95542

Signature of person administering oath

Return signed original form to the Humboldt County Office of Elections:

2426 6th Street, Eureka, CA 95501

SoHum Health

Subject:	Manual:
Use of Personal Social Media Accounts	**Outreach**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District that employees who participate in social media must ensure their behavior aligns with the organization's Code of Conduct and protects patient confidentiality, when their affiliation with the District is apparent.

DEFINITIONS:

Social Media: For the purpose of this policy, social media shall be considered technology and software that allows user-generated content to be shared and exchanged online (e.g., blogs, Facebook, ~~X~~Twitter, YouTube, Instagram, TikTok, Threads, News Outlets, review sites).

~~**POLICY:**~~

~~**It is the policy of Southern Humboldt Community Healthcare District that employees who participate in social media must ensure their behavior aligns with the organization's Code of Conduct and protects patient confidentiality, when their affiliation with the District is apparent.**~~

PROCEDURE:

- SoHum Health recognizes that the use of social media can provide ~~provides~~ a number of benefits for employees both professionally and personally. Within the organization, however, access to social media is ~~shall be~~ restricted.
- ~~Unauthorized e~~Employees shall not engage with ~~participate in~~ social media from district-owned electronics~~a network computer~~unless specifically related to their job duties~~.~~
- Use of social media on behalf of the district~~this facility~~ shall only be done by members of the Outreach department and authorized users.
- Personal use of social media does not/is not exempt from legal or professional obligations related to the protection of patient privacy.
- ~~Social media for personal use does not exempt a healthcare provider or employee from legal and professional obligations to protect patient privacy.~~
- When posting on social media outside of working hours, district staff and providers must adhere to patient privacy and confidentiality standards.
- ~~When posting on social media outside of working hours, healthcare providers shall be aware of patient privacy and confidentiality standards and maintain those standards online.~~
- To ensure HIPAA compliance, clinicians, behavioral health professionals, ~~and~~ patient care and support staff ~~-~~are prohibited from communicating with patients on social media. All patient care communications should be conducted via secure avenues, including, but not limited to, phone calls, business email accounts, patient portals, and in-person interactions.

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- Employees shall not disclose any confidential or proprietary information about SoHum Health, its affiliates, vendors, or suppliers, including but not limited to, business and financial information.

- Guidelines:

  1. Write in the first person: When your affiliation with SoHum Health is evident, you should make it clear that you are speaking for yourself and not on behalf of the organization.

  2. Use a disclaimer: In instances when your affiliation to SoHum Health is evident, include a disclaimer, such as "The views expressed on this (blog; website; post) are my own and do not reflect the views of my employer."

  3. Be respectful: Do not post any content that is obscene, defamatory, profane, libelous, threatening, harassing, abusive, hateful, or embarrassing to another person or entity.

  4. Always protect patient privacy: Never reveal any information that would make the identity of a patient or client apparent.

  5. Adherence to all laws and regulations: Individuals publishing content on social media ~~should be~~ are reminded to adhere to all laws and regulations.

  6. Confidential information: Never ~~Do not~~ disclose confidential information, either organizational or patient information, deliberately or inadvertently.

  7. Identification: Identifying yourself as an employee of an organization associates the content you publish with your place of work. Only create content that is consistent with the professional standard to which district providers and staff are expected to adhere.~~you wish to be associated~~.

  8. Personal responsibility: Individuals are ~~shall be r~~responsible for any content they publish on social media.

- Sanctions:

  - Employees shall be sanctioned if it has been discovered that protected health information has been breached.

    - Any staff member who knowingly/willingly breaches confidentiality/security of data or information shall receive, at a minimum, a written disciplinary warning and, at a maximum, termination.

    - If the breach of confidentiality was committed accidentally, with no intent to violate confidentiality or security of data/information, all efforts shall be made to provide education to the responsible staff member to eliminate repeat incidents.

  - ~~Sanctions shall be applied against employees who fail to comply with the security policies and procedures to ensure the integrity of protected health information.~~

~~REFERENCE:~~

~~American Medical Association (AMA). (2016). Professionalism in the use of social media. Opinion 2.3.2. Chapter 2: Consent, communication, decision making. *Code of medical ethics*. AMA.. https://code-medical-ethics.ama-assn.org/ethics-opinions/professionalism-use-social-media~~

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SoHum Health

Subject: Managing Social Media Presence	Manual: Outreach

~~Definitions:~~

~~**For the purpose of this policy, social media shall be considered to be technology and software that allows user-generated content to be shared and exchanged online (e.g., blogs, Facebook, Twitter, YouTube, Instagram, TikTok, Threads, News Outlets, review sites).**~~

Policy:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that the use of social media on behalf of SoHum Health and its subsidiaries shall only be done by authorized users in the Outreach Department in compliance with organizational procedures and Codes of Conduct.

DEFINITIONS:

Social Media: For the purpose of this policy, social media shall be considered to be technology and software that allows user-generated content to be shared and exchanged online (e.g., blogs, Facebook, ~~X~~Twitter, YouTube, Instagram, TikTok, Threads, News Outlets, review sites).

PROCEDURE:

- Confidential information: Do not disclose any confidential information, either organizational or patient information, deliberately or inadvertently. All authorized social media users shall be aware of patient privacy and confidentiality standards and maintain those standards at all times when posting on behalf of the District online.

- Direct Communication: Do not communicate directly with patients or offer specific medical advice online. If a patient communicates directly or asks a specific question, they should be directed to phone or email SoHum Health through a secure means of communication. SoHum Health's Outreach Manager or designee holds the right to disable direct messaging on any social media platform to prevent a breach of patient privacy and confidentiality, slander, and intent to harm.

- Professionalism: All posts shall be reviewed by the Outreach Manager or designee prior to posting to ensure correct grammar, spelling, tone, and professionalism. Authorized users should not engage in long direct conversations on social media and should instead refer members of the public to visit the website or contact SoHum Health via phone or email to acquire further information.

- Medical Accuracy: Content for all social media posts should be acquired from reputable medical websites, publications, or directly from licensed medical staff to ensure it complies with the most recent medical standards and recommendations.

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- Use of Photos: Authorized users shall comply with anti-plagiarism guidelines. It is preferred to use self-generated photos and images whenever possible. When using a photo someone else created, photo attribution must be included in the post. Seek photos that are public domain, open license, or creative commons.

- Accessibility: Every effort should be made to make social media posts accessible to those with disabilities and impairments. All videos and photos should include captions and images and should follow guidelines to maximize readability.

- Trolls/Blocking/Removing posts: Individuals who personally attack members of the SoHum Health staff on any organizational social media page, may be blocked to prevent further abuse. Posts should be carefully evaluated for slander and intent to harm prior to removal.

- Correcting Errors: From time to time a post may be made public that includes an error. If it is a simple spelling or grammatical error, staff may immediately correct the post. If it is an error in content resulting in misinformation about medical advice or services, a disclaimer must be added to the post, calling out the error and providing the corrected information.

- Personal responsibility: Individuals shall be responsible for any content they publish on social media. Those posting on behalf of SoHum Health are responsible for the reputation of the organization and must act with the highest regard for professionalism, accuracy, and approachability.

- Sanctions:

1. SoHum Health has the right to monitor, prohibit, restrict, block, suspend, terminate, delete, or discontinue an employee's access to the District's social media at any time, without notice, for any reason, and in its sole discretion.

2. Employees shall be sanctioned if it has been discovered that protected health information has been breached.

    a. Any staff member who knowingly/willingly breaches confidentiality/security of data or information shall receive, at a minimum, a written disciplinary warning and, at a maximum, termination.

    b. If the breach of confidentiality was committed accidentally, with no intent to violate confidentiality or security of data/information, all efforts shall be made to provide education to the responsible staff member to eliminate repeat incidents.

3. Sanctions shall be applied against employees who fail to comply with policies and procedures to ensure the integrity of protected health information.

~~**REFERENCE:**~~

~~FEMA US Department of Homeland Security – Social Media Engagement Strategies, PER-343, September 2023, version 3.0.~~

SoHum Health

Subject:	Manual:
Separation of Psychotherapy Notes from Mental Health Record	**Senior Life Solutions**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to describe how Senior Life Solutions handles psychotherapy notes and designates where these records may be maintained.

- Psychotherapy notes is a narrowly defined subset of protected health information (PHI) that has stronger protection provisions under the Health Insurance Portability and Accountability Act (HIPAA) than other types of PHI. The purpose for the heightened protection is to foster effective treatment by increasing patient confidence that intimate mental healthcare information will not be used or disclosed without the patient's authorization, except in certain instances.
- To comply with federal CMS regulation 45 CFR §164.501 regarding separation of psychotherapy notes from the Mental Health Record.

Under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), *psychotherapy notes* mean notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Definitions:

Mental Health Records: Mental healthcare professionals maintain information as necessary to document the provision of mental health treatment. Mental health information includes information typically shared with a patient and by definition is part of a mental health note. Examples of information found in the designated record set include:

a. Strategies for promoting treatment adherence and optimizing disease management;

b. Medication prescription and monitoring;

c. Counseling session start and stop times;

d. Objective behavioral assessments upon which clinical treatment decisions are made;

e. The modalities and frequencies of treatment furnished;

f. Results of clinical tests, and

Any summary assessment of the following items: diagnosis, functional state, treatment plan, patient's presenting symptoms, prognosis, and progress to date.

Examples of Nnotes that are Iincluded in the Ddesignated Rrecord set Iinclude:

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a. Physician progress notes;

b. Nursing notes;

c. Case management notes;

d. Individual and group therapy notes; and

e. Other mental health notes.

2. **Psychotherapy Notes**: are notes recorded in any medium, by a mental health professional analyzing or detailing the explicit contents of conversation during a private counseling session or a group, joint, or family counseling session; and that are separated from the rest of the individual's medical record. Examples of psychotherapy notes include:

a. Documentation of intimate personal content;

b. Details of fantasies and dreams;

c. Process interactions;

d. Sensitive information about other individuals in the patient's life; or

e. The mental health provider's personal reactions, hypotheses or speculations as a result of a patient or group interaction.

PROCEDURE:

- At SoHum Health[Hospital Name], psychotherapy notes are only used by the mental health provider who creates the notes except as set forth below. Mental health records that do not qualify as psychotherapy notes are subject to the general privacy and access requirements as for other PHI. The general exceptions allowing use or disclosure of PHI without patient authorization do not apply to psychotherapy notes.

- An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes. Psychotherapy notes will not be released by SoHum Health during routine disclosure of other requested records. Even if the use is an iInternal SoHum Health[Hospital Name] use, and access to and use of psychotherapy notes is restricted.

- To ensure that psychotherapy notes are maintained at the highest level of privacy the psychiatrist must take the proper steps within the SoHum Health EHR system. The psychiatrist will use the system tools provided to document their specialty psychotherapy notes within the patient encounter.

- Psychotherapy notes may be used and disclosed, absent patient authorization, only for the following purposes:

A. The mental health professional that created the psychotherapy notes can use the notes for treatment purposes. Psychotherapy notes maintained in electronic format must only be accessible by the author of the notes. The author of psychotherapy notes is responsible for the maintenance, storage and safeguarding of the notes. The author of the notes can determine the retention time frame based upon when the notes are no longer useful for treatment and/or after treatment has been concluded. Psychotherapy notes must be destroyed in accordance with SoHum Health[Hospital Name] destruction policies and procedures;

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B. Senior Life Solutions may use or disclose psychotherapy notes to conduct training programs in which students, trainees or practitioners in mental health learn, under supervision, to practice or improve their skill in group, joint, family or individual counseling. De-identified information should be used when appropriate for these activities.

C. SoHum Health ~~[Hospital Name]~~ may use psychotherapy notes to defend a legal action or other proceeding brought by the individual who is the subject of the notes. The mental health provider who created the psychotherapy notes may disclose the psychotherapy notes to the SoHum Health~~[Hospital Name]~~ attorney for the purpose of defending against the action or proceeding.

D. To the Secretary of the U.S. Department of Health and Human Services (DHHS), to assure compliance with HIPAA;

E. When required by law;

F. To a health oversight agency for the purpose of oversight of the provider who created the notes;

G. To a coroner or medical examiner for official duties;

H. To prevent or lessen a serious and imminent threat to health or safety of a person or the public, to a person(s) reasonably able to prevent or lessen the threat, including the target of the threat.

- The patient does not have the right to access psychotherapy notes. In the event that a patient submits a written request for access to psychotherapy notes, the mental health provider may deny the individual's request from the individual. Any denial must be in writing. The provider is not required to make a determination that release of the notes would be harmful to the patient. The patient does not have a right to review or appeal of the denial.

SoHum Health

Subject:	Manual:
Risk Management	**Senior Life Solutions**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure that documentation on risk management issues is~~will be~~ maintained in order to address identified issues and problems.

PROCEDURE:

- Data is collected by the program staff from incident reports, medical record documentation and patient/family complaints.
- Reports, including activities and follow-up are directed to SoHum Health's Quality department event reporting software. ~~the Hospital Risk Manager and to~~ These events are then directed to Psychiatric Medical Care's Regional Director and Chief Clinical Officer.
- Reports are maintained in the Quality~~Risk Management~~ Department.
- Risk management indicators may include, but not be limited to, the following:
    - Occurrence/Incident Reports:
        - Adverse drug reaction
        - AMA discharges
        - Cardiac arrest
        - Contraband, use of alcohol or drugs
        - Death
        - Employee injuries:
            - Patient related
            - Not patient related
        - Facility property damage
        - Inappropriate sexual behavior

- Medical emergencies - sent to ED
- Healthcare associated infections
- Patient falls
- Patient injuries:
  - Non-deliberate, accidental
  - Recreational injury
  - Self mutilative, self inflicted
  - Indirectly to self
- Patient injury to another patient:
  - Assaultive fighting
  - Unprovoked
- Patient property damage/missing
- Patient rights violations
- Suicide attempts
- Visitor incidents

- Prospective Risk Management:
  - Consent to treat not signed upon admission
  - Orientation not provided for new employees
  - Patient family complaints
  - Patient not given a copy of patient rights
  - Required medication consent not obtained

DEFINITIONS:

NONE

SoHum Health

Subject:	Manual:
Requirements for the Telepsychiatry Process	**Senior Life Solutions**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure that all staff members follow effective patient practice and documentation standards for physician services and that all Senior Life Solutions (SLS) Telepsychiatry/Telehealth/Telemedicine sessions are conducted within practice and documentation guidelines for effective care.

PROCEDURE:

A. Staff allowed to facilitate SLS telepsychiatry/telemedicine sessions include,
   - Qualified Mental Health Professionals
   - Registered Nurse or Licensed Practical Nurse
   - Other staff adequately trained and approved by the SLS Pprogram dDirector

B. Requirements of staff for Telepsychiatry/telemedicine sessions
   - Telepsychiatry/telemedicine sessions are scheduled by program director and psychiatrist or other qualified, trained, and approved staff. The SLS Program director will give psychiatrist advanced notice (at least 3 days) and a list of patients to be seen during the scheduled Telepsychiatry/telemedicine session.
   - The SLS Program director and psychiatrist will coordinate to review patient's chart in the SoHum Health Electronic Health Record (EHR) system. ~~Program Director will send 1 day prior the last progress note for each patient scheduled for the scheduled telepsychiatry session. The progress note must be sent either by HIPAA compliant encrypted e-mail or by standard fax-to-fax transmission. Use of unencrypted e-mail or e-fax by either party is not HIPAA compliant.~~
   - AThequalified SLS program nurse ~~at the program~~ will ~~review~~ assist in the review of patient chart/information with the pPsychiatrist prior to the psychiatrist seeing the patient. ~~(updating additional patient information since the last psychiatric session; five minutes prior to the patient entering the session).~~
   - When a new patient is scheduled, the SLS program nurse will spend additional time ensuring all patient information is updated, including the admission assessment, nursing assessment, and psychosocial assessment.
   - The pPsychiatrist will see patient alone or with an accompanying family member, as patient prefers. ~~When a new patient is scheduled, the nurse will spend more time providing additional information (admission assessment, nursing assessment, psychosocial assessment).~~ The session time will vary per patient need.
   - Once the patient session has ended and the patient has left the session ~~room~~, the psychiatrist will collaborate with the SLS program nurse to complete all required documentation in the SoHum Health EHR system~~paperwork~~ for that patient before the next patient session begins.
   - No patient will be seen by the psychiatrist until the EHR documentation~~paperwork~~ from the previous session is updated/completed. The SLS program nurse will confirm the session note is updated/completed before presenting the next patient.
   - The SLS program Nurse will complete each of these steps for each additional patient.

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- ~~Once all the patients are seen, the psychiatrist will then fax/or scan all paperwork to the program nurse immediately following the Telepsychiatry sessions (or collaborate with the Telepsychiatry Supervisor/administrative assistant/staff support person at the physician practice responsible for transmitting the documentation to the outpatient hospital psychiatry services program before the end of the day). The updated note must be sent either by HIPAA-compliant encrypted e-mail or by standard fax-to-fax transmission. Use of unencrypted e-mail or e-fax by either party is not HIPAA-compliant.~~
- The SLS program director will confirm ~~receipt with t~~he psychiatrist has documented as needed in the SoHum Health EHR system~~once received~~. If the program director ~~does not receive~~ finds any deficiencies, they~~he or she~~ will be accountable for contacting the psychiatrist to ensure documentation is completed~~these are submitted to the program~~ as soon as possible. The program must have this documentation within five (5) days of admission ~~or risk compliance issues~~.
- ~~The psychiatrist can elect to either keep the documentation originals on-site at the physician practice/university office or mail these originals to the outpatient hospital psychiatry services program. If sending by mail, the program director will ensure the faxed/scanned documents are shredded upon receipt of the originals.~~

C. Billing

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- The pPsychiatrist providing the telepsychiatry/telemedicine service ~~(from the remote location)~~ will file a claim with the patient's ~~Medicare or other~~ insurance plan using the appropriate CPT code for the service provided with the modifier GT to indicate that the service was provided as telepsychiatry/telemedicine~~via telemedicine link~~. The place of service shown on the claim should be consistent with the location of the patient at the originating facility~~, usually 22-hospital outpatient department~~. The address of the originating site should be shown in box 32 of the HCFA 1500 claim form or its electronic counterpart. ~~(~~
- When ~~seeing a the~~ patient is seen face-to-face ~~at the program~~, use place of service code 22, the hospital outpatient department, and do not add the modifier GT to the procedure code.~~)~~
- The~~is~~ professional fee claim should be submitted to the patient's insurance plan~~Medicare within days or weeks of the service~~ timely so that it can be computer-matched with the hospital's claim for the originating site facility fee.

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- The SLS pProgram dDirector will enter a charge of HCPCS code Q3014 representing the telepsychiatry/telemedicine~~telemedicine~~ originating facility fee into the SoHum Health EHR system.~~on the daily/weekly charge sheet and submit to the hospital billing department.~~
- The hospital may not submit a separate charge for the use of outpatient department services for the same telepsychiatry/telemedicine~~telemedicine~~ physician's visit.
- The SLS pProgram director should confirm with psychiatrist ~~doctor~~ or psychiatrist~~doctor~~'s billing office that the professional fee claim has been submitted using GT modifier.
- The hHospital billing department will submit the claim for Q3014 as soon as possible. As Q3014 is not considered a recurring charge, it is not necessary to delay its submission until the end of the calendar month. This should be submitted as a separate Part B claim to Medicare, not on the recurring bill type with other program charges.

- If the hospital's claim as originating site cannot be matched to the physician's claim for service with modifier GT, then neither party will be reimbursed for the service until such time that the claims are corrected, resubmitted and computer-matched.

DEFINITIONS:

None~~Word:~~ ~~None~~

SoHum Health

Subject:	Manual:
Routine Syphilis, HIV, & HCV Testing, Treatment, and Linkage to Care Program (EDSP)	**Emergency Department**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide comprehensive care and improve public health by providing routine screening, treatment, and linkage to care for people who have contracted syphilis, HIV, and HCV using funds provided by the Emergency Department Screening Program (EDSP) grant.

DEFINITIONS:

California Morbidity Report (CMR)

Emergency Department Screening Program (EDSP)

Electronic Health Record (EHR)

Emergency Department (ED)

Local Health Department (LHD)

Public Health Department (PHD)

Southern Humboldt Community Healthcare District (SHCHD)

Standard Script-Standard Script shall be defined as the script the provider or nurse will use to inform patients of the program.

PROCEDURE:

- Testing will be performed on an opt-out basis on all ED patients who meet the criteria set out in the EDSP Screening and Treatment Protocol (Appendix A).
- Testing will be conducted following existing district policy and procedure, except as noted in document, in compliance with applicable regulations and best practices.
- When required, confidential morbidity reporting of findings will be made to public health agencies following existing district procedures.
- When one or more of the screening tests indicates a person has contracted one or more of the infectious agents tested for under the EDSP, qualified district personnel will counsel the patient regarding the meaning of the test result(s), prescribe appropriate medications to begin treatment for the infectious agent(s), supply medications to initiate therapy, provide case management to link the patient to appropriate primary or specialty care, and when necessary provide a follow-up outpatient medical consultation with the ED physician while waiting for linkage to care. Patient Navigation for EDSP will be carried in accordance with criteria set out in the EDSP, Patient Navigator Protocol. (Appendix B).
- Data required for compliance with the EDSP grant will be gathered and documented for quality assurance and compliance with the grant's requirements.
- Reports will be made as required under the EDSP grant.

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- Testing may also be performed on an opt-in basis on patients not meeting criteria for the EDSP. Qualified district personnel will follow EDSP Screening and Treatment Protocol.

- Nothing in this policy and procedure is intended to limit the ordering of any test by any district provider when, in the provider's judgment, the test is clinically indicated for the care of the patient, following district policy and applicable regulations for laboratory testing of patients in the provider's setting of care.

- Infection Prevention: If necessary, follow the Manual CMR Procedure below[1,2,3].

INFECTION PREVENTION MANUAL CMR PROCEDURE:

- Perform manual CMR reporting when all of the following apply:
  - The test was performed by the SoHum laboratory;
  - The test result is definitive.
  - The test result is a reportable finding.
    - HIV: Positive for antigen, antibody, or both.
    - HCV: Positive for HCV antibody.
    - Syphilis: Positive for syphilis by algorithm.
  - The result is not expected to be reported by the EMR via the CalREDIE interface.[4]

- Report the finding(s) at the correct time and by the correct method.
  - HIV: Within one working day by telephone to Humboldt County Public Health when the finding is "acute HIV".
    - Presume that the case is acute if the HIV antigen result is definitively positive.
    - Treat the case as acute if the treating provider determines the case is acute.
  - All reportable diseases covered in this procedure, including "acute HIV": Within one week by CMR form to Humboldt County Public Health.
    - Locate the current version of the CMR manual form. At the time of writing this procedure, it was available at:
    - Communicable Disease Prevention | Humboldt County, CA - Official Website
    - ~~http://www.humboldtgov.org/DocumentCenter/View/52309~~
    - Fax the completed form to (707) 445-7346.

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[1] All healthcare providers are required by law to report known or suspected cases of specific diseases or conditions to the jurisdiction in which the patient resides. The required reporting format is the California Morbidity Report (CMR).
[2] County and state public health authorities have confirmed to SoHum Health that CMR reporting should only come from the performing laboratory. They do not want or appreciate duplicate reports.
[3] County public health authorities have confirmed to SoHum Health that preliminary or presumptive positive results that will go on for more definitive testing should not be reported. Because all SoHum testing gives only presumptive results, it is not expected that CMR reporting will be required.
[4] CalREDIE interfacing for HIV has been tested and is available should definitive result testing begin in the future at SoHum lab.

SoHum Health

Subject:	Manual:
Medical Staff Credentialing and Privileging	Medical Staff~~Quality~~

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") and the Medical Staff to assure all medical practitioners are credentialed and privileged to provide medical care to the standards of Centers for Medicare and Medicaid Services (CMS) and all other federal and state laws.
~~To delineate the methods used to credential and privilege practitioners to ensure the patients receive the highest level of care from SHCHD's practitioners who have undergone evaluation and inquiry regarding their ability to practice medicine~~.

DEFINITIONS:

Allied Health Practitioner (AHP): A non-physician provider, including a Clinical Psychologist, Nurse Practitioner, Physician Assistant or Doctor of Optometry licensed to ~~as who may~~ provide medical care within their California license and scope of practice.

Physician: An individual with a M.D. or D.O. degree who is currently licensed to practice medicine in the State of California.

Practitioner: A health care professional licensed to practice one of the professions eligible for membership on either the Medical Staff or Allied Health Professional Staff, as defined in the Medical Staff Bylaws.

PROCEDURE:

1. It is the responsibility of the applicant/practitioner to provide~~Medical Staff Coordinator to obtain~~ all information necessary to assure an appropriate appointment and privileging decision ~~regarding the applicant~~ can be made by the Medical Staff Committee.

2. Each credential ~~physician~~ file will be reviewed by the Chief of Staff or Vice Chief of Staff for the character, competence, training, experience, ~~judgmentjudgementjudgement~~ and ability of the practitioner for membership and/or to perform the requested clinical privileges.

   - References will be checked, and the physician reviewer will sign the request indicating recommendation to the Medical Executive Staff Committee for granting of these appropriate privileges. In some instances, the District may enter into a contract, upon recommendation of the Medical Staff, to permit a Distant Site Entity, as defined in the Medical Staff Bylaws, to provide credentialing and privileging information for Telemedicine Professionals. In such cases, the Medical Staff may rely upon the information provided by the Distant Site Entity, and need not check references or perform primary source verification, unless review of the application by the Chief of Staff or Vice-Chief of Staff raises reasonable concern as to the professional competence and/or conduct of the applicant, or their ability to exercise the clinical privileges requested. **The Medical Staff remains responsible for providing a recommendation to the Governing Board in all cases and may request information from the Distant Site Entity or undertake other actions to resolve reasonable doubts about an application.**

   - Once the Chief of Staff or Vice Chief of Staff signs the requested privileges forms, the file will be taken to the Medical Executive Staff Committee meeting where it will be ~~is~~ reviewed by its the Medical Staff Committee members. The Medical Executive Committee will either recommend or not recommend, by vote, the applicant's request for membership and/or clinical privileges, which shall be communicated ~~file be forwarded~~ to the Governing Boardy. ~~A vote will be taken as to the recommendation to the Governing Board for approval.~~

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- Each file sent to the Governing Body~~Board~~ for approval will be shared with the Governing Bo~~ar~~dy before their decision is made. The Governing Bo~~ar~~dy shall give great weigh to the recommendation of the Medical Executive Committee and shall not act in an arbitrary or capricious manner and shall keep in mind its legal responsibilities to act to protect the quality of medical care provided, the competency of the Medical Staff and to ensure the responsible governance of the Hospital in making its ~~will make the~~ decision ~~for it~~sto approv~~e~~al, deny~~ial~~, remand deny,or take other action as is reasonable and warranted~~deferment of the appointment~~.

3. Requests for Emergency and Locum Tenens credentials may be granted as per the Medical Staff Bylaws, Rules and Regulations, and Appointment Process Supplemental Attachment.

4. All practitioner credential files will contain the following:
   a. A signed application
   b. Copy of ~~their~~ their~~physician's~~ current, valid and unencumbered ~~California Medical~~ license to practice medicine
      i. Physican: As issued by either the Medical Board of California or the Osteopathic Medical Board of California;
      ii. Nurse Practitioner: California Board of Registered Nursing (BRN) and Nurse Practitioner certification from BRN;
      iii. Physician Assistant: PA license issued by the California Physician Assistant Board license; and Certification by the National Commission on Certification of Physician Assistants.
      iv. Optometrist:license from the California State Board of Optometry.
      ~~b.~~
   c. Copy of applicant's ~~their~~ current DEA registration certificate applicable in California
   d. National Practitioner Date Bank (NPDB) ~~-~~report~~Profile~~
   e. Diplomas and/or Certificates for the medical school education, internship, residency (if applicable), and fellowship (if applicable).
   f. Signed authorization for release of information
   g. Current BLS, ACLS,~~ ATLS~~, and PALS certification. An ATLS certificate~~documentation,~~ will be kept in the file if the practitioner has current certification~~available~~
   h. Request for appointment or reappointment signed by the applicant
   i. Request for Privileges signed by the applicant
   j. Other documentation as required by state and federal laws, and the Medical Staff Bylaws and supplemental documents.
   k. The credentials files of Telemedicine Professionals may contain a summary of information provided by a Distant Site entity to satisfy the requirements listed in (e) and (g) above, as well as any primary source verifications and peer references.
   ~~i.~~

5. All medical staff and AHP files are kept secure on the shared drive and by other electronic means separate from administration files and protected by the confidentiality afforded by the Bylaws and Ev. Code §1157~~e.~~

6. All locum tenens privileges are valid for a period of no more than two months. If a continuation is requested, the Medical Staff Coordinator will resubmit the file for one ~~an~~ additional two month periods as a locum. Thereafter, If the locum tenens wishes to apply for Medical Staff membership, an initial application will need to be submitted for processing.

7. Upon the approval of the Governing Bo~~ar~~dy, practitioners will be granted Provisional status for the first 12 months of their initial appointment. After a successful provisional period, they can apply for a two-year appointment to Medical Staff or Allied Health Practitioner Staff.

8. At least every 24 months, practitioners are required to be re-credentialed and re-privileged. A re-appointment application will need to be submitted by the practitioner prior to the end of their appointment period, with all necessary documentation for further consideration of the Medical Staff membership.

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~~**DEFINITIONS:**~~

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SoHum Health

Subject: Corrective Action	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to that a routine monitoring of QA/QC data and protocol for corrective measures be established.

PURPOSE:

The mammography QC technologist shall perform routine monitoring procedures, maintain data logs and provide appropriate corrective action as necessary.

PROCEDURE:

- The technologist shall perform QC procedures as established for each test.
- All data shall be charted on the appropriate form.
- Results noted to be outside the acceptable limits for each test shall be followed by appropriate corrective action to include:
    - Retest to confirm results and/or to isolate the source of the problem.
    - Remove damaged equipment if possible.
    - Contact Hologic, Inc. for mammography machine repair.
    - Consult with medical physicist as needed.
    - After appropriate service, repeat QC procedures prior to performing. mammography on a patient.
    - Discontinue mammography service until corrective actions are completed, and controls are within acceptable limits.
- Minor variations, within acceptable parameters, with respect to image quality shall be noted and observed for trends. Mammography will continue.
- All problems, corrective actions and results shall be charted in the Quality Control logbook.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Emergency Department Screening Program (EDSP) Screening and Treatment Protocol (Appendix A)	**Emergency Department**

Purpose:

The purpose of this protocol is to guide Emergency Department physicians and staff in their efforts to provide routine, opt-out, screening and treatment for HIV, HCV, and Syphilis at the Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") Emergency Department.

DEFINITIONS:

EMR: Electronic Medical Record

Standard Script: Standard Script shall be defined as the script the provider or nurse will use to inform patients of the program.

PROTOCOL:

ED Personnel: Identification of EDSP patients, opt-out script, and EMR Documentation

- Order screening testing for HIV, HCV, and Syphilis on all patients who meet the EDSP criteria unless a patient opts out of testing.
    - Order[1] screening on all patients registered for care in the ED who meet the following criteria:
        - Registered as an ED patient
        - At least 18 years old[2]
        - Having other blood tests ordered for their care in the ED
- Offer the patient the opportunity to opt-out before testing is performed.
    - The provider or nurse will offer opt-out testing using the following script: "*Our emergency department screens all individuals getting a blood draw for syphilis, HIV, & hepatitis C. Please let us know if you do not want any of these tests today.*"
    - If the patient opts-out of testing, do all the following:
        - Document the opt-out in the patient's record in the EMR.
        - Cancel screening test orders if they have already been placed[3].
        - Inform laboratory personnel that the patient has opted out of testing when the blood specimens are delivered to the lab.

[1] This order may be placed in the EMR manually by the ED physician , or the registered nurse following this procedure as a protocol under the physician , or by the EMR automatically if it is configured to do so.

[2] Patients under 18 years of age are not included in EDSP screening. The physician may order screening testing if clinically indicated on a patient of any age. Per SHCHD Minors in the Emergency Department policy: minors 12 years and older may consent without parent or guardian. The physician is NOT permitted to inform the parent or guardian without the minor's consent. The health department must be notified per SHCHD ED Administrative Policy: Confidential Morbidity Reporting.

[3] Prompt cancellation of these orders is essential. Once testing has been performed, it must be reported to the patient's chart, and reportable findings must be transmitted to public health agencies.

- Answer any questions regarding billing and payment for the EDSP tests by verbal explanation[4], or refer the patient to official documents prepared for this purpose by SoHum Health.

- Ask questions required by the EDSP grant to all patients who do not opt-out and document the answers in the patient's record in the EMR.

Laboratory Personnel: Testing of EDSP patient specimens

- Check each blood specimen delivered by the ED for possible inclusion of the patient in EDSP testing.
    - Check the patient's age to see that the patient qualifies for the EDSP.
    - Look to see if the screening tests are already ordered.
    - Ask ED personnel whether the patient has opted out if screening tests are not ordered.
    - If the patient has not opted out but the screening tests have not been ordered, ask ED personnel to initiate the EDSP ordering process given above.

- Verify that the correct test codes have been ordered in the EMR.

    - Check that the test codes ordered for HIV, HCV, and syphilis screenings match the EMR codes for the test methods currently available on the SoHum laboratory menu of in-house or reference tests.
    - If incorrect test codes have been used, cancel the incorrect tests and order the correct tests in the EMR under the ED provider, including a comment about the reason for the change.

- Process, test, and report results following the current laboratory policies and procedures for these tests.
- Notify the ED physician promptly of in-house findings other than Negative and document the notification as a critical-value call.
- Notify the care team of non-Negative findings coming back from reference laboratory tests.

    - Call the value to the ED physician and document in the EMR if the report format allows.
    - Report the finding to the Patient Navigator via Webex or the current method for official internal communication that includes PHI.
    - Call the Infection Preventionist if a finding of "acute HIV" infection is made (positive HIV antigen); otherwise notify IP of positive findings via Webex. Include a reminder to IP if the reference lab is making the required CMR report.

Response to Positive / Indeterminate Findings

- Laboratory: Make notifications as indicated above.
- ED Physician: Provide counseling, treatment, and linkage to further care[5].
    - Explain the finding, the follow-up testing to be done, precautions the patient should take, what comes next in the patient's care, and invite the patient to ask questions.
    - Prescribe an appropriate initial course of therapy in consultation with SoHum pharmacy personnel.
        - For syphilis, consider:
            - Benzathine Penicillin G 2.4 million units IM for all adult patients
            - If late or unknown stage, consider adding Doxycycline 200 mg PO BID for 28 days, unless patient is pregnant
            - Consider Doxycycline 200 mg PO BID for 28 days instead of Penicillin G if there are shortages or patient declines the injection
        - For HIV and/or HCV:

[4] Unless otherwise indicated in official SoHum written documentation, patients who do not opt out of testing will be billed for the screening tests as they would be for all other testing provided in the course of their care.

[5] During the ED visit if results are available; later by telephone if results come after the patient has been discharged.

        - Consider prescribing a 10-day course of antiretroviral therapy to be dispensed from the ED, along with a prescription for an additional 30-day supply.
        - Consult with the SoHum pharmacist regarding the recommended drug(s) and current supply on hand.
    - Tell the patient that SoHum personnel will try to link the patient to appropriate primary care, but the patient is encouraged to follow up with the ED physician as an outpatient before the initial course of therapy runs out if other care is not available.
    - Notify the Patient Navigator via Webex message.

- Infection Prevention: If necessary, follow the Manual CMR Procedure below[6,7,8].

INFECTION PREVENTION MANUAL CMR PROCEDURE:

- Perform manual CMR reporting when all of the following apply:
    - The test was performed by the SoHum laboratory;
    - The test result is definitive.
    - The test result is a reportable finding.
        - HIV: Positive for antigen, antibody, or both.
        - HCV: Positive for HCV antibody.
        - Syphilis: Positive for syphilis by algorithm.
    - The result is not expected to be reported by the EMR via the CalREDIE interface.[9]

- Report the finding(s) at the correct time and by the correct method.

    - HIV: Within one working day by telephone to Humboldt County Public Health when the finding is "acute HIV".
        - Presume that the case is acute if the HIV antigen result is definitively positive.
        - Treat the case as acute if the treating provider determines the case is acute.
    - All reportable diseases covered in this procedure, including "acute HIV": Within one week by CMR form to Humboldt County Public Health.
        - Locate the current version of the CMR manual form. At the time of writing this procedure, it was available at
        - Communicable Disease Prevention | Humboldt County, CA - Official WebsiteFax the completed form to (707) 445-7346.

[6] All healthcare providers are required by law to report known or suspected cases of specific diseases or conditions to the jurisdiction in which the patient resides. The required reporting format is the California Morbidity Report (CMR).
[7] County and state public health authorities have confirmed to SoHum Health that CMR reporting should only come from the performing laboratory. They do not want or appreciate duplicate reports.
[8] County public health authorities have confirmed to SoHum Health that preliminary or presumptive positive results that will go on for more definitive testing should not be reported. Because all SoHum testing gives only presumptive results, it is not expected that CMR reporting will be required.
[9] CalREDIE interfacing for HIV has been tested and is available should definitive result testing begin in the future at SoHum lab.

Subject:	Manual:
Emergency Department Screening Program (EDSP) Patient Navigator Protocol (Appendix B)	**Emergency Department**

Purpose:

The purpose of this protocol is to guide the Emergency Department Screening Program (EDSP)'s Patient Navigator in their efforts to provide Linkage to Care (LTC) services for patients that test positive during the opt-out screening a testing process at the Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") Emergency Department.

DEFINITIONS:

EMR: Electronic Medical Record

PHD: Public Heath Department

LTCT: Linkage to Care Tool

PROTOCOL:

- Patient Navigator: Provide linkage to care.
    - Make contact promptly with all patients with positive findings or otherwise referred by the ED physician.
    - Help the patient find a pharmacy to fill a prescription for a regular course of drug therapy, if prescribed.
    - Help the patient find and make an appointment with primary care and/or an appropriate specialist for ongoing care.
    - Verify that results have been received by the Humboldt County PHD and the patient's primary care provider.
    - Inform Primary Care Provider, if necessary.
    - Initiate subsequent contacts with the patient on a regular basis until:
        - The patient has been successfully linked to care;
        - The Patient Navigator is reasonably assured that the patient is receiving care, understands the ramifications of the finding, and understands the issues involved in the transmission of this and other similar diseases.
        - The patient has received help from other appropriate resources available from SoHum Health or in the community.
        - The patient acknowledges that linkage to care and sufficient follow-up have occurred.

        - Unless or until the patient becomes resistant.

- Complete the EDSP LTCT per the EDSP agreement.

- Infection Prevention: If necessary, follow the Manual CMR Procedure below[1,2,3].

INFECTION PREVENTION MANUAL CMR PROCEDURE:

- Perform manual CMR reporting when all of the following apply:
    - The test was performed by the SoHum laboratory;
    - The test result is definitive.
    - The test result is a reportable finding.
        - HIV: Positive for antigen, antibody, or both.
        - HCV: Positive for HCV antibody.
        - Syphilis: Positive for syphilis by algorithm.

    - The result is not expected to be reported by the EMR via the CalREDIE interface.[4]
        - Within one working day by telephone to Humboldt County Public Health when the finding is "acute HIV".
        - Presume that the case is acute if the HIV antigen result is definitively positive.
        - Treat the case as acute if the treating provider determines the case is acute.
    - All reportable diseases covered in this procedure, including "acute HIV": Within one week by CMR form to Humboldt County Public Health.
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[3] County public health authorities have confirmed to SoHum Health that preliminary or presumptive positive results that will go on for more definitive testing should not be reported. Because all SoHum testing gives only presumptive results, it is not expected that CMR reporting will be required.
[4] CalREDIE interfacing for HIV has been tested and is available should definitive result testing begin in the future at SoHum lab.

SoHum Health

Subject:	Manual:
Program Content and Codes Protocol	**Senior Life Solutions**

PURPOSE:

THE PURPOSE OF THIS PROTOCOL IS TO ENSURE THAT OUTPATIENT HOSPITAL PSYCHIATRIC SERVICES PROVIDED BY SENIOR LIFE SOLUTIONS (SLS) ARE TAILORED TO EACH PATIENT AND THAT THE BILLING CODES USED BY SLS ARE EASILY ACCESSIBLE TO THE BILLING, CODING, AND MEDICAL STAFF AT THE SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT (SHCHD).

PROTOCOL:

Section I. Psychiatric Diagnostic Evaluation

Two CPT codes (90791 and 90792) differentiate between diagnostic services done without medical services (90791) and with medical services (90792). The following information pertains to both (1) CPT code 90791, psychiatric diagnostic evaluation (often referred to as the psychosocial assessment); and (2) CPT code 90792, psychiatric diagnostic evaluation with medical services;

a) Cannot be reported with an E/M code on the same day by the same provider

b) Cannot be reported with a psychotherapy service code on the same day

c) May only be reported once per day

d) May be reported more than once for a patient when separate evaluations are conducted with the patient and other informants (i.e., family members, guardians, significant others) on different days. *However, if 90791 or 90792 are reported more than once per episode of illness, documentation will be required for the establishment of medical necessity.

e) In certain circumstances family members, guardians, or significant others may be seen in lieu of the patient.

90791: A psychiatric diagnostic evaluation (90791) is an integrated assessment that includes history, mental status and recommendations. It may include communicating with the family and ordering further diagnostic studies. Use add-on code 90785 in conjunction with 90791 when the diagnostic evaluation includes interactive complexity services.

90792: A psychiatric diagnostic evaluation with medical services (90792) includes 90791 and a medical assessment. It may require a physical exam, communication with the family, prescription medications and ordering laboratory or other diagnostic studies. Use add-on code 90785 in conjunction with 90792 when the diagnostic evaluation includes Interactive Complexity services

Section II. Psychotherapy Psychiatric Therapeutic Procedures (90832, 90834, 90837-90838, 90845-90853, 90865:

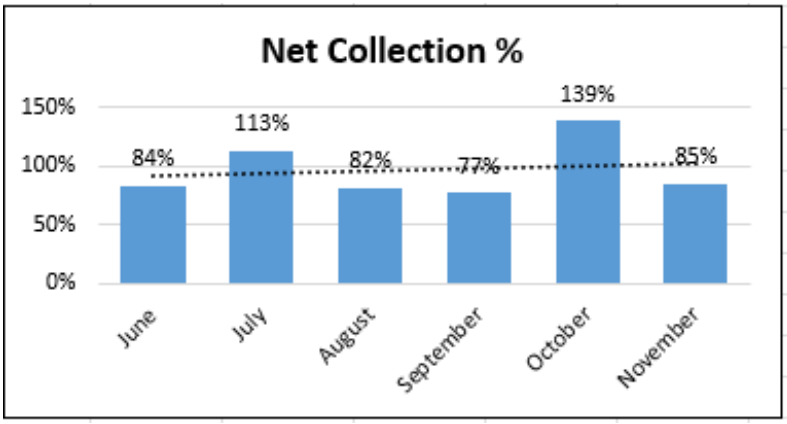
Southern Humboldt Community Healthcare District

November 2024 – Centriq & Epic Combined

SoHum Health

Key Items

- **Cash totaled $1M, 85% of net revenue**
- **AR is up 1.8 days**
- **Third Party aging is down $238K**
- **Unbilled AR increased 1 day**



Detailed Initiatives & Obstacles

- **Overall AR:** The figures calculated continue to include both the legacy system (Centriq) and Epic figures combined. November closed with $7.5M in gross AR or 94.6 days. Revenue ended at $2.3M, $567K lower than what we reported in October. Contributing to the decrease in Revenue is a reduction in visits from October to November by 369. A detailed breakdown by date of service and charge post date has been provided to the SoHum team. Third Party AR is up .5 days ending at 63.3 days. Unbilled AR increased 1 day ending at 11.5 AR days. Cash collections were $308 less than in October ending at just over $1M or 85% of net revenue. The decrease in cash is due to the PHP LTC issue, as well as pending payments on Medicare Swing Bed and Inpatient claims. We expect to see cash rebound in December.
- **Denials:** Denials are down 14%, or $345K from October, bringing us to the set goal of 5%. The LTC accounts previously denied are held until the denial issue is resolved to prevent an influx in denied claims. We have worked closely with PHP and identified an issue between the TAR (authorization) submitted and the billing of the claim. We are working with the SoHum team to get the TAR updated and claims rebilled. We anticipate payment in January.
- **Self-Pay:** Self-Pay AR increased slightly ending at 19.8 AR days. Self-pay collections remain steady, ending at $31K. Our Self-pay team continues to review and manually prompt statements in anticipation of a much larger Bad Debt drop for Centriq in December in an effort to reduce the legacy system Centriq. We transferred $230K to bad debt for Centriq and Epic combined in November.
- **Third-Party Aging:** November closed with $2.5M in third-party balances aged over 90 days, totaling 41.1% and down $238K from October and expect to see a continued decrease in aging in December. Contributing to the aged AR is $78K in the existing Anthem issues. We have confirmed the address is updated in the Anthem system and are resubmitting claims for repayment. The LTC issue impacts $489K or 6.2 days in A/R.
- **A/R Reduction Breakdown:** Moving forward we will provide the areas of needed improvement month over month to reduce the AR. At month end the top 3 areas needed to bring AR to goal is $2.2M or 28.9 days in Epic AR Clean up assigned to Trubridge, $673K or 8.5 days in Coding, $489K or 6.2 days in PHP issues (Trubridge). $6.9K remains in Centriq 3rd party (excluding the Anthem Issue).

Southern Humboldt Community Healthcare District

December 2024

EPIC

Overall A/R Health

- **Overall AR:** AR decreased in the month of December. Additionally, we decreased our outstanding unbilled charges.

Total AR by Financial Class	Dec Total	Nov Total	Overall Decrease/Increase
Blue Cross	330,930.83	364,351.44	(33,420.61)
Blue Shield	61,687.18	134,847.02	(73,159.84)
Commercial	235,127.18	328,463.97	(93,336.79)
Medicaid	2,701,667.89	3,220,040.63	(518,372.74)
Medicare	1,382,472.66	1,724,529.79	(342,057.13)
Other	27,386.00	54,398.72	(27,012.72)
Self-Pay	1,412,587.50	1,449,082.36	(36,494.86)
Tricare	92,292.53	53,976.30	38,316.23
Worker's Comp	75,983.89	62,925.29	13,058.60
Undistributed	(32,369.34)	(26,144.61)	(6,224.73)
Grand Total	**6,287,766.32**	**7,366,470.91**	**(1,078,704.59)**

- **Days in AR:** Represents the average number of days it takes to collect payment for services billed.

  SoHum target - 55 days.

  December actual - 75 days; 19.6 day decrease from last month.

- **Self-Pay:** Due to the addition of dedicated staff and active involvement from the Self-pay management team Self-pay continues to trend in a positive direction.

Roadblocks

- **Denials:** Denials increased from November primarily due to an increase in Medicare denials. While Medicare errors account for some increase, the cause of a majority of SoHum errors was identified quickly and resolved in December.
- **Anthem Issue:** This issue has been outstanding for a year. However, we have submitted Anthem claims paid to the incorrect address and are pending payments. We expect this is almost resolved.
- **PHP LTC** (Medicaid Long-term care patients)**:** We continue to work with PHP to resolve the claims denied due to authorization/billing mismatch. We are expecting payment on these in early February.

Centriq

- We continue to push to close Centriq AR in its entirety. The remaining balance @ 12/31/2025 is as follows:

Remaining A/R	December
3rd Party Payer	294.49
Self Pay	36,484.47
Total	**36,778.96**

Refunds: We have several refund checks that still have to be printed and are working on updating the process and getting these out. We have set a target date for 01/31/2025.

Brandy Jensen /| Revenue Cycle Manager

Healthcare Resource Group

Office 251-405-2865| brandy.jensen@trubridge.com

Southern Humboldt Community Healthcare District

SoHum Income Statement Budget vs. Actual

From Jul 2024 to Nov 2024

Financial Row	Amount	Budget Amount	Amount Over Budget	% of Budget
Revenue				
Gross Patient Revenue				
Inpatient	$1,460,566.75	$916,666.60	$543,900.15	159.33%
Inpatient Ancillary	$205,336.35	$158,333.30	$47,003.05	129.69%
Outpatient	$7,543,480.94	$8,958,333.46	($1,414,852.52)	84.21%
Outpatient Ancillary	$3,585,218.65	$2,999,999.95	$585,218.70	119.51%
Total Patient Revenue	$12,794,602.69	$13,033,333.31	($238,730.62)	98.17%
Deductions from Revenue				
9060-913 - Supplemental Revenue	($2,746,394.03)	($2,916,666.65)	$170,272.62	94.16%
Contractual Allowances	$3,870,702.71	$3,416,666.20	$454,036.51	113.29%
Provision for Bad Debts	$538,834.07	$500,000.00	$38,834.07	107.77%
Other Allowances / Deductions	$99,281.23	$100,000.00	($718.77)	99.28%
Cost Of Sales	$105.50	$0.00	$105.50	0.00%
Total Deductions	$1,762,529.48	$1,099,999.55	$662,529.93	160.23%
Net Patient Revenue	$11,032,073.21	$11,933,333.76	($901,260.55)	92.45%
Other Operating Revenue	$2,188,509.76	$2,024,999.60	$163,510.16	108.07%
Total Operating Revenue	$13,220,582.97	$13,958,333.36	($737,750.39)	94.71%
Expenses				
Salaries & Wages	$4,639,393.32	$5,531,249.51	($891,856.19)	83.88%
Employee Benefits	$1,586,407.05	$1,437,500.20	$148,906.85	110.36%
Professional Fees	$2,041,174.87	$1,500,000.05	$541,174.82	136.08%
Supplies	$2,633,213.16	$2,089,671.30	$543,541.86	126.01%
Repairs & Maintenance	$146,848.46	$150,000.05	($3,151.59)	97.90%
Purchased Services	$1,181,916.56	$999,996.99	$181,919.57	118.19%
Utilities	$129,805.59	$149,999.60	($20,194.01)	86.54%
Insurance	$105,006.15	$91,666.70	$13,339.45	114.55%
Depreciation/ Amortization	$304,402.69	$272,007.90	$32,394.79	111.91%
Other	$751,762.58	$524,969.50	$226,793.08	143.20%
Total Operating Expenses	$13,519,930.43	$12,747,061.80	$772,868.63	106.06%
Operating Profit (Loss)	($299,347.46)	$1,211,271.56	($1,510,619.02)	-24.71%
Tax Revenue	$463,563.30	$462,500.00	$1,063.30	
Other Non Operating Revenue (Expense)	$46,975.64	$125,000.05	($78,024.41)	
Interest Income	$2,438.00	$83,333.35	($80,895.35)	
Net Non Operating Revenue (Expense)	$512,976.94	$670,833.40	($157,856.46)	
Net Income (Loss)	$213,629.48	$1,882,104.96	($1,668,475.48)	

Southern Humboldt Community Healthcare District

SoHum Income Statement Budget vs. Actual

From Jul 2024 to Dec 2024

Financial Row	Amount	Budget Amount	Amount Over Budget	% of Budget
Revenue				
Gross Patient Revenue				
Inpatient	$1,708,375.40	$1,100,000.08	$608,375.32	155.31%
Inpatient Ancillary	$235,435.18	$190,000.04	$45,435.14	123.91%
Outpatient	$9,160,562.69	$10,749,999.80	($1,589,437.11)	85.21%
Outpatient Ancillary	$4,368,092.98	$3,600,000.06	$768,092.92	121.34%
Total Patient Revenue	$15,472,466.25	$15,639,999.98	($167,533.73)	98.93%
Deductions from Revenue				
9060-913 - Supplemental Revenue	($3,327,887.85)	($3,499,999.98)	$172,112.13	95.08%
Contractual Allowances	$5,437,784.66	$4,100,000.56	$1,337,784.10	132.63%
Provision for Bad Debts	$676,851.48	$600,000.00	$76,851.48	112.81%
Other Allowances / Deductions	$122,412.30	$120,000.00	$2,412.30	102.01%
Cost Of Sales	$105.59	$0.00	$105.59	0.00%
Total Deductions	$2,909,266.18	$1,320,000.58	$1,589,265.60	220.40%
Net Patient Revenue	$12,563,200.07	$14,319,999.40	($1,756,799.33)	87.73%
Other Operating Revenue	$2,606,239.03	$2,430,000.48	$176,238.55	107.25%
Total Operating Revenue	$15,169,439.10	$16,749,999.88	($1,580,560.78)	90.56%
Expenses				
Salaries & Wages	$5,530,815.80	$6,637,499.58	($1,106,683.78)	83.33%
Employee Benefits	$1,965,124.06	$1,724,999.76	$240,124.30	113.92%
Professional Fees	$2,335,443.25	$1,799,999.94	$535,443.31	129.75%
Supplies	$2,931,348.78	$2,496,432.44	$434,916.34	117.42%
Repairs & Maintenance	$171,958.88	$179,999.94	($8,041.06)	95.53%
Purchased Services	$1,374,647.20	$1,199,997.42	$174,649.78	114.55%
Utilities	$157,559.74	$180,000.48	($22,440.74)	87.53%
Insurance	$123,545.58	$109,999.96	$13,545.62	112.31%
Depreciation/ Amortization	$364,770.46	$323,590.52	$41,179.94	112.73%
Other	$970,129.34	$630,036.60	$340,092.74	153.98%
Total Operating Expenses	$15,925,343.09	$15,282,556.64	$642,786.45	104.21%
Operating Profit (Loss)	($755,903.99)	$1,467,443.24	($2,223,347.23)	-51.51%
Tax Revenue	$564,148.30	$555,000.00	$9,148.30	
Other Non Operating Revenue (Expense)	($18,486.82)	$149,999.94	($168,486.76)	
Interest Income	$2,574.33	$99,999.98	($97,425.65)	
Net Non Operating Revenue (Expense)	$548,235.81	$804,999.92	($256,764.11)	
Net Income (Loss)	($207,668.18)	$2,272,443.16	($2,480,111.34)	

Southern Humboldt Community Healthcare District

SoHum Comparative Balance Sheet

Dec 2024 (Compared to Nov 2024)

Financial Row	Amount (As of Dec 2024)	Comparison Amount (As of Nov 2024)	Variance	% Variance
Assets				
Current Assets				
Cash - Checking & Investments	$2,970,877.88	$1,581,409.39	$1,389,468.49	87.86%
Patients Accounts Receivable	$22,992,945.92	$22,657,687.57	$335,258.35	1.48%
Less Allowances	($16,562,404.24)	($14,983,493.42)	($1,578,910.82)	10.54%
Other Receivables	$5,428,852.56	$4,836,352.56	$592,500.00	12.25%
Inventories	$674,309.08	$665,918.54	$8,390.54	1.26%
Prepaid Expenses and Deposits	$4,487,888.19	$4,521,834.18	($33,945.99)	-0.75%
Total Current Assets	$19,992,469.39	$19,279,708.82	$712,760.57	3.70%
Property and Equipment				
Land	$1,193,526.09	$1,193,526.09	$0.00	0.00%
Land Improvements	$553,251.44	$553,251.44	$0.00	0.00%
Buildings	$5,603,069.34	$5,603,069.34	$0.00	0.00%
Equipment	$7,660,026.90	$7,650,473.04	$9,553.86	0.12%
Construction in progress	$12,756,000.04	$12,611,241.42	$144,758.62	1.15%
Less: Accumulated Depreciation	($9,341,125.79)	($9,280,758.02)	($60,367.77)	0.65%
Net Property and Equipment	$18,424,748.02	$18,330,803.31	$93,944.71	0.51%
Total Assets	**$38,417,217.41**	**$37,610,512.13**	**$806,705.28**	**2.14%**
Liabilities & Fund Balance				
Current Liabilities				
Accounts Payable	$587,410.45	$1,237,690.36	($650,279.91)	-52.54%
Accrued Payroll & Related costs	$290,090.62	$300,397.65	($10,307.03)	-3.43%
Other Current Liabilities				
Deferred Revenue IGT	($181.64)	($80.67)	($100.97)	125.16%
Loans & Current Portion of Lease Obligations	$3,622,529.00	$3,622,529.00	$0.00	0.00%
Reimbursement/Settlement	($265,298.71)	($265,298.71)	$0.00	0.00%
Total Other Current Liabilities	$3,357,048.65	$3,357,149.62	($100.97)	0.00%
Total Current Liabilities	$4,234,549.72	$4,895,237.63	($660,687.91)	-13.50%
Long Term Debt, Less Current Portion				
LEAF Data Backup Liability	$53,134.90	$53,134.90	$0.00	0.00%
Maple Lane Loan	$210,137.72	$213,101.33	($2,963.61)	-1.39%
CHFFA Help II Loan	$1,865,531.32	$1,872,623.36	($7,092.04)	-0.38%
Lease Obligations	$236,003.00	$236,003.00	$0.00	0.00%
Net Long Term Debt	$2,364,806.94	$2,374,862.59	($10,055.65)	-0.42%
Equity				
Unrestricted Fund Balance - Prior Years	$2,830,961.19	$2,830,961.19	$0.00	0.00%
Retained Earnings	$27,297,262.36	$27,297,262.36	$0.00	0.00%
Net Income	($210,165.72)	$212,188,36	($422,354.08)	-199.05%
Total Fund Balance	$29,918,057.83	$30,340,411.91	($422,354.08)	-1.39%
Total Liabilities & Fund Balance	**$36,517,414.49**	**$37,610,512.13**	**($1,093,097.64)**	**-2.91%**

Information in this part of the policy has been subdivided into three (3) sections. These sections address the following CPT/HCPCS procedure codes:

1. Codes 90832, 90834, 90837 represent insight oriented, behavior modifying, supportive, and/or interactive psychotherapy
2. Codes 90846, 90847, 90853 represent family psychotherapy and/or group psychotherapy

A. Codes 90832, 90834 and 90837 represent insight-oriented, behavior modifying and/or, supportive psychotherapy without medical services provided by licensed mental health professionals.

Description: Procedures 90832-90837 (psychotherapy) are defined as "the treatment for mental illness and behavioral disturbances in which the physician or other qualified health care professional through definitive therapeutic communication attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development." (CPT 2013, *Professional Edition,* p.485)

Documentation: The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment.

Procedure codes 90832-90838 (psychotherapy for 30 to 60 minutes) – report the code closest to the actual time (i.e., 16-37 minutes for 90832, 38-52 minutes for 90834, and 53 or more minutes for 90837. Procedure codes 90833, 90836 and 90838 are add on codes that should be used only in conjunction with evaluation and management (E/M) codes 99201-99239, 99304-99337, 99341-99350).

Comments: While a variety of psychotherapeutic techniques are recognized for coverage under these codes, the services must be performed by persons authorized by their state to render psychotherapy services. Healthcare providers would include: physicians, clinical psychologists, registered nurses with special training (as described in the "Indications" section), and clinical social workers. Medicare coverage of psychotherapy procedure codes does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. Therefore, procedure codes 90832-90838 should not be used to bill for ADL training and/or teaching social interaction skills.

Psychotherapy that include an evaluation and management component (90833, 90836, 90838 are payable only to physicians, NPs, CNSs and PAs. The evaluation and management component of the services must be documented in the record. A psychotherapy code should not be billed when the service is not primarily a psychotherapy service, that is, when the service could be more accurately described by an evaluation and management or other code.

The duration of a course of psychotherapy must be individualized for each patient. Prolonged treatment may be subject to medical necessity review. The provider must document the medical necessity for prolonged treatment.

B. Codes 90846-90853 represent family psychotherapy, with or without the patient present, and group psychotherapy

Codes 90846, 90847, 90849:

Description: Procedure codes 90846, 90847, 90849 describe the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. Code 90846 is used when the patient is not present. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions to support multiple families when

similar dynamics are occurring due to common issues confronted in the family members under treatment.

Documentation: The medical record must document the conditions described under the "Description" and "Comments" sections relative to codes 90846, 90847, and 90849.

Comments: *The Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Section 70.1, states that family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:

- When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (90847).
- Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient (90846 or 90847).

The term "family" may apply to traditional family members, live-in companions, or significant others involved in the care of the patient. Codes 90846 and 90847 are not timed but are typically 45 to 60 minutes in duration.

Codes 90846 and 90847 do not pertain to consultation and interaction with paid staff members at an institution. Facility staff members are not considered "significant others" for the purposes of this service.

Documentation: The medical record must indicate the time spent in the psychotherapy encounter

Code 90849 represents multiple-family group psychotherapy and is generally non-covered by Medicare. Such group therapy is usually directed to the effects of the patient's condition on the family and its purpose is to support the affected family members. Therefore, code 90849 does not meet Medicare's standards of being a therapy primarily directed toward treating the beneficiary's condition.

Code 90853:

Description: Code 90853 represents psychotherapy administered in a group setting, involving no more than 10 participants (some states permit a maximum of 12 patients in a group), facilitated by a trained therapist simultaneously providing therapy to these multiple patients. The group therapy session typically lasts 45 to 60 minutes. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support.

Documentation: The record must indicate that the guidelines under the "Description" and "Comments" sections were followed.

Comments: Group therapy, since it involves psychotherapy, must be led by a person who is licensed or otherwise authorized by the state in which he or she practices to perform this service. This will usually mean a psychiatrist, psychologist, clinical social worker, clinical nurse specialist, or other person authorized by the state to perform this service. Registered nurses with special training, as described in the "Indications and Limitations of Coverage and/or Medical Necessity" section, may also be considered eligible for coverage. For Medicare coverage, group therapy does not include: socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy, etc.

As a reminder, code 90785 is used when the patient or patients in the group setting do not have the ability to interact by ordinary verbal communication and therefore, non-verbal communication skills are employed or an interpreter may be necessary.

DEFINITIONS:

None

Annual Periodic Evaluation and Quality Assurance Review FY 2024

June 1, 2023-June 30, 2024

Introduction

Southern Humboldt Community Health Care District (SHCHD) is in Garberville, California. SHCHD serves a diverse population of Southern Humboldt, Mendocino, and Trinity County residents. The area supports a largely rural area of approximately 775 square miles. It includes the communities of Alderpoint, Blocksburg, Garberville, Harris, Honeydew, Miranda, Meyers Flat, Leggett, Petrolia, Phillipsville, Piercy, Redcrest, Redway, Shelter Cove, Weott, Whitethorn, and Zenia. This service area has a population of about 10,365 full-time residents. In addition to the local community, the hospital and clinic serve several tourists traveling through the area. SHCHD is comprised of the Jerold Phelps Community Hospital, the Southern Humboldt Community Clinic, which is a certified rural health clinic, and the Family Resource Center, as well as a retail pharmacy located on the District's Sprowel Creek Campus at 286 Sprowel Creek Road. Jerold Phelps Community Hospital is a small critical access hospital licensed for nine acute care beds. It can alternately serve as a swing bed program for orthopedic rehabilitation or any patient needing a more extended recovery from a surgical procedure or an illness. Jerold Phelps Community Hospital also encompasses a Distinct Part Skilled Nursing Facility (SNF) with eight licensed beds. Jerold Phelps Community Hospital operates a standby Emergency Department (ED) with four patient care beds and an Emergency Department Physician 24 hours a day, seven days a week. Radiology and laboratory services are available 24 hours a day, seven days a week, through the Emergency Department and on an outpatient basis either through the clinic or upon presentation of an order from a provider-patient relationship during business hours. SHCHD does not offer specialty services but does transfer patients from the ED and/or the acute beds if a patient needs a higher level of care. Referrals can be made through the ED and the Rural Health Clinic for services not offered through the District.

Southern Humboldt Community Healthcare Foundation

Southern Humboldt Community Healthcare Foundation, or SoHum Health Foundation, is a 501(c)(3) non-profit organization supporting the Healthcare District in sustaining high-quality healthcare services in our rural community. The Foundation Board of Directors has nine members who hold board meetings five times per year. The Board has three subcommittees - Finance, Auction, and the Executive Committee. Foundation board

members engage in special events, community outreach, and the solicitation of donations and long-term pledges. The Foundation also hosted an annual auction fundraiser at Benbow Inn in November, which raised $90,498 this year.

SoHum Health Foundation continues raising money to construct our new community hospital and clinic in Garberville. In 2024, SoHum Health Foundation distributed $536,236.57 to the Healthcare District for invoices related to architect fees for the project. This year, the Foundation also provided grant funds to purchase supplies for behavioral health clients and emergency department patients who are struggling with homelessness.

As of the end of Quarter 3 (September 30, 2024), SoHum Health Foundation held $1,862,062.25. These funds were secured through various avenues, including grants, individual donations, business sponsorships, employee giving, and fundraising events. There is roughly $1M in outstanding capital campaign pledges, and the Foundation Board continues to steward and maintain donor relationships to ensure these long-term pledges come to fruition.

Foundation Strategic Priorities FY 2024-2026

SoHum Health Foundation has adopted a strategic plan that includes four priority objectives:

1. Develop and maintain a diverse fundraising program.
2. Maintain a robust and productive relationship with the Healthcare District.
3. Support Healthcare District values, goals, and projects to promote optimal patient and community health.
4. Continue to build and strengthen a sustainable Foundation.

Outreach Department

In addition, the Foundation Development Director serves as the Outreach Manager for the Healthcare District, with the support of a full-time Outreach Coordinator and a part-time Foundation Clerk. The Outreach Department nurtures community partnerships and collaborations and provides ongoing marketing communications to promote health, dispel misinformation, and address community concerns. It serves as a hub between the goings-on of all the departments at the Healthcare District, the Ratcliff architect team, consultants, the media, and the public at large.

2024 Outreach Department Activities:

- Represented SoHum Health at community events, including SoHum Pride, Apple Harvest Festival, Soroptimist's Lighted Truck Parade, North Country Fair, and more.
- Produced marketing and advertisements about health services, including radio, digital, print, and banners.
- Managed SoHum Health's social media and website.
- Recruitment: developed print and digital materials for employee recruitment and represented SoHum Health at Cal Poly Humboldt, College of the Redwoods, and other job fairs.
- Provided communications to KMUD, Redheaded Blackbelt, Times-Standard, Lost Coast Outpost, and other news outlets, including the bi-monthly "Living Well with SoHum Health" column in Redheaded Blackbelt.
- Produced print and email letters and communications to patients.
- Created a large Southern Humboldt map displayed on Redwood Drive in our Humboldt Hunnies storefront with an accompanying brochure.
- Managed and produced all internal signage for our facilities, including mandatory compliance postings.
- Supported other local organizations through sponsorships for activities aligned with the SoHum Health Mission, including school sports, the Shelter Cove labyrinth, and non-profit events.
- Sponsored free exercise classes for the community – Restorative Movement on Tuesdays and Thursdays and Tabata on Tuesdays, Wednesdays, and Thursdays.
- Collaborated with the Family Resource Center to support community members of all ages at Community Baby Showers, Touch-a-Truck, Holding Spaces, and holiday food bag initiatives.
- Produced community updates and press releases related to progress on the new hospital build and hosted two in-person community meetings.
- Served as the liaison between Ratcliff Architects and SoHum Health management in scheduling necessary meetings and relaying communications during the design phase.
- Spearheaded the summer staff campout event, the annual winter party, and other staff and board appreciation events.
- Produced the monthly District Vitals staff newsletter.

- Spearheaded the 2024 Community Health Needs Assessment, including conducting a community survey and compiling the subsequent report.

Acute Care

Jerold Phelps Community Hospital is licensed for nine acute care beds, of which eight currently operate. The ninth bed can be available during an emergency or surge event within a few hours. The hospital treats patients with various diagnoses, including Pneumonia, Exacerbation of Congestive Heart Failure, Exacerbation of Chronic Obstructive Pulmonary Disease, Urinary Tract Infection, Pyelonephritis, Cellulitis Sepsis, Chest Pain, and Shortness of Breath. However, the hospital's admission diagnoses are not limited to these conditions. The hospital takes a holistic approach to patient care and accepts patients if the admitting physician deems the facility can meet their needs based on its services.

Jerold Phelps Community Hospital does not provide specialty services. Instead, it collaborates with other hospitals in Humboldt County through a Community-Wide Call Plan to fulfill the EMTALA requirements for specialty physician on-call requirements.

The staffing for the acute care beds is set per the California Staffing Ratio Law AB 394, which mandates a maximum of one registered nurse for every five patients (1:5). The Acute Care Nurse Manager oversees Quality Assurance Performance Improvement (QAPI) initiatives in conjunction with the Quality Assurance Performance Improvement Committee. The hospital develops quality initiatives for acute care using S.M.A.R.T. goals (Specific, Measurable, Achievable, Realistic, and Time-anchored). Examples of SMART goals for acute care include monitoring Physician Orders for Life-Sustaining Treatment (P.O.S.L.T.) forms, screening for Influenza, Pneumonia, and Tuberculosis on admission, and ensuring that patients are vaccinated against COVID-19.

The Infection Preventionist reviews each patient's vaccination status to ensure that the hospital offers appropriate vaccinations to the community to positively address population health and protect Skilled Nursing residents who may not be able to receive various vaccinations due to allergies or pre-existing conditions. The QAPI initiatives for the Acute Care department are fully integrated into the Hospital-wide QAPI program, overseen by the Quality Assurance Performance Improvement Committee, and reported to the Board of Directors every quarter.

The Acute Care Department's goals for 2025 include increasing local outreach for nursing staff, improving retention of nursing staff, decreasing the number of traveling nurses, and

always maintaining a patient census of 6-7, a combination of Inpatients and Swing Bed status.

Emergency Services

Jerold Phelps Community Hospital runs a standby emergency department. This medical service has a doctor on call to provide emergency medical care in a designated part of the hospital. This area is always equipped and ready to receive patients with urgent medical needs and can offer physician services promptly. (22 CA ADC 70649)

Emergency Department:

The Emergency Department (ED) at Jerold Phelps Hospital is open 24/7 and has a general Emergency Physician on call. The ED Registered Nurses are certified and trained to triage patients using the Emergency Severity Index triage tool, which prioritizes patients based on the severity of their condition and required resources. All ED staff must maintain Advanced Cardiac Life Support (ACLS) and Pediatric Advance Life Support (PALS) training every two years.

Our Emergency Department has provided care to 3671 patients in 2024. Out of those encounters, over 399 of those patients were homeless or had housing insecurity. Our department continues to work with other hospital resources, such as our LCSW and case management support when needed to ensure that we provide compassionate medical care and that they have appropriate resources upon discharge from the hospital. We also began to participate in the CDPH Emergency Department Syphilis/HIV/HCV Screening Program (EDSP). As an ED, we are uniquely positioned to identify and treat those who might otherwise remain undiagnosed, and we can help to reduce care barriers and get treatment to those who may otherwise not receive it.

For quality programs in the ED, we continued to work on our Pediatric Weight/Temperatures and Homeless Discharge Assessment. In the coming year, we hope to begin work on other quality measures, such as the length of time from when the patient enters the Emergency Department until the medical screening exam begins by the physician, known as "Door to Doc" time.

Inpatient/Swing Bed:

Our acute side provided care to 86 admissions, which accounted for 1165 patient days. We also provided care for 108 observation-status patients. For our quality programs in the Acute unit, we continued to work on our Inpatient-OBS Admissions project. The admission

assessment is the first step of the five stages of the nursing process that helps tailor a proper care plan for the patient. We identified the areas we were consistently missing and, with a team of both Acute and SNF nurses, worked together to create an educational board that was presented at Nursing Skills Day in October, and our admission process since then has significantly improved.

We recently added a bariatric bed to our unit, which will allow us to expand our ability to care for a wider population. We continue to support our local community by being a resource for their wound and ostomy care needs, a place where they come back to recover and strengthen before going home. At times, we provide the comfort they need for those who transition to end-of-life care. We have a great team of nurses who truly care for the patients and the community they serve.

Infection Prevention Department

The Infection Prevention Department underwent a year of transition. For nine months out of the year, a traveler RN partially filled the position.

This was a challenging year for the District as it was the first time that COVID-19 reached our skilled nursing residents, and we were unfortunate enough to have some COVID-related deaths due to the outbreak. The nursing staff pulled together with teamwork from other departments such as EVS, Lab, Materials, and Pharmacy; some came early, some stayed late, and some picked up extra shifts to help support the team providing direct patient care.

This year, Infection Prevention was involved in four on-site inspections. One was specific to the SNF unit from CDPH, one related to the disposal of hazardous waste, one specific to the COVID outbreak and the facility response, and the last one was a periodic site review for the clinic from the California Department of Health Care Services.

Our traveler IP left at the beginning of November, and since then, the previous IP nurse has filled the position. We recently hired a full-time infection preventionist from within our District, and we are very excited to have him transition to this role.

Dietary Report for January-Sept. 2024

Monitoring of the Resident Refrigerator for unlabeled, outdated, or uncovered food items brought in by family members and/or staff members for the SNF resident/acute/SWB population.

The Resident's refrigerator is checked once daily by the dietary Staff. Dietary Staff must check for foods in the resident refrigerator with no patient names, no receiving dates, food items not completely covered, and outdates that will be discarded. Dietary Staff then documented in the Compliance Monitoring Report that the Resident's refrigerator was checked that day. According to Dietary policy, some prepared foods that are TCS foods (time/temperature controlled for safety) must be discarded within 24 hours of receipt. Other foods will be monitored for use by date/expiration dates/open dates. The Resident Refrigerator is also monitored for foods that employees may have stored for their own use. The Resident Refrigerator can only store foods belonging to patients/residents. Employees can store their food items in the employee breakroom in the employee refrigerator. A list of what is allowed to be stored and how to store food items for patient/Resident use is posted above the Resident refrigerator and on the door of the refrigerator. The task of checking the Resident refrigerator daily has been assigned to the AM cook shift. Certified Dietary Manager trains Dietary Staff on procedures for checking Resident refrigerators and discarding food products if they do not meet standards. The Certified Dietary Manager also checks the Resident's refrigerator daily during my rounds/monitoring. The process for checking the Resident's refrigerator is also reviewed with Dietary Staff upon hire and during their annual review in-service training.
Regarding the incident on 3/4/2024. Perishable food belonging to patient S.C. was found dated 3/1/2024. The food found was prepared pasta in the sauce from Il Forno. This product should have been discarded on 3/2/2024 by a Dietary cook. I spoke with a cook who worked that weekend. The employee stated that a large brown bag containing those food items was not in the refrigerator when they checked the Resident's refrigerator every morning. They stated, "No way I would have missed a brown bag that big." They noted this could have been moved from the employee refrigerator or the small staff refrigerator next to the SNF manager's office and placed in the Resident refrigerator after the daily check. I asked them to start taking a picture of the Resident refrigerator's contents at the end of each of their am shifts to prove they checked and emptied and discarded foods that needed to be tossed. No issues were found for the rest of the month of March 2024. The cook has been showing me pictures of the resident refrigerator all day. She was scheduled for the morning shift. I have been checking these pictures weekly.

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January 2024 February 2024 March 2024
31 Days correct, 29 Days correct, 30 Days correct
31 Days total, 29 Days total, 31 Days total
100% 100% 97%

April 2024 May 2024 June 2024
30 Days correct, 31 days correct, 30 days correct
30 Days total, 31 days total, 30 days total
100% 100% 100%

July 2024 August 2024 September 2024
31 days correct, 31 days correct, 30 days correct
31 days total 31 days total 30 days total
100% 100% 100%

Infection Prevention/Employee Health
Covid-19 Immunization/Testing

The Infection Prevention Program, in concert with the Infection Prevention Registered Nurse, oversaw and offered COVID-19 immunizations to all employees who requested the vaccine. The Infection Prevention Program, with the assistance of nursing personnel, vaccinated all Skilled Nursing Residents (SNF). All residents were up to date with the CDC definition.

During FY 2023, the federal Public Health Emergency (PHE) for COVID-19 was officially ended in May 2023. At the end of the second quarter, there was a 95% vaccination rate for hospital employees. For contracted Staff, the vaccination rate for the primary dose is 100%, and all but one had consented to receive the mandated booster vaccine. 57 employees were considered up to date by the end of the PHE.

All new admissions to the Facility are tested upon admission and again on day 3 and day 5. As long as they remain asymptomatic, confinement to the patient room is not required, but masking when in the halls and other common areas is requested and encouraged. For those

admitted who are unvaccinated, we offer education and the vaccine for those who request one.

COVID-19 symptoms screening of SNF residents/Acute patients continues to be conducted daily.

Employees and Visitation

During FE 2023, masking mandates were lifted for employees and visitors, and they were permitted to begin self-screening for symptoms before entry to the hospital. Visitors were requested not to visit if they had symptoms, and employees were required to wear masks and report symptoms to their managers and IPs, who would determine if further testing was needed. The Facility masking mandate continued for the Acute/SNF unit. A total of 43 employees tested positive for COVID-19 in FYE 2023. Response testing was performed when the criteria were met. No cases of COVID-19 in SNF residents were ever detected. Twice-weekly testing for unvaccinated employees is no longer required if asymptomatic.

Rate for Hospital: 95% vaccination rate, with 58 employees who had received the bivalent vaccine and were considered up to date, for an up-to-date vaccination rate of 47%.

6% of hospital employees were unvaccinated.

Influenza Immunization Program:

We continued with the policy requiring surgical masks for unvaccinated healthcare personnel for the 2022-2023 influenza season.

- Approximately 67% of employees, contract staff, and licensed independent practitioners had received the seasonal influenza vaccination.
- All Skilled Nursing Residents were vaccinated, but despite being vaccinated, five residents developed influenza-like illness (ILI), and three of those residents tested positive for Influenza A early in the 2022-2023 Flu Season. All were vaccinated before their positive tests. All residents, even those asymptomatic, were treated with antiviral medication per hospital policy. Droplet precautions were initiated for all involved.

Evaluation: The staff vaccination rate of 72% fell short of the Healthy People 2020 revised goal of 90% for the influenza season. We suspect that the mandatory masking during the pandemic continued to be a deterrent to getting the vaccine to avoid having to wear a mask.

· 85 employees received Flu vaccinations from the District

New Employees:

Thirty new employees were hired in 2023 FYE. All were screened for immunity (by vaccination or titer) to measles, mumps, rubella, and varicella. Nonimmune employees were offered the appropriate vaccine(s) at no cost. All employees were offered the Tdap vaccine if they had not previously received it. Those with occupational risk for bloodborne pathogen exposure were screened for immunity to hepatitis B and offered the vaccine series if not immune.

Evaluation: The vaccine screening process is functioning well. There will be no changes at this time.

N-95 Particulate Respirator Program:

As required by the Aerosol Transmissible Disease program, all employees who have the potential to encounter aerosol-transmissible diseases must be fit-tested for respiratory protection to decrease the possibility of disease transmission. Employees must be fit-tested upon hire and annually. The Facility does not have unfavorable airflow rooms for patients with suspected airborne disease. Therefore, patients with airborne conditions are transferred as soon as possible.

- 23 employees were successfully fit-tested for N-95 respirators in FY 2023.

Evaluation: Annual FIT testing will be performed upon hire and then annually in March and September. I have trained and enlisted Clinic LVN to assist with FIT testing for new hires, travelers, and employees.

Infection Prevention Program:

FYE 2023 Accomplishments

- Healthcare-associated infections: One publicly reportable healthcare-acquired infection occurred in FYE 2023.
- Policies and Procedures: The Infection Prevention Department's Policy and Procedure Manual is being reviewed and updated as appropriate. Numerous changes to the policy and procedure process have delayed progress, but by the end of FYE, 30+ policies have been reviewed and updated as appropriate. Final approval through med Staff and the Board is pending.
- Infection Prevention Committee: The Infection Prevention Committee held three meetings in FYE 2023. Meeting reports are sent to the Medical Staff quarterly.
- Sterile Processing: Sterile processing is no longer done in the District due to challenges in finding Staff with the available time to train and perform the duties with

enough frequency to ensure competency. The District switched to single-use instruments throughout.

- Antibiotic Stewardship Program: Monitoring and tracking of inpatient antimicrobial orders continue, and Infection Prevention continues to follow up with positive ED, Acute, Inpatient, Observation, Swing, and SNF cultures, communicating to MD/NP and patients if an ineffective antibiotic has been prescribed. The plan is for the Antibiotic Stewardship Committee to hold quarterly meetings. In FYE 2023, three meetings were held. In the first Quarter of the FY, no meeting was held. Meeting reports go to the Medical Staff quarterly.
- Water Program: The Water Program has not been a priority since the pandemic; plans are being made to revisit it in the next fiscal year. The Infection Preventionist is scheduled for a Water Management Program Development workshop to understand the IP role further. Engineering continues to keep logs of changes in water filters and monitor the courtyard fountain when it is in use. The report is sent to the IPC meeting as part of the Engineering quarterly report.
- Environmental Rounds: Five Environmental Rounds were performed in FYE 2023 with IP, Department Managers of Skilled/Swing and Acute/OBS, and EVS lead. Acute/SNF, ED, including ED entrance and registration area. Since the primary focus has been survey readiness, the ACUTE/SNF and ED physical environment were inspected for cleanliness, safety, supply outdates, repair, and other issues. Findings were sent to the appropriate managers for correction, and results were reported to the medical Staff quarterly. The plan in the future with the Infection Preventionist will be for quarterly environmental rounds to be performed with areas to be divided up into four major regions: hospital, clinic/lab, administration, and Sprowel Creek Campus. Beginning Q1, 2024, plan to schedule each location for each quarter.

Laboratory

Laboratory

<u>New Year, New Laboratory Services</u>

The lab continued expanding its offerings for the care of our patients in 2024.

- HIV testing is now performed in our laboratory and available on a stat basis, supporting the testing of all adults who have blood tests in our ED except those who opt out. We have also been sending out specimens from these patients for syphilis, and Hepatitis C testing under the EDSP grant SoHum Health was awarded last year.

Testing implementation within the time required under the grant secured a substantial financial award. Even better, we are confident that this program will identify people with these diseases of public health concern, connect them to treatment, reduce transmission of the diseases, and ultimately save lives.

- Providence ended outpatient laboratory services under its contract with LabCorp, so our lab has seen an influx of patients outside our District. Although it is difficult to quantify, we regularly see laboratory outpatients who would previously have received services in North County.
- Testing for blood cultures – the first traditional microbiology in the SoHum lab in at least 15 years – has completed the required verification studies and will soon be rolled out for patient testing.

We expect to continue offering new services in 2025, though we are being selective because this year's focus is on completing what is in progress and stabilizing services across the District.

- PCR-based identification of pathogens found in the blood cultures we perform;
- Evaluation of spinal-fluid specimens in suspected cases of meningitis;
- Implementation of the MDW, an additional piece of data from a complete blood count that can indicate bloodstream infection in ED patients;
- In-house stat screening for syphilis (bringing more of the EDSP-testing algorithm into our lab with much faster results).

Epic, Year 2

We began to like our Epic EMR and its Beaker laboratory information system in 2024. Although we got off to a very rough start in 2023, this year has been marked by a reasonably stable EMR/LIS and a reliable support relationship with OCHIN, the collaborative that provides Epic to us. For example, when a patient comes to us with an order for a test that has not yet been set up in Epic, it used to take weeks for OCHIN and us to take all the steps to configure the test record. Now, these requests are handled so quickly that our Epic is often configured for the test before the result comes back to us from Quest.

The struggle continues with work queues – lists of patient tests or accounts that some error has held up. Mid-year, we had more than 100 cases of patient charts held up in one or more work queue for various reasons, holding up more than a million dollars of billing. This situation did not risk harm to the patient, but it was a financial calamity. Our lab hero Todd

Gregory took the lead in working through this backlog, and with support from lab and billing teams at SoHum and OCHIN, these work queues are now caught up and being managed on a routine basis.

COVID-19

Although the declared public health emergency is over, COVID-19 continued to be a factor during 2024. After the SoHum team valiantly – almost miraculously – fending it off from our skilled nursing facility for more than four years, cases occurred among our residents and triggered a massive wave of testing – residents, patients, staff, volunteers, and visitors. This event reminded us of the need to be vigilant and prepared. Having two test systems—one rapid-molecular and one PCR-based—able to perform testing for SARS-CoV-2 allowed us to offer the right combination of speed and testing sensitivity in each situation and ensured we did not run out of testing supplies.

This autumn, we've also seen a rise in people with upper-respiratory infections whose COVID-19 were negative. We are evaluating the possibility of implementing a one-and-done panel of respiratory pathogen testing that would include the COVID-19 virus, influenza viruses, and a panel of other respiratory pathogens. The panel is available on the same platform that will do our testing for blood culture pathogens rather than requiring its own test system. It might also replace one of the current systems for COVID-19 testing, saving space and costs.

Accreditation and Licensure

This part of maintaining our laboratory caused more concern this year. We did all the right things, but the California agency tasked with processing the renewal of our federal license (known as a CLIA certificate) disregarded our communications for almost six months. By November, we were becoming concerned about completing our biennial renewal before the current CLIA certificate expires in late January 2025.

What was a source of great concern turned into a series of blessings. First, the head of the federal CLIA program assured us in writing that we would be deemed compliant, even if the state failed to process our paperwork timely. Next, we joined an organization known as ACHC, a non-profit healthcare accreditation agency whose member laboratories are held to high standards and deemed automatically compliant with federal and state regulations. Although this new affiliation will require an extensive rewriting of our lab's policies and procedures to align us with ACHC's standards, we look forward to the process as a kind of

"fresh start" for the paperwork side of our operation. As of this writing (December 19, 2024), the state has acknowledged that our CLIA certificate renewal application is complete, and we have paid our fees, so renewal for another two years is assured.

Personnel

In 2023, this section began: "Our lab is fully and excellently staffed."

For 2024, we will open it this way: "Our lab is fully and excellently staffed."

The lab team of Todd, Joy, Shyanna, Jennifer, Selena, and Adam continues operating as a well-oiled team despite a tough year on many fronts. Having zero lab turnover for more than two years has been a huge blessing. We continue to enjoy the leadership and support of our CNO, Adela Vargas de Yanez, and our laboratory medical director, Dr. Fangluo Liu.

Last year, I also said: "The challenge ahead with staffing isn't hiring but sustainability. Burnout is real after the pandemic and the Epic transition." The past year has not relieved this situation. We are sustaining, and the seamless support of each other has allowed those of us most in need of time off or support to carry on, but we are doing it in the face of increasing test volumes and ongoing projects.

We look forward to the district strategic plan's focus in 2025 on completing projects in progress and stabilizing existing services rather than our usual menu of ambitious new ones.

Gratitude

Although many deserve gratitude, I'd like to recognize Adam Dias. He's jumped into his role of coordinating the EDSP grant program like a man on a mission. His fresh perspective and optimism have kept us hitting milestones I didn't believe we'd hit, which will turn into saved lives and funds that expand our mission. He also has played a key role in implementing the MCN system for policies and procedures that the lab can use to inundate the policy development committee, med staff, and Board with more than 100 redrafted P&Ps. Thanks to Adam and his colleagues in the Quality department; it will at least be a smooth and orderly process.

On behalf of the whole lab team, I am grateful for a year of supportive colleagues, heartwarming patients, and good leadership. This isn't the place for details, but several of us faced bad news personally or in our families this year that could mean real tragedy. Grace and fortune brought all of us through—a blessing we know was no.

Radiology

Radiology FY 2024

From 7/1/23 until 6/30/24, the Radiology department provided diagnostic X-rays utilizing DR (direct radiography), CT scan services utilizing a 64-slice GE Revolution Evo 770 CT machine, and screening mammography utilizing a Hologic Full-Field Digital 3D mammography machine. The department also provided Ultrasound exams utilizing our new GE LOGIQ E10 Ultrasound machine.

For the fiscal year 2023, the radiology department performed a total of 3,814 exams:

- 2,018 X-ray exams
- 266 screening mammograms
- 1,078 CT scans
- 451 US exams

The radiology manager and the director oversee Quality Assurance/Performance Improvement (QAPI) Initiatives for Radiology. Currently, the goal is to meet the quality measures for mammography.

Radiology goal FY 2024

The Radiology department hopes to add DEXA services and relocate to the US to accommodate patients in wheelchairs or walkers for FY 2024.

Materials Management

Over the last year, we have had many changes in Materials, continuing to optimize our Netsuite and EPIC systems.

- Materials PNPs were added to the MCN folder.
- We established a charge table for chargeable items and are working with them to make them scannable.
- Glen has been trained as a backup for Materials. When Nechia is on vacation, he can help with ordering and dispensing materials.
- Working with a new consulting company for Netsuite. Making sure all new GL codes are used correctly.
- Contracting continues to be time-consuming. We have been using Quality reporting to track our renewals and new contract data, which has helped keep everything updated promptly.
- We are working with Architects on the new design for Materials, and we are very excited to see our new space.

- I completed the ADS feed for contracts with Cardinal and Netsuite.
- Valuation reports are performed 2 to 3 times a month, which helps with inventory accuracy.
- Continue to monitor outdated materials monthly in all locations.

Goals for FY 2024

- I am working in the new MCN to update our Materials policies and procedures. I hope to complete this **by March 2025**.
- We want to have scannable items completed **by March of 2025**.
- We are continuing to have issues with IV solutions. We are ordering weekly to try and keep ahead on this. We are also working with pharmacy and nursing to make sure they are dispensing and ordering according to what we can get in stock.
- Backorders are increasing from our central warehouse. We continue to adjust our inventory and manufacturers according to what is available.

340B Program

SHCHD implemented a 340B program that went live on October 31, 2017. The program aims to help our community by providing lower-cost medications to our cash-paying customers. We receive discounts through the program, which we pass on to our cash-paying customers. Since we are a rural health center, this is helping our patients receive their medications and be more compliant with taking them.

- Our savings and profits have increased rapidly over the last few years. We are on track to over 800K this year.
- We currently work with two contract pharmacies. Garberville Pharmacy and Walgreens.
- Garberville Pharmacy is contracted with Redwood Rural Health, and we have formed a great partnership to help more community members get what they need.
- We work monthly with RRHC, Pharmaforce, and Cervey to receive the best capture.
- This year, we identified new eligible hospital locations, which has helped increase our medication cost savings.
- Continuing monthly internal audits: Recently, we changed our outside audits to monthly ones.
- UD modifiers are being uploaded correctly to all Split use bills. We continue to audit monthly to ensure ongoing accuracy.

Goals for FY 2024

- Continue monitoring closely with monthly audits of the Split billing and contract programs.
- We found an issue with the 340B capture at the retail pharmacy. Carvey had accidentally carved in partnership/medical claims. We found this issue within a few months and reversed all incorrect claims. To ensure the problem is fixed, we are continuing internal monthly audits and adding external monthly audits for the next six months. The survey gave us credit for the months that affected our program.
- We now have a new referral coordinator. I want to start a conversation about referrals in the 340B modules. This will create much more auditing, so I want to be sure before we turn it on.
- We are working with RRHC to maximize their capture. We recently had an issue with their TPA and turned off their auto-replenishment, which greatly impacted our October and November profitability.

Patient Financial Services

General:

The Revenue Cycle, including registration/ PFS for the clinic, emergency department, and hospital, is responsible for assisting patients while in the Facility, handling the flow of information, paperwork, and follow-up to ensure that patients are billed appropriately, and the facility operates within compliance with the law and CMS guidelines.

- Register patients for the full range of services offered by SoHum Health. This includes verifying the patient's identity, updating all demographic and relevant information, obtaining patient insurance information, and determining how to properly order and bill the services provided to the payor(s).
- Request, verify, and file patient medical records. Work with patients and providers to ensure all needed documentation is in the patient's chart.
- Work with Staff in all departments to ensure that legal and compliance requirements are met and proper documentation is obtained.

FYE 2020 Summary:

Patient Financial Services

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- Request, verify, and file patient medical records. Work with patients and providers to ensure all needed documentation is in the patient's chart.
- Work with Staff in all departments to meet legal and compliance requirements and obtain proper demographic documentation.

2024 Summary:

Projects:

Quality Measures

Hiring & Cross -Training Employees in all areas of the PFS department

Workqueus

HACI reporting- Hospital Fair Billing & Price Transparency

SWG Program- Building a strong SWG program with the UR team.

New Services: PT/OT/BH/ Mobile Optometry

Accomplishments:

The PFS department has had a challenging year and has accomplished several things.

Submitted HCAI Report by due date 1-1-25 with all changes required by the state.

Quality Measures for Breast Cancer Screening and Tabacco Screening. With Staff from the clinic, PFS, and the quality team working together, we met this year's Quality Measures.

We hired new employees for PFS in March and November. Some of them came with experience with Epic and other EHR systems. We have spent most of the year cross-training in all areas of PFS, including additional AUTH & TAR training and outpatient training. I also had Panda jump into the referral role in the clinic, as we had a team member out on leave to fill in for 12 weeks.

We spent many hours working with ESA/Ochin on the EPIC build, verifying UAT scripts/workflows, and trying to work out the bugs in PFS.

We added Fortuna Optometry to the District with staffing this year. I am working side-by-side with Jacob during this transition. I am working on getting Dr. Miskin's credentials while he shadows Dr. French.
We end the 2024 year with patient visit counts showing how busy the PFS staff have been.
Emergency room visits: 3561
Inpatient Visits: 25
LTC visits: 10
Swing Bed Visits: 42
Clinic Visits: 5870

QAPIC

Quality Assurance Performance Improvement Committee

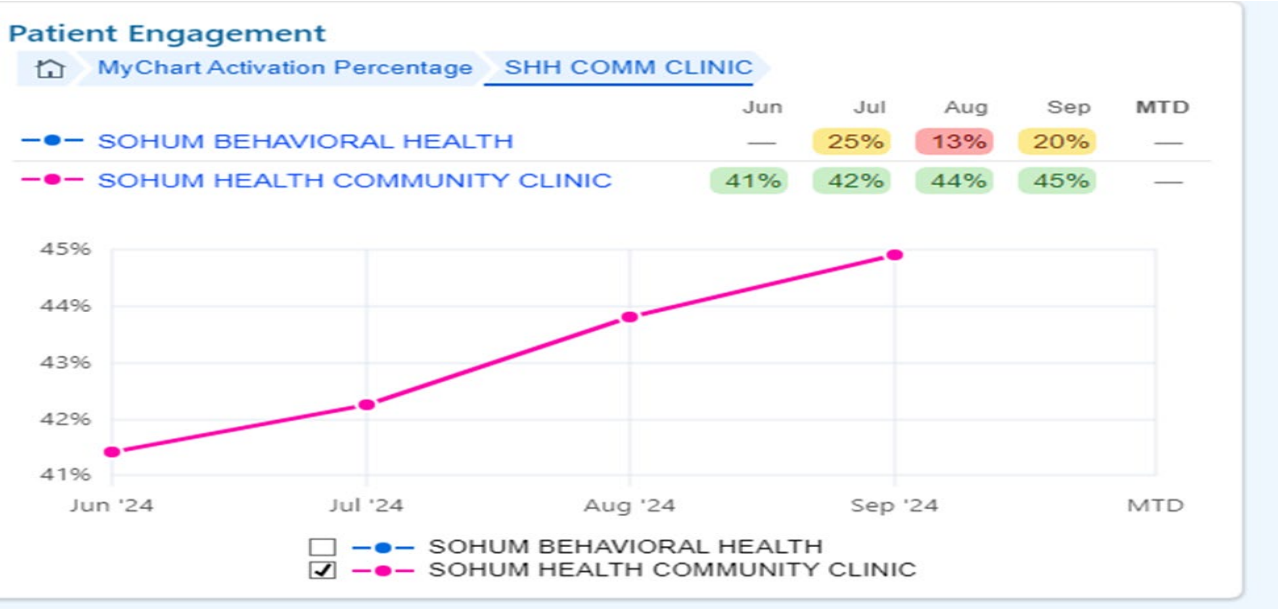
Clinic

The goal is to increase the number of clinic patients signed up for MyChart by 50%, allowing them to access their health information in a more timely and efficient manner. To achieve this, clinic staff will assist patients with the sign-up process and provide ongoing support as needed. This initiative aims to improve patient satisfaction and engagement by empowering them to take an active role in managing their healthcare.

Progress will be tracked by running an initial report to establish how many patients are currently signed up for MyChart, followed by monthly reports to monitor new sign-ups. The clinic staff are already trained to send patients the sign-up link and assist them if needed. The motivation behind this goal is to enhance patient satisfaction and streamline access to important health information, aligning with the broader objective of improving communication between patients and providers.

The effort required is reasonable given the significant benefits of increased patient engagement and communication. The goal is set to be completed by December 31, 2024, with continuous monitoring to ensure that it is realistic and achievable.

Current Progress:



Environmental Service

This quarter was particularly eventful, as we conducted three QAPI reviews, all focused on the Clinic. Although the initial goal was to complete more, we faced some challenges that limited progress.

- **August**: One QAPI review was conducted in Room 4 with a new team member. The new hire is showing good progress, though there was one area missed during the review.
- **September**: A review was conducted in Room 7, this time with an experienced Environmental Services staff member. The performance was excellent, with no areas missed.

- **October**: We revisited Room 4 for another QAPI. While one item was missed, the overall performance remains strong, with continuous improvement being a key focus.

We look forward to further progress in the upcoming quarter as we continue to strive for excellence in our environmental services.

H.I.M.

2024 Goal:

By the end of calendar year 2024 the HIM Department will ensure that our departmental policies and process comply with applicable federal and state regulations. We will review and update our policies to adhere to the most up-to-date laws and regulations.

How this will be measured: We will quantify our progress via percentage completion of total policies and procedures overhauled/reviewed.

Monthly Updates

February: 51 Policies or Procedures are identified as needing updating.

March: 9 additional policies missing procedures are identified.

April: Drafts sent to Remy for approval.

May: We have now identified 62 items needing updates/review.

June: Policies and Procedures must be recombined before being submitted for approval. We lost Jason Hendrix as HIM Lead.

July: Remy submitted 6 recombined draft to the board. The board approved all 6! New hire training is taking time away from the project. Additional time will be available after training is complete.

Q3 Update

This past quarter, HIM faced several challenges that impacted progress on the Policy and Procedure (P&P) updates. Personnel changes and a two-week delay caused by issues accessing the MCN folder on the S: drive slowed the project significantly. Despite completing training and seeking assistance, uploading the HIM P&Ps to MCN has been a trial-and-error process, resulting in inefficiencies and wasted time.

Key progress includes:

- 28 previously approved P&Ps have been re-combined, updated to the new template, and uploaded to MCN.
- 5 P&Ps have been submitted to and approved by the Policy Development Committee (PDC).
- 5 additional P&Ps have been reviewed and are ready for further revisions.

In terms of progress:

- 18% of P&Ps have been approved.
- 36% of P&Ps have been reviewed and are in the process of revision.

Possible Challenges

Other projects continue to pop up and take priority away from the Goal. Changes to MCN and combining the Policies and Procedures into one document is taking additional time. HIM Department personnel being onboarded will help to free up resources.

Progress has been made in transferring existing P&Ps into MCN, but learning to navigate the system efficiently, particularly with features like tracking changes, has taken more time than anticipated. While the system functions properly, there is still a learning curve in mastering its tools, which has slowed down the process. To ensure accuracy, we have been downloading P&Ps for revisions, which adds extra steps. Despite this, we are continuing to learn and improve, and we remain confident that with our current staff and resources, the updates will be completed on time.

Infection Prevention

Hand Hygiene

Research (ongoing since Ignaz Semmelweiss c.1847) has consistently demonstrated that appropriate hand hygiene by healthcare workers is the single most effective way to prevent healthcare associated infections. The CDC strongly recommends that healthcare facilities provide hand hygiene programs with compliance monitoring and feedback.

Monitoring occurred in Q3 by the Infection Prevention department with assistance from EVS and Nursing leadership with use of a compliance tool developed by CDPH.

Staff compliance with hand hygiene is observed before entering and upon exiting patient rooms ("gel-in, gel-out") and after providing care.

Data includes:

- # of observations completed
- # of times hand hygiene was performed
- Compliance rate

Results:

Hand Hygiene Compliance	**July 2024**	**August 2024**	**September 2024**	**2024 Q3**
Total # HH Successful	71	87	122	280
Total # HH observations	90	90	130	310
RATE:	78%	96%	93%	90%

Evaluation:

- Hand Hygiene compliance for Q3 was 90%. The goal was 95%. Hand hygiene education continues to be assigned for all new hires and travelers with return demonstration of competency shown along with review of hand washing with soap and water as well as verbal review of how to properly use alcohol-based hand sanitizer.
- Hand hygiene education was reviewed at Nursing Skills day in May 2024.

Plan:

Continue to enlist help from managers and other staff members to perform hand hygiene surveillance. Results are reviewed with nursing staff at quarterly meetings, Patient Safety Committee and Infection Prevention Committee.

Admission MRSA Screening (required by California SB 1058 and SHCHD policy)

A total of 18 patients were admitted in Q3 2024 as acute in-patients or Swing Bed patients and required MRSA screening. Screening is not required for Observation patients.

- ☐ 17 out of 18 patients (94%) received admission MRSA screening within the first 24 hours.
- ☐ Of the specimens collected, one was positive.

Results/Evaluation:

- 94% of admissions were screened for MRSA in Q3 2024. Quarterly goal of 100% compliance was not met. One screening was not collected within the 24-hour from time patient was admitted.

MRSA Screening	**July 2024**	**August 2024**	**September 2024**	**2024 Q3**
# of patients screened within 24 hours	9	4	4	17
# of patients that	10	4	4	18

required screening				
RATE:	90%	100%	100%	94%

Plan:

Infection Control will continue to utilize MRSA collection kits, continue to monitor, provide feedback to nursing, and report to QAPI committee.

Materials Management

We are continuing to print Inventory reports monthly and adjust items to be Non-inventory or Inventory, depending on necessity. We are also adjusting quantities and shelf locations as needed. This continued auditing will make our semi-annual inventory much smoother.

CONTRACTING:

I have had a lot of contracts coming up for renewal or needing new contracts signed and loaded.

I will be meeting with our Vizient account manager to review eligibility and any new contracts due to purchase changes.

I have started QAPI on Vizient contract renewals.

340B:

We are starting a new QAPI on 340B Split use audits in June 2024. We were able to identify a possible opportunity for capture in CT locations. I will be meeting with Cervey and ACI to implement a new location capture.

I had a recent auditing issue with our Contract pharmacy billing. Medical claims were being captured due to a Cervey issue. We were able to reverse all captured claims and mark them as ineligible. To keep this from happening again, I have asked for ACI to do outside auditing monthly for the next 6-12 months. I will also be doing monthly audits.

Patient Financial Services

We collaborated closely with TruBridge/HRG, Human Resources, and the Quality departments to successfully credential new providers, including Licensed Clinical Social Workers (LCSWs), physical therapists, and occupational therapists. This initiative is essential for enhancing our service offerings and ensuring that we have a robust team in place to meet patient needs.

In addition, we partnered with Employee Health and Pharmacy to set up the system for employee COVID-19 and flu vaccinations, ensuring that our staff vaccine clinics can commence by October 1st. This proactive approach reflects our commitment to maintaining a healthy workforce and safeguarding the well-being of both staff and patients.

We also undertook a comprehensive review and update of the job descriptions for both nighttime and daytime registration roles. Following the posting of the nighttime registration position, we received an impressive 19 applications. After a careful evaluation process, we interviewed several candidates and identified two exceptionally strong contenders for the nighttime ED registration position, enhancing our team's capability in this critical area.

Furthermore, we engaged with Panda and Mara to implement cross-training initiatives aimed at providing additional support for authorization/TAR and outpatient scheduling as we expand our services. This strategic move is designed to improve workflow efficiency and ensure that our staff is well-equipped to handle the increased demands. During this time, Panda also stepped in to assist with clinic referrals while a staff member was out of the office from early August through the end of September, showcasing our team's adaptability and commitment to continuity of care.

Skilled Nursing Unit (SNF)

Project: Correct and Monitor Deficiencies from State Survey

In March 2024, Jerold Phelps Skilled Nursing Unit received six standard deficiencies, with no substandard findings. The average number of deficiencies in California is 10, making our results better than average. This survey increased our Star rating from 1 to 2.

The six deficient practices identified were failures to:

1. Ensure psychotropics were adequately consented to and monitored.
2. Adequately follow up on psychotropic dose reductions.
3. Present baseline care plans in a timely manner.
4. Create comprehensive care plans for unique resident situations.
5. Ensure safe smoking assessments, care plans, and smoking areas.

Psychotropic Consents

	July 2024	Aug 2024	Sept 2024	2024 Q3
# completed	6	6	6	18
# required	6	8	6	20
% Compliance	100%	75%	100%	90%
Root Cause	The Admissions process checklist needs to be updated to remind admitting nurse to obtain consents for residents on Psychotropics.			

Dose Reductions

	July 2024	Aug 2024	Sept 2024	2024 Q3
# completed	1	1	3	7
# recommended	1	1	3	7

% Compliance	100%	100%	100%	100%
Root Cause	Thank you to PJ and Dr. Rogers for 100% compliance from date of survey			

Baseline Care Plans

	July 2024	Aug 2024	Sept 2024	2024 Q3
# completed	5	4	5	14
# required	5	6	5	16
% Compliance	100%	67%	100%	88%
Root Cause	Admissions should be clearly communicated to administrative team so that baseline care plans and MDS can be completed timely.			

Comprehensive Care Plans

	July 2024	Aug 2024	Sept 2024	2024 Q3
# completed	160	101	160	421
# required	160	160	160	480
% Compliance	100%	63%	100%	88%
Root Cause	Admissions should be clearly communicated to administrative team so that Comprehensive Care Plans can be done in timely manner			

Smoking Deficiency

The smoking deficiencies present a unique challenge. The facility has mitigated much of the risk by declaring the campus non-smoking. However, this may not fully eliminate the risk,

as one resident with a medical history of smoking continues to pose a challenge. This deficiency carries the potential for substandard severity.

Plan: We will continue to audit for compliance, address omissions with nursing staff, and provide additional training as needed. We will explore further strategies to mitigate the risk of future smoking-related deficiencies.

SNF Activities

Summary:

This month, we experienced a virus outbreak in the Skilled Nursing Facility (SNF), which spread quickly and affected many residents. During my visits, most residents preferred to rest and sleep, with only a few needing extra attention from activities. I continued to make rounds and provided treats like ice cream bites, chocolate, and onion rings, which were the favorites. The Memory Care patients had a harder time with isolation, and one patient became particularly restless. The staff did an excellent job maintaining calm while showing great patience. Overall, everyone handled the increased workload admirably.

In addition to managing the virus outbreak, I kept busy researching, preparing craft projects, and reading about Dementia and one-handed adaptations for daily living. I also assisted with various errands, such as gathering clothing for residents who needed it.

Key Activities:

- Continued working with a resident who has difficulty with manual dexterity. I created a chest tray to help her manage spills when eating from small containers.
- Prepared stone flower craft blanks for residents to paint. These are plaster-cast flowers glued to river stones for painting.
- Wrote a grant to provide an extra pair of shoes for a resident.
- Arranged for the brakes on a resident's chair to be repaired.

- Coordinated a swing patient's trip to Eureka to ensure a smooth experience on the day of the appointment.
- Continued reading on Dementia and strategies for working with Memory Care patients.
- Progressed on an ongoing birdhouse painting project.
- Held a Gelli Plate printing session with a resident.
- Developed meaningful busy work for a Memory Care patient in the swing unit.
- Took a resident to pick up his hearing aids, followed by a lunch outing in town. He was very appreciative.
- Assisted a swing patient with transportation to his final doctor appointment and getting his walker. I also helped him settle back into his home afterward.
- Organized a pizza party for residents and staff to show appreciation for their hard work.
- Shopped for crafting supplies.
- Ordered a typewriter ink ribbon for a resident who requested it.
- Gathered stones for upcoming projects.
- Prepared comfort care music for a sick resident.
- Worked on clearing the Relias backlog.
- Created a chest tray assistive device for a resident to help collect spills and added a small plate to the call buzzer to prevent it from falling off her bed.
- Set up tablets in the acute/swing unit for Netflix use and provided a container for safekeeping.
- Created memorial buttons, desk photos, and candles to honor residents who passed away.

Throughout this month, my focus remained on providing support to residents and ensuring they had meaningful activities and resources during the challenging circumstances.

No Report Submitted

Accounting, Acute Department, Behavioral Health, Dietary, Emergency Department, Information Technology, Laboratory, Radiology, Pharmacy-In House, Pharmacy

Quality and Compliance Department

Below is a list of highlighted projects. This is only a portion of the current projects, but some of the most important projects include:

1. **MCN- Policy & Procedure (P&P) Project**
    - *Project Coordinator*: Adam Dias
    - *Status:* Ongoing
    - *Description:* The transition to compliance with regulations and standards for policy and procedure is a significant project managed by our department. This project's impact extends across all aspects of our facility, including planned initiatives like building a new hospital, transportation, optometry, and mobile health. Despite its importance, this project lacks a defined budget or revenue stream, making its cost and savings unknown. This has been a difficult and time-consuming project. It will take time to get policy and procedure to where it needs to be across departments with the various competing priorities. Hopefully this project will require less time going forward but has

required a lot of time to this point. We had a temporary employee assisting with a lot of the manual entry. That employee's temp status has ended and they are no longer with us, so we are moving forward with less man power.

- *Full-Time Equivalent (FTE):* 1.50

2. **Emergency Department Screening Program (EDSP)**
    - *Project Coordinator:* Adam Dias
    - *Funding:* $375,000 State Grant
    - *Description:* Upgrade Lab equipment, implement opt-out testing for HIV, Syphilis, and HCV (Hep-c) testing in ED. The project represents a critical addition to our services, facilitating opt-out testing for sexually transmitted diseases in our community.
    - *Duration:* 2.5 years
    - *FTE:* 1.00
3. **UCLA Clinical Trial**
    - *Project Coordinator*: Kristen Rees
    - *Funding:* $400,000 Federal Grant
    - *Description:* Clinical Trial with UCLA. This study presents a rare opportunity and is moving forward.
    - *Grant Responsibilities:* Site principle investigator, Kristen Rees, is overseeing site implementation. Research assistants very helpful.
    - *Duration:* 2 years
    - *FTE:* 1.50
4. **Equity, Practice, Transformation (EPT) Quality Improvement Program**
    - *Project Coordinator*: James Dement
    - *Funding:* $375,000 State Funding Mechanism (subject to Governor's budget)

- *Description:* Project management for clinic practice transformation state grant.
- *Duration:* 5 years
- *FTE:* 0.2

5. **Small Rural Hospitals Improvement Program (SHIP)**
    - *Project Coordinator*: Kristen Rees/James Dement
    - *Funding:* $13,000+ State Grant
    - *Description:* Grant for process improvements in rural facilities. We are contracted to participate in this grant for 5 years. We are in year two. Each year the funding amount is different, but similar. This program can be frustrating, especially for how relatively small the amount is and the reporting requirements. That said, it is a grant that allows us to apply for other grants. We were able to win COVID and ARP SHIP grants in the past because we participate in this program.
    - *Duration:* 5 years (amount renewed annually, contract renewed every 5 years)
    - *FTE:* 0.05
6. **FLEX Grant**
    - *Project Coordinator*: Kristen Rees
    - *Funding:* $6,342.60 State Grant
    - *Description:* This competitive grant is for quality and operational improvements and requires a different focus area each year.
    - *Duration:* 1 year
    - *FTE:* 0.05
7. **Paperwork Updates**
    - *Project Coordinator: Kristen Rees*

- *Description:* Kristen has been updating documents across the district to be more compliant with current regulation and best practices. Remy has been incredibly involved in reviewing these updates and making changes with Kristen. Adela, Katherine, and Season have also given valuable feedback. Some documents which have been updated include the Notice of Privacy Practices (NPP), Acknowledgement of Notice of Privacy Practices, Consent, Permission to Share, Admission Agreement, Business Associate Agreement, and the Compliance Plan. References for these documents include the Health Care Compliance Association (HCCA), California Hospital Association, and the District's legal counsel.
- *Duration:* Ongoing, but documents on the project list currently should be updated by 8/31/2024.
- *Potential benefits*: legal protection and clarity for staff, patients, vendors, and family members

8. **Investigation Process**
    - *Project Coordinator*: Kristen Rees
    - *Description*: The investigation process at SoHum Health has been ill-defined or organized to this point. Given complexities identified in recent investigations and issues Season, Karen, and Kristen are working on better-defined processes, investigation scripts, and investigation tools/documents.
9. **Partnership Health Plan of California Grant Opportunity**
    - *Project Coordinator*: Kristen Rees
    - *Funding Potential*: $ 100,000
    - *Description*: Partnership reached out with a potential funding opportunity for an emergency department community health worker. We will send a letter of intent.
10. **QIP**
    - *Project Coordinator*: Kristen Rees/James Dement/Joshua Andrews

- Funding potential this year: $ 750,000
- *Description*: We are in the midst of our audit for this program. It is time-consuming and hopefully we can meet improvement benchmarks and deadlines for the upcoming year to earn funds for next year.

11. **OCHIN/EPIC/ESA**
    - *Project Coordinator*: Joshua Andrews
    - *Description*: Going live with the new electronic health record has not been an easy endeavor. Josh and Kristen have expended significant effort in meeting attendance, documentation, resolving issues, and supporting the project in general. Support is ongoing, but should lessen as the new ESA Lead, Kana, is brought up to speed and the project stabilizes.
12. **Partnership QIP projects**
    - *Description:* Partnership Health Plan of California has multiple QIP programs of which we are a part. There are long-term care, primary care, and hospital QIP programs. All have unique measures and requirements. These programs are tracked and reported in various departments and involve the Quality team and the departments in which the services are provided.
13. **American Medical Association Blood Pressure Program**
    - *Project Manager:* James Dement
    - *Description:* We are working with the American Medical Association to implement a blood pressure monitoring, acting, and partnering with patients (MAP). It had significant hiccups as we went live with the new EHR and purchased new equipment. As data and equipment stabilize, we will have greater improvement with this program. This may lead to future involvement with the American Medical Association.
14. **Compliance Training**
    - *Project Coordinator:* Kristen Rees

- *Description:* Compliance Training for 2024 is completed. Kristen and the team will put together the training for 2025.

15. **Event Reporting**
    - *Project Coordinator:* James Dement/Kristen Rees
    - *Description:* May 6th, we went live with a new software, Performance Health Partners, or PHP, for event reporting. The new software will significantly streamline processes, enhance user-friendliness, and make form management much easier. So far there have been minor changes and issues, but it has gone well.
16. **Policy and Procedure for the Quality and Compliance Department**
    - *Project Coordinator:* Kristen Rees/James Dement
    - *Description:* There are several policies and procedures which need development in the quality and compliance department. This includes revisions as well as completely new policies and procedures. These are being developed as time allows but constitute an important project for the department.
17. **i2i Re-Implementation**
    - *Project Coordinator:* Joshua Andrews
    - *Description:* i2i is a population health tool utilized by multiple departments. It integrates with the electronic health record and helps to run reports involving multiple service lines. It allows patient list upload for those who are assigned to us but have not had a visit. The software can also print or send letters, emails, and text messages to patients. Integration with the electronic health record took considerable time. Validation continues.
18. **California Fair Billing Act Compliance**
    - *Project Members:* Marie Brown, Remy Quinn, Kristen Rees, Dustin Cunningham
    - *Description*: We have responded to requests from HCAI

19. **Compliance Committee, Cybersecurity Sub-committee, and Audit Sub-committee**
    - *Project Coordinator:* Kristen Rees
    - *Description:* Kristen completed a draft compliance committee charter, the compliance committee meet to discuss a variety of projects, sub-committees, etc.
20. **Business Associate Agreements (BAA)**
    - *Project Coordinators:* Kristen Rees, Remy Quinn
    - *Description:* Recently, a new emphasis on ensuring all business associates have a BAA in place, and that it utilizes updated California compliant language has been a project Remy and Kristen have undertaken. BAA is completed. Audit planning is underway.
21. **Medicare Beneficiary Quality Improvement Program**
    - *Project Coordinator:* Coral Ciarabellini
    - *Description:* Reporting for this program is required for some funding programs in which we participate. Data is reported to various entities on various schedules.
22. **Data Request Process**
    - *Project Coordinator:* Kristen Rees, Joshua Andrews
    - *Description*: Created and implemented a data request process to define who is responsible for creating and approving reports. The form was built and put into PHP, the event reporting software. After reviewing the report requirements, data requested, and privacy level involved, an appropriate resource is assigned, the report is developed, and appropriate information is shared. Several reports have gone through this process already.
23. **Improvement Suggestion Form**
    - *Project Coordinator*: Kristen Rees, James Dement

- *Description*: This is also another form that was developed and entered into the new event reporting software. This allows us to review improvement suggestions from employees and decide what action is appropriate. We look forward to meaningful and positive change as a result. We will hopefully have an initiative around this later this year or early next year to increase utilization.

24. **Medical Staff Bylaws**
    - *Project Coordinator*: Karen Johnson
    - *Description*: There have been multiple medical staff bylaw changes which must be combined and approved. Many updates have been made and it is likely this will be an ongoing project as updates are needed.
25. **Medical Staff Credentialing**
    - *Project Coordinator*: Karen Johnson
    - *Description*: The work of incorporating proxy credentialing has been challenging and legal counsel has provided valuable insight. While we move to this possibly time-saving solution, the work of credentialing all new and current providers continues. Some of the Bylaws' changes will allow for proxy credentialing. We need to build that process as we work with each business associate.
26. **Peer Review**
    - *Project Coordinator:* Karen Johnson
    - *Description:* Peer review, both ongoing and focused for clinicians is an important process that has changed multiple times in recent years. Ongoing peer review refers to regular, random chart reviews done to ensure quality of care. Focused refers to peer reviews done as the result of a complaint or other identified issue. To streamline this process and remove ambiguity, we are putting a software management solution in place. Updates and build to the software are in progress. Draft questions have been approved for the emergency department providers and the clinic draft questions are in

progress. This is through the same software as the event reporting solution, PHP. The build is complete in PHP and is being tested.

27. **Medical Staff Updates**
    - *Project Coordinator*: Karen Johnson
    - *Description:* Documents including privileges, scope of practice, policies and procedures, and others are in progress as the medical staff makes multiple changes to improve their effectiveness and workability.
28. **Non-Medical Staff Credentialing**
    - Project Coordinator: Karen Johnson
    - Description: Karen, Kristen, and Season are working through solutions to streamline credentialing and provider enrollment for non-medical staff credentialing.

As required by CMS Conditions of Participation; C330, C331, C332; 485.641, Periodic Evaluation and Quality Assurance Review; Submitted by Adelaida Vargas de Yanez, BSN, RN, CNO for Medical Staff and the Board January 2025.