AGENDA
Board of Directors Meeting
6:00 PM - Wednesday, May 25, 2022
Click link to join Zoom meeting
Meeting ID: 878 0782 1015 Pwd: 931197
Phone Line: 669-900-9128 or 301-715-8592

Kelly Cooper, President		Keriann Baker		Aaron Weisser	
Melissa Jacobsen, Vice Pres.		M. Todd Boling, DO		Bernadette Wilson	
Julie Woodworth, Secretary		Matthew Hambrick		Beth Wythe	
Walter Partridge, Treasurer		Edson Knapp, MD		Ryan Smith, CEO	

Page

1. CALL TO ORDER

2. ROLL CALL

3. REFLECT ON LIVING OUR VALUES

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

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

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

6. APPROVAL OF THE AGENDA

7. APPROVAL OF THE CONSENT CALENDAR

6 - 10 7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for April 27, 2022.
Board of Directors - Apr 27 2022 - Minutes - DRAFT

11 - 14 7.2. Consideration to Approve April FY22 Financials
Balance Sheet April FY22
Income Statement April FY22
Cash Flows Statement April FY22

15 - 18 7.3. Consideration to Approve South Peninsula Hospital Policy LTC-147, Long Term Care Infection Prevention & Control Program, as recommended by Hospital Administration and the Medical Staff
LTC-147 Long Term Care Infection Prevention Program

19 - 26 7.4. Consideration to Approve SPH Policy HW-278 Tuberculosis Exposure and Control Plan as recommended by the Infection Prevention/Employee Health Departments and Medical Staff.
HW-278 Tuberculosis Exposure and Control Plan

27 - 35 7.5. Consideration to Approve SPH Policy HW-269, Infection Prevention Plan as recommended by Hospital Administration and the Medical Staff.
HW-269 Infection Prevention Plan

36 - 58 7.6. Consideration to Approve the Revised South Peninsula Hospital and Long Term Care Facility Quality Plan and Long Term Care QAPI Plan for 2022-2023, as recommended by the Patient Centered Care Quality Committee and Medical Staff.
Memo
Quality Plan
QAPI Plan 2022-2023 - LTC Addendum

8. PRESENTATIONS

8.1. Ongoing Discussion Between City of Homer and Borough Regarding Land Swap

Presenter: Lane Chesley, KPB Assembly

9. UNFINISHED BUSINESS

59 - 61 9.1. Consideration to Approve Amended SPH Resolution 2022-08, A Resolution of the South Peninsula Hospital Board of Directors Approving the Request of Unobligated Service Area Funds to Support Replacement of Domestic Water Tank, Adjusting the Total Amount for the Project to $389,491.
SPH Resolution 2022-08
Probable Cost Statement

10. NEW BUSINESS

62 - 68 10.1. Consideration To Approve SPH Resolution 2022-09, A Resolution of the South Peninsula Hospital Board of Directors Approving the Fiscal Year 2023 Operating Budget

SPH Resolution 2022-09

Operating Budget in Review FYE 2023

11. REPORTS

11.1. Chief Executive Officer

Presenter: Ryan Smith

11.2. BOD Committee: Pension

Presenter: Walter Partridge

11.3. BOD Committee: Finance

Presenter: Walter Partridge

11.4. BOD Committee: Education

Presenter: Melissa Jacobsen

11.5. Service Area Board Representative

Presenter: Willy Dunne

12. DISCUSSION

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

14.2. Board Members

15. INFORMATIONAL ITEMS

16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Credentialing

18. ADJOURNMENT

South Peninsula Hospital

MEMO

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

To: Public Participants

From: Operating Board of Directors – South Peninsula Hospital

Re: Rules for Participating in a Public Meeting

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

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

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

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

MINUTES
Board of Directors Meeting
6:00 PM - Wednesday, April 27, 2022
Conference Rooms 1 & 2 / Zoom

The Board of Directors of the South Peninsula Hospital was called to order on Wednesday, April 27, 2022, at 6:00 PM, in Conference Rooms 1 & 2 and via Zoom.

1. CALL TO ORDER

The BOD went into Executive Session at 5:15pm to discuss personnel and financial matters prior to the start of the regular meeting. Executive Session was adjourned at 5:55pm.

President Kelly Cooper called the regular meeting to order at 6:00 p.m.

2. ROLL CALL

BOARD PRESENT: **President Kelly Cooper, Keriann Baker, Todd Boling, Melissa Jacobsen, Walter Partridge, Aaron Weisser, Bernadette Wilson, Julie Woodworth, Beth Wythe, and CEO Ryan Smith**

BOARD EXCUSED: **Edson Knapp, Matthew Hambrick**

ALSO PRESENT: **Angela Hinnegan, CFO; Derotha Ferraro, Marketing Director; Maura Jones, Executive Assistant**

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

A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Ms. Ferraro read an In Memoriam statement from the Alaska Legislature for Dr. Kenneth Hahn, who served on South Peninsula Hospital's medical staff for 20 years.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

4.1. Rules for Participating in a Public Meeting

Ms. Cooper noted the Rules for Participating in a Public Meeting were provided in the meeting packet.

5. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

There were no comments from the audience.

6. APPROVAL OF THE AGENDA

Julie Woodworth made a motion to approve the agenda as written. Melissa Jacobsen seconded the motion. Motion Carried.

7. APPROVAL OF THE CONSENT CALENDAR

Ms. Woodworth read the consent calendar into the record.

7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for March 23, 2022

7.2. Consideration to Approve March 2022 Financials

7.3. Consideration to Approve SPH Board Resolution 2022-07, A Resolution of the South Peninsula Hospital Board of Directors Authorizing the CFO to Sign, File and Submit the IRS Form 990

Julie Woodworth made a motion to approve the consent calendar as read. Melissa Jacobsen seconded the motion. Motion Carried.

8. PRESENTATIONS

There were no scheduled presentations.

9. UNFINISHED BUSINESS

There was no unfinished business.

10. NEW BUSINESS

10.1. Consideration to Approve SPH Board Resolution 2022-08, A Resolution of the South Peninsula Hospital Board of Directors Approving the Request of Unobligated Service Area Funds to Support Replacement of Domestic Water Tank

Staff Report by Angela Hinnegan, CFO. This resolution is requesting funds to replace an old hot water tank at end-of-life that needs to be replaced before we can move forward with the HVAC project. We have additional funds available in unobligated service area funds, so we are asking the Service Area Board to approve the unobligated funds to pay for this hot water tank replacement.

Mr. Partridge added the Finance Committee reviewed this in detail and recommends approving the resolution. There was no additional discussion.

Julie Woodworth made a motion to Approve SPH Board Resolution 2022-08, A Resolution of the South Peninsula Hospital Board of Directors Approving the Request of Unobligated Service Area Funds to Support Replacement of Domestic Water Tank. Keriann Baker seconded the motion. Motion Carried.
Results of the Roll Call Vote:

Melissa Jacobsen Yes
Julie Woodworth Yes

Walter Partridge	*Yes*
Keriann Baker	*Yes*
Todd Boling	*Yes*
Aaron Weisser	*Yes*
Bernadette Wilson	*Yes*
Beth Wythe	*Yes*
Kelly Cooper	*Yes*

11. REPORTS

11.1. Chief Executive Officer

Ryan Smith, CEO reported to the board. He reviewed the Balanced Scorecard in detail, as it has been updated this month. He highlighted the work on sepsis and moving to a real-time, fail-safe process in order to be successful in this area. Rachael Kincaid, int. CNO and Jane Nollar, Acute Care Director, are working with the Quality Management department to put new processes in place. Ms. Cooper requested an update on this measure next month. Mr. Smith shared a few other updates, including the hiring of a new family medicine physician, Dr. Joe Llenos, who will be joining the team on August 15th, continued work on the hospitalist program, and working with the State of Alaska on the Medicaid project.

11.2. BOD Committee: Finance

Walter Partridge, Finance Committee Chair, reported. This month the committee met and reviewed the IRS Form 990. He commended Anna Hermanson and her team for their work on it. Revenue for March was very good, driven by a census increase. Long Term Care is back up to 22 residents. OB had a record month for births. The Patient Financial Service team did strong work in bringing down the AR days.

11.3. BOD Committee: Education

Melissa Jacobsen, Education Chair, reported. At the March meeting, the committee heard a presentation from a board education platform, iProtean. The company has changed a lot since the board used it previously. There are several options for purchase. The committee is proposing to enter into a one year agreement to see if the board finds it useful before making a longer commitment. The board discussed their experiences with the program. Ms. Cooper asked the Education Committee to bring their recommendation to the Finance Committee, and bring it forth to the full Board for a formal vote.

11.4. BOD Committee: CEO Evaluation

Keriann Baker, chair of the committee, reported. She included the timeline for CEO Evaluations going forward, for the board's reference. All of the data collected by the committee has been given to Ms. Cooper and she will meet with Mr. Smith and follow up and the next meeting.

11.5. Service Area Board Representative

Amber Cabana reported on behalf of the Service Area Board. The board met on the 14th. Willy Dunne and Kathryn Ault shared their experience at the AHA Healthcare Leadership Conference. Mr. Dunne also gave an update on opioid settlement funding, and on Master Facility Planning for the hospital.

12. DISCUSSION

12.1. Board of Directors Work Session

Ms. Cooper shared that the Board is planning a work session for the fall, and is looking for suggestions on what should be included. The board agreed that a speaker of facilitator is ideal. Board members mentioned cyber security as a possible topic, as well as "top 10 things staff members don't want to tell their board". Please send any further ideas to Ms. Cooper.

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER

There were no comments from the audience.

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

Mr. Smith thanked Maura Jones and Nyla Lightcap in the Administration office for their hard work, as it is Administrative Professionals Day. He also congratulated Anna Hermanson and the finance team on the beautiful IRS Form 990.

14.2. Board Members

Ms. Jacobsen thanked the group for the education feedback and for a good meeting.

Ms. Woodworth, Ms. Wilson, Ms. Cooper and Ms. Wythe had no comments.

Mr. Partridge thanked leadership for their departmental reports.

Ms. Baker congratulated Ms. Ferraro for winning the Haven House's Women of Distinction award, "Woman of Wisdom".

Mr. Weisser thanked the dietary department for the delicious dinner.

15. INFORMATIONAL ITEMS

There were none.

16. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

16.1. Credentialing

After review of the applicants' files in Executive Session, Ms. Jacobsen moved to approve the following positions in the medical staff as requested and recommended by the Medical Executive Committee:

Appointments (Telemed/Telehealth*)

- Duerinckx, Andre MD Radiology/vRad Telemedicine
- Greensweig, Tobin MD Critical Care/eICU Telemedicine
- Jimenez, Guillermo MD Radiology/vRad Telemedicine
- Kujak, Jennifer MD Radiology/vRad Telemedicine
- Van Sanford, Carson MD Neurology/telestroke Telemedicine

Reappointments (Telemed/Telehealth*)

- Bhattacharya, Pratik MD Neurology/telestroke Telemedicine
- Salyers, Laura MD Psychiatry/telep

17. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

The board adjourned to Executive Session at 7:15pm.

18. ADJOURNMENT

The board exited Executive Session at 8:00pm and adjourned.

Respectfully Submitted,

Maura Jones, Executive Assistant

Accepted:

Kelly Cooper, President

Minutes Approved:

Julie Woodworth, Secretary

DRAFT-UNAUDITED

South Peninsula Hospital

BALANCE SHEET
As of April 30, 2022

		As of April 30, 2022	As of Apr 30, 2021	As of March 31, 2022	CHANGE FROM APR 30, 2021
	ASSETS				
	CURRENT ASSETS:				
1	CASH AND CASH EQUIVALENTS	24,974,566	19,529,516	19,332,369	5,445,050
2	EQUITY IN CENTRAL TREASURY	7,221,795	5,730,960	7,533,159	1,490,835
3	TOTAL CASH	32,196,361	25,260,476	26,865,528	6,935,885
4	PATIENT ACCOUNTS RECEIVABLE	28,398,330	25,105,987	30,906,362	3,292,343
5	LESS: ALLOWANCES & ADJ	(13,729,821)	(12,906,274)	(14,402,878)	(823,547)
6	NET PATIENT ACCT RECEIVABLE	14,668,509	12,199,713	16,503,484	2,468,796
7	PROPERTY TAXES RECV - KPB	111,858	137,805	158,451	(25,947)
8	LESS: ALLOW PROP TAX - KPB	(3,599)	(3,048)	(3,599)	(551)
9	NET PROPERTY TAX RECV - KPB	108,259	134,757	154,852	(26,498)
10	OTHER RECEIVABLES - SPH	340,842	281,144	261,173	59,698
11	INVENTORIES	1,815,960	1,487,655	1,838,559	328,305
12	NET PENSION ASSET- GASB	9,550,712	4,514,836	9,450,712	5,035,876
13	PREPAID EXPENSES	866,830	798,566	915,598	68,264
		-	-	-	
14	TOTAL CURRENT ASSETS	59,547,473	44,677,147	55,989,906	14,870,326
	ASSETS WHOSE USE IS LIMITED				
15	PREF UNOBLIGATED	5,868,669	8,619,053	10,441,196	(2,750,384)
16	PREF OBLIGATED	2,236,342	1,817,412	2,312,376	418,930
17	OTHER RESTRICTED FUNDS	189,341	18,325,427	90,451	(18,136,086)
		8,294,352	28,761,892	12,844,023	(20,467,540)
	PROPERTY AND EQUIPMENT:				
18	LAND AND LAND IMPROVEMENTS	4,114,693	3,816,772	4,111,915	297,921
19	BUILDINGS	67,298,990	65,169,095	67,122,976	2,129,895
20	EQUIPMENT	29,858,032	28,233,581	29,796,835	1,624,451
21	IMPROVEMENTS OTHER THAN BUILDINGS	273,639	213,357	273,640	60,282
22	CONSTRUCTION IN PROGRESS	390,278	939,480	603,622	(549,202)
23	LESS: ACCUMULATED DEPRECIATION	(60,860,898)	(57,143,586)	(60,545,894)	(3,717,312)
24	NET CAPITAL ASSETS	41,074,734	41,228,699	41,363,094	(153,965)
25	GOODWILL	19,000	31,000	20,000	(12,000)
26	**TOTAL ASSETS**	108,935,559	114,698,738	110,217,023	(5,763,179)
	DEFERRED OUTFLOWS OF RESOURCES				
27	PENSION RELATED (GASB 68)	(568,607)	1,743,772	(568,607)	(2,312,379)
28	UNAMORTIZED DEFERRED CHARGE ON REFUNDING	366,668	435,614	372,619	(68,946)
29	TOTAL DEFERRED OUTFLOWS OF RESOURCES	(201,939)	2,179,386	(195,988)	(2,381,325)
30	TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	108,733,620	116,875,125	110,021,035	(8,141,505)

		As of April 30, 2022	As of Apr 30, 2021	As of March 31, 2022	CHANGE FROM APR 30, 2021
	LIABILITIES & FUND BALANCE				
	CURRENT LIABILITIES:				
31	ACCOUNTS AND CONTRACTS PAYABLE	1,980,396	886,697	1,971,162	1,093,699
32	ACCRUED LIABILITIES	8,188,519	7,275,383	7,978,679	913,136
33	DEFERRED CREDITS	34,266	689,399	730,235	(655,133)
35	CURRENT PORTIONS OF NOTES DUE	0	2,647,561	0	(2,647,561)
36	CURRENT PORTIONS OF BONDS PAYABLE	1,510,000	1,445,000	1,770,000	65,000
37	BOND INTEREST PAYABLE	62,737	79,266	90,679	(16,529)
38	DUE TO/(FROM) THIRD PARTY PAYERS	1,080,294	12,943,526	968,134	(11,863,232)
40	TOTAL CURRENT LIABILITIES	12,856,212	25,966,832	13,508,889	(13,110,620)
41	LONG-TERM LIABILITIES				
42	NOTES PAYABLE	0	3,881,070	0	(3,881,070)
43	BONDS PAYABLE NET OF CURRENT PORTION	8,740,000	10,510,000	8,740,000	(1,770,000)
44	PREMIUM ON BONDS PAYABLE	565,345	750,268	580,331	(184,923)
45	CAPITAL LEASE, NET OF CURRENT PORTION	26,531	35,127	26,531	(8,596)
46	TOTAL NONCURRENT LIABILITIES	9,331,876	15,176,465	9,346,862	(5,844,589)
		0	0	0	
47	TOTAL LIABILITIES	22,188,088	41,143,297	22,855,751	(18,955,209)
48	DEFERRED INFLOW OF RESOURCES	-	0	0	0
49	PROPERTY TAXES RECEIVED IN ADVANCE	0	0	0	0
50	**NET POSITION**				
51	INVESTED IN CAPITAL ASSETS	5,731,963	5,731,963	5,731,963	0
52	CONTRIBUTED CAPITAL - KPB	0	0	0	0
53	RESTRICTED	25,286	25,286	25,286	0
54	UNRESTRICTED FUND BALANCE - SPH	80,788,283	69,974,579	81,408,035	10,813,704
55	UNRESTRICTED FUND BALANCE - KPB	0	0	0	0
		-	-	-	
56	**TOTAL LIAB & FUND BALANCE**	108,733,620	116,875,125	110,021,035	(8,141,505)

South Peninsula Hospital

INCOME STATEMENT
As of April 30, 2022
DRAFT-UNAUDITED

		MONTH				YEAR TO DATE			
		04/30/22			04/30/21	04/30/22			04/30/21
		Actual	Budget	Var B/(W)	Actual	Actual	Budget	Var B/(W)	Actual
	Patient Service Revenue								
1	Inpatient	2,158,762	2,631,240	-17.96%	2,169,936	29,407,816	26,774,509	9.84%	23,540,573
2	Outpatient	10,919,433	10,044,917	8.71%	10,917,963	109,366,520	102,213,306	7.00%	96,447,576
3	Long Term Care	971,882	842,614	15.34%	583,672	8,584,747	8,574,124	0.12%	6,253,805
4	Total Patient Services	14,050,077	13,518,771	3.93%	13,671,571	147,359,083	137,561,939	7.12%	126,241,954
	Deductions from Revenue								
5	Medicare	3,077,110	2,924,478	-5.22%	2,721,624	29,985,912	29,758,394	-0.76%	25,256,225
6	Medicaid	2,235,048	1,853,537	-20.58%	2,030,949	20,182,372	18,860,891	-7.01%	16,041,602
7	Charity Care	(286,284)	208,166	237.53%	9,486	385,210	2,118,223	81.81%	1,428,240
8	Commercial and Admin	1,485,010	938,842	-58.17%	1,112,447	12,944,771	9,553,301	-35.50%	9,702,710
9	Bad Debt	385,641	275,394	-40.03%	499,762	2,535,426	2,802,310	9.52%	2,770,744
10	Total Deductions	6,896,525	6,200,417	-11.23%	6,374,268	66,033,691	63,093,119	-4.66%	55,199,521
11	Net Patient Services	7,153,552	7,318,354	-2.25%	7,297,303	81,325,392	74,468,820	9.21%	71,042,433
12	USAC and Other Revenue	59,590	49,721	19.85%	68,140	558,200	503,836	10.79%	507,222
13	Total Operating Revenues	7,213,142	7,368,075	-2.10%	7,365,443	81,883,592	74,972,656	9.22%	71,549,655
	Operating Expenses								
14	Salaries and Wages	3,692,864	3,841,301	3.86%	3,651,974	39,136,874	37,696,474	-3.82%	35,838,521
15	Employee Benefits	1,548,253	1,528,227	-1.31%	1,496,889	17,439,493	13,570,057	-28.51%	13,253,735
16	Supplies, Drugs and Food	977,171	808,076	-20.93%	790,413	10,602,939	8,188,503	-29.49%	8,245,822
17	Contract Staffing	622,068	114,455	-443.50%	186,257	3,862,531	1,159,807	-233.03%	2,558,886
18	Professional Fees	400,557	375,786	-6.59%	410,605	4,742,146	3,807,968	-24.53%	3,824,721
19	Utilities and Telephone	211,968	140,852	-50.49%	152,736	1,415,965	1,427,297	0.79%	1,384,184
20	Insurance (gen'l, prof liab, property)	55,415	53,389	-3.79%	54,117	584,559	541,008	-8.05%	521,221
21	Dues, Books, and Subscriptions	16,348	17,674	7.50%	18,669	194,283	179,095	-8.48%	200,184
22	Software Maint/Support	162,225	142,536	-13.81%	129,830	1,555,820	1,444,369	-7.72%	1,181,501
23	Travel, Meetings, Education	22,358	59,257	62.27%	21,334	447,803	600,477	25.43%	270,332
24	Repairs and Maintenance	152,717	122,076	-25.10%	154,827	1,306,308	1,237,040	-5.60%	1,303,858
25	Leases and Rentals	98,311	74,230	-32.44%	73,925	738,851	752,196	1.77%	740,115
26	Other (Recruiting, Advertising, etc.)	122,636	77,847	-57.53%	63,341	956,683	788,850	-21.28%	726,017
27	Depreciation & Amortization	336,993	293,374	-14.87%	304,209	3,283,993	2,972,851	-10.47%	2,923,355
28	Total Operating Expenses	8,419,884	7,649,080	-10.08%	7,509,126	86,268,248	74,365,992	-16.00%	72,972,452
29	**Gain (Loss) from Operations**	**(1,206,742)**	**(281,005)**	**329.44%**	**(143,683)**	**(4,384,656)**	**606,664**	**-822.75%**	**(1,422,797)**
	Non-Operating Revenues								
30	General Property Taxes	27,987	26,076	7.33%	26,169	4,654,928	4,624,149	0.67%	4,640,565
31	Investment Income	(63,730)	19,659	-424.18%	35,284	(67,343)	199,214	-133.80%	134,363
32	Governmental Subsidies	690,030	123,288	459.69%	298,001	3,118,212	1,249,315	149.59%	1,935,184
33	Other Non Operating Revenue	0	0	100.00%	0	79,384	0	100.00%	0
34	Gifts & Contributions	0	0	0.00%	0	0	0	0.00%	50
35	Gain <Loss> on Disposal	0	(1,150)	-100.00%	0	0	(11,660)	-100.00%	26,999
36	SPH Auxiliary	1	0	0.00%	1	44	0	0.00%	3,059
37	Total Non-Operating Revenues	654,288	167,873	289.75%	359,455	7,785,225	6,061,018	28.45%	6,740,220
	Non-Operating Expenses								
38	Insurance	0	0	0.00%	0	0	0	0.00%	0
39	Service Area Board	11,710	9,123	-28.36%	19,640	73,210	92,449	20.81%	90,084
40	Other Direct Expense	5,020	411	0.00%	(12,474)	41,939	4,165	0.00%	16,056
41	Administrative Non-Recurring	0	0	0.00%	0	0	0	0.00%	0
42	Interest Expense	32,233	31,792	-1.39%	36,358	322,330	322,153	-0.05%	363,583
43	Total Non-Operating Expenses	48,963	41,326	-18.48%	43,524	437,479	418,767	-4.47%	469,723
	Grants								
44	Grant Revenue	0	0	100.00%	0	1,202,810	0	100.00%	773,557
45	Grant Expense	18,336	24,658	0.00%	0	606,495	249,863	0.00%	3,929
46	Total Non-Operating Gains, net	(18,336)	(24,658)	-25.64%	0	596,315	(249,863)	-338.66%	769,628
47	Income <Loss> Before Transfers	(619,753)	(179,116)	246.01%	172,248	3,559,405	5,999,052	-40.67%	5,617,328
48	Operating Transfers	0	0	0.00%	0	0	0	0.00%	0
49	**Net Income**	**(619,753)**	**(179,116)**	**246.01%**	**172,248**	**3,559,405**	**5,999,052**	**-40.67%**	**5,617,328**

DRAFT-UNAUDITED

South Peninsula Hospital

Statement of Cash Flows
As of April 30, 2022

	Cash Flow from Operations:		
1	YTD Net Income		3,559,405
2	Add: Depreciation Expense		3,283,993
3	Adj: Inventory (increase) / decrease		(7,345)
4	Patient Receivable (increase) / decrease		(1,486,099)
5	Prepaid Expenses (increase) / decrease		(148,323)
6	Other Current assets (increase) / decrease		429,055
7	Accounts payable increase / (decrease)		(698,391)
8	Accrued Salaries increase / (decrease)		1,258,277
9	Net Pension Asset (increase) / decrease		(950,000)
10	Other current liability increase / (decrease)		386,121
11	Net Cash Flow from Operations		5,626,693
	Cash Flow from Investing:		
12	Cash paid for the purchase of property/equip		(2,600,981)
13	Cash transferred to plant replacement fund		1,198,233
14	Proceeds from disposal of equipment		-
15	Net Cash Flow from Investing		(1,402,748)
	Cash Flow from Financing		
16	Cash paid for Lease Payable		-
17	Cash paid for Debt Service		(1,705,000)
18	Net Cash from Financing		(1,705,000)
19	Net increase in Cash	$	2,518,945
20	Beginning Cash as of July 1, 2021	$	29,677,416
21	Ending Cash as of April 30, 2022	$	32,196,361

South Peninsula Hospital	**SUBJECT:** Long Term Care Infection Prevention & Control Program	**POLICY #** LTC-147 **Page 1** of **4**
SCOPE: Long Term Care, Infection Prevention, Pharmacy **RESPONSIBLE DEPARTMENT:** Long Term Care		**ORIGINAL DATE:** 1/29/21 **REVISED:** draft
APPROVED BY: Chief Nursing Officer, LTC Director, LTC Medical Director, Infection Preventionist		**EFFECTIVE:** draft

PURPOSE:
An infection prevention and control program (IPCP) is maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. To utilize evidence based practice to minimize risk of infections and to optimize safety and quality outcomes for the resident population.

DEFINITION(S):
APIC: Association for Professionals in Infection Control and Epidemiology
CDC: Centers for Disease Control
CMS: Centers for Medicare and Medicaid Services / Regulatory F880 – F883.
Infection Preventionist (IP): Refers to the practitioner assigned to clinical infection prevention, and infection prevention surveillance. Clinical Infection Preventionists are responsible for the oversight and daily management of infection control and prevention activities. Surveillance includes data collection, reporting, integrity and communication of findings to the clinical IP committees. The LTC Infection Preventionist reports to the Hospital Chief Nurse Officer but collaborates as needed to accomplish the goals of the IPCP. The IPs collaborates the LTC ICPC into the hospital IC Committee and includes interface with the Antimicrobial Stewardship Committee and the Laboratory for disease diagnosis tracking.
Infection Prevention Team: A team process including the LTC IP, DON, Quality, LNHA as needed and others who collaborate on operational issues, share information, and support the work needed to carry out LTC ICPC.
Infection Prevention Committee: Long Term Care does not operate a separate Infection Prevention Committee, but relies on the LTC Quality Committee (QAPI) for facility specific Infection Prevention oversight and direction to the LTC IP as well as inclusion in the Hospital Infection Control Committee. This Committee meets quarterly.
Employee Health: The IP and the EH Nurse, along with the LTC DON collaborates on surveillance of staff screening and staff exposure and/or immunity to infectious diseases, and performs employment tuberculosis testing per national and state standards. Exposures to communicable diseases will be evaluated as they occur and follow-up implemented through the collaborative effort of IP and EH. All employee blood and body fluid exposures will be identified and referred for post exposure follow-up per the Blood-borne Pathogen Exposure Control Plan. EH provides HCWs with testing and/or immunizations consistent with applicable laws, CDC and Advisory Committee on Immunization Practices (APIC) recommendations.
McGeer: Established industry criteria used for identification, surveillance and reporting of epidemiologic disease
NHSN: National Healthcare Safety Network; a CDC database for reporting designated infectious disease
Outcome surveillance: incidence and prevalence of healthcare acquired infections
Process surveillance: adherence to infection prevention and control practices
QAPI: Quality Assurance and Performance Improvement Committee; the LTC Quality Committee

POLICY:
A. The infection prevention and control program is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment.
B. Conduct surveillance to contain and control healthcare associated infections (HAI).
C. Assure compliance for required HAI data validation to internal and external stakeholders.
D. The IP Plan outlines Infection Prevention (IP) procedures, policies and strategies that reduce and eliminate Healthcare-associated infections (HAI), reduce the spread of infections, reduce the incidence of resistant micro-organisms, and reduce the misuse of antimicrobial therapy in the long-term care population. This program plan encompasses pandemic planning and protocols as needed and evaluates and assesses the

IPCP on a continuing basis. The ICPC assures that the Plan is aligned and integrated with the Quality Assurance and Process Improvement (QAPI) Committee as well as strategic plans and initiatives of SPH and SPH LTC as may be applicable to the resident population served.

E. The ICPC promotes and fosters a culture of safety with respect to infectious diseases and seeks to improve provider, nursing, and staff engagement, and to improve multidisciplinary teamwork to accomplish goals related to infectious disease.

F. This ICPC Plan will incorporate yearly Risk Assessments and Plans specific to the needs of the LTC facility and the population it serves in accordance with the respective state regulatory requirements for infection control and prevention.

G. The ICPC incorporate the following component parts:
   1. Risk Assessment: The IP and select entities are responsible for conducting an annual risk assessment to include site specific metrics. Risk assessments should follow a standardized ICRA format.
   2. Identification of Goals: Infection Prevention goals will be based on risk assessment results and will be evaluated and modified as necessary on an annual basis.
   3. Surveillance, Data collection, Analysis and Reporting: LTC site specific surveillance will be conducted by the IP. Findings will be reported to the Infection Prevention Committee, and the Long Term Care specific surveillance findings will be reported to LTC Quality Committee (QAPI).
   4. Policy Drafting and Review: Infection Preventionists (IPs) will create, and review policies and procedures associated with or specifically focused on infection control and prevention. Policies and procedures will be reviewed using input and collaboration with the LTC facility DON.
   5. Education and Training: IPs will provide support for education of caregivers, residents, visitors to ensure that key stakeholders understand infection prevention policies, interventions, and processes. The IP will share their expertise across the LTC and promote IP goals, seeking to embed IP interventions into standardized care processes in LTC.
   6. Program Evaluation and Performance Improvement: The IP Plan will be monitored as needed to assure goals and objectives are met and reviewed annually, and a summary of activities, process measures, outcome metrics, and statement of effectiveness will be reported to the Long Term Care Quality Committee, and the LTC DON /Administrator who reports to the SPH LTC Board of Directors as needed. Recommendations for each year will be based on Long Term Care priorities, goals, strategies, as well as areas of risk identified and emerging areas of concern.

H. Under delegation from the SPH LTC Governing Board, the LTC Infection Prevention Plan covers all activities related to infection prevention, assessment, performance improvement, and risk identification mitigation/management. This work is confidential and may be protected under Alaska 18.23.020 in certain situations (provider peer protection). In addition to demonstrating compliance with the requirements set forth, the ICPC will demonstrate compliance with all applicable local, State, Federal, accreditation, and certification standards and regulations.

PROCEDURE:

A. Goals and Objectives
   1. Identify, assess, and prioritize Infection Prevention risks for SPH LTC.
   2. Maintain Infection Prevention guidelines in accordance with current standards and literature.
   3. Provide initial and recurring Infection Prevention education.
   4. Protect staff from occupational injuries and illnesses (e.g., tracking needlesticks and back injuries).
   5. Monitor the environment to reduce or eliminate environmental hazards to residents, caregivers, and visitors.
   6. Conduct surveillance to contain and control significant pathogens.
   7. Conduct surveillance to contain and control healthcare associated infections(HAI)
   8. Assure compliance for required HAI data validation to internal and external stakeholders.
   9. Report data as required by the CDC through their National Safety Healthcare Network (NHSN) data reporting tool
   10. Collaborate with staff, leaders and providers on process improvement projects, research, and publication.
   11. To be in compliance with the CMS Phase III regulations found at: F880 – F883.

B. Surveillance
   1. Process surveillance and outcome surveillance are used as measures of the IPCP effectiveness.
   2. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection in collaboration with Employee Health Nurse, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications.
   3. The information obtained from infection control surveillance activities is compared with that from other facilities via state reporting and nationally thru National Health and Safety Network (NHSN) and with acknowledged standards (for example, acceptable rates of new infections), and used to assess the effectiveness of established infection prevention and control practices.
   4. Standard criteria are used to distinguish community-acquired from healthcare associated acquired infections.

C. Antibiotic Stewardship
   1. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities.
   2. Medical criteria and standardized definitions of infections are used to help recognize and manage infections for urine testing and UTI treatment, upper respiratory tract infection treatment, and skin and soft tissue infection treatment.
   3. Pharmacy guidelines have criteria for treatment, antibiotic selection, and duration of treatment.
   4. Antibiotic usage is evaluated and practitioners are provided feedback on reviews.

D. Data Analysis
   1. Data gathered during surveillance is used to oversee infections and spot trends.
   2. Data analysis includes calculating number of infections per 1000 resident days as follows:
      1) The infection preventionist collects data, categorizes each infection by body site and records the absolute number of infections;
      2) Monthly rates are compared side-by-side to allow for trend comparison.
   3. Data collection instruments, such as infection assessment, surveillance reports and antibiotic usage surveillance forms are used by the Infection Preventionist.

E. Outbreak Management
   1. Outbreak management is managed by the Emergency Operations Plan (EOP).
      1) LTC is represented in the EOP by the Licensed Nursing Home Administrator and/or Director of Nursing, and the Infection Prevention Physician
   2. Specific criteria are used to help differentiate sporadic cases from true outbreaks or epidemics.
   3. The Infection Prevention Physician, SPH Lab, and IP Nurse helps the facility comply with pertinent state and local regulations concerning the reporting and management of those with reportable communicable diseases.

F. Prevention of Infection
   1. Important facets of infection prevention include:
      1) Oversee infection surveillance activities including the ordering of necessary surveillance tests.
      2) Institute any surveillance, prevention or control measures or studies when there is a potential or actual outbreak of, or exposure to an infectious disease.
      3) Initiate, change or discontinue isolation measures as necessary, ensuring that the least restrictive possible isolation measures are used for each resident's specific circumstances.
      4) Educating and communicating to staff the importance of proper protocols and procedures stressing the importance of isolation precautions including visitors and family
      5) Utilize the Centers for Disease Control (CDC), National Healthcare Safety Network (NHSN), Association of Professionals in Infection Control and Surveillance (APIC), and updated McGeer criteria classification of infections as a guide in determining Healthcare Associated Infections (HAI's) criteria
      6) Facilitate compliance with reporting requirements to various public health officials/ agencies via SPH laboratory Department
      7) Reports to LTC Quality Committee and the DON/Administrator who reports to the Quality committee of the board of directors as needed.

G. Immunization/Vaccination
   1. The facility has an immunization policy following CDC recommendations
   2. Refer to policy LTC-062 Resident Vaccinations

H. Monitoring Employee Health and Safety
   1. The facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers, including education of communicable diseases when these individuals should stay home when ill and report their signs or symptoms of infections for identification and tracking of trends
   2. Employee Health provides the following:
      1) Surveillance of HCW's;
      2) Screens HCWs upon hire and as needed for exposure and or immunity to infectious diseases;
      3) Performs tuberculosis testing and administers vaccines following CDC recommendations;
      4) Exposures to communicable diseases will be evaluated as they occur and follow up implemented through the collaborative effort of IP and EH including annual Sharps Safety Healthstream
      5) All employee blood and body fluid exposures will be identified and referred for post exposure follow up per the Blood borne Pathogen Post Exposure Control Plan;
      6) Guidelines and educational resources are located on the SIS site under clinical tools.

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. 2018 MED-PASS – Infection Control Policy and Procedure Manual, pp. 15-19, v.1.1 (H5MAPL1445)
2. OBRA Regulatory §483.80 Infection Control
3. Survey Tag Number F880

CONTRIBUTOR(S):
LTC Director; Infection Preventionist; LTC Medical Director

South Peninsula Hospital	**SUBJECT:** Tuberculosis Exposure and Control Plan	**POLICY #:** HW-278
		Page 1 of **8**
SCOPE: Hospital-Wide **RESPONSIBLE DEPARTMENT:** Infection Prevention; Employee Health		**ORIGINAL DATE:** 4/29/13 **REVISED:** 4/20/21
APPROVED BY: draft		**EFFECTIVE:** draft

PURPOSE:
Exposure prevent and control plan to achieve early detection, isolation, and treatment of persons with active Tuberculosis (TB) and to minimize the risk of TB transmission to patients and staff.

DEFINITION(S):
N/A

POLICY:
A. The Infection Prevention Nurse (IP RN), working with the Employee Health Nurse (EH RN) will provide supervisory responsibility for the TB control plan.
B. The risk assessment will be reviewed annually by the IP RN and physician.
C. Plan Control Measures include:
   1. Administrative
   2. Engineering
   3. Work practices
D. SPH has three negative pressure rooms for patient isolation: two in the Acute Care Unit and one in the Emergency Department.
E. The IP RN will monitor indicators of nosocomial transmission and review every positive lab for TB received at SPH.
F. The IP RN working with the EH RN will assess on an on-going basis, the level of potential occupational risk.
G. Engineering evaluation:
   - Engineering controls of a negative pressure room are tested monthly by Facilities Management.
H. Periodic Assessment:
   - Risk assessment will be reviewed annually
   - TB Control Plan will be reviewed annually

PROCEDURES:
A. Analysis of Employee TB Data
   1. Results of employee TB testing or screening shall be kept in a retrievable aggregate data base.
   2. Tuberculosis testing and screening conversion rates are analyzed to determine where risk of occupational rates of conversion may be increased.
      A TB conversion rate will be calculated when a trend is noted, as follows:
      A= # health care workers with new positive TB Screening Test (TBST) in each area or group
      B = # health care workers with negative TBST's in each area or group
      $$\% \text{ Conversion} = \frac{A \times 100}{A + B}$$
   3. All tuberculosis testing with positive results or screening conversions will receive further evaluation by the Employee Health nurse or Infection Prevention nurse. A report will be provided to the Infection Prevention Committee.
   4. Tuberculosis testing and screening of employees, volunteers, students, and contractors is completed as outlined in SPH policy HW-057

B. Observation of Infection Prevention Practices
   1. Compliance is considered to be a standard of performance and should be included in the annual performance evaluation for all employees with potential for exposure.
   2. Recommended practices are stated within this plan which is located in the policy manager.

3. Strategies for compliance monitoring:
   a) Follow-up on the report of an employee's failure to comply with the required protective measures will be the responsibility of the employee's supervisor.
   b) Follow-up of problems identified through informal reports, staff complaints, quality management or safety reports, committee minutes, employee surveys, staff logs, and evaluation comments received from education or training programs will be the responsibility of individual departments.
   c) Problems identified during the normal Infection Prevention surveillance rounds by the Infection Prevention Nurse will be reported to managers.
4. Noncompliance will be reported to an employee's immediate supervisor by all employees who observe an employee's failure to comply with the required protective measures.
5. Incidents of noncompliance will be investigated by the noncompliant employee's immediate supervisor/director to determine the cause and corrective measures to be implemented.

C. Detection Of Patients Who May Have Active TB
1. Considerations of TB Diagnosis
   a) Patients with signs/symptoms
      1) Persistent cough > 3 weeks
      2) Bloody sputum
      3) Night sweats
      4) Weight loss
      5) Anorexia
      6) Fever
   b) Groups with a higher prevalence of TB infection
      1) Medically underserved populations, including some African-Americans,
      2) Hispanics, Asians and Pacific Islanders, American Indians and Alaska
      3) Natives.
      4) Homeless persons
      5) Current or past prison inmates
      6) Alcoholics
      7) Injecting drug-users
      8) Elderly
      9) Foreign-born persons from Asia, Africa, the Caribbean and Latin America
      10) Contacts to persons with active TB
      11) HIV positive individuals
   c) Groups with a higher risk to progress from latent TB infection to active disease
      1) Persons with HIV infection, silicosis, S/P gastrostomy or jejuno-ileal bypass surgery, >10% below normal body weight, chronic renal failure, diabetes mellitus, immunosuppressed due to medication, and those with some malignancies.
      2) Persons who have been infected within the past two years.
      3) Children < 5 years old
      4) Persons with fibrotic lesions on chest x-ray.
2. Diagnostic Measures for Identifying TB
   a) History and physical examination
   b) Chest x-ray
   c) Smear and culture of sputum or other appropriate specimen
   d) Quantiferon-Gold blood test
   e) Bronchoscopy or biopsy, in indicated
3. Laboratory Response
   1) If TB is suspected, the AFB smear and culture will be sent to Alaska State Public Health Laboratory. AFB smear results will normally be available within 48 hours with the exception of specimens collected or shipped on holidays and weekends.
   2) The most rapid methods available should be used.
   3) CPH lab will perform 2 Cepheid Xpert MTB/RIF Assays on 2 sputum samples. Each sputum sample must be collected at a minimum of 8 hours apart.
      - Positive results will be called to the designated caregiver
4. Additional Considerations

a) Patients having positive or history of positive PPD, previous TB, exposure to TB and those in a high risk group, have a higher probability of TB. Active TB is strongly suspected if a chest x-ray is suggestive of TB, the sputum smear is positive for AFB, or symptoms are suggestive of TB.
b) Immunosuppressed patients with pulmonary sign and symptoms initially ascribed to other etiologies should be evaluated for co-existing TB initially and the evaluation repeated if the patient does not respond to appropriate therapy for the presumed etiology of the pulmonary abnormalities. Other organisms, such as Pneumocystis carinii or M.avium complex may occur simultaneously and TB should be sought in the diagnostic evaluation of all patients with symptoms compatible with TB.
c) Persons with HIV infection or other conditions associated with severe suppression of the cell-mediated immunity may present with atypical clinical or radiographic presentation and/or the simultaneous occurrence of other pulmonary infections, such as overgrowth of cultures with M. avium complex when both MAI and Mycobacterium tuberculosis are present.
d) Persons who are diagnosed with active TB prior to admission to this facility will be given a surgical mask to wear as they enter the facility. They will be taken to the negative pressure isolation room.
e) All employees who provide care for the patient will wear an OSHA approved N95 mask or portable air-purifying respirator (PAPR) that they have been evaluated and approved to use through Employee Health.

5. Public Health Reports
   All patients with confirmed TB will be reported to the appropriate health department immediately for identifying and evaluating TB contacts. In Alaska this is: Dept. of Health and Social Services, division of Epidemiology at 907-269-8000 or 1-800-478-0084 (after hours).

D. Management of Hospitalized Patients with TB
1. Evaluation for TB:
   Pulmonary TB should always be included in the differential diagnosis of persons with signs and symptoms suggestive of TB and appropriate diagnostic measures should be used. The recommended diagnostic measures are Interferon Gamma Release Assay (IGRA) - QuantiFERON-TB Gold (QFT), sputum testing, and chest x-ray.
2. Initiation of Treatment
   Patients with confirmed active TB or highly likely to have active TB, are started on appropriate treatment promptly, based on analysis of surveillance data of TB isolates susceptibility.
3. Initiation of Isolation
   All patients with suspected or confirmed TB are evaluated for potential infectiousness and those with pulmonary or laryngeal TB are placed in TB isolation until they are determined to be noninfectious. Patients with previously diagnosed TB who are readmitted before confirmation of complete cure, are placed in TB isolation until infectiousness has been ruled out.
4. TB Isolation Practice
   Patients in TB isolation are educated about TB transmission and taught to contain secretions from coughing or sneezing by staff. Patients in TB isolation remain in the negative pressure isolation room with the door closed. Transporting the TB patient outside isolation room should occur only when medically essential procedures cannot be performed in the isolation room. A surgical mask must be worn by the patient when outside the isolation room. The transporter does not need to wear a mask, but timing of transport is planned to occur when the procedure can be performed rapidly, and the patient does not have to wait in a crowded area.
5. If treatment and procedure rooms do not have a separately ventilated area or meet ventilation recommendations for TB isolation, the patient should remain masked and be returned promptly to the isolation room. Minimal staff should enter the TB isolation room and all who enter must wear an OSHA approved N95 mask or PAPR hood for which they have been evaluated and approved to use through Employee Health Fit testing (FITT) of the N95 respirator by the Employee Health Nurse/designee. Not all employees will be FITT. Some employees will be FITT on an “as needed” basis. The employees in this facility who may be fit tested for an N95 respirator include:
   1. Supervisors
   2. Respiratory therapists
   3. Nursing Staff
   4. ED physicians
   5. Hospitalists

6. On-call personnel in the OR
7. X-ray techs
8. Lab techs
9. Registration staff as needed
10. EVS staff
11. All other employees on an "as needed basis"

6. TB Isolation Room
   a) Purpose
      1) Isolate patients who are likely to have infectious TB.
      2) Prevent escape of droplet nuclei from the room, preventing entry of Mycobacterium Tuberculosis bacillus into the hall and other areas.
      3) Provide an environment that will allow reduction of the concentration of droplet nuclei through various engineering controls.
   b) Characteristics
      1) 1. Maintained under negative pressure and monitored constantly while in use. An alarm sounds when the room is no longer considered to be negative pressure (e.g. the door is left open). Acute care rooms (17 and 18) are always negative pressure and do not have an ante room.
      2) Door will be open only when patient or personnel must enter or leave.
      3) Achievement of best possible ventilation air flows, but a minimum requirement of 6 air changes per hour.
      4) Rooms 17 and 18 are engineered to be used for TB isolation in that the air from isolation room will be maintained as negative pressure in accordance with guidelines for Design and Construction of Healthcare facilities. In the ED, room 3 can be made a negative pressure room.
      5) If all three negative pressure rooms are in use for TB patients, any additional TB patients would need to be transferred to another facility that is equipped to care for TB patients.
7. Discontinuation of Airborne Isolation
   a) Patients with no present history of TB (this excludes patients previously treated for active or latent TB)—Airborne isolation may be discontinued after 2 consecutive negative Cepheid Xpert MTB/RIF Assays (collected at a minimum of 8 hours apart, with one of these samples collected in the early morning upon patient awakening) and a physician order for airborne isolation removal.
   b) Patients with known active TB at time of admission (regardless of treatment status)—Airborne isolation should be discontinued only when the patient is on appropriate therapy, is improving clinically, has 3 negative AFB smears and a physician order for airborne isolation removal.
      1) Patients with active TB should be monitored for relapse with sputum smears on a regular basis.
      2) Consideration for isolation continuance should be given to multi-drug resistant TB patients throughout their hospitalization.
8. Discharge Planning
   a) Plans to be initiated and in place before discharge
      1) Confirm appointment with provider who will follow the patient.
      2) Sufficient medication to take until outpatient appointment
      3) Public Health is notified to direct treatment compliance.
   b) When an infectious patient is discharged to another facility, the accepting facility is notified of the positive TB diagnosis and the need for TB isolation.

E. Tuberculosis Surveillance and Screening for SPH Long Term Care Facility

1. SPH Long Term Care (LTC) Facility is not equipped to provide airborne infection isolation for Tuberculosis (TB). All residents of LTC that develop TB disease will be transferred to SPH Acute Care for appropriate treatment per current federal guidelines. Residents with known active tuberculosis should not be admitted to LTC.
2. All newly admitted residents to SPH LTC should receive a QFT Blood Test for TB. Those residents with a history of positive TST or history of severe hypersensitivity to the purified protein derivative may be placed on TB surveillance by order of their physician. Residents who cannot have a QFT should be screened annually using the TB surveillance LTC TB flow sheet. A chest x-ray will be done initially and as needed thereafter by physician direction.
3. In addition, current residents, except those with known treated active tuberculosis, history of positive TST or BAMT, will participate in an annual testing program per LTC policy.

4. Physician Referral: Referring physicians or facilities should be questioned as to the patient's possible TB status, in order to facilitate the patient's admission into appropriate isolation and care.

F. Engineering Controls
1. Ventilation accomplishes the dilution and removal of contaminants from the air and provides for room air flow, velocity and patterns that meet federal, state, and local regulations.
2. Prevention of nosocomial transmission requires patient rooms and area where patients with suspected or confirmed TB are treated, be at negative pressure to adjacent areas, have at least 12 air changes per hour, be directly exhausted to the outside or to have air recirculation through a HEPA filtration system with 99.97% filtration.
3. The ventilation system is comprised of:
   a) Surface filters which capture airborne contaminants at or near the source and removes them without exposing persons in the area.
      1) If cough inducing procedures are done, they are done in the negative pressure isolation room
      2) Local exhaust areas of the hospital are: all bathrooms, the operating room and the obstetrics department.
   b) General Ventilation reduces the concentration of contaminants in the air.
      1) Single pass system: 100% of the room air is exhausted to the outside. The supply air is air from the outside that has undergone appropriate heating and cooling or is from a central system supplying a number of areas.
      2) Recirculating system only a small portion of the total room or area exhaust is discharged to the outside. This volume of exhaust air is then replaced with fresh outside air. The resulting mixture is then recirculated to the rooms or areas serviced by the system.
      3) Ventilation Rates of a minimum of 12 air changes per hour (ACH) for isolation and treatment rooms are maintained.
      4) Room air flow patterns are designed to prevent stagnation of the air and prevent "short circulating" of the supply to the exhaust (i.e. passage of air directly from the air intake to the air exhaust). The supply and exhaust locations should first direct the clean air to areas where healthcare workers are likely to work, across the infection source and then to the exhaust.
      5) Facility air flow direction is designed and balanced to provide air flow patterns from more clean to less clean (or less-contaminated to more-contaminated) areas.
   c) Negative pressure rooms prevents airborne contaminants from escaping a room.
      1) The pressure differential is necessary to maintain negative pressure in a room. It is very small and can be altered by small changes in the ventilation system, or by opening and closing of the isolation room door, corridor doors and windows. All doors and windows must remain closed in both the isolation room and other areas except when needed to enter or leave an area.
      2) Monitoring of negative pressure rooms is done by electronic room pressure monitoring, providing audio and visual alarm on a continuous basis when the room is in use.
   d) TB isolation rooms are to isolate patients with known or suspected TB in rooms that are designed to prevent the spread of droplet nuclei generated by infectious TB patients. These rooms are single-patient rooms with negative pressure relative to the corridor or other areas connected to the room. Doors between the isolation room and other areas remain closed except for entry or exit from the room, and there should be a small gap of 1/8 to 1/2 inch at the bottom of the door to provide an air flow path.
      1) Alternative methods for achieving negative pressure include an anteroom with positive pressure with respect to the isolation room and neutral with respect to the corridor; CPH utilizes anterooms for negative pressure rooms
      2) Exhaust from TB isolation rooms is to be exhausted directly to the outside of the building, away from people, and animals in accordance with federal, state and local regulation. Exhaust from isolation room must be exhausted above the roof at least 25 feet from an air intake source. If direct exhaust to the outside is impossible, air should only be exhausted within the facility through a properly designed, installed and maintained HEPA filter.
   e) HEPA Filtration
      1) HEPA filtration is used to remove contaminants from the air; HEPA filters remove at least 99.7% of particles greater than 0.3 microns in diameter.
      2) The filtration described in this section is in excess of the standard filtration in the main air

conditioning system and are specifically for the purpose of eliminating TB aerosols/particles.

G. Respiratory Protection
   1. Respiratory protective devices used for TB meet the following criteria:
      a) Ability to filter particles greater than 3 micron in size in the unloaded state with a filter efficiency of equal to or greater than 95% (i.e., filter leakage of equal to or less than 5%), given flow rates up to 50 liters per minute.
      b) The PFR 95 is qualitative fit tested using the 3M FT-10/FT-10S or quantitatively via the PortaCount Pro+. This must be done for all healthcare workers before they are to enter the TB isolation room by the Employee Health Nurse/designee. There are two styles which are each available in two sizes to fit healthcare workers with different facial size and characteristics.
      c) The face piece fit is to be checked by the wearer each and every time he or she puts on the respirator using the manufacturer's face piece fitting instructions, by using positive-pressure test.
      d) For those healthcare workers who are unable to wear the PFR 95 mask secondary to inability to fit, the AIR-MATE HEPA 12 Powered Air Purifying Respirator (PAPR) unit is to be used according to manufacturer's instructions. No fit testing is required as there is a continuous flow of HEPA filtered air within the breathing zone.
      e) Reuse of masks is dependent on conscientious mask inspection and maintenance. Manufacturer's instructions for inspecting, cleaning, and maintaining masks should be followed to ensure that the mask continues to function properly. Before each use, the outside of the mask should be inspected. If the filter material is physically damaged or soiled, the mask should be discarded.
      f) Clean, unused masks may be ordered from materials management

H. Cough Inducing Procedures
   1. General guidelines: Procedures that involve instrumentation of the lower respiratory tract or induce cough may increase the probability of droplet nuclei being expelled in the air. These cough-inducing procedures include endotracheal intubation and suctioning, diagnostic sputum induction, aerosol treatments and bronchoscopy. Other procedures that may generate aerosols (e.g., irrigation of tuberculosis abscess, homogenized or lyophilizing tissue), are also included in these recommendations.
      a) Do not perform on patients who may have infectious TB unless absolutely necessary.
      b) These are to be done in room 17 or 18 which are negative pressure isolation rooms, when possible.
      c) During cough-inducing procedures, healthcare workers will wear the N-95 mask or PAPR.
      d) Patients will be kept in the isolation room or treatment room until coughing subsides. Give tissues and instructions to cover their mouth and nose when coughing. Post sedatives or anesthesia, patients will be kept in the TB isolation room in ICU and not in the recovery areas with other patients.
      e) Before the TB isolation room is used for another patient, follow the room closure time for airborne isolation recommendations (Appendix A) to ensure that any droplet nuclei have been expelled into the air, are removed.

I. Healthcare Workers (HCWs)
   1. Education and Training
      a) All HCWs will receive education about Tuberculosis. Specific information and training about occupational hazards and required protective measures will be provided to new employees before the initial assignment and annually to all employees. This training will occur through specific department orientation programs, mandatory annual review and through ongoing in-service educational programs. The training is provided at no cost to the employee.
      b) Although the level and detail of this education may vary according to the job description, the following elements will be included in the education of all HCWs: basic concepts of TB, the potential for occupational exposure, the principles and practice of infection prevention, the purpose of the tuberculosis testing and screening program, medical evaluation, contact investigation, and the higher risk to immunocompromised persons.
   2. Counseling, Screening, and Evaluation
      a) A TB screening and prevention program for HCWs following state and national guidelines is in place for protection of both HCWs and patients. See HW-057 Tuberculosis Screening and Testing.

J. Patient-to-Patient Transmission of TB

1. Investigating possible patient-to-patient transmission of TB
   a) Conduct surveillance of active TB cases in patients. If surveillance suggests the possibility of patient-to-patient transmission, such as
      - high proportion of TB patients had prior admission in the past year
      - sudden increase in patients with drug-resistant TB
      - multiple patients with identical and characteristic drug-susceptibility
   b) take the following steps:
      1) Review HCW and patient TB test surveillance data for the suspected areas to detect additional patients or HCW with TB conversions or active disease.
      2) Look for possible exposures of the new TB patients to other patients with TB during prior admissions
         - admitted to the same room or area
         - received the same procedures
         - were in the same treatment area on the same day.
   c) Take the following steps if the above evaluation suggests transmission has occurred:
      1) Conduct a problem evaluation to determine possible cause of the transmission:
         - problem with institutional barriers to implementation
         - of appropriate TB isolation practices
         - problems with engineering controls
      2) Determine which additional patients or HCW may have been exposed and evaluate with TB testing and screening.
      3) Consult with the public health department for assistance in community contact investigation
      4) Investigating contacts of persons with TB who were not recognized and isolated appropriately
2. Identify HCW and other patients who were exposed to the patient:
   a) Interview patient and appropriate personnel
   b) Review patient's medical record to determine which areas and persons may have been exposed to the patient prior to appropriate isolation, such as:
      - outpatient clinics
      - hospital rooms
      - treatment, radiology and procedure areas
      - waiting areas
      - persons providing direct care
      - other personnel such as therapists, clerks, transportation personnel, housekeepers, and social workers.
   c) Contact investigation follows a concentric circle, expanding from closest to less close contacts, if transmission to the former is found.
   d) Exposed HCW will follow HW-057 Tuberculosis Screening and Testing for appropriate follow up procedures.
   e) Promptly evaluate exposed persons with TB test conversions or with symptoms suggestive of TB clinically and with chest radiographs.
   f) Persons with previously known positive TB test who have been exposed to an infectious patient do not require a repeat TB test or a chest radiograph unless they have symptoms of TB.
   g) Conduct an investigation to determine why TB was not recognized in the patient or, if recognized, why the patient was not isolated promptly so that appropriate protective actions could be taken. A report will be forwarded to the Infection Prevention Committee and to appropriate department directors.

K. Coordination with Public Health Department

1. Report suspected/diagnosed TB cases when known, to facilitate appropriate community contact investigation, follow-up, and continuation of therapy.
2. Implement coordinated discharge plan involving patient, HCW and the Public Health Department.
3. The confidentiality of HCW will be maintained as prescribed by state and local laws.
4. Appropriate contact investigations of patients and HCW with active TB will be coordinated by South Peninsula Hospital and the Public Health Department.

L. Additional Consideration for Selected Areas
   1. Operating Rooms
      a) Elective procedures on patients with active TB will be delayed until the patient is no longer infectious.
      b) If procedures must be performed, they should be done in OR rooms with the door closed and traffic at a minimum. Procedures will be done when other patients are not present in the operating suite (at the end of the day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary sites.
      c) A bacterial filter is built into disposable circuits for each patient receiving anesthesia to reduce the risk of contamination of anesthesia equipment or discharge of tubercle bacilli into the ambient air when anesthesia is being administered to a patient with possible TB.
      d) The pulmonary TB patient will be monitored during recovery in room 251 of the ICU if appropriate. Personnel present when operative procedures are performed on patients who have infectious TB will wear N95 respirator rather than standard surgical masks alone.
   2. Laboratory
      a) All AFB specimens are tested per protocol. Per routine laboratory practice, all cultures are set up under a biological safety hood.

M. Environmental Cleaning of Room
   1. Negative pressure rooms vary in the number of air exchanges per hour. The amount of room closure time prior to cleaning varies for negative pressure and non-negative pressure rooms throughout the facility. These room closure time have been calculated needed using CDC Guidelines for Environmental Infection Control in Health-Care Facilities (2003), Airborne Contaminant Removal, Table B.1. Air changes/hour (ACH).
      a) After the patient leaves, keep the door closed for the recommended amount of time per the Room Closure Time for Airborne Isolation guidelines, Appendix A
      b) After the recommended amount of room closure time, staff may enter the room for cleaning, etc.
      c) When cleaning the isolation room, Environmental Services will follow their established housekeeping protocols for cleaning isolation rooms.

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. Attachments:
   - SPH's Isolation Manual
   - CDC's TB risk assessment and worksheet https://www.cdc.gov/tb/publications/guidelines/AppendixB_092706.pdf
2. Tuberculosis Control in Alaska, http://www.epi.hss.state.ak.us/pubs/webtb/tbjuly2001rev.pdf
3. **CDC** www.cdc.gov/mmw/preview/mmwrrhtml/rr5415a1.htm
4. Anon.n.d Safety and health Topics: Tuberculosis. http://www.osha.gov/SLTC/tuberculosis/index.html
5. Anon..nd. The Section of Epidemiology, Tuberculosis Control http://www.epi.alaska.gov/id/tb.stm
6. Architects, American institute of 2006 Guidelines for Design and Construction of
7. health Care Facilities. 2006 ed. American institute of Architects/Facility Guidelines institute, June 15
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9. Gitterman, Steven. Revised Device Labeling for the Cepheid Xpert MTB/RIF Assay for Detecting Mycobacterium tuberculosis, February 27, 2015. MMWR. Centers for Disease Control, Vol. 64/ No. 7, page 193
10. Centers of Disease Control and Prevention, Guidelines for Environmental Infection in Health-Care Facilities (2003), Appendix B. Air, Available at: https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html

CONTRIBUTOR(S):
Infection Prevention RN; Employee Health RN; Chief Nursing Officer; Infection Prevention Medical Director

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

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PURPOSE:

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

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

DEFINITION(S):

N/A

POLICY:

I. Missions, Vision, Values:

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

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

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

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

Compassion**:** We provide compassionate patient and resident centered quality care, and a safe and caring environment for all individuals.

Respect**:** We show respect for the dignity, beliefs, perspectives, and abilities of everyone.

Trust**:** We are open, honest, fair, and trustworthy.
Teamwork**:** We work together as a dynamic, collaborative team, embracing change, and speaking as one.
Commitment**:** We are responsible and accountable for supporting the vision, mission, values, strategies, and processes of our organization.

II. Background:

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

III. Goals:

- The primary goal of the Infection Prevention Program (IPP) is to reduce the risk of acquisition and transmission of HAIs at the SPH Organization. In order to accomplish this goal, the hospital will:
- Incorporate the Infection Prevention Program as a major component of its safety and performance improvement programs
- Perform ongoing assessments to identify its risks for the acquisition and transmission of infectious agents
- Use an epidemiological approach that consists of surveillance, data collection, and trend identification
- Effectively implement infection prevention/control processes
- Educate and collaborate with organization-wide leaders to effectively participate in design and implementation of the IPP.
- Integrate its infection prevention efforts with healthcare and community leaders to the extent practical, recognizing that infection prevention and control is a community wide effort
- Plan for its response to infections that could potentially overwhelm its resources
- To communicate to physicians, employees, students, trainees, volunteers, subcontractors, construction workers, and as appropriate, visitors, residents, and patients about infection prevention and control issues, including their responsibilities in preventing the spread of infection within the hospital.
- In the event of an infectious disease outbreak, provide liaison activities with facility management in order that

decisions may be made regarding temporary halting of services, to limiting visitors within the facility, to fully activate the organization's Emergency Operations Plan.
- Provide documentation of recognition and compliance with appropriate regulatory and accrediting agencies.
- To report appropriate information to the organization and public health agencies.

IV. Program Objectives:

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

V. Program Authority and Responsibility

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

reporting, and follow-up as directed annually by the IPC.

D. Statement of Authority

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

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

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

VI. Infection Prevention Committee (IPC)

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

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

B. The IPC is responsible to:

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

7. Integrate findings with the Quality Management Department to collate, trend, analyze, and disseminate data to departments/areas of concern or interest.
8. Assess the overall success or failure of key processes for preventing and controlling infection.
9. Assess the adequacy of the human, information, physical, and financial resources allocated to support the IPP.
10. Review and revise the OPP at least annually and as needed based upon identified risks.
11. Facilitate annual education/training of Infection Prevention/Employee Health to all staff.

C. The IPC shall meet quarterly or as necessary to conduct business and shall review the following data in assessing the effectiveness of the IPP:
   1. Surveillance and Infection Prevention Data
      - Policies governing asepsis and Infection Prevention
      - QI reports
      - Outbreak investigations
      - Results of environmental tours
      - Preventing and controlling the spread of infection and communicable diseases among patients and staff, in coordination with EHS.
   2. Patient Safety
      - Compliance with Hand Hygiene Guidelines
      - Identification and reporting of any deaths due to HAIs
   3. Coordination with Other Programs, Services, Agencies
      - Cooperating with hospital-wide orientation and in-service education programs
      - Environmental Services
      - Microbiology
      - Reprocessing
      - Sterile Processing Department
      - Pharmacy Intervention
      - City/County Health Notifiable Conditions
      - Emergency Preparedness
   4. Oversee Healthcare Worker Health and Safety
      - Bloodborne Pathogens (BBP) Exposures – Sharps injury log
      - Tuberculosis (TB) exposures
      - Any employee health surveillance/education
   5. Management of the Environment of Care
      - Maintenance reports of ventilation equipment to provide appropriate air exchanges.
   6. Evaluate all new or proposed disinfecting and sterilization materials and procedures.

D. The IPC shall report its findings and recommendations to the Board of Directors and Medical Staff through the Chief Nursing Officer. Written minutes of all committee meetings will be maintained and be made available upon request. Pertinent findings of the IPC shall be a part of the hospital's continuing education program, including the New Employee Orientation Program, which is reviewed/updated annually.

E. Dissemination of Infection Prevention information is crucial. Both surveillance data and policy decisions will be communicated throughout the organization. This is accomplished through routine QI reports to specific department directors for review. This information is then communicated to the appropriate staff members. Routine reports to specific departments will be presented to the department manager for their review and communicated as appropriate to staff members.

F. In the event that an issue should arise that requires decision and action between meetings, the IP RN will communicate with the Infection Prevention Physician. Any action required will be under the authority of the Infection Prevention Physician and implemented by the IP RN.

VII. Scope and Description of Services

A. The design and scope of the IPP will be based on the level of risk identified by the SPH Organization and are appropriate to the geographic location, the volume of patients encountered, the patients populations served, the clinical focus, and number of employees and residents.

B. SPH is a 22-bed Critical Access Hospital, and 28 bed Long Term Care Facility providing both inpatient and outpatient health services and Skilled Nursing services to the South Peninsula area. The hospital has an average daily census of 12 patients and is a full service hospital that services adult and pediatric patients. The

hospital offers many specialized services in addition to 24-hour emergency services, intensive care (ICU), medical & surgical services, maternal-child services, and rehabilitation and Skilled Nursing Facility services. Ambulatory clinics/services include:

- South Peninsula's Physical and Occupational Therapy Centers
- Emergency Services
- Home Health Program
- Laboratory
- Imaging
- Homer Medical Center
- Orthopedic/Surgical Clinic
- Specialty Clinic

C. The Infection Prevention Nurse (IP RN), Employee Health Nurse (EH RN), Chief Nursing Officer (CNO) have responsibility for the implementation of this Plan in all listed areas as deemed appropriate and epidemiologically significant.

1. Infectious Diseases that impact the Kenai Peninsula: Infectious disease are transmissible, through a variety of channels beyond person-to-person infection, including livestock, insects, and avian migration. Contact with sea faring vessels such as cruise ships with diverse populations and foreign visitors can move about freely along the Kenai Peninsula. The possibility of a Tsunami hitting the region is not unrealistic, therefore, the water borne illnesses associated with such an incident would be considered.
2. Bioterrorism Threat Risk: While Homer is located in the southern region of the state and 4 hours from the major city of Anchorage, the state of Alaska is at a heightened threat for bioterrorist activity for several reasons:
    - Due to proximity to foreign nations and access/exposure to international shipping
    - Presence of military installations

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

A. The Infection Prevention and Employee Health Departments are under the supervision of the Infection Prevention Committee, Chief Nursing Officer, and Infection Prevention Physician, respectively.

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

POSITION	HOURS	CODE
Infection Prevention RN	flexible	1.0 Full Time

C. The IP RN participates on the following committees and task forces:

i. SPH
    - Infection Prevention Committee
    - Sharps Safety Committee
    - Safety Committee
    - Patient Centered Care Quality Committee
    - Hospital Incident Management Team
    - LTC Quality Improvement Committee

ii. Community
    - Disaster Plan Committee
    - Pandemic Flu Committee
    - MAPP (Mobilizing for Action through Planning and Partnerships)

IX. Resources

A. Information Management Systems available include:

- Laboratory Data Bank
- Personal Computers with Internet Access
- List Servers from CDC, APIC (Association for Professionals in Infection Control and Epidemiology), Joint Commission, Alaska Department of Health and Social Services, AOHP (Association of Occupational Health Professionals in Healthcare)

B. Support Services include:
- Laboratory support to provide reports for surveillance and employee exposures
- Pharmacy support in review of data for trending, assessment, intervention, and evaluation of action plans.
- Data collection support from other department managers.
- Public Health Department and the Alaska Department of State Health Services provide consultative services
- Environmental Services will recommend the specific solutions for organization-wide cleaning and disinfection purposes. It will be supplied by the department with specific instructions for its use, as well as stated in the department policy.

X. Infection Prevention Surveillance Activities

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

XI. Recording and Reporting Infections

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

B. Sources of Data
   5. Daily census reports
   6. Emergency Department records
   7. Microbiological reports
   8. Serological reports
   9. Isolation Reports
   10. Occurrence reports
   11. Pharmacy reports
   12. Initial Tuberculosis (TB) assessment reports
   13. Multidrug resistant organism (MDRO) surveillance admission reports
   14. Mortality reviews
   15. Chart reviews
   16. Surveillance round reports on the patient care units to identify problems
   17. Employee Health alerts and reports related to increased call-ins for infectious conditions
   18. Reports from support departments regarding suspicious signs and symptoms of infection
   19. Nursing staff reports
   20. Physician consultations
   21. Physician/Surgeon feedback

XII. Evaluation of Data

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

XIII. Confidentiality

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

XIV. Infection Prevention Policies and Procedures

A. There are written policies and procedures for infection surveillance, prevention, and control for all patient care departments/services, which include but are not limited to the following:
   - Nursing units
   - Central Sterile Processing
   - Food Services

- Laundry
- Pharmacy
- Physical Therapy
- Imaging
- Surgical Services
- Environmental Services
- Long Term Care Facility

B. The written policies and procedures are made known to employees performing patient care procedures that are associated with the potential for infection. The Infection Prevention and/or Employee Health Nurse introduces general orientation to new employees at New Employee Orientation. Each Manager is responsible for department specific training of their staff to pertinent Infection Prevention Policies and Procedures in collaboration with the Infection Prevention Nurse. Infection Prevention Policies will be reviewed and/or revised and approved by the Infection Prevention Committee at least annually.

XV. Annual Reappraisal

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

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. South Peninsula Hospital Long Term Care Facility Infection Prevention Plan

CONTRIBUTOR(S):
Infection Prevention RN; Employee Health RN; Chief Nursing Officer; Infection Prevention Medical Director; Infection Prevention Committee

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MEMO

To: SPH Board of Directors

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

Date: May 18, 2022

Re: Quality Plan

The SPH and LTC Facility Quality Plan is the overarching plan for the organization, including LTC and has recently been updated to reflect changes that have occurred since May 2021. Many of the changes reflect formatting and streamlining some of the language although there are specific content changes to reflect progression of quality activities in the organization.

Some of the content changes to the Plan include the addition of Trauma Informed Care Committee engagement as a Risk Mitigation strategy and policy work under the Quality Management Roles and Responsibilities. The Decision Tree for Determining the Culpability Unsafe Acts and Just Culture principles have been added as tools for follow-up to concerns, errors and near misses under the Safety Statement for Fair, Equitable and Just Culture**.** The engagement from department Directors and Managers to provide quality accomplishments and establish quality goals for inclusion in the annual Critical Access Program Evaluation has also been added under the Goal Setting session.

The updated version of the SPH and LTC Facility Quality Plan has been shared with and approved by the Medical Executive Committee (MEC) and Patient Centered Care Quality Committee during their April committee meetings.

The LTC Quality Assurance Performance Improvement (QAPI) Plan is included as an attachment and outlines the specific quality activities for the LTC Facility for 2022-2023. The LTC QAPI Plan is included so both the SPH Quality Plan and the LTC QAPI Plan will be in alignment and presented to the Board of Directors at the same time each year.

Recommended Motion: Consideration to approve the revised South Peninsula Hospital and LTC Facility Quality Plan along with the LTC QAPI Plan for 2022-2023.

South Peninsula Hospital	**SUBJECT:** Quality Plan	**POLICY #** HW-267 **Page 1** of **14**
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/xx/2022
APPROVED BY: Quality Director, Chief Executive Officer, Medical Executive Committee, Board of Directors		**EFFECTIVE:** 5/~~26~~xx/202~~1~~2

Table of Contents

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

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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," (Institute of Medicine, 2015). Patient and resident centered care is supported 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.

~~1.~~2. *Hospital Board of Trustees Balanced Scorecard Report (BSC):* The SPH BSC provides an overview of specifically selected indicators to monitor the organizations quality and financial health. The BSC is updated ~~on a~~ quarterly ~~basis~~ and communicated monthly to the BOD and MEC, and quarterly to the Patient Centered Care Quality Committee (PCCQC). ~~Those indicators falling below the established target will have an associated improvement plan utilizing the "Plan-Do-Study-Act" Improvement Change Model.~~

~~2.~~3. *Quality Improvement Change Model:* ~~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 and is based upon the Quality Improvement change model "Plan-Do-Study-Act" (PDSA).~~ The Quality Improvement Change Model "Plan-Do-Study-Act" (PDSA) 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.

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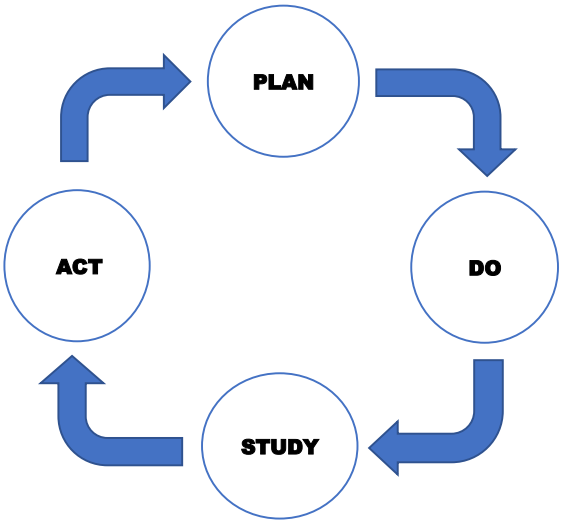
PDSA Cycle for Improvement



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

~~3.~~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 Hospital Compare and Nursing Home Compare
- Reported Patient/resident and/or staff concerns
- Patient Satisfaction survey data/responses
- ~~Staff concerns~~
- Failure Modes and Effects Analysis (FMEA), Root-Cause-Analysis and/or Sentinel Event Alerts
- Identified quality improvement opportunities
- CMS Core Measures or other nationally accepted measures
- Statewide quality improvement opportunities through the Hospital Engagement Network (HEN), Telligen Hospital Quality Improvement Contractor (HCIQ) or Medicare Beneficiary Quality Improvement Project (MBQIP)
- ~~Adverse Drug Events~~
- ~~Trends identified through occurrence reports, grievances, or complains received~~

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~~Infection Prevention surveillance~~

4.5. *Employee Engagement:* Employees on all levels of the organization are expected to contribute to quality improvement initiatives and risk identification to improve care provided to the customers 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, 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.

5.6. *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 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. Each patient's and resident's need for care, intervention, or treatment is assessed by qualified individuals (as defined by credentialing procedures, licensing, and hospital-approved job descriptions) and continues throughout the patient's or residents contact with SPH, LTC Facility, and/or Home-Based Health Services.

IV. Roles and Responsibilities:

Leadership of SPH and LTC Facility includes the Operating Board of Directors (BOD), Medical Executive Committee (MEC), Senior Leadership Team, Quality Management Department, Patient Centered Care Quality Committee, Safety/Hospital Incident Management Team (HIMT) Committees, and SPH staff.

Active leadership participation and contribution fosters~~assures~~ quality improvement and safety initiatives ~~are~~ 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 which improve patient and resident care and facilitate safety and satisfaction. ~~Additionally, the Board will ensure the Quality Plan is consistent with leading practices.~~ 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 and Medical Staff represented by the MEC. The Board will maintain responsibility for, review, evaluate, and approve the Quality Plan annually. The Board will:
   - Actively participate in and co-chair 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,

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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, residents, and customers. The Director of QM along with the QM team will:
   - 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 monthly
   - Be responsible for ensuring appropriate quality actions are implemented, and within established time frames, as directed by the PCCQC~~atient Centered Care Quality Committee~~, 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), Hospital Engagement Network (HEN), Medicare Beneficiary Quality Improvement Program (MBQIP), Telligen Hospital Quality Improvement Contractor (HQIC) and Core Measure CMS reporting

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- Aggregate quality data findings for presentation to the Board, Medical Staff, SPH & LTC staff, SLT, Departmental Managers/Directors and Patient Centered Care Quality Committee
- 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
- Engage with SPH Trauma Informed Care Committee as a Risk Mitigation strategy
- 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
- 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 two Board members, member(s) of SLT with the Director of QM 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 or Director of Quality Management, 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 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 customers 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, 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~~improvement aims of quality~~ proposed by the Agency for Healthcare Research and Quality (AHRQ)~~Institute of Medicine~~: 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

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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 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. ~~This is a safety-supportive system of shared accountability where health care organizations are accountable for the facility's values and system designs and for responding to the behaviors of our staff in a fair and just manner. Staff is accountable for the quality of their choices and behaviors and for reporting both their errors and system vulnerabilities.~~

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 ~~that~~ the patient or resident has the right to be involved in making decisions regarding their care. Patients and their families are afforded the right and opportunity 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. encouragement of collaboration among departments and disciplines to seek solutions to patient safety problems
iv. organizational commitment of resources to address quality and safety concerns
v. improving the culture of safety within our organization is an essential component of preventing or reducing errors and improving health care quality to our customers.

2. Identification of Risks, Hazards and Errors: Prospective, Concurrent and Retrospective review ~~before, during, and after~~ 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.

b. Concurrent Review: Concurrent Quality Improvement (QI) review begins when ~~facility leadership, Quality Management staff, medical director or others evaluate~~ 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

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Managers/Directors will document quality accomplishments and establish quality improvement goals in the annual Critical Access Program Evaluation with BOD review and approval. The PCCQC~~atient Centered Care Quality (PCCQ) Committee~~ will assist with providinge specifics on how to meet and achieve organizational quality and safety goals. ~~The committee will submit, through the Director of Quality Management, specifics of the Quality Plan to reach organizational goals to the Board yearly and as needed for approval. These priorities, goals and indicators will at a minimum, be in alignment with publicly reported data on the Care Compare website and feedback received from Patient Satisfaction surveys. Additional factors influencing quality and safety indicators and goals are access to care, appropriateness of care, safety of care and satisfaction with care.~~

~~3.~~ 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.

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~~a.~~ 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.

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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~~is to~~ 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:

PROBABILITY, LOW → HIGH	**South Peninsula Hospital Identified Risk Classification Grid**			
		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**	**1A**
	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
LEVEL OF HARM, LOW → HIGH				
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 (NFQ).
- 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. The Director of QM and QM team reviews all reports, evaluates them for possible risk prevention, reduction or resolution and forwards to the appropriate Director/Manager for follow-up, process improvement and/or risk reduction~~hospital committees. Upon identification of potential or actual risk, actions are taken to reduce the risk or hazard. Trends identified are assessed for process change/resolution of problem and reported to PCCQ Committee as appropriate.~~

~~-~~ d. Audits: Process review and improvement is conducted by various audits including random sampling, specific stratified sampling, department rounding, etc.

~~-~~ e. Feedback: ~~Occurrence reports and Patient Grievance Forms provide o~~Opportunity~~ies~~ for quality, safety and process improvement. Feedback and data~~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.

~~- Feedback is also received from staff, patients and families through leader and staff rounding, patient satisfaction surveys, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), meetings and forums (not all encomassing).~~

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. ~~based upon our commitment to place patient and resident needs first. The purpose of an initiative is to improve the performance of existing services or to design new ones.~~

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- Elevation of Sentinel, Never & Near Miss Events: Should a sentinel event occur, the Director of QM, with guidance from SLT as needed, will work with those involved to review the incident and conduct a root-cause analysis (RCA) 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 ~~and may reach out to~~ Quality Management Department.~~for assistance.~~ After investigation is completed, the occurrence report with all pertinent findings is sent back to the Director of QM for review of the findings, determination if additional steps are needed, and/or accepted as complete. 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. ~~Suggestions or requests for a PET is submitted in writing to the~~The QM Department is a resource and~~who~~ will~~may~~ 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 customer 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.
- Deployment of Lessons Learned: A "lesson learned" (in the context of evaluations) is defined as a generalization based on an experience (e.g., projects, policies, or programs) which was evaluated. ~~Lessons learned provide useful project management information gained through experience.~~ Our organization retains and applies this knowledge to future practice and clinical decision making to enhance overall quality and safety.

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 report information back to their departments
     - Newsletters and/or handouts
   - Education: M~~100% of all m~~anagers, 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 State Hospital and Nursing Home Association webinars, ~~and~~ 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.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. Attachment A – "Our Values In Action"
~~1.~~2. Attachment B - Performance Management Decision Guide
~~2.~~3. Duquette, CLeadership and management; Q solutions: Essential resources for the healthcare quality professional. *National Association for Healthcare quality. Third edition*. (2012)
4. National Coordinating Council for Medication Error Reporting and Prevention. *Index for Categorizing Medication Errors*. 2001
5. Six Domains of Health Case Quality. Retrieved from *https://www.ahrq.gov/talkingquality/measures/six-domains.html*
6. The Incident Decision Tree. Retrieved from https://www.ahrq.gov/downloads/pub/advances/vol4/meadows.pdf
~~3.~~
7. 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/
8. Key Ingredients for Successful Trauma-Informed Care Implementation. Menschner, C. and Maul, A.; Center for Health Care Strategies. (April, 2016).
~~4.~~

~~5.~~9. 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 142 LTC Quality Assurance Performance Improvement (QAPI) Plan and Policy~~
   ~~13.~~14. LTC Facility Assessment 2021-2022
   ~~14.~~15. PCS-143 Provision of Care

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~~15.~~16. Q-01 Medical Staff Credentialing Privileges

B. The following plans are incorporated by reference in this plan:
   1. Infection Prevention Plan
   2. SPH and LTC Facility Medical Staff Bylaws, Rules and Regulations
   3. ~~Enterprise Risk Management Plan~~
   4. ~~SPH Rules and Regulations~~
   5. Safety Plan
   ~~5.~~6. LTC QAPI Plan 2022-2023; Attachment xx

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

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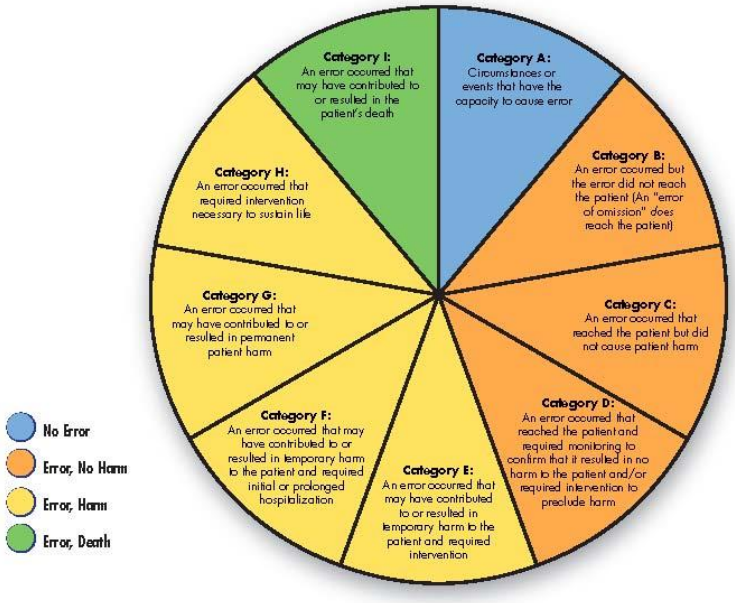
NCC MERP Index for Categorizing Medication Errors

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.)

PSR0306

QAPI Plan

SPH LTC 2022-2023

Effective Date: April 13, 2022

025031: South Peninsula Hospital Long Term Care, Homer, AK

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Design and Scope

Statements and Guiding Principles:

Vision
We will be the premier providers in Long-Term Care.

Mission
Our organization's mission is 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.

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 to place blame.

LTC makes QAPI decisions based on data gathered from the input and experience of caregivers, residents, providers, families, and other stakeholders.

LTC sets goals for performance and measures progress toward those goals.

LTC supports performance improvement by encouraging our employees to support each other as well as to 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.

Types of Care and Services:

Skilled Nursing

Long-Term Care

Hospice/Palliative Care

Pharmacy

Radiology Services

Laboratory Services

Dietary

Dining

Dietician

Nutritionist

Health Information Services

EHR/EMR

MDS

Therapy

Outpatient

Physical

Occupational

SLP

Housekeeping

Laundry

Janitorial

Social Services

Activities

Care Coordination

Behavioral/Mental Health

Transportation

Maintenance

Building

Landscaping/Groundskeeping

Equipment

Staff Education

On-boarding and Orientation

Business Office

Staffing

Billing

Human Resources

Other Services Provided:

N/A

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.

Defining and Measuring Goals:

LTC will use internal and national benchmarks provided by national associations, clinical organizations, and federal and 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 toward 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.

Governance and Leadership

Administrative Leaders:

Name	Title/Role
Rachael Kincaid, DNP	Director of Nursing and Licensed Nursing Home Administrator
South Peninsula Hospital Board of Directors	
Dr. William Bell	Medical Director
Susan Shover, RN	Director of Quality Management

Direction of QAPI Activities:

The Governing Body and Quality Care Committee of LTC develop a culture that involves leadership-seeking input from nursing center staff, residents, their families, and other stakeholders.

The Governing Body is responsible for the development and implementation of the QAPI program. The Governing Body is responsible for:
1) Identifying and prioritizing problems based on performance indicator data
2) Incorporating resident and staff input that reflects organizational processes, functions, and services provided to residents
3) Ensuring that corrective actions address gaps in the system and are evaluated for effectiveness
4) Setting clear expectations for safety, quality, rights, choice, and respect
5) Ensuring adequate resources exist to conduct QAPI efforts

The Quality Care Committee reports to the executive leadership and Governing Body and is responsible for:
1) Meeting, at 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

Staff QAPI Adoption:

The QAPI program will be structured to incorporate input, participation, and responsibility at all levels. The Governing Body and Quality Care Committee of LTC 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.

QA&A Committee

Medical Director/Designee

Dr. William Bell

Director of Nursing Services

Rachael Kincaid, DNP

Administrator/Owner/Board Member/Other Leader

Katie Martin, RN, ADON

Infection Prevention & Control Officer

Anna Lewald, RN

Additional Members:

Name	Title/Role
Kappa Kuzmin	CNA
Bonnie Betley	RN
Mike Tupper	Quality Support Specialist
Tabibeth Cosper	CNA
Amy Christiansen	RN
Trena Dagenhart	Care Coordinator

Feedback, Data Systems and Monitoring

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.

Monitored Data Sources:

abaqis Assessments

QAPI Assessments

Resident-Level Investigations

Facility-Level Investigations

Resident Satisfaction

Family Satisfaction

PAC Assessments

CMS

Survey Data

Five Star Quality Rating System

CMS Quality Measures

State Survey Reports

Industry Associations

None

Internal Systems

Resident/Family Complaints

Resident/Family Suggestions

Staff Complaints

Staff Suggestions

MDS

EMR/EHR

Corporate Balanced Score Card

Additional Systems:

Occurrence reports, daily huddles, fall/safety huddles, QAPI audits

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 (NFQ). These events are tracked, investigated, and monitored through the occurrence reporting system.

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 systematized 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.

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.

Performance Improvement Projects

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.

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.

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 Quality Care Committee or Quality Coordinator, and with relationship to their skills, service provision, job function, and/or area of expertise to address the performance improvement topic.

Managing PIP Teams:

The Quality Coordinator will manage the day-to-day operations of the PIP and will report directly to the Quality Care Committee.

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.

Systematic Analysis and Systemic Action

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.

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.

Supporting Documents

Document Name	Date Uploaded
PDSA TEMPLATE.docx	Apr 14, 2022

Communications, Evaluation, Review Date

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.

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 Quality Care Committee. 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.

Revising your QAPI Plan:

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

Record of Plan Review:

Name	Date Reviewed

Katie Martin (kmartin@sphosp.org)	2022-04-14

Printed Apr 14, 2022

Introduced by: Administration
Date: ~~April 27~~May 25, 2022
Action: Approved
Vote: Yes - XX, No - X, Exc.- X

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2022-08

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS APPROVING THE REQUEST OF UNOBLIGATED SERVICE AREA FUNDS TO SUPPORT REPLACEMENT OF DOMESTIC WATER TANK

WHEREAS, South Peninsula Hospital Administration has identified a legacy need to replace our 350-gallon Domestic Water Tank in order to support long-term hot water generation, and

WHEREAS, the Hospital has two independent tank-type hot water heaters and one of those tanks is failing, and

WHEREAS, there is currently no redundancy or back up for these two water heaters and it is a strategic priority of Hospital management to provide the safest possible healing environment for our patients and staff, and

WHEREAS, RESPEC an independent design and engineering consultant was engaged to evaluate our hot water needs and develop a plan to address failure, redundancy, backup, efficiency, risks, and costs, and

WHEREAS, the cost replace and improve the hot water system is estimated at $~~368,750~~389,491; and

WHEREAS, SPH Management would like to request that unobligated monies from the Service Area Board Fund be appropriated to complete the replacement and upgrade of the SPH Hot Water System; and

WHEREAS, the Hot Water Upgrade Project was discussed at Finance Committee on ~~March~~ April 21, 2022 and May 19, 2022.

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 Hot Water System Replacement and Upgrade Project in the amount of $~~368,750~~389,491.
2. That the South Kenai Peninsula Service Area Board make a recommendation to approve the use of unobligated Service Area Funds in the amount of $~~368,750~~389,491 for the SPH Hot Water System Replacement and Upgrade Project.
3. That the South Peninsula Hospital Board of Directors requests that the Kenai Peninsula Borough appropriate $~~368,750~~389,491 in unobligated Service Area Funds for the SPH Hot Water System Replacement and Upgrade Project.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA AT ITS MEETING HELD ON THIS ~~27rd~~ 25th DAY OF ~~APRIL~~ May~~27~~, 2022.

ATTEST:

Kelly Cooper, Board President

Julie Woodworth, Board Secretary

STATEMENT OF PROBABLE COST
KENAI PENINSULA BOROUGH CAPITAL PROJECTS DEPARTMENT

Project Name: SPH DHW System replacement **Date:** 4/25/2022

Description: Demo and 2 existing DHW systems with a Tankless Gas fired Heat Pump, Heat Exchanger Rejection piping for future use and a Heat Recovery Pump to reduce Heat in Boiler Room.

A/E Firm: RESPEC **Project Manager: Carmen Vick**

Funding: TBD

Account Number: N/A

PROJECT COST ESTIMATE

1. Construction Costs		
A. Heat Rejection HX& Piping	$25,000.00	
B. Heat Recover Heat Pump	$42,800.00	
C. Tankless Gas Fired Heat Generator	$235,874.00	
D. Mob/Demob	$15,183.70	
Subtotal	$318,857.70	
Construction contingency 15%	$47,828.66	
Total Construction Cost:		**$366,686.36**
2. Design & CA Services		
A. Construction Documents Revised		
B. Advertisment	$500.00	
C. CA Services	$0.00	
3. Other Project Costs		
A. Reproduction and Advertising		
B. Project Management (4%)	$14,667.45	
C. Permits		
D. Testing & Inspections		
E. FF&E	$0.00	
Total Other Costs:	**$15,167.45**	
3. Subtotal Project Cost:	$381,853.81	
A. Annual Inflation Rate 5% over 16 months =6.7%		
B. Legal & Admin. Costs: 2% up to 1M, 2% >1M	$7,637.08	
Total Inflation and Administrative Costs	**$389,490.89**	
Project Contingency 4%		
Total Project Cost:	$389,490.89	

Introduced by:	Administration
Date:	05/25/2022
Action:	
Vote:	Yes – X , No – X, Excused - X

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2022-09

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS APPROVING THE FISCAL YEAR 2023 OPERATING BUDGET

WHEREAS, Administration uses a systematic, fiscally responsible process for developing the South Peninsula Hospital, Inc., FY 2023 Operating Budget, which includes participation of department directors, managers and administration; and identification of strategic growth need; and

WHEREAS, the FY 2023 Operating Budget is critical to the mission and vision of South Peninsula Hospital, Inc; and

WHEREAS, the FY 2023 Operating Budget was approved by the Finance Committee on May 19, 2022.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL, INC., TO APPROVE THE FISCAL YEAR 2023 OPERATING BUDGET.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA HOSPITAL, INC. THIS WEDNESDAY, MAY 25th, 2022.

Kelly Cooper, Board President

ATTEST:

Julie Woodworth, Secretary

SOUTH PENINSULA HOSPITAL OPERATING BUDGET FISCAL YEAR 2023

In Review

Abstract

$200.5m gross revenue, $109.5m net patient revenue, $739k other revenue, $109.8m operating expense, $484k operating margin (0.44%)

Accounting & Finance Team

South Peninsula Hospital

Contents

Summary of Proposal

Budget Proposal

The FY 2023 South Peninsula Hospital budget proposed is the following:

A	Gross Revenue	$200,562,126
B	Deductions	$ 91,022,393
A-B=C	Net Patient Revenue	$109,539,733
+	Other Operating Revenue	$ 739,978
C+	Total Operating Revenue	$110,279,712
D	Total Operating Expenses	$109,795,368
(C+)-D=E	Operating Margin	$ 484,344 (0.44%)
F	Total Margin	$ 4,862,350 (4.41%)

Monthly Service Statistics

Service Production Proposed

The FY 2023 South Peninsula Hospital budget uses monthly averages shown below:

Service	FY 2021	FY 2022	FY 2023	# Variance	% Variance
IP Surgery	16.8	15.4	18.3	3.3	19%
ADC (Acute & Swing)	9.2	10.6	10.6	0	0%
Swing Bed	79	85.2	85.2	0	0%
OP Visits	7,814	9,220	10,052	832	9%
Clinic Visits	2,402	2,687	3,296	609	23%
OP Surgeries	110	110	126	16	15%
LTC Patients	17.5	19.0	23.0	4	21%

Discussion of Statistics

The service production statistics in the preceding table are monthly averages for FY22 through the month of April. FY23 projected numbers are assumed to see increases in surgeries with the recent addition of an Orthopedic Surgeon and General Surgeon, an increase in clinic visits with the recent addition of providers in Mental Health and Family Practice, and an increase in ancillary outpatient services including imaging and rehab. Patient days are assumed to remain flat from FY22 volumes.

Revenue

	FY2020 Actual	FY2021 Actual	FY2022 Annualized	FY2023 Budget	% Diff from Projected
Inpatient	28,295,059	28,328,773	35,289,379	39,697,046	12.49%
Outpatient	93,824,395	117,018,357	131,239,824	147,691,516	12.54%
LTC	8,466,702	7,614,567	10,301,696	13,173,564	27.88%
Total Revenue	**13,586,156**	**152,961,698**	**176,830,900**	**200,562,126**	**13.42%**

Revenue growth is expected to increase with the following assumptions: implementation of a 6% Chargemaster increase for Hospital inpatient and outpatient charges and increase in volumes for specified service lines (see Monthly Service Statistics above).

Deductions

The FY23 budget assumes no change in current payer mix, nor any changes from current deduction allowance estimates.

	FY22 Payer Mix	FY23 Payer Mix	FY23 Inpatient Allowance	FY23 Outpatient Allowance
Medicare	40%	40%	39.2%	56.6%
Medicaid	24%	24%	49.4%	59.4%
Commercial	17%	17%	25.9%	26.7%
Blue Cross	15%	15%	12.3%	12.9%
Self-pay Bad Debt	2.7%	2.7%	50.5%	50.5%
Self-pay Charity	1.3%	1.3%	23.0%	23.0%

Deductions	FY2020 Actual	FY2021 Actual	FY2022 Projected	FY2023 Budget
Medicare	23,326,585	31,768,778	35,983,094	40,567,617
Medicaid	17,406,965	19,054,608	24,218,846	28,793,289
Charity Care	2,323,402	1,266,505	462,252	1,722,068
Other Adjustments	9,817,570	11,943,302	15,533,725	16,152,253
Bad Debt	1,632,346	3,332,151	3,042,511	3,787,166
Total Deductions	**54,506,869**	**67,365,344**	**79,240,429**	**91,022,393**

Expenses

Overall operating expenses are expected to increase 6% over annualized FY2022 projections. Annualized projected expenses are based upon operations for the period July 2021 through April 2022. FY2023 budget increases/decreases from FY2022 projections are shown below:

Expense Highlights

- *FTE Increase* *7.8% Increase*
- *Regular Wages* *7.7% increase*
- *Employee Benefits* *19.97% Increase*
- *Supplies Drugs & Food* *7.3% Increase*

	FY2020 Actual	FY2021 Actual	FY 22 Projected	FY2023 Budget	% Change
Salary & Wages	36,586,330	43,867,200	46,964,249	50,557,659	7.65%
Employee Benefits	14,116,266	14,611,588	20,927,392	25,106,495	19.97%
Other Operating Expenses	1,427,475	894,307	1,148,020	996,774	-13.17%
Supplies Drugs & Food	7,966,362	9,732,515	12,723,527	13,657,917	7.34%
Contract Staffing	2,408,830	3,362,632	4,635,037	2,053,314	-55.70%
Professional Fees	4,877,491	4,989,523	5,690,575	5,282,985	-7.16%
Utilities & Telephone	1,531,994	1,618,910	1,699,158	1,719,717	1.21%
Insurance	656,656	632,594	701,471	737,010	5.07%
Dues Books & Subscriptions	206,694	243,641	233,140	253,034	8.53%
Software Maint/Support	1,436,636	1,484,150	1,866,984	2,110,797	13.06%
Travel Meetings & Education	309,322	365,068	537,364	749,793	39.53%
Repairs & Maintenance	1,235,753	1,658,843	1,567,570	1,608,826	2.63%
Leases & Rentals	751,861	892,139	886,621	810,377	-8.60%
Depreciation & Amortization	3,288,093	3,555,630	3,940,792	4,150,670	5.33%
Total Operating Expenses	76,799,763	87,908,740	103,521,898	109,795,368	6.06%

Full Time Equivalent (FTE)

Total FY2023 budgeted FTEs is 464.34 across all departments, is a 7.8% increase in staffing from FY2022 (430.84 FTE). The majority of this staffing increase is based upon the assumption that key clinical and nursing positions will be filled, adds additional leadership, and factors in that contract labor will be significantly reduced (-56%).

Non-Operating Revenue/Expense

	FY2020 Actual	FY2021 Actual	FY22 Projected	FY2023 Budget
Non-Operating Revenue	10,060,253	13,953,628	9,507,916	4,830,386
Service Area Board Exp.	55,027	113,593	82,000	118,000

Our Non-Operating Revenues and Expenses include the assumption that no further COVID related funding will occur. While we are still working on FEMA funding, the receipt of such funding is uncertain and hence it has not been budgeted. Service Area Board expenditures have been approved and forward to the Kenai Peninsula Borough Assembly for discussion and approval in May 2022.

FY2023 Budget Summary

A	Gross Revenue	$200,562,126
B	Deductions	$ 91,022,393
A-B=C	Net Patient Revenue	$109,539,733
+	Other Operating Revenue	$ 739,978
C+	Total Operating Revenue	$110,279,712
D	Total Operating Expenses	$109,795,368
(C+)-D=E	Operating Margin	$ 484,344 (0.44%)
F	Total Margin	$ 4,862,350 (4.41%)

The Budget Summary is representative of a significant push in patient volumes both for inpatient and outpatient care, fully maximizing our capacity in surgery, ancillaries, and outpatient clinics. We have estimated an overall 6% price increase to our charge master in order to stay ahead of the increasing cost of operations. Among some of our largest operating costs are employee benefits with a 14% increase in health insurance expenses projected for FY2023. We will continue to seek creative solutions to promote employee health and wellness in order to contain costs, while actively engaging with an interest-based problem solving group.

Conclusion

While there is some uncertainty around expected volume increases as healthcare rebounds from impacts of the COVID 19 pandemic, the FY2023 budget is based on the best information we have. We will continue to apply sound business judgment to staffing and to variable operating expenses in an effort to maintain financial viability.

We expect to see modest volume increases in many areas, and modest price increases are planned to cover increasing costs. SPH has also successfully recruited several contract laborers this year and expects that trend to continue resulting in lower contract staffing expenses and lower recruiting costs.

Operating margin is expected to be nearly break even, at 0.44%.