AGENDA
Board of Directors Meeting
6:30 PM - Wednesday, October 28, 2026
Click link to join Zoom meeting
SPH Conference Rooms 1&2
Meeting ID: 878 0782 1015 Pwd: 931197
Phone Line: 669-900-9128 or 301-715-8592

Aaron Weisser, President		Jim Anderson		Matthew Bullard	
Preston Simmons Vice President		Ken Ciccoli		Kim Frost	
Mary E. "Beth" Wythe, Secretary		Edson Knapp, MD		Christopher Landess, MD	
Michael Dye, Treasurer		Bernadette Wilson			

Board Master Reports List

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

Page

1. CALL TO ORDER

2. ROLL CALL

3. REFLECT ON LIVING OUR VALUES

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

5 4.1. Rules for Participating in a Public Meeting
Rules for Participating in a Public Meeting 2025

5. COMMENTS FROM THE AUDIENCE ON ITEMS APPEARING ON THE AGENDA - 3 MINUTES PER PERSON; 20 MINUTES TOTAL

6. APPROVAL OF THE AGENDA

7. APPROVAL OF THE CONSENT CALENDAR

6 - 12 7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for September 30, 2026
Board of Directors - Sep 30 2026 - Minutes - DRAFT

13 - 15 7.2. Consideration to Approve September FY2027 Financials
September FY2027 Balance Sheet
September FY2027 Income Statement
September FY2027Capital Report

16 - 41 7.3. Consideration to Approve the revised South Peninsula Hospital Bloodborne Pathogen Exposure Control Plan, as recommended by the Quality Committee
Bloodborne Pathogen Plan

42 - 58 7.4. Consideration to Approve the revised South Peninsula Hospital Respiratory Protection Plan as recommended by the Quality Committee
Respiratory Protection Plan

59 - 66 7.5. Consideration to Approve the revised South Peninsula Hospital Utilization Management Plan as recommended by the Quality Committee
Utilization Management Plan, revised

67 - 68 7.6. Consideration to Approve Revised Policy F-09 Capital Purchases, as recommended by the Finance & Pension Committee
F-09 Policy Update

8. PRESENTATIONS

8.1. BDO Budget Presentation - POSTPONED TO DECEMBER

Presenter: Joy Merriner

9. UNFINISHED BUSINESS

10. NEW BUSINESS

69 - 71 10.1. Consideration to Approve SPH Resolution 2026-21, A Resolution of the South Peninsula Hospital Board of Directors Requesting that the Kenai Peninsula Borough Move Forward Funding for the Pharmacy Expansion and Infusion Relocation Certificate of Need Project
SPH Resolution 2026-21

72 10.2. Consideration to Approve the Appointment of Bryan Harter, OT and Tallee Boyd, RN to the Professional Advisory Committee for South Peninsula Hospital Home Health, effective immediately upon approval
Memo - PAC Appointments

73 10.3. Consideration to Approve the Addition of Timely Submission of Outcome and Assessment Information Set (OASIS) Assessments as a Quality Measure in the South Peninsula Hospital Home Health 2026 Quality Assurance & Performance Improvement (QAPI) Plan, effective immediately upon approval
Memo - Home Health QAPI

11. REPORTS

74 - 78 11.1. Balanced Scorecard
Balanced Scorecard Q1 FY27

11.2. Chief Executive Officer

11.3. BOD Committee: Finance & Pension

11.4. BOD Committee: Strategic Planning & Community Relations

79 - 81 11.5. BOD Committee: Governance
F-12 Approval and Adoption of Operating Budget, revised
SM-02 Responsibilities of Board Members, revised

11.6. BOD Committee: Quality

82 - 85 11.7. Chief of Staff
Medical Staff Letter
Med Staff Letter - updated 10.28.2026

11.8. Board President Report

11.9. Service Area Board Representative: Erin Workman

12. DISCUSSION

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER - 3 MINUTES PER PERSON; 20 MINUTES TOTAL

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

14.2. Board Members

15. INFORMATIONAL ITEMS

15.1. 2027 Conferences

- AHA Rural Healthcare Leadership Conference, January 31-February 3, 2027
- AHHA Physician Leadership Conference February 18-19, 2027 (Credentialing, Peer Review, etc.)

86 - 87 15.2. 2027 Calendars

Board Calendar of Meetings - Proposed
Service Area Board Meetings 2027

16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

17.1. Consideration to Approve Resolution 2026-22, Approving the Medical Staff Credentialing for October 2026

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

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

- *Comments are restricted to policies or proposed actions of the SPH Operating Board of Directors.*
- *Those who wish to speak will need to sign in on the sign in sheet being circulated. When the chair recognizes you to speak, you need to clearly give your name and the policy or proposed action you wish to address.*
- *Please be concise and courteous. There is a limit of 3 minutes per speaker; total time allotted for public comment is at the discretion of the chair.*
- *Please observe normal rules of decorum and avoid disparaging by name the reputation or character of any member of the Operating Board of directors, the administration or personnel of SPHI, or the public. You cannot mention or use names of individuals.*
- *The Operating Board Directors may ask you to respond to their questions following your comments. You could be asked to give further testimony in "Executive Session" if your comments are directly related to a member of personnel, or management of SPHI, or dealing with specific financial matters, either of which could be damaging to the character of an individual or the financial health of SPHI, however, you are under no obligation to answer any question put to you by the Operating Board Directors.*
- *If you have questions, you may direct them to the chair. Questions will not be addressed by the board during the public comment period, but may be addressed at a later time.*

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

MINUTES
Board of Directors Meeting
6:30 PM - Wednesday, September 30, 2026
Conference Rooms 1&2 and Zoom

The meeting of the Board of Directors of South Peninsula Hospital was called to order on Wednesday, September 30, 2026, at 6:30 PM, in the Conference Rooms 1 and 2 and on Zoom.

1. CALL TO ORDER

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

2. ROLL CALL

BOARD PRESENT: **Mary E. "Beth" Wythe, Edson Knapp, Michael Dye, Bernadette Wilson, Preston Simmons, Christopher Landess, Kim Frost, Jim Anderson, and Ken Ciccoli**

BOARD EXCUSED: **Aaron Weisser and Matthew Bullard**

ALSO PRESENT: **Rachael Kincaid, COO; Amber Gall, CNO;**
Only meeting participants who comment, report or give presentations are noted in the minutes. Others may be present on the room or on the virtual meeting.

2.1. A quorum was present.

3. REFLECT ON LIVING OUR VALUES

Dr. Edson Knapp shared a personal story about the compassionate long-term care his father received. He highlighted specific staff members, including Katie, Christy, Allicia, Bonnie, Dr. Llenos, and Teresa, for their exceptional care. The reflection emphasized how the facility provided dignity and comfort during his father's final days.

4. WELCOME GUESTS & PUBLIC / INTRODUCTIONS / ANNOUNCEMENTS

4.1. Rules for Participating in a Public Meeting

5. COMMENTS FROM THE AUDIENCE ON ITEMS APPEARING ON THE AGENDA - 3 MINUTES PER PERSON; 20 MINUTES TOTAL

6. APPROVAL OF THE AGENDA

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

DRAFT

7. APPROVAL OF THE CONSENT CALENDAR

Beth Wythe read the consent calendar into the record.

7.1. Consideration to Approve the South Peninsula Hospital (SPH) Board of Directors meeting minutes for August 26, 2026

7.2. Consideration to Approve August FY2027 Financials

7.3. Consideration to Approve EMP-01 Board-Administrator Communication with Minor Revisions

7.4. Consideration to Approve Q-01 Consent for Treatment and Q-02 Quality Monitoring with minor revisions as recommended by the Quality Committee

7.5. Consideration to Approve a Proclamation for Christine Anderson on her Retirement after 30 Years of Service to South Peninsula Hospital

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

8. PRESENTATIONS

8.1. Proclamation for Christine Anderson on her Retirement after 30 Years of Service to South Peninsula Hospital

The presentation for Christine Anderson was done at the top of the meeting. Ryan Smith read her proclamation, which highlighted her career from obstetrics night-shift nurse to Chief Nursing Officer to Clinical Informatics Director. It credited her with advancing patient care, helping implement electronic medical records and other technology, leading major projects, and contributing to hospital expansion and community service.

Ms. Anderson thanked the hospital, the board, her colleagues, and her family, reflecting on the support and opportunities she had throughout her career. Ms. Wilson also praised her leadership and recalled her advocacy for more efficient hospital layouts

9. UNFINISHED BUSINESS

There was no unfinished business.

10. NEW BUSINESS

There was no new business.

11. REPORTS

11.1. Balanced Scorecard

The balanced scorecard was provided in the packet; the data was unchanged from the previous month. Mr. Smith will provide a detailed presentation of the new quarter's data next month.

11.2. Chief Executive Officer

Ryan Smith, CEO, gave a verbal report on several items. The hospital received approval for two projects through the Rural Health Transformation Project: upgrading medication-dispensing units to OmniCell, at an estimated cost of $220,000, and expanding rehabilitation services, including renovations to support cardiopulmonary rehab. Mr. Smith said he would meet with the borough mayor the next day to discuss the rehab project and other initiatives.

The “Rooted in Community” event raised about $256,000 toward purchasing a new mammography unit, including a matching $100,000 contribution. The Seaside Women’s Center team received an award for integrating behavioral health into women’s services at the Alaska Hospital and Healthcare Association (AHHA) meeting. Mr. Smith said the next meeting would include a detailed review of the first-quarter scorecard and its indicators, as requested by the Board.

11.3. BOD Committee: Finance & Pension

Mike Dye said the committee reviewed the August financials. Net revenues and net income were substantially below budget in both July and August. Management is working to improve results by reducing claim denials, increasing charge capture, lowering contract staffing expenses, and growing service volumes, including orthopedic procedures. Mr. Dye said the committee remained concerned about the approaching winter months, when the hospital typically experiences significant seasonal losses, and would continue to monitor the financial picture.

11.4. BOD Committee: Strategic Planning & Community Relations

The committee did not meet this month. Its planned presentation from Stroudwater, a firm that assists hospitals and boards with strategic planning, was postponed until next month. The firm is expected to review information gathered from stakeholders and help guide the hospital’s three-year strategic planning process.

11.5. BOD Committee: Governance

Beth Wythe said staff feedback prompted revisions to the board-governance policy so it focuses more clearly on the Board’s role. The committee discussed upcoming board peer assessments and a board self-assessment, expected next month.

Other work includes reviewing appointments and reappointments for the next election cycle, conducting background checks on active Board members, and reviewing the Board’s public comment procedures. The committee also plans to develop a governance Q&A that explains the responsibilities of the Board, the Service Area Board, and the Borough. Its routine review of the strategic planning policy is planned for the next meeting.

11.6. BOD Committee: Quality

Preston Simmons reported on the September Quality Committee. heard about improvements in colonoscopy outcomes led by general surgeon Dr. Kincaid. The hospital's adenoma detection rate (ADR) increased from 16% in early 2022 to 51%, above the 90th percentile nationally. The committee heard that the improvements involved changes in technique, new equipment, and other operational changes; if sustained, they are projected to prevent 28 cases of colorectal cancer over the next decade. The hospital is also meeting its aspirational target for detecting sessile serrated lesions.

The committee reviewed and forwarded several plans to the full Board, including the bloodborne pathogen exposure control, respiratory protection, and utilization management plans. It also requested a future presentation explaining how the hospital's Press Ganey patient-satisfaction scores compare with percentile rankings and what those measures indicate about performance

11.7. Chief of Staff

Dr. Tuomi shared on behalf of Dr. Roberts, Chief of Staff. Nominations were underway for Medical Executive Committee membership ahead of the November election, which begins a two-year term. Dr. Roberts does not plan to run for Chief of Staff again, so nominations for that role will also be open. No other major updates were reported.

11.8. Board President Report

There was no official board president's report. Aaron was excused from the meeting for preparations for his daughter's wedding.

11.9. Service Area Board Representative

Brandy Zollars reported a strong public turnout at the September 10 meeting. She noted that the Board's minutes are moving to concise summary-action minutes, but meeting audio is available online. Candidates for the three open elected seats are expected to appear on the ballot, with information available on the Borough website. A separate vacancy created by former president Helen Armstrong's departure will be filled by appointment of the Borough mayor.

The Board approved Resolution 2026-04, authorizing an obligation of roughly $230,000 from preferred funds for generator replacement. Ms. Zollars also described a discussion of a resolution submitted by a community member, proposing an elected hospital Board and Open Meetings Act compliance. Though the proposal did not move forward as presented, members unanimously supported drafting a new resolution for the Borough Assembly, which has final authority over the Board's governance.

12. DISCUSSION

There were no additional discussion items.

13. COMMENTS FROM THE AUDIENCE ON ITEMS OF ANY MATTER - 3 MINUTES PER PERSON; 20 MINUTES TOTAL

DRAFT

Dr. Nathan Kincaid addressed the board regarding his positive experience working at South Peninsula Hospital.

Kim Dickinson addressed the board regarding objective data, action plans, communication and transparency.

Chris Story addressed the board regarding his mother's end-of-life care and his desire to join the hospital board.

Guy Rosi addressed the board regarding the founding members of the hospital and his belief that they would not appreciate the hospital's current trajectory.

Laura Brandt addressed the board regarding a wedding that staff held for an Acute Care patient, and the magic of working in a hospital like SPH.

Dr. Lucy Fisher addressed the board about the hospital's commitment to growing mental health services in the community and her positive experience of working at SPH.

Dr. Katie Ostrom addressed the board about her negative experience as a former member of the medical staff and her perception that the board doesn't have full transparency into hospital affairs.

Marilyn Shroyer addressed the board regarding the great care provided by the hospital and the appropriate channels for raising concerns.

Ashley Story addressed the CEO with questions about what he would have done if she had contacted him about her grandmother's care.

14. COMMENTS FROM THE BOARD

(Announcements/Congratulations)

14.1. Chief Executive Officer

Mr. Smith described the hospital’s accountability structure and said he welcomed community feedback. Addressing a concern raised during public comment, he said he is willing to intervene and help a family navigate a difficult situation if he knows about it at the time.

14.2. Board Members

Preston Simmons had no additional comments.

Ken Ciccoli expressed support for the hospital's current structure and for the CEO.

Jim Anderson called for better communication and transparency, including clearer explanations of property purchases, construction, and staffing. He

encouraged the Board and community to stay engaged and address difficult issues constructively.

Mike Dye supported healthy hospital growth, saying expanded services can help people receive more care locally and may reduce the need for medevacs.

Kim Frost said quality was a key reason she joined the Board and emphasized that members care about it. She noted that understanding hospital operations and quality-improvement practices takes time.

Edson Knapp recalled the hospital's precarious finances when he joined and credited Ryan Smith's leadership, particularly during COVID, with helping stabilize the organization. He also congratulated Christine Anderson on her retirement and thanked Dr. Kincaid for improving colonoscopy quality.

Bernadette Wilson congratulated the Seaside Women's Center team on its award and noted that the hospital has received several Alaska Hospital and Healthcare Association awards in recent years.

Beth Wythe thanked community members for speaking, said the Board values public input, and noted that Board members can be contacted via the Board email address on the hospital website.

15. INFORMATIONAL ITEMS

There were no additional information items.

16. ADJOURN TO EXECUTIVE SESSION (IF NEEDED)

The meeting adjourned to Executive Session at 7:48pm.

17. ANNOUNCEMENTS AS A RESULT OF EXECUTIVE SESSION

The board returned to open session at 8:30pm for announcements.

17.1. Consideration to Approve Resolution 2026-20, Approving the Medical Staff Credentialing for September, 2026

Bernadette Wilson made a motion to approve Resolution 2026-20, Approving the Medical Staff Credentialing for September, 2026 to include the reappointment of the following providers with an effective date September 30, 2026:

Babak Akbarian, MD	*Psychiatry*	*TelePsych-Providence*
Ross Dodge, MD	*Internal Medicine*	*Part-Time Active*
Catalina Draghici, MD	*Psychiatry*	*TelePsych-Providence*
Adam Karz, MD	*Psychiatry*	*TeleStroke-Providence*
William Lou, MD	*Neurology*	*Telestroke-Providence*
Cherie' Inglis, MD	*Family Medicine*	*Active*
Emma Mayfield, DO	*Family Medicine*	*Active*
Erin Murphy, MD	*Emergency Medicine*	*Active*

Kyle Ogami, MD	*Neurology*	*TeleStroke-Providence*
Margarita Oveian, MD	*Neurology*	*TeleStroke-Providence*
Joseph Perry, MD	*Psychiatry*	*TelePsych-Providence*
Sarah Roberts, MD	*Family Medicine*	*Active*
Christy Tuomi, DO	*Family Medicine*	*Active*
Amy Velsko, FNP	*Family Medicine*	*Community*

And the initial appointment of the following providers with an effective date of September 30, 2026:

Scott Caganap, MD	*Neurology*	*TeleStroke-Providence*
Syed Jafri, DO	*Neurology*	*TeleStroke-Providence*
Briana Poynor, MD	*Neurology*	*TeleStroke-Providence*

And the status change request for Dr. Ahmed Abuzaid, Cardiologist, requesting Cardiology Core Privileges and moving from Telemedicine to a Part-Time Active membership.

Edson Knapp seconded the motion. Motion Carried.

18. ADJOURNMENT

The meeting adjourned at 8:32pm.

Respectfully Submitted,

Maura Jones, Executive Assistant

Accepted:

Aaron Weisser, President

Minutes Approved:

Mary E. Wythe, Secretary

DRAFT

South Peninsula Hospital

DRAFT-UNAUDITED

BALANCE SHEET
As of September 30, 2026

	Month Ending 09/30/2026	Month Ending 09/30/2025	Month Ending 08/31/2026	Change From Prior Year
CURRENT ASSETS				
CASH				
CASH AND CASH EQUIVALENTS	35,569,519	27,941,144	35,486,924	7,628,375
EQUITY IN CENTRAL TREASURY	10,148,365	10,478,951	9,038,620	(330,586)
TOTAL CASH	45,717,884	38,420,095	44,525,544	7,297,789
NET PATIENT ACCOUNTS RECEIVABLE				
PATIENT RECEIVABLES	59,680,297	57,375,283	60,277,611	2,305,013
LESS ALLOWANCES AND ADJUSTMENTS	(31,555,624)	(26,394,062)	(31,579,280)	(5,161,561)
TOTAL NET PATIENT ACCOUNTS RECEIVABLE	28,124,673	30,981,221	28,698,331	(2,856,548)
NET PROPERTY TAXES RECEIVABLE - KPB				
PROPERTY TAX RECEIVABLE	1,873,761	2,074,107	3,279,875	(200,346)
LESS ALLOWANCE PROPERTY TAX - KPB	(13,770)	(4,165)	(13,770)	9,605
TOTAL NET PROPERTY TAXES RECEIVABLE - KPB	1,859,991	2,069,942	3,266,105	(209,951)
OTHER RECEIVABLES	540,130	354,551	720,591	185,579
INVENTORY	2,868,006	2,889,121	2,875,473	(21,115)
NET PENSION ASSET	0	534,985	0	(534,985)
PREPAID EXPENSE	1,649,471	1,509,869	1,839,627	139,602
TOTAL CURRENT ASSETS	80,760,155	76,759,784	81,925,671	4,000,371
ASSETS WHOSE USE IS LIMITED				
PREF UNOBLIGATED	4,717,600	4,160,269	4,979,211	557,331
PREF OBLIGATED	259,002	3,084,187	28,209	(2,825,185)
OTHER RESTRICTED FUNDS	38,001	540,769	37,554	(502,768)
TOTAL ASSETS WHOSE USE IS LIMITED	5,014,603	7,785,225	5,044,974	(2,770,622)
PROPERTY AND EQUIPMENT				
LAND AND IMPROVEMENTS	4,996,554	4,345,607	4,936,411	650,947
BUILDING	70,207,138	68,165,135	70,168,604	2,042,004
EQUIPMENT	25,597,798	33,360,757	25,392,338	(7,762,960)
BUILDINGS INTANGIBLE ASSETS	3,482,363	4,257,906	3,482,363	(775,543)
EQUIPMENT INTANGIBLE ASSETS	1,911,211	1,750,895	1,911,210	160,315
SPH INTANGIBLE SOFTWARE ASSETS	7,969,004	0	7,969,005	7,969,005
SOFTWARE INTANGIBLE ASSETS	3,930,467	890,141	3,930,467	3,040,326
IMPROVEMENTS OTHER THAN BUILDINGS	1,750,004	1,544,013	1,750,004	205,991
CONSTRUCTION IN PROGRESS	3,173,763	4,318,052	2,373,483	(1,144,289)
LESS ACCUMULATED DEPRECIATION FOR FIXED ASSETS	(62,949,922)	(63,131,819)	(62,539,081)	181,897
LESS ACCUMULATED AMORTIZATION FOR LEASED ASSETS	(5,127,698)	(3,111,708)	(4,953,483)	(2,015,991)
NET CAPITAL ASSETS	54,940,682	52,388,979	54,421,321	2,551,702
GOODWILL	0	0	0	0
TOTAL ASSETS	140,715,440	136,933,988	141,391,966	3,781,451
DEFERRED OUTFLOW OF RESOURCES				
PENSION RELATED (GASB 68)	3,048,733	5,077,652	3,192,491	(2,028,919)
UNAMORTIZED DEFERRED CHARGE ON REFUNDING	86,482	147,528	91,569	(61,046)
TOTAL DEFERRED OUTFLOW OF RESOURCES	3,135,215	5,225,180	3,284,060	(2,089,965)
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**143,850,655**	**142,159,168**	**144,676,026**	**1,691,486**
TOTAL LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
ACCOUNTS AND CONTRACTS PAYABLE	3,006,251	2,848,768	3,436,358	157,483
ACCRUED LIABILITIES	9,314,887	9,567,137	10,479,511	(252,249)
DEFERRED CREDITS	516,983	508,449	470,327	8,533
CURRENT PORTION OF LEASE PAYABLE	1,005,009	1,014,194	980,120	(9,185)
CURRENT PORTION OF SOFTWARE INTANGIBLE PAYABLE	1,171,651	199,887	1,172,314	971,764
CURRENT PORTION OF NOTES DUE	941,386	911,689	930,043	29,697
CURRENT PORTION OF BOND PAYABLE	1,315,000	1,250,000	1,315,000	65,000
BOND INTEREST PAYABLE	34,539	64,654	21,521	(30,115)
DUE TO/FROM THIRD PARTY PAYERS	1,279,746	1,076,864	1,279,746	202,882
COMPENSATED ABSENCES CURRENT	7,122,321	6,919,937	7,124,353	202,384
TOTAL CURRENT LIABILITIES	25,707,773	24,361,579	27,209,293	1,346,194
LONG-TERM LIABILITIES				
NOTES PAYABLE	2,709,995	2,747,494	2,949,307	(37,499)
COMPENSATED ABSENCES NET OF CURRENT	3,062,939	3,113,434	3,493,740	(50,495)
BONDS PAYABLE NET OF CURRENT PORTION	2,855,000	4,170,000	2,855,000	(1,315,000)
PREMIUM ON BONDS PAYABLE	96,369	163,109	100,684	(66,740)
NET PENSION LIABILITY	56,332	0	56,332	56,332
CAPITAL LEASE, NET OF CURRENT PORTION	2,447,967	3,657,881	2,543,781	(1,209,914)
SOFTWARE INTANGIBLE LEASE, NET OF CURRENT PORTION	731,567	(13,348)	831,612	744,916
TOTAL NONCURRENT LIABILITIES	11,960,169	13,838,570	12,830,456	(1,878,400)
TOTAL LIABILITIES	37,667,942	38,200,149	40,039,749	(532,206)
PROPERTY TAXES RECEIVED IN ADVANCE	189,554	0	189,553	189,553
INVESTED IN CAPITAL ASSETS	55,027,164	52,536,507	54,512,890	2,490,656
RESTRICTED	38,001	1,075,754	37,554	(1,037,753)
UNRESTRICTED FUND BALANCE SPH	49,381,559	45,755,064	49,579,829	3,626,495
CHANGE IN FUND BALANCE	1,546,435	4,591,694	506,005	(3,045,259)
TOTAL UNRESTRICTED FUND BALANCE SPH	106,182,713	103,959,019	104,636,278	2,034,139
TOTAL LIABILITIES AND FUND BALANCE	**143,850,655**	**142,159,168**	**144,676,026**	**1,691,487**

South Peninsula Hospital

INCOME STATEMENT
As of September 30, 2026
DRAFT-UNAUDITED

		Month Ending 09/30/2026			Month Ending 09/30/2025	Year To Date 09/30/2026			Prior Year To Date 09/30/2025
		Actual	Budget FY26	Var B (W)	Actual	Actual	Budget FY26	Var B (W)	Actual
	PATIENT SERVICE REVENUE								
1	INPATIENT REVENUE	2,971,788	4,469,788	-33.5%	4,110,595	9,171,592	12,962,390	-29.2%	10,943,425
2	OUTPATIENT REVENUE	23,687,096	22,292,604	6.3%	21,419,585	70,898,258	69,647,623	1.8%	60,107,523
3	LONG TERM CARE	1,582,744	1,605,857	-1.4%	1,420,582	4,690,579	4,817,570	-2.6%	4,379,331
4	TOTAL PATIENT SERVICE REVENUE	28,241,628	28,368,249	-0.5%	26,950,762	84,760,429	87,427,583	-3.1%	75,430,279
	DEDUCTIONS FROM REVENUE								
5	MEDICARE	7,258,955	6,623,994	9.6%	5,432,616	21,684,180	19,871,982	9.1%	16,166,735
6	MEDICAID	3,023,773	2,988,872	1.2%	2,590,977	8,997,094	8,966,614	0.3%	8,295,403
7	CHARITY CARE	469,381	466,285	0.7%	83,545	1,031,646	1,398,855	-26.3%	985,511
8	COMMERICAL AND ADMIN	3,067,765	2,539,519	20.8%	2,421,160	8,444,168	7,618,559	10.8%	7,099,587
9	BAD DEBT	877,069	498,157	76.1%	120,060	2,965,690	1,431,254	107.2%	1,177,771
10	TOTAL DEDUCTIONS	14,696,943	13,116,827	12.1%	10,648,358	43,122,778	39,287,264	9.8%	33,725,007
11	NET PATIENT SERVICES	13,544,685	15,251,422	-11.2%	16,302,404	41,637,651	48,140,319	-13.5%	41,705,272
12	USAC AND OTHER REVENUE	132,941	170,266	-21.9%	102,790	405,421	510,797	-20.6%	315,274
13	TOTAL OPERATING REVENUE	13,677,626	15,421,688	-11.3%	16,405,194	42,043,072	48,651,116	-13.6%	42,020,546
	TOTAL OPERATING EXPENSES								
14	SALARIES AND WAGES	5,745,507	6,616,542	-13.2%	6,028,754	18,815,676	19,849,625	-5.2%	17,801,747
15	EMPLOYEE BENEFITS	3,183,426	3,098,559	2.7%	2,915,270	9,504,224	9,722,758	-2.3%	9,621,122
16	SUPPLIES AND DRUGS	1,935,912	1,852,657	4.5%	1,452,081	5,805,550	5,557,972	4.5%	4,583,888
17	CONTRACT STAFFING	487,323	143,611	239.3%	472,509	1,512,169	451,348	235.0%	1,407,937
18	PROFESSIONAL FEES	680,152	531,870	27.9%	695,490	2,338,051	1,744,274	34.0%	2,155,876
19	UTILITIES AND TELEPHONE	222,678	208,015	7.1%	203,159	638,664	624,044	2.3%	573,388
20	INSURANCE	131,008	108,100	21.2%	43,046	456,876	339,727	34.5%	238,409
21	DUES, BOOKS, AND SUBSCRIPTIONS	22,788	23,571	-3.3%	12,526	60,017	70,712	-15.1%	48,902
22	SOFTWARE MAINT/SUPPORT	163,875	318,059	-48.5%	235,323	582,596	918,843	-36.6%	661,043
23	TRAVEL, MEETINGS AND EDUCATION	63,194	98,018	-35.5%	71,614	203,735	234,914	-13.3%	127,674
24	REPAIRS AND MAINTENANCE	162,365	196,022	-17.2%	187,837	552,651	588,064	-6.0%	565,839
25	LEASES AND RENTALS	38,477	65,356	-41.1%	46,125	165,221	196,069	-15.7%	157,201
26	OTHER (RECRUIT, ADVERT, ETC.)	199,843	189,636	5.4%	274,641	595,082	568,908	4.6%	633,004
27	DEPRECIATION AND AMORTIZATION	585,057	606,750	-3.6%	487,834	1,761,847	1,820,250	-3.2%	1,387,525
28	TOTAL OPERATING EXPENSES	13,621,605	14,056,766	-3.1%	13,126,209	42,992,359	42,687,508	0.7%	39,963,555
29	GAIN (LOSS) FROM OPERATIONS	56,021	1,364,922	-95.9%	3,278,985	(949,287)	5,963,608	-115.9%	2,056,991
	NON-OPERATING REVENUE								
30	GENERAL PROPERTY TAXES	1,455,183	1,292,718	12.6%	1,313,756	2,500,578	2,518,572	-0.7%	2,326,297
31	INVESTMENT INCOME	109,019	105,378	3.5%	107,774	301,289	316,132	-4.7%	312,286
32	GOVERNMENTAL SUBSIDIES	0	0	0.0%	0	0	0	0.0%	0
33	OTHER NON-OPERATING REVENUE	0	1,522	-100.0%	0	0	4,566	-100.0%	2,043
34	GIFTS AND CONTRIBUTIONS	22,500	513,750	-95.6%	326,265	67,500	1,541,250	-95.6%	440,885
35	GAIN LOSS ON DISPOSAL	0	0	0.0%	(346,465)	0	0	0.0%	(346,465)
36	SPH AUXILIARY	677	799	-15.4%	329	1,968	2,399	-18.0%	1,463
37	TOTAL NON-OPERATING REVENUE	1,587,379	1,914,167	-17.1%	1,401,659	2,871,335	4,382,919	-34.5%	2,736,509
	NON-OPERATING EXPENSES								
38									
39	SERVICE AREA BOARD	0	0	0.0%	0	0	0	0.0%	0
40	OTHER DIRECT EXPENSE	6,043	9,634	-37.3%	(727)	6,471	28,904	-77.6%	680
41	ADMINISTRATIVE NON-RECURRING	0	0	0.0%	0	0	0	0.0%	0
42	INTEREST EXPENSE	90,922	72,033	26.2%	89,677	181,682	216,098	-15.9%	202,605
43	TOTAL NON-OPERATING EXPENSES	96,965	81,667	18.7%	88,950	188,153	245,002	-23.2%	203,285
47	TOTAL INCOME (LOSS) BEFORE TRANSFERS	1,546,435	3,197,422	0.0%	4,591,694	1,733,895	4,868,147	-64.4%	9,639,836
48	OPERATING TRANSFERS	0	0	0.0%	0	0	0	0.0%	0
49	**NET INCOME**	**1,546,435**	**3,197,422**	**-51.6%**	**4,591,694**	**1,733,895**	**10,101,525**	**-82.8%**	**0**

Operating EBITDA Disclosure (Non-GAAP)							
GAIN (LOSS) FROM OPERATIONS	**56,021**	**1,364,922**		**3,278,985**	**(949,287)**	**5,963,608**		**2,056,991**
DEPRECIATION AND AMORTIZATION	585,057	606,750		487,834	1,761,847	1,820,250		1,387,525
OPERATING EBITDA	**641,078**	**1,971,672**		**3,766,819**	**812,560**	**7,783,858**		**3,444,516**

South Peninsula Hospital

Capital Report
As of September 30, 2026

Prior Years Budgeted Capital Projects

Source:	Service Area / PREF		
22SHY	SPH Hot Water System	$	63,113
23SHQ	Entrance C Replacement	$	4,426
25SHG	Behavioral Health Acute Care Room	$	40,507
25SHR	Fluro/Xray Room	$	471
25SHR	Deaerator (backup)	$	44,141
	Total	$	152,657

Current Year Budgeted Capital

Source:	Service Area		
27SHB	Therapeutic Mattresses & Control Units	$	18,859
27SHB	Nitrous Oxide Machine	$	11,662
27SHB	Resident Beds	$	85,162
27SHB	Bladder Scanners	$	24,950
27SHC	Endoeye 3D	$	22,561
27SHC	Sterile Processing Sink	$	15,456
27SHC	Slit Lamp	$	12,380
27SHF	Floor Lift	$	6,357
27SHI	Kitchen Flooring	$	31,086
	Total	$	228,473

SPH Operating Cash Projects

Source:	SPH Operations		
2643	New SPH Website	$	2,175
2586	Waiting Room Flooring	$	5,914
2653	Cafeteria Expansion	$	36,163
2658	Stryker Hydro	$	17,976
2660	Zeiss Microscope	$	23,386
2741	Double Oven	$	1,057
2744	Hohe Parking Lot	$	40,859
2746	Replacement Amag Server	$	22,011
2747	Midas Kit	$	61,068
2748	Metrix Spine set 1	$	62,265
2749	Paving for Urgent Care/Home Health	$	41,682
2750	Paving for Hohe 4135	$	2,600
2751	Metrix Spine set 2	$	62,431
	Total	$	379,585

Grant Funded Projects

Source	Grant Operations		
Grant	Mammography Replacement	$	400,107
Grant	Mammography Construction	$	9,053
	Total	$	409,160

Total Capital Purchases 2026	$	1,169,875
Total Capital purchases from Service Area/PREF Funds	$	381,130
Total Capital purchases from Operating/Grant Funds	$	788,745

Table of Contents

I. Missions, Vision, Values: 3
II. Program & Purpose 3
III. Responsibilities: 4
A. Chief Nursing Officer: 4
B. Infection Prevention Committee: 4
C. Infection Prevention Nurse (IP RN): 4
D. Employee Health Nurse (EH RN): 4
E. Department Manager: ..... 5~~4~~
F. Staff: 5
IV. Bloodborne Pathogen Exposure Control: 5
V. Methods of Compliance. 5
VI. Hepatitis B Vaccination Program ..... 9~~8~~
VII. Post-Exposure Evaluation & Follow-up 9
VIII. Information and Training 10
IX. Record Keeping 11
X. Table A: Employees at Risk 14
XI. Table B: Employees Who May Be at Risk ..... 22~~17~~

PURPOSE:
Program components and outline for the South Peninsula Hospital (SPH) Bloodborne Pathogen Exposure Control Plan in accordance with federal, state, and local regulatory guidelines and requirements.

DEFINITION(S):
Blood - Includes plasma, platelets, and serosanguinous fluids (e.g. exudates from wounds). Also included are medications derived from blood, such as immunoglobulins, albumin, and factors 8 and 9.
Bloodborne Pathogens - Microorganisms that are present in human blood or OPIM which can infect and cause disease in persons who are exposed. While HBV and HIV are specifically identified in the standard, the term includes pathogenic microorganisms that can also cause diseases such as hepatitis C, malaria, syphilis, babesiosis, brucellosis, leptospirosis, arboviral infections, relapsing fever, Creutzfeldt-Jakob disease, adult T-cell leukemia/lymphoma (caused by HTLV-I), HTLV-I associated myelopathy, disease associated with HTLV-OO, and viral hemorrhagic fever.
CNO – Chief Nursing Officer.
Clinical Laboratory - A workplace where diagnostic or other screening procedures are performed on blood or OPIM.

Contaminated - An item or surface with the presence or reasonably anticipated presence of blood or OPIM.
Contaminated Laundry - Laundry which has been soiled with blood or OPIM materials or which may contain sharps.
Contaminated Sharps - Any contaminated object that can penetrate the skin including but not limited to needles, scalpels, broken glass, broken capillary tubes and exposed ends of dental wires.
Decontamination - The use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious microorganisms and the surface or item is rendered safe for handling, use or disposal.
Engineering Controls - Controls (i.e., sharps disposal containers, self-sheathing needles, safer medical devices such as sharps with engineered sharps injury protections and needleless systems) that isolate, reduce or remove the bloodborne pathogen hazards from the workplace.
Exposure Incident – Contact or potential contact between blood or OPIM and any of the following: eye, mouth, other mucous membrane, non-intact skin (skin with dermatitis, hangnails, cuts, abrasions, chafing, acne, etc.);or by means of a wound such as a needlestick.
Front-line worker - Non-managerial employee responsible for direct or indirect patient care with a potential for occupational exposure.
Handwashing Equipment - A facility providing an adequate supply of potable running water, soap and single use towels or Alcohol based hand wash
HBV - Hepatitis B virus.
HCV - Hepatitis C virus.
HIV - Human immunodeficiency virus.
Needleless Systems - A device that does not use needles for: (1) the collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established; (2) the administration of medication or fluids; or (3) any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps. “Needleless Systems” provide an alternative to needles for the specified procedures, thereby reducing the risk of percutaneous injury involving contaminated sharps.
Occupational Exposure - A reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or OPIM, that results from the performance of an employee’s duties. This includes potential for contact as well as actual contact with blood or OPIM (including RMW).
OPIM - Other Potentially Infectious Materials - OPIM includes the following human body fluids: cerebrospinal fluid; synovial fluid; pleural fluid; amniotic fluid; saliva in dental procedures; semen; vaginal secretions; any body fluid that is visibly contaminated with blood; all body fluids in situations where it is difficult to differentiate between body fluids; any unfixed tissue or organ (other than intact skin) from a human (living or dead); HIV-containing cell or tissue cultures; HIV- HBV- or HCV-containing culture medium or other solutions blood, organs, or other tissue from experimental animals infected with HIV, HBV or HCV
Parenteral (percutaneous) - Piercing the mucous membranes or skin barrier through such events as needle sticks, sharps injuries, human bites that break skin, cuts, and abrasions.
PEP – Post Exposure Prophylaxis - “PEP” is a term commonly used for HIV preventative treatment.
PPE - Personal Protective Equipment - Specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (i.e. uniform, pants, shirts, or blouses) are not intended to function as protection against a hazard and are not considered to be protective equipment. PPE will be considered “appropriate” only if it does not permit blood or other potentially infectious materials to pass through to the employee’s work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use for the duration of time the protective equipment will be used.
Recipient Individual - Person who is subjected to an exposure. Examples: employees, patients, visitors.
RMW - Regulated Medical Waste - Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or OPIM.
SESIPs - Sharps with Engineered Sharps Injury Protections - Non-needle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident. This term

encompasses a broad array of devices that make injury involving a contaminated sharp less likely. They include, but are not limited to: syringes with guards or sliding sheaths that shield the attached retracting catheters used to access the bloodstream for intravenous administration of medication or fluids; intravenous medication delivery systems that administer medication or fluids through a catheter port or connector site using a needle that is housed on a protective covering; blunt suture needles; and plastic capillary tubes.

SIPP - Sharps Injury Protection Program

Source Individual - Any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee/recipient. Examples include hospital patients; healthcare workers; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Standard Precautions - Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infections in hospitals. They involve use of PPE appropriate to the task; handwashing; housecleaning; and handling linens, laundry, eating utensils, dishes, waste and sharps.

Sterilize - The use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Transmission-Based Precautions - These precautions are designed to be used in caring for patients documented or suspected to be infected or colonized with highly transmissible and/or disease producing organisms for which additional precautions beyond Standard Precautions are needed to interrupt transmission. (For more, see HW-139 Transmission Based Precautions)

Work Practice Controls - Controls that reduce the likelihood of exposure by altering the manner in which a task is performed (i.e. prohibiting recapping of needles by a two-handed technique).

Workforce Members - employees/caregivers, volunteers, trainees, interns, medical staff, students, vendors and independent contractors who are not of an infrequent nature, employees working from home, employees who do not work directly with patients, and all other individuals working at or for SPH whether or not they are paid by or under the direct control of the facility.

POLICY:

I. Missions, Vision, Values:

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

Mission: *SPH promotes 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 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. Program & Purpose

A. SPH's Bloodborne Pathogen Exposure Control Plan (BBPECP) is in compliance with the OSHA Regulations and has developed this plan as part of the requirements.

B. SPH is concerned about the safety and health of its employees. This plan is formulated to reduce

the risk to employees who may be exposed to blood or other potentially infectious materials (OPIM), in accordance with our Mission and Values. Standard Precautions are utilized to prevent reasonably anticipated potential skin eye, and mucous membrane exposure to blood or OPIM that may occur during the performance of an employee's duties.

C. This plan is available to all employees through the Staff Information Site (SIS). The BBPECP will be accessible to all employees. The plan will be reviewed on an annual basis and whenever necessary by the Infection Prevention Committee. 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 and EH RN. Any action required will be under the authority of the Infection Prevention Physician and implemented by the IP RN or EH RN.

D. The review and update of such plans shall also reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens; and document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.

E. Input will be solicited from non-managerial employees responsible for direct patient care who are potentially exposed to injury from contaminated sharps, in the identification, evaluation, and selection of effective engineering and work practice controls and the solicitation will be documented in the Infection Prevention Committee Minutes.

III. Responsibilities:

A. Chief Nursing Officer:
Is Responsible for implementation of this plan.

B. Infection Prevention Committee:
The Committee will:

- Maintain, review and update the BBPECP at least annually, and whenever necessary to include new or modified tasks and procedures.
- Review and revise SPH policies regarding isolation protocols and Standard Precautions, as needed.
- Provide ongoing consultation regarding implementation and use of isolation protocols and Standard Precautions.
- Assist with development and coordination of educational programs.
- Assist with compliance evaluation.
- Provide oversight of the Sharps Injury Protection Program

C. Infection Prevention Nurse (IP RN):
The IP RN will:

- Maintain, review and update the BBPECP at least annually and whenever necessary, to include new or modified tasks and procedures.
- Keep abreast of changes in government regulations that require revisions to the BBPECP.
- Make the written ECP available to employees, OSHA, and NIOSH representatives.
- Coordinate the Sharps Injury Protection Program
- Oversee initial employee orientation, and provide updates for established employees annually and as needed.

D. Employee Health Nurse (EH RN):
The EH RN will:

- Offer the Hepatitis B vaccine to all staff.
- Identify and list all job classifications in which employees may have occasional occupational exposure in the normal performance of duties.
- Identify and list job classifications in which an occupational exposure is not anticipated in the normal performances of duties.
- Ensure that all required medical actions are performed when there is a suspected exposure,

and that appropriate employee health and OSHA records are maintained.
- Develop and maintain procedures for post-exposure follow-up
- Assist with the Sharps Injury Protection Program

E. Department Manager:
- Revise all applicable procedures in the department to include requirements for Personal Protective Equipment (PPE) and the management of waste and soiled equipment.
- Assure employee orientation to the unit and annual refresher training through the training management system.
- Assure PPE in appropriate sizes and other necessary supplies are available in accessible locations.
- Ensures training of the staff for new devices.
- Evaluate compliance by:
  - Initiating and documenting occurrence reporting for continued non-compliance.

F. Staff:
Those employees who are determined to be at risk for occupational exposure to blood or Other Potentially Infectious Materials (OPIM) must comply with the procedures and work practices outlined in this BBPECP.

IV. Bloodborne Pathogen Exposure Control Plan:

The BBPECP will be accessible to all employees. The plan will be reviewed on an annual basis and whenever necessary by the Infection Prevention Committee. 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 and EH RN. Any action required will be under the authority of the Infection Prevention Physician and implemented by the IP RN or EH RN.
The review and update of such plans shall also reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens; and document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.
Input will be solicited from non-managerial employees responsible for direct patient care who are potentially exposed to injury from contaminated sharps, in the identification, evaluation, and selection of effective engineering and work practice controls and the solicitation will be documented in the Infection Prevention Committee Minutes.

V. Methods of Compliance.

A. Standard Precautions
To minimize the risk of disease transmission and prevent contact with blood or OPIM all hospital employees will follow Standard Precautions. Under circumstances in which differentiation between body fluids is difficult or impossible, all body fluids shall be considered to contain bloodborne pathogens.

B. BBPECP
All employees at SPH will receive an explanation of this BBPECP during their initial employee orientation. It will also be reviewed in annual refresher training sessions. All employees have an opportunity to review this plan by locating it on the Staff Information Site (SIS).

C. Sharps Injury Protection Program (SIPP)
In accordance with the Needlestick Safety and Prevention Act of January 1, 2001, a Sharps Injury Protection Program (SIPP) has been incorporated into the BBPECP for SPH, and will be co-managed by the IP RN and EH RN.

1. Basic Components of the SIPP
   a) The program is designed to be integrated into existing SPH performance improvement, infection control, and safety programs. It is based on a model of continuous quality

improvement.

b) Identify the need for changes in engineering controls and workplace practices through review of OSHA records, employee evaluation and surveys, Infection Prevention committee activities, and by acquiring and utilizing newly developed safety devices which have been proven to reduce injury or provide significant protection against bloodborne pathogens.

c) Coordinate with Materials Management to evaluate new procedures and new products by researching available products, acquiring and utilizing sample products, employee evaluation and survey of new products and procedures and committee evaluation of survey results.

d) Regular review of safety equipment.

e) Maintain a Sharps Injury Log in coordination with Employee Health and Human Resources.

f) Provide employee training.

2. Responsibilities for the SIPP

a) The Infection Control Committee:
Reviews guidelines and revises SPH policies regarding Transmission Based Precautions; provides ongoing consultation regarding implementation of the OSHA Standard; assists with the development and coordination of training programs; assists with compliance evaluation and evaluations of new equipment and supplies.

b) Infection Prevention Nurse (IP RN):

- Coordinates and maintains the SIPP.
- Keeps abreast of changes in technology of devices that are engineered to prevent exposures.
- Keeps abreast of changes in government regulations that require revisions to the SIPP and ensures an annual review and update of the program.
- Ensures there are ongoing (at least annually) identification, evaluation and selection of SESIPs, and workplace practices by the Product Evaluation Committee with committee membership as required by government standards.
- Ensures proper recordkeeping with documentation of the solicitation for input from non-managerial employees; identification, evaluation and selection of sharps; and changes in workplace practices.
- Ensures the Sharps Injury Log is maintained by Employee Health.
- Ensures training of the staff for changes in the BBPECP.

c) Product Evaluation Committee
This committee will include representatives from departments using safety devices. They will select, evaluate, and test targeted devices.

D. Engineering and Work Practice Controls
Engineering controls will be used to reduce employee exposure by either removing the hazard or isolating the employee from exposure. Work practice controls will be used to reduce risks by altering the manner in which a task is performed. Where occupational exposure remains after institution of these controls, appropriate PPE must be used.

E. Engineering Controls

1. Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.
2. The specific engineering controls used throughout the facility include, but are not limited to:
   a) Self-sheathing needle devices, needleless devices, blunt needles, and shielded scalpels.
   b) Autoclaves
   c) Sharps Disposal containers

F. Work Practice Controls

1. Handwashing and hand hygiene; refer to HW-136, Hand Hygiene, for complete information.
2. Handling of Contaminated Sharps:
   - All sharps (including syringes) used at SPH will be placed in appropriate sharps disposal containers immediately after use. Sharps containers will be placed at the point of use for

easy access, not easily accessible by children, maintained in an upright position and closeable.
- Contaminated needles and other contaminated sharps may not be bent, recapped or removed, except in the event that it is necessary to recap or remove the needle because of a specific medical procedure. Then a mechanical device (i.e. hemostat) or a one-handed recapping technique must be used. Shearing or breaking of contaminated needles is prohibited.
- For more, see HW-102 Regulated Medical Waste

3. Eating, drinking, smoking, applying lip cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure.
4. Food and drink may not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or OPIM are present. (See HW-219 Employee Food and Drink in Patient Care Areas)
5. All procedures involving blood or OPIM must be performed in such a manner as to minimize splashing, spraying, splattering, and generation of droplets of these substances.
6. Mouth pipetting or suctioning of blood or OPIM is prohibited.
7. Specimens of blood or OPIM must be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping. Standard Precautions will be used when handling all specimens. For more, see HW-102 Regulated Medical Waste and HW-141 Blood and Body Fluid Spills.
8. Equipment which may become contaminated with blood or OPIM must be examined before servicing or shipping and must be decontaminated as necessary, unless decontamination of the equipment or portions of the equipment is not feasible. If complete decontamination is not possible, the equipment must be labeled with a biohazard sign identifying the portions that remain contaminated. The employer shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, and prior to handling, servicing, or shipping so that appropriate precautions will be taken.
9. Healthcare workers with exudative lesions or weeping dermatitis will refer to policy HW-103 Employee Infection for guidance on work restrictions.

G. Personal Protective Equipment

All personnel must routinely use PPE when there is a potential for exposure to blood or OPIM. Appropriate PPE, such as gloves, gowns, laboratory coats, face shields or masks, and eye protection will be provided in the appropriate size, at no cost to the employee and will be readily available in the work area (see policy HW-176 PPE Hazard Assessment).

1. All PPE must be removed before leaving the work area.
2. When PPE is removed it must be placed in the appropriately designated area or container for storage, washing, decontamination, or disposal.
3. Wash hands immediately or as soon as feasible after removal of PPE.
4. Garment(s) saturated with blood or OPIM, must be removed immediately or as soon as possible. Launderable garments must be placed in a leak proof bag per protocol.
5. SPH will be responsible for cleaning, laundering, disposal, repair, and replacement of PPE, as needed.
6. Gloves must be worn when the employee has the potential to have direct skin contact with blood or OPIM, mucous membranes, non-intact skin, and when handling items or surfaces soiled with blood or potentially infectious materials.
   - Disposable single-use gloves must be changed as soon as possible when visibly soiled, torn, punctured, or when their ability to function as a barrier is compromised.
   - Disposable single-use gloves cannot be washed or disinfected for re-use.
   - Gloves must be changed after contact with each patient.
   -

7. Masks and protective eye wear combinations (goggles or glasses with solid side shields), or a face shield which protect all mucous membranes will be worn when performing procedures that are likely to generate splashes, sprays, splatter, or droplets of blood or OPIM.
8. Gowns, aprons or other protective body clothing shall be worn when there is a potential risk for an occupational exposure. Type and characteristics will depend upon the task and degree of exposure anticipated.
9. Surgical caps or hoods and shoe covers will be worn in all surgeries or surgical procedures and in any other procedures where gross contamination can reasonably be anticipated.

H. Housekeeping

SPH will be maintained in a clean and sanitary condition. Written schedules for the routine cleaning of all areas of the hospital and the methods used in this cleaning are maintained by the Environmental Services Department. These schedules are monitored, reviewed and up-dated on an annual basis. Certain work surfaces, walls, windows, curtains, ceilings, etc., are cleaned on a project basis, depending on soiling potential, or when visibly soiled. In general, the following practices are used:

1. All equipment and environmental work surfaces will be properly cleaned and disinfected after contact with blood or other potentially infectious materials. Work surfaces will be disinfected with an appropriate hospital grade disinfectant after completion of procedures, and any time they may have become contaminated. All bins, pails, cans, and similar receptacles intended for re-use which have a reasonable likelihood of becoming contaminated with blood or OPIM will be inspected and decontaminated on a regularly scheduled basis, and decontaminated immediately or as soon as feasible when visibly contaminated.
2. Broken glassware may not be picked up directly with the hands. It must be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

I. Regulated Medical Waste

Regulated Medical Waste (RMW) is defined as contaminated material potentially containing pathogens of sufficient virulence and quantity so that exposure to the waste by susceptible host could result in an infectious disease. For more, see policy HW-102 Regulated Medical Waste Management.

J. Laundry

Laundering will be performed by SPH Laundry Department daily and as needed in the designated laundry area. Laundry functions may also be performed by a vendor. See policy EVS-502 Handling, Transporting, Processing, and Storage of Linen

K. Labels – Communication of Hazards to Employees

1. Specific Biohazard labels or the use of red bags and/or containers will be used to warn employees of potential hazards.
2. Warning labels must be affixed to containers of regulated medical waste, refrigerators and freezers containing blood and OPIM, contaminated equipment and containers used to store, transport, or ship blood or OPIM.
3. Biohazard labels must be fluorescent orange or orange-red with lettering or symbols in a contrasting color. The labels must be an integral part of the container, or must be affixed in a manner that prevents their loss or intentional removal.
4. Red bags or containers may be substituted for labels.
5. Exemptions from these labeling regulations:
    - Containers of blood, blood components, or blood products labeled as to their contents and released for transfusion or other clinical use because they have been screened for HBV and HIV prior to their release;
    - Individual containers of blood or OPIM that are placed in secondary labeled containers during storage, and/or transporting
    - Specimen containers, if Standard Precautions are used when handling all specimens;
    - Laundry bags or containers since Standard Precautions are used for handling all laundry;

- Regulated Medical Waste that has been decontaminated.

VI. Hepatitis B Vaccination Program

Hepatitis B Virus (HBV) vaccine is available at no cost to all SPH staff. Employees may decline the HBV vaccination, and then request to be vaccinated at a later date. If the HBV vaccine is declined, employees will sign a statement per OSHA. Documentation of refusal of the vaccine is kept in the Eemployee Hhealth records. If one or more routine booster doses of HBV vaccine are recommended by the Centers for Disease Control and Prevention (CDC) at a future date, the booster dose will be made available to employees.

Hepatitis B vaccine will be made available to the employee at a reasonable time and place, performed by a licensed healthcare professional.

VII. Post-Exposure Evaluation & Follow-up

Per AK 29 CFR 1910.1030(f)(3), all employees of SPH who have an occupational exposure to blood or OPIM are instructed to report immediately to the ER for a post-exposure medical evaluation and follow-up conducted by ER doctor according to the OSHA Bloodborne Pathogen (BBP) Standard 1910.1030. The medical evaluation and procedures, including prophylaxis and follow-up are available at a reasonable time and place at no cost to employees and are performed by or under the supervision of a licensed physician or another licensed healthcare professional. The Workers' Compensation Insurance Plan for SPH is responsible for the costs incurred for healthcare workers covered by this plan. Non-employee providers are also eligible for follow-up through the ER and Employee Health Department. Laboratory tests will be conducted by an accredited laboratory at no cost to the employee. Following the report of an exposure incident, the employee has the right to, and should have, a confidential medical evaluation and follow-up, the steps described in the SPH BBP Post-Exposure Packet and HW-119 Work Related Injury or Illness, including at least the following elements:

1. The circumstances under which the exposure occurred, department or work area where the exposure occurred, documentation of the routes of exposure, and the type and name brand of the device involved.
2. Identification and documentation of the source individual, unless identification is not feasible.
   - The source individual's blood must be tested as soon as possible~~,~~ in order to determine infections with HBV, HCV, HIV, syphilis and other bloodborne pathogens as indicated.
     - Consent is to be obtained from the source prior to performing the lab tests. If the source refuses to consent, the lab tests cannot be performed, and it will be documented in the employee/recipient's post exposure record that consent could not be obtained.
     - If the lab already has blood from the source, but the source is not available to provide consent, a reasonable attempt must be made to contact the source. If the source cannot be located, the blood shall be tested, and the results documented in the employee/recipient's post exposure record.
   - When the source individual is already known to be infected with HBV, HCV, HIV, or syphilis, testing the source for these diseases need not be repeated, but appropriate records documenting this status shall be made available to the medical evaluator.
   - Results of the source individual's testing must be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious state of the source individual;
3. Collection and testing of recipient/staff blood for HBV, HCV, and HIV serological status;
4. The exposed employee's blood must be collected as soon as possible and tested after consent is obtained;
5. If the employee consents to baseline blood collection, but does not consent at that time for serologic testing, the sample must be preserved for at least 90 days; if within 90 days of the exposure incident, the employee elects to have the base line sample tested, the testing will be done as soon as feasible;
6. Post-exposure prophylaxis, when medically indicated and as recommended by the CDC;

7. Counseling regarding risks and treatment options;
8. Evaluation of reported illnesses;
9. The IP Nurse or EH Nurse ensures that healthcare professional(s) responsible for employee's HBV, HIV risk and post-exposure evaluation and follow-up are given a copy of OSHA's Bloodborne Pathogen Standard.
10. The EH Nurse or ER Nurse ensures that the healthcare professional evaluating an employee after an exposure incident receives the following:
    - A description of the employee's job duties relevant to the exposure incident~~.~~
    - Route(s) of the exposure~~.~~
    - Circumstances of exposure~~.~~
    - If possible, a result of the source individual's blood test~~.~~
    - Relevant employee medical records, including hepatitis B ~~vaccination~~immunity status~~.~~
11. The EH Nurse will review the circumstances of all exposure incidents to determine:
    - Engineering controls in use at the time~~.~~
    - Work practices being followed~~.~~
    - Description, including brand name of the device being used~~.~~
    - PPE or clothing that was used at the time of the exposure incident~~.~~
    - Location of the incident~~.~~
    - Procedure being performed when the incident occurred~~.~~
    - Employee's training in collaboration with employee's manager~~.~~
    - EH nurse will document all percutaneous injuries from contaminated sharps in the Sharps Injury Log~~;~~
12. The ER Nurse shall provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.
13. The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee received such vaccination.~~;~~
14. The healthcare professional's written opinion for post- exposure evaluation and follow-up shall include the following information:
    - That the employee has been informed of the results of the evaluation; and
    - That the employee has been told about any medical conditions resulting from exposure to blood or OPIM which require further evaluation or treatment~~.~~
15. All findings or diagnoses shall remain confidential and access to this information will be by the employee's authorization except by the Worker's Comp insurance carrier, OSHA and State Epidemiology Department.
16. The Employee Health Nurse will provide periodic surveillance of the exposed employee as needed to include lab tests and review of health status.
17. If as a result of the exposure incident, it is determined that revisions need to be made, the CNO will ensure appropriate changes are made to this ECP.
18. Refer to:
    - SPH BBP Post-Exposure Packet
    - SPH policies HW-056, Employee Health; HW-119 Work Related Injury or Illness; HW-137 Occupational Exposure to Bloodborne Pathogens

VIII. Information and Training

Training will be provided to all employees with occupational exposure to blood or OPIM during work hours and at no cost to the employee. Training will take place at the time of initial assignment to tasks where occupational exposure may take place and at least annually thereafter and within 90 days after the effective date of the new or revised regulations. Additional training will be provided when changes, such as modifications of tests and procedures, or new tasks, affect the employee's occupational

exposure. Training records will be maintained for a minimum of three years. The training will be provided via the training management system, by the EH RN, IP RN, Manager, or other person knowledgeable in the subject matter covered by the elements contained in the training program as it relates to SPH.

The training will include, at a minimum, the following elements:

1. Location of an accessible copy of the bloodborne pathogen regulations and an explanation of their content;
2. A general explanation of the epidemiology and symptoms of bloodborne diseases;
3. An explanation of the modes of transmission of bloodborne pathogens;
4. An explanation of the SPH BBPECP and the means by which the employee can obtain a written copy of the plan;
5. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and OPIM;
6. An explanation of the use and limitations of methods that will prevent or reduce exposure, including appropriate engineering controls, work practices, and PPE;
7. Information on the types, proper use, location, removal, handling, decontamination, and disposal of PPE;
8. An explanation of the basis for selection of PPE;
9. Information on the HBV vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;
10. Information on the appropriate actions to take and the persons to contact in an emergency involving blood or OPIM;
11. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;
12. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;
13. An explanation of the signs and labels or color coding utilized to designate contaminated articles;
14. An opportunity for interactive questions and answers with the person conducting the training session.
15. Material appropriate in content and vocabulary to educational level, literacy, and language of employees shall be used.
16. Training materials are available through the EH RN, IP RN, Manager and the Education Department.

IX. Record Keeping

A. Medical Records

The EH RN will maintain records of all exposure incidents, post-exposure follow-ups, and the hepatitis B vaccination status of all employees with occupational exposure to blood or OPIM. These records are confidential and are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as may be required by law. These records will be maintained for the duration of the person's employment with SPH, plus 30 years, in accordance with OSHA Standard 29 CFR 1910.20, (d) (I) (ii).

Medical records will include:

1. The name and date of birth of the employee;
2. A copy of the employee's HBV status involving the dates of all the HBV vaccinations and any medical records relative to the employee's ability to receive vaccination as required by OSHA regulations;
3. A copy of all results of examinations, medical testing, and follow-up procedures as required by this plan;

4. The employer's copy of the healthcare professional's written opinion, as required following an exposure incident, including the information that the employee was informed of the results of the post-exposure medical examination and the need for further follow-up, if any;
5. A copy of the information provided to the healthcare professional, as required by OSHA, evaluating an exposure incident including a description of the employee's duties as they relate to the exposure incident, routes of exposure and circumstances under which exposure occurred;
6. Signed declination statements if the employee declined the HBV vaccination series, post exposure prophylaxis or any declined portion of recommended treatment;
7. OSHA Recordkeeping – An exposure incident is evaluated to determine if the case meets OSHA's Recordkeeping Requirements (29 CFR 1904). This determination and the recording activities are done by Human Resources or the Employee Health Department.

B. Sharps Injury Log

In addition to the 1904.8 OSHA Recordkeeping Requirements, all percutaneous injuries from contaminated sharps are also recorded in Sharps Injury Log. All incidences must include at least:

1. Date of the injury
2. Type and brand of the device involved (syringe, suture needle) when available
3. Department or work area where the incident occurred
4. Explanation of how the incident occurred.

This log is reviewed as part of the annual program evaluation and maintained for at least five (5) years following the end of the calendar year covered. If a copy is requested by anyone, it must have any personal identifiers removed from the report.

C. Training Records

Training records are completed for each employee upon completion of training. These documents will be kept for at least three years at Employee Health Office for New Employee Onboarding, Human Resources office for New Employee Orientation, and SPH Staff Education Office for annual training.

The training records will include:

1. The dates of the training sessions
2. The contents or a summary of the training sessions
3. The names and qualifications of persons conducting the training sessions
4. The names and job titles of all persons conducting the training.
5. Training records will be maintained for three years from the date on which the training occurred.

Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to Employee Health Department, Staff Education Department, or Human Resources Department.

D. Availability of Records

1. SPH shall ensure that all records required to be maintained by this plan will be made available upon request to the Commissioner and the Director of the Alaska Department of Labor and the Federal Department of Labor (OSHA) for examination and copying.
2. Employee training records required to be maintained by this plan will be provided upon request for examination and copying to employees, to employee representatives, to the Director and to the Commissioner in accordance with 8 AAC 61.270 and to the Assistant Secretary and the Director of the Department of Labor in accordance with 29 CFR 1910.20.
3. Employee medical records required to be maintained by this plan will be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Director, and to the Commissioner in accordance with 8 AAC 61.270 and to the Assistant Secretary and the Director of the Department of Labor in accordance with 29 CFR 1910.20.

PROCEDURE:

N/A

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. SPH Bloodborne Pathogen Post-Exposure Packet [FORM EH.NAF.011]
2. Occupational Safety and Health Administration. Standard 1910.1030. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030
3. Occupational Safety and Health Administration. Standard 1910.1020 https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1020
4. UCSF National Clinical Consultation Center. PEP: Post-Exposure Prophylaxis. https://nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/
5. State of Alaska Department of Health, Division of Public Health, Section of Epidemiology. HIV/STD Provider Packet. https://health.alaska.gov/dph/Epi/hivstd/Documents/resources/HIV-STD-2023-Provider-Packet.pdf
6.5. Centers for Disease Control and Prevention. HIV NEXUS; CDC Resources for Clinicians. https://www.cdc.gov/hiv/clinicians/index.html
7. Los Angeles County Health Services. Policy 925.200 EHS' Bloodborne Pathogen Exposure Control Program. https://secure2.compliancebridge.com/lacdhs/DHSpublic/index.php?fuseaction=header.download&policyID=959&descriptor=header1&doc=DHS925-200.pdf

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

X. Table A: Employees at Risk

Job classifications and associated tasks identifying employees at risk of exposure to blood or other potentially infectious materials. Exposure determinations are made without regard to use of PPE.

Department	**Job Classification/Title**
Acute Care	Activity Aide
	Assistant Director
	Director
	Discharge Planner & Case Manager
	Patient Care Tech
	Registered Nurse
	RN Coordinator
	Hospitalist
Childcare Center	Childcare Administrator
	Childcare Assistant Administrator
	Early Childhood Educator Assistant
	Early Childhood Educator
Emergency Department	Director of Emergency Services
	Emergency Services Manager
	Patient Care Tech
	Registered Nurse
	Physician
Environmental Services	Director of Environmental Services
	EVS Coordinator
	EVS Technician
	Laundry Aide
Family Care Clinic	Clinic Manager
	Licensed Practical Nurse
	Medical Assistant

	Nurse Practitioner
	Physician
	POD Clinical Assistant
	Registered Nurse
Forensics	Forensics Services Supervisor
	Registered Nurse
Home Health	Director of Home Health
	Occupational Therapist
	Physical Therapist
	Registered Nurse
	Registered Nurse Coordinator
Homer Medical Center	Clinic Manager
	Diabetes Health Coordinator
	Licensed Practical Nurse
	Medical Assistant
	Nurse Practitioner
	Physician
	POD Clinical Assistant
	Registered Nurse
	Vaccine Program Lead
Imaging/Radiology	Director of Imaging
	Echocardiographer
	Imaging Manager
	Imaging Tech Lead
	PACS/Imaging Senior Technician
	Physician
	Radiology Technologist
	Registered Nurse

	Sonographer
Infusion Clinic	Infusion Clinic Manager
	Medical Assistant
	Registered Nurse
Laboratory	Clinical Lab Assistant Manager
	Clinical Lab Scientist
	Director of Laboratory
	Laboratory Assistant
	Phlebotomist/Clerk
Long Term Care	Assistant Director of Nursing
	Care Coordinator
	Certified Nursing Assistant
	Clinical Care Coordinator
	Clinical Systems Support RN
	Director of Nursing
	Licensed Practical Nurse
	Nurse Practitioner
	Physician
	Registered Nurse
	RN Coordinator
Neurology	Clinic Manager
	Medical Assistant
	Physician
Obstetrics / L&D	OB Director
	Registered Nurse
Orthopedic Clinic	Medical Assistant
	Orthopedic Surgeon
	Physician Assistant

Pharmacy	Director
	Pharmacist
	Pharmacy Clinical Lead
	Pharmacy Tech
Quality	Employee Health RN
	Infection Prevention RN
	Quality Management RN
Rehabilitation	Director of Rehab Services
	Occupational Therapist
	Pediatric Therapist
	Physical Therapist
	Physical Therapy Assistant
	Rehabilitation Aide
	Speech Language Pathologist
Renew Plastic Surgery & Derm	Clinic Manager
	Registered Nurse
	Physician
Respiratory Therapy	Cardiopulmonary Services Technician
	Respiratory Services Manager
	Respiratory Therapist
Seaside Women's Care	Certified Nurse Midwife
	Medical Assistant
	Nurse Practitioner
	Physician
	POD Clinical Assistant
	Registered Nurse
Seaworthy Functional Medicine	Clinic Manager
	Medical Assistant

	Nurse Practitioner
	Physician
Serene Waters Behavioral Health	Mental Health Counselor
	Nurse Practitioner
	Physician
	Registered Nurse
Sleep Lab	Cardiopulmonary Services Manager
	Sleep Lab Technician
South Peninsula General Surgery	Clinic Manager
	Medical Assistant
	Nurse Practitioner
	Physician
	Registered Nurse
Specialty Clinic	Clinic Manager
	Medical Assistant
	POD Clinical Assistant
	Registered Nurse
	Provider
Surgical Services/PACU	Certified Surgical First Assistant
	CRNA
	Director of Surgical Services
	Registered Nurse
	Sterile Processing Tech
	Surgical Services Coordinator
	Surgical Technician

Job classifications and associated tasks identifying employees at risk of exposure to blood or other potentially infectious materials. Exposure determinations are made without regard to use of PPE.

Department	Job Classification/Title
Acute Care	Activity Aide
	Certified Nursing Assistant
	Director
	Discharge Planner
	Patient Care Tech
	Registered Nurse
	RN Coordinator
	Hospitalist
Aesthetics & Reconstructive Surgery	Medical Assistant
	Physician
Administration	Chief Medical Officer
	Chief Nursing Officer
Behavioral Health	Mental Health Counselor
	Nurse Practitioner
	Physician
	Registered Nurse
Emergency Room	Director
	ED Tech
	Health Unit Clerk
	Patient Care Tech
	Registered Nurse
	RN Coordinator
	Physician
Employee Health	Employee Health RN
Family Care Clinic	Assistant Clinical Manager
	Medical Assistant
	Nurse Practitioner
	Physician
	Physician Assistant
	Registered Nurse
Forensics	Registered Nurse
	RN Coordinator
Functional Medicine	Medical Assistant
	Physician
General Surgery	Medical Assistant
	Nurse Practitioner
	Physician
	Physician Assistant
	Registered Nurse
Health and Wellness	Community Health & Wellness Educator
Home Health	Certified Nursing Assistant
	Clinical Care Sup
	Director
	Occupational Therapist
	Physical Therapist

	~~Registered Nurse~~
	~~Respite/Chore Provider~~
	~~RN Case Manager~~
	~~Speech Language Pathologist~~
~~Homer Medical Center~~	~~Assistant Clinical Manager~~
	~~Certified Addiction Counselor~~
	~~Diabetes Health Coordinator~~
	~~Lead Medical Assistant~~
	~~Licensed Practical Nurse~~
	~~Medical Assistant~~
	~~Nurse Practitioner~~
	~~Physician~~
	~~Physician Assistant~~
	~~Registered Nurse~~
~~Homer Medical OB/GYN~~	~~Certified Nurse Midwife~~
	~~Clinical Assistant~~
	~~Medical Assistant~~
	~~Physician~~
	~~Registered Nurse~~
~~Imaging/Radiology~~	~~Director~~
	~~PACS Administrator~~
	~~Radiology Technologist~~
	~~Registered Nurse~~
	~~Physician~~
	~~Echocardiographer~~
	~~Sonographer~~
~~Infusion Clinic~~	~~Medical Assistant~~
	~~Registered Nurse~~
~~Laboratory~~	~~Clin Lab Science Coord.~~
	~~Clinical Lab Scientist~~
	~~Director of Laboratory~~
	~~Medical Laboratory Technologist~~
	~~Phlebotomist/Clerk~~
~~Long Term Care~~	~~Activity Aide~~
	~~Activity Coordinator~~
	~~Assistant Director of Nursing~~
	~~Certified Nursing Assistant / Trainee~~
	~~Clinical Systems Support RN~~
	~~Director of Nursing~~
	~~Health Unit Clerk~~
	~~Licensed Practical Nurse~~
	~~Nurse Practitioner~~
	~~Physician~~
	~~Registered Nurse~~
	~~RN Coordinator~~
	~~Social Worker BA/BS~~
~~Neurology~~	~~Medical Assistant~~
	~~Neurodiaognostic Technologist~~
	~~Physician~~
~~Obstetrics / L&D~~	~~Activities Aide/CNA~~

	OB Director
	Registered Nurse
Orthopedic Clinic	Lead Medical Assistant
	Medical Assistant
	Orthopedic Surgeon
	Physician Assistant
Pharmacy	Director
	Pharmacist
	Pharmacy Clinical Lead
	Pharmacy Tech
Rehabilitation	Director
	Physical Therapist
	Physical Therapy Assistant
	Rehabilitation Aide
	Occupational Therapist
	Occupational Therapy Assistant
	Pediatric Therapist
	Speech Language Pathologist
Respiratory Therapy	Respiratory Services Director
	Respiratory Therapist
Sleep Lab	Manager
	Medical Assistant
	Sleep Lab Technician
	Physician
Specialty Clinic	Medical Assistant
	Physician
	Physician Assistant
Surgical Services/PACU	CRNA/Anesthesiologist
	Director of Surgical Services
	Registered Nurse
	Sterile Processing Tech
	Surgical Services Coordinator
	Surgical Technologist / Trainee
	Surgical First Assistant

XI. Table B: Employees Who May Be at Risk

Job classifications and tasks in which some employees may have occupational exposures to blood or OPIM.

Department	**Job Classification/Title**
Acute Care	Health Unit Clerk
	Operations Specialist
	Patient Companion
	Social Worker
	Utilization RN
Administration	Chief Medical Officer
	Chief Nursing Officer
BioMed	Biomed Engineer
Education	Clinical Educator
	Education Development Specialist
	Education Manager
	Instructor
	RN Coordinator
Emergency Department	Chaplain
	Emergency Department Tech
Facilities/Maintenance	Assistant Electrical Technician
	Assistant Facilities Manager
	Carpenter
	Facilities Director
	Facilities Electrician
	Facilities Engineer
	Facilities Equipment Operator
	Finish Carpenter
	Network Technician
	Plumber Pipe Fitter

Family Care Clinic	Receptionist
Health and Wellness	Community Health and Wellness Educator
Home Health	Care Coordinator
Homer Medical Center	Care Coordinator
	Operations Specialist
	Prior Authorization Specialist
	Receptionist
	Scheduler
Imaging/Radiology	Health Unit Clerk
	Imaging Office Coordinator
	Scheduler
Laboratory	Courier
Long Term Care	Activity Coordinator
	Operations Specialist
	Social Services Coordinator
	Social Services Supervisor
Materials Management/Med Sup	Expeditor
	Materials Management Director
	Medical Supply Technician
	Purchasing Tech
Neurology	Receptionist
Nutrition Services	Clinical Dietician
Orthopedic Clinic	Clinic Manager
	Receptionist
Rehabilitation	Rehab Office Coordinator
	Rehab Office Tech
Renew Plastic Surgery & Derm	Receptionist
Seaside Women's Care	Mental Health Counselor

	Operations Specialist
	Receptionist
	Scheduler
Security	Safety & Security Supervisor
	Security Guard
Serene Waters Behavioral Health	Receptionist
Sleep Lab	Manager
	Sleep Lab Technician
	Physician
Specialty Clinic	Prior Authorization Specialist
	Receptionist
	Scheduler
Surgical Services/PACU	Purchasing Tech

~~Job classifications and tasks in which some employees may have occupational exposures to blood or OPIM.~~

~~**Department**~~	~~**Job Classification/Title**~~
~~Acute Care~~	~~Health Unit Clerk~~
	~~Operations Specialist~~
	~~Patient Companion~~
	~~Social Worker~~
	~~Utilization RN~~
~~Behavioral Health~~	~~Patient Account Rep~~
~~BioMed~~	~~Biomed Engineer~~
~~Clinical Informatics~~	~~HLT Info Specialist~~
	~~Informatics Analyst~~
~~Daycare Center~~	~~Childcare Administrator~~
	~~Childcare Assistant/Teacher~~
~~Education~~	~~Clinical Educator~~
	~~Instructor~~
	~~Operations Specialist~~
	~~RN Coordinator~~
~~Employee Health~~	~~Administrative Assistant~~
~~Environmental Services~~	~~EVS Technician~~
	~~Laundry Aide~~
	~~Manager~~
~~Facilities/Maintenance~~	~~Carpenter~~
	~~Clerk~~
	~~Facilities Electrician~~

	~~Facilities Engineer~~
	~~Facilities Manager~~
	~~Plumber~~
~~Family Care Clinic~~	~~Patient Acct Rep~~
~~Health and Wellness~~	~~Health and Wellness Educator~~
~~Homer Medical Center~~	~~Care Coordinator~~
	~~Lead Receptionist~~
	~~Patient Acct Rep~~
	~~Receptionist~~
~~Homer Medical OB/GYN~~	~~Lead Receptionist~~
	~~Patient Acct Rep~~
~~Imaging/Radiology~~	~~Health Unit Clerk~~
	~~Office Coordinator~~
~~Laboratory~~	~~Clin Lab Science Coord.~~
	~~Clinical Lab Scientist~~
	~~Courier~~
	~~Director of Laboratory~~
	~~Phlebotomist/Clerk~~
~~Long Term Care~~	~~Care Coordinator~~
	~~Ops Specialist~~
~~Nutrition Services~~	~~Clinical Dietician~~
~~Orthopedic Clinic~~	~~Clinic Manager~~
	~~Patient Acct Rep~~
~~Patient Financial Services~~	~~Patient Acct Rep~~
~~Quality~~	~~Infection Prevention RN~~
~~Rehabilitation~~	~~Patient Acct Rep~~
	~~Rehab Office Coord.~~
~~Security~~	~~Greeter~~
	~~Safety & Security Supervisor~~
	~~Security Guard~~
~~Sleep Lab~~	~~Manager~~
	~~Sleep Lab Technician~~
	~~Physician~~
~~Specialty Clinic~~	~~Patient Acct Rep~~
~~Surgical Services/PACU~~	~~Purchasing Tech~~

APPENDIX A



Our Values in Action

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

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

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

RESPECT IS NOT:
- I bully and intimidate.
- I raise my voice and curse.
- I shame and embarrass others.
- I am divisive and judgmental.
- I manipulate and undermine.
- I ignore you.

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

TRUST IS NOT:
- I say one thing and do another.
- I gossip and spread rumors.
- I withhold information and conceal mistakes.
- I undermine the chain of command.
- I discuss issues outside appropriate channels.
- I draw conclusions before facts are known.
- I cause or tolerate retribution to the reporting of harm or near misses.

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

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

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

COMMITMENT IS NOT:
- I compromise the quality, safety and reputation of my organization.
- I act inappropriately.
- I delay or fail to hold myself or others accountable.
- I avoid review of my performance.
- I am defensive and make excuses.
- I blame others.
- I disregard policies and procedures.

South Peninsula Hospital	**SUBJECT:** Respiratory Protection Plan	**POLICY #** HW-276 **Page 1** of **17**
SCOPE: Hospital-Wide **RESPONSIBLE DEPARTMENT:** Employee Health		**ORIGINAL DATE:** 7/10/09 **REVISED:** 2/28/18; 10/19/21; 1/25/23; 2/28/24; 4/30/25
APPROVED BY: Employee Health RN; Infection Prevention RN; Infection Prevention Medical Director; Chief Nursing Officer; MEC; BOD, Facilities Manager		**EFFECTIVE:** 4/30/25

Table of Contents

I. Missions, Vision, Values: 2
II. Purpose, Applicability, & Scope 2
III. Roles and Responsibilities: 2
A. Respiratory Program Administrator (RPA) 2
B. Supervisors 3
C. Employees 3
IV. Respirator Selection 3
A. Hazard Assessment 3
B. Updating the Hazard Assessment: 4
C. NIOSH Certified Equipment 4
D. Assignment of Respirators by Task and Location 4
E. Voluntary Use of Respirators ..... 4~~5~~
V. Respiratory Medical Evaluation 5
VI. Fit Testing ..... 5~~6~~
VII. Training 6
A. General Use Procedures ..... 6~~7~~
B. Maintenance, Cleaning, and Storage of Respirators 7
C. Defective Respirators ..... 7~~8~~
D. Respirator Malfunction 8
E. Cleaning and storage 8
F. Program Evaluation ..... 8~~9~~
G. Recordkeeping ..... 8~~9~~
Appendix A - Respirator Assignments by Task or Location 10
Appendix B – Information for Voluntary Use ..... 15~~14~~
Appendix C - Respiratory Medical Clearance Evaluation ..... 17~~15~~
Appendix D1 – Fit Testing Procedures, General Requirements; Test Exercises; Testing Procedures, Saccharin Solution Aerosol Protocol; Fit Testing Procedures, Bitrex™ (Denatonium Benzoate) Solution Aerosol Qualitative Fit Test Protocol ..... 17~~15~~
Appendix D2 – Respirator Training & Fit Test Checklist ..... 17~~15~~
Appendix D3 – Fit Test Card ..... 17~~15~~
Appendix E – User Seal Check Procedures ..... 17~~15~~
Appendix F – Extended Use & Limited Reuse of PPE; PPE Color Coded Capacity Strategies ..... 17~~15~~

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

PURPOSE:
Program components and outline for the South Peninsula Hospital & Long Term Care Facility (SPH) Respiratory Protection Plan (RPP) 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 Respiratory Protection Plan is the organization's mission, vision, values, and associated behaviors:
Mission: *SPH promotes 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**:**

- 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. Purpose, Applicability, & Scope
A. SPH protects the health and safety of its employees by (1) eliminating hazardous exposures where feasible; (2) using engineering and administrative controls to minimize hazardous exposures that cannot be eliminated; and (3) using respiratory protection and other personal protective equipment (PPE) when the frequency and duration of exposures cannot be substantially reduced or eliminated.
B. The purpose of this RPP is to maximize the protection afforded by respirators when they must be used. It establishes the procedures necessary to meet the regulatory requirements described in OSHA's Respiratory Protection standard (29 CFR 1910.134).
C. This program applies to all employees, clinical contractors, and students (referred to as staff or employees in this document hereafter) who are required to wear respiratory protection due to the nature of their work at SPH. It applies to the use of air-purifying and air-supplying respirators, including filtering facepiece respirators.
D. Employees participating in the respiratory protection program do so at no cost to them. The expense associated with training, medical evaluations, and SPH provided respiratory protection equipment will be borne by SPH.
E. This plan is available to all employees through the Staff Information Site (SIS) under Policy Manager.

III. Roles and Responsibilities:
A. Respiratory Program Administrator (RPA)
1. The RPA duties for SPH are shared by the Employee Health Nurse and Facilities Manager.
2. The RPA is responsible for administering and oversight of the respiratory protection program, in accordance with OSHA's Respiratory Protection standard (29 CFR 1910.134), and will:
   - Oversee the conduction of a hazard assessment and select the appropriate level of respiratory protection for each task or job title with potential exposure and record this information in the "Respirator Assignments by Task or Location" in Appendix A of this RPP.
   - Oversee the respirator maintenance procedures.

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

- Coordinate the purchase, maintenance, repair, and replacement of respirators.
- Routinely evaluate the effectiveness of the RPP, with employee input, and make necessary changes to the program.
- Ensure that annual respirator fit testing is provided
- Provide or arrange for annual training on the use and limitations of respirators.
- Maintain records of respirator training, medical clearance, and fit testing as required.
- Maintain a copy of this written RPP and ensure that it is readily accessible to anyone in the program.

B. Supervisors
1. Supervisors of employees included in the RPP will:
   - Participate in the hazard assessment by evaluating all potential exposures to respiratory hazards, including exposure to chemicals and aerosol transmissible disease (ATD) pathogens, and communicating this information to the RPA.
   - Continually monitor work areas for operations to identify respiratory hazards.
   - Coordinate with the RPA on how to address respiratory hazards or other concerns with the RPP.
   - Identify employees and/or tasks for which respirators may be required and communicate this information to the RPA.
   - Be responsible for ensuring that employees in their units follow the procedures outlined in the RPP and in SPH PPE Guidelines for using, cleaning, maintaining, and storing respirators.
   - Schedule employees for medical evaluations, training, and fit testing and ensure that they are allowed to attend these appointments during work hours.
   - Ensure the availability of appropriate respirators and accessories in their units.

C. Employees
1. Employees have the responsibility to wear their respirator when and where required and in the manner in which they were trained.
2. Employees assigned to jobs/tasks requiring the use of a respirator will also:
   - Complete the required questionnaire for medical clearance and participate in a medical examination if necessary.
   - Adhere to SPH PPE policies and guidelines.
   - Attend annual training and respirator fit testing as required in the RPP.
   - Use, maintain, and dispose of respirators properly in accord with training and the procedures in the RPP and per SPH PPE guidelines.
   - Inform their supervisor if the respirator no longer fits well; request a new one that fits properly. Respirators relying on facepiece-to-face seal must not be worn when conditions prevent a good seal. Employees are not permitted to wear tight-fitting respirators if they have any condition, such as facial scars, facial hair, or missing dentures, that prevents them from achieving a good seal.
   - Inform their supervisor or the RPA of any respiratory hazards that they feel are not adequately addressed in the workplace and of any other concerns that they have regarding the RPP.

IV. Respirator Selection

A. Hazard Assessment
1. The RPA will oversee the selection of respirators to be used onsite based on the hazards to which workers are exposed and in accord with OSHA regulations and Centers for Disease Control and Prevention (CDC), Healthcare Infection Control Practices Advisor Committee (HICPAC), and other public health guidelines. The RPA will oversee a hazard evaluation for each task, procedure, or work area where airborne contaminants may be present in routine operations or during an emergency. The hazard evaluation will include the following:
   - Identification of potential exposures. The most common potential exposure for employees involved in patient care with be pathogens associated with aerosol transmissible diseases

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

ATDs, such as tuberculosis and COVID-19. Maintenance, housekeeping, laboratory, or other staff may have the potential to be exposed to hazardous gases, vapors, or dusts in addition to ATD pathogens. A list of all hazardous substances used in the workplace can be found on the SIS site under the Safety tab in MSDS online.

- A review of work processes to determine potential exposures to respiratory hazards that may occur. This review shall be conducted by surveying the workplace, reviewing process records, and talking with employees and supervisors.

B. Updating the Hazard Assessment:
   1. The RPA will revise and update the hazard assessment any time an employee or supervisor identifies or anticipates a new exposure or changes to existing exposures.
   2. Any employee who believes that respiratory protection is needed during a particular activity must contact his or her supervisor or the RPA. The supervisor must contact the RPA whenever respiratory protection is requested. The RPA will assess the potential hazard with the employee and supervisor. If it is determined that respiratory protection is needed, all elements of this program will be in effect for those tasks and the program will be updated accordingly.

C. NIOSH Certified Equipment
   1. All respirators must be certified by the National Institute for Occupational Safety and Health (NIOSH) and shall be used in accordance with the terms of that certification. Also, all filters, cartridges, and canisters must be labeled with the appropriate NIOSH approval label. The label must not be removed or defaced while it is in use.
   2. The following definitions apply to equipment that may be issued to employees under this program:
      - **Air-purifying respirators (APR):** respirators with a filter, canister, or cartridge that removes specific air contaminants from the ambient air by passing through an air-purifying element. APRs must have been tested and approved by NIOSH for use in specific types of contaminated atmospheres. These respirators do not supply oxygen and therefore cannot be used to enter an atmosphere that is oxygen-deficient.
        - **Filtering facepiece respirators (FFR):** disposable, negative-pressure, air-purifying respirator where an integral part of the facepiece or the entire facepiece is made of filtering material. These respirators are designed to be used once and then properly disposed of. However, the FFR may be reused by the same user, under some circumstances, as long as the respirator has not been obviously soiled or damaged (Refer to Section 8 and to Appendix F **PPE Color Coded Capacity Strategies & Extended Use and Limited Reuse of PPE** for specific conditions in which FFR reuse may be acceptable.
        - **Half mask elastomeric respirators:** reusable air-purifying respirators that fit over the nose and mouth. They are made of rubber or silicone with attached cartridges or filters from removal of gases, vapors, or dusts
        - **N-95 respirator:** generally used term for a half-mask negative pressure, air-purifying respirator with NIOSH-approved N95 filters or filter material (i.e., includes N95 filtering facepiece respirator or equivalent protection).
      - **Powered air-purifying respirators (PAPR):** air-purifying respirators that use a blower to force ambient air through air-purifying elements and into the respirator facepiece, helmet, or hood.

D. Assignment of Respirators by Task and Location
   1. The RPA will use the hazard assessment to assign appropriate types of respirators for use by specific types of personnel during specific procedures or in specific areas of the hospital. These assignments are listed in Appendix A of this RPP.

E. Voluntary Use of Respirators
   1. When the use of a respirator is not required by a substance-specific OSHA standard, the OSH Act, or hospital policies, and the RPA has determined that its use is not necessary to protect the health of the employee, an employee may still request to use a respirator voluntarily.
   2. Employees using respirators voluntarily will be provided with the information in Appendix D of 29 CFR 1910.134 (Appendix B of this RPP). If they are using a respirator other than a filtering

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

facepiece respirator, they will also be provided initial medical clearance and required to clean, store, and maintain the respirator as per the requirements of this RPP. Employees who choose to voluntarily use respirators should advise their supervisors of the need to be included in the applicable sections of the respirator program. If approved, the employees using a respirator other than a filtering facepiece respirator are required to attend annual training provided to those in the full respirator program, as 29 CFR 1910.134(k)(1)(v) requires training in the procedures for cleaning, maintenance, and storage of respirator. If employees voluntarily using respirators are aware of a change that warrants review of medical clearance or repeat fit testing, they should bring that to the attention of their supervisor.

V. Respiratory Medical Evaluation

A. Employees whose work activities require the use of respiratory protective equipment shall receive medical clearance prior to the use of a respirator and prior to being fit tested for a respirator. Employees voluntarily using respirators other than a filtering facepiece respirator will also be provided initial medical clearance.
B. Employees will complete the Respiratory Medical Evaluation (Appendix C) of this RPP.
   1) Employees will be permitted to fill out the questionnaire on company time
   2) To the extent feasible, the company will assist employees who are unable to read the questionnaire (by providing help in reading the questionnaire). When this is not possible, the employee will be sent directly to the physician for medical evaluation.
   3) Employees may speak directly with the physician or other licensed health care provider (PLHCP) if they have questions
C. The PLHCP will review completed questionnaires and make a medical determination as to whether the employee can wear a respirator safely.
   1) The PLHCP may make this determination based on the questionnaire alone but may also require a physical examination of the employee and any tests, consultations, or procedures the PLHCP deems are necessary.
   2) The PLHCP will provide a written recommendation on the questionnaire and return to Employee Health. This recommendation may clear the employee for all respirator use, or may specify restrictions or limitations on use, such as the type of respirator that may be worn, the duration that it may be worn, and the acceptable level of exertion while wearing the respirator.
   3) A copy of this written determination shall be provided by the PLHCP to the employee upon request.
   4) All examinations and questionnaires are to remain confidential between the employee, the provider, and the Employee Health department.
D. An additional medical evaluation may be required when:
   1) The employee reports medical signs or symptoms that are related to the ability to use a respirator, such as shortness of breath, dizziness, chest pains, or wheezing.
   2) A PLHCP, supervisor, or the RPA requests a re-evaluation.
   3) Observations made during fit testing or program evaluation indicate a need for re-evaluation (e.g., the employee experiences claustrophobia or difficulty breathing during the fit test).
   4) A change occurs in workplace conditions (e.g., physical work effort, protective clothing, or temperature) that may result in a substantial increase in the physiological burden placed on an employee wearing a respirator.

VI. Fit Testing

A. Fit testing is required for SPH employees who are required to wear any respirator with a tight-fitting facepiece. Employees voluntarily wearing respirator may also be fit tested upon request.
B. Applicable employees will be fit tested:
   1) Prior to being allowed to wear any respirator with a tight fitting facepiece
   2) Annually
   3) Whenever the employee experiences or the supervisor or RPA observes physical changes that could affect respirator fit. These changes include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.
C. Fit testing is not required for loose fitting respirators (i.e., PAPR with loose-fitting facepiece, a hood

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

or helmet that does not rely upon a tight-fitting facepiece-to-face seal). PAPR will be an option for those who are unable to pass a fit test with a tight-fitting facepiece respirator.

D. Employees will be fit tested with the make, model, and size respirator that they will actually wear. Employees will be provided with a variety of models/sizes of respirators so that they may find an optimal fit.
E. Employees who use tight-fitting respirators are not permitted to have facial hair that interferes with the facepiece seal or valve function.
F. Employees who wear corrective glasses or other PPE must wear these during their fit testing to ensure that it does not interfere with the facepiece seal.
G. The RPA has determined that QNFT is not required for the respirators used under current conditions at SPH. If conditions affecting respirator use change, the RPA will evaluate whether QNFT is required. QNFT and QLFT fit testing are done at South Peninsula Hospital with determination made by RPA.
H. The Program Administrator will oversee QNFT fit testing following the OSHA approved Ambient Aerosol Condensation Nuclei Counter (CNC) Quantitative Fit Testing Protocol of the Respiratory Protection standard (Appendix D1 of this RPP).
I. The RPA will oversee the fit testing following the OSHA approved Saccharin or Bitrex Solution Aerosol QLFT Protocol of the Respiratory Protection standard (Appendix D1 of this RPP).
J. All employees who must wear respiratory protection shall receive medical clearance before fit testing is performed or the respirator is worn (per "Medical Evaluation" section, above).

VII. Training

A. Annual respirator training will be provided for all employees covered by this program. Training shall be provided at the time of initial assignment to respirator use, but before actual use, and annually thereafter. The training will be overseen by the Program Administration and will include the following:
   1) The general requirements of the OSHA Respiratory Protection standard.
   2) The specific circumstances under which respirators are to be used.
   3) Respiratory hazards employees are potentially exposed to during routine and emergency situations.
   4) Why the respirator is necessary and how proper fit, usage, and maintenance can ensure the protective effect of the respirator as well as how improper fit, usage, or maintenance can compromise the protective effect of the respirator.
   5) The limitations and capabilities of the respirators that will be used.
   6) How to effectively use the respirators, including emergency situations and situations in which the respirator malfunctions.
   7) How to inspect, put on, remove, use, and check the seals of the respirator (for tight-fitting respirators such as N95 filtering facepiece respirators).
   8) The procedures for maintenance, storage, and cleaning or disposal of respirators. Employees who are issued PAPRs will be instructed in procedures for charging and maintaining the batteries, and for checking the air flow rate.
   9) How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.
   10) How and when to decontaminate (or safely dispose of) a respirator that has been contaminated with chemicals or hazardous/infectious biological materials.
B. Additional training will be provided when there is a change in the type of respiratory protection used, or when inadequacies in the employee's knowledge or use of the respirator indicate that he or she has not retained the requisite understanding or skill.
C. Employees will be given the opportunity during training, annual retraining, and throughout the year to provide feedback on the effectiveness of the program and suggestions for its improvement.

PROCEDURE:

A. General Use Procedures

1. Employees will use their respirators under conditions specified by this program, and in accordance with the training they receive on the use of each particular model. In addition, the respirator shall not be

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

used in a manner for which it is not certified by NIOSH or by its manufacturer. The appropriate types of respirators to be used and the exposure conditions are listed in the respirator selection chart in Appendix A of this RPP.

a) Employees and supervisors are expected to be diligent in observing practices pertaining to ensuring the safe use of respirators.
b) To ensure proper protection, the wearer will perform a user seal check, in accord with manufacturer's instructions and the training provided at the time of fit testing, each time he or she puts on a tight-fitting respirator.
c) Employees are not permitted to wear tight-fitting respirators if they have any condition, such as facial scars, facial hair, or missing dentures, that prevents them from achieving a good seal.
d) Employees are not permitted to wear headphones, jewelry, or other articles that may interfere with the facepiece-to-face seal.
e) If unsure of respirator needed, employees must discuss with supervisor before entering any suspected hazardous area.
f) Filters on reusable particulate respirators will be changed by the wearer according to manufacturer's recommendations and whenever it becomes difficult to breathe. Odor or taste may not be used as the primary basis for determining the useful life of a cartridge for gases or vapors
g) When filtering facepiece respirators are used, respirators should be discarded after each use or sooner if breathing becomes difficult or if the respirator is damaged, soiled, or contaminated. However, a FFR may be reused by the same user, under some circumstances, as long as the respirator has not been obviously soiled or damaged (Refer to Appendix F attachments PPE Color Coded Capacity Strategies & Extended Use and Limited Reuse off PPE for specific conditions in which FFR reuse may be acceptable).

B. Maintenance, Cleaning, and Storage of Respirators

1. Respirators are to be properly maintained at all times in order to ensure that they function properly and adequately protect the employee. Maintenance involves a thorough visual inspection for cleanliness and defects.
2. Biomed is responsible for charging and maintaining PAPR pumps, filters, and batteries when they are stored or not in use.
3. Worn or deteriorated parts will be replaced prior to use. No components will be replaced or repaired beyond those recommended by the manufacturer. Repairs to regulators or alarms of atmosphere-supplying respirators will be conducted by the manufacturer.
4. All respirators will be inspected by the user prior to each use. Inspections should include a check of:
   a) Facepiece:
      - Cracks, tears, or holes
      - Facemask distortion
      - Cracked or loose lenses/faceshield
   b) Headstraps:
      - Breaks or tears
      - Broken buckles
   c) Valves:
      - Residue or dirt
      - Cracks or tears in valve material
   d) Filters/Cartridges:
      - Approval designation
      - Gaskets
      - Cracks or dents in housing
      - Proper cartridge for hazard
   e) All rubber or plastic parts, for pliability and signs of deterioration
   f) PAPR connecting tubes or hoses, air flow, and batteries

C. Defective Respirators

1. Respirators that are defective or have defective parts shall be taken out of service immediately. If, during an inspection, an employee discovers a defect in a respirator, they are to bring the defect to the attention of their supervisor/manager and Biomed. Biomed will decide whether to:

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

a) Temporarily take the respirator out of service until it can be repaired
b) Perform a simple fix on the spot such as replacing a head strap
c) Dispose of the respirator due to an irreparable problem or defect.

2. When a respirator is taken out of service for an extended period of time, the respirator will be tagged out of service, and the employee will be given a replacement of similar make, model, and size.

D. Respirator Malfunction

1. Employees must leave the respirator use area:
   a) To adjust their respirator if the respirator is not fitting correctly or impeding their ability to work
   b) To wash their face if the respirator is causing discomfort or rash
   c) To change the respirator, filters, cartridges, or canister elements
   d) To inspect the respirator if it stops functioning as intended, such as detection of vapor or gas breakthrough, changes in breathing resistance or leakage of the facepiece (e.g., fogging of eyeglasses)

E. Cleaning and storage

1. Respirators must be stored in a clean, dry area, and in accordance with the manufacturer's recommendations in a manner to protect them from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, and damaging chemicals. Managers will instruct staff on appropriate cleaning and storage locations and will ensure an adequate supply of appropriate cleaning and disinfection material at the cleaning station.
2. Employees should contact their supervisor/manager with questions or for necessary supplies.
3. Each employee will clean and inspect the respirator in accordance with the provisions of this program.
4. Reusable respirators are to be regularly cleaned and disinfected at a suitable location after use. The following procedure is to be used when cleaning and disinfecting non-disposable respirators after termination of use:
   a) Disassemble respirator removing any filters, canisters, or cartridges.
   b) Wash the facepiece and associated parts in a mild detergent with warm water. Do not use organic solvents.
   c) Rise completely in clean warm water.
   d) Wipe the respirator with disinfectant wipes to kill germs.
   e) Air dry in a clean area.
   f) Reassemble the respirator and replace any defective parts.
   g) Place in a clean, dry plastic bag or other designated container in designated storage area.
   h) Reusable respirators used in fit testing and training will be cleaned and disinfected after each use. **NOTE:** Refer to Appendix F attachment PPE Color Coded Capacity Strategies for specific cleaning and storing conditions during times of reduced capacity.

F. Program Evaluation

1. The RPA will conduct a periodic evaluation of the RPP to ensure that all aspects of the program meet the requirements of the OSHA Respiratory Protection standard and that the RPP is being implemented effectively to protect employees from respiratory hazards. This evaluation will be done annually.
2. Program evaluation will include, but is not limited to:
   a) A review of the written program
   b) Completion of a program evaluation checklist in Appendix C of the Hospital Respiratory Protection Program Toolkit (Appendix G of this RPP).
   c) A review of feedback obtained from employees (to include respirator fit, selection, use, and maintenance issues) that will be collected during the annual training session.
3. The RPP will be revised as necessary, and records of revisions will be kept on file with the written program. Any procedural changes that are implemented as a result of program evaluation will be communicated to the employees and reinforced by their supervisors.

G. Recordkeeping

1. The RPA will ensure the records below are maintained as follows:
   a) Personnel medical records such as medical clearance to wear a respirator shall be retained by Employee Health as part of a confidential medical file
   b) Documentation of training and fit testing will be kept by Employee Health until the next training or fit test. A copy of this RPP and records of program evaluations and revisions shall be kept by the RPA and on the SPH SIS and made available to all affected employees, their representatives, and

representatives of OSHA upon request.

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. Appendix A – Respirator Assignments by Task or Location
2. Appendix B – Information for Voluntary Users
3. Appendix C – Respiratory Medical Evaluation
4. Appendix D1 – Fit Testing Procedures, General Requirements; Test Exercises; Testing Procedures, Saccharin Solution Aerosol Protocol; Fit Testing Procedures, Ambient Aerosol Condensation Nuclei Counter (CNC) Quantitative Fit Testing Protocol, Bitrex™ (Denatonium Benzoate) Solution Aerosol Qualitative Fit Test Protocol
5. Appendix D2 – Respirator Training, & Fit Test Checklist
6. Appendix D3 – Fit Test Card
7. Appendix E – User Seal Check Procedures
8. Appendix F – Related SPH PPE Documents
9. Appendix G - DHHS (NIOSH) Publication 2015-117, Hospital Respiratory Protection Toolkit

CONTRIBUTOR(S):
Employee Health RN; Infection Prevention RN; Facilities Manager

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

Formatted: Font: 8 pt

Formatted: Font: 8 pt, Bold

Formatted: Font: 8 pt

Appendix A - Respirator Assignments by Task or Location

Task or Location	Potential Exposure	Respiratory Protection	Employees Included
Performing, or present during aerosol-generating procedures or routine patient care and support operations on a patient suspected or confirmed with a disease requiring Airborne Precautions	Infectious aerosols	N95 respirator or PAPR	APRNs, Cardiopulmonary services techs, Clinical students, CNAs, CNMs, CRNAs, Environmental services staff, ER techs, Imaging techs, Lab techs, Maintenance staff, MAs, Mental health counselors, Nurse practitioners, Nurses (RN, LPN), Occupational therapists, PAs, PCTs, Pharmacists, Pharmacy techs, Phlebotomists, Physical therapists, Physical therapy assistants, Physicians (MD, DO), Radiology techs, Respiratory therapists, Security, Sleep technicians, Social workers, Speech language pathologists, Surgical techs
Cleaning/decontaminating an area occupied by a patient suspected or confirmed with a disease requiring Airborne Precautions, or cleaning/decontaminating such an area after a patient has left but before the space has been adequately ventilated	Infectious aerosols	N95 respirator or PAPR	APRNs, Cardiopulmonary services techs, Clinical students, CNAs, CNMs, CRNAs, Environmental services staff, ER techs, Imaging techs, Lab techs, Maintenance staff, MAs, Mental health counselors, Nurse practitioners, Nurses (RN, LPN), Occupational therapists, PAs, PCTs, Pharmacists, Pharmacy techs, Phlebotomists, Physical therapists, Physical therapy assistants, Physicians (MD, DO), Radiology techs, Respiratory therapists, Security, Sleep technicians,

			Social workers, Speech language pathologists, Surgical techs
Laboratory operations involving aerosol transmissible disease pathogens	Infectious aerosols	Prepared in biological safety cabinet Level 2 laboratory hood	Clinical laboratory scientists, laboratory assistants
Hazardous medication preparation by Pharmacy	Hazardous medication aerosols	Prepared in negative pressure biological safety cabinet	Pharmacists, Pharmacy Techs
Hazardous medication (i.e. chemotherapy) spill per USP 800 Pharmacy Binder	Hazardous medication aerosols	PAPR	Pharmacists, Pharmacy Techs, Environmental Services Techs, Nurses
Cutting or sanding wood (work shop)	Dust or particles	N95 dust respirator (fit testing not necessary)	Lead Carpenter, Facilities Engineers
Chemical use (boiler room)	Hazardous chemical vapor	Half face respirator with 6001 chemical/multi-gas cartridge (cartridge changed per manufacturers' recommendation)	Facilities staff
Aerosolized paint/vapor (metal frames and doors)(work shop)	Paint particles & vapor	Half face respirator with 6001 chemical/multi-gas cartridge (cartridge changed per manufacturers' recommendation)	Facilities staff
Dust particles; Zeolite bead dust (oxygen generation room)	Dust particles	N95 dust respirator (fit testing not necessary)	Facilities staff

~~Task or Location~~	~~Potential Exposure~~	~~Respiratory Protection~~	~~Employees Included~~

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt
Formatted Table

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

Performing or present for aerosol-generating procedures on patients suspected or confirmed with a disease requiring Airborne Precautions or present when such procedures are performed, including but not limited to: **Sputum induction** **Cardiopulmonary resuscitation** **Open suctioning of airways** **Endotracheal intubation and extubation** **Non-invasive ventilation (e.g., BiPAP, CPAP)** **Manual ventilation** **EGD** **Bronchoscopy** **Aerosolized administration of medications** **Pulmonary function testing** **High flow O2 delivery**	Infectious aerosols	N95 respirator or PAPR	**Physicians, CRNAs, PAs, ARNPs, CNMs, Respiratory Therapists, Nurses, CNAs, MAs, PCTs, ER Techs, Lab Techs, Phlebotomists, Surgical Techs, Social Workers, Registration Staff, Security, Maintenance & Facilities Staff, Covid Care Assistants, Pharmacists, Pharmacy Techs, Sleep Technicians, Physical Therapists, Physical Therapy Assistants, Speech Language Pathologists, Occupational Therapists, Environmental Services Techs, Clinical Students; Radiology Techs**
Performing or present during aerosol-generating procedures on patients suspected or confirmed with influenza or COVID-19	Infectious aerosols	N95 respirator or PAPR	**Physicians, CRNAs, PAs, ARNPs, CNMs, Respiratory Therapists, Nurses, CNAs, MAs, PCTs, ER Techs, Lab Techs, Phlebotomists, Surgical Techs, Social Workers, Registration Staff, Security, Maintenance & Facilities Staff, Covid Care Assistants, Pharmacists, Pharmacy Techs, Sleep Technicians, Physical Therapists, Physical Therapy**

Formatted: Font: 8 pt

Formatted: Font: 8 pt, Bold

Formatted: Font: 8 pt

			Assistants, Speech Language Pathologists, Occupational Therapists, Environmental Services Techs, Clinical Students
Entry into airborne infection isolation room or other area occupied by patients suspected or confirmed with a disease requiring Airborne Precautions.	Infectious aerosols	N95 respirator or PAPR	Physicians, CRNAs, PAs, ARNPs, CNMs, Respiratory Therapists, Nurses, CNAs, MAs, PCTs, ER Techs, Lab Techs, Phlebotomists, Surgical Techs, Social Workers, Registration Staff, Security, Maintenance & Facilities Staff, Covid Care Assistants, Pharmacists, Pharmacy Techs, Sleep Technicians, Physical Therapists, Physical Therapy Assistants, Speech Language Pathologists, Occupational Therapists, Environmental Services Techs, Clinical Students
Performing, or present during, routine patient care and support operations on a patient suspected or confirmed with a disease requiring Airborne Precautions.	Infectious aerosols	N95 respirator or PAPR	Physicians, CRNAs, PAs, ARNPs, CNMs, Respiratory Therapists, Nurses, CNAs, MAs, PCTs, ER Techs, Lab Techs, Phlebotomists, Surgical Techs, Social Workers, Registration Staff, Security, Maintenance & Facilities Staff,

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

			Covid Care Assistants, Pharmacists, Pharmacy Techs, Sleep Technicians, Physical Therapists, Physical Therapy Assistants, Speech Language Pathologists, Occupational Therapists, Environmental Services Techs, Clinical Students
Cleaning/decontaminating an area occupied by a patient suspected or confirmed with a disease requiring Airborne Precautions, or cleaning/decontaminating such an area after a patient has left but before the space has been adequately ventilated.	Infectious aerosols	N95 respirator or PAPR	Physicians, CRNAs, PAs, ARNPs, CNMs, Respiratory Therapists, Nurses, CNAs, MAs, PCTs, ER Techs, Lab Techs, Phlebotomists, Surgical Techs, Social Workers, Registration Staff, Security, Maintenance & Facilities Staff, Covid Care Assistants, Pharmacists, Pharmacy Techs, Sleep Technicians, Physical Therapists, Physical Therapy Assistants, Speech Language Pathologists, Occupational Therapists, Environmental Services Techs, Clinical Students
Laboratory operations involving aerosol transmissible disease pathogens. Resource: HCPro Lab Manual *COMPLETE GUIDE TO LABORATORY SAFETY*	Infectious aerosols	Prepared in biological safety cabinet Level 2 laboratory hood	Lab Techs

Formatted: Font: 8 pt

Formatted: Font: 8 pt, Bold

Formatted: Font: 8 pt

~~Hazardous medication preparation by Pharmacy~~	~~Hazardous medication aerosols~~	~~Prepared in negative pressure biological safety cabinet~~	~~**Pharmacists, Pharmacy Techs**~~
~~Hazardous medication (i.e. chemotherapy) spill per USP 800 Pharmacy Binder~~	~~Hazardous medication aerosols~~	~~PAPR~~	~~**Pharmacists, Pharmacy Techs, Environmental Services Techs, Nurses**~~
~~Cutting or sanding wood (work shop)~~	~~Dust particles~~	~~N95 dust respirator (fit testing not necessary)~~	~~Lead Carpenter, Facilities Engineers~~
~~Chemical use (boiler room)~~	~~Hazardous chemical vapor~~	~~Half face respirator with 6001 chemical/multi-gas cartridge (cartridge changed per manufacturers' recommendation)~~	~~Facilities Engineers 1,2,3,4~~
~~Aerosolized paint/vapor (metal frames and doors)(work shop)~~	~~Paint particles & vapor~~	~~Half face respirator with 6001 chemical/multi-gas cartridge (cartridge changed per manufacturers' recommendation)~~	~~Lead Carpenter and Facilities Engineer 1,2,3,4~~
~~Dust particles; Zeolite bead dust (oxygen generation room)~~	~~Dust particles~~	~~N95 dust respirator (fit testing not necessary)~~	~~Facilities Engineers 1,2,3,4~~

Appendix B – Information for Voluntary Use

Information for Employees Using Respirators When Not Required Under Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept

clean, the respirator itself can become a hazard to the workers.

Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1. Read and head all instructions provided by the manufacturer on use, maintenance, cleaning & care, and warnings regarding the respirator's limitations.
2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the US Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designed to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors, or very small solid particles of fumes or smoke.
4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

Formatted: Font: 8 pt
Formatted: Font: 8 pt, Bold
Formatted: Font: 8 pt

Formatted: Font: 8 pt

Formatted: Font: 8 pt, Bold

Formatted: Font: 8 pt

Appendix C - Respiratory Medical Clearance Evaluation

Appendix D1 – Fit Testing Procedures, General Requirements; Test Exercises; Testing Procedures, Saccharin Solution Aerosol Protocol; Fit Testing Procedures, Ambient Aerosol Condensation Nuclei Counter (CNC) Quantitative Fit Testing Protocol, **Bitrex™ (Denatonium Benzoate) Solution Aerosol Qualitative Fit Test Protocol**

Appendix D2 – Respirator Training, & Fit Test Checklist

Appendix D3 – Fit Test Card

Appendix E – User Seal Check Procedures

Appendix F – PPE Color Coded Capacity Strategies

Appendix G - DHHS (NIOSH) Publication 2015-117, Hospital Respiratory Protection Toolkit

I. Table of Contents

II. Missions, Vision, Values: 1
III. Goals and Objectives 2
IV. Responsibilities: 2
A. Governing Body: 2
B. Administration: 2
C. Medical Staff: 2
D. Physician Review: 2
E. Finance: 3
F. Utilization Management Nurse: 3
G. Utilization Management (UM) Committee: 4
V. Evaluation of the Utilization Management Program: 6
VI. Approval of the Plan. 7

PURPOSE:
Program components and outline for the South Peninsula Hospital (SPH) Utilization Management Plan in accordance with federal, state, and local regulatory guidelines and requirements.

DEFINITION(S):
N/A

POLICY:

II. Missions, Vision, Values:

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

Mission: *SPH promotes 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 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.*

III. Goals and Objectives

The Utilization Management Plan (UMP) supports the Mission and Vision of SPH by identifying processes which provide the hospital with strategies, systems, and methodologies required to monitor and optimize the use of resources in the provision of patient care.

A. The goal of the UMP is to assure both quality patient care and effective/efficient utilization of the healthcare facility and services offered throughout the continuum of care. The UMP applies to all patients, regardless of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, gender identity, and sex characteristics), or payment source. The core functions of the UMP are as follows:
   - Case Management
   - Utilization Management
   - Discharge Planning
   - Evaluation of compliance with federal and state rules and regulations

B. Cooperation between Administration, the Medical Staff, and third party payers ensures that these goals are achieved. The UMP outlines continued efforts on the part of the Utilization Management (UM) Committee to inform and update Medical Staff and Administration on the emerging regulations and requirements for insurers, and the hospital's clinical and quality outcome experience.

C. The objective of the UMP is to:
   1. Assess the efficiency of the healthcare process, including but not limited to:
      a) The appropriateness of decision-making related to the site of care
      b) Frequency and duration as per established guidelines
      c) Timely review of the appropriateness of admissions and services ordered and provided
      d) Review of the length of stay, particularly as it applies to Critical Access Hospitals
   2. Assess discharge practices.
   3. Establish guidelines for medical record documentation with specific attention to federal guidelines and other sources of standards, and periodically review medical records to assess compliance with the guidelines.
   4. Systematically review hospital compliance with core measures and facilitate improving compliance with nationally recognized core measures and review any other internal or external UM or Quality Improvement (QI) data which could impact the financial health of the hospital.
   5. Review all Observation admissions for compliance with accepted criteria, and specially identify and report Observation admissions which would be more appropriately Acute Care admissions (Inpatient Status).
   6. Review all Inpatient admissions which are retrospectively changed to Observation status (condition code 44).
   7. Review all Swing Bed, current and potential.

IV. Responsibilities:

A. Governing Body:
   The Board of Directors, as the governing body, delegates the Medical Staff as the authority to evaluate the appropriateness of care and use of hospital medical resources. The Governing Body monitors the program through reports brought to the Board of Directors Quality Committee.

B. Administration:
   Administration ensures that the Medical Staff is provided with the administrative and technical assistance to conduct the UM program.

C. Medical Staff:
   The Medical Staff has the overall authority and responsibility for quality and appropriateness of medical services provided. The Medical Staff monitors the program through reports from the physician member of the UM Committee.

D. Physician Review:
   The UMP will maintain two Physician Reviewers. The Physician Reviewers are physician members of the Medical Staff and UM Committee. These physicians are responsible for the review of all

cases referred by the UM Nurse, making appropriate determination regarding the medical necessity for the patient's need for the specified level of care based on clinical judgement, and on screening criteria. In addition, the Physician Reviewer(s) serve as liaison between the UM Committee and the Medical Executive Committee (MEC). In cases where there is disagreement regarding the UM Nurse recommendations having to do with admission status, length of stay, levels of care, intensity of service criteria, severity of illness criteria, and/or discharge recommendations, the following dispute resolution process will be followed.

1. The Physician Reviewer is notified concurrently by the UM Nurse or other UM staff and will review the information within one business day. If the Physician Reviewer is unavailable, then the Chief of Staff will conduct the concurrent review as the second UM physician reviewer.
2. The Physician Reviewer will then discuss his or her recommendations with the Attending Physician. If there is ongoing disagreement between the Physician Reviewer, and Attending Physician, then the Physician Reviewer will be required to obtain an opinion from another member of the Medical Staff; the decision of the Physician Reviewer and the other Medical Staff member will make the final determination and will communicate this determination to the UM Nurse and Administration.
3. A report of the case where there is ongoing disagreement will be sent to the MEC for review.

E. Finance:

The Finance Division ensures that revenue is being obtained by the hospital and that all appropriate avenues to obtaining revenue are being achieved. The Finance Division staff is responsible for collaborating with the UM Nurse and other staff as appropriate to identify areas of improvement for cost efficiency, both in providing services and in obtaining payment for those services. This division will collect and analyze statistical data to assist the UM Committee in review processes.

F. Utilization Management Nurse:

The UM Nurse is obligated to administer the UM Plan, and to facilitate the ongoing activities of the Committee. The UM Nurse is responsible for the collaborative discharge planning with appropriate Medical Staff and ~~Social Services~~Case Management:

1. Prospective Review coordination
2. Admission Review, to be performed within one business day following admission. Exception would be admissions on weekends or holidays
3. Continued Stay Review, to be performed concurrently.
4. The following are specific criteria which mandate a concurrent UM review by the UM Physician Reviewer(s):
   a) Disagreement between Medical Staff Attending Physician and the Nurse Reviewer with respect to Discharge Recommendations, Admission vs. Observation status, and transfer to Swing Bed status.
   b) Physician failure to comply with Observation time limitations
   c) Patients who do not meet Standardized Severity of Illness and/or Intensity of Service criteria for admission or continued stay in the hospital
5. Maintain all Committee meeting minutes and records
6. Performance of other duties as delegated by the UM Committee
7. Prepare reports for MEC, other committee reporting, and Board (through the Board of Directors Quality Committee); The reports shall occur quarterly, and should contain at a minimum, the following:
   a) Average Acute Care (Inpatient) Length of Stay (LOS)
   b) Average Observation, Inpatient, and Swing Bed Census
   c) Length of Stay Outliers (both Observation and Inpatient)
   d) Compliance with Documentation Guidelines, if measured
   e) Review and analysis of national reports such as the Medicare Hospital Compare Reports.
8. Request for provider team meeting for patients with the following:
   a) Complex medical issues/diagnosis
   b) Re-admissions
   c) Admissions of seven days or more

G. Utilization Management (UM) Committee:
1. The UM Committee works to fulfill the purpose, goals and objectives of the UM Plan. The Committee is a multidisciplinary team The UM Committee meets quarterly. The UM Committee shall maintain a record of its proceedings and shall report on its activities and recommendations at the Medical Staff meetings. The Committee forwards issues where opportunities for improvement have been identified to the Quality Improvement Committee, when appropriate.
2. Committee Records: The UM Committee maintains written records of all its activities. The proceedings of the Committee, its subcommittees and its derivative documents and minutes are confidential. Members of the committee have a duty to preserve this confidentiality. Minutes of each committee meeting, including a list of attendees, shall be documented and will include:
   a) A summary of admissions/discharges
   b) Reports of re-admissions, transfers, and extended stays
   c) Cases discussed (identified by medical record number)
   d) Committee action/recommendations
   e) Copies of notification letters sent to physicians and responses
   f) Record of cases indicated as reviewed concurrently
   g) A summary of denials/appeals in progress
   h) Insurance concerns/denials
   i) Focused reviews, including subject studies, the reasons for the study, the date the study was started, the date the study was completed, as well as the follow-up recommendations made from previous studies that have been implemented.
4. Upon request, a copy of the approved and signed UM Committee meeting minutes will be sent to the Chief of Staff for review. All records and minutes from the UM Committee will be maintained by the UM Nurse.
3. Conflict Of Interest: Physicians or staff may participate in the review of cases in which they have been or anticipate being professionally involved. Physicians or staff having either a direct or indirect financial interest in the case(s) being reviewed may not make the final decision in such cases. In these cases, the final review will be delegated to another appropriate and qualified physician or staff member.
4. Confidentiality: All employees and physicians involved in any component of the review system will be made aware of their responsibility to follow the confidentiality guidelines. All medical information that is related to and identifies specific individual patients and certain data related to practitioners and health care institutions is strictly confidential and shall not be made known or accessible to the public nor to any governmental unit, agency, or department without proper release of information documentation, with the exception of that information required to meet the Medicare Conditions of Participation. To ensure confidentiality, patient references will be only as a medical record number and physician references will be only as an assigned code number.
5. Review Criteria: Criteria, established by the UM Committee and approved by the Medical Staff for use by non-physician personnel, is used in screening utilization. The review criteria will be reviewed for appropriateness on a regular basis and revised as necessary. The guidelines currently utilized by SPH are the most recent Screening Criteria for Severity of Illness and Intensity of Service (SI/IS), published by InterQual, and recommended by 1) ~~Mountain Pacific Quality Health Foundation~~Acentra Health 2) QualisHealth for review of patients covered by Medicare & Medicaid.
6. Review Activity: The review process focuses on five (5) primary areas of activity: prospective review, admission review, concurrent review, retrospective review and patient care evaluation studies. The review process may also include other areas of activity, as appropriate.
   a) Prospective Review/Pre-admission Review: The prospective review function is coordinated by the UM Nurse and includes Registration, Patient Accounting, and the admitting physician. Problems identified are resolved through the UM process. Appropriate steps shall be taken to ensure that patient well-being will not be compromised as the result of financial considerations.

b) Admission Review: Admission review is performed on all patients using an approved screening tool. Additional in-depth review will be performed as required by third party payers and external professional review organizations. Inpatient records will be reviewed for compliance with the SI/IS criteria. Admission Review focuses on the medical necessity for admission and continued hospital stay for all patients. The source of payment must not be the sole determinant in identifying patients for concurrent review.
   1) The UM Nurse conducts an admission review within one working day of admission. The Attending Physician is responsible for providing documented information for admission within 24 hours of admission. This will include, but is not limited to, the admitting diagnosis, presenting signs and symptoms, and the physician's specific plan of care (treatment plan). The UM Nurse will gather information from the patient's medical record, compare the findings with the SI/IS criteria and record the results on a UM worksheet. If the admission meets criteria and is considered appropriate, the UM nurse will certify the admission and assign a continued stay review date based on the principle diagnosis and current plan of treatment.
   2) Hospital admissions are reviewed ~~either prior to or~~ within one working day of admission for purposes of determining which cases require pre-admission certification or notification. The required information is obtained and reported to the appropriate external review agencies and third-party payers. Any authorization numbers assigned are also reported to the Patient Accounting office.
   3) If the UM Nurse is unable to determine the need for admission, based on criteria, that same day the Attending Physician will be contacted for further information/documentation. Should this result in inability to determine that the patient meets admission criteria, the case will be referred to the Physician Reviewer, following the process outlined under § III. RESPONSIBILITIES, A-C.

c) Concurrent/Continued Stay Review: The concurrent or continued stay review is based on the patient's principal diagnosis, severity of illness, intensity of service, and/or other criteria established by the UM Committee. The same procedure will be used for continued and concurrent stay as the Admission Review. If a case meets criteria for continued stay, the UM Nurse will certify continued stay.
   1) If on the days under review, the UM Nurse cannot find adequate documentation to explain the need for continued stay at the specified level of care, he/she will approach the Attending Physician for the needed information or documentation. Justification for continued stay is based on the Attending Physician's documentation in the medical record.
   2) Cases that do not meet the criteria for continued stay after consultation and review with the Attending Physician will be referred to a Physician Reviewer, following the process outlined under § III. RESPONSIBILITIES, A-C. If this process determines that the case does not meet criteria for continued stay, the UM Nurse, after consultation with Administration, will then initiate ~~an Advanced Beneficiary Notice (ABN) letter~~ the HINN 12 to be sent to the patient and/or family indicating the fact that the insurance may be discontinued for the remaining days of the hospital stay, and that the patient or guardian may be responsible for payment. Copies of the letter will be sent to the patient's medical record/EHR, and the Patient Accounting Office ~~and the UM Nurse's file~~. Attending physician will be notified.

d) Discharge Planning: Discharge Planning is an integral part of Utilization Management and shall be initiated early after admission to facilitate timely discharge. Discharge planning does not require a physician order. Discharge planning is a component of the combined duties of the UM Nurse, Social Services, and Nursing Staff. The hospital's discharge planning activities shall include placement in alternative care facilities, and arrangement for appropriate community resources to improve or maintain the patient's health status on an outpatient basis. The patient's family and Attending Physician must be involved in the

discharge planning process. Discharge planning interventions must be documented in the medical record.

1) There are occasions when the Attending Physician has written an order for discharge and the UM Nurse may identify that there is a delay in discharge due to lack of family (or patient) cooperation and decision-making or lack of family (or patient) resources. The UM Nurse will then initiate ~~a HABN letter~~ the HINN 12 to be sent to the patient and/or family indicating the fact that the insurance may be discontinued for the remaining days of the hospital stay after the specified discharge date and that the patient or guardian may be responsible for payment. Copies of the letter will be sent to the patient's medical record/EHR, and the Patient Accounting Office ~~and the UM Nurse's file~~. The attending physician will be notified.

e) Retrospective Review: Retrospective review will be performed in the following circumstances:

1) To address cases of under- or over-utilization
2) When third party payers question or deny care
3) When required by third-party payer; and
4) Focused review for known or suspected specific problems

- The UM Committee initiates focused reviews of records and approves the sampling methods. Focused review will apply to all patients in the selected category regardless of payment source.
- Focused reviews may be required based on data and trends related to diagnosis, procedures, admission, length of stay, ancillary services furnished, Observation status, Inpatient status, Swing Bed admissions, delay of services, and all professional services performed on the hospital premises with respect to the medical necessity for these services. Cases denied for payment by third party payers are also included.
- The UM Committee identifies cases that are associated with unusually high costs or excessive services or identify classes of admissions wherein patterns of care are found to be questionable.
- If analysis indicates inappropriate use of hospital resources, corrective action should be specific to the problem and may include a variety of problem-solving techniques, including, but not limited to, concurrent review, educational or training programs, amended policies or procedures, etc. Questions that deal with appropriateness and quality of the professional services rendered will be referred to the MEC. The MEC will, in turn, study, analyze and act upon its findings. A report of the results of such studies will be sent to the UM Committee.

7. Quality Improvement: The Quality Department may, as appropriate, refer problems to the UM Committee in order for the UM Committee to conduct reviews of appropriateness and medical necessity upon admission, continued stays, and supportive services, delays in provision of supportive services, and the provision of discharge planning. The UM Committee may, as appropriate, refer those issues that are relevant to the quality of care provided to the Quality Department for their input, recommendations, or suggested referrals.
8. Discipline: The UM Committee is not a disciplinary committee. Any perceived problems with Medical Staff members will be forwarded to the MEC by the Physician Reviewer(s) for consideration. Medical Staff members who frequently experience utilization review denials may be subjected to pre-admission monitoring or other restrictions that the Medical Staff deems necessary to correct the utilization-related problem(s).

V. Evaluation of the Utilization Management Program:

The SPH UM Plan is reviewed ~~every three years~~yearly and updated or modified as necessary, based upon the ongoing evaluation of the utilization review activities and their relationship to the quality of patient care. A summary of findings and specific recommendations resulting from the UM Program are reported to the MEC.

VI. Approval of the Plan.
The UM Plan will be reviewed, evaluated, and approved by the MEC and Board of Directors, and constitutes the official plan for performance and utilization review of this hospital's services.

CONTRIBUTOR(S):
Acute Care Nursing Director; Acute Care Medical Director; Social Services; Utilization Management; Chief Nursing Officer; Chief Medical Officer

APPENDIX A


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

South Peninsula Hospital	**SUBJECT:** Capital Purchases	**POLICY #:** F-09 **Page 1** of **2**
Scope: Finance **Approved by:** Board of Directors		**Original Date:** 10/22/03 **Effective:** 9/25/24
Revised: 4/07; 12/07; 6/08; 8/08; 9/14; 9/15; 6/17; 2/20; 6/28/23; 9/25/24 **Reviewed:** 1/25/23; 1/24/24		**Revision Responsibility:** Board of Directors

PURPOSE:
Guidelines for the management of capital purchase requests.

DEFINITION(S):
N/A

POLICY:
A. South Peninsula Hospital (SPH) purchases will be made with the commitment to being a good steward of resources.
B. Purchases will comply in all respects with the Kenai Peninsula Borough (KPB) Purchasing Code as specified in the Operating Agreement, including, but not limited to, applicable requirements for competitive bidding and nondiscrimination.
C. Capital equipment purchases or construction projects in excess of the financial threshold requiring a Certificate of Need (CON) will not be approved by the Board until a CON is obtained.

PROCEDURE:
A. Approval Levels
1. Board or Borough approval of purchases is required as follows:

Approver	SPH Operating Cash Funds	Plant Replacement/Service Area Funds
CEO	<=$200,000	
BOD	>$200,000 <$499,999	
BOD & SAB & KPB	>$500,000	>$5,000

2. Purchases will be made through the hospital's approved Group Purchasing Organizations (GPO) to the maximum extent possible. When used, GPO contact numbers will be noted on purchasing requisitions. When the GPO is not used, documentation of compliance with the KPB Purchasing Code will be provided.

B. Capital Purchase Items
1. Capital purchases are defined as individual items which are greater than or equal to $5,000 and with a useful life greater than 1 year.
2. Requisitions for capital items which require KPB funding and are not on the KPB approved list must be accompanied by written authorization citing KPB approval.
3. Additionally, the CFO or CEO must approve the requisition before it is submitted to the SPH Purchasing Department.
4. All items on the KPB-approved capital list will be acquired by the SPH Purchasing Department except for specific construction projects or construction-related expenses. Purchases related to construction projects will be coordinated by the Support Services Division working with the KPB Public Works Department.
5. Approval Guidelines for items not available through GPO:
   a) Purchases below $5,000 do not require bids; however, bids may be obtained whenever it is advantageous to SPH.
   b) Purchases between $5,000 and $40,000 require informal bids.
   c) Purchases projected to be in excess of $40,000 require formal bids and should have specifications drawn and appropriate advertising done.
6. SPH will budget for operational and capital expenses through the annual budget process except for those items that may become necessary to purchase during the year to facilitate patient safety, cost savings, or to meet a need that would be unnecessarily delayed by the budget process. Unbudgeted capital expenditures may be made from operating funds in accordance with the provisions of the

Operating Agreement and the Borough Purchasing Code for budgeted capital.

7. All unbudgeted capital expenditures from KPB funds will require KPB approval. Substitutions for items on the approved budget may not be made without KPB approval. Substitutions for line-item appropriations on the approved capital budget require Borough Assembly action for reappropriation.

C. Capital Leases and Property Leases
1. Capital equipment leases in excess of one year and $200,000 will require Board of Directors approval.
2. Real property leases intended for use as Medical facilities, and which are greater than $100,000 annually, will require approval by the SPH Board and the KPB.
   a) Medical Facilities leases (in total) may not exceed the annual cap (currently $~~650~~800,000) without first approving an amendment to the SPH Operating Agreement
3. Employee housing and Administrative ~~office~~ spaces leases will require CEO approval up to $200,000 annually (when unbudgeted), and SPH Board of Directors approval in excess of $200,000 annually (when unbudgeted).

D. Disposal of Capital
Disposal of Capital items acquired with KPB funding will be made in accordance with the Borough Code requirements for disposal of surplus property.

E. Proprietary Procurement (Sole Source)
Contracts for supplies, services, professional services or construction may be awarded by the Director of Material Management without competition under the following conditions:
1. Where it is determined by the Director of Material Management that SPH's requirements reasonably limit the procurement to a sole source. The determination will be based on a written justification provided by the requesting Manager or Director and;
2. Where it is determined by the CEO that it is in the best interest of the SPH to standardize the procurement in order to maintain compatibility with existing SPH requirements.
3. Purchases without competition costing more than $100,000 must first be approved by the BOD by resolution.

ADDITIONAL CONSIDERATION(S):
N/A

REFERENCE(S):
1. South Peninsula Hospital Board Resolution 2023-20 – 6/28/23
2. South Peninsula Hospital Values & Behaviors as adopted by the Board of Directors
3. Operating Agreement Kenai Peninsula Borough and South Peninsula Hospital, 2020
4. Alaska Statutes 18.07.021 and 18.07.111
5. Alaska Regulation 7 AAC 07
6. Hospital policy HW-092 Purchasing Authority

CONTRIBUTOR(S):
Chief Financial Officer; Board Finance Committee

Introduced by: Administration
Date:
Action:
Vote: Yes-; No-; Exc.

SOUTH PENINSULA HOSPITAL
BOARD RESOLUTION
2026-21

A RESOLUTION OF THE SOUTH PENINSULA HOSPITAL BOARD OF DIRECTORS REQUESTING THAT THE KENAI PENINSULA BOROUGH MOVE FORWARD FUNDING FOR THE PHARMACY EXPANSION AND INFUSION RELOCATION CERTIFICATE OF NEED PROJECT

WHEREAS, South Peninsula Hospital, Inc. ("SPH") operates healthcare facilities within the South Kenai Peninsula Hospital Service Area pursuant to an Operating Agreement with the Kenai Peninsula Borough ("KPB"); and

WHEREAS, SPH has obtained a Certificate of Need and developed plans for the Pharmacy Expansion and Infusion Relocation Project to improve access to healthcare services and support the long-term healthcare needs of the community; and

WHEREAS, the total project budget for the Pharmacy Expansion and Infusion Relocation Project is $6,774,787; and

WHEREAS, approximately $940,000 in previously authorized Service Area capital funding has been identified and remains available for the project; and

WHEREAS, the Board has evaluated multiple funding alternatives, including Rural Health Transformation Program opportunities, Congressionally Directed Spending requests ($2 million currently pending), grants, appropriations, and other funding sources, but such funding is uncertain as to amount and timing; and

WHEREAS, dedicating $1,500,000 of property tax revenues allocated for capital projects in the Kenai Peninsula Borough Fiscal Year 2028 Capital Budget toward the Pharmacy Expansion and Infusion Relocation Project would reduce the required use of Plant Replacement and Expansion Fund (PREF) reserves, preserve resources for future healthcare infrastructure needs, and maintain the financial feasibility of the project; and

WHEREAS, the Board believes it is prudent to preserve a portion of the Plant Replacement and Expansion Fund for future healthcare infrastructure and capital replacement needs while also advancing this critical project; and

WHEREAS, the Board's preferred funding option would propose utilizing up to $4,263,697 of Plant Replacement and Expansion funds, thereby preserving approximately $400,000 of PREF reserves for future capital needs; and

WHEREAS, the Board wishes to provide the Kenai Peninsula Borough Assembly with two alternative funding options for consideration to complete the Pharmacy Expansion and Infusion Relocation Project.

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

Section 1. Preferred Funding Option

The Board requests that the Kenai Peninsula Borough consider as its preferred funding option the use of existing available Service Area and Borough capital resources to complete the Pharmacy Expansion and Infusion Relocation Project, specifically:

A. $940,000 of previously obligated Service Area capital funds identified in Exhibit A;

B. Up to $4,300,000 from the PREF, with the final amount to be reduced by any grant awards, appropriations, or other external funding secured for the project;

C. $1,500,000 from Kenai Peninsula Borough property tax revenues allocated for capital projects in the Borough's Fiscal Year 2028 Capital Budget; and

D. Continued pursuit of Rural Health Transformation Program funding, Congressionally Directed Spending opportunities, grants, appropriations, and other external funding opportunities that may reduce the amount of local funding ultimately required.

The Board finds that this funding option represents the most fiscally responsible approach currently available because it utilizes existing Service Area resources, available reserve funding, and future Borough capital allocations while minimizing long-term financing costs, preserving a portion of PREF reserves for future healthcare infrastructure needs, and preserving the existing Certificate of Need approval.

Section 2. Alternative General Obligation Bond Funding Option

As an alternative to the funding option described in Section 1, the Board requests and supports the enactment of a Kenai Peninsula Borough ordinance providing for submission to the qualified voters of the South Kenai Peninsula Hospital Service Area the question of the issuance of General Obligation Bonds for the purpose of financing costs associated with the Pharmacy Expansion and Infusion Relocation Project, including planning, design, construction, equipment acquisition, and related project expenses.

Should the Borough determine that preservation of Property Replacement and Expansion Fund reserves or other financial considerations warrant an alternative funding approach, the Board requests consideration of General Obligation Bond financing in an amount sufficient to fund the remaining project costs.

The Board recognizes that General Obligation Bond financing would provide voters within the South Kenai Peninsula Hospital Service Area the opportunity to determine whether they wish to support the project's financing through bonded indebtedness.

Section 3. External Funding Efforts

Hospital Administration shall continue pursuing Rural Health Transformation Program funding, Congressionally Directed Spending opportunities, grants, appropriations, and other available external funding sources to offset project costs and reduce the use of local funding resources.

Section 4. Preservation of Certificate of Need

Hospital Administration is authorized to take all actions necessary to preserve the existing Certificate of Need approval and advance the Pharmacy Expansion and Infusion Relocation Project.

Section 5. Recommendation and Forwarding

The South Peninsula Hospital Board of Directors recommends the funding approach described in Section 1 as its preferred option and respectfully submits the General Obligation Bond alternative described in Section 2 for Borough consideration.

The Chief Executive Officer is directed to provide a copy of this Resolution to the Kenai Peninsula Borough Mayor, the Kenai Peninsula Borough Assembly, and other appropriate Borough officials for consideration.

PASSED AND ADOPTED BY THE BOARD OF DIRECTORS OF SOUTH PENINSULA AT ITS MEETING HELD ON THIS 28th DAY OF OCTOBER, 2026.

ATTEST:

_____
Aaron Weisser, Board President

_____
Mary E. Wythe, Board Secretary

South Peninsula Hospital

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

MEMO

To: SPH Board of Directors

From: Ivy Stuart, RN, Home Health Director

Date: October 23, 2026

Re: Home Health Professional Advisory Committee (PAC) Membership

---

Home Health is requesting approval to appoint two additional members, Bryan Harter, OT, and Tallee Boyd, Quality/Intake RN, to the Professional Advisory Committee (PAC) for South Peninsula Hospital's Home Health, to expand interdisciplinary representation and support the PAC's advisory role in quality assurance and performance improvement.

Upon Board approval, the PAC membership roster in the 2026 QAPI Plan shall be amended to include the following members:

Member	Role	Appointment Status
Ivy Stuart	Administrator/Director	Previously appointed
Marissa Frank	RN	Previously appointed
Dr. Christy Martinez	MD	Previously appointed
Mary Fries	Community Member	Previously appointed
Marilyn Shroyer	Community Member	Previously appointed
Emily Munns	Care Coordinator	Previously appointed
Bryan Harter	*OT*	*Proposed appointment*
Tallee Boyd	*Quality/Intake RN*	*Proposed appointment*

All other provisions of the 2026 QAPI Plan remain unchanged. This change will take effect upon approval by the Board of Directors.

South Peninsula Hospital

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

MEMO

To: SPH Board of Directors

From: Ivy Stuart, RN, Home Health Director

Date: October 23, 2026

Re: Home Health Professional Advisory Committee (PAC) Membership

---

Home Health is requesting approval to add timely submission of Outcome and Assessment Information Set (OASIS) assessments as a quality measure in the South Peninsula Hospital Home Health 2026 Quality Assurance & Performance Improvement (QAPI) Plan, effective immediately upon approval.

Upon Board approval, the following quality measure shall be added to the 2026 QAPI Plan:

Quality Measure: Percentage of OASIS assessments submitted within the applicable submission deadline.

Objective: Ensure timely OASIS submission through routine monitoring, identification of outstanding assessments, and follow-up to address delays.

Data Collection and Monitoring: Home Health staff will run and review a weekly report of all open OASIS assessments to identify approaching deadlines, overdue assessments, and barriers to timely submission.

Monthly Calculation: The percentage of timely OASIS submissions will be calculated by dividing the number of assessments submitted on or before their applicable deadline by the total number of assessments due for submission during the reporting month, multiplied by 100. Assessments remaining unsubmitted after their deadline will be counted as untimely.

Performance Target: 100% timely submission.
Reporting: Home Health will report the monthly percentage of OASIS assessments submitted timely in the monthly Statistics and Updates Report submitted to the Board of Directors. Identified delays and corrective actions will be included as appropriate.

All other provisions of the 2026 QAPI Plan remain unchanged. This change shall take effect upon approval by the Board of Directors.

South Peninsula Hospital
Hospital Board of Directors Balanced Scorecard Report
1st Quarter FY 2027 (July, August, September)

Overall Indicators	Q1 FY27	Target	Note
Care Compare Overall Hospital Star Rating	N/A	5	Mortality, Safety of Care, Readmission, Patient Experience, Timely & Effective Care
Care Compare Overall Nursing Home Star Rating	5	5	Staffing, Health Inspections, Quality Measures
Care Compare Home Health Quality Rating	2.5	4	Activities of Daily Living, Symptoms, Harm, Hospitalization, Value of Care

Clinical & Service Excellence

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

Quality of Care / Patient Safety	Q1 FY27	Target	Note
Severe Sepsis & Septic Shock Care	25%	100%	***CMS Hospital Compare: 54 % (10/1/24-9/30/25)*** ***Nat. Avg: 65% AK Avg: 61%***
Percentage of patients who received appropriate care for SEVERE sepsis and/or septic shock.			Passed 1 of 4 cases
Stroke Care	100%	100%	***CMS Hospital Compare: NA% (10/1/24-9/30/25)*** ***Nat. Avg: 69% AK Avg: 62%***
Percentage of patients who receive CT/MRI within 45 minutes of arrival to ED w/stroke symptoms.			1 CMS reportable strokes; 5 excluded cases
Median Emergency Room Time	146	< 129min	***CMS Hospital Compare: 140min (10/1/24-9/30/25)*** ***Nat. Avg: 130min AK Avg: 136min***
Average minutes spent in department before leaving the Emergency Department including patients transferred to another facility and psychiatric care/mental health patients.			
Colonoscopy Follow-up	100%	100%	***CMS Hospital Compare: 100% (1/1/24-12/31/24)*** ***Nat. Avg: 93% AK Avg: 87%***
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy.			
Patient Fall Rate (AC)	5.24	< 5	**# of patient falls / # patient days x 1000** Q4 FY26 1.028: Q3 FY26 6.3: Q2 FY26 3.04: Q1 FY26 4.3
Measures the number of patient falls per 1,000 patient days.			5 Fall(s), no injury

Medication Errors	**3**	**≤6**	
Number of patient medication errors that reach the patient. *(Level C on the NCC MERP Index)*			
NQF's Serious Reportable Events	**0**	**0**	
A patient safety event that is serious, harmful and preventable.			
UTI rate (LTC)	**0.41%**	**< 1.6%**	***CMS Hospital Compare: 0 (4/1/25-3/31/26)*** ***Nat. Avg: 1.6% AK Avg: 2.5%***
Percentage of long-stay residents with a urinary tract infection			
Independent Oral Medication (HH)	**81%**	**> 75%**	***CMS Care Compare: 72.6% (10/1/24-9/30/25)*** ***Nat. Avg: 88.1% AK Avg: 82.1% Goal reflects patient population served by SPH HH***
Percentage of home health patients demonstrating improvement with ability to take oral medications more independently.			N=26; 100% improved or unchanged
Primary Care MIPS Pathways	**76%**	**> 75%**	***2026 Year to Date***
CMS Merit-Based Incentive Payment System *(MIPS)* for outpatient clinics.			Special focuses: cervical cancer screening, specialist referrals, high blood pressure, hemoglobin A1c, medication reconciliation, fall risk

Patient & Resident Experience

Patient Satisfaction Through Press Ganey (PG)	**Q1 FY27**	**Target**	
Inpatient Percentile	**95th**	**75th**	% of Pts who marked 9 or 10 best hospital: 86.67; Survey Responses: 15 **4-Star Rating** Care Compare (10/1/24-9/30/25) Survey Responses: 102
Measures the overall satisfaction of inpatient pts. respondents.			Q4 FY26 81st: Q3 FY26 71st: Q2 FY26 99th: Q1 FY26 94th
Ambulatory Surgery (AS) Percentile	**27th**	**75th**	% of Pts who marked 9 or 10 best hospital: 86.11; Survey Responses: 72
Measures the overall satisfaction of AS pts. respondents.			Q4 FY26 9th: Q3 FY26 15th: Q2 FY26 10th: Q1 FY26 94th
Home Health (HH) Percentile	**88th**	**75th**	% of Pts who marked 9 or 10 best hospital: 93.75; Survey Responses: 48
Measures the overall satisfaction of HH pts. respondents.			Q4 FY26 62nd: Q3 FY26 72nd: Q2 FY26 67th: Q1 FY26 64th
Outpatient Percentile	**33rd**	**75th**	Mean Score: 94.6 Survey Responses: 501
Measures the overall satisfaction of outpatient pts. respondents.			Q4 FY26 29th: Q3 FY26 46th: Q2 FY26 27th: Q1 FY26 7th
Emergency Department Percentile	**86th**	**75th**	Mean Score: 92.82 Survey Responses: 117
Measures the overall satisfaction of emergency pts. respondents.			Q4 FY26 86th: Q3 FY26 90th: Q2 FY26 86th: Q1 FY26 79th
Medical Practice Percentile	**29th**	**75th**	Mean Score: 93.72 Survey Responses: 459
Measures the overall satisfaction of pts. respondents at SPH Clinics.			Q4 FY26 38th: Q3 FY26 35th: Q2 FY26 37th: Q1 FY26 51st

Medical Staff Alignment

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

Provider Alignment	2026	Target	Note
Provider Satisfaction Percentile	**44th**	**75th**	
Measures the satisfaction of physician respondents as indicated by Press Ganey physician survey results. Measured as a percentile.			Result of provider survey 2026

Employee Engagement

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

Staff Alignment	2026	Target	Note
Employee Satisfaction Percentile	**41st**	**75th**	
Measures the satisfaction of staff respondents as indicated in Press Ganey staff survey results Measured as a percentile.			Result of employee survey 2026
Workforce	**Q1 FY27**	**Target**	**Note**
Turnover: All Employees	**7.05%**	**< 5%**	
Percentage of all employees separated from the hospital for any reason			49 Terminations / 695 Total Employees
Turnover: Voluntary All Employees	**6.19%**	**< 4.75%**	
Measures the percentage of voluntary staff separations from the hospital			43 Voluntary Terminations / 695 Total Employees
First Year Total Turnover	**10.49%**	**< 7%**	
Measures the percentage of staff hired in the last 12 months and who separated from the hospital for any reason during the quarter.			17 New Staff Terminated 162 Total New Hires from 09/30/2025-09/30/2026
Contract Utilization	**27**	**< 20**	
Measure average number of contract staff utilized.			MLT x2, MRI x1, CT/XRAY x2, MAMMO x1, PT x1, SLP x1, RN x15, CNA x2, PHARM x1, FACILITIES x1
Information System Solutions	**Q1 FY27**	**Target**	**Note**
Phishing Test Pass Rate	**98%**	**> 95%**	
% of Phishing test emails that were not failed.			3,607 Test phishing emails sent; 70 fails.

Financial Health

SPH is financially positioned to support our dedication to the Mission, Vision and Values, and our continued investment in our employees, medical staff, physical plant and equipment.

Financial Health	Q1 FY27	Target	Note
Outpatient Revenue Growth	**18.0%**	**16%**	
Measures percentage increase (decrease) in outpatient revenue for the quarter, compared to the same period in the prior year.			Target is based on budgeted outpatient revenue for the period compared to outpatient revenue for the same period prior year.
Operating Margin	**-2.1%**	**15%**	
Measures the surplus (deficit) of operating income over operating expenses as a percentage of net patient service revenue for the quarter.			Target is based on budgeted operating margin for the period.
Adjusted Patient Discharges	**1,213**	**915**	**Total Discharges: # 139 *(Acute, OB, Swing, ICU)***
Measures the number of patient discharges adjusted by inpatient revenues for the quarter, divided by (inpatient + outpatient revenues).			LTC Revenue & discharges not included, Target is same Q Prior Year Target Discharges: 141
Net Revenue Growth	**12%**	**16%**	
Measures the percentage increase *(decrease)* in net patient revenue for the quarter compared to the same period in the prior year.			Target is based on budgeted net patient service revenue for the period compared to net patient service revenue for the same period in prior year.
FTE vs Budget	**621**	**648**	
FTE is calculated based on hours paid + Contract FTE			Actual FTE + Contract FTE based on hours paid compared to budgeted FTE for the quarter.
Net Days in Accounts Receivable	**61**	**55**	
Measures the rate of speed with which the hospital is paid for health care services.			Target is based on industry target.
Cash on Hand	**91**	**90**	**80 Total Days Cash on Hand, Operating +11 Unobligated PREF**
Measure the actual unrestricted cash on hand (including Unobligated PREF and excluding Service Area) that the hospital has to meet daily operating expenses.			Cash available for operations based on average daily operating expenses during the quarter less depreciation for the quarter.
Uncompensated Care as a Percentage of Gross Revenue	**4.7%**	**4-7%**	
Measures bad debt & charity write offs as a percentage of gross patient service revenue			Target is based on industry standards & SPH Payer Mix Budgeted total is 2.4% Expected range of 2-3%

Surgical Case Growth	**-17%**	**32%**	
Measures the increase *(decrease)* in surgical cases for the quarter compared to the same period in the prior year.			Target is based on budgeted surgeries above actual from same quarter prior yr. Budgeted Surgeries 567/Actual 485
Average Age of Plant	**9.4**	**10.0**	
Measures the financial age of the fixed assets of the hospital calculated by dividing accumlated depreciation by annualized depreciation for the year.			Target is based on hospital optimal age of plant for a critical access hospital.

South Peninsula Hospital	**SUBJECT:** Approval and Adoption of Operating Budget	**POLICY #:** F-12 **Page 1** of **1**
Scope: Finance **Approved by:** Board of Directors		**Original Date:** 6/25/08 **Effective:** 1/24/24
Revised: 1/22/20 **Reviewed:** 1/25/23; 1/24/24; 1/29/25; 1/28/26		**Revision Responsibility:** Board of Directors

PURPOSE:
Guidelines for the approval and adoption of the Operating Budget.

DEFINITION(S):
N/A

POLICY:
A. The Operating Budget for South Peninsula Hospital will be approved and adopted by the Board of Directors via resolution with a roll call vote.
B. A resolution will be presented to the Board of Directors addressing the fiscal year operating budget with recitals to include references to the Board goals, strategic plan, Mission, Vision, and Values, and Operating Agreement.
C. The resolution will include the requested action of the Board of Directors that will adopt the budget and authorize the monies needed for the for the following fiscal year.
~~C.~~D. As part of the budgeting process each year, the Board will review its own expenditures including board member stipends, education, retreats and conferences, consultants and other operating costs in order to ensure continued fiscal responsibility.

PROCEDURE:
N/A

ADDITIONAL CONSIDERATIONS:
N/A

REFERENCE(S):
1. Operating Agreement for South Peninsula Hospital with Kenai Peninsula Borough, 2020

CONTRIBUTORS:
Board of Directors

South Peninsula Hospital	**SUBJECT:** Responsibilities of Board Members	**POLICY #:** SM-02 **Page 1** of **1**
Scope: Hospital-Wide **Approved by:** Board of Directors		**Original Date:** 9/24/03 **Effective:** 7/30/25
Revised: 5/28/08; 9/24/14; 11/17/15; 8/25/21; 7/30/25 **Reviewed:** 1/24/24		**Revision Responsibility:** Board of Directors

PURPOSE:
Defining roles and responsibilities of the Board of Directors.

DEFINITION(S):
N/A

POLICY:
A. The power and authority of the board comes from the board as a whole; individual members do not have decision making or directive authority unless specifically designated by the board. The Board of Directors alone has directive or tasking authority over the CEO.
B. Board Member Responsibility: Be a conscientious member of the board, helping the board to fulfill its responsibilities for directing the hospital, fulfilling its mission, protecting and furthering its assets, and being accountable to the public at large for the ethical conduct of all hospital affairs.

PROCEDURE:
1. Be loyal to the hospital, always furthering the interests of the hospital in its pursuit of its mission, and disclosing and avoiding any potential conflict of interest.
2. Be diligent in the fulfillment of board responsibilities; always be prepared for decisions addressed by the board; prepare to attend and actively participate in board meetings and in continuing education opportunities. Make an effort to become knowledgeable about healthcare issues and trends and South Peninsula Hospital operations.
3. Stay focused at board meetings; come prepared; be a good listener; participate and ask questions to gain knowledge; maintain ethics and values.
4. Be prudent in all decisions made on behalf of the hospital, employing judgment consistent with generally accepted standards and/or practices for the issue at hand, based on the information that is available.
5. Support the decisions and policies of the board until such time as those decisions or policies are changed by an official action of the board.
6. Help define and then support the roles delegated to management and the medical staff and to assure that accountability mechanisms exist to receive reports on the delegated duties.
7. Be a champion of the South Peninsula Hospital Values and Behaviors.
8. Engage in regular self-evaluation processes of the board and be responsible to notify the board president or nominating committee at such time as the member determines that he/she cannot continue to carry out the duties of the position.
9. Be aware that all public comments and actions, whether or not made as a representative of South Peninsula Hospital, may be perceived as such and may have a negative impact on the hospital's reputation in the community.
10. Respect the confidentiality of the boardroom.
~~10.~~11. Limit meetings or conversations of a confidential nature to private spaces, such as hospital conference rooms, private offices, private residences with no unauthorized persons present, other private meeting rooms (ex. Homer Public Library), or secure video conferencing from a private location.
~~11.~~12. When talking points have not been previously agreed upon by the Board, refer all media inquiries for public statements to the hospital's PR/Marketing Director.
~~12.~~13. When talking points have not been previously agreed upon by the Board, direct all non-media requests for operational information or assistance to the CEO or Acting CEO or designee.

Formatted: Not Expanded by / Condensed by

ADDITIONAL CONSIDERATION(S):
N/A

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

CONTRIBUTOR(S):
Operating Board; Chief Executive Officer

South Peninsula Hospital

4300 Bartlett Street
Homer, AK 99603
(907) 235-8101• sphosp.org

Letter the Community from SPH Medical Staff

To our patients and neighbors:

At 3 a.m., someone arrives at South Peninsula Hospital scared, hurting, and unsure of what comes next. The nurse who welcomes them might be a neighbor. Their doctor could be someone they've chatted with at a school event or seen at the grocery store. The people caring for you aren't just medical professionals. They are part of this community, sharing the rewards and challenges of life on the Kenai Peninsula. Caring for this community is deeply personal to us.

Recent public commentary has painted a troubling picture of our hospital and the people who work here. We respect the community's right to ask questions, but some of this commentary does not reflect the hospital we know.

Some of our colleagues have been publicly criticized without prior notice or a meaningful opportunity to respond. Confidentiality rules strictly limit any response that can be made. We cannot share details that might provide important context. Our silence isn't indifference or agreement. It's about respecting privacy and professionalism. We are listening and will continue using feedback to improve.

There have also been allegations of a toxic culture and financial impropriety. Such allegations are false. The medical staff's relationship with hospital leadership and the board are grounded in mutual respect and accountability. Having SPH medical staff on the board is important to us, and we reaffirmed that support in 2024 because we believe medical staff representation strengthens hospital governance and brings vital clinical expertise.

We all work together to maintain a culture grounded in professionalism, accountability, respect, and, above all, a commitment to high-quality care. These values guide how we care for patients, collaborate with colleagues, evaluate our performance, and address concerns. Clinical outcomes and complications are carefully reviewed, and established peer-review and professional-conduct processes address concerns when they arise. Our commitment to quality is reflected in five-star CMS ratings for long-term care and patient experience, as well as national Top 100 Critical Access Hospital recognitions. Caring for this community is a privilege we do not take lightly.

We want you to know that we care. We have been with you in the past, are with you now, and will remain here for you in the years to come.

Respectfully,

SPH Medical Staff Signatories

Jenna Aird, MD
Gregory Aird, MD
Hans Amen, DO
Jonathan Bloch, MD
Robert Cadoff, MD
Alyssa DeConto, MSN, CNM
Lauren Dorsey-Spitz, DO
Rob Downey, MD
Maureen Filipek, MD
Frederick Freeman, MD
Lucy Fisher, MD
Devry Garity, PNP
Tyler Haas, MD
Michael Hennigan, MD
Natalie Hoshaw, MD
Cherie' Inglis, MD
Susan Jackson, FNP
Jessica Jordan, PA-C
Jessica Jule, MSNA, CRNA
Nathan Kincaid, MD
Edson Knapp, MD
Renda K Knapp, MD
Ragina Lancaster, DO
Christopher Landess, MD
Joe Marie Llenos, MD
Kathy Madej, CRNA
Jessica Malone, MD
Miranda Marsh, MSN, CRNA
Roger Martinez, MD
Marek Martynowicz, MD
Lars Matkin, MD
Emma Mayfield, DO
Brian McCorison, CRNA
Kurt Mentzer, MD
Justin Metzler, CRNA
Heather Moon, AGNP
Erin Murphy, MD
Jill Rife, DNP
Sarah Roberts, MD
Garret Sitenga, MD
Sarah Spencer, DO
Teresa Thompson, DNP, APRN
Clare Thompson, DNP, CNM
Wesley Turner, MD
Giulia Tortora, MD, ABFM
Christy Tuomi, DO
Hans Wilhelm, DO
Pamela Williams, DO
Ian Wisecarver, MD
Kara Zimmerman, MPAS, PA-C

South Peninsula Hospital

4300 Bartlett Street
Homer, AK 99603
(907) 235-8101 • sphosp.org

Letter to the Community from SPH Medical Staff

To our patients and neighbors:

At 3 a.m., someone arrives at South Peninsula Hospital scared, hurting, and unsure of what comes next. The nurse who welcomes them might be a neighbor. Their doctor could be someone they've chatted with at a school event or seen at the grocery store. The people caring for you aren't just medical professionals. They are part of this community, sharing the rewards and challenges of life on the Kenai Peninsula. Caring for this community is deeply personal to us.

Recent public commentary has painted a troubling picture of our hospital and the people who work here. We respect the community's right to ask questions, but some of this commentary does not reflect the hospital we know.

Some of our colleagues have been publicly criticized without prior notice or a meaningful opportunity to respond. Confidentiality rules strictly limit any response that can be made. We cannot share details that might provide important context. Our silence isn’t indifference or agreement. It’s about respecting privacy and professionalism. We are listening and will continue using feedback to improve.

There have also been allegations of a toxic culture and financial impropriety. Such allegations are false. The medical staff’s relationship with hospital leadership and the board are grounded in mutual respect and accountability. Having SPH medical staff on the board is important to us, and we reaffirmed that support in 2024 because we believe medical staff representation strengthens hospital governance and brings vital clinical expertise.

We all work together to maintain a culture grounded in professionalism, accountability, respect, and, above all, a commitment to high-quality care. These values guide how we care for patients, collaborate with colleagues, evaluate our performance, and address concerns. Clinical outcomes and complications are carefully reviewed, and established peer-review and professional-conduct processes address concerns when they arise. Our commitment to quality is reflected in five-star CMS ratings for long-term care and patient experience, as well as national Top 100 Critical Access Hospital recognitions. Caring for this community is a privilege we do not take lightly.

We want you to know that we care. We have been with you in the past, are with you now, and will remain here for you in the years to come.

Respectfully,

SPH Medical Staff Signatories as of October 28, 2026

Jenna Aird, MD
Gregory Aird, MD
Hans Amen, DO
Jonathan Bloch, MD
Robert Cadoff, MD
Alyssa DeConto, MSN, CNM
Ross Dodge, MD
Lauren Dorsey-Spitz, DO
Rob Downey, MD
Maureen Filipek, MD
Lucy Fisher, MD
Frederick Freeman, MD
Devry Garity, PNP
Tyler Haas, MD
Michael Hennigan, MD
Natalie Hoshaw, MD
Cherie' Inglis, MD
Susan Jackson, FNP
Jessica Jordan, PA-C
Jessica Jule, CRNA
Nathan Kincaid, MD
Edson Knapp, MD
Renda Knapp, MD
Ragina Lancaster, DO
Christopher Landess, MD
Joe Llenos, MD
Kathy Madej, CRNA
Jessica Malone, MD
Miranda Marsh, MSN, CRNA
Roger Martinez, MD
Marek Martynowicz, MD
Lars Matkin, MD
Emma Mayfield, DO
Brian McCorison, CRNA
Kurt Mentzer, MD
Justin Metzler, CRNA
Heather Moon, AGNP
Erin Murphy, MD
Jill Rife, DNP
Sarah Roberts, MD
Garret Sitenga, MD
Sarah Spencer, DO
Teresa Thompson, DNP, APRN
Clare Thompson, DNP, CNM
Giulia Tortora, MD
Christy Tuomi, DO
Wesley Turner, MD
Hans Wilhelm, DO
Pamela Williams, DO
Ian Wisecarver, MD
Kara Zimmerman, MPAS, PA-C
James Zirul, DO

DRAFT - PROPOSED DATES

Board of Directors: Calendar of Meetings 2027

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Governance Committee *2nd Wednesday @ 10:30*	1/13	2/10	3/10	4/14	5/12	6/9	7/14	8/11	9/8	10/13	11/10	12/8
Quality Committee *2nd Wednesday @ 4pm*	1/13	2/10	3/10	4/14	5/12	6/9	7/14	8/11	9/8	10/13	11/10	12/8
Strategic Planning Committee *Quarterly, TBD*												
Community Relations Committee *Wed prior to BOD mtg @ 11am*	1/20	2/17	3/24	4/21	5/19	6/23	7/21	8/18	9/22	10/20	11/18/2025 (Pension only)	12/1
Finance/Pension Committee *Wed prior to BOD mtg @ 1:30**	1/20	2/17	3/24	4/21	5/19	6/23	7/21	8/18	9/22	10/20	No mtg	12/8
Operating Board Meeting 5:30pm (open sesssion)	**1/27**	**2/24**	**3/31**	**4/28**	**5/26**	**6/30**	**7/28**	**8/25**	**9/29**	**10/27**	**No mtg**	**12/15**

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

South Peninsula Hospital

MEMO

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

Re: Service Area Board Representatives 2027

The SPH Board sends a representative to attend each Service Area Board meeting.

Committee of the Whole begins at 5:30pm *(you may attend, but it is not required)*

Meeting starts at 6:30pm.

Location: SPH Conference Rooms or Zoom. More info here.

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

Date of Meeting 6:30pm	**BOD Member**
January 14, 2027	
February 11, 2027	
March 11, 2027	
April 8, 2027	
May 13, 2027	
August 12, 2027	
September 9, 2027	
October 14, 2027	
November 11, 2027	
December 9, 2027	