

MEETING NOTICE

Governing Board

A regular meeting of the Board of Directors of the Southern Humboldt Community Healthcare District will be held on February 25, 2026, 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: Join by phone +1-415-655-0001 US Toll

Webex Link:

<https://shchd.webex.com/shchd/j.php?MTID=m65c1024281b4ef67076bbe032ec5f0d9>

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

G. Consent Agenda –

- 6 - 13
 - 1. Approval of Previous Minutes
 - a. Governing Board Meeting, January 29, 2026
- 14
 - 2. SHCHD New and Updated Policies
 - Dietary**
 - a. Cooling Large Cuts of Meat
 - Pharmacy**
 - b. Defective Medications
 - c. Disposition of Medications
 - Engineering**
 - d. Medical Waste Management
- 15 - 17
- 18 - 23
- 24 - 27
 - 3. Quarterly Reports - (Feb, May, Aug, Nov)
 - a. Human Resources – Season Bradley Koskinen, HR Manager
 - b. Foundation – Chelsea Brown, Outreach Manager
 - c. Operations – Kent Scown, Chief Operations Officer – Not Received
- 28 - 29

Approval of Consent Agenda

H. Last Action Items for Discussion

- 30 - 37
 - 1. Optometry Statistics According to Budget
 - 2. Board Credentialing By Proxy Access for Darrin
 - 3. Peer Review Policy

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

J. Administrator's Report – Matt Rees, CEO

- 38 - 41
 - 1. Department Updates
 - a. Milestones
 - b. January Employee Anniversaries
 - 1 Year: ED Tech Matthew Quinton
 - 10 EVS Lead Shannon Bauman
 - c. Approval of the January Financials - Paul Eves – See Separate Packet
 - d. CNO Report – Adela Yanez – See Report
 - e. Family Resource Center – Amy Terrones – Mar and Oct – None

K. Old Business – None

L. New Business – None

M. Parking Lot -None

N. Meeting Evaluation

O. New Action Items

P. Next Meetings

1. Medical Staff Committee – Thursday, March 12, 2026, at 12:30 p.m
2. Medical Staff Policy Development Committee – Tuesday, March 17, 2026, 10:00 a.m
3. QAPI Meeting – Wednesday, March 11, 2026, at 10:00 a.m.
4. Finance Committee – Friday, March 20, 2026, at 10:00 a.m.
5. Governing Board Meeting – Thursday, March 26, 2025, at 1:30 p.m.

Q. Adjourn to Closed Session

1. Closed Session
2. Update on Peer Review, Credentialing, and Appointment/Reappointments – Medstaff
3. Compliance, Risk, and Reports of Quality Assurance Committees **[H&S Code § 32155]** - Kristen Rees, CQCO
4. Annual Hospital Periodic Evaluation Report FY 2025 – See Report
5. Quarterly Reports - None
 - a. Quality and Risk Management **H&S Code § 32155** – Feb., May, Aug., Dec. – Not Received
 - b. Patient Safety – Mar., June, Sept., Dec.
 - c. Medication Error – Feb., May, Aug., Dec. – Not Received
6. Approval of Medical Staff Appointments/Reappointments **[H&S Code § 32155]** - None
7. Personnel Matter –Evaluation § 54957
 - a. 360 Evaluations Admin
8. Personnel Matter –Evaluation § 54957
 - a. CEO Matt Rees

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

S. Resume Open Session

T. Adjourn

Abbreviations

<i>ACHD</i>	Association of California Healthcare Districts	<i>ACLS</i>	Advanced Cardiac Life Support Certification
<i>AR</i>	Accounts Receivable	<i>BLS</i>	Basic Life Support Certification
<i>CAIR</i>	California Immunization Registry	<i>CEO</i>	Chief Executive Officer
<i>CFO</i>	Chief Financial Officer	<i>CMS</i>	Centers for Medicare and Medicaid Services
<i>CNO</i>	Chief Nursing Officer	<i>COO</i>	Chief Operating Officer
<i>CPHQ</i>	Certified Professional in Healthcare Quality	<i>COO</i>	Chief Quality and Compliance Officer
<i>EMR/EHR</i>	Electronic Medical Record/Electronic Health Record	<i>ER</i>	Emergency Room
<i>FTE</i>	Full Time Equivalent/Full Time Employee	<i>HIM</i>	Health Information Management
<i>HRG</i>	Healthcare Resource Group	<i>HVAC</i>	Heating, Ventilation and Air Conditioning system
<i>IGT</i>	Intergovernmental transfer	<i>IT</i>	Information Technology
<i>JPCH</i>	Jerold Phelps Community Hospital	<i>LCSW</i>	Licensed Clinical Social Worker
<i>LVN</i>	Licensed Vocational Nurse	<i>MPH</i>	Master of Public Health
<i>OBS</i>	Observation	<i>PALS</i>	Pediatric Advanced Life Support Certification
<i>PFS</i>	Patient Financial Services	<i>QAPI</i>	Quality Assurance Performance Improvement
<i>OIP</i>	Quality Improvement Project/Program	<i>RN</i>	Registered Nurse
<i>SHCC</i>	Southern Humboldt Community Clinic	<i>SHCHD</i>	Southern Humboldt Community Healthcare District
<i>SNF</i>	Skilled Nursing Facility	<i>SWG</i>	Swing beds
<i>DO</i>	Doctor of Osteopathic Medicine	<i>Resident</i>	Patients Residing in the Skilled Nursing Facility

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 February 21, 2026

Governing Board

Date: January 29, 2025
Time: 1:30 p.m.
Location: Sprowel Creek Campus and Via Webex Conferencing
Facilitator: Board President, Kevin Church

Minutes

The following people attended at Sprowel Creek Campus and via Webex

The Governing Board consists of Corinne Stromstad, Kevin Church, Yvonne Hendrix, Galen Latsko, and all in person, and Christopher Schille, with accommodation via Webex.

Not Present: None

Also in person: Administrative Assistant Darrin Guerra, CFO Paul Eves, PFS Manager Marie Brown, CQCO Kristen Rees, Chief of Staff Dr. Raisonni, Outreach Manager Chelsea Brown, CEO Matt Rees, and Compliance Lead Coral Ciarabellini

Also via Webex: FRC Manager Amy Terrones, Business Development Director Ryan Staples, and COO Kent Scown

A. Call to Order – Board President Kevin Church called the meeting to order at 1:30 pm.

B. Approval of the Teleconferencing of a Board Member

1. Chris Schille utilized the reasonable accommodation granted in SB707.

C. Approval of the Agenda

Motion: Yvonne Hendrix motioned to approve the agenda with a correction to line-item Q.5.a to read “**Lawrence Gettler, MD** – Reappointment as Active status in Emergency Medicine privileges for March 31, 2026 – January 31, 2028”.

Second: Corinne Stromstad

Ayes: Corinne Stromstad, Christopher Schille, Yvonne Hendrix, and Kevin Church

Noes: None

Not Present: Galen Latsko

Motion Carried

D. Public Comment on Non-Agendized Items

E. Board Member Comments

1. Kevin shared that he would like to receive updates on recommended Board training throughout 2026.
2. The Board would like EHR (Electronic Health Record) to be added to the Abbreviations page next to EHR (Electronic Health Record) at the back of the Agenda and Minutes.

F. Announcements - None

G. Approval of Consent Agenda

1. Approval of Previous Minutes
 - a. Governing Board Meeting, December 10, 2026
2. SHCHD New and Updated Policies
 - Engineering**
 - a. Emergency Preparedness Countywide Resource List
 - b. Earthquake Response SNF and Acute Nursing
 - c. Fire Prevention Plan
 - d. Fire Watch Procedure
 - e. Emergency Operation Plan (EOP) Waiver Declared By Secretary
 - District Wide**
 - f. EHR Access Readiness and Password Reset Escalation
 - Radiology**
 - g. Infection Control
 - h. Negative and Benign Mammogram Reports
 - Materials**
 - i. Product Recall and Product Hazard Report
 - j. Scope of Service
 - k. Back Orders
 - l. Infection Control
 - m. Inventory Policy
 - n. Organizational Structure
 - o. Departmental Access-Visitor

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

Kevin Church pulled G.1.a, and G.2.a, b, and g from the consent agenda.

Motion: Corinne Stromstad motioned to approve the consent agenda.
Second: Yvonne Hendrix
Ayes: Corinne Stromstad, Christopher Schille, Yvonne Hendrix, and Kevin Church
Noes: None
Not Present: Galen Latsko
Motion Carried

Motion: Yvonne Hendrix motioned to approve agenda item G. 1. a with corrections, marking Kevin Church as the one who pulled items from the Consent Agenda, adding the word “Amended” to the approval of the Consent Agenda, and adding the correction of who made the motion and seconded the CEO Retention Contract Negotiation.
Second: Christopher Schille
Ayes: Corinne Stromstad, Christopher Schille, Yvonne Hendrix, and Kevin Church
Noes: None
Not Present: Galen Latsko
Motion Carried

Motion: Yvonne Hendrix motioned to approve agenda item G.2.a as is, G.2.b with the correction to section 2 clarifying that an earthquake may impact patient care, and G.2.g with the correction to bullet point 7 clarifying that the device is a portable digital reader.
Second: Christopher Schille
Ayes: Corinne Stromstad, Christopher Schille, Yvonne Hendrix, and Kevin Church
Noes: None
Not Present: Galen Latsko
Motion Carried

H. Last Action Items for Discussion

1. Financial Trend Graph
 - a. Paul Eves added graphs to the Finance packets to provide an “At a Glance” trend for the Governing Board.

2. Action Plan and Steps to Stabilize Optometry
 - a. Matt shared some of his plans on ensuring the growth and success of our Optometry sites. This included hiring a new full-time Optometrist and the possibility of adding Ophthalmology services on the Redwood Drive property.
3. Peer Review Policy
 - a. Due to a minor miscommunication, the Peer Review policy will be brought to the February Board meeting.

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

J. Administrator’s Report – Matt Rees, CEO

Matt shared some of the major highlights from the 2025 calendar year, such as our additions of Optometry, PT, and OT. As well as our increase in behavioral health, Pharmacy, and the chance to receive 25 million in additional funding for the hospital project through various grant opportunities. Matt also took this opportunity to discuss future service lines and the potential to expand Optometry and PT services by adding additional providers.

1. Department Updates

- a. Milestones – None
- b. August Employee Anniversaries
 - 1 Year: LCSW Tara Huff and Business Development Director Ryan Staples
 - 5 Years Case Manager Shirley Hillman
- c. Approval of the December Financials - Paul Eves – See Report
 - i. Paul presented the December financials and answered corresponding questions.
- d. CNO Report – Adela Yanez – See Report
 - i. Adela presented her staff report.
- e. Family Resource Center – Amy Terrones – Mar and Oct - None

Motion: Christopher Schille motioned to approve the December 2025 Financials.

Second: Corinne Stromstad

Ayes: Corinne Stromstad, Christopher Schille, Yvonne Hendrix, and Kevin Church

Noes: None

Not Present: Galen Latsko

Motion Carried

K. Old Business

1. Med Staff Coordinator Update

- a. VSP Update
 - i. In process
- b. Commercial Insurance/ Credentialing in the Clinic and Optometry
 - i. In process

- c. 360 Review for Administration.
 - i. 360 reviews will be brought to the February Board meetings' closed session under Personal Matter § 54957

L. New Business

1. Approval of Resolution 26:01 Annual Public Meeting Notice

Motion: Yvonne Hendrix motioned to Resolution 26:01 Annual Public Meeting Notice.
Second: Christopher Schille
Ayes: Corinne Stromstad, Christopher Schille, Yvonne Hendrix, and Kevin Church
Noes: None
Not Present: Galen Latsko
Motion Carried

2. Elections of Officers

- a. There has been no change in Officers.

3. Committee Assignments

- a. Outreach – Chris Schille and Kevin Church
- b. Bylaws – Kevin Church
- c. Finance – Kevin Church and Corinne Stromstad
- d. Quality – Chris Schille and Yvonne Hendrix

4. Update of Medical Staff and Governing Board Bylaws Timeline

- a. Darrin Guerra will be working with Admin and Med Staff to propose an updated version of the Medical Staff Bylaws in March.

5. Addition of MRI Services

Motion: Yvonne Hendrix motioned to approve the negotiations and signing of the MRI service contract with Heritage Imaging
Second: Chris Schille
Ayes: Corinne Stromstad, Christopher Schille, Yvonne Hendrix, and Kevin Church
Noes: None
Not Present: Galen Latsko
Motion Carried

M. Parking Lot - None

N. Meeting Evaluation – “Good meeting.” – Corinne

O. New Action Items

- 1. Optometry Costs and Statistics Compared to Budget
- 2. Board Credentialing by Proxy for Darrin Update

P. Next Meetings

1. Medical Staff Committee – Thursday, February 12, 2025, at 12:30 p.m
2. Medical Staff Policy Development Committee – Tuesday, February 17, 2025, 10:00 a.m
3. QAPI Meeting – Wednesday, February 11, 2025, at 10:00 a.m.
4. Finance Committee – Friday, February 20, 2025, at 10:00 a.m.
5. Governing Board Meeting – Wednesday, February 25, 2025, at 1:30 p.m

Q. Closed Session

1. Closed Session Opened at 2:57 p.m.
2. Update on Peer Review, Credentialing, and Appointment/Reappointments – Medstaff
3. Compliance, Risk, and Reports of Quality Assurance Committees [**H&S Code § 32155**] - Kristen Rees, CQCO
4. Quarterly Reports -
 - a. Quality and Risk Management **H&S Code § 32155** – Feb., May, Aug., Dec.
 - b. Patient Safety – Mar., June, Sept., Dec.
 - c. Medication Error – Feb., May, Aug., Dec.
5. Approval of Medical Staff Appointments/Reappointments [**H&S Code § 32155**]
 - a. Approval of Lawrence Gettler, MD, Reappointment as Active in Emergency Medicine Privileges for March 1, 2026 – January 31, 2028
 - b. Approval of Fungluo Liu, MD, Reappointment as Associate status in Anatomical and Clinical Pathology privileges for March 1, 2026 – January 31, 2028
 - c. Approval of Mahdieh Assar, MD, (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges for February 1, 2026 – January 31, 2028
 - d. Approval of Ari Plosker, MD, (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges for February 1, 2026 – January 31, 2028
 - e. Approval of Ann-Elise Zarkwoer, NP, Initial Appointment as Provisional status in Clinic/Ambulatory privileges-- for February 1, 2026 – January 31, 2027
 - f. Approval of David Brosan, OD, Initial Appointment as Provisional status in Optometry – for February 1, 2026 – January 31, 2027
6. Personnel Matter –Evaluation § 54957
 - a. CQCO Kristen Rees

R. Kevin Church Adjourned Closed Session

S. Kevin Church Resumed Open Session

1. Action Items to Report in Open Session

Motion: Yvonne Hendrix motioned to approve Lawrence Gettler, MD, Reappointment as Active in Emergency Medicine Privileges for March 1, 2026 – January 31, 2028, Funghuo Liu, MD, Reappointment as Associate status in Anatomical and Clinical Pathology privileges for March 1, 2026 – January 31, 2028, Mahdieh Assar, MD, (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges for February 1, 2026 – January 31, 2028, Ari Plosker, MD, (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges for February 1, 2026 – January 31, 2028, Ann-Elise Zarkwoer, NP, Initial Appointment as Provisional status in Clinic/Ambulatory privileges-- for February 1, 2026 – January 31, 2027, David Brosan, OD, Initial Appointment as Provisional status in Optometry – for February 1, 2026 – January 31, 2027

Second: Christopher Schille

Ayes: Corinne Stromstad, Christopher Schille, Yvonne Hendrix, and Kevin Church

Noes: None

Not Present: Galen Latsko

Motion Carried

T. Kevin Church Adjourned Open Session

Submitted by Darrin Guerra

Abbreviations

<i>ACHD</i>	Association of California Healthcare Districts	<i>ACLS</i>	Advanced Cardiac Life Support Certification
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<i>CPHQ</i>	Certified Professional in Healthcare Quality	<i>CQO</i>	Chief Quality Officer
<i>EMR/EHR</i>	Electronic Medical Record Electronic Health Record	<i>ER</i>	Emergency Room
<i>FTE</i>	Full-Time Equivalent/Full-Time Employee	<i>HIM</i>	Health Information Management
<i>HRG</i>	Healthcare Resource Group	<i>HVAC</i>	Heating, Ventilation and Air Conditioning system
<i>IGT</i>	Intergovernmental transfer	<i>IT</i>	Information Technology
<i>JPCH</i>	Jerold Phelps Community Hospital	<i>LCSW</i>	Licensed Clinical Social Worker
<i>LVN</i>	Licensed Vocational Nurse	<i>MPH</i>	Master of Public Health
<i>OBS</i>	Observation	<i>PALS</i>	Pediatric Advanced Life Support Certification
<i>PFS</i>	Patient Financial Services	<i>QAPI</i>	Quality Assurance Performance Improvement
<i>QIP</i>	Quality Improvement Project/Program	<i>RN</i>	Registered Nurse
<i>SHCC</i>	Southern Humboldt Community Clinic	<i>SHCHD</i>	Southern Humboldt Community Healthcare District
<i>SNF</i>	Skilled Nursing Facility	<i>SWG</i>	Swing beds
<i>DO</i>	Doctor of Osteopathic Medicine		



SoHum Health

733 Cedar Street
Garberville, CA 95542
(707) 923-3921
shchd.org

Southern Humboldt Community Healthcare District

GOVERNING BOARD RESOLUTION 26:01

APPROVAL OF THE 2026 REGULAR BOARD MEETING SCHEDULE

WHEREAS, the Southern Humboldt Community Healthcare District (the "District") will maintain by Resolution the Scheduled Meeting Date and Time of Regular Meetings of the Governing Board.

Regular Meetings

1. Time of Regular Meetings. Regular meetings of the Board of Directors of the District in the year 2026 shall be held on the Last Thursday of every month at the hour of 1:30 p.m.
2. Place of Regular Meetings. The regular meeting place of the Board of Directors in the year 2026 shall be at the Sprowel Creek Campus, 286 Sprowel Creek Rd, Garberville, CA 95542.

PASSED AND ADOPTED by the Board of Directors of SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT, this 29th day of January 2026, by the following vote:

Ayes: Corinne Stromstad, Kevin Church, Yvonne Hendrix, Chris Schille

Noes: _____

Abstain: _____

Absent: Galen Latsko

Kevin Church
Witnessed by: Kevin Church, President

Corinne Stromstad
Witnessed by: Corinne Stromstad, Vice President/Secretary

Subject:

Cooling Large Cuts of Meat

Manual:

Dietary

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District Dietary Department to assure that foods are prepared following established food safety guidelines, specifically when large cuts of meats are prepared the day prior to service, the cooling process is closely monitored to prevent bacterial growth, which leads to food borne illness.

PROCEDURE:

- Roasts will be cooked to appropriate temperatures as per policy.
- Final cooking temperature will be documented.
- Roasts will be cut into pieces no more than 5-6 inches thick.
- Roasts may be allowed to cool at room temperature until they reach approximately 180°F, but never below 140°F.
- Roasts are transferred to the refrigerator uncovered for the cooling process. The time and temperature must be documented when the roast is put into the refrigerator.
- In two hours after putting the roast into the refrigerator, the time and temperature must be checked. The roast must have cooled to 70°F. If it has not cooled down to 70°F, the roast must be reheated to 165°F and cut into smaller pieces. The cooling process would begin again; therefore, the temperature of roast would have to be checked at or before 2 hours has passed and must be 70° F or below.
- The temperature is again checked at or before additional 4 hours has passed. The temperature must go from 70°F to 41°F within these last four hours. Time and temperature must be documented when it reaches 41°F or below.
- At this time, it is covered, labeled and dated, and stored in the refrigerator.

DEFINITIONS:

None

Subject: Defective Medications	Manual: Hospital Pharmacy
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POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to notify the pharmacist of, and quarantine, all medications suspected of being defective or altered. All reported suspect medications will be investigated by the pharmacist to assure that defective drug products are not used, and that they are reported through the proper channels.

PROCEDURE:

If a drug product is suspected to be defective, contaminated, or unfit for use for any reason, the following procedure will be followed:

1. Stop the use of the product in question.
2. Notify the pharmacist and place it in the Return Bin, identifying the drug as defective.
3. Quarantine the medication for the pharmacist to review.
4. Apply a note to the product stating, “DO NOT USE”.
5. Email the pharmacy @ ipharmacy@shchd.org, detailing the reason for concern.
6. If the product has been used, notify the prescriber immediately and document in EPIC and complete an Event Report.
7. Pharmacy Staff will inform the drug product manufacturer, if appropriate.
8. If appropriate, notify the FDA through the FDA-Drug Quality Reporting System at <https://www.fda.gov/safety/medwatch-fda-safety-information-and-adverse-event-reporting-program>

DEFINITIONS:

None

Subject: Disposition of Medications	Manual: Hospital Pharmacy
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POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to dispose of medications in a manner which prevents diversion and is safe for both the staff and environment.

DEFINITIONS:

Cactus Smart Sink: Is a device which securely captures partially administered or unused controlled substances and renders them non-retrievable and unusable.

Multi-Dose Vials: A vial of liquid medication that contains more than one dose of medication.

Single Dose Vials: A Vial of liquid medication that contains one dose of a drug to be used one time for a single patient.

Beyond-Use Date (BUDs): The date or time after which a product or compounded preparation should not be used. BUDs are different from expiration dates, which are defined by the manufacturer for commercially available products. BUDs are important because they help to reduce the risk of chemical degradation, physical degradation, and microbial contamination. Medications are no longer considered safe to use after their BUD because the risk of microbial proliferation increases over time and the medication may lose potency.

PROCEDURE:

1. All medications in solid, liquid, and patch formulation will be discarded into the Cactus Smart Sink device.
2. Used medication vials and inhalers will be discarded into the blue and white pharmaceutical incineration bins, which are collected by Environmental Services when full and taken to locked storage to be picked up weekly by a licensed hauler.

Disposal of discontinued Controlled Substances require extra steps and precautions:

1. Controlled Substances will require a nurse and pharmacist to sign on the patient medication administration log sheet specifying the quantity, date, and time of the disposition.
2. The nurse shall send the sheet to HIM to upload into the patient chart.
3. When a resident’s medication is discontinued, the nurse who receives, or is made aware of, the order shall notify the pharmacist for immediate disposal of the discontinued medication.

Efforts shall be made by the Pharmacy to dispense only single dose vials (SDV) whenever possible to limit waste. Certain multi-dose vials (MDV) may be treated as single dose vial and discarded following initial use in most cases. This shall be communicated to staff through Pyxis

at the time of dispensation and through the *Admin Instructions* within EPIC upon administration. True MDV's are considered usable until their beyond use date (BUD), or the manufacturer's expiration date, whichever comes first. Beyond use dates for injectables will be 30 days or less after opening, according to the manufacturer.

Subject: Medical Waste Management	Manual: Environmental Services
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PURPOSE:

The purpose of this policy is to provide for the safe handling of biohazardous waste from points of origin through final disposal.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) that all waste generated within the hospital be properly and safely segregated and disposed of in compliance with all applicable state and federal regulations.

This facility is registered with the State of California as a “ Large Quantity Generator.” (The monthly volume of medical waste generated is more than 200 pounds). There is no on-site treatment of medical waste. All medical waste is removed by a registered medical waste hauler (Shred Aware).

Facility Contact: Operations Manager or Engineering/Environmental Services Manager

NOTE: The term “Medical Waste” includes biohazardous/infectious waste, sharps, trace chemotherapy, pathology, and pharmaceutical waste. The terms “biohazardous waste” and “infectious waste” are synonymous.

REGULATORY COMPLIANCE:

Procedures written regarding the definition, handling, storage, treatment, and disposal of biohazardous waste comply with:

- Title XXII, California State Administrative Code
- Humboldt County Department of Public Health
- OSHA Bloodborne Pathogen Standard CFR 1910.1030
- State of California, Department of Public Health, Medical Waste Management Act of 2017.

DEFINITIONS:

Medical waste: any biohazardous, pathologic, pharmaceutical, or trace chemotherapy waste not regulated by the federal Resource Conservation and Recovery Act of 1976 (Public Law 94-580), as amended. It includes the following:

- Sharps and trace chemotherapy wastes generated in a health care setting in the diagnosis, treatment, immunization, or care of humans or animals

- Waste generated in autopsy or necropsy
- Waste generated during the preparation of a body for final disposition such as cremation or interment
- Waste generated in research pertaining to the production or testing of microbiological materials or substances
- Waste generated in research using human or animal pathogens
- Sharps and laboratory waste generated in the inoculation of animals in commercial farming operations that pose a potential risk of infection to humans
- Waste generated from the consolidation of home-generated sharps
- Waste generated in the cleanup of trauma scenes

Laboratory waste: includes, but is not limited to, all the following:

- Human specimen cultures from medical and pathologic laboratories
- Cultures and stocks of infectious agents from research and industrial laboratories
- Wastes from the production of bacteria, viruses, or the use of spores, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures
- Waste containing any microbiological specimens sent to a laboratory for analysis

Body fluid waste: discarded materials contaminated with excretion, exudates, or secretions from humans who are required to be isolated (by the infection prevention staff, the attending physician, or the local health officer) to protect others from highly communicable diseases (Biosafety Level III or higher). Body fluid waste also means items containing large amounts of liquid blood or body fluids, e.g., suction containers, and chest drainage units. If a solidifier is used it must be managed as pathology waste.

Sharps waste: any device having acute rigid corners, edges, or protuberances capable of cutting or piercing, including, but not limited to, all of the following:

- Empty Hypodermic needles, syringes with needles, blades, and needles with attached tubing.
- Broken glass items such as Pasteur pipettes and blood vials contaminated with other medical waste.

Pharmaceutical waste: a pharmaceutical, as defined in Section 117747, including trace chemotherapy waste, which is a waste, as defined in Section 25124. For purposes of this part, “pharmaceutical waste” does not include a pharmaceutical that meets either of the following criteria:

- The pharmaceutical is being sent out of the state to a reverse distributor, as defined in Section 4040.5 of the Business and Professions Code that is licensed as a wholesaler of dangerous drugs by the California State Board of Pharmacy pursuant to Section 4161 of the Business and Professions Code.
- The pharmaceutical is being sent by a reverse distributor, as defined in Section 4040.5 of the Business and Professions Code, offsite for treatment and disposal in accordance with applicable laws, or to a reverse distributor that is licensed as a wholesaler of dangerous drugs by the California State Board of Pharmacy pursuant to Section 4160 of

the Business and Professions Code and as a permitted transfer station if the reverse distributor is located within the state.

Mixed waste: mixtures of medical and non-medical waste. Mixed waste is considered medical waste except for medical waste which is mixed with hazardous waste and is subject to regulation as specified in the statutes and regulations applicable to hazardous waste.

PROCEDURE:

Locations Of Medical Waste In The Hospital

- Areas of the hospital that generate biohazardous/infectious waste include but are not limited to the following. Waste from these areas is collected in “red” biohazardous/infectious waste bags.
 - Laboratory (specific areas):
 - Microbiology section
 - Blood Bank Section
 - Any other laboratory area where specimens or human tissue wastes are discarded as defined in this policy
 - Sharps containers used at the point of blood draw
 - Chemistry section
 - Hematology/coagulation section
 - Serology/Urinalysis/Point-of-care section
 - Hospital
 - All suction containers containing liquid blood or body fluid from general acute care beds and skilled nursing facility beds.
 - All sharps containers in patient rooms, med room, and utility room.
 - All pharmaceutical waste containers in the Acute nurse station.
 - Isolation Rooms (when occupied by patients known or suspected to be infected with highly communicable diseases)
 - Emergency Department
 - Emergency Department trauma rooms where large amounts of blood disposal are expected
 - All sharps containers
 - All pharmaceutical waste containers
 - Clinic
 - All sharps containers in exam rooms
 - Nurse station
 - Pharmaceutical waste containers in nurse station
 - Drug room
 - Pharmaceutical waste containers
 - Sprowel Creek Campus
 - ☒ Pharmacist Office (Pharmacy)
 - ☒ Mobile Clinic

Important Notice: California Health and Safety code HSC §117700 clearly states: “Waste that is not biohazardous, such as paper towels, paper products, articles containing non-fluid

blood, and other medical solid waste products commonly found in the facilities of medical waste generators may be disposed of as non-hazardous, non-infectious waste.”

Authorized Personnel

1. The collection, transport, storage, and storage of all biohazardous waste is the responsibility of the Environmental Services Department.
2. All Environmental Services personnel are trained to safely handle, transport, and dispose of biohazardous waste.
3. Training is documented and kept on file in the employee Relias profile.

Containment of Medical Waste

1. A biohazard bag that is used to collect medical waste within a facility shall be manufacturer-certified to meet the ASTM D1709 dart drop test, provided that when the bag is prepared for transport offsite, it is placed into a USDOT-approved container lined with a biohazard bag that is ASTM D1709 and ASTM D1922 certified. The bags shall be securely tied to prevent leakage or expulsion of contents during storage and handling.
2. Sharps shall be contained for disposal in leakproof puncture-resistant containers that are tightly lidded or closed to preclude loss of the contents. The containers will be labeled with the words “Infectious” or “Biohazardous” and have the international biohazard symbol on the container. Containers are considered full at 2/3 capacity. Lids are snapped closed according to the manufacturer’s recommendations. Taping is optional based on the likelihood of the container opening during transport or storage.
3. All bags used for containment and disposal of biohazardous waste are red in color and may be labeled with the words “Infectious” or “Biohazardous Waste”, and must be ASTM D1709 and ASTM D1922 certified.
4. Medical waste will be kept separate from other waste at the point of generation.
5. Environmental Services personnel will clean biohazard (red bag) containers in the various departments. After emptying, these will be cleaned whenever visibly soiled or emits an odor (per section 118295) by using a hospital-approved quaternary ammonia product (at least 400 ppm).

Transportation of Medical Waste

1. Red biohazardous waste bags collected at the point of origin are deposited into rigid portable containers with tight-fitting lids labeled with the words “Biohazardous Waste”, with the international biohazard symbol and the word “Biohazard” on the lid and sides to be visible from any lateral direction. Used exclusively for this purpose.
2. The waste containers are transported out of the hospital to the designated waste storage area where biohazardous waste is kept.
3. After emptying, transport containers are cleaned with a hospital-approved quaternary ammonia product (at least 400 ppm) when visibly soiled or emitting odor.

Storage of Medical Waste

1. The biohazardous waste storage container is located behind the hospital, on hospital property.
2. The storage container is constructed to afford protection from animals, rain, and wind, and does not provide a breeding place or food source for insects or rodents.

3. The storage building is secured with locked doors to deny access to unauthorized persons.
4. The door on the storage container is posted with a warning sign in both English and Spanish reading “*Caution – Biohazardous Waste Storage Area – Unauthorized Persons Keep Out.*” The sign is readable from a distance of 25 feet.
5. Storage of biohazardous waste in the storage areas shall not exceed seven (7) days if it is kept at or above 32°F.
6. The storage container is cleaned and decontaminated as needed, or at the time of a spill or visible leakage from a red bag.

Treatment and Disposal of Medical Waste

1. On-site treatment: there is no on-site treatment of medical waste.
2. Off-site disposal: the facility will use “off-site” disposal for all medical waste.
 - a. The biohazardous waste is transported to an approved disposal site or facility by a licensed contracted hauler. The hauler under contract to the facility is:
Bio Waste Resources
2237 3rd St.
Eureka, CA 95501
(707) 445-0500
 - b. The waste is treated at an approved off-site treatment facility. The facility used by Bio Waste Resources is:
HealthWise Services
4800 E Lincoln Avenue
Fowler, CA 93625
(559) 834-3333
 - c. Each load of biohazardous waste to be transported off-site is documented. A manifest is kept on record in the Environmental Services Department and by the licensed transporter and disposer.

Biohazardous Spills (Blood/Body Fluids)

1. All visible blood and body fluid spills will be covered immediately with absorbent material by the employee who is present. A liquid solidifier (such as Isolyzer) may be used for large spills. If a solidifier is used it must be managed as pathology waste to ensure proper disposal.
2. Gloves are worn by the healthcare worker while cleaning up the spill. Both the gloves and the spill kit should be discarded into a red bag.
3. Environmental Services should be contacted to complete the cleaning process following the procedure outlined in the Bloodborne Pathogens Exposure Control Plan.
4. If nursing personnel is urgently needed for patient care, environmental services staff may be asked to complete steps 1 and 2.

Record Keeping

Medical Waste tracking documents are kept in the Environmental Services Department for a period of not less than 3 years. Documents are scanned into EVS policies and the end of each year.

Emergency Action Plan

In case of an emergency SHCHD will follow the following steps to ensure the continued handling of medical waste:

1. Alternative action plan includes retention of medical waste for not more than 7 days from the point of generation (above 32°F). The following agencies will be contacted to ensure waste management disposal goes uninterrupted:

The Department of Health Services, Medical Waste Management Program may be contacted for guidance at (916) 449-5671.

Bio Waste Resources LLC
PO Box 2339, McKinleyville CA 95519
kyle@biowasteresources.com | BioWasteResources.com
Phone: 707/445-0500 Fax: 707/633-3122



SoHum Health

HUMAN RESOURCES QUARTERLY REPORT Q4 Statistics

	October	November	December	Q4 Totals
New Hires	3	7	1	11
Separations from Employment	0	3	4	7
Injuries/Illness	1	3	0	4

Quarter 2 Separation Reasons
Moved – 0; Retired – 0; Other -- 7

Turnover Rates

Separations	District Turnover Rate Q4	2024 90 th percentile National Turnover rate (2025 NSI National HealthCare Retention & Staffing Report).	Paylocity Benchmark for Health Care and Social Assistance
7	4.02%	14.4%	14.0%

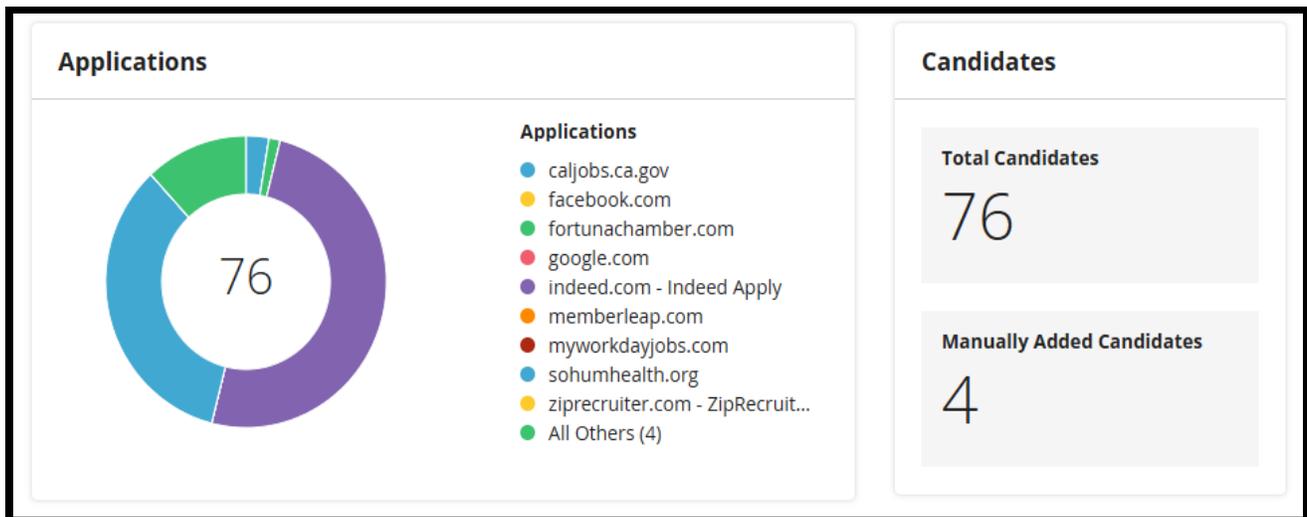
Recruiting

We had up to 18 total published jobs during Quarter four.

One of HR's key focus areas for 2025 is expediting the onboarding process. We are proud to see that some key changes to the onboarding process have helped reduce the timeline. We will have a clearer picture if we exclude outliers such as providers, applicants moving here from outside the area, or those with red flags on their background checks that require additional due diligence. Our average time from signed offer letter to onboarding day for Q4 is 27 days. In 2024 and early 2025, we typically averaged 40 days from the date of the signed offer letter to the onboarding day.

In Q4 of 2024, we had 148 active employees; in Q4 of 2025, we had 174. We are actively growing and refining processes to stay efficient in a dynamic environment.

We received applications from the following sources:



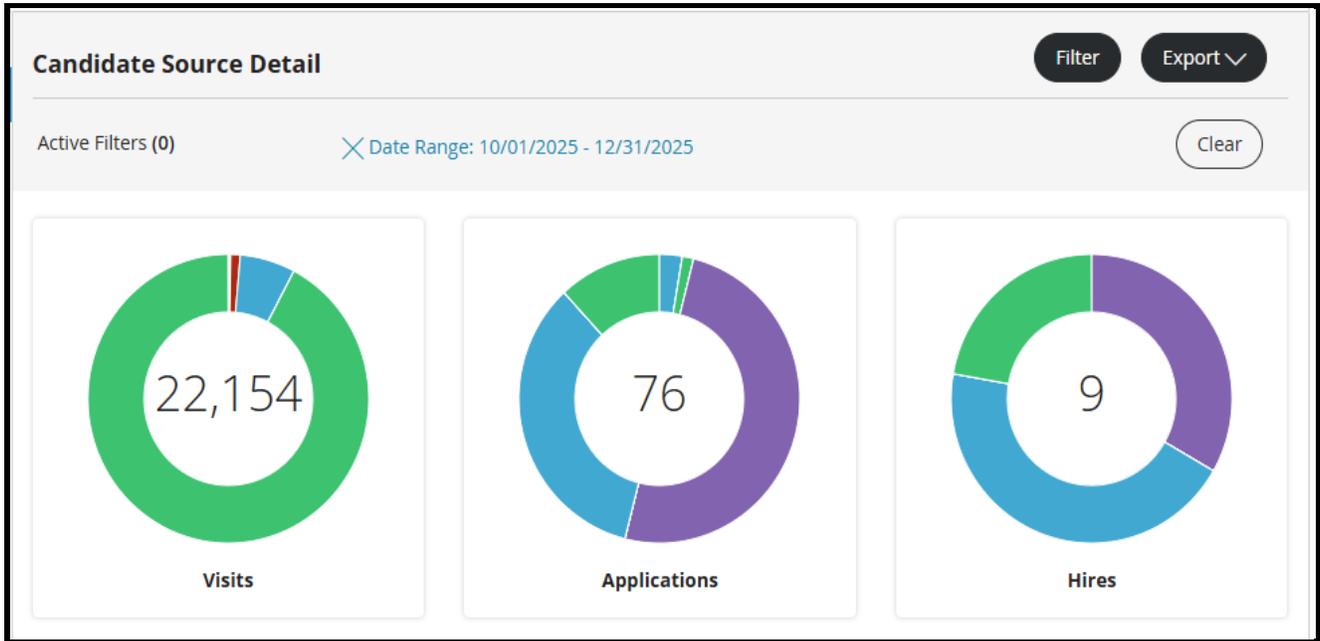
Candidate Source Detail

To broaden our reach, we are exploring the number of visits each source is receiving and which sources our applicants are coming from. We will focus on changing how we post positions to increase visits.

We continue to struggle to fill key roles, but we are happy to note that we have filled our Optometrist position.



SoHum Health



Source*	Visits	Applications	Hired
caljobs.ca.gov	4	2	0
facebook.com	3	0	0
fortunachamber.com	6	1	0
google.com	11	0	0
indeed.com - Indeed Apply	38	38	3
memberleap.com	2	0	0
myworkdayjobs.com	237	0	0
sohumhealth.org	1,415	26	4
ziprecruiter.com - ZipRecruiter_Feed	2	0	0
All Others (4)	20,436	9	2

* Top 10 sources displayed.

Other Projects

- **HR launched open enrollment for our new Self-Insured Medical coverage.**
- **We continued to prepare to launch the 360 reviews for the Admin Team. Allowing subordinates and team members to give performance feedback along with supervisor and self-evaluations. Hopefully, insights from this feedback will allow additional growth opportunities.**
- **We updated and prepared to launch the Employee Reviews in Paylocity.**
- **Updating and creating needed Policy and Procedures**
- **Building written protocols for common HR tasks. We hope to have a written Standard Operating Procedure by the end of 2026 Q2.**
- **Updating the Employee Handbook.**
- **Updating the Illness Injury Prevention Plan and Workplace Violence Plan.**
- **We began putting together training plans for all departments to comply with the law SB513.**

Governing Board Report

Submitted by Chelsea Brown

Foundation Director & Outreach Manager

February 2026



SoHum Health
FOUNDATION

Foundation Report:

- Finances:** The Foundation continues to steward capital campaign funds and is keeping assets in low-risk, short-term investments in preparation to release 50% of the money to the Healthcare District upon meeting their first established milestone.

4th Quarter (Oct-Nov-Dec)	Beginning Balance	Income	Expense	Quarterly Ending Balance	Total Quarterly Change	Pending	Pending Balance
HAF Mid-Term	\$ 890,080.96	\$ 34,935.67	\$ (881,639.22)	\$ 43,377.41	\$ (846,703.55)	\$ -	\$ 43,377.41
Morgan Stanley CDs (3mo 3/16/26)	\$ 727,830.18	\$ 5,518.08	\$ (241,000.00)	\$ 492,348.26	\$ (235,481.92)	\$ -	\$ 492,348.26
CFCU Savings	\$ 81.72	\$ -	\$ -	\$ 81.72	\$ -	\$ -	\$ 81.72
CFCU Checking	\$ 4,100.81	\$ 506,494.84	\$ (502,317.56)	\$ 8,278.09	\$ 4,177.28	\$ -	\$ 8,278.09
CFCU Money Market	\$ 56,667.99	\$ 329,001.73	\$ (146,006.00)	\$ 239,663.72	\$ 182,995.73	\$ -	\$ 239,663.72
CFCU CD (matures 1/28/26)	\$ 263,310.59	\$ 2,873.32	\$ -	\$ 266,183.91	\$ 2,873.32	\$ -	\$ 266,183.91
Coast Central Savings	\$ 43.56	\$ 207,709.33	\$ (207,709.19)	\$ 43.70	\$ 0.14	\$ -	\$ 43.70
Coast Central CD 04 (closed 11/4)	\$ 206,976.35	\$ 732.84	\$ (207,709.19)	\$ -	\$ (206,976.35)	\$ -	\$ -
Accounts Receivable(Capital Loan)					\$ -	\$ 1,300,000.00	\$ 1,300,000.00
Totals		\$ 1,087,265.81	\$ (2,186,381.16)	\$ 1,049,976.81	\$ (1,099,115.35)	\$ 1,300,000.00	\$ 2,349,976.81

- The Foundation Board will be holding their annual board retreat on April 2nd where they will set fundraising and outreach priorities for the coming year.
- SoHum Health Foundation will be participating in Access Humboldt's Bold Day of Giving on May 29th – a county-wide non-profit giving day which includes TV and radio promotions, and outside corporate matching gifts.
- Our team continues to provide updates on progress towards the new hospital and ongoing funding needs, to build our local support base and build donor support.

Grants:

- In October, our grants team submitted an application for the Behavioral Health Continuum Infrastructure Program Grant from the State requesting \$15,944,296 for the new hospital and clinic construction, to fund the build-out of a Behavioral Health program. We continue to await a response and expect to hear back this spring.
- In January 2026, a local foundation, which wishes to remain anonymous, awarded SoHum Health Foundation \$100,000 towards the new hospital's helistop build.
- We are submitting some small grant requests to support bringing our mobile optometry unit to the local school district to provide no-cost eye exams for all students.
- Legislative Earmarks:** we are in ongoing communication with our state and federal assemblymembers, senators, and congressmen to apply for legislative earmarks in the 2026/27 FY to support the construction of the new hospital facility.

- We continue to analyze additional funding opportunities and submit inquiries at the local, state, and federal levels.

Outreach Report:

- SoHum Health outreach staff is supporting the Family Resource Center with their annual Community Baby Shower event on Saturday, March 7th 12-3pm at the South Fork HS Wellness Center. Expecting parents, parents of 0 to 2-year-olds, those considering pregnancy, and their support people are invited to this FREE community gathering. The event features prizes, baby supply giveaways, games, snacks, and refreshments. Participating agencies include Early Head Start, Nueva Vida Doulas, WIC, First 5, Little Redwoods, Sacred Bridges, CA Highway Patrol, Redwood Coast Regional Services, DHHS Maternal, Child & Adolescent Health, Changing Tides, Providence, Redwoods Rural Health Center, and more.
- The outreach team tabled at the Cal Poly Humboldt Career Fair on February 12th and plans to attend the College of Redwoods Health Professions Fair on April 8th to support our staff recruitment efforts.
- Outreach has been focused on promoting services that are still working to get to a full patient load, including Fortuna Optometry, the mobile clinic in Shelter Cove (next date will be March 20th), and Behavioral Health. Outreach works to keep our website and social media current and provides ongoing support to all SHCHD departments for signage and other communications related needs.



Subject: Peer Review Program	Manual: Medical Staff
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Policy:

Southern Humboldt Community Healthcare District (“SHCHD” or “District”), which owns and operates the Jerold Phelps Community Hospital (“Hospital”) and its Medical Staff are committed to maintaining high standards of clinical care and ensuring continuous quality improvement through a structured Peer Review program. This policy outlines the procedures for conducting peer review to assess, monitor, and improve the quality of care provided by individuals working in the Hospital and its associated clinics operated under the Hospital’s license. The scope of this policy applies to all Medical Staff members and other healthcare providers credentialed and privileged by the Medical Staff (collectively referred to as “Practitioners”). The purpose of the Peer Review program is to promote excellence in clinical practice, enhance patient safety, and ensure compliance with applicable laws and regulations.

I. Definitions:

Allied Health Practitioners (AHP): AHP include clinical psychologists, physician’s assistants, nurse practitioners, licensed clinical social workers and doctors of optometry who are licensed in the State of California to provide medical care within the scope of their license.

Case Review: A detailed assessment of a specific clinical case to evaluate the quality of care provided.

Case Review Form: The form developed by the Medical Staff and approved by the Governing Board of the District for use in Case Review that captures the Reviewer(s)’ impressions of the Case Review. See -**Appendix A**.

Committee of the Whole (CW): As defined in the Medical Staff Bylaws, Section 6.4.

Medical Staff Support Staff: The individual(s) responsible for supporting the Medical Staff in its Peer Review functions, including carrying out administrative tasks on behalf of the Medical Staff.

Peer Review: Peer review is the process by which the Medical Staff evaluates Practitioners applying and reapplying for staff membership and privileges, establishes standards and procedures for patient care, assesses the performance of Practitioners currently on staff, and reviews other matters critical to the District’s functioning. Peer Review helps assure patient safety and is intended to be performed efficiently on an ongoing basis, and with an emphasis on early detection of potential quality problems and resolutions through informal educational interventions, where possible. In accordance with Business and Professions Section 805, peer review also includes all other activities of the Medical Staff which is the District’s peer review body. All peer review information is confidential in accordance with the Medical Staff Bylaws, state and federal laws, and

regulations pertaining to confidentiality and non-discoverability, including but not limited to California Evidence Code Section 1157.

Practitioner Competencies: The six general Practitioner competencies for evaluation are as follows:

- Patient Care
- Medical Knowledge
- Interpersonal and Communication Skills
- Professionalism
- Systems Based Practice
- Practice Based Learning and Improvement

Quality Indicators: Measures of Practitioner performance will be selected by the CW in consultation with District Administration and approved by the Governing Board using multiple sources of data to reflect the six general Practitioner competencies and the standards for Practitioners established in the Medical Staff Bylaws. Copies of the current indicators will be maintained by the Quality, HIM, and Compliance Departments. Any changes will be presented to CW and Governing Board of the District on an annual basis by the Medical Staff Support Staff.

Reviewer: A physician member of the Medical Staff responsible for Case Review and completion of the Case Review Form. Cases may also be assigned to a non-physician member of the Medical Staff or a member of the AHP staff for their input if the case involves their particular expertise and is within their scope of practice but will always be reviewed by a physician. [For example, an Optometrist may be assigned to complete a Case Review of another Optometrist.](#)

II. Case Selection

Cases referred for Peer Review may include, but are not limited to:

- Cases referred by members of the Medical Staff or another Practitioner.
- Cases identified by the Quality Compliance Departments, including those based on quality indicators selected by the Medical Staff and approved by the Governing Board.
- Any sentinel event or event reportable to regulatory authorities.
- Other event reports, adverse events or complications.
- Complaints by patients or patient representatives.

- Random review of a minimum of no less than 5 cases per calendar year per Practitioner.

III. Review Process:

A. Assignment of Case.

1. Each case indicated for review will be assigned by Medical Staff Support Staff (under the guidance of the Chief of Staff or their designee) to a Reviewer who has not been involved in the care of the patient.
2. Reports of unprofessional conduct by a Practitioner in circumstances not involving the care of a patient will be assigned by Medical Staff-Support Staff (under the guidance of the Chief of Staff or their designee) to a Reviewer who was not involved in the alleged event.
3. To the extent the case subject to Case Review involves the Chief of Staff, the case will be assigned to a Reviewer by Medical Staff Support Staff or designee under the guidance of the Vice-Chief of Staff who shall provide guidance throughout the review process.
4. If the assigned Reviewer is unable to conduct the Case Review due to a conflict of interest, lack of expertise, personal involvement in the care, or other justifiable reason(s), the case will be assigned to another Reviewer.
5. External peer review may be used to complement Medical Staff Peer Review as delineated below.

B. Responsibilities of Practitioners.

1. All Practitioners have a responsibility to cooperate in the Peer Review process, including, but not limited to, responding to inquiries regarding their care or allegations of unprofessional conduct.
2. All Practitioners have the responsibility to:
 - (a) Act as a Reviewer when requested.
 - (b) Promptly and thoroughly conduct and complete any assigned Case Review.
 - (c) Promptly return Case Review Forms to Medical Staff-Support Staff.
 - (d) Present Peer Review information at executive sessions of CW meetings.
 - (e) Maintain the confidentiality of the Peer Review process in accordance with regulation and the Medical Staff Bylaws.

C. Review Guidelines.

Each case is assessed for adherence to clinical guidelines, appropriate standards of care, compliance with Medical Staff Bylaws, and Medical Staff rules and policies, and patient outcomes. The assigned Reviewer shall conduct a thorough review of selected/referred cases, such as:

1. Medical records;
2. Clinical documentation;
3. Feedback from the Practitioner(s) involved in the care of the patient;
4. Interviews with other healthcare practitioners; and
5. Other relevant available data.

The Reviewer may review the case with the involved Practitioner verbally, by phone, or by e-mail (using secured SHCHD email addresses only). The Practitioner may respond to the Reviewer either verbally or via written communication (letter or internal SHCHD e-mail). Communication from the Practitioner should be attached to the respective Case Review Form.

D. Completion of Case Review Form.

The Reviewer shall complete all fields in the Case Review Form, as is determined to be relevant, and comment on the care provided in the case and/or the professionalism of the Practitioner.

1. To the extent the Reviewer indicates that referral to CW is appropriate, Medical Staff Support Staff will add the case to the next CW agenda for discussion.
2. The Case Review Form and data derived from the Case Review Form will be retained as part of the OPPE process, for purposes of tracking peer review outcomes, and for consideration at the time of reappointment.

Commented [RH1]: Anything scored a Major Opportunity for Improvement should be reviewed by the CW.

E. Initial Case Disposition Score.

The Reviewer will assign a Case Disposition Score regarding the Practitioner's clinical performance. To the extent the case involves deviation(s) from policies and procedures or allegations of unprofessional behavior, this will also be indicated in the Case Review Form and assigned a Case Disposition Score:

1. APPROPRIATE CARE – No deviation from expected practice.
2. APPROPRIATE CARE WITH EDUCATIONAL OPORTUNITY – No deviation from expected practice but educational opportunity present.
3. MINIMAL OPPORTUNITY FOR IMPROVEMENT – Minimal or moderate deviation from the standard of care but no actual or potential adverse outcome for the patient.

4. MAJOR OPPORTUNITY FOR IMPROVEMENT – Care below standard of care and there was possible or actual adverse outcome for the patient.
5. SYSTEM ISSUE IDENTIFIED – Issues identified were a result of equipment, materials, manpower, or other administrative issues or concerns.

IV.

A. Reviewer Recommendation.

The Reviewer will recommend one or more action(s) for the CW to take, choosing from the options on the Case Review Form. This includes, but is not limited to, asking for further input from the Practitioner subject to review or conducting additional review at CW. Cases involving egregious outcomes or demonstrating a trend of major opportunity for improvement scores may be referred to the Chief of Staff, (or the Vice-Chief of Staff if it involves the Chief of Staff), for expedited review.

B. CW Review and Final Case Disposition.

1. Case Reviews referred to CW will be set for discussion during executive session attended by voting members of the Medical Staff only unless an invitation is extended to others by the Chief of Staff or designee. To the extent the case involves a non-physician Practitioner, someone with the same privileges and/or scope of practice should be present to provide their input to the CW. At the discretion of the CW, AHPs may also attend meetings for educational purposes, but shall not vote on Case Disposition Scores.
2. Prior to the meeting, the Practitioner subject to review shall be notified that his or her case will be discussed at the meeting and given an opportunity to respond to the committee in writing or during the committee discussion.
3. The CW will determine by majority vote whether it agrees with the initial case disposition score or whether to assign a new score. The CW will also decide what, if any, further action will be taken, including but not limited to, education, additional training, or corrective action consistent with the Medical Staff Bylaws.
4. Once a final score has been assigned and the follow-up action has been taken, this will be indicated on the Case Review Form and the Case Review will be deemed “closed.” The final disposition and closure of the Case Review will be logged in the electronic peer review platform and maintained by Medical Staff Support Staff.

C. Referral to Administration

The CW may refer any concern or question related to issues outside of the purview of Medical Staff (e.g., operational concerns, issues involvement District employees) to the District Administration.

D. Expected Timeframe for Review

1. When a case has been referred to the Medical Staff for review, a Reviewer shall be assigned within 14 days, ideally sooner in high-risk or harm event cases.
2. Case Reviews and the Case Review Form will be completed by the assigned Reviewer within 14 days of receiving the assignment.
3. Completed Case Reviews referred to the CW that which are received seven or more business days prior to the CW meeting will be on the meeting agenda.
4. Completed Case Reviews will be routed to the practitioner involved for a response. Responses from the practitioner received two business days before the meeting will be presented at the CW meeting.
5. If a Cease Rreview is not completed within a timely manner, the Medical Staff Support Staff will notify the Reviewer to ensure the Cease Rreview is expedited.
6. All deadlines stated herein are meant to serve as guidelines, as circumstances may warrant the more immediate review of a case or a delayed review while additional information is gathered.
7. The Medical Staff-Support Staff shall be responsible for assisting the CW with the coordination of the peer review process and meeting scheduling, as applicable.

E. External Peer Review Process.

1. The Chief of Staff (or their designee) or the CW may determine that external peer review is necessary when:
 - (a) The concern at issue is sufficiently complex to warrant outside review;
 - (b) There is a conflict of interest between the subject Practitioner and the other Practitioners (e.g., current partner) such that there is no other Practitioner available to perform a review; or
 - (c) As otherwise deemed necessary by the Chief of Staff in collaboration with District Administration

2. No Practitioner is entitled to an external review.
3. An external reviewer may be provided access to records and information following the signing of a confidentiality agreement and Business Associate Agreement, if required by the District.
4. The CW, in its sole discretion, will determine the nature of the involvement for the Practitioner under review.
5. An external review may be conducted under peer review confidentiality and afforded the protections of Evidence Code Section 1157 or may be conducted by legal counsel under attorney/client privilege.
6. Once the results of external peer review are obtained, the report will be reviewed by the CW. The CW will determine if improvement opportunities exist, ~~as determined by the CW,~~ and [how to address the matter with the Practitioner, it will be addressed.](#)

V. **Action Following Case Review Closure:**

- A. Once a case is closed, the subject Practitioner is informed, in writing, of the final disposition of the Case Review and a copy of the closing letter will be maintained by the Medical Staff Support Staff in the subject Practitioner's Peer Review file.
- B. **Retention of Case Review Forms or Other Peer Review Documents.**
 1. Case Review Forms, letters, or other documents are maintained by the Medical Staff-Support Staff in a secure location and available only to the ~~Chief of Staff, Vice Chief of Staff, and~~ Medical Staff Support Staff [who will provide access to the Chief of Staff or Vice Chief of Staff when needed to fulfill their responsibilities as officers of the Medical Staff.](#) Should there be any hard copies, they will be maintained-until the form is scanned and saved in a secure, file on the District's network.
 2. Any electronic copies of Case Review Forms are saved in a secure, file on the District's network. Access to the folder is granted to the-Chief of Staff, Vice-Chief of Staff, and the Medical Staff Support Staff.
 3. Peer Review information in a Practitioner's peer review file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. The Chief of Staff, or their designee, and Medical Staff Support Staff will assure that only authorized individuals have access to individual Practitioner files.
 4. [No copies of peer review documents will be created or distributed unless authorized by Medical Staff policy or Bylaws, or the-current attorney for the SHCHD Medical Staff.](#)

Commented [RH2]: I think we can take this out. The Bylaws address confidentiality.

VI. Reporting to Governing Board:

- A. The CW, via the Chief of Staff or designee, will provide a semi-annual report to the Governing Board of the District in a closed session meeting summarizing overall peer review activities, including the number of cases reviewed and quality trends.
- B. The Medical Staff will use the Practitioner-specific Peer Review results in making its recommendations to the Governing Board of the District regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

VII. Statutory Authority and Peer Review Protections

This Policy is based on the statutory authority of Business and Professions Code Section 805 et seq., Section 809 et seq., Evidence Code Section 1157, the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101, et seq.) and any other applicable Federal and California statutes and case law. All peer review conducted under this policy is subject to any available peer review privilege(s) and immunities provided under both state and federal law.

All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy, should be labeled consistent with the following language: “Privileged & Confidential [Peer Review Document](#)—Protected by California law, including, but not limited to Evidence Code Section 1157.”



CNO Board Report – February 2026

Infection Prevention Update

The flu season continues, and although multiple cases have been reported to public health, our patients and residents have remained free from COVID-19 and the flu. We kindly ask that any visitors to the hospital or skilled nursing facility (SNF) who have not been vaccinated wear a face mask to protect our patients and residents.

Vaccination significantly reduces the risk of flu and its complications; approximately 130 million doses have been distributed this season.

Prescription antiviral drugs are available for treating the flu, particularly for high-risk patients.

According to the local Public Health:

“Vaccination is the most effective preventive measure, and everyone aged 6 months and older is strongly encouraged to get vaccinated annually, especially those at higher risk. If you have any questions, consult your healthcare provider.

Additional Tips for Preventing the Flu:

- Cover your cough.
- Wash your hands frequently.
- Avoid touching your face.
- Stay home if you are sick.”

Emergency Department and Acute Care Update

In January, the Emergency Department (ED) provided care to 309 patients, while the Acute Care unit managed 11 swing-bed patients and 4 inpatients. The Elevate ED providers have been positively received within the community, consistently delivering high-quality care. Feedback from patients has been encouraging, highlighting the caliber of service provided in the Emergency Department.

The ED and Acute Care units are currently prioritizing updating training across all areas, including Basic Life Support (BLS), Advanced Cardiovascular Life Support (ACLS), Pediatric Advanced Life Support (PALS), and various competencies. Efforts are underway to establish a more streamlined approach to continuing education that encompasses both onboarding and annual training initiatives. Furthermore, there is a concerted effort to cross-train more staff members across different departments to ensure coverage as required. Management is also engaged in training related to the new MCG system.

There is an increasing demand for additional traveler nurses, and currently, one traveler RN is working on the hospital side. We are looking to hire one more traveler RN and one traveler LVN.



Laboratory

The laboratory concluded the year 2025 on a strong note, achieving several significant milestones:

-The laboratory had 503 visits in January 2026.

- We provided care for a substantial number of patients, performing more test procedures than in any previous year, even surpassing the challenging periods of the COVID-19 pandemic. The number of procedures increased from 20,387 in the previous year to 25,729, representing an impressive 26% growth.

- We advanced our quality standards, highlighted by our successful accreditation from the Accreditation Commission for Healthcare, which demonstrates our dedication to maintaining high-quality service.

Remarkably, the laboratory has reached a milestone of three years without adding new hires. Our team of six has remained intact and effective since 2022.

We also emphasized teamwork. The laboratory provided practical training for two students, enabling them to obtain their California phlebotomist certifications. Although job openings in the laboratory are limited, both individuals are now contributing to the Security and Transportation team at SoHum.

On January 7th, the laboratory team convened for an annual kickoff meeting. We reviewed our accomplishments, gathered suggestions from colleagues across other departments, and outlined our objectives for 2026.

Skilled Nursing Update

Katherine, the Director of Nursing at our Skilled Nursing Facility, reports that January was a successful month, during which the residents enjoyed the festivities. The residents received presents, stockings, and hot chocolate in December. In January, they continued the spirit of festivity, offering a variety of festive crafts and activities with the residents.

Our resident census remains stable at eight, and we've received positive feedback from our recent survey, reflecting our commitment to excellence.

We continue to develop new policies that ensure high standards in operations and regulatory compliance, prioritizing the safety and rights of our residents.

Our activity director continues to offer a diverse range of activities for residents, including Healy Center lunches in our calendar and hosting a Friday Afternoon Music Event featuring local performers, both of which enhance our community spirit.



Clinic Update

The clinic is committed to delivering high-quality healthcare services to the community. In January 2026, we recorded a total of 524 patient visits. This includes 78 outpatient visits in Behavioral Health, as well as visits to the Emergency Department (ED), Inpatient (IP), Swing Bed, and Skilled Nursing Facility (SNF). Our Mobile Optometry department recorded 61 visits.

Our team consists of three Medical Doctors (MDs) and one Physician Assistant (PA): Dr. Raisoni, Dr. Murphy, Dr. Ordonez, and Linda.

The mobile clinic initiative conducted at the Cove on January 23, 2026, proved successful, with eight patients in attendance. We have satisfactorily completed all annual performance evaluations for our clinic staff.

In response to provider feedback, we have rescheduled the Clinic Provider Meetings to better align with their availability. These meetings will now occur on Wednesdays from 1:00 PM to 2:00 PM, with Dr. Raisoni facilitating the discussions.

Additionally, we are collaborating with the Partnership team to explore funding opportunities for a new Vaccines for Children (VFC) vaccine refrigerator to replace the one relocated from the Pyxis system back to the clinic.

Lastly, we will continue to offer telehealth services to our patients until December 31, 2026, in accordance with the guidelines of our Rural Health Clinic (RHC) status.

Radiology Update

Radiology continues to provide essential services to the community, even amid staffing shortages. On January 23, 2026, we will welcome one traveling radiology technician and are actively considering hiring a second. Despite our dedicated recruitment efforts over the past three years, attracting qualified radiology technicians has proven to be a significant challenge.

In January 2026, the Radiology department conducted the following exams: 234 x-rays, 116 CT scans, 37 ultrasounds, and 18 mammograms. We also completed our annual FDA, MQSA, and State survey for mammography, all of which went well with no deficiencies noted.

Throughout 2025, the department experienced increased volume across all modalities. We performed a total of 2,403 X-ray exams (up from 2,008 in 2024), 1,361 CT scans (up from 1,211 in 2024), 613 ultrasound exams (up from 459 in 2024), and 342 mammograms (up from 304 in 2024).

Pharmacy

The pharmacy department is currently reviewing and developing Workflow Aids to ensure compliance with existing policies and procedures. We are collaborating with various departments to identify and implement strategies to manage refrigeration downtime and related issues across the district. Additionally, we are working closely with emergency department providers to enhance our formulary, ensuring it better addresses the specific needs of the emergency room.



Furthermore, we are partnering with Garberville Pharmacy to maintain consistent order quality across both inpatient and outpatient channels. We will continue fostering a strong working relationship with our Long-Term Care provider to ensure accurate and timely ordering as we navigate the complexities of multiple formularies within the EPIC system.

Physical and Occupational Therapy Update

In January 2026, the Physical and Occupational Therapy departments recorded 79 outpatient visits, in addition to care provided in acute settings, through the SWING program, and in the skilled nursing facility. Sierra, the Physical Therapy Manager, has observed marked improvements following the relocation of therapy treatments to a newly expanded therapy room, which has enabled a more comprehensive range of services.

Additionally, the physical therapy team is recruiting a traveler physical therapist, which we anticipate will enhance our capacity to manage an increased volume of outpatients effectively. Our objective remains focused on delivering high-quality care while welcoming new patients, as demand for our services continues to grow.

Senior Life Solutions (SLS)

In December, the SLS team conducted 92 visits despite a staff shortage. The SLS team plans to host an open house at the beginning of 2026 to introduce both the new location and the SLS program to the community.

Thank you for your ongoing support and dedication!

Adela Yanez, RN, BSN, CNO