AGENDA
Board of Directors Meeting
6:30 PM - Wednesday, December 17, 2025
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

Aaron Weisser, President		Matthew Bullard		Edson Knapp, MD	
Preston Simmons Vice President		Kim Frost		Christopher Landess, MD	
Beth Wythe, Secretary		Michael Dye		Bernadette Wilson	
Walter Partridge, Treasurer					

Board Master Reports List

Mission: South Peninsula Hospital promotes community health and wellness by providing personalized, high quality, locally coordinated healthcare.
Vision: South Peninsula Hospital is the provider of choice with a dynamic team committed to service excellence.
Values: Compassion, Respect, Trust, Teamwork and Commitment

Page

1. CALL TO ORDER

2. ROLL CALL

3. REFLECT ON LIVING OUR VALUES

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

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

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

6. APPROVAL OF THE AGENDA

7. APPROVAL OF THE CONSENT CALENDAR

6 - 10 7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for October 29, 2025
Board of Directors - Oct 29 2025 - Minutes - DRAFT

11 - 14 7.2. Consideration to Approve October FY2026 Financials
Balance Sheet October FY26
Cash Flow Statement October FY26
Income Statement October FY26

15 7.3. Consideration to Approve the Election of Officers at the December 2025 meeting, one month earlier than provided for in the current bylaws
Memo

16 7.4. Consideration to Ratify the Executive Committee's Approval of Resolution 2025-24, A Resolution of the South Peninsula Hospital Board of Directors Approving Medical Staff Credentialing for November 2025
SPH Resolution 25-24 Medical Staff Credentialing November 2025

17 7.5. Consideration to Approve the 2026 Board of Directors Calendar of Meetings
Calendar

18 - 21 7.6. Consideration to Approve Policy SM-10, Board Orientation and Continuing Education, as revised by the Governance Committee, and retire SM-07 Board Member Orientation, as its content was incorporated into SM-10.
SM-10, revised
SM-07 - to retire

22 - 23 7.7. Consideration to Approve New Board Policy SM-14, Board Member Responsibilities and Expectations
SM-14

24 - 25 7.8. Consideration to Approve new Board Policy SM-15 Board President Evaluation
SM-15

8. PRESENTATIONS

8.1. Kachemak Bay Recovery Connection

Presenter: Willy Dunne

9. UNFINISHED BUSINESS

10. NEW BUSINESS

26 - 27 10.1. Election of Officers
Officer Election Memo

28 - 47 10.2. Consideration to Approve HW-267, SPH Quality Assessment and Performance Improvement Program; Calendar Year 2026 Quality Assurance & Performance Improvement (QAPI) Plan for South Peninsula Hospital Home Health; HH-010 Home Health Quality Plan, and LTC-184 Long Term Care Quality Plan
HW-267
LTC-184
HH-010
HH-010 Attachment-HH QAPI

48 - 59 10.3. FIRST READING: Revised Board of Directors Bylaws
Board of Directors Bylaws, revised fall 2025

60 - 101 10.4. Consideration to Approve South Peninsula Hospital & Long Term Care Medical Staff Rules and Regulations, as Revised by the Medical Staff
MSO Rules and Regulations Memo
Rules and Regs- MEC approved 12.8.25 Red line

11. REPORTS

102 - 106 11.1. Chief Executive Officer
Scorecard FY2026 Q1

11.2. BOD Committee: Finance & Pension

11.3. BOD Committee: Strategic Planning & Communication

11.4. BOD Committee: Governance

11.5. BOD Committee: Quality

11.6. Chief of Staff

11.7. Board President Report (Executive Committee, Education Sessions & Generative Discussions)

11.8. Service Area Board Representative

12. DISCUSSION

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

14.2. Board Members

15. INFORMATIONAL ITEMS

16. ACTION ITEMS

17. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

18. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

18.1. Board Member Elections for 2026

107 18.2. Consideration to Approve Resolution 2025-25, Approving the Medical Staff Credentialing for December 2025
SPH Resolution 25-25 Medical Staff Credentialing December 2025

19. 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 and reflects language from the Operating Agreement with the Kenai Peninsula Borough.

Each member of the public desiring to comment upon policies or proposed actions of the SPH Operating Board of Directors at tonight's meeting will be given an opportunity to speak within the following guidelines:

- *Comments are restricted to policies or proposed actions of the SPH Operating Board of Directors.*
- *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 policy or proposed action you wish to address.*
- *Please be concise and courteous. There is a limit of 3 minutes per speaker; total time allotted for public comment is at the discretion of the chair.*
- *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.*
- *If you have questions, you may direct them to the chair. Questions will not be addressed by the board during the public comment period, but may be addressed at a later time.*

These rules for participating in a public meeting were discussed and approved at the Board of Directors meeting on September 25, 2024.

MINUTES
Board of Directors Meeting

6:30 PM - Wednesday, October 29, 2025
Conference Rooms 1&2 and Zoom

The meeting of the Board of Directors of South Peninsula Hospital was called to order on Wednesday, October 29, 2025, at 6:30 PM, in the Conference Rooms 1&2 and Zoom.

1. CALL TO ORDER

The board went into Executive Session to discuss personnel and financial matters prior to the start of the regular meeting. The board when into Executive Session at 5:30pm. President Aaron Weisser called the regular meeting to order at 6:30pm.

2. ROLL CALL

BOARD PRESENT: **Aaron Weisser, Edson Knapp, Walter Partridge, Michael Dye, Bernadette Wilson, Beth Wythe, Preston Simmons, Matthew Bullard, Christopher Landess, Kim Frost, and CEO Ryan Smith**

BOARD EXCUSED:

ALSO PRESENT:

Only meeting participants who comment, report or give presentations are noted in the minutes. Others may be present on the room or on the virtual meeting.

2.1. A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Amber Gall, CNO, read a letter from a patient family. Aaron Weisser read a letter he received from a community member who was impressed with the response from Keagen Chase in the HIS department on problem-solving portal issues.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

4.1. Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

There were no comments from the audience.

6. APPROVAL OF THE AGENDA

6.1.

Beth Wythe made a motion to approve the agenda. Michael Dye seconded the motion. Motion Carried.

7. APPROVAL OF THE CONSENT CALENDAR

Beth Wythe read the consent calendar into the record.

7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for September 24, 2025

7.2. Consideration to Approve September FY26 Financials

7.3. Consideration to Approve SM-13 Political Candidates with no revisions as recommended by the Governance Committee

7.4. Consideration to Approve SM-09, Board Terms and Officers, as revised by the Governance Committee

7.5. Consideration to Approve New Board Policy EMP-10 Investigation of Chief Executive Officer Misconduct

Beth Wythe made a motion to approve the consent calendar as read. Michael Dye seconded the motion. Motion Carried.

8. PRESENTATIONS

There were no presentations.

9. UNFINISHED BUSINESS

There was no unfinished business.

10. NEW BUSINESS

10.1. SECOND READING and Consideration to Approve an Amendment to the SPH Board of Directors Bylaws to Remove the Reference to Robert's Rules and Replace with Succinct Meeting Rules that Reflect Current Practice

The bylaws revision was provided in the September packet for a first reading. The reference to Robert's Rules was removed, and Ms. Wythe replaced it with simpler meeting rules.

Bernadette Wilson made a motion to approve an Amendment to the SPH Board of Directors Bylaws to Remove the Reference to Robert's Rules and Replace with Succinct Meeting Rules that Reflect Current Practice Beth Wythe seconded the motion. Motion Carried.

10.2. Consideration to Approve South Peninsula Hospital Resolution 2025-22, A Resolution of the Board of Directors Resolving to Provide the Resources Necessary to Achieve and Sustain a Level IV Trauma Hospital Designation

Rachael Kincaid, COO, reported. This resolution documents the board's support of the hospital's designation as a Level IV Trauma site. The hospital

has held this designation for a number of years, and is currently in the process of recertification.

Beth Wythe made a motion to approve South Peninsula Hospital Resolution 2025-22, A Resolution of the Board of Directors Resolving to Provide the Resources Necessary to Achieve and Sustain a Level IV Trauma Hospital Designation. Bernadette Wilson seconded the motion. Motion Carried.

11. REPORTS

11.1. Chief Executive Officer

The senior leadership team reviewed the balanced scorecard data for FY2026 Q1.

11.2. BOD Committee: Finance & Pension

Walter Partridge, committee chair, reported. The committee met last week and discussed the financial results for September, as well as the financial indicators on the scorecard. The A/R is up and the cash is down, which was expected after the conversion to epic. The committee felt that the revenue, volumes and expenses were adequate and the cash will rebound when the billing is able to catch up.

11.3. BOD Committee: Strategic Planning & Communication

Aaron Weisser, committee chair, reported. There are community conversations planned for Homer and Anchor Point next week. Ryan Smith, board members, Mayor Micciche, and assembly member Kelly Cooper will be in attendance to share information about the hospital and answer questions from the audience. Derotha Ferraro, Marketing Director, shared some of the materials for the community conversations.

11.4. BOD Committee: Governance

Beth Wythe, committee chair, reported. The Governance Committee is working on a number of policies, which were provided in the packet for initial review. SM-10 Board Orientation and Continuing Education has been revised, and now incorporates SM-07, which can be retired. Two new policies, SM-14 Board Member Responsibilities and Expectations and SM-15 Board President Evaluation, were also presented for initial review. These policies will be placed on the consent agenda at the December meeting. Ms. Wythe added that the Governance Committee has recommended that officer elections be held in December instead of January moving forward, so the board can start the new year with officers in place.

11.5. BOD Committee: Quality

Preston Simmons, committee chair, reported. The Quality Committee heard a presentation from Tiffany Park, Imaging Director, and Dr. Edson Knapp, Radiologist, on the Imaging department's quality. Highlights included scope of services and volume metrics. There has been 3-13% annualized growth. Some key challenges include staffing challenges and the lack of backup for CT. That can affect our quality metrics. The department is accredited through ACR, and

MRI, CT and mammography are all accredited. The did a training overview, very comprehensive. The department has very aggressive downtime and error reduction goals for this year, with 10 different initiatives to work on. The department had a good focus on areas where they can continue to make care better for patients.

11.6. Chief of Staff

Dr. Roberts was working and unable to attend the meeting.

11.7. Service Area Board Representative

Helen Armstrong reported on behalf of the Service Area Board. There are four new members this year. Amber Cabana was reelected, Storm Hansen, Brandy Zollars, Catriona Reynolds and Erin Workman also joined the board this year. We are in the process of reviewing the member manual and bylaws. We are hoping the December meeting will consist of a tour of the Childcare Center and training by the borough.

12. DISCUSSION

There was no additional discussion.

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

Derotha Ferraro, Marketing Director, shared the hospital is in the midst of the deeply discounted blood draws through the Rotary Health Fair. This unique partnership with the Rotary helps fund their scholarships.

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

Mr. Smith had no additional comments.

14.2. Board Members

Mike Dye shared an excellent experience he had at the hospital recently. Beth Wythe thanked all the board members who assisted with the board and medical staff dinner.

15. INFORMATIONAL ITEMS

15.1. Board Officer and Committee Form 2026

15.2. AHA Rural Healthcare Conference February 2026

15.3. Service Area Board Schedule for 2026 (sign up)

16. ACTION ITEMS

17. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

The board adjourned to Executive Session at 7:40pm, and moved back into Open Session at 8:11pm.

18. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

18.1. Consideration to Approve Resolution 2025-23, Approving the Medical Staff Credentialing for October 2025

Beth Wythe made a motion to approve Resolution 2025-21, Approving the Medical Staff Credentialing for September, 2025 to include:

The reappointment of:

Lindsey Frischmann, DO	*Neurology*	*TeleStroke-Providence*
Kathy Madej, CRNA	*Anesthesia*	*Active*
Neha Mirchandani, MD	*Neurology*	*TeleStroke-Providence*

The appointment of:

Edith Jones, PMHNP-BC	*Psychiatry*	*Active*

19. ADJOURNMENT

The meeting adjourned at 8:12pm.

Respectfully Submitted,

Maura Jones, Executive Assistant

Accepted:

Aaron Weisser, President

Minutes Approved:

Mary E. Wythe, Secretary

South Peninsula Hospital

DRAFT-UNAUDITED

BALANCE SHEET
As of October 31, 2025

		As of October 31, 2025	As October 31, 2024	As of September 30, 2025	CHANGE FROM October, 2024
	ASSETS				
	CURRENT ASSETS:				
1	CASH AND CASH EQUIVALENTS	26,351,753	28,020,353	27,941,144	(1,668,600)
2	EQUITY IN CENTRAL TREASURY	9,463,078	8,685,913	10,511,323	777,165
3	TOTAL CASH	35,814,831	36,706,266	38,452,467	(891,435)
4	PATIENT ACCOUNTS RECEIVABLE	70,083,420	41,987,775	57,375,283	28,095,645
5	LESS: ALLOWANCES & ADJ	(37,515,717)	(20,257,408)	(26,394,062)	(17,258,309)
6	NET PATIENT ACCT RECEIVABLE	32,567,703	21,730,367	30,981,221	10,837,336
7	PROPERTY TAXES RECV - KPB	1,260,007	998,600	2,074,107	261,407
8	LESS: ALLOW PROP TAX - KPB	(4,165)	(4,165)	(4,165)	(0)
9	NET PROPERTY TAX RECV - KPB	1,255,842	994,435	2,069,942	261,407
10	OTHER RECEIVABLES - SPH	296,485	201,717	354,550	94,768
11	INVENTORIES	2,882,641	2,769,136	2,889,122	113,505
12	NET PENSION ASSET- GASB	534,985	3,225,068	534,985	(2,690,083)
13	PREPAID EXPENSES	1,714,780	1,188,347	1,509,869	526,433
14	TOTAL CURRENT ASSETS	75,067,267	66,815,336	76,792,156	8,251,931
	ASSETS WHOSE USE IS LIMITED				
15	PREF UNOBLIGATED	4,269,444	7,001,156	4,201,555	(2,731,712)
16	PREF OBLIGATED	3,084,187	1,163,509	3,084,187	1,920,678
17	OTHER RESTRICTED FUNDS	540,420	1,078,912	542,249	(538,492)
		7,894,051	9,243,577	7,827,991	(1,349,526)
	PROPERTY AND EQUIPMENT:				
18	LAND AND LAND IMPROVEMENTS	4,345,607	4,124,558	4,345,607	221,049
19	BUILDINGS	68,290,259	67,085,718	68,165,134	1,204,541
20	EQUIPMENT	34,377,962	30,187,936	33,360,758	4,190,026
21	BUILDINGS INTANGIBLE ASSETS	4,257,905	4,028,135	4,257,905	229,770
22	EQUIPMENT INTANGIBLE ASSETS	1,750,896	1,207,638	1,750,896	543,258
23	SOFTWARE INTANGIBLE ASSETS	890,141	2,135,559	890,140	(1,245,418)
24	IMPROVEMENTS OTHER THAN BUILDINGS	1,544,013	926,889	1,544,013	617,124
25	CONSTRUCTION IN PROGRESS	5,500,976	4,607,913	4,242,915	893,063
26	LESS: ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(63,471,798)	(63,260,510)	(63,131,820)	(211,288)
27	LESS: ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(3,129,547)	(3,500,552)	(3,111,707)	371,005
28	NET CAPITAL ASSETS	54,356,414	47,543,284	52,313,841	6,813,130
29	GOODWILL	0	0	0	0
30	**TOTAL ASSETS**	137,317,732	123,602,197	136,933,988	13,715,535
	DEFERRED OUTFLOWS OF RESOURCES				
31	PENSION RELATED (GASB 68)	4,840,055	4,692,297	5,077,652	147,758
32	UNAMORTIZED DEFERRED CHARGE ON REFUNDING	142,441	203,487	147,528	(61,046)
33	TOTAL DEFERRED OUTFLOWS OF RESOURCES	4,982,496	4,895,784	5,225,180	86,712
34	TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	142,300,228	128,497,981	142,159,168	13,802,247

		As of October 31, 2025	As October 31, 2024	As of September 30, 2025	CHANGE FROM October, 2024
	LIABILITIES & FUND BALANCE				
	CURRENT LIABILITIES:				
35	ACCOUNTS AND CONTRACTS PAYABLE	3,026,193	2,864,796	2,848,768	161,397
36	ACCRUED LIABILITIES	8,439,748	10,819,164	9,567,137	(2,379,416)
37	DEFERRED CREDITS	523,456	1,067,485	508,449	(544,029)
38	CURRENT PORTION OF LEASE PAYABLE	1,014,194	186,702	1,014,193	827,492
39	CURRENT PORTION SOFTWARE INTANGIBLE PAYABLE	160,225	252,782	199,887	(92,557)
40	CURRENT PORTIONS OF NOTES DUE	866,989	43,503	911,690	823,486
41	CURRENT PORTIONS OF BONDS PAYABLE	1,250,000	1,195,000	1,250,000	55,000
42	BOND INTEREST PAYABLE	44,625	26,389	64,654	18,236
43	DUE TO/(FROM) THIRD PARTY PAYERS	1,076,864	876,864	1,076,864	200,000
44	COMPENSATED ABSENCES CURRENT PORTION	6,797,532	0	6,919,937	6,797,532
45	TOTAL CURRENT LIABILITIES	23,199,826	17,332,685	24,361,580	5,867,141
	LONG-TERM LIABILITIES				
46	NOTES PAYABLE	2,870,213	0	2,747,494	2,870,213
47	COMPENSATED ABSENCES NET OF CURRENT PORTION	2,962,757	0	3,113,434	2,962,757
48	BONDS PAYABLE NET OF CURRENT PORTION	4,170,000	5,420,000	4,170,000	(1,250,000)
49	PREMIUM ON BONDS PAYABLE	157,132	241,581	163,109	(84,449)
50	CAPITAL LEASE, NET OF CURRENT PORTION	3,592,487	3,640,550	3,657,881	(48,063)
51	SOFTWARE INTANGIBLE LEASE, NET OF CURRENT PORTION	8,086	167,195	0	(159,109)
	TOTAL NONCURRENT LIABILITIES	13,760,675	9,469,326	13,851,918	4,291,349
51					
	TOTAL LIABILITIES	36,960,501	26,802,011	38,213,497	10,158,490
52					
53	DEFERRED INFLOW OF RESOURCES	0	0	0	0
	PROPERTY TAXES RECEIVED IN ADVANCE	0	0	0	0
	NET POSITION				
54					
55	INVESTED IN CAPITAL ASSETS	5,731,963	5,731,963	5,731,962	(0)
56	CONTRIBUTED CAPITAL - KPB	0	0	0	0
57	RESTRICTED	25,286	25,286	25,286	0
58	UNRESTRICTED FUND BALANCE - SPH	99,565,010	95,938,721	98,170,956	3,626,289
59	UNRESTRICTED FUND BALANCE - KPB	17,467	0	17,467	17,467
60	**TOTAL LIAB & FUND BALANCE**	142,300,228	128,497,981	142,159,168	13,802,247

DRAFT-UNAUDITED

South Peninsula Hospital

Statement of Cash Flows
As of October 31, 2025

	Cash Flow from Operations:		
1	YTD Net Income		5,970,923
2	Add: Depreciation Expense		1,806,455
3	Adj: Inventory (increase) / decrease		(204,370)
4	Patient Receivable (increase) / decrease		(6,587,396)
5	Prepaid Expenses (increase) / decrease		(487,285)
6	Other Current assets (increase) / decrease		461,773
7	Accounts payable increase / (decrease)		868,481
8	Accrued Salaries increase / (decrease)		93,257
9	Net Pension Asset (increase) / decrease		-
10	Other current liability increase / (decrease)		(1,277,584)
11	Net Cash Flow from Operations		644,254
	Cash Flow from Investing:		
12	Cash paid for the purchase of property/equip		(3,020,062)
13	Cash transferred to plant replacement fund		-
14	Proceeds from disposal of equipment		(438,130)
15	Net Cash Flow from Investing		(3,458,192)
	Cash Flow from Financing		
16	Cash (paid) / received for Lease Payable		(251,377)
17	Cash paid for Debt Service		-
18	Net Cash from Financing		(251,377)
19	Net increase in Cash	$	(3,065,315)
20	Beginning Cash as of July 1, 2025	$	38,880,147
21	Ending Cash as of October 31, 2025	$	35,814,831

South Peninsula Hospital

INCOME STATEMENT
As of October 31, 2025
DRAFT-UNAUDITED

		MONTH				YEAR TO DATE			
		10/31/25			10/31/24	10/31/25			10/31/24
		Actual	Budget	Var B/(W)	Actual	Actual	Budget	Var B/(W)	Actual
	Patient Service Revenue								
1	Inpatient	2,814,137	3,109,359	-9.49%	2,813,949	13,757,563	13,992,114	-1.68%	13,139,533
2	Outpatient	22,186,553	21,155,569	4.87%	19,183,045	82,294,076	79,921,040	2.97%	74,825,055
3	Long Term Care	1,510,545	1,491,919	1.25%	1,231,247	5,889,876	5,967,676	-1.30%	5,007,071
4	Total Patient Services	26,511,236	25,756,847	2.93%	23,228,241	101,941,515	99,880,830	2.06%	92,971,659
	Deductions from Revenue								
5	Medicare	6,268,492	6,100,567	-2.75%	5,877,298	22,435,227	20,967,649	-7.00%	23,119,797
6	Medicaid	2,866,568	3,365,970	14.84%	1,298,220	10,570,622	11,568,839	8.63%	9,525,938
7	Charity Care	157,427	289,656	45.65%	286,655	748,775	995,547	24.79%	869,486
8	Commercial and Admin	3,716,241	2,959,971	-25.55%	3,228,912	11,664,172	10,173,421	-14.65%	9,402,348
9	Bad Debt	137,571	379,025	63.70%	949,735	1,452,508	1,302,710	-11.50%	1,763,989
10	Total Deductions	13,146,299	13,095,189	-0.39%	11,640,820	46,871,305	45,008,166	-4.14%	44,681,558
11	Net Patient Services	13,364,937	12,661,658	5.55%	11,587,421	55,070,210	54,872,664	0.36%	48,290,101
12	USAC and Other Revenue	109,102	131,067	-16.76%	95,597	429,019	524,268	-18.17%	381,317
13	Total Operating Revenues	13,474,039	12,792,725	5.33%	11,683,018	55,499,229	55,396,932	0.18%	48,671,418
	Operating Expenses								
14	Salaries and Wages	5,584,224	6,052,647	7.74%	5,259,310	23,385,972	24,210,587	3.41%	21,453,220
15	Employee Benefits	2,791,145	2,979,739	6.33%	2,279,787	12,388,401	11,187,437	-10.73%	8,945,301
16	Supplies, Drugs and Food	1,829,199	1,863,960	1.86%	1,339,057	6,413,086	7,249,337	11.54%	5,915,454
17	Contract Staffing	373,453	118,566	-214.97%	211,761	1,781,390	451,757	-294.32%	805,245
18	Professional Fees	773,036	519,324	-48.85%	722,840	2,928,912	1,950,238	-50.18%	2,264,423
19	Utilities and Telephone	179,642	201,604	10.89%	177,201	753,029	806,416	6.62%	722,175
20	Insurance (gen'l, prof liab, property)	144,494	111,593	-29.48%	82,781	382,903	421,574	9.17%	360,909
21	Dues, Books, and Subscriptions	16,314	24,767	34.13%	27,619	65,215	95,530	31.73%	85,714
22	Software Maint/Support	385,593	145,336	-165.31%	148,830	1,046,636	774,572	-35.12%	635,903
23	Travel, Meetings, Education	69,974	121,258	42.29%	98,008	197,649	367,677	46.24%	220,502
24	Repairs and Maintenance	163,155	233,430	30.11%	217,278	728,993	778,099	6.31%	712,478
25	Leases and Rentals	78,813	60,856	-29.51%	99,548	236,014	232,246	-1.62%	388,976
26	Other (Recruiting, Advertising, etc.)	170,820	214,902	20.51%	177,850	795,472	859,607	7.46%	718,396
27	Depreciation & Amortization	418,929	565,765	25.95%	412,297	1,806,455	2,263,061	20.18%	1,710,059
28	Total Operating Expenses	12,978,791	13,213,747	1.78%	11,254,167	52,910,128	51,648,138	-2.44%	44,938,755
29	**Gain (Loss) from Operations**	**495,248**	**(421,022)**	**217.63%**	**428,851**	**2,589,101**	**3,748,794**	**30.94%**	**3,732,663**
	Non-Operating Revenues								
30	General Property Taxes	815,785	835,627	-2.37%	775,649	3,142,083	3,430,467	-8.41%	3,028,156
31	Investment Income	209,905	132,515	58.40%	234,406	519,590	530,061	-1.98%	485,698
32	Governmental Subsidies	0	0	0.00%	0	0	0	0.00%	0
33	Other Non Operating Revenue	0	216	100.00%	1,865	0	866	100.00%	11,779
34	Gifts & Contributions	0	0	0.00%	0	0	0	0.00%	0
35	Gain <Loss> on Disposal	(91,665)	0	0.00%	0	(438,130)	0	0.00%	100
36	SPH Auxiliary	718	794	-9.58%	542	2,181	3,174	-31.29%	3,498
37	Total Non-Operating Revenues	934,743	969,152	-3.55%	1,012,462	3,225,724	3,964,568	-18.64%	3,529,231
	Non-Operating Expenses								
38	Insurance	0	0	0.00%	0	0	0	0.00%	0
39	Service Area Board	0	0	0.00%	2,824	0	0	0.00%	6,652
40	Other Direct Expense	7,509	9,500	20.96%	10,965	32,054	38,000	15.65%	60,965
41	Administrative Non-Recurring	0	0	0.00%	0	0	0	0.00%	0
42	Interest Expense	35,906	60,786	40.93%	45,588	238,511	243,143	1.91%	185,593
43	Total Non-Operating Expenses	43,414	70,286	38.23%	59,377	270,565	281,143	3.76%	253,210
	Grants								
44	Grant Revenue	0	139,880	0.00%	145,030	440,885	559,520	0.00%	297,172
45	Grant Expense	5,869	15,986	63.28%	0	14,221	63,944	77.76%	63,990
46	Total Non-Operating Gains, net	(5,869)	123,894	-104.74%	145,030	426,664	495,576	13.91%	233,182
47	Income <Loss> Before Transfers	1,380,707	601,738	-129.45%	1,526,966	5,970,923	7,927,795	-24.68%	7,241,866
48	Operating Transfers	0	0	0.00%	0	0	0	0.00%	0
49	**Net Income**	**1,380,707**	**601,738**	**129.45%**	**1,526,966**	**5,970,923**	**7,927,795**	**-24.68%**	**7,241,866**

South Peninsula Hospital

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

MEMO

To: SPH Board of Directors

From: Governance Committee

Date: December 11, 2025

Re: Election of Officers

According to the current bylaws, officer elections are to be held at the January meeting of every even year. There is a bylaws amendment under consideration that would move the election of officers to the December meeting of odd years, which will allow the board to enter the new year with the officers in place, instead of waiting until late January. This amendment is presented for a first reading tonight, and will be available for approval in January 2026.

If there are no objections, the Governance Committee would like to propose officer elections be held at the December meeting, even though the bylaw change would not go into effect until next month.

Motion: Consideration to Approve the Election of Officers at the December 2025 meeting, one month earlier than provided for in the current Hospital Bylaws.

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

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2025-24

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS APPROVING MEDICAL STAFF CREDENTIALING FOR NOVEMBER 2025

WHEREAS, the following recommendations were approved by the South Peninsula Hospital Medical Staff through the Credentials Committee and the Medical Executive Committee; and

WHEREAS, the Executive Committee met, reviewed and approved the credentialing at their meeting on November 24th since there was no meeting of the full board scheduled in November; and

WHEREAS, the medical staff files were reviewed by the full Board in Executive Session.

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

1. That the South Peninsula Hospital Board of Directors approve the initial appointment of:

Kirshna Iyer, MD	Diagnostic Radiology	vRad
Douglas Katein-Taylor, MD	Internal Medicine	Foundation Health
Kelly Mead, MD	Orthopedic Surgery	JBER

2. That the South Peninsula Hospital Board of Directors approve the reappointment of:

Graham Baluh, MD	General Surgery	JBER
Musaberk Goksel, MD	Oncology	
Jasmine Neeno, MD	Emergency Medicine	JBER/Prov
Kaitlin Peace, MD	General Surgery	MatSu
Sheila Smith, MD	Neurology	Providence
Richard Wood, MD	Emergency Medicine	
Carol Klamser, FNP	Family Medicine	SPH

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS EXECUTIVE COMMITTEE AT THEIR MEETING ON THE 24TH OF NOVEMBER, 2025, AND RATIFIED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA AT ITS MEETING HELD ON THIS 17TH DAY OF DECEMBER, 2025.

ATTEST:

Aaron Weisser, Board President

Mary E. Wythe, Board Secretary

DRAFT

Board of Directors: Calendar of Meetings 2026

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Governance Committee *2nd Wednesday @ 10:30*	1/14	2/11	3/11	4/8	5/13	6/10	7/8	8/12	9/9	10/14	11/11	12/9
Quality Committee *2nd Wednesday @ 4pm*	1/14	2/11	3/11	4/8	5/13	6/10	7/8	8/12	9/9	10/14	11/11	12/9
Strategic Planning Committee *Wed prior to BOD mtg @ 11am*	1/21	2/18	3/18	4/22	5/20	6/17	7/22	8/19	9/23	10/21	11/18	12/3
Finance/Pension Committee *Thurs prior to BOD mtg @ 8**	1/22	2/19	3/19	4/23	5/21	6/18	7/23	8/20	9/24	10/22	No mtg	12/10
Operating Board Meeting 5:30pm (open sesssion)	**1/28**	**2/25**	**3/25**	**4/29**	**5/27**	**6/24**	**7/29**	**8/26**	**9/30**	**10/28**	**No mtg**	**12/16**

*Pension reporting at February, May, August and December meetings

South Peninsula Hospital	**SUBJECT:** Board Orientation and Continuing Education	**POLICY #:** SM-10 **Page 1** of **3**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** 8/27/08 **Effective:** 1/24/24
Revised: 4/2019; 11/20/19 **Reviewed:** 9/29/21; 1/24/24		**Revision Responsibility:** Board of Directors

PURPOSE:
Requirements for Board member orientation and continuing education.

DEFINITION(S):
N/A

POLICY:

A. The Board of Directors recognizes the importance of continuing education for Board members, and the benefits of attending workshops and seminars to further Board effectiveness.

B. Pursuant to the Operating Agreement, the South Peninsula Hospital, Inc. Board ~~SPHI~~ (the Board) will establish a Board Orientation and Continuing Education Program. Per section 17 b 1 of Operating Agreement, the Board will report annually on compliance with the Program to the Contract Administrator. ~~The Board Orientation plan is contained in Policy SM-07.~~

C. New members of the Board will be oriented to the hospital and their role and responsibilities as a board member as soon as practical after appointment. The Board President will assign a mentor to the new member to act as a resource, answer questions and ensure completion of the orientation.

D. The ~~Executive Assistant~~ mentor will meet with the new Board member and provide them with a Board Member handbook.

E. Throughout their first year on the Board, the mentor will meet with the new member as prescribed in the Board Member Orientation schedule (Appendix B), or more frequently if needed, to ensure the completion of the orientation schedule and the development of the new member's understanding of their role on the Board and the operations of the hospital.

F. When the orientation year is completed, the mentor will verify completion of the process with the Governance Committee.

G. An annual Education budget ~~of hours and dollars~~ will be established ~~based on the plan~~ during the Operating Budget Preparation Cycle.

H. Every Board member will be required to attend one educational conference at least every other year. The Alaska ~~State~~ Hospital and ~~Nursing Home Association~~Healthcare Association (~~ASHNHA~~AHA) Annual Conference and the American Hospital Association's Rural Health Care Leadership Conference are strongly encouraged. The National Rural Health Association (NRHA) also provides two opprotunitites for education each year, the Rural Health Policy Institute in February and a Critical Access Hospital Conference in September.

I. Attendance of other affiliated conferences that fit the training recommendations in Appendix A, may be approved at the request of interested participants.

J. Due to the expense of attending out of town educational opportunities, attendance will be limited to Board members who are in good standing with regards to meeting attendance and committee participation and have 12 months or more left of their term unless they indicate their intent to renew their term. **Attendance will be determined by the President of the Board of Directors.??**

~~F.~~ Possible subject matter areas for Board Education include the items in Appendix A to this Policy. The annual content ~~will~~ may vary based on Board needs at the time of the Planning Cycle, but will, in general, contain information from the Subject Matter Areas~~.~~

~~G.~~

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):

South Peninsula Hospital's Values & Behaviors as adopted by the Board of Directors

Operating Agreement for South Peninsula Hospital with Kenai Peninsula Borough, 2020
Board Work – Pointer and Orlikoff
MASH 99603 – History of South Peninsula Hospital
Appendix A – SM-10 Board Orientation and Continuing Education Subject Matter Areas
Appendix B – Orientation Schedule

CONTRIBUTOR(S):
Board of Directors

Appendix A
SM-10 Board Orientation and Continuing Education
Subject Matter Areas

1. Credentialing
2. The Basic Roles and Responsibilities of Today's Board
3. This Hospital: (Services, Management, and Administration)
4. Fiduciary Responsibilities (Hospital Finances and Budgets)
5. The Board's Leadership Role
6. Th Board's Role in Mission, Vision, and Values
7. Understanding Key Stakeholders (Regulatory Entities; the Community; etc.)
8. Defining the Organization's Future and Strategically Managing for the Future
    a. Strategic Planning
    b. Trends in Healthcare
9. Rural Hospital Issues
10. Board Effectiveness and Orientation
    a. Analyzing performance
    b. Role of Board committees
    c. Improving performance
11. The Board's Role in Quality (Patient Safety & Quality)
12. The Board's Relationship with the:
    a. CEO
    b. Medical Staff
    c. Workforce
13. The Board's Role in Managing Change
14. Conflict Management at the Board Level
15. Medical and Information Technologies
16. Trustees as Health Advocates
17. Critical Access Hospital

RETIRE POLICY

South Peninsula Hospital	**SUBJECT:** Board Member Orientation	**POLICY #:** SM-07 **Page 1** of **1**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** 9/24/03 **Effective:** 1/24/24
Revised: 3/24/04; 5/28/08; 6/24/09; 6/23/10; 4/29/13; 6/25/14; 1/28/15; 11/17/15; 10/17/16; 8/28/19; 6/23/21 **Reviewed:** 1/25/23; 1/24/24		**Revision Responsibility:** Board of Directors

PURPOSE:
Orientation requirements of new members of the Board of Directors of South Peninsula Hospital, Inc.

DEFINITION(S):
N/A

POLICY:
A. New members of the board will be oriented to the hospital and their role and responsibilities as a board member as soon as practical after appointment. The Board President will assign a mentor to the new member to act as a resource, answer questions and ensure completion of the orientation.
B. The Executive Assistant will schedule orientation day(s) for the new Board member to facilitate completion of the Board Member Orientation Checklist and compile and deliver a Board Orientation Binder. The checklist will be used by the new board member to follow progress of their orientation.
C. When the checklist is completed, it will be returned to the mentor, who will verify completion. The mentor will forward the checklist to the Education Committee.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. South Peninsula Hospital's Values & Behaviors as adopted by the Board of Directors
2. Board Work – Pointer and Orlikoff
3. MASH 99603 – History of South Peninsula Hospital

CONTRIBUTOR(S):
Board of Directors

South Peninsula Hospital	**SUBJECT:** Board Member Responsibilities and Expectations	**POLICY #:** SM-14
		Page 1 of **2**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** **Effective:**
Revised: **Reviewed:**		**Revision Responsibility:** Board of Directors

PURPOSE:
To establish clear and measurable expectations for members of South Peninsula Hospital Operating Board (the Board) to ensure active participation, accountability, and effective governance.

DEFINITION(S):
N/A

POLICY:
Board members are expected to actively participate in meetings, engage with hospital governance materials, and contribute to the overall success of the hospital. This policy outlines specific requirements for board member engagement.

PROCEDURE:

1. **Attendance**
   - Board members are required to attend at least **75%** of scheduled board meetings annually.
   - Attendance records will be maintained and reviewed at the end of each calendar year.
2. **Engagement with Board Portal**
   - Board members are expected to log into the board portal a minimum of **twice per month** to review documents, updates, and relevant information.
   - Members should spend interact at least twice **per month** with the portal.
3. **Continuing Education (CE) Participation**
   - Board members are required to attend at least one educational conference at least every other year.
   - Board members are required to complete a minimum of **8 hours of continuing education** relevant to healthcare governance, leadership, or board responsibilities annually (see Appendix A of Policy SM-10 for available resources).
   - Documentation of completed CE activities must be submitted to the Executive Assistant for the record.
4. **Knowledge of Discussion Materials**
   - Board members must review all materials related to upcoming meetings prior to the meeting.
   - Acknowledgment of understanding may be conducted periodically to assess familiarity with the materials.
5. **Meeting Participation**
   - Board members should actively participate in discussions during board meetings, contributing insights and asking questions when appropriate.
   - Members are expected to provide input on agenda items and decisions, demonstrating an understanding of the hospital's mission and strategic goals.
6. **Committee Participation**
   - Board members are required to serve on at least one committee and are expected to attend 80% of committee meetings unless otherwise excused.
   - Committee members should contribute to the development of goals, strategies, and recommendations within their committee's focus area.
7. **Performance Evaluation**
   - An annual review to evaluate each board member's adherence to these expectations will be completed by the Governance Committee.

- The results will be discussed in a confidential session with the Board Chair, and if areas for improvement are identified, they will be brought to the member's attention by the Chair.

8. **Accountability**
   - Failure to meet these expectations may result in a review by the Board and could lead to recommendations for additional training, mentorship, or, in extreme cases, discussions regarding continued board membership.

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):

CONTRIBUTOR(S):
Board of Directors

South Peninsula Hospital	**SUBJECT:** Board President Evaluation	**POLICY #:** SM-15
		Page 1 of **2**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** **Effective:**
Revised: **Reviewed:**		**Revision Responsibility:** Board of Directors

PURPOSE:
To establish a comprehensive evaluation process for South Peninsula Hospital's Board President. To review accountability, review leadership effectiveness, and encourage continuous improvement in fulfilling responsibilities related to hospital governance, community engagement, and strategic oversight.

DEFINITION(S):
N/A

POLICY: This evaluation applies to the Board President and covers performance in areas including strategic leadership, governance, communication, stakeholder relations, fiscal oversight, ethical conduct, and overall contribution to the hospital's mission and vision. The evaluation will be conducted annually and may be used as a performance improvement guide.

Evaluation Goals
- Assess the Chairman's effectiveness in leading the board and guiding hospital strategy.
- Identify strengths and areas that may need improvement in leadership, decision-making, and stakeholder engagement.
- Encourage professional development and support strong leadership in hospital governance practices.
- Identify any concerns about transparency and accountability in senior leadership.

Evaluation Criteria and Performance Metrics
The evaluation will focus on the following key areas as established in the Board President Job Description (attached):
- Role of the Chair
- Governance and Presiding Officer
- Representation and Relationships
- Skills and Qualifications

PROCEDURE:
Evaluation Timing and Review Types
1. Formal biennial Review:
   During the annual board self-evaluation period, in the fall prior to the reappointment of the president, a review of the president's performance will be conducted by the consultant performing the board self-evaluation, providing a more in-depth evaluation of the board president's performance. This evaluation will provide feedback for the board when considering the reappointment, or the replacement of the president.
2. Periodic Reviews:
   Periodic reviews will be conducted periodically during the president's term of office. These reviews will be informal, and the data will be reviewed and compiled by the Governance Committee.

Methodology
1. Formal biennial Review:
   Board members, the CEO and other executive staff as deemed appropriate, will complete confidential evaluation forms rating the president's performance over the term of office. The results of the review will be shared with the president and the board. Recommendations for improvement may be included.
2. Periodic Reviews: A questionnaire regarding meeting performance will be provided following board meetings, at least twice per year. The results of these reviews will be shared with the president and will be intended to identify areas where improvements may improve meeting conduct and flow, if any.

Documentation and Confidentiality
All evaluations will be disclosed during executive sessions and will remain confidential

Outcome and Follow-Up
If performance needs to be modified or improved in order for the president to continue representing the board, a plan may be collaboratively developed outlining specific, measurable improvement goals. Progress towards these goals will be monitored through periodic reviews, and feedback will be provided during executive committee meetings, if necessary.

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. South Peninsula Hospital's Values & Behaviors as adopted by the Board of Directors

CONTRIBUTORS:
Board of Directors

South Peninsula Hospital

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

MEMO

To: SPH Board of Directors

From: Administration

Date: December 11, 2025

Re: Election of Officers

Officers for 2026-2027 will be elected at the December board meeting. The incumbents Aaron Weisser (President), Preston Simmons (Vice President), and Beth Wythe (Secretary) have all expressed a willingness to continue to serve for a second term. No other board members have been nominated or self-nominated to these positions.

Walter Partridge, Treasurer, is stepping off the board. Mike Dye has been nominated to serve as Treasurer.

Per the Bylaws, members of the Medical Staff may not serve in officer positions.

Officer elections will be held by secret ballot. Paper ballots will be distributed to those present in the room. Anyone attending remotely may text their vote to Maura Gibson, Executive Assistant.

The following board members have been nominated for officer positions, and other nominations may be taken from the floor during the meeting:

President: Aaron Weisser (incumbent)

Vice President: Preston Simmons (incumbent)

Secretary: Beth Wythe (incumbent)

Treasurer: Mike Dye

Board Members (excluding medical staff):
Matthew Bullard
Kim Frost
Walter Partridge
Preston Simmons
Bernadette Wilson
Aaron Weisser
Beth Wythe

BALLOT

President: _____

Vice President: _____

Secretary: _____

Treasurer: _____

South Peninsula Hospital	**SUBJECT:** SPH Quality Assessment and Performance Improvement Program	**POLICY #** HW-267 **Page 1** of **3**
SCOPE: Hospital-Wide **RESPONSIBLE DEPARTMENT:** Quality Management, Administration		**ORIGINAL DATE:** 12/2015 **REVISED:** 12/1/15; 4/2/18; 5/6/19; 10/28/2020; 5/26/2021, 05/25/2022, 5/25/2023, 5/22/24; 12/27/24; 5/28/25
APPROVED BY: Chief Nursing Officer Chief Executive Officer, Medical Executive Committee, Board of Directors		**EFFECTIVE:** 5/28/25

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

DEFINITION(S):
N/A

POLICY:

I. Patient & Resident Centered Care:
Patient and resident centered care is supported by South Peninsula Hospital (SPH), ~~and the~~ Long Term Care (LTC), and Home Health (HH) ~~facility~~ through the active involvement of ~~patients'~~patients, ~~residents'~~residents, and ~~their designated~~ caregivers and/or families as appropriate, in ~~decision making~~decision-making ~~about options for treatment~~. SPH, ~~and the~~ LTC, and HH ~~Facility~~ will hereafter be referred to as "The ~~SPH~~ Organization."

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

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

II. Quality Foundation:

A. Quality Plan: The Quality Plan serves as the foundation of commitment the ~~SPH~~ Organization has to reduce harm while continuously improving the quality and safety of the treatment and services provided.

B. Balanced Scorecard Report (BSC): The ~~SPH~~ BSC tracks specifically selected organizational indicators, which include Quality and Safety, Patient and Resident Experience, Medical Staff Alignment, Employee Engagement, and Financial Health. The BSC is updated quarterly and communicated to the Board o~~O~~f Directors (BOD) and the Medical Executive Committee (MEC).

C. Quality Improvement Change Model: The "Plan-Do-Study-Act" (PDSA) model is used to communicate~~, track and trend specific~~ department quality improvement activities, as well as indicators falling below the established target on the BSC. Guiding principles are as follows:
1. Plan: Identify a problem or process to improve and determine the objective or goal
2. Do: Carry out the plan. Collect data and begin to analyze the data
3. Study: Complete the analysis of the collected data and summarize what was learned
4. Act: Determine next steps. Adopt, abandon, or modify the plan.

D. Measurement/Monitoring and Data Analysis: Quality monitoring allows ongoing surveillance of activities. Data is analyzed for performance improvement opportunities. Measures include but are not limited to the following:

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- Balanced Scorecard Report (BSC)
- Trends identified through occurrence reports, grievances, or complaints
- National Patient Safety Goals
- CMS Core Measures, Hospital and Nursing Home Care Compare
- Patient Satisfaction survey data/responses
- Events that involve Root Cause Analysis
- Quality improvement opportunities identified through state and federal partners

III. Roles and Responsibilities:

1. Board of Directors (BOD): The SPH BOD shall review and evaluate overall quality activities of the organization. The Board will review, evaluate, and approve ~~the~~ all Quality Plans annually.
2. ~~Medical Executive Committee (MEC): The MEC is the primary governance committee for the medical staff and is accountable to the Board of Directors for oversight, monitoring, and evaluation of medical staff credentialing and services.~~
3. ~~Quality Management: The Quality Department assists with facilitating quality improvement and safety initiatives throughout the organization.~~
4. ~~2.~~ SPH Quality of Care Committee: The ~~Patient Centered Care Quality~~ Committee provides oversight and support~~ongoing operational leadership~~ of continuous quality improvement activities at ~~SPH~~the Organization ~~& LTC~~. The committee is composed of ~~at least one~~ BOD members, Medical Staff, ~~a nurse, a member of the medical staff,~~ and department leadership~~. The committee will meet quarterly~~.
5. ~~3.~~ Staff: All employees of the organization are expected to contribute to quality care and improvement at ~~SPH~~the Organization. Education is provided during ~~hospital~~ orientation and annually through individual departmental offerings~~s~~.
6. ~~4.~~ Patients/Residents/Caregivers: These valuable stakeholders have the right to be involved in making decisions regarding their care and to have any complaints, suggestions or concerns heard, investigated promptly and resolved.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):

1. Related Documents:
   - LTC-184 Long Term Care Quality Plan
   - HH-010 Home Health Quality Plan

~~1.~~2. Duquette, CLeadership and management; Q solutions: Essential resources for the healthcare quality professional. National Association for Healthcare quality. Third edition. (2012)

~~2.~~3. National Coordinating Council for Medication Error Reporting and Prevention. Index for Categorizing Medication Errors. 2001.

~~3.~~4. The Incident Decision Tree. Retrieved from https://www.ahrq.gov/downloads/pub/advances/vol4/meadows.pdf.

~~4.~~5. Patient-Centered Care. Institute of Medicine. Crossing the chasm: A new health system for the 21st century. Retrieved from http://www.oneviewhealthcare.com/the-eight-principles-of-patient-centered-care/.

~~5.~~6. Key Ingredients for Successful Trauma-Informed Care Implementation. Menschner, C. and Maul, A.; Center for Health Care Strategies. (April, 2016).

~~6.~~7. CMS.gov. Retrieved from: www.cms.gov/newsroom/fact-sheets/eliminating-serious-preventable-and-costly-medical-errors-never-events

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CONTRIBUTOR(S):
Senior Leadership Team, Board of Directors, LTC Facility Management, Medical Executive Committee.

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South Peninsula Hospital	**SUBJECT:** Quality Plan	**POLICY #** LTC-184 **Page 1** of **7**
SCOPE: Long Term Care Facility **RESPONSIBLE DEPARTMENT:** Long Term Care		**ORIGINAL DATE:** 8/26/21 **REVISED:** 4/14/22; 2/7/23; 3/14/23; 3/5/24; 1/3/25
APPROVED BY: LTC Nursing Director; LTC Administrator; LTC Medical Director; Chief Executive Officer		**EFFECTIVE:** 1/3/25

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

DEFINITION(S):
N/A

POLICY:

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

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

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

III. Types of Care and Services:

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

IV. Addressing Care and Services:

The QAPI program will aim for safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family by ensuring our data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action. We will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure our goals.

The scope of the QAPI program encompasses all types and segments of care and services that impact clinical care, quality of life, resident choice, and care transitions. These include, but are not limited to, customer service, care management, resident safety, provider relations, finance, and information technology. Aspects of service and care are measured against established performance goals and key measures are monitored and trended on a quarterly basis.
Abaqis supplies the fundamental core of the QAPI program by providing a structured, electronic system for the collection and analysis of quality data from residents, family, staff, resident records, and the MDS. To accomplish this, Abaqis includes a series of sampling, assessment, and data collection tools, and provides for analysis through in-depth investigation, the comparison of an organization's performance against established indicators, and thresholds of quality as well as national benchmarks. Abaqis also provides a data-driven and scientifically proven methodology for monitoring QAPI program efforts to ensure that they are comprehensive in scope, continuously executed and monitored, include the appropriate coverage of unique residents and care areas, and proactively initiate appropriate investigative and improvement actions for areas identified as needing correction.

V. Defining and Measuring Goals:
LTC will use internal and national benchmarks provided by national associations, clinical organizations, and federal & state provided databases (e.g., CMS Quality Measures, Five-Star Quality Rating System, survey data) to establish baselines for organizational practices and goal setting. In addition, the organization will continue to monitor progress towards goals by comparing its results to these benchmarks and its historical performance,
The sampling, assessment, and data collection tolls along with statistically verified thresholds in Abaqis are used to identify potential areas of concern. Additional, Abaqis contains Critical Element Pathways, Surveyor Guidance, and national benchmarks that provide a framework for defining and measuring QAPI program goals.

VI. Governance and Leadership

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

- Additional Members:
  - Assistant Director of Nursing - Janyce Bridges, RN
  - Quality Coordinator – Joyce Rider~~Bridges~~, RN
  - Nurse Practitioner - Teresa Kirchner, NP
  - Care Coordinator - Martie Hensley-Meyer, LPN

VII. Feedback, Data Systems, and Monitoring:

A. Monitoring Process:

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

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

B. Monitored Data Sources:

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

C. Adverse/Never Event Tracking System:

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

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

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

VIII. Performance Improvement Projects

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

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

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

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

E. Documenting PIPS:
PIPs will be documented continuously during execution. The documentation will include the overall goals for the project and will identify team members, define appropriate measures, root cause analysis findings, interventions, PDSA cycle findings, meeting minutes, target dates, and overall conclusions.
Abaqis provides an electronic platform for developing a PIP charter and for continuous PIP documentation in a structured format. Abaqis also allows for PIP team collaboration and visibility into PIP activity for team management and coordination of PIP efforts; provides a method of tracking PIP progress and documentation of findings for widespread and systemic improvement efforts; and allows for retaining and updating information related to ongoing projects for potential reference and future submission for survey compliance.

IX. Systematic Analysis and Systemic Action

A. Recognizing Problems and Improvement Opportunities:

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

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

X. Communications, Evaluation, Review Data

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

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

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

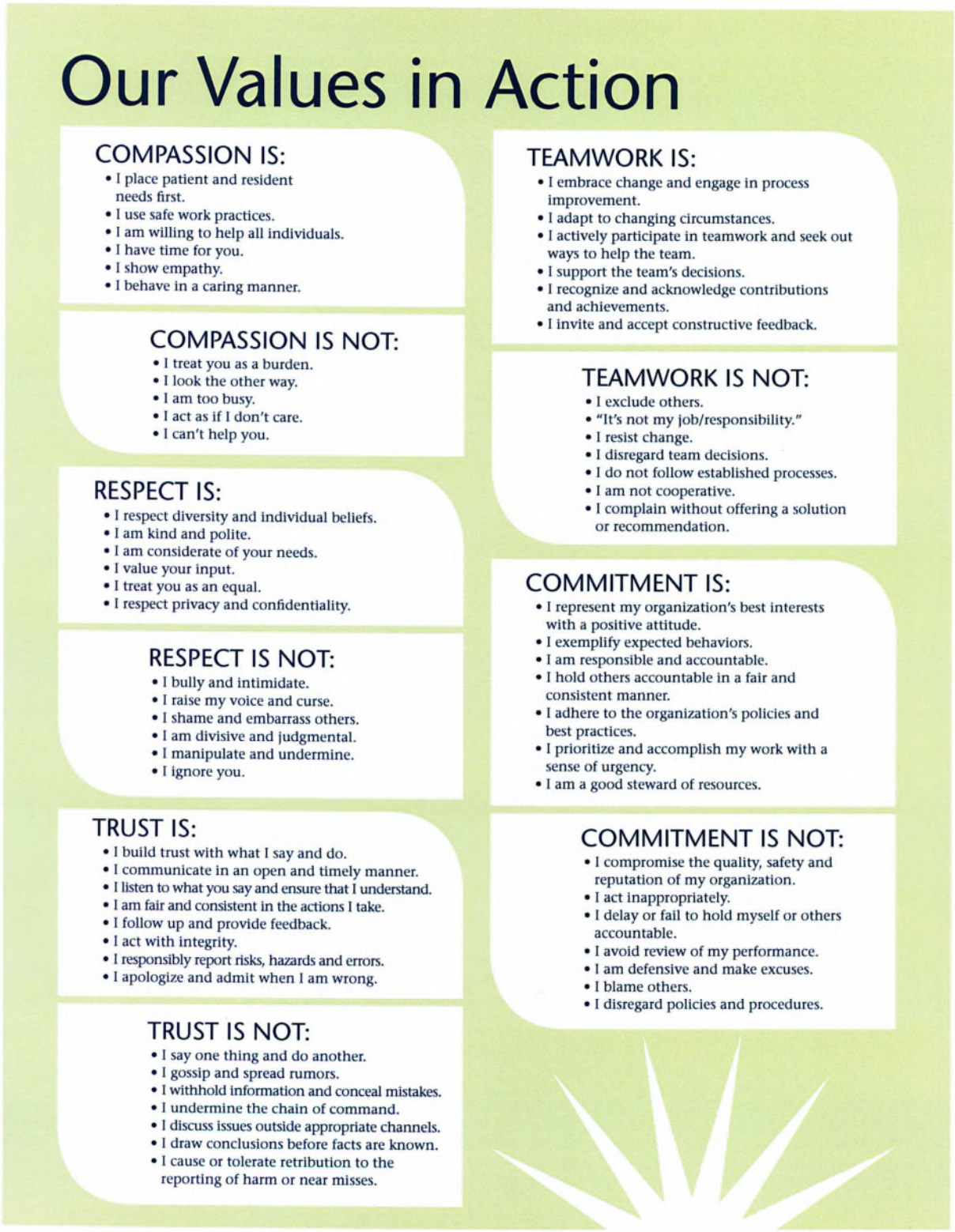
PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

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

CONTRIBUTOR(S):
LTC Nursing Director; LTC Administrator

APPENDIX A


Our Values in Action
COMPASSION IS:
• I place patient and resident needs first.
• I use safe work practices.
• I am willing to help all individuals.
• I have time for you.
• I show empathy.
• I behave in a caring manner.
COMPASSION IS NOT:
• I treat you as a burden.
• I look the other way.
• I am too busy.
• I act as if I don't care.
• I can't help you.
RESPECT IS:
• I respect diversity and individual beliefs.
• I am kind and polite.
• I am considerate of your needs.
• I value your input.
• I treat you as an equal.
• I respect privacy and confidentiality.
RESPECT IS NOT:
• I bully and intimidate.
• I raise my voice and curse.
• I shame and embarrass others.
• I am divisive and judgmental.
• I manipulate and undermine.
• I ignore you.
TRUST IS:
• I build trust with what I say and do.
• I communicate in an open and timely manner.
• I listen to what you say and ensure that I understand.
• I am fair and consistent in the actions I take.
• I follow up and provide feedback.
• I act with integrity.
• I responsibly report risks, hazards and errors.
• I apologize and admit when I am wrong.
TRUST IS NOT:
• I say one thing and do another.
• I gossip and spread rumors.
• I withhold information and conceal mistakes.
• I undermine the chain of command.
• I discuss issues outside appropriate channels.
• I draw conclusions before facts are known.
• I cause or tolerate retribution to the reporting of harm or near misses.
TEAMWORK IS:
• I embrace change and engage in process improvement.
• I adapt to changing circumstances.
• I actively participate in teamwork and seek out ways to help the team.
• I support the team's decisions.
• I recognize and acknowledge contributions and achievements.
• I invite and accept constructive feedback.
TEAMWORK IS NOT:
• I exclude others.
• "It's not my job/responsibility."
• I resist change.
• I disregard team decisions.
• I do not follow established processes.
• I am not cooperative.
• I complain without offering a solution or recommendation.
COMMITMENT IS:
• I represent my organization's best interests with a positive attitude.
• I exemplify expected behaviors.
• I am responsible and accountable.
• I hold others accountable in a fair and consistent manner.
• I adhere to the organization's policies and best practices.
• I prioritize and accomplish my work with a sense of urgency.
• I am a good steward of resources.
COMMITMENT IS NOT:
• I compromise the quality, safety and reputation of my organization.
• I act inappropriately.
• I delay or fail to hold myself or others accountable.
• I avoid review of my performance.
• I am defensive and make excuses.
• I blame others.
• I disregard policies and procedures.

South Peninsula Hospital	**SUBJECT:** Home Health Quality Plan	**POLICY #** HH-010 **Page 1** of **8**
SCOPE: Home Health ~~Services~~ **RESPONSIBLE DEPARTMENT:** Home Health		**ORIGINAL DATE:** Unknown **REVISED:** xx/xx/xx
APPROVED BY: draft		**EFFECTIVE:** draft

PURPOSE:
Program components and outline for the South Peninsula Hospital Home Health Agency Quality Plan in accordance with federal, state, and local regulatory guidelines and requirements.

DEFINITION(S):
Surveillance: "the ongoing, systematic collection, analysis, interpretation and evaluation of health data closely integrated with the timely dissemination of this data to those who need it", in accordance with the Centers for Disease Control and Prevention guidelines.

POLICY:
A. In accordance with §484.65 Condition of participation: Quality assessment and performance improvement (QAPI), SPH Home Health must develop, implement, evaluate, and maintain an effective, ongoing, Agency-wide, data- driven QAPI program.
   1. The program performance improvement activities must focus on high risk, high volume, or problem-prone areas.
   2. SPH Home Health's governing body must ensure that the program:
      - Reflects the complexity of its organization and services
      - Involves Home Health services (including those services provided under contract or arrangement)
      - Focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions
      - Takes actions that address Home Health performance across the spectrum of care, including the prevention and reduction of medical errors.
   3. All skilled professional staff, including direct employees and contractors, must provide input into and participate in the implementation of the agency's QAPI program.
   4. The Agency must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.

B. <u>Program Scope</u>
   1. The agency's QAPI program involves the following:
      a) Services
         - Skilled Nursing
         - Therapy Services – PT, SLP, OT
         - Personal Care and Support Services
         - Services provided under contract or by arrangement
      b) Patient Population
         - Pediatric to Geriatric depending on agency's demographic of patients
      c) Customers
         - Patients / Caregivers
         - Physicians
         - Employees
         - Contracted Service Providers
         - Medical Community
   1. The program must be capable of showing measurable improvement in quality indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care.

2. The agency must measure, analyze, and track quality indicators including adverse patient events, and other aspects of performance that enable the agency to assess processes of care, their services, and operations.
3. Selection of indicators will be based upon identified adverse or negative patient outcomes of agency processes with can be measured through data in order to evaluate change in agency procedure, policy or interventions.
4. Direct staff and contractors should make contributions to all phases of the QAPI program by identifying problem areas, recommendations to address problem areas, collection of data, attendance at periodic QAPI meetings, and participation in performance improvement projects.
5. The program must include documented procedures for measurement and analysis of indicators and address the frequency with which the measurement and analysis will occur.
6. Home Health will maintain a coordinated agency-wide program for the surveillance, investigation, identification, prevention, control and investigation of infectious and communicable disease [see §484.70(a)-(c)] as part of the QAPI program.
   a) The infection control program, as part of the QAPI program, should observe and evaluate services from all disciplines to identify sources or causative factors of infection.
   b) It should also track patterns and trends of infections, and in turn, establish a corrective plan for infection control as appropriate and monitor the effectiveness of the corrective plan. The corrective plan may include policy, procedure or practice changes and education of staff, patients and caregivers.

PROCEDURE:

A. Program Data, Measurement, and Analysis
1. The QAPI program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program.
2. The agency should incorporate data sources such as CMS' CASPER Agency Patient-Related Characteristics, Potentially Avoidable Events, OBQI Outcomes and other sources to establish demographics and determine areas for improvement.
3. The agency will document corrective action to ensure that improvements are sustained over time.
4. Collected data will be used to:
   - Monitor the effectiveness and safety of services and quality of care; and
   - Identify opportunities for improvement.
5. Procedures for measurement and analysis of indicators will be included in the program and will address the frequency with which the measurement and analysis will occur as approved by the governing body.
6. Selection of the indicators utilized will be based upon identified adverse or negative patient outcomes of the agency processes which can be measured through data in order to evaluate change in agency procedure, policy or interventions. Each indicator must be measurable through data in order to track adverse patient events, analyze their causes and implement preventive actions as well as measure the success and track performance to sustain improvements in practice, policy or process.
7. Additionally as an integral part of the QAPI program, the Agency must include data from their infection control program.
8. The QAPI program will use the measures in the care planning and coordination of services and events. The measures must include the following as appropriate for the scope of services provided by the agency:
   a) An analysis of a representative sample of services furnished to clients contained in both active and closed records;
   b) A review of:
      1) Use of emergent care services, hospital admissions and re-admissions;
      2) Negative client care outcomes;
      3) Complaints and incidents of unprofessional conduct by licensed staff and misconduct by unlicensed staff [see §484.50(e)];
      4) Infection control activities [see §484.70(a)-(c)];
      5) Medication administration and errors; and
      6) Effectiveness and safety of all services provided [see §484.75(a)], including:

i. the competency of the agency's clinical staff;
ii. the promptness of service delivery; and
iii. the appropriateness of the agency's responses to client complaints and incidents;
iv. services provided under contract or arrangement

c) A determination that services have been performed as outlined in the individualized service plan, care plan, or plan of care [see §484.75(a)]; and
d) An analysis of client complaint [see §484.50(c)]; and satisfaction survey data; and
e) An annual evaluation of the total operation which includes services provided under contract or by arrangement.

9. For each measurable quality indicator selected, a systematic process will be used to track and analyze data. This plan is based on the "Plan, Do, Study~~Check~~, Act" (PDSC~~A~~) method. Data will be collected in order to:
   - Improve health outcomes
   - Patient safety
   - Quality care
   - Assess processes of care
   - Services provided
   - Agency operations
   - Identify areas for improvement
   - Determine whether changes have resulted in improvement
10. The measurement activity must be approved by the agency's governing body and shall define the:
    - Data to be collected
    - Method of data collection
    - Sources of data
    - Frequency of data collection
    - Personnel responsible for data collection
    - Frequency of data assessment/interpretation and statistical analysis

B. Data Assessment/Interpretation
1. The results of data collection will determine:
   - The current level of performance and the stability of current processes.
   - Areas for improvement.
   - Strategies to stabilize or improve performance effectiveness.
   - Priorities for possible improvement of existing processes.
   - Actions to improve the performance of processes.
   - Whether changes in the processes resulted in improvement.
2. Interpretation of the results / statistical analysis may include:
   - Internal comparisons over time
   - Comparisons to state-of-the-art sources
   - Standards
   - Best practice guidelines
   - Comparisons with the performance of similar organizations
   - Reference
   - External databases such as OASIS, OBQM and OBQI, Home Health Compare, Star Ratings, and other relevant data
   - Benchmarking

C. Program Activities
1. The Agency's performance improvement activities must:
   a) Focus on high risk, high volume, or problem-prone areas
      1) High risk includes all factors associated with significant risk to the health or safety of patients including types of services, geographic concerns, or specific patient care services.

2) High volume refers to care or service areas that are frequently provided by the agency to a large patient population which may increase the scope of the problem.
3) Problem-prone areas refer to care or service areas that have the potential for negative outcomes and are associated with diagnosis or condition for a particular patient group or component the agency's operation or historical problem areas.

b) Involve all agency services provided under contract or by arrangement
c) Consider incidence, prevalence, and severity of problems in those areas
d) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.

2. The QAPI program is designed to assess and improve the quality of client care. This shall include, but not be limited to:
   a) Individuals providing care
   b) Types of services
   c) Types of clients served
   d) Support activities
   e) Governance activities

D. Performance Improvement Projects
1. The agency will review and update or revise the plan of implementation at least once within a calendar year, or more often as needed.
2. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the Agency's services and operations.
3. The Agency must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects.
4. The Agency should have one performance improvement project either in development, on-going or completed each calendar year beginning January 13, 2018 and thereafter.
5. The Agency decides, based on the QAPI program activities and data, what projects are indicated and the priority of the projects.

E. Tracking/Analysis and Prevention
1. Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. The Agency must take actions aimed at performance improvement, and, after implementing those actions, the Agency must measure its success and track performance to ensure that improvements are sustained.
2. Adverse patient events are those patient events which are negative and unexpected; impact the patient's Agency plan of care; and have the potential to cause a decline in the patient condition.

F. Executive Responsibilities & Approval
1. The Governing Body must ensure the program reflects the complexity of its organization and services; involves all services (including those provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the Agency's performance across the spectrum of care, including the prevention and reduction of medical errors.
2. The frequency and detail of the data collection must be approved by the Agency's governing body. The governing body ensures that the Agency systematically collects data to measure various aspects of quality of care; the frequency of data collection; how the data will be collected and analyzed; that data collected is used to assess quality and stimulate performance improvement.
3. The Agency's governing body is responsible for ensuring the following:
   - That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained.
   - That the Agency-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.
   - That clear expectations for patient safety are established, implemented, and maintained.

- That any findings of fraud or waste are appropriately addressed.

4. In the event that the Agency identifies a possible illegal action by its employees, contractors or responsible/relevant physicians, it is the responsibility of the Agency to report the actions to the appropriate authorities according to the individual State laws and the nature of the action(s).

G. Confidentiality
1. All patient and employee documentation and communication regarding QAPI activities will be kept strictly confidential.
2. Patient/employee numbers, not names, will be utilized in reports.
3. Data collection, analysis, and reports will be kept in a secure location under the supervision of the QAPI designee.
4. All QAPI activities will adhere to the confidentiality policy.
5. QAPI documents must be made available to CMS staff upon request.

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. Attachments: Ongoing Data Collection forms (next page)
2. §484.50(c)
3. §484.65
4. §484.70(a)-(c)
5. §484.75(a)

CONTRIBUTOR(S):
Home Health Administrator

QAPI Program

ONGOING DATA COLLECTION

Infection Control

- Follow policies related to infection control.
- Complete infection/communicable disease report for each occurrence involving patients and employees.
- Log all reports on the Infection Control Log; agency director or designee will be responsible for reporting any communicable diseases to authorities.

~~Risk Identification~~Occurrence Reports

- Follow policies related to the definition of an “occurrence” and complete a Occurrence ~~Risk Identification (Risk ID)~~ Report as necessary.
- Document any follow-up as required.
- Report sentinel events immediately to supervisor.
    - Sentinel event is defined by CMS as "an unexpected occurrence involving death or serious physiological or psychological injury, or the risk thereof."
- Log all reports through Hospital-Wide Occurrence Reporting system.~~on the Risk ID Report Log~~.
- Log all sharps injuries through Hospital-Wide Policy~~on the Sharps Injury Log~~.

Clinical Record Review

A sample of active and closed clinical records should be periodically reviewed by the appropriate health professionals, representing the scope of the program. This will be done to determine whether established policies are followed in furnishing services directly, or under arrangement.

- Reviews need not be performed at a face to face meeting of the professionals performing the review.
- Each professional may review the records independently.
- ~~The review by appropriate health professionals should include those professionals representing the scope of services provided for the period of time established for the audit (e.g., quarterly). For example, if no speech therapy services were performed during the period under review, the speech therapist need not be a part of the audit.~~

Analysis from audits will be reviewed for trends and opportunities for improvement.

Grievances

- Maintain Provider ~~hysician~~ Complaint Log with follow-up documentation
- Maintain a Patient ~~Client~~ Complaint Log with follow-up documentation
- Adhere to policy regarding employee grievance procedures with follow-up documentation as indicated.

Contracted Services

- Evaluations are maintained for all contracted services and those under arrangement providing patient care/services.

Customer Satisfaction

The Agency contracts with a CMS-approved HHCAHPS vendor to survey Home Health ~~discharged~~ patients for patient satisfaction. Process Measures and HHCAHPS reports will be reviewed and reported in summary.

Agency Compliance

This Agency has implemented a voluntary compliance plan. Leadership determined a written compliance plan would concretely demonstrate a strong commitment to honesty and responsible corporate citizenship, fulfill legal duties to government and private payers, outline procedures to promptly correct any misconduct, and mitigate any sanction imposed by the government. It also reinforces compliance expectations of employees and enhances patient care. Follow Hospital-Wide Corporate Complaince & Ethics Program.

Program Evaluation

An overall evaluation of the agency's total program will be completed at least once a year.

Quality Assessment and Performance Improvement (QAPI) Program

This plan must be reviewed and updated or revised at least once within a calendar year, or more if needed, by the QAPI designated staff / committee.

~~QAPI Program Review Log~~				
~~Section of Plan Being Reviewed~~	**~~Review~~**	**~~Revise~~**	**~~Update~~**	**~~Date~~**
~~QAPI Members~~				

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

Calendar Year 2026 Quality Assurance & Performance Improvement (QAPI) Plan for South Peninsula Hospital Home Health

Vision

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

Mission

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

Purpose

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

Plan

For Calendar Year 2026 SPH Home Health will have three separate performance improvement plans (PIPs) They will be

1. Improvement in ambulation.
2. Improvement in management of oral medications.
3. Improvement in dyspnea.

When choosing these items as our PIPs for 2026, we looked at the publicly reported data from 2025 as well as quality data from our electronic medical record (Kinnser). CareInsight data and Value-Based Insight data was pulled for the dates of January 1st 2025 through November 26th 2025. SPH HH scored a 74.1% for Medicare/Medicaid patients that showed improvement in ambulation, 67.9% improvement in management of oral medications and 73.9% improvement in dyspnea. This is a decrease from 81.5% from calendar year 2025 for ambulation and a slight decrease from 68.4% for improvement in oral medications. Improvement in dyspnea is a new measure we added on for 2026. On Care Compare October 2025 refresh, SPH HH scored 81.0% improvement in ambulation compared to the national middle score of 87.3%, 69.5% improvement in oral medications compared to the national middle score of 85.8% and 68.3% improvement in dyspnea with a national middle score of 90.1%. In January 2026 Care Compare' refresh will reflect SPH HH at 82.1% for improvement in ambulation with the national middle score of 87.5%, 72.4% for improvement in oral medications with the national middle score of 85.9%, and 67.6% for improvement in dyspnea with the national middle score of 90.3%. These three measures will be reported to the board monthly via a combination of the Balanced Score Card (quarterly) and CNO updates (monthly).

As part of HH's QAPI program, we will also be tracking our overall Discharge Function Score (DFS). DFS was a new measure in 2025 that is publically reported on Care Compare. DFS is calculated using the risk-adjusted scores from 11 functional items on the OASIS assessment. The DFS is also used in Value-Based Purchasing. This data will go to the board quarterly through the CNO report.

South Peninsula Hospital

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

Every year at least one new PIP is created based off the review of the data we collect. The frequency and the detail of the data collection must be approved by HH's governing body. Below is an outline of the data collection.

Data Collection:

1. Monthly-
    a. All OASIS SOCs are reviewed from the previous month.
    b. All OASIS Discharges are reviewed from the prior month.
    c. CareInsights Reports reviewed (Kinnser)
    d. Value-Based Insight reports reviewed (Kinnser)
    e. HHCAHPS are reviewed monthly (Press Ganey)
2. Quarterly
    a. HHA provider preview report is reviewed- this is a preview of HHA quality measures scores that will be posted on HH Compare the following quarter.
    b. QAO interim score is reviewed- this looks at the number of quality assessments submitted to CMS vs. Non quality assessments. This number can affect our reimbursement. SPH HH has to maintain 90% or more. For July 1, 2024 to June 30, 2025, our agency is at 96.8%.
    c. HH Quality of Patient Care Star Ratings preview report is reviewed.
    d. Home Health Value-Based Purchasing (HHVBP) Model Interim Performance Report (IPR) is a report we look at quarterly. This report shows us where we are for value-based purchasing. We are in the large cohort group, so we compete nationally with all Medicare certified agencies that had more than 60 HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year. For 2025, SPH HH had a **decrease** of -3.471% on all traditional Medicare payments. For 2026, SPH HH will have an **increase** of 1.261% on all traditional Medicare payments.
    e. Potentially avoidable events- this report each event goes through an investigation to see if there is anything HH could have done to prevent this event or to help prevent a related future event.
    f. Quarterly Clinical Record reviews are completed.
3. Annually
    a. PEPPER Report- statistic based report that is used to help us look at things like top diagnosis, number of episodes, case mix data, etc.
    b. Outcomes Report- Pulled annually to look specifically for areas that SPH HH is below state or National averages and see where we need to focus upcoming Performance Improvement Plans.
    c. HHVBP Annual Performance Report (APR)

Recommended Motion: Consideration to Approve the 2026 QAPI Plan for South Peninsula Hospital Home Health as presented.

Administrator, Director of Home Health – Ivy Stuart, RN
Quality Nurse – Katie Watson, RN
Clinical Supervisor, Back-up Administrator – Marissa Frank, RN

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 meetings~~special meetings. 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.

Commented [A1]: Maybe change to:

Members shall be notified of the time, place, date, and purpose of special meetings.

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 reviewing strategic plans for the coming year and may include election of officers and ~~may include~~ appointment of Board members. The Annual meeting will count as one of the ten required meetings per year, and may include the conduct of regular business items.

ARTICLE III - MEMBERS

Section 1.

Qualifications.

1. Board members must be at least 21 years old and a resident of the South Kenai Peninsula Hospital Service Area (" Service Area") of the Kenai Peninsula Borough~~; except that as many as three directors may reside outside the Service Area~~. The Board may establish other qualifications for Directors by resolution or policy. The Board may also establish criteria for the composition of the Board as a whole by resolution or policy, provided that at least 51% of the Board must be independent directors. By resolution or policy, the Board may impose restrictions on the eligibility of and guidelines for directors, including non-independent directors such as Medical Staff Members with privileges, to serve as committee members on Board committees.

2. Medical Staff Members with privileges to practice in corporation facilities, including employees of the corporation, are eligible to serve on the Board of Directors, provided that the number of such Medical Staff Members concurrently serving on the Board shall not exceed two (2) directors at any time, and the number of non-physician medical staff members shall not exceed one (1) director at any time. Medical Staff Board Members will be recused from influencing the following Board decisions:
    - Physician compensation including pay for performance considerations
    - CEO compensation
    - Approval of the annual audit
    - Legal matters of which the Physician or a family member is the subject
    - Medical Staff Board Members cannot serve on or have family relationships with members of the Physician Peer Review Committee

3. Except as provided in Section 2.B. employees of the corporation's facilities may not serve as Board members while so employed or within one year after termination of employment.

The number or Directors of this corporation shall be nine (9) to eleven (11). The Board may change the number of Directors at any time by amendment to these Bylaws, but a decrease cannot have the effect of shortening the term of an incumbent Director.

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. Elections 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~~vacated seat shall serve the remainder of the term for the seat the member has been appointed to fill. If the vacancy results in fewer than nine (9) active members, every effort will be made to fill the vacant seat as quickly as possible. There is no requirement to fill a seat, as long as the minimum required number of active board members is met.

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 2/3 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. Non-independent board members may serve in executive capacities, however the President and Vice-President may not both be non-independent board members.

Section 2.

At the ~~annual~~ December meeting ~~in the month of January~~ each ~~even~~ odd year, the officers shall be elected, all of whom shall be from among ~~its~~ the board's 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, or when the President has a conflict of interest regarding a topic, 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~~President shall appoint 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, maintain records of each board member's attendance of special and regular board and assigned committee meetings, training attendance, and ensure posting of the agenda and minutes on the website, ensure that notification is provided to the Kenai Peninsula Borough for any changes to board 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 act as the Finance and Pension Committee Chair and 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.

Non-Board Committee members shall serve without remuneration. Board Committee members will receive no additional remuneration for committee service. Reimbursement for out-of-pocket expenses of committee members may be made only by H~~h~~ospital 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 Chief Executive Officer (CEO) will serve as the Administrator of the hospital and shall be selected by the Hospital Board to serve under its direction and be responsible for carrying out its policies. The ~~Administrator~~ CEO shall have charge of and be responsible for the administration of the hospital.

Section 2.

The ~~Administrator~~ CEO 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~~ CEO shall prepare an annual budget showing the expected receipts and expenditures of the hospital, for the review and approval of the Hospital Board.

Section 4.

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

Section 6.

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

Section 7.

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

Section 8.

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

Section 9.

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

Section 10.

The ~~Administrator~~ CEO 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 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, and 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 Hospital Board 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 completed with a resolution of the Hospital Board that is to be read by title only at two meetings, prior to a vote. The vote may be conducted at the meeting of the second reading. "Read" in this capacity applies to the provision of all amendments and the reading of the resolution title.

Section 2.

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

Section 3.

These Bylaws shall be reviewed and updated as required, but at a minimum will be restated 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~~consistent with the following procedure.

An agenda will be prepared and posted prior to each regular meeting, special meeting, or committee meeting, stating the intended topics of discussion/review at the meeting.

Except in the case of an emergent topic, no additional topics will be included in the agenda once it has been finalized and posted.

The agenda will be approved at the beginning of each meeting using the motion, second, vote process, and may include amendments to the order of business only.

If a Board Member has a conflict of interest with any item on the consent agenda, that item will be removed for individual consideration using the amendment procedure above.

Business will be conducted using a motion, second, discussion and vote format. When reviewing and discussing resolutions, amendments may be proposed using the same format and must be approved or declined before moving forward with the final approval of the resolution.

In order to keep track of the discussion, only one amendment may be introduced, discussed and voted on at a time, and "friendly amendments" should not be considered. Clear each proposed amendment and make additional amendments if desired.

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~~ contendere 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, January 29, 2025.

- Aaron Weisser, President

- Mary E. Wythe, Secretary

Medical Staff Office
4300 Bartlett Street
Homer, AK 99603
(907) 235-0849
medstaffoffice@sphosp.org

MEMO

To: South Peninsula Hospital Board of Directors

From: Medical Staff Office

Date: December 15th, 2026

Re: South Peninsula Hospital & Long Term Care Rules & Regulations

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On November 5, 2025, a draft of the South Peninsula Hospital & Long Term Care Rules and Regulations was distributed to the General Medical Staff via email for the required 30-day review period, in accordance with the South Peninsula Hospital & Long Term Care Medical Staff Bylaws, section 9.3.3.

Subsequently, on December 5, 2025, the Medical Executive Committee convened and voted to approve the draft of the South Peninsula Hospital & Long Term Care Rules and Regulations as presented.

It is important to note that the review of the Medical Staff Rules and Regulations is mandated to occur at least once every three years, as stipulated in the Medical Staff Bylaws. The most recent approved review and update took place on May 26, 2021.

South Peninsula Hospital & Long Term Care Facility

Medical Staff Rules and Regulations

Adopted: May 26, 2021

Revised:

Approved by MEC on December 8th, 2025

Formatted: Superscript

Table of Contents

ARTICLE I. INTRODUCTION

1.1 INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee and approved by the Board of Directors to define further the general policies contained in the *Medical Staff Bylaws*, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising Clinical Privileges. Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict.

These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the *Medical Staff Bylaws*. This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

The specific responsibilities of each Practitioner are to render specific professional services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among Practitioners of the same profession, in a manner consistent with licensure, education and expertise, and in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, and Case Management/utilization standards in effect in the Hospital.

1.2 DEFINITIONS

The terms used in these Rules and Regulations are consistent with the definitions in the *Medical Staff Bylaws* unless otherwise noted.

"Anesthesia" consists of general Anesthesia and spinal or major regional Anesthesia, does not include local Anesthesia. General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuro-muscular function. Cardiovascular function may be impaired.

"Deep Sedation" is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance and maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

"Moderate Sedation" is a drug-induced depression of consciousness during which patients respond to purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a pain stimulus is not considered a purposeful response. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

"Swing Bed" is an approved bed by the Centers for Medicare & Medicaid Services (CMS) for South Peninsula Hospital (Hospital) to provide either acute or skilled nursing facility (SNF) care.

ARTICLE II. ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

The Hospital accepts short-term patients for care and treatment provided suitable facilities are available.

a. Admitting Privileges: A patient may be admitted to the Hospital only by a Practitioner on the Medical Staff with admitting Privileges.

b. Admitting Diagnosis: Except in an emergency, no patient will be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been documented in the medical record. In the case of an emergency, the provisional diagnosis or reason for admission will be recorded as soon as possible.

c. Admission Procedure: Admissions must be scheduled with the Hospital's ~~Acute Care Health Unit Clerk~~charge nurse. A bed will be assigned based on the patient's medical condition and the availability of Hospital staff and services. Except in an emergency, the attending Practitioner or designee shall contact the Hospital's charge nurse ~~Acute Care Health Unit Clerk~~ to ascertain whether there is an available bed.

d. PCS-014 ICU Admission Criteria, OB-001 Admission to Nursery, SWB-002 Admission to swing bed

2.1.2 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area. Patients in active labor will be admitted directly to Labor and Delivery per Hospital policy.

2.2 UNASSIGNED EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must, at a minimum, provide for an appropriate medical screening examination within the capability of the Hospital's Emergency Department, including ancillary services routinely available to the Emergency Department, to determine whether or not an emergency medical condition exists. Pregnant patients, greater than twenty (20) weeks' gestation, with a primary obstetrical complaint can have their medical screening exam done in the obstetrics area. The Hospital's policy, ~~TITLE~~PCS-132 Medical Screening, and PCS-155 EMTALA Guidelines for Emergency Department Services.

2.2.1 Definition of Unassigned Patient

Patients who present to the Emergency Department and require admission and/or treatment shall have a Practitioner assigned by the Emergency Department physician if one or more of the following criteria are met:

a. The patient does not have an established relationship with a Practitioner, within the past three (3) years outside of that in an unassigned capacity, or does not indicate a preference;

b. The patient's established Practitioner does not have admitting Privileges; or

c. The patient's injuries or condition fall outside the scope of the patient's established Practitioner.

2.2.2 Unassigned Call Service

a. Unassigned Call Schedule: The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. If there is a dedicated Hospitalist program in place, with 24/7 on-call coverage, the assigned Hospitalist physician will serve as the on-call physician for unassigned patients. With a Hospitalist program in place, Medical Staff Leadership will develop a list of physicians who are scheduled to take emergency call on a rotating basis and send it to the Medical Staff Office and Emergency Department to make it accessible.

~~b. Response Time: Response Time: It is the responsibility of the on-call physician, APP, or designee to respond in an appropriate time frame. The on-call physician, APP, or designee will respond to calls from the relevant/pertinent department within thirty (30) minutes by telephone. They must arrive at the Hospital if requested to see the patient.~~

~~c.~~b. Substitute Coverage: The assigned Hospitalist physician or the Medical Director of Hospitalist Medicine is responsible for arranging substitute coverage. Failure to update the Hospitalist call schedule or notify the Emergency Department of alternate call coverage may result in disciplinary action, as outlined in the *Medical Staff Bylaws*~~.s~~.

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2.2.3 Patients Not Requiring Admission

In cases where the Emergency Department consults with the unassigned call physician and no admission is deemed necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care.

If the consultant, in disagreement with the emergency physician, feels 1) that inpatient admission is not warranted, or 2) the patient requires transfer to another facility, then the consultant is required to come into the Emergency Department to make appropriate arrangements.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who present to the Emergency Department will be referred to the Practitioner taking unassigned call that day unless a patient-physician relationship has been developed and the patient is no longer considered Unassigned.

2.2.5 Guidelines for Policies on Unassigned Call

The following rules should be used in developing policies regarding unassigned emergency call obligations:

a. Unassigned call duties, to supply basic stabilization and disposition of the patient, should be based on the physician's clinical core Privileges, even though the physician may not hold specific privileges within the core. If there is not a Hospitalist program in place, physicians with admitting Privileges residing within thirty (30) minutes of the Hospital will be expected to serve on the unassigned call roster; ~~Unassigned call duties, to supply basic stabilization and disposition of the patient, should be based on the physician's clinical core Privileges even though specific items in the core may be deleted. If there is not a Hospitalist program in place, physicians with admitting Privileges residing within thirty (30) minutes of the Hospital will be expected to serve on the unassigned call roster;~~

b. To meet the emergency health care needs of our community and comply with Federal EMTALA regulations and ACOG standards, the below~~following~~ guidelines are ~~will be~~ adopted in relation to physician on-call coverage:

~~b.~~

Surgical specialists, i.e., Anesthesia, General Surgery, Orthopedics, and Ophthalmology, and other specialties contracted to provide on-call services, shall provide a call schedule to the Medical Staff Office fifty (50) days before the first day of the month. The Medical Staff Office will provide internal electronic access and distribute it to other required parties.~~Surgical specialists, i.e. Anesthesia, General Surgery, Orthopedics, and Ophthalmology and other specialties contracted to provide on-call services, shall provide a call schedule to the Medical Staff Office fifty (50) days prior to the first day of the month. The Medical Staff Office will provide internal electronic access and distribute to other required parties.~~

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i. Non-employed or contracted Physicians and Advanced Practice Professionals (for their own patients) providing Obstetrical services shall provide a call schedule to the Medical Staff Office by the 15th of the preceding month.

~~i.~~ii. The Medical Staff Office will distribute the call schedule to clinical departments and any other required parties and provide electronic access internally. The call schedule shall provide for uninterrupted Obstetric coverage. Unassigned obstetric patients will be examined and treated by the qualified medical personnel on call. ~~Non-employed or contracted Physicians and Advance Practice Professionals (for their own patients) providing Obstetrical services shall provide a call schedule to the Medical Staff Office by the 15th of the preceding month. The Medical Staff Office will distribute the call schedule to clinical departments and any other required parties and provide electronic access internally. The call schedule shall provide for uninterrupted Obstetric coverage. Unassigned obstetric patients will be examined and treated by the ED physician on call, if the ED physician has obstetric Privileges. If the ED physician does not have obstetric Privileges, patients will be seen by the obstetric call physician.~~

~~ii.~~iii. ~~Physicians and Advanced Practice Professionals~~Practitioners providing inpatient medicine services will provide call as follows: If there is a dedicated Hospitalist program in place, with 24/7 on-call coverage, the assigned Hospitalist physician will serve as the on-call physician for unassigned patients. If there is not a Hospitalist program in place, physicians with admitting Privileges will provide on-call coverage for unassigned patients on a rotating basis to be determined by Medical Staff Leadership.

~~iii.~~iv. Non-employed or s~~S~~olo specialists will provide a schedule reflecting reasonable availability to the ED, per their contract with the Hospital.

c. Specialties ~~with three (3) or more physicians~~ or specialists, agreed upon by the Medical Staff and Board of Directors, and contracted to provide call require that physicians take call no more often than one (1) in three (3) nights and weekends, unless they volunteer to be on call more often.

~~c.~~d. All changes to Medical Staff call schedules will be communicated to the Medical Staff Office for notation in the master schedule as soon as possible.

e. When immediate c~~C~~hanges to the call schedule, ~~-~~which ~~that~~ do not result in a gap in on-call coverage are ~~may be~~ made, both practitioners agreeing to the switch will telephonically inform the Acute Care Charge Nurse. ~~by switching coverage with another physician. Changes may be made telephonically by calling the Acute Care Unit Clerk or Charge Nurse.~~

~~The name of the individual making the change will be recorded by the Unit Clerk or Charge Nurse when the change request is received.~~

~~d. It is the on-call physician's responsibility to notify the ED of this change. Changes may be made telephonically by calling the Acute Care Unit Clerk or Charge Nurse. The Acute Care Unit Clerk or Charge Nurse will directly communicate back the updated call schedule to the physicians who are assuming call. The name of the individual making the change will be recorded by the Unit Clerk or Charge Nurse when the change request is received.~~

~~e.~~f. In cases of personal or family emergencies that will result in a gap in ~~in~~ on-call coverage, the practitioner will discuss, inperson or telephonically, with their department Medical Director and the Acute Care charge nurse. ~~Acute Care Director~~

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~~or Acute Care Medical Director~~If their department Medical Director is unavailable, the practitioner will contact the CMO, or available administrator, ~~will be notified as far in advance as possible~~ to allow the Hospital ~~and ED on-call physician~~ to make other reasonable arrangements.

~~f. All changes to Medical Staff call schedules will be communicated with the Medical Staff Office to be noted in master schedule.~~

g. An impairment that is alleged to limit a practitioner's ability to provide ~~Unassigned~~unassigned call services shall also be grounds for limiting the Practitioner's privileges for delivering care to their assigned or private patients.

No Practitioner shall care for a patient, or attempt to care for a patient while under the influence of alcohol or any cognition-impairing substance while on call.

2.2.6 **Use of the Unassigned Call Roster**

The Unassigned call roster may be used as default consultation coverage when a Practitioner cannot obtain consultation on a patient on a voluntary basis.

2.2.7 **Failure to Meet Unassigned Call Obligations**

All failures to meet ~~Unassigned~~unassigned call responsibilities shall be reported to the Chief of Staff and the Medical Executive Committee. Recurrent failure to meet call obligations may result in Corrective Action per the *Medical Staff Bylaws*.

2.3 TRANSFERS

2.3.1 Transfers from Other Acute Care Facilities

Transfers from other acute care facilities must meet the following criteria:

a. The patient must be medically stable for transfer;

~~b.~~ The patient's condition must meet medical necessity criteria;

c. The patient must require, and this Hospital must be able to provide a specific inpatient service not available at the transferring facility, or that the patient or family requests the transfer;

d. Responsibility for the patient must be accepted by a physician with appropriate Privileges at this Hospital; and

e. The transfer must be approved by the Hospital representative with authority for accepting transfers.

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2.3.2 Transfers Within the Hospital

~~2.3.2~~

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All Practitioners actively providing care to the patient will be notified of all transfers per the methods noted in Hospital policy.

2.3.3 Transfers to Another Hospital

~~2.3.3~~

Patients who are transferred to another Hospital must follow ~~the~~ Hospital policy HW-076 Emergency Transfers on transfers to ensure EMTALA compliance.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending Practitioner, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Practitioners who have patients who are a danger to themselves and/or others should follow the Hospital policy : ~~TITLE~~PCS-156 At Risk Behavior Assessment, PCS-017 Close Observation Patients, Safety Interventions, HW-315 Involuntarily Detained Patients in Mental Health Crisis, and HW-316 Involuntarily Detained Patient Rights

~~2.4.1~~

2.5 **PROMPT ASSESSMENT**

2.5.1 All new admissions must be personally assessed in a timely manner, usually within twelve (12) hours for routine admissions, or sooner as the patient's condition dictates for all urgent admissions.

2.5.2 All new admissions will have a history and physical examination completed and on the record within twenty-four (24) hours of admission or registration.

DISCHARGE ORDERS AND INSTRUCTIONS

2.6

Patients will be discharged or transferred only upon the authenticated order of the attending practitioner ~~physician or Privileged designee~~ who shall provide, or assist Hospital personnel in providing, written discharge instructions in a form that can be understood by all individuals and organizations responsible for the patient's care.

i. Discharge diagnoses
ii. A list of all medications the patient is to take post-discharge;
iii. Dietary instructions and modifications;
iv. Medical equipment and supplies;
v. Instructions for pain management;

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vi. Any restrictions or modification of activity;
vii. Follow up appointments and continuing care instructions;
viii. Referrals to rehabilitation, physical therapy, and home health services, etc.; and
ix. Recommended lifestyle changes, such as smoking cessation.

~~2.5.3 These instructions should include, if appropriate:~~
~~a. A list of all medications the patient is to take post-discharge;~~
~~b. Dietary instructions and modifications;~~
~~c. Medical equipment and supplies;~~
~~d. Instructions for pain management;~~
~~e. Any restrictions or modification of activity;~~
~~f. Follow up appointments and continuing care instructions;~~
~~g. Referrals to rehabilitation, physical therapy, and home health services; and~~
~~h. Recommended lifestyle changes, such as smoking cessation.~~

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~~2.6~~2.7 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the Hospital against the advice of the attending physician, or without a discharge order, Hospital policy ~~s~~ PCS-096 Discharge Against Medical Advice, Elopement, Wandering shall be followed. The attending physician shall be notified that the patient has left against medical advice.

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~~2.7~~2.8 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the Hospital only for as long as medically necessary. All Practitioners are expected to participate in the discharge planning activities. ~~activities established by the Hospital and approved by the Medical Executive Committee.~~

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ARTICLE III. MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

3.1.1 The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement.

3.1.2 The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care.

3.1.3 Only authorized individuals may have access to and make entries into the medical record.

3.1.4 The attending physician is responsible for the preparation of the physician components to ensure a complete and legible medical record for each patient.

3.1.5 In order to practice medicine, all healthcare providers who exercise Privileges in the facility are required to utilize the electronic health record (EHR) in order to meet regulatory requirements and provide efficiencies in delivering healthcare to the community.

3.1.6 All healthcare providers will undergo appropriate EHR training, and comply with security guidelines, per the Hospital's policy on use of and access to the EHR.

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the Practitioner's legible signature or by approved electronic means.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering Practitioner immediately. The authorized individual will contact the Practitioner, request a verbal order for clarification, read back the order, and document the clarification in the medical record. This verbal order must be signed by the ordering Practitioner as described in Subsection 4.4.2.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents.

3.4.1 Prohibited Abbreviations, Acronyms, and Symbols
The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders. These will include at a minimum:

a. U for Units
b. IU for International Units
c. QD for Daily
d. QOD for Every Other Day
e. Trailing Zero (X.0)
f. Always Use Leading Zero (0.X)
g. MS or MSO4 for Morphine Sulfate
h. MGSO4 for Magnesium Sulfate

3.4.2 Situations Where Abbreviations Are Not Allowed
The MEC may create a policy of additional abbreviations, acronyms, and symbols that may not be used, which will include at a minimum, prohibition against using in recording the final diagnoses, on informed consents, or on operative procedures.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for the performance of the history and physical examination are noted in Part I, Section 2 of the *Medical Staff Bylaws*.

3.5.2 Who May Perform and Document the Admission History and Physical Examination
The history and physical shall be completed by Practitioners privileged to do so as further described in the *Medical Staff Bylaws*."

3.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

A complete history and physical examination is required for all admissions, all inpatient surgeries requiring Anesthesia (general, regional, MAC, or Deep Sedation), and all observation patients. A complete history and physical examination report must include the following information:

a. Chief complaint or reason for the admission or procedure;
~~b.~~ A description of the present illness;

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b.

c. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;

d. An age-appropriate social history

e. Advanced care planning;

f. A pertinent family history;

g. A review of systems;

h. Cardiopulmonary~~respiratory~~ exams and other relevant physical findings;

i. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

A focused history and physical examination (outpatient assessment) report, used for outpatient procedures including the use of Anesthesia or Moderate Sedation, should include the following information:

a. Chief complaint or reason for the admission or procedure;

b. A description of the present illness;

c. Past medical history, including current medications, allergies, and current diagnoses;

d. Relevant physical findings, including an evaluation of the cardiac and respiratory systems and the affected body area;

e. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

A. Responsibility for the Admission History and Physical Examination

~~A.~~

a. Completion of the patient's admission history and physical examination is the responsibility of the admitting ~~physician, or designee~~practitioner.

b. For Practitioners requiring supervision or collaboration, a Privileged physician shall review and countersign the history and physical examination within twenty-four (24) hours.

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3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

a. all invasive procedures performed in the Hospital's surgical suites;

b. certain procedures performed in the Radiology Department (angiography, angioplasty, myelograms, (abdominal and intrathoracic biopsy or aspiration, and

c. certain procedures performed in other treatment areas (bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, and elective electrical cardioversion).

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if an H&P is not completed.

3.7 PROGRESS NOTES

~~3.7~~

3.7.1 The attending ~~physician/APP, or designee~~practitioner, or designee, will record a progress note each day~~,~~ and for each significant patient encounter~~,~~ on all Hospitalized patients.

~~3.7.2 Progress notes must document the need for continued Hospitalization.~~

~~3.7.3 All patients in the acute care and intensive care units must be seen daily by a physician, evidenced by a daily progress note.~~

3.7.2 ~~All other patients~~Swing bed patients must be seen at least every third (3rd) day by attending ~~physician/APP~~practitioner evidenced by a progress note.

~~3.7.4~~3.7.3 Progress notes must document the need for continued Hospitalization.

~~3.7.5 Swing Bed patients may be seen by attending physician/APP twice a week.~~

~~3.7.6~~3.7.4 Progress notes documented by APPs do not require co-signature.

~~3.7.7~~3.7.5 Progress notes documented by residents require co-signature.

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3.8 OPERATIVE / PROCEDURE REPORTS

Operative reports will be written or dictated immediately after surgery prior to transferring the patient to the next level of care, and in no case later than twenty-four (24) hours after the end of the procedure if a post-operative note is entered as described in Section 3.9, and the report promptly signed by the surgeon and made a part of the patient's current medical record. Operative/procedure reports will include:

a. name and Hospital identification number of the patient,
b. date and times of the surgery,
c. the name of the surgeon(s) who performed the procedure and any assistants and a description of their tasks,
d. the pre-operative and post-operative diagnoses,
e. the name of the procedure performed,
f. a description of the procedure performed,
g. the type of Anesthesia administered,
h. findings of the procedure,
i. complications, if any,
j. any estimated blood loss,
k. any specimen(s) removed, and
l. any prosthetic devices, transplants, grafts, or tissues implanted.

3.9 POST-OPERATIVE / PROCEDURE NOTES

If there is a delay in getting the operative/procedure report in the medical record, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. This note needs to be finalized prior to transfer out of the Post Anesthesia Care Unit (PACU) or in an intensive care unit if the surgeon accompanies the patient to the intensive care unit. Operative/procedure notes will include:

a. the name of the surgeon(s) who performed the procedure and any assistants,
b. the name of the procedure performed,
c. findings of the procedure,
d. any estimated blood loss,
e. any specimen(s) removed, and
f. the post-operative/procedure diagnosis.

3.10 PRE-ANESTHESIA NOTES AND PRE-SEDATION ASSESSMENTS

3.10.1 Pre-Anesthesia Notes
Anesthesia/Deep Sedation: A pre-Anesthesia note, reflecting evaluation of the patient and review of the patient record prior to administration of Anesthesia, shall be made by the Practitioner administering Anesthesia and entered into the medical record of each patient receiving Anesthesia at any anesthetizing location and shall contain the following information:

a. Notation of Anesthesia risk,
b. Anesthesia, drug and allergy history,
c. Any potential Anesthesia problems identified, and

d. Patient's condition prior to induction of Anesthesia.

The pre-Anesthesia evaluation should be performed by an individual, qualified, and Privileged to administer Anesthesia/sedation, within forty-eight (48) hours prior to inpatient or outpatient surgery or procedure requiring Anesthesia services. Delivery of the first dose of medications for the purpose of inducing Anesthesia marks the end of the forty-eight (48) hour time frame.

3.10.2 Pre-Sedation Assessments
Patients who will be receiving Moderate Sedation must be monitored and evaluated before, during and after a procedure by a trained Practitioner, however a pre-Anesthesia evaluation is not required because Moderate Sedation is not considered to be "Anesthesia". The pre-sedation assessment, performed within forty-eight (48) hours of the administration of Anesthesia, shall include the following:

a. Physical examination of the airway (by those qualified and Privileged to administer sedation);

b. Assessment of risk to the patient for receiving sedation;

c. Drug and allergy history regarding sedation; and

d. Physical condition of the patient prior to induction of sedation.

3.11 ANESTHESIA RECORD

A record of Anesthesia that conforms to the policies and procedures developed by the Anesthesia Practitioners shall be made for each patient receiving sedation or Anesthesia at any anesthetizing location.

3.12 POST-ANESTHESIA NOTES AND POST-SEDATION NOTES

3.12.1 Post-A~~A~~nesthesia Notes
A post-Anesthesia evaluation shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving Anesthesia or Deep Sedation. The note shall be entered by an Anesthesia provider or by the Practitioner who administered the Deep Sedation. This note should contain the following information:

a. Cardiopulmonary status;

b. Level of consciousness;

c. Any follow-up care and/or observations; and

d. Any complications occurring during post-Anesthesia recovery.

3.12.2 Post-sedation notes
A post-sedation note shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving Moderate Sedation. The note shall contain the same information as noted in the post-Anesthesia note.

3.13 CONSULTATION REPORTS

3.13.1 The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

3.13.2 Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record.

3.13.3 The consultation report should be completed and entered in the patient's chart within the time frame specified by the Practitioner ordering the consult and no later than twenty-four (24) hours after receipt of notification of the consult request.

3.13.4 If a full consult note is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient.

3.13.5 If the report is not in the record within the prescribed time, an explanatory note should be recorded in the record. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.14 OBSTETRICAL RECORD

The obstetrical record must include a medical history, including a complete prenatal record if available, and an appropriate physical examination. A copy of the Practitioner's office prenatal record may serve as the history and physical for uncomplicated vaginal deliveries if it is legible and complete and the last prenatal visit was within thirty (30) days of admission. If the office prenatal record is used as the history and physical examination, an update must be performed as described in Part I, Section 2.6 of the *Medical Staff Bylaws* will be documented.

3.15 FINAL DIAGNOSES

The final diagnoses will be recorded in full, without the use of symbols or abbreviations dated and signed by the discharging Practitioner in the discharge summary, transfer note, or death summary of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the Practitioner will be required to document such in the patient's record.

3.16 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. The practitioner, or designee, on duty the day the patient

is discharged is responsible to complete the discharge summary. ~~All discharge summaries are the responsibility of the discharging Practitioner on the day of discharge, or Privileged designee.~~

a. Content: A discharge summary will be ~~written or dictated~~completed upon the discharge or transfer of Hospitalized patients. The discharge summary will contain:

   1. Reason for Hospitalization;
   2. Summary of Hospital course, including significant findings, the procedures performed, and treatment rendered;
   3. Condition of the patient at discharge;
   4. Instructions given to the patient and family, including medications, referrals, and follow- up appointments; and
   5. Final diagnoses.

b. Short-term Stays: A discharge summary is not required for uncomplicated inpatient and observation Hospital stays of less than forty-eight (48) hours, uncomplicated vaginal deliveries, and normal newborn infants, provided the discharging Practitioner, or designee, enters a final progress note documenting:

   1. The condition of the patient at discharge; and
   2. Instructions given to the patient and family, including medications, referrals, and follow- up appointments.

c. Deaths: A discharge summary is required on all inpatients who have expired and will include:

1. Reason for admission;
2. Summary of Hospital course; and
3. Final diagnoses.

Timing: A discharge summary will ~~should~~ be completed and signed by the attending Practitioner, or designee, ~~and in the medical record~~ within three (3) days after discharge, transfer, or death. A transfer summary will be completed and travel with the patient and if it contains the content identified in 3.16a, will be accepted as the discharge summary.

d.

D~~Any d~~ischarge summari~~esy~~ used for readmission, ~~purposes~~ must be completed within one (1) day.

3.17 ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professionals are defined in the *Medical Staff Bylaws* ~~Practitioner.~~

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a. The collaborating/supervising physician will either enter their own note or attest to the APP's note, within one (1) calendar day, for all history and physical examinations;

~~b.~~ The collaborating/supervising physician is not required to enter their own note or attest to the APP's note, within one (1) calendar day, for all consultations;

b.

c. The collaborating/supervising physician does not need to cosign any progress notes performed by APPs.

d. Routine orders of an APP do not need co-signature by a physician except for orders for controlled substances when the APP does not have their own independent DEA number;

e. Delivery notes done by Certified Nurse Midwives do not require co-signature by a physician;

~~f.~~ Discharge summaries prepared by APPs do not require co-signature by a physician.~~.~~

f.

3.18 APP STUDENTS, MEDICAL STUDENTS, RESIDENTS OR FELLOWS IN TRAINING

3.18.1 Students, residents, or fellows in training, who are not moonlighting outside of their training program, must have their:

a. History and physical examinations, operative notes, and operative reports cosigned within one (1) calendar day by the attending physician, or their physician designee;

b. Discharge summaries cosigned by the attending physician, or their physician designee, within three (3) days after discharge of the patient;

c. Progress notes cosigned within one (1) calendar day by the attending physician;

d. Consultations may not be performed independently by students; and those completed by a resident or fellow mush be cosigned within one (1) calendar day by the attending physician;

e. Orders of a student must be cosigned before the order is implemented by Hospital staff;

~~f.~~ Orders of the resident need to be cosigned within thirty (30) days post discharge. These orders do not need to be cosigned before being implemented by Hospital staff.

~~3.18.2~~f.

3.18.2 APP/Medical Students, Residents & Fellows in training shall be permitted to function clinically only in accordance with the written training protocols & policies developed by the Medical Staff in conjunction with the ~~residency~~ training program.

~~3.18.3 The protocols must delineate the roles, responsibilities, and patient care activities of residents including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign.~~

3.19 PROVIDER-BASED CLINICS

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In provider-based clinics, all office notes must be completed within two (2) days of visit. A problem list (medications, allergies, and chronic illnesses) must be completed by the end of the third (3rd) visit.

3.20 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, protected health information (PHI) contained in the record will be made available to any member of the Medical Staff attending the patient, to members of medical staffs of other Hospitals, and to others in accordance with the Health Insurance Portability and Accountability Act (HIPAA), state privacy laws, and Hospital policy regarding use, access, and disclosure of PHI. Records must be retained pursuant to Hospital medical record retention policies.

a. Access to Old Records: In case of readmission of a patient, all records still maintained will be available to the attending Practitioner whether the patient was attended by the same Practitioner or by another Practitioner.

b. Unauthorized Transmission or Removal of Records: Unauthorized transmission or deletion of medical records from their designated space(s) is grounds for suspension of Privileges of the Practitioner for a period to be determined by the Medical Executive Committee.

c. Access for Medical Research: Access to the medical records for research will be afforded to members of the Medical Staff for a bona fide study and research in accordance with the HIPAA privacy and security requirements for research, state privacy and security laws, and Hospital policies. All such projects require approval of the Institutional Review Board prior to using, accessing, or disclosing any PHI. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.

d. Access for Former Members: Former members of the Medical Staff may request access to former patient records by following the Health Information Management policy. Use and access of PHI will be granted in compliance with HIPAA and state privacy and security laws.

3.21 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the MEC.

3.21.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the following standards:

a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record in the timeframes noted in the *Medical Staff Bylaws*;

b. A Preoperative History and Physical Examination or Focused Preoperative History and Physical Examination (outpatient assessment) must be entered in the medical record prior to the surgery or procedure;

c. An Admission Prenatal Record with update, or a de novo history and physical, must be entered in the medical record by the attending ~~physician or designated~~practitioner covering Practitioner within twenty-four (24) hours after an obstetrical admission;

d. An Operative Report must be entered in the medical record by the performing Practitioner immediately, but in no case later than twenty-four (24) hours, following the surgery or procedure;

~~e.~~ If the Operative Report is not immediately available, a Post-Operative Note must be entered in the medical record by the performing Practitioner prior to transfer of the patient to the next level of care;

e.

f. An Inpatient Progress Note must be recorded and authenticated by the attending Practitioner, or designee, each day and for each significant patient encounter on all Hospitalized patients;

g. An Emergency Department Record must be completed by the responsible Practitioner:

   i. Transferred patient – prior to transfer,

   ii. Admitted patient– by end of shift

   iii. Patient discharged home – within one (1) day

h. A Consultation Note must be completed by the consulting Practitioner, or designee, within twenty-four (24) hours of notification of the consult request;

~~i. A Discharge Summary must be entered in the medical record by the discharging Practitioner or designee within three (3) days after an inpatient or observation discharge or transfer; and~~

~~j.~~i. The Inpatient or Observation Medical Record must be completed within thirty (30) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary.

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ARTICLE IV. STANDARDS OF PRACTICE

4.1 ADMITTING, ATTENDING, AND DISCHARGING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted Hospital shall have an attending Practitioner with admitting Privileges. The Emergency Department Practitioner may enter "bridging orders" to suffice until the admitting Practitioner enters their own orders.

The admitting Practitioner, or designee, is the Practitioner who accepts the admission and is responsible for completion of the history and physical examination. If a patient is admitted by an Advanced Practice Professional then a physician will co-sign the History and Physical.

The attending Practitioner will be responsible for:

a. the medical care and treatment of each patient in the Hospital;
b. making daily rounds;
c. the prompt, complete, and accurate preparation of the medical record; and
d. necessary special instructions regarding the care of the patient.

The discharging Practitioner, or designee, is the Practitioner who enters the discharge order and is responsible for completion of the Discharge Summary.

4.1.2 Identification of Attending Practitioner

At all times during a patient's Hospitalization, the identity of the attending Practitioner shall be clearly documented in the medical record.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending Practitioner are transferred to another Practitioner, a note covering the transfer of responsibility will be entered in the medical record by the attending Practitioner.

4.2 **COVERAGE AND CALL SCHEDULES**

Each Practitioner shall provide the Medical Staff Office with a list of designated Medical Staff appointees who have Privileges in the same or like specialties, or less ideally by generalists who have expressed a willingness to assume the responsibility for those patients, who shall be responsible for the care of their patients in the Hospital when the Practitioner is not available.

4.3 **RESPONDING TO CALLS AND PAGES**

4.3.1 Telephonic Response. Practitioners are expected to respond timely, generally in no more than thirty (30) minutes.

4.3.2 Physical Response: Practitioners are expected to respond in person, in a timely manner based on the Practitioner-to-Practitioner communication about the patients condition, or communication about the patients condition from staff unless otherwise dictated by a contract, policy or accreditation requirements.

4.4 **ORDERS**

4.4.1 General Principles

a. All orders for treatment will be entered into the medical record.

b. All orders must be specifically given by a Practitioner who is privileged by the Medical Staff with the exception of outpatient infusion orders. They must be written by an Alaska-licensed independent practitioner per HW-309 Orders.

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c. Vague or "blanket" orders (such as "continue home medication" or "resume previous orders") will not be accepted.

d. Instructions should be written out in plain English. Prohibited abbreviations may not be used.

e. All orders for treatment shall be recorded in the medical record and authenticated by

the ordering Practitioner with a legible signature, date, and time.

4.4.2 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the Practitioner to write the order or enter it in the electronic medical record. Verbal orders are given directly Practitioner-to-Hospital staff; telephone orders are given Practitioner-to Hospital staff via telephonic communication means. Verbal/telephone orders must comply with the following criteria:

a. The order must be given to an authorized individual as defined in Hospital policy HW-309 Orders.

b. Verbal/telephone orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal/telephone orders, like written/electronic orders, should be conveyed in plain English without the use of prohibited abbreviations.

c. The order must be read back to the prescribing Practitioner by the authorized person receiving the order.

d. All face-to-face verbal orders must be signed by the ordering Practitioner prior to leaving the treatment area.

e. All telephone orders must be verified according to Hospital policy HW-309 Orders.

f. Orders for cancer chemotherapy may not be given verbally.

g. Verbal/telephone orders may be given only by Practitioners Privileged at the Hospital or working under training protocols.

4.4.3 Facsimile and Electronically Transmitted Orders

Orders transmitted electronically or by facsimile shall be considered properly authenticated and executable provided that:

a. It is legible and received as it was originally transmitted;
b. The order is legible, clear, and complete
c. The identity of the patient is clearly documented; and
d. The transmission contains the name of the ordering Practitioner, address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law

4.4.4 Drugs and Medications

Orders for drugs and medications must follow Hospital policy HW-309 Orders and HW-306 Medication Administration.

4.5 CONSULTATION

4.5.1 Any qualified Practitioner with Clinical Privileges may be requested for consultation within their area of expertise.

4.5.2 The attending Practitioner is responsible for obtaining consultation whenever patients in their care require services that fall outside their scope of delineated clinical privileges.

4.5.3 It is recommended that consultation be obtained in the following circumstances: the diagnosis is obscure after ordinary diagnostic procedures have been completed, there is doubt as to the best therapeutic measures to be used, unusually complicated situations are present that may require specific skills of other Practitioners, the patient exhibits severe symptoms of mental illness or psychosis,

4.5.4 The attending Practitioner will provide written authorization in the EMR requesting the consultation, and permitting the consulting Practitioner to attend or examine their patient. This request shall specify:

a. the reason for the consultation, and

b. the urgency of the consultation (routine – within twenty-four (24) hours; nonroutine – in a timeframe determined by closed loop communication between the referring practitioner~~hysician~~ and the consultant).

4.5.5 All other consultations will be for "consultation and treatment" unless otherwise noted.

4.5.6 All consultations should be communicated Practitioner-to-Practitioner, unless there are extraordinary circumstances that would preclude doing so. All consultation requests will be noted in the medical record.

4.5.7 Consultants should not order consultations with other specialties without informing the attending practitioner~~physician~~ unless the need is urgent/emergent.

a. APP's may perform the consultation with the knowledge and collaboration of their collaborating/supervising physician.

b. The attending ~~physician~~ practitioner may utilize consultants of their choice. In general, if a patient has chronic consultative care by a consultant prior to this episode of care, that practitioner ~~physician~~ should be consulted if that medical issue is unstable. If desired, the attending practitioner m~~physician m~~ay utilize the ED on call list for consultation.

c. If nurses have any reason to question the care provided to any patient, or believe that appropriate consultation is needed, the nurse shall follow Hospital policy.

d. All Practitioners should be receptive to obtaining consultation when requested by patients, their families, and Hospital personnel per the Medical Staff Code of Conduct.

e. Formal consultation with a Hospitalist is encouraged for patients receiving Surgical Critical Care.

4.6 CRITICAL CARE UNITS

4.6.1 Critical Care Unit Privileges

The privilege to admit patients to, and manage patients in, critical care units shall be specifically delineated. When there are concerns regarding the continued stay within a critical care unit, consultation with the medical director of the unit will be obtained.

4.6.2 Prompt Evaluation of Critical Care Patients

Each patient admitted or transferred to a critical care unit shall be examined by a practitioner ~~physician, or designee,~~ in a timely manner as the patient's status dictates, following admission or transfer unless that transfer is solely for non-critical care reasons such as monitoring of certain IV infusions or for one-on-one observation.

4.6.3 Critical Care Services

Certain services and procedures may be provided to patients only in critical care units. The Medical Executive Committee shall establish policies that specify which services may be provided only in a critical care unit.

4.7 DEATH IN HOSPITAL

4.7.1 Pronouncing and Certifying the Cause of Death

In the event of a Hospital death, the deceased shall be pronounced dead by a practitioner ~~physician, an APP,~~ or a registered nurse in cases where death is noted to be imminent per hospital policy PCS-130, LTC-127. Policies with respect to the release of dead bodies shall conform to local law and are noted in Hospital policy HW-313.

For inpatients, the attending practitioner ~~physician or physician designee~~ shall complete the death certificate within twenty-four (24) hours of receipt.

4.7.2 Organ Procurement

When death is imminent, practitioners ~~physicians~~ should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable per Hospital policy HW-313 Post-Mortem Management.

4.8 AUTOPSY

Practitioners are encouraged to obtain autopsies on the following:

a. Deaths in which autopsy may help explain unknown and unanticipated medical complications to the attending physician.
b. Deaths in which the cause of death is not known with certainty on clinical grounds.
c. Deaths in which autopsy may help to allay concerns of the family and/or the public regarding same.
d. Unexpected or unexplained deaths in the Hospital occurring during or following any medical or surgical diagnostic procedure and/or therapy.
e. Deaths of patients who currently are participating in clinical trials approved by the Institutional Review Board.

f. Deaths in which patient has sustained or apparently sustained injury while Hospitalized.
g. Deaths resulting from high-risk infectious and contagious disease.
h. Obstetric deaths.
i. Neonatal and pediatric deaths.
j. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which may also have a bearing on survivors or recipients of transplant organs.

4.9 DEATHS REPORTABLE TO THE MEDICAL EXAMINER

Deaths will be reported to the Medical Examiner when required by Alaska law.

4.10 SUPERVISION OF ADVANCED PRACTICE PROFESSIONALS

4.10.1 Definition of Advanced Practice Professionals

a. Advanced Practice Professionals ~~Practitioner~~ are licensed or certified health care Practitioners whose license or certification does not permit, and/or the Hospital does not authorize, the independent exercise of clinical privileges in the inpatient setting. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals may provide inpatient care only under the supervision/collaboration of a physician(s) with Privileges.

~~a.~~b. Under Alaska law CRNAs are allowed to administer Anesthesia without physician supervision. CRNAs must have a collaborative plan signed by the Chief of Staff, or~~OR~~ Medical Director, or designee.

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~~4.10.2~~ .

~~4.10.3~~4.10.2 Guidelines for Supervising Advanced Practice Professionals

a. The physician(s) is(are) responsible for managing the health care of patients in all settings.
b. Health care services delivered by physicians and by Advanced Practice Professionals under their supervision/collaboration must be within the scope of each Practitioner's authorized practice, as defined by state law.
c. The physician(s) is(are) ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, ensuring the quality of health care provided to patients.
d. The role of the Advanced Practice Professional in the delivery of care shall be defined through mutually agreed upon a Supervision/Collaboration Agreement that is developed by the physician and the Advanced Practice Professional.
e. The physician(s) must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or other means. A physician must be able to respond telephonically and or physically in a timely manner when needed by the Advanced Practice Professional.
f. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the APP, as determined between the physician and the APP in a collaborative conversation.
g. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.

h. The physician(s) and Advanced Practice Professional together should review all delegated patient services on a regular basis, as well as the mutually agreed upon Scope of Practice Guidelines.
i. The supervising/collaborating physician(s) is(are) responsible for clarifying and familiarizing the Advanced Practice Professional with supervising methods and style of delegating patient care.
j. Each Advanced Practice Professional must document the identity of their supervising or collaborating physician and any alternate supervising physician(s), as applicable.

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~~4.10.4~~4.10.3 Supervision/Collaborative Practice Agreements

Each Advanced Practice Professional must have on file in the Medical Staff Office written Supervision/Collaboration Agreement, if applicable, that describes all health care- related tasks which may be performed by the Advanced Practice Professional. This document must be signed by the Advanced Practice Professional and the supervising/collaborating physician. The Supervision/Collaboration Agreement shall be submitted to the Credentials Committee and the Medical Executive Committee for approval before the Advanced Practice Practitioner can provide services to patients at the Hospital.~~r~~

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~~approval before the Advanced Practice Practitioner can provide services to patients at the Hospital.~~

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~~4.10.5~~4.10.4 Supervising/Collaborating Physician

An Advanced Practice Professional may provide services to patients only if the supervising/collaborating physician, or alternate physician, is within normal backup coverage range. A physician may not supervise more APPs than is allowed by state law.

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of or collaboration with an Advanced Practice Professional or other dependent health care professional shall be subject to appropriate Corrective Action as provided in the *Medical Staff Bylaws*.

~~4.10.6~~4.10.5 Medical Record Documentation

Advanced Practice Professionals medical record documentation is noted in Section 3.17.

~~4.10.7~~4.10.6 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not:

a. provide a service which is not listed and approved in the Supervision Agreement on file in the Medical Staff Office, or
b. provide a medical service that exceeds the Clinical Privileges granted to the supervising/collaborating physician.

4.11 INFECTION CONTROL

All Practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties, including hand hygiene.

4.12 EVIDENCE-BASED ORDER SETS, PROTOCOLS, AND STANDING ORDERS

Evidence-based order sets, protocols, and standing orders provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Evidence-based order sets assist Practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. Protocols and Standing Orders are developed collaboratively between the Medical Staff, nursing, and pharmacy.

4.13 LONG TERM CARE

The following are to be followed for patients in the Long Term Care unit:

a. No patient shall be admitted to the Long Term Care Facility without the authorization of the Medical Director, Licensed Nursing Home Administrator and Director of Nursing.
b. At the time the resident is admitted, there shall be physician admission orders for the resident's immediate care and indicating the level of care.

c. The medical care of each resident shall be supervised by a physician.
d. All orders for medications, labs, and procedures shall include a written diagnosis.
e. A history and physical shall be performed within 7 days ~~24 hours~~ of admission and, at a minimum, annually thereafter.
f. A patient must be seen by a practitioner ~~physician~~ at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. During practitioner ~~physician~~ visits, the practitioner ~~physician~~ shall:
    i. review of the resident's total program of care, including medications and treatments, at each visit;
    ii. write, sign and date progress notes at each visit; and
    iii. sign and date all orders with the exception of influenza and pneumococcal vaccines which may be administered per facility policy after an assessment for contraindications.
g. Practitioner ~~Physician~~ progress notes shall also be completed as needed for any change in the resident's condition, care, treatment, or therapy.
h. Review and approval of changes to a progress note; sign/date of monthly physician orders and monthly drug regimen reviews.
i. Enter a progress note for quarterly, annual, and significant change care conferences.
j. When a patient is transferred or discharged out of long term care, the patient's physician shall make an appropriate entry into the patient's clinical record when the patient is transferred or discharged per regulations.

4.13.1 Advance Practice Professionals in Long Term Care

a. Advance Practice Professionals will follow the Federal and State Nursing Facility Guidelines when working in the Long Term Care facility.
b. Advance Practice Professionals do not have authorization to admit a resident to Long Term Care.

ARTICLE V. PATIENT RIGHTS

5.1 PATIENT RIGHTS

All Practitioners shall respect the patient rights as delineated in Hospital policy HW-068 Patient and Swingbed Patient Rights.

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make their own determination regarding medical treatment. The Practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The Practitioner has an ethical and legal obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the Practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow the Hospital *Consent for Treatment* policy.

5.3 WITHDRAWING AND WITHHOLDING LIFE SUSTAINING TREATMENT

~~Long Term Care *Comfort Care*~~The SPH policy delineates the responsibilities, procedures, and documentation that must occur when withdrawing or withholding life-sustaining treatment in the Long Term Care Facility.

5.4 DO-NOT-RESUSCITATE ORDERS

The ~~Long Term Care and Hospital~~SPH DNR policies delineate the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order in the Long Term Care Facility and within the Hospital campus.

5.5 DISCLOSURE OF SENTINEL OF NEVER EVENTS

The Hospital policy HW-160 Sentinel Events delineates the responsibilities, procedure, and documentation that must occur when sentinel event does occur.

5.6 RESTRAINTS AND SECLUSION

The Long Term Care and Hospital policies LTC-123 Use of Restraints and PCS-006 Restraints delineate the responsibilities, procedures, and documentation that must occur when ordering restraints or seclusion.

5.7 ADVANCE DIRECTIVES

The Long Term Care and Hospital policies LTC-135 Advance Directives in Long Term Care and HW-175 Advance Directors delineate the responsibilities, procedures, and documentation that must occur regarding Advance Directives.

5.8 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board (IRB). When patients are asked to participate in investigational studies, Hospital IRB policies should be followed.

ARTICLE VI. SURGICAL CARE

6.1 SURGICAL PRIVILEGES

A Practitioner may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical Privileges will be delineated for all Practitioners performing surgery in accordance with the competencies of each Practitioner. The Medical Staff Office will maintain a roster of Practitioners specifying the surgical Privileges held by each Practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All Practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to Anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

A complete Anesthesia record (including evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition must be completed for each patient receiving general/regional/MAC Anesthesia. Only anesthesiologists, certified registered nurse anesthetists, or physicians Privileged to perform Deep Sedation (which is part of MAC) shall be able to perform these procedures.

Moderate sedation may only be provided by qualified Practitioners who have been granted Clinical Privileges to perform these services. The Practitioner responsible for the ordering the administration of Moderate Sedation will document a pre-sedation evaluation and post-sedation follow-up examination per Hospital policy.

6.4 TISSUE SPECIMENS

Specimens removed during the operation will be sent to Pathology, who will make

necessary examinations to obtain a tissue diagnosis. Certain specimens, as defined in pathology policy, are exempt from pathology examination. The pathologist's report will be made a part of the patient's medical record.

6.5 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the Hospital. The Hospital *Time-Out* policy shall be followed.

ARTICLE VII. RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Practitioners are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The *Medical Staff Code of Conduct*~~"~~ shall be followed.

7.2 IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the Medical Staff policy MSO-010 Medical Staff Health on Practitioner health and impairment or will be referred to an ad hoc committee as determined by the Chief of Staff.

7.3 TREATMENT OF FAMILY MEMBERS

7.3.1 The following is based on the AMA *Code of Medical Ethics*' Opinion on Physicians Treating Family Members. In general, Practitioners should not treat themselves or their family members. Family members are deemed to include spouses, domestic partners, parents, parents-in-law, children, stepchildren, siblings, siblings-in-law, grandparents, aunts, uncles, nieces and nephews.

7.3.2 In emergency settings or isolated settings where there is no other qualified practitioner ~~physician~~ available, practitioner, ~~physicians~~ should not hesitate to treat themselves or family members until another practitioner~~physician~~ becomes available. In addition, while practitioners ~~physicians~~ are discouraged to serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for practitioners~~physicians~~ to write prescriptions for controlled substances for themselves or immediate family members.

7.4 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

7.4.1 Practitioners may access their own medical record through the patient portal or by following the policy and process of requesting medical records through Health Information Management.

7.4.2 Practitioners may view the medical records of family members who are not their patients through the patient portal when authorized to do so (parent or guardian of minor child or through authorized access by the adult family member).

7.4.3 Practitioners are not permitted to access the medical records of family, friends, or others unless they are assigned as an attending or consulting Practitioner or for another purpose permitted under HIPAA and state privacy and security laws.

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7.4.4 Violations of this will be addressed through the protocol for unauthorized use of medical records\per Hospital policy.

7.5 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

7.5.1 All Practitioners must comply with the Hospital's policy on TB testing, influenza vaccination, and any testing/vaccinations. ~~as noted in policy.~~

7.6 COMMUNICATION

7.6.1 All Practitioners must maintain a current accessible e-mail address on file in the Medical Staff Office.

7.6.2 All Practitioners must use the accepted method of communication determined by the MEC.

7.7 CONFIDENTIALITY

7.7.1 All Practitioners are required to maintain the confidentiality of peer-protected and other confidential or sensitive information. This includes but is not limited to not disclosing confidential information to others and only using secure and approved devices to access and store confidential information.

7.7.2 Use of Artificial Intelligence (AI) applications or bots, audio recorders, or other recording devices to record meetings or create transcripts is not permitted unless utilized by support staff for the intent of taking minutes. All recordings will be destroyed once pertinent information is extracted. .

~~ARTICLE VIII. MEDICAL STAFF COMMITTEES~~

~~8.1 CREDENTIALS COMMITTEE~~

~~8.2 UTILIZATION MANAGEMENT COMMITTEE (HOSPITAL COMMITTEE)~~

~~8.2.1 Purpose~~

~~a. Study recommendations from Medical Staff members, quality assessment coordinators and others to identify problems in utilization and the review program;~~

~~b. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;~~

~~c. Forward all unjustified cases in any review category to the appropriate committee for review and action;~~

~~d. Review case-mix financial data and any other internal/external statistical data;~~

~~e. Upon review of any data, conduct further studies, perform education or refer the data to the Medical Staff Quality Committee for their review and action;~~

~~f. Develop, with the aid of legal counsel, policies to guide the director of utilization management, Medical Staff, and administration in matters of privileged communication and legal release of information;~~

~~g. Develop a utilization management plan for approval by the Board;~~

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~~8.2.2 Chair~~

~~a. The Chair shall be appointed by the Chief of Staff.~~

~~8.2.3 Membership~~

~~a. There shall be at least two (2) physicians who are members of the Medical Staff.~~

~~8.2.4 Member Responsibilities~~

~~a. Attend at least fifty percent (50%) of regularly scheduled meetings.~~

~~b. Maintain confidentiality.~~

~~8.2.5 Meeting Frequency~~

~~a. The Committee shall meet at least six (6) times a year and more often as needed to conduct business.~~

~~8.2.6 Quorum and Voting~~

~~8.2.7 Oversight~~

~~a. The Utilization Management Committee reports to the Medical Executive Committee.~~

~~b. Meeting minutes shall be taken for each meeting and forwarded to the Medical Executive Committee.~~

~~8.3 PRACTITIONER WELLNESS COMMITTEE~~

~~8.3.1 Purpose~~

~~a. Develop a confidential reporting process for suspicion of medical staff impairment~~

~~b. Develop a policy and procedures to address medical staff wellness~~

~~c. Educate the medical staff about wellness, and recognizing and reporting impairment~~

~~d. Develop a self-referral process consistent with state law and state programs~~

~~8.3.2 Chair~~

~~8.3.3 Membership~~

~~8.3.4 Meeting Frequency~~

~~8.3.5 Quorum and Voting~~

~~8.3.6 Oversight~~

~~a. The Practitioner Wellness Committee reports to the Medical Executive Committee.~~

~~b. Meeting minutes shall be taken for each meeting and forwarded to the Medical Executive Committee.~~

~~8.4 MEDICAL STAFF QUALITY COMMITTEE~~

~~8.4.1 Purpose~~

~~8.4.2 Chair~~

~~8.4.3 Membership~~

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~~8.4.4 Meeting Frequency~~

~~8.4.5 Quorum and Voting~~

~~8.4.6 Oversight~~

~~8.4.7~~

South Peninsula Hospital
Hospital Board of Directors Balanced Scorecard Report
1st Quarter FY 2026 *(July, August, September)*

Overall Indicators	Q1 FY26	Target	Note
Care Compare Overall Hospital Star Rating	**N/A**	**5**	Mortality, Safety of Care, Readmission, Patient Experience, Timely & Effective Care
Care Compare Overall Nursing Home Star Rating	**5**	**5**	Staffing, Health Inspections, Quality Measures
Care Compare Home Health Quality Rating	**3**	**5**	Activities of Daily Living, Symptoms, Harm, Hospitalization, Value of Care *Care Compare reflects 2.5 stars due to October update on hold

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	Q1 FY26	Target	Note
Severe Sepsis & Septic Shock Care	**78%**	**> 75%**	***CMS Hospital Compare: 79%***
Percentage *of patients who received appropriate care for sepsis and/or septic shock.*			Passed 7 of 9 cases (lactate and fluid resuscitation volume documentation)
Stroke Care	**50%**	**> 75%**	***CMS Hospital Compare: 67%***
Percentage of patients who receive CT/MRI within 45 minutes of arrival to ED w/stroke symptoms.			2 cases per CMS, CT down/MRI read at 49 min (5-49 minutes on stroke alerts)
Median Emergency Room Time	**142**	**< 180min**	***CMS Hospital Compare: 126 min***
Average minutes spent in department before leaving the Emergency Department.			Average throughput time of ED visits (CMS allows for certain exclusions).
ER Admission Rate	**9.20%**	**>10%**	***CAH Target***
Measures the percentage of ER patients admitted.			
Colonoscopy Follow-up	**100%**	**> 75%**	***CMS Hospital Compare: 100%***
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy.			
Patient Fall Rate (AC)	**4.3**	**< 5**	**# of patient falls / # patient days x 1000**
Measures the number of patient falls per 1,000 patient days.			*4 falls*
Medication Errors	**0**	**0**	
Number of patient medication errors that cause harm. *(Level E on the NCC MERP Index)*			*(Tracking through occurrence reporting system.)*
Never Events	**1**	**0**	
Unexpected occurrence involving serious injury or death.			*Fall with major injury LTC (hip fracture with staff present, day room)*

Independent Ambulation (HH)	**79%**	**> 75%**	
Percentage of home health patients demonstrating improvement with ability to ambulate more independently.			*(Tracked through OASIS Reporting.) No patients worsened.*
Independent Oral Medication (HH)	**71%**	**> 75%**	
Percentage of home health patients demonstrating improvement with ability to take oral medications more independently.			*(Tracked through OASIS Reporting.) No patients worsened.*
Pressure Ulcers (LTC)	**0**	**< 3**	
Number of residents who develop pressure ulcers after admission.			*(Tracked through Minimum Data Set Reporting.)*
Primary Care MIPS Pathways	**75%**	**> 75%**	**Scoring tabulated as a running, annual score.**
CMS Merit-Based Incentive Payment System *(MIPS)* for outpatient clinics.			Special focuses: cervical cancer screening, specialist referrals, high blood pressure, hemoglobin A1c, medication reconcilation, fall risk

Patient & Resident Experience

Patient Satisfaction Through Press Ganey (PG)	**Q1 FY26**	**Target**	
Inpatient Percentile	**94th/95th**	**75th**	9 or 10 best hospital/definitely recommend; Survey Responses: 28
Measures the overall satisfaction of inpatient pts. respondents.			Q4 FY25 63rd: Q3 FY25 90th: Q2 FY25 69th: Q1 FY25 89th
Outpatient Percentile	**7th**	**75th**	Mean Score: 92.51 Survey Responses: 507
Measures the overall satisfaction of outpatient pts. respondents.			Q4 FY25 34th: Q3 FY25 31st: Q2 FY25 39th: Q1 FY25 23rd
Emergency Department Percentile	**79th**	**75th**	Mean Score: 91.67 Survey Responses: 133
Measures the overall satisfaction of emergency pts. respondents.			Q4 FY25 92nd: Q3 FY25 71st: Q2 FY25 80th: Q1 FY25 91st
Medical Practice Percentile	**51st**	**75th**	Mean Score: 94.18 Survey Responses: 296
Measures the overall satisfaction of pts. respondents at SPH Clinics.			Q4 FY25 59th: Q3 FY25 55th: Q2 FY25 71st: Q1 FY25 67th
Ambulatory Surgery (AS) Percentile	**94th/58th**	**75th**	9 or 10 best hospital/definitely recommend; Survey Responses: 25
Measures the overall satisfaction of AS pts. respondents.			Q4 FY25 25th: Q3 FY25 87th: Q2 FY25 29th: Q1 FY25 61st
Home Health (HH) Percentile	**64th/84th**	**75th**	9 or 10 best hospital/definitely recommend; Survey Responses: 44
Measures the overall satisfaction of HH pts. respondents.			Q4 FY25 43rd: Q3 FY25 60th: Q2 FY25 25th: Q1 FY25 32nd

Information System Solutions	Q1 FY26	Target	Note
Eligible Hospital (EH) Promoting Interoperability	**79**	**≥ 60**	**CMS score 60 and above = pass**
Hospital-based measures for inpatient and observation stays.			Focuses include: electronic prescribing accuracy and safety, health information exchange topics, patient access to electronic records
Eligible Provider (EP) - Promoting Interoperability (Group)	**100%**	**> 95%**	**Target quarterly for annual score**
Merit Based Incentive Payment System Promoting Interoperability score. *(MIPS tracking is in Athena)*			Special focuses: patient electronic access to health information, electronic referrals, electronic prescriptions
IT Security Awareness Training Complete Rate	**90%**	**> 95%**	
% of employees who have completed assigned security training			1874 Training videos sent; 1691 were completed.
Phishing Test Pass Rate	**98%**	**> 95%**	
% of Phishing test emails that were not failed.			2043 Test phishing emails sent; 41 links were clicked.

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	2024	Target	Note
Provider Satisfaction Percentile	**85th**	**75th**	
Measures the satisfaction of physician respondents as indicated by Press Ganey physician survey results. Measured as a percentile.			Result of provider survey 2024

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	2024	Target	Note
Employee Satisfaction Percentile	**60th**	**75th**	
Measures the satisfaction of staff respondents as indicated in Press Ganey staff survey results Measured as a percentile.			Result of employee survey 2024

Workforce	Q1 FY26	Target	Note
Turnover: All Employees	**5.15%**	**< 5%**	
Percentage of all employees separated from the hospital for any reason			37 Terminations / 651 Total Employees
Turnover: Voluntary All Employees	**4.60%**	**< 4.75%**	
Measures the percentage of voluntary staff separations from the hospital			30 Voluntary Terminations / 651 Total Employees
First Year Total Turnover	**6.95%**	**< 7%**	
Measures the percentage of staff hired in the last 12 months and who separated from the hospital for any reason during the quarter.			8 New Staff Terminated 115 Total New Hires from 09/01/2024-09/30/2025
Contract Utilization	**30**	**< 20**	
Measure average number of contract staff utilized.			CNA, CST, MLT, MRI, OT, PT, RN

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	Q1 FY26	Target	Note
Operating Margin	**4%**	**10%**	
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	**1018**	**960**	**Total Discharges: # 157 *(Acute, OB, Swing, ICU)***
Measures the number of patient discharges adjusted by inpatient revenues for the quarter.			Adjusted Patient Days = [Inpatient Days(Excludes Nursery)] X [Gross Patient Revenue/Gross Inpatient Revenue] Target Discharges 150
Net Revenue Growth	**13%**	**15%**	
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 yr.
FTE vs Budget	**579.0**	**621.0**	
FTE is calculated based on hours paid + Contract FTE			Target is based on budget
Overtime as a Percentage of Hours Worked	**3%**	**<5%**	
Measures overtime hours as a percentage of regular hours worked indicative of understaffing or schedulig inefficiencies			Target is based on industry standard

Net Days in Accounts Receivable	**68**	**55**	
Measures the rate of speed with which the hospital is paid for health care services.			Target is based on industry standard
Cash on Hand	**70**	**90**	**93 Total Days Cash on Hand, Operating +Unobligated PREF**
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%**	**2-3%**	
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 2.4% Expected range of 2-3%
Average Age of Plant	**11.4**	**10**	
Average age of assets used to provide services			Target is based on hospital optimal age of plant for a critical access hospital
Intense Market Focus to Expand Market Share	**Q1 FY26**	**Target**	**Note**
Outpatient Revenue Growth	**8%**	**6%**	
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 yr.
Surgical Case Growth	**-23%**	**-2%**	
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 yr.

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

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2025-25

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS APPROVING MEDICAL STAFF CREDENTIALING FOR DECEMBER 2025

WHEREAS, the following recommendations were approved by the South Peninsula Hospital Medical Staff through the Credentials Committee and the Medical Executive Committee; and

WHEREAS, the medical staff files were reviewed by the Board in Executive Session;

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

1. That the South Peninsula Hospital Board of Directors approve the initial appointment of:

Edem Binka, MD	Peds Cardiology	Part-Time Active
Mark Simon, MD	Emergency Medicine	Part-Time Active
Emma Simpson, MD	Internal Med/ICU/Pulmonology	TeleICU

2. That the South Peninsula Hospital Board of Directors approve the reappointment of:

Robert Austin, CRNA	Anesthesia	Part-Time Active
Abdelraham Beltagy, MD	Neurology	TeleStroke
Lucy Fisher, MD	Psychiatry	Active
Edson Knapp, MD	Dx Radiology	Active
Julie McCarron, CNM	Midwifery	Active
Brian McCorrison, CRNA	Anesthesia	Active
Jasleen Tiwana, MD	Cardiology	Part-Time Active

3. That the South Peninsula Hospital Board of Directors approve the 1 year reappointment of:

Ernst Hansch, MD	Dx Radiology	TeleRad

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA AT ITS MEETING HELD ON THIS 17th DAY OF DECEMBER 2025.

ATTEST:

Aaron Weisser, Board President

Mary E. Wythe, Board Secretary