AGENDA
Board of Directors Meeting
5:30 PM - Wednesday, July 26, 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

4 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

5 - 13 7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for June 28, 2023

Board of Directors - Jun 28 2023 - Minutes - DRAFT

14 - 17 7.2. Consideration to Approve June FY2023 Financials
Balance Sheet - June FY2023
Income Statement - June FY2023
Cash Flows Statement - June FY2023

18 - 25 7.3. Consideration to Approve the revised Utilization Management Plan, as updated by a workgroup to reconcile it to CMS regulations and update it to current best practice.
Utilization Management Plan draft

26 7.4. Consideration to Approve revised SPH Board Policy EMP-05, Hiring or Terminating Individuals in Key Positions, defining those individuals as all those in Chief Executive positions, and changing the notification timeline to 48 hours.
EMP-05

8. PRESENTATIONS

9. UNFINISHED BUSINESS

10. NEW BUSINESS

27 - 78 10.1. Consideration to Approve Annual Critical Access Hospital (CAH) Quality Assessment and Performance Improvement Evaluation for 2023

Memo
2023 SPH CAH QAPI Evaluation

11. REPORTS

79 - 83 11.1. Chief Executive Officer
Q2 2023 Balanced Scorecard

11.2. BOD Committee: Finance

11.3. BOD Committee: Governance

11.4. BOD Committee: Education

11.5. Chief of Staff

11.6. Service Area Board Representative

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

15.1. AHHA Annual Conference September 20-21st
https://www.alaskahha.org/conference

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, June 28, 2023
Conference Rooms 1&2 and Zoom

The Board of Directors of the South Peninsula Hospital was called to order on Wednesday, June 28, 2023, at 5:30 PM, in the Conference Rooms 1&2 and Zoom.

1. CALL TO ORDER

Vice President Aaron Weisser called the regular meeting to order at 5:32pm. President Kelly Cooper was excused.

2. ROLL CALL

BOARD PRESENT:	**Vice President Aaron Weisser, Keriann Baker, Todd Boling, Matthew Hambrick, Edson Knapp, Aaron Weisser, Bernadette Wilson, Julie Woodworth, and Beth Wythe.**
BOARD EXCUSED:	**Kelly Cooper, Melissa Jacobsen and Walter Partridge.**
ALSO PRESENT:	**Ryan Smith, CEO; Angela Hinnegan, COO; Derotha Ferraro, Marketing/PR Director; Maura Jones, Executive Assistant; Willy Dunne; Lane Chesley, KPB Assembly Representative**
	Due to the Zoom meeting format, only meeting participants who comment, give reports, presentations, or public comments are noted in the minutes. Others may be present on the virtual meeting.

2.1. A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Derotha Ferraro shared a story about a patient dealing with cancer, who wrote a newspaper article about her experience. She specifically called out Dr. Knapp for being an excellent member of her care team, who would sit and go through her imaging, and explain the processes to her. That kind of patient-centered care is what make this hospital a great place to work.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

Ms. Cooper welcomed members of the public.

4.1. Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

Willy Dunne, Service Area Board member, made a comment as a representative of the board of the Kachemak Bay Recovery Connection. Mr. Dunne saw the Community Health Needs Assessment was on the agenda, and has been involved in the report since 2009. Issues around substance use disorders consistently come up as a top concern for the community. Mr. Dunne asked the board and hospital administration to get involved with helping our community support recovery. Central

Peninsula Hospital has a robust program to support recovery, and South Peninsula Hospital does not. We would like to have a better way to deal with folks going through withdrawals than the Emergency Department.

6. APPROVAL OF THE AGENDA

Julie Woodworth made a motion to approve the agenda. Edson Knapp 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 May 24, 2023.

7.2. Consideration to Approve May FY2023 Financials

7.3. Consideration to Approve Policy EMP-06, Revised for Administrative Purposes to Correct the Name of Governing Documents

7.4. Consideration to Approve a Job Description for the Board President Position

Julie Woodworth made a motion to approve the consent calendar as read. Edson Knapp seconded the motion. Motion Carried.

8. PRESENTATIONS

8.1. 2023 Community Health Needs Assessment

Derotha Ferraro, Public Relations/Marketing Director, gave a presentation on the Community Health Needs Assessment, which is conducted every three years. The full report was included in the packet, however Ms. Ferraro gave an overview of all the work that went into data gathering, from various community stakeholders, and the resulting information about health needs in the community. South Peninsula Hospital will now develop an implementation strategy plan this fall, to address the needs identified.

9. UNFINISHED BUSINESS

There was no unfinished business on the agenda.

10. NEW BUSINESS

10.1. Consideration to Adopt the 2023 Community Health Needs Assessment

The board took action on the assessment presented by Ms. Ferraro.

Julie Woodworth made a motion to adopt the 2023 Community Health Needs Assessment Edson Knapp seconded the motion. Motion Carried.

10.2. Consideration to Approve SPH Resolution 2023-18, A Resolution of the South Peninsula Hospital Board of Directors Requesting a Third

Amendment to the Kenai Peninsula Borough and South Peninsula Hospital Operating Agreement Amendment A to Include Updates to the Listed Medical Facilities

Staff Report: Angela Hinnegan, COO. In December and January, while updating some language in the Operating Agreement, we noticed that Amendment A that describes all our medical facilities was inaccurate. The borough recommended we do an annual review, at the end of our fiscal year, to make any necessary updates. This resolution requests an amendment to update the square footage of certain leased properties and which properties are leased vs. owned.

Discussion: Dr. Knapp noted this was discussed and approved in the Finance Committee meeting.

Julie Woodworth made a motion to approve SPH Resolution 2023-18, A Resolution of the South Peninsula Hospital Board of Directors Requesting a Third Amendment to the Kenai Peninsula Borough and South Peninsula Hospital Operating Agreement Amendment A to Include Updates to the Listed Medical Facilities Edson Knapp seconded the motion. Motion Carried.

A roll call vote was conducted:

Aaron Weisser	*Abstained*
Julie Woodworth	*Yes*
Walter Partridge	*Excused*
Keriann Baker	*Yes*
M. Todd Boling	*Yes*
Matthew Hambrick	*Yes*
Melissa Jacobsen	*Excused*
Edson Knapp	*Yes*
Bernadette Wilson	*Yes*
Beth Wythe	*Yes*
Kelly Cooper	*Excused*

10.3. Consideration to Approve SPH Resolution 2023-19, A Resolution of the South Peninsula Hospital Board of Directors Approving an Increase to the Limitation on the Total Cumulative Annual Cost of Real Property Leases in Which SPH, Inc. is the Sole Lessee.

Staff Report: Angela Hinnegan, COO. This resolution would request a change to the operating agreement to raise the lease cap. As we expand, we will likely need to continue leasing spaces, so this will allow us to increase from $550k to $650k. We plan to revisit this annually.

Discussion: Dr. Knapp noted this resolution was discussed and approved in Finance Committee.

Treasurer Matthew Hambrick made a motion to approve SPH Resolution 2023-19, A Resolution of the South Peninsula Hospital Board of Directors Approving an Increase

to the Limitation on the Total Cumulative Annual Cost of Real Property Leases in Which SPH, Inc. is the Sole Lessee. Secretary Julie Woodworth seconded the motion. Motion Carried.

A roll call vote was conducted:

Aaron Weisser	*Abstained*
Julie Woodworth	*Yes*
Walter Partridge	*Excused*
Keriann Baker	*Yes*
M. Todd Boling	*Yes*
Matthew Hambrick	*Yes*
Melissa Jacobsen	*Excused*
Edson Knapp	*Yes*
Bernadette Wilson	*Yes*
Beth Wythe	*Yes*
Kelly Cooper	*Excused*

10.4. Consideration to Approve SPH Resolution 2023-20, A Resolution of the South Peninsula Hospital Board of Directors to Update Policy F-16 Budget Modifications to Increase the Limit of Unbudgeted Purchases Requiring Board of Directors Approval from $100,000 to $200,000

Report: Aaron Weisser, Governance Committee Chair. This resolution requests an increase to the spending limit for the CEO. This came out of post-COVID discussions, when the limit was temporarily raised during the pandemic, however costs have increased so dramatically over the past few years that the board decided to consider a permanent increase. Governance Committee asked Finance Committee to make a recommendation, as the spending authority is identified in a Finance Policy.

Discussion: Dr. Knapp noted this was reviewed and approved in Finance Committee. The committee felt this was related to a positive Board/CEO relationship, and the number could always be revisited in the future if needed.

Secretary Julie Woodworth made a motion to approve SPH Resolution 2023-20, A Resolution of the South Peninsula Hospital Board of Directors to Update Policy F-16 Budget Modifications to Increase the Limit of Unbudgeted Purchases Requiring Board of Directors Approval from $100,000 to $200,000 Treasurer Matthew Hambrick seconded the motion. Motion Carried.

A roll call vote was conducted:

Aaron Weisser	*Abstained*
Julie Woodworth	*Yes*
Walter Partridge	*Excused*
Keriann Baker	*Yes*
M. Todd Boling	*Yes*
Matthew Hambrick	*Yes*

Melissa Jacobsen	*Excused*
Edson Knapp	*Yes*
Bernadette Wilson	*Yes*
Beth Wythe	*Yes*
Kelly Cooper	*Excused*

10.5. Consideration to Approve SPH Resolution 2023-21, A Resolution of the South Peninsula Hospital Board of Directors to Support an Interfund Loan to South Kenai Peninsula Hospital Service Area from the Kenai Peninsula Borough General Fund for Acquisition of New Electronic Medical Record Software and Authorizing Repayment of the Loan from South Peninsula Hospital, Inc. Operating Funds

Staff Report: Ryan Smith, CEO. The original plan was to go out to bond for the Certificate of Need (CON) project and to transition our Electronic Health Record (EHR) from Evident to Epic. We then learned there would not be a sponsor for the ordinance at the assembly level, so we had a meeting with representatives from the borough, and had some conversations about a different path forward. The borough offered a interfund loan for the EHR project, and we could go for bonds next year. This resolution came from those conversations. Using this loan will shorten the timeframe, essentially making it a five year project. Ms. Hinnegan added that Hospital Administration would be bringing forward a request to sole source this project to Epic, as all of the surrounding medical facilities in Alaska have been moving to Epic, but that would come after approval of the loan.

Discussion: Dr. Knapp inquired how the loan will work in practice. Ms. Hinnegan said she will have some further discussion with Brandi Harbaugh at the borough. In terms of the EHR, one lump sum is due at signing, and the other is due 30 days before implementation. There is a waiting list for the EHR implementation, so we are hoping to get on the waiting list after securing the funding. Dr. Boling asked if Epic would replace all of the hospital's systems. Ms. Hinnegan clarified that the financial systems wouldn't be integrated, but that was included in the total cost. We would keep Long Term Care's system (Point Click Care) but Athena, which is used in the clinics, would be replaced by Epic. Mr. Hambrick asked for clarification on the funding changes for the project, and Mr. Smith confirmed that while the Board of Directors and Service Area Board members were ready to move forward to put bonds out for a public vote this year, they were not able to find support at the borough assembly level. Dr. Knapp asked if there is a compelling reason to move forward with the EHR project now, instead of waiting until we can go out to bonds. Mr. Smith answered that the most compelling reason is improving the patient experience. It has been proven that our EHR causes consternation to our patients and we owe it to our community to solve this as soon as we can. Dr. Knapp noted the Finance Committee discussed and approved this resolution at their meeting. Dr. Boling needed to step out of the meeting to attend to a patient need.

Treasurer Matthew Hambrick made a motion to approve SPH Resolution 2023-21, A Resolution of the South Peninsula Hospital Board of Directors to Support an Interfund Loan to South Kenai Peninsula Hospital Service Area from the Kenai Peninsula Borough General Fund for Acquisition of New Electronic Medical Record Software and Authorizing Repayment of the Loan from South Peninsula Hospital, Inc. Operating Funds Edson Knapp seconded the motion. Motion Carried.

A roll call vote was conducted:

Aaron Weisser	*Abstained*
Julie Woodworth	*Yes*
Walter Partridge	*Excused*
Keriann Baker	*Yes*
M. Todd Boling	*Excused*
Matthew Hambrick	*Yes*
Melissa Jacobsen	*Excused*
Edson Knapp	*Yes*
Bernadette Wilson	*Yes*
Beth Wythe	*Yes*
Kelly Cooper	*Excused*

10.6. Consideration to Approve SPH Resolution 2023-22, A Resolution of the South Peninsula Hospital Board of Directors Approving the Fiscal Year 2024 Operating Budget

Staff Report: Angela Hinnegan, COO. An overview of the FY2024 Operating Budget is included in the packet. Thanks to Anna Hermanson, CFO, for putting this together. We budgeted for flat days and average daily census, as well as a slight increase in surgeries and Long Term Care. It is essentially a break even budget.

Discussion: Dr. Knapp noted this was presented and approved in Finance Committee. Mr. Weisser added that there was a thorough and excellent presentation given in Finance Committee on the budget, and thanked Ms. Hermanson for all her work.

Secretary Julie Woodworth made a motion to approve SPH Resolution 2023-22, A Resolution of the South Peninsula Hospital Board of Directors Approving the Fiscal Year 2024 Operating Budget Treasurer Matthew Hambrick seconded the motion. Motion Carried.

A roll call vote was conducted:

Aaron Weisser	*Abstained*
Julie Woodworth	*Yes*
Walter Partridge	*Excused*
Keriann Baker	*Yes*
M. Todd Boling	*Excused*
Matthew Hambrick	*Yes*

Melissa Jacobsen	*Excused*
Edson Knapp	*Yes*
Bernadette Wilson	*Yes*
Beth Wythe	*Yes*
Kelly Cooper	*Excused*

11. REPORTS

11.1. Chief Executive Officer

Ryan Smith, CEO, gave a verbal report. Some highlights include:

- Trauma Level IV Reverification came through - thanks to Dr. Godfrey, Frank Klima and Craig Caldwell
- New health plan through Moda starts on Saturday. Will start the transition with Alaska Regional being the in-network provider. We are still working to contract separately with Providence

11.2. BOD Committee: Finance

Dr. Knapp noted that Finance Committee met and reviewed the financials, as well as all the resolutions brought to the full board at this meeting.

11.3. BOD Committee: Governance

Aaron Weisser, Governance Chair, reported. A written report was provided in the packet. The committee made revisions to policy EMP-05, and updated the terms to include the whole executive team. We also changed the wording to request notice within 48 hours for hiring and firing of key individuals, instead of advance notice. We finalized the Board President job description on the consent agenda tonight. We also discussed Doctor's Dinner, which is in the works.

11.4. BOD Committee: Education

There was no Education Committee report this month.

11.5. Service Area Board Representative - Helen Armstrong

Helen Armstrong, Service Area Board President, reported. The SAB did not meet in June. The board was planning to have a special meeting to consider the bond proposition and was disappointed to learn that they could not find a sponsor. There was some discussion over whether the SAB should call a special meeting in July to vote on the interfund loan, but the group agreed it could wait until the August meeting.

12. DISCUSSION

There were no discussion items.

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

Lane Chesley, Kenai Peninsula Borough Assembly Representative, drew Ms. Hinnegan's attention to an email from Brandi Harbaugh at the borough, detailing the specifications of the interfund loan. It would be set up as a line of credit that can be

drawn on as needed, and would only accrue interest as it is drawn upon. Mr. Chesley began to bring this to her attention during the discussion of the resolution, however it was noted as a point of order that guests are only permitted to join the discussion during the Comments from the Audience portion of the agenda, so Mr. Chesley finished his comment at this time.

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

Mr. Smith had no additional comments.

14.2. Board Members

Ms. Wilson thanked the whole executive team for all their hard work on so many different projects. Mr. Hambrick expressed his confusion and disappointment over not having a sponsor for the bond ordinance this year, but thanked the administrative team, service area board and board of directors on all their hard work to fund necessary projects. Dr. Knapp thanked Derotha for her presentation, for all of the work she does and how much she cares about her job and this community. She has a very special impact on this community and he is grateful to have her as a part of the SPH team. Mr. Weisser shared how he is proud to serve as a member of the hospital board.

15. INFORMATIONAL ITEMS

16. ADJOURN TO EXECUTIVE SESSION

The board adjourned to Executive Session at 7:05pm.

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Credentialing

After review of the applicant's files through the secure online portal, Julie Woodworth moved to certify the email vote of 2/20/23, approving the following positions in the medical staff as requested and recommended by the Medical Executive Committee. Matthew Hambrick seconded the motion. Motion carried.

<u>Reappointment (Telemed)</u>
Burton, Stephen MD; Telestroke/Neurology; Telemedicine
Singh, Tarvinder MD Telestroke/Neurology Telemedicine

<u>Reappointment</u>
Glass, Graham Alec MD; Neurology/Sleep Med; Courtesy Staff
Lada, Robert MD; Neurology/Sleep Med; Courtesy Staff
Spencer, Sarah DO; Addiction Medicine; Courtesy Staff
Whittaker, Dana CNM; Midwifery; Active Staff

<u>Appointments (Telemed)</u>

Chen, Michael MD; Telestroke/Neurology; Telemedicine
Khan, Faraz MD; Radiology (Vrad); Telemedicine

Appointments
Amen, Hans DO; Family Medicine; Active Staff
Ezrati, Raquel, FNP; Family Medicine; Active Staff
Hwang, Jimin, FNP; Family Medicine; Courtesy Staff
Jackson, Susan FNP; Family Medicine; Active Staff
Lancaster, Ragina DO; Family Medicine; Active Staff
Nawabi, Mohammed MD; Oncology; Courtesy Staff

18. ADJOURNMENT

The meeting was adjourned at 7:42pm.

Respectfully Submitted,

Maura Jones, Executive Assistant

Accepted:

Kelly Cooper, President

Minutes Approved:

Julie Woodworth, Secretary

South Peninsula Hospital

DRAFT-UNAUDITED

BALANCE SHEET
As of June 30, 2023

		As of June 30, 2023	As of June 30, 2022	As of May 31, 2023	CHANGE FROM June 30, 2022
	ASSETS				
	CURRENT ASSETS:				
1	CASH AND CASH EQUIVALENTS	26,124,541	25,722,672	25,333,334	401,869
2	EQUITY IN CENTRAL TREASURY	7,807,542	7,327,769	8,347,613	479,773
3	TOTAL CASH	33,932,083	33,050,441	33,680,947	881,642
4	PATIENT ACCOUNTS RECEIVABLE	31,649,600	30,319,294	30,250,113	1,330,306
5	LESS: ALLOWANCES & ADJ	(16,220,321)	(13,801,084)	(15,375,533)	(2,419,237)
6	NET PATIENT ACCT RECEIVABLE	15,429,279	16,518,210	14,874,580	(1,088,931)
7	PROPERTY TAXES RECV - KPB	105,670	102,233	105,476	3,437
8	LESS: ALLOW PROP TAX - KPB	(4,165)	(4,165)	(4,165)	0
9	NET PROPERTY TAX RECV - KPB	101,505	98,068	101,311	3,437
10	OTHER RECEIVABLES - SPH	368,940	630,717	428,809	(261,777)
11	INVENTORIES	2,130,033	2,062,504	1,892,655	67,529
12	NET PENSION ASSET- GASB	5,080,272	4,675,709	5,052,584	404,563
13	PREPAID EXPENSES	767,435	760,219	780,325	7,216
		-	-	-	
14	TOTAL CURRENT ASSETS	57,809,547	57,795,868	56,811,211	13,679
	ASSETS WHOSE USE IS LIMITED				
15	PREF UNOBLIGATED	6,042,608	5,939,928	6,634,037	102,680
16	PREF OBLIGATED	2,960,466	1,964,169	2,347,446	996,297
17	OTHER RESTRICTED FUNDS	24,983	47,049	46,409	(22,065)
		9,028,057	7,951,145	9,027,891	1,076,912
	PROPERTY AND EQUIPMENT:				
18	LAND AND LAND IMPROVEMENTS	4,114,693	4,114,693	4,114,693	0
19	BUILDINGS	63,059,362	67,421,851	63,059,362	(4,362,489)
20	EQUIPMENT	27,518,044	30,084,169	27,516,737	(2,566,125)
21	BUILDINGS INTANGIBLE ASSETS	2,478,113	2,382,262	2,456,899	95,851
22	EQUIPMENT INTANGIBLE ASSETS	462,427	462,427	462,427	0
23	IMPROVEMENTS OTHER THAN BUILDINGS	309,171	290,386	309,171	18,785
24	CONSTRUCTION IN PROGRESS	2,376,439	651,900	1,356,454	1,724,539
25	LESS: ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(57,371,399)	(61,534,270)	(57,024,950)	4,162,871
26	LESS: ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(863,032)	(416,130)	(824,623)	(446,902)
27	NET CAPITAL ASSETS	42,083,818	43,457,288	41,426,170	(1,373,470)
28	GOODWILL	5,000	17,000	6,000	(12,000)
29	**TOTAL ASSETS**	108,926,422	109,221,301	107,271,272	(294,879)
	DEFERRED OUTFLOWS OF RESOURCES				
30	PENSION RELATED (GASB 68)	4,530,917	4,530,917	4,530,917	0
31	UNAMORTIZED DEFERRED CHARGE ON REFUNDING	287,119	354,766	292,756	(67,647)
32	TOTAL DEFERRED OUTFLOWS OF RESOURCES	4,818,036	4,885,683	4,823,673	(67,647)
33	TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	113,744,458	114,106,984	112,094,945	(362,526)

		As of June 30, 2023	As of June 30, 2022	As of May 31, 2023	CHANGE FROM June 30, 2022
	LIABILITIES & FUND BALANCE				
	CURRENT LIABILITIES:				
34	ACCOUNTS AND CONTRACTS PAYABLE	1,339,386	1,814,587	1,286,244	(475,201)
35	ACCRUED LIABILITIES	8,339,224	8,110,926	7,273,493	228,298
36	DEFERRED CREDITS	74,840	29,927	(38,606)	44,913
37	CURRENT PORTION OF LEASE PAYABLE	409,930	391,790	403,847	18,140
38	CURRENT PORTIONS OF NOTES DUE	0	0	0	0
39	CURRENT PORTIONS OF BONDS PAYABLE	1,850,000	1,510,000	1,850,000	340,000
40	BOND INTEREST PAYABLE	100,216	135,734	65,254	(35,518)
41	DUE TO/(FROM) THIRD PARTY PAYERS	938,761	1,329,604	913,761	(390,843)
43	TOTAL CURRENT LIABILITIES	13,052,357	13,322,568	11,753,993	(270,211)
	LONG-TERM LIABILITIES				
44	NOTES PAYABLE	0	0	0	0
45	BONDS PAYABLE NET OF CURRENT PORTION	6,615,000	8,740,000	6,615,000	(2,125,000)
46	PREMIUM ON BONDS PAYABLE	389,368	535,373	401,535	(146,005)
47	CAPITAL LEASE, NET OF CURRENT PORTION	1,840,126	2,137,055	1,895,116	(296,929)
48	TOTAL NONCURRENT LIABILITIES	8,844,494	11,412,428	8,911,651	(2,567,934)
49	TOTAL LIABILITIES	21,896,851	24,734,996	20,665,644	(2,838,145)
50	DEFERRED INFLOW OF RESOURCES	0	0	0	0
51	PROPERTY TAXES RECEIVED IN ADVANCE	521,224	524,471	0	(3,247)
	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	85,569,134	83,090,268	85,672,052	2,478,866
56	UNRESTRICTED FUND BALANCE - KPB	0	0	0	0
		-	-	-	
57	**TOTAL LIAB & FUND BALANCE**	113,744,458	114,106,984	112,094,945	(362,526)

South Peninsula Hospital

INCOME STATEMENT
As of June 30, 2023
DRAFT-UNAUDITED

		MONTH				YEAR TO DATE			
		06/30/23			06/30/22	06/30/23			06/30/22
		Actual	Budget	Var B/(W)	Actual	Actual	Budget	Var B/(W)	Actual
	Patient Service Revenue								
1	Inpatient	2,256,940	3,874,819	-41.75%	3,998,319	29,692,327	39,697,046	-25.20%	36,792,325
2	Outpatient	14,281,977	13,046,430	9.47%	13,349,412	153,028,600	147,691,514	3.61%	134,629,817
3	Long Term Care	1,237,315	1,097,797	12.71%	744,542	13,025,807	13,173,563	-1.12%	10,335,760
4	Total Patient Services	17,776,232	18,019,046	-1.35%	18,092,273	195,746,734	200,562,123	-2.40%	181,757,902
	Deductions from Revenue								
5	Medicare	4,261,773	3,505,439	-21.58%	4,426,647	39,593,859	40,567,617	2.40%	37,850,170
6	Medicaid	1,604,483	2,488,022	35.51%	2,237,194	25,541,239	28,793,289	11.29%	24,401,598
7	Charity Care	210,289	148,804	-41.32%	50,783	2,006,711	1,722,068	-16.53%	226,295
8	Commercial and Admin	1,495,573	1,395,713	-7.15%	1,748,413	17,979,731	16,152,253	-11.31%	15,888,772
9	Bad Debt	773,381	327,246	-136.33%	540,256	3,258,563	3,787,166	13.96%	3,568,228
10	Total Deductions	8,345,499	7,865,224	-6.11%	9,003,293	88,380,103	91,022,393	2.90%	81,935,063
11	Net Patient Services	9,430,733	10,153,822	-7.12%	9,088,980	107,366,631	109,539,730	-1.98%	99,822,839
12	USAC and Other Revenue	58,347	61,665	-5.38%	58,904	755,856	739,978	2.15%	675,414
13	Total Operating Revenues	9,489,080	10,215,487	-7.11%	9,147,884	108,122,487	110,279,708	-1.96%	100,498,253
	Operating Expenses								
14	Salaries and Wages	4,780,586	4,539,624	-5.31%	3,935,215	51,627,763	50,557,659	-2.12%	47,034,508
15	Employee Benefits	2,110,145	1,235,336	-70.82%	1,365,682	22,896,504	25,105,944	8.80%	20,387,855
16	Supplies, Drugs and Food	817,607	1,189,486	31.26%	1,078,857	12,085,414	13,657,917	11.51%	12,827,585
17	Contract Staffing	196,312	229,401	14.42%	398,960	2,995,404	2,053,314	-45.88%	4,632,097
18	Professional Fees	448,187	522,487	14.22%	644,407	6,367,751	5,282,985	-20.53%	5,969,141
19	Utilities and Telephone	150,172	138,595	-8.35%	150,246	1,769,204	1,719,717	-2.88%	1,673,368
20	Insurance (gen'l, prof liab, property)	61,435	59,772	-2.78%	55,465	725,647	737,010	1.54%	654,421
21	Dues, Books, and Subscriptions	20,034	22,697	11.73%	17,054	225,413	253,034	10.92%	232,511
22	Software Maint/Support	138,063	221,678	37.72%	199,037	1,987,084	2,110,797	5.86%	1,893,583
23	Travel, Meetings, Education	49,807	83,294	40.20%	51,350	607,772	749,793	18.94%	552,188
24	Repairs and Maintenance	169,271	175,611	3.61%	187,221	1,868,153	1,608,826	-16.12%	1,635,672
25	Leases and Rentals	47,744	64,662	26.16%	8,274	754,629	810,377	6.88%	807,730
26	Other (Recruiting, Advertising, etc.)	299,789	83,092	-260.79%	156,413	1,823,605	997,325	-82.85%	1,206,740
27	Depreciation & Amortization	347,448	345,889	-0.45%	338,248	4,083,733	4,150,670	1.61%	3,959,365
28	Total Operating Expenses	9,636,600	8,911,624	-8.14%	8,586,429	109,818,076	109,795,368	-0.02%	103,466,764
29	**Gain (Loss) from Operations**	**(147,520)**	**1,303,863**	**111.31%**	**561,455**	**(1,695,589)**	**484,340**	**450.08%**	**(2,968,511)**
	Non-Operating Revenues								
30	General Property Taxes	19	80,306	-99.98%	22,673	4,895,002	4,713,311	3.85%	4,689,619
31	Investment Income	78,635	9,750	706.51%	(21,036)	561,753	117,005	380.11%	(155,225)
32	Governmental Subsidies	0	0	0.00%	0	0	0	0.00%	3,118,212
33	Other Non Operating Revenue	338	0	100.00%	0	8,408	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	551	6	9083.33%	2	4,376	70	6151.43%	47
37	Total Non-Operating Revenues	79,543	90,062	-11.68%	1,639	5,476,111	4,830,386	13.37%	7,732,037
	Non-Operating Expenses								
38	Insurance	0	0	0.00%	0	0	0	0.00%	0
39	Service Area Board	987	29,406	96.64%	(13,419)	100,656	118,000	0.00%	91,653
40	Other Direct Expense	7,655	3,600	-112.64%	12,407	27,774	43,202	35.71%	54,346
41	Administrative Non-Recurring	0	0	0.00%	0	0	0	0.00%	0
42	Interest Expense	38,347	28,432	-34.87%	156,247	465,841	341,178	-36.54%	510,810
43	Total Non-Operating Expenses	46,989	61,438	23.52%	155,235	594,271	502,380	-18.29%	656,809
	Grants								
44	Grant Revenue	14,551	29,167	0.00%	121,562	314,868	350,000	0.00%	1,372,032
45	Grant Expense	2,502	25,000	89.99%	3,101	30,018	300,000	89.99%	609,596
46	Total Non-Operating Gains, net	12,049	4,167	189.15%	118,461	284,850	50,000	-469.70%	762,436
47	Income <Loss> Before Transfers	(102,917)	1,336,654	107.70%	526,320	3,471,101	4,862,346	-28.61%	4,869,153
48	Operating Transfers	0	0	0.00%	0	0	0	0.00%	0
49	**Net Income**	**(102,917)**	**1,336,654**	**-107.70%**	**526,320**	**3,471,101**	**4,862,346**	**-28.61%**	**4,869,153**

DRAFT-UNAUDITED

South Peninsula Hospital

Statement of Cash Flows
As of June 30, 2023

	Cash Flow from Operations:		
1	YTD Net Income		3,471,101
2	Add: Depreciation Expense		4,083,733
3	Adj: Inventory (increase) / decrease		(67,529)
4	Patient Receivable (increase) / decrease		1,088,931
5	Prepaid Expenses (increase) / decrease		(7,216)
6	Other Current assets (increase) / decrease		258,340
7	Accounts payable increase / (decrease)		(457,061)
8	Accrued Salaries increase / (decrease)		228,298
9	Net Pension Asset (increase) / decrease		(404,563)
10	Other current liability increase / (decrease)		(682,209)
11	Net Cash Flow from Operations		7,511,825
	Cash Flow from Investing:		
12	Cash paid for the purchase of property/equip		(3,145,163)
13	Cash transferred to plant replacement fund		(1,276,373)
14	Proceeds from disposal of equipment		6,572
15	Net Cash Flow from Investing		(4,414,964)
	Cash Flow from Financing		
16	Cash paid for Lease Payable		-
17	Cash paid for Debt Service		(2,215,219)
18	Net Cash from Financing		(2,215,219)
19	Net increase in Cash	$	881,642
20	Beginning Cash as of July 1, 2022	$	33,050,441
21	Ending Cash as of June 30, 2023	$	33,932,083

South Peninsula Hospital	**SUBJECT:** Utilization Management Plan	**POLICY #** HW-312
		Page 1 of **8**
SCOPE: Hospital-Wide **RESPONSIBLE DEPARTMENT:** Nursing Administration		**ORIGINAL DATE:** 4/29/13 **REVISED:** draft
APPROVED BY: draft		**EFFECTIVE:** draft

I. Table of Contents

PURPOSE:
Program components and outline for the South Peninsula Hospital (SPH) Utilization Management Plan in accordance with federal, state, and local regulatory guidelines and requirements.

DEFINITION(S):
N/A

POLICY:

II. Missions, Vision, Values:

The foundation of the SPH Utility Management Plan is the organization's mission, vision, values, and associated behaviors:

Mission: *SPH promotes community health and wellness by providing personalized, high quality, locally coordinated healthcare.*

Vision: *SPH 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.*

III. Goals and Objectives

The Utilization Management Plan (UMP) supports the Mission and Vision of SPH by identifying processes which provide the hospital with strategies, systems, and methodologies required to monitor

and optimize the use of resources in the provision of patient care.

A. The goal of the UMP is to assure both quality patient care and effective/efficient utilization of the healthcare facility and services offered throughout the continuum of care. The UMP applies to all patients, regardless of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, gender identity, and sex characteristics), or payment source. The core functions of the UMP are as follows:
   - Case Management
   - Utilization Management
   - Discharge Planning
   - Evaluation of compliance with federal and state rules and regulations

B. Cooperation between Administration, the Medical Staff, and third party payers ensures that these goals are achieved. The UMP outlines continued efforts on the part of the Utilization Management (UM) Committee to inform and update Medical Staff and Administration on the emerging regulations and requirements for insurers, and the hospital's clinical and quality outcome experience.

C. The objective of the UMP is to:
   1. Assess the efficiency of the healthcare process, including but not limited to:
      a) The appropriateness of decision-making related to the site of care
      b) Frequency and duration as per established guidelines
      c) Timely review of the appropriateness of admissions and services ordered and provided
      d) Review of the length of stay, particularly as it applies to Critical Access Hospitals
   2. Assess discharge practices.
   3. Establish guidelines for medical record documentation with specific attention to federal guidelines and other sources of standards, and periodically review medical records to assess compliance with the guidelines.
   4. Systematically review hospital compliance with core measures and facilitate improving compliance with nationally recognized core measures and review any other internal or external UM or Quality Improvement (QI) data which could impact the financial health of the hospital.
   5. Review all Observation admissions for compliance with accepted criteria, and specially identify and report Observation admissions which would be more appropriately Acute Care admissions (Inpatient Status).
   6. Review all Inpatient admissions which are retrospectively changed to Observation status (condition code 44).
   7. Review all Swing Bed, current and potential.

IV. Responsibilities:

A. Governing Body:
The Board of Directors, as the governing body, delegates the Medical Staff as the authority to evaluate the appropriateness of care and use of hospital medical resources. The Governing Body monitors the program through reports generated by the Patient Centered Care Quality (PCCQ) Committee.

B. Administration:
Administration ensures that the Medical Staff is provided with the administrative and technical assistance to conduct the UM program.

C. Medical Staff:
The Medical Staff has the overall authority and responsibility for quality and appropriateness of medical services provided. The Medical Staff monitors the program through reports from the physician member of the UM Committee.

D. Physician Review:
The UMP will maintain two Physician Reviewers. The Physician Reviewers are physician members of the Medical Staff and UM Committee. These physicians are responsible for the review of all cases referred by the UM Nurse, making appropriate determination regarding the medical necessity for the patient's need for the specified level of care based on clinical judgement, and on screening

criteria. In addition, the Physician Reviewer(s) serve as liaison between the UM Committee and the Medical Executive Committee (MEC). In cases where there is disagreement regarding the UM Nurse recommendations having to do with admission status, length of stay, levels of care, intensity of service criteria, severity of illness criteria, and/or discharge recommendations, the following dispute resolution process will be followed.

1. The Physician Reviewer is notified concurrently by the UM Nurse or other UM staff and will review the information within one business day. If the Physician Reviewer is unavailable, then the Chief of Staff will conduct the concurrent review as the second UM physician reviewer.
2. The Physician Reviewer will then discuss his or her recommendations with the Attending Physician. If there is ongoing disagreement between the Physician Reviewer, and Attending Physician, then the Physician Reviewer will be required to obtain an opinion from another member of the Medical Staff; the decision of the Physician Reviewer and the other Medical Staff member will make the final determination and will communicate this determination to the UM Nurse and Administration.
3. A report of the case where there is ongoing disagreement will be sent to the MEC for review.

E. Finance:

The Finance Division ensures that revenue is being obtained by the hospital and that all appropriate avenues to obtaining revenue are being achieved. The Finance Division staff is responsible for collaborating with the UM Nurse and other staff as appropriate to identify areas of improvement for cost efficiency, both in providing services and in obtaining payment for those services. This division will collect and analyze statistical data to assist the UM Committee in review processes.

F. Utilization Management Nurse:

The UM Nurse is obligated to administer the UM Plan, and to facilitate the ongoing activities of the Committee. The UM Nurse is responsible for the collaborative discharge planning with appropriate Medical Staff and Social Services:

1. Prospective Review coordination
2. Admission Review, to be performed within one business day following admission. Exception would be admissions on weekends or holidays
3. Continued Stay Review, to be performed concurrently.
4. The following are specific criteria which mandate a concurrent UM review by the UM Physician Reviewer(s):
    a) Disagreement between Medical Staff Attending Physician and the Nurse Reviewer with respect to Discharge Recommendations, Admission vs. Observation status, and transfer to Swing Bed status.
    b) Physician failure to comply with Observation time limitations
    c) Patients who do not meet Standardized Severity of Illness and/or Intensity of Service criteria for admission or continued stay in the hospital
5. Maintain all Committee meeting minutes and records
6. Performance of other duties as delegated by the UM Committee
7. Prepare reports for MEC, other committee reporting, and Board (through the PCCQ Committee); The reports shall occur quarterly, and should contain at a minimum, the following:
    a) Average Acute Care (Inpatient) Length of Stay (LOS)
    b) Average Observation, Inpatient, and Swing Bed Census
    c) Length of Stay Outliers (both Observation and Inpatient)
    d) Compliance with Documentation Guidelines, if measured
    e) Review and analysis of national reports such as the Medicare Hospital Compare Reports.
8. Request for provider team meeting for patients with the following:
    a) Complex medical issues/diagnosis
    b) Re-admissions
    c) Admissions of seven days or more

G. Utilization Management (UM) Committee:

1. The UM Committee works to fulfill the purpose, goals and objectives of the UM Plan. The Committee is a multidisciplinary team The UM Committee meets quarterly. The UM Committee

shall maintain a record of its proceedings and shall report on its activities and recommendations at the Medical Staff meetings. The Committee forwards issues where opportunities for improvement have been identified to the Quality Improvement Committee, when appropriate.

2. Committee Records: The UM Committee maintains written records of all its activities. The proceedings of the Committee, its subcommittees and its derivative documents and minutes are confidential. Members of the committee have a duty to preserve this confidentiality. Minutes of each committee meeting, including a list of attendees, shall be documented and will include:
   a) A summary of admissions/discharges
   b) Reports of re-admissions, transfers, and extended stays
   c) Cases discussed (identified by medical record number)
   d) Committee action/recommendations
   e) Copies of notification letters sent to physicians and responses
   f) Record of cases indicated as reviewed concurrently
   g) A summary of denials/appeals in progress
   h) Insurance concerns/denials
   i) Focused reviews, including subject studies, the reasons for the study, the date the study was started, the date the study was completed, as well as the follow-up recommendations made from previous studies that have been implemented.
4. Upon request, a copy of the approved and signed UM Committee meeting minutes will be sent to the Chief of Staff for review. All records and minutes from the UM Committee will be maintained by the UM Nurse.
3. Conflict Of Interest: Physicians or staff may participate in the review of cases in which they have been or anticipate being professionally involved. Physicians or staff having either a direct or indirect financial interest in the case(s) being reviewed may not make the final decision in such cases. In these cases, the final review will be delegated to another appropriate and qualified physician or staff member.
4. Confidentiality: All employees and physicians involved in any component of the review system will be made aware of their responsibility to follow the confidentiality guidelines. All medical information that is related to and identifies specific individual patients and certain data related to practitioners and health care institutions is strictly confidential and shall not be made known or accessible to the public nor to any governmental unit, agency, or department without proper release of information documentation, with the exception of that information required to meet the Medicare Conditions of Participation. To ensure confidentiality, patient references will be only as a medical record number and physician references will be only as an assigned code number.
5. Review Criteria: Criteria, established by the UM Committee and approved by the Medical Staff for use by non-physician personnel, is used in screening utilization. The review criteria will be reviewed for appropriateness on a regular basis and revised as necessary. The guidelines currently utilized by SPH are the most recent Screening Criteria for Severity of Illness and Intensity of Service (SI/IS), published by InterQual, and recommended by 1) Mountain Pacific Quality Health Foundation 2) QualisHealth for review of patients covered by Medicare & Medicaid.
6. Review Activity: The review process focuses on five (5) primary areas of activity: prospective review, admission review, concurrent review, retrospective review and patient care evaluation studies. The review process may also include other areas of activity, as appropriate.
   a) Prospective Review/Pre-admission Review: The prospective review function is coordinated by the UM Nurse and includes Registration, Patient Accounting, and the admitting physician. Problems identified are resolved through the UM process. Appropriate steps shall be taken to ensure that patient well-being will not be compromised as the result of financial considerations.
   b) Admission Review: Admission review is performed on all patients using an approved screening tool. Additional in-depth review will be performed as required by third party payers and external professional review organizations. Inpatient records will be reviewed for compliance with the SI/IS criteria. Admission Review focuses on the medical necessity for

admission and continued hospital stay for all patients. The source of payment must not be the sole determinant in identifying patients for concurrent review.

1) The UM Nurse conducts an admission review within one working day of admission. The Attending Physician is responsible for providing documented information for admission within 24 hours of admission. This will include, but is not limited to, the admitting diagnosis, presenting signs and symptoms, and the physician's specific plan of care (treatment plan). The UM Nurse will gather information from the patient's medical record, compare the findings with the SI/IS criteria and record the results on a UM worksheet. If the admission meets criteria and is considered appropriate, the UM nurse will certify the admission and assign a continued stay review date based on the principle diagnosis and current plan of treatment.
2) Hospital admissions are reviewed either prior to or within one working day of admission for purposes of determining which cases require pre-admission certification or notification. The required information is obtained and reported to the appropriate external review agencies and third-party payers. Any authorization numbers assigned are also reported to the Patient Accounting office.
3) If the UM Nurse is unable to determine the need for admission, based on criteria, that same day the Attending Physician will be contacted for further information/documentation. Should this result in inability to determine that the patient meets admission criteria, the case will be referred to the Physician Reviewer, following the process outlined under § III. RESPONSIBILITIES, A-C.

c) Concurrent/Continued Stay Review: The concurrent or continued stay review is based on the patient's principal diagnosis, severity of illness, intensity of service, and/or other criteria established by the UM Committee. The same procedure will be used for continued and concurrent stay as the Admission Review. If a case meets criteria for continued stay, the UM Nurse will certify continued stay.
    1) If on the days under review, the UM Nurse cannot find adequate documentation to explain the need for continued stay at the specified level of care, he/she will approach the Attending Physician for the needed information or documentation. Justification for continued stay is based on the Attending Physician's documentation in the medical record.
    2) Cases that do not meet the criteria for continued stay after consultation and review with the Attending Physician will be referred to a Physician Reviewer, following the process outlined under § III. RESPONSIBILITIES, A-C. If this process determines that the case does not meet criteria for continued stay, the UM Nurse, after consultation with Administration, will then initiate an Advanced Beneficiary Notice (ABN) letter to be sent to the patient and/or family indicating the fact that the insurance may be discontinued for the remaining days of the hospital stay, and that the patient or guardian may be responsible for payment. Copies of the letter will be sent to the patient's medical record/EHR, the Patient Accounting Office and the UM Nurse's file. Attending physician will be notified.
d) Discharge Planning: Discharge Planning is an integral part of Utilization Management and shall be initiated early after admission to facilitate timely discharge. Discharge planning does not require a physician order. Discharge planning is a component of the combined duties of the UM Nurse, Social Services, and Nursing Staff. The hospital's discharge planning activities shall include placement in alternative care facilities, and arrangement for appropriate community resources to improve or maintain the patient's health status on an outpatient basis. The patient's family and Attending Physician must be involved in the discharge planning process. Discharge planning interventions must be documented in the medical record.
    1) There are occasions when the Attending Physician has written an order for discharge and the UM Nurse may identify that there is a delay in discharge due to lack of family (or patient) cooperation and decision-making or lack of family (or patient) resources. The

UM Nurse will then initiate a HABN letter to be sent to the patient and/or family indicating the fact that the insurance may be discontinued for the remaining days of the hospital stay after the specified discharge date and that the patient or guardian may be responsible for payment. Copies of the letter will be sent to the patient's medical record/EHR, the Patient Accounting Office and the UM Nurse's file. The attending physician will be notified.

e) Retrospective Review: Retrospective review will be performed in the following circumstances:
   1) To address cases of under- or over-utilization
   2) When third party payers question or deny care
   3) When required by third-party payer; and
   4) Focused review for known or suspected specific problems
      - The UM Committee initiates focused reviews of records and approves the sampling methods. Focused review will apply to all patients in the selected category regardless of payment source.
      - Focused reviews may be required based on data and trends related to diagnosis, procedures, admission, length of stay, ancillary services furnished, Observation status, Inpatient status, Swing Bed admissions, delay of services, and all professional services performed on the hospital premises with respect to the medical necessity for these services. Cases denied for payment by third party payers are also included.
      - The UM Committee identifies cases that are associated with unusually high costs or excessive services or identify classes of admissions wherein patterns of care are found to be questionable.
      - If analysis indicates inappropriate use of hospital resources, corrective action should be specific to the problem and may include a variety of problem-solving techniques, including, but not limited to, concurrent review, educational or training programs, amended policies or procedures, etc. Questions that deal with appropriateness and quality of the professional services rendered will be referred to the MEC. The MEC will, in turn, study, analyze and act upon its findings. A report of the results of such studies will be sent to the UM Committee.

7. Quality Improvement: The PCCQ Committee may, as appropriate, refer problems to the UM Committee in order for the UM Committee to conduct reviews of appropriateness and medical necessity upon admission, continued stays, and supportive services, delays in provision of supportive services, and the provision of discharge planning. The UM Committee may, as appropriate, refer those issues that are relevant to the quality of care provided to the PCCQ Committee for their input, recommendations, or suggested referrals.
8. Discipline: The UM Committee is not a disciplinary committee. Any perceived problems with Medical Staff members will be forwarded to the MEC by the Physician Reviewer(s) for consideration. Medical Staff members who frequently experience utilization review denials may be subjected to pre-admission monitoring or other restrictions that the Medical Staff deems necessary to correct the utilization-related problem(s).

V. Evaluation of the Utilization Management Program:

The SPH UM Plan is reviewed every three years and updated or modified as necessary, based upon the ongoing evaluation of the utilization review activities and their relationship to the quality of patient care. A summary of findings and specific recommendations resulting from the UM Program are reported to the MEC.

VI. Approval of the Plan.

The UM Plan will be reviewed, evaluated, and approved by the MEC and Board of Directors, and constitutes the official plan for performance and utilization review of this hospital's services.

CONTRIBUTOR(S):
Acute Care Nursing Director; Acute Care Medical Director; Social Services; Utilization Management; Chief Nursing Officer; Chief Medical Officer

APPENDIX A


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.

South Peninsula Hospital	**SUBJECT:** Hiring or Terminating Individuals in Key Positions	**POLICY #:** EMP-05 **Page 1** of **1**
Scope: Executive Leadership **Approved by:** Board of Directors		**Original Date:** 10/22/03 **Effective:** ~~6/23/2021~~
Revised: ~~11/20/19~~ **Reviewed:** ~~1/25/23~~		**Revision Responsibility:** Board of Directors

PURPOSE:
Requirements for hiring or termination of executive leadership personnel.

DEFINITION(S):
N/A

POLICY:
A. The CEO will notify the board in writing within 48 hours of hiring or terminating individuals in chief executive positions. ~~not terminate or hire individuals in the positions of the Chief Financial Officer or Chief Nursing Officer without first advising the Board of the planned action.~~
B. The borough must be notified within 14 days of any changes in ~~these positions or the~~ Chief Executive Officer, Chief Financial Officer or Chief Nursing Officer ~~position~~ in accordance with section 17 (e) of the Operating Agreement.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
1. Operating Agreement for South Peninsula Hospital with Kenai Peninsula Borough, 2020

CONTRIBUTORS:
Board of Directors

South Peninsula Hospital

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

MEMO

To: SPH Board of Directors

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

Date: July 19, 2023

Re: Annual Critical Access Hospital (CAH) Quality Assessment and Performance Improvement Evaluation

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The Annual CAH Quality Assessment and Performance Improvement Evaluation provides an evaluation of the quality activities and departmental accomplishments for FY 2023 along with goals developed for FY 2024 that impact the quality of care provided at South Peninsula Hospital (SPH). The Program evaluation also allows the opportunity to review and update current contracts and services offered/utilized as well as key statistics.

This evaluation is completed by the Quality Management Department with input from the SPH Administration and Department Directors and Managers to meet regulatory requirement §485.64: Periodic Evaluation and Quality Assurance Review per the State Operations Manual. The CAH Quality Assessment and Performance Improvement Evaluation is a tool available to State/Federal survey teams during the survey process.

Recommended Motion: Consideration to Approve the SPH CAH Quality Assessment Performance Improvement Evaluation for FY 2023.

2023

South Peninsula Hospital (SPH)

CRITICAL ACCESS HOSPITAL (CAH)
2023 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT EVALUATION

South Peninsula Hospital

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SOUTH PENINSULA HOSPITAL-CRITICAL ACCESS HOSPITAL
FY 2023 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT EVALUATION

The designation of Critical Access Hospital (CAH) for South Peninsula Hospital (SPH) continues to be beneficial for both the hospital and the service area. The overall annual CAH Program Evaluation of SPH activities for FY 2023 has been completed as indicated in this document per State Operations Manual interpretive guidelines§485.641: Periodic Evaluation and Quality Assurance Review.

I. INTERVAL OF REPORTING PERIOD

This annual Critical Access Hospital Program Evaluation review period coincides with the fiscal year beginning July 01, 2022 and ending June 30, 2023. The hospital was designated Critical Access on August 07, 2008.

II. PATIENT VOLUME AND SERVICES UTILIZED

Acute Care and Swing bed days were 3,373 during this reporting period, a 13% decrease from the prior year. Emergency Department visits increased 6 % from the prior year to 5,502visits. Other outpatient visits decreased 16% from the year prior 91,793 visits with the biggest decrease being lab visits related to COVID-19 testing. The number of births decreased 10% from the year prior down to 124 births. Inpatient surgical procedures decreased by 44% to 120 surgeries. Outpatient surgical procedures increased 9% up to 1,464 total outpatient surgeries. Imaging procedures experienced an 4% increase in volume: X-Ray increased by 3%, CT scans increased by 5%, Ultrasound increased by 7%, Mammography volume increased by 8%, MRI decreased by 4%.

KEY STATISTICS

	2019	2020	2021	2022	2023	% Chg. 2021- 2022
Acute Care Patient Days with Swing Bed	2,875	3,196	3,420	3,867	3,373	-13%
Newborn Deliveries	157	131	145	138	124	-10%
Emergency Dept. Visits	4,629	4,285	4,382	5,181	5,502	6%
Surgery Outpatient	1,376	1,029	1,327	1,344	1,464	9%
Surgery Inpatient	261	267	201	213	120	-44%
Outpatient visits	78,519	77,307	93,961	109,452	91,793	-16%
X-Ray	7,400	6,926	7,150	7,812	8,026	3%
CT Scan	3,843	3,469	3,753	4,540	4,782	5%
Ultrasound	3,044	2,765	2,843	2,824	3,017	7%
Mammography	1,152	947	1,250	1,159	1,250	8%
MRI	1,470	1,358	1,513	1,552	1,485	-4%
Imaging Total	17,211	15,717	16,852	17,887	18,567	4%

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III. NEW SERVICES

SPH welcomed new additions to the administrative/management team:

- Angela Hinnegan, CPA, MHL: COO
- Anna Hermanson, MS, MBA, CHFP, CSAF: CFO
- Matthew Dickinson, Nut. Serv.: Asst. Manager
- Adam Darden: Security Supervisor
- Janyce Bridges: Asst. Director of Nursing, LTC
- Stephen Goetz/Daniel Skousen: RT Super *(Job Share)*, RS
- Leann Matysczak, RN: Asst. Manager, HMC
- Craig Caldwell, RN: ED Director
- Vincent Greear: Pharmacy Director
- Kelly Gallios: HIM Manager
- Mesille Mershon: Asst. Clinic Manager, FCC

- Kira Bendixen, DO, C-NMM/OMM, joined South Peninsula Hospital *(SPH)* full-time in the hospitalist program.
- Erin Murphy, MD, an emergency medicine trained physician joined SPH Emergency Department.
- Raquel Ezrati, FNP joined SPH Long Term Care to provide adult and gerontology services.
- Pamela Williams, DO joined Homer Medical Center *(HMC)* to provide occasional obstetrics coverage.
- Joe Llenos, MD, joined HMC to provide full time family practice services.
- Emma Mayfield, DO, also joined HMC to provide full time family practice services.
- Susan Jackson, RN, NP joined SPH's general surgery team supporting the outpatient South Peninsula General Surgery Clinic.
- Kathy Madej, CRNA, joined the SPH anesthesia team, providing nurse anesthetist service within the Surgical Services Department.
- Bonnie Turner, FNP, joined HMC
- Pamela Williams, DO, joined HMC OB/GYN

IV. MANAGEMENT AND DEPARTMENT ACTIVITIES/ACCOMPLISHMENTS

Department Reports – Past year Accomplishments and Highlights, along with FY 2024 Goals and Objectives found in Appendix A

V. SURVEYS

- August 25, 2022: SPH Laboratory complaint survey regarding collecting and labeling blood bank specimens. Recertification survey conducted on December 14 and 15, 2022; with recommendation for SPH Laboratory be recertified in the CLIA program.
- September 27, 2022: Successful State of Alaska On-site and Remote Inspection of Facility/Device-Three sites providing Imaging Services. No issues of non-compliance were found.
- October 04, 2022: State of Alaska Board of Pharmacy conducted an Inspection of the SPH Pharmacy with no deficiencies identified.
- October 11, 2022: Trauma Level IV reverification, this is a voluntary status SPH has chosen to participate in and focus ED efforts. Trauma Registry with corresponding quality improvement activities related to trauma cases is focus moving forward with revisit in June 2023.
- Updates for K916 Waiver Extension, related to the annunciator panel for the emergency generator room are provided to State of Alaska quarterly as required.
- May 08-12, 2023: LTC Facility CMS survey. Ancillary department participation in the LTC Facility survey.

- June 19, 2023: Successful completion of SPH focused review for Level IV Trauma Center designation.

VI. INPATIENT AVERAGE LENGTH OF STAY

The average length of stay was 3.3 days for this annual reporting period, well within the 96-hour maximum average requirement for CAHs.

VII. NUMBER OF INPATIENT/SWING BED EXCEEDING LIMIT

The number of Swing Bed patients and Inpatients did not exceed the 22 Acute Care licensed bed capacity for this reporting period.

VIII. ON-CALL HEALTH PROVIDERS

Health Provider specialties routinely on-call for 24-hour/day coverage are as follows: General Surgeons; Orthopedist and PA; OB/GYN physicians; CRNAs; CNMs; Radiology techs; OR nurses & techs & Respiratory Therapists.

IX. APPROPRIATE TRANSFERS

All patient transfers routinely reviewed by the Trauma Coordinator and Trauma Medical Director. The transfer records continue to be reviewed by the appropriate individuals to include the Utilization Management nurse, the Director of ED or Medical Records managers on a concurrent basis.

X. EMERGENCY DEPARTMENT RECORD REVIEW

A system of patient chart review of physician and nursing documentation was performed by Emergency Department staff. The HIM department audit nursing documentation to determine the appropriate charge.

XI. PROCESS UTILIZED TO EVALUATE THE QUALITY OF CARE

The quality of care for South Peninsula Hospital *(SPH)* is evaluated in multiple ways as outlined in the SPH Quality Plan. The SPH and LTC Facility Quality Plan was updated, shared with Patient Centered Quality Care Committee *(PCCQC),* and approved May 24, 2023 by the SPH Board of Directors *(BOD).* The LTC Facility QAPI Plan is an addendum to the SPH and LTC Facility Quality Plan and was also approved by the BOD at their May meeting.

SPH strives to reduce potential or actual harm by focusing on quality and safety improvements. A risk classification grid found in the Quality Plan, was utilized to determine the level of harm to specific events reported. Medication errors were classified according to the National Coordinating Council for Medication Error Reporting and Prevention *(NCC MERP).* The SPH Board of Trustees Balanced Scorecard *(BSC)* was used to track and measure progress of organizational indicators chosen to represent the entire organization. The BSC was shared quarterly with the PCCQC, monthly with BOD, and was available for all staff on the Staff Information Site. The Quality Improvement change model, Plan-Do-Study-Act *(PDSA)* was utilized to track progress of those indicators not meeting identified targets on the Balanced Scorecard.

SPH continued to work closely with the Alaska Hospital and Healthcare Association *(AHHA)* and participated in the Hospital Engagement Network *(HEN).* As part of the HEN and through the Partnership for Patients Initiative, SPH agreed to participate in a multi-state quality initiative to improve care provided at the bedside. In coordination with AHHA, SPH reported monthly quality data to Telligen QI Connect, Hospital Quality Improvement Contractor *(HQIC)* through the American Hospital Association Comprehensive Data System. SPH participated in Consumer Assessment of Healthcare Providers and Systems *(CAHPS)* surveys for

qualifying inpatients of the hospital and clients of Home Health. The Hospital CAHPS and Home Health CAHPS survey results were reviewed and communicated for opportunities of improvement in care provided. SPH contracts with Press-Ganey Associates, Inc., for completing CAHPS surveys as well as obtaining patient satisfaction information for outpatient services including Laboratory, Imaging, Rehabilitation, Emergency Room, Ambulatory Surgery and Clinic Services.

The Patient Centered Care Quality Committee *(PCCQC)* is an organization-wide committee including Home Health Services and the Long Term Care Facility. The PCCQC meets quarterly and oversees the existing and new quality improvement activities. The reporting focus to PCCQC include Department Quality Improvement Activities, Balanced Scorecard indicators falling below target numbers, and Root-Cause-Analysis activities conducted in the organization. The Balanced Scorecard has been presented to the committee along with PDSA information to reflect areas of improvement opportunities. PCCQC meeting minutes and CAHPS information was shared quarterly with the SPH Board of Directors.

SPH continued to participate in the Medicare Beneficiary Quality Improvement Project through the State of Alaska with reporting requirements of Core Measure data to Centers for Medicare and Medicaid Services *(CMS).* This was accomplished, by completing chart abstractions for Inpatient Sepsis Core Measure data and Outpatient measures including Stroke, Acute Myocardial Infarction, and admit to discharge timelines in the Emergency Room. Reporting for *"Left without Being Seen", "Elective Delivery"* of infants before thirty-nine *(39)* weeks and appropriate follow up recommendations for Colonoscopy continues annually. Emergency Department Transfer Communication *(EDTC)* is completed quarterly by ED staff.

Revision of the SPH and LTC Facility Corporate Compliance & Ethics Program was completed and approved by the SPH Board of Directors on December 07, 2022. The SPH Enterprise Risk Management Plan is undergoing revisions including assessment and prioritization of organizational risks.

XII. HEALTHCARE ASSOCIATED INFECTIONS – APPROPRIATE USE OF MEDICATION

South Peninsula Hospital voluntarily reports to the National Health Safety Network (NHSN) for the following, both the entire hospital and the Long Term Care Facility:

- Catheter associated urinary tract infections
- Central line infections
- Ventilator associated pneumonia
- Multi drug resistant organisms *(MRSA Bacteremia and C-difficile)*
- Surgical Site Infections *(inpatient surgeries of the colon, knee replacement and abdominal hysterectomies)*
- Influenza vaccination rates for all hospital facility personnel *(includes Contract Staff, volunteers, and students)*
- Antimicrobial Use/ Resistance
- Mandatory COVID-19 data *(Healthcare Worker Vaccination Summaries, daily census reporting, LTC preparedness and resident vaccination data)*

Surgical site infections were reported and reviewed quarterly at the SPH Infection Prevention Committee Meeting. An Antimicrobial Stewardship Program focusing on prevention and organism specific guidelines for treatment is in place. Team members include the Infection Prevention Nurse, Infection Prevention Physician, and a Clinical Pharmacist with infectious disease training.

South Peninsula Hospital

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XIII. CONTRACT SERVICES REVIEW

1. 340B DIRECT

Type of Service
Accumulates and processes information on outpatient prescriptions from our providers and filled at the local Safeway Pharmacy. They pull out data on medications that can be purchased at 340B pricing for sale to the pharmacy, and manage invoicing for these items.

Evaluation Comments
Necessary and meeting our needs in running a successful 340B outpatient program.

2. 3M FLUENCY

Type of Service
A compilation of various medical transcription support programs utilized for provider documentation in the electronic medical record systems used at South Peninsula Hospital. The programs include:

- Fluency for Imaging *(FFI):* voice recognition software *(VRS)* specially designed for radiologists that supports imaging reports completion, including signature, at the time of service.
- Aquity Solutions: supports provider transcription services through a contracted, domestic transcription service. SPH HIM staff manage the Aquity Solutions incoming queue.
- Fluency Direct *(FD):* VRS that supports provider medical care notes completion, including signature, at the time of service.

Evaluation Comments
Effective software supporting real-time provider documentation within the electronic medical record systems.

- FFI is utilized 100% of the time to complete imaging reports by the radiologists.
- Aquity Solutions is regularly utilized by SPH surgeons for operative notes and patient progress notes. The turnaround time from dictation to transcription ready for signature is most often less than 1 hour.
- The FD application is available for all providers at SPH. Approximately fifty percent of SPH providers actively utilize this voice recognition software to complete their patient documentation responsibilities.

3. ALASKA HEART INSTITUTE

Type of Service
Provides interpretations of echocardiograms and EKGs performed at SPH. Provides Cardiology Clinic Services through a space-use agreement 1-2 days/month and device clinic for pacemakers/defibrillators quarterly. SPH has contracts in place to cover these types of services listed.

Evaluation Comments
All cardiologists associated with the Alaska Heart Institute are licensed by the State of Alaska and credentialed by SPH. Alaska Heart providers are courteous, knowledgeable and provide excellent care and a great service for our cardiac patients.

4. ALASKA IMAGING ASSOCIATES

Type of Service
Provides LOCUM radiologist to cover for radiologist vacations and they provide tele-radiology support to supplement our on-site radiologists to ensure that we keep acceptable turn-around times.

Evaluation Comments
Anticipate they will eventually replace vRad for nighthawk coverage.

5. ALASKA REGIONAL

Type of Service
Patient Transfer Agreement

Evaluation Comments
Very cooperative and helpful with transfers.

6. ALASKA REGIONAL HOSPITAL BLOOD BANK

Type of Service
Alaska Regional Blood Bank provides antibody identification testing for SPH. The main laboratory also does a few esoteric tests if a test is needed quickly.

Evaluation Comments
SPH has been pleased with the services offered by Alaska Regional and the contract pricing received on the few esoteric tests that need to be performed with quick turn-around-time not provided by Quest Diagnostics Laboratory.

Alaska Regional has CLIA and College of American Pathologists *(CAP)* Certifications.

7. ALASKA HOSPITAL AND HEALTHCARE ASSOCIATION *(AHHA)*

Type of Service
State hospital association representing Alaska hospitals and nursing homes to meet common goals and improve quality of care provided to the patients and residents served. AHHA provides multiple educational and quality improvement opportunities to meet best practice standards. AHHA facilitated coordination and data sharing between Alaska State hospitals including SPH and Telligen QI Connect, Hospital Quality Improvement Contractor *(HQIC).* SPH has a data sharing agreement with AHHA and Telligen. The SPH Home Health Agency and Long Term Care Facility are also supported by AHHA activities.

Evaluation Comments
SPH continues to have an excellent partnership with AHHA. Over the past year, SPH received grant support facilitated by AHHA for our quality improvement activities. The funding has assisted with patient satisfaction survey, data gathering and analysis. The leadership for AHHA has been responsive to all questions the QM department and others in the organization has had regarding quality improvement opportunities/process improvement, legislative issues, etc. They have been a wonderful resource for our organization.

8. ALSCO, AMERICAN LINEN DIVISION

Type of Service
Linen and Uniform Rental Service

Evaluation Comments
Supplies the hospital and clinics with linen and laundry service as well as provides employee scrubs and Nutrition Services uniforms. This service provides an adequate supply of clean linens and uniforms.

9. ATHENAHEALTH

Type of Service
Athenahealth provides an electronic medical record and billing platform for our provider clinics.

Evaluation Comments
Necessary and meeting our clinical and billing needs.

10. BLOOD BANK OF ALASKA *(BBA)*

Type of Service
Provides for the blood supply for the hospital, including packed red cells, fresh frozen plasma, and platelets. This stock is provided on a rotating basis, with unused units being shipped back to BBA before they outdate for credit. The BBA also screens units for known antibodies for units and supplies to SPH.

Evaluation Comments
The service provided is timely and efficient. The Lab Director would like to see BBA expand their services to provide antibody identification to Alaska hospitals. Currently SPH sends specimens to Alaska Regional Laboratory for antibody identification and then the information is transferred to BBA to complete the screening of units. The units are then shipped to SPH where a cross match is performed. In most Blood Bank facilities, antibody identification is performed, units screened, and a cross match performed and then the units are shipped to the hospital, saving time and money. There is a contract with the facility that is ongoing, copy on file in the laboratory.

Blood Bank of Alaska has Clinical Laboratory Improvement Amendments (*CLIA*) and American Association of Blood Bank (*AABB*) Certifications.

11. BLOODWORKS NORTHWEST

Type of Service:
Bloodworks Northwest performs difficult workups for antibody identification and special blood bank procedures that are not available at Alaska Regional Blood Bank Laboratory.

Evaluation Comments:
Excellent staff with broad blood bank knowledge base. There is no annual contract. Bloodworks Northwest is certified by CLIA, the State of Washington, CAP and AABB.

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12. CENTRAL PENINSULA HOSPITAL

Type of Service
Patient Transfer Agreement

Evaluation Comments
Available, cooperative and responsive as needed.

13. CENTRAL PENINSULA HOSPITAL PATHOLOGY

Type of Service
Pathology Services

Evaluation Comments
All surgical specimens and non-gynecological cytology specimens go to Central Peninsula Hospital (*CPH*) Pathology for examination. CPH Pathology became our pathology provider on May 1, 2022. Surgical specimens are transported Monday through Friday by expeditor from SPH to CPH Pathology around noon. CPH Pathology covers the cost of transportation for one time each day. CPH Pathology bills the patients directly for the services, with the exception of the technical component for Medicare, VA, and Medicaid patients, with reports sent directly to the ordering physician and a copy goes to SPH Health Information Management. CPH Pathology is CLIA and CAP certified.

14. CIRRUS 340B

Type of Service
Accumulates and processes information on outpatient prescriptions from our providers and filled at the local Ulmers Drug and Hardware Pharmacy. They retrieve data on medications that can be purchased at 340B pricing for sale to the pharmacy, and manage invoicing for these items.

Evaluation Comments
Necessary and meeting our needs in running a successful 340B outpatient program.

15. CONTRACT PHYSICAL THERAPY AGENCY

Type of Service
Contract Physical Therapy

Evaluation Comments
Currently we do not have any contract staffing**.**

16. CPSI/EVIDENT

Type of Service
CPSI/Evident provides an electronic medical record and billing platform for our hospital and outpatient services**.**

Evaluation Comments
Necessary and meeting our hospital-based and billing needs.

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17. CROWDSTRIKE

Type of Service
Anti-virus System

Evaluation Comments
Computer processed based detection with 24/7 vendor management.

18. DUO

Type of Service
Multifactor Authentication for remote access

Evaluation Comments:
Cyber security program layer. Requires accepting push notification with remote access attempt.

19. ECONET

Type of Service
Sentinel Intrusion Prevention System and Intrusion Detection System (*IPS and IDS*)

Evaluation Comments
IPS and IDS have proven to be a very important layer to the SPH cyber security program. As managed devices by the company and IT staff, it blocks offending IP addresses as they try to access our network. As proof to its success, our security assessment firm was penetration testing our network and they could not make it past these devices until we whitelisted their IP's.

20. ENTECH ALASKA, LLC

Type of Service
Biohazard waste disposal

Evaluation Comments
This service picks-up, transports and properly disposes of the biohazard waste on a bi-monthly basis. It is also available for extra pick-ups as needed when called. This service meets the hospital's biohazard waste disposal requirements.

21. HEALTHSTREAM

Type of Service
Learning Management System, Course Authoring Center, Educational Libraries & Certification Tracking

Evaluation Comments
Primary vehicle for online staff education. Provides appropriate content to meet regulatory training requirements and offers contact hours needed for license renewals.

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22. HOSPICE OF HOMER

Type of Service
Provides coordinated volunteer hospice services, a volunteer visitor program and an equipment loan program**.**

Evaluation Comments
SPH currently has an Independent Contractor Agreement with this charitable organization. Hospice of Homer is a volunteer group and are not certified, nor considered an agency. Hospice of Homer is a resource to SPH.

23. IBOSS

Type of Service
Web filter

Evaluation Comments:
Web filter is another layered asset to our cyber security program. It filters and monitors traffic incoming and outgoing from our network. It performs very well and we are very pleased with the device.

24. ICOMETRIX

Type of Service
Artificial Intelligence (AI) software that is capable of detecting the progress of diseases like Multiple Sclerosis (*MS*) and dementia in the brain and creating a report for clinicians to help in the treatment of MS and Dementia.

Evaluation Comments
This software has been installed, tested and is in full use. The improved diagnostics produced by this AI software has greatly increased the value of our advanced imaging services to patients and providers.

25. IMPRIVATA

Type of Service
Biometric Password Management

Evaluation Comments:
Instead of manually typing ID's and passwords, Imprivata allows for badge-reader and finger print recognition and logging onto workstations and applications. It is proven to allow auto locking of workstations when not in use. Ease of use logging back into the PCs while saving clinicians time and effort of manually logging in. It saves ID's and passwords for multiple applications so staff can log into those applications with just one click of a mouse.

26. IOWA STATE HYGIENIC LABORATORY – THE UNIVERSITY OF IOWA

Type of Service
Perform newborn screening testing on all newborns from SPH.

Evaluation Comments
Quality laboratory with good communication and follow up. The State of Alaska administers the Newborn Screening Program and determines the laboratory that will perform the testing. There is no contract with Iowa State Hygienic Laboratory. The lab is CLIA certified.

27. KACHEMAK BAY FAMILY PLANNING CLINIC (*KBFPC)*

Type of Service
Memorandum of Agreement to provide vasectomy procedures for KBFPC Title X clients.

Evaluation Comments
Our General Surgery Department provides in-office vasectomies for a predetermined cost to these clients.

28. KACE

Type of Service
Endpoint and server operating system software patching management system.

Evaluation Comments
Very important process in our cyber security defenses.

29. KEPRO

Type of Service:
Beneficiary and Family Centered Care (*FCC*) Quality Improvement Organization (*QIO*) for Medicare beneficiaries through Centers for Medicare and Medicaid Services (*CMS*).

Evaluation Comments
Minimal interaction with this QIO. Policies and communications are updated with their information.as required.

30. KINNSER/WELLSKY

Type of Service
Electronic medical record for Home Health Department

Evaluation Comments:
Effective software that meets the needs of the Home Health Department. No paper records in the Home Health Department. Software meets the needs for Home Health at this time.

31. MAAS360

Type of Service
Email program for Non and SPH owned mobile devices.

Evaluation Comments:
Requires IT hands on the device to set up. Reduces un-authorized devices from accessing our email system.

32.* MCKESSON *(CHANGE HEALTHCARE)

Type of Service
Software used to determine appropriate inpatient level of care.

Evaluation Comments
Valuable to confirm patient's admission status is correct to match level of care.

33. MCN HEALTHCARE *(POLICY MANAGER SYSTEM)*

Type of Service
Electronic Policy Management software utilized for review, update and revision of departmental and hospital-wide policies, plans and forms. Allows for an automated electronic approval process.

Evaluation Comments
The system is becoming more user friendly as the team is educated on the functions available. SPH continues to utilize a contracted consultant to help update and reorganize policies within the system. The Policy Manager System is dependent upon good internal processes maintaining the email system and training/engagement of the users. This system continues to be of great help with organization of policies, associated documents, forms and protocols.

34. MD-STAFF / MD-STAT

Type of Service
MD Staff is the credentialing software, which includes predefined reports and customizable form letters with complete document tracking, including the ability to build your own custom reports and documents. MD-STAT is the peer review portion of the system.

Evaluation Comments
A newly implemented software that better meets the current needs of the organization regarding credentialing. Peer reviews through MD-STAT is functional but not completely implemented as of yet. The Ongoing Professional Practice Evaluation tool is currently under development.

35. MEDICAL DIRECTOR FOR SPH LAB

Type of Service
South Peninsula Hospital has a contract with Central Peninsula Hospital (*CPH*), Dr. Nicole Nilson and Dr. Mensch, for services as the Medical Director of the Laboratory. This contract is reviewed by administration annually. Dr. Nilson has a quarterly onsite visit to the SPH laboratory to review Quality Control records, proficiency testing results, and policies and procedures.

Evaluation Comments
Dr. Nilson has been the Medical Director since May 01, 2022 and the contractual relationship with CPH is going well. Dr. Nilson is responsive and timely and our laboratory is pleased with the pathology services received.

36. MEDICAL SOLUTIONS

Type of Service
Travel nursing agency.

Evaluation Comments
Staffing partner to fill workforce gaps that are unable to be occupied by regular staff. SPH created a positive and productive relationship.

37. MEDICATION REVIEW *(TELEPHARMACY SERVICES)*

Type of Service
Provides for remote pharmacist to review/initiate medications after hours, weekends and as needed. This individual assists nursing staff and physician with medication issues – working in concert with our in-house pharmacy staff.

Evaluation Comments
Service continues to function well.

38. MEDITRAX

Type of Service
Software enables documentation of employee health and worker's compensation surveillance.

Evaluation Comments
This program is effective and meets departmental needs.

39. MEDTRONICS

Type of Service
Diabetes Insulin Pump Patient Usage Training.

Evaluation Comments
Reimbursement for Diabetes Educator to provide training for patients on new Medtronics diabetic insulin pump units.

40. MIMECAST AT

Type of Service
Security Awareness Training.

Evaluation Comments:
Awareness training is the best form of defense. The IT Department provides monthly training and tests all staff members with different phishing campaigns to see if they could fall for a real phishing email threat. Once a quarter we provide additional training for staff that fail phishing tests.

41. MONIDA HEALTHCARE NETWORK

Type of Service
Hospital Peer Review Services.

Evaluation Comments
Primary agency for peer review requests through Medical Staff Office. Customer Services is typically good with a quick turnaround time and tends to be more affordable.

42. MOUNTAIN PACIFIC QUALITY HEALTH

Type of Service:
A quality improvement organization assisting hospitals with reporting requirements and quality initiatives.

Evaluation Comments:
Mountain Pacific provides free materials for educational purposes through their website. Mountain Pacific remains an important resource for Core Measure reporting and is responsive to all questions from the Quality Management Department.

43. MSDS ONLINE

Type of Service
Provides 24/7 availability to chemical Safety Data Sheets through a computer database as well as a fax back service.

Evaluation Comments
System meets the hospital needs.

44. NEWPORT GROUP

Type of Service
Retirement plans record-keeper.

Evaluation Comments
Selected record-keeper based on the user experience for administrators and staff. Able to consolidate defined benefit and 403(b) and 457 plan to this record-keeper.

45. OBIX SYSTEM

Type Service
OBIX provides an electronic medical record and electronic fetal monitoring platform for our inpatient labor and delivery department for antepartum and intrapartum patients.

Evaluation Comments
Essential software service and is satisfactorily meeting our clinical and patient care needs. OBIX will no longer support our current software version and will be providing a free upgrade to us before January 2024. The upgrade will allow SPH OB to better screen and document for sepsis and other high-risk categories. With that upgrade, we will be adding a Uterine Assessment Tool that will allow nurses to

more accurately assess the electronic fetal monitoring tracing, identify labor complications, and is a staff multiplier.

46. OMNIA

Type of Service
Non-medical Group Purchasing Organization (GPO).

Evaluation Comments
Need identified, as Healthcare GPOs are unable to provide for non-medical needs *(i.e. Maintenance, supplies, IT…).* Joined in concert with Kenai Peninsula Borough. Available and responsive as needed.

47. OMNIPOD PUMP TRAINING

Type of Service
Diabetes Insulin Pump Patient Usage Training.

Evaluation Comments
Reimbursement for Diabetes Educator to provide training for patients on new Tandem diabetic insulin pump units.

48. POINT CLICK CARE

Type of Service
Electronic medical record for Long Term Care facility.

Evaluation Comments:
Effective software specialized to meet the needs of Long Term Care.

49. POWERSHARE

Type of Service
PowerShare is an image-sharing platform that is HIPAA complaint and enables secure sharing of radiology images and reports between disparate institutions and physicians via the Internet.

Evaluation Comments
PowerShare is a 24 hours a day, 7 days a week software program provided by Nuance, a vendor of PACS associated systems. The account with Nuance is a flat rate, which seems better for SPH due to the frequent use of the system. Imaging is very pleased with PowerShare and is currently sending all echocardiograms to Alaska Heart Institute via PowerShare.

50. PREMIER

Type of Service
Healthcare Group Purchasing Organization (GPO).

Evaluation Comments
Provider of medical supplies. Available and responsive as needed.

51. PRESSGANEY ASSOCIATES, INC.

Type of Service
Data collection of patient satisfaction for patients receiving care as Inpatients or through the Emergency Department, Ambulatory Surgery, Outpatient Services, Home Health as well as Medical Practice. PressGaney is the vendor of choice for SPH HCAHPS and HHCAHPS data collection and reporting.

Evaluation Comments
The voice of the consumer that Press Ganey data collection provides SPH is invaluable. They are effective at collecting feedback through survey and their platform is useful for manipulating and displaying the data. One issue SPH had is that Press Ganey will not suppress surveys from going to patients that request not to receive them. Press Ganey sends out HHCAHPS only via mail. HHCAHPS questions are listed after the Press Ganey questions on the mailed material and the HHCAHPS question fields are set up less effectively than the Press Ganey questions on the forms. Some surveys are not reviewable independently unless patient clicks a certain box. If a patient wants their name removed the entire survey is not viewable. You can only see results on the report that has all surveys grouped together.

52. PROVIDENCE MEDICAL CENTER

Type of Service
Patient Transfer Agreement, eICU, TeleStroke and Telepsych services.

Evaluation Comments
Very cooperative and responsive with transfers. Cooperative in supporting telemedicine services within our facility and utilizing eICU, TeleStroke, and Telepsych.

53. QUEST DIAGNOSTICS

Type of Service
Quest Diagnostics is South Peninsula Hospital's primary reference laboratory for esoteric testing. It has been our reference laboratory for seventeen years.

Evaluation Comments
SPH has had a good relationship with them, and Quest continues to offer excellent results and customer service. Our customer representative is responsive to our needs. There is an interface with our hospital system and the Quest computer. There is a contract that is reviewed annually. Quest is certified by CLIA, the State of Washington, and CAP.

54. QURE4U

Type of Service
Digital health platform integrated within the AthenaHealth EHR to streamline and simplify setting appointments, completing medical appointment intake forms, and supporting telehealth visits within the HIPAA-compliant application.

Evaluation Comments
This platform supports improved patient engagement between the patient and healthcare provider to help meet the patient's personal healthcare needs. Two SPH specialty providers use this application.

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55. RADIOLOGY CONSULTANTS INC.

Type of Service
Provides LOCUM radiologist to cover for radiologist vacations and they provide tele-radiology support to supplement our on-site radiologists to ensure that we keep acceptable turn-around times.

Evaluation Comments
SPH did experience a transition in our remote and locums Radiologist coverage from Alaska Imaging Associates (*AIA*) in Anchorage to Radiology Consultants Inc. (*RCI*) in Fairbanks during the year. AIA was unable to meet our needs for coverage due to staffing. SPH is currently receiving night, weekend, and on-site Radiologist coverage from RCI for all modalities except for Mammography. Currently our Mammography coverage is supplied by Dr. Maureen Filipek when our employed Radiologist is unavailable. RCI has begun to replace vRad for night and weekend reads (*Nighthawk*), however a contract still exists with vRad as a backup measure.

56. REDSAIL TECHNOLOGIES

Type of Service
Software for processing and billing Long Term Care prescriptions.

Evaluation Comments
Necessary and meeting our needs for electronic communication of medication orders from Point Click Care and for submitting electronic claims to our residents medication insurance.

57. RLDATIX

Type of Service
Electronic system for reporting incidents and occurrences in the organization.

Evaluation Comments
Staff are able to electronically submit occurrence reports and track where the occurrence reporting is in the system. Implementation continues with changes to flow of system and dashboard development.

58. RQI PARTNERS LLC

Type of Service
This service offers flexible certification options utilizing online adaptive learning and a voice-assisted manikin for BLS, ACLS and PALS.

Evaluation Comments
Staff used this service to obtain certification during the COVID pandemic when classes were limited. This service continues to offer flexible certification renewal options for staff increasing provider certifications.

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59. SEATTLE CHILDREN'S HOSPITAL

Type of Service
Interpretations of Pediatric echocardiograms performed at SPH.

Evaluation Comments
Echo preliminary reads are generally received within one to two days of the time that the echo is sent for reading. Final reads are generally received within three to four days. This service has been working well to date.

60. SIMITREE

Type of Service
Out-Sourced ICD-10 coding, OASIS review and compile Plan of Care. Intermittent audit support.

Evaluation Comments
Outstanding service. Helps with accurate coding and OASIS review to maximize our episodic reimbursement. No changes in quality of service with merger.

61. SPECIALTY CLINIC PRACTITIONERS

Type of Service
Provision of various Specialty Clinic services within the facility.

Evaluation Comments
All Specialty Clinic practitioners are credentialed by the SPH Medical Staff and Board of Directors, including:

James Andrews, MD -- Otolaryngology
Rob Cadoff, MD - Urology
Ross Dodge, MD – Sleep
David Rankine, MD - Neurology
Donald Endres, MD – Otolaryngology
Graham Glass, MD – Neurology / Sleep
Michael Hennigan - Endocrinology
Marek Martynowicz, MD – Pulmonology
Steven Schaffer, MD - Otolaryngology
Jeffrey Simerville, MD – Urology
Ross Tanner, DO - Endocrinology
Wes Turner, MD – Urology

62. SPENDMEND 340B

Type of Service
Accumulates and processes data of medication usage from our outpatient and covered entities that are eligible for 340B pricing. They process this data on the medications used that can then be purchased at 340B pricing for use on eligible patients.

Evaluation Comments
Necessary for meeting our needs for running a successful 340B program.

63. STATE OF ALASKA LABORATORIES

Type of Service
The state laboratories in Anchorage and Fairbanks provide various testing for SPH, including routine hepatitis testing, virology testing and some microbiology cultures, such as Pertussis, Salmonella and Shigella.

Evaluation Comments
Most of the routine testing is batched, so turnaround time is slow, but there is no cost for testing. Therefore, Quest is utilized for results that are needed quickly. There is no contract. State Laboratories certified by CLIA.

64. SUBTLE MEDICAL

Type of Service
Artificial Intelligence software to reduce MRI scan times and improve image quality.

Evaluation Comments
This software is a successful enhancement to reduction in exam times and image quality.

65. TANDEM CLINICAL CENTER

Type of Service
Diabetes Insulin Pump Patient Usage Training.

Evaluation Comments
Reimbursement for Diabetes Educator to provide training for patients on new Tandem diabetic insulin pump units.

66. TEXLA BILLING AND CONSULTING LLC

Type of Service
Billing consulting services. Monthly retainer for access to billing expert as needed for problem solving.

Evaluation Comments
Home Health biller has an "as needed" resource to problem solve issues regarding billing and collecting payment. This has been very beneficial with keeping our Accounts Receivable (*AR*) down and making sure claims are billed correctly the first time.

67. UKG/KRONOS

Type of Service
Human Resources Information System, Timekeeping and Payroll System.

Evaluation Comments
After extensive research, service required to facilitate enhanced workflows, maintain data integrity and accurate payroll processing.

Department managers, or their delegates, are now responsible for inputting and approving all employee payroll within their department. Time charged to departments by employees whose home department is not viewable nor approved by the department that is being charged.

68. UNIVERSITY OF WASHINGTON HEMOPATHOLOGY LAB

Type of Service
This laboratory is used to send flow cytometry specimens for diagnosis of leukemia and other blood dyscrasias.

Evaluation Comments
They are an excellent laboratory with an experienced pathology staff. We have no contract. University of Washington is CLIA and CAP certified.

69. VACTRAK

Type of Service
Collects and stores vaccination records for Alaska residents.

Evaluation Comments
This is a required program. A functional and efficient database for those with access.

70. VIRTUAL RADIOLOGIC

Type of Service
After hours imaging interpretation.

Evaluation Comments
Diagna Radiology, the group who began providing teleradiology services to SPH in 2005, merged with Virtual Radiologic in April 2008. Virtual Radiologic is not accredited with The Joint Commission. All radiologists who give preliminary reads on the exams sent to Virtual Radiologic are licensed by the State of Alaska and credentialed by SPH. Imaging has been very pleased with Virtual Radiologic's services up to this time. The preliminary reads are received within 30 minutes after the images have been received by Virtual Radiologists for reading which meets the provision of services as outlined in the contract. To meet critical timing for reading of head CT's for stroke patients, Virtual Radiologic has implemented a stroke protocol, which escalates the exam to the top of the Radiologist worklist. The protocol also initiates a call to the ER physician with critical findings. Virtual Radiologic has a Quality Assurance process that provides periodic reports and feedback to clients.

SPH discovered some QA issues in the last 12 months and requested vRad review. The organization responded with fixing the concerns at hand. While vRad is a continuing contract for back up radiology read services, they are used as a read of last resort due to the exceptional service relationship we have developed with RCI.

71. ZIRMED / WAYSTAR

Type of Service
Clearinghouse for Kinnser - Send claims electronically to insurance companies.

Evaluation Comments
This clearinghouse is working well with getting claims sent electronically.

72. ZIX

Type of Service
Secure email for confidential information.

Evaluation Comments:
It automatically secures emails with confidential information and allows for the manual process of sending information to caregivers or patients. Zix has worked well for sending and receiving confidential information securely. It allows the sharing of confidential information timelier and easier via email.

XIV. POLICY MANAGEMENT

Policy Management for annual review and/or revising the SPH Critical Access Hospital *(CAH)* departmental and hospital wide policies and plans conducted via the electronic program called Policy Manager. Pathways for revisions and approvals are built into the system and include department Directors and Managers, Medical Directors, Nurse Practitioners, other Advanced Practice providers and/or various committees as appropriate. All employees are able to access the Policy Manager program electronically through the Staff Information Site *(SIS).*

The SPH organization has a contracted consultant who works under the direction of the Quality Management Director and is assisting with reformatting approval processes and streamlining the policy system for a less cumbersome process. Reorganization and updates within the system continue. Development of a Hospital-Wide Policy Committee has been effective for review and approval of Hospital-Wide and Patient Care Services policies. The Acute Care Department policies (*PSC policies*), are now being reviewed and updated as led by the AC Director and CNO. The PCS policies no longer need to go through the Hospital Wide Policy Committee as of April 2023 due to policy efforts by the clinical team. The committee consists of a core number of individuals with involvement of subject matter experts as needed and meets every two weeks.

XV. EMERGENCY PREPAREDNESS

- Activated HICS/Emergency Operation Plan
- Great Alaska ShakeOut *(facility wide participation)*
- Homer Storm – Information Technology Failure Drill *(facility wide functional drill)*
- The Great Homer Quake (*table top drill*)
- Hospital Incident Management Team:
    - Committee continued to have regular meetings
    - Committee reviewed policies and plans related to HIMT
    - Incident Command System (ICS) training for committee members
- Finalized and operationalized any outstanding COVID-19 practices
- SPH Fire drills as required
- LTC-Fire drills and emergency equipment evacuation training (stair chairs and med sleds)

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APPENDIX A
Department Reports
Annual Accomplishments and Highlights - FY 2023
Goals and Objectives - FY 2024

1) ACUTE CARE DEPARTMENT

Acute Care Accomplishments and Highlights FY 2023:

- 100% permanent staff in RT
- Four new graduate RNs brought on by the preceptor program.
- Trained Two AC RN's into ICU.
- Real time data collection for Sepsis. Collaborated with Education department on learning activities, new procedures and equipment.
- Resurrected Unit Based Council with the aim to improve patient's safety, comfort and well-being and/or to improve staff satisfaction and cohesion.

Acute Care Goals and Objectives FY 2024:

- Update and revise department specific policies.
- Grow existing staff skills in OB & ICU specialties.
- Continue to hire, train and educate new graduate nurses.
- Continued collaboration with the Education Department for new staff training and the development of equipment and procedural training.
- Continue to recruit and hire permanent staff reducing the need for travelers.
- Work with the Security and Quality Management staff to improve room safety for patients on close observations or a title 47 court ordered hold.
- Utilize results from the Workplace Burnout Program to improve staff satisfaction.

2) EDUCATION DEPARTMENT

Education Department Accomplishments and Highlights for FY 2023:

- Montana Nurses Association *(MNA)* Provider Unit application was approved with distinction for three years.
- Awarded 1528.6 contact hours through MNA, a 47% increase from the previous year.
- HealthStream course completions increased by 195% with 14,261 courses completed.
- Increased staff use of Lippincott Procedures from 13,000 page views in FY 2022 to 25,000 page views in FY 2023.
- Achieved 97% on-time completions for hospital-wide annual HealthStream education.
- Created and launched orientation programs for Medical Assistants, PACU RNs and ER RNs.
- Revised and launched hospital-wide orientation programs and volunteer programs.
- Awarded 668 certificates; a 30% increase from the previous year including sixteen instructors.
- Launched a new version of HealthStream annual training using micro-learning modules to achieve compliance with Occupational Safety and Health Administration *(OSHA),* state and Centers for Medicare & Medicaid Services *(CMS)* regulatory standards.
- Authored nine new HealthStream courses.
- Hired a Clinical Educator.
- Facilitated preceptor program for five new graduate RNs and two new ICU RNs.

- Hosted Skills Fairs for AC, OR, ER, OB and ICU.
- Organized training opportunities for eleven new pieces of equipment, two of which increased the RN scope of practice.
- Organized inter-disciplinary and professional development opportunities on thirteen topics including: death and end of life care, cardiac rhythms, telehealth, giving feedback, IM injections, sepsis, pediatric respiratory drills, OB drills, and criminal charges against nurses, TEAM De-escalation, restraints, and PCS guidelines.

Education Department Goals and Objectives for FY 2024:

- Continue supporting the mission, values and strategic plan of the hospital by providing Continuing Nurse Education *(CNE)*, annual regulatory education, orientation and support for the goals of the hospital wide QI plans, providing evidence based education to improve patient quality outcomes.
- Provide six nursing continuing professional development activities, focusing on the needs of the nursing staff in all clinical departments, arising from identified gaps after environmental scanning.
- Provide four inter-professional activities with content experts on evidence based practice.
- Increase the Education Department involvement in staff meetings, quality initiatives and educational responsiveness to audit findings.
- Focus on creating curated resources, readily available, to staff using Lippincott and the Staff Information Site *(SIS)*.
- Expand educational offerings, orientation programs and skills fair opportunities, to ancillary departments and clinics.
- Expand the preceptor program for additional departments.
- Create annual skills fairs to ensure nursing practice is evidence based.
- Create sustainable in-house onboarding for BLS, ACLS, and PALS instructors by providing instructor courses.
- Create a mobile computer lab to improve education quality and accessibility.
- Expand our learning platform to increase team engagement and accountability.
- Launch Sharable Content Object Reference Model *(SCORM)* compliant e-learning authoring tools.
- Expand the Education Department's team.
- Increase the use of technology in educational offerings.

3) EMERGENCY DEPARTMENT

Emergency Department Accomplishments and Highlights FY 2023:

- Trauma Level IV Reverification site survey inspection.
- Continued collaboration with the Education Department for new staff and the development of learning videos for equipment and procedures training.
- Acquired new ultrasound equipment along with training for all Emergency Department *(ED)* staff.
- Added a new Health Unit Clerk *(HUC)* position to the ED staff.
- Rebuilt the Trauma Level IV program and hired a new Trauma Coordinator.

Emergency Department Goals and Objectives FY 2024:

- Create and implement a new Grad Program.
- Update and revise department specific policies.
- Add new position to the ED team, such as an ED Tech.
- Complete the ED renovations.

4) EMPLOYEE HEALTH

Employee Health Accomplishments and Highlights FY 2023:

- Collaboration with Infection Prevention *(IP)* in ongoing maintenance and updates to the COVID information, policy and guidelines.
- Retired COVID SPH System Information Site (SIS) intranet page.
- Track, guide and document COVID positive staff and staff missing work with potentially infectious illnesses.
- Ongoing collaboration with Human Resources *(HR)*, Education, Medical Staff and Volunteer Coordinators to improve new hire/student/volunteer onboarding processes.
- Reconvened Employee Wellness Committee- currently meets monthly.
- Expanded Wellness Reimbursement Allotment per staff response to survey.
- Added wellness offerings including Personal Wellness Challenges and Lunch & Learn presentations.
- Continued to update employee health files.

Employee Health Goals and Objectives FY 2024:

- Continue offering Wellness Programs/incentives for SPH staff.
- Review and update policies, procedures and processes as needed.
- Consider replacing MediTrax Employee Health software.
- Attend Association of Occupational Health Professionals in Healthcare *(AOHP)* conference.

5) ENVIRONMENTAL SERVICES

Environmental Services (EVS) Accomplishments and Highlights FY 2023:

- Department Manager obtained Certified Healthcare Environmental Services Technician *(CHEST)* Train the Trainer certification through the Association for the Healthcare Environment *(AHE).*
- Implemented EVS Department monthly hand-hygiene compliance observations.
- Updated laundry-chemical dispensing units to reduce cost and waste.
- Maintained quarterly cleaning of all privacy curtains.
- Department Manager began leadership coaching through FutureSync.
- Implemented cleaning and disinfection of new OBGYN Clinic.
- Implemented cleaning and disinfection of new South Peninsula Surgery Clinic.

Environmental Services Goals and Objectives FY 2024:

- Evaluate Environmental Services policies and procedures.
- Department manager to continue education through the Healthcare Environment and International Housekeeping Association.
- Evaluate opportunities to improve job-specific education for team members.
- Develop program for team members to obtain Certified Healthcare Environmental Services Technicities *(CHEST)* certification for EVS Tech II advancement.
- Continue quality assurance surveillances to evaluate facility cleanliness and identify training needs.
- Improve staff retention.
- Develop and monitor performance improvement measures from Press Ganey surveys.
- Improve staff hydration and break-time compliance.
- Improve employee satisfaction.
- Implement team-oriented quality assurance program, as opposed to individual scores.

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6) FACILITIES / ENGINEERING

Facilities / Engineering Accomplishments and Highlights of FY 2023:

- Completed Deaerator softener installed in boiler room.
- Completed fire damper inspection for main hospital building.
- Completed Ortho Clinic x-ray machine install.
- Completed security camera and access control system phase 4 upgrade to the Emergency Department.
- Upgraded 95% of main hospital building, to LED lighting.
- Completed negative pressure rooms in Specialty Clinic basement.
- Completed vaccine clinic in Specialty Clinic basement.
- Completed HOHE building remodel from residential building into a billing office.
- Completed Homer Medical Center roof remodel.
- Completed Security office remodel.
- Completed install of new X-ray table in the Specialty Clinic/Family Care Clinic building.
- Completed addition of six new parking spots in the ER/Registration parking area.
- Completed heated sidewalk for Administration entrance.

Facilities / Engineering Goals and Objective for FY 2024:

- Develop a Tool asset vending machine for higher valued equipment for tracking.
- Install wall protection in hallways and main areas through the building.
- Ongoing develop and Staff an in-house Security Department and implement this into the Support Services Division.
- Complete lighting upgrade to LED lights in 100% of the building.
- Generator switch gear upgrade to meet current code requirements before January 2024.
- Upgrade Long Term Care's Heating, Ventilation and Air Conditioning *(HVAC)* system.
- Ongoing Re-roof the 1985/99 addition of the hospital.
- Ongoing architectural design for Dietary, Specialty Clinic, Pharmacy and Oncology room.
- Install new X-ray table in the Ortho Department building.
- Continue ongoing SPH landscape beautification project.
- Re-cabling of communication and data at the Community Health Services (*CHS*) building.
- Complete the replacement of carpeting with vinyl flooring in the Long Term Care *(LTC)* Facility.
- Repair, painting, acoustic ceiling replacement in 1985 addition.
- Replacing current patients and residents bulky TV systems with a new Wi-Fi system.
- MSI software and hardware upgrades to Building automation systems.
- Improving security and building safety throughout the campus.
- Minor renovation to HMC providers work spaces and exam rooms.
- Fire damper repair on all findings through inspection with CMI.
- Installation to new entry sliding doors in main lobby of hospital.
- Replacing doors in ER rooms 5,6,7,8 to accommodate new gurneys.
- Replacing Physical Therapy entrance door, handicap operators and hardware.

7) FAMILY CARE CLINIC

Family Care Clinic Accomplishments and Highlights of FY 2023:

- Mesille Mershon, RN, promoted to Assistant Clinic RN Manager.
- Hired another health coach.
- Continued community outreach for obesity, including high school and community presentations.
- Increased visits from 3,428 in calendar year 2021 to 4,519 in calendar year 2022.

Family Care Clinic Goals and Objectives for FY 2024:

- Increase family care visits by 10%.
- Expand pediatric patient panel.
- Move toward a more consolidated clinic structure with Homer Medical Center.
- Open Walk-In Community Lab.
- Increase number of family care providers

8) GENERAL ACCOUNTING DEPARTMENT

General Accounting Department Accomplishments and Highlights for FY 2023:

- Successful fiscal year-end financial statement audit.
- Continued cross training elements that will help our department be more efficient.
- Enhanced capital project tracking and reporting, with continued improvement work being done to make tracking easier.
- Implemented employee reimbursements being done through UKG to prevent having to create vendor profiles for employees in the AP system.
- Complete annuity buyouts for retirees and terminated vested employees to reduce pension risk and liability.

General Accounting Department Goals and Objectives for FY 2024:

- Recruit and hire a Controller to lead the department.
- Continue working toward another successful fiscal year-end financial statement audit and quality of analysis provided to the Board and CFO.
- Continue to ensure standardized processes and efficiencies through the month end closes.
- Continue to enhance our capital expense & project tracking to be more automated.

9) HEALTH INFORMATION MANAGEMENT

Health Information Management Accomplishments and Highlights for FY 2023:

- Continued chart destruction project, added 1.0 FTE to focus on project, ongoing.
- Hired Kelly Gallios as HIM Manager.
- Contracted with TruBridge for coding of accounts
- Process improvement for charge capture of infusion and Neurology services.
- Work with clinical directors to improve nursing documentation to increase revenue.
- Review charging process with Respiratory Therapy to ensure all appropriate revenue is captured.
- Implement a standard process for Coder review of ordered services to assist with Cost Estimates.

Health Information Management Objectives/Goals for FY 2024:

- Continued chart destruction project, projected completion date 2025.
- Cross training Coder 1 to fill in for charge capture and records Release needs.
- Fill open coding positions.
- Reduce coding currently contracted to TruBridge by 50%.
- Create viable coding career ladder and place current staff appropriately.
- Work with Clinic Coders to unify coding processes, education and alignment.

10) HEALTH INFORMATION SYSTEM

Health Information System Accomplishments and Highlights FY 2023:

- Successful submission of CY22 Eligible Hospital *(EH) (CAH)* Promoting Interoperability Stage 3, Year 4 data in March 2023 maintaining full payment for hospital-based services.
- Met and exceeded Eligible Provider *(EP)* Quality Payment Program - Merit-based Incentive Payment System *(MIPS)* measures for CY2022.
- Maintained goal of Level 5 within Electronic Medical Record Adoption Model *(EMRAM).*
- Collaborated in multi-disciplinary teams

  Worked closely with Acute Care Nursing leadership team updating several inpatient-nursing flowcharts in the Electronic Health Record *(EHR)* to maximize efficiencies.
  - State of Alaska Order Entry/Result interface development team supporting direct ordering & resulting via the Evident Electronic Health Record (EHR).
  - Sepsis Steering Committee: Best practice response to sepsis leveraging the Evident System to support documentation prompts and workflow efficiency.
  - Stroke Task Force: Best practice response to stroke leveraging the Evident System to support documentation prompts and workflow efficiency.
  - Medication Reconciliation Task Force to improve medication reconciliation processes at transitions of care across the facility.
  - Member of Hospital-wide Policy & Forms Committees.
- Project Management support for:
  - Updated Evident Patient Portal, MyCareCorner, from Thrive Patient Portal in June.
  - Communication Center, a new application within Thrive Web Client that stores outpatient diagnostic test orders within the Patient Profile for improved outcomes from testing to result reporting. Migration to Thrive Web Client in select clinical areas to support continued use of electronic forms with sunset of Internet Explorer.
  - Direct, single-sign-on linkage via interface between Evident and Bamboo Health.

Health Information System Goals and Objectives for FY 2024:

- Maximize functionality of SPH Health Information Systems to improve patient care coordination and outcomes via the new Thrive Web Client platform:
- Prepare for successful CY23
  - EH Stage 3, Year 5 Promoting Interoperability data submission, including eCQMs *(electronic Clinical Quality Measures)*, and
  - EP MIPS program submissions.
- Maintain full and optimal use of the Evident, AthenaHealth, PointClickCare & Wellsky (Kinnser) health information systems.

  - Implement Patient Scheduling application in Evident for clinical departments scheduling patient visits/exams. These services include:
    - Respiratory Services
    - OB Services
    - Imaging Services
    - Rehabilitation Services
    - Outpatient/Infusion Clinic
- Transition to a centralized, single workspace to co-locate all HIS staff for improved department communications and work coordination.

11) HOME HEALTH

Home Health (HH) Department Accomplishments and Highlights for FY 2023:

- Average monthly census of 56 patients FY 2023 YTD. This is up from 50 patients in FY 2022.
- AHHA Home Health and Hospice Committee, Ivy Stuart RN remains the chair of this committee for Calendar year 2023. This committee chair now has a seat at the AHHA board meetings.
- TexLa Billing and Consulting remains as a resource for a small monthly retainer fee for any billing/collecting issues that surface.
- Updated Emergency Response Plan, Updated HVA.
- Marissa Frank RN has continued as the Clinical Supervisor/back up Administrator. She holds a 0.6 FTE.
- Performance improvement plan focused on COVID pandemic/infection control throughout the National public health emergency. HH is working on two Process Improvement Plans *(PIPs)* for CY2023. First is improvement, shortness of breath and the second is focuses on improvement in patient's management of oral medication. Home Health *(HH)* is now under value-based purchasing. CY2023 is our first performance year. How we perform in 2023 will affect our payments in 2025. There are many barriers with value-based purchasing. Agencies are penalized for patients using ER services or being admitted to the hospital while under HH care. In this community there are many barriers to prevent hospitalizations and ER usage such as, limited same day appointments, part-time providers, burnout related to pandemic; HH does not provide 24/7 access to nurses unless patient is actively dying. In addition, HH cares for patients at the end of life whereas many other HH agencies would transfer these patients to a hospice or formalized palliative care program. We do not have either of those services in our service area so we see these patients under their home health benefits. Death of a patient brings down our outcome score, which then are connected to our Medicare payment. Hired a full time RN coordinator; this role focuses on HH's Quality Assurance Improvement Performance *(QAPI)* program and patient intake.
- Hired a full time care coordinator. This role will bridge gaps between patients and all the resources and services they need to remain as independent in their home as possible.
- Assisted with vaccinations, COVID testing and COVID treatment of homebound patients. Continued to run the Monoclonal Antibody program for COVID treatment.
- Star Ratings July 2023: 2 stars. Successfully implemented OASIS E January 01, 2023. This is the new comprehensive assessment for Home Health patients.
- Successfully implemented electronic visit verification requirement using the state provided Therap system for Medicaid patients. This is a State requirement for staff to clock in and out of Medicaid patient visits. It locates staff via Global Positioning System *(GPS)* and data is sent to an aggregator. This had to be completed before we could bill out claims.

- Implemented four new programs in FY 2023. Implemented standardized programs for Congestive Heart Failure *(CHF)* and Chronic Obstructive Pulmonary Disease *(COPD)* patients. We also implemented a more robust and standardized palliative care program and a fall reduction program. These programs were presented to medical staff and local primary care clinics.
- Director/Administrator attended two National conferences for Home Health in FY 2023. The Home Health and Hospice Medicare Summit and The National Association for Home Care and Hospice annual conference. Best practice and regulatory compliance knowledge was obtained and implement from both of these conferences.
- Updated estimated contractual adjustments in Electronic Medical Record *(EMR)* for each payer source.

Home Health Department Goals and Objectives for FY 2024:

- Continue to grow HH census to maintain a monthly average of 65 clients by end of FY 2024.
- Implement Progress to Goals feature in EMR to streamline clinical documentation and set up care pathways.
- Maintain and grow HH QAPI program.
- HH is working on two performance improvement plans for CY2023.
    - Improvement in shortness of breath
    - Improvement in patient's management of oral medication.
- HH Care Coordinator will create partnerships and grow relationships with local resources to ensure patients have access to available resources in the community.
- HH to work with EMR vendor on issues and maximizing the use of financial reports that are available in our EMR.
- Continue to update Home Health policies and procedures to meet regulatory compliance.
- Ongoing OASIS training for accuracy of assessments. Continue to provide education to providers on Home Health referrals.
- HH Director to attend National Association for Home Care and Hospice *(NAHC)* annual conference in October 2023.
- HH director to attend the Medicare Summit in September.
- Implement process to engage patients to participate in HHCAHP surveys. This will be combined with a patient outreach program we are currently working on creating.

12) HOMER MEDICAL CENTER

Homer Medical Center Accomplishments and Highlights for FY 2023:

- Received official Merit-Based Incentive Payment System *(MIPS)* score of 100% for CY2022.
- Hired Emma Mayfield, DO, with board certification in Family Medicine.
- Hired Pamela Williams, MD, OBGYN, with board certification in Obstetrics and Gynecology.
- Developed a clinic medication assistant treatment program for substance use an abuse, adding additional DEA X-waivered providers.
- Contracted Tamara Shrader, ACNP, to help manage patient backlog.
- Collaborated with the Family Care Clinic to cross train Bonnie Turner, FNP, to be able to work in both clinics to help address patient backlog.
- Hired LeAnn Matysczak, RN, as Assistant Clinical Manager to support clinic leadership.

- Moved Obstetrics and Gynecological services into new location on Fairview Ave, generating two additional exam rooms within Homer Medical Center.

Homer Medical Center Goals and Objectives for FY 2024:

- Continue to fulfill and report requirements for Merit-Based Incentive Payment System *(MIPS)* in FY 2024.
- Increase clinic patient volumes, services and access to care.
- Focus on increased staff moral and team building.
- Work with consultant to build a more intentionally efficient workflow processes.
- Improve patient phone system/scheduling workflow for a smoother, quicker and efficient process.
- Onboard Josie Bradshaw, RN, to fill vacated Clinic Manager Position.
- Onboard Ragina Lancaster, DO, with board certification in Family Medicine.
- Onboard Hans Amen, DO, with board certification in Family Medicine.
- Collaborate with the Family Care Clinic to have Christine Pratt, PA-C, help address patient backlog.
- Complete clinic remodel to provide two additional exam rooms to support community growth.

13) HUMAN RESOURCES

Human Resources Accomplishments and Highlights for FY 2023:

- Executed Recruitment Strategy to address contract staffing, recruitment and retention. This included hiring a SR HR Recruiter to handle all clinical recruitment.
- Successfully executed Marketing strategy plan including Radio ads, online campaign and a postcard mailer.
- Completed successful active Benefits Open Enrollment for FY 2023, which included transition to new Benefit Third Party Administrator *(TPA)* and stop loss carrier – MODA Health.
- Request for Proposal *(RFP)* process and selection of our new Benefits Broker – Parker Smith and Feek.
- Filled and on-boarded key leadership positions: COO, CFO, ER Director, Pharmacy Director, Assistant Director of Nursing Long Term Care, Assistant Clinic RN Manager for HMC and Family Care Center, Assistant Kitchen Manager, Safety & Security Supervisor and RT Supervisor job share.
- Streamlined hospital-wide orientation program and new hire onboarding experience.

Human Resources Goals and Objectives for FY 2024:

- Continue to implement automated HR processes and workflows using Kronos full potential.
- Work with a consultant to optimize Ultimate Kronos Group *(UKG).*
- End contract with existing applicant tracking system: HealthCare Source.
- Develop new onboarding process to inform and acclimate new managers to the business.
- Prepare for Union Negotiations.
- Develop an HR Performance Survey to identify areas of opportunity for better customer service.

South Peninsula Hospital

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14) IMAGING DEPARTMENT

Imaging Department Accomplishments and Highlights FY 2023:

- Passed our 2022 Mammography Quality Standards Act *(MQSA)* inspection.
- Continued to be a clinical site for local University of Alaska *(UAA)* Rad Tech program. Two students trained in the past year, and one hired as a Rad Tech.
- Passed a surprise State of Alaska Radiologic Inspection on 09/27/2022.
- Finished FY 2023 with a positive operating margin.
- Have enjoyed the second year with our new CT suite and showed over 20% volume growth in the past year. It has improved the flow of patient traffic, especially from the Emergency Department *(ED)* and Acute Care *(AC)* Department.
- New chiller for Magnetic Resonance Imaging *(MRI)* installation has been completed and is in service reducing downtime from failures.
- Finding opportunities to strengthen the bench for radiologist coverage by negotiating a new contractual relationship with Radiology Consultants Inc. in Fairbanks.
- Conducted an annual review of all imaging radiation and fluoroscopy dose protocols to ensure the protocols adhere to the Society for Pediatric Radiology's Image Gently guidelines and Adult Image Wisely guidelines and to ALARA *(as low as reasonably achievable)* radiation guidelines.
- Implemented a new artificial intelligence software program (Icometrix) to provide better data for diagnosing dementia, cognitive decline, multiple sclerosis, and more.
- Began the architectural design phase of a Nuclear medicine service line, and wrote a Certificate of Need request for Nuclear Medicine/Pharmacy/Infusion
- Received re-accreditation for mammography program through the American College of Radiology.
- Received accreditation for new CT machine through the American College of Radiology.
- Renewed facility membership with the National Consortium of Breast Centers *(NCBC).* Continued to collect data necessary to participate in the NCBC National Quality Measures for Breast Centers *(NQMBC)* Program. Obtained the designation of Certified Quality Breast Center *(CQBC),* the second step to achieving the designation of Certified Breast Center of Excellence for our breast health services.
- Researching and creating a solid plan to create a safer Picture Archiving and Communication System *(PACS)* infrastructure, removing outside accesses to PACS while providing outside partners and patients with images, using new image sharing technology.
- Ongoing participation in the American College of Radiology National Mammography Data Base to enable SPH to access aggregate reports for comparison of our Mammography program with others of similar size.

Imaging Department Goals and Objectives for FY 2024:

- Continue to support the Nuclear Medicine Certificate of Need (*CON*) process to add this new service line for SPH.
- Create an Imaging registration team, which can pro-actively reach out, after patient orders are received, and pull patients into care.
- Implement a new scheduling module, which was recently rolled out in our Electronic Medical Record *(EMR).*
- Implement a new patient order module, which was recently rolled out in our EMR.

- Create more redundancy in our PACS support team to manage system downtime and maintenance needs.
- Replace outdated hardware *(computers/monitors)* in the Imaging department to become compliant with our new McKesson PACS upgrade this fall.
- Create an alternative resource for critical CT studies when the current *(only)* CT machine is down, still in progress.
- Conduct an annual review of all imaging radiation and fluoroscopy dose protocols to ensure that the protocols adhere to the Society for Pediatric Radiology's Image Gently guidelines and Adult Image Wisely guidelines and to ALARA *(as low as reasonably achievable*) radiation guidelines.
- Continue to participate in the National Consortium of Breast Centers *(NCBC)* and National Quality Measures for Breast Centers *(NQMBC)* Program to compare our service performance with other breast centers in the U.S. and achieve the designation of Certified Breast Center of Excellence for our breast health services.
- Continue to participate in the American College of Radiology *(ACR)* National Mammography Data Base.
- Work collaboratively with the Alaska eHealth Network *(AeHN)* to develop a Health Image Exchange that has functionality to view, query retrieve and download images from other sites in Alaska.
- Provide continuing education resources to staff so they can use the information obtained through education to meet licensing requirements and to increase imaging services.
- Evaluate the Imaging Quality Improvement program. Identify, develop and implement specific Quality Improvement *(QI)* opportunities.
- Conduct an ongoing review and revision of the Charge Master for all imaging modalities to ensure appropriate coding, billing and reimbursement.
- Continue to review and update all policies and procedures as necessary to ensure compliance with the American College of Radiology imaging appropriateness criteria guidelines, Food and Drug Administration *(FDA)*, Centers for Medicare & Medicaid *(CMS)*, state and other regulatory agencies.
- Purchase, buildout, and test new interfaces required to transmit images to Radiology Consultants of Iowa *(RCI)* through Intelerad, the PACS system that has been selected by our contractor.
- Create a sustainable workforce in Diagnostic Imaging, by participating with the UAA Radiologic Technology program as a clinical site and training our future technologists.
- Completion of Nuclear Medicine suite and implementation of Nuclear Medicine services.
- Removing access to SPH PACS network and working with facilities to create a network with our new image-sharing platform to provide HIPAA compliant image sharing practices that provide patient privacy and security of PACS network. Improving radiologist workflows by minimizing various applications and workstations that radiologist have to use.
- Replace all Imaging PACS workstations to 14.0 operating systems to prepare for software upgrade to Change Healthcare *(McKesson)* operating software.
- Prepare for Medicare changes to the pre-authorization process for MRI and CT exams.
- Enhance PACS archive storage capability by updating and increasing storage servers and adding additional security measures with a secure off-site data storage facility.
- Evaluate a MRI room alert system for additional security for personnel and patients in the MRI suite.
- Purchase a new portable x-ray machine to replace aging unit that is used and kept in the ED area.
- Purchase a MR Microscopy coil for high-resolution imaging of extremities.
- Purchase and install Functional Cardiac Syngo software for enhanced CT cardiac imaging.

- Purchase and install Contrast Enhanced Mammography software for additional Mammography imaging capabilities.
- Upgrade the unsupported Computer Aided Diagnosis *(CAD)* software for MRI breast imaging to an updated software that will provide enhanced prostate and breast imaging capabilities.

15) INFECTION PREVENTION

Infection Prevention Accomplishments and Highlights for FY 2023:

- Started Infection Prevention training modules specific to Long Term Care from the Association for Professionals in Infection Control and Epidemiology *(APIC),* and completed the CDC's Nursing Home Infection Preventionist Training Course
- Monitored and investigated reports of hospital acquired infections *(HAIs).*
- Oversaw the majority of COVID-19 operations, including:
    - Tracking metrics of performance, swab collection, positivity rates, and vaccinations.
    - Successfully closing the Vaccine and Testing Site (swab site) in January, as part of the transition from acute response to normal operations.
    - Ordering and managing inventory of vaccines *(with Pharmacy).*
    - Reporting COVID data to National HealthCare Safety Network *(NHSN)* for South Peninsula Hospital and Long Term Care.
    - Answering staff and community questions, responding to exposures and events.
    - Communicating changes to Center for Disease Control *(CDC)* guidelines and South Peninsula Hospital guidelines.
    - Collaborated with community agencies for local vaccination and testing efforts.
    - Collaborating with Employee Health and Materials Management staff to monitor PPE usage and improve PPE supply amounts and variety.
    - Collaborated with Management Team in efforts to address operations as the COVID-19 Public Health Emergency *(PHE)* ended.
- Updated Infection Prevention policies and procedures *(Notably the Infection Prevention Plans for South Peninsula Hospital and Long Term Care, the South Peninsula Hospital Risk Assessment, the Isolation Manual, and the Bloodborne Pathogen Exposure Control Plan).*
- Provided education for staff and departments on topics of C. Diff infection, Bloodborne pathogens, and COVID-19.
- Consulted with staff on construction projects, procedure modification, and equipment upgrades.
- Participated in skills fairs in Long Term Care and Acute Care.
- Organized quarterly Infection Prevention Committee meetings, with representatives from every clinical department.
- Worked to monitor clinical response to sepsis, in regards to CMS guidelines *(with CNO and Sepsis Committee).*

Infection Prevention Goals and Objectives for FY 2024:

- Improve process for hand hygiene monitoring and compliance throughout SPH departments.
- Continue to manage the quarterly Infection Prevention Committee and improve reporting metrics from each department.
- Continue to monitor and report cases of hospital acquired infections.
- Work on Infection Prevention Policies and Procedures.
- Respond to staff requests for subject matter expertise and group education events.

- Manage COVID-19 response in regards to testing and vaccination; continue efforts to as the PHE ends.
- Collaborate with Employee Health to improve Employee vaccination compliance.
- Complete additional training from agencies such as the Center for Disease Control *(CDC),* National HealthCare Safety Network *(NHSN),* and the Association for Professionals in Infection Control and Epidemiology *(APIC),* and achieve certification in Infection Prevention and Control through APIC.

16) LABORATORY

Laboratory Department Accomplishments and Highlights FY 2023:

- The laboratory worked in collaboration with Employee Health and Infection Prevention to offer Covid-19 testing for employees. Outpatients COVID-19 testing was available through the "Request a Test Program" or by provider requisition. Testing is performed on two testing platforms:
    - COVID-19 testing with the Cepheid analyzer.
    - COVID-19 testing as part of the multiplex respiratory panel on the BioFire analyzer.
- Testing volumes have remained steady and staffing additions that were added during COVID has continued to contribute to the laboratory being able to staff appropriately for the workload.
- The Rotary Health Fair testing was performed at South Peninsula Hospital laboratory. Blood draws were performed on campus at separate building that allowed for participants to be staged outside the building in their cars until a draw station was open to receive the next participant. This past year there were 806 participants and feedback continues to be very positive concerning the process used to transition participants into the draw stations. Running the tests in-house streamlined paperwork, allowed for timelier resulting, and allowed all health fair participant results to be available the same day as the fair, which was held in person for the first time since COVID-19.
- Employee Health Fair had 336 employees take advantage of the laboratory test offerings.
- A Clinical Laboratory Improvement Amendments *(CLIA)* inspection was conducted in May 2022 with no deficiencies cited.
- The immunochemistry analyzer and the main chemistry analyzer were replaced January 2023 and April 2023 respectively.
- Collaboration with the sepsis committee and providing timely performance of lactic acid and other reportable measures is ongoing. This is an ongoing process.
- Work is being done with the State of Alaska to set up an interface with SPH for state lab orderable via the Health Information Exchange. This project is still ongoing with an anticipated completion date in the summer of 2023.
- Work is being done to improve outpatient satisfaction scores: Migrate FAX system from ZetaFax to Evident Faxage system. Pending orders be held on patient profiles instead of a file kept on the N Drive. A tentative start date has been set for 06.01.23.
- A Lab Walk-In Phlebotomy site is being created at the Kachemak Medical Building and the anticipated go live is 07.01.23. SPH laboratory services will be migrated to appointment based over the course of the next year.
- The Laboratory Director has been a member of the Mobilizing for Action through Planning and Partnership *(MAPP)* Community Health Needs Assessment *(CHNA)* Steering Committee. A CHNA is being conducted by the hospital in collaboration with MAPP of the Southern Kenai Peninsula. This project has continued running since April 2022 and will be completed in June 2023.
- The general lab freezer was replaced.

- An in-service on high sensitivity Troponin testing for SPH Providers was completed June 2023.

Laboratory Department Goals and Objectives for FY 2024:

- Work on Meaningful Use objectives.
- Continue to offer access to COVID-19 testing to employees and the public.
- High sensitivity Troponin testing algorithm will be finalized and implemented in the Fall 2023, after obtaining physician input.
- Open the OP Service location at the Kachemak Professional Building location with the objective of improving the OP experience for the community. The goal is to see improvement in Press Ganey patient satisfaction surveys in regards to these services.
- Complete the bi-directional State of Alaska interface so tests can be ordered and resulted electronically.
- Upgrade bi-direction interface between Quest and SPH laboratory.
- Replacement of blood bank freezer due to end of their useful life and ongoing maintenance issues.
- Point of care lead analyzer will be placed at Homer Medical Center to support the practice of Devry Garity, pediatric nurse practitioner.
- Replace the current Troponin assay with a highly sensitive Troponin assay is on hold until the placement of the new immunochemistry analyzer.
- Provide off-bench time for the technical coordinator to engage in succession training with the laboratory director.
- Split the Chemistry Department into two sub departments with a lead tech over each department to make oversight more manageable.
- Delegate hematology lead responsibilities.
- Create an assistant laboratory manager position to allow for more in depth succession training that cannot occur with a union employee. In addition, to provide support to the laboratory director with duties and tasks that could be assigned if not in the union.

17) MARKETING

Marketing Accomplishments and Highlights for FY 2023:

- Served as Public Information Office for SPH continued pandemic response, including health education and disease prevention related to COVID-19 pandemic *(testing, vaccines, treatments, prevention, patient care and hospital protocols)*. Methods included website, social media, radio ad, weekly radio talk show, newspaper and presentations at City Council, Rotary and other local groups. Worked closely with City of Homer and State Public Health office.
- Supported outreach into outer lying areas of service area with COVID-19 education, testing and vaccine clinics, utilizing community partners for communication and implementation when possible.
- Conducted a new Community Health Needs Assessment, publish date in June 2023.
- Maintained our leadership role in our local health coalition by:
    - Service on the Coalition Steering Committee.
    - Serving as fiscal agent.
    - Serving on the Leadership Team of the Resilience Coalition which manages a grant to adopt Trauma Informed Care in the community;
    - Serve on the Leadership Team and Treatment Workgroup of All Things Recovery *(formerly Opioid Task Force).*

    - Shifted funding from Service Area Board funds to hospital operations
- Continued general community health outreach via e-newsletter, public forums, monthly wellness walks, free weekly community yoga and community wide month-long steps challenge, in which nearly 700 individuals enrolled on 70 teams.
- Sponsored six SafeSitter babysitting classes, providing training to dozens of local youth.
- Provided logistics and communications for flu shot clinic in conjunction with Rotary Health Fair blood draws where over 300 shots were administered.
- Co-sponsored the Rotary Health Fair, where 900 individuals received low cost blood screenings and we offered the return of in-person fair, which had nearly 300 in attendance. Sixty booths covered physical, spiritual and emotional wellness topics and offerings, and individuals had free consults with local providers to review their health fair labs.
- Co-sponsored the Safe and Healthy Kids Fair, where 30 vendors provided an outdoor education and safety fair for over 300 children and their families, a noticeable increase in attendance over the prior year.
- Co-sponsored Homeless Connect, (Community Resource Connect) where nearly 100 participants got access to much needed goods and services, and we conducted our annual homeless count.
- Supported numerous local programs, including but not limited to sports teams, arts events, Hospice virtual fundraiser, high school graduation, running programs, teams and more with volunteers, donations or program advertising.
- Maintained and distributed a communitywide resource directory of peer support groups.
- Continued broad awareness of hospital services via mailings, newspaper, radio, web, social media, grocery carts, grocery receipts, phone books and more.
- Provided communications support for numerous system changes (hospitalists, new providers, new clinics, new locations of clinics, etc.)
- Developed and implemented a successful digital clinical recruitment campaign in the greater Anchorage area, resulting in multiple job offers.
- Assisted in numerous grant applications, including but not limited to: support for creation of a Community Health Improvement Plan through Mobilizing for Action through Planning and Partnerships *(MAPP)*, the development of an employer sponsored childcare center and expanded behavioral health services.
- Hired an SPH Foundation Coordinator to elevate the Foundation's presence and lay the groundwork for a giving program at SPH.

<u>Marketing Goals and Objectives for FY 2024:</u>

- Re-establish the Substance Use, Misuse and Addiction *(SUMA)* Task Force at SPH to continue tracking our improvement in addiction related services.
- Improve market reach for primary care and behavioral health, in preparation for an increase of competing services soon to be offered in the community.
- Develop and publish an implementation plan in direct response to the community health needs identified in the 2023 Community Health Needs Assessment.
- Continue to grow and establish SPH Foundation.
- Support the need for promotion of and education of capital project needs at SPH.

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18) MATERIALS MANAGEMENT

Materials Management Department Accomplishments and Highlights FY 2023:

- Continued hospital-wide product review, including cost and availability, focusing on cost reduction, efficiency of processes, and improved logistics.
- Created and implemented policies, procedures, and processes for a hospital-wide product review committee.
- Continued implementation of consolidated hospital-wide policies and procedures for Procurement, including standardization and separation of duties.

Materials Management Department Goals and Objectives FY 2024:

- Initiate and complete RFI process to consider new ERP system in anticipation of transition to Epic EHR, with possible selection and implementation.
- Identify, select, and implement a dedicated secondary medical supply vendor.
- Select and implement a contract management system.

19) NUTRITION SERVICES

Nutrition Services Department Accomplishments and Highlights FY 2023:

- Successfully opened up the cafeteria to the public once again. Community members have enjoyed stopping by for meals and the availability of the cafeteria once again.
- Serv-Safe certification for all staff have been kept up to date and available for any upcoming inspections.
- There has been financial growth of revenue from the cafeteria and espresso stand along with catered requisitions for 2022.
- Double stack convection ovens have been installed in the main kitchen.
- Critical short staffing during COVID staffing crisis has been stabilized and we remain nearly fully staffed.
- Matthew Dickenson has accepted the position of assistant manager as of April 2023.

Nutrition Services Department Goals and Objectives for FY 2024:

- Develop and implement a targeted food waste plan for tray service and fruit and vegetable compostable byproducts.
- Increased catering opportunities within the facilities for our designated catering cook *(New Position filled by Randall Pine)*.
- Continue to keep all staff ServSafe certified, and provide ServSafe management course for all cooks and kitchen coordinator.
- Install and implement Blue Print 360 software as a new menu software program that will help streamline menu recipes and menu orders.
- Updating menus for Cafeteria, LTC and AC with fresh new ideas for the upcoming seasons.
- Continue to collect data on quality tray service, and identify any needed process changes.
- Show a financial growth of revenue from the cafeteria, coffee stand and catering requisitions.

20) OBSTETRICS DEPARTMENT

Obstetrics Department (OB) Accomplishments and Highlights FY 2023:

- Continued midwife led simulations, including NRP quarterly simulations, unscheduled C-Sections and OR skills training, and Trauma OB patients involving all departments and disciplines across SPH.
- Hosted Stacy Brundquist, Neonatal NP from PAMC NICU for our biannual STABLE certification course.
- Continued systematic hiring and successfully trained 4 new-to-specialty RNs through the in-house OB training program. Developed and provided a self-study postpartum care module and a second-on delivery training for non-OB nurses who can safely care for patients during periods of high census and acuity.
- Hosted a Safe Kids Car Seat Technician training for SPH staff and community members; trained 6 new SPH Child Safety Seat Technicians; creating policies to address discharge car seat safety from our OB unit; car seat technicians attended Safe and Healthy Kids Fair 2023.
- Addressing safe staffing and staff burn out: Staff 1 OB RN to department, regardless of unit census, to aide in recruiting/retaining staff, policy review, chart audits, unit readiness, continued staff education and mastery of skilled-nursing area. Second nurse to flex to OB for any patients in unit to facilitate safe staffing, adherence to AWHONN staffing guidelines, and promote patient safety in a high acuity, low frequency standards.

Obstetrics (OB) Department Goals and Objectives FY 2024:

- Continue with in-house OB training program—expect four (4) new to specialty OB nurses 2023-2024.
- Decrease need for OB skilled travel staff. – Our day shift is fully staffed without travelers, with last day shift traveler slated to leave early July. We have hired an experienced OB nurse to night shift who will tentatively start August 2023. As we train and hire, we are reducing, our night travel staff needs.
- Increase unit safety and security with increased surveillance and badging out function and additionally staffing department with an extra nurse per shift with ancillary unlicensed nursing personnel.
- Continue unit modifications to comply with infection prevention standards.
- Continue educational opportunities for OB staff in areas of neonatal resuscitation/stabilization, postpartum hemorrhage, interdepartmental communication, and evidence-based standards of practice.
- Review and update policies to reflect current evidence based practice.

21) PATIENT FINANCIAL SERVICES

Patient Financial Services (PFS) Accomplishments and Highlights FY 2023:

- Competition American Academy of Professional Coders *(AAPC)* billing course by billing staff:
  - Danielle Peltola and Rhiannon Elliott.
- Registration Dashboard implemented to track training opportunities and registration improvement processes. Goal of 98% accuracy rate in registration.
- Maintained Accounts Receivable collection goal for 12 months at 55 or less days.
- Improved Registration Training program by utilizing Evident training videos, revised training manual and set core competencies.
- Resolved aging patient credit balances through work completed by Patient Financial Navigators.

- Enrolled with California, Idaho and Colorado Medicaid Programs.
- Improved registration wait time for ER and Outpatient services.

Patient Financial Services (PFS) Goals and Objectives for FY 2024:

- Enhance customer services by relocating Financial Navigator to registration area to support walk in services to patients Monday – Friday 9:00 am to 6:00 pm
- Manage insurance credit balance accounts and denials management through timely and effective review process by addition of PFS staff focused in this area.
- Financial Counselor to acquire certification to help patients enroll in Medicare and Medicaid services.
- Increase Charity Care by enhancing our Financial Assistance Program by actively obtaining signed applications at the time of registration for Medicaid recipients.
- Collaboration with Lab to increase collection of consents and Advance Beneficiary Notice *(ABN)* at time of service.

22) PHARMACY

Pharmacy Department Accomplishments and Highlights for FY 2023:

- Expand patient education to include discharge counseling, and provide follow-up post discharge services.
- Remodel our sterile preparation area to maintain compliance with future revisions to USP 797/800.
- Re-establish a multi-disciplinary Pharmacy and Therapeutics Committee.

Pharmacy Department Goals and Objectives for FY 2024:

- Design new pharmacy work space and IV rooms in planned hospital expansion of shelled space.
- Revise/update pharmacy policies and procedures.
- Update and expand 340B program to new child sites as added to SPH cost report.
- Increase LTC Medicare Part D reimbursements and reestablish our Medicaid billing for outpatient prescriptions.

23) QUALITY MANAGEMENT DEPARTMENT

SPH Quality Management Department encompasses the following areas:

- Quality monitoring, measuring, improvements and projects
- Patient Satisfaction
- Accreditation and Surveys
- Risk Management and Claims Reporting
- Policy Management
- Corporate Compliance
- Privacy – HIPAA

Quality Management Accomplishments and Highlights FY 2023:

- Facilitated the South Peninsula Hospital *(SPH)* Critical Access Hospital *(CAH)* Program evaluation 2022-2023 with input from departments throughout the organization.
- Completed 2022-2023 Small Rural Hospital Improvement Grant Program *(SHIP)* interim and final reports as required for SPH to receive reimbursement of $11,855.00.
- Completed application, then received completed Memorandum of Agreement for SHIP grant from State of AK for the year 2023-2024 for SPH to receive funds of $11,550.00.

- Updated SPH and LTC Facility Quality Plan and SPH and LTC Facility Corporate Compliance and Ethics Plan and HW-101 Corporate Compliance and Ethics Policy.
- Recruited new Quality Management RN to replace Quality Support Specialist. This position was restructure to provide additional assistance with chart audits and abstraction for quality activities.
- QM team participated in SPH Survey activities:
    - Provided copies of patient records for review for Trauma Level IV reverification process in October 2022. QM Director participated in presentation and exit review.
    - Assisted Laboratory Department with complaint survey to include Plan of Correction response.
    - Assisted Facilities Manager with quarterly responses related to K916 waiver Extension as needed.
    - QM Director participated in LTC Facility survey as LTC Grievance Officer
- Worked closely with Optima Healthcare Insurance to develop Risk Management Status report for organization, including Program goals and Organizational Specific goals.
- Facilitated quarterly submissions to Optima Healthcare Insurance with updated actions taken to address the areas identified for improvement during FY 2022 Emergency Care Research Institute *(ECRI)* INsight Hospital Risk assessment.
- QM Director and Risk Mitigation RN participated in Optima Healthcare webinars and other educational offerings available to assist risk reduction and solidify processes, which involve our management team.
- Managed all grievances, complaints, and legal issues related to patient care filed with QM Department.
- Worked with SPH Insurance Companies, attorneys and CEO related to risk and/or legal issues.
- Facilitated completion and updates to Hospital Board of Trustees Balance Scorecard Report *(BSC).* BSC shared monthly with Board of Directors *(BOD)* and quarterly with Patient Centered Quality Care Committee *(PCCQ).*
- Organized and facilitated Root-Cause-Analysis *(RCA)* multidisciplinary meetings for near misses or actual patient events.
- Facilitated Plan-Do-Study-Act *(PDSA)* improvement reports for all indicators falling below target on the BSC as well as departmental quality improvement opportunities.
- Continued work/outreach to managers regarding PDSA reports and provided assistance with graph development and/or update for department quality initiatives.
- Quality reporting and improvement opportunities: QM team completes and transmits core measure data from chart abstraction to CMS that are found on the Care Compare website, meeting criteria for the Small Rural Hospital Improvement Program *(SHIP)* grant. Measures include:
    - Inpatient Sepsis based on discharge diagnosis.
    - Outpatient measures; Stroke, Acute Myocardial Infarction, Left without Being Seen, and Emergency Room admission to discharge.
    - Reported two optional measures to increase opportunity to gain back star rating on Care Compare website to include follow-up documentation related to colonoscopies and Elective Delivery data.
- Organized and facilitated quarterly Patient Centered Care Quality Committee.
- Celebrated all quality efforts and improvement throughout the organization during National Quality Week.
- Quality Support Specialist and/or QM Director participated in LTC QAPI Committee.

- QM team participated in multiple committee meetings to improve quality throughout the organization including Sepsis Steering Committee, Hospital Incident Management Team and Stroke Steering Committee. Provided sepsis guidance, case review and feedback for committee members.
- Conducted eleven (11) Root-Cause-Analysis meetings related to opportunities for process improvement.
- QM Director and/or Risk Mitigation RN participated in bi-monthly Nurse Leader Work Group meetings providing support and input for nursing-specific issues throughout the organization.
- QM Director transitioned off the Senior Leadership Team to support the new established structure. Board reports continue to be provided monthly related to QM activities within the organization.
- QM team worked with Med Staff Coordinator working on implementation of the Peer Review software system, MD-STAT.
- Implementation of RLDatix occurrence reporting and tracking system completed and went live October 2022.
- Ongoing policy work and oversight for the SPH organization with the goal to reduce the number of overdue Hospital Wide and department policies.
    - Continued work on electronic format of policies, procedures and protocols through the Policy Management system.
    - Continue to work with Policy Manager Consultant to facilitate Q2 week Hospital Policy Committee for review, update and approval of policies.
    - Ongoing Bi-monthly meetings between QM staff and Policy Management Consultant to plan and work on action items for policy completion, staff support and agenda setting.
    - Providing support to new management staff on policy platform and adjusting templates as needed for changes occurring.
    - Bi-weekly planning and action meetings with Policy Management Consultant and Administration staff to develop and facilitate conversion of forms from SIS and N-Drive to Policy Manager System.
    - Updated and/or assisted in updating multiple policies and plans over the last year.
    - Ongoing work with staff from security, acute care, and behavioral health to develop hospital wide policies focused on patients in mental health crisis.
- Ongoing management of credentialing, privileging and peer review programs through May 2023 when Medical Staff Office shifted to reporting to the Chief Medical Officer.
- Organized and provided administrative support for monthly Credentialing, Peer Review and Medical Executive Committees through May 2023.
- The organization of Peer Review Ongoing Professional Practice Evaluation *(OPPE)* indicators and reviewing indicators that can be pulled from EVIDENT system by new platform was started.
- Conducted over 15 HIPAA orientations for staff and physicians.
- Sent regular *"All Staff"* emails with HIPAA-focused scenarios and education.
- Conducted eight *(8)* one-on-one individual HIPAA trainings, due to HIPAA complaints, utilizing the HealthStream presentation *"HIPAA Policy Review".*
- QM Team participated in HealthStream mandatory education.
- QM Director, Quality Support Specialist and/or Risk Mitigation RN participated in monthly new employee orientation and new nurse orientations as needed.
- QM Director participated in Leadership Development through FutureSync as scheduled.
- QM Director conducted staff meetings with QM team. Disc profile review and discussion at the February meeting.

Quality Management Goals and Objectives for FY 2024:

- Patient Safety and Zero Harm #1 objective.
- Complete Optima Healthcare Insurance recommendations for Performance as identified during FY 2022 ECRI Insight Hospital Risk Assessment.
- Complete Optima Healthcare webinars and educational offerings as available for risk reduction and solidify process to involve management team.
- Complete and support managers on the development/update of Plan-Do-Study-Act *(PDSA)* reports for departmental quality improvement efforts & indicators falling below target on the BSC.
- Support concurrent review, real-time, fail-safe patient care best practice processes; specifically stroke and sepsis care.
- Complete quarterly CMS Core Measure reporting to include inpatient Sepsis based on discharge diagnosis, and outpatient measures: Stroke, Acute Myocardial Infarction, Left without Being Seen and Emergency Room Admission to Discharge.
- Update all Quality and Risk Hospital Wide and department policies.
- Complete the update to the Enterprise Risk Management Plan and develop a plan for improvement opportunities for issues identified.
- Assure Corporate Compliance and HIPAA auditing processes in place and conduct audits as established by regulation, policy and as needed.
- Facilitate and assist Managers/Directors with CMS Survey readiness.
- Solidify education and implementation of Just Culture throughout organization.
- Participate in 2024 Quality and Patient Safety Awards sponsored by Alaska Hospital and Healthcare Association *(AHHA).*
- Completion of secure archiving of occurrence reports and scan past occurrence reports documented on paper.
- Review all process pathways and make appropriate adjustments in the RLDatix occurrence reporting system. Update forms and complete quality dashboards within the system.
- Continue transition of forms found on SIS into Policy Manager System.
- Carry out requirements of 2023-2024 SHIP Grant.
- Ongoing focus on improving HCAHPS performance to improve inpatient Press Ganey patient satisfaction scores.
- Quality Management Assistant, QM RN and QM Risk Mitigation RN to obtain Just Culture certification. QM Director to obtain Corporate Compliance education.
- QM Risk Mitigation RN/Privacy Office to obtain certification for Healthcare Privacy Compliance *(CHPC).*
- Complete tracking log to monitor QM responsibilities and activities.
- Complete full reviews of current Business Associate Agreements *(BAA)* and tracking system.
- Create HIPAA training packets for all on-site contract workers.
- Begin quality rounding throughout organization and identify opportunities for improvement.
- Continue to work with staff from security, acute care, and behavioral health to finalize hospital wide policies focused on patient in mental health crisis.

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24) REHABILITATION DEPARTMENT

Rehabilitation Department Accomplishments and Highlights for FY 2023:

- The COVID-19 Employee Health requirements affected the abilities of staff to work if they had any symptoms, which affects service and productivity.
- The rehab department offers telehealth treatment options to patients, partially in response to the COVID-19 pandemic and health mandates; telehealth is utilized on an as needed basis. The majority of our services are performed in person.
- Rehabilitation continues to have staffing challenges. The new Speech-Language Pathology *(SLP)* graduate completed her *"Certificate of Clinical Competency";* our other SLP desires to drop down to a .5 or less position, causing us a need to advertise for an additional SLP position. We have a fully staffed Occupational Therapy *(OT)* Department with the addition of a Pediatric/Generalist OT who started in January. The new Pediatric/Generalist Physical Therapist *(PT)* position will join the team mid-July 2023. Continue to advertise for a PT Assistant that has been vacant for over a year. We had Physical Therapist staff off work for various reasons, which affected volumes. SLP and OT volumes increased in the last year.
- Participated in community education seminars including: KBC-UAA CNA/RN training, Hospice Volunteer Training, Safe and Healthy Kids Fair, Rotary Health Fair and Wellness Walks.
- SPH rehab also trained the LTC CNA students in proper body mechanics and transfer techniques, and expanded the Unit Peer Leader Program at SPH.
- SPH Rehab continues to be a provider of key ergonomic services that impact hospital wellness including: pre-employment and post-offer job function testing, functional job analysis, injured worker return to work screening and ergonomic work station analysis.
- PT/OT staff completed updated training with *"DSI Work Solutions"* in Functional Job Analysis, Job Function Description, Job Function Testing, Job Function Matching as well as Functional Capacity Assessment.
- Current wait times for PT non-surgical cases is 4-6 weeks, SLP 3 weeks, OT *(hand therapy)* 1-2 weeks, and pediatric OT 2-6 weeks..
- Rehabilitation is anticipating a busy Pediatric Therapy caseload with the new PT/OT position.
- The Pelvic Floor therapy needs are being addressed in a limited capacity.
- Speech Therapy received an additional grant for the *"Speak Out Loud, a Parkinson's Voice Project".*
- The educational videos on *"Safe Patient Movement and Lifting"* are being used Unit Peer Leader program to assist with staff clinical staff education.
- Rehab staff provide SPH departments with ergonomic training on request.
- Several of the staff have obtained a "*Lymphedema Therapists Certification"* now serving the community with improved treatment offerings.

Rehabilitation Department Goals and Objectives for FY 2024:

- Decrease wait time for nonsurgical outpatients seeking an appointment.
- Retain PT, OT and SLP staff.
- Increase our presence at community and school events.
- Provide additional public education in areas of Parkinson's disease and Pelvic Floor PT intervention.
- Provide structure and support to South Peninsula Hospital's ergonomic intervention, return to work, pre-employment and post offer functional screening in an ongoing effort to reduce worker's compensation costs.

- Continue to provide ergonomic education/training to other departments at SPH.
- Update and revalidate all of the job function descriptions, job function tests for improved job matching and pre work screening process as well as post injury/illness return to work for employees.
- Continue to work with several Universities, including UAA, to offer clinical opportunities for internships for therapy students.
- Work with other providers to help with Community Health Needs Assessment objectives and needs identified in the community, i.e.: fall risk assessment for seniors, etc.
- Improve treatment space options for the department, especially for OT and SLP.

25) SECURITY SERVICES

Security Services Department Accomplishments and Highlights for FY 2023

- Hired new Safety and Security Supervisor.
- Hired/trained one full time security officer.
- Reviewed the security assessment.
- Updated 3-year implementation plan for security needs based off assessment.
- Developed security related policies.
- Reviewed current access control system and implemented a plan to bring the system current.
- Developed a training plan for Security officers.

Security Services Department Goals and Objectives for FY 2024:

- Add additional functionality to our camera and access control system by expanding both programs.
- Add additional training and tools to security staff.
- Continue to improve add additional policies and procedures related to security and patient safety.
- Continue to integrate with security throughout SPH campus.
- Work with Acute Care and Quality Management staff to improve room safety for patients on close observations or have a title 47 court ordered hold.

26) SPECIALTY CLINIC

Includes the following specialty clinics:

- Cardiology
- Diabetes and Lipidology
- Functional Medicine
- General Surgery
- Infusion
- Neurology
- Oncology
- Orthopedics
- Otolaryngology (Ear, Nose and Throat)
- Pacemaker
- Pulmonology
- Sleep Clinic
- Sleep Lab Home and In Lab studies
- Urology
- VA

Specialty Clinic Department Accomplishments and Highlights for FY 2023:

- Neurologist David Rankine, MD – clinics 2 weeks per month. Adult and Pediatric patients.
- Purchased new Electromyography *(EMG)* equipment with evoked potentials *(auditory and visual).*
- Peninsula Surgical Clinic was moved within 250 yards of hospital.

- Peninsula Surgical Clinic – addition of Dr. Nathan Kincaid full time surgeon.
- Neurology clinic moved into expanded space to accommodate added clinic days.
- Created Functional Medicine Facebook page with YouTube videos, podcasts, blog and new webpage.
- Rob Downey, MD participated with Walk with the Doc series and provided two presentations to the Rotary Club.
- Functional Medicine participated in and Rotary Health Fair.
- Rob Downey, MD is a facilitator for applying the Institute for Functional Medicine's *(IFM)* in Functional Medicine Clinical Practice, as well as, a case grader for certification applicants for the Institute for Functional Medicine.
- On boarded two additional otolaryngologists.

Specialty Clinic Major Objectives/Goals for FY 2024:

- Add pediatric cardiology clinic beginning with 2 days per year (travel from Seattle).
- Implement Telemedicine with Neurology Clinic.
- Implement Group visits for Hypothyroidism and Functional Medicine.
- Increase infusions by reaching out to providers in order to meet their patients' needs.
- Add pediatric neurologist to read EEG results for patients 18 and younger.
- Add dermatology provider.
- Transition part-time orthopedic provider to full-time.

27) SURGICAL SERVICES

Surgical Services Department Accomplishments and Highlights for FY 2023:

- Welcomed Kathy Madej, CRNA, to the surgical team.
- Successful implementation of Peri-op 101 program for a new graduate RN hired into the OR Circulator position.
- Welcomed new Surgical Services full time staff member, Nicole Simons CST, to eliminate the cost of utilizing travel staff.
- Welcomed new Surgical Services full time staff member, Jordan Sandquist RN, to eliminate the cost of utilizing travel staff.
- Welcomed new Surgical Services full time staff member, Julie Hawkins RN, to eliminate the cost of utilizing contract staff.
- Cross-trained some surgical staff interdepartmentally to OR Purchasing, Surgery Coordinator, Scrub RN, and SPD to improve staffing model.
- Continued collaboration with OB Department for training of staff on urgent and stat C-section care.
- Consolidating supplies and continually placing surgical supplies infrequently used on do not reorder status to increase savings.

Surgical Services Department Major Objectives/Goals for FY 2024:

- Continue to grow volume of existing specialties by increasing marketing and education of staff and physicians.
- Continue to evaluate utilization of supplies, condensing necessary supplies, and updating Periodic Automatic Replenishment *(PAR)* levels for cost effective budgeting.
- Increase recruiting and networking efforts to recruit full time staff to reduce cost of travel personnel contracts and promote consistency in surgery.

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- Complete and implement SPH new to specialty PACU training.
- Orient two new PREOP/PACU RNs, filling all positions in the department.
- Work to cross train surgical staff interdepartmentally to improve staffing model. Encourage specialty certifications for RN staff to promote best practice care and increase educational reach.
- Continue to evaluate and develop Surgical Services policies and procedures.
- Develop and monitor Performance Improvement measures form Press Ganey surveys.
- Plan to install and put into service the third new Draeger Apollo anesthesia machine.

APPROVED BY THE BOARD OF DIRECTORS (BOD) DURING JULY 26, 2023 BOD MEETING.

Kelly Cooper, President _____ Date _____

Completed by:
Ryan Smith, Chief Executive Officer
Susan M. Shover, BSN, RN, CPHQ; Director of Quality Management
Tracy Ansell, Quality Management Assistant
SPH Department Directors and Managers

South Peninsula Hospital
Hospital Board of Trustees Balanced Scorecard Report
2nd Quarter Calendar 2023 *(Apr, May, Jun)*

Overall Indicators	2Q 2023	Target	n	Note
Medicare Care Compare Overall Hospital Star Rating	N/A	5		There are too few measures or measure groups reported to calculate.
Medicare Care Compare Overall Hospital Survey Star Rating	4	5		
Medicare Care Compare Overall Nursing Home Star Rating	5	5		
Medicare Merit Based Incentive Payment System Total Score	34.33	25		2019-- 60.6; 2020--75.2; 2021--81.34

Clinical & Service Excellence

Using evidence-based practices, South Peninsula Hospital is dedicated to achieving consistent and demonstrated excellence in clinical quality and safety.

Quality of Care / Patient Safety	2Q 2023	Target	n	Note
Severe Sepsis & Septic Shock Care	100%	>75%	52	*(Care Compare : 29 cases - 66%, 7/1/21-6/30/22)*
Sepsis *(% of patients who received appropriate care for sepsis and/or septic shock.)*				# of cases passing/total # of cases-exceptions *(52 cases reviewed: 15 pass, 0 fail, 37 exclusions)*
Stroke Care	44%	> 95%	16	*(Care Compare N/A, 7/1/21-6/30/22)*
Percentage of patients who came to ED w/Stroke symptoms and received CT/MRI within 45 minutes of arrival.				Numerator = CT/MRI within 45 min & documented last known well. Denominator = Patients with Stroke presenting within 2 hours of symptoms. *(7- pass, 9- failed, 0- exclusions)*
Median Emergency Room Time	179 min	180 min	1409	**Target *(minutes)*** *(Care Compare: 158 min, 7/1/21-6/30/22)*
Average time spent in department before leaving.				Average throughput time of all ED visits
Readmission	5.5%	< 15%	164	*(Care Compare 15.8%, 7/1/20-6/30/21))*
The readmission measures are estimates of the rate of unplanned readmission to an acute care hospital in 30 days after discharged from a hospitalization. Patients may have had an unplanned readmission for any reason.				% of patients with unplanned readmission to (IP/Obs) within 30 days of discharge - exclusions/Eligible admissions- (0 readmits/total admits*0)
Elective Deliveries	0%	0%	31	*(Care Compare 0%, 22 patients 7/1/21-6/30/22))*
Percentage of mothers whose deliveries were scheduled too early *(1-2 weeks early)* , when a scheduled delivery wasn't medically necessary.				# of non-medically indicated deliveries before 39 weeks gestation / total deliveries.
Provider Quality Score (Group)	19 pts	15 pts	N/A	**Scoring tabulated as a running, annual score.**
CMS Merit-Based Incentive Payment System *(MIPS)* for providers				Target to be adjusted Quarterly as appropriate
Patient Fall Rate AC	0	< 5	1054	**# of patient falls / # patient days x 1000**
Measures the number of patient falls per 1,000 patient days				n = IP, observations and swing bed patient days. **Note:** AC had 1 falls - 0 without injury, 0 with minor injuries, 0 were same patient.

Quality of Care / Patient Safety *(continued)*	2Q 2023	Target	n	Note
Medication Errors	**0**	**0**	**N/A**	
Measures the number of reported medication errors causing patient harm or death.				Reported errors classified as type E-I by the National Coordinating Council for Med Error Reporting and Prevention/CMS
Never Events	**0**	**0**	**N/A**	
Unexpected occurrence involving death/serious physiological or psychological injury, or the risk thereof.				
Home Health (HH)	**2Q 2023**	**Target**	**n**	**Note**
Improvement in Breathing	**72.7%**	**> 80%**	**22**	
Percentage of home health quality episodes patient became less short of breath.				100% of the patients stayed the same or improved. No patient declined.
Correct Medication Administration	**69.6%**	**> 75%**	**23**	
Percentage of home health quality episodes patients improved taking oral medication correctly.				95.7% of the patients stayed the same or improved. One patient declined.
Nursing Home	**2Q 2023**	**Target**	**n**	**Note**
Fall with Major Injury	**0**	**< 3%**	**N/A**	
Number of residents who sustained a fall resulting in fracture, dislocation, head injury w/altered consciousness, or subdural hematoma.				Last fall with major injury: September 2021
Urinary Tract Infections *(UTI)*	**0**	**< 3**	**N/A**	
Number of residents diagnosed with a UTI.				Last UTI: June 2022

Patient & Resident Experience

As the patient and resident experience is a prime indicator of the organization's overall health, South Peninsula Hospital strives to tenaciously pursue patient and resident experience improvements.

Consumer Assessment of Healthcare Providers and Services	2Q 2023	Target	n	Note: Measures as a % ranking across PG clients.
HCAHPS Percentile	**97th**	**75th**	**35**	
Measures the 1-10 ranking received by inpatient client *(or family)* respondents.				Q4 -2022, 63rd, n = 42 Q1 -2023, 88th, n = 25
HHCAHPS Percentile	**94th**	**75th**	**29**	***Running 12 months due to low quarterly returns**
Measures the 1-10 ranking received by Home Health Care client (or family) respondents.				Q4 -2022 , 87th, n = 33 Q1 -2022, 99th, n = 33

Patient Satisfaction Through Press Ganey (PG)	2Q 2023	Target	n	Note: % ranking across PG clients.
Inpatient Percentile	**82nd**	**75th**	**36**	
Measures the satisfaction of inpatient pts. respondents.				Q4 -2022: 69th, n = 43 Q1 -2023: 84th, n = 25
Outpatient Percentile	**15th**	**75th**	**290**	
Measures the satisfaction of outpatient pts. respondents.				Q4 -2022: 12th, n = 252 Q4 -2023: 24th, n = 271
Emergency Department Percentile	**97th**	**75th**	**97**	
Measures the satisfaction of emergency pts. respondents.				Q1 -2022: 96th, n = 43 Q1 -2023: 88th, n = 59
Medical Practice Percentile	**60th**	**75th**	**425**	
Measures the satisfaction of pts. respondents at SPH Clinics.				Q4 -2022: 58th, n = 454 Q1 -2023: 62nd, n = 358
Ambulatory Surgery (AS) Percentile	**38th**	**75th**	**83**	
Measures the satisfaction of AS pts. respondents.				Q4 -2022: 74th, n = 69 Q0 -2023: 67th, n = 75
Home Health Care Percentile (HHC)	**85th**	**75th**	**8**	***Running 12 months due to low quarterly returns**
Measures the satisfaction of HHC clients *(or family)* respondents.				Q4 -2022: 99th, n = 2 Q1 -2023: 99th, n = 9
Information System Solutions	**2Q 2023**	**Target**	**n**	**Note**
Eligible Hospital (EH) Promoting Interoperability: hospital-based measures for inpatient and observation stays.	**85**	**> 60**		**CMS score 60 and above = pass**
e-Prescribing: Electronic Prescribing *(Rx)*	**8**	**10**	352	290 of 352
Query PDMP	**10**	**10**		PDMP Query via EHR interface
Health Information Exchange: Support Electronic Referral Loops by receiving and incorporating health information	**15**	**15**	3	3 of 3
HIE: Suppt. Electronic Referral Loops by sending health info. *(Sum.of Care sent)*	**4**	**15**	174	44 of 174
Provider to patient exchange: Provide patients electronic access to their health information *(timely access via the patient portal)*	**23**	**25**	226	203 of 226
Public Health & Clinical Data Exchange	**25**	**25**	4	4 of 4
Eligible Provider (EP) - Promoting Interoperability (Group)	**N/A**	**10 pts**		**Target quarterly for annual score**
Merit Based Incentive Payment System Promoting Interoperability score *(MIPS tracking is in Athena)*				Promoting Interoperability for Providers: N/A * Athena hasn't calculated our score yet
Electronic Medical Record (EMR) Adoption Stage	**5**	**5**		
Health Information Management & Systems Society *(HIMSS)* Electronic Medical Record Adoption Model *(EMRAM)* stage.				The current US average is 2.4 out of a possible 7.0 stages. Stage 0 and 0 require site visit validation.

Information System Solutions *(Continued)*	2Q 2023	Target	n	Note
IT Security Awareness Training Complete Rate	**86%**	**97%**	**1714**	
% of employees who have completed assigned security training				1714 videos training sent, 1473 completed.
Phishing Test Pass Rate	**99.4%**	**97%**	**1177**	
% of Phishing test emails that were not failed.				**1177** test phishing emails sent out to staff. **7** of the email links were clicked, causing **7** potential security risks.

Medical Staff Alignment

South Peninsula Hospital desires to be an employer and/or provider of choice for medical staff practitioners by fostering an atmosphere of continuous collaboration.

Provider Alignment	2021	Target	n	Note
Provider Satisfaction Percentile	**74th**	**75th**		
Measures the satisfaction of physician respondents as indicated by Press Ganey physician survey results. Measured as a percentile.				Result of provider survey 2021

Employee Engagement

South Peninsula Hospital desires to be an employer of choice that offers our staff an opportunity to make positive impact in our community.

Staff Alignment	2021			
Employee Satisfaction Percentile	**70th**	**75th**		
Measures the satisfaction of staff respondents as indicated in Press Ganey staff survey results Measured as a percentile.				Result of employee survey 2021
Workforce	**2Q 2023**	**Target**	**n**	**Note**
Turnover: All Employees	**4.12%**	**< 5%**	**582**	
Percentage of all employees separated from the hospital for any reason				24 Terminations / 582 Total Employees
Turnover: Voluntary All Employees	**2.92%**	**< 4.75%**	**582**	
Measures the percentage of voluntary staff separations from the hospital				17 Voluntary Terminations / 582 Total Employees
First Year Total Turnover	**10.74%**	**< 7%**	**121**	
Measures the percentage of staff hired in the last 12 months and who separated from the hospital for any reason during the quarter.				13 New Staff Terminated in Q2 121 Total New Hires from - 7/1/2022 -6/30/2023
Travel Nursing Utilization	**23**	**< 20**	**86**	
Measure total travel staff utilized in a previous quarter (Internal & External)				0-202 - External: 0 / Internal: 0, Total: 0

Financial Health

SPH is financially positioned to support our dedication to the Mission, Vision and Values, and our continued investment in our employees, medical staff, physical plant and equipment.

Financial Health	2Q 2023	Target	n	Note
Operating Margin	**-4.49%**	**2.6%**		
Measures the surplus (deficit) of operating income over operating expenses as a percentage of net patient service revenue for the quarter.				Target is based on budgeted operating margin for the period.
Adjusted Patient Discharges	**926.75**	**954.84**		
Measures the number of patients discharged, adjusted by inpatient revenues for the quarter divided by *(inpatient + outpatient revenues).*				Total Discharges: 142 *(Acute, OB, Swing, ICU)* *(LTC Revenue & discharges not included)*
Net Revenue Growth	**4.3%**	**7.3%**		
Measures the percentage increase *(decrease)* in net patient revenue for the quarter compared to the same period in the prior year.				Target is based on budgeted net patient service revenue for the period compared to net patient service revenue for the same period in prior year.
Full Time Equivalents *(FTEs)* per Adjusted Occupied Bed	**8.21**	**9.33**		
Measures the average number of staff FTEs per adjusted occupied bed for the quarter.				Target is based on budgeted paid hours *(FTE)* divided by *(budget gross patient revenue/budget gross inpatient rev)* X budgeted average daily census for the quarter.
Net Days in Accounts Receivable	**51.0**	**55**		
Measures the rate of speed with which the hospital is paid for health care services.				
Cash on Hand	**90**	**90**		**# Represents days**
Measure the actual unrestricted cash on hand (excluding PREF and Service Area) that the hospital has to meet daily operating expenses.				Cash available for operations based average daily operating expenses during the quarter less depreciation for the quarter.
Uncompensated Care as a Percentage of Gross Revenue	**3.3%**	**2.5-3.5%**		
Measures bad debt & charity write offs as a percentage of gross patient service revenue				Target is based on industry standards & SPH Payer Mix Budgeted total is 2.9% Expected range of 2.5-3.5%
Average Age of Plant	**14.09**	**8 yrs.**		
Average age of assets used to provide services				The average age of plant is calculated based on accumulated depreciation, divided by depreciation expense.
Intense Market Focus to Expand Market Share	**2Q 2023**	**Target**	**n**	**Note**
Outpatient Revenue Growth	**10.2%**	**4%**		
Measures percentage increase (decrease) in outpatient revenue for the quarter, compared to the same period in the prior year.				Target is based on budgeted outpatient revenue for the period compared to outpatient revenue for the same period prior year.
Surgical Case Growth	**-9.8%**	**3.4%**		
Measures the increase *(decrease)* in surgical cases for the quarter compared to the same period in the prior year.				Target is based on budgeted surgeries above actual from same quarter prior year.