AGENDA

Board of Directors Meeting

5:30 PM - Wednesday, July 24, 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		Jared Baker		Christopher Landess, MD	
Melissa Jacobsen, Vice President		Matthew Bullard		Preston Simmons	
Beth Wythe, Secretary		Matthew Hambrick		Bernadette Wilson	
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 - 12	7.1.	Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for June 26, 2024 Board of Directors - Jun 26 2024 - Minutes - DRAFT
13 - 16	7.2.	Consideration to Approve June FY2024 Financials Balance Sheet - June FY24 Income Statement - June FY24 Cash Flow Statement - June FY24
17 - 21	7.3.	Consideration to Approve the Revised Conflict of Interest Policy, as Recommended by the Governance Committee SM-01 with revisions SM-01, updated, clean
22	7.4.	Consideration to Approve Policy F-16 Budget Modifications with no revisions, as recommended by the Finance and Governance Committees F-16 Budget Modifications Policy

8. PRESENTATIONS

9. UNFINISHED BUSINESS

10. NEW BUSINESS

23 - 35	10.1.	Consideration to Retire the Medical Staff Development Plan and Policy Medical Staff Development Plan Medical Staff Development Policy
36 - 91	10.2.	Consideration to Approve the Critical Access Hospital 2023-2024 Quality Assessment and Performance Improvement Evaluation Memo QM 2023-2024 CAH-QAPI EVAL
92 - 93	10.3.	Consideration to Approve SPH Board Resolution 2024-18, A Resolution of the South Peninsula Hospital Board of Directors Approving the Use of $993,661 of Plant Replacement and Expansion Funds to Fund the Relocation and Co-location of Obstetrics and Gynecology and Midwifery Clinics Within the Main Hospital Building SPH Resolution 2024-18
94 - 95	10.4.	Consideration to Approve SPH Board Resolution 2024-19, A Resolution Approving the Use of Up to $50,000 of Operating Funds for the Costs of Distributing Promotional Information about the Ballot Proposition

Seeking Voter Approval for the Issuance of Bonds to Pay for the South Kenai Peninsula Hospital Service Area Campus Expansion, Renovation and Acquisition Project to Ensure Compliance with Legal Restrictions on the Use of Borough Funds and Assets Related to Ballot Propositions
SPH Resolution 2024-19

11. REPORTS

96 - 100 11.1. Chief Executive Officer
Q2-2024 Balanced Scorecard

11.2. BOD Committee: Finance

101 - 103 11.3. BOD Committee: Governance
F-15 New Service Approval and Service Elimination Policy Updates
F-17 Discretionary Contributions Policy

11.4. BOD Committee: Education

11.5. Chief of Staff

11.6. Service Area Board Representative

12. DISCUSSION

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

14.2. Board Members

15. INFORMATIONAL ITEMS

16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Credentialing

18. ADJOURNMENT

South Peninsula Hospital

MEMO

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

To: Public Participants

From: Operating Board of Directors – South Peninsula Hospital

Re: Rules for Participating in a Public Meeting

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

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

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

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

MINUTES

Board of Directors Meeting

5:30 PM - Wednesday, June 26, 2024

Conference Rooms 1&2 and Zoom

The meeting of the Board of Directors of South Peninsula Hospital was called to order on Wednesday, June 26, 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 & CONFLICT OF INTEREST CHECK

BOARD PRESENT: **Matthew Hambrick, Melissa Jacobsen, Walter Partridge, Aaron Weisser, Bernadette Wilson, Beth Wythe, Preston Simmons, Matthew Bullard, and Jared Baker**

BOARD EXCUSED: **Edson Knapp**

ALSO PRESENT: **Ryan Smith, CEO; Angela Hinnegan, COO; Rachael Kincaid, CNO;**

**Outside of SPH Board members, only meeting participants who comment, give report or give presentations are noted in the minutes. Others may be present in the conference rooms or on Zoom.*

2.1. A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Rachael Kincaid, CNO, shared a Values story. She read an email from a patient who had a great experience at South Peninsula Hospital as an inpatient. All the nurses had a wonderful bedside manner and she never had to wait for any of her needs. The CNAs were also incredible and quick to assist. The new TVs and being able to log into her streaming service were the icing on the cake.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

Mr. Weisser welcomed Adam Hays, from Hays Research Group.

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

Melissa Jacobsen made a motion to approve the agenda as presented. Preston Simmons seconded the motion. Motion Carried.

7. APPROVAL OF THE CONSENT CALENDAR

Beth Wythe read the consent calendar into the record.

7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for May 22, 2024

7.2. Consideration to Approve May FY2024 Financials

7.3. Consideration to Approve the South Peninsula Hospital Bloodborne Pathogen Plan with no changes as recommended by Hospital Administration

7.4. Consideration to Approve SPH Board Policy F-14, Grant Applications, with no revisions, as recommended by the Finance Committee

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

8. PRESENTATIONS

8.1. Focus Group Report

Adam Hays, of Hays Research Group gave a presentation on the results of focus groups on hospital bonds. He reported on his methodology, and his observations, including what were the strongest arguments for and against the bond, what information participants wanted before voting, and how they'd like to receive that information.

9. UNFINISHED BUSINESS

There was no unfinished business

10. NEW BUSINESS

10.1. Consideration to Approve SPH Resolution 2024-17, A Resolution of the South Peninsula Board of Directors Approving the Use of an Additional $499,500 of Operating Cash to Fund the Already Approved $499,500 of Operating Cash for the Remodel of 203 W Pioneer in Resolution 2024-09 Making the Total Spend for the Project $999,476 to Remodel 203 W Pioneer to Open a Daycare

Angela Hinnegan, COO, reported. This resolution was approved by the Service Area Board (SAB) at a special meeting in June. It has become clear that the plumbing and electrical in the 203 W Pioneer building are not where they need to be in order to get licensed. We provided an attachment with the line items for the budget including electrical, plumbing, and sprinklers. We have some funding sources, which are at the bottom of the sheet. We've been very aggressive with all grant opportunities. We do have a 15% contingency built into this request.

Mr. Partridge added this resolution was reviewed and approved in Finance Committee.

Beth Wythe made a motion to approve SPH Resolution 2024-17, A Resolution of the South Peninsula Board of Directors Approving the Use of an Additional $499,500 of Operating Cash to Fund the Already Approved $499,500 of Operating Cash for the Remodel of 203 W Pioneer in Resolution 2024-09 Making the Total Spend for the Project $999,476 to Remodel 203 W Pioneer to Open a Daycare. Matthew Hambrick seconded the motion. A roll call vote was conducted.

Jared Baker	*Yes*
Matthew Bullard	*Yes*
Matthew Hambrick	*Yes*
Melissa Jacobsen	*Yes*
Edson Knapp	*Excused*
Walter Partridge	*Yes*
Preston Simmons	*Yes*
Bernadette Wilson	*Yes*
Beth Wythe	*Yes*
Aaron Weisser	*Yes*

Motion Carried.

10.2. Consideration to Approve the Delineation of Privileges for Reconstruction and Plastic Surgery Privileges as recommended and approved by the Medical Staff

Christina Tuomi, DO, CMO, reported. These privileges were developed for a new surgical specialty, in conjunction with Dr. Ian Wisecarver, in anticipation of his arrival. He worked with Dr. Tuomi and the medical staff office to develop the privileges, which were then approved by the Credentials Committee and the Medical Executive Committee.

Beth Wythe made a motion to approve the Delineation of Privileges for Reconstruction and Plastic Surgery Privileges as recommended and approved by the Medical Staff. Preston Simmons seconded the motion. None opposed. The motion carried.

10.3. Consideration to Approve the Retirement of SPH Board Policy Q-05, Non-Physician Medical Screening Examinations

Ryan Smith, CEO, reported. He and Dr. Tuomi reviewed this policy at the request of the Governance Committee as part of their regular review of board policies. As the hospital has a much more detailed EMTALA policy, this board policy is redundant. We are recommending that the board retire this policy.

Beth Wythe made a motion to approve the retirement of SPH Board Policy Q-05, Non-Physician Medical Screening Examinations. Matthew Hambrick seconded the motion. None opposed. The motion carried.

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10.4. Second Reading/Consideration to Approve Proposed Revision to SPH Board of Directors Bylaws

This is the second reading of a proposed bylaws revision to further clarify and define membership requirements for serving on the Board of Directors.

Beth Wythe made a motion to approve a change in the South Peninsula Hospital Bylaws so that Article III, Section 5 will read as follows:

Qualifications.

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

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

Medical Staff Board Members cannot serve on or have family relationships with members of the Physician Peer Review Committee

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

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

Matthew Hambrick seconded the motion. Motion Carried.

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11. REPORTS

11.1. Chief Executive Officer

Ryan Smith, CEO, reported. The hospital conducted an employee satisfaction survey and we will share those results when we have them. Mr. Smith felt the bond focus groups were successful and very helpful. A Friends of SPH group is being formed, and Ship Creek has been engaged as a PR firm.

11.2. BOD Committee: Finance

Walter Partridge, committee chair, reported. The Finance Committee reviewed three policies. One was placed on the consent agenda, the other two had recommended changes and were forwarded to the Governance Committee. We reviewed the resolution on tonight's agenda, as well as the financials for May. Revenue was mostly driven by outpatient, and revenue was good but expenses were also very high. Health insurance expenses were high for the month. We ended with a -5.8 operating margin.

11.3. BOD Committee: Governance

Beth Wythe, committee chair, reported. The Conflict of Interest policy was updated with primary goals to address clearly and succinctly how conflicts of interest are handled by the board. Matt and Bernie are continuing to do a review of the bylaws, and will bring all any revisions to the September meeting. We're moving forward with reviewing board policies, and completed the CEO evaluation process for the year.

11.4. BOD Committee: Education

Melissa Jacobsen, committee chair, reported. The committee met in June and discussed quarterly education sessions for the board. The committee proposed doing the education sessions prior to the board meeting while eating dinner, but wanted to poll the rest of the members to see if that would work for everyone's schedules. The first education session will be on APOC rules and the hospital bonds. The board members present at the meeting supported the idea of education sessions prior to the full board meetings on a quarterly basis.

11.5. Chief of Staff

Dr. Sarah Roberts, Chief of Staff, introduced herself to the board. She is stepped into the Chief of Staff role when Dr. Christopher Landess stepped down in order to join the Board of Directors. She will serve that role for the next 5 months until the next Medical Election. Dr. Roberts shared she has been with South Peninsula Hospital for 13 years, but is new to the role of Chief of Staff. She is excited to see all the new physicians and services being offered by the hospital.

11.6. Service Area Board Representative

Helen Armstrong, SAB President, reported on behalf of the Service Area Board. The SAB held a special meeting in June to consider the resolution the operating board passed today. The SAB will now take a break for July and meet again in August. Two members are stepping down this year when their terms end - Willy Dunne and Kathryn Ault - so we will be recruiting for new

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members. Mr. Weisser thanked Ms. Armstrong for all her help these past few months.

12. DISCUSSION

There were no 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 thanked Mayor Micciche, Kelly Cooper, Mike Tupper, Brent Johnson and Helen Armstrong for working with the hospital to allow the bond proposition to go out to the voters this year. The bond resolution and property purchases were all unanimous votes at the Assembly and Service Area Board and he appreciates their support of the hospital.

14.2. Board Members

Dr. Landess thanked the board for welcoming him as a part of the team. Ms. Jacobsen welcomed Dr. Roberts to her new role. Mr. Weisser recommended all board members sign up for the hospital briefing emails if they have not yet done so.

15. INFORMATIONAL ITEMS

15.1. Board of Directors Agenda Calendar 2024

The calendar was provided in the packet for informational purposes.

15.2. Upcoming Conferences:

AHHA Annual Conference 2024: September 24-25, 2024 in Girdwood, AK
Rural Healthcare Leadership Conference 2025: February 23-26, 2025 in San Antonio, TX

Links to upcoming conferences were provided for board members' reference. If anyone is interested in attending a conference, please reach out to Ms. Jones in the Administration office.

16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

The board adjourned to Executive Session at 6:25pm.

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

The board moved back into open session at 6:50pm.

17.1. Credentialing

After review of the applicant's files through the secure online portal, Beth Wythe moved to approve the following positions in the medical staff as requested and recommended by the Medical Executive Committee. Edson Knapp seconded the motion. Motion carried.

Appointments
Meghana Kinariwala, MD; Telestroke; Telemedicine privileges only
Amin Rabiei, MD; Telestroke; Telemedicine privileges only
Leah Bassentt, MD; Telepsych; Telemedicine privileges only
Bruce Geryk, MD; Telestroke; Telemedicine privileges only

Ian Wisecarver, MD; Reconstruction & Plastic Surgery; Active Staff
Jessica Jordan, PA-C; Family Medicine PA; Active Staff
Andrew Shacklett, MD; Orthopedic Surgery; Courtesy Staff
Sadie Marden, MD; OB/Gyn; Active Staff

Privilege Requests
Dr. Lucy Fisher, psychiatry, to add Transcranial Magnetic Stimulation (TMS) privileges.

18. ADJOURNMENT

The board meeting adjourned at 6:52pm.

Respectfully Submitted,

Maura Jones, Executive Assistant

Accepted:

Aaron Weisser, President

Minutes Approved:

Mary E. Wythe, Secretary

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DRAFT-UNAUDITED

BALANCE SHEET
As of June 30, 2024

		As of June 30, 2024	As of June 30, 2023	As of May 31, 2024	CHANGE FROM June 30, 2023
	ASSETS				
	CURRENT ASSETS:				
1	CASH AND CASH EQUIVALENTS	24,998,027	26,124,541	26,280,250	(1,126,514)
2	EQUITY IN CENTRAL TREASURY	7,480,333	8,502,601	7,458,475	(1,022,268)
3	TOTAL CASH	32,478,360	34,627,142	33,738,725	(2,148,782)
4	PATIENT ACCOUNTS RECEIVABLE	37,246,852	31,834,920	36,189,004	5,411,932
5	LESS: ALLOWANCES & ADJ	(17,791,087)	(16,801,733)	(17,690,371)	(989,354)
6	NET PATIENT ACCT RECEIVABLE	19,455,765	15,033,187	18,498,633	4,422,578
7	PROPERTY TAXES RECV - KPB	1,129,956	95,078	107,545	1,034,878
8	LESS: ALLOW PROP TAX - KPB	(4,165)	(5,417)	(4,165)	1,252
9	NET PROPERTY TAX RECV - KPB	1,125,791	89,661	103,380	1,036,130
10	OTHER RECEIVABLES - SPH	379,025	366,977	329,223	12,048
11	INVENTORIES	2,034,103	2,130,033	2,061,446	(95,930)
12	NET PENSION ASSET- GASB	3,559,619	3,559,619	3,559,619	0
13	PREPAID EXPENSES	922,205	737,229	1,000,139	184,976
14	TOTAL CURRENT ASSETS	59,954,868	56,543,848	59,291,165	3,411,020
	ASSETS WHOSE USE IS LIMITED				
15	PREF UNOBLIGATED	6,974,645	6,156,930	6,974,645	817,715
16	PREF OBLIGATED	1,662,098	2,112,254	1,662,098	(450,156)
17	OTHER RESTRICTED FUNDS	1,267,923	46,575	1,344,467	1,221,348
		9,904,666	8,315,759	9,981,210	1,588,907
	PROPERTY AND EQUIPMENT:				
18	LAND AND LAND IMPROVEMENTS	4,124,558	4,114,693	4,124,558	9,865
19	BUILDINGS	66,055,624	63,998,829	65,997,328	2,056,795
20	EQUIPMENT	30,290,962	27,858,476	30,258,619	2,432,486
21	BUILDINGS INTANGIBLE ASSETS	3,411,295	2,478,113	3,411,295	933,182
22	EQUIPMENT INTANGIBLE ASSETS	851,479	462,427	851,479	389,052
23	SOFTWARE INTANGIBLE ASSETS	2,135,559	1,986,711	2,135,559	148,848
24	IMPROVEMENTS OTHER THAN BUILDINGS	926,889	311,331	926,889	615,558
25	CONSTRUCTION IN PROGRESS	2,677,231	1,254,244	2,585,594	1,422,987
26	LESS: ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(62,737,309)	(57,325,874)	(62,314,940)	(5,411,435)
27	LESS: ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(1,958,778)	(1,762,115)	(1,896,051)	(196,663)
28	NET CAPITAL ASSETS	45,777,510	43,376,835	46,080,330	2,400,675
29	GOODWILL	0	5,000	0	(5,000)
30	**TOTAL ASSETS**	115,637,044	108,241,442	115,352,705	7,395,602
	DEFERRED OUTFLOWS OF RESOURCES				
31	PENSION RELATED (GASB 68)	5,196,732	5,789,464	5,394,310	(592,732)
32	UNAMORTIZED DEFERRED CHARGE ON REFUNDING	223,835	287,119	231,218	(63,284)
33	TOTAL DEFERRED OUTFLOWS OF RESOURCES	5,420,567	6,076,583	5,625,528	(656,016)
34	TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	121,057,611	114,318,025	120,978,233	6,739,586

		As of June 30, 2024	As of June 30, 2023	As of May 31, 2024	CHANGE FROM June 30, 2023
	LIABILITIES & FUND BALANCE				
	CURRENT LIABILITIES:				
35	ACCOUNTS AND CONTRACTS PAYABLE	2,344,816	1,484,870	2,375,071	859,946
36	ACCRUED LIABILITIES	9,813,952	8,335,462	9,167,119	1,478,490
37	DEFERRED CREDITS	1,223,421	74,840	1,299,248	1,148,581
38	CURRENT PORTION OF LEASE PAYABLE	217,290	504,897	217,290	(287,607)
39	CURRENT PORTION SOFTWARE INTANGIBLE PAYABLE	581,797	488,995	585,084	92,802
40	CURRENT PORTIONS OF NOTES DUE	0	0	0	0
41	CURRENT PORTIONS OF BONDS PAYABLE	1,195,000	1,850,000	1,195,000	(655,000)
42	BOND INTEREST PAYABLE	81,820	100,216	71,577	(18,396)
43	DUE TO/(FROM) THIRD PARTY PAYERS	879,746	938,761	938,653	(59,015)
44	TOTAL CURRENT LIABILITIES	16,337,842	13,778,041	15,849,042	2,559,801
	LONG-TERM LIABILITIES				
45	NOTES PAYABLE	0	0	0	0
46	BONDS PAYABLE NET OF CURRENT PORTION	5,420,000	6,615,000	5,420,000	(1,195,000)
47	PREMIUM ON BONDS PAYABLE	271,851	389,368	285,561	(117,517)
48	CAPITAL LEASE, NET OF CURRENT PORTION	3,203,883	1,912,204	3,250,442	1,291,679
49	SOFTWARE INTANGIBLE LEASE, NET OF CURRENT PORTION	241,257	459,902	260,742	(218,645)
50	TOTAL NONCURRENT LIABILITIES	9,136,991	9,376,474	9,216,745	(239,483)
51	TOTAL LIABILITIES	25,474,833	23,154,515	25,065,787	2,320,318
52	DEFERRED INFLOW OF RESOURCES	0	0	0	0
53	PROPERTY TAXES RECEIVED IN ADVANCE	200,005	495,208	5	(295,203)
	NET POSITION				
54	INVESTED IN CAPITAL ASSETS	5,731,963	5,731,963	5,731,963	0
55	CONTRIBUTED CAPITAL - KPB	0	0	0	0
56	RESTRICTED	25,286	25,286	25,286	0
57	UNRESTRICTED FUND BALANCE - SPH	89,625,524	84,911,053	90,155,192	4,714,471
58	UNRESTRICTED FUND BALANCE - KPB	0	0	0	0
59	**TOTAL LIAB & FUND BALANCE**	121,057,611	114,318,025	120,978,233	6,739,586

South Peninsula Hospital

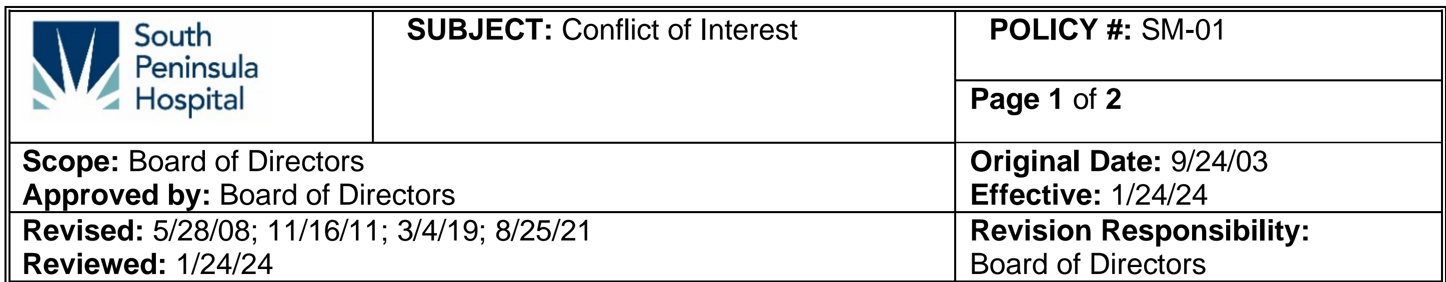
INCOME STATEMENT
As of June 30, 2024
DRAFT-UNAUDITED

		MONTH				YEAR TO DATE			
		06/30/24			06/30/23	06/30/24			06/30/23
		Actual	Budget	Var B/(W)	Actual	Actual	Budget	Var B/(W)	Actual
	Patient Service Revenue								
1	Inpatient	2,619,136	2,590,929	1.09%	2,269,869	33,921,562	31,936,435	6.22%	29,705,256
2	Outpatient	14,901,936	14,904,056	-0.01%	14,454,230	180,723,894	165,909,620	8.93%	153,200,853
3	Long Term Care	1,155,763	1,182,412	-2.25%	1,237,453	13,093,293	14,188,953	-7.72%	13,025,945
4	Total Patient Services	18,676,835	18,677,397	0.00%	17,961,552	227,738,749	212,035,008	7.41%	195,932,054
	Deductions from Revenue								
5	Medicare	4,601,215	4,166,680	-10.43%	4,625,191	50,007,115	41,708,511	-19.90%	39,957,276
6	Medicaid	2,331,824	2,622,437	11.08%	1,808,509	27,628,649	26,250,622	-5.25%	25,745,264
7	Charity Care	38,084	231,756	83.57%	200,897	1,834,705	2,319,877	20.91%	1,997,320
8	Commercial and Admin	1,713,059	1,841,496	6.97%	1,604,258	20,986,333	18,433,397	-13.85%	18,088,416
9	Bad Debt	191,100	308,326	38.02%	719,567	3,876,326	3,086,347	-25.60%	3,204,750
10	Total Deductions	8,875,282	9,170,695	3.22%	8,958,422	104,333,128	91,798,754	-13.65%	88,993,026
11	Net Patient Services	9,801,553	9,506,702	3.10%	9,003,130	123,405,621	120,236,254	2.64%	106,939,028
12	USAC and Other Revenue	111,462	76,689	45.34%	58,347	1,070,793	920,272	16.36%	755,856
13	Total Operating Revenues	9,913,015	9,583,391	3.44%	9,061,477	124,476,414	121,156,526	2.74%	107,694,884
	Operating Expenses								
14	Salaries and Wages	5,280,858	5,264,139	-0.32%	4,780,586	60,245,813	58,854,719	-2.36%	51,627,763
15	Employee Benefits	1,368,475	1,435,439	4.67%	2,119,110	25,501,713	25,276,866	-0.89%	22,905,469
16	Supplies, Drugs and Food	1,222,020	1,117,171	-9.39%	803,607	14,860,556	14,100,260	-5.39%	12,071,414
17	Contract Staffing	300,094	146,463	-104.89%	196,312	2,827,055	1,410,489	-100.43%	2,995,404
18	Professional Fees	783,194	620,105	-26.30%	469,307	7,301,716	6,719,037	-8.67%	6,388,871
19	Utilities and Telephone	171,092	150,577	-13.62%	150,172	2,130,276	1,829,340	-16.45%	1,769,204
20	Insurance (gen'l, prof liab, property)	78,460	71,799	-9.28%	62,435	884,188	877,739	-0.73%	726,647
21	Dues, Books, and Subscriptions	37,978	26,329	-44.24%	20,034	288,495	266,055	-8.43%	225,413
22	Software Maint/Support	136,377	222,071	38.59%	90,014	1,524,331	2,239,142	31.92%	1,939,035
23	Travel, Meetings, Education	79,162	113,663	30.35%	49,677	747,236	1,089,738	31.43%	607,642
24	Repairs and Maintenance	170,336	199,729	14.72%	169,271	2,266,163	1,969,130	-15.08%	1,868,153
25	Leases and Rentals	82,356	62,991	-30.74%	47,744	896,047	888,175	-0.89%	754,629
26	Other (Recruiting, Advertising, etc.)	479,425	155,569	-208.18%	308,839	2,734,170	1,866,997	-46.45%	1,832,655
27	Depreciation & Amortization	429,101	345,139	-24.33%	360,375	4,990,586	4,141,663	-20.50%	4,096,656
28	Total Operating Expenses	10,618,928	9,931,184	-6.93%	9,627,483	127,198,345	121,529,350	-4.66%	109,808,955
29	**Gain (Loss) from Operations**	**(705,913)**	**(347,793)**	**-102.97%**	**(566,006)**	**(2,721,931)**	**(372,824)**	**-630.08%**	**(2,114,071)**
	Non-Operating Revenues								
30	General Property Taxes	65,340	45,999	42.05%	38,798	5,203,620	4,543,798	14.52%	4,933,781
31	Investment Income	77,448	34,521	124.35%	73,327	1,468,797	414,249	254.57%	556,445
32	Governmental Subsidies	0	0	0.00%	0	0	0	0.00%	0
33	Other Non Operating Revenue	0	419	100.00%	338	38,159	5,033	100.00%	8,408
34	Gifts & Contributions	0	0	0.00%	0	0	0	0.00%	0
35	Gain <Loss> on Disposal	331	0	0.00%	0	0	0	0.00%	6,572
36	SPH Auxiliary	0	375	-100.00%	551	5,565	4,500	23.67%	4,376
37	Total Non-Operating Revenues	143,119	81,314	76.01%	113,014	6,716,141	4,967,580	35.20%	5,509,582
	Non-Operating Expenses								
38	Insurance	0	0	0.00%	0	0	0	0.00%	0
39	Service Area Board	0	38	100.00%	987	8,546	25,000	0.00%	100,656
40	Other Direct Expense	15,000	6,056	-147.69%	24,975	82,257	72,677	-13.18%	45,094
41	Administrative Non-Recurring	0	0	0.00%	0	0	0	0.00%	0
42	Interest Expense	24,998	34,394	27.32%	38,346	513,366	412,729	-24.38%	465,840
43	Total Non-Operating Expenses	39,998	40,488	1.21%	64,308	604,169	510,406	-18.37%	611,590
	Grants								
44	Grant Revenue	74,168	67,216	0.00%	25,301	1,334,656	806,596	0.00%	325,619
45	Grant Expense	845	2,501	66.21%	5,736	10,025	30,012	66.60%	33,252
46	Total Non-Operating Gains, net	73,323	64,715	13.30%	19,565	1,324,631	776,584	-70.57%	292,367
47	Income <Loss> Before Transfers	(529,469)	(242,252)	-118.56%	(497,735)	4,714,672	4,860,934	-3.01%	3,076,288
48	Operating Transfers	0	0	0.00%	0	0	0	0.00%	0
49	**Net Income**	**(529,469)**	**(242,252)**	**118.56%**	**(497,735)**	**4,714,672**	**4,860,934**	**-3.01%**	**3,076,288**

DRAFT-UNAUDITED

Statement of Cash Flows
As of June 30, 2024

#			Amount
	Cash Flow from Operations:		
1	YTD Net Income		4,714,672
2	Add:	Depreciation Expense	4,990,586
3	Adj:	Inventory (increase) / decrease	95,930
4		Patient Receivable (increase) / decrease	(4,422,578)
5		Prepaid Expenses (increase) / decrease	(184,976)
6		Other Current assets (increase) / decrease	(1,048,178)
7		Accounts payable increase / (decrease)	572,339
8		Accrued Salaries increase / (decrease)	1,478,490
9		Net Pension Asset (increase) / decrease	1,341,756
10		Other current liability increase / (decrease)	1,071,170
11	Net Cash Flow from Operations		8,609,211
	Cash Flow from Investing:		
12		Cash paid for the purchase of property/equip	(8,008,773)
13		Cash transferred to plant replacement fund	(711,889)
14		Proceeds from disposal of equipment	-
15	Net Cash Flow from Investing		(8,720,662)
	Cash Flow from Financing		
16		Cash (paid) / received for Lease Payable	(69,331)
17		Cash paid for Debt Service	(1,968,000)
18	Net Cash from Financing		(2,037,331)
19	Net increase in Cash		$ (2,148,782)
20	Beginning Cash as of July 1, 2023		$ 34,627,142
21	Ending Cash as of June 30, 2024		$ 32,478,360



South Peninsula Hospital	**SUBJECT:** Conflict of Interest	**POLICY #:** SM-01
		Page 1 of **2**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** 9/24/03 **Effective:** 1/24/24
Revised: 5/28/08; 11/16/11; 3/4/19; 8/25/21 **Reviewed:** 1/24/24		**Revision Responsibility:** Board of Directors

PURPOSE:

To protect the organization and board members by providing guidance for reducing or eliminating the ~~Compliance requirements for Board members to report~~ potential of ~~or~~ actual and perceived conflicts of interest.

DEFINITION(S):

Actual conflicts of interest include, but are not limited to:

a. Being employed by South Peninsula Hospital (SPH), or having family member(s) that are employed by SPH,
b. Receiving, or having a family member that receives direct or indirect transactions which are reportable on Form 990, Schedule L including loans, excess benefit transactions, grants assistance or business transactions.
c. Being employed by, or an officer for any related organization,
d. Other activities or associations that may create a direct or indirect conflict

Family members include spouse/domestic partner; brother or sister (by whole or half-blood); spouses/domestic partners of brothers or sisters (by whole or half-blood); ancestors, children (including legally adopted); grandchildren, great grandchildren, and spouses/domestic partners of children, grandchildren, and great grandchildren.

Excess benefit transactions are those in which remuneration to an individual or business exceeds the value of the services provided.

Related organizations are organizations that stand in a parent/subsidiary relationship, brother/sister relationship, or supporting/supported organization relationship.

Potential conflicts of interest may include, but are not limited to:

a. Close personal relationships with individuals that are covered by the items listed above, or
b. Activities or relationships that may appear to be covered by the items listed above.
c. For additional considerations for physician board members see Attachment A.

~~N/A~~

POLICY:

A. Board service carries with it a requirement of loyalty and fidelity to the hospital. It is the responsibility of the members of the board to govern the hospital's affairs honestly and economically, exercising their best care, skill, and judgment for the benefit of the hospital.
B. Any duality of interest or possible conflict of interest can best be handled through full disclosure of such interest, together with abstention from any discussion or vote where the interest is involved.
C. Each board member is responsible for identifying actual or perceived conflicts of interest at the appointed time on the agenda.
D. A board member who believes another member has a conflict or personal interest and hasn't disclosed it, may move that the member has a conflict so the board can discuss the matter.
~~B.~~

PROCEDURE:

1. The board has identified potential conflict of interest situations in the "Conflict of Interest Questionnaire." Candidates for appointment shall complete the questionnaire prior to appointment. Responses to the questionnaire will be considered by the board when evaluating candidates.
~~2.~~ Any duality of interest or possible conflict of interest on the part of board members will be disclosed to the other members of the board and made a matter of record, annually or when the interest becomes a matter of board action. Members will file a Conflict of Interest Questionnaire at the Annual Meeting each January.
2. Any board member having a duality of interest or possible conflict of interest on any matter will not participate in discussions regarding the matter or vote ~~or use his/her personal influence~~ on the matter. He/she

must leave the room prior to the discussion and vote, and will not be counted in determining the quorum for the vote and must leave the room prior to the vote. The minutes of the meeting will reflect that a disclosure was made, the abstention from votingabsence from the room, and the quorum situation. The minutes will reflect the return of the member to the room following the completion of the discussion and vote.
3.
3. The foregoing requirements will not be construed as preventing the board member from stating his/her position in the matter, nor from answering pertinent questions of other board members, since his/her knowledge may be of assistance.
4. Following the declaration of conflict, a motion and second will be made that the member has a conflict of interest. The Board may discuss the matter and ask questions of the conflicted member. Following the discussion, a roll-call vote of the remaining board members will be taken. The conflicted member will not vote. If the motion passes, the member deemed to have a conflict must leave the room while the board takes up the matter. This process will also be followed when a board member identifies a conflict or potential conflict of another board member.
4.5.

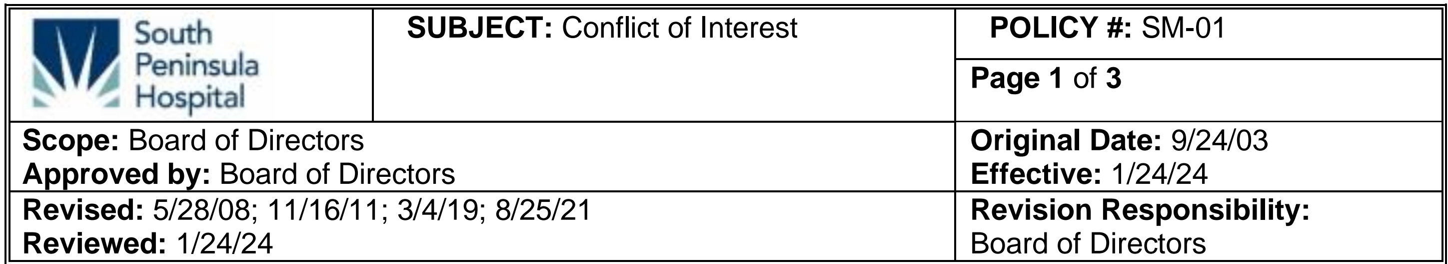
ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
1. IRS Form 990

CONTRIBUTORS:
Governance Committee, Board of Directors

South Peninsula Hospital, Inc. Operating Board (“the Board”) recognizes the value of including Medial Staff members on the Board, therefore, up to two Board seats may be filled by Medical Staff members.

- Physician (Medical Staff) Board Members will represent the mission, goals, and values of SPH and bring the knowledge of medicine, clinical experience, public health and the medical community to the Board.
- Medical Staff Board Member candidates will apply for open seats using the standard candidate application procedures.
- Physician Board Members will not serve in officer roles on the Board
- Physician Board Members will follow the conflict-of-interest procedures and will additionally be recused from the following Board decisions:
  - Physician compensation including pay for performance considerations
  - CEO compensation
  - Approval of the annual audit
  - Legal matters of which the Physician or a family member is the subject
- Physician Board Members cannot serve on or have family relationships with members of the Physician Peer Review Committee
- Physician Board Members may not be employed in Chief Executive positions with SPH.



South Peninsula Hospital	**SUBJECT:** Conflict of Interest	**POLICY #:** SM-01 **Page 1** of **3**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** 9/24/03 **Effective:** 1/24/24
Revised: 5/28/08; 11/16/11; 3/4/19; 8/25/21 **Reviewed:** 1/24/24		**Revision Responsibility:** Board of Directors

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POLICY:

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B. Any duality of interest or possible conflict of interest can best be handled through full disclosure of such interest, together with abstention from any discussion or vote where the interest is involved.
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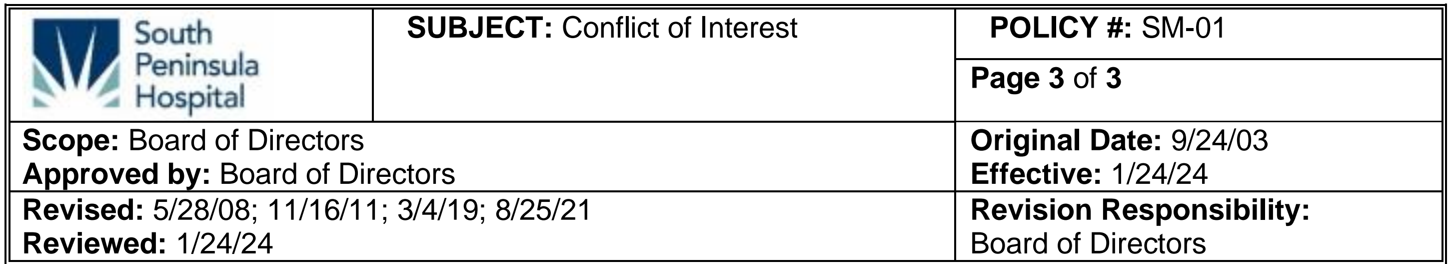
ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
1. IRS Form 990

CONTRIBUTORS:
Governance Committee, Board of Director



South Peninsula Hospital	**SUBJECT:** Conflict of Interest	**POLICY #:** SM-01
		Page 3 of **3**
Scope: Board of Directors **Approved by:** Board of Directors		**Original Date:** 9/24/03 **Effective:** 1/24/24
Revised: 5/28/08; 11/16/11; 3/4/19; 8/25/21 **Reviewed:** 1/24/24		**Revision Responsibility:** Board of Directors

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    - CEO compensation
    - Approval of the annual audit
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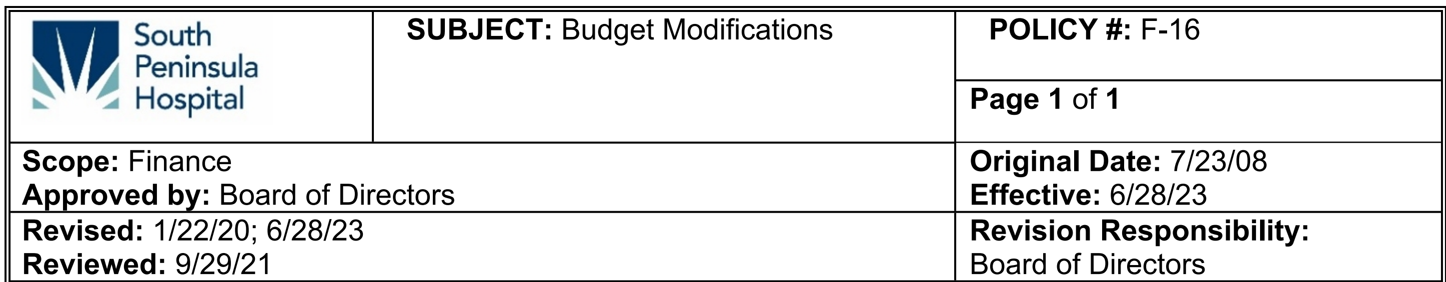

South Peninsula Hospital	**SUBJECT:** Budget Modifications	**POLICY #:** F-16 **Page 1** of **1**
Scope: Finance **Approved by:** Board of Directors		**Original Date:** 7/23/08 **Effective:** 6/28/23
Revised: 1/22/20; 6/28/23 **Reviewed:** 9/29/21		**Revision Responsibility:** Board of Directors

PURPOSE:
Requirements for budget approval based on spending levels.

DEFINITION(S):
N/A

POLICY:

A. Capital Budget
    1. It will be the policy of the Board of Directors of South Peninsula Hospital (SPH) that any unbudgeted capital assets equal to or exceeding $200,000 individually or projects which exceed $200,000 in total must be approved by the Board.
    2. The Board will receive a list of all capital asset purchases including all unbudgeted capital, on a monthly basis.

B. Operating Budget
    1. It will be the policy of the Board of Directors of SPH that any operating budget modifications in excess of $200,000 be approved by the Board.
    2. Adoption of budget modifications to the operating budget will be by resolution with a roll call vote.
    3. Request to amend the operating budget will identify the need and account involved.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

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

CONTRIBUTOR(S):
Board of Directors

SOUTH PENINSULA HOSPITAL HOMER, AK – MEDICAL STAFF DEVELOPMENT PLAN
Approved by the Board of Directors December 19, 2018

Retire

	CATEGORY 1	CATEGORY 2		CATEGORY 3	EXCLUSIVE CONTRACT	GOAL	COMMENTS
	Recruitment	Open	Open with Limits	Closed			**Population Service Area – 14,000 Residents**
Primary Care							
Family Practice (Physicians in this category also cover: Internal Medicine OB/GYN Hospitalist Pediatrics ER Medicine			X			Projected need of .8 for Med Director's * schedule cut-back	Need more full time physicians. Active Staff: William Bell * Medical Director Rob Downey Functional Medicine – outpatient only Giulia Tortora Teresa Johnson (part time - .5 FTE) Sarah Roberts (part time - .8 FTE) Christy Martinez Christina Tuomi
Nurse Practitioner				X			Use nurse practitioners to supplement the family practice and Functional Medicine physicians in focusing on services and clinical excellence.
Note: When evaluating the need for primary care in Homer in particular family practitioners, it must be considered that the family practice scope of practice is very traditional in that family practitioners in Homer conduct outpatient clinics, they do pediatrics, internal medicine, take on-call guidance for OB at times, they sometimes function as hospitalists for inpatient care, and some family practitioners work as ER physicians. Therefore, their many functions must be considered in calculating the need for family practice and thereby lessening some of the need for internal medicine and pediatrics. However, we are having more clinic demand and find we may need to have separate hospitalists to address the inpatient/rounding needs.							
Geriatric Medicine (LTC)			X				Paul Eneboe (nursing home practice only) Rob Downey
Medicine							
Addiction Medicine			X				Sarah Spencer – Ninilchik only
Anesthesiology	1 FTE					24/365	Active Staff: 2.6 FT CRNA's
Cardiology			.3 FTE X				Courtesy Staff: William Mayer (once/quarter) Rotating providers for cardiology and pacemaker/device clinics
Dentistry		X					Courtesy Staff: Brandon Astin Vickey Hodnik Jay Marley Susan Polis
Dermatology			.35 FTE X				
ER Physicians				X		24/365	Active Staff: Christopher Landess, Med Director Martha Cotten (part time) Paula Godfrey Roger Martinez Robert Gear Angus Warren Paul Davis Jim Cisek 30 24-hr shifts or 60 12-hr shifts – more than half ER physicians, up to 30 – 40% Family Practice physicians

Retire

	CATEGORY 1	CATEGORY 2		CATEGORY 3	EXCLUSIVE CONTRACT	GOAL	COMMENTS
	Recruitment	Open	Open with Limits	Closed			
Medicine (cont'd)							
Gastroenterology				X			Covered by two general surgeons
Hospitalist				X		Prefer to use Family Practice Hospitalists	Dr. Ross Dodge .2
Infectious Diseases				X			Population base too small
Lipidologist / Diabetes Internal Medicine				X		4 - 5 times/mo.	Courtesy Staff: J Ross Tanner 2 - 3 times/mo.
Nephrology			. 2 FTE X			"Should" Have	
Neurology			.3 FTE X			6 - 8 times/month	Graham Glass Marcie Troxell 2 – 4 times/month collectively Robert Lada Need more Neurology coverage
OB/GYN				X		"Must" Have 1.5 FTE	Katie Ostrom – 1 FTE as Medical Director Renda Knapp 0.5
Oncology				X		"Must" Have 2 – 3 times/mo.	Darren Mullins - twice/month
Optometrist				X		Provides backup for on-call Ophthalmologist	Courtesy Staff: Andrew Peter
Pathology				X	X		Courtesy Staff: Randy Van Antwerp
Pain Procedure Mgt.				X	X		Active Staff: Maureen Filipek Edson Knapp
Pain – Medical Pain Mgt.		X					
Pediatrics			X				Family Practice doctors perform Pediatrics Part time open; also have Allergy/Asthma Pediatric NP
Physical Medicine & Rehabilitation				X		Not needed	Population base too small
Podiatry		X	.			"Should" Have 4 times/mo. + surgery	Danny Romman, DPM – once month
Pulmonology				X		3 - 4 times/mo.	Courtesy Staff: Marek Martynowicz – 3 - 4 times/mo.

Retire

	CATEGORY 1	CATEGORY 2		CATEGORY 3	XCLUSIVE ONTRACT	GOAL	COMMENTS
	Recruitment	Open	Open with Limits	Closed			
Medicine (cont'd)							
Psychiatry						"Must" Have Full Time need, currently filled by two providers	Courtesy Staff: Donna Rollins, RPMHNP-BC, RN, Psychiatric NP, fulfills a partial need Rona Haberman, LCSW – Mental Health Counselor
Radiology				X	X		Active Staff: Maureen Filipek Edson Knapp
Rheumatology			.1 FTE X			"Should" Have - 1 – 2 times/mo.	
Sleep Medicine				X	X	2 – 3 times/mo.	Peak Neurology & Sleep Medicine Graham Glass Ross Dodge 1 – 2 times/mo.
Surgery							
Colon / Rectal Surgery				X			Some performed by General Surgeons
General Surgery				X		Also cover gastroenterology and colon/rectal	Active Staff: Todd Boling Greg Hough
Neurosurgery				X			Not service capable yet – population base too small
Ophthalmologist				X			Active Staff: Garrett Sitenga
Orthopedics				X		"Must" Have	Active Staff: Brent Adcox Use Locums for vacation/weekend coverage Jones/Laudermilch/Driftmier
Otolaryngology (ENT)				X		3 - 4 times/mo.	Courtesy Staff: Donald Endres Dwight M. Ellerbe Stephen B. Schaffer Mark Lorenz
Plastic Surgery			X				
Urology				X		"Must" Have; need 4 times/mo.	Courtesy Staff: Wesley Turner Jeffrey Simerville Robert Cadoff
Vascular Surgery			X				Not service capable yet – Population base too small

DEFINITIONS:

Recruitment: Open or Open with Limits; SPH, Inc. resources will be used to fill this category.
Open: SPH, Inc. resources may be used to fill this category
Open with Limits: SPH, Inc. resources may be used to fill this category.
Considerations include: Existing services; facility availability; capacity; necessary medical equipment; community need and qualifications
Closed: Services not needed.

Retire

Need for Physician Specialties based on National Population Standards

Practice	National Avg. Pop to Support	Homer Needs [1] (13,899 pop.)	Providers w/ SPH Privileges [1]	Variance
Family Practice [2]	1:3,600	3.9	5.3	1.4
Internal Medicine [2]	1:5,400	2.6	0	(2.6)
OBGYN [2]	1:12,000	1.2	1.5	0.3
Pediatrics [2]	1:11,000	1.3	0	(1.3)
Allergy	1:85,000	0.16	0	(.16)
Anesthesiology	1:7,400	1.9	2.6	0.7
Cardiology	1:33,000	0.4	0.1	(.30)
Dermatology	1:40,000	0.35	0	(0.35)
Diabetes/Lipidology	1:100,000	0.2	0.2	0
Emergency Medicine		5[3]	5	0
Gastroenterology [4]	1:30,000	0.46	0	(0.46)
Neurology	1:35,000	0.40	0.10	(0.30)
Nephrology	1:70,000	0.2		
Psychiatry	1:7,000	2.0	1.8	(0.2)
Pulmonary Diseases	1:30,000	0.46	0.2	(0.26)
Hematology/Oncology	1:40,000	0.33	0.1	(0.23)
General Surgery [4]	1:9.000	1.5	2.0	0.5
Neurosurgery	1:100,000	0.13	0	(0.13)
Ophthalmology	1:20,000	0.65	0.5	(0.15)
Orthopedic Surgery	1:13,000	1.1	1	(0.1)
Otolaryngology (ENT)	1:40,000	0.35	0.2	(0.15)
Plastic	1:80,000	0.17	0	(0.17)
Podiatrist	1:28,000	0.46	0	(0.46)
Radiology	1:10,000	1.3	1	0.3
Thoracic	1:70,000	0.2	0	(0.2)
Urology	1:30,000	0.43	0.3	(0.13)

Sources: Health Leaders Guide 2009

[1] These numbers represent full time equivalent providers, not number of individual providers.

[2] Family Practice, Internal Medicine, OB and Pediatrics need to be considered as a primary care group need. When no Internal Medicine, OB, Pediatrics or too few, there will be a need for more Family Practice.

[3] Emergency Physicians cover 60 shifts/month resulting in need of 5 full time providers

[4] Some of our General Surgeons are part-time. Additional local Surgeons not affiliated with the hospital have an impact also. Our General Surgeons cover Gastroenterology and some Colon/Rectal Surgery.

Retire

MSO-007 Medical Staff Development Policy

SOUTH PENINSULA HOSPITAL

```
POLICY #: MSO_007
SUBJECT: MEDICAL STAFF DEVELOPMENT POLICY
SCOPE: MEDICAL STAFF
APPROVED BY: BOARD OF DIRECTORS
APPROVAL DATE: 02-25-2015
Revised:  11-17-2015; 02-25-2016
RESPONSIBLE DEPT.: ADMINISTRATION / BOARD OF DIRECTORS
```

PURPOSE

The purpose of this Policy is to develop and maintain at South Peninsula Hospital and its related facilities (the "Hospital") a medical staff comprised of physicians and other practitioners who are committed to support and use this Hospital, who are committed to its community and its mission, vision and values and who are highly qualified and capable of supporting that mission and exemplifying the values. The Policy has been developed because of the Hospital's commitment to provide year round quality health care service to its community. Specifically, in meeting this goal, the Hospital must consider the following:

1. The Hospital is committed to providing year round quality health care. This involves not only appropriate utilization of facilities and hospital services, but also the selection and retention of highly qualified practitioners on its medical staff.
2. As part of its commitment, the Hospital must have some means of monitoring and evaluating the quality of care. To assist in meeting this responsibility, initial review, ongoing evaluation, and recommendations concerning year-round quality of care and professional qualifications of practitioners are delegated to the medical staff.
3. To meet its commitment, the Hospital must remain financially viable, appointing a medical staff committed to an appropriate utilization of its facilities and services.

Therefore, in determining what practitioners should be included on the medical staff, the Hospital must consider the practitioner's specialty, training, background and qualifications, commitment to and use of the Hospital's facilities, and willingness to assist the Hospital in monitoring and evaluating the year-round quality of care rendered at the Hospital and its related facilities.

This Policy is designed to direct medical staff growth in response to the need for professional services within the Hospital and the community it serves. Therefore, the implementation of this Policy and the Medical Staff Development Plan will be reassessed at least annually. The Hospital will consistently evaluate the health needs of the population in the hospital service area and those we serve from outside the service area (referred to collectively as the service population), the manner in which those services can be provided most efficiently and economically, and the number and kinds of practitioners on the medical staff required to best provide those services.

Retire

The Medical Staff Development Committee and the Board will be watchful and mindful of significant trends in the delivery of health services and will develop the medical staff accordingly. In particular, medical staff development will incorporate the following endeavors:

1. the Hospital will work to maintain a balance of primary and specialty services to meet the requirements of the community; and
2. the Hospital will seek to grow through the continued addition of practitioners who are willing to work harmoniously, cooperatively and positively with the Hospital to continue to meet the needs of the service population it is committed to serve.

Decisions relative to this Policy and the Medical Staff Development Plan shall be made by the Board, recusing any physician Board members, after seeking the recommendation of its Medical Staff Development Committee. Physician input is essential as one of the Committee's many considerations. Such input shall be solicited as part of each periodic review of the Plan and will be welcomed by the Medical Staff Development Committee at any time.

All of the foregoing are designed to maintain the Hospital as a dynamic institution with the resources and facilities to provide the year-round quality health care its community needs and deserves.

DEFINITION

Medical Staff Development Committee will be comprised of all seated board members of the SPH Operating Board of Directors excluding any practicing physicians.

The Board may appoint an Advisory Group comprised of no less than three board members, the CEO and three physicians of diverse employment representation, to support the work of the committee. This Advisory Group will have no voting rights.

ARTICLE 1

GUIDELINES FOR DETERMINING NEED FOR

PRACTITIONERS AS AN EXTENSION OF

THE HOSPITAL'S STRATEGIC PLANNING PROCESS

1. The Board will review annually the current analysis of community need, hospital utilization and medical staff needs. That analysis will be collected by the Medical Staff Development Committee and will include a specialty-by-specialty report on the need for additional practitioners, the criteria or qualifications of the practitioners sought, and recruitment priorities. This analysis is referred to as the Medical Staff Development Plan, which will be adopted by the SPH Board of Directors.
2. Specialties may be designated as one of the following categories:
   1. "Recruitment"

Retire

    2. “Open” and “Open with limits” and
    3. “Closed” as defined by the Medical Staff Development Plan.
3. A category (3) specialty does not automatically open when a practitioner in that specialty leaves. A category (3) specialty only opens when, upon recommendation of the Medical Staff Development Committee, the Board has determined that there is a need in the Hospital and in the community for an additional practitioner(s) in that specialty and the most appropriate manner in which to meet that need, including the qualifications of any potential applicants.
4. If and when a category (3) specialty opens and becomes a category (1) or (2) specialty, practitioners who inquire at that time will be informed that the Hospital will grant privileges up to the number of practitioners who meet certain defined qualifications determined to be appropriate for the needs of that specialty, as determined by the Board, based on the Medical Staff Development Plan.
5. Each determination shall be based on the Hospital’s need or plan to:
    1. provide better or more comprehensive services;
    2. maximize utilization of its facilities; and
    3. enhance its financial viability and thus its ability to serve.
6. The Strategic Plan shall be reviewed to determine:
    1. what new services should be offered;
    2. what services should be phased out;
    3. what services should be expanded or reduced;
    4. what additional specialties are needed; and
    5. what geographic or demographic areas should be served.
7. The reports and information provided by each department chair are critical to the periodic reevaluation of practitioner utilization and medical staffing needs. The Medical Staff Development Committee or its designated representative shall solicit information from time to time from physician leadership regarding hospital and patient needs. Information sought will relate to perceived needs within the Hospital and community generally.
8. Active Staff practitioners shall be surveyed periodically to determine their views on services needed, current utilization of facilities and medical staffing needs.
9. The Hospital President and CEO or his designee shall report to the Medical Staff Development Committee regarding:
    1. the role of the Hospital in the community;
    2. its strengths and weaknesses as he perceives them;
    3. how well community needs are served;
    4. what fewer or additional services should be provided;
    5. current Hospital utilization; and
    6. the contribution margin (net revenues-expenses) of the areas of service.
10. Utilization statistics on a practitioner-specific basis should be available for the Medical Staff Development Committee’s review.
11. Surgeons who come from out of town to assist our local surgeons with specific complicated cases, would not be counted in our Medical Staff Development Plan as their assistance would only be as needed, and would not fill a regular position in the long term needs of the community.

Retire

ARTICLE 2

PROCESS FOR COMMUNICATING WITH APPLICANTS AND

POTENTIAL APPLICANTS AND FOR REVIEWING APPLICATIONS

1. **Threshold Criteria Development** Threshold criteria and general qualifications for appointment [reappointment] and clinical privileges are included in Article 3 of this Policy. Additional criteria will be developed from time to time as follows.
    1. Upon input from physicians, other providers on the staff, and department managers, the Board will recommend to the Medical Staff Credentials Committee appropriate qualifications for the practice of each specialty or subspecialty.
    2. The recommendations of department or committee chairs shall be forwarded to the Medical Staff Credentials Committee, which shall review, amend and revise them as necessary to eliminate conflicts or inconsistencies among departments, or with Hospital or medical staff bylaws or policies. The Medical Staff Credentials Committee may also consult with others when necessary.
    3. The Medical Staff Credentials Committee's recommendations shall be forwarded to the Medical Executive Committee, which shall consider the criteria and forward its recommendations to the Medical Staff Development Committee.
    4. The Medical Staff Development Committee shall prepare final recommendations to submit to the Board for approval.
2. **Process for Practitioners Seeking Clinical Privileges**
    1. When a practitioner requests an application in a category (1) or (2) specialty, a pre-application form and the threshold criteria shall be sent to the practitioner, with a letter advising that the form be completed and submitted, to the CEO or Medical Staff Office within 30 days.
    2. When a practitioner requests an application for staff privileges in a specialty that is designated as category (3), the practitioner will be advised that the Hospital is not currently accepting applications in that specialty, but that the Board periodically reevaluates the need for practitioners in each specialty. The practitioner should be advised to inquire again at a later time. A list of those persons shall be maintained.
3. **Pre-Application Process**
    1. The purpose of the pre-application screening is to determine if the potential applicant satisfies the threshold criteria referenced in Article 2 of this Policy. If the CEO or a designee determines that the potential applicant meets the threshold criteria, an application form (See Appendix A1) shall be provided, and the practitioner shall be requested to return it, along with the application fee, within 30 days to the Medical Staff Office. An interview with the potential applicant may be conducted by the CEO or his designee. The purpose of the interview is to discuss and review any aspect of the potential applicant's qualifications.
    2. If the CEO or a designee determines that the practitioner does not meet such threshold criteria, the practitioner will not be provided an application form and shall be so notified. Such individual shall not be entitled to the hearing and appeal

Retire

process provided in the medical staff bylaws, but may request a verbal explanation of the refusal from the CEO or designee.

4. Application P[illegible]

1. Applications deemed to be complete shall be considered in accordance with the procedures set forth in the medical staff bylaws, except as described herein.
2. Candidates with completed and approved applications will be sent an Approval to Medical Staff Letter and an Appointment Contract which must be signed and returned before the appointment becomes effective (see Appendix A2 and A3).
3. If the Medical Executive Committee's recommendation is that an applicant is unqualified for staff appointment and clinical privileges, the applicant shall be so notified in accordance with the medical staff bylaws. The hearing and appeals procedures outlined in the medical staff bylaws shall then apply.
4. If the number of qualified applicants exceeds the number of openings in a particular specialty, the Medical Staff Credentials Committee shall recommend which applicant(s) is (are) best qualified for the position(s) available by considering each applicant's education, training, experience, commitment, and willingness to cooperate and harmoniously work with staff at the Hospital (based on individual interviews). The Medical Staff Credentials Committee's recommendation shall be forwarded to the MEC and on to the Board for final action.
5. Applicants who are not selected to fill the limited number of openings shall be advised in writing that:
    1. the specialty in which they sought clinical privileges is once again closed;
    2. the need for practitioners in that specialty will be reevaluated in the future;
    3. applications will be kept on file for two years and will be considered if and when the specialty reopens; at that time, each applicant will be notified of the number of openings available and will be asked to update his or her application if interested; and

Deferral of an application is not a denial and not reportable to the National Practitioner Data Bank or the state medical board.

ARTICLE 3

GUIDELINES FOR EVALUATING CANDIDATES

FOR PRIVILEGES IN OPEN SPECIALTIES

1. **Fiduciary Obligation** The Hospital has set a goal of providing effective and efficient health care services that are accessible to the community. This duty involves the Hospital's services and facilities and the selection and retention of qualified practitioners on the medical staff who share the Hospital's commitment to the community. Specifically, as part of this duty, the Hospital has the following obligations to the community:
    1. to select and retain qualified practitioners who are:
        1. able to provide timely, year round care to their patients;

Retire

        2. committed to care for all Hospital patients, regardless of their ability to pay;
        3. committed to actively utilize the Hospital's facilities, so as to permit the ongoing monitoring and evaluation of their practices; and
        4. willing to make an active commitment to assist the Hospital in continually overseeing and improving the Hospital's facilities and services;
    2. to have appropriate facilities and equipment and ensure that they are used efficiently and cost-effectively by selecting and retaining only those clinically competent practitioners who intend to use them appropriately; and
    3. to continually monitor the quality of the services that the Hospital provides.
2. **Threshold Criteria** Only those applicants who satisfy the following threshold criteria shall be eligible to apply for medical staff appointment [reappointment] and clinical privileges at the Hospital.
    1. The potential applicant must meet the general qualifications as stated in the SPH Medical Staff Bylaws.
    2. The potential applicant must be able to comply with the SPH Medical Staff Rules and Regulations.
    3. The potential applicant must be able to support / align with SPH values and behaviors.
    4. The potential applicant must have no unusual malpractice litigation history
    5. The potential applicant must have no significant history of disciplinary action or revocation, suspension or restriction of clinical privileges at this Hospital or any other hospital.
    6. The potential applicant must not have any history of disruptive behavior.
    7. The potential applicant must be willing to actively utilize the Hospital's facilities so as to permit reasonable monitoring and evaluation of his/her practice in accordance with the Hospital's quality assessment/performance improvement plan and to promote and ensure familiarity with the Hospital's facilities and practices.
    8. The potential applicant must not have an ownership interest in, contract with, or be employed by an entity that would cause his or her interests to be in conflict with the Hospital's commitment to the community or provide incentives for the practitioner to refer patients to other facilities for reasons unrelated to patient preference or medical needs.
    9. The potential applicant must be proficient in the use of relevant technology, such as EHRs, etc.
    10. Potential applicants must be willing to abide by all best practice, quality core measures and provide thorough documentation.
3. **Priorities When Multiple Applicants Exist for Limited Openings**

- **Priority Rank 1**: An applicant replacing a productive staff member who has had a long history of meritorious service at the Hospital, provided that both the new and replaced practitioners generally practice only at this Hospital. This applicant would replace a member of an active group or take over the practice of an existing sole practitioner.
- **Priority Rank 2**: An applicant joining an individual or group presently holding medical staff appointment and privileges at the Hospital, provided that both the existing member or group and the applicant generally practice only or principally at this Hospital.

Retire

- **Priority Rank 3**: An applicant joining an individual or group who or which does not generally practice only or principally at this Hospital, but who has a significant percentage of his or its practice at this Hospital, or an applicant in solo practice recently established in close proximity to the Hospital and who intends to practice generally only at this Hospital.

APPENDIX A.1

APPLICATION CONTRACT

Your signature on this application signifies that you agree to the following conditions of application to the medical staff of South Peninsula Hospital:

- I have the burden of producing adequate information as requested by South Peninsula Hospital, for proper evaluation of my professional training, experience, clinical competence, ethics and other qualifications. I agree to assist, in every way possible, this medical staff and its representatives in gathering the information necessary to determine my qualifications. It also signifies I am willing to appear for interviews in regard to this application. I understand failure by me to timely complete the application form will cause it to be considered incomplete.
- I agree to pay Medical Staff dues and assessments and acknowledge responsibility for timely payment.
- I pledge to provide for continuous quality care in a reasonably efficient manner for my patients.
- I Agree to exhaust all remedies available under these Medical Staff Bylaws before commencing a legal action against the Medical Staff or any committee or Member of the Medical Staff, or against the Hospital for any investigation or action taken in accordance with the provisions of the Medical Staff Bylaws, the Medical Staff Rules and Regulations or the Corporate Bylaws of the Hospital.
- I agree to immediately inform the Hospital of any changes or developments affecting or changing the information provided in or with my application.
- I agree to report to SPH any changes in physical and mental health status, including any impairment due to chemical dependency that may affect my ability to perform the privileges granted.
- I agree to notify SPH within 30 days, if I receive notification an Adverse Action Report or Medical Malpractice Payment report has been filed on me with the National Practitioner Databank (NPDB).
- I attest all of the information contained in this application is complete, true and accurate to the best of my knowledge, information and belief. I understand that any falsification, misstatement or omission of material facts, whether intentional or not, whether discovered prior to or after reappointment and/or privileges have been granted, will be sufficient cause for termination, denial or revocation of membership and/or privileges.
- I acknowledge I have read and agree to be bound by the Bylaws, Rules and Regulations of the Medical Staff of South Peninsula Hospital.

Retire

Signature: Date:

APPENDIX A.2

APPROVAL TO MEDICAL STAFF LETTER

DATE

DOCTOR NAME ADDRESS

Dear: DOCTOR NAME,

It is my pleasure to inform you that the Board of Directors of South Peninsula Hospital, Inc. has approved your request for reappointment to the Active Medical Staff, of South Peninsula Hospital, from May 28, 2014, through May 28, 2016. A copy of your approval form and privileges granted are enclosed. Your appointment and privileges will become effective upon receipt of the attached signed Appointment Contract. We are delighted that you are part of the South Peninsula medical community and we look forward to working with you in the service of our community.

Sincerely,

Robert Letson, FACHE Chief Executive Officer

Retire

APPENDIX A.3

APPOINTMENT CONTRACT

Dear Dr. _______________:

As you are aware, appointment to the medical staff of South Peninsula Hospital is a privilege, not a right. Therefore, in exchange for the privilege of appointment and in accordance with the best interests of our patients, it is the policy of the Hospital to extend medical staff appointment only to practitioners who have agreed to abide by the bylaws, rules, regulations, and policies of the Hospital. By signing this document and accepting our offer of medical staff appointment, you will contractually obligate yourself to the following:

1. To abide by, and be subject to, the application contract, the terms of the Medical Staff Bylaws, Rules and Regulations of the Medical Staff & Allied Practitioners and all hospital policies.
2. To abide by, and be subject to, the terms of the Medical Staff Development Plan. The Board has developed this Plan to respond to the economic and quality factors that interfere, or have substantial potential to interfere, with the best interests of patient care. We believe that compliance with the Plan is necessary to ensure the long-term success of the Hospital in serving the medical needs of the community.
3. To abide by the following restrictions placed on your practice:

____

____

____

EXECUTION In consideration of my appointment to the medical staff of South Peninsula Hospital, I certify that I have read, am familiar with, and agree to abide by the terms of the Medical Staff Bylaws, Rules & Regulations of the Medical Staff & Allied Practitioners, the Medical Staff Development Plan and all hospital policies. I hereby accept appointment to the medical staff of South Peninsula Hospital and agree to abide by the terms outlined in this Appointment Contract. I understand that my failure to comply with these conditions may render me ineligible to apply for reappointment.

South Peninsula Hospital

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

MEMO

To: SPH Board of Directors

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

Date: July 16, 2024

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

---

The Annual CAH Quality Assessment and Performance Improvement Evaluation provides an evaluation of the quality activities and departmental accomplishments for FY 2024 along with goals developed for FY 2025 that impact the quality of care provided at South Peninsula Hospital (SPH). The Program evaluation also allows the opportunity to review and update current contracts and services offered/utilized as well as key statistics.

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

Recommended Motion: Consideration to Approve the SPH CAH Quality Assessment Performance Improvement Evaluation for FY 2024.

South Peninsula Hospital (SPH)

CRITICAL ACCESS HOSPITAL (CAH)
2023-2024 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT EVALUATION

SOUTH PENINSULA HOSPITAL | 4300 Bartlett Street, Homer, AK 99603

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SOUTH PENINSULA HOSPITAL-CRITICAL ACCESS HOSPITAL
FY 2024 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT EVALUATION

The designation of Critical Access Hospital (CAH) for South Peninsula Hospital (SPH) continues to be beneficial for both the hospital and the service area. The overall annual CAH Program Evaluation of SPH activities for FY 2024 has been completed as indicated in this document per State Operations Manual interpretive guidelines §485.641: Periodic Evaluation and Quality Assurance Review.

I. INTERVAL OF REPORTING PERIOD

This annual Critical Access Hospital Program Evaluation review period coincides with the fiscal year beginning July 01, 2023 and ending June 30, 2024. The hospital was designated Critical Access on August 07, 2008.

II. PATIENT VOLUME AND SERVICES UTILIZED

Acute Care and Swing bed days were 3,180 during this reporting period, a 6% decrease from the prior year. Emergency Department visits increased 6 % from the prior year to 5,823 visits. Other outpatient visits increased 4% from the year prior up to 96,787. The number of births increased 4% from the year prior up to 129 births. Inpatient surgical procedures increased by 24% to 149 surgeries. Outpatient surgical procedures increased 6% up to 1,549 total outpatient surgeries. Imaging procedures experienced a 9% increase in volume: X-Ray increased by 7%, CT scans increased by 12%, Ultrasound increased by 12%, Mammography volume increased by 9%, MRI increased by 13%.

KEY STATISTICS

	2020	2021	2022	2023	2024	% Chg. 2023- 2024
Acute Care Patient Days with Swing Bed	3,196	3,420	3,867	3,373	3,180	-6%
Newborn Deliveries	131	145	138	124	129	4%
Emergency Dept. Visits	4,285	4,382	5,181	5,502	5,823	6%
Surgery Outpatient	1,029	1,327	1,344	1,464	1,549	6%
Surgery Inpatient	267	201	213	120	149	24%
Outpatient visits	77,307	93,961	109,816	92,627	96,787	4%
X-Ray	6,926	7,150	7,812	8,026	8,558	7%
CT Scan	3,469	3,753	4,540	4,782	5,337	12%
Ultrasound	2,765	2,843	2,824	3,017	3,366	12%
Mammography	947	1,250	1,159	1,250	1,365	9%
MRI	1,358	1,513	1,552	1,485	1,684	13%
Imaging Total	15,717	16,852	17,887	18,567	20,320	9%

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III. NEW SERVICES

SPH welcomed new additions to the administrative/management team:

Josie Bradshaw, RN: HMC Manager
Tiffany Park: Imaging Director
Susan Dunson, RN: Infusion Clinic Supervisor
Holley Hightower: Lab Assistant Manager
Daniel Skousen, RT: RT Director
Christine Fontaine RN: Forensics Supervisor

Kamala Austin: Controller
Joanna Fonkert: Childcare Asst. Administrator
Kyle Settles: Childcare Administrator
Melissa Blair: Foundation Director
Susan Dunson, RN: Infusion Clinic Supervisor
Frank Klima, RN: Emergency Super/Trauma Coordinator

- Kurt Mentzer, MD – Orthopedics Physician
- Jenni Godbold, CNM, DNP – West Wing Certified Nurse Midwife
- Jessica Julie, CRNA – Certified Registered Nurse Anesthetist
- Katelynn Bailey, DO – Emergency Physician
- Tyler Haas, MD – Emergency Physician
- Jeremy Serreyn, DO - Emergency Physician Fill-In
- Jasmine Neeno, MD - Emergency Physician Fill-In
- Steven Ferrell, DO - Emergency Physician Fill-In
- Jonathan Bloch, MD – General Surgeon
- Michael Clarke, MD – Lab Medical Director Services
- Alyssa DeConto, MSN, CNM – Certified Nurse Midwife Fill-in
- Hans Amen, DO, Homer Medical Center Family Medicine Physician
- Ragina Lancaster, DO - Homer Medical Center Family Medicine Physician
- Jimin Hwang, ANP Peak Neurology – Sleep Clinic Additional Coverage
- Jaclyn Housley, FNP - Peak Neurology – Sleep Clinic Additional Coverage
- James Andrews, MD – Specialty Clinic, Ears Nose and Throat *(ENT)*
- Musaberk Goksel, MD – Specialty Clinic Oncologist
- David Eilender, MD – Specialty Clinic Oncologist

IV. MANAGEMENT AND DEPARTMENT ACTIVITIES/ACCOMPLISHMENTS

Department Reports – Past year Accomplishments and Highlights, along with FY 2025 Goals and Objectives found in Appendix A

V. SURVEYS

- July 10, 2023: Mammography Quality Standards Act *(MQSA)* Certification: State of Alaska *(SOA),* Food and Drug Administration *(FDA):* Facility Inspection
- August 17, 2023: Alaska VA visit to LTC
- January 03, 2024: Drug Enforcement Administration *(DEA)* registration renewal visit
- February 12, 2024: Offsite review of Life Safety Code waived citations from 11/15/2021 survey SPH CAH found to be in substantial compliance effective 01/31/2024
- February 24, 2024: Fume and Laminar Hood Performance Inspection
- May 13, 2024: Medicare site visit for new location of Home Health

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- May 1-2, 2024: Unannounced Complaint Survey to determine compliance with Federal Medicare/Medicaid participation requirements for CAH. SPH found to be in substantial compliance and no deficiencies found.
- June 06, 2024: Alaska Department of Environmental Conservation *(DEC)* inspection of SPH kitchen.

VI. INPATIENT AVERAGE LENGTH OF STAY

The average length of stay was 3.7 days for this annual reporting period, well within the 96-hour maximum average requirement for CAHs.

VII. NUMBER OF INPATIENT/SWING BED EXCEEDING LIMIT

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

VIII. ON-CALL HEALTH PROVIDERS

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

IX. APPROPRIATE TRANSFERS

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

X. EMERGENCY DEPARTMENT RECORD REVIEW

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

XI. PROCESS UTILIZED TO EVALUATE THE QUALITY OF CARE

The quality of care for South Peninsula Hospital *(SPH)* is evaluated in multiple ways as outlined in the SPH Quality Plan. The SPH and LTC Facility Quality Plan was reviewed and updated, shared with Patient Centered Quality Care Committee *(PCCQC),* and approved May 22, 2024 by the SPH Board of Directors *(BOD).* The LTC Facility QAPI Plan is an addendum to the SPH and LTC Facility Quality Plan and shared with the BOD at their May meeting.

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

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

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SPH participated in Consumer Assessment of Healthcare Providers and Systems *(CAHPS)* surveys for qualifying inpatients of the hospital and clients of Home Health. SPH contracts with Press-Ganey Associates, Inc., for completing CAHPS surveys as well as obtaining patient satisfaction information for outpatient services including Laboratory, Imaging, Rehabilitation, Emergency Room, Ambulatory Surgery and Clinic Services.

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

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

Revision of the SPH and LTC Facility Corporate Compliance & Ethics Program was completed and approved by the SPH Board of Directors on November 29, 2023. The SPH Enterprise Risk Management Plan is undergoing revisions including assessment and prioritization of organizational risks.

XII. HEALTHCARE ASSOCIATED INFECTIONS – APPROPRIATE USE OF MEDICATION

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

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

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

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XIII. CONTRACT SERVICES REVIEW

1. 3M FLUENCY

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

- Fluency for Imaging *(FFI)*: Voice Recognition Software *(VRS)* specifically designed for radiologists that supports imaging reports completion, including signature, at the time of interpretation.
- Aquity Solutions: supports provider transcription services through a contracted, domestic transcription service. SPH Health Information Management staff *(HIM)* manage the Aquity Solutions incoming queue.
- Fluency Direct *(FD):* VRS that supports provider medical care notes completion, including signature, at the time of service.

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

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

2. ALASKA HEART INSTITUTE

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

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

3. ALASKA REGIONAL

Type of Service
Patient Transfer Agreement

Evaluation Comments
Very cooperative and helpful with transfers.

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4. **ALASKA REGIONAL HOSPITAL BLOOD BANK**

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

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

Alaska Regional has Clinical Laboratory Improvement Amendments *(CLIA)* and College of American Pathologists *(CAP)* Certifications.

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

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

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

6. **ALSCO, AMERICAN LINEN DIVISION**

Type of Service
Linen and Uniform Rental Service

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

7. **APPLIED STATISTICS MANAGEMENT**

Type of Service
Applied Statistics Management is a suite of systems offering many programs, three main components; MD Staff, MD-STAT and Virtual Committee. MD Staff is the credentialing software, which includes predefined reports and customizable form letters with complete document tracking, including the ability to build your own custom reports and documents. MD-STAT houses Peer review utilized for tracking

Ongoing Professional Practice Evaluation *(OPPE)* and Focused Professional Practice Evaluation *(FPPE)* as well as rate, rule and cases reviewed. Virtual Committee is the Physician/Advanced Practice Professional *(APP)* facing platform that allows review of data, providing input and meeting management.

Evaluation Comments
Credentialing portion of the software meets the current needs of the organization. The OPPE, FPPE and Virtual Committee continue to be in various stages of development and usage. It is anticipated the OPPE and FPPE portion of the system will be more functional when the organization transitions to EPIC as Evident poses challenges to extracting information from its system.

8. ATHENAHEALTH

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

Evaluation Comments
Necessary and meeting our clinical and billing needs.

9. BLOOD BANK OF ALASKA (BBA)

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

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

Blood Bank of Alaska has CLIA and American Association of Blood Bank *(AABB)* Certifications.

10. BLOODWORKS NORTHWEST

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

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

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11. CENTRAL PENINSULA HOSPITAL

Type of Service
Patient Transfer Agreement

Evaluation Comments
Available, cooperative and responsive as needed.

12. CENTRAL PENINSULA HOSPITAL PATHOLOGY

Type of Service
Pathology Services

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

13. +CIRRUS 340B

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

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

14. CONTRACT PHYSICAL THERAPY AGENCY

Type of Service
Contract Physical Therapy

Evaluation Comments
Physical Therapy *(PT)* required the use of one travel PT this fiscal year.

15. CPSI/EVIDENT

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

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

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16. **CROWDSTRIKE**

Type of Service
Anti-virus

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

17. **DUO**

Type of Service
Multifactor Authentication for remote access

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

18. **ECONET**
Type of Service
Sentinel IPS and IDS (Intrusion prevention system and intrusion detection system)

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

19. **ENT SPECIALISTS OF ALASKA**

Type of Service
Timeshare agreement for ENT Specialists of Alaska to rent space in the Specialty Clinic for their audiologists to treat patients.

Evaluation Comments
This provides a valuable service to the community, which lost its only audiology service when the practitioner passed away.

20. **ENTECH ALASKA, LLC**

Type of Service
Biohazard waste disposal

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

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21. HEALTHSTREAM

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

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

22. HOSPICE OF HOMER

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

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

23. IBOSS

Type of Service
Web filter

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

24. ICOMETRIX

Type of Service
Artificial Intelligence software that is capable of detecting the progress of diseases like multiple sclerosis and dementia in the brain and creating a report for clinicians to help in the treatment of MS and Dementia.

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

25. IMPRIVATA

Type of Service
Biometric Password Management

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

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26. IOWA STATE HYGIENIC LABORATORY – THE UNIVERSITY OF IOWA

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

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

27. KACHEMAK BAY FAMILY PLANNING CLINIC (KBFPC)

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

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

28. KACE

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

Evaluation Comments
Very important process in our cyber security defenses.

29. KEPRO

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

Evaluation Comments
Minimal interaction with this QIO. Policies and communications are updated with their information as required. Starting July 01, 2024, the KEPRO name will change to Ascentra Health although services will be the same.

30. KINNSER/WELLSKY

Type of Service
Electronic medical record for Home Health Department

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

31. MAAS360

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

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

32. MCKESSON (CHANGE HEALTHCARE)

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

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

33. MCN HEALTHCARE (POLICY MANAGER SYSTEM)

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

Evaluation Comments
The system is functional and is easy to use and navigate. SPH continues to utilize a contracted consultant to help update and reorganize policies within the system. The Policy Manager System is dependent upon good internal processes maintaining the email system and training/engagement of the users. This system continues to be of great help with organization of policies, associated documents, forms and protocols.

34. MEDICAL DIRECTOR FOR SPH LAB

Type of Service
South Peninsula Hospital has a contract with Central Peninsula Hospital (*CPH*), Dr. Nicole Nilson and Dr. Mensch, for services as the Medical Director of the Laboratory. When Dr. Nilson left CPH, we contracted with Dr. Nilson directly for Medical Director Services, from November 1, 2023 through April 30, 2024. On May 1, 2024, we resumed contracting with CPH with their new pathologist Dr. Michael Clark. Dr. Nilson had quarterly onsite visits to the SPH laboratory to review Quality Control records, proficiency testing results, and policies and procedures, and Dr. Clark will continue this process.

Evaluation Comments
Dr. Nilson was the Medical Director from May 1, 2022 through April 30, 2024. Dr. Nilson was responsive and timely and our laboratory was pleased with the pathology services received. The transition to Dr. Clark providing these services has been smooth and the expectation is the continuation of high quality service.

35. **MEDICAL SOLUTIONS**

Type of Service
Travel nursing agency

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

36. **MEDICATION REVIEW (TELEPHARMACY SERVICES)**

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

Evaluation Comments
Service continues to function well.

37. **MEDITRAX**

Type of Service
Software enables documentation of employee health surveillance

Evaluation Comments
This program is not fully meeting department needs. Replacement software has been explored and will be requested for next budget.

38. **MEDTRONICS**

Type of Service
Diabetes Insulin Pump Patient Usage Training

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

39. **MIMECAST AT**

Type of Service
Security Awareness Training

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

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40. MONIDA HEALTHCARE NETWORK

Type of Service
Hospital Peer Review Services

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

41. MOUNTAIN PACIFIC QUALITY HEALTH

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

Evaluation Comments
Mountain Pacific provides educational materials at no cost through their website. Mountain Pacific remains an important resource for Core Measure reporting questions.

42. MSDS ONLINE

Type of Service
Computer database for Chemical Safety Data Sheets

Evaluation Comments
Provides 24/7 availability to Chemical Safety Data Sheets as well as a fax backup service. This system meets the organizations current needs.

43. NEWPORT GROUP

Type of Service
Retirement plans record-keeper

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

44. OBIX SYSTEM

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

Evaluation Comments
Essential software service and is satisfactorily meeting our clinical and patient care needs. OB received our free OBIX upgrade in January 2024 and our purchased Uterine Assessment Tool upgrade.

45. OMNIA

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

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

46. OMNIPOD PUMP TRAINING

Type of Service
Diabetes Insulin Pump Patient Usage Training

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

47. POINT CLICK CARE

Type of Service
Electronic medical record for Long Term Care facility

Evaluation Comments
Effective software specialized to meet the needs of Long Term Care at this time.

48. POWERSHARE

Type of Service
PowerShare is a cloud-based platform that allows image sharing via a HIPAA complaint website. This service allows for the sharing of radiology images and reports to patients, disparate institutions and physicians via the Internet.

Evaluation Comments
PowerShare is a 24 hour a day; 7 days a week software program provided by Nuance, a vendor of PACS associated systems. The account with Nuance is a flat rate, which seems better for SPH due to the frequent use of the system. Imaging is very pleased with PowerShare and is currently sending all echocardiograms to Alaska Heart Institute via PowerShare. PowerShare has allowed for the streamlined and timely transfer of images in emergent stroke and trauma consults and transfers.

49. PREMIER

Type of Service
Healthcare Group Purchasing Organization *(GPO)*

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

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50. PRESS GANEY ASSOCIATES, INC.

Type of Service
Data collection of patient satisfaction for patients receiving care as Inpatients or through the Emergency Department, Ambulatory Surgery, Outpatients, Home Health as well as Medical Practice. Press Ganey *(PG)* is also the vendor of choice for SPH HCAHPS and HHCAHPS data collection and reporting.

Evaluation Comments
The voice of the consumer that PG data collection provides SPH is invaluable. PG is effective at collecting feedback through survey and their platform is useful for manipulating and displaying the data. PG will not suppress surveys from going to patients that request not to receive them.

Press Ganey sends out HHCAHPS only via mail. January 2024 Home Health *(HH)* changed our PG surveys and now only send out HHCAHP questions to reduce survey burden with so many questions. The goal is to increase survey responses, capturing Home Health Value Based Purchasing. HHCAHP results are not reviewable independently unless patient clicks a certain box. If a patient wants their name removed from the survey, the entire survey is not viewable. You can only see results on the report that has all surveys grouped together.

51. PROVIDENCE MEDICAL CENTER

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

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

52. QUEST DIAGNOSTICS

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

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

53. QURE4U

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

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

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54. RADIOLOGY CONSULTANTS, INC. (RCI)

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

Evaluation Comments
SPH is receiving night, weekend, and on-site Radiologist coverage from RCI for all modalities except for Mammography. Currently mammography coverage is supplied by Dr. Maureen Filipek when our employed Radiologist is unavailable. RCI has replaced vRad for night and weekend reads (*Nighthawk*), however a contract still exists with vRad as a backup measure.

55. REDSAIL TECHNOLOGIES

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

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

56. RLDATIX

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

Evaluation Comments
Staff are able to electronically submit occurrence reports and track where the occurrence reporting is in the system. This system have been effective in converting to an electronic format but it is time consuming, requiring review and manual tasking to those the report does not automatically process to in the system set-up. The system also requires a staff member to review each report to assess the response to assure follow-up is accomplished and close.

57. RQI PARTNERS, LLC.

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

Evaluation Comments
This service allows for timely certification of staff during onboarding and for ongoing certification renewals.

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58. SEATTLE CHILDREN'S HOSPITAL

Type of Service
Interpretations of Pediatric echocardiograms performed at SPH

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

59. SIMITREE

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

Evaluation Comments
Outstanding service. Helps us with accurate coding and OASIS review to maximize our episodic reimbursement. No changes in quality of service with merger. Helped us through a RAC audit this year and impressed with their attention to detail and prompt services.

60. SPECIALTY CLINIC PRACTITIONERS

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

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

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

61. SPENDMEND 340B

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

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

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62. STATE OF ALASKA LABORATORIES

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

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

63. SUBTLE MEDICAL

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

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

64. TANDEM CLINICAL CENTER

Type of Service
Diabetes Insulin Pump Patient Usage Training

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

65. TEXLA BILLING AND CONSULTING, LLC.

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

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

66. UKG/KRONOS

Type of Service
Human resources information system, timekeeping and payroll system

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

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

67. UNIVERSITY OF WASHINGTON HEMOPATHOLOGY LAB

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

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

68. VACTRAK

Type of Service
Collects and stores vaccination records for Alaska residents

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

69. VIRTUAL RADIOLOGIC (vRad)

Type of Service
Provide supplemental tele-radiology support

Evaluation Comments
vRad provides supplemental and back up teleradiology services via preliminary reporting to SPH employed Radiologist. All radiologists who give preliminary reads on the exams sent to vRad are licensed by the State of Alaska and credentialed by SPH. While vRad is a continuing contract for back up radiology read services, they are used as a read of last resort due to the exceptional service relationship we have developed with Radiology Consultants, Inc. *(RCI).*

70. ZIRMED / WAYSTAR

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

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

71. ZIX

Type of Service
Secure email for confidential information

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

XIV. POLICY MANAGEMENT

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

The SPH organization has a contracted consultant who works under the direction of the Quality Management Director who assists with reformatting approval processes and streamlining the policy approval system. Reorganization and updates within the system continue. The Hospital-Wide Policy Committee, co-chaired by the Director of Quality Management and the Policy Management Consultant, has been effective for review and approval of Hospital-Wide and some Patient Care Services policies that are being considered for change to Hospital-Wide. The committee consists of a core number of individuals with involvement of subject matter experts as needed and meets every two weeks.

XV. EMERGENCY PREPAREDNESS

- Activated Hospital Incident Command Center System *(HICS)/*Emergency Operation Plan *(EOP)*
- Great Alaska ShakeOut *(Facility-wide Participation)*
- Homer Fury Drill- Mass Causality Drill with state partners Code Green held September 29, 2023 *(Tabletop Drill)*
- Hospital Incident Management Team *(HIMT):*
    - Committee continued to have regular meetings
    - Committee reviewed policies and plans related to HIMT
    - Incident Command System *(ICS)* training for committee members *(ICS 300 & ICS 400)*
- Updated Emergency Operation Plan *(EOP).*
- SPH Fire drills as required
- LTC-Fire drills and emergency equipment evacuation training *(Stair Chairs and Med Sleds).*
- Code Silver drill held June 25, 2024 *(Tabletop Drill)*

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APPENDIX A
Department Reports
Annual Accomplishments and Highlights - FY 2024
Goals and Objectives - FY 2025

1) *ACUTE CARE DEPARTMENT*

Acute Care *(AC)* Accomplishments and Highlights FY 2024:

- Four new graduate Registered Nurses brought on by the Preceptor Program.
- Sent two Registered Nurses to wound care training and certification provided by Alaska Hospital & Healthcare Association *(AHHA).*
- Real time data collection for sepsis. Collaborated with Education Department on learning activities, new procedures and equipment.
- Staff led Unit Improvement Council instead of Unit-Based Council for staff identified areas or processes for improvement.

Acute Care *(AC)* Goals and Objectives FY 2025:

- Update and revise department specific policies.
- Grow existing staff skills in Obstetrics *(OB)* & Intensive Care Unit *(ICU)* specialties.
- Continue to hire, train and educate new graduate nurses.
- Continued collaboration with the Education Department for new staff training and the development of equipment and procedural training.
- Continue to recruit and hire permanent staff reducing the need for travelers.
- Work with the Security and Quality Management staff to improve room safety for patients on close observations or a title 47 court ordered hold.
- Utilize results from Press Ganey Employee Engagement Survey to improve areas identified.

2) *EDUCATION DEPARTMENT*

Education Department Accomplishments and Highlights for FY 2024:

- Increased HealthStream course completions by 55% with 22,062 courses completed.
- Authored seven new HealthStream courses.
- Awarded 1,522 contact hours through Montana Nurses Association *(MNA).*
- Awarded 488 certificates such as S.T.A.B.L.E., BLS, PALS, Team De-escalation, etc..
- Facilitated instructor certification for five new American Heart Association instructors & three new TEAM De-escalation instructors.
- Created sustainable in-house onboarding for Advanced Cardiovascular Life Support *(ACLS)* and Pediatric Advanced Life Support *(PALS)* instructors.
- Hosted Skills Fairs for Acute Care, Surgical Services, Emergency, Obstetrics and Intensive Care Unit *(ICU).*
- Provided training to increase the scope of Registered Nurses in Long Term Care.
- Launched quarterly education for Medical Assistants, and Registered Nurses in Acute Care & Intensive Care Unit *(ICU).*
- Created or revised 26 Lippincott procedures/competencies.

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- Standardized intradepartmental process and training resources.
- Created a preceptor program for the Emergency Department.
- Created orientation packets for Homer Medical Center receptionists, Respiratory Therapist, volunteers and medical staff.
- Facilitated nine practice drills; four of which focused on interdepartmental participation.
- Launched new restraint training curriculum to include practice drills.
- Moved to a new training center; inventoried and organized all educational supplies.
- Created a patient simulation room.
- Expanded the education department's team with one additional clinical educator.

Education Department Goals and Objectives for FY 2025:

- Continue supporting the mission, values and strategic plan of the hospital by providing annual regulatory education, Continuing Nurse Education *(CNE),* orientation and support for the goals of the hospital wide QI plans, providing evidence-based education to improve patient quality outcomes.
- Identify Intensive Care Unit *(ICU)* educational needs and standardize scope of practice at SPH.
- Create standardized intradepartmental processes for creation of educational opportunities.
- Increase the Education Department involvement in staff meetings, quality initiatives and educational responsiveness to audit findings both clinical and non-clinical.
- Focus on creating curated resources, readily available, to staff using Lippincott and the Staff Information Site *(SIS).*
- Utilize the mobile computer lab to improve education quality and accessibility.
- Increase the use of technology in educational offerings.
- Increase volume of educational activities by 20%.
- Facilitate and plan two educational activities created by nursing staff content experts.
- Plan and implement two inter-professional activities.
- Host a provider activity with outside experts providing evidence-based best practice.
- Improve nursing competency in two areas identified as needing improvement.
- Increase the number of drills by 40%.

3) EMERGENCY DEPARTMENT

Emergency Department *(ED)* Accomplishments and Highlights FY 2024:

- Passed our Trauma Level IV Reverification site survey inspection.
- Continued collaboration with the Education Department for new staff and the development of learning videos for equipment and procedures training.
- Added a ED Techs to the department.
- Created and implement a New Grad Program.
- Update and revise department specific policies.
- Completed our new doors renovations.
- Added a new ED Supervisor / Trauma Coordinator.

Emergency Department *(ED)* Goals and Objectives FY 2025:

- Update and revise department specific policies.
- Complete the Emergency Department renovations.

- Streamline process to work with the new Epic Electronic Medical Record *(EMR)*.
- Continue to adjust the New Grad Program.

4) EMPLOYEE HEALTH

Employee Health *(EH)* Accomplishments and Highlights FY 2024:

- Attended Association of Occupational Health Professionals *(AOHP)* in Healthcare Conference.
- Collaboration with Infection Prevention *(IP)* in ongoing maintenance and updates to COVID and other infectious conditions information, policies and guidelines.
- Tracked, guided and documented COVID positive staff and staff missed work with potentially infectious illnesses.
- Updated Employee Health standing orders, forms, policies and procedures *(Bloodborne Pathogen Exposure Control Plan, Occupational Exposure to Bloodborne Pathogens and Workforce Member Packet).*
- Implemented Employee Health Over-the-Counter Medication Process.
- Ongoing collaboration with Human Resources *(HR),* Education, Medical Staff and Volunteer Coordinators, to improve new hire/student/volunteer/medical provider onboarding processes.
- Implemented the DAISY Nursing Awards at South Peninsula Hospital.
- Lead the Employee Wellness Committee.
- Facilitated Employee Wellness offerings including employee labs, an employee-clothing swap and the Employee Emporium Shop with local vendors, Personal Wellness Challenges and Lunch & Learn presentations.
- Continued updating of employee health files.

Employee Health *(EH)* Goals and Objectives FY 2025:

- Continue to offer the Employee Wellness Program incentives for SPH staff; explore integrating MODA benefits into Employee Wellness Program.
- Continue to oversee DAISY Award selection and celebration activities.
- Review and update policies, procedures and processes as needed.
- Request budget approval to replace the outdated MediTrax Employee Health software with a more efficient technology software.
- Add formal process improvement projects.

5) ENVIRONMENTAL SERVICES

Environmental Services *(EVS)* Accomplishments and Highlights FY 2024:

- Updated laundry-chemical dispensing units to reduce cost and waste.
- Maintained quarterly cleaning of all privacy curtains.
- Department Manager continued leadership coaching through FutureSync.
- Implemented cleaning and disinfection of new SPH Training Center and Education Department.
- Implemented cleaning and disinfection of new Functional Medicine and General Surgery Clinics.
- Acquired new floor scrubber to utilize on LTC Luxury Vinyl plank flooring.
- Acquired new carpet extractor.

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Environmental Services *(EVS)* Goals and Objectives FY 2025:

- Evaluate Environmental Services policies and procedures.
- Acquire two new washing machines to increase department's capacity for laundering and efficiency.
- Increase staffing by 2 team members to accommodate new off-site Rehab facility, Surgery Center, and Childcare Centers as well as staying prepared for continued organizational growth.
- Department manager to continue education through the Healthcare Environment and International Housekeeping Association.
- Evaluate opportunities to improve job-specific education for team members.
- Develop program for team members to obtain Certified Healthcare Environmental Services Technicities *(CHEST)* certification for EVS Tech II advancement.
- Continue quality assurance surveillances to evaluate facility cleanliness and identify training needs.
- Improve staff retention.
- Hire evening-shift department supervisor and provide education and certification through Association of the Healthcare Environment
- Develop and monitor performance improvement measures from Press Ganey surveys.
- Improve employee satisfaction.

6) FACILITIES / ENGINEERING

Facilities / Engineering Accomplishments and Highlights of FY 2024:

- Completed Deaerator softener installed in boiler room.
- Completed fire damper inspection for main hospital building.
- Completed Ortho Clinic x-ray machine install.
- Completed security camera and access control system phase 4 upgrade to the Emergency Department.
- Upgraded 95% of main hospital building, to LED lighting.
- Completed negative pressure rooms in the Specialty Clinic basement.
- Completed Vaccine Clinic in Specialty Clinic basement.
- Completed Hohe street building remodel from residential building into a billing office.
- Completed Homer Medical Center roof remodel.
- Completed Security office remodel.
- Completed install of new x-ray table in the Specialty Clinic/Family Care Clinic building.
- Completed addition of six new parking spots in the ER/Registration parking area.
- Completed heated sidewalk for Administration entrance.
- Developed a tool asset vending machine for equipment inventory tracking.
- Completed ongoing develop and Staff an in-house Security Department and implement this into the Support Services Division.
- Completed upgrade of Long Term Care Heating, Ventilation and Air Conditioning *(HVAC)* system.
- Completed install of new X-ray table in the Ortho Department building.
- Re-cabling of communication and data at the Community Health Services (*CHS*) building.
- Completed the replacement of carpeting with vinyl flooring in the Long Term Care *(LTC)* Facility
- Replaced current patients and residents bulky TV systems with a new Wi-Fi system.
- Completed minor renovation to Homer Medical Center providers work spaces and exam rooms.
- Completed fire damper repair on all findings through inspection with Certified Master Inspectors *(CMI).*

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- Completed installation to new entry sliding doors in main lobby of hospital.
- Replaced doors in ER rooms 5,6,7,8 to accommodate new gurneys.
- Upgraded generator switchgear to meet current code requirements - January 2024.
- Completed the Auto clave replacement in surgical department.
- Patient accounting working in the old HIM area moved to the 4-plex.

Facilities / Engineering Goals and Objective for FY 2025:

- Install wall protection in hallways and main areas through the building. *(Ongoing)*
- Complete lighting upgrade to LED lights in 100% of the building. *(Ongoing)*
- Generator breakers replacement to be performed in July.
- Re-roof the 1985/99 addition of the hospital. Completed 1985, 1999 still needs to be done.
- Stay on top of the CMS requirements.
- Continue architectural design for Dietary, Specialty Clinic, Pharmacy and SPH landscape beautification project. *(Ongoing)*
- Complete Backflow Preventer Maintenance Repair and Inspection Safety Training for confined space and lock out tag out.
- Repairs, paint, and replace acoustic ceiling in 1985 addition. *(Ongoing)*
- Master Systems Integrator *(MSI)* software and hardware upgrades for better system automation, 96 % complete.
- Install boiler chemical treatment system.
- Continue to improve security and building safety throughout the campus. *(Ongoing)*
- Replace Physical Therapy entrance door, handicap operators and hardware. *(Ongoing)*
- Install handicap assisted door opener on registration bathroom main lobby 1of 2.
- In house lawn care and Snow removal crew. *(ongoing)*
- Replace concrete sidewalks at 203 West Pioneer Ave. with heated concrete sidewalks.
- Replace Homer Medical Center sidewalks to heated sidewalks.
- Install a Behavioral Health holding room in the Emergency Department and extended stay behavioral holding rooms in Acute Care.
- Replace the hallway flooring in the 1985 area from concrete to vinyl flooring.
- Legionella program for CMS compliance for building water system.
- Replacement of old sterilizer with new sterilizer unit in OR completed.
- General Account and Home Health Departments from 203 West Pioneer Ave. to the Orotho Clinic basement 4201.
- Functional medicine moved up to 4300 Bartlett Street old HIM office Suite.
- New Acute Care air handler replacement for MRI suite.
- Re-cable communication rooms C1-C6 and wire management.

7) *FAMILY CARE CLINIC*

Family Care Clinic *(FCC)* Accomplishments and Highlights of FY 2024:

- Added Christine Pratt, PA-C to Family Care Providers, which was an objective last year.
- Opened Walk-In Community Lab.
- Continued community outreach for obesity, including community presentations.
- Increased visits from 4,519 in calendar year 2022 to 4,971 in calendar year 2023.

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Family Care Clinic *(FCC)* Goals and Objectives for FY 2025:

- Increase family care visits by 10%.
- Move toward a more consolidated clinic structure with Homer Medical Center.

8) *GENERAL ACCOUNTING DEPARTMENT*

General Accounting *(GA)* Department Accomplishments and Highlights for FY 2024:

- Successful fiscal year-end financial statement audit.
- Continued cross training elements that will help our department be more efficient.
- Enhanced capital project tracking and reporting, with continued improvement work being done to make tracking easier.
- On boarded a new Controller after a one-year vacancy.

General Accounting *(GA)* Department Goals and Objectives for FY 2025:

- Implement a new Enterprise Resource Planning *(ERP)* Accounting system, which will automate reporting, streamline capital project expense, asset management and streamline bank reconciliations.
- Implement efficiencies for 990 and governmental reporting and auditing.
- Continue with staff training & development.
- Continue working toward another successful fiscal year-end financial statement audit and quality of analysis provided to the Board and Chief Financial Officer *(CFO).*
- Continue to ensure standardized processes and efficiencies through the month end closes.

9) *HEALTH INFORMATION MANAGEMENT*

Health Information Management *(HIM)* Accomplishments and Highlights for FY 2024:

- Continued chart destruction project, ongoing.
- Combined Homer Medical Clinic coding with Health Information Management coding team.
- Reduced contracted coding volumes by greater than 50% with TruBridge for coding.
- Process improvement for charge capture.
- Work with clinical directors to improve nursing documentation to increase revenue.
- Review charging process with Respiratory Therapy to ensure all appropriate revenue is captured.
- Went live with FinThrive, educational portal for registration, billing and coding teams June 2024.
- Created coding career ladder for growth opportunities.

Health Information Management *(HIM)* Objectives/Goals for FY 2025:

- Continued chart destruction project, projected completion (phase 1) date 2025.
- Create coding teams for cross training and coverage.
- Fill open Coder 4 position.
- Work with Clinic Coders to unify coding processes, education and alignment.
- Support three current staff members into new roles with American Academy of Professional Coders *(AAPC)* coding certifications.
- Create optimal transition into new Epic Electronic Health Record *(EHR).*

10) HEALTH INFORMATION SYSTEM

Health Information System *(HIS)* Accomplishments and Highlights FY 2024:

- Successful submission of CY23 Eligible Hospital *(EH) (CAH)* Promoting Interoperability Stage 3, Year 5 data in February 2024 maintaining full payment for hospital-based services.
- Met requirements of the Eligible Provider *(EP)* Quality Payment Program - Merit-based Incentive Payment System *(MIPS)* measures for CY2023.
- Maintained goal of Level 5 within Electronic Medical Record Adoption Model *(EMRAM).*
- Collaborated in multi-disciplinary teams:
    - Developed multiple problem-focused provider documentation templates to improve documentation quality and efficiencies within the ambulatory EHR.
    - Worked closely with Acute Care Nursing leadership team collaborating on several nursing quality initiatives supported by the Electronic Health Record *(EHR)* to maximize efficiencies.
        - State of Alaska Order Entry/Result interface development team supporting direct ordering & resulting via the Evident Electronic Health Record (EHR) continued in 2024.
        - Sepsis Steering Committee: Best practice response to sepsis leveraging the Evident System to support documentation prompts and workflow efficiency.
        - Stroke Task Force: Best practice response to stroke leveraging the Evident System to support documentation prompts and workflow efficiency.
        - Member of Hospital-wide Policy & Forms Committees.
- Project Management support for:
    - Facilitated move to Evident *Patient Scheduling* application for Infusion Clinic to optimize patient access to this OP department services.
    - Maximized functionality of SPH Health Information Systems for improved patient care coordination and outcomes using the new *Thrive Web Client* platform.
    - *Qliq*, a secure messaging platform, was rolled out to several hospital-based departments for HIPAA-compliant messaging between members of the patient care team(s).
    - Lead Epic EHR pre-implementation activities in support of transition from current Evident and Athena EHRs to Community Connect Providence Epic.

Health Information System *(HIS)* Goals and Objectives for FY 2025:

- Continue to support and maximize functionality of SPH Health Information Systems to improve patient care coordination and outcomes, while preparing for conversion to Epic HIS for hospital-based and Ambulatory Clinic services.
- Prepare for successful CY24
    - EH Stage 3, Year 6 Promoting Interoperability data submission, including electronic Clinical Quality Measures *(eCQMs)*, and
    - EP MIPS program submissions.
- Actively promote and support the HIS conversion project, moving from CPSI Evident and AthenaOne to Community Connect Providence Epic.

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11) HOME HEALTH

Home Health *(HH)* Department Accomplishments and Highlights for FY 2024:

- Average monthly census of 61 patients FY 2024 YTD. This is up from 56 patients in FY 2023.
- Alaska Hospital & Healthcare Association *(AHHA),* Home Health and Hospice Committee, Ivy Stuart RN, remains active with this committee. AHHA has a new chair for 2024 and Ivy Stuart represents AHHA on the Forum of the States Associations Committee with National Association of Home Care and Hospice *(NAHC).*
- TexLa Billing and Consulting remains as a resource for a small monthly retainer fee for any billing/collecting issues that surface.
- Updated Home Health Emergency Response Plan *(EOP)* and the Hazard Vulnerability Assessment *(HVA).*
- Home Health Performance Improvement Plan *(PIP)* for CY2024 focuses on improvement in bathing and continues two PIP's from CY2023 into CY2024, improvement in dyspnea and improvement in oral medications. Home Health continues under value-based purchasing.
- Star Ratings July 2024: 2 stars.
- Director/Administrator attended two National conferences for Home Health in FY 2024. The Home Health and Hospice Medicare Contractors *(MAC)* Collaborative Summit and the National Association for Home Care & Hospice Annual Conference. Best practice and regulatory compliance knowledge was obtained and implement from both of these conferences.
- Leisa Olivieri, RN became Wound Care Certified *(WCC),* in March 2024. Home Health utilized discounted course offered through the Alaska Hospital & Healthcare Association *(AHHA)* for training.
- Updated our end of life packets with up to date information and resources.
- Protocols created for a more thorough intake process.
- Home Health relocated to new site at 4201 Bartlett Street, lower level.

Home Health *(HH)* Department Goals and Objectives for FY 2025:

- Continue to grow Home Health census, to maintain a monthly average of 67 patients by end of FY 2025.
- Implement Progress to Goals feature in Electronic Medical Record *(EMR)* to streamline clinical documentation and set up care pathways.
- Maintain and grow Home Health Quality Assurance Improvement Performance *(QAPI)* program.
- Hire a full time Home Health Admission RN.
- Expand Physical Therapy throughout our entire service area.
- Review the 2023 Community Health Needs Assessment *(CHNA)* for areas to grow or expand our services.
- Matt Byrd, RN and Brian Burns, RN get Wound Care Certified *(WCC)* certification through the course Alaska Hospital & Healthcare Association *(AHHA)* in October 2024. This will put Home Health at five RNs that are wound care certified.
- Work on a new Performance Improvement Plan *(PIP)* for CY2024.
    - Improvement in bathing
- Continue two PIPs from CY2023
    - Improvement in dyspnea

  - Improvement in oral medications
- Continue to create and grow partnerships and relationships with local resources to ensure patients have access to available resources in the community.
- Care Coordinator to create a more robust Social Service intake process.
- Work with Electronic Medical Record *(EMR)* vendor on issues and maximizing the use of financial reports that are available in our EMR.
- Continue to grow and expand palliative care services.
- Implement OASIS E-1 January 1 2025.
- Continue to update department policies and procedures to meet regulatory compliance.
- Ongoing OASIS training for accuracy of assessments. Continue to provide education to providers on Home Health referrals.
- Attend National Association for Home Care and Hospice *(NAHC)* annual conference in October 2024. Attend the in-person Forum of the States Association meeting prior to NAHC conference.
- Attend the Medicare Administrative Contractor *(MAC)* Summit in early October 2024.
- Implement a patient outreach program.

12) HOMER MEDICAL CENTER

Homer Medical Center *(HMC)* Accomplishments and Highlights for FY 2024:

- Developed training program for medical assistants and front desk.
- Implemented Product Oriented Delivery *(POD)* and full time employee ratios from Medical Group Management Association *(MGMA)* consultant.
- Developed a Medicare Wellness Nurse Service line.
- Remodeled building to accommodate workflow of Product Oriented Delivery *(POD)* structure.
- Hired medical assistants to support our provider ratios.
- Hired Josie Bradshaw, RN as Clinic Manager.
- Moved obstetrics and gynecological services into new location on Fairview Ave., generating two additional exam rooms within Homer Medical Center.

Homer Medical Center *(HMC)* Goals and Objectives for FY 2025:

- Continue to trend Merit Based Incentive Payment System *(MIPS)* and implement improvement plans.
- Increase clinic patient volumes, services and access to care.
- Implement consultant recommendations in accordance with best practice.
- Develop scheduling department with ability to practice more global scheduling.
- Improve aesthetics in patient waiting area.
- Recruit another pediatric provider to support the growing population.
- Dedicated triage room to ensure patient privacy without utilizing an exam room.
- Establish a wound care clinic.
- Integrate OB/GYN and midwifery into a full service women's health center.

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13) HUMAN RESOURCES

Human Resources *(HR)* Accomplishments and Highlights for FY 2024:

- Successfully ratified a new Collective Bargaining Agreement with the Local Teamsters Union 959 that went into place January 1, 2024 through December 31, 2026.
- Executed Recruitment Strategy to address contract staffing, recruitment and retention.
- Successfully executed Marketing strategy plan for key positions in Radiology and Rehab departments.
- Completed successful active Benefits Open Enrollment for FY 2024.
- Filled and on-boarded key leadership positions: Controller, Radiology Director, Clinic Manager, Childcare Administrator, & Childcare Assistant Administrator/Teacher.
- Reduced Contract Labor by filling hard to recruit positions.
- New Leader Onboarding Process developed to prepare new leaders to the organization.

Human Resources *(HR)* Goals and Objectives for FY 2025:

- Optimize Ultimate Kronos Group *(UKG)*.
- Complete UKG Onboarding and Recruitment Module build.
- End contract with existing applicant tracking system: HealthCare Source.
- Press Ganey Employee Satisfaction Survey.
- Recruit Childcare staff and establish guidelines for high school work study program.
- Improve onboarding experience for new hires including but not limited to pre-employment appointments, orientation, and preparing for EPIC implementation in 2025.

14) IMAGING DEPARTMENT

Imaging Department Accomplishments and Highlights FY 2024:

- Finished FY 2024 with a net positive operating margin.
- Have enjoyed the third year with our new Computer Tomography *(CT)* Suite and showed over 10% volume growth in the past year. The flow of patient traffic has improved, especially from the Emergency Department *(ED)* and Acute Care *(AC)* Department aiding in reduced turnaround times for stroke and trauma care.
- Improved workflows with remote radiologists after hours to ensure meeting and exceeding the goal for stroke turnaround times to under 45 minutes from arrival to interpretation.
- Passed July 2023 Mammography Quality Standards Act *(MQSA/FDA)* inspection.
- Ongoing participation in the American College of Radiology National Mammography Database *(NMD)* to enable SPH to access aggregate reports for comparison of SPH Mammography program with others of similar size.
- Submit for re-accreditation of our Computer Tomography *(CT)* machine and services through the American College of Radiology *(ACR)*.
- Conducted an annual review of all imaging radiation and fluoroscopy dose protocols to ensure the protocols adhere to the Society for Pediatric Radiology's Image Gently guidelines and Adult Image Wisely Guidelines and to As Low as Reasonably Achievable *(ALARA)* Radiation Guidelines.

- Continued the architectural design phase of a Nuclear medicine service line, and successfully received approval on our Certificate of Need request for Nuclear Medicine/Pharmacy/Infusion project.
- Renewed facility membership with the National Consortium of Breast Centers *(NCBC).* Continued to collect data necessary to participate in the NCBC (NQMBC) Program. Obtained the designation of Certified Quality Breast Center (CQBC), the second step to achieving the designation of Certified Breast Center of Excellence for our breast health services.
- Replaced outdated hardware (PACS Workstations) in the Imaging department and throughout the hospital/clinics to become compliant with our system update to McKesson PACS this fall. Replaced all Imaging PACS workstations to windows version 10 operating systems to prepare for software upgrade to Change Healthcare (McKesson) version 14.0 software.
- Researching and creating a solid plan to create a safer Picture Archiving and Communication System *(PACS)* infrastructure, removing outside accesses to PACS when appropriate while providing outside partners and patients with images, using new HIPAA compliant image sharing technology.
- Enhance PACS existing archive storage capability by updating and increasing storage servers.
- Conduct an ongoing review and revision of the Charge Master for all imaging modalities to ensure appropriate coding, billing and reimbursement.
- Received signed letter of intent for second fulltime radiologist with a planned start date in summer 2025 following fellowship at the Mayo Clinic.
- Began cross training of internal employees to obtain higher-level certifications in both CT and MRI.
- Promoted internal candidates to the roles of Lead in CT, MRI and Ultrasound to ensure subject matter experts in each specialty with a focus on policy improvements and safety initiatives.
- Created an Imaging scheduling team, which pro-actively reaches out to patients after patient orders are received, and authorization obtained to schedule exams timely.
- Rebuilt our scheduling module to optimize access to care and to schedule the appropriate length of appointment, ensuring proper pre-appointment instruction are given to patients.
- Created more redundancy in our PACS support team to manage system downtime, maintenance needs and call coverage by expanding the career ladder opportunity in radiology to include PACS support training for technologists.
- Implemented staffing schedule to ensure 24/7/265 coverage in the CT/X-ray department to remove the need for call techs and any potential delay of care.
- Converted travel MRI staff to fulltime employment. This increase in fulltime specialty trained staff allows for scheduling Saturday MRI outpatients and having MRI technologists in house 6 days a week for acute and emergent care needs.
- Continued to be a clinical site for local University of Alaska *(UAA)* Rad Tech program. One student training this year, and one graduate hired as a Rad Tech PRN.
- Implemented new software in CT for Cardiac CT Angiography. Purchased, installed and trained on Functional Cardiac Syngo software for enhanced CT cardiac imaging.
- Purchased and installed a new portable x-ray machine located in the Emergency Department area and offers state of the art dose reduction and imaging quality.
- Purchased an MRI coil for high-resolution imaging of hands and wrists for orthopedic surgeons.
- Held an imaging open house during Breast Cancer Awareness month to welcome the community to the hospital and highlight our mammography services.
- Offered shadowing opportunities to our community partners at SVT Health & Wellness to improve their quality of x-ray imaging for interpretation by the SPH Radiologist.

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Imaging Department Goals and Objectives for FY 2025:

- Submit for re-accreditation of our mammography machine and services through the American College of Radiology *(ACR).*
- Continue to support the Nuclear Medicine/Infusion/Pharmacy project to add this new service line for SPH. Completion of Nuclear Medicine suite design and implementation of Nuclear Medicine services.
- Create an alternative resource for critical CT studies when the current *(only)* CT machine is down. This is still in progress and we will have a redundancy offered by the Nuclear Medicine scanner, which is planned to be a backup diagnostic quality SPECT/CT scanner.
- Conduct an ongoing review and revision of the Charge Master for all imaging modalities to ensure appropriate coding, billing and reimbursement.
- Conduct an annual review of all imaging radiation and fluoroscopy dose protocols to ensure that the protocols adhere to the Society for Pediatric Radiology's Image Gently guidelines and Adult Image Wisely guidelines and to As Low as Reasonably Achievable *(ALARA)* Radiation Guidelines.
- Continue to participate in the National Consortium of Breast Centers *(NCBC)* and National Quality Measures for Breast Centers *(NQMBC)* Program to compare our service performance with other breast centers in the U.S. and achieve the designation of Certified Breast Center of Excellence for our breast health services.
- Continue to participate in the American College of Radiology *(ACR)* National Mammography Data Base.
- Work collaboratively with the Alaska eHealth Network *(AeHN)* to develop a Health Image Exchange that has functionality to view, query retrieve and download images from other sites in Alaska.
- Provide continuing education resources to staff so they can use the information obtained through education to meet licensing requirements and to increase imaging services.
- Evaluate the Imaging Quality Improvement Program. Identify, develop and implement specific Quality Improvement *(QI)* opportunities.
- Continue to review and update all policies and procedures as necessary to ensure compliance with the American College of Radiology imaging appropriateness criteria guidelines, Food and Drug Administration *(FDA),* Centers for Medicare & Medicaid *(CMS),* state and other regulatory agencies.
- Purchase, buildout, and test new interfaces required to transmit images to Radiology Consultants of Inc. *(RCI)* through Intelerad, the PACS system that has been selected by our contractor.
- Create a sustainable workforce in Diagnostic Imaging, by participating with the UAA Radiologic Technology program as a clinical site and training our future technologists.
- Implement a new Imaging Archive and cache and the associated hardware to ensure business continuity and improve security of PACS imaging archive. This project will allow for proper retention of all imaging files with the increased volumes of scans and the size of files growing due to the size of MRI, CT and 3D mammography and AI Interpretation.
- Plan for the offsite black hole storage for Business Continuity Offsite Solution.
- Upgrade the unsupported Computer Aided Detection *(CAD)* Aegis software for MRI breast imaging to an updated software DynaCAD that will provide enhanced prostate and breast imaging capabilities offering MRI Guided Breast Biopsies.
- Purchase and install AI software *(Rapid AI)* to ensure timely evaluation of stroke patients and the potential need to transfer for intervention or keep patient in SPH for care. This is in alignment with the Alaska Stroke Coalition and the efforts of driving down time to intervention for stroke patients in rural and remote Alaska.

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15) INFECTION PREVENTION

Infection Prevention *(IP)* Accomplishments and Highlights for FY 2024:

- Completed Infection Prevention training modules specific to Long Term Care from the Association for Professionals in Infection Control and Epidemiology *(APIC).*
- Monitored and investigated reports of Hospital Acquired Infections *(HAIs).*
- Oversaw the majority of COVID-19 operations, including:
  - Tracking metrics of performance, swab collection, positivity rates, and vaccinations.
  - Ordering and managing inventory of vaccines *(with Pharmacy).*
  - Reporting COVID data to National HealthCare Safety Network *(NHSN)* for South Peninsula Hospital and Long Term Care.
  - Answering staff and community questions, responding to exposures and events.
  - Communicating changes to Center for Disease Control *(CDC)* guidelines and South Peninsula Hospital guidelines.
  - Collaborated with community agencies for local vaccination and testing efforts.
  - Collaborating with Employee Health and Materials Management staff to monitor Personal protective equipment *(PPE)* usage and improve PPE supply amounts and variety.
- Updated Infection Prevention policies and procedures *(Notably the Infection Prevention Plans for South Peninsula Hospital and Long Term Care, the South Peninsula Hospital Risk Assessment, the Isolation Manual, and the Bloodborne Pathogen Exposure Control Plan).*
- Provided education for staff and departments on topics of C. Diff infection, Bloodborne pathogens, and COVID-19.
- Consulted with staff on construction projects, procedure modification, and equipment upgrades.
- Participated in skills fairs in Long Term Care and Acute Care.
- Organized quarterly Infection Prevention Committee meetings, with representatives from every clinical department.
- Worked to monitor clinical response to sepsis, in regards to Centers for Medicare & Medicaid Services *(CMS)* guidelines *(with CNO and Sepsis Committee).*

Infection Prevention *(IP)* Goals and Objectives for FY 2025:

- Improve process for hand hygiene monitoring and compliance throughout SPH departments.
- Continue to manage the quarterly Infection Prevention Committee and improve reporting metrics from each department.
- Continue to monitor and report cases of hospital acquired infections.
- Work on Infection Prevention Policies and Procedures.
- Respond to staff requests for subject matter expertise and group education events.
- Collaborate with Employee Health to improve Employee vaccination compliance.
- Complete additional training from agencies such as the Center for Disease Control *(CDC),* National HealthCare Safety Network *(NHSN),* and the Association for Professionals in Infection Control and Epidemiology *(APIC),* and achieve certification in Infection Prevention and Control through APIC.
- Facilitate update to Transmission Based Precautions and provide organizational education of changes.

16) INFORMATION TECHNOLOGY

Information Technology *(IT)* Accomplishments and Highlights FY 2024:

- Conducted annual security assessments and implemented suggestions.
- Implemented Security Event and Incident Management *(SEIM).*
- Increased completion rate without security awareness-training program for all employees, average 97%.
- Expanded email system security capabilities for disaster recovery.
- Conducted cyber event drill.

Information Technology *(IT)* Goals and Objectives for FY 2025:

- Conduct annual security assessments and implement suggestions.
- Support other department's system implementations.
- Expand email system security capabilities for disaster recovery.

17) LABORATORY

Laboratory Department Accomplishments and Highlights FY 2024:

- The testing volume for 2023 was 156,458 with a projection of ~158680 tests in 2024.
- The Rotary Health Fair testing was performed at South Peninsula Hospital Laboratory. Blood draws were performed on campus at separate building that allowed for participants to be staged outside the building in their cars until a draw station was open to receive the next participant. This past year there were 799 participants and feedback continues to be very positive concerning the process used to transition participants into the draw stations. Running the tests in-house streamlined paperwork, allowed for timelier resulting, and allowed all health fair participant results to be available the same day as the fair, which was held in person for the first time since COVID-19.
- Employee Health Fair had 419 employees take advantage of the laboratory test offerings.
- The hematology analyzers were replaced in October, August 2023 and February 2024 respectively.
- Collaboration with the sepsis committee and providing timely performance of lactic acid and other reportable measures is ongoing. This is an ongoing process.
- The laboratory lead microbiologist is an active member of the Infection Prevention team and Antibiotic Stewardship program.
- Work is being done with the State of Alaska to set up an interface with SPH for state lab orderable via the Health Information Exchange. This project is still ongoing with an anticipated completion date in the summer of 2024.
- Work is being done to improve outpatient satisfaction scores: Migration of fax system from ZetaFax to Evident Faxage system. Pending orders be held now held on patient profiles instead of a file kept on the N Drive.
- A Lab walk-in phlebotomy site was opened at the Kachemak Medical Building in July 2023. SPH laboratory services implemented an appointment-based model that began mid-March 2024.
- The general blood bank lab freezer was replaced.
- An in-service on high sensitivity Troponin testing for SPH Providers was completed June 2023 was added to the in-house test menu in July 2023.

- A Point of care lead analyzer was placed at Homer Medical Center to support the practice of Devry Garity, Pediatric Nurse Practitioner.
- A phlebotomist float position was added to give additional support for the Homer Medical Center phlebotomist since the workload has outgrown what one phlebotomist can handle. The float also provides lunch coverage for the clinic phlebotomists at Homer Medical Clinic and the Family Care Clinic.
- The laboratory clinical coordinator position and hematology lead position were separated into two different positions to free the clinical coordinator to focus on the specific dates assigned to that role.
- Implementation of the laboratory succession plan began with the hiring of an assistant laboratory manager in March 2024.
- Fentanyl testing was brought in-house in April of 2024 after several years of looking for an FDA approved test for clinical use.
- A limited test menu offering for veterinary specimens began in February 2024 to support dog-breeding services offered by a local veterinary clinic.

Laboratory Department Goals and Objectives for FY 2025:

- The laboratory continues to support Promoting Interoperability measures related to the laboratory interface and data sharing *(Syndromic Surveillance and Electronic Lab Reporting).*
- Improve Press Ganey Patient Survey satisfaction scores.
- Improve Microbiology services through the addition of a Matrix-Assisted Laser Desorption/Ionization Time-of-Flight Mass Spectrometry *(MALDI-TOF MS*) analyzer. The MALDI-TOF is a diagnostic tool used for microbial identification and characterization based on the detection of the mass of molecules. This methodology would significantly decrease the turn-around-time on the identification and reporting of organism identifications.
- Replace the microbiology refrigerator.
- Look into the feasibility of a backup analyzer for hs Troponin and the main chemistry analyzer.
- Continue to promote the use of the Family Care Clinic walk-in laboratory services, located in the Kachemak Professional Building.
- Continue to promote and grow participation of patients utilizing the option to make appointments in addition to walk-in services. The goal is to make the experience for patients more streamlined with wait times at registration and in the laboratory.
- The State of Alaska bidirectional interface, will allow tests performed at the Alaska State Laboratory to be ordered and resulted electronically, has a targeted completion date for the end of 2024.
- The laboratory is working in conjunction with the Rotary Health Fair committee to determine an alternate pre-draw site since the current location on campus at the hospital is no longer a viable option.
- Expand the laboratory succession plan to the laboratory departmental level, training co-leads who can cover the duties of the department lead techs if necessary.
- A Clinical Laboratory Improvement Amendments *(CLIA)* inspection will be conducted in November 2024.

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18) MARKETING

Marketing Accomplishments and Highlights for FY 2024:

- Published the new Community Health Needs Assessment *(CHNA)* in June 2023. Presented findings to the community July – August.
- Published Community Health Needs Assessment *(CHNA)* Implementation Strategy on SPH website in December 2023. *(The SPH response to CHNA)*
- Maintained our leadership role in our local health coalition by:
    - Service on the Coalition Steering Committee.
    - Serving as fiscal agent.
    - Serving on the Leadership Team of the Resilience Coalition.
    - Served on the Leadership Team of Kachemak Bay Recovery Coalition.
    - Served on the Leadership Team and Treatment Workgroup of All Things Recovery *(formerly Opioid Task Force)*.
    - Supported community meetings to identify Community Health Needs Assessment *(CHNA)* priorities and develop a community wide Community Health Improvement Plan.
- Continued general community health outreach via e-newsletter, public forums, and community wide month-long steps challenge, in which nearly 600+ individuals enrolled on 60 teams.
- Launched two new programs – Wellness Wednesday, a weekly event at the local college, which features a different presenter on a topic of wellness, followed by free yoga; and Brake for Breakfast, a free meal program one day in October for outreach and awareness of breast cancer and the importance of screening mammograms.
- Sponsored four SafeSitter babysitting classes, providing training to dozens of local youth.
- Provided logistics and communications for flu shot clinic in conjunction with Rotary Health Fair blood draws where over 200 shots were administered.
- Co-sponsored the Rotary Health Fair, where 900 individuals received low cost blood screenings and we offered the return of in-person fair, which had over 300 in attendance. Seventy booths covered physical, spiritual and emotional wellness topics and offerings, and dozens of individuals had free consults with local providers to review their health fair labs.
- Co-sponsored the Safe and Healthy Kids Fair, where 30+ vendors provided an outdoor education and safety fair for over 200 children and their families.
- Co-sponsored Homeless Connect, *(Community Resource Connect)* where over 100 participants got access to much needed goods and services, and we conducted our annual homeless count.
- Supported numerous local programs, including but not limited to sports teams, arts events, high school graduation, native Olympics, running programs, teams and more with volunteers, donations or program advertising.
- Maintained and distributed a communitywide resource directory of peer support groups.
- Continued broad awareness of hospital services via mailings, newspaper, radio, web, social media, grocery carts, grocery receipts, phone books and more.
- Provided communications support for numerous new providers, new clinics and clinic relocates.
- Conducted focus groups and basic market research to support the KPB proposal to issue general obligation bonds in support of hospital expansion.
- Increase grant research and writing efforts to help fund SPH priorities.

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Marketing Goals and Objectives for FY 2025:

- Re-establish the Substance Use, Misuse and Addiction *(SUMA)* Task Force at SPH to continue tracking our improvement in addiction related services.
- Improve market reach for primary care and behavioral health, in preparation for an increase of competing services soon to be offered in the community.
- Support community education in support of KPB general obligation bond proposal in support of capital project needs at SPH.
- Develop and publish a new SPH website for a more modern look and features.
- Better utilize Press Ganey's patient satisfaction results to help improve the digital reputation of SPH.

19) MATERIALS MANAGEMENT

Materials Management *(MM)* Department Accomplishments and Highlights FY 2024:

- Continued hospital-wide product review, including cost and availability, focusing on cost reduction, efficiency of processes, and improved logistics.
- Created and implemented policies, procedures, and processes for a hospital-wide product review committee.
- Continued implementation of consolidated hospital-wide policies and procedures for Procurement, including standardization and separation of duties.
- Initiated and completed Request for Proposal *(RFP)* process to replace current Enterprise Resource Planning *(ERP)* system within EVIDENT in anticipation of transition to Epic Electronic Health Record *(EHR).*
- Identified, selected, and implemented a dedicated secondary medical supply vendor.
- Replaced defunct United States Postal Service *(USPS)* processes, as well as United Parcel Service *(UPS)* and FedEx labeling, with new metered and scaled label devices.

Materials Management *(MM)* Department Goals and Objectives FY 2025:

- Select and implement a contract management system.
- Replace current Enterprise Resource Planning *(ERP)* system within EVIDENT with a more updated system, Sage Intacct.
- Widespread deployment of scanning commercial bar codes for all aspects of fulfillment.
- Begin planning process for safer warehouse, more efficient storage and distribution of medical supplies.

20) MEDICAL STAFF OFFICE

Medical Staff Office *(MSO)* Accomplishments and Highlights FY 2024:

- Initiated updates to Peer Review Charter.
- Contract for services and education with Greeley – A Chartis group for consultation and support for medical staff quality, organization with ongoing use of their services through FY 2025.
- Increased SPH Continuing Medical Education *(CME)* opportunities for medical staff.
- Medical Staff Leadership development series initiated with ongoing session planned on a quarterly basis.
- Initiation of hs Troponin use in lab with new algorithm created and adopted.

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- Continued efforts to define Ongoing Professional Practice Evaluation *(OPPE)* metrics and initiation.
- Initiated privileges review and updates with ongoing effort to conduct a thorough review of all current privileges.
- Coordination with department chairs, medical directors, and department leaders to evaluate and bring new services to SPH – TMS, ongoing efforts for Reconstruction and Aesthetics, Dermatology for 2025
- Organizational Chart updated to move Medical Staff Office to the Chief Medical Officer *(CMO)* and Administration.
- Coordinated and developed Medical Staff onboarding processes.

Medical Staff Office *(MSO)* Goals and Objectives FY 2025:

- Continue revising and updating privileges as above.
- Planned training opportunities for MEC, Peer Review, and Credentialing.
- Onboarding a new team member to Medical Staff Office *(MSO)* for additional assistance and support with growing medical staff.
- Transition of provider specific marketing to MSO.
- In conjunction with Greeley consultation, update Medical Staff Bylaws, Rules, and Regulations to reflect organizational changes including committee membership changes, SPH leadership changes.
- Ongoing and completion of projects listed above.

21) NUTRITION SERVICES

Nutrition Services *(NS)* Department Accomplishments and Highlights FY 2024:

- Continued to provide compostable by-products for local farmers and gardeners. Lessened food waste on commonly un-used food products. Provided food pantry donations of unused food items.
- Implemented new hospitality opportunities:
  - Take home chicken noodle soup for discharging Surgical Services patients.
  - Snacks for take home goody bags for the Lab.
  - Soup and bread provided weekly for Health and Wellness community events.
- Serv-Safe kept up to date for all staff.
- Financial growth for the cafeteria has increased 37.62%, and the espresso stand has increased 31.71% since the last CAH. Catering requisitions have also increased. Working on an appropriate formula for calculating catering increases.
- Added an additional part time prep cook position due to growth and demand.

Nutrition Services *(NS)* Department Goals and Objectives for FY 2025:

- Continue to provide compostable by-products to local farmers and gardeners. Provide unused food donations to the local food pantry.
- Expand our hospitality growth by providing snacks for Radiology waiting area along with other requested departmental hospitality needs.
- Create a new lead cook position for the cafeteria Salad bar.
- Order new carts for food service to decrease noise in both Acute Care and Long Term Care, and maintain better food temps during transportation.
- Show financial growth of revenue in both cafeteria espresso stand and catering requisition.

- Keep Serv-Safe up to date for all staff.

22) *OBSTETRICS DEPARTMENT*

Obstetrics Department *(OB)* Accomplishments and Highlights FY 2024:

- Continued midwife led simulations, including Neonatal Resuscitation Program *(NRP)* quarterly simulations, unscheduled C-Sections, OR skills training and Mass Transfusion Simulation involving all departments and disciplines across SPH.
- Continued systematic hiring and successfully trained 2 new-to-specialty RNs through the in-house OB training program. Developed and provided a self-study postpartum care module and a second-on delivery training for non-OB nurses who can safely care for patients during periods of high census and acuity.
- Participated in nurse-driven programs such as: quarterly childbirth classes and Safe and Healthy Kids Fair car seat checks 2024.
- On boarded and welcomed two skilled permanent RN, two new Certified Nurse Midwives *(CNM),* and one new OBGYN to our department.
- Policy updates, trainings, and safety improvements to areas of: hypertensive disorders of pregnancy, infant security, car seat safety, Vaginal Birth after Cesarean Section *(VBAC)*, Neonatal Abstinence Syndrome, unscheduled C-sections, mass transfusion, and magnesium sulfate administration.

Obstetrics *(OB)* Department Goals and Objectives FY 2025:

- Continue with in-house OB training program—expect 2-4 new to specialty OB nurses FY 2025.
- Decrease need for OB skilled travel staff. – Our day shift is fully staffed with permanent staff and we have reduced travelers to two on nights. We have trained two new to specialty nurses starting on nights July 2024, which we trained through our in-house training program.
- Continue unit modifications to comply with infection prevention standards and enhanced organization.
- Continue educational opportunities for OB staff in areas of neonatal resuscitation/stabilization, postpartum hemorrhage, interdepartmental communication, and evidence-based standards of practice. We plan to host the following courses for our OB, ER, Charge, and OR staff:
    - Car Seat Training Program to increase number of car seat technicians in our community
    - Sugar, Temperature, Airway, Blood pressure, Lab work, and Emotional support *(S.T.A.B.L.E.)* course with Stacy Brundquist Neonatal NP from Providence Alaska Medical Center *(PAMC)* Newborn Intensive Care Unit *(NICU)*
    - Advanced Life Support of the Obstetric Patient *(ALSO)* course.
- Review and update policies to reflect current evidence-based practice.

23) *PATIENT FINANCIAL SERVICES*

Patient Financial Services *(PFS)* Accomplishments and Highlights FY 2024:

- Enhanced customer services by relocating Financial Navigator to registration area to support walk in services to patients Monday – Friday 8:30 am to 5:00 pm
- Increased Charity Care by enhancing our Financial Assistance Program by actively obtaining signed applications at the time of registration for Medicaid recipients and updating the Financial Assistance Policy.

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- Collaboration with Lab to increase collection of consents and Advance Beneficiary Notice *(ABN)* at time of service.
- Implemented LexisNexis to identify patient addresses and phone numbers to decrease amount of returned mail and help resolve aging patient accounts
- Maintained accounts receivable collection goal of 55 days or less for entire Fiscal Year.
- Implemented new training and education requirements in HealthStream for PFS Billing and PFS Patient Access to increase accuracy in registration and claim submissions.
- Worked with Imaging to improve process of scheduling after insurance authorization is obtained.

Patient Financial Services *(PFS)* Goals and Objectives for FY 2025:

- Manage insurance credit balance accounts and denials management through timely and effective review process by addition of PFS staff focused in this area.
- Financial Counselor to acquire certification to help patients enroll in Medicare and Medicaid services.
- Add a new per diem position for PAR II specific to assist and cover for Financial Navigators, Insurance Verification and Financial Counselors.
- Update the Collections and Bad Debt Policy to a more efficient process for deceased patients.
- Ensure compliance with the 501(r) publication requirements with the new Financial Assistance Policy and posting financial assistance information in Russian and English.
- Improve training for billers in insurance authorizations to assist in coverage for Insurance Verification.

24) PHARMACY

Pharmacy Department Accomplishments and Highlights for FY 2024:

- Maintained sterile preparation area to the required International Organization for Standardization *(ISO)* standards and lowered the beyond use time of SPH compounded products to the United States Pharmacopeia *(USP)* 797/800 set limitations with the current capabilities of the preparation area.
- Increased use of pre-made infusions and adjusted products concentrations to those available through wholesalers and updated infusion pumps to match these changes.
- Re-established a multi-disciplinary Pharmacy and Therapeutics Committee.
- Reviewed and up-dated the SPH drug formulary.
- Trained 3 new pharmacists, 2 casual, 1 part time.
- Hired new full time pharmacy technician.

Pharmacy Department Goals and Objectives for FY 2025:

- Continue to improve airflow in the current sterile preparation areas to meet United States Pharmacopeia *(USP)* standards and continue to design new pharmacy workspace and IV rooms in planned future hospital expansion of shelled space.
- Revise/update pharmacy policies and procedures.
- Update and expand 340B program to new child sites as services are brought onto the SPH campus and as new clinics are opened and added to SPH cost report.
- Increase Long Term Care Medicare Part D reimbursements and reestablish our Medicaid billing for outpatient prescriptions.

- Continue to switch to products pre-made by manufacturers instead of preparing in house to meet United States Pharmacopeia *(USP)* requirements and allow for longer beyond us times.
- Train new pharmacy technician to compound sterile products and consider training at an outside center for sterile compounding that could be brought back to SPH to share with the staff.
- Recruit casual pharmacy technician.

25) QUALITY MANAGEMENT DEPARTMENT

SPH Quality Management *(QM)* Department encompasses the following areas:

Quality Monitoring, Measuring, Improvements and Projects
Patient Satisfaction
Accreditation and Surveys
Risk Management and Claims Reporting
Policy Management
Corporate Compliance
Privacy – HIPAA

Quality Management *(QM)* Accomplishments and Highlights FY 2024:

- QM Department welcomed Meredith Pearson, RN as the Quality Management RN to complete quality improvement activities/reporting for the department on behalf of the SPH organization.
- Facilitated the completion of the South Peninsula Hospital *(SPH)* Critical Access Hospital *(CAH)* Quality Assessment and Performance Improvement Evaluation 2023-2024 with input from departments throughout the organization.
- Completed 2023-2024 Small Rural Hospital Improvement Grant Program *(SHIP)* interim and final reports as required for SPH to receive reimbursement of $13,312.00
- Completed application for SHIP grant from State of AK for the year 2024-2025 in order for SPH to receive funds of $13,312.00.
- Updated SPH and LTC Facility Quality Plan and SPH and LTC Facility Corporate Compliance and Ethics Plan and HW-101 Corporate Compliance and Ethics Policy.
- QM team participated in SPH Survey activities:
  - Assisted with updated quarterly communications to State of Alaska related to K916 waiver extension until substantial compliance obtained.
  - Assisted with response to unannounced complaint survey for the CAH that occurred May 1-2, 2024.
  - Participating in survey readiness meetings as scheduled by CNO.
- Worked closely with Optima Healthcare Insurance to develop Risk Management Status report for organization, including Program goals and Organizational Specific goals for 2024.
- QM Director and Risk Mitigation RN participated in Optima Healthcare webinars and other educational offerings available to assist risk reduction and solidify processes, which involve our management team.
- Organized and facilitated annual on-site visit with the Optima Healthcare Insurance team.
- Managed grievances, complaints, and legal issues related to patient care filed with QM Department.
- Worked with SPH Insurance Companies, attorneys and CEO related to risk and/or legal issues. Organized and hosted deposition meetings as needed.
- Facilitated completion and updates to Hospital Board of Trustees Balance Scorecard Report *(BSC)*. BSC shared monthly with Board of Directors *(BOD)* and quarterly with Patient Centered Quality Care Committee *(PCCQC)*.

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- Organized and facilitated Root-Cause-Analysis *(RCA)* multidisciplinary meetings for near misses or actual patient events.
- Facilitated Plan-Do-Study-Act *(PDSA)* improvement reports for all indicators falling below target on the BSC as well as departmental quality improvement opportunities.
- Continued work/outreach to managers regarding PDSA reports and provided assistance with graph development and/or update for department quality initiatives.
- Quality reporting and improvement opportunities: QM team completes and transmits core measure data from chart abstraction to CMS that are found on the Care Compare website, meeting criteria for the Small Rural Hospital Improvement Program *(SHIP)* grant. Measures include:
    - Inpatient Sepsis based on discharge diagnosis.
    - Outpatient measures; Stroke, Acute Myocardial Infarction, Left without Being Seen, and Emergency Room admission to discharge.
    - Reported two optional measures to increase opportunity to gain back star rating on Care Compare website to include follow-up documentation related to colonoscopies and Elective Delivery data. Worked with Press-Ganey Company and Alaska Hospital and Healthcare Association *(AHHA)* to troubleshoot opportunities to increase survey numbers and for reporting to CMS to improve or obtain Star ratings on Hospital Compare.
- Organized and facilitated quarterly Patient Centered Care Quality Committee.
- Celebrated quality efforts and improvement throughout the organization during National Quality Week.
- Quality Management RN and/or QM Director participated in LTC QAPI Committee as able.
- QM team participated in multiple committee meetings to improve quality throughout the organization including Sepsis Steering Committee, Hospital Incident Management Team, Health Information Systems, and Stroke Steering Committee. Provided sepsis guidance, case review and feedback for committee members.
- Conducted twenty-two (22) Root-Cause-Analysis meetings related to opportunities for process improvement.
- Ongoing policy work and oversight for the SPH organization with the goal to reduce the number of overdue Hospital Wide and department policies.
    - Continued work on electronic format of policies, procedures and protocols through the Policy Management system.
    - Continue to work with Policy Manager Consultant to facilitate Q2 week Hospital Policy Committee for review, update and approval of policies.
    - Ongoing Bi-monthly meetings between QM staff and Policy Management Consultant to plan and work on action items for policy completion, staff support and agenda setting.
    - Providing support to new management staff on policy platform and adjusting templates/approvals as needed for changes occurring.
    - Bi-weekly planning and action meetings with Policy Management Consultant and Administration staff to develop and facilitate conversion of forms from SIS and N-Drive to Policy Manager System.
    - Updated and/or assisted in updating multiple policies and plans over the last year.
- Conducted twice-monthly HIPAA orientations for staff and physicians.
- Conducted seven *(7)* one-on-one individual HIPAA trainings, due to HIPAA complaints, utilizing the HealthStream presentation *"HIPAA Policy Review"*.
- QM Team participated in HealthStream mandatory education.

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- QM Director, QM RN and/or Risk Mitigation RN participated in monthly new employee orientation and new nurse orientations as needed.
- QM Director participated in Leadership Development through FutureSync as scheduled.
- QM Director conducted staff meetings with QM team.
- Regulatory Compliance information shared with management staff as appropriate.
- Completed scanning and uploading hard copy Physician/Advanced Practice Professional *(APP)* credentialing files into the MD staff software system through August 2023 approvals.
- Nominated staff members/Stroke Steering Committee for 2024 Patient Quality and Safety Awards through AHHA.
- QM Department checklists developed for QM responsibilities and activities.
- Participated in Hospital Incident Management Team *(HIMT)* tabletop drills for disaster preparedness.

Quality Management *(QM)* Goals and Objectives for FY 2025:

- Patient Safety and Zero Harm #1 objective.
- Complete Optima Healthcare webinars and educational offerings as available for risk reduction and solidify process to involve management team.
- Complete and support managers on the development/update of Plan-Do-Study-Act *(PDSA)* reports for departmental quality improvement efforts & indicators falling below target on the BSC.
- Support concurrent review, real-time, fail-safe patient care best practice processes; specifically stroke and sepsis care.
- Complete quarterly CMS Core Measure reporting to include inpatient Sepsis based on discharge diagnosis, and outpatient measures: Stroke, Left without Being Seen and Emergency Room Admission to Discharge.
- Complete initial orientation and start reporting on stroke data through Get with the Guidelines reporting program.
- Begin non-mandatory reporting Social Determinates of Health to Centers for Medicare and Medicaid.
- Complete the project started for updating all Quality and Risk Hospital Wide and department policies.
- Complete the update to the Enterprise Risk Management Plan and develop a plan for improvement opportunities for issues identified.
- Assure Corporate Compliance and HIPAA auditing processes in place and conduct audits as established by regulation, policy and as needed.
- Solidify education and implementation of Just Culture principles for staff throughout organization.
- Participate in 2025 Quality and Patient Safety Awards sponsored by Alaska Hospital and Healthcare Association *(AHHA).*
- Completion of secure archiving of occurrence reports and scan past occurrence reports documented on paper.
- Review all process pathways and make appropriate adjustments in the RLDatix occurrence reporting system. Update forms and complete quality dashboards within the system.
- Continue transition of forms found on SIS into Policy Manager System.
- Carry out requirements of 2024-2025 SHIP Grant.
- Ongoing focus on improving HCAHPS performance to improve inpatient Press Ganey patient satisfaction scores.

- Quality Management Assistant, QM RN and QM Risk Mitigation RN to obtain Just Culture certification. QM Director to obtain Corporate Compliance education and possible certification for Healthcare Privacy Compliance *(CHPC)*.
- Complete full reviews of current Business Associate Agreements *(BAA)* and tracking system.
- Create HIPAA training packets for all on-site contract workers.
- Begin quality rounding throughout organization and identify opportunities for improvement.
- Assist with implementation and transition to EPIC Electronic Health System.
- QM Director to continue participation in the LDI Leadership trainings offered to the SPH Management team.

26) REHABILITATION DEPARTMENT

Rehabilitation Department Accomplishments and Highlights for FY 2024:

- Billing corrections for April average 3.1% per therapist, slightly above our target of less than 3 per therapist. Physical therapy chart review for documentation supporting charges was 96.9%.
- The rehab department offers telehealth treatment options to patients, partially in response to the COVID-19 pandemic and health mandates; telehealth is utilized on an as needed basis. The majority of our services are performed in person.
- Rehabilitation continues to have staffing challenges. We currently have two full time Speech-Language Pathologist *(SLP),* one of whom is completing her clinical competency requirements, and an additional casual Speech-Language Pathologist *(SLP)*. We have three Occupational Therapists *(OT),* one of whom is a Certified Hand Therapist. The other two Occupational Therapists *(OT)* are generalists with interests in pediatric and mental health. The new Pediatric/Generalist Physical Therapist *(PT)* joined the team in July 2023, and a Physical Therapists *(PT)* with pelvic health treatment skills joined in November 2023. Our Physical Therapist Assistant *(PTA)* position that has been open for nearly 2 years will be filled in July 2024. We have had a travel Physical Therapists since September 2023, and have openings for 1.5 full time employee Physical Therapist at this time. Volumes are increased with all three disciplines this year, which is great to see.
- Participated in community education seminars including: Kenai Peninsula College University of Alaska Anchorage *(KBC-UAA)* Certified Nursing Assistant/Registered Nurse training, Hospice Volunteer Training, Safe and Healthy Kids Fair, Rotary Health Fair and Wellness Walks.
- SPH rehab also trained the Long Term Care Certified Nursing Assistant *(CNA)* students in proper body mechanics and transfer techniques, and expanded the Unit Peer Leader Program at SPH.
- SPH Rehab continues to be a provider of key ergonomic services that impact hospital wellness including: pre-employment and post-offer job function testing, functional job analysis, injured worker “return to work” screening and ergonomic work station analysis. We are about halfway through re-validating existing Job Function Descriptions/Tests, and hope to complete the process this year.
- SPH rehab continues to provide Functional Capacity Assessments as requested to aid in disability and return to work decisions.
- Current wait times for Physical Therapist non-surgical cases is 4-6 weeks, Speech-Language Pathologist 0 weeks, Occupational Therapist *(hand therapy)* 1-2 weeks, and other Occupational Therapist 1-2 weeks.
- Pediatric therapy caseload has increased with the new Physical Therapist/Occupational Therapist position and we are starting to encounter space issues for pediatric treatments, which we hope we can resolve soon.

- Speech Therapy received an additional grant for the *"Speak Out Loud, a Parkinson's Voice Project"*.
- The educational videos on "Safe Patient Movement and Lifting" are being used in the Unit Peer Leader program to assist with staff clinical staff education.
- Rehab staff provide SPH departments with ergonomic training on request.
- Several of the staff have obtained a *"Lymphedema Therapists Certification"* now serving the community with improved treatment offerings.
- Summer of 2024 rehabilitation will be hosting a occupational therapy student, physical therapy student and speech-language pathology student for clinical internships. This is the first time we have had students for all three disciplines.
- The Rehab Department has been active in planning and designing a new off campus treatment space, located 2 miles from SPH. The plan is for outpatient orthopedic physical therapy and occupational therapy services to be offered in this space. This move will happen during 2024.
- Concurrently the rehab department has been planning for the services that will remain at SPH: pediatric therapy (PT/OT/SLP), neurological outpatient rehabilitation, inpatient care in Acute Care/Long Term Care, and Swing Bed rehabilitation. We are looking to update service provision and optimize to state of the art for all disciplines, including a *"Life Skills Lab"*. There is also potential for cardio-pulmonary rehabilitation to be included in this setting.

Rehabilitation Department Goals and Objectives for FY 2025:

- Decrease wait time for nonsurgical outpatients seeking an appointment.
- Retain Physical Therapy *(PT),* Occupational Therapy *(OT)* and Speech-Language Pathology *(SLP)* staff to meet community needs.
- Increase presence at community and school events.
- Provide additional public education in areas of Parkinson's disease and Pelvic Floor Physical Therapy intervention.
- Provide structure and support to South Peninsula Hospital's ergonomic intervention, return to work, pre-employment and post offer functional screening, in an ongoing effort to reduce Workers' Compensation costs.
- Continue to provide ergonomic education/training to other SPH departments.
- Update and revalidate all employee, job function descriptions and job function tests, for improved job matching and pre-work screening process, as well as post injury/illness return to work.
- Continue to work with multiple universities, including the University of Alaska Anchorage (*UAA),* to offer clinical opportunities for internships for physical therapy students.
- Work with other providers to help with Community Health Needs Assessment *(CHNA)* Objectives identified within the community.
- Improve treatment space options for the department, especially for Occupational Therapy *(OT)* and Speech-Language Pathology *(SLP).*

27) SECURITY SERVICES

Security Services Department Accomplishments and Highlights for FY 2024

- Hired/trained two full time security officers.
- Reviewed the security assessment.
- Updated 3-year implementation plan for security needs based off assessment.
- Developed security related policies.

- Reviewed current access control system and implemented a plan to bring the system current. Applied for and was awarded a Federal Emergency Management Agency *(FEMA)* security grant.
- Developed a security officers training plan with monthly training sessions.

Security Services Department Goals and Objectives for FY 2025:

- Add additional functionality to our camera and access control system by expanding both programs.
- Add additional training and defensive tools to security staff.
- Continue to improve add additional policies and procedures related to security and patient safety.
- Apply for FEMA security grant.
- Continue to integrate security throughout SPH campus.
- Work with Acute Care and Quality Management staff to improve room safety for patients on close observations or with a title 47 court ordered hold. Build seclusion room and remodel room 201 to meet the growing need for a safe space.

28) SPECIALTY CLINIC

Includes the following specialty clinics:

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

Specialty Clinic Department Accomplishments and Highlights for FY 2024:

- SPH General Surgery Clinic moved into the main hospital building.
- On boarded Dr. Jonathan Bloch full time surgeon.
- Seaworthy Functional Medicine Clinic moved into the main hospital building.
- Rob Downey, MD, provided educational podcasts and recorded interviews with numerous providers in the field of Functional Medicine. Recordings are available to view on Seaworthy Clinic website.
- Functional Medicine, General Surgery, Sleep Lab/Clinic and Neurology, participated in Rotary Health Fair.
- Transcranial Magnetic Stimulation *(TMS)* equipment for the treatment of medication resistant Depression. Staff and providers have completed necessary training.
- On boarded two Nurse Practitioners for the Sleep Clinics.
- On boarded a Nurse Practitioner for the General Surgery Clinic.
- On boarded two additional otolaryngologists.
- Seattle Children's Cardiology Clinic 2 days per year.
- Transitioned part-time orthopedic provider to full-time.
- Added audiology visits through timeshare agreement with Ears Nose and Throat *(ENT)* Specialists of Alaska.

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

Specialty Clinic Major Objectives/Goals for FY 2025:

- Increase infusions, by reaching out to providers, in order to meet infusion patient needs.
- Add a dermatology provider.
- Transition part-time orthopedic provider to full-time.
- Open a full-time reconstructive and plastic surgery clinic.

29) SPH DAYCARE

SPH Daycare Department Accomplishments and Highlights for FY 2024:

- Hired Childcare Administrator, Kyle Settles, to begin the task and duties of working toward childcare licensing and project management and development of the future childcare center.
- Solidified floor plans to include four classrooms to support children 3 months through 5 years and one classroom to support school-aged kids for before and after school care.
- Created a staff advisory group of eight SPH employees that acts as an instrumental collaborative soundboard.
- Hired Childcare Assistant Administrator/Teacher, Joanna Fonkert, to assist in the duties of childcare licensing and project management, as well as primarily acting as an early childhood educator once our center opens.
- Attended the Alaska Association for the Education of Young Children.
- Established a cohesive construction budget that connects to our Thread INNOVATION grant.
- Began hosting monthly forums for all staff (bi-weekly for managers) that focus on up to date information, timeline, and opportunities for Q&A.

SPH Daycare Department Goals and Objectives for FY 2025

- Begin interior renovations of existing space in summer/fall 2024.
- Begin exterior projects *(fencing, playground)* summer 2024.
- Obtain proper Alaska childcare licensure.
- Hire 20+ early childhood educators to support 60+ kids for licensed childcare center.
- Open our childcare center at 50% occupancy for three months, then 100% occupancy.
- Grow and learn with the childcare process while continuing to build a sustainable workforce to support the overall well-being of its educators and children.

30) SURGICAL SERVICES

Surgical Services *(SS)* Department Accomplishments and Highlights for FY 2024:

- Welcomed Jessica Jule, CRNA, to the surgical team.
- Welcomed general surgeon Jonathon Bloch, MD.
- Welcomed new Surgical Services full time staff members, one Certified Surgical Technologists *(CST),* two circulating Registered Nurse's, one Post-Anesthesia Care Unit Registered Nurse *(PACU RN),* and one Sterile Processing Technician *(SPD),* to eliminate the cost of utilizing travel staff.
- Cross-trained more surgical staff interdepartmentally to Operating Room Purchasing, Surgery Coordinator, Scrub Registered Nurse, and Sterile Processing Technician *(SPD)* to improve staffing model.

Administration
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- Continued collaboration with Obstetrics Department for training of staff on urgent and stat C-section care, as well as simulation of patients requiring Mass Transfusion Protocol.
- Consolidating supplies and continually placing surgical supplies infrequently used on do not reorder status to increase savings.
- Completed and implemented SPH new to Specialty Post-Anesthesia Care Unit *(PACU)* training.
- Began performing robotic assisted total knee replacement surgeries with the use of the Stryker MAKO Orthopedic robot.
- Began performing Mixed Reality assisted total shoulder replacements with the use of the Stryker Mixed reality equipment.
- Began performing laparoscopies with 3-D scope and camera equipment for increased visualization.

Surgical Services *(SS)* Department Major Objectives/Goals for FY 2025:

- Continue to grow volume of existing specialties by increasing marketing and education of staff and physicians.
- Expand surgical block time hours for physicians and patients.
- Start performing plastic surgeries and grow the volume of plastic surgical cases.
- Continue to evaluate utilization of supplies, condensing necessary supplies, and updating Periodic Automatic Replenishment *(PAR)* levels for cost effective budgeting.
- Increase recruiting and networking efforts to recruit full time staff to reduce cost of travel personnel contracts and promote consistency in surgery.
- Orient new Preoperative/Post-Anesthesia Care Unit *(PREOP/PACU)* Registered Nurse, filling all positions in the department.
- Work to cross train surgical staff interdepartmentally to improve staffing model. Encourage specialty certifications for Registered Nurse staff to promote best practice care and increase educational reach.
- Continue to evaluate and develop Surgical Services policies and procedures.
- Develop and monitor Performance Improvement measures form Press Ganey surveys.

APPROVED BY THE BOARD OF DIRECTORS *(BOD)* DURING JULY 24, 2024 BOD MEETING.

______________________________ ______________________________

Aaron Weisser, President Date

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

Introduced by:	Administration
Date:	July 24, 2024
Action:	
Vote:	Yes-, No- Exc-, Abst-

SOUTH PENINSULA HOSPITAL BOARD RESOLUTION 2024-18

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS APPROVING THE USE OF $993,661 OF PLANT REPLACEMENT AND EXPANSION FUNDS TO FUND THE RELOCATION AND CO-LOCATION OF OBSTETRICS AND GYNECOLOGY AND MIDWIFERY CLINICS WITHIN THE MAIN HOSPITAL BUILDING

WHEREAS, South Peninsula Hospital's Obstetrics, Gynecology and Midwifery services are important components of our mission to provide high quality, locally coordinated care; and

WHEREAS, South Peninsula Hospital's Obstetrics, Gynecology and Midwifery Department has outgrown its two existing facilities after adding an additional provider to meet community needs; and

WHEREAS, South Peninsula Hospital's 2023 Master facility plan identified Co-location of physician offices on the hospital campus as a strategic priority; and

WHEREAS, South Peninsula Hospital currently operates two separate clinic locations which offer Obstetrics/Gynecology and Midwifery/Gynecology, respectively, and co-locating these clinics will allow for greater patient convenience, provider collaboration, and better coordinated patient care and

WHEREAS, the Obstetrics, Gynecology and Midwifery Department now employs a total of 6 providers and their support teams, requiring a space with square footage which can only be located within the main hospital building. Consequently, this location will allow our providers to be closer to laboring patients, offering greater convenience and access to emergency services; and

WHEREAS, the proposed location for the new SPH Women's Health Center is currently occupied by South Peninsula Hospital's Rehabilitation department; and

WHEREAS, the estimated cost to remodel this 4,000 square foot space is $993,661 (approximately $250 per square foot); and

WHEREAS, South Peninsula Hospital currently has $6,974,644 in unobligated Plant Replacement and Expansion Funds which are held for the express purpose of capital repairs and replacement, and it is the intention of Administration to request that an amount not to exceed $993,661 of these funds be obligated for the renovation and buildout of an SPH Women's Health Clinic at 4300 Bartlett Street; and

WHEREAS, the South Peninsula Hospital Board Finance Committee reviewed and approved this resolution at their meeting on July 18, 2024.

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 obligation and use of Plant Replacement and Expansion Funds in an amount not to exceed $993,661for the renovation of space located at 4300 Bartlett Street for the creation of an SPH Women's Health Clinic.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA AT ITS MEETING HELD ON THIS 24th DAY OF July, 2024.

ATTEST:

____
Aaron Weisser, Board President

____
Mary E. Wythe, Board Secretary

Introduced by: Administration
Date: July 24, 2024
Action:
Vote: Yes-, No-
Exc-, Abst-

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2024-19

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS APPROVING THE USE OF UP TO $50,000 OF OPERATING FUNDS FOR THE COSTS OF DISTRIBUTING PROMOTIONAL INFORMATION ABOUT THE BALLOT PROPOSITION SEEKING VOTER APPROVAL FOR THE ISSUANCE OF BONDS TO PAY FOR THE SOUTH KENAI PENINSULA HOSPITAL SERVICE AREA CAMPUS EXPANSION, RENOVATION, AND ACQUISITION PROJECT TO ENSURE COMPLIANCE WITH LEGAL RESTRICTIONS ON THE USE OF BOROUGH FUNDS AND ASSETS RELATED TO BALLOT PROPOSITIONS

WHEREAS, the Kenai Peninsula Borough ("KPB") owns, and provides for the management and operation of, the South Peninsula Hospital and campus ("South Peninsula Hospital" or "Hospital") located in KPB's South Kenai Peninsula Hospital Service Area ("Service Area"); and

WHEREAS, KPB has entered into a management and operating agreement with South Peninsula Hospital, Inc., a nonprofit organization organized and existing under the laws of the state of Alaska ("SPHI") for the management and operation of the Hospital located in the Service Area; and

WHEREAS, KPB and SPHI have identified the need to plan, design, acquire property for, renovate, construct, and equip capital improvements for, and in connection with, the Hospital (collectively, the "Projects"); and

WHEREAS, the Service Area does not have sufficient funds available to pay the costs of the Projects and has determined it advisable to finance such costs through the issuance of general obligation bonds of the Service Area, in the principal amount not to exceed Thirty-Eight Million Five Hundred Thousand Dollars ($38,500,000); and

WHEREAS, SPHI's administration intends to use its operating funds to cover the costs of informing the public of the needs and impacts associated with the proposition, and promoting the proposition, seeking voter approval for the issuance of bonds to pay the costs of planning, designing, acquiring property, renovating, constructing, and equipping capital improvements to, and for, the South Peninsula Hospital and campus, all located in the Service Area; and

WHEREAS, as 15.13.145 prohibits municipalities from influencing the outcome of an election concerning a ballot proposition unless funds have been specifically appropriated for that purpose by municipal ordinance; and

WHEREAS, KPB 4.10.100 prohibits the use of public funds, facilities, equipment or supplies purchased with public funds, and services of public employees in-kind to promote the passage of a ballot proposition; and

WHEREAS, the determination of what explicitly constitutes influencing or supporting passage of a ballot proposition is an undefined, subjective area; and

WHEREAS, SPHI will use hospital operating funds, along with additional community or non-profit donations, as part of a campaign related to the Hospital bond ballot proposition; and

WHEREAS, per the operating agreement between KPB and SPHI, KPB does not direct SPHI regarding the use of its operating funds nor oversee expenditures of the funds; and

WHEREAS, due to the fact that it is unclear what might constitute public funds for purposes of AS 15.13.145 and KPB 4.10.100 this ordinance provides a one-time approval of the use of operating funds for the purpose of a campaign related to the Hospital bond ballot proposition; and

WHEREAS, since SPHI will use operating cash funds for this purpose, no appropriation of Service Area funds is requested or required; and

WHEREAS, shortened hearing is justified because time is of the essence with the upcoming October 1, 2024 election date and SPHI seeks clarity to immediately move forward with its campaign;

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

1. That the South Peninsula Hospital, Inc. Board of Directors hereby approves of the use of up to $50,000 in South Peninsula Hospital operating funds for an informational and promotional campaign, which may be used to influence the outcome of the election on October 1, 2024, on the ballot proposition concerning the proposed issuance of Services Area general obligation bonds to pay for the cost of planning, designing, acquiring property, renovating, constructing, and equipping capital improvements to, and for, the South Peninsula Hospital and campus.

2. This resolution shall be effective retroactively to July 1, 2024.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA AT ITS MEETING HELD ON THIS 24th DAY OF JULY, 2024.

ATTEST:

____
Aaron Weisser, Board President

____
Mary E. Wythe, Board Secretary

South Peninsula Hospital
Hospital Board of Trustees Balanced Scorecard Report
2nd Quarter Calendar 2024 *(Apr, May, Jun)*

Overall Indicators	1Q 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	4	5	105	7/1/2022-6/30/2023 *(21% Survey Response Rate)*
Medicare Care Compare Overall Nursing Home Star Rating	5	5		

Clinical & Service Excellence

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

Quality of Care / Patient Safety	2Q 2024	Target	n	Note
Severe Sepsis & Septic Shock Care	**100%**	**> 75%**	**48**	***(Care Compare: 58 cases - 88%, 7/1/2022-6/30/2023)***
Percentage *of patients who received appropriate care for sepsis and/or septic shock.*				# of cases passing / total # of cases-exceptions *(Q2-2024: 48 cases reviewed: 12 pass, 0 fail, 36 exclusions)*
Stroke Care	**83%**	**> 95%**	**15**	***(Care Compare: N/A , 7/1/2022-6/31/2023)***
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. *(Q2-2024: 15 cases, 5- pass, 1- failed, 9- exclusions)*
Median Emergency Room Time	**171min**	**< 180min**	**1520**	**Target *(minutes)(Care Compare: 140 min, 7/1/2022-6/30/2023)***
Average minutes spent in department before leaving the Emergency Department.				Average throughput time of all ED visits. *(Q2-2024: 1520 cases: 171 min. Median Time)*
Readmission	**5.5%**	**< 15%**	**128**	***(Care Compare 15.3%, 214 patients 7/1/2021-6/30/2022)***
Percentage of unplanned readmission to an acute care hospital in 30 days after discharged from a hospitalization.				5.5% of patients with unplanned readmission to (IP/Obs) within 30 days of discharge - exclusions / Eligible admissions- 7 readmits / 128 total admits.
OB – C-Section Rate	**20%**	**< 30%**	**5**	**# NTSV C-Sections / Total # NTSV births**
Percentage of patients in the NTSV *(nulliparous, term, singleton, vertex)* category delivering by cesarean section.				*1 NTSV C-Sec. (1st Pregnancy), term (>37 weeks), / 5 total #NTSV births (Measured by chart abstractions.)*
Provider Quality Score (Group)	**54%**	**75%**	**N/A**	**Scoring tabulated as a running, annual score.**
CMS Merit-Based Incentive Payment System *(MIPS)* for providers				Target to be adjusted Quarterly as appropriate
Patient Fall Rate AC	**2.11**	**< 5**	**2**	**# of patient falls / # patient days x 1000**
Measures the number of patient falls per 1,000 patient days.				n = IP, observations and swing bed patient days. **Note:** AC had 2 falls total; 1 falls without injury and 1 falls with injury. *(Tracking through occurrence reporting system.)*

Quality of Care / Patient Safety *(continued)*	2Q 2024	Target	n	Note
Medication Errors	1	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. *(Tracking through occurrence reporting system.)*
Never Events	0	0	N/A	
Unexpected occurrence involving death/serious physiological or psychological injury, or the risk thereof.				*(Tracking through occurrence reporting system.)*
Home Health (HH)	**2Q 2024**	**Target**	**n**	**Note**
Independent Bathing	100%	> 75%	30	
Percentage of home health patients demonstrating improvement with ability to bathe more independently.				100% of the patients stayed the same or improved. 27 Patients improved, 3 stayed the same. *(Tracked through OASIS Reporting.)*
Nursing Home (LTC)	**2Q 2024**	**Target**	**n**	**Note**
Depressive Symptoms	1	≤ 2	N/A	
Number of residents who develop symptoms of depression after admission.				*(Tracked through MDS Reporting.)*

Patient & Resident Experience

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

Consumer Assessment of Healthcare Providers and Services	2Q 2024	Target	n	Note: Measures as a % ranking across PG clients.
HCAHPS Percentile	97th	75th	39	
Measures the 1-10 ranking received by inpatient client *(or family)* respondents.				Q4-2023: 40th, n=28, Q1 -2024: 43rd, n = 25, Q2 -2023: 97, n = 39
HHCAHPS Percentile	87%	75%	38	***Running 12 months due to low quarterly returns**
Percentage of patients rating the agency as 9-10/10" with a goal of 75%.				Q4-2023: 89%, n = 28, Q1-2024: 88%, n=33, Q2-2024: 87, n=38

Patient Satisfaction Through Press Ganey (PG)	2Q 2024	Target	n	Note: % ranking across PG clients.
Inpatient Percentile	**91st**	**75th**	**39**	
Measures the satisfaction of inpatient pts. respondents.				Q4 -2023: 78th, n =28, Q1 -2024: 89th, n = 25, Q2-2024: 91st, n= 39
Outpatient Percentile	**13th**	**75th**	**362**	
Measures the satisfaction of outpatient pts. respondents.				Q4 -2023: 22nd, n = 271, Q1 -2024: 40th, n = 224, Q2-2024: 13th, n= 362
Emergency Department Percentile	**91st**	**75th**	**112**	
Measures the satisfaction of emergency pts. respondents.				Q4 -2023: 95th, n =64, Q1 -2024: 84th, n = 76, Q2 -2024: 91st, n = 112,
Medical Practice Percentile	**44th**	**75th**	**515**	
Measures the satisfaction of pts. respondents at SPH Clinics.				Q4 -2023: 51st, n = 366, Q1 -2024: 48th, n = 533, Q2 -2024: 44th, n = 515
Ambulatory Surgery (AS) Percentile	**99th**	**75th**	**70**	
Measures the satisfaction of AS pts. respondents.				Q4 -2023: 67th, n = 88, Q1 -2024: 39th, n =52, Q2 -2024: 99th, n =70
Information System Solutions	**2Q 2024**	**Target**	**n**	**Note**
Eligible Hospital (EH) Promoting Interoperability: hospital-based measures for inpatient and observation stays.	**88**	**≥ 60**	**N/A**	**CMS score 60 and above = pass**
e-Prescribing: Electronic Prescribing *(Rx)*	**8**	**10**	374 of 442	FY24 to date = 701 of 862
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	**15**	**15**	3 of 3	FY24 to date = 4 of 4
HIE: Support. Electronic Referral Loops by sending health info. *(Sum of Care sent)*	**6**	**15**	66 of 171	FY24 to date = 134 of 372
Provider to patient exchange: Provide patients electronic access to their health information. *(timely access via the patient portal)*	**24**	**25**	209 of 222	FY24 to date = 399 of 431
Public Health & Clinical Data Exchange	**25**	**25**	N/A	Public Health and Clinical Data Exchange interfaces in place.
Eligible Provider (EP) - Promoting Interoperability (Group)	**100%**	**95%**	**N/A**	**Target quarterly for annual score**
Merit Based Incentive Payment System Promoting Interoperability score. *(MIPS tracking is in Athena)*				Promoting Interoperability for Providers: N/A * Athena hasn't calculated our score yet
Electronic Medical Record (EMR) Adoption Stage	**5**	**5**	**N/A**	
Health Information Management & Systems Society *(HIMSS)* Electronic Medical Record Adoption Model *(EMRAM)* 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.

Information System Solutions *(Continued)*	2Q 2024	Target	n	Note
IT Security Awareness Training Complete Rate	81%	97%	1874	
% of employees who have completed assigned security training				1874 Training videos sent, 1615 were completed.
Phishing Test Pass Rate	97%	97%	3739	
% of Phishing test emails that were not failed.				3739 Test phishing emails sent out to staff. 96 of the email links were clicked, causing 96 potential security risks.

Medical Staff Alignment

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

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

Employee Engagement

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

Staff Alignment	2021			
Employee Satisfaction Percentile	70th	75th		
Measures the satisfaction of staff respondents as indicated in Press Ganey staff survey results Measured as a percentile.				Result of employee survey 2021

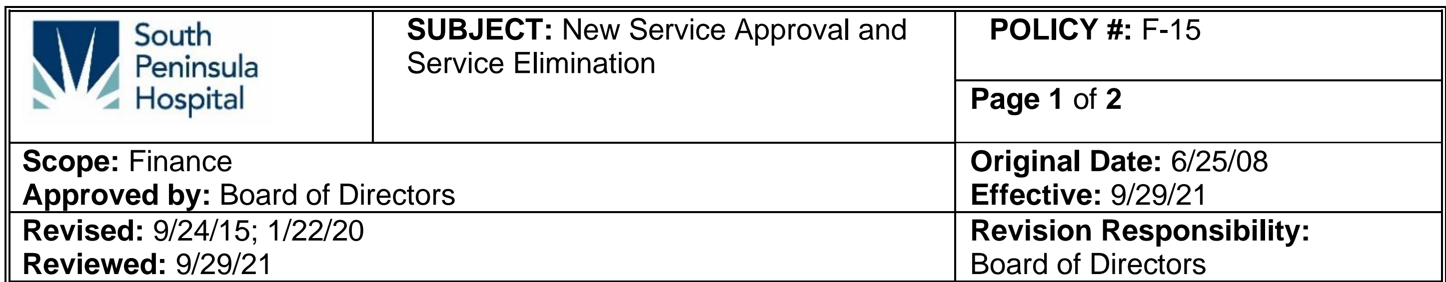
Workforce	2Q 2023	Target	n	Note
Turnover: All Employees	5.1%	< 5%	642	
Percentage of all employees separated from the hospital for any reason				33 Terminations / 642 Total Employees
Turnover: Voluntary All Employees	3.9%	< 4.75%	642	
Measures the percentage of voluntary staff separations from the hospital				23 Voluntary Terminations / 642 Total Employees
First Year Total Turnover	6.8%	< 7%	110	
Measures the percentage of staff hired in the last 12 months and who separated from the hospital for any reason during the quarter.				10 New Staff Terminated in Q2-2024 145 Total New Hires from - 7/1/2023 -6/30/2024
Travel Nursing Utilization	16	< 15		
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	2Q 2024	Target	n	Note
Operating Margin	**TBD**	**-0.2%**		
Measures the surplus (deficit) of operating income over operating expenses as a percentage of net patient service revenue for the quarter.				Target is based on budgeted operating margin for the period.
Adjusted Patient Discharges	**TBD**	**899.84**		**Total Discharges: # 160 *(Acute, OB, Swing, ICU)***
Measures the number of patients discharged, adjusted by inpatient revenues for the quarter divided by *(inpatient + outpatient revenues).*				*(LTC Revenue & discharges not included, Target is same Q Prior Year. Target Discharges: 142)*
Net Revenue Growth	**TBD**	**19.5%**		
Measures the percentage increase *(decrease)* in net patient revenue for the quarter compared to the same period in the prior year.				Target is based on budgeted net patient service revenue for the period compared to net patient service revenue for the same period in prior year.
Full Time Equivalents *(FTEs)* per Adjusted Occupied Bed	**TBD**	**7.35**		
Measures the average number of staff FTEs per adjusted occupied bed for the quarter.				Target is based on budgeted paid hours *(FTE)* divided by *(budget gross patient revenue/budget gross inpatient rev)* X budgeted average daily census for the quarter.
Net Days in Accounts Receivable	**TBD**	**55**		
Measures the rate of speed with which the hospital is paid for health care services.				
Cash on Hand	**TBD**	**90**		**104 Total Days Cash on Hand, Operating +Unobligated PREF**
Measure the actual unrestricted cash on hand (excluding PREF and Service Area) that the hospital has to meet daily operating expenses.				Cash available for operations based average daily operating expenses during the quarter less depreciation for the quarter.
Uncompensated Care as a Percentage of Gross Revenue	**TBD**	**2.5-3.5%**		
Measures bad debt & charity write offs as a percentage of gross patient service revenue				Target is based on industry standards & SPH Payer Mix Budgeted total is 2.9% Expected range of 2.5-3.5%
Average Age of Plant	**TBD**	**8 yrs.**		
Average age of assets used to provide services				Target is based on hospital optimal age of plant.

Intense Market Focus to Expand Market Share	2Q 2024	Target	n	Note
Outpatient Revenue Growth	**TBD**	**13%**		
Measures percentage increase (decrease) in outpatient revenue for the quarter, compared to the same period in the prior year.				Target is based on budgeted outpatient revenue for the period compared to outpatient revenue for the same period prior year.
Surgical Case Growth	**TBD**	**2.2%**		
Measures the increase *(decrease)* in surgical cases for the quarter compared to the same period in the prior year.				Target is based on budgeted surgeries above actual from same quarter prior year.



South Peninsula Hospital	**SUBJECT:** New Service Approval and Service Elimination	**POLICY #:** F-15 **Page 1 of 2**
Scope: Finance **Approved by:** Board of Directors		**Original Date:** 6/25/08 **Effective:** 9/29/21
Revised: 9/24/15; 1/22/20 **Reviewed:** 9/29/21		**Revision Responsibility:** Board of Directors

PURPOSE:
Guidelines for the proposal and evaluation of new or eliminated services provided at South Peninsula Hospital (SPH).

DEFINITION(S):
~~N/A~~New Service: New services include but are not limited to joint ventures or ownership participation or management participation in other health care services, and other business arrangements with health care providers and businesses. Expansion of services or new services do not include changes in the method of delivering existing services or the use of new technology or techniques to provide those services even if this may involve additional personnel or training or enhancement of current capabilities to meet standards for proper patient care, or changes required to meet basic accreditation standards and licensing for the hospital.

POLICY:
A. SPH will evaluate the provision of new services that align with our mission, vision, and values via the use of Business Plans which evaluate, at a minimum:
   1. The service being proposed
   2. The client target
   3. The capital and expense resources required
   4. The cash flow analysis of service profitability
   5. The anticipated social and operations impacts
B. Proposal of provision of new services will ~~also be compared to the Medical Staff Development Plan following policy MSO-007, Medical Staff Development. These services will~~ be approved and forwarded pursuant to the provisions of the Operating Agreement. All joint ventures or ownership participation or management participation in other health care services require prior approval by the Borough Assembly by ordinance. Prior notice of expansion of services or new services shall be provided in writing to the Borough Contract ~~The~~Administrator. The financial performance of new services will be reviewed quarterly for the first two years, in comparison with the original business plan and proforma.
C. SPH will evaluate the elimination of services via the use of Business Plans which will evaluate, at a minimum:
   1. The service being proposed for elimination
   2. The client base which will be impacted by the elimination
   3. The financial impact, such as capital or expenses saved via the elimination
   4. The cash flow impact of the elimination of the service
   5. The anticipated social and operations impact
D. The service line elimination will be approved and forwarded pursuant to the provisions of the Operating Agreement.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

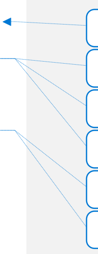
REFERENCE(S):

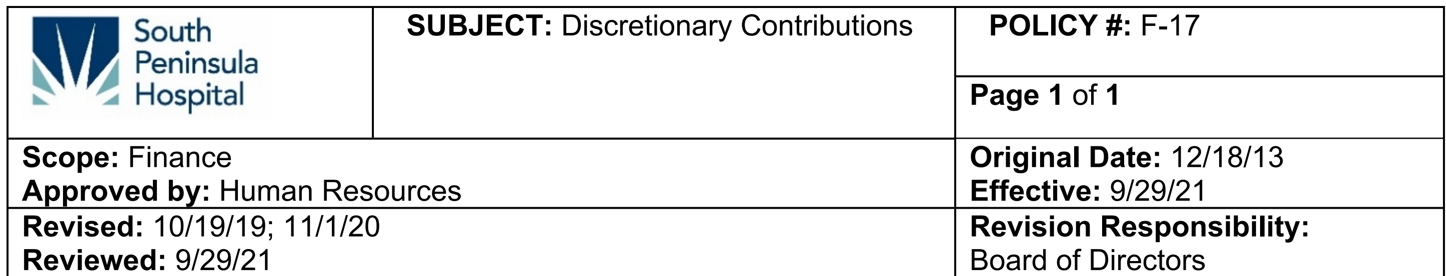
1. Operating Agreement for South Peninsula Hospital with Kenai Peninsula Borough, 2020

CONTRIBUTOR(S):
Board of Directors

POLICY #: F-15

SUBJECT: New Service Approval and Service Elimination





South Peninsula Hospital	**SUBJECT:** Discretionary Contributions	**POLICY #:** F-17
		Page 1 of 1
Scope: Finance **Approved by:** Human Resources		**Original Date:** 12/18/13 **Effective:** 9/29/21
Revised: 10/19/19; 11/1/20 **Reviewed:** 9/29/21		**Revision Responsibility:** Board of Directors

PURPOSE:
Budgeting guidelines for discretionary contributions.

DEFINITION(S):
N/A

POLICY:
A. South Peninsula Hospital may budget for the discretionary contribution for non-union employees annually.
B. The budget will be approved and adopted by the Board of Directors annually, per policy F-12.
C. In January of each year, the board of Directors may approve a discretionary contribution for the Non-Union 403(b) in an amount not to exceed 4% of annual eligible compensation for the previous calendar year considering the financial position of the Hospital at that time.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
N/A

CONTRIBUTOR(S):
Chief Financial Officer, Board of Directors