AGENDA
Board of Directors Meeting
5:30 PM - Wednesday, August 23, 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 - 9 7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for July 26, 2023

Board of Directors - Jul 26 2023 - Minutes - DRAFT

10 - 13 7.2. Consideration to Approve July FY2024 Financials
Balance Sheet July FY24
Income Statement July FY24
Cash Flows Statement July FY24

14 - 39 7.3. Consideration to Approve the Updated Bloodborne Pathogen Exposure Plan
Memo
Bloodborne Pathogen Exposure Control Plan, revised

40 - 42 7.4. Consideration to Approve SPH Board of Directors Resolution 2023-23, A Resolution of the South Peninsula Hospital Board of Directors Authorizing Bank Account Signers
SPH Resolution 2023-23

43 7.5. Consideration to Approve SPH Resolution 2023-25, A Resolution of the South Peninsula Hospital Board of Directors Approving a Minor Alteration of Scope to Project 21SHB Remodel of Kachemak Bay Professional Building
SPH Resolution 2023-25

8. PRESENTATIONS

9. UNFINISHED BUSINESS

10. NEW BUSINESS

44 - 45 10.1. Consideration to Approve SPH Resolution 2023-24, A Resolution of hte South Peninsula Hospital Board of Directors Approving the Use of Operating Cash to Fund the Capital Lease of the Stryker Mako SmartRobotics System
SPH Resolution 2023-24

46 - 56 10.2. FIRST READING: Consideration to Revise the Board of Directors Bylaws to Clarify Language Regarding Number of Votes Required for Censure or Removal of a Board Member.
Memo - Bylaw Change
Bylaws, proposed changes 08 18 2023

11. REPORTS

57 - 61 11.1. Chief Executive Officer
Balanced Scorecard 2Q 2023

11.2. BOD Committee: Pension

11.3. BOD Committee: Finance

62 - 63 11.4. BOD Committee: Governance
Board Governance Committee - Aug 17 2023 - Minutes - DRAFT

11.5. BOD Committee: Education

11.6. Chief of Staff

11.7. Service Area Board Representative: Kathryn Ault

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

64 - 70 15.1. Patient Centered Care Quality Committee Minutes.
PCCQ Minutes - July 2023

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, July 26, 2023
Conference Rooms 1&2 and Zoom

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

1. CALL TO ORDER

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

2. ROLL CALL

BOARD PRESENT: **President Kelly Cooper, Keriann Baker, Todd Boling, Melissa Jacobsen, Edson Knapp, Walter Partridge, Aaron Weisser, Bernadette Wilson, Julie Woodworth, Beth Wythe.**

BOARD EXCUSED: **Matthew Hambrick,**

ALSO PRESENT: **Ryan Smith (CEO), Rachael Kincaid (CNO), Angela Hinnegan (COO), Anna Hermanson (CFO), Christina Tuomi (CMO), Maura Jones (Executive Assistant), Mike Tupper (KPB Assembly), Lane Chesley (KPB Assembly), Brent Hibbert (KPB Assembly), Peter Micciche (KPB Mayor), John Hedges (KPB Project Manager), Brandi Harbaugh (KPB Finance Director)**
Due to the hybrid Zoom meeting format, only meeting participants who comment, give report or give presentations are noted in the minutes. Others may be present on the virtual meeting.

A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Rachael Kincaid, CNO, shared a Living Our Values story. A patient in distress recently presented at the loading dock, and non-clinical staff had to react quickly to help. They did an excellent job and helped the patient get to the care they needed.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

There were no comments from the audience at this time.

6. APPROVAL OF THE AGENDA

Melissa Jacobsen made a motion to approve the agenda. Walter Partridge seconded the motion. Motion Carried.

7. APPROVAL OF THE CONSENT CALENDAR

Aaron Weisser read the consent calendar into the record.

8. PRESENTATIONS

There were no presentations.

9. UNFINISHED BUSINESS

There was no unfinished business.

10. NEW BUSINESS

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

Ryan Smith reported. Included in the packet is a copy of 2023's Critical Access Hospital QAPI Evaluation. The Quality Management department creates this document each year with input from staff all over the facility. Ms. Cooper expressed her appreciation for Sue Shover (Quality Director) and her team for putting this document together.

Aaron Weisser made a motion to approve the Annual Critical Access Hospital (CAH) Quality Assessment and Performance Improvement Evaluation for 2023 Melissa Jacobsen seconded the motion. Motion Carried.

11. REPORTS

11.2. BOD Committee: Finance

Walter Partridge, Finance Committee Chair, reported. The Finance Committee met last week and reviewed the financials for the month.

11.3. BOD Committee: Governance

Aaron Weisser, Governance Committee Chair, reported on the committee's progress towards completing the task list compiled at last fall's board work session. The committee has clarified Conflict of Interest policies, and added relevant language to board membership forms. We have reinstituted Board/Medical Staff dinners, with one scheduled for August. We have separated the CEO Evaluation process from the Governance Committee, and developed a job description for the Board President, which was approved at the previous board meeting. We decided not to move forward with making any changes to the statement in the bylaws that we follow Robert's Rules of Order, though this can be revisited in the future if the board wishes to adopt its own meeting rules. The committee made changes to the officer terms, but elected not to institute term limits for membership. We considered the idea of having a President-elect instead of a Vice President, but decided against that option. At the next meeting, we'll look at supermajority requirements in our policies and bylaws. We will also circle back to recusal requirements when we have new legal counsel identified for the board.

11.4. BOD Committee: Education

Melissa Jacobsen, Education Committee Chair, reported. The Education Committee did not meet this month. The board education software, iProtean,

has been acquired by Veralon, and we're planning to meet with new representatives next month.

11.5. Chief of Staff

Dr. Tuomi reported on behalf of Dr. Landess. We have welcomed several new physicians over the past month and are happy to have them on board. The Emergency Room and patient floor have been very busy lately.

11.6. Service Area Board Representative

Amber Cabana reported on behalf of the Service Area Board (SAB). The SAB did not meet last month so there was not much to report. The next scheduled meeting is August 10th. There will be several open seats on the board this fall, so there has been a recruitment effort.

12. DISCUSSION

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

Mayor Micciche spoke to the board. He shared how important South Peninsula Hospital is to the borough, and how they plan to be partners with SPH, as owners of the hospital. He explained that although they was not comfortable going out to bonds this year, the borough did come up with other options for SPH to move forward with their projects, and the borough will support going out for a bigger bond project in 2024.

John Hedges, KPB Purchasing & Contract Director, gave an update on the current process of assessing the SPH facility and targeting the highest priority for replacement and restoration of the aging plant.

Mayor Micciche and Ryan Smith discussed how the borough and hospital leadership could support each other. Mr. Smith mentioned that we are operating a declining asset and what the hospital needs going forward is for the borough to help move quickly on projects to help with the aging plant. He appreciates Mayor Micciche and Mr. Hedges for meeting with him to support the hospital on its goals to update the electronic medical record, to find consistent housing for staff and physicians, and to move forward with the certificate of need project.

Lane Chesley, KPB Assembly member, suggested that South Peninsula Hospital give their quarterly report on a different day from Central Peninsula Hospital, to allow more discussion with assembly member. He also encouraged hospital representation at committee meetings.

Brent Hibbert, KPB Assembly member, encouraged the hospital administration and board to share information with Lane Chesley and Mike Tupper, so they can continue to update the assembly.

Mike Tupper, KPB Assembly member, encouraged the board to consider membership term limits, as a way to make sure a board doesn't turn into an echo chamber.

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

Mr. Smith had no further comments.

14.2. Board Members

Julie Woodworth appreciated the governance report and the balanced scorecard update. Dr. Knapp thanked the mayor and borough representatives for being present. Bernadette Wilson welcomed the new physicians and congratulated the finance team on meeting their goals of Days in Accounts REceiveable and Days Cash on Hand. She thanked the mayor and his team for attending the meeting, and for their support. She thanked Mr. Weisser for everything the Governance Committee has accomplished. Aaron Weisser thanked the kitchen crew for hte excellent dinner. Melissa Jacobsen thanked the mayor and his staff for attending the meeting. Walter Partridge expressed his appreciation for the financial staff at the hospital. Beth Wythe thanked the mayor for attending the meeting, and appreciates that he is stepping up to help the hospital with long term needs. She congratulated the hospital staff for all the improvements in the scorecard. Kelly Cooper thanked Mayor Micciche for making the trip to Homer. She also thanked hospital staff working on making the outpatient order process more smooth. As a patient of the hospital, she has noticed a marked improvement.

15. INFORMATIONAL ITEMS

15.1. AHHA Annual Conference September 20-21st

https://www.alaskahha.org/conference

16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

The board adjourned to executive session at 7:00pm, and returned to open session at 7:55pm.

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 approve the following positions in the medical staff as requested and recommended by the Medical Executive Committee. Melissa Jacobsen seconded the motion. Motion carried.

Reappointment (Telemed)

Desai, Kinjal MD; Telestroke/Neurology; Telemedicine
Goueli, Hisam MD; Telepsych/Psychiatry; Telemedicine
Mao, Yi MD; Telestroke/Neurology; Telemedicine

Skolnick, Alan MD; Cardiology/Remote Echo Interp; Courtesy Staff

Reappointment
Marsh, Miranda CRNA; Anesthesia; Active Staff

18. ADJOURNMENT

The meeting was adjourned at 7:57pm.

Respectfully Submitted,

Maura Jones, Executive Assistant

Accepted:

Kelly Cooper, President

Minutes Approved:

Julie Woodworth, Secretary

South Peninsula Hospital

DRAFT-UNAUDITED

BALANCE SHEET
As of July 31, 2023

		As of July 31, 2023	As of July 31, 2022	As of June 30, 2023	CHANGE FROM July 31, 2022
	ASSETS				
	CURRENT ASSETS:				
1	CASH AND CASH EQUIVALENTS	25,634,075	24,064,135	26,124,541	1,569,940
2	EQUITY IN CENTRAL TREASURY	8,859,818	7,551,132	8,502,601	1,308,686
3	TOTAL CASH	34,493,893	31,615,267	34,627,142	2,878,626
4	PATIENT ACCOUNTS RECEIVABLE	35,482,311	31,328,967	31,834,920	4,153,344
5	LESS: ALLOWANCES & ADJ	(18,586,042)	(14,365,837)	(16,801,733)	(4,220,205)
6	NET PATIENT ACCT RECEIVABLE	16,896,269	16,963,130	15,033,187	(66,861)
7	PROPERTY TAXES RECV - KPB	4,148,966	3,886,128	95,078	262,838
8	LESS: ALLOW PROP TAX - KPB	(4,165)	(4,165)	(5,417)	0
9	NET PROPERTY TAX RECV - KPB	4,144,801	3,881,963	89,661	262,838
10	OTHER RECEIVABLES - SPH	363,077	445,259	366,977	(82,182)
11	INVENTORIES	2,105,887	2,056,445	2,130,033	49,442
12	NET PENSION ASSET- GASB	5,107,959	4,775,709	5,080,272	332,250
13	PREPAID EXPENSES	921,634	748,043	737,229	173,591
		-	-	-	
14	TOTAL CURRENT ASSETS	64,033,520	60,485,816	58,064,501	3,547,704
	ASSETS WHOSE USE IS LIMITED				
15	PREF UNOBLIGATED	6,156,930	5,939,928	6,156,930	217,002
16	PREF OBLIGATED	2,112,254	1,964,169	2,112,254	148,085
17	OTHER RESTRICTED FUNDS	46,575	47,050	46,575	(475)
		8,315,759	7,951,146	8,315,759	364,613
	PROPERTY AND EQUIPMENT:				
18	LAND AND LAND IMPROVEMENTS	4,114,693	4,114,693	4,114,693	0
19	BUILDINGS	63,998,829	67,424,631	63,998,829	(3,425,802)
20	EQUIPMENT	28,019,765	30,161,106	28,019,765	(2,141,341)
21	BUILDINGS INTANGIBLE ASSETS	2,478,113	2,382,262	2,478,113	95,851
22	EQUIPMENT INTANGIBLE ASSETS	462,427	462,427	462,427	0
23	IMPROVEMENTS OTHER THAN BUILDINGS	311,331	290,386	311,331	20,945
24	CONSTRUCTION IN PROGRESS	1,426,104	566,276	1,254,244	859,828
25	LESS: ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(57,743,702)	(61,870,858)	(57,384,325)	4,127,156
26	LESS: ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(901,442)	(453,815)	(863,032)	(447,627)
27	NET CAPITAL ASSETS	42,166,118	43,077,108	42,392,045	(910,990)
28	GOODWILL	4,000	16,000	5,000	(12,000)
29	**TOTAL ASSETS**	114,519,397	111,530,070	108,777,305	2,989,327
	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	281,845	349,128	287,119	(67,283)
32	TOTAL DEFERRED OUTFLOWS OF RESOURCES	4,812,762	4,880,045	4,818,036	(67,283)
33	TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	119,332,159	116,410,115	113,595,341	2,922,044

		As of July 31, 2023	As of July 31, 2022	As of June 30, 2023	CHANGE FROM July 31, 2022
	LIABILITIES & FUND BALANCE				
	CURRENT LIABILITIES:				
34	ACCOUNTS AND CONTRACTS PAYABLE	1,951,468	1,064,753	1,447,819	886,715
35	ACCRUED LIABILITIES	12,767,598	11,124,952	8,335,462	1,642,646
36	DEFERRED CREDITS	68,007	24,836	74,840	43,171
37	CURRENT PORTION OF LEASE PAYABLE	506,340	390,935	504,897	115,405
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	128,624	170,696	100,216	(42,072)
41	DUE TO/(FROM) THIRD PARTY PAYERS	938,830	1,005,761	938,761	(66,931)
43	TOTAL CURRENT LIABILITIES	18,210,867	15,291,933	13,251,995	2,918,934
	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	379,575	523,205	389,368	(143,630)
47	CAPITAL LEASE, NET OF CURRENT PORTION	1,876,539	2,106,221	1,912,204	(229,682)
48	TOTAL NONCURRENT LIABILITIES	8,871,114	11,369,426	8,916,572	(2,498,312)
49	TOTAL LIABILITIES	27,081,981	26,661,359	22,168,567	420,622
50	DEFERRED INFLOW OF RESOURCES	0	0	0	0
51	PROPERTY TAXES RECEIVED IN ADVANCE	0	0	495,208	0
	NET POSITION				
52	INVESTED IN CAPITAL ASSETS	5,731,963	5,731,963	5,731,963	0
53	CONTRIBUTED CAPITAL - KPB	0	0	0	0
54	RESTRICTED	25,286	25,286	25,286	0
55	UNRESTRICTED FUND BALANCE - SPH	86,492,929	83,991,507	85,174,317	2,501,422
56	UNRESTRICTED FUND BALANCE - KPB	0	0	0	0
		-	-	-	
57	**TOTAL LIAB & FUND BALANCE**	119,332,159	116,410,115	113,595,341	2,922,044

South Peninsula Hospital

INCOME STATEMENT
As of July 31, 2023
DRAFT-UNAUDITED

		MONTH				YEAR TO DATE			
		07/31/23			07/31/22	07/31/23			07/31/22
		Actual	Budget	Var B/(W)	Actual	Actual	Budget	Var B/(W)	Actual
	Patient Service Revenue								
1	Inpatient	3,055,084	2,558,542	19.41%	2,639,659	3,055,084	2,558,542	19.41%	2,639,659
2	Outpatient	13,988,887	13,322,061	5.01%	11,509,791	13,988,887	13,322,061	5.01%	11,509,791
3	Long Term Care	1,161,784	1,182,413	-1.74%	1,033,352	1,161,784	1,182,413	-1.74%	1,033,352
4	Total Patient Services	18,205,755	17,063,016	6.70%	15,182,802	18,205,755	17,063,016	6.70%	15,182,802
	Deductions from Revenue								
5	Medicare	4,197,215	3,349,193	-25.32%	3,423,329	4,197,215	3,349,193	-25.32%	3,423,329
6	Medicaid	1,911,142	2,107,925	9.34%	1,836,597	1,911,142	2,107,925	9.34%	1,836,597
7	Charity Care	272,733	186,286	-46.41%	97,396	272,733	186,286	-46.41%	97,396
8	Commercial and Admin	1,468,556	1,480,202	0.79%	1,353,685	1,468,556	1,480,202	0.79%	1,353,685
9	Bad Debt	473,319	247,834	-90.98%	202,856	473,319	247,834	-90.98%	202,856
10	Total Deductions	8,322,965	7,371,440	-12.91%	6,913,863	8,322,965	7,371,440	-12.91%	6,913,863
11	Net Patient Services	9,882,790	9,691,576	1.97%	8,268,939	9,882,790	9,691,576	1.97%	8,268,939
12	USAC and Other Revenue	97,304	76,689	26.88%	73,591	97,304	76,689	26.88%	73,591
13	Total Operating Revenues	9,980,094	9,768,265	2.17%	8,342,530	9,980,094	9,768,265	2.17%	8,342,530
	Operating Expenses								
14	Salaries and Wages	4,651,074	4,629,415	-0.47%	4,025,917	4,651,074	4,629,415	-0.47%	4,025,917
15	Employee Benefits	1,762,606	1,978,783	10.92%	1,743,494	1,762,606	1,978,783	10.92%	1,743,494
16	Supplies, Drugs and Food	1,243,153	1,108,688	-12.13%	1,079,849	1,243,153	1,108,688	-12.13%	1,079,849
17	Contract Staffing	212,323	96,597	-119.80%	243,177	212,323	96,597	-119.80%	243,177
18	Professional Fees	513,286	501,190	-2.41%	471,900	513,286	501,190	-2.41%	471,900
19	Utilities and Telephone	163,470	109,831	-48.84%	129,379	163,470	109,831	-48.84%	129,379
20	Insurance (gen'l, prof liab, property)	75,904	73,203	-3.69%	57,220	75,904	73,203	-3.69%	57,220
21	Dues, Books, and Subscriptions	18,049	17,114	-5.46%	15,236	18,049	17,114	-5.46%	15,236
22	Software Maint/Support	154,874	151,008	-2.56%	175,139	154,874	151,008	-2.56%	175,139
23	Travel, Meetings, Education	37,534	74,128	49.37%	42,558	37,534	74,128	49.37%	42,558
24	Repairs and Maintenance	184,543	134,018	-37.70%	132,931	184,543	134,018	-37.70%	132,931
25	Leases and Rentals	67,742	71,990	5.90%	62,513	67,742	71,990	5.90%	62,513
26	Other (Recruiting, Advertising, etc.)	235,336	155,580	-51.26%	95,031	235,336	155,580	-51.26%	95,031
27	Depreciation & Amortization	360,375	345,139	-4.41%	337,587	360,375	345,139	-4.41%	337,587
28	Total Operating Expenses	9,680,269	9,446,684	-2.47%	8,611,931	9,680,269	9,446,684	-2.47%	8,611,931
29	**Gain (Loss) from Operations**	**299,825**	**321,581**	**6.77%**	**(269,401)**	**299,825**	**321,581**	**6.77%**	**(269,401)**
	Non-Operating Revenues								
30	General Property Taxes	1,006,547	837,185	20.23%	1,035,010	1,006,547	837,185	20.23%	1,035,010
31	Investment Income	43,859	34,521	27.05%	17,863	43,859	34,521	27.05%	17,863
32	Governmental Subsidies	0	0	0.00%	0	0	0	0.00%	0
33	Other Non Operating Revenue	0	419	100.00%	0	0	419	100.00%	0
34	Gifts & Contributions	0	0	0.00%	0	0	0	0.00%	0
35	Gain <Loss> on Disposal	0	0	0.00%	0	0	0	0.00%	0
36	SPH Auxiliary	0	375	-100.00%	1	0	375	-100.00%	1
37	Total Non-Operating Revenues	1,050,406	872,500	20.39%	1,052,874	1,050,406	872,500	20.39%	1,052,874
	Non-Operating Expenses								
38	Insurance	0	0	0.00%	0	0	0	0.00%	0
39	Service Area Board	(833)	2,002	141.61%	8,067	(833)	2,002	0.00%	8,067
40	Other Direct Expense	0	6,056	100.00%	(37)	0	6,056	100.00%	(37)
41	Administrative Non-Recurring	0	0	0.00%	0	0	0	0.00%	0
42	Interest Expense	33,818	34,394	1.67%	39,505	33,818	34,394	1.67%	39,504
43	Total Non-Operating Expenses	32,985	42,452	22.30%	47,535	32,985	42,452	22.30%	47,534
	Grants								
44	Grant Revenue	38,420	67,216	0.00%	0	38,420	67,216	0.00%	0
45	Grant Expense	0	2,501	100.00%	2,501	0	2,501	100.00%	2,501
46	Total Non-Operating Gains, net	38,420	64,715	-40.63%	(2,501)	38,420	64,715	40.63%	(2,501)
47	Income <Loss> Before Transfers	1,355,666	1,216,344	-11.45%	733,437	1,355,666	1,216,344	11.45%	733,438
48	Operating Transfers	0	0	0.00%	0	0	0	0.00%	0
49	**Net Income**	**1,355,666**	**1,216,344**	**11.45%**	**733,437**	**1,355,666**	**1,216,344**	**11.45%**	**733,438**

DRAFT-UNAUDITED

South Peninsula Hospital

Statement of Cash Flows
As of July 31, 2023

	Cash Flow from Operations:		
1	YTD Net Income		1,355,666
2	Add: Depreciation Expense		360,375
3	Adj: Inventory (increase) / decrease		24,146
4	Patient Receivable (increase) / decrease		(1,863,082)
5	Prepaid Expenses (increase) / decrease		(184,405)
6	Other Current assets (increase) / decrease		(4,051,240)
7	Accounts payable increase / (decrease)		505,092
8	Accrued Salaries increase / (decrease)		4,432,136
9	Net Pension Asset (increase) / decrease		(27,687)
10	Other current liability increase / (decrease)		(512,390)
11	Net Cash Flow from Operations		38,611
	Cash Flow from Investing:		
12	Cash paid for the purchase of property/equip		(171,860)
13	Cash transferred to plant replacement fund		-
14	Proceeds from disposal of equipment		-
15	Net Cash Flow from Investing		(171,860)
	Cash Flow from Financing		
16	Cash paid for Lease Payable		-
17	Cash paid for Debt Service		-
18	Net Cash from Financing		-
19	Net increase in Cash	$	(133,249)
20	Beginning Cash as of July 1, 2022	$	34,627,142
21	Ending Cash as of July 31, 2023	$	34,493,893

South Peninsula Hospital

MEMO

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

To: SPH Board of Directors

From: Employee Health/Infection Prevention

Date: August 18, 2023

Re: Bloodborne Pathogen Exposure Control Plan Updates

The Bloodborne Pathogen Exposure Control Plan was updated to incorporate elements of HW-137-*Occupational Exposure to Bloodborne Pathogens* into the plan to reduce redundancies. It was also updated to reflect current standards of care and SPH lab changes. We removed a lot of direct quotations of existing policies and instead referenced them, so that the plan wouldn't have to be updated each time one of those policies is updated.

The revisions also clarify roles and responsibilities, since job positions have changed since the last time the plan was edited, for example, Employee Health and Infection Prevention are now separate roles. The algorithm was also updated for improved clarity and efficiency.

Bloodborne Pathogen Exposure Control Plan

HW-299

South Peninsula Hospital
Bloodborne Pathogen Exposure Control Plan
August 18, 2017 by Policy Committee
September 27, 2017 BOD Approved

MISSION, VISION, PURPOSE, SCOPE

MISSION STATEMENT

South Peninsula Hospital promotes community health and wellness by providing personalized, high quality, locally coordinated health care.

VISION STATEMENT

South Peninsula Hospital is the healthcare provider of choice with a dynamic and dedicated team committed to service excellence.

PURPOSE

South Peninsula Hospital's Bloodborne Pathogen Exposure Control Plan (~~ECP~~BBPECP) is in compliance with the OSHA Regulations and has developed this plan as part of the requirements.

South Peninsula Hospital (SPH) is concerned about the safety and health of its employees. This ~~ECP~~BBPECP is formulated to reduce the risk to employees who may be exposed to blood or other potentially infectious materials (OPIM), in accordance with our Mission and Values~~ and Behaviors~~. Standard Precautions are utilized to prevent reasonably anticipated potential skin, eye, and mucous membrane exposure to blood or OPIM that may occur during the performance of an employee's duties.

This plan is available to all employees through the Staff Information Site (SIS).

SCOPE

This Plan applies to all ~~employees~~ workforce members and departments in the hospital and other sites managed by the hospital.

SECTION I

Designation of Responsibilities

1. Chief Nursing Officer of SPH is responsible for the implementation of the ~~ECP~~BBPECP.
2. Infection Prevention Committee will:
    - Maintain, review and update the ~~ECP~~BBPECP at least annually, and whenever necessary to include new or modified tasks and procedures.
    - Review and revise SPH policies regarding isolation protocols and Standard Precautions, as needed.
    - Provide ongoing consultation regarding implementation and use of isolation protocols and Standard Precautions.
    - Assist with development and coordination of educational programs.
    - Assist with compliance evaluation.
    - Provide oversight of the Sharps Injury Protection Program
3. Infection Prevention Nurse (IP RN) will:
    - Maintain, review and update the ~~ECP~~BBPECP at least annually and whenever necessary, to include new or modified tasks and procedures.
    - Keep abreast of changes in government regulations that require revisions to the ~~ECP~~BBPECP.
    - Make the written ECP available to employees, OSHA, and NIOSH representatives.
    - ~~Develop and maintain procedures for post-exposure follow-up.~~
    - Coordinate the Sharps Injury Protection Program
    - ~~Provide~~ Oversee ~~and document~~ initial employee orientation, and provide updates for established employees annually and as needed.
4. Employee Health Nurse (EH RN) will:
    - Offer the Hepatitis B vaccine to all staff.
    - Identify and list all job classifications in which employees may have occasional occupational exposure in the normal performance of duties.
    - Identify and list job classifications in which an occupational exposure is not anticipated in the normal performances of duties.
    - Ensure that all required medical actions are performed when there is a suspected exposure, and that appropriate employee health and OSHA records are maintained.
    - ~~Assist in~~ Develop and maintain ~~developing and maintaining~~ procedures for post-exposure follow-up
    - Assist with the Sharps Injury Protection Program
5. Department Managers will:
    - Revise all applicable procedures in the department to include requirements for Personal Protective Equipment (PPE) and the management of waste and soiled equipment. ~~All policy changes will be reviewed and approved by the Infection Control Committee.~~

- Assure employee orientation to the unit and annual refresher training through the training management system.
- Assure PPE in appropriate sizes and other necessary supplies are available in accessible locations.
- Evaluate compliance by:
  - ~~Including compliance with standards in performance appraisal.~~
  - Initiating and documenting occurrence reporting for continued non-compliance.

6. Those employees who are determined to be at risk for occupational exposure to blood or Other Potentially Infectious Materials (OPIM) must comply with the procedures and work practices outlined in this ~~ECP~~BBPECP.

SECTION II

Definitions and Acronyms

The following are definitions and acronyms for the terms used in this ~~exposure control plan~~BPPECP:

1. **Blood -** Includes plasma, platelets, and serosanguinous fluids (e.g. exudates from wounds). Also included are medications derived from blood, such as immunoglobulins, albumin, and factors 8 and 9.
2. **Bloodborne Pathogens -** Microorganisms that are present in human blood or OPIM which can infect and cause disease in persons who are exposed. While HBV and HIV are specifically identified in the standard, the term includes pathogenic microorganisms that can also cause diseases such as hepatitis C, malaria, syphilis, babesiosis, brucellosis, leptospirosis, arboviral infections, relapsing fever, Creutzfeldt-Jakob disease, adult T-cell leukemia/lymphoma (caused by HTLV-I), HTLV-I associated myelopathy, disease associated with HTLV-OO, and viral hemorrhagic fever.
3. **CNO** – Chief Nursing Officer.
4. **Clinical Laboratory** - A workplace where diagnostic or other screening procedures are performed on blood or OPIM.
5. **Contaminated** - An item or surface with the presence or reasonably anticipated presence of blood or OPIM.
6. **Contaminated Laundry** - Laundry which has been soiled with blood or OPIM materials or which may contain sharps.
7. **Contaminated Sharps** - Any contaminated object that can penetrate the skin including but not limited to needles, scalpels, broken glass, broken capillary tubes and exposed ends of dental wires.

~~8.~~ **Decontamination -** The use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious microorganisms and the surface or item is rendered safe for handling, use or disposal.

~~9.~~8. **~~ECP – Exposure Control Plan for bloodborne pathogen exposures.~~**

~~10.~~9. **Engineering Controls -** Controls (i.e. sharps disposal containers, self-sheathing needles, safer medical devices such as sharps with engineered sharps injury protections

and needleless systems) that isolate, reduce or remove the bloodborne pathogen hazards from the workplace.

~~11.~~10. **Exposure Incident** – Contact or potential contact between blood or OPIM and any of the following: eye, mouth, other mucous membrane, non-intact skin (skin with dermatitis, hangnails, cuts, abrasions, chafing, acne, etc.); ~~or~~ or by means of a wound such as a needlestick~~or extensive and prolonged contact with intact skin~~.

~~12.~~11. **Front-line worker -** Non-managerial employee responsible for direct or indirect patient care with a potential for occupational exposure.

~~13.~~12. **Handwashing Equipment** - A facility providing an adequate supply of potable running water, soap and single use towels or Alcohol based hand wash

~~14.~~13. **HBV** - Hepatitis B virus.

~~15.~~14. **HCV -** Hepatitis C virus.

~~16.~~15. **HIV -** Human immunodeficiency virus.

~~17.~~16. **Needleless Systems** - A device that does not use needles for: (1) the collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established; (2) the administration of medication or fluids; or (3) any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps. "Needleless Systems" provide an alternative to needles for the specified procedures, thereby reducing the risk of percutaneous injury involving contaminated sharps.

~~18.~~17. **Occupational Exposure** - A reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or OPIM, that results from the performance of an employee's duties. This includes potential for contact as well as actual contact with blood or OPIM (including RMW).

~~19.~~18. **OPIM - Other Potentially Infectious Materials** - OPIM includes the following human body fluids:

- cerebrospinal fluid
- synovial fluid
- pleural fluid
- amniotic fluid
- saliva in dental procedures
- semen
- vaginal secretions
- any body fluid that is visibly contaminated with blood
- all body fluids in situations where it is difficult to differentiate between body fluids
- any unfixed tissue or organ (other than intact skin) from a human (living or dead)
- HIV-containing cell or tissue cultures
- HIV- HBV- or HCV-containing culture medium or other solutions
- blood, organs, or other tissue from experimental animals infected with HIV, HBV or HCV

~~20.~~19. **Parenteral (percutaneous) -** Piercing the mucous membranes or skin barrier through such events as needle sticks, sharps injuries, human bites that break skin, cuts, and abrasions.

~~21.~~20. **PEP – Post Exposure Prophylaxis** - "PEP" is a term commonly used for HIV preventative treatment.

~~22.~~21. **PPE - Personal Protective Equipment** - Specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (i.e. uniform, pants, shirts, or blouses) are not intended to function as protection against a hazard and are not considered to be protective equipment. PPE will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use for the duration of time the protective equipment will be used.

~~23.~~22. **Recipient Individual** - Person who is subjected to an exposure. Examples: employees, patients, visitors.

~~24.~~23. **RMW - Regulated Medical Waste** - Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or OPIM.

~~25.~~24. **SESIPs - Sharps with Engineered Sharps Injury Protections** - Non-needle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident. This term encompasses a broad array of devices that make injury involving a contaminated sharp less likely. They include, but are not limited to: syringes with guards or sliding sheaths that shield the attached retracting catheters used to access the bloodstream for intravenous administration of medication or fluids; intravenous medication delivery systems that administer medication or fluids through a catheter port or connector site using a needle that is housed on a protective covering; blunt suture needles; and plastic capillary tubes.

~~26.~~25. **SIPP - Sharps Injury Protection Program**

~~27.~~26. **Source Individual** - Any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee/recipient. Examples include hospital patients; healthcare workers; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

~~28.~~27. **Standard Precautions** - Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infections in hospitals. They involve use of PPE appropriate to the task; handwashing; housecleaning; and handling linens, laundry, eating utensils, dishes, waste and sharps.

~~29.~~28. **Sterilize** - The use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

~~30.~~ **Transmission-Based Precautions** - These precautions are designed to be used in caring for patients documented or suspected to be infected or colonized with highly transmissible and/or disease producing organisms for which additional precautions beyond Standard Precautions are needed to interrupt transmission. (For more, see HW-139 ~~Isolation~~Transmission Based Precautions)~~There are three types of Transmission-Based Precautions and they may be combined for diseases that have multiple routes of~~

~~transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.~~

- ~~Airborne Precautions require special patient placement, (rooms 217 & 218) special air handling and ventilation, and use of respirator mask by the healthcare worker.~~
- ~~Droplet Precautions require special patient placement and use of a mask and eye protection when working near the patient.~~
- ~~Contact Precautions require special patient placement, use of gloves and gown, and dedicated patient care equipment.~~

~~o~~29. ~~Enhanced Precautions require individualized disease-specific consideration. Refer to the Isolation Precautions manual for complete information.~~

30. **Work Practice Controls** - Controls that reduce the likelihood of exposure by altering the manner in which a task is performed (i.e. prohibiting recapping of needles by a two-handed technique).
31. **Workforce Members** - employees/caregivers, volunteers, trainees, interns, medical staff, students, vendors and independent contractors who are not of an infrequent nature, employees working from home, employees who do not work directly with patients, and all other individuals working at or for SPH whether or not they are paid by or under the direct control of the facility.

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SECTION III — BLOODBORNE PATHOGEN EXPOSURE CONTROL

~~ECP~~BBPECP

The ~~Exposure Control Plan~~BBPECP will be accessible to all employees. The plan will be reviewed on an annual basis and whenever necessary by the Infection ~~Control~~ Prevention Committee~~, and whenever necessary~~. In the event that an issue should arise that requires decision and action between meetings, the IP RN will communicate with the Infection Prevention Physician and EH RN. Any action required will be under the authority of the Infection Prevention Physician and implemented by the IP RN or EH RN.

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~~Revision of the plan will occur with every significant change that will affect the plan, i.e. new or revised regulations.~~

The review and update of such plans shall also reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens; and document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.

Input will be solicited from non-managerial employees responsible for direct patient care who are potentially exposed to injury from contaminated sharps, in the identification, evaluation, and selection of effective engineering and work practice controls and the solicitation will be documented in the Infection Prevention Committee Minutes.

SECTION IV - METHODS OF COMPLIANCE

Standard Precautions

To minimize the risk of disease transmission and prevent contact with blood or OPIM all hospital employees will follow Standard Precautions. Under circumstances in which differentiation between body fluids is difficult or impossible, all body fluids shall be considered to contain bloodborne pathogens.

~~ECP~~BBPECP

All employees at SPH will receive an explanation of this ~~ECP~~BBPECP during their initial employee orientation~~training session~~. It will also be reviewed in ~~their~~ annual refresher training sessions. All employees have an opportunity to review this plan by locating~~contacting their department manager, or the Infection Prevention Nurse or located~~ it on the Staff Information Site (SIS). ~~under policies and plans. If requested, SPH will provide an employee with a copy of the ECP free of charge and within 15 days of the request.~~

~~The Infection Prevention Nurse is responsible for reviewing and updating the ECP annually, or more frequently if necessary.~~

Sharps Injury Protection Program (SIPP)

In accordance with the Needlestick Safety and Prevention Act of January 1, 2001, a Sharps Injury Protection Program (SIPP) has been incorporated into the ~~ECP~~BBPECP for SPH, and will be co-managed by the IP RN and EH RN.

Basic components of the SIPP

1. The program is designed to be integrated into existing SPH performance improvement, infection control, and safety programs. It is based on a model of continuous quality improvement.
2. Identify the need for changes in engineering controls and workplace practices through review of OSHA records, employee evaluation and surveys, Infection Prevention committee activities, and by acquiring and utilizing newly developed safety devices which have been proven to reduce injury or provide significant protection against bloodborne pathogens.

~~2.~~3. Coordinate with Materials Management to e~~E~~valuate new procedures and new products by researching available products, acquiring and utilizing sample products, employee evaluation and survey of new products and procedures and committee evaluation of survey results.

~~3.~~4. Annual and periodic review of safety equipment. ~~with required documentation~~.

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4.5. Maintain a Sharps Injury Log in coordination with Employee Health and Human Resources.
5.6. Provide employee training.

Responsibilities for the SIPP

1. **Chief Nursing Officer** - ensures effective compliance of the SIPP.
2.1. **The Infection Control Committee** reviews guidelines and revises SPH policies regarding Transmission Based Standard Precautions; provides ongoing consultation regarding implementation of the OSHA Standard; assists with the development and coordination of training programs; assists with compliance evaluation and evaluations of new equipment and supplies.
3.2. **Infection Prevention Nurse (IP RN):**
    - Coordinates and maintains the SIPP.
    - Keeps abreast of changes in technology of devices that are engineered to prevent exposures.
    - Keeps abreast of changes in government regulations that require revisions to the SIPP and ensures an annual review and update of the program.
    - Ensures there are ongoing (at least annually) identification, evaluation and selection of SESIPs, and workplace practices by the Sharps Product Evaluation Committee with committee membership as required by government standards.
    - Ensures proper recordkeeping with documentation of the solicitation for input from non-managerial employees; identification, evaluation and selection of sharps; and changes in workplace practices.
    - Ensures the Sharps Injury Log is maintained by Employee Health.
    - Ensures training and documentation of training of the staff for new devices and changes in the PlanBBPECP.
4.3. **Sharps Product Evaluation Committee** - This committee will include **representatives** front-line workers from departments using safety devices. They will select, evaluate, and test targeted devices, and collect data after the device is adopted to evaluate its impact.

Engineering and Work Practice Controls

Engineering controls will be used to reduce employee exposure by either removing the hazard or isolating the employee from exposure. Work practice controls will be used to reduce risks by altering the manner in which a task is performed. Where occupational exposure remains after institution of these controls, appropriate PPE must be used.

Engineering Controls

1. Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.
2. The specific engineering controls used throughout the facility include, but are not limited to:
    3.a) Self-sheathing needle devices, needleless devices, blunt needles, and shielded scalpels.

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~~4.~~b) Autoclaves
~~5.~~c) Sharps Disposal containers

Work Practice Controls

1. **Handwashing and hand hygiene; refer to HW-136, Hand Hygiene, for complete information.**

- ~~Wash hands immediately after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. To avoid transfer of microorganisms to other patients or environments, wash hands before gloving and immediately after gloves are removed, between patient contacts, and when otherwise indicated. It may be necessary to wash hands between tasks and procedures on the same patients to prevent cross contamination between different body sites.~~

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- ~~Use a plain (non anti-microbial) soap for routine handwashing.~~

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- ~~Use an anti-microbial agent for specific circumstances (e.g. Control of outbreaks, and as defined by the Infection Control Program.)~~

- ~~Antiseptic hand cleansers or towelettes will be used if handwashing facilities are not available. When antiseptic cleansers or towelettes are used, hands must be washed with soap and running water as soon as feasible.~~

- ~~1. Wash hands or any other skin with soap and water or flush mucous membranes with water immediately or as soon as feasible following contact of those body areas with blood or OPIM.~~

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2. **Handling of Contaminated Sharps:**
   - All sharps (including syringes) used at SPH will be placed in appropriate sharps disposal containers immediately after use. Sharps containers will be placed at the point of use for easy access, not easily accessible by children, maintained in an upright position and closeable.
   - Contaminated needles and other contaminated sharps may not be bent, recapped or removed, except in the event that it is necessary to recap or remove the needle because of a specific medical procedure. Then a mechanical device (i.e. hemostat) or a one-handed recapping technique must be used. Shearing or breaking of contaminated needles is prohibited.
   - For more, see HW-102 Regulated Medical Waste
   - ~~All sharps containers must be puncture resistant, leak resistant, labeled or color-coded in accordance with OSHA standards.~~
   - ~~Sharps containers must be sealed in the appropriate manner when 3/4 full before transporting.~~
   - ~~Reusable sharps that are contaminated with blood or OPIM may not be stored in a manner that requires employees to reach by hand into the container where the sharps have been placed.~~

3. **Eating, drinking, smoking, applying lip cosmetics or lip balm, and handling contact lenses** are prohibited in work areas where there is reasonable likelihood of occupational exposure.
4. **Food and drink** may not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or OPIM are present. (See HW-219 Employee Food and Drink in Patient Care Areas)
5. **All procedures involving blood or OPIM** must be performed in such a manner as to minimize splashing, spraying, splattering, and generation of droplets of these substances.
6. **Mouth pipetting or suctioning** of blood or OPIM is prohibited.
7. **Specimens** of blood or OPIM must be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping. Standard Precautions will be used when handling all specimens. For more, see HW-102 Regulated Medical Waste and HW-141 Blood and Body Fluid Spills. ~~Containers must be recognizable as containing specimens, or be labeled and color coded according to OSHA guidelines. Specimens that leave the facility will be labeled and color coded in the same manner. If contamination of the outside of the primary container occurs, the primary container shall be placed in a second container which prevents leakage. If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.~~
8. **Equipment** which may become contaminated with blood or OPIM must be examined before servicing or shipping and must be decontaminated as necessary, unless decontamination of the equipment or portions of the equipment is not feasible. If complete decontamination is not possible, the equipment must be labeled with a biohazard sign identifying the portions that remain contaminated. The employer shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, and prior to handling, servicing, or shipping so that appropriate precautions will be taken.
9. **Healthcare workers with exudative lesions or weeping dermatitis** will refer to ~~will refrain from all direct patient care, from handling patient care equipment, or specimens of blood or other OPIM, until the condition resolves~~policy HW-103 Employee Infection for guidance on work restrictions. ~~.~~

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Personal Protective Equipment (PPE)

All personnel must routinely use PPE when there is a potential for exposure to blood or OPIM. Appropriate PPE, such as gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, will be provided in the appropriate size, at no cost to the employee and will be readily available in the work area (see policy HW-176 PPE Hazard Assessment).

1. All PPE must be removed before leaving the work area.
2. When PPE is removed it must be placed in the appropriately designated area or container for storage, washing, decontamination, or disposal.
3. Wash hands immediately or as soon as feasible after removal of PPE.
4. Garment(s) saturated with blood or OPIM, must be removed immediately or as soon as possible. Launderable garments must be placed in a leak proof bag and taken to the laundry area for laundering.

5. SPH will be responsible for cleaning, laundering, disposal, repair, and replacement of PPE, as needed.
6. Gloves must be worn when the employee has the potential to have direct skin contact with blood or OPIM, mucous membranes, non-intact skin, and when handling items or surfaces soiled with blood or potentially infectious materials.
    - Disposable single-use gloves must be changed as soon as possible when visibly soiled, torn, punctured, or when their ability to function as a barrier is compromised.
    - Disposable single-use gloves cannot be washed or disinfected for re-use.
    - Gloves must be changed after contact with each patient.
    - Utility gloves may be disinfected for re-use if the integrity of the gloves is not compromised.
    - Hypoallergenic gloves, glove liners, powderless gloves and other similar alternatives, are readily available to employees who are allergic to the gloves normally provided.
7. Masks and protective eye wear combinations (goggles or glasses with solid side shields), or a face shield which protect all mucous membranes will be worn when performing procedures that are likely to generate splashes, sprays, splatter, or droplets of blood or OPIM.
8. Gowns, aprons or other protective body clothing shall be worn when there is a potential risk for an occupational exposure. Type and characteristics will depend upon the task and degree of exposure anticipated.
9. Surgical caps or hoods and shoe covers will be worn in all surgeries or surgical procedures and in any other procedures where gross contamination can reasonably be anticipated.

Housekeeping

SPH will be maintained in a clean and sanitary condition. Written schedules for the routine cleaning of all areas of the hospital and the methods used in this cleaning are maintained by the Environmental Services Department. These schedules are monitored, reviewed and up-dated on an annual basis. Certain work surfaces, walls, windows, curtains, ceilings, etc., are cleaned on a project basis, depending on soiling potential, or when visibly soiled. In general, the following practices are used:

1. All equipment and environmental work surfaces will be properly cleaned and disinfected after contact with blood or other potentially infectious materials. Work surfaces will be disinfected with an appropriate hospital grade disinfectant after completion of procedures, and any time they may have become contaminated. All bins, pails, cans, and similar receptacles intended for re-use which have a reasonable likelihood of becoming contaminated with blood or OPIM will be inspected and decontaminated on a regularly scheduled basis, and decontaminated immediately or as soon as feasible when visibly contaminated.
2. Broken glassware may not be picked up directly with the hands. It must be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

Regulated Medical Waste

Regulated Medical Waste (RMW) is defined as contaminated material potentially containing pathogens of sufficient virulence and quantity so that exposure to the waste by susceptible host could result in an infectious disease. For more, see policy HW-102 Regulated Medical Waste Management.

1. ~~RMW must be placed in appropriate containers which are closeable, contain all contents and prevent leakage of fluids. These containers must be labeled or color-coded according to OSHA guidelines. Containers must be closed before handling, storage, transport or shipping.~~
2. ~~If outside contamination of the RMW container occurs, it shall be placed in a second container which is closeable, color coded and leak-proof before handling or storing.~~
3. ~~The specific definitions, procedures and handling of RMW are explained in detail in HW-102, Regulated Medical Waste.~~

Laundry

Laundering will be performed by the South Peninsula Hospital laundry department daily and as needed in the designated laundry area. Laundry functions may also be performed by a vendor.

~~1.~~ See policy EVS-502 Handling, Transporting, Processing, and Storage of Linen.

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~~2. Contaminated laundry must be bagged at the location where it was used and shall not be sorted or rinsed in the location of use.~~

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~~3. The following laundering requirements must be met:~~

~~o Handle contaminated laundry as little as possible, with minimal agitation~~

~~o Place wet contaminated laundry in leak-proof, labeled or color-coded containers before transport marked with biohazard symbol or labels for this purpose.~~

~~o Wear the following PPE when handling and/or sorting contaminated laundry: protective gloves, gown, and other appropriate PPE as needed.~~

Labels – Communication of Hazards to Employees

1. Specific Biohazard labels or the use of red bags and/or containers will be used to warn employees of potential hazards.
2. Warning labels must be affixed to containers of regulated medical waste, refrigerators and freezers containing blood and OPIM, contaminated equipment and containers used to store, transport, or ship blood or OPIM.

3. Biohazard labels must be fluorescent orange or orange-red with lettering or symbols in a contrasting color. The labels must be an integral part of the container, or must be affixed in a manner that prevents their loss or intentional removal.
4. Red bags or containers may be substituted for labels.
5. Exemptions from these labeling regulations:
    - Containers of blood, blood components, or blood products labeled as to their contents and released for transfusion or other clinical use because they have been screened for HBV and HIV prior to their release;
    - Individual containers of blood or OPIM that are placed in secondary labeled containers during storage, and/or transporting
    - Specimen containers, if Standard Precautions are used when handling all specimens;
    - Laundry bags or containers since Standard Precautions are used for handling all laundry;
    - Regulated Medical Waste that has been decontaminated.

SECTION V

Hepatitis B Vaccination Program

Hepatitis B Virus (HBV) vaccine is available at no cost to all SPH staff ~~after the training required by OSHA, and~~ within 10 working days of assignment, unless the employee has previously received the complete HBV vaccine series, antibody testing has revealed the person is immune, or the vaccine is contraindicated for medical reasons. Employees may decline the HBV vaccination, and then request to be vaccinated at a later date. If the HBV vaccine is declined, employees will sign a statement ~~as published by~~per OSHA. Documentation of refusal of the vaccine is kept in the employee health records. If one or more routine booster doses of HBV vaccine are recommended by the U.S. Public Health Service at a future date, the booster dose will be made available to employees.

Hepatitis B vaccine will be made available to the employee at a reasonable time and place, performed by or under the supervision of a licensed physician or another licensed healthcare professional. HB~~V~~ vaccine will be provided according to the recommendation U.S. Public Health Service current at the time these evaluations and procedures take place. ~~Documentation of refusal of the vaccine is kept in the employee health records~~

~~Participation in a prescreening program is not mandatory, but is recommended for employees prior to receiving HBV vaccine.~~ All laboratory tests will be conducted by an accredited laboratory at no cost to the employee.

SECTION VI

Post—Exposure Evaluation and Follow-Up

Per AK 29 CFR 1910.1030(f)(3), ~~A~~all employees of SPH who have an occupational exposure to blood or OPIM ~~will~~ are instructed to report immediately to the ER for a post-exposure medical evaluation and follow-up conducted by ER doctor according to the OSHA Bloodborne Pathogen (BBP) Standard 1910.1030.~~.~~ The medical evaluation and procedures, including prophylaxis and follow-up are available at a reasonable time and place at no cost to employees and are performed by or under the supervision of a licensed physician or another licensed healthcare professional. The Workers' Compensation Insurance Plan for SPH is responsible for the costs incurred for healthcare workers covered by this plan. Non-employee providers are also eligible for follow-up through the Employee Health Department. Laboratory tests will be conducted by an accredited laboratory at no cost to the employee.

Following the report of an exposure incident, the employee has the right to, and should have, a confidential medical evaluation and follow-up, the steps described in the SPH BBP Post-Exposure Packet and HW-119 Work Related Injury or Illness, including at least the following elements:

1. The circumstances under which the exposure occurred, department or work area where the exposure occurred, documentation of the routes of exposure, and the type and name brand of the device involved.
2. Identification and documentation of the source individual, unless identification is not feasible.
    - The source individual's blood must be tested as soon as possible, in order to determine infections with HBV, HCV, HIV, syphilis and other bloodborne pathogens as indicated.
        - Consent is to be obtained from the source prior to performing the lab tests. If the source refuses to consent, the lab tests cannot be performed, and it will be documented in the employee/recipient's post exposure record that consent could not be obtained.
        - If the lab already has blood from the source, but the source is not available to provide consent, a reasonable attempt must be made to contact the source. If the source cannot be located, the blood shall be tested, and the results documented in the employee/recipient's post exposure record.
    - When the source individual is already known to be infected with HBV, HCV, HIV, or syphilis, testing the source for these diseases need not be repeated, but appropriate records documenting this status shall be made available to the medical evaluator.
    - Results of the source individual's testing must be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious state of the source individual;
3. Collection and testing of recipient/staff blood for HBV, HCV, and HIV serological status:
    - ~~o~~4. The exposed employee's blood must be collected as soon as possible and tested after consent is obtained;
    - ~~o~~5. If the employee consents to baseline blood collection, but does not consent at that time for serologic testing, the sample must be preserved for at least 90 days; if within 90 days

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of the exposure incident, the employee elects to have the base line sample tested, the testing will be done as soon as feasible;

~~4.~~6. Post-exposure prophylaxis, when medically indicated and as recommended by the U.S. Public Health Service~~.~~;

~~5.~~7. Counseling;

~~6.~~8. Evaluation of reported illnesses~~.~~;

~~7.~~9. The ~~Infection Prevention~~IP Nurse or ~~ER~~ EH Nurse ensures that healthcare professional(s) responsible for employee's HBV, HIV risk and post-exposure evaluation and follow-up are given a copy of OSHA's Bloodborne Pathogen Standard.

~~8.~~10. The ~~Employee Health~~EH Nurse or ER Nurse ensures that the healthcare professional evaluating an employee after an exposure incident receives the following:

- A description of the employee's job duties relevant to the exposure incident.
- Route(s) of the exposure.
- Circumstances of exposure.
- If possible, a result of the source individual's blood test.
- Relevant employee medical records, including vaccination status.

~~9.~~11. The ~~Employee Health~~EH Nurse will review the circumstances of all exposure incidents to determine:

- Engineering controls in use at the time.
- Work practices being followed.
- Description, including brand name of the device being used.
- PPE or clothing that was used at the time of the exposure incident.
- Location of the incident.
- Procedure being performed when the incident occurred.
- Employee's training.
- EH nurse will document all percutaneous injuries from contaminated sharps in the Sharps Injury Log~~. (See Section VIII.)~~;

~~10.~~12. The ~~Employee Health~~EH or ER Nurse shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.

~~11.~~13. The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee received such vaccination

~~12.~~14. The healthcare professional's written opinion for post- exposure evaluation and follow-up shall be limited to the following information:

- That the employee has been informed of the results of the evaluation; and
- That the employee has been told about any medical conditions resulting from exposure to blood or OPIM which require further evaluation or treatment.

~~13.~~15. All findings or diagnoses shall remain confidential and access to this information will be by the employee's authorization except by the Worker's Comp insurance carrier, OSHA and State Epidemiology Department.

~~14.~~16. The Employee Health Nurse will provide periodic surveillance of the exposed employee to include lab tests and review of health status.

~~15.~~17. If as a result of the exposure incident, it is determined that revisions need to be made, the CNO will ensure appropriate changes are made to this ECP.

~~16.~~18. Refer to:

- SPH BBP Post-Exposure Packet
- ~~Employee Health Follow-up Packet~~
- SPH policies HW-056, Employee Health, HW-119, and Work Related Injury or Illness~~, and HW-137 Occupational Exposure to Bloodborne Pathogens~~.
- ~~https://pubmed.ncbi.nlm.nih.gov/23917901/~~
- ~~https://stacks.cdc.gov/view/cdc/20711~~

SPECIAL CONSIDERATIONS:

1. A resource manual is maintained on the SIS and at the ER Nurses' Station.
2. The source individual's identification will be documented only on the "Recipient/SPH Workforce Member Summary of Exposure" form.
3. Workforce Members who terminate working before the surveillance period is completed will continue to be followed by Employee Health until the post-exposure period is completed.

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SECTION VII

Information and Training

Training will be provided to all employees with occupational exposure to blood or OPIM during work hours and at no cost to the employee. Training will take place at the time of initial assignment to tasks where occupational exposure may take place and at least annually thereafter and within 90 days after the effective date of the new or revised regulations. Additional training will be provided when changes, such as modifications of tests and procedures, or new tasks, affect the employee's occupational exposure. Training records will be maintained for a minimum of three years. The training will be ~~conducted~~ provided via the training management system, by the ~~Employee Health nurse~~EH RN, IP RN, Manager, or other person knowledgeable in the subject matter covered by the elements contained in the training program as it relates to SPH.

The training will include, at a minimum, the following elements:

1. Location of a~~A~~n accessible copy of the bloodborne pathogen regulations and an explanation of their content;
2. A general explanation of the epidemiology and symptoms of bloodborne diseases;
3. An explanation of the modes of transmission of bloodborne pathogens;
4. An explanation of the SPH ~~exposure control plan~~BBPECP and the means by which the employee can obtain a written copy of the plan;

5. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and OPIM;
6. An explanation of the use and limitations of methods that will prevent or reduce exposure, including appropriate engineering controls, work practices, and PPE;
7. Information on the types, proper use, location, removal, handling, decontamination, and disposal of PPE;
8. An explanation of the basis for selection of PPE;
9. Information on the HBV vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;
10. Information on the appropriate actions to take and the persons to contact in an emergency involving blood or OPIM;
11. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;
12. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;
13. An explanation of the signs and labels or color coding utilized to designate contaminated articles;
14. An opportunity for interactive questions and answers with the person conducting the training session.
15. Material appropriate in content and vocabulary to educational level, literacy, and language of employees shall be used.
16. Training materials are available through the ~~Employee Health Nurse~~EH RN, ~~Infection Prevention Nurse~~IP RN, Manager and the Education Department.

SECTION VIII - RECORDKEEPING

Medical Records

The ~~Employee Health Nurse~~EH RN will maintain records of all exposure incidents, post-exposure follow-ups, and the hepatitis B vaccination status of all employees with occupational exposure to blood or OPIM. These records are confidential and are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as may be required by law. These records will be maintained for the duration of the person's employment with SPH, plus 30 years, in accordance with OSHA Standard 29 CFR 1910.20, (d) (I) (ii).

Medical records will include:

1. The name and social security number of the employee;
2. A copy of the employee's HBV status involving the dates of all the HBV vaccinations and any medical records relative to the employee's ability to receive vaccination as required by OSHA regulations;
3. A copy of all results of examinations, medical testing, and follow-up procedures as required by this plan;

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4. The employer's copy of the healthcare professional's written opinion, as required following an exposure incident, including the information that the employee was informed of the results of the post-exposure medical examination and the need for further follow-up, if any;
5. A copy of the information provided to the healthcare professional, as required by OSHA, evaluating an exposure incident including a description of the employee's duties as they relate to the exposure incident, routes of exposure and circumstances under which exposure occurred;
6. Signed declination statements if the employee declined the HBV vaccination series, post exposure prophylaxis or any declined portion of recommended treatment;
7. OSHA Recordkeeping – An exposure incident is evaluated to determine if the case meets OSHA's Recordkeeping Requirements (29 CFR 1904). This determination and the recording activities are done by Employee Health Department.

Sharps Injury Log

In addition to the 1904.8 OSHA Recordkeeping Requirements, all percutaneous injuries from contaminated sharps are also recorded in Sharps Injury Log. All incidences must include at least:

1. Date of the injury
2. Type and brand of the device involved (syringe, suture needle)
3. Department or work area where the incident occurred
4. Explanation of how the incident occurred.

This log is reviewed as part of the annual program evaluation and maintained for at least five (5) years following the end of the calendar year covered. If a copy is requested by anyone, it must have any personal identifiers removed from the report.

Training Records

Training records are completed for each employee upon completion of training. These documents will be kept for at least three years at Employee Health Office for New Employee Onboarding, Human Resources office for New Employee Orientation, ~~Orientation~~ and SPH Staff Education Office for annual training.

The training records will include:

1. The dates of the training sessions
2. The contents or a summary of the training sessions
3. The names and qualifications of persons conducting the training sessions
4. The names and job titles of all persons conducting the training.
5. Training records will be maintained for three years from the date on which the training occurred.

Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to

Employee Health Department, ~~or~~ Staff Education Department, or Human Resources Department. ~~,~~

Availability of Records

1. SPH shall ensure that all records required to be maintained by this plan will be made available upon request to the Commissioner and the Director of the Alaska Department of Labor and the Federal Department of Labor (OSHA) for examination and copying.
2. Employee training records required to be maintained by this plan will be provided upon request for examination and copying to employees, to employee representatives, to the Director and to the Commissioner in accordance with 8 AAC 61.270 and to the Assistant Secretary and the Director of the Department of Labor in accordance with 29 CFR 1910.20.
3. Employee medical records required to be maintained by this plan will be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Director, and to the Commissioner in accordance with 8 AAC 61.270 and to the Assistant Secretary and the Director of the Department of Labor in accordance with 29 CFR 1910.20.

REFERENCES:

1. SPH Bloodborne Pathogen Post-Exposure Packet (SIS link)
2. Occupational Safety and Health Administration. Standard 1910.1030. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030
3. Occupational Safety and Health Administration. Standard 1910.1020 https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1020
4. UCSF National Clinical Consultation Center. PEP: Post-Exposure Prophylaxis. https://nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/
5. State of Alaska Department of Health, Division of Public Health, Section of Epidemiology. HIV/STD Provider Packet. https://health.alaska.gov/dph/Epi/hivstd/Documents/resources/HIV-STD-2023-Provider-Packet.pdf
6. Centers for Disease Control and Prevention. HIV NEXUS; CDC Resources for Clinicians. https://www.cdc.gov/hiv/clinicians/index.html
7. Los Angeles County Health Services. Policy 925.200 EHS' Bloodborne Pathogen Exposure Control Program. https://secure2.compliancebridge.com/lacdhs/DHSpublic/index.php?fuseaction=header.download&policyID=959&descriptor=header1&doc=DHS925-200.pdf

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SOUTH PENINSULA HOSPITAL
BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN APPROVALS

_____	_____	_____
Infection Prevent Committee Chair	Signature	Date
_____	_____	_____
Chief Nursing Officer	Signature	Date
_____	_____	_____
Chief Medical Officer	Signature	Date

Table A: Employees at risk

Job classifications and associated tasks identifying employees at risk of exposure to blood or other potentially infectious materials. Exposure determinations are made without regard to use of PPE.

Department	**Job Classification/Title**
Acute Care	Activity Aide
	Director
	Discharge Planner
	Patient Care Tech
	Registered Nurse
	RN Coordinator
	Hospitalist
Administration	Chief Medical Officer
	Chief Nursing Officer
Behavioral Health	Mental Health Counselor
	Nurse Practitioner
	Physician
	Registered Nurse
Emergency Room	Director
	ED Tech
	Patient Care Tech
	Registered Nurse
	RN Coordinator
	Physician
Employee Health	Employee Health RN
	Infection Prevention RN
Family Care Clinic	Certified Health Coach
	Medical Assistant
	Nurse Practitioner
	Physician
	Registered Nurse
	RN Coordinator
Forensics	Registered Nurse
	RN Coordinator
Functional Medicine	Medical Assistant
	Physician
Health and Wellness	Community Health & Wellness Educator
Home Health	Certified Nursing Assistant
	Clinical Care Sup
	Director
	Occupational Therapist
	Physical Therapist
	Registered Nurse

	RN Case Manager
Homer Medical Center	Assistant Clinical Manager
	Certified Addiction Counselor
	Diabetes Health Coordinator
	Lead Medical Assistant
	Licensed Practical Nurse
	Medical Assistant
	Nurse Practitioner
	Physician
	Physician Assistant
	Registered Nurse
Homer Medical OB/GYN	Certified Nurse Midwife
	Medical Assistant
	Physician
	Registered Nurse
Imaging/Radiology	Director
	PACS Administrator
	Radiology Technologist
	Registered Nurse
	Physician
	Echocardiographer
	Sonographer
Infusion Clinic	Medical Assistant
	Registered Nurse
Laboratory	Clin Lab Science Coord.
	Clinical Lab Scientist
	Director of Laboratory
	Phlebotomist/Clerk
Long Term Care	Activity Aide
	Activity Coordinator
	Assistant Director of Nursing
	Certified Nursing Assistant
	Clinical Systems Support RN
	Director of Nursing
	Health Unit Clerk
	Licensed Practical Nurse
	Nurse Practitioner
	Physician
	Registered Nurse
	RN Coordinator
	Social Worker BA/BS
Neurology	Medical Assistant
	Physician
Obstetrics / L&D	Activities Aide/CNA
	OB Director

	Registered Nurse
Orthopedic Clinic	Lead Medical Assistant
	Medical Assistant
	Orthopedic Surgeon
Peninsula Surgical Clinic	Medical Assistant
	Physician
	Physician Assistant
	Registered Nurse
Pharmacy	Director
	Pharmacist
	Pharmacy Clinical Lead
	Pharmacy Tech
Rehabilitation	Director
	Physical Therapist
	Physical Therapy Assistant
	Rehabilitation Aide
	Occupational Therapist
	Pediatric Therapist
	Speech Language Pathologist
Respiratory Therapy	Respiratory Services Supervisor
	Respiratory Therapist
Sleep Lab	Manager
	Medical Assistant
	Sleep Lab Technician
	Physician
Specialty Clinic	Medical Assistant
	Providers
Surgical Services/PACU	CRNA
	Director of Surgical Services
	Registered Nurse
	Sterile Processing Tech
	Surgical Services Coordinator
	Surgical Tech, Certified
	Surgical Technologist Trainee

Table B: Employees who may be at risk

Job classifications and tasks in which some employees may have occupational exposures to blood or OPIM.

Department	**Job Classification/Title**
Acute Care	Health Unit Clerk
	Operations Specialist
	Patient Companion
	Social Worker
	Utilization RN
Behavioral Health	Patient Account Rep
BioMed	Biomed Engineer
Clinical Informatics	HLT Info Specialist
	Informatics Analyst
Education	Clinical Educator
	Instructor
	Operations Specialist
	RN Coordinator
Emergency Room	Health Unit Clerk
Employee Health	Administrative Assistant
Environmental Services	EVS Technician
	Laundry Aide
	Manager
Facilities/Maintenance	Clerk
	Facilities Electrician
	Facilities Engineer
	Facilities Manager
	Lead Carpenter
Family Care Clinic	Patient Acct Rep
Health and Wellness	Health and Wellness Educator
Homer Medical Center	Care Coordinator
	Lead Receptionist
	Patient Acct Rep
	Receptionist
Homer Medical OB/GYN	Lead Receptionist
	Patient Acct Rep
Imaging/Radiology	Health Unit Clerk
	Office Coordinator
Laboratory	Clin Lab Science Coord.
	Clinical Lab Scientist
	Director of Laboratory
	Phlebotomist/Clerk
Long Term Care	Ops Specialist
Medical Staff	Med Staff Coord
Nutrition Services	Clinical Dietician

Orthopedic Clinic	Clinic Manager
	Patient Acct Rep
Patient Financial Services	Patient Acct Rep
Peninsula Surgical Clinic	Lead Receptionist
Rehabilitation	Patient Acct Rep
	Rehab Office Coord.
Security	Safety & Security Supervisor
	Security Guard
Sleep Lab	Manager
	Sleep Lab Technician
	Physician
Specialty Clinic	Patient Acct Rep
Surgical Services/PACU	Purchasing Tech

Introduced by: Administration
Date: August 23, 2023
Action:
Vote:

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2023-23

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS AUTHORIZING BANK ACCOUNT SIGNERS

WHEREAS, the persons approved for authorizing bank transactions has changed; and

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

1. That the below listed persons may transact business as authorized signers of this corporations' following banking accounts; and
2. That new persons duly appointed or elected to the positions listed shall be authorized by this resolution to act in the same capacity as those listed below; and
3. The Secretary of this Board is hereby authorized to sign new bank signature cards indicating that this Board approves the additions reflected below.

FIRST NATIONAL BANK ALASKA, Checking Account # ****3233 (General)
FIRST NATIONAL BANK ALASKA, Checking Account # ****3241 (Payroll)
FIRST NATIONAL BANK ALASKA, Checking Account # ****4510 (Health Claims)
FIRST NATIONAL BANK ALASKA, Checking Account # ****7193 (Pharmacy 340B)
FIRST NATIONAL BANK ALASKA, Savings Account # ****8740

Title	**Incumbent**
Chief Executive Officer	Ryan Smith
Chief Operating Officer	Angela Hinnegan
Chief Financial Officer	Anna Hermanson ~~(interim)~~
Chief Nursing Officer	Rachael Kincaid
Chief Medical Officer	Christina Tuomi

Authorized individuals may sign checks for amounts up to their Purchasing Authority. Checks for amounts greater than $10,000 will require two signatures. In addition, the CFO, COO, CEO or Finance Director may transfer funds to other banking instruments in the name of South Peninsula Hospital according to the following schedule:

Type of Transaction	**Limit**
Funds within SPH Accounts	No Limit
Taxes	$700,000
Payroll	~~$1,500,000~~$2,000,000
Outside Vendors	$100,000
Wire Transfers	$10,000

FIRST NATIONAL BANK ALASKA, New Checking– General, Overnight Investment Account # ****0149 – Auto Sweep; no signers

WELLS FARGO BANK ALASKA, Checking Account # ****2520 (Seaworthy Functional Medicine)
WELLS FARGO BANK ALASKA, Savings Account # ****5725 (Health Benefit Reserve Account)

Title	Incumbent
Chief Executive Officer	Ryan Smith
Chief Operating Officer	Angela Hinnegan
Chief Financial Officer	Anna Hermanson ~~(interim)~~
Chief Nursing Officer	Rachael Kincaid
Chief Medical Officer	Christina Tuomi

WELLS FARGO BANK ALASKA, Checking Account # ****6656 (Medical Staff)

Title	Incumbent
Chief Executive Officer	Ryan Smith
Chief Operating Officer	Angela Hinnegan
Chief Financial Officer	Anna Hermanson ~~(interim)~~
Chief Nursing Officer	Rachael Kincaid
Chief Medical Officer	Christina Tuomi
Medical Staff Coordinator	~~Andrea Konik~~Molly Kerce

WELLS FARGO BANK ALASKA, Savings Account # ****5344 (LTC Resident Trust)

Title	Incumbent
Chief Executive Officer	Ryan Smith
Chief Operating Officer	Angela Hinnegan
Chief Financial Officer	Anna Hermanson ~~(interim)~~
Chief Nursing Officer	Rachael Kincaid
Chief Medical Officer	Christina Tuomi
Long Term Care Director	Katie Martin

ALASKA USA FEDERAL CREDIT UNION Money Market Account # ****2523-20 (Auxiliary)
ALASKA USA FEDERAL CREDIT UNION Checking Account # ****2523-70 (Auxiliary)

Title	Incumbent
Unknown	Dawn Cabana
Unknown	Teresa Plant
Unknown	Carole Mann
Chief Operating Officer	Angela Hinnegan
Director of Public Relations	Derotha Ferraro

US BANK, Pledge Account # ****1981 (AthenaNet)

Title	Incumbent
Chief Executive Officer	Ryan Smith
Chief Operating Officer	Angela Hinnegan
Chief Financial Officer	Anna Hermanson ~~(interim)~~

BANK CARDS THROUGH FIRST NATIONAL BANK OF ALASKA

Title	Incumbent
Chief Executive Officer	Ryan Smith
Chief Operating Officer	Angela Hinnegan
Chief Financial Officer	Anna Hermanson
Chief Medical Officer	Christine Tuomi
Chief Nursing Officer	Rachael Kincaid
Director of Quality	Susan Shover
Director of Public Relations	Derotha Ferraro
Human Resources Director	Stacy Froese
Facilities Manager	Harrison Smith

Director of Information Technology	James Bartilson
Purchasing Technician	John Bishop
Director of Materials Management	Royal Brown
Manager of Specialty Clinic	Sara Woltjen
Sr. Executive Assistant	Maura Jones
~~Homer Medical Center~~ HIM- Manager	Kelly Gallios
Homer Medical Center Manager	Josie Bradshaw
Homer Medical Center Asst Clinical Mgr	LeAnn Matysczak
Health & Wellness Coordinator	Magdalena Wyatt
Medical Staff Coordinator	~~Andrea Konik~~Molly Kerce
Specialty Services Manager	Dee Dahmann
Environmental Services Manager	Justin Herrmann
Director of Rehabilitation	Karen Northrop
Director of Health Information Systems	Christine Anderson
Revenue Cycle Director	Penny Kinnard
Home Health Manager	Ivy Stuart
Laboratory Director	Laura Miller
Imaging Director	~~Brent Lautenschlager~~Tiffany Park
Education Operations Specialist	Rebekah Eagerton
Director of Surgery	Amber Gall
Nutrition Services Manager	Rhoda Ostman
Nutrition Services Asst. Manager	Matthew Dickinson
~~Pharmacy Director~~	~~Mike Ostrom (retiring 9/1/22)~~
Pharmacy Director	Vince Greear
Long Term Care Director	Katie Martin
Long Term Care Asst Director	Janyce Bridges
Emergency Department Director	Craig Caldwell
Acute Care Director	Jane Nollar
Respiratory Therapy Manager	Daniel Skousen
Safety & Security ~~Manager~~Superviser	~~Joshua Harville~~Adam Darden
Obstetrics Director	Joelle Burdick
Community Health & Wellness Educator	Annie Garay
Patient Account Rep II	Amber Bailey
Purchasing Tech/Med Supply Tech	Evdokia Fefelov
LTC Activities Coordinator	Allicia Raymond
Biomed Engineer	Jessica Mikhail
Expediter	Kari Avendano
Expediter/Med Supply Tech	Marlene McDonough
G.A. – Accounts Payable	~~Finance Director~~Controller
G.A. – Travel	~~Administrative~~ Executive Assistant

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL, INC. THIS 24th DAY OF AUGUST, 2022.

_____

Kelly Cooper, Board President

ATTEST:_____

Julie Woodworth, Secretary

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

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2023-25

A RESOLUTION APPROVING A MINOR ALTERATION OF SCOPE TO PROJECT 21SHB REMODEL OF KACHEMAK PROFESSIONAL BUILDING

WHEREAS, South Peninsula Hospital Board of Directors approved resolution 2020-01 in January 2020 approving project 21SHB; and

WHEREAS, the established scope of the project was to approve $500,000 in lease renovations to the 4201 Bartlett St leased property to collocate Medical Staff offices and to provide a one-stop shop for Specialty Physician Services and Behavioral Health; and

WHEREAS, Project 21SHB has $451,703 remaining, as the majority of work has not commenced; and

WHEREAS, South Peninsula Hospital has purchased property on Hohe Street since the passing of the Resolution 2020-01 to locate Behavioral Health; and

WHEREAS, South Peninsula Hospital has since leased additional clinical space to locate General Surgery and has been able to accommodate other specialty providers in already established clinic space at 4201 Bartlett; and

WHEREAS, the needs for space for Behavioral Health and Specialty Providers has been solved, South Peninsula Hospital would like to amend the scope of project 21SHB to complete leasehold improvements to the 4201 Bartlett St property to provide clinical services and support offices to meet the needs of the organization; and

WHEREAS, the resolution to amend the scope of project 21SHB Remodel Kachemak Professional Building was discussed at Finance Committee on August 17, 2023.

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

1. That the South Peninsula Hospital Board of Directors approves amending the scope of Project 21SHB Remodel of Kachemak Professional Building to allow for renovations for clinical services and support offices.

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

ATTEST:

Kelly Cooper, Board President

Julie Woodworth, Board Secretary

Introduced by: Administration
Date: 8/23/2023
Action:
Vote: Yes -X; No-X; Exc. X-

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2023-24

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS APPROVING THE USE OF OPERATING CASH TO FUND THE CAPITAL LEASE OF THE STRYKER MAKO SMARTROBOTICS SYSTEM

WHEREAS, South Peninsula Hospital's Orthopedic Department is an important component of our mission to provide high quality, locally coordinated care; and

WHEREAS, South Peninsula Hospital has demonstrated that it can safely and effectively provide the highest quality healthcare through the use of advanced technology such as advanced imaging and wishes to improve orthopedic throughput, quality, and patient experience with the use of the Stryker Mako SmartRobotics Total Joint Arthroplasty System; and

WHEREAS, South Peninsula Hospital has performed approximately 48% of Total Knee Replacements (Total Joint Arthroplasty) for residents of the Southern Kenai Peninsula over the past five years; and

WHEREAS, a growing number of surgical patients are leaving the service area to have their Total Joint Arthroplasty performed with a robotic system due to improved outcome and patient satisfaction; and

WHEREAS, the 2023 Community Health Needs Assessment highlights a need for broader healthcare services to support our aging demographic and a projected increase in Total Joint Arthroplasty procedures; and

WHEREAS, South Peninsula Hospital has been offered an option to enter into a 7-year Capital Lease of the Stryker Mako SmartRobotics System through an implant purchase commitment with Stryker. At the end of that Capital Lease commitment period, the title to the Mako SmartRobotics System shall transfer to South Peninsula Hospital for $1; and

WHEREAS, the cost of the Stryker Mako SmartRobotics System with discounts is $675,000 and the implicit lending rate in the capital purchase commitment master agreement is based on the Bloomberg SOFR Swap rate (approximately prime plus 2%); and

WHEREAS, the projected increase in market share for Total Joint Arthroplasty Surgeries and the associated net income from these procedures shall pay for the Stryker Mako SmartRobotics System from Operating Cash; and

WHEREAS, the South Peninsula Hospital Board Finance Committee reviewed and approved this resolution at their meeting on August 17, 2023.

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

1. That the South Peninsula Hospital Board of Directors approves the use of Operating Cash to fund the 7-year embedded Capital lease for a Stryker Mako SmartRobotics System through an Implant Purchase Commitment Master Agreement with Stryker.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA AT ITS MEETING HELD ON THIS 23rd DAY OF AUGUST, 2023.

ATTEST:

_____
Kelly Cooper, Board President

_____
Julie Woodworth, Board Secretary

South Peninsula Hospital

MEMO

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

To: SPH Board of Directors

From: BOD Governance Committee

Date: August 18, 2023

Re: Board Bylaws Amendment Proposal

The Governance Committee is proposing a change to the bylaws, after noticing some unclear wording while reviewing the bylaws for another purpose.

The proposed change clarifies the language around censure or removal of board members. The board member under consideration for censure/removal would not be included in the tally of votes, so the requirement should read 75% *of the remaining* Board members.

Section 1 of ARTICLE IX – AMENDMENTS asks for two readings of the change to be made prior to vote, with a required 75% of the entire membership needed to ratify the amendment. This is the first reading of the proposed amendment.

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

ARTICLE III - MEMBERS

Section 5.

Censure of, or removal from the Board of any member shall require a 75% affirmative vote of the remaining Board members, excluding the board member in question.

No motion at this time. First reading of proposed amendment.

BYLAWS
SOUTH PENINSULA HOSPITAL, INC.

ARTICLE I - NAME AND OBJECTIVES

Section 1.

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

Section 2.

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

Section 3.

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

ARTICLE II - MEETINGS

Section 1. Regular Meetings.

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

Section 2. Special Meetings.

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

Section 3. Quorum.

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

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

Section 4. Minutes.

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

Section 5. Reconsideration:

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

Section 6. Annual Meeting.

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

ARTICLE III - MEMBERS

Section 1.

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

Section 2.

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

Section 3.

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

Section 4.

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

Section 5.

Censure of, or removal from the Board of any member shall require a 75% affirmative vote of the remaining Board members, excluding the board member in question.

Section 6.

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

Section 7.

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

ARTICLE IV - OFFICERS

Section 1.

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

Section 2.

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

Section 3.

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

Section 4.

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

Section 5.

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

Section 6.

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

Section 7.

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

ARTICLE V - COMMITTEES

Section 1.

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

Section 2.

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

Section 3.

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

ARTICLE VI - ADMINISTRATOR

Section 1.

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

Section 2.

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

Section 3.

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

Section 4.

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

Section 5.

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

Section 6.

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

Section 7.

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

Section 8.

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

Section 9.

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

Section 10.

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

ARTICLE VII - MEDICAL STAFF

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

Section 1.

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

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

Section 2.

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

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

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

Section 3.

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

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

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

ARTICLE VIII - AUTHORIZATION OF INDEBTEDNESS

Section 1. Indebtedness.

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

ARTICLE IX - AMENDMENTS

Section 1.

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

Section 2.

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

Section 3.

These Bylaws shall be reviewed at the annual meeting.

ARTICLE X - ORDER OF BUSINESS

Section 1.

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

ARTICLE XI - INDEMNIFICATION

Section 1.

The corporation shall indemnify every person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal,

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

Section 2.

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

Section 3.

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

Section 4.

Any indemnification under subsections 1 and 2 hereof (unless ordered by a court) shall be made by the corporation only as authorized in the specific case upon a determination that indemnification of the board member, director, officer, employee or agent is proper in the circumstances because he has met the applicable standard of conduct set forth in subsections 1 and 2 hereof. Such determination shall be made (a) by the Board of Directors by a majority vote of a quorum consisting of directors who were not parties to such action, suit or proceedings, or

(b) if such quorum is not obtainable, or even if obtainable, a quorum of disinterested directors so directs, by independent legal counsel in a written opinion.

Section 5.

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

Section 6.

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

- Adopted by the South Peninsula Hospital Board of Directors, June 28, 2023.

- Kelly Cooper, President

- Julie Woodworth, Secretary

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

** Updated 8/15/2023*

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 : 33 cases - 76%, 10/1/21-9/30/22)*
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, 10/1/21-9/30/22)*
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:151 min, 10/1/21-9/30/22)*
Average time spent in department before leaving.				Average throughput time of all ED visits
Readmission	5.5%	< 15%	164	** (Care Compare 15.3%, 214 patients 7/1/21-6/30/22))*
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%, 18 patients 10/1/21-9/30/22)*
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.

MINUTES
Board Governance Committee Meeting

11:00 AM - Thursday, August 17, 2023
Zoom

The Board Governance Committee of the South Peninsula Hospital was called to order on Thursday, August 17, 2023, at 11:00 AM, in the Zoom, with the following members present:

PRESENT: Aaron Weisser, Beth Wythe, Bernadette Wilson, Melissa Jacobsen, Ryan Smith (CEO) and Maura Jones (Executive Asst)

1. CALL TO ORDER / REVIEW OF AGENDA & MINUTES

The meeting was called to order at 11:01am.

2. ITEMS

2.1. Doctors Dinner Update

Maura has confirmed the date, time and venue. There was some discussion over whether there would be a presentation, or remarks, or whether time should be set aside for medical staff to bring concerns to the whole group.

The committee is generally in favor of making this a social event, with an initial introduction and few remarks, and then letting everyone interact. Aaron will run this by the full board during the meeting next week.

2.2. Policy Review: EMP-09

There was a lengthy discussion around the intent and effectiveness of this policy. The committee suggested a standing item on the annual meeting where the CEO submits a name for the person who would act as interim CEO in case of an emergency, and the board then approves. Beth will make initial revisions of this policy and send to Maura for further discussion at the next meeting.

2.3. Rules for supermajority

There were three places identified in the bylaws where a supermajority is required: Article III, Section 5 (censure or removal of a board member); Article VIII, Section 1 (indebtedness) and Article IX, Section 2 (amendments to, or repeal of the bylaws.) The committee agreed these were all appropriate situations to require supermajority. There was some discussion of changing our requirement from 75% of board members to 2/3 of board members, to align with Robert's Rules, but the committee decided not to make the change at this time.

In reviewing the bylaws, the committee decided to recommend a change to Article III, Section 5, to clarify that when taking a vote on the possible censure or removal of a board member, the board member in question would not get a vote, and therefore would not be counted in total required for a supermajority. This will be brought to the board for first reading at their August meeting.

2.4. Membership Recruitment

The committee approved placing a board membership ad in the newspaper, as well as on Facebook. Maura will reach out to prior applicants from the previous couple of years to let them know the application process is open (as an FYI).

3. DISCUSSION

The committee decided to cancel the September Governance Committee meeting, since several members are unavailable, including Aaron. Aaron will check in with Maura late September regarding board applications to discuss next steps for board candidates.

4. ADJOURNMENT

South Peninsula Hospital
Patient Centered Care Quality Committee
July 19, 2023

DATE OF MEETING: July 19, 2023

x	Shover, Susan *(Quality Management Director, CMTE Chair)*	E	Wilson, Bernadette (*Board of Director)*	x	Wythe, Beth *(Board of Director)*

x=Present

x	Ansell, Tracy *(QM Admin Asst. / Scribe.)*	E	Kinnard, Penny (*Mgr. HIM)*	x	Stuart, Ivy *(Dir. Home Health)*
x	Banks, Bonita *(Risk Mitigation RN)*	x	Lewald, Anna *(I.P. Nurse)*	x	Stearns, Linda *(RN Coordinator)*
	Bartilson, James *(Dir. of Info. Services)*	E	Matysczak, LeAnn (Interim HMC Manager)	E	Tuomi, Christina *(CMO)*
x	Burdick, Joelle *(OB Director)*	x	Martin, Katie *(LTC Director)*		
x	Caldwell, Craig *(ER Director)*		Miller, Laura *(Dir. Lab)*		
	Dahmann, Dee *(Spec. Serv. Cl. Manager)*	x	Nollar, Jane *(AC Director)*		
x	Deaver, Nancy *(Pt. Access Super.)*	x	Northrop, Karen *(Mgr. Rehab Services)*		
E	Gall, Amber *(Dir Of Surgical Serv.)*	x	Ostman, Rhoda *(Nutritional Serv. Mgr.)*		
x	Greear, Vince *(Mgr. Pharmacy)*	x	Smith, Harrison *(Facilities Manager)*		
x	Herrmann, Justin *(Mgr. EVS*)	E	Park, Tiffany *(Dir. Imaging)*		
x	Kincaid, Rachael (CNO)	x	Pearson, Meredith *(QM RN)*		

GUESTS (NONMEMBERS) PRESENT: Marketing Director Derotha Ferraro, ED Trauma Coordinator Frank Klima

SUBMITTED BY: _____

Susan Shover, RN BSN, CPHQ; Director of Quality Management, PCCQ Chair

	Discussion	**Action**	**Follow-Up**
I. Call to Order	Susan Shover, RN, Quality Management Director called the meeting to order at 12:33 pm.		**CLOSED**

II. Approval of Minutes	Anna Lewald, Infection Prevention RN motioned to approve the April 2023 PCCQ minutes with a second from Craig Caldwell, Emergency Department (ED) Director.	**APPROVED**	**CLOSED**
III. Approval of Agenda	Susan Shover made the request to add Home Health under Quality of Care/Patient Safety and Table HMC's department report. Bonita Banks, Risk Mitigation RN moved to approve with changes and Meredith Pearson, Quality Management RN motioned to approved as second.	**APPROVED**	**CLOSED**
IV. Living Our Values	Jane Nollar, Acute Care Director shared about how a Patient Companion Maxi Jones, stepped in to assist with patients on a night when they were short One-to-One Sitters. Maxi took time with each of the patients, checking in on them, talking with them and sometimes singing with them.		**CLOSED**
V. New Business	**A. Balanced Scorecard Format** Susan Shover presented the newly formatted Balanced Scorecard (BSC) to the committee. Susan shared the new format follows the format of the SPH Strategic Plan and initiated by Derotha Ferrara, Marketing Director Ferraro and Beth Wythe, Board of Director's member. Thank you to Tracy Ansell, Quality Management Assistant who made the formatting changes. The new scorecard goes to the BOD this month.		**CLOSED**

VI. Balanced Scorecard	**Q2 2023 Balanced Scorecard (BSC)** **A. Overall Indicators** Susan Shover congratulated LTC for the 5 star rating on Care Compare. **B. Quality of Care** **i. Sepsis** Rachael Kincaid, Chief Nursing Officer (CNO) and Anna Lewald, IP RN are tracking the sepsis data in real-time. Q2-2023 data is showing at real-time score 100% and in the green with 52 cases reviewed; 15 passed, 0 failed with 37 exclusions. Rachael shared they are getting better results after making improvements to charting and added staff education. Susan Shover explained the Q1-2023 Sepsis core measures chart abstractions in process. Twenty (20) abstractions have been completed with most passing thus far. There are with 34 cases in all. Susan explained the chart abstractions are based on discharged diagnosis. **ii. Stroke** Stroke cases show the percentage of patients with stroke symptoms that receive a CT/MRI within the 45 minutes of the time they arrived in the ED. Real-time data shows 16 cases reviewed; 7 passed, 9 failed, and no exclusions. This gives the percentage at 44% which is below target, down from the 71% last quarter. Craig Caldwell, is working with Rachael Kincaid on reviewing cases that might have slipped through the cracks. They are developing new tools to assist with evaluating the data. Chart abstractions for core measures are still in process for the quarter Q-2023. **iii. Home Health (HH)** Home Health measures that are new on the Balanced Scorecard; "Improvement in Breathing" and "Correct Medication Administration". Ivy Stuart, Home Health Director explained it is hard to show improvement for home patients, especially those near end-of-life. HH is working on making sure the documentation narrative		**ONGOING** **ONGOING**

	matches what the HH system (Oasis) shows. Most will not show an improvement, due to the type of patients, but will show if they stayed the same or declined. "100% stay the same or improved" is what want to see. Admitted patients or those that expired are not included in the data. All included are Medicare and Medicaid patients only. **C. Patient Satisfaction reported through Press Ganey** **i. Outpatient *(PFS Registration)*** Nancy Deaver, Patient Access Supervisor reported she has been working with the Front Desk Registration staff on patient wait times. A tool is utilized to help track the time a patient checks in to the time they are seen. Nancy explained the average time went up in February as they added new staff but then went back down from March to current after staff received training. PFS is also looking at data accuracy rates. Percentage rates went down to 95%, but increased to 98% accuracy in June. Another improvement made was adding a financial counselor office across the hall from registration. A patient can usually get right in, with ease, to talk with someone about his or her account. **ii. Medical Practice - Tabled** **iii. Ambulatory Surgery** With Surgical Services Director Amber Gall unavailable, Meredith Pearson, who had worked with Amber on their PDSA, was able to speak to the subject of Ambulatory Surgery in her place. The OR has been working hard on notifying patients with changes. They have even given out complementary coffee cards when there have been miss communications. The have also implemented a process of having the surgeons at the patient's bedside post anesthesia. Patients did not always remember seeing the surgeon, so they added to the process of writing down the time the surgeon was there. They also encourage a medical advocate to be with the patient before and after surgery. They continue to look for ways to improve patient communication.		**ONGOING**

VII. Department Reporting	**A. Patient Financial Services** – See above *(Patient Satisfaction reported through Press Ganey)* **B. Infection Prevention** Anna Lewald reported the Infection Prevention Committee meeting met yesterday. There will be some changes to the COVID procedures and recently there was a potential TB case. The patient did not have TB but staff were able to use the opportunity to make sure all protocols were in place in case of a possible outbreak. **Other items reported:** • There were some COVID positive labs reported. • There has been an increase in urine-contaminated labs recently. Currently working on staff education to lower those numbers. • Updated the Bloodborne Pathogen packet that resides on the Staff Information Site (SIS). **C. SUMA Update** Derotha Ferraro, Director of Marketing updated the committee on the SUMA Report *(Substance Use, Misuse and Addiction).* There has not been active meetings since the end of 2019 and was meetings were tabled in 2020 due to the COVID pandemic. Derotha has followed up with action leads during 2021-2023 to generate an annual report for PCCQ and the CHNA *(Community Health Needs Assessment)*. Staff turnover has also taken a toll on the committee. There have been a couple items with movement. ATR *(All Things Recovery)* and SPH Community Health have continued to build community relationships through education during public events, and SPH has increased its security to have a 24/7 presence, for campus safety. **D. Environmental Services (EVS)** Justine Hermann, Manager of Environmental Services reported he has increased rounding to make sure staff needs are met during their shift. After attending the Shapero Training, he has been putting what he learned into practice buy making sure his staff are taking their breaks, staying hydrated, etc…		**ANNUAL REPORTING** **ANNUAL REPORTING** **ANNUAL REPORTING** **ANNUAL REPORTING**

	Justin presented the EVS Quality Dashboard that shows usage tracking of the UVDI (Advanced UV Disinfecting) units, the laundering of privacy curtains and the completion of EVS Backlight Surveys. EVS has one Process Improvement Plan (PIP) for pest management solutions for OR bugs. **E. Homer Medical Center**	**Report at October 2023 meeting**	**TABLED**
	F. Infusion Clinic Craig Caldwell reported the department changes for the Infusion Clinic. The Infusion Clinic is currently looking for a new supervisor since Meredith Pearson has moved to a position with Quality Management. Craig reported total oncology visits data for 2020-2023. With the increase in visits, they are focusing on how best to expand the space. • 2020 – 1147 visits • 2021 – 1621 visits • 2022 – 1626 visits • 2023 – 2049 visits		**ANNUAL REPORTING**
	G. Obstetrics Joelle Burdick, OB Director reported working on infant car seat policies, checklist and documentation form. OB now has five car seat techs who can provide car seat tolerance tests. The goal is to carry forward marketing of conducting car seat tests in the community through events such as Safe Kids Fair. This would be a free service provided to the community.		**ANNUAL REPORTING**
	H. Rehabilitation Manager of Rehab Services Karen Northrop reports they are continuing to track billing errors. They cross check the documentation to make sure it reflects correctly within the system. They saw a change in the first quarter and are working with Informatics on the system response issue to some documentation.		**ANNUAL REPORTING CLOSED**
	I. Support Services Facilities Manager Harrison Smith reports updates on the previous generator citation. He is working with engineers on some minor remote monitoring details added to the proposal. CEO Ryan Smith signed off and		**ANNUAL REPORTING**

	the proposal went to the borough. Project starts this August and will run to January of 2024.		
VIII. Pending Business	• **Trauma Re-verification Update** Frank Klima, ED Trauma Coordinator reported the ED was recertified for Trauma Level IV on June 19th. Frank shared the Quality Improvement activities conducted in preparation of the revisit. Congratulations to all that helped with the reverification. • **Critical Access Hospital Program Evaluation** As a Critical Access Hospital, SPH is required to annually review our overall quality program, which includes department quality accomplishments, goals and objectives, key statistics, survey activities and contracted services used. The 2023 report is complete and will go to the Board of Directors this month. Once approved, the report will go into Policy Manager and the Quality Department SIS page.		**CLOSED** **CLOSED**
IX. Informational Items	No informational items.		
X. Adjourn to Executive Session	Quality Director Sue Shover adjourns to executive session at 1:25 pm.		
	Note: Next Meeting – October 18th, 2023		