AGENDA

Board of Directors Meeting

5:30 PM - Wednesday, May 24, 2023

Click link to join Zoom meeting

SPH Conference Rooms 1&2

Meeting ID: 878 0782 1015 Pwd: 931197

Phone Line: 669-900-9128 or 301-715-8592

Kelly Cooper President		Keriann Baker		Edson Knapp, MD	
Aaron Weisser Vice Pres.		M. Todd Boling, DO		Bernadette Wilson	
Julie Woodworth Secretary		Matthew Hambrick		Beth Wythe	
Walter Partridge Treasurer		Melissa Jacobsen		Ryan Smith, CEO	

Page

1. CALL TO ORDER

2. ROLL CALL

3. REFLECT ON LIVING OUR VALUES

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

5 4.1. Rules for Participating in a Public Meeting
Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

6. APPROVAL OF THE AGENDA

7. APPROVAL OF THE CONSENT CALENDAR

6 - 12 7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for April 26, 2023

Board of Directors - Apr 26 2023 - Minutes - DRAFT

13 - 16 7.2. Consideration to Approve April 2023 Financials
Balance Sheet April 2023
Income Statement April 2023
Cash Flow Statement April 2023

17 - 38 7.3. Consideration to Approve the SPH Quality Plan and LTC Facility QAPI Addendum
Memo
Quality Plan, revised 2023
LTC QAPI, revised April 2023

39 - 114 7.4. Consideration to Approve the SPH Hospital Hazard Vulnerability Analysis, SPH Hospital Emergency Operations Plan, SPH Long Term Care Hazard Vulnerability Analysis, SPH Long Term Care Emergency Operations Plan, and SPH Home Health Emergency Operations Plan
Emergency Operations Planning Documents

115 - 122 7.5. Consideration to Approve Long Term Care Infection Prevention Plan and Risk Assessment
Infection Prevention Plan and Risk Assessment

123 7.6. Consideration to Approve revised policy EMP-03, Disruptive Conduct & Abusive Behavior, to correct a grammatical error
EMP-03

8. PRESENTATIONS

9. UNFINISHED BUSINESS

10. NEW BUSINESS

124 - 134 10.1. Consideration to Amend the South Peninsula Hospital Board of Directors Bylaws, Article IV, Section 2, to change the term of officers from one to two years
Memo
BOD Bylaws, proposed changes

135 - 136 10.2. Consideration to Approve 2023-15, A Resolution of the South Peninsula Hospital Board of Directors Supporting the Hospital's Request for a Certificate of Need to Add the Service Line of Nuclear Medicine to South Peninsula Hospital, Relocate the Pharmacy and Expand and Relocate Infusion Services.
SPH Resolution 2023-15

137 - 139 10.3.

Consideration to Approve SPH Resolution 2023-13, A Resolution of the South Peninsula Hospital Board of Directors Approving the Request of $613,020 of Plant Replacement and Expansion Funds to Support Upgrades to the Generator Annunciator and Switch Gear
Memo
SPH Resolution 2023-13

140 - 141 10.4. Consideration to Approve SPH Resolution 2023-16, A Resolution of the South Peninsula Hospital Board of Directors Approving a Plan Amendment for the 403b Plans to Adhere to the Requirements of the Secure Act and the Coronavirus Aid, Relief, and Economic Security Act
SPH Resolution 2023-16

142 - 143 10.5. Consideration to Approve SPH Resolution 2023-17, A Resolution of the South Peninsula Hospital Board of Directors Supporting the Issuance of Bonds to support the addition of the Nuclear Medicine Service Line and expansion of Pharmacy and Infusion Into Shelled Space and the Purchase of a New Electronic Medical Record.
SPH Resolution 2023-17

11. REPORTS

11.1. Chief Executive Officer

11.2. BOD Committee: Pension

11.3. BOD Committee: Finance

11.4. BOD Committee: Governance

11.5. BOD Committee: Education

11.6. Chief of Staff

11.7. Service Area Board Representative - Roberta Highland

12. DISCUSSION

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

14.2. Board Members

15. INFORMATIONAL ITEMS

144 - 150 15.1. Patient Centered Care Quality Committee Minutes.
April PCCQ Minutes

16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Credentialing

18. ADJOURNMENT

South Peninsula Hospital

MEMO

Administration
4300 Bartlett Street
Homer, AK 99603
907-235-0325 ~ 907-235-0253, fax

To: Public Participants

From: Operating Board of Directors – South Peninsula Hospital

Re: Rules for Participating in a Public Meeting

The following has been adapted from the "Rules for Participating in a Public Meeting" used by Kenai Peninsula SAB of SPHI.

Each member of the public desiring to speak on any issue before the SPH Operating Board of Directors at tonight's meeting will be given an opportunity to speak to the following guidelines:

- *Those who wish to speak will need to sign in on the sign in sheet being circulated. When the chair recognizes you to speak, you need to clearly give your name and the subject you wish to address.*
- *Please be concise and courteous, in time, so others present will have an opportunity to speak.*
- *Please observe normal rules of decorum and avoid disparaging by name the reputation or character of any member of the Operating Board of directors, the administration or personnel of SPHI, or the public. You cannot mention or use names of individuals.*
- *The Operating Board Directors may ask you to respond to their questions following your comments. You could be asked to give further testimony in "Executive Session" if your comments are directly related to a member of personnel, or management of SPHI, or dealing with specific financial matters, either of which could be damaging to the character of an individual or the financial health of SPHI, however, you are under no obligation to answer any question put to you by the Operating Board Directors.*
- *This is your opportunity to provide your support or opposition to matters that are within the areas of Operating Board of Directors governance. If you have questions, you may direct them to the chair.*

These rules for participating in a public meeting were discussed and approved at the Board Governance Committee meeting on February 24, 2013.

MINUTES

Board of Directors Meeting

5:30 PM - Wednesday, April 26, 2023
Conference Rooms 1&2 and Zoom

DRAFT

The Board of Directors of the South Peninsula Hospital was called to order on Wednesday, April 26, 2023, at 5:30 PM, in the Conference Rooms 1&2 and via Zoom.

1. CALL TO ORDER

President Kelly Cooper called the regular meeting to order at 5:30 p.m.

2. ROLL CALL

BOARD PRESENT: **President Kelly Cooper, Keriann Baker, Todd Boling, Matthew Hambrick, Edson Knapp, Treasurer Walter Partridge, Vice President Aaron Weisser, Bernadette Wilson, Secretary Julie Woodworth.**

BOARD EXCUSED: **Keriann Baker, Melissa Jacobsen and Beth Wythe**

ALSO PRESENT: **Ryan Smith (CEO), Angela Hinnegan (COO), Dr. Christina Tuomi (CMO), Maura Jones (Executive Assistant), Kathryn Ault (Service Area Board)**
Due to the Zoom meeting format, only meeting participants who comment, give report or give presentations are noted in the minutes. Others may be present on the virtual meeting.

A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Rachael Kincaid, CNO, shared a story of a trauma activation. There was a tragic accident last night that resulted in loss of life. The accident happened during an emergency department staff meeting, so the staff was able to mobilize and the best possible care. Angela Hinnegan, COO, shared the incredible teamwork that was required to apply for 4 grants over just a few weeks.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

4.1. Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

There were no comments from the audience.

6. APPROVAL OF THE AGENDA

Julie Woodworth made a motion to approve the agenda with the removal of item 10.2, because additional work needs to be done on this resolution. Aaron Weisser seconded the motion. Motion Carried.

7. APPROVAL OF THE CONSENT CALENDAR

Julie Woodworth read the consent calendar into the record.

7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for March 22, 2023.

7.2. Consideration to Approve March FY2023 Financials

7.3. Resolution 23-14, Approving Hospital Administration to File IRS Form 990 for Fiscal Year 2022, Tax Year 2021.

Secretary Julie Woodworth made a motion to approve the consent calendar as read. Treasurer Walter Partridge seconded the motion. Motion Carried.

8. PRESENTATIONS

There were no presentations.

9. UNFINISHED BUSINESS

There was no unfinished business.

10. NEW BUSINESS

10.1. Consideration to Approve SPH Resolution 2023-12, A Resolution of the South Peninsula Hospital Board of Directors Sunsetting South Peninsula Hospital Board of Directors Resolution 2020-03 and South Peninsula Hospital Board of Directors Resolution 2020-06, Which Provided Special Provisions for Operating During the COVID-19 Public Health Emergency

Angela Hinnegan, COO, reported. The Board passed several resolutions during the pandemic that made changes to normal operations. With the end of the public health emergency, this would officially sunset those resolutions and return to standard operations.

Mr. Partridge noted the resolution was reviewed and approved in Finance Committee. Ms. Cooper added that SPH has used all of the emergency COVID funding, so that is no longer a factor. There was some discussion about telehealth, and whether it will become a more permanent part of health care, and Ms. Hermanson agreed to report on reimbursement for telehealth visits at the next Finance Committee meeting.

Edson Knapp made a motion to approve SPH Resolution 2023-12, A Resolution of the South Peninsula Hospital Board of Directors Sunsetting South Peninsula Hospital Board of Directors Resolution 2020-03 and South Peninsula Hospital Board of Directors Resolution 2020-06, Which Provided Special Provisions for Operating During the COVID-19 Public Health Emergency. Walter Partridge seconded the motion. Motion Carried.

10.2. Consideration to Approve South Peninsula Hospital Board of Directors Resolution 2023-13, A Resolution of the South Peninsula Hospital Board of Directors Approving the Request of $613,020 of Plant Replacement

DRAFT

and Expansion Funds to Support Upgrades to the Generator Annunciator and Switch Gear

This item was removed from the agenda, as there was new information from the borough affecting the content of the resolution.

10.3. Consideration to Approve Revised CRNA Privileges as recommended by the Medical Staff

Christina Tuomi, DO, CMO, reported. The medical staff approved new privileges for the CRNAs that better reflect their current practice, and a copy of the revised privileges were provided in the packet.

There were no further questions or comments.

Aaron Weisser made a motion to approve revised CRNA Privileges as recommended by the Medical Staff. Edson Knapp seconded the motion. Motion Carried.

10.4. First Reading: Consideration to Amend the South Peninsula Hospital Board of Director Bylaws, Article IV, Section 2, to change the term of officers from one to two years

Mr. Weisser reported. The Governance Committee is recommending this bylaw revision to increase the effectiveness of officer positions. This would extend officer terms from one year to two years, allowing time to learn the position and to provide for continuity and stability. The committee also discussed that board terms are three years, and if officer terms are two years there is a chance that an officer's membership term will end in the middle of their officer term. The committee didn't see this as a problem, just something to keep in mind.

11. REPORTS

11.1. Chief Executive Officer

Ryan Smith, CEO, reported. The hospital has been busy with physician and APP recruitment, and he thanked everyone involved in that process. Dr. Ragina Lancaster and Dr. Hans Amen are joining Homer Medical Center in July as Family Medicine physicians. Susan Jackson, FNP will be joining the General Surgery Clinic in an outpatient capacity, and Christine Pratt, PA will be moving back into family medicine. Dr. Ellis is leaving SPH for a fellowship program next month, and Dr. Pamela Williams will be replacing her as an employed OB/Gyn. Dr. Gregory Aird, radiology medical student, and Dr. Jenna Aird, dermatology medical student, have been given letters of intent. We are also speaking with Dr. Ian Wisecarver, a Plastic Surgeon.

This year we've selected Moda to be the new third party administrator for our self-funded employee insurance program. Our trauma recertification is scheduled for June 19th. Mr. Smith spent some time in AHA meetings this past month. We spent some time speaking with the CMS Deputy Administrator, about the 96 hour rule. We continue to talk about the importance of cyber security.

DRAFT

Mr. Smith also reviewed the first Balanced Scorecard data from calendar year 2023. It is a new scorecard, with some new indicators. The team has done a great job moving towards real time data. Sepsis has greatly improved. While the numbers are not finalized, we believe we're at over 90%. We are currently working on stroke, though we've working though troubles with the EMR, and revisiting tools we had in place a few years ago. Though falls look like, 8 falls had to do with one resident turned patient. In patient satisfaction, we struggle in the outpatient services area, but have been consistently very high in the Emergency Department. Our turnover in the first year is high, so we are looking at that.

Dr. Knapp mentioned that the outpatient satisfaction scores are mostly Imaging and Lab, and he hopes the new incoming leadership in the Imaging Department will focus on how to make the patient intake experience better. Mr. Smith agreed that patients typically have a great experience in the Imaging and Lab departments, but do not have a good experience with the flow of getting in to their appointment.

11.2. BOD Committee: Finance

Walter Partridge, committee chair, reported. The committee met last week and reviewed the financials, which were better than anticipated, and also reviewed the finance indicators for the balanced scorecard. Net days in A/R is exceptional right now. Mr. Partridge referenced the memo included in the packet. The Finance Committee proposed the idea of having interim goals for certain metrics, such as Days Cash on Hand, so we are not holding the leadership team responsible for hitting goals that are unachievable. Mr. Weisser added that the days cash was lower than 90 days due to the unbudgeted employee bonus last fall, which the board had supported and approved. The board was supportive of the measures outlined in the memo.

11.3. BOD Committee: Governance

Aaron Weisser, committee chair, reported. The Governance Committee met last week, and discussed Doctor's Dinners, as well as working on a master calendar of reports. We are refining a job description for the board chair. We've currently tabled our discussion of Robert's Rules of Order, hoping to get more information from Jamie Orlikoff. We've begun our in-depth policy review for the year, starting with EMP-01 and EMP-02, and we're not recommending any changes. As we go through the policies, we will bring any with suggested revisions to the full board.

11.4. BOD Committee: Education

Melissa Jacobsen was excused from the meeting, but a written report was provided in the packet.

11.5. Chief of Staff

Dr. Landess was working in the Emergency Department and not able to join the group until Executive Session.

11.6. Service Area Board Representative

DRAFT

Kathryn Ault reported on behalf of the Service Area Board (SAB). At the April SAB meeting, the board heard a presentation on the Health Care Provider Scholarship Fund and approved the resolution regarding the roof repairs to the 203 W Pioneer building.

12. DISCUSSION

12.1. NRHA Certification Program

The board members discussed a webinar they recently participated in, exploring the possibility of obtaining a certification for healthcare board members. As a whole, there was not a strong feeling of support for participating in this program, as it seemed to be still in the early development phases, there were not a lot of answers, and it did seem to be costly and a large time commitment without giving a strong sense of the program. The group asked Education Committee to look into iProtean's options for certification.

12.2. Discussion of iProtean video

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

There were no comments from the audience.

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

Mr. Smith thanked Maura Jones and Nyla Lightcap in the administrative office.

14.2. Board Members

Julie Woodworth thanked Ms. Jones and Ms. Lightcap as well. She also mentioned she heard an SPH recruitment ad for nurses it was spectacular! Bernadette Wilson and Matthew Hambrick also thanked Ms. Jones and Ms. Lightcap. Mr. Weisser complimented the quality of the daily briefing reports, and suggested the hospital find a pathway for some components of that email to be shared outward with the community. There was some discussion about if the board receiving these emails could encourage them to slide into a more operational role, but it was generally determined it was good for the Board to know the good things happening inside the hospital. Any board members who would like to receive these emails can reach out to Ms. Jones. Dr. Knapp thanked Ms. Jones and Ms. Lightcap for their positive and lighthearted communications. Mr. Partridge commented that every time he is a patient at South Peninsula Hospital, he receives wonderful care. He also restated the days in A/R is really exceptional. Ms. Cooper gave kudos to the finance team for all their hard work on making the financial experience better for the patients. She also thanked Ms. Jones and Ms. Lightcap.

15. INFORMATIONAL ITEMS

DRAFT

16. ADJOURN TO EXECUTIVE SESSION

Julie Woodworth made a motion to adjourn to Executive Session. Aaron Weisser second. The motion Carried.

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Credentialing

After review of the applicants' files in Executive Session of tonight's meeting, Ms. Woodworth moved to approve the following positions in the medical staff as requested and recommended by the Medical Executive Committee. Walter Partridge seconded the motion. Motion carried.

Reappointments (Telemed)

Akopov, Sergey, MD; Telestroke/Providence; Telemedicine
Atkinson, Benjamin, MD; Telestroke/Providence; Telemedicine
Atwal, Sarabjit, MD; Telestroke/Providence; Telemedicine
Bhanushali, Minal, MD; Telestroke/Providence; Telemedicine
Bhatt, Archit, MD; Telestroke/Providence; Telemedicine
Binder, Mario, MD; Cardiology/Echo Interp;. Courtesy Staff
Freeburg, Joseph, MD; Telestroke/Providence; Telemedicine
Judd, Lilith, MD; Telestroke/Providence; Telemedicine;
Kansara, Amit, MD; Telestroke/Providence; Telemedicine
Lopez, George, MD; Telestroke/Providence; Telemedicine
Lowenkopf, Theodore, MD; Telestroke/Providence; Telemedicine
Marvi, Michael, MD; Telestroke/Providence; Telemedicine
Menon, Ravi, MD; Telestroke/Providence; Telemedicine
Musee, Joel M., MD; eICU/Providence; Telemedicine
Recio-Restrepo, Maria, MD; Telestroke/Providence; Telemedicine
Rontal, Andrew, MD; Telestroke/Providence; Telemedicine
Sapkota, Biggya, MD; Telestroke/Providence; Telemedicine
White, Corey, DO; Telestroke/Providence; Telemedicine
Zurasky, John, MD; Telestroke/Providence; Telemedicine

Reappointments

Oswald, Dana L., ANP Oncology/NP; Courtesy Staff
Tortora, Giulia M., MD; Family Medicine; Active Staff
Warren, Angus M., MD; Emergency Medicine; Courtesy Staff

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18. ADJOURNMENT

Respectfully Submitted,

Maura Jones, Executive Assistant

Accepted:

Kelly Cooper, President

Minutes Approved:

Julie Woodworth, Secretary

DRAFT

South Peninsula Hospital

DRAFT-UNAUDITED

BALANCE SHEET
As of April 30, 2023

		As of April 30, 2023	As of April 30, 2022	As of March 31, 2023	CHANGE FROM April 30, 2022
	ASSETS				
	CURRENT ASSETS:				
1	CASH AND CASH EQUIVALENTS	25,368,795	24,974,566	23,808,636	394,229
2	EQUITY IN CENTRAL TREASURY	8,331,964	7,221,795	8,623,594	1,110,169
3	TOTAL CASH	33,700,759	32,196,361	32,432,230	1,504,398
4	PATIENT ACCOUNTS RECEIVABLE	31,194,515	28,398,330	29,970,631	2,796,185
5	LESS: ALLOWANCES & ADJ	(15,047,554)	(13,729,821)	(14,960,933)	(1,317,733)
6	NET PATIENT ACCT RECEIVABLE	16,146,961	14,668,509	15,009,698	1,478,452
7	PROPERTY TAXES RECV - KPB	110,208	111,858	134,853	(1,650)
8	LESS: ALLOW PROP TAX - KPB	(4,165)	(3,599)	(4,165)	(566)
9	NET PROPERTY TAX RECV - KPB	106,043	108,259	130,688	(2,216)
10	OTHER RECEIVABLES - SPH	336,149	340,842	2,182,213	(4,693)
11	INVENTORIES	1,905,167	1,815,960	1,916,511	89,207
12	NET PENSION ASSET- GASB	5,024,897	9,550,712	4,997,209	(4,525,815)
13	PREPAID EXPENSES	830,411	866,830	911,096	(36,419)
		-	-	-	
14	TOTAL CURRENT ASSETS	58,050,387	59,547,473	57,579,645	(1,497,086)
	ASSETS WHOSE USE IS LIMITED				
15	PREF UNOBLIGATED	6,556,828	5,868,669	7,212,959	688,160
16	PREF OBLIGATED	2,347,446	2,236,342	1,781,135	111,103
17	OTHER RESTRICTED FUNDS	50,434	189,341	27,064	(138,907)
		8,954,708	8,294,352	9,021,158	660,356
	PROPERTY AND EQUIPMENT:				
18	LAND AND LAND IMPROVEMENTS	4,114,693	4,114,693	4,114,693	0
19	BUILDINGS	63,059,362	67,298,990	67,648,703	(4,239,628)
20	EQUIPMENT	27,257,835	29,858,032	30,878,006	(2,600,197)
21	BUILDINGS INTANGIBLE ASSETS	2,456,899	0	2,456,899	2,456,899
22	EQUIPMENT INTANGIBLE ASSETS	462,427	0	462,427	462,427
23	IMPROVEMENTS OTHER THAN BUILDINGS	309,171	273,639	273,935	35,532
24	CONSTRUCTION IN PROGRESS	1,506,279	390,278	1,405,224	1,116,001
25	LESS: ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(56,678,505)	(60,860,898)	(64,572,577)	4,182,393
26	LESS: ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(787,627)	0	(750,630)	(787,627)
27	NET CAPITAL ASSETS	41,700,534	41,074,734	41,916,680	625,800
28	GOODWILL	7,000	19,000	8,000	(12,000)
29	**TOTAL ASSETS**	108,712,629	108,935,559	108,525,483	(222,930)
	DEFERRED OUTFLOWS OF RESOURCES				
30	PENSION RELATED (GASB 68)	4,530,917	(568,607)	4,530,917	5,099,524
31	UNAMORTIZED DEFERRED CHARGE ON REFUNDING	298,393	366,668	304,030	(68,275)
32	TOTAL DEFERRED OUTFLOWS OF RESOURCES	4,829,310	(201,939)	4,834,947	5,031,249
33	TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	113,541,939	108,733,620	113,360,430	4,808,319

		As of April 30, 2023	As of April 30, 2022	As of March 31, 2023	CHANGE FROM April 30, 2022
	LIABILITIES & FUND BALANCE				
	CURRENT LIABILITIES:				
34	ACCOUNTS AND CONTRACTS PAYABLE	1,725,362	1,980,396	1,254,561	(255,034)
35	ACCRUED LIABILITIES	8,103,685	8,188,519	7,153,626	(84,834)
36	DEFERRED CREDITS	9,937	34,266	5,189	(24,329)
37	CURRENT PORTION OF LEASE PAYABLE	402,561	0	401,282	402,561
38	CURRENT PORTIONS OF NOTES DUE	0	0	0	0
39	CURRENT PORTIONS OF BONDS PAYABLE	1,850,000	1,510,000	1,835,000	340,000
40	BOND INTEREST PAYABLE	47,918	62,737	75,666	(14,819)
41	DUE TO/(FROM) THIRD PARTY PAYERS	788,761	1,080,294	1,288,761	(291,533)
43	TOTAL CURRENT LIABILITIES	12,928,224	12,856,212	12,014,085	72,012
	LONG-TERM LIABILITIES				
44	NOTES PAYABLE	0	0	0	0
45	BONDS PAYABLE NET OF CURRENT PORTION	6,615,000	8,740,000	6,905,000	(2,125,000)
46	PREMIUM ON BONDS PAYABLE	413,702	565,345	425,869	(151,643)
47	CAPITAL LEASE, NET OF CURRENT PORTION	1,928,987	26,531	1,962,699	1,902,456
48	TOTAL NONCURRENT LIABILITIES	8,957,689	9,331,876	9,293,568	(374,187)
49	TOTAL LIABILITIES	21,885,913	22,188,088	21,307,653	(302,175)
50	DEFERRED INFLOW OF RESOURCES	0	0	0	0
51	PROPERTY TAXES RECEIVED IN ADVANCE	0	0	0	0
	NET POSITION				
52	INVESTED IN CAPITAL ASSETS	5,731,963	5,731,963	5,731,963	0
53	CONTRIBUTED CAPITAL - KPB	0	0	0	0
54	RESTRICTED	25,286	25,286	25,286	0
55	UNRESTRICTED FUND BALANCE - SPH	85,898,777	80,788,283	86,295,528	5,110,494
56	UNRESTRICTED FUND BALANCE - KPB	0	0	0	0
		-	-	-	
57	**TOTAL LIAB & FUND BALANCE**	113,541,939	108,733,620	113,360,430	4,808,319

South Peninsula Hospital

INCOME STATEMENT
As of April 30, 2023
DRAFT-UNAUDITED

		MONTH				YEAR TO DATE			
		04/30/23			04/30/22	04/30/23			04/30/22
		Actual	Budget	Var B/(W)	Actual	Actual	Budget	Var B/(W)	Actual
	Patient Service Revenue								
1	Inpatient	2,651,052	2,898,174	-8.53%	2,158,762	25,054,786	32,328,537	-22.50%	29,407,816
2	Outpatient	12,014,942	11,771,438	2.07%	10,919,433	124,946,172	121,909,990	2.49%	109,366,520
3	Long Term Care	1,084,714	1,097,797	-1.19%	971,882	10,591,381	10,977,970	-3.52%	8,584,747
4	Total Patient Services	15,750,708	15,767,409	-0.11%	14,050,077	160,592,339	165,216,497	-2.80%	147,359,083
	Deductions from Revenue								
5	Medicare	3,416,636	3,504,649	2.51%	3,077,110	31,219,117	33,556,740	6.97%	29,985,912
6	Medicaid	1,373,209	2,487,461	44.79%	2,235,048	21,542,507	23,817,246	9.55%	20,182,372
7	Charity Care	20,709	148,770	86.08%	(286,284)	1,459,353	1,424,461	-2.45%	385,210
8	Commercial and Admin	1,741,254	1,395,398	-24.79%	1,485,010	14,991,465	13,360,828	-12.20%	12,944,771
9	Bad Debt	5,112	327,174	98.44%	385,641	2,184,543	3,132,669	30.27%	2,535,426
10	Total Deductions	6,556,920	7,863,452	16.62%	6,896,525	71,396,985	75,291,944	5.17%	66,033,691
11	Net Patient Services	9,193,788	7,903,957	16.32%	7,153,552	89,195,354	89,924,553	-0.81%	81,325,392
12	USAC and Other Revenue	69,413	61,664	12.57%	59,590	627,737	616,649	1.80%	558,200
13	Total Operating Revenues	9,263,201	7,965,621	16.29%	7,213,142	89,823,091	90,541,202	-0.79%	81,883,592
	Operating Expenses								
14	Salaries and Wages	4,659,064	4,125,092	-12.94%	3,692,864	42,644,220	41,751,395	-2.14%	39,136,874
15	Employee Benefits	1,852,981	2,094,045	11.51%	1,548,253	18,831,101	21,871,975	13.90%	17,439,493
16	Supplies, Drugs and Food	1,014,115	1,007,853	-0.62%	977,171	10,192,086	11,302,162	9.82%	10,602,939
17	Contract Staffing	355,241	183,808	-93.27%	622,068	2,495,870	1,634,560	-52.69%	3,862,531
18	Professional Fees	572,732	379,847	-50.78%	400,557	5,448,393	4,299,293	-26.73%	4,742,146
19	Utilities and Telephone	163,665	197,920	17.31%	211,968	1,472,864	1,450,264	-1.56%	1,415,965
20	Insurance (gen'l, prof liab, property)	61,120	71,858	14.94%	55,415	595,186	634,123	6.14%	584,559
21	Dues, Books, and Subscriptions	16,660	17,535	4.99%	16,348	187,082	210,980	11.33%	194,283
22	Software Maint/Support	186,389	176,292	-5.73%	162,225	1,692,558	1,708,835	0.95%	1,555,820
23	Travel, Meetings, Education	40,623	33,737	-20.41%	22,358	486,464	597,975	18.65%	447,803
24	Repairs and Maintenance	137,048	140,682	2.58%	152,717	1,544,356	1,311,205	-17.78%	1,306,308
25	Leases and Rentals	54,825	80,828	32.17%	98,311	637,837	685,094	6.90%	738,851
26	Other (Recruiting, Advertising, etc.)	226,898	83,110	-173.01%	122,636	1,396,365	831,125	-68.01%	956,683
27	Depreciation & Amortization	341,533	345,891	1.26%	336,993	3,388,836	3,458,893	2.03%	3,283,993
28	Total Operating Expenses	9,682,894	8,938,498	-8.33%	8,419,884	91,013,218	91,747,879	0.80%	86,268,248
29	**Gain (Loss) from Operations**	**(419,693)**	**(972,877)**	**56.86%**	**(1,206,742)**	**(1,190,127)**	**(1,206,677)**	**1.37%**	**(4,384,656)**
	Non-Operating Revenues								
30	General Property Taxes	27,007	27,738	-2.64%	27,987	4,886,086	4,618,040	5.80%	4,654,928
31	Investment Income	4,499	9,750	-53.86%	(63,730)	336,508	97,504	245.12%	(67,343)
32	Governmental Subsidies	0	0	0.00%	690,030	0	0	0.00%	3,118,212
33	Other Non Operating Revenue	54	0	100.00%	0	5,573	0	100.00%	79,384
34	Gifts & Contributions	0	0	0.00%	0	0	0	0.00%	0
35	Gain <Loss> on Disposal	0	0	0.00%	0	6,572	0	0.00%	0
36	SPH Auxiliary	479	6	7883.33%	1	3,219	58	5450.00%	44
37	Total Non-Operating Revenues	32,039	37,494	-14.55%	654,288	5,237,958	4,715,602	11.08%	7,785,225
	Non-Operating Expenses								
38	Insurance	0	0	0.00%	0	0	0	0.00%	0
39	Service Area Board	(838)	10,586	107.92%	11,710	91,346	72,127	0.00%	73,210
40	Other Direct Expense	4,959	3,600	-37.75%	5,020	19,926	36,001	44.65%	41,939
41	Administrative Non-Recurring	0	0	0.00%	0	0	0	0.00%	0
42	Interest Expense	38,651	28,431	-35.95%	32,233	388,995	284,315	-36.82%	322,330
43	Total Non-Operating Expenses	42,772	42,617	-0.36%	48,963	500,267	392,443	-27.48%	437,479
	Grants								
44	Grant Revenue	36,179	29,167	0.00%	0	278,198	291,667	0.00%	1,202,810
45	Grant Expense	2,502	25,000	89.99%	18,336	25,015	250,000	89.99%	606,495
46	Total Non-Operating Gains, net	33,677	4,167	708.18%	(18,336)	253,183	41,667	-507.63%	596,315
47	Income <Loss> Before Transfers	(396,749)	(973,833)	59.26%	(619,753)	3,800,747	3,158,149	20.35%	3,559,405
48	Operating Transfers	0	0	0.00%	0	0	0	0.00%	0
49	**Net Income**	**(396,749)**	**(973,833)**	**-59.26%**	**(619,753)**	**3,800,747**	**3,158,149**	**20.35%**	**3,559,405**

DRAFT-UNAUDITED

Statement of Cash Flows
As of April 30, 2023

#	Description		Amount
	Cash Flow from Operations:		
1	YTD Net Income		3,800,747
2	Add: Depreciation Expense		3,388,836
3	Adj: Inventory (increase) / decrease		157,337
4	Patient Receivable (increase) / decrease		371,249
5	Prepaid Expenses (increase) / decrease		(70,192)
6	Other Current assets (increase) / decrease		286,593
7	Accounts payable increase / (decrease)		(78,454)
8	Accrued Salaries increase / (decrease)		(7,241)
9	Net Pension Asset (increase) / decrease		(349,188)
10	Other current liability increase / (decrease)		(1,388,394)
11	Net Cash Flow from Operations		6,111,293
	Cash Flow from Investing:		
12	Cash paid for the purchase of property/equip		(1,993,580)
13	Cash transferred to plant replacement fund		(1,276,373)
14	Proceeds from disposal of equipment		6,572
15	Net Cash Flow from Investing		(3,263,381)
	Cash Flow from Financing		
16	Cash paid for Lease Payable		-
17	Cash paid for Debt Service		(2,197,594)
18	Net Cash from Financing		(2,197,594)
19	Net increase in Cash	$	650,318
20	Beginning Cash as of July 1, 2022	$	33,050,441
21	Ending Cash as of April 30, 2023	$	33,700,759

South Peninsula Hospital

MEMO

Administration
4300 Bartlett Street
Homer, AK 99603
907-235-0325 (f) 907-235-0253

To: SPH Board of Directors

From: Susan Shover, BSN, RN, CPHQ; Director of Quality Management

Date: May 17, 2023

Re: Quality Plan

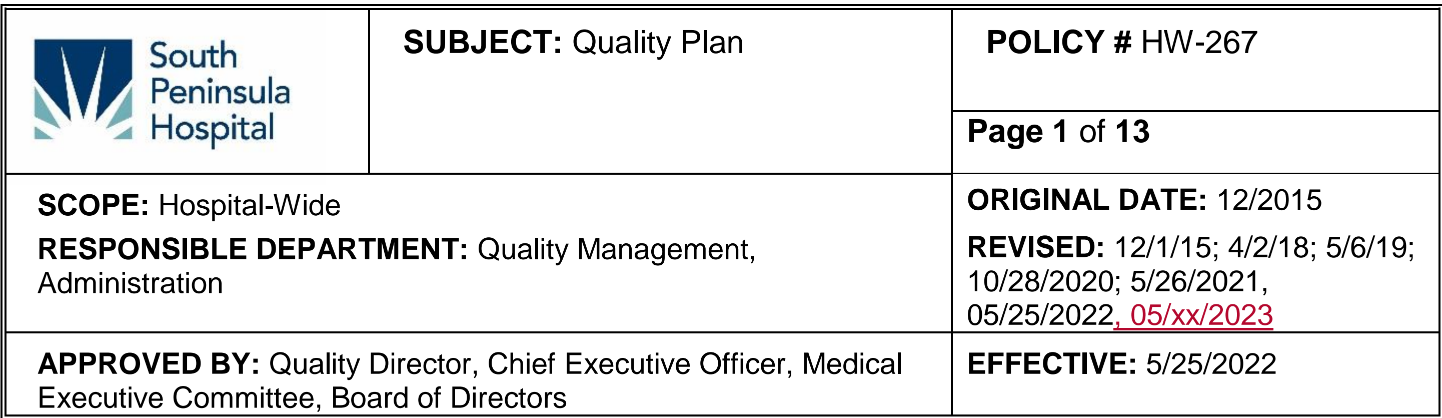
The SPH and LTC Facility Quality Plan is the overarching plan for the organization and has recently been updated to reflect changes that have occurred since May 2022. There has been some formatting changes and streamlining of language with a couple specific content changes.

The LTC Facility QAPI Plan, which is specific to LTC Quality activities, received Board of Director (BOD) approval earlier this year. The LTC Facility QAPI Plan is coming before the BOD at this time so both the SPH and LTC Facility Quality Plan and the LTC QAPI Plan will be on the same annual approval schedule.

The content changes for the SPH and LTC Facility Quality Plan include updating the term "customers" in four (4) areas of the document to state patients and residents. Under the Roles and Responsibilities section, the BOD co-chair was removed at the request of the current Patient Centered Care Quality Committee co-chair, to be in line with BOD policy. Two BOD members will continue to participate in the quarterly quality meetings. There were no changes made to the LTC QAPI Plan.

The updated versions of the SPH and LTC Facility Quality Plan and the LTC QAPI Plan have been shared with, and approved by the Medical Executive Committee (MEC) and Patient Centered Care Quality Committee during their April committee meetings.

Recommended Motion: Consideration to approve the revised South Peninsula Hospital and LTC Facility Quality Plan along with the LTC QAPI Plan for 2023-2024.



South Peninsula Hospital	**SUBJECT:** Quality Plan	**POLICY #** HW-267 **Page 1** of **13**
SCOPE: Hospital-Wide **RESPONSIBLE DEPARTMENT:** Quality Management, Administration		**ORIGINAL DATE:** 12/2015 **REVISED:** 12/1/15; 4/2/18; 5/6/19; 10/28/2020; 5/26/2021, 05/25/2022, 05/xx/2023
APPROVED BY: Quality Director, Chief Executive Officer, Medical Executive Committee, Board of Directors		**EFFECTIVE:** 5/25/2022

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PURPOSE:
Program components and outline for the South Peninsula Hospital (SPH) & Long Term Care (LTC) Facility Quality Plan in accordance with federal, state, and local regulatory guidelines and requirements.

DEFINITION(S):

N/A

POLICY:

I. Missions, Vision, Values:

The foundation of the SPH & LTC Facility Quality Plan is the organization's mission, vision, values, and associated behaviors:

Mission: *SPH & LTC Facility promote community health and wellness by providing personalized, high quality, locally coordinated healthcare.*

Vision: *SPH & LTC Facility is the healthcare provider of choice with a dynamic and dedicated team committed to service excellence and safety.*

Values & associated behaviors**:** *(See Appendix A – 'Our Values in Action' for additional details)*

- Compassion**:** *We provide compassionate patient and resident centered quality care, and a safe and caring environment for all individuals.*
- Respect**:** *We show respect for the dignity, beliefs, perspectives, and abilities of everyone.*
- Trust**:** *We are open, honest, fair, and trustworthy.*
- Teamwork**:** *We work together as a dynamic, collaborative team, embracing change, and speaking as one.*
- Commitment**:** *We are responsible and accountable for supporting the vision, mission, values, strategies, and processes of our organization.*

II. Patient & Resident Centered Care:

"Providing care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions," (Institute of Medicine, 2015). Patient and resident centered care is supported by SPH and the LTC Facility through the active involvement of patients', residents', and their designated caregivers and/or families as appropriate, in decision making about options for treatment. SPH and the LTC Facility will hereafter be referred to as "The SPH Organization."

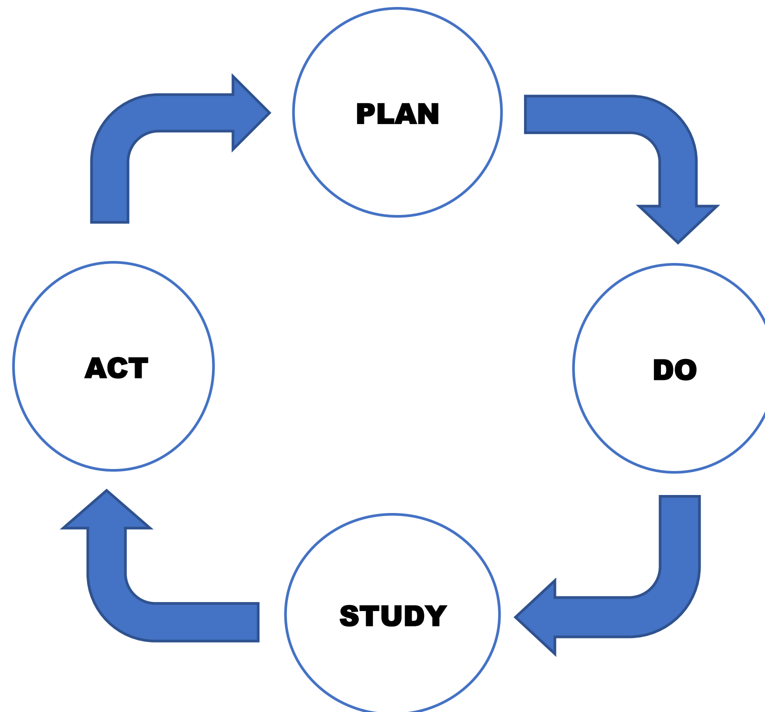
A. Patient and Resident Centered Care is provided:
- In accordance with the SPH Organization values & behaviors
- In a safe, timely, and cost effective manner
- Consistent with achievable goals
- With proper documentation to facilitate continuous evaluation and improvement
- Adhering to evidence based, effective practices

B. Patient and Resident Centered Care is delivered:
- By qualified and/or licensed personnel who are lawfully vetted
- Utilizing clear channels of supervision
- By effectively supervised personnel fostering patient and resident care

III. Quality Foundation:

1. *Quality Plan:* The Quality Plan serves as the foundation of commitment the SPH Organization has to reduce harm while continuously improving the quality and safety of the treatment and services provided.
2. *Hospital Board of Trustees Balanced Scorecard Report (BSC):* The SPH BSC provides an overview of specifically selected indicators to monitor the organizations quality and financial health. The BSC is updated quarterly and communicated monthly to the BOD and MEC, and quarterly to the Patient Centered Care Quality Committee (PCCQC).
3. *Quality Improvement Change Model:* The Quality Improvement Change Model "Plan-Do-Study-Act" (PDSA) will be used to communicate, track and trend specific department quality improvement activities as well as for those indicators falling below the established target on the SPH BSC.

PDSA Cycle for Improvement



A. Plan: Identify a problem or process to improve and determine the objective or goal
B. Do: Carry out the plan. Collect data and begin to analyze the data
C. Study: Complete the analysis of the collected data and summarize what was learned
D. Act: Determine next steps. Adopt, abandon, or modify the plan. Prepare the plan for the next PDSA is needed. If the plan was successful and adopted, plan for periodic review to assure the plan is effective.

4. *Measurement/Monitoring and Data Analysis:* Quality monitoring is intended to allow ongoing surveillance of important activities through sampling measures. Data, once collected, will be analyzed for opportunities of performance improvement. Quality and safety monitors and measures include but are not limited to the following:
   - Hospital Board of Trustees Balanced Scorecard Report (BSC)
   - Adverse Drug Events
   - Trends identified through occurrence reports, grievances, or complains received
   - Infection Prevention surveillance
   - National Patient Safety Goals
   - CMS Core Measures, Hospital Compare and Nursing Home Compare
   - Reported Patient/resident and/or staff concerns
   - Patient Satisfaction survey data/responses
   - Failure Modes and Effects Analysis (FMEA), Root-Cause-Analysis and/or Sentinel Event Alerts
   - Identified quality improvement opportunities
   - ~~CMS Core Measures or other nationally accepted measures~~
   - Statewide quality improvement opportunities through ~~the Hospital Engagement Network (HEN),~~ Telligen Hospital Quality Improvement Contractor (HCIQ) or Medicare Beneficiary Quality Improvement Project (MBQIP)
5. *Employee Engagement:* Employees ~~on all levels of the organization~~ are expected to contribute to quality improvement initiatives and risk identification to improve care provided to the patients and residents~~customers~~ of the SPH Organization. Employees are able to contribute to quality

improvement and risk reduction through the Patient Centered Care Quality Committee (PCCQC), Process Enhancement Teams, Root-Cause-Analysis meetings, Rapid Cycle Quality Improvement Process, occurrence report system, employee suggestion box system, internal departmental communication, and employee satisfaction surveys. Individuals or departments will be recognized for their quality improvement efforts.

6. *Services:* The SPH Organization will deliver service to preserve and advance the quality of patient and resident care, promote patient and resident centered care, enhance appropriate utilization of resources, deliver care by qualified individuals utilizing evidence-based best-practice principles and reduce or eliminate unnecessary risks and hazards within the facility. The Organization will integrate the use of Trauma Informed Principles into patient and resident care to support patient and resident engagement, reduce re-traumatization and provide a safe and welcoming environment for all. ~~Each patient's and resident's need for care, intervention, or treatment is assessed by qualified individuals (as defined by credentialing procedures, licensing, and hospital-approved job descriptions) and continues throughout the patient's or residents contact with SPH, LTC Facility, and/or Home-Based Health Services.~~

IV. Roles and Responsibilities:

Leadership of SPH and LTC Facility includes the Operating Board of Directors (BOD), Medical Executive Committee (MEC), Senior Leadership Team, Quality Management Department, Patient Centered Care Quality Committee, Safety/Hospital Incident Management Team (HIMT) Committees, and SPH staff.

Active leadership participation and contribution fosters quality improvement and safety initiatives consistent with our mission, vision, and values.

1. *Operating Board of Directors (BOD):* The SPH BOD shall review and evaluate overall quality activities to promote improvement and efficiencies to patient and resident care. The BOD will provide support and guidance of quality improvement activities, dedicate appropriate resources necessary to support the quality improvement process from the planning and development phase through the implementation of measures, actions, or ~~changes which~~changes that improve patient and resident care and facilitate safety and satisfaction. While maintaining overall responsibility, the Board delegates an oversight role to the Patient Centered Care Quality Committee and operational authority to the Senior Leadership Team, The Quality Management team and Medical Staff represented by the MEC. The Board will maintain responsibility for~~,~~ review, evaluatione, and the approvale the Quality Plan annually. The Board will:
   - Actively participate in ~~and co-chair~~ the Patient Centered Care Quality Committee
   - Receive and review periodic quality improvement performance reports on findings, conclusions, recommendations, actions, and results of plan activities
   - Assess the plan's effectiveness and efficacy and require modification in organizational structure and systems where necessary to improve Plan performance
   - Verify the overall goal of patient and resident centered care is being achieved
   - Require a process designed to ensure all individuals responsible for the assessment, treatment, or care of patients and residents are competent
   - Commit to and support the organization's values
2. *Medical Executive Committee (MEC):* The MEC is the primary governance committee for the medical staff and is accountable to the Board of Directors for oversight, monitoring, and evaluation of medical services. The MEC, with input from the medical staff will:
   - Play a significant role in performance improvement and assessment of each provider's clinical competence and professional behavior, through the Medical Staff Bylaws/Rules & Regulations, credentialing, ongoing and focused professional practice evaluation, and/or medical staff committees
   - Make key leadership decisions related to medical staff policies, procedures, and rules with an

emphasis on patient and resident quality and improvement initiatives
- Work collaboratively with nursing and other patient/resident care departments to develop policies and procedures necessary to provide safe and effective care
- Participate in quality improvement activities and monitoring to facilitate patient safety and standard of care
- Oversee the quality of patient care, treatment, and services provided by practitioners privileged through the Medical Staff credentialing process
- Commit to and uphold the organization's values

3. *Senior Leadership Team (SLT):* The SLT works collaboratively with the BOD, Management team, Quality Management Department and SPH staff to support quality improvement activities and facilitate excellent clinical care that aligns with best practice. The SLT will:
- Embody a culture of patient/resident centered care
- Ensure sufficient resources and personnel are provided to support patient and resident safety and quality improvement activities
- Assure staff are provided adequate time to participate in quality improvement and patient and resident safety activities
- Establish a culture of communication to encourage appropriate interaction between and among patients, residents, families & caregivers, and members working within and utilizing the services of SPH
- Support Quality Improvement initiatives by encouraging Departmental Managers/Directors to engage in unit specific quality and safety monitoring
- Support and actively engage in improvement opportunities for quality indicators identified on the SPH BSC
- Embrace and demonstrate the organization's values and behaviors

4. *Quality Management:* Quality Improvement and risk reduction activities for the SPH organization are led by the Director of Quality Management (QM). The Director of Quality Management, along with the assistance of the QM team, is responsible to facilitate quality improvement and safety initiatives to reduce risk throughout the organization. The quality improvement and safety initiatives are to reflect evidenced-based practice and promote improved care to our patients, and residents., and customers. The Director of QM along with the QM team will:
- Oversee quality improvement, safety initiatives and risk management activities for SPH and LTC
- Facilitate completion of quarterly Hospital Board of Trustees Balanced Scorecard Report and support departmental improvement activities, including development of PDSA's to meet established targets
- Communicate BSC updates and PDSA's along with risk and/or safety concerns to BOD quarterlymonthly
- Be responsible for ensuring appropriate quality actions are implemented, and within established time frames, as directed by the PCCQC, for quality and safety matters
- Provide orientation and training on quality improvement and risk functions
- Report known changes in regulations, laws, and certifications/accreditation standards to the staff
- Ensure data retrieval functions are completed for ongoing quality improvement to meet best practice standards utilizing: National Patient Safety Goals & quality indicators, Patient satisfaction data through Press Ganey, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Hospital Engagement Network (HEN), Medicare Beneficiary Quality Improvement Program (MBQIP), Telligen Hospital Quality Improvement Contractor (HQIC) and Core Measure CMS reporting
- Aggregate quality data findings for presentation to the Board, Medical Staff, SPH & LTC staff, SLT, Departmental Managers/Directors and Patient Centered Care Quality Committee
- Conduct data analysis for data collected falling outside statistical norms

- Assist Departmental Managers/Directors with systemic occurrence review
- Conduct and/or participate in a timely root cause analysis for sentinel or serious safety events or to facilitate improvement related to specific process-driven events
- Assist departments with identifying opportunities for improvement, planning & implementing changes, and departmental Quality dashboard/PDSA reporting
- ~~Engage with SPH Trauma Informed Care Committee as a Risk Mitigation strategy~~
- Chair and facilitate the SPH Hospital-Wide Policy Committee and assist with policy writing, review and work to ensure SPH policies meet State, Federal and regulatory requirements
- Actively and enthusiastically promote the organization's values

5. *Patient Centered Care Quality Committee:* The Patient Centered Care Quality Committee provides ongoing operational leadership of continuous quality improvement activities at SPH & LTC. The PCCQC is composed of at least one~~two~~ Board member~~s~~, ~~member(s) of SLT with~~ the Director of QM as co-chair, Department Managers/Directors and staff, a designated physician from patient or resident care/service area. The PCCQC will meet quarterly. Functions of the committee include:
   - Providing input and recommending approval of the Quality Plan to the BOD
   - Suggesting and supporting priority indicators of quality for the BSC
   - Assessing information based on the indicators, taking action as evidenced through the quality improvement initiatives to solve problems and pursue opportunities to improve quality
   - Establishing and supporting specific quality improvement and safety initiatives
   - Reporting to the Board through committee minutes, ~~or Director of Quality Management,~~ CNO, or CEO on quality improvement activities on a regular basis
6. *Safety/Hospital Incident Management Team (HIMT) Committees:* The Safety/HIMT Committees are responsible to provide an update to the PCCQC at least quarterly on the committee's active quality improvement and safety initiatives.
7. *Staff:* All employees of the organization are expected to engage and contribute with improving the quality of care provided to the patients and residents~~customers~~ of SPH. Importance of organizational quality improvement is conveyed during initial hospital orientation and through individual departments by the department managers/directors.

V. Quality Plan

A. SPH is dedicated to the ongoing improvement of the quality and safety of care our patients and residents receive as evidenced by the outcomes of that care. The goal of this plan is to strive for and achieve system-wide quality and safety best practices to improve patient experiences, outcomes, and also provide accountability for reaching the highest possible quality and value for healthcare provided.

B. *Quality Statement:* The SPH Organization has adopted the six Domains of Healthcare Quality proposed by the Agency for Healthcare Research and Quality (AHRQ): Quality – care delivered in a safe, effective, patient-centered, timely, efficient, and equitable fashion.

C. *Safety Statement:* The SPH Organization contends safety is the foundation upon which all other aspects of quality care are built.

1. Empowerment of Stakeholders: To achieve the greatest level of success in our quality improvement efforts, we include all involved stakeholders in patient and resident care. The SPH Organization's goal is collaboration of leadership and stakeholders in all aspects of quality improvement so all are empowered to guide its success. This will be achieved by:
   a. Employee Disclosure: The SPH Organization expects employees to speak-up and speak-out by identifying improvement and process opportunities, reporting occurrences, sentinel or serious safety events, near misses, the existence of hazardous conditions, and related opportunities for improvement as a means to identify systems and behavior changes needed to avoid future adverse events. It is acknowledged that errors must be identified before they can be corrected.

b. Patient Disclosure: Hospital or Facility Representative at SPH and LTC will notify patients and residents or their family and/or significant other/designated caregiver when an unanticipated medical risk, hazard or error occurs in a patient or resident's care and will explain the unexpected outcome to the patient or resident, and/or family if the patient or resident is not able to understand. Hospital or Facility Representative will also coordinate with the attending physician, when appropriate.

c. Fair, Equitable and Just Culture: The SPH Organization operates within a fair, equitable and just culture where the organization's values and behaviors are actively promoted. Front-line staff or others are not punished for actions, omissions or decisions which are commensurate with their experience and training. The Decision Tree for Determining the Culpability of Unsafe Acts and the Incident Decision Tree along with Just Culture principles will be used for follow-up to concerns, errors or near misses.

d. Patient and Family Engagement: The SPH Organization recognizes each patient or resident is an individual with unique health care needs and to the best of our ability will provide considerate, respectful care focusing on those needs. It is recognized the patient or resident has the right to be involved in making decisions regarding their care and to . Patients and their families are afforded the right and opportunity to have any complaints, suggestions or concerns heard, investigated promptly and resolved.

e. Culture of Safety: The SPH Organization is committed to minimizing adverse events. We maintain a commitment to safety for all staff. This commitment establishes a "culture of safety" that encompasses these key features:
   i. acknowledgment of the high-risk nature of the organization's activities and the determination to achieve consistently safe operations
   ii. a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
   iii. encouragement of collaboration among departments and disciplines to seek solutions to patient safety problems
   iv. organizational commitment of resources to address quality and safety concerns
   v. iv. improving the culture of safety within our organization is an essential component of preventing or reducing errors and improving health care quality to our customers.

2. Identification of Risks, Hazards and Errors: Prospective, Concurrent and Retrospective review of patient/resident care is utilized to identify quality improvement opportunities and to assess for risks, hazards, and errors.
   a. Prospective Identification: Prospective identification occurs prior to patient interaction. This review involves identifying risks, hazards and error potential before occurrences happen.
   b. Concurrent Review: Concurrent Quality Improvement (QI) review begins when quality and safety measures or initiatives are evaluated at the point of care.
   c. Retrospective Review: Retrospective review includes after-care appraisal to evaluate and/or measure performance.

3. Goal Setting: The SLT and Departmental Managers/Directors will be responsible for determining organizational priorities and goals identified on the BSC. The BOD will review and may provide input for yearly quality and safety indicators, and organizational goals on the BSC. Department Managers/Directors will document quality accomplishments and establish quality improvement goals in the annual Critical Access Program Evaluation with BOD review and approval. The PCCQC will assist with providing specifics on how to meet and achieve organizational quality and safety goals.
   a. The goal setting philosophy of The SPH Organization is prioritizing goals most important to our patient and resident population and achieving zero harm or 100% compliance in quality and safety indicators.

b. The SPH Organization will utilize state and/or national patient/resident outcome quality and safety database reports (including CMS reports) to compare the hospital's performance with other facilities which is used to identify areas for quality improvement.

4. Measurement & Assessment: Categorical and/or Continuous Data will be captured, assessed, analyzed, and communicated through facility and departmental Quality Department Dashboards and BSC. Department Dashboard analytic data may be communicated through visual displays such as Run Charts, Pareto Charts, Histograms, etc. Continuous quality improvement requires adjustments to processes and/or procedures based on data analysis and the opportunities for performance improvement identified.
   a. Classification Systems: The SPH Organization will utilize the SPH Risk Classification Grid for assessment and classification of the severity of the identified risks and occurrence reports. For medication events, the National Coordinating Council for Medication Error Reporting and Prevention Index for categorizing medication errors will be used for classification and determination of patient/resident harm. These tools are the foundation for patient and resident safety and risk measurement for South Peninsula Hospital and LTC Facility:

South Peninsula Hospital Identified Risk Classification Grid

PROBABILITY, LOW → HIGH		No Injury, Potential or Unknown Harm:	Moderate - Minor Harm:	Great Harm or Substantial Potential for Great Harm: (Never/Sentinel Events
	Great Likelihood of Risk, Hazard or Error Recurrence: Daily or hourly Probability almost certain or likely	**2C**	**2A**	**1A**
	Moderate Likelihood of Risk, Hazard or Error Recurrence: Monthly or weekly Probability possible ***Use if probability is unknown	**3B**	**2B**	**1B**
	Little Probability of Risk, Hazard or Error Recurrence: Quarterly or Annually Probability Unlikely or Rare	**3C**	**3A**	**1C**
	LEVEL OF HARM, LOW → HIGH			

Incidents with the potential of Great Harm-Never/Sentinel Events will be shared with the Board of Directors and PCCQ as appropriate following completion of a Root-Cause-Analysis (RCA). The reporting format will be the Plan-Do-Study-Act (PDSA).

Definitions:

- A near miss**:** An unexpected occurrence in which there was no adverse outcome to the patient/resident, but which had the potential to cause serious injury or harm to the patient/resident.
- Never Event: Errors in medical care that are clearly identifiable, preventable and serious in their consequences as defined by CMS and National Quality Forum (NFQ).

- Sentinel event: An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof, i.e. loss of patient/resident life, limb, or function. The National Quality Forum (NQF) Never Events are also considered Sentinel Events.

b. Assessment: Measurement and assessment procedures include:

- Identify problems and opportunities to improve the performance of processes
- Assess the outcome of the care provided
- Assess whether a new or improved process meets performance expectations
- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level
- Assess and analyze data gathered through State/Federal quality reporting and internal quality improvement departmental and facility initiatives

c. Risk Mitigation: The SPH Organization strives to design effective processes to achieve excellent outcomes. Staff report occurrences relating to patients, residents, visitors, employees, property, systems and devices related to unusual or adverse events along with actual or potential injuries. The goal of this system is to identify opportunities for improvement, risk prevention, reduction and/or resolution and monitored for trends. ~~The Director of QM and QM team reviews all reports, evaluates them for possible risk prevention, reduction or resolution and forwards to the appropriate Director/Manager for follow-up, process improvement and/or risk reduction.~~

d. Audits: Process review and improvement is conducted by various audits including random sampling, specific stratified sampling, department rounding, etc.

e. Feedback: Opportunities for quality, safety and process improvement. Feedback and data from Press-Ganey satisfaction surveys, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), SPH Quality email, occurrence and grievance reports is used to inform practice and measure results. Grievances and complaints are documented, monitored for trends, with grievances communicated at the executive session of PCCQC and with the BOD as requested by PCCQC BOD members.

5. Optimization of Performance: Once the performance of a selected process has been measured, assessed and analyzed, the data gathered is used to identify the quality improvement initiative to be undertaken.
   - Elevation of Sentinel, Never & Near Miss Events: Should a sentinel event occur, the Director of QM, with guidance from SLT as needed, will work with those involved to review the incident. A ~~and conduct a~~ root-cause analysis (RCA) will be conducted to determine if there was either:
     - Special cause variation - human error, or
     - Common cause variation - underlying system or process issue

       Once the root-cause analysis has been conducted, the RCA team will develop an appropriate action plan to address any variations identified and establish measures for any changes made which will be documented in the PDSA format and shared with the PCCQ Committee and the Board at the next scheduled meeting. Quarterly updates of PDSA Reports will be shared with the Committee until the issue is determined to be resolved. Once resolved, QI indicators may be continued to ensure the problem remains corrected.
   - Root Cause Analysis or Investigation: Occurrences are evaluated by Investigation or Root Cause Analysis in a fair and equitable manner.
     - Investigation: Departmental Managers/Directors investigate occurrences with guidance provided by the Quality Management Department. After investigation is completed, the occurrence report is reviewed to determine if additional steps are needed and/or accepted as complete and closed within the electronic system.~~with all pertinent findings is sent back to the Director of QM for review of the findings, determination if additional steps are needed, and/or accepted as complete.~~ Occurrence investigation may lead to a root cause analysis.

- Performance Enhancement Teams (PETs): A Performance Enhancement Team is developed when a process in need of improvement has been identified. The team is a group of people who work together on the improvement process/initiative and has a team leader, facilitator and subject expert members. The QM Department is a resource and will assist with facilitation, tracking and trending of goals and outcomes as needed.
- Standardization of Work: Standardized work leads to increased patient safety, faster care and better quality outcomes. The SPH Organization strives to reduce harm and increase patient, resident, and staff satisfaction through standardization of work processes and care decisions.
- Evidence Based Practice: The SPH Organization provides healthcare using the best, research-proven assessments and treatments in our day-to-day patient and residentcustomer care and service delivery. Each clinician is expected to stay in touch with the research literature and to use it as a part of their clinical decision makingdecision-making.
- ~~Deployment of Lessons Learned: A "lesson learned" (in the context of evaluations) is defined as a generalization based on an experience (e.g., projects, policies, or programs) which was evaluated. Our organization retains and applies this knowledge to future practice and clinical decision making to enhance overall quality and safety.~~

6. Support to Ensure Quality Plan Effectiveness:
   - Communication: communication may take place through the following methods:
     - Balanced Scorecard, PDSA's, Departmental Quality Dashboards, story boards, graphs and posters displayed in common areas, on the Staff Information Site (SIS) and/or SPH website
     - Members participating in the PCCQ Committee report information back to their departments
     - Newsletters and/or handouts
   - Education: Managers, clinicians, and staff will be educated in the principles and practices of quality improvement. The SPH Organization offers continuing education in-house, and off campus and supports new or higher education for improved clinical competency.
   - Training for improved education/competence: Various methods for staff education include:
     - Computer based programs such as Up-To-Date and eLippincott
     - Healthstream
     - Skills Fairs/Labs
     - Alaska State Hospital and HealthcareNursing Home Association (AHHA) webinars, in-services and conferences
     - Quality Improvement educational offerings and conferences for individuals with leadership roles and responsibilities to enhance and develop quality improvement efforts
     - Quality Improvement/Risk reduction webinars and Bite-sized Learning offerings through Optima Healthcare Insurance.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. Attachment A – "Our Values In Action"
2. Attachment B - Performance Management Decision Guide
3. Duquette, CLeadership and management; Q solutions: Essential resources for the healthcare quality professional. *National Association for Healthcare quality. Third edition.* (2012)

4. National Coordinating Council for Medication Error Reporting and Prevention. *Index for Categorizing Medication Errors.* 2001
5. Six Domains of Health Case Quality. Retrieved from *https://www.ahrq.gov/talkingquality/measures/six-domains.html*
6. The Incident Decision Tree. Retrieved from https://www.ahrq.gov/downloads/pub/advances/vol4/meadows.pdf
7. Patient-Centered Care. Institute of Medicine. Crossing the chasm: A new health system for the 21st century. Retrieved from http://www.oneviewhealthcare.com/the-eight-principles-of-patient-centered-care/
8. Key Ingredients for Successful Trauma-Informed Care Implementation. Menschner, C. and Maul, A.; Center for Health Care Strategies. (April, 2016).

9. Plan Incorporation:
   A. The following policies are incorporated by reference in this plan:
      1. ED-001 Nursing Continuing Education Administrative Support
      2. EMP-03 Disruptive Conduct & Abusive Behavior
      3. HW-007 Employee Suggestion System
      4. HW-014 Occurrence Reports
      5. HW-068 Patient and Resident Rights
      6. HW-144 Patient Grievance Process
      7. HW-147 Disclosure of Medical Errors
      8. HW-151 HIPAA
      9. HW-160 Sentinel Events
      10. HW-168 Employee Service Awards
      11. HW-218 Workplace Bullying
      12. HW-229 Incident Review
      ~~13.~~
      ~~14.~~13. LTC Facility Assessment 2023~~1-2022~~
      ~~15.~~14. PCS-143 Provision of Care
      ~~16.~~15. Q-01 Medical Staff Credentialing Privileges
   B. The following plans are incorporated by reference in this plan:
      1. Infection Prevention Plan
      2. SPH and LTC Facility Medical Staff Bylaws, Rules and Regulations
      ~~3.~~
      ~~4.~~
      ~~5.~~3. ~~Safety Plan~~
      ~~6.~~4. LTC QAPI Plan ~~2022~~2023; Attachment C~~xx~~

CONTRIBUTOR(S):
Quality Management Director, PCCQ Committee, Members of Senior Leadership Team, Board of Directors, and SPH/LTC Facility Management, and Medical Executive Committee.

APPENDIX A & B

Our Values in Action

COMPASSION IS:
- I place patient and resident needs first.
- I use safe work practices.
- I am willing to help all individuals.
- I have time for you.
- I show empathy.
- I behave in a caring manner.

COMPASSION IS NOT:
- I treat you as a burden.
- I look the other way.
- I am too busy.
- I act as if I don't care.
- I can't help you.

RESPECT IS:
- I respect diversity and individual beliefs.
- I am kind and polite.
- I am considerate of your needs.
- I value your input.
- I treat you as an equal.
- I respect privacy and confidentiality.

RESPECT IS NOT:
- I bully and intimidate.
- I raise my voice and curse.
- I shame and embarrass others.
- I am divisive and judgmental.
- I manipulate and undermine.
- I ignore you.

TRUST IS:
- I build trust with what I say and do.
- I communicate in an open and timely manner.
- I listen to what you say and ensure that I understand.
- I am fair and consistent in the actions I take.
- I follow up and provide feedback.
- I act with integrity.
- I responsibly report risks, hazards and errors.
- I apologize and admit when I am wrong.

TRUST IS NOT:
- I say one thing and do another.
- I gossip and spread rumors.
- I withhold information and conceal mistakes.
- I undermine the chain of command.
- I discuss issues outside appropriate channels.
- I draw conclusions before facts are known.
- I cause or tolerate retribution to the reporting of harm or near misses.

TEAMWORK IS:
- I embrace change and engage in process improvement.
- I adapt to changing circumstances.
- I actively participate in teamwork and seek out ways to help the team.
- I support the team's decisions.
- I recognize and acknowledge contributions and achievements.
- I invite and accept constructive feedback.

TEAMWORK IS NOT:
- I exclude others.
- "It's not my job/responsibility."
- I resist change.
- I disregard team decisions.
- I do not follow established processes.
- I am not cooperative.
- I complain without offering a solution or recommendation.

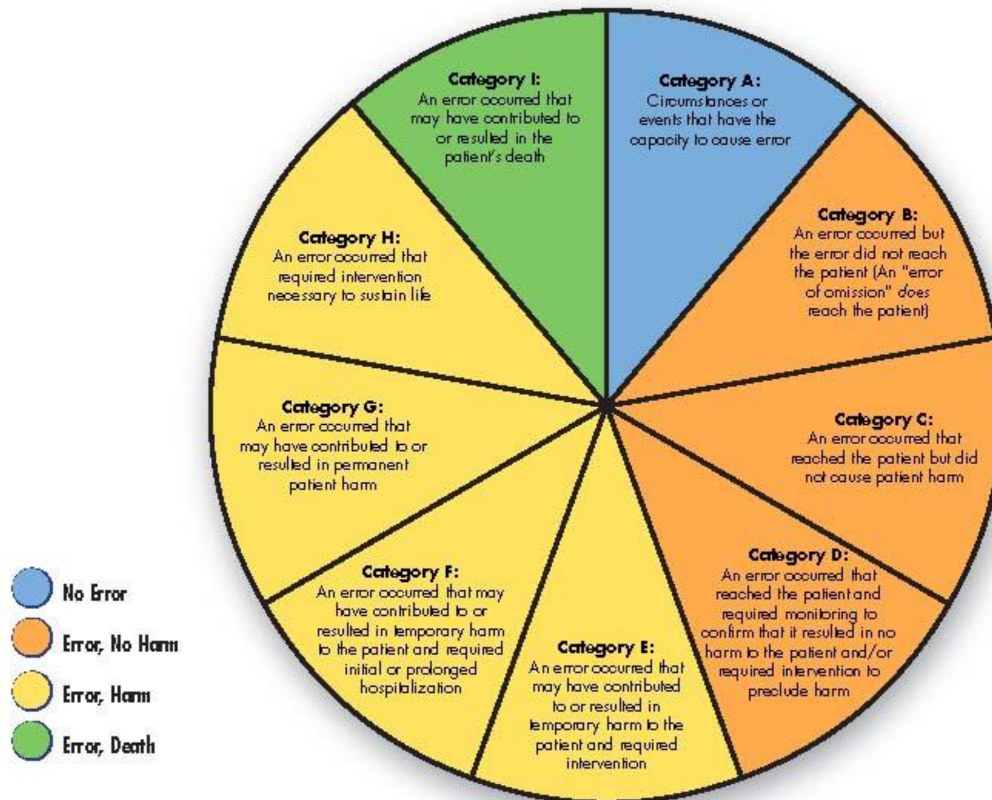
COMMITMENT IS:
- I represent my organization's best interests with a positive attitude.
- I exemplify expected behaviors.
- I am responsible and accountable.
- I hold others accountable in a fair and consistent manner.
- I adhere to the organization's policies and best practices.
- I prioritize and accomplish my work with a sense of urgency.
- I am a good steward of resources.

COMMITMENT IS NOT:
- I compromise the quality, safety and reputation of my organization.
- I act inappropriately.
- I delay or fail to hold myself or others accountable.
- I avoid review of my performance.
- I am defensive and make excuses.
- I blame others.
- I disregard policies and procedures.

Appendix B

NCC MERP Index for Categorizing Medication Errors

Appendix B



Definitions

Harm
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring
To observe or record relevant physiological or psychological signs.

Intervention
May include change in therapy or active medical/surgical treatment.

Intervention Necessary to Sustain Life
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)

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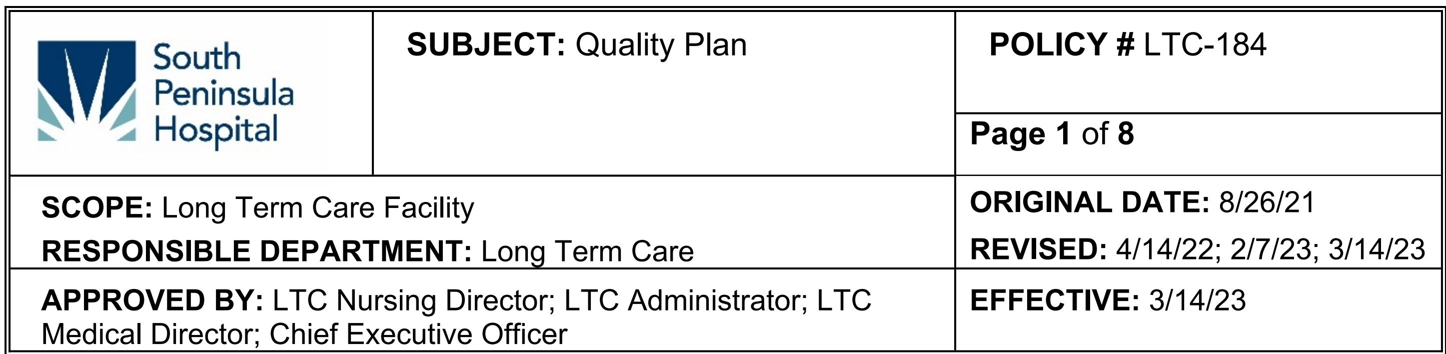

	SUBJECT: Quality Plan	POLICY # LTC-184
		Page 1 of 8
SCOPE: Long Term Care Facility RESPONSIBLE DEPARTMENT: Long Term Care		ORIGINAL DATE: 8/26/21 REVISED: 4/14/22; 2/7/23; 3/14/23
APPROVED BY: LTC Nursing Director; LTC Administrator; LTC Medical Director; Chief Executive Officer		EFFECTIVE: 3/14/23

I. Missions, Vision, Values: 1
II. Guiding Principles: 1
III. Types of Care and Services: 2
IV. Addressing Care and Services: 2
V. Defining and Measuring Goals: 3
VI. Governance and Leadership 3
VII. Feedback, Data Systems, and Monitoring: 4
VIII. Performance Improvement Projects 5
IX. Systematic Analysis and Systemic Action 6
X. Communications, Evaluation, Review Data 6

PURPOSE:
Program components and outline for the South Peninsula Hospital Long Term Care (LTC) Facility Quality Plan in accordance with federal, state, and local regulatory guidelines and requirements.

DEFINITION(S):
N/A

POLICY:

I. Missions, Vision, Values:
The foundation of the SPH LTC Facility Quality Plan is the organization's mission, vision, values, and associated behaviors:
Mission: *To provide resident-centered healthcare services, excellence in clinical care, and to promote caregiver engagement and empowerment to better serve the resident, family, and the community.*
Vision: *SPH LTC Facility will be the premier provider in Long-Term Care.*
Values & associated behaviors**:** *(See Appendix A – 'Our Values in Action' for additional details)*
- Compassion**:** *We provide compassionate patient and resident centered quality care, and a safe and caring environment for all individuals.*
- Respect**:** *We show respect for the dignity, beliefs, perspectives, and abilities of everyone.*
- Trust**:** *We are open, honest, fair, and trustworthy.*
- Teamwork**:** *We work together as a dynamic, collaborative team, embracing change, and speaking as one.*
- Commitment**:** *We are responsible and accountable for supporting the vision, mission, values, strategies, and processes of our organization.*

II. Guiding Principles:
Quality Assurance and Performance Improvement (QAPI) has a prominent role in our management and board functions. In LTC, the outcome of QAPI is the quality of care and the quality of life of our residents. LTC uses QAPI to make decisions and guide our day-to-day operations. QAPI includes all employees, all departments, and all services provided. Our QAPI program focuses on our unit and organization's systems and processes rather than on the performance of individuals, and we strive to

identify and improve system gaps rather than place blame.
Our QAPI program is closely integrated with our Compliance & Ethics Plan. LTC makes QAPI decisions based on data gathered from input and experience of caregivers, residents, providers, families, and other stakeholders. LTC sets goals for performance and measures progress towards those goals. LTC supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice. LTC maintains a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.

III. Types of Care and Services:

1. Skilled Nursing
2. Long-Term Care
3. Hospice/Palliative Care
4. Pharmacy
5. Radiology Services
6. Laboratory Services
7. Dietary
    - Dining
    - Dietician
8. Health Information Services
    - EHR/EMR
    - MDS
9. Therapy
    - Outpatient
    - Physical
    - Occupational
    - Respiratory
    - SLP
10. Housekeeping
    - Laundry
    - Janitorial
11. Social Services
    - Activities
    - Behavioral Health/Mental Health
    - Transportation
12. Maintenance
    - Building
    - Landscaping/Groundskeeping
    - Equipment
13. Staff Education
    - Onboarding and Orientation
    - Internal Continuing Education
    - External Continuing Education (Conferences, Symposiums, etc.)
14. Business Office
    - Staffing
    - Billing
    - Human Resources

IV. Addressing Care and Services:

The QAPI program will aim for safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family by ensuring our data collection tools and monitoring systems are in place and are consistent for proactive analysis,

system failure analysis, and corrective action. We will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure our goals. The scope of the QAPI program encompasses all types and segments of care and services that impact clinical care, quality of life, resident choice, and care transitions. These include, but are not limited to, customer service, care management, resident safety, provider relations, finance, and information technology. Aspects of service and care are measured against established performance goals and key measures are monitored and trended on a quarterly basis.

Abaqis supplies the fundamental core of the QAPI program by providing a structured, electronic system for the collection and analysis of quality data from residents, family, staff, resident records, and the MDS. To accomplish this, Abaqis includes a series of sampling, assessment, and data collection tools, and provides for analysis through in-depth investigation, the comparison of an organization's performance against established indicators, and thresholds of quality as well as national benchmarks. Abaqis also provides a data-driven and scientifically proven methodology for monitoring QAPI program efforts to ensure that they are comprehensive in scope, continuously executed and monitored, include the appropriate coverage of unique residents and care areas, and proactively initiate appropriate investigative and improvement actions for areas identified as needing correction.

V. <u>Defining and Measuring Goals:</u>

LTC will use internal and national benchmarks provided by national associations, clinical organizations, and federal & state provided databases (e.g., CMS Quality Measures, Five-Star Quality Rating System, survey data) to establish baselines for organizational practices and goal setting. In addition, the organization will continue to monitor progress towards goals by comparing its results to these benchmarks and its historical performance,

The sampling, assessment, and data collection tolls along with statistically verified thresholds in Abaqis are used to identify potential areas of concern. Additional, Abaqis contains Critical Element Pathways, Surveyor Guidance, and national benchmarks that provide a framework for defining and measuring QAPI program goals.

VI. <u>Governance and Leadership</u>

1. <u>*Administrative* Leaders</u> – *South Peninsula Hospital Board of Directors*
   A. Direction of QAPI Activities: The Governing Body and LTC QAPI Team develop a culture that involves leadership-seeking input from nursing center staff, residents, their families, and other stakeholders.
   B. The LTC QAPI Team reports to the executive leadership and Governing Body and is responsible for:
      1) Meeting, at a minimum, on a quarterly basis; more frequently, if necessary
      2) Coordinating and evaluating QAPI program activities
      3) Developing and implementing appropriate plans of action to correct identified quality deficiencies
      4) Regularly reviewing and analyzing data collected under the QAPI program and data resulting from drug regimen review and acting on available data to make improvements
      5) Determining areas for PIPs and Plan-Do-Study-Act (PDSA) rapid cycle improvement projects
      6) Analyzing the QAPI program performance to identify and follow up on areas of concern and/or opportunities for improvement
   C. Staff QAPI Adoption: The QAPI program will be structured to incorporate input, participation, and responsibility at all levels. The Governing Body and LTC QAPI Team will develop a culture that involves leadership-seeking input from nursing center staff, residents, their families, and other stakeholders; encourages and requires staff participation in QAPI initiatives when necessary; and holds staff accountable for taking ownership and responsibility of assigned QAPI activities and duties.
2. <u>QA&A *Committee*</u>

- Medical Director/Designee – Dr. William Bell
- Director of Nursing Services – Katie Martin, RN
- Administrator/Owner/Board Member/Other Leader – Rachael Kincaid, DNP, LNHA
- Infection Prevention & Control Officer – Anna Lewald, RN
- Additional Members:
  - Assistant Director of Nursing - Janyce Bridges, RN
  - Quality Coordinator – Joyce Bridges, RN

VII. Feedback, Data Systems, and Monitoring:

A. Monitoring Process:

The system to monitor care and services will continuously draw data from multiple sources. These feedback systems will actively incorporate input from staff, residents, families, and others, as appropriate. Performance indicators will be used to monitor a wide range of processes and outcomes and will include a review of findings against benchmarks and/or targets that have been established to identify potential opportunities for improvement and corrective action. The system also maintains a system that will track and monitor adverse advents that will be investigated every time they occur. Action plans will be implemented to prevent recurrence.

Abaqis provides a systematic approach to evaluating potential problems and opportunities for improvement through continuous cycles of data gathering and analysis. This is accomplished through a variety of assessments such as resident, family, and staff interviews; resident observations; medical record reviews; in-depth clinical reviews; facility-level process reviews; and MDS data analysis.

B. Monitored Data Sources:

1. Abaqis Assessments
2. QAPI Assessments
3. Resident-Level Investigations
4. Facility-Level Investigations
5. Resident Satisfaction
6. PAC Assessments
7. CMS
   - Comparative Survey Data
   - Survey Data
   - Five Star Quality Rating System
   - CMS Quality Measures
   - State Survey Reports
8. Industry Associations
   - Alaska Hospital & Healthcare Association (AHHA)
   - Mountain-Pacific Quality Health
9. Internal Systems
   - Resident/Family Complaints
   - Resident/Family Suggestions
   - Staff Complaints
   - Staff Suggestions
   - MDS
   - EMR/EHR
   - Corporate Balance Score Card
10. Additional Systems:
    - Occurrence Reports
    - Daily Clinical Huddles
    - Fall/Safety Huddles
    - QAPI audits

C. Adverse/Never Event Tracking System:
Never Events are errors in medial care that are clearly identifiable, preventable, and serious in their consequences as defined by CMS and National Quality Forum (NQF). These events are tracked, investigated, and monitored through the occurrence reporting system.

D. Method of Monitoring Multiple Data Sources:
Information will be collected on a routine basis from the previously identified sources and the data will be analyzed against the appropriate benchmarks and target goals for the organization.
Abaqis is a systemized and secure platform for data collection. Abaqis provides tools for establishing quality assessment and improvement cycles, includes a collection of turnkey quality assessments and investigations, and provides a structured and electronic repository for QAPI program coordination and documentation.
Abaqis includes robust data analysis and reporting tools that draw from multiple data sources and allow organizations to identify Care Areas that exceed thresholds, track hospital readmission risk and ED transfers, and monitor rates for hospital readmissions, community discharge, and resident and family satisfaction.

E. Planned Abaqis QAPI Usage:
Abaqis will be used by generating random QAPI samples of residents for analysis periodically throughout the year. At the end of data collection periods, the QAPI Coordinator will review reports to identify areas for improvement by utilizing thresholds of quality and in-depth investigations.

VIII. Performance Improvement Projects

A. Overall PIP Plan:
Performance Improvement Projects will be a concentrated effort on a particular problem in one area of the nursing center or on a facility-wide basis. They will involve gathering information systematically to clarify issues or problems and intervening for improvements. The nursing center will conduct, at minimum, one PIP annually to examine and improve care or services in areas that the nursing center identifies as needing attention.

B. PIP Determination Process:
Areas for improvement are identified by routinely and systematically assessing quality of care and service, and include high risk, high volume, and problem prone areas. Consideration will be given to the incidence, prevalence, and severity of problems, especially those that affect health outcomes, resident safety, autonomy, choice, quality of life, and care coordination. All staff are responsible for assisting in the identification of opportunities for improvement and are subject to selection for participation in PIPs.

C. Assigning Team Members:
When a performance improvement opportunity is identified as a priority, the Quality Care Committee will initiate the process to charter a PIP team. This charter describes the scope and objectives of the improvement project so the team working on it has a clear understanding of what they are being asked to accomplish. Team members will be identified from internal and external sources by the LTC QAPI Team or Quality Coordinator, and with relationship to their skills, service provision, job function, and/or area of expertise to address the performance improvement topic.

D. Managing PIP Teams:
The Quality Coordinator will manage the day-to-day operations of the PIP and will report directly to the LTC QAPI Team.

E. Documenting PIPS:
PIPs will be documented continuously during execution. The documentation will include the overall goals for the project and will identify team members, define appropriate measures, root cause analysis findings, interventions, PDSA cycle findings, meeting minutes, target dates, and overall conclusions.
Abaqis provides an electronic platform for developing a PIP charter and for continuous PIP documentation in a structured format. Abaqis also allows for PIP team collaboration and visibility into PIP activity for team management and coordination of PIP efforts; provides a method of

tracking PIP progress and documentation of findings for widespread and systemic improvement efforts; and allows for retaining and updating information related to ongoing projects for potential reference and future submission for survey compliance.

IX. Systematic Analysis and Systemic Action

A. Recognizing Problems and Improvement Opportunities:
We will use a thorough and highly organized/structured root cause analysis approach (e.g. Five Whys, Fishbone Diagrams, etc.) to determine if and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. This systematic approach will help to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. These systemic actions will look comprehensively across all involved systems to prevent future events and promote sustained improvement. The focus will be on continuous learning and improvement.

B. Identifying Change as an Improvement:
Changes will be implemented using an organized and systematic process. The process will depend on the nature of the change to be implemented, but will always include clear communication of the structure, purpose, and goals of the change to all involved parties. Measures will be established that will monitor progress.

X. Communications, Evaluation, Review Data

A. Internal and External QAPI Communication:
Regular reports and updates will be provided to the Board of Directors, Quality Management Department, staff, and other stakeholders. This will be accomplished through multiple communications channels such as QAPI Dashboards, staff meetings, new hire orientation, e-mail updates and communication memos.

B. Identifying a Working QAPI Plan:
On at least an annual basis, the QAPI Self Assessment will be conducted. This will be completed with the input from the entire LTC QAPI Team. The results of this assessment will direct us to areas we need to work on in order to establish and improve QAPI programs and processes in our organization.
We will also conduct an annual facility assessment to identify gaps in care and service delivery in order to provide necessary services. These items will be considered in the development and implementation of the QAPI plan.
Abaqis provides an electronic platform for documenting QAPI Self Assessments and tracking changes in the QAPI Self Assessment results over time.

C. Revisions to QAPI Plan:
LTC Leadership will review and submit proposed revisions to the Governing Body for approval on an annual basis

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. Appendix A – “Our Values In Action”
2. HW-267 Quality Plan

CONTRIBUTOR(S):
LTC Nursing Director; LTC Administrator

APPENDIX A

Our Values in Action

COMPASSION IS:
- I place patient and resident needs first.
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TRUST IS:
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- I am fair and consistent in the actions I take.
- I follow up and provide feedback.
- I act with integrity.
- I responsibly report risks, hazards and errors.
- I apologize and admit when I am wrong.

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- I say one thing and do another.
- I gossip and spread rumors.
- I withhold information and conceal mistakes.
- I undermine the chain of command.
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- I complain without offering a solution or recommendation.

COMMITMENT IS:
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- I exemplify expected behaviors.
- I am responsible and accountable.
- I hold others accountable in a fair and consistent manner.
- I adhere to the organization's policies and best practices.
- I prioritize and accomplish my work with a sense of urgency.
- I am a good steward of resources.

COMMITMENT IS NOT:
- I compromise the quality, safety and reputation of my organization.
- I act inappropriately.
- I delay or fail to hold myself or others accountable.
- I avoid review of my performance.
- I am defensive and make excuses.
- I blame others.
- I disregard policies and procedures.

Emergency Operations Plan 2023
Documents for Review & Approval

Emergency Operations Planning Documents

SPH Hospital Hazard Vulnerability Analysis (HVA)……………………………………………2

SPH Hospital Emergency Operations Plan (EOP) ………………………………………….3

LTC HVA………………………………………………………………………………………65

LTC EOP………………………………………………………………………………………66

Home Health EOP……………………………………………………………………………72

The following table represents the hospital's current vulnerability assessment, listed in order of highest to lowest vulnerability.

South Peninsula Hospital Hazard Vulnerability Assessment - February 2023

Emergency Management

	EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITGATION) HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	INTERNAL RESPONSE	EXTERNAL RESPONSE	RISK
		Likelihood this will occur	Possibility of dealth or injury	Physical losses and damages	Interuption of services	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	* Relative threat
	SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 =High 2 = Moderate 3 = Low	0 - 100%
1	Earthquake	3	3	3	3	2	1	40%
2	Winter Blizzard / Ice Storm	3	1	1	2	3	3	33%
3	Pandemic Influenza	3	3	1	3	2	1	33%
4	Epidemic	3	3	1	3	1	1	30%
5	Patient Surge	3	2	1	2	1	3	30%
6	Workplace Violence	3	3	1	1	2	1	27%
7	Critical Supply Shortage	3	2	1	3	1	1	27%
8	Information Systems Interruption	3	1	2	2	1	2	27%
9	Fire, Internal	2	3	3	3	1	1	24%
10	Volcano	3	1	2	2	1	1	23%
11	Mass Casualty Incident	2	3	2	3	1	1	22%
12	Active Shooter	2	3	1	3	2	1	22%
13	Elevator Failure	2	2	2	2	1	2	20%
14	Landslide	2	2	3	2	1	1	20%
15	Gale Force Winds	2	2	2	2	1	1	18%
16	Wildfire	2	1	2	2	2	1	18%
17	Steam Failure	1	2	3	2	2	2	12%
18	Substantial Structural Damage	1	3	3	3	1	1	12%
19	HVAC Failure	1	2	2	2	2	3	12%
20	Water Supply Failure/Disruption	1	3	3	3	1	1	12%
21	Generator Failure	1	2	3	3	1	2	12%
22	Electrical Power Failure	1	3	3	2	1	2	12%
23	Bomb Threat	1	3	2	2	2	2	12%
24	96 Hrs W/out External Supplies	1	3	2	3	1	1	11%
25	Facility Evacuation	1	3	2	3	1	1	11%
26	Terrorism, Biological	1	3	1	2	3	1	11%
27	Terrorism, Nuclear, Radiological	1	3	2	2	2	1	11%
28	Tsunami / Seiche	1	1	1	2	1	1	11%
29	Natural Gas Pipeline Incident	1	3	3	2	1	1	11%
30	Flood, Internal	1	2	2	2	2	2	11%
31	Mass Fatality	1	2	2	2	2	2	11%
32	Terrorism, Chemical	1	3	2	2	2	1	11%
33	Hostage Situation, Internal	1	3	2	2	2	1	11%
34	Labor Action	1	2	2	2	2	2	11%
35	VIP Patient	2	1	1	1	1	1	11%
36	Nurse Call System Failure	2	1	1	2	1	0	11%
37	Communications Interruption	1	2	2	2	2	1	10%
38	Flood, External	1	2	2	2	2	1	10%
39	Smoke or Fumes, Internal	1	2	2	2	2	1	10%
40	Fire Alarm Failure	1	2	2	3	1	1	10%
41	Mass Casualty Incident/HazMat	1	2	2	2	2	1	10%
42	HazMat Spill/ Exposure, Internal	1	2	2	2	2	1	10%
43	Civil Disturbance	1	3	2	1	2	1	10%
44	HazMat Incident, External	1	2	2	1	2	2	10%
45	Barricaded Person	1	1	1	2	2	2	9%
46	Medical Vacuum Failure	1	2	2	3	1	0	9%
47	Sewer Failure	1	2	2	2	1	1	9%
48	Medical Gas Failure	1	2	1	3	1	1	9%
49	Fuel Oil Shortage	1	2	2	2	1	1	9%
50	Forensic Admission	2	1	0	1	1	1	9%
51	Cold Wave	1	0	1	1	2	3	8%
52	Heat Wave	1	1	1	1	2	2	8%
53	Drought	1	1	2	2	1	1	8%
54	Radiological Spill/Exposure	1	1	1	1	2	1	7%

South Peninsula Hospital
Emergency Operations Plan

EMERGENCY OPERATIONS PLAN

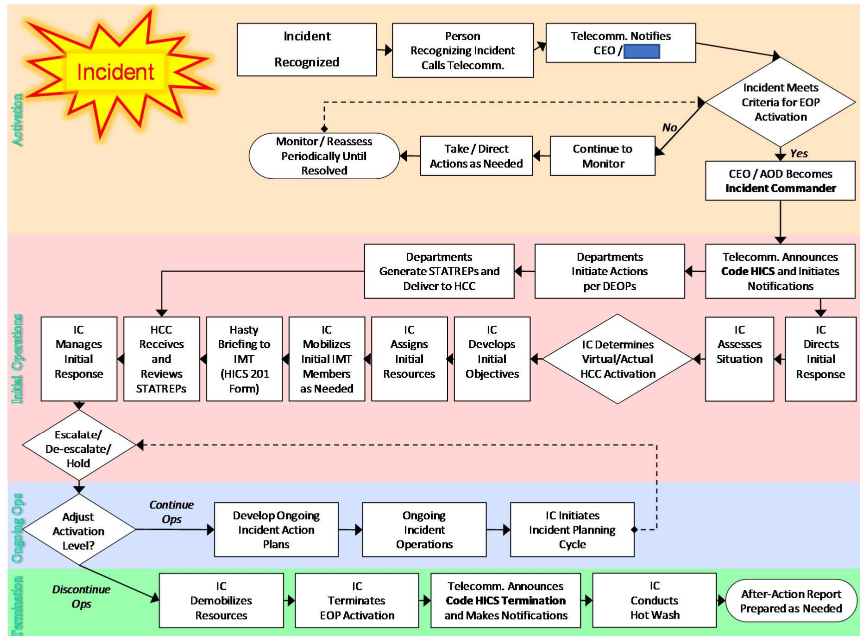
~~August 2022~~February 2023

To activate this plan:
- **NOTIFY HOSPITAL OPERATOR** (Dial "0")
- State: "**This is a Code HICS ALERT**"
- **DESCRIBE LOCATION, SITUATION** and SPECIFIC **ASSISTANCE NEEDED**

During an incident, refer directly to the EMERGENCY OPERATIONS PLAN ACTIVATION for procedures, checklists, and forms that are required for Hospital Incident Command System implementation.

INITIAL ACTION QUICK-START GUIDE

1. Any person discovering an unusual or emergent~~cy~~ incident calls hospital operator (Dial “0”) to report the situation. *“If you see something, say something.”*
2. Hospital operator immediately notifies Chief Executive Officer (CEO) or designee
3. CEO or designee determines if incident meets criteria for Emergency Operations Plan (EOP) activation ***(See Related Document “Appendix A-L” to reference Appendix B: EOP Activation Matrix)***
4. If Activation Criteria is met ***(See Related Document “Hospital Wide – Emergency Operations Plan Activation”)***, CEO or designee:
   a. Activates the EOP
   b. Assumes command / becomes the Incident Commander (IC)
   c. Activates the Hospital Incident Command Center (HCC) and determines is on-site or virtual
5. Hospital operator, Public Information Officer (PIO), or designee as delegated by IC will announce~~s~~ Code HICS and initiate~~s~~ notifications as directed
6. Departments to refer to~~Each department carries out actions as specified in~~ their Department Emergency Operations Plan (DEOP) and carry out appropriate actions
7. ~~The IC determines whether the HCC activation is actual or virtual~~
8. Refer to algorithm below to determine flow of ~~Operations proceed as shown below, using~~ the Hospital Incident Command System (HICS). ~~under the direction and control of the Incident Commander~~



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EMERGENCY OPERATIONS PLAN

ADVANCE PREPARATIONS

1.1 HCC Security and Safety

- Assess overall Safety and Security of SPH grounds:
  - Remove/secure outdoor items that could become airborne, lost, or damaged (e.g., patio furniture, trash receptacles, fuel tanks, medical gas cylinders, maintenance equipment); secure windows/doors; Apply ice/snow melt, etc.
- ~~Secure doors and windows~~
- ~~Apply ice/snow melting agents~~
  - Secure materials (e.g., pharmaceuticals, narcotics, radioisotopes) requiring special handling or security measures
  - Deploy enhanced security measures, ranging from 100 percent identification checks to facility or campus lockdown
  - Evaluate parking areas for restriction or traffic flow adjustment
  - Establish staging areas for incoming resources
- Conduct an event-specific threat and vulnerability assessment of the facility
- Review policies/procedures for security as well as ~~and~~ accommodations for community influx for shelter or resources
- ~~Review procedures for security reinforcement (including external vendor and law enforcement contacts)~~
- ~~Consider plans for restriction of facility access/egress~~

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1.2 Utility Management

- Review and practice event-specific utility management, shutdown, restoration, and recovery procedures
- Activate protective air filtration systems or ventilation zoning controls
- Activate systems requiring advance priming before operations (e.g., generators ((***See Related Document "ENG-002 Emergency Generator [CMS Tag 15]"***)), utility backup, electronics)
- Consider engineered pre-event shutdown or controlled degradation of utilities and/or critical systems (e.g., telecommunications; information technology)
- Review the business continuity plan and consider the need for activation of a hot backup data site. Store fresh backup files off-site, out of the impact area~~.~~
- Establish contact with service and support vendors and public utilities
- Review and update emergency service contact information

For additional information, see 12.8 Utility Management.

1.3 Patient, Resident and Home Health Client Management

- Prepare modifications of clinical scheduling, including cancellation of elective procedures, census reduction, and discontinuation of outpatient activities. Pre-assign available staff to meet projected facility staffing needs~~.~~

- Notify patients and clinicians regarding the potential cancellation/suspension/delay in planned services (e.g., admission, treatment, procedure)
- Implement alternate care plans for out-patients requiring life-dependent procedures and services (e.g., renal dialysis; electrical support for home equipment)
- Prepare home care clients for extended periods without staff visitation. Identify those clients who will be leaving the area or who will be assisted by an alternate caretaker. Identify clients who may require assistance with shelter-in-place and/or evacuation plans. Prioritize service needs for scheduling purposes when visits can be resumed.
- Prepare to activate surge-capacity spaces for intake of evacuated special needs populations, overflow, evacuees from other impacted medical facilities, or patients generated by the event.

2. CONCEPT OF OPERATIONS -- INCIDENT MANAGEMENT

2.1 Assumption of Command

~~Once the plan is activated, T~~The CEO or designee shall assume command, and be designated as the South Peninsula Hospital **Incident Commander** (IC) for that incident or until relieved of the role. The IC is responsible for:

- ~~,~~all organizational resources and operations necessary to manage the incident and for~~. The IC is responsible for~~ making policy decisions during incident~~emergency operations~~.
- Activation of Hospital Command Center (HCC) and determination of on-site or virtual command
- IF the IC needs to leave HCC, IC will communicate to command staff and determine point person to maintain communication with IC
- IC may delegate command for HICS Level 1 or 2 or isolated event(s). If escalation of the event, the CEO or designee will assume command.

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~~Upon assuming command, the IC shall immediately activate the Hospital Command Center (HCC), either virtually or by proceeding to the actual HCC location. The IC should generally remain at the HCC throughout the emergency, maintaining a visible command posture. If leaving the HCC, the IC shall identify an HCC Manager who will be in direct contact at all times with the IC, preferably by clear radio channel, until their return.~~

~~For an isolated, localized Level 1 or Level 2 incident affecting only one department or area, CEO or designee may elect to designate the senior manager or supervisor in that department to be the IC. However, should conditions warrant or the incident escalate the CEO or designee shall assume command. In any event, CEO or designee shall retain overall responsibility and accountability for the hospital's response to the incident until relieved by competent authority.~~

2.2 HCC Assignment of Incident Command Functions

Consistent with HICS principles, the only position that **must** be activated is ~~that of~~ the IC. Should the IC determine ~~that~~ they can manage all necessary functions for the incident without additional assistance, no further positions need be activated. IC will be responsible to activate additional positions depending on the incident.~~Additional positions are activated after the IC has assessed the situation, developed a plan to manage it, and can assign individual leaders to manage elements of the plan.~~

T~~For each position in the HICS organization, t~~he Order of Succession Table identifies a primary person (Tier 1, business hours) and a secondary person (Tier 2, non-business hours) for each HICS position. The Tier 2 coverage, if activated, requires additional staff outside of those currently working ~~identifies those positions that cannot be filled with on-duty staff during non-business hours, an on-call person be needed for those specific roles to be activated.~~ It is expected the organization should be able to manage up to a Level 2 incident with existing staff during non-business hours, but may need additional staff for Level 3 or greater.~~It is anticipated that the organization can be effectively staffed through a Level 2 incident during non-business hours with existing staff on duty, but will need staff augmentation for any Level 3 or greater incident.~~

In every department, the senior person present shall take charge and make all necessary decisions until relieved by a superior or otherwise directed by the HCC. Department heads are responsible for succession and continuity planning for leadership within their departments.

2.3 ~~Further Plan Implementation~~

~~Once notification of the incident has occurred, the plan has been activated, and command assumed, further plan implementation will occur. The sequence for this implementation is noted below. Note that these steps need not be sequential; several processes may occur simultaneously.~~

2.~~4~~3 Assessment of Event and Available Facility Resources

The IC, command staff, and section chiefs will assess the situation and the facility resources in three categories: event, logistics, and operations. The initial response to the incident will be based on ~~that~~ primary review ~~as~~ related to personnel, equipment, supplies, structural components, and utilities available at the time of activation.

Identification and Prioritization of Incident Objectives

Based on assessment of the incident and the status of facility resources, the IC will decide upon the initial response to the incident. ~~For example, in the event of an earthquake, based on the effects of the earthquake on the physical plant and operation of utilities, the IC may decide to shut down operations in some areas, augment operations in other areas, evacuate the facility, or accept patients or residents from other facilities.~~

Incident objectives should always be developed in the NIMS-standard sequence of events:

- First:
  - address life safety issues and objectives ~~are always considered and addressed first,~~
  - followed by incident stabilization and management issues, ~~then~~
  - consider~~ations of~~ preserving property and conserving resources. ~~For example, in a fire, RACE is applied: **R**escue people in harm's way (life safety), **A**larm and **C**onfine (incident stabilization), and finally **E**xtinguish the fire (property conservation). As in this example, certain objectives meet more than one priority; for example, confining the fire is at once a life safety, incident stabilization, and property conservation measure. The key is to ensure that objectives are selected and assigned in the proper priority.~~
- Second:
  - Use SMART objectives:~~The second consideration for assigning objectives is that they should always be SMART objectives:~~
    - ***S****pecific:* Clearly state the task
    - ***M****easurable:* A point of completion (and progress along the way) can be definitively assessed
    - ***A****ttainable:* Resources being assigned can accomplish the mission
    - ***R****elevant:* Show a relationship to the situation at hand

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- ***T****imely:* Establish a clear target for completion or prioritization

2.~~5~~4 Identification of Key Personnel

~~A key element of effective incident management is the ready identification of leadership personnel and their assignments.~~ Each leader in the HICS command/incident~~organization will be issued a HICS vest, and shall~~ is to wear the assigned position HICS vest for the duration of their assignment. The vest is ~~. The vests are~~ color-coded by HICS section, with the~~and have the~~ position title prominently displayed on the front and rear for high visibility.

S~~In addition, all s~~taff members will display their employee photo-identification badges prominently on their outermost garments during a HICS activation. Security officers may stop and deny access to incident facilities to any staff member not properly identified.

2.~~6~~5 Transfer of Command

~~As conditions evolve or higher-level leadership arrives at the hospital, c~~Command may be transferred between leaders with the~~. The~~ decision to do so ~~is generally~~ at the discretion of the higher-ranking leader. During~~However, at~~ an incident of Level 3 or greater, ~~magnitude,~~ the most senior leader~~shi~~p (as noted in the Order of Succession, tier 1) is expected to assume command functions.

The transfer of command requires~~is accomplished following~~ a face-to-face briefing from the current to next IC to include~~, during which the IC informs the person relieving them of~~ conditions at the hospital, impacts, problems, progress, the incident~~strateg~~ objectives~~y for managing the incident,~~ and ~~any~~ other pertinent information. ~~The oncoming IC should consider retaining~~ Tthe off-going commander may be requested to stay in the HCC for a brief time~~for a period of time in the HCC~~ to maintain continuity in leadership and knowledge transfer.

~~As an incident de-escalates, consideration may be given to having lower-level leadership assume command roles, both for relief purposes, and for ongoing leadership development.~~

2.~~7~~6 Departmental Status Reporting

~~A critical component in development of an effective emergency response is timely, accurate information.~~ The **STATREP** (Status Report Form) provides concise information on **S**taffing, **T**racking (patient/resident count), **A**vailable beds, **T**echnology status, **R**esources available/needed, **E**vent impact on department, and **P**roblems or progress toward resolution and is a critical communication tool during an event. The information on the STATRep provides information for~~, is the basis for the~~ decision-making and prioritization during the~~an emergency~~ response.

- Within 15 minutes of a Code HICS, EOP activation, or additional request by HCC, each on-duty department head, or person in charge shall immediately complete~~prepare~~ a ~~Status Report (~~STATRep~~EP~~ form~~)~~, and send by~~which must be transmitted by~~ email to iCommand@sphosp.org, or deliver~~ed~~ by runner to the HCC. All problems encountered are to be communicate to the HCC.

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Additional Status Reports may be requested periodically throughout the incident by the HCC. Forms should be completed by each department and sent to HCC within 15 minutes of request. Problems encountered shall be commutated immediately to the next level in HICS organization, or to the HCC.

2.87 Identification of Incident Objectives/Incident Action Plan (IAP)

Based upon assessment of the incident and the status of facility resources, the IC will decide upon the initial response to the incident and identify specific manageable objectives. Based on this process, the IC will develop an Incident Action Plan, and then divide the work into manageable objectives in accordance with generally accepted ICS principles. Where possible, these objectives should correspond to functions within the HICS organizational chart, and those functions will then be activated and assigned to available staff members.

The Planning Section is responsible to develop/document and maintain the Incident Action Plan based on information from the IC and Incident Command team. The purpose of the IAP is to enable incident command staff to receive and disseminate information, perform an ongoing assessment of the incident, and monitor, coordinate and document plan response.

2.98 Development of the HICS Organization

The IC will build the HICS organization to implement the incident objectives. Using the organizational chart template, the various positions and functions will be activated as needed. Not all positions necessarily need be activated to achieve the incident objectives, and one individual may be assigned to more than one position without compromising span of control.

A primary function of the IC is to ensure that expansion or escalation of the incident is sufficient to meet the incident objectives, while simultaneously minimizing the impact of the event on non-involved areas of the organization. As much as possible, normal routine activities and operations shall be maintained throughout the organization during a HICS activation.

2.10 Development of an Incident Action Plan

With the HICS organization in place based on an assessment, or “size-up”, an Incident Action Plan (IAP) will be developed to enable incident command staff to receive and disseminate information, perform an ongoing assessment of the incident, and monitor, coordinate and document plan response. Depending on the scope, complexity, and anticipated duration of the incident, the plan may be disseminated verbally, or may be written down and communicated more formally using the HICS IAP forms. When an incident extends beyond a single operational period (e.g., a single work shift), a written IAP shall be created and maintained by the Planning Section.

2.911 Delegation of Authority

Delegation of authority will occur based upon the requirements of the incident, the facility resources, and the available personnel.

As with any management system, all responsibilities belong to a higher organizational level, until delegated by establishing a lower level. The IC is responsible for all incident functions, until they delegate some functions to section chiefs and unit leaders to carry out. Clinical and operational functions will be managed administratively in the same manner.

~~Delegation of authority can include objectives, priorities, expectations, constraints and other considerations or guidelines as needed.~~

2.10~~2~~ Escalation of Response

~~An incident may be appropriately handled with the initial response activities according to the above process, but it may also require escalation because of a need for additional resources, personnel, or because of incident scope or duration. In this case, other procedures, such as a staff augmentation plan (e.g., 12-hour emergency shifts), or transfer of supplies from other facilities, may be implemented.~~

Escalation of plan activation is at the discretion of the IC, based on the need for additional resources or due to the incident scope or duration. ~~impact that an event actually or potentially has on the organization.~~ The rationale for escalating plan activation is that at each level of activation, additional pre-planned sets of nonessential functions may be set aside in each department, making staff and other resources available for higher-priority assignments. Each department's DEOP identifies its nonessential functions by HICS activation level, as well as the number of staff by title that will be made available as a result.

2.11~~3~~ Planned Degradation of Services

In the event ~~that~~ demand exceeds capabilities and external support and solutions (including patient and resident transfers or evacuation) are not available, a plan for degradation of services shall be developed and initiated by the IC. Such degradation of services may include (but is not limited to):

- Conserving, consolidating, and/or rationing scarce resources
- Reducing or curtailing services, capacity, and capabilities
- ~~Closing the hospital to new patients~~
- Altering standards of care
- Closing the hospital to new patients
- ~~Staged or partial evacuation~~
- ~~Full facility evacuation and relocation~~

Should the incident require partial or full facility evaculation and relocation refer to ~~Comprehensive~~ evacuation strategies and tactics located~~are found~~ in the Code Green Facility Evacuation Annex ***(See Related Document "Code Green Facility Evacuation Annex")***

3. HICS INCIDENT MANAGEMENT TEAM AND ORDER OF SUCCESSION

For each activated position in the HICS Incident Management Team, three (3) tiers of succession are optimal. While the "first tier" staffing is optimal, providing additional tiers assures ~~that~~ each position can be staffed, if needed, at any time utilizing managerial, supervisory, or senior trained staff on duty in the facility. The IC always retains the option of assigning staff based on assessment of the needs and objectives and availability of personnel as needed. ***(See Related Document "Appendix A-L – HICS Activation References")***

The ***HICS Order of Succession Matrix*** - ***Appendix D.***

4. INCIDENT FACILITIES / DESIGNATED AREAS

SPH has pre-established specific locations on ~~the~~ campus where ~~predetermined~~ incident management activities may occur. Refer to~~The table in~~ **Appendix E**: HICS Incident Facilities/Designated Areas Matrix, ~~-~~for~~depicts~~ those locations, known as *incident facilities*.~~, which may be activated for use during EOP activation.~~ Should a particular facility or location be unsuitable for any reason, the responsible unit leader or section chief shall notify IC and determine an~~ensure that a suitable~~ alternate site.~~ is selected, and its location is communicated to the HCC and all concerned parties.~~ ***(See Related Document "Appendix A-L – HICS Activation References")***

~~The ***HICS Incident Facilities/Designated Areas Matrix*** may be found in ***Appendix E.***~~

5. ESTABLISHMENT AND FUNCTIONS OF THE HOSPITAL COMMAND CENTER

5.1 Hospital Command Center Staffing

The HCC is staffed with (as the positions are activated) the IC, section chiefs (i.e., Operations, Planning, Logistics, and Finance Chiefs), command staff (i.e., Safety, Liaison, and PIOs and Medical/Technical Specialists), the Resource and Situation Unit Leaders, Documentation Unit Leader and other staff as needed. All other HICS position staff should be deployed to appropriate work locations to carry out their duties. The Planning Section shall The gatekeeper shall maintain a log of all HCC participants and visitors.

Actual HCC

The IC or designee will determine activation of Hospital Command Center (HCC) based on HICS Level and situation and decide of on-site or virtual command. HCC should be established for Level 2 or greater and is to be operational within fifteen (15) minutes of the activation decision. If the HCC is virtual and changes to on-site, maintin virtual connection until on-site HCC is assembled. Avoid loss of communication to prevent disruption to HCC and objectives of the response.

An actual HCC is established for any event of Level 2 or greater, or when the conditions permitting a virtual HCC cannot be met or maintained. The actual HCC provides the distinct advantages of shortening lines of communication, avoiding reliance on technology for command and control actions, improving access to information, and hastening the decision-making process. When activated, an actual HCC shall be operational within 15 minutes of the activation decision.

The IC will direct the organizational transition from a virtual HCC to an actual HCC. The virtual HCC environment will be maintained while the actual HCC participants are assembling. In the event that conditions require the loss of virtual contact between HCC participants during the assembly process (e.g., leaders must travel off-site and may be unavailable for contact), alternates shall be identified to maintain command and control until such contact can be reliably re-established. At no time shall the loss of communication be permitted to disrupt the command and control process of the organization.

The IC should generally remain at the HCC throughout the emergency, maintaining a visible command posture. If leaving the HCC, the IC shall identify an HCC Manager who will be in direct contact at all times with the IC, preferably by clear radio channel, until their return.

5.2 HCC Operations

(1) Call in additional help as necessary, Useusing the HICS organizational structure to determine resources needed, provide specific assignments, prevent freelancing, and ensure control, coordination, and integration of effort.

(2) The Documentation Unit Leader, under the Planning Section will eEstablish a process to collate forms, reports, and logs to assist with decision making and coordination of effort to the response. described in this plan to facilitate decision-making, documentation, and business continuity. This is the Documentation Unit Leader's responsibility.

5.35.3 HCC Communications Area

- (1) Designate oneOne area of the HCC (which may be an adjacent external space, such as exterior offices, based on conditions) shall be designated as the HCC Communications Area. The mission of the HCC Communications Area is to ensure constant monitoring and an uninterrupted line of communication between HICS leadership and key areas of the facility., without the

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~~communication process or technology disrupting the HCC activities or distracting the leadership from their primary responsibilities.~~

(2) Activities occurring in the communications area~~there shall~~ include monitoring the telephones, radios, email, and text messaging. Qualified staff shall be assigned to the Communications Area, under the direction of the Communications Unit Leader.

(3) All significant message traffic into and out of the HCC shall be documented using HICS 213 Message Forms and/or logged in the Communications Area. Completed HICS 213 forms are to be provided to the Documentation Unit Leader.

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6. NOTIFICATIONS AND COMMUNICATIONS

6.1 General Announcement of Plan Activation

Upon activation of the EOP, the IC shall:

(1) Direct hospital operator, ~~or~~ PIO, or designee to activate the voice page system and announce, **"Attention, Attention, Code HICS Level (*1, 2, 3*, or *4*) has been activated."** and repeat the message three (3) times at approximately 30 second intervals. This will be the signal to all personnel to carry out the specific duties specified in this EOP manual and their~~-~~ DEOP.

a. If the event is a drill/exercise, the operator shall add: "**This is a drill. Exercise, exercise, exercise.**"

(2) Assign the PIO or Logistics Section Chief to set up Emergency Message instructions and activate the Communications Unit if needed. A Communications Unit Leader will be assigned by the Logistics Section Chief.

(3) As conditions warrant, make notifications as listed on the Activation Matrix and Telecommunications Notification List.

6.2 On-Duty Personnel Notified of an Emergency

(1) Follow DEOP and c~~C~~ontinue working in usual areas unless otherwise instructed. If working in an area remote from their assigned supervisor (e.g., a social worker working with a patient in the patient's room), an employee shall connect with immediate supervisor for accountability and instructions.~~:~~

~~a. Make immediate contact with the supervisor responsible for their current location (e.g., department manager/director or charge nurse in the unit) to establish accountability and ensure that help is not needed in that unit~~

~~b. Make phone contact with the employee's immediate supervisor for accountability and instructions~~

(2) If reassigned by Hospital Incident Command and/or Labor Pool, follow instructions of the supervisor in new area.

(3) The Logistics Section Chief shall ensure ~~that~~ ongoing communication of information and instructions is accomplished by the most appropriate, available communication mechanism. ~~(e.g., public address announcement, text message, e-mail, Employee Information Hotline update).~~

(4) The PIO is responsible for updating and communicating with employees, patients, residents and their families/POA's, and other stakeholders. ~~to ensure a flow of accurate, consistent information through the course of the incident.~~

6.3 Management of Patient and Resident Information

(1) The communications plan addresses the timely collection, transfer, storage, and retrieval of patient and resident (e.g., clinical; medication-related) and operational information generated at primary or alternate care locations—whether the alternate care location is located within a designated health care facility (e.g., conversion of a waiting room or other typically nonclinical area within the primary facility) or in another building on or off the campus grounds. ~~The~~

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(2) Medical Care Branch will identify information-sharing requirements and work with the Logistics Section to provide communications, equipment and support to primary or alternate care sites.

6.4 HIPAA Privacy Rule and Disclosures during Emergency Operations

The HIPAA Privacy Rule allows patient/resident information to be shared by providers and health plans covered by the HIPAA Privacy~~to assist in~~ during severe disasters~~s relief efforts, thus providers and health plans covered by the HIPAA Privacy Rule can share patient/resident information~~ in all the following ways[1]:

(1) Treatment

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Health care providers ("covered entities") can share patient/resident information as necessary to provide treatment.

Treatment includes:

- Sharing information with other providers (including hospitals, Nursing Homes and clinics),
- Referring patients/residents for treatment (including linking patients/residents with available providers in areas where they have relocated), and
- Coordinating patient/resident care with others (such as emergency relief workers or others that can help in finding appropriate health services).

Providers can also share patient/resident information to the extent necessary to seek payment for these health care services.

(2) Notification

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Health care providers can share patient/resident information as necessary to identify, locate, and notify family members, POA's, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death.

The health care provider should get verbal permission from individuals, when possible; but if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the individual's best interest.

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Thus, w~~W~~hen necessary, the facility may notify the police, the press, or the public at large to the extent necessary to help locate, identify or otherwise notify family members and others as to the location and general condition of their loved ones.

- In addition, when a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's or resident's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

(3) Imminent Danger

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Providers can share patient/resident information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct.

(4) Facility Directory

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Health care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and their general condition.

[1] Source: https://www.hhs.gov/hipaa/for-professionals/faq/disclosures-in-emergency-situations, viewed ~~October 16, 2019~~January 27, 2023

Field Code Changed

7. SAFETY AND SECURITY

SPH is committed to maintaining the safety and security of the facility and its occupants as an essential function during every activation of the EOP . The IC ~~(IC)~~ maintains overall responsibility for safety and security of the facility as a primary and critical objective~~ion~~. Conducting a safety assessment and authority for planning and carrying out safety-related objectives may be delegated to the Safety Officer or Security Branch Director, (HICS Command Staff members). ~~Conducting a security assessment and authority for planning and carrying out security-related objectives may be delegated to the Security Branch Director (HICS Operations Section). The IC shall ensure that safety and security needs are addressed as a primary and critical function of EOP activities.~~

7.1 ~~Safety~~ Safety Officer

The Safety Officer is assigned to ensure the safety of staff, patients, residents and visitors, and to monitor and correct hazardous conditions related to the incident. The Safety Officer has the authority to halt any incident-related activity that poses an immediate threat to life and health.

The Safety Officer shall carry out the activities described on the Job Action Sheet (JAS) as applicable to the incident. In general, these activities include assessing and understanding the situation and the hospital's response, conducting a focused safety threat/risk assessment, determining and directing implementation of necessary risk reduction and protective measures (including use of personal protective equipment), and maintaining situational awareness of self and others regarding safety risks and evolving hazards or their mitigation.

7.2 ~~Security~~ Security Branch Director

The Security Branch Director is assigned to manage all incident-related activities related to personnel and facility security such as access control, crowd and traffic control, and law enforcement interface. The Security Branch Director has the authority to carry out any incident-related activity deemed necessary to maintain order and protect the facility and its occupants from criminal threat or activity during an emergency event. Such activities include but are not limited to:

- Controlling vehicular and pedestrian traffic flow on the campus and in the immediate vicinity
- Controlling personnel movement in the facility and on campus grounds.
- Controlling access and egress to and from buildings, including access and egress management within the buildings and critical areas
- Controlling visitation, including shortening visit length, limiting numbers of visitors, ending visitation, and escorting visitors off the premises
- Identifying and verifying the identity of all persons on or the property
- Maintaining order, including management of crowds and control of disturbances/restoration of order
- Preventing crime or threat of criminal activity
- Protection of critical infrastructure
- Searching the property for people (including unauthorized occupants, perpetrators, escapees, eloped patients or residents, abducted infants or children) and threats (including investigation of threats of explosives or suspicious substances, and reports of weapons or other contraband)
- Safeguarding of damaged areas, evidence, and crime scenes until properly relieved by a law enforcement agency
- ~~Deputizing~~ Assigning non-security staff members to assist in carrying out risk-limited security objectives such as traffic and visitor control when needed

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- Coordinating activities on and off the campus with external law enforcement and investigative agencies

7.3 Use of Force

The Security Branch Director may authorize use of necessary force consistent with the Alaska State Penal Law. It is the policy of SPH that security officers use only the force that reasonably appears necessary to effectively bring an incident under control, while protecting the lives of the security officer(s) and others. A security officer will exhaust every other reasonable means of force before resorting to the use of deadly physical force. Homer Police and Alaska State Troopers will be notified for assistance as needed during the incident.

- Security Officers should assess the incident and use techniques to best de-escalate an incident to bring it under control safely.

Parameters for Use of Deadly Force

In accordance with the Alaska State Penal Law, security officers may use deadly force only when the officer reasonably believes that the action is in defense of human life, including the officer's own life, or in defense of any person in imminent danger of death or serious physical injury and retreating is not possible.

Parameters for Use of Less-Lethal Force

Where deadly force is not authorized, security officers should assess the incident in order to determine which less-lethal technique will best de-escalate the incident and bring it under control in a safe manner.

Officers are authorized to use hospital-approved less-lethal force techniques and training for resolution of incidents to protect themselves or another from physical harm, or bring an unlawful situation safely and effectively under control.

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7.4 Coordination of Security Activities with Community Security Agencies

SPH Security maintains an ongoing relationship with the public safety agencies in Kenai Peninsula Borough. Should an incident warrant active participation of community security agencies in the facility's emergency management process, each appropriate agency may be requested to assign a liaison to the HCC. For an incident with a primary security focus (i.e.g., a search for a perpetrator), the Security Branch Director shall establish a Security Command Post (SCP) at the Security Communications Center (see Incident Facilities Matrix). Each community security agency participating in on-site security activities shall assign a radio-equipped senior officer to the SCP as a liaison with the SPH Security to ensure optimal coordination and maximize effectiveness. As needed, the SCP may issue radios to ensure interoperability and coordination with community security agency liaisons. The SPH Security Branch Director shall participate in a unified command structure with the responding community security agency commanders, where possible.

7.5 Control of Facility Access, Egress, and Individual Movement

(1) Access Restriction

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All staff members will display their employee photo-identification badges prominently on their outermost garments during EOP activation. Security officers may stop and deny access to incident facilities to any staff member not properly identified.

When the EOP is activated at Level Three or greater, or at the discretion of the IC, SPH will close and secure all entrances with the following exceptions:

- *ED Entrance:* casualties only
- *Administration Entrance:* employees only
- *Main Entrance:* family waiting area

(2) Signage

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Signs shall be posted at all secured entrances, noting ~~that the entrance has been~~ partial or full lock~~ed~~ down in place with ~~and~~ specific instructions/information as appropriate.~~showing the direction and name of the nearest accessible entrance.~~ Security officers and/or appointed ~~deputized~~ staff members will be assigned to all entrances to control visitors. ~~Social Work personnel, facility volunteers, and chaplains may be assigned to assist visitors as needed.~~

(3) Facility Visitor Control

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~~As appropriate, s~~Security officers may be asked to institute 100 percent identification check of every person entering incident facility buildings. Only people carrying employee identification badges or accompanied by such a person will be allowed into the building. Relatives of incident victims will be assisted~~directed~~ to the Patient Information Area. Direct deliveries (i.e.~~g.~~, food, flowers) will not be permitted and only left ~~; items will be left~~ at the Lobby Information Desk with security approval, to be delivered ~~for staff delivery~~ within the building.

(4) Media Access

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Security officers should be alert to the potential for news media presence, be prepared to escort credentialed members of the press to the Media Briefing Area (see Incident Facilities Matrix) where press briefings will be given, and keep news media away from family members. At no time will members of the press be permitted access to the facility without authorized escort.

(5) Security Deployment

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Security or designated staff~~personnel~~ will be assigned to the Triage Area, Main Lobby, and~~,~~ other areas as~~where~~ needed, for purpose of crowd/traffic control and access control (see Security Control Post map, confidential/restricted distribution). ~~Security officers shall be deployed to the Triage Area's point of entry to monitor access and restrict it to assigned employees or those from an ancillary department or have a HICS JAS and have been assigned to the area during a Level 2, 3, or 4 activation. Security officers shall be assigned to provide crowd control at incident-related/affected areas.~~ Officers should establish contact with on-scene police department representatives immediately upon their arrival. Police should be asked to assist with traffic and crowd control, if available.

(6) Visitors Already Present

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Any or all visitors in clinical areas may be asked to leave facility grounds upon EOP activation. In general, visitors will be permitted to remain in the facility unless their presence creates or increases the risk. If visitors are asked to leave, families should be told ~~that~~ they would be notified if ~~they are~~ needed. ~~Where human compassion dictates, families/POAs and visitors will be permitted to remain with patients or residents if it is at all possible.~~

7.6 Control of Facility Vehicular Access, Traffic, and Parking

(1) Vehicular Restriction

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As directed, Security officers shall establish barriers at all vehicular entrances to the grounds and parking lots. Officers shall attempt to expedite removal of vehicles from key areas to facilitate access for emergency equipment. When vehicular restrictions are in effect, only the following vehicles shall be permitted on the grounds:

- SPH Staff (with proper identification badge)

- Police Department
- Fire Department
- Emergency Medical Services (Ambulances)
- Kenai Peninsula Borough Office of Emergency Management (OEM)
- Authorized Emergency Vehicles
- Medical Examiner
- Funeral hearses (with proper identification)
- ~~SPH Staff (with proper identification badge)~~

(2) Campus Visitor Control

As directed, officers shall institute 100 percent identification check of every person entering the campus. Only people carrying employee identification badges or accompanied by such a person will be allowed onto the grounds. Relatives of incident victims will be directed to park in the visitor lot, or as designated by the Security Department, and be assisted~~directed~~ to the Patient Information Area.

Unattended vehicles will not be permitted in restricted areas and may be towed. ~~Such vehicles shall be towed promptly.~~

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(3) Security Staffing Augmentation

Depending on the incident and resources available,~~situation and time of day,~~ additional staff may be ~~deputized and~~ assigned to assist with security-related tasks. SPH has trained staff in the following departments/job titles to perform security measures, and they should be deployed as needed at the discretion of the IC. Security staff will receive a reflective security vest and Job Action Sheet (JAS) from the Logistics Section Chief. Traffic control kits—containing portable radios, illuminated wands, road flares, and traffic control signs—are also available for deployment as needed.

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Security Assignment	Auxiliary Department or Staff Assignment
Controlling vehicular and pedestrian traffic flow on the campus and in the immediate vicinity Controlling vehicular and personnel access to the campus property	Engineering staff have been trained in traffic control, including setting up access control and staffing traffic posts in the parking lots
Controlling access and egress to and from campus buildings, including access and egress management within buildings and critical areas	Staff in departments nearest to exit doors haves been trained to secure ~~the doors~~ and stand by the door to control access/egress.
Controlling visitation, including shortening visit length, limiting numbers of visitors, ending visitation, and escorting visitors off the premises	Department staff have assigned areas to end visitation and ensure visitor departure. In cases of compassionate need or need for departure escort, the Security Command Post will be notified for assistance.
Identifying and verifying the identity of all persons on the property	Security or Engineering staff
Maintaining order, including management of crowds and control of disturbances/restoration of order	Security or Engineering staff
Protection of critical infrastructure	Engineering

Security Assignment	**Auxiliary Department or Staff Assignment**
Searching the property for people (including unauthorized occupants, perpetrators, escapees, eloped patients/residents, abducted infants or children) and threats (including investigation of threats of explosives or suspicious substances, and reports of weapons or other contraband)	Staff in all departments should secure and search their individual areas/workspaces and report findings. Assigned patient and resident escorts, and Engineering staff may conduct organized searches of -public interior areas and the building exterior/, as well as outside grounds., including the parking lots.
Securing and safeguarding of damaged areas, evidence, and crime scenes until properly relieved by a law enforcement agency	Security or Engineering staff

7.7 Law Enforcement Coordination

At the discretion of the police department, if requested, a Homer police officer will be assigned to the Security Command Post to help coordinate traffic in and around the hospital.

7.8 Hazardous Materials and Waste Management during EOP Activation

In the absence of functioning processes for management of sewage, biohazardous waste, and/or other hazardous materials during an emergency, the Infrastructure Branch Director (Operations Section) shall assume responsibility for waste management. Strategies may include (but are not limited to):

- Waste stream reduction strategies
- Use of alternate waste collection and disposal methods
- Use of improvised on-site storage facilities for securing toxic or hazardous materials until proper disposal methods can be re-established

8. INTEGRATION AND LIAISON WITH LOCAL GOVERNMENT AND EXTERNAL EMERGENCY RESPONSE AGENCIES

8.1 Mutual Aid Agreements

SPH ~~recognizes the need and value of mutual aid agreements, and~~ will participate in and promote NIMS-compliant interagency and inter-organizational mutual aid programs with public, private, and non-governmental organizations that are supportive in meeting mutual goals during an emergency.

8.2 Medical Facility Mutual Aid

Generally, the three geographically closest hospitals would be used for medical mutual aid. See **Related Document *"AHHA~~SHNHA~~ Mutual Aid Agreement [CMS Tag 25]"***

The following geographically closest hospitals will be contacted for mutual aid as needed. Each hospital has the ability to surge and create additional capacity.

- Central Peninsula Hospital
  Phone: (907) 714-4404
  250 Hospital Place, Soldotna, AK 99669~~-7559~~

- Providence Alaska Medical Center
  Phone: (907) 562-2211
  3200 Providence Drive, Anchorage, AK 99508

- Alaska Regional Hospital
  Phone: ~~24-Hour Main Hospital Number:~~ (907) 276-1131
  2801 DeBarr Road, Anchorage, AK 99508

- Alaska Native Medical Center (ANMC)
  Phone: (907) ~~562-2211~~563-2662
  4315 Diplomacy Dr, Anchorage, AK 99508

The IC has the authority to request assistance via mutual aid as needed, and will ascertain resource availability at alternate institutions listed above via phone from the HCC. ~~The IC will determine if additional resources are needed. We may call~~ AKDOH 24-hour duty officer Emergency Preparedness and Response Manager (907) 269-4990 or Health and Medical Emergency Duty Officer (907) 903-3721may be called to coordinate surge bed capacity in state.

A component of SPH mutual aid planning ensures timely interaction with other local and regional health care organizations that also provide services in the geographic area. For each of the partnering health care organizations, the mutual aid agreements or attachments identifies:

- Essential elements of their command structures and control centers;
- Names and roles of individuals in their command structures;
- Command center contact information (e.g., phone, facsimile, e-mail);
- Resources and assets that potentially could be shared in an emergency response (coordinated with the Logistics Section during plan activation); and
- The collection of names of patients and deceased individuals brought to their organizations in accordance with applicable law and regulation, when requested

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Commented [SS5]: Refer to list: ? Emergency Preparedness and Response Manager (907) 269-4990 or Health and Medical Emergency Duty Officer (907) 903-3721

8.3 Public Safety

Public safety agencies in Homer have specific responsibilities in emergencies. These responsibilities include:

- Fire Department: Fire prevention and suppression; pre-hospital emergency medical care; search and rescue of injured and trapped persons; structural evacuation, management of Chemical, Biological, Radiological, Nuclear and Explosive (CBRN)/hazardous materials life safety and mass decontamination, and arson investigation
- Police Department: Law enforcement and investigation; intelligence collection and analysis; crime scene processing and evidence reservation; perimeter security; traffic control; crowd control; site security and force protection; population evacuation or in-place sheltering; safeguarding of property; and criminal investigation.

Under most circumstances, the ranking officer of the agency with primary responsibility for the situation (the “lead agency”) will be in command of the overall response, and will utilize NIMS. Under some circumstances, where multiple governmental jurisdictions are involved and/or multiple agency responsibilities must be carried out simultaneously, the ranking agency commanders are expected to operate within a unified command system. In a unified command system, all participating jurisdictions and agencies contribute to the establishment and prioritization of incident goals and objectives and may provide resources to support them.

SPH maintains an ongoing relationship with various municipal agencies in Homer, as well as throughout Kenai Peninsula Borough. The Homer Police Department and Homer Volunteer Fire Department may be available to assist us in any incident.

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Should an incident warrant active participation of public safety agencies in the facility’s emergency management process, each appropriate agency may be requested to assign a liaison to the HCC. In an internal incident involving the facility (e.g., a fire), the IC should participate in a unified command structure with the responding fire and police commanders, where possible.

8.4 Multi-Agency Coordination System (MACS)

~~When the scope of an incident requires,~~ Homer may establish a multi-agency coordination system (MACS). During a large-scale or widespread event, such as a natural disaster, disease outbreak, or terrorist attack, a MACS serves to support incident management policies and priorities across the entire borough, a large area, or several individual events; facilitates logistics support and resource tracking; makes resource allocation decisions based on incident management priorities; coordinates incident-related information; and coordinates interagency and inter-governmental issues. The MACS would be established and coordinated by the Kenai Peninsula Borough OEM~~, and would serve to integrate the varied activities of other agency and organization emergency operations centers across the region. SPH may be asked to participate or assign a liaison.~~ As needed, SPH will communicate its ability to share resources and assets (i.e.~~g.~~, personnel, beds, transportation, linens, fuel, personal protective equipment, medical equipment and supplies) with other health care organizations outside the community in the event of a regional or prolonged incident.

8.5 Oversight

SPH has liaisons and communication lines established with other health care facilities, networks, and organizations in the region including Alaska Department of Health.

8.6 Governmental

Should an incident warrant close integration of local government in the emergency management process, OEM may assign a liaison to the HCC may assign a representative to Kenai Peninsula Borough's Emergency Operations Center.

9. MEDIA INTERACTION AND PUBLIC INFORMATION

9.1 Media Relations

SPH remains committed to the principles of the public's right to know, balanced with~~against~~ the rights of the facility, patients, residents, staff, and visitors right to privacy, and SPH's obligation to preserve and protect those rights. When an incident involving EOP activation generates media interest, the IC shall assign a PIO.~~.~~ The ~~mission of the~~ PIO~~, ,~~ iwill~~s to~~ serve as the conduit for information to internal and external stakeholders, including staff, visitors and families, and the news media. The PIO shall gather the necessary information to provide to the appropriate stakeholder groups, develop appropriate messaging (including content, format, and medium, covering traditional and social media, as appropriate), and, with the approval of the IC, release the information.

9.2 Media Access

When members of the press present themselves (or are expected)~~,~~, the PIO shall establish a Media Staging Area. The PIO will be in charge of this area, and will release information to the media as directed by the IC, CEO, or designee.

Consideration shall be given to assigning media relations staff or a deputy PIO to the Emergency Department or the Main Lobby, to address immediate media and public inquiries in the absence of an on-site PIO, or until a Media Briefing Area is established.

The following general policies apply to any situations involving the media during EOP activation:

(1) Members of the press will not be allowed elsewhere inside the facility without prior approval from the IC.

(2) In the event ~~that~~ a member of the press is granted access to any part of the facility, they shall be accompanied and escorted at all times by the PIO or an assigned assistant.

(3) Still or video photography is only permitted with signed written authorization from the hospital IC.~~Office of Media Relations.~~

Commented [SS7]: Not sure what this refers to?

(4) Written consents will be required prior to any photographs or video taken of people (including patients, residents, staff, and visitors) on facility grounds.

9.3 Public Information System

When multiple agencies are involved in a response, a Public Information System (PIS) may be implemented to provide consistent messaging from "one voice". When a PIS is established—as directed by the Office of Emergency Management (OEM) or other authority—SPH will ensure that any information released is only done in coordination with the PIS guidelines as established at the time of the incident.

~~During an incident involving multiple agencies or organizations, it is vital that public information be communicated using "one voice," that is, a consistent message delivered across all participating community response entities. A Public Information System (PIS) provides accurate, timely, and coordinated information to incident leadership and the public. When a PIS is established—as directed by the Office of Emergency Management (OEM) or other authority—SPH will ensure that any information released is only done in coordination with the PIS guidelines as established at the time of the incident.~~

9.4 Joint Information Center

At the discretion of the City of Homer ~~EOC~~ or Kenai Peninsula Borough EOC, a PIS may be supported through the establishment of a Joint Information Center (JIC). In a JIC, the PIOs of all health care partners and jurisdictional authorities, including SPH, if participating ~~(if it is a participating agency)~~, co-locate and develop a joint public information message for dissemination. Under those circumstances, all media releases would be coordinated through the JIC.

10. DEPARTMENTAL RESPONSIBILITIES (GENERAL)

The following are general emergency responsibilities listed by department, and are included in, or ~~support~~supported by~~,~~ the posted Department Emergency Operations Plans (DEOP). Duties involving suspension of non-essential functions or disruption of normal activities or services. Deployment~~, including deployment~~ of staff to the Labor Pool shall only be implemented when so directed by the IC or HICS leadership.

10.1 Non-Clinical Departments

Administration

(1) Prompt departments to send STAT-REPS
(2) Assist Incident Command
(3) Report to the Labor Pool when directed

Education

(1) Cancel all planned education events/meetings during HICS activation Levels 3 & 4.
(2) Report to Labor Pool if directed.

Patient Financial Services / Registration

(1) Be prepared to assist Admitting personnel in their assignments.
(2) Be prepared to assist Medical Records personnel in their assignments (See Administrative Departments - Medical Records).
(3) Report to Labor Pool if directed.

Discharge Planning

Discharge Planning personnel will evaluate patients identified as able to be discharged home to determine what type, if any, post-hospitalization services are required.

(1) For Certified Home Health Agency and Long Term Home Health Care Program referrals, Discharge Planning personnel, in coordination with the provider, will develop point of contact and make referral to appropriate agency.
(2) For patients requiring equipment and/or supplies at home, Discharge Planning personnel will arrange for equipment to be delivered to home or transferring medical facility.
(3) For patients requiring privately arranged para-professional services, Discharge Planning personnel will provide patients and families with list of agencies and assist in securing arrangements.
(4) For patients requiring transportation home, Discharge Planning personnel will arrange for transportation.

Engineering

(1) Maintain uninterrupted heat, steam, electrical, and other required services. Maintain the environment of care.
(2) Be prepared to supply personnel to assist in Emergency Department, if required.
(3) Assist Security with traffic/crowd control until relieved by additional Security personnel or police.
(4) If assigned to Damage Assessment and Control, determine the extent of damage to the facility.

(5) Rapidly make repairs that will return the hospital to as close to normal operations as possible.

Environmental Services / Laundry

(1) As directed, have available personnel to report to the Labor Pool.

(2) Assign personnel to incident areas as directed by the HCC. Be prepared to curtail all non-essential functions.

(3) Assist in evacuation of patients and residents from incident-related/affected units when directed.

(4) Maintain adequate supplies of linens, supplies, and equipment as directed.

General Accounting

(1) Wait assignment to Labor Pool.

Nutrition Services

(1) Maintain normal services.

(2) As directed, prepare special meal or refreshment service for incident-related/affected units/personnel and/or responders, i.e. HCC.

(3) Maintain adequate supply of food, condiments, and other associated supplies to allow for self-sufficiency for period of incident. ***(See Related Document "NS-105 Nutrition Services Emergency Management [CMS Tag 15]")***

(4) Where required, initiate mechanisms for immediate re-supply of any apparent or potential shortage.

Medical Records / Health Information

(1) Upon notification of EOP activation, prepare to curtail non-essential functions.

(2) Medical Records Supervisors will assign necessary personnel to report to Treatment Areas Supervisor for patient tracking.

(3) Prepare casualty lists and distribute to HCC, Administration, and Registration/Admitting, according to instructions on the area of the form.

(4) Acquire additional identifying information from Ambulatory Care patients prior to discharge, as required. Assure properly registered.

(5) Be prepared to assist with preparation of Emergency Medical Tags, if required.

(6) Report to Labor Pool if directed.

Purchasing

(1) Survey affected depts. & ensure areas are well stocked.

(2) Issue and deliver emergency medical supplies and other equipment to incident-related/affected units and other locations as required.

(3) Maintain normal operations consistent with incident requirements.

Quality ~~Improvement / Risk~~ Management

(1) Department will sustain only essential functions.

(2) Support ~~Labor Pool and~~ Incident Command and labor pool as able.

(3) RN's will report to Labor Pool.

Religious Affairs

See Social Work

Safety

(1) Supported by Engineering Department.

(2) See Section 19 for additional information.

Security

(1) When EOP is activated at HICS Level 2 or greater, close and secure all Hospital entrances as directed by IC with the following exceptions:

a. ED Entrance - injured only

b. Main parking lot entrance - for relatives, and authorized personnel

c. Main Lobby entrance - for access to family waiting area

(2) Establish barriers at all entrances to campus grounds. Attempt to expedite removal of vehicles from key areas to provide access for emergency equipment. Only the following vehicles shall be permitted onto Hospital grounds:

a. SPH Staff (with proper ID)

~~a.~~b. Police Department

~~b.~~c. Fire Department

~~c.~~d. Emergency Medical Service

~~d.~~e. Office of Emergency Management

f. Authorized Emergency Vehicles

g. Medical Examiner

~~e.~~h. Funeral hearses (with proper identification)

~~f.a. SPH Staff (with proper ID)~~

(3) Only people carrying employee ID cards or accompanied by such a person will be allowed in Hospital. Relatives of incident victims will be assisted to the Patient Information Area.~~directed to the Information Desk/Lobby.~~ Press will be excorted~~directed~~ to the Media Briefing Area and kept away from family members. As directed, prepare to institute 100 percent ID check of~~by~~ every person entering the campus.

(4) Security personnel will be assigned to the Emergency Department, Main entrance, and where needed for purpose of crowd/traffic control.

(5) At the discretion of the Police Department, a police officer from Homer PD will be located in the HCC with the Hospital's Security Branch Director to help coordinate traffic in and around the Hospital.

(6) Provide crowd control at incident-related/affected areas.

(7) Establish contact with police department immediately upon their arrival. ~~.~~

Telecommunications

(1) Maintain up-to-date lists of attending provider telephone numbers in Communications. Maintain current list of Emergency Team Assignments, first and second call alert rosters, and incident mobilization plans.

(2) Upon notification of potential incident, notify CEO or designee.~~IC CEO or designee.~~

(3) Activate Code, make notifications as directed by the IC

(4) As directed, notify providers listed on call alert rosters, emergency team assignments, attending providers, and departments that do not have 24-hour coverage, in that order.

(5) Maintain routine operations.

(6) Supervise utilization of back-up communications (pages, portable radio and messengers) where required.

10.2 Ancillary Services

Anesthesiology

(1) Provide normal services to incident patients as required.

(2) Provide normal service where possible.

(3) Maintain adequate staff to accomplish assigned missions.

(4) Be prepared to assist Trauma Team in Emergency Area, as directed.

Blood Bank

(1) Maintain adequate supply of whole blood through liaison with The Blood Bank of Alaska in Anchorage

Employee Health

(1) Provide necessary services to staff to extent possible

(2) Assist Infection Prevention in active surveillance for affected areas and provide assistance as needed

(3) Assist Infection Prevention in delegating necessary precautions/immunizations, PPE required etc.

(4) Report to Labor Pool

Home Health Services

(1) Provide normal services to incident clients as required.

(2) Provide normal service where possible.

(3) Maintain adequate staff to accomplish assigned missions.

Homer Medical Center

(1) Brief staff and prepare needed supplies.

(2) Prepare for possible influx of minor treatment patients from Emergency Department.

(3) Cancel non-essential administrative functions & non-essential clinical services.

(4) Report to Labor Pool if directed.

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Human Resources

(1) Delay/Cancel meetings and training sessions.

(2) Run Labor Pool.

(3) Participate in emergency credentialing.

Imaging

(1) Provide necessary radiological services to incident patients and continue normal service to Hospital to extent possible.

(2) Delay/cancel non-urgent outpatient appointments.

(3) Defer outpatient x-rays to clinic locations.

(4) Identify resource needs. Call in additional staff as needed.

(5) Provide staffing to permit maximum utilization of equipment in ED.

(6) Transport incident patients to and from Radiology Department where required.

(7) Staff remain in Imaging department unless otherwise instructed.

Infection Prevention

(1) Active surveillance for affected areas and provide assistance as needed.

(2) Delegate necessary precautions/immunizations, PPE required etc.

(3) Report to Labor Pool

Information Technology

(1) Contact on-call IT at (907) 235-0899.

(2) Monitor network and systems.

(3) Respond to critical problems.

Infusion Clinic

(1) Cancel non-essential administrative functions & non-essential clinical services.

(2) Report to Labor Pool if directed.

(3) Prepare for patient overflow.

Laboratories

(1) Upon notification of EOP activation, prepare to curtail non-essential functions.

Specialty Clinic

(1) Identify number of staff available for Labor Pool.

(2) Delay non-critical functions.

(3) Call in additional staff if needed and cancel clinic appointments.

(4) Be ready to report to Labor Pool.

Surgical Services

(1) Provide necessary services and continue normal service as possible.

(2) Delay elective cases for urgent or emergent.

(3) Notify patients and providers of possible delay in surgery schedule.

(4) Pull critical surgery supplies, stock as needed.

(5) Staff remain in Surgical Suite unless otherwise instructed.

(6) Prepare for admits, rapid transfers/discharges as needed.

Pharmacy

(1) Stand by. Call in off-duty Pharmacist and/or Tech

(2) Regular pharmacy procedures/duties

~~(1)~~(3) ensure adequate supplies.

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Post-Anesthesia Care Unit (PACU)

(1) See Surgical Services.

Rehabilitation

(1) Provide necessary rehabilitation services to incident patients and continue normal service to Hospital to extent possible.

(2) Delay meetings/training and non-critical work orders as needed.

(3) Delay/cancel non-urgent patient care activities, outpatient appointments/ elective procedures.

(4) Report to Labor Pool when directed.

Respiratory Therapy

(1) Complete impending treatments.

(2) Delay/cancel outpatient appointments as needed.

(3) Respond to patient care needs – assist nursing.

(4) Evaluate / prioritize patient needs.

Social Services

(1) Social Service function will be performed in Social Work Offices.

(2) Social Work personnel will also be assigned to Discharge Area (see Appendix E: HICS Incident Facilities/Designated Areas Matrix) to assist relatives of discharged patients. When all discharged patients have left Hospital, these personnel will return to Social Work Offices for further assignment.

10.3 Clinical Services

Emergency Department

(1) Request additional staff and HICS position Scribes as needed

(2) Hold non-critical nursing functions/procedures/ using staff for emergent needs

(3) Consider Mass Casualty or Mass Fatality annex activation (as needed)

(4) Assist with identification of incident patients.

(5) Prepare for influx of patients.

(6) Evaluate needs of the unit

(7) Collect and identify patient valuables.

(8) Maintain record of all incident-related admissions.

(9) Maintain record of all transfers within Hospital.

(10) ***See Related Document "Patient, Resident, and Staff Tracking [CMS Tag 18]"***

Acute Care Department

(1) Review personnel requirements and assignment needs predicated on type and scope of incident. Evaluate resources, beds.

(2) As directed by the HCC, in consultation with the Discharge Unit Leader, assigned Chiefs of Service, and Discharge Planning, assist in determining discharge of in-house patients.

(3) Keep Nursing Unit Leader informed of stress areas; advise on deployment of nursing personnel.

(4) Collaborate with ER for beds, staffing and patient census.

(5) Coordinate activities of and assign duties to all nursing staff. Cover incident-related/affected units, coordinating activities with HICS leaders as assigned.

(6) Establish liaison with operating suites.

(7) Coordinate movements to and from holding area.

(8) Maintain normal care to non-incident-related patients.

(9) Be prepared to receive and deploy personnel assets from other departmental services.

(10) If required, plan incident area coverage for following shift.

(11) Only if directed, prepare to cancel non-incident-related admissions upon notification of EOP activation.

(12) Coordinate with Discharge Planning regarding patients to be discharged.

(13) Coordinate with Medical Care Director to determine those non-incident-related admissions that are most critical and not related to emergency.

Long Term Care

(1) Suspend extra activities, meetings and trainings.

(2) Print EMAR for each resident. Designate a medication nurse.

(3) Prepare dayroom for potential day care.

(4) Suspend all non-critical nursing & functions/procedures.

OB – Labor and Delivery

(1) Delay elective and non-urgent outpatient procedures.

(2) Discharge patients if able.

(3) Report to Acute Care or Labor Pool when directed.

10.4 Provider Staffing

(1) Medical Care Branch Director shall make provider assignments to emergency teams.

(2) Hospitalists, on-staff providers and Medical Director, in conjunction with Administration, determine discharge of in-house patients.

(3) Emergency teams and locations:

a. Emergency Department Provider: Work in ED Triage, Trauma Room, ED Treatment Rooms and Delayed Treatment Area.

b. Triage Team: ED Ambulance Entrance

c. Surgical Team: ED Trauma Room will be assigned by Medical Care Branch Director in conjunction with ED Provider in Charge.

(4) When directed, Family Practice Staff on duty will report immediately to the Medical Care Branch Director in the Medical Staff Pool to be assigned to the Emergency Department or wherever needed.

(5) When directed, members of Medical Staff will report to the Provider Labor Pool and will be assigned by the Medical Care Branch Director.

(6) No member of the medical staff is authorized to respond off the campus to an emergency or incident scene without the express authorization of the IC.

11. OPERATIONS

11.1 Clinical Operations

The Medical Care Branch Director is responsible for oversight of all clinical activities to include:

- Tracking the location and movement of patients and residents within the facility.
- Services provided for vulnerable populations, such as LTC residents, geriatric, pediatric, disabled, serious chronic conditions, substance abusers;
- Identification and protection of patients and residents who are susceptible to wandering or at risk for elopement or abduction;
- Patient and resident's personal hygiene and sanitation needs;
- Mental health service needs;
- Mortuary services; and
- Documentation and tracking of patient/residents clinical information

In coordination with the Operations Chief, Medical Staff Director, and Nursing Unit Leaders, the Medical Care Director will determine the need for modification, discontinuation, restoration of clinical and resident services, and make appropriate recommendations to the IC.

- ~~(1)~~ When directed, members of Medical Staff will report to the Labor Pool and will be assigned by the Medical Staff Unit Leader or Medical Care Director.
- ~~(2)~~ No member of the medical staff is authorized to respond off the campus to an incident scene without the express authorization of the IC.

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11.2 Bed Capacity Expansion

When the IC determines ~~that~~ normal bed vacancies cannot accommodate the admission requirements of casualties, the following steps shall be taken:

- ~~(1)~~ ~~As many p~~Patients ~~as possible expecting to be~~~~normally scheduled for~~ discharged the following day will be assessed and discharged immediately if possible. Available house staff providers shall be prepared to discharge these patients upon notification.
- ~~(2)~~ Those patients admitted for elective surgery will be discharged and re-admitted at a later date.
- ~~(3)~~ Additional beds can be made available by doubling bed capacity in existing Acute Care patient rooms
- Patients ~~or residents~~ assessed to ~~selected for evacuation,~~ either discharged home or to another facility, will be sent to the Main Lobby to await transport. Logistics will supply appropriate staff to oversee these areas.
- ~~(4)~~ Long Term Care Facility bed status should be addressed to identify if AC Swing-Bed patients can be effectively and safely transferred to the LTC Facility.
- ~~(5)~~ For additional information, ***See Related Document "Mass Casualty Annex".***

(1) Surge Capacity

For additional information, see *Mass Casualty Annex.*

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(2) Airborne Infectious Isolation Capacity (AIIR)

The facility has ~~three~~ ~~rooms with~~ negative pressure capabilities: ED-1, AC-2, OB-1 and ability to add more as needed..~~,~~

The matrix of AIIR rooms may be found in Appendix F ***(See Related Document "Appendix A-L – HICS Activation References")***

In addition, the facility maintains two freestanding (mobile) air filtration units equipped with HEPA filtration and ultraviolet lights.

The Infection Prevention MD/RN is authorized to direct any facility activities related to infectious or communicable diseases, and will serve as a technical specialist/advisor to the IC as conditions warrant.

11.3 Patient Discharge

(1) Discharging Patients: The Utilization Nurse will participate in the process of transferring patients to other medically appropriate settings in order to make hospital beds available for those patients requiring inpatient care.

(2) Patient Pick-Up: During emergency conditions, family members will be instructed to pick up patients who have been discharged.

11.4 Alternate Care Site Operations

~~There are several circumstances under which establishment of~~ Aan alternate care site may become necessary~~. These include~~ if there is a~~the~~ need to evacuate all or part of the facility due to an:

- ~~an i~~Internal or external event threatening the facility or its occupants;
- ~~an e~~External incident producing a patient load that exceeds the facility's in-patient capacity for care; ~~an e~~
- Event where special circumstances, such as a communicable disease threat, require separation of some patients/residents from the general hospital or LTC population; or ~~an~~
- ~~e~~Event where the facility is tasked with establishing a screening facility or point of distribution for medication or vaccination during a community-wide crisis.

~~Under such circumstances, t~~The IC may elect to activate one or more pre-planned alternate care facilities.(Ref HW-290 Evacuation to Alternate Care site)

When activated, the following general procedures shall be implemented:

(1) The EOP will be activated by IC ~~at a minimum of HICS Level 3~~. Notification will be made to the Homer Police Dispatch Supervisor, and to local government and oversight agencies as appropriate.

(2) A suitable command structure will be established and staffed for each alternate care site. The site commander will be known as the "Alternate Site Operations Chief", and will report at the general staff level to the IC. The level of command staff provided will be determined by the nature, scope, and anticipated duration of the alternate site activation.

(3) Clinical and support staff for the alternate site will be determined by the Alternate Site Operations Chief, and resourced as available from the hospital labor and medical staff pools.

(4) The Logistics Section Chief will address logistical needs, including medical and pharmaceutical supplies, and transportation and communications between the facility and the alternate site. At

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a minimum, telephone, facsimile and two-way radio communications links should be established. ~~Transportation will be required for movement of patients, residents, staff, and equipment.~~ In the event of anticipated operation in excess of 24 hours, efforts should be made to establish computer data links as well. ~~The Logistics Section will also support medical and pharmaceutical supply needs.~~

(5) The P~~l~~lanning Section will be responsible for planning and documentation needs, including management of patient and resident tracking and records. HICS standard forms will be used for tracking and incident documentation.

(6) As the need for an alternate care facility decreases, the Alternate Site Operations Chief, in consultation with the IC, general staff, Demobilizational Unit Leader, and Medical Care Director, will develop a written action plan for de-escalation of alternate care site operations; return of patients, residents, staff, records, and resources to the facility, ~~l;~~ and discontinuation of alternate care site operations.

11.5 Loss of Local Community Support

There may be incidents or times when the local community is unable to support the facility in six critical areas: communications; resources and assets; safety and security; staff responsibilities; utilities management; and clinical and resident support activities. Significant degradation or loss of local community support for any of the six critical areas may result in the suspension of specific services, alterations to the standards of care temporary or partial facility closure, or facility-wide evacuation.

11.6 Staff Support Functions

(1) Housing

When conditions warrant the implementation of staffing augmentation plans and/or require boarding arrangements for staff members, the Staff Support Unit shall coordinate such arrangements. Temporary facilities will be set up in the Ambulatory Care Area. As needed, the Planning Section will develop staff schedules that establish appropriate downtime periods, and staff members will be rotated out of their work duties for planned downtime.

(2) Transportation

External conditions may create transportation difficulties for staff, inhibiting their ability to report for duty. ~~Such conditions may include, but are not limited to, weather or environmental emergencies, disruptions of public transportation, or establishment of security perimeters.~~ When needed, the Transportation Unit shall coordinate transportation resources and arrangements, supported by the Facilities Department. If necessary, the Kenai Peninsula Borough EOC should be contacted to assist in providing regional transportation arrangements or coordinating SPH and outside agency transportation assets.

(3) Dependent Care

Staff members who also provide care for personal dependents generally have their own arrangements for dependent care when they must report for duty. SPH recognizes that under some unusual circumstances, individual staff members may be called to duty without having arrangements for personal dependents. At the discretion of the IC, when conditions warrant, the hospital will provide on-site child and elder dependent care for staff dependents, enabling the staff members to report for duty. Staff should call the Employee Emergency Information Hotline (907.235.0872) for incident-specific information.

Adult and pediatric dependent care area will be established as needed. These areas will be supervised by the Dependent Care Unit Leader, and staffed by volunteers if available. If volunteers are not

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available, designated staff members will be utilized. Arrangements will be provided for on-duty staff to visit with their dependents as schedules permit. While all employees should have an individual family plan, the dependent care process will provide a temporary location for sheltering of dependent family members by using volunteers and personnel from the Labor Pool to provide limited dependent care. ~~The primary focus of the dependent care process is to ensure that sufficient staff is available to adequately care for the residents and existing and incoming patient population during and following an incident.~~

(4) Critical Incident Stress Debriefing (CISD)

Following a crisis, it is essential ~~that~~ all participating staff come together within 24~~-~~hours for a debriefing to~~hat will~~ focus on the prevention and alleviation of Critical Incident Stress. The debriefing will be held with members of the Critical Incident Stress Debriefing Team, which is a crisis intervention peer support service.

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The goal of the CISD Team is to provide assistance to help staff manage their reactions to the crisis so ~~that~~ they may return to their normal daily routine. The team offers confidential, non-judgmental, emotional support and may suggest coping strategies to~~hat can~~ assist in preventing delayed reactions to critical incident stress.

As conditions warrant, the Psychological Support Unit Leader will contact the team ~~at~~ to schedule debriefing sessions. If necessary, the SPH CISD team can be reinforced by the CISD teams from other facilities or Kenai Peninsula Borough.

(5) Pet Care

Staff members who also provide care for household pets are expected to have their own arrangements for pet care when they must report for duty.

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12. LOGISTICS

12.1 Logistics Section Activities

Logistics Section functions include all activities necessary to establish and support the environment of care, and provide the resources (including personnel) necessary for the facility to carry out its mission. Such activities include, but are not limited to:

- ~~; o~~Oversight of support activities such as patient and resident transportation;
- ~~c~~Critical supplies [i.e.~~g.~~, pharmaceuticals; medical hardware and software; food and water; linen;
- ~~m~~Maintenance of essential building utility needs;
- ~~p~~Physical plant management during evacuation and re-occupancy;
- ~~b~~Backup internal and external communications systems; and
- ~~h~~Hazardous materials/decontamination support.] ~~Annexes to this plan provide department, system, or event-specific details of logistical functions. The Homer EOC may be called upon for additional support in the event that the facility requires external assistance in logistical support.~~

12.2 Staffing Augmentation

~~By their very nature, unusual events tend to be staff-intensive, as additional resources are needed for a multitude of tasks.~~ It is SPH's policy to consider any employee on the premises during an EOP activation to be on duty. An employee may be called upon to aid in other than job-prescribed duties, work in departments or carry out functions other than those normally assigned, and/or work hours in excess of (or different from) their normal schedule. ~~Any employee found leaving the premises without authorization during the period of EOP activation will be subject to disciplinary action.~~

12.3 Labor Pool

(1) Labor Pool and Credentialing Area

- A **Labor Pool and Credentialing Area** ~~(formerly known as a "Manpower Pool")~~ may be established as an initial response strategy when conditions indicate ~~that~~ staffing augmentation will be needed to respond to a particular incident.
- The mission of the Labor Pool and Credentialing Areas is to serve as a mobilization point for medical and non-medical personnel and volunteers, and a credentialing area for any situation where medical volunteer credentialing or identification is required. ~~During most incidents, which are typically of a minor (lesser) impact, full use of the Labor Pool and Credentialing Area is not required.~~
  - For incidents related to an ED patient influx, a limited Labor Pool may be established at a designated location adjacent to the Emergency Department, for rapid deployment of pre-determined staff directly to the ED.
- The Labor Pool consists of three separate components, which may be activated individually or collectively, as conditions warrant:
  - General Labor Pool and Credentialing Areas, established initially as a gathering location for staff ~~that will be~~ awaiting assignment.
  - Medical Staff Pool co-located with the Labor Pool or established in a separate location, as a mobilization point for provider staffing.

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  - Nursing Staff Pool co-located with the Labor Pool or established in a separate location, as a mobilization point for nursing staffing.
- The Labor Pool and the Credentialing Unit Leaders are responsible for the operation of the Labor Pool and Credentialing Units, regardless of location(s). The Unit Leaders are responsible to:
  - Collect and inventory available staff and volunteers at the designated location (Labor Pool) for assignment by the Staging Officer.
  - Maintain adequate numbers of both medical and non-medical personnel, as directed by the Logistics Section Chief.
  - Assist in the maintenance of staff morale.
- Each department's DEOPs specifies, by title and shift (time of day), the specific number of clinicians and employees that may be sent to the Labor Pool when directed. **Staff shall only report to the Labor Pool when specifically directed to do so by the HCC.**
- When arriving at the Labor Pool, staff shall report directly to the Unit Leader, sign in, and remain in the designated area, available for assignment, until assigned or relieved.
- The Labor Pool and Credentialing Area shall be activated for HICS Level 3 or greater incidents, or other situations as directed by the IC where its use would improve intra-organizational staffing. Once activated, it shall remain activated and staffed ~~in accordance with each department's DEOP *when directed*~~ until the activation is de-escalated or until otherwise directed.

(2) Staff Deployment from the Labor Pool

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- When activated, the first manager or supervisory staff member to arrive at the Labor Pool location shall assume the role of the Labor Pool and Credentialing Unit Leader until relieved by the individual assigned by the HCC.
- The Unit Leader shall immediately develop a roster of staff members reporting, using a HICS 253A *Labor Pool Staff Registration form.*
- The Unit Leader shall establish and maintain a positive communications link with the HCC ~~using the~~ by telephone or ~~by~~ radio. An additional telephone line shall be established for direct communication to the Labor Pool.

HICS 253A – Labor Pool Staff Registration ❑ Labor Pool ❑ Medical Staff Pool ❑ Nursing Staff Pool ❑ Other ______

1. OPERATIONAL PERIOD FROM DATE/TIME	2. OPERATIONAL PERIOD TO DATE/TIME	3. SECTION	4. LABOR POOL UNIT LEADER

5. REGISTRATION *Please* Print *All Information*

Name *(Last Name, First Name)*	Title	Department	Cell or Pager Number	Regularly Scheduled Shift/Hours Today	Time IN at Labor Pool	Time OUT from Labor Pool	Assignment from Labor Pool
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

6. CERTIFYING OFFICER	7. Date/Time Submitted:
8. Facility Name	

Purpose: Labor Pool staff sign-in for operational period Origination: Labor Pool & Credentialing Unit Leader HICS 253A
Copies to: Time Unit Leader, Personnel Tracking Manager, and Documentation Unit Leader Page ____ of ____

- When a HICS leader requires staff support, the request shall be made directly to the Labor Pool Unit Leader who will ~~. Available resources shall be~~ assign~~ed~~ staff from the Labor Pool. Every effort shall be made to assign staff to tasks consistent with their level of training or credentialing. ~~If additional staffing is needed, the Labor Pool Unit Leader shall request a specific additional staff assignment from the HCC.~~
- The Labor Pool Unit Leader shall provide periodic updates to the HCC on staffing levels available and assigned, by title.
- In addition to deploying clinical staff as needed for patient and resident care activities, non-medical assignments from the Labor Pool may include (but are not limited to):
  - Patient and resident transport

- Security augmentation
- Evacuation teams
- Runners / messengers
- Telecommunications support
- Clerical or ancillary support
- Patient and resident information
- Proving information, escorts, assistance, or other services to family members and visitors
- Other tasks or assignments as needed

(3) Virtual Labor Pool

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- For incidents of extended duration, or where it is desirable to have pre-designated staff available for deployment but not productive to maintain them in a personnel staging area for a prolonged time, the Support Branch Director or Logistics Section Chief shall consider establishing a virtual labor pool.
- For a virtual labor pool, the Labor Pool Unit Leader develops a roster of staff available for deployment by establishing contact with each department. The roster is maintained, and updated for each operational period. The employees so registered remain at their current work assignments until directed by the Labor Pool Unit through their immediate supervisor or direct communication.~~unless specifically needed. When needed, the immediate supervisor will be contacted by the Labor Pool and the employee will be directed when and where to report.~~

12.4 Emergency Shift Schedule

At the determination of the IC, all or some staff members may be changed to 12-hour emergency shifts in order to maximize staffing. These shifts may be scheduled as needed to meet emergency response objectives.

12.5 Staffing Expansion Considerations

Some options for expansion of both professional and non-clinical staff include the following:

- Temporarily ~~decrease~~ increase nursing staff-to-patient/resident ratios on floors
- Hold current staff on overtime after shift
- Change from three 8-hour shifts to two 12-hour shifts
- Call back off-duty staff from earlier shift
- Call in next shift staff early
- Contract additional agency nurses if necessary
- Cancel staff days off (first one per week, then both)
- Cancel holidays and vacation leaves
- Coordinate through the Kenai Peninsula Borough DOH~~SS~~ and Alaska Hospital & Healthcare Association (AHHA) for staffing support from outside the facility (consider credentialing needs) – including other hospitals; home-based care staff; Medical Reserve Corps; and staff from an unaffected area of the Kenai Peninsula Borough/region/state/country

12.6 Administrative and Temporary Clinical Privileges / "Disaster Privileges"

~~SPH may activate its EOP for an incident when it has been they are unable to meet immediate patient needs due to a shortage of provider staffing.~~ Providing temporary clinical privileges ~~This process~~ applies to all providers, licensed independent practitioners and ~~allied health~~advanced practice professionals who are not members of the Medical Staff who may provide ~~important~~ patient care services in the event of a disaster when there is a shortage of provider staffing.

Temporary Privileges "Disaster Privileges" will be granted according to the SPH and LTC Facility Medical Staff Bylaws section 5.11 Disaster Privileges.

5.11.1 If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

a. A current picture hospital ID card that clearly identifies professional designation;
b. A current license to practice;
c. Primary source verification of the license;
d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
f. Identification by a current hospital or Medical Staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

5.11.2 The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

5.11.3 The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

5.11.4 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

5.11.5 Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

5.11.6 Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

Licensed Independent Practitioners

- The CEO, CMO, Chief of the Medical Staff, or designee(s) should the need arise, may grant disaster privileges upon presentation of ANY of the following forms of identification:
    - Current picture employee ID card.
    - Current licenses and a picture ID issued by state, federal, or regulatory agency.
    - Identification indicating member of a Disaster Medical Assistance Team (DMAT)
    - Identification granting authority to render patient care in emergency circumstances, such authority granted by a federal, state, or municipal entity
    - Presentation by current employee or medical staff member(s) with personal knowledge regarding practitioner's identity.
- The responsible individual(s) is not required to grant privileges to any individual and is expected to make such decisions on a case-by-case basis at his/her discretion.
- Disaster privileges will be granted within the provider's scope of practice and pertinent SPH Core Privileges.
- Individuals granted disaster privileges will be issued official employee identification badges issued by the Human Resources Department.
- They will be identified by name and title, and identified as "Disaster Privileges" on the name badge.
- All individuals granted disaster privileges will be responsible for reporting to the CMO, Chief of the Medical Staff, or designee, during the emergency.
- The Chief of the Medical Staff may delegate the individual to report to another Medical Staff member, such as the Emergency Department provider, depending on the circumstances.
- A list of all persons granted disaster privileges will be posted in the Nursing Station in the Emergency Department and provided to the IC.
- The Medical Staff Services Office will verify the current medical license, Office of Inspector General/General Services Administration (OIG/GSA), and run an American Medical Association (AMA) profile.
- Verification of credentials of individuals granted disaster privileges is a high priority and will be done as soon as the immediate emergency/disaster is under control.

If extraordinary circumstances intervene, the Logistics Section Chief shall document the following:

- Reason(s) verification could not be performed within 72 hours of the practitioner's arrival
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
- Evidence of the facilities attempt to perform primary source verification as soon as possible

Non-Licensed Independent Practitioners

During EOP activation, the need for assigning disaster responsibilities to volunteer non-licensed independent practitioners may arise. A volunteer non-licensed independent practitioner is defined as

a person other than a licensed independent practitioner who is qualified to practice a healthcare profession; is required by law and regulation to have a license, certification, or registration; and is engaged in the provision of care and services (e.g., a registered nurse or respiratory therapist). SPH may modify the usual process for determining qualifications and competencies of volunteer non-licensed independent practitioners only if necessary to meet immediate patient and residents needs during an emergency. Assigning disaster responsibilities to volunteer practitioners shall be made on a case-by case basis, taking into consideration the needs of the organization and the patient(s)/resident(s). ***(See Related Document "Volunteers Management [CMS Tag 24]")***

Identification requirements for those volunteer non-licensed independent practitioners assigned disaster responsibilities must be met before the practitioner shall be considered eligible to provide care and services. Minimum identification credentials shall include a valid photo-identification issued by a state, federal, or government regulatory agency (e.g., driver's license, passport) and at least one of the following:

- A current, valid employee photo-identification card clearly identifying professional designation
- A current, valid license, certification, or registration as required by their professional discipline
- Primary source verification of license, certification, or registration (if required by law and regulation in order to practice)
- Identification indicating that the individual is a member of a federal or state DMAT or the Medical Reserve Corps, ESAR-VHP, or other recognized state or federal response organizations or groups
- Identification indicating that the individual has been granted authority by a government entity to provide medical care, treatment, or services in disaster circumstances
- Confirmation by a facility employed staff member with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during an emergency

Human Resources shall maintain a list of all volunteer practitioners and the responsibilities they have been assigned. Oversight of the professional performance of volunteer practitioners, including direct observation, mentoring, and clinical record review will be performed by the Medical Director or designee. Based on this oversight, the Medical Director or designee shall recommend to the Operations Section Chief whether assigned disaster responsibilities should continue.

As soon as the immediate emergency situation is under control (but not more than 72 hours from the time the volunteer non-licensed independent practitioner presents to the facility, unless documented extraordinary circumstances intervene), primary source verification of the licensure, certification, or registration of individuals who were assigned disaster responsibilities will be undertaken. Primary source verification is not required if the individual has not provided care, treatment, or services under their assigned disaster responsibilities.

If extraordinary circumstances intervene, the facility shall document the following:

- Reason(s) verification could not be performed within 72 hours of the practitioner's arrival
- Evidence of the volunteer non-licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
- Evidence of the facilities attempt to perform primary source verification as soon as possible

Non-Medical Volunteer Management
The Logistics Section Chief will ensure that, as conditions warrant, appropriate identity and credentialing verification processes are followed. The Medical Staff Office will be consulted as

necessary in the credentialing process. SPH identification indicating "Volunteer Non-Licensed Practitioner" and the individual's name and title shall be provided and displayed conspicuously at all times while the practitioner is engaged in providing care and services.

12.7 Resource and Asset Management

(1) Inventory Management

The HIMT maintains a Critical Resource Inventory ~~-~~documenting SPH critical resources available to support the organization, LTC residents and hospital patients, and staff required during an emergency. Assets listed include PPE, food and water, medical/surgical supplies, pharmaceuticals, fuel for generators and vehicles, emergency lighting and communications equipment, evacuation movement equipment, durable medical equipment and other items. The Critical Resource Inventory is updated at least bi-annually to ensure that adequate resource levels are maintained.

(2) Communication with Purveyors of Essential Supplies, Services, and Equipment

Contact information for access to primary, secondary, and tertiary/alternate vendors for all critical supplies, services, and equipment (as noted in the HICS 258) is maintained:

- By the department head of the department that routinely orders and maintains the stock of the particular good or service
- By the Purchasing Department, which assumes the role of the Procurement Unit during EOP activation
- In the HCC HICS 258 Resource Directory

At the outset of an incident during which critical resources may be needed, the Finance Section Chief will notify the Procurement Unit Leader ~~shall be notified by the Planning Section C~~hief of a projected resource shortfall, and vendor contact(s) shall be initiated. ~~As conditions warrant, the Procurement Unit Leader shall contact one or more vendors, including others not listed in the~~ Refer to Resource Annex, Critical Resource Inventory or others outside of the list~~,~~ until an acceptable source of supply is identified and arrangements are made to meet the need.

(3) Resource Monitoring

During EOP activation, the Resource Unit (Planning Section) shall maintain current operational inventory status on all resources used for, or affected by, the incident. Such information shall be gathered and documented during the first eight hours of the incident, and every operational period thereafter, via departmental STATREP submissions and supply center resource updates. When pre-identified par level thresholds are met, the Planning Section shall follow up with Finance/Administration and Logistics Sections to ensure that necessary resource replenishment has been accomplished.

In the event ~~that~~ resource replenishment cannot be accomplished, the Planning Section shall develop alternative strategies for resource conservation and/or service reduction. This shall be done in coordination with the appropriate department heads of Telecommunications, Materials Management, Pharmacy, and Facilities Management. In the event ~~that~~ resource shortfalls are projected, the following actions may be implemented at the direction of the IC:

- Procurement from alternate or nontraditional vendors
- Procurement from communities outside the affected region
- Resource substitution
- Resource sharing arrangements with mutual aid partners
- Request for external stockpile support from the Kenai Peninsula Borough logistics cache

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- Request for external stockpile support from the State Department of Health Medical Emergency Response Cache (MERC), or the Strategic National Stockpile (these requests go through the Kenai Peninsula Borough Office of Emergency Management) (see Support Annex, Strategic National Stockpile for additional information)

(4) Resource Sharing

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In the event of a large-scale emergency or regional crisis, there may be a need for sharing resources and assets with mutual aid partners, other healthcare organizations in the community or contiguous geographic area, or organizations across a larger region of the country. ~~Resources and assets that may be shared include but are not limited to beds, transportation resources, linen, fuel, PPE, medical equipment, and supplies. Such resources may be needed by the facility or SPH may be asked to provide support to other organizations.~~

Communication and coordination regarding the need for resources and assets shall be communicated initially through the Liaison Officer to or from the mutual aid partner or local entity requesting or providing support. If another entity requests resources, the call shall be routed to the Liaison Officer, who will document the information and refer the matter to the Logistics Section Chief who will review the request and ~~. The Logistics Section Chief shall determine the feasibility of meeting the request, and shall~~ make recommendations to the IC. The IC~~, who~~ is responsible for directing the course of action and authorizing the external deployment of resources. ~~If we seek resources from a mutual aid partner or local entity, the Logistics Section Chief shall direct the Liaison Officer to establish initial contact with the outside organization. Once contacts are established through the respective Command Centers, the Logistics Chiefs from participating agencies are free to coordinate their interactions directly to shorten the lines of communication.~~

If resources are needed beyond the scope of mutual aid partners or local entities, the Logistics Section Chief shall direct the Liaison Officer to establish contact with the Kenai Peninsula Borough Office of Emergency Management Emergency Support Function (ESF) Public Health and Medical Services desk. City OEM will serve as the coordinating point for managing resources and asset deployment both within and outside the Kenai Peninsula Borough during a large-scale incident.

(5) Donation Management

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Three donation scenarios may arise when SPH is affected by a major emergency in the community to~~. These donation scenarios~~ include offers of miscellaneous goods and services from members of the public, blood donations from individuals, and donations of medical supplies and/or equipment, including pharmaceuticals, from an identified supplier/vendor. ~~Note that management of unsolicited volunteer services should be carried out in accordance with the provisions of Section 28.3—Administrative and Temporary Clinical Privileges.~~

The following processes will be used to ensure the most efficient and effective utilization of donated goods received by the facility during an incident. ~~It is likely the receipt of goods and services will not coincide with the needs of SPH or the healthcare needs of the community. Therefore, goods and services must be coordinated to realistically assess what is available versus what is needed.~~

i. Miscellaneous Goods and Services—General Policy

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Except in extraordinary circumstances, unsolicited offers of donated goods or services should be referred to the Kenai Peninsula Borough EOC. Depending on the scope of the incident, the Kenai Peninsula Borough, or a designated Voluntary Organization Active in Disaster (VOAD), may establish a Donations Coordination Center (DCC) under the direction of a Donations Specialist. The DCC will

be the responsible entity for receipt, cataloging~~cataloguing~~, warehousing, and integration/distribution of donated goods into and through the Kenai Peninsula Borough's overall disaster supply system.

Press releases and other forms of public information through the PIO, will be used to encourage and guide public donations. Donors will be discouraged from sending unsolicited goods directly to SPH. ~~Donors should be encouraged to make cash donations to locally sponsored funds or to established local charitable organizations.~~

~~As needed, the Logistics Section Chief shall be responsible for assessing unmet needs and coordinating with the DCC regarding availability of donated goods and services to meet these needs from the available donations and volunteers responding. The Logistics Chief shall also arrange for the transport of goods and materials to or from the facility as conditions warrant.~~

~~**Responsibility**~~

The Logistics Section Chief shall be responsible for leading the donations management process (goods other than blood). If necessary, a Donations Specialist shall be assigned to the Logistics Section. The Logistics Section shall:

- Establish a process for receiving and securing donated goods
- Establish a database and maintain tracking of all donated goods and services, including a record of the source and date received
- Warehouse and safeguard donated goods until they can be distributed
- Be alert for perishable items (e.g., food), hazardous or unidentified items (which may pose a threat), or items requiring special handling (e.g., medications requiring refrigeration)
- Maintain a listing of goods and services offered or available from any source
- Coordinate with recognized local support agencies to determine available resources and needs, and to arrange for distribution of donated goods to the community as available

ii. Blood Donations

~~Often, during a traumatic event, people present themselves at community hospitals to donate blood. The need for this is often promoted by the media, typically without a request from the hospital. In fact, any blood donated during a disaster must be screened by multiple tests to maximize the safety of transfused blood and components. These tests may be performed at a hospital laboratory or at the Alaska Blood Program, and will take about 48 hours to complete. However, to reinforce initial blood stores that may be rapidly depleted during a crisis, t~~The hospital ~~will~~may establish an emergency blood donation program if the need arises. The need for blood donors will be communicated through the PIO and blood donations will be handled and screened per laboratory protocols to maximize the safety of transfused blood and components.~~Prospective donors shall be directed to SPH and transportation may be provided as necessary.~~

iii. Donations from an Identified Supplier/Vendor

~~In the event that an unsolicited apparent donation of supplies or equipment arrives at the SPH, the shipment shall not be accepted without the express authorization of t~~The Finance Section Chief is responsible to oversee any unsolicited donation of supplies or equipment and will work directly with the Supply Unit Leader and Director of Materials Management regarding the need or use of the items.~~. The identity of the purveyor shall be established, and the Supply Unit Leader, in consultation with the Director of Materials Management, shall determine whether the goods have been ordered or are needed. If no valid order can be verified, o~~Only the Finance Section Chief or designee is authorized to accept the delivery of unsolicited donations~~. This policy exists~~ in order to protect the facility from taking "donated" goods~~delivery of unneeded "donations"~~ that are subsequently billed after the crisis.

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12.8 Utility Management

SPH has identified alternative means of providing critical utility services including but not limited to:

- Electricity ***(See Related Document "ENG-002 Emergency Generator [CMS Tag 15]")***
- Water needed for consumption and essential care activities ***(See Related Document "HW-207 Emergency Water [CMS Tag 15]")***
- Water needed for equipment and sanitary purposes
- Fuel required for building operations, generators, and essential transport services
- Medical gas/vacuum systems
- Fire Detection, alarm systems and response
- Elevators
- Temperature Control (Heating, ventilation, and air conditioning HVAC)
- Steam for sterilization
- Sewage and waste disposal

Provisions for advance preparation in anticipation of a possible utility loss/failure/shutdown can be found along with additional information in Section 1; Advanced Preparations.are addressed in Section 14—Advance Preparations. Utility-specific alternate means, including detailed interruption/restoration procedures, are addressed in the utility-specific annexes.

For additional information see Section 1.2.

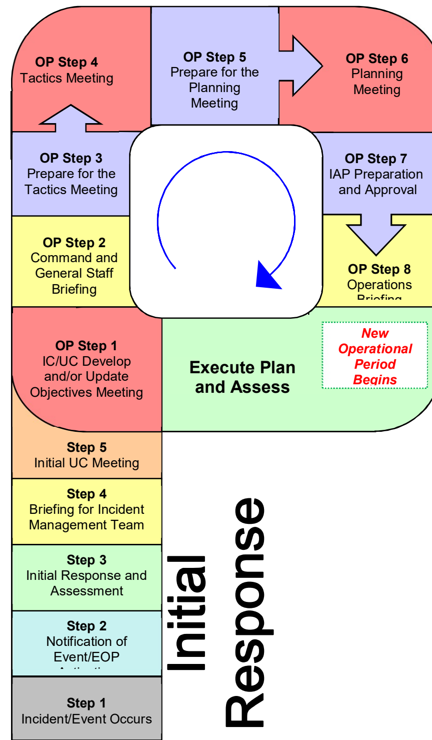
13. PLANNING

13.1 General

~~SPH is committed to using a~~An organized planning process ~~a~~is an essential function of EOP (EOP) activation. The planning process establishes a focused environment for effective incident-related data gathering and analysis regarding incident operations and assigned resources, development of alternatives for tactical operations, conduct of planning meetings, and preparation of the ~~IAP~~Incident Action Plan (IAP) for each operational period.

The IC maintains overall responsibility for planning functions. Incident planning activities involve developing strategies and outlining tasks and schedules to accomplish the incident goals as determined by the IC. Planning functions include resource and situation tracking and status-keeping, IAP documentation and maintenance of records, medical staff assignments, and planning for demobilization. Authority for carrying out these activities may be delegated to the Planning Section Chief or subordinate elements within the Planning Section. ~~The IC shall ensure that incident planning needs are addressed as a primary and critical function of EOP activities.~~

Figure 13-1. Incident Planning Cycle.



13.2 Operational Periods

~~As soon as practical following the activation of the EOP, t~~The IC shall organize the response objectives or operational activities into specified time periods~~. These time periods are~~ called Operational Periods.

Operational periods may be~~will initially be~~ of short duration~~, but for extended incidents, they may be~~ as long as 24 hours, or longer as determined by the incident. ~~For extended incidents (greater than a 24-hour period), a standard incident planning cycle with 12- or 24-hour operational periods should be established.~~ The use of operational periods is an important function to enable effective resource management and tracking of task completion.

13.3 Incident Planning Cycle

For most incidents encountered at the facility, the ~~HICS activation level will be limited to Level 2 (minor impact),~~ total incident time will be of short duration (less than four hours), and the need for a full Planning Section operation will be limited. ~~During such incidents, only one or two short-duration operational periods are typically needed beyond the initial action period, only limited Incident Management Team (IMT) leadership changes will occur, and not more than a single incident-planning meeting will be necessary.~~ Planning Section functions will typically focus on short-term forecasting, situation- and resource-status

monitoring, and documentation. A written IAP, if needed, may be limited to a HICS 200 (Cover Sheet) and an IAP~~-~~ Quick Start form.

For incidents of greater significance or longer duration, the use of an incident planning cycle is needed to ensure ongoing, coordinated, and efficient incident management. The operational period planning cycle, depicted in Figure 13-1, follows an eight-step operational period process once the incident is underway and the IC has conducted an initial briefing of the Incident Management Team (IMT). ~~(and, if applicable, the Unified Command team).~~ During each of these eight steps, specific actions are taken by each of the major sections in support of the planning cycle.

13.4 Planning Section Responsibilities

During EOP activation, the Planning Section is focused primarily on the following activities.

(1) Situation Status Monitoring and the Situation Unit

~~There are two critical functions that t~~The Situation Unit Leader is responsible for: monitoring the current location of patient's and resident's location (patient/resident tracking) and monitoring patient and bed deployment during the incident (bed tracking). This information may also be shared externally (e.g., with EMS agencies, other healthcare facilities, and DOH~~SS~~) as needed.

(2) Resource Status Monitoring and the Resource Unit

~~There are two critical functions that t~~The Resource Unit Leader is responsible for: tracking the status of personnel (Personnel Tracking Manager) and tracking material resources (Materials Tracking Manager) ~~that are~~ being utilized in various locations of the hospital.

(3) Incident Documentation and the Documentation Unit

All documentation related to the incident is collected, compiled, and archived by the Documentation Unit Leader. Incident documentation is crucial for ongoing leadership activities as well as for the post-incident cost-recovery process. The Documentation Unit Leader is responsible for maintaining an ongoing record of the hospital's IAPs and other incident management forms so that IMT personnel can refer back to them if needed. At the termination of the incident, all the collated IAPs will be used to help document the emergency response activities and decision-making processes.

(4) Incident Documentation

Multiple methods of documentation will likely be used during an incident including written, and electronic formats. ~~Written documentation will be the primary method of information recording.~~ Each IMT position is tasked with maintaining their own log of issues, actions, and outcomes. ~~Actual recording of the information may be done on paper or on computers using standard word-processing, database, or spreadsheet programs.~~ The continuous recording of phone lines or even the HCC operation itself can be helpful in reconstructing information received and actions taken during an incident.

Forms to support incident management activities are provided in the HICS Forms Annex. Each form is intended to assist in identifying the various types of information to record and archive during an incident. The forms may be found on the SIS under Emergency Operation Plan.

(5) Contents of the IAP

A formal written IAP should contain the following documents, arranged in order. The actual IAP contents will depend on the specifics of the incident and are determined by the Planning Section Chief. A Quick Start IAP~~-~~ can be used, which combines HICS 201-202-203-204-215A

- HICS 201, Incident Briefing
- HICS 202, Incident Objectives
- HICS 203, Organization Assignment List

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- HICS 204, Assignment List
- HICS 215A, Incident Action Plan Safety Analysis
- HICS 206, Staff Medical Plan
- HICS 207, Hospital Incident Management Team Organization Chart
- HICS 251, Facility System Status Report

(6) Sharing Information with Outside Agencies

~~Depending on the nature of the incident and its duration, t~~The community Emergency Operations Center (EOC) or Kenai Peninsula Borough (KPB) Office of Emergency Management (OEM) may request ~~that~~ medical facilities to submit their IAPs at designated times for regional updates. This information will help community emergency response officials better understand the issues the medical facilities are confronting and determine what future assistance may be required. Other information such as patient and resident data, resource availability (i.e.~~g.~~, personnel, equipment/supplies, medications) and response cost information may also be requested from the local and/or state EOC. Any requests for information from assisting or cooperating agencies~~, including external EOCs,~~ shall be routed through the Liaison Officer. The release of any such information requires authorization of the IC or Planning Section Chief prior to dissemination.

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(7) Incident Demobilization and the Demobilization Unit

Demobilization is the orderly, efficient disengagement and release of resources from the incident response and the organizations return to normal operations and will be carried out under the guidance of the Demobilization Unit Leader or designee as assigned by the Planning Section Chief.~~.~~ Planning for demobilization should actually begin from the outset of the response. ~~While short-duration Level 2 (minor impact) activations will typically be resolved and demobilized rapidly by simply releasing the few involved resources, a higher-level activation, or an incident with many resources participating, requires a structured demobilization process to ensure the orderly release of resources.~~ The Demobilization Plan, which incorporates specific responsibilities and release priorities, becomes a component of the IAP. The ultimate decision as to when to move from response mode to demobilization will be made by the IC.

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The criteria to begin demobilization will vary ~~incident~~ by incident, but fundamental considerations are based on a reduction of impact of the event. Impact assessment should include the following:

- The number of incoming patients is declining to a level manageable using normal staffing patterns and resources.
- There is no secondary rise in patient volume expected.
- Other responders are beginning their demobilization.
- Other critical community infrastructure returns to normal operations.

For large-scale and/or community-involved incidents, the IC shall consult not only with Command and General Staff but also with external decision makers~~, such as other hospitals, nursing homes, public health/public safety agencies, and the local EOC, before~~ prior to making a final decision to begin demobilization. ~~Depending on the situation, not all areas of the facility may be able to begin demobilization at the same time. Thus, p~~Planning will need to address ~~not only~~ when the demobilization process is to begin and~~but also~~ how ~~it~~to implement and communicate the demobilization process.~~ will be implemented.~~

~~An important component of demobilization is notification of the demobilization process, both within and outside the organization. The demobilization plan shall ensure that necessary notifications are carried out as required as.~~

14. FINANCE / ADMINISTRATION

14.1 Background

~~SPH recognizes that m~~Monitoring and tracking costs and expenses associated with an emergency response is vital to expediting recovery by optimizing reimbursement and minimizing the financial impact on the organization. ~~SPH is committed to using an organized, incident-related financial monitoring and tracking process as an essential function of EOP activation.~~ The finance/administration process establishes a focused environment for monitoring the utilization of financial assets and accounting for financial expenditures, as well as ensuring documentation of expenditures and cost reimbursement activities.

The I~~ncident~~C ~~Commander (IC)~~ maintains overall responsibility for tracking and managing incident-related costs and expenditures and will maintain communication with the Finance Section Chief. Incident financial activities involve developing financial monitoring strategies and outlining costs, expenses, funding sources, and contracting arrangements to accomplish the incident goals as determined by the IC. Finance/administration functions include:

- ~~t~~Tracking of personnel time and related costs~~,~~
- ~~o~~Ordering items and initiating contracts~~,~~
- A~~a~~rranging for personnel-related payments and Workers' Compensation~~,~~
- ~~t~~Tracking of response and recovery costs~~, and~~
- P~~p~~ayment of invoices.

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Authority for carrying out these activities may be delegated to ~~the Finance Section Chief or~~ other positions~~subordinate elements~~ within the Finance Section. The IC shall ensure that incident financial and administrative needs are addressed as a primary and critical function of EOP activities tp prevent costs associated to the incident from becoming a crisis in itself..

~~The costs associated with an emergency response to any large-scale emergency can be enormous and can potentially become a crisis in itself. This is especially true if documentation is not collected properly and submitted within reimbursement deadlines set by the local, state, and federal government.~~

To optimize the tracking process, incident-related costs (direct and indirect), shall be accounted for from the outset of the response. ~~The primary costs to be closely tracked should include any expense that may be considered either directly or indirectly incident-related.~~ Costs that would be incurred on a routine basis (such as routine facility operations, or staff that would have been working their regular shifts anyway) are not generally reimbursable, so their tracking is not essential.

Costs to be monitored closely include:

- Personnel (especially overtime and fee-for-service staff)
- Event-related patient/resident care and clinical support activities
- Incident-related resources
- Equipment repair and replacement
- Costs for event-related facility operations
- Vendor expenses
- Mutual aid financial remuneration
- Personnel illness, injury, or property damage claims

- Loss of revenue-generating activities
- Cleanup, repair, replacement, and/or rebuild expenses

The tracking of these costs should be done using SPH existing cost accounting and documentation practices, augmented by the use of the Emergency Management Cost Center (an event-specific cost center number will be determined by the Finance Section Chief at the time of the incident) and HICS financial tracking forms.

~~In some cases, normal reimbursement methods will be used and third-party insurance companies invoiced for all medical services rendered. However, in situations involving state or federally declared disasters, SPH may be eligible to recover additional response monies not otherwise being reimbursed. To be considered for reimbursement, SPH will have to submit special applications that require detailed explanations and accurate records. Daily financial reporting requirements are likely to be modified and, in select situations, new requirements outlined by state and federal officials.~~

14.2 Finance/Administration and the Incident Planning Cycle

~~For most incidents encountered at SPH, the HICS activation level will be limited to Level 2 (Minor Impact), total incident time will be of short duration (less than four hours), and t~~The need for a Finance/Administration operation will be limited for incident of Minor Impact or short duration.~~. During such incidents, only one or two short-duration operational periods are typically needed beyond the initial action period, only limited Incident Management Team (IMT) leadership changes will occur, and not more than a single incident-planning meeting will be necessary.~~ Finance/Administration Section functions will typically focus on short-term cost projections and tracking, including incident-related overtime expenses and any associated emergency procurement items. The Section's contribution to the written IAP, if needed, may be limited to a HICS 256, Procurement Summary Report.

For incidents of greater significance or longer duration, the Finance/Administration Section will participate in the incident planning cycle to ensure ongoing, coordinated, and efficient incident management. Refer to~~The operational period planning cycle, depicted in~~ Figure 29-1, for the~~follows an~~ eight-step operational period process.~~ once the incident is underway and the IC has conducted an initial briefing of the IMT (and, if applicable, the Unified Command team).~~ The Finance/Administration Section Chief will support the incident goals by ensuring ~~that~~ the necessary financial tracking, contracting, and documentation components are in place to support the activities of the other sections. Once a state or federal disaster declaration is made by government officials, the Finance/Administration Section Chief shall coordinate with the Kenai Peninsula Borough OEM to identify what state and federal financial aid documents must be completed for receiving reimbursement.

14.3 Finance/Administration Section

During EOP activation, the Finance/Administration Section is focused primarily on the following activities.

(1) Personnel Time Monitoring and the Time Unit

The Time Unit Leader is responsible for identifying, tracking, and documenting all costs associated with incident-related staffing of the organization. This includes costs associated with staff overtime, addition of fee-for-service (per diem) personnel, and recall of off-duty staff.

(2) Procurement Status Monitoring and the Procurement Unit

The Procurement Unit Leader manages incident-related contracting arrangements with external vendors. This may include but is not limited to activating or creating emergency purchase orders and triggering preplanned resource acquisition arrangements. The Procurement Unit Leader coordinates

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closely with the Materials Tracking Manager to document and track resources needed and/or projections for future needs, to ensure that the supply chain is maintained and needed resources are acquired.

(3) Incident-Related Claims and the Compensation/Claims Unit

The Compensation/Claims Unit Leader investigates and documents and claims of accident, incident, illness, or injury caused or experienced by staff or others on the campus that are or may be related to the incident. Activities may range from generating routine Workers' Compensation documents for post-incident follow-up to investigating allegations of primary or secondary incident-related damage or losses. Tracking and processing these claims becomes an important component of the post-incident cost-recovery process.

(4) Incident-Related Costs and the Cost Unit

The Cost Unit Leader provides incident-related cost accounting and tracking, taking into consideration the activities of the other Finance/Administration Section units and the documentation generated. Tracking incident-related costs is a vital component of ensuring fiscal responsibility and the organization's business viability both during the ongoing incident and to optimize reimbursement during the post-incident cost-recovery process.

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15. DE-ESCALATION / DEMOBILIZATION

As the incident evolves, the Planning Section Chief shall begin to develop a strategy for demobilization of the response and associated resources, to facilitate an orderly return to normal operations. Depending on the scope of the incident, the demobilization process ranges from simple to complex. The Demobilization Unit will be utilized tomay be established to develop the assessment and plan for the demobilization and recovery and will be addressed in the IAP. Demobilization and recovery plans should be carefully addressed as part of the IAP (IAP) for the event.

The IC, the Section Chiefs, and other HICS general staff members will analyze data and decide when to institute the de-escalation process. The Planning Section is responsible for creating a demobilization plan consistent with the needs of the incident.

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Incident Termination

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16. 16.INCIDENT TERMINATION

As information is received at the HCC regarding resolution of the incident, a decision is made by the IC to call an "All Clear" to secure the hospital from EOP activation status, terminate the plan response, and resume normal operations. This decision will be made based upon assessments of internal conditions (as reported by each department and evaluated by the HCC), liaison with public safety agencies and, if appropriate, direct contact with involved external organizations. Restoration, recovery and demobilization of EOP activation will occur.

The unusual location and distribution of patients, residents, equipment, supplies, and staff will require proper guidance in order to accomplish a smooth transition to a more normal state. Only rarely will an all-clear signal be received from outside authorities; more often, management will note that the need for emergency procedures has passed. At this point, restoration and recovery measures should be thoughtfully initiated.

Termination of the response will include an orderly reduction (de-mobilization) of EOP activation, making the pProper notifications regarding plan termination, and collection of the documentation made during the plan response will be completed. The final position to be demobilized is that of the IC, who is demobilized when all incident operations have been terminated and facility operations have returned to normal.

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To secure EOP activation status, the IC or designee will contact the Communications Unit Leader; identify him/herself by name and title, and state: "the emergency incident is now over, announce "Code HICS All Clear". The hospital operator, PIO or designee will activate the voice page system and announce:

"Attention, Attention, Code HICS All Clear" and repeat this two (2)three (3) more times.

If the event is a drill or exercise, the operator will add: **"This has been a drill"** and repeat this (23) more times.

~~17.~~ 17. RECOVERY AND RESUMPTION OF NORMAL ACTIVITIES

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Recovery activities are those actions taken following an event with the intent of returning the organization to its pre-event state. Recovery actions may range from the concluding steps taken by each member of the incident management team (described on their Job Action Sheets) to compiling documentation, conducting a critique, preparing an after-action report, performing critical incident stress debriefing, replenishing stock, repairing or replacing equipment, addressing physical plant issues, reviewing and revising the EOP, and training or re-training personnel, as necessary.

~~As the incident evolves, the Planning Section Chief shall begin to develop a strategy for demobilization of the response and associated resources. Depending on the scope of the incident, the demobilization process ranges from simple to complex. The Demobilization Unit may be established to develop the assessment and plan for the demobilization and recovery. Demobilization and recovery plans should be carefully addressed as part of the IAP for the event.~~

The IC, in consultation with senior executive and clinical leadership, shall make the determination of when to transition from the response phase to the recovery phase and when to terminate the recovery phase. The HCC will remain active and staffed through the recovery process, or until the IC deems it appropriate to secure.

All HICS officers will complete the recovery tasks itemized on their Job Action Sheets, and forward all incident-related documentation to the HCC for compilation by the Documentation Unit Leader/Planning Section. ~~The HCC will assign staff as necessary to consolidate and process the paperwork and record keeping.~~

17.1 ~~17.1~~ Facility Repair and Inspection

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As the organization enters the recovery phase, there are several facility issues to consider; General Housekeeping/clean-up, damage assessment and mitigation, and long-term recovery needs.

- ~~The first, g~~General housekeeping and clean up; ~~, is likely to be indicated following almost any response. The combination of response-related activity, coupled with the possible suspension of non-essential routine housekeeping services to free up staffing for other assignments, suggests that early attention is needed in this area.~~ The Facilities Unit shall take the lead in inspecting the facility, and planning, prioritizing, and organizing the cleanup personnel and assignments to accomplish the work expeditiously.
- D~~The second issue, d~~amage assessment and mitigation: ~~, is indicated if the facility was involved in the problem (e.g.; fire, flood, earthquake) or has been unable to maintain an environment of care. In such cases, t~~The Buildings/Grounds Damage Unit, working within the Infrastructure Branch and the Safety Officer, shall be activated. One or more damage assessment teams shall be sent out to mitigate immediate threats, assess general safety and habitability; and survey and document damage. The Infrastructure Branch Director shall develop a plan of action for facility restoration, and begin to carry out the plan as approved by the IC.
- Longer-term recovery: ~~, is the third issue.~~ Depending on the extent of the damage, repairs and restoration may take days to months to carry out. To expedite the necessary activities, outside vendors or contractors may be used to perform some or all of the work. The Facilities Unit, supported by the Infrastructure Branch, shall initiate the planning process, transitioning the information into the IAP process when possible.

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17.2 Resumption of Clinical Services

Once an environment of care is restored, the restoration of on-campus clinical service can begin. The Medical Care Branch Director shall investigate and report on the status of clinical services; specifically, what can be resumed (and in what time frame), and what must continue to remain out of commission pending further activity or developments. If significant, the resumption and restoration process shall be prioritized, and incorporated into the IAP for each operational period until completed.

17.3 Repatriation of Patients, Residents and Staff

Repatriation is the process of returning patients, residents and staff from there relocated locations outside the normal service areas to their original placement within SPH. Key elements of any repatriation planning include establishing excellent communications between the facility and the returning individuals; and leadership consideration of the evacuees' difficulties when returning to the facility.

The Logistics Section should consider assignment of "recovery ambassadors" – individuals who are exceptionally compassionate and can be deployed to assist returning individuals (patients, residents and staff) with the myriad challenges that face them.

17.4 Resumption of Pre-Incident Staff Scheduling

As circumstances allow, pPersonnel should be released from emergency duties to resume normal duties, attend to personal or family needs, be sent home, or to attend critical incident stress debriefing sessions, memorial services, or religious services. A staffing schedule should be quickly established, with early efforts targeted at releasing mutual aid personnel from other facilities, as well as volunteer licensed and non-licensed independent practitioners. Alternately, if the mutual aid and volunteer staffing will be used to provide relief for staff, then one-for-one relief scheduling should be arranged, and a relief schedule posted. Other staff members may be released based on personal necessity. Personnel from other departments that were temporarily reassigned should be returned to their own departments for assignment. Personnel schedules may need to be adjusted to allow for rest periods and resumption of normal scheduling.

17.5 Resource Inventory and Accountability

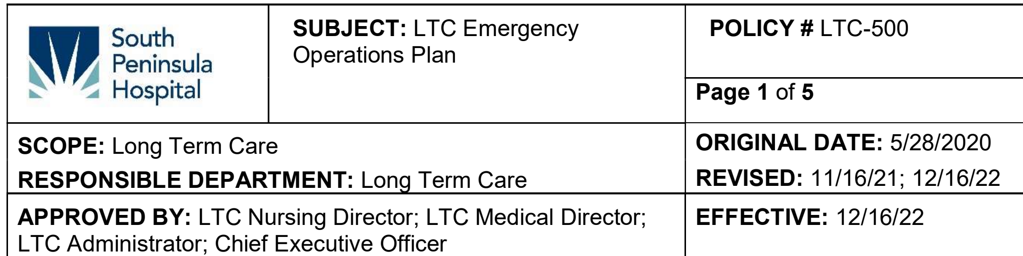
Department Directors/Mmanagers shall initiate an inventory of all supplies and equipment, and should request repair, replacement, or replenishment as needed from the Logistics Section and/or from appropriate departments.; Completing this should be done by on-duty personnel immediately after the EOP is secured and should not be postponed until the next shift or ordering day to ensure. Department managers shall ensure that their areas are returned to a state of full operational readiness as quickly as possible.

The following table represents the hospital's current vulnerability assessment, listed in order of highest to lowest vulnerability.

South Peninsula Hospital LTC Hazard Vulnerability Assessment - February, 2023

Emergency Management

	EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITGATION)					RISK
			HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	INTERNAL RESPONSE	EXTERNAL RESPONSE	
		Likelihood this will occur	Possibility of death or injury	Physical losses and damages	Interuption of services	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	* Relative threat
	SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 =High 2 = Moderate 3 = Low	0 - 100%
1	Earthquake	3	3	3	3	2	1	40%
2	Winter Blizzard / Ice Storm	3	1	1	2	3	3	33%
3	Pandemic Influenza	3	3	1	3	2	1	33%
4	Epidemic	3	3	1	3	1	1	30%
5	Patient Surge	3	2	1	2	1	3	30%
6	Workplace Violence	3	3	1	1	2	1	27%
7	Critical Supply Shortage	3	2	1	3	1	1	27%
8	Information Systems Interruption	3	1	2	2	1	2	27%
9	Fire, Internal	2	3	3	3	1	1	24%
10	Volcano	3	1	2	2	1	1	23%
11	Mass Casualty Incident	2	3	2	3	1	1	22%
12	Active Shooter	2	3	1	3	2	1	22%
13	Elevator Failure	2	2	2	2	1	2	20%
14	Landslide	2	2	3	2	1	1	20%
15	Gale Force Winds	2	2	2	2	1	1	18%
16	Wildfire	2	1	2	2	2	1	18%
17	Steam Failure	1	2	3	2	2	2	12%
18	Substantial Structural Damage	1	3	3	3	1	1	12%
19	HVAC Failure	1	2	2	2	2	3	12%
20	Water Supply Failure/Disruption	1	3	3	3	1	1	12%
21	Generator Failure	1	2	3	3	1	2	12%
22	Electrical Power Failure	1	3	3	2	1	2	12%
23	Bomb Threat	1	3	2	2	2	2	12%
24	96 Hrs W/out External Supplies	1	3	2	3	1	1	11%
25	Facility Evacuation	1	3	2	3	1	1	11%
26	Terrorism, Biological	1	3	1	2	3	1	11%
27	Terrorism, Nuclear, Radiological	1	3	2	2	2	1	11%
28	Tsunami / Seiche	1	1	1	2	1	1	11%
29	Natural Gas Pipeline Incident	1	3	3	2	1	1	11%
30	Flood, Internal	1	2	2	2	2	2	11%
31	Mass Fatality	1	2	2	2	2	2	11%
32	Terrorism, Chemical	1	3	2	2	2	1	11%
33	Hostage Situation, Internal	1	3	2	2	2	1	11%
34	Labor Action	1	2	2	2	2	2	11%
35	VIP Patient	2	1	1	1	1	1	11%
36	Nurse Call System Failure	2	1	1	2	1	0	11%
37	Communications Interruption	1	2	2	2	2	1	10%
38	Flood, External	1	2	2	2	2	1	10%
39	Smoke or Fumes, Internal	1	2	2	2	2	1	10%
40	Fire Alarm Failure	1	2	2	3	1	1	10%
41	Mass Casualty Incident/HazMat	1	2	2	2	2	1	10%
42	HazMat Spill/ Exposure, Internal	1	2	2	2	2	1	10%
43	Civil Disturbance	1	3	2	1	2	1	10%
44	HazMat Incident, External	1	2	2	1	2	2	10%
45	Barricaded Person	1	1	1	2	2	2	9%
46	Medical Vacuum Failure	1	2	2	3	1	0	9%
47	Sewer Failure	1	2	2	2	1	1	9%
48	Medical Gas Failure	1	2	1	3	1	1	9%
49	Fuel Oil Shortage	1	2	2	2	1	1	9%
50	Forensic Admission	2	1	0	1	1	1	9%
51	Cold Wave	1	0	1	1	2	3	8%
52	Heat Wave	1	1	1	1	2	2	8%
53	Drought	1	1	2	2	1	1	8%
54	Radiological Spill/Exposure	1	1	1	1	2	1	7%



South Peninsula Hospital	**SUBJECT:** LTC Emergency Operations Plan	**POLICY #** LTC-500 **Page 1** of **5**
SCOPE: Long Term Care **RESPONSIBLE DEPARTMENT:** Long Term Care		**ORIGINAL DATE:** 5/28/2020 **REVISED:** 11/16/21; 12/16/22
APPROVED BY: LTC Nursing Director; LTC Medical Director; LTC Administrator; Chief Executive Officer		**EFFECTIVE:** 12/16/22

PURPOSE:
Emergency response guidelines, outlining program components of the Emergency Operations Plan, including staff roles & responsibilities.

DEFINITION(S):
Appendix Z (CMS): Describes LTC EOP requirements
CMS: Centers for Medicare and Medicaid Services
EOP: Emergency Operations Plan
HICS: Hospital Incident Command System
(HSPD)-5: Homeland Security Presidential Directive
NIMS: National Incident Management System

POLICY:

A. This policy pertains to South Peninsula Hospital - Long Term Care (LTC hereafter) and all employees, visitors, and residents. LTC is a co-located facility which takes its emergency operations plan guidance and scope from the South Peninsula Hospital Emergency Operations Plan (EOP hereafter), as an integrated facility under CMS regulation: **E025 Arrangement with Other Facilities CFR(s): 483.73(b)(7)**
B. This policy serves as an annex to the comprehensive South Peninsula Hospital Emergency Operations Plan (EOP). This LTC policy addresses requirements that are specific to a nursing home as well as the unique needs of our resident population.
C. Emergency preparedness and its associated processes are the responsibility of the South Peninsula Hospital EOP Coordinator, Facilities Director. South Peninsula Hospital Long Term Care is an independently licensed LTC and is co-located within the physical building (campus) of South Peninsula Hospital. Where there is language-conflict between the EOP document and this LTC policy, *this policy document will have precedence* unless (a) specifically overruled as a result of decisions made during an Incident Command activation or (b) in conflict with the overarching EOP. The hospital utilizes Hospital Incident Command Structure (HICS), a command structure based on principles of the Incident Command System (ICS) as described by the National Incident Management System (NIMS).
D. When LTC is notified of an internal or external emergency impacting our operations as a long-term care unit, we will begin immediate preparations to protect and possibly shelter in place the residents on census. While LTC will take direction from the Hospital Incident Command/delegated Incident Commander, LTC will begin the following preparations.
E. **Residents**
   1. On average there are 25-28 residents on census. All residents in LTC are at high risk in the event of an emergency requiring an Incident Command response, due to the nature of the LTC environment and residents who have many of the following conditions and diagnoses:
      - Geriatric
      - Frail
      - Generalized Debility
      - Alzheimer's and Alzheimer's related Dementia
      - Immobility/Non-ambulatory
      - Assistive Device Dependent
      - Oxygen and other Therapy-dependence
      - Disease-progression Processes
      - Bed-bound
      - Wheel-chair Dependent
   2. In response to the unique needs of the residents, LTC has developed and will maintain two distinct

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processes to aid in the emergency preparedness awareness of residents, their families and/or guardians:

a) Resident Family Brochure as required by: **E007 Program Patient Population CFR(s): 483.73(a)(3)** and **E035 LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)**
[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.
b) The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.
   1) Provides that families and residents are aware of the emergency preparedness practices at SPH-LTC Long Term Care
   2) Establishes the procedure for LTC to contact families if an event impacts the care of their family member of guardianship responsibility in our care at LTC
   3) Describes mitigating processes underway in LTC to ensure that care is sustainable including redundancies for the following resources:
      - Water
      - Power
      - Food
      - Communication
c) LTC Individualized Resident EOP:
   - Establishes a primary and secondary contact for residents in care at SPH-LTC
   - Describes the intent to utilize shelter-in-place processes unless otherwise necessary to evacuate

F. **Shelter In Place & Evacuation**
The primary reference for Shelter in Place and Evacuation procedures are found in the Shelter in Place and Code Green Evacuation Annex of the South Peninsula Hospital EOP. Contained within these annexes are information and processes specific to LTC regarding shelter in place and evacuation procedures.

1. Early or Temporary Discharge:
Under the following circumstances, and as requested through HICS, residents may be temporarily sent home with family, when possible. This may occur if the following conditions are met:
   a) It is determined by HICS and the LTC DON that this would be in the best interest of the resident *and* the Medical Director concurs; *and*
   b) It is safe for the resident and family to leave the facility (versus sheltering in place), and the family can meet the needs of the resident for the projected duration of the event; *and*
   c) If HICS has indicated a short-term need to open available beds in the facility for critically wounded individuals; *and*
   d) Resident medications can be provided for the resident for the projected duration of the event, to the extent that the LTC Pyxis/pharmacy is stocked.
2. Shelter in Place:
   a) If the physical plant and hospital and LTC infrastructure are not affected by the event, all efforts will be made to avoid disruption in the resident's normal routine.
   b) If the physical plant and/or infrastructure have been compromised by the event, but Incident Command has not issued an evacuation order, all residents may be moved to ~~one of~~ the day room of LTC. This provides for access to food items as necessary and provides an immediate means of egress out the building should it become necessary to evacuate as well as an alternate route of egress if required. A toilet facility is also available: adjacent to LTC room 9 and behind the LTC nurses station. Further, this area provides adequate space for any family that happens to be in the facility when an emergency is declared. This location allows for more efficient use of staff serving residents during an emergency.
3. Evacuation:
   a) Residents will not be moved from the unit, unless this is ordered by Incident Command or there is an immediate threat to life or well-being that precedes the activation of Incident Command. If evacuation is to take place, it will be conducted as defined in the South Peninsula Hospital - Long Term Care, EOP.

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b) Residents evacuated from the unit will be accompanied, at all times, by a LTC Caregiver or designated caregiver assigned by Hospital Incident Command. This Caregiver will be responsible for maintaining communication with the LTC Evacuation Branch Unit Leader and ensuring that the resident's location is updated as movement occurs. This Caregiver is also responsible for maintaining the accuracy and security of the resident's medical record once movement begins. The responsibilities continue until care of the resident/patient is transferred to another authorized Caregiver/facility or the event has concluded. All information will be shared with Hospital Incident Command through the LTC Evacuation Branch Leader.

c) Locations for evacuation will be determined by Hospital Incident Command or another *Authority having Jurisdiction* if necessary. Potential locations include locations outside of LTC. South Peninsula Hospital maintains agreements with other pre-determined facilities as outlined by the Mutual Aid Agreement/Memorandum of Understanding section of this policy and the SPH EOP.

G. **Transportation**

1. LTC may utilize the following resources for transportation:
   - LTC wheelchair accessible van
   - Other Hospital owned vehicles as available
   - Vans provided by Homer Transportation Inc., a service with whom SPH has a Memorandum of Understanding (MOU)
   - Private vehicles as appropriate
   - For those residents that absolutely are unable to sit or be moved in the usual manner, an ambulance will be requested
2. Prior to transportation:
   - The resident will be moved in their bed to the safest space in the LTC facility or moved to the acute care hospital, if it is safe and expeditious to do so
   - One LTC staff member will be assigned to wait with the resident until the form of transportation ambulance arrives.
   - If it becomes unsafe to wait any longer, the staff member will evacuate the resident and themselves, by any means necessary, to an immediate safe location.

H. **Staff Roles**

1. LTC Director of Nursing (Charge Nurse if DON is not available) provides for and/or delegates as necessary:
   a) Ensures the immediate and continued safety of residents, visitors and staff
   b) Assesses and determines the impact on the LTC facility
   c) Clearly defines actions/duties of staff and ensures follow-through
   d) Notifies residents and family members of event and status of the facility
   e) Ensures the continuity of essential cares and services for residents
   f) Cancels non-essential services in order to utilize available staff for essential resident care
   g) Maintains direct communication with Hospital Incident Command (HIC)
2. Staff Nurses, CNAs, and Activities Staff:
   Takes direction from Director of Nursinges or their designee to assist as needed to maintain resident safety and provide essential care as indicated to the residents
3. LTC Administrator:
   Assists the Director of Nursinges or their designee and/or takes direction from Hospital Incident Command as directed to maintain resident safety and staff safety and ensure essential services are provided.

I. **Communication**

1. LTC utilizes the SPH EOP Communication Plan as the primary resource in processes and considerations for event-based communications. Contained within the plan are methods and processes for redundant communication, primary stakeholder contact information, communication with staff, and other extraordinary communication needs. Below are additional elements specific to the processes of LTC in regard to communication. *Note:* State, Federal, and municipal contacts are maintained in the SPH EOP Plan.
2. LTC Officials Contact Information:
   - Health Facilities Licensing and Certification: 907-334-2483
   - Long Term Care State Ombudsman's Office: 800-730-6393

- Resident Next of Kin and/or Guardians (resource = LTC Resident EOP Contact Sheet)

3. Other emergency calls are made in accord with the HICS/Incident Commander and under incident command structure would include the appropriate emergency response officials such as Emergency Management, Police, State Trooper, Fire, EMS, and other respondent organizations; locally, state and national and follow the SPH EOP.
4. Caregiver Contact Information:
   LTC leadership maintains the contact information of caregivers assigned to the facility in digital and paper format. This is updated periodically as well as when a caregiver begins or ends employment. Furthermore, staff are regularly encouraged to inform their leadership of any changes to their contact information.
5. Patient/Resident/Family Contact Information:
   LTC utilizes the "LTC Individualized Resident EOP" for collecting primary and secondary contact information of families and guardians of residents.
6. Facility communication (Ascom phones, HillRom call system):
   a. Emergency generator power should restore function to communication devices immediately.
   b. In the event of prolonged downtime, a bell system will be implemented for residents, along with increased staff rounding, to ensure alternate means of communication. For more information on SPH LTC tool kit, see Downtime policy LTC-099.

J. **Continuity Of Operations:**

1. LTC will follow the mandates as developed in **E015 Subsistence Needs for Staff and Patients** CFR(s): 483.73(b)(1)[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a)of this section, risk assessment at paragraph(a)(1) of this section, and the communication plan at paragraph (c) of this section.
2. The policies and procedures will be reviewed and updated at least annually and at a minimum, the policies and procedures will address the following variables.
   a) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
      - Food, water, medical and pharmaceutical supplies
      - Alternate sources of energy to maintain the following:
   b) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
   c) Emergency lighting.
   d) Fire detection, extinguishing, and alarm systems.
   e) Sewage and waste disposal.
3. LTC utilizes the South Peninsula Hospital EOP/Continuity of Operations plans for business continuity and continued provision of care processes. Considerations specific to the sustainment of care for LTC residents and caregivers are contained within this section.

K. **Essential Resources**

1. Potable Water: SPH has an MOU with a local water truck service and will hook up to the hospital building's water system to provide potable water in an emergency. We also maintain twelve (12) 55Gallon barrels of potable water with pumps in inventory that can be easily relocated to areas within the facility.
2. Food: A 4-day supply of food is available on site in Nutrition Services to serve residents, patients, and staff. In addition, dehydrated emergency food is available to feed 120 persons, three meals a day for four days. LTC in specific maintains a smaller stock of food in the resident kitchen.
3. Diesel Fuel: Stored in a 10,000 gallon fuel tank, that at a minimum is kept half full. The Fuel is used to fuel the two electric generators, as well as the three dual fuel boilers if the natural gas supply is interrupted.
4. Generators: Two emergency generators will supply emergency power during a power outage. Each generator is capable of supplying energy to the facility, using the other as a back-up. The generators are connected to selected circuits and specifically identified outlets.
5. Medication: This is available from both the LTC Pyxis machine and from the in-house pharmacy, or a local pharmacy in town.
6. Oxygen: The facility has two redundant oxygen generating machines, as well as an additional 100 H

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cylinder bottles of compressed oxygen on site. LTC also has portable oxygen concentrators available.

7. Power: The facility is equipped with two emergency generators and these are connected to selected circuits and specifically identified outlets.
8. Providers: The Medical Staff Bylaws of SPH and Long Term Care specifically allow for the credentialing of providers in the event of a community disaster. LTC will following the guidance set by the SPH Medical Staff Office and the Bylaws of the SPH-LTC Medical Staff.
9. Sewage Treatment: Sewage processes for SPH-LTC are monitored by the Facilities department and operated by the City of Homer. SPH has a back-up Emergency Sewage Disposal Policy. Modifications to internal Long Term Care processes regarding sewage management will be at the discretion of Facilities as a component of Incident Command or other leadership decision-making process.
10. Medical Records: LTC through its Hospital EOP maintains requirements found at E018 Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2).
    If the Point, Click, Care EMR system becomes inoperable, there are processes in place which define specific paper documents to be used to maintain an ongoing record.
    a) A stand-alone down-time EMR device on a uniform power source (UPS)
    b) Per the evacuation processes outlined within this policy an assigned Caregiver will be responsible for maintaining the accuracy and security of their patient/resident's medical record.
    c) At a minimum a hand carried paper-record will be maintained for each resident/patient.

L. **1135 Hospital Waivers**
   As needed for natural and other human-made disasters, LTC recognizes Waivers Declared by the Secretary as outlined in **E026 Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)** is contained within the Hospital EOP.

M. **Mutual Aid Agreements And Memorandums Of Understanding:**
   1. Mutual Aid Agreement with Alaska State Hospital and Nursing Home Association (ASHNHA)
   2. Internal transfer agreements (TBA) **E025 Arrangement with Other Facilities CFR(s): 483.73(b)(7)**

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
South Peninsula Hospital Emergency Operations Plan

CONTRIBUTOR(S):
LTC Director
LTC Administrator
SPH Support Services Director

Home Health Emergency Operations Plan

Policy

South Peninsula Hospital Home Health will follow the hospital-wide E~~e~~mergency O~~o~~perations ~~p~~lan (EOP) put in place by South Peninsula Hospital.

The Agency Administrator/Director of Home Health, ~~Clinical Manager~~ Clinical Supervisor and staff implement the Home Health ~~emergency operations plan~~EOP, as appropriate.

Purpose

To describe the Agency's approach to responding to internal and external emergencies that would suddenly and significantly affect the need for services, plans for patients or the ability to provide such services. An emergency is defined as a natural or man-made disaster that significantly:

Disrupts the Agency's environment, e.g., damage to the Agency's building and grounds due to natural disasters such as: strong winds, ice/snow storms, flooding, earthquake explosion, fire or bomb.

Disrupts care and services, e.g., loss of utilities (power, water or telephone), floods, snow/ice storms, hazardous chemical spills, accidents and multiple staff illnesses. Results in a sudden, significant change or increase in demand for Agency services, e.g., terrorism attack, bio terrorism attack, communicable disease outbreak and community mass casualty event.

Reference

The Joint Commission CAMHC Standards: EM.01.01.01 - .03.01.03; Medicare CoP #s: 484.102; CHAP Standards: CI.5b, CI.5c, CII.3b, CII.3c, HHI.5b; ACHC Standards: HH7-3A.01, HH7-3B.01, HH7-3C.01;

Related Documents

"*Hazard Vulnerability Analysis,*" "*Annual Evaluation of Hazard Vulnerability Analysis,*" "*Annual Emergency Operations Plan Evaluation*" forms

Procedure

1. Hazard Vulnerability Analysis (HVA) will be conducted and evaluated annually. The Hazard Vulnerability Analysis is an "all hazards" integrated approach to planning that focuses on Agency capacities and capabilities that are critical to preparedness planning for a full spectrum of emergencies or disasters in Agency's location, considering the particular types of hazards which may most likely occur in Agency's area.

2. The Agency will coordinate efforts with area emergency management agencies, to mitigate, prepare, respond and recover from high priority emergencies that impact the community, e.g., local health department, law enforcement and office of emergency management.

3. Mitigation activities (designed to reduce the risk of and potential damage from an emergency) will be undertaken in an effort to lessen the severity and impact of a potential emergency. Such activities include:
   - Developing an individual emergency preparedness plan for each patient as part of the comprehensive assessment.
   - Individual patient preparation: prioritizing patients who might require care/service during emergency and advanced planning for extra supplies/equipment.
   - Communication systems, including back-up systems.
   - Conducting the Hazard Vulnerability Analysis.
   - Maintenance of Agency fire detection equipment, e.g., smoke detectors.
   - Maintenance of Agency fire suppression equipment, e.g., fire extinguishers.
   - Maintenance of Agency information systems, including process for back-up of computer files.
   - Assisting patients and families to develop a home emergency plan.
   - Educating patients and families about self-care, sources of alternate care in the community and Agency role during an emergency.
   - Providing staff with information about developing their family's emergency response plan before an emergency.
   - Working collaboratively with South Peninsula Hospital (SPH) to plan for disasters and emergency situations.

4. Preparation activities will be undertaken to build capacity. Resources that may be used during an emergency include: ambulance transport, hospitals, National Guard, Red Cross, law enforcement, fire departments, and state troopers, other home care organizations, suppliers and vendors. Other preparation activities include:
   - Staff orientation and ongoing training.
   - Maintenance of back-up supplies, e.g., flashlights and patient medical supplies.

5. The Home Health Agency will work as a part of South Peninsula Hospital's emergency response plan. Agency Staff will actively participate in the development, annual reviews and updates of SPH's integrated emergency response plan.

6. The Agency's location for responding to and recovering from emergencies is the Agency office at 203 W Pioneer Avenue.

7. Emergency response procedures: In the event of interruption of patient services due to an emergency, the ~~Clinical Manager and/or Administrator~~Home Health Director and/or Clinical Supervisor will immediately implement the ~~emergency operations plan~~EOP and will be responsible for triaging patients based on needs, severity of illness and availability

of staff.

8. The Agency Administrator/Home Health Director and/or Clinical ~~Manager~~ Supervisor is responsible for contacting and tracking on-duty staff when emergency measures are implemented. This task may be delegated as appropriate. State or Local officials will be notified by the Administrator/Home Health Director or Clinical ~~Manager~~ Supervisor if unable to contact any on-duty staff. For employees in city limits contact Homer Police Department at (907)235-3150 and for employee out of city limits notify State Troopers at (907)235-8239.

   - The Home Health Agency will keep an updated staff roster with primary and secondary means of communication including employee’s residential addresses. This will be updated as warranted and verified annually.

9. The Agency Administrator/Home Health Director, and/or Clinical ~~Manager~~ Supervisor will inform the appropriate state and local emergency preparedness officials by telephone about patients in need of evacuation from their homes at any time due to an emergency situation based on the patient’s medical and/or psychiatric condition and home environment. For patients in city ~~limits~~ limits contact Homer Police ~~will be notified~~ at (907) 235-3150, for patients outside of city limits contact State Troopers at (907)235-8239. The Agency will comply with HIPPA Privacy Regulations as appropriate when communicating such information.

10. The Agency will maintain at all times a current list of patients who might need evacuation on an ongoing basis, staff will evaluate/assess such factors as transportation, evacuation and patient’s medical and/or psychiatric condition and home environment.

11. Those patients who must have home visits performed will be considered as top priority patients and every effort will be made by staff to perform home visits during the emergency. At the time of admission, each patient's acuity level is determined.

    Level 1 patients are high priority patients and whose care cannot be interrupted.
    Level 2 patient are those that may go without visits for 48-72 hours.
    Level 3 patients are those that may go without visits for greater than 72 hours.
    Level 4 patients are those that reside at an Assisted Living Facility (ALF) and will follow the emergency plan of the ALF.
    The Agency will use their software system to report the patient’s level and will have access to pull a report that lists all patient~~’~~s’ acuity level. Administrative person on-call maintains current lists. The ~~Clinical Manager~~Home Health Director will be responsible for assigning available staff for completing those visits. Efforts will be made to attempt to contact the remaining patients by telephone to ascertain needs for services, if any.

12. In the event that staff is not able to perform home visits as a result of the emergency, patients will be instructed to use local emergency shelters.

Created: 10.27.2017
Reviewed: 01.17.2019; 10.18.2020; 07.29.2021; 02-14-2023

13. During an emergency, staff will primarily communicate by telephone or cellular phone. When no internal or external means of communication exists, available staff should report to the command structure at the Agency as soon as feasible for assignment. The ~~Clinical Manager and/or Agency Administrator~~Home Health Director and Clinical Supervisor are ultimately responsible for assuring continuation of service.

14. Patient care providers who will be assigned and report to the ~~Clinical Manager~~Home Health Director during an emergency ~~include:~~include nurses, therapists, ~~social workers~~ and home health aides.
    Ancillary staff members (~~receptionist~~assistant, biller, etc.) are to report to the command structure at the Agency office to the ~~Clinical Manager or Administrator~~Home Health Director or Clinical Supervisor for assignments.

15. During an emergency, the following activities will be managed:
    - The Administrator/Home Health Director or Clinical ~~Manager~~ Supervisor will provide information by telephone (or in person, if no telephone service exists) about the Agency's needs and capability to provide any assistance to SPH's Incident Command Center or the authority having local jurisdiction during the emergency.
    - Patient care-related activities, including patient communication, scheduling, curtailing admissions, modifying or discontinuing services, control of patient information (by administration), coordinating home visits at an alternate care site in the community (if applicable) and patient transfer or referral will be managed by the Agency Administrator/Home Health Director and/or Clinical ~~Manager~~Supervisor.
    - Patients will be responsible for replenishing their own medications and related supplies. If communication systems are in operation, nursing staff will assist patients by telephone and work with patients' retail pharmacies to get needed medications dispensed in order that patient/family can obtain.
    - The Agency will work with supply vendors, local home medical equipment companies, local hospital and/or local medical clinics to replenish medical supplies and non-medical supplies.
    - Agency staff are responsible for providing their own transportation and housing.
    - Staff will be identified by name/ID badges.
    - The Administrator/Home Health Director, Clinical ~~Manager~~ Supervisor and clinical and ancillary staff will manage logistics related to critical pharmaceuticals, equipment and supplies. If the Hospital Wide plan is implemented these needs will go through the Logistics Chief.

16. To access medical records in the event of an emergency that disrupts access to the EHR contact our software provider Kinnser at (877)399-6538 or agency staff or contractor out of the affected area. Back up documentation will be on paper and scanned into the EHR when able.

17. Recovery strategies include those activities undertaken after an emergency to restore the Agency to normal function. The Agency Administrator/Home Health Director and/or Clinical ~~Manager~~ Supervisor will initiate the recovery phase as soon

as possible following the emergency. Activities will include:

- Restoring Agency site.
- Restoring normal operating hours.
- The Administrator/Home Health Director and/or Clinical ~~Manager~~ Supervisor will decide if Agency has capacity and ability to accept new referrals.
- If new referrals are accepted, the clinician will develop an individual emergency preparedness plan for each patient and determine the acuity level, which determines and directs care for each patient.
- Re-establishing normal business operating procedures.
- Re-establishing full staffing and scheduling.
- Resuming normal patient care visits and services.
- Testing communication systems and implementing.
- Testing information systems (computer) and implementing.
- Ascertaining current inventory and returning to pre-emergency inventory levels for supplies and equipment.

The Agency Administrator/Home Health Director and/or Clinical Supervisor ~~and/or Clinical Manager~~ is responsible for terminating the recovery phase.

18. If a hospital wide emergency occurs and the hospital's command structure is implemented, staff should follow the hospital wide emergency preparedness plan for assignment.

19. All new staff will be oriented and trained to the ~~emergency operations plan~~EOP. Ongoing staff education and training will occur annually as part of an exercise or in response to an actual emergency.

20. The plan will be tested and evaluated annually by the Home Health agency, either in response to an actual emergency or in a planned exercise. The planned exercise will focus on the Agency's response to an emergency that would likely affect the Agency's ability to continue to serve patients in the event of an emergency.

21. Exercises will incorporate likely disaster scenarios that allow the Agency to assess its handling of communications, resources and assets, staff and patients.

22. Exercises will review and confirm:
    - Staff communication procedures and content.
    - Assigned staff roles related to essential response functions.
    - How Agency will communicate with patients during an emergency.
    - Communication with key community partners, e.g., local hospital, health department, law enforcement, pharmacies, ambulance transport, etc.
    - Business continuity and recovery strategies for restoring Agency's capabilities to provide care after an emergency.
    - Exercises must sufficiently stress Agency's plan to identify weaknesses.
    - Exercises must activate and test:
        - Patient acuity assignment and tracking procedures to validate the

ability to identify and locate high risk patients.
  - Key care processes consistent with planned response activities: management of medication, medical equipment and supplies, instructions for self-evacuation, medical record documentation and coordination of information with alternative care site.
- Leaders, managers and staff will evaluate each emergency response exercise and all responses to actual emergencies.
- Evaluation will include the identification of deficiencies and opportunities for improvement.
- The plan will be modified based on the evaluation of deficiencies and opportunities for improvement.
- Future planned exercises will reflect modifications and any interim measures described in the plan.

Board of Directors

May 2023

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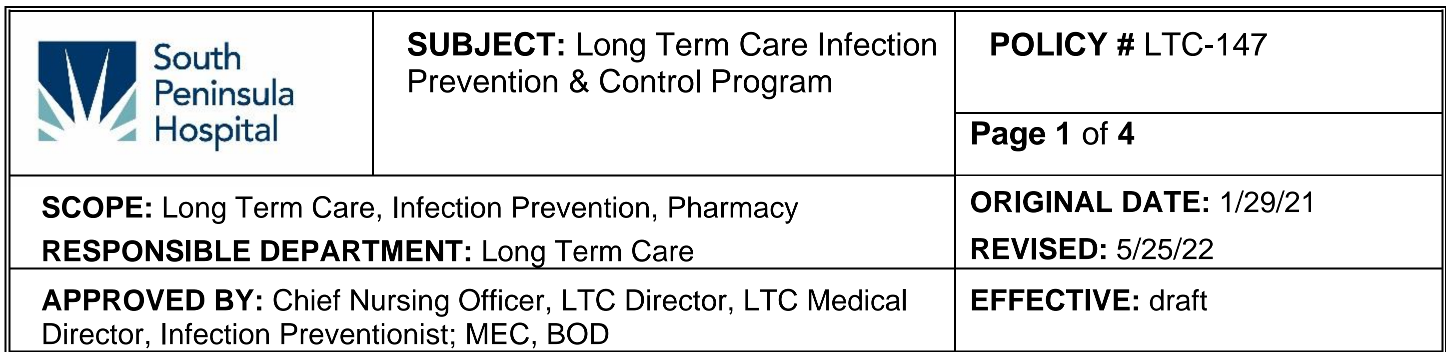
LTC Infection Prevention Risk Assessment .... pg 6



South Peninsula Hospital	**SUBJECT:** Long Term Care Infection Prevention & Control Program	**POLICY #** LTC-147 **Page 1** of **4**
SCOPE: Long Term Care, Infection Prevention, Pharmacy **RESPONSIBLE DEPARTMENT:** Long Term Care		**ORIGINAL DATE:** 1/29/21 **REVISED:** 5/25/22
APPROVED BY: Chief Nursing Officer, LTC Director, LTC Medical Director, Infection Preventionist; MEC, BOD		**EFFECTIVE:** draft

PURPOSE:
An infection prevention and control program (IPCP) is maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. To utilize evidence based practice to minimize risk of infections and to optimize safety and quality outcomes for the resident population.

DEFINITION(S):
APIC: Association for Professionals in Infection Control and Epidemiology
CDC: Centers for Disease Control
CMS: Centers for Medicare and Medicaid Services / Regulatory F880 – F883.
Infection Preventionist (IP): Refers to the practitioner assigned to clinical infection prevention, and infection prevention surveillance. Clinical Infection Preventionists are responsible for the oversight and daily management of infection control and prevention activities. Surveillance includes data collection, reporting, integrity and communication of findings to the clinical IP committees. The LTC Infection Preventionist reports to the Hospital Chief Nurse Officer but collaborates as needed to accomplish the goals of the IPCP. The IPs collaborates the LTC ICPC into the hospital IC Committee and includes interface with the Antimicrobial Stewardship Committee and the Laboratory for disease diagnosis tracking.
Infection Prevention Team: A team process including the LTC IP, DON, Quality, LNHA as needed and others who collaborate on operational issues, share information, and support the work needed to carry out LTC ICPC.
Infection Prevention Committee: Long Term Care does not operate a separate Infection Prevention Committee, but relies on the LTC Quality Committee (QAPI) for facility specific Infection Prevention oversight and direction to the LTC IP as well as inclusion in the Hospital Infection Control Committee. This Committee meets quarterly.
Employee Health: The IP and the EH Nurse, along with the LTC DON collaborates on surveillance of staff screening and staff exposure and/or immunity to infectious diseases, and performs employment tuberculosis testing per national and state standards. Exposures to communicable diseases will be evaluated as they occur and follow-up implemented through the collaborative effort of IP and EH. All employee blood and body fluid exposures will be identified and referred for post exposure follow-up per the Blood-borne Pathogen Exposure Control Plan. EH provides HCWs with testing and/or immunizations consistent with applicable laws, CDC and Advisory Committee on Immunization Practices (APIC) recommendations.
McGeer: Established industry criteria used for identification, surveillance and reporting of epidemiologic disease
NHSN: National Healthcare Safety Network; a CDC database for reporting designated infectious disease
Outcome surveillance: incidence and prevalence of healthcare acquired infections
Process surveillance: adherence to infection prevention and control practices
QAPI: Quality Assurance and Performance Improvement Committee; the LTC Quality Committee

POLICY:
A. The infection prevention and control program is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment.
B. Conduct surveillance to contain and control healthcare associated infections (HAI).
C. Assure compliance for required HAI data validation to internal and external stakeholders.
D. The IP Plan outlines Infection Prevention (IP) procedures, policies and strategies that reduce and eliminate Healthcare-associated infections (HAI), reduce the spread of infections, reduce the incidence of resistant micro-organisms, and reduce the misuse of antimicrobial therapy in the long-term care population. This program plan encompasses pandemic planning and protocols as needed and evaluates and assesses the

IPCP on a continuing basis. The ICPC assures that the Plan is aligned and integrated with the Quality Assurance and Process Improvement (QAPI) Committee as well as strategic plans and initiatives of SPH and SPH LTC as may be applicable to the resident population served.

E. The ICPC promotes and fosters a culture of safety with respect to infectious diseases and seeks to improve provider, nursing, and staff engagement, and to improve multidisciplinary teamwork to accomplish goals related to infectious disease.
F. This ICPC Plan will incorporate yearly Risk Assessments and Plans specific to the needs of the LTC facility and the population it serves in accordance with the respective state regulatory requirements for infection control and prevention.
G. The ICPC incorporate the following component parts:
    1. Risk Assessment: The IP and select entities are responsible for conducting an annual risk assessment to include site specific metrics. Risk assessments should follow a standardized ICRA format.
    2. Identification of Goals: Infection Prevention goals will be based on risk assessment results and will be evaluated and modified as necessary on an annual basis.
    3. Surveillance, Data collection, Analysis and Reporting: LTC site specific surveillance will be conducted by the IP. Findings will be reported to the Infection Prevention Committee, and the Long Term Care specific surveillance findings will be reported to LTC Quality Committee (QAPI).
    4. Policy Drafting and Review: Infection Preventionists (IPs) will create, and review policies and procedures associated with or specifically focused on infection control and prevention. Policies and procedures will be reviewed using input and collaboration with the LTC facility DON.
    5. Education and Training: IPs will provide support for education of caregivers, residents, visitors to ensure that key stakeholders understand infection prevention policies, interventions, and processes. The IP will share their expertise across the LTC and promote IP goals, seeking to embed IP interventions into standardized care processes in LTC.
    6. Program Evaluation and Performance Improvement: The IP Plan will be monitored as needed to assure goals and objectives are met and reviewed annually, and a summary of activities, process measures, outcome metrics, and statement of effectiveness will be reported to the Long Term Care Quality Committee, and the LTC DON /Administrator who reports to the SPH LTC Board of Directors as needed. Recommendations for each year will be based on Long Term Care priorities, goals, strategies, as well as areas of risk identified and emerging areas of concern.
H. Under delegation from the SPH LTC Governing Board, the LTC Infection Prevention Plan covers all activities related to infection prevention, assessment, performance improvement, and risk identification mitigation/management. This work is confidential and may be protected under Alaska 18.23.020 in certain situations (provider peer protection). In addition to demonstrating compliance with the requirements set forth, the ICPC will demonstrate compliance with all applicable local, State, Federal, accreditation, and certification standards and regulations.

PROCEDURE:

A. Goals and Objectives
    1. Identify, assess, and prioritize Infection Prevention risks for SPH LTC.
    2. Maintain Infection Prevention guidelines in accordance with current standards and literature.
    3. Provide initial and recurring Infection Prevention education.
    4. Protect staff from occupational injuries and illnesses (e.g., tracking needlesticks and back injuries).
    5. Monitor the environment to reduce or eliminate environmental hazards to residents, caregivers, and visitors.
    6. Conduct surveillance to contain and control significant pathogens.
    7. Conduct surveillance to contain and control healthcare associated infections(HAI)
    8. Assure compliance for required HAI data validation to internal and external stakeholders.
    9. Report data as required by the CDC through their National Safety Healthcare Network (NHSN) data reporting tool
    10. Collaborate with staff, leaders and providers on process improvement projects, research, and publication.
    11. To be in compliance with the CMS Phase III regulations found at: F880 – F883.

B. Surveillance
   1. Process surveillance and outcome surveillance are used as measures of the IPCP effectiveness.
   2. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection in collaboration with Employee Health Nurse, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications.
   3. The information obtained from infection control surveillance activities is compared with that from other facilities via state reporting and nationally thru National Health and Safety Network (NHSN) and with acknowledged standards (for example, acceptable rates of new infections), and used to assess the effectiveness of established infection prevention and control practices.
   4. Standard criteria are used to distinguish community-acquired from healthcare associated acquired infections.

C. Antibiotic Stewardship
   1. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities.
   2. Medical criteria and standardized definitions of infections are used to help recognize and manage infections for urine testing and UTI treatment, upper respiratory tract infection treatment, and skin and soft tissue infection treatment.
   3. Pharmacy guidelines have criteria for treatment, antibiotic selection, and duration of treatment.
   4. Antibiotic usage is evaluated and practitioners are provided feedback on reviews.

D. Data Analysis
   1. Data gathered during surveillance is used to oversee infections and spot trends.
   2. Data analysis includes calculating number of infections per 1000 resident days as follows:
      1) The infection preventionist collects data, categorizes each infection by body site and records the absolute number of infections;
      2) Monthly rates are compared side-by-side to allow for trend comparison.
   3. Data collection instruments, such as infection assessment, surveillance reports and antibiotic usage surveillance forms are used by the Infection Preventionist.

E. Outbreak Management
   1. Outbreak management is managed by the Emergency Operations Plan (EOP).
      1) LTC is represented in the EOP by the Licensed Nursing Home Administrator and/or Director of Nursing, and the Infection Prevention Physician
   2. Specific criteria are used to help differentiate sporadic cases from true outbreaks or epidemics.
   3. The Infection Prevention Physician, SPH Lab, and IP Nurse helps the facility comply with pertinent state and local regulations concerning the reporting and management of those with reportable communicable diseases.

F. Prevention of Infection
   1. Important facets of infection prevention include:
      1) Oversee infection surveillance activities including the ordering of necessary surveillance tests.
      2) Institute any surveillance, prevention or control measures or studies when there is a potential or actual outbreak of, or exposure to an infectious disease.
      3) Initiate, change or discontinue isolation measures as necessary, ensuring that the least restrictive possible isolation measures are used for each resident’s specific circumstances.
      4) Educating and communicating to staff the importance of proper protocols and procedures stressing the importance of isolation precautions including visitors and family
      5) Utilize the Centers for Disease Control (CDC), National Healthcare Safety Network (NHSN), Association of Professionals in Infection Control and Surveillance (APIC), and updated McGeer criteria classification of infections as a guide in determining Healthcare Associated Infections (HAI’s) criteria
      6) Facilitate compliance with reporting requirements to various public health officials/ agencies via SPH laboratory Department
      7) Reports to LTC Quality Committee and the DON/Administrator who reports to the Quality committee of the board of directors as needed.

G. Immunization/Vaccination
   1. The facility has an immunization policy following CDC recommendations
   2. Refer to policy LTC-062 Resident Vaccinations

H. Monitoring Employee Health and Safety
   1. The facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers, including education of communicable diseases when these individuals should stay home when ill and report their signs or symptoms of infections for identification and tracking of trends
   2. Employee Health provides the following:
      1) Surveillance of HCW's;
      2) Screens HCWs upon hire and as needed for exposure and or immunity to infectious diseases;
      3) Performs tuberculosis testing and administers vaccines following CDC recommendations;
      4) Exposures to communicable diseases will be evaluated as they occur and follow up implemented through the collaborative effort of IP and EH including annual Sharps Safety Healthstream
      5) All employee blood and body fluid exposures will be identified and referred for post exposure follow up per the Blood borne Pathogen Post Exposure Control Plan;
      6) Guidelines and educational resources are located on the SIS site under clinical tools.

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. 2018 MED-PASS – Infection Control Policy and Procedure Manual, pp. 15-19, v.1.1 (H5MAPL1445)
2. OBRA Regulatory §483.80 Infection Control
3. Survey Tag Number F880

CONTRIBUTOR(S):
LTC Director; Infection Preventionist; LTC Medical Director

South Peninsula Hospital Long Term Care

Infection Prevention and Control Risk Assessment

Jul-05

INFECTION EVENT	PROBABILITY OF OCCURRENCE (How likely is this to occur?)				LEVEL OF HARM FROM EVENT (What would be the most likely?)				IMPACT ON CARE (Will new treatment/care be needed for resident/staff?)				READINESS TO PREVENT (Are processes/resources in place to identify/address this event?)			RISK LEVEL (Scores ≥ 8 are considered highest priority for improvement efforts.)
Score	**High**	**Med.**	**Low**	**None**	**Serious Harm**	**Moderate Harm**	**Temp. Harm**	**None**	**High**	**Med.**	**Low**	**None**	**Poor**	**Fair**	**Good**	
	3	**2**	**1**	**0**	**3**	**2**	**1**	**0**	**3**	**2**	**1**	**0**	**3**	**2**	**1**	
Facility-onset Infections(s)																
Device- or care-related																
Catheter-associated urinary tract infection (CAUTI)			1			2				2					1	6
Central line-associated bloodstream infection (CLABSI)				0				0				0				0
Tracheostomy-associated respiratory infection				0				0				0				0
Percutaneous-gastrostomy insertion site infection				0				0				0				0
Wound infection			1			2				2					1	6
Resident-related																
Symptomatic urinary tract infection (SUTI)		2				2				2					1	7
Pneumonia			1		3					2					1	7
Cellulitis/soft tissue	3						1				1				1	6
Clostridioides difficile infection			1			2			3						1	7
Tuberculosis*			1		3				3				3			10
Outbreak-related																
Influenza*			1		3				3						1	8
Other viral respiratory pathogens*	3						1		3						1	8
Norovirus gastroenteritis*			1		3					2					1	7
Bacterial gastroenteritis (e.g.,*Salmonella, Shigella*)			1		3					2					1	7
Scabies			1			2				2				2		7
Conjunctivitis			1				1				1				1	4
Group A *Streptococcus**			1			2					1				1	5
MDRO			1			2			3						1	7

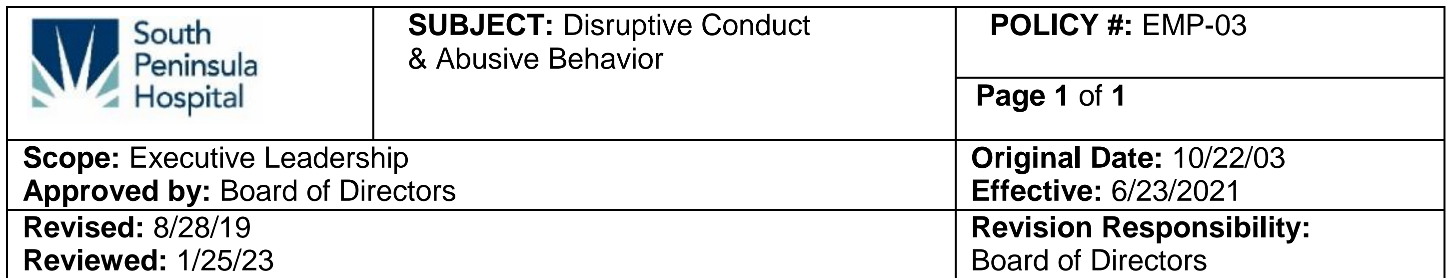
* Risk assessment should take into account the frequncy of this disease in the community as part of determining probability of occurrence. Data from State/local health department may be informative.

Date Prepared: draft 2023

Adapted from https://spice.unc.edu/resources/template-risk-assessment-for-ltc/

IPC PRACTICE FAILURES	PROBABILITY OF OCCURRENCE				IMPACT ON RESIDENT/STAFF SAFETY				CAPACITY TO DETECT			READINESS TO PREVENT			RISK LEVEL
	(How likely is this to occur?)				(Will this failure directly impact safety?)				(Are processes in place to identify this failure?)			(Are policies, procedures, and resources available to address this failure?)			(Scores ≥ 8 are considered highest priority for improvement efforts.)
Score	High	Med.	Low	None	High	Med.	Low	None	Poor	Fair	Good	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	3	2	1	3	2	1	
Care activity															
Lack of accessible alcohol-based hand rub			1			2					1			1	5
Lack of accessible personal protective equipment (PPE)			1		3						1			1	7
Inappropriate selection and use of PPE			1		3						1			1	6
Inadequate staff adherence to hand hygiene			1		3						1			1	6
Inadequate staff adherence to glove and gown use when resident in Contact Precautions			1		3						1			1	6
Inadequate staff adherence to facemask use when resident in Droplet Precautions			1			2					1			1	5
Other (specify):_______________															
Other (specify):_______________															
Occupational health															
Low influenza immunization rates among staff		2				2				2			2		8
Lack of notification of employee illness or working sick			1		3						1			1	6
Low compliance with annual tuberculosis (TB) screening among staff			1		3						1			1	6
Other (specify):_______________															
Resident/visitor health															
Low rates of TB screening among new resident admissions			1		3						1			1	6
Low rate of resident acceptance of influenza immunization			1		3						1		2		7
Low rate of resident acceptance of pneumococcal			1		3						1		2		7
Visitors entering facility when ill			1		3						1			1	6
Lack of notification to visitors during facility outbreaks			1			2					1			1	5
Inadequate resident/visitor education on facility hand hygiene policies			1			2					1			1	5
Inadequate resident/visitor education on facility respiratory etiquette			1			2					1			1	5
Other (specify):_______________															
Environment															
Lack of access to U.S. Environmental Protection Agency (EPA)-registered products for routine cleaning and disinfection			1		3						1			1	6
Lack of access to EPA-registered products with sporicidal activity for cleaning and disinfection (e.g., for *C. difficile)*			1		3						1			1	6
Inadequate cleaning and disinfection of high touch surfaces in resident room			1			2					1			1	5
Inadequate terminal cleaning and disinfection of resident rooms			1			2					1			1	5
Inadequate cleaning and disinfection of resident common areas			1			2					1			1	5
Other (specify):_______________															
Medical Devices and Equipment															
Improper handling of medications and injection equipment (e.g., reuse of syringes)			1		3						1			1	6
Lack of access to single-use, auto-disabling fingerstick devices			1			2					1			1	5
Inappropriate sharing of devices labeled for single-patient use			1			2					1			1	5
Improper cleaning and disinfection of point-of-care devices (e.g., blood glucose meter) between residents			1				1				1			1	4

Improper cleaning and disinfection of shared equipment (e.g., blood pressure cuff) between residents			1				1				1			1	4
Lack of separation between clean supplies and dirty/contaminated medical supplies			1			2					1			1	5
Improper storage and/or transport of linen			1				1				1			1	4
Other (specify):_________________															
Antibiotic Stewardship															
Lack of leadership support for antibiotic stewardship			1			2					1		2		6
Inadequate written policies guiding antibiotic use			1			2					1			1	5
Unable to obtain antibiotic usage report from pharmacy			1				1				1		2		5
Unable to obtain report summarizing antibiotic resistance patterns (e.g., antibiogram)			1				1				1		2		5
Other (specify):_______________															
Date Prepared: draft 2023															
Adapted from https://spice.unc.edu/resources/template-risk-assessment-for-ltc/															



South Peninsula Hospital	**SUBJECT:** Disruptive Conduct & Abusive Behavior	**POLICY #:** EMP-03 **Page 1 of 1**
Scope: Executive Leadership **Approved by:** Board of Directors		**Original Date:** 10/22/03 **Effective:** 6/23/2021
Revised: 8/28/19 **Reviewed:** 1/25/23		**Revision Responsibility:** Board of Directors

PURPOSE:
~~Provisions of~~To provide authority for establishing appropriate workplace behavioral expectations.

DEFINITION(S):
N/A

POLICY:
A. The CEO will ensure that the hospital maintains a work environment free from disruptive and abusive behavior and to this end will establish the necessary policies and procedures.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
1. HW-021 Sexual Harassment
2. HW-218 Work Place Bullying
3. HW-106 Code of Conduct
4. Medical Staff Rules & Regulations, Rule 20, Disruptive Behavior

CONTRIBUTORS:
Board of Directors

South Peninsula Hospital

MEMO

Administration
4300 Bartlett Street
Homer, AK 99603
907-235-0325 (f)907-235-0253

To: SPH Board of Directors
From: BOD Governance Committee
Date: May 19, 2023
Re: Board Bylaws Amendment Proposal

After discussion at several Governance Committee meetings, the committee is proposing a change to the bylaws.

The proposal will change the officer terms from one year, to two years. Many committee members felt that one year is not enough time to learn an officer role and execute it effectively. The CEO agreed that extending the officer terms to two years would provide continuity for the executive staff as well.

Section 1 of ARTICLE IX – AMENDMENTS asks for two readings of the change to be made prior to vote, with a required 75% of the entire membership needed to ratify the amendment. Nine member must be present and vote in the affirmative in order for the amendment to pass. This is the second reading of the proposed amendment.

The full copy of the proposed revised bylaws are attached for review as well.

ARTICLE IV - OFFICERS

Section 1.

The officers of the Hospital Board shall be a President, Vice-President, Secretary, and Treasurer.

Section 2.

At the annual meeting in the month of January each even year, the officers shall be elected, all of whom shall be from among its own membership, and shall hold office for a period of ~~one~~ two years.

Recommended Motion: Consideration to Amend the South Peninsula Hospital Board of Directors Bylaws, Article IV, Section 2, to change the term of officers from one to two years.

BYLAWS
SOUTH PENINSULA HOSPITAL, INC.

ARTICLE I - NAME AND OBJECTIVES

Section 1.

The name of this corporation shall be South Peninsula Hospital, Inc., and its mailing address shall be 4300 Bartlett Street, Homer, Alaska 99603.

Section 2.

The name of the Board shall be the South Peninsula Hospital Board of Directors, and shall be referred to in these Bylaws as the Hospital Board.

Section 3.

The objective of the Hospital Board shall be to construct, maintain, and operate a hospital and authorized services in accordance with the laws and regulations of the State of Alaska and in fulfillment of our responsibility to the taxpayers and citizens of the South Kenai Peninsula Hospital Service Area. The Hospital Board shall be responsible for the control and operation of the Hospital and authorized services including the appointment of a qualified medical staff, the conservation and use of hospital monies, and the formulation of administrative policy.

ARTICLE II - MEETINGS

Section 1. Regular Meetings.

The Hospital Board shall hold regular meetings with a minimum of ten (10) meetings a year. Meetings shall be held at South Peninsula Hospital or such other place as may be designated, or virtually through telephonic or other electronic means

Section 2. Special Meetings.

Special meetings may be called by the President, Vice-President, Secretary, or Treasurer, at the request of the Administrator, Chief of Staff, or three Board members. Members shall be notified of special meetings, the time, place, date, and purpose of said meeting. Notice will be given verbally or by email. A minimum of five days' notice shall be given to members except in the event of an emergency. Notice will be provided to borough clerk and posted on SPHI website.

Section 3. Quorum.

A quorum for the transaction of business at any regular, special, or emergency meeting shall consist of a majority of the seated members of the Hospital Board, but a majority of those present

shall have the power to adjourn the meeting to a future time. Attendance may be in person through telephonic or other electronic means.

Section 4. Minutes.

All proceedings of meetings shall be permanently recorded in writing by the Secretary and distributed to the members of the Hospital Board and ex-officio members. Copies of minutes will be posted on the SPHI website.

Section 5. Reconsideration:

A member of the board of directors who voted with the prevailing side on any issue may move to reconsider the board's action at the same meeting or at the next regularly scheduled meeting. Notice of reconsideration can be made immediately or made within forty-eight hours from the time of the original action was taken by notifying the president or secretary of the board.

Section 6. Annual Meeting.

The annual meeting of the Board of South Peninsula Hospital, Inc. shall be held in January, at a time and place determined by the Board of Directors. The purpose of the annual meeting shall include election of officers and may include appointment of Board members.

ARTICLE III - MEMBERS

Section 1.

The Hospital Board shall consist of nine (9) to eleven (11) members. No more than three (3) members may reside outside of the Hospital Service Area. No more than two (2) members may be physicians.

Section 2.

Appointments to the Hospital Board shall be made by the Hospital Board with an affirmative vote of the majority of the Board. Term of office shall be three (3) years with appointments staggered so that at least three members' terms will expire each year on December 31. Members may be reappointed by an affirmative vote of the majority of the Board. Election shall be by secret ballot. Elections may be held by any electronic means that provides the required anonymity of the ballot.

Section 3.

Vacancies created by a member no longer able to serve shall be filled by the procedure described in Section 2 for the unexpired term. Any member appointed to fill a vacant seat shall serve the remainder of the term for the seat the member has been appointed to fill.

Section 4.

Any Hospital Board member who is absent from two (2) consecutive regular meetings without prior notice may be replaced. In the event of sickness or circumstances beyond the control of the absent member, the absence may be excused by the President of the Board or the President's designee. Any Board member who misses over 50% of the Board meetings during a year may be replaced.

Section 5.

Censure of, or removal from the Board of any member shall require a 75% affirmative vote of the Board members.

Section 6.

No member shall commit the Hospital Board unless specifically appointed to do so by the Hospital Board, and the appointment recorded in the minutes of the meeting at which the appointment was made.

Section 7.

Hospital Board members will receive a stipend according to a schedule adopted by the board and outlined in Board Policy SM-12 Board Member Stipends.

ARTICLE IV - OFFICERS

Section 1.

The officers of the Hospital Board shall be a President, Vice-President, Secretary, and Treasurer.

Section 2.

At the annual meeting in the month of January each even year, the officers shall be elected, all of whom shall be from among its own membership, and shall hold office for a period of ~~one~~ two years.

Section 3.

President. The President shall preside at all meetings of the Hospital Board. The President may be an appointed member to any committee and shall be an ex-officio member of each committee.

Section 4.

Vice-President. The Vice-President shall act as President in the absence of the President, and when so acting, shall have all of the power and authority of the President.

Section 5.

In the absence of the President and the Vice-President, the members present shall elect a presiding officer.

Section 6.

Secretary. The secretary shall be responsible for the minutes of the meeting, act as custodian of all records and reports, ensure posting of the agenda and minutes on the website, ensure that notification is provided to the Kenai Peninsula Borough for any changes to bard membership or officer assignments, and other duties as set forth by the Hospital Board. These duties shall be performed in conjunction with SPH Hospital Staff assigned to assist the Board.

Section 7.

Treasurer. The Treasurer shall have charge and custody of, and be responsible to the Hospital Board for all funds, properties and securities of South Peninsula Hospital, Inc. in keeping with such directives as may be enacted by the Hospital Board.

ARTICLE V - COMMITTEES

Section 1.

The President shall appoint the number and types of committees consistent with the size and scope of activities of the hospital. The committees shall provide advice or recommendations to the Board as directed by the President. The President may appoint any person including, but not limited to, members of the Board to serve as a committee member. Only members of the Board will have voting rights on any Board committee. All appointments shall be made a part of the minutes of the meeting at which they are made.

Section 2.

Committee members shall serve without remuneration. Reimbursement for out-of-pocket expenses of committee members may be made only by hospital Board approval through the Finance Committee.

Section 3.

Committee reports, to be presented by the appropriate committee, shall be made a part of the minutes of the meeting at which they are presented. Substance of committee work will be fully disclosed to the full board.

ARTICLE VI - ADMINISTRATOR

Section 1.

The Administrator shall be selected by the Hospital Board to serve under its direction and be responsible for carrying out its policies. The Administrator shall have charge of and be responsible for the administration of the hospital.

Section 2.

The Administrator shall supervise all business affairs such as the records of financial transactions, collection of accounts and purchases, issuance of supplies, and to ensure that all funds are collected and expended to the best possible advantage. All books and records of account shall be maintained within the hospital facilities and shall be current at all times.

Section 3.

The Administrator shall prepare an annual budget showing the expected receipts and expenditures of the hospital.

Section 4.

The Administrator shall prepare and submit a written monthly report of all expenses and revenues of the hospital, preferably in advance of meetings. This report shall be included in the minutes of that meeting. Other special reports shall be prepared and submitted as required by the Hospital Board.

Section 5.

The Administrator shall appoint a Medical Director of the Long Term Care Facility. The Medical Director shall be responsible for the clinical quality of care in the Long Term Care Facility and shall report directly to the Administrator.

Section 6.

The Administrator shall serve as the liaison between the Hospital Board and the Medical Staff.

Section 7.

The Administrator shall provide a Collective Bargaining Agreement to the Hospital Board for approval.

Section 8.

The Administrator shall see that all physical properties are kept in a good state of repair and operating condition.

Section 9.

The Administrator shall perform any other duty that the Hospital Board may assign.

Section 10.

The Administrator shall be held accountable to the Hospital Board in total and not to individual Hospital Board members.

ARTICLE VII - MEDICAL STAFF

The Hospital Board will appoint a Medical Staff in accordance with these Bylaws, the Medical Staff Development Plan, and the Bylaws of the Medical Staff approved by the Hospital Board. The Medical Staff will operate as an integral part of the hospital corporation and will be responsible and accountable to the Hospital Board for the discharge of those responsibilities delegated to it by the Hospital Board from time to time. The delegation of responsibilities to the Medical Staff under these Bylaws or the Medical Staff Bylaws does not limit the inherent power of the Hospital Board to act directly in the interests of the Hospital.

Section 1.

The Hospital Board has authorized the creation of a Medical Staff to be known as the Medical Staff of South Peninsula Hospital. The membership of the Medical Staff will be comprised of all practitioners who are eligible under Alaska state law and otherwise satisfy requirements established by the Hospital Board Membership in this organization shall not be limited to physicians only. Membership in this organization is a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws. The Medical Staff organization, and its members will be responsible to the Hospital Board for the quality of patient care practiced under their direction and the Medical Staff will be responsible for the ethical and clinical practice of its members.

The Chief of Staff will be responsible for regular communication with the Hospital Board.

Section 2.

The Hospital Board delegates to the Medical Staff its responsibility to develop Bylaws, Rules and Regulations for the internal governance and operation of the Medical Staff. Neither will be effective until approved by the Hospital Board.

The following purposes and procedures will be incorporated into the Bylaws and Rules and Regulations of the Medical Staff:

1. The Bylaws and Rules and Regulations of the Medical Staff will state the purposes, functions and organization of the Medical Staff and will set forth the policies by which the Professional Staff exercises and accounts for its delegated authority and responsibilities.
2. The Medical Staff Bylaws will require adherence to an identified code of behavior within the Hospital. The Bylaws will state that the ability to work harmoniously and cooperatively with others is a basic requirement for initial appointment and reappointment. Such Bylaws will state that appointment and reappointment is subject to compliance with Medical Staff Bylaws and Hospital Board Bylaws.
3. The Medical Staff Bylaws or Rules and Regulations will clearly define a regular method of quality assessment if not established by Hospital Board policy.

Section 3.

The following tenets will be applicable to Medical Staff membership and clinical privileges:

1. The Hospital Board delegates to the Medical Staff the responsibility and authority to investigate and evaluate matters relating to Medical Staff membership, clinical privileges, behavior and disciplinary action, and will require that the Medical Staff adopt, and forward to the Hospital Board, specific written recommendations with appropriate supporting documentation that will allow the Hospital Board to take informed action when necessary.
2. Final actions on all matters relating to Medical Staff membership, clinical privileges, behavior and disciplinary action will generally be taken by the Hospital Board following consideration of Medical Staff recommendations. However, the Hospital Board has the right to directly review and act upon any action or failure to act by the Medical Staff if, in the opinion of the Hospital Board, the Medical Staff does not or is unable to carry out its duties and responsibilities as provided in the Medical Staff Bylaws.
3. In acting on matters involving granting and defining Medical Staff membership and in defining and granting clinical privileges, the Hospital Board, through the Medical Staff's recommendations, the supporting information on which such recommendations are based, and such criteria as are set forth in the Medical Staff Bylaws. No aspect of membership nor specific clinical privileges will be limited or denied to a practitioner on the basis of sex, race, age, color, disability, national origin, religion, or status as a veteran.
4. The terms and conditions of membership on the Medical Staff and exercise of clinical privileges will be specifically described in the notice of individual appointment or reappointment.
5. Subject to its authority to act directly, the Hospital Board will require that any adverse recommendations or requests for disciplinary action concerning a practitioner's Medical Staff appointment, reappointment, clinical unit affiliation, Medical Staff category, admitting prerogatives or clinical privileges, will follow the requirements set forth in the Medical Staff Bylaws.

6. From time to time, the Hospital Board will establish professional liability insurance requirements that must be maintained by members of the Medical Staff as a condition of membership. Such requirements will be specific as to amount and kind of insurance and must be provided by a rated insurance company acceptable to the Hospital Board.

ARTICLE VIII - AUTHORIZATION OF INDEBTEDNESS

Section 1. Indebtedness.

It shall require seventy five percent (75%) of the entire Hospital Board to commit funds beyond current income, cash available, and appropriations of the current budget.

ARTICLE IX - AMENDMENTS

Section 1.

The Bylaws may be altered, amended, or repealed by the members at any regular or special meeting provided that notice of such meeting shall have contained a copy of the proposed alteration, amendment or repeal and that said proposed alteration, amendment, or repeal shall be read at two meetings prior to a vote.

Section 2.

An affirmative vote of seventy-five percent (75%) of the entire membership shall be required to ratify amendments, alterations or repeals to these Bylaws.

Section 3.

These Bylaws shall be reviewed at the annual meeting.

ARTICLE X - ORDER OF BUSINESS

Section 1.

The order and conduct of business at all meetings of the Hospital Board shall be governed by Roberts Rules of Order Revised, except when provided otherwise in these Bylaws.

ARTICLE XI - INDEMNIFICATION

Section 1.

The corporation shall indemnify every person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative (other than an action by or in the right of the corporation) by reason of the fact that he is or was a board member, director, officer, employee or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust of other enterprise, against expenses (including attorneys' fees), judgment, fines and amounts paid in settlement actually and reasonably incurred by him in connection with such action, suit or proceeding if he acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the corporation and, with respect to any criminal action or proceeding, had no reasonable cause to believe his conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contender or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he reasonably believed to be in or not opposed to any criminal action or proceeding, had reasonable cause to believe that his conduct was unlawful.

Section 2.

The corporation shall indemnify every person who has or is threatened to be made a party to any threatened, pending or completed action or suit by or in the right of the corporation to procure a judgment in its favor by reason of the fact that he is or was a board member, director, officer, employee or agent of the corporation, partnership, joint venture, trust of other enterprise against expenses (including attorneys' fees) actually and reasonably incurred by him in connection with the defense or settlement of such action or suit if he acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the corporation except that no indemnification shall be made in respect of any claim, issue or matter as to which such person shall have been adjudged to be liable for negligence or misconduct in the performance of his duty to the corporation unless and only to the extent that the court in which such action or suit was brought shall determine upon application that, despite the adjudication of liability but in view of all circumstances of the case, such person is fairly and reasonably entitled to indemnify for such expenses which such court shall deem proper.

Section 3.

To the extent that a board member, director, officer, employee or agent of the corporation has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in subsections 1 and 2 hereof, or in defense of any claim, issue or matter therein, he shall be indemnified against expenses (including attorneys' fees) actually and reasonably incurred by him in connection therewith.

Section 4.

Any indemnification under subsections 1 and 2 hereof (unless ordered by a court) shall be made by the corporation only as authorized in the specific case upon a determination that

indemnification of the board member, director, officer, employee or agent is proper in the circumstances because he has met the applicable standard of conduct set forth in subsections 1 and 2 hereof. Such determination shall be made (a) by the Board of Directors by a majority vote of a quorum consisting of directors who were not parties to such action, suit or proceedings, or (b) if such quorum is not obtainable, or even if obtainable, a quorum of disinterested directors so directs, by independent legal counsel in a written opinion.

Section 5.

Expenses incurred in defending a civil or criminal action, suit, or proceeding may be applied by the corporation in advance of the final disposition of such action, suit or proceeding as authorized by the Board of Directors in the manner provided in subsection 4 upon receipt of any undertaking by or on behalf of the board member, director, officer, employee or agent, to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the corporation as authorized in this section.

Section 6.

The indemnification provided by this Article shall not be deemed exclusive of any other rights to which those indemnified may be entitled under any resolution adopted by the members after notice, both as to action in his official capacity and as to action in another capacity while holding office, and shall continue as to a person who has ceased to be a board member, director, officer, employee or agent and shall inure to the benefit of the heirs, executors and administrators of such a person.

- Adopted by the South Peninsula Hospital Board of Directors. December 7, 2022.

- Kelly Cooper, President

- Julie Woodworth, Secretary

Introduced by:	Administration
Date:	
Action:	
Vote:	Yes -, No -, Exc -

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2023-15

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS SUPPORTING THE HOSPITAL'S REQUEST FOR A CERTIFICATE OF NEED TO ADD THE SERVICE LINE OF NUCLEAR MEDICINE TO SOUTH PENINSULA HOSPITAL, RELOCATE THE PHARMACY AND EXPAND AND RELOCATE INFUSION SERVICES

WHEREAS, South Peninsula Hospital wishes to add the new service line of Nuclear Medicine, relocate the Pharmacy and expand and bring back in-house Infusion Services ; and

WHEREAS, Nuclear Medicine has been the standard of care for diagnosing illnesses and disorders related to Heart Health, Neurology, and Cancer for over 30 years; and

WHEREAS, bringing this service line to Homer will allow patients to receive vital diagnostic services close to home which will bring access to populations who may not otherwise receive the service, resulting in better outcomes for our service area; and

WHEREAS, the relocation and expansion of the Pharmacy will bring South Peninsula Hospital into compliance with USP standards for sterile compounding and allow it to continue to provide greatly needed services to Kenai Peninsula residents; and

WHEREAS, bringing the Infusion services back into the main hospital building and will allow the Infusion department to be more closely located to Pharmacy and Emergency services should they be needed and allow the growing Infusion department to expand services to meet the ever-increasing demand; and

WHEREAS, the South Peninsula Hospital Board of Directors approved the allocation of funds towards this project in previous Board Resolution 2022-16; and

WHEREAS, this project will require a Certificate of Need per State of Alaska regulations.

WHEREAS, this resolution was discussed and recommended for approval at Finance Committee on May 18, 2023.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL:

1. That the South Peninsula Hospital Board of Directors supports the Hospital's plan to create the new service line of Nuclear Medicine, and the resulting project to construct the nuclear medicine space, as well as the relocation and expansion of the Pharmacy and Infusion Services.

2. That the South Peninsula Hospital Board of Directors instructs Hospital Administration to apply for a Certificate of Need for this project as required by State of Alaska regulations.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL AT ITS MEETING HELD ON THIS 24TH DAY OF MAY, 2023.

ATTEST:

____
Kelly Cooper, Board President

____
Julie Woodworth, Board Secretary

South Peninsula Hospital

Administration
4300 Bartlett Street
Homer, AK 99603
907-235-0325 F.907-235-0253

MEMO

To: South Peninsula Hospital Inc. Operating Board & Southern Kenai Peninsula Service Area Board

From: Anna Hermanson, Chief Financial Officer

Date: May 22, 2023

RE: Resolution 23-13, Requesting $613,020 of Plant Replacement and Expansion Funds to support upgrades to the generator annunciator and switch gear

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South Peninsula Hospital Administration has identified the need to upgrade the annunciator and switch gears for the backup generators in order to meet current life safety codes and remedy an outstanding CMS (Centers for Medicare and Medicaid Service) citation. The Hospital has two backup generators, the older of which is well past its usual life expectancy and thus difficult to service or repair, with parts being difficult to find.

In order to maintain redundancy for backup power generation and comply with current life safety codes, the following upgrades are proposed:

- Replace main generator breakers with newer up to date load breakers.
- Pull out 1980's out-of-date RUSS gear equipment and replace with upgraded digital monitoring components.
- Install two digital monitoring cabinets that tie into switch gear interface.
- Install two remote enunciators that will feed alarm panels that are monitored 24/7 at the Acute Care nurses station and Security office.
- Install external tie-in with disconnect for future testing and emergency generator tie in box.
- Prepare engineered drawings for connections and components that are up to date to meet CMS requirements.

The cost to upgrade the annunciator and switch gear is estimated at $601,000 and the Kenai Peninsula Borough charges a project administration fee is estimated to be $12,020. In total, the estimated cost is $613,020. South Peninsula Hospital is requesting the use of Plant Replacement and Expansion Funds to cover the cost of this project.

Introduced by:	Administration
Date:	May
Action:	
Vote:	Y/N

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2023-13

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS APPROVING THE REQUEST OF $613,020 OF PLANT REPLACEMENT AND EXPANSION FUNDS TO SUPPORT UPGRADES TO THE GENERATOR ANNUNCIATOR AND SWITCH GEAR

WHEREAS, South Peninsula Hospital Administration has identified the need to upgrade the annunciator and switch gears for the backup generators in order to meet current life safety codes and remedy an outstanding CMS (Centers for Medicare and Medicaid Service) citation, and

WHEREAS, the Hospital has two backup generators, the older of which is well past its usual life expectancy and thus difficult to service or repair, with parts being difficult to find, and

WHEREAS, in order to maintain redundancy for backup power generation and comply with current life safety codes, upgrades to the switch gear and annunciator along with other related work is necessary; and

WHEREAS, the cost to upgrade the annunciator and switch gear is estimated at $613,020; and

WHEREAS, South Peninsula Hospital did reach out to multiple vendors for quotes on this upgrade, and ultimately decided to sole source this work to NC Machinery due to the proprietary nature of the generator components and NC Machinery's proven track record of past performance on this equipment; and

WHEREAS, SPH Management would like to request $613,020 from the Plant Replacement and Expansion Fund to be appropriated to complete the upgrade of the annunciator and switch gear; and

WHEREAS, the upgrades to the annunciator and switch gear were discussed at Finance Committee on May 18, 2023.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL:

1. That the South Peninsula Hospital Board of Directors approves the use of $613,020 from the Plant Replacement and Expansion fund to upgrade the annunciator and switch gear, following recommendation from the Service Area Board and approved by the Kenai Peninsula Borough Assembly.

2. That Management is hereby authorized to take any other actions that are necessary or desirable to achieve the intent of these Resolutions.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL AT ITS MEETING HELD ON THIS 24TH DAY OF MAY, 2023.

ATTEST:

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Kelly Cooper, Board President

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Julie Woodworth, Board Secretary

Introduced by:	Administration
Date:	May 24, 2023
Action:	
Vote:	

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2023-16

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS APPROVING A PLAN AMENDMENT FOR THE 403b PLANS TO ADHERE TO THE REQUIREMENTS OF THE SECURE ACT AND THE CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT

WHEREAS South Peninsula Hospital offers 403b plans to Union and Non-Union employees; and

WHEREAS South Peninsula Hospital management was notified by its Plan Administrator/Custodian that the *Setting Every Community Up for Retirement Enhancement Act* (SECURE) and the *Coronavirus Aid, Relief, and Economic Security Act* (CARES) requires that we make an amendment to our 403b plans; and

WHEREAS the amendment from the SECURE Act will allow employees to request a distribution of up to $5,000 per child as a Qualified Birth or Adoption Distribution (QBAD), provided certain conditions are met only from the vested portion of the employee’s retirement account; and

WHEREAS the amendment from the SECURE Act will effectively change the timing of Required Minimum Distributions (RMD) to Beneficiary/ies of a Participant who dies prior to the Required Beginning Date (RBD) or latest date to which a plan participant may defer distributions. The beneficiary RMD election will be changed from 5 years to 10 years in the absence of an election or age 72; and

WHEREAS the amendment from the CARES Act retroactively waives the requirement of participants who meet the requirement for a required minimum distribution (RMD) to do so in 2020. Those receiving an RMD as part of a series of equal distributions would continue to receive their distribution in 2020, however, those who would otherwise be required to take an RMD would not distribute one unless a participant elected to do so in 2020. This amendment is retroactively effective March 27, 2020; and

WHEREAS South Peninsula Hospital follows all Federal and State Regulatory requirements with regard to its qualified and non-qualified employee retirement plans; and

WHEREAS South Peninsula Hospital desires to amend the 403b Voluntary Plan, 403b Union Plan, and 403b Non-Union plan to meet the requirements of the SECURE Act and CARES Act; and

WHEREAS the provisions of this amendment are being made to bring the Plan’s terms into compliance with its operation pursuant to the SECURE Act and CARES Act; and

WHEREAS this Resolution was reviewed at the Pension Committee on May 18, 2023.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL:

1. That Management is hereby authorized to take any actions that are necessary to comply with the requirements of the SECURE Act of 2019 and the CARES Act as it relates to our SPH 403b Voluntary, Union, and Non-Union plans.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL THIS 24th DAY OF May, 2023.

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Kelly Cooper, Board President

ATTEST:

____

Julie Woodworth, Secretary

Introduced by:	Administration
Date:	May 24,2023
Action:	
Vote:	Yes - , No –, Excused -

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2023-17

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS SUPPORTING THE ENACTMENT OF A KPB ORDINANCE FOR SUBMISSION OF A VOTE TO THE SOUTH KENAI PENINSULA HOSPITAL SERVICE AREA ON ISSUANCE OF GENERAL OBLIGATION BONDS IN SUPPORT OF SOUTH PENINSULA HOSPITAL

WHEREAS, South Peninsula Hospital, Inc. ("SPHI") the current operator of South Peninsula Hospital and other medical facilities is requesting that the Kenai Peninsula Borough move forward with an ordinance providing for the Submission to the qualified voters of South Kenai Peninsula Hospital Service Area the Question of the Issuance of Not-To-Exceed Seventeen Million Dollars ($17,000,000) of General Obligation Bonds of the South Kenai Peninsula Hospital Service Area to Pay Costs of Planning, Design, Construction, and Equipping of Facilities at the South Peninsula Hospital for the addition of a Nuclear Medicine program, the expansion of Pharmacy and Oncology/Infusion services and to replace its Electronic Medical Records (EMR) and Enterprise Resource Planning (ERP) software, at an Election in and for the Kenai Peninsula Borough on October 3, 2023; and

WHEREAS, the Kenai Peninsula Borough ("Borough") owns and provides for the operation of a 22-bed acute care and 28-bed long-term care hospital ("South Peninsula Hospital") and for other health services and medical facilities, through the South Kenai Peninsula Hospital Service Area ("SKPHSA"); and

WHEREAS, the Borough has entered into an Operating Agreement ("OA") with SPHI for the operation of the hospital and other medical facilities, to operate these medical facilities on a nonprofit basis in order to ensure the continued availability of the medical services to the service area residents and visitors; and

WHEREAS, the OA provides that the Borough may make capital improvements to the hospital and other medical facilities; and

WHEREAS, the South Peninsula Hospital is located in the South Kenai Peninsula Hospital Service Area ("Service Area"); and

WHEREAS, SPHI wishes to expand its health services to meet community needs and also replace its patient care medical record and organizational planning systems to support high quality, locally coordinated care; and

WHEREAS, SPHI has identified a need to add Nuclear Medicine diagnostic services which is the standard of care for diagnosing certain illnesses and disorders related to Organ dysfunction, Cardiac Health, Neurology, Thyroid and Breast Cancer, and much more, and

WHEREAS, SPHI has identified a 31% Service Gap in Nuclear Medicine diagnostic care for residents of the Southern Kenai Peninsula which will be reduced by bringing this service line closer to home; and

WHEREAS, SPHI needs to expand and upgrade its current Pharmacy to comply with new U.S. Pharmacopeia standards, and

WHEREAS, SPHI requires expansion and colocation of its Oncology / Infusion Center to allow for rapid growth and improve patient quality and safety; and

WHEREAS, SPHI has the ability to expand Pharmacy and Infusion by relocating these service lines into an undeveloped shelled-in space on the first floor of the Hospital; and

WHEREAS, SPHI has determined that the addition of Nuclear Medicine Services and the development of the shelled-in space requires a Certificate of Need (CON) and is in the process of completing the CON; and

WHEREAS,SPHI has continued to grow its healthcare services and as a result of that expansion, has multiple electronic medical records to support its Hospital, Long-term Care, Home Health, and Outpatient Clinics, impacting its ability to provide the highest quality care and patient experience. An upgraded EMR/ERP will also improve physician access to patient medical records, staff satisfaction, and improve reporting capabilities for internal and external stakeholders; and

WHEREAS, the South Peninsula Hospital has estimated a cost of approximately $10,000,000 for the design, planning, construction and equipment of the Nuclear Medicine Program, Pharmacy Upgrade and Oncology/Infusion Colocation and expansion project, and approximately $7,000,000 for the purchase, design, planning, hardware, software, and installation of a new EMR/ERP including project management and administrative costs; and

WHEREAS, under provisions of AS 29.47.190 a municipality may incur general obligation debt only after a bond authorization ordinance is approved by a majority of those voting on the question at a regular or special election; and

WHEREAS, the capital improvements mentioned above are necessary and beneficial to the community;

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL:

1. That the South Peninsula Hospital, Inc. Board of Directors requests and supports the enactment of a Kenai Peninsula Borough Ordinance providing for Submission to the qualified voters of South Kenai Peninsula Hospital Service Area the Question of the Issuance of Not-To-Exceed Seventeen Million Dollars ($17,000,000) of General Obligation Bonds of the South Kenai Peninsula Hospital Service Area to Pay Costs of Planning, Design, Equipment, and Construction for the addition of Nuclear Medicine, Pharmacy Upgrades, and Oncology/Infusion Expansion and Colocation, AND the for the Planning, Design, Software, Hardware, and Installation of a new Electronic Medical Record and Enterprise Resource Planning System for South Peninsula Hospital at an Election in and for the Kenai Peninsula Borough on October 3, 2023;

2. That the South Peninsula Hospital, Inc. Board of Directors will forward this resolution to the KPB Administration as support of a Kenai Peninsula Borough Ordinance as described in Section 1.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL THIS 24th DAY of MAY, 2023.

ATTEST:

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Kelly Cooper, Board President

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Julie Woodworth, Secretary

South Peninsula Hospital
Patient Centered Care Quality Committee
April 26, 2023

DATE OF MEETING: April 26, 2023

MEMBERS PRESENT: x = Present

x	Shover, Susan *(Quality Management Director, CMTE Co-Chair)*	x	Wilson, Bernadette (*Board of Directors, CMTE Co-Chair)*
	Wythe, Beth *(Board of Directors)*		

x	Ansell, Tracy *(QM Admin Asst. / Scribe.)*	x	Kincaid, Rachael (CNO)	x	Stuart, Ivy *(Dir. Home Health)*
x	Banks, Bonita *(Risk Mitigation RN)*	E	Kinnard, Penny (*Mgr. HIM)*	x	Stearns, Linda *(RN Coordinator)*
A	Bartilson, James *(Dir. of Info. Services)*		Konik, Andrea *(Med Staff Coordinator)*	x	Tuomi, Christina *(CMO)*
x	Burdick, Joelle *(OB Director)*		*(Imaging Representative)*		
x	Caldwell, Craig *(ER Director)*	x	Lewald, Anna *(I.P. Nurse)*		
	Dahmann, Dee *(Spec. Serv. Cl. Manager)*	x	Martin, Katie *(LTC Director)*		
E	Deaver, Nancy *(Pt. Access Super.)*		Miller, Laura *(Dir. Lab)*		
x	Gall, Amber *(Dir Of Surgical Serv.)*	E	Nollar, Jane *(AC Director)*		
	(HMC Representative)	x	Northrop, Karen *(Mgr. Rehab Services.)*		
x	Greear, Vince *(Mgr. Pharmacy)*	x	Ostman, Rhoda *(Nutritional Serv. Mgr.)*		
x	Herrmann, Justin *(Mgr. EVS)*	x	Smith, Harrison *(Facilities Manager)*	x	= Present

OTHERS (NONMEMBERS) PRESENT: Frank Kilma, Trauma Coordinator

SUBMITTED BY: ____

Susan Shover and/or Bernadette Wilson, Co-chairs

	Discussion	Action	Follow Up
I. Call to Order	Quality Management (QM) Director Susan Shover called the meeting to order at 12:30 pm.		**CLOSED**
II. Approval of Minutes/ **III. Agenda**	Craig Caldwell, Emergency Department (ED) Director motioned to approve the January 2023 minutes and Anna Lewald, Infection Prevention RN seconded the motion. Susan Shover, Quality Management Director requested to make a couple minor changes in the agenda. Karen Northrup, Rehab Services Director motioned to approve the agenda with changes. Harrison Smith, Facilities Manager seconded the motion.	**APPROVED**	**CLOSED**

DRAFT

	Discussion	Action	Follow Up
IV. Living Our Values Commitment	Susan Shover communicated that today is Administrative Professionals Day. Tracy Ansell, Quality Management Assistant was recognized for all her hard work and dedication to the Patient Centered Care Quality (PCCQ) Committee and the QM Department. An appreciation to all the hard working Administrative Assistant in the organization was also shared.		**CLOSED**
V. New Business	No new business.		**CLOSED**
VI. Balanced Scorecard	**Q1 of 2023 Balanced Scorecard (BSC)** **A. Overall Indicators** Susan Shover showed the committee the new Q1-2023 Balanced Scorecard.		**ONGOING**
	B. Quality of Care i. **Sepsis/Stroke** Rachael Kincaid, CNO explained some of the steps taken to improve both sepsis and stroke scores. Rachael is pulling as close to real-time inpatient data as possible according to triggers from documentation. New alerts in Evident have been set up to alarm with certain criteria, including organ dysfunction. The idea is to catch symptoms earlier, before there is an issue. She is still working out the process kinks to make sure the correct data is being captured. The scorecard reflects both real-time and Care Compare lookback data. Susan Shover shared Q4-2022 chart abstraction for Sepsis care of 92% and stroke data of 100%. ii. **Readmissions** – Numbers are within target.		**ONGOING**
	C. Patient Safety i. **Acute Care Falls** ***(injurious fall rate)*** There were nine falls recorded for Q1-2023. Five of the falls resulted in minor injury with four having no injury. Eight of the nine falls were the same patient.		**ONGOING**

	Discussion	Action	Follow Up
	D. Patient Satisfaction reported through Press-Ganey **i. Inpatient** – Inpatient scores are above the established target. **ii. Outpatient** – Work has been completed on the registration piece of outpatient care. Patient Financial Services (PFS) collects data for average number of registration and their wait time. This data helps determine if patients are moving through registration in a timely and efficient manner. Press Ganey ranking is starting to move in a positive direction. A new dashboard is in development. **iii. Ambulatory Surgery –** Amber Gall, Surgical Services Director spoke about what her department is doing to bring their Press Ganey scores up. The Ambulatory Surgery ranking is just below target. Surgical Services is using different strategies by education patient on the importance of filling out the surveys. They also have been paying attention to the questions that consistently get lower scores. Patients have consistently given feedback they did not see their doctor after a procedure due to still being medicated. There is now an area on the discharge form to document the physician visit in the Recovery Room so patient are aware the surgeon saw the patient after a procedure.		**ONGOING**
	E. Consumer Assessment of Healthcare Providers and Services **i. HCAHPS** Susan Shover spoke briefly about the HCAHPS scores. She explained the importance of understanding the rating comes from the patient's perspective of their care. The graphs tell the story about how well we are doing in the patient's eyes. Explanation of monitoring the trend and not one specific quarter was provided. Side effects of medications was identified as an area to focus as these scores have trended lower for the past year.		

	Discussion	Action	Follow Up
VII. Departmental Reporting	**A. Patient Financial Services**	**TABLED**	**ANNUAL REPORTING**
	B. Emergency **Stroke Care:** Craig Caldwell spoke to the stroke quality activities the ED is working to improve upon. A quality improvement tool was developed to track patient information that meets stroke criteria. Alerts were added to Evident for patients that reach a certain criteria. **Trauma Reverification** Frank Kilma, ED Trauma Coordinator, updated the committee on the Trauma Reverification process. During the overall process of improvement, weakness and deficiencies was identified. A new case log has been developed. There is now a log for trauma injuries to identify whether staff are meeting criteria for care. Audit filters in Evident have been helpful in identifying patients admitted within 2 hours and discharged by 6 hours. Trauma provider meetings are on Mondays with a newly developed two-tiered stakeholders committee. There has been increase engagement and discussion. Frank is currently working on an EMS update, provider follow-up along with Providence follow-up letters with a short review of the patient's status. Review of the documentation must be considered to make sure no Protected Health Information (PHI) is shared inappropriately. Registry is another area of improvement with updated data entry goal of 30 days to current. The State requires 60 days to current so we are providing ourselves with a small buffer to assure completion. The state will return on June 19th for a review.	Update of reverification at July 2023 meeting	**ANNUAL REPORTING**
	C. Home Health *(HH)* Ivy Stuart, HH Director reports on the department's two-performance improvement plans for this reporting period. • Improving patient's episodes indicating reduced shortness of breath. Data for the months of January and February this year are showing a 79% improvement.		**ANNUAL REPORTING**

	Discussion	Action	Follow Up
	• Oral medication management with emphasis on improved ability of patient ability to take medication correctly. With the new Oasis training, staff have learned what questions to ask with good documentation noted with the change. SPH HH cares for patients at end-of-life whereas many other HH agencies actually discharge those patients. Death of a patient bring down the scores, which are connected to Medicare pay for performance payments. HH focuses on a much positive as they can.		
	D. Information Technology Susan reported in the absence of Jim Bartilson, IT Director. 1669 video assignments were sent out this quester with 1469 completed decreasing the overall scores to 88%. 3924 phishing test emails were sent out to staff. 15 of those emails were clicked on, making the fail rate 99.6%. The score sound good but one should think about the 15 opportunities for cyber security to fail.		**ANNUAL REPORTING**
	E. Nutrition Services (NS) Rhoda Ostman, Nutrition Services Manager reported on the department's Press Ganey (PG) process improvement projects. The two score items to improve were quality and temperature of food. Staff have taken extra measures to make sure the food trays visual presentation look good before leaving the kitchen. A log was created to track the time the food left the kitchen to the time provided to the patient. The times decreased dramatically since the project started resulting in increased compliments for the department. Besides the PG improvement project, NS has taken notice to the amount of food waste from the patient meals. They started paying close attention to the food that was consistently left on trays and made changes accordingly. An example would be the milk left unopened. NS has eliminated milk on trays for those patients not requesting it.		**ANNUAL REPORTING**

	Discussion	Action	Follow Up
	The department has also started participating in a community compost initiative. Now much of the food waste goes to the compost project. This is good for the community and the organization.		
	F. SUMA	**TABLED**	**ANNUAL REPORTING**
	G. Quality Management (QM) Susan Shover provided an update on a few of the activities happening in the Quality Management Department. • **Sepsis and Stroke** data was reported under the BSC. • **AMI** *(Acute Myocardial Infarction*: Core measure that is abstracted and transmitted to CMS quarterly. There were no cases in Q4-2022. • **CAH** Program Evaluation: An annual report of the hospital's quality goals and activities completed within the fiscal year. It was explained the draft report would be sent out early next week for the Management team to review and update. The final report will go to the Board of Directors in July. • **Quality Support Specialist** - Looking for a replacement for Mike Tupper's position. We are currently in the interview process.		**ANNUAL REPORTING**
VIII. Pending Business	**A. Quality Plan Approval** Minor changes have been made to the Quality Plan since it was sent to the PCCQ committee for review. • The Medical Executive Committee (MEC) and one of the Board members on PCCQ requested the word "customer" to be changed to patients/residents, which was completed. • The Board of Directors no longer co-chairs the PCCQ committee per BOD policy so the Roles and Responsibility section has been updated to reflect that change. • Removed some unnecessary redundant information.		**CLOSED**

	Discussion	Action	Follow Up
	Anna Lewald moves to approve the Quality Plan with changes. Ivy Stuart seconds the motion. The Long Term Care QAIP *(Quality Assurance Improvement Performance)* Addendum – Ivy Stuart moves to approve the LTC QAIP Addendum and Risk Mitigation RN Bonita Banks seconded the motion.		
IX.Informational Items	A. **Trauma Certification** See above Emergency Department report. B. Anna Lewald will prepare to present Infection Prevention at the July meeting since her reported had been previously tabled. C. Pharmacy reporting medication errors, on a more regular cycle, is being considered.		**ONGOING**
XI. Adjourn Executive Session	The meeting was adjourned to executive session at 1:30 pm.		
Note:	Next Meeting: July 19, 2023		