



AGENDA

Board of Directors Meeting

5:30 PM - Wednesday, May 22, 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		Preston Simmons	
Melissa Jacobsen, Vice President		Matthew Bullard		Bernadette Wilson	
Beth Wythe, Secretary		Matthew Hambrick			
Walter Partridge, Treasurer		Edson Knapp, MD			

[Board Master Reports List](#)

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

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

Values: Compassion, Respect, Trust, Teamwork and Commitment

Page

1. CALL TO ORDER

2. ROLL CALL

3. REFLECT ON LIVING OUR VALUES

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

- 5 4.1. Rules for Participating in a Public Meeting
[Rules for Participating in a Public Meeting](#)

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

6. APPROVAL OF THE AGENDA

7. APPROVAL OF THE CONSENT CALENDAR

- 6 - 11 7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for April 24, 2024.
[Board of Directors - Apr 24 2024 - Minutes - DRAFT](#)
- 12 - 15 7.2. Consideration to Approve April FY2024 Financials
[Balance Sheet April 2024](#)
[Income Statement April 2024](#)
[Cash Flow Statement April 2024](#)
- 16 - 19 7.3. Consideration to Approve Board Policy F-12 Approval and Adoption of Operating Budget, Board Policy F-13 Finance Reports and Board Policy MS-02 Peer Review
[Memo](#)
[F-12](#)
[F-13](#)
[Q-02 - change to MS-02](#)
- 20 - 44 7.4. Consideration to Approve the Revised South Peninsula Hospital Quality Assessment and Performance Improvement Program (Quality Plan) and the Long Term Care QAPI Plan for 2024-2025
[Memo](#)
[SPH Quality Plan, revised](#)
[LTC QAPI](#)
- 45 7.5. Consideration to Approve A Proclamation Recognizing Eva Stovall for Twenty-Three Years of Service to South Peninsula Hospital
[Eva Stovall Board Proclamation](#)

8. PRESENTATIONS

- 8.1. Presentation to Eva Stovall of Proclamation Honoring her Twenty-Three Years of Service to South Peninsula Hospital

9. UNFINISHED BUSINESS

10. NEW BUSINESS

- 46 - 47 10.1. Consideration to Approve SPH Resolution 2024-13, A Resolution Of The South Peninsula Hospital Board Of Directors Approving The Use Of \$80,726 Of Operating Cash To Fund The Additional Project Needs For The Relocation Of The General Surgery Clinic And Functional Medicine Clinic Within The Main Hospital Building
[SPH Resolution 2024-13](#)

- 48 10.2. Consideration to Approve SPH Resolution 2024-14, A Resolution Of The South Peninsula Hospital Board Of Directors Approving An Additional \$87,304 Of Operating Cash To Fund The Already Active 4201 Bartlett St Remodel Project Approved In The SPH Resolution 2020-01 At \$500,000 And Amended In Scope In The SPH Resolution 2023-25 To Make The Total Approved Amount Of This Project \$587,304
[SPH Resolution 2024-14](#)
- 49 - 50 10.3. Consideration to Approve SPH Resolution 2024-15, A Resolution Of The South Peninsula Hospital Board Of Directors Recommending The Submission To The Qualified Voters Of The South Kenai Peninsula Hospital Service Area The Question Of The Issuance Of Not-To-Exceed Thirty Eight Million Five Hundred Thousand Dollars (\$38,500,000.00) Of General Obligation Bonds Of The South Kenai Peninsula Hospital Service Area To Pay The Costs Of Planning, Designing, Acquiring Property For, Renovating, Constructing, And Equipping Of Facilities At The South Peninsula Hospital And Campus Located In The South Kenai Peninsula Hospital Service Area At The Regular Election In And For The Kenai Peninsula Borough On October 1, 2024
[SPH Resolution 2024-15](#)
- 51 10.4. Consideration to Approve SPH Resolution 2024-16, A Resolution Of The South Peninsula Hospital Board Of Directors Approving The Fiscal Year 2025 Operating Budget
[SPH Resolution 2024-16](#)

11. REPORTS

- 11.1. Chief Executive Officer
- 11.2. BOD Committee: Pension
- 11.3. BOD Committee: Finance
- 52 - 62 11.4. BOD Committee: Governance
[First Reading: Proposed Revisions to SPH Board Bylaws, Article III, Section 1](#)
- 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

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15.1. Annual Board Calendar

[Board Agenda Calendar 2024](#)

16. ADJOURN TO EXECUTIVE SESSION

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Credentialing

18. ADJOURNMENT

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, April 24, 2024
Conference Rooms 1&2 and Zoom

The meeting of the Board of Directors of South Peninsula Hospital was called to order on Wednesday, April 24, 2024, at 5:30 PM, in the Conference Rooms 1&2 and Zoom.

1. CALL TO ORDER

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

2. ROLL CALL

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

BOARD EXCUSED:

ALSO PRESENT: Ryan Smith

**Only meeting participants who comment, give report or give presentations are noted in the minutes.*

2.1. A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Rachael Kincaid, CNO, shared a story about one of our Speech Language Pathologists, who has been working on communication with a non-verbal client and found some assistive communication devices and apps that enabled him to communicate. The family did not have funds to get the needed device/app, so she applied to the Alaska Mental Health Trust for a Developmental Disabilities Mini-Grant, which was approved for about \$400. The SLP was able to work with the SPH accounting department to set up an account to receive the funds, and we were able to purchase the app and devices for the patient. This was a great win, with great multi-agency cooperation and inter-department collaboration. Mr. Weisser took a moment to thank Nyla Lightcap and Maura Jones, Executive Assistants in the Administration office, on Administrative Professionals Day.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

4.1. Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

There were no comments from the audience.

6. APPROVAL OF THE AGENDA

Melissa Jacobsen made a motion to approve the agenda. Edson Knapp seconded the motion. Motion Carried.

7. APPROVAL OF THE CONSENT CALENDAR

Ms. Jacobsen read the consent calendar into the record.

7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for March 27, 2024

7.2. Consideration to Approve March FY2024 Financials

7.3. Consideration to Approve 2024-12, Authorizing the CFO to Sign, File and Submit the IRS Form 990

7.4. Consideration to Accept Final Committee Assignments for 2024

Melissa Jacobsen made a motion to approve the consent calendar. Beth Wythe seconded the motion. Motion Carried.

8. PRESENTATIONS

There were no presentations.

9. UNFINISHED BUSINESS

There was no unfinished business.

10. NEW BUSINESS

10.1. Consideration to Approve Revised General Surgery Privileges as Recommended by the Medical Staff

Dr. Tuomi, CMO, reported. The medical staff approved updates to the general surgery privileges. The second page lists the available special privileges and the required qualifications. There's also space to add other requests not specifically listed. Mr. Weisser inquired about the process for updating privileges. Dr. Tuomi responded they are first reviewed by the medical director of the department, working with the department manager. The updated privileges are then reviewed at Credentials Committee and the Medical Executive Committee before coming to the Board for final approval.

10.2. Consideration to Approve SPH Resolution 2024-10, Requesting \$5,000 from South Kenai Peninsula Hospital Service Area Fund Balance to Provide for Bond Counsel Expenditures on Preliminary Bond Related Services

Ryan Smith, CEO, reported. This resolution was prepared by the mayor's office and approves \$5,000 to obtain bond council in anticipation of going out for bonds this fall. The resolution has already been approved by the Service Area Board (SAB). Mr. Weisser inquired about the purpose of bond council, and Mr. Smith answered they will help do preparatory work for disclosures to the bond

bank. This resolution will show the board's support for initiating all the necessary preparations to go out for bonds.

Beth Wythe made a motion to approve SPH Resolution 2024-10, Requesting \$5,000 from South Kenai Peninsula Hospital Service Area Fund Balance to Provide for Bond Counsel Expenditures on Preliminary Bond Related Services. Melissa Jacobsen seconded the motion. Motion Carried.

10.3. Consideration to Approve SPH Resolution 2024-11, Requesting Approval of a Lease Agreement for Medical Office Space Located at 4251 Hohe Street, Requesting Funds for Conditional Acquisition for Three Commercial Properties in Homer, Alaska

Mr. Baker shared a possible conflict, in that he was previously employed by the seller of the properties named in the resolution. That employment ended four years ago. Mr. Weisser asked if anyone would like to take a vote on conflict of interest, but no one felt there was a conflict, so no conflict was established.

Mr. Smith reported. This resolution will authorize the hospital to lease one additional property adjacent to the hospital, and also to support the borough purchase of that property and two additional properties that are currently leased by the hospital. If approved, this purchase would be part of the bond package.

Beth Wythe made a motion to approve SPH Resolution 2024-11, Requesting Approval of a Lease Agreement for Medical Office Space Located at 4251 Hohe Street, Requesting Funds for Conditional Acquisition for Three Commercial Properties in Homer, Alaska Melissa Jacobsen seconded the motion. A roll call vote was conducted.

<i>Jared Baker</i>	<i>Yes</i>
<i>Matthew Bullard</i>	<i>Yes</i>
<i>Matthew Hambrick</i>	<i>Yes</i>
<i>Melissa Jacobsen</i>	<i>Yes</i>
<i>Edson Knapp</i>	<i>Yes</i>
<i>Walter Partridge</i>	<i>Yes</i>
<i>Preston Simmons</i>	<i>Yes</i>
<i>Bernadette Wilson</i>	<i>Yes</i>
<i>Beth Wythe</i>	<i>Yes</i>
<i>Aaron Weisser</i>	<i>Yes</i>

Motion Carried.

11. REPORTS

11.1. Chief Executive Officer

A new scorecard was provided, showing data from the first quarter of 2024. The leadership team provided a detailed update of the scorecard. Rachael Kincaid,

CNO, reviewed the clinical indicators, and Anna Hermanson, CFO, reviewed the financial indicators.

11.2. BOD Committee: Finance

Walter Partridge, committee chair, reported. The Finance Committee met on April 18th and discussed and approved the resolutions presented earlier in the meeting. We also discussed the financial policies F-09 and F-10 that are under the Governance Report. The Capital Expenditures Policy underwent extensive revisions, as Ms. Hermanson did an excellent job of bringing the policy up to date with the Operating Agreement. We also discussed the March financials. It was not a strong month. Revenue was down, and deductions and expenses were up. There was a -18% margin. The committee also discussed the indicators on the balanced scorecard. Anna has put together some run charts on those numbers so we can see them over time. The committee reviewed the 990, which is an extensive document that takes a lot of work from the finance team. Mr. Baker added that Ms. Hermanson had reported that the billing teams were working hard on accounts receivable to draw cash in, which was really helpful in a financially difficult month.

11.3. BOD Committee: Governance

Beth Wythe, committee chair, reported. The Governance Committee met on April 18th. The committee appointed a CEO Evaluation subcommittee consisting of Walter Partridge, Jared Baker and Melissa Jacobsen. The committee also discussed candidates for the open board seat. There were two candidates interviewed, and they will be discussed in executive session. The committee also continued their review of the bylaws, and will be bringing forward a change to the membership section at the next meeting. We also continued with ongoing policy review, and policies F-09 and F-10 are included in the packet for initial review. If there are no questions or additional revisions, they will be placed on the consent calendar for the May meeting.

11.4. BOD Committee: Education

Ms. Jacobsen thanked everyone for their participation in the board work session.

11.5. Chief of Staff

Dr. Landess had nothing to add to his written report.

11.6. Service Area Board Representative

Francie Roberts reported on behalf of the Service Area Board. The SAB met on April 11th and passed two resolutions which supported the bonding and purchase resolutions that the operating board voted on tonight.

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 again thanked Ms. Jones for all her work assisting the board.

14.2. Board Members

Ms. Wythe shared she has been reading some excellent books on board governance that she would be happy to share. Mr. Simmons reminded the board members to sign up for the Homer Steps Up walking challenge. Mr. Hambrick thanked Melissa and the Education Committee for an engaging and positive work session. Ms. Wilson thanked the finance team for their extensive work on the 990 form. Mr. Partridge thanked Ms. Jones for all her work in assisting the board.

15. INFORMATIONAL ITEMS

15.1. Board Calendar

The board calendar was provided in the packet for reference.

16. ADJOURN TO EXECUTIVE SESSION

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Credentialing

After review of the applicant's files through the secure online portal, Melissa Jacobsen 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.

Reappointments

Leon Mensch, MD; Pathology; Courtesy Staff
Evan Jones, MD; Orthopedics; Courtesy Staff
Justin Metzler, CRNA; Anesthesiology; Courtesy Staff
Tamara Shrader, ANP; Nurse Practitioner; Active Staff
Sarah Godsey, CRNA; Anesthesiology; Courtesy Staff
Bernadette Curtis, MD; Teleradiology; Telehealth Privileges
Krishnan Kartha, MD; Teleradiology; Telehealth Privileges
Stephanie Runyan, DO; Teleradiology; Telehealth Privileges
Christopher Rickman, MD; Teleradiology; Telehealth Privileges

New Appointments

Katelynn Bailey, DO; Emergency Medicine; Active Staff
Joseph Knight, DMP; Podiatry; Courtesy Staff*
Michelle Pearce, MS, AGNCP; Oncology; Courtesy Staff

*The appointment of Dr. Knight is conditional pending review and verification of case logs.

17.2. Appointment to Fill Vacant Board Seat

After review of the candidates' applications and vote by secret ballot in Executive Session, Melissa Jacobsen moved to appoint Dr. Christopher Landess to the South Peninsula Hospital Board of Directors. Dr. Landess received the majority of board members voting in the affirmative for his appointment, as required in the bylaws. Matt Hambrick seconded the motion. Motion carried.

18. ADJOURNMENT

The meeting was adjourned at 8:26pm.

Respectfully Submitted,

Accepted:

Maura Jones, Executive Assistant

David Groesbeck, President

Minutes Approved:

Mary E. Wythe, Secretary



DRAFT-UNAUDITED

BALANCE SHEET
As of April 30, 2024

	As of April 30, 2024	As of April 30, 2023	As of March 31, 2024	CHANGE FROM April 30, 2023
ASSETS				
CURRENT ASSETS:				
1 CASH AND CASH EQUIVALENTS	26,870,119	25,368,795	26,166,032	1,501,324
2 EQUITY IN CENTRAL TREASURY	7,264,825	8,331,964	7,710,347	(1,067,139)
3 TOTAL CASH	<u>34,134,944</u>	<u>33,700,759</u>	<u>33,876,379</u>	<u>434,185</u>
4 PATIENT ACCOUNTS RECEIVABLE	35,457,691	31,194,515	33,751,929	4,263,176
5 LESS: ALLOWANCES & ADJ	(17,725,322)	(15,047,554)	(16,511,999)	(2,677,768)
6 NET PATIENT ACCT RECEIVABLE	<u>17,732,369</u>	<u>16,146,961</u>	<u>17,239,930</u>	<u>1,585,408</u>
7 PROPERTY TAXES RECV - KPB	116,876	110,208	154,240	6,668
8 LESS: ALLOW PROP TAX - KPB	(4,165)	(4,165)	(4,165)	0
9 NET PROPERTY TAX RECV - KPB	<u>112,711</u>	<u>106,043</u>	<u>150,075</u>	<u>6,668</u>
10 OTHER RECEIVABLES - SPH	275,028	336,149	229,323	(61,121)
11 INVENTORIES	2,053,151	1,905,167	2,051,188	147,984
12 NET PENSION ASSET- GASB	3,559,619	5,024,897	3,559,619	(1,465,278)
13 PREPAID EXPENSES	<u>1,005,186</u>	<u>830,411</u>	<u>1,035,406</u>	<u>174,775</u>
14 TOTAL CURRENT ASSETS	<u>58,873,008</u>	<u>58,050,387</u>	<u>58,141,920</u>	<u>822,621</u>
ASSETS WHOSE USE IS LIMITED				
15 PREF UNOBLIGATED	6,958,193	6,556,828	6,976,485	401,365
16 PREF OBLIGATED	2,123,724	2,347,446	2,123,724	(223,722)
17 OTHER RESTRICTED FUNDS	1,293,065	50,434	1,317,454	1,242,631
	<u>10,374,982</u>	<u>8,954,708</u>	<u>10,417,663</u>	<u>1,420,274</u>
PROPERTY AND EQUIPMENT:				
18 LAND AND LAND IMPROVEMENTS	4,124,558	4,114,693	4,124,558	9,865
19 BUILDINGS	65,997,328	63,059,362	65,544,986	2,937,966
20 EQUIPMENT	30,258,619	27,257,835	30,040,055	3,000,784
21 BUILDINGS INTANGIBLE ASSETS	3,411,295	2,456,899	3,411,295	954,396
22 EQUIPMENT INTANGIBLE ASSETS	851,479	462,427	851,479	389,052
23 SOFTWARE INTANGIBLE ASSETS	2,135,559	0	2,135,559	2,135,559
24 IMPROVEMENTS OTHER THAN BUILDINGS	926,889	309,171	517,414	617,718
25 CONSTRUCTION IN PROGRESS	1,952,086	1,506,279	2,701,383	445,807
26 LESS: ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(61,887,387)	(56,678,505)	(61,470,663)	(5,208,882)
27 LESS: ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(1,831,552)	(787,627)	(1,769,266)	(1,043,925)
28 NET CAPITAL ASSETS	<u>45,938,874</u>	<u>41,700,534</u>	<u>46,086,800</u>	<u>4,238,340</u>
29 GOODWILL	0	7,000	0	(7,000)
30 TOTAL ASSETS	<u>115,186,864</u>	<u>108,712,629</u>	<u>114,646,383</u>	<u>6,474,235</u>
DEFERRED OUTFLOWS OF RESOURCES				
31 PENSION RELATED (GASB 68)	5,591,887	4,530,917	5,789,464	1,060,970
32 UNAMORTIZED DEFERRED CHARGE ON REFUNDING	<u>238,601</u>	<u>298,393</u>	<u>245,984</u>	<u>(59,792)</u>
33 TOTAL DEFERRED OUTFLOWS OF RESOURCES	5,830,488	4,829,310	6,035,448	1,001,178
34 TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	<u>121,017,352</u>	<u>113,541,939</u>	<u>120,681,831</u>	<u>7,475,413</u>

	<u>As of April 30, 2024</u>	<u>As of April 30, 2023</u>	<u>As of March 31, 2024</u>	<u>CHANGE FROM April 30, 2023</u>
LIABILITIES & FUND BALANCE				
CURRENT LIABILITIES:				
35	ACCOUNTS AND CONTRACTS PAYABLE 2,251,387	1,725,362	2,292,740	526,025
36	ACCRUED LIABILITIES 8,814,848	8,103,685	7,575,473	711,163
37	DEFERRED CREDITS 1,254,625	9,937	1,276,141	1,244,688
38	CURRENT PORTION OF LEASE PAYABLE 217,290	402,561	217,290	(185,271)
39	CURRENT PORTION SOFTWARE INTANGIBLE PAYABLE 596,124	0	599,373	596,124
40	CURRENT PORTIONS OF NOTES DUE 0	0	0	0
41	CURRENT PORTIONS OF BONDS PAYABLE 1,195,000	1,850,000	1,190,000	(655,000)
42	BOND INTEREST PAYABLE 30,606	47,918	45,469	(17,312)
43	DUE TO/(FROM) THIRD PARTY PAYERS 940,817	788,761	940,709	152,056
44	<u>TOTAL CURRENT LIABILITIES 15,300,697</u>	<u>12,928,224</u>	<u>14,137,195</u>	<u>2,372,473</u>
LONG-TERM LIABILITIES				
45	NOTES PAYABLE 0	0	0	0
46	BONDS PAYABLE NET OF CURRENT PORTION 5,420,000	6,615,000	5,715,000	(1,195,000)
47	PREMIUM ON BONDS PAYABLE 299,271	413,702	312,981	(114,431)
48	CAPITAL LEASE, NET OF CURRENT PORTION 3,296,732	1,928,987	3,342,753	1,367,745
49	SOFTWARE INTANGIBLE LEASE, NET OF CURRENT PORTION 285,498	0	307,959	285,498
50	<u>TOTAL NONCURRENT LIABILITIES 9,301,501</u>	<u>8,957,689</u>	<u>9,678,693</u>	<u>343,812</u>
51	<u>TOTAL LIABILITIES 24,602,198</u>	<u>21,885,913</u>	<u>23,815,888</u>	<u>2,716,285</u>
52	DEFERRED INFLOW OF RESOURCES 0	0	0	0
53	PROPERTY TAXES RECEIVED IN ADVANCE 5	0	5	5
NET POSITION				
54	INVESTED IN CAPITAL ASSETS 5,731,963	5,731,963	5,731,963	0
55	CONTRIBUTED CAPITAL - KPБ 0	0	0	0
56	RESTRICTED 25,286	25,286	25,286	0
57	UNRESTRICTED FUND BALANCE - SPH 90,657,900	85,898,777	91,108,689	4,759,123
58	<u>UNRESTRICTED FUND BALANCE - KPБ 0</u>	<u>0</u>	<u>0</u>	<u>0</u>
59	<u><u>TOTAL LIAB & FUND BALANCE 121,017,352</u></u>	<u><u>113,541,939</u></u>	<u><u>120,681,831</u></u>	<u><u>7,475,413</u></u>

	MONTH			YEAR TO DATE				
	04/30/24		04/30/23	04/30/24		04/30/23		
	Actual	Budget	Var B/(W)	Actual	Actual	Budget	Var B/(W)	Actual
Patient Service Revenue								
1 Inpatient	2,656,131	2,448,428	8.48%	2,651,052	28,823,311	26,534,348	8.63%	25,054,786
2 Outpatient	15,986,751	13,205,493	21.06%	12,014,942	148,460,145	136,534,476	8.73%	124,946,172
3 Long Term Care	1,040,376	1,182,413	-12.01%	1,084,714	10,773,969	11,824,127	-8.88%	10,591,381
4 Total Patient Services	19,683,258	16,836,334	16.91%	15,750,708	188,057,425	174,892,951	7.53%	160,592,339
Deductions from Revenue								
5 Medicare	4,338,508	3,353,364	-29.38%	3,416,636	40,915,444	34,009,120	-20.31%	31,219,117
6 Medicaid	2,238,703	2,110,550	-6.07%	1,373,209	22,931,337	21,404,757	-7.13%	21,542,507
7 Charity Care	83,523	186,518	55.22%	20,709	1,429,434	1,891,628	24.43%	1,459,353
8 Commercial and Admin	2,272,417	1,482,045	-53.33%	1,741,254	17,341,832	15,030,592	-15.38%	14,991,465
9 Bad Debt	31,020	248,142	87.50%	5,112	3,225,837	2,516,607	-28.18%	2,184,543
10 Total Deductions	8,964,171	7,380,619	-21.46%	6,556,920	85,843,884	74,852,704	-14.68%	71,396,985
11 Net Patient Services	10,719,087	9,455,715	13.36%	9,193,788	102,213,541	100,040,247	2.17%	89,195,354
12 USAC and Other Revenue	95,750	76,689	24.85%	69,413	880,606	766,894	14.83%	627,737
13 Total Operating Revenues	10,814,837	9,532,404	13.45%	9,263,201	103,094,147	100,807,141	2.27%	89,823,091
Operating Expenses								
14 Salaries and Wages	5,265,933	4,856,519	-8.43%	4,659,064	49,488,076	48,716,590	-1.58%	42,644,220
15 Employee Benefits	2,609,047	2,100,088	-24.24%	1,852,981	21,268,264	21,791,884	2.40%	18,831,101
16 Supplies, Drugs and Food	1,321,267	994,165	-32.90%	1,014,115	12,169,264	11,755,637	-3.52%	10,192,086
17 Contract Staffing	233,236	135,350	-72.32%	355,241	2,142,125	1,144,348	-87.19%	2,495,870
18 Professional Fees	597,643	506,565	-17.98%	572,732	5,904,292	5,527,871	-6.81%	5,448,393
19 Utilities and Telephone	174,868	206,512	15.32%	163,665	1,768,751	1,549,115	-14.18%	1,472,864
20 Insurance (gen'l, prof liab, property)	62,653	83,385	24.86%	61,120	716,676	748,536	4.26%	595,186
21 Dues, Books, and Subscriptions	66,429	18,457	-259.91%	16,660	233,558	219,400	-6.45%	187,082
22 Software Maint/Support	140,344	191,203	26.60%	186,389	1,263,546	1,829,643	30.94%	1,692,558
23 Travel, Meetings, Education	60,275	55,239	-9.12%	40,623	621,354	877,237	29.17%	486,464
24 Repairs and Maintenance	182,637	168,571	-8.34%	137,048	1,900,956	1,615,010	-17.71%	1,544,356
25 Leases and Rentals	82,693	89,987	8.11%	54,825	728,107	762,193	4.47%	637,837
26 Other (Recruiting, Advertising, etc.)	169,664	155,583	-9.05%	226,898	2,111,967	1,555,846	-35.74%	1,396,365
27 Depreciation & Amortization	423,015	345,138	-22.56%	341,533	4,136,677	3,451,385	-19.86%	3,388,836
28 Total Operating Expenses	11,389,704	9,906,762	-14.97%	9,682,894	104,453,613	101,544,695	-2.86%	91,013,218
29 Gain (Loss) from Operations	(574,867)	(374,358)	-53.56%	(419,693)	(1,359,466)	(737,554)	-84.32%	(1,190,127)
Non-Operating Revenues								
30 General Property Taxes	45,776	26,680	71.57%	27,007	5,125,826	4,484,459	14.30%	4,886,086
31 Investment Income	65,209	34,520	88.90%	4,499	1,241,208	345,207	259.55%	336,508
32 Governmental Subsidies	0	0	0.00%	0	0	0	0.00%	0
33 Other Non Operating Revenue	2,265	419	100.00%	54	38,159	4,194	100.00%	5,573
34 Gifts & Contributions	0	0	0.00%	0	0	0	0.00%	0
35 Gain <Loss> on Disposal	0	0	0.00%	0	0	0	0.00%	6,572
36 SPH Auxiliary	243	375	-35.20%	479	4,832	3,750	28.85%	3,219
37 Total Non-Operating Revenues	113,493	61,994	83.07%	32,039	6,410,025	4,837,610	32.50%	5,237,958
Non-Operating Expenses								
38 Insurance	0	0	0.00%	0	0	0	0.00%	0
39 Service Area Board	0	0	#DIV/0!	(838)	4,062	22,895	0.00%	91,346
40 Other Direct Expense	25,503	6,056	-321.12%	4,959	52,256	60,564	13.72%	19,926
41 Administrative Non-Recurring	0	0	0.00%	0	0	0	0.00%	0
42 Interest Expense	56,342	34,394	-63.81%	38,651	431,992	343,941	-25.60%	388,995
43 Total Non-Operating Expenses	81,845	40,450	-102.34%	42,772	488,310	427,400	-14.25%	500,267
Grants								
44 Grant Revenue	94,160	67,216	0.00%	36,179	1,192,379	672,163	0.00%	278,198
45 Grant Expense	1,730	2,501	30.83%	2,502	7,780	25,010	68.89%	25,015
46 Total Non-Operating Gains, net	92,430	64,715	42.83%	33,677	1,184,599	647,153	-83.05%	253,183
47 Income <Loss> Before Transfers	(450,789)	(288,099)	-56.47%	(396,749)	5,746,848	4,319,809	33.03%	3,800,747
48 Operating Transfers	0	0	0.00%	0	0	0	0.00%	0
49 Net Income	(450,789)	(288,099)	56.47%	(396,749)	5,746,848	4,319,809	33.03%	3,800,747



Statement of Cash Flows
As of April 30, 2024

Cash Flow from Operations:

1	YTD Net Income	5,746,848
2	Add: Depreciation Expense	4,136,677
3	Adj: Inventory (increase) / decrease	76,882
4	Patient Receivable (increase) / decrease	(2,699,182)
5	Prepaid Expenses (increase) / decrease	(267,957)
6	Other Current assets (increase) / decrease	68,899
7	Accounts payable increase / (decrease)	478,910
8	Accrued Salaries increase / (decrease)	479,386
9	Net Pension Asset (increase) / decrease	-
10	Other current liability increase / (decrease)	1,431,948
11	Net Cash Flow from Operations	9,452,411

Cash Flow from Investing:

12	Cash paid for the purchase of property/equip	(7,192,989)
13	Cash transferred to plant replacement fund	(711,889)
14	Proceeds from disposal of equipment	-
15	Net Cash Flow from Investing	(7,904,878)


Cash Flow from Financing

16	Cash (paid) / received for Lease Payable	(71,731)
17	Cash paid for Debt Service	(1,968,000)
18	Net Cash from Financing	(2,039,731)
19	Net increase in Cash	\$ (492,198)
20	Beginning Cash as of July 1, 2023	\$ 34,627,142
21	Ending Cash as of April 30, 2024	\$ 34,134,944

To: SPH Board of Directors
From: Board Governance Committee
Date: May 20, 2024
Re: Board Policy Review

The following Board policies were reviewed by the Governance Committee, and the Finance policies were reviewed by the Finance Committee as well. No substantive changes were made to the policies, though a few spelling and grammatical changes were made. Some of the Quality (Q) policies are being renamed Medical Staff (MS) policies, to better reflect their content, and to keep in line with SPH org chart changes. The formatting of all policies has been updated, and the reviewed date will be updated to reflect review at this board meeting.

- F-12 Approval and Adoption of Operating Budget
- F-13 Finance Reports
- MS-02 (formerly Q-02) Peer Review

 South Peninsula Hospital	SUBJECT: Approval and Adoption of Operating Budget	POLICY #: F-12
		Page 1 of 1
Scope: Finance Approved by: Board of Directors		Original Date: 6/25/08 Effective: 7/28/21
Revised: 1/22/20 Reviewed: 1/25/23; <u>5/16/24</u>		Revision Responsibility: Board of Directors

PURPOSE:

Guidelines for the approval and adoption of the Operating Budget.

DEFINITION(S):

N/A

POLICY:

- A. The Operating Budget for South Peninsula Hospital will be approved and adopted by the Board of Directors via resolution with a roll call vote.
- B. A resolution will be presented to the Board of Directors addressing the fiscal year operating budget with recitals to include references to the Board goals, strategic plan, Mission, Vision, and Values, and Operating Agreement.
- C. The resolution will include the requested action of the Board of Directors that will adopt the budget and authorize the monies needed for the for the following fiscal year.

PROCEDURE:

N/A

ADDITIONAL CONSIDERATIONS:


N/A

REFERENCE(S):

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

CONTRIBUTORS:

Board of Directors

 South Peninsula Hospital	SUBJECT: Finance Reports	POLICY #: F-13
		Page 1 of 1
Scope: Hospital-Wide Finance Approved by: Human Resources Board of Directors		Original Date: 6/25/08 Effective: 7/28/21
Revised: 1/22/20 Reviewed: 1/25/23; <u>5/16/24</u>		Revision Responsibility: Board of Directors

PURPOSE:

Reporting requirements from South Peninsula Hospital to the Mayor of Kenai.

DEFINITION(S):

N/A

POLICY:

- A. SPH will provide ~~to~~ the Mayor of Kenai Peninsula Borough (KPB), the Operating Agreement Contract Administrator, with finance reports.
- B. Board-~~A~~approved monthly financial reports will be provided to the KPB Finance Director within 14 days of approval.
- C. These reports, which consist of the Balance Sheet, Income Statement, and Cash Flow Statement, will be sent via email to the KPB Finance Director in accordance with the 2020 Operating Agreement.

PROCEDURE:

N/A

ADDITIONAL CONSIDERATIONS:


N/A

REFERENCE(S):

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

CONTRIBUTORS:

Board of Directors

	SUBJECT: Peer Review	POLICY #: <u>QMS-02</u>
		Page 1 of 1
Scope: Medical Staff Approved by: Board of Directors		Original Date: 9/24/3 Effective: 12/1/21
Revised: 8/28/19; 12/1/21 Reviewed: 1/25/23; <u>5/16/24</u>		Revision Responsibility: Board of Directors

PURPOSE:

Guidelines for the evaluation Medical Staff performance to promote continuous improvement of the quality of care.

DEFINITION(S):

N/A

POLICY:

- A. The Medical Staff, through the Credentials Committee and the Peer Review Committee, will assess the performance of individuals granted clinical privileges at South Peninsula Hospital.
- B. The Peer Review Committee is a multi-specialty approach to evaluate and improve practitioner performance and help create a systems approach culture related to performance improvement and peer review thus improving quality of care provided.
- C. The Credentials and Peer Review Committees will report to the Medical Executive Committee (MEC). The MEC is responsible for reporting the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges to the Board of Directors.
- D. Information generated through this process will be treated with the maximum confidentiality and privilege protections under applicable Federal and State laws.
- E. The Medical Staff will use the organizational values and expected behaviors and the process detailed in the Medical Staff Bylaws, Medical Staff Rules and Regulations and policy Medical Staff Peer Review, MSO-008 to accomplish the peer review.

PROCEDURE:

N/A

ADDITIONAL CONSIDERATION(S):

N/A

REFERENCE(S):

1. South Peninsula Hospital's Values & Behaviors as adopted by the Board of Directors
2. Medical Staff Bylaws, August 26, 2020
3. Rules and Regulations, May 26, 2021
4. Medical Staff Peer Review, MSO-008
5. Quality Plan, May 26, 2021; Section IV: Roles and Responsibilities, Medical Executive Committee
6. Alaska Statute AS 18.23.030, AS 18.23.070 (5) and the Healthcare Quality Improvement Act of 1986/42 USC 11101 60.10

CONTRIBUTOR(S):

Board of Directors; Quality Management Director; Medical Staff Office Coordinator


To: SPH Board of Directors
From: Susan Shover, BSN, RN, CPHQ; Director of Quality Management
Date: May 15, 2024
Re: SPH Quality Assessment and Performance Improvement Program (Quality Plan)

The South Peninsula Hospital (SPH) Quality Assessment and Performance Improvement Program (Quality Plan) is the overarching plan for the SPH organization. The Quality Plan has gone through the annual review process with updates to reflect changes that have occurred since May 2023. There has been some formatting changes and streamlining of language.

Please note the Table of Contents has been updated to eliminate the copy/paste box it was in previously. The page numbers for the Table of Contents will be completed during the final formatting process. The Quality Plan was shared and approved by the Patient Centered Care Committee, at the April-2024 meeting and the Medical Executive Committee this month.

The LTC Facility QAPI Plan, which is specific to LTC Quality activities, went through its approval process in March 2024, and is included for review and is shared with the BOD as an addendum to the SPH Quality Plan with the goal to stay on the same BOD annual approval schedule.

Recommended Motion: Consideration to approve the revised South Peninsula Hospital Quality Assessment and Performance Improvement Program (Quality Plan) along with the LTC QAPI Plan for 2024-2025.

	SUBJECT: <u>SPH Quality Assessment and Performance Improvement Program Plan</u>	POLICY # HW-267
		Page 1 of 16
SCOPE: Hospital-Wide RESPONSIBLE DEPARTMENT: Quality Management, Administration	ORIGINAL DATE: 12/2015 REVISED: 12/1/15; 4/2/18; 5/6/19; 10/28/2020; 5/26/2021, 05/25/2022, 5/25/2023, <u>05/xx/2024</u>	
APPROVED BY: Quality <u>Management</u> Director, Chief Executive Officer, Medical Executive Committee, Board of Directors	EFFECTIVE: <u>5/25/2023</u> <u>05/xx/2024</u>	

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- II. Patient & Resident Centered Care:
- III. Quality Foundation:
- 1. Quality Plan:
- 2. Hospital Board of Trustees Balanced Scorecard Report (BSC):
- 3. Quality Improvement Change Model:
- 4. Measurement/Monitoring and Data Analysis:
- 5. Employee Engagement:
- 6. Services:
- IV. Roles and Responsibilities:
- 1. Operating Board of Directors (BOD):
- 2. Medical Executive Committee (MEC):
- 3. Senior Leadership Team (SLT):
- 4. Quality Management:
- 5. Patient Centered Care Committee:
- 6. Safety/Hospital Incident Management Team (HIMT) Committee:
- 7. Staff:
- V. Quality Plan:
- 1. Empowerment of Stakeholds:
- 2. Identification of Risks, Hazards and Errors:
- 3. Goal Setting:
- 4. Measurement and Assessment:
- 5. Optimization of Performance:
- 6. Support to Ensure Quality Plan Effectiveness:
- VI. Plan Incorporation:

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PURPOSE:

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

DEFINITION(S):

N/A

POLICY:

I. Missions, Vision, Values:

The foundation of the SPH & LTC Facility Quality Plan is the organization's mission, vision, values, and associated behaviors:

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

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

Values & associated behaviors: (See Appendix A – 'Our Values in Action' for additional details)

- Compassion: *We provide compassionate patient and resident centered quality care, and a safe and caring environment for all individuals.*
- Respect: *We show respect for the dignity, beliefs, perspectives, and abilities of everyone.*
- Trust: *We are open, honest, fair, and trustworthy.*
- Teamwork: *We work together as a dynamic, collaborative team, embracing change, and speaking as one.*
- Commitment: *We are responsible and accountable for supporting the vision, mission, values, strategies, and processes of our organization.*

II. Patient & Resident Centered Care:

"Providing care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions," (Agency for Healthcare Research and Quality, (AHRQ), 2022Institute of Medicine, 2015). Patient and resident centered care is supported

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by SPH and the LTC Facility through the active involvement of patients', residents', and their designated caregivers and/or families as appropriate, in decision making about options for treatment. SPH and the LTC Facility will hereafter be referred to as "The SPH Organization."

A. Patient and Resident Centered Care is provided:

- In accordance with the SPH Organization values & behaviors
- In a safe, timely, and cost effective manner
- Consistent with achievable goals
- With proper documentation to facilitate continuous evaluation and improvement
- Adhering to evidence based, effective practices

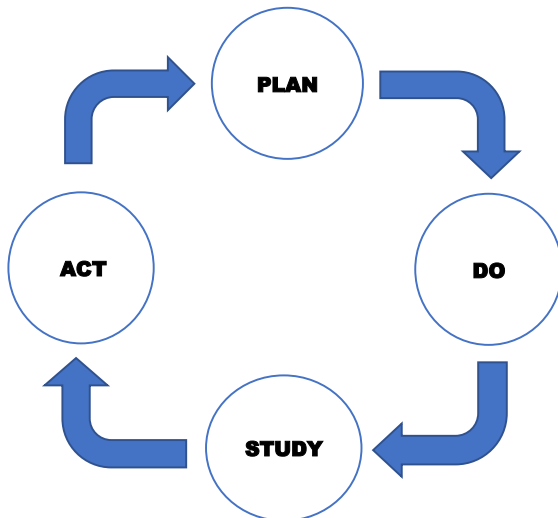
B. Patient and Resident Centered Care is delivered:

- By qualified and/or licensed personnel who are lawfully vetted
- Utilizing clear channels of supervision
- By effectively supervised personnel fostering patient and resident care

III. Quality Foundation:

1. Quality Plan: The Quality Plan serves as the foundation of commitment the SPH Organization has to reduce harm while continuously improving the quality and safety of the treatment and services provided.
2. Hospital Board of Trustees Balanced Scorecard Report (BSC): The SPH BSC provides an overview of specifically selected organizational indicators to monitor which include Quality of Care/Patient Safety, Patient and Resident Experience, Information System Solutions, Medical Staff Alignment, Employee Engagement and Financial Health. The BSC is updated quarterly and communicated monthly to the BOD and MEC, and quarterly to the Patient Centered Care Quality Committee (PCCQC).
3. Quality Improvement Change Model: The Quality Improvement Change Model "Plan-Do-Study-Act" (PDSA) ~~is~~ will be used to communicate, track and trend specific department quality improvement activities as well as for those indicators falling below the established target on the SPH BSC.

PDSA Cycle for Improvement



- A. Plan: Identify a problem or process to improve and determine the objective or goal

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- B. Do: Carry out the plan. Collect data and begin to analyze the data
- C. Study: Complete the analysis of the collected data and summarize what was learned
- D. Act: Determine next steps. Adopt, abandon, or modify the plan. Prepare the plan for the next PDSA is needed. If the plan was successful and adopted, plan for periodic review to assure the plan is effective.
4. *Measurement/Monitoring and Data Analysis*: Quality monitoring is intended to allow ongoing surveillance of important activities through sampling measures. Data, once collected, will be analyzed for opportunities of performance improvement. Quality and safety monitors and measures include but are not limited to the following:
- Hospital Board of Trustees Balanced Scorecard Report (BSC)
 - Adverse Drug Events
 - Trends identified through occurrence reports, grievances, or complains received
 - Infection Prevention surveillance
 - National Patient Safety Goals
 - CMS Core Measures, Hospital Compare and Nursing Home Care Compare
 - Reported Patient/~~R~~Resident and/or staff concerns
 - Patient Satisfaction survey data/responses
 - Failure Modes and Effects Analysis (FMEA), Root-Cause-Analysis and/or Sentinel Event Alerts
 - Identified quality improvement opportunities
 - ~~Statewide quality improvement opportunities through Telligen Hospital Quality Improvement Contractor (HCIQ) or Medicare Beneficiary Quality Improvement Project (MBQIP)~~
5. *Employee Engagement*: ~~Employees are expected to contribute to quality improvement initiatives and risk identification to improve care provided to the patients and residents of the SPH Organization.~~ Employees are able to contribute to quality improvement and risk reduction through the Patient Centered Care Quality Committee (PCCQC), Process Enhancement Teams, Root-Cause-Analysis meetings, Rapid Cycle Quality Improvement Process, occurrence report system, employee suggestion box system, internal departmental communication, and employee satisfaction surveys. Individuals or departments will be recognized for their quality improvement efforts.
6. *Services*: The SPH Organization will deliver service to preserve and advance the quality of patient and resident care, promote patient and resident centered care, enhance appropriate utilization of resources, deliver care by qualified individuals utilizing evidence-based best-practice principles and reduce or eliminate unnecessary risks and hazards within the facility. The Organization will integrate the use of Trauma Informed Principles into patient and resident care to support patient and resident engagement, reduce re-traumatization and provide a safe and welcoming environment for all.

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IV. Roles and Responsibilities:

Leadership of SPH and LTC Facility includes the Operating Board of Directors (BOD), Medical Executive Committee (MEC), Senior Leadership Team (SLT), Quality Management (QM) Department, Patient Centered Care Quality Committee (PCCQC), Safety/Hospital Incident Management Team (HIMT) Committees, and South Peninsula Hospital (SPH) staff. Active leadership participation and contribution fosters quality improvement and safety initiatives consistent with our mission, vision, and values.

1. *Operating Board of Directors (BOD)*: The SPH BOD shall review and evaluate overall quality activities to promote improvement and efficiencies to patient and resident care. The BOD will provide support and guidance of quality improvement activities, dedicate appropriate resources necessary to support the quality improvement process from the planning and development phase through the implementation of measures, actions, or changes that improve patient and resident care and facilitate safety and satisfaction. While maintaining overall responsibility, the Board delegates an oversight role to the Patient Centered Care Quality Committee and operational

authority to the Senior Leadership Team, The Quality Management team and Medical Staff represented by the MEC. The Board will maintain responsibility for review, evaluation, and the approval the Quality Plan annually. The Board will:

- Actively participate in the Patient Centered Care Quality Committee
 - Receive and review periodic quality improvement performance reports on findings, conclusions, recommendations, actions, and results of plan activities
 - Assess the plan's effectiveness and efficacy and require modification in organizational structure and systems where necessary to improve Plan performance
 - Verify the overall goal of patient and resident centered care is being achieved
 - Require a process designed to ensure all individuals responsible for the assessment, treatment, or care of patients and residents are competent
 - Commit to and support the organization's values
2. *Medical Executive Committee (MEC):* The MEC is the primary governance committee for the medical staff and is accountable to the Board of Directors for oversight, monitoring, and evaluation of medical services. The MEC, with input from the medical staff will:
- Play a significant role in performance improvement and assessment of each provider's clinical competence and professional behavior, through the Medical Staff Bylaws/Rules & Regulations, credentialing, ongoing and focused professional practice evaluation, and/or medical staff committees
 - Make key leadership decisions related to medical staff policies, procedures, and rules with an emphasis on patient and resident quality and improvement initiatives
 - Work collaboratively with nursing and other patient/resident care departments to develop policies and procedures necessary to provide safe and effective care
 - Participate in quality improvement activities and monitoring to facilitate patient safety and standard of care
 - Oversee the quality of patient care, treatment, and services provided by practitioners privileged through the Medical Staff credentialing process
 - Commit to and uphold the organization's values
3. *Senior Leadership Team (SLT):* The SLT works collaboratively with the BOD, Management team, Quality Management Department and SPH staff to support quality improvement activities and facilitate excellent clinical care that aligns with best practice. The SLT will:
- Embody a culture of patient/resident centered care
 - Ensure sufficient resources and personnel are provided to support patient and resident safety and quality improvement activities
 - Assure staff are provided adequate time to participate in quality improvement and patient and resident safety activities
 - Establish a culture of communication to encourage appropriate interaction between and among patients, residents, families & caregivers, and members working within and utilizing the services of SPH
 - Support Quality Improvement initiatives by encouraging Departmental Managers/Directors to engage in unit specific quality and safety monitoring
 - Support and actively engage in improvement opportunities for quality indicators identified on the SPH BSC
 - Embrace and demonstrate the organization's values and behaviors
4. *Quality Management:* Quality Improvement and risk reduction activities for the SPH organization are led by the Director of Quality Management (QM). The Director of Quality Management, along with the assistance of the QM team, is responsible to facilitate quality improvement and safety initiatives to reduce risk throughout the organization. The quality improvement and safety initiatives are to reflect evidenced-based practice and promote improved care to our patients and residents. The Director of QM along with the QM team will:

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- Oversee quality improvement, safety initiatives and risk management activities for SPH and LTC
 - Facilitate completion of quarterly Hospital Board of Trustees Balanced Scorecard Report and support departmental improvement activities, including development of PDSA's to meet established targets
 - Communicate BSC updates and PDSA's along with risk and/or safety concerns to BOD quarterly
 - Be responsible for ensuring appropriate quality actions are implemented, and within established time frames, as directed by the PCCQC, for quality and safety matters
 - Provide orientation and training on quality improvement and risk functions
 - Report known changes in regulations, laws, and certifications/accreditation standards to the staff
 - Ensure data retrieval functions are completed for ongoing quality improvement to meet best practice standards utilizing: National Patient Safety Goals & quality indicators, Patient satisfaction data through Press Ganey, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Medicare Beneficiary Quality Improvement Program (MBQIP), Telligen Hospital Quality Improvement Contractor (HQIC) and Core Measure CMS reporting
 - Aggregate quality data findings for presentation to the Board, Medical Staff, SPH & LTC staff, SLT, Departmental Managers/Directors, and Patient Centered Care Quality Committee and others as needed/requested
 - Conduct data analysis for data collected falling outside statistical norms
 - Assist Departmental Managers/Directors with systemic occurrence review
 - Conduct and/or participate in a timely root cause analysis for sentinel or serious safety events or to facilitate improvement related to specific process-driven events
 - Assist departments with identifying opportunities for improvement, planning & implementing changes, and departmental Quality dashboard/PDSA reporting
 - Chair and facilitate the SPH Hospital-Wide Policy Committee and assist with policy writing, review and work to ensure SPH policies meet State, Federal and regulatory requirements along with best practice standards
 - Embrace and Actively and enthusiastically promote the organization's values
5. *Patient Centered Care Quality Committee:* The Patient Centered Care Quality Committee provides ongoing operational leadership of continuous quality improvement activities at SPH & LTC. The PCCQC is composed of at least one Board member, the Director of QM or designee as co-chair, Department Managers/Directors and staff, a designated physician from patient or resident care/service area. The PCCQC will meet quarterly. Functions of the committee include:
- Providing input and recommending approval of the Quality Plan to the BOD
 - Suggesting and supporting priority indicators of quality for the BSC
 - Assessing information based on the indicators, taking action as evidenced through the quality improvement initiatives to solve problems and pursue opportunities to improve quality
 - Establishing and supporting specific quality improvement and safety initiatives
 - Reporting to the Board through committee minutes, CNO, or CEO on quality improvement activities on a regular basis
6. *Safety/Hospital Incident Management Team (HIMT) Committees:* The Safety/HIMT Committees are responsible to provide an update to the PCCQC at least annually/at least quarterly on the committee's active quality improvement and safety initiatives.
7. *Staff:* All employees of the organization are expected to engage and contribute with improving the quality of care provided to the patients and residents of SPH. Importance of organizational quality improvement is conveyed during initial hospital orientation and through individual departments by the department managers/directors.
- V. Quality Plan
- A. SPH is dedicated to the ongoing improvement of the quality and safety of care our patients and

residents receive as evidenced by the outcomes of that care. The goal of this plan is to strive for and achieve system-wide quality and safety best practices to improve patient experiences and outcomes, ~~and also provide accountability for reaching the highest possible quality and value for healthcare provided.~~

- B. **Quality Statement:** The SPH Organization has adopted the six Domains of Healthcare Quality proposed by the Agency for Healthcare Research and Quality (AHRQ): Quality – care delivered in a safe, effective, patient-centered, timely, efficient, and equitable fashion.
- C. **Safety Statement:** The SPH Organization contends safety is the foundation upon which all other aspects of quality care are built.
 - 1. **Empowerment of Stakeholders:** To achieve the greatest level of success in our quality improvement efforts, we include ~~all involved~~ stakeholders in patient and resident care. The SPH Organization's goal is collaboration of leadership and stakeholders in all aspects of quality improvement so all are empowered to guide its success. This will be achieved by:
 - a. **Employee Disclosure:** The SPH Organization expects employees to speak-up and speak-out by identifying improvement and process opportunities, reporting occurrences, sentinel or serious safety events, near misses, the existence of hazardous conditions, and related opportunities for improvement as a means to identify systems and behavior changes needed to avoid future adverse events. It is acknowledged that errors must be identified before they can be corrected.
 - b. **Patient Disclosure:** Hospital or Facility Representative at SPH and LTC will notify patients and residents or their family and/or significant other/designated caregiver when an unanticipated medical risk, hazard or error occurs in a patient or resident's care and will explain the unexpected outcome to the patient or resident, and/or family if the patient or resident is not able to understand. Hospital or Facility Representative will also coordinate with the attending physician, when appropriate.
 - c. **Fair, Equitable and Just Culture:** The SPH Organization operates within a fair, equitable and just culture where the organization's values and behaviors are actively promoted. Front-line staff or others are not punished for actions, omissions or decisions which are commensurate with their experience and training. The Performance Management Decision Guide~~Decision Tree~~ for Determining the Culpability of Unsafe Acts and the Incident Decision Tree along with Just Culture principles will be used for follow-up to concerns, errors or near misses.
 - d. **Patient and Family Engagement:** The SPH Organization recognizes each patient or resident is an individual with unique health care needs and to the best of our ability will provide considerate, respectful care focusing on those needs. It is recognized the patient or resident has the right to be involved in making decisions regarding their care and to have any complaints, suggestions or concerns heard, investigated promptly and resolved.
 - e. **Culture of Safety:** The SPH Organization is committed to minimizing adverse events. We maintain a commitment to safety for all staff. This commitment establishes a "culture of safety" that encompasses these key features:
 - i. acknowledgment of the high-risk nature of the organization's activities and the determination to achieve consistently safe operations
 - ii. a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
 - iii. collaboration among departments and disciplines to seek solutions to patient safety problems
 - iv. organizational commitment of resources to address quality and safety concerns
 - 2. **Identification of Risks, Hazards and Errors:** Prospective, Concurrent and Retrospective review of patient/resident care is utilized to identify quality improvement opportunities and to assess for risks, hazards, and errors.
 - a. **Prospective Identification:** Prospective identification occurs prior to patient interaction. This review involves identifying risks, hazards and error potential before occurrences happen.

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- b. Concurrent Review: Concurrent Quality Improvement (QI) review begins when quality and safety measures or initiatives are evaluated at the point of care.
 - c. Retrospective Review: Retrospective review includes after-care appraisal to evaluate and/or measure performance.
3. Goal Setting: The SLT and Departmental Managers/Directors will be responsible for determining organizational priorities and goals identified on the BSC. The BOD will review and may provide input for yearly quality and safety indicators, and organizational goals on the BSC. Department Managers/Directors will document quality accomplishments and establish quality improvement goals in the annual Critical Access Program Evaluation with BOD review and approval.
- a. The goal setting philosophy of The SPH Organization is prioritizing goals most important to our patient and resident population and achieving zero harm or 100% compliance in quality and safety indicators.
 - b. The SPH Organization will utilize state and/or national patient/resident outcome quality and safety database reports (including CMS reports) to compare the hospital's performance with other facilities which is used to identify areas for quality improvement.
 - b.c. The QM Department will facilitate the Optima Healthcare annual goal to promote patient safety and prevent harm.
4. Measurement & Assessment: Categorical and/or Continuous Data will be captured, assessed, analyzed, and communicated through facility and departmental Quality Department Dashboards and BSC. Department Dashboard analytic data may be communicated through visual displays such as Run Charts, Pareto Charts, Histograms, etc. Continuous quality improvement requires adjustments to processes and/or procedures based on data analysis and the opportunities for performance improvement identified.
- a. Classification Systems: The SPH Organization will utilize the SPH Risk Classification Grid for assessment and classification of the severity of the identified risks and occurrence reports. For medication events, the National Coordinating Council for Medication Error Reporting and Prevention Index for categorizing medication errors will be used for classification and determination of patient/resident harm. These tools are the foundation for patient and resident safety and risk measurement for South Peninsula Hospital and LTC Facility:

(See next page)

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South Peninsula Hospital Identified Risk Classification Grid			
PROBABILITY, LOW → HIGH	No Injury, Potential or Unknown Harm:	Moderate - Minor Harm:	Great Harm or Substantial Potential for Great Harm: (Never/Sentinel Events)
	Great Likelihood of Risk, Hazard or Error Recurrence: Daily or hourly Probability almost certain or likely	2C	2A

Moderate Likelihood of Risk, Hazard or Error Recurrence: Monthly or weekly Probability possible ***Use if probability is unknown	3B	2B	1B
Little Probability of Risk, Hazard or Error Recurrence: Quarterly or Annually Probability Unlikely or Rare	3C	3A	1C
<i>LEVEL OF HARM, LOW → HIGH</i>			
Incidents with the potential of Great Harm-Never/Sentinel Events will be shared with the Board of Directors and PCCQ as appropriate following completion of a Root-Cause-Analysis (RCA). The reporting format will be the Plan-Do-Study-Act (PDSA).			

Definitions:

- A near miss: An unexpected occurrence in which there was no adverse outcome to the patient/resident, but which had the potential to cause serious injury or harm to the patient/resident.
- Never Event: Errors in medical care that are clearly identifiable, preventable and serious in their consequences as defined by CMS and National Quality Forum (NQF).
- Sentinel event: An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof, i.e. loss of patient/resident life, limb, or function. The National Quality Forum (NQF) Never Events are also considered Sentinel Events.
 - b. Assessment: Measurement and assessment procedures include:
 - Identify problems and opportunities to improve the performance of processes
 - Assess the outcome of the care provided
 - Assess whether a new or improved process meets performance expectations
 - Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level
 - Assess and analyze data gathered through State/Federal quality reporting and internal quality improvement departmental and facility initiatives
 - c. Risk Mitigation: The SPH Organization strives to design effective processes to achieve excellent outcomes. Staff report occurrences relating to patients, residents, visitors, employees, property, systems and devices related to unusual or adverse events along with actual or potential injuries. The goal of this system is to identify opportunities for improvement, risk prevention, reduction and/or resolution and monitored for trends.
 - d. Audits: Process review and improvement is conducted by various audits including random sampling, specific stratified sampling, department rounding, etc.
 - e. Feedback: Opportunities for quality, safety and process improvement. Feedback and data from Press-Ganey satisfaction surveys, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), SPH Quality email, occurrence and grievance reports is used to inform practice and measure results. -Grievances and complaints are documented, monitored for trends, with grievances communicated at the executive session of PCCQC and with the BOD as requested by PCCQC BOD members.
- 5. Optimization of Performance: Once the performance of a selected process has been measured, assessed and analyzed, the data gathered is used to identify the quality improvement initiative to be undertaken.
 - o Elevation of Sentinel, Never & Near Miss Events: Should a sentinel event occur, the Director of QM or designee, with guidance from SLT as needed, will -work with those involved to

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review the incident. A root-cause analysis (RCA) will be conducted to determine if there was either:

- Special cause variation - human error, or
- Common cause variation - underlying system or process issue

Once the root-cause analysis has been conducted, the RCA team will develop an appropriate action plan to address any variations identified and establish measures for any changes made which will be documented in the PDSA format and shared with the PCCQ Committee and the Board at the next scheduled meeting. Quarterly updates of PDSA Reports will be shared with the Committee until the issue is determined to be resolved. Once resolved, QI indicators may be continued to ensure the problem remains corrected.

- Root Cause Analysis or Investigation: Occurrences are evaluated by Investigation or Root Cause Analysis in a fair and equitable manner.
 - Investigation: Departmental Managers/Directors investigate occurrences with guidance provided by the Quality Management Department. After investigation is completed, the occurrence report is reviewed to determine if additional steps are needed and/or accepted as complete and closed within the electronic system. Occurrence investigation may lead to a root cause analysis.
- Performance Enhancement Teams (PETs): A Performance Enhancement Team is developed when a process in need of improvement has been identified. The team is a group of people who work together on the improvement process/initiative and has a team leader, facilitator and subject expert members. The QM Department is a resource and will assist with facilitation, tracking and trending of goals and outcomes as needed.
- Standardization of Work: Standardized work leads to increased patient safety, faster care and better quality outcomes. The SPH Organization strives to reduce harm and increase patient, resident, and staff satisfaction through standardization of work processes and care decisions.
- Evidence Based Practice: The SPH Organization provides healthcare using the best, research-proven assessments and treatments in our day-to-day patient and resident care and service delivery. Each clinician is expected to stay in touch with the research literature and to use it as a part of their clinical decision-making.
- 6. Support to Ensure Quality Plan Effectiveness:
 - Communication: communication may take place through the following methods:
 - Balanced Scorecard, PDSA's, Departmental Quality Dashboards, story boards, graphs and posters displayed in common areas, on the Staff Information Site (SIS) and/or SPH website
 - Members participating in the PCCQ Committee are to report information back to their departments
 - Newsletters and/or handouts
 - Education: Managers, clinicians, and staff will be educated in the principles and practices of quality improvement. The SPH Organization offers continuing education in-house, and off campus and supports new or higher education for improved clinical competency.
 - Training for improved education/competence: Various methods for staff education include:
 - Computer based programs such as Up-To-Date and eLippincott
 - Healthstream
 - Skills Fairs/Labs
 - Alaska Hospital and Healthcare Association (AHH) webinars, in-services and conferences
 - Quality Improvement educational offerings and conferences for individuals with leadership roles and responsibilities to enhance and develop quality improvement efforts
 - Quality Improvement/Risk reduction webinars and Bite-sized Learning offerings through Optima Healthcare Insurance.

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PROCEDURE:

N/A

ADDITIONAL CONSIDERATION(S):

N/A

REFERENCE(S):

1. Attachment A – “Our Values In Action”
2. Attachment B - Performance Management Decision Guide National Coordinating Council for Medication Error Reporting and Prevention-Index for Categorizing Medication Errors
3. Attachment C - Performance Management Decision Guide
4. Duquette, C. Leadership and management; Q solutions: Essential resources for the healthcare quality professional. *National Association for Healthcare quality. Third edition. (2012)*
5. National Coordinating Council for Medication Error Reporting and Prevention. Index for Categorizing Medication Errors. 2001
6. Six Domains of Health Case Quality. Retrieved from <https://www.ahrq.gov/talkingquality/measures/six-domains.html>, December 2022
7. The Incident Decision Tree. Retrieved from <https://www.ahrq.gov/downloads/pub/advances/vol4/meadows.pdf>
8. Patient-Centered Care. Institute of Medicine. Crossing the chasm: A new health system for the 21st century. Retrieved from <http://www.oneviewhealthcare.com/the-eight-principles-of-patient-centered-care/>
9. Key Ingredients for Successful Trauma-Informed Care Implementation. Menschner, C. and Maul, A.; Center for Health Care Strategies. (April, 2016).
10. CMS.gov. Retrieved from: www.cms.gov/newsroom/fact-sheets/eliminating-serious-preventable-and-costly-medical-errors-never-events
11. Plan Incorporation:
 - A. The following policies are incorporated by reference in this plan:
 1. ED-001 Nursing Continuing Education Administrative Support
 2. EMP-03 Disruptive Conduct & Abusive Behavior
 3. HW-007 Employee Suggestion System
 4. HW-014 Occurrence Reports
 5. HW-068 Patient and Resident Rights
 6. HW-144 Patient Grievance Process
 7. HW-147 Disclosure of Medical Errors
 8. HW-151 HIPAA
 9. HW-160 Sentinel Events
 10. HW-168 Employee Service Awards
 11. HW-218 Workplace Bullying
 12. HW-229 Incident Review
 13. LTC Facility Assessment 2023
 14. PCS-143 Provision of Care
 15. Q-01 Medical Staff Credentialing Privileges
 - B. The following plans are incorporated by reference in this plan:
 1. Infection Prevention Plan (HW-269)
 2. SPH and LTC Facility Medical Staff Bylaws, Rules and Regulations
 3. LTC QAPI Plan 2023 (LTC-184); Attachment G Addendum to SPH Quality Assessment and Performance Program (Quality Plan)

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South Peninsula Hospital

POLICY # HW-267

POLICY # HW-267

SUBJECT: SPH Quality Assessment and Performance Improvement Program

Page 12 of 16

CONTRIBUTOR(S):

Quality Management Director, PCCQ Committee, Members of Senior Leadership Team, Board of Directors, and SPH/LTC Facility Management, and Medical Executive Committee.

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APPENDIX A & B

Our Values in Action

COMPASSION IS:

- I place patient and resident needs first.
- I use safe work practices.
- I am willing to help all individuals.
- I have time for you.
- I show empathy.
- I behave in a caring manner.

COMPASSION IS NOT:

- I treat you as a burden.
- I look the other way.
- I am too busy.
- I act as if I don't care.
- I can't help you.

RESPECT IS:

- I respect diversity and individual beliefs.
- I am kind and polite.
- I am considerate of your needs.
- I value your input.
- I treat you as an equal.
- I respect privacy and confidentiality.

RESPECT IS NOT:

- I bully and intimidate.
- I raise my voice and curse.
- I shame and embarrass others.
- I am divisive and judgmental.
- I manipulate and undermine.
- I ignore you.

TRUST IS:

- I build trust with what I say and do.
- I communicate in an open and timely manner.
- I listen to what you say and ensure that I understand.
- I am fair and consistent in the actions I take.
- I follow up and provide feedback.
- I act with integrity.
- I responsibly report risks, hazards and errors.
- I apologize and admit when I am wrong.

TRUST IS NOT:

- I say one thing and do another.
- I gossip and spread rumors.
- I withhold information and conceal mistakes.
- I undermine the chain of command.
- I discuss issues outside appropriate channels.
- I draw conclusions before facts are known.
- I cause or tolerate retribution to the reporting of harm or near misses.

TEAMWORK IS:

- I embrace change and engage in process improvement.
- I adapt to changing circumstances.
- I actively participate in teamwork and seek out ways to help the team.
- I support the team's decisions.
- I recognize and acknowledge contributions and achievements.
- I invite and accept constructive feedback.

TEAMWORK IS NOT:

- I exclude others.
- "It's not my job/responsibility."
- I resist change.
- I disregard team decisions.
- I do not follow established processes.
- I am not cooperative.
- I complain without offering a solution or recommendation.

COMMITMENT IS:

- I represent my organization's best interests with a positive attitude.
- I exemplify expected behaviors.
- I am responsible and accountable.
- I hold others accountable in a fair and consistent manner.
- I adhere to the organization's policies and best practices.
- I prioritize and accomplish my work with a sense of urgency.
- I am a good steward of resources.

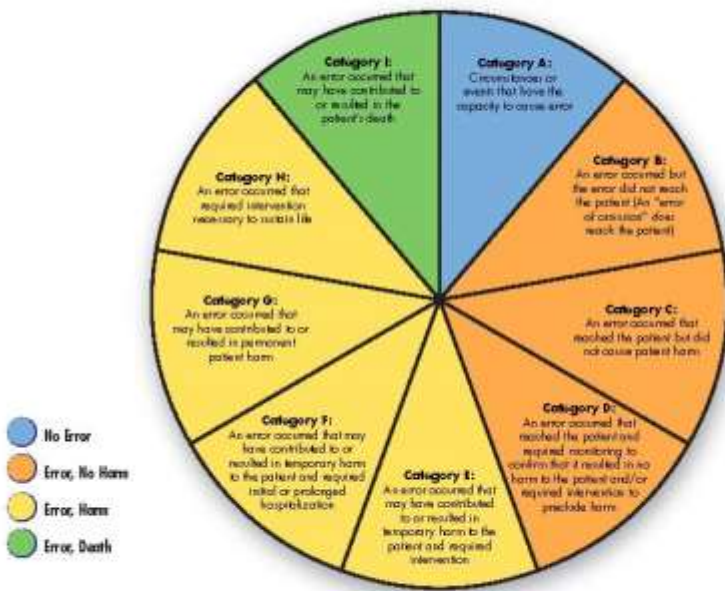
COMMITMENT IS NOT:

- I compromise the quality, safety and reputation of my organization.
- I act inappropriately.
- I delay or fail to hold myself or others accountable.
- I avoid review of my performance.
- I am defensive and make excuses.
- I blame others.
- I disregard policies and procedures.

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APPENDIX Appendix B

NCC MERP Index for Categorizing Medication Errors Appendix B



Definitions

Harm: Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring: To observe or record relevant physiological or psychological signs.

Intervention: May include change in therapy or active medical/surgical treatment.

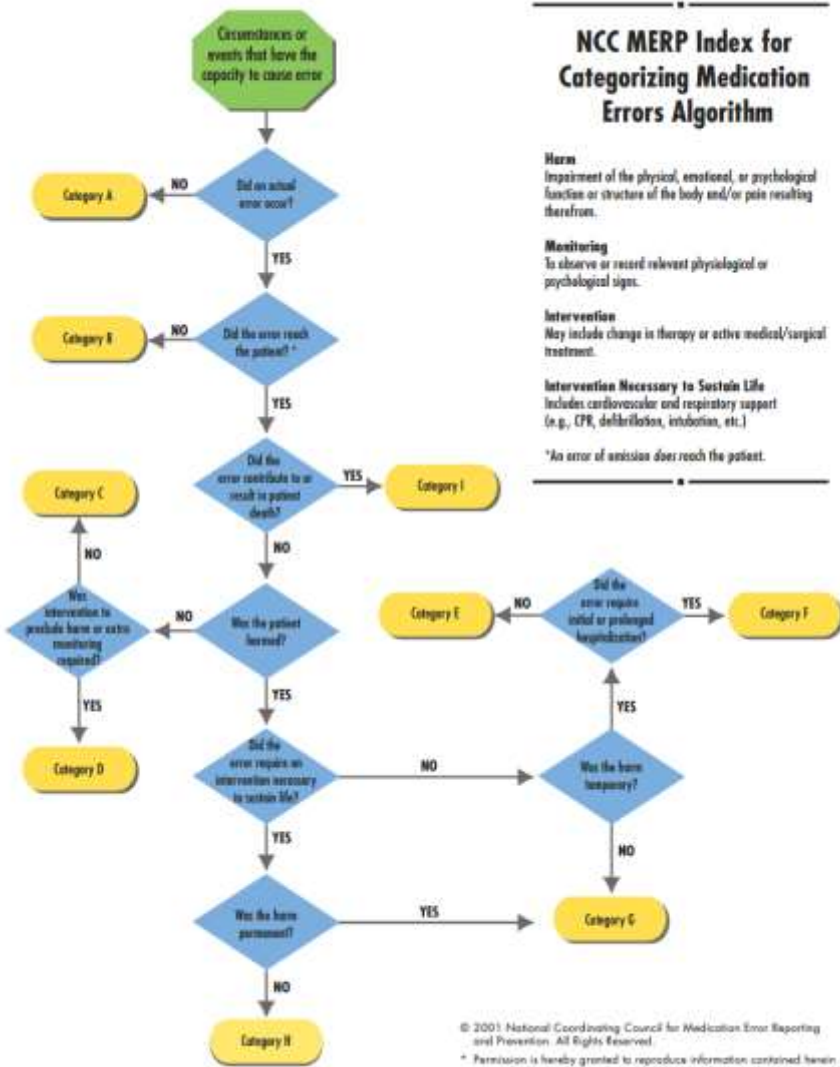
Intervention Necessary to Sustain Life: Includes cardiovascular and respiratory support [e.g., CPR, defibrillation, intubation, etc.]

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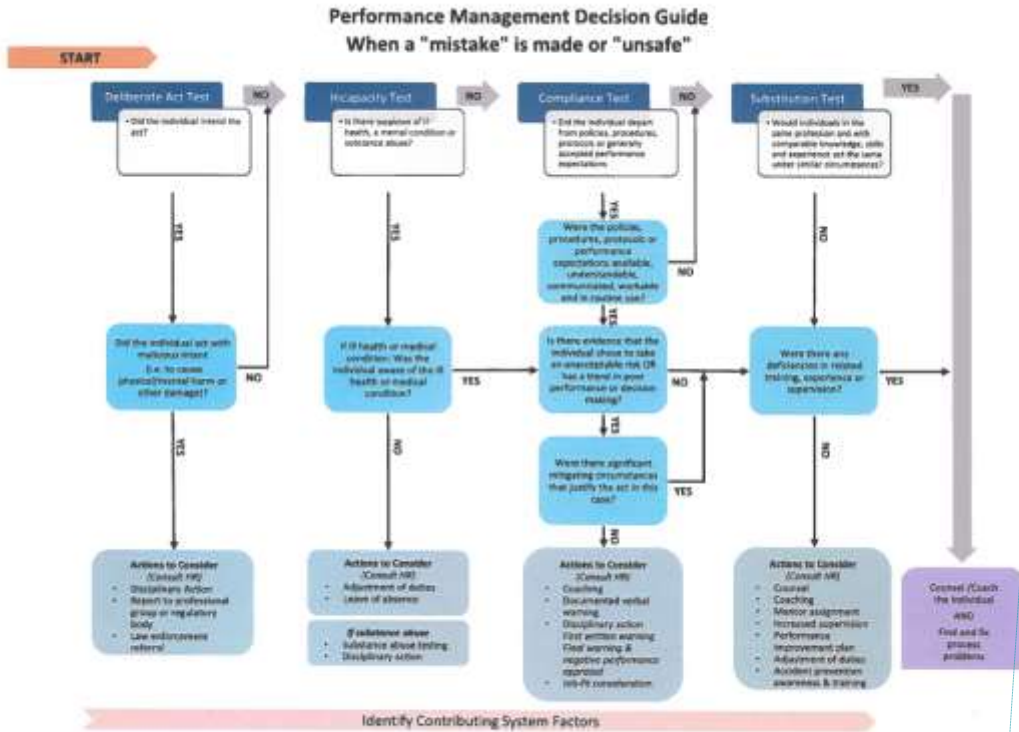
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APPENDIX C



Adapted from James Reason's Decision Tree for Determining the Culpability of Unsafe Acts and the Incident Decision Tree of the National Patient Safety Agency (United Kingdom National Health Service)

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

I.	Missions, Vision, Values:	1
II.	Guiding Principles:	1
III.	Types of Care and Services:.....	2
IV.	Addressing Care and Services:	2
V.	Defining and Measuring Goals:.....	3
VI.	Governance and Leadership.....	3
VII.	Feedback, Data Systems, and Monitoring:	4
VIII.	Performance Improvement Projects	5
IX.	Systematic Analysis and Systemic Action	6
X.	Communications, Evaluation, Review Data	6

PURPOSE:

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

DEFINITION(S):

N/A

POLICY:

I. Missions, Vision, Values:

The foundation of the SPH LTC Facility Quality Plan is the organization’s mission, vision, values, and associated behaviors:

Mission: *To provide resident-centered healthcare services, excellence in clinical care, and to promote caregiver engagement and empowerment to better serve the resident, family, and the community.*

Vision: *SPH LTC Facility will be the premier provider in Long-Term Care.*

Values & associated behaviors: *(See Appendix A – ‘Our Values in Action’ for additional details)*

- Compassion: *We provide compassionate patient and resident centered quality care, and a safe and caring environment for all individuals.*
- Respect: *We show respect for the dignity, beliefs, perspectives, and abilities of everyone.*
- Trust: *We are open, honest, fair, and trustworthy.*
- Teamwork: *We work together as a dynamic, collaborative team, embracing change, and speaking as one.*
- Commitment: *We are responsible and accountable for supporting the vision, mission, values, strategies, and processes of our organization.*

II. Guiding Principles:

Quality Assurance and Performance Improvement (QAPI) has a prominent role in our management and board functions. In LTC, the outcome of QAPI is the quality of care and the quality of life of our residents. LTC uses QAPI to make decisions and guide our day-to-day operations. QAPI includes all employees, all departments, and all services provided. Our QAPI program focuses on our unit and

organization's systems and processes rather than on the performance of individuals, and we strive to identify and improve system gaps rather than place blame.

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

III. Types of Care and Services:

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

IV. Addressing Care and Services:

The QAPI program will aim for safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family by ensuring our

data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action. We will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure our goals. The scope of the QAPI program encompasses all types and segments of care and services that impact clinical care, quality of life, resident choice, and care transitions. These include, but are not limited to, customer service, care management, resident safety, provider relations, finance, and information technology. Aspects of service and care are measured against established performance goals and key measures are monitored and trended on a quarterly basis.

Abaqis supplies the fundamental core of the QAPI program by providing a structured, electronic system for the collection and analysis of quality data from residents, family, staff, resident records, and the MDS. To accomplish this, Abaqis includes a series of sampling, assessment, and data collection tools, and provides for analysis through in-depth investigation, the comparison of an organization's performance against established indicators, and thresholds of quality as well as national benchmarks. Abaqis also provides a data-driven and scientifically proven methodology for monitoring QAPI program efforts to ensure that they are comprehensive in scope, continuously executed and monitored, include the appropriate coverage of unique residents and care areas, and proactively initiate appropriate investigative and improvement actions for areas identified as needing correction.

V. Defining and Measuring Goals:

LTC will use internal and national benchmarks provided by national associations, clinical organizations, and federal & state provided databases (e.g., CMS Quality Measures, Five-Star Quality Rating System, survey data) to establish baselines for organizational practices and goal setting. In addition, the organization will continue to monitor progress towards goals by comparing its results to these benchmarks and its historical performance,

The sampling, assessment, and data collection tools along with statistically verified thresholds in Abaqis are used to identify potential areas of concern. Additionally, Abaqis contains Critical Element Pathways, Surveyor Guidance, and national benchmarks that provide a framework for defining and measuring QAPI program goals.

VI. Governance and Leadership

1. Administrative Leaders – *South Peninsula Hospital Board of Directors*

- A. Direction of QAPI Activities: The Governing Body and LTC QAPI Team develop a culture that involves leadership-seeking input from nursing center staff, residents, their families, and other stakeholders.
- B. The LTC QAPI Team reports to the executive leadership and Governing Body and is responsible for:
 - 1) Meeting, at a minimum, on a quarterly basis; more frequently, if necessary
 - 2) Coordinating and evaluating QAPI program activities
 - 3) Developing and implementing appropriate plans of action to correct identified quality deficiencies
 - 4) Regularly reviewing and analyzing data collected under the QAPI program and data resulting from drug regimen review and acting on available data to make improvements
 - 5) Determining areas for PIPs and Plan-Do-Study-Act (PDSA) rapid cycle improvement projects
 - 6) Analyzing the QAPI program performance to identify and follow up on areas of concern and/or opportunities for improvement
- C. Staff QAPI Adoption: The QAPI program will be structured to incorporate input, participation, and responsibility at all levels. The Governing Body and LTC QAPI Team will develop a culture that involves leadership-seeking input from nursing center staff, residents, their families, and other stakeholders; encourages and requires staff participation in QAPI initiatives when necessary; and holds staff accountable for taking ownership and responsibility of assigned QAPI activities and duties.

2. QA&A Committee

- Medical Director/Designee – Dr. William Bell
- Director of Nursing Services – Katie Martin, RN
- Administrator/Owner/Board Member/Other Leader – Rachael Kincaid, DNP, LNHA
- Infection Prevention & Control Officer – Anna Lewald, RN
- Additional Members:
 - Assistant Director of Nursing - Janyce Bridges, RN
 - Quality Coordinator – Joyce Bridges, RN

VII. Feedback, Data Systems, and Monitoring:

A. Monitoring Process:

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

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

B. Monitored Data Sources:

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

C. Adverse/Never Event Tracking System:

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

D. Method of Monitoring Multiple Data Sources:

Information will be collected on a routine basis from the previously identified sources and the data will be analyzed against the appropriate benchmarks and target goals for the organization.

Abaqis is a systemized and secure platform for data collection. Abaqis provides tools for establishing quality assessment and improvement cycles, includes a collection of turnkey quality assessments and investigations, and provides a structured and electronic repository for QAPI program coordination and documentation.

Abaqis includes robust data analysis and reporting tools that draw from multiple data sources and allow organizations to identify Care Areas that exceed thresholds, track hospital readmission risk and ED transfers, and monitor rates for hospital readmissions, community discharge, and resident and family satisfaction.

E. Planned Abaqis QAPI Usage:

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

VIII. Performance Improvement Projects

A. Overall PIP Plan:

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

B. PIP Determination Process:

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

C. Assigning Team Members:

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

D. Managing PIP Teams:

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

E. Documenting PIPs:

PIPs will be documented continuously during execution. The documentation will include the overall goals for the project and will identify team members, define appropriate measures, root cause analysis findings, interventions, PDSA cycle findings, meeting minutes, target dates, and overall conclusions.

Abaqis provides an electronic platform for developing a PIP charter and for continuous PIP documentation in a structured format. Abaqis also allows for PIP team collaboration and visibility into PIP activity for team management and coordination of PIP efforts; provides a method of tracking PIP progress and documentation of findings for widespread and systemic improvement

efforts; and allows for retaining and updating information related to ongoing projects for potential reference and future submission for survey compliance.

IX. Systematic Analysis and Systemic Action

A. Recognizing Problems and Improvement Opportunities:

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

B. Identifying Change as an Improvement:

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

X. Communications, Evaluation, Review Data

A. Internal and External QAPI Communication:

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

B. Identifying a Working QAPI Plan:

On at least an annual basis, the QAPI Self Assessment will be conducted. This will be completed with the input from the entire LTC QAPI Team. The results of this assessment will direct us to areas we need to work on in order to establish and improve QAPI programs and processes in our organization.

We will also conduct an annual facility assessment to identify gaps in care and service delivery in order to provide necessary services. These items will be considered in the development and implementation of the QAPI plan.

Abaqis provides an electronic platform for documenting QAPI Self Assessments and tracking changes in the QAPI Self Assessment results over time.

C. Revisions to QAPI Plan:

LTC Leadership will review and submit proposed revisions to the Governing Body for approval on an annual basis

PROCEDURE:

N/A

ADDITIONAL CONSIDERATION(S):

N/A

REFERENCE(S):

1. Appendix A – “Our Values In Action”
2. HW-267 Quality Plan

CONTRIBUTOR(S):

LTC Nursing Director; LTC Administrator

APPENDIX A

Our Values in Action

COMPASSION IS:

- I place patient and resident needs first.
- I use safe work practices.
- I am willing to help all individuals.
- I have time for you.
- I show empathy.
- I behave in a caring manner.

COMPASSION IS NOT:

- I treat you as a burden.
- I look the other way.
- I am too busy.
- I act as if I don't care.
- I can't help you.

RESPECT IS:

- I respect diversity and individual beliefs.
- I am kind and polite.
- I am considerate of your needs.
- I value your input.
- I treat you as an equal.
- I respect privacy and confidentiality.

RESPECT IS NOT:

- I bully and intimidate.
- I raise my voice and curse.
- I shame and embarrass others.
- I am divisive and judgmental.
- I manipulate and undermine.
- I ignore you.

TRUST IS:

- I build trust with what I say and do.
- I communicate in an open and timely manner.
- I listen to what you say and ensure that I understand.
- I am fair and consistent in the actions I take.
- I follow up and provide feedback.
- I act with integrity.
- I responsibly report risks, hazards and errors.
- I apologize and admit when I am wrong.

TRUST IS NOT:

- I say one thing and do another.
- I gossip and spread rumors.
- I withhold information and conceal mistakes.
- I undermine the chain of command.
- I discuss issues outside appropriate channels.
- I draw conclusions before facts are known.
- I cause or tolerate retribution to the reporting of harm or near misses.

TEAMWORK IS:

- I embrace change and engage in process improvement.
- I adapt to changing circumstances.
- I actively participate in teamwork and seek out ways to help the team.
- I support the team's decisions.
- I recognize and acknowledge contributions and achievements.
- I invite and accept constructive feedback.

TEAMWORK IS NOT:

- I exclude others.
- "It's not my job/responsibility."
- I resist change.
- I disregard team decisions.
- I do not follow established processes.
- I am not cooperative.
- I complain without offering a solution or recommendation.

COMMITMENT IS:

- I represent my organization's best interests with a positive attitude.
- I exemplify expected behaviors.
- I am responsible and accountable.
- I hold others accountable in a fair and consistent manner.
- I adhere to the organization's policies and best practices.
- I prioritize and accomplish my work with a sense of urgency.
- I am a good steward of resources.

COMMITMENT IS NOT:

- I compromise the quality, safety and reputation of my organization.
- I act inappropriately.
- I delay or fail to hold myself or others accountable.
- I avoid review of my performance.
- I am defensive and make excuses.
- I blame others.
- I disregard policies and procedures.



PROCLAMATION

A PROCLAMATION RECOGNIZING EVA STOVALL FOR TWENTY-THREE YEARS OF SERVICE TO SOUTH PENINSULA HOSPITAL

WHEREAS, after 23 years at South Peninsula Hospital, Eva Stovall will retire June 9, 2024; and

WHEREAS, Eva is retiring from the role of Health Unit Clerk; Eva previously held the role of CNA on Acute Care and Emergency Room Technician; and

WHEREAS, Eva is known know by her teammates as a strong patient advocate, wonderful caregiver to her patients and family; and

WHEREAS, Eva is a dedicated employee that goes above and beyond for her patients giving haircuts, playing games and doing artwork; and

WHEREAS, Eva is a jewelry maker and every year for her birthday makes earrings to share with her teammates; and

WHEREAS, Eva has served as a Unit Peer Leader and on Unit Based Council; and

WHEREAS, Eva delivers high quality safe patient care with compassion, empathy and a positive attitude

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

THAT EVA STOVALL IS RECOGNIZED BY THE BOARD OF DIRECTORS FOR TWENTY THREE YEARS OF SERVICE TO SOUTH PENINSULA HOSPITAL

PROCLAIMED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL THIS 22ND DAY OF MAY 2024.

Ryan Smith, Administrator

Aaron Weisser, Board President

Introduced by: Administration
Date: May 22, 2024
Action:
Vote: Yes-, No-,
Exc, Abst-

**SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2024-13**

**A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS
APPROVING THE USE OF \$80,726 OF OPERATING CASH TO FUND THE
ADDITIONAL PROJECT NEEDS FOR THE RELOCATION OF THE GENERAL
SURGERY CLINIC AND FUNCTIONAL MEDICINE CLINIC WITHIN THE MAIN
HOSPITAL BUILDING**

WHEREAS, South Peninsula Hospital’s General Surgery and Functional Medicine clinics are an important component of our mission to provide high quality, locally coordinated care; and

WHEREAS, South Peninsula Hospital recently completed master facility planning and item number two from that study was to Co-locate physician offices; and

WHEREAS, South Peninsula Hospital has recently initiated opening a daycare to assist with staff recruitment and retention and that daycare will displace the Functional Medicine Clinic; and

WHEREAS, relocating multiple services will be necessary to add the daycare and an opportunity arose to Co-locate both General Surgery and Functional Medicine within the main hospital building to align with item number two from the Master Facility Plan; and

WHEREAS, relocating the General Surgery Clinic within the main hospital building will allow additional clinic procedures to be performed safely in a clinic setting; and

WHEREAS, there is a need to remodel space where Health Information Management and Clinical Informatics offices were located to relocate these clinics within the main hospital building; and

WHEREAS, through SPH Resolution 2024-03 the SPH Hospital Operating Board of Directors approved the use of \$250,000 for the performance of this project; and

WHEREAS, additional plumbing replacement needs were identified due to aged infrastructure, as well as surgical lights, and other fixtures and finishes resulting in project overages of \$80,276; and

WHEREAS, the South Peninsula Hospital Board Finance Committee reviewed and approved this resolution at their meeting on May 16, 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 use of Operating Cash to fund the additional expenses associated with the remodel of hospital space to relocate and Co-locate the General Surgery Clinic and Functional Medicine clinic within the main hospital building.
2. This resolution is retro dated to be effective as of May 1, 2024.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA AT ITS MEETING HELD ON THIS 22nd DAY OF May, 2024.

ATTEST:

Aaron Weisser, Board President

Mary E. Wythe, Board Secretary

Introduced by: Administration
Date: 05/22/2024
Action:
Vote: Yes - , No - , Exc -

**SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2023-14**

**A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS
APPROVING AN ADDITIONAL \$87,304 OF OPERATING CASH TO FUND THE
ALREADY ACTIVE 4201 BARTLETT ST REMODEL PROJECT APPROVED IN THE
SPH RESOLUTION 2020-01 AT \$500,000 AND AMENDED IN SCOPE IN THE SPH
RESOLUTION 2023-25 TO MAKE THE TOTAL APPROVED AMOUNT OF THIS
PROJECT \$587,304**

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

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

WHEREAS, Project 21SHB had \$451,703 remaining when the original scope was changed in SPH resolution 2023-25 to complete leasehold improvements to the 4201 Bartlett St property to provide clinical services and support offices to meet the needs of the organization; and

WHEREAS, during the renovation of this building, it was identified that air exchange systems were inadequate to support occupancy of the first floor, additionally costs for interior fixtures and finishes came in higher than budgeted due to price increases causing the project to exceed budget by \$87,304; and

WHEREAS, the resolution to approve additional use of \$87,304 of operating funds to finalize the remodel of 4201 Bartlett St was discussed at Finance Committee on May 16, 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 additional use of \$87,304 to complete the remodel at 4201 Bartlett St.
2. This resolution is retro dated effective May 1, 2024.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL AT ITS MEETING HELD ON THIS 22nd DAY OF May, 2024.

ATTEST:

Aaron Weisser, Board President

Mary E. Wythe, Board Secretary

**SOUTH KENAI PENINSULA HOSPITAL
BOARD RESOLUTION**

RESOLUTION 2024-15

**A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL
BOARD OF DIRECTORS RECOMMENDING THE SUBMISSION TO THE QUALIFIED
VOTERS OF THE SOUTH KENAI PENINSULA HOSPITAL SERVICE AREA THE
QUESTION OF THE ISSUANCE OF NOT-TO-EXCEED THIRTY EIGHT MILLION
FIVE HUNDRED THOUSAND DOLLARS (\$38,500,000.00) OF GENERAL OBLIGATION
BONDS OF THE SOUTH KENAI PENINSULA HOSPITAL SERVICE AREA TO PAY
THE COSTS OF PLANNING, DESIGNING, ACQUIRING PROPERTY FOR,
RENOVATING, CONSTRUCTING, AND EQUIPPING OF FACILITIES AT THE SOUTH
PENINSULA HOSPITAL AND CAMPUS LOCATED IN THE SOUTH KENAI
PENINSULA HOSPITAL SERVICE AREA AT THE REGULAR ELECTION IN AND FOR
THE KENAI PENINSULA BOROUGH ON OCTOBER 1, 2024**

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, voter approval of the Service Area general obligation bonds authorizes for each \$100,000 of assessed taxable property value in the Service Area (based on an estimated total FY 2025 assessed valuation) an annual tax increase of approximately \$67.00 (an amount equal to 0.67 mills) to retire the proposed bond debt in the principal amount of \$38,500,000; and

WHEREAS, under provisions of AS 29.47.190 a municipality may incur general obligation debt

only after a bond authorization ordinance is approved by a majority of those voting on the question at a regular or special election; and

WHEREAS, the Hospital capital improvements mentioned above are necessary and beneficial to the Service Area and KPB community;

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

SECTION 1. That the South Peninsula Hospital, Inc. Board of Directors finds there is a public purpose and it is in the public interest of the Kenai Peninsula Borough ("KPB") that the South Kenai Peninsula Hospital Service Area ("Service Area") incur general obligation bonded indebtedness in the principal amount not to exceed Thirty-Eight Million Five Hundred Thousand Dollars (\$38,500,000), for the purpose of paying the costs of planning, designing, acquiring property for, renovating, constructing, and equipping capital improvements to, and for, the South Peninsula Hospital and campus (collectively, the "Projects"), all located in the Service Area,

SECTION 2. That this resolution takes effect immediately.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL AT ITS MEETING HELD ON THIS 22ND DAY OF MAY 2024.

ATTEST:

Aaron Weisser, President

Mary E. Wythe, Secretary

Introduced by: Administration
Date: 05/22/2024
Action:
Vote: Y-, N-, Exc.-, Abstain-

**SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2024-16**

**A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS
APPROVING THE FISCAL YEAR 2025 OPERATING BUDGET**

WHEREAS, Administration uses a systematic, fiscally responsible process for developing the South Peninsula Hospital, Inc., FY 2025 Operating Budget, which includes participation of department directors, managers and administration; and identification of strategic growth need; and

WHEREAS, the FY 2025 Operating Budget is critical to the mission and vision of South Peninsula Hospital, Inc and ensures resources are sufficient to execute priorities within the Strategic Plan including employee engagement, patient and resident experience, clinical & service excellence, medical staff alignment, and financial position; and

WHEREAS, the FY 2025 Operating Budget was approved by the Finance Committee on May 16, 2024.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL, INC., TO APPROVE THE FISCAL YEAR 2025 OPERATING BUDGET.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL, INC. MAY 22nd, 2024.

ATTEST:

Aaron Weisser, President

Mary E. Wythe, Secretary

**BYLAWS
SOUTH PENINSULA HOSPITAL, INC.**

ARTICLE I - NAME AND OBJECTIVES

Section 1.

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

Section 2.

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

Section 3.

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

ARTICLE II - MEETINGS

Section 1. Regular Meetings.

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

Section 2. Special Meetings.

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

Section 3. Quorum.

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

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

Section 4. Minutes.

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

Section 5. Reconsideration:

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

Section 6. Annual Meeting.

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

ARTICLE III - MEMBERS

Section 1.

Qualifications.

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

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

- o CEO compensation
- o Approval of the annual audit
- o Legal matters of which the Physician or a family member is the subject
- Medical Staff Board Members cannot serve on or have family relationships with members of the Physician Peer Review Committee

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

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

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

Section 2.

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

Section 3.

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

Section 4.

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

Section 5.

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

Section 6.

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

Section 7.

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

ARTICLE IV - OFFICERS

Section 1.

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

Section 2.

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

Section 3.

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

Section 4.

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

Section 5.

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

Section 6.

Secretary. The secretary shall be responsible for the minutes of the meeting, act as custodian of all records and reports, ensure posting of the agenda and minutes on the website, ensure that notification is provided to the Kenai Peninsula Borough for any changes to board membership or

officer assignments, and other duties as set forth by the Hospital Board. These duties shall be performed in conjunction with SPH Hospital Staff assigned to assist the Board.

Section 7.

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

ARTICLE V - COMMITTEES

Section 1.

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

Section 2.

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

Section 3.

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

ARTICLE VI - ADMINISTRATOR

Section 1.

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

Section 2.

The Administrator shall supervise all business affairs such as the records of financial transactions, collection of accounts and purchases, issuance of supplies, and to ensure that all

funds are collected and expended to the best possible advantage. All books and records of account shall be maintained within the hospital facilities and shall be current at all times.

Section 3.

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

Section 4.

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

Section 5.

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

Section 6.

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

Section 7.

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

Section 8.

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

Section 9.

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

Section 10.

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

ARTICLE VII - MEDICAL STAFF

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

Section 1.

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

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

Section 2.

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

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

1. The Bylaws and Rules and Regulations of the Medical Staff will state the purposes, functions and organization of the Medical Staff and will set forth the policies by which the Professional Staff exercises and accounts for its delegated authority and responsibilities.
2. The Medical Staff Bylaws will require adherence to an identified code of behavior within the Hospital. The Bylaws will state that the ability to work harmoniously and cooperatively with others is a basic requirement for initial appointment and reappointment. Such Bylaws will state that appointment and reappointment is subject to compliance with Medical Staff Bylaws and Hospital Board Bylaws.

3. The Medical Staff Bylaws or Rules and Regulations will clearly define a regular method of quality assessment if not established by Hospital Board policy.

Section 3.

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

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

ARTICLE VIII - AUTHORIZATION OF INDEBTEDNESS

Section 1. Indebtedness.

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

ARTICLE IX - AMENDMENTS

Section 1.

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

Section 2.

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

Section 3.

These Bylaws shall be reviewed at the annual meeting.

ARTICLE X - ORDER OF BUSINESS

Section 1.

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

ARTICLE XI - INDEMNIFICATION

Section 1.

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

Section 2.

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

Section 3.

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

Section 4.

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

Section 5.

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

Section 6.

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

- Adopted by the South Peninsula Hospital Board of Directors, September 27, 2023.
- Kelly Cooper, President
- Julie Woodworth, Secretary

ANNUAL BOARD CALENDAR - 2024

January

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

February

- **Retirement: Patti Russell**
- Credentialing Report
- Annual Report to the Contract Administrator
 - Corporate Compliance Report
- Committee Assignments (if not ready for Jan mtg) noted in minutes
- CEO Evaluation packet prepared and sent out by 2/20
- AHA Rural Health Care Leadership Conference
- PC: Pension Committee Annual Report
- PC: Review/update PEN-001 & PEN-002
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Quarterly Grants Report
- FC: Policy Review - F-03 & F-05

March

- 3/6 – Doctors Dinner
- **Retirement: Cheryl Riley, Jay Inama, Pam Carpenter**
- Credentialing Report
- Strategic Plan Approval
- CEO Eval – Assessments reviewed by Gov or CEO Eval Cmte
- PC: Pension Plan Contributions Approval
- FC: Policy Review - F-07 & F-08
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)

ANNUAL BOARD CALENDAR - 2024

April

- April 12&13 - Board Worksession/Retreat
- Credentialing Report
- Balanced Scorecard (new data)
- CEO Eval: CEO Compensation Cmte meets to review compensation
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Resolution authorizing CFO to file the IRS 990
- FC: Policy Review - F-09 & F-10

May

- **Retirements: Eva Stovall**
- Credentialing Report
- Quality Plan Review
- CEO Eval: Board approved compensation during Exec Session
- FC: Annual IT Security Report
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: FY Operating Budget Approval
- FC: Quarterly Grants Report
- FC: Policy Review - F-12 & F-13

June

- **Retirements: Cindy Bolognani**
- Credentialing Report
- CEO Eval: Board Chair meets with CEO to review evaluation
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Policy Review - F-14 & F-15

July

- Credentialing Report
- Balanced Scorecard (new data)
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Financial Audit planning doc provided to Board
- CAH Program Evaluation Summary Approval
- FC: Policy Review - F-16 & F-17

ANNUAL BOARD CALENDAR - 2024

August

- Credentialing Report
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- FC: Quarterly Grants Report
- GC: Place ad for open board seats
- GC: Host Doctor's Dinner

September

- Credentialing Report
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- GC: Conduct Board Self Evaluation

October

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

November

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

December

- Credentialing Report
- Next year's Board meeting calendar approval
- Board Member Elections
- FC: Finance Reporting (F-10) – FC & Exec Session packet
- FC: Balance Sheet, Income Statement, Cash Flow Statement (consent agenda)
- PC: Pension Committee Audit Report

ANNUAL BOARD CALENDAR - 2024

Any Month, As Needed

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