



# AGENDA

## Board of Directors Meeting

5:30 PM - Wednesday, December 18, 2024

[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		Christopher Landess, MD	
Preston Simmons Vice President		Matthew Hambrick		Bernadette Wilson	
Beth Wythe, Secretary		Michael Dye			
Walter Partridge, Treasurer		Edson Knapp, MD			

[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 - 11      7.1.      Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for October 23, 2024  
[Board of Directors - Oct 23 2024 - Minutes - DRAFT](#)
- 12 - 15      7.2.      Consideration to Approve October FY2025 Financials  
[Balance Sheet Oct FY25](#)  
[Income Statement Oct FY25](#)  
[Cash Flow Statement Oct FY25](#)
- 16 - 34      7.3.      Consideration to Approve the Revised South Peninsula Hospital and Long Term Care Facility Corporate Compliance & Ethics Program and Corporate Compliance and Ethics Policy, HW-101  
[Memo](#)  
[Corporate Compliance Program, revised](#)  
[HW-101, revised](#)
- 35 - 38      7.4.      Consideration to Approve the South Peninsula Board of Directors Calendar for 2025  
[Board Agenda Calendar 2025](#)
- 39 - 50      7.5.      Consideration to Approve the South Peninsula Hospital and Long Term Care Infection Prevention Plan and Risk Assessment  
[HW-269, revised](#)  
[LTC IP Risk Assessment 2024](#)

## **8. PRESENTATIONS**

## **9. UNFINISHED BUSINESS**

## **10. NEW BUSINESS**

- 51 - 57      10.1.      Consideration to Approve SPH Board Resolution 2024-26, A Resolution of the South Peninsula Hospital Board of Directors Supporting the Hospital's Request to List the Pharmacy Relocation, Infusion Relocation and Expansion, and Nuclear Medicine Addition as Legislative Priorities for the Kenai Peninsula Borough to Request Congressionally Designated Spending Funds  
[SPH Resolution 24-26](#)  
[SAB Resolution 24-10](#)
- 58            10.2.      Consideration to Confirm Sarah Roberts, MD as Chief of Staff for 2025 and 2026 as elected by the South Peninsula Hospital Medical Staff.  
[Memo - Chief of Staff](#)

- 59 - 69 10.3. First Reading (No Action Required)  
Consideration to Approve a Bylaws Amendment to Update Article III, Section 5 to Change the Affirmative Votes Required to Censure or Remove a Board Member from 75% to 2/3, and to Update Article VIII to Remove References to the Retired Medical Staff Development Plan.  
[Bylaws, proposed changes](#)

## **11. REPORTS**

- 70 - 75 11.1. Chief Executive Officer  
[Balanced Scorecard Q1 FY2025](#)
- 11.2. BOD Committee: Pension
- 11.3. BOD Committee: Finance
- 11.4. BOD Committee: Governance/Education
- 11.5. Chief of Staff
- 11.6. Service Area Board Representative

## **12. DISCUSSION**

## **13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER**

## **14. COMMENTS FROM THE BOARD**

(Announcements/Congratulations)

- 14.1. Chief Executive Officer
- 14.2. Board Members

## **15. INFORMATIONAL ITEMS**

- 76 15.1. Service Area Board Schedule - Volunteers Needed  
[BOD members to SAB meetings 2025](#)

## **16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)**

## **17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION**

- 77 - 78 17.1. Consideration to Approve SPH Resolution 2024-28, A Resolution of the South Peninsula Hospital Board of Directors Approving Medical Staff

Credentialing for December 2024  
[SPH Resolution 24-28](#)

17.2. Board Member Election for 2025

## **18. ADJOURNMENT**

To: Public Participants  
From: Operating Board of Directors – South Peninsula Hospital  
Re: Rules for Participating in a Public Meeting

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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

5:30 PM - Wednesday, October 23, 2024

Conference Rooms 1&2 and Zoom

The meeting of the Board of Directors of South Peninsula Hospital was called to order on Wednesday, October 23, 2024, at 5:30 PM, in the Conference Rooms 1&2 and via Zoom.

### 1. CALL TO ORDER

President Aaron Weisser called the regular meeting to order at 5:30pm.

### 2. ROLL CALL

**BOARD PRESENT:** Aaron Weisser, Matthew Hambrick, Edson Knapp, Bernadette Wilson, Mary "Beth" Wythe, Preston Simmons, and Matthew Bullard

**BOARD EXCUSED:** Walter Partridge

**ALSO PRESENT:** Ryan Smith (CEO), Angela Hinnegan (COO), Anna Hermanson (CFO), Rachael Kincaid (CNO), Dr. Christina Tuomi (CMO), Dr. Sarah Roberts (Chief of Staff), Maura Jones (Executive Assistant), Roberta Highland (Service Area Board)

*\*Due to the Zoom meeting format, only meeting participants who comment, give report or give presentations are noted in the minutes. Others may be present on the virtual meeting.*

A quorum was present.

### 3. REFLECT ON LIVING OUR VALUES

Angela Hinnegan, COO, shared a values story. The Serene Waters building on Hohe Street flooded after the heavy rains and many departments have put in a lot of work. Members of the EVS and Facilities team started responding on Sunday, and the behavioral health team was displaced and had to work to take care of patients through telehealth and in other spaces. The billing team was also displaced.

### 4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

Mr. Weisser welcomed guests to the meeting. Rules for participating in a public meeting were provided in the packet and in the board room.

#### 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

*Beth Wythe made a motion to approve the agenda as presented. Edson Knapp seconded the motion. Motion Carried.*

**7. APPROVAL OF THE CONSENT CALENDAR**

Ms. 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 25, 2024**
- 7.2. Consideration to Approve September 2024 Financials**
- 7.3. Consideration to approve revised Board Medical Staff Policies MS-01, Medical Staff Credentialing Privileges and MS-02, Professional Liability Insurance as recommended by Hospital Administration and the Medical Staff Office**
- 7.4. Consideration to approve revised Board Quality policies Q-01 Consent for Treatment and Q-02 Quality Monitoring as recommended by Hospital Administration and the Quality Department**
- 7.5. Consideration to approve revised Rules for Participating in a Public Meeting as recommended by the Governance Committee**

*Beth Wythe made a motion to approve the consent calendar as read. Edson Knapp seconded the motion. Motion Carried.*

**8. PRESENTATIONS**

**8.1. AI in Hospitals**

Dr. Edson Knapp gave a presentation on the use of AI in hospitals, summarizing information from a presentation he attended at the AHHA Annual Conference in Girdwood in September.

**9. UNFINISHED BUSINESS**

**10. NEW BUSINESS**

**10.1. Bond Follow-up Discussion**

Mr. Weisser read a letter on behalf of the board. The entirety of the letter is recorded in these minutes:

*To our employees, providers, and service area stakeholders,*

*We want to express our appreciation for your support and involvement with South Peninsula Hospital through the Prop 1 efforts. Although the outcome was not what we hoped for, we are so proud of the work of SPH and remain committed to pursuing the best possible health and wellness outcomes on behalf of all those we serve.*

*The following is a brief response to some of the key points that made it into the public discourse over the last month.*

*Regarding facility expansion and improvements:*

*The inability to consolidate services at our main Bartlett Street campus continues to pose the greatest financial and strategic challenge for South Peninsula Hospital. SPH currently spends over \$500,000 annually on additional leased medical office space properties and has invested nearly \$40 million toward capital updates and improvements of hospital properties over the last 10 years. We will continue to seek bold solutions to this strategic challenge.*

*Regarding South Peninsula Hospital's staff housing and childcare efforts:*

*In response to the 2023 Community Health Needs Assessment conducted by the Mobilizing for Action through Planning and Partnerships (MAPPS) coalition, insufficient housing and daycare options were identified as top-tier community needs for the southern peninsula. SPH is proactively responding to these needs through strategic housing and daycare initiatives for SPH employees. We will continue to pursue Community Health outcomes.*

*Regarding the appointment of board members:*

*South Peninsula Hospital is a private, locally-owned and operated corporation recognized by the IRS as a 501(c)(3) non-profit, under contract to operate a hospital in a facility owned by the Kenai Peninsula Borough, and managed by the Borough's elected leaders. Consistent with all applicable laws and code, South Peninsula Hospital is governed by a self-perpetuating board of directors. We will continue to appoint board leaders suited to the governance role.*

*Regarding employed physician board members:*

*The Center for Medicare and Medicaid Services, The American Hospital Association, the American Medical Association, The Joint Commission on the Accreditation of Hospitals, the National Institute of Health and the Journal of Hospital and Medical Management all agree that physician board members are essential in the effort to deliver quality care to patients. Potential conflicts of interest are addressed through policy. We unequivocally stand by the integrity of our physician board members*

*Regarding our CEO*

*Our award winning and nationally recognized CEO, Ryan Smith, continues to deliver unprecedented results on behalf of South Peninsula Hospital and our service area. Improvements in quality of care, employee satisfaction, personnel recruitment, and financial health metrics speak for themselves. We unequivocally stand by the work of our CEO.*

*We thank you for the opportunity to serve and we look forward to what is ahead,*

*The Operating Board of South Peninsula Hospital*

**10.2. Consideration to Approve an Amendment to the Medical Staff Rules and Regulations Changing the Requirements to Response Times for On-Call Practitioners to Prevent Contradictions and to Allow for Flexibility Based on Patient Condition**

Dr. Sarah Roberts, Chief of Staff, reported. This amendment was approved by the MEC at their previous meeting. It is a long overdue update to the Medical Staff Rules and Regulations. In order to align our medical staff and avoid contradictions with contracts and with trauma certifications, the medical staff decided to consolidate and standardize appropriate response times.

*Beth Wythe made a motion to approve an amendment to the Medical Staff Rules and Regulations changing the requirements to response times for on-call practitioners to prevent contradictions and to allow for flexibility based on patient condition Preston Simmons seconded the motion. Motion Carried.*

**11. REPORTS**

**11.1. Chief Executive Officer**

Ryan Smith, CEO, gave a detailed report on the updated balanced scorecard for the first quarter of fiscal year 2025.

**11.2. BOD Committee: Finance**

Anna Hermanson, CFO, reported. The Finance Committee met and discussed the September financial reports, as well as the financial indicators on the balanced scorecard. She thanked Mr. Dye for chairing the meeting in Mr. Partridge's absence.

**11.3. BOD Committee: Governance/Education**

Ms. Wythe, Governance Committee Chair, reported. The Governance Committee met this month and completed interviews for board applicants. She encouraged any board members who were unable to attend the interviews to watch the Zoom recordings. The committee wrapped up any loose ends with policy work for the year. Those items were included on the consent agenda. The committee completed a review of the bylaws and is recommending some minor edits, which will come to the board in December for a first reading. The committee has also absorbed the Education Committee, since the membership has a lot of overlap and the work aligns.

**11.4. Chief of Staff**

Dr. Roberts thanked the board for the Board and Medical Staff dinner. It was well received by the medical staff. She expressed appreciation for the board's continued support in hosting residents and students at the facility. It reinvigates those acting as teachers and is a great recruiting tool. She

attended the Greeley conference last week and it was a very valuable experience.

#### **11.5. Service Area Board Representative - Roberta Highland**

Roberta Highland reported on behalf of the Service Area Board (SAB). The October meeting was Willy Dunne's last meeting, as he's moving on to serve on the Kenai Peninsula Borough Assembly. The SAB discussed the results of the bond vote and heard reports from those who attended the AHHA conference in Girdwood. Devony is looking at all ages quality trail along the Anchor River and the SAB agreed to send the assembly a letter of support.

#### **12. DISCUSSION**

There were no additional discussion items.

#### **13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER**

There were no comments from the audience.

#### **14. COMMENTS FROM THE BOARD**

(Announcements/Congratulations)

##### **14.1. Chief Executive Officer**

Mr. Smith noted the hospital is actively recruiting a pediatrician, and have been for over a year. He appreciated hearing a story at the Service Area Board meeting about a member's family member with cancer who had a good experience with Dr. Wisecarver, the plastic surgeon.

##### **14.2. Board Members**

Mr. Simmons thanked the hospital team for the deeper dive into the scorecard this meeting. Mr. Hambrick shared some changes in the Foundation membership - Angie Newby has resigned and Dr. Rob Downey has taken over as the chair.

#### **15. INFORMATIONAL ITEMS**

##### **15.1. [AHA Rural Health Care Leadership Conference 2025](#)**

*Please refer to email from Maura and complete the registration form if you'd like to attend.*

##### **15.2. 2024 Board Agenda Calendar**

##### **15.3. Annual Board Forms**

*Please refer to email from Maura and return all forms to Administration by December meeting.*

#### **16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)**

The meeting adjourned to Executive Session.

#### **17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION**

**17.1. Credentialing**

Beth Wythe made a motion Consideration to Approve SPH Resolution 2024-25, A Resolution of the South Peninsula Hospital Board of Directors Approving Medical Staff Credentialing for October 2024 to include:

- 1. That the South Peninsula Hospital Board of Directors approves:
  - a) Status Modification Request: Pamela Williams, DO – from Courtesy to Active Staff
- 2. That the South Peninsula Hospital Board of Directors approves the reappointment of:

Erin Murphy, MD	Emergency Medicine	Active
Cherie Inglis, MD	Family Medicine	Active
Emma Mayfield, DO	Family Medicine	Active
Christina Tuomi, DO	Family Medicine	Active
Kira Bendixen, DO	Family Medicine	Active
Ross Dodge, MD	Internal & Sleep Med	Courtesy
Sarah Roberts, MD	Family Medicine	Active
Jeffery Dixon, MD	Cardiology- AHVI	Courtesy
Adam Mason, MD	Cardiology- AHVI	Courtesy
Douglas Herrin, MD	Radiology- RCI	Courtesy
Amy Velsko, ANP	Family Med- Chugachmiut	Courtesy
Kyle Ogami, MD	TeleStroke-Prov	Telemedicine
Margarita Oveian, MD	TeleStroke-Prov	Telemedicine
Babak Akbarian, MD	TelePsych- Prov	Telemedicine
Catalina Draghici, MD	TelePsych- Prov	Telemedicine
Adam Karz, MD	TelePsych- Prov	Telemedicine
Joseph Perry, MD	TelePsych- Prov	Telemedicine
Consuelo Reddick, MD	TelePsych- Prov	Telemedicine
Edson Knapp	seconded the motion. Motion Carried.	

**18. ADJOURNMENT**

The meeting adjourned at 8:07pm.

Respectfully Submitted,

Accepted:

\_\_\_\_\_  
Maura Jones, Executive Assistant

\_\_\_\_\_  
Aaron Weisser, President

Minutes Approved:

\_\_\_\_\_  
Mary E. Wythe, Secretary



DRAFT-UNAUDITED

BALANCE SHEET  
As of October 31, 2024

	As of October 31, 2024	As of October 31, 2023	As of September 30, 2024	CHANGE FROM October, 2023
<b>ASSETS</b>				
CURRENT ASSETS:				
1 CASH AND CASH EQUIVALENTS	28,020,353	27,557,618	25,344,990	462,735
2 EQUITY IN CENTRAL TREASURY	8,685,913	11,225,309	9,324,381	(2,539,396)
3 TOTAL CASH	<u>36,706,266</u>	<u>38,782,927</u>	<u>34,669,371</u>	<u>(2,076,661)</u>
4 PATIENT ACCOUNTS RECEIVABLE	41,987,775	34,137,201	44,059,236	7,850,574
5 LESS: ALLOWANCES & ADJ	(20,257,408)	(17,250,834)	(21,031,330)	(3,006,574)
6 NET PATIENT ACCT RECEIVABLE	<u>21,730,367</u>	<u>16,886,367</u>	<u>23,027,906</u>	<u>4,844,000</u>
7 PROPERTY TAXES REC'V - KPB	998,600	1,152,163	1,767,870	(153,563)
8 LESS: ALLOW PROP TAX - KPB	(4,165)	(4,165)	(4,165)	0
9 NET PROPERTY TAX REC'V - KPB	<u>994,435</u>	<u>1,147,998</u>	<u>1,763,705</u>	<u>(153,563)</u>
10 OTHER RECEIVABLES - SPH	201,717	344,554	150,802	(142,837)
11 INVENTORIES	2,769,136	2,078,763	2,613,878	690,373
12 NET PENSION ASSET- GASB	3,225,068	3,559,619	3,225,068	(334,551)
13 PREPAID EXPENSES	<u>1,188,347</u>	<u>1,006,290</u>	<u>1,191,201</u>	<u>182,057</u>
14 TOTAL CURRENT ASSETS	<u>66,815,336</u>	<u>63,806,518</u>	<u>66,641,931</u>	<u>3,008,818</u>
ASSETS WHOSE USE IS LIMITED				
15 PREF UNOBLIGATED	7,001,156	6,745,415	6,926,833	255,741
16 PREF OBLIGATED	1,163,509	2,172,324	1,255,227	(1,008,815)
17 OTHER RESTRICTED FUNDS	<u>1,078,912</u>	<u>19,298</u>	<u>1,211,456</u>	<u>1,059,614</u>
	9,243,577	8,937,037	9,393,516	306,540
PROPERTY AND EQUIPMENT:				
18 LAND AND LAND IMPROVEMENTS	4,124,558	4,124,558	4,124,559	0
19 BUILDINGS	67,085,718	64,069,452	67,085,718	3,016,266
20 EQUIPMENT	30,187,936	28,773,915	30,187,936	1,414,021
21 BUILDINGS INTANGIBLE ASSETS	4,028,135	2,871,299	4,028,135	1,156,836
22 EQUIPMENT INTANGIBLE ASSETS	1,207,638	851,479	1,207,638	356,159
23 SOFTWARE INTANGIBLE ASSETS	2,135,559	1,986,711	2,135,560	148,848
24 IMPROVEMENTS OTHER THAN BUILDINGS	926,889	312,979	926,889	613,910
25 CONSTRUCTION IN PROGRESS	4,607,913	1,932,158	4,133,463	2,675,755
26 LESS: ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(63,260,510)	(58,727,950)	(62,882,670)	(4,532,560)
27 LESS: ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(3,500,552)	(2,176,213)	(3,402,909)	(1,324,339)
28 NET CAPITAL ASSETS	<u>47,543,284</u>	<u>44,018,388</u>	<u>47,544,319</u>	<u>3,524,896</u>
29 GOODWILL	<u>0</u>	<u>1,000</u>	<u>0</u>	<u>(1,000)</u>
30 TOTAL ASSETS	<u>123,602,197</u>	<u>116,762,943</u>	<u>123,579,766</u>	<u>6,839,254</u>
DEFERRED OUTFLOWS OF RESOURCES				
31 PENSION RELATED (GASB 68)	4,692,297	5,789,464	4,845,265	(1,097,167)
32 UNAMORTIZED DEFERRED CHARGE ON REFUNDING	<u>203,487</u>	<u>271,298</u>	<u>208,574</u>	<u>(67,811)</u>
33 TOTAL DEFERRED OUTFLOWS OF RESOURCES	4,895,784	6,060,762	5,053,839	(1,164,978)
34 TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	<u>128,497,981</u>	<u>122,823,705</u>	<u>128,633,605</u>	<u>5,674,276</u>

	As of October 31, 2024	As of October 31, 2023	As of September 30, 2024	CHANGE FROM October, 2023
<b>LIABILITIES &amp; FUND BALANCE</b>				
CURRENT LIABILITIES:				
35	2,864,796	1,648,072	3,808,274	1,216,724
36	10,819,164	9,530,352	11,147,119	1,288,812
37	1,067,485	17,243	1,236,092	1,050,242
38	186,702	654,790	186,702	(468,088)
39	252,782	450,065	269,135	(197,283)
40	43,503	0	43,503	43,503
41	1,195,000	1,850,000	1,195,000	(655,000)
42	26,389	11,606	55,247	14,783
43	876,864	1,440,709	876,864	(563,845)
44	<u>17,332,685</u>	<u>15,602,837</u>	<u>18,817,936</u>	<u>1,729,848</u>
LONG-TERM LIABILITIES				
45	0	0	0	0
46	5,420,000	6,615,000	5,420,000	(1,195,000)
47	241,581	359,988	249,148	(118,407)
48	3,640,550	2,285,338	3,784,016	1,355,212
49	167,195	322,237	185,016	(155,042)
50	<u>9,469,326</u>	<u>9,582,563</u>	<u>9,638,180</u>	<u>(113,237)</u>
51	26,802,011	25,185,400	28,456,116	1,616,611
52	0	0	0	0
53	0	0	5	0
<b>NET POSITION</b>				
54	5,731,963	5,731,963	5,731,963	0
55	0	0	0	0
56	25,286	25,286	25,286	0
57	95,938,721	91,881,056	94,420,235	4,057,665
58	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
59	<u><u>128,497,981</u></u>	<u><u>122,823,705</u></u>	<u><u>128,633,605</u></u>	<u><u>5,674,276</u></u>

	MONTH			YEAR TO DATE					
	10/31/24		Var B/(W)	10/31/23	10/31/24		10/31/23		
	Actual	Budget		Actual	Actual	Budget		Actual	
<b>Patient Service Revenue</b>									
1	Inpatient	2,813,949	3,279,253	-14.19%	2,610,805	13,139,533	14,215,402	-7.57%	12,259,577
2	Outpatient	19,183,045	18,954,079	1.21%	15,608,628	74,825,055	71,902,119	4.07%	60,277,449
3	Long Term Care	1,231,247	1,234,794	-0.29%	1,018,308	5,007,071	4,939,175	1.37%	4,301,064
4	<b>Total Patient Services</b>	<b>23,228,241</b>	<b>23,468,126</b>	<b>-1.02%</b>	<b>19,237,741</b>	<b>92,971,659</b>	<b>91,056,696</b>	<b>2.10%</b>	<b>76,838,090</b>
<b>Deductions from Revenue</b>									
5	Medicare	5,877,298	5,539,343	-6.10%	4,493,907	23,119,797	18,889,158	-22.40%	17,970,627
6	Medicaid	1,298,220	4,015,346	67.67%	2,157,949	9,525,938	13,692,330	30.43%	8,600,284
7	Charity Care	286,655	264,974	-8.18%	11,242	869,486	903,563	3.77%	695,008
8	Commercial and Admin	3,228,912	2,519,455	-28.16%	2,037,614	9,402,348	8,591,340	-9.44%	6,748,588
9	Bad Debt	949,735	397,974	-138.64%	54,227	1,763,989	1,357,091	-29.98%	1,256,637
10	<b>Total Deductions</b>	<b>11,640,820</b>	<b>12,737,092</b>	<b>8.61%</b>	<b>8,754,939</b>	<b>44,681,558</b>	<b>43,433,482</b>	<b>-2.87%</b>	<b>35,271,144</b>
11	<b>Net Patient Services</b>	<b>11,587,421</b>	<b>10,731,034</b>	<b>7.98%</b>	<b>10,482,802</b>	<b>48,290,101</b>	<b>47,623,214</b>	<b>1.40%</b>	<b>41,566,946</b>
12	USAC and Other Revenue	95,597	137,718	-30.58%	86,661	381,317	550,872	-30.78%	341,387
13	<b>Total Operating Revenues</b>	<b>11,683,018</b>	<b>10,868,752</b>	<b>7.49%</b>	<b>10,569,463</b>	<b>48,671,418</b>	<b>48,174,086</b>	<b>1.03%</b>	<b>41,908,333</b>
<b>Operating Expenses</b>									
14	Salaries and Wages	5,259,310	5,627,805	6.55%	4,951,135	21,453,220	22,391,180	4.19%	19,140,190
15	Employee Benefits	2,279,787	2,485,108	8.26%	2,322,016	8,945,301	8,872,884	-0.82%	6,899,872
16	Supplies, Drugs and Food	1,339,057	1,517,088	11.74%	1,292,377	5,915,454	5,758,192	-2.73%	4,883,653
17	Contract Staffing	211,761	106,578	-98.69%	222,141	805,245	395,861	-103.42%	829,492
18	Professional Fees	722,840	535,024	-35.10%	501,702	2,264,423	2,111,832	-7.23%	2,178,759
19	Utilities and Telephone	177,201	195,073	9.16%	154,158	722,175	786,255	8.15%	651,997
20	Insurance (gen'l, prof liab, property)	82,781	89,393	7.40%	69,136	360,909	373,284	3.32%	285,161
21	Dues, Books, and Subscriptions	27,619	27,908	1.04%	7,769	85,714	114,542	25.17%	60,816
22	Software Maint/Support	148,830	147,938	-0.60%	(16,284)	635,903	754,120	15.68%	494,965
23	Travel, Meetings, Education	98,008	104,630	6.33%	96,726	220,502	340,366	35.22%	242,578
24	Repairs and Maintenance	217,278	227,698	4.58%	244,813	712,478	752,238	5.29%	779,340
25	Leases and Rentals	99,548	111,490	10.71%	61,295	388,976	423,415	8.13%	260,768
26	Other (Recruiting, Advertising, etc.)	177,850	210,986	15.71%	109,478	718,396	843,926	14.87%	840,168
27	Depreciation & Amortization	412,297	392,696	-4.99%	586,543	1,710,059	1,570,786	-8.87%	1,631,978
28	<b>Total Operating Expenses</b>	<b>11,254,167</b>	<b>11,779,415</b>	<b>4.46%</b>	<b>10,603,005</b>	<b>44,938,755</b>	<b>45,488,881</b>	<b>1.21%</b>	<b>39,179,737</b>
29	<b>Gain (Loss) from Operations</b>	<b>428,851</b>	<b>(910,663)</b>	<b>147.09%</b>	<b>(33,542)</b>	<b>3,732,663</b>	<b>2,685,205</b>	<b>-39.01%</b>	<b>2,728,596</b>
<b>Non-Operating Revenues</b>									
30	General Property Taxes	775,649	765,141	1.37%	1,032,720	3,028,156	3,188,631	-5.03%	4,054,449
31	Investment Income	234,406	82,040	185.72%	111,754	485,698	328,160	48.01%	263,400
32	Governmental Subsidies	0	0	0.00%	0	0	0	0.00%	0
33	Other Non Operating Revenue	1,865	1,085	100.00%	487	11,779	4,339	100.00%	1,470
34	Gifts & Contributions	0	0	0.00%	0	0	0	0.00%	0
35	Gain <Loss> on Disposal	0	0	0.00%	0	100	0	0.00%	0
36	SPH Auxiliary	542	583	-7.03%	199	3,498	2,333	49.94%	1,599
37	<b>Total Non-Operating Revenues</b>	<b>1,012,462</b>	<b>848,849</b>	<b>19.27%</b>	<b>1,145,160</b>	<b>3,529,231</b>	<b>3,523,463</b>	<b>0.16%</b>	<b>4,320,918</b>
<b>Non-Operating Expenses</b>									
38	Insurance	0	0	0.00%	0	0	0	0.00%	0
39	Service Area Board	2,824	1,242	-127.38%	1,484	6,652	8,176	0.00%	3,083
40	Other Direct Expense	10,965	3,339	-228.39%	3,267	60,965	13,357	-356.43%	4,255
41	Administrative Non-Recurring	0	0	0.00%	0	0	0	0.00%	0
42	Interest Expense	45,588	39,621	-15.06%	24,304	185,593	158,483	-17.11%	134,961
43	<b>Total Non-Operating Expenses</b>	<b>59,377</b>	<b>44,202</b>	<b>-34.33%</b>	<b>29,055</b>	<b>253,210</b>	<b>180,016</b>	<b>-40.66%</b>	<b>142,299</b>
<b>Grants</b>									
44	Grant Revenue	145,030	95,833	0.00%	0	297,172	383,333	0.00%	62,790
45	Grant Expense	0	2,500	100.00%	0	63,990	10,000	-539.90%	0
46	<b>Total Non-Operating Gains, net</b>	<b>145,030</b>	<b>93,333</b>	<b>55.39%</b>	<b>0</b>	<b>233,182</b>	<b>373,333</b>	<b>37.54%</b>	<b>62,790</b>
47	<b>Income &lt;Loss&gt; Before Transfers</b>	<b>1,526,966</b>	<b>(12,683)</b>	<b>12139.47%</b>	<b>1,082,563</b>	<b>7,241,866</b>	<b>6,401,985</b>	<b>13.12%</b>	<b>6,970,005</b>
48	Operating Transfers	0	0	0.00%	0	0	0	0.00%	0
49	<b>Net Income</b>	<b>1,526,966</b>	<b>(12,683)</b>	<b>-12139.47%</b>	<b>1,082,563</b>	<b>7,241,866</b>	<b>6,401,985</b>	<b>13.12%</b>	<b>6,970,005</b>



**Statement of Cash Flows**  
**As of October 31, 2024**

*Cash Flow from Operations:*

1	YTD Net Income	7,241,866
2	Add: Depreciation Expense	1,710,059
3	Adj: Inventory (increase) / decrease	(428,464)
4	Patient Receivable (increase) / decrease	(1,803,103)
5	Prepaid Expenses (increase) / decrease	(302,819)
6	Other Current assets (increase) / decrease	(683,041)
7	Accounts payable increase / (decrease)	292,124
8	Accrued Salaries increase / (decrease)	646,874
9	Net Pension Asset (increase) / decrease	-
10	Other current liability increase / (decrease)	(286,875)
11	Net Cash Flow from Operations	6,386,621

*Cash Flow from Investing:*

12	Cash paid for the purchase of property/equip	(2,729,077)
13	Cash transferred to plant replacement fund	-
14	Proceeds from disposal of equipment	100
15	Net Cash Flow from Investing	(2,728,977)

*Cash Flow from Financing*

16	Cash (paid) / received for Lease Payable	(177,640)
17	Cash paid for Debt Service	-
18	Net Cash from Financing	(177,640)
19	Net increase in Cash	\$ 3,480,004
20	Beginning Cash as of July 1, 2024	\$ 33,226,262
21	Ending Cash as of October 31, 2024	\$ 36,706,266

To: SPH Board of Directors  
From: Susan Shover, BSN, RN, CPHQ; Corporate Compliance Officer  
Date: December 10, 2024  
Re: SPH and LTC Facility Corporate Compliance & Ethics Program and Policy

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The SPH and LTC Facility Corporate Compliance & Ethics Program is to be reviewed annually per CMS §483.85 (e).

South Peninsula Hospital (SPH) and its Long Term Care Facility (LTC) maintain a Compliance and Ethics Program to ensure quality of care and the prevention and detection of possible violations of SPH and LTC policies and procedures, criminal, civil, and administrative violations under the Social Security Act (“Act”). The Program also provides an appropriate setting for discussion of ethical issues and for protecting human dignity and patient/resident rights.

The language related to the Stark Law was updated to include some of the allowable exceptions in order to clarify activities occurring between SPH Clinics and Hospital. Some of the other language changes include removal of redundancy, clarification of Emergency Medical Treatment and Labor Act (EMTALA) language, Reference updates, as well as the addition of a designated Compliance email under the Reporting section. Regulatory information indicated throughout the document remains current. Stakeholders including LTC Administrator and DON, along with the CFO were able to review and provide input. Any changes made are indicated in red or blue-lines. This document, along with other compliance policies and annual training, continue to provide a good foundation for South Peninsula Hospital’s Compliance and Ethics Program.

The Hospital Wide Corporate Compliance and Ethics policy, HW-101 was also reviewed by stakeholders and received approval through the Hospital Wide Policy Committee November 22, 2024.

***Recommended Motion: Consideration to Approve the SPH and LTC Facility Corporate Compliance & Ethics Program and Corporate Compliance and Ethics policy, HW-101 as presented.***

**SOUTH PENINSULA HOSPITAL  
AND  
LONG TERM CARE FACILITY**

**CORPORATE COMPLIANCE AND  
ETHICS PROGRAM**



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## 1. MISSION, VISION, VALUES

- a. Mission – South Peninsula Hospital promotes community health and wellness by providing personalized, high quality, locally coordinated healthcare.
- b. Vision - South Peninsula Hospital is the provider of choice with a dynamic and dedicated team committed to service excellence.
- c. Values
  - i. Compassion – We provide compassionate patient- and resident-centered quality care, and a safe and caring environment for all individuals
  - ii. Respect – We show respect for the dignity, beliefs, perspectives and abilities of everyone
  - iii. Trust – We are open, honest, fair and trustworthy
  - iv. Teamwork – We work together as a dynamic, collaborative team embracing change and speaking as one.
  - v. Commitment – We are responsible and accountable for supporting the vision, mission, values, strategies and processes of our organization.

## 2. OVERVIEW

South Peninsula Hospital (SPH) and its Long Term Care facility (LTC) shall maintain a Compliance and Ethics Program to ensure quality of care, the prevention and detection of possible violations of SPH and LTC policies and procedures; criminal, civil, and administrative violations under the Social Security Act (“Act”) by any staff member, individuals providing services under contractual agreements, and volunteers (non-SPH staff collectively referred to as agents). The program is also intended to provide an appropriate setting for discussion of ethical issues and to protect human dignity and patient rights. This Program is supported by the Corporate Compliance and Ethics Policy (HW-101).

## 3. STANDARDS & STAFF CONDUCT

- a. Ensuring Ethical Practices  
Policies on Conflict of Interest, Code of Conduct and Medical Staff Bylaws provides guidance for all Board Members, Employees and members of the Medical Staff on expectations for their conduct. These expectations include, but are not limited to commit to:
  - i. ~~To the community, this organization is committed to t~~The promotion of health and to using this organization's best efforts to satisfy the

medical needs of the community while operating this organization in a fiscally responsible manner.

- ii. ~~To this organization's patients and residents, this organization is committed to~~ providing an appropriate quality of care, consistent with this organization's facilities and resources, which is responsive to patient/resident needs and complies with government laws and resources that govern the operation of a tax-exempt organization. This organization is also committed to complying with such accreditation bodies as this organization may determine.
- iii. ~~To this organization's employees, this organization will~~ implement and maintain employment practices and programs that comply with all applicable federal and state laws.
- iv. ~~To third-party payers, both private and public, this organization is committed to~~ submitting statements for inpatient, outpatient and LTC services in a timely and accurate fashion and reporting all reimbursable costs to the Medicare, Medicaid, and to any other third party in a legally appropriate manner.
- v. ~~To this organization's suppliers, this organization~~ stresses a sense of responsibility that enables it to be a good customer to our suppliers. When this organization determines that is in its best interest to utilize a competitive bidding process, this organization is committed to a fair and equitable bidding process.
- vi. ~~To all who do business with this organization, this organization shall~~ conduct its business in a manner that is consistent with this organization's tax-exempt status and all other applicable laws and regulations.
- vii. ~~To all parties we serve, SPH and LTC will~~ supporting and demonstrating our Mission, Vision and Values.

b. Medical Executive Committee duties include ad hoc ethical consultations should clinical ethical issues or concerns arise. Refer to Medical Staff Bylaws 6.2.2 Duties, q.

c. Standards

Compliance and Ethics Standards include, but are not limited to:

i. Medicare Regulations

1. Must comply with Medicare regulations
2. Meet standards for care
3. Not bill Medicare for unnecessary care, services not rendered, or in violation of the Medicare/Medicaid bundling regulations

ii. Federal False Claims Act

1. This act makes it illegal to submit a false bill to a government agency (Medicare and Medicaid are government agencies)

2. "Allows a citizen who has evidence of fraud to sue on behalf of the government. This "whistleblower" is protected from retaliation for reporting the fraud".
3. For additional information, see HW-257, Reporting False or Fraudulent Claims – False Claim Acts

iii. Stark Law

1. Also called the Ethics in Patient Referrals Act
2. Unless an exception exists this act makes it illegal for certain physician referrals:
  - a. If the facility and/or the provider has a financial relationship with the referring physician
  - b. If the immediate family of the referring physician has a financial relationship with the facility or provider
  - c. Prohibits the "presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third party payer) for those referred services."

3. Exceptions (not all inclusive) to the referral prohibition related to compensation arrangements may include (§411.353):

- a. Rental of office space and/or equipment, written and signed by both parties, with the specifications identifying arrangements such as timelines of lease, equipment covered.
- b. Physician/Employer relationship for identified services assuring this is consistent with fair market value of the services and account/value of referrals by the referring physician.
- c. Financial relationships identified that do not pose a risk to program guidelines and are related to designated health services include (not all inclusive), clinical laboratory services, Physical therapy services, Radiology services, Home Health services. And/or Inpatient and Outpatient hospital services.

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iv. Anti-Kickback Statute

1. Also known as The Medicare and Medicaid Patient Protection Act of 1987
2. Hospital staff or agents shall not knowingly and willfully solicit, offer to pay, actually pay or receive, any remuneration, directly, indirectly, overtly, covertly, in cash and/or in return for:
  - a. Referring an individual to a person for the furnishing,

- or arranging for the furnishing, of any item or service for which payment shall be made, in whole or in part, under any state or federal healthcare program
    - b. Purchasing, leasing, ordering, or arranging for, or recommending the purchasing, leasing, or ordering of any good(s), facility, service or item for which payment shall be made in whole or in part, under any federal or state healthcare program
    - c. Specific “safe harbors” are excluded from this prohibition. An example of a “safe harbor” agreement would be a volume purchasing and/or group purchasing discount agreement
- v. Sections of the Social Security Act
  - 1. Makes it illegal for hospitals to
    - a. Pay physicians to limit services provided by Medicare or Medicaid patients
    - b. Offer gifts to patients with Medicare or Medicaid to gain their business.
- vi. Emergency Medical Treatment and Labor Act (EMTALA)
  - ~~1. Staff working for the hospital. Hospital staff or agents shall comply with all federal and state regulations and laws regarding the evaluation, admission and treatment of patients with emergency medical conditions and/or women in labor, regardless of the nature of the medical condition.~~
  - ~~2. The staff will provide a medical screening examination (MSE) when a request is made for an examination or treatment for an Emergency Medical Condition (EMC), which includes active labor, regardless of the person’s ability to pay or insurance status.~~
  - ~~4.3. The hospital is required to provide stabilizing treatment for patients with an EMC and if unable to stabilize the patient or at the patients request, transfer a patient to a higher level of care. Staff and agents shall utilize and follow all policies regarding medical screening examinations and treatment of patients with emergency medical conditions, including women in labor, policies regarding transfers or referrals of patients to other facilities or physicians for appropriate treatment. Staff and agents shall provide initial medical screening examinations to all potential patients presenting themselves to the hospital for examination and/or treatment without regard as to financial or insurance status.~~
- vii. Red Flags Rule
  - 1. Requires certain entities to have written policies/procedures

in place to protect patients from identify theft. Refer to HW-170: Identity Theft Prevention policy for additional information.

viii. Section 501 (c)(3) – Federal and State Tax-Exempt Status

1. ~~SPH~~~~This hospital~~ is a not-for-profit entity ~~that is~~ exempt from federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code. That tax-exempt status could be jeopardized if any of the tax-exempt benefits enjoyed by this hospital inure to the benefit of certain private individuals/interest. All employees, consultants, and agents who contract with this hospital must do so in a manner that is consistent with this hospital's federal tax-exempt status.

ix. HIPAA Regulations

1. South Peninsula Hospital is considered a covered entity under the Health Insurance Portability and Accountability Act of 1996.
2. SPH will comply with the HIPAA privacy rule, protect the confidentiality of Protected Health Information (PHI) and apply protections to how PHI may be used and disclosed.
3. For more comprehensive information, the HW-151 HIPAA Compliance Policy may be accessed [here](#).

#### 4. PROGRAM PLAN AND ADMINISTRATOR

- a. ~~Per Federal regulation §483.85, SPH will a~~Adopting a Corporate Compliance and Ethics Program that will be reviewed at least annually or more often as necessary.
- b. ~~The SPH Board of Directors (BOD) will review its Corporate Compliance and Ethics Policy and Program and make any changes necessary at least annually, or more often if necessary, CMS §483.85 (e).~~  
The BOD or Chief Executive Officer (CEO) will be responsible for appointing the~~Appointing a Corporate Compliance Officer with the CCO reporting directly to the CEO but with access to the BOD as needed.~~
  - i. ~~The Board will appoint a Corporate Compliance Officer (CCO) and ensure that proper implementation of the Corporate Compliance and Ethics Program is a component of the CCO's annual performance review.~~
  - ii. The CCO appointed should be within the high-level personnel of the operating organization or who has a substantial role in the making of policy within the operating~~director of major division in the organization.~~
- c. Functions of the Corporate Compliance Officer  
These functions include, but are not limited to:

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- i. The CCO, or designee, shall ~~also~~ review and, when the CCO determines ~~that~~ it is reasonable to do so, disseminate to appropriate parties the monthly List of Excluded Individuals and Entities (LEIE) by the Inspector General's Office and of the Department of Health and Human Services that are published in the Federal Register, ~~from time to time~~. The CCO, or designee, will also ~~assist with~~ regularly review and disseminate new statutes, regulations, pronouncements, or directives of the federal or state government, the government's fiscal intermediary, any third-party payors, or any hospital association or trade publication that might affect these Standards.
- ii. The CCO, or designee, shall monitor this hospital's continued compliance with the terms and conditions set forth in any settlement agreement that might be executed by this hospital with the federal or state government.
- iii. The CCO, or designee, shall organize and facilitate a Compliance Committee meeting to review and approve any promotional and/or marketing programs considered from South Peninsula Hospital, LTC Facility and Ambulatory Clinics and Services. The committee make-up will be determined based on the issue or request, but will include at a minimum – the CCO ~~and/or Risk Mitigation RN~~, the Revenue Cycle Director, and Director of Finance or Chief Financial Officer, the Director of Public Relations along with the department manager/director presenting the request.
- iv. The CCO, or designee, shall conduct an annual review of the SPH and LTC Facility's Corporate Compliance and Ethic Program and prepare a report to the Board of Directors as directed by the CEO. ~~This report should be prepared to allow the Board time to act if necessary and include the results of the report in~~ for the Annual Report to the Kenai Peninsula Borough Contract Administrator according to the Operating Agreement.

## 5. REPORTING

- a. Any employee who makes a "good faith" report of a potential violation of a statute or regulation shall be protected from any form of retaliation, reprisal or adverse action for making such a report. Individuals may report criminal conduct by others within the organization to his or her immediate superiors or to the institution's Corporate Compliance Officer (CCO) who can be reached through the Occurrence Reporting System on the Staff Information Site ("SIS"), email to [Compliancequality@sphosp.org](mailto:Compliancequality@sphosp.org) or by calling the Confidential Compliance Line (907) 235-0389 or x 1389.
- b. Suspected violations can be reported anonymously through the occurrence reporting system or Compliance Line.
- c. The CCO or designee will communicate issues to the Chief Executive

Officer who will communicate with the Board of Directors, (~~“Compliance Committee”~~), as appropriate.

- d. In accordance with the provisions of the Deficit Reduction Act of 2005, all employees are hereby notified of their right to take any complaints or suspicions concerning violations of Medicare or Medicaid statutes or regulations directly to the Federal Government. Reports can be made to the Office of the Inspector General of the Department of Health and Human Services.
- e. Special protections are provided under the Federal and Alaska State False Claims Acts as related to reporting fraud, which can be found outlined in *HW-257 Reporting False or Fraudulent Claims - False Claims Act*.

#### **Reporting Methods**

By phone: 1-800-HHS-TIPS (1-800-447-8477)  
By TTY: 1-800-377-4950  
By Fax: 1-800-223-8164  
By Mail: U.S. Department of Health and Human Services  
Office of Inspector General  
Attn: OIG HOTLINE OPERATIONS  
PO Box 23489  
Washington, DC 20026

## **6. EDUCATION/TRAINING**

- a. Educating and Involving the Board of Directors
  - i. The administration of SPH will ensure ~~that~~ all new Board members are oriented to the Corporate Compliance and Ethics Program and other associated hospital policies. It is imperative for all Board members to understand and execute their duties in a manner consistent with governing laws, regulations and other program requirements.
  - ii. All new/current Board members will be provided an orientation that will include:
    - 1. an overview of corporate compliance and ethics, including a brief review of current federal requirements;
    - 2. an overview of the essential components of the organization’s Corporate Compliance and Ethics Program;
    - 3. may include examples of corporate compliance and ethics problems identified in other facilities; and
    - 4. a review of the hospital’s current corporate compliance and ethics efforts.
  - ~~iii. Current Board members will be provided a brief review of the hospital’s compliance program.~~
- b. Screening, Educating and Monitoring Employees
  - i. All current and potential employees will be screened against the

LEIE published by the Office of the Inspector General, Department of Health and Human Services. This screening is conducted to identify any individuals who have been previously convicted of Medicare/Medicaid fraud or other health care related actions. After consultation with legal counsel, appropriate corrective action will be taken against any existing employees who appear on the listing. Potential employees who are on the list will not be offered a position.

- ii. A Corporate Compliance component will be maintained in the orientation either in-person or through the Healthstream platform for new employees and the annual review for current employees. All employees will be required to complete the training which will include the following:

1. an overview of corporate compliance;
2. specific information regarding the hospital's corporate compliance program, including identification of the CCO; and
3. an explanation of the importance of employee participation in the program; including detailed information regarding how employees can report suspicions they have concerning the hospital's compliance with the law or federal reimbursement guidelines.

~~iii. Following the corporate compliance orientation and education programs, all employees will be required to complete a simple examination or post-test concerning corporate compliance. The examination or post-test will be signed and retained in the employee's personnel file as evidence the hospital trains its employees in corporate compliance.~~

~~iv-iii.~~ The Compliance and Ethics Program requirements, resources, policies and procedures will be disseminated to all staff in a practical manner and will be modified to reflect the level of risk a staff member, or agent, possesses or may encounter in their current role, CMS §483.85 (c)(5).

~~v. Compliance with SPH and LTC rules, policies and procedures as well as applicable laws and standards is included as a component of the job descriptions of all hospital employees.~~

~~vi-iv.~~ Staff are required to obtain any role-specific training/education in order to maintain licensure specific to their positions.

~~vii-v.~~ Specialized training is offered per department to cover topics needed for staff to safely and competently carry out their job functions.

~~viii-vi.~~ Annual performance reviews shall be conducted for employees to provide feedback on their performance per HW-268, Employee Performance Evaluations and LTC-143, Annual Performance Evaluations.

c. Educating and Monitoring Physicians

- i. The Chief Executive Officer and the Chief of Staff, or their designee(s), will conduct an orientation for all new members of the medical staff ~~on the~~. ~~The Corporate Compliance and Ethics Program will be included in the orientation. The physician orientation will include a summary of the issues covered in the employee orientation.~~
- ii. The Utilization Management staff reviews patient care documentation for evidence of medical necessity and level of care. This systematic and periodic review ensures the documentation provides evidence that:
  1. patient admission/observation and ongoing treatment is necessary;
  2. admissions into the ICU were in accordance with the admission and discharge criteria of the hospital; and
  3. The LTC facility utilizes Medicare criteria for Severity of illness/intensity of service to assure LTC admissions are appropriate clinically and a lower level of care under the continuum of care if not possible at time of admission.

## 7. AUDITING/MONITORING/ATTESTATION

SPH and LTC have taken reasonable steps to achieve compliance with its standards, i.e., by utilizing monitoring and auditing systems reasonably designed to detect criminal conduct by its staff including those providing services under a contractual arrangement, CMS §483.85 (c)(6).

a. Auditing

- i. Coding and billing audits are periodically conducted by regulatory bodies and/or external review.
- ii. Assessments and changes shall be documented clearly.
- iii. Periodic audits of the organization's functions, ~~particularly with respect to laws on anti-kickback and referrals,~~ shall be documented.
- iv. Claim denials as well as any changes to coding regulations are reviewed and appropriate updates are made to the system to ensure compliance.

~~See Section 10 for examples of audit formats which may be used by the organization.~~

b. Monitoring

- i. Provides an ongoing system of internal, coding, billing, marketing and sale practices review and is conducted on a regular basis
- ii. Focuses on compliance to the program and performance measures
- iii. Substantiated compliance and ethics reports may be used to modify or improve processes or programs identified as vulnerable

to compliance and ethics violations, CMS §483.85 (c)(8).

- c. Attestation
  - i. Periodic and annual reports will be filed as required by CMS and other government entities.

## 8. INVESTIGATION/REMEDATION

- a. Through ~~its~~ systematic reporting, monitoring and auditing systems, SPH and LTC shall investigate and remediate identified systematic and staff/agent problems.
- b. As the Corporate Compliance Officer (CCO) is made aware of potential violations of these Standards, the CCO may contact the hospital's CEO and/or President of the Board of Directors and, when necessary, the CCO is authorized to secure the opinions of outside legal counsel, outside consultants, and other experts in compliance issues. Any investigation of a suspected violation of these standards shall be done by the CCO or designee, under the direction of this hospital's outside legal counsel.
- c. After a violation is detected, reasonable steps are taken to respond appropriately and to prevent similar violations.

## 9. ENFORCEMENT/DISCIPLINE

- a. Should the investigation show a violation occurred, SPH and LTC reserve the right to discipline any employee at any level of discipline based upon the severity or frequency of the violation in alignment with the policy HW-095, Employee Corrective Action.
- b. Agents will be held accountable to this Plan. Any known violations will be reported to the Chief Executive Officer (CEO).

## 10. RECORD CREATION/RETENTION/AUDIT GUIDELINES/TEMPLATES

- a. Record Creation.
  - i. A permanent written record of any communication (verbal, written or electronic) reporting a real or potential compliance issue, shall be maintained.
- b. Retention.
  - i. Records shall be available upon request for any state or federal official requesting review.
  - ii. All documentation related to the corporate compliance issues as outlined in this program shall be retained in alignment with the HW-

152 – Records Management policy.

c. Audit Guidelines/Templates

i. Reviewing Contracts

1. ~~All~~ Provider contract templates ~~may be~~ reviewed by attorneys to ensure contracts meet federal and state laws.
  - a. The criteria for evaluating physician contracts may include:
    - i. Is the physician compensated for administrative services?
    - ii. Annual compensation?
    - iii. Is the agreement in writing?
    - iv. Does the agreement specify the services covered?
    - v. Does the agreement cover all the services to be provided by the individual or group?
    - vi. Do the services contracted for exceed those that are reasonable and necessary for legitimate business purposes?
    - vii. Is the agreement for a term of at least one year?
    - viii. Is the compensation set in advance?
    - ix. Is the compensation consistent with fair market value?
    - x. Is the compensation determined in a manner that takes into account the volume or value of any referrals where other business is generated between the parties?
    - xi. Is a service to be performed involving the counseling or promotion of a business or other activity that violates state or federal law?
    - xii. Is the agreement signed by both parties?
    - xiii. Is the agreement dated?
    - xiv. Is the compensation reflected on a 1099 or W-2?
  - b. The CEO, Chief Operating Officer, or Chief Financial Officer will provide a report to the Board of Directors upon request that:
    - i. Identifies the contracts the organization maintains with its providers
    - ii. Provides evidence that each contract has been reviewed against the board's criteria;
    - iii. Documents those contracts that met the board's criteria; and
    - iv. Indicates those contracts for which there is a

question concerning the attainment of criteria and which are being submitted to the board or a subcommittee of the board for its direct review.

2. The Director of Materials Management or Senior Leader of the division~~Contract Administrator~~ will review all non-provider contracts to ensure conformance with current regulations. HW-178, Contracts policy.

ii. Monitoring Materials Management

- a. South Peninsula Hospital and its LTC facility will maintain policies that ensure:
  - i. all suppliers and vendors abide by state and federal laws and standards; and
  - ii. recourse is available to suppliers or hospital personnel who suspect goods, services, devices, drugs, or other supplies are being provided, secured, or used in an illegal manner.

iii. Auditing Financial Systems and Billing Practices

- a. South Peninsula Hospital and LTC ~~f~~Facility will participate in annual audit(s) by an independent auditing firm selected by the Kenai Peninsula Borough. The audit will review the accounting systems, financial position, retirement plan, internal controls and billing procedures of the hospital, and LTC as applicable, to ensure compliance with generally accepted accounting principles.
- b. Other audits may be conducted on an as-needed basis.

iv. Coding and Billing Audits conducted for SPH and LTC Facility may:

- a. Include review of:
  - i. Proper usage of ABN's.
  - ii. Misuse of provider identification numbers (NPI #'s)
  - iii. Unbundling/Bundling of Services, including spacing out services normally completed in one visit
  - iv. Duplicate billing
  - v. Proper use of coding modifiers
  - vi. Upcoding the level of service provided
  - vii. Accuracy of procedure codes
  - viii. Inconsistent coding among staff in a group
  - ix. Waiving of Medicare co-payments

- x. Billing for CMS identified “never events”
- xi. Revenue code accuracy
- xii. Assure services delivered in LTC are appropriate for resident’s level of care.
- xiii. Payroll Based Journaling review

## 11. CONCLUSION

South Peninsula Hospital and LTC Facility will regularly review its performance in terms of both financial operations and clinical performance using a variety of indicators and general accepted benchmarks where available.

## RESOURCES

- Conditions of Participation for Critical Access Hospitals (State Operations Manual)
- Federal Sentencing Guidelines, §8B2.1 – Effective Compliance and Ethics Program. Retrieved from [https://guidelines.ussc.gov/apex/r/ussc\\_apex/guidelinesapp/guidelines?app\\_gl\\_id=%C2%A78B2.1](https://guidelines.ussc.gov/apex/r/ussc_apex/guidelinesapp/guidelines?app_gl_id=%C2%A78B2.1)
- Legal Information Institute, Cornell Law School. July 13, 2017. Retrieved from: <https://www.law.cornell.edu/cfr/text/42/483.85>
- Legal Information Institute, Cornell Law School. Aug 28, 2023. Retrieved from: <https://www.law.cornell.edu/cfr/text/42/411.357>
- Emergency Medical Treatment and Labor Act (EMTALA). Dec 06, 2024. Retrieved from: <https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act>
- Physician Self-Referral; Centers for Medicare and Medicaid Services, Dec 01, 2021. Retrieved from: <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index?redirect=/physiciansselfreferral/>
- Exemption Requirement-501©(3) Organizations. IRS; June 09, 2023. Retrieved from <https://www.irs.gov/charities-non-profits/charitable-organizations/exemption-requirements-501c3-organizations>.
- Centers for Medicare & Medicaid Services, Health and Human Services Final Rule, published October 4, 2016 and amended on November 11, 2017 for Long Term Care Facilities (CMS) §483.85, Compliance and Ethics Program; §483.95 (f), Training Requirements – Compliance and Ethics
- New Guidance from HHS-OIG Offers Insights for Health Care Compliance Programs. January 06, 2024. Retrieved from: Federal Register Compliance Program Guidance for Hospitals <https://www.ropesgray.com/en/insights/alerts/2024/01/new-guidance-from-hhs-oig-offers-insights-for-health-care-compliance-programs>
- ~~Federal Register Compliance Program Guidance for Nursing Facilities~~
- Office of Inspector General - <https://oig.hhs.gov/compliance/compliance-guidance/index.asp>

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- [Contact Us: Office of Inspector General. Retrieved from https://oig.hhs.gov/about-oig/contact-us/](https://oig.hhs.gov/about-oig/contact-us/)
- Safe Harbor regulations. [Oct 02, 2024](https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001/subpart-C/section-1001.952). Retrieved from: https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001/subpart-C/section-1001.952
- HealthStream Annual Education – Corporate Compliance
- HW-004, Conflict of Interest
- HW-095, Employee Corrective Action
- HW-101, Corporate Compliance Policy
- HW-106, Code of Conduct
- EMP-02, Corporate Compliance (BOD policy)
- HW-151, HIPAA Compliance Policy
- HW-257, Reporting False or Fraudulent Claims – False Claim Acts
- Kenai Peninsula Borough Operating Agreement for South Peninsula Hospital
- Medical Staff Bylaws, Part I: Governance, Section 6.2.2 Duties.

**Approvals by** Board of Directors

Original: May 2008

Revisions: ~~\_\_\_\_\_~~ October 23, 2019, October 2021, December 2022,  
November 2023, [December 10, 2024](#)

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	<b>SUBJECT:</b> Corporate Compliance and Ethics	<b>POLICY #:</b> HW-101
		<b>Page 1 of 2</b>
<b>SCOPE:</b> Hospital-Wide <b>RESPONSIBLE DEPARTMENT:</b> RiskQuality Management		<b>ORIGINAL DATE:</b> 7/22/98 <b>REVISED:</b> 1/25/07; 4/23/08; 9/04/12; 9/3/15; 5/13/16; 10/31/16; 10/23/19; 12/9/22; 12/06/2023
<b>APPROVED BY:</b> RiskQuality Management Director; Chief Executive Officer; Chief Medical Officer; Board of Directors		<b>EFFECTIVE:</b> 12/06/2023 12/xx/2024

**PURPOSE:**

The Corporate Compliance and Ethics policy supports the Corporate Compliance and Ethics Program providing an overview of Compliance and Ethics information for employees.

**DEFINITION(S):**

N/A

**POLICY:**

South Peninsula Hospital (SPH), which includes Long Term Care and Ambulatory Clinics and Services, shall maintain a Compliance and Ethics Program to ensure quality of care and the prevention and detection of possible violations of SPH policies and procedures, criminal, civil, and administrative violations under the Social Security Act (“Act”) by any staff member, individuals providing services under contractual agreements, and volunteers (non-SPH staff collectively referred to as agents). (Centers for Medicare & Medicaid Services, Health and Human Services Final Rule, published October 4, 2016 for Long Term Care Facilities (CMS) §483.85 (1))

The Corporate Compliance and Ethics Program allows for an appropriate setting for discussion of ethical issues to protect human dignity and patient rights.

**PROCEDURE:**

1. Components of Compliance and Ethics Program
  - a) No employee has ~~any~~ authority to act contrary to the provision of the law or to authorize, direct, or condone violations offered by any other employee.
  - b) Any employee or agent of this hospital who has knowledge of facts concerning this hospital's activities ~~that~~ they believe might violate the law has an obligation, promptly after learning such facts, to report the matter to their immediate supervisor or to the ~~organization's institution's~~ Corporate Compliance Officer (CCO) who can be reached anonymously through the Occurrence Reporting System on the Staff Information Site (“SIS”) or by calling the Confidential Compliance Line (907) 235-0389 or x 1389.
  - c) Any employee who makes a good faith report of a potential violation of a statute or regulation shall be protected from any form of retaliation, reprisal or adverse action for making such a report.
  - d) Human Resource policies and procedures that prohibit the selection, employment or delegation of authority to any candidate or anyone employed by the SPH organization with propensity to engage in violation of any Federal, State or local criminal, civil or administrative law or regulations, CMS §483.85 (c)(4).
  - e) SPH will take steps to effectively communicate its standards and procedures to all employees and agents by requiring participation in annual and periodic training programs, CMS §483.85 (c)(5).
  - f) SPH will take steps to achieve compliance with its standards, policies and procedures by utilizing monitoring and auditing systems reasonably designed to detect violations, CMS §483.85 (c)(6).
  - g) This Compliance and Ethics Program will be consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact, CMS §483.85 (c)(7). The appropriate form of discipline will be case-specific.
  - h) SPH will assure that reasonable steps are taken if a violation is detected to prevent future similar violations.
2. Corporate Compliance Officer CMS §483.85 (c)(2-4)

- a) This hospital designates the Director of ~~Risk~~Quality Management as its Corporate Compliance Officer (CCO). Each employee has a duty to report any suspected violations of any of these Standards to the Compliance Officer.
- b) The Compliance Officer will report to the Chief Executive Officer and Operating Board responsible to oversee the organization's compliance with the Program's standards, policies and procedures, CMS §483.85 (c)(2).

For more comprehensive information, the Corporate Compliance and Ethics Program may be accessed [here](#).

**ADDITIONAL CONSIDERATION(S):**

- A. Special protections are provided under the Federal and Alaska State False Claims Acts as related to reporting fraud, which can be found outlined in HW-257 Reporting False or Fraudulent Claims - False Claims Act
- B. For Long Term Care, Compliance and Ethics training will be provided to those under a contractual arrangement, volunteers and students consistent with their roles.

**REFERENCE(S):**

1. Corporate Compliance and Ethics Program
2. Social Security Act, Sections 1819 and 1919
3. Centers for Medicare & Medicaid Services, Health and Human Services Final Rule, published October 4, 2016 for Long Term Care Facilities - CMS §483.85 Compliance and ~~e~~Ethics ~~p~~Program and CMS §483.95 Training requirements, section (f) Compliance and ethics.
4. HW-004, Conflict of Interest
5. HW-106, Code of Conduct
6. HW-095, Employee Corrective Action
7. HW-228 HIPAA Disciplinary Guidelines
8. HW-257 Reporting False or Fraudulent Claims, False Claims Act
9. Medical Staff Bylaws, 6.2 Medical Executive Committee (MEC), section 6.2.2 q.
10. Legal Information Institute, Cornell Law School. July 13, 2017. Retrieved from: <https://www.law.cornell.edu/cfr/text/42/483.85>

**CONTRIBUTOR(S):**

~~Director of Risk Management~~/Corporate Compliance Officer; ~~Quality Management Department~~; ~~Director~~-Long Term Care Administrator; Policy Committee

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## ANNUAL BOARD CALENDAR - 2025

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### January 29, 2025

- Retirement: Kim Greer
- Credentialing Report
- Balanced Scorecard (new data)
- Report on Emergency Succession Plan for the calendar year (EMP-09)
- Annual Board Forms Collected
- Financial Audit Presentation (BDO) & accept the Financial Audit
- Board Officers Election
- Approve Board Roster & Committee Assignments, note in minutes
- FC: Report out whether funds are maintained separately from the KPB funds (see F-03)
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Capital Budget Approval
- GC: Annual Review of Policies (Governance Chair)
- GC: Annual Bylaws Review

### February – DATE TBD DUE TO AHA CONFERENCE

- Credentialing Report
- Annual Report to the Contract Administrator
  - Corporate Compliance Report
- Committee Assignments (if not ready for Jan mtg) noted in minutes
- CEO Evaluation packet prepared and sent out by 2/20
- AHA Rural Health Care Leadership Conference
- PC: Pension Committee Annual Report
- PC: Review/update PEN-001 & PEN-002
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Quarterly Grants Report
- GC: Policy Review – SM-01

### March 26, 2025

- Doctors Dinner
- Credentialing Report
- Strategic Plan Approval
- Infection Prevention Plan/LTC Inf Prev Plan Approval
- CEO Eval – Assessments reviewed by Gov or CEO Eval Cmte
- PC: Pension Plan Contributions Approval
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- GC: Policy Review – SM-02, SM-03

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## ***ANNUAL BOARD CALENDAR - 2025***

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### **April 30, 2025**

- Credentialing Report
- Balanced Scorecard (new data)
- CEO Eval: CEO Compensation Cmte meets to review compensation
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Resolution authorizing CFO to file the IRS 990
- GC: Policy Review – SM-04, SM-05

### **May 28, 2025**

- Credentialing Report
- Quality Plan Review
- CEO Eval: Board approved compensation during Exec Session
- FC: Annual IT Security Report
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: FY Operating Budget Approval
- FC: Quarterly Grants Report
- GC: Policy Review – SM-06

### **June 25, 2025**

- Credentialing Report
- CEO Eval: Board Chair meets with CEO to review evaluation
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- GC: Policy Review – SM-07

### **July 30, 2025**

- Credentialing Report
- Balanced Scorecard (new data)
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Financial Audit planning doc provided to Board
- CAH Program Evaluation Summary Approval
- GC: Policy Review – SM-08

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## ANNUAL BOARD CALENDAR - 2025

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### August 27, 2025

- Credentialing Report
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Quarterly Grants Report
- GC: Place ad for open board seats
- GC: Policy Review – SM-09, SM-10

### September 24, 2025

- AHHA Annual Conference
- Credentialing Report
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- GC: Conduct Board Self Evaluation
- GC: Host Doctor’s Dinner
- GC: Policy Review – SM-11, SM-12

### October 29, 2025

- Credentialing Report
- Balanced Scorecard (new data)
- Start planning/gauging interest for AHA Conference in February
- Include SAB schedule for next year to begin signups
- President: Gauge interest in committees for next year
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- GC: Query board members on interest for next year (committees, officer positions)
- GC: Interview board applicants
- GC: Policy Review – SM-13

### November

- No BOD meeting
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Quarterly Grants Report

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## **ANNUAL BOARD CALENDAR - 2025**

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### **December 17, 2025**

- Credentialing Report
- Next year's Board meeting calendar approval
- Board Member Elections
- Approval of Chief of Staff as elected by the Medical Staff
- Chief of Staff Approval (every other year)
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- PC: Pension Committee Audit Report

### **Any Month, As Needed**

- Updates to Medical Staff Bylaws or Rules & Regulations
- New Services – quarterly review of financial performance of new services
- Updated Medical Staff Privileges
- Proclamations for Retirees +20 years
- Resolution to transfer over 90 days cash on hand (if we hit 90 days at end of previous quarter)
- New bank account signers/limits/credit card holders
- GC: Any revised policies
- Changes to Board Bylaws
- Acceptance of Board resignations

**Retirements: Cindy Bolognani – postponed to 2025**

	<b>SUBJECT:</b> Infection Prevention Plan	POLICY # HW-269
		Page 1 of 10
<b>SCOPE:</b> Hospital-Wide <b>RESPONSIBLE DEPARTMENT:</b> Infection Prevention, Administration		<b>ORIGINAL DATE:</b> 10/1/08 <b>REVISED:</b> 6/24/11; 9/24/14; 1/27/17; 7/13/20; 5/28/22; 9/27/23
<b>APPROVED BY:</b> Infection Prevention RN, Chief Nursing Officer, Infection Prevention Medical Director & Chief Medical Officer; Infection Prevention Committee; Medical Executive Committee, Board of Directors		<b>EFFECTIVE:</b> 9/27/23

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**PURPOSE:**

Program components and outline for the South Peninsula Hospital (SPH) Infection Prevention Plan in accordance with federal, state, and local regulatory guidelines and requirements, including:

- Defining the Infection Prevention Program, its goals, objectives, authority, and responsibilities
- Outlining the processes used to determine and evaluate Healthcare-Associated Infections (HAIs)
- Determination of HAIs, type of surveillance used, data source, patient sources, and reporting of analysis
- Identification of process improvement opportunities, plan intervention activities, implementation of action plans, and evaluation of plans for effectiveness.
- Integration of the Infection Prevention Program into all disciplines, services, and settings throughout South Peninsula Hospital and Long Term Care. (See Long Term Care Infection Prevention Plan for more details)

**DEFINITION(S):**

N/A

**POLICY:**

I. Missions, Vision, Values:

The foundation of the SPH Infection Prevention Plan is the organization’s mission, vision, values, and associated behaviors:

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

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

Values & associated behaviors: (See Attachment 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. Background:

- The Infection Prevention Program provides a plan of action designed to identify infections that occur in patients, residents, healthcare workers, visitors, and others in the healthcare environment in coordination with Employee Health (EH) that have the potential for disease transmission and recommends risk reduction practices by integrating principles of infection prevention into all direct and indirect standards of practice.
- Infection Prevention services are provided by Infection Prevention/Employee Health/Chief Nursing Officer 8 hours a day, 5 days per week, with phone access to the Infection Prevention Physician 24/7, in accordance with our Values and Behaviors.
- The Infection Prevention Program has been established to define a realistic framework that contributes to organizational effectiveness through the identification of risk and risk reduction methods. This support will influence and improve the quality of healthcare in the facility by preventing disease transmission using evidence-based, cost-effective, epidemiological approach to patient care.
- The SPH Organization is committed to preventing adverse outcomes such as HAIs and their sequelae, to improve patient care by supporting the staff in all areas of the facility when appropriate, to minimize occupational hazards associated with the delivery of healthcare, and to foster scientifically based decision making.
- The Infection Prevention Program is a multidisciplinary, systematic approach to quality patient care that emphasizes risk reduction of disease transmission of the hospital environment by using sound epidemiological principles. This Infection Prevention Plan is a plan of action to prevent disease transmission when possible, monitor its occurrence, and initiate measures to minimize the impact in those cases that cannot be prevented.
- The goals are accomplished by setting preventions or standards that have proven effective in decreasing infections that cannot be prevented, preventing those that can be, and providing early diagnosis and appropriate treatment of all infections. These Preventions include hospital policies and procedures and departmental protocols. The effectiveness is achieved by integrating principles of infection prevention within each of the hospital's department's standards.
- As standards are reviewed, measures are taken to identify practices that follow infection prevention standards and evaluate them for effectiveness.
- The Infection Prevention Program at the SPH Organization is coordinated by the Infection Prevention Committee and is in compliance with all regulatory agencies.

## III. Goals:

The primary goal of the Infection Prevention Program (IPP) is to reduce the risk of acquisition and transmission of HAIs at the SPH Organization. In order to accomplish this goal, the hospital will:

- Incorporate the Infection Prevention Program as a major component of its safety and performance improvement programs
- Perform ongoing assessments to identify its risks for the acquisition and transmission of infectious agents
- Use an epidemiological approach that consists of surveillance, data collection, and trend identification
- Effectively implement infection prevention/control processes
- Educate and collaborate with organization-wide leaders to effectively participate in design and implementation of the IPP
- Integrate its infection prevention efforts with healthcare and community leaders to the extent practical, recognizing that infection prevention and control is a community wide effort
- Plan for its response to infections that could potentially overwhelm its resources
- Communicate to physicians, employees, students, trainees, volunteers, subcontractors, construction workers, and as appropriate, visitors, residents, and patients about infection prevention and control issues, including their responsibilities in preventing the spread of infection within the hospital
- In the event of an infectious disease outbreak, provide liaison activities with facility management in order that decisions may be made regarding temporary halting of services, to limiting visitors within the facility, to fully

activate the organization's Emergency Operations Plan

- Provide documentation of recognition and compliance with appropriate regulatory and accrediting agencies
- Report appropriate information to the organization and public health agencies

IV. Program Objectives:

1. To prevent or limit unprotected exposure to pathogens within the hospital.
2. To recommend methods for early identification and appropriate therapy when infections are considered inevitable.
3. To recommend practice oriented towards preventing introduction of infection into the facility and/or containing the spread of infection if it is introduced.
4. To mitigate the unintended consequences of antimicrobial use (resistance, morbidity & mortality, cost).
5. To systematically identify and minimize the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices.
6. To incorporate the CDC Recommendations for Prevention of HAIs into policy and practice within the facility as they relate to:
  - Ventilator Associated Pneumonia
  - Central Line Associated Bloodstream Infections
  - Catheter Associated Urinary Tract Infections
  - Surgical Site Infections (Inpatient)
    - To implement practices that decrease the risk of transmission of microorganisms within the organization, such as ensuring effective hand hygiene practices throughout the facility.
7. To support EH, quality improvement, risk management, safety, and utilization management efforts, using epidemiological and scientific methodologies.
8. To facilitate compliance with reporting requirements in coordination with EH of the hospital to the various public health officials/agencies via SPH Laboratory Department.

V. Program Authority and Responsibility

- A. The IPP receives dual authority and responsibility based on function and anticipated outcome.
- B. The Infection Prevention Physician Liaison is responsible for the medical direction and decisions as indicated. Their credentials will show evidence of knowledge and special interest in Infection Prevention. They serve as an advisor and consultant to the Infection Prevention Nurse and Employee Health Nurse. They are also responsible for the review, analysis, and presentation of infection reports and policies to the Medical Staff. They provide guidance, clinical expertise in the assessment and evaluation of the infection prevention measures and activities throughout the health system.
- C. The Infection Prevention Nurse (IP RN) is a registered nurse who has documented evidence of education, training, and experience related to surveillance, prevention, and control of infections and is responsible for:
  1. Coordinating all infection prevention and control within the SPH Organization. Facilitating ongoing monitoring and the effectiveness of prevention and/or control activities and interventions.
  2. Implementing policies governing asepsis and infection prevention.
  3. Developing a system for identifying, investigating, reporting, and preventing the spread of infections and communicable diseases among patients and healthcare workers.
  4. Identifying, investigating, and reporting infection and outbreak of communicable diseases among patients, residents, and patient care staff in coordination with EH.
  5. Preventing and controlling the spread of infections and communicable diseases among patients, residents, and staff.
  6. Cooperating with hospital-wide orientation and in-service education programs.
  7. Cooperating with other departments and services in the performance of quality assurance activities.
  8. Cooperating with disease prevention activities of the local health authority.
  9. Maintaining a log of incidents related to infections and communicable diseases for patients.
  10. Collaborating and investigating information from the log of incidents related to infections and communicable diseases for employees, contract workers, and volunteers received from EH.
  11. Preparing budget proposal to support general program activities that support data collection, evaluation, reporting, and follow-up as directed annually by the IPC.

D. Statement of Authority

The Infection Prevention Committee (IPC) shall be responsible for developing and monitoring the hospital Infection Prevention Program for the SPH Organization. The Physician Liaison of the IPC or their designee\* is authorized by the Governing Board and Medical Staff to institute any surveillance, prevention, and appropriate prevention measures or studies, and to recommend corrective action within any department, when there is a reason to believe that any patient, personnel, resident, or visitor may be in danger. When any of these actions are taken the patient's attending physician will be notified.

The IPC has the ultimate authority in the event that there is a question or disagreement in relation to Infection Prevention policy or procedure.

*\*The designee is defined as the Infection Prevention Nurse (IP RN). In the absence of the IP RN, the IP RN, with the approval of the Infection Prevention Physician and Chief Nursing Officer, will appoint a representative from the Nursing Department.*

VI. Infection Prevention Committee (IPC)

A. The IPC reports to the Medical Executive Committee (MEC), Quality Management committee, and the Governing Body. It is a multidisciplinary committee from all relevant departments and services. The composition of the committee shall be as follows:

- Infection Prevention Physician
- Infection Prevention Nurse
- Medical Staff Representation
- Senior Administration as needed
- Nursing Administration
- Employee Health Nurse
- Acute Care Nurse/Manager
- Emergency Department Manager
- Laboratory (Microbiology)
- Environmental Services (EVS, Laundry)
- Pharmacy
- Surgical Services
- Engineering/Safety
- Food Services
- Long Term Care
- 
- Home Health
- Quality Management
- Any clinical area on an as-needed liaison basis

B. The IPC is responsible to:

1. Establish guidelines/policies for the function and scope of the prevention, control, and surveillance of infection.
2. Assess/evaluate/revise the type(s) and scope of surveillance and reporting programs at least annually by reviewing:
  - Changes in the scope of services provided
  - Changes in results of the Infection Prevention Risk Analysis
  - Emerging/re-emerging pathogens
  - Success or failure of current interventions
  - Concerns of leadership with the IPP
  - Changes in guidelines relevant to infection prevention and control
3. Provide standard criteria for determining all types of infections including: respiratory, gastrointestinal, surgical wounds, skin, urinary tract, bacteremia, and those related with the usage of devices.
4. Utilize the Centers for Disease Control (CDC) classification of infections as guide in determining criteria.
5. Utilize National Healthcare Safety Network (NHSN) to determine HAIs at SPH.
6. Participate in determining the minimum content and scope of the Employee Health Program, which will include assessing, implementing, and evaluating policies, to control and prevent infections and exposures to and from all employees, physicians, students, and volunteers.
7. Integrate findings with the Quality Management Department to collate, trend, analyze, and disseminate data to departments/areas of concern or interest.

8. Assess the overall success or failure of key processes for preventing and controlling infection.
  9. Assess the adequacy of the human, information, physical, and financial resources allocated to support the IPP.
  10. Review and revise the IPP at least annually and as needed based upon identified risks.
  11. Facilitate annual education/training of Infection Prevention/Employee Health to all staff.
- C. The IPC shall meet quarterly or as necessary to conduct business and shall review the following data in assessing the effectiveness of the IPP:
1. Surveillance and Infection Prevention Data
    - Policies governing asepsis and Infection Prevention
    - QI reports
    - Outbreak investigations
    - Results of environmental tours
    - [Employee vaccination rates](#)
    - Preventing and controlling the spread of infection and communicable diseases among patients and staff, in coordination with EH.
  2. Patient Safety
    - Compliance with Hand Hygiene Guidelines
    - Identification and reporting of any deaths due to HAIs
  3. Coordination with Other Programs, Services, Agencies
    - Cooperating with hospital-wide orientation and in-service education programs
    - Environmental Services
    - Microbiology
    - Sterile Processing Department
    - Pharmacy Intervention
    - City/County Health Notifiable Conditions
    - Emergency Preparedness
  4. Management of the Environment of Care
    - Maintenance reports of ventilation equipment to provide appropriate air exchanges.
  5. Evaluate all new or proposed disinfecting and sterilization materials and procedures.
- D. The IPC shall report its findings and recommendations to the Board of Directors and Medical Staff through the Chief Nursing Officer. Written minutes of all committee meetings will be maintained and be made available upon request. Pertinent findings of the IPC shall be a part of the hospital's continuing education program, including the New Employee Orientation Program, which is reviewed/updated annually.
- E. Dissemination of Infection Prevention information is crucial. Both surveillance data and policy decisions will be communicated throughout the organization. This is accomplished through routine QI reports to specific department directors for review. This information is then communicated to the appropriate staff members. Routine reports to specific departments will be presented to the department manager for their review and communicated as appropriate to staff members.
- F. In the event that an issue should arise that requires decision and action between meetings, the IP RN will communicate with the Infection Prevention Physician. Any action required will be under the authority of the Infection Prevention Physician and implemented by the IP RN.

**VII. Scope and Description of Services**

- A. The design and scope of the IPP will be based on the level of risk identified by the SPH Organization and are appropriate to the geographic location, the volume of patients encountered, the patients populations served, the clinical focus, and number of employees and residents.
- B. SPH is a 22-bed Critical Access Hospital, and 28 bed Long Term Care Facility providing both inpatient and outpatient health services and Skilled Nursing services to the South Peninsula area. The hospital has an average daily census of 12 patients and is a full service hospital that services adult and pediatric patients. The hospital offers many specialized services in addition to 24-hour emergency services, intensive care (ICU), medical & surgical services, maternal-child services, and rehabilitation and Skilled Nursing Facility services. Ambulatory clinics/services include:
  - South Peninsula's Physical and Occupational Therapy Centers
  - Emergency Services

- Home Health Program
- Laboratory
- Imaging
- Homer Medical Center
- Orthopedic/Surgical Clinic
- Specialty Clinic

- C. The Infection Prevention Nurse (IP RN), Employee Health Nurse (EH RN), Chief Nursing Officer (CNO) have responsibility for the implementation of this Plan in all listed areas as deemed appropriate and epidemiologically significant.
1. Infectious Diseases that impact the Kenai Peninsula: Infectious disease are transmissible, through a variety of channels beyond person-to-person infection, including livestock, insects, and avian migration. Contact with sea faring vessels such as cruise ships with diverse populations and foreign visitors can move about freely along the Kenai Peninsula. The possibility of a Tsunami hitting the region is not unrealistic, therefore, the water borne illnesses associated with such an incident would be considered.
  2. Bioterrorism Threat Risk: While Homer is located in the southern region of the state and 4 hours from the major city of Anchorage, the state of Alaska is at a heightened threat for bioterrorist activity for several reasons:
    - Due to proximity to foreign nations and access/exposure to international shipping
    - Presence of military installations

VIII. Organization and Staffing of the Infection Prevention Program (IPP)

- A. The Infection Prevention and Employee Health Departments are under the supervision of the Infection Prevention Committee, Chief Nursing Officer, and Infection Prevention Physician, respectively.
- B. Based on the needs of the facility and related services, 1.0 FTE has been allotted to coordinate the Infection Prevention. The number of FTEs allotted to each program is related to the needs of the patients/employees and not solely on the bed size or number of patients served. During off hours, the Nursing Supervisor/Charge RN are available for consult in the absence of the IP RN and EH RN

<u>POSITION</u>	<u>HOURS</u>	<u>CODE</u>
Infection Prevention RN flexible	1.0 Full Time	

- C. The IP RN participates on the following committees and task forces:
- i. SPH
    - Infection Prevention Committee
    - Sharps Safety Committee
    - Patient Centered Care Quality Committee
    - Hospital Incident Management Team
    - LTC Quality Assurance and Performance Improvement (QAPI)
  - ii. Community
    - Disaster Plan Committee
    - Pandemic Flu Committee
    - MAPP (Mobilizing for Action through Planning and Partnerships)

IX. Resources

- A. Information Management Systems available include:
  - Laboratory Data Bank
  - Personal Computers with Internet Access
  - List Servers from CDC, APIC (Association for Professionals in Infection Control and Epidemiology), Joint Commission, Alaska Department of Health and Social Services, AOHP (Association of Occupational Health Professionals in Healthcare)
- B. Support Services include:
  - Laboratory support to provide reports for surveillance and employee exposures.
  - Pharmacy support in review of data for trending, assessment, intervention, and evaluation of action plans.
  - Data collection support from other department managers.
  - Public Health Department and the Alaska Department of State Health Services provide consultative services.
  - Environmental Services will recommend the specific solutions for organization-wide cleaning and disinfection

purposes. It will be supplied by the department with specific instructions for its use, as well as stated in the department policy.

## X. Infection Prevention Surveillance Activities

A. Utilizing a targeted methodology, the SPH Organization's surveillance measures include the following indicators:

1. Outbreak Investigations
2. Prevalence surveillance with multidrug resistant or especially virulent organisms and coordinates with Pharmacy of Antibiotic Stewardship.
3. Identification and reporting of diseases/infections designated as reportable by the CDC, Alaska Department of Health and other regulatory agencies.
4. Surgical Site Infections –
  - Outpatient / inpatient – Surgical patients readmitted for infection within 30 days or 90 days diagnosis specific per CDC of a surgical procedure via post op SSI (surgical site surveillance) letters to surgeons
  - Surgical staff performs post-op follow up calls and reports to Infection Prevention (IP) any signs or symptoms of infection for further investigation
5. Acid-Fast Bacillus/Tuberculosis (AFB/TB) Isolation Protocols
6. Employee Health (EH) to report to Infection Prevention:
  - Employee tuberculosis (TB) exposures, evaluation and follow up
  - Employee blood borne pathogen exposures
7. Selected Healthcare-Associated Infections (HAI)
  - Central Line Associated Blood Stream Infection (CLABSI)
  - Ventilator-Associated Pneumonias (VAP) – ICU
  - Catheter-Associated Urinary Tract Infection (CAUTI)
8. Environmental Surveillance
  - Construction Compliance Rounds in coordination with Support Services
  - Ventilation air quality report from Support Services and Surgery Department Log
  - Terminal cleaning procedures in coordination with Environmental Services
9. Patient Safety
  - Sterilization processes in coordination with Surgical Services
    - Positive biological indicators
    - Flash sterilization usage
  - Refrigerator/freezer quality control
  - Hand hygiene compliance
10. Healthcare-Associated Infections related to unexpected death or permanent loss of function (Sentinel Events)

## XI. Recording and Reporting Infections

A. Data Collection Methods

1. Retrospective data – Review of patient records to determine healthcare-acquired vs. community-acquired infections.
2. Prospective data – Review of patient records from onset to discharge.
3. Surveillance rounds – Rounds of various areas to monitor selected quality prevention issues, procedural implementation, and employee knowledge of processes.
4. Quality Prevention data – Reports from other departments relating to Infection Prevention issues.

B. Sources of Data

1. Daily census reports
2. Emergency Department records
3. Microbiological reports
4. Serological reports
5. Isolation Reports
6. Occurrence reports
7. Pharmacy reports
8. Initial Tuberculosis (TB) assessment reports
9. Multidrug resistant organism (MDRO) surveillance admission reports

10. Mortality reviews
11. Chart reviews
12. Surveillance round reports on the patient care units to identify problems
13. Employee Health alerts and reports related to increased call-ins for infectious conditions
14. Reports from support departments regarding suspicious signs and symptoms of infection
15. Nursing staff reports
16. Physician consultations
17. Physician/Surgeon feedback

XII. Evaluation of Data

- A. The Infection Prevention Nurse will be responsible for trending the data collected and presenting such to the Infection Prevention Physician and Infection Prevention Committee for further evaluation of findings that exceed the threshold.
- B. If at any point in the evaluation process a problem has been identified, the Infection Prevention Nurse will consult with the Infection Prevention Committee to develop a plan of action. Action plans will include recommendations, actions taken, and conclusions, with follow-up and re-evaluation noted. Assessment of all corrective actions will be conducted continuously following implementation. Conclusions will be developed after corrective actions have been in place long enough to result change. Follow-up will continue for a sufficient period of time to ensure resolution.
- C. The hospital Performance Improvement Model is utilized for monitoring and evaluation of the program. The following ten steps are utilized in the Quality Improvement Program for Infection Prevention:
  1. Assign responsibility
  2. Delineate scope of care
  3. Identify important aspects of care
  4. Identify indicators
  5. Establish thresholds for evaluation
  6. Collect and organize data
  7. Evaluate care
  8. Take actions to solve identified problems
  9. Assess actions and document improvement
  10. Communicate relevant information to organization-wide quality improvement

XIII. Confidentiality

All activities including minutes, reports, and worksheets shall be held in strictest confidences and safeguarded against unauthorized disclosure.

XIV. Infection Prevention Policies and Procedures

- A. There are written policies and procedures for infection surveillance, prevention, and control for all patient care departments/services, which include but are not limited to the following:
  - Nursing units
  - Central Sterile Processing
  - Food Services
  - Laundry
  - Pharmacy
  - Physical Therapy
  - Imaging
  - Surgical Services
  - Employee health
  - Environmental Services
  - Long Term Care Facility
- B. The written policies and procedures are made known to employees performing patient care procedures that are associated with the potential for infection. The Infection Prevention and/or Employee Health Nurse introduces

general orientation to new employees at New Employee Orientation. Each Manager is responsible for department specific training of their staff to pertinent Infection Prevention Policies and Procedures in collaboration with the Infection Prevention Nurse. Infection Prevention Policies will be reviewed and/or revised and approved by the Infection Prevention Committee at least annually.

XV. Annual Reappraisal

- A. The Infection Prevention Program will be evaluated at least annually to determine the effectiveness of prevention and control intervention strategies in reducing healthcare–acquired infection risk. The goals will be revised at least annually to reflect the type and scope of surveillance activities based on data analysis, services/procedures added, and/or problems identified during the last year. The evaluation will include at least the following elements:
- Changes in the scope of services
  - Changes in the results of the Infection Prevention risk analysis
  - Emerging and reemerging problems in the healthcare community that potentially affect the hospital
  - An assessment of the success or failure of interventions for preventing and controlling infections
  - Responses to concerns raised by leadership and others within the hospital
  - The evolution of relevant infection prevention and control guidelines that are based on evidence, or in the absence of evidence, expert consensus

**PROCEDURE:**

N/A

**ADDITIONAL CONSIDERATION(S):**

N/A

**REFERENCE(S):**

1. South Peninsula Hospital Long Term Care Facility Infection Prevention Plan

**CONTRIBUTOR(S):**

Infection Prevention RN; Employee Health RN; Chief Nursing Officer; Infection Prevention Medical Director; Infection Prevention Committee

Attachment 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.

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

Lack of separation between clean supplies and dirty/contaminated medical supplies			1			2					1			1		5
Improper storage and/or transport of linen			1							1				1		4
Other (specify): _____																
<b>Antibiotic Stewardship</b>																
Lack of leadership support for antibiotic stewardship			1			2					1		2	1		65
Inadequate written policies guiding antibiotic use			1			2					1			1		5
Unable to obtain antibiotic usage report from pharmacy			1							1			2	1		16
Unable to obtain report summarizing antibiotic resistance patterns (e.g., antibiogram)			1							1			2	1		16
Other (specify): _____																
Date Prepared: 3/28/23																
Adapted from <a href="https://spice.unc.edu/resources/template-risk-assessment-for-icc/">https://spice.unc.edu/resources/template-risk-assessment-for-icc/</a>																

Introduced by:  
Date:  
Action:  
Vote:

Administration  
Dec 18, 2024  
Yes - , No - , Exc -

**SOUTH PENINSULA HOSPITAL  
BOARD RESOLUTION  
2024-26**

**A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS  
SUPPORTING THE HOSPITAL’S REQUEST TO LIST THE PHARMACY RELOCATION,  
INFUSION RELOCATION & EXPANSION, AND NUCLEAR MEDICINE ADDITION AS  
LEGISLATIVE PRIORITIES FOR THE KENAI PENINSULA BOROUGH TO REQUEST  
CONGRESSIONALLY DESIGNATED SPENDING FUNDS**

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

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

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

**WHEREAS**, the relocation and expansion of the Pharmacy will bring South Peninsula Hospital into compliance with USP standards which were federally mandated without funding for sterile compounding and allow it to continue to provide greatly needed services to Kenai Peninsula residents; and

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

**WHEREAS**, the South Peninsula Hospital Board of Directors approved the support of a certificate of need in previous Board Resolution 2023-15; and

**WHEREAS**, this project was reviewed by the state and awarded Certificate of Need per State of Alaska regulations.

**WHEREAS**, this project requires \$9,835,760 in funding to proceed and South Peninsula Hospital is requesting that this project be included in a legislative priority list for the Kenai Peninsula Borough requesting Congressionally Designated Spending.

**WHEREAS**, this resolution was discussed and recommended for approval at Finance Committee on November 21, 2024.

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

1. That the South Peninsula Hospital Board of Directors supports the Hospital’s request for the Pharmacy, Infusion, and Nuclear Medicine Certificate of Need project to be listed as a legislative priority request for congressionally designated spending.
2. The South Peninsula Hospital Board of Directors respectfully requests that the Kenai Peninsula Hospital Service Area Board recommends this resolution for approval at their November 14, 2024 meeting.

3. The South Peninsula Hospital Board of Directors respectfully requests that the Kenai Peninsula Borough Assembly approve this resolution and include the South Peninsula Hospital Certificate of Need project in the amount of \$9,835,760 be included in its annual legislative priority funding request for congressionally designated spending.

**PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL AT ITS MEETING HELD ON THIS 18<sup>TH</sup> DAY OF December, 2024.**

ATTEST:

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Aaron Weisser, Board President

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Mary E. Wythe, Board Secretary



# Kenai Peninsula Borough

Year 2024 State Capital Improvement Projects

## SERVICE AREA: South Kenai Peninsula Hospital

<b>Funding Recipient:</b>	Kenai Peninsula Borough		
<b>Project Name:</b>	<b>South Peninsula Hospital Certificate of Need for Pharmacy Remodel, Infusion Expansion, and Nuclear Medicine Service Line Addition</b>	Project Priority Ranking:	1

### Detailed Project Description and Justification:

South Peninsula Hospital is a 22-bed acute care and 28-bed long term care Critical Access Hospital in Homer, Alaska serving 16 communities which make up the South Kenai Peninsula Hospital Service Area. The main Hospital Building located at 4300 Bartlett Street in Homer, has been built in many phases over the past 45 years, with the most recent addition and expansion in 2008-2009. The next closest hospital is 76 miles away and can easily be over 2 hours in the winter to travel to through mountainous icy terrain. The current hospital building contains shelled in space that was designed to allow for expansion of future services. In 2023, South Peninsula Hospital completed and received a state certificate of need to utilize this space to relocate and remodel the pharmacy to comply with updated regulations, expand and re-locate infusion services, and to add a nuclear medicine service line.

Recently, updated regulations were released that require our Pharmacy be remodeled to comply with USP 797 & USP 800. These updated regulations did not come with funding. It is vital that our pharmacy be updated to comply with these standards so we can continue to provide vitally needed infusion services so patients do not need to travel long distances for care. Data shows that infusion service visits are expected to grow by 29% by 2032. The hospital would like to relocate the Pharmacy to shelled space so that it can expand and update to be compliant with new standards.

Infusion services currently are in a building outside the hospital which requires transport of medications between buildings. This service is isolated to a 960 square foot location. The projected growth of demand for visits demonstrates a need to identify a larger space to provide expanded services. The ideal location for this growth would be within the hospital building close to Pharmacy and Emergency services. Relocating to shelled space would be ideal.

Nuclear medicine has been the standard of care for diagnosing illnesses and disorders related to heart health, neurology, and cancer for over 30 years and demand for this service grows with an aging population. The population of those 65+ is expected to grow 31% on the Kenai Peninsula. By adding this service line the hospital will be able to allow patients to receive vital diagnostic services and follow up care close to home which will bring access to an aging population who may not otherwise receive this service.

We are humbly seeking Legislative priority to assist with the update and expansion of services.

Funding Requested:	\$	9,835,760	Election District:	Senate:	
Total Project Cost:	\$	11,434,903		House:	
Local Match (if any):	\$	1,599,143			

### CONTACT INFORMATION

Name, Title:	Ryan Smith, CEO	Phone:	907-235-0241
Address:	4300 Bartlett St	Fax:	
City, State Zip:	Homer, AK 99603	E-mail:	rsmith@sphosp.org

<b>Funding Plan:</b>		
Total Project Cost:	\$ 11,434,903	This should be the most accurate estimate of how much this project will cost.
Funding Secured:	\$ 1,599,143	How much of the project costs are in hand, secured, guaranteed, appropriated, etc. You may include in-kind contributions and volunteer labor. Do not include hypothetical funds.
Funding Requested:	\$ 9,835,760	How much is being requested from this year's capital budget.
Pending Requests	\$	Amount requested from other sources not yet received.
Project Deficit:	\$ 9,835,760	Additional funding needed to complete the project.

**Please list Secured Funding Sources and Amounts:** SPH, Inc. currently has Plant Replacement and Expansion funds which are obligated and 'in hand' but not secured. Remaining project deficit are expected to come from Federal legislative priority funding, and philanthropy requests.

**If this project is funded this year, will you be requesting state funding again?** Yes:  No:

**Please describe the project time-line and when the expenditures will occur:**

The architectural engineering project should finalize in on our about March 2025. We expect that the funding deficit can be secured by October 2025 and that work could commence on this project beginning Spring/Summer 2025.

**Has this project gone through a public review process at the local level?** Yes:  No:   
Yes:  No:   
Is it a community or service area priority demonstrated by resolution or other official action?

**If a community or service area meeting was conducted, how was it advertised? When and where was it held? Who attended?**

This project has been discussed and prioritized by several governing bodies including the SPH Operating Board (legislation passed in May 2023), the South Peninsula Hospital Service Area Board discussed and issued a letter of support in May 2023, and a State of Alaska Certificate of Need advertised the project and solicited community feedback both in writing and through scheduled sessions and was approved December 28, 2023.

**Who will own the project or facility?** Kenai Peninsula Borough

**Entity responsible for providing ongoing operation and maintenance of this project?** South Peninsula Hospital, Inc.

**How will operations and maintenance be funded after the project is complete?**

Hospital Operations managed by SPH, Inc. are being strategically grown such that future hospital revenues can sustain the maintenance of the needed upgrades/replacement of our building components. By updating the pharmacy to the latest standards and expanding infusion services, revenues will grow and sustain the improved services. The addition of the Nuclear Medicine service line will save patients from being transported to other facilities and result in increased revenue and patient volumes not only from diagnostic services, but also follow up surgical and post operative care.

**Please select a project type** (chosed only one):

- Planning and Research
- Maintenance and Repairs
- Remodel, Reconstruction and Upgrades
- New Construction and Land Acquisition
- Equipment and Materials
- Information System and Technology
- Other:

**Recipients Federal Tax ID: 92-0037099 SPH, Inc.**  
**92-0030894 KPB**

**SOUTH KENAI PENINSULA HOSPITAL SERVICE AREA BOARD  
RESOLUTION 2024-10**

**A RESOLUTION OF THE SOUTH KENAI PENINSULA HOSPITAL SERVICE  
AREA BOARD SUPPORTING THE SOUTH PENINSULA HOSPITAL, INC.’S  
REQUEST TO LIST THE PHARMACY RELOCATION, INFUSION  
RELOCATION & EXPANSION, AND NUCLEAR MEDICINE ADDITION AS  
LEGISLATIVE PRIORITIES FOR THE KENAI PENINSULA BOROUGH TO  
REQUEST CONGRESSIONALLY DESIGNATED SPENDING FUNDS IN  
THE AMOUNT OF \$9,835,760**

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

**WHEREAS** Nuclear Medicine has been the standard of care for diagnosing illnesses and disorders related to Heart Health, Neurology, and Cancer for over 30 years and is not available at SPH; and

**WHEREAS** bringing this service line to the South Kenai Peninsula Hospital Service Area will allow patients to receive vital diagnostic services close to home, which will make these services accessible to populations who may not otherwise receive them, resulting in better outcomes for our service area residents and visitors; and

**WHEREAS** the relocation and expansion of the Pharmacy will bring the South Peninsula Hospital into compliance with USP standards for sterile compounding, which were federally mandated without funding, and allow SPH to continue to provide greatly needed services to the South Kenai Peninsula Hospital Service Area; and

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

**WHEREAS** the South Peninsula Hospital, Inc. Board of Directors previously approved support of a Certificate of Need in SPH Board Resolution 2023-15; and

**WHEREAS** this project was reviewed by the state and awarded a Certificate of Need per State of Alaska regulations; and

**WHEREAS** this project requires \$9,835,760 in funding to proceed and South Peninsula Hospital is requesting that this project be included in a legislative priority list for the Kenai Peninsula Borough requesting Congressionally Designated Spending Funds; and

**WHEREAS** SPH Resolution 2024-26—which is complementary to SKPHSAB Resolution 2024-10—will be reviewed by the SPHI Finance Committee on November 21, 2024, and by the SPHI Board of Directors on December 18, 2024, and will formalize SPHI’s request that this

project be included in a legislative priority list for the Kenai Peninsula Borough requesting Congressionally Designated Spending Funds;

**NOW, THEREFORE, BE IT RESOLVED THAT THE SOUTH KENAI PENINSULA HOSPITAL SERVICE AREA BOARD:**

Respectfully requests that the Kenai Peninsula Borough Assembly approve this resolution and include the South Peninsula Hospital Certificate of Need project in the amount of \$9,835,760 in its annual legislative priority funding request for Congressionally Designated Spending Funds.

**PASSED AND ADOPTED BY THE SOUTH KENAI PENINSULA HOSPITAL SERVICE AREA BOARD AT ITS MEETING HELD ON THIS 14<sup>th</sup> DAY OF NOVEMBER 2024.**

ATTEST:

A handwritten signature in black ink, appearing to read "Helen Armstrong", written over a horizontal line.

Helen Armstrong, Chair  
South Kenai Peninsula Hospital Service Area Board

November 14, 2024

To: SPH Board of Directors  
From: Molly Kerce, Medical Staff Coordinator  
Date: December 2024  
Re: Board Confirmation of the 2025 & 2026 Chief of the Medical Staff

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On November 13<sup>th</sup>, 2024 the Medical Staff held its Annual Meeting and Medical Executive Committee election for the 2025 and 2026 leadership positions.

Sarah Roberts, MD ran unopposed and received the majority of the votes.

Per the Medical Staff Bylaws, Part I: Governance Manual, 4.3; 4.3.6:

*The Chief of Staff nominee receiving the majority of the vote, must be confirmed by the Board, prior to assuming office. If the Board does not confirm the Chief of Staff nominee, the Board shall discuss this with the current MEC, and instruct the MEC to reconvene the election process.*

Informational Only:

Elected to the officer and leadership positions:

Vice Chief of Staff – Dr. Nathan Kincaid  
Credentials Chair – Dr. Hans Amen  
APP Member at Large – Brian McCorison, CRNA  
Physician Member at Large – Dr. Brent Adcox  
Physician Member at Large – Dr. Lucy Fisher

***Recommended Motion(s):***

***Consideration to Confirm Sarah Roberts, MD as Chief of Staff for 2025 and 2026 as elected by the South Peninsula Hospital Medical Staff.***

**BYLAWS  
SOUTH PENINSULA HOSPITAL, INC.**

## **ARTICLE I - NAME AND OBJECTIVES**

### **Section 1.**

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

### **Section 2.**

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

### **Section 3.**

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

## **ARTICLE II - MEETINGS**

### **Section 1. Regular Meetings.**

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

### **Section 2. Special Meetings.**

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

### **Section 3. Quorum.**

A quorum for the transaction of business at any regular, special, or emergency meeting shall consist of a majority of the seated members of the Hospital Board, but a majority of those present shall have the power to adjourn the meeting to a future time. Attendance may be in person through telephonic or other electronic means.

### **Section 4. Minutes.**

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

### **Section 5. Reconsideration:**

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

### **Section 6. Annual Meeting.**

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

## **ARTICLE III - MEMBERS**

### **Section 1.**

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:

- o Physician compensation including pay for performance considerations
  - o CEO compensation
  - o Approval of the annual audit
  - o 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 of 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. Election shall be by secret ballot. Elections may be held by any electronic means that provides the required anonymity of the ballot.

## **Section 3.**

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

## **Section 4.**

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

## **Section 5.**

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

## **Section 2.**

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

## **Section 3.**

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

## **Section 4.**

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

## **Section 5.**

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

## **Section 6.**

**Secretary.** The secretary shall be responsible for the minutes of the meeting, act as custodian of all records and reports, ensure posting of the agenda and minutes on the website, ensure that notification is provided to the Kenai Peninsula Borough for any changes to 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 have charge and custody of, and be responsible to the Hospital Board for all funds, properties and securities of South Peninsula Hospital, Inc. in keeping with such directives as may be enacted by the Hospital Board.

# **ARTICLE V - COMMITTEES**

## **Section 1.**

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

## **Section 2.**

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

## **Section 3.**

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

# **ARTICLE VI - ADMINISTRATOR**

## **Section 1.**

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

## **Section 2.**

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

## **Section 3.**

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

## **Section 4.**

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

## **Section 5.**

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

## **Section 6.**

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

## **Section 7.**

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

## **Section 8.**

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

## **Section 9.**

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

## **Section 10.**

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

## **ARTICLE VII - MEDICAL STAFF**

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

### **Section 1.**

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

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

### **Section 2.**

The Hospital Board delegates to the Medical Staff its responsibility to develop Bylaws, 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 members at any regular or special meeting provided that notice of such meeting shall have contained a copy of the proposed alteration, amendment or repeal and that said proposed alteration, amendment, or repeal shall be read at two meetings prior to a vote.

### **Section 2.**

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

### **Section 3.**

These Bylaws shall be reviewed at the annual meeting.

## **ARTICLE X - ORDER OF BUSINESS**

### **Section 1.**

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

## **ARTICLE XI - INDEMNIFICATION**

### **Section 1.**

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

## **Section 3.**

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

## **Section 4.**

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

## **Section 5.**

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

## **Section 6.**

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

- Adopted by the South Peninsula Hospital Board of Directors, June 26, 2024.
- Aaron Weisser, President
- Mary E. Wythe, Secretary

**South Peninsula Hospital**  
**Hospital Board of Trustees Balanced Scorecard Report**  
**3rd Quarter Calendar 2024 (Jul, Aug, Sep)**

*Last updated: 11/5/2024*

Overall Indicators	3Q 2024	Target	n	Note
Medicare Care Compare Overall Hospital Star Rating	N/A	5		There are too few measures or measure groups reported to calculate.
Medicare Care Compare Overall Patient Survey Star Rating	N/A	5		There are too few measures or measure groups reported to calculate.
Medicare Care Compare Overall Nursing Home Star Rating	5	5		Last updated 9/25/2024

**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	3Q 2024	Target	n	Note
<b>Severe Sepsis &amp; Septic Shock Care</b>	92%	> 75%	70	<i>(Care Compare: 61 cases - 87%, 1/1/2023-12/31/2023)</i>
Percentage of patients who received appropriate care for sepsis and/or septic shock.				# of cases passing / total # of cases-exceptions <i>(Q3-2024: 70 cases reviewed: 12 pass, 1 fail, 57 exclusions)</i>
<b>Stroke Care</b>	82%	> 95%	11	<i>(Care Compare: 11 cases - 64%, 1/1/2023-12/31/2023)</i>
Percentage of patients who receive CT/MRI within 45 minutes of arrival to ED w/stroke symptoms.				Numerator = CT/MRI within 45 min & documented last known well. Denominator = Patients with Stroke presenting within 2 hours of symptoms. <i>(Q3-2024: 11 cases, 9 - pass, 2 - failed, 0 - exclusions)</i>
<b>Median Emergency Room Time</b>	194	< 180min	1786	<b>Target (minutes)</b> <i>(Care Compare: 127 min, 1/1/2023-12/31/2023)</i>
Average minutes spent in department before leaving the Emergency Department.				Average throughput time of all ED visits. <i>(Q3-2024: 1786 cases: 194 min. Median Time)</i>
<b>Readmission</b>	5%	< 15%	79	<i>(Care Compare 14.3%, 177 patients 7/1/2022-6/30/2023)</i>
Percentage of unplanned readmission to an acute care hospital in 30 days after discharged from a hospitalization.				5% of patients with unplanned readmission to (IP/Obs) within 30 days of discharge - exclusions / Eligible admissions- 79 readmits / 4 total admits.
<b>OB – C-Section Rate</b>	29%	< 30%	14	<b># NTSV C-Sections / Total # NTSV births</b>
Percentage of patients in the NTSV ( <i>nulliparous, term, singleton, vertex</i> ) category delivering by cesarean section.				<i>4 NTSV C-Sec. (1st Pregnancy), term (&gt;37 weeks), / 14 total #NTSV births (Measured by chart abstractions.)</i>
<b>Provider Quality Score (Group)</b>	69%	75%	N/A	<b>Scoring tabulated as a running, annual score.</b>
CMS Merit-Based Incentive Payment System ( <i>MIPS</i> ) for providers				
<b>Patient Fall Rate AC</b>	2.63	< 5	3	<b># of patient falls / # patient days x 1000</b>
Measures the number of patient falls per 1,000 patient days.				n = IP, observations and swing bed patient days. <b>Note:</b> AC had 3 falls total; 3 falls without injury and 0 falls with injury. <i>(Tracking through occurrence reporting system.)</i>

Quality of Care / Patient Safety <i>(continued)</i>	3Q 2024	Target	n	Note
<b>Medication Errors</b>	0	0	N/A	
Measures the number of reported medication errors causing patient harm or death.				Reported errors classified as type E-I by the National Coordinating Council for Med Error Reporting and Prevention/CMS. <i>(Tracking through occurrence reporting system.)</i>
<b>Never Events</b>	0	0	N/A	
Unexpected occurrence involving death/serious physiological or psychological injury, or the risk thereof.				<i>(Tracking through occurrence reporting system.)</i>
Home Health (HH)	3Q 2024	Target	n	Note
<b>Independent Bathing</b>	84.2%	> 75%	38	
Percentage of home health patients demonstrating improvement with ability to bathe more independently.				100% of the patients stayed the same or improved. 21 Patients improved, 13 stayed the same. <i>(Tracked through OASIS Reporting.)</i>
Nursing Home (LTC)	3Q 2024	Target	n	Note
<b>Depressive Symptoms</b>	0	≤ 2	N/A	
Number of residents who develop symptoms of depression after admission.				<i>(Tracked through MDS Reporting.)</i>
<b><u>Patient &amp; Resident Experience</u></b>				
As the patient and resident experience is a prime indicator of the organization's overall health, South Peninsula Hospital strives to tenaciously pursue patient and resident experience improvements.				
Consumer Assessment of Healthcare Providers and Services	3Q 2024	Target	n	Note: Measures as a % ranking across PG clients.
<b>HCAHPS Percentile</b>	79 <sup>th</sup>	75 <sup>th</sup>	42	
Measures the 1-10 ranking received by inpatient client <i>(or family)</i> respondents.				Q1 -2024: 43 <sup>rd</sup> , n = 25, Q2 -2023: 97 <sup>th</sup> , n = 39, Q3-2024: 79 <sup>th</sup> , n=42,
<b>HHCAHPS Percentile</b>	32 <sup>nd</sup>	75 <sup>th</sup>	46	<b>*Running 12 months due to low quarterly returns</b>
Percentage of patients rating the agency as 9-10/10" with a goal of 75%.				Q1-2024: 88 <sup>th</sup> , n=33, Q2-2024: 87 <sup>th</sup> , n=38, Q3-2024: 32 <sup>nd</sup> , n=46,

<b>Patient Satisfaction Through Press Ganey (PG)</b>	3Q 2024	Target	n	Note: % ranking across PG clients.
<b>Inpatient Percentile</b>	89 <sup>th</sup>	75 <sup>th</sup>	42	
Measures the satisfaction of inpatient pts. respondents.				Q1 -2024: 89 <sup>th</sup> , n = 25, Q2-2024: 90 <sup>th</sup> , n= 39, Q3-2024: 89 <sup>th</sup> , n=42,
<b>Outpatient Percentile</b>	23 <sup>rd</sup>	75 <sup>th</sup>	378	
Measures the satisfaction of outpatient pts. respondents.				Q1 -2024: 40 <sup>th</sup> , n = 224, Q2-2024: 12 <sup>th</sup> , n= 362, Q3-2024: 23 <sup>rd</sup> , n=378,
<b>Emergency Department Percentile</b>	91 <sup>st</sup>	75 <sup>th</sup>	129	
Measures the satisfaction of emergency pts. respondents.				Q1 -2024: 84 <sup>th</sup> , n = 76, Q2 -2024: 90 <sup>st</sup> , n = 112, Q3-2024: 91 <sup>st</sup> , n=129,
<b>Medical Practice Percentile</b>	67 <sup>th</sup>	75 <sup>th</sup>	480	
Measures the satisfaction of pts. respondents at SPH Clinics.				Q1 -2024: 49 <sup>th</sup> , n = 546, Q2 -2024: 46 <sup>th</sup> , n = 528, Q3-2024: 67 <sup>th</sup> , n=480,
<b>Ambulatory Surgery (AS) Percentile</b>	61 <sup>st</sup>	75 <sup>th</sup>	77	
Measures the satisfaction of AS pts. respondents.				Q1 -2024: 39 <sup>th</sup> , n =52, Q2 -2024: 99 <sup>th</sup> , n =70, Q3-2024: 61 <sup>st</sup> , n=77,
<b>Information System Solutions</b>	3Q 2024	Target	n	Note
<b>Eligible Hospital (EH) Promoting Interoperability: hospital-based measures for inpatient and observation stays.</b>	83	≥ 60	N/A	<b>CMS score 60 and above = pass</b>
e-Prescribing: Electronic Prescribing ( <i>Rx</i> )	8	10	403 of 484	FY24 to date = 1111 of 1353
Query PDMP	10	10	N/A	Yes, providers are using PDMP Query via EHR interface
Health Information Exchange: Support Electronic Referral Loops by receiving and incorporating health information	12	15	4 of 5	FY24 to date = 8 of 9
HIE: Support. Electronic Referral Loops by sending health info. ( <i>Sum of Care sent</i> )	5	15	63 of 181	FY24 to date = 197 of 554
Provider to patient exchange: Provide patients electronic access to their health information. ( <i>timely access via the patient portal</i> )	23	25	241 of 259	FY24 to date = 598 of 647
Public Health & Clinical Data Exchange	25	25	N/A	Public Health, electronic Case Reporting (eCR), and Clinical Data Exchange interfaces in place.
<b>Eligible Provider (EP) - Promoting Interoperability (Group)</b>	100%	95%	N/A	<b>Target quarterly for annual score</b>
Merit Based Incentive Payment System Promoting Interoperability score. ( <i>MIPS tracking is in Athena</i> )				Promoting Interoperability for Providers: N/A * Athena hasn't calculated our score yet
<b>Electronic Medical Record (EMR) Adoption Stage</b>	5	5	N/A	
Health Information Management & Systems Society ( <i>HIMSS</i> ) Electronic Medical Record Adoption Model ( <i>EMRAM</i> ) stage.				SPH has maximized EHR functionality to reach and maintain Stage 5. We re-evaluate EMRAM Staging with Epic implementation. Stages 6 and 7 site visit validation.

<b>Information System Solutions (Continued)</b>	<b>3Q 2024</b>	<b>Target</b>	<b>n</b>	<b>Note</b>
<b>IT Security Awareness Training Complete Rate</b>	<b>91%</b>	<b>97%</b>		
% of employees who have completed assigned security training				1858 Training videos sent, 1695 were completed.
<b>Phishing Test Pass Rate</b>	<b>99%</b>	<b>97%</b>		
% of Phishing test emails that were not failed.				630 Test phishing emails sent out to staff. 5 of the email links were clicked, causing 5 potential security risks.
<b><u>Medical Staff Alignment</u></b>				
South Peninsula Hospital desires to be an employer and/or provider of choice for medical staff practitioners by fostering an atmosphere of continuous collaboration.				
<b>Provider Alignment</b>	<b>2021</b>	<b>Target</b>	<b>n</b>	<b>Note</b>
<b>Provider Satisfaction Percentile</b>	<b>85th</b>	<b>75th</b>		
Measures the satisfaction of physician respondents as indicated by Press Ganey physician survey results. Measured as a percentile.				Result of provider survey 2024
<b><u>Employee Engagement</u></b>				
South Peninsula Hospital desires to be an employer of choice that offers our staff an opportunity to make positive impact in our community.				
<b>Staff Alignment</b>	<b>2024</b>			
<b>Employee Satisfaction Percentile</b>	<b>60th</b>	<b>75th</b>		
Measures the satisfaction of staff respondents as indicated in Press Ganey staff survey results Measured as a percentile.				Result of employee survey 2024
<b>Workforce</b>	<b>3Q 2024</b>	<b>Target</b>	<b>n</b>	<b>Note</b>
<b>Turnover: All Employees</b>	<b>4%</b>	<b>&lt; 5%</b>	<b>658</b>	
Percentage of all employees separated from the hospital for any reason				25 Terminations / 658 Total Employees
<b>Turnover: Voluntary All Employees</b>	<b>3%</b>	<b>&lt; 4.75%</b>	<b>658</b>	
Measures the percentage of voluntary staff separations from the hospital				17 Voluntary Terminations / 658 Total Employees
<b>First Year Total Turnover</b>	<b>3%</b>	<b>&lt; 7%</b>	<b>115</b>	
Measures the percentage of staff hired in the last 12 months and who separated from the hospital for any reason during the quarter.				30 New Staff Terminated in Q3-2024 115 Total New Hires from 1/1/2024 - 9/30/2024
<b>Travel Nursing Utilization</b>	<b>9</b>	<b>&lt; 15</b>		
Measure average number of travel nurses utilized in the previous quarter.				

## 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	3Q 2024	Target	n	Note
<b>Operating Margin</b>	9%	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.
<b>Adjusted Patient Discharges</b>	1,188	1,116		<b>Total Discharges: # 186 (Acute, OB, Swing, ICU)</b>
Measures the number of patients discharged, adjusted by inpatient revenues for the quarter divided by <i>(inpatient + outpatient revenues)</i> .				<i>(LTC Revenue &amp; discharges not included, Target is same Q Prior Year. Target Discharges: 191)</i>
<b>Net Revenue Growth</b>	18%	19%		
Measures the percentage increase <i>(decrease)</i> in net patient revenue for the quarter compared to the same period in the prior year.				Target is based on budgeted net patient service revenue for the period compared to net patient service revenue for the same period in prior year.
<b>Full Time Equivalents (FTEs) per Adjusted Occupied Bed</b>	8.1	10.3		
Measures the average number of staff FTEs per adjusted occupied bed for the quarter.				Target is based on budgeted paid hours <i>(FTE)</i> divided by <i>(budget gross patient revenue/budget gross inpatient rev) X budgeted average daily census</i> for the quarter.
<b>Net Days in Accounts Receivable</b>	57	55		
Measures the rate of speed with which the hospital is paid for health care services.				
<b>Cash on Hand</b>	72	90		<b>91.7 Total Days Cash on Hand, Operating +Unobligated PREF</b>
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.
<b>Uncompensated Care as a Percentage of Gross Revenue</b>	2%	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%
<b>Average Age of Plant</b>	12.9	8 yrs.		
Average age of assets used to provide services				Target is based on hospital optimal age of plant.
<b>Intense Market Focus to Expand Market Share</b>	3Q 2024	Target	n	Note
<b>Outpatient Revenue Growth</b>	25%	19%		
Measures percentage increase (decrease) in outpatient revenue for the quarter, compared to the same period in the prior year.				Target is based on budgeted outpatient revenue for the period compared to outpatient revenue for the same period prior year.
<b>Surgical Case Growth</b>	18%	11.0%		
Measures the increase <i>(decrease)</i> in surgical cases for the quarter compared to the same period in the prior year.				Target is based on budgeted surgeries above actual from same quarter prior year.





MEMO

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

Re: Service Area Board Representatives 2025

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The SPH Board sends a representative to attend each Service Area Board meeting. Committee of the Whole begins at 5:30pm (*you may attend, but it is not required*) Meeting starts at 6:30pm.

Location: SPH Conference Rooms or Zoom. [More info here.](#)

SAB Secretary Devony Lehner will send you the packet on your assigned month. You will be expected to give a (very brief) report of any SPH Board news from the previous board meeting.

Date of Meeting 6:30pm	BOD Member
January 9, 2024	
February 13, 2024	
March 13, 2024	
April 10, 2024	
May 8, 2024	
August 14, 2024	
September 11, 2024	
October 9, 2024	
November 13, 2024	
December 11, 2024	

**SOUTH PENINSULA HOSPITAL  
 BOARD RESOLUTION  
 2024-28**

**A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS  
 APPROVING MEDICAL STAFF CREDENTIALING FOR DECEMBER 2024**

**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 approves the initial appointment of:

Christopher Dale, MD	TeleICU-Prov	Telemedicine
Joshua Jones, MD	TelePsych-Prov	Telemedicine
Matthew MacKinnon, MC	TelePsych-Prov	Telemedicine
Michael Doherty, MD	TeleEEG-Prov	Telemedicine
Paula Gerber-Gore, MD	TeleEEG-Prov	Telemedicine
Kitti Kaiboriboon, MD	TeleEEG-Prov	Telemedicine
Madhavi Lekkala, MD	TeleEEG-Prov	Telemedicine
Eric Prince, MD	TeleEEG-Prov	Telemedicine
Ednea Simon, MD	TeleEEG-Prov	Telemedicine
Steven Smith, MD	TeleEEG-Prov	Telemedicine
Natasha Sparrow, DO	TeleEEG-Prov	Telemedicine
Derek Yu, MD	TeleEEG-Prov	Telemedicine
Christopher Varani, MD	TeleICU-Prov	Telemedicine
Bionod Wagem, MD	TeleStroke-Prov	Telemedicine

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

James Andrews, MD	Otolaryngology	Courtesy
Christine Pratt, PA-C	Family Medicine	Active
William Oley, MD	Emergency Medicine	Courtesy
Rena Blanton, ANP, FNPBC	Family Medicine	Community
Claire Waite, MD	Radiology-vRad	Courtesy
Sonja Martin-Young, CNM	Midwifery	Community
Jessie Wray, MD	Emergency Medicine	Courtesy
Carrie Warren, FNP	Family Medicine	Active

Christopher Barton, MD  
Soo Young Kwon, MD

TeleICU-Prov  
TeleStroke-Prov

Telemedicine  
Telemedicine

3. That the South Peninsula Hospital Board of Directors approves the following status modification requests:

Melissa Heiry, MD  
Maureen Filipek, MD

Skin Biopsy Privilege  
Courtesy to Active Category

**PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA AT ITS MEETING HELD ON THIS 18<sup>th</sup> DAY OF DECEMBER, 2024.**

ATTEST:

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Aaron Weisser, Board President

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Mary E. Wythe, Board Secretary